Your Participation

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Submit questions and comments via the Questions panel
Meet our Presenters

Jean Terranova, JD  
Director of Food and Health Policy  
Community Servings  
Boston, MA

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VP of Clinical Services  
Serving Seniors  
San Diego, CA

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Department of Family and Preventive Medicine  
University of Utah
defeat malnutrition today

Bob Blancato
National Coordinator
Brenda Schmitthenner, MPA
Senior Director, Successful Aging
West Health: Partnering to Make Significant Impact

Dedicated to lowering healthcare costs to enable seniors to successfully age in place with access to high-quality, affordable health and support services that preserve and protect their dignity, quality of life and independence.

Outcomes-based philanthropy

Applied medical research

Policy research and education
The Human and Financial Impact of Malnutrition

• Up to 1 out of 2 older adults is either at risk of becoming or is malnourished

• Disease-associated malnutrition in older adults is estimated to cost $51.3 billion annually

• In community care settings an estimated 6%-30% of seniors are malnourished
Executing the Roadmap for Comprehensive Malnutrition Care

Senior Malnutrition Visioning Session

- Comprehensive Malnutrition Care
  - Identify
    - Universal screening & diagnosis
    - Standardized definition & tools
    - Social determinants of health
  - Intervene
    - Holistic, person-centered care plan
    - Care coordination (communication)
    - Care transitions
    - Community-based services & supports
  - Evaluate
    - Measured outcomes
    - Demonstration projects
    - Research
  - Senior Malnutrition is prevented
    - When present, it is rapidly addressed
    - Identify payment incentives and penalties (clinicians)
    - Identify reimbursement opportunities (communities)

- Call to Action
  - Define & prevent malnutrition
    - Not the same as hunger
    - Affects us all (equity)
  - Recognize it as a crisis
  - Bring together government, non-profits
  - Prevent & address malnutrition where seniors receive care, live, work, pray, & play
  - Quality measurement & reporting

- Incentivize
  - Incentives for care
Jean Terranova, JD
Director of Food and Health Policy
Community Servings
Boston, MA
The Role of Medically-Tailored Home-Delivered Meals in Holistic Patient-Centered Models of Care

Bridging the Silos of Health and Social Malnutrition Care
July 18, 2019
About Community Servings

Founded in 1990 to provide home-delivered meals to individuals living with HIV/AIDS, we initially served 30 clients a day in two neighborhoods of Boston.

We now serve medically-tailored home-delivered meals to 1200 clients a day in 21 cities and towns in Massachusetts, and will soon have the capacity to serve the entire state. Through a Food is Medicine Accelerator, we are working towards expanding the service to un-served and under-served communities throughout the US.
We serve high-need, high-cost patients who have multiple chronic conditions.

- 32% HIV/AIDS
- 20% Cancer
- 18% Renal
- 12% Diabetes
- 4% Lung
- 3% Cardiac
- 2% MS
- 9% Other

71% of clients have multiple diagnoses. 90+% also experience poverty.
Medically-tailored home-delivered meals (MTM) program design

- Scratch-cooking with whole, fresh ingredients
- Menus developed and executed by a Registered Dietitian Nutritionist (RDN) and Chef
- 15 medically tailored meal selections, customized with up to three combinations
- Initial nutrition assessment and optional ongoing nutrition counseling
- Continuous evaluation and quality improvement

*My health has been improving week by week since receiving your meals: I have been able to get to all of my doctors’ appointments, and my fears about not eating, and not eating well have been erased.* -- A Meals Client
MTM Impact

Peer-reviewed claims-based and clinical studies demonstrate that medically-tailored home-delivered meals:

• Reduce utilization of acute-care services including hospital admissions, emergency room visits, and ambulance service
• Reduce medical costs
• Improve health outcomes for individuals with complex illnesses, including HIV, diabetes, and Congestive Heart Failure
• Improve self-efficacy and quality of life
Integration of MTM into healthcare payment and delivery models

- Reimbursed through managed care plans serving individuals dually-eligible for Medicaid and Medicare
- Piloting reimbursement through a Medicare Advantage plan
- Pursuing contracts through the Massachusetts Medicaid Flexible Services Program
- Qualified as a First Tier, Downstream, and Related Entity
The need to break down silos

Full integration requires uniformity or consensus on:

• Screening and referral criteria and processes
• Program design (duration of service, inclusion of nutrition assessments, counseling, and education, providing meals to family members)
• Evaluation
• Feedback
• Continuous quality improvement

To streamline program administration and realize the potential of the program’s impact.
Our vision of how to integrate MTM services into the healthcare system

<table>
<thead>
<tr>
<th>Provider knowledge &amp; screening</th>
<th>Patient Referral System</th>
<th>CBO Scaling and Replication</th>
<th>Sustainable Funding</th>
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</thead>
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<tr>
<td>• Provider education on the role of nutrition in healthcare</td>
<td>• Bi-directional referral with warm hand-off</td>
<td>• Well-supported CBOs offer services in areas currently unserved or underserved by MTM programs</td>
<td>• Medicare, Medicaid, ACOs, and private insurers reimburse for MTM services</td>
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<tr>
<td>• Standard screening protocols embedded in EMRs and tracked</td>
<td>• Seamless integration of referral platform</td>
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<td>• Screening incentives</td>
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Systematic change throughout private and public sectors to support MTM

Similar conclusions and recommendations have been published in the Massachusetts Food is Medicine State Plan, a project we are co-leading with the Center for Health Law & Policy Innovation of Harvard Law School
Jennifer Sinnott, MSW
VP of Clinical Services
Serving Seniors
San Diego, CA
Helping seniors in poverty live healthy and fulfilling lives
History & Mission

• Helping seniors in poverty live healthy and fulfilling lives.
• Since 1970, Serving Seniors has been transforming the aging experience through our innovative approach in the provision of comprehensive services.
• In April 2010, Serving Seniors opened the Gary and Mary West Senior Wellness Center in downtown San Diego.
Demographics

Gender
• 49% Female
• 51% Male

Race
• Asian – 21%
• African/African American – 12%
• Latino – 21%
• White – 39%
• Other – 7%

Income
• Median Income – $950/per month
• Social Security is the primary source of income

80% of senior clients live at or below the poverty level.
Programs & Services
Nutrition

A hot meal is the #1 reason people seek our assistance.

• 620,000 meals served annually
• 175,000 meals served to more than 2,200 low income seniors each year at the GMWSWC
• 600 clients receive home delivered meals daily
• Meals developed in partnership with a Registered Dietician, meeting 1/3 of the dietary recommendations for older adults
• 10 congregate meal sites
• Access to meals 365 days of the year
Services Include…

- Nutrition
- Social Services
- Health & Wellness
- Activities and Events
- Transitional Housing
- Permanent, Supportive Housing
- Collaborative Partnerships
- West Senior Dental Center
Comprehensive Geriatric Assessment (CGA)
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<th>Dimension</th>
<th>Details</th>
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<td>Demographics</td>
<td>Age, sex, race, ethnicity, primary language</td>
<td>UCLA Rand CGA</td>
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<td>Loneliness</td>
<td>UCLA 3-Item Revised Loneliness Scale</td>
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<td>Social Determinates</td>
<td>Health behaviors (smoking, drinking)</td>
<td>Don’t know</td>
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<td></td>
<td>Health literacy, education, monthly income, housing, insurance, household size, need for translation, Social Support, Isolation and Loneliness</td>
<td>MICASA, Chew, Bradley &amp; Boyko 2004</td>
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<td>Nutrition</td>
<td>Appropriate Food consumption</td>
<td>National Health and Nutrition Examination Survey</td>
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<td>Food worry</td>
<td>The Q</td>
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<td>Function</td>
<td>Functional Status, Fall History</td>
<td>Vulnerable Elder’s Survey 13—Saliba et al. (2000)</td>
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<td>Hearing, Vision, Memory problems</td>
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<td>Quality of Life</td>
<td>Older People’s Quality of Life—Brief</td>
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<td>Medical</td>
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<td>Active Medical Problem</td>
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<td>Recent symptoms</td>
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<td>Access Barriers</td>
<td>SOL, NHANES</td>
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<td>Utilization History</td>
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<td>Recent Symptoms</td>
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<td>Dental</td>
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<td>Hygiene Behaviors</td>
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<td>Barriers to care</td>
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<td>Dental pain</td>
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<td>Mental Health History (active problems)</td>
<td>UCLA RAND CGA</td>
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<td>Mental</td>
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<td>Patient Health Questionnaire</td>
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<td>Depression and Suicide screen</td>
<td>PHQ-9</td>
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Collaborative Partnerships

- Consumer Center for Health Education and Advocacy
- Sharp HealthCare
- Elder Law & Advocacy
- AmeriCorps
- San Diego State University
- County of San Diego’s Aging & Independence Services
- Family Health Centers of San Diego
Thank you!
Susan Saffel-Shrier, MS, RDN, Certified Gerontologist
Professor, Department of Family and Preventive Medicine
University of Utah
Bridging High Quality Malnutrition Screening, Assessment, and Intervention for Older Adults from Hospital to Home

SUSAN SAFFEL-SHRIER, MS, RDN, CERTIFIED GERONTOLOGIST
CHARLOTTE VINCENT, PHD, RDN, CD
AMY COVINGTON, MS, RDN
The Blind Men and the Elephant John Godfrey Saxe
(1816-1887)
Malnutrition Cycle

Home

Home Health

Hospital

Rehab
Overview of Pilot Study

University of Utah and Aging and Adult Protective Services and three Utah Area Agencies on Aging (AAA)

High-quality malnutrition home visitation pilot program for home delivered meal (HDM) Recipients Recently Discharged to Home

Malnutrition project outcomes:
- Implement malnutrition protocol, training, and resources for nutrition home visitation programs
- Demonstrate a transferable home visitation model program
- Provide RDN directed nutritional assessment and interventions
- Improve coordination of home- and community- based services (HCBS) to address malnutrition risk factors
- Tailor nutrition home visitation programs for urban, rural or frontier
Area Agency on Aging Flowchart

Meals on Wheels Program

Participant qualifies for study if:
1. 60yrs. or older
2. Recently discharged from hospital/SNF/rehab
3. Positive malnutrition score (Determine score of 6 or higher)

Participant is provided with a flyer and asked if they would like to be part of the nutrition study

If YES
Have participant sign consent to contact form

Send signed consent to contact through unencrypted email to Research RDN

Research RDN will contact potential participant to discuss study and enrollment

If Yes. Research RDN will email signed consent to participant to using secure email.

If NO stop here

Research RDN will contact participant to begin the study

AAA will send encrypted email with participants intake evaluation form to Research RDN
Pilot Project Evolution

Extensive recruitment process analysis
- Multiple processes
- Silo effect
  - Internal identification only
  - Development of processes beyond participant identification

Continual training
- Comprehensive geriatric assessment and standardization

Continual contact with project partners
- Attend regularly-scheduled meetings with both AAA and hospital and clinics

Active recruitment
- Expansion from only hospital referrals and added skilled nursing home and rehabilitation
- Expansion to multiple hospital discharge groups
- Provide contact information for AAAs
Thank You!
Questions?
Thank you!

defeat malnutrition today

defeatmalnutrition.today

westhealth

westhealth.org