MALNUTRITION QUALITY IMPROVEMENT INITIATIVE

Welcome to Today's Expert Webinar for the 2018 MQii Learning Collaborative:

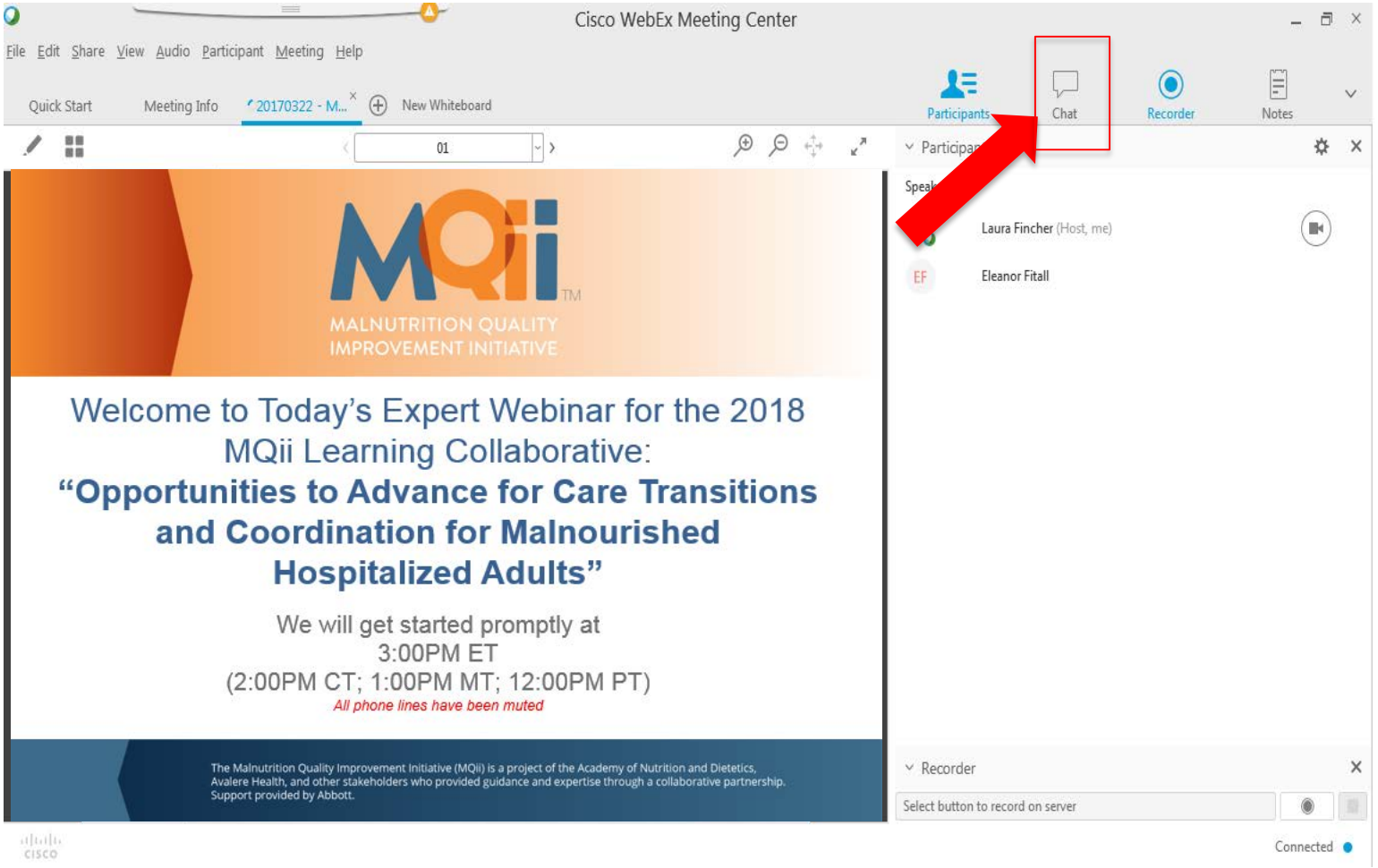
"Opportunities to Advance Care Transitions and Coordination for Malnourished Hospitalized Adults"

We will get started promptly at
3:00PM ET
(2:00PM CT; 1:00PM MT; 12:00PM PT)

All phone lines have been muted

The Malnutrition Quality Improvement Initiative (MQii) is a project of the Academy of Nutrition and Dietetics, Avalere Health, and other stakeholders who provided guidance and expertise through a collaborative partnership. Support provided by Abbott.

Before We Get Started…



Today's Agenda

Agenda Item	Presenter
Welcome and Introduction	Kelsey Jones, MPA
Addressing Malnutrition by Connecting the Dots in Transitions of Care: From Hospital Bedside to Where One Calls Home	Josefina Carbonell and Dalila Suazo, RDN, LDN, CDE
Embrace & Integrate: Multi-disciplinary Approach to Care Transition Planning	Rya Clark, RD, LD, CNSC
Questions – 15 mins	

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Addressing Malnutrition by Connecting the Dots in Transitions of Care:

From Hospital Bedside to Where One Calls Home

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- Communication and Handoffs from Hospital to Next-in-line Provider
- Patient Engagement and Counseling on the role of Nutrition in Recovery and Chronic Care Management
- Connecting the Dots: Opportunities to Connect Patients to Benefits and Services to Support their Nutrition Needs & Social Supports

Josefina Carbonell, Senior Vice President of Long Term Care & Nutrition, ILS
and President,
FLORIDA COMMUNITY CARE

Dalila Suazo, RDN, LDN, CDE
Sr. Director Nutrition Operations
INDEPENDENT LIVING SYSTEMS, LLC

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ILS' History & DNA Is Around Caring for Vulnerable Medicare Advantage, Medicaid, Duals and MLTSS Members

- Company founded in 2001
- 700+ Employees across 10 locations nationwide
- *ILS services 1 out every 4 Medicare Advantage members*
- Support 30+ clients
- 17+ Years of Care Management experience

- Serving the Nutritional Benefits to Health plan clients since 2005
- Proprietary eCare Care Management system serves as the engine behind our clinical expertise
- Florida Community Care - 1st Long Term Care PLUS PSN Health Plan in Florida's Medicaid Managed Care Program.

ILS Transitional Care 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[SM]) Program developed by Dr. Eric Coleman, University of Colorado.
- Care Transition program designed to coordinate and manage the transition of individuals from the Acute Inpatient setting to the Home & Community Setting.
  - PASS is *not* replacement for case management, discharge planning or home health.
  - PASS *is* patient advocacy, education, communication and coordination.

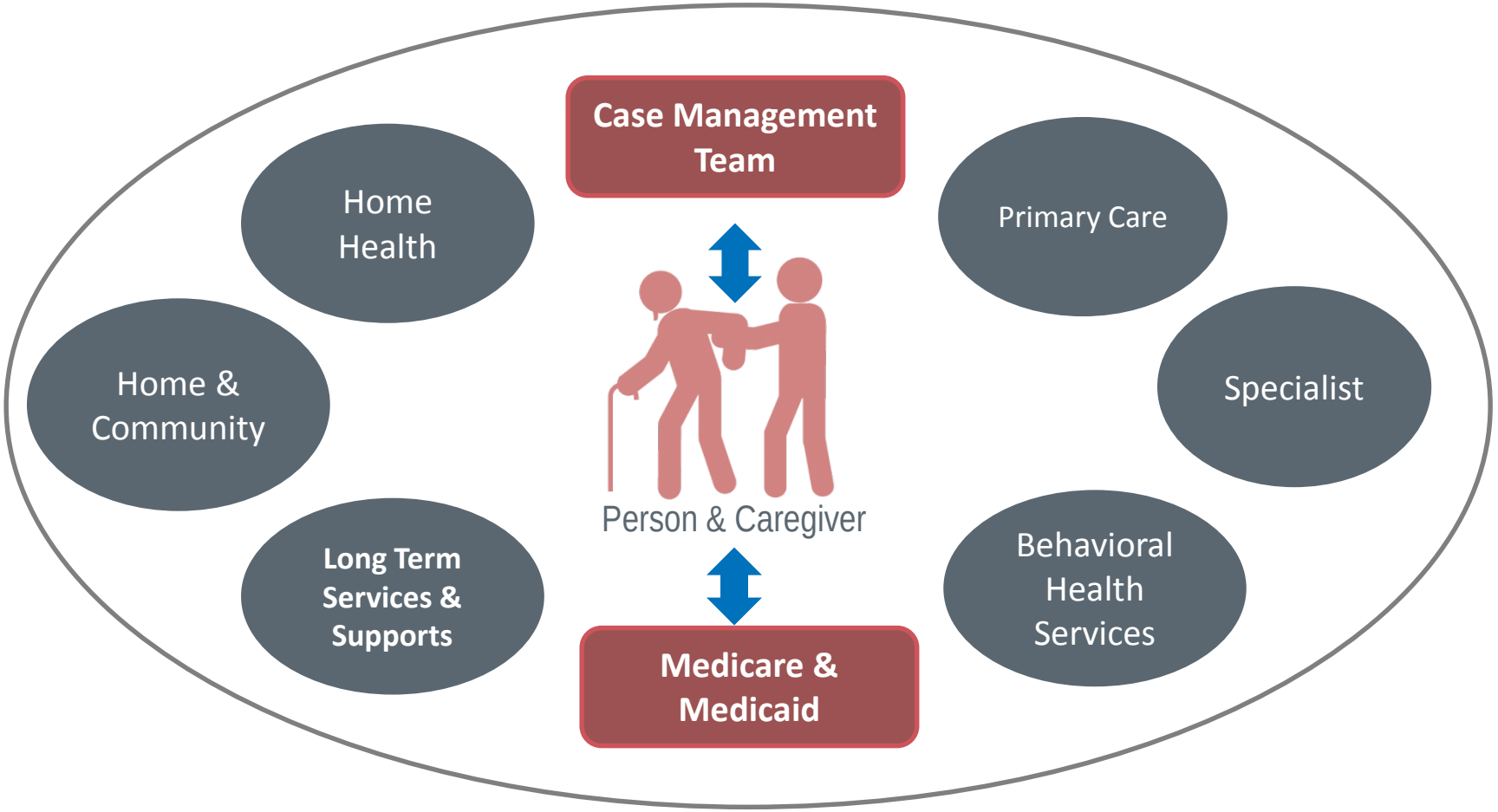
ILS TCS Operating Model

- 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

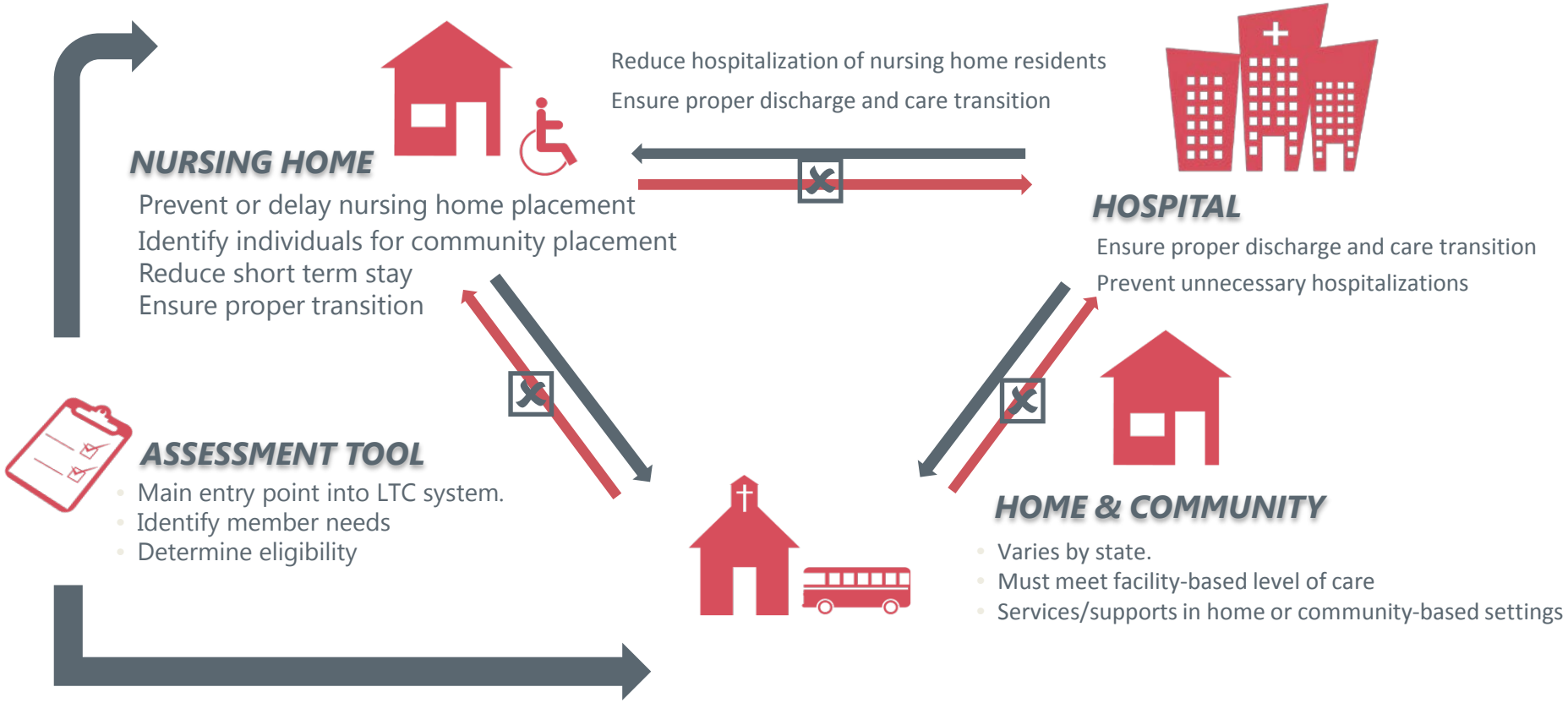
1. PASS Coaches are assigned by facility and visit that facility each day.

Person Centered Model



Wagner EH. Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness? Effective Clinical Practice. 1998;1(1):2–4.

Care Transitions



Program Options

	Standard Intervention	Modified Intervention	Complex Intervention
Hospital Visit(s)	✓	✓	✓
Face-To-Face Home Visit	✓		✓
Follow-up Calls	✓	✓	✓
Nutrition & Meals	✓	✓	✓
HCBS Coordination	✓	✓	✓
Medication Transition Program	✓	✓	✓
Tele-monitoring & Follow-up			✓

TCM Outcomes

Program began in June 2014 and concluded in April 2015

Locations (facilities):

- Initially 5 hospitals
- Expanded to 29 hospitals
  - 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***

* *Assuming each readmission is at an average cost of $10,409*

Independent Living Systems' Transitional Care Management results for a national Medicare Advantage Plan in Ohio. (2014-2015)

ILS Experience

National CMS Readmissions Project	Florida QIO: FMQAI Miami-Dade Community	Duals and MLTC
14 QIOs / 14 States 14 target communities • 70 Hospitals • 277 SNFs • 316 HHAs • 1.1M Medicare Beneficiaries	ILS subcontractor to provide Care Transition Intervention • 11 Hospitals • 45 SNFs • 12 HHA • 60,000 Medicare Beneficiaries	• Multistate • More than 50,000 Dual members • Several different models and service offerings • Component of Care Management continuum

ILS Outcomes Posted by CMS

2011	Coaching	Coaching Only N = 660	Coaching + Nutritional Support N = 234	Coaching + Community Support Services N = 28	p-value
	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)

2013	Coaching	Coaching + Nutritional Support N = 613
	30-Day Readmission Rate*	12.9%
	30-Day Mortality Rate	3.7%

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%

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

The Role of Nutrition in CCTP

"Poor nutrition, or malnutrition, leads to poorer health outcomes including slower healing rates, increased risk for medical and surgical complications, delayed recovery, increased length of stay, and increased readmission rates and mortality."

- Nutrition screening and intervention can improve outcomes

- Providing adequate nutrition care across healthcare sectors can improve care transitions, improve quality of care, decrease costs and help prevent avoidable readmissions

Sullivan DH. Risk of early hospital readmission in a select population of geriatric rehabilitation patients: The significance of nutritional status. J Am Geriatric Soc. 192;40:792-798

Major Nutritional Issues Impacting Home Health Clients

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

51% At Risk[4]

Condition	% of Home Care Patients
Malnutrition[1]	13-21%
*Loss of Lean Body Mass[2]	~25%
Wounds[3]	44%

**Statistic is from community-dwelling older adults*

1. Tackling Malnutrition: Oral nutritional supplements as an integrated part of patient and disease management in hospital and in the community. Medical Nutrition International Industry. July 2010.
2. Iannuzzi-Sucich M et al. J Gerontol A Biol Sci Med Sci 2002; 57: M772-M777.
3. Johnston P, et al. *Remington Report*, May 2008; 18-20.
4. Yang Y et al. J Am Med Dir Assoc 2011; 12: 287-294.

Post Discharge Meals & Chronic Meals for those w/Food Insecurity

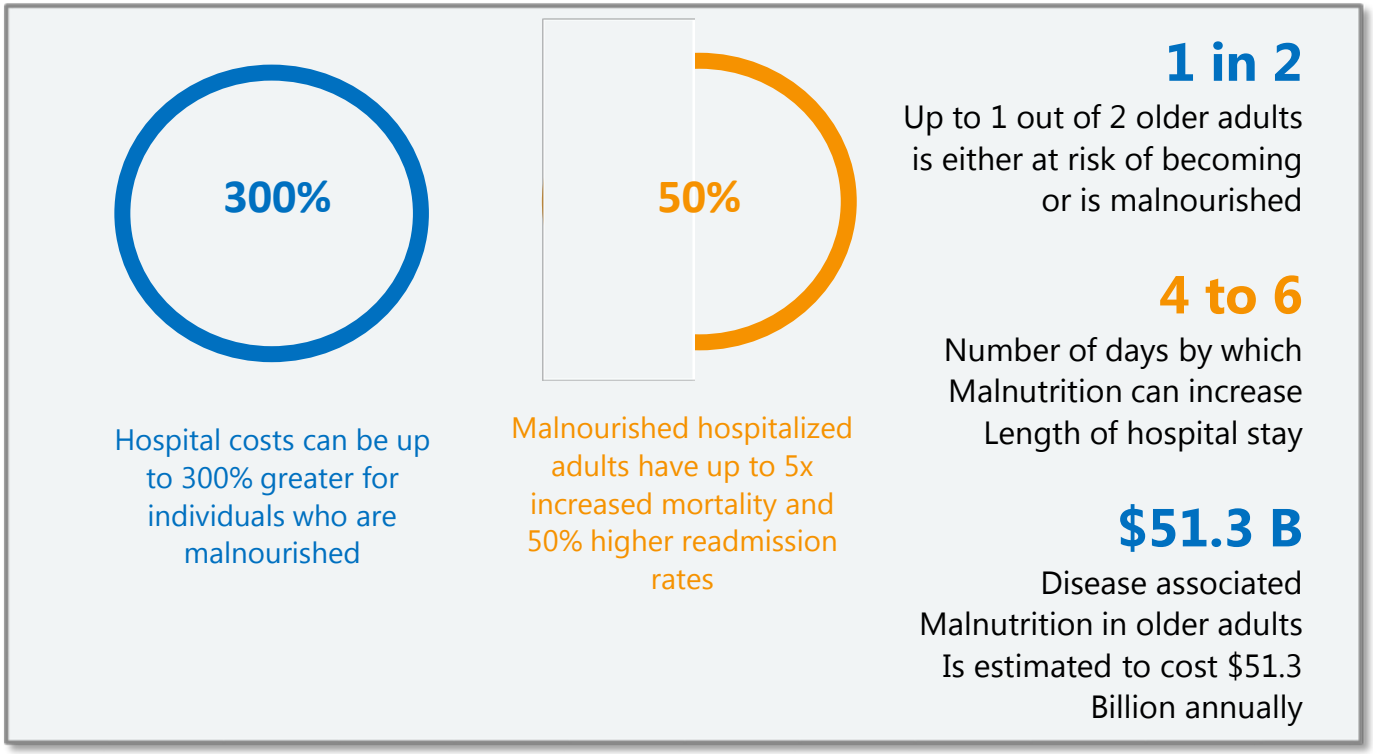
- Meals should meet the client/patients dietary needs
- Specialized meals are best such as:
  - Diabetic Meals
  - Renal Meals
  - Puree
  - Low/Fat Sodium
- Oral Supplements

ILS Experience in Managed Care

Program	Benefit Description	Recommendation/Plan Benefit is Offered to?	Rationale
Post Discharge	Episodic number of meals per discharge from a hospital or SNF; up to a maximum per year	MA, D-SNPs	The Journal of Primary Care & Community Health reports that subjects who receive home-delivered meals experience: • 55% reduction in overall health care costs • 50% reduction in readmission rates • 37% reduction in average lengths of stay
Support Meals	Short supply of meals per month for emergency episodes	Benefit is offered to members identified as food insecure	
Chronic Meals	Special Diet Meals as a Clinical Tool for diagnosed chronic condition; available once per year per condition	Members in C-SNPs and members with chronic conditions in the D-SNP and Medicare Advantage programs.	
Nutritional Counseling	A number of sessions per year	D-SNP programs nationally	After speaking with a Dietitian: • 62% made dietary changes • 57% felt better emotionally • 37% felt better physically • 64% felt in control of their condition

Meal and Nutrition Market Opportunity and Dynamics

- Addressing older adult malnutrition is a critical health and public safety issue
- With CMS' expanded interpretation of supplemental benefits, MA plans can now integrate quality malnutrition care in the form of a food insecurity benefit into existing Care Models



Source: National Blueprint: Achieving Quality Malnutrition Care for Older Adults developed by the Defeat Malnutrition Today Coalition, Avalere Health, and the Malnutrition Quality Collaborative with support provided by Abbott, 2018.

Supplemental Benefits

Current: CMS Guidance

- CMS currently defines a supplemental health care benefit in the Medicare Managed Care Manual (section 30.1) as an item or service
  - not covered by Original Medicare,
  - that is primarily health related, and
  - for which the MA plan must incur a non-zero direct medical cost.

- Derives from section 1852(a)(3) of the Act, which permits MA plans to offer only "supplemental health care benefits" in addition to the benefits covered by original Medicare. An item or service that meets all three conditions may be proposed as a supplemental benefit in an MA plan's bid and submitted plan benefit package.

Supplemental Benefits

2019 CMS Call Letter Guidance:

- ***Details of change:*** "Under the new definition, the agency will allow supplemental benefits if they compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable emergency room utilization
- CMS is expanding the scope of the primarily health related supplemental benefit standard. Section 1852(a)(3) permits the offering of "healthcare benefits" as supplemental benefits,
- "Primarily Health Related" means:
  - it must diagnose, prevent, or treat an illness or injury
  - compensate for physical impairments
  - act to ameliorate the functional/psychological impact of injuries or health conditions
  - reduce avoidable emergency and healthcare utilization.

Proposed Nutrition Related Opportunities

Benefit	Outcome
Meals upon Discharge	• Lower readmission rates • Increased member engagement • Brand loyalty (meals can be branded) • Increase medication adherence
Meals benefit for Chronic Conditions	• Improved STAR ratings • Monthly contact provide greater assurance of member compliance • Member retention
Nutrition Assessments and Counseling	• Improved health literacy and compliance • Detailed individualized nutrition plan

Connecting the dots

- Currently there are different Medicare Health Plans that are providing Post Discharge and Chronic Care Nutrition Management for high risk populations.

- Effective 2019 because of CMS Call Letter Guidance the Medicare Advantage plans will be adding additional wrap around services under the Supplemental Benefit Standards. That includes Health Related interventions under their Medicare Advantage (MA) and Special Needs Populations (SNP) in their Health Plan Markets.

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Embrace & Integrate: Multi-disciplinary Approach to Care Transition Planning

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Rya Clark RD LD CNSC
Clinical Nutrition Manager
TIRR Memorial Hermann

- Case Study: Patient-Centric Care Transition Map
- What's the difference between SNF, IRF, and LTACH?
- Discuss Action Item Steps in Multidisciplinary Discharge Care Planning

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Case Study: Unexpected Holiday in the Hospital

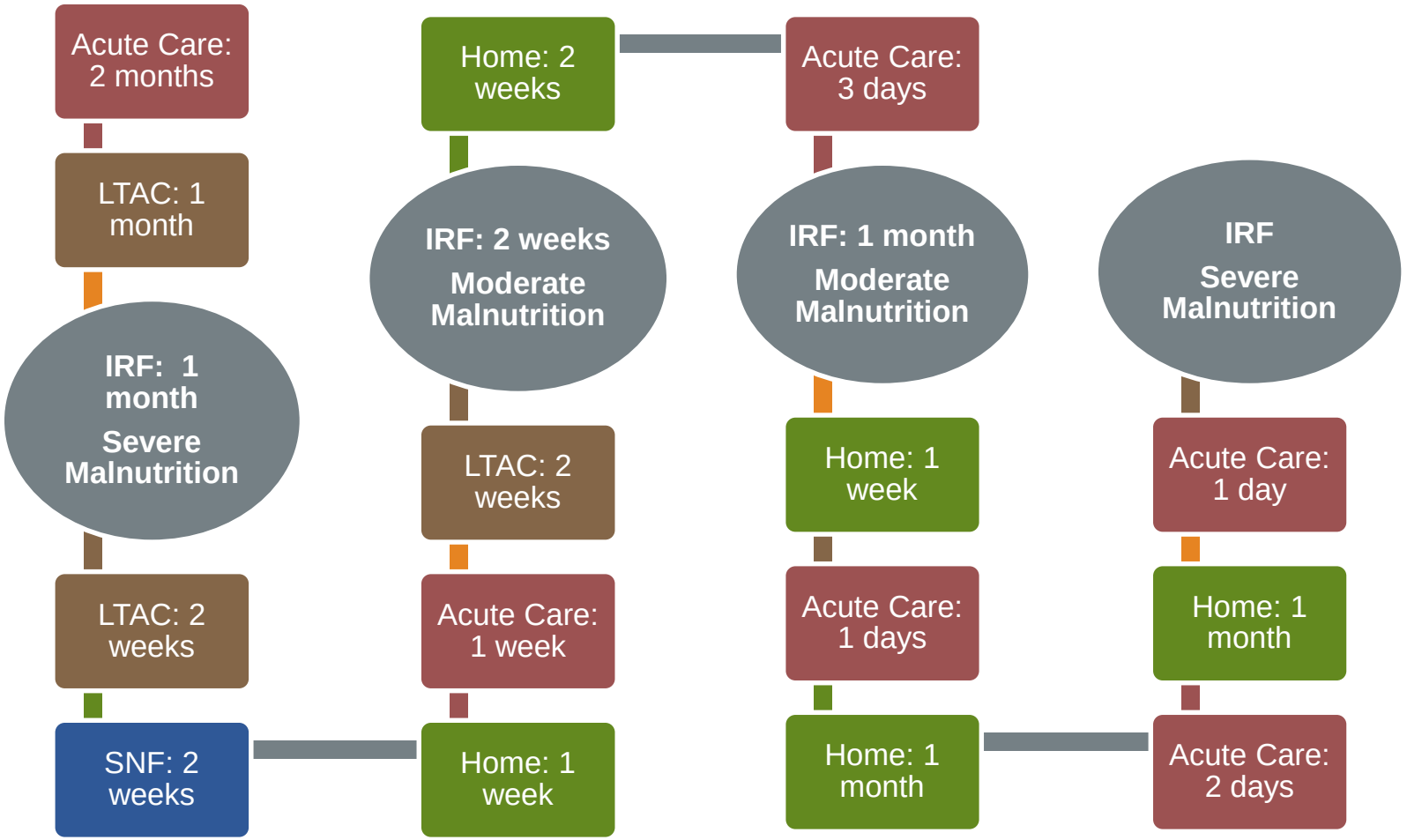
12/23/17 LC was admitted to Acute Care

- Intra-abdominal Sepsis
- Incarcerated Ileocolic Anastomosis with Perforation

7 surgeries over 3 weeks

- 3 Feet of Small Bowel Resected
- Open Abdominal Wound 35 X 20cm
- Large Entero-atmospheric Fistulas
- TPN-dependent

A Patient in Transition: 11 Months



Post-Acute Alphabet Soup

Long-Term Acute Care Hospital

- Typically directly discharged from the ICU and require a high level of care but no longer require ICU-level care or extensive interventions.

Inpatient Rehabilitation Facility

- Purpose is to restore function for patients that require a combination of hospital-level care and intensive rehabilitation.
- Some very specialized centers can accept direct ICU transfers.

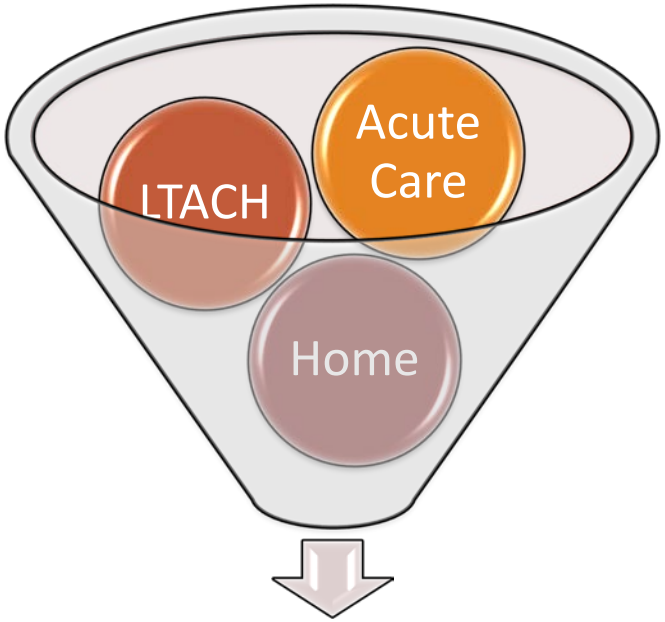
Skilled Nursing Facility

- Offers nursing and ancillary therapy services and able to provide 24 hour medical care.
- Typically short-term.

Long-Term Care Facility

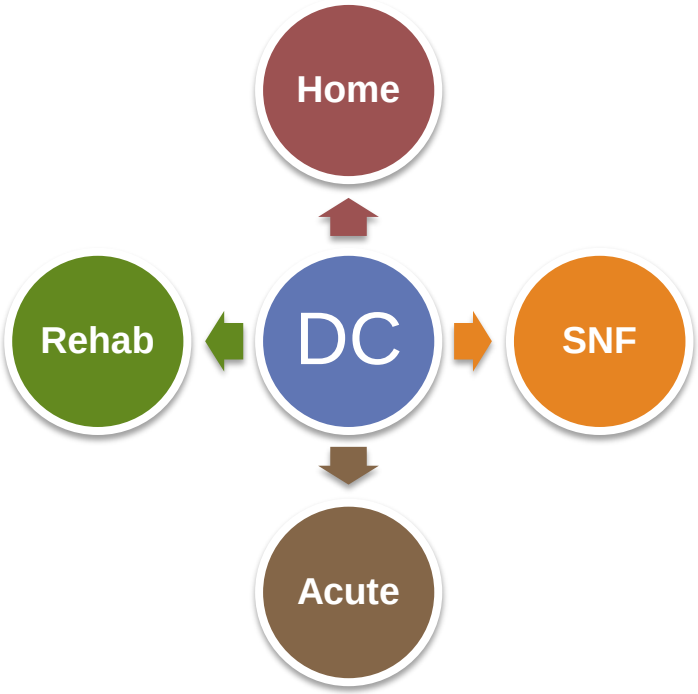
- Offers rehabilitative and ongoing skilled nursing/ancillary care for those requiring assistance in ADLs.

Action Item: *Map* Patient Flow

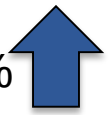


What Types of Settings Do Malnourished Patients Admit From?

What Types of Settings Do Malnourished Patients Discharge To?



TIRR Patient Flow

	PRE-INTERVENTION		POST-INTERVENTION	
	% DC to Community	CMG ALOS	% DC to Community	CMG ALOS
PATIENTS W/ MALNUTRITION DX (*17% of TIRR pts meet diagnostic criteria)	63.6%	21.5 Days	66.9% 	19.1
ALL PATIENTS	72.4%	20.7 Days	71.9% 	19.3

Malnutrition Prevalence
Acute Care 20-50%
Post-Acute Care 14-51%
Community 6-30%

Action Item: *Multi-Disciplinary* Discharge Rounds (MDDR)

Opportunity Identified

- TIRR serves the highest acuity rehab population in the country
- TIRR ranked a top 10 IRF by US News & World Report for 28 consecutive years
- Shifting healthcare landscapes meant a focus on effective care transition without compromising outcomes was imperative

MDDRs Were Born

- 2017: MDDRs Process was implemented with immediate results
- 2018: TIRR's MDDR Process was featured as leading best practice in rehabilitation by the American Hospital Association
- Enhancing Rehabilitation Care Structures and Processes From Leading Organizations

MDDR Objectives

» Identify barriers to patient progression

» Identify possible resource utilization issues

» Identify possible discharge needs

» Initiate interventions to prevent complications and delays in discharge

» Coordinate plan of care among disciplines

» Manage patient care for quality and utilization improvement opportunities

Action Item: *Identifying* Discharge Needs

Discharge Needs

- EN or Transitioning Off EN
- Poor appetite
- Grocery and Meal Assistance
- **Food Insecurity**

Resources

- Outpatient RD
  - Facility, Home, or Community
- Community-Based Organizations

Action Item: Build Relationships

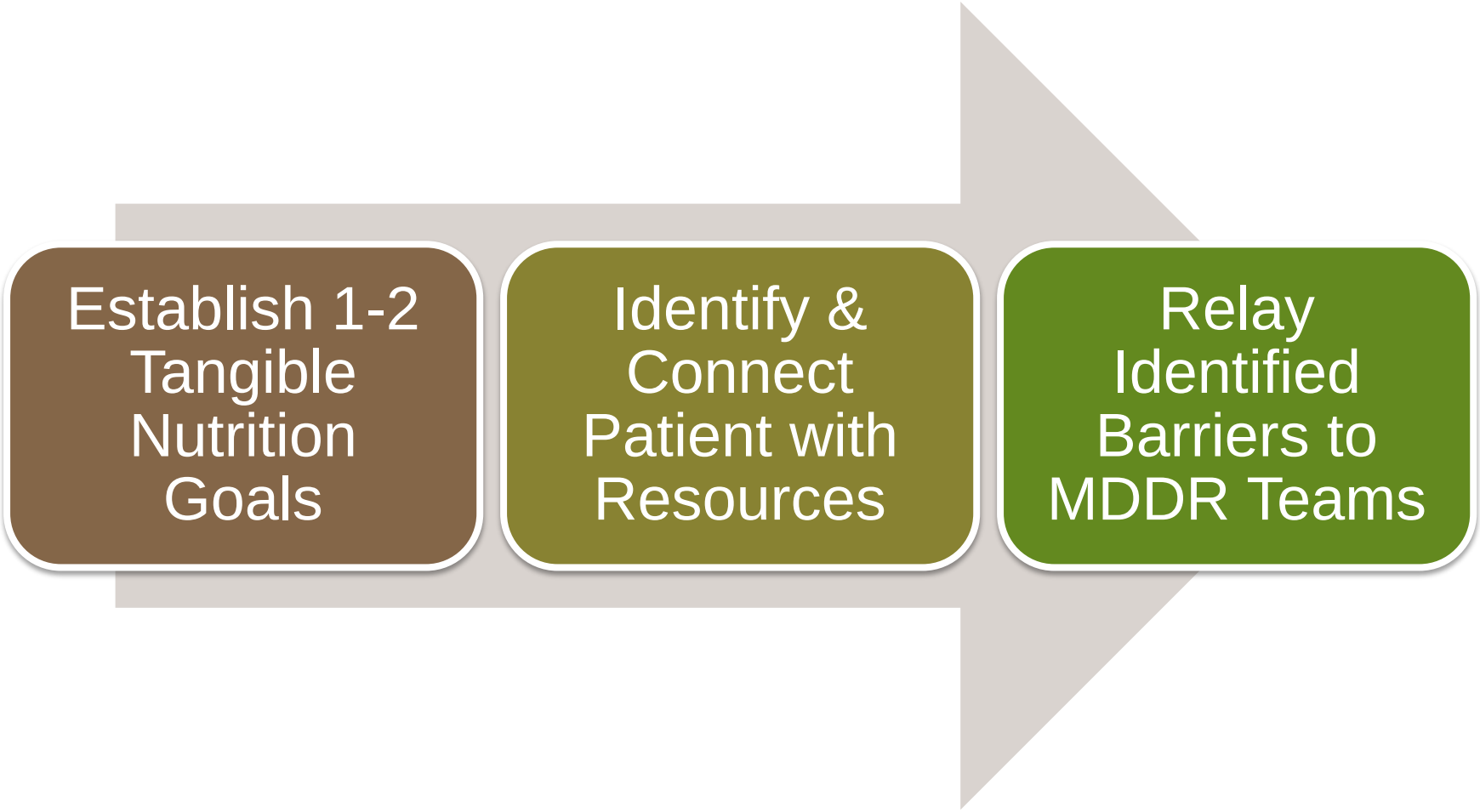
Phone Call & Introduction:

Home Health and DME Directors

Clinical Nutrition Council Advocated for Home Health RD

MH-HH Hired RD to Assess, Treat, & Monitor EN Patients

Action Item: *Patient & Caregiver* Education



Final Thoughts

Continue To Hardwire Malnutrition Through QI In Care Transition Planning

- **Map** Patient Admission & Discharge Flow
- **Align** With And/Or **Implement** A **Discharge Planning Infrastructure** At Your Facility
- Embrace **Multi-disciplinary** & Build Relationships
- Collaborate With Your **Patients**
- If It's Successful **Publish** It!

Additional Resources

- Ohio Malnutrition Prevention Commission: 1 Year Findings
- Dialogue Proceedings: Advancing Patient-Centered Malnutrition Care Transitions
  - Presented by Avalere, the Academy of Nutrition and Dietetics, and the Defeat Malnutrition Today coalition, supported by Abbott.
  - Summary Infographic of Dialogue Proceedings
- Keep an eye out for a great resource in Feb/Mar 2019:

  "Community-based resources for individuals and families experiencing food insecurity: Time for a coordinated nationwide registry".

  Target Journal: Mayo Clinic Proceedings

  First Author: Karolina Brook

  PI: Dr. Sadeq Quraishi

Questions?

15 mins