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Huntington Hospital Senior Care Network

Perspective

A NEWSLETTER ON AGING AND SERVICES *for* OLDER ADULTS

Partnering with Patients *for Better Health*

*Health navigator
Clara Iniguez,
MSW, explains
how to use a
Personal Health
Record.*



In the changing world of healthcare, hospitals are seeing compelling reasons to keep people well and away from their emergency room doors. Government mandates are encouraging the trend, but at Huntington Memorial Hospital, helping people avoid unnecessary hospitalization not only reflects our mission to excel at the delivery of healthcare to our community, it's how we view ourselves as a hospital, asserts Eileen Koons, MSW, ACSW, director of Huntington Hospital Senior Care Network.

“An excellent healthcare system promotes wellness and does not rely on acute care services unnecessarily,” she says. “It helps people find ways to stay out of the hospital.”

One such effort is the Patient Partners Project (PPP), formerly the Chronic Disease Management program, which is successfully using evidence-based practices >

“Thank you for Senior Care Network. It has been a source of help when I don’t know what to do or where to go. You are a breath of fresh air.”

~ A caller to HSCN’s Resource Center

to reduce readmissions of patients with congestive heart failure, the number one diagnosis of patients readmitted to Huntington Hospital. Based on data reported in July, patients enrolled in the program had nearly half the readmission rate as patients not enrolled in the program.

PPP uses an educational model that empowers patients to manage their illness in partnership with their healthcare providers. The project utilizes Huntington Hospital Senior Care Network (HSCN) health navigators who are social workers to see the patients while they are in the hospital. Patients also see a cardiac nurse educator who instructs them about their illness at the bedside.

Within two days of discharge, the health navigator telephones patients to reinforce the instructions and information they received before discharge and ensure they have a follow-up appointment with their doctor. Additional telephone calls for another month and a home visit where necessary continue the support.

“The goals are to help patients maintain their health by encouraging them to connect with their healthcare provider after discharge and to provide support to help them integrate into their lifestyle the parts of healthcare that are in their control,” explains HSCN clinical supervisor Chris Garcia, LCSW.

As people live longer with diseases like congestive heart failure that are not cured but need to be managed, patients have a bigger role in their care, Garcia notes. Behaviors they need to engage in can require challenging lifestyle changes, such as taking medications and following dietary restrictions.

“The reins of their healthcare management are in patients’ hands,” she says. “It’s a shock to many patients to think they’re in charge when they go home.”

And changes can be hard to make. “We stretch like rubber bands and when the pressure is off, we snap back to our original shape,” she remarks.

A tool called motivational interviewing (see article, page 3) is helping health navigators address the barriers people have when they’re presented with making changes. It’s a non-confrontational, structured technique that supports patients making their own healthcare choices and helps them explore their ambivalence to change.

“Health navigators partner with patients — not tell them what to do,” Garcia says. “Motivational interviewing allows for questions like ‘What is important to you?’ ‘What do you want?’ It makes it a two-sided conversation.”

“It’s a very important feature of the PPP intervention,” adds Eileen Koons. “People don’t want to be sick but everyone has barriers. It helps patients articulate them and remove them. For patients with a high chance of readmission, it can give them a feeling of hope to avoid landing back in the hospital.” ‡

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Clients Provide the Solution *in Motivational Interviewing*

Health navigator Edward Cordero, MSW, uses motivational interviewing to help patients make choices.



IT SEEMED ALMOST IMPOSSIBLE to help the new Huntington Hospital Senior Care Network (HSCN) client. In a clean facility after years of being homeless, the woman certainly qualified for the Multipurpose Senior Services Program (MSSP), which helps low-income individuals age 65 and older and certifiable for nursing home placement to live at home. Unconnected to any healthcare providers, she had physical and mental health issues that needed attention. But when the care coordinator attempted to put any services in place, the woman steadfastly resisted. Nothing was working.

MSSP clinical supervisor Charleen Crean, LMSW, decided to telephone the client and “begin with what she’s telling us she needs.” Using an approach called motivational interviewing, also known as brief negotiation, Crean listened to why the woman didn’t want to see a doctor. She summarized her responses, which included needing clothes, a haircut, her toenails clipped and having any services only between 3 and 5 p.m. “I will arrange those things if you see the doctor,” Crean told her. The client agreed and is now accepting services.

The 15-minute conversation may seem to have produced near miraculous results, but with 20 years of experience using motivational interviewing, Crean has honed her skills. She now conducts training sessions for HSCN care coordinators and Patient Partners Project health navigators (see article, page 1) to help them manage resistance and ambivalence in clients and patients. >

Originally designed for people with chemical dependency, motivational interviewing is a series of interventions to help a person find motivation to do things differently. “It’s client-directed, so motivation is elicited from the client and not imposed. The client is in charge,” says Crean.

“Most of it is active listening — asking for clarification and summarizing. You reflect the emotional content of what they tell you, not just the words. You stay non-reactive but empathic and engaged.”

People have valid reasons for resistance, Crean maintains. Comments like “help me understand that” or “what is that about” help pinpoint where the obstacles are and get at the real problem. The MSSP client who wanted services only between limited hours was fearful of leaving her home. Agreeing to arrange a doctor’s appointment and have other services done during those hours became part of the solution.

Crean knows it’s a different approach for many healthcare providers. It takes practice to use effectively and it’s not suitable for every client and situation. “It’s one of the arrows in the quiver,” she says. “You slip into it when you encounter resistance. Embrace the resistance, grab it and try to understand it. Resistance becomes the lights on the runway directing where you need to be going.” ‡

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A Practice Change Fellow Talks About Making Change Happen



*In 2009 Huntington Hospital Senior Care Network director **Eileen Koons**, MSW, ACSW, was named one of 10 national participants in the Practice Change Fellows program supported by the Atlantic Philanthropies and the John A. Hartford Foundation. Through monetary support and mentoring, the prestigious program aims to build leadership capacity among nurses, physicians and social workers in geriatric care to create a national network of specialists dedicated to influencing healthcare delivery and improving the health of older adults. With the conclusion of the two-year opportunity, Koons reflects on her experiences as a Practice Change Fellow.*

Perspective: *What is distinctive about the Practice Change Fellows (PCF) program?*

Eileen Koons: PCF is intended for the leadership in aging — icons who are now leading efforts in

the nation and emergent leaders. For me it was access to people who are deep and experienced thinkers. It was an amazing and gratifying experience to put everybody on the same plane.

Why did you decide to apply?

I could see we’re heading for a time of great change in healthcare and aging. I felt I needed to take some intentional efforts to be prepared for this change. >

“Equipping staff with the vision and skills needed for success is an important aspect of effective practice change.”

How does the program align with the goals of the hospital and Senior Care Network?

The whole PCF premise is to prepare people to embrace and implement change that improves the world for the people we serve. The clear message I've been seeing is it's not okay to do the same thing year after year. The hospital and Senior Care Network have always been about providing excellent care and implementing best practices. We sit in a community that has more than its share of older adults. The hospital has an opportunity to position itself as a leader in aging and I want to help them get there.

Each Fellow developed a project and yours was a diabetes care program for older adults. What have you learned?

We are starting to learn, and need to learn more, about the best way to target our efforts so that ideally we spend every resource necessary to help the person who needs help in making a care transition and less or none on those who don't need help. You don't give every patient the same treatment even though they have the same diagnosis, and the differences are important to understand. Equipping staff with the vision and the skills needed for success is an important aspect of effective practice change. This project launched what we're now doing in the Patient Partners Project (see article, page 1).

What impact did the program have on your own development?

It re-enforced that it's so important to have your network and keep on top of what other people are doing. Reading is okay, but to have access to others who are doing it is even better. It's easy to isolate yourself and just focus on the steps you are taking. Staying connected with

others and knowing where things are going is more important than it was 10 to 20 years ago. The more I can access the resources around me, the greater the opportunity for success.

How did the PCF experience enhance your leadership skills?

I learned more about how Senior Care Network fits into the bigger picture. Leadership is about leading the present into the future and seizing opportunity — being ready to make change at the right moment in time. I definitely see opportunities in a different way. There is a much greater awareness starting to emerge in the healthcare system of the social determinants of health and treating the whole person, which we've been doing for 25 years. Being a PCF has helped me prepare for this shift and to have the confidence to move us in that direction. We have an important role and skill set to offer and there are so many possibilities for where we head. ‡

A Powerful Class for Caregivers *Makes a Difference*

Family caregivers are at the core of providing support and care for adults who are frail and disabled. An AARP report put the number of family caregivers who were caring for an adult with limitations in daily activities



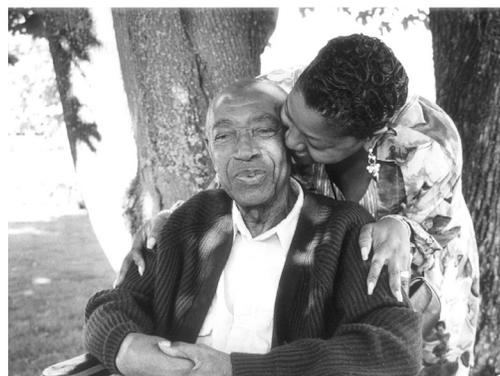
at 42.1 million in 2009. The economic value of their unpaid contributions was estimated at \$450 billion — the cost if that care had to be replaced with paid services.

But caregiving comes with another steep price — high rates of depression, stress and other physical and mental health problems. Recognizing the need for caregiver-focused support, Huntington Hospital Senior Care Network (HSCN) began offering a six-session class called *Taking Care of You: Powerful Tools for Caregivers* over a decade ago.

This evidence-based educational program has reached over 70,000 caregivers nationally. Trained co-leaders use a scripted curriculum and intricately-detailed materials to help caregivers gain self-care skills and increase their confi-

dence to make difficult decisions.

Patty Watson-Wood, RN, BSN, senior health and caregiver support coordinator and class co-leader, has seen the difference the program makes firsthand. “Many caregivers experience a sense of powerlessness,” she notes. “They grapple with



the concept that they really can change their attitude. There are so many factors in their life they didn't plan on.

“But they see that they are all caregivers. The class gets at basic issues and helps them make changes. They leave with their attitude reframed and better able to manage caregiving challenges.”

Powerful Tools is the result of over three years of testing and evaluation and is based on a successful chronic disease self-management program developed at Stanford University. Self-confidence to make changes and practice self-care is gained through strategies such as making action plans, modeling by the class leaders and reinterpreting beliefs and thoughts.

Watson-Wood finds that an evidence-based program is a plus for >

“As a result of this class, I’m a more confident caregiver because I’m a better communicator and understand the need to care for myself.”

~ A Powerful Tools participant

participants and class leaders. “It creates a sense of security for the potential vulnerability of the caregivers,” she says. “We deal with a lot of emotional topics so it’s important to know what is reasonable to ask caregivers to do.”

The class has been shown to have a positive impact on caregiver health for caregivers at different stages of caregiving as well as those from different living situations and financial and educational backgrounds. In a recent study appearing in an international journal, participants reported significantly lower levels of stress and infringement of caregiver role on their lives than a comparison group.

Rosanna Baranets was not in the throes of caregiving when she attended the program, but with her mother in the early stages of dementia, she wanted to be

prepared. “I already knew about the power of others’ experiences and the importance of seeking help and information instead of worrying,” she says. “I was not disappointed. Sharing with others and getting the packets of information made me feel pro-active and know what’s ahead.”

When her mother took a turn for the worse recently, Baranets was ready. “Instead of anguishing over it, I knew it was coming,” she recounts. “I felt empowered to be able to tell the others in the family it’s okay.”

HSCN will soon offer its twenty-first *Powerful Tools* class, a testament to the need for ongoing caregiver support in an aging society. There’s no real mystery as to why caregivers find the class powerful. Summing up its success, Watson-Wood says, “It just works.” †

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Eileen Koons, MSW, ACSW

Director

Gladys Gundrum, MA

Writer/Editor

Huntington Hospital Senior Care Network provides access to a complete range of medical, social and personal services for adults, older adults with disabilities and their families. For more information, call (626) 397-3110 or (800) 664-4664 or visit our website at www.huntingtonhospital.com/SCN.