GOT Care! Creating Synergy through a DNP/Ph.D. Partnership Model to Improve Care for Older Adults

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Presentation Objectives

1. **Describe how a DNP and PhD partnership can enhance excellence in programs of practice, education, and research.**

2. **Present experiences, outcomes, and dissemination of a DNP and PhD partnership within an interprofessional student and faculty training and outreach program focused on improving outcomes for vulnerable older adults with multiple chronic conditions and high emergency department (ED) use.**

3. **Discuss implications for future interprofessional programs and DNP/Ph.D. partnerships to improve the health and well-being of older adults.**

Background

- **Increasing numbers of DNP/PhD graduates.**
- **Need for partnership - translation of EBP, supported by research, into practice to improve health outcomes.**
- **Doctoral nursing students need experiences combining unique expertise and resources to foster this partnership into their professional careers.**
- **DNP/PhD faculty collaboration provides students opportunities to experience academic-practice partnerships.**
- **Much confusion related to the different degrees.**

(AACN Task Force Report, 2015; Bednash, et al., 2014; Carlson, et al, 2018; Edwards, et al., 2016; Staffileno et al., 2017)

Determinants of Doctoral Faculty Partnership

(Staffelino et al., 2017)

Determinant	Facilitators	Barriers
Interpersonal Relationships	Sharing common interests Appreciating skill sets	Lack of respect Feeling undervalued
Organizational Structures	Committee work Co-teaching Shared Governance	Lack of infrastructure for other than research scholarship (no pilot funding, stat support, mentoring, grant writing for DNP)
Systemic Determinants	National Organizations (AACN, IOM)	Less inclusive opportunities for funding, presentations, publications for DNP.

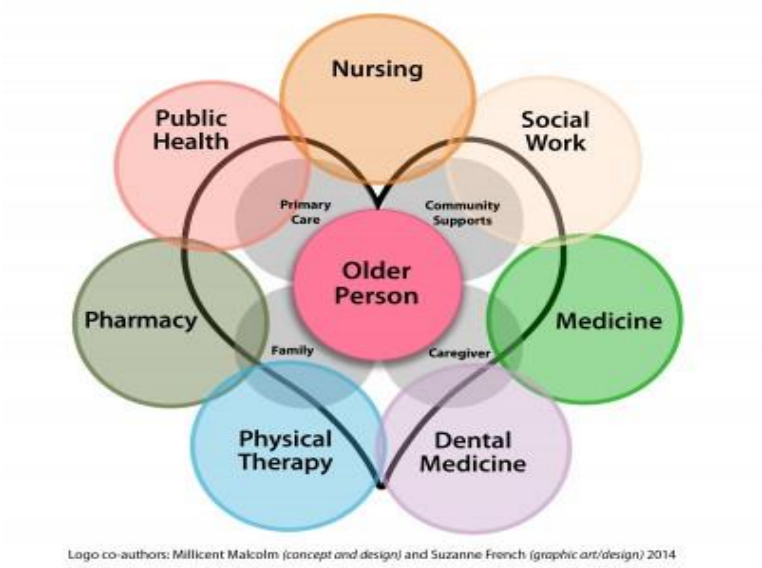
Leveraging the Skills and Resources from DNP-PhD Partnership

	DNP	PhD
Program Outcome	Highest level of nursing practice • improve patient outcomes • Improve population health • translate research into practice	Highest level of nursing science • conduct scientific inquiry • develop new nursing knowledge • advance science of nursing
Career Focus	Commitment to Practice	Commitment to Research
Resources	Access to • diverse practice settings • patient care technology • funding opportunities for practice improvements	Access to • research settings • information and research technology • research funding opportunities
Contributions to Healthcare and Nursing	Practice Scholarship Translate research knowledge to • implement and study practice improvements • stimulate policy change	Research Scholarship Develop new knowledge to • advance nursing science • disseminate new knowledge to promote translation to practice/policy

**Modified from American Association of Colleges of Nursing DNP-PhD/DNS Contrast Grid accessed from http://www.aacnnursing.org/Nursing-Education-Programs/DNP-Education.

GOT Care! is…

- **Theoretically-based, geriatric education and practice model using a DNP and PHD collaborative model.**
- **Designed to develop a cadre of healthcare providers skilled in interprofessional, geriatric care (5 cohorts, total of 264 students).**
- **An exemplar for leveraging the expertise and resources of the DNP and PhD, while role modeling this partnership for doctoral nursing students.**



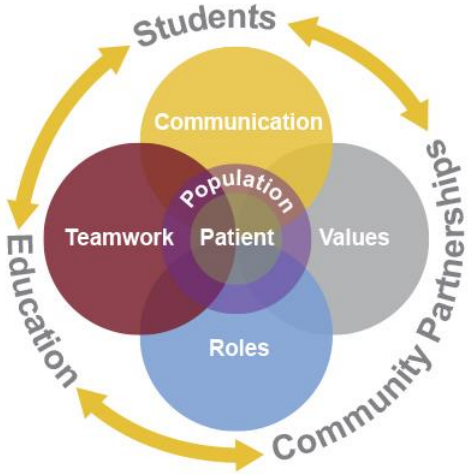
Logo co-authors: Millicent Malcolm *(concept and design)* and Suzanne French *(graphic art/design)* 2014

Foundations of the Project – Theoretical Framework

Interprofessional Education for Collaborative Patient-Centered Practice Model

Systematic Approach:

- **Consistent sharing of information and collaboration**
- **Reconciliation of differences between members of the team**
- **Engagement of the patient/family or population to optimize health care outcomes**



Source: Interprofessional Education for Collaborative Patient-centered Practice Model (IECPCP) (D'Amour & Oandasan, 2005)

Concept of Interprofessionality:

- **Disciplines come together to collectively reflect on and address complex health care needs of a patient/family or population**
- **Differs from "interdisciplinary" which includes combined but still fragmented knowledge obtained from multiple disciplines**

Source: IECPCP Model integrates the concept of *interprofessionality* (D'Amour & Oandasan , 2005)

Program Steps

Step 1 – Two Training Days, Start of Semester: pre-outreach, students from all disciplines participate in interprofessional collaborative and geriatric training conducted by faculty/team

Step 2 - In-Home CGAs: Outreach by IPCP faculty and trained students where home visits for discipline-specific comprehensive geriatric assessments are directed by team based on problem list

Step 3 – Case Conferences: Weekly interprofessional case conferences where students and faculty/team employs shared problem solving and healthcare-coordination and report out on CGA results

Step 4 – Primary Care Involvement: Telephonic contact made with PCPs; Suggestion letter to reduce risks for hospitalization and institutionalization prepared and sent to PCPs based on CGA findings

Step 5 – Follow-Up: faculty/team and students conduct follow-up visits and report out at case conference; Follow-up letter sent to primary care providers

Step 6 – Wrap-Up, End of Semester: Students and faculty/team reflect on the semester; Nurse Navigator continues patient follow-up, when necessary

- **Target Population:** vulnerable older persons with multiple chronic conditions and high ED use
- **Nurse Navigator (Homecare):** face of the program to patient/family/PCP/Community. Directs outreach process and performs ongoing follow up

GOT Care! Student and Faculty DNP-PhD Partnership

	DNP	PhD
Faculty	**Millicent Malcolm, DNP, GNP-BC, AGPCNP-BC, APRN** • Project Director/Primary Investigator • Project development/ lead for education and practice program • Project reporting: accomplishments, barriers, outcomes, financials • Dissemination	**Juliette Shellman, PhD, RN** • Project Evaluator/Co-Investigator • Evaluation Plan: development, data management and analysis • Program outcomes reporting • Participation in training (cultural competence) • Dissemination
Students	**Jessica Cave, MS, AGPCNP-BC, APRN (DNP Student)** • GA for Program • Assisted in education, practice, and reporting • Data collection students, faculty, and patients • Data management and analysis with Evaluator • Participation in dissemination efforts	**Anna-Rae LeClaire, MS, RN-BC (PhD Student)** • GA of Program Evaluator • Assisted in program evaluation functions • Participated in dissemination efforts • Interest in specific program interventions and outcomes as launching for dissertation work

Foundations of the Partnership -Theoretical Framework

Partners in Caring Model (Bernal, Shellman, & Reid, 2004)

- Based on Anderson & McFarlane Community as Partner (1996;2005).
- Central thesis of the model is the creation of a partnership whose commitment to the population being served is paramount.
- Major assumption of the Partners in Caring Model is that the creation of a culture of caring will provide the best learning experience for students, regardless of the curriculum model being implemented.
- Creating a culture of caring was facilitated by choosing faculty who share similar values, beliefs, and goals. This included the belief in the centrality of caring for both the students and older adults.
- A paramount value has been the creation of an environment of support for students that helped them feel part of the important undertaking of GOT Care!

Foundations of the Partnership – Theoretical Framework

Partners in Caring Model (Bernal, Shellman, & Reid, 2004)

Essential Constructs	Application
Knowledge of the community	Understanding of DNP Essentials DNP/PhD Program mission, requirements. Student skills Faculty expertise (research and practice) Faculty serving on both Ph.D. and DNP committees.
Culture of caring	Faculty commitment to mentoring students. Faculty role modeling. Appreciate value of different roles. Unified presence of nursing on interprofessional team.
Open communication	Inclusion of students in GOT Care! activities including dissemination. Meetings with stakeholders. Provide feedback so students are clear with responsibilities.

Partnership Dissemination

Team Dissemination	DNP/PHD led	Other IP Led	Student Led
Manuscripts	3 published 1 in review		
Symposium or Podium Presentations	1 International 2 National 8 State 7 Local	3 National Dental & SW 3 State SW & MPH	1 State Social Work
Poster Presentations	1 National NICHE 1st Prize 1 Local	2 National AHEC & PT	1 International 1 National DNP/PhD 1 State Pharmacy 1 Local BSNs
Workshops	2 National		

Forums for DNP/PhD Collaborative Research in Geriatrics

National Hartford Center of Gerontological Nursing Excellence

THE GERONTOLOGICAL SOCIETY OF AMERICA

SAN FRANCISCO IAGG 2017

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EDUCATION OUTCOMES

GOT Care! Program Learners

Discipline Students	Cohort 1 Spring 2015	Cohort 2 Fall 2015	Cohort 3 Spring 2016	Cohort 4 Fall 2016	Cohort 5 Spring 2017	Total
Dental	12	23	0	0	0	35
Nursing						
→ Undergraduate	14	7	13	16	12	62
→ Graduate	12	15	15	12	13	67
Medicine	1	5	5	1	0	12
Pharmacy	11	10	8	5	6	40
Physical Therapy	7	6	6	7	9	35
Public Health	0	1	0	1	1 **	3**
Social Work	3	2	1	2	2 **	10**
Totals	60	69	48	44	43	264 262 unique students

Interprofessional Collaborative Practice Outcomes and Measurement Tools

Likert Scale - Strongly Disagree = 1 to Strongly Agree = 7	Domain	M	SD
1. Our team mission embodies an interprofessional collaborative approach to patient/client care.	Team Leadership	6.0	1.0
2. Respect among team members improves with our ability to work together.	General Relationships	6.1	1.0
3. Team leadership assures that roles and responsibilities for patient/client care are clearly defined.	Team leadership	5.8	.06
4. Team members acknowledge the aspects of care where members of my profession have more skills and expertise.	General Roles and Responsibilities	6.5	.07
5. Patients/clients concerns are addressed effectively through regular team meetings and discussion	Communication/Information Exchange	6.4	.05
6. Members of our team share information relating to community resources.	Communication and Coordination of Care	6.6	.06
7. Processes are in place to quickly identify and respond to a problem.	Decision-Making/Conflict Management	6.0	1.1
8. The patient/client is considered a member of their health care team.	Patient Involvement	6.2	1.0

Student Contextual Process Data

Question	Themes	Exemplar Quotes
What does your team do well with regards to collaborative practice?	1. High degree of mutual respect for team members 2. Patient-centered team members 3. Strong desire to collaborate together 4. Networking with other agencies to link patients with appropriate services.	*"My group had a good mix of different health care professionals and I enjoyed learning the different perspectives each had to offer. Having the opportunity to interact with students from other professions was very valuable because it further opened my eyes to what each profession can contribute to give the patient optimal care."*
In your practice, what are the most difficult challenges to collaboration?	1. Time and scheduling 2. More hands on experiences for students 3. Environmental challenges.	*"The most obvious barrier is that there just isn't adequate room in homes of most patients to fit a whole team of healthcare professions. This is difficult for a program to manage due to time."* *"Time constraints – it is difficult to collaborate when the appointments are very short and there are multiple providers going in and out of the home."*
What does your team need help with to improve collaborative practice?	1. Need for a designated point person for follow-up care 2. Team members without hospital emails yet. Hinders communications, and timely follow-up 3. Create a pointed question intake form to identify most important patient needs	*"This was a great experience. I would have liked to have had more days to participate in these types (hands-on) of learning activities."* *"Communication can always improve no matter what."*

RESEARCH OUTCOMES

Patient Demographics

Patient Demographics	
Number Seen	60
Unique Patients	51
Female Participants	23
% Female Participants	45.1%
Male Participants	28
% Male Participants	54.9%
Veteran Status	18
% Veteran Participation	35.3%
Ethnicity/Race	
Hispanic or Latino only	0
Hispanic or Latino	2
African American or Black	5
White	41
Asian	0
Native American or Alaska Native	1

Comprehensive Geriatric Assessments

Patient Assessments (5 Cohorts):

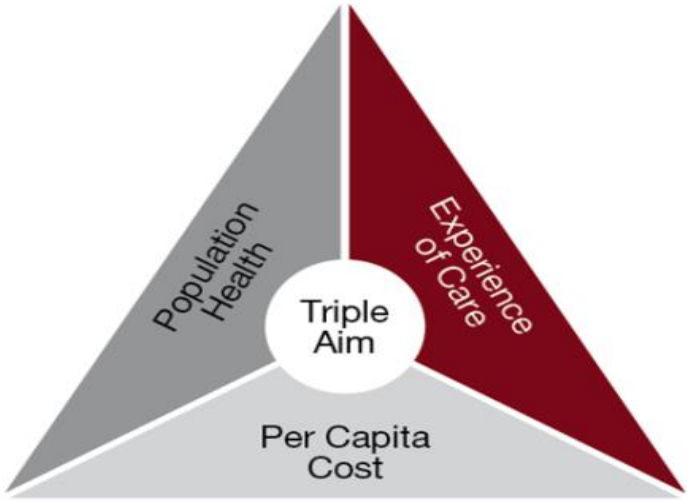
- 60 completed
  - 51 unique individuals
  - 6 were re-assessed
  - 3 did not complete the program

Snapshot of Common CGA Results:

- High ED utilization in previous 6 months
- Majority of patients have history of or current mental health disorder or substance abuse problem
- Majority of patients have high risk for falls
- High rates of polypharmacy and inappropriate medication use
- Many social determinants of health uncovered (lack of linkage to services, etc.)
- Complex family issues (lack of family supports; caregiver burden)

IHI Triple AIM – Improving Health and Health Care

A Framework to Optimize Health System Performance



1)Improving the patient experience of care
(including quality and satisfaction)
2) Reducing the per capita cost of health care
3) Improving the health of populations (determinants of health)
4) Quadruple AIM: health provider satisfaction

Triple Aim 1 Experience of Care

Quality

GOT Care! Team Recommendations to PCPs

- **Referrals to 20 different community services including:**
  - **Nutrition education (*n*=5)**
  - **Chronic disease management (*n*=6)**
  - **Middlesex Home Care for skilled nursing and/or Physical therapy (*n*=19)**
  - **Social work referrals (*n*=4)**
  - **Palliative care consults (*n*=4)**
  - **Dental services (*n*=5)**
  - **Center for Behavioral Health (*n*=7)**
  - **Audiology and Vision**
  - **Medication reconciliation**
  - **Home safety evaluations**

Patient Satisfaction

- **100% (*N*=40) reported they were always treated with courtesy and respect.**

- **90% (*N*=36) reported the GOT Care Team (GCT) always explained things in a way that was easy to understand.**

- **Patient contextual data:**
  - **Highly satisfied with care**
  - ***"It's wonderful students can learn from us"***
  - **Take the time to find out what is going on**

Triple Aim 2: Reducing Per Capita Costs

- **Final aggregate data indicates a reduction in Emergency Department utilization → pre and post GOT Care! Team visits by 26.2% (6 months) for the 5 cohorts.**

- **The number of ER visits made by the GOT! Care patients was assessed by reviewing EMR data pre-admission to the GOT! Care program and post GOT! Care participation at 6 - 8 - 12 months.**

- **Future Analysis:**
  - **Pre-post- associated cost reduction.**
  - **Patient specific comorbidities, risk factors and other potential variables that may influence ED visits → to determine level of influence the GOT Care program had on the reduction of ED visits.**

Triple Aim 3 Population Health

Component	N	Mean	SD	T-score
Global Physical Health Pre	42	11.16	2.15	37.4
Global Physical Health Post	38	11.23	2.48	37.4
Global Mental Health Pre	42	12.11	2.50	43.5
Global Mental Health Post	38	11.31	2.21	41.1

Triple Aim 3 Population Health

PROMIS® (Patient Reported Outcomes Measurement Information System)

In general would you say your health is.....

Rating	Pre-test		Post-test	
	Frequency	%	Freq	%
Poor	11	23.4%	8	21.6%
Fair	9	19.6%	8	21.6%
Good	17	37.4%	11	23.6%
Very good	3	17.4%	9	19.6%
Excellent	1	1.2%	1	2.2%
Missing data	0		9	19.6%
Total	46	100%	46	100%

Quadruple Aim Provider Satisfaction

Based on Likert Scale Strongly Disagree = 1 to Strongly Agree = 7	N=33	
Communication and Information Exchange Items	**M**	**SD**
1. The GOT Care! Team provided relevant suggestions for my patient.	6.4	.69
2. The GOT Care! Team comprehensive assessment may help adverse events including emergency room visits.	6.0	.81
3. I would not hesitate to recommend other frail patients to the GOT Care! Team.	6.7	.48
4. After reviewing information from the Got Care! Interprofessional Team, I am more likely to use an interprofessional approach to manage my frail patients in the future	6.6	.41

Implications & Next Steps

Our Partnership Experience

- **Cohesion:** successful because we focused on mission, vision, and goals of the DNP/PhD programs.
  - Using and combining the strengths of each doctorally prepared nurse faculty member
  - Interdependence – creating culture of caring –faculty – student - patient
- We demonstrated that DNP/PhD partnerships can improve older adult outcomes.
- **Increased access to:** research, funding and manuscript opportunities
  - Publications regarding DNP/PhD partnership and GOT Care! outcomes in process
- **Co-chairs:** added depth and breadth of expertise to DNP/PhD student committees
- UConn culture provides facilitators for DNP/PhD partnership such as organizational support, pilot funding, statistical support.

Discussion/ Recommendations

- **Successful DNP/PhD partnerships require open communication, mutual respect and caring, and an understanding of each other's skills and expertise.**
- **Openness to evaluating the partnership.**
- **Purposeful pairing of DNP and PhD faculty as part of a DNP Project or Ph.D. Dissertation Committee (Edwards et al., 2016).**
- **Create opportunities for collaboration through shared courses.**

Next steps…….

GOT! Care 2.0: An Interprofessional Geriatric Academic-Practice Innovation

- **Funded through UConn Center for Nursing Scholarship and Innovation (CNSI) 2018 Awards for Pilot Research, Innovation, and Teaching Projects.**

Project Aims

1. Assess the needs and capacities of the community stakeholders including patients, UConn faculty, and Middlesex Healthcare System.
2. Evaluate the legal and regulatory requirements, and cost benefit and reimbursement potential for a fully functional interprofessional geriatric clinical service line.
3. Develop a GOT! Care 2.0 logic model to map out the program plan, evaluation plan and outcomes.

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