

## **Spice-Bridge Partnership Project**

### **Evaluation summary**

#### ***About the project***

The SPICE Partnership (Senior Program for Integrated Care for Elders) received a grant to bring together a collaboration of health care providers and community-based Living at Home/Block Nurse Programs to serve older adults in a more integrated way. The Bridge Partnership was funded at the same time to strengthen the delivery of culturally appropriate services to the same population in Saint Paul. The SPICE-Bridge collaboration is an effort to more closely link and combine two groups that have been working separately to build 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 mission of the joint 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.

#### ***About the evaluation***

The SPICE-Bridge Partnership wanted to evaluate its effectiveness in meeting its mission. To accomplish this, Wilder Research conducted telephone interviews with a sample of 34 participants who had received services through the Living At Home/Block Nurse Programs and analyzed administrative data on 186 participants that provided information about levels of service, need for and implementation of medication management, completion of falls risk assessment, and home safety checks. Analysis was based on pre-and post-enrollment data collected over a three year period.

#### ***About the participants***

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 enrolled in Minnesota Senior Health Options (MSHO). A few participants were enrolled in more than one program.

#### ***Key findings***

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

#### **Client satisfaction**

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

- **Accessing services** – Nearly all or all said they “agree” or “strongly agree” that it was easy to find out about available services and it was easy to schedule the first block nurse appointment. Nearly all also said that the service scheduling process met their needs, and that it was easy to set up services.
- **Helpfulness of services** – Over 95 percent who used any of the services reported that the service was helpful. Those most commonly used include 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.

- **Service benefits** –The following were described as being important benefits: knowing support was available, having someone who could answer questions available, and receiving assistance with medication management and arranging services.

### ***In-home services received***

85 percent of those receiving services during the three years of the evaluation remain in their home, despite increasing care needs and increased levels of disability.

Assessments are routinely conducted for the following: activities of daily living, falls prevention, medication management, blood pressure, home safety check. Some participants were also screened for depression and suspected abuse. In all areas the percentage of participants with concerns noted during assessments declined or held steady. The number of participants receiving depression screening increased. Advocacy, support, and health care services stayed consistent.

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.

### ***Funding***

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.

### ***System change***

A valuable system change that has occurred is that the two 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.

### ***Additional observations***

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 found in 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.

- 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

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 informational meetings to educate practitioners on Alzheimer's and a screening tool in Spanish, and to discuss the difficulty that older Somali adults immigrants have with using social and health related services in the United States.

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**For more information**

This summary presents highlights of the *Spice Bridge Partnership Project evaluation*. For more information about this report, contact June Heineman at Wilder Research, 651-280-2693.

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