Bridging Housing and Healthcare through Interprofessional Collaboration in Senior Affordable Living

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Session Objectives

- Identify professionals that may serve on interprofessional collaborative practice teams.
- Discuss best practices and barriers to establishing and maintaining interprofessional collaboration and healthcare partnerships in affordable living.
- Describe the importance of service coordination, interprofessional collaborative practice, senior resident and family-centered care, and The Triple Aim in serving low-income seniors.

NEPQR-IPCP Background

Xavier University School of Nursing partnered with the Cincinnati Health Department – Community Nursing Home Health Program, Home Care by Black Stone, and Episcopal Retirement Services in July 2015 to participate in the three year grant awarded by The Nurse Education, Practice, Quality, and Retention Program – Interprofessional Collaborative Practice (NEPQR-IPCP), HRSA-14-070, CFDA No. 93.359. XU IRB #15-060
Purpose of the Grant

The purposes of this project are to create new and expand Interprofessional Collaborative Practice (IPCP) environments through academic-practice IPCP partnerships through three key aims:

1) Support a paradigm shift to IPCP environments by training increased numbers of nurse leaders and other health professionals in IPCP core competencies so they can work in a culture of well-trained interprofessional teams;

2) Oversee, monitor, and evaluate the creation and expansion of innovative IPCP environments; and

3) Provide improved patient/family experiences and health outcomes with reduced per capita costs (The Triple Aim) through increased access to comprehensive, culturally competent, holistic preventative and primary health care services for patients, families, and communities.

The Triple Aim Model

What is "The Triple Aim"? A framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance in order to improve patient experience of care (quality and satisfaction), overall health, while reducing per capita cost of healthcare.
# Bee Healthy Wellness Program

<table>
<thead>
<tr>
<th>Senior Resident Site  (Zip Code)</th>
<th>Date Partner Site Added</th>
<th>Total/Number of Senior Resident Units</th>
<th>Total Number (%) of Senior Residents Enrolled in the “Bee Healthy” Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Paul Village (45227)</td>
<td>11/2/2015</td>
<td>168</td>
<td>87 (52%)</td>
</tr>
<tr>
<td>Walnut Court (45209)</td>
<td>7/19/2016</td>
<td>30</td>
<td>7 (23%)</td>
</tr>
<tr>
<td>Central Parkway Place (45203)</td>
<td>2/22/2017</td>
<td>45</td>
<td>34 (75%)</td>
</tr>
<tr>
<td>Total</td>
<td>N/A</td>
<td>263</td>
<td>118 (45%)</td>
</tr>
</tbody>
</table>

**WEEKLY DEDICATED INTERPROFESSIONAL COLLABORATIVE PRACTICE (IPCP) TEAM MEETINGS (1 HR)**
- Mary Krysztofiak (Service Coordinator)
- Ann Patterson (Service Coordinator)
- Melanie Ruhe (Service Coordinator)
- Caroline Repar (Wellness Coordinator)
- Anthony Williams (Director of Resident and Health Services)
- Sandra Menefield (Nurse Aide)
- Tracey Masson (IPCP Coordinator and Wellness RN)
- Karen Kortt (Occupational Therapist)
- Odette Black (Nurse Aide)
- Erica Engelman (Nurse Aide Supervisor and LPN)
- Mary Painter-Romanello (Nurse Practitioner)
- Wendy Knight, MHA, and Jennifer Evans, RN and Sarah Minges, Physical Therapist
- Not Pictured:
  - Saundra Menefield (Nurse Aide)
  - Caroline Repar (Wellness Coordinator)
  - Tracey Masson (IPCP Coordinator and Wellness RN)

**Blue = ERS**
**Orange = Home Care by Black Stone**
**Green = Kindred**

- Monthly Health Talks with SAME TEAM
Bee Healthy Wellness Program

• Nurse Clinic 1-2x/Week

Bee Healthy Wellness Program

• Wellness Coordination/Personal Training (Funded partially through HRSA grant and partially through other grants we’ve sought out).

Bee Healthy Wellness Program

• Exploring V-Go Capabilities
• Exploring integration of Health Plan Case Managers
• Explored Nurse Practitioner Clinic (Piloting at non-Bee Healthy site as well)
• Implemented incentive program (Bee Bucks)
Surveys

**IPCP Team Survey**

The IPCP Team Survey has 22 items which include a likert rating from:
- Domain 1: Team Culture (Items #1 - #6)
- Domain 2: Appreciation, Respect, and Effectiveness (Items #7 - #12)
- Domain 3: Recognition and Reflection (Items #13 - #17)
- Domain 4: Communication, Engagement, and Professional Development (Items #18 - #22).

**IPCP Evaluator Survey**

The IPCP Evaluator Survey has 22 items which include a likert rating from:
- Domain 1: Team Culture (Items #1 - #6)
- Domain 2: Appreciation, Respect, and Effectiveness (Items #7 - #12)
- Domain 3: Recognition and Reflection (Items #13 - #17)
- Domain 4: Communication, Engagement, and Professional Development (Items #18 - #22).

**Tracking Outcomes**

**Operational Definition of High Risk Residents**

<table>
<thead>
<tr>
<th>Vulnerable Elder Survey (VES)</th>
<th>New Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIN-13</td>
<td>Non-adherence or non-utilization of Medications (medication management problems)</td>
</tr>
<tr>
<td>Frequency of Hospitalizations/ED visits</td>
<td>Co-Morbidities</td>
</tr>
<tr>
<td>Frequent Falls</td>
<td>Actively involved in &quot;Bee Healthy&quot; Activities</td>
</tr>
<tr>
<td>Dementia Memory</td>
<td>Need assistance for 3 or more activities of daily living</td>
</tr>
</tbody>
</table>

**Clinical Outcomes of "Bee Healthy" Senior Residents**

- Documented increase in the number of assessments of who is at risk using the Vulnerable Elder Survey (VES-19)
- Increase preventative care screenings (Blood Pressure, Glucose, and BMI) on senior resident and family members
- Documented increase in the number of assessments of who is at risk using the Patient Activation Measure (PAM-13)
- Decrease the number of hospitalizations or hospitalization for residents with high risk.
Data Evaluation Plan and Workbook

Vulnerable Elder Survey (VES-13)
Baseline by location

<table>
<thead>
<tr>
<th>Location</th>
<th>Total (%)</th>
<th>Average Age (Years)</th>
<th>Gender and Total Number (%) Male (Female)</th>
<th>Total Score of VES-13</th>
<th>Risk Level &amp; Patients %</th>
<th>Average Scores for all VES-13 questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Paul Village (K257)</td>
<td>20 (80%)</td>
<td>76.9</td>
<td>M = 9 (12%) F = 44 (87%)</td>
<td>33 (100%)</td>
<td>Low = 3 Moderate = 2</td>
<td>4.2</td>
</tr>
<tr>
<td>Welhol Court (K220)</td>
<td>5 (43%)</td>
<td>68.5</td>
<td>M = 3 (100%) F = 0 (0%)</td>
<td>0 (0%)</td>
<td>Low = 1</td>
<td>5.7</td>
</tr>
</tbody>
</table>

Note: Vulnerable Elder Survey (VES-13) is a simple self-rated function-based tool for screening community-dwelling populations to identify those at risk for health deterioration. Overall score is calculated combining age, health limitations, and functional disabilities. Risk levels are defined as follows: Risk level = 1 Low (VES 0–3; PAM 3–4); 2 Moderate (VES 4–7; PAM 3–4); 3 Elevated (VES 4–7; PAM 1–2 or VES 8–10; PAM 3–4); 4 High (VES 8–10; PAM 1–2). The combination of VES-13 score and PAM-10 activation level.

Patient Activation Measure (PAM-10)
Baseline by Location

<table>
<thead>
<tr>
<th>Location</th>
<th>Total (%)</th>
<th>Average Age (Years)</th>
<th>Gender and Total Number (%) Male (Female)</th>
<th>Total Score of PAM-10</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Average Scores for all PAM-10 questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Paul Village (K257)</td>
<td>70 (80%)</td>
<td>76.9</td>
<td>M = 9 (12%) F = 61 (87%)</td>
<td>12 (18%)</td>
<td>Level 2</td>
<td>Level 3</td>
<td>Level 4</td>
<td>Level 4</td>
<td>3.0</td>
</tr>
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<td>3 (43%)</td>
<td>68.5</td>
<td>M = 3 (100%) F = 0 (0%)</td>
<td>0 (0%)</td>
<td>Level 2</td>
<td>Level 4</td>
<td>Level 4</td>
<td>Level 4</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Note: Patient Activation Measure (PAM-10) is a commercial product which assesses the individual’s knowledge, skill, and confidence for managing one’s own health and healthcare. Measures patients on a 0–100 scale and can segment patients into one of four activation levels across a continuum of stages 1–4. The higher the score, the higher the activation level.
IPCP TEAM and Incident Report Results

- Since 11/1/2015, the IPCP “Bee Healthy” Team has met 47 times with an average of 12 team members present at each weekly meeting.
- In the first 12 months since the IPCP Team was created:
  - Forty (40) incidents required 911 to be called
  - Forty (40) “Bee Healthy” participants were transferred to hospital/urgent care
  - Twenty-five (25) “Bee Healthy” participants were admitted to the hospital

Discussion and Next Steps

- The Blackstone/ERS IPCP Team is well-established and will continue to meet weekly to implement the “Bee Healthy” Wellness Program.
- Additional IPCP Team and Evaluator Survey Data will be collected and analyzed at 24 and 36 months.
- Additional data related to the clinical outcomes will be collected and analyzed at 6, 12, 24 and 36 months.
- Senior Resident and Family Satisfaction Surveys will be completed at 6, 12, 24 and 36 months.
- Meaning of family to be further evaluated.
- Sustainability of the “Bee Healthy” Program will be a high priority in the next 12 months.
- Monetization (lowering per capita costs) will be explored by the Blackstone/ERS IPCP Team related to the clinical outcomes identified.

Lessons Learned and Knowledge Gained…
Action Items: Build a Collaborative Team & Team Communication Strategy

• Identify key partners.
  • Resident Census; Medicare.gov Ratings; Scope of Services; Culture
• Build strategic relationships for a win/win partnership – might get corporate office involved in initiating MOUs, BA Agreements, Etc.
• Reach out and develop relationships with home care leadership, not just clinical team and “marketing” staff in building.
• Advocate for dedicated staff to the building (build a financial argument based on potential efficiencies and quality of care).
• Talk in terms of referrals.
• Legalities of Home Care Promotion.
• Maintain and Promote Resident Choice!

Action Items: Build a Collaborative Team & Team Communication Strategy

• Know and build trust with the FULL team.
• Stability of the team important.
• Consistency is powerful!
  • Set a STANDING TIME that works for all involved at the decided frequency.
    • In person vs Conference Call
• A note on team culture:
  • Get to know the team on a personal level as you go through this process.
    • It is okay to smile and have a laugh or two or three. We need it!
• Identify a focus/goal.

Action Item: Design the Program

• Look for connections to existing supports you have in place and how they can be integrated into your existing program. Try to avoid creating duplicate work for yourself!
  • Integrate what you are already doing.
  • Don’t overextend yourself.
  • Know that a good program won’t develop overnight.
• Spend time laying out the framework for the program prior to introducing it to residents.
Action Item: Design the Program

- Remember partnerships need to be mutually beneficial.
- Look to build a clinical component into assessment through referral.
  - Discuss your program with residents during assessments.
  - Identify processes, referral triggers, and communication/handoff forms.
  - Link assessments to clinic times.
  - Debrief (with permission) with your clinical contact.
  - Preferred Provider/Care Coordination Options and Agreements
- Remember residents have choice and should give written consent!

Action Item: Implement the Program

- Resident "Buy-In"
  - Make it fun (e.g., Bee Healthy "Club")
  - Importance of branding
  - Get resident buy-in – identify informal community leaders.
  - Incentives/Rewards program
    - Conference "trinkets"
    - Solicit partners for donations (e.g., pens, bags, etc.)
    - Dollar Store (if you have funds available to support this)
  - Consistent communication (embed in newsletters, resident meetings, and/or separate communication)
  - Explore how residents can get involved in leading health and wellness initiatives (e.g., friendly visitor program, work with sick and shut in residents).

Action Item: Implement the Program

- Track Outcomes
  - What?
    - Participation
    - Qualitative data (Stories!)
    - Simple clinical measures
  - Look at what you're already tracking in AASC or elsewhere
  - See what your local firehouse can provide you re: squad utilization
  - Referrals
  - Why?
    - Builds a business case for the program.
    - Future funding opportunities and innovation grants.
Action Item: Assess the Program

- Designate time to discuss the program with the team, key stakeholders, and residents on a regular basis.
- Important for continuous quality improvement.
- Learn from the past.
- Find ways to improve and become more efficient.
- If at first you don’t succeed, make changes, and try again.
- Don’t feel bad asking for help or suggestions. Call or email me or your colleagues!

Active Learning #1- Barriers

**Directions:**

- Each of you have a colored 3X5 card that was in your chair. Using the 3X5 card, write the word “Barriers” on the top.
- Consider what types of barriers you might face or have faced when trying to create, implement, and evaluate the IPCP model or health partnerships in your organization (2 minutes)
- Write down 2 – 3 barriers (1 minute)
- Share the barriers with someone nearby (2 minutes)
Active Learning #2-Best Practices

Directions:
- Each of you have a colored 3X5 card that was in your chair. Using the other side of the 3X5 card, write the word "Best Practices" on the top.
- Consider what best practices you might find or have found when trying to create, implement, and evaluate the IPCP model or health partnerships in your organization (2 minutes)
- Write down 2–3 best practices (1 minute)
- Share the best practices with someone nearby (2 minutes)

Questions?

Thank you for attending this session today!

Please feel free to leave your 3X5 cards on your chairs. We will collect them, analyze the responses, and send a summary to you if you have written your e-mail address somewhere on the index card.
References

3. Triple Aim Model. Retrieved from, https://www.google.com/search?q=the+triple+aim&source=lnms&tbm=isch&sa=X&ved=0ahUKEwit_cOg5ODSAhWqD8AKHSz3CG4Q_AUIBigB&biw=1417&bih=760&dpr=1#imgrc=yaAZDw5sJuD5IM: