A CS/SD Project in West Metro

NASUA Home & Community-Based Services Conference and Age & Disabilities Odyssey
Minneapolis, MN: October 5, 2006
Outline / Agenda

• Understand components & scope of project
• Describe assessment tools & population enrolled
• Illustrate project in action through case study
• Identify 3 lessons learned around success factors
• Describe 2 challenges
• Share next steps & “take away understanding” for other organizations and systems
Purpose of *Partners in Care* Project

- **Build linkages** between informal, quasi-formal, and formal systems
- **Improve methods** of partner organizations
- **Demonstrate value** to seniors and family caregivers of a package of supportive services
- **Improve knowledge** of community services & supports
Two Areas of Focus

**Systems**
- Partners in Care organizations
- Other community services organizations & providers in the “formal” health care and long-term care system

**Persons**
- Seniors
- Family caregivers

[Image of two elderly women]
### Partner Organizations’ Roles/Activities*

<table>
<thead>
<tr>
<th>Organization</th>
<th>Role(s)/Activities</th>
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<tbody>
<tr>
<td>Normandale H&amp;W</td>
<td>Guiding (68 enrollees) Project Management, Evaluation</td>
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<tr>
<td>Our Lady of Grace</td>
<td>Guiding organization (49 enrollees)</td>
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<tr>
<td>Edina Resource Center</td>
<td>Resource Coordination support (OLG &amp; back-up)</td>
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<tr>
<td>Fairview Southdale</td>
<td>Stroke Prevention Health Ed, Screening (all enrollees)</td>
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<td>Fairview Ridges</td>
<td>Falls Prevention Ed, Screening; in-home evals (high-risk)</td>
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<td>Fairview Riverside/Southdale-</td>
<td>Health Ed, Wellness (small group at-risk, community education)</td>
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<td>Diabetes</td>
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<td>Metropolitan AAA</td>
<td>I&amp;R, Health insurance counseling &amp; Medicare Part D</td>
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<td>Hennepin County</td>
<td>LTCC consultation/Waiver eligibility, HIPAA training</td>
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<td>ElderCare Rights Alliance</td>
<td>Caregiver workshop/Advocacy support to seniors</td>
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* Original organizations also included American Red Cross and Neighborhood Partnerships; both experienced structural changes unrelated to this project
Project Components – Persons

• One year (12 months) of service to seniors and caregivers; “walking with” them on their care journey—tailored to their needs/interests
  – Health education, wellness, prevention, fitness
  – Volunteer support (care teams, one-on-one, drivers/rides)
  – Resource coordination, information & referral to local services
  – Condition/disease awareness around stroke, falls, diabetes
  – Caregiver training and support; resource information
  – Tailored personal assessment
Project Components - Systems

- Create inter-agency data sharing agreements
- Create and use common assessment tool(s) and common consent form
- Set up referral and tracking methods
- Share strategies for volunteer support (recruitment, training, monitoring)
- Implement community health/wellness programming
- Offer caregiver training
- Evaluate impact on ability to remain at home
Enrollment Process

• Contact by staff member – interested in program?
• A few people responded to notices, presentations
• Visit in person – signed informed consent, left materials
• With permission, contacted caregiver, if any
• Scheduled time for first assessment
Tools/Instruments

1) **Senior Self-Assessment** – developed through previous research on geriatric assessment tools and risk screening instruments; modified for this project and population

2) **Caregiver Self-Assessment** – developed previously by researcher for the Caregiver Assistance Registry and Enhanced Support Services project in Chicago (one of the 39 National Family Caregiver Support Program sites); modified for this project
Areas of Inquiry in
Senior Self-Assessment Tool

- Health Status & Personal Goal
- Living Arrangement
- Housing concerns
- Activities of Daily Living
- Current help—who/what
- Nutrition
- Sleep, Exercise
- Primary care provider
- Selected medical conditions
- Confidence/self-efficacy

- Health services utilization (hospital, ER, nursing facility, rehab center)
- Medications
- Falls
- Pain
- Emotional health
- Advance directives
- Spirituality
- Knowledge of community resources
Areas of Inquiry in Caregiver Self-Assessment Tool

- Demographics
- Employment status
- Caregiving role(s)
- Health status
- Primary care presence
- Type/level of assistance provided to care recipient
- Emergency contact info
- Modified caregiver burden scale (Zarit)
- Services to help cope
Administration of Senior Self-Assessment

• Does not require clinical observation or administration of instrument

• Primarily conducted in-person, in home, however a few chose to complete and mail in

• Primarily done by parish nurse (interest in cementing relationship and having baseline questions answered; health info more predominant)

• Baseline assessment took between 35-90+ minutes (some like to share many stories)
Profile of Enrolled Population

• 117 individuals (enrolled November ’05 – February ’06)
• 72% women, 28% men
• Age range of seniors: 65-94, avg. age of 81
• 17 enrollees <65 (caregivers) age range 39-60 years
• 71% “Very Good” or “Good” Health Status (Senior)
  9% Excellent, 36% Very Good, 35% Good, 17% Fair, 3% Poor
• Health compared to last year: 14% better, 66% same, 20% worse (Senior)
Profile of Enrolled Population

- 57% live alone, 41% w/spouse, 2% w/relatives
- 78% live in own home, townhome or condo; 22% in senior apartment
- 27% hospitalized in last year, 43+ admissions
- 10% no doctor visits in last 6 months, 37% had 5 or more
- 31 people reported having fallen to the ground in last year, 10 people had 3 or more falls
Profile of Population

• Characteristics:
  – Resiliency
  – Acceptance
  – Spirituality

• Changes in 9 months:
  3 deaths, several moved to assisted living, 1 permanent nursing home placement
Accomplishments to Date

- Informed consent form
- Assessments & home visits
- 117 seniors and caregivers
- Stroke Screening Workshops & clinics (3)
- Falls Prevention Workshops & clinics (2)
- In-home falls evaluation for high-risk
- Wellness and community education on key topics
- Caregiver Workshops (2)

- Newsletters (quarterly)
- Resource Toolkit
- Outreach to community Contracts, Agreements
- Networking, planning, shared learning among all partner organizations
- Inter-agency data sharing agreement
- Outline of systems measures and instruments
- Initial review of population health status & other indicies
Example: Assessment Case Stories

Q&A
Success Factors

Success Factor #1 – Champions/Common Goals

Success Factor #2 – Collaboration

Success Factor #3 – Relationship with individuals & through that, TRUST
Success Factor #1

Champions & Commitment to Common Goals

- Each organization has a person “of passion” as main contact (champion)
- Aligned goals of programs
- Commitment to seniors in the neighborhood/local area
Success Factor #2

It Does Take a Village…

Through collaboration we have been able to:

• Complement each others’ strengths
• Add capacity to what we can offer
• Bring an audience to community education, screenings, clinics, workshops (make better use of resources expended; improve outreach)
• Highlight work outside of the PIC project
Success Factor #3

You can lead a horse to water but you cannot make it drink…

• This is personal; each person/situation is different
• Work cannot be rushed
• Worth the wait

RELATIONSHIPS = TRUST
Real World Example

Food, Food, Food:

*It’s more than just nutrition…*

Convenience

Accessibility

Variety

Companionship
Challenges

We recognize our challenges, but each challenge has had a corresponding strength/benefit

• Guiding organizations are small, other partners are BIG
• Faith-based & community-based mix
• Measuring effect
Size: Smaller Guiding Organizations

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<th>Strengths</th>
<th>Challenges</th>
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<td>• We know each other (professional contacts) on a face-to-face basis</td>
<td>• We are stretched with many obligations</td>
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<td>• We can move faster and put things in motion that make sense (greater flexibility, fewer layers)</td>
<td>• We have very small staffs, and fewer hands to do the work. Loss of one person can be significant</td>
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<tr>
<td>• Strong personal relationships lead to better follow up and fewer “falling through the cracks”</td>
<td>• Limited programming or capacity to expand</td>
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<td>• We are financially vulnerable</td>
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Size: Bigger Partners

Strengths

• More available resources
• Specialized skills
• Interested in connecting with “on the ground” faith-based and community-based organizations
• Willing to donate in-kind toward community goodwill

Challenges

• More bureaucracy (“hoops”)
• Organizational constraints (e.g., HIPAA compliance)
• Role must be defined in a way that fits within current programming and service
Example: HIPAA Laws restrict access to client information

- Client confidentiality is carefully guarded
- No ability to follow up on client referrals (we can give MAAA client information, but they cannot share information with us)
- Difficult to evaluate effectiveness of larger partner organizations for PIC clients since no tracking data for PIC clients is available from organizations bound by HIPAA
Programs within Faith-based Institutions & Community Partners

- We are in the same neighborhoods
- Seniors have a high level of trust with staff (seen as extension of their church home; credibility; sense of being there for the long haul)
- We know these people by name; we have an opportunity to notice needs given multiple interactions needs (worship services & programs)

- Missions aligned, but not the same; can be competing priorities
- Staff need to recognize boundaries
- Oversight, communication and feedback critical
- The larger community partners see & respect the primary relationship—which is with the neighborhood program
Measuring Effect

Our effect is to make connections, offer relief, encourage informed decision-making, help people feel “not so alone”. . .

How do you show this on a graph?
Evaluation Approach - What to Measure?

• Changes due to project within organization (e.g., effects on outreach, service, knowledge, tracking/reporting, capacity, resources, etc.)

• Discernable effects on “clients”- seniors and caregivers

• Increase or improvement in how/way seniors and caregivers are “using the system”

• New linkages between informal, quasi-formal & formal

• Value added from participating in project/Lessons learned

• External/environmental factors impacting organization during this time
Measures of Success - Persons

- Enrolled & Served 100 seniors and family caregivers for at least 12 months?
- Increased their awareness of community services and supports?
- Increased their interest/participation in self-care, condition management?
- Decreased social isolation, caregiver burnout?
- Increased understanding of and planning for long-term care issues and planning?
Measures of Success - Organizations

• New Volunteers Recruited?

• New Awareness of each community partner organization’s services and strengths?

• New/Improved Organizational Methods or Services? For example: Database, Communication, Recording, Reporting methods, Service components, Referral methods, Client assessment, Intake methods
What It’s Meant for Edina Resource Center

PIC has had a significant impact/effect on ERC and on how we connect services to seniors and caregivers:

• We have built a larger network of community care options for our senior clients
• We listen more carefully and more fully so that we can provide very personal service
• We have “slowed” down our service
What It’s Meant for
Our Lady of Grace

• PIC has enabled OLG to hire a part time Parish Nurse
• We are able to provide in-home client assessments
• OLG staff has greater awareness of senior needs and resources, and can provide increased volunteer and other support
• We are more effective in referring seniors to community resources; able to coach and guide family caregivers.
• We can respond collaboratively to senior needs (e.g., “Senior Food Fest” and “Health Care Directives”)
• We are able to provide stronger programming for seniors through collaborative partnerships (e.g., on-site programs like Fairview Stroke and Falls Prevention workshops, screenings, and in-home follow-up)
What It’s Meant for the Normandale Center for Healing & Wholeness

• We have strengthened our relationships with community partners and with seniors/caregivers
• We’ve increased our awareness & referrals to/from local resources
• We are tangible to seniors in ways not realized before (through increased programming, home visits, visibility in community, and tailored resources)
• Home visits by parish nurse add a new dimension and value to the overall support—bring back to the team, offer baseline understanding that is more formal and documented
• We have been able to add/pay for additional staff hours
• We have also added to workloads and administrative time (communication with 9 different organizations, keeping track); hard to be the lead, but can be done with the right partners!

Partners in Care
Policy & Practice Implications

• This collaborative approach depends on internal champions with top administrative support in each organization... How to identify “ready organizations” and maintain commitment?

• Value in tying small to big organizations (each offers value to the senior/caregiver). . .How to manage organizational differences?
Policy & Practice Implications

• As the senior population increases, the demand for PIC-like programs will increase, but the capacity to respond is constrained... How to create infrastructure that is sustainable and offers consistent service?

• Word-of-mouth referrals increase the client load to those not within the faith community... How to ensure follow up?
Policy & Practice Implications

• Encouraging other area faith-based communities to develop PIC-like programs helps stabilize the influx of potential clients (clients would prefer to stay within their own faith community for care and service). Who/How to replicate and sustain?

• Needs of current client base tend to increase over time as senior ages… How to increase volunteer support? (volunteers are aging too)
“Systems” Impact

- Communication
- Outreach to seniors/caregivers
- Linkages with other organizations
- Methods for service provision & measurement
- Advocacy to promote advance LTC planning
“Persons” Impact

Better connections

More awareness

Increased ability/willingness to call, & follow-up
“Walking With”

• Being present to what’s happening in their lives
• Knowing them by name
• Allowing trust and relationship to develop
• Taking some of the mystery or fear out of everything they are facing
• Witnessing their power and strength

From: “Old is Not a Four Letter Word”
More Info

- Web site – download pdf and other documents from the Healing & Wholeness web site, under the *Partners in Care* tab (including entire Resource Toolkit)

  [http://healing.normluth.org](http://healing.normluth.org)

- As we have findings and reports, we will add to the site