SPICE-Bridge Partnership project

Progress toward service integration
August 1, 2004 – June 30, 2008

DECEMBER 2008

SPICE-Bridge Partnership project

Part 1

Summary evaluation report

Progress toward service integration
August 1, 2004 – June 30, 2008

This section is the summary evaluation of the SPICE-Bridge project. Pages are numbered 1-13.

Part 2

Appendix

This section includes data tables and other detailed information that supports the study findings. Pages are numbered 1-76.

SPICE-Bridge Partnership project
Summary evaluation report

Progress toward service integration
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Project background and purpose

The SPICE **(Senior Program for Integrated Care for Elders)** partnership was funded by Community Services/Community Services Development grants from the Minnesota Department of Human Services to bring together a collaboration of health care providers and community-based Living at Home/ Block Nurse Programs (LAH/BNP) to serve older adults in a more integrated way. The Bridge Partnership was funded at the same time to strengthen the delivery of culturally appropriate services to the same population in Saint Paul. The SPICE-Bridge collaboration is an effort to more closely link and combine two groups that have been working separately to build strong, interconnected community services that will support successful aging at home for older adults and their families.

The members of the SPICE-Bridge collaboration include:

- The Elderberry Institute (fiscal agent and intermediary)
- St. John's Hospital
- St. Joseph's Hospital
- United Hospital
- Six neighborhood Living at Home/Block Nurse Programs: Highland, Macalester-Groveland, Payne-Phalen, Summit Hill, Summit-University, and West Seventh Community Center
- Wilder Home Health Care
- Health Partners Specialty Center, Adult and Senior Services
- West Side Health Care
- Golden Living Center, Lake Ridge
- United Family Practice Health Center
- Allina Hospice and Palliative Care (participating July 2005 through December 2007)
- Regions Hospital (not participating after July 2005)
- Several other agencies were actively involved in planning and collaboration, including: Evercare, the Metropolitan Area Agency on Aging, Wingspan, and Ramsey County

Specific project goals include the following:

1. Expand the number of persons served by the SPICE-Bridge Partnership from 65 to approximately 275 across the four years of the project (August 2004 – June 2008).
2. Help participants feel safe in their homes and comfortable receiving care and support.
3. Facilitate transitions from care sites to home without problems.
4. Assess and manage safety hazards including medication management and risk of falls.
5. Inform participants of advance directives regarding health care decisions; encourage and facilitate their completion as appropriate.
6. Help participants keep health care appointments and reduce unnecessary hospitalizations and emergency room visits.
7. Reach out and work with new partners to replicate and improve services, improve cultural literacy, and strengthen referral processes.
8. Better meet the needs of culturally and ethnically diverse populations.
9. Improve opportunities for reimbursement from health plans for the Living at Home/ Block Nurse Program services.

Living at Home/Block Nurse Programs

Living at Home/Block Nurse Programs are nonprofit neighborhood-based organizations that use both professional and volunteer services of local residents to provide information, health care, social, and support services for older, primarily frail adults, enabling them to continue living in their own homes. Living at Home/Block Nurse Programs mobilize resources, including volunteers, churches, businesses, and schools to provide social and community supports. They also contract with certified home care agencies to provide skilled nursing services. Living at Home/Blocks Nurse Programs provide case management and provide or coordinate Meals on Wheels, adult day services, transportation services, chore and homemaking services, and a variety of other services, if needed.

Evaluation methods

Wilder Research worked with the Elderberry Institute project manager to develop the evaluation procedures, many of which were based on a previous experience with the Senior Care Community Partnership.

Evaluation of the effectiveness of the SPICE-Bridge Partnership in meeting its mission involved telephone interviews with participants who have received services through the Living At Home/Block Nurse Programs and analysis of administrative data that includes: Client Services and Contacts forms that tracked service usage, hospital admissions and emergency room visit data tracked by Regions Hospital, St. John's Hospital, St. Joseph's Hospital, and Untied Hospital, and missed clinic appointment data tracked by Health Partners Specialty Center, Adult and Senior Services (formerly Regions Senior Clinic) and United Family Practice Health Center. The evaluation of implementation and effectiveness included six data sources:

Participant interviews

Wilder Research conducted telephone follow-up interviews with older adults who had received services through the SPICE-Bridge Partnership in 2005, 2007, and 2008. Information gathered through the participant interviews included the respondent's level of comfort with the care and support received through the Living At Home/Block Nurse Program, the kinds of services provided or arranged for the respondent by the Living At Home/Block Nurse Program, the respondent's satisfaction with the process of scheduling services and the convenience of the services provided, and the benefits experienced by the respondent as a result of services received through the Living at Home/Block Nurse Program.

Partner interviews

Wilder Research conducted telephone interviews with partners involved with the SPICE-Bridge Partnership. Information gathered through the partners included their perspectives on the effectiveness of the project and progress made toward achieving the overall goals of the Partnership.

Direct service provider interviews

Wilder Research conducted telephone interviews with Living at Home/Block Nurse Program staff who provided direct services to older adult participants. Information gathered through direct service providers included their impressions of the benefits of the program to participants and progress made in achieving project goals.

Self-administered surveys completed by clinic and hospital staff

The SPICE-Bridge Partnership project manager worked with partners to distribute surveys for completion by clinic and hospital staff. The information gathered through these self-administered surveys included their opinions about working with the Living At Home/ Block Nurse Program staff, their perceptions of the benefits of the program to participants, and their thoughts about the overall effectiveness of the project.

Services and Contacts forms

The Living at Home/Block Nurse Programs maintained a "Services and Contacts" form for each program participant. This form includes the following types of information:

- The number of home visits, contacts, and services (nurse visits, home health aide visits, clinic advocacy contacts, health advocacy contacts, other advocacy contacts, staff contacts with client, volunteer services, transportation to clinic) provided, by quarter
- Connections to community services made (including referral and follow-up with Meals-on-Wheels, blood pressure screening, LifeLine, chore/homemaking, screening for Alternative Care and Elderly Waiver eligibility, and occupational or physical therapy)
- Safety and health monitoring related to falls prevention, medication management, activities of daily living, home safety, depression screening, and vulnerable or suspected abuse assessment
- Participants' status in completing Health Care Directives

This data provided information about the levels of service received, the need for and implementation of medication management, completion of falls risk assessments, and home safety checks.

Hospital and clinic data

Kept and missed clinic appointments, hospital admissions, readmissions, and emergency room utilization were tracked through an Excel spreadsheet by the partners. However, participant data prior to enrollment is limited.

Characteristics of the population served

Over the four years of the study there have been significant changes among the client population. Key among them is the fact that the SPICE-Bridge Partnership LAH/BNPs have been serving an increasingly low-income population, with a total of 60 persons in the first year of the project qualifying for low-income elderly service programs and a total of 93 persons in the final year qualifying for low-income programs.

In addition, in-home assessment data indicate that this is an increasingly frail population requiring more assistance to continue living safely at home. This is evidenced by:

- The average number of Activities of Daily Living problems reported by participants doubled from 2004 to 2008.
- Visits by a home health aide increased substantially in the most recent study, from an average of 46 visits in 2004 to 65.3 in 2008.
- The average number of nurse visits more than doubled over the four years of the study, from 13.6 visits in 2004 to 29.1 in 2008.
- LAH/BNP staff contacts with participants increased from an average of 9.8 contacts in the first year of the study to 14.2 in the fourth year. Similarly, the number of hours of volunteer assistance provided to participants increased from an average of 16.4 hours in 2004 to 24.2 hours in 2008.
- Of those participants who had problems identified on the falls assessment, the percentage with physical problems that increase the risk of falls rose from 37% in 2004 to 91% in 2008.
- There has been a steady increase in the average number of clinic visits for participants. In 2004, participants averaged 4.6 visits, compared to 10.7 in 2008.

Progress made on project goals

Goal 1: Expand the number of persons served by the SPICE-Bridge Partnership from 65 to approximately 275 across the four years of the project (August 2004 – June 2008)

This goal was met. A total of 280 persons (unduplicated number) were served by the Partnership between August 2004 and June 2008.

1. Older adults served through SPICE-Bridge Partnership

	August 2004-June 2005	July 2005-June 2006	July 2006-June 2007	July 2007 - June 2008
	Number	Number	Number	Number
Participants served	141	168	184	205
Participants continued from previous year	-	106	130	182
Participants added during year	-	62	54	23
Unduplicated participant sum	141	203	257	280

Goal 2: Help participants feel safe in their homes and comfortable receiving care and support

Evidence that the project is meeting this goal comes from the results of the surveys conducted with participants in 2005, 2007, and 2008.

- In each of the three survey periods, 97% or more of respondents said they would recommend the Living at Home/Block Nurse Program to others with similar needs.
- From 2005 to 2008, there was an increase in the percentage of participants who reported that, overall, they were "very satisfied" with the services of the Living at Home/Block Nurse Program (79% to 86%).
- Almost all respondents (95% or more) who had contact with LAH/BNP staff in each survey period felt it was helpful to have the Living at Home/Block Nurse Program staff come to their home to evaluate their needs and help them get connected to appropriate services in the community.

Feedback from participants during follow-up interviews supports the high levels of satisfaction reported here:

> They guided and enlightened me on some of the services available – federal, county, state services. They gave me a great amount of help obtaining the data, so I can get the services and fill out the applications. The program staff have been absolutely wonderful – one of the nicest groups I've encountered. I am legally blind and my wife had a stroke. We are trying to stay in our home.
>
> It is all beneficial. I call when I need something. One of the ladies is just like my daughter, and she helps me with everything.
>
> The information is there. If you really need something, they can really help you.
>
> They check up on me, help with medications. They talked with my doctor.
>
> …. I wish everybody could have it. They are very, very nice – I could not have made it without their help. They found me a really nice place – a nursing home [to recuperate] – and they helped me through my operation. I don't think I would be living if I didn't have them to help me out. They check up on how you are doing and how your mind is doing, and they bring vegetables. I appreciate them, I really do.

It should be noted that over the four years of the project, 45 elders served by the project died. When these are excluded from the total numbers served, the results show that 182 of 235 (77%) continue living in their homes. Of those who moved out of their homes, about half went to nursing homes or assisted living care because of increased service needs.

Goal 3: Facilitate transitions from care sites to home without problems

Study results indicate that the project made considerable progress facilitating smooth transitions from hospitals or other health care settings to home. Ninety percent of partners and 89 percent of direct service staff agreed that this goal had been fully or partially met. They cited:

- Improved communications between the LAH/BNPs and social workers and discharge planners
- A greater willingness on the part of hospital and clinic staff to coordinate work with the Living at Home/Block Nurse Programs
- Better understanding on the part of participating hospitals and clinics of how community services can increase the likelihood of successful transitions to home

- More established procedures in place to coordinate with the LAH/BNP in addressing the needs of the patient who is returning home

However, it was clear from respondents' comments that notifying the LAH/BNPs of participants' hospitalizations or results of clinic visits is not automatic. Several respondents noted that when the LAH/BNP is brought into the transition, the process works well, but this does not always happen, and that much of the success of this effort so far has been realized through the efforts of individual social workers and discharge planners who take the initiative to contact the LAH/BNP.

A continuing need to expand activities designed to enhance awareness of the services of the LAH/BNPs among hospital and clinic staff was reiterated by both partners and direct service providers.

Goal 4: Assess and manage home safety hazards including medication management and risk of falls

Individual client records in the Services and Contact forms provide strong evidence that this goal has been met:

- Between 70 percent and 94 percent of participants received home safety hazard assessments in each of the four years of the project. (These in-home assessments were done only with client consent.)

- On the whole, the safety of participants' home environment appears to have improved since the beginning of the project. The percentage of participants with concerns noted on the home safety check declined from 44 percent in the first year to 32 percent in the fourth year.

- The average number of problems recorded during home safety checks declined from .61 to .40 over the four years of the project.

- Home environment problems noted on the falls assessment that could increase the risk of falling declined from 35 percent in the first year to 11 percent in the last year.

- There has been a decrease in the percentage of participants with unresolved medication management problems.

Goal 5: Inform participants of advance directives regarding health care decisions; encourage and facilitate their completion as appropriate

This goal was met. Approximately 90 percent of participants in each year had a Health Care Directive in place, were in the process of preparing one, or had a preliminary discussion about advanced directives with LAH/BNP staff.

2. Status of Health Care Directives (HCD)

	August 2004-June 2005	July 2005-June 2006	July 2006-June 2007	July 2007 - June 2008
	Number	Number	Number	Number
Participants served *	140	164	182	205
Participants with HCDs under discussion	50	67	71	98
Participants with completed forms	78	78	91	85
Percent of all participants with HCDs in progress or completed	91%	88%	89%	89%

* *Status information on advanced directives was missing for 7 clients.*

Goal 6: Help participants keep health care appointments and reduce unnecessary hospitalizations and emergency room visits

Progress toward achieving this goal is difficult to assess. Hospital and clinic data show an increased number of missed clinic appointments, hospitalizations, and emergency room visits post-enrollment compared to pre-enrollment.

However, this data is suspect because it appears more likely that, prior to enrollment, some participants used clinics or hospitals that were not one of the SPICE-Bridge partners, and therefore did not provide data on kept or missed appointments, hospitalizations, or emergency room visits. It is more likely that the study would detect these events after enrollment in the SPICE-Bridge project because of closer alignment with project affiliated clinics and hospitals.

In addition, data prior to service was available for a more limited time frame than was available for participants after program involvement.

Finally, study findings suggest that the program is now serving an older, frailer, and more at-risk population than in earlier years, and consequently there is a greater likelihood of emergency room visits and hospital admission based on illness or other types of physical

distress. It is notable that there has been a steady increase in average number of clinic visits for participants over the four years of the project.

Data on kept and missed clinic visits were available for 137 participants. Despite data limitations described above and greater health related needs of participants in later project years, the difference in the average number of kept and missed clinic appointments pre- and post-enrollment was not statistically significant. Data on hospitalizations and emergency room visits were available for 197 participants. These measures showed a significant increase from pre- to post-enrollment periods. However, for the reasons described above, this data should be interpreted with caution.

Goal 7: Reach out and work with new partners to replicate and improve services, improve cultural literacy, and strengthen referral processes

Study results show progress in this goal area.

- From 2004 to 2008, SPICE-Bridge LAH/BNP staff initiated a variety of meetings, seminars, and workshops aimed at increasing understanding of health care related needs and improving services in the Latino, Somali, and Hmong communities of St. Paul. Topics included Alzheimer's disease, diabetes, and problems encountered by older adult immigrants in using social services and health care services in the United States. These programs were open to all SPICE-Bridge partners and some were open to the community at large.

- SPICE-Bridge project LAH/BNP staff have partnered with the University of Minnesota, Century College, Inver Hills Community College and Metropolitan State University to provide experience working with culturally diverse seniors to approximately 80 Service Learning students each year. The Payne Phalen LAH/BNP has become known as a hub for service learning in the last five years.

- Living at Home/Block Nurse Program staff members were instrumental in establishing the East Side Wellness Collaborative in 2006, a group of individuals representing 25 health care companies, clinics, agencies, and community programs on St. Paul's East Side. Through the collaborative clinics were set up in two public housing sites: Edgerton Hi-Rise and Parkway Gardens.

- The project has also achieved success in expanding referral sources. There has been an increase in referrals from community-based groups and social service agencies during the project, as well as an increase in referrals from friends and family, indicating a greater likelihood of community connectedness within and among programs.

- Evaluation interviews conducted in 2008 with a sample of Spanish-speaking participants revealed satisfaction rates as high or higher than found in the general population of participants served. The following comments illustrate the relationship of trust and respect the program has built with many of these participants:

> I have a place to call where they know me and help me all the time. They are like family to me.
>
> They helped us get Medicaid Assistance to help pay for my medical bills.
>
> They supported me and encouraged me to go through the operation that I needed in May of last year. They explained the procedures to me.
>
> I feel safe around them. The transportation to and from the appointments I have – Social Security office, clinic, etc. helps a lot. And they help me fill out forms, because I am 90 percent blind with glaucoma.
>
> [The worker] has a background in the medical field. She's also a woman, and I feel comfortable with her at my side [clinic visits].

Goal 8: Better meet the needs of culturally and ethnically diverse populations

The Living at Home/Block Nurse Programs have made considerable progress toward meeting this goal:

- A Payne-Phalen Living at Home/Block Nurse Program representative has helped develop a dementia screening tool in Spanish and consults with other Living At Home/Block Nurse Programs regarding their Latino clients who have dementia.
- The Living At Home/Block Nurse Programs have established contact with the Somali community in St. Paul and have offered assistance to adult immigrants in this population.
- The proportion of SPICE-Bridge project participants of color increased from 14 percent in 2004 to 28 percent in 2008.
- There were no significant differences in satisfaction rates reported by white participants compared to participants of color.

Goal 9: Improve opportunities for reimbursement from health plans for the Living at Home/block Nurse Program services.

Over the course of the project, Elderberry Institute, in conjunction with the Living at Home/Block Nurse Programs and the larger SPICE-Bridge collaboration, were successful in securing reimbursement from Evercare health plan for service coordination performed

by some LAH/BNPs. In addition, work with UCare resulted in an agreement to pay the LAH/BNPs for a limited number of interventions to provide Independent Living Skills services. Progress in this area has proven difficult, but several key elements in the health care needs of the population as well as the service requirements of health care plans may improve opportunities for progress in the future. These include:

- Significant growth in the population of older adults
- Increased competition for scarce health care resources
- Public policy initiatives stressing the desirability of home-based services
- Efforts to reduce institutionalization
- Increased use of structured assessments and formal care coordination processes by community-based providers
- Continued interest by elders in remaining at home
- Initial recognition by health plans that these services may be helpful enough to their overall patient care goals that programs like LAH/BNP should qualify for reimbursement

Overall, there would be value in conducting return-on-investment studies in order to demonstrate to health plans any value that might be gained by investments in community-based care.

Issues to consider

Overall, these findings show strong positive results among participants, direct service providers, and SPICE-Bridge partners, and reasonably positive results among hospital and clinic staff, depending on their relationship with the Living at Home/Block Nurse Program. More progress appears to have been made in the areas of improving care and enhancing communication with participants. Less progress has been made in creating sustainability of services by obtaining reimbursement for services or reducing costs associated with hospital readmissions or reduced number of clinic visits.

Key areas in which to focus improvement efforts include the following:

- Improved record keeping with hospital and clinic information to strengthen study comparisons pre- and post-enrollment
- Continued outreach to hospital and clinic staff to strengthen referrals and improve communications with LAH/BNP staff

Other areas meriting additional attention include:

- The potential for standardizing procedures and core services among LAH/BNPs to make it easier for hospitals and clinics to understand and use their services
- Strategies for demonstrating how program benefits relate to service costs
- Continued efforts to understand how and in what ways the LAH/BNP services could be considered reimbursable through health care plans

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Appendix 1

Project goals

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2. Help participants feel safe in their homes and comfortable receiving care and support.
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8. Better meet the needs of culturally and ethnically diverse populations.
9. Improve opportunities for reimbursement from health plans for the Living at Home/Block Nurse Program services.

Appendix 2

Notes on interpreting data tables

Individual percentages do not always add to exactly 100 percent. Calculations can result in "fractional" percentages. We use rounding to adjust for this, therefore, the percentages do not always add up exactly to 100 percent.

The total number of responses is different for each question, based on the number of valid responses to that question. Missing data (cases when a respondent did not answer a question) are not reported or included in the percentages, unless otherwise indicated.

Appendix 3

Data sources and evaluation methods

Wilder Research worked with the Elderberry Institute project manager to develop the evaluation procedures, many of which were based on a previous experience with the Senior Care Community Partnership. Descriptions of the six data sources used to evaluate the implementation and effectiveness of the SPICE-Bridge project follow:

Participant interviews

In the summer of 2005, Wilder Research conducted telephone follow-up interviews with a random sample of participants who had received services through the SPICE-Bridge Partnership. Of the 106 sampled, 96 were interviewed for a response rate of 91 percent. Interviews were conducted with clients or their caregivers in English (88), Spanish (6), and Hmong (2).

In the fall of 2007, Wilder Research completed telephone interviews with 34 SPICE-Bridge Partnership participants who had received services in the previous two years. Participants were randomly selected and at least four were interviewed from each of the six participating LAH/BNPs. Only care recipients were interviewed; all interviews were conducted in English.

In the fall of 2008, Wilder Research completed 35 telephone interviews with SPICE-Bridge Partnership participants who had received services in the previous year. At least four randomly selected participants were interviewed from each of the six participating LAH/BNPs. Only care recipients were interviewed; 31 interviews were conducted in English and 4 in Spanish.

Information gathered included:

- The respondent's level of comfort with the care and support received through the Living At Home/Block Nurse Programs
- The kinds of services provided or arranged for by the Living At Home/Block Nurse Programs
- The respondent's satisfaction with the process of scheduling services and the convenience of the services provided
- The benefits experienced by respondent as a result of services received through the Living at Home/Block Nurse Programs

Partner interviews

Wilder Research conducted telephone interviews with partners involved with the SPICE-Bridge Partnership. In 2005, 20 of 25 partners completed an interview for a response rate of 80 percent. In 2008, 17 of 17 partners completed an interview for a response rate of 100 percent. Information gathered included partners' perspectives on the effectiveness of the project and progress made toward achieving the overall goals of the Partnership.

Direct service provider interviews

In 2005, Wilder Research conducted telephone interviews with 14 of 15 Living at Home/Block Nurse Program staff who provided direct services to SPICE-Bridge participants (93% response rate). In 2008, Wilder Research conducted telephone interviews with 18 of 19 Living at Home/Block Nurse Program staff who provided direct services to SPICE-Bridge participants (95% response rate). Information gathered included providers' impressions of the benefits of the program to participants and progress made in achieving project goals.

Self-administered surveys completed by clinic and hospital staff

The SPICE-Bridge Partnership project manager worked with partners to distribute surveys for completion by clinic and hospital staff. In 2005, self-administered questionnaires were completed by 10 clinic staff and 24 hospital staff. In 2008, self-administered questionnaires were completed by 3 clinic staff and 18 hospital staff. It is not known how many staff did not complete the questionnaires. Information gathered included clinic and hospital staff opinions about working with the Living At Home/Block Nurse Program staff, their perceptions of the benefits of the program to participants, and their thoughts about the overall effectiveness of the project.

Services and Contacts forms

The Living at Home/Block Nurse Programs maintained a Services and Contacts form for each program participant. This form includes the following types of information:

- The number of home visits, contacts, and services (nurse visits, home health aide visits, clinic advocacy contacts, health advocacy contacts, other advocacy contacts, staff contacts with client, volunteer services, transportation to clinic) provided, by quarter

- Connections to community services made (including referral and follow-up with Meals-on-Wheels, blood pressure screening, LifeLine, chore/homemaking, screening for Alternative Care and Elderly Waiver eligibility, and occupational or physical therapy)

- Safety and health monitoring related to falls prevention, medication management, activities of daily living, home safety, depression screening, and vulnerable or suspected abuse assessment

- Participants' status in completing Health Care Directives

Wilder Research received complete Services and Contac forms for 141 participants in the first year of the study (August 2004-June 2005); 168 participants in the second year (July 2005-June 2006), including 62 participants who had not been enrolled previously; 184 participants in the third year (July 2006-June 2007), including 54 participants who had not been enrolled previously; and 205 participants in the fourth year (July 2007-June 2008), including 23 participants who had not been enrolled previously.

Hospital and clinic data

Kept and missed clinic appointments, hospital admissions, readmissions, and emergency room utilization were tracked through an Excel spreadsheet by the partners. This information was available for 133 of the 141 participants (94%) in the first year of the study, 129 of 168 participants (77%) in the second year, 136 of 184 participants (74%) in the third year, and 184 of 205 participants (90%) in the fourth year of the study. Participant data prior to enrollment was limited.

Appendix 4

Characteristics of participants

Number of older adults served

The SPICE-Bridge Partnership served a total of 280 older adults (unduplicated number) between August 2004 and June 2008. According to data reported to the Elderberry Institute by the six participating Living at Home/Block Nurse Programs, these participants were a subset of the 2,404 persons served August 2004 through June 2005; the 1,266 persons served July 2005 through June 2006; the 947 persons served July 2006 through June 2007; and the 993 persons served July 2007 through June 2008 in their programs. An unduplicated number of all persons served by these LAH/BNPs during the study period is not available.

Of the 280 participants served by the SPICE-Bridge Partnership during the four years of the project, 182 (65%) continue to be in their homes and participating in the project. At the end of the four years, 45 participants had died (16%); 13 participants were living in nursing homes (5%), 13 participants were living in assisted living facilities (5%), 21 participants had moved out of the area (8%), 5 participants were being cared for by a Personal Care Attendant (2%), and one person (<1%) had chosen to leave the program.

Eligibility criteria for SPICE-Bridge Partnership services

As part of their enrollment in the SPICE-Bridge Partnership, participants agreed to share information and participate in evaluation activities and receive additional assessments. In addition, all participants used at least one of the SPICE-Bridge Partnership clinics or hospitals.

Ages and races of participants

The majority of participants served in the SPICE-Bridge Partnership were 80 years of age or older (60% in the first year, 62% in the second year, 58% in the third year, and 57% in the fourth year). The average age of participants ranged from 80.8 years to 82.1 years over the four years of the project. The average age of the participants across all four years of the project was 81.5 years.

1. Ages of older adults served through the SPICE-Bridge Partnership

	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007		July 2007-June 2008	
Age	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Less than 65 years	1	1%	1	1%	1	1%	-	-
65-69 years	15	11%	14	8%	15	8%	14	7%
70-74 years	17	12%	24	14%	34	19%	42	21%
75-79 years	24	17%	25	15%	27	15%	31	15%
80-84 years	34	24%	30	18%	30	16%	32	16%
85-89 years	29	21%	38	23%	44	24%	43	21%
90-94 years	16	11%	22	13%	22	12%	28	14%
95-99 years	5	4%	11	7%	10	5%	13	6%
100+ years	-	-	2	1%	1	1%	1	1%
Total	141	100%	167	100%	184	100%	204	100%
Average age	80.8 years		82.1 years		81.4 years		81.6 years	

About three-quarters of the participants served in the SPICE-Bridge Partnership were Caucasian. The next largest group served was African American.

2. Races of older adults served through the SPICE-Bridge Partnership

	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007		July 2007-June 2008	
Race	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Caucasian	121	86%	122	73%	135	73%	148	72%
African American	6	4%	31	18%	39	21%	41	20%
Hispanic	8	6%	13	8%	7	4%	11	5%
Native American	4	3%	1	1%	1	<1%	2	2%
Hmong	-	-	1	1%	-	-	-	-
Multi-racial	1	1%	-	-	2	1%	1	<1%
African Native	-	-	-	-	-	-	1	<1%
Total	140	100%	168	100%	184	100%	204	100%

Eligibility for public assistance for health-related services

Many SPICE-Bridge participants are low-income individuals who qualify for some type of public assistance to pay for health related services. Across the four years of the project, 10 percent to 19 percent of participants received Alternative Care grants, 13 percent to 21 percent received assistance through Elderly Waivers, and 9 percent to 21 percent were in enrolled in Minnesota Senior Health Options (MSHO). A few participants were enrolled in more than one program.

3. SPICE-Bridge participants eligible for Alternative Care grants, Elderly Waiver, and MSHO

	August 2004-June 2005 (N=141)		July 2005-June 2006 (N=168)		July 2006-June 2007 (N=184)		July 2007-June 2008 (N=205)	
Program	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Alternative Care grants	20	14%	31	19%	28	15%	20	10%
Elderly Waiver	28	20%	34	21%	23	13%	30	15%
MSHO	12	9%	33	20%	34	19%	43	21%

Appendix 5

Data related to project goals

Goal 1: Expand the number of persons served by the SPICE-Bridge Partnership from 65 to approximately 275 across the four years of the project (August 2004 – June 2008)

4. Older adults served through SPICE-Bridge Partnership

	August 2004-June 2005	July 2005-June 2006	July 2006-June 2007	July 2007-June 2008
	Number	Number	Number	Number
Participants served	141	168	184	205
Participants continued from previous year	-	106	130	182
Participants added during year	-	62	54	23
Unduplicated participant sum	141	203	257	280

5. Home neighborhoods of older adults served through SPICE-Bridge Partnership

Living at Home Block Nurse Program	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007		July 2007-June 2008	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Highland	35	25%	39	23%	32	17%	30	15%
Macalester-Groveland	29	21%	32	19%	46	25%	47	23%
Payne-Phalen	13	9%	11	7%	11	6%	13	6%
Summit Hill	19	13%	25	15%	17	9%	19	9%
Summit-University	-	-	25	15%	44	24%	54	26%
West 7th	45	32%	36	21%	34	19%	42	21%
Total	141	100%	168	100%	184	100%	205	100%

Goal 2: Help participants feel safe in their homes and comfortable receiving care and support

Overall satisfaction with services

In each reporting period, participants and caregivers expressed high levels of satisfaction with the services received as part of the SPICE-Bridge Partnership. Over 90 percent (100% in 2005, 97% in 2007, and 94% in 2008) of survey respondents were satisfied with the services. In addition, more than 95 percent (98% in 2005, 97% in 2007, 97% in 2008) of respondents said they would recommend the Living at Home/Block Nurse Program to others who needed similar services.

6. Overall satisfaction with services

	August 2004 – June 2005		July 2005 – June 2007		July 2007 – June 2008	
	Number	Percent	Number	Percent	Number	Percent
Very satisfied	5	-	27	79%	30	86%
Satisfied	2	-	6	18%	3	9%
Dissatisfied	-	-	1	3%	1	3%
Very dissatisfied	-	-	-	-	1	3%
Total	7	-	34	100%	35	100%

Notes. *1. In the 2005 survey, only caregivers were asked this question.*
2. Percentages are not reported when the number of respondents is less than 10.

7. Recommendation of services to others

	August 2004 – June 2005		July 2005 – June 2007		July 2007 – June 2008	
	Number	Percent	Number	Percent	Number	Percent
Yes	89	98%	31	97%	34	97%
No	2	2%	1	3%	1	3%
Total	91	100%	32	100%	35	100%

Ease of accessing services

Satisfaction with access to the services provided through the Living At Home/Block Nurse Programs remained high over the four years of the project.

- Almost all survey respondents (96% in 2008, 97% in 2007, 96% in 2005) "agreed" or "strongly agreed" that it was easy to find out about the services that were available
- Almost all survey respondents (94% in 2008, 100% in 2007, 99% in 2005) "agreed" or "strongly agreed" that it was easy to schedule the first appointment
- Almost all survey respondents (97% in 2008, 100% in 2007, 94% in 2005) "agreed" or "strongly agreed" that the services scheduling process met their needs
- Almost all survey respondents (97% in 2008, 100% in 2007, 94% in 2005) "agreed" or "strongly agreed" that it was easy to set up services

Helpfulness of services

The services most commonly received by survey respondents were home visiting, getting connected to other community services, getting help with rides to doctor's appointments, getting help with paperwork, and getting help with advance directives for health care. In all three reporting periods, over 95 percent of respondents who used any of these services reported that the service was "helpful" to them.

8. Specific types of services received by participants (August 2004 – June 2005)

Did you…	Number	Percent
Have a visitor from (PROGRAM) come to (your/your care recipient's) home? (N=92)	80	87%
Get help connecting to other services you needed in the community? (N=90)	57	63%
Get help setting up medications or have someone call with a reminder to take medications? (N=93)	23	25%
Get help with rides to doctor's appointments or other places? (N=92)	48	52%
Get help with paperwork or forms needed for services? (N=90)	40	44%
Get help with figuring out medical bills or understanding health benefits? (N=93)	19	20%
Get help understanding advance directives for health care such as a living will or other instruction for health care staff? (N=91)	44	48%
Get help writing an advance directive for health care? (N=91)	34	37%
Have someone call the clinic for you? (N=93)	24	26%
Have someone go to the clinic with you and help you talk with the nurse or doctor? (N=93)	30	32%
Did you have problems setting up services? (N=88)	4	5%

9. Helpfulness of services as reported by participants* (August 2004 – June 2005)

Was…	Helpful	Not helpful
Having a visitor from (PROGRAM) come to (your/your care recipient's) home? (N=80)	98%	3%
Getting help connecting to other services you needed in the community? (N=56)	97%	4%
Getting help setting up medications or have someone call with a reminder to take medications? (N=23)	100%	-
Getting help with rides to doctor's appointments or other places? (N=47)	100%	-
Getting help with paperwork or forms needed for services? (N=40)	100%	-
Getting help with figuring out medical bills or understanding health benefits? (N=19)	95%	5%
Getting help understanding advance directives for health care such as a living will or other instruction for health care staff? (N=44)	98%	2%
Getting help writing an advance directive for health care? (N=34)	97%	3%
Having someone call the clinic for you? (N=21)	100%	-
Having someone go to the clinic with you to talk with the nurse or doctor? (N=30)	100%	-

***Note.** *Only those participants who said they had received the service were asked if it was helpful.*

10. Specific types of services received by participants (July 2005 – June 2007)

Did you…	Number	Percent
Have a visitor from (PROGRAM) come to (your/your care recipient's) home? (N=34)	30	88%
Get help connecting to other services you needed in the community? (N=32)	21	66%
Get help setting up medications or have someone call with a reminder to take medications? (N=34)	10	29%
Get help with rides to doctor's appointments or other places? (N=33)	18	55%
Get help with paperwork or forms needed for services? (N=34)	11	32%
Get help with figuring out medical bills or understanding health benefits? (N=34)	6	18%
Get help understanding advance directives for health care such as a living will or other instruction for health care staff? (N=34)	11	32%
Get help writing an advance directive for health care? (N=34)	5	15%
Have someone call the clinic for you? (N=34)	6	18%
Have someone go to the clinic with you and help you talk with the nurse or doctor? (N=34)	7	21%
Did you have problems setting up services? (N=34)	2	6%

11. Helpfulness of services as reported by participants* (July 2005 – June 2007)

Was…	Helpful	Not helpful
Having a visitor from (PROGRAM) come to (your/your care recipient's) home? (N=30)	100%	-
Getting help connecting to other services you needed in the community? (N=21)	95%	5%
Getting help setting up medications or have someone call with a reminder to take medications? (N=10)	100%	-
Getting help with rides to doctor's appointments or other places? (N=18)	100%	-
Getting help with paperwork or forms needed for services? (N=11)	100%	-
Getting help with figuring out medical bills or understanding health benefits? (N=6)	100%	-
Getting help understanding advance directives for health care such as a living will or other instruction for health care staff? (N=11)	100%	-
Getting help writing an advance directive for health care? (N=5)	100%	-
Having someone call the clinic for you? (N=6)	100%	-
Having someone go to the clinic with you to talk with the nurse or doctor? (N=7)	100%	-

***Note.** *Only those participants who said they had received the service were asked if it was helpful.*

12. Specific types of services received by participants (July 2007 – June 2008)

Did you…	Number	Percent
Have a visitor from (PROGRAM) come to (your/your care recipient's) home? (N=35)	34	97%
Get help connecting to other services you needed in the community? (N=33)	22	67%
Get help setting up medications or have someone call with a reminder to take medications? (N=35)	14	40%
Get help with rides to doctor's appointments or other places? (N=35)	21	60%
Get help with paperwork or forms needed for services? (N=35)	17	49%
Get help with figuring out medical bills or understanding health benefits? (N=35)	12	34%
Get help understanding advance directives for health care such as a living will or other instruction for health care staff? (N=31)	12	39%
Get help writing an advance directive for health care? (N=32)	9	28%
Have someone call the clinic for you? (N=35)	8	23%
Have someone go to the clinic with you and help you talk with the nurse or doctor? (N=35)	6	17%
Did you have problems setting up services? (N=35)	4	11%

13. Helpfulness of services as reported by participants* (July 2007 – June 2008)

Was…	Helpful	Not helpful
Having a visitor from (PROGRAM) come to (your/your care recipient's) home? (N=34)	97%	3%
Getting help connecting to other services you needed in the community? (N=22)	100%	-
Getting help setting up medications or have someone call with a reminder to take medications? (N=10)	100%	-
Getting help with rides to doctor's appointments or other places? (N=21)	100%	-
Getting help with paperwork or forms needed for services? (N=17)	100%	-
Getting help with figuring out medical bills or understanding health benefits? (N=12)	100%	-
Getting help understanding advance directives for health care such as a living will or other instruction for health care staff? (N=12)	100%	-
Getting help writing an advance directive for health care? (N=9)	100%	-
Having someone call the clinic for you? (N=8)	100%	-
Having someone go to the clinic with you to talk with the nurse or doctor? (N=6)	100%	-

***Note.** Only those participants who said they had received the service were asked if it was helpful.*

Benefits of services

Survey respondents were asked to describe the one or two most important benefits they had experienced as a result of receiving services through the Living at Home/Block Nurse Program. The most commonly mentioned benefit, in all three surveys, was the reassurance of knowing that there was support available, that there was someone there to talk to if they had questions or needed help. Medication management and arranging services were also frequently mentioned as "most important" benefits.

In 2005, caregivers also reported the kinds of relief they had realized as a result of the Living at Home/Block Nurse Program services (Figure 14).

14. Types of relief reported by caregivers* (August 2004 – June 2005)

Since working with (service coordinator) at the Block Nurse Program, have you…	(N=8) Yes	No	If "YES," Would you say this has been... Very important	Somewhat important	Not too important
Received relief from care giving responsibilities?	7	1	5	2	-
Felt less stressed?	6	2	6	-	-
Felt less isolated?	5	2	4	1	-
Spent time with friends and engaged in social activities?	4	4	4	-	-
Spent time with the rest of the family?	5	3	4	1	-
Had time to pursue personal interests?	5	3	4	1	-
Been able to go to work?	3	5	2	1	-

Note. *This table applies only to the 2005 survey; no caregivers were interviewed in 2007 or 2008.*

Goal 3: Facilitate transitions from care sites to home without problems

Coordination between LAH/BNPs and hospital and clinic staff

Partners and direct service staff described a number of positive changes that they believe are smoothing participants' transitions from hospitals or other health care settings to home and helping prevent unnecessary institutional placements and hospital readmissions. They include:

- Improved communications between the LAH/BNPs and social workers and discharge planners
- A greater willingness on the part of hospital and clinic staff to coordinate work with the Living at Home/Block Nurse Programs
- Better understanding on the part of participating hospitals and clinics of how community services can increase the likelihood of successful transitions to home
- More established procedures in place to coordinate with the LAH/BNP in addressing the needs of the patient who is returning home

The Referral Line

The Referral Line was put in place to assure that participants have appropriate transitions between and among hospitals, primary care clinics, transitional care programs, and other health and social services. The Referral Line, operated by the Wilder Foundation, receives and responds to calls 24 hours a day/7days a week to enhance the quality of these transitions. Use of the Referral Line increased somewhat from 2005 to 2008. The Referral Line received 53 calls from July 2005 through June 2006, 76 calls from July 2006 through June 2007, and 84 calls from July 2007 through June 2008.

Help before and/or after hospitalizations

A significant proportion of survey respondents reported that they had received help from the LAH/BNP related to a hospitalization.

15. Participants reporting service use before or after hospitalization

Did you receive help from the Block Nurse Program before or after your hospitalization, or both times?	August 2004 – June 2005		July 2005 – June 2007		July 2007 – June 2008	
	Number	Percent	Number	Percent	Number	Percent
Before	7	12%	5	28%	2	11%
After	29	48%	7	39%	10	53%
Both	25	41%	6	33%	7	37%
Total	61	100%	18	100%	19	100%

Participants who had been hospitalized were asked if they received help from the Living at Home/Block Nurse Program before or after their hospitalization. In 2005, of the 64 participants who reported a hospitalization, seven received help before being hospitalized, 29 received help after hospitalization, and 25 received help both before and after. Three participants did not know or could not remember.

In 2007, of the 20 participants who reported a hospitalization, five received help before being hospitalized, seven received help after being hospitalized, and six received help both before and after. Two participants did not know or could not remember.

In 2008, of the 19 participants who reported a hospitalization, two received help before being hospitalized, 10 received help after being hospitalized, and seven received help both before and after.

Participants were also asked to describe the ways in which the program staff were helpful to them before or after hospitalization. In all three survey periods, participants most often mentioned having someone call or check on them, knowing someone was there, or having someone to talk to. The following table provides a summary of participants' responses.

16. Ways in which SPICE-Bridge Partnership staff were helpful to participants before or after hospitalization

	August 2004-June 2005 (N=64)		July 2005-June 2007 (N=20)		July 2007-June 2008 (N=19)	
Themes given by participants	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Having someone call or check on them/knowing someone is there/having someone to talk to	12	19%	18	90%	7	37%
Helped with medication/medication management	12	19%	-	-	5	26%
Helped with daily tasks/chores	7	11%	2	10%	5	26%
Provided helpful information (in general)	-	-	6	30%	4	21%
Accompanied participant to hospital/doctor	-	-	1	5%	4	21%
Helped arrange transportation, housing, medical benefits, translation services/medical equipment	7	11%	6	30%	2	11%
Helped set up the needed services	9	14%	2	10%	2	11%
Helped with bathing/personal hygiene	6	9%	2	10%	2	11%
Helped with physical therapy	-	-	1	5%	2	11%
Helped with medical tests	8	13%	-	-	1	5%
Helped with paperwork/filling out forms	5	8%	-	-	1	5%
Helped set up a living will	-	-	1	5%	-	-

Goal 4: Assess and manage home safety hazards including medication management and risk of falls

Assessments

The Living at Home/Block Nurse Programs either conduct an assessment or confirm that an assessment has been done in each of the following areas: falls prevention, home safety, medication management, blood pressure, Activities of Daily Living , Alternative Care/Elderly Waiver eligibility (if indicated), and depression screening (if indicated). Assessment results are recorded on the Services and Contacts form.

17. Assessments and screenings completed or confirmed

Type of assessment or screening	August 2004-June 2005 (N=141)		July 2005-June 2006 (N=168)		July 2006-June 2007 (N=184)		July 2007-June 2008 (N=205)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Falls prevention	133	94%	150	89%	161	88%	173	84%
Home safety checks	131	93%	143	85%	145	79%	151	74%
Medication management	130	92%	147	88%	143	78%	144	70%
Activities of Daily Living	128	91%	151	90%	160	88%	169	82%
Depression screening	28	20%	53	32%	103	56%	124	61%
Blood pressure screenings	73	52%	97	58%	97	53%	129	63%
Alternative Care/Elderly Waiver eligibility screening	56	40%	83	49%	82	45%	105	51%

Falls prevention assessment

The percentage of participants who had problems noted on their falls prevention assessment remained relatively steady across the four years of the project (40% in the first year, 31% in the second year, 37% in the third year, and 43% in the fourth year). The average number of problems noted in the falls assessment declined from .86 in the first year to .59 in the third year, and increased considerably in the fourth year to 1.1 problems on average.

18. Number of problems noted on falls assessment

Number of problems	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007		July 2007-June 2008	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
No problems noted	79	60%	103	69%	102	63%	99	57%
One problem noted	22	17%	26	17%	43	27%	39	23%
Two problems noted	11	8%	7	5%	8	5%	11	6%
Three problems noted	13	10%	4	3%	4	3%	2	1%
Four problems noted	4	3%	9	6%	3	2%	17	10%
Five problems noted	-	-	-	-	-	-	-	-
Six problems noted	1	1%	1	1%	-	-	-	-
Seven problems noted	1	1%	-	-	-	-	1	1%
Eight problems noted	-	-	-	-	-	-	2	1%
Twelve problems noted					1	1%	2	1%
Total	**131**	**100%**	**150**	**100%**	**161**	**100%**	**173**	**100%**
Average number of problems noted	.86		.75		.59		1.1	

The types of problems noted on the falls assessments are summarized in the following table. The percentage of participants with physical problems that increase the risk of falling rose from 37 percent in 2004 to 91 percent in 2008, while the percentage with home environment problems declined from 35 percent in the first year to 11 percent in the last year.

19. Types of problems noted on falls assessment

	August 2004-June 2005 (N=52)		July 2005-June 2006 (N=47)		July 2006-June 2007 (N=59)		July 2007-June 2008 (N=74)	
Types of problems	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Physical problems (heavy medication, dizziness, poor vision, confusion, etc.)	19	37%	38	81%	51	86%	67	91%
Uses or needs assistive devices (wheelchair, walkers, canes, etc.)	21	40%	17	36%	19	32%	32	43%
Has history of falls	8	15%	9	19%	9	15%	13	18%
Home environment (stairs, railings, rugs, lacks grab bars, etc.)	18	35%	4	9%	5	8%	8	11%
Other problems	4	8%	8	17%	3	5%	7	9%

Home safety checks

The percentage of participants with concerns noted on the home safety check declined across the first three years of the project, and increased slightly in the fourth year (44% in the first year, 29% in the second year, 24% in the third year, 32% in the fourth year). The average number of concerns noted during the home safety check declined from .61 in the first year to .29 in the third year, and then increased somewhat to .40 in the fourth year.

20. Number of concerns noted on home safety check

	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007		July 2007-June 2008	
Number of concerns	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
No concerns noted	73	56%	102	71%	110	76%	103	68%
One concern noted	43	33%	32	22%	29	20%	36	24%
Two concerns noted	8	6%	8	6%	5	3%	11	7%
Three concerns noted	7	5%	1	1%	1	1%	1	1%
Total	**131**	**100%**	**143**	**100%**	**145**	**100%**	**151**	**100%**
Average number of concerns noted on home safety check	.61		.36		.29		.40	

A majority of the types of concerns noted on the home safety check are related to a combination of the house environment and the lack of adaptive devices. Other safety concerns are related to the participant's physical health, the need for someone to check on the participant, and keeping safety alarms in working condition.

21. Types of concerns noted on home safety check

Types of concerns	August 2004-June 2005 (N=58)		July 2005-June 2006 (N=41)		July 2006-June 2007 (N=35)		July 2007-June 2008 (N=48)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Safety concerns due to house environment (stairs, rugs, difficult to maneuver wheelchair, etc.)	30	52%	8	20%	15	43%	23	48%
Safety concerns due to lack of adaptive devices (grab bars, railings, etc.)	4	7%	15	37%	8	23%	7	15%
Safety concerns due to physical health	6	10%	3	7%	6	17%	9	19%
Lack of/needs "Lifeline," someone to regularly check on participant's safety	9	16%	8	20%	6	17%	4	8%
Safety concerns due to lack of or inoperative safety alarms (smoke detector, carbon monoxide detector, etc.)	-	-	6	15%	4	11%	4	8%
Lack of a working phone	-	-	-	-	-	-	2	4%

Medication management review

The percentage of participants with problems noted on the medication management review declined somewhat over the four years of the project (26% in the first year, 21% in the second year, 20% in the third year, 17% in the fourth year). In addition, the average number of problems noted on the medication management review declined from .50 in the first year to .29 in the third and fourth years.

22. Number of problems noted on medication management review

Number of problems	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007		July 2007-June 2008	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
No problems noted	91	74%	95	79%	114	80%	120	83%
One problem noted	18	15%	10	8%	22	16%	18	13%
Two problems noted	4	3%	2	2%	1	1%	2	1%
Three problems noted	8	6%	1	1%	3	2%	-	-
Four problems noted	-	-	13	11%	2	1%	3	2%
Five problems noted	-	-	-	-	-	-	-	-
Six problems noted	2	2%	-	-	-	-	-	-
Eight problems noted	-	-	-	-	-	-	1	1%
Total	**123**	**100%**	**121**	**100%**	**142**	**100%**	**144**	**100%**
Average number of problems noted	.50		.57		.29		.29	

According to worker comments on the medication management review, participants who had at least one problem noted, but were capable of handling their own medication management, increased from 38 percent in the first year to 54 percent in the second year, then decreased to 39 percent in the third year and to 33 percent in the fourth year. Conversely, participants needing help with medication management decreased from 62 percent in the first year to 46 percent in the second year, then rose to 61 percent in the third year and to 67 percent in the fourth year. The following table shows the types of problems noted during the medication review.

23. Types of problems noted on medication management review

Types of problems	August 2004-June 2005 (N=32)		July 2005-June 2006 (N=26)		July 2006-June 2007 (N=28)		July 2007-June 2008 (N=24)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Needs or is receiving help monitoring medication	20	62%	12	46%	17	61%	16	67%
Can handle own medication management	12	38%	14	54%	11	39%	8	33%
Changing/reducing medication	1	3%	3	12%	2	7%	1	4%
Not taking medication/ non-compliance/not filling prescriptions	-	-	4	15%	8	29%	3	13%
Other problems	3	9%	1	4%	1	4%	-	-

Activities of Daily Living

The percentage of participants with problems noted on the Activities of Daily Living assessment rose somewhat over the four years of the project (from 39% in the first year to 48% in the fourth year). The average number of problems noted on Activities of Daily Living assessment also rose, from .47 in the first year to .99 in the fourth year.

24. Number of problems noted on Activities of Daily Living assessment

	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007		July 2007-June 2008	
Number of problems	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
No problems noted	77	61%	110	73%	91	57%	88	52%
One problem noted	41	32%	26	17%	31	19%	14	8%
Two problems noted	8	6%	9	6%	19	12%	47	28%
Three problems noted	1	1%	6	4%	19	12%	20	12%
Total	**127**	**100%**	**151**	**100%**	**160**	**100%**	**169**	**100%**
Average number of problems noted on ADL assessment	.47		.41		.79		.99	

Problems noted on the Activities of Daily Living assessment were grouped according to the level of assistance thought to be needed by the participant. Worker notes on assessment forms indicate that, across all four years of the project, about three-quarters of participants who had at least one problem noted needed "some help" and fewer than 10 percent of participants needed "a lot of help" carrying out their activities of daily living.

25. Level of assistance needed as noted on Activities of Daily Living assessment

	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007		July 2007-June 2008	
Types of problems	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Needs minimal help	6	10%	15	23%	11	22%	8	10%
Needs some help	45	75%	46	72%	37	73%	64	79%
Needs a lot of help	5	8%	3	5%	2	4%	5	6%
Participant is receiving help from family caregiver or agency (level of help needed not noted)	4	7%	-	-	1	2%	4	5%
Total	**60**	**100%**	**64**	**100%**	**51**	**100%**	**81**	**100%**

Depression screening

The percentage of participants who received screening for depression increased threefold over the four years of the SPICE-Bridge project: 28 participants (20%) in the first year, 53 participants (32%) in the second year, 103 participants (56%) in the third year, and 124 participants (60%) in the fourth year.

During the second, third, and fourth years of the project, LAH/BNP staff recorded concerns noted during screening. The type of concern most often noted was that the participant showed signs of depression, including sadness, mood changes, loneliness, and nervousness.

26. Types of concerns noted on the depression screening

	July 2005-June 2006 (N=53)		July 2006-June 2007 (N=103)		July 2007-June 2008 (N=124)	
Types of concerns	Number	Percent	Number	Percent	Number	Percent
Participant shows signs of being depressed (sadness, mood changes, loneliness, nervousness, etc.)	7	13%	25	24%	29	23%
Participant appears to be in denial	2	4%	-	-	2	2%
Participant is experiencing family issues	2	4%	2	2%	2	2%
Participant is grieving/experiencing loss of a loved one	1	2%	5	5%	4	3%
Participant is currently on anti- depressant medication	3	6%	7	7%	6	5%

Vulnerable adult/suspected abuse review

A review of older adult vulnerability or suspected abuse was conducted for a substantial proportion of participants (37% in the first year, 34% in the second year, 36% in the third year, and 24% in the fourth year). This assessment is conducted only when the worker thinks the participant is at risk for vulnerable adult status or for suspected abuse. Comments that workers made on these reviews are summarized in Figure 27.

27. Types of concerns noted on the vulnerable adult/suspected abuse review

Types of problems noted during review of vulnerable adult status or suspected abuse	July 2005-June 2006 (N=57)		July 2006-June 2007 (N=66)		July 2007-June 2008 (N=50)	
	Number	Percent	Number	Percent	Number	Percent
Participant is a vulnerable adult/lives alone	1	2%	2	3%	3	6%
Participant is not safe at home without services/needs support of program	2	7%	1	2%	3	6%
Participant has memory loss/dementia	-	-	3	5%	1	2%
Participant is at risk of financial exploitation	-	-	2	3%	5	10%
Participant lets people into apartment/ many people in and out of home	-	-	4	6%	1	2%
Adult Protection is involved	1	2%	-	-	3	6%
Participant drinks heavily	-	-	2	3%	1	2%
Participant is not taking care of self	-	-	1	2%	1	2%

Advocacy, support, and health care services

The Living at Home/Block Nurse Program staff made clinic, health, or other types of advocacy contacts on behalf of about half of the SPICE-Bridge participants. Health advocacy contacts include any health-related contacts other than clinic contacts. Examples include advocating on behalf of the participant with health plans, ancillary health care providers, pharmacies, therapists, hospitals, nursing homes, transitional care units, and mental health workers. Other advocacy includes advocating with non-health-related contacts such as lawyers, banks, cleaning services, accountants, credit card companies, and retail stores. The figure below shows the average number of hours of advocacy provided to participants.

28. Average number of hours the Living at Home/Block Nurse Program staff spent on advocacy

Type of advocacy	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007		July 2007-June 2008	
	Number receiving service	Average hours of service	Number receiving service	Average hours of service	Number receiving service	Average hours of service	Number receiving service	Average hours of service
Health advocacy	62	7.2 hours	74	7.3 hours	99	5.5 hours	111	4.5 hours
Clinic advocacy	47	10.0 hours	44	5.9 hours	43	3.6 hours	63	4.5 hours
Other advocacy	101	10.5 hours	87	7.8 hours	116	6.3 hours	131	7.0 hours

Figure 29 shows the percentage of participants who received a home visit from a nurse or home health aide and the average number of visits provided by either a nurse or home health aide. The percentage of participants who received a visit from a nurse remained relatively stable over the four years of the project while the average number of visits per participant increased. The percentage of participants who received a visit from a home health aide also remained relatively stable. However, the average number of visits by a home health aide increased substantially in the last two years of the study.

29. Home visits made by nurse and home health aide

	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007		July 2007-June 2008	
	Nurse	Home Health Aide	Nurse	Home Health Aide	Nurse	Home Health Aide	Nurse	Home Health Aide
Percent of participants who received a visit	47%	26%	47%	31%	48%	25%	43%	27%
Average number of visits	13.6 visits	46.0 visits	15.9 visits	29.7 visits	19.8 visits	76.0 visits	29.1 visits	65.3 visits

Participants received many types of assistance. Figure 30 shows the most common types of assistance received by SPICE-Bridge participants.

30. Assistance received by participants

Type of assistance/service	August 2004-June 2005 (N=141)		July 2005-June 2006 (N=168)		July 2006-June 2007 (N=184)		July 2007-June 2008 (N=205)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Contact with staff	136	97%	156	93%	176	96%	192	94%
Average number of contacts	9.8 contacts		10.9 contacts		13.9 contacts		14.2 contacts	
Volunteer assistance provided	55	40%	61	36%	78	42%	94	46%
Average service hours provided by volunteers	16.4 hours		15.2 hours		25.1 hours		24.2 hours	
Transportation to clinic	48	34%	41	24%	45	25%	50	24%
Average number of clinic trips	4.6 trips		5.7 trips		6.3 trips		10.7 trips	
Meals-on-Wheels	37	26%	58	35%	62	34%	60	29%
Blood pressure screening	73	52%	97	58%	97	53%	129	63%
LifeLine installed	44	31%	48	29%	63	34%	67	33%
Chore/Homemaker services	64	45%	68	41%	80	44%	92	45%
Occupational/physical therapy	15	11%	21	13%	22	12%	36	18%

Palliative Care

Palliative care records are available from the Services and Contacts forms for the second through fourth years of the project.

Service and Contacts form records show that one participant received a palliative care visit during the second year of the project. The follow-up recommendation based on that visit was to be sure that the family understood the issues. Following that visit, a hospice benefit was obtained. The participant was in hospice care for one month preceding death.

Seven participants received a palliative visit during the third year of the project. No recommendations were recorded following those visits. One participant obtained a hospice benefit. The participant was in hospice care for one month preceding death.

In the last year of the project, three participants received a palliative visit. Three recommendations were made following those visits. Two participants obtained a hospice benefit. Both participants were in hospice care for one month preceding death.

Goal 5: Inform participants of advance directives regarding health care decisions; encourage and facilitate their completion as appropriate

Health Care Directives (HCD)

One of the primary objectives of the SPICE-Bridge Partnership project was to have participants complete a Health Care Directive. The percentage of participants with a completed Health Care Directive ranged from 56 percent in the first year to 42 percent in the last year. However, about 90 percent of participants in each year had a Health Care Directive in place, were in the process of preparing one, or had had a preliminary discussion regarding health care decisions. Workers recorded HCD status on the Services and Contacts forms.

31. Status of Health Care Directives (HCD)

	August 2004-June 2005	July 2005-June 2006	July 2006-June 2007	July 2007-June 2008
	Number	Number	Number	Number
Participants served *	140	164	182	205
Participants with HCDs under discussion	50	67	71	98
Participants with completed forms	78	78	91	85
Percent of all participants with HCDs in progress or completed	91%	88%	89%	89%

* *Status information on advance directives was missing for 7 clients.*

File of Life and Resuscitation Form

Living at Home/Block Nurse Program staff also provided information to participants about the File of Life and Resuscitation Form, and were available to facilitate their completion if appropriate.

The table below shows the number and percentage of participants with a completed File of Life and a completed Resuscitation Forms in each of the four years of the project, based on workers' notes on the Services and Contacts forms.

32. File of Life, and Resuscitation Form status

	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007		July 2007-June 2008	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Completed File of Life	109	77%	98	58%	114	62%	124	61%
Completed Resuscitation Form	92	65%	68	41%	68	37%	69	34%

Goal 6: Help participants to maintain health care appointments and reduce unnecessary hospitalizations and emergency room visits

Wilder Research analyzed kept and missed clinic appointments, hospital admissions and readmissions, and emergency room utilization tracked by the partners. Hospital and clinic data show an increased number of missed clinic appointments, hospitalizations, and emergency room visits post-enrollment compared to pre-enrollment.

Clinic appointments

Across the four years represented in this report, clinic appointment data were available for 137 older adults for the 12 months prior to their enrollment in the SPICE-Bridge Partnership and for the time they were enrolled in the project. The number of kept appointments prior to enrolling in the project ranged from 0 to 80 visits, and the number of missed appointments ranged from 0 to 28. The average number of kept appointments prior to enrollment was 6.3, and the average number of missed appointments was 2.0. The number of kept clinic appointments following enrollment in the project ranged from 0 to 113, and the number of missed appointments ranged from 0 to 34. The average number of kept appointment following enrollment was 22.7, and the average number of missed appointments was 21.2. The difference in the average number of kept and missed appointments pre- and post-enrollment was not statistically significant.

However, if we look at the percentage of participants who missed appointments after enrolling in the program, we find that a larger percentage of participants missed

appointments after enrolling in the SPICE-Bridge program than they missed before they enrolled. The percentage of missed appointments was higher post-enrollment for 58 percent of participants, lower for 28 percent of participants, and the same for 14 percent of participants. The difference based on the change in the percentage of participants with missed appointments is statistically significant ($p<.001$).

Hospital admissions, readmissions and emergency room visits

SPICE-Bridge Partnership staff kept logs of emergency room visits, hospital admissions, and hospital readmissions in the year prior to enrolling into the SPICE project as well as during the project period. Across the four years of the project, pre- and post-enrollment information was available for 197 participants.

- Pre-enrollment hospital admission data are only available for a one year period prior to project enrollment. It is therefore not surprising that records post-enrollment over a four year time period would show a significantly larger number of hospitalizations, hospital readmissions, and emergency room visits than in this brief look-back period. However, if the 45 participants who were admitted to the hospital just preceding their death are removed from the analysis, the difference in hospital admissions is not statistically significant.

- The number of hospital admissions ranged from 0 to 9 pre-enrollment and 0 to 12 post-enrollment. The average number of admissions to the hospital pre-enrollment was .75 and at post-enrollment was 1.6. The difference based on changes in the percentage of participants with hospital admissions prior to enrollment (7%) and post-enrollment (13%) is statistically significant ($p<.05$). This may be a reflection of the population being served and their deteriorating physical health conditions.

- The number of emergency room visits ranged from 0 to 8 pre-enrollment and 0 to 12 post-enrollment. The average was .53 pre-enrollment and 1.1 post-enrollment. The difference based on changes in the percentage of participants with emergency room visits prior to enrollment (12%) and post-enrollment (37%) is statistically significant ($p<.001$). There is an indication that this increase may be a result of the health industry practice of admitting many patients to the hospital through the emergency room.

- The number of hospital readmissions within 30 days of being admitted ranged from 0 to 3 pre-enrollment and 0 to 6 post-enrollment. The average number of readmissions to the hospital within 30 days of being admitted was .09 pre-enrollment and .24 post-enrollment. The difference based on changes in the percentage of participants with readmissions to the hospital prior to enrollment (18%) and post-enrollment (44%) is statistically significant ($p<.001$). This may be a reflection of the population being served and their deteriorating physical health.

A note on interpreting data on clinic appointments, hospitalizations, and emergency room visits

The clinic and hospital data presented above that show an increased number of missed clinic appointments, hospitalizations and emergency room visits post-enrollment compared to pre-enrollment should be interpreted with caution.

It appears more likely that, prior to enrollment, some participants used clinics or hospitals that were not one of the SPICE-Bridge partners and, therefore, did not provide data on kept or missed appointments, hospitalizations, or emergency room visits. It is more likely that the study would detect these events after enrollment in the SPICE-Bridge project because of the likelihood of alignment with project affiliated clinics and hospitals.

In addition, data prior to service was available for a more limited time frame than was available for participants after program involvement.

Study findings also suggest that the program is now serving an older, frailer, and more at-risk population than in earlier years and, consequently, there is a greater likelihood of emergency room visits and hospital admission based on illness or other types of physical distress. It is notable that there has been a steady increase in average number of clinic visits for participants over the four years of the project.

Goal 7: Reach out and work with new partners to replicate and improve services, improve cultural literacy, and strengthen referral processes

Outreach

From 2004 to 2008, SPICE-Bridge LAH/BNP staff initiated and participated in a variety of meeting, seminars, and workshops aimed at increasing understanding of health care related needs and improving services in the Latino, Somali, and Hmong communities of St. Paul. Topics included Alzheimer's disease, diabetes, and problems encountered by older adult immigrants in using social services and health care services in the United States.

SPICE-Bridge project LAH/BNP staff have partnered with the University of Minnesota, Century College, Inver Hills Community College and Metropolitan State University to provide experience working with culturally diverse seniors to approximately 80 Service Learning students each year. The Payne-Phalen LAH/BNP has become known as a hub for service learning in the last five years.

Living at Home/Block Nurse Program staff members were instrumental in establishing the East Side Wellness Collaborative in 2006, a group of individuals representing 25 health care companies, clinics, agencies, and community programs on St. Paul's East

Side. The collaborative clinics were set up in two public housing sites: Edgerton Hi-rise and Parkway Gardens.

Evaluation interviews conducted in 2008 with Spanish-speaking participants revealed satisfaction rates as high or higher than found in the general population of participants served.

Referral sources

Over the four years of the project, the main referral sources for the SPICE-Bridge project were internal referrals (staff or previous participants of the Living At Home/Block Nurse Programs), Wilder Community Services, United Family Practice Health Center or United Hospital, and friends or family members.

The number of referral sources increased from 9 in 2004-05 to 28 in 2007-08. Almost all of the more recent referral sources are community-based home services or social service organizations. Only one community service agency (other than Wilder Community Services) made referrals to the program in 2004-05; 13 made referrals in 2007-08. This expansion of referral sources indicates a greater likelihood of community connectedness within and among programs.

Some additional changes that have occurred in referral sources across the four years of the project:

- Participants who had previously been served through Living at Home/Block Nurse Programs made up 40 percent of the persons served in year one, only 9 percent in years two and three, and 19 percent in year four
- Referrals from clinics and/or hospitals (including physician and nurse referrals) declined from 27 percent in the first year to 18 percent in the fourth year
- The percentage of referrals from Ramsey County social workers or adult protection workers increased from 1 percent in the first year to 5 percent, 7 percent, and 4 percent in years two, three and four
- Self-referrals more than doubled from 2004 to 2008 (8 in 2004-05; 21 in 2007-08)
- Referrals by friends or family increased steadily from 4 percent in the first year to 21 percent in the fourth year

The table below shows the sources of referrals made to the SPICE-Bridge Partnership during the project period, based on information from the Services and Contacts forms.

33. Referral sources of older adults served through the SPICE-Bridge Partnership

Referral source	August 2004-June 2005 (N=140)		July 2005-June 2006 (N=165)		July 2006-June 2007 (N=183)		July 2007-June 2008 (N=203)	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Living At Home/Block Nurse Programs								
Previously served by LAH/BNP	56	40%	15	9%	17	9%	39	19%
Internal referral (LAH/BNP staff)	23	16%	40	24%	50	27%	9	4%
Hospitals/clinics								
United Family Health Center/ Hospital	24	17%	21	13%	23	13%	22	11%
Physician/nurse	12	9%	12	7%	5	3%	7	3%
Hospital/clinic – not identified	2	1%	1	1%	1	1%	4	2%
HealthEast	-	-	2	1%	2	1%	1	1%
St. Joseph's Hospital	-	-	-	-	1	1%	1	1%
Health Partners	-	-	2	1%	1	1%	-	-
Regions Hospital/Regions Senior Clinic	-	-	1	1%	-	-	-	-
Midway Clinic	-	-	1	1%	-	-	-	-
Discharge planner	-	-	-	-	1	1%	-	-
Wilder Community Services	-	-	12	7%	25	14%	24	12%
Other community/social service agencies								
Pastoral worker/church	-	-	2	1%	-	-	3	2%
Two Sister's Professional Cleaning	-	-	-	-	-	-	3	2%
Meals on Wheels	-	-	1	1%	2	1%	2	1%
Jewish Family Service	-	-	1	1%	-	-	2	1%
Catholic Charities	-	-	-	-	-	-	2	1%
Heartland Home Care	-	-	-	-	1	1%	1	1%
Senior Linkage Line	-	-	-	-	1	1%	1	1%
Aspen Home Care	-	-	-	-	-	-	1	1%
Collum Mura Family Services	-	-	-	-	-	-	1	1%
Volunteers of America	-	-	-	-	-	-	1	1%
Neil Hi-Rise	-	-	-	-	-	-	1	1%
Highland Chateau Nursing Home	-	-	-	-	-	-	1	1%
CLUES	8	6%	2	1%	2	1%	1	1%
West 7th Senior Program	-	-	9	6%	2	1%	-	-
Franciscan Home Health	-	-	1	1%	-	-	-	-
SPICE/Elderberry	-	-	1	1%	-	-	-	-

33. Referral sources of older adults served through the SPICE-Bridge Partnership (continued)

Referral source	August 2004-June 2005 (N=140) Number	Percent	July 2005-June 2006 (N=165) Number	Percent	July 2006-June 2007 (N=183) Number	Percent	July 2007-June 2008 (N=203) Number	Percent
Ramsey County	2	1%	8	5%	12	7%	8	4%
Health care insurance programs								
UCare	-	-	-	-	-	-	1	1%
Evercare	-	-	-	-	2	1%	1	1%
Other sources								
Friends or relatives	5	4%	9	6%	19	10%	43	21%
Self-referral	8	6%	15	9%	12	7%	21	10%
Other person (relationship not given)	-	-	9	6%	4	2%	2	1%
Total	**140**	**100%**	**165**	**100%**	**183**	**100%**	**203**	**100%**

Goal 8: Better meet the needs of culturally and ethnically diverse populations

Partners in the SPICE-Bridge project have made efforts to better understand and address the needs of culturally and ethnically diverse populations in St. Paul. They include the following:

- In July 2007, a Payne-Phalen Living at Home Block Nurse Program representative presented at a SPICE Neighborhood Group meeting on her work with Alzheimer's disease in the Latino Community
- In September 2007, Omar Jamal, from the Somali Justice Center, met with the SPICE Neighborhood Group to discuss the difficulties that older Somali adults immigrants have with using social and health-related services in the United States
- A Payne-Phalen Living at Home Block Nurse Program staff person helped develop a dementia screening tool in Spanish and consults with other Living At Home/Block Nurse Programs regarding their Latino clients who have dementia
- The Living At Home/Block Nurse Programs established contact with the Somali community in St. Paul and offered assistance to adult immigrants in this population, many of whom live in isolation or with few supports

Additional evidence that the SPICE-Bridge project has taken steps to better serve diverse populations in their service areas is indicated by the following study findings:

- The percentage of African American participants increased from 4 percent in the first year to approximately 20 percent in the second through fourth years of the project
- The proportion of all SPICE-Bridge project participants of color increased from 14 percent to 28 percent over the four years of the project
- There were no significant differences in satisfaction rates reported by white participants compared to participants of color

Goal 9: Improve opportunities for reimbursement from health plans for the Living at Home/Block Nurse Program services.

The project has secured reimbursement for some Living at Home/Block Nurse Program services through Evercare and UCare.

- Evercare authorizes some of the Living at Home/Block Nurse Programs to provide service coordination on behalf of their clients
- UCare pays the Living at Home/Block Nurse Programs for a specified number of interventions to provide Independent Living Skills services

Appendix 6

Partner interviews

In 2005, Wilder Research staff conducted telephone interviews with 20 SPICE-Bridge Partnership partners. Respondents' roles in the Partnership varied: four respondents worked directly for hospitals involved in the Partnership, four represented Living at Home/Block Nurse Programs, five were administrators for nonprofit agencies involved in the Partnership, two had expertise in reimbursement for care, two worked to coordinate services for seniors in the community, two directed programs for volunteers or interns, and one was a consultant to the Partnership.

In 2008, Wilder Research interviewed 17 SPICE-Bridge Partnership project partners. Groups represented by partners interviewed in 2008 were similar to those in 2005: four respondents worked directly for clinics or hospitals involved in the Partnership, six represented Living at Home/Block Nurse Programs, four were administrators for nonprofit agencies involved in the Partnership, two had expertise in reimbursement for care, and one served as a consultant to the Partnership.

Progress toward overall Partnership goals

Goal One: To link all partners together to improve care, enhance effective communication (physical, emotional, and cultural) for participants, and contain costs during transitions from home to clinic to hospital to transitional care, and back home.

In 2005, respondents were asked only to rate the extent to which they agreed or disagreed that this goal was met. Ninety percent (18 of 20) of the partners interviewed "agreed" or "strongly agreed" that the SPICE-Bridge Partnership had achieved this goal. Two respondents "disagreed."

In 2008, respondents were asked to rate separately the extent to which they thought that the Partnership had met each of the three parts of Goal One: Respondents' ratings and comments about Goal One were mixed. Respondents appear to feel that more progress was made in meeting the first two parts of the goal – improving care and enhancing effective communication for participants than was made toward achieving the third part of the goal – containing costs during transitions between health care settings.

Goal One - Part One: Improve care for participants

When asked about the extent to which they thought the Partnership had met this goal, seven respondents (41%) said "almost entirely," nine respondents (53%) said "somewhat," and one respondent (6%), said "a little." Respondents were also asked to comment on their ratings. Their responses, in their own words, follow:

Goal almost entirely met

> Because of our regular meetings, discussing this, and then being in action about it.
>
> I feel we have been able to avoid crises. We have met the goal of making a difference.
>
> I think the expectations we had were realistic. What we were looking for was that compliance with visits would improve, and that there were people in the community who could observe conditions and report on them. Compliance was a big issue with us, and it isn't anymore.
>
> It has prevented ER visits and hospitalizations. It helps to provide good decision-making. They are able to identify needs and appropriate resources to meet those needs. They provide advocacy.
>
> It is the communication piece. The patient is landing in a better spot because someone is there to help them with their medications and to navigate the system.
>
> I think there is a vast improvement in what has happened over the past few years, in light of all that has been happening in the health care system. There is a lot we cannot control.
>
> People are able to receive a service they may not have received because of their income level or other reasons. They were able to call on SPICE to receive those services. I do not know if it is a program strictly based on income guidelines; I have not been with it that long.

Goal somewhat met

> It is like moving mountains. Some is back to staffing changes. Also, the issue of whether there is ongoing commitment from the partners.
>
> I think there are always communication issues. There is lots of continuing turnover among staff, and what you think you accomplished one day doesn't always translate to the next day when there is staff turnover.
>
> We didn't meet all the goals we set out to meet. I think there was not enough time. We had to build a model before we could start implementing the model, and that took time.
>
> I think that it improved care in certain circumstances, but I don't know that it improved care when they were enrolled but did not have a transition situation. I don't think their care changed.

> That was the first thing that came to my mind. I do think the involvement of professional staff keeps the participants motivated, keeps them healthier by making sure they keep their appointments, providing someone to be checking on them, etc.
>
> I don't feel there was full participation from some of the partners.
>
> It is very hard to move a battleship. As much as we would have liked to have been on top of every situation where a person went into the hospital, it just didn't happen all the time.
>
> In the best case scenario, things would always go smoothly, but with staff turnover and changes in protocol, and new computer systems, improvements in participant care are not always as great as hoped.

Goal has been met a little

> We work with all the programs. Some have really shined. For others, it would have been better if they had not been involved. I tried to average it. Also, for those we have been involved with, we have to communicate directly with the hospital and clinics rather than with the LAH/BNPs. The LAH/BNPs don't have to be part of that loop for us to do our job. They complement what we do but aren't essential services for us.

Goal One – Part Two: Enhance effective communication for participants

When asked the extent to which they thought the Partnership had met this part of the goal, five respondents (29%) said "almost entirely," 11 respondents (65%) said "somewhat," and one respondent (6%), said "not sure." Respondents were asked to comment on their ratings. Their responses, in their own words, follow:

Goal almost entirely met

> We did a great job in our cultural piece. We presented it in different places, and it is discussed.
>
> They come in with them on their appointments. They can communicate what they see in the home. And they are right there and are able to hear what the doctor is saying, and vice versa.
>
> I have a very high expectation, with regard to communication and what it can do to make a difference in the lives of the participants and in making the work of all the different agencies, the coordination of that work, improve the quality of life for the participant.
>
> I think there were a lot of meetings and opportunities to share those things and to strengthen that.

> With all the services that are available, the communication can be relayed on to them as a participant. Otherwise, they might not have been able to afford to go to the doctor or have the other services, along with going to the service. It stops them from going into the emergency room and having us taxpayers pay for that.

Goal somewhat met

> All of the partners' direct service did not have the same commitment.
>
> We were not as able to focus on cultural and ethnic uniqueness as I would like to see.
>
> We didn't meet that goal for all participants, not as a result of the collaborative not trying, but some of the clients didn't fit into the model, or they were ideal participants on paper, but they wouldn't participate. Not all clients needing services will accept them.
>
> Some LAH/BNPs' communication systems are better than others.
>
> There are occasions, with certain LAH/BNPs, where communication was not enhanced. I cannot give any examples off the top of my head.
>
> Looking at the different programs, some are always doing a better job, some are sketchy.
>
> I am not sure about the cultural component. That hasn't seemed to be an issue. That has been in the forefront a lot.
>
> The Partnership is setting up systems. It really depends on how each program is using those systems. Speaking for myself, I think it has worked well for us for communicating. But I am not sure it has, across the board, for all partners. Depending upon their other commitments with their work, I don't know just how engaged they are in this project.
>
> We never quite got a handle on the cultural part of it. There was supposed to be some very significant work done with regard to the cultural part. There was some work done, but not as much done as I would have expected.
>
> Staff turnover has gotten in the way of achieving this goal entirely (also new protocols and computer systems). Participants and social workers get used to working with certain staff workers, and when they leave you are back to square one in many ways. Time taken to learn new protocols and computer systems also gets in the way of effective communication, at least in the short term.

Goal One – Part Three: Contain costs during transitions between health care settings and home

Four respondents (24%) rated this goal as "almost entirely met," six respondents (35%) said "somewhat met," two respondents (12%) said "met a little," and five respondents (29%), said "not sure." Respondents were asked to comment on their ratings. Their responses, in their own words, appear below:

Goal almost entirely met

> It is my strong belief we have avoided crises and the need to transfer people to more living arrangements – nursing homes, assisted living, etc.
>
> If people don't know what to do, this is a program designed to help in all those needs. That is why this program is very beneficial to continue, so we can help all those who need it.
>
> By preventing return hospitalization, through knowing the participant well enough, and knowing neighborhood resources well enough to identify needs and assure successful care.
>
> If our services are used then there is some cost containment. If our services were not used, there would have been expensive care in a nursing facility, etc.

Goal somewhat met

> Sometimes, we were not aware the participant was in the hospital or were not aware of appointments when they were in the program, or we were not aware that they had not kept any of their appointments. Any time, if there is a good transition, and the client doesn't have to go to the nursing home, that saves costs. And when the BNP is involved and appointments are kept, etc, so that the client does not have to end up in the nursing home, that is a containment of costs.
>
> One of the goals was to reduce readmissions. I think what we did was not necessarily reduce readmissions, but it was better care. More appropriate – meaning actually getting the person in, who needs to be in, quicker.
>
> They are here, getting patients to be more compliant keeping appointments, coming in with patients, getting them to do what they should be doing for their health, keeping them compliant with that. All of this helps cut down on the need for hospitalizations and emergency visits.
>
> I think there is a lot to be developed with the health care plans as far as reimbursement. It is a work in progress. It is reflective of what is going on in health care. Unless we are working with some of the big systems, we cannot benefit from the economies of scale.
>
> It's hard to comment, because it's hard to evaluate on cost. For example, if the client is in the hospital, and we are involved, they may go home right away, rather than into some other care setting. Plus, we can do things in the home that may alleviate hospital visits.

Goal has been met a little

> I don’t necessarily see them containing costs or influencing that.
>
> It would be around having some streamlined process, where it would take less time, and there would be some efficiencies gained. From my perspective, I never saw written documentation, evaluative data, etc, to base an answer on. I am just speculating at what it might be. That might be from my own limited involvement in the project; we are not a very involved partner.

Goal Two: To create sustainability of Living at Home/Block Nurse Program services through more direct reimbursement of covered services by Evercare, health care plans, and AC-EW.

In 2005, respondents were asked only to rate the extent to which they agreed or disagreed that Goal Two had been met. Six respondents (30%) did not feel that they knew enough to rate the Partnership's progress in this goal area. Nine respondents (45%) agreed that the partnership had achieved this goal, and five respondents (25%) disagreed.

In 2008, respondents were asked to rate the extent to which Goal Two was met. Two respondents (12%) said "almost entirely," nine respondents (53%) said "somewhat," five respondents (29%) said "a little," and one respondent (6%), was not sure how to answer. Overall, respondents' ratings indicate that they feel the Partnership made less progress toward meeting this goal than they made toward meeting Goal One. Respondents were asked to comment on their ratings. Their responses, in their own words, appear below.

Goal almost entirely met

> It has adequately demonstrated that it does work. It has been shown that it is cost effective, through the coordination of activities which not only benefit the lives and care of participants, but avoid the costs of hospitalizations and expensive care arrangements.
>
> I believe everybody wants to stay at home as long as possible. If we didn't have that kind of care with our nurses, nobody would be able to stay at home. Our hospitals and care centers would be completely full. And then the people who really need the hospitals and care centers – there wouldn't be any room for them, because they would already be full.

Goal somewhat met

> Our program has been fortunate to work with Evercare and with Elderly Waiver, which has generated sustainable money. Some neighborhoods do not have as many clients who are eligible.
>
> We have been very pleased with the effort at West 7th with Evercare. Some others have adopted it. I would like to see more programs adopt the Evercare reimbursement model.
>
> Not all, but some, of the partners entered into contracts with Evercare, and there was some reimbursement flowing to those partners.
>
> I think that the block nurses [LAH/BNPs] tend to be open to patients that are not going to be open to other agencies, because they are more homebound. They may be more likely to "open" to them when they are in need of a sliding fee scale, don't have the money to pay for services, their insurance doesn't cover the services they need, etc.

I think some LAH/BNPs either have more professional staff or are able to provide more returns, so providers subscribe to them. To get a contract for third-party services, you have to be capable of providing a ton of services, and some don't have the staff to do it.

I think it has been difficult to get reimbursement from the health plans, more difficult than from Evercare.

They are not being reimbursed for all those pieces. As I understand, they are not being reimbursed for case management by Alternative Care or Elderly Waiver.

They have developed a relationship with Evercare and are working to develop relationships with others. It depends on the neighborhood. For us, there is only one who would qualify for Evercare, and that person did not want to do it. [For] the people that are not on waiver, there is the need for being able to set up reimbursement for services and case management.

For my own program, I don't have these options (Evercare and other health plans), so as hard as I could work on this, it just would not happen. The Macalester-Groveland LAH/BNP is in the same boat. Only one program I know has had success with Evercare. Not many of our clients are eligible for AC or EW, although the project has opened my eyes to the opportunity of this funding for participants who might qualify.

Goal has been met a little

One of our goals was to have more BNPs involved with Evercare and the Alternative Care and Elderly Waiver. One of our programs was doing well with Evercare clients, mine is not, and another program has jumped out. Part of that, many of our clients are HealthPartners clients, not Evercare. Evercare care benefits those who use United Hospital and United Health Care, mostly.

We tried to get reimbursement from Evercare, and it did not work. We also tried from UCare, but their forms are too complicated, and it doesn't work. I am so frustrated. We have spent more time involved to try to get reimbursed than it was worth.

> If they wanted to grow the relationship with our program, they would make referrals into our program. This program is not finding a reciprocal relationship. However, in my role, I advocate to maintain the relationship because of the benefits to participants. Another reason it is difficult for us to work with LAH/BNPs is that there is a lack of consistency, program to program [among BNPs], requiring great effort on our part to know which participants and which issues are appropriate to refer to which program. And there is unreliability in the different programs and questionable decision-making, which raised concerns from previous relationships with some LAH/BNPs. The relationship with LAH/BNPs is a small one within our organization, which is large. There are only a few participants which we have in common, which makes it difficult for the large plan to adapt billing and record keeping to the needs of a small, very unique program, such as a LAH/BNP. If there was continuity among programs, the relationship could more easily grow, without [BNPs] losing their uniqueness. It would be nice if the plans could standardize how the BNPs will be identified and compensated for their services provided. For example, billing codes used on large scale, such as independent living specialists, etc.
>
> I only know of one client that really seemed to be providing much service that was billable. The others, I don't know that they have.
>
> There was a fair amount of success in having contracts with Evercare and a health plan, but the numbers of clients who were participating in those were very small, resulting in not very much actual reimbursement. There wasn't the opportunity.

Progress toward smoothing the transitions between care settings and home

In 2005, examples of the types of progress that partners felt were made by the SPICE-Bridge Partnership in improving the process of transition included:

- improving connections and communications with clinics and doctors
- expanding the Living At Home/Block Nurse Programs' presence in the community to meet the needs of older adults
- creating a more realistic picture of what is happening in the homes of older adults
- establishing a central intake process

In 2008, the types of progress or improvements mentioned by the partners were similar to those given in 2005, with an emphasis on improvements in communication between organizations to provide better transitions.

Benefits to the participants

In 2005 and 2008, partners were asked to describe the one or two most important benefits that participants have experienced as a result of the SPICE-Bridge Partnership project. The most common responses were:

- The Partnership improved continuity of care for patients after hospital discharge (9 responses in 2005, 3 responses in 2008)
- The Partnership enabled a smoother transition between hospital and home (6 responses in 2005, 1 response in 2008)
- The Partnership improved networking and shared learning among organizations (5 responses in 2005, 3 responses in 2008)
- The Partnership improved communication between partners (3 responses in 2005, 4 responses in 2008)
- The Partnership helps allow people to live in their own homes (3 responses in 2005, 5 responses in 2008)
- The Partnership leads to few emergency situations for participants (2 responses in 2005, 1 response in 2008)
- The Partnership allows access to more services (1 response in 2005)

In 2008, partners were also asked the extent to which they agreed or disagreed with the following statements about potential benefits of the Spice-Bridge Partnership to participants. While almost all respondents agreed with the statements, there were some differences among those with which they strongly agreed and somewhat agreed (Figure 34).

34. Benefits to participants as seen by Spice-Bridge partners

Spice-Bridge partners who strongly agree or somewhat agreed with the following statements:	2008 (N=16)			
	Strongly agree		Somewhat agree	
	Number	Percent	Number	Percent
Increased networking and sharing of information among organizations	14	88%	2	13%
Improved continuity of care for participants or patients	10	63%	6	38%
Improved access to services for participants	10	63%	5	31%
Improved ability of participants to remain living in their own homes	10	63%	6	38%
Smoother transitions between hospital or other care settings and home	8	50%	7	44%
Improved communications among partners	8	50%	8	50%
Improved safety of participants; fewer emergency situations for participants	6	38%	7	44%

Rating scale: *strongly agree, somewhat agree, somewhat disagree, or disagree.*

Helpfulness of SPICE-Bridge Partnership to the work of the partners

In 2005, partners were asked how the SPICE-Bridge Partnership project has helped them in their role or in the work of the partners. Responses included the following:

- Linking different programs and improved networking (6 responses in 2005)
- They gained an increased understanding of community resources that are available to them (6 responses in 2005)
- They gained understanding of the needs that community members have (3 responses in 2005)
- Felt able to provide better services (3 responses in 2005)
- Improved general knowledge of health care delivery (2 responses in 2005)
- Felt more comfortable working with hospital and clinic staff (1 response in 2005)

In 2008, the responses given in 2005 were used as a base to ask partners to rate the extent to which they felt the Partnership had been helpful to them in those areas. In addition, respondents could add other areas or ways in which they felt the Spice-Bridge Partnership had been helpful to them (Figure 35).

35. Benefits of the SPICE-Bridge Partnership to the work of the partners

Number and percent of Spice-Bridge partners who felt that the SPICE-Bridge Partnership project provided a lot of help of some help to them in the following areas:	2008 (N=16)			
	Provided a lot of help		Provided some help	
	Number	Percent	Number	Percent
Strengthening the links and networks among participating organizations	10	63%	5	31%
Helping you become more familiar with other organizations and available community resources	9	56%	5	31%
Gaining a better understanding of the health care needs in the community	4	25%	8	50%
Improving your ability to provide appropriate and effective services	7	44%	5	31%
Improving your general knowledge of health care delivery systems	8	50%	4	25%
Areas added by respondents				
Building ongoing relationships	6	38%	1	6%
Learning about the network of services and support that the LAH/BNPs provide in the community to help patients once they leave the hospital	3	19%	-	-
Providing an understanding of how partners can work with the system and the LAH/BNPs	1	6%	-	-
Learning that there is a person to call within the system	1	6%	-	-
Understanding that the various LAH/BNPs have various needs	1	6%	-	-
Informing the other partners about culturally specific challenges	1	6%	-	-
Increasing the visibility of the LAH/BNPs	1	6%	-	-
Preventing some hospitalizations and readmissions	1	6%	-	-
Understanding the frustrations and challenges of the clinics and hospitals	-	-	1	6%
Providing an understanding of the challenges in establishing reimbursement for LAH/BNP services	-	-	1	6%
Enhancing the development of consistent expectations among the LAH/BNPs	-	-	1	6%

Rating scale: *a lot, some, a little, or not at all*

Partnership successes

In 2005, partners were asked to name the things that the Partnership had done well. In general, they felt that the Partnership was working well together in developing clear communication, establishing the referral line, providing good follow-up with clients in the community, taking part in the monthly meetings with the hospitals, and establishing good relationships between hospital, clinics, and the Living at Home/Block Nurse Programs.

In 2008, respondents were asked to give their opinions of things that the Partnership had done best. The themes of their responses included improved communication, increased understanding between organizations, and improved service delivery to SPICE-Bridge participants. Their responses, in their own words, follow:

Improved communication

> The communication has improved somewhat between the hospitals and the LAH/BNPs, which makes it easier for seniors to transition from hospital to home.
>
> Basically, communication. There has been consistent communication back and forth, following the person into care and back home, communicating back to the clinic. They keep us updated. They provide more of the social type services, going above and beyond the nursing care, like transportation, providing help in things like getting groceries, getting meds to them – things a regular nursing agency would likely not do.
>
> I have seen the LAH/BNPs realize the need for excellent and ongoing communications with discharging organizations. Also, that they need to be prompt in their response and responsible in the work with discharge plans. They have learned to respond quickly and to be accessible and timely with their responses and their follow-through.
>
> It appears that there has been improved communication between hospitals, clinics and the LAH/BNP.
>
> Again the communication tools with the clinics and hospitals, with information that is helpful to them for their charts and health care directives. I think there is better communication. We always have a point person to talk to. If someone leaves an organization, someone steps up to the plate, so we don't lose that connection.

When it [the procedures put in place] works, it has provided the formal health care with the non-medical resource that does not have the requirements – income race, etc. that are often put on clients to receive services. It has created a more structured system, especially for outpatient clients, a mechanism to be able to discuss issues that arise with various clients. I only heard stories: Generalizations would be that the programs would get calls from the hospitals that clients were in the hospital, they would hear that the services had kept a client from being in a nursing facility, or that they were able to get a client into the clinic right away to get services.

Increased understanding and service linkage between organizations

Sometimes, just listening to the other partners and the challenges and solutions they have had, how they have approached things, has sometimes been very helpful.

Linking the organizations that support seniors in their health care; improving communications between organizations.

Understanding roles or relationships is key. The hospital discharge people had not been really very familiar with what happens once someone leaves the door and what they as dischargers could expect when someone left the hospital. Likewise, I don't think the LAH/BNP had a very good picture of what dischargers had to face when they had to get someone out – that they have maybe 20 minutes to make all the decisions. Similar things can be said about the clinic and about the palliative care component.

I have no idea. I have only been at my agency a year, and didn't know until 5 months into my job that I was part of SPICE. I am really bummed out that it is not getting refunded. I didn't have a full understanding of it. It would have been good for both me and the LAH/BNPs to use each other as resources.

Now the programs know who to call at the hospitals and clinics, and know the protocols and systems at various hospitals and clinics.

Having one place to call for multiple sites was very helpful. There are several of the agencies that we would call just the one intake number, if we were making a referral. If we were calling for participation in the SPICE program, we would call only one number, and they would make the referral to the appropriate community location.

Improved service delivery to Spice-Bridge participants

The in-home evaluation helped physicians get information. The health care directive has helped all the systems to get information quickly.

> It has helped that there is a recognizable person from the community that both the clinic and the hospital are familiar, who they know has been in the person's home. Knowing if there are physical challenges in the home (stairs, etc.) – that has helped us in the planning, whether a person should go home or go somewhere else, or knowing the family's situation to help or not.
>
> It has increased the likelihood that participants enrolled in the SPICE program would go home to adequate services after enrollment in the SPICE program. I think it has streamlined the process of organizing services in a timely fashion.
>
> The systems we have worked out have been effective, sometimes innovative and creative. That is vital. A lot of times there is nothing, no interface. A lot of times a patient walks out of the hospital or clinic, and there is no one, no family there to see that things are followed through on. The discharge planning has been a major benefit to the participant.
>
> By attending care conferences either in the health care units or community, having donated equipment available, having trusting relationships over time. For example, we assisted a member with behavioral problems who was a vulnerable adult, transitioned them to a safe place with family and then when the person became terminal, we provided them with emotional support and helped them through the decision making process of problem solving, as well as providing services.

Suggestions for improvement

In 2005, partners were asked to give suggestions for improving the Partnership. Responses varied. They are summarized in the following themes: streamline the paperwork, improve and have more timely communications from the program director, increase the visibility of the program, find a way to increase program revenue, clarify when to call the referral line, and establish more consistency in the level of participation among the Living at Home/Block Nurse Programs.

In 2008, partners were asked to suggest ways that the Partnership could have been more effective. The themes that emerge from their responses include improving the planning and communication about the program; increasing the commitment and participation of Partnership members, improving the referral process, expanding the services of the Living at Home/Block Nurse Programs, and including more Living at Home/Block Nurse Programs in the project. Their responses, in their own words, follow:

Improve planning and communication about program

> My overall impression is the Partnership has to do so many things, as challenges to survive, that take an effort. It would take more money to be more effective. The grant they received was small, and they had to work hard for that small piece of money.

> If we had had more planning time. When we started, we all dove in feet first, creating a model, reaching out to partners to build relationships and build trust. It was hard to do all that in one fell swoop.
>
> Having various staff attend a meeting now and again, so they could understand better what we are trying to accomplish. It comes down to education and communication again. We didn't get funded again. But we are not done, and now it is gone. It saddens me that here is a missed opportunity, because this is a very worthwhile process, and it is ended too soon.
>
> I think the project could have placed greater emphasis on the importance of using a business plan to help LAH/BNPs become sustainable. The Partnership could have been more robust on the importance of using business plans, rather than that they are something that just needed to be done, something to be checked off a list.

Partnership members should be more involved and committed

> I think better leadership and accountability of partners. I think the project director needed to be more engaged and proactive, and look at what the involvement was of the partners and address it.
>
> The meetings between the partners were frequent and well organized. Maybe more corresponding between the partners and the services so you would know who did what.
>
> If they would have been able to commit more time to this project, it could have been more effective.
>
> Generally, not every partner fully bought into the project. For example, not showing up at meetings, not following through on commitments, not doing the work of the sub-committees.

More referrals to the SPICE-Bridge program

> More referrals from the hospitals and clinics. I think we have only touched the tip of the iceberg of seniors who could have used LAH/BNP services. More routine referrals to the LAH/BNPs would have been an improvement.
>
> I wish they could have included more patients. I have hundreds of patients. The ones who were SPICE participants were a small percentage. As a demonstration project, it was highly successful. I wish I could have had services for more of them. It would have been an improvement if we could have had more person-to-person interactions, even if only by phone. We went through the nurse, but would it have been better if the communication could have been direct between participant and doctor, without going through the nurse? The question is whether that could have been practical. I think we got the best system we could.

> The "flagging" system. I think in the world of computers, a "flagging" system could have been developed. "Flagging" – so clinics and hospitals know we [LAH/BNPs] are involved; there was no commitment to this from them.

Expansion of services provided by the Living at Home/Block Nurse Programs

> More enhanced or more diligent follow-through, in all the details of transitions. We could have still done better – use of the referral line, personal commitments on each part. The process does not occur overnight. We have made progress, but it hasn't completely turned.
>
> I think they did a good job in trying to let people know about what they did and do. But they don't have a tie to a particular clinic. If they could somehow connect to clinics in their area a little bit more, that might be more effective for them. Trying to have affiliations with particular clinics in their neighborhoods.
>
> One thing would be the ability to offer patients 24/7 [service]. So the LAH/BNP could be called in right away if someone is being released home from the hospital at 6:00 pm on a Friday, for example, in the same way you could with a skilled nursing program.

Including more Living at Home/Block Nurse Programs in project

> It could have been more effective if they had brought all the LAH/BNPs in, rather than focusing on a core group. That may have caused some rifts. I think they could have all definitely learned the concept of all working together in the community, as a whole, presenting services to large organizations.

Systems change

In 2008, partners were also asked to report what changes have occurred in their organizations as a result of their involvement in the Partnership. Five respondents (31%) reported that they were not aware of any changes. In general, respondents reported better communication and a strengthened relationship among the partners, improved methods of identifying and working with clients, and creating more consistency across all Living at Home/Block Nurse Programs and joint efforts to work with other community groups

Their responses, in their own words, appear below:

Improved communication and strengthened relationships between hospital, clinics and the Living at Home/Block Nurse Programs

> We are continuing to use the tools that were developed, like the assessment forms, and working with those with other clients now. We are continuing our connections that we have developed with the clinics and the hospitals.

I think for us it created a relationship with the SPICE-Bridge organization that didn't exist before, which has created different ways of thinking and the potential of different ways of working with each other.

I find it to be an enhancement of member care. It has expanded my knowledge of community resources.

We are being more proactive in working with hospitals and clinics on the discharge piece. That is the learning that we have gotten from it.

We have become more aware of the importance of what can happen with a system that allows coordination across the silos in the health care system. We are prepared to fight to get that. That it be the community standard for at least that portion of the population that are multi-impaired and vulnerable. We need to do it. It is not an option not to do it. It is stupid not to do it. It is wasteful not to do it.

We are working on a marketing plan with all of them. We are going to continue to communicate to the large clinics and hospitals about services.

We have put in our computer as a contact person the LAH/BNP contact as an immediate pop-up with contact information so they can be contacted right away.

Use of standard forms with the other LAH/BNPs, and better communication with the clinics regarding participant needs.

Improved methods of identifying and working with clients

We [LAH/BNP] are identifying clients in a more structured way in the neighborhood and following them more closely – resulting in a better evaluation process. Also, we understand the hospital system better, so we can ask better questions and provide better service.

We are targeting the seniors who need and want help with maintaining doctor's appointments, need transportation to appointments, and want someone to accompany them to their appointments and to sit in on their appointments with them. The toll it takes on some elderly clients is great in worry. The toll that it takes in setting appointments, keeping appointments, and not only wanting transportation, but in having curb-to-curb transportation, which is a big issue for some clients given their mobility issues.

We've always been proactive on the part of clients; now we are more so. For example, if a client is hospitalized we will follow up right away because we know the procedures, and we know how to call directly and who to speak with. We know the system and the clinic, and the hospital people know us.

Creating more consistency across the Living at Home/Block Nurse Programs and joint efforts to work with other community groups

> Putting a greater emphasis on consistent expectations, as far as helping our LAH/BNPs to do that. To develop a document that will describe more uniform practice patterns. Another one is the relatively new effort to do some joint marketing with Wilder Home Care. Ongoing relationships for other kinds of efforts are potentially underway. When people are familiar with each other, they create new ways to work together, and that is of benefit.

The results of the Partner interviews indicate clearly that SPICE-Bridge Partnership has been more effective at systems change related to improving communication between providers to ease transitions for older adults (the first major goal of the Partnership), than it has been with attaining reimbursement for services (the second major goal of the Partnership).

Appendix 7

Direct service provider interviews

Fourteen Living at Home/Block Nurse Program direct service staff completed interviews in August and September 2005, and 18 direct service staff completed interviews in the summer of 2008 about their experiences with the SPICE-Bridge Partnership project.

In the 2008 interviews, direct service providers were asked to estimate the number of participants they personally had served in the SPICE-Bridge Partnership over the last three years. Seven providers (39%) had each served over 20 participants, one provider (6%) had served between 10 and 19 participants, six providers (33%) had served between three and nine participants, and one provider had served one or two participants in the past three years. Three providers (17%) were not sure how many participants they had served.

Benefits for participants

Direct service providers were asked to describe the one or two most important benefits that participants experienced as a result of the SPICE-Bridge Partnership project. In 2005, the most common responses were providing preventive safety (3), accompanying participants to hospital/clinic (3), providing transportation to appointments (3), getting more information from the hospital prior to discharge (2), providing ongoing health care in participants' homes (2), and using the LAH/BNP staff's knowledge about available resources to help participants (2).

In 2008, the benefits to participants most frequently mentioned were a feeling of more support from a system that includes clinic, hospital, and community resources (9), better continuity of care and communication between agencies (6), and smoother transitions to and from hospital to home (2).

In 2008, direct service providers were also asked the extent to which they agreed or disagreed with a series of statements about potential benefits of the SPICE-Bridge Partnership for participants. These statements were generated from the responses given by providers who completed interviews in 2005. Virtually all of the direct service providers agreed that there is increased networking and sharing of information, and that the Partnership has increased the ability of participants to remain in their own homes. Their responses are shown in Figure 36.

36. Benefits to participants as seen by direct service providers

Number and percent of direct service providers who strongly agreed or somewhat agreed with the following statements	2008 (N=18)			
	Strongly agree		Somewhat agree	
	Number	Percent	Number	Percent
Improved ability of participants to remain living in their own homes	15	83%	2	11%
Increased networking and sharing of information among organizations	11	61%	6	33%
Improved continuity of care for participants or patients	8	44%	8	44%
Improved communication among partners	8	44%	8	44%
Smoother transitions between hospital and other care settings to home	7	39%	9	50%
Improved safety of participants; fewer emergency situations for participants	9	50%	5	28%
Improved access to services for participants	8	44%	6	33%

Rating scale: *strongly agree, somewhat agree, somewhat disagree, or disagree.*

Outcomes for participants

In 2008, direct service providers were prompted to think back to the last SPICE-Bridge participant with whom they had worked and to answer the following question: "How would the kind of care setting or health care outcomes have been different for that person if your services did not include the help that the Partnership makes possible?" Three themes emerged from their responses: 1) participants could remain in their own homes because they received needed services, 2) participants would have been placed in a nursing home or long-term care facility, and 3) the Living at Home/Block Nurse Program helped prevent participants from experiencing a crisis situation. Their responses appear below.

Living at Home/Block Nurse Program provided support and advocacy to keep participant living at home (8)

> The person had mental health issues, was not taking their medications, and went to the emergency room a lot because of anxiety. The Block Nurse Program was a place she could call to talk through her anxiety, and we would take her to clinic visits to monitor her meds and care. When she did get hospitalized briefly, we were informed quickly and could work with them. We were able to eliminate a lot of emergency room visits.

The senior would have felt more isolated, less support. Things would have been more fragmented – no one to go to appointments with them, transportation would have just been a drop-off at the door, etc.

Her health has declined significantly. Through this grant, she has become known to us. We are able to better serve her because of the relationship we have been able to build as a result of the grant. It is not just about the services that we provide. It is also about referring her to other services she needs so that she can stay at home.

Good communication of the participants' needs makes us aware and we are not rushed like a hospital. We are able to do so much more, such as home care, meals, work with family – so much to keep them in their own homes. Without the Partnership some of this would not be done. I'm not sure if it is a reflection of the Partnership or of West 7th Community Center.

There would have been increased isolation. They would not have able to return home as soon as they did and get improved services.

Less hospitalization and more preventative care [possible due to Partnership].

They would struggle more than they did. They would not have had a certain service if I had not advocated for it.

They would not have received all the services they got. Things would not have been as smooth as they were. Communication between providers would not have been as good.

Participant would be in a nursing home or long-term care facility (6)

They would have been in the nursing home. That is an absolute fact.

The person would be in a nursing home or other institution. Her memory loss made it difficult to be in her home but the Spice-Bridge program made it possible to support her at home.

Kept the person in their home longer.

This person would be prematurely institutionalized into a nursing home.

Their chance of staying at home is much improved with the program.

She would no longer be living in her own home. She would be living in a long-term care facility.

Living at Home/Block Nurse Program helped prevent a crisis situation (3)

> The patient was selling his narcotics. He would have been kicked out of his apartment. Without SPICE, he would not ever have come into the clinic for his appointments. They were able to keep his smoldering problems from becoming crises, ending up in the ER. The costs saved by the program, just with regard to him, would have paid for the entire SPICE program. Without SPICE, for him, nothing is going to work.
>
> More emergency situations.
>
> One would have ended up in a crisis situation in her home had we not been there to work with her in her home. Her home also started to become very unsanitary so we assisted her with that.

Benefits of the SPICE-Bridge Partnership to direct service providers

When asked to describe in their own words how the SPICE-Bridge Partnership has helped them in their role, three providers in 2005 and two providers in 2008 did not see a change in their role and felt it was the same as before. For the rest, the most common responses included the following:

- Better communication between programs (4 responses in 2005, 5 responses in 2008)
- Hospital information is on time and accurate (2 responses in 2005, 3 responses in 2008)
- Improved assessment, screening, and evaluation tools has improved the transition process for participant and health care organizations (1 response in 2005, 5 responses in 2008)
- Helped provide a continuum of care (2 responses in 2005, 2 responses in 2008)
- More familiarity with other organizations (2 responses in 2005)
- More support from the health care system (2 responses in 2005)
- Better able to tap health care resources (1 in 2005)
- Better preventive care for patients (1 in 2005)

In addition, in 2008, direct service providers were asked to respond to a series of statements about how much they thought the SPICE-Bridge Partnership had helped them in various aspects of their work. The statements were based on responses given by providers who completed an interview in 2005. The following table shows their responses.

37. Benefits of the SPICE-Bridge Partnership to the work of the direct service providers

Number and percent of direct service providers who felt the SPICE-Bridge Partnership provided a lot of help or some help to them in their work:	2008 (N=18) A lot of help Number	A lot of help Percent	Some help Number	Some help Percent
Helping to raise awareness of participant's needs	6	33%	9	50%
Gaining or increasing support from the health care system	4	22%	10	56%
Providing a continuum of care for your participants	9	50%	5	28%
Helping to provide better preventive care for participants	11	61%	3	17%
Fostering better communication between programs or organizations involved in the patient's care	8	44%	5	28%
Helping you become more familiar with other organizations and their services	6	33%	5	28%
Receiving more timely and accurate information about participants from the clinic(s)	6	33%	5	28%
Improving your ability to access health care for participants	7	39%	4	22%
Receiving more timely and accurate information about participants from the hospital(s)	3	17%	6	33%

Rating scale: *a lot, some, a little, or not al all.*

Coordination with hospitals and clinics

Hospitals: 2005 feedback from direct service providers

What hospital staff has done well. In 2005, direct service providers were asked to comment on what they thought the hospitals had done well when working with Living at Home/Block Nurse Programs. The most common response was that hospitals had improved their ability to give advance notice of patients that are going to be discharged so that Living at Home/Block Nurse Program staff can plan for the discharge (two-thirds of respondents gave this response, in their own words). Also in 2005, two respondents mentioned that hospital and Living at Home/Block Nurse Program staff are communicating more effectively.

How often LAH/BNP was notified when a participant was hospitalized. In 2005, respondents were also asked how often they were informed when a participant is hospitalized. Three-quarters (75%) replied "sometimes," and one quarter (25%) replied "most of the time." In 2008, about two-fifths (41%) of respondents said they were informed "sometimes," 29 percent said "most of the time," and one said "every time." Four respondents (24%) reported that they were never informed.

Hospitals: 2008 feedback from direct service providers

In 2008, 15 direct service providers (83%) reported that in the past three years they had worked with United Hospital, 14 respondents (78%) had worked with St. John's Hospital, and five respondents (28%) had worked with St. Joseph's Hospital. Three respondents reported that they had not worked with any of the above hospitals.

What hospital staff has done best. Respondents were asked what the hospital staff has done best when working with the Living at Home/Block Nurse Programs. Overall, respondents felt that hospital social workers and discharge planners were best at communicating with the Living at Home/Block Nurse Program when participants enter the hospital and coordinating needed services as part of their discharge planning. Responses, in their own words, follow:

> I think they tried very hard to get the clients out as referrals, given the time constraints.
>
> Alerting us when someone is about to come home.
>
> A couple of the hospitals, the social workers were very good at following up and keeping us informed. The clinic staff were much better than hospital staff.
>
> They were willing to have us be involved in the discharge planning. The frustration came in that there could be new social workers involved on a daily basis, so things didn't always get followed through on, or us not being included in the discharge planning, because the next social worker was not informed of our involvement. The breakdown was in inner-hospital communication.
>
> It is easier for them if they know they [the patients] are in the Block Nurse Program. The hospital staff contacts us when they need services for the participants at exit time.
>
> It depends on who the social worker is. Some of the social workers are great and get back with you when you contact them, some don't. Some clients you don't even know when they are in.
>
> Explaining to me about the patient and their care at home.
>
> Calling us about clients who are in the hospital.
>
> The social worker at United Hospital communicated frequently when a participant entered the hospital.
>
> Discharge planners and social workers' willingness to discuss and brainstorm the needs of the client at home upon their admission. Conversations during the participant's stay; not just at the end or at discharge.
>
> They have come to the monthly SPICE meetings.

> Listening to what I had to say about patients and participating in the monthly meetings.
>
> Taking care of acute needs.

How hospital staff could be more effective in working with the LAH/BNPs. In addition, in 2008, direct service providers were asked how hospital staff could be more effective in working with the Living at Home/Block Nurse Programs. The main themes that emerged from their responses were that hospitals could provide a better understanding of the role that the Living at Home/Block Nurse Program can play in helping older adults upon release from the hospital, and provide better communication about the Living at Home/Block Nurse Program's role among hospital staff. Their responses appear below.

> The problem was the personnel would change, so there was a problem carrying the torch to the new person, informing them about the project and what their role would be with the project.
>
> More referrals. Letting more people know that they live in an area with a Block Nurse Program.
>
> Just to know about the programs, what we do, and how to contact us, and the types of services we provide. Hospitals can have so many levels of bureaucracy, and it can be difficult for information to be passed along. Some at a hospital may be very aware, while others at the same hospital may not know and may not care to know. For some, because we are not connected with their system, they may not care to know. At the very end, a discharge planner may contact us, and it feels that it is more just to move the person out, without a lot of planning with us. Over the three years, there has been very little movement, and it probably will remain that way. It is going to be incumbent upon the Block Nurse Program to maintain the contact with the hospitals, because they either cannot or will not do it. I feel it is because we are not part of their system. Because of the amount of time and energy they would have to put into the relationship, I don't know that they will do that, even though there is benefit to their clients. The Block Nurse Programs work on a very small scale, while the hospitals work on a very large scale.
>
> Be open to the Block Nurse Programs doing presentations so their staff will be informed about us and be aware that we are a community partner. I think it is all a matter of education and communication.
>
> Better internal communication with new staff, during staff turnover at the hospitals, so the new staff knows about the Block Nurse Program and can contact us. The Block Nurse Program could figure out a way to keep our service card to travel with the patient when hospitalized.
>
> Always better communication.
>
> Give us more information about diseases that our patients have.

> Communicate with each other (internal communication) more. They are unpredictable; they say one thing and do another. Stop discharging patients on Friday night without notice to the Living at Home/Block Nurse Program, and with no supports in place.
>
> Better follow-up. We might get an initial call and then they are dismissed, and we don't know that.
>
> If the hospital could have been more in the communication loop. The hospital rarely communicates with the Block Nurse Program.
>
> Early communication with the Block Nurse Program, so we can be more a part of discharge planning.
>
> We would like them to alert us when a patient goes into the ER or the hospital; however, it does not work.
>
> The hospitals should be educating their staff about the SPICE program.
>
> Be more open to listening to someone else and what they have to say to save a patient's life.
>
> I think they did a pretty good job.

Clinics: 2005 feedback from direct service providers

Ease of contacting clinic staff. In 2005, 10 of 14 (71%) direct service providers rated the ease of contacting someone at the clinic about a participant as "somewhat easy" or "very easy."

Clinics: 2008 feedback from direct service providers

In 2008, 16 direct service providers (89%) reported that in the past three years they had worked with Health Partners Specialty Center: Adult and Senior Services, and 15 (83%) had worked with United Family Practice Health Center. One respondent had not worked with the clinics associated with the SPICE-Bridge project.

Ease of contacting clinic staff. In 2008, 12 of 18 (67%) direct service providers rated the ease of contacting someone at the clinic about a participant as "somewhat easy" or "very easy."

What hospital staff has done best. In 2008, direct service providers were asked what the clinic staff has done best when working with the Living at Home/Block Nurse Programs. Overall, respondents reported improved communication, better coordination of services, and more frequent referrals to the Living at Home/Block Nurse Programs. Their responses appear below:

The fact that we had a contact person there – we could connect faster with the physicians and get communication to them sooner.

Some have been excellent at following up, but not all the time. It was hit and miss. For some clients, there has not been any follow-up, and we were not aware that clients had even been to the clinic. But when it occurred, it was a good thing, very helpful.

They have understood our mission and have been supportive in giving us what we need to help us help their patients. They look to us to support them in supporting their patients. Calling us back when we have mutual participants and listening to our recommendations, taking the senior into appointments that are urgent, and then following through.

They could call to check to see if a senior they are serving is being served by us, so we can work together. And if we are not working with the senior, facilitate or recommend to the senior that they work with us to provide services to them. At the Specialty Center they created a meeting between the primary doctor, the nurse, and the Block Nurse Program, so we could go over the needs of the participant, like in a case management meeting. SPICE rotated who attended the meetings.

Keeping me informed about things I otherwise would know nothing about. For example, if someone had been hospitalized at another hospital outside of our system.

It's the best communication with any agency we deal with.

UFPHC – getting immediate information from the nurses from their computer systems. That has been very helpful.

Follow-up calls. If they know a client is one of ours, they may call us to let us know that they are in the hospital, are having more issues, or are in need of services.

The nurses get right back with you at Health Partners Senior Clinic.

Willingness to work with us more because we know who to call. We have more of a direct line to the clinic.

The triage nurses or team leads at United Family. However, I had set much of that up before Spice-Bridge Partnership. Most were not aware of the program.

Staff listened to me and we worked together.

Being able to access a point person or a particular person that I could go directly to instead of going through the chain of phone commands.

They have made referrals to us when concerns are raised by the doctor, outreach worker, or advocate, or when a client is not medication compliant, not coming in for appointments, or if there have been care needs at home.

> The monthly meetings were powerful. The doctors are calling us and we are more of a team.
>
> United Family gave us referrals.

How hospital staff could be more effective in working with the LAH/BNPs. In addition, direct service providers were asked what clinic staff could do to be more effective in working with the Living at Home/Block Nurse Program. The main themes in their responses were that clinics could learn more about the LAH/BNPs, let the LAH/BNPs know about scheduled or missed appointments, make more referrals to the LAH/BNPs, and continue to communicate with the LAH/BNPs about program participants. Their responses, in their own words, follow:

> They could do more with flagging the identification system on the computer, so they know quicker which patients are SPICE participants.
>
> There could be more referrals. There are probably a lot more who could use our services.
>
> Call the Block Nurse Program when we have clients seen in the clinics. That happens rarely. We understand that the Block Nurse Programs are not on their radar. Some use the programs, while others don't, simply because they don't know of us yet. It is not that they are intentionally not using the programs. They may not know of us, or we may just be one of many resources they have available to use.
>
> If the world were perfect, in person meetings would be better than phone meetings, but that would be almost impossible. But it would be helpful.
>
> I wish more clinics would have the service where you could talk to the nurses.
>
> Let us know when participants scheduled and/or missed appointments and called us with concerns.
>
> I would like the nurses to return my calls more often and more quickly.
>
> Letting us know when someone misses an appointment and when the appointments are.
>
> Alert us to patient appointments so we could help patients make those appointments.
>
> The management people of the grant should have educated their staff more about the SPICE program.
>
> Keep listening.

Direct service providers perceptions of improvements in the process of making transitions from health care setting to home.

In 2008, direct service providers were asked about the ways in which the process of making transitions from hospital or other health care settings to home had improved in the past three years. In general, respondents reported better communication, smoother transitions, standardized assessments and health care directives, and increased awareness of community services designed to help seniors remain in their own homes. Below are their responses in their own words.

> From the clinic side, it has improved quite a bit. The communication is better. The clinics appreciate that there is an advocate who comes with the patient. The hospitals are more difficult, due to time constraints (discharge planners have to discharge quickly), but it has helped a lot that there has been education for hospitals about the Block Nurse Programs and what we do.
>
> There seems to be better understanding of the community services. It used to be that they only looked at Medicare-supported services, but now there seems to be more awareness of the broader needs of seniors that can keep them in their home longer or [keep them] out of the hospital.
>
> I think the transitions have improved if we have worked together. When that happens it really works, even though it doesn't work that often. That gives me insight to how good it can work. But I don't feel confident that it will get integrated into such a large system. Also, as far as how often I was informed, often the block nurse was not informed about a hospitalization.
>
> When the BNP is brought into the discharge planning, everyone benefits. The senior and the caregiver/their families know that when they come home there will be someone to support them so they can stay at home. The hospitals and care facilities also can have peace of mind that there will be someone there for the participant when they leave.
>
> It has improved a lot. I think because of the involvement of the SPICE program, because they ask the questions, get people involved. Discharge planning is better (the key thing improved). It is one thing to write orders when someone leaves the hospital, but it doesn't get done if no one makes sure it gets done. SPICE is the link that gets that done. That is the key.
>
> When we get the right social worker and it is not a weekend, we get the information faxed about the client, which makes it easier to open a client.
>
> Better preparation to set services up before the patient arrives home.
>
> Relationships with some of the discharge personnel have improved. We get faxed discharge orders now with the medications list on it.

I think we have better tools to communicate, so there is a paper trail for communication. We are trying to standardize some things as far as assessments and directives. In one situation, we were notified the client was in the hospital. We talked with the nurse and case managers, as far as where she would transition. We discussed some transitional care units where she would be more successful, since she has been turned down from some of them. There was continuous communication following her as she moved from transitional care unit to hospital to another transitional care unit, etc. There is that continual follow-up. They, meaning the client, don't always know all the things you are doing behind the scenes to make it easy.

The Block Nurse Program to Wilder Home Health services makes it a smoother transition.

Someone in our office talks with me about arranging a volunteer visit.

There is more of a coordinated effort and the services for the senior are more comprehensive.

The discharge plan has improved when we were a part of the plan.

What hospitals and clinics are doing differently

In 2008, direct service providers were asked about what the hospitals and clinics are doing now that they didn't do before. With regard to hospital changes, respondents reported better discharge planning and more awareness of the services offered by the Living at Home/Block Nurse Programs. With regard to clinic changes, respondents reported more awareness of the services offered by the Living at Home/Block Nurse Programs. Their responses below are organized by comments about both hospital and clinic changes, clinic changes, and then hospital changes.

Both clinic and hospital changes observed

They are using the referral line, which has streamlined the process for them. They also like that we are doing health care directives with their clients, and that the directives are on file and available to them.

There is more awareness of programs that support services in the community, so it's helpful they are telling people about them.

Sometimes they call the Block Nurse Program, are more aware of the Block Nurse Program and will follow up. It seems like three years is a long time, but there had to be time for introducing ourselves to the clinic and hospital staff. Much was very good, but much was also very frustrating. We focused much attention on the hospitals, but I think we could have been more effective if we had focused more with the clinics and the clinic staff, who were more familiar with the clients.

They are contacting the Block Nurse Programs. It is not as much as I would like, but it is significantly more than it was three years ago.

Once the clinic or hospital staff understands that there is a coordinating person involved who can affect things. For example, if there is an order for the patient to weigh themselves daily, but they don't have a scale, it is the SPICE person who can make that known and see that they get a scale and that the information gets reported to the clinic. The people at the hospital or the clinic are not aware of what is going on at home. They may not be aware that the patient is selling or exchanging his narcotic prescriptions for the alcohol. With that knowledge, I was able to make major changes. I would never have known about it without the SPICE involvement.

I think it is easier to get a hold of someone who will talk with you about a client. There are usually people available instead of leaving a message.

Communication is better.

Clinic changes observed

They are the ones with a little more intimate relationship with the clients. A really positive thing is that I was able to establish good relationships with clients because I was providing transportation, etc., and was able, through that, to have more conversations with clients to help them and to let them know and feel that they had some place they could call.

They would know they could call and work with me to help them remember appointments, etc. There were other SPICE clients where I did not have such intense contact – for example, clients who only needed transportation once a month, while others needed more assistance. It was a spectrum.

Client follow-up and reminders for participants (appointments, lab work and so forth).

I think they give more thought to referring over to the Block Nurse Programs.

The clinics are doing a decent job of communicating. I sent a note with my clients so I got a lot of feedback.

We are having meetings. Every six to eight weeks the Block Nurse Program and the outreach workers at United Family Practice meet.

Hospital changes observed

There is an awareness of the programs. Sometimes in the hospitals you are so busy that you don't know if you should just refer over. I think they give more thought to referring over to the Block Nurse Programs.

They are involving us in the discharge planning process.

> The hospitals are not sending clients home with enough information to go home and be ready. Clients are being sent home without access to medication and without enough support to be at home alone.
>
> Social work is getting involved more and there is a little better discharge planning.

Appendix 8

Surveys of hospital staff

Hospital staff were asked to complete a self-administered survey. These surveys were collected by a partner and submitted to Wilder Research. In 2005, 24 hospital staff completed surveys. At least 10 of the surveys were completed by Regions staff. The rest were received through the mail and the hospitals were not identified. In 2008, hospital staff from United Hospital completed 11 of 17 surveys (65%) and hospital staff from St. John's Hospital and St. Joseph's Hospital completed 7 of 15 surveys (47%).

All hospital staff who completed surveys in 2005 and 2008 knew of the Living at Home/Block Nurse Programs and had worked with patients who were served by the Living at Home/Block Nurse Programs.

Referrals to the Living at Home/Block Nurse Program

In 2005, 18 of 24 hospital staff respondents reported they had made specific referrals to the Living at Home/Block Nurse Program. Sixteen of the referrals were made by phone, two were unknown. The respondents who made referrals were looking for the following types of assistance: home nursing help (11), safety assessment (3), medical monitoring (3), pharmacy benefit assistance (2), housekeeping (2), case management (1), and unspecified medical help (1).

Fifteen of the respondents who made referrals said they received the type of help they had requested. Six respondents (33%) rated the referral process "very easy," six (33%) said it was "somewhat easy," and four respondents (22%) said it was "somewhat difficult." Suggestions for improving the referral process included: making the LAH/BNP staff easier to reach, returning phone calls, and taking on the difficult cases as well as the easy ones.

In 2008, all 19 hospital staff who responded to the survey reported that they had made specific referrals to the Living at Home/Block Nurse Program. Sixteen of the referrals were made by phone, two were made by fax, and one was unknown. The respondents who made referrals were looking for the following types of assistance: home nursing help (10 responses), case management (5 responses), someone to check on medications (2 responses), bathing assistance (2 responses), assistance with chores (2 responses), and someone to help connect patient with community resources (1 response). Sixteen respondents (84%) who made referrals said they received the type of help they had requested. Nine respondents (56%) rated the referral process "very easy" and eight (42%) said it was "somewhat easy." Suggestions for improving the referral process included:

having a central referral line to call, creating a "how to" cheat sheet, confirming with hospital staff immediately upon receiving the referral, and having a map showing which program serves which area.

Awareness of Living at Home/Block Nurse Program services

The table below shows hospital staff survey respondents' awareness of services provided through the Living at Home/Block Nurse Programs, and the number who asked the programs to provide the specified services for their patients.

38. Hospital staff awareness of and requests for Living at Home/Block Nurse Program services

	2005		2008	
	Number aware of LAH/BNP service	Number who requested service	Number aware of LAH/BNP service	Number who requested service
Help in monitoring health problems	21	7	18	11
Help with Health Care Directives or living wills	12	0	18	2
Help with medical follow-up when a patient is discharged from the hospital	19	6	17	7
Provide relief from loneliness or isolation	17	2	17	10
Help to prevent unnecessary clinic visits	19	4	16	4
Help with non-medical follow-up when a patient is discharged from the hospital	18	6	15	8
Arrange for Meals on Wheels	17	5	15	5
Help with long-term care planning	14	1	14	8
Set up LifeLine or other emergency contact system	16	3	13	5
Arrange for transportation	14	2	13	4

Benefits of the Living at Home/Block Nurse Programs

When hospital staff members were asked what they thought was the biggest benefit of having Living at Home/Block Nurse Programs available in Saint Paul neighborhoods, the responses were as follows:

- More comprehensive services (4 responses in 2005, 6 responses in 2008)
- Care recipients feelings of independence/ability to stay in their own home (2 responses in 2005, 8 responses in 2008)
- More weekend coverage for patients (5 responses in 2005)

- Services provided at the local level (2 responses in 2005, 2 responses in 2008)
- Increased communication (3 responses in 2005)
- Continued support from Living at Home/Block Nurse Program while patient is in the hospital (3 responses in 2005)
- Easier intake system (2 responses in 2005)
- Fills the gap that regular health care cannot do (1 response in 2008)
- Reduction in hospital readmissions (1 response in 2008)

Suggestions for improvements

In 2005, 7 of 24 hospital staff members made suggestions for improvement. These suggestions included: increased communication (1), a person to answer phone, instead of voice mail (1), ID cards for participants with Block Nurse's name on them (1), more weekend coverage (1), continued support while patient is in the hospital (1), accept younger patients (1), and an easier intake system (1).

In 2008, 11 of 19 hospital staff members made suggestions for improvement. Suggestions included: have LAH/BNPs available in more communities (6), have more services available (1), keep the program operating (1), provide weekend coverage (1), have one place to call to make a referral (1), and work with Medicare to find a way to transition care to the LAH/BNPs after skilled care is completed.

Appendix 9

Surveys of clinic staff

Ten clinic staff members completed a self-administered survey coordinated by the project during the summer of 2005. Of those who completed the survey, six were doctors, two were nurses, one was a "provider," and one was an outreach worker. All respondents said the Living at Home/Block Nurse Program had worked directly with their patients. All three clinic staff had contact with staff members of the Living at Home/Block Nurse Programs.

In the summer of 2008, only three clinic staff members completed a self-administered survey coordinated by the project. Of those who completed the survey, two were doctors and one was a registered nurse. All respondents said the Living at Home/Block Nurse Program had worked directly with their patients.

In-Home Evaluations

Seven of 10 clinic staff respondents in 2005 and one clinic staff respondent in 2008 said they have seen In-Home Evaluations done by program staff for some clinic patients. These respondents were asked about the various uses of the In-Home Evaluation, in terms of how they help clinic staff. The uses mentioned and the number of respondents who rated them as "very helpful" or "somewhat helpful" appear below:

- Seven respondents (2005) said the In-Home Evaluation helped staff get to know participants better; two rated this as "very helpful," four as "somewhat helpful."
- Six respondents (2005) said the In-Home Evaluation made it easier to complete a diagnosis; two rated this as "very helpful," one as "somewhat helpful."
- Six respondents (2005) said the In-Home Evaluation made it easier to develop a treatment plan; three rated this as "very helpful," one as "somewhat helpful."
- Six respondents (2005), and one respondent (2008) said the In-Home Evaluation provided a good snapshot of the participant's home situation; five (2005) rated this as "very helpful."
- Six respondents (2005) said the In-Home Evaluation helped identify potential services or help that the participants may have at home or in the community; four rated this as "very helpful," one as "somewhat helpful."

- Five respondents (2005) said the In-Home Evaluation increased staff's comfort with participants' ability to live in their current housing; four rated this as "very helpful."

- Six respondents (2005) and one respondent (2008) said the In-Home Evaluation increased staff's confidence that participants' needs will be attended to when they return home; five (2005) rated this as "very helpful," and one did not respond.

Accompanying patients to the clinic

In 2005, seven of ten clinic staff respondents and, in 2008, two of three clinic staff respondents said they have had a patient who was accompanied to the clinic by a Living at Home/Block Nurse Program staff member. All respondents in 2005 and in 2008 felt that it was helpful to their patients to have LAH/BNP staff there. The reasons clinic staff mentioned include:

- Helped patient understand situation and doctor's instructions (4 responses in 2005, 2 responses in 2008)

- Living at Home/Block Nurse Program staff was able to provide information about patient to clinic staff (2 responses in 2005, 2 responses in 2008)

- Helped patient get where he/she needed to be (2 responses in 2005, 1 response in 2008)

In 2005, the three clinic staff respondents who had not had any patients accompanied by Living at Home/Block Nurse Program staff all felt that it would be helpful to the patient to have program staff with them at their clinic visits. They gave the following reasons: more continuity of care and someone there to look out for patient needs. In 2008, the one respondent who had not had any patients accompanied by Living at Home/Block Nurse Program staff felt that it would be helpful to have program staff with patients at their clinic visits to assist the patient in getting to the appointment, advocate for the patient, help the patient prioritize concerns, and provide insight into how the patient is doing at home.

Referrals to the Living at Home/Block Nurse Program

In 2005, eight of ten clinic staff members who participated in the survey said they had made specific referrals to the Living at Home/Block Nurse Programs. Four of the referrals were made by phone, two were made by fax, one was made in person, and one was unknown. The respondents who made referrals were looking for the following types of assistance: safety assessment (3), meals (2), home nursing help (2), pharmacy benefit assistance (1), companionship (1), needs assessment (1), and unspecified medical help (1). All eight respondents who made referrals said they had received the type of help they requested. Two respondents rated the referral process "very easy" and six said it

was "somewhat easy." Suggestions for improving the referral process included: posting the referral number in a strategic location, confirming with clinic staff immediately upon receiving the referral, and informing more staff about the referral system.

In 2008, all of the three clinic staff members who participated in the survey said they had made specific referrals to the Living at Home/Block Nurse Programs. Two of the referrals were made through a social worker and one was made by phone. All three respondents who made referrals were looking for home nursing help and all said they received the type of help they had requested. Two clinic staff rated the referral process "somewhat easy" and one did not rate it, saying that it had been set up by a social worker.

Benefits of the Living at Home/Block Nurse Program

When asked to describe the biggest benefit of having the Living at Home/Block Nurse Programs available in Saint Paul neighborhoods, the seven respondents in 2005 and three respondents in 2008 mentioned the following benefits:

- It helps seniors stay in their own homes; stay independent (4 responses in 2005, 1 response in 2008)
- Clients stay healthier (4 responses in 2005)
- Improved continuity of care (2 responses in 2005, 1 response in 2008)
- Increased safety for and checking-in on seniors (2 responses in 2005)
- Improved ability to connect patients to needed community resources (2 responses in 2005)
- Better communication between patient and health providers (1 response in 2005, 1 response in 2008)
- Cost savings to the community (1 response in 2005)
- Reduced unnecessary hospitalization (1 response in 2005)
- Increased visibility of the program (1 response in 2005)

Awareness of Living at Home/Block Nurse Program services

The table below shows clinic staff members' awareness of services provided through the Living at Home/Block Nurse Programs, and the number who have asked the programs to provide the specified services for their patients.

39. Clinic staff awareness of and requests for Living at Home/Block Nurse Program services

	2005		2008	
	Number aware of LAH/BNP service	Number who requested service	Number aware of LAH/BNP service	Number who requested service
Arrange for transportation assistance	6	3	3	2
Arrange for Meals-on-Wheels	7	4	3	2
Help with long-term care planning	6	3	3	3
Help with advance directives or living wills	7	3	2	1
Set up LifeLine or other emergency contact systems	8	3	2	1
Provide relief from loneliness or isolation	9	3	3	1
Help to prevent unnecessary clinic visits	7	2	2	2
Help with medical follow-up when a patient leaves the clinic	8	4	3	3
Help with non-medical follow-up when a patient leaves the clinic	8	4	3	3
Help in monitoring health problems	9	5	3	3

Suggestions for improvement

Clinic staff were also asked what they would do if they could improve one thing about the Living at Home/Block Nurse Programs. Four respondents provided comments in 2005 and two respondents provided comments in 2008. In 2005, two respondents suggested improved recognition and awareness of available services, one respondent suggested more energetic marketing of the program, and one respondent suggested that the program be made available to care recipients of different ages. In 2008, both respondents suggested that the Living at Home/Block Nurse Programs expand to cover more neighborhoods.

Appendix 10

Participant survey open-ended comments

Ways in which SPICE-Bridge staff were helpful at clinic visits

In what way(s) was it helpful to have this person with you at the clinic?

I had someone along at that time when I was unsteady. I was not up to snuff at the time.

[The worker] is understanding and good company, nice to visit with, helpful. She gets me to the appointment on time. We fit hand-in-glove, like we were meant to be together. I'm glad to see her because I miss her.

[The worker] has a background in the medical field. She's also a woman, and I feel comfortable with her at my side [clinic visits].

[The worker] waits for me, and the doctor tells me when to make another appointment, and then he [worker] brings me home.

Because there are things that I don't understand, especially medical terms. It's also been helpful because I feel that the clinics make mistakes when they are charging me – it's been two times that they overcharged me.

Because the worker speaks English and I don't. And transportation is provided.

Ways in which SPICE-Bridge were helpful before or after hospitalization

What were one or two of the most important ways that the Block Nurse Program was of help to you before or after being hospitalized?

Setting up appointments. (2 responses)

They helped with getting groceries and getting my house cleaned. They came to visit and ran errands.

Housecleaning help.

To set up Medical Assistance with Ramsey County. In fact, they are coming over today. There were many items that I can't recall. They were very helpful, even to the point of volunteering help – yard clean up in the fall, general house clean up. We are both medically handicapped.

Knowing that someone is there and that you can call in an emergency.

I was able to get help showering. I guess they would see how I was getting along after the operation. And, they set up some exercises that I could do in the house with a trainer to help my recovery.

Setting up the medications.

Being able to have the services. For my benefit to help me recuperate. I didn't really know there were all those services. I would have used more, but I wasn't sure I could use it or how much time or service was available. And what services were available.

The exercises they gave me helped a lot.

I have a place to call where they know me and help me all the time. They are like family to me.

I had my aide come in to help with my bath and I had my housekeeper. That was very, very helpful to me. And helping me with my wound.

They do my laundry.

The nurse didn't help me. I got help from the Volunteers of America with food, and she's helping me with information on the different scams going on. She told me about the Wilder nursing service. The Wilder nurse did the first intake.

They helped me access hospital services; one helped me pack to go the hospital and one person brought my clothes to me in the hospital.

They supported me and encouraged me to go through the operation that I needed in May of last year. They explained the procedures to me.

[*Name of staff*] has helped me to become a U.S. citizen.

I don't remember (2 responses)

Most important benefits of SPICE-Bridge program to participants

As you see it, what are one or two of the most important benefits that you have experienced as a result of receiving services from the Block Nurse Program?

Information on how to write the living will and the workshops they provided.

I like the visits and love their health programs and Fair Share.

Rides through Evercare

They check up on me, help with medications. They talked with my doctor.

Well, I like doing things for myself. The rides were helpful.

The rides were good. Help with the heavy cleaning was very helpful.

Rides to and from dialysis.

That the provider was still interested in me and she checked in with me.

I know they are there if I need them, that's the only thing I can tell you.

When I had questions to ask – the provider, she answered them for me.

They guided and enlightened me on some of the services available – federal, county, state services. They gave me a great amount of help obtaining the data, so I can get the services and fill out the applications. The program staff have been absolutely wonderful – one of the nicest groups I've encountered. I am legally blind and my wife had a stroke. We are trying to stay in our home.

The information is there. If you really need something, they can really help you.

I was able to recuperate a little faster than I would have on my own. I always look forward to them. They were very good volunteers.

I have an RN. She understands my medical problems.

That they were there to help me.

Someone that could come and stay with my husband. Free time to go out. To have another pair of eyes and hands to help with his care and see what he needs.

Taking us to the hospital and the doctor. I never use them for shopping. I'm 88 and still can get around. And the rides.

Knowing that when I call, I can get help. When the other provider was ill, she called ahead of time to let me know. Knowing that I had a back-up if no one else could take me. She even called to be sure that my son would be there and able to take off work to get over to the appointment.

The programs at CLUES – attend two times a week. Having Medicaid (Medical Assistance).

I feel safe around them. The transportation to and from the appointments I have – Social Security office, clinic, etc. helps a lot. And they help me fill out forms, because I am 90 percent blind with glaucoma.

Helping with my legs that are very bad. They help me to buy my lotion. The aide helps me. My stomach busted open. She helped me to get my gloves, gauze, and lotion – and all of that other stuff that I need to care for the wound. I wish everybody could have it. They are very, very nice – I could not have made it without their help. They found me a really nice place – a nursing home [to recuperate] – and they helped me through my operation. I don't think I would be living if I didn't have them to help me out. They check up on how you are doing and how your mind is doing, and they bring vegetables. I appreciate them, I really do.

Transportation (2 responses)

The help and the company that the program provides.

Knowing that I had someone available to talk with and they would answer my questions.

I get my toenails cut and she has helped with my medical questions.

It is all beneficial. I call when I need something. One of the ladies is just like my daughter, and she helps me with everything.

Rides to my doctor appointments and the foot care I receive.

They helped us get Medicaid Assistance to help pay for my medical bills.

The breakfast and getting together in the mornings to visit and the outings.

I got to know most of the girls from there over the years. The girls came over to pay their respects after my mother died. I've deal with the coordinator over the years. She is such a knowledgeable lady and helped me. They gave me a check to help with my energy bill. I can't say enough about them. They have just been wonderful.

Appendix 11

Logic Model

SPICE-Bridge Elements for Living at Home/Block Nurse Programs

RESOURCES	ACTIVITIES	OUTPUTS	SHORT-TERM OUTCOMES	LONG-TERM OUTCOMES
Funded Partner organizations (accountable per Memorandum of Agreement): ▪ 5 Living at Home Block Nurse Programs ▪ Elderberry Institute ▪ United Hospital ▪ Regions Hospital ▪ Regions Senior Clinic ▪ Bridge Partnership (Payne-Phalen LAH/BNP, Chicanos Latinos Unidos en Servicio (CLUES), Hmong American Partnership (HAP)) ▪ Wilder Home Care Non-Funded SPICE Partnership Organizations: ▪ Ramsey County ▪ MAAA ▪ Evercare **Non-Funded Bridge Partnership organizations:** ▪ American Indian Family Center(AIC) ▪ Regions International Clinic ▪ Inver Hills/ ▪ Century colleges ▪ Regions Family Physicians ▪ La Clinica ▪ Wingspan **Named participant organizations:** ▪ United Family Health Center ▪ Lakeridge Health Care ▪ Other Health Plans **Others:** ▪ Project Coordinator ▪ Care Coordinator ▪ Marketing Design Consultant ▪ Volunteers	**1.** Referring partners receive information on how to refer **2.** Referrals communicated to a central site to reduce turn-around time **3.** Visit and assessment completed by LAH/BNP staff **4.** In-home support provided by LAH/BNP staff to participants **5.** Arrange needed services to participants by LAH/BNP staff **6.** Hospital and clinic staff are supported by LAH/BNP staff and volunteers **7**. Advocacy for participant needs (Ex.: accompany participants on clinic visits) **8.** In-service training for LAH/BNP staff members to address issues related to cultural literacy **9.** Review of training needs for improved reimbursement opportunity **10.** Reimbursement process (MSHO, AC/EW) initiated for LAH/BNP services	***1. 200 SPICE-Bridge participants receiving needed support at home*** **2.** SPICE-Bridge participants transferred from care site to home with assistance of LAH/BNP ***3. Health care directives discussed with all SPICE-Bridge participants, as is appropriate*** ***4. Increased use of referral line by hospital and clinic staff*** **5.** In-service training sessions offered to improve the reimbursement opportunities for SPICE-Bridge **6.** In-service training sessions offered to improve the cultural literacy of SPICE-Bridge partners and their staff members ***7. All participants eligible for ACG/EW/MSHO will be enrolled in ACG/EW/MSHO***	**1.** SPICE-Bridge participants feel comfortable receiving care and support **2.** Transition from care site to home occurs without problems **3.** Participants feel safer in their homes than they did prior to receiving LAH/BNP services **4.** SPICE-Bridge participants miss fewer clinic appointments **5.** Participants improve medication compliance **6.** Participants reduce risk of falling ***7. All participants will have advance directives in place, as is appropriate*** **8.** ***Greater clarity for referring entities on how to get help for participants, resulting in increased use of the referral line*** **9.** Decreased hospital and clinic staff time required to arrange for appropriate care **10.** Arranging for appropriate care for participants becomes easier for hospital and clinic staff **11.** SPICE-Bridge partners and their staff members improve their skill to a level required for reimbursable service providers **12.** SPICE-Bridge partners and their staff members improve their cultural literacy	**1.** SPICE-Bridge participants able to remain at home **2.** ***Fewer emergency room visits and fewer hospital readmissions*** **3.** SPICE-Bridge partners establish strong and helpful referring relationships **4.** ***LAH/BNP services will be reimbursable as evidenced by signed contract(s)*** **5.** Participants from all cultural backgrounds benefit from and are satisfied with services

Note: *Bold italics indicate outcomes to be reported.*