Role of Nutrition in an Integrated Care Coordination Model

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Sr. Nutrition & Operations Director
Our Commitment

ILS is a health services company delivering innovative, cost effective community based services that improve the daily living experience for millions of America’s special needs populations from children to the elderly, while rebalancing costs across the healthcare system.

• Founded in 2001
• Rebalances costs by using home and community based services as an alternative to facility based care
• Operates programs for managed care companies, SNPs, ACOs, hospitals, IPAs and others, on a risk, shared-risk and administrative basis
Learning objectives

• Highlight nutritional issues in older adults

• Understand the connection between nutrition intervention and outcomes

• Discuss community-based care transitions and explain a new approach to improve outcomes and reduce cost of care
Nutritionals Issues in Community-dwelling Older Adults and the Impact of Nutrition Intervention
Americans are aging and living longer

US Population, Adults 55+ (MM)
- 2010: 77
- 2020: 98
- 2030: 112

Average Life Expectancy in the US (Years)
- 1976: 69.1 (Women), 73.7 (Men)
- 1996: 76.5 (Women), 79.1 (Men)
- 2025: 76.5 (Women), 82.6 (Men)

1. CDC 2010 preliminary data _040912
http://www.aarp.org/personal-growth/transitions/boomers_

Everyday, for the next 18 years, 8,000 “baby boomers” will be turning 65¹.

By 2010, overall life expectancy in the US increased to ~79 years¹.
Older patients suffer from one or more chronic diseases

Key challenges among nutritional intake and access to nutrition exacerbate problem of malnutrition

- Inadequate Food & Fluid Intake
  - 93% had at least one problem with eating and digestion

- Physical Impairments
  - 50% required assistance with shopping and food preparation

- Socioeconomic Status

Patients who suffer from malnutrition will also have a loss of lean body mass.

Lean body mass includes muscle, skin, bones, and organs.

Aging & Bed rest / decreased activity

Loss of Lean Body Mass

Illness & Injury (Inflammation)

Progressive loss of lean body mass is a natural part of aging.
Illness and injury accelerate muscle loss

Healthy Young (36-28 years of age)
28 Days Inactivity

Healthy Older Adult (67 years of age)
10 Days Inactivity

Elderly Inpatients (Age: 65+)
3 Days Hospitalization

Loss of Lean Leg Mass (lb)

Approx 1 lb

Approx 2.2 lbs

Approx 2.2 lbs

2.2 lb steak =
Loss of lean body mass leads to difficulty performing ADLs

- Eating
- Transferring
- Toileting
- Ambulating

Difficulties performing activities of Daily Living (ADLs)
Patient’s nutritional status and lean body mass becomes progressively compromised as they travel through the continuum of care.

**Upon Admission to the Hospital**
- 30% to 50% are malnourished upon admission

**During Hospital Stay**
- 37% of patients hospitalized for 1-2 days have lean body mass loss

**Post-discharge**
- Many patients continue to lose weight after discharge
Poor nutrition leads to re-hospitalizations as measured by refrigerator content

Objective
Measure outcomes associated with refrigerator contents of elderly patients (nutrition in home)

Population
N = 132 adults aged 65+ who received home visits at least 1 month after hospital discharge

Key Findings
Elderly people were more frequently readmitted (P = 0.032) and admitted 3 times sooner (34 vs. 100 days); (P = 0.002) compared to those who did not have an empty refrigerator

Fayetteville, North Carolina
May 2015
What are we doing at ILS?

Rx: Nutrition

• Nutrition is very important to an individual’s ability to maintain health
• Providing Post discharge meals and Nutrition Counseling
• Reducing readmission rates to acute and sub-acute facilities
• Reducing overall cost

The *Journal of Primary Care & Community Health* reports that subjects who received home-delivered meals experienced:
- 55% reduction in overall health care costs
- 50% reduction in readmission rates
- 37% reduction in average lengths of stay
Post Discharge Meals

Providing therapeutic post discharge meals after a hospitalization

Meal types:

- Regular – Heart Friendly
- Fish Free
- Pork Free
- Diabetic
- Gluten Free
- Renal
- Vegetarian
- Puree
- Kosher
Nutrition Counseling

- Post-discharge nutrition counseling and meal delivery to maintain recovery and reduce readmissions

- Clinical nutrition counseling & support to improve member health
  - Telephonic
  - Face to face
  - Group
Poor nutrition in adults with a chronic condition increases healthcare costs

Malnourished patients are **significantly** more likely than well-nourished patients to experience rehospitalizations.¹⁻⁴

Transition of care is becoming increasingly important in driving improved patient outcomes. Hospitals must pay much more attention to the transition of patient care into post acute / community. Transition of care has not historically been their responsibility.

- Increased attention on follow-up care
- Greater opportunity for active involvement of home health care

Thank you!

www.ilshealth.com
Nutritional Support Programs

Nutrition is very important to an individual’s ability to maintain health status; reduced readmission rates to acute and sub-acute facilities; and the overall cost reduction.

- Post-discharge nutrition counseling and meal delivery to maintain recovery and reduce readmissions
- Clinical nutrition counseling & support to improve member health
  - Telephonic
  - Face to face
- Chronic care nutrition
- Disease management
- Meal Menus: Regular, Diabetic, Renal, Vegetarian, Kosher, Puree, Gluten-Free, Pediatric, Southwestern, Asian, and Latin

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Care Management Services

Enhances effectiveness of managing members with complex care needs by:

- Aggregating data to develop an initial risk stratification
- Health Risk Assessment (HRA) used to create a Personal Health Record and identify targets for issue resolution
- Stratifying risk with consideration to clinical and medical information as well as psycho/social financial and environmental issues
- Developing an individualized person-centered care plan
- Providing state of the art reporting, analysis, data warehousing and access, and outreach
The ILS Approach Keeps Members out of High-Cost Environments

The ILS patient-centered, holistic approach helps healthcare organizations satisfy their desire to shift care into home- and community-based settings while yielding improved outcomes in addition to reducing costs.

<table>
<thead>
<tr>
<th>Enrollment</th>
<th>Assessment</th>
<th>Care Plan Development</th>
<th>Care Plan Execution</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Gather / analyze multiple data feeds</td>
<td>✓ Analyze member-centric data</td>
<td>✓ Assign member to a care plan</td>
<td>✓ Coordinate / authorize care</td>
</tr>
<tr>
<td>✓ Determine member eligibility</td>
<td>✓ Conduct risk analysis</td>
<td>✓ Price care plan</td>
<td>✓ Monitor member</td>
</tr>
<tr>
<td>✓ Enroll member</td>
<td>✓ Stratify member</td>
<td>✓ Create clinical guard rails / authorization requirements</td>
<td>✓ Facilitate transitions in care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>✓ Create prior authorizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>✓ Notifications for change in condition</td>
</tr>
</tbody>
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**eCare Central – ILS Proprietary IT Platform**
Comprehensive Care Management - Outcomes

Results of STARS Measure:

A. CMS STARS measure for HRA compliance for Initial and Reassessments:
   ILS achieved a 4 STAR rating on all of its managed SNP plans

B. Colorectal Cancer Screening: 95.45\% 5 STARS
   +35.56 above the plan’s goal of 59.85\%. Also passed the 90\% best practice

C. Controlling Blood Pressure: 72.16\% 4 STARS
   +7.69 above the plan’s goal of 64.47

Source: Executive Summary by health plan client, December 5, 2014
ILS delivers a care optimization/management platform to support a member-centric, holistic approach that drives superior clinical outcomes at lower costs.
Program Origins & Focus

PASS® focuses on the care transition between the institutional setting (Acute inpatient, Sub-Acute, Nursing Home) back to the home & community setting.

Based on Care Transition Intervention (CTI\textsuperscript{SM}) Program developed by Dr. Eric Coleman, University of Colorado.

Care Transition program designed to coordinate and manage the transition of individuals from the Acute Inpatient setting to the Home & Community Setting.

- PASS is not replacement for case management, discharge planning or home health.
- PASS is patient advocacy, education, communication and coordination.

Operating Model

- Driven by the PASS Coach, supported by PASS Care Coordinators and PASS system technology.
- Interaction with patient:
  - Face-to-face during inpatient admission\textsuperscript{1}
  - Face-to-face at Home post discharge (48 – 72 hours)
  - Telephonic, day 2, 7, 14, 21 and 30 post discharge

\textsuperscript{1}PASS Coaches are assigned by facility and visit that facility each day.
PASS® Core Components

**Medication Self Management** – patient is knowledgeable about medications and has a medication management system. Home Visit: Face-to-face medication reconciliation.

**Nutrition Management** – patient is knowledgeable about nutrition status, meal planning and diet as it relates to chronic conditions. Home Visit: Home based nutrition assessment, kitchen and environment evaluation, daily meal plan.

**Personal Health Record** – patient understands and utilizes a PHR to facilitate communication and ensure continuity of care plan across providers & settings. Home Visit: Reconciliation of PHR data, education.

**PCP and Specialist Physician Follow-Up** – patient schedules and completes follow-up visits with PCP / Specialists & is empowered to be an active participant in these interactions. Home Visit: Schedule and coordinate PCP follow-up visit, direct coordination if necessary.
Care Transition Services

Reduces avoidable readmissions with “high-touch” interventions and access to community based support services coordinated through our unique technology platform which can be seamlessly integrated within an existing medical management processes.

- Member-centric, holistic approach
- Comprehensive assessments performed in the hospital and home to include medication reconciliation and nutritional assessments
- Coordination with home and community based providers
- Reduction of avoidable hospital admissions and long-term institutionalization
- Outcomes:
  - ILS Clients reporting 30-65% reduction in readmissions and lengths of stay (2015)
Care Transition Services - Outcomes*

- **Program began in June 2014 and concluded in April 2015**
  - Locations (facilities):
    - Initially 5 hospitals in Akron/Canton
    - Expanded to 29 hospitals throughout the state
  - Total engaged membership: 1,168 members
  - Baseline readmission rate: 14.61%
  - 30 day readmission rate of engaged membership: 5.48%
  - Readmission rate percentage decrease: 65%
  - Number of readmissions avoided: 87 readmissions
  - Cost savings of readmission avoidance: $900,000*
  - **Return on Investment** 63%

*Assuming each readmission is at an average cost of $10,409
### Care Transition Services Outcomes

Posted by CMS

<table>
<thead>
<tr>
<th>Coaching</th>
<th>Coaching Only N = 660</th>
<th>Coaching + Nutritional Support N = 234</th>
<th>Coaching + Community Support Services N = 28</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-Day Readmission Rate*</td>
<td>17.88% (118)</td>
<td>8.55% (20)</td>
<td>3.57% (1)</td>
<td>p = 0.0006</td>
</tr>
<tr>
<td>60-Day Readmission Rate</td>
<td>27.27% (180)</td>
<td>17.52% (41)</td>
<td>14.29% (4)</td>
<td>p = 0.005</td>
</tr>
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*Baseline 30-Day Readmission Rate – 23.1% (Population – 14K; 8 hospitals)

**Baseline 30-Day Readmission Rate – 24.3% (9 hospitals)

**Source 1: Medicare Part A claims. Patients discharged from an acute care hospital who utilize home health services, reside in the target zip codes, and are readmitted within 30-days. Data represent a 12-month period reported quarterly ending in specified month (March 2008 – June 2010).

PASS Nutrition Support

The Nutrition Support offered through the PASS program includes:

10 frozen Home Delivered Meals (condition appropriate)

Post DC survey that provides additional coaching to good post DC behavior such as: visiting PCP or Specialist, understanding DC instructions.

The telephonic outreach is an emotional untellable support..

- Provides another opportunity to share status updates that can lead to better
Fine Dining and Social Engagement – In Demand

CVAA’s Restaurant Ticket Program

Redefining Community Meals
CVAA Total Community Meals Trend

CVAA Community Meals Program (Thousands)
History of the CVAA Ticket Program

- $3.00
- $4.00
- $5.00

Benefits

- For seniors who do not want to join large senior gatherings, this is the perfect alternative
- Eat in an intimate setting in a restaurant
- Multiple restaurants participate in this program
- Selection of menu items to choose from
- Meals are available at breakfast, lunch and dinner seven days a week
- Same affordable price at each restaurant
- CVAA serves between 600 and 1000 tickets per month and the program is growing
- Naturally some restaurants close but we are always adding new ones so seniors get to try new places
Recruiting a New Restaurant

- Schedule meeting with restaurant manager or owner
- Share list of participating restaurants and encourage them to call for feedback on participating
- Explain advantages – fills up slow times, seniors bring back family members who pay full price, restaurant is giving back to the community
All restaurants are paid $5 per senior meal served
CVAA RD, Manager and restaurant manager review
restaurant menu and build special ticket program menu that
is in compliance with Older Americans Act criteria
Review memorandum agreement that will be signed
between CVAA and restaurant
Share State of VT letter designating CVAA restaurant
programs as part of OAA and are exempt from rooms and
meals tax
Review with restaurant State of Vermont OAA Nutrition
Program Manual which includes nutritional OAA guidelines,
food safety, etc and give them a copy of the guidelines for
reference
How a Senior uses the Restaurant Ticket Program

- Seniors call and come to our office to inquire about the program.
- Since 1994 we have yet to advertise, word of mouth has been very powerful, a testament to the success of the program.
- The program is explained to them in detail when they arrive.
- They must fill out a nutrition program registration form which includes verifying their date of birth and other federal information that we must collect.
- The suggested donation is $5, the same amount we pay the restaurant.
- No one is turned away due to inability to donate according to OAA.
- The average has always been in the range of the suggested donation.
Ticket Sample

July 2015 Senior Community Meals Ticket Program

(802) 865-0360 • www.cvaa.org

This ticket entitles named senior, 60 years of age or over, to eat at one of the participating ticket program restaurants.

Suggested Donation $5.00 - Tip is not included

Please present ticket to server before ordering off the senior menu. This ticket cannot be used for take out meals. Restaurants may not honor tickets on certain holidays.

Name: __________________________

You must print your full name to make this ticket valid.
Pat Long, Chittenden Community Meals Coordinator

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