MEALS ON WHEELS ANNUAL CONFERENCE AND EXPO

AUGUST 27-29, 2019

DALLAS, TX

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BEING THERE MATTERS: Physician Care Coordination in the Home

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WHO WE ARE

ACCA
ATHENS COMMUNITY COUNCIL ON AGING
Age Well. Live Well.

The mission of the Athens Community Council on Aging is to promote a lifetime of wellness through engagement, advocacy, education and support.

Health & Wellness

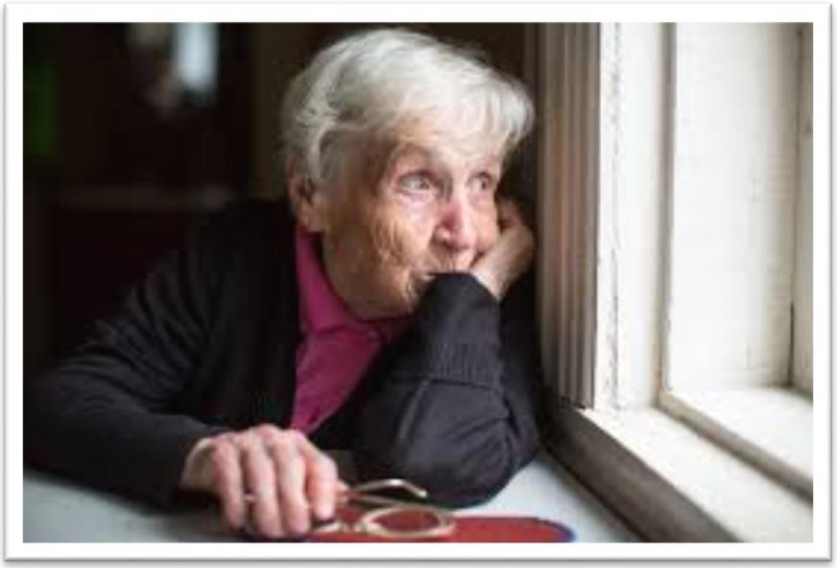
- Center for Active Living
- Adult Day Health
- Transportation
- Senior Employment Program
- GeorgiaCares
- Long Term Care Ombudsman

Meals

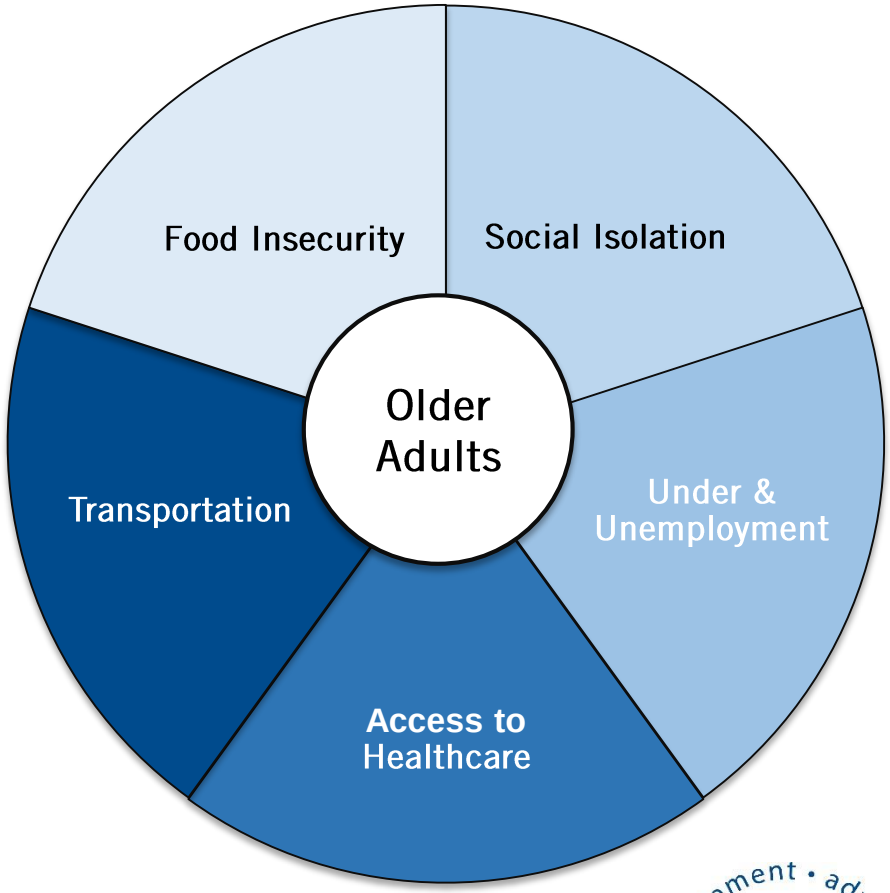
- Meals on Wheels
- Center for Active Living *Plus*
- Lunch Buddy
- Athens Senior Hunger Coalition
- Community Garden
- Good Measure Meals

Caregiver Support

- Geriatric Care Management
- Grandparents Raising Grandchildren
- Caregiver Education
- The Buddy Program
- Senior Companion Program



- **90%** live with at least one chronic disease
- **42%** are food insecure
- **70%** report barriers to routine healthcare
- **14%** admitted to the hospital at least one time in the last 12 months



engagement • advocacy • education • support
ACCA


ATHENS GA
CREATURE COMFORTS
Brewing Co.


NEGRC
NORTHEAST GEORGIA
REGIONAL COMMISSION


United Way
United Way
of Northeast Georgia


NATIONAL
FOUNDATION
TO END
SENIOR
HUNGER


ST. MARY'S
HEALTH CARE SYSTEM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Piedmont
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THE OFFICE OF
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FAMILY AND CONSUMER SCIENCES


ATHENS AREA
Community
Foundation


The University of Georgia
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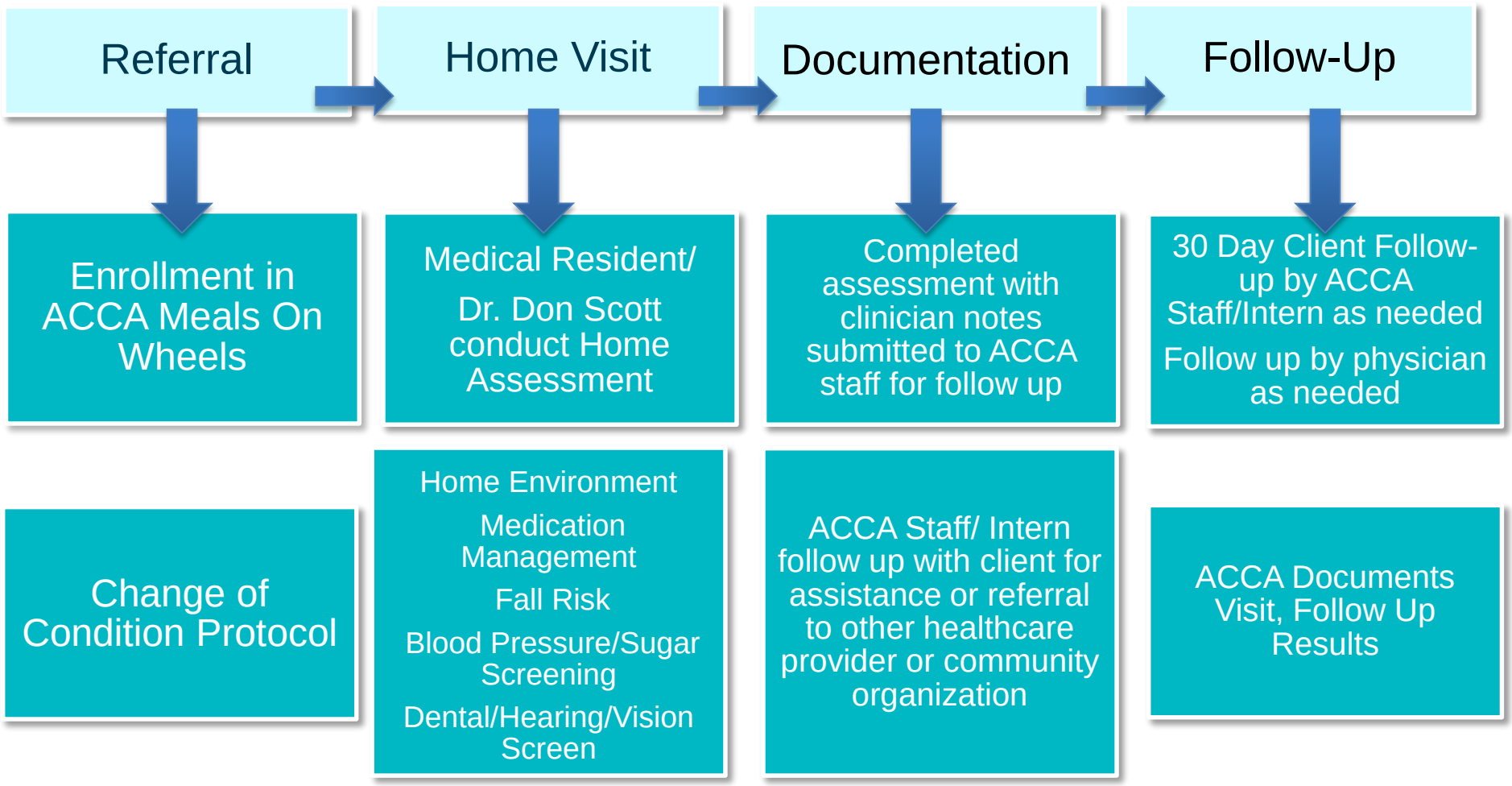
AARP℠

ACCA
ATHENS COMMUNITY COUNCIL ON AGING
Age Well. Live Well.

AUGUSTA UNIVERSITY
MEDICAL PARTNERSHIP
UNIVERSITY OF GEORGIA

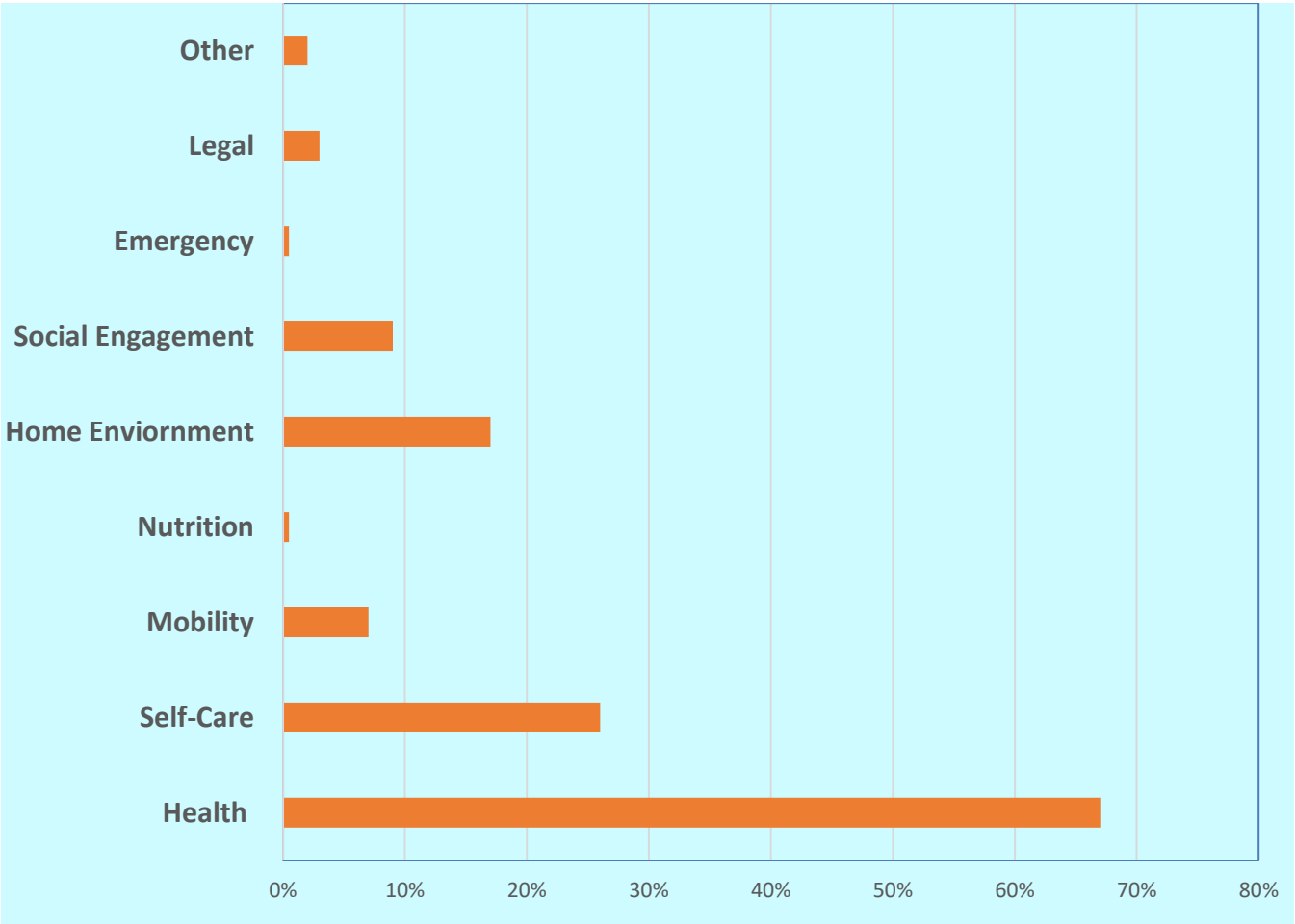
- Developed in collaboration between ACCA and AU/UGA Medical Partnership
- Designed to provide community-based learning opportunities for Medical Students and Residents while providing access to healthcare providers to an at-risk, homebound senior population
- Medical Students and Residents, supervised by a Geriatrician, visit Meals on Wheels clients in their homes.

PROGRAM DESIGN



RESULTS

In 2018-2019, students and residents completed **50 home visits** with **187 noted observations.**



CHALLENGES

- Staff Capacity
- Intern Utilization
- Physician Boundaries
- Communication
- Scheduling
- Self-Determination
- Barriers to Additional Help

IMPACT

95% report access to healthcare has increased

87% received additional help

92% report health has improved or stabilized

Habitat for Humanity®

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College of Veterinary Medicine
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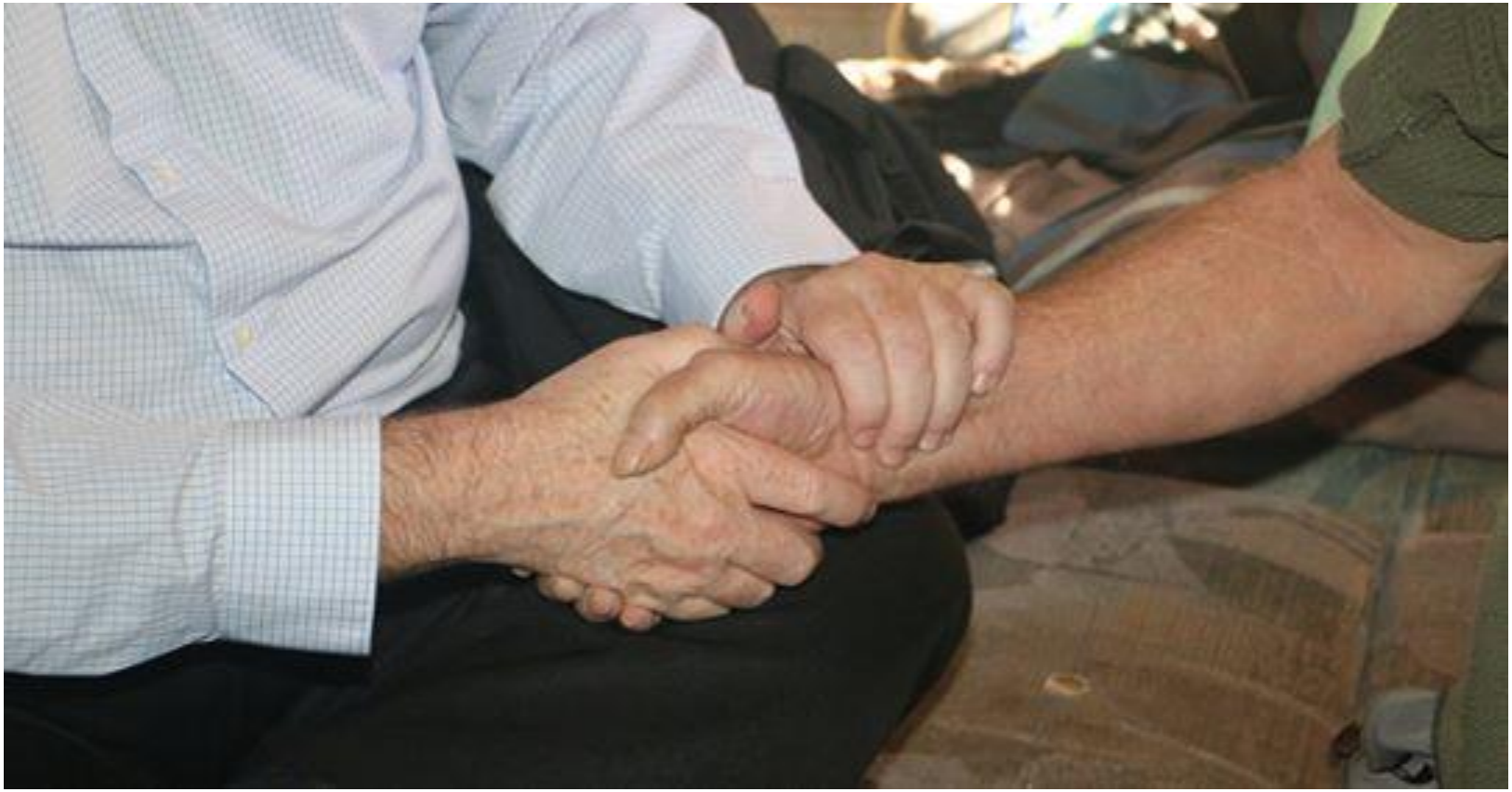
LESSONS LEARNED



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The Big Picture- Transitioning from Old to New

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ABOUT CAC MOBILE MEALS

- Knoxville – Knox County Community Action Committee (CAC)
- Meals on Wheels / CAC Mobile Meals: since 1971
- Mobile Meals Kitchen, an EatREAL Certified Kitchen

mobile meals

CAC
Knoxville-Knox County
Community Action Committee

Helping People. Changing Lives.

WHO WE SERVE

Knox County Current Population – 460,000

Meal Service

- Daily Delivery, Monday – Friday
- 925 Home Delivered
- 275 Congregate

Routes

- 70 Meal Routes
- 65 Volunteer Routes
- 100 Volunteers A Day: *1.3 Million Dollar Value*
- 5 Paid Driver Routes

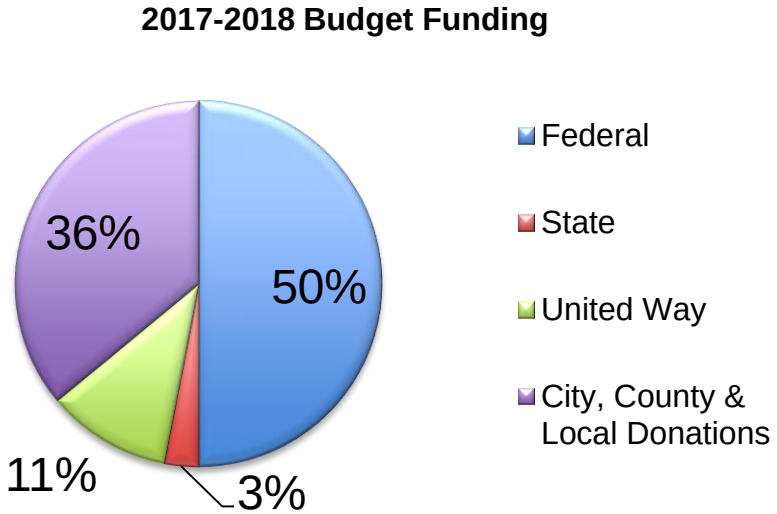
Menu

- Home delivered clients served a Choice Menu
- Regular & Alternative (Vegetarian/Fish)

Knox County Goal: No Waiting List

Previous approach

- Small fundraisers
- Annual large fundraiser
- Business funding and grants
- United Way
- City / County funding
- Large grants for new projects



PRIORITY RESET

Align your priorities to ensure that you are achieving your defined goals.

- **Review staff responsibilities**
  - Realigned employee roles, enlisted a CAC AmeriCorps VISTA service member
- **Evaluate fundraising**
  - Make sure manpower is available to staff events
- **Remember your volunteers**
  - Invested time and resources to help volunteers; volunteer focused staff, email, and cell phone

INFORMATION IS KEY

- **Locate additional income streams**
  - Looked for additional fee for service opportunities, e.g. Caring Plate
  - Explored healthcare meal service through webinars and conferences
- **Apply for grants**
  - Looked for grants that provide a skill set or funding to advance our program goals
- **Collect data- Keep your audience informed**
  - Gained insight to expand the types of funding that could help us serve more seniors
  - More Than A Meal grant data speaks volumes
  - Utilized media and social media
  - Spent more time showing the impact of what we do than asking for money or help

Mobile Meals Continues to Provide

MORE THAN A MEAL

Volunteer app users currently cover 7% of Mobile Meals clients

We have **19** *volunteers as well as* **12** *staff members trained and using the app*

We receive Wellness Alerts in real time

In less than two months of use:

68 changes have been reported on **60** unduplicated clients

- **24** *alerts regarding physical or mental health*
- **23** *alerts of an issue in the home environment*
- **8** *alerts of an emergency situation*
- **8** *alerts of an issue with self care*
- **3** *alerts regarding a nutrition concern*
- **1** *alert of a mobility issue*
- **1** *alert regarding social isolation*

leading to 37 referrals for service

Benefits of the app include:

- Quicker response time to client issues
- Better communication with volunteers
- A more environmentally friendly operation

STAYING THE COURSE

CHANGE TAKES TIME …

You may feel like a lost ball in high weeds, but with the right tools you can reach your program's goal.

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Care Coordination: A Paradigm for Assessing and Providing Care for Clients

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Bio

Steven R. Cook has been with Meals On Wheels, Inc. of Tarrant County since 2004. He earned a Bachelor of Science degree in Human Services in 1998, a Master of Divinity degree in 2006, and a Doctor of Ministry degree in 2017. He was a Caseworker for twelve years before becoming Vice President of the Client Services department in 2016. He currently oversees twelve degreed Caseworkers who provide direct care for approximately 2,400 clients in Tarrant County, comprised mainly of elderly and disabled persons. The Caseworkers make nearly 12,000 home visits annually, determining eligibility for the Meals on Wheels program and coordinating additional services as needed.

In addition to his work at Meals on Wheels, Steven serves on the Tarrant County Adult Protective Services Community Board, the Falls Prevention Taskforce, the Elder Abuse Prevention Taskforce and the Tarrant County Hoarding Taskforce.

Purpose

This presentation is intended to provide a framework for care coordination that is applicable to all Meals on Wheels agencies regardless of size, location, or available resources.

Meals On Wheels, Inc. of Tarrant County Mission Statement

To promote the dignity and independence of older adults, persons with disabilities, and other homebound persons by delivering nutritious meals and providing or coordinating needed services.

A team approach optimizes care

“Many hands make light work”

Brief Overview of Services

Because client care is complex, Meals On Wheels, Inc. of Tarrant County has established **transdisciplinary teams** that work together to assess client needs and provide or connect them with needed resources or services. These teams include:

- **Case Managers** – the primary agents who assess, plan, and coordinate the delivery of meals, equipment and services to clients.
  - Client Assistance Program – assists clients with home repairs, AC installation, DME, supplemental food, etc.
  - Client Well-check – a dedicated person who checks on clients when they don't answer the door to get their meals.
  - Hello Program – volunteers who call and talk with clients over the phone.
  - Errands Program – volunteers who go to the store for clients.
  - Companion Pet Meals – deliver pet food, pay for minor veterinarian services, and pay for semi-annual pet grooming.

Brief Overview of Services

- **Dieticians** – assess client's nutritional needs and provide education and resources to improve health.
- **Pharmacy techs** – input client medications into HomeMeds database, which cross-references them, looking for duplication or adverse reactions.
- **Volunteers** – help with meal delivery and report if client is not home and/or a change of condition in the client or their environment.
    - ➢Friend to Friend program – weekly visits from volunteers in client home.

What is Care Coordination?

Care coordination is the assessing of client needs and connecting them with available resources and/or services necessary to improve their health and keep them safely in their home for as long as possible. Needed services are based on health and safety. Much of what we do is detective work, as we assess before we offer equipment or services.

What is Care Coordination?

Care coordination is both a science and an art. As a science, we employ proven tools that help us assess the client's nutritional, physical and mental health (Nutrition Assessment, AD8, CNE, etc.). As an art, we utilize our tools within the context of a relationship with the client, and that relationship is fluid, ever changing and influenced by numerous variables.

Who is the Care Coordinator?

The care coordinator is anyone who connects resources and services with those in need. In our facility, the Case Manager is the primary care coordinator; however, it can be anyone who is willing to assess a client and bridge the gap between client needs and available resources.

Community Challenges

Effective care provides tailored support to the client for as long as the need exists. Ideally, this support will stabilize or improve client health (story about Joe), keep them safe in their home, reduce hospitalizations, and improve quality of life (story about Marvin).

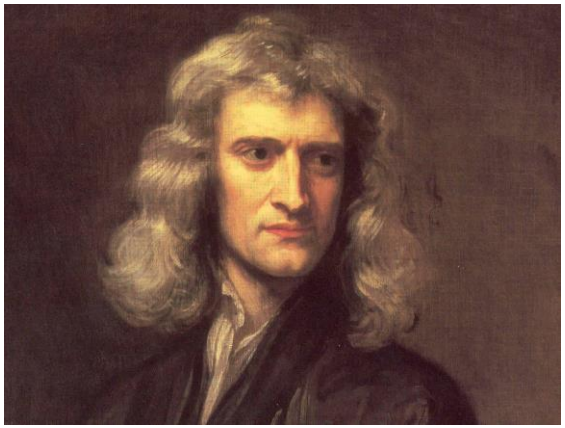
Community Challenges

Care coordinators face the daunting challenge of identifying resources that are scattered and ever changing. There are hundreds of community resources in Tarrant County which offer services to the elderly, children, disabled, etc. Out of that pool of agencies, only a certain percentage will be relevant to our clients. Sometimes those services are available only within a specific time frame or community.

Community Challenges

Sometimes meeting needs is simple such as spraying for wasps, taking out trash, collecting mail or making phone calls. Sometimes the needs are more complex such as obtaining legal services so a client can stay in their home, or calling Adult Protective Services to report physical or financial abuse.

Community Challenges



The care coordinator must be assertive, persistent, and diplomatic.

“Diplomacy is the art of making points without making enemies” – Sir Isaac Newton

Common Barriers to Providing Care

1. **Ignorance** – not knowing how to assess or what resources are available
2. **Volition** – the right of self-determination (client refuses services)
3. **Change** – client's situation is constantly changing
4. **Dementia** – client cannot comprehend
5. **Language** – not able to communicate with others
6. **Trust** – client not opening up because they don't know if they can trust you
7. **Limited resources** – not having enough money to cover the cost of services
8. **Unsafe environment** – crime in neighborhood, mean dogs, bugs, hoarder, trash

The Search for Resources

We realize that agencies and services are always changing, and this means we must be vigilant in our search for new practices and resources. Care coordinators are on a constant quest for useful information and resources and regularly call or email:

- County, city, or local governments
- Universities, colleges, or public schools
- Churches, synagogues, or other religious institutions
- Community groups such as the Habitat for Humanity, YMCA, local furniture banks (*organizations set up with resources to serve the community*), etc.

The Search for Resources

Cont…

- Community Membership groups such as the Lions Club, Optimist Clubs, Rotary Clubs, Dog Scouts of America, etc. *(member groups with a desire to serve the community)*.
- Participate in community meetings. A call or e-mail may not get them the actual connection they need; it's just a foot in the door. It's an opportunity to find the "right person" and get basic information.

Implementing Care

Implementing Care

Once we've assessed the need and identified available resources, we then implement the following steps:

1. Educate clients in an effort to get them to advocate for themselves. Sometimes a client has the mental and financial ability to meet their own needs, and in these situations, we prefer to educate them about what's available and let them fix their own problems.
2. Work with client's family to meet needs. If the client lacks the cognitive and/or financial resources to fix their own problems, we'll reach out to family for help. Sometimes they can solve the problem by themselves, and sometimes we'll partner with them.

Implementing Care

Cont…

3. Find community resource. In cases where clients cannot solve a problem themselves, and there's no family assistance, we'll search in the community to find suitable resources to meet the need. This could mean a call to the county, local city, or community agency to help.
4. Partner with others in the community. There are instances where a community resource may be able to meet part of the need, but not all of it, and we'll partner with them to share the cost and/or labor.
5. Utilize one's own resources. If there is no other help, then it may fall to the agency itself to find a way to meet the need, and it's often in these moments that new programs are born.

Care Coordinators Must Care for Themselves!!

Building relationships is paramount to a successful care coordinator, as it's in the rapport that we learn about needs and how to help them. The life of a care coordinator can be rewarding and enjoyable as we seek to affect change in the lives of disabled and senior persons living in the community. Being a care coordinator means getting close to those in need, and that is both enjoyable and draining.

There are many lovely clients and charming homes where we feel at ease as we chat with delightful people whose health is declining and are in need of our services. We enjoy these visits. We love delivering wheelchairs and walkers, rollators and canes, shower chairs and grab bars, undergarments and bed pads, and supplemental groceries and toiletries.

Care Coordinators Must Care for Themselves!!

There are also those difficult clients who live in a dirty home and where we have to be careful where we stand or sit because there are bedbugs, roaches, or fleas everywhere. Sometimes the bugs are crawling all over the client we're trying to help. Then there's the hoarder's home where the garbage starts in the driveway, runs up the sidewalk, and grows in volume well into the house. Once inside we do our best to step over dozens of fecal bombs that have been sporadically placed by the cats and dogs that share the filth. The smell gets trapped in your nostrils and sometimes you have to wash your clothes more than once to get rid of the odor.

Care Coordinators Must Care for Themselves!!

We enjoy going to our own homes after a day of troubling visits, but sadly, the clients don't get to leave their troubles, and sometimes we wonder if we've done enough to help. Occasionally we get frustrated by the reality that we're very limited in our resources, and in that sense, we cannot fix every problem or alleviate every concern. Some days it seems were merely applying band aids.

It takes a certain kind of personality to be a care coordinator. The work is not for everyone. Care coordinators are caring and strong, but we're not impervious to the pressures of the work, and over time it can chip away at the joyful disposition that often sustains us. **You, as a care coordinator, have an ethical responsibility to care for yourself**; otherwise you'll experience compassion fatigue which can lead to burnout and withdrawal.

Caring for Self Involves

Caring for self involves:

- Maintaining professional boundaries – If we get too close, we can lose objectivity and this can affect the quality of our care.
- Getting good physical rest – Good rest impacts our cognition, enthusiasm, and physical stamina.
- Getting good mental rest – Mental rest means we leave work at work and focus our attention on other things—pleasant things—that allow the mind to recover.
- Proper nutrition – Good nutrition enhances mental and physical performance.

Caring for Self Involves

Caring for self involves:

- Regular exercise – Strengthens the heart, increases blood flow, raises your oxygen levels, and improves mental health and mood.
- Take time off – Sometimes a few days off work allows to recover physically and mentally.
- Manage your time – Set regular times for working, eating, sleeping, socializing, playing, etc. This helps your biological and mental clock stay on track.
- Talk through concerns – Find someone who will listen to your concerns and offer caring and objective advice. Debriefing is healthy when a care coordinator experiences a difficult situation.
- Keep a strong support network – surround yourself with people who will encourage you and build you up.

“Teamwork makes the dream work”

Don’t forget to evaluate today’s session in the Conference App!