April 4, 2014

To: **Joan Weiss, PhD, RN, CRNP**
Chief, Geriatrics and Allied Health Branch

Nina Tumosa , PhD
Public Health Analyst

Bureau of Health Professions
Health Resources and Services Administration

From: **Thomas V. Caprio, MD, MPH, CMD, FACP**
President, National Association of Geriatric Education Centers (NAGEC)
on behalf of the NAGEC White Paper Committee

Re: **Collaboration with HRSA in Charting the Future Direction of Geriatric Education Centers**

The Geriatric Education Center (GEC) community is strongly motivated to enter into a productive dialogue with the Health Resources and Services Administration (HRSA) to provide input in the development of guidelines for the next grant cycle. Hopefully, these guidelines will help both existing GECs and new applicants to produce proposals that meet HRSA's goals. With this aim in mind, we need to better understand HRSA's overarching goals and expectations for the GECs' accomplishments through this grant program.

Background

The National Association of Geriatric Education Centers (NAGEC) has entered into a productive dialogue since November 2013, when it was proposed at our annual membership meeting to form a workgroup to formulate recommendations inclusive of the membership feedback and experiences with GEC operations under federal funds. The goal was to develop a white paper that would then be presented on behalf of NAGEC to HRSA encompassing this dialogue. Through a series of conference calls and working documents, the workgroup guided the development of national survey which was distributed to all 45 GECs with a 100% response rate. The survey provided specific input by each GEC to guide the dialogue and recommendations to HRSA. Concurrently with these efforts, the members of the White Paper Workgroup also participated in HRSA EBP focus group calls conducted in 4 sessions facilitated by Dr. Tumosa with all GEC members. The content of these calls were then included in the workgroup discussions to identify trends, recommendations, and specific input areas to enrich the survey work and group activities. Through this multistage process we have developed and purpose a series of questions and talking point to facilitate an ongoing dialogue. Our hope is that this discussion will be used as a framework in assisting HRSA in developing the next funding opportunity announcement and grant guidance.

How should educational outcomes be oriented?

The GECs at their core and by definition are <u>educational organizations</u> conducting outreach to health care professionals working with older adults. If education is designed as purposive change in behavior, to what extent does HRSA desire that the GECs demonstrate their abilities to impact clinical care delivery outcomes over and above the traditional didactic training implied by the mandatory activities in the authorizing legislation?

How to utilize GEC resources most efficiently?

We assume that HRSA may not specifically assign resources to tasks, but as we look forward to the next funding opportunity announcement for the GEC awards, we need to think about how GEC efforts and resources can be best used individually and collectively. The current GECs have several major tasks: 1) the five mandated training components, 2) the Evidence Based Projects (EBPs), and 3) the 160-hour faculty training. We need to consider how the GEC resources can be best applied to meeting these diverse tasks. Does it make sense to concentrate on fewer tasks or provide guidance as to which are truly core efforts?

Proposed Educational Strategies

Several educational strategies and evaluation implications for GECs have been discussed as part of this workgroup process. These strategies are summarized in the table below:

Strategy	Evaluation	Application
Level I--Traditional Didactic/Clinical training to increase knowledge	Pre/post changes in skills, knowledge, attitude	Undergraduate and graduate training, CME's, CEU's
Level II--Traditional Didactic/Clinical Training with an EBP focus with goal to implement EBP	Pre/post changes in skills, knowledge, attitude Measure Clinical application of EBP	Management of a clinical condition with an EBP and evaluate implementation
Level III--Traditional Didactic/Clinical Training with an EBP focus with goal to improve patient outcomes	Changes in care performance Changes in patient outcomes May use controls, even RCT	Management of a clinical condition with an EBP and evaluate patient outcomes
Level IV - - System Change—design QI Project	Changes in care Performance Changes in patient outcomes May use controls, even RCT	Using a QI model, Manage a clinical condition with an EBP and evaluate patient outcomes

The GEC's have used the above levels to varying degrees. If we consider a more sustained change, we must recognize that Institutional support is critical. However, many hospitals and nursing homes may pull back on an EBP when resources are limited. Hospitals that have lost money due to fines based on readmissions within 30 days of discharge and are laying off nursing and even medical staff; some have been forced to merge. This changes institutional priorities and disrupts processes and projects. Many demonstration efforts flounder after the initial stimulus is removed and sustainability with project partners has been identified as an ongoing challenge. The more ambitious the goals for the EBPs in particular, the more resources will be required. Current resources will only adequately cover the first level of educational strategies as outlined.

How important is a "systems approach" to HRSA in developing educational methods and outcome evaluation?

The EBP activities can be viewed a several levels:

- Demonstrating the art of the possible, essentially feasibility studies, using Quality Improvement (QI) methods, and thereby demonstrating that systems change can be influenced or catalyzed by GECs through an EBP
- Making clinically significant impacts on substantial numbers of patients. This may be improving care of patients in the system by reducing certain outcomes linked to the EBP (i.e., readmissions, LOS, restraint use, Rx reduction, fall reduction, etc.)
- Working with health systems to change the way care is delivered and changing the performance and competence of staff trained through the EBP

In the current grant cycle, there has been substantial variation in the EBPs' scope and design. Despite a great deal of time and effort spent on coordination among sites working on each specific EBP, it does not appear that data can easily be combined when framed around the concept of multi-site EBP Projects and evaluation. Neither can a strong publication be prepared due to the heterogeneity among the sites, including the methods used, trainees/ institutions targeted, etc. From what has been learned in the current cycle, we have identified several possible areas of concern to be addressed for this new effort in evidence based practice:

- To demonstrate the ability to apply extant evidence to improve care for older persons. This would imply a strong evaluative design that uses some variation of a quasi-experimental or even RCT design, but could address a variety of topics. However, it requires being able to measure patient outcomes as an end-point and this is extremely difficult to do in most settings where a GEC is not an integral part of the patient care delivery system. The latter varies greatly from one GEC to another.
- To demonstrate a response to an important health care problem. This implies a coordinated implementation of one or more intervention strategies across GECs. Although this was attempted in the current cycle, and did not succeed as planned, it is possible to learn from what was done so as to improve the approach next time around.
- To demonstrate the capacity of GECs to work with a variety of organizations in various quality improvement efforts. This implies a lower level of coordination and some effort at cross-cutting summarization. This seems to us to hold a great deal of promise, going forward. This would be a way of demonstrating that GECs can be catalysts for change. They could achieve this end working with partners like the Quality Improvement Organizations (QIOs).

While HRSA may not want to prescribe how GEC resources should be allocated across tasks, some redesign of the tasks might help. How much of the GECs' resources should be directed to the 5 mandated tasks (which do not specifically include impacting patient care outcomes through EBP training)? How much of our resources should be devoted to EBPs? Clearly, the scope and ambition of an EBP project could easily consume all of the remaining resources of a GEC. Many quality improvement projects, especially if they are well evaluated, have budgets greater than a typical GEC budget. We recognize that HRSA will not prescribe amounts, but we hope you consider the implications of an ambitious agenda. No one will benefit if GECs spread themselves too thin in both personnel and

finances. This also presents a challenge for new applicant GECs which may not have the experience or guidance from HRSA to realize the scope of EBP and the resource demands on evaluation.

Systems Perspective

If HRSA is interested in using some form of a "systems perspective", GECs could work on ways to improve and sustain behaviors and to improve care in a variety of settings. This could include developing (or disseminating) tools, examining the process of care and finding points of intervention, conducting PDSA rapid cycle studies. Projects would use **quality improvement** as a basic strategy. Such an approach recognizes that training in itself (even when focused on specific skill acquisition) is a relatively weak technique to evaluate the educational impact. The ultimate goal might be to create an environment that supports better performance. Relevant skills for this type of work include root cause analysis and process mapping—but all GECs may not be familiar or experienced in using these methods, so there would need to be training set up, perhaps in year 1, to ensure that all GECs were competent in these approaches. These projects could show an impact in improved care and possibly effects on clients (patient-centered outcomes wherever possible) depending on the individual GEC and its position in the stream of health care delivery. Questions have been raised among the GECs about whether undertaking QI and systems change is beyond their available resources.

Choice of Topics for the EBPs.

Does HRSA have particular topics in mind for future EBPs? Are there options to continue in the same EBP topic areas and targets as in the prior grant cycle? The choice of topics will inevitably reflect their salience in the current practice climate and the amount of evidence available to support an intervention. To what extent is the weight of evidence a driving issue? For example, multimorbidty (management of multiple chronic conditions) is a major challenge with regards to the care of older persons, but the evidence base to support interventions is weak at present. More is known about effective approaches to managing individual chronic illnesses and the interaction of medical and mental health issues. Alzheimer's disease is central to many aging efforts and a legislative priority. Although there is great enthusiasm for moving away from pharmacological management of problematic behaviors, the evidence base for non-pharmacological approaches is still relatively weak. Likewise, while both elder justice/financial abuse and LGBT concerns are salient, the data bases for interventions are weak. So another key question: How will HRSA decide what the topic area(s) will be a priority for any new EBP? What are the "decision rules"?

A number of topics present themselves in our ongoing discussions with members of the GEC network. In addition to chronic disease care, organizational issues like transitional care are pressing and have good data behind them. The ACA offers opportunities to address issues like care coordination (e.g., ACOs and medical/healthcare homes) and value-based purchasing. This might be an opportunity to consider expanding the GEC target groups to put more emphasis on training caregivers (both paid and informal), including community and institutional health workers; as caregiving has been identified as a central challenge for the next decade. Considerations about the costs of care suggest that relying more on less trained persons to provide care (and providing them with appropriate supports) may be a key part of the strategy to contain costs. ACOVE has identified a number of topics for quality improvement. The QAPI (Quality Assurance and Performance Improvement) programs mandated by the ACA operate in several settings. (NH, hospital, hospice, home care, ESRD/dialysis). Under this model, GECs would work with providers to help them identify areas that need improvement and develop interventions to fit the

individual situations. The core elements for QAPI projects include both performance improvement projects and systematic change. Partnerships with QIOs would be an important strategy here.

Heterogeneity of GECs

The GECs are heterogeneous in areas of focus, resources, geographic coverage, and evaluation strategy. Not all are prepared to participate in large-scale EBP projects. Several organizational strategies might be considered to address the heterogeneity of GECs.

1. One GEC in each region (yet to be defined) could be designated as a lead. They would be responsible to working with the other GECs in the area to provide technical assistance.

2. One GEC could be designated as the coordinating center for each EBP topic. They would take a lead role in either coordinating joint project or r assisting with individual projects on the topic. Assistance would include evaluation help.

3. GECs that are interested in and able to mount collaborative efforts might be invited to participate in larger coordinated projects. It would be helpful to have an overall Coordinating Center to assist in the design and evaluation of projects. These coordinated projects could be aimed at using extant knowledge to improve care (similar to EBP) or they could even be designed to test new ways of providing care. For example, a project could be designed, and GECs invited to participate, that used a randomized design comparing "treatment as usual" with a dyad or even family intervention on key patients and outcomes. As an example of a topic that fits into the larger policy environment, GECs could work with nursing homes or hospices under the QAPI mandate to develop QI projects that meet local needs and work to sustain them.

This approach may not be feasible for all GECs, but if even a dozen were interested and able to participate, this could potentially generate new knowledge over the course of 5 years. This in turn adds to the existing evidence base. Other GECs (not the same ones as those doing the work just described) would focus on whatever EBPs were chosen, using a quality improvement model as described above. This strategy would save resources for everyone and GECs would not feel so "divided" and pressured.

In the interests of promoting a dialogue, we have tried to lay out some issues. We would like to propose a meeting, either in person or by phone, to discuss the issues we have laid out here. We look forward to hearing from you.