Public Housing Authority, to Create On-Site Interdisciplinary Primary Care Clinic for Older Adults

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Background

- Approximately 2 million Americans are considered highly vulnerable due to multiple chronic illnesses, advanced age, and homebound status.[1]
- Top five chronic conditions include hypertension, hyperlipidemia, heart disease, arthritis, and diabetes. [2]
- Underprivileged adults are five times more likely to experience these chronic conditions and to report being in fair to poor health. [3]

Partnership

A Doctor of Nursing Practice Nurse Practitioner (DNP-NP) academic program created an innovative partnership with local Urban Housing Authorities (UHA). This partnership will provide on-site primary care to seniors living in urban low-income housing communities. The care team will be led by DNP-NPs and include therapists, pharmacists, and dieticians.

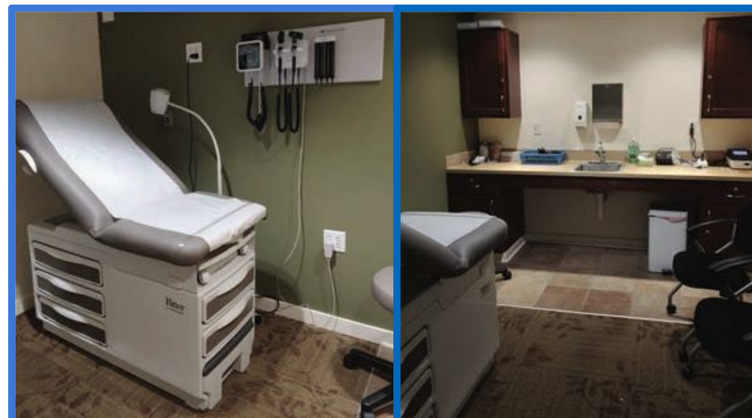
Settings & Methods

<u>Settings</u>: On-site clinic services and health educational classes will be offered to 400 residents at two urban low-income housing communities where residents are age 55 and older and have an average annual income of $12,000-14,000.

<u>Methods</u>: New patient visits will include an assessment of health characteristics and patient health care needs. Data will be collected from electronic medical records then de-identified and analyzed. This data will guide the formation of strategic interventions and targeted resources.

Purpose

This 2-year project includes 4 phases. Phase 1 completed the creation of the clinical site infrastructures and practice processes. The purpose of Phase 2 is to establish clientele and initiate the evaluation of health care characteristics. The data collected will determine the interventions and resources needed to promote health within this patient population. Phase 3-4 will include further development and analysis of these interventions.



Newly constructed clinic exam room located within urban low-income housing community.

Measurable Outcomes

Descriptive study findings of this patient population will include:

- Health literacy
- Healthcare utilization
- Smoking/ ETOH
- State reported opioid/ sedation scale
- USPSTF screening rates
- Fall risk
- Up/ Go test
- Katz ADL scale
- Anxiety/ depression (GAD7, PHQ9)
- MoCA Cognitive test
- Blood pressure
- Variety of biomarkers
- Medication Reconciliation

Nursing Implications

The information from this project will allow DNP-NPs to have a greater understanding of the mental, physical, and functional health needs of this patient population. DNP-NPs will then be able to influence reallocation of healthcare resources, public-policy change, and targeted interventions needed to decrease emergency room visits and hospitalizations, and delay nursing home placements in this most vulnerable patient population.

Funding

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1. Katherine Ornstein et al. “Epidemiology of the Homebound Population in the United States.” *JAMA Internal Medicine* 175, no. 7 (July 1, 2015): 1180. https://doi.org/10.1001/jamainternmed.2015.1849.
2. “Medicare - CCW Condition Period Prevalence, 2016.” *Chronic Conditions Data Warehouse (CCW)* online, last modified October 11, 2018. https://www.ccwdata.org/web/guest/medicare-charts/medicare-chronic-condition-charts.
3. Steven H. Woolf, et al. “How are income and wealth linked to health and longevity?” *Urban Institute and Virginia Commonwealth University*, (2015): 1-21. https://societyhealth.vcu.edu/work/the-projects/the-health-of-the-states.html.