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Innovative Title III Senior Healthcare Program: Year 2 Transition Lessons Learned and Intermediate Outcomes

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PROGRAM BACKGROUND

INTRODUCTION

This report serves as an evaluative summary and offers lessons learned from the WeCare program, a federally funded pilot partnership designed to support innovative health services to older adults through the Administration for Community Living (ACL). Information provided primarily represents year two (October 2020-August 2021) of the three -year program but draws comparisons to year 1 work plans, and addresses some of the themes and lessons learned from the year 1 report. These comparisons highlight how the program has evolved and adapted.

As part of the Continuous Quality Improvement (CQI) process described in the ACL grant program goals, this information aims to inform all involved partners so that the program can be refined and improved accordingly.

YEAR 1 RECAP

In 2019, CHEER, an organization located in Sussex County, Delaware that provides a full range of services for mature adults, including Meals on Wheels and congregate meals as part of Title IIIA nutrition program, was awarded a grant from the ACL to develop a wellness benefit program for home delivered meal recipients. The grant-funded program titled "Innovative Title III Senior Healthcare Program" represented a partnership between CHEER, Education, Health, and Research International (EHRI), the Delaware Division of Services for the Aged and Adults with Physical Disabilities (DSAAPD), LaRed Health Center (a federally qualified health center), Highmark Delaware, and the University of Delaware (UD). The initiative aimed to leverage the great work of Title III home meal providers to serve as a critical mechanism for understanding and responding to the health needs of home-bound senior citizens aged 60 years or more. Through the use of CHEER's front-line support for seniors via volunteer meal deliverers and its data management infrastructure, and EHRI's WeCare program as a nurse-administered health service delivery program, the ACL-funded initiative examines how meal service providers are positioned as critical link-makers to skilled nursing care coordination, and, subsequently, to an accountable and networked system of health care. The goal of the initiative mirrored the goal of the Older Americans Act (OAA) and ACL to help seniors age in place gracefully and healthfully, avoiding unnecessary hospitalization and staving off institutionalization.

During the first year, the outbreak of COVID-19 presented considerable challenges, particularly in recruitment efforts and in proceeding with the client case finding approach that had been uniquely customized to the CHEER operation; i.e., their existing use of a nationally recognized data platform ServTracker (ST), and the project's original structure to use an available ST module "Change of Condition." Whereas the first six months of year 1 had focused on defining the work flow and process customized to CHEER, COVID disrupted the momentum of this process at nearly same the time those protocols were to be put in place. The demands of COVID on the CHEER organization, combined with the need to completely overhaul the client case finding process for WeCare, led CHEER to the decision to withdraw and recommend EHRI to continue in a lead role.

DESCRIPTION OF YEAR 2 TRANSITIONAL APPROACH

At what would have been the start of year 2, efforts were underway for EHRI to take the lead formally with the ACL grant, and with a local funding partner who had committed the required match for the project. During this period of transition, vetting for a new Title III meal service partner informally began on the part of EHRI. There are only four such providers in the state of Delaware, two of which are in Sussex County. In addition to CHEER, the other Sussex-based organization is much smaller in scope than CHEER and did not have the capacity required to move forward during the chaos of the COVID-19 pandemic.

In the Fall of 2020 the Modern Maturity Center, LLC (MMC), located in Kent County, Delaware, was selected to take the place of CHEER in recruiting and servicing WeCare clients. MMC serves as a primary senior service provider in central Delaware, and administers a variety of social, recreational, fitness and educational opportunities, as well as adult day care services, caregiver resources, and an early memory loss program. MMC also serves as the lead provider organization for the area's homebound meal delivery services, through the state's Title III, OAA program.

While Sussex County is experiencing the largest percentage increase of older adults in Delaware, Kent County is home to many lower income and rural seniors. As of 2019, Kent County's percentage of older adults 65 and older (65+) is about 18 percent (US Census, Retrieved November 30, 2021). The county is home to approximately 19 percent of the state's total low-income seniors (ACS, 2021). As the area's older adults age, these demographics are important considerations for addressing long-term health and nutrition needs.

Simultaneous with the ERHI leadership transition, and in conjunction with MMC's new partnership, a review of year 1 goals and objectives was conducted and thereafter updated to reflect a new partnership agreement between primary project partners in conjunction with the aims of the ACL grant. In addition to a memorandum of understanding between EHRI and UD (represented by three organizational units) that documented UD's role in carrying out an evaluative strategy and summary of years 2 and 3 of the federal grant, EHRI collaboratively developed an amended work plan that detailed program goals and related activities (see Appendix 1).

Therefore, the beginning of year 2 involved a coalescing around MMC staff and resources, a newly hired nurse advocate, and bridging existing client connections with the recruitment and services to be offered within a new service area.

Similar to the year 1 report, data for this report is generated from multiple sources. Based on year 2 program goals and processes, data described and analyzed in this document include: 1) client interviews; 2) nurse advocate interviews and related content provided by WeCare; 3) client baseline data review and collection using Delaware Health and Social Services Home-Delivered Nutrition Services Specifications; 4) participant registration data regarding status of their medical home; and, 5) logs of nurse advocate weekly calls to participants. Data collection efforts are detailed in a subsequent section of this document.

The following section details the program strategy processes developed and facilitated during year 2.

PROGRAM STRATEGY PROCESSES

This section provides an overview of the core processes used in the operation of the program in year 2. Changes in processes from program inception are identified and described.

Given the transition in partnership to MMC, the hiring of a new nurse advocate, and the new project lead (EHRI) year 2 was in many ways a start-up year during which new systems and relationships needed to be forged, and with consideration to the ongoing COVID-19 pandemic.

Notably, and in August 2020, in the midst of the COVID-19 pandemic and prior to the beginning of year 2, a new WeCare nurse advocate was hired. To introduce the newly hired nurse advocate to

the various project partners and organizational staff, a virtual "meet and greet" was held that same month, prior to MMC taking over as the lead service organization. Upon the transition from CHEER to MMC, several meetings were held to help connect the nurse advocate with MMC staff responsible for outreach and referral of MMC's homebound nutrition program.

Many facets of the context in which MMC operates, including logistical operations, differ from CHEER's; e.g., data sharing approaches, communication mechanisms and the role of delivery drivers. The WeCare model organically shifted as part of this transition. The CHEER operational model meant that drivers were both less centralized and generally more independent; they also had access to software to manage their routes and report changes in client conditions that would initiate a check-in from the nurse. Further, drivers traveled further between client homes due to the rural geography of the area, and, saw fewer clients as a result.

As WeCare shifted to MMC at the start of year 2, the process continued to focus on homebound meal delivery clients as the primary recruitment pool; however, some of the approaches to conducting that recruitment, and reporting changes in conditions, shifted to be more personalized. This model shift was needed in part too because volunteers had more limited contact with households during the COVID-19 pandemic.

At MMC a cohesive link exists between the agency point person and the drivers such that drivers can call and make a verbal report regarding a client's condition to a centralized individual who then is able to direct concerns to the nurse advocate. This process is distinct from year 1 when it was the role of the volunteer drivers to address many facets of the program's operations including recruitment, intake and/or referrals related to the WeCare program. In the MMC model, the nurse advocate became the primary source and connection with MMC's homebound clients in signing up for WeCare.

During the year 2 time frame, the nurse advocate has essentially served as an intermediary between clients and other service providers, including assuring the availability of a medical home. She has become a critical liaison and support system to ensure older adult community members: are connected with appropriate health and social services; receive both regular check-ins and follow up; and, are supported in establishing and working with their medical home. This has been particularly

important during the COVID-19 pandemic when individuals' vaccine outreach and transport were restricted due to physical distancing measures; the nurse advocate's partnership activities served to address these needs at the start of year 2 efforts. Daily, the work of the nurse advocate includes regular calls to clients, and outreach/referral to other medical and social service providers such as home healthcare resources and medical providers. Phone work is voluminous. Interactions between clients, the nurse advocate, and doctors is cumbersome, marked by frequent messages, call backs, and phone trees – all of which are difficult for the client to navigate alone. Of equal importance is that many phone calls address basic living needs and issues related to social determinants of health.

RECRUITMENT AND OUTREACH STRATEGY: HOMEBOUND CLIENTS

Whereas the year 1 program sought to empower Meals on Wheels volunteers to be the "eyes on the ground," the shift in the primary service provider from CHEER to MMC also shifted some responsibilities away from the volunteers. With respect to recruitment, these efforts relied instead on a strong partnership between MMC staff and the nurse advocate, and were complimented by outreach conducted by volunteers (see Appendix 2 for Homebound Meals Delivery Notification Card). Specifically, several approaches were undertaken to identify potential WeCare clients in year 2. First and at the program's onset, MMC identified points of data, and times, when client case review is routine and recurring. When these MMC screening revealed needs, the client was referred to the nurse advocate. For existing MMC clients, the nurse advocate and volunteers both went directly to their homes and rapidly recruited new WeCare participants. Recruitment efforts also relied in part on assessments conducted by a State of Delaware nutritionist who completed dietary assessments and conducted a food insecurity screen. When resulting data triggered concern, patients were referred to Meals on Wheels and, at the same time, referred to the nurse advocate for outreach and potential participation in the WeCare program. All members of the research team, including the nurse advocate, completed human subject's research training protocols (i.e., CITI).

As shown in Table 1, participant enrollment during year 2 occurred largely during December 2020, January 2021, and March 2021, and through September 2021, enrollment is at slightly over 100 participants among the three programs currently or formerly affiliated with EHRI. EHRI secured patient consent from clients identified during year 1's CHEER partnership, so that the clients who were initially involved in the program could continue to receive services despite program shifts. Table 1 includes a small number of WeCare clients who were referred from the La Red Health

Center. WeCare and La Red are co-located at the Milford Wellness Village; further, these clients receive primary care services from La Red.

TABLE 1: WECARE CLIENTS ENROLLMENT BY DATE AND LOCATION

Monthly Enrollment	MMC	La Red	CHEER
August, 2020	0	0	8
September, 2020	0	0	1
October, 2020	0	1	0
November, 2020	0	0	0
December, 2020	34	0	0
January, 2021	11	0	0
February, 2021	0	2	0
March, 2021	19	0	0
April, 2021	4	0	0
May, 2021	0	0	0
June, 2021	6	0	0
July, 2021	5	0	0
August, 2021	1	0	0
September, 2021	9	0	0
Enrollment date not indicated	1	0	0
Sub total	90	3	9
Total enrolled	**102**		

TRACKING PROGRESS AND IMPACTS: YEAR 2 DATA COLLECTION

Researchers at UD completed four data collection and analysis efforts over the past year. These data sources included: 1) client interviews; 2) nurse advocate interviews and related content provided by WeCare; 3) client baseline data review and collection using Delaware Health and Social Services Home-Delivered Nutrition Services Specifications; 4) participant registration data regarding status of their medical home; and, 5) logs of nurse advocate weekly calls to participants. A review of each effort and its findings is presented below.

1. CLIENT INTERVIEWS.

To better understand the personal experiences of WeCare clients and the program itself, UD conducted qualitative interviews with participants, pursuant to the expectations set in the project's IRB submittal. UD worked with MMC to identify WeCare program clients who would be willing to have a brief conversation via phone about the WeCare program in general as well as its strengths and weaknesses.

Five clients (5% of the sample) were contacted by MMC to gauge their interest in participating in these phone interviews and, if interested, let them know that a member of the UD team would be contacting them soon. The qualitative interviews followed an interview guide developed by the UD team (Appendix 3). The guide consisted of 11 questions and focused on the client's personal experiences with the WeCare program and its staff. Each interview began with securing the client's understanding of and consent to participate (Appendix 4); each one lasted around ten minutes (although interviews were not restricted to this timeframe), and were recorded via a portable recorder. These interviews were transcribed by a third-party service which allowed the UD team to conduct thematic analysis.

The two common themes from the interviews are presented as follows:

a. *Clients benefit from WeCare's weekly, individualized check-in calls*. Many clients appreciate having somebody outside of their family and personal network to check on them. These calls, conducted by the nurse advocate, allow the client to air any concerns about their health or home condition, connect with greater resources in their community, and receive assistance with medical services that they may need (e.g., refilling prescriptions or scheduling appointments with their primary care provider). This appreciation was expressed by one client specifically who, when asked about the weekly calls, said that they:

> *"...really made me feel good because I didn't even know her. She was a stranger to me and that she cared enough to keep calling ... And she would always build me up."*

Another client expressed that the weekly calls had been of assistance; for example:

> *"I have to use a CPAP machine and I've had a lot of trouble getting the machine that I have repaired. It took five and a half months and she made calls for me and spoke with my doctor and spoke with the people who were going to repair it. And she just took a lot of the frustration off my shoulders that I was having with the company."*

b. *Clients would benefit from a greater understanding of the WeCare program.* When clients are enrolled they may not fully understand why they have been referred into this program, what services are offered through WeCare, and how to better engage in the program. With an improved knowledge of WeCare, clients would be better equipped to benefit from the program. A few clients indicated that they did not remember enrolling in WeCare or know what it was. When asked about why they enrolled in WeCare, one client said,

> *"...now what is WeCare? Now tell me again."*

One reason why it might be challenging for clients to realize, and restate, the nature of the services is that, when done well, "care coordination" is relatively difficult to describe. It should appear relatively seamless to the senior, or vulnerable client, in such that their issues are handled in a way that does not overly burden them, and at times may not even be called to their attention in a significant way.

2. NURSE ADVOCATE INTERVIEWS AND RELATED CONTENT

Over the course of two meetings on January 12 and February 12, 2021, UD staff collected qualitative data and narrative surrounding the nurse advocate's work. Analysis of the meeting recordings identified the following four themes that are described as follows; these themes were confirmed by the related content provided by WeCare. It is notable that these themes are not an exhaustive list of WeCare's strengths; however, they do represent four core areas of the WeCare program.

a. *The program has succeeded in creating a collaborative relationship between WeCare, MMC, physicians, insurance companies, home health agencies, and clients.* It is recognized that at times a significant disconnect exists between an understanding of the services and care that are provided by insurance companies, what the client health care needs are, and

healthcare providers' time, availability, and responsiveness to be able to address concerns efficiently and in a cost-effective manner. Providing a continuum of care and responding to needs can be overwhelming and patients can have a difficult time receiving coordinated care. The work of the nurse advocate fills this gap, and field notes and contextual information from interviews provides some strong examples. WeCare is a community resource for those that might need information about a spectrum of resources beyond healthcare alone. This allows for information to be provided about other social services that are not covered benefits in the healthcare system per se, but would ultimately improve quality of life and well-being.

In one case, WeCare, through the nurse advocate, coordinated husband/wife cancer care, so they went to the same oncologist instead of two different providers. WeCare communicated with their primary care physician for home health care assessment and service provision when the husband's condition weakened. Specifically, the couple was connected with an occupational therapist, physical therapist, home health nursing, and home health aides who, in total, helped the husband get stronger and relieve his wife of some caretaking duties.

In another example, an oxygen-dependent WeCare client was being removed from their home due to personal circumstances. The nurse advocate coordinated with housing management, doctor's office, social services and the client themself, resulting in multiple agencies working together to find the client a place to live so that they did not face homelessness.

In a final example, one of the challenges that many seniors face in being self-advocates, was when a client's scheduled home health assistant did not show up on two consecutive Fridays, they contacted the nurse advocate who in turn coordinated with the home health agency to resume the weekly Friday visits.

b. *Through a myriad of examples, findings show that WeCare clients receive assistance and necessary services that they may not have received otherwise.* For example, the nurse advocate has facilitated the refill and delivery of clients' prescriptions, from the Veteran's

Administration and other providers, so that clients did not experience an interruption in their medications and resulting in better pain management as well as overall stable or improved health. Especially during the COVID-19 pandemic, this was crucial as many people were unable to visit pharmacies or leave their homes. In another example, and when a client's Continuous Positive Airway Pressure (CPAP) machine had not worked properly for weeks, the nurse advocate coordinated with the client's doctor to obtain a suitable CPAP machine. Prior to enrolling in WeCare, this patient indicated that they did not necessarily need the services but now realized their benefit, and requested enrollment eligibility information to give to friends and family. The final group of examples includes when the nurse advocate assisted, and continues to assist, a client with routine replacement of their hearing aid battery. Or, when the urgent nature of another client's diabetes-related toe and finger infections were not being considered by the podiatrist's office when scheduling appointments, the nurse advocate secured a timely appointment and also made sure the client received an over-the-counter medication to use in the interim. In another example, the nurse advocate connected clients with transportation services, bereavement groups, and employment opportunities through the Senior Community Service Employment Program.

c. *WeCare provides a support system outside of family/friends, creating a level of comfort for them to reach out for help when needed.* For example and when explaining the WeCare program to potential participants, the nurse advocate most often hears,

"Are you really sure someone will be checking on me every week? It's about time."

In additional examples, the nurse advocate took a client to out-patient surgery and followup appointments since the client did not have friends or family on whom to rely. Or, the nurse advocate coordinated with a client's physician to arrange for a home health aide since the client's daughter was no longer able to provide the care. The nurse advocate ensured that someone called the client in the interim. The nurse advocate has also assisted a client, new to Delaware, in receiving a needed weekly shot from a hematologist.

d. *The WeCare program provides a network to monitor and respond in cases of clients' decline or change in health.* For example, MMC staff informed the nurse advocate about a client who did not respond during social activities and was otherwise isolating themselves. The nurse advocate coordinated with the client's physician for evaluation and hearing aids; it turned out that they had lost 60% of their hearing function. In another example, the nurse advocate assisted a client to secure a reputable home health service, and connect him to housing services to assist with rent payment since the client had experienced financial theft. However, and in spite of the nurse advocate's best efforts, some advocacy efforts do not succeed. In another example, the meals on wheels driver found a client was confused and unkempt, resulting in a referral to the nurse advocate who worked with the client's primary care provider to establish home health aide services. A final example is when the nurse advocate attempted to establish four hours of in-home healthcare each week for a diabetic client who had to have two toes amputated. However, the physician's office did not provide the needed justification and WeCare was left with few options to further support the client.

3. CLIENT HEALTH STATUS: BASELINE AND 6-MONTH FOLLOW-UP DATA REVIEW AND COLLECTION.

Using Attachment H (Appendix 5) of Delaware Health and Social Services' Home Delivered Nutrition Services Specifications, UD collected and analyzed data related to participants' health status, food insecurity, and changes thereto from MMC.

CHRONIC CONDITIONS AT BASELINE

As shown in Table 2 below, WeCare clients at baseline (i.e., at or close to enrollment in the WeCare program) reported considerable disability and/or morbidity, reflecting a high level of risk for advanced healthcare needs. More than three of every four clients (77.3%) reported having hypertension. Other commonly reported chronic conditions reported were COPD (45.2%), diabetes (31.1%), stroke (28.1%), and neurological disorders (23.6%). The vast majority of clients reported having some type of physical dependence (93.5%) and over half were visually impaired (53.2%).

When looking at all reported chronic conditions, most of the WeCare clients reported having more than one chronic condition (85.4%), and of those with multiple conditions most had three or four. Data show that 18.8% of WeCare clients have two chronic conditions, 27.1% have three conditions, 37.3% have four conditions, and 8.3% have five conditions.

TABLE 2: CHRONIC CONDITIONS OF WECARE CLIENTS AT ENROLLMENT

Condition	Yes, Frequency (%)	Total
Physical Dependence	72 (93.5%)	77
Hypertension	58 (77.3%)	75
Visual Impairment	33 (53.2%)	62
COPD	28 (45.2%)	62
Diabetes	19 (31.1%)	61
Stroke	16 (28.1%)	57
Neurological Disorder	13 (23.6%)	55
Cancer	10 (17.9%)	56
Renal Failure	9 (16.4%)	55

FOOD INSECURITY RISK AT BASELINE

In addition to the chronic conditions, UD also examined food insecurity data from clients; responses were given to these statements that are based on the validated, two question Hunger Vital Sign™ screener: "We worried whether our food would run out before we got money to buy more" and "The food that we bought just didn't last, and we didn't have money to get more." Responses at baseline indicated that 48.08% (25) of WeCare clients, with data, were not concerned about food insecurity. However, 51.92% (27) indicated that they "sometimes" or "often" were concerned about food running out before getting money or that the food they had would not last.

FALL RISK AT BASELINE

While the WeCare program does not specifically address fall risk, fall risk is a major concern related to both health care costs and healthy aging at home. Further, the data is an indicator of overall frailty. Data on fall risk upon arrival to the WeCare program showed a high risk;

i.e., nearly 91% of clients were determined to be at moderate or high risk for falls. The majority of clients (71.4%) were at moderate risk for falls, while 19.5% at high risk for falls. Only 9.1% were determined to be at no risk for falls.

ADLS AND IADLS AT BASELINE

Finally, we examined the extent to which clients were able to perform both activities of daily living (ADLS) and independent activities of daily living (IADLS), and calculated total risk scores (Table 3). ADLs include self-care tasks such as bathing, dressing, grooming and feeding, while IADLS include tasks that are integral to maintaining an independent household such as using the telephone, shopping for groceries, preparing meals, and doing laundry.

An inability to perform basic ADLs is associated with a higher risk for functional decline, including hospitalization, and therefore is relevant to the WeCare program which seeks to reduce healthcare costs while maintaining well-being.

The state required assessment, which is different than the common Lawton Scale, includes six ADL items which are scored as either 0 (performs independently), or 3 or 5 (dependent on support to perform task), resulting in a score ranges of 0-30 for ADLs. The score range for IADLs is calculated using eight total items, also scored on a 0 (performs independently), or 3 or 5 (dependent on support to perform) point scale, resulting in a range of 0-40 possible points. Together the range is 0-70. Those with total scores over 40 are automatically eligible for Title III home delivered meals.

TABLE 3: ADL AND IADL SCORES AT BASELINE

Variable	Baseline (mean, SD)	Total possible score (lower = less functioning)
ADLs	8.42 $\pm$6.00	30
IADL	20.81$\pm$6.78	40
Total Score	49.07$\pm$11.30	70 (>40 receives meals on wheels automatically)

4. PARTICIPANT MEDICAL HOME STATUS.

As shown in Table 1, 102 persons are currently enrolled in WeCare representing affiliation with three programs, primarily MMC. All of these participants have a medical home with a primary care provider or specialist as determined by their current situation. Further, the nurse advocate facilitated establishment of a medical home for twelve (13.3%) of the 90 participants affiliated with MMC; i.e., those who enrolled in WeCare since the start of year 2.

5. NURSE ADVOCATE WEEKLY CALL LOGS.

In order to understand the type and volume of calls made by the nurse advocate, the evaluation team examined the call-logs associated with the daily/weekly contact calls made to clients or made on clients' behalf to other service providers in order to resolve issues, make appointments etc. Data from the logs of these client calls are summarized in Table 4 below.

During the 13-month period (i.e., August 2020-September 2021) covered by this report, the nurse advocate made 3,085 phone calls to WeCare participants. The vast majority of these phone calls (2,879 or 93.3%) of these calls were categorized as a general client check-ins and often included leaving a message for the client. Many however, were related to solving a particular issue, whereby 352 (11.4%)of the calls were wellness/prevention, including COVID -19 vaccine discussions and annual medical wellness visits scheduling. Further, 175 (5.7%) of the calls were for assisting clients with coordinating their medical appointments. Other calls that directly impacted the client's quality of life included 20 calls (0.6%) for transportation support, 25 calls (0.8%) for housing support, and 28 calls (0.9%) for medical equipment. Fifty-one calls (1.7%) were made to assist clients with their medication and 93 calls were follow ups to hospitalizations.

TABLE 4: WECARE CALL LOG TOTALS, AUGUST 2020-SEPTEMBER 2021

Type of Call	Frequency	Percent
General check-in or left message	2879	93.3%
Other	246	8.0%
COVID-19 Discussion	184	6.0%
Support with MD appointments	175	5.7%
Hospital related	93	3.0%
Medicare annual wellness visit	68	2.2%
Medication related	51	1.7%
Medical equipment related	28	.9%
Medical advice	27	.9%
Housing support	25	.8%
Transportation support	20	.6%
Total Calls	3085	

WHAT WE LEARNED: LESSONS FROM YEAR 2 TRANSITION

Because evaluation should inform not just outcomes but also processes in an ongoing way, the evaluation team recognizes that transition between providers as well as during the COVID-19 pandemic has resulted in considerable learnings and strategic pivots.

Not surprisingly it is clear that transitions in primary partners can heavily influence recruitment of new clients, outreach to existing clients, the role and approaches of the nurse advocate, data collection efforts, and overall shifts in program processes. Between the time of program inception and now, several significant shifts have occurred in the operation of the program, perhaps most notably the pivotal role of the nurse advocate who stands out as a pillar of support for WeCare clients. This relationship too between the nurse advocate and MMC is foundational to the program's ability to smoothly and efficiently serve clients. Related are the mechanisms of data collection and data management efforts across partners, which too requires alignment and coordination.

It remains of critical importance that data collection efforts and organization of information collected and tracked over time is done so systematically, consistently, and is conceived collectively and early on in the process – particularly when adding new clients and in taking on significant outreach and referral activities (also reported as part of Lesson 6 of year 1). Related, partners must share common definitions and a common understanding of data collection objectives, timeframes, and information sources.

During the second year of the program, many data quality and extraction challenges that were inherent in the ServTracker system (used in year 1) were ameliorated. However, shifting to a new partnership required new data management conversations as well as clarifications of processes and data sharing agreements. Efforts to collect health data (e.g., Attachment H) referral information, call information, and related program process data is still segregated. While partners are coordinated and cooperative, tracking mechanisms across all systems remain as components and are not yet part of a comprehensive, systems approach. As the project moves into its third year, careful consideration will need to be given to the extent to which aspects of the model can be refined to maximize sustainability and replicability.

CONCLUSIONS

Despite considerable shifts in the programs' operation partners and resulting processes, as well as challenges related to volunteers' ability to interface with high-risk homebound clients, considerable and critical efforts were undertaken to support clients. Overall, it is notable that the unexpected timing of a staff vacancy at year 2's start allowed EHRI to refine staffing needs such that the new nurse advocate was able to establish a trusting relationship with both existing and new clients as well as the meal service organization, a key component for the current WeCare program as well as any others seeking to replicate it.

Data from client interviews and nurse advocate interviews corroborate evidence from health intake assessments that clients are high need with multiple (often three or more) co-morbidities requiring regular communication (over 3,000 phone calls) and constant outreach to maintain strong, trusting relationships as well as to actively coordinate care. While many in the healthcare sector would agree that care coordination is critical, the evidence gathered through the WeCare program during year 2 enhances our understanding of the levels of chronic conditions and types of health care challenges,

as well as care management issues that clients face on a regular basis, all in order to avoid more costly ER visits, falls, and related hardships. The nurse advocate, along with the MMC partnership team, have undertaken critical efforts to: share knowledge of conditions and needs with other members of the care team; ensure seamless and low-stress transitions in providers and care; improve collaboration in a more personalized and proactive way such that health care needs are addressed proactively (vs. waiting for an acute issue that requires an ER visit); support patient mental health; ensure client healthcare goals and stressors are considered and addressed; and, connect with community resources, such as housing or other critical services. These efforts and coordination are advancing an improved patient experience in terms of both care quality and satisfaction. They are an important step toward closing gaps in care. Such efforts have been documented by the American Nurses Association and others to result in: fewer ER visits; greater confidence in self-managing care; reductions in overall costs and charges for care; and, improved survival rates for the patients themselves.

Over the next six months, UD will examine follow up data on patients enrolled in MMC who have undergone a second assessment of ADL, IADL, health status, and related indicators. We hypothesize that patient health and activity status, as a result of the WeCare program's work, will result in stable data (i.e., not declining with age as we might expect), and, perhaps, for some, improvements in scores. Early analysis of the 31 clients with some follow-up data show, for example stability in total ADL and IADL scores with some suggestion that ADL's may be declining as shown in Table 5 below.

TABLE 5: MAINTENANCE OF CONDITIONS FROM ENROLLMENT TO 6 MONTHS

Variable	Baseline (mean, SD)	6 months (mean, SD)	Significance (p value)
ADLs	8.42 ±6.00	8.00±4.45	0.54
IADL	20.81±6.78	20.48 ±7.16	0.74
Total Score	49.07±11.30	49.59±9.75	0.78

Data show conclusively that to date, WeCare bridges a substantial gap between clients and the various needs and institutional supports that impact their daily life. Time and time again, WeCare has helped clients to secure required medications resolved health issues that otherwise would have left clients without needed care or resources, resolved confusion or issues with insurance agencies, supported communication with home health agencies, and physicians to ensure the best possible care for WeCare clients.

APPENDIX 1: 2020-2022 WORKPLAN

ACL-INNU WORKPLAN
October 2020 – August 2022 (rev 03.02.21)
Quarters equal (Q1=Sept-Nov, Q2=Dec-Feb, Q3=March-May, Q4= June-Aug)

Goal 1: Improve health and well-being of 200 homebound seniors in Kent County, DE (via their WeCare participation)

Objective 1:
Utilize Home Delivered Meal **(HDM) volunteer drivers to identify** seniors for WeCare program participation.

Strategy 1:
Train volunteer HDM drivers to outreach for the WeCare program.

Expected Outcomes:
Leveraged, no-cost, outreach team with "eyes and ears" directly in the community.

Objective 1, Strategy 1, Activities	Lead Party	YR2				YR3				Progress or Process Measure(s)
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Activity 1.1.a Identify HDM routes, and drivers for WeCare training.	Modern Maturity Center (MMC)		x	x	x					• Net # of drivers trained • Gross # of clients who receive WeCare promotional material/information
Activity 1.1.b Gather and/or survey HDM volunteer drivers for continuous feedback about experiences.	MMC		x	x	x					• Feedback from drivers that informs program development
Activity 1.1.c Annually recognize volunteers for donated service.	MMC/ EHRI				x					• Min 1 driver per year acknowledged by Project Team for contributions.

Goal 1: Improve health and well-being of 200 homebound seniors in Kent County, DE (via their WeCare participation)

Objective 2
Utilize **other MMC personnel/processes to identify** seniors for WeCare program participation.

Strategy 1:
Complete data mining and process mapping to identify additional opportunities for targeted WeCare outreach.

Expected Outcomes:
Integration of WeCare client outreach and referral within Modern Maturity Center organization.

Objective 2, Strategy 1, Activities	Lead Party	YR2				YR3				Progress or Process Measure(s)
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Activity 2.1.a Review Database to target high risk clients based on established risk criteria.	MMC	x	x		x					• Alternative method to identify potential clients for WeCare service.
Activity 2.1.b Identify MMC service lines w/ implicit client screening/assessment processes in which to build a WeCare referral prompt(s).	MMC		x							• Alternative method to identify potential clients for WeCare service.
Activity 2.1.c Train indicated staff and provide WeCare support materials.	MMC		x							• Inhouse familiarity with WeCare as a client resource. • Training conducted. # Trained.
Activity 2.1.d Create/utilize method to capture source of referral and assess outreach efficacy.	MMC		x	x	x					• # of referrals made by source • # of clients connected,
Activity 2.1.e Create & maintain info. sharing mechanism between Nurse Advocate & referral staff.	MMC/ EHRI		x	x	x					• Feedback loop created that facilitates continuous communication about client.
Activity 2.1.f Assure HDM drivers know which clients on their routes are in WeCare.	MMC/ EHRI		x	x	x					• Feedback loop created that facilitates continuous communication about client.

Goal 1: Improve health and well-being of 200 homebound seniors in Kent County, DE (via their WeCare participation)

Objective 3:
Utilize Home Delivered Meal **(HDM) volunteer drivers to observe & monitor** signs/signals of need/distress in WeCare program participants.

Strategy 1:
Train volunteers to assess/report any observed signs of need/distress in WeCare program participants.

Expected Outcomes:
"Eyes and Ears" in the community help to alert the WeCare Nurse Advocate to concerns, and prevent crisis.

Objective 3, Strategy 1, Activities	Lead Party	YR2				YR3				Progress or Process Measure(s)
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 1	Q 2	
Activity 3.1.a Define process to communicate signs/signals observed by drivers to the Nurse Advocate.	MMC		x							• Gross # reported observations • Reports identify category of observation • Periodic case review/highlight of examples
Activity 3.1.b: Create two-way info. sharing mechanism between Nurse Advocate & HDM drivers.	MMC/ EHRI		x							• Feedback loop created that facilitates continuous communication about client.

Goal 1: Improve health and well-being of 200 homebound seniors in Kent County, DE (via their WeCare participation)

Objective 4:
Establish a Nurse Advocate 1:1 relationship with every WeCare participant.

Strategy 1:
WeCare Nurse Advocate obtains Client Consent, completes Assessment, prioritizes needs, and creates unique client record.

Expected Outcomes:
Unique client records are created for each WeCare participant.

Objective 4, Strategy 1, Activities	Lead Party	YR2				YR3				Progress or Process Measure(s)
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Activity 4.1.a Build a custom data solution for client information and management reporting.	EHRI	x								• Client Data system created
Activity 4.1.b Create standard materials including information sheet, consent, and assessment tool.	EHRI	x								• Informational materials, and standard program forms developed.
Activity 4.1.c Uniform completion of clinical assessment of client's health status, risk(s), problems & goals.	EHRI		x	x	x					• Identification of chronic conditions • Level of acuity/risk assignment • Categorized needs/problems.
Activity 4.1.d Provide weekly update to MMC regarding client participation status. Complete month end reconciliation.	EHRI									• Total# referred, by source, and total # enrolled.

Goal 1: Improve health and well-being of 200 homebound seniors in Kent County, DE (via their WeCare participation)

Objective 4:
Establish a Nurse Advocate 1:1 relationship with every WeCare participant.

Strategy 2:
Assure that every client has an effective, active, Primary Care Provider (PCP) relationship.

Expected Outcomes:
Access to primary care is associated with positive health outcomes. Primary care providers offer a usual source of medical care, early detection and treatment of disease, chronic disease management, and preventive care. (Healthy People 2030)

Objective 4, Strategy 2, Activities	Lead Party	YR2				YR3				Progress or Process Measure(s)
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Activity 4.2.a Facilitate **PCP linkage** for any client w/o effective relationship.	EHRI		x	x	x					• Net # of PCP assignments
Activity 4.2.b Encourage use of LaRed for PCP, behavioral health, & dental.	EHRI		x	x	x					• Net # of LaRed placements • Informational piece about LRHC services
Activity 4.2.c Create and pilot a co-located project w La Red to field test, point of service coordination.	EHRI/ LRHC			x	x					• Model for completing inperson nurse coordination immediately subsequent to PCP visit, for possible expansion to other PCP sites.
Activity 4.2.d Establish/maintain information-sharing with PCPs on behalf of WeCare clients.	EHRI		x	x	x					• ↑ provider awareness of WeCare program. • Form letters to share key case information w/ provider.
Activity 4.2.e Facilitate client completion of **Medicare Annual Wellness Visit.**	EHRI			x	x					• Assistance to client to prepare for the MAWV • Net# MAWV scheduled & completed.
Activity 4.2.f Incorporate followup priorities from the MAWV into the client care plan.	EHRI			x	x					• Assistance to client to follow-through w/ advice, after the MAWV.

Goal 1: Improve health and well-being of 200 homebound seniors in Kent County, DE (via their WeCare participation)

Objective 4:
Establish a Nurse Advocate 1:1 relationship with every WeCare participant.

Strategy 3:
Maintain routine contact, provide resource and service linkage, provide client follow up, respond to HDM volunteer driver alerts, and documents all client encounters.

Expected Outcomes:
Care coordination facilitates client's service needs, improves adherence and health literacy, facilitates chronic condition self-management, and improves clients self-reported health status.

Objective 4, Strategy 3, Activities	Lead Party	YR2				YR3				Progress or Process Measure(s)
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Activity 4.3.a Create and manage individual care plans.	EHRI		x	x	x					• Client record established for every WeCare participant. • % goal completion.
Activity 4.3.b Identify community resources to support client needs and goals.	EHRI		x	x	x					• A local resource network to which to refer clients and/or seek supports on behalf of clients.
Activity 4.3.c Provide transportation as indicated to facilitate clients' access to services.	EHRI		x	x	x					• # transports provided and why
Activity 4.4.d Identify and implement strategies to use technological tools (in targeted client homes).	EHRI/ PROJECT TEAM		x	x	x					• cellular enabled i-pads? smart phones? • adopt some of the strategies used by the previous INNU grantees, or others?

Goal 2: Contain and/or Reduce the Health Costs of We Care Participants.

Objective 1:
Evaluate the impact of WeCare participation on **client primary care and prevention utilization**.

Strategy 1:
Nurse Advocate maintains data about PCP, MAWV, continuum of care, and community resource linkages.

Expected Outcomes:
PCP utilization increases as result of Nurse Advocate intervention(s). Nurse Advocate relationship enhances client adherence to PCP recommendations and appointments.

Objective 1, Strategy 1, Activities	Responsible Party	YR2				YR3				Progress or Process Measure(s)
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Activity 1,1,a Nurse Advocate 1:1 relationship with client fosters effective use of PC.	EHRI		x	x	x					• Net # of WeCare clients. • Net new PCP placements • Net # MAWVs completed
Activity 1.1.b Nurse Advocate to serve as liaison between client and PCP to support provider identified priorities, and client identified concerns.	EHRI		x	x	x					• Net # PCP interactions on behalf client • Net # client interventions on behalf PCP
Activity 1.1.c Coordinate with UDE Evaluation team to collect and assess process measures and qualitative feedback from clients, PCPs	EHRI/UDE									• Identification of metrics, data collection processes, production, and format for routine short-term, and annual, progress reporting.
Activity 1.1.d Request health plan data on volume and costs of Primary Care/Medical Home visits in any setting for all clients at 1 year of WeCare participation.	EHRI/ MCOs					x	x	x		• Longitudinal information from indicated MCOs about client's PCP utilization levels and costs pre and post WeCare participation.

Goal 2: Contain and/or Reduce the Health Costs of We Care Participants.

Objective 2:
Evaluate the impact of WeCare participation on **client utilization/consumption of high-cost, health care**.

Strategy 1:
Analyze pre- and post- WeCare data about a) emergency department visits, b) hospital admissions, c) home health interventions, and d) skilled nursing facility admissions.

Expected Outcomes:
Net number of high-cost health episodes 1 year pre- and post client WeCare participation is the **same or less** in volume & cost.

Objective 2, Strategy 1, Activities	Responsible Party	YR2				YR3				Progress or Process Measure(s)
		Q 1	Q 2	Q 3	Q 3	Q 1	Q 2	Q 3	Q 4	
Activity 2.1.a Request health plan data on volume and costs of ED use, inpatient stays, home health interventions, and SNF admissions at 1 year of WeCare participation.	EHRI/ MCOs					x	x	x		• Longitudinal information from indicated MCOs about client's utilization levels and costs pre and post WeCare participation.
Activity 2.1.b Determine feasibility of a pilot project with La Red, to solicit medical record information, including admissions data from the DE Health Information Network, on shared clients.	EHRI		x	x	x					• Quality Control measure to spot check accuracy of self-reported information.
Activity 2.1.c Determine requirements and scope of service for a contractual relationship with a financial analyst or other TBD cost/savings evaluator.	EHRI		x	x	x					• framework for cost impact analysis
Activity 2.1.d Assure collaboration between any financial eval contractor and UDE Eval team.	EHRI/UDE									• Identification of opportunities to integrate and reinforce respective' evaluator findings in progress reporting.

Goal 3:
The ACL:INNU Demonstration Project fosters camaraderie, collaboration, and sustainability.

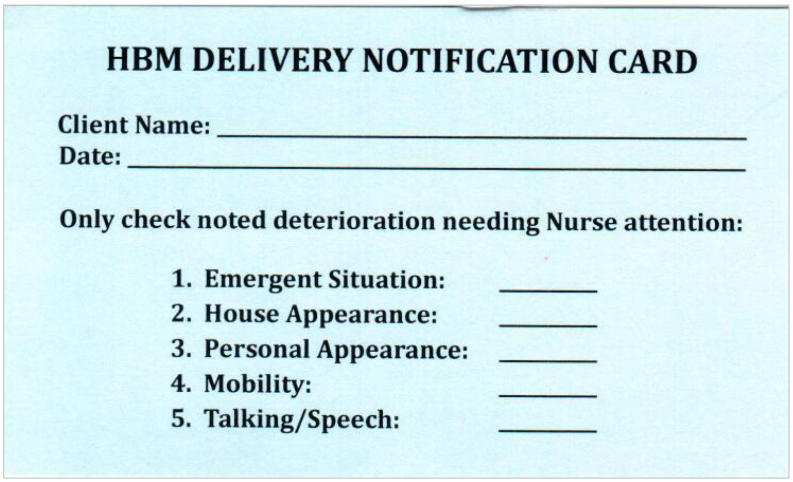
Objective 1
Annually review and update management processes for communication, decision-making, grants management, stakeholder engagement, and program sustainability planning.

Strategy 1
Maintain effective communication with project partners.

Expected Outcomes;
A sustainable, collaborative, program.

Objective 1, Strategy 1, Activities	Responsible Party	YR2				YR3				Progress or Process Measure(s)
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Activity 1.1.a Review and adjust **communication and problem-solving** framework.	EHRI		x							• Differentiation of executive, operational, and stakeholder meetings.
Activity 1.1.b Review **reporting requirements** with ACL:INNU & Highmark	EHRI		x							• Specification of report development responsibilities per funding source.
Activity 1.1.c Refresh individual **partners' roles** in the program to encourage active participation in ctd program development and expansion.	EHRI		x							• Increased participation in relevant meetings. • Updated deliverables to support evolving program needs.
Activity 1.1.d. **Replication Guides and Tools** finalized for sharing with ACL:INNU.	PROJECT TEAM					x	x	x	x	• ACL:INNU deliverables reviewed, compiled, and fulfilled.
Activity 1.1.e Finalize post grant **Transition/Sustainability Plan.**	EHRI					x	x	x	x	• Method/procedures identified to continue Nurse Advocate services to participating clients.

APPENDIX 2: HOMEBOUND MEALS DELIVERY NOTIFICATION CARD



HBM DELIVERY NOTIFICATION CARD

Client Name: _____

Date: _____

Only check noted deterioration needing Nurse attention:

1. **Emergent Situation:** _____
2. **House Appearance:** _____
3. **Personal Appearance:** _____
4. **Mobility:** _____
5. **Talking/Speech:** _____

APPENDIX 3: WE CARE CLIENT SURVEY

Thank you for agreeing to talk with me today. We are having discussions with We Care clients to better understand their experience with the program. This informal discussion will be based on a list of questions and should take no longer than 30 minutes. As we move through the questions, you might recall additional information related to a previous question, so feel free to tell me that.

Also, as a reminder, I am not a We Care staff member and I will not share your name attached with your responses with anyone from We Care or its affiliates. So please feel free to bring up positive or negative experiences -- we really want to learn from you, so it's ok to be honest even if that means being negative. In fact, some of the best information for We Care will be ideas about how to make the program stronger.

Please feel free to let me know if you need a break at any point during our discussion. Ok, let's get started.

1. How did you learn about the We Care program?
2. Why did you decide to enroll in We Care?
3. What was the enrollment process like?
4. Please share an example of how being enrolled in We Care has helped you.
5. Would you also please provide an example, or more than one, of how the We Care program has helped
6. What services do you have from programs or agencies other than We Care to assist you living in your home?
7. What are these programs or agencies?
8. How often would you like someone from We Care to contact you, compared to weekly which is the current rate?
9. Would you recommend a friend to participate in the We Care program? Why or why not?
10. Overall, what do you think about the We Care program?
11. What are the one or two things that the We Care program could do to make the program even more beneficial for you or for other people?

APPENDIX 4: CONSENT, WE CARE CLIENT SURVEY

Thank you for agreeing to talk with me today. We are having discussions with WeCare clients to better understand their experience with the program. This informal discussion will be based on a list of questions and should take no longer than 20 minutes. As we move through the questions, you might recall additional information related to a previous question, so feel free to tell me that. Also, as a reminder, I am not a WeCare staff member, and I will not share your name attached with your responses with anyone from WeCare or its affiliates. So please feel free to bring up positive or negative experiences. We really want to learn from you, so it's okay to be honest, even if it means being negative. In fact, some of the best information for WeCare will be ideas about how to make the program stronger. Please feel free to let me know if you need a break at any point of our discussion. Any questions?

APPENDIX 5: DELAWARE HEALTH AND SOCIAL SERVICES HOME, DELIVERED NUTRITION SERVICES SPECIFICATIONS, ATTACHMENT H

ATTACHMENT H

Client Name: Initial Date of Assessment:

Home Delivered Meals Criteria Guide				Date	Date	Date	Date	Date	Date	Date	Date
I. ADL's (Activities of Daily Living)	**I**	**A**	**D**								
a. bathing	0	3	5								
b. walking	0	3	5								
c. dressing	0	3	5								
d. toileting (bowl/bladder control)	0	3	5								
e. transferring	0	3	5								
f. eating	0	3	5								
II. IADL's (Independent Activities of Daily Living)	**I**	**A**	**D**								
a. use telephone	0	3	5								
b. shopping	0	3	5								
c. meal prep	0	3	5								
d. light housekeeping	0	3	5								
e. heavy housekeeping	0	3	5								
f. travel/transportation	0	3	5								
g. following medication directions	0	3	5								
h. managing own finances	0	3	5								
			ADL/IADL SUM								
III. Prior Nursing Home (or Rehabilitation Facility) Admission											
a. within past year		5									
b. within past 5 years		3									
c. greater than 5 years ago		1									
IV. Cognitive Impairment (0=never 1=sometimes3=often)											
a. Do you forget to eat?											
b. Do you ever begin cooking and then forget you started?											
c. Is preparing food confusing or mentally challenging?											
V. Diagnosed Mental Disorder (bipolar, schizophrenia, anxiety d/o, etc.) Please score if ***actively*** problematic and interferes with the ability to shop, prepare or eat meals. 0=not a problem 3=sometimes a problem 5=often a problem											
VI. Living Arrangement/Caregiver Availability/Meal Support Please score degree of supportive care available (in regard to meals) 0=always 1=sometimes 3=no support available											
VI. Annual Income											
a. at or below current poverty level		3									
b. above the current poverty level		0									
VII. Prior Acute Care Hospitalization											
a. Within past 0-4 weeks		5									
b. Within past 1-3 months		3									
c. Within past year		1									
VIII. Age											
a. 91+		5									
b. 76-90		3									

		Date	Date	Date	Date	Date	Date	Date	Date
XIV. Health									
Please score if *actively* problematic *and interferes* with the ability to shop, prepare or eat meals. 0=not severe 3=moderately severe 5=severe									
a. diabetes (brittle & uncontrolled)	0-5								
b. hypo or hypertension/heart disease (CHF, cardiomyopathy, etc.)	0-5								
c. cancer	0-5								
d. stroke	0-5								
e. COPD	0-5								
f. renal failure/dialysis	0-5								
g. neurological (tremors/palsy/seizure disorder)	0-5								
h. physically debilitating condition (please specify):	0-5								
i. blind or visually impaired	0-5								
XV. Fall Risk. Scoring: 0=no risk 3=moderate risk 5=high risk	0-5								
XVI. <60 Recognized Spouse	NO YES								
XVII. <60 SSI Living in Home	NO YES								
XVIII. Eligible Spouse >60	NO YES								
<40 refer to Congregate >= 40 refer for HDM	**TOTAL SCORE**								
	Recommended for HDM (y=yes, n=no)								
	Initials:								
1. Do you believe client would benefit from socialization at senior center? Comments:	NO YES	**XIX. Outreach Worker Additional Thoughts/Comments:**							
2. Does client need transportation?	NO YES								
3. Do you believe HDM are needed? why/why not:	NO YES								

XX. Food Insecurity Screen: 'I'm going to read you two statements that people have made about their food situation. For each statement, please tell me whether the statement was ***often true***, ***sometimes true***, or ***never true*** for your household in the last 12 months':

1. 'We worried whether our food would run out before we got money to buy more.' ***OFTEN SOMETIMES NEVER***

2. 'The food that we bought just didn't last, and we didn't have money toget more.' ***OFTEN SOMETIMES NEVER***

If 'often or sometimes' is selected for either question, client would benefit from referral to: SNAP, food banks or pantries, or other community-based food assistance resources.