Care and learning: Snigdha Menon, a nursing student at Virginia Commonwealth University (VCU), holds a light while Kathie Falls, a nurse practitioner and instructor in VCU's Department of Family and Community Nursing, examines Cletis Bailey, a Dominion Place resident. Partially obscured is Jacklyn Atkins, a fourth-year pharmacy PhD student.

DOI: 10.1377/hlthaff.2019.00225

A SERIES ON
HEALTH SYSTEM TRANSFORMATION

An Education In Meeting Patients Where They Live

In Richmond, Virginia, an interprofessional group of health care students and faculty members is helping seniors solve problems early.

BY T. R. GOLDMAN

The common room on the ground floor of Dominion Place, an independent living community in downtown Richmond, Virginia, has an ambling, street-corner feel of a mild summer evening. Some tenants sit side by side, talking at each other, jocular, relaxed. Others are mostly silent, speaking only when they have something to say.

Almost all of the building's 250 residents live in identical, 452-square-foot one-bedroom apartments (two dozen apartments have been modified to make them accessible to people with disabilities), with the rent subsidized by the Department of Housing and Urban Development (HUD). The structure's bunker-style concrete façade was popular at the time the building was constructed in 1977.

One out of ten residents are older than age sixty-two; 60 percent have a high school diploma or GED and 35 percent do not, while 5 percent spent some time in college; 70 percent are African American; and just over half are women, says Gregory Ford, the area resident-service manager for Beacon Communities, the Boston-based management firm that owns the twelve-story apartment building. The average resident's monthly income is $800. Thirty percent of that must go toward the rent, with HUD picking up the rest.

In a health care system that costs more money—US per capita spending on health care was over two and a half times the average for countries in the Organization for Economic Cooperation and Development in 2017[1]—yet whose outcomes are consistently worse than those in other large and wealthy countries,[2] change is essential. The interprofessional group of health care students and faculty members who show up here every Thursday as part of the Richmond Health and Wellness Program (RHWP), setting up shop in the drab but comfortable community room, may represent one of the best ways to improve those metrics.

The RHWP is all about health and wellness. It is most emphatically not a medical model, and the twenty or so students who arrive here and at a handful of similar locations each week in business casual attire (not scrubs) and then split into teams of four or five students each have only the most rudimentary medical equipment—stethoscope, otoscope, glucometer, blood pressure monitor, and smartphone flashlight—on hand. If the medical model focuses on repairing a damaged organ, the health and wellness model focuses on repairing and sustaining the entire human being. Health in the RHWP model is "one's physical, mental and social peace of mind," while wellness is "a state of

Photographs by T. R. Goldman

optimal well-being" that, among other things, allows someone to deal with the vicissitudes of life or quite simply "to cope."[3]

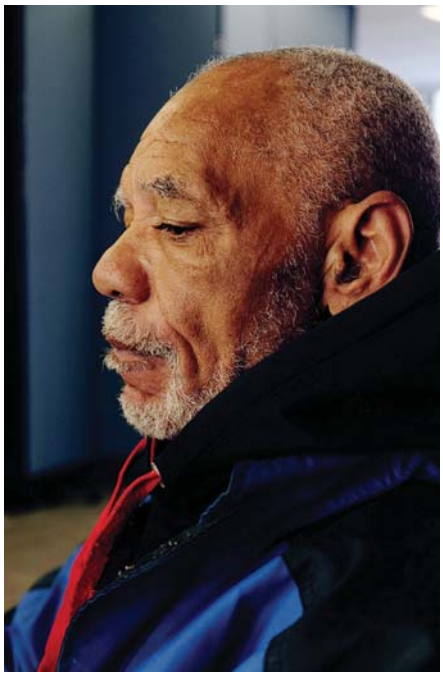
The RHWP teams meet separately with individual residents—sometimes as many as a couple dozen during the day—who complain of particular ailments, providing advice, taking vital signs, and making referral appointments. Though it's not a formal clinic, one of its most valuable functions is giving residents the vocabulary, clinical data, and context related to their medical issues so that a subsequent visit with their primary care physicians is not only less intimidating but more productive.

Equally important are the conversations with residents about more quotidian issues, especially those involving the management of complicated pharmaceutical regimens and how to pay for them. Sometimes the team will visit residents with functional impairment in their apartments upstairs, to help those who have just returned from a hospital stay, provide advice on how to make one's living space less dangerous, or help arrange transportation to and from the doctor. Sometimes the team simply provides an antidote to the loneliness of social isolation.

Interprofessional Meets Interpersonal

The literature of health care is awash in a jargon of easily attenuated meanings, but the RHWP actually practices the precepts behind several of today's best-known buzzwords: It is in the most literal sense community based and patient centered. The program is actually built around what the residents have said they want, and its goal is to support their aging in place—that is, helping residents remain part of their apartment building community and avoid, if at all possible, the perils of the nursing home.

The RHWP is by definition interprofessional, a much-ballyhooed but rarely practiced training method that fits well with the trend toward value-based care, which "reward[s] working together to untangle knotty societal problems," as a 2017 piece in the *New England Journal of Medicine* puts it.[4] And unlike a classic acute care setting where physicians' orders rule, the informal yet intensely personal interactions with residents that are part of the RHWP model force students to be creative in ways a more institutional setting would not, allowing them to see firsthand, and at times try to mitigate, a host of negative social determinants of health.



Patient: Cletis Bailey, a Dominion Place resident, moved to Richmond two years ago from his hometown of Newport News, Virginia.

The six-year-old program is run out of Virginia Commonwealth University (VCU), a public research university with a range of health professional schools, including medicine. The university is allied with VCU Health, a health care system with $3.4 billion in annual revenue.[5] VCU Health also operates an academic health center and owns a managed care firm, Virginia Premier, the second-largest managed care organization in Virginia. The program—which draws heavily, but not exclusively, on VCU faculty and students—is part of a scattershot movement across the United States whose methods might differ but whose goal is the same: holistic preventive care for high-risk, chronically ill patients that can stop minor problems from escalating into major ones, which inevitably seem to lead to an ambulance ride to the local emergency room (ER).

"And it's the ER where the costs *start*," notes Peter Boling, the chair of VCU's Division of Geriatric Medicine and an adviser to the program. Anyone admitted to an ER is almost always seen by a physician—who, Boling adds, "doesn't know you from Adam"—and must then undergo a battery of tests to rule out all but the most unlikely causes of his or her malady. There's a strong chance that the ambulance ride will also end in a hospital stay. For older, more vulnerable patients, such a stay is inherently fraught with risks (including infection, medication errors, pneumonia, and deep vein thrombosis), which in turn can lead to an even longer time in the hospital. And there's always the possibility that the deleterious impact of lying in bed for several days, which can lead to vertebral bone loss, among other things,[6] will require a nursing home stay to resolve.

In an often inflexible and fragmented health care system, however, where there is a financial incentive to compete rather than cooperate, crafting a program that is able to operate within the interstices of the hospital and the primary care provider and that is both sustainable and replicable has been difficult. Progress is "very slow," says Robyn Stone, the senior vice president for research at LeadingAge, a research and advocacy organization for the aging, letting out a long sigh. "I think there's a lot of talk about service coordination, person-centered care—these kinds of interventions. But for the most part they tend to be one-offs, and there's not enough investment in understanding their value," adds Stone, who has seen the RHWP in action and is highly supportive.

Addressing Social Determinants Outside The Doctor's Office

Somehow the RHWP has managed to thread a very delicate needle, successfully combining an inordinate number of progressive ideas that are percolating throughout the health care system. It provides VCU students with training in motivational interviewing techniques as well as a real-world interprofessional learning experience: Students watch how people on their team in other disciplines, both medical and nonmedical, question and interact with residents and then share their particular expertise when they discuss a resident's situation among themselves.

Faculty participants—a group that tends to include a large number of PhDs and PhD candidates—can use the site not just for teaching but for grant-based research. And the parameters of the program are in large part driven by the residents, sometimes with unexpected results. At Dominion Place, says Ford, the area resident-service manager, tenants asked the RHWP not just for the expected blood pressure and glucose checks, but for mental health services as well. "That was a welcome surprise," says Ford, noting that Dominion Place's population is nearly three-quarters African American. "Admitting you have some mental health issue isn't widely acceptable in our community," he explains. "There's a lot of shame, and a lot of hiding that goes on. So for this to become an environment where it's acceptable and OK and we can have dialogue about it and connect resources—that's been good."

More to the point, there are nascent data to back the model up. A pilot study of 227 people who took part in the RHWP over three years, adjusted for disease burden, found that they had 8.6 percent fewer ER visits and 9.8 percent fewer hospital admissions than similar patients in a control group.[7]

"It's like a tune-up," explains Roosevelt Byrd, a resident of Church Hill house, a 297-unit complex where the RHWP visits every Wednesday morning. "I can get my blood pressure checked, get my sugar checked. That's what we really need. On a bad day you might not make it to the doctors. But you can make it downstairs."

The RHWP has placed itself in a very specific role within the great maw of the US health care system: as an interface between the patient and the primary care physician, who is rarely equipped to understand the complexities of the patient's social determinants—having a 400-square-foot apartment, no help, and no family and being functionally illiterate, for example—that are often the subtext behind a visit to the doctor.

"The burden placed on primary care providers in office settings is to deal holistically and comprehensively…with all the social determinants that wrap around why people go to a physician or a nurse practitioner in the first place. My life is the reason I'm coming to you," explains Michael Bleich, a senior professor at VCU's School of Nursing, who was also a consultant to the RHWP.

"But it's a very unfair expectation. Holistic care is not time feasible," Bleich adds. "And the usual understanding of what that means, at least in a physician's office, is often quite limited. A nurse, a nurse practitioner, a physician, maybe one other wrap-around profession—a social worker, perhaps? It's usually not a PT [physical therapist], not a nutritionist, [and] there's sure not a psychologist."

The RHWP is different. It is nurse led—BSN nursing and nurse practitioner students predominate—but it is, by design, interprofessional. And there are nearly as many pharmacy students, as well as a large number of occupational therapy, medical, and social work students and a smaller number of students studying psychology. There are even law students who focus on helping residents draft advance medical directives and powers of attorney.

This spring the RHWP will offer its services—from health screenings and chronic disease management to nutrition advice—at VCU's new nearly $1 million Health Hub, a 5,600-square-foot building in east Richmond where "people will come to us, and you don't have to just live in a senior housing apartment," explains RHWP cofounder Pamela Parsons, a geriatric nurse practitioner and associate dean for practice and community engagement at VCU's School of Nursing. There are also plans to expand the interdisciplinary footprint to include engineering and art students, and possibly other professions as well.

Dental hygiene students will be joining the resident housing program this fall. Like the other students, they will not be providing care (in their case, cleaning teeth) because the RHWP is not a formal "medical home," Parsons says. Rather, "it is teaching and preventive education and connecting people to care services. It's what can you do to train your students in a community-based setting that also enhances wellness for individuals—and that's a cognitive leap."

The program has operated every Thursday at Dominion Place since 2012, and it has expanded to four more low-income, elderly residences in Richmond that serve a total of more than five hundred people. It's this continuity and "frequent touch"—the accretive impact of the weekly visits—that allow the program to normalize itself in the community and provide RHWP team members with a more personal and nuanced view of the residents. It also means that they're more likely to spot potential problems early on. "All of a sudden their speech is a little different, they look like they're losing weight, there's a failure to thrive," Parsons explains. "We know this because we've seen them over time and seen them consistently."

In effect, she says, the program's aim is to serve as the eyes and ears of the primary care physician—or more. One resident suffered from white-coat hypertension, explains Ana Diallo, an assistant professor at VCU's Department of Family and Community Health Nursing and one of the RHWP faculty members. "When she comes to us, her blood pressure is fine. But when she goes to the doctor, it's high. So the PCP [primary care physician] asks her to have her blood pressure taken here. I call it in, and she has a card where it's written down as well."

Bringing Wellness Home

Dominion Place sits in the middle of the VCU campus, a collection of buildings spread out over the streets of central Richmond. It is a mile and a half from the State Capitol and a five-minute walk to Monument Avenue, where Richmond's heritage as the former capital of the Confederacy is on full display and statues of Civil War heroes (as well as the African American tennis star Arthur Ashe) stretch for several blocks to the northwest.

It made sense as a starting point for a wellness intervention program. Not only is there a large population of elderly people—if *elderly* can be defined as those older than sixty-two. It is also a population whose general lack of financial resources means that a small personal problem such as a stolen phone can easily mushroom into something far more significant, since it's now much harder to call insurers and doctors and to schedule appointments.

In a country that spends some $3.5 trillion a year on health care, a large percentage of it wasted on medically super-

fluous expenditures, Dominion Place also stood out as especially ripe for improvement. In 2012, for example, 151 of the 153 transports by the Richmond Ambulance Authority from Dominion Place to the hospital were later classified as nonemergency. What if, Parsons asked, many of those trips could be prevented by bringing help to people where they live?

By choosing to treat an entire apartment complex, the RHWP has turned the traditional hot-spotting model on its head.[8] Whereas many programs are aimed at identifying at-risk patients within a particular hospital system, for example, to provide extra support when they transition back home, the RHWP model focuses on a whole population—people who live in one of Richmond's many senior-based low-income independent living communities.

"They didn't start by identifying people who'd been heavy users of their health system," says Stone, referring to VCU Health. "They started with low-income housing and assumed they were all at risk. And the value of the senior housing piece is that you've got economies of scale, with so many people living close together," Stone adds. "It's much harder to do this when people are dispersed and living all over the place."

On a frigid Thursday morning in late January, Cletis Bailey, age sixty-eight, walked into the community room at Dominion Place from his upstairs apartment, leaving a pot of chicken, onions, and potatoes simmering on the stove. He said he had a terrible pain in his mouth, one that had moved all the way up the left side of his head. He'd run out of Aleve, and it was too cold to go to the store. And besides, he was short of cash as well.

"The pain in my teeth, anything that touches it hurts. It's killing me, man," he told Ashley Stanley, the clinic coordinator who was doing an intake assessment before deciding which of three different interprofessional student teams there that day to send him to.

Bailey, whose gray hair is closely cropped, was wearing khaki cargo pants and tennis shoes. He said he'd moved to Richmond two years earlier from Newport News, Virginia, where he grew up. He'd been working as a gang leader on a cement finishing crew, where the pay was $25–$30 an hour. He'd also been to barber school and was a second-class electrician.

The RHWP is all about health and wellness. It is most emphatically not a medical model.

"On a scale of one to ten, where is the pain?" asks Stanley.

"Ten," Bailey replies, with no hesitation.

"Are you dizzy?"

"Yes—seems like my head wants to go somewhere else."

Stanley sends him into a small room that contains little more than a table, a few chairs, and three students: Beth Chau, who is in a nurse practitioner program; Snigdha Menon, who's in the last year of her BSN nursing degree program; and a fourth-year pharmacy PhD student, Jacklyn Atkins.

"I felt it throbbing in my head last night," Bailey tells the students. "I'm glad you all came today."

Bailey is lucky: He has family, the ultimate financial life support: four children ages 46–50 and a brother and three sisters, one of whom lives in Germany. "I was a knee baby boy," he tells the students, using a Southern expression for the second-youngest child. "If I were really to run out [of money]...." And he makes a phone call motion with his hand.

"Mind if I use my phone?" Chau asks Bailey. "I'm only using it for the light," she explains, peering inside his mouth. Chau asks Bailey to stick out his tongue to make sure it is protruding straight out and not to one side or the other, to check his hypoglossal nerve—the twelfth cranial nerve that innervates most of the tongue. It seems clear that Bailey needs to go to a dentist as soon as he can, but the weekend is coming.

The students take their phones and start calling, but they discover the free clinics either are not answering the phone or are full. One student telephones the number on Bailey's insurance card to see whether emergency dental care is covered. It's not. VCU Health has a dental clinic, but it's $150. Bailey lets out a loud exhalation. "That's a lot of money," he says.

Kathie Falls, a nurse practitioner and geriatrics specialist and instructor in VCU's Department of Family and Community Nursing, stops by to look in on the students and check Bailey's ears with an otoscope. "There's no adenopathy," Chau tells Falls, referring to swollen lymph nodes. "The neuro exam was unremarkable. He's cognitively stable."

Bailey eventually did get an appointment at a dental clinic, but he didn't go. The RHWP team, however, is back every week, and, Parsons says, "we can follow up and reassess. We have the ability to reconnect with him. That's the beauty of increased touches."

After Bailey leaves, the students discuss what they had seen. "People come to us for questions about everything," says Chau, who finishes her nurse practitioner program this spring. "Can I talk about this or that?"

Understanding The Patient

Sometimes, the talk makes clear the challenges of health literacy, as patients dutifully recite medical myths that are difficult to dislodge. Some ideas—that drinking coffee helps prevent constipation, for example—can have unfortunate side effects such as interfering with sleep. Others can be downright dangerous, such as the belief that Tylenol is more hazardous than nonsteroid anti-inflammatory drugs (NSAIDs) like Aleve and ibuprofen. In fact, for older adults it is NSAIDs that can be risky, causing spontaneous gastrointestinal bleeding or worse.

Team members have also sought to dispel the notion among some residents that for a condition such as high blood sugar, "as long as it's not 600 [mg/dL] and I don't have to go to the ER," there's no reason to worry, explains retiring VCU pharmacy professor Patricia Slattum, who cofounded the program with Parsons. Other residents may believe that there's nothing wrong with taking only half a regimen of prescribed antibiotics, hoarding the rest to save money the next time one gets sick.

For the program's future pharmacists, who often work in relative isolation from other health system professionals, it is a rare chance "to see medication not in isolation but firsthand, as with a resi-

dent who is in pain—rather than simply handing those pills across the counter," says Slattum, who in addition to teaching ran VCU's Geriatric Pharmacotherapy Program.

And because the teams often visit residents in their apartments upstairs, a clinical and educational benefit that's hard to overstate, it's also a rare chance to connect patient to pill and to fully appreciate the complexities, if not impossibilities, of swallowing anywhere from ten to two dozen pills a day—in addition to an unknown number of over-the-counter medications. One student recalls meeting a patient who was taking pain medication, thinking it was an antibiotic. She still had her infection, she said, but her back pain was gone.

"We have medicalized late life in this society," says Slattum. "There's a pill for everything." Doctors get little if any training on deprescribing medications, either. Indeed, she says, a bad reaction to a drug is sometimes not interpreted as an adverse event "but seen as either a new diagnosis or a worsening of a prior condition, so there's this prescription cascade, where you're treating side effects with pills."

Elderly pharmacology is especially tricky. While younger people react with relative consistency to medications, the pharmacological metabolism of the elderly is far more individualized, the brain becomes more susceptible to side effects, and the liver does not metabolize or the kidneys eliminate waste as efficiently. Sleeping pills are also frowned upon because they increase the likelihood of falls—a particularly perilous prospect for older people.

All of this calls for a different type of patient interaction than one might find in an acute care hospital setting, says Tamara Zurakowski, a clinical associate professor and undergraduate program director at VCU's School of Nursing and an RHWP faculty member. "In the hospital, we feed you what we want and give you the pills we want you to take," she says. "Here, we're teaching autonomous clinical decision making instead of an acute care model based on a physician's order. That's a big shift. To work where someone lives requires a lot of creative thinking."

Scaling The Model Across Richmond And Beyond

Richmond has been an especially good fit as a proving ground for the RHWP. "It is big enough to have all the urban problems of a major city, but small enough to get those collaborating on change to the table," says Steven Woolf, a physician and the former director of the VCU Center on Society and Health. And its health equity chasm is large. According to a life expectancy map produced by the center, there is as much as a twenty-year gap, from age sixty-three to age eighty-three, between the average length of life in two different Richmond ZIP codes.

One-quarter of Richmond's 225,000 residents and nearly 40 percent of its children live in poverty, according to the 2010 American Community Survey, while some 20 percent of its population is food insecure.[9] The city is steeped in history, much of it racially charged, and over the years there was a concerted effort by local officials to keep its long-standing and prominent African American community sequestered on one side of town.

After the Creighton Court housing project opened in east Richmond in 1952, the Richmond Redevelopment and Housing Authority built three more projects in east Richmond over the next ten years, "concentrating 1848 units of public housing for African American families within an approximately one-mile radius," according to a 2015 article in *Cities*.[10]

"Poor neighborhoods produce poor schools, which produce poor educational outcomes, which lead to less chances to make money, which puts you right back here," says Albert Walker, a Richmond native and director of Bon Secours Health System's Healthy Communities, as he shows a visitor around Richmond's East End.

After several years of foundational work, the RHWP has become a solid presence at VCU and is on the cusp of an all-but-inevitable step: costing out the program so that other academic health centers—whose generally urban locations and tripartite mission of clinical care, research, and education make the program an ideal fit—can try it themselves. Understanding how to pay for the program is also important in Richmond, because at some point, the grant money will run out.

So far, in addition to substantial support for faculty salaries from VCU, the bulk of the funding has come from a three-year, $1.5 million grant from the Nurse Education, Practice, Quality, and Retention program of the Health Resources and Services Administration.

"The cost of the supplies is nil," Parsons says. "But then you have to figure the cost of three or four faculty members for half a day. And if you don't separate out how much was for research, how much for teaching, and how much for the delivering of the wellness service, you have a false number." In addition, she says, not every VCU school can afford to have a faculty member at the program as a preceptor, yet "most students need practicum hours—that's why they are there."

The RHWP is nothing if not adaptable, however, and its essential model of providing research and teaching opportunities to faculty, educational opportunities to students, a health and wellness service to residents, and a second pair of eyes and ears for primary care doctors can be tweaked in innumerable ways to meet specific academic health centers' demands.

The Richmond program, in particular, prides itself on its approach to research, Slattum says, focusing on the needs of residents "versus writing a grant, coming in and inflicting on a community whatever we want, then disappearing." The program's emphasis is on "solving real-world problems by using the [resident] community to shape your research." Current projects are studying cognitive frailty as well as the genetic basis for variability in drug response.

The crucial ingredient for replication anywhere, say those involved in the program at VCU, is buy-in from leaders at every level, from the president to the various deans of the health schools, department chairs, and those running a school's interprofessional efforts and health innovation work, assuming such positions exist at every interested school.

Yet even then, the specter of bureaucratic inertia hangs heavy in the air. "Even though we're moving our resources away from acute care, the education model is still everything about acute

care," notes the dean of VCU's School of Nursing, Jean Giddens. "Academia moves at glacial speed. And it takes time for a good idea to be tested—and for other people to notice."

Ultimately, to move into sustained and widespread use, any financing model will have to include financial support from the Medicaid and Medicare managed care plans, ideally through a case rate model—that is, a fixed payment for each of their members who are served by the RHWP, plus an incentive payment to the RHWP on top of that if certain targets are met.

"If you are able to keep people in the community longer, that's a huge plus, because the average nursing home cost is about $5,000 a month. If they're there in perpetuity, that's a huge cost, almost equally costly to having multiple hospital stays," notes Linda Hines, the chief executive of Virginia Premier, VCU Health's managed care subsidiary.

"We're going to look at how many people avoided going into a nursing facility—literally, we can measure that—and put a dollar [figure] on that, and how many people did we avoid going to the hospital or avoid getting readmitted. These are hard dollars," Hines continues. "As a model, payers will pay for this. But getting to how we will do this will take some time."

No doubt insurers will be clamoring for rigorous data from gold-standard randomized controlled clinical trials, an inherently difficult metric to obtain given the wide range of variables in patients with complex chronic illnesses—from individual variances in primary care to differing self-management skills. That point was forcefully argued in a 2015 article in the *Journal of the American Geriatrics Society* on a concept analogous and similar to the RHWP's aging in place model: care coordination. "The question is not whether coordinated care 'works,'" wrote Christopher Callahan of the Indiana University School of Medicine. "The question is how best to apply coordinated care principles to obtain the most out of the knowledge and resources available."[11]

And it remains an open question whether replication also requires whatever intangible personality traits the RHWP's two founders, Pamela Parsons and Patricia Slattum, brought to the program, or whether a set of detailed instructions and a procedural flow chart will suffice.

"Pam, she has a habit of getting me to do anything," says Helen D. Jones, who is seventy-four years old and has been a Dominion Place resident for the past ten years. "She's a good old girl. I got to meet her son and her husband and daughter," she adds, referring in fact to Slattum's daughter, a former VCU nursing student who was an RHWP research assistant and frequent visitor at Dominion Place. ■

This article is part of a series on transforming health systems published with support from The Robert Wood Johnson Foundation. **T. R. Goldman** (trgoldman1@gmail.com) is a Washington, D.C.–based freelance journalist.

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