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Occupational Therapy in Adult Day Services:

Transitional Programming to Promote Aging in Place

Program Development Plan

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Executive Summary

The goal of this Occupational Therapy program is to provide Occupational Therapy services to older adults with chronic conditions through transitional day programming. An overarching theme of the Occupational Therapy programming for this population is aging in place, meaning the ability to age in the community, rather than in an institution. The focus of programming designed to help older adults age in place is to allow older adults to stay in their homes or with their families in the community with the supports in place that work for them. The hope is to also reduce the number of hospital readmissions for this population through providing meaningful and purposeful social and educational supports in the community.

Participants will include individuals who are recently discharged from the hospital and have any sort of chronic condition, where re-admission may be a concern. The first phase of the program will focus on individuals with chronic obstructive pulmonary disease (COPD). These individuals will participate in transitional programming to gain the knowledge and supports necessary to handle their condition while maintaining independence in the community. Supportive services include existing adult day programming (The Club and the ElderCenter), the Geriatric Assessment Program, and a driver self-assessment program.

The adult day programming currently takes place at the Health Education Center (HEC), a facility run by UH Parma Medical Center which houses many services for the community at large. Other services available in this building include child care, community exercise classes, WIC (women, infant, children) offices, and Paramedic/Emergency Medical Technician training. Due to the nature of the programming offered, the HEC is an accessible and community-based

location. The transitional care programming would also take place at this facility. The Geriatric Assessment Center is located at the UH Parma Medical Center hospital, but it is the hope that this assessment would be moved to the HEC as well.

The Occupational Therapy programming for this setting would take place at the HEC. Ideally, the Geriatric Assessment Center would be relocated to the HEC to allow for a "one-stop-shop" for the older adult and their loved ones, meaning all programming for older adults would be located in one building. Programming would be focused on maximizing independence and allowing for successful aging in place for the individual. Each program for older adults would be supportive of and overlap with the other programs and services. Evaluation of the Transitions Program will take place in the form of formative and summative evaluations, as well as participant satisfaction and overall outcome.

Introduction

Program Goal

The goal of an Occupational Therapy position in the Transitions Program would be to enable maximum independence in the participants, as well as to help them reach goals of aging in place. Additionally, an Occupational Therapist position in this program would be part of the hospital's larger goal, which is to reduce 30-day readmissions from patients with chronic conditions.

Sponsoring Agency

Adult Day Services is a branch of services provided by University Hospital's Parma Medical Center. University Hospital's mission is "To Heal. To Teach. To Discover". The Adult

Day Services are housed in the Health Education Center, a community building that provides services to the community including, but not limited to, fitness classes and child care.

Adult Day services is inclusive of an array of programs and levels of care, covering the continuum of caregiving needs for the older adult. The first level of care is the Adult Day Service programming at the HEC. There are two program options available for individuals who are involved in adult day programming. The ElderCenter is a full service medical-model day service for individuals with mild to moderate cognitive decline. Adults of all ages are welcome to participate in this program, and services include nursing supervised assistance, balanced daily meals, cognitive stimulation, socialization, and minimal physical assistance for activities of daily living (ADLs). The other program is The Club. This is a social program for individuals with mild memory loss, and is only one of two similar programs in Ohio. Adults of all ages are welcome to participate, receive supervised assistance, participate in social, cognitive and physical activities, enjoy various forms of entertainment, as well as mental stimulation. Individuals participating in The Club should be independent with toileting.

The second level of proposed programming is transitional care. The future of adult day services lies in designing and implementing specially-designed programming to allow for older adults who are discharged from the hospital to transition to the next level of care. This would include having a safe and stimulating environment in which to ready themselves for independent return to home, returning to home with supports, or transition into day programming. This program does not currently exist at the HEC, but is being introduced as a way to support other hospital initiatives, such as NICHE (Nurses Improving Care for Healthcare Elders) efforts, and to expand and support the current day programming. These individuals might have any variety of diagnoses, but the focus would be on providing services for individuals with chronic conditions.

Programming would take place one to two days per week, and participants would have the opportunity to be connected with relevant resources, get information regarding medications, exercise, and build social supports with other participants. It might also be beneficial for individuals who are hospitalized but could benefit from participation prior to their return home.

The third level of programming available through adult day services is the Geriatric Assessment Center at UH Parma Medical Center. The Geriatric Assessment Center is designed to evaluate older adults who are experiencing a decline in their abilities that is impacting their safety and independence with functional mobility and/or daily living skills for the purpose of making recommendations as deemed appropriate based upon the findings of the assessments performed. The individuals served in all three of these levels are connected through services that support one another, which makes up a holistic spectrum of care for older adults.

An interview was conducted with the manager of adult day services and site mentor, Laura Matthews, BS, MS, LNHA and can be found in Appendix A. Ms. Matthews stated that the mission of Adult Day Services is to provide an enriching and stimulating day for their participants based on what is meaningful to them, and to provide respite for their caregivers. One thing she stated that really seems to depict their role is that, “For every person who enters an adult day center, two people get their lives back, the day care participant and their family caregiver. Visiting an adult day center can help visitors realize that life doesn’t end with a diagnosis. Adult day services can be the cornerstone of community based care”. There is currently no Occupational Therapist working for adult day services as a whole. Ms. Matthews expressed a good understanding of Occupational Therapy and that an OT would be a good fit for all levels of their programming.

Organizational Chart

An organizational chart for the proposed program can be found in Appendix B. An Occupational Therapist would fit into the organization on the same level as the Registered nurse (RN). The Occupational Therapist would report to the manager of adult day services, and would be responsible for any volunteers helping with the Transitions Program group sessions. As a unique role of an Occupational Therapist (OT) in this organization, the OT would have a hand in both managerial responsibilities and developing programming, as well as leading groups and individual participants in interventions.

Service Profile

The service profile for this program is older adults who live in the Cleveland area and who have been diagnosed and recently hospitalized for a chronic condition. These individuals would require help in maintaining independence and safety in the home. A secondary population might also be the families of these individuals, needing support and strategies for care of their loved ones at home.

Needs Assessment

Contact with Stakeholders

According to the interview with Ms. Matthews, stakeholders of adult day services at the HEC would include: participants, their families and caregivers, employees, the members of the communities of the people we serve (since individuals are able to stay in their homes and participate in their communities), physicians who refer, the hospital in general, the hospital

foundation who has invested money and equipment into the programming, and The Harley family who founded the ElderCenter program.

The interview with a stakeholder, Ms. Matthews showed that the needs of the Adult Day Services programming are really that of allowing for safety and maximal independence for the individuals who are participating. Also, the Adult Day Services branch will need to transition in the near future to meet the needs of a new and growing generation of older adults. Inclusion of Occupational Therapy will change the way the programs are able to collect revenue and will connect them to more aspects of the UH system. In this way, an OT would help the adult day services programming to remain viable in the future.

The possibility of an Occupational Therapy position at the HEC in Adult Day Services is realistic. Because of their connection to the UH Parma Medical Cetner hospital, insurance reimbursement would be easier with systems in place already for that type of billing. Billing will consist of both individual and group sessions, which will be described further in the programming and budgeting sections.

A pilot program including Occupational Therapy was done a few years ago at this location, and was found to be successful in reducing the 30-day readmission rate for participants who had experienced a stroke, as compared to a group of non-participants who has experienced a stroke. A nurse was assigned to evaluate patients in the associated hospital for appropriate candidates for this transitional program. Upon discharge, the participants began an 8 week graduated care program, which included a multidisciplinary team of Occupational Therapy, Speech Language Pathology, Physical Therapy, and Nursing. This program was piloted through funding from the hospital’s foundation with the goal being to research the value of the program.

Further development and funding was necessary to create a more permanent program. This study lays the backbone for the current programming at the Capstone Site (Jones et al., 2011).

A scholarship fund has been approved from the UH Parma Medical Center Hospital's Foundation to sponsor participants in a pilot Transitions Program. This pilot program will be called Phase 1, and will include all aspects of the proposed day program except for part B therapy services. Phase 2 will be introduced after the pilot program and will include the addition of therapy services. The layout for the program will be discussed within the Programming, as well as Budgeting and Staffing sections.

Data Gathering Methods

There are three data gathering methods I would like to propose using for this needs assessment. First, a semi-structured interview was conducted with a stakeholder in Adult Day Services, Laura Matthews and is included in Appendix A.

Second, a caregiver questionnaire was given out to caregivers of current participants at The Club and the ElderCenter to gather information about their needs and their opinions on current programming. The caregiver questionnaire can be found in Appendix C. There were 11 questionnaires completed and returned. The majority of caregivers (9) reported that they were not employed, and were either a significant other/spouse (5) or a child (4) of the participant. Only 3 caregivers reported being the sole caregiver for their loved one, and the majority (8) of caregivers lived within 3-8 miles from the day service facility. Caregivers reported feeling confident in their current abilities to care for the loved one, with a majority (7) choosing either agree or strongly agree, while that same majority reported feeling either neutral or disagreeable

about their ability to care for their loved one in the future. Most caregivers (7) also felt that their homes provided a conducive environment in which to care for their loved one, however all caregivers took handouts on home safety and falls prevention. The largest reported area of need was respite time, with other areas being communication with their loved one, getting their loved one out and involved in activities, and more help with caregiving. Overall, this questionnaire was helpful in allowing me to understand the needs of the specific caregivers I am working with.

Third, standardized Occupational Therapy assessments will be administered to participants who are identified as appropriate candidates for the first phase of the Transitions Program. Although these Phase 1 participants will not be receiving OT services through the Transitions Program, it would be important for the OT to assess them in preparation for meeting the needs of the Phase 2 participants. Assessments will include the Functional Independence Measure (FIM) and the Occupational Self-Assessment (OSA). Based on the results of these assessments, the Occupational Therapist will determine the overarching educational needs of the participants, as well as the individual needs for OT intervention.

Cultural Factors

There are some cultural factors that might influence the methods of data collection I have chosen. The first factor to consider is literacy level. The National Institute of Health suggests keeping health-related written information at about a 6th-7th grade reading level (National Institute of Health (NIH), 2013) Since the questionnaire was designed for the family members of participants to fill out, dementia-related reading levels will not be a consideration. Based on two online readability calculators, the grade level of the caregiver questionnaire is 6th grade. This is in line with the NIH's recommendation.

A second cultural factor to consider is the culture of the Adult Day Center itself. The employees, participants, and caregivers all have their daily routines and roles. In collecting data, I would want to attempt not to alter those routines. In coordination with my Capstone Site Mentor, I have come up with a method to gain caregiver participation. I advertisd for one week in advance the time and place of the questionnaire. I was in a convenient location to be available for both adult day programs, and offered those caregivers who participate refreshments as a way to show appreciation for taking the time to complete the questionnaire. My Capstone Site Mentor, Ms. Matthews, also entered the individuals into a drawing to win a complimentary day of programming for their loved one.

The physical environment of the location for caregiver questionnaires, as well as for participant assessments will be an important factor. For caregivers, the location needs to be near the ElderCenter or The Club, as they bring their loved ones in for the day. For participant assessments the room needs to be quiet and private. There should also be adequate light and all necessary supplies to complete the assessment.

Priority of Needs

The main priority in conducting a needs assessment for Adult Day Services at the HEC will be to be congruent with their existing mission, which is the service of older adults and their loved ones. Respect for the needs of both the participants and their caregivers will be an underlying principle of the occupational therapy programming.

A second underlying principle will be to stay true to Occupational Therapy and keep the focus on independence and function in the forefront of my investigation. Safety will always be a

consideration of my programming and of the needs assessment. Safety for the individual and for the reputation of the Adult Day Services as a whole is important to this project.

Lastly, practicality of this program will be important. I will be investigating the needs of these individuals and of the program itself so that I am able to design programming that will complement the programming that currently exits, while providing services that would expand current programming, while also adhering to the mission and vision of University Hospitals as a whole.

Literature Review

As we see the numbers of older adults grow over the next few decades, choice is going to become an increasingly important factor in health care. Older adults value having choices about where and how they age. This is where the term “aging in place” becomes relevant. Older adults value the freedom to age with a sense of attachment, community, safety, and familiarity. Aging in place provides a sense of identity and autonomy within the older adult (Wiles, Leibing, Guberman, Reeve, & Allen, 2011). To this point then, aging in place does not necessarily refer to the individual remaining in their home independently for the rest of their lives, rather, that the individual age in the place of their choice, whether that be their home, the home of a family member, or an assisted living community. Choices related to aging in place are influenced by personal preference and the meaning of home for that person.

For many older adults, the ability to make choices that will influence their ability to age in place are time-dependent. Many older adults who are hospitalized are unable to transition home at the time of discharge from the acute care hospital. In today’s health care system, there continues to be a growing emphasis on discharging patients from the hospital as soon as they are

deemed medically stable, regardless of their level of safety and independence. Older adults are frequently transferred to skilled nursing facilities where they may participate in skilled therapy services with the goal being to return to home independently. Skilled nursing environments are typically designed to provide skilled nursing and are not intended to provide a home-like atmosphere within a community based environment. Furthermore, if the individual is unable to achieve the milestones deemed necessary for return home, both the individual and their family members may experience disappointment and/or dissatisfaction with long-term care. Transitional programming would be appropriate for individuals who may find themselves in this situation. These types of programming, which help the individual with the transition from hospital to home-going, help reduce hospital re-admissions and associated costs, provide social support for the individual and the family members, and keep older adults connected to important services (Watkins, Hall, & Kring, 2012).

Researchers studying chronic conditions and their effect on function found a unique roll on functional status, depending on the individual's diagnosis. Individuals with myocardial infarcts, congestive heart failure, and diabetes experienced effects on both physical and social functioning, while individuals reporting chronic back problems largely reported difficulties only in the physical domain of function. Overall, the researchers were able to say that, overall, individuals with chronic conditions, and especially those with multiple chronic conditions, experience a negative and substantial effect on all aspects of functioning. In determining the effects of chronic conditions on one's function, it is important to take into consideration all aspects of functioning (physical, roles, and social aspects), as well as one's well-being (pain, mental health, and perceptions of one's health) (Stewart et al., 1989).

Demographic Statistics

The population of older adults aged 65 and older is growing in our country. The population of "baby boomers" are now reaching the age of older adulthood, and couples with the rise in life expectancy, we can expect to see 72 million older Americans in the next 25 years. By the year 2030, older adults will account for 20% of our population. With this increase in the older adult population comes higher health care costs. The cost for providing health care for someone over the age of 65 is three to five times higher than the cost of care for someone under the age of 65. By the year 2030, health care costs are projected to have grown by 25% (Center for Disease Control and Prevention (CDC), 2013).

The Center for Disease Control reports that 75% of health care dollars in the United States are spent on chronic conditions (Center for Disease Control and Prevention (CDC), 2013). About 80% of older adults have at least one chronic conditions, with 68% of older adults having at least two (National Council on Aging, n.d.). With a growing number of older adults with these conditions, it is become vital to address the needs of this population and assure that they are able to age in place at their maximal level of independence.

In the past century, chronic diseases have surpassed infectious diseases as a leading cause of death. Older adults were found to be more likely to report having a chronic condition, making this population an important one to target. In a survey research study of older adults with chronic conditions, 28% of respondents reported having at least one area of difficulty in their ADLs (Ralph, 2013). Decreased levels of function can come along with chronic conditions due to many factors. One factor might be fatigue, which is present with many chronic conditions including COPD and CHF. Another factor that could contribute to decreased ADL function is mental health. Older adults with chronic conditions often experience co-morbidities including psychiatric distress (depression, anxiety, etc.). (Piane, 2014)

Government Initiatives

The state of Ohio is supporting aging in place for older adults with their initiative STEADY U Ohio. This website gives older adults information on preventing falls, one of the largest factors in senior living decisions (The Ohio Department of Aging, n.d.-b). The Ohio Department of Aging is a state government body who supports aging in place through their beliefs that “elders… continue to grow, thrive, and contribute throughout their lives” (The Ohio Department of Aging, n.d.-a)

The Centers for Medicare and Medicaid Services (CMS) are also promoting reduced hospital readmission rates. Beginning in 2012, the CMS began decreasing payment to hospitals with excess readmissions. Since that date, the CMS has been updating its plan and continuing to hold payments for those institutions that do not meet their readmission standards. This policy provides a drive for hospitals to reduce the number of readmissions they receive (The Centers for Medicare and Medicaid Services, 2016)

Occupation-based Programming

Occupational Therapy services for adult day services and transitional programming would be occupation-based. Programming would be designed to meet the functional goals of the individual, taking into account the things they like to do. Interventions would include functional mobility, ADLs utilizing the kitchen and other facilities the site has to offer, utilizing the music and entertainment scheduled for day services for social and exercise opportunities, and home safety scenarios. If appropriate, a family education session would be held, allowing for the

caregivers of the individual to practice the hands-on caregiving skills they will need to support the individual at home.

Model of Practice

There are models of practice I believe are relevant for an Occupational Therapy program for older adults with in day service programs who are looking to age in place. The first model of practice is the Occupational Adaptation model (Schkade & Schultz, 1992). This model stresses the relationship between the person, the environment, and the occupation. Individuals experiencing dementia and oftentimes chronic comorbidities, may become unable to function safely and independently in their prior home and community environment and engage in their prior occupations. Because of this, adaptation is required. Something in the environment, whether it be a cue, a reconfiguration of the occupational form, or any other change, would be needed in order to bring about the adaptation in the individual needed to perform the given occupation.

A second model of practice that would be relevant to Occupational Therapy in this setting would be the Model of Human Occupation (Kielhofner, 2008). The model focuses on volition and habitation as two main subsystems contributing to occupational participation. Volition is important for individuals with dementia due to an alteration in their perception. They are motivated by unique factors, and we need to work with them to figure out what these factors are, and to incorporate them into our interventions. This is also important for all older adults, as we need to know what motivates them to engage in meaningful occupation and what they want to work towards in order to make therapy meaningful to them. In the same way, engaging in meaningful occupation can influence motivation by increasing mood and perception of one's own ability. Habituation is something that each person has, regardless of disability. We all have

our habits and roles, especially in how we perform every day occupations. Learning these factors for the individuals we are working with will make our interventions more successful and more meaningful to them. In addition, older adults might be facing a shift in their habits and routines with a recent diagnosis or hospital stay. Occupational Therapy's role with this population is to provide services to help individuals to maximize independence in their daily routines. The Model of Human Occupation can also be applied to caregivers. We need to look at their needs, habits, and motivation in order to help them in the most meaningful way.

Summary

After interviewing Ms. Matthews with adult day services and researching the role OTs play with individuals with dementia and older adults in transitional services, I believe that there is a need for Occupational Therapy in this type of setting. I think that Occupational Therapy brings a different perspective for treating individuals with dementia and their caregivers, as well as in the transition from hospital to home for older adults. The values of the profession of Occupational Therapy and Adult Day Services at UH Parma Medical Center align in a way that would make a good partnership. Occupational Therapy looks at maintain quality of life and enabling the individuals involved to live their lives to the fullest through every stage of the disease. In the same way, the mission of Adult Day Services is to restore the lives of the individual and the caregiver by providing a day of stimulating occupations that are designed to elicit an adaptive response and the chance to be autonomous with the supports the individual needs.

Program goal

The goal of an Occupational Therapy position in the Transitions Program would be to enable maximum independence in the participants, as well as to help them reach goals of aging in place. Additionally, an Occupational Therapist would be part of the hospital's larger goal, which is to reduce 30-day readmissions from patients with chronic conditions.

Objectives

1.) Participants will interact socially with other group members and with direct care staff, as judged by observation of the OT, during day programming by the end of the program.

2.) Participants will work one-on-one with OT to promote maximization of independence in daily function, to the highest extent possible by the end of the program.

3.) Participants will display an increase in overall scores on The Functional Independence Measure (FIM) and the Occupational Self-Assessment (OSA) as measured and recorded by the Occupational Therapist, by the end of the program.

4.) By the halfway point of the program, each participant and their family will identify 3 ways to modify their home environment or home safety to improve the participant's independent function, based on Occupational Therapy home evaluation.

5.) Participants of the Transitions Program will display safety awareness in symptomology related to their diagnosis by the completion of the program.

6.) Participants of the Transitions Program will identify 3 falls prevention strategies for the home by the completion of the program.

7.) Participants of the Transitions Program will identify 2 social or community supports available to them by the completion of the program.

8.) Participants of the Transitions Program will not be readmitted to Parma Hospital during the 30 day period following their discharge.

Marketing and Recruitment

Important stakeholders to adult day services and the Transitions program would include the manager of adult day services and Site Mentor, Laura Matthews, the UH Parma Hospital foundation, the NICHE program group (which includes individuals from all departments of the hospital), and the rehabilitation director at the hospital. It will be important to approach these individuals for support of OT in the Transitions program. Sample marketing materials can be found in Appendix D. The first flyer would be used as an aid to inform potential participants and their caregivers of the services Occupational Therapy provides in the Transitions Program. The second flyer would be used as an aid to present the benefits of such a program to shareholders.

A main marketing strategy for Occupational Therapy in the Transitions Program would be to educate the social workers and therapists at UH Parma about the program and its advantages. They would then be able to present the option to their patients, along with traditional post-acute care options. Marketing in this way will help to get information on the Transitions Program to all appropriate patients. A graphic showing the sources of recruitment to the Transitions Program can be found in Appendix E.

Marketing would also be done in the form a presentation to the hospital's board members. Once the program was laid out, all disciplines involved would present their take on its advantages and how participants, and the hospital itself, would benefit.

Potential participants would be individuals who are close to their discharge date from UH Parma. Participants could have any diagnosis, but should be recommended for continued therapy

services. Participants would be medically stable enough to be discharged from the hospital, and would display behavior that is appropriate for a group setting. They should also have a desire to age in place. Participants for whom there is a concern for 24 hour supervision would also be appropriate for the Transitions Program, as the program environment would provide supervision during the day, and a caregiver or family member could continue supervision at the home. Overall, participants who would typically be referred to a skilled nursing facility, home health care, or outpatient therapy would all be appropriate for the therapy component of the Transitions Program.

Currently, this program is being proposed to the NICHE board members, whose goal it is to target individuals with COPD and reduce their hospital readmissions. NICHE board members are supportive of the proposed program. Also, members of the UH Parma Hospital Foundation have approved funding for Phase 1 of this program to pilot the program and measure the effectiveness for participants.

Programming

Programming for the Transitions Program in Phase 2 will be delivered in two ways, one-on-one traditional therapy, and group education sessions. The one-on-one therapy sessions will, in many cases, take the place of traditional outpatient or be after the completion of home care therapy. The focus will be on promoting independence in self-care and home safety techniques. Group education sessions will be held once a week and will address topics such as exercise, energy conservation, assistive equipment in the home, and community mobility. These topics, along with the one-on-one therapy sessions will address the objectives listed for this program in that the goals will be functional independence, home safety, awareness and connection with resources in the community, and social interaction with peers. This type of programming is

supported by AOTA, stating that OTs are skilled in prevention, lifestyle modification, physical and psychosocial rehabilitation for this population (American Occupational Therapy Association, 2011).

The programming for the Transitions Program will be reflective of the Models of Practice that were identified for the population. In keeping with the Occupational Adaptation Model of Practice, programming would be based on using occupation to promote adaptation within the individual. Occupation will be the means, or the therapeutic intervention, and the end, or the participant's goal. The second Model of Practice that will be used in the Transition programming will be the Model of Human Occupation. In keeping with this model, programming will be based on the habits, volition, and performance capacity. The participants will be the center of care in the Occupational Therapy programming for the Transitions Program.

Assessment of program participants will take place on an individual level, based on both one-on-one and group sessions with the OT. Intake assessment will be a combination of a participant self-assessment associated with the MOHO, the Occupational Self-Assessment (OSA), as well as the Function Independence Measure (FIM) (Keith, Granger, Hamilton, & Sherwin, 1987). These assessments are noted to be appropriate to use together by the authors of the OSA (Baron, Kielhofner, & Reinhartz, 2000). The OSA is a self-assessment that can be completed by the participant and analyzed by the therapist in order to create a client-centered Occupational Therapy intervention plan. The assessments are related to the chosen models of practice, are reliable, valid, and practical for communication to other health care professionals. The FIM is an assessment that is used and understood by many disciplines, as well as by third party payers.

Intervention Occupational Forms would include: the Transitions Program group room (living room, large dining table, chalk board, kitchen located around the corner), kitchen set up in the therapy room, laundry set up, exercise equipment, and an accessible public restroom. The services provided would include traditional one-on-one outpatient Occupational Therapy, but in a community setting. The sessions would be 1 hour long twice per week. The Occupational Therapist would also provide group education to the Transitions Program participants as a whole once every other week, on a rotating basis with other professionals. Education topics would include falls prevention, energy conservation, home safety, community resources, exercise, assistive equipment for the home, and anything else the group expressed a need for.

Another intervention technique would include Occupational Performance Coaching (OPC), which was found to be appropriate for populations with chronic conditions. This technique involves the Occupational Therapist giving emotional support, exchanging information with the client, and providing a structured process to guide interactions. The OT’s role is to complement the participant’s own knowledge to gain progress toward a desired outcome. When using OPC, the occupational therapist partners with the client to identify occupational performance issues thereby enabling them to problem-solve and implement potential changes. Goals are established by the client who also drives the problem-solving process, with the occupational therapist providing reflection, guidance, direction and, to a lesser extent, information or specific strategies. The therapist encourages self-observation of occupational performance challenges and shares external observations where applicable. Barriers and facilitators to achieving goals are discussed between the client and therapist. This structured process, which guides interactions, relies heavily on the therapist using occupational therapy

knowledge and theory, such as the Model of Human Occupation (MOHO), to prompt the client's reflections (Alcorn & Broome, 2014).

Documentation

Documentation will be done electronically using the hospital's existing system. This will ensure simple communication between therapists and other disciplines. Patient privacy will be at the forefront of the Transitions Program, as the electronic medical record system requires a user to have an active username and password to log in. The computers will be for use by authorized personnel only, and will be located in an area in which documentation can be done privately.

Program Schedule

The sequence of programming for the one-on-one therapy sessions will depend on the level of the individual, however all participants will begin with an assessment. The participant's functional abilities, strength, range of motion, and cognitive status will all be assessed, both through standardized testing and skilled clinical observation. For the remaining sessions, the participant and the therapist will work on those areas identified during the assessment.

The group education sessions will run once every other week. Participants will enter the Transitions Program on a rolling basis, so each session may bring a new participant. Sessions would start with a brief introduction to Occupational Therapy and what an OT can do for an individual with a chronic condition. Session topics would include: falls prevention, assistive equipment, home safety, coming up with participant goals as a group, and various community resources. These sessions would be an informal conversation between the Occupational Therapist and the members of the group. The Occupational Therapist would present the information on the given topic, take questions, pose questions to the group, and get participant

input to make the session meet the needs of the group. This schedule will serve as an example of the types of programming Occupational Therapy might do with the participants in the Transitions Program in a typical 30 day rotation.

Group 1

Falls Prevention

This group session will take place in the Transitions Program room in the living room area. The Occupational Therapist would present information on how to prevent falls at home and in the community. Examples would include exercise, using an appropriate assistive device, safe transfers, and a home checklist. The Occupational Therapist would ask for examples of falls from participants, and the group would work together to address the issue and prevent the fall. The therapist would hand out all information for the group's reference, including checklists and general balance exercises (See Appendix F). The therapist would make sure that the exercises were safe for all members of the group.

Group 2

Home Safety

This group session will take place in the Transitions Program room in the living room area. The Occupational Therapist would present information on home safety, including checklists from the Center for Disease Control and the Cuyahoga County Board of Health (See Appendix G). The therapist and the group would have a conversation about common health risks in the home and

how they can be addressed. Addressing risks relevant to the participant's chronic conditions would be a priority, including oxygen safety if appropriate.

Group 3

Assistive Equipment

This session would be held in the Transitions Program room in the living room area. The Occupational Therapist would present information and have examples of various types of assistive equipment. The emphasis of this equipment might be energy conservation, safety, or increased independence, depending on the needs of the group. Participants would be able to try out the equipment and talk to the therapist about how they might be able to use it to maximize their independence and safety at home. The therapist would discuss affordable options for purchasing necessary equipment, or community options available.

Discharge

The participants will be discharged from one-on-one therapy sessions once their initial goals have been met. Discharge from the group will occur after the 30-day mark after hospital discharge for the individual. This discharge means that the scholarship from the University Hospital Foundation will expire, however the participant can choose to continue to participate in group sessions on a private pay basis indefinitely. They may also choose to join one of the existing adult day programs at the same location.

Budgeting and Staffing

The budgeting for this program is divided into an initial program cost (phase I), and a complete program cost (phase II). As a pilot program, the UH Parma Medical Center Foundation is sponsoring participants with a total of $5,000 in scholarships. The initial program will include social supports, daily education and group exercise, smoking cessation, lunch and entertainment. The program will be run by an STNA with experience in this area. Table 1 breaks down the cost of Phase 1 of this program. Upon completion of the pilot program, phase II will be implemented. Phase II includes the addition of part b therapies, as well as an art therapy program for individuals with all chronic conditions. The cost estimates for phase II can be found in Table 2.

Table 1

Phase I budget for participants with COPD

Item	Cost
Transitions Program Staff (STNA)	$18.14/hour x26% benefits x5 hours =$137.16
Education: Pharmacy, Respiratory, PT, OT, SLP, Dietician, etc. 1 hour/week on a rotating basis	In Kind- UH Parma
Room and facilities	Covered by Adult Day Services
Lunch	$3.00 x max 12 participants = $36
Activities/Entertainment	Covered by Adult Day Services
Massage Therapy *1 hour/week	In Kind- UH Parma

Tobacco Treatment Specialist	In Kind- UH Parma

(Bureau of Labor Statistics, 2014)

Estimated total weekly programming cost: $185.16

Price for 4 participants: $46.29/person

Price for 8 participants: $23.15/person

Price for 12 participants: $15.43/person

Table 2

Phase II for participants with any chronic condition

Item	**Cost**
Transitions Program Staff (STNA)	$18.14/hour x26% benefits x12 hours =$274.32
Education: Pharmacy, Respiratory, PT, OT, SLP, Dietician, etc. *1 hour/week on a rotating basis	In Kind- UH Parma
Room and facilities	In Kind-UH Parma
Lunch	$3.00 x max 12 participants = $36
Activities/Entertainment	Covered by Adult Day Services
Massage Therapy *1 hour/week	In Kind- UH Parma
Tobacco Treatment Specialist	In Kind- UH Parma
Occupational Therapist	$38.76/hour x26% benefits x25 hours =$1,220.94

Physical Therapist	$39.79/hour x26% benefits x25 hours = $1,253.39
Kitchen appliances and supplies	Existing in facility
Mat treatment tables (2)	$579.90 x2 =$1,159.80
Goniometer set	$207.95
Upper/lower extremity peddler	$50.44
Weight rack (includes therapy bands, weights, and cuff weights)	$406.27
Hot/cold combo packs	$11.20x5 = $56.00
Recumbent Bike	$3,899.00
Hip Kit Assistive Equipment (Reacher, sock aid, dressing stick, shoe horn)	$36.97 x2 = $73.94

(Bureau of Labor Statistics, 2014)

Estimated total weekly programming cost: $2,858.59

Price for 4 participants: $714.50/person

Price for 8 participants: $357.32.25/person

Price for 12 participants: $238.22/person

Estimated total equipment cost (one-time): $5,853.40

Table 3

Estimate of Therapy Revenue session per participant

Discipline	**Therapy Service**	**Code**	**Units per patient**	**Price per Unit**	**Total Price**

OT	Therapeutic Activity	97530	2	$24.79	$49.58
	Self-care/ Home management	97535	2	$24.98	$49.96
	OT Evaluation	97003	1	$63.39	**$63.39**
PT	Gait training	97116	1	$21.06	$21.06
	Neuromuscular reeducation	97112	2	$24.32	$48.64
	Manual Therapy	97140	1	$22.29	$22.29
	PT Evaluation	97001	1	$58.60	**$58.60**
				Total price w/o eval	**$191.53**
				Total price w/ eval	**$313.52**

Table 4

Estimated total revenue from therapy services

Daily Price w/o eval per patient	**Weekly (2 days)**	**Yearly (52 weeks)**	**Participants (12)**	**Evaluation[1]**	**Gross Yearly Total (with evaluations)**
$191.53	$383.06	$383.06x52 (weeks)=$19,919.12	$19,919.12 X12=$239,029.44	$38,060.88	**$277,090.32**

[1]Evaluation costs calculated by taking the total revenue of evaluations and multiplying by the estimated number of program cycles (average patient attends program for 2 weeks)

Table 5

Estimated overall yearly program revenue

Weekly programming cost	**Yearly programming cost**	**Gross Year 1Revenue from Therapies**	**Year 1 Program Profit**	**Yearly Program Profit years 2+**
$2,858.59	$2858.59 x52= $148,646.68 + first year equipment cost (5,835.40) = $154,482.08	$277,090.32	$122,608.24	**$128,443.64**

Staffing

In phase II, an Occupational Therapist will be hired for a part time position, at an estimated 25 hours per week. The Occupational Therapist should be licensed in the state of Ohio, and should have experience working in an adult outpatient setting. The job description for this position can be found in Appendix H, and a recruitment flyer in Appendix I

As depicted in table 3, the Transitions Program would gain revenue through reimbursable services provided by a licensed Occupational Therapist. Because the program will be open and operate with rolling admission, the revenue is only an estimate. The estimated therapy revenue from Occupational Therapy would put the program in a position to be profitable. Given any revenue from Physical Therapy services, the Transitions Program is set up to not only reduce 30-day readmission rates for this group, but also to bring in additional revenue to benefit adult day services, and the hospital as a whole.

Program Evaluation

Measuring objectives

1.) Participants will interact socially with other group members and with direct care staff, as judged by observation of the OT, during day programming by the end of the program.

This objective will be measured via OT observation, as well as with input from the STNA program facilitator. A major part of the Transitions Program is developing peer relationships and the social support of a group. In order to gain these benefits, participants must have a social presence in the group.

2.) Participants will work one-on-one with OT to promote maximization of independence in daily function, to the highest extent possible by the end of the program.

This objective will be met through assessment of all participants in the Transitions Program. If found appropriate, participants will work with the OT twice a week towards their individualized goals.

3.) Participants will display an increase in overall scores on The Functional Independence Measure (FIM) and the Occupational Self-Assessment (OSA) as measured and recorded by the Occupational Therapist, by the end of the program.

This objective will be met through comparing the pre and post program standardized evaluations. The evaluations will be administered by the OT, and should reflect improvement in the identified areas for each individual. The improvements in scores will be recorded in the patient's electronic

medical record, as well as in a separate record with all patient identifiers removed for program records.

4.) By the halfway point of the program, each participant and their family will identify 3 ways to modify their home environment or home safety to improve the participant's independent function, based on Occupational Therapy home evaluation.

Upon discharge from OT, each participant should be able to state 3 ways to make their homes safer or to allow for more independence in the home on OT exit survey. Family members will attend the last OT session and participate in family education. They should also be able to identify these areas of improvement.

5.) Participants of the Transitions Program will display safety awareness skills related to their diagnosis by the completion of the program.

Participants should be able to create a weekly calendar of maintenance tasks, including physical activity, medications, and home safety upkeep specific to their individual concerns. The calendar will be reviewed by the OT and the STNA. An example weekly participant calendar can be found in Appendix

6.) Participants of the Transitions Program will identify 3 falls prevention strategies for the home by the completion of the program.

Participants should be able to list these fall prevention strategies upon discharge from OT on OT exit survey, as judged and documented by the OT.

7.) Participants of the Transitions Program will identify 2 social or community supports available to them by the completion of the program.

Participants should be able to list appropriate community supports or programs on OT exit survey by the end of the Transitions Program.

See Appendix K for OT exit survey template.

8.) Participants of the Transitions Program will not be readmitted to Parma Hospital during the 30 day period following their discharge.

During both Phases 1 and 2 of the Transitions Program, hospital personnel will follow participants through their hospital records to determine the number of emergency room visits and hospital readmissions during the 30 days post-discharge.

Timeline

A timeline for Transitions Day Program is attached in Appendix L. The timeline includes when major tasks and milestones of the program are to be completed. The length of the Transitions Program will vary for each client, but will remain within their 30-day window post-discharge. The timeline is set up to show 4 weeks of programming for a client.

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Appendix A

Interview with a Stakeholder

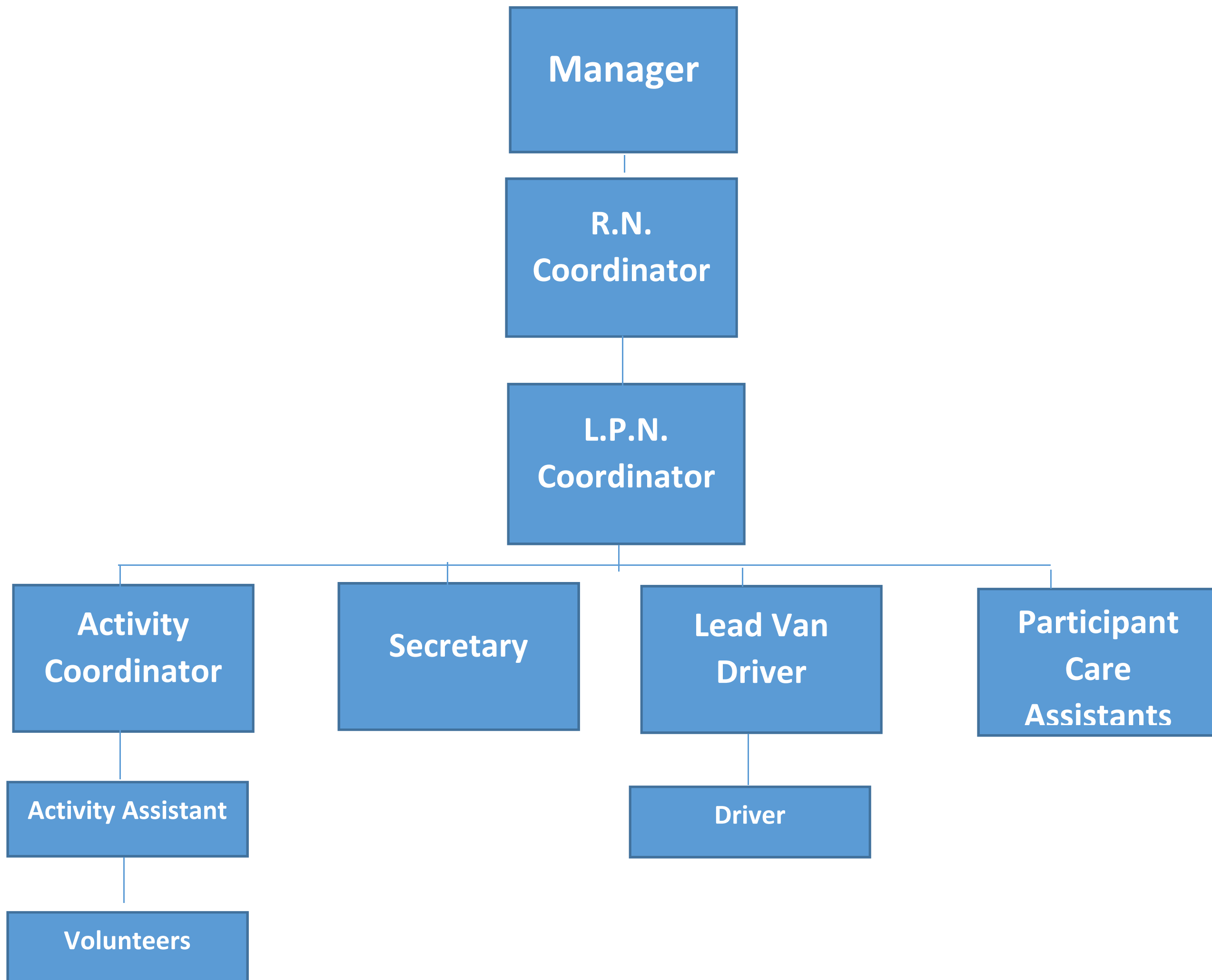
Laura Matthews, Manager of Adult Day Services

1.) What is the overall purpose/mission of the adult day services in this facility?

To provide an enriching and stimulation day for individuals with dementia and to provide a day/respite for their caregivers. We aim to provide meaningful experience based on what is meaningful to the person. We set the stage for the person, but they are as autonomous as possible, with the support they need provided for them. This is my favorite quote about day programs like ours:

"For every person who enters an adult day center, two people get their lives back, the day care participant and their family caregiver. Visiting an adult day center will provide that a life doesn't end with a diagnosis. Adult day services can be the cornerstone of community based care"

2.) In term of this location, what does your organizational chart look like?



3.) What credentials are your staff required to have in order to interact with your clients?

We have one RN oversees the LPN. Activities personnel's credentialing is based on passport regulations, so they do need credentials. Our participant care assistants have received an STNA, or have been trained as patient care assistant from UH.

4.) Who would you describe as stakeholders at this site?

Our participants, their families and caregivers, employees, the community (because we are key in keeping people home for 2-3 year longer), physicians who refer, the hospital in general, the hospital foundation who have invested money and equipment into the programming (renovation, vans, etc.), and The Harley family, who founded the ElderCenter program.

5.) How are programs funded?

The foundation funds capital projects. Participants pay for programming ($50-$54/day) through private pay, plus we work with 7 payer sources (mostly associated with passport and their community waiver program). Some individuals have long term care insurance or an Alzheimer's Association respite stipend as well.

6.) What are the parameters on the transportation you offer? What other transportation options are available?

Passport providers needs to provide their own transportation or contract out for transportation. We choose to provide out own transportation for reliability reasons. We have 14 seater van that travels in a 2 mile radius or within an existing transportation line. No one can sit for more than an hour on the van, so transportation is limited as far as distance we can travel. We are a licensed ambulette. Other participants are driven by their caregivers or family members. The Cuyahoga County Board of DD provides cabs. Other options might include RTA paratransit, private companies and in-home senior services.

7.) What is the criteria for admission with regard to patient's level of function and/or diagnosis? What are the co-occurring diagnoses of persons who are served by your association?

We have behavior criteria in that the individual needs to be appropriate for the group setting we provide. He/she also needs to be weight bearing because we are not set up to provide manual maximum assist transfers and we do not have the space for lifts. We need to maintain a 1:6 ratio of staff to participants, so that drives the number of participants we can accept. We also run those numbers based on level of assistance needed by each individual. No physician referral is needed (could be more medically driven or a combination). There is also no age limit. We have had participants anywhere from 18-104 years old over the years and any number of diagnoses. Dementia is a common diagnosis, as well as diabetes. Most of our private-pay participants are diagnosed with some sort of dementia, and about 1/3 of our participants have a co-morbidity of diabetes. Many of our participants that are covered by the county have a diagnosis of a developmental disorder.

8.) **Are there specific goals for the participants or for families (if included)? What type of documentation is required with regard to the participant's performance and/or family participation?**

We do yearly plans of care with family members and other professionals based on who the payer is. We come up with goals for each participant. The individual participants in the goal-making if they are able.

9.) **Approximately how many participants do you serve? What is the breakdown of numbers with regard to specific services/programs offered?**

About 50 total, 25 per day in the ElderCenter. We average about 5-6 per day in The Club. These numbers fluctuate when we have bad weather.

10.) How are clients typically referred to this site? What options do you suggest for persons who do not meet eligibility for services offered by your association?

Mostly word of mouth as a number one source. Some physicians will recommend their patients look into our programming, sometimes the hospital. The Board of DD and the Alzheimer's Association are big contributors. The Geriatric Assessment Center that our RN is involved in, as well as the driving program because they are open to the community.

A lot of times when individuals are not appropriate for our programming, their next option is placement unfortunately. We send them to our resource wall and set up a plan of care with them.

11.) What types of programming do you offer at this site for participants and/or their families? (Fieldtrips, games, crafts, support groups, cooking, etc.)

Music, art, games, socialization, trivia/reminiscing, support groups for caregivers in this building once a month, plus the Alzheimer's Association holds other meetings

12.) Are there any marketing tools you use for recruitment, (flyers, advertisements in church bulletins, etc.) or formal presentations to stakeholders in the community?

Flyers for all programs available, as well as for the Carolyn L. Farrell association and their art classes they provide for us, and the Alzheimer's Association caregivers support group flyers. We have a whole resource wall, and part of that wall is reserved solely for our programming.

13.) Are family members involved in any aspects of care here?

Yes, we all sit down as a team upon admission for a plan of care. Some then are involved and some are not, just depending on the relationship and the needs of the family. That is something we let the family decide for themselves, although we always keep the lines of communication open to them.

14.) How long are people able to participate in services/programming offered by the association? What might be some signs that the individual is ready for the next level of care?

No limit, some of our people have been here for 15 years plus! We love to keep people here so they are able to stay in the community and with their family members. We start the conversation about taking the next step when we see that someone is functionally or behaviorally inappropriate for the group setting and for the care that we can provide. We tend to keep people as long as we possibly can.

Signs could be self-alienation, distracting or inappropriate behavior that is becoming difficult to address, a level of support that becomes difficult to provide with the 1-6 staffing ratio, overall fitting into the group and the daily programming. Deciding someone is ready for the next level of care is very individualized. It could depend on medical needs or physical needs as well.

15.) How many days per week can/do people participate?

From 1-5 days a week M-F.

16.) How long are your clients typically here with your facility (years?)

As many as 19 years at this point! Can vary

17.) Are you familiar with Occupational Therapy's role with this population? Do you think your clients and/or their families could benefit from/is there a need for Occupational Therapy services at this site?

I think we could really incorporate Occupational Therapy into our programs of the future. We need to tweak what we offer in order to stay relevant in the changing health care system, as well as for the next generation of baby boomers, who are going to want much different things than the current folks we serve. I see an OT being involved in transitional programming and building older adult back up so they can be successful in the community (with the option to continue as an adult day program participant). They could also provide daily programming for the group and tips for individual participants to keep up the level of function.

18.) What benefits would you like to see participants gain from an Occupational Therapy program?

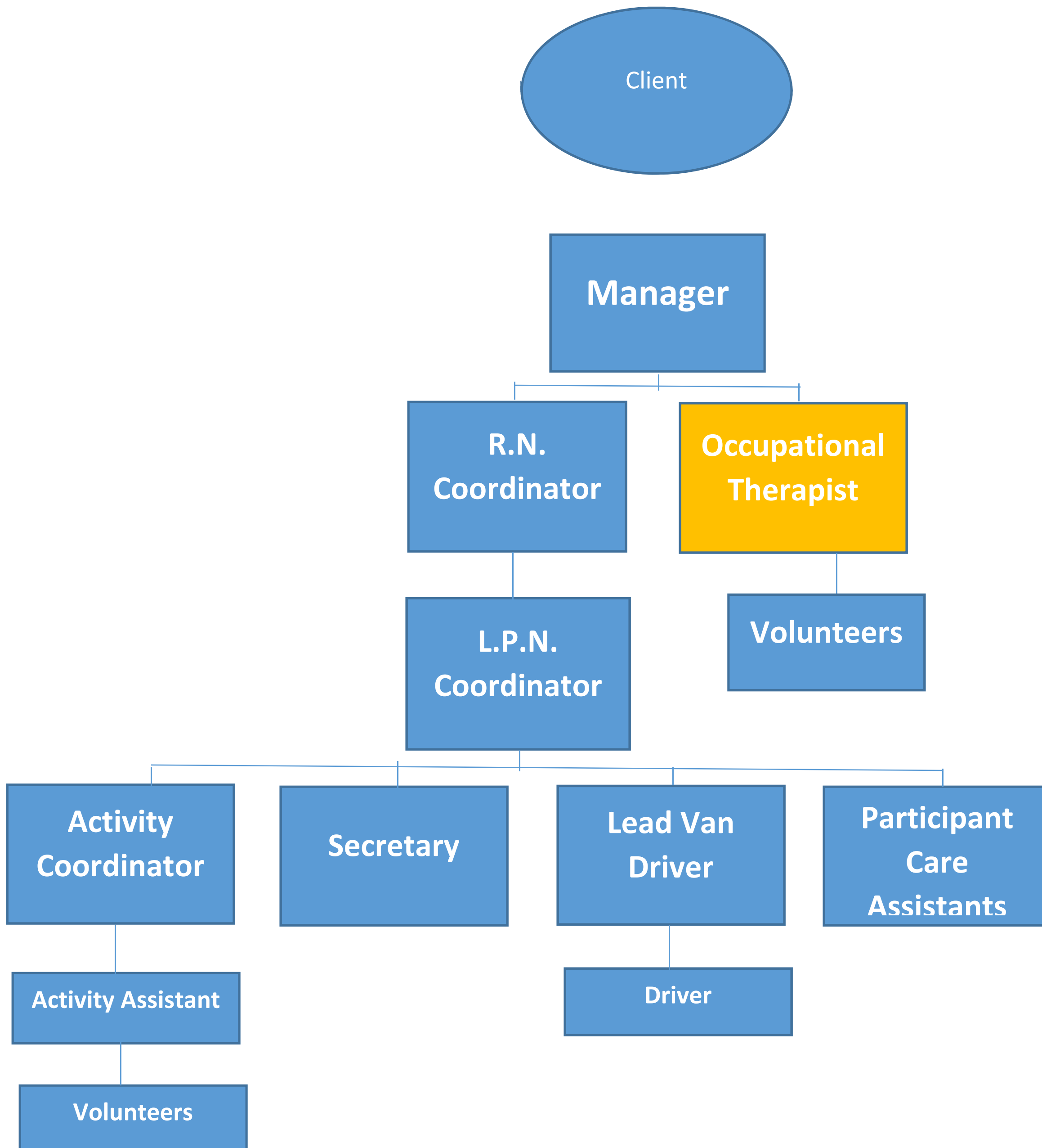
To gain or maintain independence and have fun doing it!

19.) Would it be feasible to charge insurance for OT services, given the financial structure of your services?

Yes, I think it could be billed as outpatient therapy provided under the part B Medicare umbrella. Maybe develop even a new model of care through the foundation. We need to be viable going forward so that we are able to remain here and continue to help our participants and their families.

Appendix B

Organizational Chart Including Occupational Therapy



Appendix C

Data Collection Tool

Caregiver Questionnaire

Please fill out the following questionnaire as completely and honestly as possible. All information will remain confidential and will be used to enhance programming for Adult Day Services.

1.) Are you employed? ______ Part time/full time? ________________________________

2.) What is your relationship to the participant? ___________________________________

3.) Are you the sole caregiver for your loved one, or do you receive help?

____

4.) How far away from our facility do you live? ___________________________________

5.) How did you hear about us? ____

6.) How long have you and your loved one been using our services? __________________

7.) I currently feel confident in giving care to my loved one at home

Strongly Agree Agree Neutral Disagree Strongly Disagree

8.) I feel confident in my ability to give care to my loved one at home in the future

Strongly Agree Agree Neutral Disagree Strongly Disagree

9.) I feel that my home environment is conducive for caregiving

Strongly Agree Agree Neutral Disagree Strongly Disagree

10.) Could you benefit from a list of home safety tips or a home assessment to improve your home environment?

____

My largest area of need as a caregiver is:

____

What do you like most about our programming?

What would you like to see added or improved in our programming?

Would you like to follow up with our manager Laura Matthews with any questions/concerns?

Appendix D

Marketing Materials

Occupational Therapy

In the Transitions Program

*Work with an OT to safely and independently return to daily activities in the community and in your home

*Remain in the community during rehabilitation

*Stay connected to community and social supports

*Identify and work on challenges as they arise

*Connect with peers

- The Transitions Program provides interdisciplinary care for individuals transitioning from the hospital to home. With a graduated design, individuals are prepared to return to their prior level of independence, while given the support they need during their recovery.
- Contact Marie Zipp, OTR/L for more information
- 440-123-4556
- Marie.zipp@UHhospitals.org

WHY TRANSISTIONS?

- Reduced 30-day readmission rate
- 6.1% participant vs 22.2% non-participant (Jones, K.R, et al., 2011)

- Interdisciplinary care
- Daily assessments to track patient progress and create comprehensive support for the patient

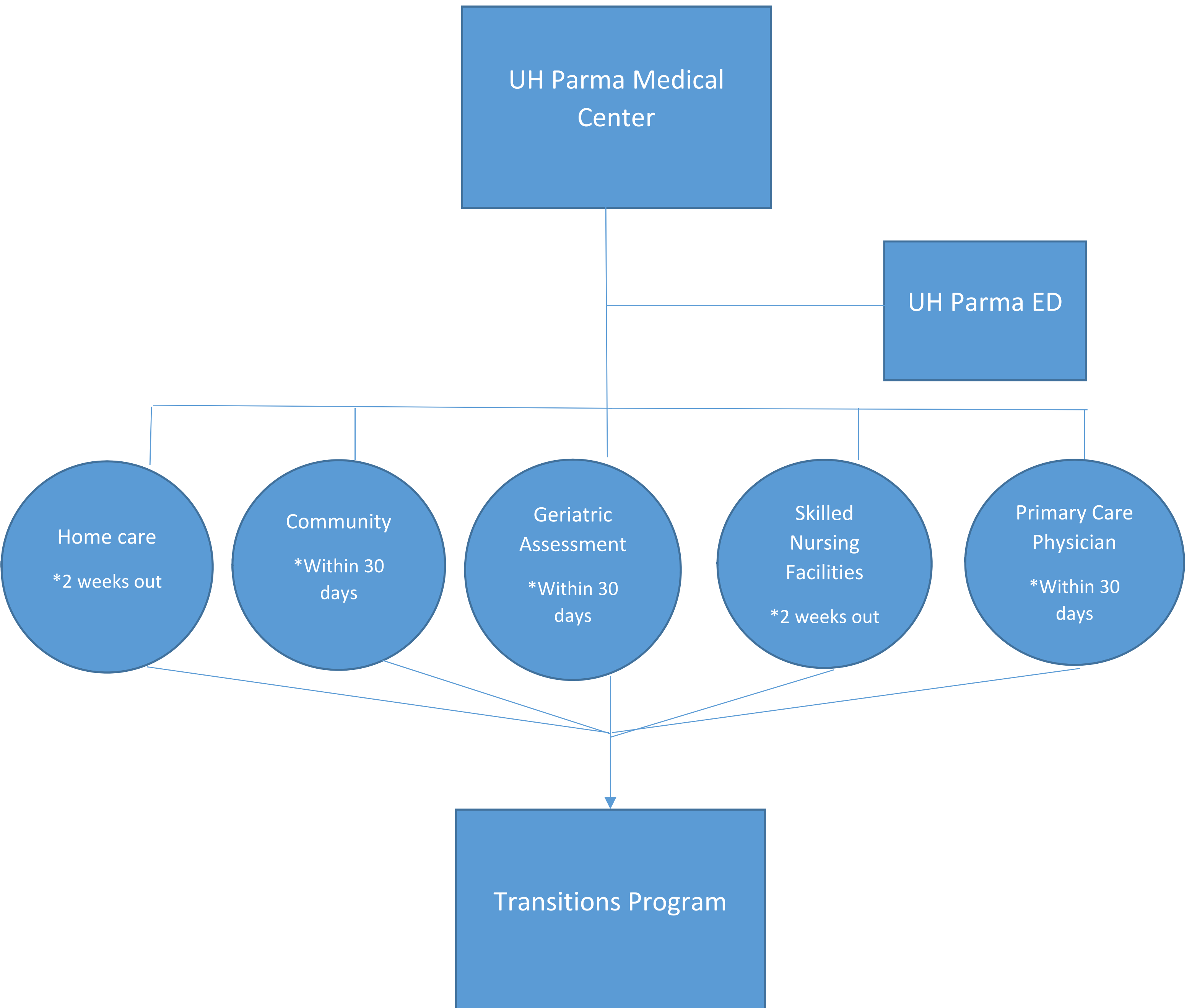
- Support for the hospital's adult day programming
- Expanding the spectrum of care for the older adult and creating options for aging in place

- Scholarships for 5 participants are being provided by the UH Parma Hospital Foundation

Jones, K. R., Tullai-McGuinness, S., Dolansky, M., Farag, A., Krivanek, M. J., & Matthews, L. (2011). Expanded adult day program as a transition option from hospital to home. *Policy, Politics, & Nursing Practice*, 1527154411409052.

Appendix E

Transitions Program Recruitment Sources



Appendix F
Fall Prevention Handouts

FALL PREVENTION TIPS

Every year, thousands of older adults fall and hurt themselves. Falls are one of the main causes of injury and disability in people age 65 and older. Those who fall once are 2 to 3 times more likely to fall again. Hip fractures are especially serious, and most of them are caused by falling.

Falls are often caused by hazards that are easy to overlook. But these hazards can also be easy to fix. This checklist helps you find hazards in each room of your home, and it gives tips on how to fix the problem.

FLOORS

_ Remove rugs or use double-sided tape or non-slip backing so rugs won't slip.
_ Keep objects off the floor and stairs.
_ Coil or tape electrical cords next to wall to prevent tripping.

STAIRS & STEPS

_ Fix loose or uneven steps.
_ Turn on lights! If one isn't present, use switches that glow in the dark.
_ Change light bulbs.
_ Fix loose handrails. They should be as long as the stairs.
_ Attach carpet firmly to every step. Use rubber treads on uncarpeted stairs.

KITCHEN

_ Move items on cabinets to bottom shelves; at waist

height.
_ Use a sturdy step stool with a bar. Never use a chair as a stool!

BEDROOM/BATHROOM

_ Place lamp close to bed within easy reach.
_ Use night lights.
_ Put non-slip mats in tub or shower.
_ Install grab bars in tub next to toilet.

OTHER PREVENTION MEASURES

_ Exercise regularly! It adds to strength and improves balance.
_ Ask your doctor or pharmacist about the medications that make you sleepy or dizzy.
_ Get up slowly after sitting or lying down.
_ Wear sturdy shoes with thin, non-slip soles.
_ Improve lighting in your home.
_ Use reflective tape at top and bottom of stairs.
_ Keep emergency numbers in large print near phones.
_ Consider using a personal emergency medical alert system.

(Cuyahoga County Board of Health, 2015)

Fall Prevention Balance Exercises

Balance Exercise - Standing on One Foot

Improve your balance by standing on one foot.

1. Stand on one foot behind a sturdy chair, holding on for balance.
2. Hold position for up to 10 seconds.
3. Repeat 10 to 15 times.
4. Repeat 10 to 15 times with other leg.
5. Repeat 10 to 15 more times with each leg.

Balance Exercise - Walking Heel to Toe

Improve your balance by walking heel to toe.

1. Position the heel of one foot just in front of the toes of the other foot. Your heel and toes should touch or almost touch.
2. Choose a spot ahead of you and focus on it to keep you steady as you walk.
3. Take a step. Put your heel just in front of the toe of your other foot.

4. Repeat for 20 steps.

Balance Exercise - Balance Walk

Improve your balance with the balance walk.

1. Raise arms to sides, shoulder height.
2. Choose a spot ahead of you and focus on it to keep you steady as you walk.
3. Walk in a straight line with one foot in front of the other.
4. As you walk, lift your back leg. Pause for 1 second before stepping forward.
5. Repeat for 20 steps, alternating legs.

Strength Exercise - Back Leg Raises

Strengthen your buttocks and lower back with back leg raises.

1. Stand behind a sturdy chair, holding on for balance. Breathe in slowly.
2. Breathe out and slowly lift one leg straight back without bending your knee or pointing your toes. Try not to lean forward. The leg you are standing on should be slightly bent.
3. Hold position for 1 second.

4. Breathe in as you slowly lower your leg.
5. Repeat 10 to 15 times.
6. Repeat 10 to 15 times with other leg.
7. Repeat 10 to 15 more times with each leg.

Strength Exercise - Side Leg Raises

Strengthen your hips, thighs, and buttocks with side leg raises.

1. Stand behind a sturdy chair with feet slightly apart, holding on for balance. Breathe in slowly.
2. Breathe out and slowly lift one leg out to the side. Keep your back straight and your toes facing forward. The leg you are standing on should be slightly bent.
3. Hold position for 1 second.
4. Breathe in as you slowly lower your leg.
5. Repeat 10 to 15 times.
6. Repeat 10 to 15 times with other leg.
7. Repeat 10 to 15 more times with each leg.

(National Institute of Health, n.d.)

Appendix G

Home Safety Information

FLOORS:

Look at the floor in each room.

Q: When you walk through a room, do you have to walk around furniture?

Ask someone to move the furniture so your path is clear.

Q: Do you have throw rugs on the floor?

Remove the rugs or use double-sided tape or a non-slip backing so the rugs won't slip.

Q: Are there papers, books, towels, shoes, magazines, boxes, blankets, or other objects on the floor?

Pick up things that are on the floor. Always keep objects off the floor.

Q: Do you have to walk over or around wires or cords (like lamp, telephone, or extension cords)?

Coil or tape cords and wires next to the wall so you can't trip over them. If needed, have an electrician put in another outlet.

STAIRS AND STEPS:

Look at the stairs you use both inside and outside your home.

Q: Are there papers, shoes, books, or other objects on the stairs?

Pick up things on the stairs. Always keep objects off stairs.

Q: Are some steps broken or uneven?

Fix loose or uneven steps.

Q: Are you missing a light over the stairway?

Have an electrician put in an over-head light at the top and bottom of the stairs.

Q: Do you have only one light switch for your stairs (only at the top or at the bottom of the stairs)?

Have an electrician put in a light switch at the top and bottom of the stairs. You can get light switches that glow.

Q: Has the stairway light bulb burned out?
Have a friend or family member change the light bulb.

Q: Is the carpet on the steps loose or torn?
Make sure the carpet is firmly attached to every step, or remove the carpet and attach non-slip rubber treads to the stairs.

Q: Are the handrails loose or broken? Is there a handrail on only one side of the stairs?
Fix loose handrails or put in new ones. Make sure handrails are on both sides of the stairs and are as long as the stairs.

KITCHEN:
Look at your kitchen and eating area.

Q: Are the things you use often on high shelves?
Move items in your cabinets. Keep things you use often on the lower shelves (about waist level).

Q: Is your step stool unsteady?
If you must use a step stool, get one with a bar to hold on to. Never use a chair as a step stool.

BATHROOMS:

Look at all your bathrooms.

Q: Is the tub or shower floor slippery?

Put a non-slip rubber mat or self-stick strips on the floor of the tub or shower.

Q: Do you need some support when you get in and out of the tub or up from the toilet?

Have a carpenter put grab bars inside the tub and next to the toilet.

BEDROOMS:

Look at all your bedrooms.

Q: Is the light near the bed hard to reach?

Place a lamp close to the bed where it’s easy to reach.

Q: Is the path from your bed to the bathroom dark?

Put in a night-light so you can see where you’re walking. Some night-lights go on by themselves after dark.

Other Things You Can Do to Prevent Falls

- Exercise regularly. Exercise makes you stronger and improves your balance and coordination.
- Have your doctor or pharmacist look at all the medicines you take, even over-the-counter medicines. Some medicines can make you sleepy or dizzy.
- Have your vision checked at least once a year by an eye doctor. Poor vision can increase your risk of falling.
- Get up slowly after you sit or lie down.

- Wear shoes both inside and outside the house. Avoid going barefoot or wearing slippers.
- Improve the lighting in your home. Put in brighter light bulbs. Florescent bulbs are bright and cost less to use.
- It's safest to have uniform lighting in a room.
- Add lighting to dark areas. Hang lightweight curtains or shades to reduce glare.
- Paint a contrasting color on the top edge of all steps so you can see the stairs better. For example, use a light color paint on dark wood.

Other Safety Tips

- Keep emergency numbers in large print near each phone.
- Put a phone near the floor in case you fall and can't get up.
- Think about wearing an alarm device that will bring help in case you fall and can't get up.

(Centers for Disease Control and Prevention, 2005)

Home Safety Checklist

Top 10 Safety Measures for Older Consumers

- Install smoke and carbon monoxide alarms throughout your home.
- Have an emergency escape plan and pre-arrange for a family member or caregiver to help you escape, if needed.
- Keep a fire extinguisher handy in the kitchen in case of fire.
- Make sure there is good lighting inside and outside your home to help prevent falls.
- Make sure walking surfaces are flat, slip resistant, free of objects, and in good condition to avoid falls.
- Keep ashtrays, smoking materials, candles, hot plates, and other potential fire sources away from curtains, furniture, beds and bedding.
- Have fuel burning appliances including furnaces and chimneys inspected by a professional every year to make sure they are working properly and not leaking poisonous carbon monoxide.
- Install ground fault circuit interrupters, or GFCIs, in potentially damp locations such as the kitchen, bathroom, garage, near utility tubs or

sinks, and on the exterior of the house to protect against electrocution.

- Make sure all medications are stored in child-resistant enclosures and are clearly marked to prevent children from accessing the medication and being poisoned.
- Set your hot water heater to no more than 120° F to help prevent burns

(Consumer Product Safety Commission, n.d.)

Appendix H

Occupational Therapy Job Description

Occupational Therapist- Transitions Program

- Assess participants of the Transitions Program. Assess and interpret evaluation and test results
- Provide outpatient Occupational Therapy services for participants of the Transitions Program.
    - Help patients develop or regain function through the provision of occupation-based intervention
    - Promote maximum independence by selecting interventions based on individual factors of the participant
    - Evaluate the results of Occupational Therapy intervention by using skilled observation, standardized assessments, and client-centered practices
- Use standardized assessment measures to assess participants (FIM, OSA, etc.)
- Document care for each participant session using electronic medical record
- Complete billing for therapy sessions for each participant
- Provide bi-weekly (or on a rotating basis) group education for the Transitions Program on topics determined by OT and STNA group facilitator
- Ensure safety and optimal operation of all equipment by following manufacturer recommendations and calling for necessary repairs
- Maintains clean and safe working environment by adhering to all safety and infection-control policies and protocols

- Maintain patient confidentiality by adhering to University Hospital's HIPAA and confidentiality guidelines
- Maintains professional and technical knowledge by attending relevant education workshops and renewing OT license as appropriate

(Monster, 2016)

Appendix I

Occupational Therapy Recruitment Flyer

Occupational Therapy Position Available

- **Part time opportunity available in a community based setting**
- **12 hours per week**
- **Be a part of a developing program for older adults**
- **Seeking an autonomous therapist with at least 1 year of experience**

Location: UH Parma Medical Center Health Education Center 7300 State Rd. Parma, OH 44134

Title: Occupational Therapist

Description: Be a part of our new Transitions Program, where older adults with chronic conditions can find holistic support after hospital discharge. Work as a member of the interdisciplinary care team to maximize participant independence and reduce hospital readmissions. We have a brand new therapy space in this community building, specifically for use by the Transitions Program. Our Occupational Therapist will also have the opportunity to do bi-weekly group education for the program participants.

- For More Information, please contact Laura Matthews, manager of adult day services at 440-730-5746

Appendix J

Sample Participant Weekly Maintenance Calendar

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
-AM Meds -AM walk with wife -Spend the day with grandkids	-AM Meds -AM walk with wife -Attend smoking cessation group	-AM Meds -AM walk with wife -Cleaning lady comes	-AM Meds -AM walk with wife -Laundry day (spend day in basement, not up and down)	-AM Meds -AM walk with wife -Attend smoking cessation group	-AM Meds -AM walk with wife -Make to-do list for son	-AM Meds -AM walk with wife -Son comes to help

Appendix K

OT Exit Survey Template

Name____

Date____

1.) 3 ways I can modify my home to increase my independence and safety are:

a. -

____

____

b. ____

____

c. ____

____

2.) 2 things I can do to prevent a fall at home are:

a. ____

____

b. ____

____

3.) 2 possibly community and social supports that will help me maintain my independence and my chronic condition are:

a. ____

____

b. ____

____

Appendix L

Timeline

Timeline

Task	Week									
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Apply for foundation funding	X	X								
Conduct needs assessment	X	X								
Marketing and recruitment	X	X	X	X						
Purchase supplies	X	X								
Communicate with potential clients	X	X	X	X	X	X	X	X	X	X
Clients complete evaluation for each discipline upon beginning the program					X	X	X	X	X	X
Create individual goals for clients					X	X	X	X	X	X
Programming Sessions					X	X	X	X	X	X
Write daily progress notes					X	X	X	X	X	X
Clients will complete formative evaluation					X	X	X	X	X	X
Clients will complete a discharge survey								X	X	X
Compile formative and summative evaluation results								X	X	X

Appendix M

Letters of Support

April 18, 2016

Regarding: Proposal for Transitional Care for COPD and Chronic Conditions

To whom it may concern:

Marie Zipp, doctoral student from the University of Toledo, in conjunction with the adult day services at University Hospitals, has been a viable member of its NICHE (Nurses Improving Care for Healthsystem Elders) committee. She has focused on the goal to reduce the 30 day re-admission rate for COPD patients using the concept of the DAY program pilot study. Her research, innovation and ability to assist with the design of this program has earned the respect and attention of the committee chair. I am confident that this transitional care model will be funded and implemented by the end of 2016 and that we will see a reduction in the readmission rate for COPD patients. Soon after the COPD program is implemented, phase II of the transitional care model will be implemented. The impact of this program will be widespread including reductions in hospital penalties, seamless care with the adult day services and an improved quality of life for our patients.

Sincerely,

Laura Matthews, Manager

*Other letters of support might be elicited from Laurie Melvin, chair of the NICHE committee, and Lenore Hoff, manager of rehabilitation at UH Parma.