

*“Role of the DNP Leading the Healthy Meal Program:
Addressing Food Insecurity in Communities of Color”*

*11th National Doctors of Nursing Practice Conference
Thursday, September 27, 2018
Breakout Session from 10-11 am
Westin Resort Mission Hills - Rancho Mirage, CA*

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Objectives for the Session

- Describe the role of the clinical doctorate (DNP) as term faculty in the Richmond Health & Wellness Program clinics – based in low income housing units for older adults in Richmond, VA
- Describe the mission and vision of the Institute of Inclusion, Inquiry and Innovation (iCubed) at Virginia Commonwealth University
- Give an overview of the Richmond Health & Wellness Program (RHWP)
 - Core components, staff and community outreach efforts
 - Inter-professional team members from various disciplines: undergraduate and graduate
- Describe the role of the DNP in community-engaged participatory research
- Describe the leadership role of the DNP in addressing food insecurity with the launch of the “Healthy Meals Program.”
 - Describe preparing undergraduate health science students, nursing and DNP students to serve in role of research assistants
 - Describe recruitment efforts and beginning analysis of data from enrolled subjects
- Next steps following analysis of data from Patient Activation Measure Tool®



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**Ethlyn McQueen-Gibson, DNP(c), MSN,
RN, BC**

Clinical assistant professor, Department
of Family & Community Health Nursing,
School of Nursing

She brings over 30 years of clinical
expertise in the area of geriatric care.
Her doctorate studies focused on
developing community-based
interventions for custodial African-
American grandmothers caring for their
grandchildren. Her role with the Core
will focus on program development and
implementation through clinical service
and effective collaboration with
community partners.

The Richmond Health and Wellness Program is a community-based, care coordination program focused on improving the health of indigent, older adults. The program includes faculty and students from the Schools of Medicine, Nursing, Pharmacy, and Social Work and the Department of Psychology. These individuals conduct weekly clinics in indigent housing settings across the metro Richmond area. At the clinics, residents of these settings meet with the team of providers to discuss any unmet health needs. The team then works to overcome any barriers to health with the patient and improve well-being.

The program was originally supported by a community engagement grant from the Center for Community Engagement. Based on the pilot data from this funding, the team received a three-year, 1.5 million dollar HRSA grant to support expanded interprofessional practice and education in these settings.

The program has become a national model for community-based interprofessional practice and education. Outcomes have been presented in several national venues and faculty have consulted with several external universities and organization about adopting similar models. The program has promised to meet the triple aim of improving health outcomes, decreasing healthcare costs, and enhancing the patient experience with the healthcare system.



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Welcome New iCubed Faculty,
Postdoctoral Fellows and Visiting Scholars



Aderonke Akinkugbe
M.P.H., Ph.D.



Ceceilia Valrie
Ph.D.



Chelsea Derlan
Ph.D.



Elvin Price
Pharm.D., Ph.D.



Ethlyn McQueen-Gibson
DNP(c), MSN, RN-BC



Faika Zanjani
Ph.D.



Jan Ivery
Ph.D.



Khalilah Johnson
Ph.D., OTR/L



Kripali Patel
Pharm.D.



Kristina Hood
Ph.D.



Meghan Abadoo
M.E.A.



Morgan Maxwell
Ph.D.



Onaje Woodbine
Ph.D.



Oswaldo Moreno
Ph.D.



Paul Rucker



Risha Berry
Ph.D.



Sarah Raskin
M.P.H., Ph.D.



iCubed Commonwealth Scholars Program
Congratulations Spring 2018 recipients!



Justice Boyd, '19
Health, Physical Education,
Exercise Science
Culture, Race and Health Core



LaMyka Brown-Jordan, '20
Business Management
*Oral Health in Childhood
and Adolescence Core*



Kristy Ferrafino, '19
International Studies
*Oral Health in Childhood
and Adolescence Core*



La-Kiesha Hobbs, '18
Psychology
Culture, Race and Health Core



Hailey Jenkins, '18
Psychology
*Health and Wellness
in Aging Populations Core*



Jazmin Macias, '19
Health Science
*Health and Wellness
in Aging Populations Core*



Jasmine Temple, '19
Applied Psychology
Culture, Race and Health Core



Jerry Van Harris, '18
Social Work
*Health and Wellness
in Aging Populations Core*



Nazirah Vines, '19
Psychology
*Health and Wellness
in Aging Populations Core*

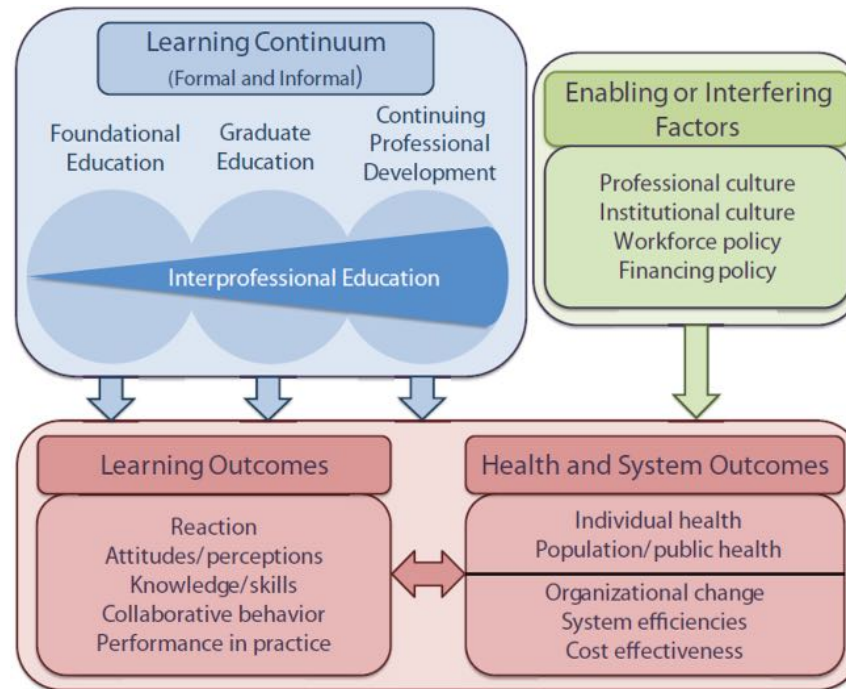


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State of the Science: Interprofessional Approaches to Caring for Older Adults



State of the Science: Interprofessional Approaches to Aging, Dementia, and Mental Health, Volume: 66, Issue: S1, Pages: S40-S47,
First published: 16 April 2018, DOI: (10.1111/jgs.15309)



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Figure 1. CDC Framework for Program Evaluation in Public Health (Fawcett, Sterling, Harris, et. al, 1995)



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*RHWP Interprofessional Teams:
Faculty & Resident Council Members*



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RHWP

Richmond Health & Wellness Program
Promoting Healthy Living at Home



The Richmond Health & Wellness Program (RHWP):
Coordinating Care for Community-Dwelling Older Adults through
Student-led Inter-professional Collaborative Practice (IPCP) Teams

RHWP Video Clip



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RHWP Model & Funding



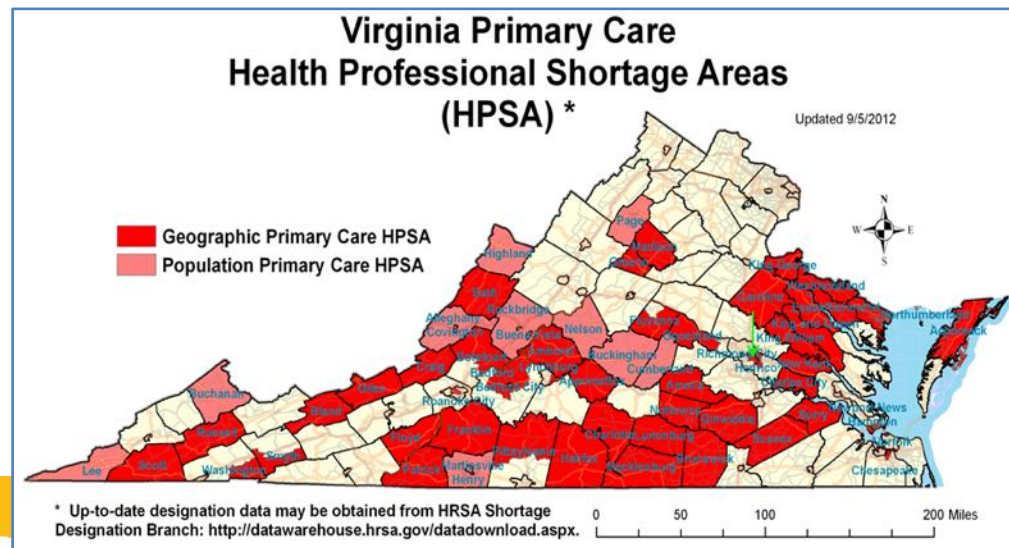
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RHWP

Identified Community Need

- ▶ Health Professional Shortage Areas (HPSA)
 - Of 930,000 elderly residents in Virginia, approximately 50% live in federally designated HPSAs



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Joint Commission on Health Care, 2009

RHWP

Identified Community Need

► Healthcare Hotspots

- Population clusters with a high burden of chronic illness that can benefit from targeted care delivery interventions



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Gawande. The Hot Spotters. The New Yorker. 2011

RHWP

Inter-professional Collaborative Practice (IPCP) Teams



How can they work together
if they don't learn together?



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Canadian Interprofessional Health Collaborative

RHWP

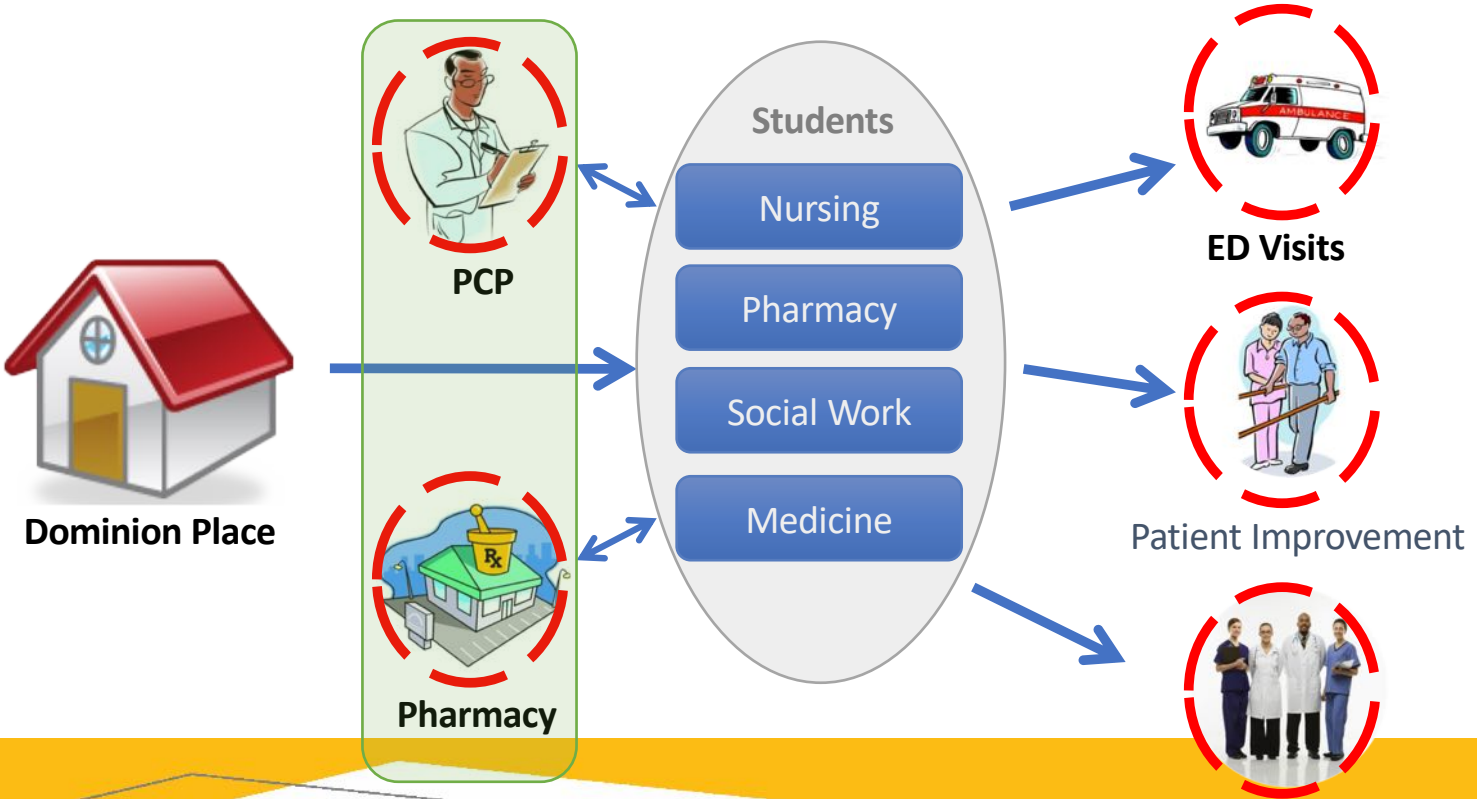
Funding

- **VCU Division of Community Engagement**
 - Community Health and Wellness Program for Older Adults
 - Brief intervention focused on diabetes and hypertension
 - Motivational Interviewing component
 - Timeline: May 2012
- **Health Resources and Services Administration (HRSA)**
 - The Nurse Education, Practice, Quality and Retention (NEPQR)
 - IPE focused grant to refine and replicate the RHWP
 - July 2013 – \$1.5 million over 3 years



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Year 1 - 2013



Community Partners



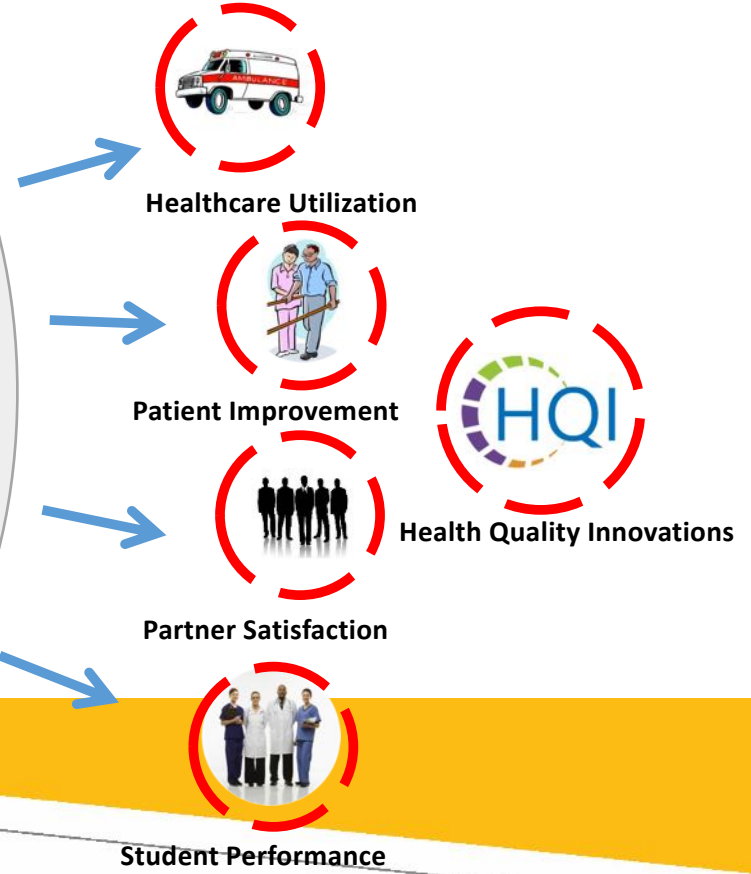
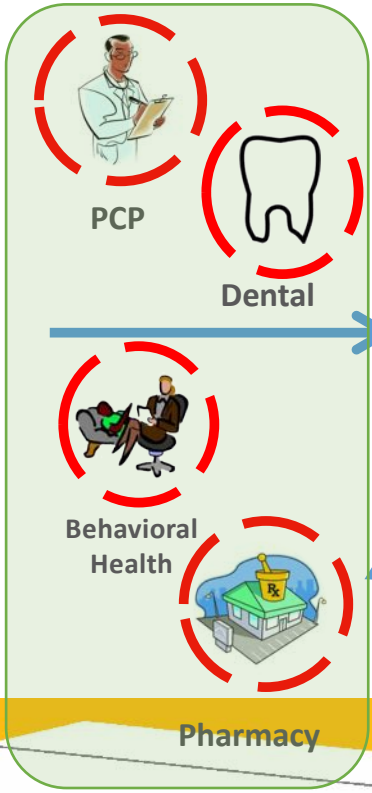
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Year 5 - 2018



-  Dominion Place
-  Randolph Place
-  Highland Park
-  Fay Towers



Health Quality Innovations



VCU Partners

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Richmond Health & Wellness Program (RHWP) Clinic Sites

RHWP operates an onsite wellness clinic in five low-income housing buildings for older adults with activities geared toward improving wellness, quality of life and addressing underlying social determinants of health.



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Randolph Place
(Better Housing Coalition)



Highland Park
(CPDC)



Church Hill House
(Winn Properties)



Dominion Place
(Beacon Communities)



4th Avenue
(RRHA)

Clinic Sites

Serving >700 residents between five buildings



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RHWP

What services do we offer?

- Wellness Checks
- Geriatric Assessment
- Care Coordination
- Referral Coordination
- Medication Management
- Patient Education
- Home Visits
- Behavioral Health Counseling
- *Social Determinants: food insecurity, social isolation, transportation, etc.*
- Advanced Care Planning



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All Sites

Background

- Patient Population:

- Residents are majority African-American
- Age \geq 55 years
- Average length of stay between 10-15 years
- Many dual eligible patients

- Our Concern:

- Aging in place with high chronic disease burden
 - Average # of chronic conditions = 5 (pilot data)
- Medication management
 - Average # of medications taken per day = 9 (pilot data)
- E.R. rates



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Clinic Flow



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Pre-visit Roles

Clinic Coordinator & Triage Nurse

- Schedule
 - Clinic coordinator, checks each patient in at the check-in desk
 - Visits are scheduled, walk-ins are accepted
 - Clinic coordinator brings chart to student team for review while triage student performs brief assessment of resident
- Triage
 - Performs brief assessment of resident
 - Debrief between triage nurse and student team after brief assessment and interview of resident
 - Nurse Triage Algorithm located on Blackboard under “Course Documents”



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The Visit

Interprofessional Team Based

- Every visit
 - Patient-driven discussion about health care needs
 - Vitals
 - Focused physical assessment
 - Update medication list
 - SOAP note- written by everyone on the team
- Residents might come for:
 - Medication help
 - Questions about health care related paperwork
 - BP check
 - Glucose check
 - Acute visit
 - Education
 - Care coordination



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Post-Visit

Debriefing

- What do we mean by debriefing?
- **Part 1:** Before resident leaves, student will find faculty member to present brief overview of visit and/or any problems or abnormalities discovered.
 - Report any abnormal vitals or to faculty before patient has left
 - Patient then checks out with clinic coordinator and is given a follow-up appointment
- **Part 2:** After resident has left, faculty member can then debrief with the student team about any educational pieces
 - Finish up charting
 - *Everyone* signs SOAP note



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Behavioral Health Clinic (BHC)

- Evidence-based psychoeducational intervention (e.g. depression, anxiety, grief, smoking cessation, insomnia, chronic pain)
- Residents who qualify for evaluation may be referred to the BHC during Wellness Clinic, discuss with faculty during de-briefing



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“The Healthy Meal Program”

Community-Engaged Participatory Research



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Abstract

1. The Healthy Meals Program builds on an earlier pilot program which delivered 1,682 meals to 339 residents at the three low income housing facilities for seniors over the age of fifty-five.
2. Outcome measures for the earlier pilot included referrals to food assistance programs, social isolation, changes in dietary intake, and satisfaction.
3. Data will be collected related to depression, social isolation, patient activation and readiness for behavior change.
4. RHWP plans to assess individuals level of readiness to engage with setting a nutrition related goal and develop interventions residents based upon their Patient Activation Measure© PAM score.



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Funding & Partners

1. Phase I of the Healthy Meals program was launched in 2016, through funding provided by United Healthcare. Phase 2 is funded by The Jenkins Foundation.
2. The Jenkins Foundation, located in Richmond, VA is focused on equitable access to health care services, and programs that help reduce risky behaviors. T
3. Grant funding amount is \$30,000 for activities between October 1, 2017 - September 1, 2018.
4. Partners for the “Healthy Meals Program”
 - a) includes Virginia Commonwealth University, FeedMore (local comprehensive hunger program), and housing partners Beacon Communities, Richmond Housing Authority and Community Preservation & Development Corporation.

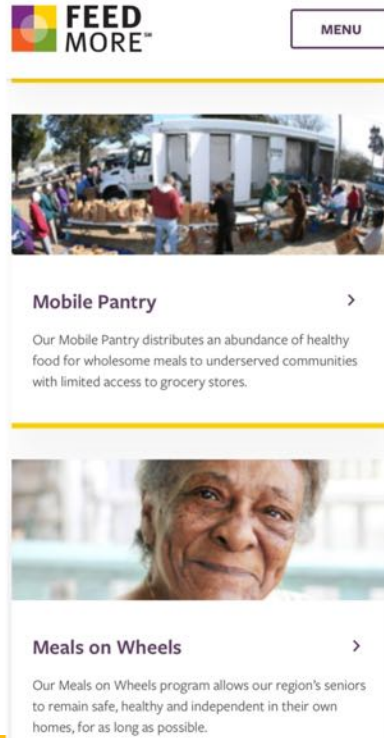


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Hypothesis

- ✓ We can begin to address ways to improve outcomes related to nutrition and health for vulnerable older adults by setting behavioral goals.
- ✓ These goals are related to nutrition and wellness, and connect individuals at risk for food insecurity to food service programs



FEED MORE™ MENU

Mobile Pantry

Our Mobile Pantry distributes an abundance of healthy food for wholesome meals to underserved communities with limited access to grocery stores.

Meals on Wheels

Our Meals on Wheels program allows our region's seniors to remain safe, healthy and independent in their own homes, for as long as possible.



Commodity Supplemental Food Program (CSFP)

CSFP supports the nutritional needs of low-income seniors by providing food to supplement their diet, while helping stretch their food dollars.

The Emergency Food Assistance Program (TEFAP)

The Emergency Assistance Food Program was created to help low-income individuals and families who are facing an emergency food shortage.



Key Variables

1. RHWP has tracked the following outcome measures for the first three years of delivery of services in the housing units:
 - a) numbers of residents receiving clinical services, care coordination activities,
 - b) evaluation of health service utilization, healthy meals participation, and student learning.
2. Variables for this current research project will include:
 - a) measure of depression, social isolation, quality of life and resident's engagement in setting behavioral change goals.



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Data Collection/Screening Tools



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Screening Tools

Assessments

- Cognitive impairment - Mini Cognitive Exam (pre-consent)
- Luben Social Connectedness Scale
- Frail Scale
- Get Up and Go – gait speed testing
- Geriatric Depression Screening-15 (GDS-15)
- Short Form Health Survey (SF-12)
- Patient Activation Measure 10
- CDC My Plate for Seniors – Tufts University



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The Patient Activation Measure® (PAM®)

- **The Patient Activation Measure® (PAM®) anchors our health activation model and suite of resources to:**
 - Strengthen risk-identification and improve predictive modeling
 - Personalize support to improve patient self-management behaviors
 - Improve patient outcomes and elevate patient satisfaction
- **Two decades of patient activation research and applied science anchor our proven solutions to improve self-management, reduce unnecessary utilization and achieve better health outcomes.**



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The Patient Activation Measure® - Literature Review



Journal homepage: www.elsevier.com/locate/pateduccon

Patient activation and the use of information to support informed health decisions

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ARTICLE INFO

Article history:
Received 1 July 2011
Accepted 7 July 2011

Keywords:
Patient engagement
Patient activation
Understanding clinical evidence

ABSTRACT

Objective: Patients and consumers make many choices that affect their health and their health care. Some of these decisions are informed by evidence, but many are not. A growing body of research indicates that those who are more activated or engaged in their health are more likely to seek out and use information to inform their health decisions. In this paper we review the evidence about patient activation and information seeking, health behaviors, and health outcomes. We also review what is known about how to increase patient activation, and how best to support patients who are at different levels of activation to use information to support their choices.

Discussion: Strategies can be tailored to support and inform patients at different levels of activation. These strategies might be implemented in different clinical settings and include tailored activation, these strategies might be implemented in different clinical settings and include tailored activation, and targeted approaches for care transitions, health coaching, and in the use of shared-decision-making. Conclusions: Efforts to support informed consumer choices have largely been a 'one size fits all' approach. Understanding consumers, and trying to meet them where they are, is likely to be the focus of the 'next generation' of interventions to support informed consumer choices.

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1. Introduction

Current health care policies aimed at improving health outcomes and constraining costs rely to a significant extent on the consumer's ability to make informed choices. Increasingly, the consumer has in shaping not only individual health but also the efficacy of the health care system itself. When consumers are active participants in their own care, use evidence to inform their choices, and when they understand and demand high quality clinical care, they can be potent agents for change. Encouraging consumers to use evidence when they make clinical choices and comparing the quality of performance data on providers, health plans, nursing homes, and hospitals are all part of this effort. Such comparative information is increasingly available. Recommended clinical guidelines for treating many conditions are also available to patients. To a degree never before possible, consumers are in a position to reduce the 'knowledge gap' between themselves and providers and, in the process, increase control over their health care experiences and health outcomes.

Yet consumers often do not access these resources or use them when making important health decisions. There are many reasons

for this, including awareness of these resources, the complexity of the information and/or the way it is presented. There is a growing body of research which indicates that making it easier to understand and use complex and unfamiliar information resources will increase their usage, even among consumers with more limited literacy and numeracy skills [1-3]. While many individual factors play into whether people seek out and use information, of particular interest are factors which are potentially mutable, such as patient activation.

1.1. Patient activation and health-related outcomes

Patient activation is defined as having the knowledge, skill, and confidence to manage one's health and healthcare [2]. It is most commonly measured using the Patient Activation Measure (PAM), a 13-item scale that has strong psychometric properties [2]. The PAM scale measures a latent construct: likely reflecting an individual's overall self-concept as a manager of his or her own health. A growing body of research that quantifies patient activation indicates that it is a significant predictor of more health behavior, many clinical indicators, and some costly service utilization such as emergency department use and hospitalizations [4-6]. Altogether, the PAM score indicates how well an individual understands the importance of his or her active role in the care process and how competent they feel in taking on that role.

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<http://dx.doi.org/10.1016/j.pec.2011.07.006>
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EVIDENCE & POTENTIAL

By Judith H. Hibbard and Jessica Greene

What The Evidence Shows About Patient Activation: Better Health Outcomes And Care Experiences; Fewer Data On Costs

ABSTRACT Patient engagement is an increasingly important component of strategies to reform health care. In this article we review the available evidence of the contribution that patient activation—the skills and confidence that equip patients to become actively engaged in their health care—makes to health outcomes, costs, and patient experience. There is a growing body of evidence showing that patients who are more activated have better health outcomes and care experiences, but there is limited evidence to date about the impact on costs. Emerging evidence indicates that interventions that tailor support to the individual's level of activation, and that build skills and confidence, are effective in increasing patient activation. Furthermore, patients who start at the lowest activation levels tend to increase the most. We conclude that policies and interventions aimed at strengthening patients' role in managing their health care can contribute to improved outcomes and that patient activation can—and should—be measured as an intermediate outcome of care that is linked to improved outcomes.

DOI: 10.1016/j.pec.2012.08.001
HEALTH AFFAIRS, Vol. 31, No. 2 (2012), pp. 267-274
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Jessica Greene is a professor and director of research at the George Washington University School of Nursing, in Washington, D.C.

The Affordable Care Act recognizes that engaging patients in their own care is a cornerstone of successful health system reform and is critical to the success of accountable care organizations and patient-centered medical homes. A growing body of evidence links patients' activation levels to their health and cost outcomes. In this article we review evidence of the contribution that patient activation makes to health outcomes, costs, and patients' experiences of care.

The terms *patient engagement* and *patient activation* are often used interchangeably. The terms are also frequently used to convey different meanings or are poorly defined. *Patient activation* emphasizes patients' willingness and ability to take independent actions to manage their health and care. We use the definition developed by an author of this article, Judith Hibbard, and colleagues. This definition equates patient activation with understanding one's role in the care process and having the knowledge, skill, and confidence to manage one's health and health care. Activation differs from compliance, in which the emphasis is on getting patients to follow medical advice.

We use patient engagement to denote a broader concept that includes activation; the interventions designed to increase activation; and patients' resulting behavior, such as obtaining preventive care or engaging in regular physical exercise. The focus on activation and engagement rather than compliance recognizes that patients manage their health on their own the vast majority of the time, making decisions daily that affect their health and costs.

The evidence linking patient activation with health outcomes, patient experience, and costs has grown substantially over the past decade. Besides reviewing the strength of that evidence, we identify important research gaps and address

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FEBRUARY 2013 • 31(2) HEALTH AFFAIRS 267
by Rachel McCartney



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Developing Plan for Coaching for Nutrition Counseling Levels of Activation(PAM®)



Name	
ID	
Date	

Below are statements people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally.

Circle the answer that is most true for you today. If the statement does not apply, select N/A.

1.	When all is said and done, I am the person who is responsible for taking care of my health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
2.	Taking an active role in my own health care is the most important thing that affects my health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
3.	I know what each of my prescribed medications do.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
4.	I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
5.	I am confident that I can tell a doctor concerns I have even when he or she does not ask.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
6.	I am confident that I can follow through on medical treatments I may need to do at home.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
7.	I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
8.	I know how to prevent problems with my health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
9.	I am confident I can figure out solutions when new problems arise with my health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
10.	I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A

Focus on the individual, not the condition.

PAM provides an objective, systematic way to assess patient capabilities for self-management, allowing disease management programs to ditch the one-size-fits-all approach to address behavioral deficits.

Personalize care plans to activation level.

Patients bring differing levels of knowledge, skill and confidence to the task of managing their health. PAM-based coaching support addresses the underlying competencies that drive poor self-management.

Tailored support doesn't mean expensive support.

As individuals become more activated, self-care best practices and evidence-based guidelines are pursued.

****Note** I Will Bring Additional Slides with This Data**

1. Subject Recruitment – 250
 - a. DNP engagement with residents at all five sites during clinic visits
 - b. Members of Resident Council from each senior apartment building
2. Data Collection – ongoing at all five senior housing complexes
 - a. Data entry started by undergraduate student serving as Commonwealth Scholar through Institute of Inclusion, Inquiry & Innovation
 - b. Utilization of RedCap data base for entry of data
3. Analysis of the Data – IBM SPSS
4. Development of Individualized Plans of Care – based on PAM[®]
 - a. Activation Levels I, II, III, IV
 - b. REVIEW OF HANDOUT ON “WHAT THE PATIENT ACTIVATION MEASURE[®] REVEALS?”



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Closing Statements & Questions . . .



Age in place transforming
Transforming health care for older adults

The Richmond Health and Wellness Program, led by Pam Parsons, director of practice and community engagement in the School of Nursing, is a community-based care coordination initiative to improve the health of older adults in the city of Richmond and help them remain independent in their home settings. The program has also become an interprofessional training ground for future teams of nurses, physicians, pharmacists, occupational therapists, counselors and social workers.

Students get to see residents — more than 446 adults are now enrolled — within their home settings, while also having the opportunity to collaborate with licensed clinical faculty. Through a weekly on-site clinic, these teams work with residents to address their chronic health conditions, as well as offer health promotion, medication management and care coordination needs.

Over the past three years, RHWP enrollees have been more medically complex than their peers who live in the same buildings and did not enroll. Adjusted for this complexity, enrollees have had lower rates of emergency department visits and hospital admissions. Both of these benefits are indeed statistically significant for the program — and the residents.

RHWP began in 2012 with Dominion Place as its flagship site in Richmond. The program is continuously evolving as community needs are identified, adding a healthy meal program in 2018 to address food insecurity. RHWP now holds clinics in four other senior apartment buildings around the city, thanks to a growing number of partnerships, including support from the U.S. Department of Health and Human Services and several community organizations. The program is making plans to expand to another site in Richmond's East End.

12 Virginia Commonwealth University EXTRAORDINARY



450
The program has grown from 40 residents in one location to nearly 450 residents among five sites throughout Richmond.

The Richmond Health and Wellness Program delivers on-site care to residents at Dominion Place.

VCU's 2016-17 Annual Report 13



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