Primary Care Trainees Learn about Aging in Place via an Academic-Area Agency on Aging Partnership

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ABSTRACT

***Background*:** Despite the essential role of Area Agencies on Aging (AAAs), a national network of agencies that help older adults age in place, there is low awareness and utilization of their community resources among primary care providers for their older patients.

***Objectives*:** We describe a partnership between an academic institution and two Washington State AAAs and the development, implementation, and feasibility of an "AAA practicum," a novel community-based experiential training opportunity for primary care trainees to increase awareness and understanding of community-based resources for older adults.

***Methods*:** AAAs and academic geriatricians collaborated to develop the practicum curriculum which includes orientation, experiential visits, and debriefs with AAA staff. The practicum was evaluated via qualitative and quantitative analysis of participant surveys.

***Conclusion*:** A community-academic partnership can be leveraged to successfully design, implement, and sustain a curriculum that teaches primary care trainees how to effectively help older adults age in place. Seventy-seven trainees completed the practicum including family medicine residents, advanced practice nursing students, and geriatric medicine fellows. Trainees described feeling empowered to connect their patients to AAA resources. Aging in place can be supported via partnerships across clinical and community organization silos, and these same partnerships can be leveraged to support curricula for future primary care providers.

KEYWORDS: Area Agency on Aging, primary care training, community-based education, experiential learning, community resources

INTRODUCTION

As the number of older adults continues to grow, there is increasing urgency to utilize community resources that support aging in place.[1] The Older Americans Act of 1965 established a national network of Area Agencies on Aging (AAAs) to address the social determinants of health and deliver evidence-based health promotion programs that can positively impact older adults' health, well-being, and ability to remain in their homes. AAAs are a core part of the Aging Network (also termed the Aging Services Network), a network of federal, state, and local agencies that plan and provide services for older adults.. AAAs provide (at minimum) five core services: nutrition (e.g., home-delivered meals[2]); family caregiver support; health and wellness (e.g., evidence-based programs on fall prevention, chronic disease management); elder rights information (e.g., abuse prevention); and supportive services (information and referral assistance, in-home services, case management). AAA programs and services have been shown to improve health outcomes for older adults. For example, evidence-based AAA programs reduce the risk of fall-related injuries,[3, 4] aid caregivers for patients with dementia,[5-7] and improve quality of life (e.g., decrease depression, fear of falling, and social isolation).[8-10] The 600 plus AAAs serve over 8 million clients yearly.[8] Intentional connections between healthcare and community resources have been found to improve health and optimize healthcare utilization.[9] Although older adults rely on healthcare providers as their main source of trusted information, many primary care providers are not aware of the resources available through an AAA.[10] While some efforts to utilize primary care as an entry point to community-based resource referrals are emerging, it will be important for today's primary care trainees to gain familiarity with and understand the benefits of community-based resources in order to recommend them to their patients.[11, 12]

Objectives

In partnership with two Washington State AAAs, the University of Washington's Northwest Geriatrics Workforce Enhancement Center (NW GWEC) developed an experiential AAA practicum to increase primary care trainee awareness and understanding of AAAs and of AAA-sponsored programs and services, with the hypothesis that this would heighten trainee self-efficacy for connecting patients, their families, and caregivers to relevant community resources. This paper describes the academic-community partnership and the development, implementation, and feasibility of the AAA practicum as lessons learned for others with similar ambitions.

METHODS

Community-Academic Partnership

The NW GWEC was is established in 2015 and is one of 42 Geriatrics Workforce Enhancement Programs, funded by the Health Resources and Services Administration, which aims to improve the primary care of older adults.[13] From its inception, the NW GWEC partnered with two Washington State AAAs and supported each to employ a Primary Care Liaison position which was charged with outreaching to primary care practices as well as coordinating their respective AAA practicum.[18] The AAA practicum was collaboratively designed by the NW GWEC and the AAAs who together could bring knowledge and experience of the needs of older adults and AAA programs and services, primary care education requirements, and medical education. AAAs were involved in and/or lead all key aspects of the project including goals and objectives, curricular content, and evaluations. AAAs implemented the program with trainees, partnered on presentation of the results at meetings and wrote portions of the manuscript describing the

curriculum as well as barriers and lessons learned. Further details of each component of the curriculum and evaluation and their respective development are provided herein.

Location

AAAs vary in structure and populations served,[14, 15]. Aging and Disability Services (ADS) for Seattle and Area Agency on Aging and Disabilities of Southwest Washington (AAADSW). ADS serves a population of over 2 million, of whom 18% are ≥60 years old.[16] AAADSW serves 5 southwest Washington counties (4 of which are rural) with over one-half million residents, of whom 24% are ≥60 years old.[17]

Targeted Learners

Practicum participants were primary care trainees recruited from programs with existing relationships with the NW GWEC. At one AAA, trainees included geriatric medicine fellows and advanced registered nurse practitioner (ARNP) students. At the other AAA, trainees were family medicine (FM) resident physicians. Geriatric medicine fellows were based at an urban academic health system; ARNP students were enrolled in a Doctor of Nursing Practice program in adult-gerontology primary care or psychiatric-mental health; and FM residents were training at a community hospital-affiliated residency program.

Practicum Development

The curriculum was collaboratively developed at all stages. The development process of the practicum spanned six months with regular meetings and included AAA staff (Primary Care Liaisons, community services managers, and senior planners) and NW GWEC's academic

geriatricians. The AAA staff created the first drafts of goals and objectives, which were then reviewed by the academic geriatricians to ensure alignment with the learning needs of the trainees (through review of program requirements and recommended geriatrics competencies as well as discussion with training program leadership). The AAAs led the development of the curriculum with iterative feedback from the academic geriatricians. In keeping with situated learning theory,[19] the practicum is largely experiential, including one-on-one discussions and field experiences with AAA staff. Although the structure of the practicum was the same across trainees, the experientials (e.g., number, frequency, and total duration) varied by trainee type (based on learner needs and schedules) and AAA characteristics (e.g., populations served; organizational structure). AAAs worked with training programs to schedule learners and delivered the curriculum.

Curriculum

[Figure 1 here]

The curriculum, detailed in Figure 1, included (in order of presentation):

- *In-Person AAA Orientation:* AAAs oriented each trainee at the agency's office at the beginning of the practicum. One AAA e-mailed introductory materials to trainees in advance; the other provided them during the orientation. The materials introduced and described each of the core components of the overall curriculum including the context and services of AAA on a local, state, and national level (Figure 1), (Supplement 1). Orientation also included an opportunity for trainees to ask questions and share any self-identified learning goals or interests.

- *Experiential Visits:* Before orientation, most trainees were offered a menu of potential options among AAA core service (e.g., case management, family caregiver support, home delivered meals) for experiential visits (Figure 1) (detailed example in Supplement 2). This allowed the AAA to customize the experience to trainees' interests whenever feasible. AAA staff pre-arranged visits with community agency staff. For visits that involved an older adult receiving AAA services, agency staff were responsible for ensuring assent to the trainee's presence, and all learners had already completed privacy (e.g., HIPAA[21, 22]) training. Trainees received additional introductory material related to their specific experiential visits.
- *Debriefs:* Trainees usually had two opportunities for unstructured (i.e. no standardized questions) debriefs with AAA staff members after their experiential visit (i.e. ride along and in office meeting). Trainees were able to solidify learning by discussing what they had observed, asking questions, and identifying any additional learning needs (which were then addressed via additional materials or future experiential visits).

Practicum Implementation

Although the above components were universally offered regardless of trainee type, the total duration and frequency of experientials varied (Table 1). Geriatric medicine fellows spent 4-5 half-days in experiential visits. ARNP students completed the practicum during one full day. Family Medicine residents were initially scheduled to complete the practicum during one full day (of their three-year residency); this evolved to include multiple half-day experiential visits over time (one or more per training year) based on trainee feedback to the residency program that the visits were of very high value and worth repeating.

[Table 1 here]

Initially, key staff at both AAAs only interacted one-on-one with trainees, repeating similar information. Subsequently, staff were invited by the training programs to supplement that approach with interactive didactics (usually once yearly) involving an entire group of trainees (e.g., in a resident physician noon conference), with content chosen to address their interests and needs.

Practicum Evaluation

AAAs tracked practicum participation and administered voluntary, anonymous, online surveys (Supplement 3). These surveys were co-created by the NW GWEC staff and the AAAs. Since evaluation was driven by the needs and capacity of the site, one AAA administered surveys pre and post practicum, while at the other AAA, surveys were administered post only. Qualitative analyses of open-ended questions were completed for post-surveys at both sites. Quantitative analysis was included for the site with pre-post surveys. For trainees who completed additional experientials over time, surveys were collected after each encounter. Ethical approval was sought through the University of Washington's Institutional Review Board, which indicated this activity was not considered human subjects research.

Survey questions (Post-Survey) included: satisfaction, intent to change practice, impact on practice, and comments. Pre and post surveys included nine items addressing self-efficacy for describing and utilizing the AAA and related community-based resources (10-point scale from 1=not at all confident to 10=totally confident). Descriptive statistics were summarized using

Microsoft Excel (2019). The Wilcoxon matched-pairs signed-rank test for the self-efficacy items (pre-post) were performed and figures were created in STATA (v13, College Station, Texas). Open-ended questions were thematically analysed[14,15] using inductive coding independently by two co-authors (AV, BC). Consensus on themes was obtained, and comments were categorized into overarching themes and sub-themes.

RESULTS

Trainees

From January 2016 to March 2020, 77 trainees completed the AAA practicum: 40 FM residents, 18 geriatric medicine fellows, and 19 ARNP students. Twenty-three trainees (30%) were 'repeaters' whose program assigned them to experiential visits on more than one separate occasion and led to multiple surveys being completed.

Experiential Visits

Of 163 experiential visits completed, the most frequent were home visits: case management (62 [38%]), family caregiver support (34 [21%]), and care coordination (32 [20%]) (Figure 2).

[Figure 2 here]

Post-Survey

Seventy of the 114 completers (including experiential repeaters) filled out a post-survey (62% response rate). Sixty-nine of these 70 respondents (99%) were highly satisfied (i.e., rated a 4 or 5 rating on 5-point scale) with the AAA practicum. Sixty-seven of the 70 respondents (96%) indicated that the AAA practicum would change the way they provided healthcare to their older patients.

Qualitative Results

From responses to the question, 'How will this experience impact your clinical practice?' three major themes emerged: 1) empowered by new knowledge, 2) readiness to refer patients to AAA

resources, and 3) awareness of resources and their importance (Table 2). Two important sub-themes were identified for the knowledge theme: understanding the benefits for caregivers and making the connection to improved health and well-being.

[Table 2 here]

Of the 42 responses to 'Is there anything else you'd like to share with us?', the most common theme was appreciation for the practicum and the availability of resources for older adults. Exemplar responses included:

- *'The experience I had with [the] social worker/case manager at the Seattle Low Income Housing Authority was one of the best learning experiences I have had so far. [The case manager] demonstrated advocacy and empathy and provided a broad range of support to her older adult clients';*
- *'I had the opportunity to observe one PEARLS[24] session which was very impressive. I am glad to find there is such [a] program to help with depression in seniors.'*

Pre- and Post-Survey Comparison

At the AAA where pre-surveys were administered, 28 of 37 trainees (76%) completed the pre-survey and 16 of 37 (43%) completed the post-survey. Analysis of pre- and post-survey responses for each of the 9 self-efficacy items indicated a significant increase in self-efficacy ($p<.01$) (Table 4).

[Table 4 here]

DISCUSSION

An AAA Practicum developed through a community-academic partnership, was found to be highly satisfactory by primary care trainees from three different health profession programs and they reported plans to change their future practice based on their practicum participation. Qualitative analyses revealed that trainees found the practicum invaluable for informing and guiding their future care of older adults with rich descriptions of just how they planned to integrate these AAA resources into their practice. They also recognized the importance of community programs and services for caregivers, something not routinely highlighted in primary care training. For the subset for whom pre-post comparison was available, the results reinforced the qualitative results, namely awareness of AAA resources increased and self-efficacy for connecting older patients to those resources increased significantly. The planned changes reported by trainees represent important steps toward ensuring primary care providers (a trusted source for information[22]) work in concert with community programs and services to enable older adults to maintain their health and successfully age in place.

Links to Existing Literature

To our knowledge, this is the first AAA practicum designed for a range of primary care trainees. Others have described exposure to AAAs integrated into specific health professional training. One program included AAA staff as part of a didactic and case-based interprofessional curriculum.[25] An internal medicine residency program partnered with the a AAA to implement a service-learning curriculum in which resident physicians provided a health education session for older adults, received a tour of the community site (e.g., housing unit or senior center), and learned about resources available to older adults.[26] A nursing baccalaureate program partnered

with an AAA to provide its students with a home-based experience with case-managed clients at risk for institutionalization and reported that the experience was highly valued by the students and the Agency.[27] Findings from these reports resemble our own in that exposure to AAAs appears to be well received and has positive impacts on trainee knowledge and self-reported ability to provide care for older adults. However, none of these efforts were as comprehensive in their integration of knowledge about the organizational structure and role of AAAs, and the range of programs, services, and supports they provide.

Strengths and Limitations

The present evaluation has several notable strengths. First, the program was collaboratively designed by community agencies and an academic institution which helped ensure that it addressed the learning needs of trainees and provided exposure to key community resources. Anonymous surveys enabled frank feedback. The analysis of qualitative data generated concrete examples and rich descriptions of the potential impact of changes in self-efficacy on trainees' future practice. The mixed-methods analysis available for a subset of participants provided complementary data and yielded consistent results, thereby increasing confidence in the authenticity of the findings.

Limitations of our evaluation include having pre-post data collected at only one AAA with a relatively low response rate, which limits the ability to generalize across the program. Experiential repeaters who completed additional surveys may have had a positive bias. Additionally, the trainees were a convenience sample, which could bias our results toward finding positive outcomes, though all trainees of each participating training program were

required to participate. We also did not have a comparison group. Although the core components were consistent, given the customization, attribution of the results to particular elements of the practicum is impossible. Finally, because some of the trainees participated in other educational activities of our NW GWEC, it is not possible to attribute changes in self-efficacy exclusively to the practicum.[28]

Based on these limitations, there are several identified opportunities for future evaluation of this and similar programs. To minimize low response rate and harmonize outcomes, evaluations should be standardized across sites and delivery of evaluations could be shifted to the academic partner/program who have ongoing trainee contact. The addition of graduate surveys could determine the impact of the program on trainees once out in practice. Finally, evaluation of the downstream impact on the agency and/or patients could highlight the impact of a AAA practicum.

Implications

Implications of this program and its evaluation are several. Co-creation of a curriculum between an academic program and a AAA leads to a curriculum that leverages deep knowledge of the AAA and expertise in tailoring the curriculum to the needs of the trainees. Although some trainees spent a single day with the AAA, brief experiences are common in clinical training, and the baseline lack of awareness made even brief exposure valuable. This, along with the practicum being implemented at two AAAs with different geographic locations and operational structures with various trainees suggests that it is a disseminable model. The perceived value of

this curriculum was high, based on the fact that it has been integrated as a required yearly activity by the training programs that initially participated.

Practicum leads at the AAAs provided perspectives on the benefits to the agency, barriers, and lessons learned (Table 3). Perceived benefits included knowing their work was valued, increased referrals, and improved communication. The biggest barrier was scheduling within the constraints of training programs. Key lessons learned included clear communication and flexibility, knowing your learners, engaging AAA staff champions, and recognizing that health care providers value AAA education. These key lessons show not only the value of the practicum to trainees, staff, and agencies, but important strategies to ease implementation elsewhere. Subsequently, the AAAs have adapted practicum components to a virtual format that is being separately evaluated. This may facilitate delivery of the practicum to a broader, geographically dispersed audience of trainees (including additional health professions) and will facilitate exploring dissemination to practicing primary care teams.

[Table 3 here]

We utilized grant funding to support development and administration of this training, but for sustainability this exposure to community-based resources should ideally be integrated into primary care training programs. However, there are barriers within the funding paradigm that will need to be overcome. Within graduate medical education, curricular focus is partially driven by funding, which is mainly distributed through clinical entities (e.g., a hospital). Within nursing programs, the clinical focus and sites are driven by state quality assurance boards and national

accreditation standards. The value of bridging primary care and community organization silos raises the question of whether the funding paradigm for U.S. clinical education best meets both educational and community needs.

Conclusion

An academic-community partnership can successfully implement a AAA practicum that increases primary care trainees' recognition of the importance of utilizing resources available throughout the Aging Network. The exposure during training is anticipated to optimize the chances that relevant programs and services will be brought to bear on the lives of older adults and help them to age in place. Given the promising results of our practicum, expansion to other AAAs and primary care training programs should be considered.

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TABLES

Table 1. Area Agency on Aging Practicum differences by type of trainee

	Geriatric Medicine Fellows	Nurse Practitioner Students	Family Medicine Residents
Site	ADS[a]	ADS[a]	AADSWA[b]
Orientation	In-person and emailed	In-person and emailed	In-person
Number of experientials per trainee	4-5	1	1-3
Typical total duration for entire practicum	32 hours	8 hours	8-12 hours
Typical time span	1-2 months	1 day	1-3 years

a ADS = Aging and Disability Services – Seattle-King County, WA

b AAADSW = Area Agency on Aging and Disabilities of Southwest Washington – Vancouver, WA

Table 2. Themes identified from the question, 'How will this experience impact your clinical practice?'

Theme	Sub-Theme (frequency)	Exemplar Quotes
Empowered by new knowledge	Understanding and being familiar with the resources	• *Going out into the community to get to know resources is incredibly valuable, because it makes the resources tangible.* • *Having an exposure to these resources will allow me to incorporate these community connections into my practice.* • *Each resource becomes an additional care tool that I can use.* • *I have a lot more familiarity with the services the [AAA] offers, and now feel comfortable referring patients to those.*
	Understanding the benefits for caregivers	• *I also think it is helpful to know resources that are available to family member caregivers. I have seen family members in the inpatient setting who are worn out and need assistance, so now I know how to help them.* • *I learned how to connect with advocates at community living connections to access community resources and family caregiver support services.* • *I can support unpaid caregivers by referring them to resources that might be beneficial to them.*
	Making the connection to improved health and well-being	• *I hope to be able to connect my patients with needed resources which would contribute positively to their overall health and wellness.* • *[The practicum will] help me take care of my patients better because I have new knowledge of community resources.* • *Allows me to see first-hand what resources I can refer my patients to and how this can impact their day to day lives.*
Readiness to refer patients to AAA resources	Planning for future referrals and matching patient needs to resources	• *It is imperative that I can identify those in need of additional support and refer them to the appropriate resources.* • *I now know one distinct phone number to give to patients where even if I don't know the exact resource to guide them toward, [the] AAA does.* • *I had no idea this was available, will be referring my patients when I see ones I feel could benefit from this (which will likely be many)* • *This will allow me to confidently refer my patients to the [AAA] and know that they will be well served and supported.*

Theme	Sub-Theme (frequency)	Exemplar Quotes
	How to talk to my patients about community-based resources	• *I can better explain what services will be provided as a result of the referral.* • *[I] have learned about many resources I wasn't familiar with… Also much more familiar with role of Case Management and look forward to using them as a way to help communicate to patients.* • *Also [know] how to describe or "sell" the services to patients*
	Seeing AAA as a partner in care	• *Also knowing what the care coordinators do with our patients after the referral is helpful, so we know how to follow up.* • *I know more details about when to refer or check in with [AAA] about shared patient*
<u>Awareness</u> of resources and their importance	--	• *I will be more aware of the needs of my patients [who are older adults with disabilities]* • *I was able to gain insight into how much support patient[s who are older adults with disabilities] need to live independently.* • *[I have a] better understanding of the social support provid[ed] by the [AAA] which can assist me greatly as a primary care doctor as social determinants of health greatly impact healthcare and chronic disease* • *It will help me to be more aware of underlying concerns that patients will have medically and socially that do not normally come up explicitly in office visits.* • *It increased my recognition that just because I prescribe or order a medication or test, there may be multiple barriers to care that are still present.* • *It increased my awareness of the discrepancy that can exist between my clinical impression and the real world experience of a patient.*

Table 3. Summary of practicum benefits to the agency, barriers, and lessons learned from the perspective of practicum leads at the AAAs.

Topic and Key Themes:	Exemplar Quotes
Benefits of the practicum to the Agency • Sharing the Agency's role and the importance of AAA services • Increasing referrals to the AAA • Easing communication between AAA staff/case managers and healthcare providers • Increasing staff morale	• *"The AAA practicum helped increase local provider knowledge of what we do at the AAA. The vast majority did not know anything about us. The providers who had heard of our agency had a very limited understanding of our role. They believed the only thing we did was case management and provision of Medicaid Long Term Services and Supports, which is just a fraction of what we do. When providers have more knowledge, it helps drive referrals to our agency and allowed us to boost enrollment in certain programs (so that we don't leave funding on the table). When providers have greater awareness of what an AAA does, it also makes it easier for our case managers to coordinate with the healthcare team as they often have to call a healthcare provider to staff a case, share concerning information, or request a prescription for durable medical equipment."* • *"The residents were genuinely interested in learning about the complexities facing the case managers and how their future practice could work more effectively and collaboratively with the AAA staff."* • *"Staff can see engagement of clinicians and feel less siloed in their work. Staff have encountered difficulty navigating health systems on behalf of clients. [It is] helpful to know there is a caring professional on the other side, [and both] can gain and share perspective on system barriers"*
Barriers • Trainee scheduling challenges • Case management staff schedule challenges • Staff engagement	• *"Scheduling the [trainees] for the AAA practicum was a challenge, due to their busy schedules. They offered various times of the day when they would be available for in-home shadow visits for the case managers, however sometimes the time that the [trainee] was available wasn't always a time that the client was available."* • *"The biggest challenge for me was scheduling and coordinating the experiential visits . . . The [trainee] coordinator would generally send us a schedule about 2 months in advance, for a 4 hour block in either the morning or afternoon. From there, I had to find an appropriate staff person to host the . . . experiential visit. [When I didn't get volunteers], I would have to look at each case manager's calendar to see who had an assessment at the appropriate*

Topic and Key Themes:	Exemplar Quotes
	time and ask them individually to allow the [trainee] to shadow."
Lessons learned • Communication, flexibility, and anticipation can help with scheduling challenges • Engage in staff champions • The importance of providing AAA education for healthcare teams • Importance of knowing your learners	• *"Develop opportunities where you can to anticipate availability in advance. We developed a menu of standard experiences and then tailored some as practicable to trainee specific interests."* • *"We had a few seasoned staff who are invested in mentoring others. Can't solely rely on them but they can be champions of this program across other staff."* • *"We learned that providers are grateful to have this information. It helped us recognize the importance of providing AAA education for healthcare teams."* • *"Knowing what they know, what they don't know, as well as what interests them is fundamental. When a resident believes the information as well as the experiential visit will help and support their future practice, they see the benefits of the AAA practicum."*

Table 4. Pre-Post Practicum Gains in Describing and Utilizing Area Agency on Aging and Related Community-Based Resources*

Self-Efficacy Question (10-point scale from 1=not at all confident to 10=totally confident)	**Pre, Median *(n* = 28)**	**Post, Median *(n* = 16)**	**Median Difference**	**Wilcoxon Signed-Rank Test** zW	***p***
Describing the Aging Network and the roles of the Area Agencies on Aging fulfill within that structure (4)	2	8	6	3.5	<0.001
Identifying community resources that support unpaid caregivers (e.g. family members). (2)	2	8	6	3.2	0.001
Describe the community-based needs that are covered by Medicaid. (8)	2	7.5	5.5	2.8	0.006
Describing the role of an Area Agency on Aging case manager in the care of older adults. (1)	3	8	5	3.5	<0.001
Describing community resources that help maintain an older adult's independence. (3)	3	8	5	3.4	<0.001

Describing the Older Americans Act and how the Area Agencies on Aging came to exist. (5)	2	7	5	3.5	<0.001
Describing community-based mental health resources. (7)	3	7.5	4.5	2.7	0.006
Identifying and referring older adults to evidence-based programs (fall prevention, exercise, depression, etc.) available in the community. (6)	4	8	4	3.1	0.002
Identifying the signs of elder abuse and referring to resources to prevent / address it. (9)	5	8	3	2.9	0.004

* Geriatric Medicine Fellows and Nurse Practitioner Students at Seattle King County Aging and Disability Services

FIGURES AND FIGURE LEGENDS

Figure 1. Core components of the AAA practicum curriculum

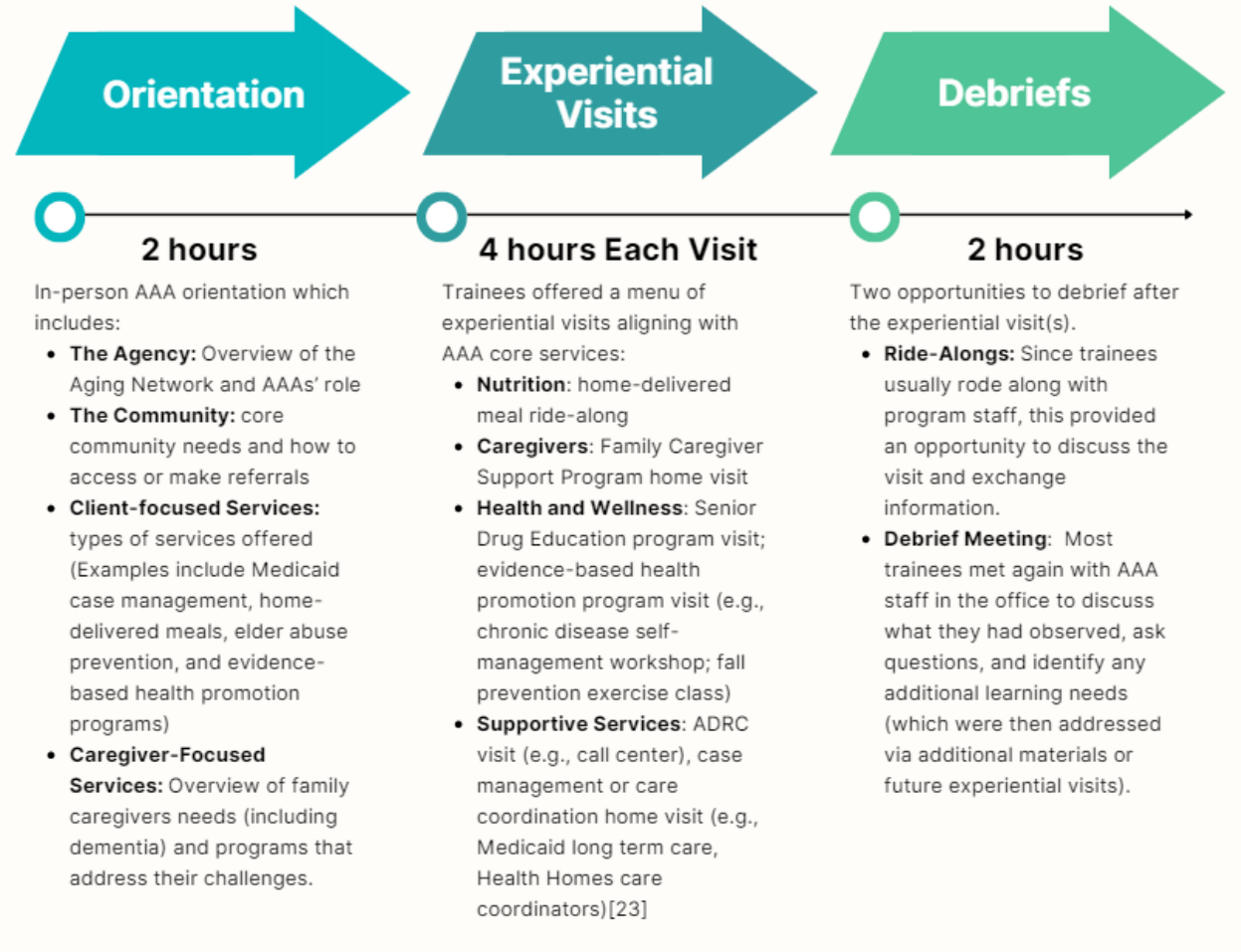
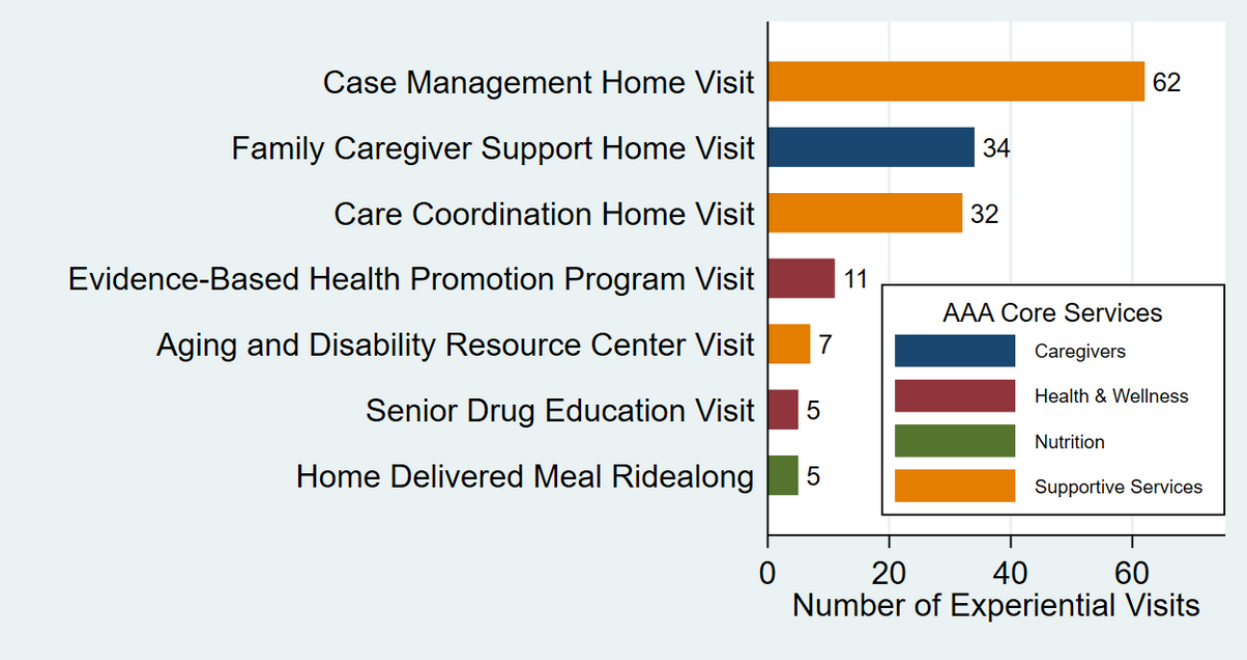


Figure 2. Type and frequency of experiential visits (n=163) completed by trainees.[a]



[a] Bar colors represent the relationship between visit type and core services provided by Area Agencies on Aging (see legend).

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AREA AGENCY ON Aging & Disabilities OF SOUTHWEST WASHINGTON

Curriculum Outline

Module 1: The Community

Module 1 Description:

This module builds on participant's knowledge of Area Agencies on Aging and prepares participants to identify needs that can be addressed by organizations, groups and professionals in the local aging network. The content of this module is designed to help participants recognize their role as practitioners in the aging network and encourages community and consumer engagement in their work.

Module 1 Content Outline:

1. Gathering Community Demographics
    a. Community Needs Assessment
    b. AAA Area Plan
    c. County Health Department
2. Community Partners
    a. Housing
    b. Transportation
    c. Senior Centers
    d. Nutrition Programs
    e. Community Action Programs
    f. Mental Health
        i. Mental Health Ombudsman
    a. Substance Abuse
    b. SHIBA
    c. Energy Assistance
    d. Telephone Assistance
    e. Elder Justice Centers
3. Finding Resources
    a. Eldercare Locator
    b. WA Community Living Connections
    c. 211
    d. Local Chapters of National Associations
4. Community Engagement

Module 1 Learning Outcomes:

- Resident Interns will be able to identify means to obtain resources in their community
- Resident Interns will recognize and explore the role they play within their community as a part of the aging network.

Resources:

Washington Community Living Connections

Eldercare Locator

211 Resource Database

Module 2: The Agency

Module 2 Description:

This module provides an overview of National, State and Organizational level initiatives related to funding and service provision for Older Americans. The module is designed to help participants understand how these initiatives impact available programs and resources through the State Units on Aging and the local Area Agency on Aging.

Module 2 Content Outline:

1. Older Americans Act
    a. History and Overview
    b. Objectives
    c. Establishment of AAAs
2. National Aging Services Network
    a. National Association of Area Agencies on Aging (N4A)
    b. Washington Association of Area Agencies on Aging (W4A)
3. Area Agency on Aging and Disabilities of Southwest Washington (AAADSW)
    a. Aging Network
    b. Vision
    c. Mission
    d. Governance
    e. Organization
    f. Advisory Council
    g. Area Plan

Module 2 Learning Outcomes:

- Resident Interns will have increased knowledge of National and State level initiatives related to funding and service provision for Older Americans as they relate to available programs and resources.
- Resident Interns will be able to describe AAADSW's function, structure and governance systems.

Resources:

Area Agencies on Aging: Local Leaders in Aging and Community Living

n4a

AAADSW Area Plan

Module 3: Client Focused Services

Module 3 Description:

This module provides an overview of services available to older adults through the Area Agency on Aging and organizations in the local aging network. It offers a summary of program goals and eligibility requirements, incorporating experiential opportunities that prepare participants to asses consumer needs and make effective referrals.

1. Aging and Disability Resource Center/Network
    a. Information and Assistance
    b. Community Living Connections
2. Senior Health and Wellness
    a. AAADSW Programs
        i. Oral Health
        ii. Enhance Fitness (EBP)
        iii. CDSMP (EBP)
        iv. Senior Drug
        v. Dakim Brain Fitness (EBP)
    b. Other Community Based Programs In Our Area
        i. Stay Active and Independent for Life - SAIL (EBP)
        ii. TaiChi (EBP)
        iii. Fall Prevention (EBP)
        iv. Strong Women (EBP)
        v. Walk with Ease (EBP)
        vi. Diabetes Education
        vii. Heart Failure Education
        viii. Nutrition Education
3. Long Term Care Ombudsman Program
4. Senior Nutrition
    a. AAADSW Initiatives
    b. Other Community Agencies
5. Senior Transportation
    a. AAADSW Initiatives
    b. Other Community Agencies
6. Medicaid Case Management
    a. DSHS
        i. HCS
        ii. APS
    b. Assessment/ Algorithm
    c. **Medicaid Case Management Home Visit**
7. Care Coordination
    a. **Care Coordination Visit (Home or Medical Appt.)**
8. Transitional Care Services (TCS)

   a. Bridge Model
   b. Care Transitions Intervention (CTI)
   c. Introduction of "Red Flags"
   d. **TCS Home Visit**
9. Aging Network Case Management
   a. Senior Personal Care
10. MIPPA
11. Senior Employment
   a. AAADSW Initiatives
      i. Steps to Employment
   b. Other Community Based Programs in Our Area
      i. Senior Employment Programs
12. Legal Services
13. Case Study and Discussion

Module 3 Learning Outcomes:

- Resident Interns will be able to articulate AAADSW's work to meet the needs of aging individuals by having increased awareness and understanding of programs and services available in the community.
- Resident Interns will illustrate understanding of systems in place to support older adults and be prepared to introduce these programs to patients and make relevant referrals to these programs in the community they serve.

Resources:

Red Flags Self-Management Plans

ALTSA Services to help an adult remain in their home

Module 4: Caregiver Focused Services (4 Hours)

Module 4 Description:

This module provides an overview of the needs of family caregivers and introduces participants to programs that address the burdens of family caregiving, including Alzheimer's disease and related dementia programs and services. This module will prepare participants to connect caregivers and care receivers to relevant services offered by the Area Agency on Aging and other community agencies.

Module 4 Content Outline:

1. Family Caregiver Support Program (FCSP)
    a. Family Caregiving Overview
        i. **FCSP Visit**
    b. AAADSW Initiatives
        i. Powerful Tools for Caregivers (PTC)
        ii. Caring for Your Loved One at Home
        iii. Caregiver Yoga
        iv. Direct Skills
        v. Counseling
        vi. Conferences
        vii. Respite
        viii. Supplemental Services
    c. Other Community Agencies
        i. Caregiver-Related Support Groups
        ii. Veteran Assistance i.e. Aid and Attendance
2. Alzheimer's Disease and Related Dementias (ADRD) Programs and Services
        i. AAADSW Initiatives
            1. STAR-C (EBP)
            2. Staying Connected
            3. Dementia Capable Options Counseling
            4. Teepa Snow Resources
        ii. Other Community Agencies
            1. Alzheimer's Association
            2. ADRD-Related Support Groups
3. Kinship Caregiver Services

Module 4 Learning Outcomes:

- Resident Interns will develop increased knowledge and awareness of the needs of family caregivers and potential emotional, financial and physical burdens related to the role of family caregiving
- Resident Interns will demonstrate an understanding of how to connect caregivers to services that address identified burdens.
- Resident Interns will demonstrate understanding and awareness of ADRD programs and services available to family caregivers and their care receivers and how to access these types of assistance.

Resources:

T-Care

Washington Dementia Roadmap

Area Agency on Aging and Disabilities of Southwest Washington Experiential Practicum Opportunities

The following is a list of potential experiential opportunities for resident trainees to participate in as a part of their time with the Area Agency on Aging and Disabilities of Southwest Washington (AAADSW).

Transitional Care Services (TCS):

Transitional Care Services empowers individuals to successfully transition back to the community following a hospital or skilled nursing facility stay. Transitional Care Coordinators partner with individuals to provide tools, information and guidance to help manage health conditions and avoid readmission into more costly settings. A TCS visit will take place in a client's place of residence and will have a focus of reviewing discharge instructions from recent hospitalization/nursing home stay, medication review, clarification and/or scheduling of follow up appointments, red flags for diagnoses as well as resource finding for community supports and services that may be helpful.

Examples of What You May See by Participating in a TCS Visit:

- A TCS visit typically occurs in the client's place of residence and with the client, as well as any family/support individuals/key learners the client wishes to be involved.
- Interactions between the client and TCS staff are limited prior to the visit. TCS staff may have had a short interaction with the client at the hospital or skilled nursing facility, and then a phone call to schedule the visit.
- Client's readiness for the visit varies. Some are well prepared and have a good grasp of their discharge instructions. Others may have little to no understanding of their discharge instructions and/or their medications.
- One component of the visit includes discussion of community based resources that may be helpful for the client and/or their family.

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Family Caregiver Support Program (FCSP)

FCSP provides services to family and friends (family caregivers) to continue at-home care of a relative or friend. TCare is an evidence based assessment tool, utilized as a part of FCSP that guides supports and services tailored to each individual family caregiver. Through this program, family caregivers have access to community services, education and supplies which are designated to make their lives as a caregiver easier while respecting the independence and dignity of their loved one. Individuals who take part in FCSP also have access to a Family Caregiver Specialist Case Manager who can help to assess solutions for the particular family unit and be supportive throughout the caregiving journey.

Clients who participate in FCSP have access to the following in addition to their case manager, depending on their particular circumstances:

- **PTC** is a six-week, evidence based class series, caregivers develop a wealth of self-care tools to: reduce personal stress; change negative self-talk; communicate their needs to family members and healthcare or service providers; communicate more effectively in challenging situations; recognize the messages in their emotions, deal with difficult feelings; and make tough caregiving decisions.
- **Caring for Your Loved One at Home Classes** teach day to day care, lifting and moving a care receiver, home safety, managing medications, nutrition, challenging behaviors, legal & financial issues, community resources and the importance of self-care.
- **Caregiver Yoga** provides unpaid family caregivers self-care skills. Workshops are two hours and include time for personal reflection and sharing and followed by yoga practice.
- **Staying Connected** is a four week small group series for people living with early stage memory loss and their care partners. This program helps people recognize future changes and how to manage them.
- **STAR-C** helps family caregivers who are caring for someone with Alzheimer's disease or a related dementia and lowers depression in caregivers and decrease problem behaviors in the person with dementia.
- **Counseling** helps caregivers cope with stress that may occur during the caregiving journey.
- **Conferences**
- **FCSP Information and Assistance**

- **Respite** offers caregivers a break away from caregiving.
    - **In Home**
    - **Out of Home/Over Night**
    - **Adult Day Care**

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- **Supplemental Services** provides limited funding to purchase items or services intended to reduce the objective burden of caregivers.
    - **PERS**
    - **Supplies or Equipment**

Examples of What You May See by Participating in an FCSP Visit:

- The purpose of an FCSP visit is to engage a family caregiver into services or to continue their services if they have had an assessment previously by ensuring that the services they are using are helpful.
- FCSP visits usually take place in the caregiver's home. Often, the care receiver and caregiver live together, however, this is not always the case. The questions asked during the assessment can, at times, be difficult to discuss in front of the care receiver so the caregiver may choose to participate in the assessment without their loved one.
- Caregivers and care receivers participating in this program come from all different socio-economic backgrounds. Because there is no income cap on this program individual circumstances vary greatly.
- Caregivers will share about their experiences taking care of a loved one and then problem solve with the FCSP Case Manager to look for ways to improve their, as well as their loved one's quality of life. This may involve communication with their care team, adaptive equipment, respite, classes, or community resources.

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Care Coordination

The goal of care coordination is to provide better health outcomes for clients through comprehensive care management and decreasing health care costs by collaborating amongst all systems of care. Clients receiving Medicaid Insurance are referred from the state Health Care Authority via their health insurance or health home (for example, Community Health Plans of Washington). Eligible clients are identified based on their chronic health conditions, treatments and medications – clients with a high utilization rate and increased risk of hospitalization are more likely to be referred. The program is entirely optional and free of charge. It also does not replace any services the client may have in place such as case management, nursing and caregiving services, mental health, etc. Care Coordination is client-driven, in that Health Action Plans are developed around the client's goals, regardless whether those goals are directly related to their health and medical needs. If a client chooses to participate, they are eligible to receive the following services:

- **Comprehensive care management:** Assessments of their existing situation and support to improve.
- **Care coordination:** Between professionals/community resources/supports
- **Health promotion:** Coaching including goal setting, nutrition education and referrals as needed,
- **Comprehensive transitional care:** Examples include hospital to home, SNF to AL or AFH,
- **Individual and family support:** Behavior and emergency planning, end of life planning/support and support for family and other caregivers,
- **Referrals to community resources and social support services:** As needed for health, welfare and safety including advocacy for healthcare and other services.

Examples of What You May See Participating in a Care Coordination Visit:

- There are several types of Care Coordination visits. Visits can take place in a client's residence, a doctor's appointment, or while accessing another community resource.
- In order to be involved with Care Coordination, you must either have Medicaid, Medicare, or both. Care Coordination services are available to clients from birth through death, however, there are many dual-eligible clients (Medicare/Medicaid).
- Socio-economic backgrounds of clients also vary greatly.
- Relationships between care coordinators and their clients will vary depending on the length of time they have been working together, as well as the depth of their interactions.

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Medicaid Long Term Care (Community First Choice) Case Management and Nursing

Community First Choice (CFC) is a Medicaid program offering personal care and other services to eligible individuals. The program was established by the Affordable Care Act (ACA) under 1915(k) of the Social Security Act and is administered by the Washington State Department of Social and Health Services (DSHS). Offering personal care and other services under CFC allows DSHS to provide a more extensive benefit package to support clients in community settings. CFC is intended to promote choice, flexibility, and community care over institutional care. For qualified individuals, CFC offers personal care services, skills acquisition training, assistive technology, personal emergency response systems, and a few other services that help clients remain in community settings.

Individuals involved with the CFC program and are living in their own place of residence (not a nursing facility, assisted living, etc.) have a case manager through AAADSW. The primary goals of case management are to assist the client to develop a plan of care to enable them to reside in the setting of their choice and to monitor that plan. Case managers will support the client's independence by coordinating and offering assistance to access needed services. Case managers are custodians of the state's resources and must balance a client's choice with program limits.

Case managers:

- Educate clients, family members, support systems, and other service providers that a comprehensive plan of care is developed within the choices and resources available and that meeting **all** needs may not be possible.
- Provide client-centered services, evaluating informal and community supports, with an overarching goal of preventing unnecessary institutionalization.
- Support/maximize client independence and self-direction.

Nurses are also a part of the team who work as a part of the Medicaid Long Term Care Program. Nursing Services offers clients, providers, and case managers with health-related assessment and consultation in order to enhance the development and implementation of the client's plan of care. Nursing Services is not a direct care provider of intermittent or emergency nursing care, skills or services requiring physician orders and supervision.

The goal of nursing services is to help promote the client's maximum possible level of independence and contribute nursing expertise by performing the following activities:

- Comprehensive Assessment Reporting Evaluation (CARE) review;
- Nursing assessment/reassessment;

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- Instruction to care providers and clients;
- Care and health resource coordination; and/or
- Evaluation of health-related care needs affecting service planning and delivery.

Skilled *treatment* is provided by Nursing Services only in an emergency. For example, the provisions of CPR or First Aid until emergency responders arrive to provide care.

Examples of What You May See by Participating in a Medicaid Case Management Visit:

- A case management visit for this program will be either a 30-day introductory visit, a full assessment or a Targeted Case Management (TCM) visit. A home visit with a nurse may also be an option. These types of visits will involve time for introductions as well as any questions the client may have about their plan of care.
- Case Managers/Nurses will work to discuss any significant events or changes in health as well as discovery of any recent falls or hospitalizations.
- Skin observation protocol will be covered in some case management visits, and most nursing visits.
- Clients on this program are typically from lower socioeconomic backgrounds as they must meet financial eligibility to be on this program.
- The visit will take place in the client's place of residence and other support people or caregivers are welcome to participate as well.

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Aging Network Case Management

Aging Network Case Management (ANCM) consists of short-term Case Management for persons age 60+ to prevent unnecessary institutionalization. Core functions include:

- Assessment
- Care Planning
- Client Advocacy
- Technical Assistance
- Referrals
- Family Support
- Crisis Intervention
- Access to Resources

During an ANCM visit, case managers assist individuals with finding resources that may be helpful for them on a short-term basis. Visits typically take place in the client's home and involve discussion of the client's particular situation. Visits may also include filling out paperwork, gathering necessary documents for application to other programs or services, making phone calls, or referrals to other programs.

One service that is a sub-program of ANCM is the Senior Personal Care (SPC) program. This program provides up to 18 hours if in-home personal care, provided by a contracted home care agency. This time with a caregiver may be used to assist with personal care tasks as well as other household activities. In order to qualify for this service, an individual must be over the age of 60, have less than $10,000 dollars in assets ($15,000 if married) and need help with at least one ADL, but not qualify for Medicaid Long Term Care, either functionally or financially. Individuals engaged in this program have an annual assessment and access to a case manager to navigate as needed.

Examples of What You May See Participating in an ANCM Home Visit:

- Visits most often take place in the client's home
- Case managers assess for a particular client's needs, depending on the situation at the time of the visit.
- An assessment may be completed if an individual is interested in Senior Personal Care.
- A Case Manager may assist with completion of paperwork, making phone calls, or navigating websites, as needed by the client.

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S1 Supplemental Material

AAA Practicum Post-Survey

Please rate your *Overall Satisfaction* with your experience(s) at ADS:

- ○ 1 (low)
- ○ 2
- ○ 3
- ○ 4
- ○ 5 (High)

How CONFIDENT are you with the following:

	NOT AT ALL CONFIDENT				CONFIDENT					TOTALLY CONFIDENT
	1	2	3	4	5	6	7	8	9	10
Describing the role of an Area Agency on Aging case manager in the care of older adults.	○	○	○	○	○	○	○	○	○	○
Identifying community resources that support unpaid caregivers (e.g. family members).	○	○	○	○	○	○	○	○	○	○
Describing community resources that help maintain an older adult's independence.	○	○	○	○	○	○	○	○	○	○
Describing the Aging Network and the roles of the Area Agencies on Aging fulfill within that structure	○	○	○	○	○	○	○	○	○	○
Describing the Older Americans Act and how the Area Agencies on Aging came to exist.	○	○	○	○	○	○	○	○	○	○
Identifying and referring older adults to evidence-based programs (fall prevention, exercise, depression, etc.) available in the community.	○	○	○	○	○	○	○	○	○	○
Describing community-based	○	○	○	○	○	○	○	○	○	○

mental health resources.										
Describe the community-based needs that are covered by Medicaid.	○	○	○	○	○	○	○	○	○	○
Identifying the signs of elder abuse and referring to resources to prevent / address it.	○	○	○	○	○	○	○	○	○	○

As a result of your experience(s) at ADS, do you plan to do anything differently in how you practice geriatric health care?

- ○ Yes
- ○ No

How will this experience impact your clinical practice?

Is there anything else you'd like to share with us?

Thank you for your feedback!

Submit responses