



Building the Business Capacity of Senior Nutrition Programs

Business Acumen Learning Collaborative

2016 - 2017

Network Profile: Twin Cities Care Partnership (MN)

Executive Summary – Healthcare Integration Approach/Goals:

Our project provides patients discharged from the hospital who have been diagnosed with diabetes, chronic obstructive pulmonary disease, or chronic kidney disease with nutrition services for 30 days, nutrition counseling for their disease, a medication review, and daily in-home safety checks. We will provide the patients with a simple in-home recovery plan to reduce readmissions to the hospital. Our goal with the project is to reduce the thirty day readmission rates in the three specific chronic diseases by 8% overall, increase patient self-management of disease in regards to nutrition, and increase patient assessed wellness and safety in the home.

Current Partners and Contract Prospects (e.g., name of potential integrated care entities – health plan, hospitals, ACO, MCO – being targeted for contracts)

HealthVisions Midwest, Vytos Pharmacy, Methodist Hospital – Northlake Campus, Methodist Hospital – Southlake Campus, St. Catherine’s Hospital Franciscan Alliance ACO.

Potential Target Population (e.g., dual eligible, duals with multiple chronic diseases, EBP targets, high risk, vulnerable seniors, etc):

Recent hospital discharges, who have 1+ of the following conditions, chronic obstructive pulmonary disease, diabetes, and/or chronic kidney disease. The target population will also be Medicare or Dual-eligible – particularly those with little support systems in place.

Potential Services or service packages (types of services each Learning Collaborative Member will sell to contract prospects):

Our proposed service package will include 10 home-delivered meals (therapeutic if needed), an in-home, one hour nutrition consult and home safety check, and referrals to other programs as needs are identified.

Collaborative partners (i.e., a list of all partners organizations in each Learning Collaborative Member’s network):

Community Emergency Services (CES), Senior Services
Consortium of Ramsey County (SSCRC) and Metro Meals on Wheels.

Learning Collaborative Member Contact(s)

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Network Profile: Southern Maine Area Agency on Aging (ME)

Executive Summary – Healthcare Integration Approach/Goals:

The Southern Maine Agency on Aging (SMAA) will dedicate four hours a week of its Business Development Manager’s time to cultivating relationships, establishing a business model for marketing SMAA “service packages”, and ultimately developing financial contracts with healthcare partners to support its’ Simply Delivered for ME program. SMAA’s Simply Delivered for ME program provides home-delivered meals to high-risk Medicare patients who have been discharged from the hospital. Through extensive research, SMAA has proven that the provision of Simply Delivered meals reduces the risk of re-hospitalization within the subsequent 30 days after discharge. Through this grant opportunity, SMAA will improve on its knowledge of the healthcare arena, strengthen its’ business capacity and relationships with existing and potential partners, and will work collaboratively with other grantees to develop a replicable business model for establishing funding contracts in the future.

Current Partners and Contract Prospects (e.g., name of potential integrated care entities – health plan, hospitals, ACO, MCO – being targeted for contracts)

York Hospital, Martin’s Point Healthcare, Anthem BCBS of Maine

Potential Target Population (e.g., dual eligible, duals with multiple chronic diseases, EBP targets, high risk, vulnerable seniors, etc):

Older adult hospital discharges and those with chronic diseases, including hypertension, diabetes, osteoporosis, and heart disease, as well as stroke victims and those with dementia.

Potential Services or service packages (types of services each Learning Collaborative Member will sell to contract prospects):

Service packages may include evidence-based falls prevention programs like Matter of Balance and Tai Chi; Medicare and insurance counseling; and other care transitions services.

Collaborative partners (i.e., a list of all partners organizations in each Learning Collaborative Member’s network):

NHCAS is comprised of 5 New Hampshire (NH) based nonprofit 501(c) (3) organizations that provide Meals on Wheels to older and disabled adults in their respective service areas; Ossipee Concerned Citizens (OCC), Tri-County Community Action Program (TCCAP), Grafton County Senior Citizens Council (GCSCC), the Community Action Program of Belknap-Merrimack Counties, Inc. (CAPBMCI), and St. Joseph Community Services (SJCS).

Learning Collaborative Member Contact(s)

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Network Profile: Meals on Wheels of Northwest Indiana (IN)

Executive Summary – Healthcare Integration Approach/Goals:

Our project provides patients discharged from the hospital who have been diagnosed with diabetes, chronic obstructive pulmonary disease, or chronic kidney disease with nutrition services for 30 days, nutrition counseling for their disease, a medication review, and daily in-home safety checks. We will provide the patients with a simple in-home recovery plan to reduce readmissions to the hospital. Our goal with the project is to reduce the thirty day readmission rates in the three specific chronic diseases by 8% overall, increase patient self-management of disease in regards to nutrition, and increase patient assessed wellness and safety in the home.

Current Partners and Contract Prospects (e.g., name of potential integrated care entities – health plan, hospitals, ACO, MCO – being targeted for contracts)

HealthVisions Midwest, Vytos Pharmacy, Methodist Hospital – Northlake Campus, Methodist Hospital – Southlake Campus, St. Catherine’s Hospital Franciscan Alliance ACO.

Potential Target Population (e.g., dual eligible, duals with multiple chronic diseases, EBP targets, high risk, vulnerable seniors, etc):

Recent hospital discharges, who have 1+ of the following conditions, chronic obstructive pulmonary disease, diabetes, and/or chronic kidney disease. The target population will also be Medicare or Dual-eligible – particularly those with little support systems in place.

Potential Services or service packages (types of services each Learning Collaborative Member will sell to contract prospects):

Our proposed service package will include 10 home-delivered meals (therapeutic if needed), an in-home, one hour nutrition consult and home safety check, and referrals to other programs as needs are identified.

Collaborative partners (i.e., a list of all partners organizations in each Learning Collaborative Member’s network):

N/A

Learning Collaborative Member Contact(s)

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Network Profile: Minuteman Senior Services (MA)

Executive Summary – Healthcare Integration Approach/Goals:

Minuteman Senior Services has over 40 years of experience successfully delivering meals to seniors in their homes and has developed an expertise in providing other in-home services. We will leverage existing medical partnerships and utilize the expertise of a health care consultant to expand our nutrition program to a targeted population, through formal contracts with hospitals, accountable care organizations and others. Minuteman Senior Services will impact malnutrition and improve health outcomes by developing a business plan to contract with medical providers and offer therapeutic meals and community nutrition consults targeting patients with cardiac disease post hospital discharge. This fills an unmet need, as nutrition is a key factor in recovery and 70% of adults age 65 and up are at risk for malnutrition post hospitalization. Nutrition has proven efficacy to reduce readmissions regarding heart disease and other chronic conditions as well as post hospitalization.

Current Partners and Contract Prospects (e.g., name of potential integrated care entities – health plan, hospitals, ACO, MCO – being targeted for contracts)

Emerson Hospital, Healthcentric Advisors, (the New England QIN-QIO), Winchester Hospital, Lahey Health's ACO, Commonwealth Care Alliance, NaviCare, Senior Whole Health, Tufts Health Plan, and United Health Care.

Potential Target Population (e.g., dual eligible, duals with multiple chronic diseases, EBP targets, high risk, vulnerable seniors, etc):

Hospital discharged cardiac patients

Potential Services or service packages (types of services each Learning Collaborative Member will sell to contract prospects):

Our proposed service package will include 10 home-delivered meals (therapeutic if needed), an in-home, one hour nutrition consult and home safety check, and referrals to other programs as needs are identified.

Collaborative partners (i.e., a list of all partners organizations in each Learning Collaborative Member's network):

See the above.

Learning Collaborative Member Contact(s)

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Network Profile: Meals on Wheels Greater Pittsburg (PA)

Executive Summary – Healthcare Integration Approach/Goals:

The goal is to help Meals on Wheels Greater Pittsburg (MOWGP) develop contracts with health care providers including MLTSS contractors, hospitals/health systems, PACE replication programs, and Medicare Part C plans. Each MOWGP member is also a Meals on Wheels America member that operates a senior nutrition program currently receiving funds from the Older Americans Act. Project goals include: 1) Improve service packaging and service delivery options; 2) Prepare marketing plan for health plans, hospitals, and related health care providers; 3) Create simplified ordering system to better meet the needs of prospective purchasers; 4) Document impact of nutritional support services that support independence; 5) Implement cross agency Quality Assurance Performance Improvement (QAPI) program to meet/exceed MCO requirements; and 6) Execute a minimum of 3 contracts with MCOs to provide services prior to August, 2017.

Current Partners and Contract Prospects (e.g., name of potential integrated care entities – health plan, hospitals, ACO, MCO – being targeted for contracts)

Contract prospects include:

(1) MCOs, particularly those who will be implementing the new MLTSS system in southwestern Pennsylvania; (2) Stand-alone hospitals; (3) Area PACE replication projects, including Community Life and Life Pittsburgh; and (4) other healthcare providers (i.e., hospice).

Potential Target Population (e.g., dual eligible, duals with multiple chronic diseases, EBP targets, high risk, vulnerable seniors, etc):

Older adults “at-risk” of losing independence by virtue of their age, health, living situation, and other factors.

Potential Services or service packages (types of services Learning Collaborative Member will sell to contract prospects):

Traditional Meals on Wheels service plus a “safety check” (including change of condition monitoring) that takes place during each “delivery”. As needed an “alert” will be transmitted to an Intervention Specialist, who follows up on the report and takes appropriate action (referral, family notification, care management/care coordination, MD appointment).

Collaborative partners (i.e., a list of all partners organizations in each Learning Collaborative Member’s network):

Seven programs comprise Meals on Wheels of Greater Pittsburg (MOWGP): LifeSpan, Inc., Eastern Area Adult Services, Hill House Association, Plum Senior Community Center, Riverview Community Action Corporations and the Catholic Youth Association.

Learning Collaborative Member Contact(s)

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Network Profile: Southern Maine Area Agency on Aging (ME)

Executive Summary – Healthcare Integration Approach/Goals:

The Southern Maine Agency on Aging (SMAA) will dedicate four hours a week of its Business Development Manager’s time to cultivating relationships, establishing a business model for marketing SMAA “service packages”, and ultimately developing financial contracts with healthcare partners to support its’ Simply Delivered for ME program. SMAA’s Simply Delivered for ME program provides home-delivered meals to high-risk Medicare patients who have been discharged from the hospital. Through extensive research, SMAA has proven that the provision of Simply Delivered meals reduces the risk of re-hospitalization within the subsequent 30 days after discharge. Through this grant opportunity, SMAA will improve on its knowledge of the healthcare arena, strengthen its’ business capacity and relationships with existing and potential partners, and will work collaboratively with other grantees to develop a replicable business model for establishing funding contracts in the future.

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Potential Services or service packages (types of services each Learning Collaborative Member will sell to contract prospects):

Service packages may include evidence-based falls prevention programs like Matter of Balance and Tai Chi; Medicare and insurance counseling; and other care transitions services.

Potential Target Population (e.g., dual eligible, duals with multiple chronic diseases, EBP targets, high risk, vulnerable seniors, etc):

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Collaborative partners (i.e., a list of all partners organizations in each Learning Collaborative Member’s network):

NHCAS is comprised of 5 New Hampshire (NH) based nonprofit 501(c) (3) organizations that provide Meals on Wheels to older and disabled adults in their respective service areas; Ossipee Concerned Citizens (OCC), Tri-County Community Action Program (TCCAP), Grafton County Senior Citizens Council (GCSCC), the Community Action Program of Belknap-Merrimack Counties, Inc. (CAPBMCI), and St. Joseph Community Services (SJCS).

Learning Collaborative Member Contact(s)

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Network Profile: New Hampshire Coalition of Aging Services (NH)

Executive Summary – Healthcare Integration Approach/Goals:

The New Hampshire Coalition of Aging Services (NHCAS) was formed in 2011 by five non-profit organizations that provide nutrition and other essential services to older and disabled adults in NH (St. Joseph Community Services is one of the 5). Members recognize that the current healthcare system is changing from a fee-for-service based system to one that is based on outcomes and improved care coordination that also results in reduced costs. NHCAS members seek to augment their skills, knowledge and business acumen in order to better position and integrate nutrition and other important services offered by their organizations into the healthcare market. Together, members will accomplish this by engaging in strategic planning, defining their value proposition to the healthcare system, enhancing the current system of data collection and documentation of service impact, effecting the necessary culture change within each organization, developing a business plan and contracting with at least one healthcare entity within the next year.

Current Partners and Contract Prospects (e.g., name of potential integrated care entities – health plan, hospitals, ACO, MCO – being targeted for contracts)

Ascentria Care Alliance, Catholic Charities, NH Healthy Families, and Easter Seals of NH

Potential Services or service packages (types of services each Learning Collaborative Member will sell to contract prospects):

The proposed service package includes home-delivered meals, nutrition assessment and education, in-home safety checks and tracking of necessary follow-up to any issues or concerns encountered during the home visit. This ‘basic’ package represents the core of services that every member of the NHCAS offers. This service package has proven value in improved customer outcomes with high satisfaction and is an extremely cost effective option, especially as it compares to any form of institutional care.

Potential Target Population (e.g., dual eligible, duals with multiple chronic diseases, EBP targets, high risk, vulnerable seniors, etc):

Older adult hospital discharges and those with chronic diseases, including hypertension, diabetes, osteoporosis, and heart disease, as well as stroke victims and those with dementia.

Collaborative partners (i.e., a list of all partners organizations in each Learning Collaborative Member’s network):

NHCAS is comprised of 5 New Hampshire (NH) based nonprofit 501(c) (3) organizations that provide Meals on Wheels to older and disabled adults in their respective service areas; Ossipee Concerned Citizens (OCC), Tri-County Community Action Program (TCCAP), Grafton County Senior Citizens Council (GCSCC), the Community Action Program of Belknap-Merrimack Counties, Inc. (CAPBMCI), and St. Joseph Community Services (SJCS).

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Network Profile: Elmview Senior Nutrition (WA)

Executive Summary – Healthcare Integration Approach/Goals:

HomeLinks expands services currently provided by Elmview Senior Nutrition contracting with community health partners for the following services: home-delivered meals, nutrition/wellness assessments, nutrition education, in-home safety checks, and information and referral so that people remain healthy and at home. Target populations are chronically ill, people transitioning from health care institutions to home, and people identified as at risk. The outcome will be contracts for services with two community health entities.

Current Partners and Contract Prospects (e.g., name of potential integrated care entities – health plan, hospitals, ACO, MCO – being targeted for contracts)

Kittitas Valley Healthcare, Community Health of Central Washington, MCOs, and healthcare companies-Community Health Plan of Washington, Coordinated Care Corporation, United Behavioral Health, and United Healthcare of Washington.

Potential Services or service packages (types of services each Learning Collaborative Member will sell to contract prospects):

Current service package includes: home-delivered meal, nutrition and wellness assessments, nutrition education, in-home safety checks, and information and referrals as needed to needed long-term services and supports.

Potential Target Population (e.g., dual eligible, duals with multiple chronic diseases, EBP targets, high risk, vulnerable seniors, etc):

Seniors over the age of 60, with chronic illness, people transitioning from hospitals or nursing facilities, and those identified by community partners as at risk and in need of in-home nutrition services.

Collaborative partners (i.e., a list of all partners organizations in each Learning Collaborative Member's network):

N/A

Learning Collaborative Member Contact(s)

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