The Albert Schweitzer Fellowship – Detroit Chapter (Authority Health)

2020-2021 Fellow Final Report

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Title/Description: Medical Students Added to the PACE Care Model to Reduce Injurious Falls and Support Aging in Place.

This project posits that incorporating more check-in visits between the annual assessments provided by PACE would help identify new or progressing risk factors for falls and allow for swift client-focused intervention. Senior medical students are used to address the resource gap and increased burden on staff created by implementing more frequent checks-in with PACE clients.

Target Population: Senior Citizens (65+) living independently in a designated underserved area in Detroit, MI who have an increased risk for fall.

Background:

Falls are a leading cause of injury in the aging population resulting in an estimated 2.8 million visits to emergency departments annually. Adapting the physical environment to accommodate the changing mobility, cognitive, and functional needs reduces accidents and increases chance of aging in place. An interdisciplinary team-based care model is seen as essential to impact of home modifications and effectively caring for geriatric patients. The Program of All-Inclusive Care for the elderly in Southeast Michigan (PACE) offers an interdisciplinary team-based care model seen as essential to effectively caring for geriatric patients. Interprofessional education offered to medical students lags behind the rapidly growing need. Exposing trainees to caring for the geriatric population in the context of an interdisciplinary team sets precedence for learning and valuing interprofessional collaboration.

The COVID-19 Pandemic:

The COVID-19 pandemic and statewide restrictions throughout the year significantly impacted the ability to implement this service project as initially proposed. Not only did a stay-at-home order In Michigan through June 2020 render in home modifications impossible, what little information available on the Coronavirus revealed a particular vulnerability in the project's target population. The older adult population, especially in underserved areas, were at increased risk for more adverse outcomes associated with this pandemic. However, with the support of the fellowship coordinator and area networks I was able to identify ways to consistently serve the aging population in the Detroit area.

Specific Activities:

May 2020- August 2020: Short term projects with SHP-D and the Healthy Black Elders initiative. The goals were to support health and safety promotion among seniors living in low-income housing in Detroit and reduce social isolation during Michigan's stay-at-home order. I completed 18 hours of telephone wellness check-in calls to seniors living in Detroit. Calls included a 20min survey assessment and offered referrals to partner agencies/resources. Additional hours were spent working to distribute food and mask hygiene bags to SHP-D associated senior housing units in downtown Detroit.

August 2020- February 2021: COVID19 Restrictions reduced to allow for in-clinic and in home visits to resume. I worked with PACE Rehab teams in the Dearborn, Southfield, Rivertown sites to identify new intakes each month and attend in-home visits. Nearly 25 hours of service hours associated with 12 new client intakes or annual assessments were completed during this time. Throughout this time visits included introducing myself and role to the client, assisting Rehab

team member with assessment, following up with client on recommendations as well as reporting any observations to the Rehab team member.

February 2021 – May 2021: COVID19 vaccine distribution efforts sponsored by DHD/DMC in conjunction with Wayne State University School of Medicine Interdisciplinary training network requested volunteers from students. The initial outreach efforts targeted Detroit residents 65+ by dispatching vaccine teams to senior housing facilities during the week and holding vaccine clinics at local churches on the weekend. Although this was not the project knowing that the aging population in Detroit was especially vulnerable in this pandemic helping to get as many people vaccinated was an important aspect of serving this population. The hours I was able to complete through this fellowship I feel was valuable. Between February and May I have completed nearly 160 hours staffing COVID19 Vaccine clinics. I helped client's complete paperwork, answered their questions and concerns regarding the vaccine, and directly administered the first and second dose of the vaccine.

Evaluation Impact:

This project is partnership that supports PACE rehab modifications and interventions to keep clients safe in their home while increasing awareness and familiarity of new clinicians with growing geriatric population.

It also serves to expose trainees to caring for the geriatric population in the context of an interdisciplinary team sets precedence for valuing interprofessional collaboration & supports the core mission of PACE. Valuing the skills and expertise of other allied health professions strengths our understanding of scope of practice as well as enhances our ability to provide the care for our patients.

The risk of injury due to falls in this population is well known but to hear directly from the Rehab team the following:

> "That's a fall that didn't need to happen." – PACE Occupational Therapy Tech
>
> "I wish I could come back and make sure they are using it properly" – Occupational Therapist Southfield

Shows that the adverse outcomes that occur from falls not only injures to the Clients, but it is also a constant personal hit to the staff. These are preventable. It is important that we tap into the underutilized resources of senior medical students to address this need.

Sustainability Plan:

In the future this project can best be sustained by incorporating it as an interdisciplinary community patient care elective. Elective specifically designed for a fourth-year medical student with a demonstrated interest in primary care, geriatrics, and interdisciplinary practice choosing to serve over the course of their final year of medical school or as an optional fellowship year (for continuity). Specifics of how the elective works:

- Fourth year medical student accompanies PACE Rehab Team on initial or annual in-home assessments and subsequent visit to deliver any DME and to observe patient and family education. This ensures the medical student becomes a trained observer w/enhanced knowledgebase (Med Stu->Trained Observer) on that client specifically.
- Once a client's initial care plan has been approved and implemented by the interdisciplinary care team the trained observer schedules home visit with client to assess the use and proper implementation of safety recommendations.

- The trained observer identifies any changes in home environment that were not present on initial visit, reinforces patient education provided by Rehab staff during intake period, and reports back to Rehab team any emerging risk factors observed.

This is a collaboration that can be used by PACE organizations and Medical Schools across the country. However, the PACE health care model not available to all aging populations. Thus, a sustainability initiative that is more far-reaching focuses on providing a means or program that is to open to more elderly people and their families. The cohort succession on sustainability helped me to see that the issue I was addressing within PACE was and is an issue in and out of PACE. That is the ability to not only accurately assess the environment for safety but to make the recommended modifications and follow up. Elders and their families need that resource that is not medical in nature but absolutely influences health and wellbeing. I will support the development of a service that offers home assessments for individuals, provides the contractors to complete recommendations, follows up on the home modifications and the use of the proper use and implementation of recommended changes. One of the biggest issues as indicated by the pace to rehab team members is that time constraints to not allow for follow up on the recommendation. I was also clear that for legal reasons PACE southeast Michigan does not do any major structural modifications to a client's homes. Some PACE locations function differently but the point is that assessments and recommendations alone do not ensure/improve the environment. The solution but address the issue of knowledge, resource, access, & maintenance.

- 6 -- 6 -Serving this Constituency:

Geri-proofing one's home is a concept akin to Babyproofing. Everyone knows how important it is for the healthy growth and development of a young child to have a safe home environment. Most first-time caregivers know of the concept but may not know what changes need to be made and when. Those aging or caring for someone aging have similar experience. Just like raising a child, things change quickly in the aging population. The interventions to support effective aging in place are continuously changing and the level of support evolves quickly. An intervention like the service project helps normalize the existence of rapidly changing circumstances and integrates it into a model to allow for healthy aging in place.

Reflection:

I pursued this service project because I felt in danger of losing my why and needed a way to revisit and reclaim my focus and passion for service. Service for no other reason than seeing a need wanting to help address a problem largely attributable to structural and societal-ism that has leading to adverse circumstances among a group of group that's just unnecessary.

While preparing to apply to medical school in 2014, I read the book Being Mortal by Atul Gawande. Dr. Gawande's book explored:

- Productive aging, independence
- Aging in place, home environment factors
- Continuity of care
- Caregiver strain
- Quality of life and death

Around the time I was reading the book Being Mortal, I had my first exposure to an aging relative as an adult, my maternal aunt. I saw each of the topics in his books play out with my aunt and unfortunately, the outcomes were not the best.

The inspiration for this project was my experience with my aunt Gloria prior to starting medical school and the parallel exposure I got through reading the book being mortal by Atul Gawande. My aunt passed away May 2016, months before I began medical school. She lived by her faith, serving, and caring for others, especially her family. I believe everyone in my family did the best they could to care for her, but I do not feel that best was all that she deserved.

I designed this project after doing research on home modifications, the senior population, and, connecting with the coordinator for PACE southeast Michigan. I was responsible for reviewing the new intake list each month and coordinating with the Rehab team to join the initial assessment. Using the warm introduction provided by the Rehab team with the client I asked if it would be ok to follow up regarding the Rehab recommendations. Subsequent encounters were scheduled with the client.

The pandemic provided significant challenges in implementing this project because the project focused on one of the high-risk groups for COVID-19 and the intervention took place in their home. I felt personally limited because I know how vulnerable this population can be. However thinking about concept of emergent strategies it is really one's commitment to being open to the strategies that emerge along the way that help initiatives like this succeed. It is also the willingness to be vulnerable and open to pivoting and new options as they avail themselves that had the greatest impact on my leadership development. The amount of time that I wanted to spend ensuring a safe home environment ultimately shifted to outreach vaccination clinics for the senior citizens of southeast Michigan. Providing direct support in this capacity was a current need and requires focused attention. I have no doubt that I will keep the concept of this project in mind going into residency and into my professional career.