Health Network Partnering

Lisa Labonte, Director of Senior Nutrition Services

Maureen McCarthy, RN, BS, RAC-MT, QCP-MT

Who We Are

- New Opportunities, Inc. is a Community Action Agency that administers a multitude of programs from toddlers to elders. Services offered for the agency's elder population includes the provision of home delivered meals, congregate meal sites, outreach services to link elders to benefit assistance programs, emergency response system, senior companion services, homemaking, financial management assistance, and opportunities for elders to volunteer their time in the community.

- Care Transitions is a post discharge care management service provider. Care Transitions coordinates care and services for it's customers in an effort to reduce burdensome and often unnecessary hospital transfers. This is accomplished by managing the care providers and health status of each customer to achieve optimal results in their home setting.

NEW OPPORTUNITIES
Building Relationships to End Poverty℠

Care Transitions

The National Resource Center on Nutrition & Aging

How & Why

- The implementation of the Affordable Care Act.

- The need for Meals on Wheels to develop a sustainable fund source other than Federal and State funds.

- The confidence that we are in a very good position to save hospitals and insurance companies money while improving the quality of care. With the average cost of a hospital readmission ranging anywhere from $1,500 per day or higher, this pilot has a high success rate with some of the most debilitated patients with a history of multiple re-hospitalizations and was able to reduce the readmission rate down to zero in a 60-day period.

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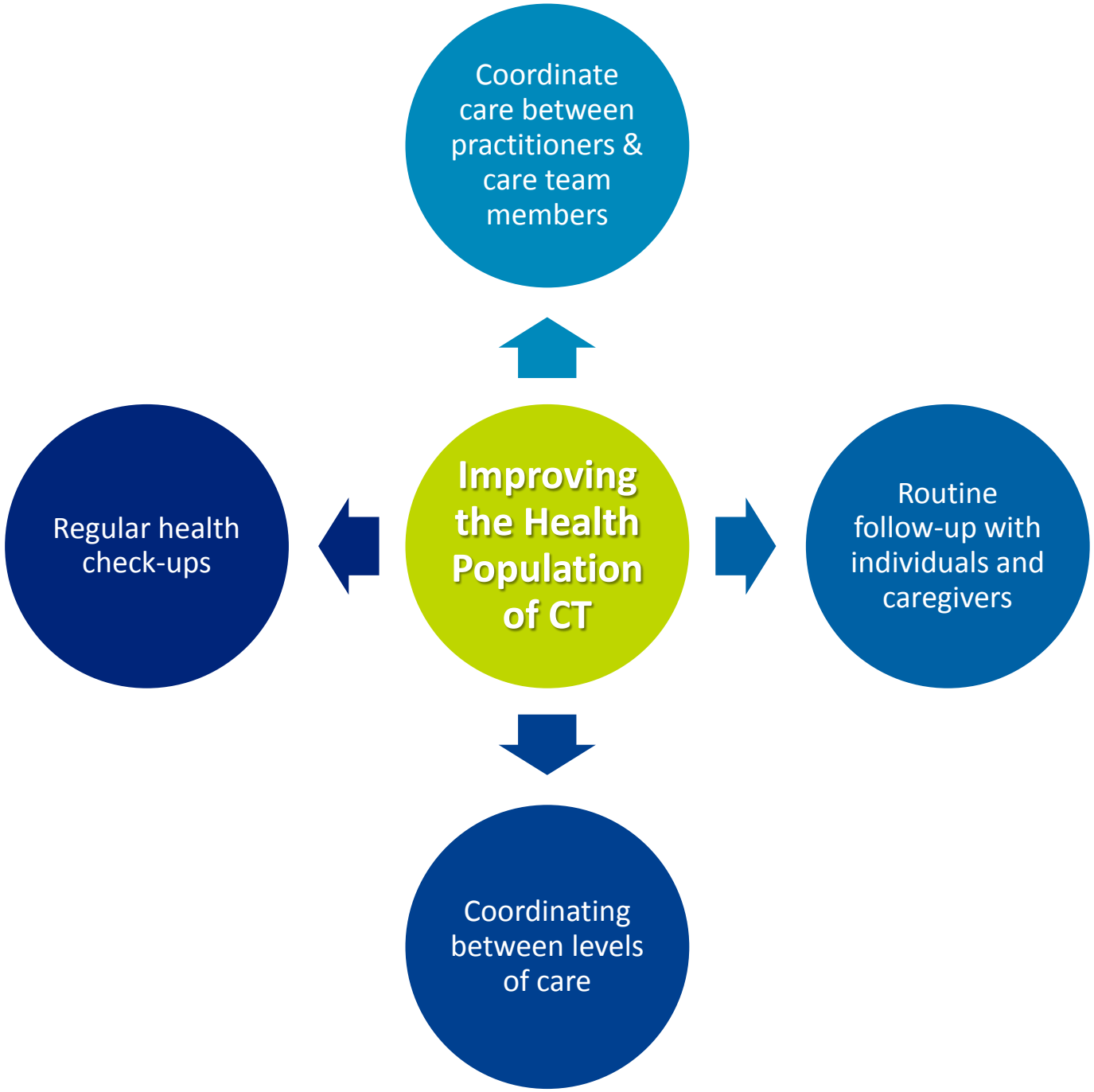

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Hospital Discharge Coordination

Consumers will only need to contact Care Transitions or New Opportunities to help coordinate post acute care and receive education on regarding all options available to consumer

Care Transitions

New Opportunities for Waterbury, Inc.

WWW.CARETRANSITIONSLLP.COM
PHONE: 860-470-3901 | FAX: 860-618-7278

Driver:	Date:
Client:	

Did you take all of your medications today?(circle one) Y N
If no, why?

What was your:

Pulse (heartbeats per minute)		Date last taken:	☐ Refused	☐ Will discuss w/Nurse
Weight		Date last taken:	☐ Refused	☐ Will discuss w/Nurse
Blood Pressure		Date last taken:	☐ Refused	☐ Will discuss w/Nurse
Temp		Date last taken:	☐ Refused	☐ Will discuss w/Nurse
Blood Sugar		Date last taken:	☐ Refused	☐ Will discuss w/Nurse
Oxygen Level		Date last taken:	☐ Refused	☐ Will discuss w/Nurse

Problems Sleeping: Y N

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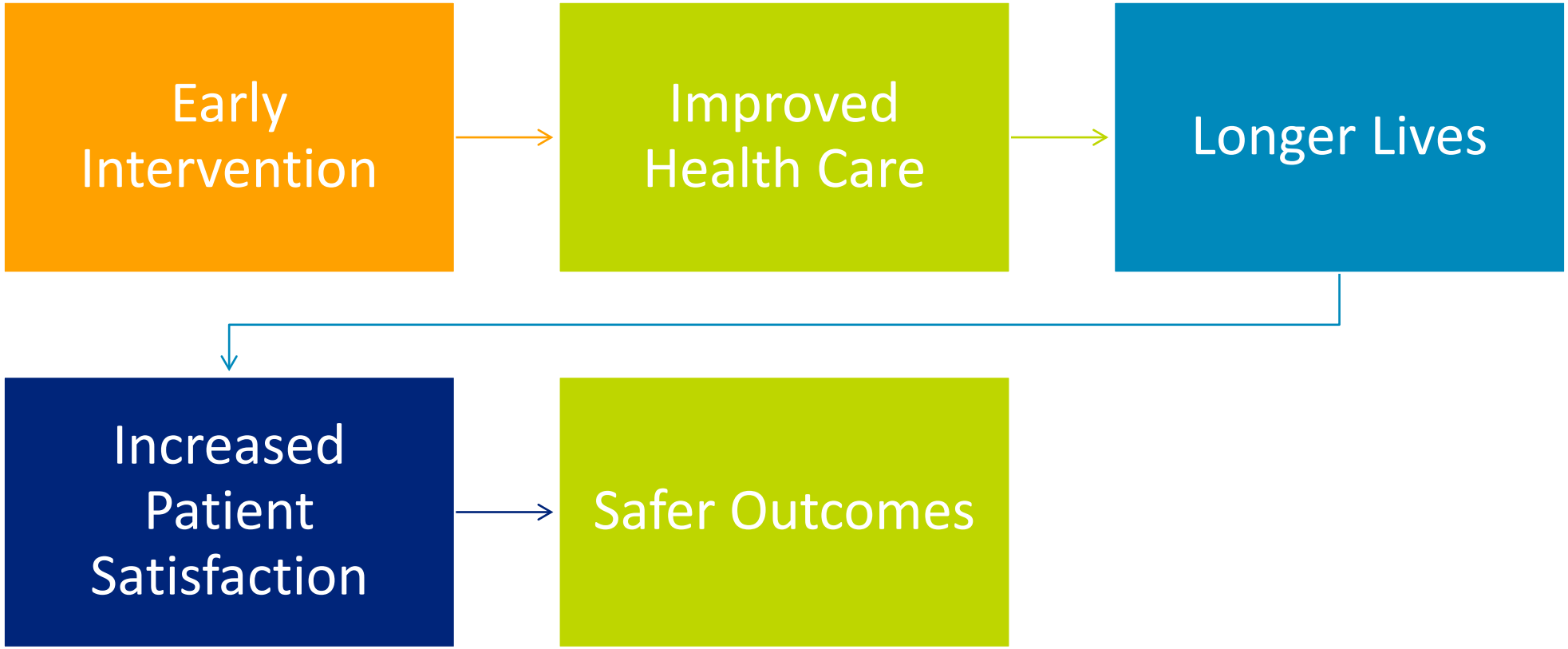
System Process

- Intake
  - Assess needs/goals of consumer
  - Determine barriers
  - Review services available (home support)
  - Evaluate current plans available
  - Develop “advanced care planning” with the consumer
- Contact service(s) provider- including transportation services, where available.
- Follow up with consumer whether “advanced care plan” needs revision
- Alter “advanced care plan” as need and adjust services according to updated health goals.
- Provide routine “check in” with consumer in order to alleviate negative outcome.

Outcomes



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Why this Partner?

- A colleague knew the Head of Cardiology at the Hospital and secured a meeting for us.

- Under the Affordable Care Act Hospitals are under pressure to improve care and avoid penalties which decrease revenue. Re-hospitalizations are a state and federal focus in the healthcare industry.

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The Partnership

Reduce Readmissions, move patients to the next level of care, improve quality of care and quality of life for the customers in the program.

Nursing oversight of patient's care, Coordination between health care providers, Heath checks, Provide nutrition counseling and education, provide home delivered meals, daily driver check on patient's condition, emergency response system

Include in the referral the diagnosis and goals of the patient. Maintain data that determines the success or failure of outcome.

100% success with small # of most difficult to manage patients referred by the hospital.

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Where Are We Now?

- Based on the success rate the Hospital invited us to apply through their Foundation to expand this model with more patients. This application is still pending.

What Next?

- We have submitted an application to a state agency that is interested in our model with the inclusion of assessing and referring for social determinants of health and an evaluation component.

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What we learned

- Even if you are giving it away, it is difficult to get hospitals to consider a partnership with a CBO. Securing a champion is key to opening doors for you.

- What seems natural to a Community Based Organization is foreign in the health care arena

- People don’t automatically take free money! Also, by partnering with the physician, we may be able to bill for some of the services.

- Patience, Patience, Patience. Network with other providers for services you are not able to provide or areas you can’t cover. Find a Champion. Develop a relationship with your State Hospital Association-a good place to find champions. Contact your local Foundations to research their interest in funding this type of initiative.

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Contact Information

Lisa LaBonte

Senior Nutrition Director

New Opportunities, Inc.

232 North Elm Street

Waterbury, CT 06702

Phone (Office): 203-575-4208

Phone (Cell): 203-465-9711

Email: llabonte@newoppinc.org

www.NewOppInc.org

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