

ISSUE 2 / 2012

- 1 A Partnership with Physicians Enhances Patient Care
- 3 Thriving in an Assisted Living Facility: A Client's Story
- 4 Patty Watson-Wood, RN, BSN — Saluting 35 Years of Service
- 6 How a Care Coordinator Makes a Difference

Huntington Hospital Senior Care Network

Perspective

A NEWSLETTER ON AGING AND SERVICES *for* OLDER ADULTS

A Partnership with Physicians *Enhances Patient Care*

*Health navigator
Wendy Sotelo,
MSW, (right)
checks on a
patient's status
with patient
care associate
Shelly Worthley.*



As [Huntington Memorial Hospital](#) continues to enhance service delivery along the continuum of care, the expertise of Huntington Hospital Senior Care Network (HSCN) has been instrumental in helping patients make a successful transition from hospital to home. In the Patient Partners Program, HSCN health navigators visit hospitalized patients diagnosed with congestive heart failure and within two days of discharge, telephone them to reinforce instructions and information they received before discharge, ensure they have a follow-up appointment with their physician and determine if they have needed support at home. Ongoing monitoring continues for another month. >

“The project has worked extremely well. It has given seamless improvement to our delivery of inpatient care and the transition from discharge process to timely follow-up of outpatient appointments.”

~ Stuart C. Miller, MD

Now under a grant from Blue Shield of California to help the hospital improve sharing of healthcare information among healthcare providers, HSCN health navigators are partnering directly with primary care physicians of the Huntington Medical Foundation to further foster improved care.

Physician concern about their patients’ unmet social needs and the impact on their health was underscored in a 2011 national survey of physicians conducted by the Robert Wood Johnson Foundation. According to the report, *Health Care’s Blind Side: The Overlooked Connection between Social Needs and Good Health*, four in five physicians surveyed say unmet social needs are directly leading to worse health and a similar number are not confident in their capacity to address these needs. Health navigators are in a unique position to respond to the call for assistance.

“As physicians have larger practices and spend more time in their offices,” notes HSCN clinical supervisor Chris Garcia, LCSW, “health navigators can facilitate communication with the physician and bridge connections. When there are bumps in the road, it’s helpful to have someone looking out for them.”

Health navigator interventions have saved patients from spending extra time in the hospital, a benefit for the patient and the hospital. In one instance, a physician working with the health navigator was requesting clearance from the pulmonologist to discharge a patient. The health navigator was able to assist by collaborating with the unit nurse who contacted the pulmonologist and received discharge clearance over the telephone. Delays were averted and the patient was discharged timely.

The health navigator stays in close contact with the physicians to determine any needs the physicians may have, visits patients to see if they or family members have concerns and stays alert to discharge planning needs. When patients return home, the health navigator telephones at regular intervals for up to a month to confirm their continued safety and conducts home visits as needed.

On one routine call to a patient, the health navigator learned that the patient had recently fallen at home. When the patient rated her pain 7-8 on a 10-point scale, with 10 the highest pain imaginable, the health navigator coached the patient’s daughter to seek medical attention. After being taken to urgent care, the patient was then sent to the emergency department for a more in-depth assessment. No fractures were identified, but the health navigator followed up to be sure home health care was in place and referred the patient for long-term care management due to her risk of premature nursing home placement.

“This project has worked extremely well,” affirms Stuart C. Miller, MD, a primary care physician in the project. “It has aided me in increasing the quality and cost-effectiveness of patient care. It has given seamless improvement to our delivery of inpatient care and also the transition from discharge process to timely follow-up of outpatient appointments. Plus it has decreased readmissions by the navigator’s personal outpatient home visits and follow-up.”

“It’s an advantage to have a person whose role is to actually look for gaps in the system and eliminate them,” Garcia agrees. “And as the hospital redefines its role to extend outside its doors, it’s a piece that goes back into the community.” †

Thriving in an Assisted Living Facility: A Client's Story

*HSCN client
Emma Gonzalez,
who is legally
blind, enjoys
sharing stories
with HSCN care
coordinator
Martha Celis, BSW.*



There may be no place like home, but for frail seniors with multiple health needs, home may no longer be a safe place to live. That's what happened to Emma Gonzalez, 86, who is legally blind due to macular degeneration, has diabetes and uses oxygen. Her life changed dramatically after she was hospitalized for bronchitis over four years ago.

When she returned home to her senior apartment, “she went downhill,” relates her daughter, Rosie Davies. “She started having memory problems and wasn’t taking her medications, including insulin twice a day. It became harder and harder.”

Even though she had several hours of in-home help three times a week, it wasn’t enough. When a caseworker told Davies about a government program that might offer the assistance her mother needed in a home-like setting as an alternative to nursing home placement, she promptly called Huntington Hospital Senior Care Network (HSCN) to learn more about the Assisted Living Waiver Program (ALW).

ALW, which serves adults eligible for Medi-Cal with no share of cost, stems from the recognition that, with extra help, some medically-needy individuals can be safe and thrive in the more home-like setting of an assisted living facility instead of residing in a nursing home. As part of the program, personal care, oversight and other supportive services are provided or coordinated for residents. Persons accepted into ALW can choose among participating facilities to find one that suits their needs.

At her present facility, where she has lived for over a year after a previous facility closed, Gonzalez has blossomed. When her HSCN care coordinator asks what >

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she likes about living there, speaking in Spanish through an interpreter she responds, “I like everything!”

She names exercise dancing as a favorite activity and offers a demonstration in her chair. Playing bingo using large font pieces, playing “catch” in the outdoor patio and talking and eating with a good friend also keep her busy, she says.

She appreciates that if she wants to go from the living room to her room, sometimes she doesn’t even need to call out for assistance — someone anticipates her need and comes to help her. She’s also happy that staff take care of her daily medication needs and blood sugar check-ups so “I don’t have to remember to do it.”

Her daughter couldn’t be more pleased. Describing her mother as formerly a very independent and social person who liked to tell stories and had lots of friends, Davies says she may be a little more tired these days, but “she’ll sing and tell jokes when I visit her.” And the “great news” is that Gonzalez no longer requires insulin.

With her mother doing well and content in her new home, Davies has found what family caregivers hope for when their loved one can no longer manage their own health-care and personal needs and must relocate.

“I don’t worry about her,” she says. “I’m very satisfied and confident they are taking good care of her. I have peace of mind.” ‡

[BACK TO PAGE ONE](#) ↑

Patty Watson-Wood, RN, BSN Saluting 35 Years of Service



*Reprinted from Huntington Hospital
Senior Care Network 2011 Annual Report*

If education is at the core of Huntington Hospital Senior Care Network’s mission, it’s surely at the heart of the 35-year hospital career of Patty Watson-Wood. Since joining HSCN in 1990, where she has been senior health and caregiver support coordinator for the past 12 years, Patty Watson-Wood has been a consistent voice in informing older adults and their families on how to stay well and access the services they need.

Perhaps it’s her distinctive blend of nursing and social service skills — what she calls her “social work style of nursing” — that best describes her role as an educator. >

“Older people have gone through so many life experiences and have much to share. I’ve learned from them to be present in the moment.”

Combining roles and reaching across disciplines just seems to come naturally. “I enjoy working collaboratively with people,” she acknowledges, “and I’ve had many opportunities at Senior Care Network.”

Watson-Wood fell into nursing “accidentally” because it was her college roommate’s choice, she says, and began her hospital career working in the intermediate and intensive care units. After she earned her bachelor’s degree in 1987, the tug to “help a sick person but get to know them better through a long-term relationship” persisted. When she became a visiting nurse, her attraction to community-based work grew.

“The idea of having some effect on keeping people well — I loved it,” she recalls. “I was working in their home, helping them recover on their own terms and giving them information.”

By the time Watson-Wood came to HSCN to help with client care planning, the fit felt perfect. Today, imparting information continues to be central to her role whether she’s planning health promotion programs on healthy aging or helping family caregivers learn self-help skills.

But she doesn’t stop there. She is a dedicated advocate of education about advance healthcare planning and is closely involved with the Coalition for Compassionate Care of California and the San Gabriel Valley End-of-Life Care Coalition. It’s a long-standing passion that stems from her experiences as a critical care nurse.

“In the 1980s we had a lot of younger patients who were actively dying of AIDS as well as older people with end-stage medical conditions who had never addressed end-of-life care. We were seeing what could go wrong. I knew it didn’t have to be that way,” she says. “I can speak from real life experience about why advance planning makes a difference.”

For Watson-Wood, the rewards of being an educator are getting back what you give. She admires the resilience she sees in older adults and finds she is continually learning from them.

“Older people have gone through so many life experiences and have much to share,” she observes. “Those who have gotten past tough times have life in perspective. They know what’s worth worrying about and what to let go. I’ve learned from them to be present in the moment.”

Patty Watson-Wood’s zest for learning and educating has enriched the lives of countless clients, patients, caregivers and community residents in a remarkable career of service to others that shows no signs of slowing. ‡

[BACK TO PAGE ONE](#) ↑

Care coordinators use their knowledge of resources to help ensure that clients live in a safe environment.



How a Care Coordinator *Makes a Difference*

When Huntington Hospital Senior Care Network (HSCN) care coordinators are able to give frail seniors the best possible chance to live safely in their own home and maintain their independence, the results can be remarkable. Deep knowledge of the community, unbounded resourcefulness and dogged persistence are just some of the tools they use to make a significant difference in the lives of clients.

For Mrs. A, 76, a client in HSCN's publicly-funded Multipurpose Senior Services Program (MSSP), the changes have benefitted her family as well. Like other MSSP clients, Mrs. A needs assistance to perform such everyday activities as dressing, bathing and getting around, and is sufficiently impaired to qualify for nursing home placement. Unsteady on her feet due to arthritis, she uses a walker. She also has limited motion in one arm that makes it difficult for her to grasp and her vision is poor. >

Deep knowledge of the community, unbounded resourcefulness and dogged persistence are just some of the tools care coordinators use to make a significant difference in the lives of clients.

She lives with her daughter and son-in-law and their two young children who help as much as they can on their tight income. She says she is reluctant to ask much of her daughter because she sees how busy she is and doesn't want to burden her. When the care coordinator first met her, Mrs. A spent much of her time confined in her house because she couldn't navigate the stairs going out of the house by herself, a dangerous situation in an emergency.

Addressing ways to improve her safety, the care coordinator knew of a community program that was able to provide Mrs. A with free glasses. Grab bars installed in the bathroom to help her stand up and a hand-held shower — seemingly small items obtained through MSSP — made personal care much easier as well as added to safety. The care coordinator found a donated medication box to help the daughter better manage her mother's medications. Available funds allowed purchase of an emergency kit as part of educating Mrs. A and the family to develop an emergency plan.

It eases Mrs. A's mind that her daughter can call upon the care coordinator for information and guidance. With the care coordinator's assistance, the daughter expects to become her mother's In-Home Supportive Services care provider, a benefit to both Mrs. A and her daughter.

Still, the care coordinator knew Mrs. A's inability to leave the house by herself remained a serious problem. Adding an outside ramp to the house would give her the mobility she needed, but the family couldn't afford the cost. The care coordinator scoured community resources for assistance without success and was able to secure resources through MSSP.

The new ramp has changed Mrs. A's life. She now goes out to the yard to watch her grandchildren and has access to public transportation. The care coordinator is working to connect her with Dial-a-Ride so she can go to activities at the local community center. Mrs. A and her daughter are thrilled with her new mobility and her improved safety at home. As the care coordinator put it, "Her smile is brighter now." ‡

[BACK TO PAGE ONE](#) ↑

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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.