Consortium on Aging
Strategic Plan
— 2015 —
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The long-anticipated aging of the Baby Boom is upon us. More than 20 percent of Texas’s population will be over age 60 by the year 2030, up by a quarter in under 20 years. Fortunately, it is not too late to act decisively to prepare. Nor is it too early.

In response to these identified needs, Dr. Giuseppe Colasurdo, president of UTHealth, has designated aging as one of its eight clinical priorities for the coming years in his 2015-2020 strategic plan. Under Dr. Carmel Dyer’s leadership, the UTHealth Consortium on Aging has assembled outstanding expertise across the spectrum of geriatric care and, most recently, organized that expertise to undertake a comprehensive strategic planning effort coordinated by Robert Mittman, an accomplished international healthcare consultant contracted to coordinate the process. Dr. Bryant Boutwell, a UTHealth faculty member and writer assisted throughout the process in the preparation of materials and the writing of this report including findings and recommendations presented here.

Findings

- The current approach to care for elderly patients typically reflects the shortcomings of the mainstream health care delivery system—fragmented, uncoordinated, inefficient, and with a focus on specialty procedures rather than on comprehensive care. With the complexities and vulnerabilities of elderly patients, especially those with multiple comorbid conditions, costs are high and outcomes are generally poor.

- UTHealth, the Consortium on Aging and its members, the Center for Healthy Aging, and other clinical enterprises in Greater Houston all have many effective approaches, which today are isolated in islands of excellence.

- UTHealth, with its six schools and its location in the Texas Medical Center, is uniquely positioned to make a bold strategic move to pull these isolated resources together into an integrated whole on behalf of its patients, Houston’s diverse community, and its health care providers, researchers, and educators.

Recommendations

- Develop a new clinical enterprise, the Pavilion for Healthy Aging, in conjunction with Memorial Hermann and other UTHealth affiliates. Put in place a comprehensive care delivery model care that includes a core physical facility with all relevant services present on site. Develop an
administrative model that supports evidence-based practice across the Pavilion. Link the clinical operations with the academic operations of the Consortium on Aging. Embody all of the principles the Consortium’s experience has shown to be effective in treating elderly patients:

- Integrated, one-stop geriatric care providing a full continuum of care
- Age-appropriate care of the highest caliber, without compromise
- Case management to meet the unique needs of elder patients
- Community and interprofessional education to support prevention and highly-trained professionals across multiple disciplines addressing elder care
- Geriatric best practices supported by rigorous evaluation
- Research supporting best practices and evidence-based care

- Evolve the role of the Consortium on Aging to bring the academic expertise of all six schools comprising UTHealth to bear on the operations of the Pavilion for Healthy Aging through the establishment of five Centers of Excellence—in cancer, palliative care, mental health, elder abuse, and trauma. Translate the academic know-how into effective geriatric clinical, educational, and research programs. Focus specifically on creating seven core developmental programs:
  - Patient assessment—build a platform (organizational and informatic) to incorporate and adapt existing assessment tools and to deploy them comprehensively in the Pavilion’s operations
  - Care delivery models—identify where high-quality care delivery models currently exist; integrate and scale them; conduct community needs assessment to identify and bridge gaps.
  - Administrative mechanisms and processes—develop and put in place administrative and informatics mechanisms and processes to make access to the best interventions “automatic” for all patients.
  - Public education—develop a public education/marketing communications capacity in concert with UTHealth’s Office of Public Affairs that can be employed by various projects, programs, and other initiatives.
  - Professional education—deliver practical geriatrics education to both patient- and public-facing professionals in the community (police officers, paramedics, social workers, etc.) and medical professionals.
  - Patient and family information and education—develop general information clearinghouses, patient-specific customized
communications, and social medial platforms for patients and their families.

- Research—develop research support tools and procedures to identify and publicize shared research agendas in aging, while creating an infrastructure to support a community of multi-center, collaborative researchers in the area. Research programs will develop a productive dialogue between the academic and clinical communities while building a critical mass of expertise with a range of research methods.

Overview

Our society is rapidly aging and becoming more diverse. The U.S. Census Bureau estimates that more than 20 percent of Texas’s population will be over age 60 by the year 2030, an increase close to 25 percent from 2012. As the proportion of Texans over age 60 grows, the proportion of Texans under 60 is shrinking. It has been estimated that by 2050, the number of people on Medicare who are 80 and older will nearly triple; the number of people in their 90s and 100s will quadruple.

The medical needs of the ever-increasing numbers of geriatric patients are both unique and complex and call for an integrated and focused approach. We face an impending crisis of care for the elderly in the Greater Houston Area and the nation at large if we do not address the shortage of caregivers addressing the specific needs of our aging population.

These trends call for immediate attention, nationally and locally, as well as action that integrates the delivery of care, education of the community and health professionals, and fosters research specifically designed to address the unique needs of our aging population.

There is a tremendous opportunity for UTHealth to position our program as the leading resource for geriatric care, education, research, and prevention in the nation. At present UTHealth, Houston’s health university, is better positioned than any other institution in Texas to step to the next level to meet the needs of our aging population.

UTHealth’s 2015-2020 strategic plan clearly outlines a commitment to lead in the development of advanced standards of care, models of delivery, and health care policy. Located in the world’s largest medical center, we are training the next generation of health professionals through our six professional schools. Our clinical expertise is expansive backed by a research mission focused on moving new knowledge to the bedside. Additionally, Houston represents the fourth largest city in America with a diverse population ideal for developing a program of excellence supporting the needs of our aging population.
The UTHealth Pavilion for Healthy Aging—a model program in geriatric medicine that is transformational in scope—is poised to capitalize on UTHealth’s strengths and strategic directions to address these impending trends.

About the Strategic Planning Process

This strategic planning process has been conducted over nine months, July 2014 through March 2015. A Core Team, consisting of the Consortium on Aging’s leadership and representing clinical care, community outreach, education, and research, has provided overall guidance and stewardship of the process, as well as provided a vision for the Consortium’s strategic direction. Five Working Groups, representing cancer, mental health, trauma, elder abuse, and palliative care, were assembled to assess the current situation, develop a vision in each of their clinical areas, and develop projects that would bridge the gap between where we stand now and their vision. A Synthesis Committee, consisting of the Core Team and the chairs of the Working Groups met to make sense of the strategic commonalities and shared directions across the five main clinical areas. A strategic consultant and a professional writer from within UTHealth were engaged to guide and document the process.

This report presents the strategic analysis of where the Consortium is and provides a roadmap for developing an integrated and innovative approach for geriatric care that will position the UTHealth Pavilion for Healthy Aging as a model program in the nation addressing the health of our aging population. It consists of a set of five recommendations for action, a vision of what the Pavilion could become between now and 2020, and a more detailed description and timeline of the actions that must be taken to make that vision a reality. An appendix includes a description of the strategic planning process (Exhibit A); a listing of the participants in the Core Team, Working Groups, and Synthesis Committee (Exhibit B); the results of an analysis of the Consortium’s strengths, weaknesses, opportunities, and threats (Exhibit C); an assessment of the Consortium developed through a series of 26 interviews with the Consortium’s leaders, members, constituencies, and critics (Exhibit D); a situation analysis conducted by the five Working Groups (Exhibit E), and short summaries of the 21 projects developed by the Working Groups (Exhibit F).

Recommendations

1. Adopt the 2020 vision and UTHealth Pavilion for Healthy Aging concept as described in this report to develop a comprehensive geriatrics program of the highest level. Use this vision as inspiration, a shared direction, and a checklist for future actions.
2. Put in place the UTHealth Pavilion for Healthy Aging—a physical presence, care delivery model, and administrative structure to allow the present Consortium on Aging to expand in scope and scale. Position this comprehensive, expanded initiative for growth and success at UTHealth by developing the Pavilion for Healthy Aging as an autonomous clinical enterprise affiliated with a strong clinical partner. Structure its academic activities, implemented through the Consortium on Aging, to report to the Office of the President of UTHealth to give it ready access to the participation and resources of all six schools.

3. Establish Centers of Excellence corresponding to the areas of specific clinical need identified in the Working Groups: mental health, cancer, trauma, elder abuse, and palliative care. Provide support for the academic activities of these Centers of Excellence through the Consortium on Aging while giving the clinical operations of the Pavilion access to their expertise (and giving them access to the clinical settings in the Pavilion for research and education). Provide opportunities for the members of the Working Groups to participate in the ongoing development of the Pavilion. They represent an invaluable resource of expertise and dedication to improving geriatric care in our community. The five Working Groups suggested 21 specific projects summarized in Exhibit F. Support the development of those projects.

4. Organize seven core developmental programs that will serve to translate and elaborate the work of the 21 projects developed by the Working Groups into clinically and academically operational programs for the Pavilion. Each listing below includes identification of the Working Group and project (i.e., EA15 is Elder Abuse Working Group, project 15 in Exhibit F).

   a. Logistics and Operations
      • Patient Assessment (Projects EA15, C09)
      • Care Delivery Models (Projects C08, MH03, MH06, PC18, T12)
      • Administrative Mechanisms/Processes (Projects T11, PC20)

   b. Education and Communications
      • Public Education (Projects PC19, EA17, T13)
      • Professional Education (Projects MH05, C10, EA16)
      • Patient and Family Information and Education (Projects MH01, T14, MH02)

   c. Research
Research (Projects C07, PC21, MH04)

5. In conjunction with using the Working Group projects as a roadmap to organize the overall program, share these projects with our Development officers. Each speaks to an important need and represents a compelling story with philanthropic appeal.

UTHealth Pavilion for Healthy Aging – 2020 Vision

This vision was developed through a series of interviews with key players in and around the Consortium on Aging, as well as through the work of the five working groups. It provides a synthesized view of what the existing consortium could become in the next five years. It is written in the present tense and is intended to provide inspiration, a shared picture of the future direction, and a checklist to verify that actions taken fulfill the Consortium’s potential reach and impact.

The year is 2020 and UTHealth is the go-to resource for geriatric care throughout our community and a model program in the nation. UTHealth is recognized throughout the Greater Houston Area and Texas as the leader in geriatric care thanks to the new UTHealth Pavilion for Healthy Aging.

Here one finds an integrated and comprehensive approach to geriatric medicine meeting the increasing needs of an aging society. Inpatient and outpatient services, housed in one location, are considered exceptional in quality and foster a continuum of care sensitive and responsive to the special needs Houston’s diverse population of older adults. Here geriatric specialists are training the next generation of health care teams focused on the needs of our aging population. Patients and their families find at the Pavilion a service-oriented and supportive continuum of care that no longer sends elder patients from one location to another in a piecemeal fashion.

The quality of care is of the highest standards in geriatric care as this program is designed as a model program in the nation with careful tracking of outcomes and cost savings. “Value” to the patient and family as well as to the health care system at large is central to the Pavilion’s approach.

Thanks to this program, community-wide resources that were once scattered and fragmented are now vetted by the Pavilion’s experts and accessible from a centralized resource. The program’s volunteer hotline and website is the go-to community resource for A to Z information covering geriatrics care and education. Whether you have an elder family member in your care and want information on fall prevention or contacts in the community to add a wheelchair ramp to your home, this
resource is handy and up-to-date. If you are a nursing home director wanting a speaker, or other timely information for your facility, the Pavilion is your first choice for vetted information. The Pavilion for Healthy Aging has greatly expanded educational resources already online on what was the Consortium on Aging’s homepage. Even back in 2014 the Consortium had logged electronic queries from more than 70 countries. The Pavilion has now greatly expanded the reach and the resources available to public and professional education.

Here researchers throughout Houston and the Texas Medical Center have electronic access to hot topics and current research teams and projects ongoing with an organized forum for collaborative efforts and sharing of interests, resources, and opportunities.

A quick inventory of media coverage of the growing need for coordinated geriatrics care will show that the UTHealth Pavilion for Healthy Aging is now the dominant source of information on all topics geriatrics. National media regularly turn to the Pavilion for its informed and comprehensive approach to geriatrics care. Throughout the country the number of Americans 65 and over has nearly doubled in the past decade and geriatrics care is the hot topic of the nation. Recent articles in JAMA and Health Affairs as well as reports aired on national network and news cable outlets continue to draw attention to the Pavilion’s comprehensive approach to geriatrics care. The Pavilion’s communications and outreach staff, working with UTHealth’s Office of Public Affairs, now requires a dedicated spokesperson to handle the positive media attention and community outreach requests.

Throughout the community, UTHealth geriatrics expertise is training health and social services professionals who are on the front lines of elder care. This includes first responders such as Houston police officers and EMS personnel who now have special training programs coordinated by the Pavilion. A new smart phone app places key information and vetted procedures at the fingertips of first responders when entering the home and is rewriting the textbook on how to identify elder abuse, potential falls, and other issues the elderly face daily.

A screening program for fall prevention, developed by the Consortium and implemented through the Pavilion, now requires additional staff to meet community demand. UTHealth, with its informatics expertise, has become a leader in developing trigger mechanisms, algorithms within the electronic patient record, that automatically identify high risk patients and situations along with preventive interventions designed to proactively prevent most costly hospital admissions and readmissions for the elderly. These algorithms recognize that “elderly” is not defined by chronological age, but by physiological age as well.

Pavilion on Healthy Aging research publications (spotlighting both academic and clinical research) are highly cited around the country and much in demand by
professional organizations who seek our UTHealth faculty and Consortium members representing this model program for presentations addressing elderly care, education, and preventive interventions.

The arrival of Dr. Carmel Dyer at UTHealth in 2007 led in 2010 to the establishment of a University-wide consortium comprised of UTHealth schools, community organizations, and invested individuals throughout the Houston-Galveston area. While UTHealth had been building a team and reputation in the field of geriatric medicine for the past two decades, the creation of this Consortium backed by the growing geriatric expertise at UTHealth signaled a new momentum in the field of geriatrics. Thanks to a 2014 strategic planning process looking to the future, UTHealth’s vision to build a name in geriatric medicine has paid off. UTHealth development officers have been able to make appeals to philanthropic organizations in recent years and the response has been impressive. Through our preeminent healthy aging program, UTHealth has successfully reminded the philanthropic community of the priority of funding programs in aging—a condition of life that each of us eventually experiences.

For two decades UTHealth had been carefully adding geriatrics expertise to the group practice. What had been in 2014 a strong program in geriatrics with exceptional talent became an initiative to develop the Pavilion for Healthy Aging in 2015 and not a moment too soon. Geriatric care requires a highly individualized team approach with outcomes that include complex ethical decision making and an understanding that quality of life must be factored in to every patient’s care plan.

Today the formerly fragmented resources and approach to elder care have become centralized, coordinated, and cohesive while supported by uncompromised and exemplary standards of care and customer/patient service. The Pavilion for Healthy Aging’s care processes, customer service procedures and standards, informatics systems, and other aspects of its infrastructure are sought out by other geriatrics centers from around the world.

In the world’s largest medical center, only one institution—UTHealth—is as well positioned with six professional schools to coordinate such a comprehensive and focused approach to geriatric care. The success of this program has not only provided excellent patient care, it has branded the Pavilion and UTHealth at large as an essential community partner addressing one of the great health care needs of our time.

**Developing a UTHealth Pavilion for Healthy Aging**

The concept is rather simple. Build a UTHealth Pavilion for Healthy Aging that houses all of the resources needed to support all aspects of geriatric health, well-being,
and medical care. This will be an integrated facility for addressing inpatient and outpatient services of the highest level to meet the needs of Greater Houston’s older adults.

The Pavilion for Health Aging will be developed around core principles or ideals:

- Centralized and integrated geriatric care providing a full continuum of care
- Age-appropriate care of the highest caliber, without compromise
- Case management to meet the unique needs of elder patients
- Community and interprofessional education to support prevention and highly-trained professionals across multiple disciplines addressing elder care
- Geriatric best practices supported by rigorous evaluation
- Research supporting best practices and evidence-based care

The Pavilion concept is visualized in the drawing on the following page. The essence of the Pavilion for Health Aging is to provide value in terms of improved functional and cognitive outcomes for patients, outstanding customer service for patients and their families, valuable educational opportunities for the community, all while reducing unnecessary tests, length of stay, complications, admissions, readmissions, and other costly and inefficient interventions.

Making the Vision a Reality

To bring this vision to life, the UTHealth Pavilion for Healthy Aging must develop a strong platform with an appropriate administrative structure, physical presence, care delivery model, staffing, and organizational capacities. In addition to delivering clinical care and conducting community outreach, it will be a center of research and education. It will assure clinical excellence with its affiliates including Memorial Hermann. Meanwhile, the Consortium on Aging and the five Centers of Excellence in mental health, cancer care, trauma, palliative care, and elder abuse will be supported by the best and brightest academics and practitioners in their respective fields throughout the Greater Houston Area. Such a program must be appropriately positioned within UTHealth to communicate the importance and significance of this undertaking. Finally, it must develop programs that support the operational and aspirational aspects of the vision.
Put in Place a Comprehensive Care Delivery Model

The care delivery model is a comprehensive approach that includes a core physical facility with all relevant services present on site, including:

- Multiple “entrances”—ways for the community and patients to access the facility and services, including an emergency room, outpatient clinics, and so on
- Publicly accessible facilities like classrooms and gyms
- A full range of outpatient clinics, optimized for the older patient’s medical, social, and economic needs, including management of multiple comorbidities
- A range of inpatient facilities, including a dedicated medical unit and a number of specialized elderly acute care units, such as cardiology, orthopedics, and others
- Additional specialized units, including long-term acute care, a skilled nursing facility, hospice, and palliative care
- Active outreach services, including house calls, elder abuse prevention and detection, fall prevention, and so on
- Excellent customer service and patient management, including case managers
- Signage and other navigation aids that are adapted to the geriatric population

The facility will include provisions for community, patient, family, and professional education. There will be substantial opportunities for research. The outcomes anticipated from this care delivery model include improved quality of life, cognition, and function, as well as decreased tests, emergency room visits, medications, hospital admissions, and nursing home admissions.

In addition to this core site, a network of affiliated facilities will use identical care and customer/patient services approaches to give patients a consistent experience no matter what facility they use.

Develop an Appropriate Administrative Model

It is essential that the UTHealth Pavilion for Healthy Aging have an administrative governance that supports its reach across the six Schools of UTHealth as well as governance for the membership of the Consortium representing community-wide expertise and resources for the program. The Pavilion for Healthy Aging must have
clear support from the President’s Office, perhaps a direct reporting relationship supporting collaboration and resource sharing across all six schools.

Naming and branding are important aspects of positioning the program, both within and outside UTHealth, to achieve the full vision stated above.

Although a specific organizational chart remains to be developed, the following functions will have to be assured:

- Patient Care
- Community Outreach
- Volunteer Coordination
- Quality
- Communications/Online Presence
- Education
- Research

All aspects of the program will embody uncompromised principles including:

- Dignity and respect
- Team-based care
- Technology, geriatrics focus
- Inclusive of families and caregivers
- Strong communications across the continuum of care.

As part of the process, an analysis of strengths, weaknesses, opportunities, and threats was conducted. That SWOT analysis is in Exhibit C.

Develop and Fund Programs to Embody the Vision

The Working Groups developed 21 specific projects that pointed the way to bridge the gap between where we stand now in five critical clinical areas in geriatric care (mental health, cancer, trauma, elder abuse, and palliative care). Those 21 projects were synthesized into seven core developmental programs. Those programs must be developed and funded as early building blocks of the Consortium’s strategy. The codes with each program represent the original projects from the Working Groups, presented in Exhibit F.

a. Logistics and Operations
• **Patient Assessment:** One of the key steps in delivering high-quality care to elderly patients is correct and comprehensive assessment of their situation and needs. This includes assessment of medical conditions in patients who may have multiple co-morbidities; assessment of family and other social support networks; risk assessment for abuse, falls, medication errors, and other potential problems; and so on. Although many clinically-specific or situation-specific tools exist, they are not integrated or deployed systematically. This program will gather, organize, and systematically deploy a range of assessment tools. The goal will be to build a platform (organizational and informatic) to incorporate and adapt existing assessment tools and to deploy them comprehensively in the Pavilion’s operations. (Projects EA 15, C09)

• **Care Delivery Models:** A key barrier to ensuring consistent quality and access to elder care is fragmentation and uneven distribution of care delivery across clinical areas and geography. In some cases, this reflects a lack of resources. In others, the fragmentation is merely a historical artifact of how the care delivery system evolved. This program will identify where high-quality care delivery models currently exist in the Greater Houston area and either associate the Pavilion with them and/or actively work to scale them up. Further, where there are gaps in services, the program will conduct needs assessment with the affected communities and work with the communities to develop effective models to bridge the gaps. To the extent possible, access to care in different clinical and social domains will be integrated through the physical and online presence of the Pavilion. (Projects C08, MH03, MH06, PC18, T12)

• **Administrative Mechanisms/Processes:** In a number of areas, including fall prevention and access to palliative care, evidence-based interventions exist that are known to improve outcomes and/or save costs that don’t routinely get selected. This program will identify those interventions and the barriers to them. It will then put in place mechanisms and processes to make access to those interventions “automatic.” This includes developing informatics systems to identify and analyze current patterns of care delivery, communicating existing and new evidence to administrators to get their support for the interventions, and developing mechanisms in the electronic medical record and the care delivery workflow, for example Medical Power Plans, to ensure that a standardized set of orders are implemented. (Projects T11, PC20)

b. Education and Communications

• **Public Education:** Numerous issues in aging are not known by the public, only partially understood, or even actively misunderstood by them. One component of many programs to address elders’ health issues is a public education campaign—raising awareness of fall risk prevention, informing people that
palliative care can be helpful well before hospice is needed, or providing strong messages that the current high rates of elder abuse are unacceptable and preventable, for example. The range and number of potential public education campaigns present risks and opportunities for the Pavilion. On one hand, the risk of message confusion and exhaustion is real. Further, following the communications instincts of advocates and subject matter experts may not lead to the most effective communications strategies. There is an opportunity to professionalize and coordinate communications about elder issues. This program will develop a public education/marketing communications capacity in the Consortium that can be employed by various projects, programs, and other initiatives of members of the Consortium. Further, this program will develop a coordinated approach to communications from the Consortium. This will mitigate the risk of message conflicts and overlaps, as well as capitalize on potential synergies, for example coordinating messages on mental health and elder abuse, or targeting specific messages to family caregivers. (Projects PC19, EA17, T13)

- **Professional Education**: There are two major aspects to professional education about elder health issues—education of medical personnel and education of non-medical generalists. Generalists include patient- and public-facing professionals in a wide range of industries and professions, including police officers, firefighters, paramedics and EMTs, social workers, bank tellers, letter carriers, delivery people, and others. This program will provide them with a range of training and other resources to identify and address both health issues and risk factors among the elderly clientele they interact with. It will include both traditional educational interventions and new tools (like smartphone apps) usable in the field. Example topics include identifying and reporting elder abuse, fall risks, etc. The program for professional education for medical personnel will include both building geriatrics capacity in professional specialties that are undersupplied, for example training geropsychiatrists, and cross-training medical professionals to identify and address (probably through referrals) geriatrics issues out of their immediate specialty, for example, training dentists to identify cancer recurrences, metastases, and side effects from cancer treatments. As with public education, the Consortium will provide both a capacity to develop and deliver professional education and a coordinating function to ensure efficiency and effectiveness. (Projects MH05, C10, EA16)

- **Patient and Family Information and Education**: Addressing the information needs of patients and their families is, perhaps, the most complex, diverse, and variable communication and education task faced by the health care system. Across the lifecycle of a given disease, from awareness, through prevention, screening, diagnosis, treatment, and follow-up; across the different
characteristics of patients—cognitive status, health status, language, culture, education; across the level of engagement of family members, from complete patient isolation to active and engaged family caregiving—there is a staggering number of possible combinations. This program will provide a capacity for three types of information and educational intervention for patients and their families. Working Groups have proposed projects that carry out each of these three types of education/communication in specific clinical areas. (Projects MH01, T14, MH02)

− First will be information clearinghouses. These resources, accessible online (and possibly by phone and in print) will gather and provide up-to-date, current information about a wide range of geriatric health and medical issues. They will provide both general information about the issues and information about specific resources in the Greater Houston area. To the extent possible, these resources will indicate actual availability of services. To the extent possible, the clearinghouses will draw upon existing information resources, rather than require developing new content.

− Second will be customized communications for the patients and their families. These will be periodic, direct communications (by e-mail or on paper) with patients and their families that are customized to fit the specific situation and anticipated needs of the patient, given his or her stage of care, language, culture, preferred method of communication, and so on.

− Third will be the development of a social media platform for patients and their families. This will enable patients and their families to communicate and share experiences with others in similar situations, as well as provide access to health care professionals.

c. Research

• Research: As part of the Texas Medical Center, the Pavilion for Healthy Aging and UTHealth are at the center of a formidable research apparatus. The clinical and academic resources are extensive and powerful. The patient base is second to none. The Pavilion concept has the opportunity to be the epicenter of geriatrics research in the TMC and beyond. This program will develop a range of research support tools and procedures to identify and publicize shared research agendas in aging, identify and catalyze potential research collaborations, link researchers and collaborations to relevant research resources and support organizations, provide an infrastructure to generate seed grants and other
research funding, connect students to research projects, and increase participation of older patients in clinical trials and other medical research. (Projects C07, PC21, MH04)
Exhibits

The following documents elaborate and provide additional detail on the following topics:

- Exhibit A – The Strategic Planning Process
- Exhibit B – Composition of Working Groups and Synthesis Committee
- Exhibit C – SWOT Analysis
- Exhibit D – Community Assessment Report
- Exhibit E – Situational Analysis by Five Working Groups
- Exhibit F – Short Summaries of Working Group 21 Project Proposals
Exhibit A- The Strategic Planning Process

Developing a clear vision of community needs and opportunities for UTHealth requires a strategic approach and guidance. The process began by identifying an external consultant, Robert Mittman, who is well-versed in large strategic planning activities with extensive national and international experience facilitating large-scale strategic planning activities for the health care sector and a professional writer, Bryant Boutwell, who has long and deep experience within UTHealth and the Texas Medical Center.

Stakeholder Interviews

A series of 26 UTHealth stakeholder interviews were conducted among leadership, members, external constituents, and other leaders throughout UTHealth. The purpose of the interviews was to understand the Consortium’s context and current situation, and to gather ideas about possible elements of the Consortium’s future direction. A brief report (Exhibit D) outlines the context for the Consortium, an assessment of its current status, and some ideas about a vision of the future of the Consortium. Striking in the interviews is the overall strong support those interviewed express for the work of the current Consortium on Aging under the leadership of Dr. Carmel Dyer. The report identified a number of identity and branding needs along with an endorsement for expansion to meet the needs of our elderly population and the opportunities UTHealth to be branded as the leader in geriatric care within the Texas Medical Center and beyond.

Core, Working Group, and Synthesis Committees

A Core Team consisting of Dr. Carmel Dyer; leaders representing the Consortium’s work in clinical care, community outreach, education, and research; the development office; and administration formed to provide overall leadership and guidance for the process. They identified more than 60 individuals (Exhibit B) representing a wide spectrum of geriatric care expertise to form five working groups:

- Mental Health (MH)
- Cancer (C)
- Trauma (CT)
- Elder Abuse (EA)
- Palliative Care (PC)

It should be noted that few institutions in the nation could assemble this level of expertise—each member a highly experienced health care or social services professional addressing geriatric care and needs on a daily basis. Membership included, among others, physicians, nurses, social workers, public health professions,
oncologists, informatics expertise, a member of the Houston Police Department and a county judge. These working groups represent front line expertise addressing the needs of the elderly.

A Synthesis Committee, consisting of the Core Team and the co-chairs of the five Working Groups, was formed to pull together the results of the Working Group’s efforts and to make sense of the whole.

Working Group Process

Each working group met for two half-day sessions with the consultant. Working together as a planning team they quickly bonded and were led through a series of carefully structured activities designed to identify by working group the current state of their field (Exhibit E), a desired future the working group would like to see in five years, and the gaps that currently hinder us from getting to that future state. All of this effort also serves as a roadmap for identifying and implementing new interventions and solutions for the future. One unique feature of these working sessions was the presence of a graphic illustrator who in real time illustrated on the board the ideas and discussion as it evolved, providing a parallel representation of the group’s thinking process.

The groups then prioritized those identified gaps and identified projects for development that would address these needs, provide a roadmap for organizing an enhanced programmatic structure, and provide development officers with compelling stories addressing high priority needs in the field to support future funding opportunities.

Working groups then split into subgroups to develop these project programs to be presented for working group review and input during the second half-day session. In all, 21 projects across the five working groups were developed. Dr. Boutwell, then worked with Robert Mittman to summarize the current state summaries, gap analysis, and the 21 projects created by the working groups. A summary sheet for the projects is included in this report (Exhibit F) and full project descriptions (approximately 3-5 pages per project) are available upon request.

As the working groups came together for their second half-day session, these projects were presented and fine-tuned with group input and organized/batched in a structural way (research, education, patient care, etc.). Thus these projects not only provide a series of individually-fundable “stories”, taken as a whole they help point toward the shape the most effective organizational structure the larger entity that houses this effort could take, whether the final program is named a UTHealth center, institute, or some other name.
Synthesis Committee

The Synthesis Committee reviewed the work of the five working groups and convened to synthesize a leadership vision with a programmatic organizational structure to support a premier geriatrics program at UTHealth second to none. The Working Group recommendations regarding the current state and desired future state along with project proposals for closing gaps were helpful and essential for the Synthesis Committee’s planning.
## Exhibit B - Composition of Working Groups and Synthesis Committee

<table>
<thead>
<tr>
<th>Strategy Synthesis Committee</th>
<th>CORE TEAM</th>
<th>Synthesis Committee</th>
<th>Working Group Chairs</th>
<th>Ex officio:</th>
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<td><strong>Strategy Synthesis Committee</strong></td>
<td><strong>CORE TEAM</strong></td>
<td><strong>Synthesis Committee</strong></td>
<td><strong>Working Group Chairs</strong></td>
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<td>Carmel Dyer</td>
<td>Kathleen Murphy</td>
<td>Barbara Tilley</td>
<td>James Booker</td>
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<td><strong>WORKING GROUP CHAIRS</strong></td>
<td>Jason Burnett</td>
<td>Charles Wade</td>
<td>Caroline Ha</td>
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<td>Victoria Titterington</td>
<td>Elda Ramirez</td>
<td>Casey Vasta</td>
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<td>Trauma</td>
<td>Palliative Care</td>
<td>Mental Health</td>
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<td><strong>Working Group Members</strong></td>
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<td>Nahid Rianon</td>
<td>Phylliss Chappell</td>
<td>Renee Flores</td>
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<td>Catherine Ambrose</td>
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<td>Cristina Bocirnea</td>
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<td>Josh Reynolds</td>
<td>Russell Short</td>
<td>Laurie Schuler</td>
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<td>Frances Stokes</td>
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Exhibit C- SWOT Analysis

The Core Team conducted a SWOT analysis to assist the ongoing planning and program development process as presented below:

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<th>Strengths</th>
<th>Opportunities</th>
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<td>Demographics on our side</td>
<td>Society’s view of the value of older patients</td>
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<tr>
<td>Support from the President</td>
<td>Other groups have not done this work well—we can</td>
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<td>Development team support</td>
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<td>Talent</td>
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<th>Weaknesses</th>
<th>Threats</th>
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<td>Need to have buy-in from other departments</td>
<td>Staffing for the needed knowledge, skills, and attitudes</td>
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<tr>
<td>Need to have buy-in from providers</td>
<td>Financial viability—need a business model</td>
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<td>Government funding could change</td>
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<td></td>
<td>Society’s view of the value of older patients</td>
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<td>Someone will copy us, but not do it well</td>
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Exhibit D - Community Assessment Report

Consortium on Aging Assessment Report

This brief report is a synthesis of 26 interviews with the Consortium on Aging’s leadership, members, external constituents, and other leaders in the UT Health system. The purpose of the interviews was to understand the Consortium’s context and current situation, and to gather ideas about possible elements of the Consortium’s future direction.

Context for the Consortium’s Future

The opportunity for the Consortium to expand in scale and scope is timely. The elderly population is set to double or triple by 2030. As Baby Boomers and their parents age, they will affect each institution they touch, including all aspects of geriatric care. There is an opportunity to expand the focus on their geriatric care beyond illness and death to include healthy aging. The Boomers are diverse in many dimensions, including education, socio-economic status, ethnicity, and so on. The existing supply of geriatricians is not adequate to serve the current population, let alone the projected growth in older adults. At the same time, the geriatric work force is becoming, well, geriatric themselves.

The Greater Houston setting provides particular challenges for the elderly. Certain parts of the metropolitan area face high levels of poverty, with attendant lack of education and poor diet. The extremes of the climate, both hot and cold, present physical difficulties and risks, as well as high costs for heating and cooling. Housing in some areas is decaying, with mold from flooding presenting particular health risks. Lack of transportation makes it difficult to access the scarce health care services for elders that do exist. Elders face abuse and neglect—medical, physical, emotional, environmental, and financial—including self-neglect. Funding social services is a relatively low priority in the State.

In an environment that doesn’t tend to the basics of managing medications, nutrition, hydration, and the home environment for the elderly, they are at risk for medication- or dehydration-induced dementia and disorientation—all risks for falls, accidents, and other trauma. Once admitted to the hospital and released, there is a high risk of readmission.

The growing importance of aging is not lost on the UT Health administration—it has made aging one of its eight strategic clinical priorities. Nonetheless, the Consortium operates in an institutional context that remains very siloed, with a lack of integration between different clinical specialties, including mental health, dentistry, and many
medical subspecialties. Funding is increasingly tight, with less surplus available from clinical activities to fund research and education. Given the importance of clinical income overall in the UT Health system, clinical operations sometimes trump its academic focus. At the same time, the Schools of Public Health, Nursing, and Medicine are all recruiting new deans right now. This is an opportunity to get someone with a focus on aging in each seat.

**Current Status of the Consortium**

The Consortium has grown substantially, in scope and in scale, in its five years of existence. Along all measures—membership, affiliated clinical operations, educational programs, research projects conducted and funded, and so on—it has had a growing presence and impact. To the extent that they understand it, people like what the Consortium is, what it represents, and what it's doing. But they don’t, on the whole, actually understand it well. They have a strong sense of its potential, and especially a high degree of faith in Carmel Dyer’s leadership.

There is not a commonly held view of the Consortium's identity.

- Although many do understand that the triangle of clinical care, research, and education is core to the Consortium’s identity and activities, there is a little bit of “the committee of blind men describing the elephant” in how people understand it. Specifically, there is more understanding of and identification with the Consortium’s clinical services than with research or education. Not many are aware of the full scope of research activities.
- The Consortium is not seen to be in the mainstream of academic life—it does not touch the majority of students and is only visible to selected faculty members.
- The Consortium’s existing strategic plan emphasizes treatment, not prevention and wellness.
- The Consortium’s “virtuality” has worked against it building a clear identity. Having a physical space would help anchor the perception of the Consortium as being tangible and “real”.

The organizational status and scope of activities of the Consortium are also not clearly understood.

- The identity of the Consortium is confused by some with that of the Division of Geriatrics and Palliative Medicine in the School of Medicine.
- The names “Consortium on Aging”, “Center on Aging”, and “Center for Healthy Aging” are sometimes confused.
• Other Schools and Divisions, even those such as Nursing and Trauma with faculty who are members of Consortium, have sometimes conflicting identities and priorities.

• Some faculty have an idea that the Consortium will support their research or them getting research grants. It doesn’t do that, so they’re disappointed.

The Consortium has not yet reached its potential.

• Geriatrics is only a small part of what most clinicians do, even among those clinicians such as oncologists whose patient base is older. Few identify it as a priority, even though their practices would benefit from a Geriatrics point of view.

• Some members of the Consortium’s Advisory Committee, even though they have been associated with the Consortium for a long time and have been involved in its strategic thinking, don’t have comprehensive knowledge of the Consortium or a strong sense of responsibility for its direction or strategy. They defer to Carmel Dyer for that.

The success of the Consortium, as it stands now and as it’s evolving presently, depends critically on Carmel Dyer. A number of the interviewees mentioned concerns that she is over-committed. (These interviews were conducted before Dr. Dyer left the position as Division Director, so that perception may be less pronounced now.)

The upshot is that the timing of this strategic planning exercise is opportune. There is a huge degree of good will and interest in the success of the Consortium. This is the time to create clarity of goals and structure, identity and membership/involvement, and priorities and expectations.

**Vision for the Consortium**

There is both an appetite for and a good supply of vision for the Consortium (and whatever it evolves into). Many interviewed agree strongly about the basics—that it should continue to focus on excellence in clinical care, community outreach, education, and research; that it needs a physical presence; that its geographic scope should increase to or beyond greater Houston for clinical care and globally for education and research; and that it must reach deep into the communities it serves. They further agree that the organizational form and identity should be free-standing and have reach across the Schools of UT Health. A clear business plan is needed that ensures financial self-sufficiency in time, has clear phasing, and embodies the basic principle of “think big, start small”.

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The Consortium, or whatever it grows into, must have an organizational status that supports its growth in scope and scale. It should be chartered within UT Health (rather than within the School of Medicine or the Division of Geriatrics). It should include connections with the Schools of Medicine, Nursing, Dentistry, Public Health, Biomedical Informatics, and Biomedical Sciences. It should continue to have associations both within and beyond UT Health.

- The organizational form should give it considerable autonomy. It could be chartered as an Institute or some form with comparable autonomy.
- Its top leadership could include Carmel Dyer, an operationally-oriented co-lead, and the President of the University.
- The Consortium must have an institutional anchor—a free-standing Center or Institute, reporting to the President, with its own budget, physical space, faculty members, etc. It should have the resources to buy out faculty’s time to participate.

There is a core strength in clinical care that must be perpetuated and scaled up. The Center for Healthy Aging represents a good starting point for the clinical care model.

- Physicians and other clinicians can spend enough time to care for patients and their families well.
- Patients and their families are 100 percent convinced they’re getting the best care.
- The care extends lives in very healthy ways and benefits patients and their families.

In addition to the focal point of outpatient care, the clinical care must extend across the medical spectrum, as well as upstream into social services. It must have high quality at each stage or the system as a whole fails. Some of the key elements include:

- Home visits to troubleshoot the home environment, nutrition, and medication management.
- Geriatric emergency care.
- ICUs, medical wards, and rehab hospitals, all adapted to elderly population.
- One-stop shopping for outpatient care, management of chronic disease, mental health, dental care, occupational therapy, physical therapy, and so on.
- Education for patients, their families, and the general public.

A core physical location that includes as many of the services listed above as possible is key to the Consortium’s success and growth. In addition to the central physical location, there should be associated clinics in many parts of greater Houston.
Moreover, the organizational norms for staffing, customer service, information management, and so on developed by the Consortium should be spread to other facilities that service the older population.

The Consortium must maintain the strength of all four of its central pillars—clinical care, community outreach, research, and education. The Consortium’s future core location and community “satellites” are an ideal focal point to integrate education and research with clinical care.

Although the geographic scope of the clinical services is difficult to scale up outside of Greater Houston, with telehealth services, it is possible to envisage reaching throughout South Texas, and even beyond. A national and even international presence are plausible for the Consortium’s research and education activities.

- The research focus should expand substantially to many issues of aging beyond the existing core strength in elder abuse and neglect.
- The Consortium has a strong opportunity, given the diversity of the population in greater Houston, to increase its multicultural emphasis.

The Consortium should aspire to build a geriatrics perspective into many of the institutions that touch older people, including transportation, city government, as well as all clinical care.

- The Consortium should increase its training capacity for clinicians-in-training in all relevant disciplines and medical specialties.
- It should be a voice in the community for considering geriatric issues in all aspects of community life.
- It should link with churches, temples, mosques, and other faith-based organizations, both for outreach and funding. Organizations that may be receptive include St. Martin’s, St. John the Divine, Temple Beth Israel, and the Catholic Archdiocese.

A clear business plan is needed that ensures financial self-sufficiency in time, has clear phasing, and embodies the basic principle of “think big, start small”. In time, the Consortium must become self-sustaining without continued grant money or money from the President’s Office. In addition to clinical revenues, possible revenue streams include charging for education; consulting revenues, such as helping institutions plan their delivery systems for elders or helping develop naturally occurring retirement communities (NORCs); and elder mediation.

There are ways to improve how the Consortium tells its story to non-academics and to the community, emphasizing positive messages, such as “We want a city where our elders are aging healthily and thriving.” One of the keys to success is establishing the Consortium in UT Health as an “action place”—a place where things get done.
Exhibit E – Situational Analysis by Five Working Groups

Each working group was asked to define the situation as it exists today.

Mental Health Working Group – Situational Analysis

- We need more geropsychiatrists. UTHealth has 65 faculty in psychiatry; only two specialize in mental health issues for the elderly. There is a shortage of clinicians in this area.
- We need teams in place that focus on the special needs of the elderly so crises don’t slip through the cracks.
- There are gaps in knowledge and in practice of mental health care for the elderly. We don’t understand loneliness, depression, and dementia in that population. Frequently, depression and anxiety go together in elderly patients. We don’t have adequate detection and interventions. Even though we have the technology to diagnose mental health needs among the elderly, few can afford it. Many professionals, from law enforcement to first responders to primary care providers don’t understand dementia or the difference between dementia and delirium.
- Home health care providers need more training. Currently their pay is low and their training is often minimal. We can do better. Burdens on families are high; we need more educational and support services for families. Mental health slips lower on a family and individual priority list when access to food, shelter, and a safe environment is not assured. Families are not educated about the mental health needs of their elderly relatives.
- We live in a young city and the elderly mental health needs don’t get the attention they deserve. In Houston we do a better job of tending to the homeless than the mental health of elderly.
- The unmet needs of mental health among the elderly in this community are high. Diagnosis and access to care is a big problem. We do not have the inpatient care services needed.
- In theory, there are plenty of social services on paper. In practice, getting access to social services for an individual patient is much more difficult. Even if services are available, reimbursement may be a problem.
- Oral health among the elderly is neglected and creates anxiety and depression. More than 500 prescription drugs cause oral health problems. Moreover, drug interactions are a big problem among the elderly. Polypharmacy is a growing problem.
• Medicare Part D coverage creates a “donut hole” problem—a gap in coverage of between $2,800 and $4,550 in medication expenses that must be paid out of pocket by elderly Medicare recipients.

• More health care providers need to go to the homes rather than wait for elderly to come to clinics or other sites of care. Baylor has a house calls program.

• Medicare takes a few months to get in. For inpatients there are long wait times and a shortage of beds.

• There is a serious maldistribution of resources in our community.

• If you have money you can get the care you need. If not, it is very difficult and time consuming, especially when you are on a fixed income and living in a city like Houston with mobility issues.

Cancer Working Group – Situational Analysis

• Our population is aging and our ability to diagnose the disease continues to improve. Given the fact that cancers generally correlate with aging means we should plan now for an increasingly elderly population living longer with associated co-morbidities requiring even greater demands for chronic long-term care and follow up.

• We must recognize that screening guidelines don’t adequately cover the elderly. In fact, our current thinking on how we define elderly are not consistent given there is a big difference between physiological age and chronological age.

• As our population ages and our societal perception of how we define “elderly” blurs, we increasing face the difficulty of measuring the competence of the elderly as individual decision makers. Nothing is more important to the elderly than their independence, yet their individual capacity to maintain that independence varies greatly and requires improved assessment capabilities with both the needs and expectations of the patient and family members in mind.

• We just don’t have a good way of addressing geriatric patients. Measures of fitness and frailty don’t always mesh with the patient’s ability to handle the therapy.

• We need to do a better job of understanding the elderly patient’s goals when it comes to quality of life as it relates to living alone with cancer rather than dying well. We live in a throw-away society and the unique needs and feelings of the elderly are increasingly ignored.
• Elderly patients are living longer with multiple co-morbidities and treated by multiple care providers who often fail to communicate and share patient-specific information leads to polypharmacy issues that must be addressed.

• We need to incorporate geriatric patients into clinical trials. There are many biases among pharmaceutical companies, society, and health providers that keep the elderly out of trials. The lack of representative elderly population in clinical trials should be addressed to produce the evidence-based medicine needed to guide patient care protocols for the elderly. Professional organizations should evaluate the need for specialized sessions devoted to geriatrics research.

• It is especially difficult for the elderly to navigate the system today given the many options and complexities of care. Family support structure varies greatly among the elderly and many geriatric patients are limited in their ability to physically get to the care they need and once there, they face greater challenges dealing with the complexities of multiple appointments by multiple specialists in multiple facilities. The elderly have greater difficulties dealing with change, are more rigid in their patterns of daily living, and most likely to be on a fixed income. These added stressors need to be better understood and accommodated by health care providers.

• There are disparities in elderly cancer care for minority communities that deserve more attention. Cultural sensitivities do impact compliance and outcomes and tend to get lost in the mix of detection, treatment, and follow-up care of elderly cancer patients.

• We need more attention paid to mental health and allied health services as the follow up of living longer with cancer and after cancer cure drives an increased need for primary care providers and specialists to communicate and coordinate care and services at a higher level.

• Let’s not forget the important role dentists play as the mouth is a window to our health and many cancers or recurrence of cancer (including second primaries) are first detected in the dentist’s chair. Likewise, advanced treatments including radiotherapy and chemotherapy lead to detrimental effects on the teeth that create special needs among the elderly population that need more attention by all health care providers.

**Trauma Working Group – Situational Analysis**

• The community generally lacks awareness of trauma among the elderly and needs more education, especially in the area of prevention and risk reduction for falls.
• Most geriatric patients are educated about risks only after an accident has occurred. More emphasis on safety in the home and how to create a safe home environment is needed.

• Health care professionals do not focus sufficiently on prevention in general and, especially, on home safety, competence to operate motor vehicles, polypharmacy, and other risks for falls, accidents, and other forms of trauma.

• Health professionals need more education about the physiology of aging with a multi-system approach to treating the elderly. Likewise, they need a common language for elderly care.

• We need better ways to define who is elderly given there is a big difference in chronological age and physiological age. We should be individualizing our approach and using existing scales (frailty scales, etc.) rather than treating all over 65 as a homogenous group we call “elderly.”

• Dental professionals lack training recognizing elderly health issues that contribute to trauma risk. They could contribute to risk reduction.

• We are not using technology to its potential for physician/patient and peer/peer communication related to risk reduction and follow-up post-trauma and acute care.

• Reduction of mortality and improved trauma care along with longer life spans leads to a growing proportion of elderly in our society with chronic conditions, higher risks for trauma, and polypharmacy issues.

• Our population is not only living longer, they are working longer and exposed to more job-related injuries.

• The elderly are typically on fixed incomes and many delay care for financial reasons. Those receiving medical care are moved out of care too fast, leading to more post-hospitalization injuries and reoccurrence of falls and other trauma.

• Families are increasingly leaving the care of the elderly to others and ignoring the needs and risks of independent living beyond the individual’s realistic ability to maintain an independent life style. This includes the fact that elderly are driving motor vehicles beyond their abilities.

• We live in a throw-away society that does not honor the old. There is a general lack of awareness in the community about aging issues. Our younger generation does not have an attitude of caring for the elderly.

• There is a major lack of transportation for the elderly, especially in the Houston area, with implications on access to care and continuity of care for the elderly.
• Our caregiver population for the elderly is aging as well, assuring a future shortage in trained professionals for the elderly if we do not address the pipeline of future health care professionals. Programs are needed to increase their career awareness and interest in geriatric medicine.

Elder Abuse Working Group – Situational Analysis

• Effective interventions to prevent elder abuse don’t exist; in fact we don’t even know what interventions are needed.

• Elderly abuse is a growing problem and we need to stop it. It is under-reported. Estimates are that only 4-5% of cases get reported and the others are hidden in the community for numerous reasons. Frequency of self-neglect ranks highest among all categories of elder abuse (65% by some estimates) but we need more and better incidence and prevalence data.

• Awareness of elder abuse is commensurately low. In contrast, child and spousal abuse have higher levels of public awareness; elder abuse is largely lost on the national radar screen. Consequently, we are in a reactive mode after abuse has occurred. We need to get into a preventive mode, create awareness, and develop effective interventions.

• Many public and private service providers—mail carriers, police officers, delivery people, Meals-on-Wheels delivery people—have frequent interactions with the elderly. These potential “gatekeepers,” who get into homes frequently, could be used to observe for forms of abuse. We are just starting to put programs together to do this and we need to do more. Programs like Meals on Wheels touch households (6,000 per day) and these individuals making even brief visits within the home can be trained to observe potential risk factors and red flags for elder abuse risk or occurrence. There is a need for training volunteers and others as gatekeepers.

• HPD has programs to educate law enforcement but they need expanding. Officers know the law but not what to look for. We have to have trained officers to look on the scene for elder abuse and not assume an elderly victim has a natural death because they are old.

• More access to services is needed. Many of the services that do exist are episodic and reactive in nature. They tend to be focused on closing a case rather than addressing root causes or creating a long term solution. Moreover, the services that exist are fragmented—they are out there but a single network or coordinating group that can help connect all the dots and get the word out
doesn’t exist. Adult Protective Services (APS) is the front line of prevention but awareness of services, funding for services, and personnel are insufficient.

- We need to evaluate the services that are there, identify and promote the good ones, create others to meet needs.
- Homecare providers (family or paid) lack information on these issues as well as awareness of services. Training programs to provide information, efficacy, assistance, and channels to report abuse are needed.
- We live in a throw-away society and elders do not get the respect or value they deserve. “Ageism” seems to encompass all aspects of this field with a community attitude (lay public and many health professionals) that “they’re just old, that’s what happens.”
- We need more education programs for the community, care providers and health professionals, and the elderly themselves.
- The cognitive status of some elderly people is low and that increases the risk for abuse.
- Although socioeconomic factors are at play, elder abuse occurs in every economic stratum.

Palliative Care Working Group – Situational Analysis

- There is much confusion between palliative care and hospice care. Even though they are often considered as one and the same, hospice care is but one resource to which palliative care providers can guide a patient and family.
- We need more information in the hands of the community and health professionals about what palliative care is.
- We need to talk to patients about what they want before, not after, they can no longer make their own decisions.
- If brought in earlier in the course of treatment, palliative care providers can be the ally of patient and the health care team. They provide much more than the perception of last resort care at the end of life.
- Palliative care is not integrated into the care of patients through the continuum of care as it should be but often considered only when the patient’s physician has given up all treatment.
• There is a lack of communication about bringing palliative care in earlier in the course of treatment and, especially, during “handoffs” of patients between providers or sites of care.

• Patients are living longer with more co-morbidities. Palliative care professionals can provide many services to the patient and family and serve as a guide within the medical team’s care.

• Palliative care services vary by region. There are strong programs in Wisconsin and Minnesota as well as the West Coast, with the Midwest lacking. In Texas palliative care has a stronger presence in urban medical centers like the Texas Medical Center and is much less available in rural counties.

• Palliative care requires a collaborative team spirit. Palliative care providers have to be included as part of the team and not treated as an outsider, last resort service. Typically, however, they are brought in as last resort.

• Billing codes hamper palliative care providers’ acceptance by their peers as they have to code for a symptom before coding for a palliative care measure like pain management. Because the symptom the palliative care physician must bill for may overlap with another physician’s coding they are often viewed in competition with other services and not needed. Moreover, multiple providers, such as a physician and a nurse practitioner, can’t bill on the same day for the same code. Thus, if two billings for pain management are made in one day, only one is paid.

• Compared to seven years ago at Memorial Hermann Texas Medical Center, the resources for and availability of palliative care have increased more than the perception of value on the part of other medical specialties has.

• Palliative care home visits give providers access to the front end of care, preventive approaches, and quality-of-life issues working with the patient and family on a long term basis. There is much room for an increase in home visits.

• There is a law to report elder abuse but Adult Protective Services has tied hands. Many elders suffering some form of abuse are competent and reluctant to report family members or family friends. They are isolated. We need to value their autonomy but in many cases it limits the abilities of agencies to intervene. For children we can take control on capacity issues, for adults, it is much more difficult to assess competency and gain control of a bad situation that is tolerated.

• Financial abuse (typically by a family member or friend) is a low risk business with little downside for the perpetrator. Banking and other financial systems could be engaged to detect or flag patterns of financial exploitation.
• Our courts address elder abuse issues but it is hard to prosecute many of these issues, as family dynamics and questions of individual autonomy and decision-making are often involved.

• Many cases of homicide are not investigated or under-investigated due to “ageism,” and other biases including first responder training, personnel and financial resource issues, awareness. Only three agencies in the Greater Houston Area out of hundreds have mandatory elderly abuse training.

• We have a large undocumented immigrant population at Harris Health who are not recognized by probate court and have housing issues and insurance issues. They don’t have access to case management or advocacy resources and get lost in the mix. Harris County probably doesn’t have the resources to provide housing and other services to that population. There are complex issues of justice at play for border states like Texas and the nation as a whole regarding allocation of services and resources for citizens vs noncitizens.

• The county has plans for an elder forensic center. Its implementation is considered not soon enough.

• Too many elderly are living in isolation with diagnosis of mental health issues too late. Many elderly simply live in misery.

• We are not using technology to address loneliness and connect with the elderly. Robots and new, innovative technologies do exist.

• There is little or no integration of information among care givers.

• The Affordable Care Act provides more with insurance but reimbursement rates are low or at least that is the perception among many physicians.
Exhibit F – Short Summaries of the Working Groups’ 21 Project Proposals*

*Full write-ups for each of these 21 project proposals are available upon request.

**Mental Health Working Group**

01: Developing a Mental Health Clearinghouse for the Elderly

Develop a comprehensive online resource of mental health resources for the elderly. The site would include up-to-date and vetted educational materials for families and elders on medical conditions, treatments, and providers. It also would support health care professionals, including research and clinical care resources, information on researchers seeking collaboration, providers seeking other providers, and so on.

02: COPE—A Support Program for Caregivers

Centering on Patient Education (COPE) is a proposal to address the informational needs of patients and caregivers through a semiannual, personalized, targeted newsletter for people with a given mental health diagnosis (print and electronic distribution formats). This newsletter would be supported by UTHealth with a multidisciplinary editorial advisory team assigned to identify and prioritize topics for development and inclusion. Team members would have expertise to identify and develop prioritized medical topics as well as community resources. The newsletter’s goal is to provide patient-friendly, non-medical-jargon literature on stages of the disease, variations in disease, and expectations of progression.

03: Building a Better Model for Coordinating Care

Develop a model of coordinated care in the Greater Houston Area for elder mental health patients and individuals at risk. Beginning with a needs assessment and a broad conceptual model of coordinated care that depicts the full range of services to be provided, identify existing resources and gaps in care. Bring those together into a model that overcomes the existing fragmentation and siloization of care.

04: Brain Matters: Finding the Biological Cause of Mental Health Disorder

Develop a central entity that catalogues needs in mental health research and facets of research support (available clinics with which to collaborate, research core facilities, local and national funding agencies, etc.). This resource would facilitate collaboration
among interested and skilled researchers and clinicians, identification and pursuit of research priorities, linkage to research resources and support organizations, an infrastructure to generate seed grants and other research funding, and access to patients and community populations.

05: Training Programs for Mental Health Professionals

Develop a fellowship training program to train geriatric psychiatrists. Establish a geropsych inpatient unit at UTHealth Harris County Psychiatric Center (UT UTHealth Consortium on Aging 2 Synopses of Working Group Reports HCPC) to provide the core component for this fellowship training program. Hire two additional geropsych faculty and establish working relationships with local area nursing homes for a necessary added component of this training. Plan, develop, and implement a specialized geriatric nursing training program with UTHealth School of Nursing.

06: Bridging Mental Health Service Gaps for the Elderly

This project intended to address the gap in services for older adults with mental health needs, including availability and coordination of elder-specific mental health services and inadequate funding of needed services for underserved elders. Rather than develop a separate program, the Working Group recommends that UTHealth Consortium on Aging become an active member of the already existing collaborative effort led by Care for Elders. UTHealth’s network of clinics and its expertise in the delivery of comprehensive geriatric care (medical care and mental health) and education of the interprofessional workforce caring for elders would provide new and welcomed resources.

Cancer Working Group

07: Supporting Geriatric Cancer Trials

Many cancer clinical trials do not provide good evidence for treating elderly patients with cancer. The elderly are under-represented in trials involving new cancer therapies. The TRials in Older Oncology Patients (TROOP) Program will link oncology trialists with healthcare providers with geriatrics and gerontology expertise. The program will help trial designers to reduce barriers to enrollment for older patients and provide consultative guidance on measures and outcomes important for geriatric patients with cancer.
08: Creating a Personal Navigator System for Geriatric Cancer Patients

“Addressing the Needs of the Elderly in Oncology Navigation (NEON)” will address and identify the needs of geriatric oncology patients. Develop and validate tools to assess the needs and priorities of geriatric oncology patients. Link patients through these tools to existing services based on these assessments. Connect these patients to resources and facilitate communication between primary care and oncology care providers using navigation services. Create a web resource for geriatric oncology navigators to provide an accessible list of common concerns and resources for patients.

09: Stage of Cancer Care Assessment Tool for Elderly Patients

Evidence indicates that the needs and goals of younger cancer patients differ from those of older cancer patients. From the initial diagnosis of cancer through the spectrum of care including treatment, post-treatment, and end of life care—the goals and needs for each individual patient are different and ever changing based on patient’s stage of disease and treatment options, as well as personal preferences. Develop an electronic assessment tool to evaluate cancer patients UTHealth Consortium on Aging Synopses of Working Group Reports at three points in time (initial diagnosis, treatment, post-treatment/survivorship) to match interventions and assistance with needs.

10: Elder-Based Interdisciplinary Training Program for Cancer Care

Develop geriatric-specific training programs for health care providers (including physicians, dentists, nurses, clinical social workers, occupational and physical therapists, and other caregivers as identified) through continuing education addressing the topics of cancer, cancer metastasis/recurrence, and psychosocial issues common among geriatric cancer patients. Deliver onsite education in nursing homes and assisted living facilities for nurses, nurse assistants, and rehabilitation staff with hands-on training in simple screening methods for oral and various other cancers. Incorporate this material in the curriculum of students in health professional schools within the Texas Medical Center to create greater awareness and knowledge about geriatric cancer patients.

Trauma Working Group

The Trauma Working Group focused all four of their projects on falls. That is not to say falls are the only form of elderly trauma—vehicle accidents and elder abuse, among other risks, are also significant. But falls present a high risk of injury and are highly preventable.
11: Utilizing the EMR to Improve Care Coordination for Falls

One out of three adults over the age of 65 falls each year; fewer than half will discuss it with their health care provider. Two areas of attention are required to address the issue. First, care providers need ask about the issue and document their findings. Second, accurate documentation of the incidence of falls and risk assessment (in an efficient process that can be translated to both billing and coding and quality data) of the patient are required. Develop and implement an algorithm for fall risk assessment and interventions. Incorporate it into the EMR to be used in patients who are deemed at high risk for a fall or who have reported having a fall. Develop a Medical Power Plan (MPP) for fall as a diagnosis to provide a standardized set of orders to require providers to assess fall risk and document the results. This will provide the required data to allow resources and interventions at UTHealth to be focused on the appropriate patient population.

12: Implementing a Community-Based Fall Prevention Program

The Houston metropolitan area lacks coordinated, community-based fall-prevention programs. This project implements well-tested risk-for-fall screening tools through a collaboration between the Consortium and interested community partners. Through interviews and an interactive conference, identify and engage community partners to assess local needs and identify current best practices. Based on the needs assessment, develop a community-wide fall risk screening program with community partners and implement train-the-trainer programs to use a fall prevention checklist, Check for Safety, as well as evidence-based community exercise interventions such as Tai Chi Moving for Better Balance or A UTHealth Consortium on Aging 4 Synopses of Working Group Reports Matter of Balance. Develop a community-wide marketing plan to increase awareness and participation.

13: Education for Fall Awareness and Prevention in Public Places

With an aging population, falls are becoming a larger risk and potential liability in many public settings, including in businesses that have an older clientele. Develop an educational intervention for fall awareness and prevention that is short and simple (ten minutes or less), entertaining and compelling to watch or participate in, video or electronic based. It would be fine-tuned to the needs specific industries or work settings, and could be institutionalized, in that it would be adopted as mandatory for all employees to participate, akin to mandatory safety and compliance training. In time the
program could be adapted for high-risk elderly people and their families as well as for other audiences.

**14: Utilizing Social Technology for Patients, Family Members and Care Professionals**

In addition to the biological and environmental risk factors contributing to fall-related trauma, researchers have also highlighted the role of social isolation and its role as a fall risk. Develop an electronic, multi-component social media platform where lay public, as well as health care professionals, can share information and talk with each other and to experts in the field about fall-related prevention and care. What could begin as a social networking and information resource online site could be expanded over time to serve as a platform or other educational projects presented in this collection of working group project proposals.

**Elder Abuse Working Group**

**15: Senior Adult Assessment Center – A Vote of Support**

This project is a vote of support for the June 2014 proposal “Senior Adult Assessment Center of Houston Harris County “SAAC.” That proposal presented as a White Paper is a collaboration of UTHealth, Texas Adult Protective Services, Houston Police Department, Harris County District Attorney’s Office, and Harris County Sheriff’s Office. The SAAC program proposes to become a model collaborative of multiple agencies to serve vulnerable aging and disabled at-risk adult populations in a large municipal area. SAAC’s mission is to improve or preserve the quality of life and protect the well-being of vulnerable senior adult victims of abuse, neglect, and financial exploitation through collaborative expert assessment and intervention.

**16: Professional Development for Addressing Elder Abuse**

Develop a program to educate and increase the efficacy of people who interact with elderly people to prevent, detect, and address elder abuse. The program UTHealth Consortium on Aging 5 Synopses of Working Group Reports would begin with an innovative program 8-hour in-service training course for Houston Police Department for the 5,000 HPD officers on patrol. It will be adapted to train the more than fifty social service provider organizations in the Greater Houston Area. It will further expand to reach pharmacists, mail carriers, bank tellers, YMCAs, faith-based organizations, EMS, Meals on Wheels personnel and others with frequent elder contact. In time the group would like to expand to elder abuse education for Memorial Hermann emergency room
personnel, nurses, nurse technicians and nursing students, medical students, fellows, and residents.

17: Building Public Awareness for Elder Abuse

Only a small share of elder abuse cases—estimated at one in twenty four—are ever reported. This gap is due to many factors, one of which is undoubtedly a lack of awareness and knowledge on the part of the general public in recognizing the signs and reportable types of elder abuse. Develop three distinct public information campaigns: 1) a public education campaign using “negative norming” approaches (what you see is not right) disseminated through mass media and social media; 2) a campaign called “Champion Discovery” that uses ten stakeholder champions (to be identified and enlisted) including private sector leaders in various industries, and 3) a public sector educational initiative with strategies to inform and support legislative/policy change by elected leaders.

Palliative Care Working Group

18: Bridge House Call Program for Palliative Care

Expand the reach of palliative care through personalized, patient/family-centered education and care in the home or assisted living setting. Develop a true multidisciplinary team approach to a model house calls program. Build on the current Harris Health Bridge House Calls initiative with a full multidisciplinary approach and the added dimension of serving nursing home and other skilled care facilities in the Greater Houston Area with enriched educational and assessment components.

19: Palliative Care Awareness Campaign for Health Providers and Public

Palliative care suffers an identity crisis—it is too often considered one and the same as hospice care. This is a program designed to increase awareness for health care professionals and the lay community of palliative care—of what it is and what it is not. The target audiences are many, including patients, family, health care professionals, caregivers tending the elderly in homes and community facilities, hospital administrators and third party payers for health care services. Program goals would not only address knowledge and awareness issues but behavioral issues that serve as barriers to the referral process as well as system issues such as coding issues that limit palliative care’s early involvement in the course of care. UTHealth Consortium on Aging 6 Synopses of Working Group Reports.
20: Family-Centered Access to Palliative Care

This project focuses on generating palliative care referrals. While the awareness and knowledge-building goals of Project 19 about palliative care will naturally increase referrals, this program will address access barriers at the institutional level. Develop an evidence base and educate hospital leadership about cost-savings from palliative care. Develop and implement trigger mechanisms in the electronic patient record to automatically make palliative care referrals for qualified patients. Assess and address payment model barriers that discourage the application and provision of palliative care services and advocate solutions.

21: Palliative Care Research Program

The UTHealth Consortium on Aging has the opportunity within our region to become the hub of palliative care research. Develop a profile of the research that is being done, and gaps in knowledge that must be addressed in palliative care. Identify researchers across the Houston community with interests in palliative care. Bring the research community together to share information on resources, common interests, funding opportunities, and more. Develop a platform for involving students and building much-needed awareness of palliative care among health professional students across UTHealth and the Texas Medical Center. Conduct multi-institution research involving institutions associated the University of Texas Consortium on Aging and with nonaffiliated institutions.