ADVANCING INTEGRATED HEALTHCARE

Breakfast of Champions:
Comprehensive Approaches to Diabetes Care

Breakfast of Champions | June 10, 2022

Care Transformation Collaborative of RI

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The AAFP has reviewed 'Advancing Comprehensive Primary Care Through Improving Care Delivery Design and Community Health,' and deemed it acceptable for AAFP credit. Term of approval is from 03/18/2022 to 03/18/2023. Physicians should claim only the credit commensurate with the extent of their participation in the activity. NPs and RNs can also receive credit through AAFP's partnership with the American Nurses Credentialing Center (ANCC) and the American Academy of Nurse Practitioners Certification Board (AANPCB).

Objectives

- Learn about and discuss practical implications of updated management guidelines and comprehensive approaches to improve care for patients with diabetes.
- Lessons learned from multi-disciplinary team efforts to improve care
- Hear about a medically-tailored food program for high risk patients with diabetes.

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CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND
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ADVANCING INTEGRATED HEALTHCARE

Agenda

Presenter/Topic	Time
Welcome ***Pano Yeracaris, MD, MPH, CTC-RI***	5 minutes
Diabetes Management ***Diana G. Mercurio, BSPharm, CDCES, CDOE, CVDOE, RIPCPC*** ***Jessica M. Ryan, PharmD, BCACP, Thundermist***	15 minutes
Report Out on Integra Project ***Diana G. Mercurio, BSPharm, CDCES, CDOE, CVDOE, RIPCPC***	15 minutes
Reducing Preventable Hospitalizations and Emergency Department Usage ***Jessica Ryan, PharmD, BCACP, Thundermist*** ***Michael Poshkus, MD, Thundermist***	15 minutes
Improving Diabetes Care From A Community Level & Community Servings ***Jean Taylor RN, BSN, CDOE, CCM, Director Clinical Programs Population Health, Integra*** ***Erin Dibacco, Director Of Strategic Growth And Business Development, Community Servings***	15 minutes
Community Health Network Resources ***S. Campbell, RN, MS, PCMH CCE, CTC-RI,***	5 minutes
Q& A/Discussion	20 minutes

Diabetes Management

Navigating the Maze

Diana G. Mercurio, BSPharm, CDCES, CDOE, CVDOE

Jessica M. Ryan, PharmD, BCACP

Complications of Diabetes

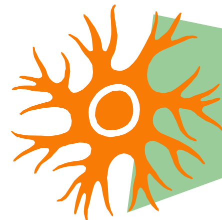
Small vessel complications

Diabetic Retinopathy

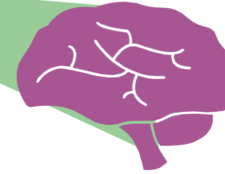
Leading cause of blindness in adults[1,2]

Diabetic Nephropathy

Leading cause of end-stage renal disease[3,4]



Large vessel complications



Stroke

2- to 4-fold increase in cardiovascular mortality and stroke[5]

Cardiovascular Disease

8/10 individuals with diabetes die from CVD[6]

Diabetic Neuropathy

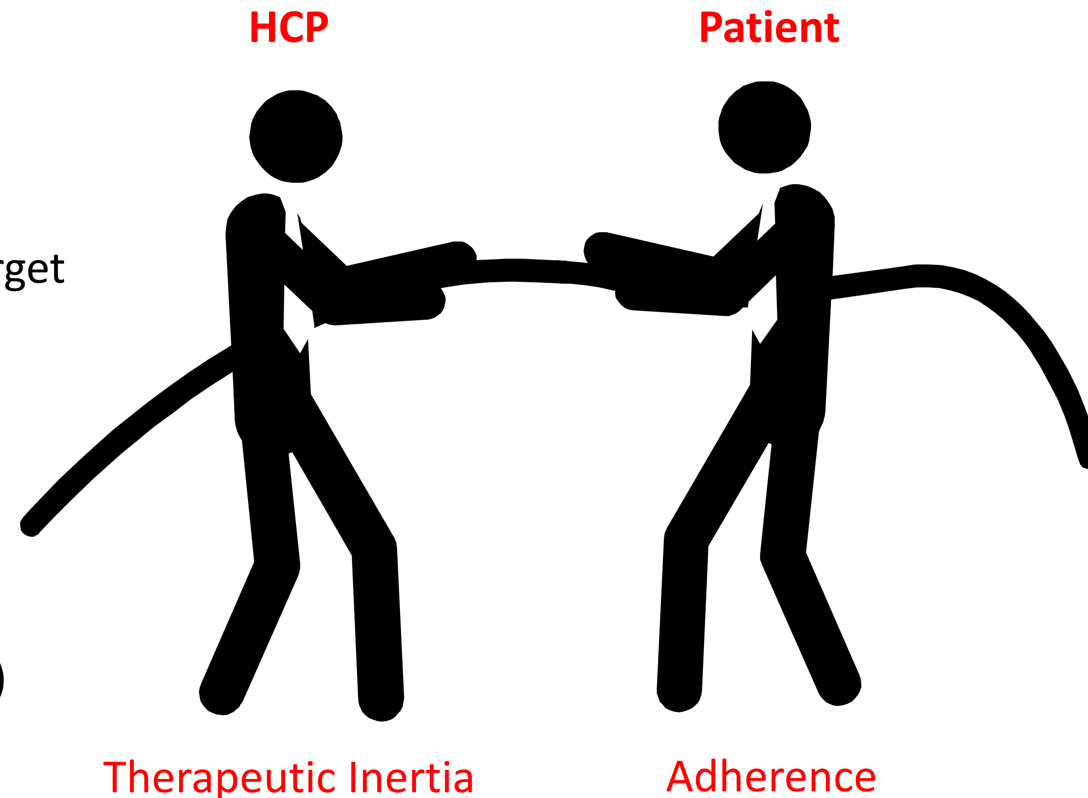
Leading cause of nontraumatic lower extremity amputations[7,8]

1. UK Prospective Diabetes Study Group. Diabetes Res 1990;13:1. 2. Fong. Diabetes Care 2003;26:S99. 3. The Hypertension in Diabetes Study Group. J Hypertens 1993; 11:309. 4. Molitch. Diabetes Care. 2003;26:S94. 5. Kannel. Am Heart J. 1990;120:672. 6. Gray. Textbook of Diabetes 2nd Edition, 1997. Blackwell Sciences. 7. King's Fund. Counting the cost. The real impact of non-insulin dependent diabetes. London: British Diabetic Association, 1996. 8. Mayfield. Diabetes Care 2003; 26:S78. 9. UKPDS Group. Diabetologia 1991;34:877.

Slide credit: clinicaloptions.com

Tug of War: Management of Diabetes

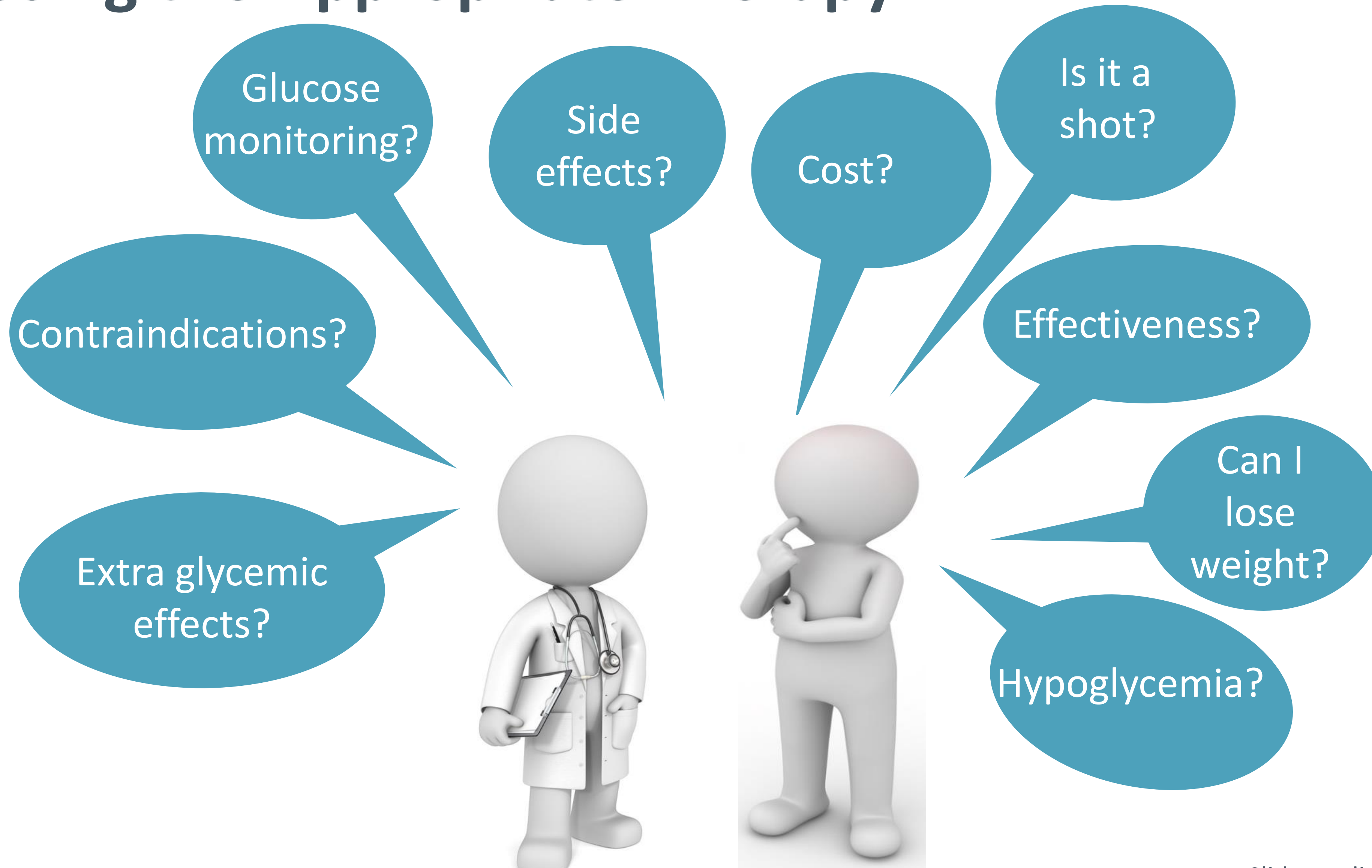
- Glycemic control
  - Generally, A1C <7.0%
- Lipid control
  - Individualized LDL target
- BP control
- Regular exams
- Healthy lifestyle
  - Weight loss ≥5%
  - Activity (150 min/wk)
  - Avoid smoking
  - Adequate sleep



- I don't understand what you want from me
- Complications won't happen to me
- Change is hard
- I prefer no interference with my life
- I don't like medications
  - Side effects
  - Expensive
  - I can do it with lifestyle

Inzucchi. Diabetes Care. 2012;35:1364.

Choosing the Appropriate Therapy

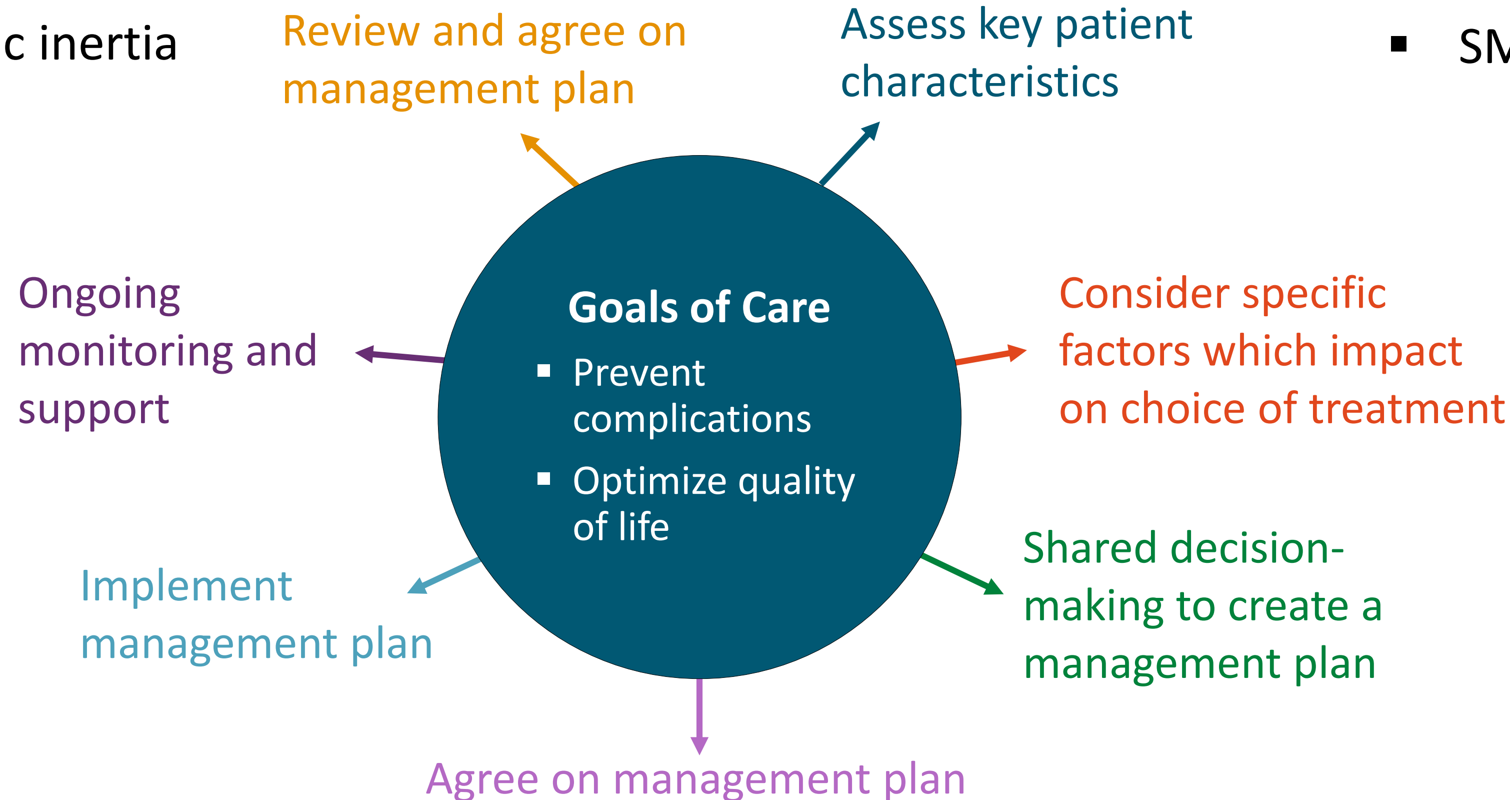


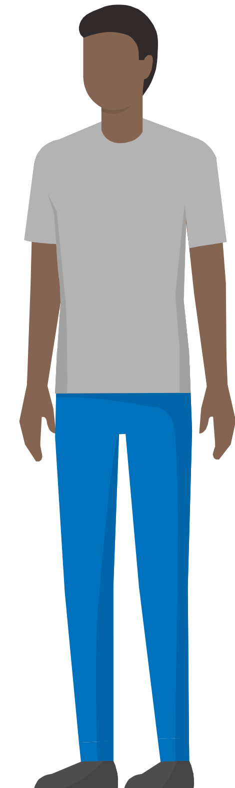
Inzucchi. Diabetes Care. 2012;35:1364.

Providing Better Diabetes Care

- Understand preferences
- Avoid therapeutic inertia

- Patient education
- SMART goals





ADA/EASD Management of Hyperglycemia

Delivery System Design

Davies. Diabetes Care. 2018;41:2669.

ADA Recommendations: Glucose-Lowering Medications in T2D

First-line Therapy Is Metformin and Comprehensive Lifestyle (including weight management and physical activity)

Indicators of High-Risk or Established ASCVD, CKD, or HF†

Consider Independently of Baseline A1C or Individualized A1C Target, or Metformin Use*

NO → If A1C Above Individualized Target, Proceed as Below

+ASCVD/Indicators of High Risk

- Established ASCVD
- Indicators of high ASCVD risk (age ≥55 yr with coronary, carotid, or lower extremity artery stenosis >50%, or LVH)

Either/or

- GLP-1 RA with proven CVD benefit[1]
- SGLT2i with proven CVD benefit[1]

If A1C above target

If further intensification is required or patient is unable to tolerate GLP-1 RA and/or SGLT2i choose agents demonstrating CV benefit and/or safety:

- For patients on a GLP-1 RA, consider adding SGLT2i with proven CVD benefit and vice versa
- TZD[2]
- DPP-4i if not on GLP-1 RA
- Basal insulin[3]
- SU[4]

+HF

- Particularly HFrEF (LVEF <45%)

SGLT2i with proven benefit in this population[5,6,7]

+CKD

DKD and albuminuria[6] (NO →)

PREFERABLY
SGLT2i with primary evidence of reducing CKD progression

OR
SGLT2i with evidence of reducing CKD progression in CVOTs[5,6,8]
OR
GLP-1 RA with proven CVD benefit[1] if SGLT2i not tolerated or contraindicated

For patients with T2D and CKD[8] (eg, eGFR <60 mL/min/1.73 m²) and thus at increased risk of cardiovascular events

Either/or

- GLP-1 RA with proven CVD benefit[1]
- SGLT2i with proven CVD benefit[1]

Compelling Need to Minimize Hypoglycemia

DPP-4i	GLP-1 RA	SGLT2i	TZD
If A1C above target	If A1C above target	If A1C above target	If A1C above target
SGLT2i **OR** TZD	SGLT2i **OR** TZD	GLP-1 RA **OR** DPP-4i **OR** TZD	SGLT2i **OR** DPP-4i **OR** GLP-1 RA

If A1C above target

Continue with addition of other agents as outlined above

If A1C above target

Consider the addition of SU[4] OR basal insulin:

- Choose later-generation SU with lower risk of hypoglycemia
- Consider basal insulin with lower risk of hypoglycemia[9]

Compelling Need to Minimize Weight Gain or Promote Weight Loss

EITHER/OR

- GLP-1 RA with good efficacy for weight loss[10]
- SGLT2i

If A1C above target

- SGLT2i[2]
- GLP-1 RA with good efficacy for weight loss[8]

If A1C above target

If quadruple therapy required, or SGLT2i and/or GLP-1 RA not tolerated or contraindicated, use regimen with lowest risk of weight gain
PREFERABLY
DPP-4i (if not on GLP-1 RA) based on weight neutrality

→ If DPP-4i not tolerated or contraindicated or patient already on GLP-1 RA, cautious addition of:
▪ SU[4] ▪ TZD[2] ▪ Basal insulin

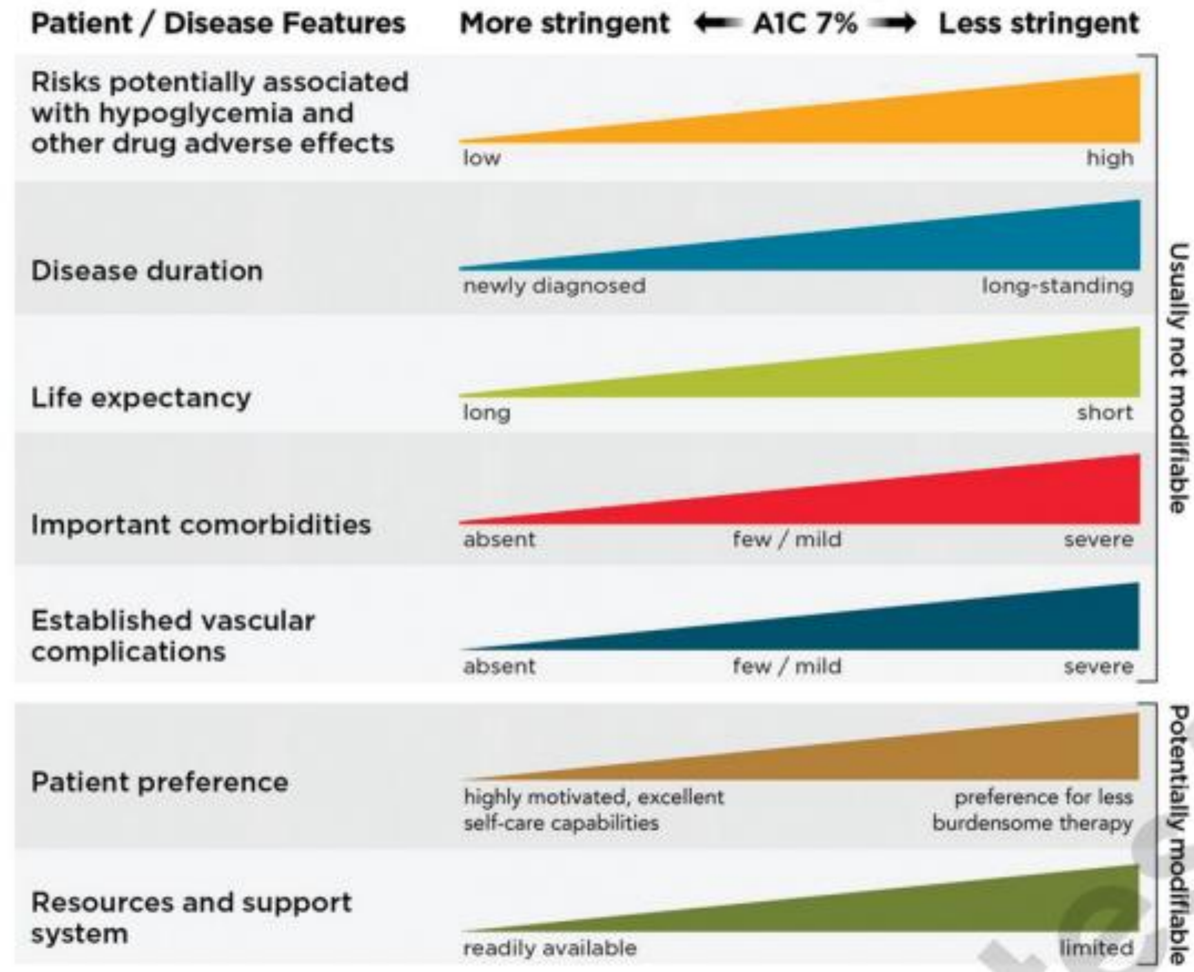
COST IS A MAJOR ISSUE[9-10]

SU[4]	TZD[12]
If A1C above target	
TZD[12]	SU[4]
If A1C above target	

Insulin therapy basal insulin with lowest acquisition cost
OR
Consider other therapies based on cost

ADA. Diabetes Care. 2022;45:S1.

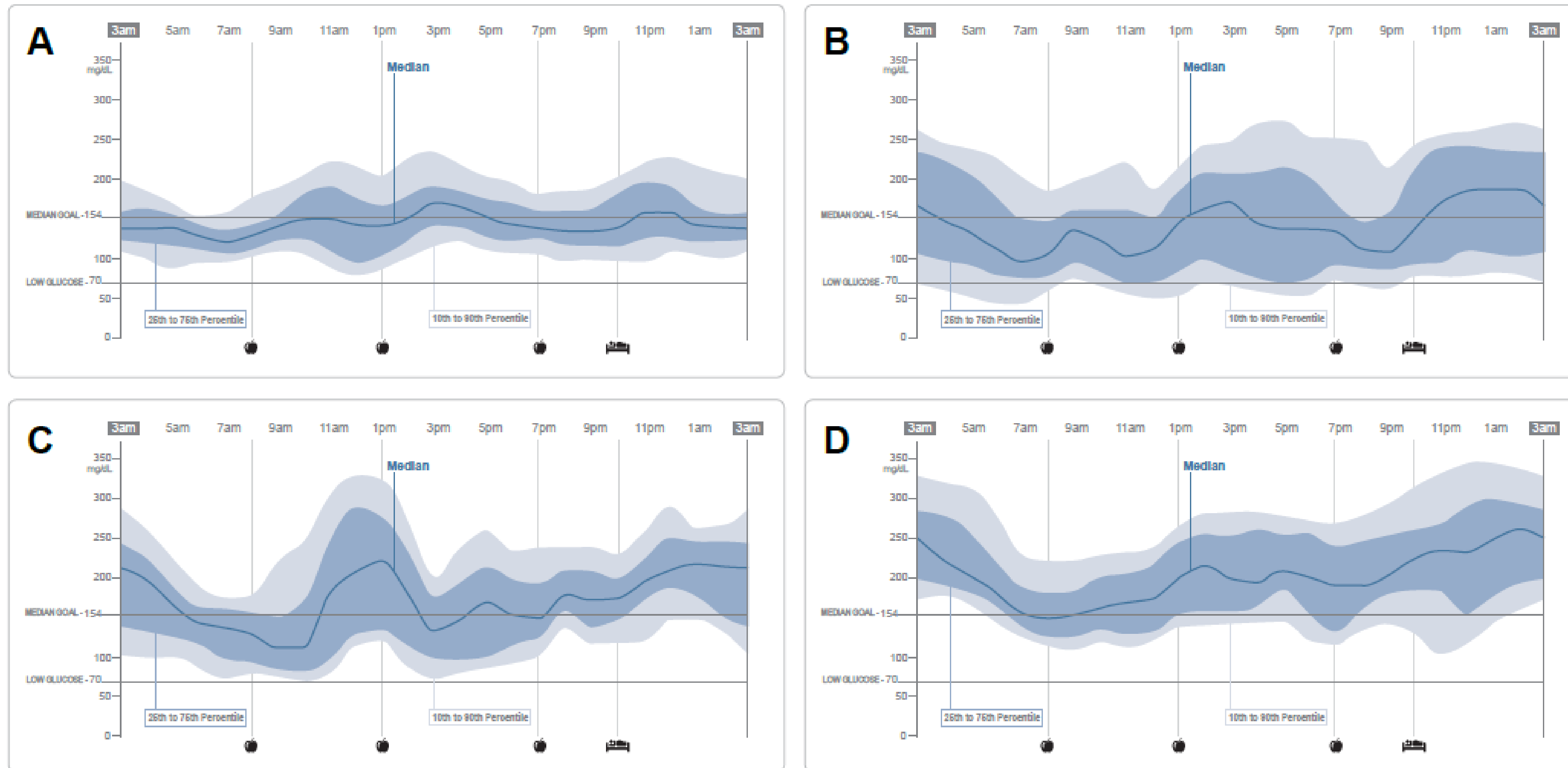
A1c Goals



ADA. Diabetes Care. 2022;45:S1.

But not all A1cs are the same…

AGP graphs of four different type 1 diabetes patients (each with an A1c of between 7.6 and 7.7%)

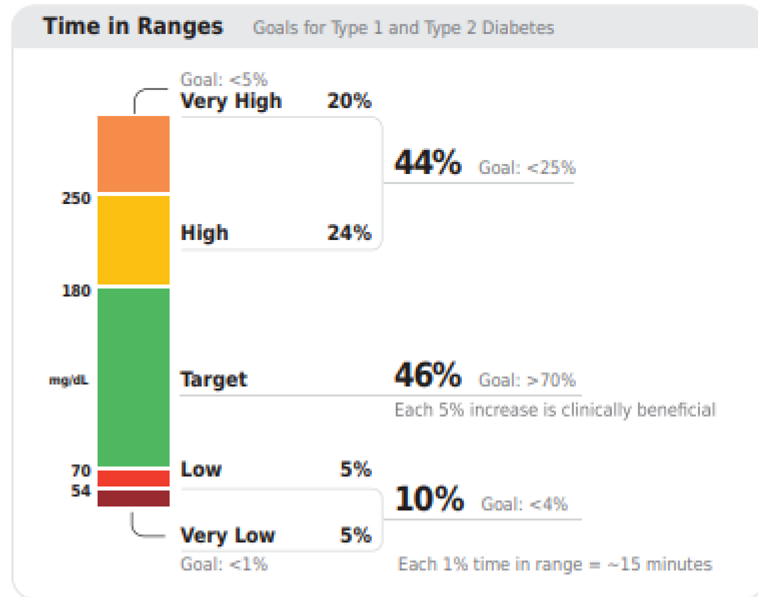


Source: Development of the Likelihood of Low Glucose (LLG) Algorithm for Evaluating Risk of Hypoglycemia: A New Approach for Using Continuous Glucose Data to Guide Therapeutic Decision Making.
Timothy C. Dunn, Gary A. Hayter, Ken J. Doniger and Howard A. Wolpert; ***J Diabetes Sci Technol*** 2014 8: 720 originally published online 17 April 2014.

Slide credit: Abbott Freestyle Libre

Ambulatory Glucose Profile (AGP) and Goals

AGP Report: Continuous Glucose Monitoring



Test Patient DOB: Jan 1, 1970

14 Days: August 8-August 21, 2021

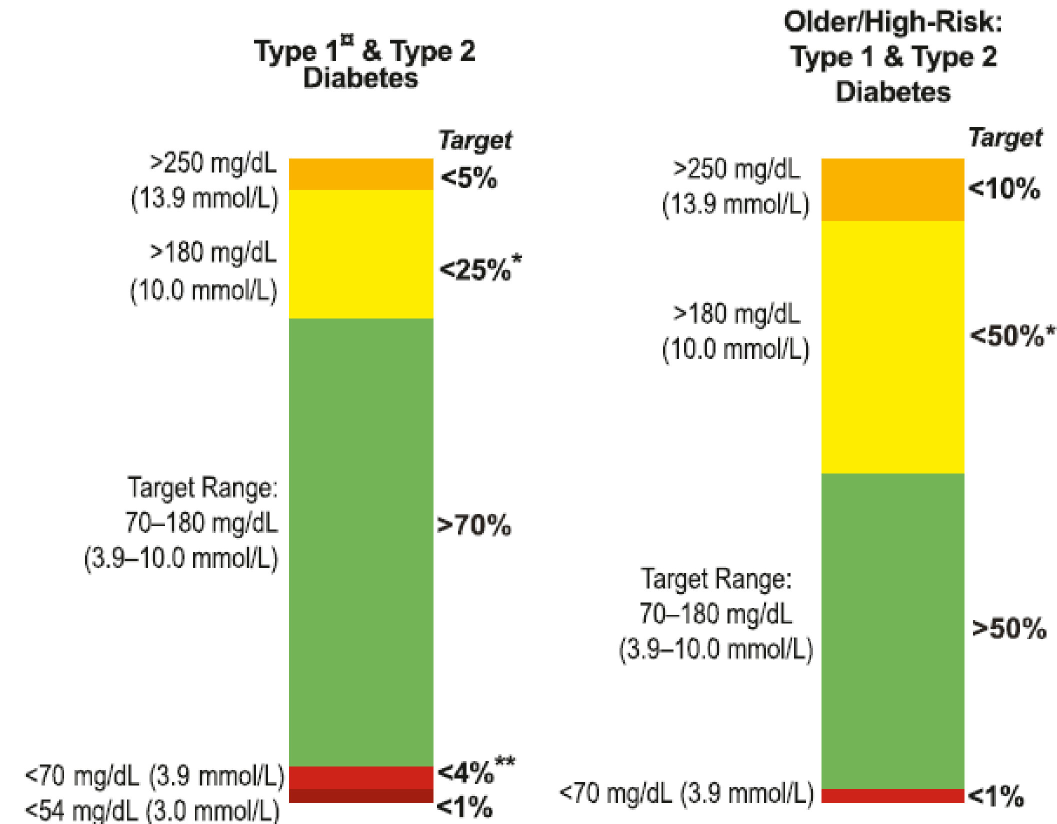
Time CGM Active: 100%

Glucose Metrics

Average Glucose .... **175 mg/dL**
Goal: <154 mg/dL

Glucose Management Indicator (GMI) **7.5%**
Goal: <7%

Glucose Variability **45.5%**
Defined as percent coefficient of variation
Goal: ≤36%



¤ For age <25 yr., if the A1C goal is 7.5%, then set TIR target to approximately 60%. (See *Clinical Applications of Time in Ranges* section in the text for additional information regarding target goal setting in pediatric management.)
† Percentages of time in ranges are based on limited evidence. More research is needed.
§ Percentages of time in ranges have not been included because there is very limited evidence in this area. More research is needed. Please see *Pregnancy* section in text for more considerations on targets for these groups.
* Includes percentage of values >250 mg/dL (13.9 mmol/L).
** Includes percentage of values <54 mg/dL (3.0 mmol/L).

ADA. Diabetes Care. 2022. 45:S1.
Battelino T, et al. *Diabetes Care.* 2019 Aug; 42(8): 1593-1603.

Devices

Freestyle Libre 14 Day or Libre2

- Intermittent CGM: scan for result
  - Must scan every 8 hours for graph/AGP data
- Libre2 has hypo/hyperglycemia alarms
- Application site: back of upper arm
- Accuracy:
  - MARD: 9.4% (14 day), 9.2% (2)
  - ± 20/20%: 92.4%
- Hypoglycemia Accuracy:
  - < 70: 94.1%

Dexcom G6

- Real-time CGM: results every 5 minutes
- Hypo/hyper alarms
- Application site: abdomen
- Accuracy:
  - MARD: 9.8%
  - ± 20/20%: : 92.5%
- Hypoglycemia Accuracy:
  - < 70: 90.8%

Both require receiver/phone to be within 20 feet to record data and receive alerts

Interstitial Glucose vs Blood Glucose

Slide credit: Abbott Freestyle Libre

Counseling

Adhesion

- Apply to clean and dry area
- Avoid hairy location (shave), scar tissue, moles
- Apply to location not easily hit or caught on clothing
- Apply sensor bandage, Skin Tac, Tegaderm or Marstisol liquid adhesive for additional support
  - Do NOT cover Libre sensor hole or Dexcom transmitter (cut bandage center or tape around)

Skin Irritation

- Rotate sites
- Fluticasone nasal spray: Apply 2 sprays to sensor site, wait 2 minutes before application

Water Resistant

- Dexcom: no greater than 8 feet or immersed for > 24 hours
- Libre: no greater than 3 feet deep or immersed for > 30 minutes

References

- American Diabetes Association Professional Practice Committee. 6. Glycemic Targets: Standards of Medical Care in Diabetes - 2022. *Diabetes Care.* 2022;45 (Suppl. 1):S83–S96. doi:10.2337/dc22-S007
- Battelino T, Danne T, Bergenstal R et al. Clinical Targets for Continuous Glucose Monitoring Data Interpretation: Recommendations From the International Consensus on Time in Range. *Diabetes Care.* 2019 Aug; 42(8): 1593-1603. doi:10.2337/dc22-S006
- Freestyle Libre Systems (CGM): Healthcare Providers. FreeStyle Libre Systems (CGM) | Healthcare Providers. https://www.freestyleprovider.abbott/us-en/home.html. Published 2022. Accessed May 23, 2022.
- Continuous Glucose Monitoring for Healthcare Professionals | Dexcom Provider. https://provider.dexcom.com/. Published 2022. Accessed May 23, 2022.
- Clinicaloptions.com/diabetes. Accessed May 20, 2022
- American Diabetes Association Professional Practice Committee. 6. Glycemic Targets: Standards of Medical Care in Diabetes - 2022. *Diabetes Care.* 2022;45 (Suppl. 1): S125-S143. doi:10.2337/dc22-S009

PHARMACY QUALITY IMPROVEMENT: Reducing Preventable Hospitalizations and Emergency Department Usage 2021-2022

Practice Name: RIPCPC /Integra
Chronic Condition: Diabetes
Pharmacist Lead: Diana Mercurio, BS Pharm, CDCES

Project Goals

1

Implement a workflow to prevent unnecessary utilization of ED/IP services for diabetes-related complications

2

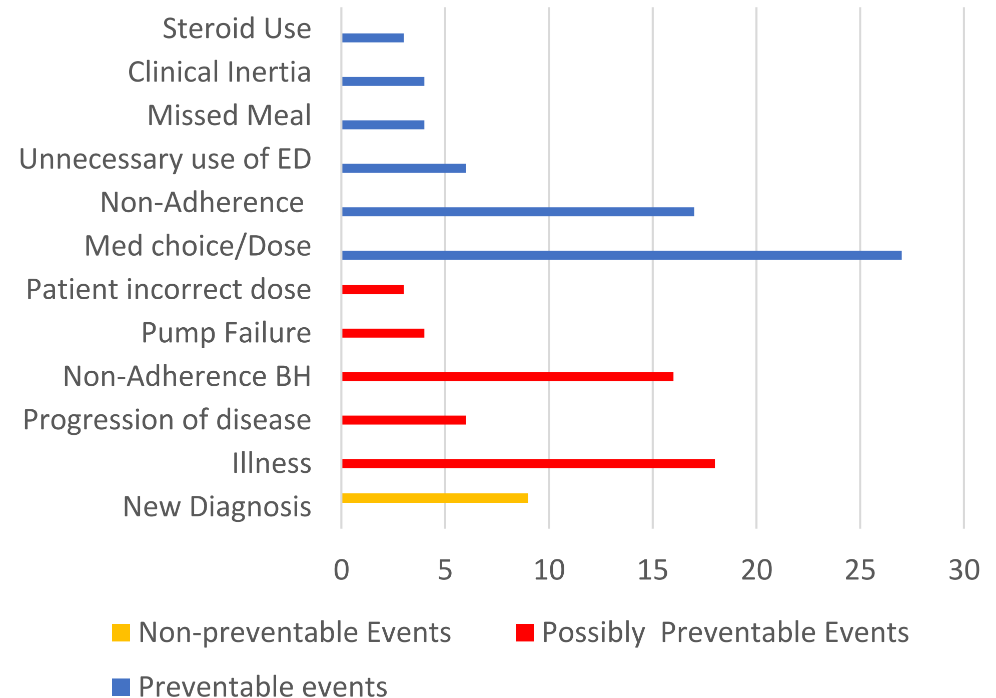
Establish consistent messaging by all members of the care team and use standardized, updated patient education materials

3

Reduce unnecessary utilization of ED/IP for diabetes-related problems

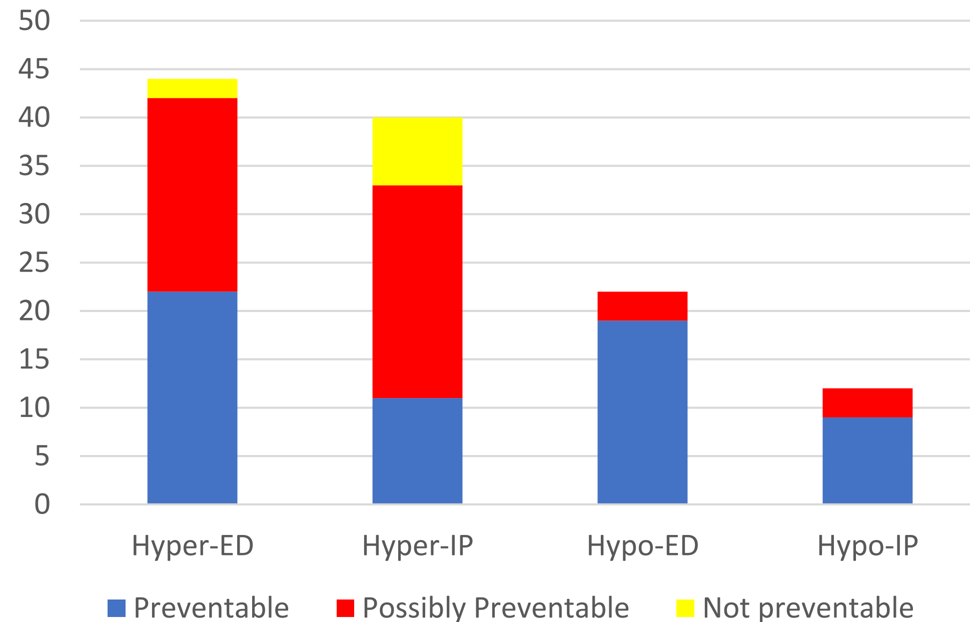
Drivers of ED/IP Utilization

- **The most prevalent cause of preventable ED/IP use was related to medication choice/dose in our population**
- **22 preventable ED/IP hypoglycemia utilizations were identified**
  - 14 were attributed to oral sulfonylurea use in older adults with A1c <7%
  - 8 were attributed to insulin dose or type



Root Cause Analysis Summary

- **102 patients used the ED/IP setting 118 times**
- **47% (55/118 events) were attributed to medication-related event**
- **37 pharmacist recommendations accepted (88%)**
  - **Most common recommendations:**
    - Discontinue sulfonylurea
    - Start SGLT2i/GLP1RA
    - Adjustment of insulin dose or product
-
- **30 patients referred to NCM/social worker for follow up**



Risk Stratification

- Patients were identified who were overdue for in-person primary care visit and/or overdue for labs
- Patients identified who have A1C above goal stratified to NCM or pharmacist team
- Developed a report with analytics/EMR team to proactively identify vulnerable patients. We identified this as patients > 64 years old who have an oral sulfonurea on current medication list.

Sustainability/Next Steps

- ✓ Created new position : Clinical Program Development and Operations Manager
- ❑ Implement evidence-based clinical care pathways and protocols in collaboration with the Medical Management, Pharmacy and Quality Committee as well as the Medical, Pharmacy and Nursing Directors.
- ❑ Establish a targeted clinical review committee
- ❑ Continue CQI to more clearly define care team roles
- ❑ Care management redesign
- ❑ Develop disease state management competencies
- ❑ Perform routine chart audits

- Diana G. Mercurio, BSPharm, CDCES
- dmercurio@ripcpc.com
- 401-580-9340

ADVANCING INTEGRATED HEALTHCARE

PHARMACY QUALITY IMPROVEMENT: Reducing Preventable Hospitalizations and Emergency Department Usage 2021-2022

Practice Site: Thundermist Health Center of West Warwick
Chronic Condition: Diabetes
Pharmacist Lead: Jessica Ryan, PharmD, BCACP
Provider Lead: Michael Poshkus, MD
Social Service Lead: Kristina Moan, BSW
Nurse Care Manager Lead: Jennifer Wagner, RN, BSN

PLAN

Problem

- Per 2019 APCD data, Thundermist had a 7.5% rate for ED visits and 2.4% rate for hospitalizations compared to RI APCD of 3.6% and 1.4%, respectively
- 69% (699/1013) of patients had an A1c < 9% as of 4/2021

Aim

- **Primary Aim:** Decrease ED visits and hospitalizations due to short-term and long-term diabetes complications by 25% using team-based care by 4/2022
- **Secondary Aim:** Achieve A1c < 9% for 73% of patients using team-based care by 7/2022

Population

- Patients with an ED visit or hospitalization from 3/2019 to 9/2021 (historical group) and patients with utilization from 9/2021 to 4/2022 (study group)

Goal

- To optimize pharmacy services and team-based care for patients with diabetes and a history of ED visits or hospitalizations for short-term and long-term complications

METHODS

Patient Engagement

- Patient identified by medical assistant (MA), nurse (RN) or nurse care manager (NCM) for ED visit or hospitalization for diabetes-related complication
- MA/RN/NCM automatically refers patient to PharmD for appointment
- PharmD books appointment. If patient declines or is unable to be reached, complete chart review instead

Pharmacist Interventions

- Review ED visit or hospitalization with patient to identify potential cause(s) and/or barrier(s)
- Recommend guideline directed therapy
- Recommend hypoglycemia treatment and continuous glucose monitor, if appropriate
- Educate on when to seek emergency care
- Update Problem List to reflect ED visit or hospitalization diabetes diagnosis

Outcomes

- Communicate recommendation(s) with provider
- Determine if 1 time referral or continue co-management
- Outreach to support staff for barriers identified (Social Services, Community Health Team, NCM, Behavioral Health)

METHODS

PharmD identifies patients with previous short-term/long-term diabetes ED visits or hospitalizations from 3/2019-9/2021

PharmD completes chart reviews

PharmD provides recommendations to PCP for treatment, barriers, outreach

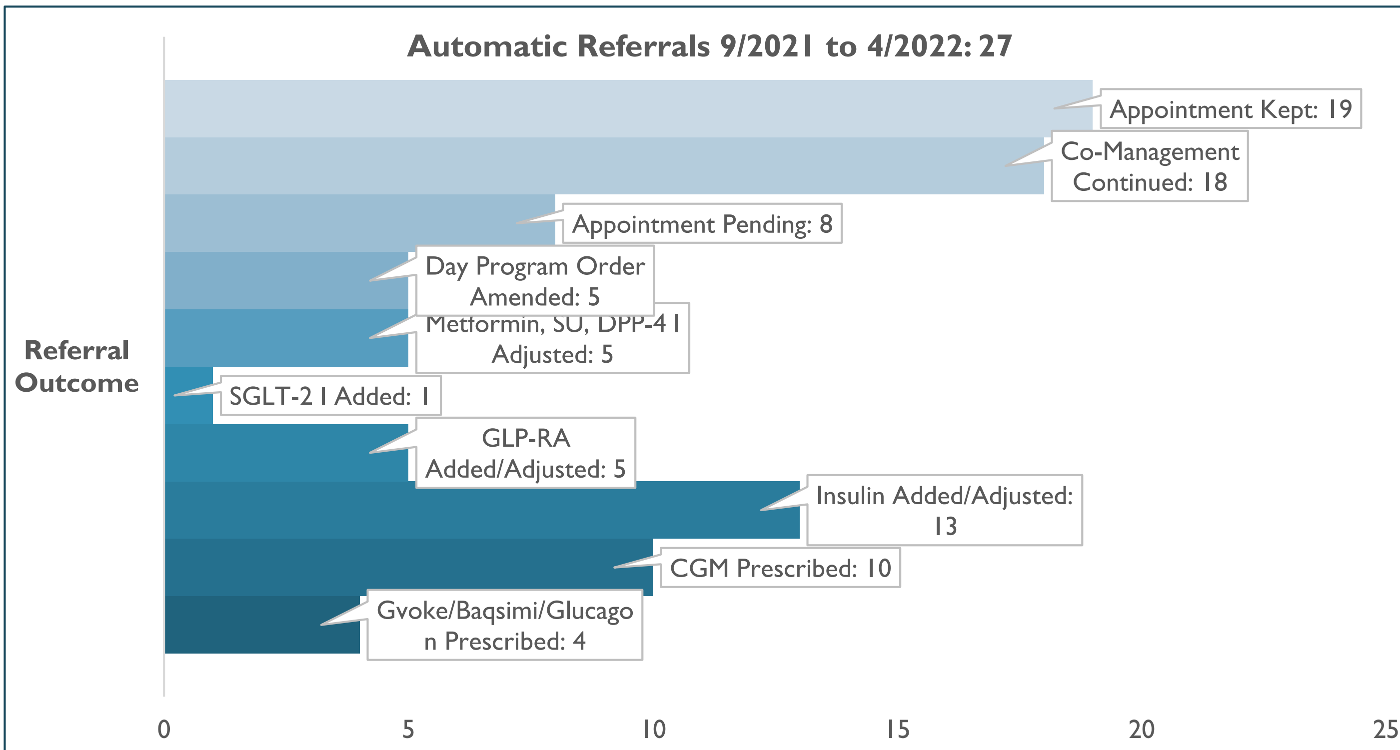
RISK STRATIFIED POPULATION

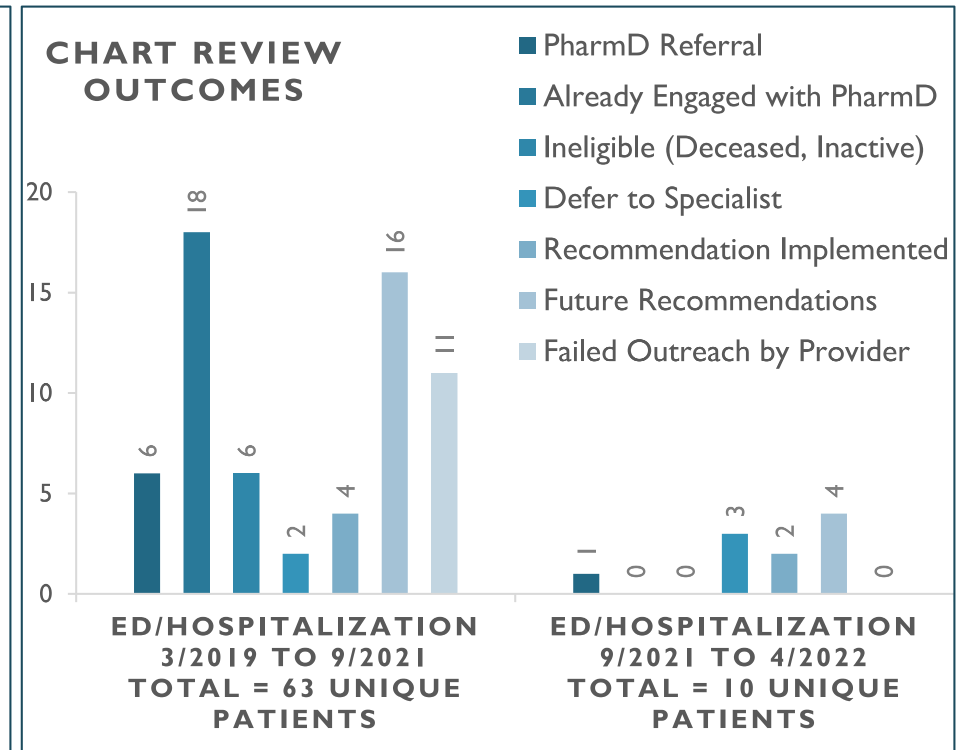
Risk Group	Plan	Outcome
Housing Insecurity	Screening questions added to housing support specialists' appointments to identify patients with barriers to medication storage and/or access. Patients that screen positive will be referred to PharmD for review. Identify homeless shelters that have medication storage	**2** PharmD referrals with resolution of medication storage concerns Results pending reply from shelters
Group/sober home, rehab facility and day program participants	Discuss hyper/hypoglycemia policies with program staff. If program agrees, PCP will provide an order to amend the program's policy. Amendment will instruct the program to contact TCHC for triage prior to sending patient to ED.	**1** standing order for a Group Home **1** standing order for a Rehab Facility **3** individual orders at Day Programs **ED visits since implementation of orders: 0**
Co-existing substance use (SUD) or behavioral health (BH) disorders	If SUD/BH is the predominant problem/priority for patient, try to engage patient with behavioral health and/or discuss treatment, if appropriate	**17** patients: increased awareness to primary care and behavioral health providers

OUTCOMES/RESULTS

- 3/2019 to 9/2021: 102 ED visits/hospitalizations (63 unique patients)
- 9/2021 to 4/2022: 54 ED visits/hospitalizations (37 unique patients)
- **As of 4/30/2022, 75% (840/1,119) of patients have an A1c < 9%**

- Patients prescribed Gvoke/Baqsimi/Glucagon per PharmD since 9/2021: **32**
- Total patients co-managed by PharmD with CGM: **64**





PROVIDER SATISFACTION

Primary Care Provider Survey	Yes	No
Did you like automatic PharmD referrals for patients with a diabetes related ED visit or hospitalization?	7	0
Would you like automatic PharmD referrals to continue once the QI project ends?	7	0
Are you comfortable providing a patient specific order to a Group Home/Sober Home/Day Program to amend their hyper/hypoglycemia policy to call TCHC for triage instead of sending patient to the ED?	6	1
Will you start prescribing Gvoke, Baqsimi or glucagon for severe hypoglycemia treatment?	5	2
Did you find PharmD chart reviews helpful?	7	0
Are you satisfied with the current communication between PharmD and Provider via TE or conversation?	7	0
Do you feel PharmD diabetes co-management decreases provider burden?	6	1

SUMMARY

- Automatic referral to Clinical Pharmacist for patients with a diabetes-related ED visit or hospitalization allowed for interventions
- Identified and implemented changes for high utilizer groups including patients that attend Group/Sober Homes or Day Programs, patients with Housing Insecurity and BH/Substance Use Disorders
- Reduced ED utilization and hospitalizations for diabetes-related complications and improved HbA1cs through team-based care
- Provider satisfaction validated workflow changes to improve patient care

Integra and Community Servings

Jean Taylor RN, BSN, CDOE, CCM
Director, Clinical Programs Population Health
Integra

Erin DiBacco
Director, Strategic Growth and Business Development
Community Servings

Integra

Belong. Be well. Integra.

Integra is a community of doctors, nurses, social workers, pharmacists, community health workers, and patients working together to improve the health and well-being of our community.

integra

Integra and Care New England

- Four acute care hospitals
- Certified home health & hospice agency
- Ambulatory behavioral health organization
- Primary care practices >120 sites
- Integra Community Care Network
- Integra is responsible for ~ 150,000 covered lives
- MA, MSSP, AE –Medicaid, Commercial

Integra Programs

- Telephonic NCM/CCM Program
- Telephonic/in-person SW Program
- **Disease Management**
- Wellness Program
- Transition Program (ED, hospital, SNF)
- SNF 30 day
- Integra at Home
- Community Paramedicine
- RPM (Remote patient monitoring)

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Integra Programs

- NP’s- in home & televideo visits
- On-call 24/7
- SDOH assessment/assistance
- MSW telephonic/in home
- BSW telephonic/in home
- CHWs

Integra and Community Servings

- Provide meals based on patients acute or chronic medical needs.
- Enhance disease management program
- Reduce hospital and SNF readmission rates by:
  - Addressing food insecurity.
  - Providing meals that are (acute and chronic) disease appropriate.
  - Provide disease specific education and management.
    - Diabetes
    - CHF
    - Cardiac
    - CKD/Renal
    - Frailty

- Funding provided by Blue Cross and Medicaid.

Target Population

- NHP, UHC Medicaid, Blue Cross MA, MSSP
- All RI communities
- A1c >/= 8.5
- Food insecurity
- Frailty/SNF

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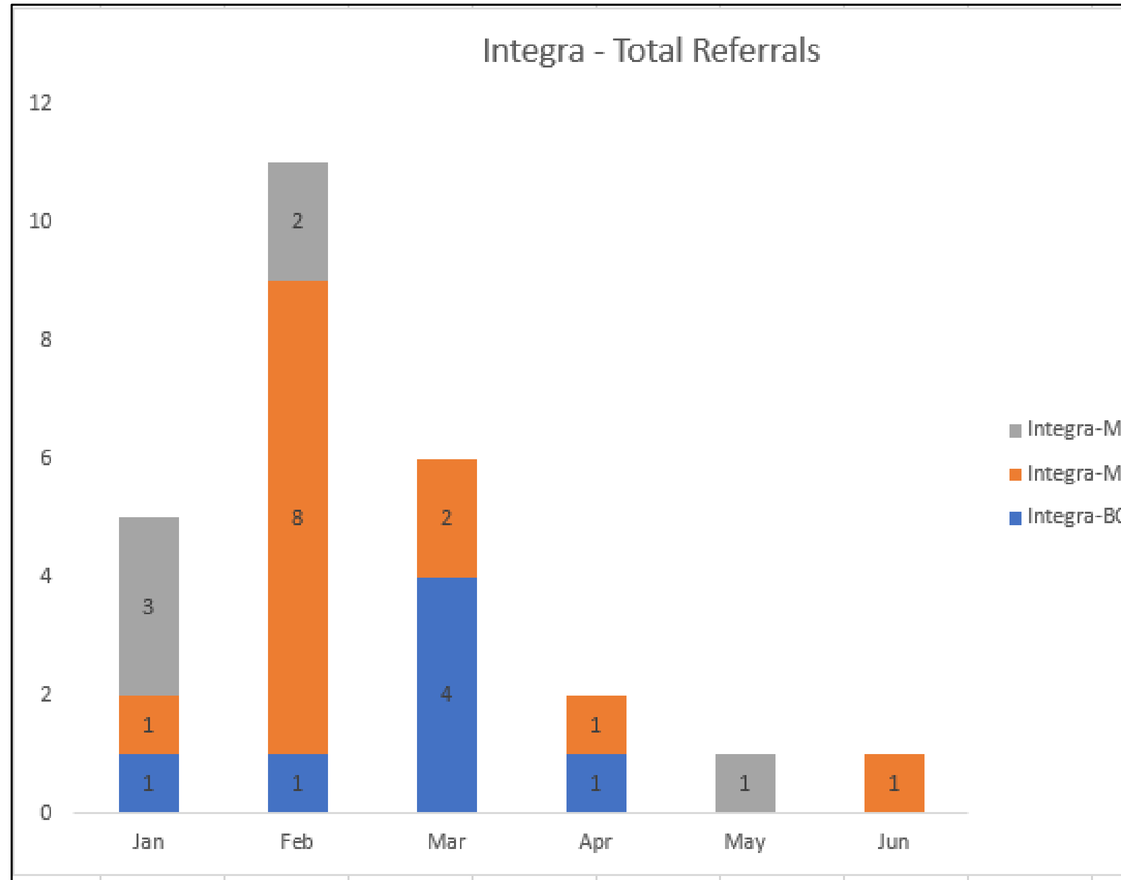
Who is eligible

Medically Tailored Meals				
CCM	Payor	Eligibility	#pts	Duration
Telephonic	Medicaid	>/= 8.5 A1c	15	6 mo (26 wks)
Telephonic	MSSP	>/= 8.5 A1c	5	6 mo (26 wks)
SNF D/C individual	MSSP	food insecurity/frailty	22	6 weeks
SNF D/C pt&spouse	MSSP	food insecurity/frailty	11 (couples)	6 weeks
Telephonic 47, In-Home 11	BCMA	>/= 8.5 A1c	58	4 months (17wks)

Total Referrals

Count of Created Date	Column Labels			
Row Labels	Integra-BCBSRI MA 4mos	Integra-Medicaid 6mos	Integra-MSSP-A1C 6mos	Grand Total
Jan	1	1	3	5
Feb	1	8	2	11
Mar	4	2		6
Apr	1	1		2
May			1	1
Jun		1		1
Grand Total	7	13	6	26



Race/ Ethnicity

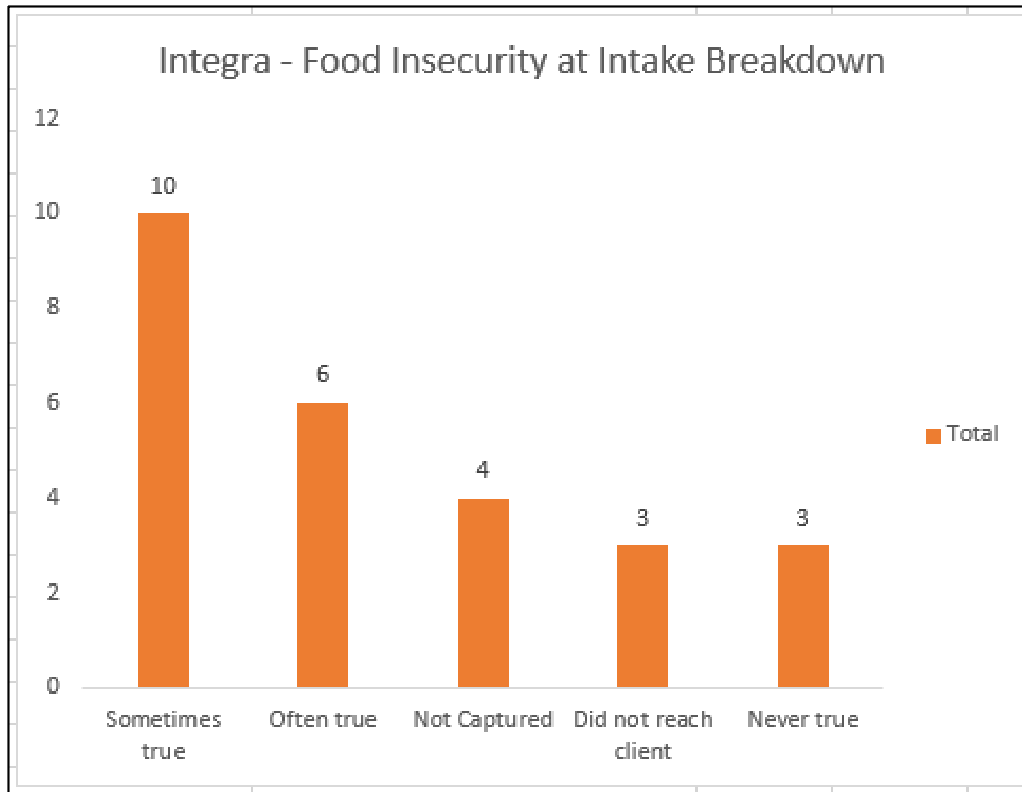
Count of Main Client Record: Race/Ethnicity		
White	14	54%
Hispanic, Latino/a, or Spanish	5	19%
Other	2	8%
Black or African American	2	8%
Not Captured	2	8%
Unknown	1	4%
Grand Total	**26**	

Integra - Race/Ethnicity Breakdown

Category	Total
White	14
Hispanic, Latino/a, or Spanish	5
Other	2
Black or African American	2
Not Captured	2
Unknown	1

Food Insecurity

integra



Row Labels	Count of Food Insecurity at Intake
Sometimes true	10
Often true	6
Not Captured	4
Did not reach client	3
Never true	3
Grand Total	**26**

integra

For more information about Integra programs:

https://www.integracare.org

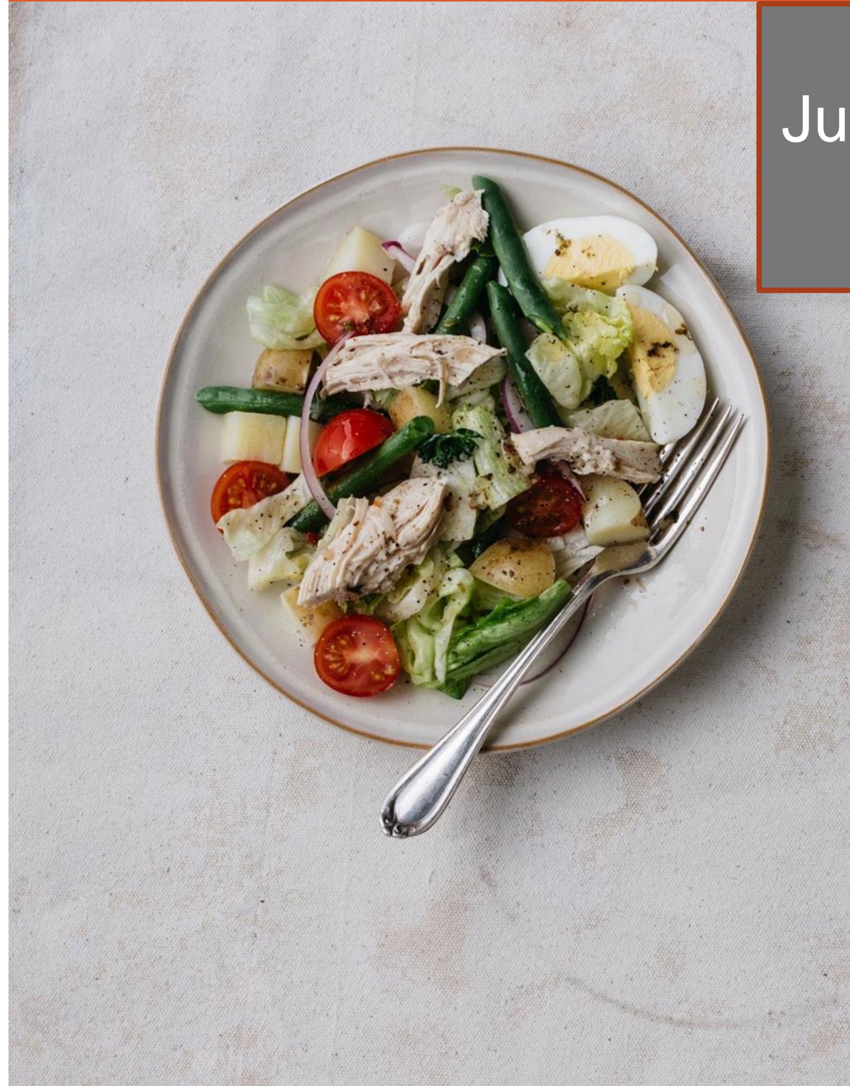
Contact:
Main phone # 401 430-2000
Ruth Scott Snr Director Population Health 401 921-7468
Jean Taylor Dir. Clinical Programs Pop Health 401 921- 7907

COMMUNITY SERVINGS
FOOD HEALS

integra

Community Servings - Integra

June 10, 2022



Erin DiBacco
Director, Strategic Growth and Business Development
Community Servings

Jean Taylor RN, BSN, CDOE, CCM
Director, Clinical Programs
Population Health
Integra

Community Servings at a Glance

30+ years experience delivering Medically Tailored Meals (MTM) as a non-profit

4,000+ people served annually

18 Health Care contacts (Integra is our first RI contract!)

Expanded "Food Campus" in Jamaica Plain

70+ Full time employees

50-75 daily volunteers

Community Servings Mission

Community Servings' mission is to actively engage the community to provide scratch-made medically tailored meals to individuals and their families experiencing critical or chronic illness and nutrition insecurity. We commit, in all our programs and business practices, to prioritize racial and economic justice and health equity.

Vision: *We envision a world in which everyone has access to the nutritious food they need for health and wellbeing as a fundamental right.*

Values: Community, Connection, Inclusion, and Nourishment.

Demonstrated ROI

Peer reviewed research and clinical studies show that with high quality meals tailored to meet the medical and nutritional needs of individuals with complex illnesses, we see...

Improved quality of life and health outcomes

16% **Reduction in monthly healthcare costs**[3]

49% **Fewer hospitalizations**[3]

72% **Fewer admissions to skilled nursing facilities**[3]

> "My weight is down, my sugar, my blood pressure is down, my asthma is controllable so yes, it keeps me out of the hospital. And, last time I went to the heart specialist, he said my heart had the right rhythm and there was no fluid in my lungs, so I think it really, really makes a difference."

1. Illnesses such as HIV/AIDs, Cancer, Advanced Diabetes, Congestive heart failure.
2. https://www.commonwealthfund.org/blog/2019/adapting-promising-innovations-meet-needs-high-need-high-cost-populations
3. Seth A. Berkowitz et al., Association Between Receipt of a Medically Tailored Meal Program and Health Care Use, JAMA Internal Medicine (2019)

   Medically Tailored Meal Delivery for Diabetes Patients with Food Insecurity: A Randomized Cross-Over Trial, J. Gen. Intern. Med. (2018)

   Meal Delivery Programs Reduce the Use of Costly Health Care in Dually Eligible Medicare and Medicaid Beneficiaries, Health Affairs (2018)

Elements of the Medical Meals Program

- Community Servings delivers five days' worth of food each week in one weekly meal delivery
- Weekly meal delivery includes 5 lunches (combination of soups, stews, salads), 5 dinner entrees, milk, fruit, desserts and snacks.
- Our medically tailored meals provide roughly 2/3 of a client's daily caloric needs – about 1,340 calories – based on a 2,000 calorie per day diet.

Members will receive meals from either a Community Servings Delivery Driver **or** UPS

Member or designee must be home for warm handoff of meals

COMMUNITY SERVINGS
FOOD HEALS

Individualized Medical Meal Plans

Our Core Diet Options

- Cardiac
- Diabetic
- Renal
- Pediatric
- Wellness

Examples of diet modifiers:

- Vegetarian
- Pescetarian
- Mild

***15** medical diets tailored to nutritional and medical needs.*

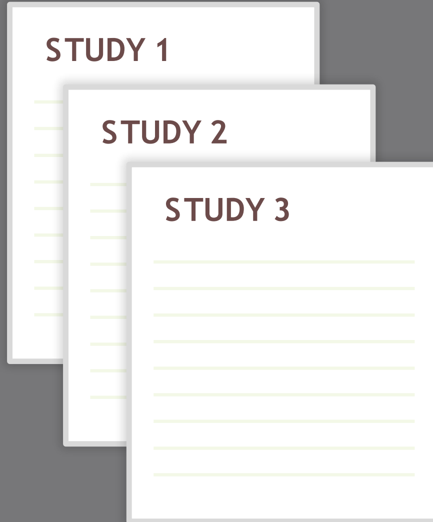
*Meals are **scratch-made** using whole, fresh ingredients.*

***Processed foods limited** to snacks and milk.*

Appendix: Research Studies

Demonstrating ROI

Research Studies



We have led **three research studies** with Dr. Seth Berkowitz, formerly of Mass. General Hospital and now at UNC Medical School, on the health and economic benefits of Medically Tailored Meals.

These studies found that MTM:

- Improves diet quality
- Reduces health care utilization
- Reduces costs for individuals with complex chronic illnesses and poverty.

COMMUNITY SERVINGS
FOOD HEALS

16%

Net Reduction

In average monthly healthcare costs for patient who received Community Servings' home-delivered, medically tailored meals

Health Affairs Study

Published in the journal *Health Affairs* in April 2018

THE STUDY

Examined the impact of home-delivered meals on **133 adults** who were dually eligible for Medicaid and Medicare.

MAIN FINDING

Demonstrated an average monthly net reduction (factoring in the cost of meals) of 16% in medical costs for individuals receiving MTMs, vs. a matched control group of 1,002 people.

Supported by a grant from the AARP Foundation

Diabetes Study

Published in the *Journal of General Internal Medicine* in November 2018

THE STUDY

Using the crossover method, the study tested whether the receipt of MTM improved dietary quality for food-insecure diabetic patients

MAIN FINDING

Study subjects showed improvements in nearly all measures of the Health Eating Index

↑ 31% Point Improvement of the Healthy Eating Index

For individuals receiving MTMs

Supported by grants from the Blue Cross Blue Shield of Massachusetts Foundation and BNY Mellon

16%

Reduction in monthly medical costs

Hospital and nursing home admissions

For individuals receiving MTMs

JAMA Study

Published in the journal *JAMA Internal Medicine* in April 2019

THE STUDY

Researchers looked at claims data from 807 medically tailored meal recipients—the largest study of its kind to date.

MAIN FINDING

Participation in a medically tailored meals program was associated with fewer hospital admissions and nursing home admissions—and less overall medical spending.

The study estimated a 16.4 percent difference in average monthly medical costs ($3,838 versus $4,591) for individuals receiving meals from Community Servings.

Funded by the Robert Wood Johnson Foundation's Evidence for Action program.

Questions?

Erin DiBacco
Director of Business Development
edibacco@servings.org

Community Health Network

Connects Rhode Islanders to free or very low cost evidence-based chronic disease prevention and management programs in person and virtually. Some of these programs are:

- **National Diabetes Prevention Program -** A year long program aimed at reducing the risk of developing type 2 diabetes through lifestyle changes like healthy eating and physical activity. Participants must be at least 18 years old, overweight, and either (1) be diagnosed with prediabetes, (2) have a history of gestational diabetes, or (3) at high risk per the CDC risk test.
- **Healthy Eating** – Uses the USDA's MyPlate as a framework to educate people on how to eat a balanced, heart and bone healthy diet.
- **Diabetes Self-Management Education & Support -** Clinical diabetes education provided by a CDOE.
- **Tools for Healthy Living** - Teaches participants how to manage their chronic condition through nutrition, physical activity, improved communication, stress management, and much more.
- **Heart Healthy Ambassadors Blood Pressure Self-Monitoring Program -** For patients with hypertension, this program teaches them how to properly measure their own BP at home. Eligibility includes HTN diagnosis, no arrythmias, and no cardiac events for at least 12 months prior to starting the program.

Resources & Links

- **Community Health Network @ RIPIN:** https://ripin.org/chn/
  - Make a referral
    - Fax or email a referral form - https://health.ri.gov/forms/referral/CommunityHealthNetwork.pdf
    - Via Unite Us – search for RIPIN and send with the Chronic Disease Management tag

September, 2020

RIPIN

Community Health Network **Program Referral Form**

Patient Information

Name: Gender: ☐ Male ☐ Female ☐ Other

Address: City/Town: State: Zip:

Best Contact Phone: ( ) - Birth Date: / / Email:

Primary Language: ☐ English ☐ Spanish ☐ Other (Please Specify)

Primary Diagnosis Code: Secondary Diagnosis Code:

Health Carrier Plan: ☐ BCBSRI ☐ United Healthcare ☐ Neighborhood Health Plan ☐ Tufts ☐ None ☐ Other:

Health Coverage Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Uninsured

Insurance Information

Insured's Name:

Insured's Address:

Relationship to Patient being referred:

Insurance ID Number:

Gender: ☐ Male ☐ Female ☐ Other Birth Date: / /

Health Concerns

☐ Pain
☐ Pre Diabetes ☐ A1C
☐ Diabetes
☐ Fall Risk/Balance
☐ Cancer
☐ Alzheimers/Dementia
☐ Caregiver Burnout
☐ Tobacco Use
☐ Arthritis
☐ Nutrition Counseling/Healthy Eating
☐ Cardiovascular Disease/Hypertension
☐ Other

Healthcare Provider Signature: Date: / / Notes:

Referrer Information

Referral Date: / / Referrer Name:

Referrer Organization:

Phone: ( ) - Fax number for feedback: ( ) -

CME Credits & Eval

Reminder to please complete the evaluation in order to claim CME credits!

Claim CME credits here: https://forms.office.com/r/kfRy3RA02t

The AAFP has reviewed 'Advancing Comprehensive Primary Care Through Improving Care Delivery Design and Community Health,' and deemed it acceptable for AAFP credit. Term of approval is from 03/18/2022 to 03/18/2023. Physicians should claim only the credit commensurate with the extent of their participation in the activity. NPs and RNs can also receive credit through AAFP's partnership with the American Nurses Credentialing Center (ANCC) and the American Academy of Nurse Practitioners Certification Board (AANPCB).

THANK YOU

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