

Advancing Senior Care and Aging in Place through Collaborative, In-Home Visits: A Novel Community-University Partnership

"Aging in place" (i.e., living independently in one's home) has become part of the national conversation as the U.S. demographically shifts towards an older population. What is interesting about aging in place is how seniors may end up in this particular situation. For some seniors, it may be their choice to age safely in their home with or without a partner and possibly other family members. For others, aging in place can occur out of necessity as a result of financial burden, lack of family support, or even isolation due to mental health or cognitive issues like dementia (see Brody, 2018). Here, we describe a novel community-university partnership that aims to provide collaborative care and recommendations by assessing the safety and independence of individuals aging in place regardless of how they ended up on this particular path.

The Need

Before we embarked on our community-university partnership in the spring of 2018, we kept hearing the same refrain from a non-profit organization that knows its senior clientele very well: "We are really worried about some of the people our volunteers see when they deliver meals." Their worry was for the safety of senior citizens, often living alone, who were receiving daily meals from Fresh Meals on Wheels (FMOW) of Sheboygan County, Wisconsin. FMOW is a farm-to-table healthy meal service that has become a de facto hub and collector of information about the people they serve. Volunteers were routinely reporting to the FMOW staff that some homes were cluttered, dangerous and hard to walk through; that multiple medication bottles were visible and seemed unorganized; and that some seniors appeared sad, lonely, and at times, showed signs of dementia.

FMOW wanted to find a way to better support the needs of the elderly whom it served, and so it reached out to the Dean of

Nursing at Concordia University Wisconsin (CUW), who then contacted CUW's Office of Interprofessional Practice and Education (IPE). Quite quickly, a pilot program was conceived that was based on the overall shared goal of aiding individuals to age in place, while remaining safe and healthy. A collaborative study and protocol was proposed and IRB approval was secured.

The protocol consisted of CUW faculty members and an FMOW case manager making a series of three visits into the homes of seniors. At visit #1, case managers would identify seniors at risk and the team, consisting of a medical anthropologist, pharmacist and nurse, would gain consent and gather background and ethnographic information, conduct a medication history, and administer a Mini-Cog™ screening test as well as a Geriatric Depression Scale Short Form™. At visit #2, either an occupational therapist or physical therapist faculty member would assess home safety and falls risk using the SAFERhome™ tool. The team would then collaborate via a shared drive, carpooling, and/or in-person meetings to determine recommendations for each FMOW client. At visit #3, the collaborative pharmacy-nursing-medical anthropology team would present the recommendations and gathered information to the FMOW clients in their homes. The written set of recommendations concerning medication, mental health status, possible referrals, and home safety improvements was provided to the clients to share with their providers, support staff, and family members.

Engaging with Seniors

Our first cohort of the pilot program, which included three FMOW clients, proved enlightening in myriad ways. We met "Betty" who was cheery and eager to speak with us and divert our attention from severe edema in her legs, which created an inability to properly care



for her own household and toileting needs. We met "Mary Jo" who, while also welcoming, was very depressed and had endured multiple falls over the previous six months. She was aware that her polypharmacy, which included opioids and a benzodiazepine, required immediate attention. And we met "Clarence" who wanted to confide in us about his daily routine of using the bus to visit his wife in a nursing home because he missed her and was deeply concerned about her welfare. As the nurse asked questions from the geriatric depression scale, Clarence's affect began to change. He began to cry, which elicited great empathy from the group. He was then able to open up about his sadness and occasional suicidal thoughts, which were related to his isolation.

All three clients were open and receptive to our collaborative recommendations made on visit #3. In general, these included gaining client buy-in for more help with seemingly mundane things: cleaning, rearranging furniture, removing throw rugs, and making simple adjustments to walkers and canes. We specifically encouraged Mary Jo, for example, to take our letter to her provider in order to discuss tapering her medications, especially the benzodiazepine and opioids (see also Oldani and Suss, n.d.). We confirmed that she spoke with her provider and began to taper meds at a 3-month follow-up visit. Clarence's situation required a more immediate intervention before visit #3, and FMOW secured a social work referral for his mental health care, which we discussed during

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the team visit. Betty continued to socialize with friends and family, especially her grandchildren. However, our team recommended more social engagement for Mary Jo and Clarence through church and community groups, friends, and reconnecting with family members. During exit interviews at visit #3, the clients expressed appreciation for the home visits, commenting that they “meant a lot” to them and “showed we cared”. One client said the visits, “helped me want to change [my situation].”

Collaborating with Students

In the fall of 2018, we expanded the pilot to include students as part of the home visit team. Each faculty member incorporated a student from their program either through a specific course or clinical rotation. Additionally, to ensure interprofessional discussions and more shared decision-making, an IPE case conference was embedded with the visit schedule to ensure deeper collaboration, debriefing, and the application of pertinent literature for making appropriate recommendations. As of May 2019, student-faculty-FMOW teams visited 17 seniors over two semesters.

Students have engaged in self-reflection, debriefing, and presentations of their collective work and have shown growth in important areas. They have reported learning “important soft skills”, “handing off [to other specialties]”, how to “get important information [from seniors]”, and how to “redirect [talkative] seniors.” A pharmacy student sat next to a senior on her couch and instructed her on how to use inhalers and followed up through long phone conversations when it was clear a human connection was needed to ensure compliance with our recommendations. Students, in general, benefited from entering a space that connects the textbook with their present and future clinical experiences in meaningful and culturally important ways. For example, an OT student realized that even though he had made home visits in the past for another rotation, he had never “looked around the house... to actually see how a person was living in their home.”

This program has also opened the eyes of all participants to the current needs of seniors, in particular, those living in lower socio-economic conditions and underserved areas. Members of the care team delivered a kitchen table the day before Thanksgiving, visited seniors off hours to check in on them, brought students to group homes to engage in evening activities like bingo, and searched for free items (e.g., walkers and grab bars) to help reduce fall risks. We have also learned that seniors are increasingly living with an older child who can be considered a

caregiver but, based on our sample, may need caregiving and social services him/herself (see AARP, 2018, on “shared living” trends).

The Importance of Community Partnerships

Having a community partner on the ground and operating locally has been the key to our program’s success. It was immediately clear to us that FMOW volunteers simply know their clients best and can be the ears and eyes that identify people at risk and in need of in-home visits and sometimes an immediate intervention (e.g., one senior required admission to assisted living, which FMOW helped facilitate during visit #1). FMOW can directly act on our recommendations. For example, when the team discovered that a senior may only be living on “three [FMOW] meals a week...” and not meeting basic nutritional needs, FMOW worked to secure additional meals. FMOW also has a network of community volunteers who can be called on to install grab bars in showers, fix railing outside of homes, paint walls, fix rugs, find rides to church or community events, and help with yard work.

As this initiative continues to evolve, we plan to address and expand in several areas. We are working with a local Federally Qualified Health Center (FQHC), a primary care medical home, to begin to focus directly on health outcomes (e.g., diabetes, mental health). We have also been working with a local hospital in a different county that wants to incorporate our protocol, which would include a meal delivery service, to study hospital readmission rates after cardiac events (e.g., Berkowitz, et al., 2018). Both of these partnerships would help overcome a limitation with the current project—namely, our lack of access to the electronic medical records (EMR) of seniors. EMR connection would help with all aspects of the in-home visit process, allowing direct connection and collaboration with providers while measuring the impact of collaborative home visits over time.

Assessing Outcomes

We are working to incorporate additional assessment tools into all aspects of our in-home visit schedule. The Jefferson Teamwork Observation Guide® (JTOG®) is one such tool we hope to begin using in the fall of 2019. The JTOG® allows for team members to assess one another and gives clients/patients and support staff the opportunity to also assess the healthcare team using a smartphone or tablet.

Scaling up will remain a challenge. However, we are confident that the pieces are now in place to incorporate more faculty and students and/or to train other organizations to create

similar collaborative partnerships. These kinds of productive relationships fall in line with the call for more robust community-based programs and initiatives; they are the kind of relationships that focus on improving outcomes through aligning emergent cultures of IPE (at the level of learners) with community organizations and local systems working toward collaborative solutions in the healthcare marketplace (Cox, Cuff, Brandt, Reeves, & Zierler 2016).

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