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PRESIDENT'S MESSAGE

What Is Possible?

By Eric De Jonge, MD

In home care medicine, each of us operates as best we can, yet we may not always know what others are doing to succeed. As a thought experiment, let's take a quick survey of creative clinical and business methods from around the U.S. Then, let's imagine what would happen if we took a few of those ideas and included them in our own practices.

In Oregon, Housecall Providers delivers primary, palliative, and hospice care. One technique this provider uses is to manage patients in and out of the hospital to ensure that acute care is consistent with goals and that patients get home safely. Its staff goes into the hospital with each patient, talks with the hospital team, and ensures a smooth transition home. This coordination of acute care helps patients avoid hazards of the hospital and contributes to a proven reduction of over 25% in Medicare costs and Independence at Home shared savings payments to their practice.

In Northern Virginia, a solo nurse practitioner works 52 weeks a year, serving the most homebound and ill people in her community. She collaborates with a physician to sign forms, builds relationships with group homes, and works with the best home care agencies in the area. She offers immediate skilled and caring visits to patients who desperately need her care.

In New York City, Mount Sinai at Home has built a wide array of home-based medical care services. Its goal is to keep hospital beds empty by providing medical care at home. In 2015, Mount Sinai at Home won a 3-year Medicare award to prove the value of hospital at home, showing a low rate of complications, high patient and family satisfaction, and reduction in total costs. This led a local payor to contract with this provider and help expand its revenue base beyond fee-for-service.

In 13 states, Landmark Health offers collaborative home-based medical care to a large volume of patients. It invests capital funding and per member per month (PMPM) payments from Medicare Advantage payors to build 24/7 urgent visit capacity and core medical, social, and behavioral health services. Landmark Health has served 97,000 patients, and saw a 40% reduction in ER visits and positive patient and family experience.

In North Carolina, Doctors Making Housecalls has developed a national model for serving senior congregate living sites. The organization built partnerships with hundreds of assisted living facilities across the state and has done well in an efficient setting and with a flexible compensation structure.

In Florida, Mobile Physician Services serves most of the state with home-based primary care and specialty services. It transports clinicians to areas of highest need and hire its own podiatrists and other key specialists. Mobile Physician Services succeeds with careful attention to quality of service, documentation and coding, and negotiated

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contracts for substantial PMPM payments for the care of high-need patients.

In 12 states and 40 house call sites, U.S. Medical Management serves over 50,000 patients. It offers a 24/7 live call center, strong administrative support, and medical assistants to accompany medical staff. The organization has built internal services of laboratory, radiology, DME, skilled home health, and hospice to ensure it meets all patient and family needs. U.S. Medical Management has found financial sustainability by tapping into a diverse array of value-based payment tools.

What are some common themes? I see a constant effort to deliver the services needed by the most ill patients, a commitment to teamwork 24/7, a willingness to change and enhance their services, and an openness to new payment methods that can support these enterprises. I am inspired by the creative and compassionate work that these teams and all of you do each day.

I hope you can learn from these examples and from each other when we gather in Chicago in October for the Annual Meeting. Please send any comments to me at edejonge@capitalcaring.org.

**SAVE THE DATE: AAHCM Annual Meeting
in Chicago, IL, October 18–19, 2019, with an
HCCI Preconference event October 17!**

The Promise of July

By Robert M. Kaiser, MD MHSc FACP AGSF

As the largest healthcare organization in the United States, the Veterans Health Administration (VHA) might seem singly focused on October 1, the beginning of the fiscal year, rather than July 1, the date when newly minted physicians begin post-graduate training. But that is not the case: the VHA is focused on education, too, and has been for a long time. Its significant relationship with academic institutions began 7 decades ago, in 1946. Seventy percent of America's physicians have trained at a Veterans Affairs (VA) Medical Center, a place where health care professionals of all disciplines—nurses, doctors, social workers, dietitians, psychologists, and physical and occupational therapists—now also come to develop their clinical expertise (Department of Veterans Affairs, 2016).

This is no less true of VA Home Based Primary Care (HBPC). July is an important time for us, too—when new learners arrive on our doorstep, eager and ready to jump right in. HBPC is a key platform for mastering specialized knowledge about caring for frail patients in the community, including the fundamentals of team-based interprofessional care, which provides an opportunity to demonstrate to new learners that the mission of a healthcare system is broad and goes well beyond medical care. To be successful, clinicians must grasp the importance of social and psychological support for patients and caregivers alike.

HBPC is an ideal platform for teaching the Accreditation Council on Graduate Medical Education (ACGME)'s six core competencies (ACGME, 2016):

- practice-based learning and improvement
- patient care and procedural skills
- systems-based practice
- medical knowledge
- interpersonal and communication skills
- professionalism.

In HBPC, these competencies can be achieved within a unique educational setting. When learners enter someone else's home, the unequal relationship between clinician and patient is reversed, and patients have the upper hand. In this situation, trainees can more easily see that deference and respect are the key to communicating with patients and their caregivers and in building strong, effective therapeutic relationships. All the complex clinical, functional, and social problems of homebound patients are front and center, serving as a stimulus for clinicians-in-training to know more, to understand how to best leverage the health care system to support and preserve the patient's well-being and independence, and to work towards improving safety and quality of care. Another important lesson can be learned—that such goals can be best accomplished by collaborating with patients, caregivers, and fellow home care professionals.

For those entering professional training programs, July is a moment of genuine promise, of idealism and enthusiasm. It provides a rare chance to teach new clinicians how to care for, and care about, Veterans. To be an expert clinician means not only mastering a body of knowledge, but also accepting a solemn responsibility as an advocate and to embrace a meaningful mission in the service of others.

The views expressed in this column are those of the author and have not been endorsed by the Department of Veterans Affairs or the American Academy of Home Care Medicine.



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Urinary Catheter Management: The Care and Changing of Urinary Catheters

By Todd Thompson, MSN-BC and Rosemary Browne, MD

Most urinary catheter guidelines and infection control policies are written for acute hospitalization and do not address the issues of long-term urinary catheterization. Highly diverse practices can be found in home care, such as reusing catheter supplies and equipment, breaking the closed urinary catheter system, and carrying out variable changing intervals and hygiene practices. This article, a first in a series, will address evidence-based standard care practices that should be utilized in the management of urinary catheters in the home. Future articles will discuss other aspects of catheter care, including alternatives to catheterization, troubleshooting common problems, and the approach to catheter blockage.

Standard Catheter Care

Catheter care in the home is distinct from the hospital, but most guidelines are developed for the inpatient setting. Current hospital guidelines emphasize that the best way to prevent Catheter Associated Urinary Tract Infections (CAUTIs) is by maintaining a closed system, ensuring proper drainage, and employing clean emptying technique (Schaeffer, Richie, & Chen, 2017).

Standard catheter care should be followed in the home. This entails using clean technique, good hand washing, maintaining dependent drainage, employing proper emptying techniques, emptying the bag when less than 50% full, ensuring adequate hydration, and performing daily catheter care and perineal care. The use of antimicrobial solutions and ointments on the meatus are ineffective in preventing CAUTIs (Redd, 2012) and are unnecessary.

Many home care patients are in the habit of changing their urinary collecting bags frequently, breaking the closed system. They sometimes even clean and reuse catheter bags. Evaluation of these practices show neither an increase nor a decrease in long-term risk of infection in chronic indwelling catheters with chronic bacterial colonization (Paterson, Hanson, Ostaszewicz, Pieters, & Townsend, 2011). Changing bags or cleaning bags, however, does increase cost and takes unnecessary extra effort without decreasing the risk of CAUTIs. Education should be provided that maintaining a closed system is preferable and that this practice is more effective than bag cleaning to prevent CAUTIs. Catheter bag covers may be provided for patients and family who feel the bag looks dirty over time.

Patients who prefer to use a leg bag during the day often switch back and forth from a leg bag to a larger catheter bag, regularly breaking the closed system. A "link system" (extension attached to the drainage outlet of the day urine collection bag and connected to a larger capacity night drainage bag) is a

useful tool to keep the system closed (National Clinical Guideline Center, 2012).

Changing catheters

A common practice in long-term catheter management is regular and frequent catheter changes, usually once every 4 weeks. This policy, however, is not evidence based. Most urinary catheters, such as hydrogel and silicone, are designed to last up to 12 weeks (Bard Product manual, 2017). Additionally, the more often you change a catheter, the higher the risk of infection and urinary tract trauma, such as ureteral strictures or bladder neck obstruction (Walliman, 2017).

So when did monthly catheter changes become routine practice? It happened when Medicare, under the Periodic Payment System (PPS), allowed for a billable visit for skilled catheter care every 30 days (Rhinehart & McGoldrick, 2006). Catheters and drainage bags only need to be changed based on clinical indications (infection, obstruction) or according to manufacturer guidelines (Gould et al., 2009). This individualized approach, centered on the needs of the patient and the workload of the nursing staff, ultimately increases efficiency and reduces cost. Policy or physician orders can direct that "catheter changes be performed as needed or per manufacturer's guidelines." Staff expertise and shared decision making with the patient should be used to determine the optimal changing frequency.

Modification of the change-out procedure is also required for patients with chronic urinary catheterization. Male patients with a chronic indwelling catheter are at risk for developing prostatitis from catheter blockage of the prostate glands. It is recommended to leave the catheter out for at least 1 hour during changes to allow the prostate glands to drain. (Tenke et al., 2008). Catheters also should be changed when any antibiotics are initiated. This has been shown to hasten clinical improvement, reduce febrile days, and decrease the rate of infection relapse (Raz, Schiller, & Nicolle, 2000).

Key Points

- Although maintaining a closed system is preferable, bag cleaning and changing does not appear to increase the risk of CAUTI.
- Use of a Link System can be used to facilitate use of a leg bag while still maintaining a closed system.
- Catheters should be left out for short periods to allow glands to drain.
- Catheter changing frequency should be individualized, and less often is better.

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Standardization and Innovation

By Michele Severson, MS RD

Benefits of Standardization

Many industries have standardized processes and procedures to promote safety and ensure consistency (Dlugacz, 2017). The healthcare industry is often cited as lagging in promoting and implementing standardized processes and procedures, when compared with other industries, leading to concerns that quality and safety may be compromised. The Institute of Medicine (IOM) defines the characteristics of high-quality care as safe, effective, reliable, patient-centered, efficient, and equitable (Sfantou, et al., 2017). In the healthcare industry, quality and performance improvement initiatives focus on improving processes, correcting deficiencies, and preventing errors and encompassing safe, effective, patient-centered, timely, efficient, and equitable care (Dlugacz, 2017).

Data collection and analysis fosters an ability to provide an objective assessment of the organization's processes, services, and outcomes (Dlugacz, 2017). Assessing data and measuring outcomes are vital activities for the healthcare organization: it allows for the assessment of the quality of care and promotes engagement in continuous quality improvement processes. Many clinicians are familiar with quality improvement initiatives such as Six Sigma or Plan-Do-Study-Act (PDSA) cycles. Implementation of quality-improvement initiatives can lead to standardization of processes and procedures, which in turn can lead to improvements in data collection and analysis of interventions and outcomes.

Standardizing Malnutrition Identification and Diagnosis

It is well established that individuals who have a diagnosis of malnutrition have higher healthcare costs (White, et al., 2012). According to a recent report, the prevalence of malnutrition in the community care setting is estimated to be between 6% and 30%. (Khan, McCauley, Pratt, Whitmire, & Blancato, 2018). Malnutrition prevalence varies widely because the criteria used to diagnose malnutrition are not standardized (Khan et al., 2018). Identification and diagnosis of malnutrition by healthcare providers remain variable and subjective.

In 2012, the Academy of Nutrition and Dietetics and the American Society for Parenteral and Enteral Nutrition released a consensus statement, which provided a framework for standardizing criteria that can be used to diagnose malnutrition (White, et al., 2012). The framework identifies six categories for evaluation: energy intakes compared with estimated needs, weight loss history and trends, lean body mass loss, subcutaneous fat mass loss, fluid accumulation, and diminished grip strength (White, et al., 2012). The criteria are intended to be used to identify malnutrition across care settings and do not require any type of invasive evaluation techniques, such as a lab draw. Registered Dietitians (RDs) in collaboration with

physician providers have begun implementing use of the standardized criteria, and several studies have recently been published evaluating the use of the standardized criteria (Hand, et al., 2016) (Mogensen, et al., 2019).

Furthermore, the Centers for Medicare and Medicaid Services (CMS) tie reimbursement to value-based measures (Dlugacz, 2017). Currently, CMS is collaborating with key stakeholders on the development of malnutrition clinical quality measures. This collaboration resulted in four malnutrition electronic clinical quality measures (eCQM) that have been developed and submitted to CMS for review and adoption (Doley, Phillips, Talaber, & Leger-LeBlanc, 2019). As reimbursement shifts to a value-based system from fee-for-service, standardized identification of malnutrition and incorporation of quality measures to evaluate quality of care will prove instrumental in improving outcomes.

Standardization and Innovation: Two Sides of the Same Plate

Malnutrition prevalence data for community-dwelling older adults would be more accurate if there were consensus and utilization of a standardized criteria across all care settings and clinical providers. Diagnostic criteria that is standardized and accurate could lead to improvements in coding and reimbursement for providers. Furthermore, standardized processes lead to an improved ability to have meaningful data collection and analysis of processes, outcomes, and interventions. Registered dietitians can take a leadership role with project management and process improvement associated with malnutrition identification or any process or project that will support the home-based primary care team and have an impact on patient outcomes. Standardization of processes and procedures can lead to value-based care that is fiscally responsible while also being innovative.

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The Heat Wave Continues

By June Leland, MD MBA

Temperatures continue to remain elevated across the country during the summer months and, in some areas, well into the fall. The very young, chronically ill, elderly, and other populations are at risk for heat-related illnesses that occur when the body's natural cooling systems fail. The range of illness can encompass mild dehydration, heat rash, heat tetany, heat cramps, heat exhaustion, and the most serious complication, heat stroke. In the United States, heat waves claim more lives each year than all other weather-related exposures combined (e.g. hurricanes, tornadoes, floods, and earthquakes). According to the Centers for Disease Control and Prevention (CDC), 8,015 deaths were attributed to excessive heat exposure from 1979 to 2003, or an average of approximately 334 deaths per year (Helman and Alcock, 2018).

Risk factors include (Domino, Baldor, Golding, and Stephens, 2018)

- poor acclimatization to heat or poor physical conditioning
- salt or water depletion
- obesity
- acute febrile or gastrointestinal illnesses
- chronic illnesses such as uncontrolled diabetes mellitus or hypertension, and cardiac disease
- alcohol and other substance abuse (e.g., cocaine, heroin, methamphetamines, and NMDA)
- high heat and humidity; poor air circulation in environment
- heavy, restrictive clothing
- skin diseases impeding sweating
- sleep deprivation
- prescribed medications (e.g., -adrenergics, anticholinergics, antihistamines, antipsychotics, benzodiazepines, -blockers, calcium channel blockers, clopidogrel, diuretics, laxatives, neuroleptics, phenothiazines, thyroid agonists, tricyclic antidepressants) as well as nonprescribed medications (cocaine, heroin, methamphetamines, NMDA, and alcohol).

Two physiologic mechanisms for decreasing body temperature as it rises are shunting blood to the skin surface and sweating. Shunting blood to the surface moves blood away from the brain, leading to symptoms of neurologic impairment. Sweating, intended to cool by evaporation, can lead to excess salt loss and dehydration. It is less effective in high-humidity environments. In addition, the direct cellular toxicity of heat, imbalance between inflammatory and anti-inflammatory cytokines, and vascular endothelial damage causes end-organ dysfunction. There is an interplay between failure of heat-dissipating mechanisms, an overwhelming heat stress, and an exaggerated acute-phase inflammatory response (Helman and Alcock, 2018).

The elderly are at particular risk for several reasons:

- They don't adjust to sudden temperature changes in temperature due to impaired acclimatization.
- They are more likely to have medical illnesses that change in response to heat.
 - Elderly persons and patients with diminished cardiovascular reserves are unable to generate and cope with the physiologic responses to heat stress and, therefore, are at risk of heat stroke. Patients with skin diseases and those taking medications that interfere with sweating also are at increased risk for heat stroke because they are unable to dissipate heat adequately. Additionally, the redistribution of blood flow to the periphery, coupled with the loss of fluids and electrolytes in sweat, place a tremendous burden on the heart, which ultimately may fail to maintain an adequate cardiac output, leading to additional morbidity and mortality (Helman and Alcock, 2018).
- They are more likely to be taking medications that alter temperature control or sweating as listed above.
- They have a reduced ability to modify the environment.

Heat-related illnesses range from heat rash (prickly heat) to heat stroke. Heat cramps are associated with exercise in hot weather and can cause muscular and abdominal cramping. Treatment involves fluid and electrolytes in addition to discontinuing the activity. Heat tetany is associated with short exposures to very high temperatures with hyperventilation and respiratory alkalosis. Heat syncope (fainting) is the result of high temperature and peripheral vasodilation. It is treated with recumbent position and fluids. Heat edema is the result of vasodilation leading to pooling in dependent areas of the body and can be seen in bedbound as well as upright patients.

Two forms of heat exhaustion exist (WebMD, 2019a):

1. Water depletion—Signs include excessive thirst, weakness, headache, and loss of consciousness.
2. Salt depletion—Signs include nausea and vomiting, muscle cramps, and dizziness.

Symptoms of heat exhaustion include

- confusion
- dark-colored urine (a sign of dehydration)
- dizziness
- syncope (fainting)
- fatigue
- headache
- muscle or abdominal cramps
- nausea, vomiting, or diarrhea
- pale skin
- profuse sweating
- rapid heartbeat
- temperature less than 104°F.

Recommendations for treatment of heat exhaustion include (WebMD, 2019a)

- Moving indoors, or if not possible, move to a cooler place outdoors.
- Drinking fluids, preferably those with electrolytes.
- Removing any tight or unnecessary clothing.
- Taking a cool shower, bath, or sponge bath.
- Applying other cooling measures such as fans or ice towels.

If such measures fail to provide relief within 15 minutes, seek emergency medical help because untreated heat exhaustion can progress to heat stroke.

Two forms of heat stroke exist. Exertional heat stroke (EHS) generally occurs in young individuals who engage in strenuous physical activity for a prolonged period in a hot environment. Classic nonexertional heat stroke (NEHS) more commonly affects sedentary elderly individuals, persons who are chronically ill, and very young persons. Classic NEHS occurs during environmental heat waves and is more common in areas that do not typically experience periods of prolonged hot weather. Heat stroke is a medical emergency. In heat stroke, the signs and symptoms of systemic inflammation, distributive/hypovolemic circulatory shock, multiple organ dysfunction, disseminated intravascular coagulopathy, electrolyte, pH, and osmotic imbalance are manifested simultaneously (Székely, Carletto, and Garami, 2015).

Symptoms of heat stroke include (WebMD, 2019b)

- body temperature over 104°F
- throbbing headache
- dizziness and light-headedness
- lack of sweating despite the heat
- red, hot, and dry skin
- muscle weakness or cramps
- nausea and vomiting
- tachycardia
- rapid, shallow breathing
- neurologic impairment with changes such as confusion, disorientation, hallucinations, or staggering
- seizures
- unconsciousness

Heat stroke is a medical emergency. Once identified, a cooling process should be initiated at home (or where the patient is located) even before medical emergency and hospital services are available:

- Remove tight or unnecessary clothing.
- Fan air over the patient while wetting his or her skin with water.
- Wrap the patient in wet sheets if the humidity is low.
- Apply ice packs to the patient's armpits, groin, neck, and back.
- Immerse the patient in a shower or tub of cool water.

- If the patient has a seizure, prevent injury. If there is vomiting, put him/her on his/her side and do not put anything in the patient's mouth.
- Stop cooling when body temperature goes below 102°F

Healthcare providers, caregivers, and family members can be instructed to recognize symptoms and begin therapy before progression to heat stroke. Prevention is the most effective approach to heat-related illness. One publication targets an outdoor temperature of 90°F as the time to take precautions. The publication can be personalized and printed for each patient, provides a space for provider notes to the patient, and contains information on where patients might get help purchasing an air conditioner (AGS Health in Aging Foundation, 2019). The CDC offers a publication which not only addresses patients but also their caregivers and providers, the latter with information on what they can do to help patients prevent heat-related illness (CDC, 2019). It is available in Spanish and English. It offers caregivers the following suggestions:

- Keep a close eye on those in your care by visiting them at least twice a day, and ask yourself these questions:
 - Are they drinking enough water?
 - Do they have access to air conditioning?
 - Do they know how to keep cool?
 - Do they show any signs of heat stress?

For patients, advice includes (CDC, 2019)

1. stay cool, stay hydrated
 - Stay in air-conditioned buildings as much as possible. If your home doesn't have air conditioning, contact your local health department or locate an air-conditioned shelter in your area.
 - Do not rely on a fan as your main cooling source when it's really hot outside.
 - Drink more water than usual and don't wait until you're thirsty to drink.
 - If your doctor limits the amount of fluids you drink or has you on water pills, ask them how much you should drink during hot weather.
 - Don't use the stove or oven to cook—it will make you and your house hotter.
 - Wear loose, lightweight, light-colored clothing.
 - Take cool showers or baths to cool down.
 - Do not engage in very strenuous activities and get plenty of rest.
 - Check on a friend or neighbor and have someone do the same for you.
 - Follow additional tips on how to prevent heat-related illness.
2. stay informed
 - Check the local news for health and safety updates.
 - Seek medical care immediately if you or someone you know has symptoms of heat-related illness, like muscle cramps, headaches, nausea, or vomiting.

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The Heatwave Continues *Continued from page 7.*

Home healthcare providers and home-health agencies would do well to consider identifying and monitoring those at risk for heat-related illness during heat waves in the same way that they identify and monitor those at risk of other natural disasters such as hurricanes or fires. Risk factors for heat-related illness can be identified, and patients and caregivers can be educated. Plans can be made in advance for taking shelter and modifying fluid restrictions and medications to mitigate the risk of heat-related illness.

Resource Links

<https://www.healthinaging.org/tools-and-tips/hot-weather-safety-tips-older-adults>

Slide 1: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4843928/>

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CUTTING-EDGE EDUCATION BY THE LEADERS IN HOME-BASED MEDICINE

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- **Quality Standards for Home Care Medicine**—Christine Seel Ritchie, MD, and Martha Twaddle, MD FACP FAAHPM HMDC
- **Long Overdue...New Ethical Dilemmas in Value-Based Care**—Ed Ratner, MD, and Nick Schneeman, MD
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The Role of Occupational Therapy in Early Childhood Intervention

By Eugenia Gonzalez, PhD OT¹; Katherine Lawson, PhD MSSW OTR²; Josephine Borges-Colon³; Joshua Herrera³; Maribel Avila-Ramirez³

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3. PIMA Medical Institute COTA student

In 1975, Congress enacted public law 94-142 giving individuals with disabilities the right to a free public education. Since then, the law has undergone several revisions and is now known as the Individuals with Disabilities Education Act (IDEA) (US Department of Education, 2019). Although the original law was conceptualized to cover only school-aged children, IDEA has evolved to include infants and toddlers from birth to three years of age. Therefore, early Intervention (EI) is a nationwide program for families of children up to three years of age who have developmental disabilities or specific medical diagnoses that put the child at risk for developmental delays. Throughout the country, EI programs are funded through federal, state, and local dollars. In Texas, early childhood intervention (ECI) is guided by principles developed by national experts on early intervention. The key element of these seven guiding principles is that family is central to the intervention process (DARS, 2019).

Experts recognized that familiar people and familiar places help children learn best from their everyday experiences. Therefore, one thing that sets ECI therapy services apart from therapy services in traditional settings is that ECI follows a parent training model rather than a medical/disability model. Because services focus on the children's and families' needs and priorities, the ECI intervention team will vary based on the family's needs and priorities. The occupational therapist is one of nine direct service providers including early intervention specialists, nurses, counselors, psychologists, dieticians, social workers, physical therapists, and speech language pathologists. The individualized family service plan (IFSP) is developed taking into consideration the family's resources, learning styles, and cultural beliefs. The focus of intervention is to prepare the child for successful participation in school.

One of the other hallmarks of early childhood intervention is that evaluation and services are provided in the child's

natural environments whether it be home, daycare, or other community settings. This is also a natural fit to the focus of occupational therapy on function. Therefore, the child's occupations, including play, rest, sleep, activities of daily living, and socializing are addressed as they present challenges to the families' routines in context rather than in a clinical setting.

Although ECI services have been a federally and state supported program in Texas since the early 1990s, there continues to be a gap in early identification of children in need of services (Gonzalez ECI article). This point is further accentuated by a recent advocacy project completed by occupational therapy assistant students. They presented information about occupational therapy services in the realm of pediatrics to a group of medical students, residents, and doctors. Two members of the audience had personal experience with ECI services, but the majority of participants were not aware of ECI or the role of occupational therapy in the treatment of children in this age category. This highlights the importance of continuing to promote early surveillance and treatment for children at risk for developmental disabilities starting with primary care providers who refer families to these services.

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How Do We Maintain Independence for Community-Dwelling Older Adults who Are at Risk of Falling?

By Katherine Lawson, PhD MSSW OTR

According to the Centers for Disease Control, during 2007 to 2016 the rate of deaths due to a fall occurrence among adults aged 65 years and older has increased by 31% in the United States (Centers for Disease Control and Prevention, 2018). Understandably, reducing fatal falls among older adults is one of the nation's primary health objectives (Healthy People 2020; U.S. Department of Health and Human Services, 2013). However, there is a scarcity of community-wide prevention programs that target specific areas or fall risk factors to reduce the incidence of falls (Chang et al., 2004; Leland et al., 2012; Lewis et al., 2004). This is further complicated by the fact that fall risks are numerous and vary widely by individual (Cesari et al., 2002; Deandrea et al., 2010).

Risk factors can be categorized as personal or environmental: personal (intrinsic) factors defined as age, gender, muscle weakness, and poor balance, and environmental (extrinsic) factors defined as poor lighting or loose rugs in the home (Ambrose et al., 2013; Cesari et al., 2002). Additionally, because mobility is a key component of most activities of daily living (ADLs), any impairments in posture and balance needed for functional mobility could result in a fall occurrence (Gill, Allore, Hardy, & Guo, 2006; Shumway-Cook, Brauer, & Woollacott, 2000). Overall, older adults are reported to be at higher risk for future falls if they have one or a combination of the following risk factors: previous fall event, primary diagnosis of depression or anhedonia, prescribed antipsychotic phenothiazines and tricyclic antidepressants, secondary diagnosis of neurological or cardiovascular disorders, balance deficits, frailty, and an absence of handrails in stairwells (Isberner et al., Lewis et al., 2004; Sheeran et al., 2004).

Access to home health nursing care and physical and occupational therapy are typically not available to community-dwelling older adults unless they have been referred by their primary care provider due to a hospital admission, emergent care visit, or after a catastrophic event. It is only after admission into a home health care service that patients are evaluated for these risk factors, including assessment of medication side effects or contraindications due to polypharmacy, uncontrolled diabetes, uncontrolled high blood pressure, malnutrition, and issues of noncompliance with medication regimens. Patients are evaluated for mobility deficits, visual acuity deficits, weakness and debility, and need for mobility aides. Specifically, occupational therapists evaluate patients' ability to perform ADLs (bathing, dressing, grooming, self-feeding, and functional transfers) and instrumental activities of daily living (meal preparation, home management, financial management, and driving). Occupational and physical therapists collaborate

to make recommendations to patients and their caregivers as applicable on any needed home modifications to ensure it is accessible (e.g., widening of doors, detachable shower hose, shower chair or transfer bench, need for a hospital bed, fabrication of ramps, and removal of rugs).

Whereas home health intervention addresses all the fall risk factors identified in the literature, those older adults who are not under the care of home health continue to be at risk of falls. The lack of interdisciplinary services available to older adults who do not receive home health is an issue that needs to be addressed. By offering preventative programs using the home health model, there is the potential to make a tremendous impact in the area of fall prevention among older adults. Currently, in El Paso, Texas, the University of Texas at El Paso Kinesiology Program offers a "Golden Age Program" to older adults who have available transportation to and from a recreational center. This is a community-based exercise program for older adults 55 years of age and older. It is a comprehensive fitness program that aims to improve overall health and functional ability of older community-dwelling adults. The Golden Age Program is an example of a university-community collaborative effort that utilizes kinesiology students as trainers. However, the program is not interdisciplinary and also does not include homebound older adults who may be at greater risk given the fall risk factors identified in the literature.

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ACADEMY NEWS

Welcome, New Members

The Academy welcomes the following new members who joined between May 1 and August 1, 2019.

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Arizona Center On Aging
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Lisa O'Neill

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Shahanshah Manzoor
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Pennsylvania

Dorothy Fisher

Tennessee

Gregory Gadbois
Jay Labine

Texas

Tacara Soones

Washington

Ebere Ugorji

Standardization and Innovation *Continued from page 5.*

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