

Evaluation of the SPICE-Bridge Partnership project

Progress toward service integration

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Summary

The SPICE-Bridge Partnership (Senior Program for Integrated Care for Elders) project was funded as a one-year systems change project to integrate community-based services and supports with large health care systems through a structured partnership. The overall goal was to strengthen the connections and communication between these entities, and thus create a model of improved care for older adults that would enable them to continue living independently in their own homes for as long as possible.

Since August 2004, 153 older adults received community support in their transitions into and out of the clinic, hospital, rehabilitation center, nursing home, and home. As part of their enrollment in the SPICE-Bridge partnership, participants agreed to share information and participate in evaluation activities and receive additional assessments. According to data reported to the Elderberry Institute by the Living at Home/Block Nurse Programs, these participants were a subset of the 2,404 persons served in the six Living at Home/Block Nurse.

The members of the collaboration included:

- The Elderberry Institute (fiscal agent)
- United Hospital
- Regions Hospital
- Six neighborhood Living at Home/Block Nurse Programs: Highland, Macalester-Groveland, Summit Hill, Summit-University, West Seventh Community Center, and Payne-Phalen)
- Hmong American Partnership
- Wilder Home Care
- Regions Senior Clinic
- CLUES

In addition, there were several other agencies actively involved in planning and collaboration including: Regions International Clinic, Inver Hills/Century College, Regions Family Physicians, West Side Health Care, Wingspan, United Family Practice Health Center, Metropolitan Area Agency on Aging, Lakeridge Health Care, Evercare, and Ramsey County.

Desired outcomes

The SPICE-Bridge Partnership project selected 12 short-term outcome areas to focus efforts. These included:

- SPICE-Bridge Partnership participants feel comfortable receiving care and support
- Transitions from care sites to home occur without problems
- Participants feel safer in their homes than they did prior to receiving services
- Participants miss fewer clinic appointments
- Participants improve medication compliance
- Participants reduce risk of falling
- All participants will have advance directives in place, as is appropriate
- Greater clarity for referring entities on how to get help for participants, resulting in increased use of the referral line; arranging for appropriate care for participants becomes easier for hospital and clinic staff
- Living at Home/Block Nurse Programs demonstrate their value to health plans resulting in reimbursement for services provided
- SPICE partners and their staff members improve their cultural literacy

Project goals

In addition to linking partners together for the improvement of care and creating long-term sustainability through the development of reimbursable services, the project has the following specific goals:

1. Expand the number of persons served by the SPICE-Bridge Partnership from 65 to approximately 200
2. Reach out and work with new partners to replicate and improve services and protocols
3. Expand services to better meet the needs of culturally and ethnically diverse populations
4. Reduce or avert admissions to nursing homes, hospitals, and emergency departments and help participants to keep needed medical appointments

5. Assure appropriate transitions between and among hospitals, primary care clinics, transitional care programs, and other health and social services
6. Secure new reimbursement from health plans for the Living at Home/Block Nurse Program services

Project activities

The relatively complex partnership represented by this project includes the following components:

- A 24-hour phone referral line principally used by hospital discharge planners, but also used by others, when setting up medical care and support services for patients being discharged to home. These referrals are assessed and passed through to the appropriate Living at Home/Block Nurse Program.
- Assistance from Living at Home/Block Nurse Program staff in discussing and preparing an advanced health care directive.
- In-home evaluation and six month updates that become a permanent part of the medical record for individuals receiving services from the Living at Home/Block Nurse Program within their neighborhood.
- Improved communication between and among the healthcare providers and the Living at Home/Block Nurse Programs in order to improve the likelihood of positive outcomes for program participants.
- Screenings for activity of daily living functioning, fall-risk and other safety and health screenings.
- As necessary, medication management procedures to improve overall compliance and reduce medication errors among program participants in their own homes.

Living at Home/Block Nurse Programs

The 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, frail adults, enabling them to continue living in their own homes. Living at Home/Block Nurse Programs mobilize resources such as individuals, churches, businesses, and schools to provide social and community supports as well as contract with certified home care agencies to provide skilled nursing services. Living at Home/Block Nurse Programs provide case management services and provide or coordinate Meals on Wheels, adult day services, transportation services, chore services, homemaking services, and other services, if needed.

For the SPICE-Bridge Partnership project, the six participating Living at Home/Block Nurse Programs enrolled a combined total of 153 participants and their caregivers over the past year. As stated previously, these participants were a subset of the 2,404 persons served in the six Living at Home/Block Nurse. However, special efforts were made to enroll these participants in the project in order to better assess and evaluate project activities.

Evaluation methods

Wilder Research worked with the SPICE-Bridge Partnership project coordinator to implement evaluation procedures for the period August 2004 – June 2005. The evaluation of implementation and effectiveness involved seven data sources including:

- Participant interviews. Telephone interviews with 96 eligible participants (91% response rate).
- Partner interviews. Telephone interviews with 20 staff from partner organizations (80% response rate).
- Direct Service Provider interviews. Telephone interviews with 14 Living at Home/Block Nurse staff who provided direct services to older adult participants (93% response rate).
- Clinic staff surveys. Self-administered questionnaires completed by 10 clinic staff.
- Hospital staff surveys. Self-administered questionnaires completed by 24 hospital staff.

- Client Services and Contacts forms. Completed for each participant by the Living at Home/Block Nurse Programs. This form tracked Living at Home/Blocks Nurse Program service usage and participant outcomes. During this period, Wilder Research received complete forms for 141 of the 153 participants (92%).
- Missed clinic appointments, hospital admissions, readmissions, and emergency room utilization tracked through an Excel spreadsheet by the partners. This information was available for 148 of the 153 participants (97%).

Participant characteristics

Through the period of data collection (August 2004-June 2005), 141 eligible older adults were enrolled in the project. Twelve additional participants were enrolled between July 2005 and September 2005 (the evaluation completion date). The analysis is based on the 141 individuals served through June 2005.

During the past year, West Seventh, Highland, and Macalester-Groveland served the most participants. Most participants served were 80 years of age or older. Many were low income with at least 20 individuals receiving alternative care grants, 28 receiving elderly waivers, and 12 participating in MSHO. A few were enrolled in more than one program.

Most older adults served during this period were White (86%). Some of these were Russian immigrants with limited English skills. Six percent were Hispanic, 4 percent were African American, and 3 percent were American Indian.

Older adults who were served by the SPICE-Bridge Partnership ranged in age from 65 to 97. The average age of persons served was 81, and 60 percent of participants were 80 years or older.

Services received by participants

SPICE-Bridge Partnership participants received a variety of services as evidenced by the Services and Contacts form completed for 141 participants. Virtually *all* participants (97%) received one or more services in their home either implemented or arranged by Living at Home/Block Nurse Programs or partner organizations.

- 94 percent were assessed for fall prevention, and 11 percent received occupational therapy.
- 92 percent received some type of advocacy either in the form of support during a clinic visit, hospital follow-up appointment, or some other type of advocacy (e.g., help with a landlord).
- 92 percent had their medication management reviewed through the program; 19 percent had medication problems addressed at least once.
- Half of all program participants (47%) received a home nurse visit as part of their program participation with an average of 14 visits per participant.
- 52 percent received blood pressure screening.
- 45 percent received chore or homemaker services.
- 40 percent were screened for eligibility in one or more county service programs; this included a financial assessment.
- 40 percent received the services of a volunteer home visitor with an average of 16 hours spent with each participant.
- 35 percent received help in obtaining transportation for a clinic visit.
- 31 percent had a LifeLine installed in their home (an electronic contact service).
- 26 percent received a visit from a home health aide with an average of 46 visits per participant.
- 26 percent received Meals-on-Wheels arranged by the program.

Participant outcomes

Participant comfort with care and support that they received

Follow-up results from participants (N=93) show high levels of satisfaction with the support received as part of the Living at Home/Block Nurse Program, hospital and clinic collaboration. Seventy-one percent of all participants surveyed reported that they were very satisfied with the services and 29 percent reported they were somewhat satisfied. Ninety-five percent of participants reported that it was easy to schedule their first Block Nurse appointment. Sixty-three percent reported that they were able to get help in connecting to other community services through the Living at Home/Block Nurse Program.

Some helpful aspects of the program as described by participants include:

By coming to my home after I was hospitalized. . .they were very helpful in letting me know it is okay to take certain meds. They are supportive and reassured me when I felt doubtful.

They taught me how to take a shower by myself and how to exercise and get going again after the knee surgery.

They helped me with my health benefits. They helped me take care of my paperwork. That is so important to me. Otherwise I would not understand it all.

Setting up my pills because there are so many of them. She talks to the nurse and my doctor. If the pills aren't working, she called my doctor to get an appointment. I never would have thought of that.

Kept appointments

An examination of clinic appointments kept by clients for the period pre-entry and post-entry into the SPICE project entry shows a statistically significant improvement in rates of kept appointments following participation in the SPICE-Bridge Partnership project. On average, program participants were twice as likely to have kept appointments with medical providers following their engagement in services with the Living at Home/Block Nurse Program.

For one participant, this meant the following:

Her attendance at doctor appointments has improved significantly as a result of SPICE involvement. Her overall care plan at home [has] improved allowing her to avoid nursing home placement. SPICE services have included frequent contact with her primary physician, RN, and pharmacist to enhance communication efforts between them as well as consistent advocacy with doctor appointments.

Health Care Directives

One of the primary objectives of the SPICE-Bridge Partnership project was to have participants complete Health Care Directives that would remain on file or have the location noted at the clinic. According to the information contained in the Services and Contacts forms (n=141), 56 percent of the participants “completed” Health Care Directives, 8 percent had Health Care Directives “in progress,” and 28 percent of the participants were in a “preliminary discussion” about Health Care Directives with their Living at Home/Block Nurse Program. In addition, two-thirds of participants have completed an Emergency Resuscitation Form.

For some participants, their culture or beliefs prohibits extensive discussion of poor health, because it is thought that discussing these conditions will make them come true. This was true for at least one respondent. As the program serves more multicultural clientele, it may be necessary to provide guidance about the methods of beginning discussions and perhaps different methods of writing Health Care Directives for these persons.

Emergency room visits and hospital readmissions

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 (70 participants with completed information pre and post-enrollment). These records show no statistically significant changes in hospital enrollment, readmission, or emergency room rates for participants pre- and post-enrollment in the project. This may be due to the limited time period examined and a correlation between those persons who needed hospital care both *before* and *after* enrolling in the project. However, the data show some trends that may be helpful in program planning.

- The average number of emergency room visits was .69 pre-enrollment and .51 post-enrollment (this reduction can be seen as a positive trend although not statistically significant). There were five fewer participants who needed emergency room care after participating in the project (42 had no emergency room visits in the year prior to the project, compared to 47 with no emergency visits after enrollment).
- About the same number of participants required a hospital admission before (37 persons) and after (36 persons) entering the project.
- 95 percent of participants did not require a readmission immediately following hospitalization. Only three clients required a readmission before enrolling and four required a readmission after enrolling.

Keeping older adults in their homes

Of the 153 participants served during this period, 139 (91%) continue to be in their homes and participate with the project. At the end of the reporting period, six clients had died (4%), three were living in nursing homes (2%), three were living in assisted living facilities (2%), one client declined service, and one client moved out of the area.

Systems outcomes

With regard to follow-up information gained from partners, study results show that partners believe that the program has been helpful to patients in the provision of health care support not usually offered through standard home care agencies and by the improvement of access to care and assistance with medication.

- All (100%) of the respondents from the hospital survey reported that the Living at Home/Block Nurse Program had been helpful to their patients.
- All (100%) of the clinic staff reported that the services had been helpful to their patients.
- 98 percent of all program participants reported that they would recommend the services to those in similar situations or with similar needs.

Improved communication between the clinic, hospital, and the Living at Home/Block Nurse Programs resulting in smoother transitions for participants between health care settings and home, as exemplified by:

- Use of a dedicated referral line by clinic and hospital staff; between January and June 2005, 33 referrals were made by clinic and hospital staff to the dedicated SPICE Line. Of these calls, 18 clients were connected with a Living at Home/Block Nurse Program. The 15 remaining calls were either about potential clients or updates about clients currently served by the SPICE-Bridge Partnership.
- According to discussions at partnership meetings and the hospital workgroup, the United Hospital chart identification flagging system that identifies potential SPICE project participants has been a catalyst to other health care providers as they move toward electronic medical records.

Reimbursable services

There is strong evidence of the potential for Living at Home/Block Nurse Programs to receive reimbursement for services they provide. As a direct result of the SPICE-Bridge Partnership, three Living at Home/Block Nurse Programs are in the final stages of contract negotiations to receive reimbursement for several of the care coordinating services they provide.

Partnership staff reported that by working through the Reimbursement Task Force, the SPICE-Bridge Partnership has nearly completed a Letter of Agreement with Evercare, a Minnesota health care delivery organization working with UCare and Medica, to establish a “pilot” care management partnership with Elderberry Institute and three local Living at Home/Block Nurse Programs (Payne-Phalen, Summit-University, and West Seventh). This pilot partnership provides the opportunity for three Living at Home/Block Nurse Programs to provide specific case management services under the direction of Evercare for persons enrolled in Minnesota Senior Health Options (MSHO). Elderberry Institute and the three Living at Home/Block Nurse Programs will receive reimbursement for authorized services needed by the elders enrolled in Evercare and provided by the Living at Home/Block Nurse Programs. Elderberry Institute will be the fiscal agent on behalf of the three programs. Reimbursement will come directly from the two health plans. They are under contract with the State MSHO Program and rates will be consistent with state rates.

Benefits of SPICE as described by the direct service providers

Fifteen direct service providers (Living at Home/Block Nurse Program staff) participated in telephone interviews about their experiences with the SPICE-Bridge Partnership project. They were asked to describe how the SPICE-Bridge Partnership has helped them in their roles as direct service providers. Three providers noticed no changes in their roles. However, most others noticed improvements in communication and more support from others in the system of care. The following are selected responses from the direct service providers.

It helps me do a better job. We have monthly contact; do initial evaluation, and ongoing evaluations. For the senior, this means better service because we are more immediately aware of needs and are continually updated on things. It also contributes to the continuum of care, particularly from the sense of prevention.

We get more accurate medical information.

Many times I set up appointments. This way I know they will have someone pick them up, be there for the appointment, drive them back, and then communicate with me about what went on. The communication is so much better.

It provides the communication between us and the service providers so it is a broader sphere of people involved in providing services. I am better able to do that because I have a wider array of people to call upon, sharing thoughts, and services.

It has provided a more formal way of manner of monitoring client needs through the paperwork that has been developed and through the goals. It has provided a better framework. Better communication between the health care entities. The overall communication has improved.

You feel like there is more support in the health care system to understand and value what the community case managers do.

Benefits of SPICE as described by partners

Twenty partners participated in telephone interviews about their experiences with the SPICE-Bridge Partnership project. They were asked to describe how the SPICE-Bridge Partnership has helped them in their roles. Most partners noticed improvements in communication and more support from others in the system of care. The following are selected responses from partners.

It allows our students to have exposure to community-based health care.

I think by wanting a more comprehensive list of services, this partnership helps us have this. Also, we have better connections in clinics and hospitals, because we have names we can call.

Being able to offer more complete patient service to help our patients stay in the community.

We have been able to learn a lot from representatives in the community. We have met with clinics, long-term care facilities, and hospitals to better understand what they do. We've also met referral sources such as public health nurses and social workers to expand communication.

Initially we had meetings. I was new a year ago. I needed to learn what the Block Nurse Programs were. I got a list from each program of the services they provide. When I had all the information, I now better understand the role of the Living at Home/Block Nurse Program. I get a lot of calls for services so it helps me better know what services are in the community available to them.

It's given me a greater appreciation of the needs of the community.

Linking different entities or the providers, better services, easier referrals back and forth.

Again getting to know each of the organizations and what we each do well has improved delivery of health care. . .work on reimbursement of health care has been major benefit.

Issues to consider

The evaluation of the first year of the SPICE-Bridge Partnership project gives information that may be helpful in project planning in the coming year. Feedback from partners, direct service staff, and healthcare providers show that there is widespread support for the work of the project and a perception that communication among entities is improving as a result of the project. Older adult participants feel very satisfied with the attention and care that they receive from the Living at Home/Block Nurse Program staff. Importantly, there is indication that participants are significantly more likely to keep appointments after enrolling in the project.

The next year will allow time to improve and expand the work done during the implementation of both the Senior Care Community Partnership and the SPICE-Bridge Partnership. The most recent work with the SPICE-Bridge Partnership shows that it is possible to influence systems of care for older adults. Future efforts will continue to focus on systems change, especially in the areas of communication, collaboration, and reimbursement for coordinated services that allow older adults to stay in their homes.

Although satisfaction levels are high, some of the administrative data show little change between pre and post-test in participant rates of hospitalization, re-admissions after hospitalization, and emergency room visits. This may be due to the relatively short-time periods measured, the severity of health problems of clients served, and the relatively low rates of re-admissions and emergency room visits in general. In the coming months, Wilder Research will work with SPICE-Bridge Partnership staff to examine the measures to see if they are sensitive enough to show improvements or declines due to project services.

The project may wish to increase efforts to focus on minority population participation. During the 12-month study period, 86 percent of clients served were White. Although the project actively involved organizations working with populations from racial and ethnic minority communities, participation in the SPICE-Bridge Partnership project was limited.

In addition, the project will wish to increase efforts to better involve and publicize the project with clinic and hospital staff. The SPICE referral line was active during this period and will continue to be a resource that can be promoted and publicized.

As with most programs in the initial stages of implementation, record keeping can be a challenge for many direct service staff. This was a hurdle described by Living at Home/Block Nurse Program staff as well as a few of the partners. Gathering data for a project that has multiple service points can be very difficult. It is recommended that all data sources be examined to find the methods that are most beneficial to the project in examining implementation issues as well as participant and systems outcomes.

Finally, the project made extensive progress toward the end of this reporting period in gaining reimbursement for services offered through the SPICE-Bridge Partnership. As noted earlier, partnership staff reported that by working through the Reimbursement Task Force, the SPICE-Bridge Partnership has nearly completed a Letter of Agreement with Evercare, a Minnesota health care delivery organization, to establish a “pilot” care management partnership with Elderberry Institute and three local Living at Home/Block Nurse Programs. Elderberry Institute and the three Living at Home/Block Nurse Programs will receive reimbursement for authorized services needed by the elders enrolled in Evercare and provided by the Living at Home/Block Nurse Programs.

Staff, also report that based on successful implantation of this partnership, it is expected that the opportunity for similar partnerships will be executed with other health plans providing MSHO services by early 2006. In addition, it is expected that the Letter of Agreement with Evercare can be expanded to all Living at Home/Block Nurse Program members in the SPICE-Bridge Partnership by mid 2006, to all Living at Home/Block Nurse Programs in the metro area by the end of 2006, and potentially to rural Living at Home/Block Nurse Programs in 2007. Similarly, such agreements can be executed with other health plans in the same time frame. These are promising developments that may need to be communicated widely to partners, community organizations, and seniors who need or use such services.

Project background and purpose

The partnership

The SPICE project was funded as a one-year systems change project working to bring together a collaboration of health care providers and community-based Living at Home/Block Nurse Programs to attempt to serve older adults in a more integrated, or “seamless,” way. The Bridge Partnership was funded at the same time for 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 over the previous three years to build a strong interconnected infrastructure of community services linked directly to health and wellness care that will support successful aging at home for older adults and their families.

The SPICE Partnership (Senior Program for Integrated Care for Elders) was founded as the Senior Care Community Partnership by four Living at Home/Block Nurse Programs in the southwest quadrant of St. Paul, United Family Practice Health Center, United Hospital, and Elderberry Institute. From October 2001 through September 2004, this partnership received several grant awards from a group of local community foundations. In 2004, the partnership expanded to include two additional Living at Home/Block Nurse Programs, Regions Hospital, and Regions Senior Clinic as well as several non-funded agencies. This expanded the partnership received a Community Services Grant with an overall emphasis on systems change.

The Bridge Partnership for Culturally Appropriate Community Elder Care was originally organized as the East Side Senior Care Partnership. It is lead by the Payne-Phalen Living at Home/Block Nurse Program and includes: Chicanos Latinos Unido En Servicio (CLUES), and the Hmong American Partnership (HAP) as primary partners. Since 2002, the Bridge Partnership has been the recipient of a Community Services Grant from the Minnesota Department of Human Services. In 2004, the Summit University Living at Home/Block Nurse Program joined the partnership. The Bridge Partnership includes: Regions Hospital, Regions Senior and International Clinics and Regions Family Physicians, as well as West side Community Health Services including, La Clinica and Roosevelt Homes Clinic. The Bridge Partnership is a separately funded and evaluated project. Some Bridge Partnership staff provided direct services to older adults participating in SPICE activities. In this capacity, Bridge Partnership staff completed data collection activities for SPICE.

The members of the SPICE project included:

- The Elderberry Institute (fiscal agent)
- United Hospital
- Regions Hospital
- Six neighborhood Living at Home/Block Nurse Programs: Highland, Macalester-Groveland, Summit Hill, Summit-University, West Seventh Community Center, and Payne Phalen
- The Bridge Partnership (Hmong American Partnership and CLUES)
- Wilder Home Care
- Regions Senior Clinic

In addition, there were several other agencies actively involved in planning and collaboration including: Regions International Clinic, Inver Hills/Century College, Regions Family Physicians, West Side Health Care, Wingspan, United Family Practice Health Center, Metropolitan Area Agency on Aging, Lakeridge Health Care, Evercare, and Ramsey County.

The project is based on a successful pilot project carried out by the Elderberry Institute with other partners from October 2001 through September 2004. This project called the Senior Care Community Partnership was part of an overall strategy to change how care could be delivered in community settings where Living at Home/Block Nurse Programs are in operation. The current project intends to expand and improve the connections between healthcare providers and quasi-formal community services offered in Ramsey County.

Partnership goals

The mission of the partnership was

- To make system changes that improve communications between community, clinic, and hospital, resulting in improved transitions for elders.
- To demonstrate the value of Living at Home/Block Nurse Program services to health plans resulting in reimbursement for services.
- To improve the quality of life and quality of care for older people in our communities.

Living at Home/Block Nurse Program

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, such as individuals, 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.

For the SPICE project, the six Living at Home/Block Nurse Programs served a combined total of 153 participants and their caregivers over the partnership's three-year period. These participants were a subset of the 2,404 persons served in the six Living at Home/Block Nurse. However, special efforts were made to enroll these 153 participants in the project in order to better assess and evaluate project activities.

Evaluation methods

Wilder Research worked with the Elderberry Institute project coordinator 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 stakeholder telephone interviews 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 United and Regions Hospital, and missed clinic appointment data tracked by Regions Senior Clinic and United Family Practice Health Center. The evaluation of implementation and effectiveness involved seven data sources including:

Participant interviews

In the summer of 2005, Wilder Research conducted telephone follow-up interviews with older adults who had participated in activities related to the SPICE-Bridge Partnership. Contact information was provided for 124 persons. Of these, 18 had participated in previous activities through the Senior Care Community Partnership, but had not participated in the past year (since SPICE was funded). Of the 106 eligible, 96 participants were interviewed for a response rate of 91 percent. Interviews were conducted in English (88 participants), Spanish (6 participants), and Hmong (2 participants).

Partner interviews

During the same time period, Wilder Research conducted telephone interviews with partners involved with the SPICE-Bridge Partnership. In all, 20 of 25 partners completed an interview for a response rate of 80 percent.

Direct service provider interviews

In addition, Wilder Research conducted telephone interviews with 14 Living at Home/Block Nurse staff who provided direct services to older adult participants (93% response rate).

Self-administered surveys completed by clinic and hospital staff

The SPICE-Bridge Partnership project coordinator worked with partners to distribute surveys for completion by clinic and hospital staff. In all, self-administered questionnaires completed by 10 clinic staff, and 24 hospital staff. It is unknown how many staff did not complete the questionnaires.

Services and Contacts forms

The Living at Home/Block Nurse Programs maintained a “Services and Contacts” form for each program participant. This form included 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 type of data provided us with information about the levels of service received, the need for and implementation of medication management, completion of falls risk assessment, and home safety checks. With this data, we were able to explore the relationships among these variables and the participants’ outcomes related to hospital admissions, emergency room visits, and the number of missed clinic appointments.

During this period, Wilder Research received complete forms for 141 of the 153 participants (92%).

Hospital and clinic data

Missed clinic appointments, hospital admissions, readmissions, and emergency room utilization tracked through an Excel spreadsheet by the partners. This information was available for 148 of the 153 participants (97%).

Participant characteristics

Through the period of data collection (August 2004-June 2005), 141 eligible older adults were enrolled in the project. Twelve additional participants were enrolled between July 2005 and September 2005 (the evaluation completion date). The analysis is based on the 141 individuals served through June 2005.

During the past year, West Seventh, Highland, and Macalester-Groveland served the most participants. Most participants served were 80 years of age or older. Many were low income with at least 20 individuals receiving alternative care grants, 28 receiving elderly waivers, and 12 participating in MSHO. A few were enrolled in more than one program.

Most older adults served during this period were White (86%). Some of these were Russian immigrants with limited English skills. Six percent were Hispanic, 4 percent were African American, and 3 percent were American Indian.

The project also collected data on how the client was referred.

- 40 percent had previously been served through the Living at Home/Block Nurse Programs
- 17 percent were referred by United Family Practice Health Center
- 16 percent had been referred by a staff person of one of the programs
- 9 percent were referred by their physician
- 6 percent contacted the program on their own
- 6 percent were referred by CLUES
- 4 percent were referred by friends or relatives
- 2 people (1%) were referred by their hospital
- 2 people (1%) were referred by Ramsey County

1. Home neighborhoods of older adults served through SPICE-Bridge Partnership, August 2004 – June 2005

Living at Home Block Nurse Program	Number	Percent
West 7th	50	33%
Highland	35	23%
Macalester-Groveland	29	19%
Summit Hill	19	12%
Payne-Phalen	13	8%
Summit-University	7	5%*
Total	153	100%

Note: Summit-University site served seven older adults during this period. However, their Services and Contacts forms were not entered for analysis because of missing information and some clients who had not yet received a six-month follow-up. Those who received a six-month follow-up after August 1, 2005 were not included in the analysis.

Older adults who were served by the SPICE-Bridge Partnership project ranged in age from 65 to 97. The average age of persons served was 81, and 60 percent of participants were 80 years or older. The ages of participants served are shown in the figure below.

2. Ages of adults served through SPICE-Bridge Partnership, August 2004 – June 2005

Age (N=141)	Number	Percent
65-69 years	16	11%
70-74 years	17	12%
75-79 years	24	17%
80-84 years	34	30%
85-89 years	29	25%
90-94 years	16	11%
95-97 years	5	4%

Feedback from participants

At the end of the first year of the SPICE-Bridge Partnership project, 109 program participants were eligible and available to be interviewed. Of these, 96 participants (91%) completed interviews, eight were caregivers, such as spouse or adult child. Interviews were conducted in English, Spanish, and Hmong. If a caregiver was interviewed, they were asked questions about the relief they may have experienced as a result of the program. If a care recipient was interviewed, they were asked about the benefits they derived from participating in the program. All participants (caregivers and care recipients) were asked about the ease of accessing services, the helpfulness of specific services, and their overall satisfaction with the Living at Home/Block Nurse Program.

Satisfaction with services

Nearly all (98%) of the participants said they would recommend the services of the Living at Home/Block Nurse Program to others in a similar situation.

Accessing services

A vast majority of participants felt that the services received from the Living at Home/Block Nurse Program were easy to access:

- 96 percent said they “agree” or “strongly agree” that it was easy to find out about the services that were available
- 99 percent said they “agree” or “strongly agree” that it was easy to schedule the first block nurse appointment
- 94 percent said they “agree” or “strongly agree” that the services scheduling process met their needs
- 94 percent said they “agree” or “strongly agree” that it was easy to set up services

Helpfulness of services

Participants, both care recipients (n=85) and caregivers (n=8), reported that the services or assistance received from the Living at Home/Block Nurse Programs was beneficial to them. For all services, over 95 percent of participants who used the services reported that the service was “helpful” to them. The most commonly used services by survey participants were home visiting, help with getting connected to other community services, getting help with rides to doctor’s appointments, and getting help with advanced directives for health care. See the Appendix for complete results.

Care recipients

Survey participants were asked to list the one or two most important benefits that they had experiences as a result of receiving services from the service coordinator. The most commonly mentioned benefit was the reassurance of knowing that there was someone there if they needed it. Also commonly mentioned was the medication management help provided, and the arrangement of various services that the participant needed.

The following are some selected responses in the participants' own words.

The nurse coming up here and helping me with my medications and calling them in. Also, she helped me with the paperwork to understand what is important and what I can throw out.

We didn't have to depend on family members so much.

It was the help she gave us by taking us to the doctor. She was always on time.

It eases your mind when you have someone there to call on when needed. I can stay at home. Just knowing she is there for me. I have that good feeling knowing she is there. She is wonderful. It's a good one.

When I have services I feel more secure. I can pick up the phone and it can keep me from feeling depressed. They always take time to talk to you and listen to you. They can be there in minutes.

Well, I have to say I always look forward to seeing [staff]. She's my connection to the medical field. One time she called the doctor and the problem was solved right away.

One thing, their volunteer program – I've had help with writing, cleaning basement, windows, and garage. Plus it's all free and the students were just wonderful. Then all the knowledge about different types of help from different programs. The Mac-Groveland Block Nurse Program knows it all.

Well, if I didn't have them, I wouldn't be able to stay in my apartment. They're like part of my family. They are excellent and I look forward to seeing them.

Setting me up with Meals on Wheels and getting the equipment that I need like hand rails, scooter, walker, and many other things I didn't know how to go about getting these for myself.

It's nice that she comes every 6 months or so just to check on me in case I have problems or concerns. At this point I'm still able to do for myself.

I think it introduced us to all the people and facilities available out there for home care. It started us thinking and has helped us decide to stay in our home as long as we can.

Caregiver relief

Nearly all (7 out of 8) caregivers said that the Living at Home/Block Nurse Programs relieved some caregiver burden specifically in the area of feeling relief from care-giving responsibilities. In addition, six of the eight caregivers surveyed felt less stressed since working with the service coordinator. Most (5 out of 8) caregivers also said that the services they received through the Living at Home/Block Nurse Program allowed them to have time to pursue personal interests, more time to spend with the rest of the family, and led them to feel less isolated. Half (4 of 8) had spent more time engaged in social activities. Three caregivers reported that the services had helped them to be able to go to work. Seven of the eight caregivers reported being “satisfied” or “very satisfied” with the service coordination provided by the Living at Home/Block Nurse services overall. One person was unsure.

Impact on hospital admissions, emergency room visits, and missed clinic appointments

Participants who had been hospitalized were asked if they received help from the Living at Home/Block Nurse Program. Of the 64 who reported a hospitalization, 7 (11%) received help before being hospitalized, 29 (45%) received help after hospitalization, and 25 (39%) received help both before and after. Three participants did not know or could not remember.

Participants were asked to list ways in which the program staff were helpful before or after hospitalization.

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

Most frequent themes of suggestions in open-ended responses (given in participants' own words)	Number	Percent
Helped with medication/medication management	12	13%
Feel less stresses/knowing someone is there/having someone to talk to	12	13%
Helped me set up the services needed	9	10%
Helped with medical tests	8	9%
Helped with daily tasks/chores	7	8%
Helped arrange transportation, housing, medical benefits, translation services	7	8%
Helped with bathing/personal hygiene	6	7%
Helped with paperwork/filling out forms	5	5%

Some selected responses in participants' own words included:

By coming to my home after I was hospitalized – they were very helpful in letting me know it is okay to take certain meds. They are supportive and reassured me when I felt doubtful.

They taught me how to take a shower by myself and how to exercise and get going again after the knee surgery.

They helped me with my health benefits. They helped me take care of my paperwork. That is so important to me. Otherwise I would not understand it all.

Setting up my pills because there are so many of them. She talks to the nurse and my doctor. If the pills aren't working, she called my doctor to get an appointment. I never would have thought of that.

Having a sense of confidence that someone is there to help me both to make the appointments and be there with me to see the doctor. That is mainly it. Also the socializing. Meeting at Summit-Hill is very important.

I could depend on her medically or otherwise.

She helped me to get my medications from the drugstore and to get my prescription discount card. She tried to help me to get to another health insurance company but I decided not to.

The fact that they got the ball rolling to bring in a nurse, physical therapy, occupational therapy, they communicated with the health care providers.

Transportation and translation into Spanish so we can understand our services and programs.

By smoothing the transition from hospital to home and between clinic and home, some of the expected outcomes of the SPICE-Bridge Partnership was a decrease in the number of hospitalizations, emergency room visits, and missed clinic appointments for participants. As stated earlier, there was a statistically significant increase in the number of kept appointments. However, the number of hospital admissions and emergency room visits remained similar before and after participants entered service. Possible explanations include the fact that some of the participants had conditions that were expected to worsen over time. For example, a participant with terminal cancer had one hospitalization prior to enrollment and five hospitalizations after enrollment. It was thought that a better measure of the impact of Living at Home/Block Nurse Program services may be to collect the number of hospital readmissions. However, at this time, there is little data available and thus no conclusions that can be drawn about hospital readmissions rates. It may be beneficial to wait for further follow-up results for this measure.

Participant services and outcomes

Service information was collected through Services and Contacts forms (141 of 153 program participants) completed by Living at Home/Block Nurse Program staff. In addition, Wilder Research analyzed missed clinic appointments, hospital admissions, readmissions, and emergency room utilization tracked through an Excel spreadsheet by the partners. This information was available for 148 of the 153 participants (97%).

Assessments

The Living at Home/Block Nurse Programs either assess or confirm that an assessment has been conducted for the following:

- Activities of daily living
- Falls prevention
- Medication management
- Blood pressure
- Home safety check
- Alternative Care/Elderly Waiver eligibility (if indicated)
- Depression screening

All of the above except the depression screening should be completed routinely with the consent of the participant. Based on the information available through the Services and Contacts forms, falls and prevention (94%), home safety checks (93%), medication management review (92%), and activities of daily living assessment (91%) are completed with nearly all clients. About half of the participants received blood pressure screenings (52%). Forty percent were screened for Alternative Care/Elderly Waiver eligibility, and less than 20 percent were screened for depression. In addition, a review of vulnerability or suspected abuse is not routine, but a substantial proportion of participants (37%) were reviewed for being a vulnerable adult or for suspected abuse.

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 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. On average, Living at Home/Block Nurse Program staff spent 3.3 hours per client on clinic advocacy, 3.2 hours per client on health advocacy, and 7.5 hours per client on other advocacy contacts.

About half of the participants received nurse visits (47%) or chore homemaking visits (45%). Forty percent received assistance from volunteers. One-third of the participants received support services such as transportation to the clinic and had LifeLine services installed in their homes. Additionally, one-quarter of the participants received Meals-on-Wheels and home health aide visits.

Problems noted

Forty percent of the participants had “falls” noted and 19 percent had “medication management problems” noted in their Services and Contacts forms.

Health Care Directives

One of the primary objectives of the SPICE-Bridge Partnership project was to have participants complete Health Care Directives that would remain on file at the clinic. According to the information contained in the Services and Contacts forms (n=141), 56 percent of the participants “completed” Health Care Directives, 8 percent had Health Care Directives “in progress,” and 28 percent of the participants were in a “preliminary discussion” about Health Care Directives with their Living at Home/Block Nurse Program. In addition, two-thirds of participants have completed an Emergency Resuscitation Form.

Emergency room visits and hospital readmissions

SPICE-Bridge Partnership staff kept logs of emergency room, hospital admissions and hospital readmissions in the year prior to enrolling into the SPICE project as well as during the project period (70 participants with completed information pre and post-enrollment). These records show no statistically significant changes in hospital enrollment, readmission, or emergency room rates for the group of participants pre- and post-enrollment in the project. This may be due to the limited time period examined and a correlation between those persons who needed hospital care both *before* and *after* enrolling in the project.¹ However, the data show some trends that may be helpful in program planning.

- The average number of emergency room visits was .69 pre-enrollment and .51 post-enrollment (this reduction can be seen as a positive trend although not statistically significant). There were five fewer participants who needed emergency room care after participating in the project (42 had no emergency room visits in the year prior to the project, compared to 47 with no emergency visits after enrollment).
- About the same number of participants required a hospital admission before (37 persons) and after (36 persons) entering the project.
- 95 percent of participants did not require a readmission immediately following hospitalization. Only three clients required a readmission before enrolling and four required a readmission after enrolling.

Keeping older adults in their homes

Of the 153 participants served during this period, 139 (91%) continue to be in their homes and participate with the project. At the end of the reporting period, six clients had died (4%), three were living in nursing homes (2%), three were living in assisted living facilities (2%), one client declined service, and one client moved out of the area.

¹ There was a statistically significant correlation (at the .01 level) between persons who required emergency room use before entry into the program compared to persons who required emergency room use after entry into the program. This was only true for those clients who had a pre-enrollment emergency room visit and a post-enrollment emergency room visit.

Feedback from collaborators

This section reports the results of three stakeholder surveys in order to better understand their perceptions of changes that resulted from the implementation of the SPICE-Bridge Partnership project.

Partner interviews

Twenty SPICE-Bridge Partnership project partners completed a telephone interview with Wilder Research staff in August and September 2005 about their experiences participating in the partnership. Respondents' roles in the partnership varied: four respondents worked directly for hospitals involved in the partnership, four respondents represented Living at Home/Block Nurse Programs, five were administrators for non-profit agencies involved in the partnership, two persons had expertise in reimbursement for care, two respondents worked to coordinate services for seniors in the community, and two respondents directed programs for volunteers or interns, and one person was a consultant to the partnership.

Perception of progress toward goals

Partners were also asked to rate how well they feel that SPICE-Bridge Partnership has achieved its goals. The first goal is:

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.

Ninety percent (18 of 20) of the partners interviewed agreed that the SPICE-Bridge Partnership has achieved this goal. Two respondents disagreed.

The second goal is:

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.

Six respondents (30%) did not feel that they knew enough to answer the question about progress on this goal area. Nine respondents (45%) agreed that the partnership had achieved this goal, and five respondents (25%) disagreed).

These findings indicate mixed feelings among participants. It appears that overall the goal of care coordination and system changes has been more successfully achieved compared to the goal of creating sustainability of services by obtaining reimbursement for services.

4. Partner perspectives: the extent to which the SPICE-Bridge Partnership has achieved its goals

To what extent has the SPICE-Bridge Partnership achieved this goal	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
Goal 1: Link all partners together to improve care, enhance effective communication for participants, and contain costs during transitions to and from home	2 (10%)	16 (80%)	1 (5%)	1 (5%)	-
Goal 2: Create sustainability of services through more direct reimbursement of covered services by Evercare, health care plans, and AC-EW	1 (5%)	8 (40%)	4 (20%)	1 (5%)	6 (30%)

When asked to give one example of the type of progress made by the SPICE-Bridge Partnership or an improvement that is in progress in smoothing the transition between care setting and home, partners gave the following responses:

- I think they are increasing their model to have it more interdisciplinary and the programs have been enlarged which will help meet the needs of the community. I think they brought in some University of Minnesota physicians or family practice doctors to help do home visits, which will help educate physicians and will assist clients with health care needs.
- The initial assessment – where there is a snapshot of what is going on at home – because doctors do not usually know that. The clients do not usually communicate those things well. There is a more realistic picture of what is going on in the home.
- I go back to their connections with the clinics and with the doctors. I think they have done a good job of that. At least to the extent they are able. Not all the doctors have been willing but they have done a lot of outreach.
- For us we need to make sure that we are referring all appropriate people. [The fact that] SPICE is helping us to do that is appreciated, but the ball is in our court.
- Having a central intake has been a big step for them. We should continue working to get the public to be more aware of the central intake.
- I have made several referrals over the last month and have been impressed with the feedback of [referral coordinator] communicating back to me about the progress of the referral.

This is not just specific to SPICE but I know it is important to have the Block Nurse program in place because if someone needs these services, it is a nice continuum of care. I assume the SPICE participants would benefit the same way as the other participants not in SPICE.

The evaluation tool that we use for the client in the home is sent to the physicians who have reported to us. They give them a good glimpse of the senior's home situation.

More frequent communication between client, doctors, nurses, and discharge planners and case managers.

Better referrals and process.

The centralized 800-number so that a provider in a health care setting can access services on behalf of the patient.

What comes to mind is the Evercare piece with reimbursement. It is time-intensive to meet and agree on all the pieces. The work with Evercare is very encouraging.

I think there has been a recognition by health care professionals of the value of the quasi-formal health care providers in helping seniors return to their homes or remain in their homes.

The setting up of a flagging system at Regions (it is there at United). It will help more once it gets formalized at Regions. It notifies the hospital staff that the person lives in a neighborhood that has a Block Nurse program and is part of the SPICE project.

A big piece is that people in the hospital setting – the care coordinators are aware that Living at Home/Block Nurse Program are a resource in the community that can really be effective when that person can go home.

Discharge planners at the hospitals are becoming more and more familiar with this project.

Knowing nursing students visit the person in the home. If there has been a recent transition out of the hospital, the nursing student can report to the agencies any issues or concerns that show up. We have not had this experience with this particular program but have with other programs. And it also helps nursing students get the whole perspective of aging by seeing seniors successfully living at home with assistance as they needed it.

Benefits of the partnership

In addition, partners were asked to describe the one or two benefits that participants have experienced as a result of SPICE-Bridge Partnership project. One respondent did not observe any benefits. The most common responses were:

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

When asked how the SPICE-Bridge Partnership project has helped them in their role, the partners' responses included the following:

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

Partnership successes

Respondents were asked to give their opinions of things that the partnership has done well. The following are their responses:

We work together to develop clear communication and to meet the needs of both the community members and the students.

Their communication. Getting heard out, getting information out in their partnership with hospitals.

We have developed good relationships with clinics and hospitals. There is better communication. We can do better but it has gone well.

I think they have worked really hard to connect with the doctors in the clinics and hospitals. Learning about the funding streams and the restrictions tied to each.

Follow-up, good follow-up, contact with patients.

The one new thing for them was accessibility at all times through our referral line. They are now up to speed on the use of cell phones and things are going well. The Block Nurses are now working together as a team which is good and good for the future.

Monthly and every other month meetings have kept us up to date on how the project is going.

Opened good lines of communication between several health providers – community based organizations.

I don't really know. I haven't really seen results and am not sure from my position whether I would be able to see results. I think when SPICE started people from the Block Nurse program went out to tell people about the services and I went to some of the meetings. We have worked to improve the responsiveness with some of the directors of the Block Nurse program now carrying cell phones.

The partners seem committed and understand the holes in the system and to fill those holes.

Collaboration between partners especially the clinics that we have partnered with.

Earlier identification of the patients who could benefit from the program.

Setting up 800 referral line, and establishing outcomes and meeting them. Engaging health care providers in the project.

I think we have done well in our attempts to make the hospitals and clinics aware of our existence. We have networked with them to let them know what we do and how we can support their patients after they get out of the hospital.

I think it gets back to communication, raising issues about systems' change, what is working/not working. What needs changing are those things that are not working. We have really been doing problem solving. Also one of the state's goals was to have the quasi-formal service providers become independently sustainable without state funds. We have been able to make progress toward getting funds through health plans.

Raised awareness among all participants of the needs of seniors. Making sure that seniors get the services they need when they are discharged from the hospital or after a clinic visit.

Build relationships. Improve transitions and coordination for seniors.

Made some very concrete decisions about referral line and followed through on those. Made some significant changes in some systems with the flagging of charts at the hospitals.

It has mostly been about the integration and coordination of services across the system.

It introduces students to the needs of seniors in the community.

Suggestions for improvement

Partners were asked to give suggestions for improving the partnership. Responses varied. The following are selected responses:

Have earlier communication before there is a request to have changes made in the relationships. We work with a number of programs. I am not sure if this is only one program or more. I often get requests needing letters written with a short turn around such as one day, and I cannot meet such short requests.

Getting the word out about it needs to improve and getting more people to know it is there.

Sometimes there is not good communication from the project director. I think sometimes she is not pulling all the strings together. . . So many of the players, the people change, so we are always playing catch up but that is just the nature of the beast.

I think for the revenue piece they need to figure out whether they are going to be willing to do what is necessary to receive the revenue. They need to know who they are serving, their income levels, and the potential revenue streams. They need to be careful not to favor one health plan over another or a health plan over the county in making referrals.

I'm new to the hospital – timely communication regarding data needed.

More effort needs to be put into keeping the program in the public eye. They should expand the partnership to all of the programs. The public is still confused when they call our line. They don't understand it when their zip code does not fall into one of the block nurse units in the program.

I would like to see more involvement with the block nurses with our providers so they can see how the block nurse providers can be helpful to our patients.

More communication within the health care system – that the community-based organizations are there to help elders.

There is some difficulty if a referral source is also a partner in the program. The difficulty is when a clinic which is a partner calls wanting SPICE services for a client but the client is outside the boundaries of the Block Nurse program. The problem is trying to find a Block Nurse program to take that client. If someone calls for services I may be able to refer them to our program and not the Block Nurse. If someone calls from a SPICE partner wanting services but the person is not within an area served by a SPICE program it can be more difficult to figure out resources for that person. It would be helpful if SPICE partners were more aware of the boundaries and of the difficulties in finding services for those not living within the boundaries.

The level of participation of some of the partners of the hospitals and clinics.

We need to streamline our paperwork so it is not so staff-time intensive. It has to be made simpler. We need to continue to meet with the hospitals or have hospital representatives come to our meetings so there is a flow of information.

I think that as the state funding is going to dry up the challenge is going to be to have the partners stay together and keep going without the state funds. I don't know. I suppose it would be that the individual partners' commitments need to be strengthened. Not at this moment.

More communication from the hospitals to the neighborhood programs. That's enough.

Continuing to sort of move forward on all of the goals, the hospitals' and clinics' implementation of flagging systems needs to continue to improve.

More commitment on certain members' parts. Increased ownership by partners and they would show this by attending more meetings.

Resolving the difference between the core character of the program and billing for service.

We find the more explicit we and the agency can be as to the expectations and limits for the students, the better. And also best to reach an understanding of the agency. We have been trying to do this with all our service learning agencies.

Can't think of anything (3 responses).

The results on these items support the conclusion that SPICE-Bridge Partnership has been more effective at system changes in terms of improving communication between providers to ease transitions for older adults, which is related to the first goal of the project, than it has been with attaining reimbursement for services, which is the second goal of the partnership. However, the project has recently made progress in the reimbursement area. It may be helpful, if not done already, to widely communicate this progress to partners and collaborators.

Direct service provider interviews

Fourteen Living at Home/Block Nurse Program direct service staff completed interviews with Wilder Researchers in August and September 2005 regarding their experiences with the SPICE-Bridge Partnership project.

Benefits for participants

Direct service staff were asked to describe the one or two benefits that participants have experienced as a result of SPICE-Bridge Partnership project. Respondents described a variety of benefits. The most common responses were:

- Preventive safety (3 responses)
- Patients accompanied to hospital/clinic (3 responses)
- Transportation to appointments (3 responses)
- Smoother transition after hospital discharge (2 responses)
- Getting more information from the hospital (2 responses)
- Ongoing health care in their homes (2 responses)
- Block nurse staff's knowledge about available resources (2 responses)

Benefits for direct service providers

When asked how the SPICE-Bridge Partnership has helped them in their role, three respondents 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)
- More familiarity with other organizations (2 responses)
- More support from the health care system (2 responses)
- Hospital information is on time and accurate (2 responses)
- Helped provide a continuum of care (2 responses)
- More aware of client needs (1), better able to tap healthcare resources (1), and better preventive care for patients (1)

Coordination with hospitals and clinics

Direct service providers were asked what hospitals have done well when working with Living at Home/Block Nurse Programs. The most common response was that hospitals have 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). Two respondents also

mentioned that hospital and Living at Home/Block Nurse Program staff are communicating more effectively. This appears to be a positive development based on partnership activities.

In addition, the direct service providers were asked a series of questions about their experiences in working with the hospitals and clinics.

5. Direct service provider perspectives: coordination between provider, hospitals, and clinics

How often...	Always	Most of the time	Sometimes	Never
Are you informed when a participant is hospitalized	-	3 (25%)	9 (75%)	-
Are clinic referrals usually appropriate for the types of services provided by your organization	1 (8%)	9 (75%)	1 (8%)	1 (8%)
Do clinic referrals include the participant contact information	2 (18%)	9 (82%)	-	-
Are clinic referrals timely	2 (22%)	7 (78%)	-	-
Are clinic referrals complete	10 (100%)	-	-	-
Are hospital referrals appropriate for the types of services provided by your organization	2 (18%)	9 (82%)	-	-
Do hospital referrals include the correct participant contact information	2 (18%)	9 (82%)	-	-
Are hospital referrals timely	3 (27%)	7 (64%)	1 (9%)	-
Are hospital referrals complete	1 (9%)	8 (73%)	2 (18%)	-

In addition, 10 of 14 direct service providers rate the ease of contacting someone at the clinic about a participant as “somewhat” or “very” easy. Four of 10 respondents with prior knowledge had noticed an improvement in the quality of the referrals received from the clinic in the past year. The other six felt that the quality had remained constant. Five of 10 respondents with prior knowledge had notice an improvement in the quality of referrals from the hospitals in the past year. The other five felt that the quality had remained constant.

Finally, 7 of 13 (54%) direct service providers felt that their relationship with their care recipients’ health care provider had improved in the past year. The other six felt that the relationship was the same.

Suggestions for improvement

Direct service providers were asked to give suggestions for improving the partnership. Responses varied. The most common theme was related to increased communication among the clinic, hospital, and Living at Home/Block Nurse Program staff. The following are selected responses:

Somehow a means of identifying potential eligible participants by the hospitals and the clinics should be improved in how they flag and refer. I would appreciate more and better contact from hospital social workers to get in touch with us when a SPICE client is admitted. Better and more timely communication.

The better flow of communication of the transition between hospitals and us.

Nothing I can think of. Maybe better communication between the director of the Block Nurse Programs and the Wilder Health Care Agency.

I think the whole idea of the transitions; we need to assure we will be contacted if a senior in our area is in the hospital. We should also increase the number of clinic referrals. They should also inform us of any seniors who may benefit from our services.

Less paperwork, more communication.

Continued communication from both parts: block nurse and hospitals and clinics.

More participation from the hospital and clinic partners.

Communication would be the biggest thing I can think of. Figuring out a better way to handle triage or something.

I think it is knowing when your client is in the hospital and being called in advance when the client is going to be returning home so you can do some planning for that too.

The flagging systems need to be improved.

Some of the partners following through on the duties that are assigned to them.

Less paperwork.

I don't see that the doctors really know anything about anyone being involved in the program. I don't see how anything can change if the doctors and nurses know nothing about the program or if they do know and still do not do anything differently.

Surveys of hospital staff

Hospital staff were asked to complete a self-administered paper survey. These surveys were collected by a partner and submitted to Wilder Research. In all, hospital staff completed 24 questionnaires. At least 10 of the surveys were completed by Regions staff. The rest are unknown and were received through the mail. Because of the self-administered nature of these surveys, some respondents left some items blank. Also, the response rate is unknown, because we do not know how many staff were eligible or able to complete the surveys.

All hospital staff completing the surveys had knowledge of the Living at Home/Block Nurse Programs. Most (16 of 24) had found out about the program through meetings or presentations, four had past experience with the program, two had found out about from a co-worker, two through a previous job, and one through a friend.

Eighteen of the 24 hospital staff respondents had made specific referrals to the Living at Home/Block Nurse Program.

Staff were asked about their awareness of various services provided by the Living at Home/Block Nurse Programs.

6. Hospital staff members' awareness of services provided through the Living at Home/Block Nurse Programs and their requests for the Programs to provide the services for their patients

Service (N=24)	Number who are aware of the service	Number who asked the Programs to provide the service to their patients
Help in monitoring health problems	21	7
Help with medical follow-up when a patient is discharged from the hospital	19	6
Help to prevent unnecessary clinic visits	19	4
Help with non-medical follow-up when a patient is discharged from the hospital	18	6
Arrange for Meals on Wheels	17	5
Provide relief from loneliness or isolation	17	2
Set up LifeLine or other emergency contact system	16	3
Arrange for transportation	14	2
Help with long-term care planning	14	1
Help with Health Care Directives or living wills	12	0

Benefits of the program

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

- More weekend coverage for patients (5 responses)
- More comprehensive services (4 responses)
- Increased communication (3 responses)
- Continued support from Living at Home/Block Nurse Program while patient is in the hospital (3 responses)
- Care recipients feelings of independence (2 responses)
- Easier intake system (2 responses)
- Services provided at the local level (2 responses)

Suggestions for improvements

When hospital staff members were asked about improvements that could be made to the Living at Home/Block Nurse Program, 7 of 24 gave a suggestion. These suggestions included: increased communication (1), have a person to answer phone instead of voice mail (1), have 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 easier intake system (1).

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. Respondents found out about the program in a variety of ways. Two already knew about it as part of their job, two had clients in the program, two heard about it through a presentation, one was part of the original team that designed the program, and one participated in SPICE meetings.

All of the respondents said the Living at Home/Block Nurse Program had worked directly with their patients. Eight of 10 respondents had contact with staff members of the Living at Home/Block Nurse Programs.

Home evaluations

Seven of 10 clinic staff respondents said they have seen Home Evaluations done by program staff for some clinic patients. The clinic staff members who have seen a Home Evaluation were asked about the various uses of the Home Evaluations, in terms of how they help clinic staff. The uses and helpfulness of the home evaluations are listed below:

- Seven respondents said the Home Evaluation helped staff get to know participants better; two thought this evaluation was “very helpful,” four thought it was “somewhat helpful,” and one did not respond.
- Six respondents said the Home Evaluation made it easier to complete a diagnosis; two thought this was “very helpful,” one thought this evaluation was “somewhat helpful,” and three did not respond.
- Six respondents said the Home Evaluation made it easier to develop a treatment plan; three thought this evaluation was “very helpful,” one thought it was “somewhat helpful,” and two did not respond.
- Six respondents said the Home Evaluation provided a good snapshot of the participant’s home situation; five thought this evaluation was “very helpful” and one did not respond.
- Six respondents said the Home Evaluation helped identify potential services or help that the participants may have at home or in the community; four thought this evaluation was “very helpful,” one thought it was “somewhat helpful,” and one did not respond.
- Five respondents said the Home Evaluation increased staff’s comfort about the participant’s ability to live in their current housing; four thought this evaluation was “very helpful” and one did not respond.
- Six respondents said the Home Evaluation increased staff’s confidence that participants’ needs will be attended to when they return home; five thought this evaluation was “very helpful” and one did not respond.

Accompanying patients to the clinic

Seven of 10 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 seven of these respondents felt that it was helpful to their patient to have the program staff there. The reasons clinic staff mentioned for why it is helpful for their patients to have a Living at Home/Block Nurse Program staff member with them at their clinic appointments include:

- Helped patient understand situation and doctor’s instructions (4 responses)
- Living at Home/Block Nurse Program staff was able to provide information about patient to clinic staff (2 responses)
- Helped patient get where he/she needed to be (2 responses)

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 for the following reasons: more continuity of care and having someone to look out for patient needs.

Referrals to the Living at Home/Block Nurse Program

Eight of 10 clinic staff members who participated in the survey have 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 responses), meals (2 responses), home nursing help (2 responses), pharmacy benefit assistance (1 response), companionship (1 response), needs assessment (1 response), and unspecified medical help (1 response).

All eight respondents who made referrals said they received the type of help they had requested. Two respondents rated the referral process “very easy” and six said it was “somewhat easy.”

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

Benefits of the program

When asked to describe the biggest benefit of having the Living at Home/Block Nurse Programs available in Saint Paul neighborhoods, respondents gave the following comments:

- Helps seniors stay in their own homes; stay independent (4 responses)
- Clients stay healthier (4 responses)
- Improved continuity of care (2 responses)
- Increased safety for and checking-in on seniors (2 responses)
- Cost savings to the community (1 response)

- Reduced unnecessary hospitalization (1 response)
- Better communication between patient and health providers (1 response)
- Increased visibility of the program (1 response)

See the Appendix for clinic staff members' awareness of services provided through the Living at Home/Block Nurse Programs and whether or not these staff have asked the programs to provide the specified services for their patients.

Suggestions for improvement

When asked what they would do if they could improve one thing about the Living at Home/Block Nurse Programs, four respondents provided comments. Two respondents suggested improved recognition and awareness of available services, one respondent spoke about more energetic marketing of the program, and one respondent suggested that the program be made available to care recipients of different ages.

Issues to consider

The evaluation of the first year of the SPICE-Bridge Partnership project gives information that may be helpful in project planning in the coming year. Feedback from partners, direct service staff, and healthcare providers show that there is widespread support for the work of the project and a perception that communication among entities is improving as a result of the project. Older adult participants feel very satisfied with the attention and care that they receive from the Living at Home/Block Nurse Program staff. Importantly, there is indication that participants are significantly more likely to keep appointments after enrolling in the project.

The next year will allow time to improve and expand the work done during the implementation of both the Senior Care Community Partnership and the SPICE-Bridge Partnership. The most recent work with the SPICE-Bridge Partnership shows that it is possible to influence systems of care for older adults. Future efforts will continue to focus on systems change, especially in the areas of communication, collaboration, and reimbursement for coordinated services that allow older adults to stay in their homes.

Although satisfaction levels are high, some of the administrative data show little change between pre and post-test in participant rates of hospitalization, re-admissions after hospitalization, and emergency room visits. This may be due to the relatively short-time periods measured, the severity of health problems of clients served, and the relatively low rates of re-admissions and emergency room visits in general. In the coming months, Wilder Research will work with SPICE-Bridge Partnership staff to examine the measures to see if they are sensitive enough to show improvements or declines due to project services.

The project may wish to increase efforts to focus on minority population participation. During the 12-month study period, 86 percent of clients served were White. Although the project actively involved organizations working with populations from racial and ethnic minority communities, participation in the SPICE-Bridge Partnership project was limited.

In addition, the project will wish to increase efforts to better involve and publicize the project with clinic and hospital staff. The SPICE referral line was active during this period and will continue to be a resource that can be promoted and publicized.

As with most programs in the initial stages of implementation, record keeping can be a challenge for many direct service staff. This was a hurdle described by Living at Home/Block Nurse Program staff as well as a few of the partners. Gathering data for a project that has multiple service points can be very difficult. It is recommended that all data

sources be examined to find the methods that are most beneficial to the project in examining implementation issues as well as participant and systems outcomes.

Finally, the project made extensive progress toward the end of this reporting period in gaining reimbursement for services offered through the SPICE-Bridge Partnership. As noted earlier, partnership staff reported that by working through the Reimbursement Task Force, the SPICE-Bridge Partnership has nearly completed a Letter of Agreement with Evercare, a Minnesota health care delivery organization, to establish a “pilot” care management partnership with Elderberry Institute and three local Living at Home/Block Nurse Programs. Elderberry Institute and the three Living at Home/Block Nurse Programs will receive reimbursement for authorized services needed by the elders enrolled in Evercare and provided by the Living at Home/Block Nurse Programs.

Staff, also report that based on successful implantation of this partnership, it is expected that the opportunity for similar partnerships will be executed with other health plans providing MSHO services by early 2006. In addition, it is expected that the Letter of Agreement with Evercare can be expanded to all Living at Home/Block Nurse Program members in the SPICE-Bridge Partnership by mid 2006, to all Living at Home/Block Nurse Programs in the metro area by the end of 2006, and potentially to rural Living at Home/Block Nurse Programs in 2007. Similarly, such agreements can be executed with other health plans in the same time frame. These are promising developments that may need to be communicated widely to partners, community organizations, and seniors who need or use such services.

Appendix

Participant survey responses

Clinic staff survey responses

Services and contacts summary

SPICE-Bridge Partnership logic model

Participant survey responses

A1. Participants reported ease of setting up services

N=93	It was easy for me to find out about the services that were available		The services scheduling process met (my/my care recipient's) needs		It was easy to set up the services (I/my care recipient) needed	
Strongly agree	30	33%	24	28%	25	29%
Agree	56	62%	58	67%	55	65%
Disagree	4	4%	5	6%	5	6%
Strongly disagree	0	-	0	-	0	-
Total	90	100%	87	100%	85	100%

A2. Specific types of relief reported by caregivers

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 caregiving 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	-

A3. Caregiver satisfaction with services

N=8

Very satisfied	5
Somewhat satisfied	2
Unsure	1

A4. Specific types of services received by participants

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 advanced directives for health care such as a living will or other instruction for health care staff? (N=91)	44	48%
Get help writing an advanced 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?	4	5%

A5. Helpfulness of services as reported by participants*

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 advanced directives for health care such as a living will or other instruction for health care staff? (n=44)	98%	2%
Getting help writing an advanced 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 and help you 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.

Clinic staff survey responses

A6. Clinic staff members' ratings of the uses and helpfulness of various aspects of Home Evaluations

Has the Home Evaluation... (N=7)	Number who said the Home Evaluations helped them	(Of those who said the Home Evaluation helped them) number who said the Home Evaluations were "very helpful"
Helped you get to know patients better	7	2
Made it easier to complete a diagnosis	6	2
Made it easier to develop a treatment plan	6	3
Provided a good snapshot of the patient's home situation	6	5
Helped you to identify potential services or help that the client may have at home in the community	6	4
Increased your comfort about the patient's ability to live in their current housing	5	4
Increased your confidence that the patient's needs will be attended to when they return home	6	5

A7. Clinic staff members' (n=10) awareness of programs provided through the Living at Home/Block Nurse Programs and their requests for the program to provide the services for their patients

Service (N=10)	Number who are aware of the service	Number who asked the program to provide the service to their patients
Arrange for transportation	6	3
Arrange for Meals on Wheels	7	4
Help with long-term care planning	6	3
Help with advance directives or living wills	7	3
Set up LifeLine or other emergency contact system	8	3
Provide relief from loneliness or isolation	9	3
Help to prevent unnecessary clinic visits	7	2
Help with medical follow-up when a patient leaves the clinic	8	4
Help with non-medical follow-up when a patient leaves the clinic	8	4
Help in monitoring health problems	9	5

Services and contacts summary

A8. Living at Home/Block Nurse Program activities and the number of participants with completed Services and Contacts forms (n=141)

Program activity	Number of persons served	Percent of total persons served
Fall prevention assessed	133	94%
Home safety check	130	93%
Medication management reviewed	127	92%
Activities of daily living assessed	127	91%
File of Life	109	78%
Other advocacy contacts	101	73%
Emergency Resuscitation Form	92	66%
Completed Health Care Directives	78	56%
Blood pressure screening	73	52%
Nurse visits	66	47%
Chore/homemaking	64	45%
Health advocacy contacts	62	44%
Volunteer services	55	40%
Screen for Alternative Care/Elderly Waiver eligibility	57	40%
Falls noted	52	40%
Vulnerable or suspected abuse assessed	52	37%
Transport to clinic	48	35%
Clinic advocacy contacts	47	34%
LifeLine	44	31%
Home health aide visits	37	26%
Meals on Wheels	37	26%
Medication problems noted	27	19%
Depression screening	25	18%
Occupational or physical therapy	15	11%

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

RESOURCES	ACTIVITIES	OUTPUTS	SHORT-TERM OUTCOMES	LONG-TERM OUTCOMES
<p><u>Funded Partner organizations (accountable per Memorandum of Agreement):</u></p> <ul style="list-style-type: none"> ▪ 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 <p>Non-Funded SPICE Partnership Organizations:</p> <ul style="list-style-type: none"> ▪ Ramsey County ▪ MAAA ▪ Evercare <p><u>Non-Funded Bridge Partnership organizations:</u></p> <ul style="list-style-type: none"> ▪ American Indian Family Center(AIC) ▪ Regions International Clinic ▪ Inver Hills/ Century colleges ▪ Regions Family Physicians ▪ La Clinica ▪ Wingspan <p><u>Named participant organizations:</u></p> <ul style="list-style-type: none"> ▪ United Family Practice Health Center ▪ Lakeridge Health Care ▪ Other Health Plans <p><u>Others:</u></p> <ul style="list-style-type: none"> ▪ Project Coordinator ▪ Care Coordinator ▪ Marketing Design Consultant ▪ Volunteers 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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.*