



The Community Connections Program: Enhancing Self-Management Support in Health Care Homes

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Introduction

- The development of Health Care Homes (HCH) is a focus of ambulatory care design with self-management support as an integral component
- Successful self-management support involves effective partnerships with community service organizations
- Most healthcare systems do not partner effectively with community resources
- Limited existing structure and processes for active partnerships between the HCH and community service providers

Purpose & Aims

Using 3 proven approaches that support self-management, design and evaluate a structure for active partnering between HCH and community service providers for use with older adults with multiple chronic health conditions

1. Describe the productive interactions among team members
2. Demonstrate the use of recommended services by older adults
3. Demonstrate the feasibility of study procedures, treatment delivery, and data collection instruments to inform a larger trial

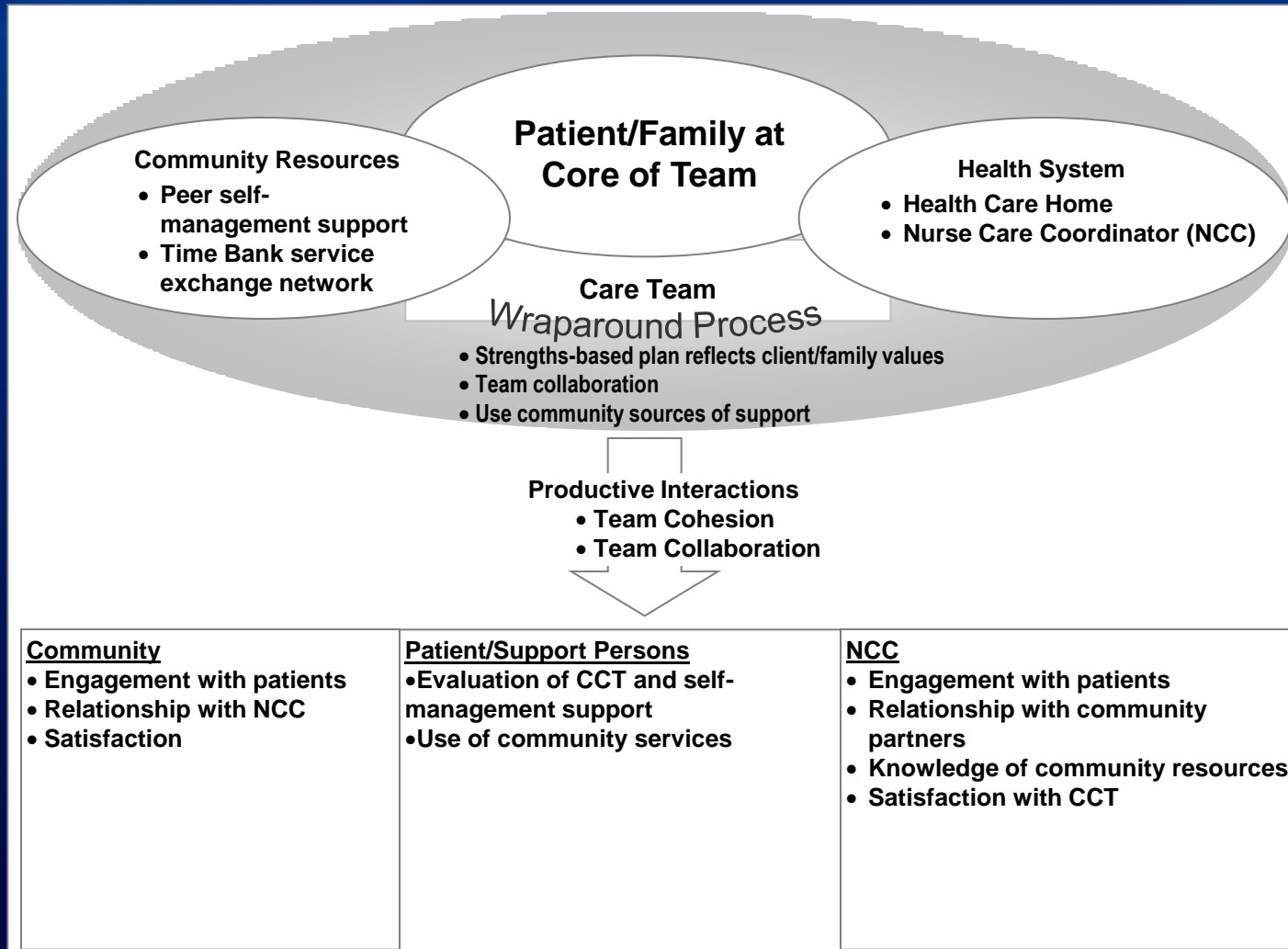
Integration of 3 Proven Approaches for Self-management Support

1. Nurse care coordination
2. Community services
3. Wraparound process
 - Developed in the 1980's
 - Origins in care of high risk adolescents
 - Cornerstone of children's mental health initiative
 - Comprehensive community based services to keep children and youth in the community rather than institutionalization

Wraparound Principles

- Family voice and choice
- Team based
- Natural supports/circle of caring
- Collaboration
- Community based
- Culturally competent
- Individualized
- Strengths based
- Unconditional
- Outcomes based

Study Framework



Study Design

- Descriptive
 - Phase 1: Feasibility study
 - Develop and Evaluate Community Connections Program (CCP)
 - Phase 2: Pilot study
 - Test CCP with 2 groups of HCH patients
 - Intervention (HCH services plus CCP)
 - Control (usual HCH services)

Sample and Setting

- Sample: 2 types
 - HCH patients and support persons
 - HCH and community service providers
- Setting: Mayo Clinic Rochester primary care practice recently certified as HCH

Intervention: Community Connections Program

1. Team Preparation
 - Engagement with patient/team; Strengths Assessment
2. Initial plan development
 - Convene team meeting
 - Discuss strengths/needs
 - Identify “difficult day”
 - Develop Action Plan including Crisis Prevention Plan
3. Implementation
 - Initiate Action plan
 - NCC follow-up on Action Plan and communication with HCH
 - Interim team meetings based on unexpected events; revise Action Plan
4. Transition
 - Plan and revise Action Plan to transition self-management support from team to circle of care

Team Members

- Patient & support person
- NCC from HCH
- Community health expert
- Community service provider ('trusted broker')
- Team meeting facilitator
- Team meeting recorder

Study Measurements

- Aim 1: Productive interactions
 - Team Cohesion (Group Cohesion Scale)
 - Team Collaboration (interagency Collaboration subscale of TMOF)
 - Care Coordination and Self-management Support (PACIC)
 - Family-centered Care (Family Centered Care Self Assessment)

Study Measurements

- Aim 2: Use of recommended community services
 - HSUQ adapted to include formal and informal community-based services
- Aim 3: Feasibility
 - Focus groups/interviews
 - Was It Worth It?

Study Procedures

- Recruitment & enrollment
- Team training
- Data collection
 - Baseline characteristics
 - Aims measured at 3 months

Aim 1 Results

- Team Cohesion/Collaboration: High scores
- Patient assessment of care: High scores
 - Activation
 - Goal setting
 - Problem solving
- Family assessment of care:
 - Care coordination & integration 100%
 - Decision making partnership 98%
 - Information and referral 90%
 - Ongoing care & support 75%
 - Support of family 72%

Aim 2: Community Services Recommended and Used

- Peer supporter
- Housekeeper
- Fitness center
- Volunteer opportunities
- Meals on wheels
- Chore/handyman services
- Handy-van transportation

Aim 2: Community Services Recommended but Not used

- Time bank service exchange network
- Senior center
- Formal moving services

Factors Impacting Self-Management

Unable to identify a support person

Clutter and hoarding precluded move to assisted living



Lack of problem solving ability for identifying and engaging with resources

Dysfunctional grief over loss of spouse

Patient and Support Person Interviews

- I liked that they were my decisions
- Got me motivated...it's not so overwhelming now
- Relief to know I can call the NCC
- Gained knowledge that there's help—a place we can go for help

Team Members Comments

- Enthusiastic about team functioning
- Different perspectives brought by team members
- Building relationships with the patient/support person is key team function
- Building on patients' strengths and opportunities is critical for Action Plan development

Implications for Nursing Practice

- Nurse Care Coordination was enhanced by collaboration with existing community service providers
- By identification of a difficult day the circle of care can work together to identify subtle cues of change
- Improving health includes attention to holistic definition of health and well-being

Next Steps

Test CCP with 2 groups of HCH patients

- Intervention (HCH care plus CCP)
- Control (usual HCH care)
- Measure
 - Patient Outcomes
 - Physical, social, and mental health
 - Use of costly healthcare
 - Use of community services
 - Identify individuals appropriate for CCP
 - High medical expenses Priority need for HHC
 - Continuing care needs NH admission
 - Long term NH Poor post acute outcomes

Funding

- MN Department of Health – Health Care Homes
- Mayo Clinic
 - Nursing Research & Evaluation Committee
 - Small Grants Program
 - Sponsorship Board



Thank you!

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