# *"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*

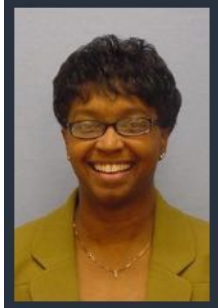
*Dr. Ethlyn McQueen-Gibson, DNP, MSN, RN-BC*
*Virginia Commonwealth University – School of Nursing*
*Clinical Assistant Professor – Department of Family & Community Health*
*The Institute for Inclusion, Inquiry & Innovation*
*Office of the Provost and Academic Affairs*

*Email: emcqueengibso@vcu.edu*

VCU **Institute for Inclusion, Inquiry and Innovation**

# 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®



**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.

## Welcome New iCubed Faculty, Postdoctoral Fellows and Visiting Scholars


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


Cecelia 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.F.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.

VCU Institute for Inclusion, Inquiry and Innovation

## 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 Ferrufino, '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*

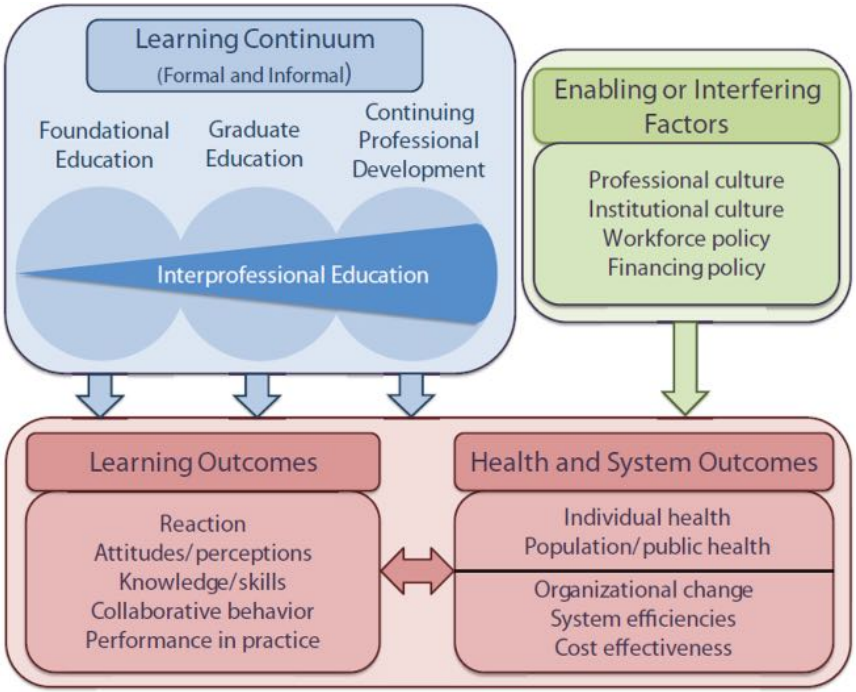

**Jasmine Temple, '19**
Applied Psychology
*Culture, Race and Health Core*


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


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

VCU Institute for Inclusion, Inquiry and Innovation

***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)**


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

# *RHWP Interprofessional Teams: Faculty & Resident Council Members*

RHWP

Richmond Health & Wellness Program

*Promoting Healthy Living at Home*

VCU

VIRGINIA COMMONWEALTH UNIVERSITY

# The Richmond Health & Wellness Program (RHWP):

## Coordinating Care for Community-Dwelling Older Adults through Student-led Inter-professional Collaborative Practice (IPCP) Teams

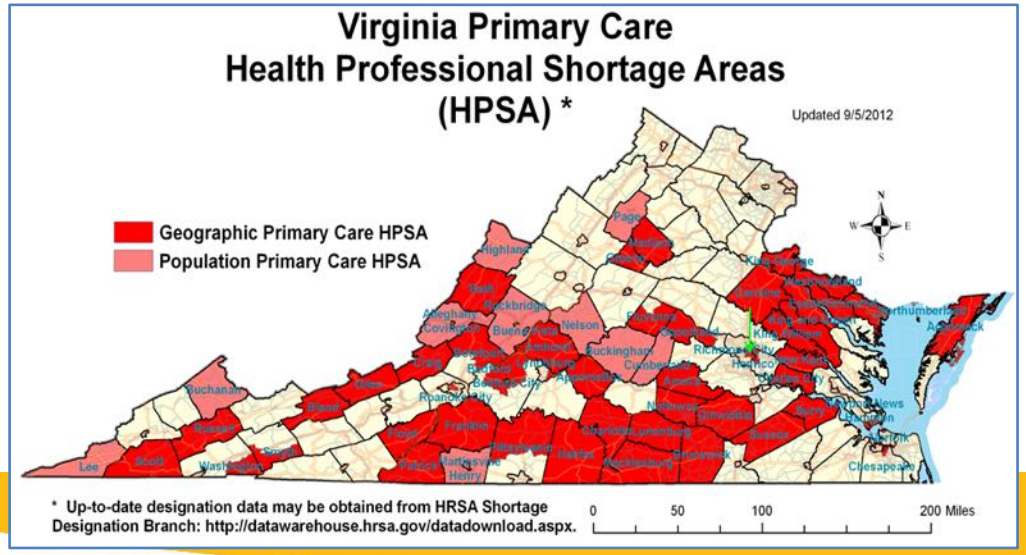
# RHWP Video Clip

# RHWP Model & Funding

# RHWP

## Identified Community Need

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

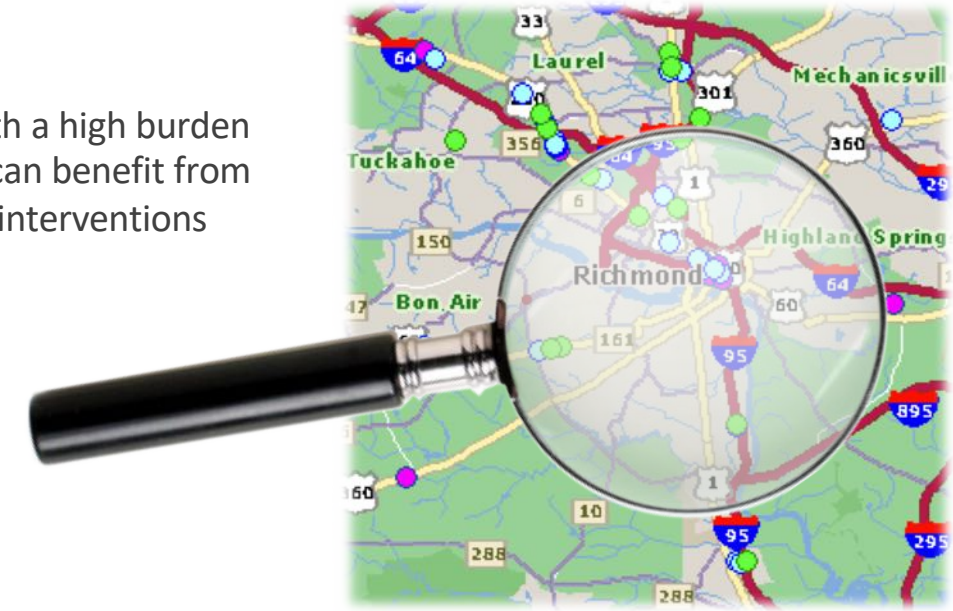



*Joint Commission on Health Care, 2009*

# RHWP

## Identified Community Need

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




*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?

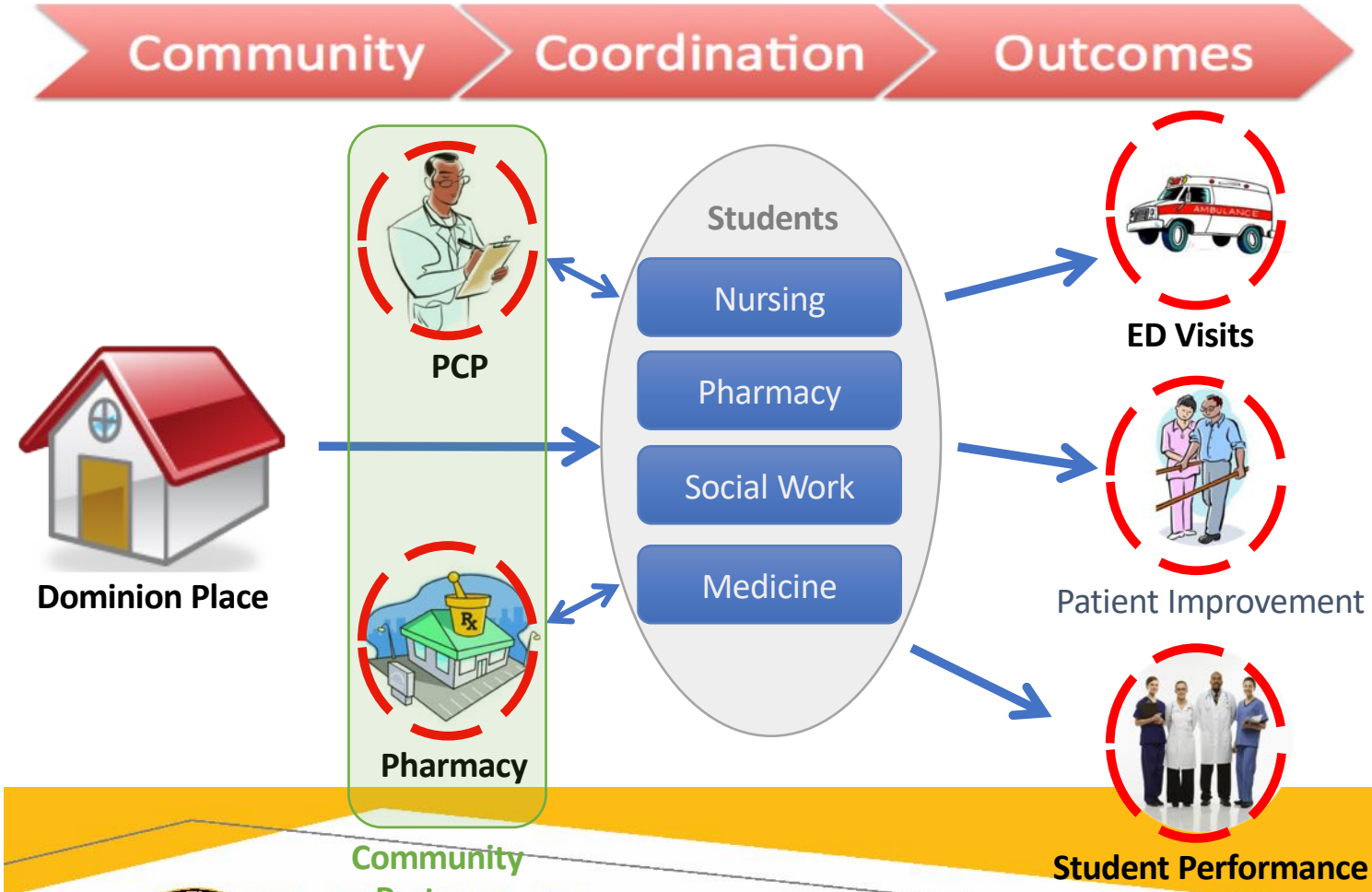
# RHWP

## 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

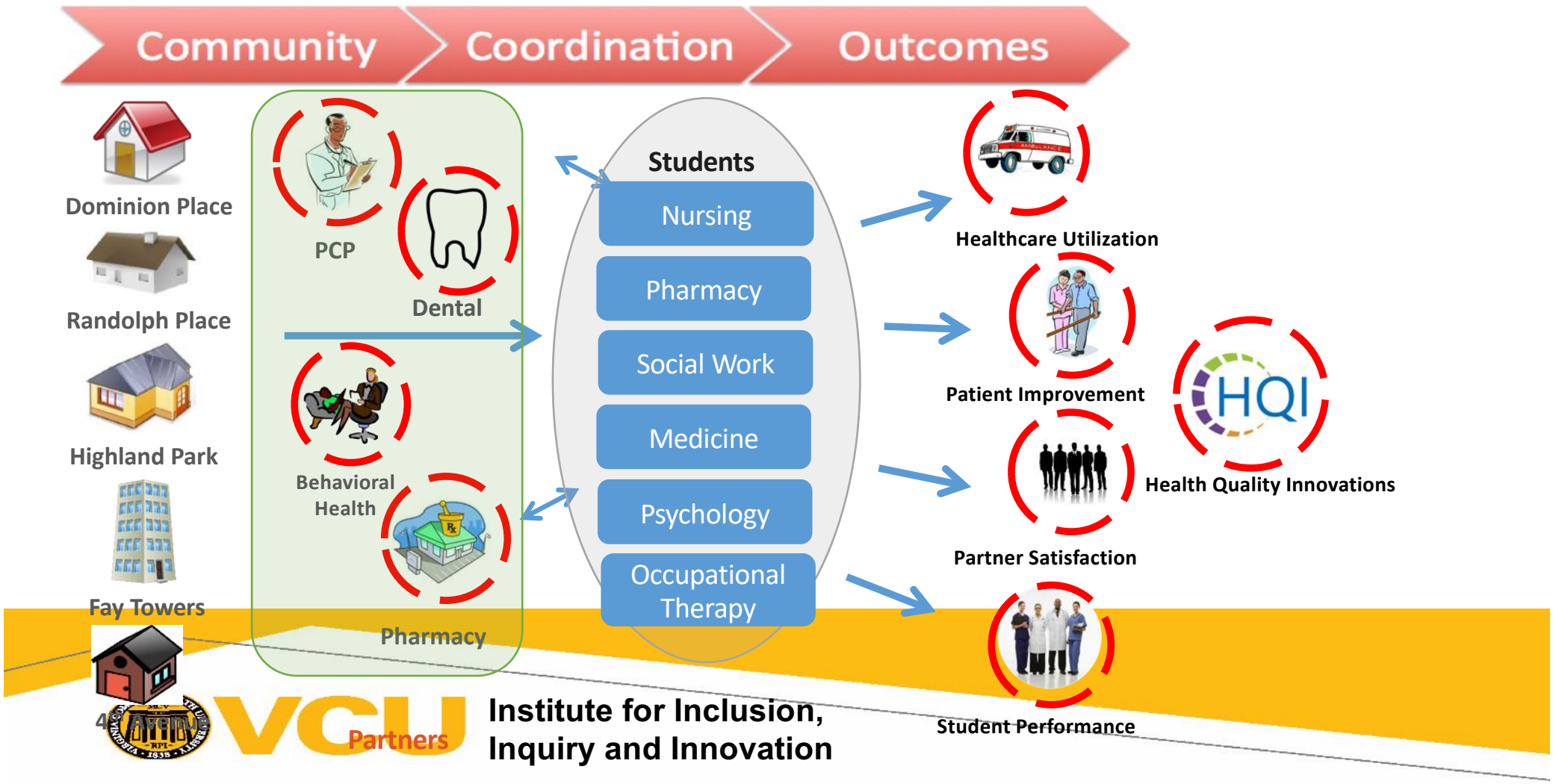
- **Health Resources and Services Administration (HRSA)**
  - ➢ The Nurse Education, Practice, Quality and Retention (NEPQR)
  - ➢ IPE focused grant to refine and replicate the RHWP
  - ➢ July 2013 – $1.5 million over 3 years

## Year 1 - 2013




Institute for Inclusion, Inquiry and Innovation

## Year 5 - 2018






Partners

**Institute for Inclusion, Inquiry and Innovation**

# 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.***

# Clinic Sites

Serving >700 residents between five buildings

**Randolph Place**
(Better Housing Coalition)

**Highland Park**
(CPDC)

**Church Hill House**
(Winn Properties)

**Dominion Place**
(Beacon Communities)

**4th Avenue**
(RRHA)

# 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

# All Sites

## Background

- Patient Population:
  - Residents are majority African-American
  - Age ≥ 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

# Clinic Flow

# 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”

# 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

# 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

# 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

# “The Healthy Meal Program”

## Community-Engaged Participatory Research

VCU Institute for Inclusion, Inquiry and Innovation

# Abstract

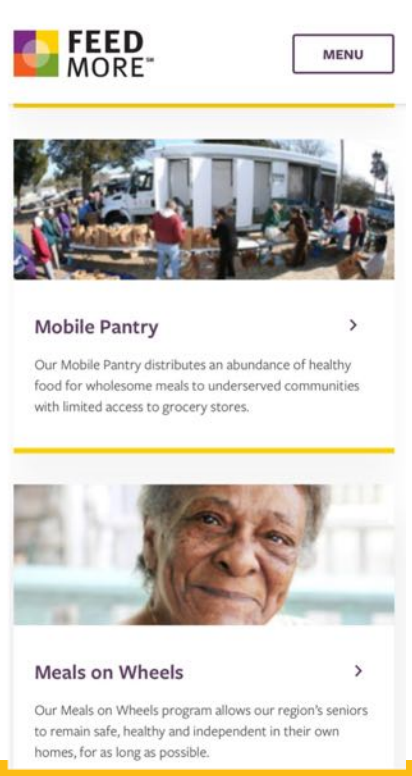

1. The Healthy Meals Program builds on an earlier pilot program which delivered 1,682 meals to 339 residents at the three low income housing facilities for seniors over the age of fifty-five.
2. Outcome measures for the earlier pilot included referrals to food assistance programs, social isolation, changes 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.

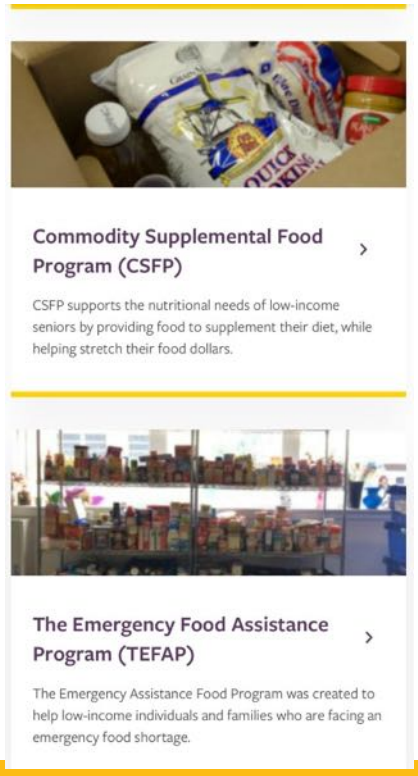
# Funding & Partners

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.

# 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



# 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.

# Data Collection/Screening Tools

# Screening Tools

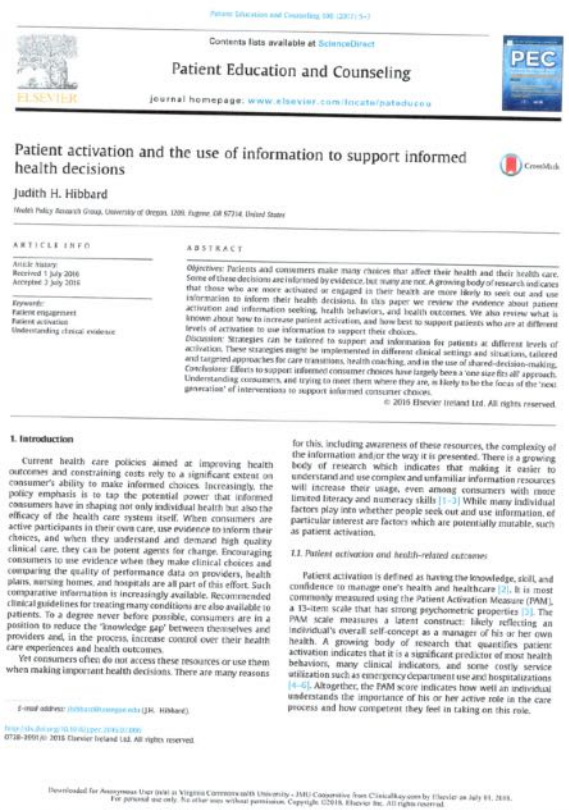
## Assessments

- 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

# 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.**

# The Patient Activation Measure® - Literature Review



Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

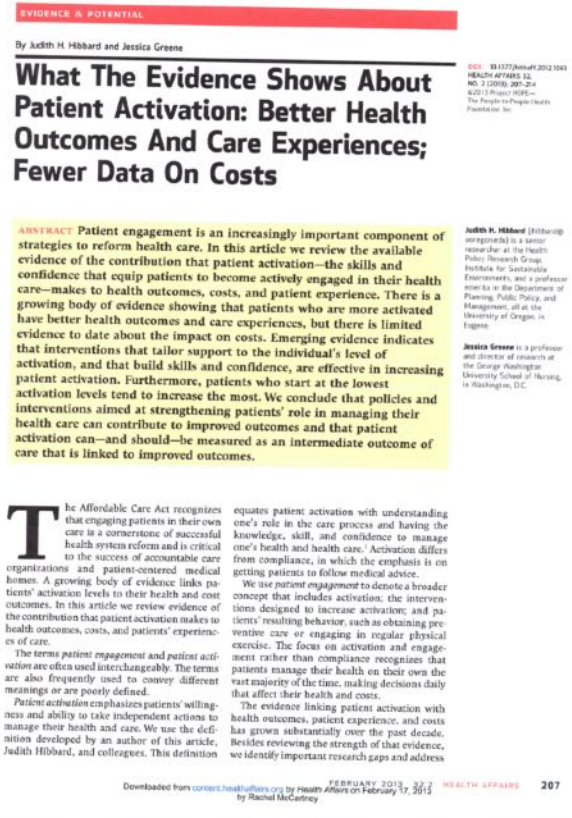
Patient activation and the use of information to support informed health decisions

Judith H. Hibbard

ARTICLE INFO

ABSTRACT

1. Introduction



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.

Judith H. Hibbard (hibbard@uoregon.edu) is a senior researcher at the Health Policy Research Group, Institute for Sustainable Environment, and a professor emerita in the Department of Planning, Public Policy, and Management, all at the University of Oregon, in Eugene.

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.

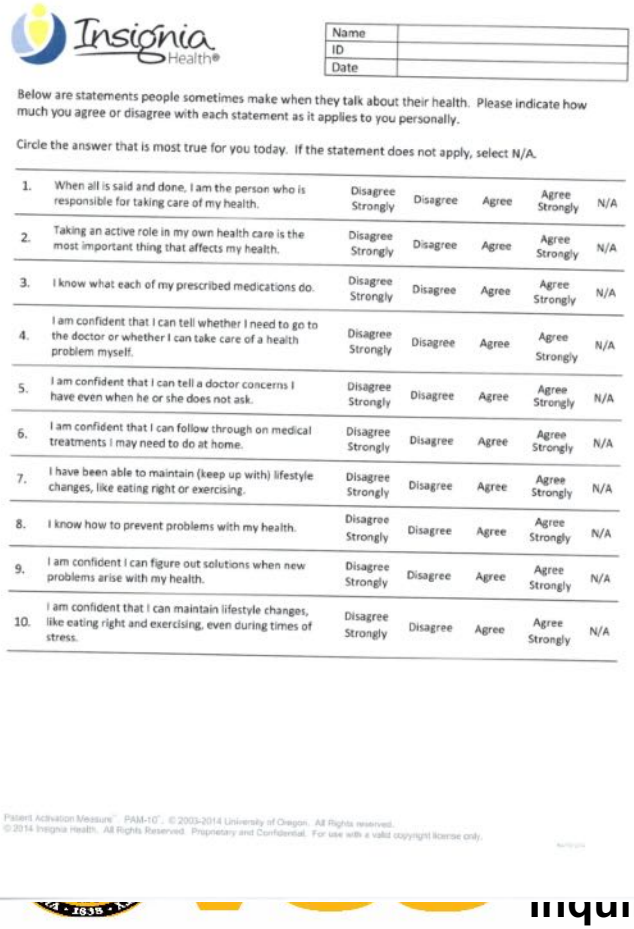
The terms *patient engagement* and *patient activation* are often used interchangeably. The terms are also frequently used to convey different meanings or are poorly defined.

*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.[1] 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

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



Insignia Health®

| | |
|---|---|
| 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?"

# 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 448 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.



**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 of Dominion Place.



**Institute for Inclusion, Inquiry and Innovation**

# References:


- Centers for Disease Control and Prevention (CDC). (2017). *Timed Up & Go (TUG).* Retrieved November 22, 2017, from https://www.cdc.gov/steadi/pdf/tug_test-a.pdf.
- Fawcett SB, Sterling TD, Paine Andrews A, Harris KJ, Francisco VT, et al. Evaluating community efforts to prevent cardiovascular diseases. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1995.
- Fritz, S., Lusardi, M. (2010). White paper: walking speed: the sixth vital sign. *Journal of Geriatric Physical Therapy, 32*(2): 2-5.
- Gana, K., Bailly, N., Broc, G., Cazauvieilh, C., and Boudouda, N. E. (2017) The Geriatric Depression Scale: does it measure depressive mood, depressive affect, or both? *Int J Geriatr Psychiatry*, 32: 1150–1157. doi: 10.1002/gps.4582.
- Hibbard, J. (2017). Patient activation and the use of information to support informed health decisions. *Patient Education and Counseling, 100*(1), 5-7.
- Hibbard, J., & Greene, J. (2013). What the evidence shows about patient activation: Better health outcomes and care experiences; fewer data on costs. *Health Affairs (Project Hope), 32*(2), 207-14.
- Human Nutrition Research Center on Aging (HNRCA) Tufts University. (2017). MyPlate for Older Adults. Retrieved November 22, 2017 from http://hnrca.tufts.edu/myplate/.
- Lubben, JE. (1988). Assessing social networks among elderly populations. *Family & Community Health: Journal of Health Promotion & Maintenance, 11*(3), pp. 42-52.
- Ware, JE, Kosinski, M., and Keller, SD. (1996). ‘‘A 12-Item Short-Form Health Survey: Construction of Scales and Preliminary Tests of Reliability and Validity.’’ Medical Care 34 (3): 220–33. Boston: The Health Institute, New England Medical Center
- Ware, JE, Kosinski, M., and Keller, SD. (1998). How to Score the SF-12 Physical and Mental Health Summary Scales, 3d. ed. Boston: The Health Institute, New England Medical Center.