Evaluation of the SPICE-Bridge Partnership project

Progress toward service integration
July 1, 2005 – June 30, 2007

FEBRUARY 2008

Evaluation of SPICE-Bridge Partnership project

Progress toward service integration
July 1, 2005 – June 30, 2007

February 2008

Prepared by:
June Heineman, Karen Ulstad, and Greg Owen

Wilder Research
451 Lexington Parkway North
Saint Paul, Minnesota 55104
651-280-2700
www.wilder.org

Contents

Figures

Acknowledgments

The authors would like to thank Arlene Pine, SPICE project coordinator, for assisting with the design of this evaluation, as well as providing us with access to contact information for the individuals interviewed for this report. The authors would also like to thank the SPICE-Bridge Partnership participants who agreed to participate in interviews and hospital, clinic, direct service provider staff, and other SPICE partners who have helped provide information needed for this evaluation.

The following Wilder Research Center staff contributed to the preparation of this report:

Mark Anton
Jacqueline Campeau
Louann Graham
Ryan McArdle
Ron Mortensen
Margie Peterson

Project background and purpose

The partnership

The SPICE grant was funded as a systems change project intended 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 to strengthen the delivery of culturally appropriate services to the same population in Saint Paul. The SPICE-Bridge collaboration is an effort to more closely link and combine two groups that have been working separately to build 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, as well as the United Family 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 (now Health Partners Specialty Center, Adult and Senior Services) as well as several non-funded agencies. This expanded partnership received a Community Services Grant from the Minnesota Department of Human Services with an overall emphasis on systems change.

The Bridge Partnership for Culturally Appropriate Community Elder Care was originally organized in 2003 as the East Side Senior Care Partnership, led by the Payne-Phalen Living at Home/Block Nurse Program and included Chicanos Latinos Unido En Servicio (CLUES) and the Hmong American Partnership (HAP) as primary partners. Due to organizational re-structuring, CLUES and HAP left the partnership in 2005. 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 currently includes Health Partners Specialty Center, Adults and Senior Services, as well as West Side Community Health Services, including La Clinica and East Side Family Clinic. Two bilingual Spanish/English staff provide expertise in culturally appropriate care for other LAH/BNPs. The Service Learning component provides training for 80 nursing, medical assistance, medical Spanish, communication and community service students through Payne-Phalen. 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.

In addition, several other agencies were actively involved in planning and collaboration, including: Evercare, the Metropolitan Area Agency on Aging, Wingspan, 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.

The members of the SPICE-Bridge collaboration currently include:

- The Elderberry Institute (fiscal agent and intermediary)
- Allina Hospice and Palliative Care
- Regions Hospital (not participating after July 2005)
- St. John's Hospital
- St. Joseph's Hospital
- United Hospital
- Six neighborhood Living at Home/Block Nurse Programs: Highland, Macalester-Groveland, Payne-Phalen, Summit Hill, Summit-University, and West Seventh Community Center)
- Wilder Home Health Care
- Health Partners Specialty Center, Adult and Senior Services
- West Side Health Care
- Golden Living Center, Lake Ridge
- United Family Practice Health Center

Partnership goals

The mission of the partnership is:

- 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.

Desired outcomes

The SPICE-Bridge Partnership project selected 12 short-term outcome areas in which 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 be informed and encouraged to complete an advance directive regarding health decisions
- Referring entities will have greater clarity on how to get help for participants, and this will results in increased use of the referral line and appropriate care for participants
- Living at Home/Block Nurse Programs demonstrate their value to health plans resulting in new opportunities for service reimbursement
- 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 275 across the four years of the project (August 2004 – June 2008).

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 premature or unnecessary 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.

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-Bridge Partnership project, the six participating Living at Home/Block Nurse Programs increased the enrollment of participants and their caregivers from 151 in the first program year (August 2004 – June 2005), to 168 in the second program year (July 2005 – June 2006), to 184 in the third program year (July 2006- June 2007). Across the three years, the unduplicated number enrolled was 257 participants and their caregivers.

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 August 2004 through June 2005, the 1,266 persons served July 2005 through June 2006, and the 947 persons served July 2006 through June 2007 in the six Living at Home/ Block Nurse Programs. An unduplicated number of persons served from August 2004 through June 2007 is not available.

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

Participant interviews

In the fall of 2007, at the end of the current reporting period, Wilder Research conducted interviews with 34 SPICE-Bridge Partnership participants who had received services from the Living at Home/Block Nurse Programs in the previous two years. All interviews were conducted in English. At least four participants from each of the six Living At Home/Block Nurse Programs were interviewed.

For the current reporting period, only care recipients were interviewed. Information gathered included:

- The respondent's level of comfort with the care and support received through the Living At Home/Block Nurse Programs
- The kinds of services provide or arranged for the respondent by the Living At Home/ Block Nurse Programs

- Respondent's satisfaction with the process of scheduling services and the convenience of the services provided

- The benefits experienced by respondent as a result of services received through the Living at Home/Block Nurse Programs

Services and Contacts forms

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

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

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

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

- Participants' status in completing Health Care Directives.

This 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.

Wilder Research received complete forms for 141 participants in the first year of the study, 168 participants in the second year including 64 participants who had also been enrolled previously, and 184 participants in the third year including 32 participants who had been enrolled previously.

Hospital and clinic data

Missed clinic appointments, hospital admissions, readmissions, and emergency room utilization were tracked through an Excel spreadsheet by the partners. This information was available for 133 of the 141 participants (94%) in the first year of the study, 129 of 168 participants (77%) in the second year, and 136 of 184 participants (74%) in the third year of the study. Across the three years of the project, pre-and post-enrollment information was available on 186 of the 257 participants (unduplicated number).

Participant characteristics

In the second year of the SPICE-Bridge project (July 2005 – June 2006), 168 older adults were enrolled in the project and in the third year of the project (July 2006 – June 2007), 184 older adults were enrolled in the project. The current analysis is based on these individuals. Comparisons are made to data collected on the 141 older adults who were enrolled in the first reporting period (August 2004 – June 2005). The unduplicated number of participants for the three years is 257.

The neighborhood locations serving the most participants remained the same (West Seventh, Highland, and Macalester-Groveland) over the three project years. The exception is Summit-University, which was not included in the first year's analysis.

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

Living at Home Block Nurse Program	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007	
	Number	Percent	Number	Percent	Number	Percent
West 7th	45	32%	36	21%	34	19%
Highland	35	25%	39	23%	32	18%
Macalester-Groveland	29	21%	32	19%	46	25%
Summit Hill	19	13%	25	15%	17	9%
Payne-Phalen	13	9%	11	7%	9	5%
Summit-University	-	-	25	15%	44	24%
Total	141	100%	168	100%	184	100%

The majority of participants served in the SPICE-Bridge Partnership were 80 years of age or older (60% in the first year, 62% in the second year, and 58% in the third year).

2. Ages of adults served through SPICE-Bridge Partnership

	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007	
Age	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Less than 65 years	-	-	1	1%	1	1%
65-69 years	16	11%	14	8%	15	8%
70-74 years	17	12%	24	14%	34	19%
75-79 years	24	17%	25	15%	27	15%
80-84 years	34	24%	30	18%	29	16%
85-89 years	29	21%	38	23%	44	24%
90-94 years	16	11%	22	13%	22	12%
95-99 years	5	4%	11	7%	10	5%
100+ years	-	-	2	1%	2	1%
Total	141	100%	167	100%	184	100%
Average age	80.8 years		82.1 years		81.5 years	

One of the goals of the SPICE-Bridge partnership is to expand services to better meet the needs of culturally and ethnically diverse populations. Although most of the older adults served across the three years of the project were White, the percentage of African Americans served increased from 4 percent in the first year to 21 percent in the third year. About 10 percent of the participants in the first and second years were Hispanic, Native American, Hmong, or of multi-racial backgrounds; this percentage dropped to 6 percent in the third year.

3. Race of adults served through SPICE-Bridge Partnership

	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007	
Age	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Caucasian	121	86%	122	73%	135	73%
African American	6	4%	31	19%	39	21%
Hispanic	8	6%	13	8%	7	4%
Native American	4	3%	1	<1%	1	<1%
Hmong	-	-	1	<1%	-	-
Multi-racial	1	1%	-	-	2	1%
Total	141	100%	168	100%	184	100%

Many of the SPICE-Bridge participants are low income individuals who qualify for some type of public assistance to pay for health related services. Across the three years of the project, 14 percent to 19 percent of participants received alternative care grants, 13 percent to 21 percent received assistance through elderly waivers, and 9 percent to 20 percent were in enrolled in Minnesota Senior Health Options (MSHO). A few participants were enrolled in more than one program.

4. Participants eligible for community-based health related services

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

Over the three years of the SPICE-Bridge project the number of referral sources has more than doubled from nine in 2004-05 to 21 in 2006-07. Almost all of the additional referral sources are community-based home service or social service organizations.

In the past two years, approximately one-half of the participants served by the SPICE-Bridge Partnership were referred through three sources: internal referrals (staff of the Living At Home/Block Nurse Programs), Wilder Community Services, and United Family Practice Health Center or United Hospital.

It is interesting to note some of the changes that have occurred in the referral sources of the participants served in the SPICE-Bridge Partnership over the three years of the project:

- Participants who had previously been served through the Living at Home/Block Nurse Programs made up 40 percent of the persons served in year one and only 9 percent in years two and three.
- Older adults referred by a staff member of one of the LAH/BHP programs increased from 16 percent in the first year, to 24 percent in the second year, to 27 percent in the third year.
- Referrals made by clinics and/or hospitals (including physician and nurse referrals) decreased from 27 percent in the first year, to 25 percent in the second year, and to 21 percent in the third year.

- Referrals from Ramsey County social workers or Adult Protection workers increased from 1 percent in the first year to 5 percent in the second year, and to 7 percent in the third year.
- Self referrals increased from 6 percent in the first year to 9 percent in the second year, then decreased slightly to 7 percent in the third year.
- Referrals from friends or family increased from 4 percent in the first year, to 6 percent in the second year, to 10 percent in the third year.

5. Referral source of older adults served through SPICE-Bridge Partnership

	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007	
Referral source	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Internal referral (staff of one of the LAH/BNPs)	23	16%	40	24%	49	27%
Wilder Community Services	-	-	12	7%	25	14%
United Family Health Center/Hospital	24	17%	21	13%	23	13%
Friends or relatives	5	4%	9	6%	19	10%
Previously served by LAH/BNP	56	40%	15	9%	17	9%
Self referral	8	6%	15	9%	12	7%
Ramsey County	2	1%	8	5%	12	7%
Physician/nurse	12	9%	12	7%	5	3%
Relationship not identified	-	-	9	6%	4	2%
HealthEast	-	-	2	1%	2	1%
CLUES	8	6%	2	1%	2	1%
West 7th Senior Program	-	-	9	6%	2	1%
Meals on Wheels	-	-	1	1%	2	1%
Evercare	-	-	-	-	2	1%
Hospital/clinic – not identified	2	1%	1	1%	1	1%
Health Partners	-	-	2	1%	1	1%
St. Joseph's Hospital	-	-	-	-	1	1%
Macalester/Groveland	-	-	-	-	1	1%
Discharge planner	-	-	-	-	1	1%

5. Referral source of older adults served through SPICE-Bridge Partnership (continued)

	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007	
Referral source	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Heartland Home care	-	-	-	-	1	1%
Senior Linkage	-	-	-	-	1	1%
Pastoral worker	-	-	2	1%	-	-
Regions Hospital/ Regions Senior Clinic	-	-	1	1%	-	-
Franciscan Home Health	-	-	1	1%	-	-
Midway Clinic	-	-	1	1%	-	-
Jewish Family Service	-	-	1	1%	-	-
SPICE/Elderberry	-	-	1	1%	-	-
Total	140	100%	165	100%	183	100%

Feedback from participants

At the end of the second reporting period (July 2005 – June 2007), Wilder Research interviewed a random sample of 34 program participants served during that time period after excluding those with serious cognitive and/or hearing impairments. Participants were asked about the ease of accessing services, the helpfulness the services they received, and their overall satisfaction with the Living at Home/Block Nurse Program. The results of these surveys, with comparison to participant interviews conducted at the end of the first reporting period, are described below. A complete set of data tables and open ended comments can be found in the appendix of this report.

Satisfaction with services

Nearly all (97% in 2007, 98% in 2005) of the participants said they would recommend the services of the Living at Home/Block Nurse Program to others.

Accessing services

Almost all participants in both reporting periods felt that the services received from the Living at Home/Block Nurse Program were easy to access:

- 97 percent of respondents in 2007 (96% in 2005) said they "agree" or "strongly agree" that it was easy to find out about the services that were available
- All respondents (100%) in 2007 (99% in 2005) said they "agree" or "strongly agree" that it was easy to schedule the first block nurse appointment
- All respondents (100%) in 2007 (94% in 2005)said they "agree" or "strongly agree" that the services scheduling process met their needs
- All respondents (100%) in 2007 (94% in 2005) said they "agree" or "strongly agree" that it was easy to set up services

Helpfulness of services

Participants interviewed in 2005 and 2007 reported that the services or assistance they received from the Living at Home/Block Nurse Programs were beneficial to them. In both reporting periods, over 95 percent of participants who used any of the services reported that the service was "helpful" to them.

The services most commonly used by survey participants in both reporting periods were home visiting, help with getting connected to other community services, getting help with

rides to doctor's appointments, getting help with paperwork, and getting help with advanced directives for health care.

Care recipients

Survey participants were asked to describe the one or two most important benefits they had experienced as a result of receiving services through the Living at Home/Block Nurse Program. The most commonly mentioned benefit, in both 2005 and 2007, was the reassurance of knowing that there was support available, that there was someone there to talk to if they had questions or needed help. Medication management and the arrangement of services were also commonly mentioned benefits.

Help before and/or after hospitalizations

Participants who had been hospitalized were asked if they received help from the Living at Home/Block Nurse Program before or after their hospitalization. In 2005, of the 64 participants who reported a hospitalization, seven (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.

In 2007, of the 20 participants who reported a hospitalization, five (25%) received help before being hospitalized, seven (35%) received help after being hospitalized, and six (30%) received help both before and after. Two participants did not know or could not remember.

Participants were asked to describe ways in which the program staff were helpful before or after hospitalization. The table below provides a summary of themes found in their responses.

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

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

Participant services and outcomes

Wilder Research received complete forms for 141 participants in the first year of the study, 168 participants in the second year including 64 participants that had also been enrolled previously, and 184 participants in the third year including 32 participants that had been enrolled previously.

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 133 of the 141 participants (94%) in the first year, 129 of 168 (77%) in the second year, and 136 of 184 (74%) in the third year.

Assessments

The Living at Home/Block Nurse Programs either conduct an assessment or confirm that an assessment has done for each of the following: activities of daily living, falls prevention, medication management, blood pressure, home safety check, Alternative Care/Elderly Waiver eligibility (if indicated), and depression screening.

All of the above are completed routinely with the participant's consent. The depression screening is only completed as needed. The figure below is based on the information available through the Services and Contacts forms and compares the percentage of participant assessments completed or confirmed during each reporting period.

7. Completed or confirmed assessments

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

In addition, a review of vulnerability or suspected abuse is not routine, but a substantial proportion of participants (37% in the first year, 34% in the second year, and 36% in the third year) were reviewed vulnerable adult status or for suspected abuse.

Problems noted

Falls prevention assessment

The percentage of participants that have problems noted on their falls prevention assessment has remained relatively steady across the three years of the project (40% in the first year, to 31% in the second year, and 37% in the third year). However, the average number of problems noted in the falls assessment has declined from .86 in the first year to .59 in the third year.

8. Number of problems noted on falls assessment

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

With regard to the types of problems in the falls assessments across the three years, the percentage of times physical issues were noted increased consistently, while the percentage of times the home environment and use or need of assistive devices were noted decreased.

9. Types of problems noted on falls assessment

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

Home safety checks

The percentage of participants that have had concerns noted during the home safety check has declined across the three years of the project (44% in the first year, to 29% in the second year, to 24% in the third year). The average number of concerns noted during the home safety check has declined from .61 in the first year to .29 in the third year.

10. Number of concerns noted during home safety check

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

With regard to the types of concerns found during the home safety check across the previous three years, safety concerns related to a combination of the house environment and the lack of adaptive devices top the list. Other concerns are related to the participant's physical health, the need for someone to check on the participant, and keeping safety alarms in working condition.

11. Types of problems noted during the home safety check

Types of problems noted during home safety check	August 2004-June 2005 (N=58)		July 2005-June 2006 (N=41)		July 2006-June 2007 (N=35)	
	Number	Percent	Number	Percent	Number	Percent
Safety concerns due to house environment (stairs, rugs, difficult to maneuver wheelchair)	30	52%	8	20%	15	43%
Safety concerns due to lack of adaptive devices (grab bars, railings)	4	7%	15	37%	8	23%
Needs/has "Lifeline", someone who regularly checks on participant's safety	9	16%	8	20%	6	17%
Safety concerns due to physical health	6	10%	3	7%	6	17%
Safety concerns due to lack of or not working safety alarms (smoke detector, carbon monoxide detector)	-	-	6	15%	4	11%

Medication management review

The percentage of participants who have had problems noted on their medication management review has declined slightly across the three years of the project (26% in the first year, 21% in the second year, and 20% in the third year). In addition, the average number of problems in medication management review has declined from .50 in the first year to .29 in the third year.

12. Number of problems noted on medication management review

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

According to the comments from the medication management review, participants capable of handling their own medication management increased from 38 percent in the first year, to a high of 52 percent in the second year, then decreased to 39 percent in the third year. Conversely, participants needing help with medication management decreased from 62 percent in the first year, to 48 percent in the second year, then rose to 61 percent in the third year.

13. Types of problems noted on medication management review

Types of problems noted during medication review	August 2004-June 2005 (N=32)		July 2005-June 2006 (N=26)		July 2006-June 2007 (N=28)	
	Number	Percent	Number	Percent	Number	Percent
Needs or is receiving help monitoring medication	20	62%	12	48%	17	61%
Can handle own medication management	12	38%	14	52%	11	39%
Changing/reducing medication	1	3%	3	12%	2	7%
Not taking medication/non-compliance/not filling prescriptions	-	-	4	15%	8	36%
Other	3	9%	1	4%	1	4%

Activities of Daily Living

The percentage of participants that had problems noted during their Activities of Daily Living Assessment has varied over the three years of the project (decreased from 39% in the first year, to a low of 27% in the second year, then increased to 43% in the third year). However, the average number of problems noted in Activities of Daily Living assessment has increased from .47 in the first year to .79 in the third year.

14. Number of problems noted during the Activities of Daily Living assessment

Number of problems noted during Activities of Daily Living assessment	August 2004-June 2005		July 2005-June 2006		July 2006-June 2007	
	Number	Percent	Number	Percent	Number	Percent
No problems noted	77	61%	110	73%	91	57%
One problem noted	41	32%	26	17%	31	19%
Two problems noted	8	6%	9	6%	19	12%
Three problems noted	1	1%	6	4%	19	12%
Total	**127**	**100%**	**151**	**100%**	**160**	**100%**
Average number of problems noted on during the ADL assessment	.47		.41		.79	

Problems listed in the Activities of Daily Living assessment were categorized into the levels of assistance needed to help the participant. Comments on assessment forms across all three years indicate that over three-quarters of participants could benefit from receiving some assistance with their daily activities.

15. Level of assistance needed as noted during Activities of Daily Living assessments

Types of problems noted during Activities of Daily Living assessment	August 2004-June 2005 (N=61)		July 2005-June 2006 (N=64)		July 2006-June 2007 (N=51)	
	Number	Percent	Number	Percent	Number	Percent
Needs minimal help	6	10%	15	23%	11	22%
Needs some help	45	74%	46	72%	37	73%
Needs a lot of help	5	8%	3	5%	2	4%
Participant is receiving help	4	7%	-	-	1	2%
Total	61	100%	64	100%	51	100%

Depression screening

The number of persons who have received a screening for depression has increased over the three years of the SPICE project, from 28 participants (20%) in the first year, to 53 participants (32%), in the second year, and to 103 participants (56%) in the third year.

During the second and third years, program staff recorded additional information about presenting concerns following screening. Most comments indicated that participants showed signs of depression including sadness, mood changes, loneliness, and nervousness.

16. Types of concerns noted on the Depression Screening

Types of concerns noted during depression screening	July 2005-June 2006 (N=53)		July 2006-June 2007 (N=103)	
	Number	Percent	Number	Percent
Participant shows sign of being depressed	7	13%	25	24%
Participant appears to be in denial	2	4%	-	-
Participant is experiencing family issues	2	4%	2	2%
Participant is grieving/experiencing loss of a loved one	1	2%	5	5%
Participant is currently on medication	3	6%	7	7%

Vulnerability/suspected abuse

In addition to the assessments and screenings previously described, a review of vulnerability or suspected abuse is not routine, but a substantial proportion of participants (37% in the first year, 34% in the second year, and 36% in the third year) were reviewed for vulnerable adult status or for suspected abuse. Results of positive findings following review are noted below.

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

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

Advocacy, support, and health care services

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

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

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

The figure below shows the percent of participants who received a visit from a nurse or home health aide and the average number of visits provided by either a nurse or home health aide. The percentage of participants receiving a visit from a nurse has remained relatively stable while the average number of visits has increased. The percent of participants receiving a visit from a Home Health Aide also has remained stable, however, the average number of visits by a Home Health Aide has increased substantially in the most recent study period.

19. Visits made by nurse and home health aide

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

Participants can receive a variety of other support services. The following table shows the participants who received support services such as transportation to the clinic, Meals-on-Wheels, support from volunteers, and/or had LifeLine services installed in their homes.

20. Assistance received by participants

Type of assistance/service	August 2004- June 2005 (N=141)		July 2005- June 2006 (N=168)		July 2006- June 2007 (N=184)	
	Number	Percent	Number	Percent	Number	Percent
Contact with staff	136	97%	156	93%	176	96%
Average number of staff contacts	9.8 contacts		10.9 contacts		13.9 contacts	
Volunteer assistance provided	55	40%	61	36%	78	42%
Average service hours provided by volunteers	16.4 hours		15.2 hours		25.1 hours	
Transportation to clinic	48	34%	41	24%	45	25%
Average number of transportation trips to clinic	4.6 trips		5.7 trips		6.3 trips	
Meals-on-Wheels	37	26%	58	35%	62	34%
Blood pressure screening	73	52%	97	58%	97	53%
LifeLine installed	44	31%	48	29%	63	34%
Chore/Homemaker services	64	45%	68	41%	80	44%

Health Care Directive, File of Life, and Resuscitation Form

One of the primary objectives of the SPICE-Bridge Partnership project was to have participants complete a Health Care Directive. About half of the participants completed a Health Care Directive in each of the three years of the project. In the most recent time period, however, 88 percent of all participants had either completed an advance directive, were in the process of preparing one, or had had a preliminary discussion regarding health care decisions. In addition, results show that a higher percentage of participants completed the File of Life in the first year and third years than did so in the second year of the project.

21. Health Care Directives, File of Life, and Resuscitation Form status

Status of Health Care Directive	August 2004- June 2005		July 2005- June 2006		July 2006- June 2007	
	Number	Percent	Number	Percent	Number	Percent
Preliminary discussion	39	28%	30	18%	54	29%
Refused	8	6%	15	9%	13	7%
In progress	11	8%	37	23%	17	9%
Completed	78	56%	78	48%	91	50%
Inappropriate	1	1%	3	2%	3	2%
Other	3	2%	1	1%	4	2%
Total	140	100%	164	100%	182	100%
Completed File of Life	109	77%	98	58%	114	62%
Completed Resuscitation Form	92	65%	68	41%	68	37%

Palliative Care

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

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

Clinic appointments, emergency room visits, and hospital admissions

The goal of reducing transition problems associated with discharge from the hospital is difficult to assess because a number of participants used either a clinic or hospital that was not a SPICE partner and could not provide data because of HIPAA regulations. Data on older adult participants was available for 133 of the 141 participants (94%) in the first year, 129 of 168 (77%) in the second year, and 136 of 184 (74%) in the third year. In addition, pre-enrollment data was collected for one year prior to enrollment, while post-enrollment data was often for a much longer time period. Therefore, caution should be used in reviewing these findings.

Clinic appointments

Across the three years represented in this report, clinic appointment data was available on 95 older adults for the 12 months prior to enrolling in the SPICE-Bridge Partnership and while being served in the project. The number of kept appointments prior to enrolling the project ranged from 0 to 80 visits and the number of missed appointments ranged from 0 to 25. The number of kept clinic appointments following enrollment in the project ranged from 0 to 71 and the number of missed appointments ranged from 0 to 34. This difference is not statistically significant.

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. During the three years of the project, pre- and post-enrollment information was available for 186 participants.

- Pre-enrollment hospital admission and clinic data are only available for a one year period prior to project enrollment. It is therefore not surprising that records post-enrollment over a three year time period would show a significantly larger number of hospitalizations than in this brief look back period. However, differences in hospital readmissions and emergency room visits were not statistically significant during this time period. Additionally, if the 18 participants who were admitted to the hospital just preceding their death are removed from the analysis, the difference in hospital admissions is not statistically significant.
- The average number of emergency room visits was .57 pre-enrollment and .81 post-enrollment. There is an indication that the increase may be a result of the health industry practice of having patients admitted to the hospital through the emergency

room. Additionally, participants are often experiencing significant and deteriorating health problems.

- The average number of readmissions to the hospital within 30 days of being admitted pre-enrollment was .09 and at post-enrollment was .21. Again, this may be a reflection of the population being served and their deteriorating physical health conditions.

Keeping older adults in their homes

Of the 257 participants served during the three years of the project, 218 (85%) continue to be in their homes and participating in the project. At the end of the three year reporting period, 19 participants had died (7%), 8 were living in nursing homes (3%), 4 were living in assisted living facilities (2%), 4 moved out of the area (2%), 1 client (1%) is being care for by a Personal Care Attendant, and 1 person (1%) chose to leave the program.

The Referral Line

One of the goals of the SPICE-Bridge Partnership project is to assure participants have appropriate transitions between and among hospitals, primary care clinics, transitional care programs, and other health and social services. The Referral Line, operated by the Wilder Foundation, receives calls 24 hours a day/7days a week to enhance the quality of these transitions. The Referral line received 53 calls from July 2005 through June 2006 and 76 calls from July 2006 through June 2007.

Services to cultural and diverse populations

Another goal of the SPICE-Bridge Partnership is to expand services to better meet the needs of culturally and ethnically diverse populations. During 2007, the SPICE Neighborhood Group sponsored two informational meetings related to these topics.

- In July 2007, Ana Diaz from Payne-Phalen Block Nurse Program presented at a SPICE Neighborhood Group meeting on her work with Alzheimer's Disease and the Latino Community. She has helped develop a dementia screening tool in Spanish and will consult with other Living At Home/Block Nurse Programs regarding their Latino clients who have dementia.
- In September 2007, Omar Jamal, from the Somali Justice Center, met with the SPICE Neighborhood Group to discuss the difficulty that older Somali adults immigrants have with using social and health related services in the Untied States. There are a significant number of old and near old Somali women who live in isolation, with few supports. The Living At Home/Block Nurse Programs are in a position to extend offers of assistance to this group.

Issues to consider

One of the key system related goals of the SPICE/Bridge Partnership is to improve the sustainability of critical community-based services for older adults. In the last Wilder report on the SPICE/Bridge partnership in 2005, we were able to observe that a new contract had been implemented to help one of the block nurse programs to receive reimbursement through Evercare for care coordination services performed for Minnesota Senior Health Options (MSHO) clients.

Work during the last two years has helped additional programs prepare to capture these reimbursements and has extended these reimbursement opportunities to seven additional LAH/BNPs, including four that are not part of the current SPICE/Bridge partnership.

The ability to capture such fees under MSHO through Evercare is further evidence of the health of this partnership and the improved sustainability of programs based on reliable funding streams. In addition, these results suggest movement toward assessment and reporting procedures that meet the criteria for government reimbursement. Finally, these results are an indicator that health plans are beginning to recognize the value that community-based partners bring to the goal of helping older adults maintain stable health and living circumstances in their own homes.

Another valuable system change that has occurred is that both participating clinics now conduct regularly scheduled case planning sessions, initiated by work with the LAH/BNPs, in order to improve continuity of care and implement appropriate services to patients.

In addition, there are now regularly scheduled meetings (four to six a year) between LAH/BNPs, the three participating hospitals (United, St. Joseph's and St. John's), Wilder Home Health, Lake Ridge Golden Living Care Center, and Allina Hospice and Palliative Care Center to coordinate practices to better support community service goals for program participants.

The study also shows that current participants have more serious health needs as evidenced by a higher number of nurse visits during the most recent study period and an increase in the average number of ADL problems identified at intake. In addition, current clients are more likely to be eligible for Elderly Waiver and Alternative Care Grants, suggesting a higher level of disability and distress than has been founding previous study periods. This is consistent with the results on hospital admissions, showing an increased number of admissions while enrolled and fewer during pre-service periods.

While the results in medication management reviews are encouraging (better monitoring), there are several areas of service that merit attention. They include a need for:

- Earlier identification and referral to community-based health services, including hospice care
- Greater focus on providing assistance to seniors in preparing and implementing advanced directives
- Additional work with hospitals to increase early and appropriate referrals for community-based services

Overall, however, the project shows significant effectiveness in helping older adults avoid long-term institutionalization and in developing services that are both valued and helpful to older adults.

Appendix

Participant survey responses

SPICE-Bridge Partnership logic model

Participant survey responses

At the end of the first reporting period of the SPICE-Bridge Partnership project in 2005, 91 of 96 (91%) program participants completed a brief telephone interview. Of these, 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.

In 2007, at the end of the second reporting period, 34 current care recipients completed the same participant survey. At least four care recipients from each program site were interviewed.

A1. Participants reported ease in finding out about services

It was easy for me to find out about the services that were available	August 2004 – June 2005		July 2005 – June 2007	
	Number	Percent	Number	Percent
Strongly agree	30	33%	10	32%
Agree	56	62%	20	65%
Disagree	4	4%	1	3%
Strongly disagree	-	-	-	-
Total	90	100%	31	100%

A2. Participants reported ease of scheduling the first block nurse appointment

It was easy for me to schedule the first block nurse appointment.	August 2004 – June 2005		July 2005 – June 2007	
	Number	Percent	Number	Percent
Strongly agree	28	30%	10	50%
Agree	60	65%	10	50%
Disagree	1	1%	-	-
Strongly disagree	-	-	-	-
Total	89	100%	20	100%
Don't know or remember			14	

A3. Participants reported ease of the services scheduling process

The process of scheduling services met (my/my care recipient's) needs	August 2004 – June 2005		July 2005 – June 2007	
	Number	Percent	Number	Percent
Strongly agree	24	28%	15	50%
Agree	58	67%	15	50%
Disagree	5	6%	-	-
Strongly disagree	-	-	-	-
Total	87	100%	30	100%

A4. Participants reported ease of setting up the services needed

It was easy to set up the services needed	August 2004 – June 2005		July 2005 – June 2007	
	Number	Percent	Number	Percent
Strongly agree	25	29%	14	52%
Agree	55	65%	13	48%
Disagree	5	6%	-	-
Strongly disagree	0	-	-	-
Total	85	100%	27	100%

A5. Specific types of relief reported by caregivers (August 2004- June 2005)

Since working with service coordinator at the block nurse program, have you...(N=8)	Yes	No	If "YES," Would you say this has been... Very important	Somewhat important	Not too important
Received relief from 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	-

Note: *In 2007, no caregivers were sampled, thus this table applies only to the 2005 survey.*

A6. Caregiver satisfaction with services (August 2004- June 2005)

N=8	
Very satisfied	5
Somewhat satisfied	2
Unsure	1

Note: *In 2007, no caregivers were sampled, thus this table applies only to the 2005 survey.*

A7. Specific types of services received by participants (August 2004 – June 2005)

Did you…	Number	Percent
Have a visitor from (PROGRAM) come to (your/your care recipient's) home? (N=92)	80	87%
Get help connecting to other services you needed in the community? (N=90)	57	63%
Get help setting up medications or have someone call with a reminder to take medications? (N=93)	23	25%
Get help with rides to doctor's appointments or other places? (N=92)	48	52%
Get help with paperwork or forms needed for services? (N=90)	40	44%
Get help with figuring out medical bills or understanding health benefits? (N=93)	19	20%
Get help understanding 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? (N=88)	4	5%

A8. Helpfulness of services as reported by participants* (August 2004-June 2005)

Was…	Helpful	Not helpful
Having a visitor from (PROGRAM) come to (your/your care recipient's) home? (n=80)	98%	3%
Getting help connecting to other services you needed in the community? (n=56)	97%	4%
Getting help setting up medications or have someone call with a reminder to take medications? (n=23)	100%	-
Getting help with rides to doctor's appointments or other places? (n=47)	100%	-
Getting help with paperwork or forms needed for services? (n=40)	100%	-
Getting help with figuring out medical bills or understanding health benefits? (n=19)	95%	5%
Getting help understanding 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 to talk with the nurse or doctor? (n=30)	100%	-

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

A9. Specific types of services received by participants (July 2005 – June 2007)

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

A10. Helpfulness of services as reported by participants* (July 2005 – June 2007)

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

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

A11. Participants reported overall satisfaction

How satisfied are you with the overall services of the block nurse program?	August 2004 – June 2005		July 2005 – June 2007	
	Number	Percent	Number	Percent
Very satisfied	5	-	27	79%
Satisfied	2	-	6	18%
Dissatisfied	-	-	1	3%
Very dissatisfied	-	-	-	-
Total	7	-	34	100%

***Note.** In 2005, Only caregivers were asked this question. Percentages are not reported when the number of respondents is less than 10.*

A12. Participants reported service use before or after hospitalization

Did you receive help from the block nurse program before or after your hospitalization, or both time?	August 2004 – June 2005		July 2005 – June 2007	
	Number	Percent	Number	Percent
Before	7	12%	5	28%
After	29	48%	7	39%
Both	25	41%	6	33%
Total	61	100%	18	100%

A13. Participants

Would you recommend the services of the block nurse program to others in a similar situation?	August 2004 – June 2005		July 2005 – June 2007	
	Number	Percent	Number	Percent
Yes	89	98%	31	97%
No	2	2%	1	3%
Total	91	100%	32	100%

Open-ended responses

In what way was it helpful to have this person with you at the clinic? (8 responses – 24%)

> (Staff person) does most of the talking for me, the doctor's let her know about the appointments I need.
>
> Coordinator took me to the doctor and then we had lunch at Snuffy's and we went to the barbers. Coordinator came in to talk with doctor.
>
> I had two heart failures this year, October and December, nurse from Block Nurse took me to kidney doctor. She talked the nurse at doctor's office about getting a cardio COM scale in my home which is very helpful to me.
>
> I just got out of the hospital at the first of the year. Nurse listened to the doctors. I was a little bit shaky at the time.
>
> It could have been. The doctor said that one was with me, she came with me. The nurse asked if she could come in, that's all I remember.
>
> It was reassuring to have someone to give me moral support and accompanying me and getting help with carrying through with what the doctor suggested.
>
> Manager came and she could see what I was putting up with in doctor not answering my questions, ex: cancer. She didn't have answers for me. So I switched doctors.
>
> The nurse knew what questions to ask. She helped me afterward to interpret the doctor's words and answers and put them in a sort of context for me. It was helpful for me to have someone to help me drive the car and not worry about parking. It was nice to have someone with medical knowledge to speak up for me.

Why was it NOT helpful to have this person with [you/{name of care recipient)] at the clinic?

> I weigh myself every morning, it goes to the doctor's office, and she keeps track of it through U-Care insurance company. For awhile I had a nurse come out twice a week, she checked my blood pressure and checked out my heart.

Did you have problems setting up this service? What were those problems?

> I called them a couple of times and never got through. I could not get to them when I want, I was disgusted. I wanted to get help from them for transportation and companionship – yackety jack.

If you had any problems with your services, what problems did you have? (3 responses – 9%)

> There was a group of nuns, I think, that used to come and clean. I was not impressed with that at all. Nun was an immigrant, India, I think. She came in her royal blue habit. I could not understand her and how she could clean in her habit. My husband said she makes me nervous, so that didn't work out. Since then we have a wonderful girl that comes to clean.
>
> Too many supplies, CHUX pads. I'm supposed to get them on demand, but they send me a box each month, and that's too much. The last time I tried to reduce the order, the cut off all my supplies like my diabetic strips. The Block Nurse program said it was the social worker's fault. I think it was them, the Block Nurse program. My next step will be to refuse them when they are delivered.
>
> I don't understand why you have to call three days ahead of time to get your ride setup. It might be the next day when I have to go. Then I have to cancel my appointment with the doctor.

As you see it, what are the one or two of the most important benefits that you have experienced as a result of receiving services from (PROGRAM NAME/SERVICE PROVIDER)?

Services, other than health service, provided through the Living at Home/Block Nurse Programs (17 responses – 50%)

> The morning help, she gets my breakfast, gets me my shower and gets me started. I get meals-on-wheels too.
>
> The one time I had to go to the doctor and no one in my family could take me (staff) coordinator did herself.
>
> The transportation has been the most important benefit to me. Also, the feeling of concern and connectedness that the program will always do the best it can to be helpful to me; checks in on me.
>
> Transportation and the sitter. Staff person and I keep in touch. I think that the program was very rewarding and want to give them credit for that.
>
> They take me for groceries once a week.
>
> Being here for me. It's a nice thing to have. They came out and did an assessment. They helped get my money back for food stamps. They took my $10 food stamps and my $81. This program helped me to get it back. (Staff person) did all the paperwork to get it back.
>
> Certainly the one is having that bath every week. It's conversing with them and it makes taking a bath much easier. I talk to coordinator quite frequently. Gets me any information and updates I want.

Having the nurse come and do pedicure on my feet, that's very important to me. The housekeeping is very important to me and that they do let me know if this (housekeeper) having a problem and will be there.

Helping me with the city inspection and get home worked on in 6 months. Helping me with the Social Security thing. They dropped my SSI because they overpaid 6-8 months with Ramsey County, Medicare, and Social Security, and SSI. He stood behind me because I didn't have anyone else.

I get meals-on-wheels. Through Dakota County, I get someone to clean for me. Through Equity I get nurse who comes a week.

I have been treated very nicely. I found out about the things that the Block nurse program could do to help me, like rides. I didn't know until she came out and explained what Block nurse program is for. Bills straightened out, worker from Catholic Association, anything goes wrong I can call her. I didn't know I could get surgical gloves and get them through Block nurse. I wanted sterile stuff and paid for it myself.

Being able to stay here in my home. Being able to do my own thing.

I'm just glad that they are there if I need them, that they are available. I'm glad I'm a member and if I need them I'll call them. I'm able to do my own shopping and things for far. It's nice to know that such an organization is available. Someone called me from there a few weeks ago, I asked about snow removal, but my neighbor took care of it.

Just the idea of giving my information on what I could do if I had to have it. I'm still able to drive.

Number one, I like the program wellness we have in our building – it's very informative. We have a newsletter that comes out and tells about community programs in the area that we can get involved in. It's nice. It's at the community center which is close by.

That I know if I need something, I could call on them.

I don't really get much help from the Block Nurse Program because I don't need it. I have her come to talk to me every six months to assess and find out if I need anything.

I feel like if I need something they are very helpful. I got to know them when I was a volunteer and that helps. The supervisor calls me up every once in awhile to keep my records updated.

Social contact and information provided by the Living at Home/Block Nurse Programs (8 responses – 24%)

> My contact with Highland Park Nurse program has been very supportive and reassuring. They are right there in the community and they are readily available. There is no confusion in reaching them. They answer the phone, it's easy and fast because there are no extensions or options on where to go to call.
>
> Their friendliness. They bring gifts at Christmas for senior that they are remembering, a loving gesture. They took me out for coffee once and that was really nice.
>
> There's a young woman, a coordinator she comes and visits me. She's great. She'll visit but if sees anything that should be done she does like lotion on my legs. She's very helpful that way, she's cheerful and lifts my spirits.
>
> They gave me a lot of information and we are getting to a point where we agree on certain things. Services, insurance and bills.
>
> To talk and stuff. Sit and talk, only 2 or 3 times.
>
> (Staff)/nurse is a truly wonderful person. I ask her different questions, she is always so wonderful about the answers. She is very kind, she is just a great person – a joy to be with. She always has the right answers, she is always truthful. She is rewarding to be with.
>
> I feel I have a place that I can go to that will coordinate my care and that I can trust. They are neighborhood oriented. They've been to my house. They know my circumstances.
>
> [Staff person] called me to see if there were any jobs I needed done that I was having trouble with. The attention they give you and they do everything they can to help you.

Health related service, provided through the Living at Home/Block Nurse Programs (6 responses – 18%)

> My nurse talks to me and takes the she gives me a few minutes to talk to me about my medicines, my doctor, my appointments. (else) No, everything is going on smoothly.
>
> The volunteers have been very nice and very helpful. It is wonderful I could call for somebody to arrange for my rides. And they stay with me and help me at the appointment, which is important for someone with equilibrium. Someone to help me so I am sure I don't fall.
>
> (Staff person) she takes blood and comes every week, fixes my medication every week, calls my drugstore and gets my medications.

At this point, the physical therapist because I needed to strengthen my legs so I wouldn't fall again and he taught me exercises that I'm still doing.

Best things is knowing that (staff person) will sit aside, when I call her it's nice to know because she give me the choice of three nurses to call if I have medical help. I only use the services for appointments. (Staff person) takes me. Those rides have been my lifeline for my doctor appointments. I can't depend on Metro Mobility.

My nurse came out and explained to me the pain (that I get and) what they mean and what to expect when I feel one coming.

Logic Model

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

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

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