Meals On Wheels
LEADERSHIP ACADEMY

MOWAA ANNUAL CONFERENCE & COMMON GOODS EXPO

How Care Transitions Impact MOW Programs

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August 24, 2012, 9:00 a.m. - 10:30 a.m.
2012 MOWAA Annual Conference
Gaylord National Harbor Hotel

Department of Health & Human Services

Administration for Community Living

For seniors and people with disabilities

How Care Transitions Impact MOW Programs

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August 24, 2012

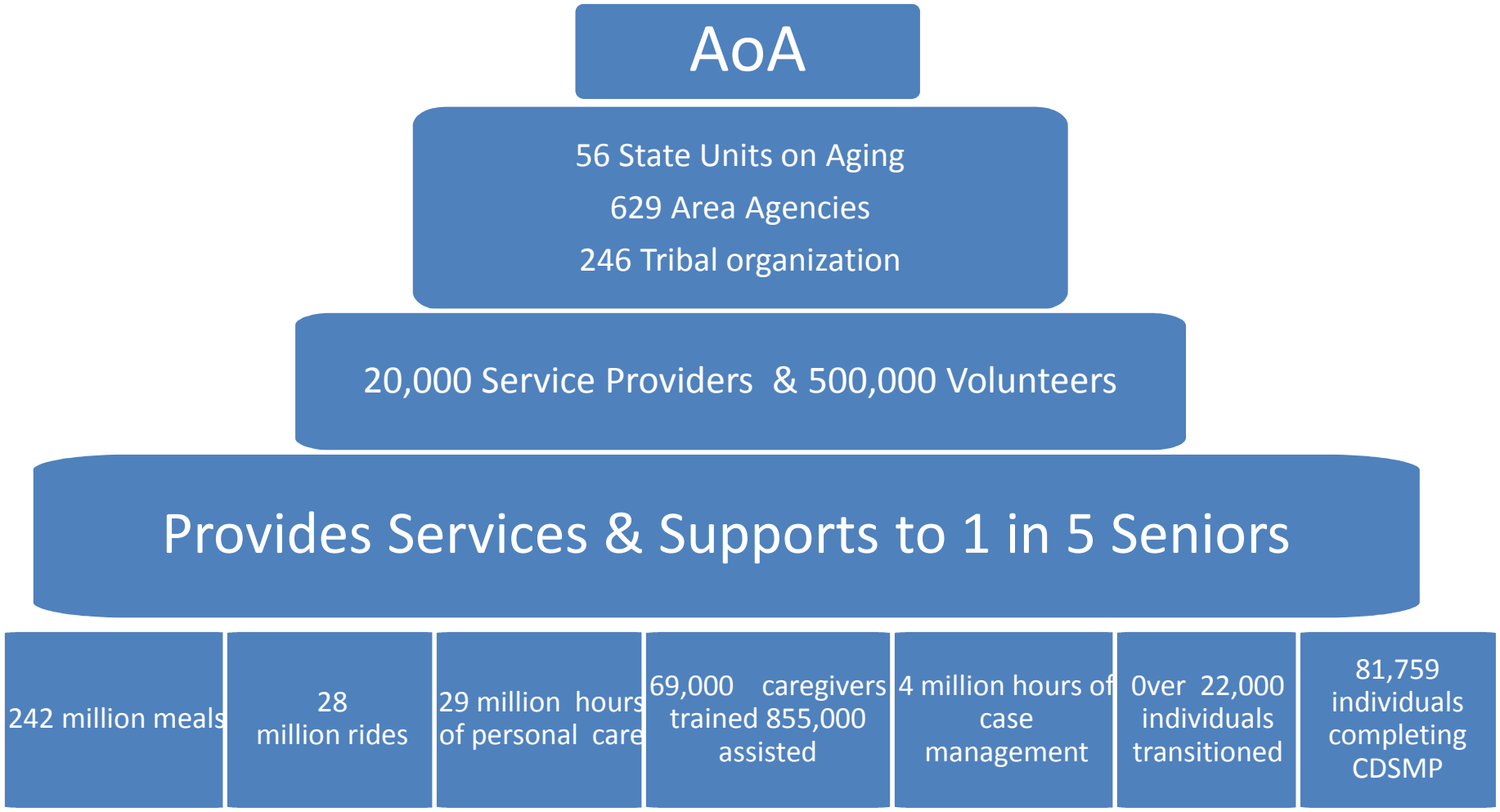
www.hhs.gov/acl

"For too long, too many Americans have faced the impossible choice between moving to an institution or living at home without the long-term services and supports they need. The goal of the new ***Administration for Community Living*** *will be to help people with disabilities and older Americans live productive, satisfying lives." - Secretary Kathleen Sebelius*

Overview

- This new HHS Operating Division brings together the Administration on Aging (AoA), the Office on Disability (OD) and the Administration on Developmental Disabilities (ADD)
- This single agency is charged with developing policies and improving supports for seniors and people with disabilities.

AOA and the Aging Network – An Infrastructure that Supports 11 Million Older Adults and Caregivers



Who We Serve:
The Poor and Near Poor

The Aging Network Serves Nearly 1 in 5 Older Adults

	US Population	OAA Clients
60+	57.8 million	11 million*
Poverty	9.30%	**30%**
Near Poor**	15-20%	**73-85%**

*3 million OAA clients receive intense services such as home-delivered nutrition and homemaker services.

**Near poor is defined as below 150% of poverty.

Note: $77,000 per year for private room nursing home care,
$35,000 per year for assisted living (2007 dollars)

Who We Serve:
The Frail & Vulnerable

	US Population 60+	OAA Clients (In Home Service)*
Lives Alone	27%	55% - 69%
Diabetes	22%	26% - 35%
Heart Condition	29%	43% - 53%
Minority**	20%	25%
Rural**	13%	37%

* Includes such services as homemaker, case management, and home-delivered nutrition.
* *US Minority & Rural figure is for the 65+ population

Health & Independence: Nutrition Services

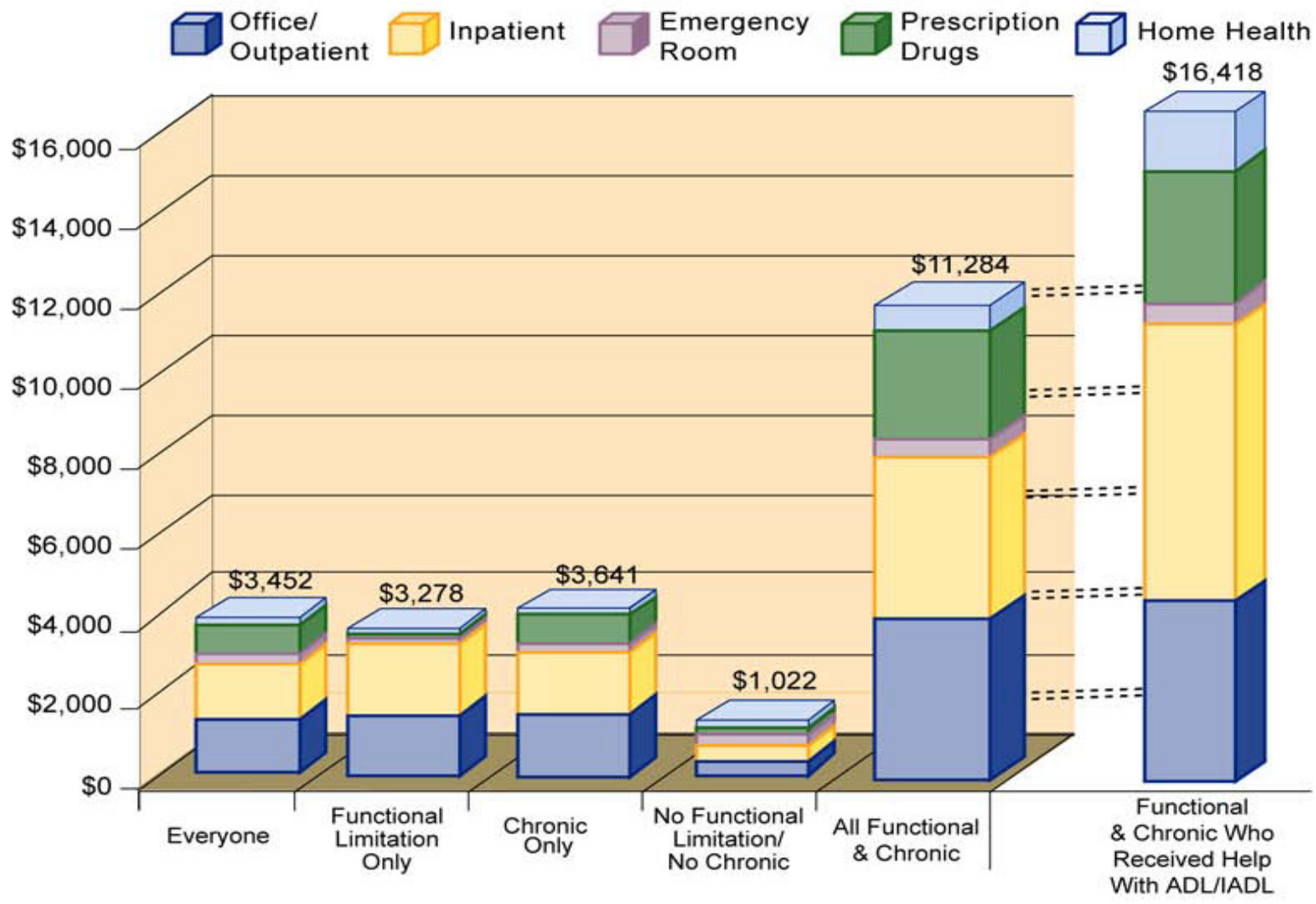
Congregate
Home-delivered
Nutrition Services Incentives Program

- **$1.4 billion in total Federal, State, local and private expenditures**
- **Expenditures/Meal: $6.64 (CN) $5.34 (HDN)**
- **Annual expenditure/Person: $370 (CN) $895 (HDN)**

- Adequate nutrition is necessary for health, functionality and the ability to remain at home in the community.
- 63% of Home-Delivered Nutrition Clients report the meal is half or more of their food for the day. 59% of Congregate Nutrition Clients report the meal is half or more of their food for the day.
- OAA meals are nutritious and meet the needs of seniors with nutrition ameliorated chronic illnesses (diabetes, hypertension, congestive heart failure)
  - Provide 33% of Dietary Reference Intake
  - Adhere to the Dietary Guidelines for Americans.

- In FY 2010, Home-Delivered Nutrition Services provided nearly 145 million meals to nearly 880,000 seniors and Congregate Nutrition Services provided over 92.4 million meals to more than 1.7 million seniors in community settings.
- In FY 2010, 48.5 thousand nutrition counseling and 2.5 million nutrition education sessions were provided.
- Researchers estimate that food insecure older adults are so functionally impaired it is as if they are chronologically 14 years older, 65 year old food insecure individual is like a 79 year old chronologically.
- Malnourishment declines upon receiving HDMs. Participants who no longer eat fewer than two meals a day decreased by 57%.

Average Spending by Type of Service for Select Groups
2006



Source: The Lewin Group analysis of 2006 Medical Expenditures Panel Survey, 2009

Source: *Individuals Living in the Community with Chronic Conditions and Functional Limitations: A Closer Look.* Report by the Lewin Group prepared for the Office of the Assistant Secretary for Planning and Evaluation. 2010.

Care Transitions: The Problem

- Transition from one source of care to another is a moment with high risk for communications failures, procedural errors, and unimplemented plan.
- People with chronic conditions, organ system failure, and frailty are at highest risk because their care is more complicated and they are less resilient when failures occur.
- Strong evidence shows that we can significantly reduce hospital readmissions caused by flawed transitions.

Home and Community Based Services and Hospital Readmissions

- In a study evaluating the home food environment of hospital-discharged older adults, 1/3 of participants reported being unable to both shop and prepare meals
- Greater volume of attendant care, homemaking services and home-delivered meals is associated with lower risk of hospital admissions

Anyanqu, Ucheoma O., Sharkey, Joseph R., Jackson, Robert T. (2011) Home Food Environment of Older Adults Transitioning From Hospital to Home. *Journal of Nutrition in Gerontology and Geriatrics* 30:105-121.
Xu, Huiping et al. (2010) Volume of Home-and Community-Based Medicaid Waiver Services and Risk of Hospital Admissions. *Journal of American Geriatric Society*

Safe, Effective Transitions Require:

- Patient and caregiver involvement
- Person-centered care plans that are shared across settings of care
- Standardized and accurate communication and information exchange between the transferring and the receiving provider
- Medication reconciliation and safe medication practices
- The sending provider maintaining responsibility for the care of the patient until the receiving clinician/location confirms the transfer and assumes responsibility.

Care Transition Themes: How Do They Relate to The Older Americans Act (OAA)

Interdisciplinary Teams & Service Coordination

- Coordination of services (medical/ human services)
- Workforce development and training
- Planning
- Partnerships
- Coordination of benefits

Enhanced Follow-Up

- Case Management/ Care Coordination
- In-home services
- Home-delivered meals
- Transportation
- Monitoring/assistive devices
- Medication management
- Disease prevention & health promotion

Patient/Client Activation

- Assessments
- Self-directed care/coaching
- Health/nutrition education
- Insurance counseling
- Family caregiver support, counseling, training

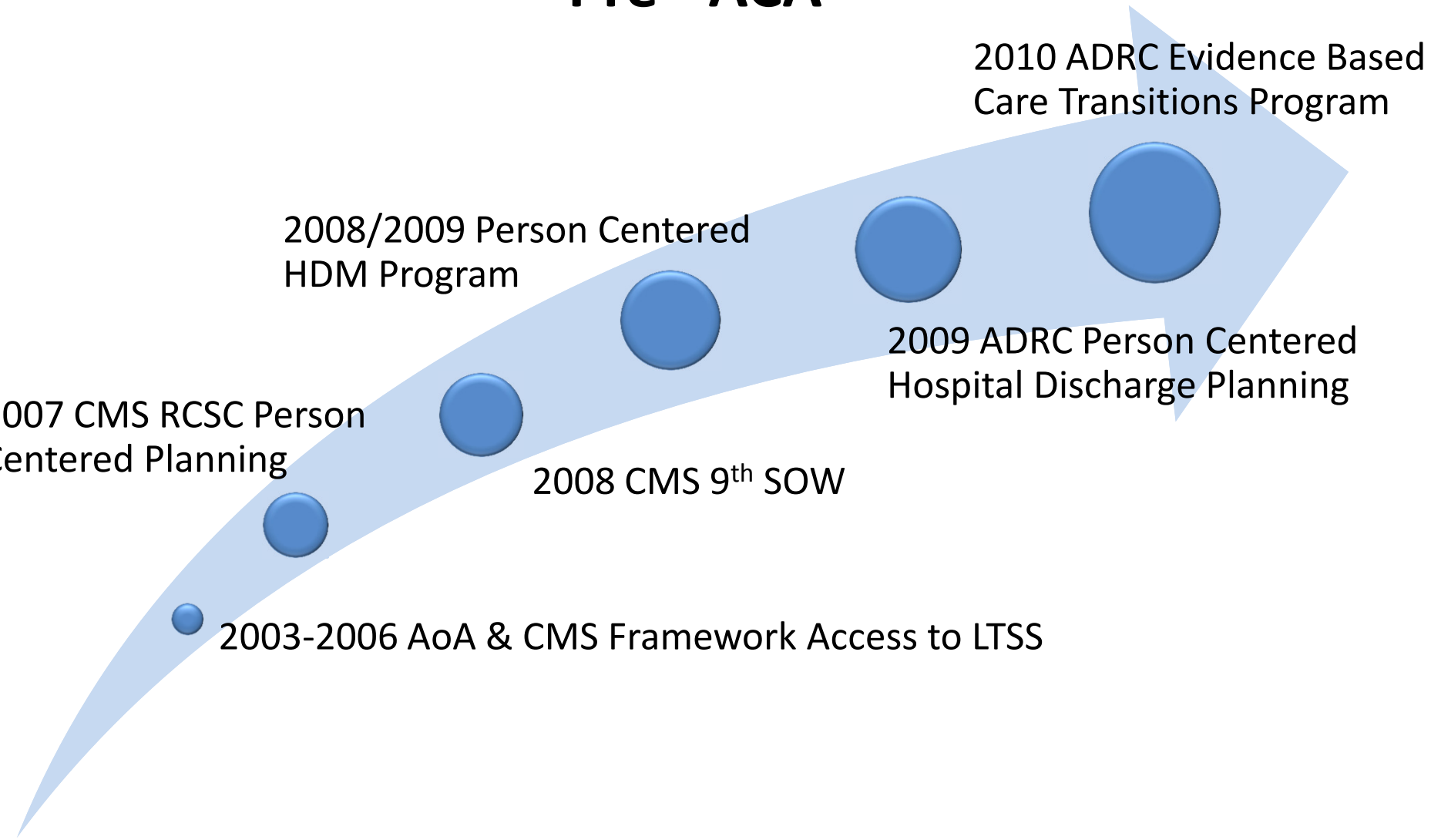
Why the Work of MOW is so Critical to Care Transitions

- Unique and trusted position in the community for over 30 Years
- Knowledge of community services
- Knowledge of elders and caregivers
- Service provision skills
- Quality assurance and outcomes

Why Care Transitions is so Critical to the Mission of MOW

- Core mission of maximizing independence for at-risk Elders
- Need to engage in changing long-term care landscape
- New revenue stream
- Existing program participants are high risk for Readmission

ACL CMS Investments in Care Transitions
Pre - ACA



ADRC Evidence Based Care Transition Program

- **Current Status:** 93 ADRC sites partnering with 242 hospitals in 27 states

- **ADRC Care Transition program readmission rate = 8.2% (n=17 sites)**

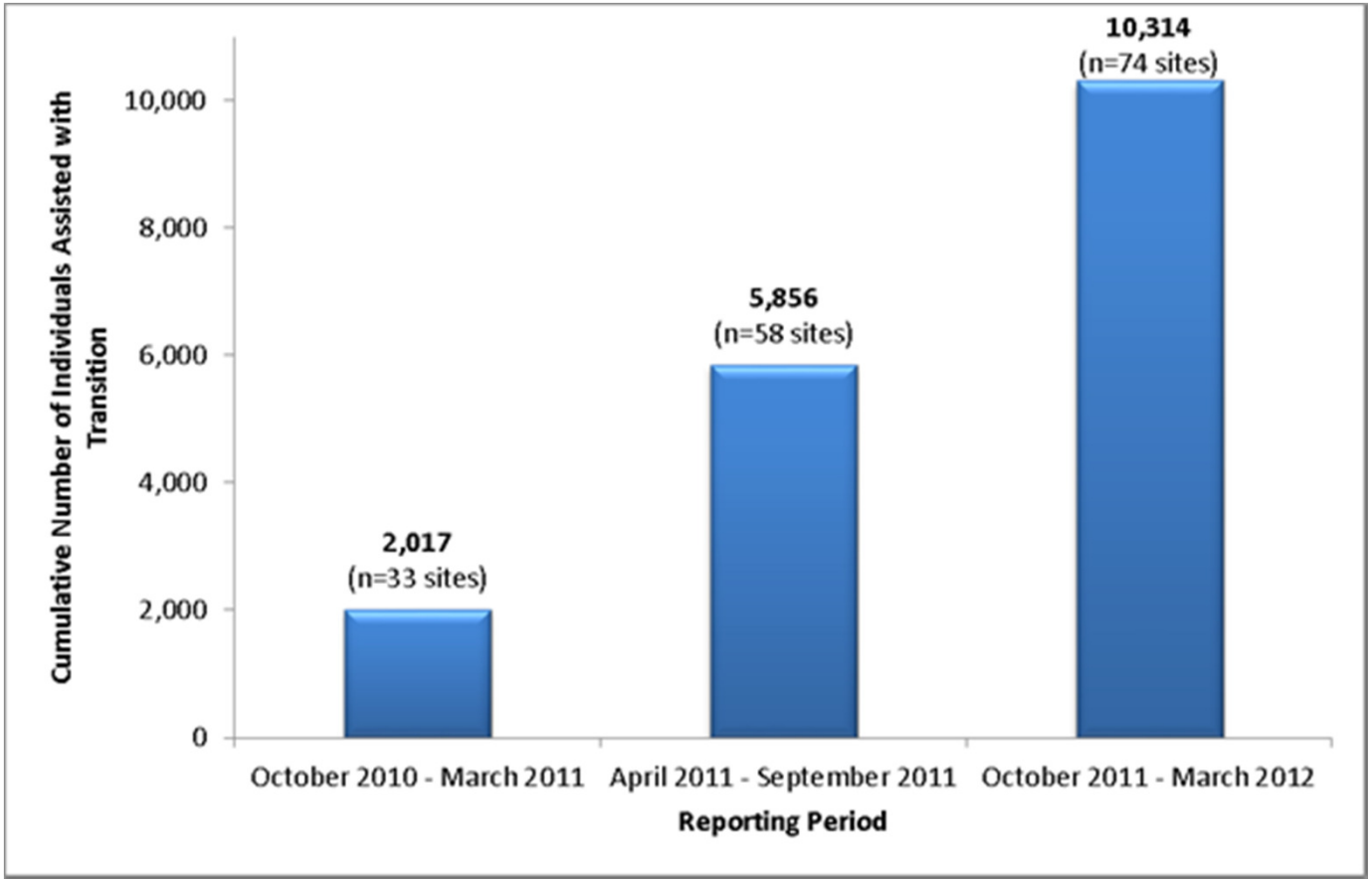
- ADRC Care Transition sites are implementing a variety of different evidence based programs, including:
  - Care Transitions Intervention®
  - Transitional Care Model
  - Project BOOST
  - Bridge
  - GRACE
  - Guided Care ®

- **2010 Option D: ADRC Evidence Based Care Transition Program**
  - 16 States received grants
  - Total Amount Awarded: $6.4 Million

Source: ACL Semi Annual Report Data October 2010- March 2012

Number of ADRC Evidence Based Care Transition Program Participants

(n=74 sites[1])

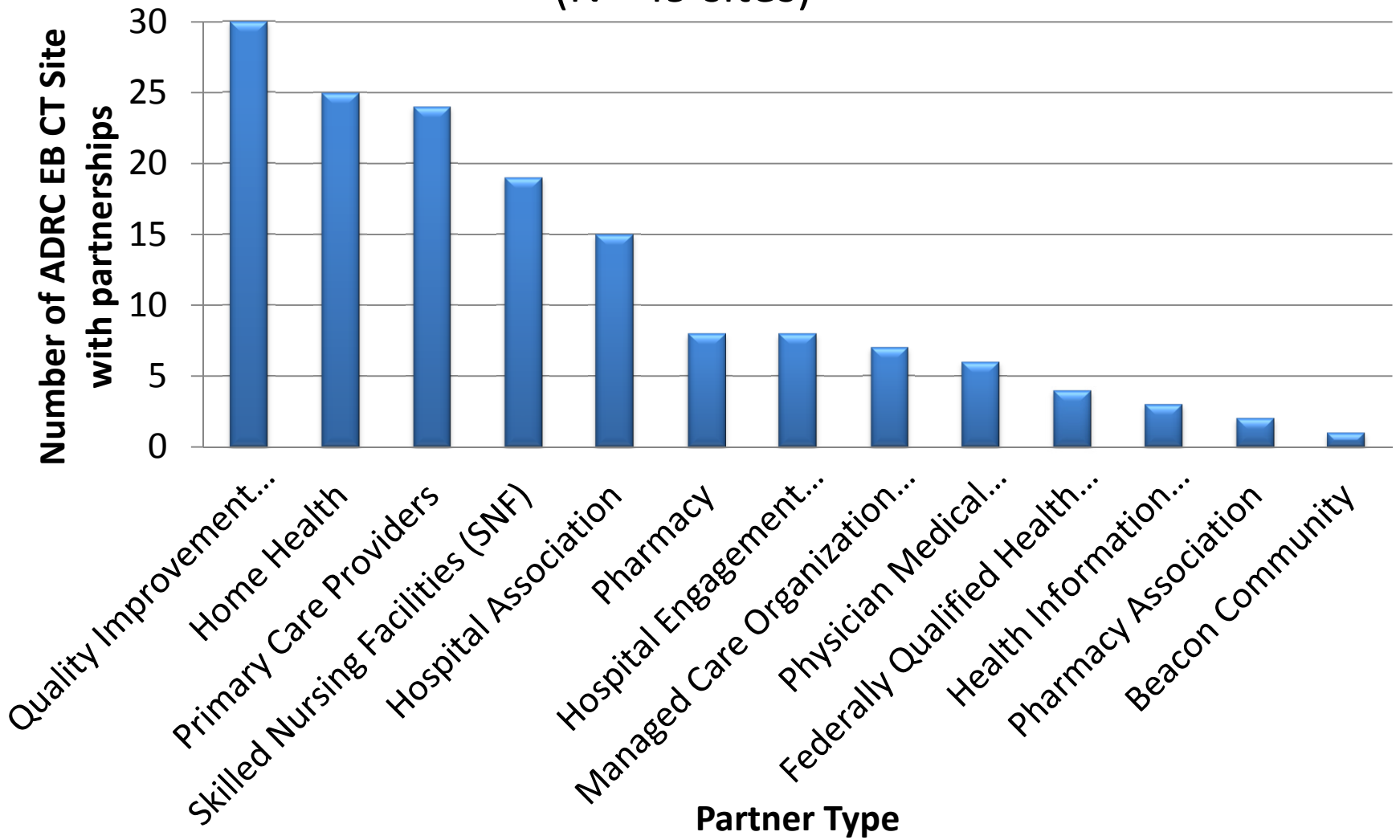


[1]Not all sites reported in all reporting periods

Source: ACL Semi Annual Report Data October 2010- March 2012

ADRC Care Transitions Partnerships

(N= 49 sites)



Source: ACL Semi Annual Report Data October 2010- March 2012

Referrals to Long Term Services and Supports

(n=64 sites[1], Total # Referrals = 7,515)

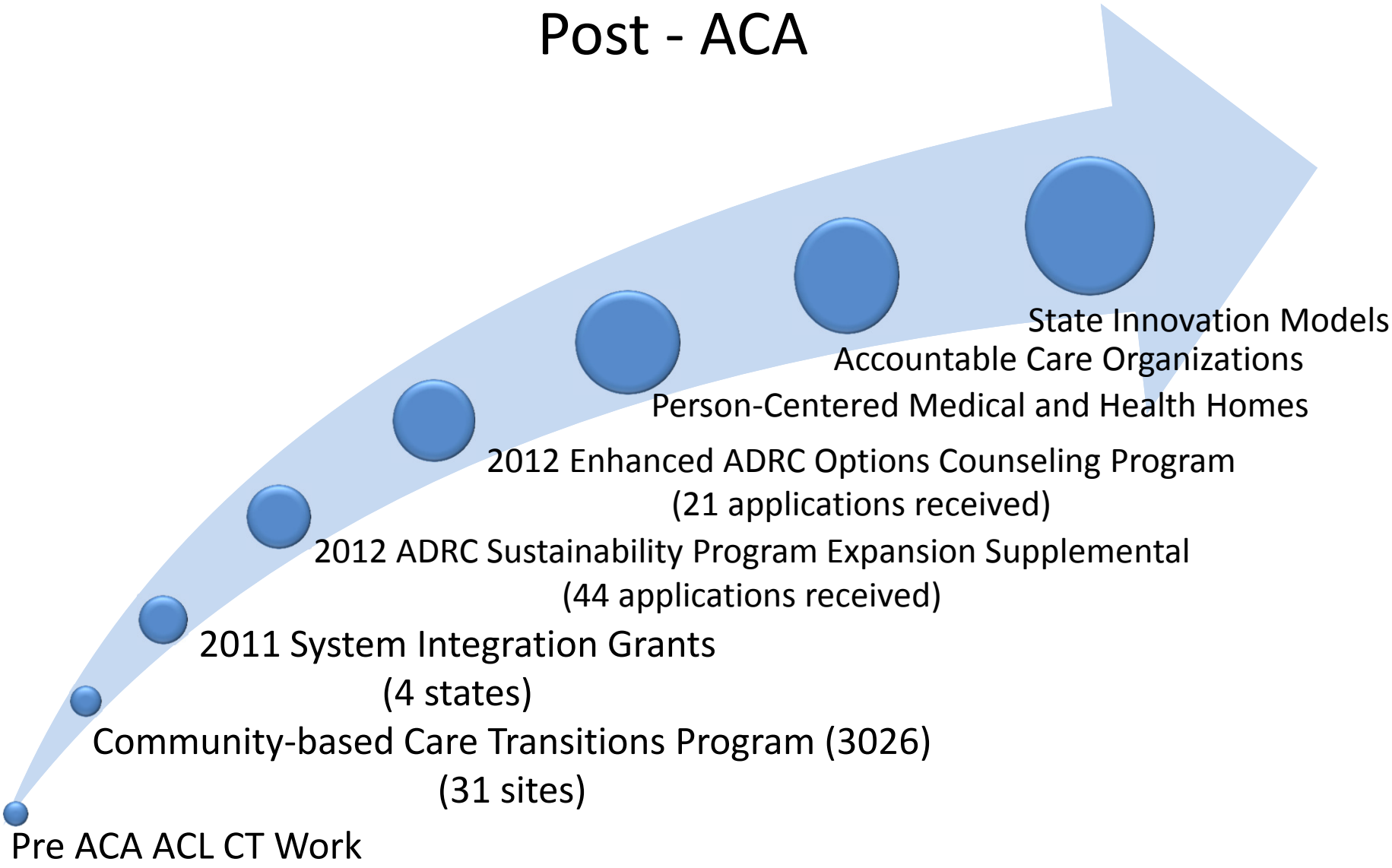
Adult Day Care	Home Health
Alzheimer's Programs	Home Injury/Risk Screenings*
Adult Protective Services	Housing Assistance
Blood Pressure Monitor	IHSS
Care Management	Legal Support
Caregiver Support*	Low cost RX program
CDSMP	LTC Assistance
CHF Education	Medicaid
Dental Care	Medication Management
DSMP	Mental Health and Substance Misuse*
Exercise Program	Nutrition Services or Counseling
Falls Management and Prevention*	Personal care/ homemaker/ choremaker
Financial Services	Rx coverage
Food stamps/food bank	Smoking Cessation
Health Eating	Social Security
Health Information	Telephone Reassurance
Home Delivered Meals*	Transportation*

Source: ACL Semi Annual Report Data April 2011-March 2012 [1]Not all sites reported in all reporting periods

Success Story: Pennsylvania

- Partnership between Delaware County ADRC and Crozer Keystone Health System
- Mary Naylor Transitional Care Model
  - Partnership designed a team based approach: Hospital provides Nurse Assessor, ADRC provides Options Counselor
  - Original 2 year goal was to serve 235 participants
    - Served 355 participants within 13 months
- ADRC CT Program Readmission Rate = 7%
  - 47% reduction from baseline
- **ACL investment of $400,000 yielded <u>$3 Million in Savings</u>**
- State provided special funding to purchase supplies, equipment, and services for participants not covered by existing programs
  - Examples: Talking scale for a consumer with a visual impairment and CHF to monitor weight; Air Conditioner; Stair Rides
- ADRC CT data was cited in successful CCTP application

ACL CMS Investments in Care Transitions Post - ACA



ACL Care Transitions Resource Page

- New webpage for organizations looking for care transitions program information within the Aging Network
  - Toolkit and webinars
  - Funding opportunities
  - Basics and background
  - Publically available technical assistance resources

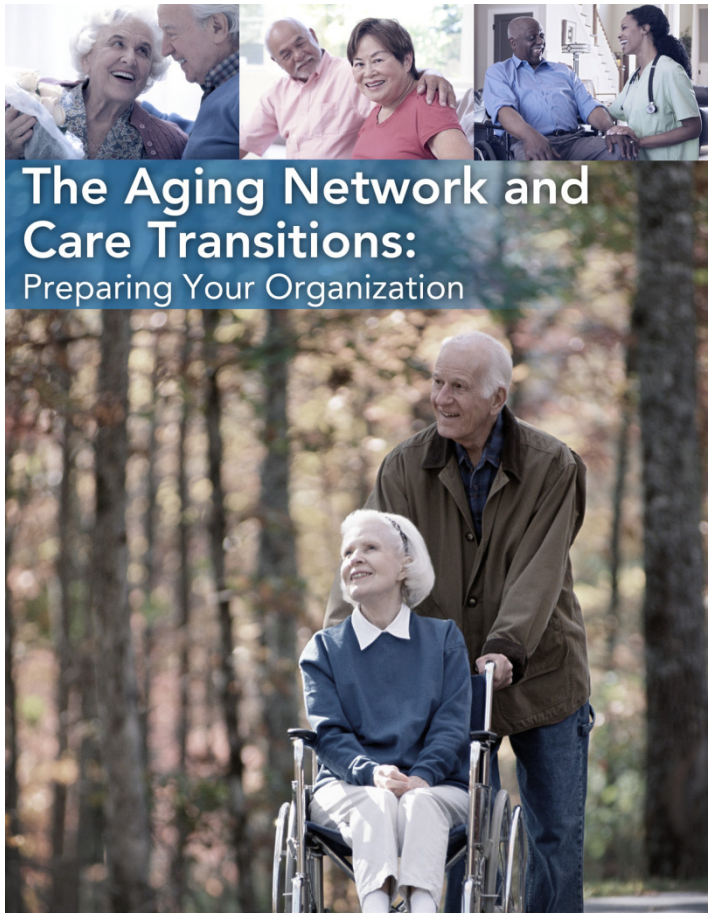
Available from AoA's Tools and Resources webpage:
http://aoa.gov/AoARoot/AoA_Programs/Tools_Resources/index.aspx

Department of Health & Human Services

ACL Administration for Community Living

For seniors and people with disabilities

Care Transitions Toolkit



Chapter One: Getting Started

Chapter Two: Taking Time to Plan

Chapter Three: Developing Effective Partnerships with Health Care Providers

Chapter Four: Measuring for Success

Chapter Five: Building Organizational Capacity

Chapter Six: Implementation and Day-to-Day Operations

http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx

Technical Assistance:

Quality Improvement Organizations (QIO)

- Coalition/charter building
- Root Cause Analysis
- Social Network Analysis
- Measurement strategy and data analysis
- Logic model development
- Learning and Action Networks
- Webinar learning sessions and archives

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

ICPC
Integrating Care for Populations & Communities

http://www.cfmc.org/integratingcare/Default.htm

Resources: Care Transitions

- http://www.healthcare.gov/center/programs/partnership/index.html (Partnership for Patients)
- http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313 (Community-based Care Transitions Program)
- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform web page)
- http://www.adrc-tae.org/tiki-index.php?page=CareTransitions (AoA's Aging and Disability Resource Centers and care transitions)
- http://www.cfmc.org/integratingcare/ (Care Transitions Quality Improvement Organization Support Center)
- http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Innovative-Communities-Report-Final-0216111.pdf (Innovative Communities report from the Long-Term Quality Alliance)

Resources: Affordable Care Act

- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform web page)
- http://www.healthcare.gov (Department of Health and Human Services' health care reform web site)
- http://www.thomas.gov/cgi-bin/bdquery/D?d111:1:./temp/~bdsYKv::|/home/LegislativeData.php?n=BSS;c=111| (Affordable Care Act text and related information)

LifeCare Alliance

Providing Nutrition Services For Hospital Discharged: The Rapid Response Program

Jennifer Fralic, RD, LD
Nutrition Programs Director

About LifeCare Alliance

- LifeCare Alliance is a not-for-profit organization that provides a comprehensive array of health and nutrition services to older adults and chronically ill or homebound residents of Central Ohio.

About LifeCare Alliance

- Signature programs: Meals-on-Wheels, Senior Dining Centers, Wellness Centers, Help-at-Home,Visiting Nurses, Columbus Cancer Clinic, Project OpenHand-Columbus, Groceries-to-Go and IMPACT Safety.
- The Agency's mission is *to lead the community in identifying and delivering health and nutrition services to meet the community's changing needs.*

Nutrition Programs

- Over one-million home-delivered and congregate meals served per year.
- Registered dietitians are available for nutrition interventions.
- The intake department screens and processes new referrals.

Meals-on-Wheels

- Deliver 365 days a year
- Daily and weekly delivery
- Extensive menu choices
  - Hot
  - Cold
  - Vegetarian
  - Kosher
  - Texture modification (pureed, mechanical soft)

"Rapid Response" program

- Long-standing program
- Agreements with local hospitals
- Referrals made by hospital directly to program intake department
- Simplified referral process
- Services start immediately
- Meals are paid for by hospital

Process overview

Identify
- Hospital discharge planning team identifies participants

Refer
- Hospital calls intake department and identifies the referral as a "Rapid Response"
- The hospital provides the minimum amount of patient information

Coordinate
- Client information and delivery schedule are entered into the database and an alert is sent to the routing department.

Process overview-continued

Deliver
- Routing area coordinates first delivery to accommodate agreement

Monitor
- Drivers' observations are shared with the referring hospital and emergency contact.

Reassess
- Near the end of the Rapid Response episode, the intake department will determine if meals are still necessary.
- Certain hospitals will reauthorize meals. If they do not, an appropriate funding source is determined if meals are still appropriate. Clients are then assessed per the funder's protocol.

Minimal Referral Information

- Name
- Address
- Telephone number
- Age
- Sex
- Functional limitations
- Meal type
- Delivery method (hot/cold daily or frozen weekly)
- Meal schedule
- Emergency contact information
- Expected start date
- Number of days (estimate) that meals will be required
- Caller's name, title and contact information

Other nutritional services

- Nutrition education
  - Based on nutrition risk screening questions
- Nutrition counseling (in-person or telephone)
- Can be coordinated during the initial referral
- Reduced-cost nutritional supplements available for delivery

Funding opportunities

- Agreement with hospital or health system
- Being a provider for a community care transition program
- Grants or fundraising
- Long-term clients transition to OAA funding or may enter case-managed program (waivers or county funding)

Sample agreement elements

- Service area
- Referral information
- Procedural requirements
  - Suggestion: do appendix or attachment
- Duration of referral
- Details on payment and invoicing

Benefits of "Rapid Response"

- Hospital
  - Quick coordination
  - Bypass screening or delays in intake process
  - Special handling of clients who are newly discharged
  - Possible prevention of a readmission
- Meal Provider
  - New referral source
  - Generate income
  - Establish your organization as a partner for a CCTP
  - Short or long-term services
  - "Front door" for vulnerable population

Contact information

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Nourishing the Human Spirit.

"Nourishing the Human Spirit"

LifeCare Alliance

AGREEMENT BETWEEN

[Name of meal provider] MEAL PROGRAM

AND

[Name of hospital] HOSPITAL

[Name of meal provider] Meal Program, hereinafter referred to as [Name of meal provider], and [Name of hospital] enter into an agreement for services as follows:

1. [Name of meal provider] agrees to provide home delivered meals to individuals identified by [Name of hospital] as participants in the "Rapid Response" program.

2. Service Area: [Name of meal provider] delivers meals seven days a week in all areas of [Name of county] County.

3. [Name of hospital] will provide client information to complete referral (See Attachment A). Client may be over or under 60 years old.

4. [Name of hospital] will indicate the length of Rapid Response Meals which may be up to and including [number of days] calendar days. Meals may be provided up to and including [number of days] calendar days in special circumstances, whereby the [Name of hospital decision maker] fax authorization to [Name of meal provider] within 2 days of meal start date.

5. Telephone referrals are to be made to the Customer Service Department [Intake phone number] between 8:00 a.m. and 4:00 p.m., Monday through Friday, to assure meal delivery the following day. Saturday and Sunday referrals are to be made between 8:30 a.m. and 3:00 p.m. by calling [Meal program number]. Please note that the delivery department will make every effort to start a new referral the next day. In an emergency, service can begin the same day if the referral is received prior to 8:30 a.m.

6. [Name of hospital] agrees to identify [Name of meal provider] as the meal provider in any promotional material describing or marketing the Rapid Response Program.

7. [Name of meal provider] will invoice [Name of hospital] by the 20th of the month for all meals delivered the previous month. [Name of hospital] agrees to make timely payment.

8. [Name of hospital] agrees to pay $6.24 per meal for the hot meal and $12.00 per day for both the hot and cold meals for participants.

9. Referrals for other [Name of meal provider] services may be given at the same time the meal referral is made.

10. Toward the end of the authorized Rapid Response meal period the patient will be contacted by Meal Provider assessment staff and evaluated for continued meal service. A sliding fee-scale will be used to assign the patient's donation for future meals.

11. This agreement is effective [start date] through [end date].

12. Either party may terminate this agreement upon 30 days written notice to the other.

_____

Date
[Name of meal provider] Meal Provider

Date
[Name of hospital]

Attachment A

[NAME OF HOSPITAL]

Rapid Response referral Procedure

1. The [Name of hospital] staff call Meal Provider Customer Service Department [Intake phone number].

   State: "I am calling from [Name of hospital] and have a Rapid Response referral."

   Give the patient's hospital discharge date. The following is the least amount of patient information upon which Meal Provider can start meal service:

   - Name
   - Address (always include apartment number, drive, street, road, lane, lot number etc.)
   - Telephone number
   - Age
   - Sex
   - Social Security Number
   - Handicap (Cane, walker, crutches, wheelchair, blind, deaf, bedridden, or other)
   - Meal type: Regular Menu or Diet Menu
   - Special: Mechanical soft or Puree (hot menus only)
   - Meal Schedule (5 days hot, 7 days hot, 5 days hot and cold, or 7 days hot and cold)
   - Emergency contact (Name, relationship to patient, telephone numbers)
   - Date of expected first day of service
   - Number of calendar days meals are required
   - Caller's name, title, and telephone number

Although not required by Meal Provider, additional information about a patient's situation may be given by phone or via fax. The basic information listed above does not need to be sent by fax after the referral is made.