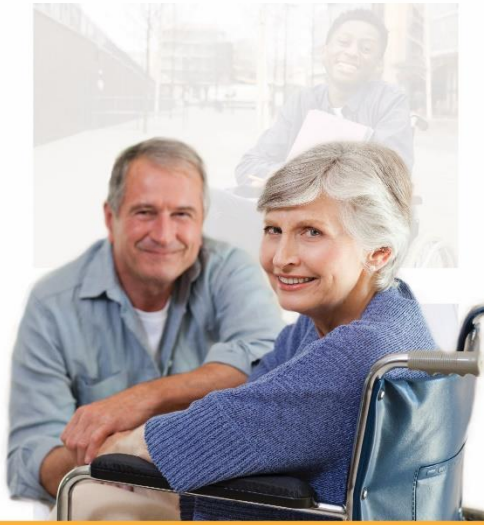
Role of Nutrition in an Integrated Care Coordination Model

Lily Suazo, RDN, LDN, CDE
Sr. Nutrition & Operations Director



"We never forget who we're taking care of. The person on the phone is someone's grandparent, parent or child. At ILS, we have a passion to help people."

Nestor Plana | Chairman & CEO

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

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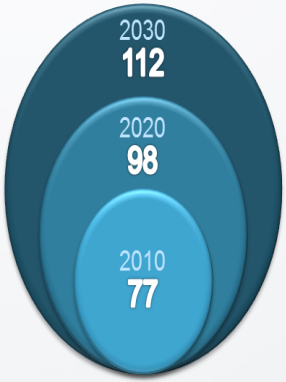
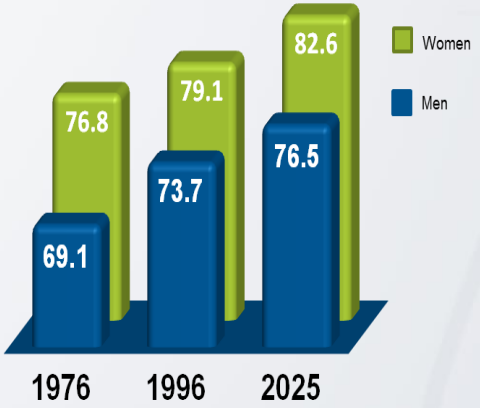
Nutritionals Issues in Community-dwelling Older Adults and the Impact of Nutrition Intervention

Americans are aging and living longer

US Population, Adults 55+ (MM)



Average Life Expectancy in the US (Years)



Everyday, for the next 18 years, 8,000 “baby boomers” will be turning 65[1].

By 2010, overall life expectancy in the US increased to ~79 years[1].

1. CDC 2010 preliminary data _040912
http://www.aarp.org/personal-growth/transitions/boomers_65/

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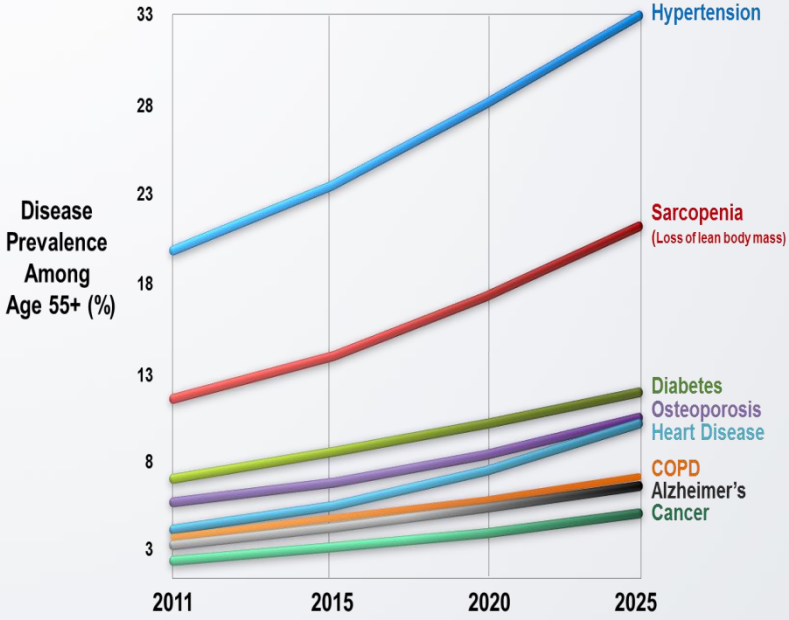
Older patients suffer from one or more chronic diseases



US Census Bureau. December 2009; Timely Data Resources, Inc. Disease incidence: a prevalence database, December 2009; Iconoculture: Consumer Outlook Health and Wellness 2008-2009.

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

- 93% had at least one problem with eating and digestion
- 50% required assistance with shopping and food preparation

Soini H, et al. *J Gerontol Nurs*. 2006;12-17.

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

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

Demling RH. *Eplasty*. 2009;9:65-94.

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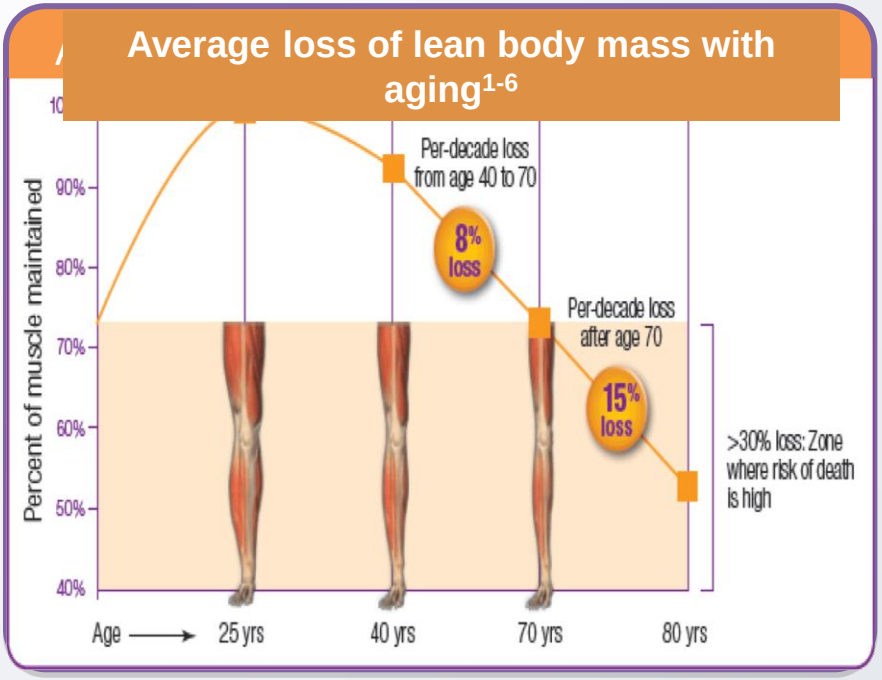
Progressive loss of lean body mass is a natural part of aging



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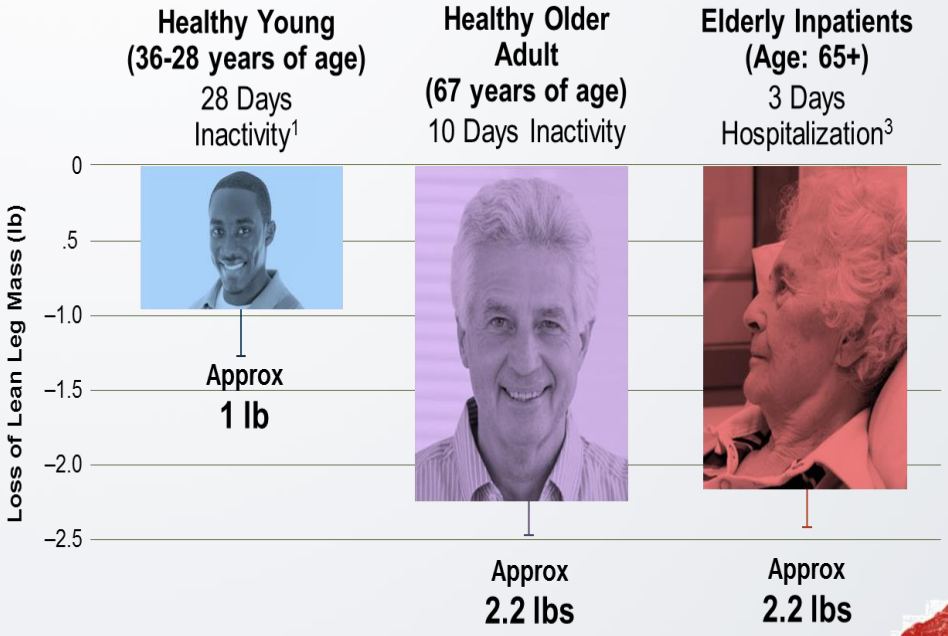
Illness and injury accelerate muscle loss



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Loss of lean body mass leads to difficulty performing ADLs

Loss of lean body mass > Loss of strength = Difficulties performing activities of Daily Living (ADLs)

- Eating
- Transferring
- Toileting
- Ambulating

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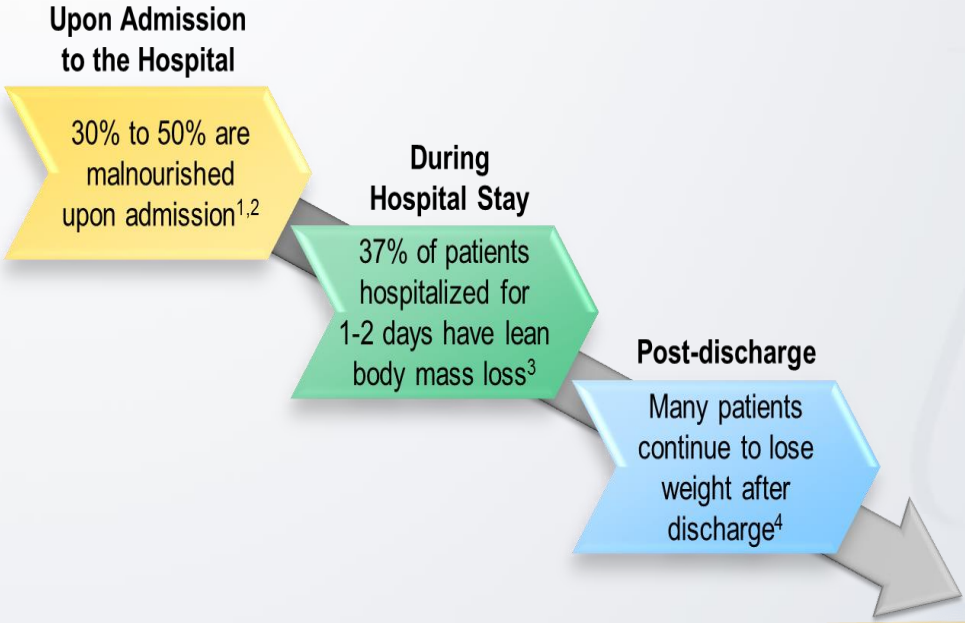
Patient's nutritional status and lean body mass becomes progressively compromised as they travel through the continuum of care



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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

Boumendjel N et al. *Lancet* 2000; 356: 563.

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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

2009 Adult ReHospitalizations

2.3MM

2009 Healthcare Costs[5]

$17B

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

1. "Tackling Malnutrition: Oral Nutritional Supplements as an integrated part of patient and disease management in hospital and the community. A summary of the evidence base." Medical Nutrition International Industry, July 2010. **2.** Mudge A, et al. *J Hosp Med*. 2011;6:61-67. **3.** Friedmann J, et al. *Am J Clin Nutr*. 1997; 65:1714-1720. **4.** Vecchiarino P, et al. Heart Lung. 2004;33:301-307. 5 Jencks SF, et al. *NEJM*. 2009; 360(14): 1418-1428.

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Transition of care is becoming increasingly important in driving improved patient outcomes

Discharge *Is now going to* Transition

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

Denniston L. New Final HHS Rules on Readmissions. http://connect.curaspan.com/articles/new-final-hhs-rules-readmissions. Accessed October 18, 2011.
http://www.gpo.gov/fdsys/pkg/FR-2011-08-18/html/2011-19719.htm

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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

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

*Source: Jill Gurvey, Kelly Rand, Susan Daugherty, Cyndi Dinger, Joan Schmeling, and Nicole Laverty
Journal of Primary Care & Community Health, October 2013; vol. 4, 4: pp. 311-317., first published on June 3, 2013

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

Enrollment	Assessment	Care Plan Development	Care Plan Execution
✓ Gather / analyze multiple data feeds ✓ Determine member eligibility ✓ Enroll member	✓ Analyze member-centric data ✓ Conduct risk analysis ✓ Stratify member	✓ Assign member to a care plan ✓ Price care plan ✓ Create clinical guard rails / authorization requirements	✓ Coordinate / authorize care ✓ Monitor member ✓ Facilitate transitions in care ✓ Create prior authorizations ✓ Notifications for change in condition

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

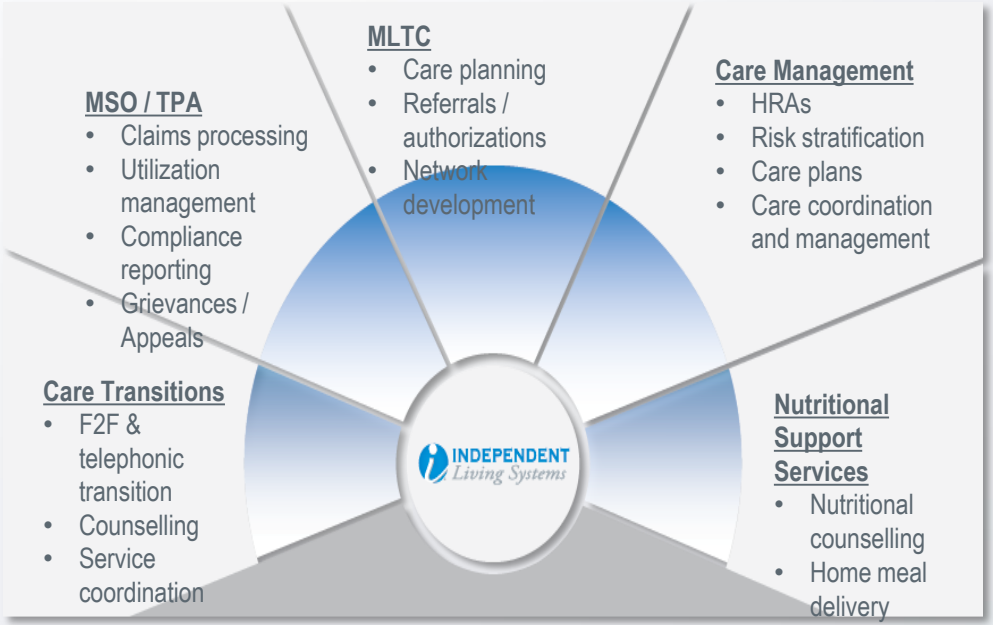
C. **Controlling Blood Pressure**: 72.16% **4 STARS**

+7.69 above the plan's goal of 64.47

Source: Executive Summary by health plan client, December 5, 2014

Products & Services

ILS delivers a care optimization/management platform to support a member-centric, holistic approach that drives superior clinical outcomes at lower costs



Key Highlights

- Readmissions
- Rx Utilization
- SNF Utilization

- Manages +3.5M covered lives
- Proprietary, scalable IP platform and logistical support
- Notable outcome experience
- Massive expansion opportunity
  - *Duals, Rx, DME*
  - *Provider Readmission Management*
  - *Commercial*

Independent Living Systems © 2015

Post Acute Support System — PASS® Product Information

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℠) 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[1]
  - Face-to-face at Home post discharge (48 – 72 hours)
  - Telephonic, day 2, 7, 14, 21 and 30 post discharge

1. PASS Coaches are assigned by facility and visit that facility each day.

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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.

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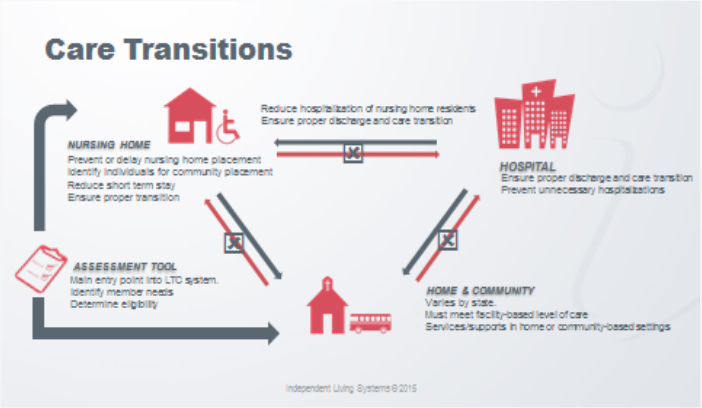
Care Transition Services

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

	Coaching	Coaching Only N = 660	Coaching + Nutritional Support N = 234	Coaching + Community Support Services N = 28	p-value
2011**	30-Day Readmission Rate*	17.88% (118)	8.55% (20)	3.57% (1)	p = 0.0006
	60-Day Readmission Rate	27.27% (180)	17.52% (41)	14.29% (4)	p = 0.005

*Baseline 30-Day Readmission Rate – 23.1% (Population – 14K; 8 hospitals)

	Coaching	Coaching Only N = 613
2013***	30-Day Readmission Rate*	12.9%
	30-Day Mortality Rate	3.7%

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

Other Benefits	
Reduction in SNF Utilization (transfers; discharge to SNF)	22%
Reduction in Rx cost / utilization	30%
% of patients seen by physician within 30 days of discharge	78%

**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).

***Source 2: Medicare Community-Based Care Transitions Program Quarterly Monitoring Report #2 Current Period: February 1, 2013 – April 30, 2013

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

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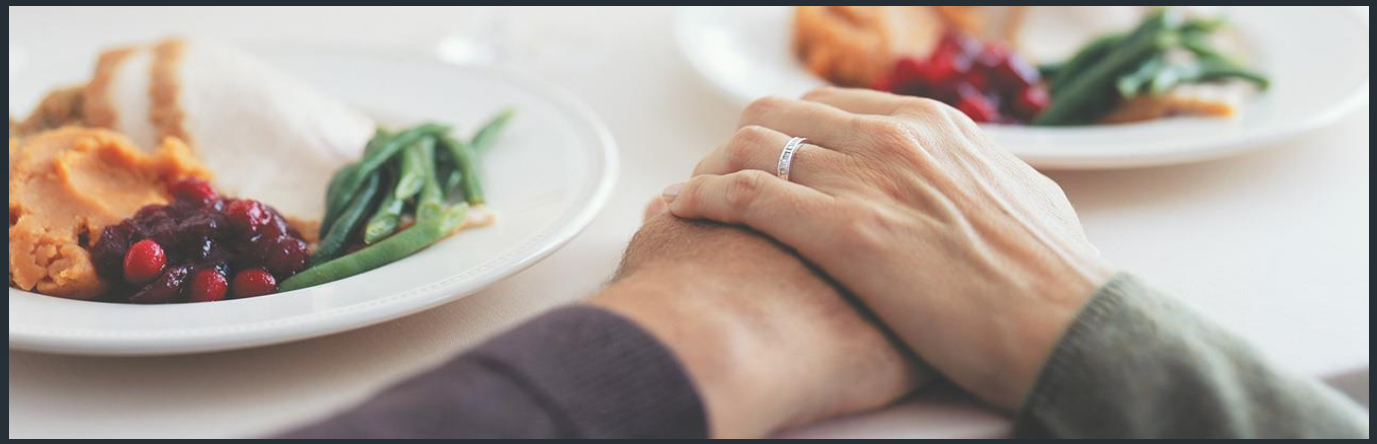
Fine Dining and Social Engagement – In Demand

CVAA's Restaurant Ticket Program

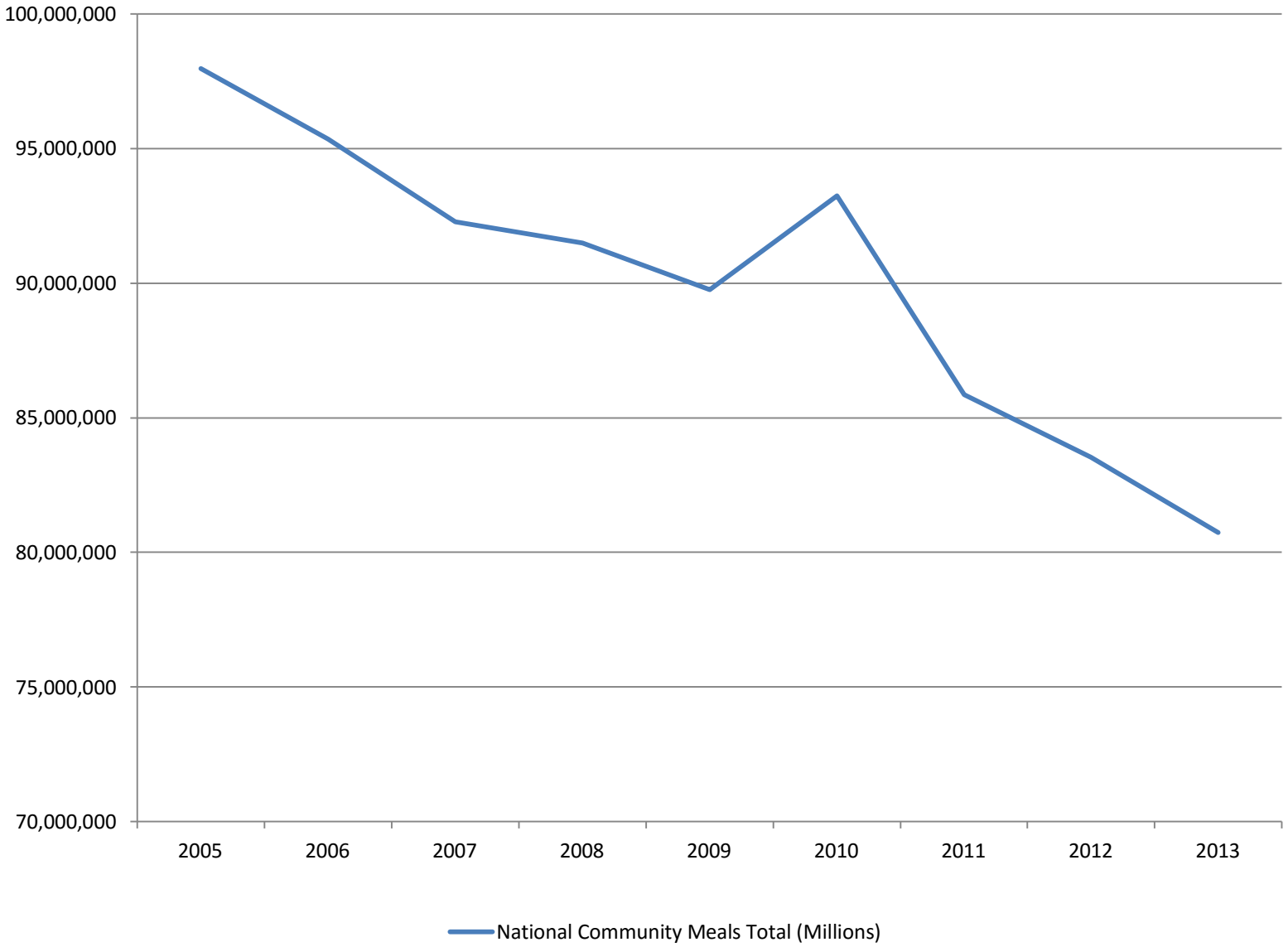


Redefining Community Meals

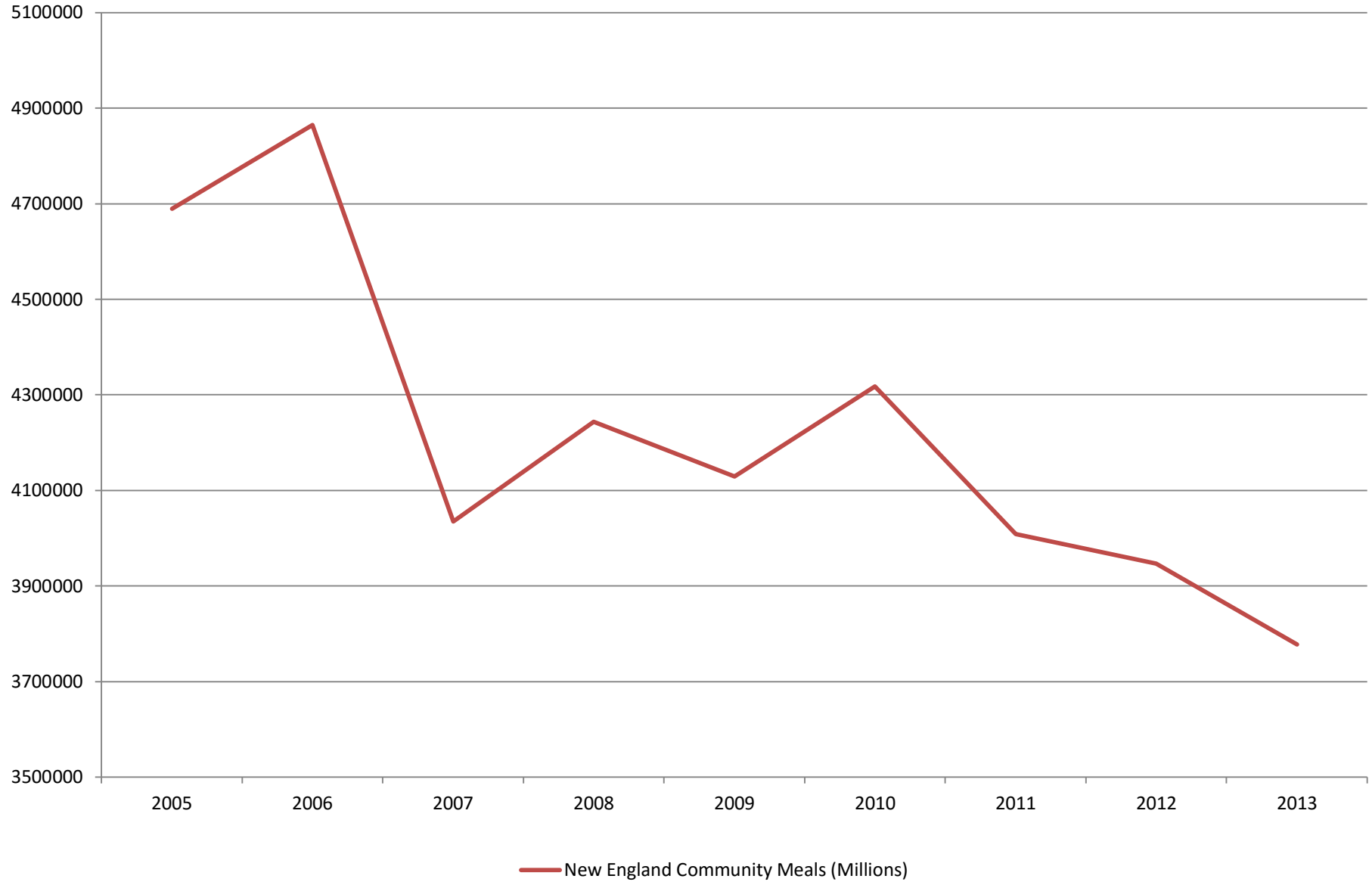
EMPOWERS.
GUIDES.
PROVIDES.

Services and Support for Seniors

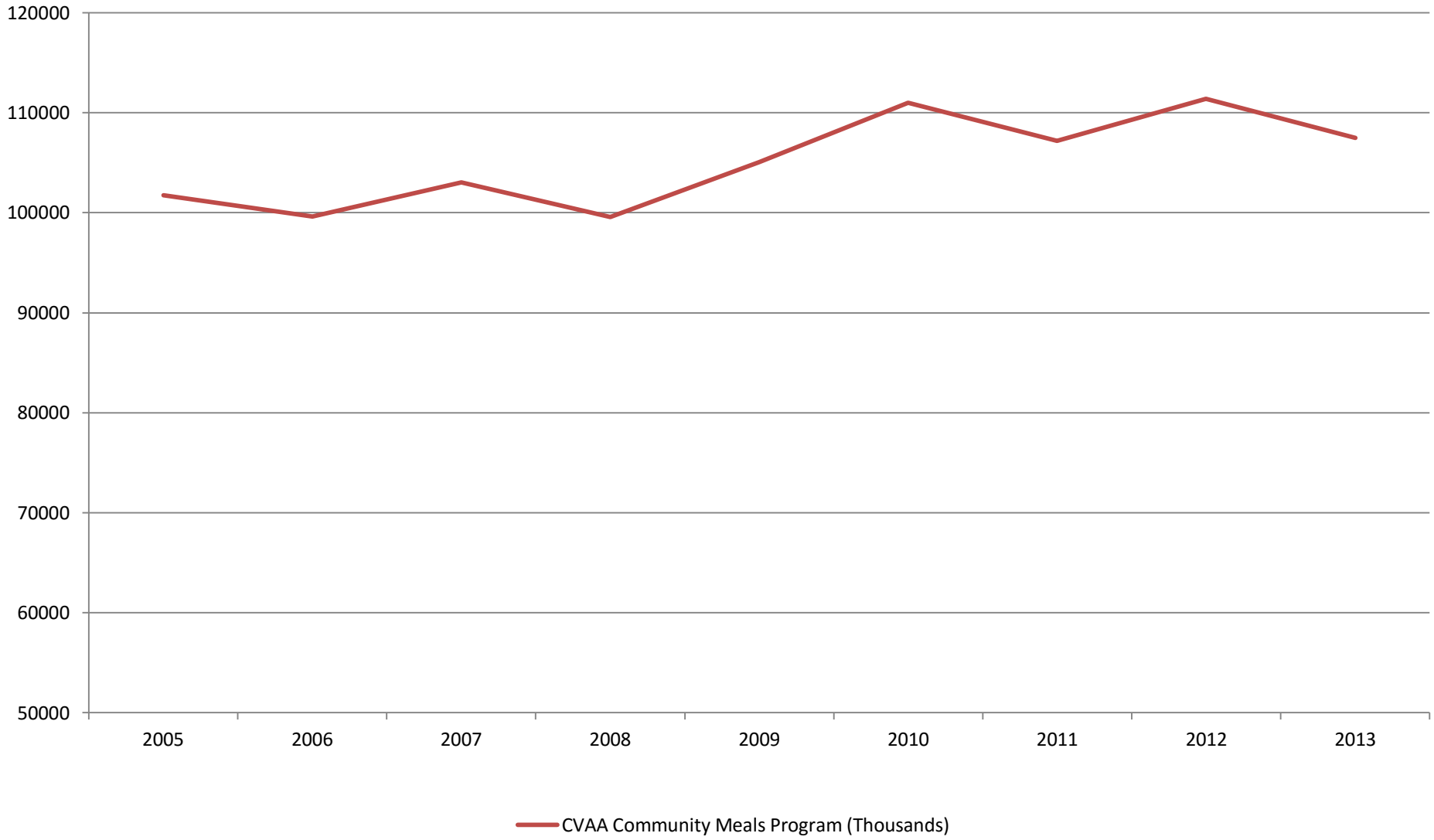
National Community Meals Trend

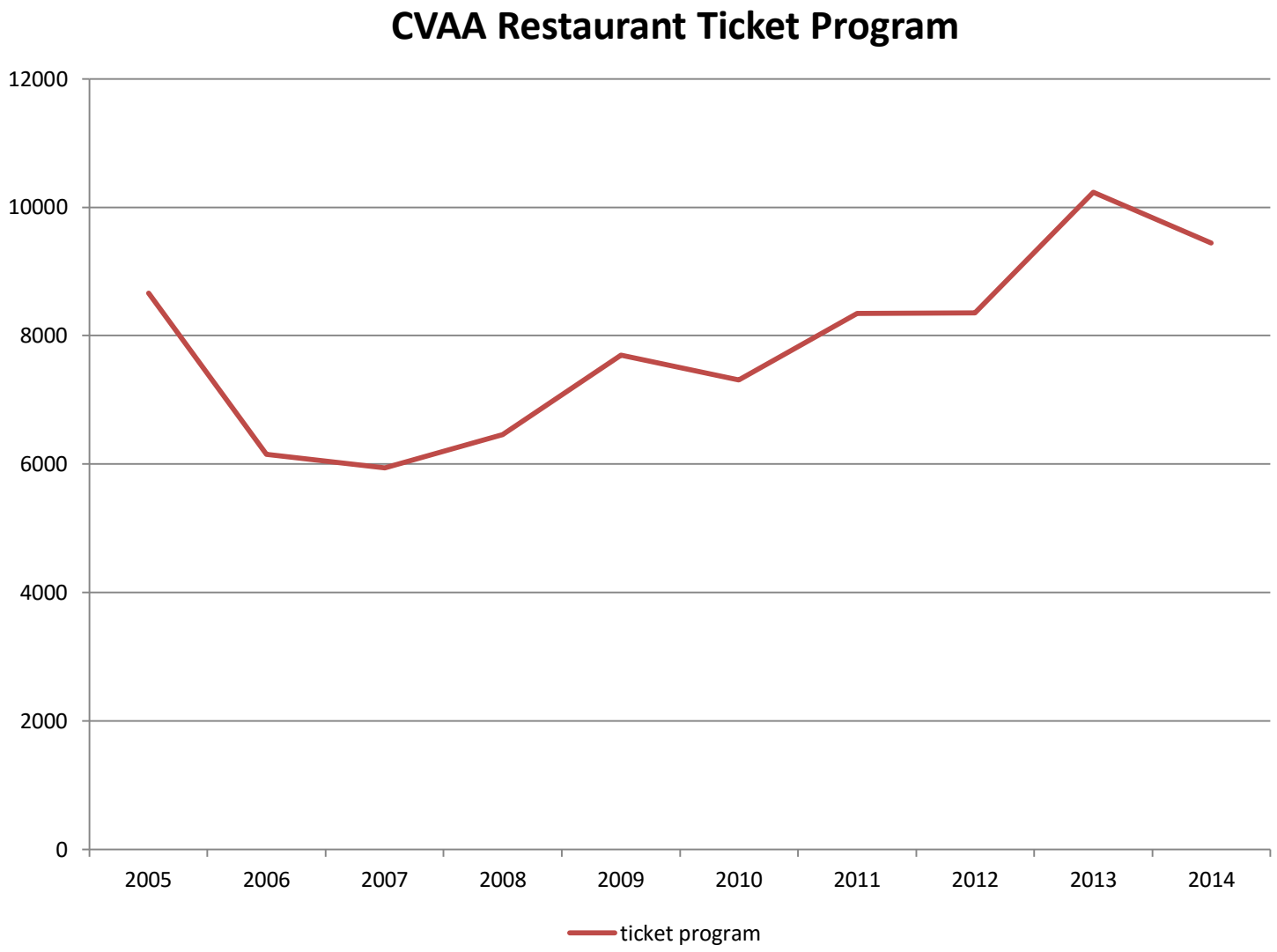


New England Community Meals Trend



CVAA Total Community Meals Trend




CVAA Restaurant Ticket Program
12000
10000
8000
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2006
2007
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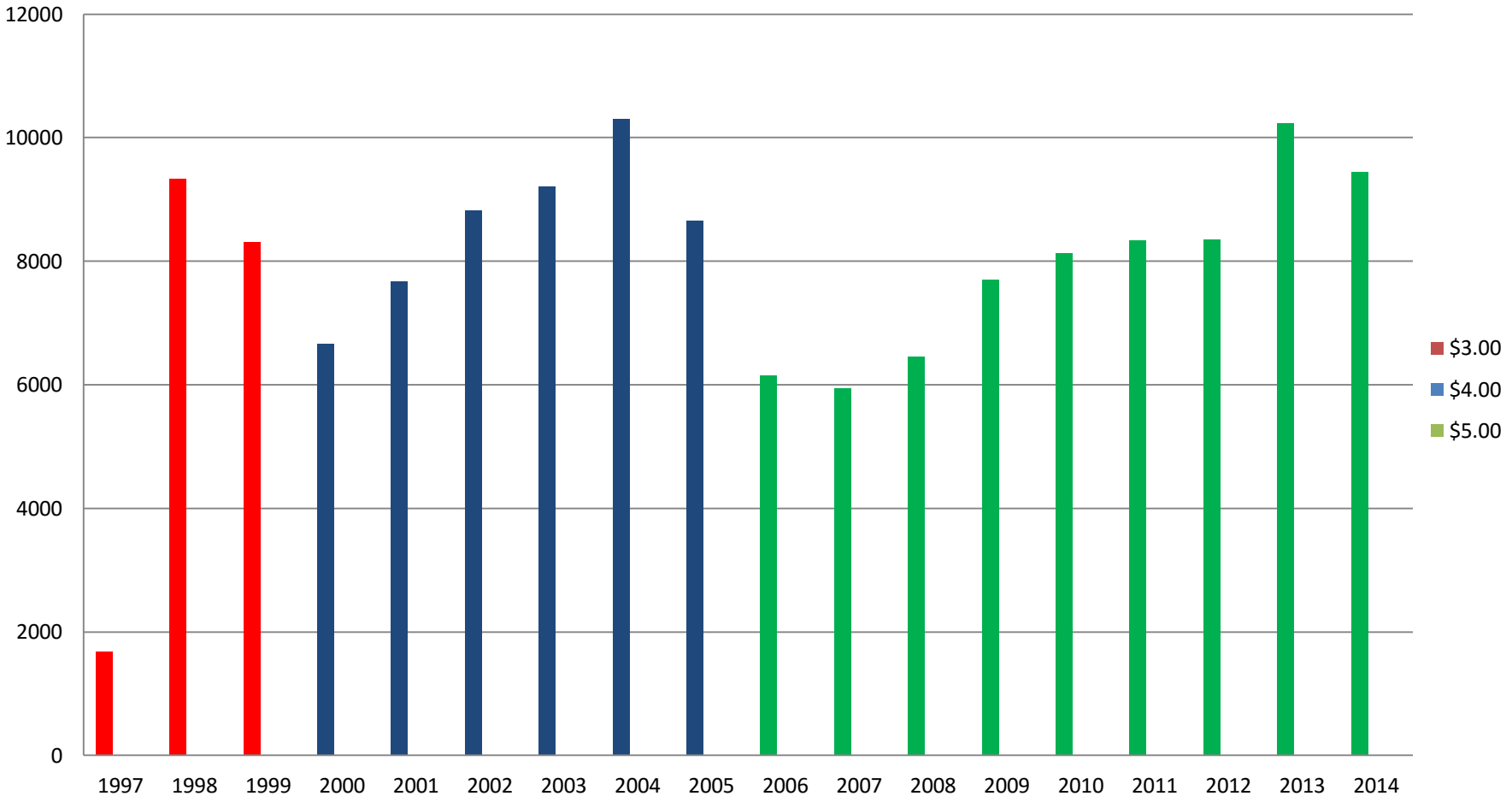
2009
2010
2011
2012
2013
2014
ticket program

History of the CVAA Ticket Program



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

CVAA **295**

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

76 Pearl Street, Suite 201

Essex Junction, VT 05452

802-865-0360

plong@cvaa.org

CVAA.org