CLINICAL QUALITY ASSURANCE:

AN INTEGRATED, EVIDENCE-BASED APPROACH TO AGING ADULT SERVICES FOR THE SAN FRANCISCO COMMUNITY

Jennifer Swift

EXECUTIVE SUMMARY

Aging is not an option, not for anyone. It's how graceful we handle the process and how lucky we are as the process handles us…..

Cindy McDonald

Humans are born to age as the saying goes, and Napa County is predicted to have an increase of 50-149% to the population aged 60 and over. Both the Comprehensive Services for Older Adults (CSOA) division of Napa County Health and Human Services and the Department of Aging Adult Services (DAAS) provide needed safety net services for seniors. For CSOA, public health nursing is a recently revived addition to Adult Protective Services, In Home Support Services, MediCal and Older Adult Mental Health (OAMH) programs already in place. DAAS created the Clinical Quality Assurance Unit (CQA) with intention to recruit RN's with public health experience and a clear process of clinical assessment and follow-up support for consumers with issues that extend beyond departmental roles. This allows a streamlined service process that reduces the likelihood of inappropriate referrals and repeated hospital visits for seniors in need. CSOA strives, in partnership with the community, to continually improve processes and services. Adoption of CQA's recruitment and workflow strategies have the potential of further strengthening program collaboration and improving consumer outcomes.

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Introduction

Napa County is a community of older persons and at present is ill-prepared for the boom in the aging population referred to as the "Silver Tsunami." Napa County has 136,500 residents, of which 15 percent (20,400) are over 65 years of age. This compares to the 12.5 percent in California, illustrating Napa County's recent history of being a retirement community. The demand for senior services is likely to increase simply because the senior population is expected to grow from 20,400 to 27,500 in five years in Napa County (Eberling 2016). Of the residents 60 and over, 6,820 live alone, 3,095 are low-income, 5,223 live in rural areas and 7,190 are labeled "minority" (California State Department of Health and Human Services, 2016).

Each of those categories can be expected to have an impact on the overall health, income, access and utilization of necessary services and life satisfaction. According to the 2016 County Health Rankings recently released by the Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, Napa had 1,023 premature deaths (occurring prior to age 75) and has a 4,700 rate of potential years of life lost during 2011-2013 (RWJ Foundation, 2016). While not the most extreme or startling of data, it does help to call attention to and support the need for well-coordinated, prevention-based services and supports not only for older adults but across the lifespan.

This paper focuses on the older adult population and the impact the Clinical Quality Assurance (CQA) unit in the Department of Aging and Adult Services (DAAS) has had on coordinated

service delivery and interdisciplinary approach in working directly with at-risk populations. It focuses on how these programs address health crisis and health promotion programs at all levels of prevention, quality improvement measures, outreach activities, programmatic support and other DAAS initiatives. While there are large differences in both population and resources between the two jurisdictions, there are commonalities of need and complementary strategies that can be continued or initiated by Napa County Health and Human Services (HHSA) and its partners.

Background of Interest in the Topic

Prior to my employment at Napa HHSA, I worked with individuals with disabilities and also worked with frail elderly persons as a Certified Nursing Assistant, for 24 years in both skilled nursing facilities and home health agencies. I saw CQA as an opportunity to become familiar with cutting-edge efforts to provide quality services to our aging community members, and also become better acquainted with the workings of the CSOA program and staff. I have also had recent personal experiences with my own frail and elderly parent and his attempts to navigate the service system and options in his county of residence.

Clinical Quality Assurance Unit (CQA) Development and Key Elements within Department of Aging Adult Services (DAAS)

The Department of Aging and Adult Services in San Francisco contains four divisions with an annual budget of $242 million and a staff level of 347 full time employees (The Hawkins Company, 2016).

The CQA unit was created to assist DAAS programs and clients with a holistic, intra/inter-departmental approach to resolve or mitigate issues. It also provides clinical consultations for complex situations where increased assessment and supports are warranted to respond to health care or social service needs.

Some of the key elements are listed below:

- CQA Unit is comprised of four bilingual public health nurses (PHN) who use knowledge from nursing and social and public health sciences. As PHN's, they are experienced and skilled in the practice of promoting and protecting the health of adults and frail elders. The CQA nurses provide clinical consultations upon request to mostly APS and IHSS consumers. The primary responsibilities of the CQA nurses are to triage/prioritize the healthcare needs of referred clients. Needs range from health crisis due to client leaving an acute care setting or hospital against medical advice (AMA), chronic disease management of consumers with chronic obstructive pulmonary disease (COPD), to health promotion programs at all levels of prevention such as infection and exposure control education and training of consumers, family members and caregivers.

- CQA RN's have specialized skills and knowledge in the assessment, formulation of the health priorities and implementation of effective Health Care Plan (HCP). From the start, the application of CQA nursing core competencies were used to assess, manage and evaluate health risks of referred clients. The nursing core competencies included the following: (a) analytic and assessment skills in the areas of cognitive impairment, medication review, functional needs, depression, fall risks and nutritional risks; (b) integration of quality assurance and improvement process in program planning skills and data collection; (c) cultural humility to assess for social determinants of health in order to work with diverse individuals, families and groups in the

community; (d) motivational and strengths-based approach to facilitate client engagement when developing and implementing health care plans in the community; and, (e) public health sciences skills are used to incorporate public health and nursing science in the delivery of individualized or client centered service planning.

The team in the CQA Unit utilizes technology to collect, analyze, store and retrieve data related to health care plan of the individual. The team collects data that can be used to identify best practice/evidence-based assessments and interventions that are meaningful to the clients and identifies service gaps and duplication of services in the community.

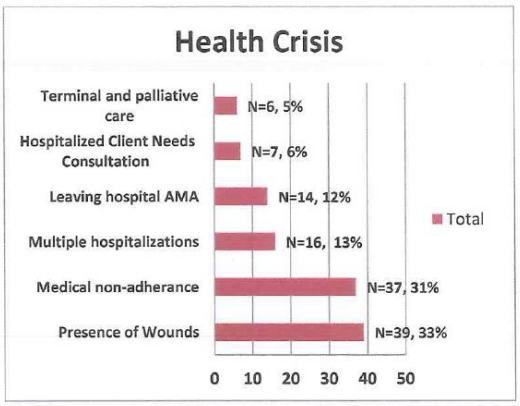
Measures of Successes and Challenges

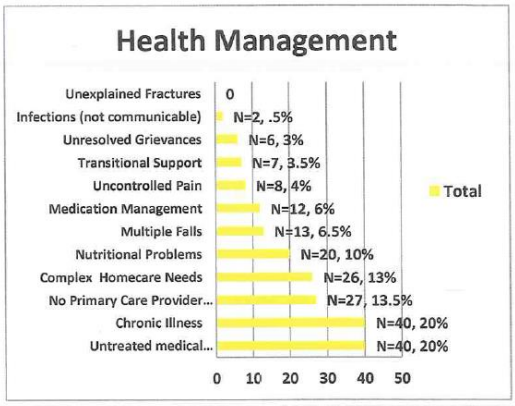
Some of the driving factors for the development of the CQA unit in addition to the DAAS mission are:

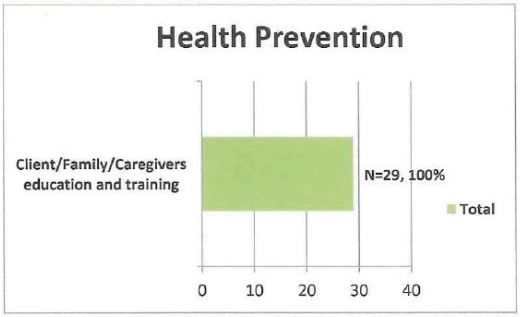
- Complex client health or social service situations sometimes exceeded the scope of a particular program or overlapped several DAAS programs.
- Before the inception of the CQA Unit, the nurses primarily functioned in the DAAS APS Unit. At that time, the nurses' primary functions were related to casework methods and the investigation of abuse/neglect allegations. As APS nurses, their roles and functions were limited and their clinical practices and responsibilities were not supported by the standard of practice for public health nursing. As part of CQA, the nurses' roles and scope were expanded to meet the growing needs of the consumers in San Francisco. More importantly, their job descriptions were updated to reflect expansion of their scope of practice in the areas of clinical competencies, leadership and services.

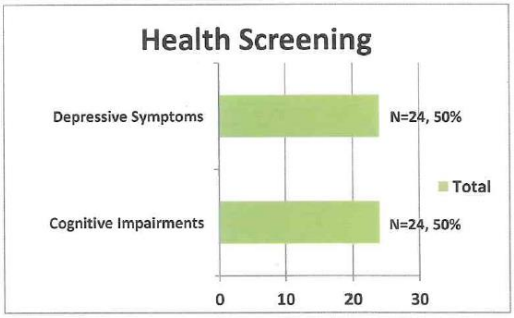
- CQA, RN's were not utilizing their entire range of clinical skills and participated in additional social work functions rather than focusing on health care needs.

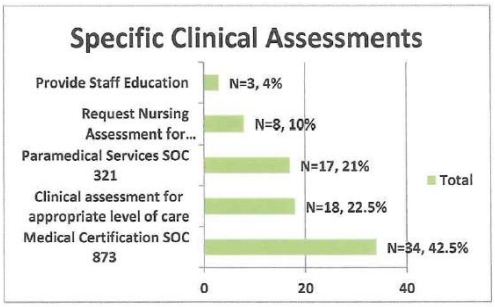
The CQA Unit was initiated in August 2015 with the training of PHN's in evidence-based practices, competency skills training, outreach to IHSS and APS, as well as the development and refining of the CQA process. In effect, while only being in operation for seven months, this unit has been able to demonstrate a positive impact on each of the major targets. From August through December 2015, there were 234 referrals and 273 home visits total. 63% of the referrals came from APS, 34% from IHSS, 3% from intake and .005% (just one) from LPS. See graphs below for referral data by type (CQA Unit DAAS).











According to Ria Mercado, RN director of Quality Management Services, with the CQA Unit available to the DAAS programs, they have been able to efficiently and effectively triage clients who left hospitals or skilled nursing services (SNF) against medical advice (AMA). The CQA RN's were able to prioritize the health care needs of the clients and connected them with their respective primary care providers (PCP). In partnering with APS, IHSS social workers, health care providers, clients and their families, the CQA RN's are able to develop health care plans based on the clients' preferences and assessed clinical needs. As a result of the CQA RNs' assessments and interventions, the majority of clients skipped unnecessary Emergency Room (ER) visits and were later supported by the community where they received outpatient services or skilled nursing services through a home health agency. Second, the majority of DAAS clients who were experiencing health crisis were triaged and later engaged with a CQA RN to receive immediate medical care in the community. Third, for DAAS clients who were experiencing sudden health changes, the CQA RN were able to reach out to clients and family members to access needed and relevant services in the community to manage chronic diseases through health prevention and screening. Fourth, DAAS clients and DAAS staff are supported through education and training to identify opportunity for health advocacy and wellness. Lastly, DAAS programs are making use of the CQA RN into their interdisciplinary team meetings to utilize their clinical inputs in developing individualized service plans.

Implications for Napa County

As previously mentioned, there is a vast difference between the service population sizes, total number of staff and financial resources available in Napa County compared to the City & County of San Francisco. It could be easy for smaller counties to dismiss innovative practices, such as CQA, as unfeasible in an environment where the size of population served often dictates who receives grants or who is selected for pilot projects. Below are some actionable steps Napa County can take to incorporate key elements of the CQA unit. Most will have a minimal impact in terms of financial and staff resources but several of these steps could respond to some of the needs identified by CSOA staff.

The recommendations to adopt referral, assessment and workflow documents and processes are as follows in order of priority and potential impact:

- Contact staff in San Francisco County to have an opportunity to discuss the tools, workflow, database, CQA training and recruitment with DAAS CQA leadership. Adoption of CQA key practices and tools could assist with a range of program goals in a short time period. The cost for seeking out this kind of input from colleagues in another county would be minimal. Once there is agreement on the assessment process and workflow, training on the documents and roles and responsibilities could be done at a regularly scheduled divisional, all-staff meeting. Database development would also require a discussion between CSOA staff and the HHSA Application Support Team Manager for pre-planning development and pilot run.
- Continue to explore financial resources that would enable the hiring of an additional PHN in CSOA, preferably bilingual in Spanish. The need of additional staffing has been ongoing and will occur when funding allows. Revenue possibilities could include the 1115 Medicaid Waiver: Whole Person Care Pilot or the development of a Wellness Fund to cover services and supports

across the life course managed by a collective impact entity such as Community Action Napa Valley (CANV). The purpose would be to expand the provision of culturally and linguistically appropriate services for the Spanish-speaking adults who are aging in Napa County. Based on San Francisco County's experience, the provision of culturally consistent services utilizing bilingual staff strengthens relationships with consumers and service providers alike and can generate positive PR for agency programs. An unmeasured but likely bi-product of positive PR and relationships is fewer refusals of service and strong APS reporting.

Estimated Cost: $85,176 annually for a bilingual PHN (excluding benefits based on current level of PHN salary at Step 2). Availability of funding for an additional PHN position could take 12-18 months although physical space has already been allocated for additional PH staffing. It will be a significantly smoother process to onboard new PHN's if there is a consistent and established protocol of roles and responsibilities regarding consumer care across programs.

Conclusion

Differences in size and financial resources should not be an impediment to Napa County Health and Human Services receiving the same benefits of having a Clinical Quality Assurance Unit embedded in CSOA. Adoption of a clear workflow could streamline services between RN's, IHSS, APS, and medical providers reducing the occurrence of inappropriate referrals, clarify follow-up responsibilities and potentially reduce the occurrence of re-hospitalizations. The implementation difference would be having one to two PHN's providing clinical consultations to IHSS, APS and OAMH, rather than five, but the practices will be established as hiring occurs to accommodate the growing senior population. The proposed action items should be quite do-able

and involve some direct conversations between those responsible for implementation as a first step in response to consumer need (and staffing availability) in Napa County.

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