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## The Health Empowerment Program: A Primary Care – Area Agency on Aging Partnership

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## Case Study

# The Health Empowerment Program: A Primary Care – Area Agency on Aging Partnership

by Daniel Bluestein, MD; Brad Lazernick BS, MPA; and Britt Gnilkka, DNP, RN-BC



### Educational Objectives

1. Appreciate the benefits of a primary care-area agency on aging collaboration.
2. Identify strategies for enhancing this cross-organizational partnership.

### Background

Family Practices and other primary care organizations are challenged to optimize care of high-risk/high-need older adults. These are patients for whom a mix of unregulated chronic illnesses, cognitive impairment, and/or poor functional status predispose to repeated hospitalizations and poor outcomes. Care is further complicated by low confidence for self-management and need for linkages to community-based services and supports (Byhoff, Freund, & Garg, 2018).

To better illustrate high-risk/high-need attributes, we introduce the cases of Mr. Andrews and Ms. Baker. Later we will see how our Health Empowerment Program (HEP) helped both of these patients.

*Case 1: Mr. Andrews is a 92-year-old male with mild dementia, a prior stroke, and osteoarthritis. His daughter, a Hampton Roads resident, moved Mr. Andrews to live with her following the death of Mr. Andrews' wife, his prior caregiver. She has established him with her own doctor and relates a high level of caregiver burden as well as concerns about injury; Mr. Andrews has had several falls since the move. The physician recommends a Medicare Wellness Visit with one of the practice's nurse care managers as a means of further assessment.*

*Case 2: Ms. Baker, a 78-year-old female, has poorly controlled diabetes and hypertension. She has flagged on quality metrics surveillance as being at high risk from preventable morbidity. She has also had multiple emergency room visits related to high sugars and hypertensive urgencies. She lives alone and has a fourth grade education. Given these concerns, Ms. Baker is assigned a nurse care manager who suggests a Medicare Wellness Visit as a means of both getting to know Ms. Baker and deciding about further assessment.*

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Partnering with Area Agencies on Aging (AAAs) can potentially address these and other challenges posed by patients such as Mr. Andrews and Ms. Baker. This approach was introduced in a 2014 *Family Practice Management* article (Coleman, Whitelaw, & Schreiber, 2014) which described the range of services AAAs provide and offered general suggestions on how to engage in collaboration. More recently, the American Academy of Family Physicians EveryONE project (AAFP, 2018) offers a toolkit for developing partnerships with community programs, again in general terms. There is a place for specific examples of how a primary care-AAA partnership can work and what one might expect as a result.

Accordingly, we are reporting our experiences partnering with our local AAA, Senior Services of Southeastern Virginia (SSSEVA). We first describe our intervention and its benefits. We then delineate next steps and conclude with suggestions on how other practices can adopt our approach.

## Who We Are

In our settings (Eastern Virginia Medical School's two family practice residencies, Sentara Healthcare's primary care practices), we prioritize Medicare Annual Wellness Visits (AWVs) as a means of improving care for older adults (Blustein, et al., 2017). The importance of the wellness visit in this regard was further highlighted in a 2017 *Age in Action* article (Blustein & Diduk-Smith, 2017) which also stressed the need for active follow-up to ensure wellness visit recommendations are enacted. The work presented here illustrates one such approach to wellness visit aftercare of high-risk/high-need patients who would benefit from linkage with resources and supports, health education, and reinforcement of self-management skills.

We saw collaboration with SSSEVA as a means of achieving these ends. However, communication with the social sector had heretofore been indirect and we sought to build bridges. SSSEVA's mission is "to provide seniors and their caregivers with access to programs and services so they may live with choice and dignity in their communities." (See Figure 1) SSSEVA has participated in multiple partnerships to enact this mission. Collaborating with primary care

was thus in keeping with this strategy and a means of furthering organizational impact and effectiveness.

## Our Intervention

Our initiative, the Health Empowerment Program (HEP), was designated a quality improvement project by the Eastern Virginia Medical School Institutional Review Board. Funding for the HEP was provided by a Hartford Foundation Practice Change Leader project enhancement award to Dr. Blustein. In 2019, the HEP received a 2019 National Association of Area Agencies on Aging Innovations Award (naa.org, 2019) and a Health Quality Innovators for Virginia runner-up award (HQI Solutions, 2019).

The HEP leveraged SSSEVA's experience in implementing the Coleman Care Transition Intervention (CTI), aimed at reducing 30-day hospital readmissions (Coleman et al., 2006). We adapted elements of the CTI model to improve care for high-risk patients identified in AWVs. These included use of a health coach who works directly with clients to complete a Personal Health Record (PHR), a patient activation tool that promotes: medication understanding and adherence, ability to recognize and respond to "red flag" symptoms of decompensation, formulation of self-management goals, and advance care planning review ([Caretransitions.org](http://Caretransitions.org), 2015). The coach also assessed client eligibility for SSSEVA services and programs.

Participants were recruited by practice nursing staff (RNs, care managers, LPNs, Nurse Practitioners) who described the program, obtained written agreement to exchange information with SSSEVA, and had enrollees complete a four-item survey of patient or caregiver level of confidence using a scale of 1-10 (1-not at all confident to 10-completely confident). Nurses communicated with the SSSEVA health coach by phone and through exchange of documents by a HIPAA-compliant, secure file exchange software (ShareFile). The health coach conducted a home visit with the patient/caregiver during which she facilitated completion of the PHR. The coach also identified eligibility for SSSEVA services and initiated referrals. The coach shared findings with nurses who contacted patients with updated care plans as necessary. The coach conducted follow-up phone

calls at 30 and 60 days to assess progress and help problem-solve any issues identified during the home visit and implementation of any updated care plan. The coach re-administered the four-item confidence survey and assessed patient/family satisfaction with the program at 60 days.

Our outcome metrics thus included change in health confidence in medication understanding and adherence, ability to recognize and respond to “red flags”, and making lifestyle changes. We also assessed satisfaction with the program, advance care planning completion, and service linkages. These measures were chosen because increased confidence (Wasson & Coleman, 2014) and higher satisfaction (Anhang Price et al., 2014) predict self-management and adherence; advance care planning is a value-based reimbursement quality indicator that may reduce futile, high-cost hospitalizations; and service linkages may improve access to care and quality of life.

## Our Findings

During 2018, we approached 42 patients who completed AWVs and were identified as high-risk due to low health literacy, poor confidence for self-management, unregulated chronic illnesses, frequent hospital and ER visits, unmet social needs, cognitive impairment, poor functional status, caregiver burden, or an admix. Of these, 27 agreed to participate and 20 completed our intervention. Of the seven non-completers, one died, two entered long-term care, and four refused follow-up. Participants’ mean age was 77 years (range 61-93); 69 percent were female; 57 percent were African-American, 38 percent were White, and five percent were Hispanic. Participant characteristics were comparable across all practices.

We measured change in confidence levels using a scale of 1-10, where 1 represented Not Confident and 10 represented Very Confident. We asked four separate questions: “How confident are you that you: Understand your medications? Can take them correctly? Know the “red flags” for which you should call your doctor? Can make lifestyle changes to improve your health?” Data (Figure 2) show increases in confidence for all domains, although not surprisingly, the increase was smallest for lifestyle changes. Patient satisfaction, the extent to which patient expectations

are met (Anhang Price et al., 2014), was measured by a single item assessing the likelihood of recommending a service (Ahmed et al., 2017). Participants uniformly viewed the HEP program positively, using a single item measure, “Would you recommend this program to someone else?” However, the four who did not complete the program were *de facto* dissatisfied. ACP was discussed with nearly all participants. Of these, six (30%) completed ACP documentation as a result of participating in the HEP. All designated power of attorney for health, five of six were “full code”, and one placed some limits on the aggressiveness of end-of-life care. Figure 3 enumerates services and programs for which participants qualified. It should be noted that actual uptake of these services was much lower, less than 50 percent.

## What We Learned

Taken together, these findings indicate that collaboration with an area agency on aging improved health confidence, facilitated advance care planning completion, and provided linkages with services that improve access to care, caregiver support, and better nutrition, safety, and chronic illness management. Participants voiced satisfaction with the program, which is important as higher satisfaction is correlated with better adherence and patient buy-in (Anhang Price et al., 2014). Direct communication between partners proved invaluable in enhancing AWV care plans. Nearly 1/3 of HEP participants completed advance care plans through HEP participation. Although only one of the six ACPs completed under this project limited care, advance care planning is a process and dialogues begun here can be continued.

These benefits are further illustrated by revisiting the cases of Mr. Andrews and Ms. Baker.

*Case 1 continued: The wellness visit revealed unmet service needs and the nurse care manager recommended enrollment in the HEP. The health coach noted multiple environmental hazards on her home visit and made suggestions for fall prevention. The patient also qualified for companion, respite, and home PT and OT. In coordination with the nurse care manager, a home health referral was placed. Telephone follow-up by the coach indicated that these various services were initially not received. The care*

*manager circled back to the home health agency and services were put in place thereafter. There were no further falls and the caregiver reported significant stress reduction. Advance care planning was initiated and documented. Although Mr. Andrews remained a full code, he and his daughter said that they would revisit this if his status deteriorated.*

*Case 2 continued: The nurse care manager who had conducted the wellness visit noted a low degree of health literacy during the wellness visit and recommended enrollment in the HEP. The health coach documented poor medication understanding and a lack of awareness of red-flag symptoms while completing the personal health record with the patient. The health coach discussed these findings with the nurse care manager and a joint educational effort was launched. As a result, the patient was better able to understand why she was on certain medication, to recognize symptoms of high and low blood sugars, and to adjust her medications accordingly. The patient's diabetic control improved, as did her blood pressure, and she had no further emergency room visits. She stated how much she appreciated the coach and care manager.*

Findings concerning health confidence are especially key in several respects (Wasson & Coleman, 2014). First, health confidence is a single item measure that is easily assessed in busy practices. Second, discussion of confidence ratings can provide entree to dialogue about behavioral change. Third, health confidence is a proxy for patient activation, with scores of seven and above strongly predicting behavioral change leading to better outcomes and reduced costs. It is noteworthy that confidence levels reported here were increased to at or above seven by our intervention. Improved quality metrics for diabetes, hypertension, and other chronic illnesses become more likely as a result. In addition, increased health confidence is associated with reduced hospitalization in a family practice setting (Nunlist et al., 2016).

Nunlist and colleagues' findings can be used to develop a business case for HEP sustainability. In their panel of 32 high-risk family practice patients (akin to those enrolled in our HEP), the reported acute care (hospitalization/emergency room visit) event rate was eight per month from June 2012-December 2014. In

early 2015, their panel received a health educational intervention wherein confidence for self-management rose from 6.6 to 8.3 on a scale of 10, gains similar to what we observed. As a result, acute care events fell to an average four per month over the ensuing 20 months. Data from the Eastern Virginia Care Transitions Partnership (Center for Healthcare strategies, 2017), indicate that approximately \$9,500 can be saved per event prevented. Using Nunlist et al.'s experience, this would translate to \$38,000 cost savings/month (reduction from eight acute events/month to four/month at cost savings of \$9,500 each). Actual results would probably vary by organization, type of patients, and health confidence intervention.

It is also important to know how likely these savings would offset HEP costs. The concept of "Number Needed to Treat (NNT)" (Siwek, 2015) can be used to address this question. NNT is the number of patients Needed to complete the HEP to avert an acute care event and is determined by comparing the rate of an event in the intervention group versus the rate of the event in a care-as-usual group. Statistically, in our case, it's the inverse of risk reduction attributable to the HEP. Based on Nunlist et al.'s findings, the NNT for the HEP is  $1 / (8/32 - 4/32) = 8$ . So, treating eight patients through the HEP would likely save one acute care event. Again, this number is an estimate but can serve as a point of departure for subsequent inquiries.

Estimated costs per HEP enrollee are \$650 (\$400-health coach; \$250-care manager), and for eight enrollees would be \$5200. HEP cost thus would be more than offset by a cost saving of \$9500 per acute episode averted. Efforts to validate this cost-saving model are needed as are efforts to assess the HEP's impact on quality metrics and thus success under value-based reimbursement.

### **A Collaboration Primer**

We also learned a great deal on the workings of our partnership, which we summarize below as guidance for other practices and organizations.

1. Networking is a start. Members of all three organizations had met in other contexts or at least knew of each other. Hence, it was easy to reach out.
2. Shared values. All involved in this project

believed in the model of team-based care for high-risk/high-need patients

3. There was mutual understanding of what all parties sought from the relationship. This made it easier to align interests and promote problem solving.

4. Communication was key to developing personalized working relationships. Use of secure communications software made document sharing easy.

5. There were frequent interactions between other members of all organizations. This continuing dialogue served to maintain momentum and facilitate problem solving.

6. It was important to look continuously at results. Frequent reviews helped us to realize we were “getting somewhere,” which was reinforcing. These frequent data reviews also served to identify and address incipient problems.

7. Participant recruitment relied on nurse “champions” who were able to describe the benefits of participation from the client perspective.

8. There was a minimum of “red tape” for participants, who were asked only to sign an interagency agreement to share information.

9. While confidence increased, this is a dynamic, process measure. It is important that physicians, nurses, and other practice staff continue to foster confidence to improve outcomes.

10. While many participants qualified for services, acceptance was variable and can be reinforced by a practice team that advocates for use.

11. Be patient. Change takes time.

12. Be persistent. There will be challenges.

## Conclusion

We have described a quality improvement project involving collaboration between family practices and an area agency on aging that led to enhanced patient self-confidence, patient satisfaction, linkage with services, and promotion of advance care planning. These are important patient-centered outcomes in their own right that can, potentially, improve quality metrics, prevent hospitalization, and advance practice performance under value-based reimbursement. There was further professional satisfaction as our work pragmatically impacted several social determinants of health factors that have major deleterious effects yet are challenging to address in the clinical realm.

Limitations should be noted. Measurement of actual quality outcomes and impact on financial performance lay beyond our scope and should be the subject of subsequent Plan, Do, Study, Act (PDSA) cycles. Over half of patients who might have benefited refused enrollment or withdrew. Many that did not participate chose not to accept services for which they were eligible. Better understanding of patient motivations is needed to improve program effectiveness and efficiency. In addition, we report on a small number of patients drawn from a few practices. Although generalizability of our approach is unknown, it is reasonable to hope that others can learn from our experience.

## Study Questions

1. Increased Health Confidence is associated with
  - a) Increased costs
  - b) Higher emergency room use
  - c) Uncontrolled Hypertension
  - d) Better diabetic control
  - e) Dissatisfaction with care

Answer “d”

2. Primary Care-Area Agency on Aging cooperation is facilitated by all except:

- a) Shared values
- b) Alignment of interests
- c) Impatience
- d) Frequent interactions
- e) Persistence

Answer “c”

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**Figure 1: SSSEVA Services and Programs (services vary by AAA)**

<b>Medicare Benefits Counseling</b>	Assists with education and enrollment counseling for Medicare Part D and other plans, Medicaid, long-term care insurances, and other programs.
<b>Options Counseling</b>	Links individuals to resource options for physical, medical, financial, or emotional needs; coordinates with other agencies as necessary; and provides caregiver support.
<b>I-Ride Transit</b>	Provides medical transportation to medical appointments and senior center wellness and nutrition sites.
<b>Nutrition Services</b>	<u>Congregate meals</u> combined with socialization opportunities at senior wellness centers; <u>Meals on Wheels</u> - for homebound seniors who cannot prepare meals on their own.
<b>Wellness Programs</b>	A Matter of Balance, Chronic Disease Self-Management (Lorig).
<b>Senior Companion Program</b>	Partners senior volunteers with adults living in the community in need of companionship and a helping hand.
<b>Senior Advocate Ombudsman</b>	Investigates complaints, mediates issues, and provides counseling and education about nursing homes, assisted living facilities, and community-based care services.
<b>Personal Care/Homemaker Programs</b>	ADL assistance/housekeeping after an illness or hospital stay, or short-term service until long-term care is in place.
<b>Senior Cool Program</b>	Provides fans or air conditioners to eligible seniors who need help cooling their homes.
<b>Coordinate linkages to other, external services and supports</b>	Medicaid, Supplemental Nutrition Assistance Program (SNAP), Veterans Services, Alzheimer’s Association, etc.

**Figure 2: Change in Confidence**

<b>Understand medications</b>		
Pre	Post	Change
5.5	7.0	1.5
<b>Knows red flags</b>		
Pre	Post	Change
6.1	8.4	1.3
<b>Takes medications correctly</b>		
Pre	Post	Change
5.9	7.4	1.5
<b>Can make lifestyle changes</b>		
Pre	Post	Change
6.1	7.0	0.9

**Figure 3: Service Linkages**

<b>Program</b>	<b>Number of linkages*</b>
Benefits counseling	10
Legal aide	3
Transport	19
Home companion	8
Nutritional services	8
Respite care	12
Durable equipment	4
Chronic illness and wellness program	3

\* There was less than 50 percent uptake of services for which participants were eligible