

Aging SUCCESSFULLY



Spring 2021
Vol. XXX, No. 1

SLU and GWEP Develop a Telehealth Platform for Geriatric Services

By John Morley, MB, BCh



In the summer of 2019, the Gateway Geriatric Workforce Enhancement Program (GWEP) began work on developing a telehealth platform, Aging Successfully, that would enable users to gather assessment data and deliver services virtually.

Collaborating with a technology development company to create a HIPAA-compliant telehealth platform, we aim to deliver services to older adults electronically.

In those pre-pandemic days, we envisioned a suite of programs to include the Rapid Geriatric Assessment and Cognitive Stimulation Therapy. With the advent of COVID-19, awareness is heightened regarding continuing increases in the number of older adults, the small numbers of healthcare professionals specializing in geriatric care (particularly geriatricians), and a need to
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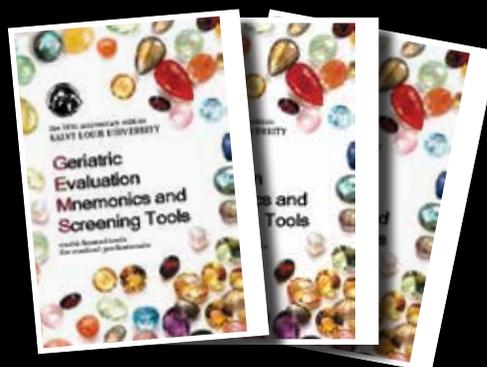


YOU and YOU and YOU!

2021 GERIATRIC EDUCATION
NEEDS ASSESSMENT

The Gateway Geriatric Education Center is requesting input regarding your needs and preferences related to geriatric education. Please complete the 2021 Geriatric Education Needs Assessment by following the link or scan the QR code above. Your feedback is invaluable for our planning. Thank you!

https://slu.az1.qualtrics.com/jfe/form/SV_eVcFctQiAqRpDYF



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EDITORIAL

Aging
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The COVID-19 Pandemic

During the last year, the COVID-19 pandemic totally changed the lives of older people. Obviously, COVID-19 selectively killed older persons, resulting in the USA in a one-year decrease in lifespan. In addition to the high mortality, both lockdown and fear of becoming infected has led to physical and social isolation of many older persons, especially those in residential facilities and nursing homes.

Isolation for older persons results in severe stress and loneliness. Loneliness leads to depression and an increase in cardiovascular disease. These result in an increase in mortality. In retrospect, the lockdown in the nursing homes which prohibited family visitors was clearly one of the great failures of social care. The lack of availability of personal protective equipment for visitors was a major reason for this. Secondly, hospitals sending infected persons to nursing homes before they had cleared the virus was a major reason for the spread of COVID-19 in the nursing home.

Another major problem is the long COVID syndrome. It is characterized by a severe lack of energy (fatigue) along

with such syndromes as cognitive dysfunction (“brain fog”), loss of taste and smell, dyspnea, a chronic cough, headaches, recurrent fever, joint and muscle pain, depression, and anxiety. These symptoms can still be present for a year with about 20% being present at ten weeks and 2 to 5% one year after having contracted the virus. Similar syndromes have been seen after other viral syndromes, such as infectious mononucleosis. It is essential that exercise



John E. Morley, MB, BCh

programs and psychological support are made available to persons following COVID-19 for the duration of their symptoms. It is also important to recognize that a subset of persons with COVID-19 can have severe lung, kidney or cardiac damage. This group is in need of specialized care. It is important that health care professionals recognize the long COVID syndrome and are not dismissive of patients with these complaints. There is a need for interprofessional “long COVID clinics” that provide the necessary support for these patients to fully recover.

A set of excellent COVID-19 vaccines has been developed. It is

important that all persons over 60 years are vaccinated as well as most young persons. However, at present getting the vaccine does not take away the need to social distance and wear a mask. As more strains of the corona virus develop, it may be necessary to regularly develop new versions of the vaccine, similar to the situation with influenza vaccinations.

The COVID-19 pandemic should be seen as a wake-up call for politicians and public health officials. Some countries, such as Taiwan, Bhutan, and New Zealand, have demonstrated that early recognition of the pandemic and rapid introduction of public health measures show that the devastating outcomes of the pandemic could have been mitigated. The need for political leaders to use scientifically supported public health measures, such as mask wearing, and the expectation for the public to do the same, is essential. It is also important that social media education programs are developed. These initiatives need to include specific programs aimed to reduce the impact of “anti-vaxers” and “anti-maskers.” Finally, design of nursing homes and senior centers should be developed to allow avoidance of social isolation.

John E. Morley

Telehealth

(continued from page 1)

enhance the telehealth options for and competencies of professionals providing primary care. As a result, we are working to expedite and expand our original vision for the platform. We hope to strengthen the capacity of the geriatric workforce to deliver services *via* telehealth. To that end, we are nearing completion of the first of the suite of programs to be developed, including the Rapid Geriatric Assessment (RGA), Medicare Annual Wellness Visit, and Cognitive Stimulation Therapy. Future plans include expanding programs to address areas of care that are specifically needed for older persons, including the assessment of and intervention in sleep apnea, home care, and loneliness and social isolation, all of which can be identified through the RGA and/or the Medicare Annual Wellness Visit.

This new Aging Successfully platform provides a HIPAA-compliant environment with secure teleconferencing solution and sophisticated data analysis. The tools to quickly develop a HIPAA-compliant application with the teleconferencing component will enable providers and researchers to input, track, and analyze data as well as track patients, and medical and social service personnel's involvement in group activities. We are working with the technology development company to create content, field testing, and training for users to implement the programs in practice settings. The applications are designed to provide immediate benefit and, in the long-term, allow the company to use the collected data to create AI (artificial intelligence) predictive models.

With fewer than 25% of older persons receiving the Medicare Annual Wellness visit (AWV) each

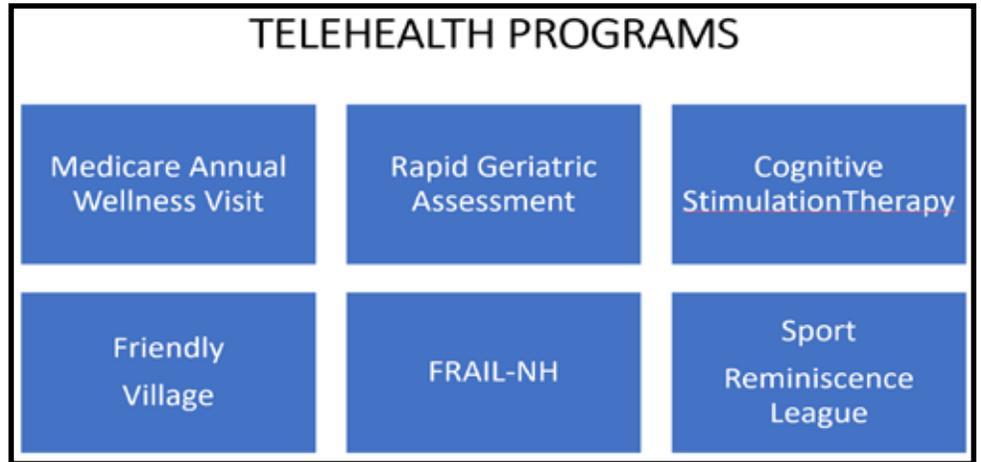


Figure 1.

year, CMS now allows the AWV to be delivered *via* telehealth. Our GWEP team previously incorporated the Rapid Geriatric Assessment (RGA) into the Annual Wellness Visit and has shown that this tool can be used as the basis for the AWV in the nursing home setting¹. With support from the CARES Act, we received supplemental funding from the Health Resources and Services Administration (HRSA) to develop a computer-assisted version of the Medicare Annual Wellness Visit. Through our work with a technology development firm, we are creating a version that can be completed by the patient and family on the computer at home, with or without assistance. The program includes a variety of screening scales to assess frailty (FRAIL and FRAIL-NH), sarcopenia (SARC-F), anorexia (SNAQ), cognition (initial Rapid Cognitive Screen (RCS) and annual (RGY)), loneliness (ALONE), quality of life (LIFEAD), depression (AMSAD), endocrine function (ADAM), activities of daily living (ADLs), and what matters (Figure 1). Depending on the response to each item, further questions are posed which provide data to make a definitive diagnosis of the reason for the problem. For example, if the person responds “yes” to the fatigue

question on FRAIL, they receive further questionnaires looking for sleep apnea and depression and suggesting the measurement of a TSH and vitamin B₁₂.

Our second major undertaking is the creation of virtual Cognitive Stimulation Therapy (CST). As regular readers of this newsletter know, CST is a non-pharmacologic intervention for persons experiencing early and moderate dementia². In addition to enhancing cognition, CST decreases depression and improves quality-of-life. Currently in the beta-testing phase, the Aging Successfully platform includes a telehealth version of CST that is delivered by Zoom. Participants and facilitators will connect *via* Zoom and have access to audio and video-based activities. The platform will also enable collection of demographic, pre- and post-assessment data, session documentation, and evaluation data.

REFERENCES

1. Little MO, Sanford AM, Malmstrom TK, Traber C, Morley JE. Incorporation of Medicare Annual Wellness visits into the routine clinical care of nursing home residents. *J Am Geriatr Soc* 2020;Dec 18 doi: 10.1111/jgs.16984 [Epub ahead of print].
2. Berg-Weger M, Tebb S, Henderson-Kalb J, Zubatsky M, Lundy J, Hayden D. Cognitive stimulation therapy: A tool for your practice with persons with dementia? *J Am Med Dir Assoc* 2015;16:795-796.

Cara Wallace Named 2020 Sojourns Leadership Scholar by Cambia Health Foundation

In January, Cambia Health Foundation announced their latest cohort of the Sojourns Scholar Leadership Program. The goal of the program includes “identifying, cultivating and advancing the next generation of palliative care leaders” and provides scholars with funding for professional development and to carry out an innovative and impactful project in the field of palliative care.

Cara L. Wallace, SLU Assistant Professor in the School of Social Work and Geriatric Workforce Enhancement Program-affiliated faculty, was one of 12 scholars selected across the U.S. Her project, building from her prior work and guided by theory, is to complete a social norms and health education campaign to reframe hospice among vulnerable residents in St. Louis.

For the general public, hospice is associated with one word – death.^{1,2} Even clinicians report confusion discerning hospice from palliative care, fear that discussing hospice will take away hope, and discomfort and lack of training in effective end-of-life conversations.^{3,4} Though hospice use is growing, the median length of stay is only 24 days, and nearly one of three patients dies in a week.⁵ In addition to overarching barriers,¹⁻⁴ cultural barriers remain apparent^{6,7,8} and structural racism creates unequal access to resources causing ongoing health disparities.⁹ Obtaining timely access to EOL care is important in improving quality of death,^{10,11} symptom management,¹² bereavement for family,^{11,13} and

cost of services through resource utilization.¹⁴⁻¹⁶

Well-suited to address long-standing needs in the St. Louis community, heightened due to circumstances amid the COVID-19 pandemic, this project will address hospice misperceptions through a culturally relevant intervention. Utilizing community engagement, project aims are to: create educational/promotional materials about hospice using art and narratives; distribute materials with a targeted approach; and evaluate impact and community perception changes to hospice care. Partnerships will include local organizations serving low-income, primarily African American older adults, community artists creating mural displays depicting hospice, and a videographer creating narrative stories of current hospice patients and families.

Dr. Wallace has established a strong team of local and national mentors to enhance her project and ongoing development as a leader including Dr. Patrick White, Division Chief of Palliative Medicine at Washington University; Dr. Ricardo Wray, SLU Professor and Chair of the Department of Behavioral Science and Health Education; and Dr. Karen Bullock, Head of the School of Social Work

at North Carolina State University. Though not formal mentors on the



award, Drs. John Morley and Marla Berg-Weger, Co-Directors of The Gateway Geriatric Education Center, express excitement about the possibilities of her project as “it enhances our current community partnerships serving our local, aging community.”

Dr. Wallace describes her vision of leadership as defined



by her roles “as a researcher, educator, and social advocate,” but adds that it is a “deep passion to impact the experience of palliative and end-of-life care in meaningful ways.” She states, “As a young hospice social worker, my patients and families became my teachers and I quickly recognized the immense value in

hospice support at the end of life. I developed deep emotions surrounding the type of death I want for myself and for my loved ones. Years later when my professional experiences with death turned into

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Wallace Named Sojourns Leadership Scholar

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personal ones, I encountered first-hand some of the challenges I witnessed as a clinician. When I teach, my students refer often to my ‘enthusiasm and passion for the material’ and my ability to make ‘difficult topics...interesting, applicable, and relevant.’ This passion, along with my personal and professional experiences, channels my drive for my professional work.”

The Sojourns Scholar Leadership Program will allow Dr. Wallace to seek additional development surrounding the application of narrative intervention and implementation science within palliative care, further preparing her for national leadership. “As a social worker, my work is patient- and family-centered and guided by the core values and ethics of the profession. My training enables me to approach situations through a systemic lens that considers problems through the interaction of various forces – psychological, social, economic, and political – and transactions between individuals and their environment. Leaders must be able to both envision the larger context for the future of palliative care and consider individual roadblocks in the realization of that vision. As a clinician first, my research is informed by clinical practice and I am committed to providing translational research that directly impacts care and services for patients and families. Participation in this program will allow

Years later, when my professional experiences with death turned into personal ones, I encountered first-hand some of the challenges I witnessed as a clinician.

me to focus on the next stage of my career...and how I might contribute to lasting change as a national leader in the field of palliative care.”

Since the program’s inception in 2014, Cambria Health Foundation has awarded 74 grants to emerging leaders nationwide. Each grantee is a member of an interdisciplinary palliative care team or is otherwise working to advance the field.

Congratulations to Dr. Wallace!

REFERENCES:

1. Andruccioli J, Montesi A, Raffaelli W, Monterubbianesi MC, Turci P, Pitturieri C, Rossi AP. (2007). Illness awareness of patients in hospice: psychological evaluation and perception of family members and medical staff. *J Palliative* 10(3), 741-748. doi:10.1089/jpm.2006.0200
2. Feeg VD, Elebiary H. (2005). Exploratory study on end-of-life issues: barriers to palliative care and advance directives. *Am J Hosp Palliat Med* 22(2), 119-124. doi:10.1177/104990910502200207
3. De Vleminck A, Houttekier D, Pardon K, et al. Barriers and facilitators for general practitioners to engage in advance care planning: a systematic review. *Scand J Prim Health Care* 2013, 31(4):215-226.
4. Song MK, Dabbs ADV, Studer SM, & Arnold RM. (2009). Palliative care referrals after lung transplantation in major transplant centers in the United States. *Crit Care Med* 37(4), 1288-1292.
5. NHPCO. (2019). Hospice Facts and Figures. Retrieved from https://www.nhpc.org/wp-content/uploads/2019/07/2018_NHPCO_Facts_Figures.pdf
6. Chung K, Essex E, & Samson LF. (2008). Ethnic variation in timing of hospice referral: Does having no informal caregiver matter? *J Pall Med* 11(3), 484-491. doi: 10.1089/jpm.2007.0149
7. Bullock K (2011). The influence of culture on end-of-life decision making. *J Soc Work End Life Palliative Care* 7(1), 83-98. doi:10.1080/15524256.2011.548048
8. Wallace CL (2017) Examining hospice enrollment through a novel lens: Decision time. *Palliat Supportive Care* 15(2), 168-175.
9. Yearby R (2018). Racial disparities in health status and access to healthcare: the continuation of inequality in the United States due to structural racism. *Am J Econ Sociol* 77(3-4), 1113-1152.
10. Teno JM, Clarridge BR, Casey V, Welch LC, Wetle T, Shield R, Mor V. (2007). Family perspectives on end-of-life care at the last place of care. *JAMA* 291(1), 88-93.
11. Higgins PC, Prigerson HG. (2013). Caregiver evaluation of the quality of end-of-life care (CEQUEL) Scale: The caregiver’s perception of patient care near death. *PLoS ONE*, 8(6). doi: 10.1371/journal.pone.0066066
12. Zhang B, Wright AA, Huskamp HA, et al (2009). Health care costs in the last week of life: associations with end-of-life conversations. *Arch Int Med* 169(5), 480-488.
13. Wright AA, Zhang B, Ray A, et al. (2008). Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *JAMA* 300(14), 1665-1673.
14. Taylor DH, Ostermann J, Van Houtven, CH, Tulskey JA, Steinhauser K. (2007). What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program? *Soc Sci Med* 65, 1466-1478.
15. Kelley AS, Deb P, Du Q, Carlson MDA, Morrison RS (2013). Hospice enrollment saves money for Medicare and improves care quality across a number of different lengths-of-stay. *Health Aff* 32(3), 552-561. doi: 10.1377/hlthaff.2012.0851
16. Gozalo PL, Miller SC, Intrator O, Barber JP, Mor V. (2008). Hospice effect on government expenditures among nursing home residents. *Health Serv Res* 43(1), 134-153.



HINDSIGHT IS 20/20

LESSONS LEARNED FROM MANAGING COVID-19 IN THE NURSING HOME

By Angela M. Sanford, MD, CMD

I am the medical director certified skilled and long-term in a large suburb. This leadership and a central team that work well as a diverse patient

of a 200-bed dually term care nursing facility nursing home has superb core of faithful employees to provide care to a population.

In March 2020, as we developed policies and put protocols in place to mitigate the effects of COVID-19, a quiet hopefulness resided in several team members that maybe COVID wouldn't "hit" our nursing facility. The rest of the team seemed to be bracing themselves for the inevitable and engaged in "watchful waiting."

On the evening of May 1, my 10-year wedding anniversary, I received a call from the Director of Nursing (DON) about a patient residing in the locked dementia unit who had been sent to the emergency room earlier in the day and incidentally tested positive for COVID. The overwhelming sense of dread immediately set in, signaling that our fortitude, teamwork, and resilience were about to be tested in ways unlike ever before. Our nursing home had been in full lock-down mode for nearly two months and none of the patients from the dementia unit had been off the unit or out of the building during that timeframe. We made a separate unit for dialysis and skilled rehabilitation patients to prevent those coming and going from the building from bringing COVID back into the building. However, getting the news that one of the patients in the locked dementia unit, where social isolation and masking is an impossibility and cohabitation is the norm, seemed incredulous. I called the emergency room physician and asked that he admit the patient to the hospital until I could figure out a plan for mass testing and isolation of those in the dementia unit who were silently positive. Initially, I was told that the patient did not meet "inpatient criteria." I must have sounded desperate enough that he agreed to admit the patient to the hospital while I worked with nursing home administration to implement a plan to stop the spread of COVID in our dementia unit.

The next day—a Saturday—we had an emergency meeting of the nursing home leadership, infection control nurse, and several employees to lay out a plan. Unfortunately, we only had ten nasal pharyngeal testing kits in the facility. The dementia unit had nearly 30 residents. Lack of testing supplies forced testing only symptomatic individuals, an

approach that does not enable success of minimizing viral spread. The next eight weeks went by in a blur with most of us working more hours than ever before. We struggled with lack of resources, numerous employees walking off of the job and not returning, and most of all, the loss of our beloved patients who were members of our nursing home community. The virus was uncontrollable without the ability to test and isolate patients and staff in a timely, effective manner. Though we eventually gained free access to all of the testing supplies needed, the majority of cases and deaths occurred while we had limited resources. After the initial, massive COVID-19 outbreak, we had periods of "quiet," followed by smaller outbreaks. The end result was that COVID touched 150 of our 200 residents. After introspecting and asking myself what could have been done different and what I have learned, I have come up with the following ten lessons:

1. The lack of testing supplies and resources was the paramount reason for our failure of containment of the COVID-19 virus in the nursing home. In the weeks after our first case, the DON and administrator spent hours on the phone trying to locate more nasopharyngeal testing kits. They called the county health department and were told that there was an outbreak in a local prison and that they could only send us two nasopharyngeal testing kits for the foreseeable future. When the DON called the state Department of Health and Senior Services, they sent our nursing home 100 testing kits with a \$50,000 bill because the state lab had no capabilities to bill patient insurances. With no means to pay \$50,000, we reluctantly returned these testing kits. I felt like I was being told subtly that the lives of my nursing home residents did not matter. How was I to contain a virus (if that is indeed possible?) if I could not test residents and test frequently—much less test the staff? In my nursing home community, staff undoubtedly unintentionally brought the virus to our patients. In addition to lack of

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testing supplies, many other essential resources such as hand sanitizer, masks, latex gloves, etc., were all being diverted to the hospital. We could not get any refills for our wall hand sanitizers for several months because the supplier diverted all units to hospitals. Again, a subtle reminder that the lives behind the walls of my building were less important than the lives elsewhere. Most assuredly, the lack of resources and testing supplies contributed to massive spread and uncontrollable outbreaks in nursing homes across the country and this was largely out of nursing homes' control.

2. The infection control guidelines from governing bodies were unclear, difficult to decipher, and there was no centralized leadership to guide struggling nursing homes. The wording in these documents was often very nebulous and started with "You may want to consider..." When one would call the governing body for clarification, the answers would vary depending on who was on the other end of the phone and answers were routinely divergent for the same question. Additionally, reporting measures were non-centralized, over-burdensome and incredibly tedious. The DON at my nursing home cites this as the number one cause of his frustration and burnout during the COVID epidemic. In addition to managing extremely high patient acuity, he was expected to report to as many as eight agencies each day, all of whom wanted slightly different information. Most nursing homes do not have a dedicated information technology department to assist with developing centralized databases that would feed these 8 different spreadsheets the requested data, and thus the data was manually inputted each day, requiring hours of precious time away from patient care.

3. The social isolation from lockdown did as much damage as contracting COVID-19 on the physical health and mental well-being of the nursing home residents. The deleterious effects of social isolation became apparent nearly immediately in many of the nursing home residents. The rates of depression, weight loss, and functional status decline soared as residents remained isolated to their rooms for months. I had and still have an ethical struggle with the idea of confining people to their rooms and severely impairing their

quality of life. I often referred to it as the "slow COVID death" and laid awake in bed many nights wondering what the best solution was. We were trying to "protect" our nursing home residents, but serious implications and negative consequences may have led to our "protection protocols" being more harmful. Especially in my facility where despite our best efforts, the majority of residents contracted COVID. I often ask myself, "Did the isolation save any lives? Was anything positive achieved? What would my personal values be if my life expectancy was very limited and I was a nursing home resident? What are the rights of each nursing home resident and did we infringe on basic human rights?" For me, I believe I would want to see my family and I would want to do activities that contributed to my sense of purpose despite the potential risks of contracting COVID. I watched as several patients who were ambulatory to the dining room and around the facility before COVID became non-ambulatory and had a marked decline in functional status because of being confined to their small rooms for so long. In the months and years to come, I foresee many literature articles addressing the short-term and long-term effects of social and physical isolation in nursing home residents. It is my hope we can learn from this research and are perhaps able to come up with innovative alternatives to complete "lock-downs."

4. Families are essential in the care of nursing home residents

and were unable to see their loved ones at a time when their advocacy would have helped understaffed facilities the most. With the absence of family from our nursing home facility for more than one year now, I have learned just how much we previously relied on their advocacy to provide high-quality, whole person-centered care. The information we routinely glean from families regarding the intricacies of their loved one's life such as what that person's favorite food is, what hobbies they had, or TV shows they like, is invaluable and assists the nursing facility in providing the degree of personalized care that improves quality of life. While transmission of information can be done over the telephone, it seems to occur much more frequently with in-person visits. Important discussions regarding advanced care planning and functional/

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cognitive decline are also more effective in-person at the bedside. Not only do families improve the care delivered, many nursing home residents find their sense of purpose in their families. Without family visits, many patients lost their sense of purpose, impairing their will to live and ultimately, passed away.



5. The COVID pandemic will have long lasting effects on nursing home staff and has resulted in the loss of many employees who have left the field completely. The nursing home I work at has a lower staff turnover rate than most facilities in our area, but several of our employees left their positions during the pandemic. Some had health co-morbidities and were fearful of working in a high-risk environment while others needed to take care of children who were out of school. Many simply became burned out from the long hours of working in an understaffed environment with very sick patients and decided to explore other options. One day, one of the residents living in the dementia unit passed away from complications of COVID-19 and the routine dayshift nurse became very emotional after the resident died. When I saw her in the hallway, she was crying and asked me how many more of her residents she must watch die. She then commented about how she did not know how I could work in the hospital with sick patients dying of COVID. In the hospital, it is in some ways easier because we typically do not develop longitudinal relationships with patients and their families in the way that is commonplace in the nursing home. I have really begun to regard the nursing home community as part of my extended family and feel a strong sense of personal responsibility for the good and bad outcomes. I imagine that many medical directors must feel this way. The emotional toll from months of stress and watching nursing home residents become very ill and die still pierces quite deeply for most nursing home employees. It has led to high rates of burnout, lack of staff to resident engagement, and even higher rates of staff turnover. This leads to the question of how does a nursing facility successfully provide high quality care with these staff shortages and what can be done to recruit more staff to the industry?

6. Teamwork in the nursing home has always been essential and was noted to be even more crucial during COVID.

When one team member was quarantined or on sick leave during the pandemic, the effects across the community were greatly felt. I remember working in our COVID unit one day and noting that every patient's floor was sticky and the rooms were unkempt. After inquiring about what happened, as our facility is typically very clean, I was told the dayshift house keeper had COVID and was quite sick. I reflected that day on how essential each person's role was and how we all work together in concert to keep the facility functional. Nursing homes present the idealistic model of cohesive teamwork

when compared to other medical settings and are among the most successful at providing true interdisciplinary care. Each interdisciplinary team member sees the patient through their own lens and plays a pivotal role in providing comprehensive, whole-person care. I saw a model of "all hands-on deck" during COVID where roles were less well defined and everyone chipped in to help other team members who were struggling to keep up and worked to fill positions where staff were absent. Teamwork in the nursing home provided the quintessential backbone of managing COVID in the nursing home.

7. The importance of self-care and caring for others on the team became paramount to mitigate the physical and emotional effects of COVID on nursing home staff. We had many "huddles" to talk about our feelings regarding what was happening around us and our responses to these events. To support staff, the nursing home administration bought lunch on many days and provided us with snacks and bottles of water. We were also given matching t-shirts highlighting how healthcare workers were "heroes." Most days, though, I do not think staff felt like heroes. I personally found it difficult to compartmentalize my work and come home and care for my small children without bringing my work home with me. With typical outlets for stress relief closed, (*i.e.*, the gym, restaurants, coffee shops, church) stress levels seemed to be sustained at an all-time high. Fortunately, there was a true sense of "we are in this together" and I could commiserate with our DON, nurses, care partners, and even patients, and we all understood the high emotional toll this was taking on

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in the **NEWS** at *SLU*

To address COVID-19 issues, Geriatric Workforce Enhancement Program Team members received funding to address the impact of COVID-19 on older adults. These grants include:



Dr. Marla Berg-Weger

Marla Berg-Weger, PhD, LCSW, Executive Director, Gateway Geriatric Education Center and **John Morley, MB, BCh**, Professor Emeritus, Division of Geriatric Medicine, received:

- A one-year supplement to the GWEP grant to provide telehealth and dementia care services. The funding, from the Health Services Resource Administration, provided an additional \$95,625 & \$5,000, respectively.
- Grant funds totaling \$10,000 from The Saint Louis University COVID-19 Rapid Response Seed Grant to support a project entitled, Technology-Assisted Intervention to Address Loneliness and Social Isolation Among Older Adults.

GWEP Team member and Coordinator of the university-wide Interprofessional Graduate Certificate in Gerontology, **Cara Wallace, PhD, LMSW, APHSW-C**, and MSW alumna and gerontology certificate awardee, Liz Ricks-Ahearn, published "Practice Considerations for Trauma-Informed Care at End of Life" in The Journal of Social Work in End-of-Life and Palliative Care. They were also featured in The Playbook, a website launched by the Institute for Healthcare Improvement (IHI) and supported by The Commonwealth Fund, The John A Hartford Foundation, and Robert Wood Johnson Foundation, among others. Goals for the Playbook are "to improve the health outcomes and daily lives of people in the U.S. with the most complex care needs.

Marla Berg-Weger, PhD, LCSW, Professor, School of Social Work, and Executive Director, Gateway Geriatric Education Center has assumed the role of President of the National Association of Geriatric Education. Berg-Weger was also named one of the Memory Care Home Solutions Champion Awardees for 2020.



Dr. Julie A. Gammack

Julie Gammack, MD, is a recipient of the Pastoral Care Department of SSM Health Saint Louis University Hospital's 2021 Caring Physician Award. Also nominated is **Lina Toledo-Franco, MD**.



Dr. Toledo-Franco

Lina Toledo-Franco, MD, joined the Division of Geriatric Medicine in August, 2020 as an Assistant Professor. Dr. Toledo-Franco graduated from Pontificia Universidad Javeriana in Bogotá, Colombia in June 2003. She completed her residency and Geriatric Fellowship at Yale University School of Medicine (St. Raphael Hospital) in June 2010. She returned home to Bogota Columbia before deciding she wanted to specialize in Hospice and Palliative Medicine. Toledo-Franco recently completed a one-year Fellowship in Hospice and Palliative Medicine at Saint Louis University.

Max Zubatsky, PhD, LMFT, Department of Family & Community Medicine, Medical Therapy Program Chair, and **Marla Berg-Weger, PhD, LCSW**, Executive Director, Gateway Geriatric Education Center were awarded two grants to help older adults during the pandemic:



Dr. Max Zubatsky

- St. Louis Community Foundation provided \$13,989 for a project entitled, Behavioral Health Outreach for Underserved and Homebound Older Adults through COVID-19 to provide information and referrals to older adults during the pandemic's early months.
- In partnership with the St. Louis Housing Authority and the Association for Aging with Developmental Disabilities, the Saint Louis University Aging & Memory Clinic received \$49,998 from the Regional Health Commission to offer the evidence-based intervention, Circle of Friends®, through virtual delivery.



Dr. Angela Sanford

Angela Sanford, MD, CMD, Associate Professor, Division of Geriatric Medicine, is providing geriatric consultation to the University of Missouri ECHO project specifically aimed at supporting longterm care facilities during the pandemic. This ECHO program is a “learning hub” of over 100 nursing homes who come together 3 days a week (35 nursing home cohorts each day) for 16 weeks to discuss best COVID-19 management strategies for nursing homes. Funded by the Health Resource and Services Administration, the information is valuable for all who work in care facilities and creates a safe space for the different homes to discuss the challenges they are facing.



Dr. Cara Wallace

SLU Research Team Receives NIH Grant to Study Live Discharge from Hospice Care. Led by **Cara Wallace, PhD**, School of Social Work, the interprofessional, inter-institutional team will be studying needs of patients’ post-hospice discharge and how patients and their caregivers attempt to meet those needs. For more information, visit [Maggie Rotermund’s story](#) on the project on page 13.

Division of Geriatric Medicine Welcomes New Fellows



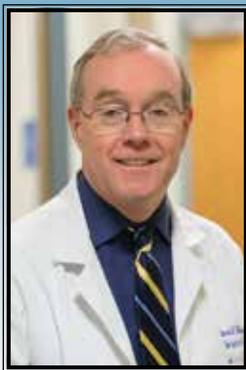
Dr. Ahmed Eltarras

Ahmed Eltarras, MD, completed medical school at the Alexandria University School of Medicine in Egypt, where he grew up. He served as a field physician in the Egyptian navy. He completed his internal medicine residency training at the American University of Beirut Medical Center. While in Lebanon, Ahmed volunteered in medical campaigns helping refugees. He was drawn to SLU’s geriatric program by the educational opportunities, diverse patient population, and the emphasis on wellness and holistic patient care. After his geriatric fellowship, Dr. Eltarras plans to complete a fellowship in cardiology and subspecialize in geriatric cardiology.

Parneeta Bhatia, MD, graduated from the Grant Government Medical College in Mumbai, India. She completed a residency in Anesthesiology at SLU and a fellowship in Critical Care Medicine and Anesthesiology at Barnes Jewish Hospital. Dr. Bhatia also served as a physician at the John Cochran Veterans Administration Medical Center in St. Louis.

SLU Geriatricians Recognized BEST DOCTORS 2020

Congratulations to these Saint Louis University geriatric physicians who were recognized as Best Doctors of 2020. The Best Doctors list includes more than 1,000 physicians, chosen by their peers.



Dr. Gerald Mahon



Dr. Christine K. Jacobs



Dr. Julie A. Gammack



Dr. Angela Sanford



each other. It was important to try and incorporate aspects of self-care in our daily routines because only when we were nourishing ourselves, could we provide wholehearted care to others.

- 8. The media portrayal of the management of COVID in the nursing home was often not accurate and did not foster trust in the care being provided. Many news programs and newspaper articles were quick to focus on the deaths occurring from COVID in nursing home residents but did not dig deeper into why there were so many deaths. Despite nursing homes appearing on the local and national news nightly as the deaths soared, the lack of testing supplies, protective equipment and overall frailty of the nursing home population was rarely discussed in detail. Instead of focusing on what critical roles the nursing homes were playing in providing care to the most vulnerable population, nursing homes were portrayed in a very negative light and blamed for the widespread mortality. The culture that was created from this biased reporting did not boost nursing home staff morale or improve nursing homes' reputations.
- 9. There is hope in the vaccine. Given the natural course of most viral pandemics and now that there are effective



vaccines against COVID-19, an end to COVID is finally in sight. As we look back in the rearview mirror, I am hopeful that nursing home communities will be able to find some positive outcomes from the pandemic.

10. The nursing home environment, despite all which was missing and in the face of adversity, was at all times one of resilience and strength. When COVID entered our buildings, we were working in the trenches and still focused on providing the best care possible for the members of our nursing home communities. Most of us felt the residents were extensions of our families and we continued to come to work day after day and care for those who were sick and those who were well. I saw so many examples of commitment, faithfulness, and selflessness.

There were countless instances of staff going above and beyond to provide personalized care for residents. They truly made a difference in these residents' lives and together, provided comfort, minimized suffering, and improved quality of life. Without the presence of families in the nursing home, staff have stepped up to become the residents' surrogate families and be their voices. Never have I been prouder and more grateful to be a medical director of a nursing home.

SLU Geriatrics is always on the move. Keep up with us!

Find us on  facebook.com/GatewayGEC



@GatewayGEC
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<http://www.youtube.com/c/GatewayGeriatricEducationCenterstl>

SLU Research Team Receives NIH Grant to Study Live Discharge from Hospice Care

What happens to hospice patients who are discharged from care after their condition stabilizes?

by Maggie Rotermund, Senior Media Relations Specialist, Saint Louis University

A new study from Saint Louis University seeks to evaluate the health and quality of life outcomes for patients and caregivers following live discharge from hospice care.

Cara Wallace, Ph.D., Assistant Professor in the School of Social Work, received a \$427,276 grant from the National Institute of Nursing Research of the National Institutes of Health (NIH) to study the needs of patients post-hospice discharge and how patients and their caregivers attempt to meet those needs.

Hospice care has been shown to improve end-of-life outcomes for adults with chronic illness, yet with eligibility limited, the system is not set up to accommodate longer term needs. Eligibility for hospice requires a patient to forgo curative treatments for his or her terminal condition and a physician to certify life expectancy of six months or less. Those adult patients who stabilize, or have a change in terminal prognosis, may be given a live discharge from hospice care.

In 2017, 6.7%, or nearly 90,000 hospice patients, were discharged after they no longer met eligibility requirements.

“Our study aims to find out what happens to the patient and the caregiver when the patient outlives this prognosis and hospice services are removed,” Wallace said.



Hospice services may include nurse and physician care; physical, occupational or speech therapy; social services; nursing aides, medical equipment and supplies; counseling; and short-term inpatient services. Care is available around the clock, in the patient’s home and is focused on symptom management.

The six-month longitudinal

survey will assess the quality of life, service utilization and health status for adult patients and their adult caregiver. The study will evaluate healthcare utilization and health status at time of live discharge and following a live discharge; determine service patterns and the continuity of care transitions; and analyze patient and caregiver perspectives on service coordination and potential impacts to quality of life.

“Without understanding the impact of a live discharge, improving care and providing appropriate support is impossible,” Wallace said. “This is the first step in developing a protocol to create effective live discharge standards.”

(continued on page 14)



The research team, from top left, includes Stephanie Wladkowski, Cara Wallace, Leslie Hinyard and Verna Hendricks-Ferguson, works via Zoom. Submitted photo.

presents the 2nd Annual

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Wednesday, June 16, 2021, 8:15 a.m. - 5:15 p.m. CT

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Continuing Education Credits and Social Workers' Education Credits applied for.

To pre-register



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Questions? Email gunjan.manocha@und.edu

Live Discharge from Hospice

(continued from page 13)

The study participants will be referred from hospice agencies affiliated with the Greater St. Louis Hospice Organization, a coalition of independent agencies who meet regularly to foster communication and collaboration.

Co-investigators include Verna Hendricks-Ferguson, Ph.D., Irene Riddle Endowed Professor in the Trudy Busch Valentine School of Nursing; Leslie Hinyard, Ph.D., director of the Advanced HEAlth Data (AHEAD) Institute and chair of the Department of Health and Clinical Outcomes Research; and Stephanie Wladkowski, Ph.D., associate professor of Social Work at Eastern Michigan University.

The partnership between Wallace and Hendricks-Ferguson was initiated as part of SLU's Interdisciplinary Health Sciences Research Grant Program. This SLU-sponsored program was



supported by the deans of the College for Public Health and Social Justice, School of Medicine, SLU Center for Outcomes Research, Trudy Busch Valentine School of Nursing, Doisy College of Health Sciences, Parks College of Engineering, Aviation and Technology, the College of Arts and

Sciences and the Office of the Vice President for Research.

For more information on referrals and registration, please visit: <https://gatewayeol.com/refer-your-patients-for-a-research-opportunity-the-impact-of-live-discharge-from-hospice-on-patients-caregivers/>

This study is supported by the National Institute of Nursing Research of the National Institutes of Health (NIH), 1R21 NR017978-01A1. This article was reprinted with permission of the author.



Interprofessional Teamwork: Improving Care for Older Adults

By Devita T. Stallings, PhD, RN

The Saint Louis University Division of Geriatric Medicine and Gateway Workforce Enhancement Program (GWEP) held its 6th Annual Interprofessional Geriatric Case Competition. For this case competition, interprofessional student teams are tasked with developing a plan of care for a complex geriatric patient that is presented to a panel of faculty judges from multiple universities and professions. Given the current COVID-19 pandemic, the annual competition was transitioned to a virtual event. An addition to the 2020 case competition was a collaboration with the Minnesota Northstar Geriatric Workforce Enhancement Program (GWEP) at the University of Minnesota. The competition consisted of three parts: first, semi-final, and the final Inter-GWEP competition. The semi-final round winning

teams from Saint Louis University and the University of Minnesota competed in the final inter-GWEP competition on Monday, November 9, 2020.

Interprofessional practice is the hallmark of geriatric care and allows students the opportunity to participate in a collaborative experiential learning opportunity that is essential for their future practice. The geriatric case competition is based on the Interprofessional Education Collaborative core competencies for interprofessional teamwork:

- 1) Work with individuals of other professions to maintain a climate of mutual respect and shared values;
- 2) Use the knowledge of one's own role and that of other professions to appropriately assess and address the healthcare needs of patients and to promote

and advance the health of populations;

- 3) Communicate with patients, families, communities and professionals in health and other fields in a responsive and responsible manner that supports a team approach to promotion and maintenance of health and the prevention and treatment of disease;
- 4) Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable.

For the case competition, students and faculty are

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Interprofessional Teamwork

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recruited to participate in a month-long interprofessional case competition. In teams of 3-4 students, a total of 26 teams were comprised of undergraduate and graduate students from occupational therapy, physical therapy, nursing, medicine, social work, pharmacy, dentistry, medical family therapy, speech language and hearing sciences, and communication sciences and disorders. A faculty mentor/coach is assigned to each team for collaboration on the geriatric case study that focused on the development of a care plan for an older patient with multiple, chronic health conditions, including COVID-19. The students created an innovative 20-minute pre-recorded electronic case presentation. The case presentations were judged by a team of interprofessional faculty. The top-rated team from the semi-final round at SLU and UMN competed via a live zoom during the Inter-GWEP.

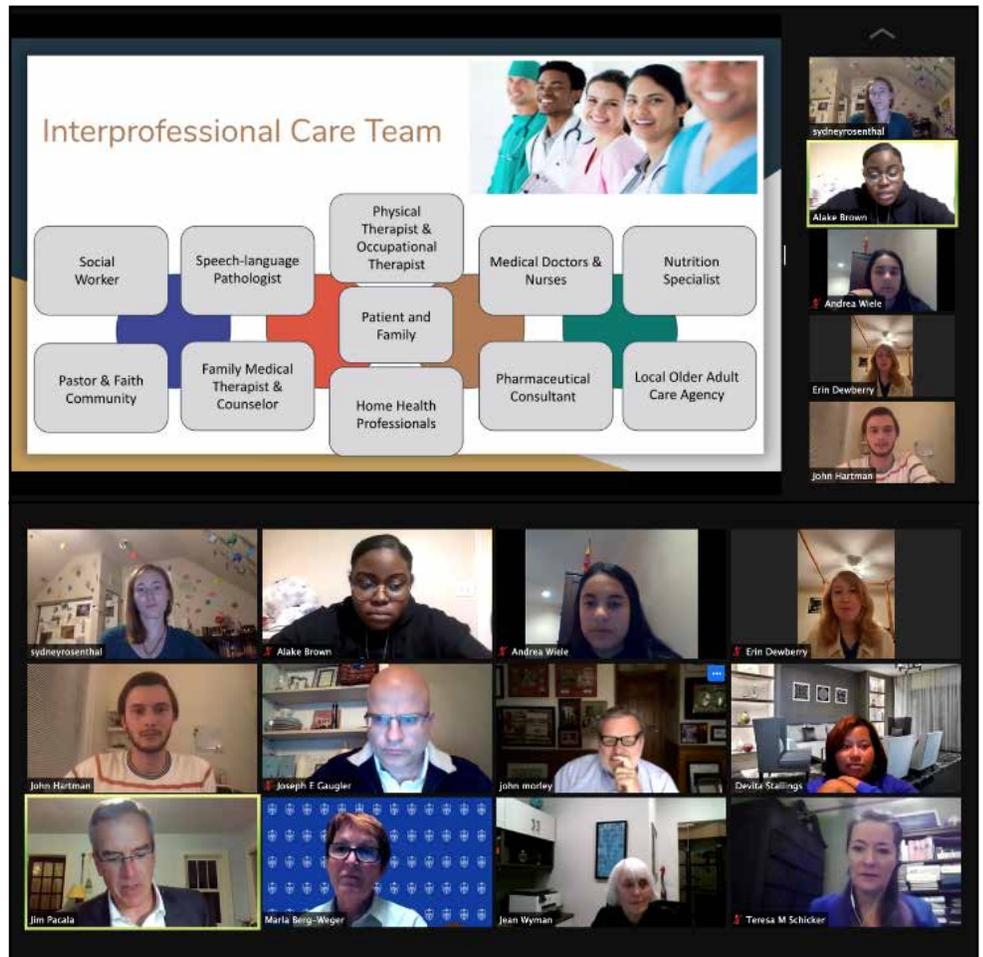
Photos: For the inter-GWEP competition, the University of Minnesota's student team received the highest scores. The top team was awarded a cash prize and each of the members of the top two teams received medallions for their participation.

We would love to engage more students from health professional programs at SLU and surrounding universities in future case competitions.

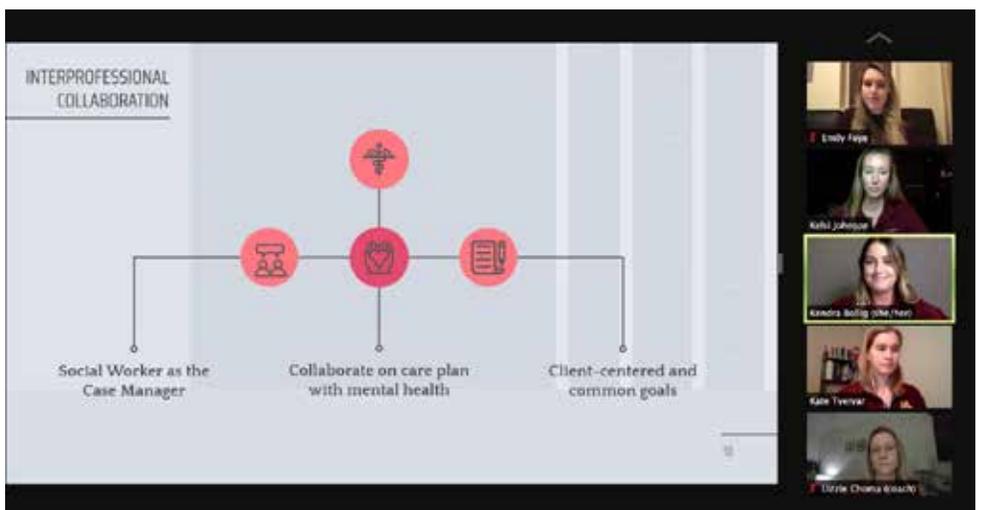
For more information, contact aging@slu.edu

REFERENCES

1. Interprofessional Education Collaborative. Core competencies for interprofessional collaborative practice: 2016 update. Retrieved from <https://ipecollaborative.org/Resources.html>



The winning team from Saint Louis University's semi-final round. Students included: Alake Brown School of Social Work, MSW student; Erin Dewberry, School of Social Work, MSW student; John Hartman School of Medicine, 2nd year medical student; Sydney Rosenthal, School of Medicine, 2nd year medical student; Andrea Weile, School of Social Work, MSW student; Team Coach: Susan Elliot, ANP, Division of Geriatric Medicine



The winning team from the University of Minnesota's semi-final round and the winners of the final Inter-GWEP competition: Students included: Emily Feye, School of Nursing, adult health/gerontological clinical nurse specialist student; Katherine Tyeryar, College of Liberal Arts, SLP student; Kelsi Johnson, Center for Allied Health Programs, OT student; Kendra Bollig, Center for Allied Health Programs, OT student; Team Coach: Lizzie Choma, PT, DPT, GCS.



Keeping the Faith

The Role of Spirituality in Older Adults with Memory Loss

By Max Zubatsky, PhD, LMFT

Eleanor (pseudonym of one participant) was a spirited 77-year-old member of our first Cognitive Stimulation Therapy (CST) group at SLU. She took so much appreciation in the little things in life, even when her recall of recent events was often compromised. During her time in an assisted living facility, she was challenged not only with ongoing memory issues, but chronic pain in her back due to past surgeries. Eleanor's sciatica caused her to have sharp pains while sitting for long periods. Yet, she had a wonderful attitude in the group and always provided a ray of sunshine for group members. Throughout the entire protocol of CST sessions and themes,^{1,2} the group bonded very well and became a vital source of support on Monday mornings.

At our last in-person session, we had a creative arts activity. Each person would get a small, blank canvas and several pictures on the table to serve as visual prompts. We also used our large screen to show pictures of the past actors, trips, movies, songs, and other things that were covered during the entire group process of CST. Part of me was excited to see how they would use different mediums of paint, pastel and colored pencil on their canvases. Another part was terrified that our conference room walls could quickly turn into a representation of Jackson Pollack. At the end of the 30-minute activity, the facilitators

saw each group members' pictures. When Eleanor showed her canvas, she commented, "I don't know if this is what you wanted, but it's the most important thing that's gotten me through rough days." Eleanor's picture was of an angled, wooden cross with a rosary draped over the side. The aesthetic detail of the piece absolutely floored all of us. She recalled this image in her

mind from her mother's old living room, where they would drape different rosary beads from their travels over a cross on the wall. She regretted not having saved this after their move, but always remembers the memories of their family and the importance faith played through tough times.

spirituality are often taboo to discuss with their own family members and friends. When we went back and reviewed the literature on reminiscence interventions and spirituality, we found very little that incorporated personal beliefs and faith into group activities.^{3,4,5} Our research team quickly realized that there was a significant gap that was missing in group-based interventions for adults with dementia.

In 2019, SLU received a grant from the Lutheran Foundation to study the impact that spirituality played in cognition and memory for older adults. Our research team partnered with Dolan Memory Homes and The SARAH Community to test how Cognitive Stimulation Therapy with a spiritual component could help improve areas of dementia and health with this population. The study showed that not only was memory of participants improved from spirituality incorporated in the groups, but overall mood and well-being as well. All group participants across five CST groups also completed a "spiritual toolkit," which was a small box that members would continually add meaningful faith-based items to across the study. Qualitative narratives were also collected from group members about their experiences in sharing faith-based information and themes during the sessions.

Photos taken from the Lutheran Foundation Event for Spiritual CST at Saint Louis University in February of 2020. Samples of spiritual toolboxes are seen on the pedestals.



The takeaway from this CST group session was profound. The facilitators not only noticed how powerful Eleanor's piece was, but how the group engaged in a conversation about the meaning of faith in their lives. It sparked further conversation amongst group members about why religion and

email: aging@slu.edu

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Keeping the Faith

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The project was capped off by a community event that was hosted by Saint Louis University. The event highlighted several spiritual toolboxes used by individuals in the CST groups at all three sites. Community partners and other SLU students attended the event and could observe the creations that CST participants made across the project. Narrative quotes and summaries of sessions were also posted for attendees to view at the event. Although the start of the COVID-19 pandemic interrupted further in person sessions, individuals continued to share their meaningful experiences with facilitators through phone and ongoing virtual groups.

The following are items and belongings that participants in the spirituality group used in their Spiritual Toolbox:

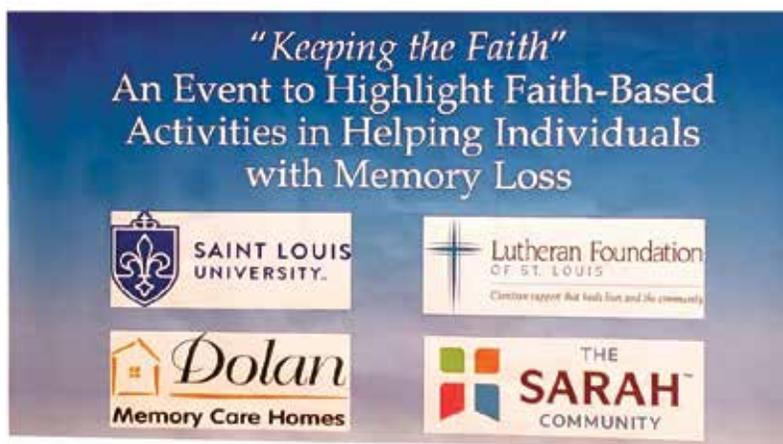
- Poems- Writings that have been meaningful to them over the years
- Hymns and scripture- Religious songs or versus that inspire individuals in their coping around memory loss and give them perspectives in life
- Old pictures: Helps to reminisce about events in peoples' lives and can help bring back stories in their childhood and early adulthood.
- Candles-Used by participants during times of prayer or meditation in their home
- Greeting Cards- Could be general cards or holiday cards that helped remind individuals about their loved ones.
- Quotes-These often came from books, readings, or notes that were collected by individuals over the years.
- Spiritual Items-Rosary beads, meditation bells, Hebrew dreidels,

malas, and statues.

As we continue CST groups on virtual platforms, members have been able to report new areas of faith and belief during COVID-19.

Among the many themes and conversations covered over the past year, faith continues to be a popular area for members to process. Participants are excited to share small items and trinkets on Zoom to other members. Others may recall their week and highlight the importance of staying connected virtually with their church, synagogue, mosque, or other faith organizations. Virtual adaptations of CST are starting to occur across the world,⁶ where facilitators are continuing to recognize the importance of reaching vulnerable adults with memory loss through technological means.

Providers who work with older adults with dementia and other memory challenges should consider how faith and spirituality play an important role in patients' lives. We often lose site of the spiritual dimension of health when factoring just biopsychosocial areas of patients' and caregivers' lives. During COVID-19, we have seen many socially isolated individuals with memory loss issues who must use any form of resiliency they can to endure disconnection from the outside world. Our group has seen how powerful faith can be for many and what can be shared with others in



their "virtual" community. Eleanor's experience was a great example of how powerful one's belief system can be in getting through life's most challenges circumstances. For more information, contact Dr. Max Zubatsky at the Saint Louis University Aging & Memory Clinic: 314-977-9759 or memoryclinic@health.slu.edu.

REFERENCES

1. Spector, A., Thorgrimsen, L., Woods, B. O. B., Royan, L., Davies, S., Butterworth, M., & Orrell, M. (2003). Efficacy of an evidence-based cognitive stimulation therapy programme for people with dementia: randomised controlled trial. *Br J Psychiatry*, 183(3), 248-254.
2. Spector, A., Orrell, M., & Woods, B. (2010). Cognitive Stimulation Therapy (CST): effects on different areas of cognitive function for people with dementia. *Int J Geriatr Psychiatry*, 25(12), 1253-1258.
3. Elias, S. M. S. (2018). A review of spiritual reminiscence therapy for older people with mental health problems. In Proceedings of Global Public Health Conference (Vol. 1, No. 1, pp. 27-36).
4. MacKinlay, E., & Trevitt, C. (2020). Spiritual factors in the experience of Alzheimer's disease and other Dementias. In Religion and Theology: Breakthroughs in Research and Practice (pp. 334-357). IGI Global.
5. Smeaton, E., & Maher, C. (2016). Supporting Spiritual Engagement for People Living with Dementia. *Health and Social Care Chaplaincy* 4(2), 130-141.
6. Cheung, G., & Peri, K. (2020). Challenges to dementia care during COVID-19: innovations in remote delivery of group cognitive stimulation therapy. *Aging Ment Health*. 2020 Jul 7; 103. doi:10.1080/13607863.2020.1789945.



GWEP Pivots to Virtual Delivery

For educators and service providers accustomed to delivering in-person education and programming, the pandemic meant postponements, suspensions, and cancellations. Need for education and services was critical for supporting older adults and professionals. Our GWEP quickly pivoted education/service initiatives to online formats. Despite technology skills, most experienced a learning curve shifting from in-person to virtual delivery. Since March, 2020, faculty, staff, and students creatively developed online access to education and services. We share our efforts to pivot and create online delivery, including lessons learned.



GERIATRIC EDUCATION—

With a need for education on caring for older adults and caregivers, we developed a COVID-19 resource page. Faculty, staff, and partners transitioned in-person events to virtual including the 31st Annual Summer Geriatric Institute and a webinar, *The Impact of COVID-19 on Older Adults* available at aging.slu.edu. Recognizing students' need for COVID-related information, we offered a student-focused webinar. With support from GWEP faculty, SLU MSW candidates recruited graduate students from across the U.S. to plan a virtual conference, *COVID: Decoded*, to increase unbiased, scientific education on COVID-19. Chaired by MSW student, Anna Brende, the executive planning committee included graduate students from SLU, A.T. Still University, University of Texas at Rio Grande Valley, University of Utah, and University of Maryland Eastern Shore. The committee researched and invited eight expert speakers, advertised, and hosted a hugely successful conference August 29th with 250 registrants from the U.S. and seven countries.

Video recordings (available on the GEC YouTube channel) have reached 950 views. Topics included a keynote lecture addressing the virus research, background & microbiology, treatments, and vaccine development, economics, gerontology, social work, education, and mental health. Pre- and post-tests show that *COVID: Decoded* decreased participants' fear about the virus and increased knowledge in all topic areas. Led by Brende, members of the planning committee published an article in the *Journal of Nutrition, Health & Aging* entitled "We need to know: A call for interdisciplinary education on COVID-19."¹ The students' hope is to spur more academic institutions and students on to increase unbiased, interdisciplinary education on the virus.



GERIATRIC ASSESSMENT CLINIC—*Julia Henderson-Kalb, OTD, OTR/L, Clinic Coordinator*

Our Geriatric Assessment Clinic, an interprofessional student-led clinic, transitioned to virtual service delivery in Fall 2020. Students and professionals from medicine, nutrition/dietetics, occupational, physical, and speech

therapies, social work, and medical family therapy meet patients and caregivers via Zoom Telemedicine to complete holistic screens and offer recommendations for care. All disciplines join the virtual clinic to complete their respective assessments while the other disciplines observe. While observing but not directly assessing, audio and video are muted so patients and family are not overwhelmed. After screenings are complete, all disciplines once again turn on their video and audio to share recommendations with patients and caregivers.

Moving to a virtual platform required changes. Patients and caregivers complete a practice session prior to the clinic date to ensure comfort with Zoom. While we normally see three patients simultaneously by different groups of healthcare professionals, a virtual clinic can now see one patient at a time. Despite changes, benefits to patients are not reduced. One caregiver shared, "I cannot stress enough how appreciative Mom was to have the evaluation. Please thank all who were involved." For more information on the Geriatric Assessment Clinic, visit the Gateway Geriatric Education Center website and phone 314/977-6793 for referrals and appointments.



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Virtual Delivery

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EXERCISE AND STRENGTHENING INITIATIVE

Kelly Hawthorne, PT, DPT, GCS and Jill FitzGerald, PT, DPT, CSCS, Co- Coordinators

As the Physical Therapists on the GWEP team, we focus on movement! Activity and exercise for older adults, especially during the pandemic, is essential to mental and physical health. Two initiatives to help older adults stay active during the COVID-19 pandemic include:

1) In a presentation for older adults to stay active during the pandemic, we emphasize the importance of exercise and how to manage exercise within ever-changing COVID-19 guidelines. We encourage exercising with others, getting outside, maintaining distance, and always wearing a face mask! Community (or home) based strength training videos are also posted in conjunction with this presentation. <https://www.youtube.com/c/GatewayGeriatricEducationCenterstl/videos>. All materials can be found at aging.slu.edu.

2) North Side Youth and Senior Services Center was offering a robust community-based strength training program for older adults when COVID-19 brought a sudden halt. NSYSSC continues to encourage older adults to exercise at home during the pandemic and requested our assistance to create exercise DVDs (preferred method for the individuals served) for distribution. DVDs, PPE, books, brochures, and exercise logbooks were delivered to 17 older residents of the neighborhood and NSYSSC checks

in weekly! Having these resources in the home has assisted our older adults in continuing their active lifestyles during this time of limited access to outside resources and facilities.



SPEECH-LANGUAGE- HEARING CLINIC

Andrea Vaughan, MS, CCC-SLP, BCS-S, Assistant Clinical Professor

Offered by students and faculty in Communication Sciences & Disorders (CSD), the Reinert Clinic halted CST when COVID-19 restrictions began. CST was soon resumed in a vastly different format. Led by faculty and graduate students, the group transitioned to Zoom and 4-5 clients attended via video or audio capabilities. Group activities continued in the same format as in-person CST including orientation, article discussion, main activity, and conclusion. We learned telehealth requires creativity to design activities that stimulate discussion and reminiscence. Technology knowledge is required to ensure the group runs seamlessly and all group members participate. Some of these activities included “Jeopardy”, “BINGO”, “The Price is Right”, “Family Feud”, and “Name that Tune.” Despite changes,



Reinert Speech-Language-Hearing Clinic Cognitive Stimulation Therapy Group

participants continue to contribute to meaningful conversation regardless of format (audio or video). Transition was much less painful than anticipated and participant feedback has been overwhelmingly positive. The pandemic has been isolating for all, but even more so for those with dementia. While not ideal as compared to in-person interactions, it has provided participants a chance to continue engaging in meaningful conversation with their peers. This group continues the telehealth format both Fall 2020 and Spring 2021 semesters.



AGING & MEMORY CLINIC—

Matthew Amick, MS, Hunter Boling, MA, Daniela Bularzik, MSW, and Anna Brende, BA—Graduate students in Medical Family Therapy and Social Work

March 2020 sent a shockwave throughout the community and across the globe. Professionals were faced with dilemmas as once reliable services and programs were forced into drastic changes to stay afloat. Our Aging & Memory Clinic found creative solutions to not only continue services but has increased groups. The uncertainty continued and rippled throughout Aging & Memory Clinic services. Connecting via Zoom from different parts of the nation, facilitators swiftly resumed services virtually. Due to ease of connection, existing Caregiver Process Groups were resumed. These groups are vital to the Clinic’s mission of enhancing the caregivers’ wellbeing rather than solely focusing on the person living with dementia. Groups offer caregivers a place to be emotionally vulnerable, share

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Virtual Delivery

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caregiving strategies, and provide an hour of respite from caregiving. The first virtual meetings served as an informal check-in on how they and their loved ones were coping with isolation. Adjusting depended on their loved one's level of functioning. Clinic facilitators soon learned the decision to restart the groups could not have come soon enough.

Reimagine those early days of the pandemic in the role of a caregiver: the struggle to maintain a virus-free environment, distinguish reliable information from pervasive misinformation, and determine who to let in your socially distanced bubble. Caregivers were overwhelmed with responsibility of preserving their own health and protecting their loved ones. Many of the early groups shifted from emotional processing of in-person services to crisis management as other in-home care, daycare, and residential care services were suspended. While facilitators offered resources and attempted to emotionally process increasing stressors, facilitators validated caregivers' positions and supported decisions made in providing the best care for their loved ones. Caregivers' resiliency in the early days of the pandemic was remarkable. Caregiver groups typically ended with "I am grateful to be reconnecting with you all, but we really wish the CST groups could get going again!"

Pre-pandemic, Cognitive Stimulation Therapy (CST) was offered in-person. In-person activities typically involve identifying scents, working with money, physical games, and the occasional inclusion of food. An active and engaging CST session

can resemble something between a social event and Wheel of Fortune. Virtual CST created a challenge for facilitators: repackage CST using a new medium limited to sight and sound with a population that required



Saint Louis University Aging & Memory Clinic Faculty and Graduate Student Facilitators

supervision, support, and consistent stimulation. While the transition would not be successful without caregivers' commitment to work through technology challenges and supervise their loved ones through the first few minutes of sessions, the enthusiastic CST participants quickly showed that they were more than ready to take on this new venture.

We're getting the band back together!" one facilitator shouted during the first virtual session. Participants' laughter quickly filled the virtual chat room as they reconnected, calling fellow participants by name and some remembering personal characteristics they had shared in person, even noticing those missing. Technology hiccups notwithstanding, they were eager to express how they were filling days while separated from society. The joy throughout the first few sessions overshadowed the pandemic's impact on participants' routines and mental status. Facilitators and some members realized that not all participants were unscathed by months of isolation with minimal stimulation. Nevertheless, all members showed patience to those that required it

in accordance with CST's spirit of acceptance. Comradery and humor filled interpersonal gaps left by the transition and boosted morale needed to continue services. The Clinic has since capitalized on these successful pioneer groups, exploring more ways to enhance CST virtual delivery and creating new groups as the flow of referrals has steadily returned.

By mid-summer, the Clinic was back at capacity and growing and we launched virtual Circle of Friends. As articles in this newsletter describe, Circle of Friends groups meet weekly for 12 weeks to alleviate loneliness and social isolation among older adults. Meetings include activities, outings and discussion around wellness, arts and culture and reflective writing. Although COVID-19 presented the challenge of needing to physically distance, Circle of Friends attempts to build and maintain social connection in a time where connection is needed most. Facilitated by MSW students Anna Brende and Jessica Leuthauser. the first group is described by Brende as "We were flying by the seat of our pants at first, but the momentum and interest kept growing. We are now halfway through our fourth virtual Circle of Friends group." Each participant meets with a facilitator by phone or Zoom to troubleshoot technology issues. Participants joined with varying levels of experience with technology, however all had the chance to learn more and find new ways to connect with one other. Although not all has access to a computer or smartphone, online groups through Zoom allow those with landline numbers to call into meetings. Online meetings enable participants to meet others from different parts of the city, county, and state. Virtual sessions eliminate transportation needs and allow scheduling flexibility.

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Virtual Delivery

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Challenges do include limitations to some activities (e.g., arts & crafts and physical activities). Through brainstorming with other Circle of Friends facilitators, new ideas, modifications, and telehealth-friendly activities continue to be developed and implemented. Groups have brought hope, laughter, and support to participants who have had their isolation compounded this year. Brende shared a recent quote from a participant that highlights connections: “Wouldn’t it be so fun if we could all be neighbors?”

The Clinic has been a virtual training for family medicine residents completing geriatrics medicine rotations. Residents observe virtual groups and participate in mock geriatric simulations, playing the role of provider to an older couple, creating the environment of a virtual primary care appointment.

A faculty member and Medical Family Therapy and/or Social Work

student observe and provide feedback to residents using the Family-Centered Observation Form. This experience helps residents develop family-centered skills with older adults in routine patient care, while meeting certain ACGME competencies.

Designed to provide education on memory and health-related topics to caregivers as a compliment to the Caregiver Process groups, the monthly Caregiver Lecture Series went virtual. Since going virtual, the reach has extended to professionals and caregivers around the country. Lectures have been provided by such experts as Dr. Annie Harmon on dementia and driving, Dr. Sue Tebb and Dr. Carol Podgorski on self-care, Dr. Barry Jacobs on caregiver stress, Dr. John Morley on medications and dementia, and Dr. Dominic Reeds on healthy eating for memory. Amy Sobrino, LCSW, from Memory Care Home Solutions, shared, “I’ve had the pleasure of presenting as a speaker for the series pre-COVID, and an attendee during COVID. The series is an opportunity for caregivers and

professionals to learn and grow. I particularly enjoyed Dr. Morley’s

presentation on dementia medications and their alternatives. Great information presented in an exciting way!” Offered the second Monday of the month, the Series continues to be a valuable experience for caregivers and professionals to gain insight and practical strategies regarding caregiving and cognitive changes. To join the invitation list, email memoryclinic@health.slu.edu.

The success and growth of the Clinic shows that virtual groups are not a temporary fix during social distancing, but a way to increase accessibility of services. Though facilitators continue to hope for the return of in-person, groups on Zoom will continue no matter what. Having a virtual option ensures that members who are home-bound, lack transportation, live in rural or distant areas, or have difficulty leaving their homes, have access. The clinic’s adult child caregiver group has an international member, and our Circle of Friends groups have had participants who are not mobile and who live too far to drive. Looking forward to a post-pandemic world, SLU students and faculty have built an arsenal of creative problem-solving skills to apply to future practice. The pandemic forced them outside comfort zones into an innovative area of growth. For information on CST, Circle of Friends, and Caregiver Support, email memoryclinic@health.slu.edu.

REFERENCES

Brende, A., Stacer, R.J., Haver, J., Darlington, A., Soto Abarca, A. Paracha, A., Suleman, S., Rainey, B., Wendel, J., & Huerta, D. (2021). We need to know: A call for interdisciplinary education on COVID-19. *J Nut Health Aging*. <https://doi.org/10.1007/s12603-021-1608-4>. Available at: <https://link.springer.com/article/10.1007/s12603-021-1608-4>

Tips on Virtual Delivery

Many lessons have been learned during the pandemic—our GWEP faculty and students offer these strategies for virtual delivery:

- Always assess for comfort with technology.
- Do a practice session with clients individually.
- Walk clients through access via phone first.
- Include client’s family/friend if technology barriers exist.
- Always practice virtual activities in advance.
- Consider adding additional confidentiality ground rules, such as, “Join the session from a private area in your home to protect the privacy of other group members.”
- Simplify standard Zoom invitation to only include necessary information.
- For a mix of audio and video participants, plan activities to ensure clients with audio only are not left out.
- For audio participants (those “calling in”), introduce a rule for other participants to say their own name before speaking to help match voices to names.



The GWEP Initiative that addresses loneliness and social isolation during the pandemic and beyond

The COVID-19 pandemic has raised awareness across the globe about an issue that has long existed but has gone nearly unnoticed by all but a select group of researchers. Loneliness and social isolation, particularly among older adults, has received little attention by most of our society. With people of all ages sheltering-in-place, working from home, social distancing, and being unable to interact as usual with friends and family, an acute sense of loneliness and social isolation has occurred since March 2020 for all age groups. Because most of us have experienced loneliness and/or social isolation to some degree, the light has been shone on the devastating toll that both can have on our physical and mental health, cognition, and risk for mortality. In fact, in an infographic created by the National Institute of Health Care Management in 2020, loneliness is noted to be more harmful than obesity and as

detrimental as smoking 15 cigarettes/day¹.

Prior to the COVID-19 pandemic, loneliness among older adults was declared by former U.S. Surgeon General Vivek Murthy² a “global epidemic” as well as a major public health concern by the National Academy of Science, Engineering, and Medicine.³ Research conducted since the pandemic began has only served to confirm these statements. Specifically, decreased contact with family increased loneliness in older adults⁴ and stay-at-home orders increased loneliness⁵. Particularly at risk for severe loneliness are those older adults residing in residential

care facilities. As noted by Aung and colleagues⁶, 100% of nursing home residents studied experience severe loneliness—25% at the moderate level and 75% at a severe level.



While research has shown that experiencing loneliness and/or social isolation creates significant risk for older adults’ wellbeing, few evidence-based interventions have been developed to prevent or combat either of these experiences. One such evidence-based intervention, Circle of Friends[®] was developed by scholars and practitioners at the Central Union for the Welfare of the Aged at Helsinki University in the early 2000s⁷⁻⁸. This person-centered group intervention strives to alleviate and prevent loneliness and social isolation by bringing groups of eight older adults together for twelve weekly meetings to engage in activities focused on art and inspiration, group exercise and health-themed discussions, and therapeutic writing with sharing and reflection on issues related to loneliness⁹⁻¹¹.

In 2019, the Gateway GWEP, with support from the founders of the Finnish-based program, began to adapt the model for older adults in the U.S. While we were well aware of the

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Community Health in Partnership/St. Louis Housing Authority Circle of Friends Facilitators 2019

Circle of Friends

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need to address loneliness and social isolation, little did we know that the severity of these experiences would skyrocket by early 2020. In the past year and a half, since announcing this new initiative, GWEP faculty, Max Zubatsky and Marla Berg-Weger, have worked with SLU graduate students in social work and medical family therapy and community partners to develop and deliver educational presentations, training, and a training guide for the facilitation of Circle of Friends[®]. To date, approximately 150 persons have been trained to facilitate the intervention. Initially, St. Louis area groups were offered as in-person gatherings through the Association for Aging with Developmental Disabilities, St. Louis Housing Authority (in collaboration with Community Health in Partnership), and the Saint Louis University Aging & Memory Clinic. Developed as an in-person intervention, the pandemic necessitated the transition Circle of Friends[®]. Please see the article on pages 20-22 in this issue for insights on virtual delivery.

For more information on Circle of Friends[®] training, visit the Geriatric Education Center website or contact Marla Berg-Weger at marla.bergweger@slu.edu.

Caption for first picture: Association for Aging with Developmental Disabilities Circle of Friends 2020

REFERENCES

1. National Institute on Health Care Management. (2020). Addressing Loneliness and Social Isolation During the Pandemic (Infographic). Available at: <https://nihcm.org/publications/addressing-loneliness-social-isolation-during-the-pandemic>
2. Murthy V. Work and the loneliness epidemic. *Harv Bus Rev* September 2017. Retrieved from: <https://www.vivekmurthy.com/single-post/2017/10/10/Work-and-the-Loneliness-Epidemic-Harvard-Business-Review>
3. National Academies of Science, Engineering, & Medicine: Health and medical dimensions of social isolation and loneliness in older adults. Retrieved from: http://nationalacademies.org/hmd/activities/publichealth/isolationandlonelinessinolderadults/2019-feb-27.aspx?_a=2.240319683.1913068659.1550866668-1537762008.1550682496
4. Losada-Baltar A, Jiménez-Gonzalo L, Gallego-Alberto L, et al. "We're staying at4home". Association of self-perceptions of aging, personal and family resources and loneliness with psychological distress during the lock-down period of COVID-19. *J Gerontol*. 2020. doi: 10.1093/geronb/gbaa048. Epub ahead of print. PMID: 32282920; PMCID: PMC7184373.
5. Tull MT, Edmonds KA, Scamaldo KM, Richmond JR, Rose JP, Gratz KL. Psychological outcomes associated with stay-at-home orders and the perceived impact of COVID-19 on daily life. *J Psych Res*, 289, 113098. <https://doi.org/10.1016/j.psychres.2020.113099>
6. Aung KT, Nurumal MS, Syakihar WN, Bukhari W. Loneliness among elderly in nursing homes. *International J for Studies on Children, Women, Elderly and Disabled*, 2017. 2:72-78.
7. Jansson AH, Savikko NM, Pitkälä KH. Training professionals to implement a group model for alleviating loneliness among older people—10-year follow-up study. *Educ Gerontol* 2017. Doi: 10.1080/03601277.2017.1420005.
8. Savikko M, Routasalo P, Tilvis RS, Strandberg TE, Pitkälä KH. Predictors and subjective causes of loneliness in an aged population. *Arch Gerontol Ger* 2005; 41:223-233.
9. Routasalo PE, Arve , Lauri S. Geriatric rehabilitation nursing: Developing a model. *Intl J Nurs Prac* 2004; 10:207-215.
10. Anu J, Tarja Y, Satu H, Pitkälä K. Circle of Friends. Group model alleviating loneliness. Retrieved from: <https://vtkl.fi/toiminta/ystavapiiri>
11. Pitkälä KH et al. Leading groups of older people: A description and evaluation of the education of professionals. *Ed Geron* 2004. 30:821-833.

Interprofessional Graduate Certificate in Gerontology Now Offered at Saint Louis University

With an emphasis on developing competencies in interprofessional care of older adults, highlights of the certificate include:

- 15 credit-hours which include interprofessional and experiential/practicum opportunities
- Designed for post-baccalaureate students, current graduate students, and professionals currently working with older adults, including: dietitians and nutritionists, health care workers, occupational therapists, physical therapists, speech-language pathologists, nurses, nurse practitioners, social workers, and more.
 - Opportunity to take courses across the university with a focus on:
 - Foundational competencies (frameworks for understanding human aging; biological, social, and psychological aspects of aging; humanities and aging; research and critical thinking)
 - Interactional competencies (attitudes and perspectives, ethics and professional standards, communication with and on behalf of older persons, interdisciplinary and community collaboration)
 - Contextual competencies (well-being, health and mental health; social health; and policy)



For more information, contact Cara L. Wallace, PhD, LMSW, Gerontology Certificate Coordinator at Cara.wallace@slu.edu or call 314-977-2746.

NOW AVAILABLE ONLINE!

COMING SOON

GEC Launches Cognitive Stimulation Therapy Facilitator Certification

In 2019, the founders of Cognitive Stimulation Therapy (CST) designated the Saint Louis University GEC as the North America CST Training Institute. The Institute was developed in collaboration and consultation with the founders at University College London. 2020 marked the inauguration of the Facilitator Certification. While originally scheduled as an in-person event in June, the CST Team pivoted the training to virtual delivery which included two half-day webinars. The Institute currently offers certification for CST facilitators and will be offering certification for CST trainers in 2022.

The main objectives of the Institute are to:

- develop and implement a standard curriculum and evaluation process for training facilitators of CST and trainers of facilitators.
- establish a leadership structure for CST training in the United States and Canada to assure fidelity and quality of program implementation.
- adapt the CST manuals to:
 - be culturally appropriate for North America-based participant groups
 - include education/direction on implementation
- develop and maintain a listing/registry of approved individuals who have successfully completed and

maintained facilitator or trainer programs.

- provide information on CST educational resources and provision in North America.
- develop an effective evaluation method as a useful model for international adoption.

While continuing to provide education, training, and consultation related to CST, the Institute's first major initiative is to offer certification for professionals trained in facilitation of CST, both on the individual and group level.

A non-pharmacological intervention for persons with mild to moderate cognitive impairment, CST can be delivered by trained health care professionals working with people with dementia, including but not limited to social workers, occupational therapists, speech language pathologists, and

registered nurses. With supervision and guidance, anyone with experience in working with those with dementia, can be trained to facilitate CST groups. CST groups can be offered in settings including residential facilities, community organizations, hospitals, and adult day centers.

CST Facilitator (CST-F) Certification

A CST-F co-leads the CST group sessions with another CST-F. Two CST-F are required to provide the individual and/or group sessions to participants. In situations in which a co-facilitator is not available, the CST-F must consult with CST-CTF.

The goal of CST-F training is to teach attendees to apply the key principles during

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CST Facilitator Certification

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CST, encouraging its use in a standardized, person-centered and effective manner. Prerequisite Qualification includes:

- Interest in helping people with cognitive challenges and their caregivers.
- Commitment to learning and implementing an evidence-based intervention.
- Documented paid and/or unpaid experience working directly with persons with dementia.
- Appreciation of the complexity of the “simple” appearing program activities.
- Experience leading group discussions, teaching, and role play.

Individuals interested in becoming an Institute-approved CST-F are required to:

- Complete approved training taught by an approved CST-T
- use the standard Institute Facilitator curriculum including lecture, live and videotaped demonstrations

- demonstrate competencies by achieving 80% on CST brief exam
- complete and submit CST-F application within 30 days of training completion and \$100 application fee.

Anyone may attend the training, but in order to be listed in the Institute registry, application to the Institute is required. Applications must be submitted within 30 days upon completing the seminar with a \$100 administrative fee. Based on professional background, there is appropriate support information that will be requested (e.g., license number or college registration number).

In-house training is available throughout the United States and Canada, which involves training up to 24 people within a setting. Training and travel expenses will be required.

Approved CST-Fs are expected to:

- Complete 2 hours of Institute on-line training updates during the two-year approval period

- Agree to facilitate 28 sessions/2 groups within two years of approval

CST-Fs will be required to renew certification every two years. To renew approval status, CST-F will complete the on-line renewal process which includes:

- documentation of courses/sessions facilitated
- completion of at least 2.5 hours of continuing education in dementia care and CST advances as required
- \$50 renewal fee

CST Facilitator training will be offered virtually on June 2 and 9 from 8:00 am – 12:00 pm in conjunction with the 32nd Annual Saint Louis University Summer Geriatric Institute (see registration information below). To learn more about CST programs and the certifications, please visit our CST page at <https://www.slu.edu/medicine/internal-medicine/geriatric-medicine/aging-successfully/>. To inquire about training, email aging@slu.edu.

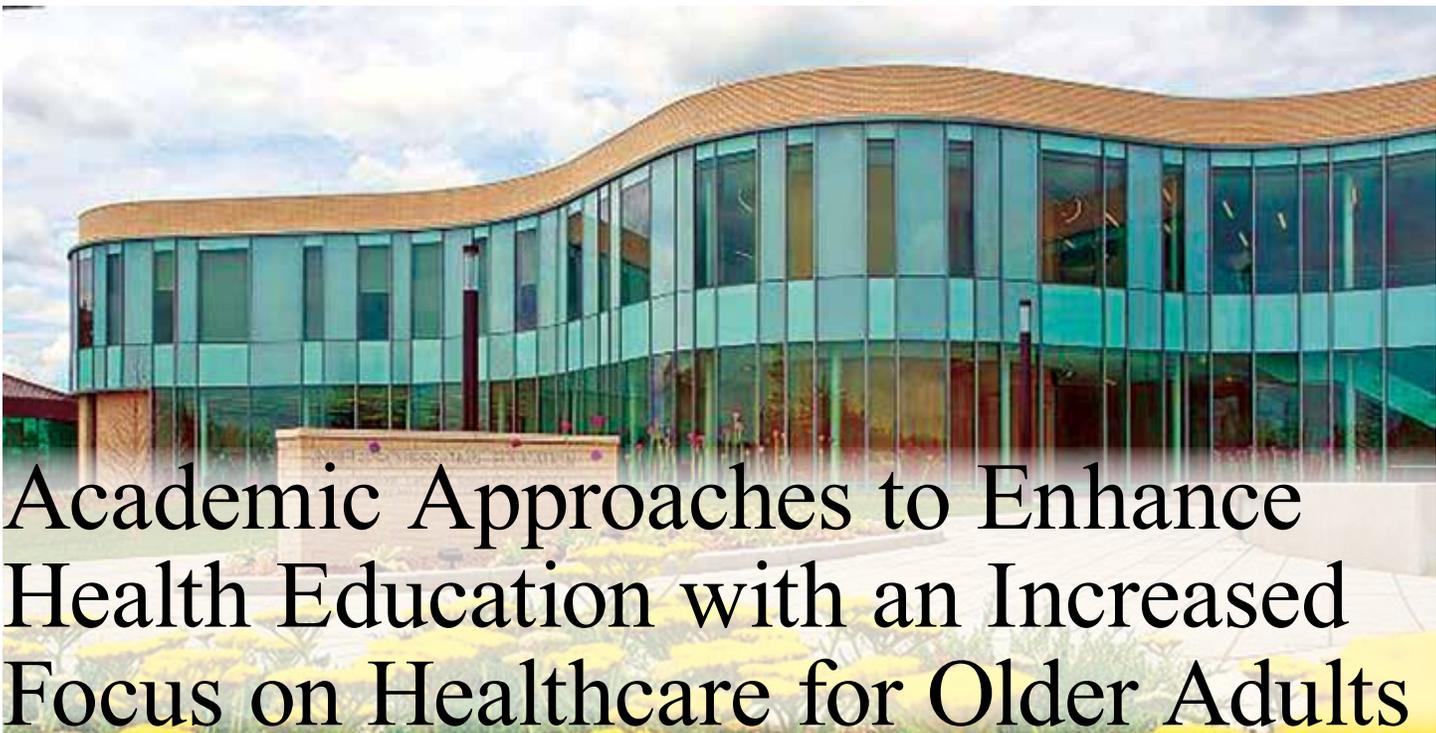


What's Next?

32nd Annual Saint Louis University Summer Geriatric Institute
The Future of Geriatric Care in Older Adults and Cognitive Stimulation Therapy (CST) Certification

Cognitive Stimulation Therapy Certification Training June 2 and June 9, 2021 8:00 am-Noon	The Future of Geriatric Care in Older Adults June 3-4, 2021 8:00 am-5:00 pm
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Information and Registration will be available April 1, 2021 at aging.slu.edu



Academic Approaches to Enhance Health Education with an Increased Focus on Healthcare for Older Adults

By Debra Blessing, B.A., GWEP Coordinator, A.T. Still University, Kirksville, Missouri

Now in the sixth year of partnership with the Saint Louis University Geriatric Workforce Enhancement Program (GWEP), A.T. Still University-Kirksville College of Osteopathic Medicine (ATSU-KCOM) and Area Health Education Centers (AHEC) Program Office have implemented GWEP initiatives on A.T. Still University of Health Sciences' (ATSU) Kirksville campus as well as throughout the Missouri AHEC (MAHEC) Network. In support of the SLU GWEP vision to strengthen the workforce that cares for older adults, specifically in underserved and rural communities, ATSU is collaborating to develop protocols for early identification of common and modifiable geriatric syndromes, including cognitive dysfunction, frailty, sarcopenia, and weight loss. ATSU is partnering to build multidisciplinary teams and collaborative partners to increase the knowledge and skill set needed to improve quality of care and access to treatment for older adults.

Established in 1892 by Andrew Taylor Still, DO, the founder of osteopathy, ATSU began as the

nation's first college of osteopathic medicine and has evolved into a leading university of health sciences comprised of a growing community with a rich history in education and osteopathic healthcare. Today, ATSU offers master's degrees across allied health disciplines and doctorates in osteopathic medicine, dental medicine, athletic training, audiology, health administration, health education, health sciences, medical science, nursing, occupational therapy, and physical therapy. ATSU's Missouri campus is located in Kirksville, in Adair County, approximately 200 miles northwest of St. Louis, with a population of approximately 17,500.

The MAHEC program began in 1988 under the direction of Janet Head, EdD, MSN, RN, and Michael French, BS, with the first program office located on ATSU's Missouri campus. Today, the MAHEC Network has grown to include two additional program offices, located on the medical campuses of Saint Louis University and the University of Missouri along with seven regional centers. For the past

30 years, the MAHEC Network has worked to enhance access to quality healthcare, particularly primary and preventive care, by growing and supporting a healthcare workforce that serves rural and urban underserved areas in Missouri. The MAHEC pipeline connects academic resources to communities to enhance training and access to healthcare in all 114 Missouri counties and City of St. Louis. Given our collaboration over the past 25 years, ATSU-KCOM AHEC Program Office was in a place to implement select GWEP initiatives.

"I believe our pre-existing relationship with SLU was really critical in being selected as a GWEP partner," said former ATSU-KCOM AHEC Program Director Dr. Head. "We knew each other, and we were in a position to apply some of the principles they identified for the program. We have enhanced many of the programs initiated at SLU, and ultimately, we changed curriculum for some of our courses.

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Academic Approaches

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Another attractive feature of ATSU-KCOM AHEC was our statewide connections through the MAHEC Network. Our long-standing working relationship with the folks at SLU made it much easier to talk and dream about making a difference.”

Highlights of two GWEP objectives for the ATSU-KCOM AHEC Program Office featured here include: 1) working with faculty, staff, students, and primary care providers to develop skills and protocols for conducting the Rapid Geriatric Assessment (RGA) in primary care settings and 2) infusing geriatrics into existing interprofessional education (IPE) courses.

facility and put into practice the skills they have learned during their first two semesters of medical school. Organized by ATSU KCOM-AHEC and the AHEC regional centers, the experience allows students to increase their familiarity with primary care and related specialties and expand their clinical skills through observation and practice. Students become familiar with the types of clinical problems prevented or managed by a primary care physician providing care in an underserved area.

With integration of the RGA into the Summer Preceptorship program, students are introduced to geriatric syndromes, including frailty, sarcopenia, weight loss,

patient had,” said Dallas Garrison, OMS III and OTM Fellow, ATSU-KCOM, reflecting on his Summer Preceptorship experience using the RGA. “When interviewing patients, it was often difficult to determine what issues a patient had since many were able to converse and interact normally with no obvious signs of deficits. However, with the RGA, these deficits were revealed and even quantified, which supported and focused clinical management of patients for their specific difficulties.”

Geriatric-infused Interprofessional Education

For nearly 20 years, the ATSU-KCOM AHEC Program Office has been providing interprofessional education (IPE) courses with an emphasis in aging-related topics to ATSU-KCOM students and Truman State University (TSU) health professions students. With the addition of the Missouri School of Dentistry & Oral Health (ATSU-MOSDOH) to ATSU in 2013, the IPE elective courses were approved by ATSU-MOSDOH’s curriculum committee in 2016.

“The nation is aging,” said ATSU-KCOM AHEC Program Director Hong Chartrand, DrPH, when discussing the value of integrating geriatrics and interprofessional teamwork. “The number of Americans aged 65 and older will double between 2000 and 2040 and will need more help with care. A cornerstone of geriatrics is the consideration to medical, mental, functional, and social well-being, which often requires a team of multidisciplinary health professionals. To have health professions students exposed to interprofessional education early on is pivotal. We collaborate with

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“The nation is aging. The number of Americans aged 65 and older will double between 2000 and 2040.”

Integrating geriatric screening in primary care settings

Having access to the multidisciplinary, clinical GWEP faculty has provided aging-related resources for ATSU’s clinical programming that are challenging to obtain in rural areas. Quite possibly one of the greatest contributions to GWEP made by ATSU-KCOM AHEC has been integrating use of the RGA, developed at SLU, into ATSU-KCOM’s curriculum through the Clinical Experiences II program and IPE elective courses.

Clinical Experiences II/ Summer Preceptorship occurs at the end of the second semester for first-year medical students. This two-week clinical immersion provides students their first opportunity to work with a physician in a clinic/

and cognitive impairment, and receive training on administering the screening tool. Preceptors are provided with online resources and the RGA. Students are encouraged to discuss its use with their preceptor and administer the RGA with two patients during their clinical rotation. Students benefit from the opportunity to administer the RGA by discussing with their preceptor the importance of early identification of common health conditions in older patients. This exercise also helps develop and enhance their doctor-patient communication skills. Since 2016, first-year ATSU medical students have administered 1,788 RGAs and 1,495 students/preceptors have been trained.

“I found the most benefit in the RGA being how it assisted me in delineating what particular cognitive and/or physical deficits a geriatric



Academic Approaches

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health professions programs at Truman State University and strive to create meaningful relationships for interprofessional teams of students while gaining knowledge about today's older population and their needs. Our multidisciplinary health professions students practice how to work together to take care of older adults in the community.”

Interprofessional Health Partners (IPHP) is an elective course that originally began in 2000 by ATSU-KCOM AHEC and Department of Family Medicine as a way for students to connect with older adults. IPHP provides students with experiential learning opportunities while working with older adult patient-volunteers in their home environment. Students are placed on interdisciplinary teams that allow students to learn about other health disciplines, work with older adults, and enhance teamwork and communication skills. Student teams then make three home visits with their “patient” to gather a health history, assess vitals, obtain a complete medication list, and administer a variety of assessments while focusing on quality of care and patient safety. In this course, each student is introduced to the RGA while some students attend a more in-depth workshop to hone their skills for administering the screening. Since 2016, a total of 517 health professions students and 24 faculty and staff have been trained on the RGA, and 187 RGAs have been administered.

In 2021, the concept of age-friendly care was added to the IPHP program. Age-friendly care is derived from Age-Friendly Health Systems, an initiative developed by the John A. Hartford Foundation and Institute for Healthcare Improvement, in partnership with the American

Hospital Association and Catholic Health Association of the United States. Age-friendly care focuses on a set of evidence-based practices referred to as the 4Ms (What Matters, Medications, Mentation, and Mobility) and is designed to improve health of each older adult by identifying and supporting their individual health-related goals and care preferences. Students are asked to speak with their patient about what matters most to them regarding their healthcare preferences and then develop an action plan as a method to help their patient meet their goals. Students gather a complete medication list to include in the patient visit report. As part of documentation, students identify any medication that is considered inappropriate for older adults or may increase fall risks by referring to the Beers Criteria and Centers for Disease Control and Prevention. In addition to screening for cognitive impairment, students complete the PHQ-2, a two-question screen,



Assessment with student and older patient

for depression and identifying the extent of their patient's social supports.

Introduced in 2013 by ATSU faculty and students on the Mesa, Arizona campus, the Interprofessional Cross-campus Collaborative Case (IP-CCC) is an opportunity for ATSU's Missouri-based students to develop their teamwork skills. IP-CCC provides students, across campuses and other universities, with a complex, web-based case that allows them to work in teams to develop leadership and communication skills while preparing a patient- and family-centered care plan focused on patient safety, quality of care, and interprofessional teamwork. Although not every case includes a geriatric focus, students are asked to consider the family or caregiver's met and unmet needs and physical and emotional health, and identify appropriate educational information and resources as part of their care plan. Since 2016, nearly 350 students have participated in the case.

With support from the GWEP grant and ATSU-KCOM faculty, ATSU-KCOMAHEC developed the Individual Cognitive Stimulation Therapy (iCST) elective course for first- and second-year medical students. CST is an evidence-based, non-pharmacological group or individual intervention designed for adults with mild to moderate dementia. The Individual Cognitive Stimulation Therapy course offers students an intergenerational experience involving patient-volunteers residing in their home, assisted living, or long-term care facilities. The course allows students the opportunity to learn about dementia, establish effective and



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meaningful communication with older adults and their caregivers, and conduct assessments on cognition, depression, and quality-of-life. The first cohort of students was enrolled in the 2017 spring semester. This course is now available in both the spring and fall semesters. “iCST gives medical students an opportunity to interact with a special population that probably is not discussed in other settings,” said Dr. Head, who is also an ATSU faculty member and former course director. “It encourages students to slow down and pay attention to the patient they are working with. It brings them face to face with a national crisis and helps them appreciate the role family plays in the lives of persons living with dementia and the role of their own profession.”

In Fall 2018, ATSU-KCOM AHEC GWEP Coordinator, Debra Blessing, adapted the existing iCST elective course to become an interprofessional opportunity as a component of her SLU Geriatric Leadership Scholars program. Each spring semester, iCST is made available to TSU health professions students to participate in the course with ATSU-KCOM first- and second-year medical students. To date, iCST has included 29 medical students, three TSU students, and one gerontology student from Missouri State University.

In 2019, an interprofessional team of students presented a research poster at the 3rd International CST conference held at Saint Louis University. The students’ poster was well received by originators of the CST program, who encouraged them to write an article about the ongoing research project through the iCST elective.

Due to the COVID-19 pandemic, the course transitioned to virtual delivery with residents

in residential and long-term care facilities. Facilitating sessions virtually provides yet another layer of experience for students as telemedicine will certainly be a part of their future medical practice. “Participating in the IPE electives and the iCST course prepared me on how to approach older adult patients,” Justin Stacer, OMS IV, said. “I think geriatrics should be more of a requirement. Treating older adult patients is so prevalent and the majority of patients are experiencing



Home visit with older woman and students

multiple health conditions. I know these courses helped me to be able to better communicate with my patients to know what matters most to them. Had I not taken the iCST elective, I wouldn’t have known anything about it. I think CST is a great option, and if I had my own patients, it would be on my list of top referrals.”

In addition to the classroom, aging-related topics are made available each year through The Michael A. Creedon Memorial Lecture on Aging. This annual, cross-campus event is held each spring and alternates between ATSU’s two campuses (Missouri and Arizona campuses). The lecture offers faculty, staff, students, health and social services professionals, and community members the opportunity to hear from leading experts on aging-related topics. Past lectures topics include sleep in aging, CST,

polypharmacy, sexual medicine in aging, and social isolation and loneliness. The ATSU-KCOM AHEC Program Office organizes the lecture for the Missouri campus.

MAHEC initiatives

In 2015, ATSU-KCOM AHEC provided stipends to four regional AHEC centers – Southwest Missouri AHEC (SWMO AHEC), Southeastern Missouri AHEC (SEMO AHEC), Northeast Missouri AHEC (NEMO AHEC), and East Central Missouri AHEC – to identify and implement GWEP programming, including training and workshops for primary care providers, community-based organizations, and health professions faculty and students. When SLU GWEP

was awarded funding again in 2019, all seven MAHEC regional centers were added in an effort to expand geriatric knowledge and skills for clinicians, especially primary care providers, healthcare professionals, and health sciences faculty, staff, and students through GWEP-related initiatives. Following are sample highlights of the work being accomplished across the state:

Missouri Region Lecture Series—supported through the MAHEC Network, this monthly series offers third- and fourth-year medical students in Missouri training sites access to live and broadcast lectures one Friday each month from August through March. With support from SLU GWEP, project clinicians and faculty have presented on primary care issues related to older adults, including the impact of COVID-19 on older

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adults, hip fractures, comprehensive geriatric assessments, resilience in caregiving, syncope, and the latest research on lifestyle modifications and Alzheimer's disease.

After a Fall, a 2020 lecture by Dr. John Morley on the impact of COVID-19 on older adults, one student commented, "I liked that this event was very pertinent to our current situation, and the level of knowledge we gained is appropriate for our skill set."

AHEC Scholars — serving AHECs across the country, this signature program focuses on preparing health professions students to work in rural and underserved communities. The program is designed to supplement education and training of current health professions students. Those who enroll must be in their final two years of their current academic program and must complete a defined set of clinical, didactic, and community-based activities. Holly Smith is a graduate of TSU's Health Science Program, and she is in the final months of completing her master's degree in public health at the Brown School at Washington University in St. Louis. She is also on the cusp of being an AHEC Scholars graduate. "My experiences in the IPE courses offered through the ATSU-KCOM AHEC office have been instrumental in my being accepted to graduate school and the research assistance positions I have held," said Smith, reflecting on how IPE courses have prepared her for her professional career. "As an AHEC Scholar, I have been able to further develop my comfort in communicating with students and professionals from other disciplines. When I enrolled in the Scholars program, I had no idea I would be able to learn from and interact with students from so many different disciplines. I also have a much deeper

understanding of social determinants of health, as it is every topic of the program. I think these experiences will set me apart from others as I begin my search for employment in the field of public health."

NEMO AHEC provided support for the 2016 and 2017 NEMO Senior Health Expo that enabled interprofessional students to administer a variety of screenings, including the RGA. A total of 113 assessments were completed.

SWMO AHEC has supported a number of training sessions for Missouri State University (MSU) students in gerontology and occupational therapy (OT) and third- and fourth-year medical students on CST and the RGA. SWMO AHEC provided fiscal support for interprofessional teams of students to administer the RGA at the Fearless Aging Expo for three consecutive years. MSU OT faculty have integrated CST training into their curriculum.

funding through 2024, ATSU-KCOM AHEC will continue to incorporate the RGA in the Clinical Experiences II/Summer Preceptorship program for first-year medical students. One goal is to increase the number of ATSU medical and dental students participating in the IPE courses offered on ATSU's Missouri campus. Another consideration is to collaborate and expand IPE programming to include additional program partners with TSU and with other universities in Missouri to further opportunities for students to participate in experiential activities that develop teamwork and communication skills. The MAHEC Network will remain a pivotal partner in helping to expand aging-related training and IPE opportunities across the state. One such opportunity will include a one-day IPE conference in Fall 2021, with a focus on current interprofessional practice trends in healthcare that looks to bring faculty, students, and clinicians together.



"My experiences in the IPE courses offered through the ATSU-KCOM AHEC office have been instrumental in my being accepted to graduate school and the research assistance positions I have held"

SEMO AHEC helps to support the biennial geriatrics conference in collaboration with Southeast Missouri State University. The 2021 conference was offered in a virtual format and featured a three-part caregiver lecture series.

In considering the increased emphasis on healthcare of older adults, ATSU-KCOM AHEC and the MAHEC Network have made a number of important contributions to enhance the quality of programs and learning experiences for students as the nation's aging population continues to increase. With GWEP

The AHEC Scholars program will continue to provide geriatric focused materials including articles, lectures, and conference opportunities and will consider developing an optional geriatric-focused module.

For more information about ATSU-KCOM AHEC or MAHEC programming, please email ahecinfo@atsu.edu or call 660.626.2121.

REFERENCES

1. Stacer RJ, Smith, HE, Blessing D, Head H.A pilot elective course to enhance geriatric medical education using cognitive stimulation therapy. *Geront & Geriatrics Ed*, 2020. DOI: 10.1080/02701960.2020.1802590

Aging SUCCESSFULLY

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This newsletter is a publication of:

Division of Geriatric Medicine
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Saint Louis University School of Medicine
Gateway Geriatric Education Center of Missouri (Gateway GEC)

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1QHP28716, Geriatrics Workforce Enhancement Program, for \$750,000. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

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