Nutrition and Aging Resource Center

WeCare Services™

Personal Health Nursing for Seniors receiving Title III Home-Delivered Meals

Principle Investigator: Rabbi Yitzchok Halberstam, Chief Strategy Officer, Education, Health, and Research International. Inc.

Authors: Betsy Wheeler and Harry Spring

October 31, 2022

ACL Disclaimer: This project was supported, in part by grant number 90INNU0030, from the Administration for Community Living, U.S. Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official ACL policy.

Table of Contents

Background and Purpose

A. Goal:

The goal of the grant is to improve the health and wellbeing of homebound seniors who are receiving home-delivered meals (from a Senior Nutrition Program (SNP)) by providing personal health nursing and to simultaneously reduce and/or contain their per member/per month (pm/pm) Medicare costs.

B. Objectives:

1) Strengthen the coordination of care and services for vulnerable seniors who are aging in place.

2) Address medical and quality of life issues to prevent crises and improve health.

3) Assess impact on costs, to petition policymakers to redirect resources to assist more seniors.

C. Overview of Project:

Education, Health, and Research International (EHRI) led an Administration for Community Living Nutrition Innovations Grant award to create an effective system of finding and serving the target area's most vulnerable seniors aging in place. The project relied upon the Title III Senior Nutrition Program (SNP) organization's strong, established relationships with homebound individuals to identify seniors most likely to benefit from personalized, no-cost, nursing services. WeCare Personal Health Nurses establish one on one client relationships that are marked by routine communication, practical problem-solving, liaison to medical services and benefits, and linkage to available community resources.

D. Project Results:

- Served 229 ***diverse seniors*** over the life of the grant; See **Figure A.**
- Completed ***over 10,464 phone calls*** to coordinate logistics, address social determinants of health and numerous circumstances related to general living problems and also to coordinate medical care, arrange needed services, link to resources and benefits, prevent isolation, and promote wellness and prevention. See **Figure B**.
- ***Reduced or maintained ADL/IADL scores*** based on review completed by the University of Delaware of charted biennial scores at the SNP site, pre- and post- WeCare enrollment.
- ***Rendered Medicare cost savings*** based on preliminary analysis by RealPHN® under formal agreement between EHRI and the DE Health Information Network, the nation's first statewide Health Information Exchange and administrator of the state's All Payer Claims Database. See **Figure C.**

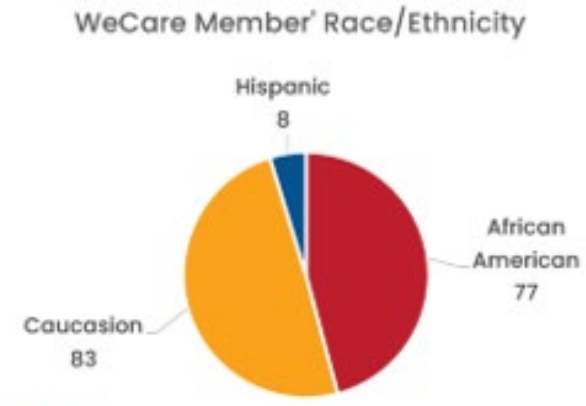


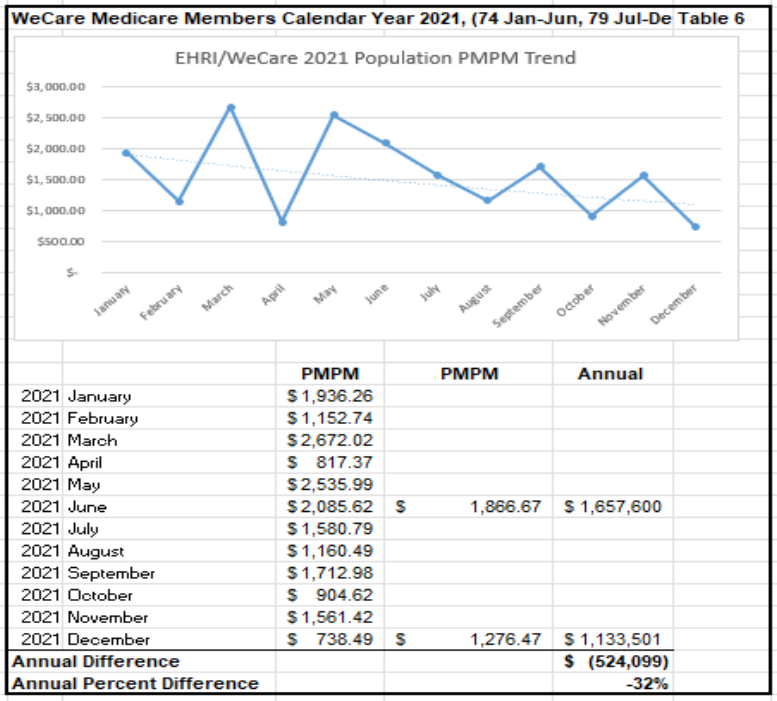
Figure A

Figure B: Nature of Calls Snapshot (Sept. 2021-August 2022)

Type of Call*	Frequency	Percent
Nurse: Client Core Relationship; "weekly check- ins"	4844	79.5%
Other Client Specific Follow-Up; e.g. health literacy, benefits, utilities, family, internet, meals, home mods, home visits	1774	29.1%
Medical advice	359	5.8%
Support with healthcare appointments	1257	39.6%
COVID-19 Discussion	79	1.3%
Medicare Annual Wellness Visit	66	1.1%
Medication related	581	9.5%
Medical equipment related	411	6.7%
Hospital related	226	3.7%
Transportation support	373	6.1%
Housing support	265	4.3%
Total Calls	6096	100%

***Call types are NOT mutually exclusive; primary call purpose extracted from case note review UDE YR3 report**.

Figure C



		PMPM	PMPM	Annual
2021	January	$ 1,936.26		
2021	February	$ 1,152.74		
2021	March	$ 2,672.02		
2021	April	$ 817.37		
2021	May	$ 2,535.99		
2021	June	$ 2,085.62	$ 1,866.67	$ 1,657,600
2021	July	$ 1,580.79		
2021	August	$ 1,160.49		
2021	September	$ 1,712.98		
2021	October	$ 904.62		
2021	November	$ 1,561.42		
2021	December	$ 738.49	$ 1,276.47	$ 1,133,501
Annual Difference				$ (524,099)
Annual Percent Difference				-32%

Partners and Project Staff

A. Partners:

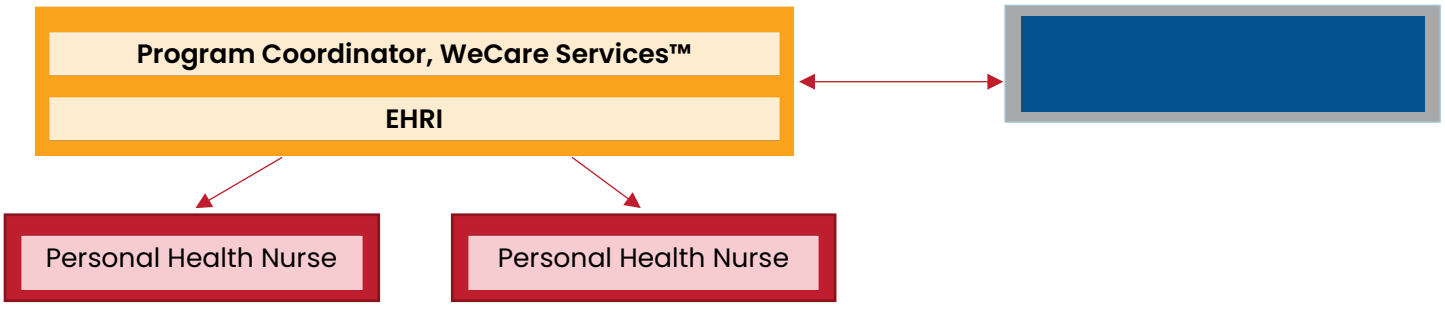
- **Education, Health, and Research International (EHRI)** is the administrator of WeCare Services™ providing nursing services, client recordkeeping and liaison to the SNP.
- **Modern Maturity Center (MMC)** is a 45-year distinguished senior service organization. MMC is the single SNP serving central, Kent County, Delaware, and provides target client case finding to WeCare.
- **Delaware Division of Services for the Aging and Adults with Physical Disabilities (DSAAPD)** is the single state Agency on Aging and the administrator of Title III federal funds in DE.
- **La Red Health Center (LRHC)** is a federally qualified health center with five ambulatory service sites that provide primary care medical homes to vulnerable and the community at-large.
- **University of Delaware (UDE)** is the oldest public, land-grant research university in Delaware and completes academic research on WeCare program structure, methodology, and impact.
- **Highmark Delaware** is the largest commercial insurer serving Delaware; including State of Delaware employees, Medicaid managed care, and Medicare supplemental coverage, and provides corporate/philanthropic funding support.

B. Project Staff Roles:

a. List number of FTEs
   - 3 FTEs

b. List staff titles and general responsibilities
   - **Program Coordinator**: Oversight of WeCare Services™ service delivery, staff, and data. The Program Coordinator is the primary clinical liaison for critical decision-making, client home visitation, and community resource development.
   - **Personal Health Nurses**: Provide 1:1 service to clients, help advance clients' unique health and wellness goals, help solve clients' individual needs, and facilitate access to primary care and the care continuum.
   - **SNP Site Coordinator:** Provides a centralized point of contact at the SNP site through which all client referrals to WeCare flow, and all applicable client related updates flow back.
   - **NOTE:** Professional Information Technology contractual services were procured for client record system development and data analysis. Not included in FTE count but critical role.

c. ***Organizational chart for innovation project***



Funding and Sustainability

A. Initial Funding:

- 2019 **Administration for Community Living** Nutrition Innovations Grant award for 75% of program implementation costs including core client service staff at EHRI and the SNP, contracted services for data systems, evaluation, and grants administration.
- Private corporate funding award from Highmark Delaware for 25% of program implementation costs described above.
- In-Kind Match from EHRI host organization for WeCare professional office space, equipment, supplies, local travel, and overhead.
- In-Kind Match from SNP for volunteer meal delivery persons, data mining resources, nutritionist and case manager time.

B. Continued Funding:

- In Kind Match from both EHRI (the host organization) and the SNP for essential staffing, office space, supplies, local travel, and overhead to support continued service delivery and centralized exchange of critical information for the existing WeCare client base.

C. Sustainability:

- Continued use of client case finding processes at SNP; direct referral to WeCare Services™.
- Embedded project roles into permanent job descriptions at the host organizations.
- State Medicaid Agency provided strong support for EHRI's data collection and analysis activity in conjunction with the State's Health Information Exchange leadership and their All-Payer Claims database.
- The Medicare cost savings identified during the preliminary cost analysis for 70+ clients in calendar year 2021 propels continued interface with Government and Commercial payers to explore funding options for contractual support and/or capitated service delivery reimbursement.
- Continued pursuit of corporate and philanthropic grant support for incremental staffing and new program services.
- The Title III Home Delivered Meal program is an enduring and naturally sustainable model that offers significant value to program design.

Recruitment

A. Participants

a) List Requirements

Title III SNP Home Delivered Meal Recipients (HDM) served by the partner SNP organization were the target audience for participation in WeCare. Criteria for identifying and referring the highest clients for WeCare participation were collaboratively defined. Client self-referral was/is also possible.

1. The target criteria were defined as a ***Title III HDM Recipient*** who lives alone, has documented IADL & ADL scores > 50, and/or who visually/verbally exhibit changes in appearance, conduct, or home environment,
2. A potential client could be identified as meeting target criteria by an SNP meal delivery volunteer, other SNP staff, or WeCare nurses in the field on meal delivery routes, through an in-person encounter and physical observation, or chart/data review.
3. An HDM recipient who received mailed, or in person, informational material about WeCare can self-refer.

b) What recruitment methods were used?

Successful:

A multi-pronged, concurrent, and continuous recruitment process was used. This **combination** approach rendered success that individual recruitment methods may not have achieved if implemented independent of each other.

- Informational correspondence about WeCare Services™ was mailed to all SNP HDM recipients.
- Internal SNP data review was completed to identify HDM delivery routes with a concentration of the defined highest-risk target client.
- The WeCare Program Coordinator completed "**Ride Alongs**". At periodic intervals, the WeCare Program Coordinator participated in the meal distribution delivery routes by car; either in the same vehicle as the driver, or separately following. Through this driver accompaniment, the Program Coordinator was able to utilize the volunteers' established client relationships as an entrée to personally explain the benefits of voluntary participation in WeCare, (and personify the information that had been received by mail) to directly elicit client interest and enrollment. In this highly effective method, the Coordinator provided a simple summary, contact information, enrollment forms, and HIPAA releases/program consent.

Internal SNP Referral based on Defined Criteria:
SNP staff and volunteers have been educated to identify target clients as new clients enter the organization to receive HDM services. Case workers, State-appointed on-site nutritionists, and HDM volunteer drivers incorporate client identification to their respective normal routines, assess clients, review charts, deliver meals, etc. High risk clients are identified to a dedicated SNP WeCare liaison, who gathers indicated client information and refers the client to the WeCare nurse team for follow-up and potential enrollment. This is conducted by WeCare, through phone and/or home visit.

Not successful:

- In the initial stages of project design, two methods of client case finding were deployed;
  a) reliance on trained HDM volunteers, and
  b) HDM cold-calling by an SNP administrative employee.
  Though some clients were ultimately identified and enrolled through these processes, the processes themselves were cumbersome and not conducive to jumpstarting the nursing relationship that has since proven itself critical to achieving client health outcomes, and cost savings.

B. Volunteers or Students, if used

Not Applicable to this project.

C. Marketing Tips

Successful:

- Direct Nurse Coordinator contact with the client capitalizes on the trusted SNP relationship.
- Maximizing the opportunity for client understanding through multiple, concurrent processes; mailed information, SNP volunteer explanation, in person introduction to the Program Coordinator (a nurse).
- General, simplistic, explanation of the service, combined with the completion of enrollment forms and consent is effective. Bundling the program explanation and completion of paperwork and signed consent is highly effective. Barriers compound as time lengthens and separates initial client interest, from form completion.

Not successful:

- It is hypothesized that general marketing technique would not be successful.

Tools

A. Technology

- An initial grant strategy was the integrated use of ServTracker® software, a recognized SNP tool, as a mechanism for HDM volunteer drivers to make a client referral to WeCare, and for shared client focused recordkeeping between SNP and EHRI's WeCare nurse team. Two problems emerged; system design and access. System access by non-SNP staff and contractors was restricted for confidentiality. The software design was not intended for longitudinal, case management types, notes thus required numerous manual workarounds. The dramatic onset of the COVID-19 Pandemic resulted in an unexpected change in SNP partnership and negated the need for problem-solving specific to the use of ServTracker®

  A proprietary, secure, on-line, Personal Health Record was custom-designed and beta-tested. The system was intended for nurse use to complete client charting but proved complicated for real-time information sharing between nurses and indicated SNP staff.

B. Resources

There were two categories of resources that were fundamental to program success:

- **Internal management resources to support the WeCare nursing team.**

The complexity of client cases, and client's wide range of resource and assistance needs crosses multiple sectors; e.g., government, health, human service, and business. This created a need for a management intervention with partnership building, state agency communication, approval of the provision of unique and extensive case support and enabling services. EHRI and the SNP provided an abundance of In-Kind management resources to the program.

- **Community resources available to clients**

The range of resources needed to serve clients presented substantial challenges and opportunities. Nurse familiarity with available resources, client eligibility requirements, and agency point persons was frequently and rapidly changing. Client assistance needs ranged from home repair, home services, transportation, utilities, financial assistance, housing, pharmacy/medicine management, health literacy, appointment coordination, to familial interface, and much more.

Project Timeline

2019 *Pre-Cursor to Operation Phase*

September-December 2019

- Formal kick-off of ACL Innovations in Nutrition Programs and Services (INNU) Grant WeCare program in conjunction with five (5) project partners. Established grants administration and communication methods.
- Developed initial operational, client service, guidelines and processes.
- Received Institutional Review Board (IRB) approval of University of Delaware human subjects research application.

2020 *Getting Established & Then Re-Established Phase*

January-April 2020

- Contracted the first WeCare Personal Health Nurse.
- Trained in use of ServTracker, and its *Change in Condition* module, for HDM drivers to make a direct referral via their cell phone.
- Launched initial WeCare client enrollment through use of traditional marketing approaches relying on SNP drivers and staff to promote program information with nominal results.
- Suspended new client intake via HDM volunteers due to COVID-19 State of Emergency impact on driver protocols.
- Integrated WeCare outreach into SNP's case management coronavirus disease 2019 (COVID-19) related telephone outreach.

May-August 2020

- Implemented weekly WeCare Personal Health Nurse telephone support to 35 enrolled clients, a pivotal program change necessitated by COVID-19, but identified as the critical foundation for client need identification and nurse relationship building.
- Cheer, Inc. (Senior Nutrition Program partner) withdrew from project due to the COVID-19 Pandemic and recommended that EHRI administer the ACL as lead.

September-December 2020

- Hired Dr. Kemi Sanni, DNP, MSN, APRN, FNP-BC, CRNP to serve as WeCare Services™ Program Coordinator.
- EHRI assumed lead role of project upon completion and approval of a transfer application to both HRSA/ACL, and the local funding partner, Highmark Delaware.
- Obtained written consent from 21 of 35 enrolled Cheer, Inc. clients to continue in WeCare.
- Identified new SNP partner, Modern Maturity Center. Modified project plan based on COVID-19 restrictions and Modern Maturity Center's infrastructure.
- Completed workflow redesign, data collection, materials updates, and volunteer and staff training for field-testing new client recruitment strategy (pg. 7-8) with Modern Maturity Center.
- New strategy rendered significant result in client referral, enrollment, and engagement; increased enrolled clients to 64 by December 31, 2020; an increase of 304% in approximately one month. The 43 net new clients enrolled in one month compared to enrollment of 35 clients over a 5-month period with the former partner and process. Nurse to client phone interactions more than doubled in net count.

2021 *Transition and Growth Phase*

January-April 2021

- Received formal Notice of Award as lead agency from ACL and Highmark Delaware.

May-August 2021

- Continued multi-pronged client recruitment strategy with Modern Maturity Center.
- Personal health nursing activities expanded in routine weekly telephone consults, service liaison, home visits and recordkeeping.

September-December 2021

- The broad scope of client needs was fully realized by year end. Nursing caseloads, and random sample University selected case studies illustrated WeCare client's magnitude. It was identified there was an extensive need, lack of resources, and frequently absent familial support, across all life areas.
- Active enrolled client number increased by 184%; call volume and nurse interaction more than doubled (211% growth in December 2021 over January 2021)

2022 *Mature Operation Period*

January-August 2022

- WeCare Services™ hit its mature stride in 2022, during the last 8 months of the grant. The needs were clearly identified and WeCare filled the gaps amongst numerous life circumstances.
- University of Delaware completed chart reviews of WeCare clients to collect pre- and post- ADL/IADL scores. Staff & volunteer informant interviews were conducted onsite at Modern Maturity Center.
- EHRI received ACL Notice of Award to implement chronic disease self-management education (CDSME) programming as an additional service available to all WeCare clients.
- Received Delaware Health Information Network (DHIN) Board of Directors approval of EHRI's claims-based data request; a request which was championed by the Delaware Division of Medicaid and Medical Assistance.
- Medicare cost data was attributed to 70+ WeCare clients with 18 continuous months of WeCare enrollment, providing a statistically significant study cohort to examine average pm/pm and annual costs in six month increments of the full 2021 calendar year of claims data. Savings were realized in both measures; pm/pm and annual cost. The DHIN data extraction fee was reduced from $30K to $8k.
- Operations continue with In Kind supports, identification of new funding sources, and continued dialogue with State officials and policymakers.

Frequently Asked Questions

Q1: Why did you create WeCare Services™?

A: The percentage of seniors in Delaware is increasing annually. As seniors age, an increasing number wish to "age in place" in their own homes and communities rather than in nursing care facilities. Our organizational leaders have a long history of success compassionately serving seniors within nursing facilities. They and facility staff witnessed a growing need to support seniors outside of the nursing facility, to help avert their unwanted residency. Together with State and local officials, an action plan was conceptualized as a multistakeholder community-based initiative to identify and assist the most vulnerable homebound seniors; to support their health and independent living**, in advance and/or instead of,** long-term care placement. The project's name "WeCare" is an extension of the founding partner organization's mission and vision.

Q2: What has been the most effective component of the program?

A: The union of personal health nursing with an SNP. The ongoing relationship between the WeCare Nurse and individual members provides the "missing piece"; someone who is qualified and skilled to help resolve and bring resources to individuals well beyond that received in the typical medical care setting. Additionally, a partnership with a SNP offers numerous economies on which to build and launch a community health service for the most vulnerable older adults in your community. The SNP enjoys an established rapport and trust with the target audience, many times serving as the most frequent form of contact for the homebound senior. The SNP's alignment with State and Federal programs and policies provides an infrastructure of critical information that can be obtained, with client consent, and without client burden. The infrastructure provides a foundation for qualitative and quantitative research.

Q3: What makes WeCare Service's nursing services unique?

A: WeCare Services™ utilizes an approach called Personal Health Nursing™ (PHN). The essence of PHN lies in its person-centered focus of establishing an individual relationship with each client. Weekly communication is maintained by telephone. Client consent enables the PHN to interact with the primary care medical home to facilitate access, adherence, and follow-up to care. Through the ongoing relationship, various needs and problems are identified on which the PHN enacts problem-solving, and creates solutions by identifying and coordinating available community resources.

Q4: What qualifications are required for WeCare Services™ Personal Health Nurses™?

A: Aside from a registered nursing degree from an accredited college or university and an active state licensure, the top five characteristics required for a PHN are compassion, trustworthiness, motivation, tenacity, and accountability.

Q5: What does an average day look like in the WeCare office?

A: Every day is different! Clients are assigned a specific day of the week for a recurring weekly "check-in" phone conversation. That conversation can result in follow-up with the medical community confirming and scheduling appointments, state agencies to apply for benefits and assistance programs, community organizations for transportation and minor home repairs, or pharmacies for prescriptions and durable medical equipment. Sometimes the conversations trigger a need to run an errand, visit the client in the home, or provide indicated feedback to family members or other emergency points of contact. No client's needs are the same as that of another, and our experience has demonstrated how quickly client needs change and/or shift in priority.

Q6: How is client information stored?

A: WeCare Services™ utilizes a proprietary client record system which captures the client demographic information provided by the SNP, and two types of nursing call notes for each client. ***Call notes*** are recorded to summarize every nurse encounter with the client. ***Service notes*** are recorded, per client, to document various action steps completed with external entities.

Q7: What information does the SNP need about the client who opts to enroll in WeCare Services™?

A: The SNP should develop an in-house system to document which of their clients have been referred to the WeCare Services™ program and which have actually enrolled. The former prevents duplication for staff of the SNP. The latter alerts SNP staff that an extra professional resource is available for communicating observations and/or concerns.

Q8: What percentage of your annual budget is spent on marketing?

A: None! Our referrals have come almost entirely from our Senior Nutrition Program partner, and word of mouth from clients served. We have produced some hand out materials that are distributed through the SNP and at client homes.

Q9: What has been the most significant expression of physician confidence in WeCare Services™?

A: A local independent practice family physician closed his practice to retire after 23 years of service. He transferred all of his remaining practice medical records (over 1000) to WeCare Services™ at the time of closure as means to ensure that his former patients seeking records, many of whom were seniors, would have access to assistance finding a new medical home.

Q10: What is a recent client case example that without intervention would have been dramatically different?

A: There are many. A recent story involved the cooperation of the whole WeCare team to assist a female client in the final stages of life in a local hospital's Intensive Care Unit (ICU). The hospital would not discharge her due to complex requirements associated with discharge for someone in need of hospice, but without. The WeCare Personal Health Nurse arranged end of life arrangements in coordination with the client, facilitating her hospital discharge, her avoidance of being placed on a ventilation unit, and most important, poignantly honoring a dying woman's final choices when the client had no one else to assist her.

Advice for Replication

1. In any community across the nation, the **Title III Senior Nutrition Program Home** Delivered Meal recipients are a naturally selected population of high-need, high-cost, and low resource individuals.
2. This uniquely identified target population can readily and directly experience improved health and wellbeing, improved health care access, and reduced healthcare system expenditures through personal health nursing in a WeCare type service configuration. Results can be quickly experienced for the client by a skilled professional who can address a myriad of gaps and needs for this population.
3. Things change **quickly** for this high-risk population. Their circumstances can deteriorate in minutes, hours, or days. Events occur through falls, loss of utility service, loss of benefits, home disrepair, lack of transportation to pick up a necessary prescription, or even lack of understanding of medical advice for a serious chronic condition. Many needs are above and beyond, or maybe invisible, to ordinary, outpatient medical care providers. Many needs that otherwise may be considered more mundane can quickly evoke or exacerbate medical complexity and urgency.
4. Personalized and skilled assistance, provided with empathy and the ability to clinically discern and prioritize is required. These high-risk clients require an ongoing relationship with a Personal Health Nurse that uniquely assesses and addresses frequently changing client needs without bounds. The full scope of nursing practice is required daily and differently; without focus on a singular need, condition, or type of service, but rather providing any and all.
5. And finally, a quote from the Program Coordinator:

   "Above all else, and staff qualifications, skills, and experience aside, these high-risk clients require someone who truly cares about seniors."

Appendix List

Appendix A

WeCare Welcome Letter**.**

Appendix B

Individual Participation and Release Form.

Appendix C

Individual Member Intake Form.

Appendix D

Physician Information Release Form.