

AGENDA

- Welcome and Introductions
- Webinar Series Purpose
- Today's Learning Objectives
- Care Coordinator Learnings Meals on Wheels of Greater San Diego
- Care Coordinator Learnings Meals on Wheels of Guernsey County
- Questions and Answers
- Next: Open Space Call/Listening and Sharing Session, November 1, 3:30
 p.m. 4:30 p.m. EDT

HOUSEKEEPING

The orange arrow button on the upper right of your screen reveals or hides the control panel

Type your questions and comments here and press send to "entire audience"





PROJECT PURPOSE

- Foster Meals on Wheels network-wide adoption of a technology-supported health and wellness monitoring protocol that can enhance the health, well-being, functioning and quality of life of community-residing older adults
- Engage 60 Member programs to adopt and implement the More Than a Meal Core Client Change of Condition Protocol through two approaches:
 - **Learning Collaborative** (10 awardees) YOU!

 50 Program Adoption sites (match with Learning Collaborative mentors)
- Contribute to development and leveraging of a National Data Repository

CARE COORDINATION 101

 Care coordination is increasingly recognized for its ability to improve outcomes for patients in multiple healthcare settings and reduce costs.



ROLE OF THE CARE COORDINATOR

• The role of the Care Coordinator receives wellness alerts from Meals on Wheels drivers when there is a change in the health, safety or well-being of a client on their route. Upon receipt of a wellness alert from a driver, the Care Coordinator contacts the Meals on Wheels client and proposes solutions and, if agreeable to the client, makes the necessary referrals or connections with health and supportive services providers to address the concern and mitigate the risk, including a warm handoff when possible and documenting these actions.

TODAY'S LEARNING OBJECTIVES

 To explore the benefits and challenges of Change of Condition Monitoring from the Care Coordinator perspective



TODAY'S AGENDA

- The Benefits (Expected and Unexpected) of Establishing the Care Navigation Role
- Recommendations for Identifying, Hiring and Training Care Coordinators
- Top Challenges You Have Experienced As a Care Coordinator
- Things that Could Have Been Approved
- Helpful Items and Advice

THE BENEFITS ESTABLISHING THE CARE NAVIGATION ROLE

- MORE THAN A MEAL
 - Identification of clients in need
 - Improvement of quality of care for seniors
- Communication Improvements
 - Client concerns are not lost
 - Consistent follow through
 - One point of contact
- Ability to compile solid data
- Protection of Client Information

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RECOMMENDATIONS FOR IDENTIFYING, HIRING AND TRAINING CARE NAVIGATORS

- Identifying and Hiring
 - Look for qualities that your organization will need for this position to succeed
 - Important to have someone that will follow through with things they say
 - Crucial to have someone that will advocate and defend on behalf of the seniors
 - Need knowledge of aging community and collaboration with partners
 - Ideally, the candidate would have connections to organizations and/or will go out into the community to make them
- Training
 - Helpful to have a toolbox and playbook
 - Learning as you go
 - Allowing the care navigator to make the position their own

MEALS WHEELS'AMERICA

TOP CHALLENGES AS A CARE NAVIGATOR

- Learning as you go (On the job training)
- You can never know enough
- Using communication for behavior change

TOP 3 THINGS THAT COULD BE IMPROVED

- Defining the role of the care navigator/coordinator
- Training volunteers how to report changes of conditions
- Not limiting assistance to just over the phone

HELPFUL ITEMS AND ADVICE

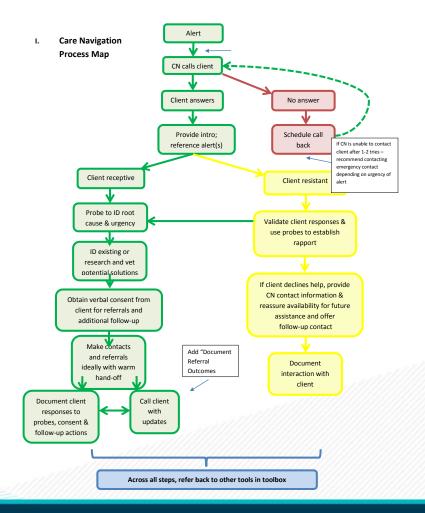
Wellness Indicators and Examples of Corresponding Observations

Wellness Alert Cheat Sheet

Health (Physical/Mental)	Self-Care/ Personal Safety	Mobility	Nutrition	Home Environment	Social Engagement / Community Connection	Emergency
Unusual breathing New bruises Apparent change in mood or behavior Confusion Swelling Muscle weakness Fatigue Facial droop Change in skin color New communication problem	Smells badly Disheveled appearance Suspected signs of neglect or abuse	New limp Takes longer than usual to answer door Unsteady on feet Less mobile than usual	Visible weight loss or gain Loss of appetite Concerns about fluid intake Uneaten meals Ill-fitting or lost dentures New dental problem	Home looks unsafe Dirtier and/or more cluttered than usual Difficulty managing home maintenance Heating/cool ing problem Unsafe electrical, carpet, or other walking surfaces	Reported loss of friend, family or pet Loss or change in support from caregiver, family or social network Change in participati on in usual social or religious activities	Call 911 Call the office *Use of this emergency alert is for tracking purposes only

HELPFUL ITEMS AND ADVICE

Toolbox and Process Map



HELPFUL ITEMS AND ADVICE

Change of Condition Follow Up and Action Plan

LIENT NAME	CLIENT FOLLOW UP/ACTION PLAN SERVICE CENTER	CLIENT ID
LIENI NAME	SERVICE CENTER	CLIENT ID
ATE OF COC - COC CATEGORY	PHONE/CITY	ZIP
ATE OF COC - COC CATEGORY	PHONE/CITY	ZIP
		DATE NEEDED
ITIAL FOLLOW UP CALL NOTES:	FOLLOW UP ACTION ITEMS	BY:
PTIONS RESEARCHED	FINAL OUTCOME/RESOLUTION/ACTION PLAN:	
		CLOSED/DATE



THE BENEFITS

Expected:

- Tracking wellness, emotional issues, safety, financial needs of clients
- Designated person to resolve client issues & concerns
- Better Client connections
- Community visibility / involvement
- Unexpected
 - Decrease feeling of isolation
 - # of Change of Conditions Clients reached out to (Jan July 31%)
 - Drivers more aware and observant

IDENTIFYING, HIRING AND TRAINING CARE COORDINATORS

- Qualities to look for:
 - Non-Judgemental
 - Able to separate own values and accept client values
 - Relate to the senior
 - Needs to have experience / training for one on one engagement
 - Caring Heart
 - Background / Training in client assistance / case management
 - Knowledgeable or have access to information on community resources
 - ServTracker Conference

CHALLENGES

- Drivers not giving a clear picture of the Change of Condition
 - Addressed in meetings / trainings
- Some (Very few) don't appreciate follow-up call
 - Deescalate the situation don't take it personally
- Unable to reach client
 - 1 Phone Call
 - 2 Home Visit
 - 3 Contact Emergency Contact
 - 4 Driver

3 THINGS WE WOULD DO DIFFERENTLY ARE

- Educating the Public about the Change of Condition
- Physician Office / Hospitals
- Publicity of the "Change of Condition"

OTHER ITEMS

- Tracking alerts is like building a Story
 - Documents a history with the client
 - Informs others about progress
 - Family
 - Physicians
 - Social Agencies

Q&A

NEXT STEPS

WHAT MEALS ON WHEELS AMERICA IS WORKING ON

- Finalizing evaluation plan
- Using your feedback to craft the open space webinar
- Refining the tools from San Diego and Guernsey County for your use (uploaded to the website by end of week)
- Developing our check-in process (Learning Collaborative and Meals on Wheels America)
- Copy of ASI training to website
- Updating ASI images on resources (early November)

NEXT STEPS

FOR YOU!

- Webinar: Open Space Call/Listening and Sharing Session, November 1, 3:30 p.m. 4:30 p.m. EDT
- Complete the brief survey following this webinar
- Contact us with any questions.

CURRENT OPEN SPACE

RECOMMENDATIONS FROM PREVIOUS WEBINARS

- Grant reporting requirements
- Evaluation plan in general
- How to get Healthcare to pay for program?
- Negotiating Change Management
- Engaging volunteers onboard and excited
- Timeline/expectations

WE'RE HERE TO HELP!

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THANK YOU!

