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Innovative Title III Senior Healthcare Program: Year 3 Final Report

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EXECUTIVE SUMMARY

The WeCare program receives federal funding through an Innovations in Nutrition Programs and Services – Research (Innovations) grant administered by the Department of Health and Human Service's Administration for Community Living to support the pilot partnership between Education, Health, and Research International (EHRI; project management and nurse advocate team), Modern Maturity Center (MMC; home delivered meals (HDM) provider), and the University of Delaware (UD; evaluation team) that is designed to support innovative health services provided to vulnerable older adults. Data in this report reflects all three years of program data; however, it both emphasizes the final year of the three-year program (September 2021-August 2022) and builds on themes and lessons learned from the year 1 and 2 reports[1]. Further, our approach is reflective of the Continuous Quality Improvement process described in the Innovations grant program goals, and it aims to inform all involved partners and serve as feedback that may also be utilized by other similar programs and organizations.

Data Examined

The report includes data from several sources, including:

- *Individual health assessment data*: Using Attachment H, Division of Services for Aging and Adults with Physical Disabilities, completed by MMC staff to document the need for HDM, data collected by this form includes, for example, chronic conditions, food security, and fall risk.
- *Client and service call data*: EHRI's nurse advocate team provided routine updates on the nature and frequency of calls to clients and to service providers on behalf of clients.
- *Interviews*: Personal discussions with HDM drivers and MMC case managers were conducted to understand current processes, identify challenges, and recommend improvements.
- *Case studies*: Also using Attachment H, as well as the numerous client and service calls conducted by the nurse advocate team, case studies of five WeCare clients were developed to document the depth and breadth of the program as well as to support accompanying analysis of these services within the context of care costs.

[1] Karpyn A., Orsega-Smith E., O'Hanlon J., Wolgast, H. & Tracy T. (October, 2020). *Innovative Title III Senior Healthcare Program: Year 1 Implementation Lessons Learned and Early Outcomes* (S20-031). Newark, DE: Center for Research in Education and Social Policy.
Karpyn A., Orsega-Smith E., O'Hanlon J., Wolfle B., Seibold M, & Tracy T. (January, 2022). *Innovative Title III Senior Healthcare Program: Year 2 Transition Lessons Learned and Intermediate Outcomes* (T22-001). Newark, DE: Center for Research in Education and Social Policy.

Findings

- The WeCare program assists a significant number of clients who experience a wide range of challenges in key factors that influence their social determinants of health – e.g., complex and interrelated health (both physical and mental), housing, transportation, and nutrition challenges, among others.
- This assistance immeasurably improves the quality of life for vulnerable older adults in a rural area of Delaware, and includes:
    - Tracking and maintaining health conditions from a prevention perspective (e.g., blood pressure monitoring, tabulating reported/recognized symptoms);
    - Communicating/navigating healthcare options (e.g., scheduling primary care appointments, obtaining prescription refills); and,
    - Creating or maintaining connections to social services and public health resources (e.g., addressing accessibility issues, identifying and arranging transportation).
- The WeCare program, over the current 11-month reporting period, provided patient support including over 5,500 calls directly to clients, and another 650 calls to service providers on behalf of clients. In comparison, the program made almost 3,100 calls to clients during the 13-month reporting period represented by year 2.
- Clients' ADL and IADL scores indicated high need, as almost 82% exhibited a high enough score to require HDM services. Some of WeCare's clients maintained their ADL/IADL scores during the WeCare intervention.
- Organizations played unique roles in the process, with an emphasis on the partnership between WeCare's nurse advocate team and the MMC. Communication, and consistent data collection and sharing methods, between and within these organizations, is critical for referrals and reciprocal understanding of needs and conditions.
- With projected increases in the number of seniors who will be aging in place, WeCare is a viable intervention to meet this need.

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 provided to older adults, as supported by an Innovations in Nutrition Programs and Services – Research (Innovations) grant administered by the US Department of Health and Human Service's Administration for Community Living. Information provided primarily represents the third and final year (September 2021-August 2022) of the three-year program and builds on themes and lessons learned from the year 1 and 2 reports[2].

As part of the Continuous Quality Improvement process described in the goals for the Innovations grant program, this report aims to inform all involved partners so that the program can be refined and improved by these partners moving forward, or so it can be utilized by other similar organizations.

YEARS 1 AND 2 RECAP

In 2019, CHEER, an organization located in Sussex County, Delaware that provides a full range of services for mature adults, including HDM and congregate meals as part of the federal Title IIIA nutrition program, was awarded an Innovations grant to develop a wellness benefit program for home delivered meal recipients. The grant-funded program titled "Innovative Title III Senior Healthcare Program" (or "WeCare") represented a partnership between CHEER; Education, Health, and Research International (EHRI); the Delaware Division of Services for the Aged and Adults with Physical Disabilities; LaRed Health Center (a Federally Qualified Health Center); Highmark Delaware; and, the University of Delaware (UD). During year 1 of the program, the COVID-19 outbreak, and the resulting public health emergency declared by the State of Delaware, presented considerable challenges leading CHEER to the decision to withdraw and recommend EHRI to continue in a lead role.

[2] Karpyn A., Orsega-Smith E., O'Hanlon J., Wolgast, H. & Tracy T. (October, 2020). *Innovative Title III Senior Healthcare Program: Year 1 Implementation Lessons Learned and Early Outcomes* (S20-031). Newark, DE: Center for Research in Education and Social Policy.
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Accordingly, and at the start of year 2 (i.e., 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. As one of the lead Title III (of the Older Americans Act (OAA)) providers in Delaware, 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. From a nutrition perspective, MMC also serves as the lead provider organization for the area's congregate and HDM services, through federal funds administered by the state's Title III program.

While Sussex County is experiencing the largest percentage increase of older adults in Delaware, Kent County is also home to many lower income and rural seniors. As of 2019, Kent County's percentage of older adults 65 and older (65+) is about 17 percent[3]. The county is home to approximately eight percent of the state's total low-income seniors[3]. As the area's older adults age, these demographics are important considerations for addressing long-term health and nutrition needs[4]. Data specific to Delaware, that utilizes the US Centers for Disease Control and Prevention's (CDC) Social Vulnerability Index, indicates that the MMC area, based on its zip code, maintains a relatively high poverty rate that is higher than the state rate. Additionally, the percentage of the area's population reported with high blood pressure is highlighted as "needing attention."[5]

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 Innovations grant. In addition to a memorandum of understanding between EHRI and UD (represented by three organizational units) that documents 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 for the final year of the grant that detailed program goals and related activities (see Appendix 1).

[3] *Census Reporter*, ACS 2020 5-year data, retrieved June 27, 2022.
[4,20] https://udspace.udel.edu/bitstream/handle/19716/31300/delaware-population-consortium-brief-2022.pdf
[5] https://myhealthycommunity.dhss.delaware.gov/portals/cpr/locations/zip-code-19904

While year 2 involved a coalescing around MMC staff and resources, a newly hired program coordinator for the nurse advocate team, and bridging existing client connections with the recruitment and services to be offered within a new service area, year 3 brought significant progress given the solid foundation created by establishment of these systems in year 2.

Similar to prior reports, data for this report is generated from multiple sources. Based on year 3 program goals and processes, data described and analyzed in this document include: interviews with HDM drivers; an interview with MMC case managers; client health status data (e.g., chronic conditions, food security, fall risk); data on client medical home status; client and service calls by the nurse advocate team; and, development of case studies within the context of care costs.

PROGRAM STRATEGY PROCESSES

This section provides an overview of the core processes used in the operation of the program in year 3.

In the prior report, year 2 was described as a "start up year" given the transitions to the partnership with MMC, a newly-hired program coordinator for the nurse advocate team, and EHRI as the new project lead. Additional significant factors in year 2 were the new systems and relationships that were developed, and of course, the ongoing COVID-19 pandemic.

Year 3 found many of the same well-established processes in place as had been developed in year 2; i.e., a focus on HDM clients as the primary recruitment pool through MMC's efforts. However, volunteer HDM drivers had more limited contact with households during the COVID-19 pandemic. MMC case managers facilitated connections between the nurse advocate team and MMC's homebound clients. The nurse advocate team then took the lead in registering clients for WeCare. While the majority of referrals came from case managers, MMC HDM drivers also referred potential clients from time-to-time.

Specifically and as in year 2, the nurse advocate team served as an intermediary between clients and other service providers, including assuring the availability of a medical home. This team is a critical liaison and support system to ensure that 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 team's partnership activities served to continue to address these needs in year 3. Daily, the work of the nurse advocate team includes regular calls to clients and outreach/referral to other medical and social service providers (e.g., home healthcare resources, medical providers) on their behalf. **Phone work is voluminous.** Interactions between clients, the nurse advocate team, 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 clients' social determinants of health. In just two examples, the nurse advocate team assisted one client with reestablishment of her Social Security payments,

> "Member called to thank WeCare today that her [Social Security] payment has been reinstated. She said now she can keep roof over her head and pay her utilities."

And for another, WeCare's efforts resulted in the client's receipt of Medicaid benefits,

> "She said the Medicaid office contacted them that their application has been received and they will be working on the application. She was appreciative of WeCare helping. She stated she has been on this case for more than three months and has been turned down before WeCare stepped in."

Additional details on the program outcomes and findings are described later in this report.

RECRUITMENT AND OUTREACH STRATEGY: IDENTIFYING HOMEBOUND CLIENTS FOR WECARE SERVICES

As noted in the previous report, the transition to the EHRI/MMC team as responsible for grant implementation also resulted in a shift of some responsibilities away from the volunteers. With respect to recruitment, these efforts relied instead on a strong partnership between MMC case managers and the nurse advocate team, and were complimented by outreach conducted by volunteer drivers' care and concern, in spite of drivers not being able to get as close to the client due to social distancing requirements (see Appendix 2 for Home Delivered Meals Notification Card and this report's next section for description of drivers' involvement). Other approaches were undertaken to identify potential WeCare clients in year 3. In the early months of this program year and as a result of these efforts, multiple referrals were received every day; this pace slowed as the program year went on to maintain a high quality of care while not overtaxing the nurse advocate team.

MMC conducts routine and recurring case reviews of clients who already receive HDM. When these client reviews reveal additional needs, clients are referred to the WeCare program through several avenues: 1) assessments conducted by a State of Delaware nutritionist who informs the MMC outreach coordinator who can then pass along information and/or a referral to the nurse advocate team; 2) other recruitment efforts occur directly through the nurse advocate team and sometimes through volunteer drivers - information provided to these potential clients include a WeCare flyer (see Appendix 3), so that the client could contact WeCare regarding potential enrollment; 3) MMC case managers also make referrals to the WeCare program based on their knowledge of and experience with existing homebound clients, and who might benefit most from additional services and resources, using the WeCare flyer; and, 4) during year 3, new WeCare participants were referred by a local doctor's office or learned about the program as a result of an article in a local publications (e.g., *The County Women's Journal*). All members of the research team, including the nurse advocate team, completed the human subject's research training protocols (i.e., CITI).

PARTICIPANT ENROLLMENT

As shown in Table 1, participant enrollment during year 3 occurred largely during the year's first four months. Specifically, more than half (n=43, 58.9%) of year 3's 73 total enrollees joined between September and December of 2021, maximizing their receipt of WeCare's services during the final program year. Also as shown in Table 1, 75 clients remained with the WeCare program during year 3. The vast majority of these (n=69, 92.0%) were affiliated with MMC. Almost all of the remaining prior enrollees (n=5, 6.7%) were affiliated with CHEER, while one enrollee (1.3%) was unaffiliated. 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: YEAR 3 WECARE CLIENTS ENROLLMENT BY DATE AND LOCATION

Monthly Enrollment	MMC	Other or Unknown Referral Source	CHEER
September, 2021	8	3	
October, 2021	14	0	
November, 2021	10	0	
December, 2021	8	0	
January, 2022	2	0	
February, 2022	4	0	
March, 2022	6	0	
April, 2022	7	0	
May, 2022	3	1	
June, 2022	1	2	
July, 2022	2	0	
Year 3 enrollment date not indicated	2	0	
Subtotals, year 3	67	6	
Years 1 and 2	69	1	5
Subtotals of all years	136	7	5
Total enrolled as of 7/31/22	148		

TRACKING PROGRESS AND IMPACTS: YEAR 3 DATA COLLECTION

As part of the WeCare program evaluation, researchers at UD completed a broad range of data collection and analysis efforts over the past year. Data sources included: interviews with HDM drivers; an interview with MMC case managers; client health status data obtained via Attachment H (e.g., chronic conditions, food security, fall risk); client medical home status; client and service calls by the nurse advocate team; and, development of case studies with accompanying analysis of services within the context of care costs. A review of each effort and its findings are presented below. All tools and protocols were reviewed by the UD Institutional Review Board.

DRIVER INTERVIEWS

In order to broaden understanding of the WeCare program's impact on its clients, UD conducted qualitative interviews with two HDM drivers, who are also MMC volunteers, in February of 2022. These persons were identified by MMC's HDM coordinator as persons who had a range of experience with, and keen perceptions of, WeCare clients. Consistent with the project's IRB submittal, the drivers were offered the opportunity to have a brief phone conversation regarding their knowledge and experience. These qualitative interviews followed an interview guide developed by the UD team (Appendix 4). The guide consisted of six questions and focused on the driver's personal experiences with the WeCare program, its staff, and its clients. Each interview was recorded via a portable recorder. These interviews were transcribed by a third-party service which allowed the UD team to conduct thematic analysis, the results of which are provided as follows:

FINDING: HOME DELIVERED MEALS DRIVERS ARE SOMETIMES THE ONLY PERSONS WECARE CLIENTS SEE, SO THEY BUILD MEANINGFUL RELATIONSHIPS EVEN THOUGH SOME INTERACTIONS ARE SHORT

Drivers work hard to create and maintain relationships with WeCare clients who receive meals at home. They are aware that MMC's clients are elderly and many live alone, so even if the meal is simply handed to the client, the driver will still say hello and ask if the recipient is doing all right. In other cases, the driver's longevity with the client will contribute to an even more meaningful relationship, as evidenced by these exemplars:

> "I'm doing this over a year and a half. You build relationships. So, some of them, there's more of a relationship now, just because of personalities and there's a little bit of a chat that goes on."

Similarly, another driver shared,

> "You start playing with the dogs, you start talking to people, and it really is amazing when you get to know these people. You're part of their lives. We have some people that we may be the only ones they see for weeks on end."

FINDING: DRIVERS ROUTINELY AND SUCCESSFULLY NAVIGATE COMPLEX HOME SITUATIONS

Drivers are familiar with the challenges experienced by clients and often go out of their way to ensure they are safe and fed. For example, drivers reported concerns over certain clients' living situations (e.g., run-down mobile homes) and also shared how they will also report to MMC concerns if significant change is noted in a client's typical personality and/or living

situation. Further, drivers are steadfast in ensuring that clients receive their food. One driver we spoke with described a situation in which the driver banged hard on the door and walked repeatedly by a home's windows, in order to get the attention of a deaf client. Another described a situation with an older client:

> "We have a 93 year old … client who still puts makeup on every day. So … she's pretty vibrant…and she's always there. I got to her house one day and there's nobody there and I'm getting concerned, and I'm standing there knocking on the door. I opened the door, it wasn't locked, which surprised me. But I didn't want to go in … And then I go down off the porch and I called Trudy [from MMC] … Her neighbor at the next mobile home, he comes out and he yells to me, "She went to lunch with her... Her daughter picked her up" ... You have to keep in mind, these people are elderly, and they generally don't think to put a note on the door … I have some people who answer the phone, but most of them you can't get through on the phone to them. And so then I knew she was okay … As long as her daughter picked her up, then she's fine."

FINDING: GIVEN THE NUMBER OF CLIENTS DRIVERS SERVE, DRIVERS WOULD LIKE A REFERENCE LIST OF WECARE CLIENTS ON THEIR ROUTES

Drivers for the program serve a variety of homebound residents, both those participating in the WeCare program, as well as those that receive meals on wheels alone. Because drivers were not always certain whether a person to whom they delivered meals was a WeCare client or not, a recommendation was made to have a list of WeCare clients, including alternate contact information and needs, since they knew these clients often require extra assistance (e.g., frozen meals). It was also noted that this list would be helpful to other HDM volunteers who were new to a route:

> "I don't know, part of the permanent route that would, somebody else coming in there, that would help them understand okay, this person, if there's a situation, a little more specific on stuff to help them out…."

When pressed further, drivers were unsure how else they could contribute to the WeCare program, noting that it takes a lot of time just to get to know the clients, let alone try to figure out what else is needed.

CASE MANAGER INTERVIEW

To facilitate a deeper understanding of the WeCare program's impact on 12 previously identified clients, UD interviewed two MMC case managers in June 2022. It was envisioned that an approach similar to the previously described driver interviews would be used, consistent with the project's IRB approval, to explore the relationships between these 12 clients and the MMC case managers. Overall, the interview focused more on the processes utilized by both MMC and WeCare. This section presents the key points from the interview, including exemplars.

FINDING: MMC CASE MANAGERS AND UD LACK ACCESS TO CERTAIN TYPES OF INFORMATION REGARDING CLIENTS WHO ARE ALSO ENROLLED IN THE WECARE PROGRAM.

Case managers noted that they keep extensive narrative notes on the MMC clients who receive HDM services; for example, the case managers' notes will document why some clients continue to receive meals even if their 'Attachment H' score (see section 3 below) exceeded the threshold. Case managers emphasized the value of these notes to evaluation of client well-being. UD was unaware of this data source and has incorporated it into the case studies also presented later in this section. Further, case managers often have a role in key aspects of client well-being such as medical equipment. An example cited by the case workers was when a client expressed a need for a walker, but they did not know whether the client received it since the client was also enrolled in WeCare and the case workers could not access WeCare's nursing and service call notes (described below).

FINDING: A STRONG RELATIONSHIP IS OFTEN CREATED BETWEEN HOME DELIVERED MEALS RECIPIENTS AND MMC CASE MANAGERS.

MMC case managers have contact with their homebound clients at least twice per year – once at enrollment or re-enrollment, and again every six-months; each of these contact points generates a new 'Attachment H' form as described below. Further, many of these clients have received HDM for a number of years, a similar length of time to, and overlapping with, the case managers' employment at MMC (i.e., seven – nine years). Accordingly, they have developed strong and trusting relationships with many clients that are "definitely much deeper than [the] paperwork." As such, the case workers try to meet in person for as many of the biennial check-ins as possible. As one of the case workers noted, they do this "…because we get attached to our clients…you get to know these clients."

While the knowledge and experience working with these clients helps case managers identify whether a referral to WeCare services might be beneficial, case managers noted an interest in maintaining a relationship with WeCare (e.g., ongoing information about programming) and when their clients were referred for support, to receive some information about client level of participation and future program growth. Case managers were active and supportive of the WeCare recruitment and enrollment process and wanted ongoing relationships with the programs efforts to the extent possible.

CLIENT HEALTH STATUS

Using Attachment H (Appendix 5) of Delaware Health and Social Services' Home Delivered Nutrition Services Specifications, UD collected and analyzed data, from MMC, that related to participants' health status, food insecurity, and changes thereto. These efforts involved data collectors working with MMC's liaison to WeCare to secure the appropriate form for each WeCare client who also receives meals on wheels through MMC, and enter that data into a longitudinal database. These Attachment H data were collected over at least two time points, depending on when the WeCare client enrolled in the program: (1) at or close to their enrollment date (i.e., baseline); and, (2) at six months after the baseline data collection time point. When data collection and analysis were completed for the current report, the enrollment period for many clients has lasted 12 months or longer, resulting in multiple time points over which changes or trends in their health statuses could be determined. This approach is based on the hypothesis that patient health and activity status, as a result of WeCare program's work, will result in stable data (i.e., not declining with age as might be expected), and, perhaps, for some, improvements in scores.

CHANGE IN CHRONIC CONDITIONS

As shown in Table 2 below, WeCare clients at baseline (i.e., at or close to enrollment in the WeCare program) reported particularly high prevalence of physical dependence and hypertension.

TABLE 2: CHRONIC CONDITIONS OF WECARE CLIENTS AT ENROLLMENT AND FOLLOWUP

Condition	Yes, Frequency (%)
Physical Dependence	110 (90.16%)
Hypertension	88 (72.13%)
Visual Impairment	58 (47.54%)
COPD	43 (35.24%)
Diabetes	33 (27.05%)
Stroke	22 (18.03%)
Neurological Disorder	18 (14.75%)
Cancer	17 (13.93%)
Renal Failure	15 (12.30%)

FOOD INSECURITY RISK

In addition to the chronic conditions, UD also examined clients' food insecurity data; we limited our sample to those persons who responded at three timepoints (N=25). Specifically, responses were given to these statements that are based on the validated, two statement Hunger Vital Sign™[6] screener:

1. "We worried whether our food would run out before we got money to buy more" and
2. "The food that we bought just didn't last, and we didn't have money to get more."

Responding "often true" or "sometimes true" (vs. "never true") to one or both of these statements indicates a risk of household food insecurity. Responses at baseline indicated that 52.2% of WeCare clients who responded to these statements were not at risk of food insecurity, while these rates were 44.0% and 41.9% at followup timepoints. Table 3 presents these trends.

[6] https://childrenshealthwatch.org/public-policy/hunger-vital-sign/

TABLE 3: FOOD INSECURITY ACROSS ALL THREE TIMEPOINTS

	Food Insecure at Baseline (N=25)	Food Insecure at 6-months (N=25)	Food Insecure at 12-months (N=25)
Yes	47.8%	56.0%	58.3%
No	52.2%	44.0%	41.9%

Additionally, examining each client who had data for all three time points, we found that:

- Eleven reported continued no food insecurity across all three time points.
- One reported no food insecurity at baseline and then always food insecure at both six and 12 months.
- One reported no food insecurity at baseline and then some food at both six and 12 months.
- One reported some food insecurity at baseline and then was always food insecure at both six and 12 months.
- Thirteen maintained the level of some food insecurity across all three time points.

FALL RISK

While the WeCare program does not specifically address fall risk, it is a major concern related to both healthcare costs and healthy aging at home; as such, fall risk is also an indicator of overall frailty. Data about participant fall risk upon enrollment in the WeCare program showed 100% (42/42) of clients were identified as at risk for falls, and that this number was unchanged at follow-up.

ADLS AND IADLS

We examined the extent to which clients were able to perform activities of daily living (ADLS) and independent activities of daily living (IADLS), and calculated total risk scores as presented in Table 4.

ADL and IADL Definitions, Metrics, and Relevance to WeCare:

- ADLs include self-care tasks such as bathing, dressing, grooming, and feeding. An inability to perform basic ADLs is associated with a higher risk for functional decline (e.g., 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 from the commonly used Lawton Scale, includes six ADL items that

are scored as either 0 (performs independently), or 3 or 5 (dependent on support to perform task), resulting in a score range of 0-30 for ADLs. As such, higher scores denote a higher level of dependence.

- IADLS include tasks that are integral to maintaining an independent household such as using the telephone, shopping for groceries, preparing meals, and doing laundry. 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. Again, higher scores denote higher levels of dependence and therefore need for programs such as WeCare; the lower the score, the greater independence.

- Together the score range is 0-70 possible points. Those with total scores over 40 are automatically eligible for Title III home delivered meals.

TABLE 4: ADL AND IADL SCORES AT ENROLLMENT AND FOLLOWUP (N=41)

Variable (n=51)	Baseline (mean, SD)	6-month (mean, SD)	12-month (mean, SD)
ADLs	9.30(4.86)	9.81(5.18))	9.50(5.37)
IADLs	22.46 (9.23)	25.84(10.25)	25.78(10.50)
Total Score (out of a possible 70)	49.77 (8.34)	51.15(8.08)	51.56(7.49)

Findings indicate significant need on the part of the WeCare clients with regard to their ability to perform their ADLs and IADLs. Of the clients assessed at baseline, for example, 36/44 (81.82%) scored higher than the 40 point threshold for services. This trend continued for those that remained in the program for six and 12 months; 92.86% exceeded the 40 point threshold at six months (n=41) while another three (95.12%) exceeded the threshold at 12-months (n=41). Factors in these trends include individuals' typical decline as they continue to age, the availability and increased cost of food, and how much more severe these trends may have been had the WeCare program not provided the services it did.

PARTICIPANT MEDICAL HOME STATUS

As shown in the Table 1, 148 persons are currently enrolled in WeCare. Virtually all of these participants (n=144, 97.3%) currently have a medical home with a primary care provider (PCP) or specialist if required by their current health situation.

NURSE ADVOCATE TEAM CALL LOGS (CLIENT AND SERVICE CALLS)

In order to understand the type and volume of calls made by the nurse advocate team, the evaluation team examined the call-logs associated with weekly contact calls made to clients, as well as those calls made on clients' behalf to other service providers for purposes that included, but were not limited to, arranging for medical transportation, prescription refills, or finding a new medical home. Data from the logs of these client calls are summarized in Table 5 below.

During the period covered by this report (i.e., September 2021-August 2022), the nurse advocate team made 6,096 phone calls to or on behalf of WeCare participants, an increase of approximately 2,000 calls from year 2. Specifically:

- The vast majority of year 3 phone calls (79.5%) were categorized as a general client check-in and often included leaving a message for the client. Many, however, were related to solving a particular issue (e.g., medication, housing, transportation, healthcare service).
- However, 2.4% (or 145) of the calls were wellness/prevention, including COVID -19 vaccine discussions and planning/scheduling annual medical wellness visits. This relatively low percentage reflects both broader trends in the COVID-19 pandemic and the fact that almost all clients were affiliated with a PCP or other specialist, depending on their condition (see Section 4 above).
- Nonetheless, the nurse advocate team made a notable number of calls to participants' providers (39.6%) to assist clients with coordinating their medical appointments.
- Almost ten percent (9.5%) of calls were made to assist clients with their medication and 3.7% of calls were follow-ups to hospitalizations.
- Other types of calls that directly impacted the client's quality of life included various types of transportation support (6.1%); housing support (e.g., assisted living options; (4.3%)); and, medical equipment such as wheelchairs, grab bars, and ramps (6.7%).

Of the 6,096 calls, 650 of those calls were service-related calls to outside agencies, organizations, and medical providers. Specifically, the calls made by the nurse advocate team included: contacting the Delaware Authority for Regional Transit (DART) to obtain service information to better assist clients with transportation to medical appointments; researching low-cost discounts for satellite internet; collecting information regarding Delaware's Home Modification Program for seniors and others; working with the state Medicaid office to obtain case manager contact information for WeCare clients who are also served by Medicaid; and, reaching out to the Office of Veteran Services for materials and services that could potentially assist veterans who are WeCare clients.

Table 5 represents the total number of calls made to clients as well as to service providers.

TABLE 5: WECARE CLIENT AND SERVICE CALL LOG TOTALS, SEPTEMBER 2021 – AUGUST 2022

Type of Call	Frequency	Percent
General check-in or left message	4844	79.5%
Support with MD appointments	1257	39.6%
Other	1774	29.1%
Medication related	581	9.5%
Medical equipment related	411	6.7%
Transportation support	373	6.1%
Medical advice	359	5.8%
Housing support	265	4.3%
Hospital related	226	3.7%
COVID-19 Discussion	79	1.3%
Medicare annual wellness visit	66	1.1%
Total Calls	6096	100%

WECARE CASE STUDIES AND SERVICES IN THE CONTEXT OF COST OF CARE

In order to better capture the cross section of data available about clients and to describe in a more holistic way the nature of WeCare's work, the evaluation team undertook a series of five case studies, each reflecting an individual client enrolled in the program (without using specific names). The case studies also discuss how WeCare services provide a context for analysis of the cost of care.

Case studies are based on multiple forms of data, including: data collected using "Delaware Health and Social Services Home, Delivered Nutrition Services Specifications" (i.e., Attachment H; Appendix 5), as well as the WeCare Meals Recipients Member's Registration Database, MMC's client summaries, and nursing/service call databases. Quotes from the nurse advocate team, who conducted weekly check-ins with WeCare clients and took detailed notes each time, are incorporated to the extent possible.

Of note, and as reported in other sections of this document, the form "Attachment H" scores a client's ADLs and IADLs. Because some clients suffered from missing score data on certain items of the ADL and IADL scoring system, the case studies utilize a standardized ratio to allow comparisons over time while also accounting for missing data. Our score was simply calculated by taking the total possible number of points for the ADL or IADL (i.e., individual task scores added), and dividing by the highest possible score, or highest possible dependency (excluding missing data) for a specific time point. For example, if only three of five categories were able to be scored, we reported the percent score for just these three categories, and termed this rate the client's "level of dependency." Generally, it is important to note that this population will need greater assistance with these tasks as they age. WeCare has played an instrumental role in slowing or stopping this increase in dependency.

CLIENT 1 CASE STUDY

Client 1 is a 76 year old homebound woman living with her son. This client joined the WeCare program in December of 2020. Prior to joining the program, the client dealt with depression, hypothyroidism, hyperlipidemia, dyslipidemia, vitamin D deficiency, right ankle pain, arthralgia, and osteoporosis. The client additionally reported having a severe physically debilitating condition which was actively problematic, critically interfering with their ability to shop, prepare, or eat meals. The client also had a moderate fall risk prior to enrollment. Baseline ADL scores indicated that the client needed the most assistance with bathing, walking/transferring, and eating. IADL evaluations indicated that the client needed the greatest assistance with transportation, shopping, meal preparation, and housekeeping.

During the 19-month period between when the client enrolled in WeCare and the writing of this report, the client was contacted 96 times for check-ins by the nurse advocate team, whose members assisted the client with obtaining needed resources, and also coordinating with doctors and health agencies to connect them with services.

As the client is unable to drive, WeCare played an essential role in both acquiring the client's medication and connecting them to services to increase its accessibility. Specifically, the nurse advocate team member "set up pick-up, delivery, and copay of medication" and "facilitated Rx refill." In one scenario, the client "complained of being nauseated and that [they] ran out of

Zofran. [They were] informed that WeCare will call the provider to refill her Zofran." During multiple check-ins, the nurse advocate team also "discussed transportation arrangements," assisting the client with DART paperwork during an in-person visit.

During their time with WeCare, the client had a "difficult relationship with their PCP" as they were seen for pain management, and "not given any Rx or help…the member is clearly depressed and feels stuck. She has had the same complaints for a very long time. I believe a new PCP is a great place to start. She needs services and has not gotten them." With this, WeCare "spoke to their daughter-in-law who agreed that a new PCP would likely be beneficial to help address medical issues and most importantly pain;" as such, WeCare set up a new PCP for the client. Without a reliable PCP, the client may have been suffering from ailments with which they have no medical care for.

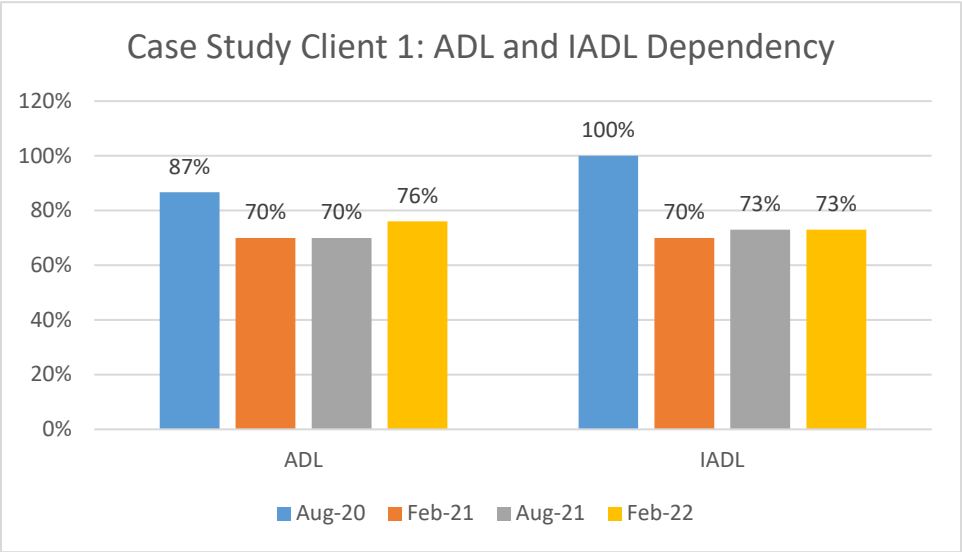
The nurse advocate team member researched ramp installation and contacted a "Case Manager through Highmark/Medicare to help with ramp installation." Miscellaneous scheduling was also managed by WeCare to alleviate confusion for the client. For example, the nurse advocate team member "assisted the client with scheduling a telehealth appointment" as well as "made a Medical Annual Wellness Visit appointment" and "contacted the Doctor regarding client's general pain and depression."

The client had requested further assistance in the home as "she stated she needs a HHA [Home Health Aide] as she cannot do ADL (Activities of Daily Living) for herself." As a result, nurse advocate team member "called [PCP name] office" regarding an HHA, and later "followed up with the HHA agency regarding a replacement HHA."

At another point, the nurse advocate team member noted that the participant was "tired of living alone and can't get anyone to help her. She opted for an LTC (Long Term Care) or assisted living." The WeCare team was able to effectively assist the client with this process by calling the "[case member name] to encourage her to initiate a long term care facility placement." The nurse advocate team member noted that the "LTC application is in process, but additional documentation is needed. WeCare is aware of what is needed and will visit [client name] to gather the necessary documentation." Further, WeCare communicated the situation to social services.

Additionally, WeCare visits were conducted to aid with food security. The nurse advocate team member noted that the "member called me at 04:09 am and 06:12 am complaining that she has no food to eat or any drink except water in the house. She said her son that lives with her left with the car for days and finished the food in the house. She said she was nervous and scared. I tried to calm her down and encouraged her to sleep. I informed her that I will inform MMC to to bring her food in the morning." As a result, an MMC staff person "went to the member's house to evaluate her nutrition situation…additional food was delivered to her today." With WeCare's nurse advocate team, the client was able to receive personalized care. Problems that may normally be ignored are taken care of by WeCare.

FIGURE 1: CLIENT 1 DEPENDENCY RATIO



**Dependency ratios are calculated as a percentage of total scored data. They are a response to some missing data (likely due to COVID) and are intended to support a more accurate calculation of the patient's level of disability based on available data.*
**ADL Standardized Ratio: T1 - 86.7% dependency, T2 - 70% dependency, T3 - 70% dependency, T4 - 76% dependency*
**IADL Standardized Ratio: T1 - 100% dependency, T2 - 70% dependency, T3 - 73.3% dependency, T4 - 73.3% dependency*

Client 1's ADL scores generally decreased in dependency and remained fairly consistent throughout their participation. Using the standardized ratio for scores and as shown on Figure 1, the client's dependency greatly decreased from 86.7% at T1to 70% dependency at T2. From there, their ADL standardized ratio score remained consistent at 70% dependency at T3 to a slightly increase to 76% dependency at T4. Specifically, bathing was rated as a 5 (dependent on others) at T1 and T2, and decreased to a 3 (needs some assistance) at T3 and T4, signifying improvement. Walking remained constant throughout all timepoints, rated as 5 (dependent on others) at each timepoint. The task of dressing increased from a 3 to a 5 between T1 and T2, and ultimately decreased to 3 at T4. Additionally, transferring was rated 5 pre-enrollment (T1), and decreased to 3 at T2, and remained consistent throughout the remaining time points. This additionally demonstrates improvement and stability with transferring after their enrollment in WeCare. Additionally, eating was rated 5 at T1 and decreased to 0 (independent task) at T2.

In terms of the client's IADLs, their dependence scores similarly and notably decreased after their enrollment in WeCare, and then remained fairly stable throughout their participation. As shown in Figure 1, their IADL dependency shifted from 100% at T1 to 70% dependency at T2, and then to 73.3% dependency at both T3 and T4. Shopping and traveling or transporting were largely dependent tasks for the client, and remained stable at 5 (dependent) throughout their enrollment. Additionally, managing finances remained at 3 (assistance) throughout their enrollment. However, scores for meal preparation, light housekeeping, and heavy housekeeping demonstrated signs of improvement. All of these tasks were rated a 5 (dependent) at both T1 and T2, and decreased to a 3 (assistance) at T3 and T4.

Reports of food security remained the same through their time enrolled in WeCare (refer to Page 17 for an explanation of how food security is measured). The client's fall risk remained consistent at 3 (moderate risk) at their T1 and T2 timepoints, and increased to a 5 (high risk) for their T3 and T4 time points. Overall, client 1's health has generally improved and then remained fairly stable during their enrollment with WeCare.

CLIENT 2 CASE STUDY

Client 2 is an 87 year old homebound woman who requires the use of a wheelchair when leaving the home. This client joined the WeCare program in April of 2021 and experiences hyperlipidemia, hypertension, diabetes, cardiomegaly, multinodular goiter, benign head trauma, osteoporosis, stroke, and anemia. This participant has a moderate fall risk. Baseline ADL scores indicated that the client needed the most assistance with walking, toileting, and transferring. IADL evaluations demonstrated that the client struggled most with shopping and transportation.

During the 15-month period between when the client enrolled in WeCare and the writing of this report, the client was contacted 53 times for check in's. The nurse advocate team assisted with acquiring medication. Specifically, the nurse advocate team member noted that the client "needs refills, and is not sure how to go about getting them. Her son is sick and in quarantine, and her daughter is in Ohio. The pharmacy was called and refills are available, and can be delivered. She needs to provide a form of payment for the transaction to go; I verified that this was completed." The nurse advocate team member's advice also included the "benefit of setting up the pill box on Monday or Tuesday (instead of Saturday) so that if she is running low, or needs a refill, it is when doctor's offices are open, and when the pharmacy can do a home delivery. I am looking for information on getting Rx delivered to the home so the member doesn't have to ask her son; the member needs to call the pharmacy and request the service when placing her refill." By providing advice about taking and acquiring medication, WeCare reduced the potential confusion and difficulty for the client.

WeCare also communicated alternative transportation options (as opposed to relying on friends/family), such as those available from DART, Uber, and HYSC (Harvest Years Senior Center).

Although the client may be comfortable with their existing services, WeCare made sure to offer and discuss available options and resources. For example, this client "pays for the Home Health Aide out of pocket through Bayada. We discussed setting up services through the PCP but she said she was comfortable with her set up and not to pursue that."

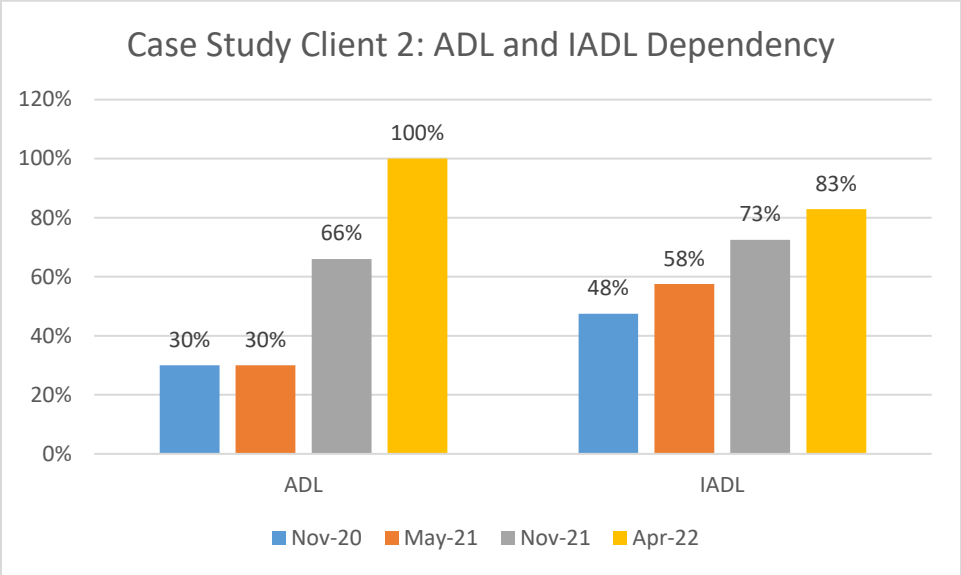
The nurse advocate team completed several at-home visits, noting, "It was nice to have a face to face encounter with this member on the homebound meals [HDM] route a couple weeks ago." Additionally, an in-person WeCare visit was completed regarding a medication problems since the client "complained that she is taking 15 medications daily and feels dizzy. [Nurse advocate team member] arranged to go to her house tomorrow to review the medications with her." This form of care plays a vital role in avoiding expenses related to potential emergency room visits.

WeCare additionally offered assistance for this client by coordinating care and providing medical advice. This client had difficulty with fatigue as a result of their medication. With this,

nurse advocate team member "encouraged her to check her BP [blood pressure] when she feels that way and keep a log" and "explained that she should try to learn how to coordinate the feelings and s/s [signs and symptoms] associated with high and low BP" and both "talked about getting parameters set for her BP meds and monitoring her BP daily" and "encouraged her to call her doctor to discuss if she has another low BP reading." More specifically, and prior to a doctor's appointment, the client was "advised to discuss her dizziness and for the doctor's office to review her medications. She validated her understanding of the information." By helping the client to communicate medication usage and symptoms with their doctor, emergency room visits and additional costs resulting from medication misuse may have been avoided.

Regarding medical advice and resource acquisition, WeCare "inquired if she could benefit from a bedside commode" and did further research on solving the issue, by "looking into utilizing her insurance for incontinent supplies." Additionally, WeCare "ordered COVID tests for her," which is important to limit the need to schedule a test and then find transportation to the testing location.

FIGURE 2: CLIENT 2 DEPENDENCY RATIO



**Dependency ratios are calculated as a percentage of total scored data. They are a response to some missing data (likely due to COVID) and are intended to support a more accurate calculation of the patient's level of disability based on available data.*
**ADL Standardized Ratio: T1 - 30% dependency, T2 - 30% dependency, T3 - 66.6% dependency, T4 - 100% dependency*
**IADL Standardized Ratio: T1 - 47.5% dependency, T2 - 57.5% dependency, T3 - 72.5% dependency, T4 - 82.9% dependency*

Since participating in WeCare, client 2's Activities of Daily Living (ADL) scores remained low and consistent at T1 and T2, and generally increased at T3 and T4, as shown in Figure 2. Using the standardized ratio for scores, the client had 30% dependency at both T1 and T2; this increased to 66.7% at T3 and increased again to 100% dependency. Specifically and for their task-based scores, bathing and dressing increased from 0 at T1 and T2, to 5 at T3 and T4. The tasks of walking as well as transferring increased from 3 at T1 and T2, to 5 at T3 and T4. However, toileting decreased from 3 at T1 and T2, to 0 at T3 (no T4 data were available).

Additionally, the task of eating remained consistent at 0 at T1, T2, and T3 (no data were available at T4).

The client's IADL standardized ratio scores slightly increased during their period of enrollment, as shown in Figure 2. Their level of dependency shifted from 47.5% dependency at T1, to 57.5% dependency at T2, to 72.5% dependency at T3, to 82.9% dependency at T4. In terms of specific tasks, telephone use, shopping, meal preparation, and travel/transportation all remained consistent throughout their enrollment. Light housekeeping as well as heavy housekeeping were rated 3 at T1, and increased to 5 at T2, T3, and T4. Following medication directions, as well as managing finances were rated 0 at T1 and T2, and increased to 3 for both T3 and T4. Fall risk increased from 3 at T2, to 5 at T3 and T4.

It is important to note that this client was experiencing multiple health problems, some resulting in hospitalizations, during their enrollment with WeCare. This must be taken into account when looking at their decrease in dependency over time.

CLIENT 3 CASE STUDY

Client 3 is a 67 year old, homebound man who lived with roommates at the beginning of his WeCare enrollment, and is currently living with his family with a long term goal of moving out of his son's house and living on his own. This client joined the WeCare program in September of 2021, and deals with dizziness, essential hypertension, type 2 diabetes, stroke, hyperlipidemia, neoplasm of prostate, vertigo, as well as blood pressure issues. This client additionally struggled with transportation, and reported frequent falls, sometimes resulting in concussions. Baseline ADL scores indicated that the client needed the most assistance with walking and transferring. IADL evaluations demonstrated that shopping, housekeeping, transportation, and following medication directions required the most assistance.

During the 12-month period between when the client enrolled in WeCare and the writing of this report, the client was contacted 94 times for check ins, resulting in nurse advocate team assistance with general care coordination and scheduling with both PCP and specialists. For example, and during at least 10 of the check-ins, the nurse advocate team member, "at client's request, confirmed the date/time for forthcoming Doctor's appointments." Regarding specialists, the nurse advocate team member helped at each step of the process, as they "contacted the Doctor regarding the status of referral to a specialist at client's request," and later "followed up with the status of a referral to a specialist," and eventually "made a specialist appointment" for the client. In more time-sensitive scenarios, WeCare was able to "schedule an emergency doctor's visit." The nurse advocate team was quick to act when there were any problems. For example, with medication, the nurse advocate team member noticed that the "client has vertigo, and the medication is not helping; contacted the doctor regarding a potential medication change." By assisting with the client's health needs, future problems may be prevented.

Further, WeCare was able to notice scheduling errors, create new appointments for the client, and additionally provide transportation. While the nurse advocate team was "making a calendar for all of the member's appointments, the [nurse advocate team member] noted the appointment date for a member is not accurate. I reached out to the company to validate the

date given to me by the member; the member has two appointments according to the company. 3/7/2022 at 09:50 for a diabetic check and 03/09/2021 at 13:50 for visual field check at the Delaware Eye Care Center... The member was informed of these times. ModivCare transportation will be called a month before per their protocol to arrange for transportation." In another scenario, "The member needed an appointment for BP medication follow-up; Appointment made for 12/14/2021 at 2:30pm with [Doctor] at 766 S State St., Dover, DE 19901; Transportation to Doctor's Office visit; Transportation arrangement made."

WeCare's assistance also reflects the client's transportation challenges, assisting with transportation needs on over 30 different occasions. This includes transportation to PCP and specialist appointments, as well as transportation to Urgent Care or other emergency visits. Some specific examples of this in the nursing notes will follow; "arranging transportation for ENT apt on 12/13/2021 @ 09:30, Confirmation #44480. Return scheduled for 11:30," as well as "Member called that he needs transportation to [Doctor] office to follow-up with his high blood pressure; Called ModivCare. Trip #38470. The member will be picked up on January 18, 2022 at 1:15 to [Doctor] at [Address] and will be picked up to return home by 3:30 pm." At another point during their client enrollment, the nurse advocate team "Contacted Christiana Care about the process if medical transport called, regarding the client's need for urgent care during the weekend." With this, the nurse advocate team member was able to "schedule transportation to the emergency doctor's visit."

WeCare also provided medically-related advice. For example, and in terms of diet and nutrition, the client is taking "multiple types of insulin and PO medications for diabetes. He is going to cut back on his food. He is 6'2" and 149 pounds." With this, the nurse advocate team member "discussed fish, protein, beans, hamburger meat to assist with his muscle weight." In order to manage his fall risk, the nurse advocate team member additionally "discussed (again) orthostatic hypotension, and reminded him to slowly adjust from laying to sitting, and from standing to walking." Similarly, the client was "educated on getting up slowly to avoid dizziness. He reports he does get dizzy when he gets up in the morning from the bed and stands. I encouraged him to sit at the end of the bed for a few minutes before standing and to use his assistive devices when walking." Medical advice also related to medications and resulting symptoms. During one check-in, the client said "he had a TIA (transient ischemic attack) episode yesterday. He said he called his doctor, and he was told to call 911. The member was taken to the hospital where he received IV antihypertensive and he was discharged home… I advised him to check his blood pressure daily and log the readings. He confirms he takes his medications daily as prescribed. Member checked his BP this morning and it was 205/110. He was advised to take his medications and recheck in 30 minutes." Further, and after having a "cardiovascular surgical procedure," the client was home recovering. The client had "an incision that he described as red. He cleaned it and removed the old dried up blood. He was reminded of the signs and symptoms of infection, and if they began to occur he was told to call the surgical doctor. [Nurse advocate team member] instructed him to keep it clean and not to touch it unless his hands were very clean, and then to be very careful."

When contacting the participant after one of their falls, the nurse advocate team member reported that the member "was running to answer the phone and fell backwards and hit his head on the carpeted floor, and he stated that it bounced like a basketball. He reports that he was dizzy and a little nauseated but he has been having nausea off and on… He reported that he has had 12 falls this year and that he has had some concussions as well." Given this scenario, the nurse advocate team member "made him aware that due to the signs and symptoms he is having he needs to seek medical attention for evaluation. I told him my concern for being home alone and asked if he can contact one of his roommates to stay with him and take him to urgent care for evaluation." WeCare also worked with the client's PCP to re-establish physical therapy services, since "The member stated that when he was walking to Wawa a few days ago his legs gave out on him and he had two falls…We talked about using his rollator walker for longer distance walking and encouraged him to take frequent sit breaks…He has gone to Physical Therapy (PT) in the past, but that was about 2 years ago. He was doing the exercises at home, but they are no longer effective for him. I made him aware that I will call his PCP to see if we can get another script for PT. He agreed and would like to go back to physical therapy in Camden. This was placed on the needs list and I called the PCP office."

Through the advice provided by the nurse advocate team member, the client learned to prevent falls, understood when to contact doctors for additional assistance, and utilized general health knowledge.

All of this advice has the ability to prevent potential emergency room visits, and overall save the client money. During enrollment, the client reported that their "money is gone now because he had to pay for his shingles vaccine and glasses. He stated that he only has Medicare. I encouraged him to apply for Medicaid to see if he qualifies…We discussed using good medication practices (rx) to help reduce the cost of his scripts." WeCare puts a great deal of effort into preventing future costs to both the medical system and individual clients.

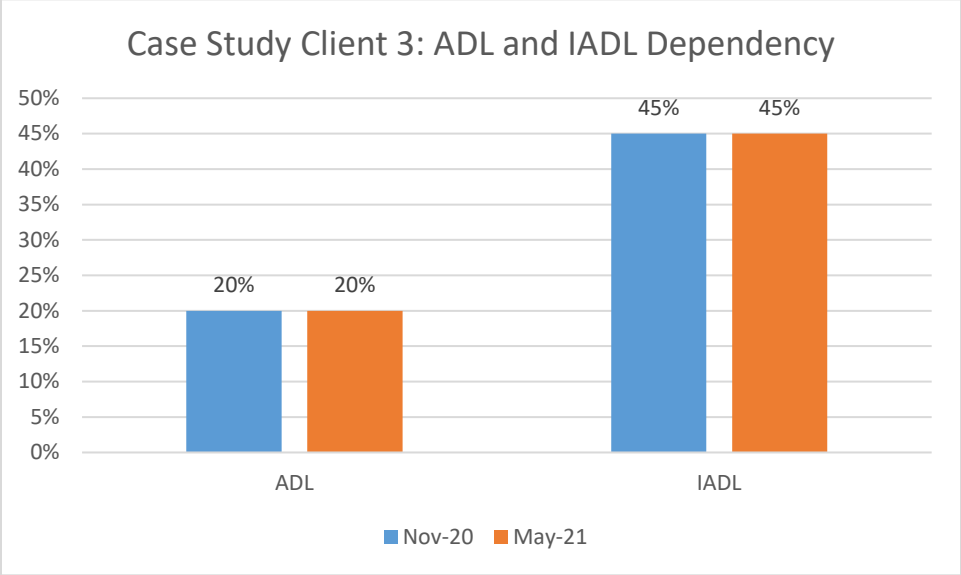
WeCare also provided emotional support around the client's medical situation and connected them to social services. For example, a nursing note discussed that the client had an "annual eye exam a few days ago, he has cataracts in both eyes. He will be getting new glasses in the next few weeks and will set up a surgery date. Cardiology appointment on Monday, will discuss angina/hypertension and the transportation is arranged. March 28 ENT with [Doctor]. We discussed the importance of post-op medical instructions, with special reference to the cataract Sx. I shared a personal story of my mom falling after the procedure and she had to have it redone. [Client 3] says he doesn't like to stay put, so this will be challenging for him. I asked if had any interest in getting involved with anything social at Modern Maturity (MM), and he said he would like that. When he renews his membership he will look into the programs available. He is most interested in joining the aquatic program, and has been told that aquatics will help with his vertigo/ balance issues. He wants to take care of these medical problems first, but when he goes to MM to renew his membership he will get the information. Joining this program is a goal set 1-2 months out." A nurse advocate team member later followed up and "inquired about his social life, and he would love to go to MM for day programming. An email was sent to inquire about the bus service to MM." The social aspect of health may often be overlooked when there

are a plethora of physical problems. However, WeCare has ensured their clients have access to resources to improve all of the facets of health.

WeCare also assisted the client with COVID vaccination. The client "requested to have someone come to his home to administer the COVID booster. I made him aware I will call Delaware Public Health to schedule this."

WeCare additionally made an in-person visit with the client to assist with their social security paperwork. During the client's enrollment, they "complained of an application from the social security office that is due to be submitted by January 31. He said he has been calling the office and staying on the phone for 3 hours and yet could not talk to anyone. I asked if the paper could be faxed to their office, but he said he doesn't have access to a fax machine. I volunteered to go pick up the letter to fax to the social secretary's office for him. He expressed his appreciation for WeCare's assistance." Overall, WeCare provided a multitude of essential services for client 3 in order to deliver the best care possible.

FIGURE 3: CLIENT 3 DEPENDENCY RATIO



**Dependency ratios are calculated as a percentage of total scored data. They are a response to some missing data (likely due to COVID) and are intended to support a more accurate calculation of the patient's level of disability based on available data.*
**ADL Standardized Ratio: T1 - 20% dependency, T2 - 20% dependency*
**IADL Standardized Ratio: T1 - 45% dependency, T2 - 45% dependency*

Since participating in WeCare, client 3's ADL scores remained low and very consistent at both T1 and T2. Specifically and regarding their standardized ratio score, ADL dependency was slightly lower than 20% at both T1 and T2, as shown in Figure 3. Their scores for each individual component were exactly the same at T1 and at T2. Bathing, dressing, toileting, as well as eating were all rated 0 at both time points. Additionally, walking and transferring were rated 3 at both time points.

In terms of the client's IADL scores, they were additionally low and consistent at both time points, also as shown in Figure 3. Specifically, the client had 45% dependency at T1, as well as at

T2 one year later. The tasks of using the telephone and managing finances were both rated 0 at both time points. Additionally, shopping, meal preparation, light as well as heavy housekeeping, travel/transportation, and following medication directions were all rated 3 at both time points. During their time in the program, the assistance required with tasks of daily living remained completely stable. With this, their level of cognitive impairment (e.g., forgetting to eat/cook, and confusion with cooking) remained the same at both time points. Health concerns (i.e., diabetes, hypertension, cancer, stroke, COPD, renal failure/dialysis, and neurological problems (tremors/palsy/seizure disorder) were rated the same at T and T2; these ratings also address whether the concerns are actively problematic and interfere with ability to shop, prepare, or eat meals.

Lastly, the client's fall risk remained the same, and they appeared to be generally food secure during their enrollment with WeCare. Overall, data from client 3 suggest that WeCare aided in the maintenance of their physical condition.

CLIENT 4 CASE STUDY

Client 4 is a 66 year old female living with her granddaughter who joined the WeCare program in November of 2021. Prior to joining the program, diabetes, hypertension, visual impairment, and chronic obstructive pulmonary disease (COPD) were all actively problematic for the client, moderately to severely interfering with their ability to shop, prepare, or eat meals. Additionally, the client had a moderate fall risk, and also suffered from obesity, hyperlipidemia, mobility dysfunction, coronary artery disease, congestive heart failure, chronic kidney disease, diabetic neuropathy, osteoarthritis of the right shoulder, insomnia, and an overactive bladder. Baseline ADL indicated the client required assistance with transferring and walking, and the IADL evaluations demonstrated the client was unable to prepare meals, and needed assistance with dressing, shopping, light housekeeping, heavy housekeeping, and travel/transportation.

During the eight-month period between when the client enrolled in WeCare and the writing of this report, they were contacted 48 times for check in's. The nurse advocate team assisted with a multitude of essential health-related tasks that contributed to the prevention of further illness as well as excess medical costs. Specifically, the nurse advocate team took the lead in scheduling appointments for the client. For example, during their time enrolled with WeCare, the "Member stated that she has not taken her Covid vaccine; Called Walgreens to make an appointment for covid vaccine. Appointment confirmed for December 23, 2021 at 2:40pm and January 13, 2021 at 2:40pm."

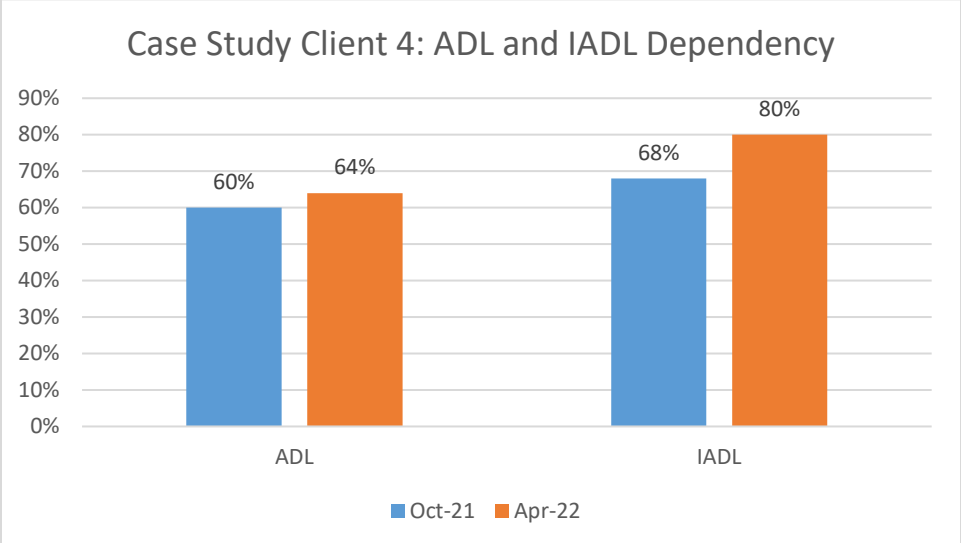
Additionally, the client struggled with the unavailability of their PCP, which in turn impacted their medication accessibility. However, WeCare was able to effectively communicate with doctors in order to rectify the situation; "member ran out of heart medication since 12/3/2021 and her next appointment is on 12/14/2021. Member called the doctor to call in a refill but he did not; called doctor this morning to follow-up. He called in a five day prescription to the pharmacy and said he will address the issue at the next visit."

Through an unfortunate series of events regarding the client's PCP, the nurse advocate team noted that "[PCP name] have closed their doors, and this person has no primary care…This

woman has no ride, no medication ordered, and not enough money to take an Uber. Her daughter has five kids, and works full time; Instructed the client to call 911 if she doesn't feel well. We will look for a new PCP, and arrange transportation through DART." WeCare was able to provide the client with available options in order to optimize their care and "informed the member of options for new PCP so that Rx refills can be made." This client was able to obtain a new PCP within a few months of the initial concerns. Specifically and considering the client's health challenges, the nurse advocate team member noted that the "member is in need of a medical home…the member was aligned with the West Side [Westside Family Healthcare] in Dover. I was told to call back Monday to secure an appointment for her, as the clinic is already booked until February 28. However, the member has been accepted and will be informed." This personalized care has the ability to prevent emergency room visits for the client and overall contribute greatly to their health and well-being.

WeCare also assisted the client with obtaining miscellaneous services; for example, a part for a medical device. The nurse advocate team member "called the supply company for new tubing needed by the client", as well as "arranged for a window A/C unit for the client with 1st State Community Action." At another point, the client reported "she needs someone to help her clean her windows and ceiling fans. Made her aware she can call Grade A Cleaning. She requested I text her the number; Text message sent." The nurse advocate team member noted that they "had an in house visit yesterday to drop off Assisted Technology scale. Member was unable to see the numbers on her scale because of her girth and lack of balance…Member is excited with the technology and is motivated to lose the weight to fix the hernia." Through WeCare's active role in the client's life, they have newfound motivation to live a healthy life through the constant medical assistance and support provided by WeCare staff.

FIGURE 4: CLIENT 4 DEPENDENCY RATIO



**Dependency ratios are calculated as a percentage of total scored data. They are a response to some missing data (likely due to COVID) and are intended to support a more accurate calculation of the patient's level of disability based on available data.*

**ADL Standardized Ratio: T1 - 60% dependency, T2 - 64% dependency*

**IADL Standardized Ratio: T1 - 68% dependency, T2 - 80% dependency*

As shown in Figure 4, client 4's ADL scores remained stable. Using the standardized ratio for scores, the client's dependency slightly increased from 60% dependency when their Time 1 (T1) data was collected before enrollment on October 19, 2021, to 64% dependency when their Time 2 (T2) data was collected on April 25, 2022. Specifically, walking remained stable at 3 (needs some assistance) at both points of data collection. The only score that increased was transferring, which increased from 3 (needs some assistance) to 5 (dependent on others). Since some ADL scores were missing at T1, a change in outcomes cannot be reported.

Regarding IADL scores, their standardized ratio score also slightly increased from 68% dependency at T1 to 80% dependency at T2 (Figure 4). Based on the available data, meal preparation remained consistent, as it was rated a 5 (dependent on others) at both T1 and T2. However, shopping, light and heavy housekeeping, and travel/transportation all increased from 3 to 5. This may be consistent with the fact that this population will need additional assistance with tasks of daily living over time.

During WeCare participation, the client had low dependency scores relating to nutrition. They never forgot to eat, began cooking and forgot they started, or thought that preparing food was confusing/mentally challenging.

CLIENT 5 CASE STUDY

Client 5 is a 91 year old homebound man. This client joined the WeCare program in October of 2021. Prior to joining the program, the client dealt with bladder cancer, hypertension, use of a pacemaker, dizziness, depression, hyperlipidemia, gastrointestinal reflux disease, benign prostatic hyperplasia, and atrial fibrillation. This client additionally had a moderate fall risk. Baseline ADL scores indicated that the client needed assistance with bathing, walking, transferring, and dressing. IADL evaluations for the client demonstrated that shopping, meal preparation, housekeeping, and transportation required the most dependence.

During the 10-month period between when the client enrolled in WeCare and the writing of this report, the client was contacted 44 times for check ins. As a result, the nurse advocate team member assisted with needs regarding home health aide, medication, transportation, and general care coordination. After a request for more in-home assistance, WeCare "Followed up on request for home services" and "Spoke to [Nurse at PCP office] regarding the start of a visiting nurse with Bayada and made her aware they will not be able to start care until next week. I encouraged the PCP office to send a new referral to either CCVNA or Aveana to see if they can start care before then." The nurse advocate team member later "followed up on the visiting nurse script. It was received, and it will take approximately 1 week to start the care." Eventually, the efforts and communication of the WeCare nurse advocate team resulted in "Bayada Home health coming to provide home care." It was noted that the client "appreciated WeCare connecting him with a Home Health Aid[e] (HHA)." This service is important for this participant's care, as they "had an episode of elevated BP and the Bayada nurses were calling the doctor to get some parameters for BP meds."

WeCare made sure to provide the support while the client waited for in-home nursing visits. For example and in discussion with the client's PCP, the nurse advocate team member "made them aware Bayada will not be able to start care this week and the member needs assistance with

bandage changes. I requested to have a referral sent to another skilled home health provider. I also made her aware that the member will need more wound care supplies at the next office visit." After a doctor's appointment for the client's arm laceration, the nurse advocate team member "encouraged [member's wife] to request a visiting nurse to assist with wound care and dressing changes." The following day, after further communication with the client and their spouse, the nurse advocate team member explained to the PCP office that "the spouse (of the member) was shown how to change dressing (arm wound) and the nurse advocate team member wrote down all the steps and placed the supplies in sequential order. [Nurse advocate team member] also made her aware that when the member comes to the appointment today, he does need more wound care supplies including normal saline, cling, nonadherent pads and tape. [PCP office staff] were made aware that the member had been encouraged to use a walker, and we reviewed potential fall hazards in the home. [PCP office staff] verbalized an understanding. The spouse will call with updates on wound care after the PCP appointment today." The coordination of this wound treatment, without the assistance of an in-home nurse, was successful, as the client later reported that the "wound is completely healed. He extends his appreciation to the WeCare team for really helping." Without this carefully planned medical assistance, an infected wound may have occurred, potentially resulting in an emergency room visit or extra out of pocket costs for care.

In regard to medical advice, the nurse advocate team member encouraged the use of medical devices, as well as provided simple suggestions for the participant to speed up recovery after returning from the hospital due to fall when he had hit his head. "Per wife, the member returned from the hospital on Tuesday last week. The member is okay…He said he is now using his walker religiously as encouraged by the WeCare nurse." After a few weeks of recovery, the client stated that he was "gaining strength and not using his walker as vigilantly as he did right after his fall. He states the physical therapy is strengthening him so much that he feels he doesn't need the walker. [The nurse advocate team member] encouraged both her and her husband to 'slow down so you can go faster.'" The medical advice provided by the WeCare team aided in the client's recovery from their fall, preventing potential future complications.

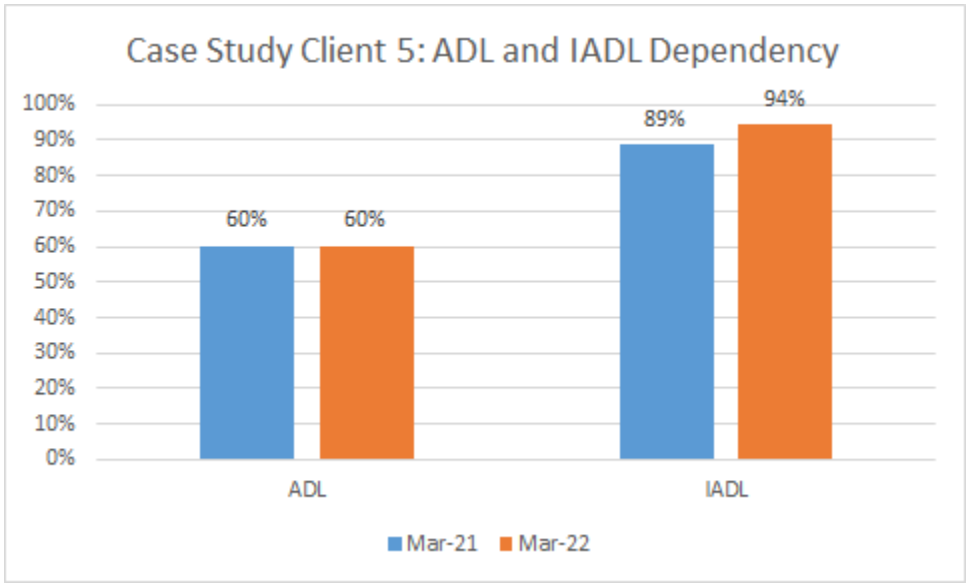
The nurse advocate team made multiple in-person visits. For example, the nurse advocate team "picked up medications for the client after coordinating availability information with the pharmacy and client's family member." At another time during the client's enrollment, the client "said he has medications sitting at the Walgreens in Camden, but there is no one to help them pick them up. He said the pharmacy will not deliver. I told him to call the pharmacy to give them my name and I will pick them up for him. He was so excited." WeCare also communicated with service providers in order to "have [Client 5]'s medications delivered." This personal care provides a link to care delivery when other medical services are not prioritizing client needs. Without medication, the client's health status may have declined. In addition to the in-person visits for medication, the nurse advocate team additionally "coordinated the members Rx (medication) for a home lab draw with the doctor's office and lab."

At one point, the client was "exposed to someone with COVID when they were at the doctor's office." Although the client tested negative, the nurse advocate team member "ordered

COVID tests for him." Care during the pandemic required WeCare to take steps in order to provide their clients with resources to ensure their safety and additionally stop the spread of the virus.

Lastly, WeCare assisted the client with transportation. The participant had a "private driver at times, but sometimes she cannot be reached." At one point, they "stated that they have a dental appointment tomorrow and his daughter came from North Carolina to take him. I gave his wife the number to DART to call for transportation needs since their account is activated." However, the client stated that they were "opposed to taking DART." As a result, the nurse advocate team provided the alternatives to ensure the participant had reliable transportation, discussing "the possibility of utilizing Harvest Years Senior Center Services," and with permission, the nurse advocate team member "emailed the daughter the information for review." In order to provide an additional transportation option, the nurse advocate team member and client additionally "discussed utilizing UBER for transportation needs going forward…[Nurse advocate team member] asked the member to discuss it with her daughter while heading to the cardiology appointment today." Although the client was reluctant to use transportation methods outside of their private driver and family, WeCare did their part by explaining the available transportation options. The overall care provided to this client by WeCare was essential in order to receive more personalized care, consistent assistance, reliable medication delivery, recovery from medical concerns, COVID, and dependable transportation.

FIGURE 5: CLIENT 5 DEPENDENCY RATIO



**Dependency ratios are calculated as a percentage of total scored data. They are a response to some missing data (likely due to COVID) and are intended to support a more accurate calculation of the patient's level of disability based on available data.*
**ADL Standardized Ratio: T1 - 60% dependency, T2 - 60% dependency*
**IADL Standardized Ratio: T1 - 88.6% dependency, T2 - 94.3% dependency*

Since participating in WeCare, client 5's ADL scores remained closely consistent at T1 and T2, as shown in Figure 5. In regard to their standardized ratio score, the client's ADL dependency was 60% at both T1 and T2. Their scores for each individual component were the same at T1 and T2. Specifically, their scores for bathing, walking, dressing, and transferring were all rated 3 at both T1 and T2 (no data was available for toileting and eating).

In terms of their IADL score, there was a higher dependency level, but the ability to complete these tasks of daily living were fairly consistent as shown in Figure 5. At their T1 data collection date before enrollment, IADL scores demonstrated 88.6% dependency. At their T2 data collection date, IADL scores demonstrated 94.3% dependency. Specifically shopping, meal preparation, light and heavy housekeeping, and travel/transportation were rated 5 at both T1 and T2. Managing finances was rated 3 at both T1 and T2. The only increase in score was for the task of following medication directions, which increased from 3 to 5.

Additionally, the clients fall risk was consistent (moderate risk) at both time points, and they seemed to be generally food secure during their enrollment with WeCare.

CASE STUDY SYNOPSIS/PRIMARY THEMES

Overall, the collaboration among, and efforts by, the nurse advocate team reflects personalized care that is thoughtfully facilitated for individual clients. Specifically, assistance with tasks of daily living, medication attainment, reliable transportation, scheduling, medical advice, and general care coordination were all at the center of WeCare's efforts. The detailed case studies of current WeCare clients and nurse advocate team interventions, as well as service calls (refer to Table 5 and accompanying discussion), help illustrate how community-based programs, like WeCare, contribute to chronic disease prevention and health maintenance in a non-emergency settings.

WHAT WE LEARNED FROM THE THREE-YEAR PROGRAM

WECARE AND THE OVERALL NEED FOR IN-HOME SERVICES

WeCare clients, as a whole, represent the deep need to connect older adults with community-based resources, including transportation options and other aging in place-related supports, are also linked with decreased risks for physical disease and mental health issues among older adults. Further, researchers and practitioners increasingly recognize the benefits of aging in place, defined by the CDC as the ability to remain in one's home "safely, independently, and comfortably, regardless of age, income, or ability level."[7] A recent systematic review and meta-ethnography of qualitative studies find that aging in place is not only more cost-effective, but is a

[7] CDC - Healthy Places - Healthy Places Terminology

preferred alternative to moving to an adult care home[8,9,10,11,12,13,14,15,16]. Beyond cost savings, aging in place also results in improved well-being and social connectedness, among other benefits[17,18].

A growing number of services are needed to care for the aging population in the U.S., and policies such as the OAA serve as an important stimulus for state and local programs. The OAA provides support for programs and activities that benefit more than 10.9 million adults over the age of 60 and has witnessed considerable increases in appropriations both during the COVID-19 pandemic and between fiscal years 2021 and 2022. These increases included more than $2.7 billion for OAA programs and activities to prevent, prepare for, and respond to the coronavirus, as well as $15 million for home-delivered nutrition services and an additional $6 million for senior centers and related supportive services[19]. Increased resources, in turn, have created new programs across states and communities.

Given the long-term demographic projections of Delaware's 65 and older (65+) population, a better understanding of costs and health impacts of community-based programs designed to manage chronic disease and promote aging in place will become increasingly important. This is particularly relevant for more rural areas in Delaware and among the state's oldest senior populations. Based on projections published by the Delaware Population Consortium, Delaware's older adult population will steadily grow over the next several decades. And, as the state's oldest senior population grows—those aged 85 and older (85+ population)—additional opportunities to support long-term needs and demands will likely be presented[20].

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[8] Rosenwohl-Mack, et al., 2020: https://doi.org/10.1016/j.ijnurstu.2019.103496
[9] Kraus, 2004: https://www.proquest.com/dissertations-theses/benefits-aging-place/docview/305124605/se-2
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[17] Wiles, et al., 2012: https://doi.org/10.1093/geront/gnr098
[18] Martins da Silva, et al., 2019: https://doi.org/10.1080/13607863.2019.1619168
[19] Congressional Research Service, 2022: https://crsreports.congress.gov/product/pdf/R/R43414
[4,20] https://udspace.udel.edu/bitstream/handle/19716/31300/delaware-population-consortium-brief-2022.pdf

ACCOMPLISHMENTS OF THE WECARE NURSE ADVOCATE TEAM

Generally, the nurse advocate team played an integral role in both the improvement and maintenance of their clients' health status by serving as a conduit for:

- *Tracking and maintaining health status/condition* - testing blood pressure and/or setting laboratory appointments, noting reported and recognized symptoms
- *Communicating and navigating appropriate and available health care options* - scheduling primary care and vaccination appointments, obtaining prescription refills
- *Connecting to social services and public health resources* - through service-related calls, addressing accessibility issues, identifying and arranging transportation options, connecting to public health agency and staff

In this sense, the WeCare model exemplifies the increasing importance of clinicians and public health professionals, working collaboratively with community-based resources now and into the future. In fact, the role of the nurse advocate team is critical in connecting resources to individuals based on their specific circumstances and conditions, including one's geographic location and ability to access needed medical and social services. Recognition and consideration of the various factors that influence individual and community health is essential to understanding the true value of a coordinated service delivery mode such as WeCare. "Healthy People 2030"[21] references the importance of these factors – such as economic, social, cultural, and geographic barriers – as important considerations for health care access, availability of services, and overall health outcomes.

COST IMPLICATIONS

In consideration of these projections, and the potential for community based programs like WeCare to become a more prominent service delivery model, additional research and analyses on appropriate cost savings and quality of life assessments of such programs will be necessary.

Nonetheless and while specific cost savings resulting from clients' participation in the WeCare program are currently unattainable, the assistance provided by the nurse advocate team provides immeasurable quality of life impacts on vulnerable older adults in a rural area of Delaware.

[21] https://health.gov/healthypeople/priority-areas/social-determinants-health

Without this essential assistance, clients may have faced excess medical costs as the result of a failure to take action during their times of need.

LESSONS LEARNED

As we noted in the year 2 report, an evaluation such as this addresses both outcomes and processes. What was learned, and the processes revised, in the early parts of year 2, resulted in a solid foundation for considerable success in year 3. With additional staff added to the nurse advocate team, year 3 also resulted in: the continued recruitment of new clients; outreach to existing clients, support of the roles and approaches of the team; and, expanded data collection efforts. The heart of this work is represented by the sheer volume of calls to clients to check in as well to help with their care coordination; these efforts have resulted in satisfied and stable clients as well as cooperative service providers.

Despite major shifts in the way that HDM programs were able to operate during COVID, WeCare demonstrated the ability to continue to enroll and serve clients through the program. The nature of the work pivoted between years 1 and 2 where COVID-related issues and vaccination were a considerable focus of care coordination efforts, to in year 3, a shift to a wider range of issues with less of a focus on COVID- specific care.

Future enhancements to data management systems may also support the work of WeCare and other similar programs; for example:

- Closing the disconnect between recruitment efforts by both MMC case managers and WeCare staff could create a more seamless system that will allow care coordinators from both agencies, as well as HDM program managers and drivers, to understand client care, needs, and outcomes.
- Data collection processes and efforts are dependent on the availability of accurate entries of file and form information (e.g., scoring process on Attachment H addendum/eligibility criteria and independent entry of data), as well as the actual process to enter, file, and manage these forms.
- Similarly, establishment of clear and consistent data collection and management protocols (e.g., collecting data for each de-identified client at baseline and established program timepoints, using a single spreadsheet) will result in more robust evaluation of clients' change

over time as a result of the program's efforts.

- The HDM manager at MMC was very effective at identifying and referring potential WeCare clients to the nurse advocate team. However, additional and protected information sharing processes should be built to facilitate client information exchange between MMC staff who have hands on clinical support roles and the nurse advocate team.

Finally, continued funding is essential for ongoing evaluation and consideration of information that examines long term costs and quality of life our most vulnerable citizens.

CONCLUSIONS

As previously noted, the beginning of year 3 was notable due to continuation of challenges faced by all, including volunteers, due to the COVID-19 pandemic. Nonetheless, WeCare thrived, resulting in considerable successes.

Based on the wide variety of data collected in year 3, WeCare's clients continue to be high need as they face multiple challenges to their social determinants of health. The WeCare nurse advocate team made over 6,000 phone calls to clients and their service providers, resulting in stabilized, or not declining as fast, home and health conditions. These efforts, and the relationships they created and expanded, helped to avoid expensive treatments (especially at an emergency room), manage living challenges (e.g., assistance with provision of a ramp to avoid a fall on stairs), and facilitate medical care through established relationships with PCPs and other providers. To benefit WeCare and other similar providers, this report conclusively documents these achievements while identifying challenges that could further improve the program. With projected increases in the number of seniors who will be aging in place, WeCare is a viable intervention to meet this need.

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.

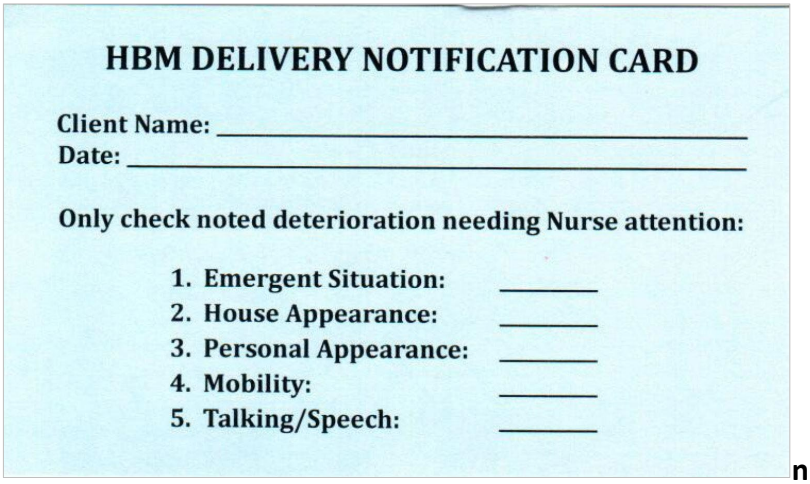
Objective 1
Annually review and update management processes for communication, decision-making, grants management, stakeholder engagement, and program sustainability planning.

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: HOME DELIVERED MEALS NOTIFICATION CARD



HBM DELIVERY NOTIFICATION CARD

Client Name: _____

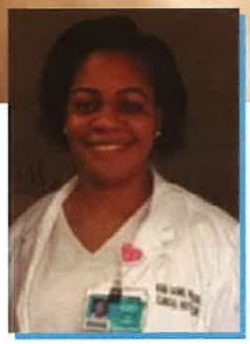
Date: _____

Only check noted deterioration needing Nurse attention:

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

nurs

APPENDIX 3: WECARE FLYER



Kemi Sanni,
DNP MSN, RN
WeCare Program Coordinator

ABOUT US

WeCare focuses on employees and seniors health and wellness. The program is based on disease and cost management for all participants and is designed to keep seniors safe and healthy in their homes. Services are at NO COST to the participants. It is funded by ACL and the Federal government.

OUR SERVICES

- Health and Wellness Program
- Biometric Screening
- Medical Home Placement
- Connect Seniors to PACE Program
- Weekly Seniors Wellness Calls
- Employees Wellness Program

Quick Appointment
No appointment necessary.

Monday - Friday
8am to 4:30pm

Medical Service
We help our clients navigate the complex medical system.

Healthcare Services
We connect clients to necessary healthcare services.

Contact Us For More Information ▪ **302-265-8686** ▪ ksanni@wecareservices.org ▪ 21 W. Clarke Ave., Milford, DE 19963

Personal **Health** **Nursing™**

What is Personal Health Nursing™

Having a **person** who-

- Knows me and my circumstances
- Is available and talks to me
- Is qualified and trained to help
- Helps me reach
  - ✓Better health
  - ✓Better health care
  - ✓Lower cost

All of us need someone to hear us, know us, understand, and help us achieve our best health, and when needed, best health/medical care

What kind of Person is a WeCare Personal Health Nurse?

There are 12 Characteristics of a WeCare Personal Health Nurse™.

1. Compassionate
2. Ethical and Trustworthy
3. Motivated
4. Tenacious
5. Accountable
6. Flexible
7. Organized
8. Educated and Qualified
9. Coordination Skills
10. Independent
11. Curious
12. Diplomatic

Four Roles of a Personal Health Nurse™

My Personal

1. Point of contact
2. Point of information, resources, and communication
3. Health improvement, avoiding unnecessary treatment
4. Coordination/Advocacy

Personal Health Nurse™ Success Measures

1. Accessible
2. Hears me
3. Asks good questions
4. Understands and relates
5. Health is maintained and improved
6. Health care coordinator and advocate
7. Information is complete, accurate, accessible and secure

WeCare

Is the

Personal Health Nursing™

Service

Associated with

Milford Wellness Village

and

Education Health and Research International

serving populations of

individuals in the greater

community.

*21st Century nursing is the glue that holds a **person's health journey** together. Across the entire **life** experience, and wherever there is someone in need of **help**, nurses work tirelessly to identify and **resolve** the needs of the individual.*

*Beyond the time-honored reputation for compassion and dedication lies a highly specialized profession, which is constantly evolving to address the needs of society. From ensuring the most accurate diagnoses to the ongoing education of the public about critical health issues; nurses are indispensable in **improving** public health*
https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/

Contact: Dr. Kemi Sanni, DNP, MSN, APRN, CRNP
WeCare Program Director
302-459-3900 (Office) * 302-503-7197 (Fax)

WECARE

because

WeCare

APPENDIX 4: WECARE DRIVER INTERVIEW QUESTIONS

1. What does a typical day look like for you in delivering meals?

2. What is your understanding of the We Care program?

3. How often do you interact with home-bound recipients who are enrolled in We Care?

4. Are there We Care clients about whom you were worried that you've referred to the We Care program through Kemi, the nurse advocate?

5. Is there any kind of situation specifically that you can think of, like a time where you did refer a client to Trudy at MMC? Where you were worried or something that might have happened?

6. In what ways do you think volunteer drivers could contribute to the program over time?

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.