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7.19.2017

Promoting a culture of health through multi-sector engagement and leadership

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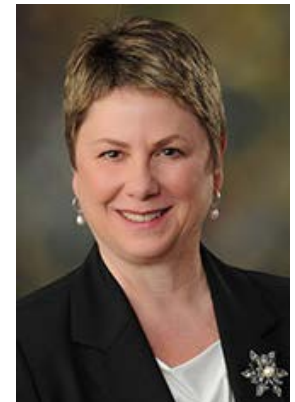
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Host
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Accelerating Initiative



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HARTFORD INSTITUTE FOR GERIATRIC NURSING
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The Community as the Key to Healthy Aging

Center for Healthy Aging
July 19th, 2017

Tara Cortes, PhD, RN, FAAN
Executive Director and Professor
Hartford Institute for Geriatric Nursing



The Problem

- We have an aging population which is plagued by multiple chronic diseases.
- We do not have a workforce prepared to address the unique needs of older adults nor can this country afford the cost of healthcare as we have known health care in the past.
- We do not have enough people in traditional roles of health care to provide care to the aging population.
- The Affordable Care Act (2010) was implemented to improve health care outcomes, increase population health and reduce cost of health care services.



The Problem: Demographics

United States

- 2015: 40 Million people 65 years old or older-
16% of our population
- 2030: 72 Million people – 20% of our population
- Nearly 10,000 people turn 65 every day!



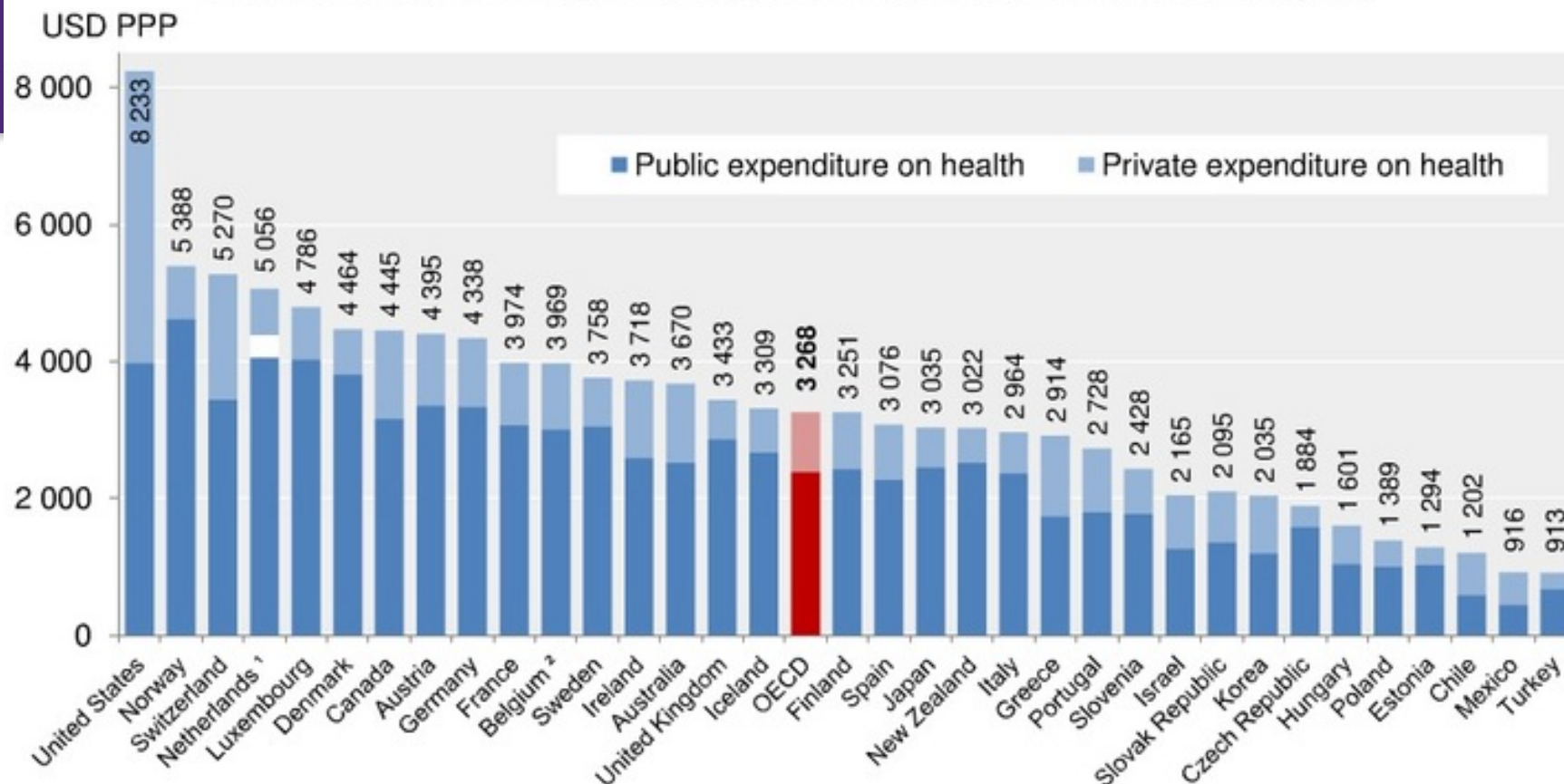
The Problem: Economics

- People **75** and older use **3-4Xs** more hospital days than people **45-55** years old
- People **85** and older spend about **5X** more on healthcare than people **45-55** years old
- Older people have more chronic conditions requiring more health care
- 50% of people over 85 have dementia. These people need caretakers – paid and unpaid. This cost cannot be calculated.



US spends two-and-a-half times the OECD average

Total health expenditure per capita, public and private, 2010 (or nearest year)



1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.

2. Total expenditure excluding investments.

Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

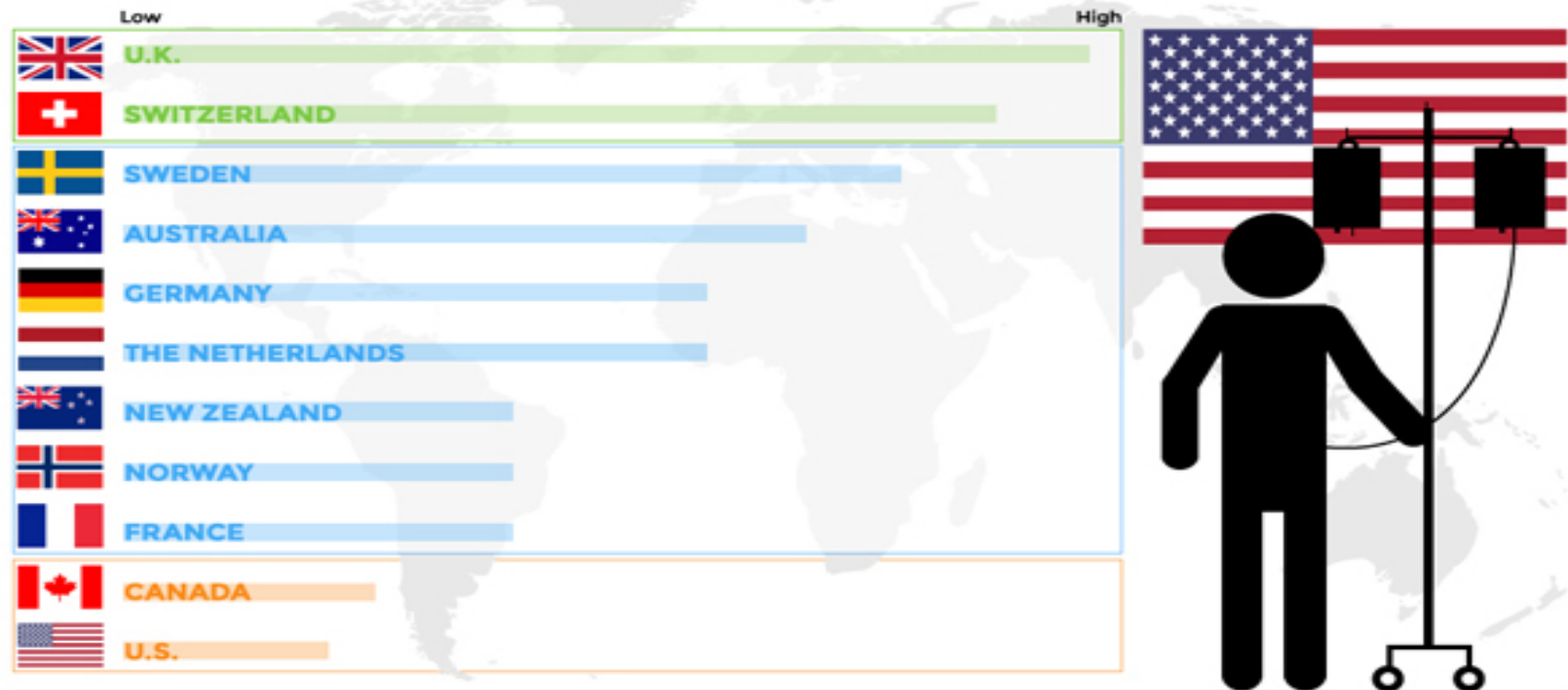
Source: OECD Health Data 2012.



U.S. HEALTH CARE RANKS LAST AMONG WEALTHY COUNTRIES

A recent international study compared 11 nations on health care quality, access, efficiency, and equity, as well as indicators of healthy lives such as infant mortality.

Overall Health Care Ranking



Source: K. Davis, K. Stremikis, D. Squires, and C. Schoen. *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally*. 2014 Update. The Commonwealth Fund, June 2014.



The
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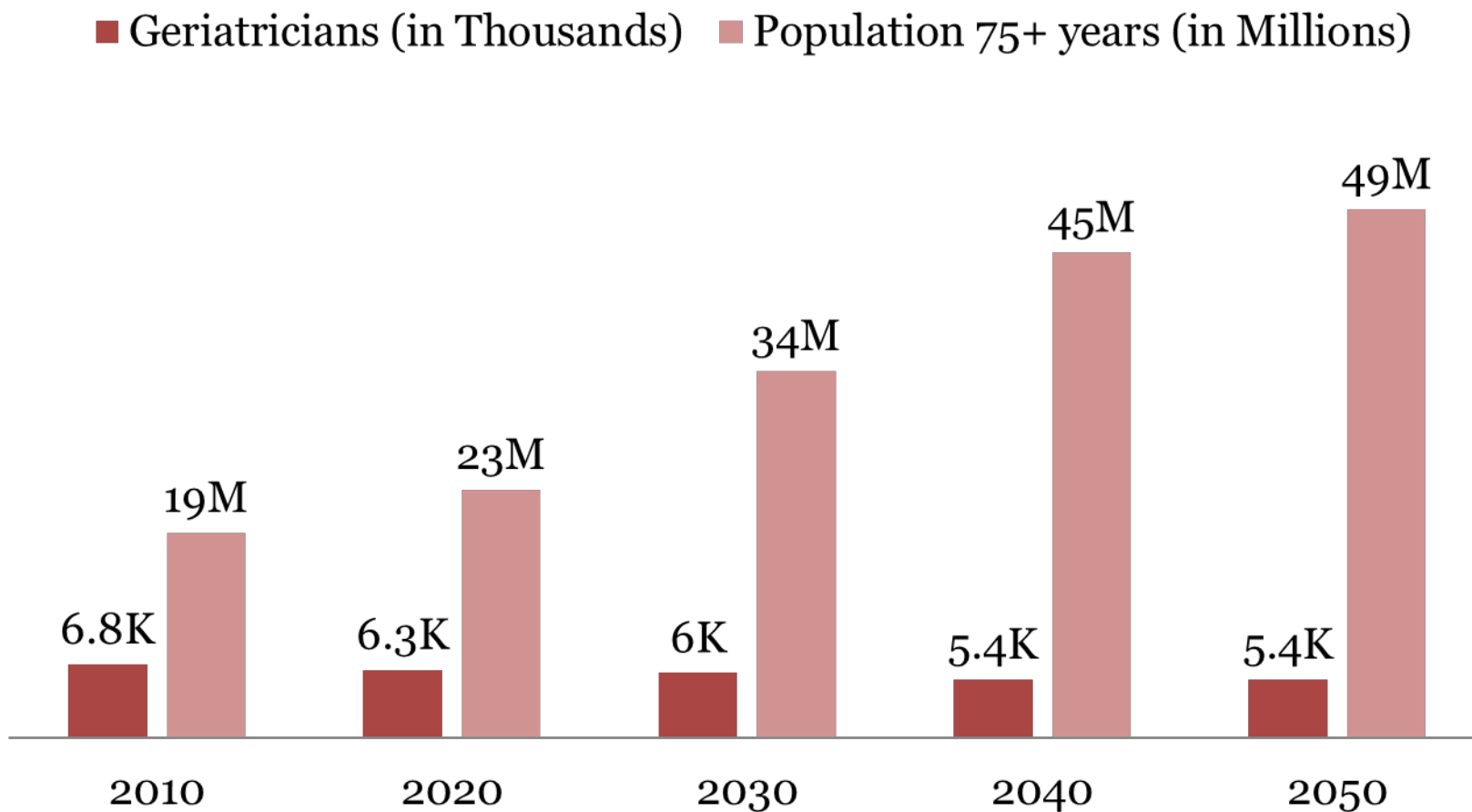
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The Problem: Workforce

- Older adults require unique health care.
- There are simply not enough healthcare providers to manage chronic disease, prevent physical or cognitive decline or encourage behaviors that enhance healthy aging.
- The workforce was educated to cure disease- not prevent it.
- The workforce was educated to develop and drive the plan of care independent of the uniqueness of the individual and their environment.
- The workforce was educated to be hospital centric negating the influence of anything else related to health and wellness.

Projection of Geriatricians

Geriatric Workforce Policy Studies (2009)



Nurse Practitioners

- Nurse practitioners are the future of primary care in this country
- Provide accessible quality care regardless of ability to pay
- There are >**55,000** Family Nurse Practitioners
- There are >**25,000** Adult Nurse Practitioners
- There are <**5,000** Geriatric Nurse Practitioners
- We need to increase the capacity of NPs to deliver age sensitive care to this growing number of older adults



Nurses

- There are nearly three million nurses
- Less than 1% are certified in geriatrics
- 63% of newly licensed nurses report that 2/3 of their practice is older adults
- Only 33% of baccalaureate programs and 20% of associate programs offer geriatrics as a free standing course
- Surveys show that nurses are not comfortable caring for older adults

National Prevention Strategy

Surgeon General's Office, 2011



National Prevention Strategy

- Healthy and safe community environments
 - Create and sustain communities that promote health and wellness through prevention
 - Safe housing, walkability, health food choices
- Clinical and community preventive services
 - Prevention focused services, education and support
 - Assistance in chronic disease management
- Empowered people
 - Support for people in making healthy decisions
- Elimination of health disparities
 - Assure equal access to health care and wellness promotion
- This can only be accomplished with clinicians, their patients and communities working together



Policy

- National Prevention Strategy
 - Critical to the change of the US health paradigm from one of treat and cure to one of promote and prevent
 - Builds on efforts to lower costs, improve quality and impact population health
 - Health is more than absence of disease; it is physical, mental and social well being
 - Many of the strongest predictors of health fall outside of the health care setting
 - Robert Wood Johnson Foundation and University of Wisconsin have developed predictors of health and ranked counties according to these predictors



Predictors of Health



The National Prevention Strategy urges us to enhance the traditional health workforce by training a non-traditional healthcare workforce and utilizing community resources and patients themselves as part of the healthcare team



Questions

1. How will we reduce costs, improve outcomes and have better health in our aging population?
2. Can we impact predictors of health?
3. Can we address the NPS?
4. Who will do it?



Community

- The National Prevention Strategy urges us to enhance the traditional health workforce.
 - train a non-traditional healthcare workforce
 - utilize community resources and patients themselves as part of the healthcare team
- Community Based Organizations (CBO) support participatory health and well being.
 - Individual level
 - People need to take greater responsibility for healthier lifestyles
 - People need to be involved in decision making regarding their care and treatment
 - Community level
 - Organizations and government need to develop and implement ways to provide individual and community participation in and shared responsibility for developing and delivering health services and initiatives.



Community Approaches

- Improve access to health care resources
- Improve the quality and cultural appropriateness of services provided
- Integrate disease management and prevention into services provided
- Organize community resources to improve environmental, physical and social well being
- Negotiate cultural and linguistic barriers to health.
- Help others become active participants in their own health.

Community Based Organizations

Services

- adult day center,
- care transition services,
- caregiver respite,
- education and training,
- congregate and home-delivered meals program,
- senior and care giver support line,
- transportation,
- screening and support to address depression,
- short-term loans of durable medical equipment,
- fall prevention and home modifications,
- immunizations,
- evidence-based health promotion self-management programs including chronic disease management*****

Community Level Barriers to Healthy Aging

- Social factors
 - Economic insecurity
 - Lack of valued role for older adults
 - Navigation of fragmented clinical care
 - Lack of education on health behaviors
- Physical factors
 - Poor transit
 - Walkability
- Environmental factors
 - Risks for falling
 - Mobility issues
 - Social isolation



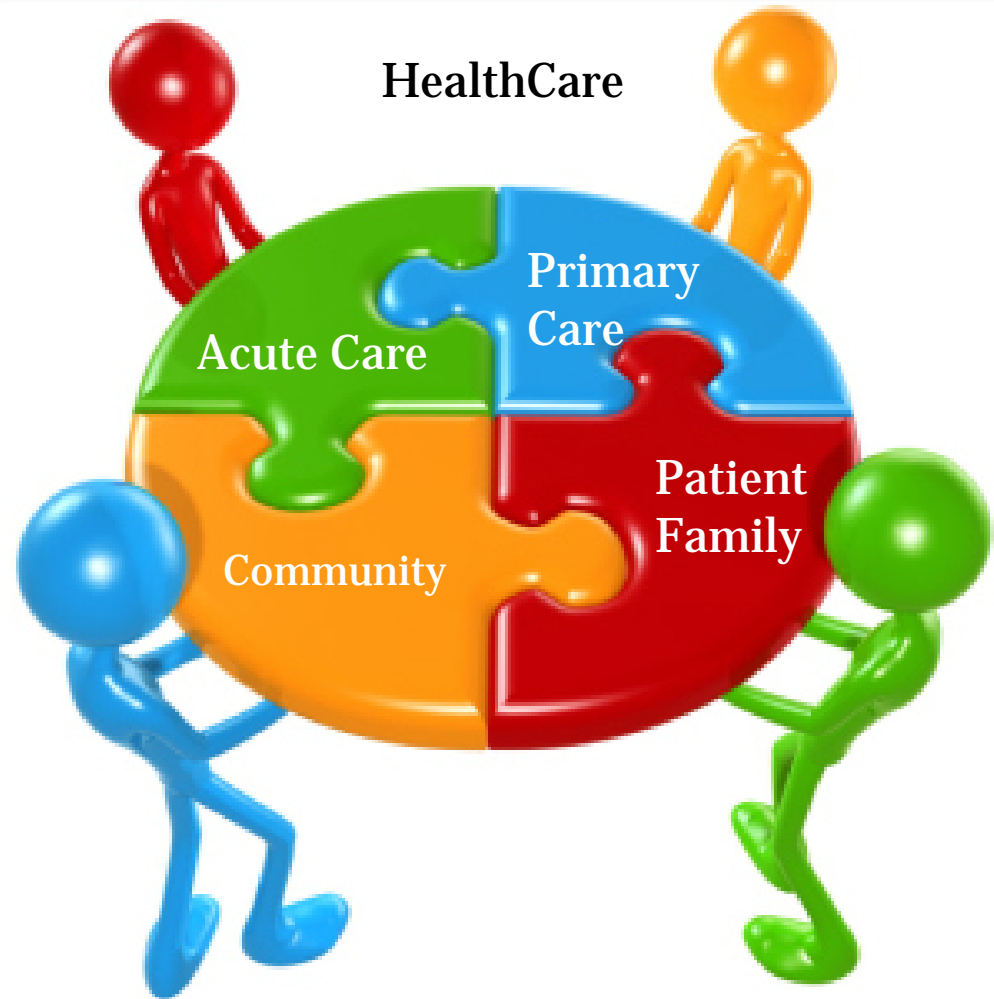
Patient and Family

- Patient engagement/activation has been proven to be a significant predictor of better health outcomes and lower cost.
- Need a certain amount of health literacy
- Participate in decision making
 - Requires knowledge of risks and benefits to make decisions
 - Need to listen to patients preferences – not just about treatment but about life goals
 - See the world from their eyes



Partnership

Quality outcomes, improved health in populations and reduced costs for health care depend on the communication, coordination and collaboration amongst these partners.



Partnerships

- Coordination of care across the health care continuum must be done by the clinical and community entities with the patient and family as full partners.
- Communication across the care continuum is essential.
- Collaboration amongst partners requires knowledge, respect and recognition of what each brings to the table.



GWEP

- Geriatric Workforce Enhancement Program (HRSA)
- Requires partnership of clinical and community organizations.
- Includes education of faculty and providers on the unique health care needs and approaches to maintaining optimum function and managing chronic diseases in our aging population.



HIGN and GWEP

- Educate a team of professionals in primary care practices and a CBO on the uniqueness of caring for older adults with a team based approach to care with the patient at the center.
- Connecting traditional clinical care organizations to CBO's
 - Establish a referral mechanism between primary care clinics (PCMHs) and CBO
- Engage the community as partners in health care
 - Establish a Community Advisory Board
 - Recruit and educate a volunteer health care
 - Educate 1000 HHA in dementia care
 - Training covers wellness and management of diabetes, asthma, dementia and congestive heart failure .



Summary

- Community Based Organizations must be prepared to take on a new role.
- CBOs are part of the health care system and in that role have the responsibility of enhancing population health.
- Our older population offers a unique challenge (opportunity!) for us to make a real difference in how one ages, the support they have and the knowledge they have to be engaged- activated- in managing their own chronic disease and maintain the highest potential of cognitive and physical function.
- Next steps – funding of these activities as part of managed care plans?
State? ACOs?



Addresses

[http://www.surgeongeneral.gov/priorities/
prevention/strategy/clinical-community-preventive-services.pdf](http://www.surgeongeneral.gov/priorities/prevention/strategy/clinical-community-preventive-services.pdf)

<http://www.hign.org/>
<http://consultgeri.org>

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Amy Barton, Eric Gilliam, Kim Paxton

ACCELERATING INTERPROFESSIONAL EDUCATION

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University of Colorado Anschutz Medical Campus

- Planning Process: Interprofessional faculty ... with an interprofessional vision
- Three Zones: Education, Research, Clinical Care



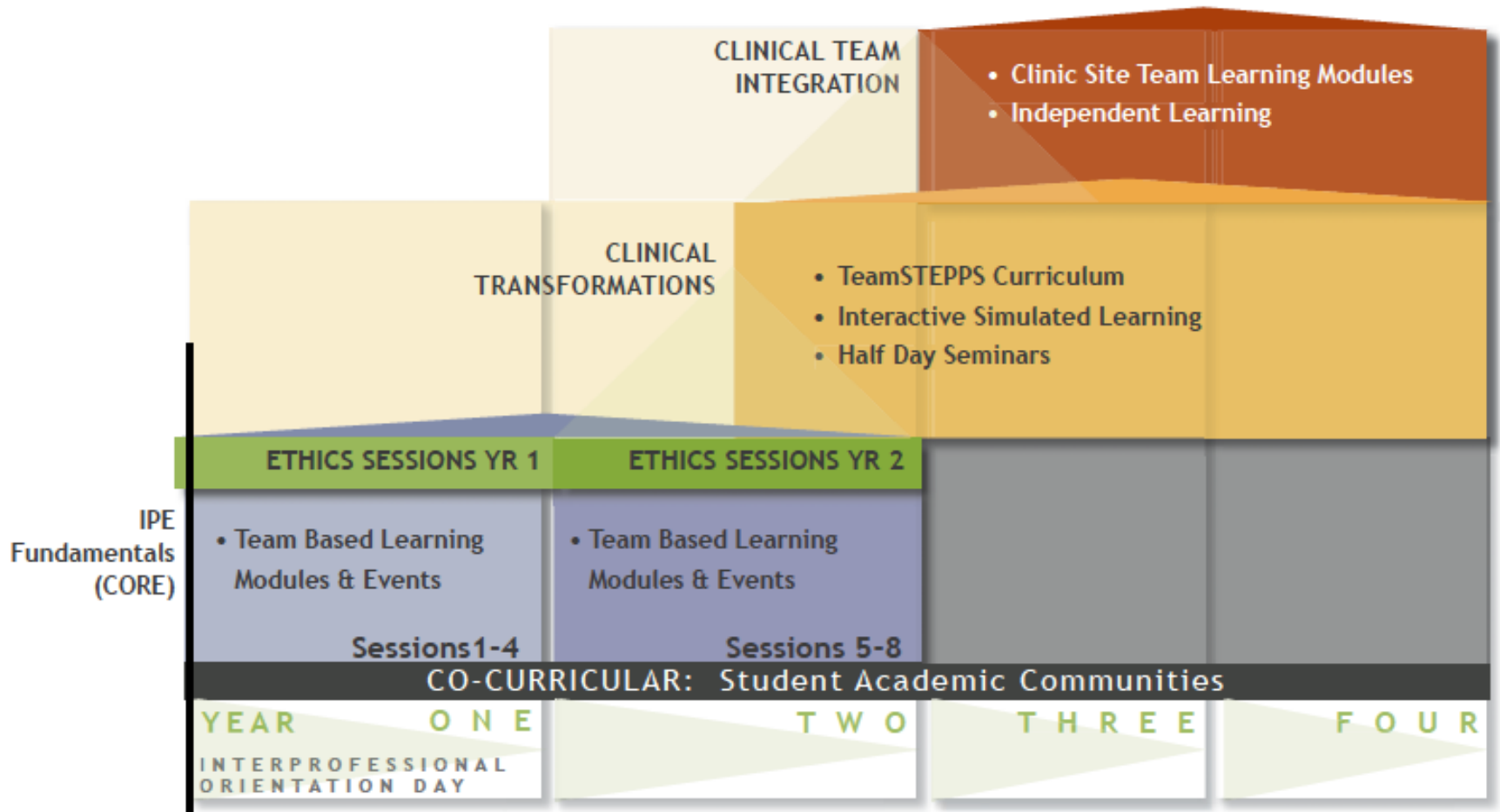
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LONGITUDINAL CURRICULUM STEPS: Fundamentals *for* COLLABORATIVE PRACTICE



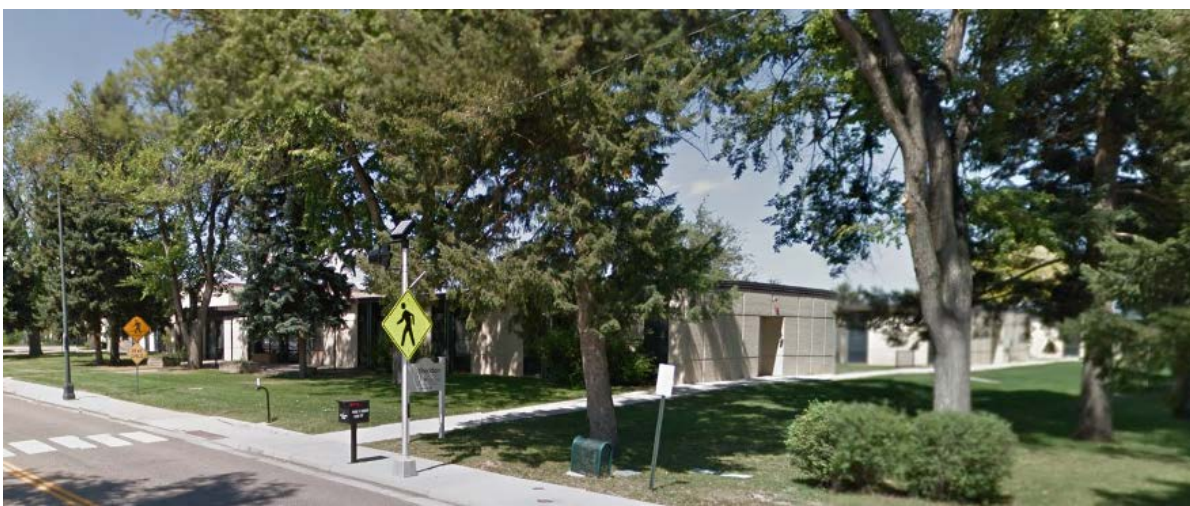
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Sheridan Health Services



Nurse-led, interprofessional, federally-qualified community health center providing services for:

- Physical health
- Behavioral health
- Dentistry
- Pharmacy



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Project Goals

- Cultivate an urban underserved practice environment such that health professions students demonstrate leadership in interprofessional team building, collaborative problem-solving, and care coordination;
- Provide interprofessional clinical training opportunities for health professions students; and
- Demonstrate innovation in collaborative care that leads to high quality patient outcomes and population outcomes for older adults in an urban underserved community.

Social Determinants of Health



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Current situation needing change:
Preventive care for community-dwelling older adults

Intervention:

Interprofessional student teams will conduct home visits with older adults receiving care at Sheridan Health Services. Students will assess medication management, fall risk, home safety, sleep, and depression.

Ecological Data/Variables:

low income
health literacy

Research Question(s):

In low-income community-dwelling older adults, what is the effect of interprofessional student home visits on preventive screening on health and safety compared with older adults who do not receive home visits within an 18 month duration?

Clinical Outcomes:

positive finding on any screening: fall risk; medication risk; depression score;
home environment ; sleep score

Learner Outcomes:

satisfaction with team work

Team Outcomes:

AGNP Student/RN Care Coordinator/NP Provider/Pharm ACE-15

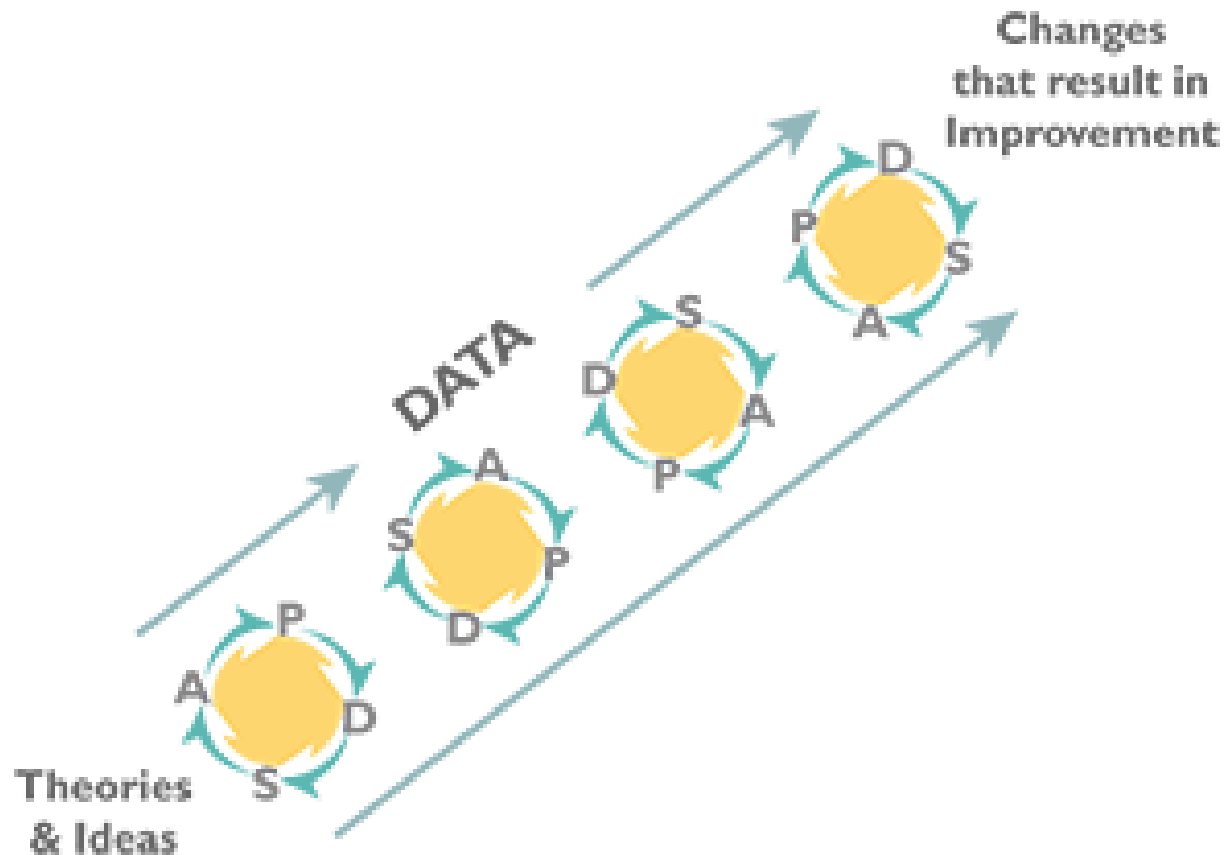
Triple Aim Outcomes Addressed:

better care -- preventive services delivered
cost -- early intervention to decrease costs
patient experience -- positive experience with home visits

Study Design with Comparison Groups:

control -- care plans of older adults at SHS who do not receive home visits
stratification of PROMIS 10 results

Rapid Cycle Quality Improvement



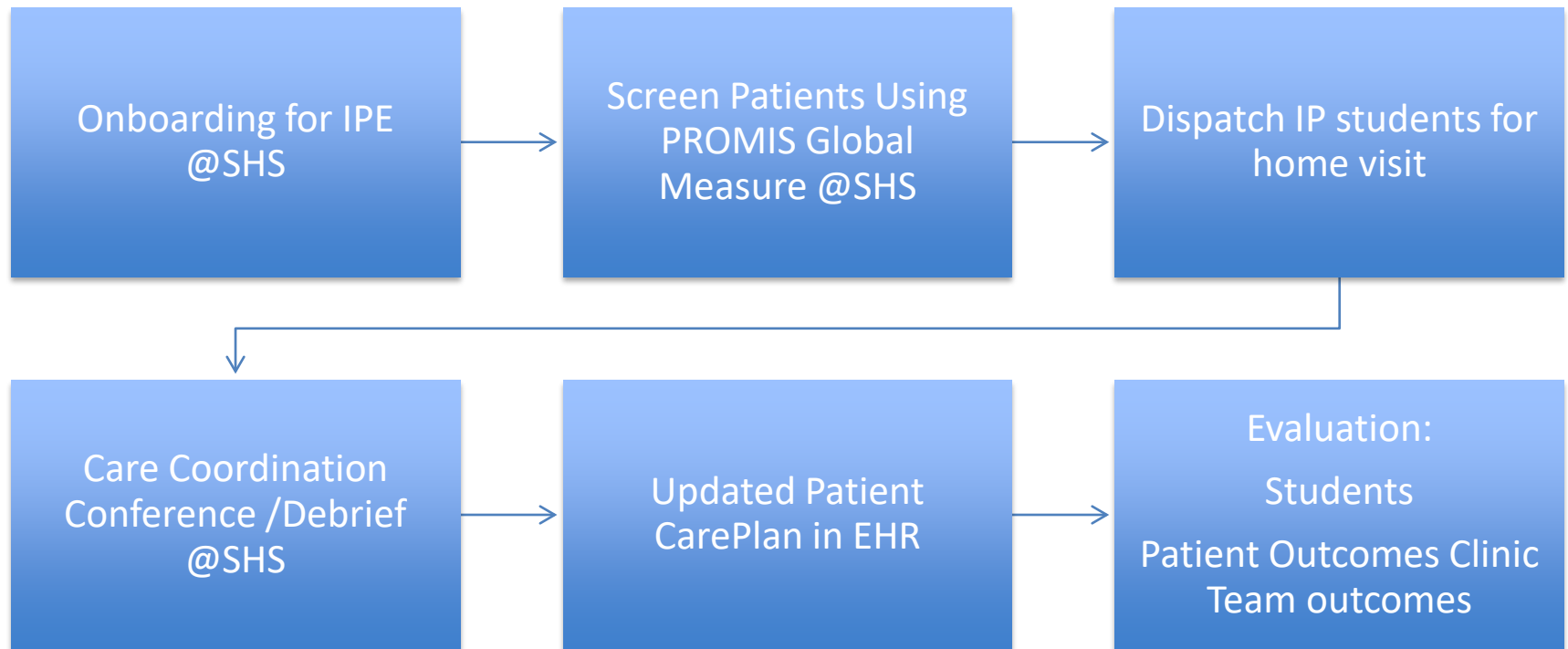
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Accelerating IPE RoadMap



Debrief



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Community Resource Packet

Medical

Dental

Vision

Mental Health

Transportation

RTD for Handicap

Medication Assistance

Integrated Family Community Services

Medication Disposal

Social

Community

SilverSneakers

Home Improvement

Community Center

Religious Services

Fitness



Community Resources

2017

In partnership with Sheridan Health Services
Serves the following communities:
Arapahoe County
Denver County
Douglas County
Jefferson County

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Classroom to Community (C2C): Implementing Patient-Centered Care in Public Housing

Shirley Dinkel, PhD, APRN-BC, FAANP
Principle Investigator
Washburn University

WASHBURN
UNIVERSITY

Why Here? Why Now?

“A person’s ZIP code is a much more powerful predictor of health than their genetic code, especially in those communities and populations experiencing the greatest health disparities.”

Harry J. Heiman, 2014

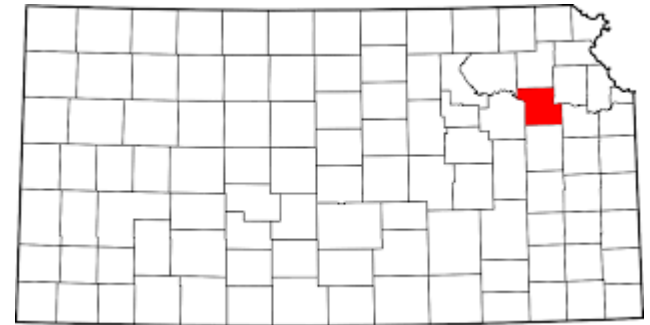
The C2C Team

- School of Nursing: Shirley Dinkel, Amanda Hartman
- School of Business: Karl Klein, Norma Juma
- Department of Communications: Tracy Routsong
- Office of Special Projects: Mari Tucker

Pine Ridge Partnership



Shawnee County



- HRSA health professional shortage area
- 80% of uninsured adults living 200% below PL
- 31% of 30,433 households < \$35,000/year
- Low rates of post-secondary education
- 9,984 residents in the 66607 zip code (Pine Ridge)
- 5,649 residents with low-income (57%)

(US Census Bureau, 2014 and Shawnee County Safety Net Report, 2016)

Shawnee County Health Rankings

96 th of 105	91 st of 105
Children in Poverty	Smoking
Education	Obesity
Parental Employment	Sexually Transmitted Infections
	Teen Births
	Drug Overdose Deaths

County Health Rankings and Roadmaps, 2016

Community Assessment

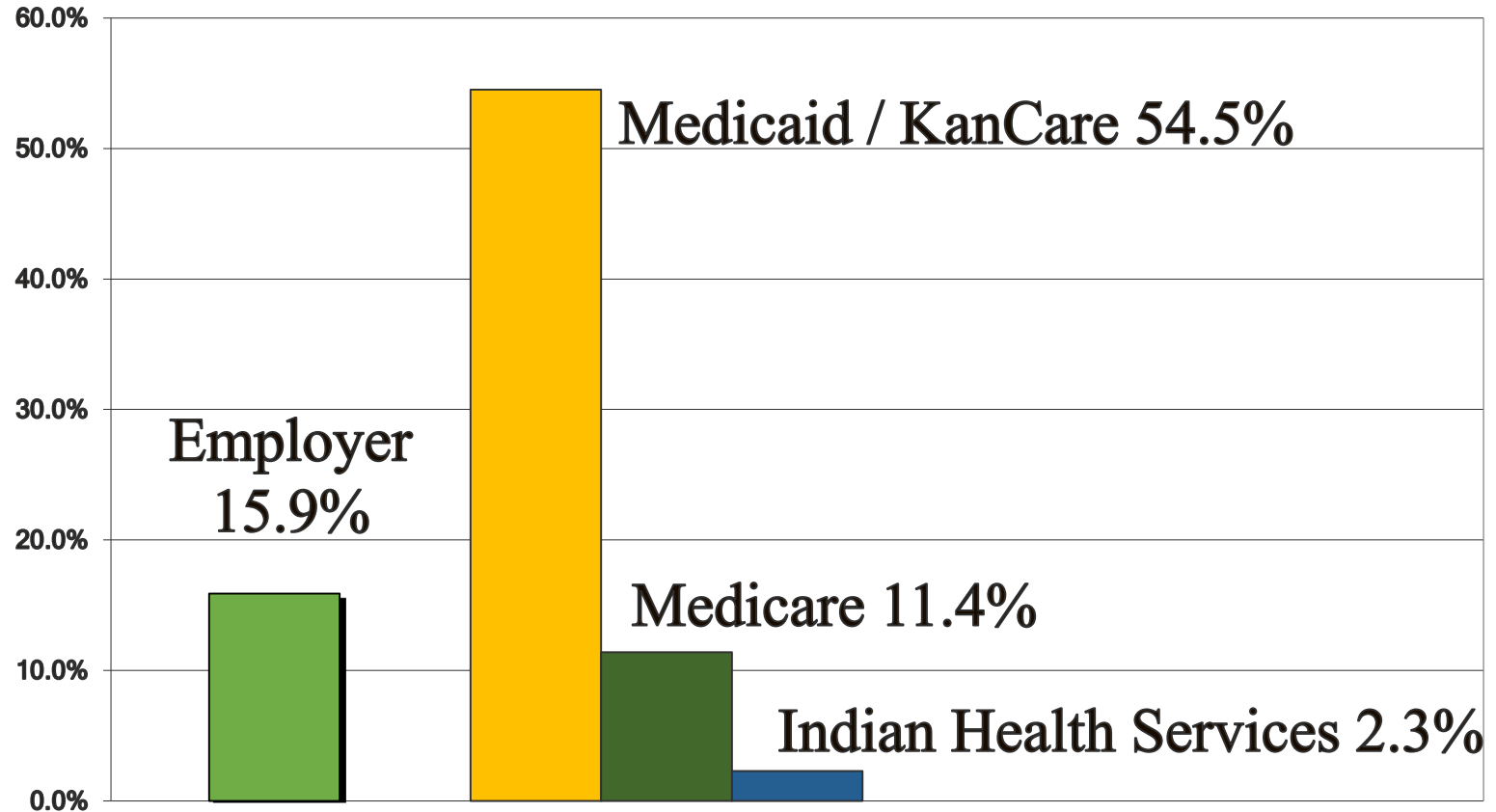
- Community Based Participatory Research – Community members are partners
- Convenience Sample of Adults 18 and Older
 - Family Holiday Event at Pine Ridge Prep
 - Follow-up door-to-door for seniors and homebound/elders
- 2 Focus groups with semi-structured interview guides
- 25 item survey development – iterative process

Community Concerns

Access*	Social Concerns	Costs*
Mental Health	Crime Prevention	Insurance
Primary Care	Youth Activities	Health Services
Specialist Care	Exercise/Fitness	Prescriptions
Preventive Health	Childcare/Education	Transportation
Family Planning	Jobs/Poverty	Healthful Foods
Healthful Food Options	Health Care Privacy	
Domestic Violence Services	Poor Treatment/ Stigmatization	* Barriers to Care

Health Insurance

Average Annual Income \$8,677



Community Strengths

- “People are friendly, helpful, & supportive”
- “People are involved in the community”
- “People have different backgrounds”
- “People include others without judgement”
- “I can contact and talk to local leaders”
- “I can make a difference”



The Future is Bright



C2C Curriculum

- Implement & evaluate shared curriculum across the three programs
- Expand IPE to include School of Law, Social Work, and Psychology
- Create a Center for Sustainability at Washburn University

Pine Ridge Partnership

- Primary Care Clinic – September
- Expanded Wellness Center
- IPE Home Visit Program
- Second Start Program
- Expanded Dental Services
- Mental Health Services
- Optometry
- Tele-psychiatry



Shirley Dinkel
Shirley.dinkel@washburn.edu

And

A special thank you to
Dr. Lori Edwards who conducted the
Community Assessment as part of her DNP
project and who shared her data analysis and
slides.

Questions?

We would love to answer your questions!
Please type them into the Q&A box in the
bottom right corner of the WebEx screen



THE NEXUS SUMMIT



AUGUST 20-23, 2017
MINNEAPOLIS

Interested in a deeper dive into the social determinants of health?

2017 Nexus Summit: Provocative Ideas for Practical IPE

Pre-Conference Workshop: Educating Health Professionals to Address the Social Determinants of Health

Presented by:

Antonia M. Villarruel, PhD, RN, FAAN – Professor and Margaret Bond Simon Dean of Nursing Senior, University of Pennsylvania School of Nursing

Jorge Delva, PhD, MSW Professor and Associate Dean, University of Michigan School of Social Work

Patricia Cuff, MS., MPH – Director, Global Forum on Innovations in Health Professions Education The National Academies of Sciences, Engineering and Medicine

More information and registration: nexusipe.org/nexussummit/2017/pre-workshops



Questions after this webinar?

accelipe@umn.edu





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