Senior Nutrition Program Meal Services Elements for Sustainability: Guide to Prioritizing Clients

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Table of Contents

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1. Overview

Aging network providers face financial and organizational challenges serving the large numbers of people eligible for the Title III-C senior nutrition program under the Older Americans Act (OAA). During the 2020 pandemic, the aging network experienced a surge in demand for services. In addition, the number of older Americans continues to increase. By the year 2030, 20% of the population will be 65 and above.

All levels of Title III-C senior nutrition programs are wise to prepare for an increased demand for services. While this emerging circumstance is testing the network's resiliency to innovate and re-imagine existing programs, expanding populations can have a positive impact. Specifically, serving more people:

- expands the reach of the network to reach persons with unmet needs
- increases the OAA's advocacy base
- leverages cost efficiencies by serving more people with existing administrative resources

The network needs tools and partnerships to meet the growing and changing needs of the clientele. A prioritizing system is an important tool when addressing these challenges. This document describes factors a State Unit on Aging (SUA)[1]/Area Agency on Aging (AAA)[2]/Local Service Provider (LSP)[3] should consider in creating a prioritizing process.

A prioritizing process offers significant advantages:

- Ensures policies and procedures meet the intent of the OAA as found in Section 330[4] and referenced in Section 2 of this document
- Prepares for sudden or unexpected changes in funding, food availability or influx of clients
- Creates a uniform framework to assure persons at highest need for meals are being served, resources permitting
- Describes the aggregate characteristics of client/applicants to identify services which address unmet needs
- Communicates with funders, constituents (community, staff, clients, etc.) and legislators to demonstrate impact and provide financial and programmatic transparency

Those eligible for OAA services are especially vulnerable when homebound, have limited mobility, or lack access to nutritious food and transportation. Home-restricted periods may be widespread (e.g., pandemic, disaster, etc.) or individual (based on a person's health or socio-economic issues). Older adults can experience physical or mental decline resulting from extended periods of isolation, decreased physical activity, poor nutritional intake, etc. Organizational readiness for these occurrences, which can

[1] State Units on Aging are agencies of state and territorial governments designated by governors to administer, manage, design and advocate for services and programs for older adults, including the services funded under the Older Americans Act as identified in their State Plan.
[2] An Area Agency on Aging is a public or private non-profit organization, designated within a specific region as a planning and service area by a State Unit on Aging. An area agency on aging is responsible to implement programs/services for older adults through a comprehensive and coordinated service system; administer, manage, monitor, and evaluate services authorized and funded under the OAA as iterated in its area plan, and serve as an advocate for older adults. AAAs may also provide non-OAA services and funding may come from a variety of entities.
[3] A local nutrition services provider/project may be a public or private non-profit organization with a formal contractual or grant arrangement with an AAA or SUA to directly provide specific nutrition services. LSPs may also provide non-OAA services and funding may come from a variety of entities.
[4] https://acl.gov/sites/default/files/about-acl/2020-04/Older%20Americans%20Act%20Of%201965%20as%20amended%20by%20Public%20Law%20116-131%20on%203-25-2020.pdf

include prioritization policies, allows for consistent and streamlined approaches for serving persons of greatest need.

2. Purpose of the Senior Nutrition Program

Title III-C nutrition services are intended to:

- Reduce hunger, malnutrition and food insecurity
- Promote socialization
- Promote the health and well-being of older people

Services are not intended to reach every individual in the community. Programs target adults age 60 and older who are in greatest social and economic need, with particular attention to older adults in the following groups:

- Low-income
- Minority groups
- Rural communities
- Limited English proficiency
- Those at risk of institutional care

3. Senior Nutrition Program Eligibility Criteria

SUAs have the responsibility to develop policies, procedures, guidance and technical assistance for nutrition service implementation including eligibility criteria for services. The SUA may delegate some of this responsibility to AAAs or LSPs, which may also establish further detailed policies and procedures.

When establishing a prioritizing framework, it is important to focus on who is eligible for OAA Title III-C meals.

The federal eligibility criteria for participation is based on age – a person must be at least 60 years old to participate in either a congregate or home-delivered nutrition programs. Spouses (of any age) of people age 60 or older are also eligible.

In addition, Section 339 of the OAA creates the option for programs to offer meals to the following:

- People who provide volunteer services during meal hours
- People with disabilities living in senior housing facilities offering congregate nutrition services (congregate dining sites held in senior housing facilities may serve person with disabilities)
- People with disabilities who reside with eligible older adults

4. Screen Versus Assessment

Before a screening tool can be established, it is important to understand the significance of the tool and how it can assist with the delivery of SNP services. Screening is the process of identifying persons who may be at risk for a condition or need for a service. The screening tool should be easy to administer and available to a large population.

The results from a screening tool are often in a "Yes (the person meets the criteria) or No (the person does not meet the criteria)" format. For example, the Nutrition Screening Initiative (e.g., DETERMINE checklist). The screening tool is out of 10 points, and persons scoring e a six or higher meet the screening criteria for high nutritional risk. A person screening at high nutritional risk could be referred to a local food assistance program, provided transportation to attend a congregate meal program, referred to a chronic disease self-management program, etc.

Screening tools should be:

- Valid (Can the tool identify persons at risk? Is it appropriate for the target population?)
- Reliable (Does it produce the same results if different people use it?)
- User-friendly (Is it acceptable to clients and staff?)
- Reasonable (What equipment does it need? How much training is required? How long does it take to complete?)
- Accurate and specific (Does it accurately identify people who may have a condition or risk? Will anyone who is actually "negative" be inappropriately identified as "positive"?)

Screening is different than an assessment. An assessment is typically performed by a professional expert (e.g. physician, registered dietitian nutritionist, social worker, etc.) who is credentialed and can perform a detailed investigation and identification of a diagnosis and treatment options.

A screening or assessment can happen first:

Assessment → Screen

A community or hospital professional performs an assessment of an individual and refers the person to an AAA/LSP. Example: a doctor diagnoses Mr. Smith with diabetes. In addition to medication prescriptions and other clinical referrals (i.e. a dietitian for meal planning), the doctor refers him to a senior center to attend physical activity classes. As part of the membership process, the senior center (which follows AAA policies and procedures) asks him screening questions through their intake form/interview related to health, nutrition and socio-economic risks to assist with referring him to programs that best meet his needs. In this case, a referral to a Diabetes Self-Management Workshop may be appropriate and other referrals such as the State Health Insurance Program, congregate meals program and others could be helpful along with the physical activity programs recommended by the physician.

Screen → Assessment

An AAA/LSP screens an individual, identifies a health risk and refers that person to a professional expert for further assistance. Example: as part of a health and wellness fair, an AAA/LSP gives Ms. Anderson a malnutrition risk screening. Her score reveals a high risk for malnutrition. The AAA/LSP refers Ms. Anderson to her physician for an in-depth assessment and also invites her to participate in their congregate meal program, attend a counseling appointment with a dietitian and access community-based food resources including the Commodity Supplemental Food Program and local food pantries (list and contact information provided).

5. Determining Prioritization Criteria

The SUA is "primarily responsible for the planning, policy development, administration, coordination, priority setting and evaluation of all State activities related to the objectives of this Act…" [5] As a result, some SUAs establish prioritization criteria. Based on state priorities (as shown in the State Plan and Area plan requirements) and in consultation with AAAs, LSPs and other stakeholders, the SUA may require specific tools, data collection, monitoring tools, protocols and evaluation activities to assure adherence to the requirements in the OAA and other state funding under its control. The SUA may allow flexibility based on criteria in policies, procedures and the area plan.

In some states, SUAs delegate this responsibility to the AAA, and the AAA may be responsible to develop the policies, procedures, guidance and monitoring, of local service providers. Utilization of specific tools may be included in the terms of its grant or contract agreement. In other states, this prioritization may be implemented by the LSP.

Variation across LSPs and AAAs may result in inconsistent practices throughout a state. This increases complexity and risk when SUAs and AAAs monitor for adherence to the OAA intent and targeting of services. Variation in policy or procedure, however, may have the advantage of allowing for flexible approaches based on staff expertise, funding levels, in-kind resources, etc.

Prioritization criteria for individuals may include screening and/or assessment with documentation of:

- ADLs/IADLs, malnutrition, food security, chronic health conditions, formal or informal support, and access to transportation
- Population/demographics: OAA target populations i.e., persons at greatest social and economic need (see Section 2. Purpose of the SNP section)
- Existing supports and services: formal and informal caregivers who assist with or provide cooking, shopping, safety checks, etc.

Prioritizing systems must be careful when rating socioeconomic issues as higher priority, because policies and procedures cannot involve means-testing. However, it is permissible to collect income information for the purposes of identifying benefits and resources that may assist the individual. The following are recommended guidelines when targeting services without means-testing[6]:

1. Identify the target population based on the OAA
2. Establish priorities within the population(s) that meet the most critical needs and can provide a LSP with a fair and consistent way to implement the prioritizing process without means-testing
3. Provide services with cultural sensitivity and effective communications
4. Develop strategic outreach and education materials
5. Coordinate with other entities in the aging network

[5] OAA Section 305 (a)(1)(C

[6] Adapted from: National Center on Law and Elder Rights, *Targeting Older Americans Act Services Without Means Testing: Meeting the Challenge*. Issue Brief, January 2018. Accessed June 29, 2020 at https://ncler.acl.gov/pdf/Targeting-OAA%20-Services-Without-Means-Testing-Issue-Brief.pdf

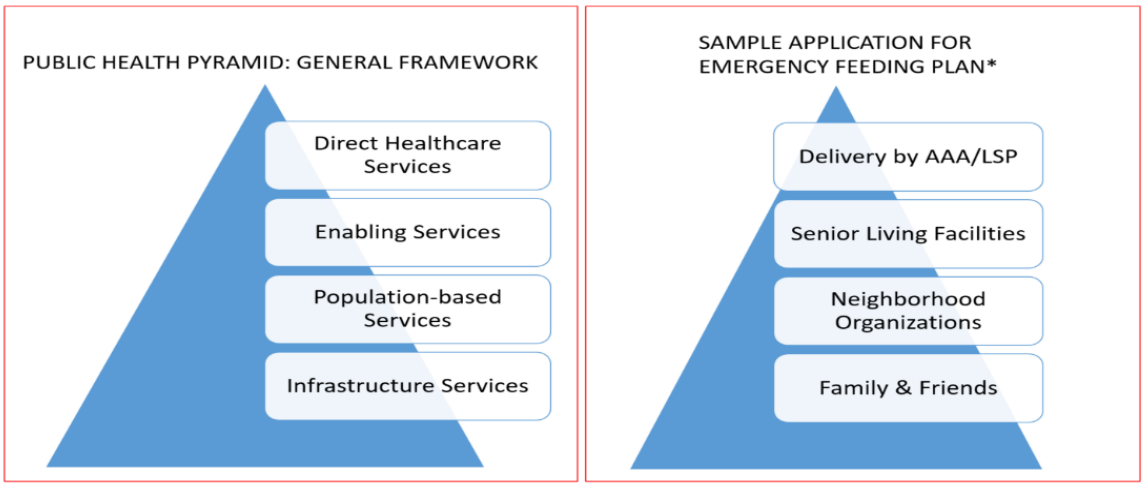
6. Make services accessible and user-friendly

The prioritizing criteria selected will help inform options for selecting tools (i.e., which specific assessments, screens or data collection instruments should be used) and the approach (i.e., phone or in-person, frequency of prioritizing, staff with appropriate training or expertise) to collect information from individuals either applying for or currently receiving services.

SUAs/AAAs/LSPs may want to consider focusing priority systems on populations instead of or in addition to screening and assessing individuals.

One example is a public health framework called the Health Impact Pyramid.[7,8] This approach can prioritize meal distribution efforts to individuals at the top of the pyramid, i.e., older adults who do not have access to or existing support from family and friends, neighborhood organizations or senior living facility meals.

Figure 1. Prioritizing Using the Public Health Impact Pyramid: Baltimore City AAA/Health Department



*Credit: Baltimore City Health Department/AAA. Approach for organizations responsible for food and meals delivery based on the need for assistance by various population segments.

Tools and strategies to address health disparities[9,10] can also be considered in the development of prioritizing policies. Socioeconomic and environmental issues likely impact some populations in an SUA/AAA/LSP jurisdiction resulting in a higher burden of illness, injury, disability or mortality. The Center for Disease Control and Prevention's Social Vulnerability Index (SVI)[11] may be a helpful tool for quantifying this priority-related issue; the SVI uses U.S. Census data to determine the resilience of communities when they are impacted by natural or human-caused disasters or disease outbreaks (i.e., social vulnerability). The SVI ranks each tract on 15 social factors including poverty, lack of vehicle access, crowded housing, etc.

[7] CDC website, Health Impact in 5 Years. https://www.cdc.gov/policy/hi5/index.html

[8] A Framework for Public Health Action: The Health Impact Pyramid (American Journal of Public Health) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/pdf/590.pdf

[9] Office of Disease Prevention and Control Healthy People: Disparities https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

[10] CDC Health Equity website: https://www.cdc.gov/healthequity/

[11] https://svi.cdc.gov/

7. General Requirements to Establish a Prioritizing System

The OAA allows Title III-C nutrition programs to set up a priority structure, seek payment for home delivered meals by establishing contracts and/or set up private pay meals for those clients who may otherwise be placed on a waiting list.

- This can be done as long as the intent of the law is intact (see Section 1. Purpose of the Senior Nutrition Program)
- Specific requirements[12] SUA/AAA/LSPs should consider when establishing a private pay system are shared in a separate ACL guidance document: Establishing a Private Pay Meal Program. Resources exist to support SNPs considering this option[13]
- The SUA/AAA/LSP must have clear policies and procedures to avoid any real or perceived bias or partiality that is not in alignment with the intent of the OAA (the Act states all persons 60 and older with greatest need are eligible (see Purpose of the SNP section above)

If an SUA/AAA/LSP subdivides priority levels (e.g., low, medium, high), they should clearly state qualifications for each category in their written policies and procedures. SUAs/AAAs/LSPs may assign highest priority to homebound individuals, persons living in rural settings, those who live alone, etc.

Example: Ohio Prioritization of Service Delivery to OAA Consumers, March 2020

High Priority individuals may be:
• Medically fragile
• Living alone with limited or no social support
• Geographically isolated
• Dependent on life-support equipment including respirator, continuous oxygen or tube feedings
• Diagnosed with a severe cognitive or mental health impairment which affects decision-making capacity
• Significantly affected by any loss of service

Medium Priority individuals may be:
• Living alone or with another person with limited or no capacity to assist with meeting the needs of the individual
• Without consistent social support (someone nearby can check on the individual)
• Intermittently dependent on oxygen
• Able to function with a temporary loss of service
• Able to follow through with a back-up and emergency plan

Low Priority individuals may be:
• Living with family or living alone with dependable social support
• Living in a supportive care environment (i.e. assisted living)
• Able to function with a temporary loss of service
• Able to follow through with a back-up plan and emergency plan

[12] OAA Section 212
[13] Aging and Disability Resource Center Business Institute: https://www.aginganddisabilitybusinessinstitute.org/

8. Title III-C Services When Waiting Lists or Private Pay Options Exist

Prioritizing systems may occur during times when a waiting list for Title III-C nutrition services exists or private pay options are available. LSPs must offer Title III-C nutrition services to all applicants who meet eligibility requirements. Key steps involved in discussing the availability of Title III-C nutrition services in these situations are listed below:

- Clients 60 and older should be given the option of Title III-C service prior to any private pay option. If there is a waiting list for Title III-C, the possibility of placement on the waitlist should be discussed. In addition, clients should be informed how long the estimated wait time will be for nutrition services. After offering the Title III-C/waiting list options, only then may the clients choose from available private pay options.
- If a provider is at maximum capacity, eligible persons should have access to a waiting list. SUAs/AAAs/LSPs must develop clear policies and procedures to ensure persons can move up to the top of a waiting list to receive services (see Section 7. Establishing Waiting Lists, and Appendix A for additional guidance).
- Once Title III-C nutrition services are offered, the LSP may indicate a private pay service option if available. Please refer to *Senior Nutrition Program Meal Services Elements for Sustainability: Guide to Establishing a Fee-for-Service Private Pay System*. Also, resources exist[14] to support Title III-C nutrition programs considering this option.

As for all potential or existing clients, additional resources and referrals should be provided to persons applying for nutrition services such as other Title III-C programs (e.g., home delivered or congregate meals, depending on which service is at capacity), community meal or food programs, homemaker services, commercial meal delivery, etc., as appropriate based on the need(s) of the participant.

9. Selecting a Priority Tool

Once priority criteria is considered, an SUA/AAA/LSP should consider which tool(s) will be used to determine an individual's priority level.

- Establish your organization's goal for implementing a prioritizing tool. Examples include:
    - Develop a unified, statewide policy for prioritizing individuals who apply for home delivered meals
    - Create and implement a prioritizing system to create a uniform approach to serve eligible SNP clients across congregate and home delivered meal programs
- Decide if you will use the tool to screen new applicants and/or whether it will be incorporated into assessments of existing clients (assessment requirements vary by State and locality) or both
- Identify existing models and determine which meets the criteria for a good screening tool (see Screening versus Assessment section)
- Select an existing, validated tool. If necessary, develop a screening process of your own using the criteria listed in the Screening versus Assessment section. Regardless of the tool selected, ensure it is consistent with the intent of the OAA (see Purpose of the SNP section)

[14] Aging and Disability Resource Center Business Institute: https://www.aginganddisabilitybusinessinstitute.org/

- Test the tool:
    - Consider working with a research partner (i.e., a University)
    - Create a workgroup with a diverse membership:
        - Expertise
        - Demographics
        - Viewpoint
        - Levels within an organization
    - Also, consider inviting partners outside the organization (i.e., the local hospital or health department)
    - Allow and plan for regular feedback from workgroup members in order to guide rollout and implementation of the tool
- Establish a policy and procedure for implementation - consider an initial "practice" period which will lead to required performance
- Perform any required cost or justification analysis
- Create and implement training - consider a variety of learning environments including a written manual, video or online training and in-person instruction
- Monitor implementation - review a summary of results (i.e., aggregate data) on a regular schedule
- Utilize data to describe populations applying for meals, better address unmet needs, report to SNP Boards or AAA/SUA and help potential or existing funders understand the needs of your community. For example, if a screening tool identifies populations with food insecurity who have the ability to prepare meals, a LSP may consider establishing or expanding grocery shopping program as a more consumer-focused, cost-efficient service instead of or in addition to meals for those individuals.

10. Establishing a Waiting List

While a prioritization system may be in place without a waiting list, they often go hand-in-hand. SUAs/AAAs/LSPs may create policies and procedures regarding what a waitlist is and how it should be handled and established. The 2015 Senior Nutrition Program Process Evaluation[15] found that some SUAs had policies, guidance or regulations pertaining to the creation and management of a waiting list for the SNP.

A first step may include defining the intent of a waitlist and differentiating it from unmet need. Second, outline a plan for implementation. In addition, AAA or SUA review of service resource usage and efficiency may be required prior to instituting a waitlist. Policies and procedures should be clear regarding the responsibility of waitlist management and any coordination necessary between the assessing organization and the LSP (if the entities are separate).

See the Appendix A: Considerations for Developing a Waitlist, which includes detailed recommendations to consider when creating a waiting list policy.

[15] https://acl.gov/sites/default/files/programs/2017-02/NSP-Process-Evaluation-Report.pdf

11. Prioritizing System Implementation

A SUA may want to establish a statewide priority system. Establishing a statewide priority system provides several advantages including uniform implementation, elimination of discrepancies between providers and a consistent client screening process. Statewide use of a single prioritizing tool also:

- Facilitates compiling statewide data to assist with state-level funding justification, policy and service development and policymaker communication
- Facilitates local data compilation and informs local communities about the need for services, allowing local communities to develop strategies to meet this need
- Streamlines monitoring, training tools and implementation
- Allows each locality to serve clients based on available resources. For example, a LSP with sufficient funding to serve all applicants may be able to accept persons at all priority levels, whereas another LSP without funding to match the number of people applying for service may accept only the highest priority level and will place others on a waiting list for service.

Local implementation may be advantageous if a priority system requires specific expertise that may not exist across a state or larger region. Whether used locally or statewide, SUAs are responsible for ensuring any priority system is in compliance with the OAA.

> **Example**: AAA shall ensure that the area-wide percentage of residents with the greatest economic and social need is proportionately represented in the characteristics of individuals served in the nutrition program.[16]

12. Summary

The aging network will continue to be challenged as the number of older adults seeking services increases. Title III-C senior nutrition programs should begin making preparations now. The network should utilize tools and develop relationships with key stakeholders to meet the growing and changing needs of their clientele. A prioritizing system provides a uniform framework to assure persons with the highest need for meals are being served with program resources.

[16] Iowa Administrative Code: https://protect2.fireeye.com/url?k=2125da8a-7d70d399-2125ebb5-0cc47adb5650-62c181efc17da8aa&u=https://www.legis.iowa.gov/law/administrativeRules/rules?agency=17&chapter=2&pubDate=05-20-2020

Appendix A: Considerations for Developing a Waitlist

Who will maintain the waitlist?

- Will your data system include a feature to be used by all intake staff/case managers?
- Is there a stand-alone spreadsheet that a specified person will maintain? Other?
- If one organization provides the services of assessment/care coordination and another organization provides the service of meal delivery, which organization will maintain the waitlist?
- What are expectations for communication between the two organizations regarding waitlist issues?

What are the criteria that will determine who is added to the waitlist?

- Are there any categories of clients that will not go on the waitlist (e.g., individuals receiving meals as part of an elder abuse prevention/intervention plan and/or individuals being discharged from a hospital who are to receive a certain number of short-term home-delivered meals)?

What are the criteria that will determine how an individual is removed from the waitlist?

- Will you use a first-come, first-served approach?
- Is there priority criteria (e.g., those with higher nutrition risk scores, ADL/IADL impairments or priority rankings) that will determine order of removal from the waitlist?

What will you offer to clients in order to meet their needs while on a waitlist?

- Are there homemaker services, informal caregivers or referrals to other faith-based or volunteer programs that can meet the individuals' needs while on a waitlist?
- Are there private pay programs available through your organization or otherwise?

How often will you contact clients while they are on the waitlist?

- Will you provide well-being checks via staff or volunteers?
- Will you conduct periodic (i.e., every six months or annually) re-screening or re-assessments of clients on a waitlist?

What is your communication plan?

- Have you talked with funders to let them know your situation, solutions you are considering and other options they may recommend?
- Have you communicated with your referral sources to let them know about your waitlist plans?
- Are there other community leaders, organizations and stakeholders with whom you should communicate (e.g., legislators, other elected officials, individual donors)?
- What needs to be edited/added to any brochures, website, fundraising, or other materials?

How will you train staff across all levels (e.g., intake, care coordination, meal delivery, data, communications, planning, and advocacy) regarding your waitlist policies and procedures?

- Do you have care coordination forms, training slides, and policies and procedure manuals, etc. that need to be updated?

How else will you use the waitlist? (e.g., To advocate for additional funding? To plan for allocation of current funding? To manage community/client/caregiver expectations?)

- Will you use waitlist numbers in your fundraising appeals?

What types of data will you need to collect in order to meet waitlist management, budgeting, reporting, and advocacy functions?

- Do you need to collect data by zip code, city, county, age, ADL/IADL impairment, priority level, and/or other criteria?
- How frequently will you review data on your waitlist?

How will the waitlist policies, procedures, and practice be evaluated?

- Will you develop a stand-alone waitlist evaluation, or will you fold the waitlist into other existing evaluation activities?
- What evaluation measures will you use?
- What evaluation timeframes will you use?

Are there other actions your organization should take prior to establishing a waitlist?

Appendix B: Sample Screening Systems

This appendix contains three examples of priority systems, to assist with learning more about how a sampling of OAA network organizations have established prioritizing frameworks.

1. Delaware Department of Health and Social Services. Delaware Home Delivered Meals Services Specifications. For further information, contact Brian Bayley, brian.bayley@delaware.gov or Irene Soucy, MS, RD, CSG, LD, irene@dietarydirectionsinc.com, at the Division of Services for Aging & Adults with Physical Disabilities, Delaware Department of Health and Social Services, https://www.dhss.delaware.gov/dhss/dsaapd/.

2. Maryland Department of Aging. Maryland Expanded Food Security Screener: Home-Delivered Meals Prioritization Tool Training Manual and the Expanded Food Security Screener. For further information contact LaTanya Clark, MS, RD, LDN, LaTanya.Clark@maryland.gov, Nutrition and Health Promotion Programs Manager at the Maryland Department of Aging https://aging.maryland.gov, Professor Nadine Sahyoun, University of Maryland at nsahyoun@umd.edu or go to: https://nfsc.umd.edu/extension/expanded-food-security-screener.

3. Meals on Wheels of Central Texas. The Intake Division administers the USDA 6-question food security questionnaire[17] by phone upon enrollment and a modified (with permission) Mini-Nutritional Assessment[18] during in-home assessments. For more information contact: Seanna Marceaux, MS, RDN, LD, Vice President for Nutrition, Health and Impact, smarceaux@mealsonwheelscentraltexas.org, 737-218-4150 or email@mealsonwheelscentraltexas.org, 512-476-6325, https://www.mealsonwheelscentraltexas.org/.

We would like to periodically update this section; thus, Appendix B: Sample Screening Systems is a separate file.

Please send additional examples to the National Resource Center on Nutrition and Aging.

[17] https://www.ers.usda.gov/media/8282/short2012.pdf

[18] https://www.mna-elderly.com/