

# The John A. Hartford Foundation

Grant # 2000-0381

## GRANTEE'S INTERIM PROGRESS REPORT

Grantee: Sacred Heart Medical Center Foundation

Project Title: A Senior Health Center Interdisciplinary Team Approach: Health and Organizational Outcomes

Starting Date: January 1, 2001 Reporting Period: July 1, 2002 through December 31, 2002

### **OBJECTIVES:**

To evaluate if the interdisciplinary team model of a specialized senior primary care center improves outcomes for older adults in an integrated healthcare system. Objectives for the fourth six months of the project were:

- Conduct project team meetings and communicate progress
- Initiate strategic planning process at the Senior Health & Wellness Center
- Apply the PeaceHealth Team Development (PTD) measure to the study groups
- Complete 6-month caregiver data collection
- Complete analysis of 6-month hospital utilization data
- Complete baseline data analysis for participants and caregivers
- Begin data analysis of 6 month participant self-report data
- Provide data request and fees to the Oregon Medical Professional Review Organization for extraction of Medicare Cost Data from CMS
- Continue development of the interdisciplinary team through training, education, and continuous quality improvement
- Develop presentations and publications
- Continue to build sustainable business model
- Provide health fairs for the community and SHWC patients

### **ACTIVITIES AND RESULTS TO DATE:**

**Project Team** – The project team meets on the third Thursday of every month for four hours. Team meetings were held on July 18, August 16, September 26, October 17, and November 21, 2002. No meeting was held in December. The meeting agendas are developed based on the project work plan and timeline. The meeting minutes, project work plan, and timeline are forwarded to Christopher A. Langston, PhD, Program Officer, John A. Hartford Foundation, Inc.

**Project Work Plan, Timeline and Budget** – The project work plan and timeline are reviewed by the team at each meeting to identify tasks and activities to accomplish in the upcoming month. The project work is currently meeting timelines. A data analysis work plan with a timeline was developed and is attached as Appendix 1.

The project is currently on budget and projected to be slightly under budget at the end of year two of the grant. This will allow us to carry some money over into year three.

**Survey Instruments** – Instrument development on a measure of “teamness” within a work group or clinic has made good progress. The PeaceHealth Team Development (PTD) instrument is a measure of the level of development of a team. Team development is the degree to which a team has in place the components needed for highly effective teamwork and how firmly these components are in place. These components consist of cohesiveness, communication, role clarity, and goal-means clarity. This measure has strong psychometric properties. We have now measured team development in all clinics involved with the study and are in the process of analyzing that data. A copy of the PTD instrument can be found in Appendix 2.

**Participant Baseline Data Analysis** - PeaceHealth’s Division of Measurement, Outcomes, Methods and Statistics (MOMS) began data analysis in January 2002. The preliminary baseline data analysis is included as Appendix 3.

**Participant 6-month Data Analysis**- Data collection at 6 months was completed May 24, 2002. Data is currently being analyzed and is not ready for attachment at this time.

**Caregiver 6-month Data Collection** – A total of 106 caregivers were interviewed at 6 months and data collection was completed July 2002. Attrition rate from baseline is 14 %. The data analysis for baseline and 6 months is currently in progress.

**Oregon Medical Professional Review Organization (OMPRO) Data** – The final data layout was completed and sent to OMPRO on July 11, 2002. OMPRO requested and received approval to extract the required data from the CMS Standard Analytical Files in July 2002. The analysis plan is included in Appendix 4. The first data pull covering calendar year 2000 and 2001 was paid for by PeaceHealth and requested by OMPRO August 1, 2002. The data should be received by OMPRO in January 2003.

**Interdisciplinary Team Development** - The Interdisciplinary team development continues to evolve. Several key changes and interventions have occurred over the reporting period:

- SHWC staff initiated a “persistent pain” assessment and management quality improvement project with a 4-hour planning workshop on 12/5/02. The SHWC team initially identified “persistent pain” during our strategic planning as one of two quality improvement initiatives that they wanted to work on in this fiscal year. Using several CQI strategies with the Chronic Care Model as a guideline, the multidisciplinary project team identified several clinical and process improvements to manage persistent pain at the SHWC. These recommended improvements will be brought to the larger SHWC team for further refinement and implementation.
- An “Interventions for Problem Behaviors in Older Adults” workshop was held for all staff. Bill Wells, a consultant from Atlanta, GA, with extensive experience in dealing with psychological and behavioral problems in long-term care facilitated this workshop. The SHWC staff expanded their basic knowledge of the problem behaviors as presented by older adults and learned management strategies for these behaviors.

- The SHWC leadership and staff have identified “boundary” issues in the involvement of the team with some patients and families as a topic for further skills training. Dan Reece, MSW, will lead a lecture and discussion on setting “boundaries” with patients and families.
- Managing the volumes of paperwork, e.g. phone calls, faxes, lab results, messages, insurance and DME forms, continues to present a challenge to the office workflow. Efficient management of VIP (Very Important Papers) has led to decreased waste of time and improved capacity to manage patient care issues and increased staff productivity. The SHWC team is currently reviewing and refining the VIP process. Results include an increase in the volume of patients seen, ability to open the practice to new Medicare patients coming into the community, and improved staff morale.
- New members have been added to the SHWC team. George Furniss, PhD, Chaplain, joined the team in October to bring a spiritual care component to the team. A copy of his job description is attached in Appendix 5. Mary Johnson, Health Information Library (HIL) librarian joined the team to assist us in better connecting our patients and families to health information, chronic disease self-management tools, and caregiver information. Katie Zolezzi joined us as a gerontology graduate student intern this fall and has focused her internship on understanding the educational needs of our patients/families and has started to develop a process to help meet those needs.
- We continue to expand our pharmacist services to SHWC patients. New patients entering the practice are automatically referred to our pharmacist, Brad Johnson, if they are taking four or more medications. Our pharmacist continues to take referrals from providers for medication reviews, co-management of patients with diabetes, hypertension, hypercholesterolemia, or if it is felt that the patient might benefit from our drug financial assistance program. We currently have 154 patients participating in the drug assistance program. This program allows patients to receive their medications through the pharmaceutical companies and on the average these patients have 4 prescriptions paid for per month. This accounts for an out-of-pocket savings per month per patient of \$257. In one year, \$474,936 out-of-pocket savings will incur for this population of patients.

**Presentations/Publications-** The following presentations have either been presented, accepted for presentation, or submitted:

Donelson S, Stock R, Mahoney B, et al. Characteristics of a self-selected patient population at a senior health center using an interdisciplinary team care model. Poster Presentation, Gerontological Society of America, Boston MA, 2002.

Stock R, Cesario L, Reece D, Backus M. The patient perspective in developing senior health services: A senior health clinic experience. Lecture presentation, NCOA-ASA, Chicago IL, April 2003.

Stock R, Donelson S, Mahoney B, et al. Successful integration of patient-centered outcomes measurement in a senior health clinic. Lecture presentation, NCOA-ASA, Chicago IL, April 2003.

(Submitted) Stock R, Donelson S, Cesario L, Mahoney B, et al. Senior health clinic hospital and ER utilization outcomes: A six month report. American Geriatrics Society Annual Meeting, Baltimore MD, May 2003.

(Submitted) Stock R, Reece D, Cesario L. Designing a senior health clinic using the chronic care model. American Geriatrics Society Annual Meeting, Baltimore MD, May 2003.

Work is currently being done on paper submissions to peer-reviewed publications. Two papers are targeted for submission in early 2003. The first paper entitled, “An unbiased measure of physical function ability: The PeaceHealth Physical Function Scale (PPF-13)” will report on the validation of this tool as an outcome measure of physical function. The second paper will report on the validation of the PeaceHealth Depression Scale (PDS-11) as an outcome measure of depression in a population of older adults.

**Business Model Development** – Extensive work has been done on improving the business model of the Senior Health & Wellness Center (SHWC). The manager and medical director have been trained to use the Proclarity software tool to extract data from the PeaceHealth datamart. This allows the monitoring of appointment schedules, provider relative value units, and a variety of other operational aspects. This has helped identify areas for improved productivity and patient care.

The team is currently reviewing and revising work flow processes specific to the large quantities of paperwork (Very Important Papers, VIP) involved in providing care for older adults. An efficient VIP process also leads to improved patient care and productivity.

Effective December 1, 2002, the SHWC began billing through Medicare provider-based rules for pharmacy consults, dietary consults and medical social work behavioral health services. The annual projected revenue is \$160,000.

Discussions are currently being held with a general surgeon to determine the feasibility of practicing at the SHWC one day per week. The SHWC patients are reluctant to go elsewhere for care and would prefer to see a surgeon at the SHWC. A CMS Part A facility fee could also be charged for the surgeon’s visits. The financial impact has not yet been calculated.

**Health Fairs for SHWC Study Participants** – In collaboration with the OASIS and Senior Class programs, a health fair was held in October 2002 to launch a new program called “Health Stages”. The health fair was a community-wide event, but personal invitations were sent to all the Senior Health & Wellness Center study participants. Over 1,500 seniors attended the fair.

### **PROBLEMS AND PROSPECTS:**

Quality Assurance – No participant complaints were reported in this interim period.

We will need to revise year three and year four budgets of the grant due to reduction of grant funds in 2004.

## Appendix 5

TO: Staff, SHWC  
FROM: George Furniss, Chaplain  
RE: Role of Chaplain in Comprehensive Health Care

Last Saturday's staff in-service with Bill Wells gave you a good introduction to the role of the chaplain in a wholistic clinic like this. Recall how he urged us with new patients to obtain a history of trauma, a history of life-roles, information about coping skills, and a complete medication history. That's a tall order for staff with limited time. The chaplain is specially trained and equipped to search out all those things except the medication history. We cultivate skills in active listening for life review and understanding of the patient's "definition of the situation." Knowing the external facts about the patient is insufficient for good medical interventions. Chaplains are detectives who search for the inner meaning of patients' experiences.

Chaplains' work with a patient or family begins with a spiritual assessment. The spiritual assessment complements the physical assessment done by the admitting physician. It focuses on four basic questions:

1. What is the patient's understanding of God or of a higher power?
2. How does the patient understand the meaning of his or her illness or present situation?
3. What social system support does the patient have?
4. What is the source of hope for the patient?

Understanding a patient's spirituality is a much broader question than simply knowing whether he or she has a religious affiliation. It involves comprehending the person's worldview, values, will to live, and sources of meaning. These deep value-orientations exert a major influence on physical health and, therefore, the outcome of medical care.

Within the health care team, chaplains share significant information derived from spiritual assessments. Consultation reports in the medical record document the most significant aspects. Just as physicians and nurse practitioners offer a physical diagnosis of the patient's medical problem, chaplains derive a spiritual diagnosis from the spiritual assessment. On the basis of this diagnosis, chaplains offer suggestions to other caregivers and, where it seems warranted, create a plan for further involvement with the patient to discuss life meaning and other spiritual issues broadly defined.

Clinical chaplains have basic theological training, usually a master of divinity degree from a theological seminary, and additional training in health care ministry known as clinical pastoral education (C.P.E.) Often they have special training and licensure in psychology to qualify them as pastoral counselors. I have a master of divinity degree from San Francisco Theological Seminary (Presbyterian Church U.S.A), a doctorate in sociology from Columbia University, and a certificate in pastoral gerontology from Luther Seminary in St. Paul, MN. Because of my former work as a university sociology professor, I am particularly interested in the social context of patients' lives. I was pastor of an urban Presbyterian church in Flint, MI; staff chaplain at Sacred Heart for fourteen years (1979-93); and a faculty member at Eden Theological Seminary (United Church of Christ) in St. Louis. I am the author of a

book entitled *The Social Context of Pastoral Care: Defining the Life Situation* (Westminster John Knox Press, 1994). Currently I am a part-time pastor at Westminster Presbyterian Church in Eugene. My wife, Sandy Larson, also an ordained Presbyterian minister, works with me as one of the church's four pastors. My late wife, Ruth, died in Nov. 2000 of cerebellar ataxia. I have four adult children by Ruth and six grandchildren and now have three step-children, one of who, Sarah, age 13, lives with Sandy and me.

In the division of labor of wholistic care (body-mind-spirit), the chaplain's role tends to be ambiguous because the domain of "spirit" is nebulous. The tendency is for people to define the role too narrowly. Sometimes patients and families react in fear at a chaplain referral, thinking it must mean a "death-and-dying" situation. Staff can see such referrals as indicated only when a clear "religious" issue is at stake. I hope to do life reviews and spiritual assessments with patients and their spouses or family members where major spiritual problems are not involved as well as where they are. The goal is understanding our patients as whole people and sharing significant information about spiritual issues with you colleague caregivers to improve the care that we together give.

Granger Westburg, a pioneer of clinical chaplaincy and originator of the parish nurse concept, helped organize a wholistic health care clinic in suburban Chicago. Every patient was required to see both a physician and a pastor. Patients complained. "I have a medical problem. Why do I have to see a pastor?" The staff answered, "Well, that's the rule." After patients had complied with the dual appointment system for a while, the reception people began to hear a different complaint: "I want an appointment with the pastor. I don't think I need to see the physician any more." "Sorry," the staff said, "you know the rule." "O.K.," the patient answered. We chaplains love this story because it indicates the close interaction that we want to have with the other health team members. I am very glad to be here at SHWC and look forward to lots of referrals!