MOVING FORWARD POST PANDEMIC

37TH MIDDLE TN GERIATRICS UPDATE

THIS PROGRAM IS SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) AS PART OF AN AWARD 5 U1QHP330850200 TOTALING $535,004 WITH 0 PERCENTAGE FINANCED WITH NONGOVERNMENTAL SOURCES. THE CONTENTS ARE THOSE OF THE AUTHOR(S) AND DO NOT NECESSARILY REPRESENT THE OFFICIAL VIEWS OF, NOR AN ENDORSEMENT, BY HRSA, HHS

LIVING WELL WITH DEMENTIA

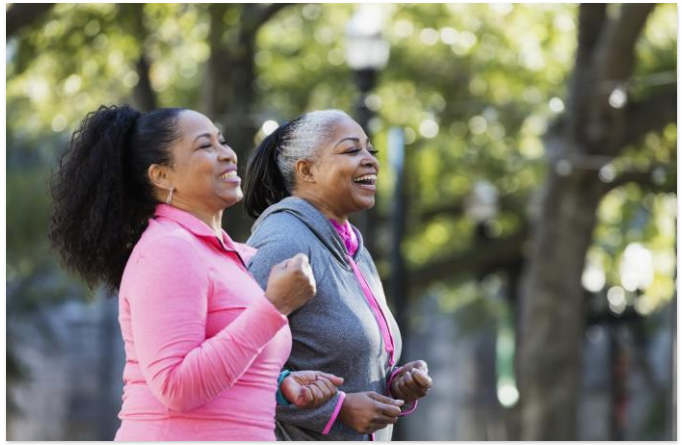
Brenda Roberts, Executive Director – National Council of Dementia Minds

National Council of Dementia Minds Panel

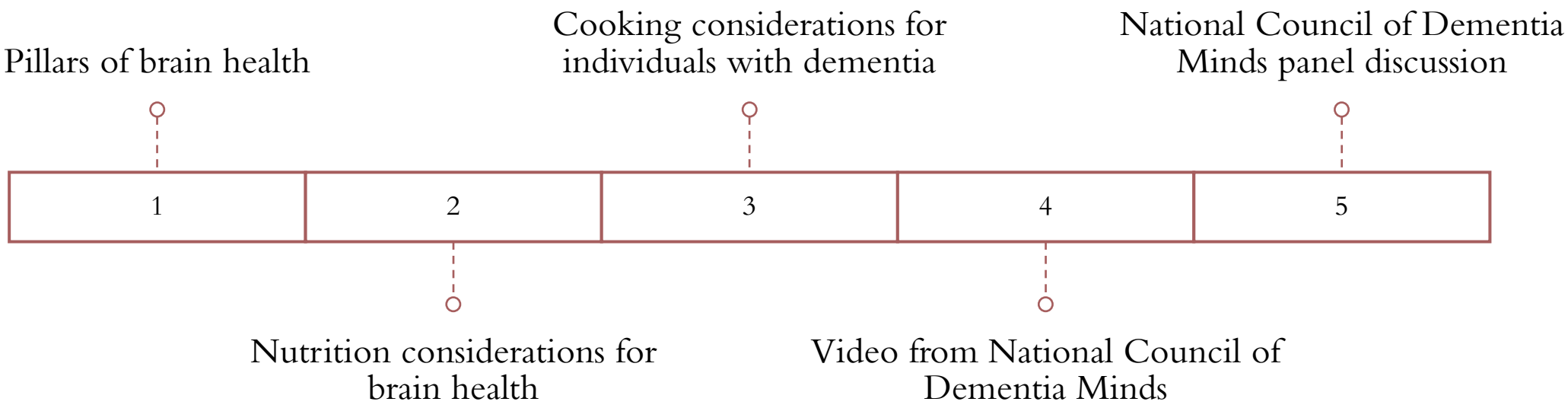
Kerri Baxter, MS, RDN, CNSC

OBJECTIVES

- Name two pillars of brain health
- State two components of an eating pattern for brain health
- Describe three cooking considerations for individuals living with dementia
- Engage with individuals living with dementia on their personalized approaches to nutrition and cooking



AGENDA


Pillars of brain health
Cooking considerations for individuals with dementia
National Council of Dementia Minds panel discussion
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2
3
4
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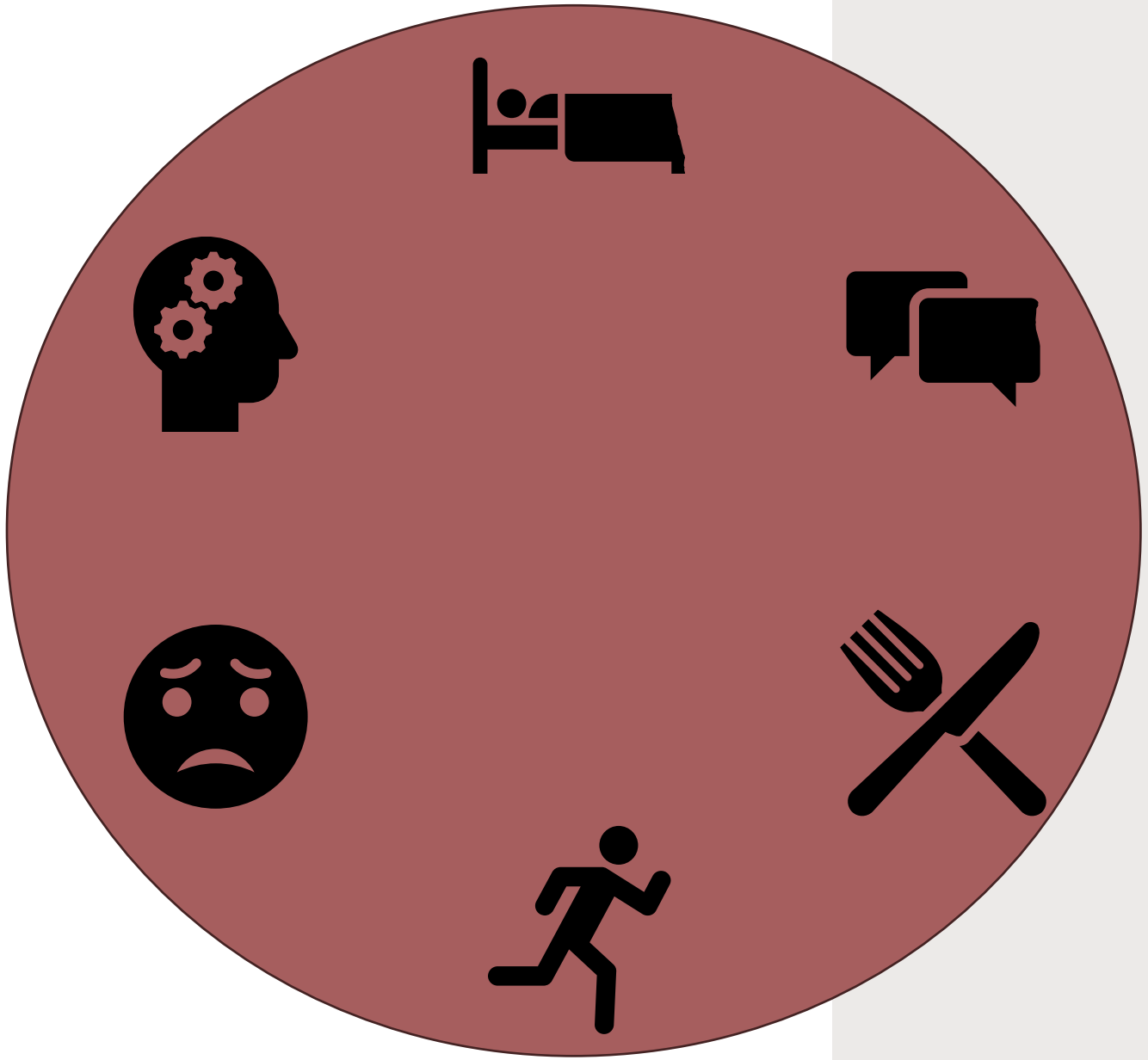
Nutrition considerations for brain health
Video from National Council of Dementia Minds



PILLARS OF BRAIN HEALTH

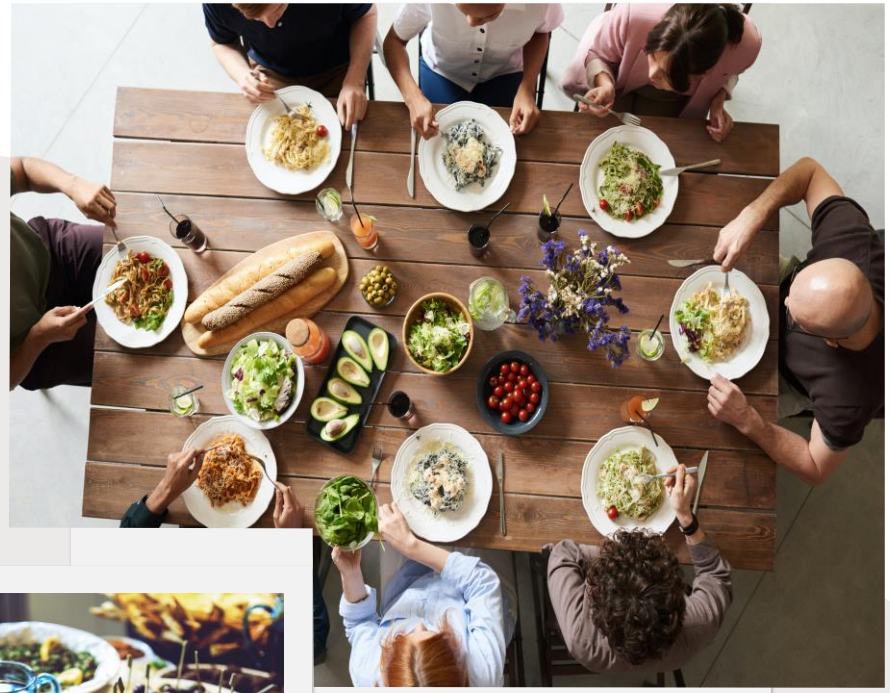
Global Council on Brain Health six pillars of brain health:

1) Be Social
2) Engage your Brain
3) Manage Stress
4) Ongoing Exercise
5) Restorative Sleep
6) Eat Right

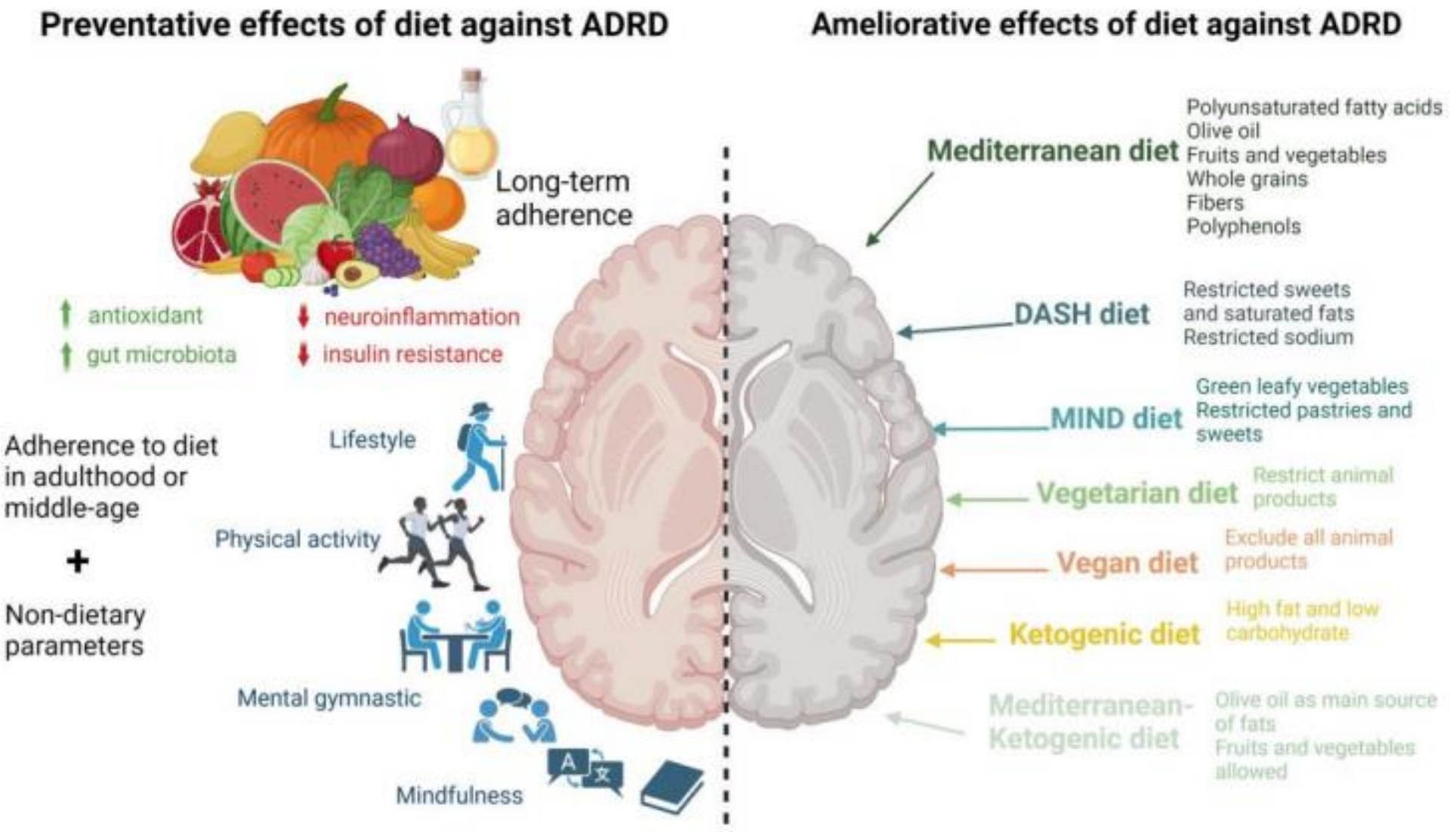
("The Global Council on Brain Health (GCBH)," 2021)

NUTRITION PILLAR

- No single vitamin/mineral/herbal supplement has been found to have a significant impact on cognition.
- Current research and recommendations are focused on patterns of eating rather than any one particular nutrient.
- The most researched patterns of eating for brain health include:
  - Mediterranean Diet
  - Dietary Approaches to Stop Hypertension (DASH)
  - Mediterranean-DASH Diet Interventions for Neurodegenerative Delay (MIND)
  - Modified Mediterranean-Ketogenic Diet.



(Ellouze, 2023)



(Ellouze, 2023)

NUTRITION RECOMMENDATIONS FOR BRAIN HEALTH

- Include unsaturated fats
  - Olive Oil
  - Nuts
  - Fatty Fish
- Include foods higher in fiber
  - Whole grains
  - Vegetables
  - Fruits
- Choose fish and lean proteins
- Choose foods high in polyphenols/antioxidants
  - Beans
  - Red Wine (in moderation)
  - Vegetables
  - Nuts

(Ellouze, 2023)

NUTRITION RECOMMENDATIONS FOR BRAIN HEALTH

- Choose the following in moderation:
  - Highly processed meats
  - Red meats
  - Butter
  - Sugar sweetened beverages
  - Refined grains
  - Refined sugars

(Ellouze, 2023)

COMBINING PILLARS OF BRAIN HEALTH

- Activities that include more than lifestyle factor have been shown to slow disease progression more than those focused on only one pillar (Corsi, 2016).
- Cooking combines engage your brain, eat right, and in some cases being social.

Dancing

Puzzles

Cooking

Walking

COGNITIVE OUTCOMES OF A COOKING PROGRAM

12-week small group cooking program incorporating five elements of brain-activating rehabilitation (BAR)

Fostering pleasant atmosphere, interactive communication, establishing social roles, giving and receiving praise, errorless learning

- Executive function was preserved in the intervention group, while deterioration occurred in the control group.
- Significant reduction of anxiety, agitation, and disinhibition in the intervention group

(Murai, 2016)

CONSIDERATIONS FOR COOKING WITH DEMENTIA

PREPARING TO COOK

Grocery Shopping

Take a list to the store.

Choose a familiar grocery store, when possible

Organize list by grocery store aisle or have someone help with this.

Utilize technology, if desired.

(*Kitchen - Dementia-Friendly Environments - SCIE*, n.d.)

Setting up the Kitchen

Consider labeling cabinets or having open shelving

Use glass/clear containers to store ingredients

Label appliance knobs/controls and hot/cold taps

Declutter – avoid overcrowding drawers, cabinets, or countertops

Ensure optimal lighting with minimal glare

(*Cooking with Dementia - National Council of Dementia Minds*, n.d.)

COOKING SAFETY

- Choose non-slip floor mats in a solid color
- Purchase prechopped items if using a knife is challenging
- Choose cold recipes if the stove/oven pose safety challenges.
- Use reminders – sticky notes, tech reminders, timers, etc.
- Confirm that appliances are turned off after cooking
- Consider disabling appliances that are not in use (i.e.: unplugging, removing knobs)
- Let caregiver(s) know before cooking.

(*Kitchen - Dementia-Friendly Environments - SCIE*, n.d.)

(*Cooking with Dementia - National Council of Dementia Minds*, n.d.)

COOKING PROCESS

Choose recipes with fewer ingredients and steps.

If desired, cook with family, caregiver(s) and/or friends.

Cross off steps after each is complete.

Pre-measure ingredients and place in order of the recipe on the counter.

Prevent clutter by putting each ingredient away once used.

(*Kitchen - Dementia-Friendly Environments - SCIE*, n.d.)

(*Cooking with Dementia - National Council of Dementia Minds*, n.d.)

National Council of DEMENTIA MINDS

Insights of Persons Living Well with Neurocognitive Disorders

Social Determinants of Health

Jeremy Holloway, PhD
University of North Dakota
Department of Geriatrics

3 Objectives for the Presentation:

1. Define Social Determinants of Health

2. Explore the importance of valuing What Matters.

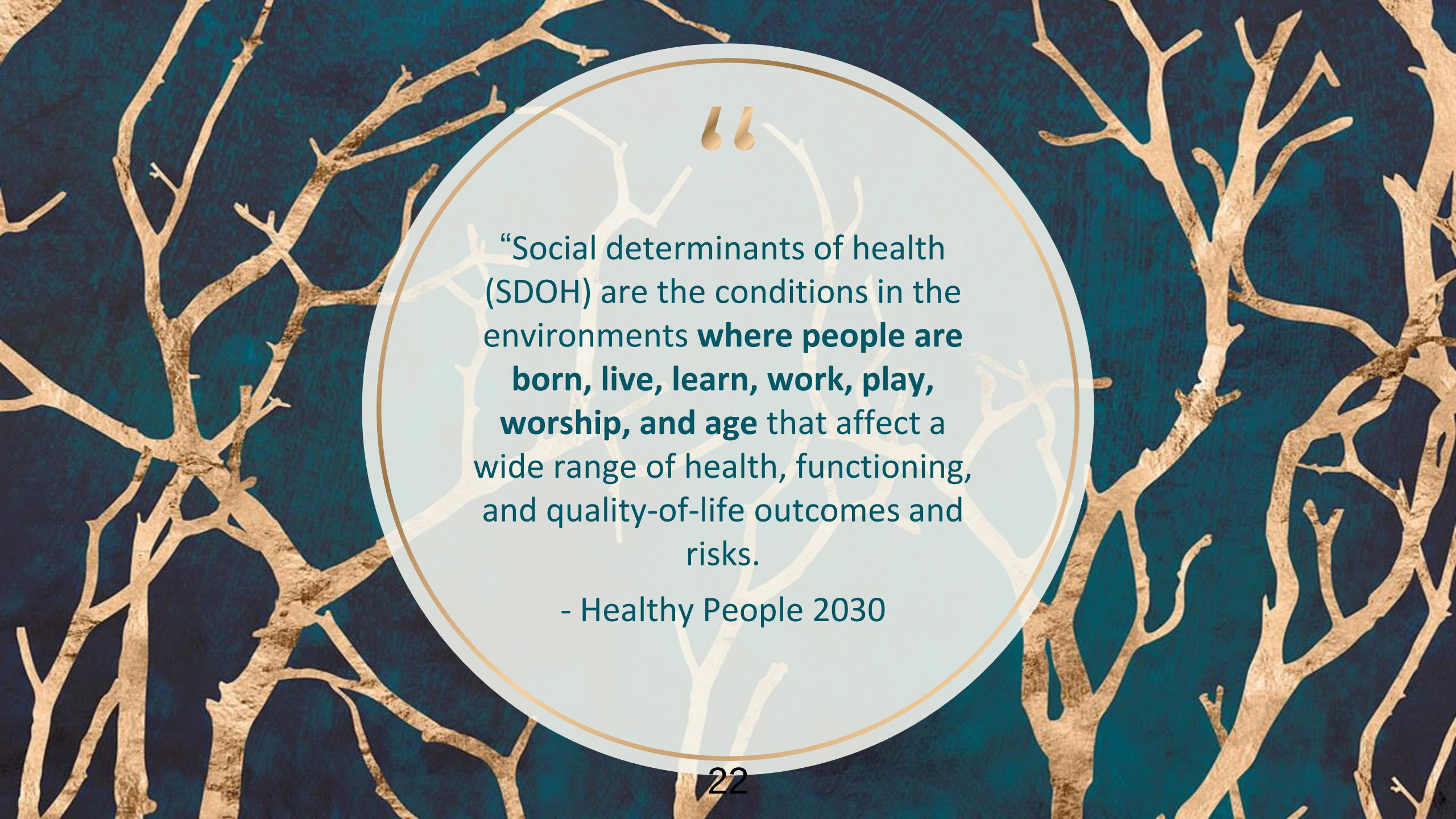
3. Describe practical ways to mitigate implicit bias.

*4. Have fun

My Story

What are Social Determinants of Health?

Definition


“Social determinants of health (SDOH) are the conditions in the environments **where people are born, live, learn, work, play, worship, and age** that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
- Healthy People 2030

SDOH High-Level Domains (Groups/Communities)

- Economic Stability (Money)
- Education Access and Quality (Education)
- Health Care Access and Quality (Healthcare)
- Neighborhood and Built Environment (Environment)
- Social and Community Context (People)

SDOH Ground Level Concerns (Individual)

- Mobility/Transportation
- Dietary/Nutrition
- Housing/Home Condition
- Their Story/What Matters

Solution

Focus on What Matters

Mate, K., Fulmer, T., Pelton, L., Berman, A., Bonner, A., Huang, W., & Zhang, J. (2021). Evidence for the 4Ms: interactions and outcomes across the care continuum. *Journal of Aging and Health*, *33*(7-8), 469-481.

What Matters: From Age-Friendly Approach

- first step: establish the core values of the older adult.
- These values are the fundamentals in which a person's beliefs are rooted, including ideas about happiness and fulfillment (Tinetti et al., 2016).
- Next steps involve dialog with a clinician who can then take those values and incorporate them into the treatment plan, such that the health priorities of the older adult are respected (Naik et al., 2018).

Note

- Medications are NOT what matters firstly to an individual.
- They are approaches to help the individual focus on What Matters.

Mate, K., Fulmer, T., Pelton, L., Berman, A., Bonner, A., Huang, W., & Zhang, J. (2021). Evidence for the 4Ms: interactions and outcomes across the care continuum. *Journal of Aging and Health*, *33*(7-8), 469-481.

Solution

Learn and value the stories of individuals and marginalized groups.

Undesirable behaviors or “problems” are the result of unmet needs and expressions. -Dr. Caroline Stephens

Narayan, M. C. (2019). CE: addressing implicit bias in nursing: a review. *AJN The American Journal of Nursing*, *119*(7), 36-43.

Major Roadblocks to Promoting One's Story (Narrative) for SDOH

Roadblock to Valuing and Learning One's Story (Narrative)

- Nothing (AKA: Excuses)

One of the Roadblocks to Valuing and Learning One's Story (Narrative)

- Unattended Implicit Bias

Implicit Bias…

- “Refers to when, rather than being neutral, we have a preference for (or aversion to) a person or group of people. Thus, we use the term **implicit bias** to describe when we have attitudes towards people or associate stereotypes with them without our conscious knowledge.” [1]
- “We may determine that one particular group is trustworthy or pleasant and another is dangerous or disagreeable.” [2]

1. Retrieved from Perception Institute: https://perception.org/research/implicit-bias/

2, Narayan, M. C. (2019). CE: addressing implicit bias in nursing: a review. *AJN The American Journal of Nursing*, *119*(7), 36-43.

Implicit Bias Example

- Providers with implicit biases…
  - Spend less time listening to Black patients
  - Hold implicit assumptions that Black and Hispanic patients are less likely to adhere to treatment and are less cooperative than White patients

Zestcott CA, et al. Examining the presence, consequences, and reduction of implicit bias in health care: a narrative review. Group Process Intergroup Relat 2016;19(4):528-42.

Taking Action

Action Plans to Dissolve Implicit Biases with New Behaviors

Action Plans to Dissolve Implicit Biases with New Behaviors

- Be involved in interventions that promote empathy, compassion, bias-mitigating strategies as often as possible for habit replacement
- Mindfulness in regard to perspective taking, and therapeutic relationship
- Reflect - Journal

Narayan, M. C. (2019). CE: addressing implicit bias in nursing: a review. *AJN The American Journal of Nursing*, *119*(7), 36-43.

Action Plans to Dissolve Implicit Biases with New Behaviors

- Journaling Topics:
  - How did I recognize the habit's damaging effects?
  - How am I making a commitment to break the habit?
  - How am I doing with my bias-mitigating strategies?
  - How did I practice humility, empathy, and compassion?

Narayan, M. C. (2019). CE: addressing implicit bias in nursing: a review. *AJN The American Journal of Nursing*, *119*(7), 36-43.

Results of Action Plans to Dissolve Implicit Biases with New Behaviors

- Seeing clients/patients (and staff) as individuals and not as obstacles (or pawns) to achieving a goal.
- Observing one's own thoughts, feelings, and assumptions.
- Being nonjudgmental (facial expressions and other body language included).
- Working from facts, to thoughts, then feelings.

Narayan, M. C. (2019). CE: addressing implicit bias in nursing: a review. *AJN The American Journal of Nursing*, *119*(7), 36-43.

What Can Staff Do?

What can Staff do to Address SDOH?

Frequent Debriefing and/or Reflective Sessions

McIntosh, R. (2019). The benefits of debriefing. *Kai Tiaki: Nursing New Zealand*, *25*(11), 22-24.

Staff Debriefs

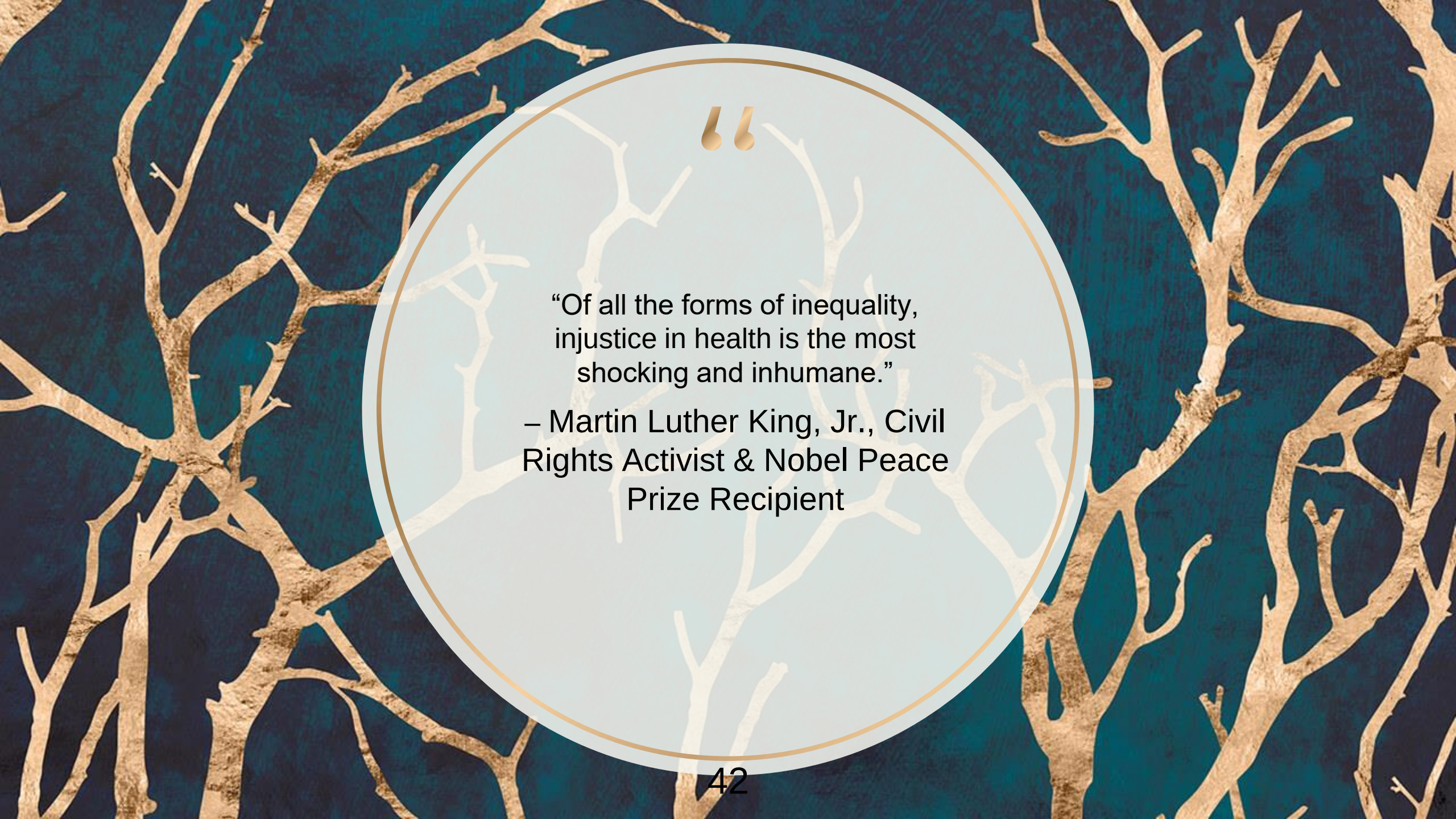
- Provide a **safe place**
- Provide a **place of learning**
- Provide a place to **make changes**

Debriefs also…

- Offer collegial support and listening to each other
  - This helps diffuse stress on the job.
- Lead to an appreciation of roles and stressors, and prompts brainstorming ways to support one another.

Cameron, F., & Brownie, S. (2010). Enhancing resilience in registered aged care nurses. Australasian Journal on Ageing, 29(2), 66-71

McIntosh, R. (2019). The benefits of debriefing. *Kai Tiaki: Nursing New Zealand*, *25*(11), 22-24.


“Of all the forms of inequality, injustice in health is the most shocking and inhumane.”
– Martin Luther King, Jr., Civil Rights Activist & Nobel Peace Prize Recipient

Debriefing Questions

Think of a situation in which you needed to reflect or debrief on a challenging encounter.

What were possible factors outside of this conflict that might be contributing to the issue?

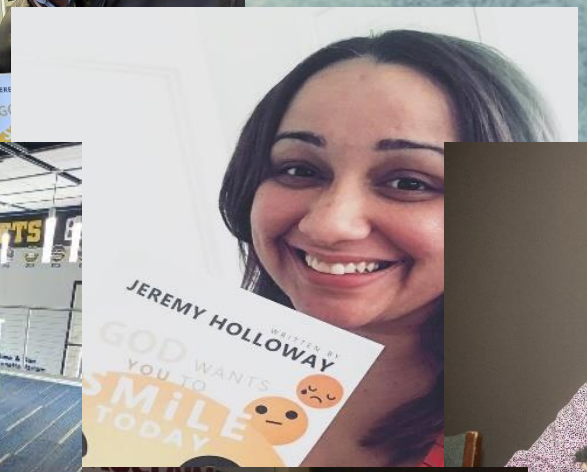
How can you set out to understand the individuals perspective (story) better?

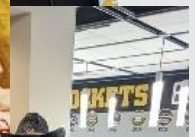
How will you implement debriefing in your respective place of work?

What’s Your Story?

WHAT DO YOU LOVE?

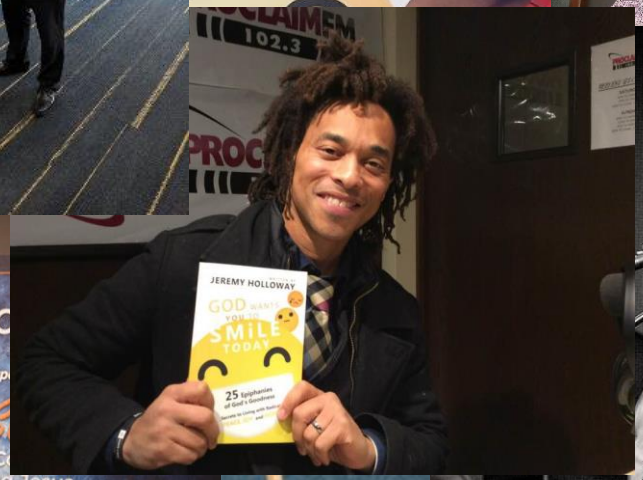
WHAT WHOLESOME HOBBIES DO YOU ENJOY?


JEREMY HOLLOWAY
GOD WANTS YOU TO SMILE TODAY




BOOK SIGNING
and Meet the Author
JEREMY HOLLOWAY


Mission
Introducing Jesus
Rebuilding Identity
Releasing the Empowered
OPEN BIBLE


102.3
JEREMY HOLLOWAY
GOD WANTS YOU TO SMILE TODAY
25 Epiphanies of God's Goodness


where passion meets
Mission
Intersecting
Releasing the

GOAL-SETTING AND VISUALIZATION

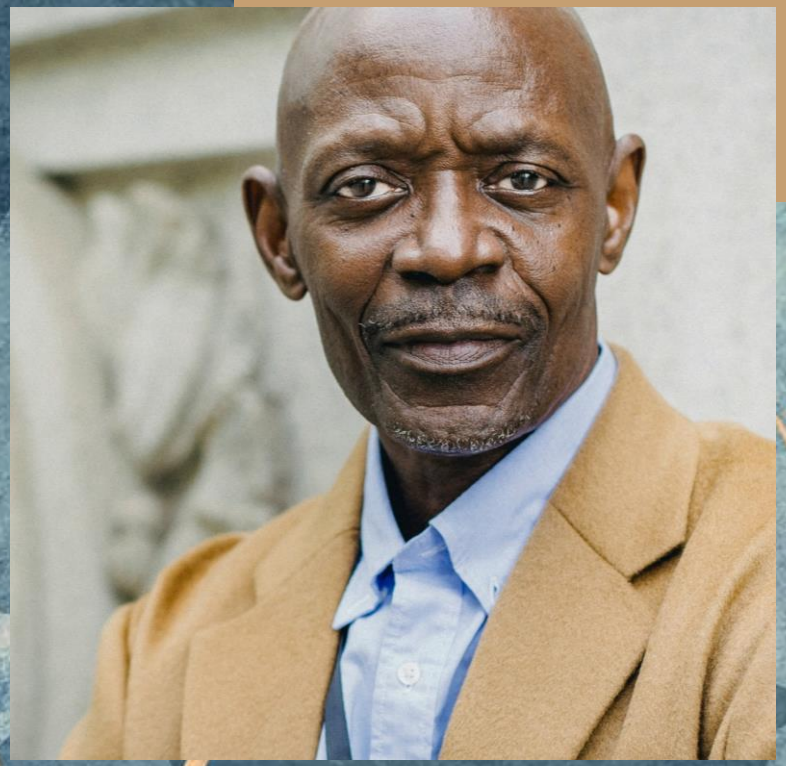
Goal-Setting is known to facilitate increased motivation, a sense of meaning, greater focus / decisiveness, and a sense of achievement.

Visualization in goal-setting utilizes the demonstrable abilities of sight, sound, feeling and emotion.

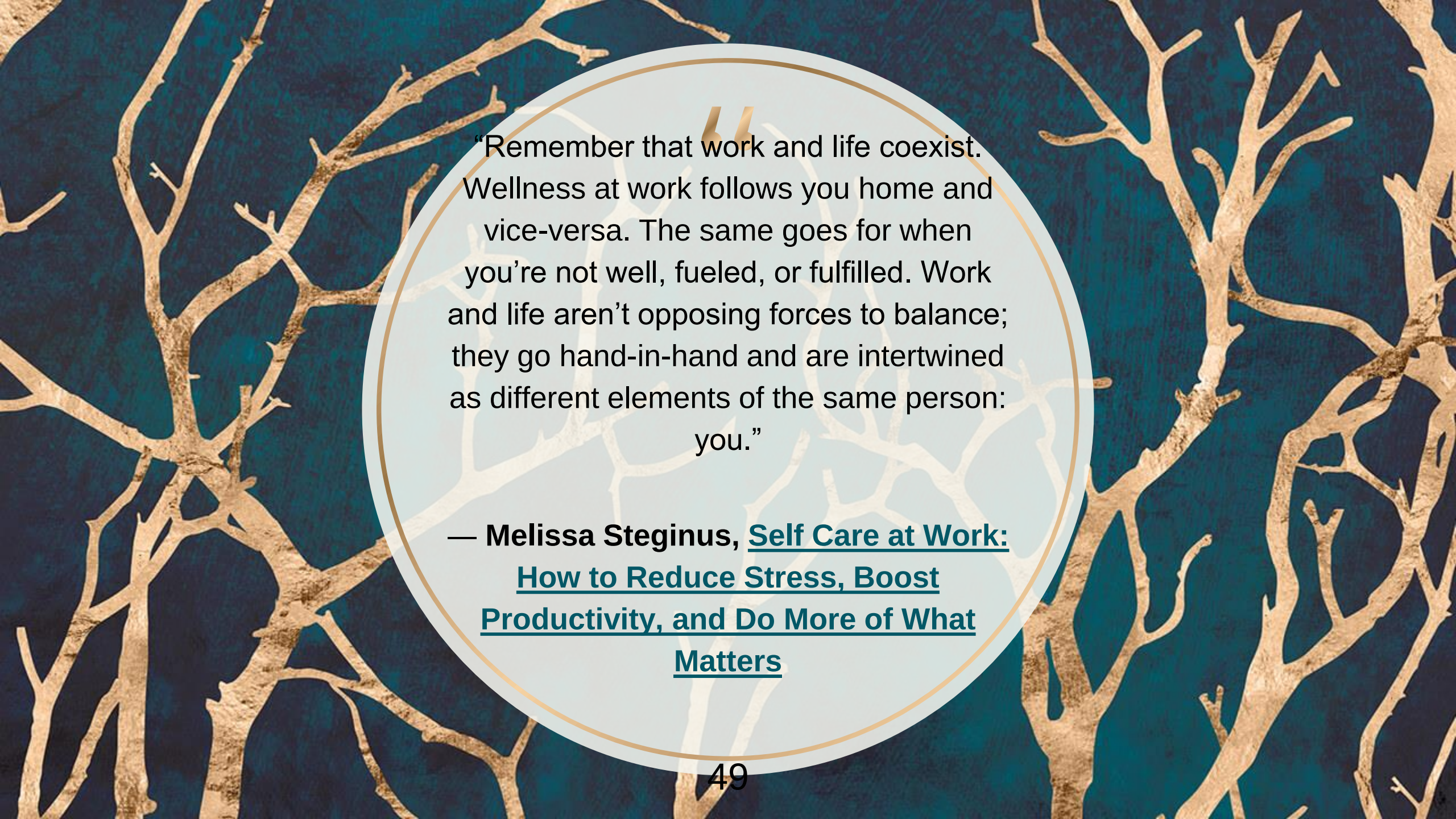
Visualization has been used for centuries and the technique is an established approach in medicine and traditions as well as other healing practices.

Source: Treadway & Lazar, 2009.

Write it down



1. WRITE DOWN WHAT YOU LEARNED FROM YOUR PERSONAL HISTORY.
2. WRITE DOWN WHAT YOU ARE THANKFUL FOR TODAY
3. WHAT DOWN YOUR (IDEAL) GOALS
4. CONNECT WITH SOMEONE AND SHARE WITHT THEM



“Remember that work and life coexist. Wellness at work follows you home and vice-versa. The same goes for when you’re not well, fueled, or fulfilled. Work and life aren’t opposing forces to balance; they go hand-in-hand and are intertwined as different elements of the same person: you.”

— **Melissa Steginus, Self Care at Work: How to Reduce Stress, Boost Productivity, and Do More of What Matters**

Social Determinants of Health

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Thank you!

Jeremy Holloway, PhD

University of North Dakota

Geriatrics

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Thank you, again.

Reflect

Discussion

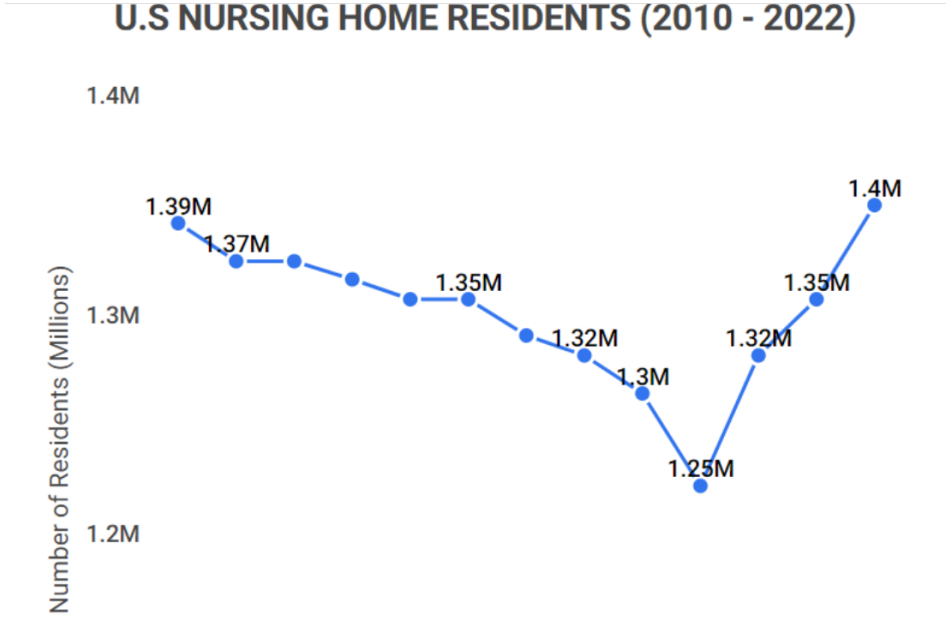
MODELS OF LONG TERM CARE POST COVID

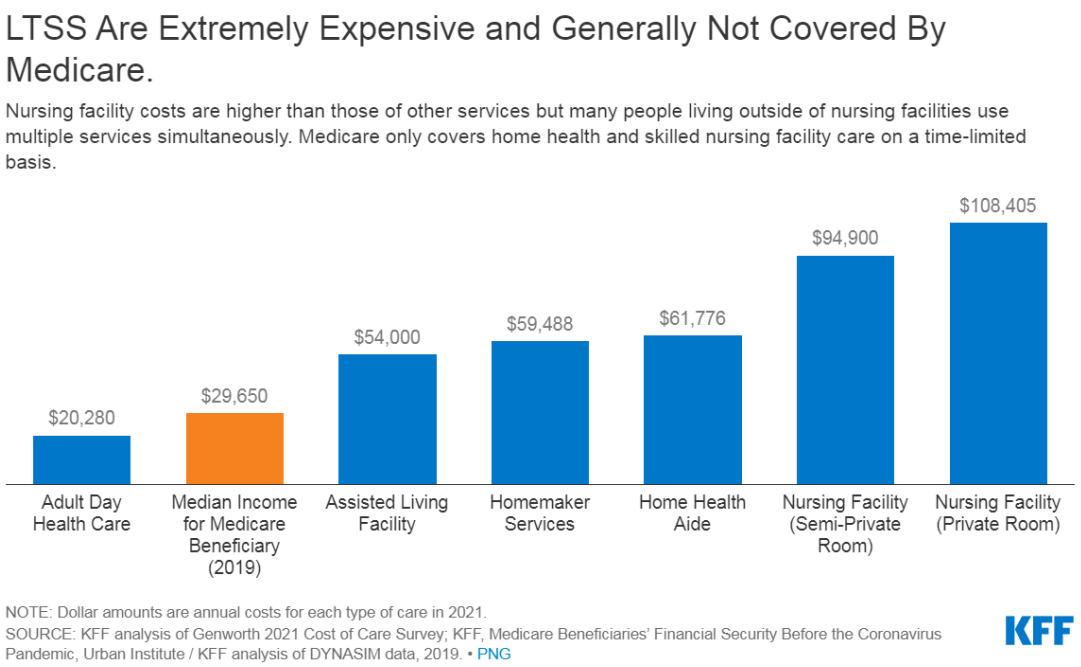
JENNIFER KIM DNP

MATTIE BRADY DNP

LONG TERM CARE PRE COVID

- 70% of seniors will need LTC in their lifetime
  - Many types of LTC:
    - Home Based Services
    - Independent, Assisted and Memory care communities
    - Skilled nursing communities
  - Diverse Workforce
  - Funding

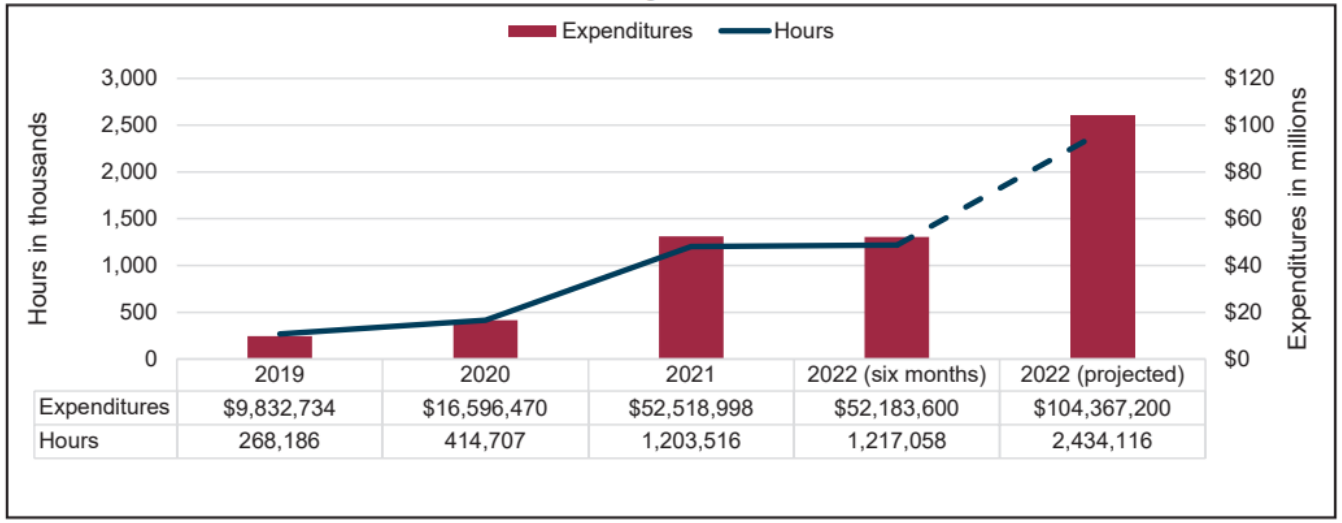




LONG TERM CARE IN THE COVID ERA

- Visitor Restriction
- Resident isolation and distancing
- Staffing Shortages
- Halt of inspections – only infection control surveys

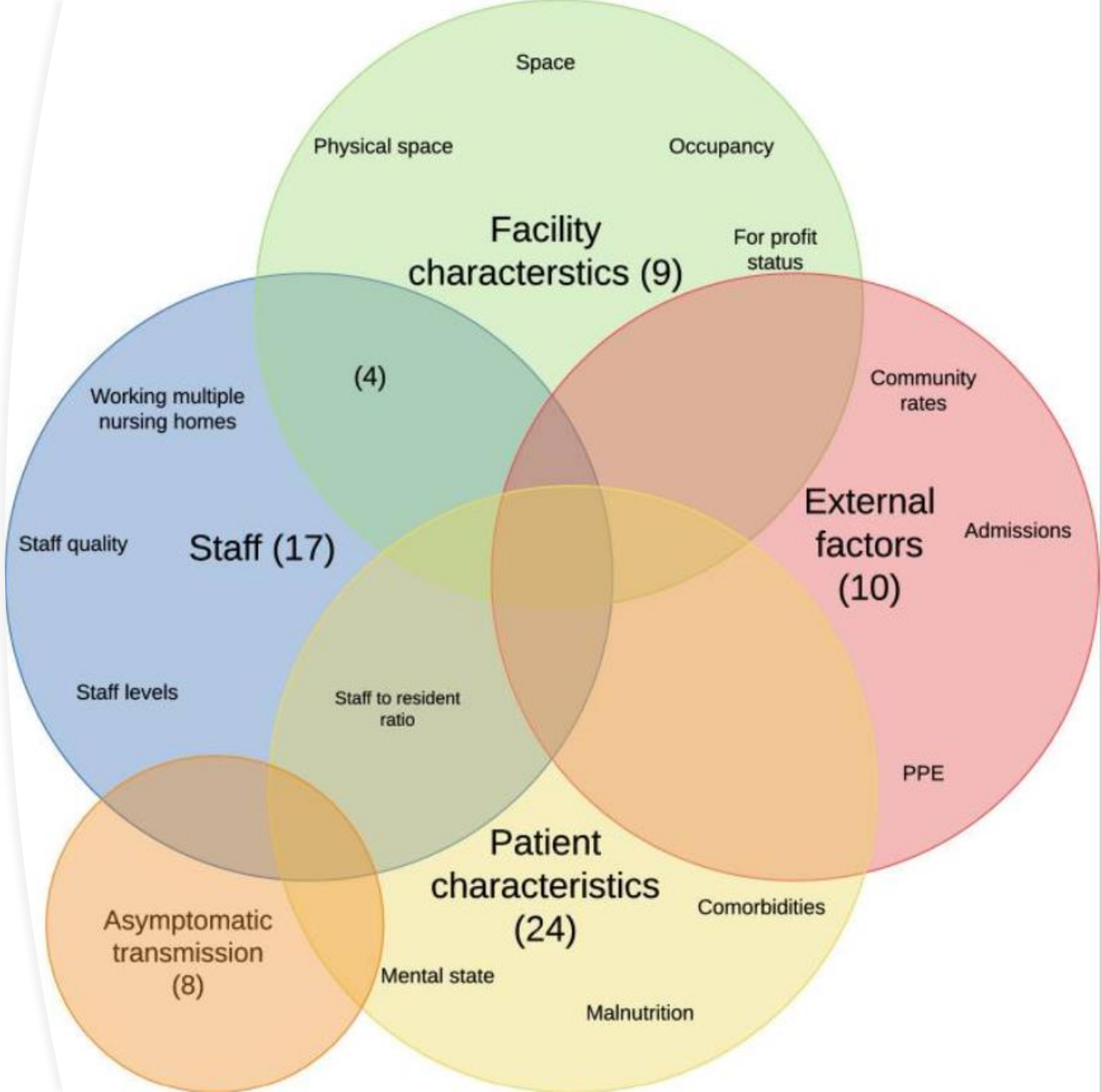
Exhibit 3: The use of temporary health care staff by long-term care facilities increased as the pandemic progressed



	2019	2020	2021	2022 (six months)	2022 (projected)
Expenditures	$9,832,734	$16,596,470	$52,518,998	$52,183,600	$104,367,200
Hours	268,186	414,707	1,203,516	1,217,058	2,434,116

PREDICTORS TRANSMISSION/ INFECTION

- Age
- Residing in congregant settings
  - Community Rates
- Personal care requirements
- Health Comorbidities
- Behavioral and cognitive challenges affecting infection control



METHODS OF MANAGEMENT

- Universal Screening
- Isolation and Cohorting
- Vaccination
- Staff Confinement
- Visitation restrictions
- Telehealth
- Vital and Symptom based testing

OUTCOMES TO LONG TERM CARE RESIDENTS

- Higher mortality
- Functional and cognitive decline
- Increase weight loss
- Increase in depressive symptoms

Barnett et al. JAMA 2022

OUTCOMES TO LONG TERM CARE CENTERS

STAFFING SHORTAGES

FACILITY CLOSURES

IMPACT ON MODELS OF LONG TERM CARE

- Fewer short stay/ rehab stays
- Increase Home and Community Services
- Increase in telehealth services
- Emphasis on small cohort settings

Middle Tennessee Nursing Home Quality Improvement Collaborative

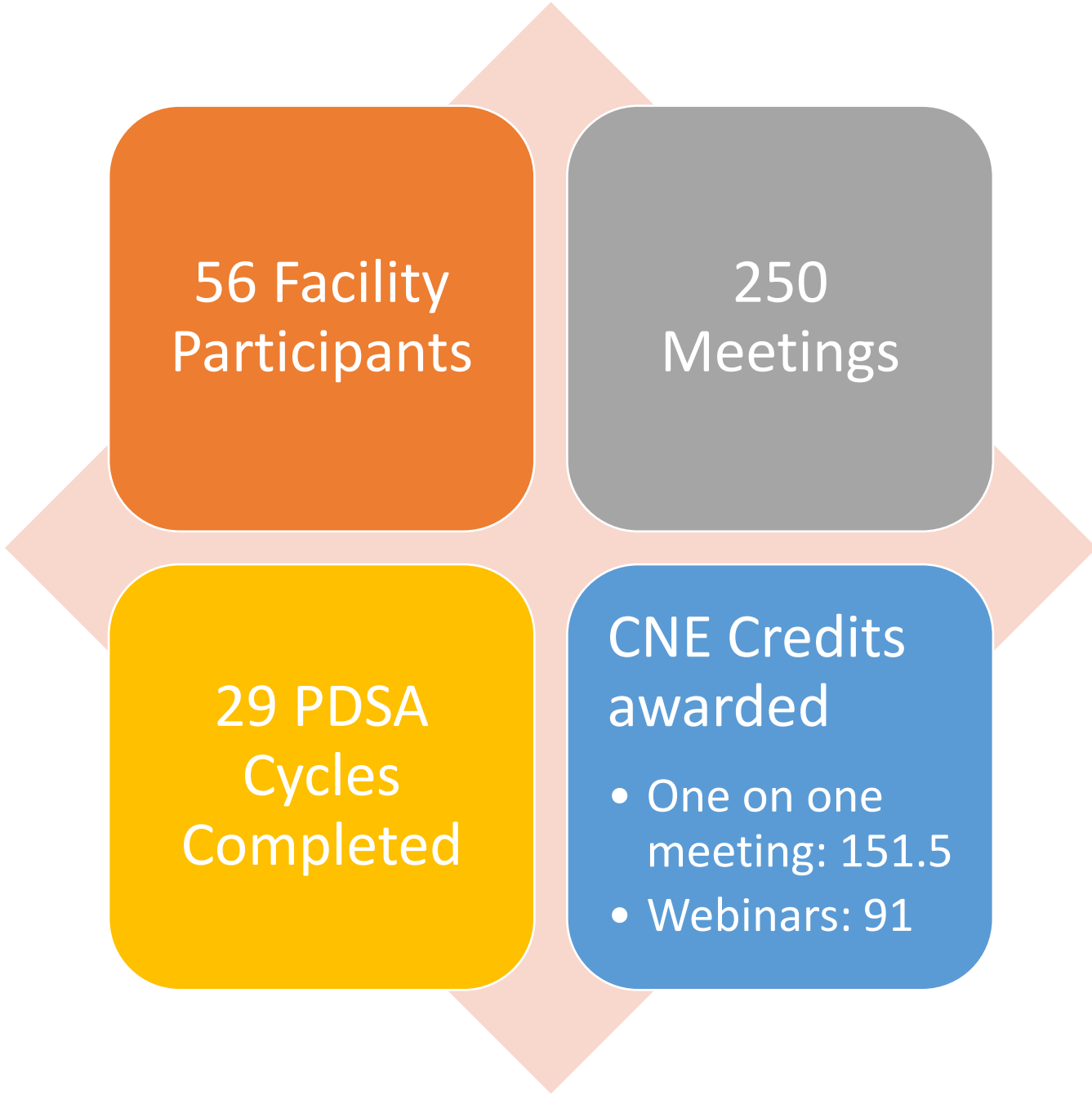
One-on-one planning and evaluation support

Sharing best practices and solutions

Free QAPI education and local expertise

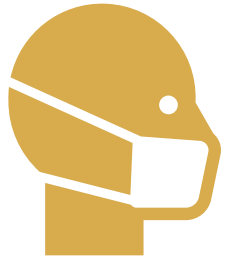
Supports fulfillment of CMS requirements

Project Data



Most Common Performance Improvement Projects

- COVID-19 vaccination education and onsite clinic events
- Nutrition support, weight loss prevention
- Improve medication reconciliation
- Streamline medication administration
- Falls prevention
- Staff support, burnout



Most Targeted MDS Outcomes Improved

Percentages in the most recent quarter with available data will be highlighted green to show its score is relatively better than other TN facilities and red to show its relatively worse. In the final project report, we will summarize trended data across quarters for each quality measure.

MDS Long-Stay Quality Metrics (%)	Participating Facilities	Regional Control Group
High-risk long-stay residents with pressure ulcers	7.14	7.85
Long-stay residents assessed and appropriately given the pneumococcal vaccine	83.53	87.08
Long-stay residents assessed and appropriately the seasonal influenza vaccine	91.14	94.32
Long-stay residents experiencing one or more falls with major injury	3.54	3.67
Long-stay residents who have depressive symptoms	10.44	9.26
Long-stay residents who lose too much weight	5.90	7.26
Long-stay residents who received an antianxiety or hypnotic medication	25.38	26.93
Long-stay residents who received an antipsychotic medication	15.86	17.10

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VANDERBILT
School *of* Nursing

Implementing A COVID Recovery Curriculum In Long Term Care

Jennifer Kim, DNP, GNP-BC, GS-C

October 6th, 2023

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- Kimberly Beiting, MD also receives support from the **HRSA** of the U.S. Department of **HHS** under grant number K01HP49070.
- Support for the REDCap survey tool utilized in this project was via the **National Institutes of Health (NIH)** Clinical and Translational Science Awards (Grant UL1 TR000430).

- No completing conflicts of interest

MID-SOUTH PROJECT ECHO

The Team

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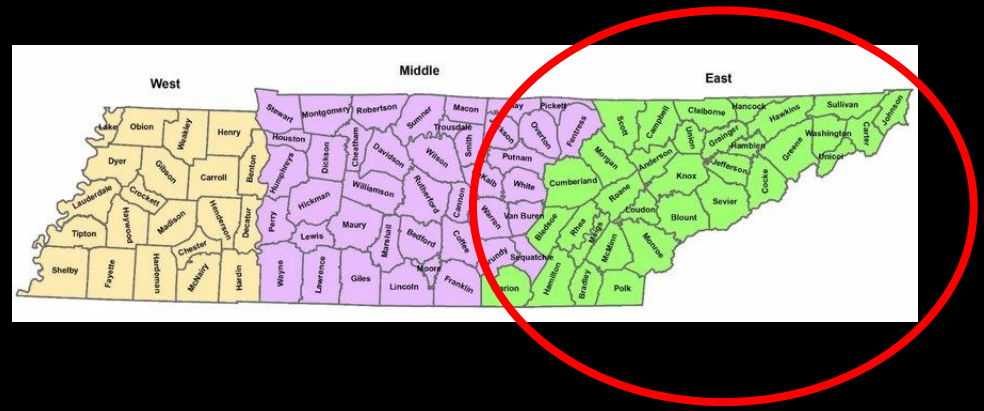
Shana Atkins, MPH

Emily Hollingsworth, MSW

MID-SOUTH PROJECT ECHO

Background

- Tennessee SNF residents represented 2% of total COVID-19 cases but 22% of deaths
- 314 skilled nursing facilities (SNFs) in Tennessee
  - 1/3 in East Tennessee
- Low COVID vaccination rates in East Tennessee

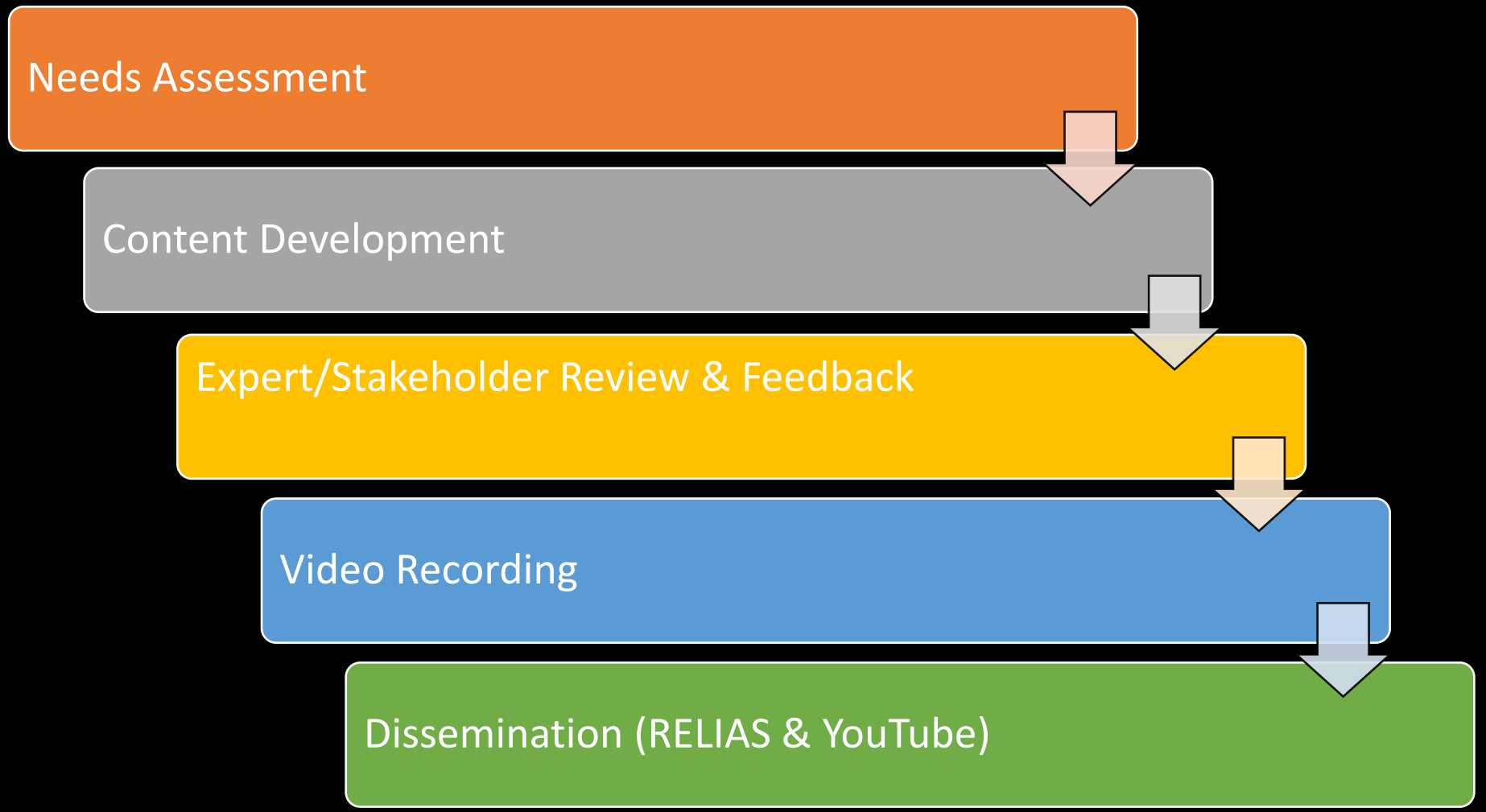


MID-SOUTH PROJECT ECHO

Project Aim

- Design & implement a COVID-19 recovery curriculum for staff and caregivers in East Tennessee SNFs
    - COVID-19 prevention and management and its long-term social, emotional, and physical impact in SNFs

Methods (At A Glance)



Needs Assessment

- Developed by project team
- Distributed to 30 LTC leaders in East Tennessee
  - 9 SNFs
  - 3 ALFs

- Self-reported facility & staff demographics
- Strengths & areas for improvement
- Preferred staff audiences & delivery methods

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Needs Assessment (Cont'd)

- Ranked preference for topics
  - COVID-19 vaccine hesitancy
  - COVID-19 management
  - COVID-19 associated isolation & depression
  - Long COVID
  - Caregiver support
  - Grief support & counseling
  - Advanced directives
  - Staff burnout

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Needs Assessment-Results

- *n*=10
- Preferred topics
  - Staff Burnout (100%)
  - COVID-19 associated isolation & Depression (50%)
  - Facility management of COVID-19 (37.5%)
  - Caregiver support (37.5%)
- Preferred learning style
  - Facility-led in-person education sessions (62.5%)
  - Asynchronous modules (50.0%)
  - Live virtual lectures with group discussion (50.0%)

Engaging Facilities

- Total # of facilities identified for potential participation: 14
- Total # of facilities who participated in ECHO trainings: 12
- Coordination with leadership at 2 ALF/LTC chains

Content Development

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Video production

- A team effort

Expert/Stakeholder Review

- Expert reviewers
  - Geriatricians
  - Gerontological nurse practitioners (NPs)
  - Educators from Alzheimer's Tennessee

- Reviewed initial course videos

Expert/Stakeholder Feedback

- Module length: < 30 minutes
- Simplify content
- Reserve COVID-19 policy-focused education for administration

Curriculum Modules

- Developed 9 curriculum modules
  - Prioritized modules (per administration preference):
    - Staff Burnout, Resilience, Recovery, & Retention
    - COVID-19 Associated Isolation & Depression
    - Dementia Caregiver Professional Training: Preventing Burnout with Realistic Expectations

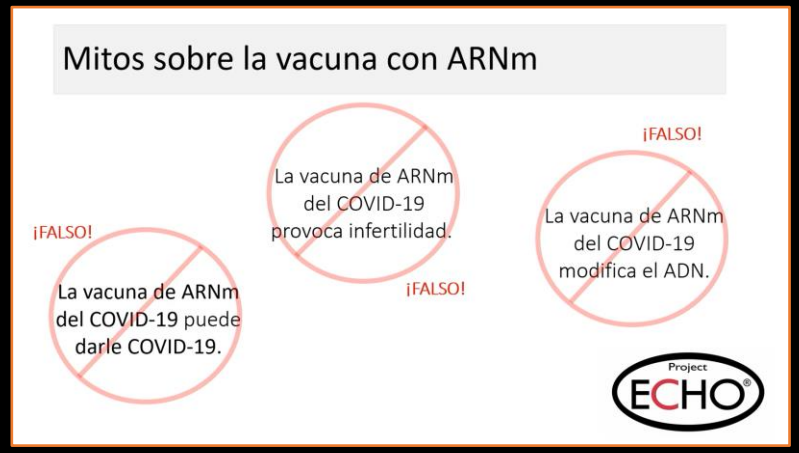
- 8 modules produced in Spanish community partners.

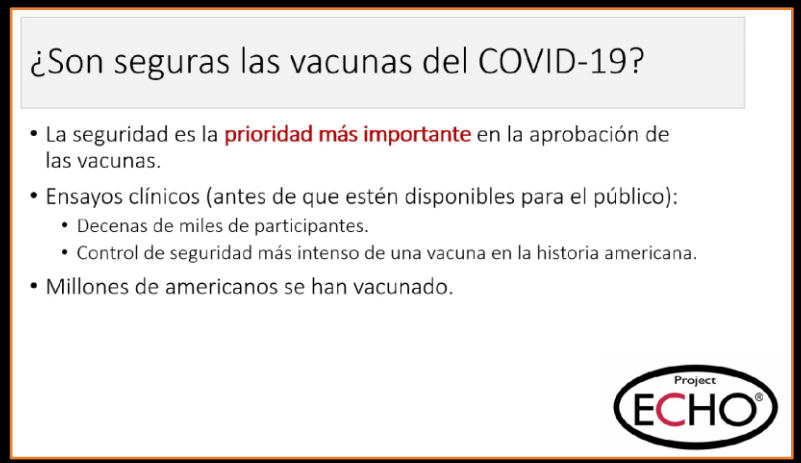
Module Stats

- Mean length: 16.85 minutes (9.13-27.32 minutes)
- Flesch-Kincaid reading grade level of 5.74 (2.7-7.6).
- Tailored to direct care staff.

Producing Spanish Educational Videos

- Identified as a need in Needs Assessment
- Slides uploaded to medical translation service
  - Fast turnaround
  - Reviewed cultural appropriateness of images
- Faculty member (School of Nursing)
  - Native Spanish speaker
  - Certified nurse practitioner
  - Workload availability





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Creating Videos in Spanish

- Videos
  - Professionally recorded & published
  - School of Nursing “green room”

- Uploaded to YouTube
  - 16 videos on *GWEP/ECHO Espanola* playlist

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Working With Alzheimer's Tennessee

- Respected & established community partner
  - Well versed in East Tennessee resources
- Participation in video production
  - Visibility is important
- Referral source for caregiver support groups

Alzheimer's® Tennessee
www.alzTennessee.org

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Dissemination

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“I hope they watch them.”

Photo: Sergey Zolkin on Unsplash.com

Viewings Within The RELIAS Learning Portal

- January 2023 (3 months)
  - Total cumulative views: 1,238 staff members
- May 2023 (6 months)
  - Total cumulative views: 2,118 staff members (18 facilities)
    - CNA: 29%
    - LPN + RN: 24.2%
    - Therapy: 19.9%
    - Social Work: 5.4%
    - Directors/Admin: 3.9%

RELIAS LEARNING

MID-SOUTH PROJECT ECHO

YouTube Video Views*

Video Title	View Count
Long Term Care: Staff Burnout, Resilience, Recovery, & Retention	923
COVID-19 Associated Isolation & Depression in Long Term Care	770
Dementia Caregiver Professional Training: Preventing Burnout With Realistic Expectations	731
Long COVID Syndromes: Physiology & Clinical Management	72
Self Care	70
COVID-19 Management in Skilled Nursing & Assisted Living Facilities	49
Advanced Care Planning	35
Grief Support & Counseling	17

** as of May 1, 2023*

MID-SOUTH PROJECT ECHO

East Tennessee LTC Facilities: Current Status

Staffing

- Slight ↑ in total nursing hours/resident after offering ECHO resiliency & retention sessions
- 10 min/resident/day

Vaccination Rates

- Prior to ECHO educational series: 65% staff received initial COVID-19 vaccine
- As of January 2023, 83% of staff members had received primary vaccination series

Depression

- >400 LTC staff have viewed module on resident isolation & depression
- Slight ↓ in residents experiencing depressive symptoms after training (6.5% to 5.7%)

Advance Directives

- Advance directive completion is > 99%

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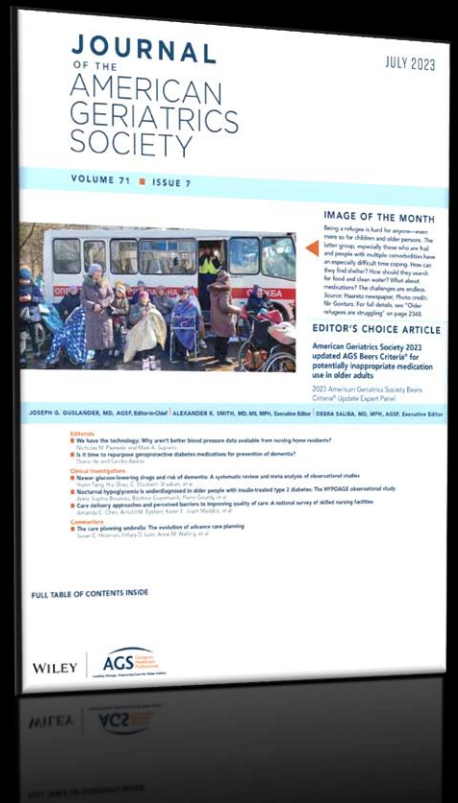
Next Steps

- Continue work with community partners & facilities
- Leverage LTC/ALF relationships for continued work
  - New initiatives?
- Repurpose work already completed
  - YouTube
- Dissemination
  - Publications



Project Take Aways

- Persistence pays off
  - Slow to respond ≠ not interested
- RELIAS learning portal → key to dissemination success
- Divide & conquer
  - Calendar coordination is challenging
- Synchronized face-to-face learning isn't always feasible

Please visit the Mid-South Project ECHO Hub to view our course offerings.

Please visit the Mid-South Project ECHO Hub to view our course offerings.

THANK YOU!

jennifer.kim@vanderbilt.edu

VANDERBILT UNIVERSITY MEDICAL CENTER

MID-SOUTH PROJECT ECHO

VANDERBILT School of Nursing

Photo: https://unsplash.com/photos/D2NvTDuPME4

VANDERBILT UNIVERSITY

October 6, 2023

Culturally Informed Care for LGBTQ+ Patients

Tara McKay

Vanderbilt University

Nothing to Disclose

Collaborators

Nathaniel Tran, PhD Candidate, Health Policy

Harry Barbee, PhD, Johns Hopkins

Ellesse Akré, PhD, Dartmouth

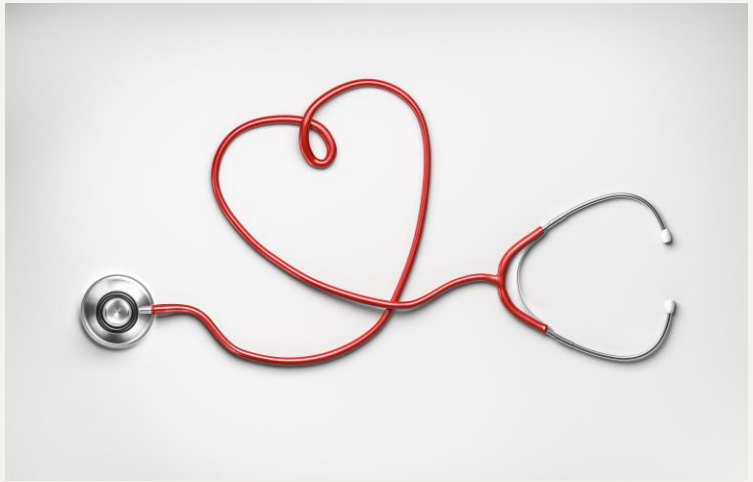
Jeffrey Henne, The Henne Group, Inc.

Nitya Kari, Adam Conway, Isabel Gothelf,

Judy Min, Lana Trautman


SUPPORT TRANS YOUTH
When we have to protect children from their government, We have failed as a society
GENDER AFFIRMING HEALTHCARE IS NECESSARY.
PROTECT TRANS KIDS

What is LGBTQ+ affirming care?



Cultural and clinical competencies

Respectful communication with LGBTQ+ individuals

Understanding, addressing specific health needs of LGBTQ+ individuals

Visible and explicit inclusion

Levels of Affirming Care

Interpersonal Level	• Gender inclusive language, rainbow pins, sharing increased risk for colorectal cancer among gay and bisexual men
Institutional Level	• Implementing LGBTQ+ competence in medical education, providing continuing education for providers, supporting LGBTQ+ trainees, showing up for colleagues
Structural Level	• Advocating for health insurance expansion, coverage of gender affirming care

Discrimination Drives Avoidance, Discomfort

1. Up to one-third of LGBTQ Americans avoid seeing a doctor for fear of discrimination
2. Many LGBTQ+ people are not out to their primary provider
   - Confidentiality
   - Mistreatment
   - Not relevant
3. Nondisclosure can lead to
   - inattention to specific health care needs
   - missed diagnostic screenings and vaccinations
   - higher unmet medical needs

What We Know about Effects on Preventive Screenings

1. Sexual minority women are significantly less likely to be offered a Pap test than heterosexual women
2. Transgender people with prostates are less likely to get screened compared to cisgender gay men and heterosexual men
3. Gay and bisexual men who do not disclose their sexual orientation to their provider are less likely to receive HPV vaccine

What We Know about LGBTQ Disparities in Diagnosis, Prognosis

1. Substantial disparities in obesity, diabetes, cardiovascular risk, mental health, suicidality, multiple morbidity
2. Evidence suggestive of disparities in aging related diseases, like Alzheimer's and dementia
3. Substantial disparities in cancer risk, especially: cervical, breast, lung, prostate, skin, anal, colorectal, oropharyngeal
4. Greater likelihood of cancer recurrence (3x higher for breast cancer)
5. Higher mortality for certain cancers, varies by population

What We Know about Effects on Care

1. Less patient-centered care and involvement in decision making
2. Greater burden of comorbidities at diagnosis
3. Reduced partner involvement in care decisions
4. Higher social isolation during treatment
5. Survivors have significantly greater physical inactivity, more medical complications, heavy episodic alcohol use, and depression, esp. transgender/gender diverse patients

Additional Challenges

1. Structural barriers (like lower rates of health insurance) → missed screenings, later initial presentation for care
2. Higher behavioral risk factors for certain diseases (e.g., smoking) not adequately addressed by prevention, intervention, or screening
3. Care fragmentation

Inclusive Practices Matter

1. When health systems are LGBTQ+ affirming, patients report higher satisfaction regardless of SOGI
2. Explicit and inclusive visitation and nondiscrimination policies are associated with greater partner engagement in cancer care

Association of Affirming Care with Chronic Disease and Preventative Care Outcomes LGBTQ Older Adults

- Seen a doctor, last 12 months
- Flu shot
- HIV test
- Cancer screenings
- Management of chronic conditions





VUSNAPS

Social Networks, Aging, and Policy Study






Measures

Has an Affirming Care Provider

Do you have an LGBT-affirming health care provider?

- Yes, they are my primary health care provider
- Yes, I see them in addition to another health care provider
- No, I don't need or want an LGBT-affirming health care provider
- No, I cannot find an LGBT-affirming health care provider in my area
- I don't know

Preventative Screenings

- Have you seen a doctor or healthcare provider in the past year?
- Have you ever had any of the following preventative care screenings or tests? In the last three years?
  - Flu shot
  - Breast cancer screening/mammogram
  - Pap test
  - Colorectal cancer screening/colonoscopy
  - HIV test

Chronic Disease Management

If condition:
Is your [high blood pressure, diabetes, heart condition, respiratory condition, mental health condition] pretty much under control (1) or is it still a problem (0)?

Who Has An Affirming Provider?

About two-thirds of sample has an LGBTQ+ affirming provider.

Compared to participants with a usual source of care, those with an LGBTQ+ affirming provider are more likely to:

- Be lesbian or gay (vs bisexual or something else)
- Be transgender or gender diverse (vs cisgender)
- Be living with HIV (vs not)
- Have a college degree or higher (vs less than college)
- Be insured (vs not)

Healthcare Outcomes Associated with Affirming Care

Participants with an LGBTQ affirming provider were:

- **4.5% more likely to have had a routine check up in last year**
- 8.6% more likely to have had a flu shot in the last 3 years
- **7.6% more likely to have ever had colorectal cancer screening**
- 12.2% more likely to have mental health condition under control

Mechanisms?

Less Avoidance

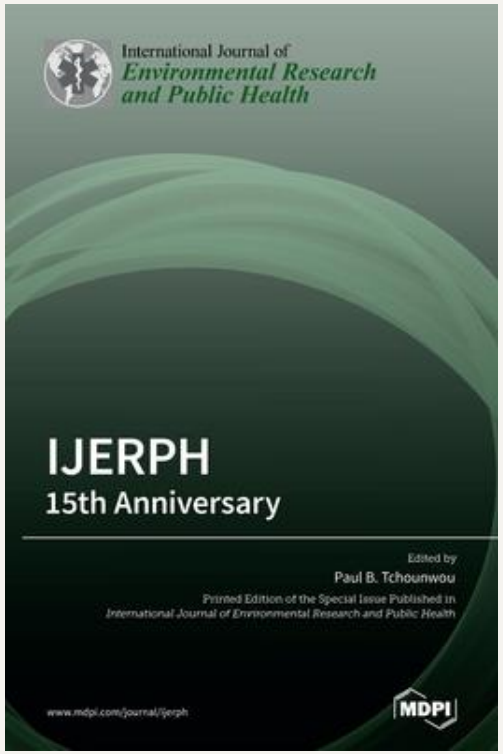
Patients anticipate less discrimination, lowering barriers to engagement and decreasing delays in care.

More Trust

- Affirming providers engender more trust, increasing openness about problems and action on recommendations.

Integration of Care

Greater engagement with primary care, less healthcare fragmentation



LGBTQ+ Affirming Care May Increase Awareness and Understanding of Undetectable = Untransmittable among Midlife and Older Gay and Bisexual Men in the US South

- U=U awareness
- U=U understanding
- U=U believability
- Risk perception
- HIV test

Take Aways from Our Research

- Expanding access to LGBTQ+ affirming providers across the health system may
  - Decrease healthcare avoidance and delay for LGBTQ populations
  - Help narrow health disparities for LGBTQ+ older adults through increased and more timely screening, uptake of provider recommendations, earlier detection
  - Intervene in the poorer health trajectories of LGBTQ+ people in many Southern states
  - Improve HIV-related outcomes via increased awareness of treatment as prevention and uptake of testing

Why aren't more providers LGBTQ+ affirming?

Actually, they are!

Healthcare providers have few reservations about caring for LGBTQ+ populations

But many feel unprepared

Limited engagement with LGBTQ+ health in medical curriculum

How do I start?

- Attend a CME focused on LGBTQ topics
- Add a rainbow pin/badge sticker
- Connect with the VUMC Program in LGBTQ Health
- Review your
  - intake forms
  - promotional materials
  - decorations around your office
  - website
- Consider the impact of gendered program titles
  - “women’s support group”

Level Up!

- Check your assumptions → if you're not sure how a patient identifies or what pronouns they use, ASK!
- Use inclusive language in patient interactions
- Pay attention to health disparity areas, but also the whole person
  - gender-related medical misattribution ("trans broken arm syndrome") and invasive questioning are significant complaints from LGBTQ patients
- Ask → we have a space for this in Epic but we don't use it
- Engage care partners, esp. nontraditional ones like close friends or community members

Do I really need to do this?

- 2.4 million Americans aged 65+ identify as LGBTQ+
- Substantial disparities in disease risk, stage of diagnosis, rates of recurrence, rates of survival
- Increasing evidence that the care partners of LGBTQ+ older adults are being left behind, isolated, struggling

Do patients really want to talk about this?

PLOS ONE

OPEN ACCESS PEER-REVIEWED

RESEARCH ARTICLE

Do Ask, Do Tell: High Levels of Acceptability by Patients of Routine Collection of Sexual Orientation and Gender Identity Data in Four Diverse American Community Health Centers

Sean Cahill, Robbie Singal, Chris Grasso, Dana King, Kenneth Mayer, Kellan Baker, Harvey Makadon

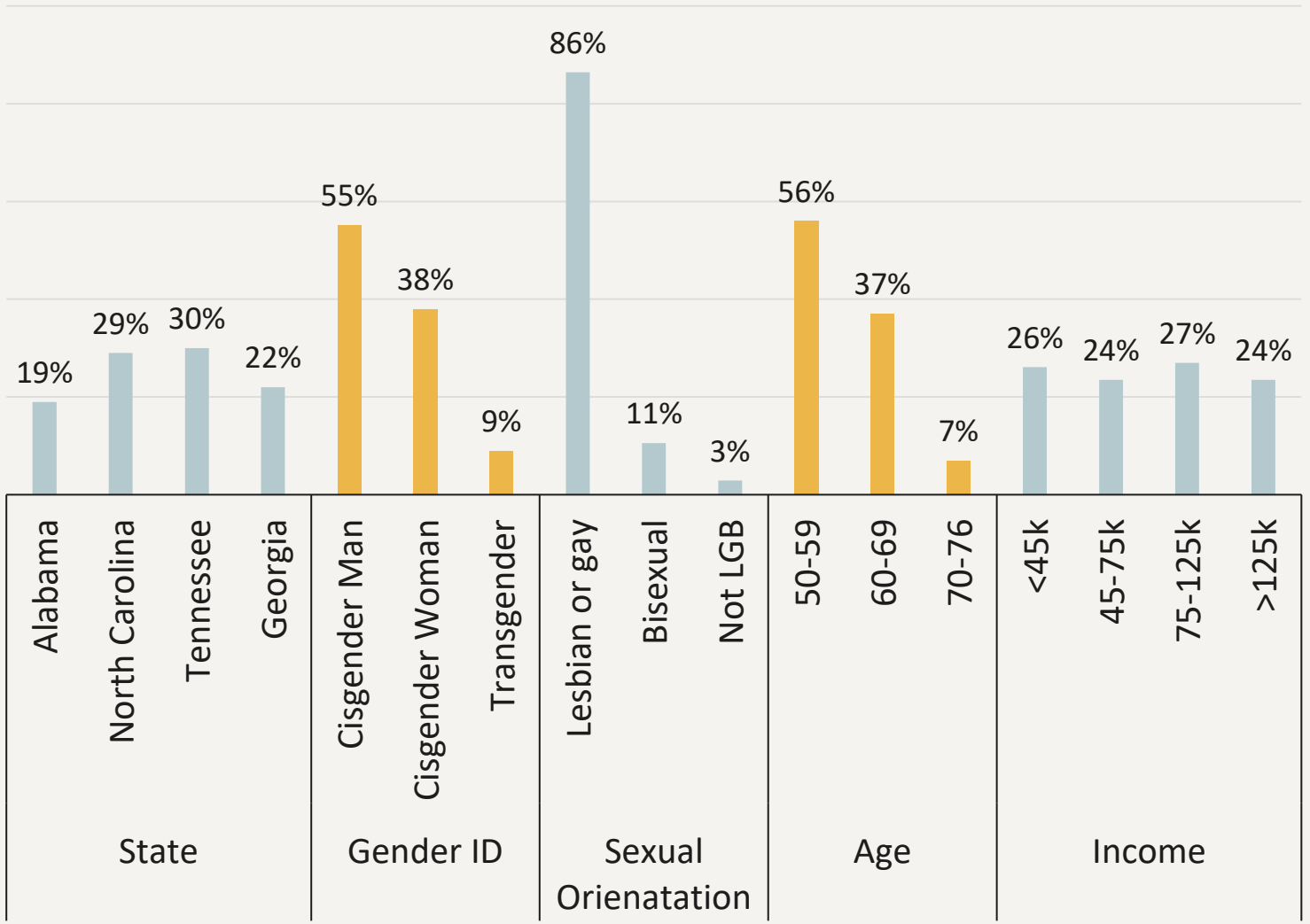
Published: September 8, 2014 • https://doi.org/10.1371/journal.pone.0107104

I need more information:

- Vanderbilt University Medical Center Program for LGBTQ Health
- American Medical Association on LGBTQ Health Issues
- National LGBT Cancer Network
- American Association for Cancer Research
- Alzheimer’s Association LGBTQ+ Resources for Dementia

Thank you!

tara.mckay@vanderbilt.edu



VUSNAPS Panel Characteristics

- Unweighted
- VUSNAPS participants are more likely to be higher educated and less likely to identify as Latino/Hispanic or bisexual compared to US population in sample states

Limitations

Cross sectional

- For now
- Wave 2 panel data now available to examine transitions in care and in outcomes

No anatomy measure

- Some preventative screening measures (e.g., Pap, mammogram) may include in the denominator transgender individuals AFAB that do not have the anatomy at risk. This biases those results to the null.

Measure of Affirming Care

- We have included additional measures of healthcare discrimination and affirming practices in Wave 2

Does Having an Affirming Provider Improve HIV Prevention Awareness?

- Healthcare providers are an important source of information about HIV prevention technologies (especially PreP and U=U)
- Many gay and bisexual men don’t talk to their healthcare provider about sexual behavior or identity
- Sexual minority men who are not out to their primary care provider are less likely to have been:
  - tested for HIV in the previous two years
  - tested for gonorrhea and syphilis
  - vaccinated against hepatitis A and B

Affirming Care Links to HIV Prevention

- Gay and bisexual men living with HIV are far more likely to report having an affirming provider compared to HIV negative men
- Among HIV negative men with a usual source of care, those who had an affirming provider were
  - 2x more likely to have ever tested for HIV
  - About 2x more likely to be generally aware of treatment as prevention principles
  - 3x more likely to have heard about U=U
  - 1.5x more likely to believe and understand U=U
  - 2x less likely to view sex with a person living with HIV who is undetectable as likely to result in HIV transmission

Role of Healthcare Providers

- Healthcare providers were one of the top three sources of information on U=U
- Overall, one in 5 men heard about U=U from a healthcare provider
- Among HIV negative men, those who reported hearing about U = U from a healthcare provider all indicated that their provider was LGBTQ affirming

Implications

More Communication

- Sexual minority patients are more likely to communicate about their specific health needs and behaviors in affirming care contexts
- LGBTQ affirming providers are more comfortable having conversations about HIV and sexual health with sexual minority men

Decreasing HIV Stigma

- Decreasing HIV stigma is important for the well-being of people living with HIV and increases testing among HIV negative men.
- More accurate understandings of risk with a partner on treatment may also reduce anxiety, fatalism that keep people from testing.

US South

- Greatest burden of HIV-related deaths, lowest rates of PreP
- Expanding access to affirming providers may help reduce HIV-related mortality by improving U=U awareness, uptake of HIV testing

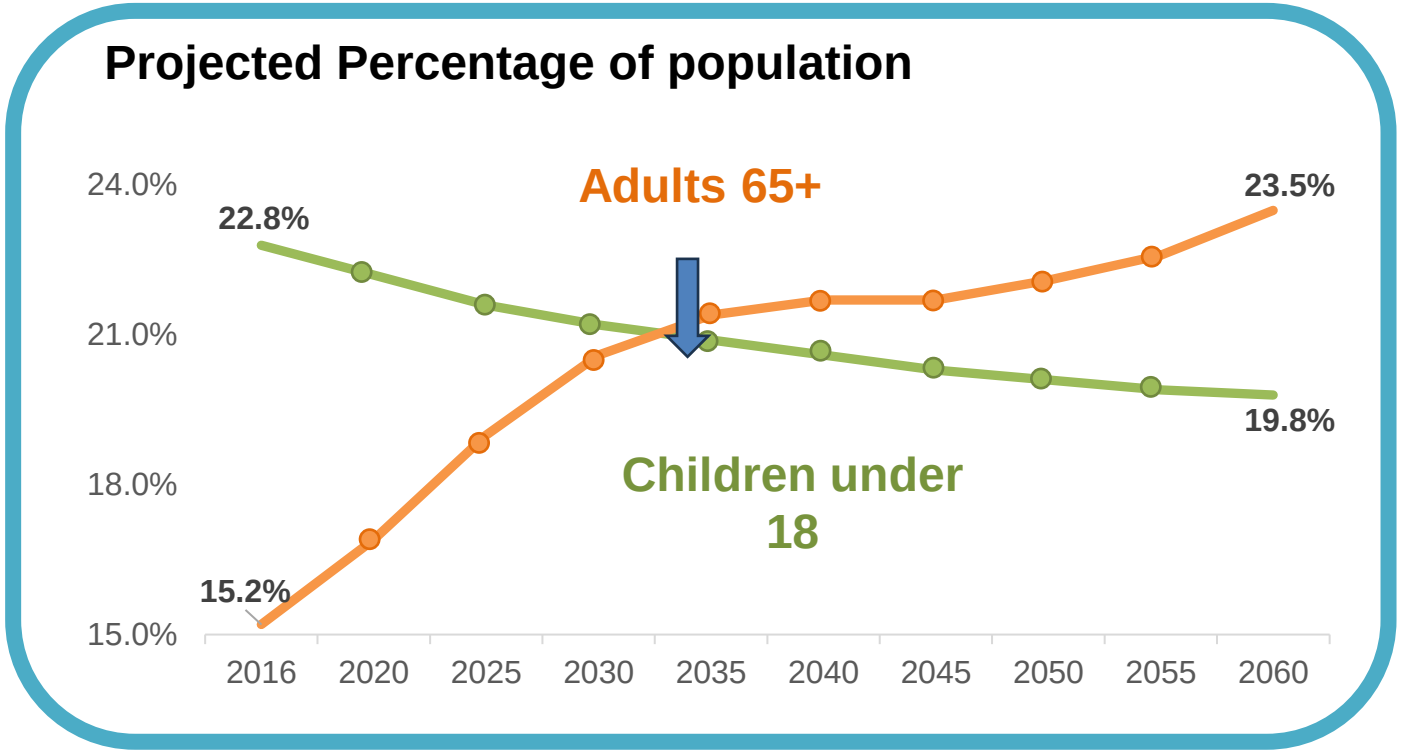
Creating Age-Friendly Livable Communities

Rita Burgett Martell| GWEP | October 6, 2023

History of Age-friendly Movement

- The World Health Organization (WHO) started the global age-friendly movement in 2006 to create communities that are inviting and accessible for people of all ages but especially for older adults.
- The AARP Age Friendly Network was launched in 2012 and is the United States affiliate of the World Health Organization Global Network.
- The Livability Index was developed in 2015 to evaluate how well a community meets the needs of its residents across multiple dimensions as they age
- Communities who want to become age friendly, develop and implement continuous improvement programs, with guidance from AARP, that help older adults, age in place, thrive, and remain socially active.

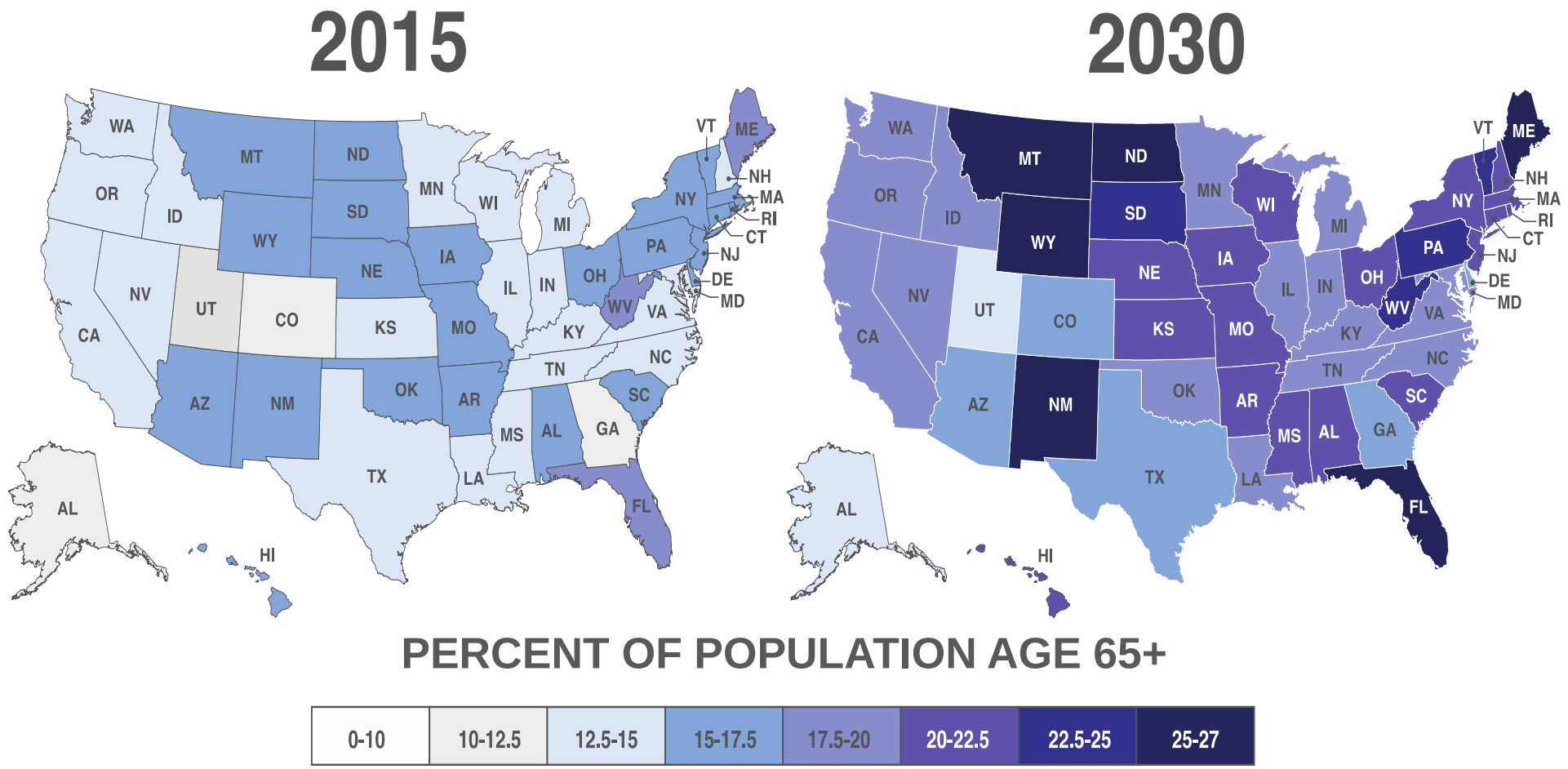
For the first time in U.S. history, older people will outnumber children.



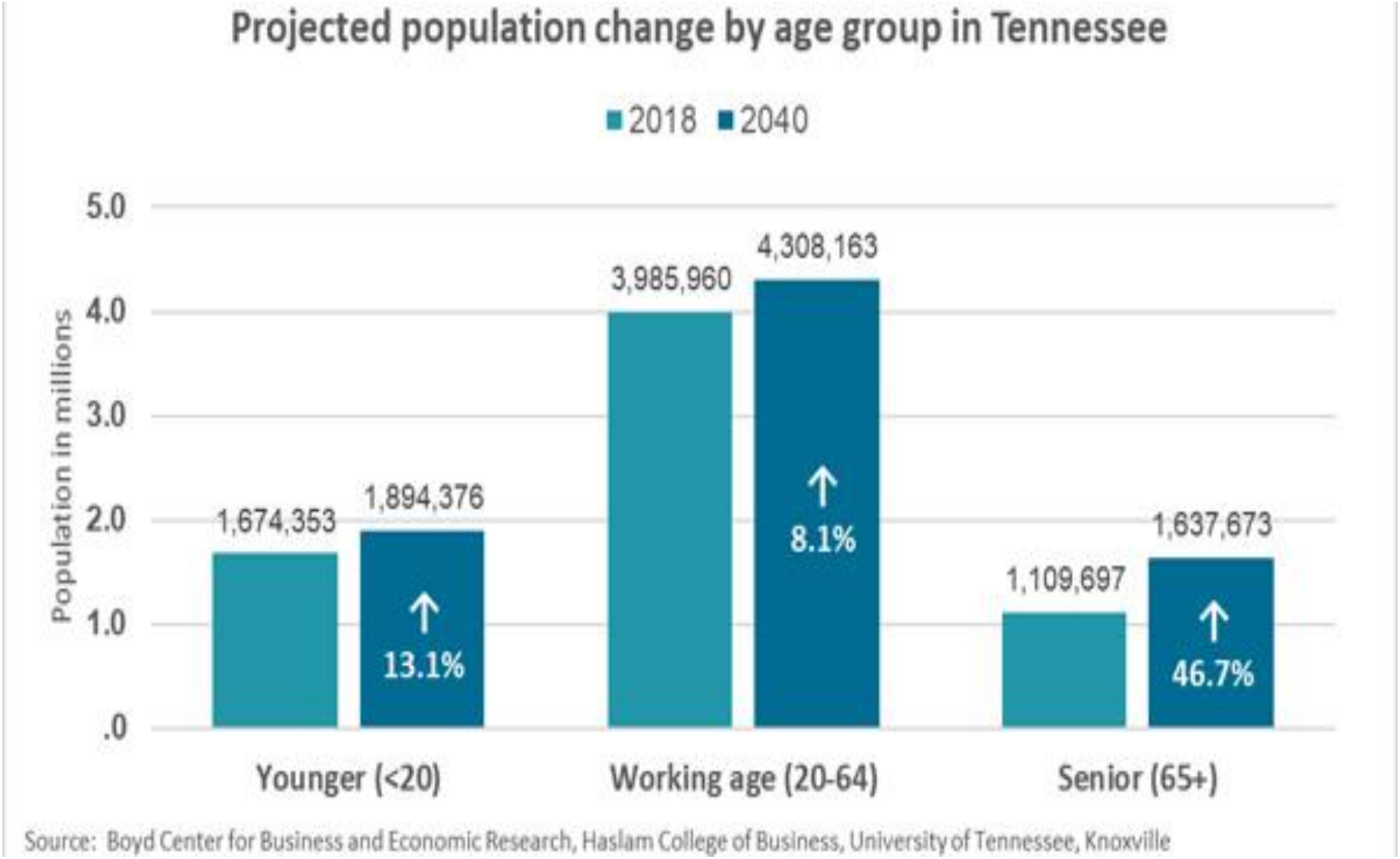
Median age will increase from 38 today to 43 in 2060.

Source: US Census Bureau (March, 2018). Older People Projected to Outnumber Children for First time in US History. Retrieved from: https://bit.ly/2p8zoQY

America is Aging



Source: US Census


Projected population change by age group in Tennessee
2018
2040
Population in millions
5.0
4.0
3.0
2.0
1.0
.0
1,674,353
1,894,376
13.1%
3,985,960
4,308,163
8.1%
1,109,697
1,637,673
46.7%
Younger (<20)
Working age (20-64)
Senior (65+)
Source: Boyd Center for Business and Economic Research, Haslam College of Business, University of Tennessee, Knoxville

Are communities ready?

American homes have traditionally been designed and built for able-bodied 35 year olds.

For the past 50 years, communities have developed around motor vehicles as the principal form of transportation.

Survey after survey finds that today's older adults want to remain in their homes.

78%

of adults ages 45+ agree or strongly agree with the statement: "What I'd really like to do is stay in my current residence for as long as possible."

Source: AARP Home and Community Preferences of the 45+ Population, 2014

Photo from ThinkStock.com

Survey after survey finds that today's older adults want to stay in their community

80%

of adults ages 45+ agree or strongly agree with the statement: "What I'd really like to do is stay in my current community for as long as possible."

Source: AARP Home and Community Preferences of the 45+ Population, 2014

Age-friendly Communities

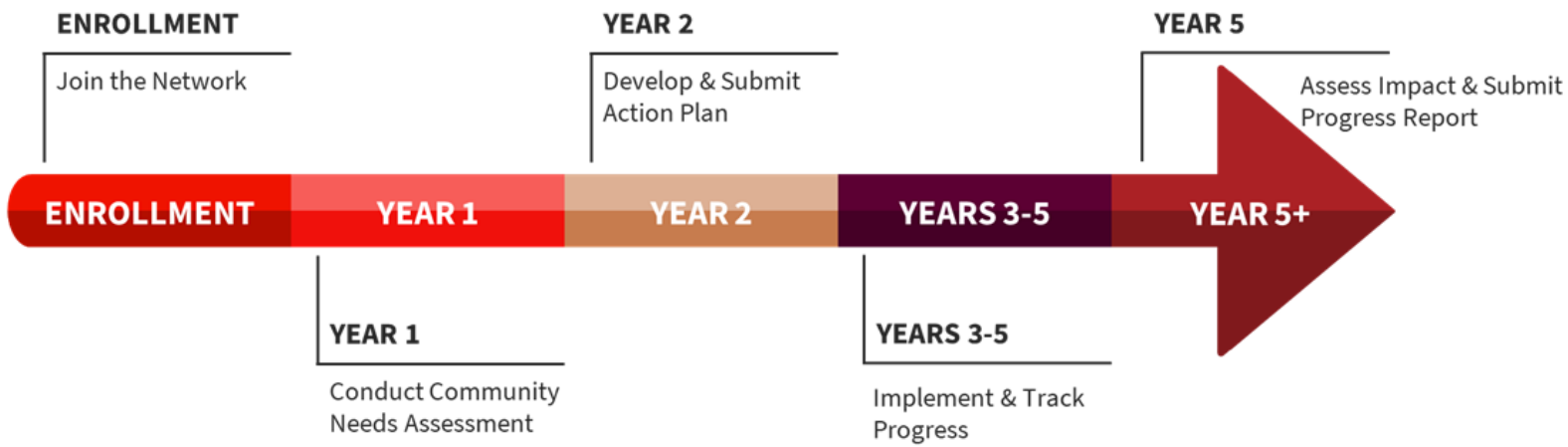
*An age-friendly community is one that is free from physical and social barriers and is supported by **policies, systems, services, products** and **technologies** that:*

- *promote health and build and maintain physical and mental capacity across the life course; and*
- *enable people, even when experiencing capacity loss, to continue to do the things they value.*

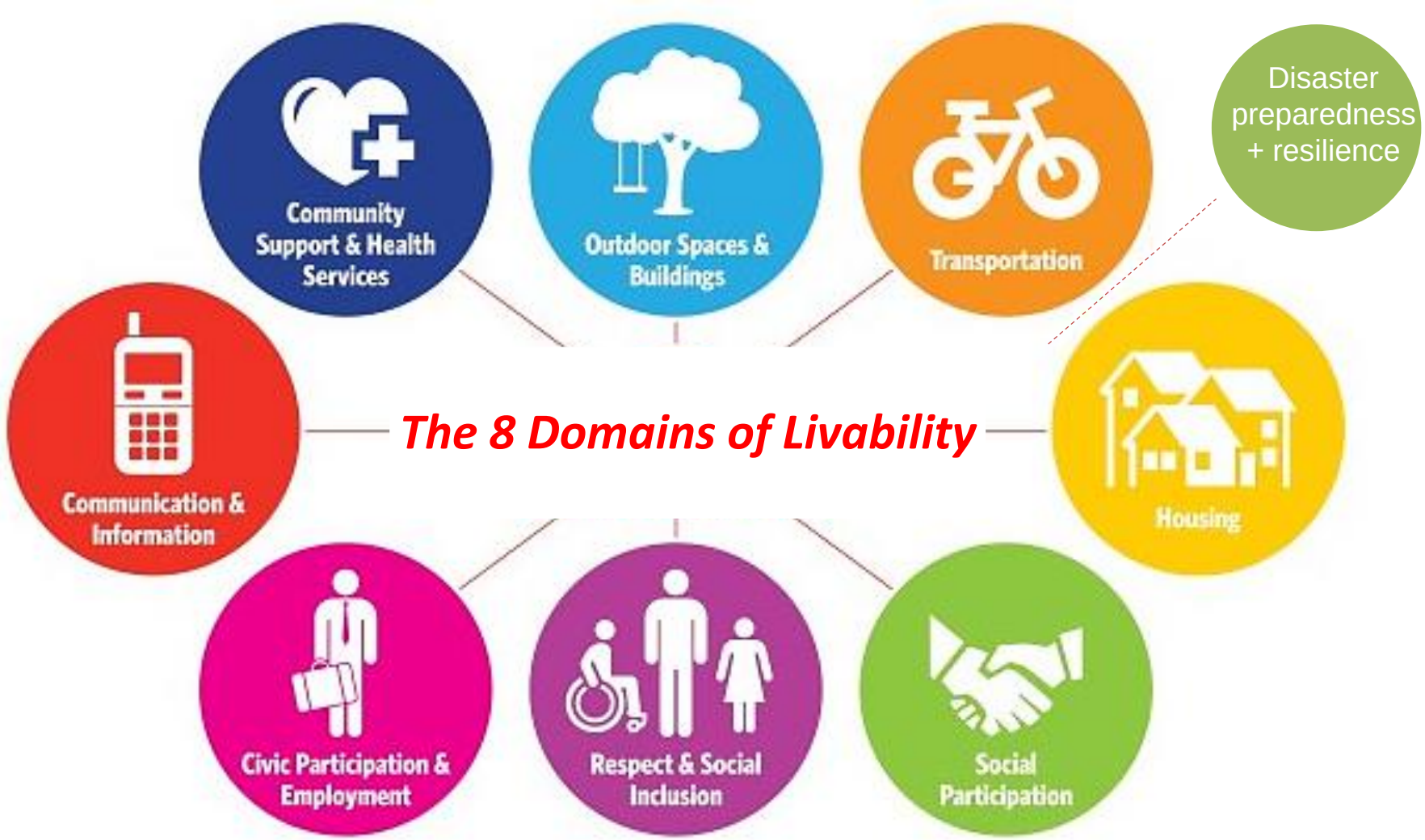
Goals of Age Friendly Program

- Eliminate physical and social barriers for older adults
- Provide options and support for aging in place
- Enable them to continue to learn, grow and make decisions
- Remain mobile
- Build and maintain a social network and relationships
- Contribute in meaningful and fulfilling ways to their communities

The Age-Friendly Program Process



Developing an age-friendly community: the foundation

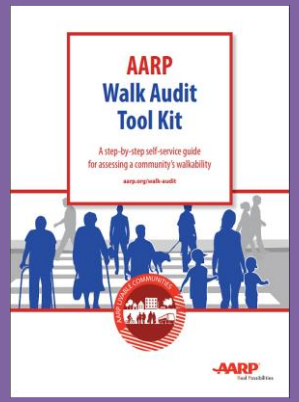


The 8 domains: housing

Most older adults want to age in place. Doing so is possible if homes are appropriately designed or modified – and if a community includes affordable housing options for varying life stages.

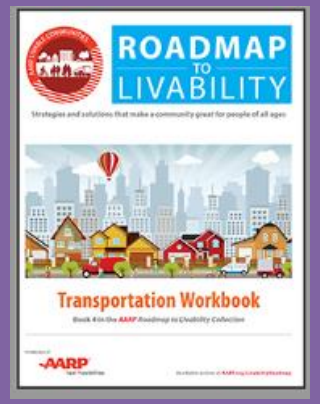
The 8 domains: outdoor spaces and buildings

People need places to gather- indoors and out. Parks, sidewalks, safe streets, outdoor seating, and accessible buildings (think elevators, stairs with railings, etc.) can be used and enjoyed by people of all ages.



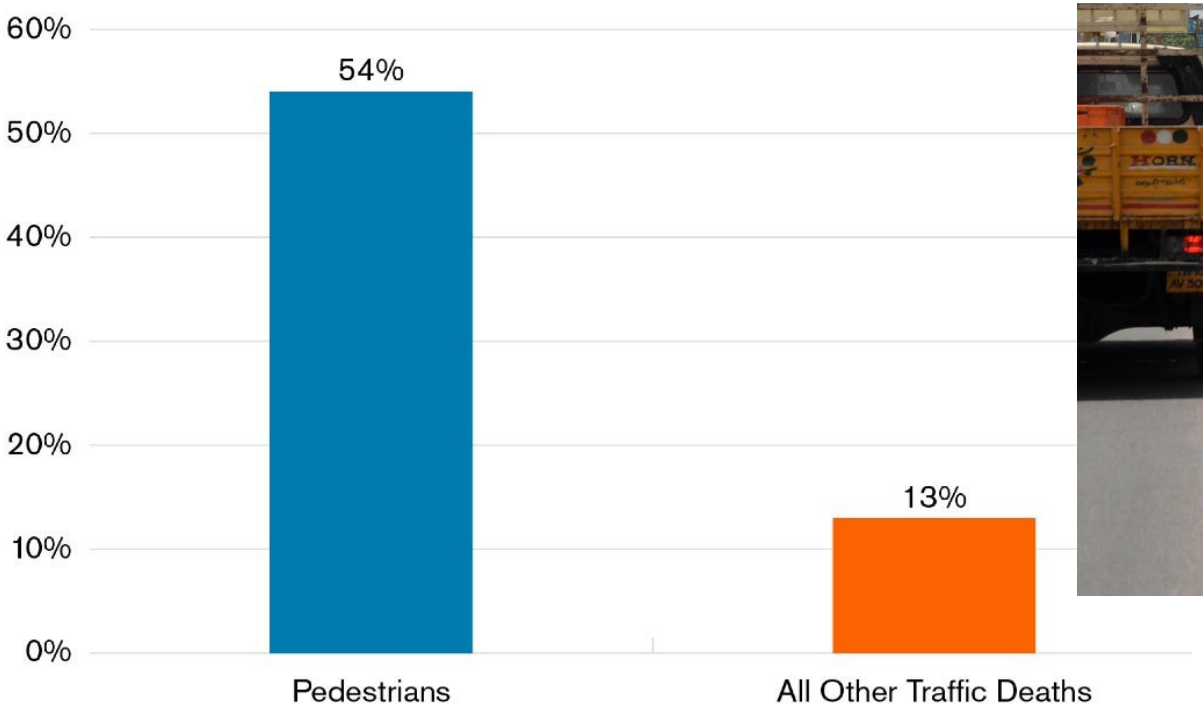
The 8 domains: transportation

Driving shouldn't be the only way to get around. Public transit options can be as expansive as a train system or as targeted as a taxi service that provides non-drivers with rides to and from a doctor's office.



Pedestrian Deaths Are Increasing Faster Than All Other Traffic Fatalities

Percent Increase in Number of Traffic Deaths, 2010-2020

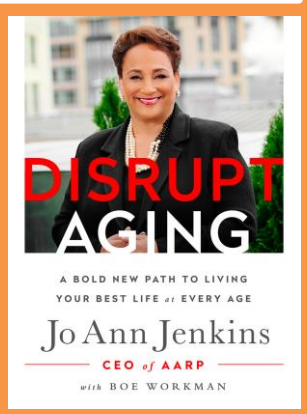


Pedestrian Safety | Transportation Safety | Injury Center | CDC

The 8 domains: social participation

Regardless of one's age, loneliness negatively affects a person's health and sense of wellbeing. Isolation can be combatted by the availability of accessible, affordable, and fun social activities.

The 8 domains: respect and social inclusion



Intergenerational activities are a great way for young and old to learn from one another, honor what each has to offer and, at the same time, feel good about themselves.

The 8 domains: communication and information

Age-friendly communities recognize that not everyone has a smartphone or Internet access and that information needs to be disseminated through a variety of means.

AARP.org/Livable

The 8 domains: civic participation and employment

An age-friendly community provides ways older people can, if they choose to, work for pay, volunteer their skills, and be actively engaged in community life.

http://www.createthegood.org/

The 8 domains: community support and health services

At some point, everyone gets hurt, becomes ill, or simply needs a bit of help. While it's important that care be available nearby, it's essential that residents are able to access and afford the services required.

Livability Index

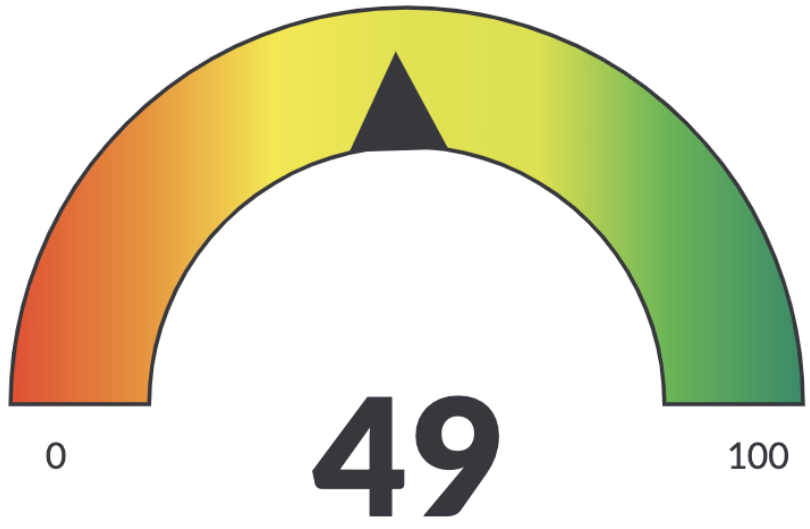
A tool for evaluating a City's Livability and how well a community meets the needs of its residents as they age.

Livabilityindex.aarp.org

Livability Score: Nashville

- **Total Population: 663,750**
- **African American:** 28%
- **Asian:** 4%
- **Hispanic:** 11%
- **White:** 63%
- **Age 50+:** 29%
- **Age 65+:** 12%
- **Households' w/Disabilities:** 12%
- **Life Expectancy:** 77 years old
- **Households Without a Vehicle:** 6%
- **Median Income:** $65,868

Data Sources – AARP Livability Index

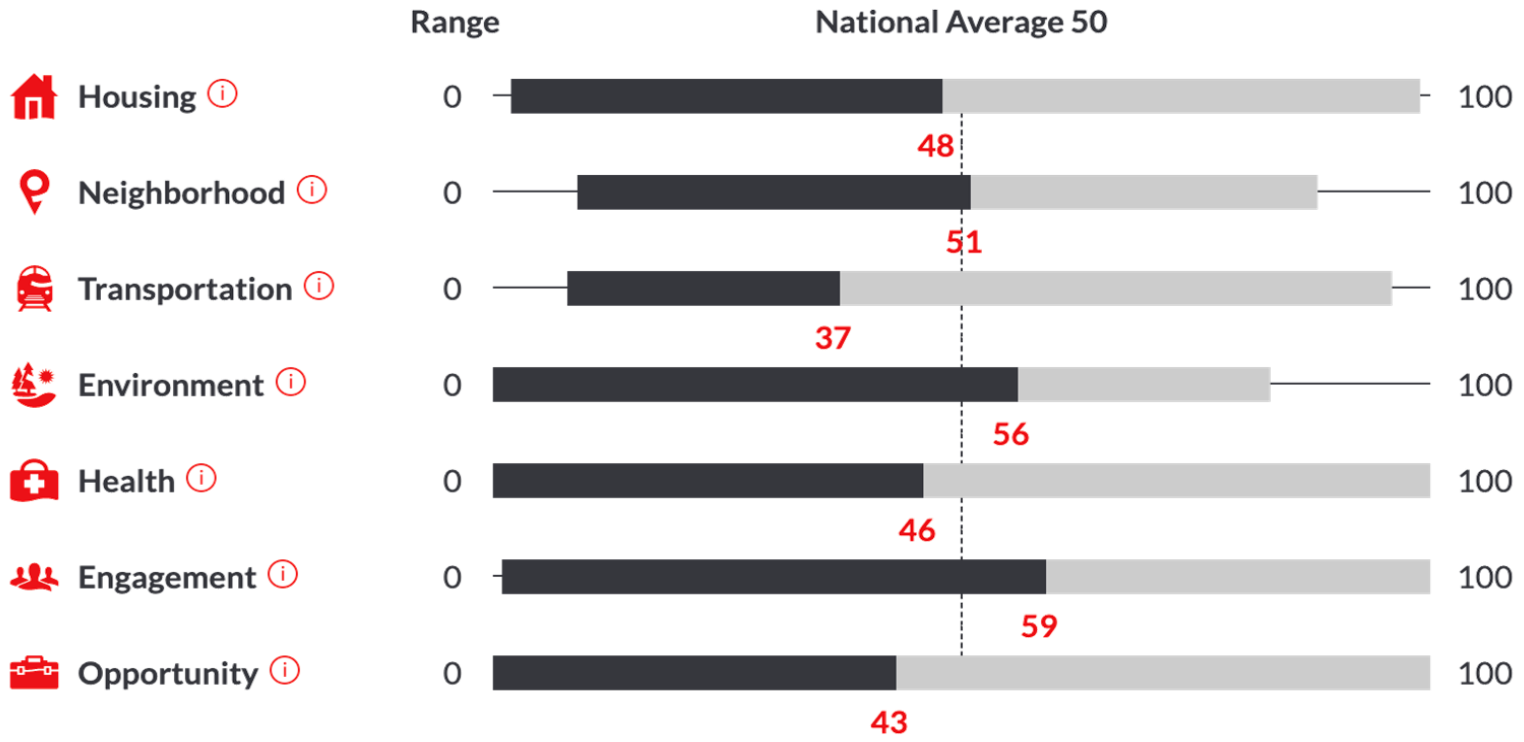


Overall Livability Score ⓘ

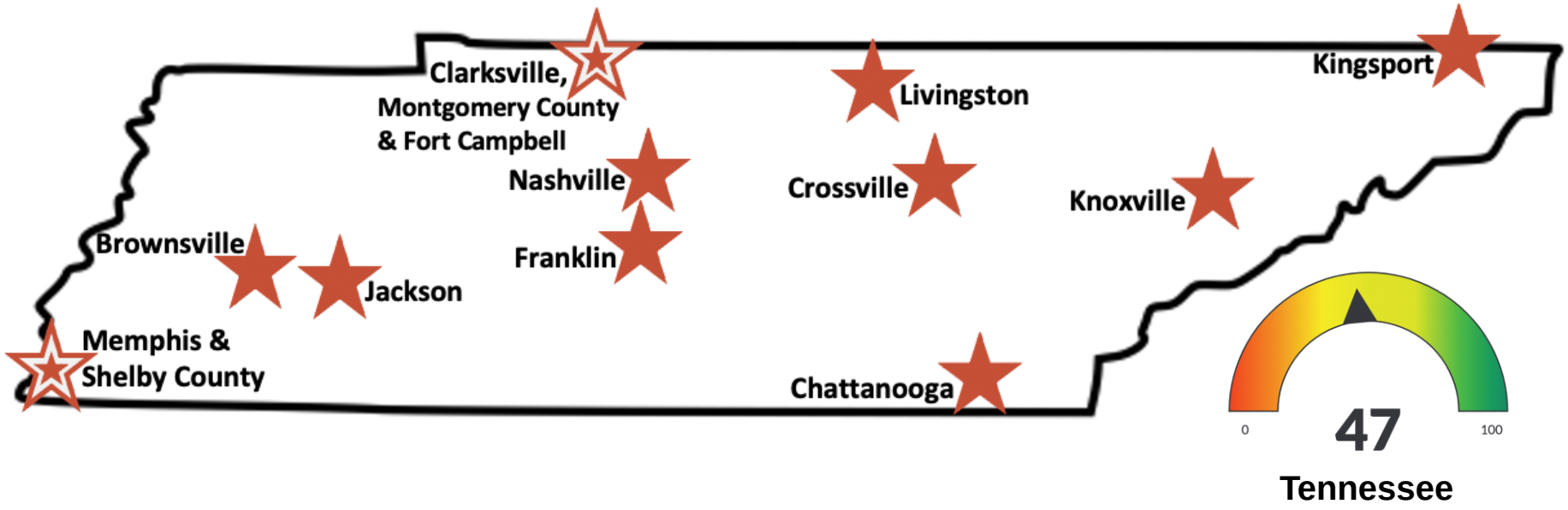
The overall livability index score for **Nashville, Tennessee** is **49**.

Home – AARP Livability Index Nashville, Tennessee – AARP Livability Index

Category Scores: Nashville

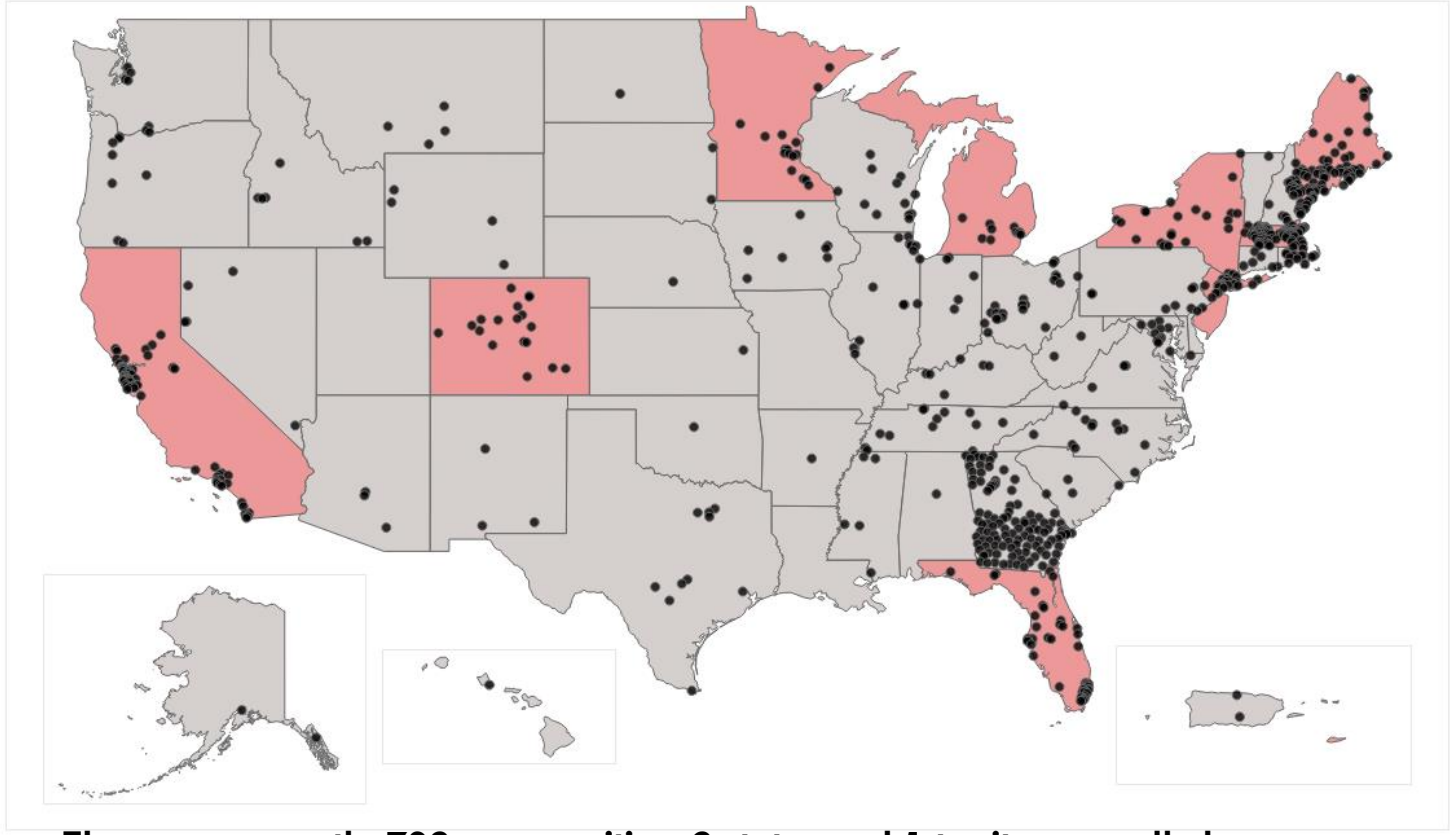


Tennessee Age-Friendly Communities



Age-Friendly Cities: 11 | Age-Friendly Counties: 2

AARP Network of Age-Friendly States and Communities (NAFSC)



There are currently 732 communities, 9 states and 1 territory enrolled

THANK YOU!

Rita Burgett-Martell

coachrita365@gmail.com

Livable Communities Newsletter: aarp.org/livable-newsletter

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EMAIL: tnaarp@aarp.org

National website: www.AARP.org

AARP Tennessee News and Updates:

AARP Tennessee webpage: www.aarp.org/tn

AARP TN Facebook: www.facebook.com/aarptennessee

AARP TN Twitter: www.Twitter.com/aarptn

AARP Tennessee

AARP LIVABLE COMMUNITIES

Preventing Hospital Harm Through Age-Friendly Care

Mariu Duggan, MD, MPH

Associate Professor

Clinical Director of Geriatric Operations, Vanderbilt University Hospital

Critical Illness, Brain dysfunction and Survivorship Center

Veteran Affairs Tennessee Valley Health System GRECC

VANDERBILT UNIVERSITY MEDICAL CENTER

Disclosures

- No conflicts of interest
- This work was supported by the West End Home Foundation

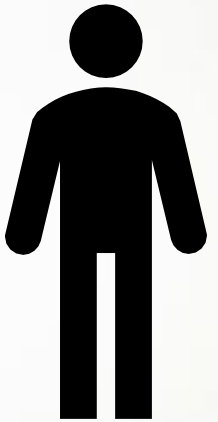
West End Home
FOUNDATION

A community-based charitable foundation that seeks to enrich the lives of older adults through grantmaking, advocacy and community collaboration

Goals

- Describe how creating age-friendly health systems can prevent harm among hospitalized older adults
- Discuss the implementation of the 4Ms of the age-friendly health systems at Vanderbilt University Hospital
- Share resources to promote age-friendly care in health systems

1 in 3 hospitalized adults are ≥ 65 years old



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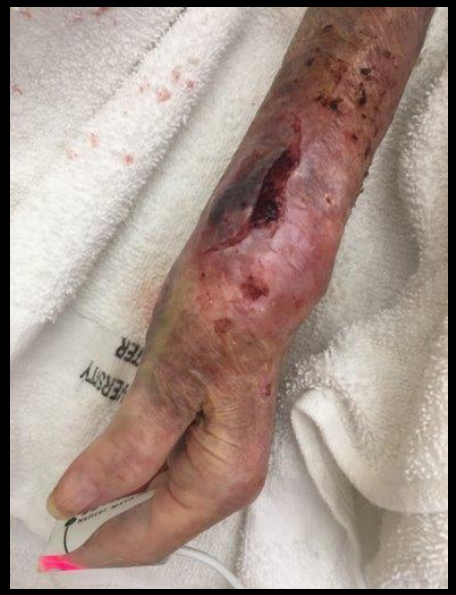
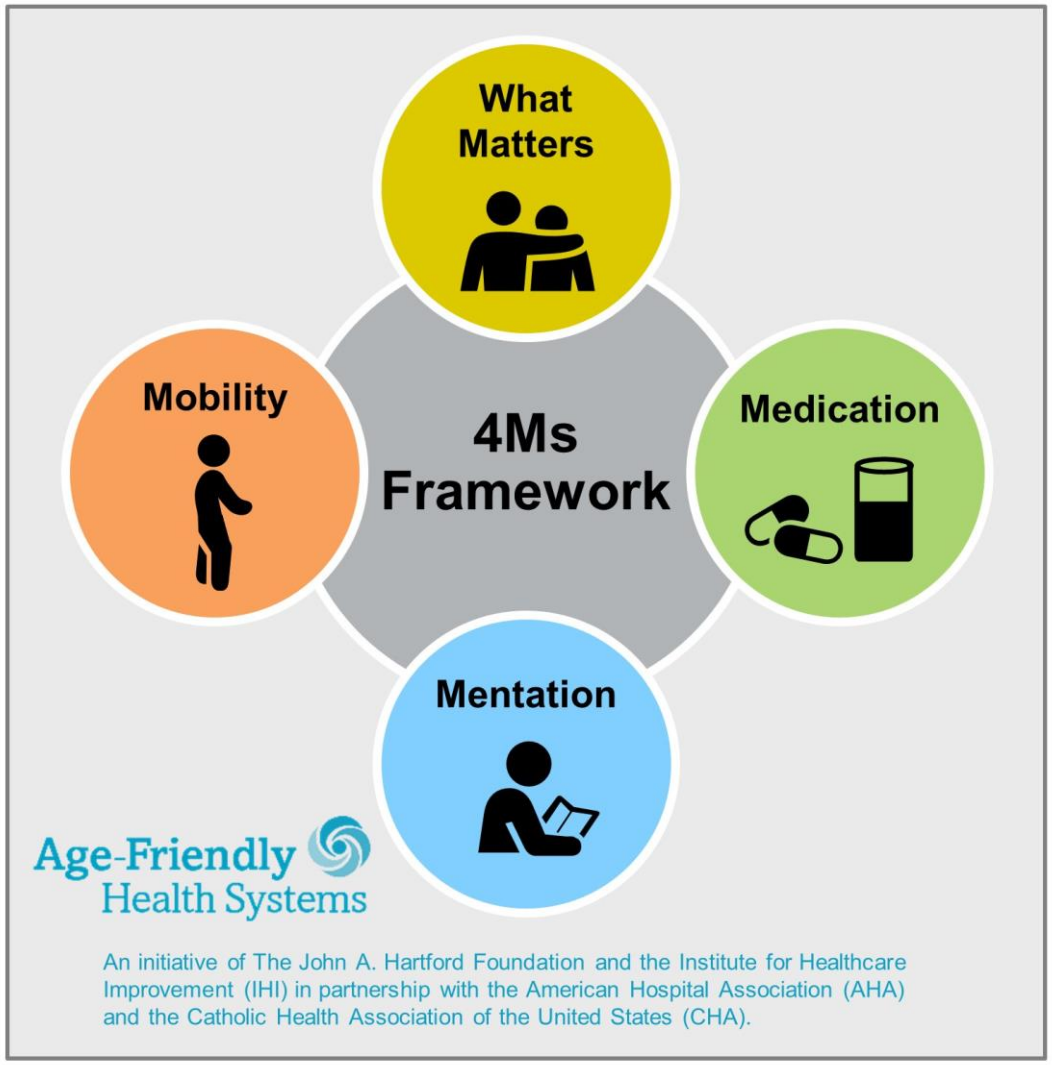
https://www.pbs.org/newshour/health/elderly-patients-hospital-stays-often-worsen-disabilities

RN Provider Notification (last day)

Date/Time	Communication/Event Note	Who
03/08/18 0000	pt becoming CAM positive and trying to crawl out of bed, verbal reorientation failed, had to initate soft restraints	BH




What Matters
Mobility
4Ms Framework
Medication
Mentation
Age-Friendly Health Systems
An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

Age-Friendly Care Aligns with Institutional Priorities

PEOPLE	SERVICE	QUALITY	GROWTH & FINANCE	INNOVATION
↑Provider satisfaction[9] (Mentation)	↑Patient satisfaction[1] (What Matters, Medication)	↓ Falls[8,9] (Mentation)	↓ Inpatient & ICU utilization[1] (What Matters)	Standardize care through clinical pathway
↑Nurse retention[9] (Mentation)	↓Burdensome treatment[3] (What Matters, Medication)	↓Delirium[8] (Mentation)	↓ Cost[4,5,6,7,8] (Mentation, Mobility, Medication)	
	↑Time at home[2] (What Matters)	↓ LOS[5,9] (Mentation, Mobility)		Recognitions: -Age-friendly - JCAHO delirium certification
		↓O/E (Medication)		

[1]AHRQ, 2013; [2]Haas 2018; [3]Tinetti 2019; [4]Klein 2015; [5]Hoyer 2016; [6]HRET 2017; [7]Reuben 2013; [8]Hshieh 2018; [9]Inouye 2006;

Key Actions of Age-Friendly Hospitals

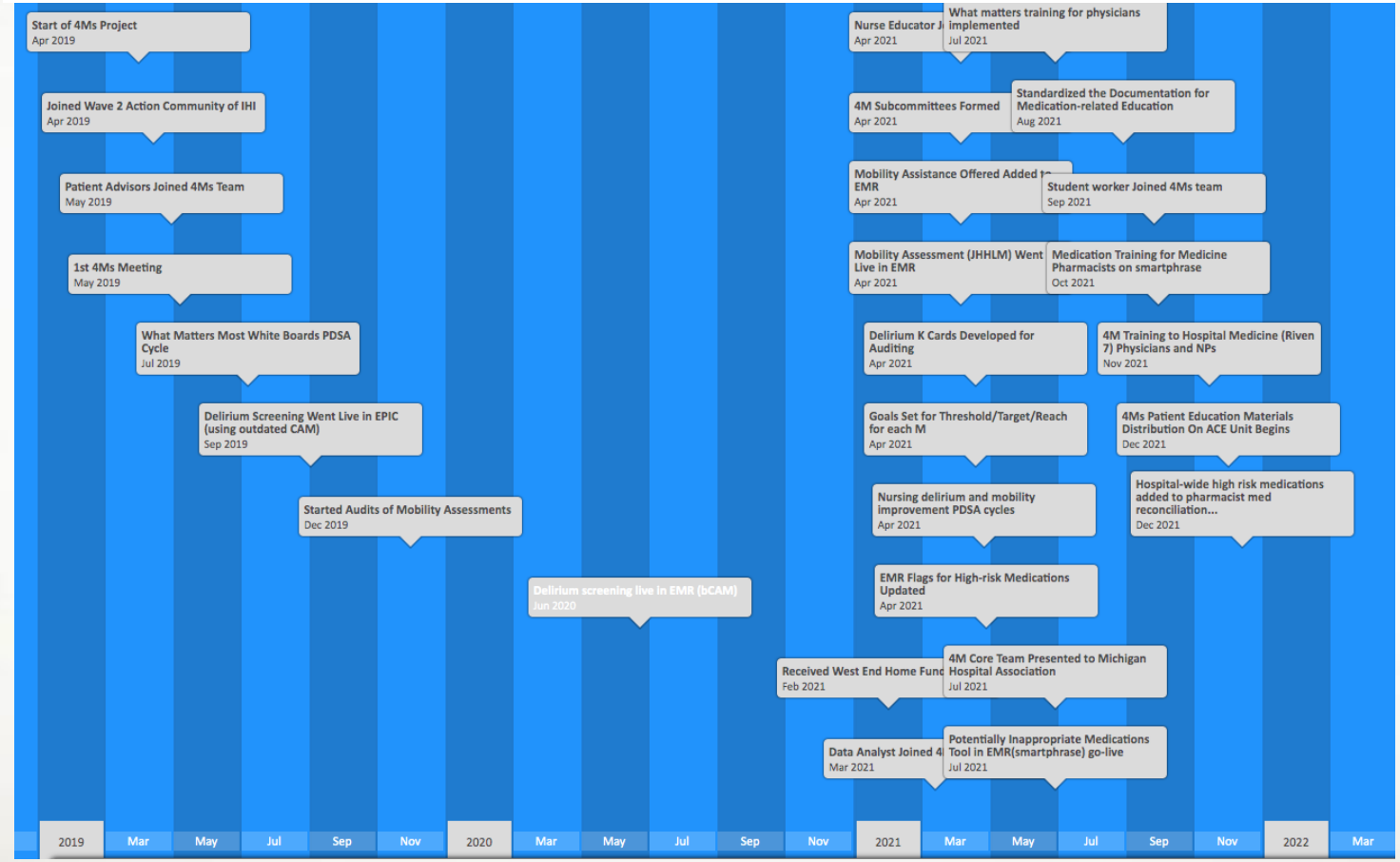
Assess 4Ms	Act on 4Ms
❑ Ask and document What Matters	❑ Align care plan with What Matters
✓ Review for high-risk medication use	❑ Deprescribe if appropriate
❑ Screen for delirium every 12 hours	❑ Ensure hydration, orientation, glasses, hearing aids, sleep protocol
❑ Screen for mobility limitations	❑ Mobilize early, frequently, safely

www.ihi.org/engage/initiatives/age-friendly-health-systems

Pilot Site: VUH Acute Care for Elders Unit (ACE)

- 22-bed Acute care for elders (ACE) Unit for medical patients ≥65 years
- Daily interdisciplinary bedside rounds (Pharmacy, nursing, clinicians)
- Weekday discharge huddles
  - Case management
  - Social work
  - PT/OT
  - Dietician
  - Discharge coordinator
  - Clinician
- Geriatrician-led provider teams

Project Timeline: Apr 2019 – Mar 2022



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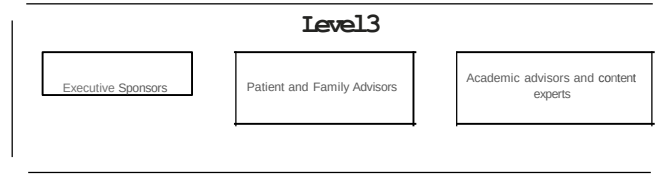
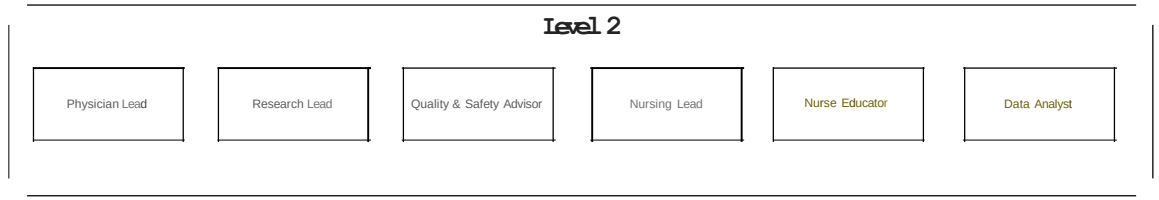
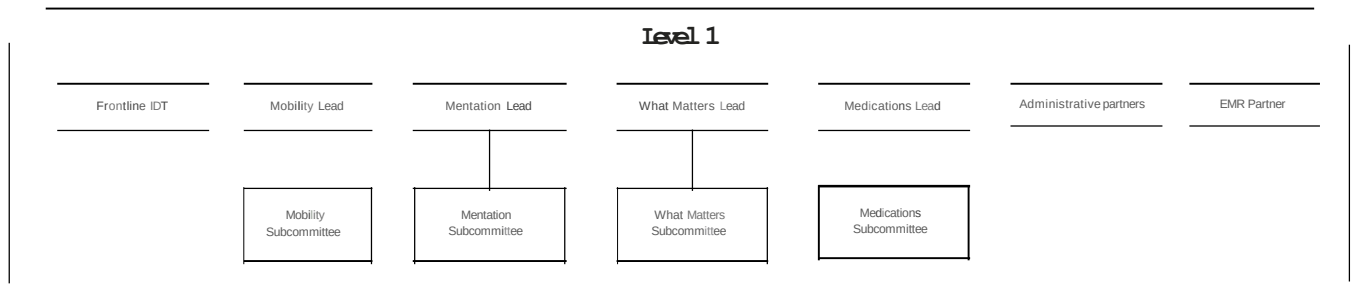
Age-Friendly Team







Level 1: This consists of frontline healthcare workers and support staff who contribute to finding the best way to implement the 4Ms that ensures patient safety and optimizes work/lows. Each subcommittee has at least one lead who coordinates the regular meetings of each subcommittee. The subcommittees decide on the best goals and workflows for each M.

Level 2: This consists of the core team that meets weekly to review 4M data and to plan PDSA cycles. The Nurse Educator coordinates PDSA cycles in regards to each Mand trains all nursing staff specifically in mentation and mobility protocols. The Nurse Educator and Data Analyst roles were added with the help of a one-year community grant and have resulted in acceleration of uptake of the 4Ms.

Level 3: This consists of the patient and family advisors, nursing and medical leaders of the inpatient medicine units, and various academic advisors and content experts.


What
Matters
VANDERBILT


What
Matters
Face Shield
Clean Hands
Save Lives


Medication


obilit

Mentation

Developed and implemented delirium prevention, screening, and management protocol

CIBS CENTER | ICUDelirium.org | CIBS@vumc.org

Delirium Toolbox

Delirium is a medical condition that increases length of stay, risk of death, functional decline, healthcare cost, caregiver burden, and impaired quality of life. The Delirium Toolbox is low-cost, efficient option of nonpharmacological tools to use in delirium prevention and management.

A Recipe to Build Your Own Toolbox

Sensory Improvement
- Hearing aid batteries
- Eyeglass wipes
- Reader glasses
- Magnifier

Engagement of Family
- Puzzles
- Crayons
- Playing cards
- Large print word search or crossword puzzle
- Stuffed animal

Sleep Promotion
- Eye masks
- Ear plugs
- Relaxation TV channel

Hydration/Nutrition
- Nutritional supplement drinks
- Denture adhesive and cleaner

Mobilize/Manage Pain
- Beers Medication List pocket card

Environment
- Light switch (reminder to turn lights on and open shades during day and turn off/close at night)

Additional Information and Resources
- bCAM badge buddies can be requested from 7RW
- Volunteer Services at VUH has items available such as blankets, activity books, magazines, etc. that are provided free of charge to units
- *Boost Nutritional Supplement* and Comfort Kits (includes eye mask and ear plugs) are available on all units
- Hearing aid batteries can be purchased using a Vanderbilt discount at *Batteries and Bulbs*

4Ms Key Actions: Where are we now?

Assess 4Ms	Act on 4Ms
✓Ask and document What Matters	✓ Align care plan with What Matters
✓Review for high-risk medication use	✓ Deprescribe if appropriate
✓Screen for delirium every 12 hours	✓ Ensure hydration, orientation, glasses, hearing aids, sleep protocol
✓Screen for mobility limitations	✓ Mobilize early, frequently, safely

www.ihi.org/engage/initiatives/age-friendly-health-systems

Institute for Healthcare Improvement

Improving Health and Health Care Worldwide

SEARCH

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- What Is an Age-Friendly Health System? »
- Join the Movement »
- Recognition »
- Health Systems Recognized by IHI »
- Why Become an Age-Friendly Health System? »
- **Resources** →
- In the News »
- Team, Faculty, & Advisors »

Age-Friendly Health Systems

An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

SHARE

Resources to Practice Age-Friendly Care

Contents:

1. Getting Started Guides
2. The 4Ms Framework
3. Making the Case for Age-Friendly Health Systems
4. Working with Older Adults
5. Case Studies and Media
6. Ensuring Equity in Age-Friendly Care

Upcoming Action Communities

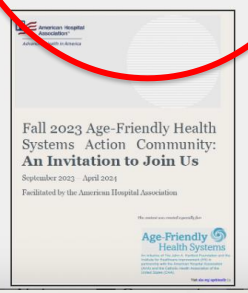
American Hospital Association

Registration Open

Beginning Fall 2023

Sign up here

Click the *Invitation to Join* to learn more.



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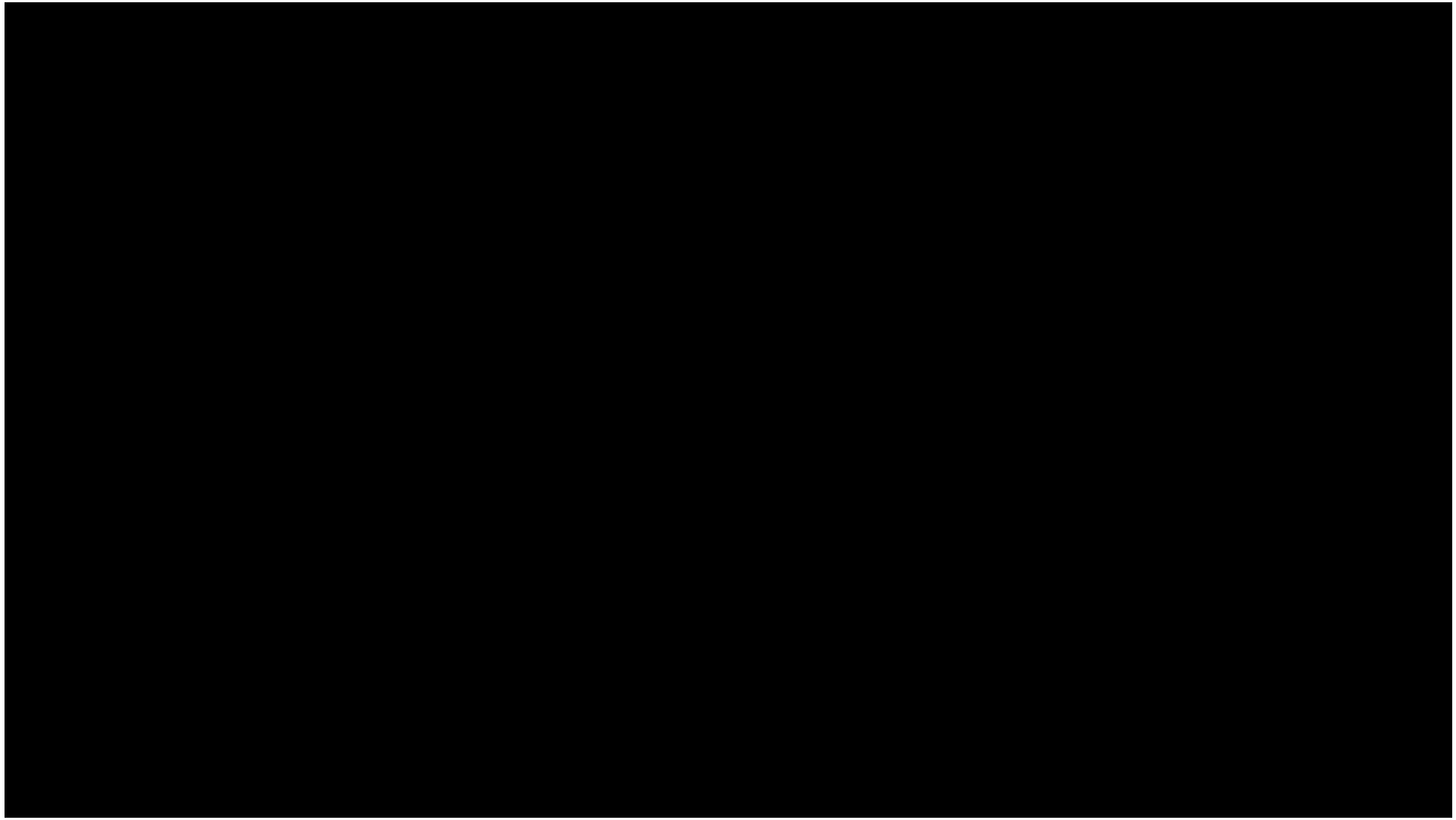
Questions?

Mariu.duggan@vumc.org



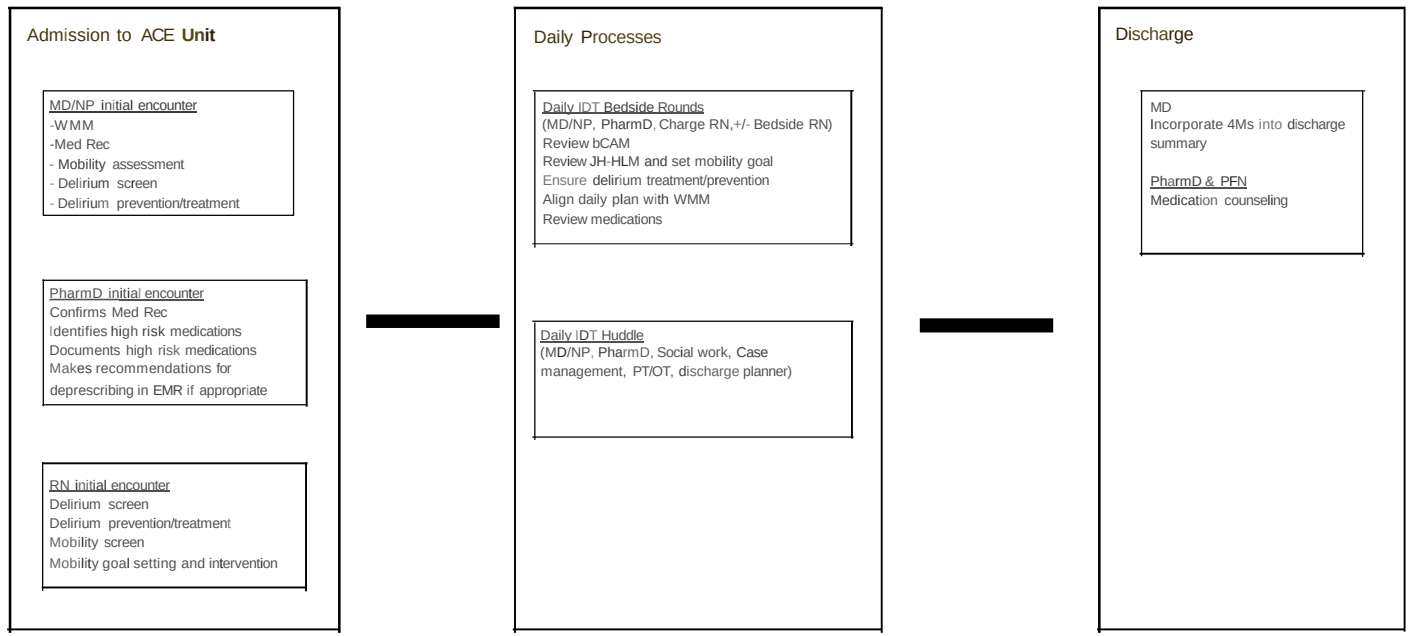
Supplement

- Workflows
- Protocols
- 4M Run charts

Workflows

- Miro Board

Overview of 4Ms Workflow



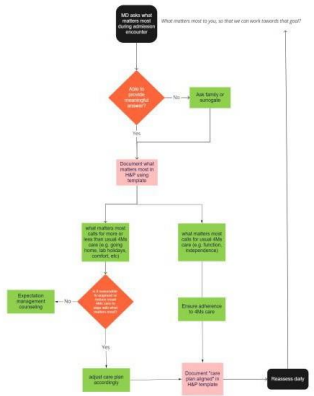
PERII,' T IVERSITY

D L ENTE

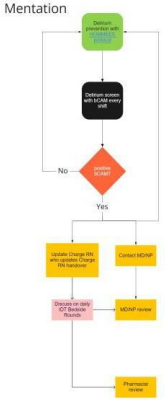
4M Workflows

Workflow by each "M"

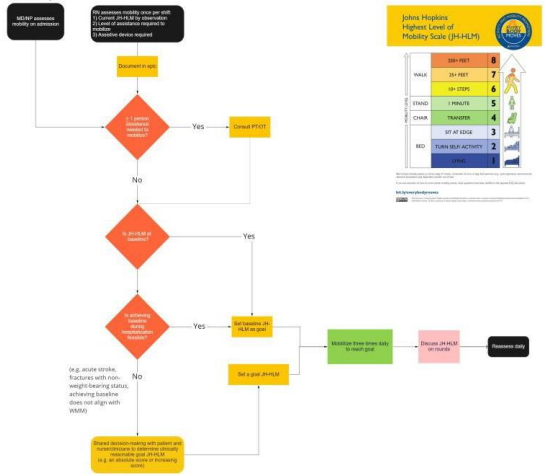
What Matters



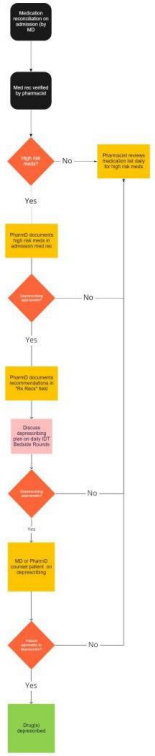
Mentation



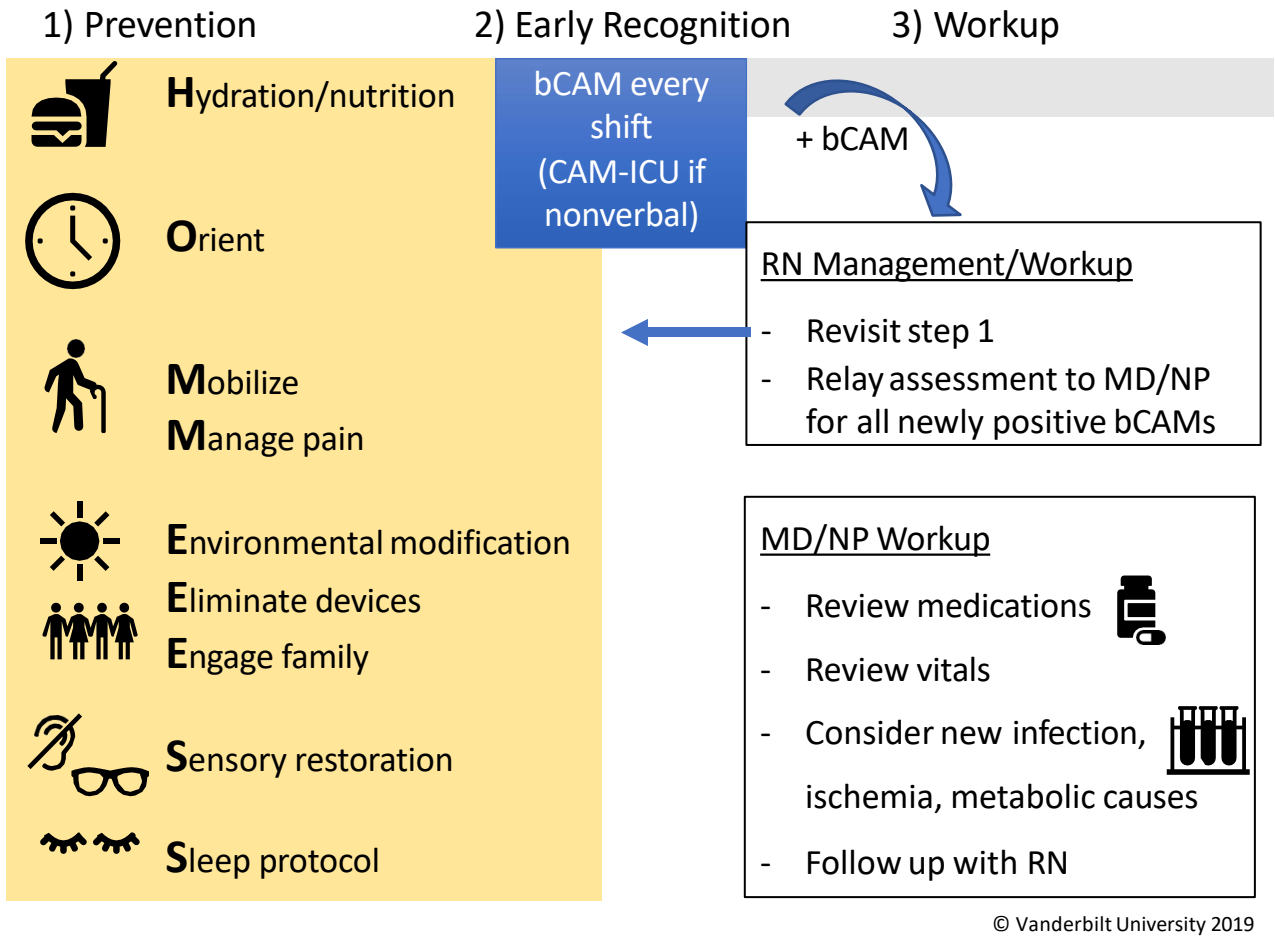
Mobility



Medication



Delirium Care: Nursing Protocol



Delirium Care: Pharmacist Protocol

1) Prevention and Identification

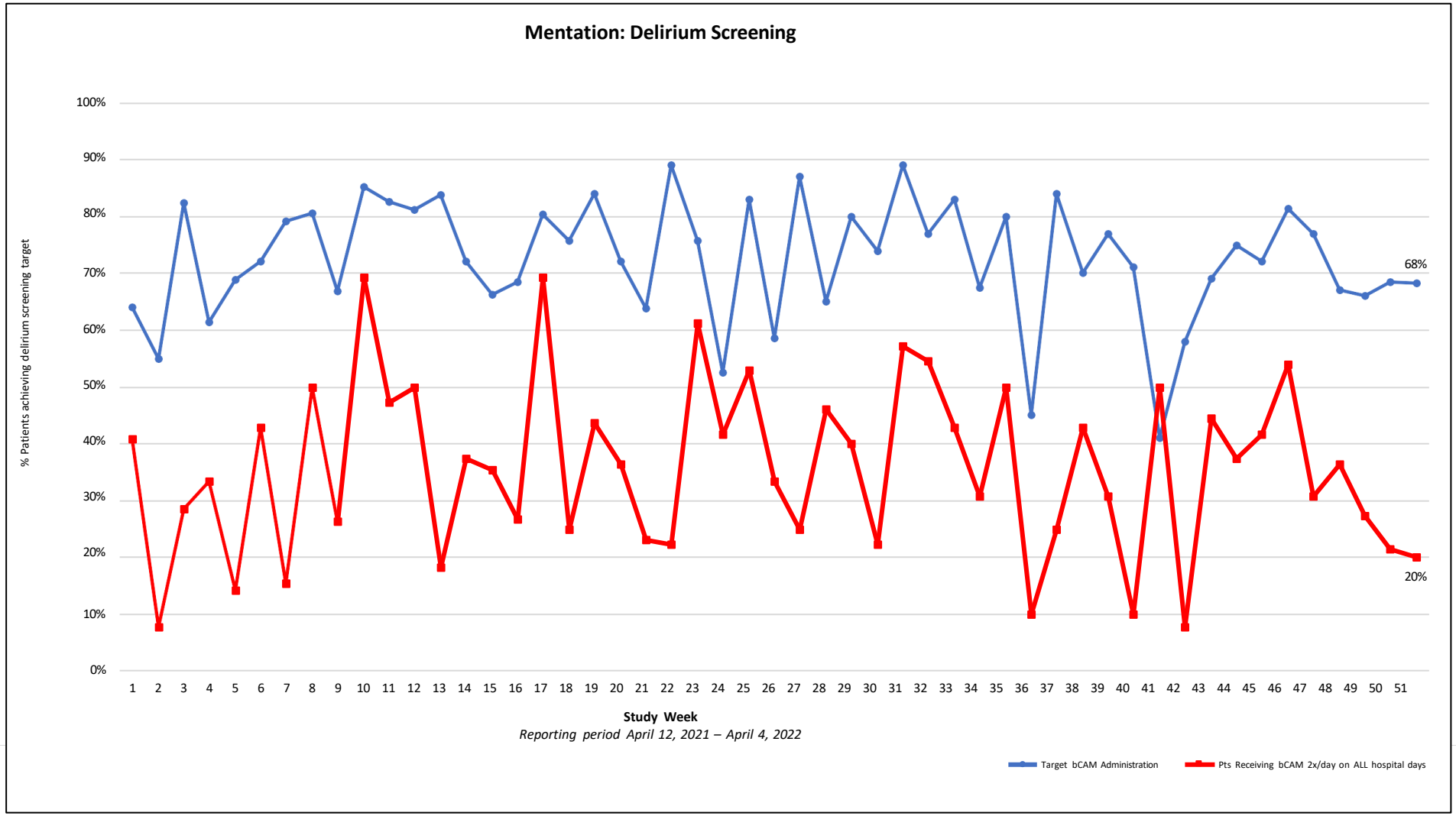
Medication-reconciliation, **A**void deliriogenic meds, **M**anage pain, **E**liminate IV drugs if possible

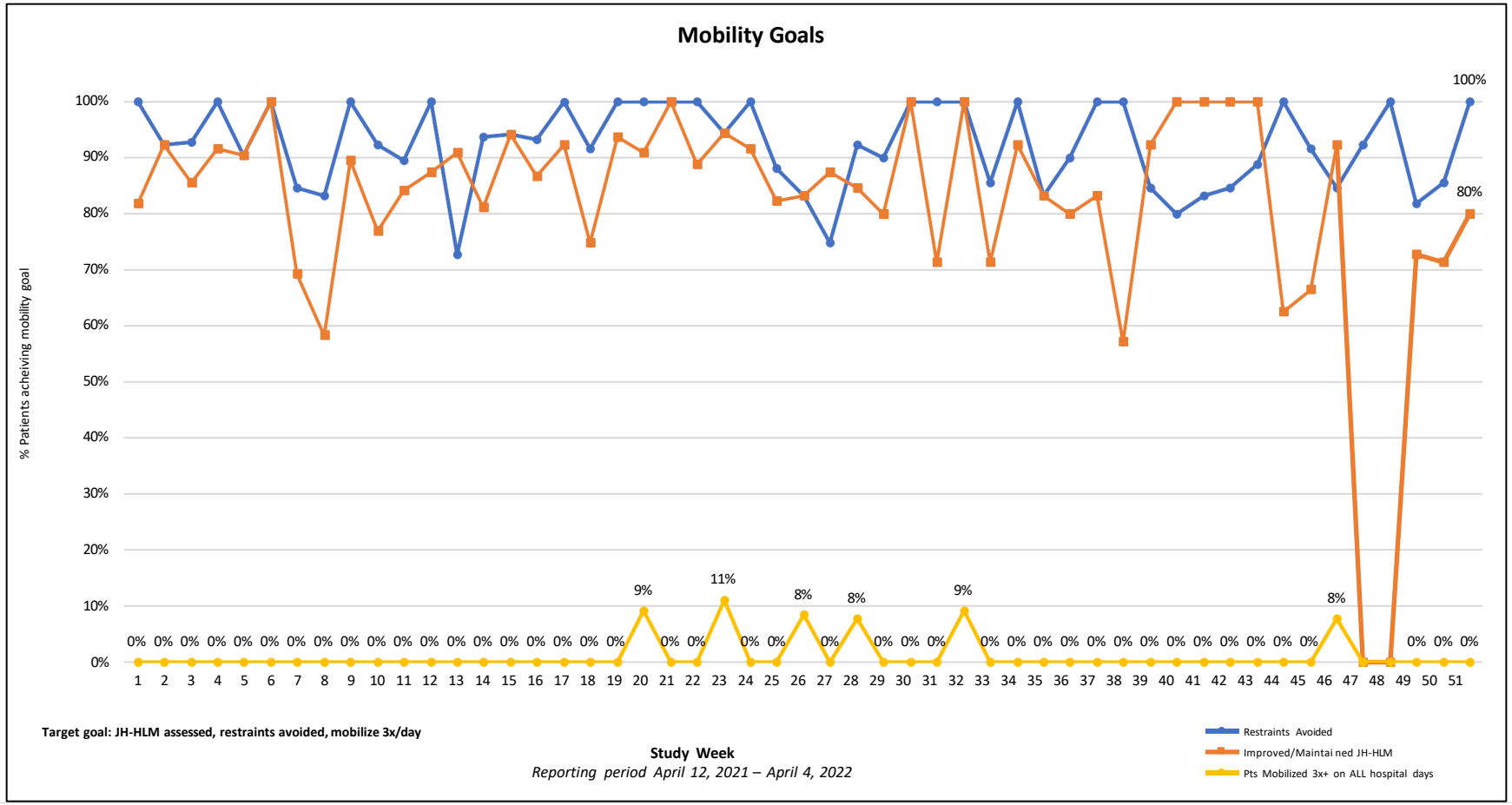
Non-pharmacologic prevention bundle

RNs screen for delirium every shift using bCAM. If bCAM+, RN revisits non-pharmacologic bundle and relays newly positive bCAM to MD/NP

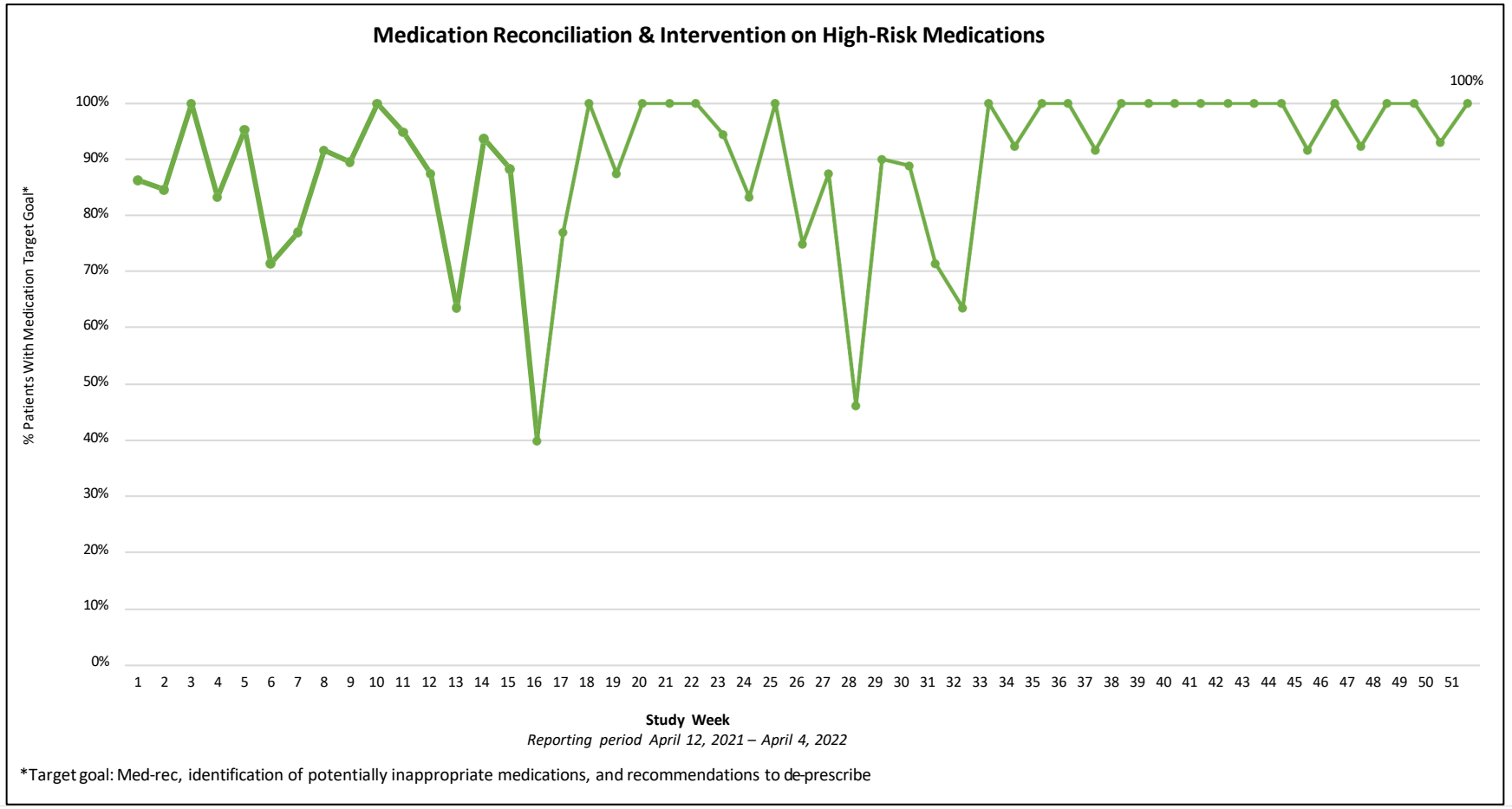
2) Workup and Treatment

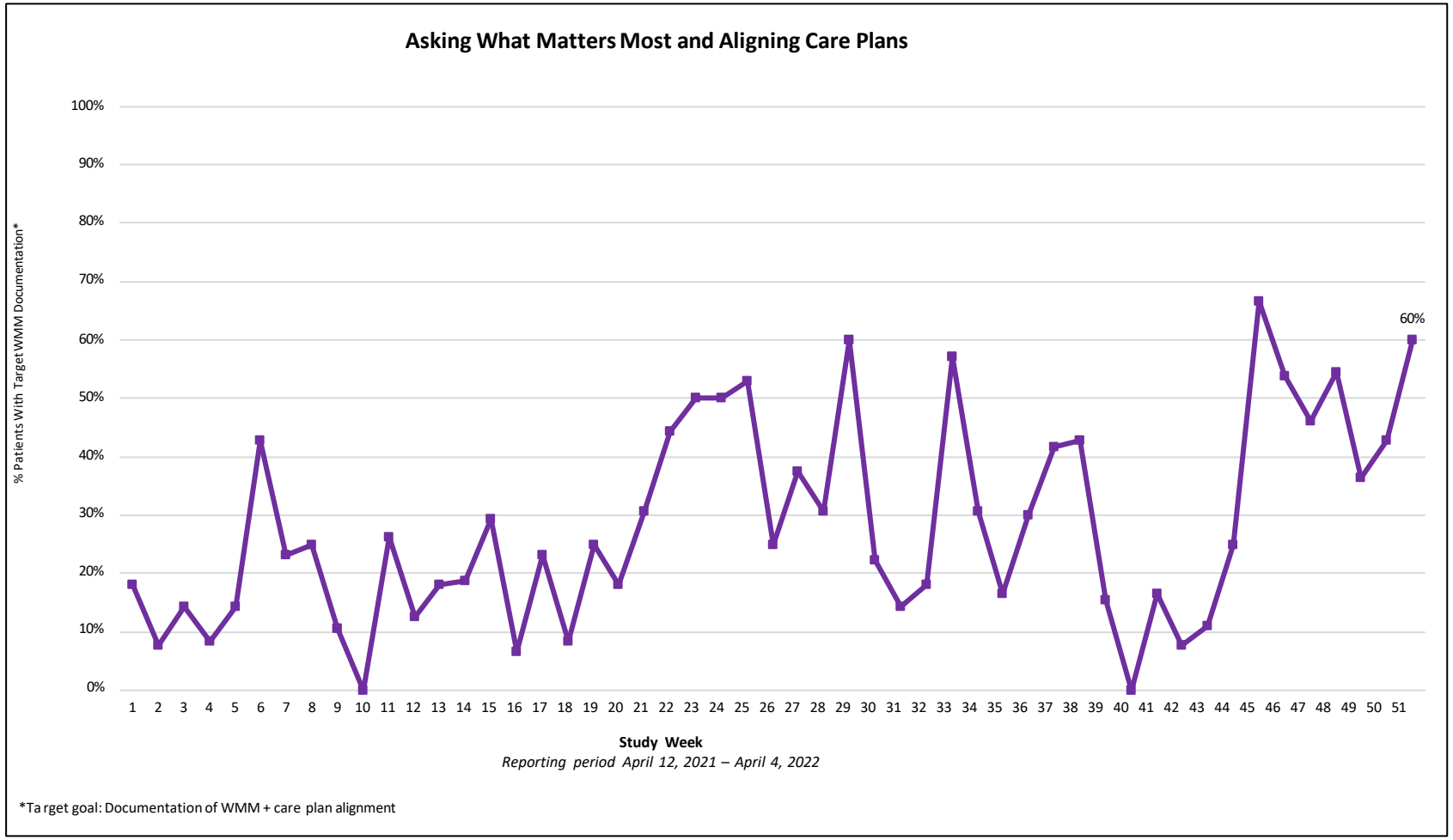
- Assess for contributing medications and stop if possible:
  - Analgesics
  - Antibiotics/antivirals
  - Anticholinergics
  - Anticonvulsants
  - Antidepressants
  - Cardiac (clonidine, digoxin, diuretics)
  - Corticosteroids
  - Dopamine agonists
  - H2 blockers, antiemetics, antispasmodics
  - Benzodiazepines
  - Muscle relaxants
  - Lithium
- Ensure adequate bowel regimen
- Ensure adequate pain regimen
- Follow up with RN and MD/NP
- <u>Only use drugs for behaviors that threaten safety of patient or staff; use lowest dose possible</u>


Mentation: Delirium Screening
% Patients achieving delirium screening target
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
68%
20%
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51
Study Week
Reporting period April 12, 2021 – April 4, 2022
Target bCAM Administration
Pts Receiving bCAM 2x/day on ALL hospital days



*Due to EMR changes, week 47 and 48 of JHHLM and patient mobilization are omitted


Medication Reconciliation & Intervention on High-Risk Medications
100%
% Patients With Medication Target Goal*
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51
Study Week
Reporting period April 12, 2021 – April 4, 2022
*Target goal: Med-rec, identification of potentially inappropriate medications, and recommendations to de-prescribe


Asking What Matters Most and Aligning Care Plans
% Patients With Target WMM Documentation*
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
60%
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51
Study Week
Reporting period April 12, 2021 – April 4, 2022
*Target goal: Documentation of WMM + care plan alignment

Policy Initiatives to Support Older Adults & Caregivers in the Community

Chris Reeder Young, Memphis Habitat for Humanity

CJ Sentell, Nashville Food Project

Jessica Dauphin, Transit Alliance of Middle TN

Habitat for Humanity of Greater Memphis

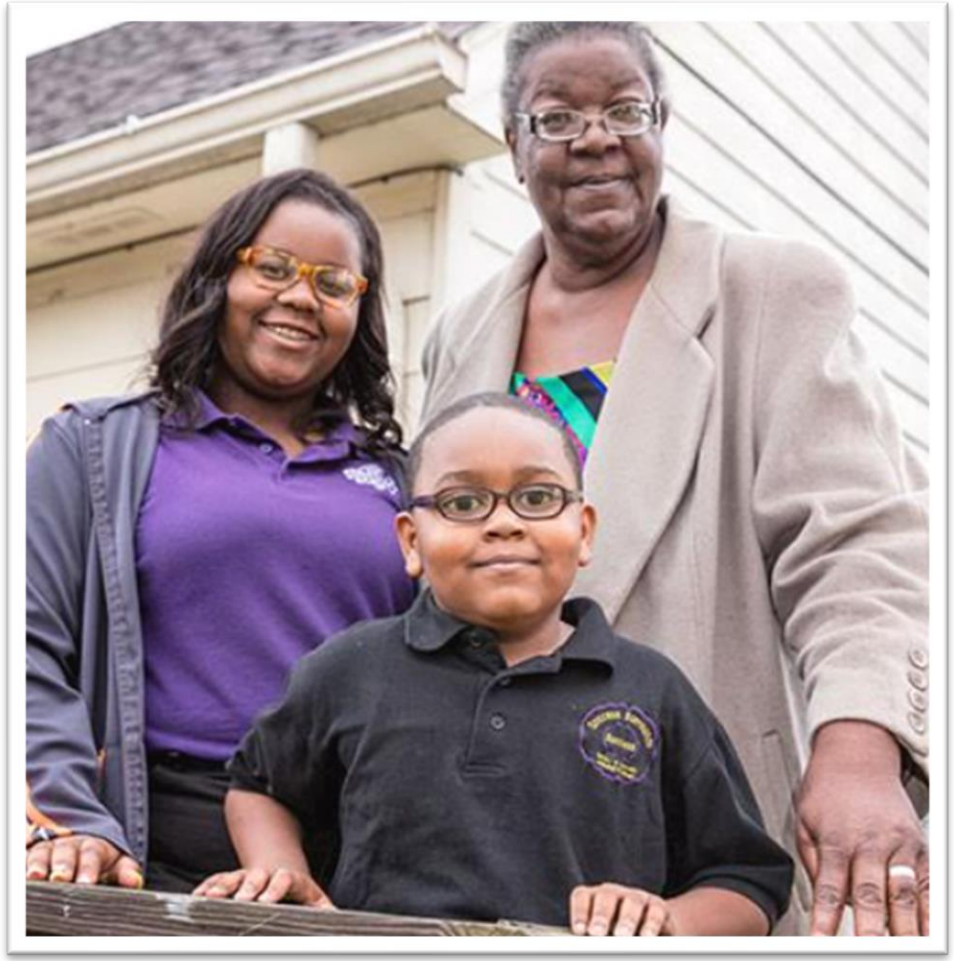
Chris Reeder Young, MA
Director of Research and Policy
37th Geriatric Conference
Session: Policy Initiatives to Support Older Adults and Caregivers in the Community

Habitat for Humanity of Greater Memphis

Preserving Affordability, Ensuring Equity, Promoting Policy

1983-Now: Homeownership

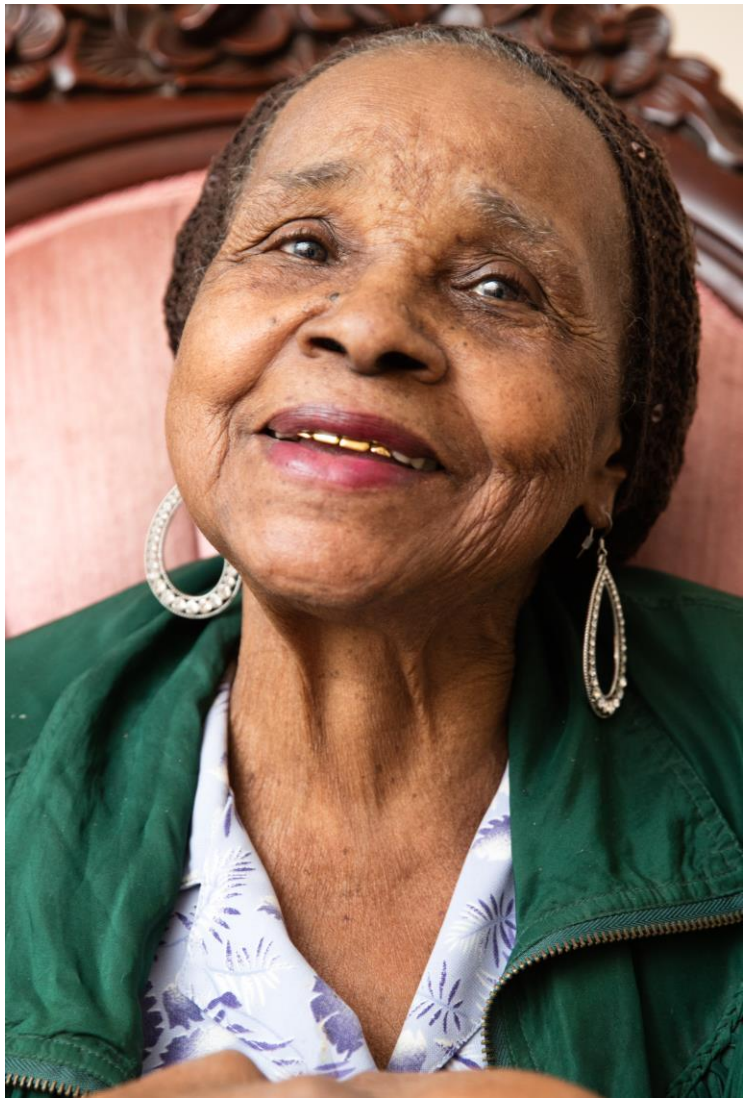
- 600+ New Homeowners
- Neighborhood Revitalization
  - Carter Work Project 2015
  - Community business facades & public art
  - Historical and business repairs



2011-Now: Aging In Place

- 1,400+ Older Adults
  - Aging In Place (local)
  - SeniorTrust (statewide)
  - Housing Plus Models

Habitat for Humanity of Greater Memphis



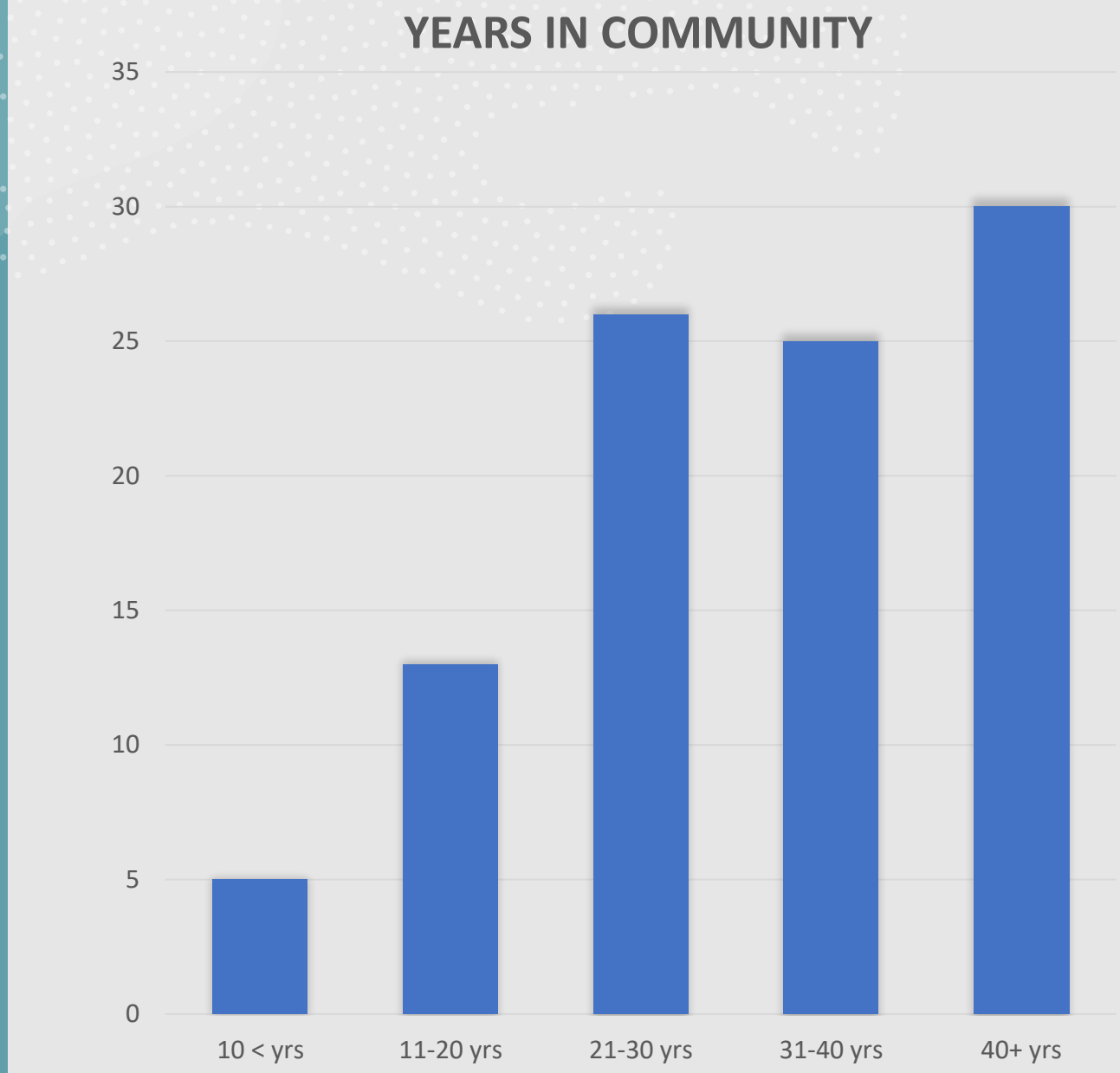
Promoting Better Policy Means Providing Authentic Evidence

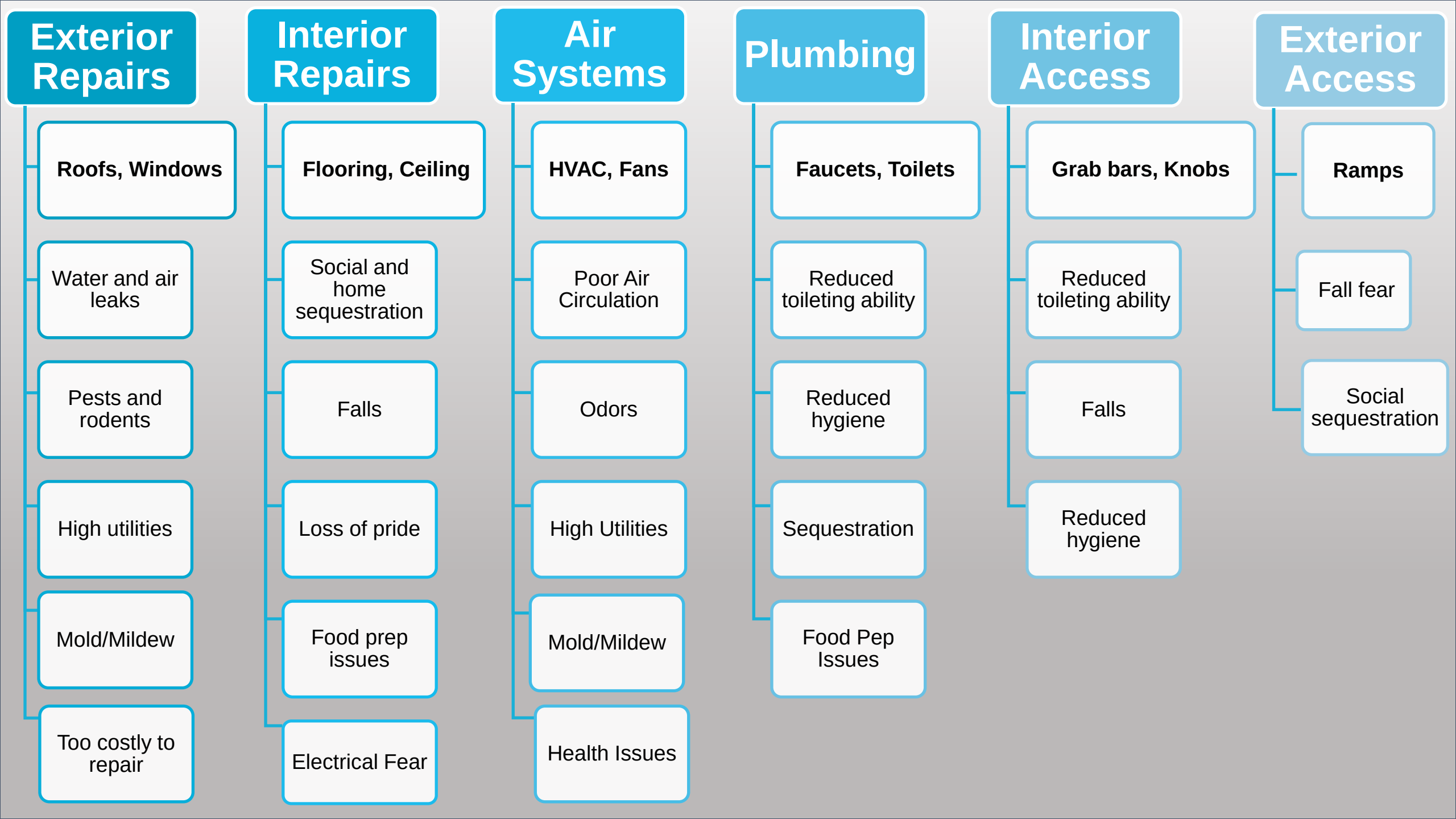
Qualitative + Quantitative Landscapes

Senior Trust: $13 million grant provided over 1400 statewide seniors with aging in place critical home repairs and accessibility modifications so they could remain in the beloved homes and communities safely.

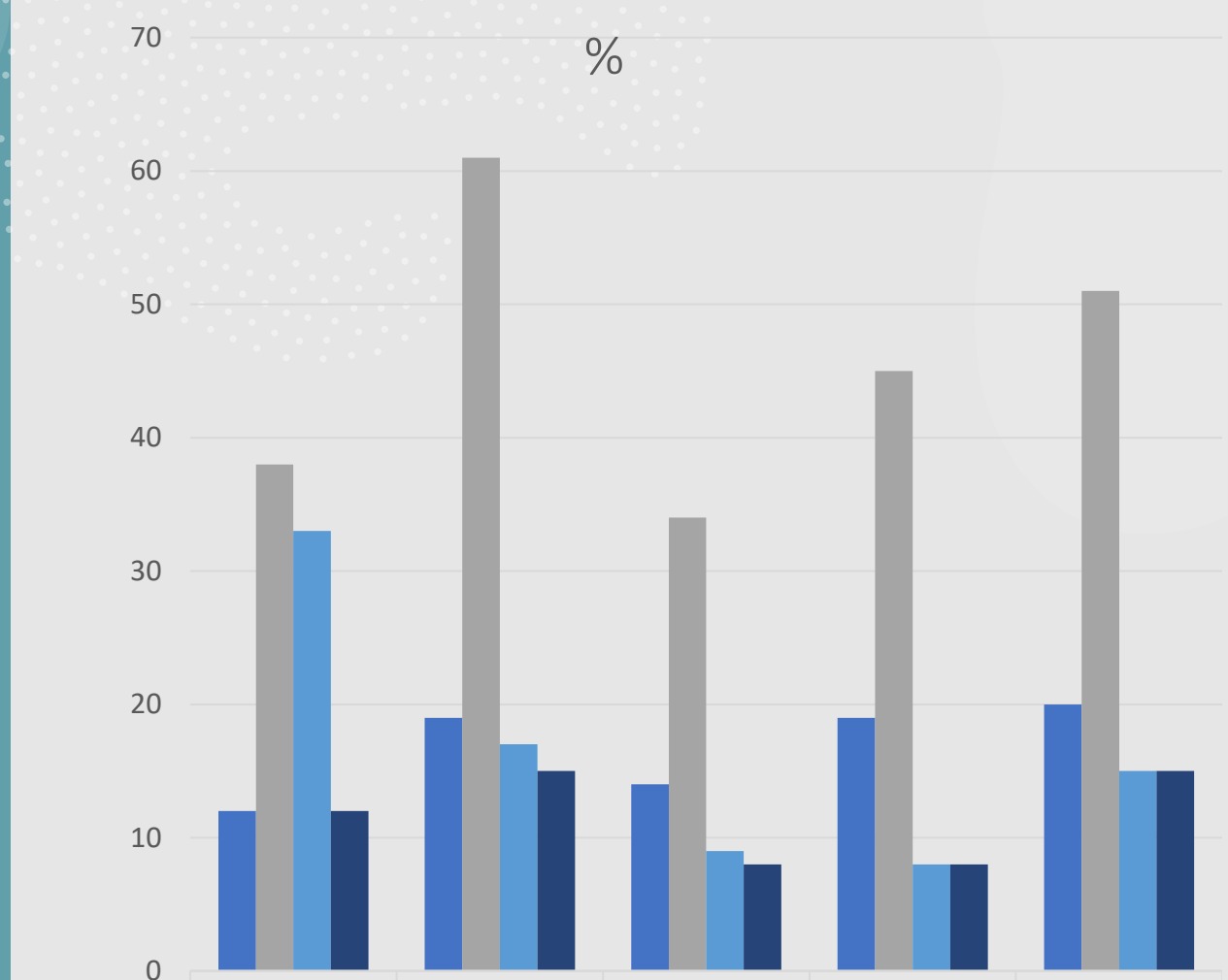
Habitat conducted 3000 qualitative longitudinal surveys + Green and Healthy Homes Initiative analyzed healthcare utilization data via Tenncare + UT in Memphis measured Activities of Daily Living pre/post repairs

Aging In Place also refers to seniors' abilities to remain in their beloved communities. This is where sustainable social capital and connections to anchors and amenities take place. This is pivotal for caretakers who are also managing multi-generational tasks.




Exterior Repairs
Roofs, Windows
Water and air leaks
Pests and rodents
High utilities
Mold/Mildew
Too costly to repair
Interior Repairs
Flooring, Ceiling
Social and home sequestration
Falls
Loss of pride
Food prep issues
Electrical Fear
Air Systems
HVAC, Fans
Poor Air Circulation
Odors
High Utilities
Mold/Mildew
Health Issues
Plumbing
Faucets, Toilets
Reduced toileting ability
Reduced hygiene
Sequestration
Food Pep Issues
Interior Access
Grab bars, Knobs
Reduced toileting ability
Falls
Reduced hygiene
Exterior Access
Ramps
Fall fear
Social sequestration

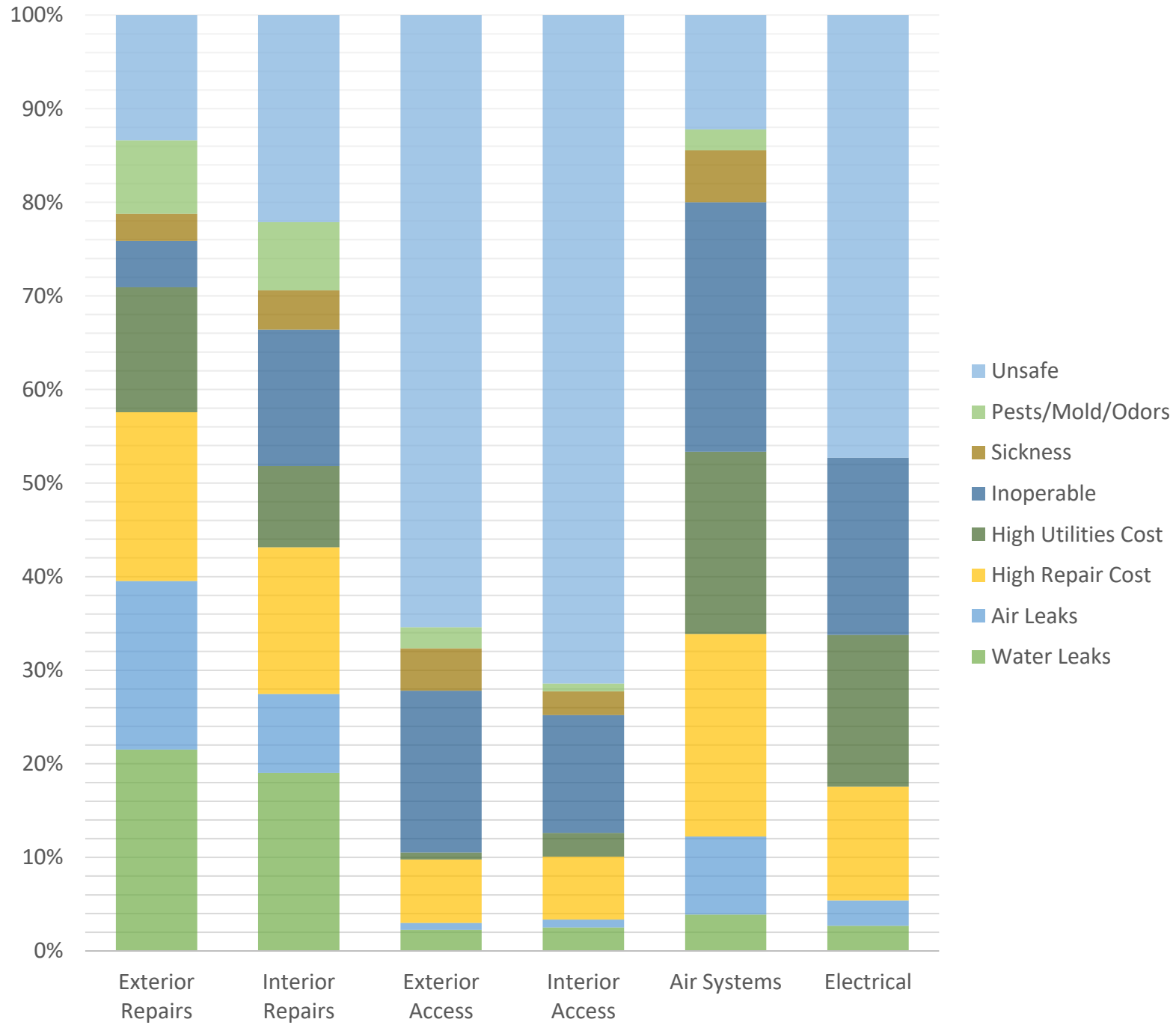
How many years had AIP clients been actively awaiting repair and accessibility assistance?



	Exterior Repairs	Interior Repairs	Exterior Access	Interior Access	Plumbing and Electrical
< 1 Year	12	19	14	19	20
1-5 Years	38	61	34	45	51
6-10 Years	33	17	9	8	15
10+ Years	12	15	8	8	15

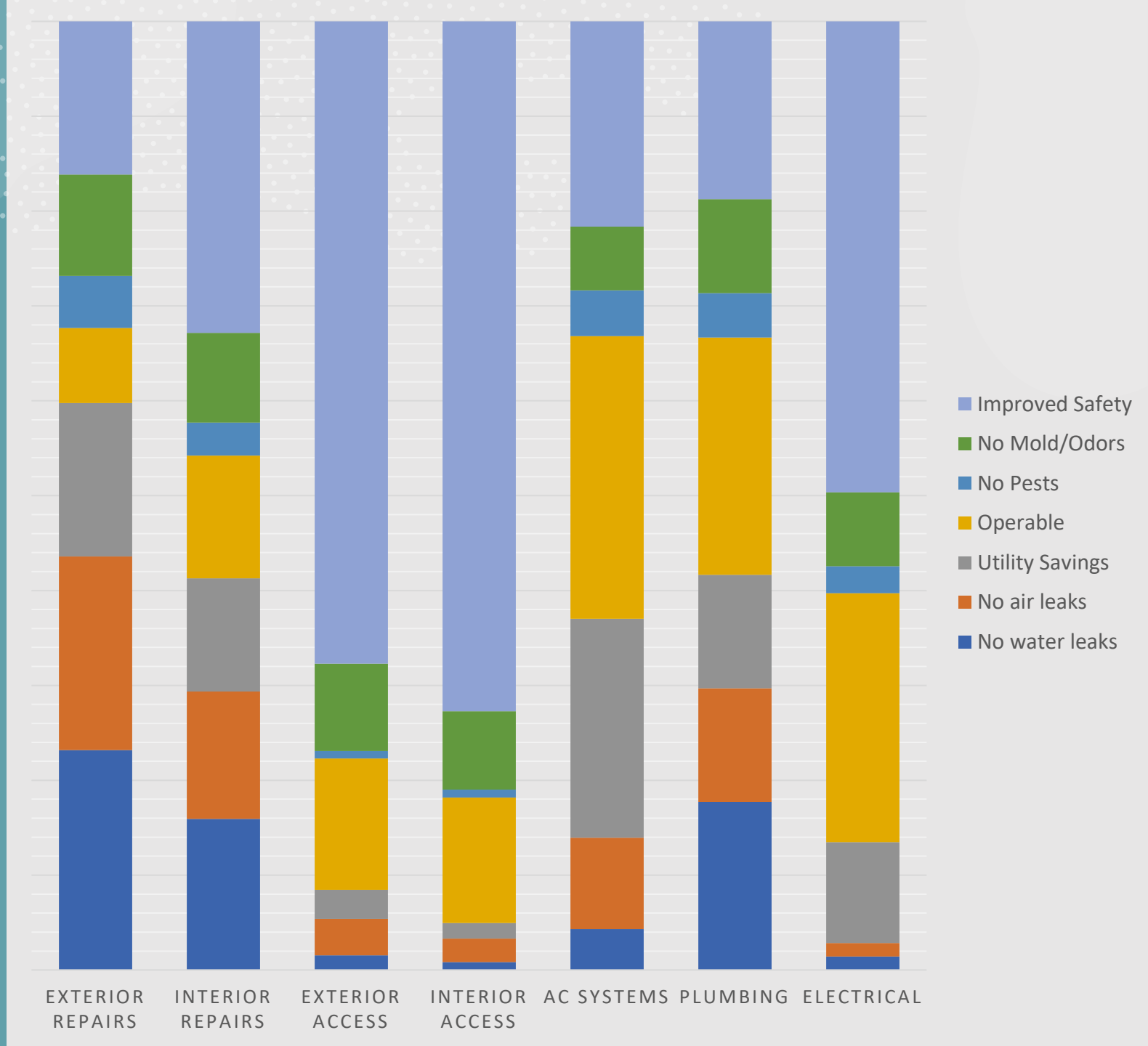
In what ways were deferred repairs and accessibility needs impacting seniors' daily lives?

*non-mutually exclusive impacts



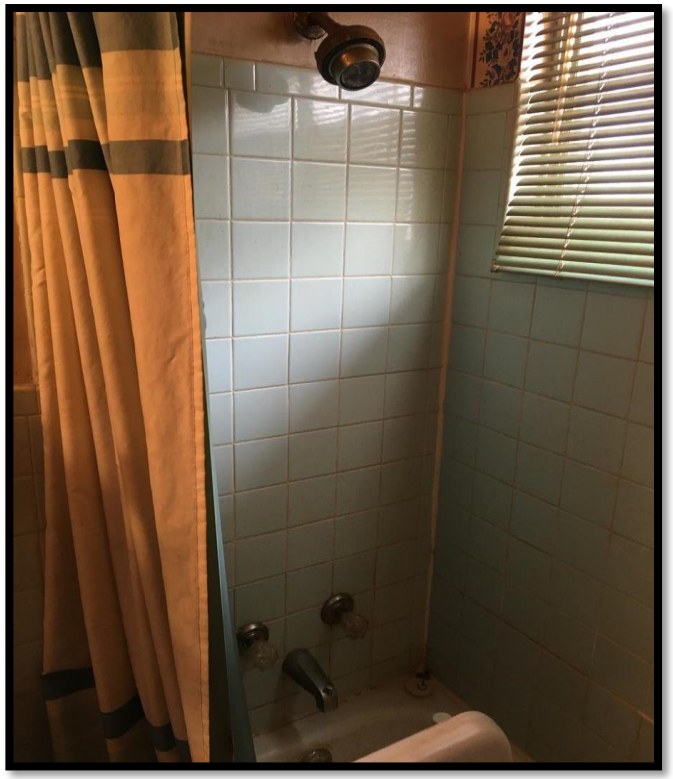
Habitat for Humanity of Greater Memphis

Seniors experienced an array of short and long term impacts post-intervention

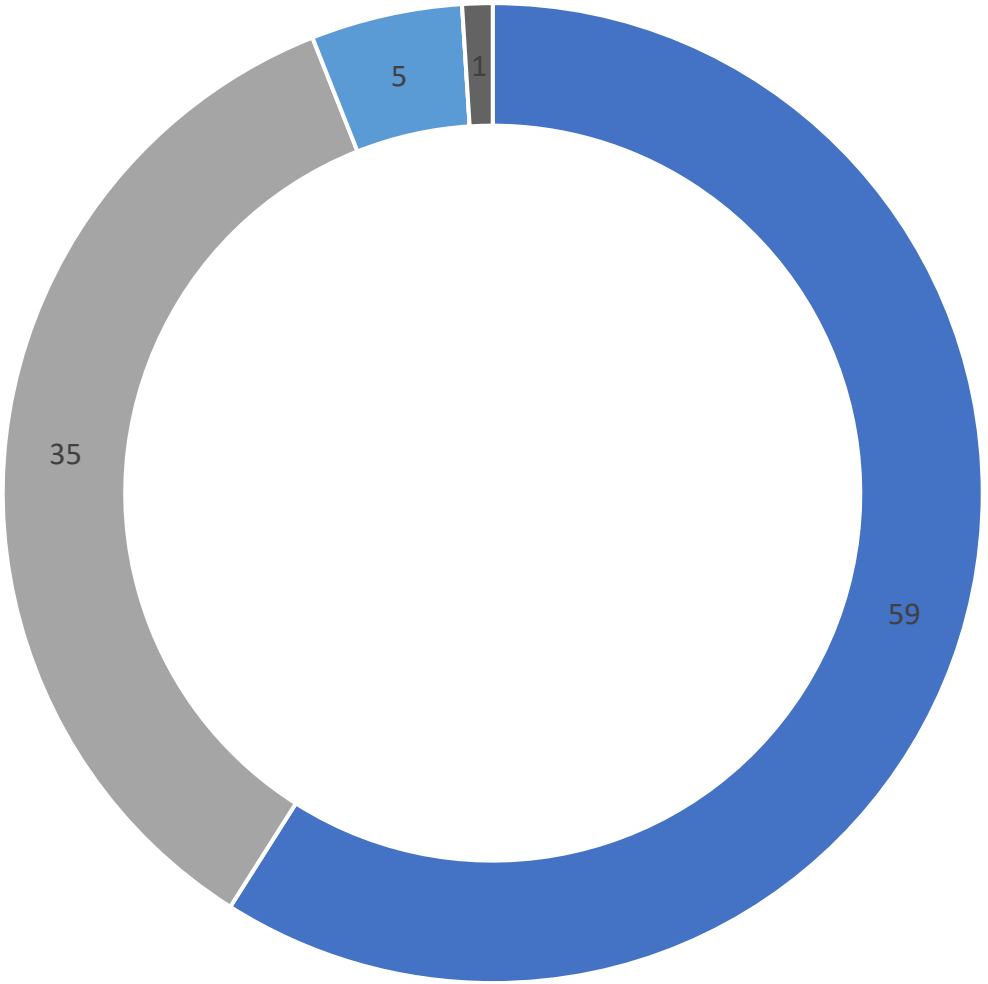


Habitat for Humanity of Greater Memphis

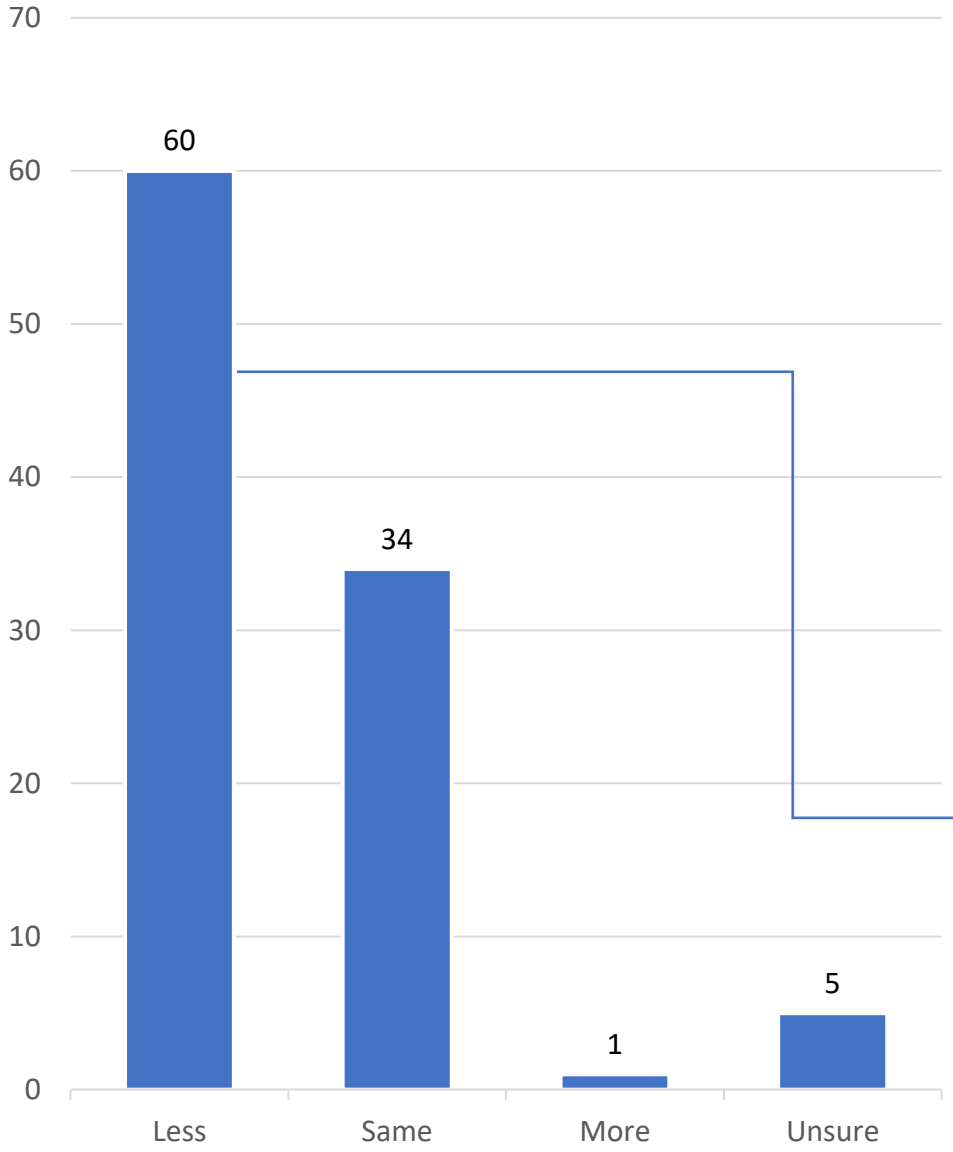
	NEITHER	NA	POSITIVE	NEGATIVE
–Safer	0%	0%	99%	1%
–Healthier	1%	0%	98%	1%
–Visitor Safety	2%	1%	96%	1%
–Visitor Health	2%	1%	96%	1%
–Remain in Home	1%	0%	98%	1%
–Quality of Work	1%	0%	98%	1%
–Respect/Habitat	0%	0%	100%	0%
–Respect/Contractors	1%	1%	97%	1%
–Pride in Home	2%	0%	97%	1%
–Recommend to others	0%	0%	99%	1%
–Good Community	5%	2%	91%	2%
–More Visitors	19%	12%	56%	13%
–Less Likely to Fall	2%	30%	67%	1%
–Less Likely to Fall Outside	2%	66%	32%	1%

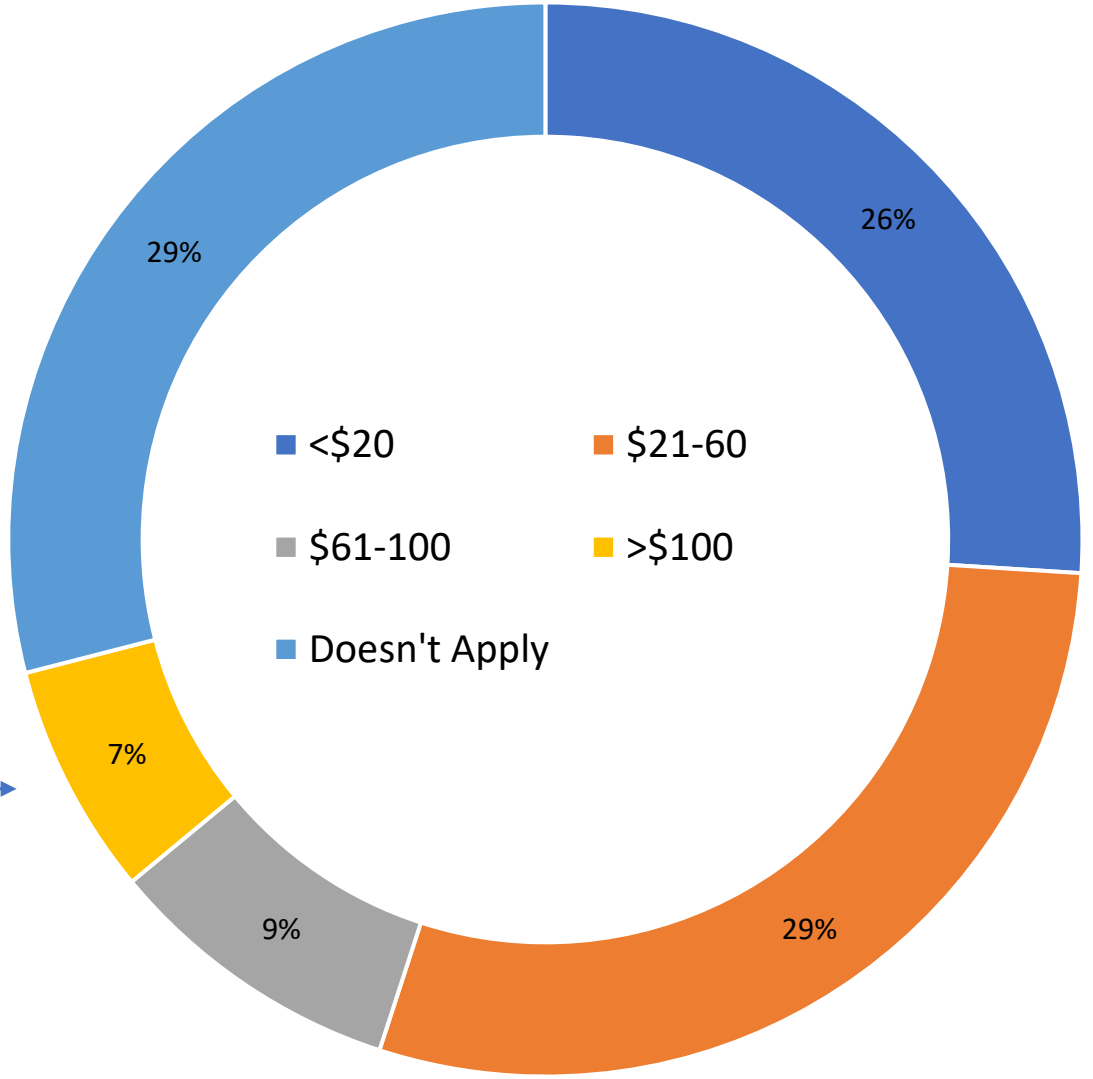


Do you think that your home is a healthier place than it was?

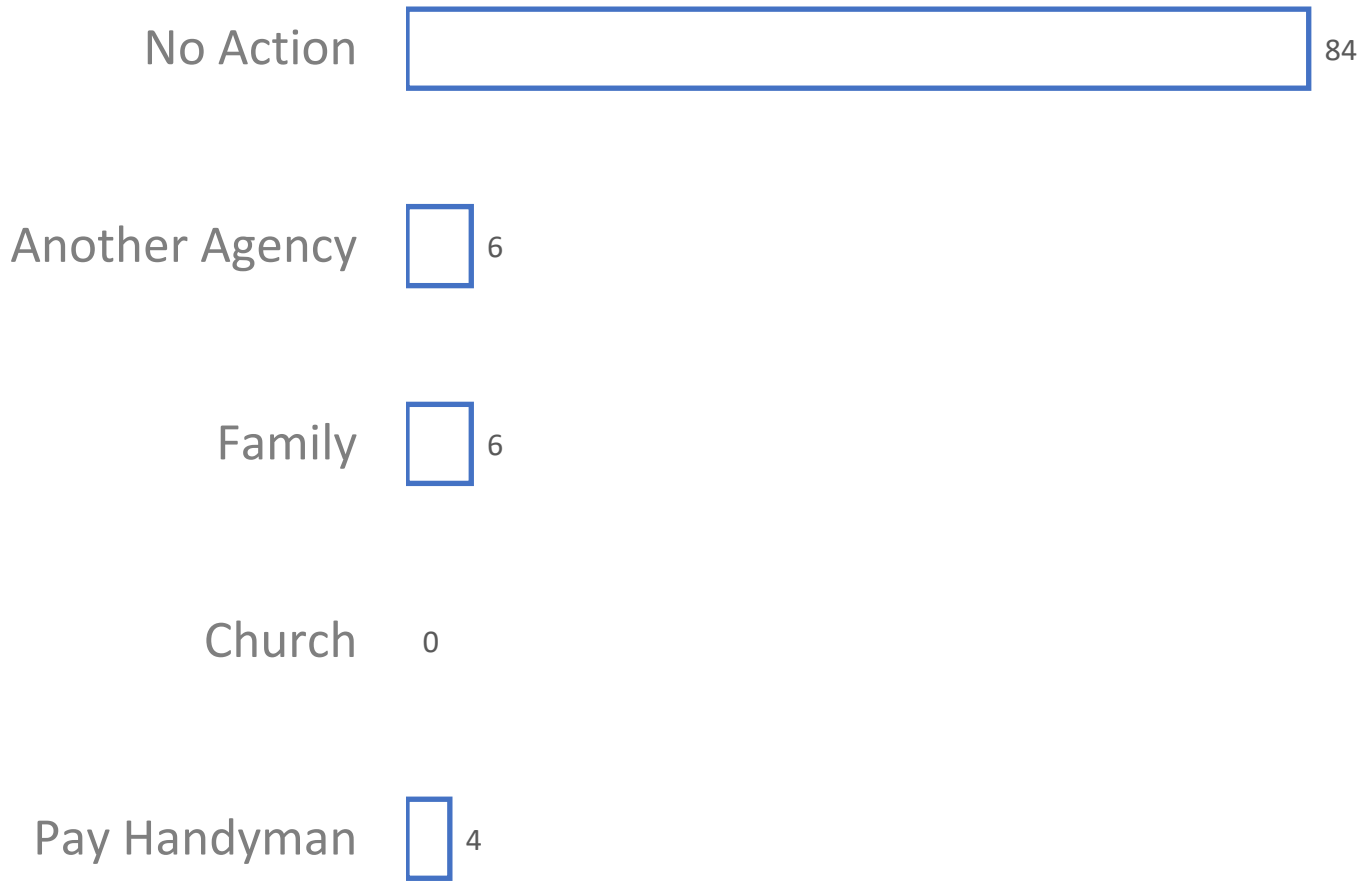


Heating and Cooling Repairs: 2-Fold Outcome

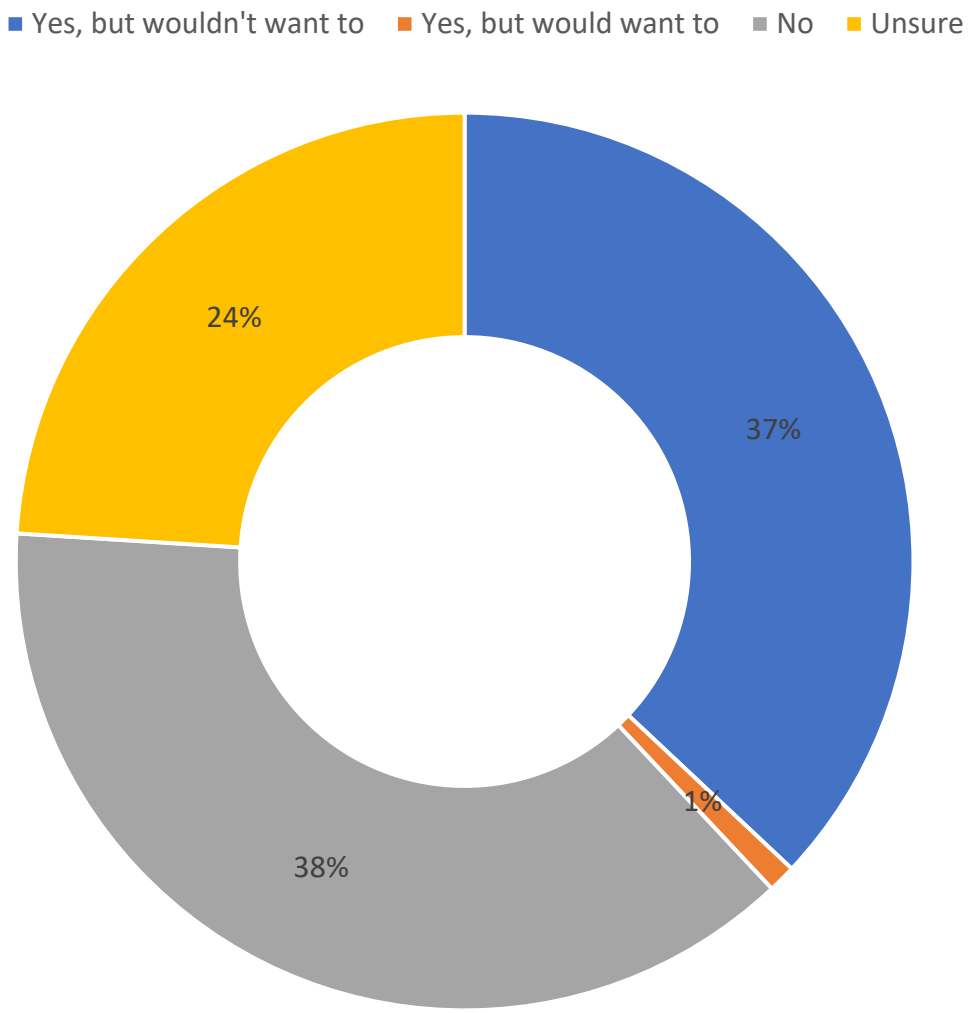




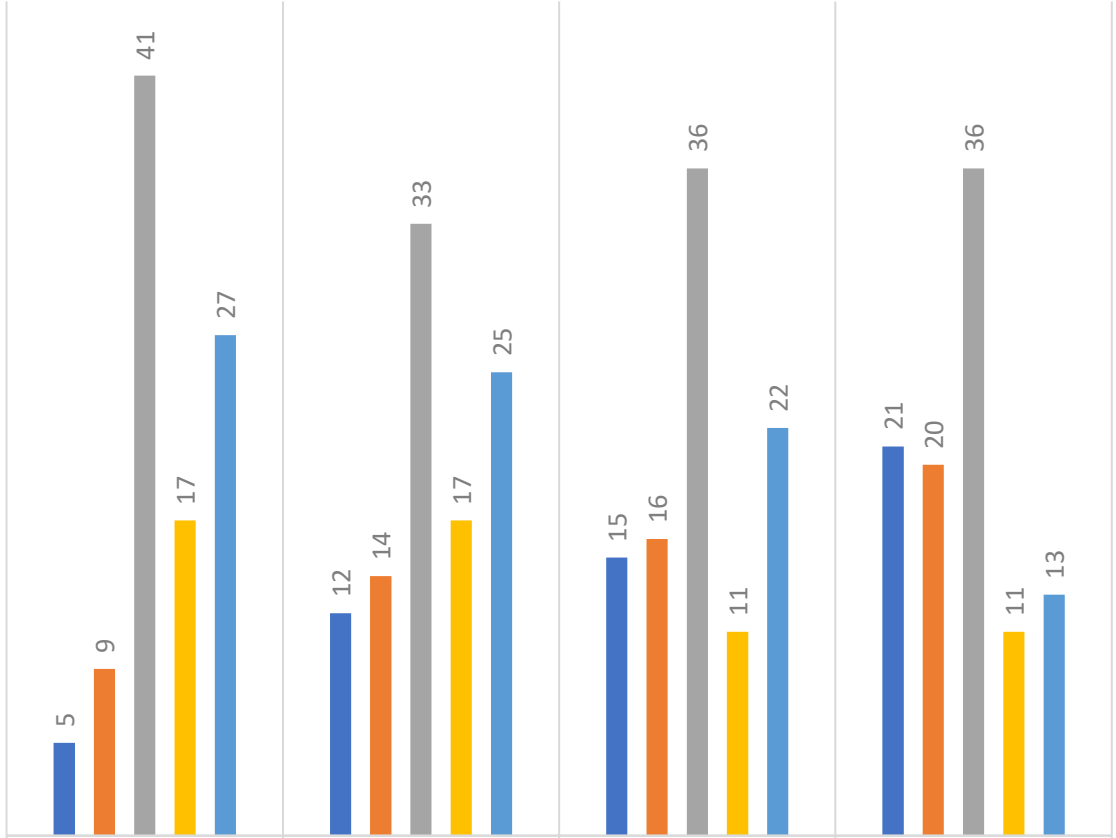
Alternatives to AIP Programming



Would You Have to Leave Without AIP?

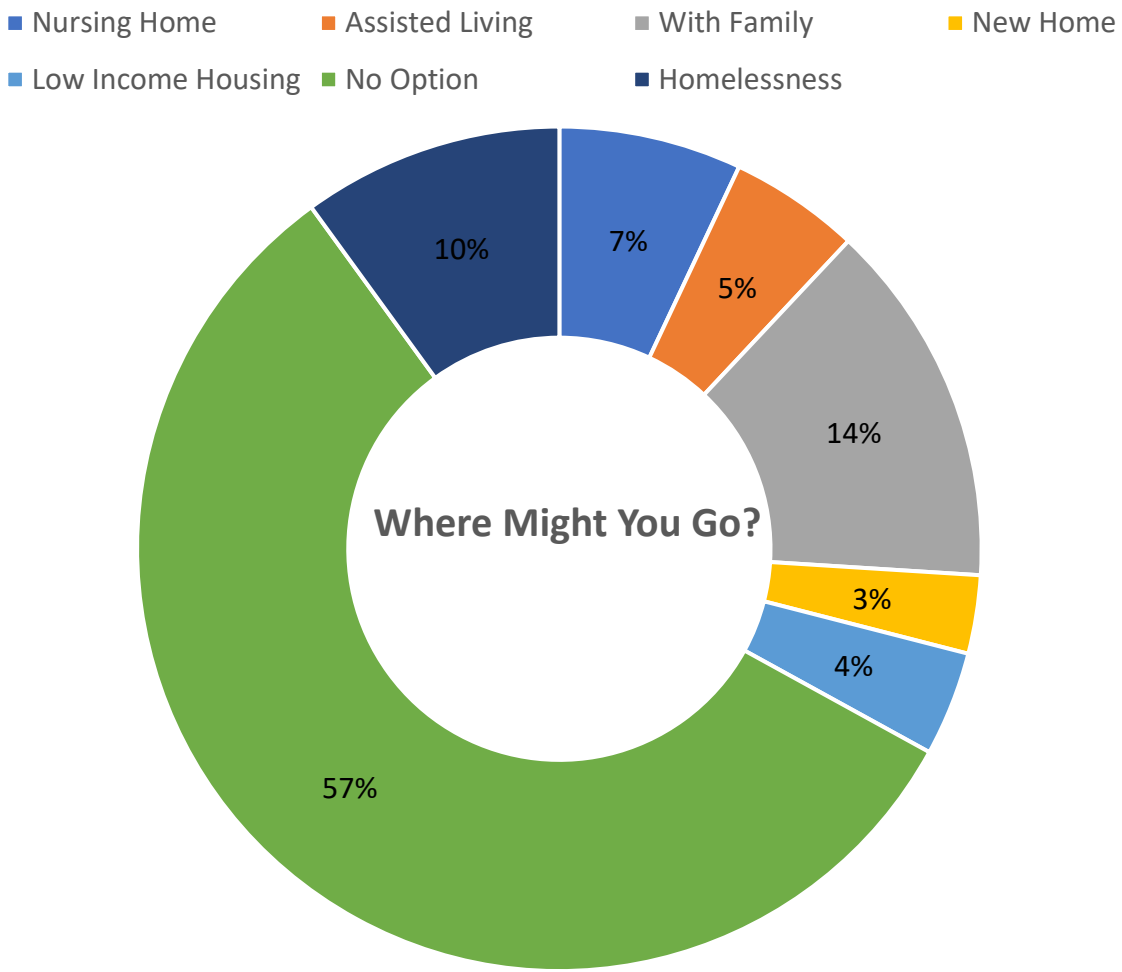


Yes



	Immediately-1 Year	2-5 Years	6-10 Years	10+
%Very Likely	5	12	15	21
Likely	9	14	16	20
Unsure	41	33	36	36
Unlikely	17	17	11	11
Very Unlikely	27	25	22	13

Without AIP, 23 seniors thought they were destined for a nursing home within the year



Nursing Home Facility	
Semi-Private Room[5]	**$85,775**
Change Since 2020[2]	1.07%
Private Room[5]	**$91,980**
Change Since 2020[2]	0.60%

Up to $2.1 million in TN tax dollars.

“MY BLOOD PRESSURE HAS GONE DOWN SINCE THE REPAIRS, AND MY DOCTOR EVEN NOTICED IT.”

“THESE REPAIRS, THEY HELPED MY STRESS. MY GRANDKIDS ARE COMING OVER SINCE IT’S NOT AS DANGEROUS TO LIVE HERE, THEY MAKE ME HAPPY.”

“I DON'T HAVE TO WORRY ABOUT THE RAIN COMING THROUGH MY ROOF OR MY ASTHMA KICKING UP. I DON'T HAVE TO WORRY ABOUT SLIPPING IN MY BATHROOM.”

“I AM SO THANKFUL FOR HABITAT. MY WINDOWS ARE SO BEAUTIFUL, AND THEY WORK PERFECTLY. I'M ALL ALONE, AND IT MADE ME FEEL SAFER.”

Opportunity for ALL

• Reduced admission to long-term care facility	$ 36 million
• Preventing falls (medical cost savings)	$ 1 million
• Utility bill savings	$ 2 million
• Increased Home Value (Mods)	$ 6 million
• Increased Home Value (Repairs)	$11 million
• Abatement Blight	$12 million

AIP programming provided around 157 full time jobs with $11.2 million in employee earnings and local spending (who circulate spending where they work)

Cumulative AIP investment: $17 million+
ROI: 3.1 times locally and statewide

Habitat for Humanity of Greater Memphis

Real World Policy Implications

Our ability to garner funding is based on our ability to stack various capital and connect to creative and compassionate leaders in the fields of health and housing. There is a greater demand coming for larger stacks.

1. How can prescriptions for repairs and accessibility modifications be funded and implemented?
    - What would it look like for Managed Care Organizations, Hospitals, and Gerontologists and supporting healthcare leaders (OT and PT) to work collaboratively with Housing Agencies to provide aging in place modifications and repairs to improve Activities of Daily Living? Can we replicate CAPABLE?
    - Healthy aging housing as a vaccine for older adults and the caretakers who support them

2. How can those who benefit from CHOICES repairs navigate the LOSS of Estate Recapture Policy?
    - Can we advocate for equitable policy to ensure that generational wealth is not being lost just because patients go through insurance to access repairs? Many people who could benefit from the CHOICES repair program skipped it and lived in unhealthy living situations to avoid the recapture policy. Habitat had been their only option* (metro and rural). * Repairs are free and there are no long-term deed restrictions.

Memphis Habitat Statewide Aging in Place

Habitat for Humanity's Aging In Place Work in Tennessee - YouTube

THE NASHVILLE FOOD PROJECT

37th Geriatric Update Conference

The Nashville Food Project

- In 2022, TNFP served 290,385 meals to some 50 community partners at 70 sites across the city.
  - 54,942 meals, or 19%, were shared with over 2,000 area seniors (65+) through 21 community partners.
  - TNFP’s two largest senior-serving partners are St. Luke’s Community House and Fifty Forward.

What we know…

- In 2021, 5.5 million Americans 60 and older faced food and nutrition insecurity. That's 1 in 14, or 7.1%, of all seniors.
- In 2018, 1-in-5 food insecure households included an adult 65 or older.
- Seniors who identify as Black, Latino, or Native American, or those with lower incomes and/or a disability, are significantly more likely to experience food and nutrition insecurity.
- The main federal program supporting seniors experiencing food and nutrition insecurity is the Supplemental Nutrition Assistance Program (SNAP). Other programs include the Congregate Nutrition Program and the Home-Delivered Nutrition Program.

What we know…

Food insecurity among older adults is going up.

Between 2007 and 2016, Leung and Wolfson (2021) report that food insecurity among seniors increase significantly, from 5.5% to 12.4%.

According to *The State of Senior Hunger in America in 2020* (Feeding America), food insecurity disproportionately affects older adults who:

- Have lower incomes
- Are relatively younger, e.g., ages 60-69
- Rent rather than own their homes

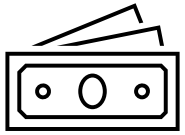
Effects of Food Insecurity

Lower nutrient intakes

Poorer health outcomes

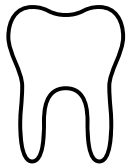
Mental health issues

Barriers to Food Access

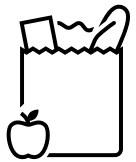


- Finances

- Physical Mobility



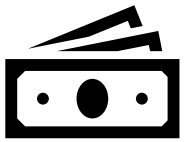
- Dental Issues



- Food Deserts

Nested and Overlapping Issues

- Lack of Affordable Housing
- High Healthcare Expenses
- Social Isolation
- Systemic Racism
- Generational Poverty
- Health Inequities

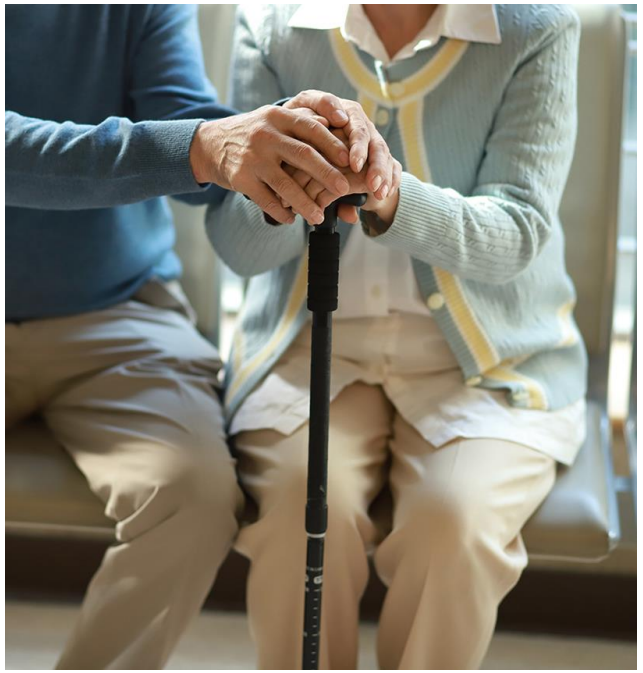


United Way of Middle Tennessee Helpline

In 2022, there were 7,361 total requests to the 211 helpline.

The Power to Age Gracefully-- We're Worth It:

Empowering Older Adults and their Caregivers in Nashville through Investments in Mobility



Mobility Empowers Older Adults & Caregivers

- Quality of life relies on Mobility and Infrastructure: Impacts on Older and Adults include Affordability, Climate, Social Isolation, Access to Food . . .
- What is available today?
- How can we improve transportation and mobility for the future of aging in Nashville?

TRANSIT ALLIANCE

The Costs & Challenges of Aging in Nashville

2022 Community Needs Evaluation: The State of Economic and Social Wellbeing Nashville-Davidson County

By Metropolitan Social Services Strategic Planning and Research

POPULATION: 703,953

13.2% 65 or older

33.5% of those over age 65 live with a disability

COMPARE LIVABILITY

Higher Score	Denver	61
	Cincinnati	59
	Raleigh	57
	St. Louis	54
	New Orleans	54
	Austin	53
	Charlotte	52
	Atlanta	52
	Indianapolis	51
	Louisville	51
Lower Score	Nashville	49

Source: Elder Index, 2022

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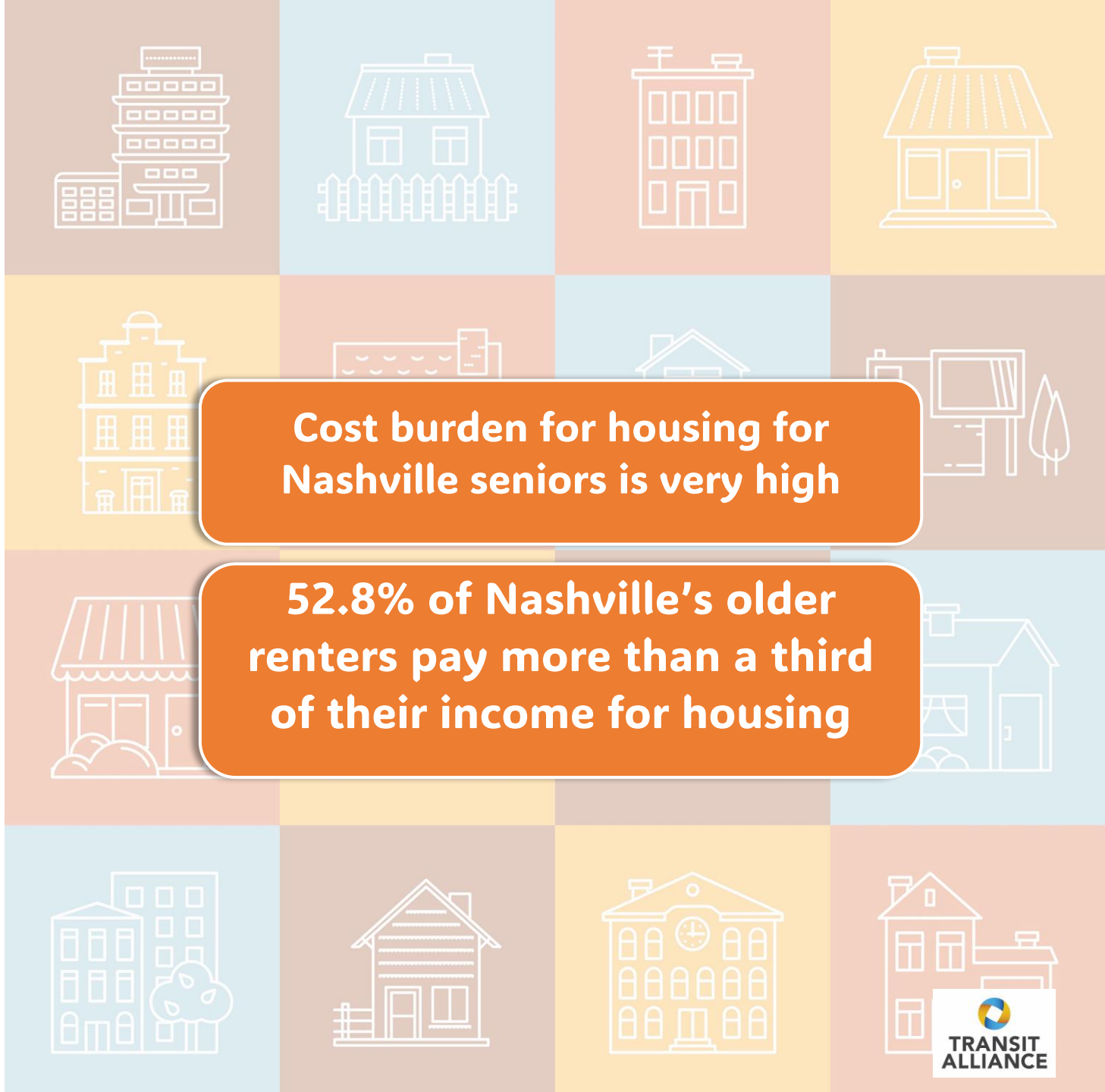
IMPACT: Quality of Life

Considering the requirements for a livable income in Nashville and the low, fixed income of older persons, ***it is possible that more than half of the city's population over age 65 is likewise in Livable Income Poverty.***



Transportation, Transit, and Mobility

Nashville Metro Area ranked **second most car-dependent large metro** in the U.S.

https://www.thecentersquare.com/national/analysis-tennessee-cities-among-the-most-car-dependent-in-america/article_db86a66c-3827-5b6d-9599-7ccc395d6929.html

Tennessee is **9th most dangerous state** to drive in.

Source: 1-800 Injured

It costs $5,500-$14,500 per year for transportation depending on living situation

TRANSIT ALLIANCE

IMPACT: Quality of Life

Lack of access to easy and safe mobility creates disconnection from healthy social fabric

"Poverty is clearly one source of **emotional suffering**, but there are others, **like loneliness."**

--Daniel Kahneman

TRANSIT ALLIANCE

Access to Mobility Can Make All the Difference

https://t4america.org/docs/SeniorsMobilityCrisis.pdf

The typical American adult makes 3.4 trips per day, or more than 1,200 per year.

Lynott, Jana and Carlos Figueiredo (2011) "How the Travel Patters of Older Adults Are Changing: Highlights from the 2009 National Household Travel Survey" AARP Public Policy Institute, Washington, D.C.

6 years/6,408+ trips

A study in the American Journal of Public Health found that people in their early 70s who stop driving will need access to transportation alternatives.

Foley, Daniel, Heimovitz, Harley, Guralnik, Jack and Dwight Brock "Driving Life Expectancy of Persons Aged 70 Years and Older in the United States" American Journal of Public Health, August 2002, Vol 92, No. 8

10 years/10,680+ trips

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Transportation: A Prerequisite for Aging in Place

85%

Nashville's older adults, 65-79, have poor access to public transit

70% of respondents aged 65+ ranked being near where they want to go (grocery stores, doctor's offices, the library and social or religious organizations) as **extremely or very important.**

Keenan, Teresa A. (2010), "Home and Community Preferences of the 45+ Population" AARP, Washington, D.C.

Seniors are increasingly taking more of their trips on public transportation.

Lynott, Jana and Carlos Figueiredo (2011) "How the Travel Patters of Older Adults Are Changing: Highlights from the 2009 National Household Travel Survey" AARP Public Policy Institute, Washington, D.C.

> 20% of seniors ages 65 and older – nearly 7 million people – do not drive at all.

Bailey, Linda (2004), "Aging Americans: Stranded without Options" Surface Transportation Policy Project, Washington, D.C.

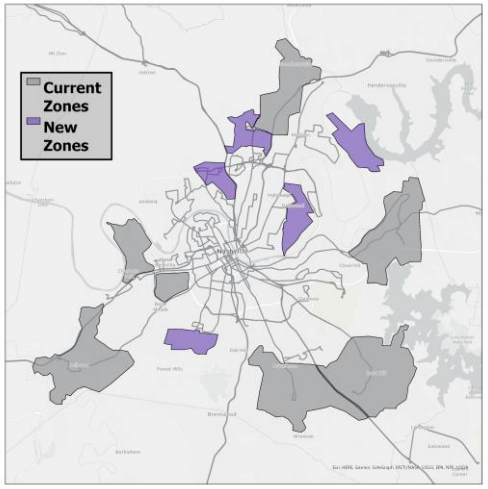
TRANSIT ALLIANCE

"A developed country is not a place where the poor have cars, it's where the rich ride public transportation."

Anonymous

Mobility Options Now

- WeGo Public Transit (MTA & RTA)
  - Bus, frequent/daily
  - Regional Express
  - Commuter Rail
  - Paratransit
  - Wego Link Zones
- Vanpool



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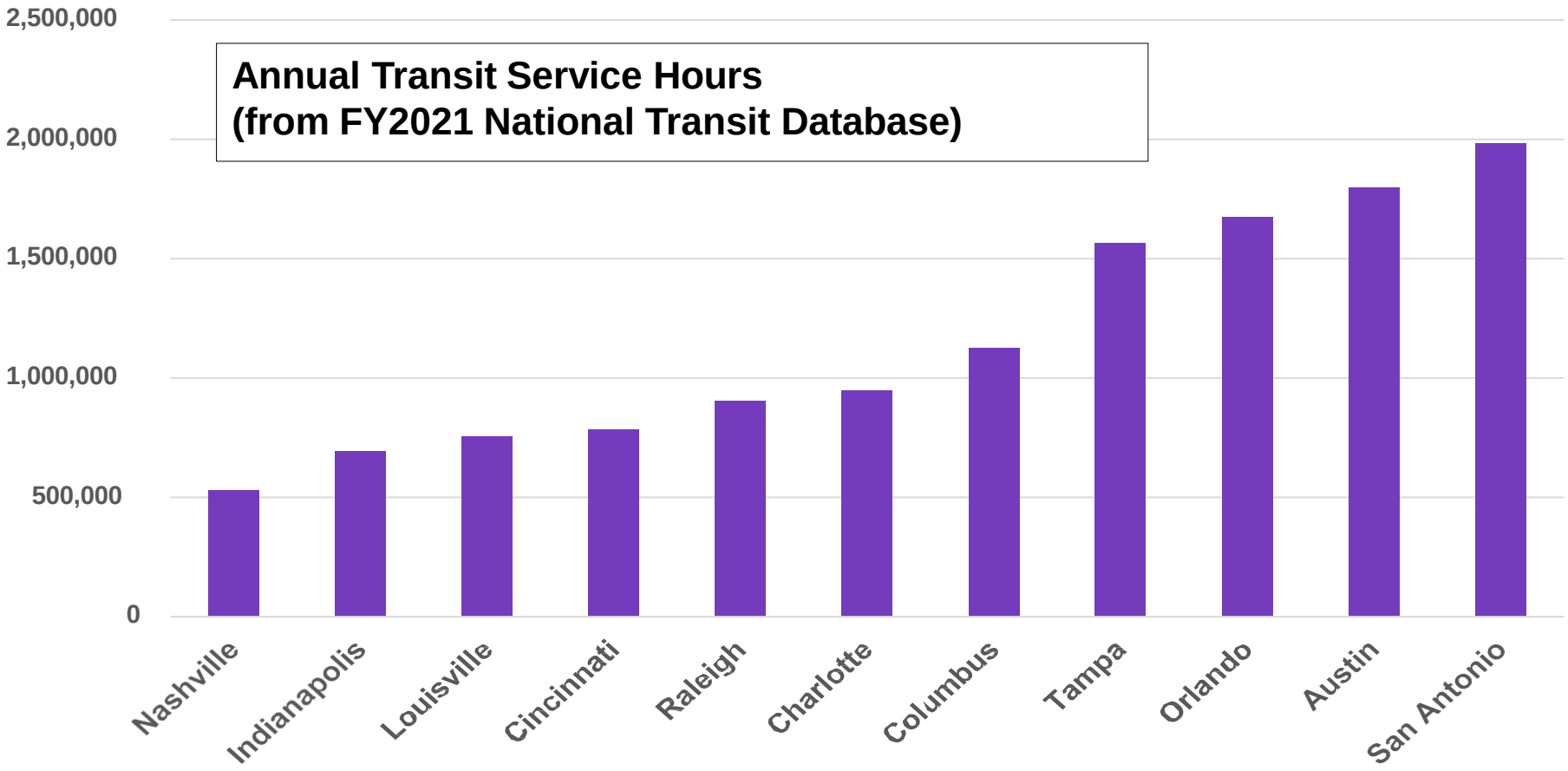
Comparison to Peer Cities



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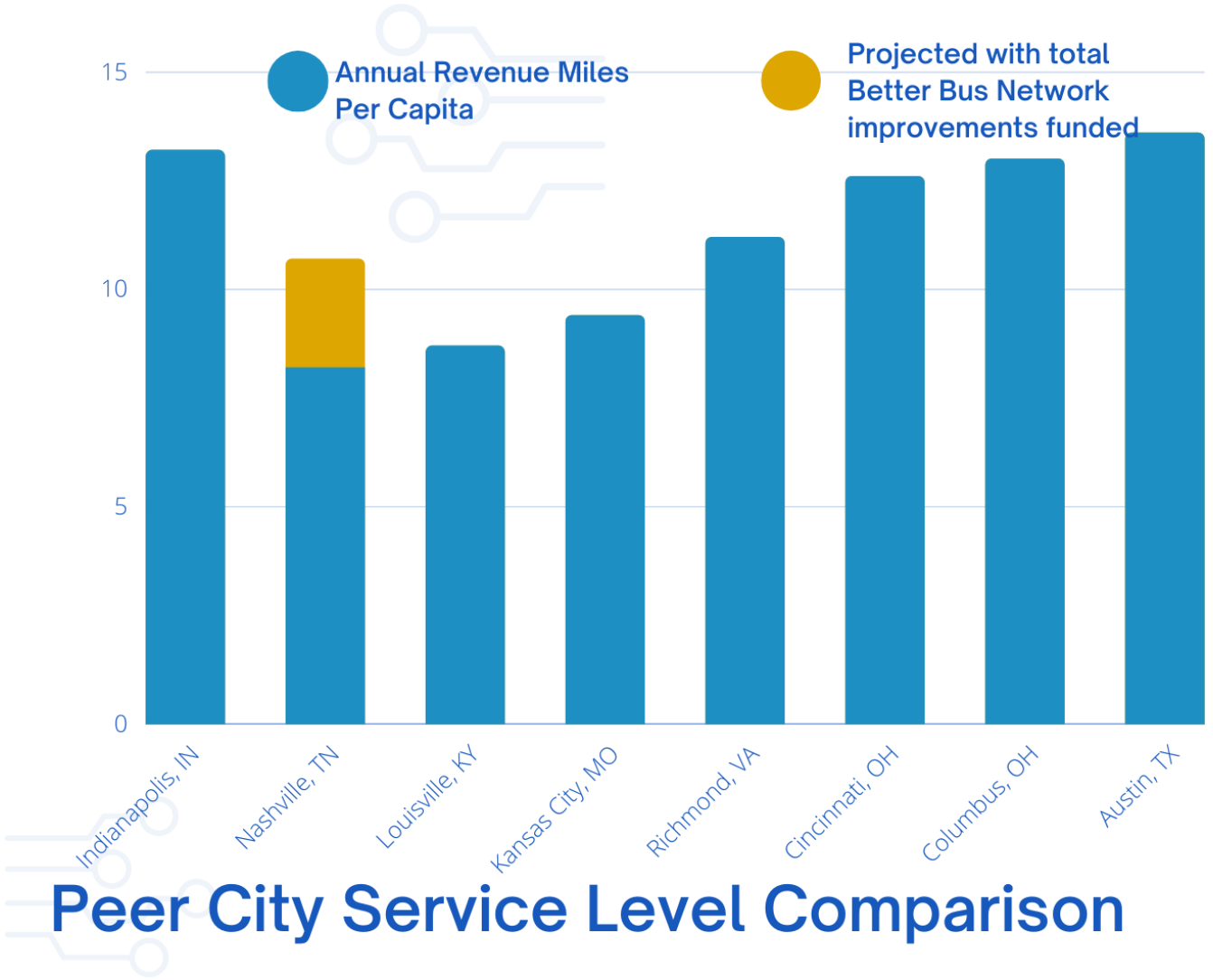
Funding Comparison



TRANSIT ALLIANCE

MPO Area	Agency Name	Service Population	Funding (Billions)	Plan Life	Annual Average Funding / Capita	Compared to Nashville
Denver	Denver Regional Council of Governments	3,139,500	$106.0	21	$1,607.78	640%
Atlanta	Atlanta Regional Commission	5,591,600	$107.0	21	$911.23	319%
Austin	Capital Area Metropolitan Planning Organization	1,759,024	$35.1	25	$798.28	267%
Kansas City	Mid-America Regional Council	1,895,595	$33.0	25	$696.35	220%
Columbus	Mid-Ohio Regional Planning Commission	1,450,000	$19.6	24	$563.22	159%
Jacksonville	North Florida Transportation Planning Organization	1,419,332	$20.7	26	$560.91	158%
Pittsburgh	Southwestern Pennsylvania Commission	2,600,000	$31.7	26	$468.93	116%
Oklahoma City	Association of Central Oklahoma Governments	1,142,407	$10.4	24	$380.17	75%
Indianapolis	Indianapolis MPO	1,970,000	$20.4	28	$370.65	71%
Louisville	Kentuckiana Regional Planning and Development Agency	1,069,677	$7.1	20	$331.88	53%
Cincinnatti	OKI Regional Council of Governments	1,999,474	$15.7	24	$326.59	50%
Orlando	MetroPlan Orlando	2,065,321	$15.1	24	$304.06	40%
Memphis	Memphis MPO	1,382,091	$12.1	31	$282.63	30%
Birmingham	Regional Planning Commission of Greater Birmingham	1,121,223	$8.2	26	$281.29	29%
Charlotte	Charlotte Regional Transportation Planning Organization	1,394,800	$8.5	27	$225.71	4%
Nashville	Greater Nashville Regional Council	**1,686,745**	**$8.8**	**24**	**$217.39**	-

Denver received a livability score of **61**.

Nashville received a **49**.

TRANSIT ALLIANCE

Empower Older Adults through Investments in Transit

- As adults age and give up driving, they will need access to adequate transportation alternatives.

- Caretakers will need access to affordable, convenient transit.

- *To address the mobility needs of seniors, communities, local elected officials and planners must confront the assumption that people would always be able to rely on the automobile as their primary mode of transport.*

TRANSIT ALLIANCE

NASHVILLE, TN

Transit Timeline

Recent background on the transit story.

2009

TAMT

Transit Alliance of Middle TN formed alongside the

2014

THE AMP (R.I.P)

The plan for a 7.1 mile bus-only lane from 5-points to St. Thomas West.

2018

LET'S MOVE NASHVILLE (R.I.P.)

Mayor Barry's transit-funding referendum.

2023

HERE WE ARE

Modest updates to transit service since 2018.

TRANSIT ALLIANCE

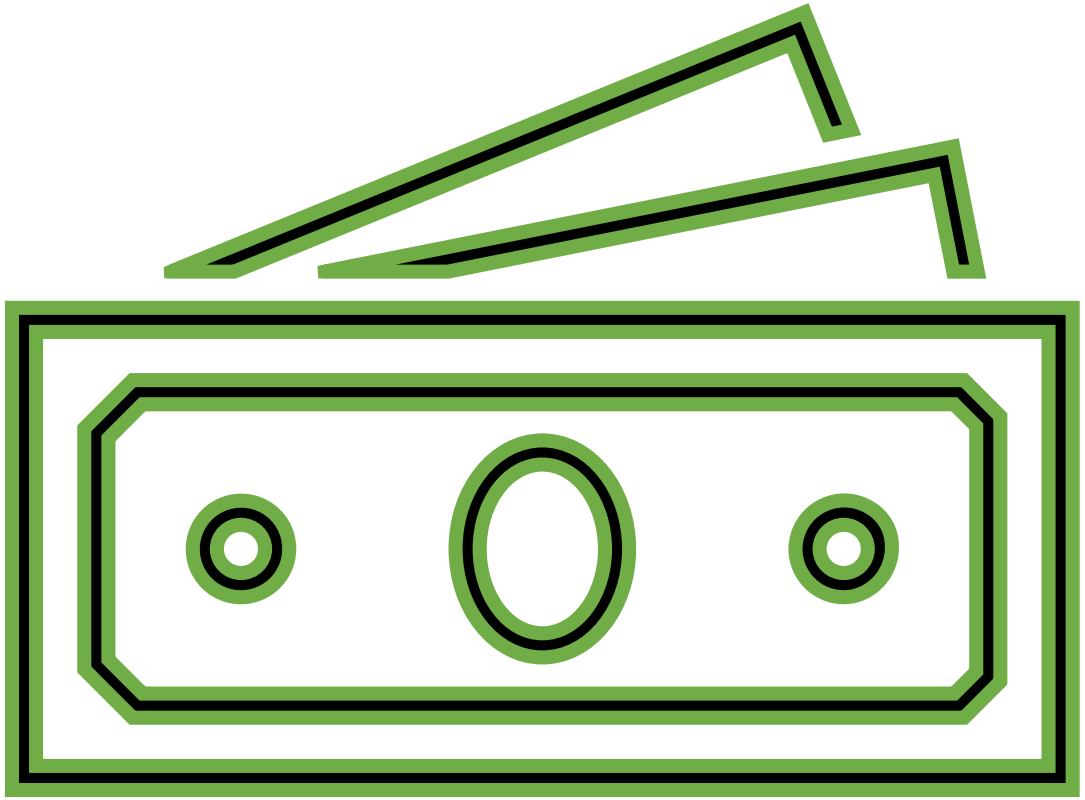
East Bank
Multimodal Spine w/Transit Priority
Mobility Center
Affordable Housing
Improved network connectivity

Connect Downtown
Transit Priority
Transit /mobility centers
Transit priority corridors
Used by multiple routes
Improved network connectivity

Murfreesboro Pike
Highest ridership route
~ 4,000 rides per day
Fast growing corridor
Connection to airport
Corridor redevelopment opportunity

TRANSIT ALLIANCE

Policy



TRANSIT ALLIANCE

What You Can Do

- Email or call your councilperson and discuss how important transit and mobility is to you and the clients you serve.
  - 615-862-6780
  - councilmembers@nashville.gov

- Ride transit yourself so you can help your clients if needed.
  - 615-880-3597
  - Learn how to ride with WeGo on Youtube! @NashvilleMTA

Thank You!

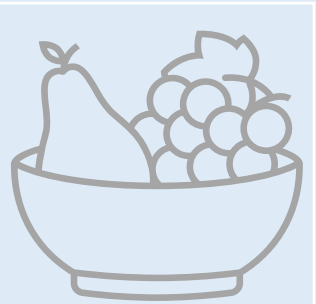
TRANSIT ALLIANCE

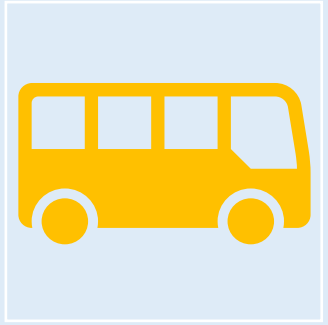
- Thetransitalliance.org
- Jessica.dauphin@thetransitalliance.org
- 615-743-3051

Questions

Habitat for Humanity Greater Memphis: Habitat for Humanity of Greater Memphis (memphishabitat.com)

The Nashville Food Project: Nashville Food Project (thenashvillefoodproject.org)





Transit Alliance of Middle Tennessee: Home Page - Transit Alliance of Middle Tennessee (thetransitalliance.org)