# MEALS ON WHEELS
## ANNUAL CONFERENCE & EXPO
2018

# DATA: MOW OPPORTUNITY & CAUTION

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# INCENTIVES AND POPULATION PRESSURES HAVE OPENED THE DOORS

- Payers, providers, researchers and policy makers are increasingly focused on how to better manage care in the undeniable near future of:
  - ✓ Unprecedented demographic shift
  - ✓ Increased population with complex and chronic conditions
  - ✓ Decreasing supply of clinicians and caregivers

- Recognizing health and wellbeing is a team effort

# RECOGNITION OF SDOH

## Payers & providers are eager to capture this data

Every additional unmet social need increases the likelihood **of fair or poor health** for older adults

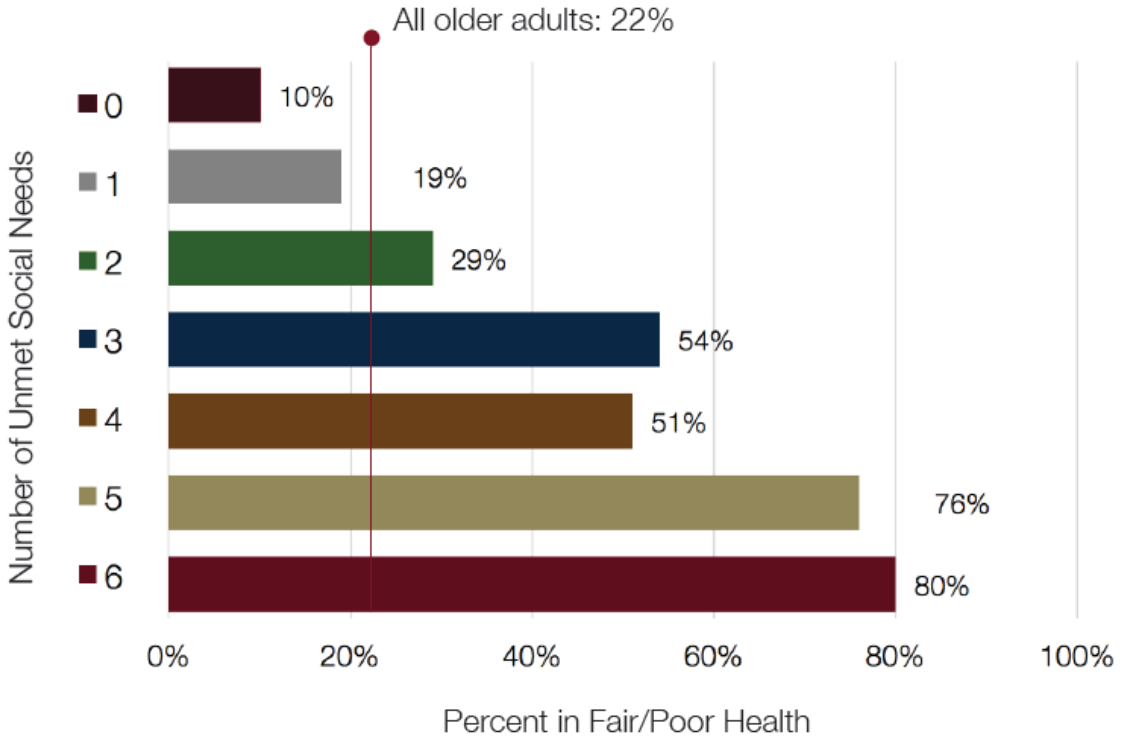



Exhibit 2. Fair/Poor Health Status among Older Adults by Number of Unmet Social Needs (n=1,590)

OLDER ADULTS AND UNMET SOCIAL NEEDS
PREVALENCE AND HEALTH IMPLICATIONS

# PROVIDER ORGANIZATION KEY MEASURES

## Improve the outcomes, improve the bottom line

1. Readmissions
2. Effectiveness of care
3. Patient experience
4. Timeliness of care

What are you seeing now that can help these measures improve?

# EVERY MEAL DELIVERY IS A DATA OPPORTUNITY

## Meal Delivery: eyes and ears of MOW

1. Visible weight loss or gain
2. Loss of appetite
3. Uneaten meals
4. Takes longer than usual to answer door
5. Less mobile than usual
6. Home looks unsafe
7. Dirtier and/or more cluttered than usual
8. Reported loss of friend, family or pet
9. Broken cane or walker
10. Confusion, speech changes

# A CAUTIONARY TALE ABOUT DATA

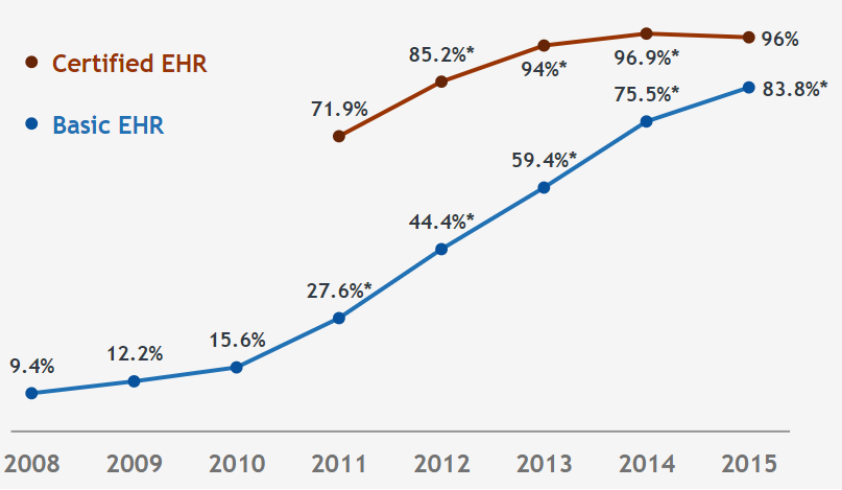
## Electronic Health Records

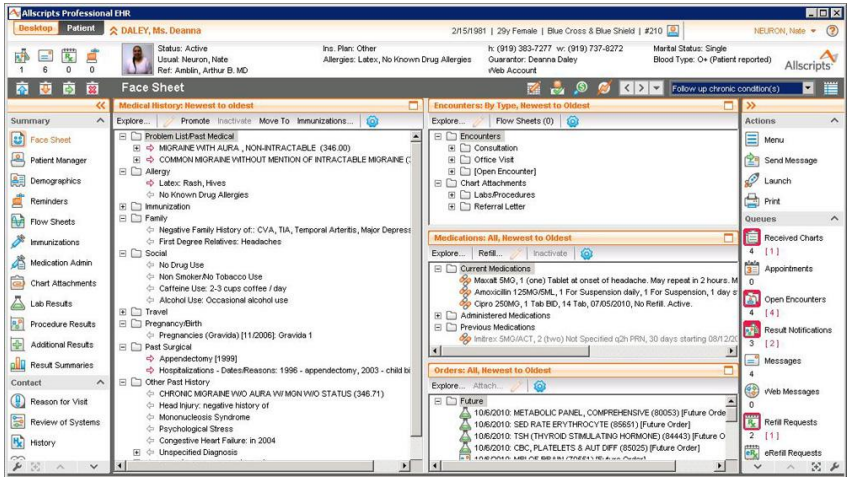
Around since the 1960s

The EMRs of today first appeared in 1972

Touted as:

1. More Productive
2. More Safe
3. Improving Outcomes

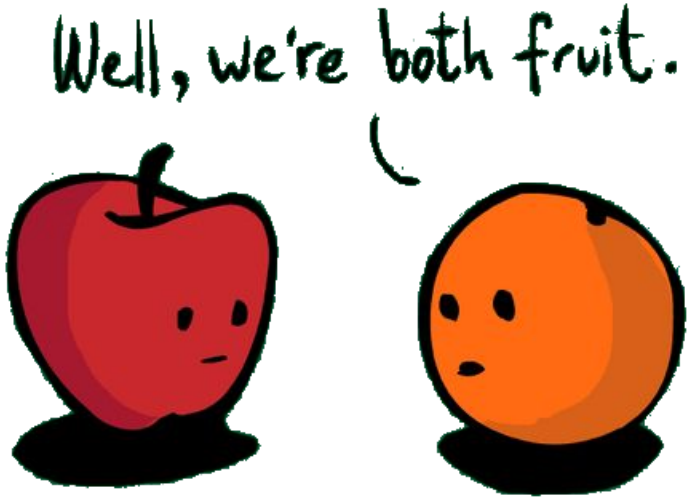


# DATA STANDARDS ARE CRITICAL

## Without standards, same data is captured differently

| Example: Date |
| --- |
| 08/29/2018 |
| 8/29/2018 |
| 8/29/18 |
| 08/29/18 |
| Tuesday, August 29, 2018 |
| 2018/08/29 |




**~80% of Data is unstructured and that's not the real problem, the real problem is that our structured data is inconsistently identified or defined.**

# BUILD CONSENSUS AROUND DATA AND PROCESSES

## Purposeful processes and actionable data

- What is the data you're going to collect?
  - ✓ **Why collect certain data?**
- Who is collecting the data?
- When is the data being collected?
- How is it being collected?

***The data has to be reportable**

# KEY CONSIDERATIONS FOR DATA COLLECTION AND SUSTAINABILITY

## People, processes and tools

1. Is the process repeatable?
   - Take into account that each program is different yet there are similarities that span across all programs
   - Can your program repeat the process over and over again or does it rely on an individual?

2. Is it scalable?
   - Can the processes be implemented in other MOW programs?

3. What tools must you have?
   - There are ideal tools and the tools you have or can realistically obtain, what combination of those are a must have?

4. What are the roles or skills needed?
   - Do you have these in house now, is there additional training needed?
   - Is it possible?

# MOW IDEALLY POSITIONED FOR SUCCESS

## Data Collection: History doesn't have to repeat itself

Learn from the Electronic Health Records data challenges:

1. Lack of Consensus
2. Resource Alignment
3. Process &Technology

## MOW: Success is an iterative process

1. Productivity impact
2. Culture change
3. Cost

# TRANSFORMATIVE OPPORTUNITY

## Data is your tool for changing the dynamic and impact

1. Payers
2. Providers
3. Reimbursement
4. Quality Measurement
5. Research
6. Policy
7. Recipient
8. Community
9. MOW Program
10. MOWA

# Thank you!!

**Michael Kurliand**

**mkurliand@westhealth.org**

# LEVERAGING DATA IN THE HOME DELIVERED MEALS LANDSCAPE

**GREG PROSSER**

*Chief Executive Officer*

Accessible Solutions, Inc.

# What Have We Learned?

# "DATA IS THE NEW GOLD"

# “*In God we trust. All others must bring data.*”

– W. Edwards Deming, statistician, professor, author, lecturer, and consultant.

# WHAT IS DRIVING THE NEED?

- Rising Costs
- Limited Funding
- Unprecedented Demand
- Increasing For-Profit Competition
- Patient Outcome Incentives
- Evidence Driven Decision Making

**Healthcare Expenses** = **17.9%** of GDP

**Almost $600 billion more than the expected benchmark**

***"The more we know, the more we can help."***

– Meals on Wheels America

# WHAT ARE THE CHALLENGES IN OUR INDUSTRY?

- What data should be collected?
- How should data be collected?
- How should data be integrated?
- How should data be shared?
- Privacy and HIPAA compliance

# What Data Should Be Collected?

# WHAT IS DATA IN THE HDM WORLD?

- Referrals for service
- Patient information
- Billing for services provided

# REFERRAL FROM THE PAYER

- Service authorizations and re-authorizations
  - Unique referral codes assigned to every client referred to your agency
  - Authorization numbers must align with the service deliveries for billing purposes
- ICD codes
  - International Classifications of Diseases
  - Most service authorizations will include an ICD code that validates the clients need for service
- Unique patient ID's
  - Medicaid numbers
  - Insurance carrier member ID

# TRACKING PATIENT INFORMATION

- Unique opportunity to capture patient data
    - Every delivery is an opportunity
    - Nobody has access to your clients like you do
- Chronic health conditions can guide data to capture
    - Healthcare partners can help determine what
    - Consistency in how we capture data is critical
- Consolidate and Analyze Data To:
    - Identify issues or concerns
    - Analyze trends
    - Provide evidence
    - Identify areas of improvement

# Tracking Patient Information (cont'd)

## Social Determinants of Health

| Economic Stability | Neighborhood and Physical Environment | Education | Food | Community and Social Context | Health Care System |
|---|---|---|---|---|---|
| Employment | Housing | Literacy | Hunger | Social integration | Health coverage |
| Income | Transportation | Language | Access to healthy options | Support systems | Provider availability |
| Expenses | Safety | Early childhood education | | Community engagement | Provider linguistic and cultural competency |
| Debt | Parks | Vocational training | | Discrimination | Quality of care |
| Medical bills | Playgrounds | Higher education | | | |
| Support | Walkability | | | | |

**Health Outcomes**

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

# Evidence-Based Approaches & Data-Based Decision Making

# =

# Lowered Costs & Better Care

# BILLING FOR SERVICES

- Direct Data Entry
    - Time consuming, but effective

- Electronic billing files
    - EDI – Electronic Data Interchange
    - 837 Professional
    - 835 Remittance Files

Even a few simple
interventions can have an

# ENORMOUS IMPACT

when

# SCALED UP

# How Do We Capture This Data?

# TECHNOLOGY

- Software Applications with Databases
  - Spreadsheets may be effective, but are not the best solution
  - Lots of data to capture and we need a clean and effective way to do it
  - Centralized Databases
    - Data aggregation
      - Visibility across multiple providers
      - Visibility across the national network
- Incorporated Data Analytic Tools
- Enhanced Messaging
  - Messages sent to appropriate people based upon certain actions

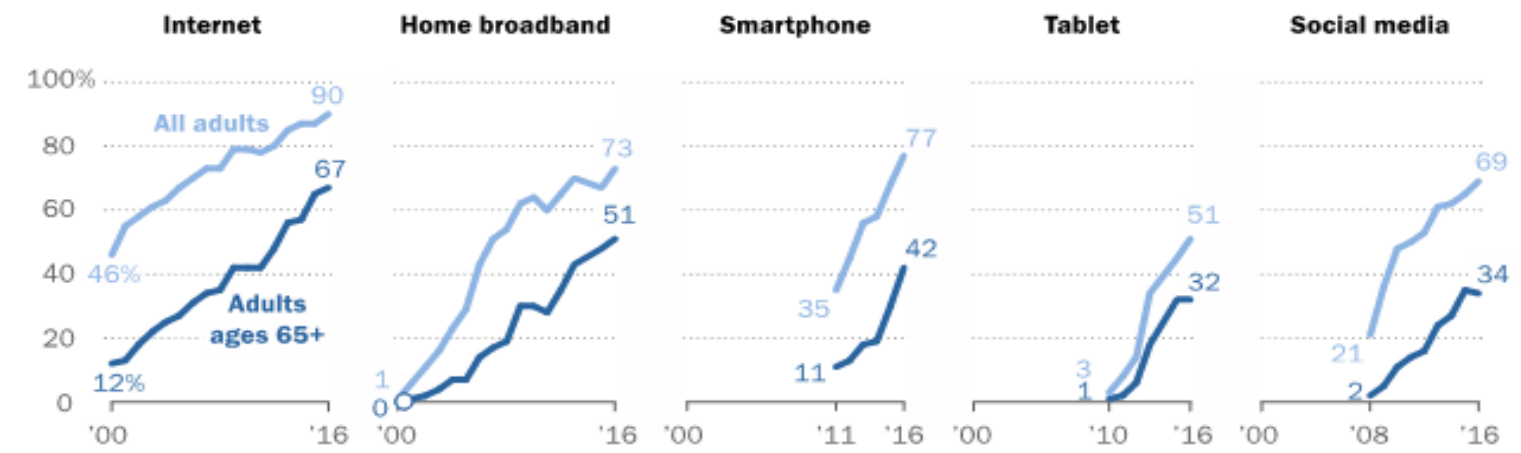
# TECHNOLOGY (CONT'D)

- Electronic Visit Verification
    - Mobile Technology
    - Capture data at the point of delivery
        - Location of delivery, date/time of delivery, signatures of the client, additional delivery comments
    - Identify changes of the clients condition
        - Go to the Panel of Peers discussion on Thursday from 11am – 12:30pm
            - Scaling What Works - Learnings from the More Than a Meal Body of Research

# TECHNOLOGY (CONT'D)

- Mobile Technology

## Smartphone adoption among seniors has nearly quadrupled in the last five years




Source: Survey conducted Sept.29-Nov.6, 2016. Trend data are from previous Pew Research Center surveys.
"Tech Adoption Climbs Among Older Adults"

PEW RESEARCH CENTER

# How (and with who) Do We Share This Data?

# WHO DO WE SHARE DATA WITH?

- Payers
  - Healthcare Insurance Companies
  - Care Coordinators
- Partners
  - Meals on Wheels America
  - West Health Institute
- Hospitals
- Physicians

# HOW DO WE SHARE DATA?

- Technology provides different options
    - Integration to payers systems through EDI, HL7, Web services
    - The payer may dictate the method in which data can be shared

- Integrated Data
    - Integration with other technology platforms i.e. healthcare provider databases, ADT systems, etc.
    - Data sharing is critical in this process
    - It is also dangerous. We must understand the legalities of data sharing

# HOW DO WE SHARE DATA? (CONT'D)

- If data is being shared with the payer, it can be identifiable
    - The payer wants to know which of their patients have health alerts
- If data is being shared for statistical analysis, then it must be de-identified
    - Think of MOW America in this instance

# HIPAA COMPLIANCE

- Ensure data capture and data sharing is safe and secure
- Most service providers don't fully understand data security
    - Find technology partners that can verify data security best practices
    - It's more than just the database to be concerned about
- Healthcare entities have more stringent guidelines than you are used to

# What Are We Doing Now?

# WE HAVE ALREADY STARTED

Initiatives in Motion:

- More Than A Meal
- Aetna Community Care Program
- Central Maryland Together in Care Program
- Statewide healthcare initiatives
- More healthcare initiatives on the way

# RECAP

- We already have the “gold”
  - Or at least some of the gold…
  - Access to the clients you have is unprecedented
- Now is the time to get involved
- Let’s now hear from Holly and see how they have put this into effect!

“DATA IS THE NEW GOLD”

# DATA DRIVES SUCCESS: OUR JOURNEY

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# ABOUT SENIORSERV

- $13 million senior nutrition and supportive services provider across 20 cities
- Congregate Meals
- Home Delivered Meals/Meals on Wheels with Case Management
- In Home Services
- Adult Day Care (1 center)
- Adult Day Health Care (2 centers; primarily Medi-Cal)
- Care Coordination

# OUR DATA / OUTCOMES JOURNEY

- Meals on Wheels / Case Management
- Community-based Care Transitions Program (CCTP)
- Care Coordination Programs

# OUR MEALS ON WHEELS DATA & OUTCOMES JOURNEY

- 2009:  Hired consultant (social sciences professor) to design a program
- Measured well-being, hospitalizations, length of stay, weight change, and other factors
- Case Managers conducted quarterly assessments
- Captured data in Excel; professor ran outcomes through SPSS

# WELL-BEING ASSESSMENT TOOL

## 2011/2012 Community SeniorServ

***Well-being Assessment***

**Case Managers/Workers: After your reassessment, mark the box under the category which best describes the client's current situation.**

| | Never | Sometimes | Almost Always |
|---|---|---|---|
| **1. I feel connected to the community around me.** | | | |
| Initial | ☐ | ☐ | ☐ |
| 3 month | ☐ | ☐ | ☐ |
| 6 month | ☐ | ☐ | ☐ |
| 9 month | ☐ | ☐ | ☐ |
| **2. I feel happy most of the day.** | | | |
| Initial | ☐ | ☐ | ☐ |
| 3 month | ☐ | ☐ | ☐ |
| 6 month | ☐ | ☐ | ☐ |
| 9 month | ☐ | ☐ | ☐ |
| **3. I feel that life is good almost everyday of the week.** | | | |
| Initial | ☐ | ☐ | ☐ |
| 3 month | ☐ | ☐ | ☐ |
| 6 month | ☐ | ☐ | ☐ |
| 9 month | ☐ | ☐ | ☐ |
| **4. I have someone that I can contact when I need it.** | | | |
| Initial | ☐ | ☐ | ☐ |
| 3 month | ☐ | ☐ | ☐ |
| 6 month | ☐ | ☐ | ☐ |
| 9 month | ☐ | ☐ | ☐ |
| **5. I am hopeful about the future.** | | | |
| Initial | ☐ | ☐ | ☐ |
| 3 month | ☐ | ☐ | ☐ |
| 6 month | ☐ | ☐ | ☐ |
| 9 month | ☐ | ☐ | ☐ |
| **6. I feel healthy.** | | | |
| Initial | ☐ | ☐ | ☐ |
| 3 month | ☐ | ☐ | ☐ |
| 6 month | ☐ | ☐ | ☐ |
| 9 month | ☐ | ☐ | ☐ |
| **7. I feel lonely.** | | | |
| Initial | ☐ | ☐ | ☐ |
| 3 month | ☐ | ☐ | ☐ |
| 6 month | ☐ | ☐ | ☐ |
| 9 month | ☐ | ☐ | ☐ |
| **For ONLY 3, 6, or 9 month visits:** | | | |
| **8. I have utilized the resources that were given to me.** | | | |
| 3 month | ☐ | ☐ | ☐ |
| 6 month | ☐ | ☐ | ☐ |
| 9 month | ☐ | ☐ | ☐ |

**Client Demographics**

*Clients Education Attainment Level*

- Less than High School ☐
- High School Graduate ☐
- Some College or Associates Degree ☐
- Bachelor's Degree or higher ☐

*Household Annual Income Level* *(write declined across box if client refused)*

| | |
|---|---|
| less than $1,800 ☐ | $12,001-$18,000 ☐ |
| $1801-$3,000 ☐ | $18,001-$24,000 ☐ |
| $3001-$6000 ☐ | $24,001-$40,000 ☐ |
| $6001-$12,000 ☐ | $40,001 and higher ☐ |

City of Residence _____

Case Manager _____

*Housing Status*

- Own home ☐
- Rent ☐
- Live with Family Member ☐
- Homeless ☐
- Other_____ ☐

*English Language Spoken in Home*

- Yes ☐
- No ☐

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# WELL-BEING ASSESSMENT QUESTIONS

Sense of Community:

- “I feel connected to the community around me”
- “I have someone that I can contact when I need it”
- “I feel lonely”

Contentment:

- “I feel happy most of the day”
- “I feel that life is good almost everyday of the week”
- “I am hopeful about the future”
- “I feel healthy”

Answer Categories

- “Never” / “Sometimes” / “Almost always”

# SUPPORTIVE SERVICES ASSESSMENT TOOL

**2011/2012**
**Community SeniorServ**
***Supportive Service Assessment***

New Client ☐

Client Name: _____
Ethnicity: Caus Hisp Asian Black Other
Age: _____ Weight: Initial _____ 3 mth _____ 6 mth _____ 9 mth _____
Income Level: 1 2 3 4 5
Gender: M F

Start Date: _____
End Date: _____

| | Date | Transportation | Utility Assistance | Informal support | Legal/Financial Assistance | Medical Insurance | SSI/IHSS | Housing | In-Home Services | SHOPP (Nurse) | Home Safety | Caregiver Support | Special Needs | Friendly Visitor | Community Referrals | Mental Health | HDM | Case Management | Other-provide explanation | Total Score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Initial Visit | | | | | | | | | | | | | | | | | | | | |
| 3 Month | | | | | | | | | | | | | | | | | | | | |
| 6 Month | | | | | | | | | | | | | | | | | | | | |
| 9 Month | | | | | | | | | | | | | | | | | | | | |

Directions: Blank box=Service is not needed; "0" = Client needs service, but has not yet been linked to the Service; Place a tally mark in appropriate box for **each** service, referral or information you provide to client. If you provide more than one referral in a category (i.e., multiple safety devices, multiple home services, multiple referrals) enter a tally mark for each.
Add all tally marks and enter in "Total Score" column

| Hospitalizations | # of Hospitalizations | Average Length of Duration (in days) |
|---|---|---|
| Previous Yr | | |
| 3 Month | | |
| 6 Month | | |
| 9 Month | | |

Reason for Discontinuing Service
1. Deceased
2. Improved/No longer needed
3. Dislike meals
4. Cultural preference
5. Moved with Family member other caregiver
6. In Skilled Nursing Facility or Board & Care
7. Hospitalization
8. Diet/Nutritional needs
9. Other _____

NOTE: Client that does not receive services for 3 months or longer, discontinue service.

* Explanation of Other Service: _____

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# MAJOR FINDINGS FOR CLIENTS AFTER 1 YEAR IN THE PROGRAM:

- 20% increase in well-being
- 30% reduction in hospitalizations
- 67% reduction in length of stay
- 2 lbs weight gain
- 141% increase in referrals to community services

*Key issue: Hospitalization and Length of Stay data are self-reported. Helps get in the door with health plans but they discount it because not tied to actual discharge or medical record data.*

*That said, foundations love the data; helps with grants.*

# WHAT'S NEXT FOR MOW OUTCOMES

- Conducted program for four years.  Discontinued with intent to revamp.  Excel spreadsheets and SPSS a challenge.
- Have been conducting annual self-report surveys with questions aimed at self-report outcomes, e.g., my health has improved.
- Implemented ServTracker, including Case Management module, last year. Now implementing ServTracker Change in Conditions App.
- Will develop a revamped MOW outcomes strategy involving Change in Conditions, Case Management Assessments and other data that we can access through ServTracker, e.g., changes in Nutritional Risk Scores

# OUR CCTP DATA & OUTCOMES JOURNEY

## Community-Based Care Transitions Program (circa 2012-2014)

- One of 102 CCTP sites for Center for Medicare & Medicaid Services (CMS) innovation program to partner with area hospitals to reduce readmissions
- Coleman Model – using our social workers – meet participants in hospitals & at home. MOW provided 10-30% of time.
- Data Challenges:
    - Four hospitals – different medical information requirements and structure
        - 2 hospitals: had Electronic Medical Records. Granted full "view" access.
        - 2 hospitals: installed EMR during project. Granted partial "view" access.
- Business Associates Agreement (BAA) required
- HIPAA Compliant Communications required; secure email
- RepTrax – Allows accessibility to different parts of hospitals and info systems
- Cyber insurance as part of liability policy

# CCTP CONTINUED

- Big challenge:  Capturing and evaluating results
- Tried Excel/Access database initially
- Finally moved to Loopback – expensive; interfaces with hospital systems; enables billing
- One of our board members, a Nurse Executive and former hospital VP of Quality, saved us with her expertise in data management and system evaluation and implementation
- CMS measured:
    - Rehospitalizations, ED or observation stay visit within 30 days of discharge
    - Visited physician within 7 days and within 14 days of discharge
    - Died within 30 days
- *We did not have our own ability to measure this information. Must come from the healthcare system.*

# CARE COORDINATION DATA JOURNEY

- Part of Partners in Care Network in CA: Health Plan contract
  - Our Care Navigators provide enhanced care coordination in the home
  - Enter data into health plan system
  - We don't have access to the data and cannot retain it.
  - Health plan shares results as they deem appropriate

- Care Coordination in Affordable Housing Community
  - Our Care Navigators enter data into HUD system
  - Can assess the data ourselves

# TIPS FOR THE JOURNEY

- Start with the end in mind: what is your destination and what do you need to get there?
- Develop strategy for outcomes (impact) as well as outputs (e.g., service units)
- **Invest in technology infrastructure**
- Manage HIPAA information requirements
- Find a strong data / health care advisor – board member, volunteer, consultant
- Get the word out about your outcomes.
- Enjoy the wild ride!

# THANK YOU!

Don’t forget to fill out the Post-Session Survey in the Conference app!