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When a Little Goes a Long Way: Expanding Home Care Services to Adults with Disabilities

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These reductions are noteworthy given the challenging nature of behavioral symptoms of dementia, and difficulties encountered historically and internationally in changing strongly-rooted clinical practices. How were these successful interventions achieved in high-performing state initiatives? What were the barriers encountered and facilitators that helped overcome these barriers? What does this experience suggest for sustainability of change? To address these questions, we draw on a mixed-methods study of antipsychotic prescribing in nursing homes incorporating analyses of prescribing data, state policy case studies, and facility case studies. Successful states integrated large-scale educational initiatives with strong regulatory action, often focusing especially on laggard facilities. Texas' initiative was particularly noteworthy, achieving a 56.5% reduction across its far-flung network of nearly 100,000 residents and 1,200 facilities. Texas used metrics to identify facilities that achieved notable reductions in antipsychotic prescribing, and encouraged them to share their strategies with "late adopters". The state deployed a designated Quality Monitoring Program (QMP), distinct from the survey process, to provide on-site technical assistance to laggard facilities, and provided education for all levels of staff and assistance in implementing data-driven improvement strategies. Successful state initiatives achieved considerable buy-in on the need to reduce antipsychotic use, a key factor in achieving successful system change.

SOCIAL FUNCTIONING AS AN IMPORTANT CLINICAL TARGET DURING CARE TRANSITIONS FROM SKILLED NURSING FACILITIES

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Care transitions from skilled nursing facilities (SNF) to home signify a period of medical risk for older adults. They also present opportunities for clinical interventions to reduce these risks and to enhance or maintain patients' quality of life. A substantial body of research has been published on improving late life care transitions (CTs), including the development of standardized CT models for acute care. However, such models typically focus on improved coordination of medical services; overlook the need to address psychosocial well-being and social connectedness; and have rarely been implemented in SNFs. This poster will present a conceptual model of social functioning in older adults that draws on constructs from the World Health Organization's World Report on Ageing and Health (2015). We propose that social functioning is a key part of overall functioning among older adults who use SNFs and is simultaneously influenced by physical, psychological, and cognitive functioning. To illustrate our model, we will present results of a qualitative study (n= 21) that describes declines in social functioning following care transitions to the community from VA SNFs. Implications for clinical practice include the need to better integrate social functioning in clinical assessments, goal

setting, discharge planning, and coordination of care activities. The need for additional research on this topic will also be addressed. Our project is highly relevant to the overall conference theme "Harnessing the Power of Networks" as it presents a conceptual model and study findings related to social connectedness and social functioning in older adults who use SNFs.

DOES THE PATIENT HEALTH QUESTIONNAIRE MEASURE MOOD-RELATED QUALITY OF LIFE IN NURSING FACILITY RESIDENTS?

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The Patient Health Questionnaire-9 (PHQ-9) is a depressive symptom questionnaire administered to nursing facility (NF) residents in the Minimum Data Set (MDS). Does the PHQ-9 measure mood-related aspects of quality of life (QoL)? We assessed the PHQ-9's convergent validity with negative and positive mood items from Minnesota's QoL survey, which is administered annually to a random sample of residents. We also examined if scores on both instruments were associated with various psychiatric diagnoses on the MDS. Using item response theory (IRT) models, we estimated that depressive symptoms (PHQ-9) had a correlation of 0.546 with negative mood and -0.425 with positive mood. With explanatory IRT modeling, we estimated that diagnoses of anxiety, depression, and bipolar disorder were respectively associated with 0.261, 0.339, and 0.301 (all $p < 0.001$) standard deviation increases in (SD) depressive symptoms, and with 0.235, 0.261, and 0.306 SD increases in negative mood (all $p < 0.001$), thus indicating convergent validity. For positive mood, depression and bipolar disorder had associations of similar magnitude as the other two constructs. However, anxiety disorders were not associated with lower positive mood (-0.014 SD, $p = 0.636$). Thus, the PHQ-9 can measure mood-related aspects of QoL. However, the PHQ-9 appears to be sensitive to relatively serious depression, whereas the Minnesota items are more sensitive to lower levels of negative mood. Also, the PHQ-9 does not measure positive mood directly. Thus, the PHQ-9 is a more limited measure of mood-related QoL than the Minnesota items.

WHEN A LITTLE GOES A LONG WAY: EXPANDING HOME CARE SERVICES TO ADULTS WITH DISABILITIES

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Policy makers are increasingly interested in reducing public spending while maintaining quality of life. Since 1975, Oregon Project Independence (OPI) has supported community-based adults aged 60 and older to avoid or delay the need for residential long-term care services by increasing access to personal and home care services. The program also aims to prevent the need for Medicaid by optimizing personal resources and natural supports. In 2014, the OPI Expansion (OPI-E) pilot project began to serve adults aged 18-59 with

disabilities in seven of Oregon's seventeen Area Agencies on Aging (AAAs). This poster describes the evaluation of the expansion using three data sources: administrative data about consumer characteristics compiled by the AAAs and State of Oregon from 2015-2017 (N=3,824 traditional consumers, N= 581 OPI-E consumers), qualitative interviews conducted with AAA directors and OPI-E case managers (N=23), and a survey of current OPI-E consumers (N=126). Compared to traditional OPI consumers, OPI-E consumers were somewhat more likely to be men and people of color. Interviews with AAA staff highlighted the need for outreach, lack of service provider capacity, unique characteristics of younger consumers, and issues related to data management and rural access. Staff reported valuing the program, noting how "even low levels of service go a long way." Qualitative and quantitative consumer responses showed consumers found OPI-E services invaluable. The majority stressed their appreciation for the program, with several describing it as "lifesaving." These three sources informed recommendations for expanding the OPI-E program statewide.

FEDERAL POLICY SUPPORTS AND GAPS IN ADDRESSING RACIAL-ETHNIC HEALTH DISPARITIES IN U.S. LONG-TERM CARE FACILITIES

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Older adults from racial and ethnic minority groups face health inequities in long-term care facilities such as nursing homes and assisted living facilities just as they do in the United States as a whole. In spite of federal policy to support minority health and ensure the well-being of long-term care facility residents, disparities persist in residents' quality of care and quality of life. This poster presents current federal policy in the United States to reduce racial and ethnic health disparities and to support long-term care facility residents' health and well-being. It includes legislation enacted by the Patient Protection and Affordable Care Act of 2010 (ACA), regulations of the U.S. Department of Health and Human Services (DHHS) for health care facilities receiving Medicare or Medicare funds, and policies of the Long-term Care Ombudsman Program. Recommendations to address threats to or gaps in these policies include monitoring congressional efforts to revise portions of the ACA, revising DHHS requirements for long-term care facilities staff training and oversight, and amending requirements for the Long-term Care Ombudsman Program to mandate collection, analysis, and reporting of resident complaint data by race and ethnicity.

SERVICE ENVIRONMENTS AND PSYCHOLOGICAL WELL-BEING AMONG RESIDENTIAL CARE FACILITY AND NURSING HOME RESIDENTS

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One's competence, or ability to cope, becomes lower as people age due to multiple factors, such as decreased physical and cognitive functioning, social isolation, and reduced income. Considering this change, providing appropriate services may help older adults to maintain their independence and improve their psychological well-being and quality of life. Therefore, this study aimed to investigate services that

are positively associated with psychological well-being (i.e., mood, psychological health, self-efficacy) of older adults. For the analysis, observations were derived from the National Health and Aging Trends Study (NHATS), which includes a nationally representative sample of Medicare beneficiaries ages 65 and older. Service environments were assessed by (1) reflect availability and usage of 13 services (i.e., service unavailable, service available/ not being used, service available/ being used by residents) and (2) number of services available within three categories (i.e., help with ADL/IADL, transportation services, social and health-related services) Both having social events and activities available and participating in it were positively associated with older residents' mood, while using housekeeping services and walking areas (e.g., outdoor walking path) were associated with better psychological health and self-efficacy. When models were estimated with service categories, having more social and/or health-related services available were associated with better psychological health and self-efficacy. Findings of this study suggests that social events and activities, housekeeping services, and areas to walk for pleasure or exercise would improve older residents' psychological well-being. For Not only providing those services, residential facilities should encourage older residents to participation in or use the services.

SESSION 915 (POSTER)

PERSONALITY, PSYCHOSOCIAL, AND EMOTIONAL ELEMENTS

THE DOCTOR-PATIENT RELATIONSHIP, PERSONALITY, MOOD, AND FUNCTIONING IN OLDER ADULTS

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Personality pathology has been tied to mental and physical health in older adulthood. Less is known regarding the combined impact of personality and the doctor-patient relationship on mental health outcomes. This study examined relationships between personality, mood, and trust in physicians. Participants (N=170) were a sample of primary care older adults ages 60-99 (M = 70.73, SD = 7.054) who completed self-report measures of personality traits (NEO-FFI), processes (IIP-PD-25), depression (GDS-30; PHQ-9), social adjustment (SAS-SR) and trust in one's physician (GTIP). Medical burden data (CIRS) were retrieved from medical records. After adjusting for relevant covariates such as age, perceived health, cumulative illness burden, and income security there were several significant predictive relationships. In combined models more neuroticism (NEO-N, $\beta = .082$, $p < .000$) and lower trust (GTIP, $\beta = -.025$, $p = .014$) but not agreeableness (NEO-A, $\beta = -.006$) or interpersonal problems (IIP-25, $\beta = .254$) predicted depression. In combined models, higher neuroticism (NEO-N, $\beta = .018$, $p < .000$) and interpersonal problems (IIP-25, $\beta = .186$, $p = .002$) but not agreeableness (NEO-A, $\beta = -.003$) or trust (GTIP, $\beta = -.002$) predicted social adjustment. The results are consistent with previous findings that neuroticism predicts both depression and social adjustment in older adults. In addition, lower