On-Site Interdisciplinary Primary Care Clinics: Promoting Living-In-Place for Older Adults in Low-Income Housing

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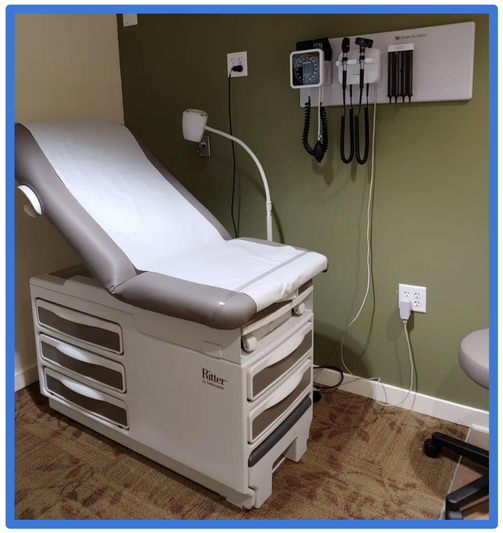
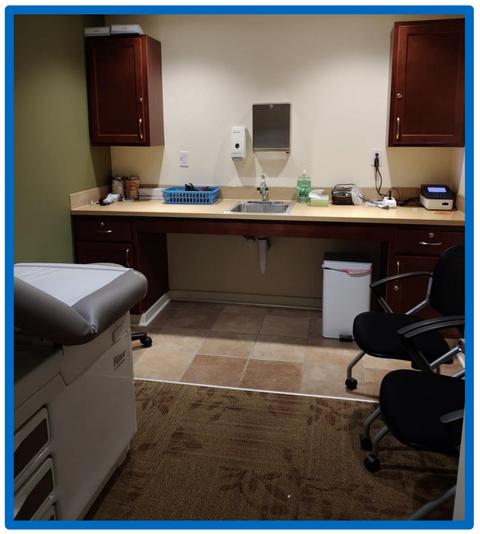
Background

Approximately 2 million Americans are considered highly vulnerable due to multiple chronic illnesses, advanced age, and homebound status.[1]

The top five chronic conditions include hypertension, hyperlipidemia, heart disease, arthritis, and diabetes. [2]

Underprivileged adults are five times more likely to experience these chronic conditions and to report being in fair to poor health. [3]





Newly constructed clinic exam room located within urban low-income housing community

Partnership

A Doctor of Nursing Practice Nurse Practitioner (DNP-NP) academic program created an innovative partnership with local Urban Housing Authorities (UHA). This partnership provides on-site primary care to seniors living in urban low-income housing communities. The care team will be led by DNP-NPs and include psychologists, pharmacists, and dieticians.

Settings & Methods

<u>Settings</u>: On-site clinic services and health educational classes will be offered to 400 residents at two urban low-income housing communities where residents are age 55 and older and have an average annual income of $12,000-14,000.

<u>Methods</u>: New patient visits will include an assessment of health characteristics and patient health care needs. Data will be collected from electronic medical records then de-identified and analyzed. This data will guide the formation of strategic interventions and targeted resources.

Current phase

PHASE 1

- Create partnerships between GVSU College of Nursing Program and local Urban Housing Associations
- Create business plan and SWOT analysis
- Establish a budget
- Apply for funding: **Awarded 100% funding from the Michigan Health Endowment Fund**
- Establish legal agreements

PHASE 2

- Build clinical site infrastructures
- Develop practice policies
- Create computer infrastructure for EMR
- Hire and train staff
- Develop and implement marketing strategies
- Build trust w/ residents
- Create assessment tools and secure storage

PHASE 3

- *<u>Fully operational clinic sites to residents</u>*
- Deliver evidence based primary health care
- Collect data on measurable outcomes
- Ongoing assessment of practice processes
- Initiate health education classes
- Engage in dissemination of work
- Incorporate student learning for population health

PHASE 4

- Statistical analysis and summary of data
- Determine residents' utilization of community resources
- Update practice processes based upon data collection
- Develop interventions to promote health within this population
- Continue data collection
- Weekly interdisciplinary meetings
- Build sustainability plan

Nursing Implications

The information from this project will allow DNP-NPs to have a greater understanding of the mental, physical, and functional health needs of this patient population. DNP-NPs will then be able to influence reallocation of healthcare resources, public-policy change, and targeted interventions needed to decrease emergency room visits and hospitalizations, and delay nursing home placements in this most vulnerable patient population.

Measurable Outcomes

The data will guide resource allocation at the population level. Descriptive study findings of this patient population will include:

- **State reported opioid/ sedation scale**
- **Depression (GAD7, PHQ9)**
- **Health literacy**
- **Healthcare utilization**
- **Smoking/ ETOH**
- **USPSTF screening rates**
- **Fall risk**
- **Up/ Go test**
- **Katz ADL scale**
- **MoCA Cognitive test**
- **Blood pressure**
- **Variety of biomarkers**
- **Medication Reconciliation**

1. Katherine Ornstein et al. "Epidemiology of the Homebound Population in the United States." *JAMA Internal Medicine* 175, no. 7 (July 1, 2015): 1180. https://doi.org/10.1001/jamainternmed.2015.1849.

2. "Medicare - CCW Condition Period Prevalence, 2016." *Chronic Conditions Data Warehouse (CCW)* online, last modified October 11, 2018. https://www.ccwdata.org/web/guest/medicare-charts/medicare-chronic-condition-charts.

3. Steven H. Woolf, et al. "How are income and wealth linked to health and longevity?" *Urban Institute and Virginia Commonwealth University*, (2015): 1-21. https://societyhealth.vcu.edu/work/the-projects/the-health-of-the-states.html.