

NWX-HHS-AOA-1

Moderator: Lauren Solkowski
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1:00 pm CT

Coordinator: Welcome and thank you for standing by. All participants are in a listen-only mode. During the question and answer session please press Star 1 and record your name as prompted.

Today's conference is being recorded. If you have any objections, you may disconnect at this time.

I would now like to turn today's meeting over to Lauren Solkowski. Thank you. You may begin.

Lauren Solkowski: Great thank you, (Carolyn). Good afternoon and thank you for joining us today for the Administration for Community Living Targeted Technical Assistance Webinar entitled Data Driven Decision Making Nutrition's Role in the Changing Healthcare Environment.

As the operator mentioned I am Lauren Solkowski with ACL and I will be facilitating our Webinar.

So before we begin our - the presentation, I have a few housekeeping announcements. If you have not done so, please use the link included in your calendar appointment to get onto WebEx so that you cannot only follow along with the slides as we go through them, but also ask your questions when you have them through the Chat function.

If you don't have access to the link that we emailed you can also access the Webinar via www.webx.com then click on the Attend a Meeting button that's at the top of the page and then enter the meeting number.

The meeting number for today's Webinar is 294779244. So that meeting number again is 294779244. If you have any problems getting onto WebEx please call the WebEx technical support at 1-866-569-3239 that's 1-866-569-3239.

As the operator mentioned all of our participants are in listen-only mode. However we welcome your questions throughout the courses of the Webinar.

There are two ways that you can ask your questions. The first through the Web using the chat function in WebEx that's located at the right-hand side of the screen.

You can enter your questions here. We'll sort through them and answer them as best we can when we take breaks for questions after our speakers present.

And then in addition to asking questions via the chat we will offer you a chance to ask through the audio line. So when that time comes the operator will give you instructions as to how to queue up to ask your question.

If there are any questions that we don't get to during the course of the Webinar we will follow-up to be sure that we get them answered.

If you think of any questions after the Webinar you are welcome to email them to me. My email address I have listed here in the chat function on the right-hand side Lauren.Solkowski@acl.hhs.gov.

And then finally we are recording this Webinar as we mentioned. We will post the recording, the slides and the transcript of the Webinar on the ACL Web site as well as the (In Forays) MLTSS Network Web site. Both of these links are also added in the chat box for your reference.

So with that I would like to introduce Linda Netterville. Linda is the Vice President of Grants Management for the Meals on Wheels Association of America as well as the Director of the National Resource Center on Nutrition and Aging.

So Linda I'll turn it over to you.

Linda Netterville: Okay, thank you Lauren. Just a reminder, this is brought to you by the National Resource Center on Nutrition and Aging and our Web site for Nutrition Resources is nutritionandaging.org.

So if you want to look at any kind of follow-up studies, data -- anything else that we may have already posted it will be [@nutritionandaging.org](https://twitter.com/nutritionandaging).

So I'd like to introduce the speakers for today and next slide Lauren. We have Sherry Simon who is Vice President of Nutrition and Health Programs at Meals on Wheels of Tarrant County in Fort Worth, Texas.

And Sherry has been a dietitian a registered licensed dietitian for over 27 years and has been with the Tarrant County Meals on Wheels Program since 2005.

And in her position she has been instrumental in developing many programs that enhance nutrition services available such as meal choice and breakfast meal delivery.

And with her talking about their program is Alan Stevens, Professor at Texas A&M Health Science Center and Centennial Chair in Gerontology Scott White Baylor Health Care at Temple, Texas.

And then lastly we have Kali Thomas, Dr. Kali Thomas, Assistant Professor Center for Gerontology and Healthcare Research from Brown University and also research health science specialist from the Providence VA Medical Center.

So next slide, so one of the challenges that all home and community based services have is collecting supported outcome data both client, programmatic or system type data.

And this data is needed for making effective and appropriate decisions in the planning management and administering of a program, developing of new programs, developing program enhancements, meeting funder requirements, developing grant funded projects and justifying budgets.

Today we're going to hear from one Meals on Wheels program their data collection methods and findings that support positive nutrition service outcomes both client and programmatic.

And then lastly we're going to look at more systemic outcomes through research analysis conducted by Dr. Kali Thomas.

So I'm going to turn it over now to Sherry Simon so next slide Sherry.

Sherry Simon: All right well welcome everyone and I'm very honored to be here to speak to everyone about what we're doing here in Tarrant County.

I have been a dietitian here at this program for almost ten years now and have been able to grow our program from just meals to other kinds of nutrition resources or services as Linda mentioned.

Lauren next slide, please. So the things we're going to talk about today are basically from its perspective of one nutrition program here in - here at Meals on Wheels in Tarrant County or Fort Worth, Texas.

We're going to talk about how we collect data, what - we're going to talk about what data is collected how we collect data, how our analysis is supported and what - how we're using those results.

And I'm going to probably take you a little through step by step and just give you ideas about how what we're doing with the data and why we're collecting that data.

Next slide, please. Okay. So what's happening here at in Tarrant County is that we have all different types of programs here.

We do everything from feed homebound residents to feeding pets to getting reading materials to our clients. So we have all kinds of things happening here.

And to do all of those different kinds of things you have to have a means of managing that. And we use a access database that has been written specifically for us. And that allows us to grow and do different things very easily.

We have a programmer that works with us. And so every time we had a program, take away a program we can change the system very easily for us.

These are just some ideas of some of the data that we collect. We of course have our meals and our meals program and so we do choice meals as Linda mentioned.

So we have to have a means of discerning who is going to get what meal? Are they going to get - is Mrs. Jones going to get in a meal and Mr. Smith get a B meal? So we have to have a way of keeping that all straight.

We also ask homeland security questions. Meals on Wheels Association of America had a grant from Homeland Security to ask specific questions for homebound clients because what they learned in Katrina is that no one knew who the most isolated seniors were.

So we've included all those questions for every one of our clients. And that is in their database. Any kind of referrals there we receive or make that is put into our database.

Of course we need it for accounting. Who's funding what meal for what client? All those decisions and all of those, you know, counting the beans is done within our database as well.

We do health, medical and medication evaluation or collection of data. So we are collecting diagnosis. We're collecting actual medication and dosage. We're collecting if a hospital is in ED utilizations, whether they can if they're hard of hearing, whether they can need a walker. All those items are collected and placed into our database.

Obviously being that we are part - we receive moneys from the state because of the federally funded older Americans Act dollars we are required to do certain assessments.

Most of those are based on the activities of daily living. We measure those as well as using some other evidence based tools such as the NIH NHIS utilization questions as well as nutrition risk.

We used the determine. We're also doing the mini nutritional assessments. So all those kinds of healthy days which we're asking how many healthy days clients may have within a 30 day period, all of those things, all of those questions are gathered those - that data is gathered input into our database.

We also need to collect data for grant funded projects. We have a substantial grant from the United Way of Tarrant County which provides for those programs you see there -- diabetes, home meds, PAM.

And then the vision grant was something that was funded by the Meals on Wheels Association of America. And that's what Dr. Stevens is going to really focus on.

But our diabetes program, we're sending dietitians in the home and we're actually providing doing nutrition assessments and providing nutrition education.

So all of that information data is collected and kept in our database. The homeless program is an evidence based program that the ACL has approved. And we are actually looking at medication issues for duplication of medication, medications causing dizziness or falls and we're trying to alleviate those alerts or problems and so that we can bring down the hospitalizations.

So that - all of that information is also captured in our database. And then PAM stands for Patient Activation Measure. So these are for - this is a program for our clients that are least likely to be engaged in their health.

And we actually have community health navigators that are helping them get more engaged and be proactive in taking control of their health, making their doctors' appointments, understanding their medications -- that kind of thing.

We also are now have embarked on with our dietitians and what we do in the home a nutrition diagnosis. And this is something that a lot of hospitals are utilizing is from the Academy of Nutrition and Dietetics that basically it's a way if you're using nutrition diagnosis you can track basically the severity of the nutrition problem. And it can be - and you can track back to dollars saved or the potential cost of the nutrition diagnosis.

And then I've already spoke about Healthy Days data. But that's basically a evidence based tool that we're using to try to see pre and post how we affect the number of days someone is healthy or reports they're healthy.

Next slide, please. Okay. So what data is collected?

Next slide, so these are the types of data that we could collect. Of course demographic and we all know what that is, programmatic kinds of information specific to different programs like our meals program, the dietitian education that has to be provided as mandated by either state or federal requirements, the home meds. We've already talked about PAM or Patient Activation Manager.

We also have another program where we have which is Sage which we have physician medical students going into the home and working with our clients.

So these we can all do start and end dates and we can gather quite a bit of information of how these programs are working for our clients and how it moves us through the operation of making sure that we are getting the items to our clients so it's operational as well as programmatic.

Meal details, this is just simply what diet or choice meal is a client going to get? We also can - we also have information about food allergies.

It also can detail the funding source who's paying for that particular meal for that particular client.

Meal history, this is an area where we can actually know exactly how many meals a client got for a specific month or a specific year and how they were funded. So this is really important to our funders.

Medical screen, so we've pretty much within the - our database using access have created pretty much an electronic medical record. And so we capture everything from diagnosis medical needs, hospitalizations, insurance type what hospital they just came out of -- all those that information is collected.

And I've already talked about medication so we just not only cover actual prescription medications but we also ask for supplements as well as any herbal items that they may be taking.

Next slide, please. We also capture height, weight other agency involvement on our health screen. We do all kinds of documentation in free form writing. So if they call in with a question or a client calls in with a question or a case manager goes out to see a client all of that is document within our database.

So all of the assessments that we need, some of them mandated, some of them we put into place ourselves. And you can see we have the 2060 which is an ADL or activities of daily living kind of screen, nutrition screen, malnutrition screen. We do a diabetes screen to see the risk of someone developing diabetes.

Emergent care screen which is a measure to see the likelihood of someone I guess the severity of their condition and the likelihood someone may report to a hospital because of the severity of their condition.

Healthy days we've already talked about. And the EQ5B is basically a quality of life measure that we also continue to do.

Dietitian notes. We have an actual screen. We've developed that electronic medical record. We can take pieces of data and input and the - it populates into the note.

So our dietitians aren't having to retype BMI if it's already figured in our database or a certain diet is already in there or the diagnosis. They don't have to retype that. It self-populates into the note.

Outcome questions, so part of being involved with funders is they want to see pre and post results. And so we have to ask those outcome questions. And all that is captured in our database as well as client contributions so that we know who is able to make a contribution to us or who is making that contribution on behalf of the client.

Next slide, please. Okay. So this is just quickly a sample of what our database can do with regards to a dietitian note. And you can see that it is just like something that you might see in a hospital setting.

Next slide, please. Okay. So these are actually the questions that we asked for healthy days. And basically it's, you know, do - would you say your health - how your health is, your general health, how many days were you thinking, your physical health which includes physical illness or injury, how many days in the past 30 days was your health not good. And so these are our some of our we ask is pre or post any kind of intervention.

Next slide, and so how is our data collected? So basically we have what makes us unique here in Tarrant County is that we have about 14 case managers that are territorial within the county.

And they go out and see the clients and they collect a lot of this data. And they have laptops. We have gone away from netbooks and now they have laptops with air cards. It allows them to go right into our database to put in this information.

They also at the same time we also have people in the office staff that's also working on the same database and updating it as we've got a client calling in, missed a meal, we're trying to find a client -- those kinds of things.

We've already talked about that we've built in this database in the electronic medical record so we can track diagnosis, waste, we can track their medication, changes in their medication -- that kind of thing.

Any data that we input into this database we can basically build a report. So if we wanted to know how many meals were delivered in a certain ZIP Code in a certain period of time we could do that.

And so any field, any data field can then be created into a report. So some of the examples I just mentioned here is when we've had severe weather here in Fort Worth and we had a couple years ago an ice storm that closed down the city for about five days Fort Worth Emergency Management contacted us and wanted to know who were the most isolated, who did the fire department need to go check on within those five days. And so we were able because of our data collection we were able to give them the kind of report.

We can also meet an ambulance on the way to a client's house with medication lists and diagnosis so that they have that available to take to the hospital whether transporting someone to the emergency room.

Next slide, please. So this is just an example of some of the reports that we can do that have already been built. But there's many times that we have to create a report just because of the need of someone calling us or some piece of information we want to now search for.

Next slide, and then this is a slide of evaluation team specific reports. Dr. Stevens who's going to speak to you next is one of my evaluators for some United Way funded grants as well as we're working on some of the research together.

So he has access to our data and so these are some reports that were built specifically for the evaluation team.

Next slide. And how is that analysis supported?

Next slide, please. So internally we have office staff that's dedicated to all different types of input into the database depending on their job.

We have an IT manager here within our facility. We also have a technology committee that's made up of volunteers outside of our agency as well as people who work here in the agency and as well as some board members.

And then just know that every call, every action, everything that we do here is documented in to the database.

Next slide, the external report we have is that we have a database programmer who works one on one with us depending on the situation or what we need done.

We have an evaluation team so different funders require different types of evaluation. And I'm all for evaluation. You want to prove your worth.

We are hosts. We have the server is hosted so we have support that way. We have interface with other organizations that provide external support for us as well as the - we have needs of funders that are also pushing us to just like our external customers.

Next slide, and how are the results used? So basically as we've talked anything we're doing that's an intervention were doing pre and post data or annual data.

We need to report to our funders especially on those United Way types of projects. We have to report to stakeholders. So at AAA will require us to have certain statistics and data that we need to report to them. So having this database is very, very important.

Of course the data adds validity to what you're doing. We can also benchmark ourselves now against other agencies or other Meals on Wheels programs or compare ourselves to different types of health programs and see how we are doing especially when we're using those evidence based tools like the Healthy Days.

We can reproduce the data. We can share among like agencies. So with our United Way funding we all have the same tools that we're using pre and post so we can benchmark ourselves against those other funded agencies of United Way.

And then the more you use these tools the stronger our message is. And then of course data equals results. And I guess that's why I'm here talking to today because we do collect so much data that we're able to show results.

And it's and if I can say anything to you programs out there it's, you know, start small, start collecting your data in small doses. And as you continue to do that process you can just grow and continue to layer it and become more sophisticated with your gathering and input of data.

Next slide, okay that's all I've got so Alan is next and I want to thank Linda for my little crown there.

Lauren Solkowski: Okay. Dr. Stevens you're welcome to start.

Dr. Alan Stevens: Hi. Thank you. And I have had the pleasure of working with Sherry and her staff at the Tarrant County Meals on Wheels Incorporated for I guess about three to three years now or slightly more. And we have we worked together on a number of different evaluation efforts to look at the data that they're collecting.

As Sherry just described it's a very rich and robust data source that they developed and have primarily used to implement their services and to expand their services from meal delivery to other nutrition based interventions.

And given the level of complexity and the level of programs complexity in the number of programs that they provide and sheer quantity of the number of clients they serve that database has served them very well in terms of really reaching and touching homebound folks in Tarrant County.

So we were, you know, delighted not only to see what a wonderful service this was to the community but also to realize that perhaps we could work with them to find ways to analyze their data and produce reports both for internally to their organization plus also as our role as an external evaluator to the Tarrant County United Way.

So we work together on a number of different initiatives. Some of them as I said are externally initiated. But to their credit many of them are internally initiated which I think is also a very telling of the organization that Sherry runs there in that they want to know not just to serve others but they are to please others that they want to know for themselves how they're doing. And that's I think that's a great attribute of how their organization is set up.

Today I just want to talk about one of the programs that we have worked with them on. And that is the Expanding the Vision grant which was provided by the national Meals on Wheels Association to Tarrant County.

And on Slide 2 please there's basic information there about the grant and the period and the funding source. It was basically through March 2013 through March of 2014.

Now I'm going to ask actually if we can now skip to my Slide Number 7.
Great.

Lauren Solkowski: Is this it?

Dr. Alan Stevens: Thank you. That's - Sherry has already given you a lot of background about organization so I'm going to skip forward to say specifically about this Vision grant.

It was a collaboration with key individuals in the area in Tarrant County including the Area Agency on Aging, the United Way of Tarrant County which is also the funder of another larger initiative called the Healthy Aging and Independent Living Initiative.

And we have one hospital system listed here. They actually worked with multiple hospitals throughout the county to identify their target audience.

Next slide, really key to the success of this project was Sherry and her staff early in the design phase of when they were writing their application is that they wrote the application in a way that set both output and outcome goals.

And so and output they were referring to the sheer process of delivering nutritional services. So here they set a goal of providing 1800 meals to a minimum of 120 recently discharged patients.

And so some key information here, not only is the number that there's serving a certain number of meals but they identified the number of actual clients that they wanted to serve.

And this was based upon their rich history of knowing approximately how many meals they would be serving, approximately what was the need that somebody would experience.

And importantly because their organization and some larger initiatives within the county were interested in reducing 30 day preventable readmissions to the hospital they targeted individuals who were recently discharged from a hospital or had had an emergency department visit but not hospital hospitalized.

So targeting here is the message that I think you should take from this is that there will always be probably a larger need than any organization can provide.

But what Sherry has shown here is the ability to identify a target population that is of high need and then develop a strategy to beat those I need individuals.

Next slide. The second part of their grant development was the setting a specific outcome goals.

So not only did they want to deliver 1800 meals to 120 people who were high need because of their recent healthcare utilization they wanted to track the impact of the meals on some health indicators for that group of individuals.

So they set goals in both what we would call health outcome utilization which would be how many people would be readmitted to the hospital during the time that they were during the next six months.

And what would - how would the clients look based upon the evaluation of their basically comorbid conditions or their chronic diseases that they were managing based on the emergent care assessment score at the end of the meals program?

They also were interested in making sure that their services of the organization were coordinated in ways that made sense given the target population.

So again the target population is not only those who are homebound and need meals but have recently had a hospitalization or an emergency room encounter.

They have another program called Home Meds which helps people they - in which someone works with the client to review their medications, they're analyzed including on a evidence based software platform and then alerts or what would be thought as threats that to the person's health based upon the medications that they were taking were then addressed by a pharmacist or a pharmacist technician as any kind of medical alert would be addressed within 30 days meaning addressed meaning feedback given to the individual of what the alert was and then some assistance in working through how to remediate

that alert or to basically remove that contraindication of their medications as they were taking them.

So that I start with as all that was done before the grant was even submitted and I think that's really an important part of this story of Meals on Wheels of Tarrant County is thinking through what did they want to achieve when they rolled out a new program?

Next slide, so this is what they did achieve. They met their goals of providing the number of meals that were expected within their funding period. And they met their goals for the number of people they actually served.

So again their use of their data, their historical data I think led to their ability to estimate goals and output goals here that were not only fundable that they received a grant but they were actually feasible because they achieve them.

Next slide, the degree of specificity in their data collection allowed us to then take the clients that they served and the data on the meals and break it out into what kind of meals were provided.

So this bar graph shows that the total number of meals and then the types of meals that were provided, noon meals as you might expect making up the majority, a number of breakfast meals as well.

Sherry mention the fact that at times there are situations in which it is difficult to reach someone's home because of ice storms or other kinds of natural situations that prevent people from delivering a hot meal.

There are these other alternatives which can be available from frozen meals to shelf stable meals that were also included but as the majority - or noon meals and breakfast meals are included in their 1800.

Next slide, the average number of meals was 131 per the 120 clients that were served. And importantly the length of the program is hundred - the average length of time that someone was receiving meals was 132 days.

That's a really key data point that we'll come back to and talk about at the end in terms of where are we going next with the use of their data and what are some interesting data points that we want to look at.

So remember that, that 132 days is the average length that people are on meals. And if for most of you this is not your first Webinar and you've heard a lot of people talk about health interventions and talk of about six month outcomes.

We'll look at this number again. We're less than six months of service delivery. But most of the time we hold people accountable for their six month follow-up assessment.

So they're not even providing meals the entire time. There's some lag here between the meals when the meals end and when six month data collection is occurring.

Next slide.

Lauren Solkowski: Just one quick question. This is Lauren. So you had referenced that the goal was 18,000 meals but your when you're speaking you're saying 1800.

Dr. Alan Stevens: Oh I'm sorry. I'm sorry, 18,000.

Lauren Solkowski: Okay, just wanted to just to clarify. Thank you though.

Dr. Alan Stevens: Thank you. Sorry Sherry. So demographic characteristics of the population, you're as you would expect there or an older population average age of 71 but a wide span here of age youngest patient being 42, 60% female, white 75%, Hispanic 6% and black African American 19%.

These numbers of race and ethnicity are generally reflective of the patient of the entire population of Tarrant County.

Next slide, as you recall that we were having the - one of the real assets of this program was targeting individuals who had recent health care encounters.

So here we show you the number of clients who were served. And 105 of them had at least one hospitalization and 20 of them had had an ER visit at the intake of the program. That means the - at the beginning of being signed up for the meals program.

Next slide, so they're reaching their target population is the point of that slide. Sherry and her colleagues set a goal of say of the - based upon hospital readmissions.

And this goal was based on the sum of their data that they had from other projects and from their meals programs that they had been collecting for a number of years.

Some of it was based upon data that they had gotten with working with other community organizations that look at health care utilization data.

So they set a target of 50% of the clients which were 60 serve would not have another hospitalization during their project period. So for six months from the point of meal service to six months later that 50% wide not have a hospitalization during that period of time.

As you can see on this slide they more than achieved this goal with only 24% or 22 of the total number of people served had a hospitalization within three months and 19% had a hospitalization at six months.

So again this is a significant finding in that they set a goal and they achieve that goal. We're working now with some other data, other individuals looking at data collection that are collecting overall health care utilization data.

And we are now going to be able to go back and look at this data from actual hospital claims data. This is self-report data.

Self-report data has been proven to be very reliable. But we also now are working to go back and confirm it against actual hospital claims data.

Next slide, again a return to an ER or use of an ER was also a target. And again they weigh more than achieved their outcome there. Their target goal of 50% or more would not experience these events.

As you can see almost both three months and six about 10% of those that we collected data on at those two time points had experienced an ER visit so very - a very low number, lower than you would expect for a homebound population, multiple chronic diseases and individuals who had been previously hospitalized or had an ER visit prior to receiving meals.

Next slide, they also the emergent care assessment is an evidence-based tool that again summarizes the number of chronic illnesses that an individual have has and the number of risk factors that they have that might lead to a hospitalization.

So their goal here are the hypothesis was the providing meals and home med services to an individual would help them improve their overall management, the management of their overall health and would lead to an improvement on emergent care assessments at six months. And that indeed was achieved as well.

Next slide, as I said earlier some not all of the patients also - patients, the clients also received a home med's intervention. And so this is the intervention which all of the person all of the client's medications were entered into an evidence-based platform.

Alerts were generated and then any alerts were consulted with a pharmacist or pharmacist tech and then reconciled with the patient.

Ninety-three of the clients enrolled in the home med program. So that's, you know, a big majority of those who are in the meals program also got home meds.

51% or 55% of them had a medication alert and the mean was 2. So that's 50% of the people we worked with who were getting meals because Sherry's ability to integrate programs. Also these folks we were able to identify medication alerts that we thought needed to be investigated.

Now the severity of those alerts do vary. Some of them are minor, others are very significant. But I think the point here is that when we're servicing a

client, a homebound person who has a need for meals these data suggest that that same patient population also can benefit from having the additional services of the home meds program.

Next slide, so here just to summarize very quickly they - the program in particular this unique program of Meals on Wheels - excuse me my slide - my screen just went blank okay, were successful in the way they developed their project to target a population, to target outcomes, to target outputs and they achieved all of - all three of those aims.

And as this slide shows I think really of importance to this project is that they targeted a high risk group, people who had recently been admitted to a hospital or had an ED experience.

And I think we are learning a lot from working with organizations that are able to target individuals who not only have a need but have a need at a high risk point or a high risk transition in their overall health course.

Next slide, and again just to summarize I think the meals program plus the home meds program adds value in terms of the amount of resources that the organization is dedicating to the individuals they serve.

Adding some of these programs together combining programs where it makes sense does seem to leverage that investment into some meaningful health outcomes.

Next slide, we are we've used the, as I said what we basically are presenting today are the utilization data and the self-report data that were collected by Sherry and her staff at Meals on Wheels.

We're now building and have actually built already a collaboration with something called the DFW Hospital Council Foundation which is a repository for health care utilization data in the Dallas-Fort Worth area.

And our partnership with them will give us access to the actual utilization data or the claims data filed from hospitals. It will be inpatient data but includes ER data from the hospitals in their county.

The DFW Hospital Council Foundation is remarkable in that they capture approximately 95% of all health care utilization in the Metroplex or DFW area. So it's a very, very rich powerful repository of data.

Most communities don't have such a thing but it's a unique aspect of the Dallas-Fort Worth area that we're leveraging in our partnership.

The partnership to investigate this will be us, the Hospital Council Foundation and Meals on Wheels. The question always here is how do you get around patient privacy or client privacy issues?

And we're able to work that out by using de-identified data by creating personal identifiers. So basically think of Meals on Wheels who is the owner of the data and who's - have clients that they're responsible for.

They control access to all personal identifiers but as playing kind of the middleman between us and the hospital foundation we're able to get claims data, match it to the meals data that Meals on Wheels has and never jeopardize a person's personal information or personal identifiers.

And we're using a health economist to help us in with this data too because we can take data like that Healthy Days, the CDC's Healthy Days and it can

be converted into a metric that will allow health economists to do return on investment or savings from the actual intervention.

Next slide, and I think that's all for me so I think we have maybe a minute for a few questions?

Lauren Solkowski: Yes. And thank you so much Dr. Stevens for your presentation and to Sherry.

Before we go to the next presentation we wanted to do Q&A. So operator if you could please provide instructions for asking a question via the audio line that would be great.

Coordinator: Thank you. We will now begin the question and answer session. If you would like to ask a question please press Star 1, make sure your phone is unmuted and you must record your first and last name slowly and clearly to introduce your question.

To withdraw that request you may press Star 2. Once again for a question or a comment please press Star 1 and record your name, one moment while we stand by for questions or comments.

Lauren Solkowski: Great thank you. And so while we wait for some questions to come in we do - we did have a question comment to chat. And Sherry I think this would be directed towards you.

So the question is can you run a report for all meals delivered in a period of time to all people with a specific disease or meals for people over a certain age or income?

Sherry Simon: Absolutely. If it's a data field then we can do it. So we collect diagnosis information. So if we wanted to just know how many clients have congestive heart failure I can do that, that we serve.

If I wanted to know how many clients have diabetes and also get our no concentrated sweets diet that we offer I can do that. So wherever we collect data we can generate a report.

Lauren Solkowski: Excellent, thank you. Okay I'm just running through the list here. I don't see any more questions via chat. Are there questions that have come in via the phone?

Coordinator: Yes we do have a question from the phones. Our first question comes from (Mary Kayshack). Your line is open.

(Mary Kayshack): Hi. My question I guess has to do with the outcomes they were really, really impressive and it was great to see outcomes and outputs presented.

I was just wondering if any of the clients that were involved were also involved in any other interventions for, you know, care transitions or hospital re-admissions?

And if you guys looked at all if there was any difference between the clients that received the meals and the home meds or perhaps or the combination or one of the interventions individually to see if there was any difference in like the combined approach working best to reduce hospital readmissions?

And then one last question is what you kind of already went through but just if you even if not on the Webinar but could share examples of some of the other pre and post data that you collect to help maybe inform others on examples of

data that they should be or could be collecting to help get at some of this think that would be really helpful?

Dr. Alan Stevens: Okay. Sherry you want me to take a start and you can follow up?

Sherry Simon: Sure.

Dr. Alan Stevens: Your first question is a good one and one that Sherry and I debated at the very beginning of this project.

The short answer to your question is no we haven't done that kind of deep dive into the data to split people up and look at total dose of support they're getting from Meals on Wheels. We just selected these two for now because this was our initial interest based upon the project aims.

The deeper part of this question is that to answer your question the most cleanly from a scientific standpoint yes we should have said let's - this group of people make sure that we control their dose of support and we're only going to allow them to roll in this project or this project.

That's how we would do it in a more in a randomized clinical trial.

Sherry and I decided differently. We decided to say, you know, this is a community driven proposed project and let's just go with it. Let's just serve people as you normally would Sherry is what I - is what we ended up saying and let us figure it out in the end.

So that deeper dive of figuring out the dose that people get is an important one. We just haven't gotten to, completely to it yet.

I suspect that well I can guarantee what we have done is made sure that we have included the individual most likely to overlap with meals and that is home meds.

We'll have to do a deeper dive to look at the other programs especially a nutrition counseling program.

And your second question is I think, you know, that the outcomes that you choose should be really carefully thought about in terms of what's meaningful to your organization, to your community, to your stakeholders in general.

What we have found to be important to the stakeholders in Tarrant County is a - some measure of quality of life. We've used different ones EQ5D and now we're using CDC healthy days.

Some measure of health com utilization, a self-report of health com utilization. And we're using the measures as Sherry said that really allow us to track number of hospitalizations, number of days and number of ER visits in the past six months.

And then generally I always say to an organization pick an indicator that really you used to know that you're doing a good job.

You know, so I think it's important to not always be driven by what other people tell you but have some introspection to say I'll know we're serving people right when.

And whatever that when is let's whatever that is let's objectify it and come up with a measure for it.

So in another one of Sherry's programs it's goal attainment that they are working, they know they've done a good job when X percent of their clients report that they have achieved their health goal. That's a really important indicator for one of their programs.

So again those are the where there. There's just some of the top thoughts that I would have let go for some standard measures. But don't be totally driven by outside sources. Look internally at what's important to your organization and stakeholders and make sure you cover that as well.

Sherry Simon: And if I can just add in I think it's important to realize that what we're doing here at Meals on Wheels this is not - we're not - our purpose is not research. Our purpose is to serve the clients the best way we can to make sure that they're able to stay in their home as long as possible.

And that is something, you know, when we first talked with Alan that is something I kind of, you know, he's always educating me but I think that's the one point I educated him on that it wasn't ethical to say this group we're going to give these interventions to and this group we're not.

We can't do that in a community setting right. That's we want to provide the best care, service possible to our clients so that we can help them maintain their health in their home as long as possible.

And the other point I wanted to make is that Alan and I have had many conversations and one of the reasons why we are moving forward with our collaboration relationship with the Dallas-Fort Worth Hospital Council Foundation is because we want to get to the point where we're looking at each layer of our services and how that impacts hospitalization.

So this we're - that's where we're moving towards. We're going to look exactly at what does a meal provide, what does the dietitian in-home intervention provide, what does the home meds provide in regards to hospital and ED utilization?

That's where we're moving towards and that's our goal right Alan?

Dr. Alan Stevens: That's right.

Lauren Solkowski: Great. Thank you both so much. So I think with that we'll - we're going to move on to our next presenter. And I know there was a couple more questions that came in. We'll get - come back to those after Dr. Thomas's presentation so we'll turn it over to her.

Dr. Kali Thomas: All right thank you. I wanted to thank ACL and the National Resource Center for the invitation to present some work I've been doing looking at the role of home delivered meals and low care residence in nursing homes.

Next slide, please. So just to give you to see what's on the menu for the next few minutes I'll describe briefly this population of low care residence that as a health services researcher interested in home and community-based services and quality of care is a really important population of study and interest of mine.

I'll present some findings from the initial study that was conducted to look at the relationship between spending on home delivered meals programs and this population of residents in nursing homes.

I'll then present some information about the financial impact on states that we found through increasing home delivered meals and thereby reducing the

number of low care residence in nursing homes and provide some suggestions on how you can utilize this information and how these national estimates that we're calculating can be used more at a local level and then give you a little bit of a teaser about some current work and future directions that we're undertaking.

Great, so since the Olmstead decision in 1999 there has been an increase in home and community-based services to serve individuals with disabilities in their home and communities where they prefer to be.

And with this increase in the numbers of individuals utilizing HCBS we've also seen an increase in the acuity of nursing home residents as many of these individuals who may not necessarily need that nursing home level of care transition to HCBS.

But despite these increases in programs there's still an alarming proportion of nursing home residents in the US that have low care needs.

And this is a population that's so important to focus on and in fact is included as a measure of the quality of this - of states long term care systems. It's included on the AARP and Scan Foundation Quality report card and is a good measure of long-term care quality.

Next slide, please. So who are these low care residents? We use the minimum data set which is the federal resident assessment information from nursing homes.

And we identify these folks as individuals who do not require any assistance in the four late loss ADLs. So this is bed mobility, toileting, transferring or

eating and also if they do not fall into the lowest functioning rugs categories which are clinically complex or if they require special rehab.

And so with these definitions we assume that these individuals have these functional and clinical capacity to be cared for in a less restrictive setting like their homes.

Next please. So in terms of how big this issue is there has been a decrease in the upper portion of nursing home residents that were classified as low care over the decade of the 2000s.

However there in 2009 there was still about 13% of nursing home residents that were identified as low care.

Next slide, please. So previous research has examined why they're there. We've found in previous work that Medicaid long-term care spending is related to a smaller proportion of low care residents.

More assisted living - more assisted living facilities were related to fewer low care residents, more nursing home competition.

But what was really missing from this literature was an examination of other HCBS programs like the Older Americans Act Services to low care residence.

Next please. Next slide, great. So the objective of the first study was to see if the we hypothesize that higher per capita state expenditures on older Americans Act Title III services would be associated with a lower percentage of nursing home residents with low care needs.

Next slide, please. And we used data from ACL's aged database which includes information from all of the state program reports that are submitted, census data, AOA survey data. And specifically we use the older Americans Act expenditures for the following programs listed here and we adjusted those per older adult age 65 and older in the state.

Next slide, please. And we merged those data with a information that we've compiled here at Brown University LPC focus.org which is a publicly available data set and includes information on nursing home characteristics, long term care market characteristics as well as the number of state policy variables that are related to the long term care system.

Next slide, please. And we found that out of all the programs we looked at including Medicaid home and community based services increased spending in home delivered meals was the only statistically significantly associate program associated with decreases in the proportion of low care residents in nursing homes. And that finding was published in Health Services Research in 2012.

And so to put these results in context we found that for every \$25 that states spent on their home delivered meals program per year was associated with a decrease in the low care nursing home population of 1 percentage point.

So in the paper we provide you the example that a state like Washington that spent approximately \$8.10 per older adult aged 65 and older would have had a low care population of around 17%.

But a state like Wyoming which spent the most on this program would've had a low care population of about 13.8%.

Next slide, please. So we wanted to do a follow-up analysis that would provide sort of a roadmap and guideline for states to understand the relationship between not just spending on the programs but the actual program capacity and how many older adults were served in the state with home delivered meals and the relationship to locate a residence.

And from this from these models we were able to calculate the potential savings that states would recognize by increasing their proportions of older adults served by these programs.

Next slide, please. And in that paper we found that every 1 percent increase in the proportion of older adults served was associated with a .2% decrease in the proportion of low care residents.

And our data using Medicare claims and enrollment records we were able to identify that the majority of low care residents are duly eligible meaning that Medicaid fits the bill for the majority of these folks.

So we were able to then calculate if a state were to increase their capacity for providing these services what their potential savings would be by decreasing the proportion of low care residents and not therefore paying for their care.

And we found that if states were - that if states were to employee just an across the board 1% increase that 26 states would have recognized savings in 2009 based on these estimates.

And those were primarily states with a high proportion of low care residents, high Medicaid per diem and a low population of older adults in the state.

And the remaining 22 states presented here might not see immediate increases. But because our estimates were very conservative we hypothesize that in the future it could be possible for them to also recognize savings. And these findings are presented in health affairs and you can read more about those discussions and limitations.

Next please. So in conclusion from those national studies we found that decreases in low care nursing home residents in the US coincide with increased HCBS spending over the past decade.

However increased spending on home delivered meals was and the increased prevalence of older adults who received these meals are related to decreasing proportions of low care residence.

So up and above these temporal trends we've seen over time the home delivered meals program is related to a decrease in low care nursing home residents.

And we would believe this to be true because as I'm sure all of you know on the call that home delivered meals services provide more than just food to vulnerable older adults.

We as drivers and volunteers are often the safety check. We're the eyes and the ears, we're in the home, we report changing needs. And these services in addition to just food may be key to allowing older adults to remain independent and in their homes.

Next slide, please. So with all this information it's important to me as a researcher to make sure that these estimates and these models and these

numbers and figures can actually be utilized by providers and practitioners and people in the field.

So I hope that these papers and these findings are - can be used in legislative testimony. We've had people include them in letters to elected officials.

They've used these arguments and these findings in grant writings. And I like to encourage all of you to visit ltcfocus.org. There you can find local low care figures and population characteristics for your area. And you can also go to aged for the state program report data.

They have the National Survey of Older Americans Act participants and census data so you can calculate the, for example the proportion of individuals with an independent living disability and the proportion of those who receive home delivered meals in your area.

So there's all types of ways you can use these data to make the argument and the business case that home delivered meals really matter.

Next slide, please. But in addition to just sort of the funding and the cost savings we're also interested in the quality of life differences in the improvements and isolation.

So we current - I'm currently involved in a project funded by AARP Foundation to Meals on Wheels Association of America.

And we have eight programs across the US. We've surveyed 620 older adults who were on waiting list for programs.

We provided hot meals to 200, frozen meals to about 200. And we employed a pre and post survey 15 week survey for these individuals and were evaluating not only the effectiveness of home delivered meals but also the home delivered meals modality so whether hot meals or frozen meals improve quality of life, social isolation, healthcare utilization after 15 weeks of service.

So that research is currently underway and we hope to have exciting results for everyone soon so next slide, please.

So I would like you all to stay tuned. There is more to come and feel free to contact me and follow-up with any questions we might not have time for in the little remaining time we have left.

Lauren Solkowski: Great. Thank you so much Dr. Thomas. Okay. So since we do have a few more minutes operator if we could open it up again for question and answer if you could please provide instructions for asking a question on via the audio line.

Coordinator: Thank you. And we'll have another question and answer session. And if you would like to ask a question it's Star 1. Make sure your phone is unmuted and record your name slowly and clearly.

Your name is required to introduce your question. And to withdraw that request you may press Star 2. Once again for a question or a comment press Star 1 and record your name at this time. One moment while we stand by for questions or comments.

Lauren Solkowski: Great, thanks. We do have a question showing in chat but this might have been from the previous presentation. It's asking if you could explain a bit

more about the PAM coaching what kinds of training is involved, what tools are used, et cetera.

Sherry Simon: Okay. I guess that's a question for me Sherry. The PAM model is the Patient Activation Measure and is a questionnaire developed by the people out of the University of Oregon.

There's many health care facilities and insurance companies that use that and it's basically a measure to see someone's activation in their healthcare.

And then based on the finding of that questionnaire people, coaches can then determine what are the needs of the clients. They can - there's certain scripts so if they have nutritional issues, there's some coaching done with the nutritional issues -- that kind of thing.

The way we do it here at Meals on Wheels is that our case managers are basically the gatekeepers and they let us know when someone is very overwhelmed with their healthcare. And then we send in a community health navigator.

The community health navigator here at Meals on Wheels basically have come from our volunteer base. We advertise the position. We trained those volunteers on how to be community health navigators. We train them on the PAM program. We talk about boundaries so we do our own in-house training.

I have a dietitian who is in charge of this program and is basically the supervisor over all the community health navigators.

We have about 15 community health navigators. We've divided them up in by territory of Tarrant County. I have one that is Spanish-speaking I also have one that is Vietnamese speaking so obviously they take those clients.

And they basically work with the clients in teaching them how to fish instead of giving them the fish. So they are teaching them how to make those phone calls, how they can access other resources -- those kinds of things and then utilize that the PAM model and questionnaire.

And actually we here at Meals on Wheels we are told by the developers of the PAM program that we have the best results of any other organization using the PAM questionnaire in the world because it's used in Europe as well.

So we have the best pre-and post-data results. So we're very excited about that.

Lauren Solkowski: Great, thank you, Sherry. And I think we have time for one more question. Are there any questions that have come in via the phone?

Coordinator: I'm currently showing no questions or comments at this time.

Lauren Solkowski: Okay. Well since we are at the very end of our session I just wanted to thank all of our speakers again for your presentations. And thank you to all of our presenters for your questions.

Again if you do think of any additional questions after the Webinar please feel free to email them to me at lauren.solkowski@acl.hhs.gov. Again my email address is listed here on the chat box. And I can and I'm happy to forward those to our presenters.

And so with that we will conclude our Webinar and thank you for joining us.

Coordinator: That concludes today's conference call. Thank you for your participation. You may disconnect at this time.

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