Nutrition and Aging
Resource Center

2019 INNU Grantee Recognition and Presentations

August 4, 2022

Nutrition and Aging
Resource Center

The Nutrition and Aging Resource Center recognizes services are not one size fits all, therefore we **celebrate the diversity** of the older adult population by **respecting the needs** for those various life experiences.

2019 INNU Grantees

- Eastern Area Agency on Aging
- Education Health Resources International (EHRI)
- Interfaith Ministries for Greater Houston
- LifeCare Alliance
- Public Health Solutions
- Texas Health and Human Services Commission
- University of Utah

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Nutrition Innovation Project

Tabatha Caso, LSW
Chief Program Officer
Eastern Area Agency on Aging

Project Overview

Multi-sector approach:

- Healthcare system (St Joseph's Hospital)
- Health Technology Company (Senscio Health Systems)
- Area Agency on Aging (Eastern Area Agency on Aging)
- University (University of Maine Center on Aging)

Project Overview Continued

Project goals:

- Improved nutritional status
- Improved health and health-related quality of life
- Improved ability to age in place
- High levels of satisfaction with services

Process:

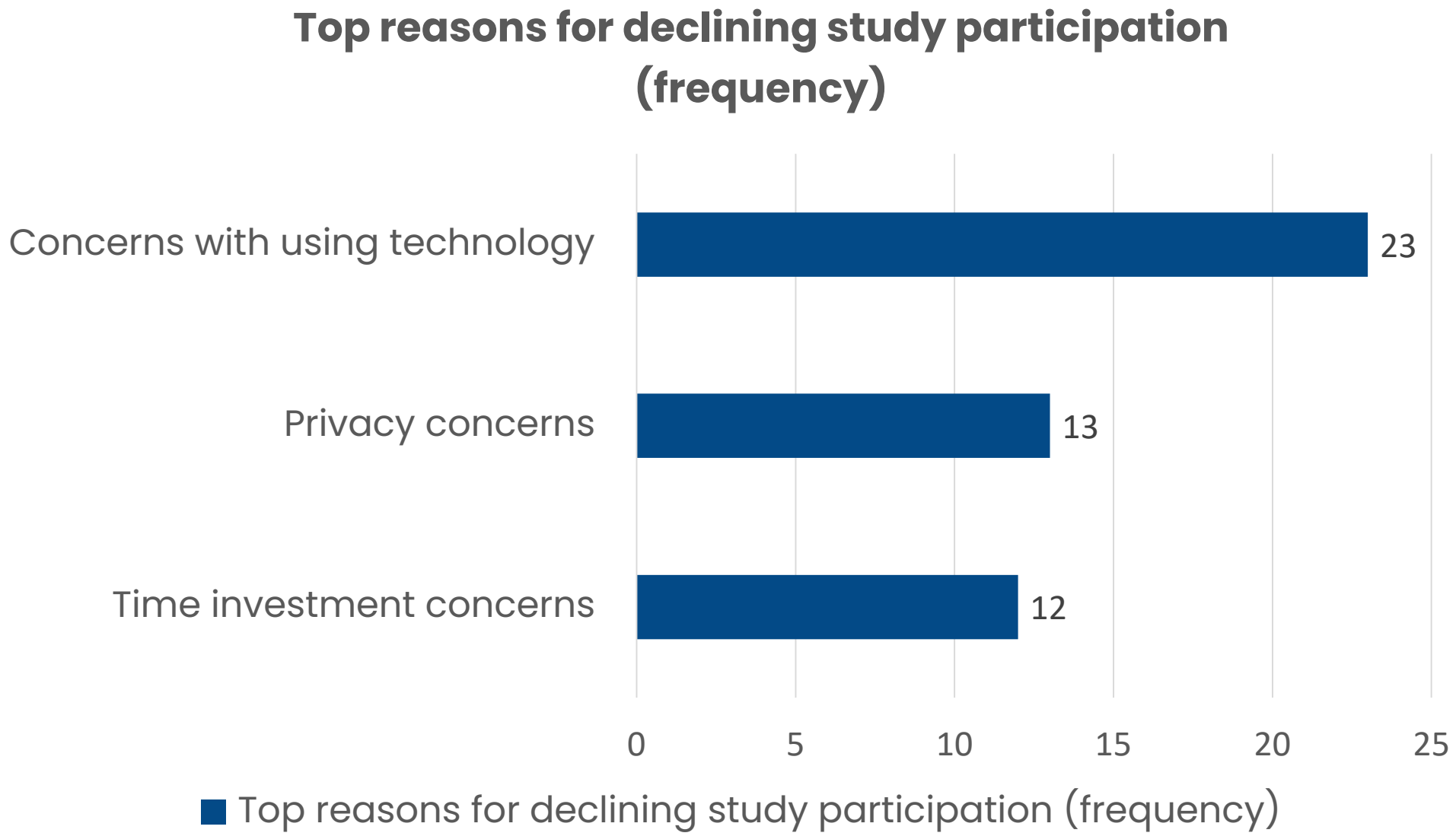
- Screening and eligibility
- Referral pathway
- Ibis
- Home Delivered Meals
- Clinical trial and evaluation

Findings

Study Participants

- 185 referrals
- 22 participants (9 completed, 13 withdrew)
  - 48% male, 52% female
  - Average age: 69
  - Averaged 2.3 of the chronic conditions for eligibility – (Diabetes, heart failure, COPD, Depression, Hypertension)
  - Mean Mini Nutritional Assessment at baseline = 7.5 [high end of “malnourished” range (0-7) and low end of “at risk of malnutrition” range (8-11)

Findings


Top reasons for declining study participation (frequency)
Concerns with using technology
23
Privacy concerns
13
Time investment concerns
12
0
5
10
15
20
25
Top reasons for declining study participation (frequency)

Findings

Interview findings with participants who completed study

- Tended not to have any formal or informal supports
- Satisfied with tablet, generally indicated it was easy to use, while having to navigate certain technical issues and some having critiques of the interface.
- Mixed reactions to food – some people liked specific dishes, not others. Generally, there was a feeling that the amount of food was too large.
    - Not all participants understood they had the ability to pick meals
    - Fresh bread and milk were particularly popular
- Participants did not cook and were unlikely to use nutrition information from Ibis

Findings

Participant Quotes – Value of reminders and nutritious food

- “I was pretty foggy, so it helped me to know this device was here. I would hear it chirp and I’d go to it, I didn’t have the responsibility of remembering. And that was really nice. Everyone who called me from Ibis was really friendly. When you're sick and away from home for a while, you become dependent and like a patient even if you’re not a patient. It’s hard to believe that you’re well again/capable again. It made me feel independent and capable.”

Findings

Participant Quotes – Value of reminders and nutritious food

- “Yes, the meal were definitely helpful for me. They helped me to get a balanced diet. I eat once a day and usually it is not very…well I eat a bologna sandwich at night whatever when I am sitting down watching TV, and that’s my supper. And that’s my meal for the day, so whatever. So it was helpful, yes, balanced meals are very helpful.”

Findings

Participant Quotes – Value of routine and phone check-ins

- “In ways it was very good, as much as I hate to do it all the time, it really was something that helped me to set-up a routine. I think I would have had it a lot worse.”

Findings

Participant Quotes – Value of routine and phone check-ins

- “Well, like I said, I loved the pancake breakfast. That was a good one for me. What normally people eat around here. And I enjoyed the phone calls to find out how I was doing and asking what you could do to improve things. Very helpful.”

Findings

Participant Quotes – Food selection and volume

- “I am trying to think what I did with the meals. Well at first, I definitely enjoyed the day I would get them, because there was a couple that I really liked and I would go through them and put the good ones in the front and put the others in the back. The one thing I wish I could have done, was more of a selection that I could pick and choose.”

Findings

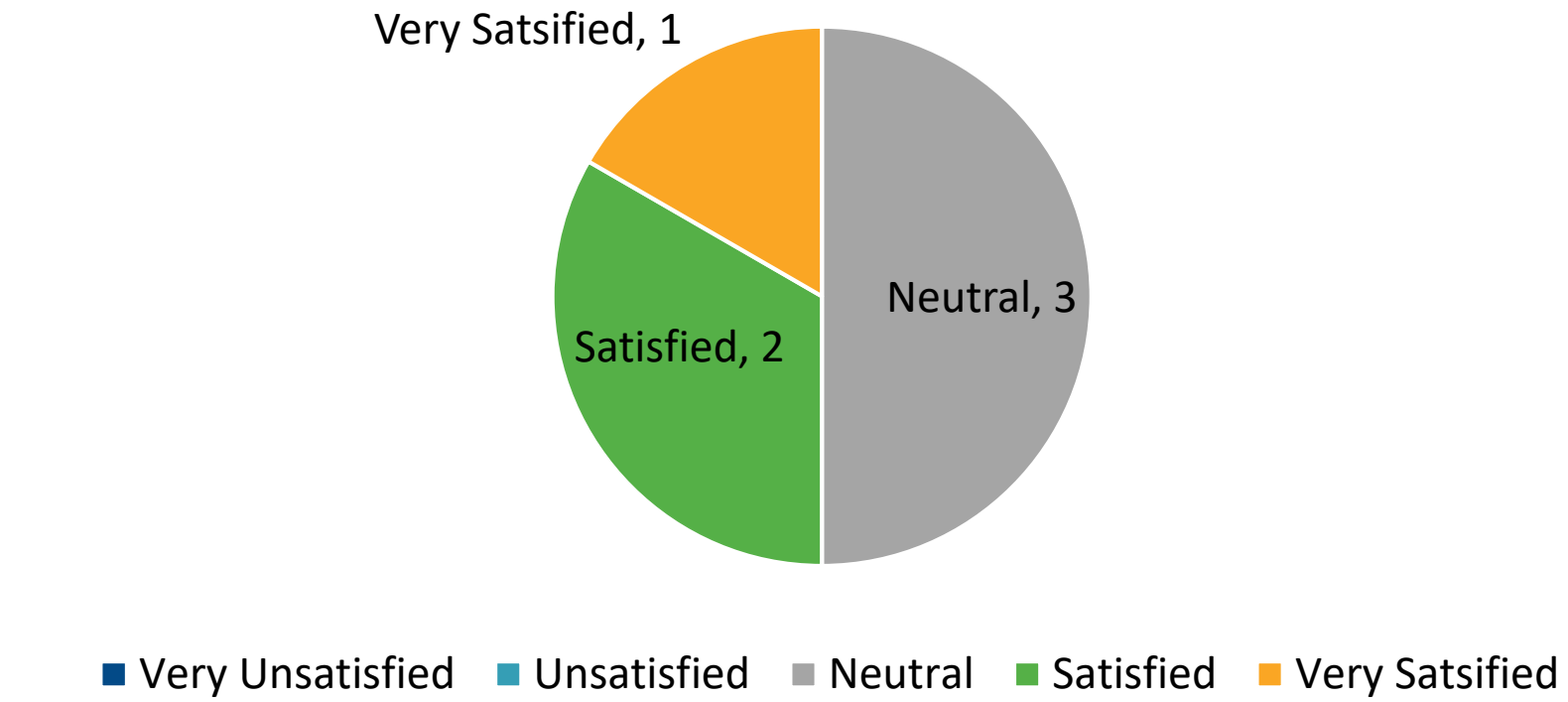
Participant Quotes – Food selection and volume

- “Five meals were too much. The bread and the milk were just stunning, the bread was homemade. And the milk was always appreciated. It was 2%, I would’ve preferred skim, but it was appreciated.”

Findings

Participant satisfaction at 6 months (intervention group)

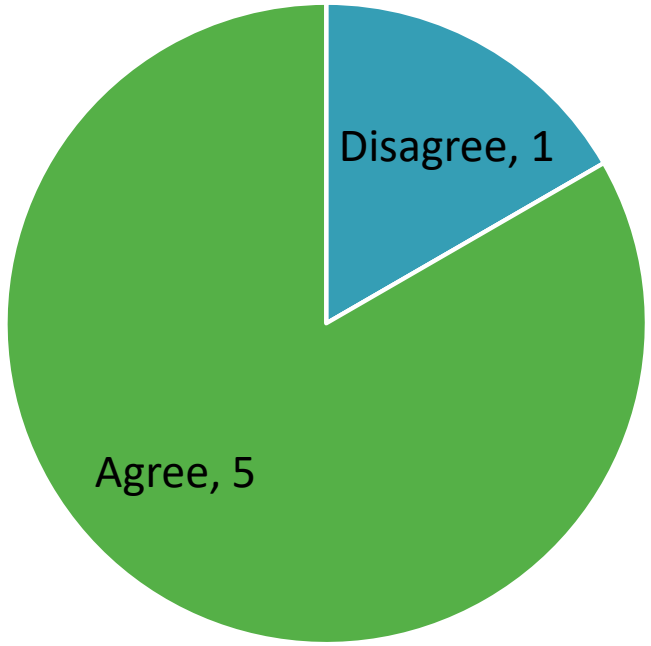
How satisfied are you with the nutrition information you get from Ibis (recipes, tips, etc.)?



Findings

Participant satisfaction at 6 months (intervention group)

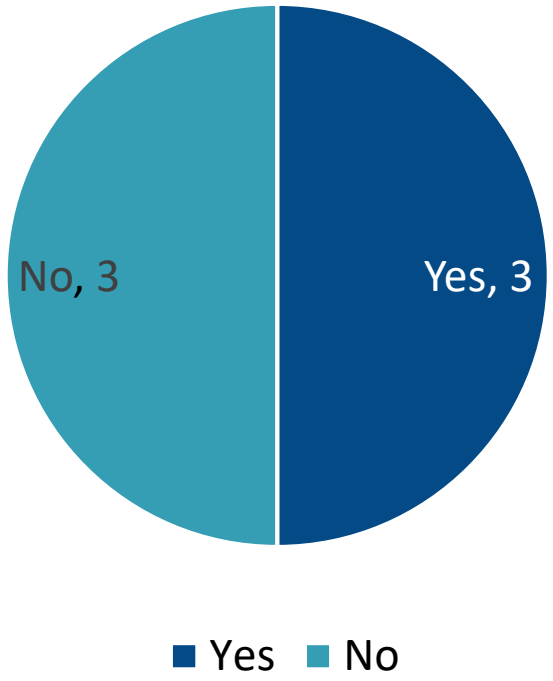
There are enough healthy food options that I like.



Findings

Participant satisfaction at 6 months (intervention group)

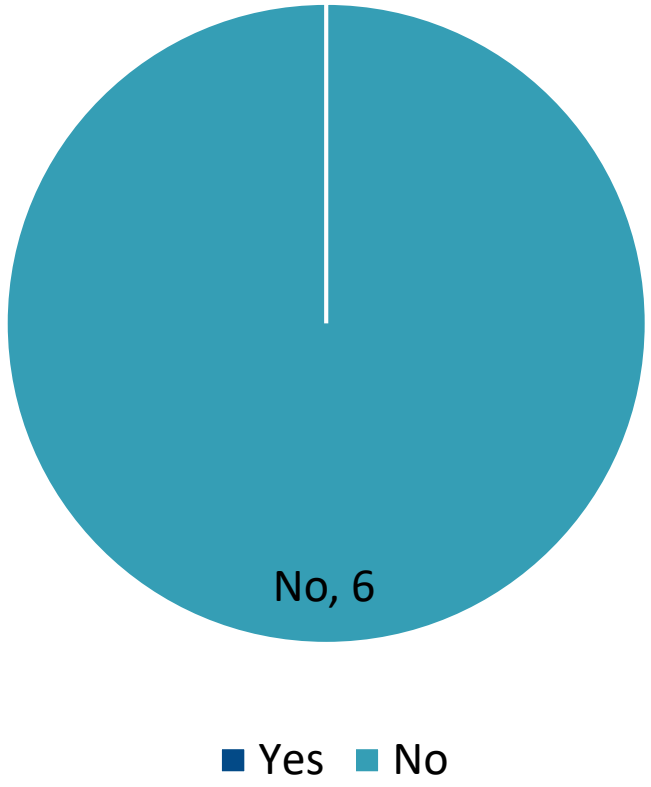
Have you been able to use the nutrition information you receive from Ibis?



Findings

Participant satisfaction at 6 months (intervention group)

Have you been able to use the recipes you receive from Ibis?



Findings

Key Findings – Study Experience

- Barriers to adoption of intervention
  - Acute care was a time of higher stress and clients were pre-occupied with health issues
  - Contact lost with people not immediately discharged to home
  - COVID made co-locating recruitment staff in hospital challenging
- Sources of study attrition
  - Participants at end of life
  - Compliance with Ibis use/receiving meals

"I would say the referrals who are really proactive and express excitement about the project from the beginning, are those who tend to be the most engaged throughout the process and [have] the most success in the program."

- Intervention staff member

Findings

Key Findings – Intervention

Most valued supports

- Vitals monitoring
- Check-in calls/reminders

Least valued supports

- Recipes
- Nutrition information

Findings

Recommendations

- Adoption of nutrition and chronic disease self-management technology and supports may be more successful outside of acute care settings. Prior to hospitalization or in primary care are potential settings for more effective intervention.
- Meals on Wheels intervention dosage may be optimal for nutrition, but practically was not ideal for some study participants.
    - Participants reported discarding, freezing, or giving meals to others.

Findings

Recommendations

- Flexibility is key when offering supports – flexibility in meals options and volume, flexibility in interactions with health monitoring technology.
- Pilot interventions in recruitment settings and with target populations to gauge potential adoption.

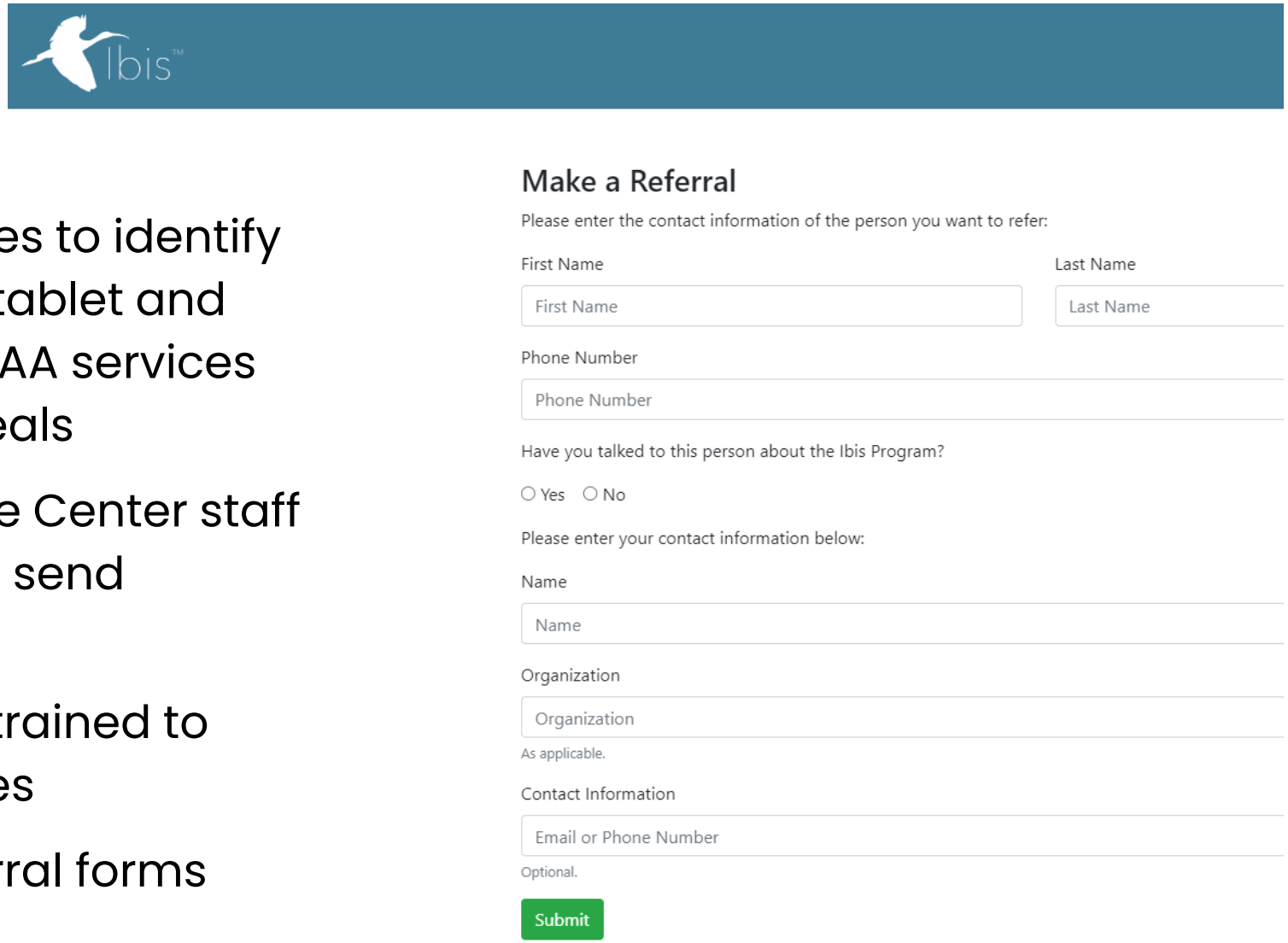
Findings

Staff Quotes – What patients want

- “They want routine and they want contact with a person who consistently reinforces the great work they're doing.”
- “I would say two major themes are flexibility and privacy. Of the denials for the program [the older adult] would say ‘oh I don't want to have to eat those meals and be tied to a tablet every day.’ [And] some folks wouldn't want to release their health information, didn't really understand where it was going or what the purpose was and also …allowing to have consistent contact with a patient representative, as well as the meals on wheels.”
- “…they want the nutritional support, they like telehealth support. They don't like interacting with the computers and things like that, but they want the support. I think it's super important that if it's an older adult that's not tech savvy to have a caregiver that can help them.”

Sustainability

- St. Joseph's Hospital continues to identify patients that need in-home tablet and monitoring devices and/or AAA services including Home Delivered Meals
- Aging and Disability Resource Center staff at AAA trained to screen and send referrals for Ibis
- Senscio Health System staff trained to send referrals for AAA services
- Online HIPAA Compliant referral forms



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Innovations in Nutrition Programs and Services

Modern Maturity, Meals on Wheels, WeCare

Kemi Sani, Personal Health Nurse™ DNP, MSN, APRN, FNP-BC, CRNP

Project Overview

Project Layout–the 2019 project genesis had three basic premises:

1. **Meals on Wheels** Home Delivered Meals (HDM) naturally selected a population with unique and frequently difficult needs much broader than medical services.
2. **Meal delivery staff and volunteers** represented unique resources serving the HDM individuals, maybe even trusted relationships with frequent contacts and connections.
3. **Connections** amongst the HDM person, the individual recipient and a nurse titled Personal Health Nurse™ might represent a unique and useful resource to the individual client.

Project Overview

The Major Findings

1. Needs are greater than expected.
2. Resources are scarcer than expected.
3. The meal delivery staff and volunteers are trusted friends, more like family.
4. When circumstances deteriorate, it's frequently **FAST and complete**.
5. A Personal Health Nurse™ is uniquely oriented, trained, suited, and trusted to fill gaps with community resources.

Project Overview

Project Goals-directly from the grant
"To use daily contact with HDM volunteers as an opportunity to improve the wellbeing and quality of life of homebound seniors and contain/reduce pm/pm (per member/per month) Medicare/Medicaid costs".

Project Objectives-Long Term Strategic

1) Strengthen the local coordination of care/services for seniors who are aging in place.
2) Address medical and life-compromising crises before they happen (thus preventing
medical and non-medical crises, costly emergency room visits and hospitalizations).
3) Contain and reduce pm/pm (per member/per month) costs, thereby freeing up more federal
and state funds to support more seniors aging in place.

Project Overview

Project Objectives-Short Term

1) Ensure that every HDM recipient has a medical home and has had an annual Medicare visit.

2) Ensure that every HDM recipient has a designated health care advocate, proxy or Care Coordinator.

3) Identify critical indicators of potential medical and non-medical crises that lead to costly emergency room visits and hospitalizations and create a simple Wellness Checklist that would be administered to HDM recipients.

Project Overview

Interventions is kind of a misnomer. When the Nurse goes along with the meal delivery person and is introduced, the positive response is almost 100%. It's not an intervention. It is more a welcome and needed relationship. They are ready to talk and tell about their needs.
The process is simple, sign up and execute release forms, assess any obvious current problems, add them to the call list, and weekly contacts and relationships unfold. The extension of the person's resources is a simple, logical, and useful added relationship in their lives.

Project Overview

Research brief excerpts from the University of Delaware January 2022 year two report.

Researchers at UD completed four data collection and analysis efforts over the past year. These data sources included:

1) client interviews;
2) nurse advocate interviews and related content provided by WeCare;
3) client baseline data review and collection using Delaware Health and Social Services Home-Delivered Nutrition Services Specifications;
4) participant registration data regarding status of their medical home; and,
5) logs of nurse advocate weekly calls to participants. A review of each effort and its findings is presented below.

Project Overview

Research continued, University of Delaware Findings

1. *Clients benefit from WeCare's weekly, individualized check-in calls.*
2. *"I have to use a CPAP machine and I've had a lot of trouble getting the machine that I have repaired. It took five and a half months and she made calls for me and spoke with my doctor and spoke with the people who were going to repair it. And she just took a lot of the frustration off my shoulders that I was having with the company."*
3. *The program has succeeded in creating a collaborative relationship between WeCare, MMC, physicians, insurance companies, home health agencies, and clients.*
4. *In one case, WeCare, through the nurse advocate, coordinated husband/wife cancer care, so they went to the same oncologist instead of two different providers.*

Project Overview

Delaware Health Information Network (DHIN)

- Claim data has been requested from DHIN.
- Scheduled to have reports by last quarter of 2022

Partners/Stakeholders

1. Education Health and Research International
2. Modern Maturity/WeCare
3. DSAAPD
4. University of Delaware
5. LaRed Health Center
6. Highmark

Findings

Stories, the magic is in the client stories, literally hundreds of day-to-day stories.

1. **Recent,** lady, terminally ill, on hospice, stuck in ICU, red-tape didn't allow discharge without assured place to go, in the interim, Sara took her Mac & Cheese in the evenings, resolved the issue, moved to safe, comfortable place for her end of life.
   Result: avoided extended ICU stay and probably prevent being on a vent.

2. **Veteran**, needed procedure, could get to the parking lot, no way to get in facility, resolved that, found his walker too wide for his home, plus no bars in bathroom,.
   Result: client got procedure needed, new narrow walker, bars installed, improved home safety.

3. **Client** couldn't get meds, or other mail communication, mailbox down.
   Result: mailbox repaired, reconnected with outside world beyond his home.

Sustainability

There is broad understanding and support for the almost universal nature, value and return on investment of the WeCare Personal Health Nursing™ services.

The original grant expected to “improve the wellbeing and quality of life for homebound seniors”. This has been proven and superseded.

Further, early evidence is that while improving life, it improves plan cost.

A next step is the recent grant for Chronic Disease Self-Management Education commenced May, 2022

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Connecting Seniors to Care

Martin Cominsky, President/CEO

Leslie Kian, Director, Meals on Wheels Healthcare Innovation

Interfaith Ministries for Greater Houston

IM
INTERFAITH MINISTRIES
FOR GREATER HOUSTON

MEALS on WHEELS
GREATER HOUSTON
&
GALVESTON COUNTY

Connecting Seniors to Care Project Overview

- **Goals & Objectives**
  - Determine if meal delivery from Meals on Wheels, in combination with a virtual assistant device (Amazon Echo Show), can improve patient/client health outcomes and enhance caregiver satisfaction in older adults with memory impairment.

- **Innovation in Nutrition**
  - With COVID-19 and other isolating issues for seniors, this project will explore the ways that a virtual assistant device can support the social determinants of health together with Meals on Wheels deliveries to improve health outcomes for older adults.

Connecting Seniors to Care Project Overview

Cohort #1 – Medical Study

- Partnered with Jessica Lee, M.D., geriatrician and researcher at University of Texas Health Science Center, to serve as the study's principal investigator
- Collected physical and mental measurements in a three-phase study over 18-weeks with 52 clients enrolled
  - Required Internal Review Board (IRB) approval
- Utilized Patient Care Intervention Center (PCIC) platform for data collection along with a professional biostatistician for results analysis

Connecting Seniors to Care Project Overview

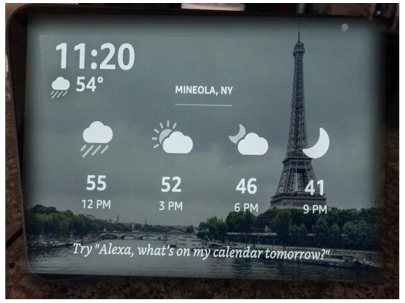
Cohort #2 – Pilot Program

- 12-week Feasibility study assessing the acceptance and usage of technology (Alexa) in 58 client's homes
- Utilized a custom-built Amazon skill to promote well-being
- Leveraged Amazon's innovative device management platform (Alexa for Senior Living)

Cohort #1: Three Phase Study

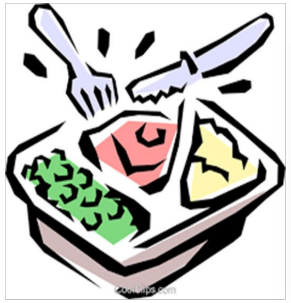
* **Phase 1- Meal Delivery**

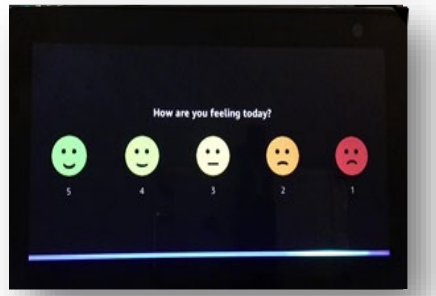
*



Phase 2- Meal Delivery + Basic Alexa Usage on Amazon Echo Show Device

*





Phase 3- Meal Delivery + Advanced Alexa Usage *

(5) Health & wellness questions twice weekly by study coordinator

(5) Health & wellness questions twice weekly by Alexa Echo Show

* Study Team visit for physical and mental measurements *(4 visits per client)*

Cohort #2: Pilot Wellbeing Skill

Developed a custom-built Amazon skill to provide a wellness menu promoting:

- Mental well-being
- Physical well-being
- Spiritual well-being
- Caregiver well-being
  - Collaboration with OnGuardian: https://www.onguardian.io/

Note: Minimal functionality, limited/static content for pilot purposes

Connecting Seniors to Care: Findings

- Interactions with the Alexa via audible and visual, including touchscreen capability
- Alexa allowed our clients to:
  - Play music specific to genre, artist, etc.
  - Set reminders for appointments, medication, etc.
  - Watch videos
  - Find recipes
  - Check the weather, traffic, bus schedule
    - Including severe weather alerts
  - Ask for information, definitions, news, and more
- Adaptive learning to client's requests (*Artificial Intelligence, AI*) can personalize interactions

Connecting Seniors to Care: Findings

- Technology acceptance was **positive**
- Voice-Based AI technology enabled clients to interact with ease
- Qualitative data indicates this technology is useful, friendly, and extremely favorable among our clients
  - “I love Alexa”
  - “Alexa is my friend”
- More clients had access to Internet than expected
  - Cohort #1 used T-Mobile hotspots vs. Cohort #2 used Wi-Fi
- More proactive interactions are desired for future success

Sustainability: Meals on Wheels “Plus” with Alexa

- Potential future value add to Well-being Skills:
    - Reducing isolation
        - Alexa interactions
        - Video conferences and Drop-ins (e.g., lunch with a friend)
    - Promoting good health
        - Physical, Mental, Spiritual with managed, customized content
    - Improved care coordination connecting with caregivers
    - Meal(s) information (e.g., menu choices by client)
    - Providing health tips
    - Conducting survey(s) and soliciting feedback
    - Requesting services

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Thank you!

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Interfaith Ministries for
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Food 911: How Meals-on-Wheels Redefines Population Health

Leah Bunck and Melinda Rowe
LifeCare Alliance
Columbus, Ohio

Project Overview – Original Plan

- Cultivate relationships with fire departments/healthcare systems to reduce emergency room visits for seniors in urban, suburban, and rural areas
- Use MOU/BAAs to exchange information and enhance all stakeholder resources
  - Community Paramedicine vs. Fire Chief and Team
- Follow clients with Frailty Scale every 90 days measure impact of HDM and other services
  - Pre-COVID referrals vs. Post COVID All OOA MOW Clients

Project Overview – Original Plan

- Diabetes Counseling/Medical Nutrition Therapy- Phone and Home
- Who: 5 formal partnerships, assessment team, registered dietitians, lead researcher, and Healthcare Economist
  - Bonus: occupational therapist

Findings – Our Pivot for the Better

- Referrals from Formal Partners
  - Not enough
  - Client level of need past MOW
  - Embedded staff helps, but lots of time and resources
- Frailty Scale Findings
  - Stable or slight improvement with Nutrition
  - Decline in mobility- Fall Interventions, OT, and durable medical equipment

Findings – Our Pivot for the Better

- Diabetes Counseling and Medical Nutrition Therapy
  - Move from external referrals to internal referrals
  - Enhancement of already provided services
  - Meet demand of increase clients and needs

Sustainability

An unexpected great turn!

- Innovation in Nutrition Grant- Part 2
- Working on creative partnerships with local AAA's
- Bill insurance when possible
  - Push for insurance to cover more health conditions on MNT
- Social Enterprise and Fundraising

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East Harlem Village

Ailin Liu, MS – Senior Program Manager, Food Initiatives

Laila Khundkar, MPH – Deputy Director, Community Health & Nutrition Access

Needs

- East Harlem, NYC
  - Has a strong Latin, Caribbean, and African American presence. Rising Asian American population.
  - One of the most food-insecure neighborhoods in NYC, and home to multiple public housing developments and Naturally Occurring Retirement Communities (NORC).
  - Needs include activities that support community engagement, empowerment, and social justice; a system that improves and quantifies connections to a broad range of needed services; and avenues for sustaining impact through steady sources of funding

Project Overview

- East Harlem Village (EHV) is a community services network led by Public Health Solutions (PHS) in partnership with Carter Burden (CBN) and other community organizations in East Harlem to combat food insecurity and social isolation among older adults 60+ and help them age in place with dignity.
- EHV helps East Harlem older adults age in place by adapting the "Village Model," and reducing barriers to aging in place (i.e., food insecurity, social isolation, and low income)
  - Community members will identify their needs and the menu of services needed
  - We ensure the ability of the network of organizations to address these needs, streamline communication between service providers and facilitate problem-solving, and are directly responsible to the community.
- Network convening meetings hosted with providers and community members build opportunities to engage older adults in leading, organizing, and advocating for their community.

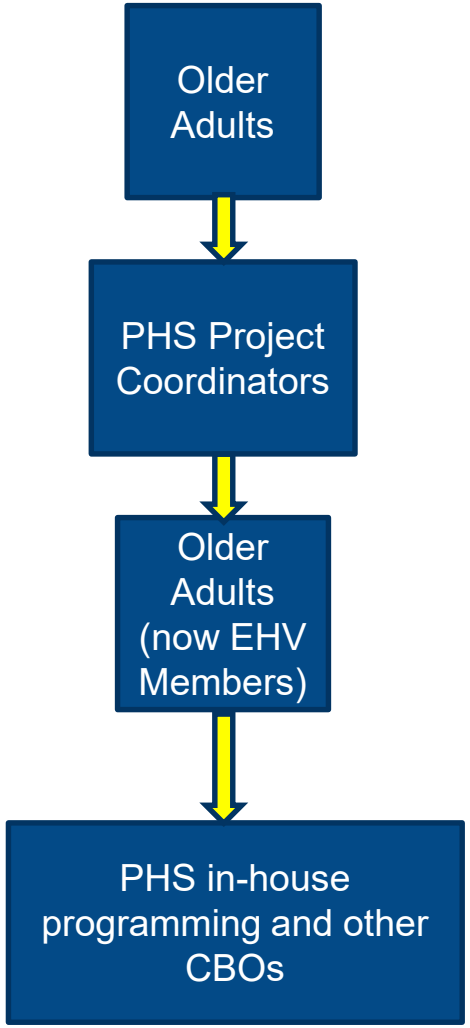
Project Overview

- EHV offers:
  - Combating Food Insecurity
    - Emergency food support to NYCHA and East Harlem residents
    - Ongoing SNAP, Health Bucks, and free food bag delivery program
  - Combating Social Isolation
    - Hybrid nutrition curriculum with a food justice component
    - Walking tours with RD (grocery store, farmers market)
    - Workshops (e.g. food justice, urban farming, and community gardens)
    - Conversations on food, family, and cultural tradition
    - Conversations on food access, food security, social determinants of health
    - GetConnected Campaign – loan tablet, free internet, technology training

Intake

- **Dynamic referral platform to screen older adults**
  - Food Insecurity (USDA Hunger Vital Sign)
  - Mobility - Activities of Daily Living (ADL)
  - Eligibility for SNAP and emergency food services
  - Needs for nutrition education, socialization, technology support
  - Older People's Quality of Life Questionnaire (OPQOL-13)

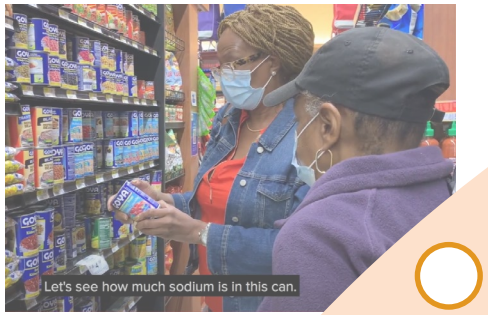
- Referrals are sent directly to CBOs and we can see outcomes in real time.



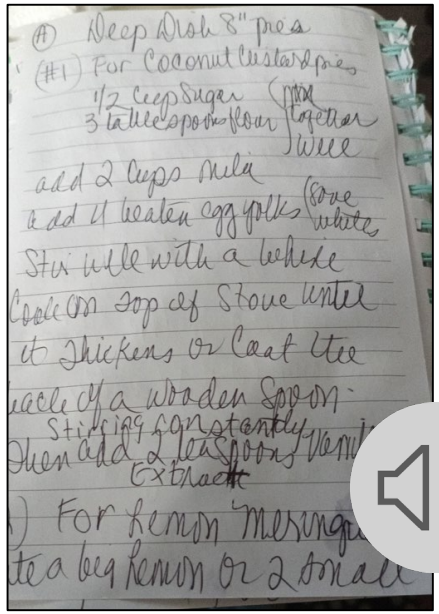
Project Overview – Timeline

Combating Social Isolation

- *We encourage members to voice their needs and we build our programming around them.*



- Guided Community Conversations
- Food and Racial Justice Conversations
- Connection to Familial and Cultural Roots
- Grocery Store and Farmers Market Tours
- Heathy Eating Curriculum
- GetConnected Campaign

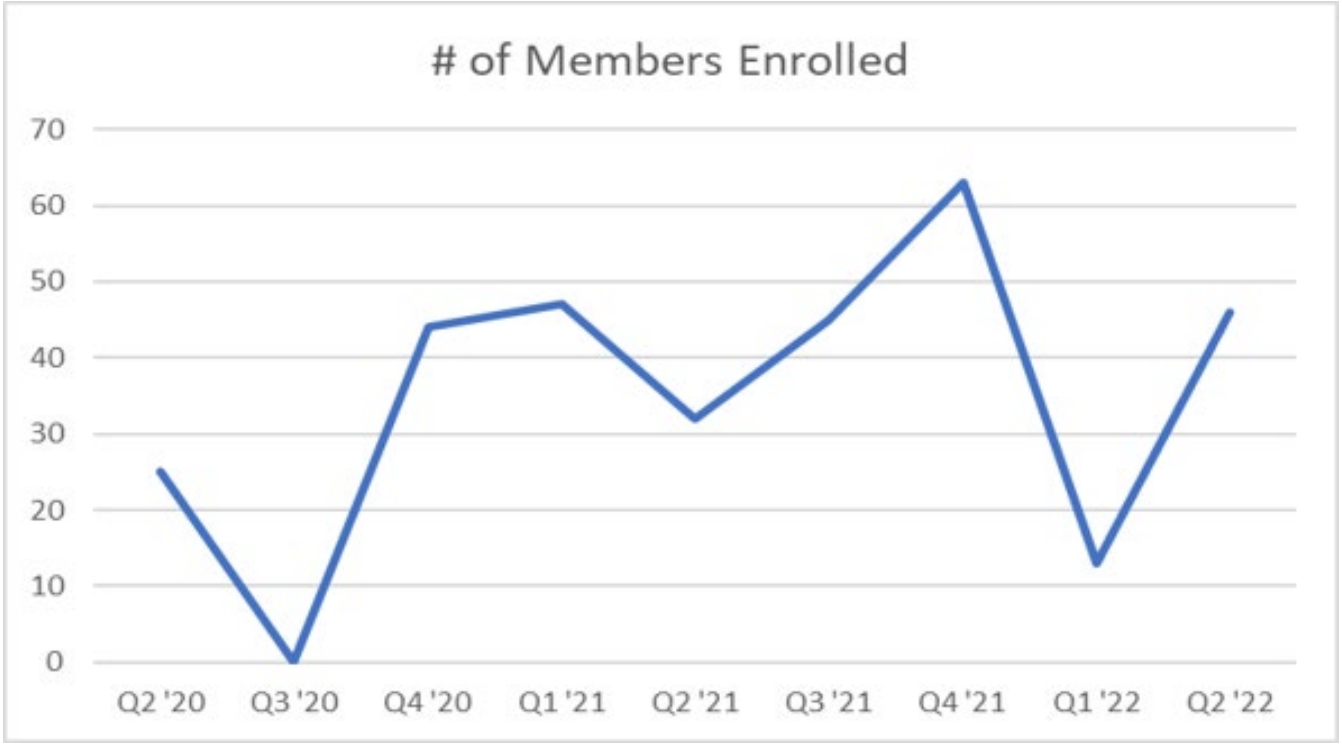


- **Sustainability & Self-Advocacy**
- **Livable Community**
- **Community Empowerment**

From Legacy Cookbook Series: a family-made Coconut Custard Pie recipe shared by an EHV member.

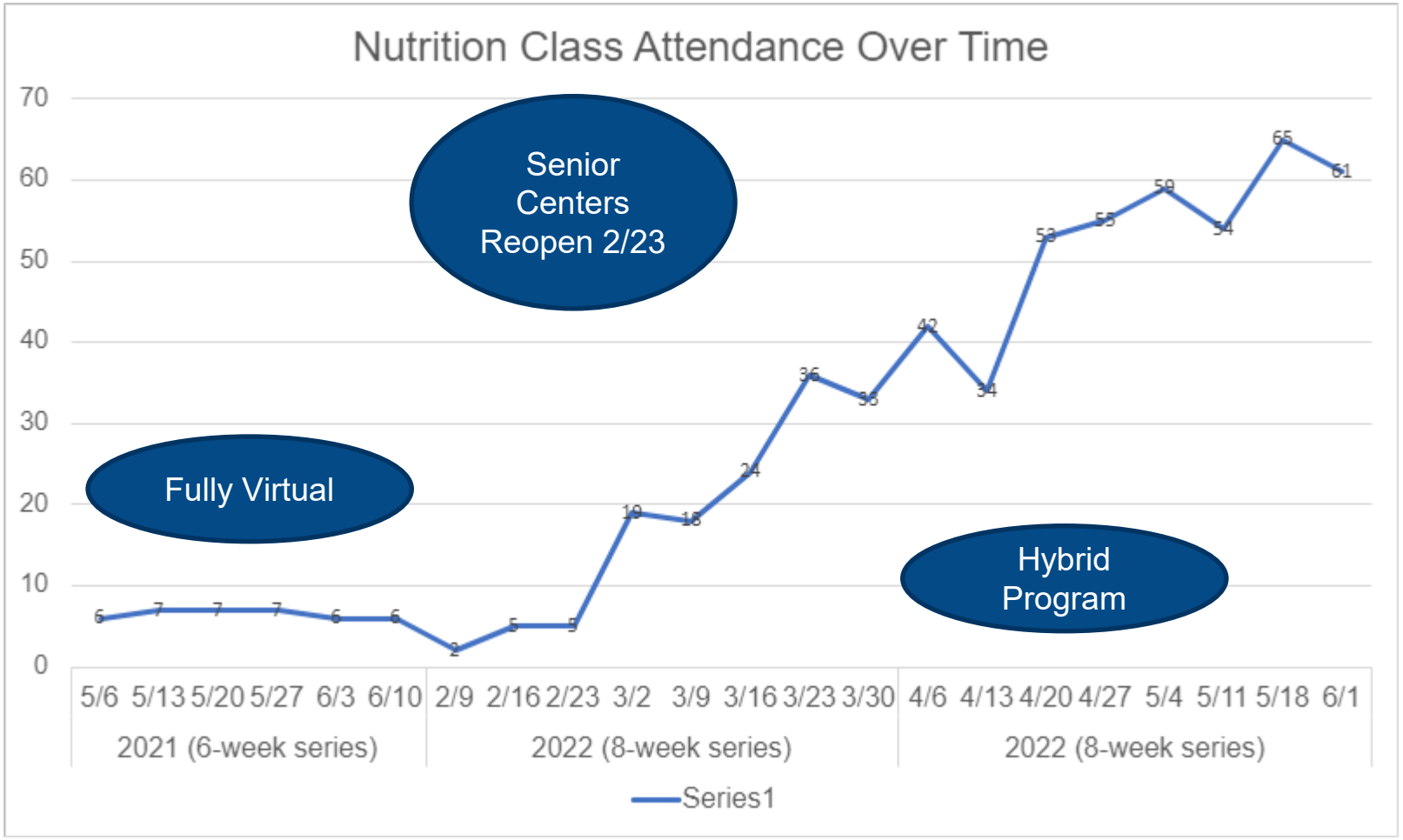
Findings – Overall Participation

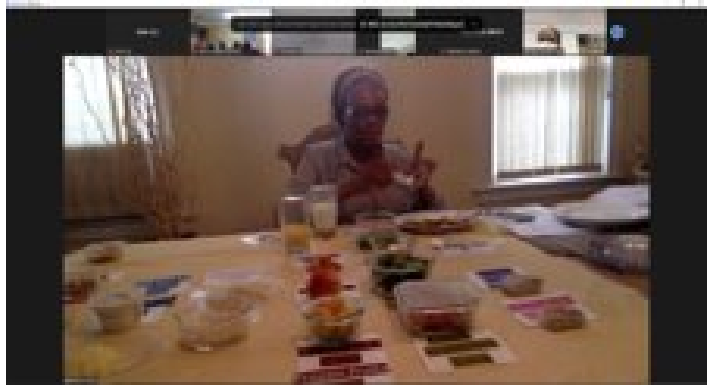
	Members Enrolled	In-Network Referral	EHV Programming	Other Referrals
Total # since project launch	321	201	443	214



Findings – Hybrid Nutrition Education

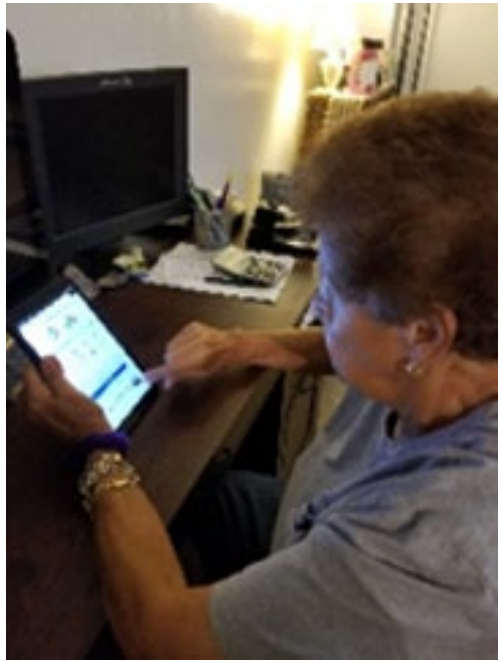
142 Unique Participants (2022)
Initial 8-week series was extended another 8 weeks because of gathered interest





Findings – Programming Data

	Total participation	Avg. participation /session	Note
Grocery Store and Farmers Market Tours	13	2-3	Total of $364 Health Bucks distributed between 5 tours, Aug-Nov 2021
Life Story Club: Legacy Cookbook Series (6-week)	15	10-15	Majority of participants surveyed expressed an increase in social connection
Workshops	77	26	Topics: Black History Month, Urban Farming and Community Gardening
Guided Community Conversations (6 sessions)	58	23	Six Topics: Community Foodways, Housing Facilities, Neighborhood Safety, Social Services, Financial Support, Community Health Needs
GetConnected Tablet Pilot	49	N/A	Majority of participants surveyed expressed an increased comfort level with their tablet, interest in new tech classes and other uses of their tablets

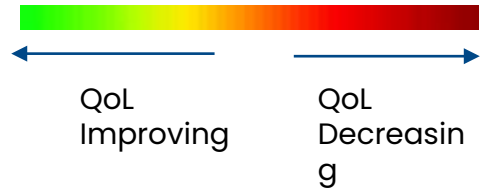


Findings – Quality of Life

Quality of Life Score Changes Among EHV Members

- Initial assessment when members join, 6-month follow-up assessments
- Using the Older People's Quality of Life Questionnaire Brief (OPQOL-Brief)
  - *Higher Score = lower QoL (1 is the best score for each question)
  - *14 Total Questions Asked, Min score = 14, Max = 70
  - Score below 28 are considered Improved/Good Status QoL
  - Score above 28 are considered In Need of Improvements QoL

	Average initial score (n=263)	Average score Follow up #1 (n=50)	Average score Follow up #2 (n=9)	Average score Follow up #3 (n=1)	Change from initial to Follow up #1**
Overall QOL*	31.45	31.49	33.78	24.00	0.04
Thinking about both the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole?	2.46	2.71	2.67	2.00	0.25
I enjoy my life overall	2.23	2.20	2.56	2.00	-0.03
I look forward to things	2.02	2.10	2.22	2.00	0.08
I am healthy enough to get out and about	2.73	2.63	2.56	1.00	-0.10
My family, friends, or neighbors would help me if needed	2.15	2.06	2.33	2.00	-0.09
I have social or leisure activities/hobbies that I enjoy doing	2.49	2.80	3.00	2.00	0.31
I try to stay involved with things	2.18	2.14	2.56	2.00	-0.04
I am healthy enough to have my independence	2.47	2.39	2.56	1.00	-0.08
I can please myself in what I do	2.13	2.04	2.22	1.00	-0.09
I feel safe where I live	2.12	2.12	2.33	1.00	0.00
I get pleasure from my home	1.92	1.96	2.22	1.00	0.04
I take life as it comes and make the best of things	1.93	1.84	1.89	1.00	-0.09
I feel lucky compared to most people	1.92	1.88	1.89	1.00	-0.04
I have enough money to pay for household bills	2.79	2.61	2.78	4.00	-0.18



Sustainability

- Harlem Health Advocacy Partners
  - Community Health Worker initiative
    - Community Engagement, advocacy, and workshops
    - Health coaching
  - Focused in Central and East Harlem
  - 6-year funding, through June 2028
- Continued partner network and referral platform activities
- Older Adult-focused SNAP, Food access, and Nutrition Education
- Medicaid Waiver & SDOH funding

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Texas Congregate Meal Initiative (TCMI)

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Public Policy Research Institute, Texas A&M University

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Independent Consultant, Texas HHSC

Grantee Meeting in Iowa, August 4-5, 2022

TCMI Project (2019-2022)

Project Goal: Modernize congregate nutrition programs in Texas

PHASE 1

Research & Gap Analysis

- Surveys of individuals 60+ and senior serving orgs
- 29 Focus Groups with 28 AAAs and Nutrition Providers
- Survey of Community Health Providers

PHASE 2

Coach & Prepare

- 16 Meal Provider Proposals ($2,500 each)
- 6-Month Targeted Learning
- Learning Collaborative Workshop & TA

PHASE 3

Implement & Evaluate Pilots

- 16 Pilots ($7,500 each)
- 7-Month Implementation
- Evaluation to develop Texas specific evidence base

PHASE 4

Share Results

- 3 National Conferences
- 2 Academic Journal Submissions
- 1 State Summit to showcase best practices

Project Partners: Texas A&M Public Policy Research Institute & Mays Business School, Texas HHSC, SNAP-Ed, 16 Texas AAAs, 16 local nutrition providers, various CBOs

TCMI Learning Collaborative

01

Selection of 16 Pilot Nutrition Providers

Virtual 3-Day Workshop Kick-Off October 2020

02

03

Targeted & Tailored TA Curriculum, Peer Learning Facilitated by SMEs

Implementation & Evaluation of TCMI Pilot Innovations & Outcomes Sharing

06

05

Innovative Pilot Categories

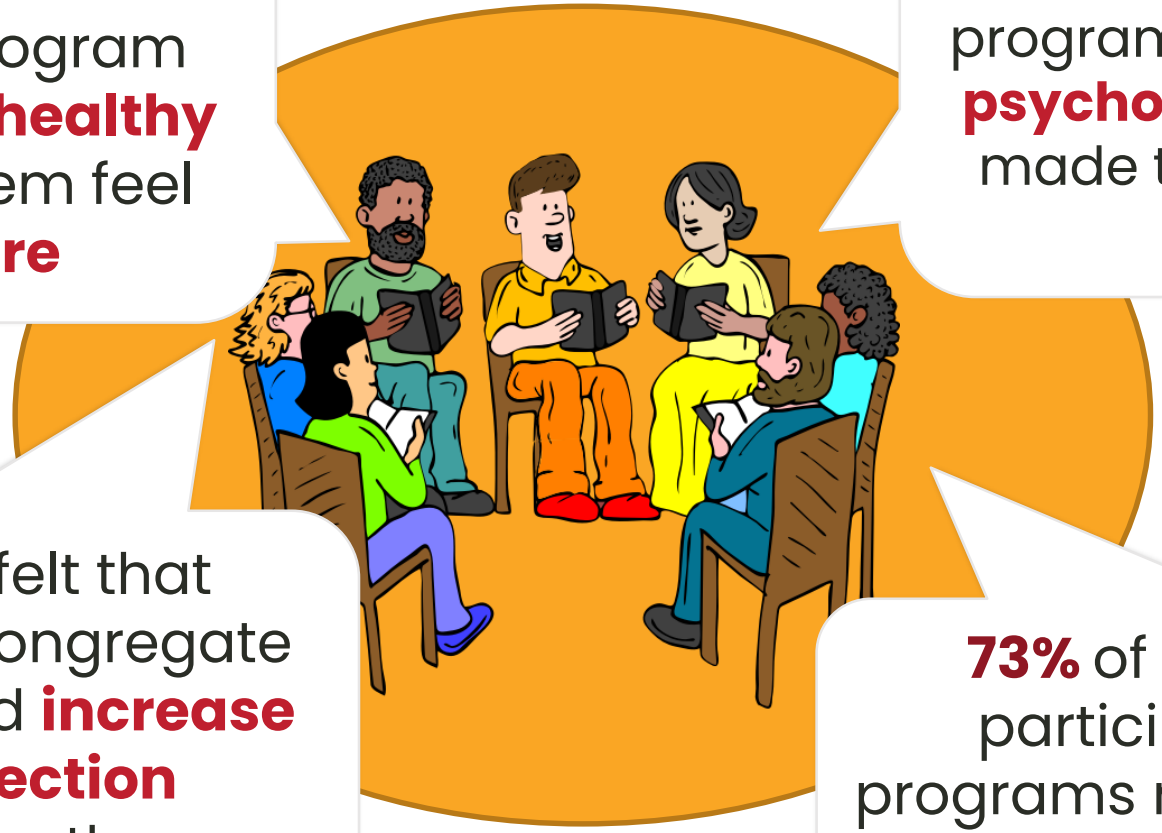
Development & Refinement of Innovative Low-Cost Business Plans

04

TCMI Client Outcomes

73% of the clients felt that participating in the congregate meal program helped them **access healthy meals** and made them feel **more food secure**

About **70%** of the clients stated that the congregate meal programs helped **improve** their **psychological well-being** and made them **feel less sad and anxious**



83% of the clients felt that participating in the congregate meal program helped **increase** their **social connection opportunities** with others

73% of the clients felt that participating in the meal programs made them **feel better overall**

TCMI Program Manager Outcomes

71% of providers felt their TCMI pilot **increased access** to vulnerable under-served Older Adult clients

89% of providers feel their community **is more aware** of the congregate program thanks to the TCMI pilot

89% believed that participating in the CMP helped **increase** their participant **social connection opportunities** with others

89% believed that participating in the CMP made their participants **feel better**

77% believed that participating in CMP helped their participants access healthy meals and made them **more food secured**

80% believed that participating in CMP made their participants feel **less sad and anxious**

Marketing Strategies

- **93%** found this helpful

Interaction between Sites

- **93%** found this helpful

Program Development & Business Skills

- **87%** found this helpful

Technical Assistance

- **80%** found this helpful

Other States

- **67%** found this helpful

Promising Practices

Low-Cost Innovations

Site Ambience

- Reorganizing seating, paints and decor

Small Equipment

- Lower-cost items (coffee maker, smoothie machine).
- I-Pads, Laptops, Pedometers, BP Check Instruments

Volunteer Staffing

- 56% of all sites utilized **external** volunteer support
- 63% of all sites utilized **older adult participant** volunteers as models

Donations

- Monetary donations, sponsorships (e.g., Bingo rewards) or item donations (ex: blood pressure cuffs, Masterclass subscriptions)
- Donation or “honor system” payment to create buy-in

Promising Practices

Community Partnerships

Businesses

- Advertising Agencies, Restaurants, Craft Stores

Civic Organizations & Special Interest Groups

- Rotary, Lions Club, AARP, Local Clubs

Other Non-Profits & Faith-based Organizations

- Food Banks & Pantries, Churches

Local Government , Healthcare & Local Schools

- Parks & Rec, Health Dept., Hospitals, Community Colleges, Culinary Schools, Local Industries

Promising Practices

Marketing & Outreach

Community Resources

- Outreach Events, Health Fairs including COVID 19 Immunization events (San Antonio)
- Community Night-Out Events, Parades (Amigos)

Healthcare Systems

- Senior Townhall Meetings introducing New Telehealth Kiosk (Dallas); Health focused Open Houses with Vaccination Camps (Amigos)

Social Connection & Outreach: Myriad Media

•Marketing videos, flyers, posters, mailouts, telephonic contacts, virtual internet sessions, billboards, advertising on local radio stations & television

•Presentation to senior housing & other senior communities (Amigos, Waco)

Promising Practices

Sustainability

Grants, In-Kind Support

- Equipment, facilities, technology purchase, telehealth volunteers, other external grants

Local government

- Location for the sites, monetary support, coordination assistance at local levels

Pay for Service

- Donations from seniors, Coffee for $0.50

Using Volunteers

- Curriculum from cooking, technology or craft classes as well as nutritional & health education
- Using volunteers from local educational institutions including nursing schools

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Implementation of a Collaborative Malnutrition-Focused Transitions of Care and Referral Process Between Healthcare Entities and Aging Services

Susan Saffel-Shrier MS, RDN, CD,
Professor, Certified Gerontologist

Project Overview

Transitions of Care Definition

"A set of actions designed to ensure the coordination and continuity of care received by patients as they transfer between different locations or levels of care." (E Coleman)

"Every transition of care involves a *throw* and a *catch*."

Project Overview

Multisystem Fumbles

- Transitions of care are complicated
  - Disjointed process
  - The ball (care) often fumbled
  - Malnutrition underrecognized
  - Older adults greatest risk

Project Overview

Malnutrition Defined

An acute, subacute or chronic state of nutrition in which varying degrees of overnutrition or undernutrition have led to a change in body composition and diminished function.

Project Overview

Partners/Stakeholders

- Administration on Aging ACL grant
- Four Area Agencies on Aging- Northern Utah
- University of Utah Post Acute Care Collaborative
  - Home health agencies

Project Overview

Project Goals

Primary

- Reduce re-hospitalization among malnourished older adults

Secondary

- Improve functionality, QoL, nutritional status, mental health, & coordination of services

Project Overview

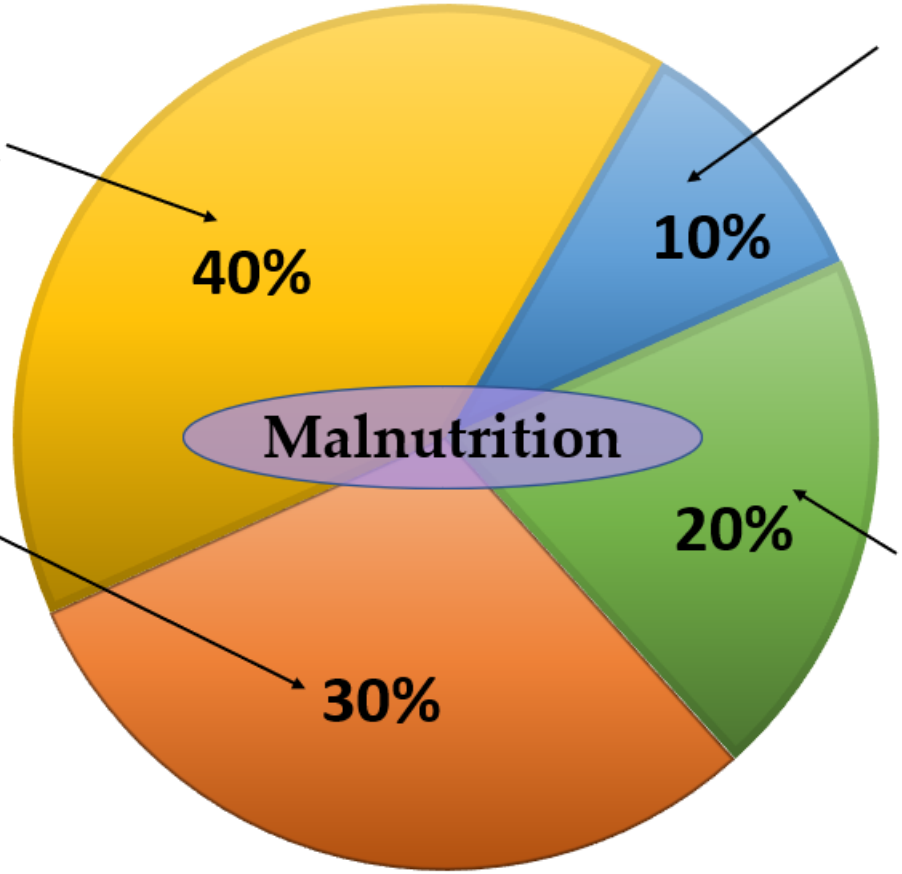
Intervention/Research Conducted

Study Objectives

- Appraise role of community RDN in assessing malnutrition
- Identify essential malnutrition assessment components
- Utilize electronic malnutrition data capture application
- Analyze malnutrition root causes

Project Overview

Malnutrition- Social Determinants of Health (root causes)



Socio-Economic
-food insecurity
-low health literacy
-social isolation
-family support

Physical Environment
-physical impairments
-transportation
-adequate food prep
-access to food
-working appliances

Health Behavior
-self-efficacy
-resilience
-life satisfaction
-addictions
-food safety
-abuse

Medical Care
-illness (chronic-acute)
-incontinence
-sensory deficits
-medications
-depression
-cognitive impairment
-pain

Project Overview

Project Layout

Recruitment

- Older adults 60+ living in home and eligible for Meals on Wheels
- Recent hospitalization and positive malnutrition screening

Control group

- 1 & 6 month home nutrition visits with RDN
- Monthly phone calls

Intervention group

- Monthly home nutrition visits with RDN
- Monthly phone calls
- Personalized nutrition care plan

Project Overview

Intervention/Research Conducted

Systematic root cause approach to identify nutrition-related health problems. Performed by RDN.

Data include:

- Client history
- Food/nutrition history
- Anthropometrics
- Biochemical, medical or procedures
- Functional status
- Nutrition-focused physical exam
- Depression and cognitive screen

Findings

Preliminary Findings

- Met calorie and/or protein needs at six months:
  - Intervention: met=69%, not met= 31%
  - Control: met= 14%, not met= 86%
- NFPE score:
  - Intervention: improved= 94%, stayed the same= 0%, became worse= 6%
  - Control: improved= 29%, stayed the same= 29%, became worse= 43%
- Grip strength:
  - Intervention: improved= 63%, stayed the same= 13%, became worse= 25%
  - Control: improved= 63%, stayed the same= 0%, became worse= 38%

Sustainability

Moving Forward/Sustainability

- Continued malnutrition awareness
- Recognition of the need for malnutrition screening and ASSESSMENT
- Tools for referral and utilization of RDN's
- Recipient of ACL 2022 malnutrition grant for further RDN services

Nutrition and Aging
Resource Center

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Certified Gerontologist

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Thank You

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