2017 Grantee

Tackling Malnutrition Through a Statewide Delivery System in Maryland

Summary:

To transform their senior nutrition program, the Maryland Department of Aging used the epidemic of older adult malnutrition as the catalyst to introduce evidence-based practices, cost-cutting measures, innovative meal products, and efficient service delivery methods to forge new health care linkages and expand service to older adults in the community.

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AAA Malnutrition Pathway Presentation

Presentation slides.

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AAAs: Hub for Community Supports Addressing Social Determinants of Health

The case for effective identification and treatment of Malnutrition Risk

Presenter: Livleen Gill, MBA RDN LDN

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AGENDA

- Payment frameworks now target Social Determinants of Health (SDOH)
- Current and changing health care landscape in Maryland
- Malnutrition's impact on healthcare cost
- How do AAAs own the mission of being the community hub – tools we will provide you to take charge

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Social Determinants of Health

- Definition of SDOH/HRSN
- SDOH screening and coding
  - ICD-10 SDOH codes - Z55-z65
- Screening tools

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Federal Legislation

& Social Determinants of Health

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Chronic Care Act 2018

- Bipartisan Act that Congress passed On February 11, 2018
- New federal law advancing integrated, person-centered care for Medicare & dually-eligible beneficiaries
- Medicare Advantage Plans and their role

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Key Medicare Advantage & SNP* Provisions

- Expands supplemental benefits & continues VBID demonstration for chronically ill MA enrollees
- Permanently authorizes D-SNP, C-SNP, & I-SNP
- Promotes additional integrated care in D-SNPs
- Updates C-SNPs care management requirements & condition list (e.g., HIV/AIDS, ESRD, & mental illness)
- Expands tele-health access

*SNP = Special Needs Plans

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Types of Covered Services

- Adult Day Services
- In-Home Support Services
- Support for Caregivers of Enrollees
- Home and Bathroom Safety Devices and Modifications
- Transportation

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Opportunities

- Focus on health beyond medical care
- Craft new partnerships to address SDOH

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Centers for Medicare and Medicaid

- HHS spends over $1 trillion a year on healthcare for the elderly and vulnerable through Medicare and Medicaid
- In 2018 CMMI launched the Accountable Health Communities model to address the human needs that may be impacting high utilizers of healthcare
- Screenings for
  - Food insecurity
  - Domestic violence risk
  - Transportation
  - Housing and utility needs

Needs assessed : connect with community resources- pay for services

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Healthcare Influencers

& Social Determinants of Health

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American Medical Association

- Integrating training on SDOH in undergraduate medical school education
- Incorporating lifestyle medicine in medical school adopted by AMA house of delegates (USC Greenville)
- Implemented training module for providers in addressing SDOH in their practices (Steps Forward)
  - Six common domains
    - Economic stability
    - Neighborhood
    - Food
    - Education
    - Community/social support
    - Healthcare system

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American Hospital Association

- Task force to improve access and delivery of care to address SDOH (www.aha.org/ensuringaccess)
- Identified 3 ways for hospitals to engage
    - Screening and information
    - Navigation
    - Alignment
- Community conversations Toolkit for hospitals
- CMS 10 question screening tool for SDOH across 5 key domains

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Maryland Healthcare

Current and changing health care landscape

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State of Maryland Landscape

- Medicaid Service delivery (MCOs)
- Medicaid community services
- Role of Maryland Access Point (MAP)
- Maryland Primary Care Program (MDPCP)

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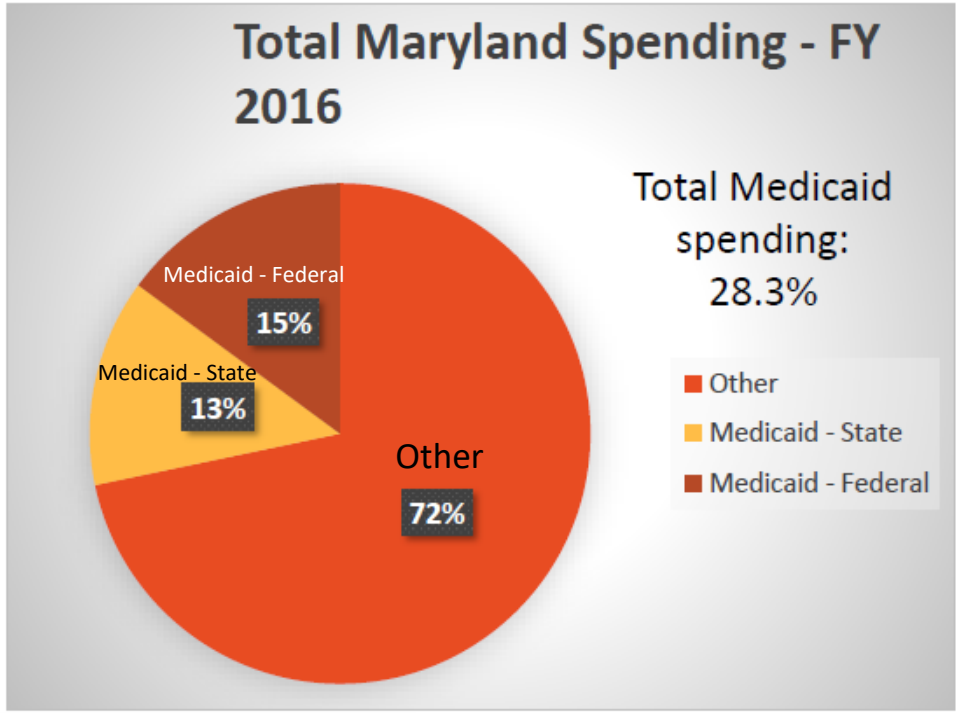
Medicaid



Maryland Medicaid's high cost areas (FY2017):

- Institutional LTSS (7.8% of enrollees)
- Hospital
- Home and community based LTSS

- In 2018, approx. 1.3 million people enrolled in Medicaid (including CHIP)
- 81.5% of enrolled beneficiaries are in Managed Care Organizations (MCOs)

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Maryland Access Point (MAP)

- Single point of entry for access to services of state agencies (https://md.getcare.com)
- 20 MAP sites in Maryland
- Funding sources are Title II and Title III
- Title III funding is for all persons 60 years and over and means testing is prohibited
  - MAP is the Aging and Disability Resource Program in Maryland. The ADRC initiative is sponsored by the federal Administration for Community Living, the Centers for Medicare and Medicaid Services and the Department of Veterans Affairs, and involves a national network operating in 54 states and territories
  - MAP is a centralized, single point of entry for anyone – individuals, concerned families or friends, or professionals – to access aging and disability programs and services provided by state agencies and private, public and community-based organizations

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Major MAP Funding Sources

Medicaid FFP
State, Local Funds, Grants, Contracts

Older Americans Act: Title IIIB	
I & A	Supportive Services: Case Management Chore Services Personal Care Homemaker

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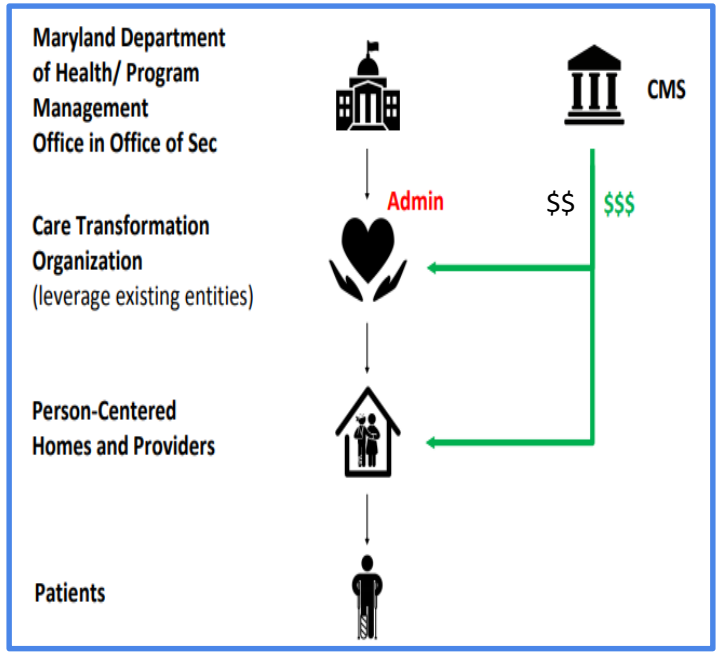
MDPCP

- Supports overall health care transformation process.
- Allows primary care providers to play an increased role in prevention, management of chronic disease, and preventing unnecessary hospital utilization.
- Voluntary program and open to all eligible primary care providers.
- Practices enrolled in the program are supported by Care Transformation (CTO) organizations and state practice coaches.
- Practices and CTO are provided additional $$ per beneficiary attributed in addition to fee for service



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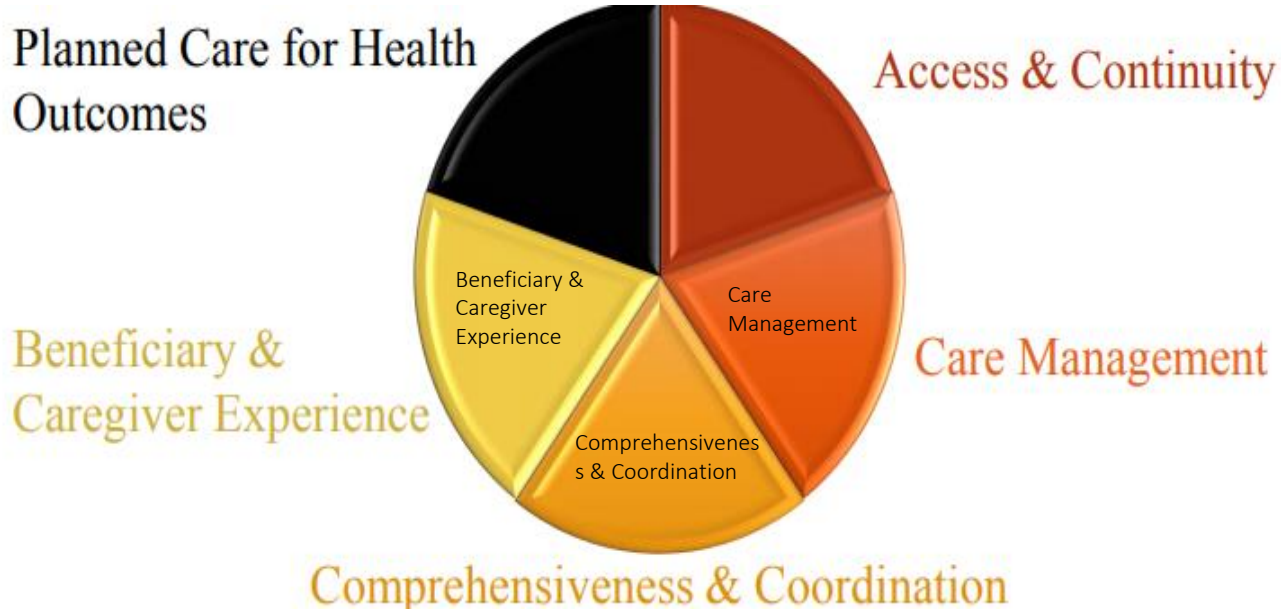
MDPCP

- Five Pillars of MDPCP
- Use of CRISP is mandatory



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Malnutrition

Impact on healthcare cost

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Malnutrition

What is Malnutrition?

- Malnutrition is the inadequate intake of nutrients, particularly protein, over time and may contribute to chronic illness and acute disease or illness and infection

Impact of Malnutrition

- Frailty
- Disability
- Loss of independence
- Increased risk for falls
- Increased risk for infections
- Delayed wound healing
- Increased medical complications for other other diseases
- Hospital readmissions
- Increased length of stay
- Decreased effectiveness of medical treatment

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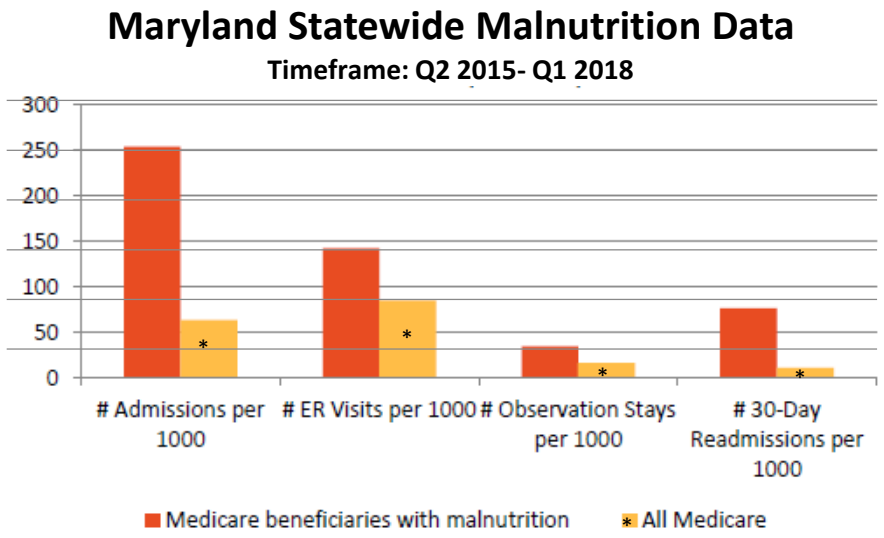
Prevalence of Malnutrition in Care Settings

- Acute care
  - 20-50% of all patients are at risk for or are malnourished at the time of hospital admission (1)
  - Only 7% of patients are typically diagnosed with malnutrition during their hospital stay (2)
- Post-Acute care
  - 14- 51% of seniors are malnourished
- Community
  - Estimated 6-30% of seniors are malnourished

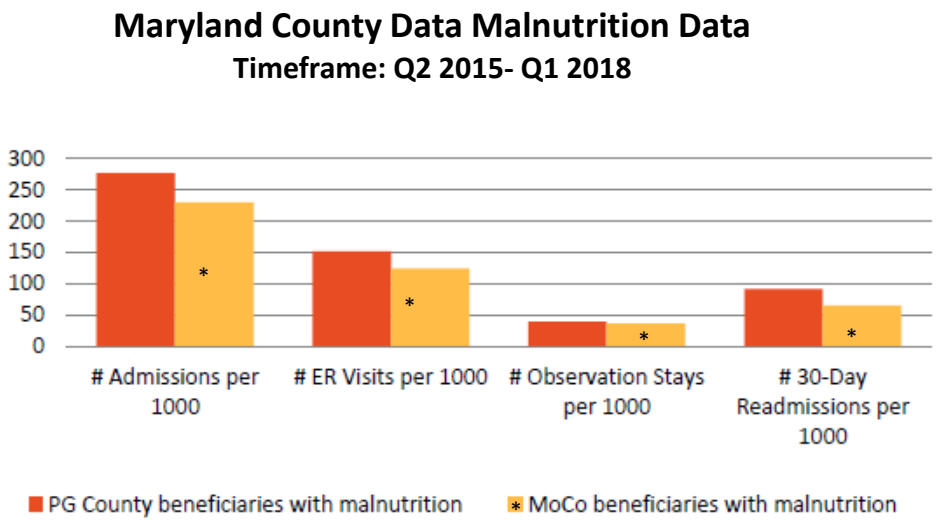
1 Barker LA, Gout BS, Crowe TC. Hospital malnutrition: Prevalence, identification, and impact on patients and the healthcare system. Int J Environ Res Public Health. 2011;8:514-527.
2 Weiss AJ, Fingar KR, Barrett ML, Elixhauser A, Steiner CA, Guenter P, Brown MH. Characteristics of hospital stays involving malnutrition, 2013. HCUP Statistical Brief #210. Rockville, MD: Agency for Healthcare Research and Quality. Available at: http://www.hcup-us.ahrq. gov/reports/statbriefs/sb210-MalnutritionHospital-Stays-2013.pdf.

Local Prevalence of Malnutrition

Maryland Malnutrition Data



County Specific Malnutrition Data



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Malnutrition Risk Factors

- Clinical- Diagnosed by physicians, NPs and PAs
- Social- Diagnosed by care managers, nurses, support care personnel

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The Role of the AAA

Own the mission of being the community hub – tools we will provide you to take charge

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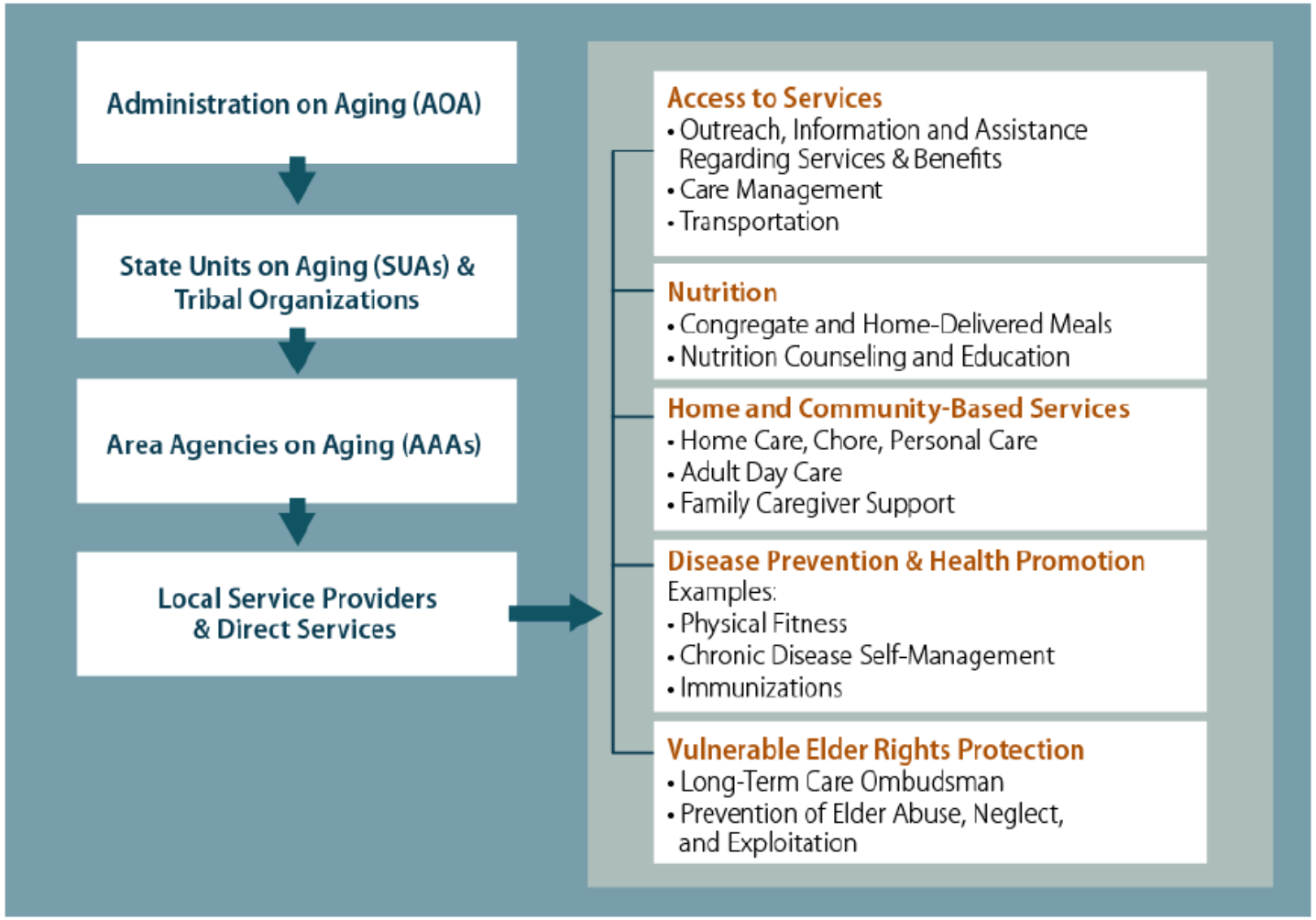
Aging Network Overview

Figure 1. The Aging Network



Source: Prepared by the Congressional Research Service.

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Screening for SDOH at MAC

Chronic Disease Assessment: 1) Do you have 2 or more chronic medical conditions? 2) Are you taking more than 5 medications? 3) Do you have difficulty managing your condition(s)?

REFER TO LIVING WELL, COMMUNITY RESOURCES, HEALTHCARE

Falls Risk Assessment for patients over 65: 1) Have you fallen in the past year? 2) Do you feel unsteady when standing or walking? 3) Do you worry about falling?

REFER TO FALLS PREVENTION WORKSHOPS, EXERCISE PROGRAMS, COMMUNITY RESOURCES

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Screening for SDOH at MAC

Depression Screen: Over the past two weeks, how often have you been bothered by any of the following problems? 1) Little interest or pleasure in doing things? 2) Feeling down, depressed or hopeless?

REFER TO PEARLS, COMMUNITY RESOURCES, ATTEND SENIOR CENTERS/ CONGREGATE MEALS

Malnutrition: 1) Have you recently lost weight without trying? 2) If yes, how much weight have you lost? (MST – Malnutrition Screening Tool)

REFER TO STEPPING UP YOUR NUTRITION, FALLS PREVENTION, LIVING WELL, MEALS PROGRAMS, EXERCISE PROGRAMS AS APPROPRIATE. IF FOOD INSECURE, FOOD PANTRIES AND OTHER RESOURCES.

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Multi-Disciplinary Approach

MAP	
Type of intervention	*Action*
Screening	• Malnutrition Screen • Falls Screen • Depression Screen
Client Support Care Plan	• Enroll/refer to Nutrition, HP and/or SHIP • Transportation to healthcare appointments and referral sites
Address Root Cause	• Program Eligibility • Refer to Behavioral Health, caregiver support, Physician, CHW • Grocery program, pet food, call reassurance, etc
Communicate Progress	• Track Referrals • Incorporate client Options Counseling goals • Assist with hospital messages and progress

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Multi-Disciplinary Approach

Nutrition Program	
Type of Intervention	*Action*
Screening	• Malnutrition Screen • Food Insecurity Priority Screen
Client Support Care Plan	• Person- centered service/meal plan • Provide Social Interaction • Nutrition education
Address Root Cause	• Nutritionally balanced food • Social isolation • Hydration • Manage chronic conditions
Communicate Progress	• Track Participation • Assist with hospital messages and progress

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Multi-Disciplinary Approach

Health Promotion	
Type of Intervention	*Action*
Screening	• Varies based on program and staff certifications
Client Support Plan	•Exercise • Strength • Nutrition • Chronic Disease Management
Address Root Cause (s)	• Social isolation • Manage chronic conditions • Falls risk
Communicate Progress	• Track Referrals • Share Client goals with healthcare team • Assist with hospital messages and progress

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Multi-Disciplinary Approach

SHIP	
Type of Intervention	*Action*
Screening	• Benefits Check-up
Client Support Care	• Identify & assist with medical insurance gaps
Addressing Root Cause (s)	• Address gaps in insurance coverage (income)
Communicate Progress	• Regular follow-up for high risk clients

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Case Study

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Case Study

- B.B. is an 85 year old woman who was referred to our practice in early February 2018. She presented socially well and was always well groomed.
- She had 42 ER visits to the local hospital in 2018
- She had two mini fires in her apartment
- She had not filled medications at the pharmacy since late 2017
- Calls would average between 2-8 times in a given day

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Case Study

- Our practice provided telephonic touch points, office visits, home visits, information to EMS, hospital SW, contacted family
- We provided food items, supplements
- Finally reported to APS as things kept escalating after 3 months
- APS kept an eye on her but could not really do much
- In January 2019 was delirious and admitted to hospital psych unit
- APS filed for temporary guardianship

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SDOH & ICD-10 Codes

SDOH Domains	ICD-10 codes for SDOH
Living Situation including housing and utilities	Z59 – Problems related to housing and economic circumstances Z60 – Problems related to social environment • Z60.2 – Problems related to living alone
Food	Z59 – Problems related to housing and economic circumstances • Z59.4 – Lack of adequate food and safe drinking water
Safety	Z60 Problems related to social environment
Financial Strain	Z59 – Problems related to housing and economic circumstances
Employment	Z56 – Problems related to employment and unemployment
Family and Community Support	Z63 – Other problems related to primary support group, including family circumstances Z60 – Problems related to social environment
Education	Z55 – Problems related to education and literacy
Mental Health	Z64 – Problems related to certain psychosocial circumstances Z65 – Problems related to other psychosocial circumstances

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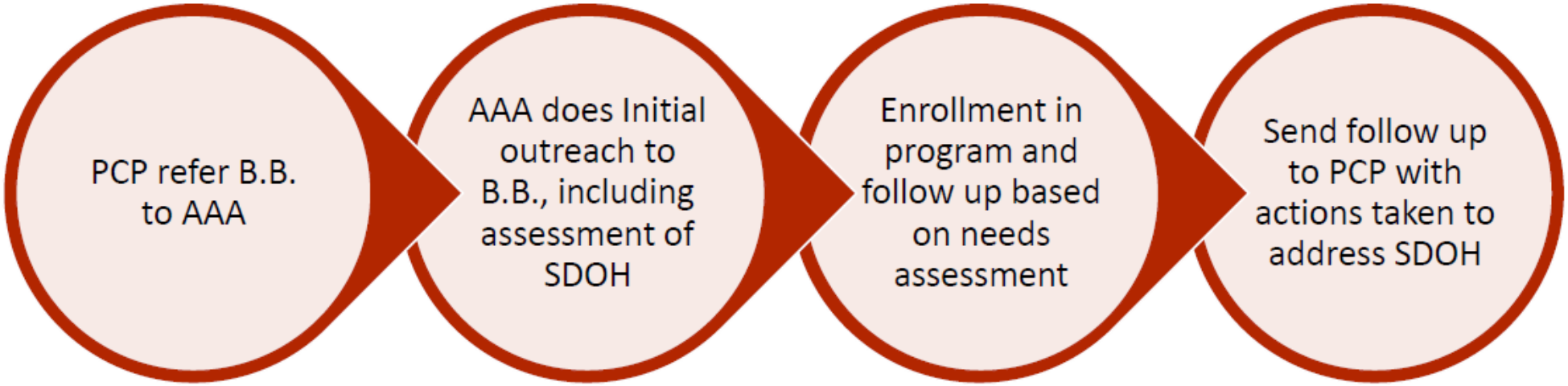
Case Study

- Ideal Pathway for B.B.



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Next Steps: Tools to Take Charge

- Malnutrition Toolkit draft one week before in person meeting:
  - Rationale for community-based interventions
  - Community-based Malnutrition care pathway
  - Professional role delineation
  - Template presentations
  - Billing codes to match interventions
- In person meetings to solicit feedback on feasibility of draft toolkit (February)→incorporate feedback in toolkit (March)
- Web meeting to disseminate toolkit (March/April)

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Thank you!

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AAA Malnutrition Pathway Site Visit Agenda

Sample schedule for Malnutrition Pathway site visit.

Malnutrition Pathway Site Visit

Washington County Commission on Aging

535 E. Franklin Street, Hagerstown, MD 21740

Friday, April 12th, 11:00-12:15PM

Attendees:

Washington County Commission on Aging

Maryland Department of Aging

Bethesda NEWtrition & Wellness Solutions

Agenda:

11:00-11:05pm: Introductions

11:05-11:10pm: Overview of Grant Goals and Purpose of Today's Meeting

11:10-11:15pm: Malnutrition Video

11:15-11:30pm: Interdisciplinary Role Activity

11:30-11:45pm: Healthcare Partnerships and Billing

11:45- 12:05pm: Community Care Plans

12:05-12:15pm: Summarize Next Steps

AAA Malnutrition Pathway Survey

Survey for AAAs to provide feedback on their understanding of malnutrition and the malnutrition toolkit.

Malnutrition Toolkit Survey
Carroll
MAC
Baltimore
Washington

INTRO: Please review the Malnutrition Toolkit prior to filling out this survey. You should also have the toolkit available and be able to reference it section-by- section as you respond to this survey.

1) Your name
2) Select your AAA
   a) Baltimore City
   b) Carroll County
   c) MAC
   d) Washington County
3) Select your position/role in your AAA? (select all that apply)
   a) Executive Director
   b) MAP
   c) Nutrition
   d) Health Promotion
   e) SHIP
   f) Senior Care
   g) Other

Rationale for Community-Based Interventions (pages 3-5)

4) Please review the risk factors for malnutrition listed in this section. How often do you interact with individuals who have one or more risk factors for malnutrition?
   a) Never
   b) Rarely
   c) Sometimes
   d) Fairly often
   e) Frequently
5) Malnutrition can lead to...? (Check all that apply)
   a) Increased healthcare costs
   b) Increased risk of falls
   c) Increased hospital readmission rates
   d) Loss of independence and frailty
6) Social determinants of health are associated with risk for malnutrition.
   a) True
   b) False

Step 1: Implement Validated Screening Tools (pages 12-14)

7) Why should AAAs screen clients for malnutrition and other health risks?
   a) To help heal the condition(s) and allow older adults to remain in the community.
   b) To make the most appropriate referrals clients need to improve their physical and mental health.
   c) Because AAAs have services that address the conditions screened for, and we refer clients to medical experts in addition to the community supports we offer.
   d) All of the above.
8) What screening tools does your AAA already use? (Check all that apply)
   a) Level One Screen
   b) DETERMINE checklist

c) HDM Priority Screening
d) Other: Fill in

Step 2: Address Root Causes (pages 15-17)

9) Look at the chart provided in this section. Please list other services/programs that you offer that are not listed to address social determinants of health?
   a) Food and Nutrition: Fill in
   b) Housing: Fill in
   c) Transportation: Fill in
   d) Financial: Fill in
   e) Utilities: Fill in
   f) Personal Safety: Fill in
   g) In-Home Care: Fill in
   h) Social Supports: Fill in
   i) Mental Health: Fill in
   j) Health Care Referral: Fill in
   k) Employment: Fill in
   l) Health Education: Fill in

Step 3: Monitor Client Progress and Quality of Services (pages 18-21)

10) Why is it important to follow up with clients? (Check all that apply)
   a) Track progress towards established goals and outcomes
   b) Provide encouragement and positive reinforcement
   c) Re-screen for continued unmet needs and additional referrals
   d) Ensure quality of services provided

Professional Roles & Responsibilities (pages 21-22)

11) Please observe your role on the chart provided. Do you feel that the suggested roles are appropriate based on your job duties? What might you remove or add? (Executive Director, please look at the chart overall and provide comments regarding any section). Fill in.

Strategies for Moving Forward (pages 23-29)

12) Which of the three partnership scenarios seems most feasible for your organization?
   a) Partnering with insurance companies
   b) Regional partnerships
   c) Partnering with hospitals and CTOs
   d) I'm not sure (N/A)

13) Please look at the separately provided 3-page list of ICD-10 codes. Please list up to three Z codes that might fit with services you are already providing.
   a) Fill in
   b) Fill in
   c) Fill in

Appendices

14) What is the most useful resource or section for you? What is missing? Fill in

Overall

15) What pieces of the toolkit did you find most helpful and why? What suggestions do you have regarding how to improve the toolkit?

16) Overall, how would you rate the toolkit?
   a) Poor - needs a lot of work
   b) Fair - needs quite a bit of work, but on the right track
   c) Good - almost there!
   d) Excellent - high quality, ready for sharing with AAAs
   e) Comment box

Addressing Malnutrition in Community Living Older Adults: A Toolkit for AAAs

Toolkit for setting up internal processes that prepare AAAs to address older adults with malnutrition.

Addressing Malnutrition in Community Living Older Adults

A Toolkit for Area Agencies on Aging

Larry Hogan, Governor Boyd K. Rutherford, Lt. Governor Rona Kramer, Secretary

Version 2 Issued July 2019

Grant funds from the Administration for Community Living (ACL), Grant Number 90INNU0002 and the Maryland Department of Aging assisted in the development of this material. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the ACL or Department.

Table of Contents

Acknowledgements

We sincerely thank the following Maryland Area Agencies on Aging (AAAs) who helped by pre-testing the toolkit and contributing feedback. Each AAA devoted significant staff time and resources to generously assist with this project.

- Baltimore City Health Department, Division of Aging and CARE Services
- Carroll County Bureau of Aging and Disabilities
- Maintaining Active Citizens (MAC, Inc.) and it's Maryland Living Well Center of Excellence
- Washington County Commission on Aging

We also are grateful to the following organizations:

- Bethesda NEWtrition & Wellness Solutions - participated in the creation of this document as well as contributed to and edited the content.
- Administration for Community Living - supported this project through grant 90INNU0002 as well as staff assisted by reviewing and providing feedback on the materials.

About this Project

In 2017, The Maryland Department of Aging was selected as one of six national "Innovations in Nutrition Services and Programs" grant awardees providing pioneering approaches for addressing the nutritional health of older adults. The Administration for Community Living (ACL), issued this first-ever "innovations" grant opportunity to drive improved health outcomes for senior meal program recipients by promoting higher service quality and increased program efficiency through innovative nutrition service delivery models. Our Department acknowledges and appreciates ACL's leadership in funding unique initiatives, such as this grant project.

The two year grant also supports: 1) creating novel post-discharge, shelf-stable meal packages that meet individual's needs based on their health condition(s), 2) testing the effectiveness of a model malnutrition awareness workshop for seniors at risk for falls (Stepping Up Your Nutrition), 3) establishing cross-referral links between the state's healthcare system and the aging network, and 4) creating a mobile phone "app" to help determine the best approaches to address nutritional risk in community settings. Grant partners include the Maryland Department of Health, Maintaining Active Citizens' (MAC, Inc.) Maryland Living Well Center of Excellence, Bethesda NEWtrition and Wellness Solutions, and the University of Maryland's School of Nutrition Science.

The Maryland Department of Aging and our grant partners recognize that Area Agencies on Aging (AAAs) have a unique opportunity to address an emerging issue driving healthcare costs: older adult malnutrition. This toolkit's goal is to develop a nationally-relevant template for aging network providers to screen for and address social determinants of health (SDOH), as well as communicate effectively with healthcare partners regarding malnutrition risk and older adults. Along with the pioneering work of national and other states' leaders who have begun turning their attention to malnutrition across the hospital, post-acute and community settings, we hope this toolkit will act as an additional and important "piece of the puzzle" to facilitate active engagement by local aging network organizations.

Executive Summary

Why Is Malnutrition Important?

- The aging network's mission to "*Maximize the independence, well-being, and health of older adults"* aligns with the importance of addressing malnutrition.
- Aging network staff often know their clients well, develop person-centered approaches, and are best-suited to identify malnutrition risk.
- Malnutrition or "poor nutrition" is more common than we realize and causes significant risk for illness, falls and poor quality of life. It often goes undetected, but there are signs that can be identified in the community, which can prevent these deleterious outcomes.
- The aging network is able to impact malnutrition through providing services that address social determinants of health, which contribute to malnutrition risk.
- Hospitals are unable to manage the complex needs of malnourished patients, but community-based organizations (CBOs) have years of experience providing services that support nutritional well-being.
- CBOs are important partners for healthcare, to smooth malnourished patients' transitions of care and prevent malnutrition in community-residing older adults.

Establish a Vision and Path to Success

- Clarify why your CBO is devoting resources to addressing malnutrition and establish a vision statement.
- Acknowledge that your organization provides services that address the social determinants of health and YOUR STAFF ARE THE EXPERTS in this arena.
- Consider how to most effectively utilize existing staff and programs; create partnerships; learn about new programs and services.

Process Flow Planning

Follow the "community-based malnutrition care pathway":

- Step 1: Implement validated screening tools and integrate into assessments.
- Step 2: Address root cause(s). Based on the screenings, conduct eligibility counseling and provide appropriate and documented referrals. A sample referral table is provided.
- Step 3: Monitor client progress and quality of services. A sample community care plan is provided and follow up is optimally provided at regular intervals. Implement quality assurance tools; upgrades to IT system may be required.

Define Roles & Responsibilities

- Malnutrition is not solved through the provision of food alone. In order to effectively address malnutrition, an interdisciplinary approach with cross-referrals to various services is required.

Engage Partners

- Partner with insurance companies, consider regional alliances, or contract directly with hospitals, Care Transition Organizations, and primary care providers.
- Review examples of successful healthcare-community partnerships including MAC, Inc. and the Southern Maine Agency on Aging.
- ICD-10 social determinants of health codes can be used for billing reimbursement with healthcare. Case studies are shared.
- Sample healthcare presentation and discussion tips are provided.

How to Use this Toolkit

This toolkit is designed to help set up *internal* processes that prepare AAAs to address older adults with malnutrition, or other health conditions. Although it suggests healthcare partnerships as the end goal and includes recommendations for setting up successful linkages, it is *not* intended to be a detailed guide on how to construct a partnership with a healthcare organization.

1. To educate yourself and your staff on what malnutrition is, what it looks like, how common it is among older adults, and how you can improve the quality of life of your clients through providing resources that address the many risk factors.

2. To help you think about why your agency may want to address malnutrition and establish an organizational vision. This process begins by identifying what your agency is already doing and then considering what additional steps you could take.

3. To understand the process components required to effectively address community-based malnutrition and utilize templates provided to create and implement a plan for your agency.

4. To acknowledge that it takes a team effort to address malnutrition and work across disciplines within an organization to establish defined roles for various staff members.

5. To understand healthcare partnership models and billing reimbursement strategies and to prepare for conversations with potential partners, both in the healthcare arena and elsewhere.

Why Is Malnutrition Important?

Community-Based Aging Network Mission

The national network of organizations serving older adults in the community, often called the “aging network,” consists of State Departments of Aging, Area Agencies on Aging (AAAs) and Local Providers such as Aging and Disability Resource Centers (ADRCs or Maryland Access Points, aka MAP), home delivered meals organizations and so on. Since 1972, when the Older American’s Act was created, this interconnected system of support programs and services has provided millions of meals, health insurance counseling sessions, physical activity programs, and much more to hundreds of thousands of people annually.

The Administration for Community Living (ACL) was created in 2012 by the U.S. Department of Health and Human Services to serve as the Federal agency responsible for improving the lives of older adults and people with disabilities through services, research and education. The ACL mission statement reads “*Maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers*.” As will be outlined throughout this toolkit, **addressing malnutrition aligns with the mission of the aging network.**

While some interactions with older adults, their families and caregivers are brief (eg, a call asking for a referral), many staff who work in the aging network feel a deep commitment to assisting participants and may know an older adult for months or years, seeing them daily or weekly (eg, at meal sites, home delivered meals, senior center gyms, etc.). These dedicated staff often describe having “a servant’s heart” and when asked will share why malnutrition, among other conditions, are important to address:

“Our seniors count on us, we have to be there for them.”

“People spend such a short time in the hospital and in the doctor’s office, so it’s really important for community staff to send positive health messages.”

"Without adequate nutrition not only do our bodies lack necessary nutrients, but our will to engage socially and for ourselves becomes impacted." - COO, AAA.

"Nutrition is a pathway to health and longevity which when addressed appropriately can reduce future economic burden of healthcare costs and prolong the need for other home and community based programs." -CEO, AAA.

Everyday Examples of How Staff Identify Malnutrition

AAA staff members are well poised to identify signs of malnutrition because they are the "eyes and ears" in the community. Nutrition staff especially get to know a lot about their participants and can be important resources to make timely referrals when there is a significant change in behavior, medical condition or living situation.

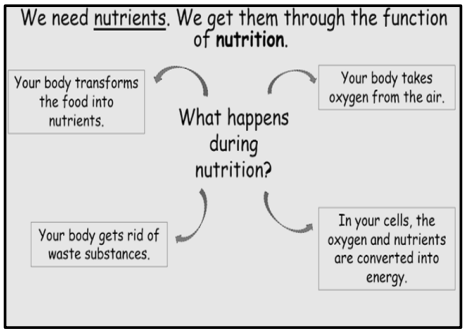
> *"My drivers know exactly what to look for to identify warning signs. If the house isn't being kept up, if a client seems more confused than usual, that can mean a change in their support system or medical status." -Home-Delivered Meals Coordinator.*

> *"I could tell from across the parking lot when I saw John that he was not taking his medications and was not doing well. I contacted our MAP office to ask them to engage with John and his medical provider to see what we could do to help." -Senior Center/Congregate Meals Supervisor.*

Malnutrition: What is it?

"You Are What You Eat" is a phrase we have all heard, and it is essentially true. The food we eat and drink makes up our heart, lungs, hormones, bones and brain. Our bodies are made up of the nutrients we get from our food (protein, calcium, water, etc.).

We can eat all the right foods, but if our hormones - insulin for example - or organs aren't working properly, the good nutrients we eat won't be used to improve our health. In fact, if nutrients don't go where they belong, they can cause problems, often seen as chronic diseases including heart disease and diabetes.



Malnutrition or "poor nutrition" is defined as "the inadequate intake of nutrients, particularly protein, over time and may contribute to chronic illness and acute disease or illness and infection." [1] It is a hidden condition in the body that affects - and is affected by - medical conditions as well as **social determinants of health**. Because malnutrition is an imbalance in the body related to nutrients, a person may be fat, thin or average build and still be at risk for this condition. **In fact, you can't tell if a person has malnutrition just by looking at them.**

When a dietitian or physician diagnoses malnutrition, they look for a person to have at least two of the following conditions: inadequate food intake, weight loss over time, loss of muscle, reduced amount of body fat, fluid retention (edema, swelling), or reduced hand grip strength. [2]

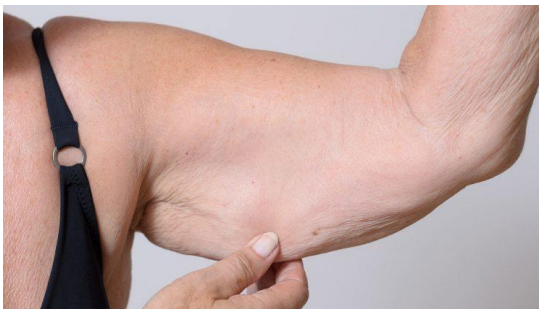
TRY THIS: What signs of malnutrition can you identify?

1

2

3

4



1. https://www.caregivers.com/blog/2012/10/senior-nutrition-poll/
2. http://www.mayoressaludables.org/en/study-finds-food-scarcity-poor-oral-health-be-major-risk-factors-malnutrition-among-older-adults
3. https://www.pccj.eu/browse/evidence-in-practice/item/5095-increasing-incidence-of-cachexia-following-stroke.html
4. http://sixtyandme.com/what-is-sarcopenia-and-how-can-older-adults-prevent-its-tragic-impacts/

ANSWER: You can't tell for sure without a physical examination but there are clues, including:

1. Hollow eye sockets, sunken temples, cheeks
2. Prominence of collarbone/clavicles
3. Muscle loss in hands
4. Fat loss in upper arm

Older adults are especially at risk for malnutrition because they may already have a weakened immune system, have several risk factors, and often have one or more chronic conditions. Many issues can lead to malnutrition, including health-related and social/economic factors including the ones listed below. [3,4]

TRY THIS: Think of the clients you have seen during the past week. Did any of them have these malnutrition risk factors? (check all that apply)

- ❑ Poor appetite
- ❑ Poor dental health
- ❑ Trouble chewing or swallowing
- ❑ Changing taste buds
- ❑ Chronic diseases
- ❑ Medication side effects
- ❑ Dementia
- ❑ Depression
- ❑ Social isolation
- ❑ Limited income
- ❑ Food insecurity

It's likely that you checked several items in the list above. That means you regularly see older adults at risk for malnutrition.

What does that mean? YOU and your staff have the ability to identify malnutrition risk and address the causes through helping with your program and referring to other services offered in the community.

Malnutrition has a number of consequences, including increased risk for infection, delayed wound healing, higher rates of falls and fractures, loss of independence, and frailty, [5] resulting in longer hospital stays, higher readmission rates, five times higher rates of illness and death, and 300% higher healthcare costs. [6,7]

In Maryland, the estimated annual cost of malnutrition is **$340,440,992**, or approximately $55 per person. [8] See **Appendix 1** for a list of websites you can visit for more information about malnutrition.

Source: http://www.mealsonwheelsnys.org/MQC_Blueprint_web.pdf

Social Determinants of Health (SDOH)

As outlined above, social determinants of health play a large role in the risk for malnutrition. **Studies show that 40-90% of poor health can be traced back to social, behavioral and economic factors.** [9]

"Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be." [10]

Source: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

By addressing the SDOH, which contribute to malnutrition, you can help to reverse this condition. The table below outlines some potential scenarios and how they relate to malnutrition and SDOH.

Table 1: Social Determinants of Health and Malnutrition.

Social Determinant	**Malnutrition Sample Scenarios** (causes and effects of malnutrition are **IN BOLD**)
Food and Nutrition	Food and Nutrition Client has always followed a low fat diet, but her new diagnosis of cancer means she needs to put aside her usual dietary restrictions to avoid losing weight and strength needed for her **cancer** treatments. Unfortunately, she is unable to "let go" of years of **dietary restrictions** so does not eat enough to maintain her strength. She **experiences weight loss, frailty and significant decline in ADLs.**
Housing	Shared housing with his daughter's family means he only eats a hot meal when the family sits down together for a meal, which is only once or twice a week. He makes do with sandwiches and canned soup. This **high salt diet** makes his **CHF worsen leading to frequent hospitalizations and ER visits**.
Transportation	A client has heard of the **falls prevention and exercise classes and meals** at the senior center but does not have access to transportation to attend. Without these low- or no-cost programs, s/he is unable to participate in exercise, learn about how to prevent falls or **receive a meal that often provides up to two-thirds of most participant's daily calories**.
Financial	The cost of **nutritious foods** to keep healthy are not affordable or accessible. Result is high blood pressure, obesity and heart disease despite medications and diet and medical counseling. These conditions increase inflammation and don't allow the body to effectively store **muscle** in his/her organs and blood. Older adult becomes **weak, lose independence and chronic conditions** worsen.
Utilities	A client may be unaware of subsidies that assist low income seniors. So, money that could be used for nutritious food or medications must go towards utilities and rent. **Chronic conditions and nutrition decline.**
Personal Safety	If a client is afraid to walk outside they may not get needed exercise for **strength and to manage diabetes.** Poor diabetes control results in the body being unable to store muscle even when s/he eats enough protein. High blood sugar leads to frequent hospital admissions, but client does not go to follow up visits due to safety concerns traveling to medical appointments.
In-Home Care	A client who has **difficulty bathing and grooming** does not wish to attend senior center activities. In-home assistance can improve confidence in social interactions and facilitate improved health and **medication management.**
Social Support	Client lives alone and is socially isolated. Meal time is brief and she often skips meals because sitting alone at the kitchen table is unappealing. **Research shows that eating with others improves food intake. Congregate meals, volunteering and senior center activities provide this support and connection.**

Mental Health	**Depression causes a decrease in appetite, resulting in weight loss, dehydration and poor nutrition**. Client becomes isolated and **weakness** results in a fall.
Health Care Referral	A client may be in **need of dental care** but there are no available referrals. Therefore, s/he eats soft foods and avoids protein items like meats. **Lack of protein results in weakness and social isolation**.
Employment	Lack of profession or volunteer opportunities may lead to **social isolation and depression. Depression can result in overeating and lack of exercise, worsening chronic conditions.**
Health Education	**Chronic Disease self-management workshops, and other evidence-based programs**, provide education and allows for clients to feel activated and in control of their health. **These classes have proven positive impacts on healthcare costs and on individuals' mental/physical health.**

Addressing Malnutrition in the Community: Sustainable, Person-Centered Impact

Research and healthcare awareness about the impact of malnutrition on health outcomes has focused mostly on improving malnutrition in the hospital setting, while acknowledging the critical importance of addressing individuals' nutritional health prior to and after hospital admission.

Only recently has progress emerged on preventing, identifying, and managing malnutrition during transitions of care and in the community setting. [4] **Hospitals only have the capacity to provide short-term intervention and are not equipped to address the complex social needs that often accompany malnutrition.** They already recognize the costly impact of malnutrition and appreciate the role of the community.

Healthcare organizations have monetary incentives and financial penalties which can motivate them to partner with community-based agencies, like AAAs, if they are aware of the services and programs AAAs offer including: 1) managing transitions of care from hospital to home, 2) offering social services and preventive health programming and 3) providing benefits counseling and eligibility screening. Social supports, including assistance with housing, nutrition and income, have been shown to improve health and reduce healthcare costs. [9]

Effective implementation of high quality AAA services can therefore reduce healthcare costs. As outlined earlier, our programs and services interact with individuals at risk for malnutrition on a regular basis.

Why should AAAs consider partnering with healthcare? Organizations may gain access to additional resources such as:

- Improved health and quality of life for our clients and community,
- Expanded referral options to appropriately assist older adult,
- Additional funding stream(s),
- Increased cost-effectiveness of existing programs such as chronic disease self-management, meals programs, SHIP, MAP etc.,
- Opportunities to offer a wider number and types of services,
- Enhanced quality assurance of current and new programs,
- New staffing resources and increased professional training opportunities for staff,
- Improved technology and documentation of high quality service delivery to better justify funding.

Questions to Consider

1. *Define malnutrition in your own words.*
2. *Describe a client who might be at risk for malnutrition, perhaps someone you've seen or spoken to this past week?*
3. *What are the benefits to your organization of taking on malnutrition? What are the barriers and how might you overcome them? Who can you partner with to be successful?*

Establish a Vision and Path to Success

What is your Vision?

Look back at the Why is Malnutrition Important? section. Clarify why your organization is becoming involved in addressing malnutrition. Establish an organization-wide vision that drives each division's roles. Some examples could include:

- *To meet the unmet needs of our community and the older adults we serve.*
- *To improve staff collaboration to enhance efficiency and effectiveness of our staff and resources.*
- *To have an impact on healthcare costs while bringing in new revenue.*

FILL IN: What is your agency's vision for defeating malnutrition?

_____

Aging Network "Owns" Social Determinants of Health!

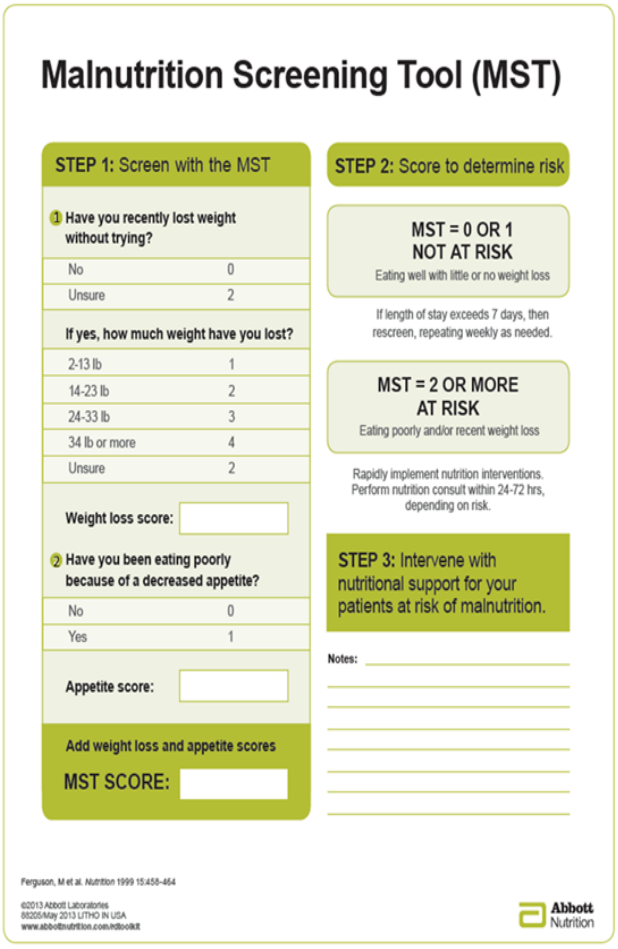
AAAs already provide a wide variety of services for older adults that address SDOH and allow them to live healthfully and safely in their homes, including in-home care, case management, home-delivered meals, transportation, prevention of elder abuse and neglect and evidence-based programs. **In fact, AAAs are the leading experts at providing social services that address social determinants of health.** Tackling malnutrition is not a matter of making changes to these programs and services, but instead thinking about how to most effectively screen and refer to these programs.

Use Existing Staff and Programs Efficiently and Effectively

Screening is a process for determining if there *may* be a problem. Screening differs from **assessment and diagnosis**, which often requires a medical expert. There are validated tools for screen for various conditions, including malnutrition. Validated tools have been tested for:[11]

1. reliability (the ability to produce consistent results),
2. validity (the ability to produce true results), and
3. sensitivity (the probability of correctly identifying a patient with the condition).

Executive Directors can establish uniform policies and procedures for staff within existing programs and services that can positively affect and even cure this and other conditions. As we pursue clinical-community partnerships, the goal for local aging organizations - where there often are no healthcare staff - will be to perform screenings for malnutrition and other conditions.



Malnutrition Screening Tool (MST)

STEP 1: Screen with the MST

1. Have you recently lost weight without trying?

No	0
Unsure	2

If yes, how much weight have you lost?

2-13 lb	1
14-23 lb	2
24-33 lb	3
34 lb or more	4
Unsure	2

Weight loss score:

2. Have you been eating poorly because of a decreased appetite?

No	0
Yes	1

Appetite score:

Add weight loss and appetite scores

MST SCORE:

STEP 2: Score to determine risk

MST = 0 OR 1
NOT AT RISK
Eating well with little or no weight loss

If length of stay exceeds 7 days, then rescreen, repeating weekly as needed.

MST = 2 OR MORE
AT RISK
Eating poorly and/or recent weight loss

Rapidly implement nutrition interventions. Perform nutrition consult within 24-72 hrs, depending on risk.

STEP 3: Intervene with nutritional support for your patients at risk of malnutrition.

Notes:

Ferguson, M et al. Nutrition 1999 15:458-464

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www.abbottnutrition.com/kdbooklt

Abbott Nutrition

There are a number of validated malnutrition risk screening tools, including the Malnutrition Screening Tool (MST), which is a quick and easy tool containing just two questions. [12]

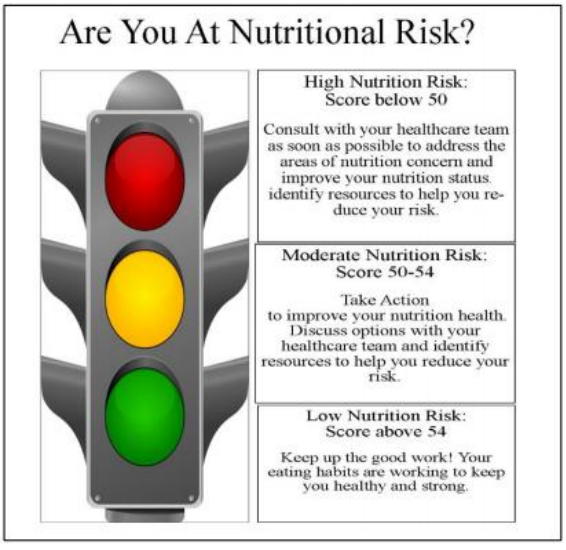
Should a "positive" screen occur, AAAs need to establish a process to notify the persons' healthcare provider in order to:

- Facilitate the healthcare provider's ordering of further tests, referrals to specialists, physical therapy, etc. and
- Communicate community-based interventions, which will both demonstrate our organization's impact, potentially secure funding based on effectiveness and allow for effective clinical-community approaches to addressing the illness(es).

Truly, only by working hand-in-hand "across care settings" (eg, between hospital and community), will individuals have the best chance at improving their health and quality of life.

Consider Offering Additional Programs and Services

Stepping Up Your Nutrition (SUYN), one of the evidence-informed workshops offered by AAAs, is specifically focused on malnutrition related to falls risk. Participants identify their personal nutrition risk status and establish their own goals to improve nutritional status and muscle strength. **SUYN could be an appropriate referral for an individual with malnutrition or could help identify a root cause for an individual referred for falls.** See **Appendix 2** for a list of evidence-based programs available across Maryland.



Source: https://nutritionandaging.org/wp-content/uploads/2018/10/steppingupyournutritionsuynfactsheet1537983645540.pdf

The phrase “food is medicine” is becoming increasingly popular among the news and media, as a number of organizations are starting to focus on this concept. The Food Is Medicine Coalition is an association of 20+ nationwide non-profit medically tailored food and nutrition providers that is leading much of the research and policy advocacy in this field. Massachusetts is also pioneering some of this work, with the launch of their Food Is Medicine State Plan in June 2019. In Maryland, the Department of Aging is piloting medically tailored, shelf-stable meal packages for older adults transitioning from hospital to home that are based on the “food is medicine” model. These packages are geared toward individuals with malnutrition, food security, and/or high risk for readmission and could serve as a bridge to integrate patients with other AAA service offerings, including home delivered meals, food assistance programs, etc.

Nutrition education and/or counseling can supplement these programs. In-home medical nutrition therapy (MNT) could be a service offering to consider. The Elder Services of the Merrimack Valley, Inc., a AAA in Massachusetts, has launched an in-home MNT program that has been popular with healthcare partners. In this program, clients with type 2 diabetes and chronic kidney disease are covered for up to three hours of counseling in year one and two hours in subsequent years by a Registered Dietitian, who is able to bill for reimbursement. You can learn more about MNT at the Academy of Nutrition and Dietetics website here.

Every AAA offers nutrition education, much of which will be helpful to prevent or address malnutrition. Consider options that focus on adequate protein, managing chronic conditions and looking for the warning signs of malnutrition. See **Appendix 1** for client education materials.

Next, we’ll share how to appropriately incorporate screening tools and refer to existing and/or new programs and services that address malnutrition.

Questions to Consider

1. *What is your organization’s vision to address malnutrition?*
2. *What services are you or your existing partners already providing that may address malnutrition risk among clients?*
3. *What additional services could you provide or connect clients with?*

Process Flow Planning

Once you have created a vision for your agency and have established a set of referral service offerings, it is time to lay out the steps you will take to identify and address malnutrition among clients in your agency. This "**community-based malnutrition care pathway**" has been divided into three steps, which include:

Step 1: Implement validated screening tools

Step 2: Address root causes(s)

Step 3: Monitor client progress and quality of services

Each of these steps will be reviewed in greater detail in the following pages.

Figure 1: Overview of Community-Based Malnutrition Care Pathway - Steps and Tools Involved.

1. IMPLEMENT VALIDATED SCREENING TOOLS

Intake clients that are self-referred from the community or referred by healthcare or outside organizations.
Screen clients with validated malnutrition and social determinant of health tools.
Tool: List of malnutrition and SDOH screening tools.

2. ADDRESS ROOT CAUSE(S)

Refer clients to new and/or existing programs and services that can address the root cause(s) of malnutrition and implement interdisciplinary cross-referrals. Document screening results and service/program referrals.
Tool: Sample Referral Table.

3. MONITOR CLIENT PROGRESS AND QUALITY OF SERVICES

Document client goals, referrals, action steps, and progress notes.
Follow up with clients at established intervals to re-screen for continued unmet needs and assure the quality of services provided.
Report positive screens, ICD-10 codes, client status and outcomes to healthcare partners.
Tool: Sample Community Care Plan.

Step 1: Implement Validated Screening Tools

Screening is the first step to identify what issues a client might need to address. Validated screening tools are processes that have been developed through extensive testing and will assure you that your result can be used with confidence. AAAs already utilize a number of screening tools on their clients, which may vary from state to state. AAAs in the state of Maryland are required by Medicaid to screen clients who have a need for long term services and supports with a Level 1 Screen, congregate/home delivered meal clients with the DETERMINE checklist, and home delivered meal clients with the Home Delivered Meals Priority Screening. See **Appendix 3** for more details regarding Maryland screening tools.

In order to adequately address malnutrition, it is important for AAAs to screen for SDOH, which may exacerbate or contribute to malnutrition. **A SDOH screening tool will allow for the identification of uncaptured social needs and for referrals to be made to appropriate services that address the root causes of malnutrition.** One AAA in Maryland, MAC, Inc., screens select clients for malnutrition using the Malnutrition Screening Tool (MST) and for social determinants of health using an internally created tool. See **Appendix 4** for a copy of this tool. **These screening tools can be integrated into program or intake assessments, disease prevention programs, evidence based health promotion classes, etc.** A more centralized approach can be employed or perhaps each department could screen for certain issues, such as social isolation, falls risk or depression.

The choice of malnutrition and SDOH screening tool(s) utilized by a AAA may vary depending on fiscal resources, staff time, training and preferences, coordination with existing AAA databases and healthcare electronic medical record (EMR) systems, the availability of programs to address screening components and other local issues. See **Appendix 5** for a list of malnutrition and SDOH tools. There is no universal tools used across the healthcare system for SDOH. The Social Interventions Research & Evaluation Network (SIREN) has created a comparison table to assist with the selection of a SDOH screening tool. It contains the most widely used tools and describes the target population and social domains addressed by each tool. SIREN is also in the process of releasing a systematic review of screening tools to assist organizations with choosing an appropriate tool for their population.

Step 2: Address Root Cause(s)

To effectively address the root, or underlying, causes of malnutrition and allow an individual to improve their mental and physical health, person-centered screening, referrals to programs and services, as well as eligibility counseling should take place. With the implementation of new screening tools, needs that may have previously gone under the radar will be identified. **This will allow for better service planning and more comprehensive care for the client.**

Generally, the more SDOH that are addressed, the better overall result will be for the person. Although, often, a few, key changes can positively affect someone's physical and mental health, which reinforces healthy actions. As outlined earlier, and below, there may be many SDOH which could be addressed to help correct malnutrition and improve health; however...

THE ONLY SOLUTIONS THAT WILL WORK ARE THOSE WHICH THE CLIENT WILL ACTUALLY DO.

The AAA staff should identify clients' wants, needs, and preferences and discuss which services and programs fit these needs. **Often, motivational interviewing skills will be helpful in working with individuals, in order to allow them to prioritize and select solutions.** A successful approach is often based on starting with one or two ideas, and then over time additional programs or services to may be added to improve their health and independence.

Once priority areas are determined by the client, and at established follow-up intervals, the sample referral table below can be completed to document the screening results and recommended services and programs.

This form can be sent to the healthcare provider along with the Community Care Plan in the following section. Social determinants ICD-10 codes are embedded in the table, which will be explained in greater detail in the Engage Partners section. Note that this is only a *sample* as each AAA offers a different set of programs and services.

Table 2: Sample Referral Table - Social Determinants of Health with ICD-10 codes.

Care Planning Components	**AAA Referral Programs and Services**
Food and Nutrition **Z594**	❑ Senior Center Congregate Meals ❑ Home-Delivered Meals ❑ Nutrition counseling, MNT, nutrition education, and care planning ❑ Commodity Supplemental Food Program (CSFP) ❑ Community food resources (Food Bank, etc.) ❑ Senior Farmers Market Nutrition Program ❑ Stepping Up Your Nutrition ❑ Post-discharge, medically-tailored meals
Housing **Z590**	❑ Assisted Living (including SALGHS) ❑ Ramp Assistance ❑ Home Modification ❑ Assistive Technology ❑ Durable Medical Equipment ❑ Congregate Housing Services Program
Transportation **Z650**	❑ County or Regional Transit ❑ Cab/Bus Vouchers ❑ Senior Village ❑ Community for Life
Financial **Z590**	Application assistance for financial aid: ❑ SNAP ❑ Medicaid ❑ State Health Insurance Program (SHIP) ❑ Energy-assistance programs ❑ Income-tax assistance ❑ Medicare Part A, B, C, D ❑ Medicare Billing, Appeals, Denials, Grievances ❑ Medicare Fraud Assistance ❑ Oral nutritional supplements (Ensure, etc) ❑ Prescription assistance ❑ Assistance for dental, eye care, hearing aids
Utilities **Z590**	❑ Low-Income Home Energy Assistance Program (LIHEAP) ❑ Electric Universal Service Program (EUSP) ❑ Universal Service Protection Program (USPP) ❑ Utility Assistance (other)
Personal Safety **Z600**	❑ Elder Abuse ❑ Legal Assistance ❑ Emergency Response Systems ❑ Falls Prevention (Stepping On, Matter of Balance, Tai Chi for Better Balance)

	❑ Arthritis foundation classes (Walk with Ease)
In-Home Care **Z602** **In-Home Care** **Z602** **(con't)**	❑ Sitters and in-home care services (personal care, chore service) ❑ Home Care agencies ❑ Community First Choice ❑ Senior Care ❑ Home-delivered meals ❑ Dietitian referral ❑ Senior Village
Social Supports **Z600 or Z630**	❑ Senior Center (exercise, socialization, Congregate Meals) ❑ Telephone Reassurance ❑ Support Groups: Caregivers, Renal, Stroke, ALS, Parkinson's ❑ Adult Day Care ❑ Volunteer opportunities
Mental Health **Z640 or Z650**	❑ PEARLS: Program to Encourage Active, Rewarding Lives ❑ Enhance Wellness ❑ Healthy IDEAS ❑ Behavioral Health Referral (Core Service Agency or Health Department)
Health Care Referral **ICD-10 code dependent on root cause**	❑ Primary Care Physician ❑ Clinics: Dental, Eye, Physical Therapy ❑ Community Health Worker ❑ Adult Medical Day Care ❑ Local health department ❑ Home care agencies ❑ Medical supplies
Employment **Z560**	❑ Senior Employment ❑ AAA volunteer coordinator ❑ Community volunteer opportunities
Health Education **Z550**	Self-management workshops: ❑ Diabetes Self-Management (Spanish version available) ❑ Chronic Disease Self-Management (Spanish version available) ❑ Chronic-Pain Self-Management ❑ Cancer Thriving and Surviving ❑ Falls Prevention (Stepping On, Matter of Balance, Tai Chi for Better Balance) ❑ SAIL (Stay Active and Independent for Life) ❑ Aging Mastery ❑ Enhance Fitness ❑ Lifelong Learning ❑ Medication Management ❑ Wellness Center Gym

Step 3: Monitor Client Progress and Quality of Services

The final but ongoing task is to monitor client progress with a care plan, re-screen clients as needed, and assure the quality of services provided.

Monitoring Progress: A Community Care Plan

A care plan outlines:

- individual assessed care needs,
- the types of services provided to meet those needs,
- who will provide the services and when.

And, it is person-centered and developed with input from the individual. **Establishing regular contact with clients is imperative to addressing the range of SDOH that may be involved and also to provide regular, positive reinforcement for each step forward.** This regular contact should be systematized, with responsibilities established and documentation incorporated.

Goals and action steps should be established with the client and a goal date should be established. Referrals to services or other staff should be made. Follow up dates are suggested for 30, 60, and 90 days, but these can be adjusted based on staff capacity. Follow up should be made to check in on progress toward goals, provide encouragement, and see if any additional referrals are needed. The updated status and referrals should be documented. This sample is an open format, but a standardized checklist could be provided if desired.

For example, consider an individual with diabetes. A malnutrition and SDOH screen are completed and the results are as follows: malnutrition (negative), personal safety (positive), health care referral (positive), and transportation (positive).

A sample care plan for this individual is provided below. **This form can be sent to the healthcare provider along with the Referral Table in the previous section**. Notice in the care plan below that the goal is person-centered, but it also addresses the healthcare provider's goal for an improvement in diabetes control.

Figure 2: Sample Community Care Plan - Initial and Follow Up Monitoring.

CLIENT NAME: *Sally Jones* DATE: *January 1, 2019*
GOAL (OUTCOME): *Feel strong enough to attend grandson's graduation.*
ACHIEVE BY DATE: *June 20, 2019*
Step 1: *Sign up for exercise class to build up strength.*
Step 2: *Set up doctor's appointment to check on diabetes medications.*
Step 3: *Establish method of transportation to get to class/appointment.*
NOTES: *Referral made to Health Promotion Coordinator to enroll in Stepping On.* *Contacted doctor regarding positive screens. Faxed referral table, care plan.* *Assisted in getting a cab voucher for transportation.* DATE: *January 1, 2019* STAFF SIGNATURE: *Linda Johnson, MAP Program Coordinator*
<u>30 DAY FOLLOW UP:</u> *Mrs. Jones attended her first Stepping On class yesterday and has an appointment scheduled with her doctor. Rescreened for social determinants of health. No changes, no new referrals made.* DATE: *February 4, 2019* STAFF SIGNATURE: *Linda Johnson, MAP Program Coordinator* <u>60 DAY FOLLOW UP:</u> DATE: STAFF SIGNATURE: <u>90 DAY FOLLOW UP:</u> DATE: STAFF SIGNATURE:

Quality Assurance

Quality assurance may include client satisfaction, evidence based workshop retention rates, fidelity monitoring of evidence-based classes, measuring of outcomes (eg, hospital readmissions, ER visits, etc.), and monitoring staff adherence to protocols for documentation and communicating with healthcare. **Contracts with healthcare will often incorporate expectations for quality measurement, so it is important to consider what you currently do and what your organization might be willing to do in the future (assuming adequate funding and staffing).**

Be prepared to measure quality of services; emphasize the importance of quality and meeting established standards with your staff. Allowing significant variety in providing referrals or documentation will not support fruitful and long-term healthcare contracting for AAA services.

A recent report listed key factors for measuring the effectiveness and quality of home and community-based services, listed below. [13] For additional quality assurance resources, see **Appendix 6**.

- Provides for a person-centered system that optimizes individual choice and control…
- Promotes social connectedness and inclusion …in accordance with individual preferences
- Includes a flexible range of services that are sufficient, accessible, appropriate, effective dependable and timely…
- Integrates healthcare and social services to promote well-being
- Promotes privacy, dignity, respect and independence….
- Ensures each individual can achieve the balance of personal safety and dignity of risk…
- Supplies and supports an appropriately skilled workforce…
- Supports family caregivers
- Engages individuals in the design, implementation, and evaluation of the system and its performance
- Reduces disparities by offering..services that are…culturally sensitive and linguistically appropriate
- Coordinates and integrates to best meet needs and maximize efficiency/affordability
- Delivers cost-effective services
- Supplies valid, meaningful, integrated, aligned, accessible, outcome-oriented data…
- Fosters accountability through measurement and reporting of quality of care and consumer outcomes

Chesapeake Regional Information System for Patients (CRISP)

When partnering with healthcare, an IT system is essential, especially for reimbursement purposes including tracking, reporting and billing. The Regional Health Information Exchange (HIE)- Chesapeake Regional Information System for Patients (CRISP), which serves Maryland, West Virginia, and the District of Columbia, has the capacity to allow AAAs to communicate with healthcare partners in real-time. Through a contract with CRISP, AAAs could:

- Embed referrals to evidence-based programs and other non-clinical services
- Report patient engagement, enrollment, and completion of programs
- Document provisions of programs and services (including ICD-10 codes)
- Alert providers of patient's conditions, gaps, or needed services through care alerts

In addition, CRISP could be utilized to track return on investment (ROI), including pre/post hospital and emergency department utilization and changes in cost of care.

CRISP has begun to work with hospitals and community-based providers to begin tracking social determinants of health needs as well as referrals to evidence-based programs and community-based services. **As this opportunity expands statewide, AAAs should be in the position to align with their hospital's or payor partner's medical records technology and CRISP data sharing infrastructure.**

Questions to Consider

1. *What screening tools does your AAA already use and which clients are screened? Would it be feasible to implement an additional SDOH screening tool for all or select clients?*
2. *Looking at Table 2, what services/programs does your AAA offer to address each of the social determinants of health? Could you create your own form?*
3. *Do you currently document a "care plan" or "person centered plan of care"? If not, what would it take to implement one?*
4. *What does your current quality assurance structure look like? If you don't have one in place, consider reviewing resources in Appendix 6.*

Define Roles & Responsibilities

In this section, we'll look at how AAAs can positively impact malnutrition by using a team approach. Traditionally, AAA staff members tend to work in "silos" and may not be aware of the full extent of activities happening across the organization. However, **an interdisciplinary team approach is required to adequately support an older adult at risk for malnutrition.** Malnutrition is not solved with food alone, although it is often a first step, but most clients will require a more comprehensive set of services. All of the SDOH domains previously discussed, including chronic conditions, financial limitations and social isolation need to be addressed.

Executive Director

As the lead administrator for your agency, creating the vision and services your organization delivers to existing and prospective clients, you can have an impact on healthcare costs while bringing in new revenue. You can work with your team as well as community healthcare partners to identify and treat malnutrition. A good place to begin is to estimate existing healthcare costs of malnutrition for individuals in your community.

In order to foster organizational commitment:

- Review existing resources and research best practices. Brainstorm ideas that are feasible given your existing resources.
- Establish cross-departmental meetings to develop healthcare-community linkages.
- Create a malnutrition coalition. Encourage your Board of Directors to reach out to healthcare providers, non-profits, community foundations and other community-based organizations (Visiting Nurses, Homemaker Services, etc.) to identify potential partners, coalition members and funding opportunities.

In order to become involved:

- Initiate meetings with hospital administration (Medical Director, Population Health, etc.) or discharge/social work personnel.
- Consider developing joint proposals with hospitals or health departments for grant opportunities which relate to providing healthcare in the community and/or preventive health approaches.
- Inform your stakeholders, including clients, caregivers, and government, about your initiatives. Enlist their in-kind support and financial resources.
- Identify which organizations in your community are paying the costs for malnourished seniors. Meet with them to understand discharge nutritional care

plans and potential service models which they feel could be appropriate for individuals discharged with malnutrition.
- Review alternative payment options for providing new or existing services. Consider starting with small changes or additions to services or assessment processes. Build a solid initial partnership model and deliver specific tasks.
- Identify organizations which provide a variety of support services that address all of the causes of malnutrition.

Program Directors

As a program director, you may see clients with lack of transportation, financial strain, issues with housing, social isolation, multiple chronic conditions, etc. which are all risk factors for malnutrition. You receive referrals and refer to services to address these social determinants of health and are therefore a key player in addressing malnutrition risk. To start, consider the many factors which can increase risk for malnutrition, including social, psychological, economic and health-related factors and think about how your organization can effectively support older adults to combat these issues.

In order to foster organizational commitment:

- Acknowledge pieces of the “malnutrition puzzle” that you can identify during screening.
- Work across your organization to determine what each department can do to screen or educate clients for their risk of malnutrition and offer validated tools.
- Consider existing and new initiatives which can address the social and environmental causes of malnutrition.
- Participate in cross-departmental meetings and list activities as potential items which your organization can use to identify or treat malnutrition.
- Support your Executive Director’s efforts and be prepared to learn more about what hospitals feel could be critical community supports for their patients. Assist with presentation materials which summarize your current services and consider adjusting them, based on healthcare partner feedback.

In order to become involved:

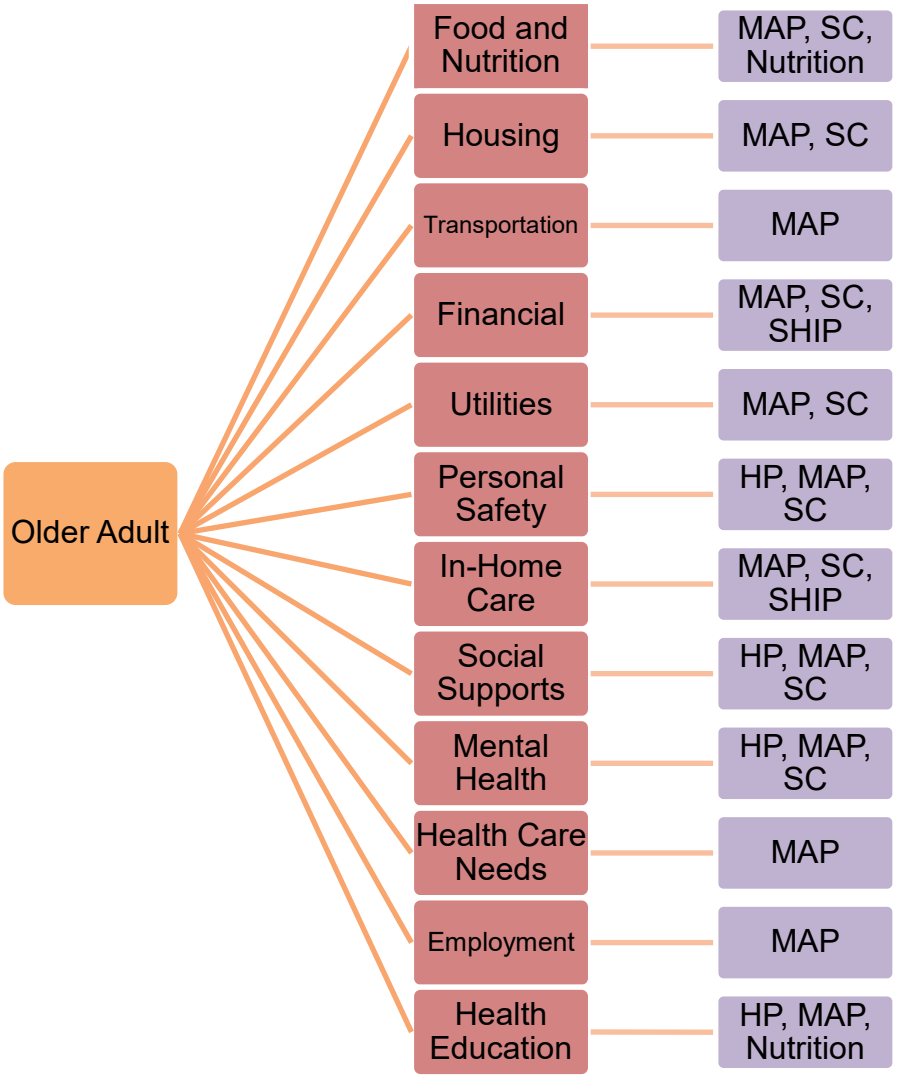
- Cross-refer to services and programs your organization offers.
- Provide follow-up with targeted client to ensure that individuals have received needed services.
- Provide information on resources, services, and benefits and assistance with completion of documents.

- Consider ways to provide regular updates to healthcare partners regarding client status and assist with supporting care plans.

Cross-Referrals

The figure below shows how interdisciplinary cross-referrals can be made to support an older adult at risk for malnutrition. As discussed in the previous section, **it is important that staff roles are established and streamlined documentation is implemented.** The team members roles below are *an example*, as staffing may vary across AAA's and some staff members may oversee multiple program areas.

Figure 3: Interdisciplinary Team Approach to Address the Social Determinants of Health.



Key. HP= Health Promotion. SC= Senior Care.

Each AAA staff can support and inform a patient's care plan, address the underlying causes of malnutrition, and communicate with healthcare partners regarding progress made and interventions implemented. See **Appendix 7** for a more detailed list of suggested professional roles that align with the three steps of the community-based malnutrition care pathway.

Questions to Consider

1. *Do you feel the suggested roles and cross-referrals apply to your agency?*
2. *What additional staff members might you include in the malnutrition pathway process?*

Engage Partners

Partnership Scenarios

Consider implementing a variety of partnerships to provide programs and services to prevent and address malnutrition in your AAA jurisdiction.

Community Partners and Food Resources

Existing partnerships may be leveraged in the fight against malnutrition. For example:

- How can a transportation provider help with getting clients to a falls prevention class?
- Consider whether SNAP referrals are being maximized for low-income clients.
- Can congregate meal sites expand beyond senior centers and include partner organizations such as churches, soup kitchens or libraries?
- If you screen for depression, does your agency have a resource for referrals such as a local PEARLS provider, outpatient counselor or Core Services Agency?

For food insecure clients, there are a number of referrals that may be appropriate. See **Appendix 8** for a sample Community Food Resource List.

- Contact your local food bank for a list of local resources and provide their number to persons inquiring about food access.
- Refer clients who need food to a congregate meal site, or refer to home delivered meals if they are homebound.
- Contact MDoA to become a local provider of the Commodity Supplemental Food Program (also known as “My Groceries to Go Program” in Maryland).
- Lastly, for individuals who are also suffering from chronic conditions, medically tailored food based on the “food is medicine” approach (see Establish a Vision and Path to Success section) may be a good choice for your organization.

Insurance Companies

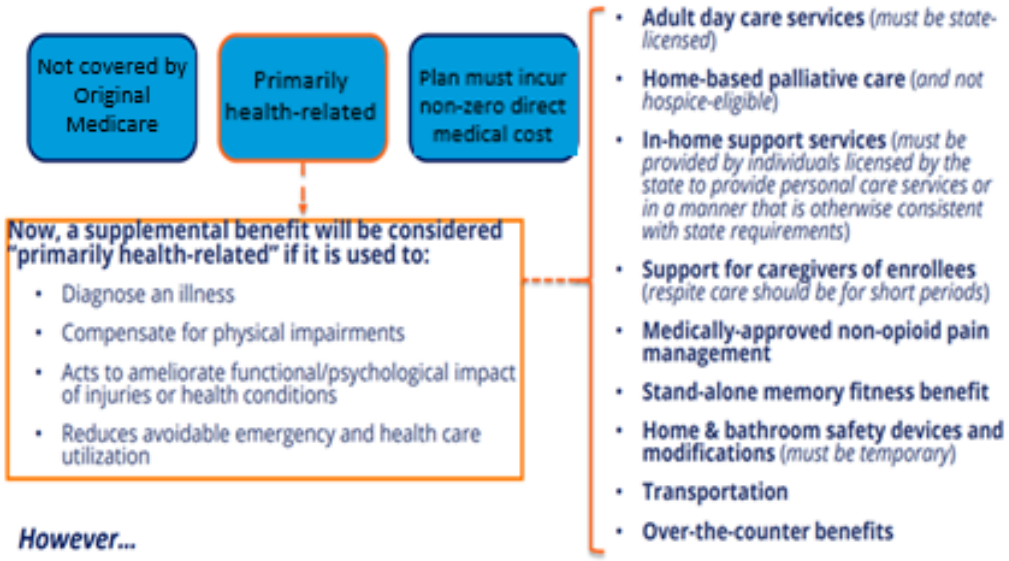
In 2018 Congress enacted the Chronic Care Act, which allows additional **supplemental benefits to Medicare beneficiaries enrolled in Medicare Advantage plans (MA)**. According to Title III of the Act, the changes are part of a MA value-based insurance design, allowing MA plans to create structures that vary benefits, cost-sharing, and supplemental benefits offered to enrollees with qualifying chronic diseases. As stated in the preamble of the Act, all of these changes are meant “*to improve*

management of chronic diseases, streamline care coordination, and improve quality outcomes."

The measures will help the chronically ill get basic treatment at home, so that they can remain independent and out of the hospital. This will reduce the frequency of chronically ill patients needing hospitalization, which will free up room for non-chronic emergency room visits. This model approach will inform policymakers of the services that offer the most benefits to different populations, which may prompt policymakers to expand those benefits to people in the rest of traditional Medicare.

Beginning January 1, 2019, the Center for Medicare and Medicaid Services (CMS) expanded supplementary benefits to be "primarily health-related" if they were used to 1) diagnose an illness 2) compensate for physical impairments, 3) ameliorate the functional/psychological impact of injuries or health conditions or 4) reduce avoidable emergency and health care utilization.

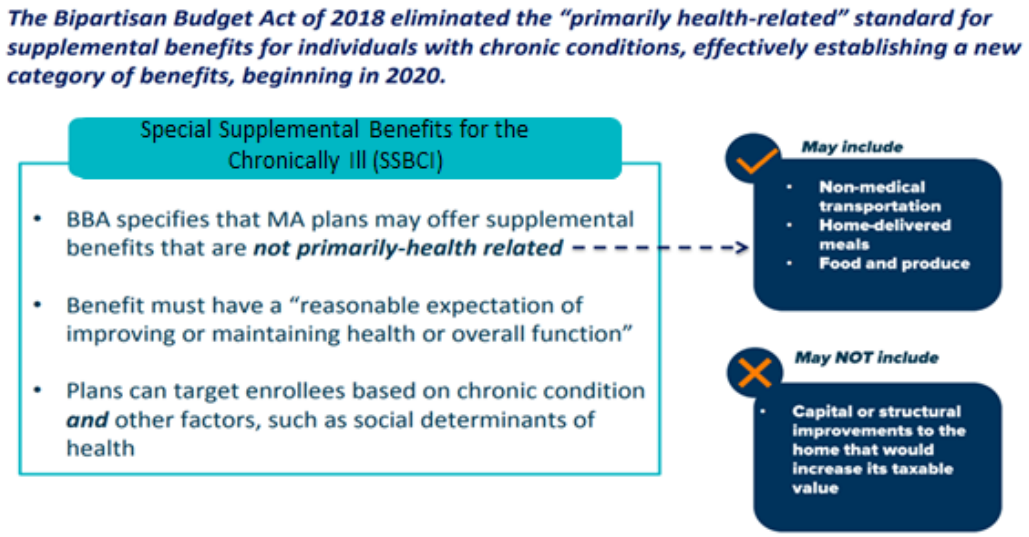
Figure 4: Expansion of Supplemental Benefits in 2019.



Source:https://nutritionandaging.org/wp-content/uploads/2019/03/Part-1_The-Evolving-Healthcare-Legislation-Landscape_Combined_Final.pdf

The Bipartisan Budget Act of 2018 further expanded supplemental benefits by eliminating the "primary health-related" standard for individuals with chronic conditions, which essentially created a new category of benefits for 2020, which must have a "reasonable expectation of improving or maintaining health or overall function." **MA plans will expand to address SDOH, most notably nutrition, housing and transportation.**

Figure 5: Further Expansion of Supplemental Benefits.



Source:https://nutritionandaging.org/wp-content/uploads/2019/03/Part-1_The-Evolving-Healthcare-Legislation-Landscape_Combined_Final.pdf

There are several commercial insurance companies in Maryland offering the Medicare Advantage plans. These plans, starting January 2019, are required to offer the above services to their beneficiaries. Every year the insurance companies submit their benefits package to Medicare for approval in early June. For the insurance companies to be able to offer a particular benefit to its members, it has to be on this plan so it is accounted for in the premium they will charge the members. The major insurance companies that offer Medicare Advantage plans in Maryland are: Aetna, Cigna, Erickson, Humana, Johns Hopkins, Lasso and United Healthcare. A full listing can be found here.

Regional AAA Partnerships

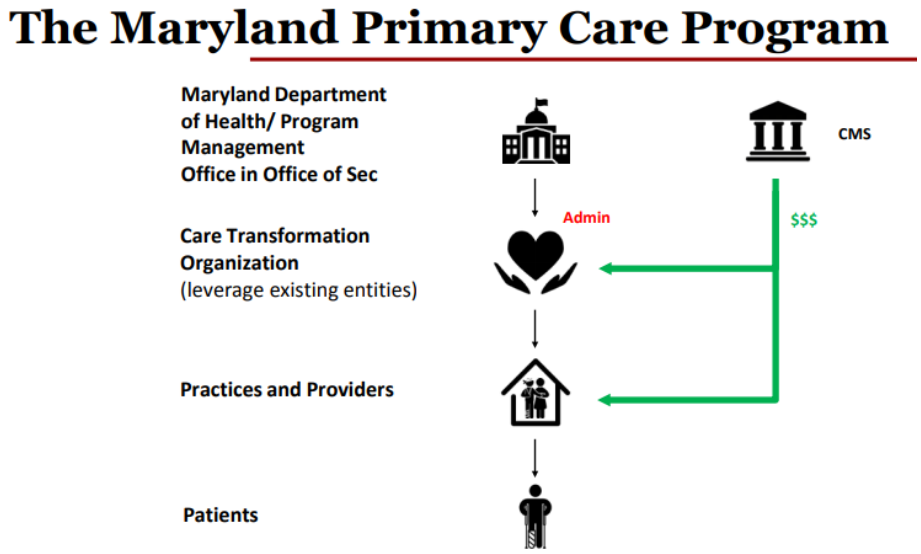
With a national network of over 600 AAAs in the National Association of Area Agencies on Aging (n4a), AAAs have the capability to join together, regionally or statewide, to scale up services to a broader population. An example is the **Eastern Virginia Care Transitions Partnership**, a coalition 5 AAAs, 4 health systems, 69 skilled nursing facilities, and 3 Medicaid managed care organizations. Discharged patients are referred by hospitals to AAAs for case management, referral assistance, benefits counseling, family caregiver support, and other non-clinical services including meals and transportation. Funding is supported by a per-member per-month reimbursement by the Medicaid MCOs. **The program led to a reduction in 30-day readmission rates from 18.2 to 8.9%, and avoided 1,804 readmissions with $17 million in savings.**[15]

Hospitals, PCPs, and CTOs

Maryland has a unique all payer hospital rate setting system whereby the Health Services Cost Review Commission (HSCRC) establishes uniform payment structures based on population health goals, which incentivizes cost reduction.

In 2019, the Maryland Department of Health (MDH) rolled out the Maryland Comprehensive Primary Care Model (MDPCP), designed to expand improvements in care and reductions in the growth of healthcare spending from hospitals to community-based healthcare providers such as primary care providers, skilled-nursing facilities, home health providers, and others. In 2019, newly created Care Transition Organizations (CTOs) began working with these providers to assist them with care management, data tools and informatics, practice transformation technical assistance, social services connections, hospital care coordination and behavioral health integration. A list of the CTOs for 2019 can be found here.

Figure 6: The Maryland Primary Care Program Structure.



Source:https://pophealth.health.maryland.gov/Documents/Maryland%20Comprehensive%20Primary%20Care%20Model/MPCP%20-%20Presentation%20Web.pdf

Across the state of Maryland there are approximately 386 primary care practices enrolled in this program (as of May 2019). The MDPCP supports the overall health care transformation process and allows primary care providers to play an increased role in prevention and management of chronic disease and prevention of unnecessary hospital utilization. Each primary care practice that has enrolled in the MDPCP program receives a care management fee (CMF) per attributed Medicare beneficiary in the practice. This CMF is to be used by the practice to help with patient needs for care coordination with social service resources and access to care as determined by the practice. **AAAs can**

partner (ie, have contracts) with primary care practices and provide care coordination services to get reimbursed with a portion of the CMF.

Another alternative could be partnering with area CTOs for specific services (home delivered meals, housing assistance etc.) to receive payment for services rendered. Any partnership or contractual arrangement would depend on each AAA's capacity for types of services they provide and would depend on the CTO's perceived needs.

Examples of Success

The MAC, Inc. Living Well Center of Excellence (LWCE) has established contracts with multiple hospitals in their regional area. Many of these partnerships began with referrals for Chronic Disease Self-Management Education (CDSME) workshops. Based on successful outcomes through consistent data reporting, these partnerships have expanded to include other programs offered by the AAA and have resulted in reimbursement for these services.

The Southern Maine Agency on Aging (SMAA) has also had success at developing contractual agreements with a number of local hospitals, health plans, and medical practices. The chief executive officer, Larry Gross, states that he was motivated to "really address our mission to improve quality of life for older adults, and to work more closely with others who shared our interests." [14] SMAA initiated these partnerships by inviting heads of local health plans and hospitals to join their board of directors. Gross emphasizes that his keys to success were talking about contracts up front, instead of performing work for free, and utilizing volunteers, who gave 80,000 hours of service in 2016, and allowed their agency to increase service volume by 25%. [14]

Billing Reimbursement Options

ICD-10 codes are used by physicians, insurance companies, public health agencies and organizations, etc. to represent diagnoses. ICD-10 stands for International Statistical Classification of Diseases and Related Health Problems 10th Revision; it is published, copyrighted, and updated by the World Health Organization. There is an ICD-10 code for every disease, disorder, injury, infection and symptom and they are utilized in many ways, including processing health insurance claims and compiling national health statistics. **ICD-10 codes Z55-Z65 capture socioeconomic and psychosocial circumstances (i.e. social determinants of health).**

Below is a shortened list of the ICD-10 codes for social determinants of health that are most relevant to AAAs. Under each of the SDOH categories there are more specific codes pertaining to situations. The categories point out where to look for more specific codes if needed. For an extended list of SDOH ICD-10 codes, click here. Identification and coding with the appropriate Z code for SDOH reflects the risk an individual is at for poor health outcomes.

These Z codes show the "risk" for individuals, which may result in a higher care management fee (CMF) paid by Medicare to primary care. **In other words, Z codes = higher risk= higher potential reimbursement.** AAAs could partner with these healthcare organizations to provide case management and document social needs with the ICD-10 codes. This CMF could then be utilized to pay the AAA. In another scenario, this coding has the potential to show insurance companies that these individuals need services like housing, meals etc. which would directly/indirectly be paid by them.

Table 3: Social Determinants of Health ICD-10 Codes.

SDOH	Sample ICD-10 Codes
Living Situation (Housing, Utilities)	Z590 - Problems related to housing and economic circumstances Z600 - Problems related to social environment Z602 - Problems related to living alone
Food	Z590 - Problems related to housing and economic circumstances Z594 - Lack of adequate food and safe drinking water
Safety	Z600 - Problems related to social environment
Financial Strain	Z590 - Problems related to housing and economic circumstances
Employment	Z560 - Problems related to employment and unemployment
Family and Community Support	Z630 - Other problems related to primary support group, including family circumstances Z600 - Problems related to social environment
Education	Z550 - Problems related to education and literacy
Mental Health	Z650 - Problems related to other psychosocial circumstances

SDOH ICD-10 Code Case Studies

SCENARIO ONE

Suzy,* who is the sole caregiver for her 78 year old bed bound mother, was referred by her church to the local AAA. Suzy revealed that she had reached her breaking point and needed help but did not have the resources to pay for assisted living or caregivers from a private agency.

Through the screening process by MAP, Suzy's mother was identified at risk for:

- ➔ Living arrangements: Z599
- ➔ Financial: Z596
- ➔ Food and nutrition: Z594
- ➔ In Home care: Z602
- ➔ Social support: Z600

In addition, Suzy herself was identified with the following risk factors:

- ➔ Dependent needing care: Z636
- ➔ Burnout: Z730
- ➔ Lack of relaxation and leisure: Z732

Suzy's mother was set up with the following services by the AAA:

1. Respite care through the local ARC.
2. Caregiver program and support group.
3. Home-delivered meals 3 times per week.
4. In-home care 4 hours a day for 5 days per week (waiting list).
5. Connection with a local bible group and volunteer from the local school 1-2 times per week.

MAP staff encouraged Suzy to call her mother's insurance company, Aetna Medicare Advantage, and check her benefit eligibility. Suzy found the Aetna MA plan would pay for in-home care and meals as long as the primary care physician (PCP) did the pre-authorization.

The AAA faxed the referral to the PCP for needed services with the ICD-10 codes for SDOH. The PCP used the codes to get the services covered. Aetna MA plan reimbursed the AAA for the meals and the private agency providing the caregiver. In addition, Suzy herself was given resources and connected to caregiver support groups near her.

SCENARIO TWO

Barbara* is an 85 year old who lives alone in a one bedroom apartment. She had multiple admissions to community hospital emergency room. The Emergency Room Department staff determined that there were no significant medical issues but that Barbara was struggling with anxiety.

The PCP took on the patient and their Nurse Practitioner (NP) did a home visit:

- Barbara was not taking her medications and many of them were expired.
- There was almost no food in the refrigerator.
- Barbara asked for water and stated she was hungry. Her lips and mouth were dry.

The NP referred Barbara to an on-staff Social Worker and Registered Dietitian (RD). The RD brought nutritional supplements; the patient declined a referral for home-delivered meals.

The family expressed they were unable to assist with Barbara's care. The PCP felt it was an unsafe environment and referred the case to Adult protective services (APS) of the county.

The following diagnosis codes were identified for this situation:

- ➔ Living arrangements: Z599
- ➔ Financial: Z596
- ➔ Food and nutrition: Z594
- ➔ Living alone: Z602

Preferred solution: This client would have been better served if referred to the AAA by the hospital and PCP.

Under the Care Redesign program and the MDPCP, the AAA could have been identified as the community resource to provide support to the patient, saving the PCP significant time resources and better meeting the needs of the client.

*Names have been changed to protect privacy.

Initiating Conversations with Healthcare

Meetings with prospective healthcare partners should outline:

1. Identify what the healthcare partner is most concerned about.
2. Share the specific services and programs provided by your organization which address SDOH and health conditions (or risks for health conditions) that can reduce their costs.
3. Formulate an agreeable initial service for funding, based on quality and outcome measures that will be transparent to both parties.
4. Once successful, continue to develop the partnership to incorporate additional programs/services. A promising approach is shared risk contracting.

Contracting with healthcare can be complicated, with many options, opportunities and pitfalls. AAAs are strongly encouraged to seek out resources and experienced peers to learn about the best approach for your organization. **Appendix 9** shares presentations you can customize for meetings with healthcare and **Appendix 10** contains additional website resources.

As demonstrated in this and earlier sections, **ongoing support, communication among AAA staff and healthcare, with adequate documentation, are key components of addressing malnutrition and health conditions in the community.**

Questions to Consider

1. *Do you have existing partnerships, programs and services that can help clients address their risk for malnutrition? If yes, how can you create an internal system to manage these clients?*
2. *Are you ready to meet with healthcare organizations - a hospital, insurance company or PCP - to create a contractual cross-referral relationship? If not, what resources do you need?*
3. *Which ICD-10 codes fit with services you are already providing or referring clients to?*

Conclusion

In summary, “Addressing Malnutrition in Community Living Older Adults: A Toolkit for Area Agencies on Aging” has shared:

- How the problem of malnutrition in our communities is relevant to the aging network’s core mission to “*Maximize the independence, well-being, and health of older adults”*
- Why AAAs are critical partners for healthcare and Maryland’s unique payment system, to smooth malnourished patients’ transitions of care and prevent malnutrition in community-residing older adults.
- The importance of establishing a vision and path to success by defining a project mission and assigning staff roles, documenting processes, and embedding quality assurance.
- How to develop your organization’s “community-based malnutrition care pathway.”
- The importance of engaging partners - new and existing - to create an effective, high quality process to expand resources and service offerings.

The toolkit also provided you with:

- Template forms that incorporate ICD-10 codes
- Internal and external cross-referral suggestions
- Case studies
- Questions to consider as you develop your plans
- Sample healthcare presentations and discussion tips

We hope you have found this toolkit helpful! The journey towards effective management and elimination of community-based older adult malnutrition is just beginning. We welcome you to join us in this emerging endeavor.

Abbreviations and Acronyms

AAA	Area Agency on Aging
ACL	Administration for Community Living
ADL	Activities of Daily Living
ADRC	Aging and Disability Resource Center
ALS	Amyotrophic Lateral Sclerosis
APS	Adult Protective Services
CBO	Community-Based Organization
CDSME	Chronic Disease Self-Management Education
CHF	Congestive Heart Failure
CHW	Community Health Worker
CMF	Case Management Fee
CMS	Center for Medicare and Medicaid Services
CRISP	Chesapeake Regional Information System for Patients
CSFB	Commodity Supplemental Food Program
CTO	Care Transformation Organization
EMR	Electronic Medical Record
EMT	Emergency Medical Technician
EUSP	Electric Universal Service Program
ER	Emergency Room
HDM	Home-Delivered Meal
HIE	Health Information Exchange
HP	Health Promotion
HSCRC	Health Services Cost Review Commission
ICD-10	International Statistical Classification of Disease and Related Health Problems, 10th Revision
IDEAS	Identifying Depression, Empowering Activities for Seniors
IT	Information Technology
LIHEAP	Low-Income Home Energy Assistance Program
LTSS	Long Term Services & Supports
LWCE	Living Well Center of Excellence
MA	Medicare Advantage
MAC	Maintaining Active Citizens
MAP	Maryland Access Point
MCO	Managed Care Organization
MDH	Maryland Department of Health
MDPCP	Maryland Primary Care Program
MNT	Medical Nutrition Therapy
MQii	Malnutrition Quality Improvement Initiative

MST	Malnutrition Screening Tool
NP	Nurse Practitioner
n4a	National Association of Area Agencies on Aging
PCP	Primary Care Provider
PEARLS	Program to Encourage Active, Rewarding Lives
RDN	Registered Dietitian Nutritionist
RD	Registered Dietitian
ROI	Return on Investment
SAIL	Stay Active and Independent for Life
SALGHS	Senior Assisted Living Group Home Subsidy
SDOH	Social Determinants of Health
SHIP	Senior Health Insurance Program
SIREN	Social Interventions Research & Evaluation Network
SMAA	Southern Maine Agency on Aging
SNAP	Supplemental Nutrition Assistance Program
SUYN	Stepping Up Your Nutrition
SW	Social Worker
USPP	Universal Services Protection Program

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Appendices

Appendix 1: Malnutrition Resources

- Alliance for Aging Research-Malnutrition in Older Adults
- American Society for Parenteral and Enteral Nutrition Malnutrition Toolkit
- Defeat Malnutrition Today
- Malnutrition Quality Improvement Initiative (MQii) Toolkit
- National Council on Aging Community Malnutrition Resource Hub
- National Council on Aging Malnutrition Toolkit
- National Resource Center on Nutrition & Aging
- The Gerontological Society of America

Appendix 2: Evidence-Based Programs in Maryland

- Aging Mastery Program
- Arthritis Foundation Classes (Aquatics, Exercise Program, Tai Chi, Walk with Ease)
- Diabetes Prevention Program (Medicare, National)
- Enhance Fitness
- Enhance Wellness
- Healthy Eating for Successful Living in Older Adults
- HomeMeds
- Matter of Balance
- Move with Balance
- Otago
- Powerful Tools for Caregivers
- Program to Encourage Active and Rewarding Lives (PEARLS)
- Self-Management Programs (Chronic Disease, Chronic Pain, Cancer Thriving & Surviving, Diabetes, Spanish versions)
- Stay Active and Independent for Life (SAIL)
- Stepping On
- Tai Ji Quan: Moving for Better Balance
- TimeSlips

The MAC, Inc. LWCE website contains descriptions about each program, flyers, and links to workshop registration: https://www.mdlivingwell.org/programs/

Appendix 3: Screening Tools Currently Required for Maryland AAA's

Screening Tool	Details	Use
Level 1 Screen *REQUIRED FOR ELIGIBILITY IN MEDICAID LONG TERM SUPPORTS AND SERVICES.*	**Purpose:** Screen and triage individuals for Medicaid community programs, including the Community Options waiver, Community First Choice, and Medical Assistance Personal Care. **Components:** ● Instrumental Activities of Daily Living ● Activities of Daily Living ● Living Arrangement ● Health Status ● Communication, Cognition and Behavior ● Financial Questions ● Referral Questions **Length:** Thirty one questions **Score:** Priority category and referral recommendations generated	● Determine functional eligibility for Medicaid community services ● Provide information, referrals, Options Counseling and access to home and community-based services
DETERMINE Your Nutritional Health (Nutrition Screening Initiative) *REQUIRED BY ACL FOR SENIOR NUTRITION PROGRAM USE (CONGREGATE AND HOME DELIVERED).*	**Purpose:** Identify persons at risk for poor nutrition, based upon SDOH. **Components**: ● Disease ● Eating poorly ● Tooth loss/mouth pain ● Economic hardship ● Alcohol problems ● Reduced social contact ● Multiple medications ● Involuntary weight loss/gain ● Ability to shop, cook and/or feed self **Length**: Ten questions **Score**: 0-2 not at risk, 3-5 moderate nutritional risk, 6 + high nutritional risk	● Home delivered or congregate meal program ● RDN counseling or nutrition education ● Social and exercise programming to address isolation ● Dental referral ● Social services or community group if elevated alcohol intake noted ● Physician/pharmacy or medication management referral if multiple medications noted ● Financial assistance if unable to afford medications and/or food
Home Delivered Meals Priority Screening *REQUIRED BY MDoA FOR ALL HOME DELIVERED MEAL SERVICE PROVIDERS.*	**Purpose:** Effectively identify persons most at need for meals and to determine other services which may best meet clients' current needs. **Components**: ● Ability to acquire groceries and prepare meals ● Food insecurity assessment **Length**: Eight questions **Score**: A-E levels of priority	Determine if client would benefit most from: ● Fully prepared home-delivered meals ● Income eligibility review and/or SNAP ● Grocery assistance, including the Commodity Supplemental Food Program

Appendix 4: MAC Inc. Maryland Living Well Center of Excellence Social Determinants of Health Screening Tool

Name:_____ Phone Number:_____
Preferred Language:_____ Best time to call:_____

In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?	____YES ____NO	NOTES:
In the last 12 months, has your utility company shut off your service for not paying your bills?	____YES ____NO	
Are you worried that in the next 2 months, you may not have stable housing?	____YES ____NO	
Do you have difficulty in taking the medicine/prescriptions prescribed by your doctor?	____YES ____NO	Are you able to get/pay for your medicine? Do you understand what medicine to take when and what it is for?
In the last 12 months, have you needed to see a doctor but could not because of cost?	____YES ____NO	
In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	____YES ____NO	
I see or talk to family members at least once a week.	____YES ____NO	
I see or talk to friends at least once a week.	____YES ____NO	
On a weekly basis I participate in social activities or attend organized groups, such as choirs, support groups, cultural performances, group meals, exercise classes, etc.	____YES ____NO	
Do you ever need help reading or understanding hospital or other materials from your physician?	____YES ____NO	
Are you afraid you might be hurt in your apartment building or house?	____YES ____NO	
In the past three months, have you had a fall? If you fell in the past three months, how many times did it limit your regular activities for at least a day, or you saw a doctor? #_____	____YES ____NO	Do you worry about falling? ____YES ____NO
Over the past two weeks, have you had little interest or pleasure in doing things, or felt down, depressed, or hopeless?	____YES ____NO	
If you checked "YES" to any boxes above, would you like to receive assistance with any of these needs?	____YES ____NO	
Are any of your needs urgent? (i.e., "I don't have food or a place to sleep tonight)	____YES ____NO	

Screened by:_____ Referred to:_____ Date:_____

Appendix 5: List of Malnutrition and Social Determinants of Health Screening Tools

Malnutrition

- Malnutrition Screening Tool (MST)
- Mini Nutritional Assessment (MNA)
    a. MNA-Short Form (MNA-SF)
- Malnutrition Universal Screening Tool (MUST)
- Nutrition Risk Screening (NRS-2002)
- Subjective Global Assessment (SGA)
- Patient Generated Subjective Global Assessment (PG-SGA)
- Seniors in the Community: Risk Evaluation for Eating and Nutrition (SCREEN I and SCREEN II)
- Short Nutritional Assessment Questionnaire (SNAQ)
- Validated Malnutrition Screening and Assessment Tools: Comparison Guide

Social Determinants of Health

- Accountable Health Communities Health-Related Social Needs Screening Tool
- PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences
- Health Leads Social Needs Screening Toolkit
- Institute of Medicine Social and Behavioral Domains and Measures
- WellRx Toolkit
- Total Health Assessment Questionnaire for Medicare Members
- Kaiser Permanente's Your Current Life Situation Survey
- HealthBegins Upstream Risk Screening Tool
- Social Need Screening Tools Comparison Table

Appendix 6: Quality Assurance Resources

- Home and Community Based Services: Quality Management Roles and Responsibilities
- Improving Quality of Services
- Measuring the Quality of Home- and Community-Based Services: A Conversation about Strategic Directions for Research and Policy
- Quality Measurement for Home and Community Based Services (HCBS) and Behavioral Health in Medicaid
- Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement
- Quality of Home- and Community-Based Services

Appendix 7: Suggested Professional Role Delineation

MAP

Implement Screening Tools

- Level 1 Screen
- Malnutrition Screen
- SDOH Screen

Address Root Cause(s)

- Enroll/refer to Nutrition, HP, Senior Care, and/or SHIP.
- Refer to behavioral health, caregiver support, physician, CHW
- Transportation to healthcare appointments and referral sites
- Groceries program, pet food, call reassurance, etc.

Monitor Progress and Quality

- Lead care plan implementation and documentation
- Track referrals
- Share client care plan goals with healthcare
- Assist with hospital messages and progress

Nutrition

Implement Screening Tools

- DETERMINE Checklist
- HDM PriorityScreen
- Malnutrition Screen
- SDOH Screen

Address Root Cause(s)

- Enroll/refer to MAP, HP, Senior Care and/or SHIP
- Person centered service/meal plan
- Provide social interaction
- Provide relevant nutrition education
- Nutritionally balanced food, hydration
- Reduce social isolation
- Manage chronic conditions

Monitor Progress and Quality

- Periodic screening, as appropriate, note in care plan
- Inform care plan as new service options become available and seem appropriate
- Perform quality assurance related to respective service(s)
- Update care plan as client participates in programs
- Adjust care plan as information changes
- Assist with communicating hospital messages

SHIP

Implement Screening Tools

- Benefits Checkup
- Malnutrition Screen
- SDOH Screen

Address Root Cause(s)

- Enroll/refer to MAP, Nutrition, HP and/or Senior Care
- Address gaps in insurance coverage (income)

- Reduce stress and financial concerns related to billing and potential fraud
- Allows client to access affordable medical care and medications

Monitor Progress and Quality

- Periodic screening, as appropriate, note in care plan
- Inform care plan as new service options become available and seem appropriate
- Perform quality assurance related to respective service(s)
- Update care plan as client participates in programs
- Adjust care plan as information changes
- Assist with communicating hospital messages

Health Promotion

Implement Screening Tools

- Varies based on program staff certifications
- Malnutrition Screen
- SDOH Screen

Address Root Cause(s)

- Enroll/refer to MAP, Nutrition, Senior Care and/or SHIP
- Chronic disease management
- Exercise to improve strength
- Improve nutrition/malnutrition
- Social isolation
- Address falls risk
- PEARLS to address depression

Monitor Progress and Quality

- Periodic screening, as appropriate, note in care plan
- Inform care plan as new service options become available and seem appropriate
- Perform quality assurance related to respective service(s)
- Update care plan as client participates in programs
- Adjust care plan as information changes
- Assist with communicating hospital messages

Senior Care

Implement Screening Tools

- Level 1 Screen
- Malnutrition Screen
- SDOH Screen

Address Root Cause(s)

- Enroll/refer to MAP, Nutrition, HP and/or SHIP
- Refer to behavioral health, caregiver support, physician, CHW
- Provide PEARLS or refer to other mental health supports

Monitor Progress and Quality

- Periodic screening, as appropriate, note in care plan
- Inform care plan as new service options become available and seem appropriate
- Perform quality assurance related to respective service(s)
- Update care plan as client participates in programs
- Adjust care plan as information changes
- Assist with communicating hospital messages

Appendix 8: Sample Community Food Resource List

Food and Nutrition Assistance in Somerset County 2019

Worrying about whether or not you will have enough food is stressful. Regular, nutritious meals are necessary for seniors to stay healthy. The following resources are here to help you.

Food Needs	Program Name	Number	Contact Name	Other Information
For homebound: Delivered meals & Grocery bags	Meals on Wheels by Somerset MAC Senior Services	410-651-3400	All staff	Delivered meals Monday, Tuesday, Thursday, for 60 and older
Therapeutic Home Delivered Meals	Moveable Feast	410-327-3420 Ext. 12	All staff	Delivered frozen meals for all ages
Senior Center Noon Meals	Westover and Deal Island MAC Senior Services Centers	410-651-3400	All staff	Noon meal Tuesday and Thursday for 60 and older
Dinner Friday & Saturday 6-7:30 PM	H.O.P.E. Ministry 11724 Somerset Ave, Princess Anne	410-726-7910 or 443-880-7871	Steve Milligan Wayne Muir	Eat dinner and take home a bag lunch
Nutrition Education and Supplement Assistance	MAC Registered Dietitian	410-742-0505 Ext. 144	Karla Beardsley	Call for appointment or questions
Nutrition Counseling	McCready Hospital Dietitian	410-968-1801 Ext. 3250	Jeannette Jardin	Call for appointment
Food Stamps (SNAP)	Social Services 30397 Mt. Vernon Rd, Princess Anne	410-677-4330	All Staff	Need proof of address, income, expenses, SS card, and picture ID
Emergency and monthly food pantry	Maryland Food Bank-Eastern Shore	410-742-0050	Teresa See Jennifer Small	Find a food pantry close by www.mdfoodbank.org click “find food”
Emergency and monthly food pantry “Food Share”	Seton Center Catholic Charities	410-651-9608	All Staff	Need proof of address, income, food stamps, SS card, and picture ID
Grocery Shopping Online	Walmart Pocomoke City Supercenter	410-957-9600	All Staff	Order at www.walmart.com and pick up at store

Appendix 9: Sample Presentations for Healthcare

A Guide to Aging and Disability Services

Presented by:
MAC, Inc. Living Well Center of Excellence
&
Baltimore City Health Department
Division of Aging and CARE Services

Older Americans Act of 1965

Older Americans Act of 1965 was the first federal level initiative aimed at providing comprehensive services for older adults. Through this act, Area Agencies on Aging at the local level were developed.

In the Aging Network

AAA

Means

Area Agency on Aging

The Mission

MARYLAND
Department of Aging

The Maryland Department of Aging in partnership with 23 Area Agencies provides leadership and advocacy to Maryland seniors and their families through information, education and services.

23 Area Agencies on Aging

- Allegany County Department of Area Agency on Aging
- Anne Arundel County Dept of Aging and Disabilities
- Baltimore City Division of Aging and Care Services **(Baltimore City Health Dept)**
- Baltimore County Dept. of Aging
- Calvert County Office on Aging
- Caroline County Office on Aging
- Carroll County Bureau of Aging and Disabilities
- Cecil County Aging & Disability Services Division
- Dorchester County Office on Aging *
- Frederick County Sr Services
- Garrett County Area Agency on Aging
- Harford County Office on Aging
- Howard County Office on Aging and Indep.
- Kent County Office on Aging
- Montgomery County Aging & Disability Services
- Prince George's County Aging & Disability Services
- Queen Anne's County Aging Division
- St. Mary's County Dept of Aging and Human Services
- Somerset County Commission on Aging *
- Talbot County Commission on Aging
- Washington County Commission on Aging
- Wicomico County Commission on Aging *
- Worcester County Commission on Aging

* Part of MAC, Inc.

AAA Services

- Information & Assistance (MAP)
- Adult Evaluation & Review Services (AERS)
- Personal Care
- Home-Delivered Meals
- Adult Day Care/Day Health
- Congregate Meals
- Transportation & Taxi Card
- Ombudsman Program
- Hospital-2-Home
- Health Promotion & Education
- Long Term Care Advocacy Program
- Senior Care Case Management
- Medicaid Waiver/Community First Choice
- Public Guardianship
- Legal Assistance
- Tax Aid Program
- Senior Assisted Group Home Subsidy Program
- SHIP (State Health Insurance Assistance Plan)
- Family Caregivers Support

Maryland Access Point

http://www.marylandaccesspoint.info/

1-844-MAPLINK /1-844-627-5465

Explanation of Services

Presented by Liz Briscoe
Baltimore City Health Department
Division of Aging and CARE Services

"No Wrong Door" Maryland Access Point (MAP) 1-844 -MAPLINK

Provides information and access to a wide range of services including social security, housing, health care, transportation, legal assistance, and leisure activities. This information resource is available to everyone at no cost, regardless of income.

Community Personal Assistance/Community First Choice

- Clients receive in-home, individualized plans of services that may delay or prevent nursing home placement.
- **Eligibility: No age requirement, however, client must be eligible for Medicaid.**

Senior Care Program

Provides services that will support aging in place.

Available services:

- Personal care
- Light housekeeping
- Meal preparation
- Nursing care
- Shopping
- Transportation

Eligibility: Age 65 or older. Must meet income and medical guide lines.

Ombudsman Program

- Provides investigation & resolution of complaints in nursing homes and assisted living facilities
- Mediates disputes
- AAA Ombudsmen investigate complaints within 24 hours as well as provide information on regulations
- Provides in-service training on topics such as residents' rights, psycho-social needs, difficult behavior, sexuality, communication, and dignity, among others.
- Program is not a 24 hour emergency response service

Senior Health Insurance Program (SHIP)

- Provides information and individual counseling for Medicare and health insurance questions.
- Helps in selecting health insurance coverage, filling out complicated forms, and intercede on their behalf when necessary.
- Assistance with enrollment in Low Income Subsidy Programs for Medicare recipients.

Maryland SMP
Empowering Seniors To Prevent Healthcare Fraud

Helps Medicare, Medicaid beneficiaries prevent, detect, and report health care fraud.

Housing Services/ Sr Assisted Group Home Subsidy Program

For low income seniors, this program provides access to assisted living in small group homes (4 – 16 residents) which are licensed by the State of Maryland.

Eligibility:

- At least 62 years of age
- Physically or mentally impaired and in need of assistance with ADL's.
- Financially eligible

Public Guardianship

Adult Public Guardianship provides protection and advocacy on behalf of older adults who are determined by a court of law to lack the capacity to communicate responsible decisions concerning their daily living needs.

An Executive Director of the Area Agency on Aging can be appointed as a legal guardian.

A public guardian can be appointed if a person exhibits an inability to make everyday decisions due to:

- Effects of disease or disability
- Mental confusion / forgetfulness
- Inability to manage money / business affairs
- Inability to meet physical needs such as food, shelter, bathing, medical appts.

Legal Services

Maryland Legal Aid provides a full range of free civil legal services to financially qualified Marylanders and to those over age 60.

Maryland Legal Aid handles civil, not criminal, cases. Areas of general civil legal services include:

Consumer rights
Elder rights
Employment
Family
Government benefits
Health care
Housing

Mealson Wheels

Provides a life-giving service to the homebound elderly who are confined to bed, lack transportation, or are too frail to cook for themselves

Support provided by United Way

Area Agency on Aging Contact Info (MAP contacts)

County	MAP Contact	E-mail	Phone
Baltimore City Health Dept	Liz Briscoe	Elizabeth.Briscoe@baltimorecity.gov	410-545-3967
Baltimore County Dept of Aging	Peggy Miller	psmiller@baltimorecountymd.gov	
St. Mary's County Dept of Aging	Jennie Beyer	Jennette.beyer@stmarysmd.com	301-475-4200 X 71057
Montgomery County Aging & Dis.	Jennifer Long	Jennifer.long@montgomerycountymd.gov	
Prince George's Co. Aging & Disab.	Deborah McBroom	dcmcroom@co.pg.md.us	301-265-8450
Howard County	Christopher Moore	cmoore@howardcountymd.gov	

National Family Caregivers Program

Services:

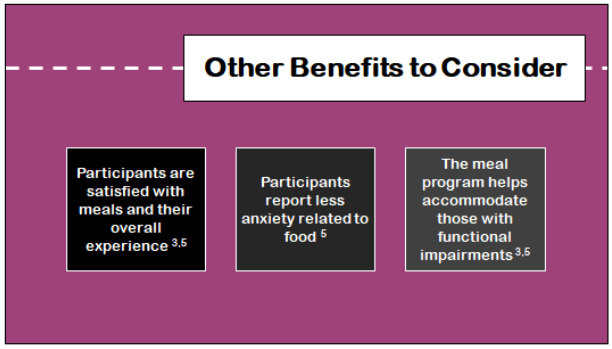
- Provides support for caregivers
- Provides caregiving training
- Connects caregivers to available services
- Respite care

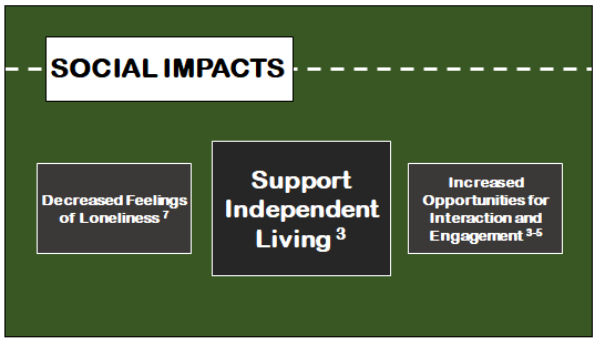
Eligibility:

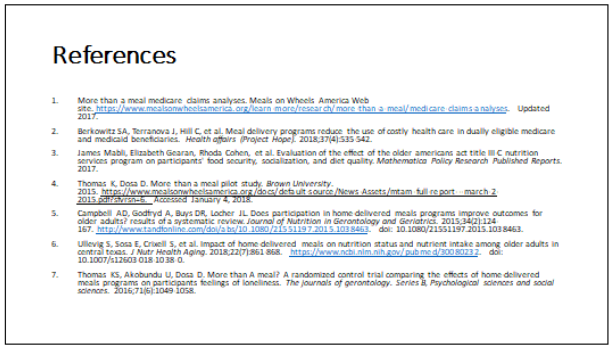
- Adult family members or other informal caregivers age 18 and older who provide care to individuals age 60 and older
- Adult family members or other informal caregivers age 18 and older who provide care to individuals of any age with Alzheimer's disease and related disorders;
- Resources available for grandparents as well

Area Agency on Aging Contact Info (MAPS contacts)

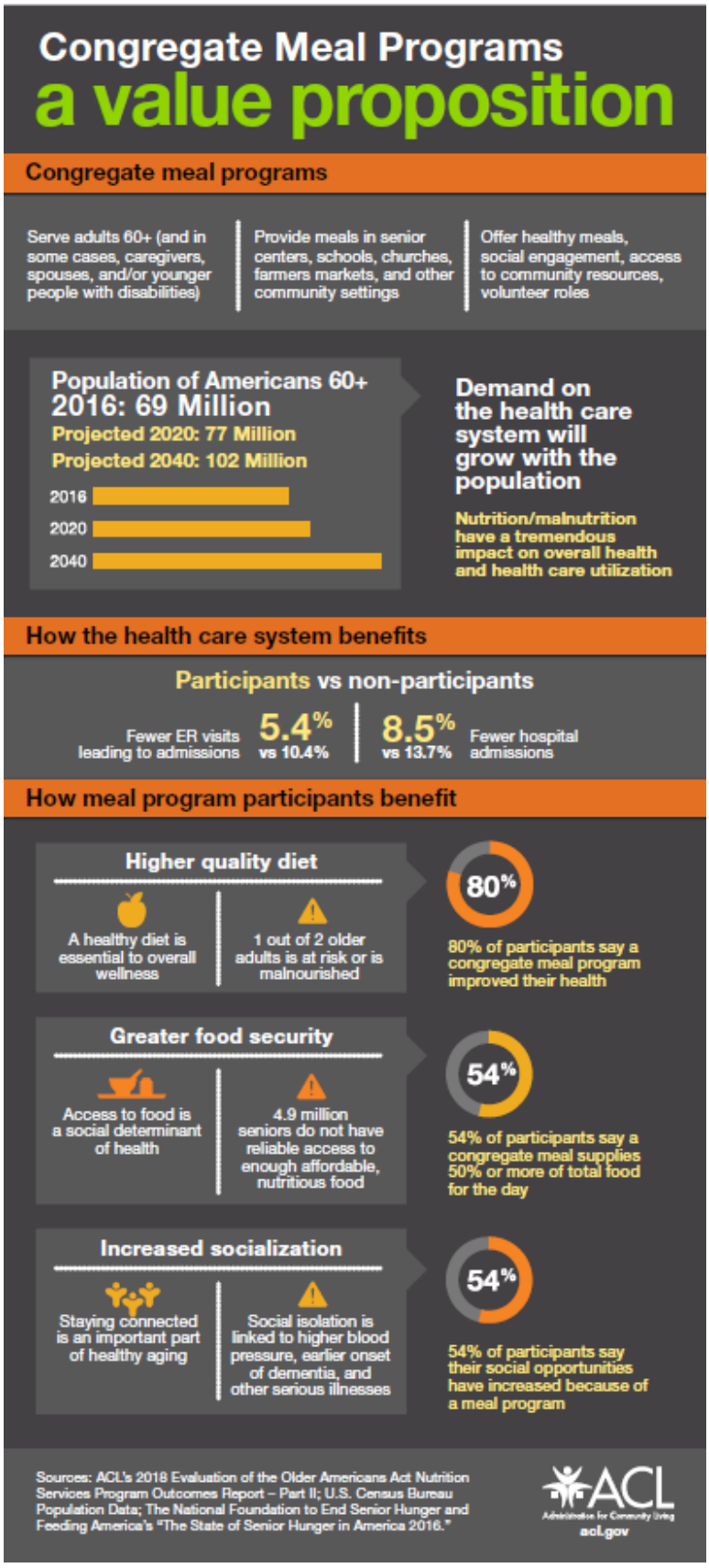
County	MAP Contact	E-mail	Phone
DC Office on Aging	(ask for Information & Assistance) Sheila is very good !	Ask.adrc@dc.gov	202-724-5626







For access to this PowerPoint, please contact Judy Simon at judy.simon@maryland.gov.



You can access this infographic at: https://acl.gov/sites/default/files/programs/2019-03/MealProgramValueProposition.pdf

Appendix 10: Healthcare-Community Partnership Resources

- A Roadmap to Financial and Programmatic Sustainability for Community-Based Organizations: Understand the Business Environment and Your Place Within It
- Aging and Disability Business Institute
- Chronic Care Management Information Resource
- Community-Clinical Linkages for the Prevention and Control of Chronic Diseases. A Practitioner's Guide
- Fundamentals of Community-Based Managed Care: A Field Guide
- HCBS Business Acumen Center
- HCBS Business Acumen Toolkit.
    - Step 1: Prepare. Understand the Business Environment and Your Place Within It.
    - Step 2: Plan. Use Business Intelligence to Build the Strategic Plan for Your Organization
- Healthcare Policy and Practice Opportunities for Senior Nutrition Programs.
    - Part 1: The Evolving Healthcare Legislation Landscape.
    - Part 2: Launching an In Home Medical Nutrition Therapy Program
- Health Care and Community-Based Organizations Have Finally Begun Partnering to Integrate Health and Long-Term Care
- Learn the Basics about Medicare Advantage and Position Your Organization for New Partnerships
- Partnerships for Health: Lessons for Bridging Community-Based Organizations and Healthcare Organizations
- Sustainability and Revenue Generation in an Evolving Senior Nutrition Business Environment
- The Aging Network in Transition: Hanging in the Balance
- Using Community Partnerships to Integrate Health and Social Services for High-Need, High-Cost Patients

Expanded Food Security Screener: Home Delivered Meals Prioritization Tool

Paper screening tool, app, and instructions.

Expanded Food Security Screener

Home-Delivered Meals Prioritization Tool

Developed by the College of Agriculture & Natural Resources Department of Nutrition and Food Science at the **University of Maryland.**

WHO should use this tool?

Home-delivered meal program administrators that:

A Have a waiting list or limited resources to serve all applicants;

B Want to demonstrate to funders and policy-makers the level of need in their community; **and/or**

C Want to understand if they are reaching those with the greatest need, or if more outreach is needed to identify the most food insecure.

HOW should it be used?

As a screening tool as early as possible at application or referral

HOW are the results useful?

The results show risk factors the applicant is experiencing, and the level of priority for home-delivered meal services, and may inform alternative or additional support services that could benefit clients.

Screening Questionnaire and Point Calculator provided on reverse.

The Researchers Behind this Tool

The research design and the assessment model was developed by **Nadine Sahyoun**, professor of nutrition epidemiology, and **Anna Vaudin**, graduate student in the college's Department of Nutrition and Food Science. Their work focuses on assessing the nutritional status of the older adult population and studying the relationship between nutrition risk factors and health outcomes.

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agnr.umd.edu

The Procedure

1. As early as possible after client application/referral and determination of elegibility for home delivered meals, the screening should be conducted via telephone or in person.
2. Priority Level is calculated and recorded for each client:

   Level A: Highest priority for service and follow-up assessments.

   Levels B, C, D, and E: See below for recommendations of support service.

Priority Levels and Recommended Nutrition Service(s)

LEVEL	CRITERIA	PRIORITY LEVEL REASONING	SERVICE
A	**Unable to cook and no reliable help**	Even if food is affordable and in the home, it cannot be prepared, therefore, it is unlikely there are consistent healthy meals.	**Home-Delivered Meals PRIORITIZED on wait list if resources are limited.**
B	**Can cook or has help. Economically food insecure. Cannot obtain groceries.**	Affordablilty and access to groceries are both issues. With financial support and grocery delivery, healthy meals could be prepared at home.	**Home-Delivered Meals ALL clients should receive home-delivered meals if resources are available.** If there is a wait list for home-delivered meals clients should be prioritized B - E. Regardless of wait list status, all clients may benefit from additional nutrition services: **USDA Supplemental Nutrition Assistance Program (SNAP)** **Grocery Delivery Services** **Additional State or Local Services as Needed**
C	**Can cook or has help. Economically food insecure. Can obtain groceries.**	Affordability is the only issue, can obtain groceries and prepare healthy meals at home.	
D	**Can cook or has help. Economically food secure. Cannot obtain groceries.**	Groceries and food delivery are affordable, not physically limited from food preparation (or help is available) therefore healthy meals can be prepared at home.	
E	**Can cook or has help. Economically food secure. Can obtain groceries.**	These individuals fulfill the basic eligibility requirements for the home delivered meal program; however, they are able to afford and obtain groceries, and are not physically limited from food preparation (or help is available), therefore healthy meals can be prepared at home.	

COLLEGE OF AGRICULTURE & NATURAL RESOURCES
DEPARTMENT OF NUTRITION AND FOOD SCIENCE

Expanded Food Security Screener

Home-Delivered Meals Prioritization Tool

Client Name

The following questions ask about your ability to get food and prepare meals. You are eligible for the service regardless of your income.

Proceed to Question 1a

1a **If you had groceries available, would you be able to use them to prepare hot meals?**

☐ **YES** — Proceed to Question 2

☐ **NO** — Proceed to Question 1b

1b **Do you have reliable help with meal preparation?**

☐ **YES** — Proceed to Question 2

☐ **NO > STOP** — Applicant is a Level A Priority

2 **During the last month...**

2a ...how often was this statement true? **The food that we bought just didn't last, and we didn't have money to get more.**

☐ **Often** (1 point) ☐ **Sometimes** (1 point) ☐ **Never** (0 point)

2b ...how often was this statement true? **We couldn't afford to eat balanced meals.**

☐ **Often** (1 point) ☐ **Sometimes** (1 point) ☐ **Never** (0 point)

2c **...did you or other adults in your household ever cut the size of your meals because there wasn't enough money for food?**

☐ **YES** (1 point) ☐ **NO** (0 point)

2d **...did you or other adults in your household ever skip meals because there wasn't enough money for food?**

☐ **YES** (1 point) ☐ **NO** (0 point)

2e **...did you ever eat less than you felt you should because there wasn't enough money for food?**

☐ **YES** (1 point) ☐ **NO** (0 point)

2f **...were you ever hungry but didn't eat because you couldn't afford enough food?**

☐ **YES** (1 point) ☐ **NO** (0 point)

Add the points from questions 2a – f and enter it here: ☐

3 **Are you able to get groceries into your home when you need them?**

☐ **YES** – Select the point range below:

- ☐ 0 – 1 Points **Level E Priority**
- ☐ 2 – 6 Points **Level C Priority**

☐ **NO** – Select the point range below:

- ☐ 0 – 1 Points **LeveL D Priority**
- ☐ 2 – 6 Points **Level B Priority**

See chart on page one for explanation of Priority Levels and recommended service(s).

Developed by the College of Agriculture & Natural Resources Department of Nutrition and Food Science at the **University of Maryland.**

Grant funds from the Administration for Community Living (ACL), Grant # 90INNU0002 and the Maryland Department of Aging (MDoA) assisted in the development of this material. This presentation is solely the responsibility of the authors and do not necessarily represent the official views of the ACL or MDoA.

COLLEGE OF AGRICULTURE & NATURAL RESOURCES
DEPARTMENT OF NUTRITION AND FOOD SCIENCE

Expanded Food Security Screener

Home-Delivered Meals Prioritization Tool

TRAINING MANUAL

Developed by the College of Agriculture & Natural Resources Department of Nutrition and Food Science at the **University of Maryland.**

Grant funds from the Administration for Community Living (ACL), Grant # 90INNU0002 and the Maryland Department of Aging (MDoA) assisted in the development of this material. This presentation is solely the responsibility of the authors and do not necessarily represent the official views of the ACL or MDoA.

COLLEGE OF AGRICULTURE & NATURAL RESOURCES
DEPARTMENT OF NUTRITION AND FOOD SCIENCE

Introduction

What is Food Security?

According to the Food and Agriculture Organization, "food security exists when all people, at all times, have physical and economic access to sufficient, safe, and nutritious food that meets their dietary needs and food preferences for an active and healthy life."

The four main dimensions of food security are:

- availability (determined by food production and markets)
- accessibility (physical and economic)
- utilization (including the preparation of food)
- stability of the other three dimensions over time

What is the Expanded Food Security Screener?

Current tools for measuring food security only measure the economic access component. However, in older adults, and especially the homebound population, there may be physical issues that interfere with an individual's ability to obtain and prepare adequate nutritious food. The Expanded Food Security Screener (FSS-Exp) builds on the US Department of Agriculture 6-item Household Food Security Survey Module (HFSSM), which is a validated tool used to assess food security based on questions that ask about ability to afford food. The FSS-Exp combines this economic access information with the other indicators of food security for older adults that indicate need for services: ability to get groceries into the home and ability to prepare meals. To fully understand an individual's level of need for a meal, the FSS-Exp also takes into account whether the person has help available to accomplish these tasks.

How does the FSS-Exp work as a Home-Delivered Meals Prioritization Tool?

The FSS-Exp quickly gathers information on an individual's economic access to food, their ability to get groceries into their home, and their ability to prepare meals, with or without help. This information is used to categorize applicants into one of five priority levels. The categorization scheme for these priority levels is based on the issues that could be specifically addressed by a meal delivered to the home. This tool provides home-delivered meal (HDM) programs with a concise version of the most essential information about each individual's food security needs. HDM programs can use this information to make quick decisions about how to use their organization's resources most efficiently and effectively to support the needs of that client, thus allowing the meal program to provide person-centered services.

What does screening mean and how is it different than assessment?

A screening tool is used to detect risk quickly and efficiently. When screening, you are trying to find those at the highest risk early on, in order to mitigate further decline. Assessment is more in-depth and thorough, but takes more time. This is why screening takes place before assessment, in order to quickly identify those who may be at high risk and thus in need of intervention. A follow-up assessment with those who are detected during screening will confirm, deny, and/or expand on the needs of an individual. Screening is less resource-intensive and tells you where to prioritize your more resource-intensive procedures (such as assessment and meals) in order to have the greatest impact.

Reasons for Use of the HDM Prioritization Tool

1. **Prioritize initial and follow up services.** The priority level generated by the tool will tell you who is at the greatest need for your services and allows you to provide the most appropriate type of service to meet the individual's need. People at a higher priority level should receive initial or follow-up assessments first, and may need immediate access to resources, as they are likely to be the most food insecure. Regardless of waitlist status, the priority level provides information on what additional or alternative services may be beneficial to a client. Using the tool this way can help your program make the greatest impact with the limited resources it has.

2. **Demonstrate need for funders and policy makers.** Using the HDM Prioritization Tool to track the priority level for each client is a quick way to generate a profile of the needs of the population you serve, and how many of your clients are high priority. This can demonstrate to funders and policymakers the importance of dedicating resources to your program, in order to meet the needs of your clients.

3. **Indicate the need for outreach.** The Older Americans Act requires HDM programs to reach those with the greatest need and to address food insecurity. This tool can help identify whether your program is meeting these goals or whether there may be persons in the community who are more food insecure and yet not receiving services.

Development of the HDM Prioritization Tool

Consultation with Community Programs

In the early stages of developing the tool, researchers from the University of Maryland, the nutrition director at the Maryland Department of Aging, and six nutrition program managers from Area Agencies on Aging throughout Maryland formed a workgroup around HDM prioritization. The goal was to work towards a standardized method for objectively assessing an applicant's need for a meal. The workgroup had several meetings to discuss HDM prioritization, and over the course of these meetings, the risk factors and categorization criteria for the HDM Prioritization Tool were established

Selection of the Three Criteria for Prioritization

The basis for the selection of the risk factors used for prioritization is the impact they may have on the ability of an older adult to eat a healthy diet. The ultimate goal of the HDM program is to make a healthy meal available to those who would not otherwise be able to get one. Therefore, all risk factors identified in the literature that can lead to poor diet, and that may be remedied by a healthy meal delivered to the home, were identified and included in the prioritization tool. The three factors that specifically indicate the need for a home-delivered meal are:

1. if hot meals can be prepared, whether by the individual or by a reliable helper (such as family or hired homecare)
2. economic access (being able to afford food)
3. physical access (being able to get food into the home, either independently or with help).

There may be other factors that affect whether or not a client is obtaining adequate nutrition (such as depression or dental health); however, these factors may not necessarily be addressed by a home-delivered meal, and so they are not considered when prioritizing a client for these services. For example, if someone has poor nutrition because they have trouble chewing, a home-delivered meal will not improve their health if they cannot chew it. If such risk factors are identified, the client may be referred to services that can help address the issue (see the section titled "Creating a referral resource for your program").

Reasoning Behind Each Priority Level

The three criteria measured by the tool are combined into 5 different priority levels. The following describes each priority level and the reasoning behind the ranking system. The priority level ranking assumes that there are limited spots for meals. If there are no limits on meal availability, clients should be added to the program first-come-first-served (see the section titled "Recommended Actions Based on Each Priority Level").

Level A

Applicants who are categorized into priority level A are unable to prepare meals and do not have help. They are considered the highest priority: even if they are able to afford groceries and get them in their homes, it is unlikely that they can consistently eat a healthy diet because they are ultimately unable to prepare their food. If there is a waiting list, these individuals are priority for follow-up assessments and service.

•

Level B

Applicants who are categorized into priority level B are able to prepare meals (with or without help), but cannot get groceries into their home and are economically food insecure. If space is available on the program, HDM programs could deliver affordable meals. However, if there is a waiting list, these individuals may get by if they can obtain both financial assistance and grocery delivery.

Level C

Applicants who are categorized into priority level C are able to obtain groceries and prepare meals (with or without help), but are economically food insecure. If HDMs are available, this is an affordable way for these individuals to get healthy meals. However, if there is a waiting list, these individuals would be able to obtain and prepare meals if they had financial assistance, such as the Supplemental Nutrition Assistance Program.

Level D

Applicants who are categorized into priority level D are economically food secure, able to prepare meals (with or without help), but have difficulty getting groceries into their home. If there is not funding to place them on the HDM program, these individuals would be able to prepare meals if they receive help with getting groceries (such as from a grocery delivery service). As they are not economically food insecure, they may be able to afford these services from a local grocery store, especially if someone is available to assist them in setting up these services.

Level E

Applicants who are categorized into priority level E are economically food secure and have the ability to get groceries into the home and prepare meals, either with or without help. These individuals are eligible for HDMs because they fulfill the basic requirement of the Older Americans Act Nutrition Program (being homebound and 60 years of age or older). However, since they are not economically food insecure, and are physically able to get and prepare food or have help, they may be considered the lowest priority and, in case of limited funds, can be placed on the waitlist and/or referred to other services.

How to Use the Tool

When the Tool Should be Used

Before you use the tool, check whether the person is eligible to receive HDMs based upon your organization's criteria. In general, this means the person must be 60 years or older and be homebound. The spouse of an eligible person may also receive meals.

The HDM Prioritization Tool is meant to be used as a screening tool. It should be administered by phone as soon as an applicant calls in or is referred to the program. The best method for administration is to incorporate the tool into your program's intake procedures. Each program can determine when it is the best time to ask questions during the intake conversation.

Many programs repeat the screen once a home visit occurs. While all of the questions don't need to be repeated, staff can check that the first screen collected accurate information. If you receive additional information in a follow-up assessment that contradicts the priority level assigned during the screening, the priority level may be adjusted based on this information. The client may not have understood the question, or may have represented their abilities in a way that is contradictory to what your staff member sees in the assessment. Additionally, their status may have changed between the screening and the assessment. For example, if a client that was screened as priority level A has obtained a home health aide who cooks for them each day, they are no longer priority level A and you should ask the additional questions in the screener to determine if they are priority level B, C, D or E.

The Different Methods of Using the Tool

Staff members have access to both a paper copy of the screening tool, a Microsoft Excel form, and a mobile application. Any of these can be used to calculate the priority level for a client. The following instructions outline each method.

Paper Tool

The questions are on one sheet of paper and can be used as follows:

1. Read the introductory statement
2. Ask Question 1a about meal preparation and mark the client's answer. If the Answer to Question 1a is "No", you will also ask Question 1b. If the client's answer is again "No", stop the questionnaire. This client is considered priority level A and no further information is needed.
3. If the client's answer to Question 1a or 1b is "Yes", continue to the next set of questions (Questions 2a-f) about ability to afford food. Ask these 6 questions and mark down the client's answers.
4. Ask the Question 3 about ability to get groceries and mark the client's answer.
5. Finish your intake conversation with the client.
6. After you finish speaking with the client you can calculate their priority level as described below.
    - As mentioned in #2 above, if they are priority A, you are finished with the screener.
    - Otherwise, look at the point values noted next to each answer for Questions 2 a-f. Add up these points and write the total in the red box.
    - Look at the client's answer to Question 3, the final question. Below the answer are two boxes, each with a point range next to it. Select the box with the point range that contains the point total you wrote in the red box. This will tell you the priority level for this client.

Excel Form

You can access a Microsoft Excel form that displays the questions, allows you to select the client's answers, and then calculates the client's priority level and stores it in an Excel sheet. It is simple to use and stores all of your client's priority levels in one place. To obtain this version of the tool, send an email to **nsahyoun@umd.edu** and **amvaudin@gmail.com**, and include the name and location of your program. You will receive an email with the Excel sheet.

Mobile Application

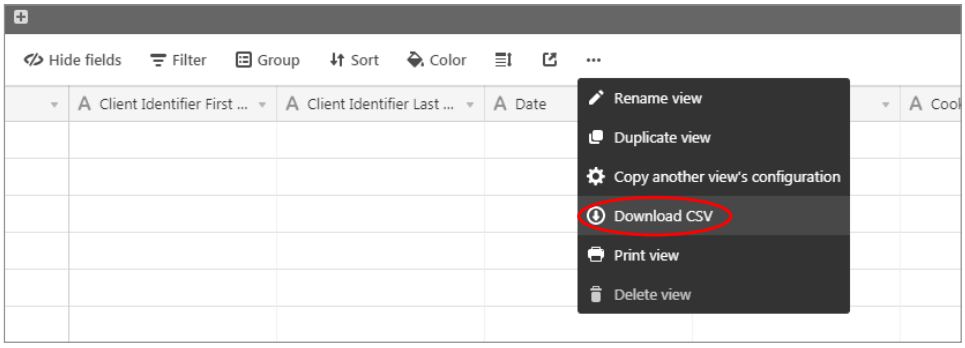
There is a mobile application ("app") available that acts as a calculator to generate a client's priority level. You can also obtain an Airtable spreadsheet: a spreadsheet that is stored on the Airtable website, and is linked to your app so that it will collect the results of the screener for your program. These are generated individually per program, and your Airtable spreadsheet will be protected by a user name and password that you generate.

Instructions for Using the Mobile Application

To obtain an app and spreadsheet for your program's use, send an email to **nsahyoun@umd.edu** and **amvaudin@gmail.com** and include the name and location of your program. You will receive an email with a link to the app, and an email with instructions for downloading the app as well as accessing the Airtable spreadsheet that is linked to it.

1. Open the app. The icon for the app should look like this:
2. On the screen that says "Welcome to the Home-Delivered Meals Prioritization Tool!" tap "Next"
3. Read the introductory statement to the client and then tap "Next".
4. The screen will now have the first question to ask the client. Read the question and select the client's answer by tapping on it. You will automatically be taken to the next question to read.
5. Continue reading the questions and tapping the client's answers. Please note: the questions that show up for you to ask may be different from client-to-client. This is because the client's answers to some of the questions determine what additional questions need to be asked to calculate their priority level. For example, if the client answers that they are unable to cook, and then that they do not have help, the questionnaire will end. The app will determine this for you, and will show you the correct questions to ask each client.
6. If you arrive at the food insecurity questions page, make sure to select an answer for every question and then scroll down to the bottom of the page and tap "next" to continue. If you do not answer every question, the priority level cannot be calculated.
7. If you have to go back to a previous page to change an answer, tap the "back" button at the bottom of the page you are on. Please note that this will erase all answers for questions that come after the page you go back to, and you will have to answer these questions again.
8. After you have selected answers for all of the questions, you will reach a page with spaces to enter the name of the client and their county. Tap each text box to type in the appropriate information, then tap "Submit". This step is essential for the app to calculate the client's priority level and submit the collected information to the Airtable spreadsheet. Once you tap "Submit", the next screen shows you the priority level that has been calculated:

   Tapping "Submit" multiple times may result in duplicate records in the Airtable spreadsheet. If this happens, you can delete the extra record from the spreadsheet.
9. Tap "Restart" to enter the information for another client. If you are finished, close the app.
10. To access the information collected by the app, open the Airtable link that was sent to you when you requested the app. Follow the directions to create an Airtable account for access to the spreadsheet. Make sure to record your username and password for future access.
11. Your spreadsheet will be under "Bases shared with me" and will have the same name as the app. Click the icon to open and view the spreadsheet, which will contain the results from all of the times you have used the app.
12. To download your results spreadsheet, click the three dots symbol at the top bar and click "Download CSV." This will download the information from the table in a file you can open in Microsoft Excel.



Recommended Actions Based On Each Priority Level

The priority level will give you information on the best actions to take for each client. Your action will also depend on whether or not your program has a waiting list. Below is a description of the best action for programs both with and without a waiting list.

If you do not have a waiting list:
Every applicant may be eligible to receive meals, regardless of priority level. All applicants may also benefit from additional services, such as those noted in the chart below. The applicant's priority level will help guide you towards the appropriate additional services. It is possible these additional services may provide enough support to these clients so that they don't need HDMs, which will create space for higher-priority individuals. However, if you have space on the program, all eligible applicants will benefit from receiving meals.

If you do have a waiting list:
Applicants should be prioritized for service based on priority level, date of application, and availability of a delivery route to provide the meals. Priority level A applicants are highest priority for receiving home-delivered meals. They should be scheduled first for a follow-up assessment and should be placed next on the waiting list for service (after the other priority level A applicants who were screened previously, and pending route availability). Next on the waiting list should be priority level B applicants, in order of screening date, then priority level C applicants, etc.

Applicants who are priority level B through E may benefit from alternative food and nutrition services other than HDMs. Your program may be able to facilitate assistance for these individuals that helps them get food, even if your program cannot provide them with meals. If these supports are sufficient for these applicants, they may not need HDMs, freeing up more space on your program for those who have the greatest need for meals. The following table shows the supports that may be helpful to clients in each priority level:

LEVEL	RECOMMENDED ACTION	POSSIBLE ADDITIONAL OR ALTERNATIVE SERVICES
A	**NWL: Home Delivered Meals** **WL: Highest** priority on wait list	Home-delivered meals are the most appropriate support for these clients Further inquiries to the applicant may reveal additional beneficial supports
B	**NWL: Home-delivered meals and suggest additional services** **WL: Second highest priority** on wait list, suggest alternative services	Financial-based nutrition support services such as SNAP Help with getting groceries, such as grocery delivery or transportation services
C	**NWL: Home-delivered meals and suggest additional services** **WL: Third highest priority** on wait list, suggest alternative services	Financial-based nutrition support services such as SNAP
D	**NWL: Home-delivered meals and suggest additional services** **WL: Fourth highest priority** on wait list, suggest alternative services	Help with getting groceries, such as grocery delivery or transportation services
E	**NWL: Home-delivered meals and suggest additional services** **WL: Lowest priority** on wait list, suggest alternative services	Further inquiries to the applicant may reveal the type of support required

NWL= No Existing Wait List **WL=** Existing Wait List

Creating a Referral Resource for Your Program

Each community and each state may have different services available for older adults. An assessment of need will indicate which services are most appropriate to assist each client. Creating a reference resource will help you smoothly and efficiently refer HDM clients or applicants to additional or alternative services. This involves collecting the names and contact information for the organizations (or people within your organization) who can start the process of enrolling them with these services. A suggested method is to create categories (financial, grocery delivery, and any other additional helpful resources, such as dental, mental health, insurance, etc) and list the available services and contact information. Examples of these resources are shown at the end of this manual.

How to Document and Use the Results in Your Program

Maintain a record of the priority level for each client. You can do this by adding it to the information you keep on that client, and/or maintaining a separate spreadsheet that contains the client's name, the date screened, the priority level, and any other information you would like to include (for example, a column showing whether or not the client is on the meal program). If you are using the appor the Excel form, they will generate a spreadsheet for you with the results of the screener that can be downloaded and modified to suit your purposes.

Looking at the priority levels of your clients can help you identify the need for additional programs or services, which can result in new partnerships or funding sources. For example, setting up a volunteer grocery shopping service or initiating the Commodity Supplemental Food Program may be a new program needed in your community.

A spreadsheet can be used to manage enrollment in your program if you have a waitlist. If you have a spot open up on your meal program, you can use this spreadsheet to find the person who is at the highest priority. If you have multiple persons at the same priority level, you can choose the one who has been waiting the longest based on the date they were screened. And, maintaining the list can identify unmet need in areas where you may not have an existing HDM route.

You can also create a report that shows the levels of need of those being served, and of those who are on your wait list (if you have one). This can be used to generate funding and support. If you are serving many people who are low priority, this may indicate the need for outreach to see if there are people who are high priority in your community but do not know about your services.

Re-screening

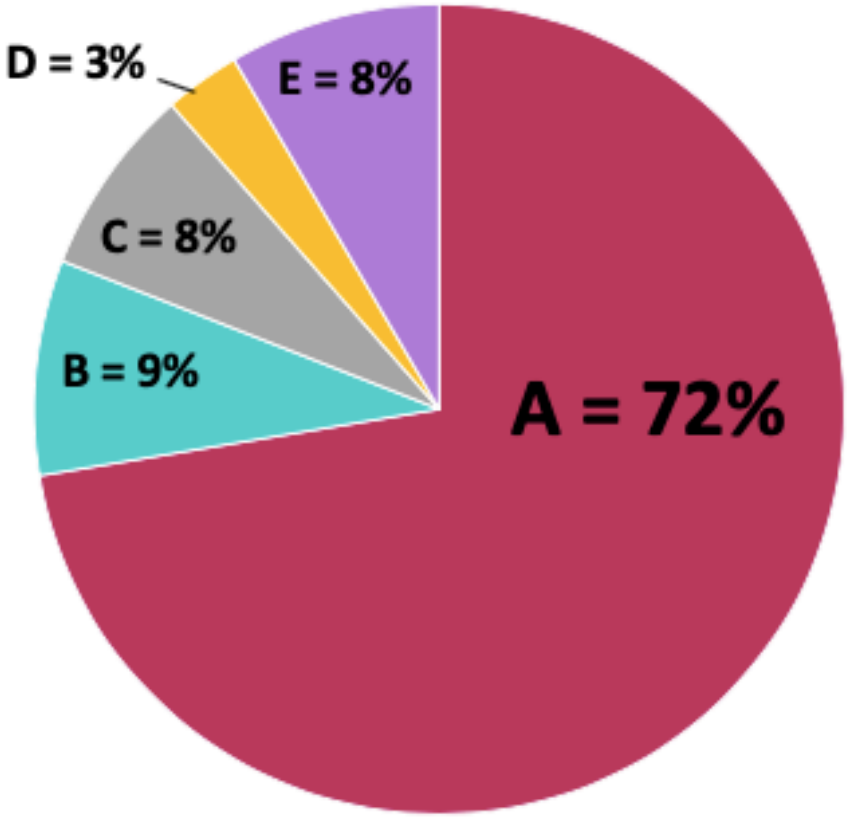
This tool was developed and tested as a screening tool, and is designed to be administered to people who are applying for or waiting to receive meals. However, when completing annual reassessments, your program may wonder whether the priority level of a client who has been on the program has changed. There may be other opportunities for re-screening, such as after a significant change in a person's health or living situation (e.g., death of a spouse, return from hospital, etc.), and it is also mandatory during regular reassessments in some states.

The questions in this tool have not been designed specifically for determining the priority level of people who are already receiving support from the program. So, when using the screening tool during a reassessment, preface the questions with the following statement:

"The following questions are about the difficulties you might have if you were not receiving home-delivered meal services. Please answer the questions based on what your abilities would be if you were not receiving home-delivered meals."

Sample Report from the Maryland Department of Aging Showing the Distribution of Priority Levels Across Maryland

Fiscal Year 2018



Sample Referral Table from the Maryland Department of Aging

Care Planning Components	AAA Referral Programs and Services
Food and Nutrition	• Senior Center Congregate Meals • Home-Delivered Meals • Nutrition counseling, education, and care planning • Commodity Supplemental Food Program • Community food resources (pantries, etc)** • Senior Farmers Market Nutrition Program • Malnutrition workshop: Stepping Up Your Nutrition • Post-discharge, medically-tailored meals
Housing	• Assisted Living (including SALGHS) • Ramp Assistance • Home Modification • Assistive Technology • Durable Medical Equipment • Congregate Housing Services Program
Transportation	• County or Regional Transit • Cab/Bus Vouchers • Senior Village • Community for Life

Financial	Application assistance for financial aid:
	  • SNAP
	  • Medicaid
	  • State Health Insurance Program (SHIP_
	  • Energy-assistance programs
	  • Income-tax assistance
	  • Medicare Part A, B, C, D
	• Medicare Billing, Appeals, Denials, Grievances
	• Medicare Fraud Assistance
	• Oral nutritional supplements (Ensure, etc)
	• Prescription assistance
	• Assistance for dental, eye care, hearing aids

Utilities	• Low-Income Home Energy Assistance Program (LIHEAP) • Electric Universal Service Program (EUSP) • Universal Service Protection Program (USPP) • Utility Assistance (other)
Personal Safety	• Elder Abuse • Legal Assistance • Emergency Response Systems • Falls Prevention (Stepping On, Matter of Balance, Tai Chi for Better Balance) • Arthritis foundation classes (Walk with Ease)

In-Home Care	• Sitters and in-home care services (personal care, chore service) • Home Care agencies • Community First Choice • Senior Care • Home-delivered meals • Dietitian referral • Senior Village
Social Supports	• Senior Center (exercise, socialization, Congregate Meals) • Telephone Reassurance • Support Groups: Caregivers, Renal, Stroke, ALS, Parkinson's • Adult Day Care • Volunteer opportunities
Mental Health	• PEARLS: Program to Encourage Active, Rewarding Lives • Enhance Wellness • Healthy IDEAS • Behavioral Health Referral (Core Service Agency or Health Department)
Health Care Referral	• Primary Care Physician • Clinics: Dental, Eye, Physical Therapy • Community Health Worker • Adult Medical Day Care • Local health department • Home care agencies • Medical supplies
Employment	• Senior Employment • AAA volunteer coordinator • Community volunteer opportunities

Health Education	Self-management workshops:
	  • Diabetes Self-Management (Spanish version available)
	  • Chronic Disease Self-Management (Spanish version available)
	  • Chronic-Pain Self-Management
	  • Cancer Thriving and Surviving
	• Falls Prevention (Stepping On, Matter of Balance, Tai Chi for Better Balance)
	• SAIL(Stay Active and Independent for Life)
	• Aging Mastery
	• Enhance Fitness
	• Lifelong Learning
	• Medication Management
	• Wellness Center Gym

Grant funds from the Administration for Community Living (ACL), Grant Number 90INNU0002 and the Maryland Department of Aging assisted in the development of this material. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the ACL or Department.

Developed by the College of Agriculture & Natural Resources Department of Nutrition and Food Science at the **University of Maryland.**

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COLLEGE OF
AGRICULTURE &
NATURAL RESOURCES

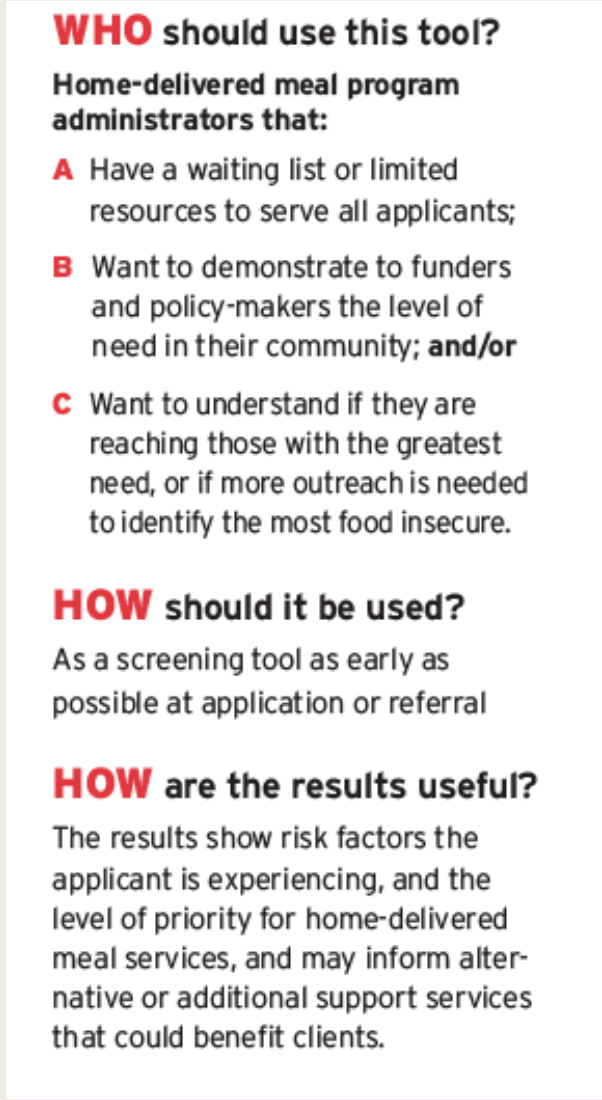
DEPARTMENT OF NUTRITION
AND FOOD SCIENCE

HDM PRIORITIZATION TOOL AND TRAINING MANUAL

Feb 26, 2020

Introduction to the Newly-Designed Tool

- Brief description of
  - *Who should use the tool*
  - *How the tool should be used*
  - *How the results are useful*



WHO should use this tool?

Home-delivered meal program administrators that:

A Have a waiting list or limited resources to serve all applicants;

B Want to demonstrate to funders and policy-makers the level of need in their community; **and/or**

C Want to understand if they are reaching those with the greatest need, or if more outreach is needed to identify the most food insecure.

HOW should it be used?

As a screening tool as early as possible at application or referral

HOW are the results useful?

The results show risk factors the applicant is experiencing, and the level of priority for home-delivered meal services, and may inform alternative or additional support services that could benefit clients.

Introduction to the Newly-Designed Tool

- Outlines the procedure for using the tool

The Procedure

1. As early as possible after client application/referral and determination of elegibility for home delivered meals, the screening should be conducted via telephone or in person.
2. Priority Level is calculated and recorded for each client:

   Level A: Highest priority for service and follow-up assessments.

   Levels B, C, D, and E: See below for recommendations of support service.

Introduction to the Newly-Designed Tool

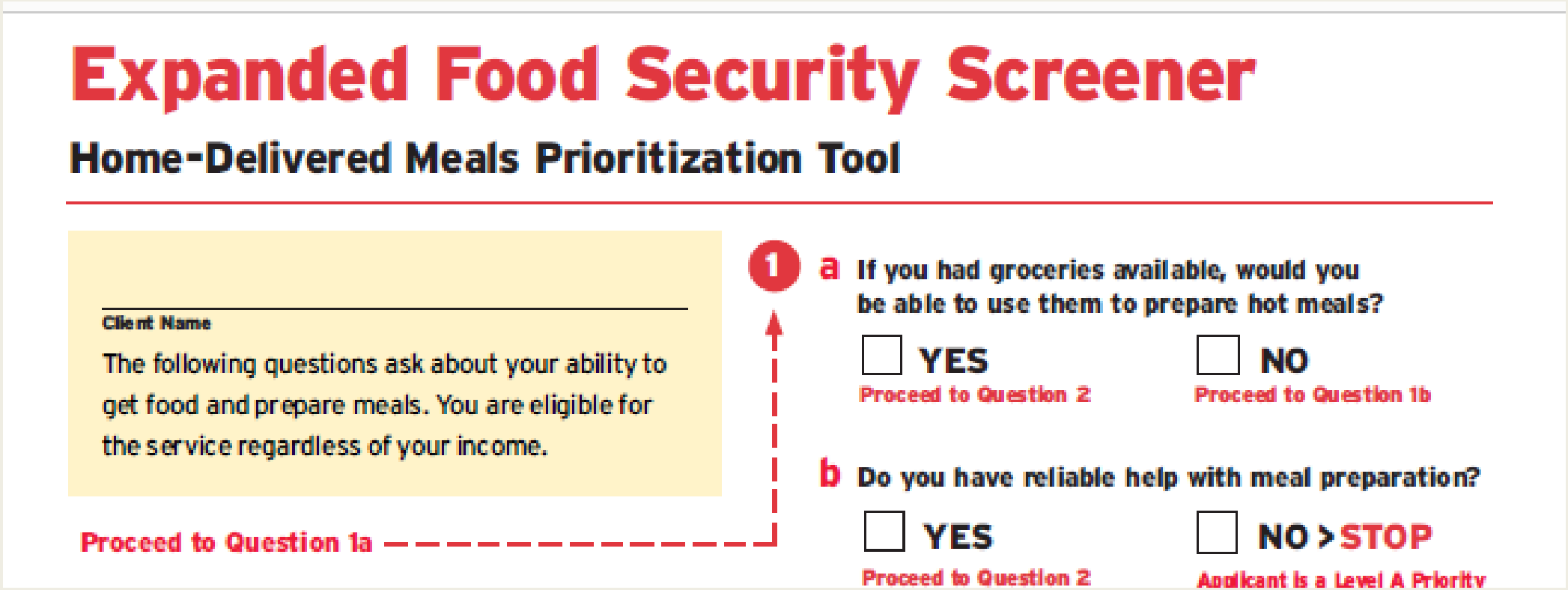
- Priority Levels
  - *Describes criteria for each level*
  - *Describes reasoning for assigning level*
  - *Outlines recommended services based on priority level and wait list status*

Priority Levels and Recommended Nutrition Service(s)

LEVEL	CRITERIA	PRIORITY LEVEL REASONING	SERVICE
A	Unable to cook and no reliable help	Even if food is affordable and in the home, it cannot be prepared, therefore, it is unlikely there are consistent healthy meals.	Home-Delivered Meals PRIORITIZED on wait list if resources are limited.
B	Can cook or has help. Economically food insecure. Cannot obtain groceries.	Affordablilty and access to groceries are both issues. With financial support and grocery delivery, healthy meals could be prepared at home.	Home-Delivered Meals ALL clients should receive home-delivered meals if resources are available. If there is a wait list for home-delivered meals clients should be prioritized B - E.
C	Can cook or has help. Economically food insecure. Can obtain groceries.	Affordability is the only issue, can obtain groceries and prepare healthy meals at home.	
D	Can cook or has help. Economically food secure. Cannot obtain groceries.	Groceries and food delivery are affordable, not physically limited from food preparation (or help is available) therefore healthy meals can be prepared at home.	Regardless of wait list status, all clients may benefit from additional nutrition services: USDA Supplemental Nutrition Assistance Program (SNAP) Grocery Delivery Services Additional State or Local Services as Needed
E	Can cook or has help. Economically food secure. Can obtain groceries.	These individuals fulfill the basic eligibility requirements for the home delivered meal program; however, they are able to afford and obtain groceries, and are not physically limited from food preparation (or help is available), therefore healthy meals can be prepared at home.	

Introduction to the Newly-Designed Tool

- Added introductory statement
- Added the word “hot” in front of meals in question 1a



Expanded Food Security Screener

Home-Delivered Meals Prioritization Tool

Client Name

The following questions ask about your ability to get food and prepare meals. You are eligible for the service regardless of your income.

Proceed to Question 1a

1 a If you had groceries available, would you be able to use them to prepare hot meals?

☐ YES — Proceed to Question 2

☐ NO — Proceed to Question 1b

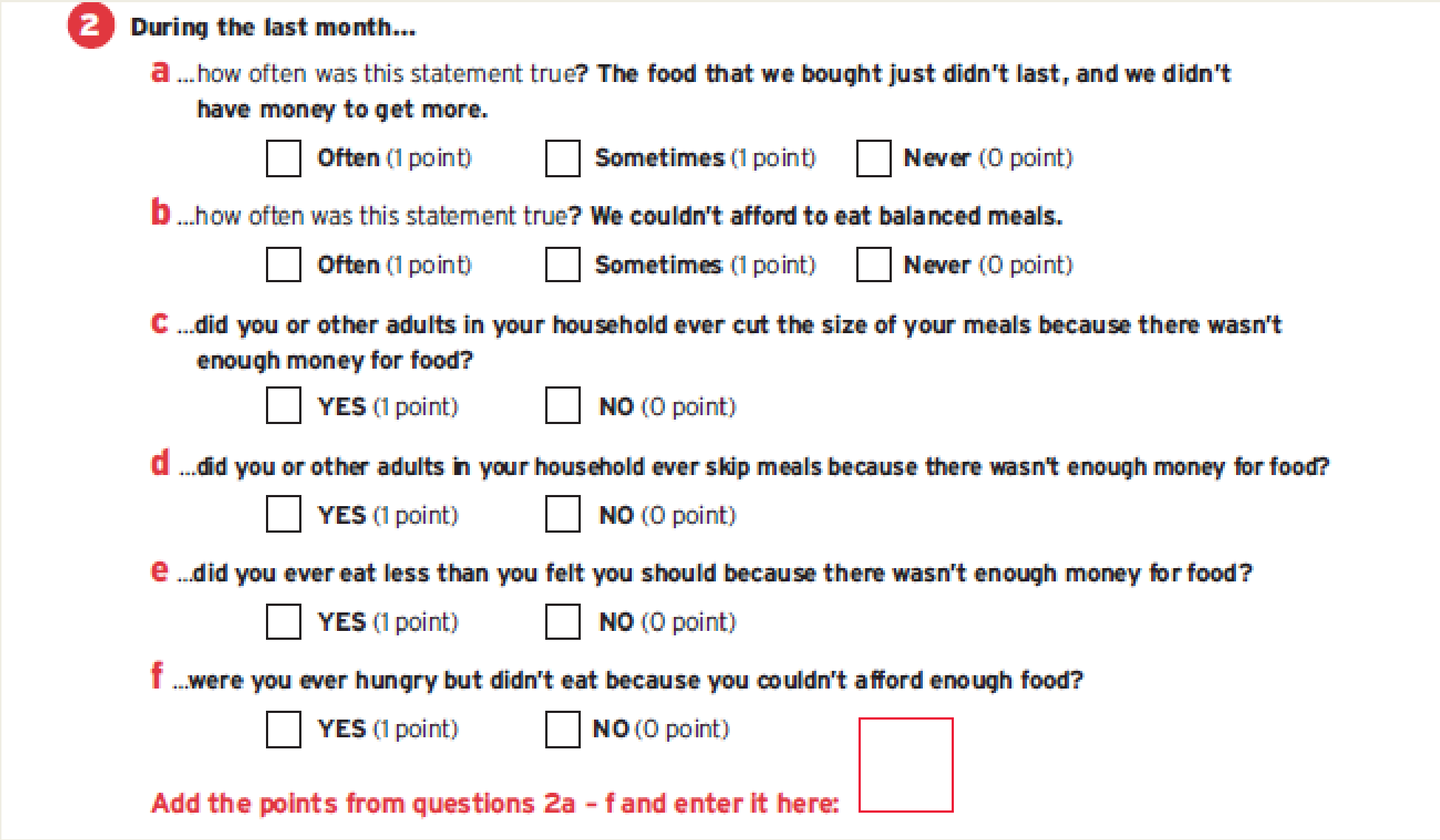
b Do you have reliable help with meal preparation?

☐ YES — Proceed to Question 2

☐ NO > STOP — Applicant is a Level A Priority

Introduction to the Newly-Designed Tool

Calculate Food Security Score



2 **During the last month...**

a ...how often was this statement true? **The food that we bought just didn't last, and we didn't have money to get more.**

☐ **Often** (1 point) ☐ **Sometimes** (1 point) ☐ **Never** (0 point)

b ...how often was this statement true? **We couldn't afford to eat balanced meals.**

☐ **Often** (1 point) ☐ **Sometimes** (1 point) ☐ **Never** (0 point)

c ...did you or other adults in your household ever cut the size of your meals because there wasn't enough money for food?

☐ **YES** (1 point) ☐ **NO** (0 point)

d ...did you or other adults in your household ever skip meals because there wasn't enough money for food?

☐ **YES** (1 point) ☐ **NO** (0 point)

e ...did you ever eat less than you felt you should because there wasn't enough money for food?

☐ **YES** (1 point) ☐ **NO** (0 point)

f ...were you ever hungry but didn't eat because you couldn't afford enough food?

☐ **YES** (1 point) ☐ **NO** (0 point)

Add the points from questions 2a – f and enter it here: ☐

Introduction to the Newly-Designed Tool

- Combine Food Security Score with ability to get groceries to obtain priority level B through E.

3 **Are you able to get groceries into your home when you need them?**

☐ **YES** – Select the point range below:

- ☐ 0 – 1 Points **Level E Priority**
- ☐ 2 – 6 Points **Level C Priority**

☐ **NO** – Select the point range below:

- ☐ 0 – 1 Points **LeveL D Priority**
- ☐ 2 – 6 Points **Level B Priority**

See chart on page one for explanation of Priority Levels and recommended service(s).

Training Manual

- Background on food security, screening, and why we should do this screening in HDM applicants
- Background on the development of the HDM Prioritization Tool
- In-depth explanation of priority levels
- How to use the tool
  - *Including the different methods*
    - Paper Tool
    - Excel Form
    - Mobile App

Excel Form Demo

Mobile Application

- Can be used on Android and Apple devices
- Instructions for obtaining the app are on page 6 of the Training Manual
- Acts as a calculator to determine priority level
- Stores data in an online spreadsheet (AirTable – password protected)

Training Manual (continued)

- Explanations of recommended actions based on priority level and wait list vs no wait list
- Guidance on creating a referral resource
- How to document the results
- Re-screening

LEVEL	RECOMMENDED ACTION	POSSIBLE ADDITIONAL OR ALTERNATIVE SERVICES
A	**NWL: Home Delivered Meals** **WL: Highest** priority on wait list	Home-delivered meals are the most appropriate support for these clients Further inquiries to the applicant may reveal additional beneficial supports
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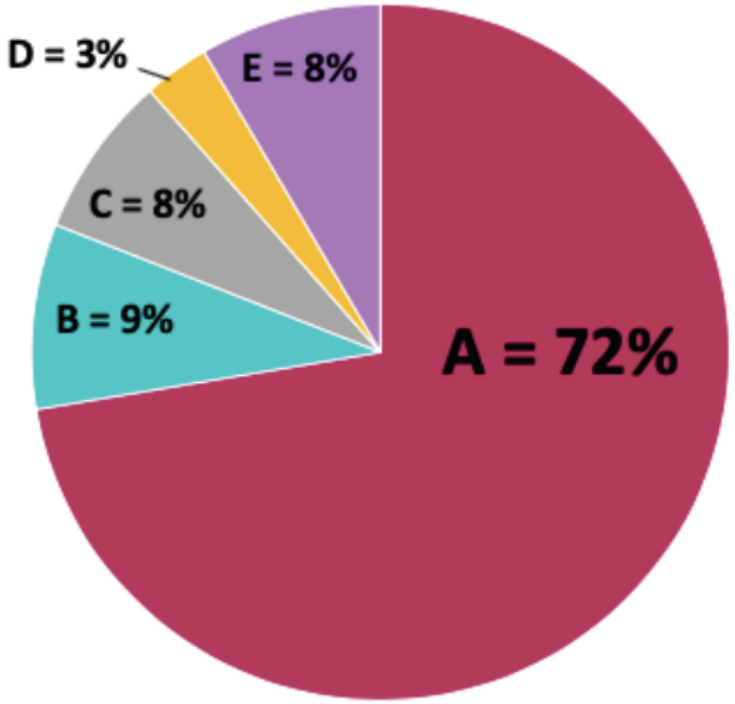
NWL= No Exsisting Wait List WL= Exisiting Wait List

Training Manual (continued)

Sample Report from the Maryland Department of Aging Showing the Distribution of Priority Levels Across Maryland

COLLEGE OF AGRICULTURE & NATURAL RESOURCES
DEPARTMENT OF NUTRITION AND FOOD SCIENCE

Fiscal Year 2018



Training Manual (continued)

- Sample Referral Table

Care Planning Components	AAA Referral Programs and Services
Food and Nutrition	• Senior Center Congregate Meals • Home-Delivered Meals • Nutrition counseling, education, and care planning • Commodity Supplemental Food Program • Community food resources (pantries, etc)** • Senior Farmers Market Nutrition Program • Malnutrition workshop: Stepping Up Your Nutrition • Post-discharge, medically-tailored meals
Housing	• Assisted Living (including SALGHS) • Ramp Assistance • Home Modification • Assistive Technology • Durable Medical Equipment • Congregate Housing Services Program
Transportation	• County or Regional Transit • Cab/Bus Vouchers • Senior Village • Community for Life

Financial	Application assistance for financial aid:
	  • SNAP
	  • Medicaid
	  • State Health Insurance Program (SHIP_
	  • Energy-assistance programs
	  • Income-tax assistance
	  • Medicare Part A, B, C, D
	• Medicare Billing, Appeals, Denials, Grievances
	• Medicare Fraud Assistance
	• Oral nutritional supplements (Ensure, etc)
	• Prescription assistance
	• Assistance for dental, eye care, hearing aids

Utilities	• Low-Income Home Energy Assistance Program (LIHEAP) • Electric Universal Service Program (EUSP) • Universal Service Protection Program (USPP) • Utility Assistance (other)
Personal Safety	• Elder Abuse • Legal Assistance • Emergency Response Systems • Falls Prevention (Stepping On, Matter of Balance, Tai Chi for Better Balance) • Arthritis foundation classes (Walk with Ease)

Maryland Discharge Meal Program Materials

Resources to provide shelf-stable, medically-tailored meals to seniors being discharged from hospitals.

MDMP TRACKING SHEET *Send this form via HIPAA compliant manner to Alice Chan at AliceChan@umm.edu by the 5th business day of each month

*Fill out these sections as they pertain to your hospital.

Patient #	Patient First Name	Patient Last Name	Medical Record Number	Admission Date	Discharge Date	Referred By	Insurance Provider	Referral Criteria Met	List Diagnosis	Diet Type (only choose ONE)	Initial Meal Package			Follow-Up Meal Package			Patient Signed Consent	Feedback Survey Administration
											Location	Days of meals	Date	Location	Days of meals	Date		
0	Example	Template	1234567	9/10/18	9/16/18	Sally Jones, Case Manager	Aetna	✓ Specific diagnosis Food insecurity ✓ Malnutrition	✓ T2DM CHF COPD	✓ CC/HH Enhanced Healing	Hospital Discharge	3	9/16/18	✓ Home Visit Care Clinic AAA	9	9/19/18	9/16/18	N/A 9/29 10/8 10/16 Phone 10/16 Mail In Person
1										CC/HH Enhanced Healing								In Person Phone Mail
2										CC/HH Enhanced Healing								In Person Phone Mail
3										CC/HH Enhanced Healing								In Person Phone Mail
4										CC/HH Enhanced Healing								In Person Phone Mail
5										CC/HH Enhanced Healing								In Person Phone Mail
6										CC/HH Enhanced Healing								In Person Phone Mail
7										CC/HH Enhanced Healing								In Person Phone Mail
8										CC/HH Enhanced Healing								In Person Phone Mail
9										CC/HH Enhanced Healing								In Person Phone Mail
10										CC/HH Enhanced Healing								In Person Phone Mail
11										CC/HH Enhanced Healing								In Person Phone Mail
12										CC/HH Enhanced Healing								In Person Phone Mail

MARYLAND DISCHARGE MEAL PROGRAM PILOT: ORDERING INSTRUCTIONS

Package sizes: Outer package dimension – 15.5”x 11.5”x 11.5”
Weight per box – 22-24 lbs. for 6 days box
Weight per bag – 11-12 lbs for each cloth grocery bag
Note: Enhanced Healing package will be slightly heavier than Carb-Controlled/Heart-Healthy

Order processing for the pilot follows:
Deliveries will occur on Thursdays and Fridays, so please place orders no later than Tuesdays at 10:30AM.
Delivery windows: either 8-12PM or 12-4PM
Minimum order size: 20 boxes
Note: Orders will be standardized to a 50/50 split of each of the 2 diet types (½ Carb-Controlled/Heart-Healthy and ½ Enhanced Healing)

Please send email orders to Tracey, the main contact, and cc Jessica, Zak, and Gary.

Email address: Tracey Ivison (Partner Services Supervisor) - tivison@mdfoodbank.org
Jessica Corcelius (Partner Services Director) – jcorcelius@mdfoodbank.org
Zak Jeffries (Warehouse Manager) - zjeffries@mdfoodbank.org
Gary Melvin (Transportation Manager) – gmelvin@mdfoodbank.org

Email is the best and most effective way to contact the team however phones are:
Tracey Ivison – 443.297.5180
Jessica Corcelius 443.297.5193
Zak Jeffries - 443.297.5207
Gary Melvin – 443.297.5149

Email instructions:
Email subject line: Maryland Discharge Meal Program New Order
Email should include:

- Desired delivery date
- Delivery location
- Quantity of boxes

What's in your Box?

Boxes either contain:

Carb-Controlled, Heart-Healthy meal plan

or

Enhanced Healing meal plan

Each patient only gets one type of meal plan

Use the Patient Selection Flowsheet to help you determine which meal plan is right for your patient

Provide tote bags to the patients

Each patient gets four (4) bags total (12 days of food) – an initial set of bags at discharge and the remainder at follow-up

Your patient will either get a **Carb-Controlled, Heart-Healthy** or a **Enhanced Healing** meal package plan.

Here are the differences between the two:

Carb-Controlled, Heart-Healthy

- Calorie range 1500 – 1700 per day
- Carbohydrates are 45-55% of total calories in accordance with the adult Dietary Reference Intake*
- Carbohydrates are spread evenly between meals.
  - Meals are about 3-4 carb choices each and snacks are 1-2 carb choices.
- Moderate total fat (25 – 33% of total calories)
- Adequate protein for maintaining muscle (18 – 20% of total calories)
- Sodium is under 2,000 mg per day

Enhanced Healing
(high energy & high protein)

- Higher calories for medical conditions that use more energy (1900 – 2500 Calories per day)
- Adequate protein for maintaining muscle (over 100 grams per day)
- No restrictions on fat, carbohydrates, or sodium

Additional information for both meal package plans:

- Easy to prepare. Requires:
  - Spreading with a knife
  - Opening a can
  - Pulling off a cap
  - Mixing
  - Puncturing with a straw
  - Pulling open a package
- Additional kitchen items required:
  - Water
  - Bowls & plates
  - Forks, knives & spoons
  - Can opener
  - Microwave
  - Optional: scissors (if patient has difficulty opening packages)

Grant funds from the Administration for Community Living (ACL) and the Maryland Department of Aging assisted in the development of this material. Points of view or opinions contained herein are those of the authors and do not necessarily represent the official position or policies of the ACL or Department.

MDMP Maryland Discharge Meal Program

Maryland Department of Aging

*SOURCE: Dietary Reference Intakes for Energy, Carbohydrate, Fiber, Fat, Fatty Acids, Cholesterol, Protein, and Amino Acids (2002/2005). https://www.ncbi.nlm.nih.gov/books/NBK56068/table/summarytables.t5/?report=objectonly

MDMP Patient Selection Flowsheet

Start — Is My Patient Eligible?

Does your patient have any of the following orders **at time of discharge**?

- ☐ A sodium restriction of less than 2000mg per day?
- ☐ A fluid restriction of less than 1500mL per day?
- ☐ A potassium, phosphorous or protein restriction
- ☐ A modified texture diet order

No to all → Is any of the following true about your patient **at time of discharge**?

- ☐ Patient is being discharged to a facility that provides more than seven (7) meals per week (assisted living facility, skilled nursing facility, etc.)
- ☐ Patient has a diagnosed food allergy
- ☐ Patient has Celiac Disease

No to all → Is any of the following true about your patient **at time of discharge**?

- ☐ Patient has no access to refrigeration or storage space (i.e. patient does not have a place of residence)
- ☐ Patient has an active substance addiction (including alcohol) and is not currently in active treatment

No to all → Is your patient older than 50?

Yes → Which Meal Package Plan?

Yes to any → STOP → Your patient is **not eligible** for meal packages.*

Yes to any → STOP → Your patient is **not eligible** for meal packages.*

Yes to any → STOP → Your patient is **not eligible** for meal packages.

Please see the Community Referral Handout for more options.

No → STOP → Your patient is **not eligible** for meal packages.

Please see the Community Referral Handout for more options.

* Please contact your inpatient dietitian for further evaluation if you have any questions or if you are unsure of patient eligibility. Provide this flowsheet to the dietitian and nutritional information for meal packages found on the back.

Which Meal Package Plan?

Patient has **higher nutritional needs** based on medical condition. This includes:

- COPD diagnosis
- Positive malnutrition risk screen or malnutrition diagnosis
- Order for dietary supplements

→ Provide patient with the **Enhanced Healing** Meal Package

Patient has need for **diabetes** diet and/or **heart-healthy** diet OR has no dietary restrictions (regular diet order)

→ Provide patient with the **Carb-Controlled, Heart-Healthy** Meal Package

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MARYLAND Department of Aging

MDMP Maryland Discharge Meal Program

Carb-Controlled, Heart-Healthy

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
Breakfast	Corn Flakes, Fruit Cup, Granola Bar, Milk 68g of Carbs	Oatmeal, Granola Bar, Milk 46g of Carbs	Cereal, Craisins, Milk 64g of Carbs	Corn Flakes, Fruit Cup, Granola Bar, Milk 68g of Carbs	Cereal, Fruit Cup, Milk 58g of Carbs	Oatmeal, Granola Bar, Milk 46g of Carbs
Lunch	Crackers, Tuna, Tomato Soup, Mayo Packet 45g of Carbs	Rice & Quinoa, Corn Cup, Salsa, Protein Bar 68g of Carbs	Tuna, Corn Cup, Vegetable Soup, Crackers, Peanut Butter 53g of Carbs	Chicken, Crackers, Chicken Noodle Soup, Carrot Cup, Craisins 57g of Carbs	Crackers, Tuna, Tomato Soup, Peanut Butter 56g of Carbs	Rice & Quinoa, Vegetable Soup 57g of Carbs
Dinner	Pasta, Chicken, Green Bean Cup, Yogurt 60g of Carbs	Raisins, Chicken, Carrot Cup, Mayo Packet, Crackers 48g of Carbs	Salmon, Pasta, Green Bean Cup, Mayo Packet 45g of Carbs	Pasta, Tuna, Green Bean Cup, Mayo Packet 44g of Carbs	Chicken, Raisins, Crackers, Mayo Packet, Carrot Cup 48g of Carbs	Salmon, Pasta, Green Bean Cup, Mayo Packet 45g of Carbs
Snacks	Crackers, Peanut Butter 33g of Carbs	Fruit Snacks, Yogurt, Applesauce 54g of Carbs	Fruit Cup, Yogurt, Granola Bar 46g of Carbs	Yogurt, Applesauce, Raisins 57g of Carbs	Applesauce, Yogurt, Granola Bar 49g of Carbs	Yogurt, Fruit Snacks, Protein Bar 51g of Carbs
Totals[1]	Kcal 1630 / Pro 76 g / Fat 62 g / CHO 206 g / Na+ 2035 mg / K+ 1875 mg	Kcal 1560 / Pro 70 g / Fat 47 g / CHO 216 g / Na+ 1850 mg / K+ 1779 mg	Kcal 1598 / Pro 79 g / Fat 57 g / CHO 208 g / Na+ 1890 mg / K+ 2018 mg	Kcal 1480 / Pro 68 g / Fat 39 g / CHO 226 g / Na+ 1855 mg / K+ 1743 mg	Kcal 1598 / Pro 71 g / Fat 60 g / CHO 211 g / Na+ 1685 mg / K+ 2269 mg	Kcal 1520 / Pro 78 g / Fat 44 g / CHO 199 g / Na+ 1545 mg / K+ 1486 mg

Enhanced Healing (high-protein, high-energy)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
Breakfast	Corn Flakes, Fruit Cup, Granola Bar, Milk	Oatmeal, Craisins, Granola Bar, Milk	Cereal, Craisins, Granola Bar, Milk	Corn Flakes, Fruit Cup, Granola Bar, Milk	Cereal, Fruit Cup, Granola Bar, Milk	Oatmeal, Raisins, Granola Bar, Milk
Lunch	Tuna, Crackers, Tomato Soup, Mayo Packet	Rice & Quinoa, Corn Cup, Salsa, Protein Bar	Tuna, Corn Cup, Vegetable Soup, Crackers, Peanut Butter	Chicken, Crackers, Chicken Noodle Soup	Tuna, Crackers, Tomato Soup, Peanut butter	Rice & Quinoa, Corn Cup, Vegetable Soup, Yogurt
Dinner	Pasta, Chicken, Green Bean Cup, Yogurt	Chicken, Raisins, Crackers, Mayo Packet, Carrot Cup, Chocolate Milk	Salmon, Mac & Cheese, Green Bean Cup	Rice & Quinoa, Tuna, Green Bean Cup, Mayo Packet, Yogurt	Chicken, Mac & Cheese, Carrot Cup	Salmon, Pasta, Carrot Cup, Mayo Packet
Snacks	Pretzels, Peanut Butter, Chocolate Milk, Ensure, Protein Bar	Pretzels, Peanut Butter, Ensure, Applesauce, Yogurt	Fruit Cup, Yogurt, Protein Bar, Fruit Snacks, Ensure	Applesauce, Ensure, Chocolate Milk, Protein Bar	Fruit Snacks, Yogurt, Ensure, Applesauce, Protein Bar	Fruit Cup, Ensure, Protein Bar, Crackers, Peanut Butter
Totals[1]	Kcal 2430 / Pro 123 g / Fat 75 g / CHO 334 g / Na+ 2850 mg / K+ 2789 mg	Kcal 2360 / Pro 99 g / Fat 76 g / CHO 322 g / Na+ 2740 mg / K+ 2895 mg	Kcal 2018 / Pro 110 g / Fat 65 g / CHO 265 g / Na+ 2565 mg / K+ 2507 mg	Kcal 1970 / Pro 105 g / Fat 58 g / CHO 274 g / Na+ 2270 mg / K+ 2684 mg	Kcal 2018 / Pro 106 g / Fat 67 g / CHO 266 g / Na+ 2365 mg / K+ 2499 mg	Kcal 2430 / Pro 105 g / Fat 77 g / CHO 334 g / Na+ 2465 mg / K+ 2750 mg

[1]Nutrition facts are estimates based on most accurate data and may not reflect the exact nutritional makeup of the meal packages. Days 1-3 and Days 4-6 are packaged together and a client may not eat everything in the exact order as described on this page.

Maryland Discharge Meal Program Pilot: Acknowledgement & Authorization

Purpose & Background

The first two weeks following a discharge from a hospital are very important for recovery. Many patients are at high risk for poor nutrition and readmission to the hospital during this time. The Maryland Discharge Meal Pilot Program is intended to help smooth the transition from hospital to home and to improve the nutritional status of the patients selected by the participating hospital for the pilot.

The Program includes 12 days of medically tailored, shelf-stable food paid for by the Maryland Department of Aging via a grant from the federal Administration for Community Living. The Maryland Food Bank assembles the food packs for the Program. The initial pack of food will be provided by the hospital upon discharge and the second pack of additional food will be available for pickup at a follow-up visit or delivered during a home visit. Participating individuals will be asked to reply to an anonymous client feedback survey.

Not all patients are medically eligible for this meal program. Eligibility criteria is included in the Patient Selection Flowsheet.

I understand, acknowledge, and agree that:

1. I am receiving the initial food pack from the hospital discharging me,
2. I will pick up (or if the hospital so provides, receive) the second pack,
3. My discharging hospital has discussed this pilot program with me in detail and explained to me where I have to go and what I have to do to pick up the second pack,
4. I have discussed the eligibility criteria and have disclosed any relevant information to the hospital,
5. This program does not deal with emergency situations and if I need immediate help, I will call 911,
6. This is a voluntary program,
7. At any time, I have the right to revoke my consent to the release of information I have provided below, and that, in any event, my consent will expire one year from the date I sign this acknowledgement, and
8. There is no cost to participate, but the food provided is for my consumption alone and must not be given or sold to others.

Client Authorization for Release of Information

I consent to:

1. The hospital contacting me in person, by telephone, or by mail for a follow up feedback survey,
2. The hospital sending the results of the survey in an anonymous* fashion so that my identity is not disclosed, to the Maryland Department of Aging,
3. My discharging hospital sharing certain anonymous* information with the Maryland Department of Aging so the Department can know what food packs have been provided by hospitals and been picked up by participants, and
4. My discharging hospital sharing certain health information developed by the hospital with the University of Maryland St. Joseph Medical Center so the effectiveness of the pilot can be evaluated.

*Anonymous means no personally identifying information, such as name or address, is reported and all data is reported in a summary format so no individual can be identified.

I have read this and understand it. If there were parts I did not understand, I asked questions and had it explained to me.

_____

Name of Patient (Printed)

_____

Signature of Patient **Date**

_____

Name of Discharging Hospital

If you need food or other support….

These resources may help!

Have you applied for SNAP?

- "SNAP" stands for "Supplemental Nutrition Assistance Program" - formerly known as food stamps. SNAP is a government program. You can apply directly to the state or get help with your application. The Maryland State Information/ Hotline Number is 1-800-332-6347.
- Maryland Food Bank has a SNAP Outreach Team that can help with your application. Phone toll-free 1-888-808-7327, Monday-Friday 8am to 5pm.

Area Agencies on Aging provide a wide array of services to people 60 or older, including hot or cold home-delivered meals and group dining (senior center meals). To get connected with your local Area Agency on Aging, call the Maryland Department of Aging at 410-767-1100.

Maryland Acccess Point (MAP) is a one-stop source of information and assistance for long term services and supports. These include…

- Information on health
- Transportation
- Income and financial aid
- Senior and community centers and clubs
- Nutrition and meals
- Pharmacy assistance
- Housing
- Volunteer opportunities
- And more!

Get connected by calling 1-844-627-5465 or go to www.MarylandAccessPoint.info

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MARYLAND Department of Aging

MDMP Maryland Discharge Meal Program

If you need food or other support….

Food Pantries want to help.

To find a food pantry in your area:

1. Go to the Maryland Food Bank website https://mdfoodbank.org
2. Click on the words “Find Food” in the top right-hand corner.

3. Scroll down, then click inside the grey box below the words “Address or Zip Code”
4. Enter your address or zip code, select the “within” miles and click on “Submit”

These resources may help!

Other services can help by easing emotional or financial burdens in other parts of your life.
The United Way has a free, confidential information and referral service.

To get help, call 2-1-1, 24 hours a day, 7 days a week.
If you can’t reach them by calling 2-1-1, use these numbers:

- Greater Baltimore: 410-685-0525
- Elsewhere in Maryland 1-800-492-0618
- TTY (for hearing impaired) 410-685-2159 (weekdays 8:30am-4:45pm).
- You can also go to the website www.211md.org

What's in your Bag?

Day 1

Breakfast

Corn Flakes, Mixed Fruit Cup, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch

Tuna, Classic Tomato Soup, Wheat Crackers, Mayonnaise To-Go

Dinner

Barilla Pasta **(1/2 bag)**, Premium Chicken **(1/2 can)**, Green Beans, Blended Yogurt

Snacks

Wheat Crackers, Natural Peanut Butter

Day 2

Breakfast

Quaker Oatmeal, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch

Brown Rice & Quinoa, Sweet Corn, Picante Sauce, Chocolate Deluxe Protein Bar

Dinner

Premium Chicken **(1/2 can)**, Raisins, Diced Carrots, Mayonnaise To-Go, Wheat Crackers

Snacks

Fruit Snacks, Blended Yogurt, Applesauce

Day 3

Breakfast

Mini Wheats, Craisins, Lowfat Milk

Lunch

Tuna, Sweet Corn, Hearty Vegetable Soup, Wheat Crackers, Natural Peanut Butter

Dinner

Pink Salmon, Barilla Pasta **(1/2 bag)**, Green Beans, Mayonnaise To-Go

Snacks

Mixed Fruit Cup, Blended Yogurt, PB & Dark Chocolate Granola Bar

Nutritional Content

Carbohydrates

190 – 220 grams per day

45 – 70 grams per meal

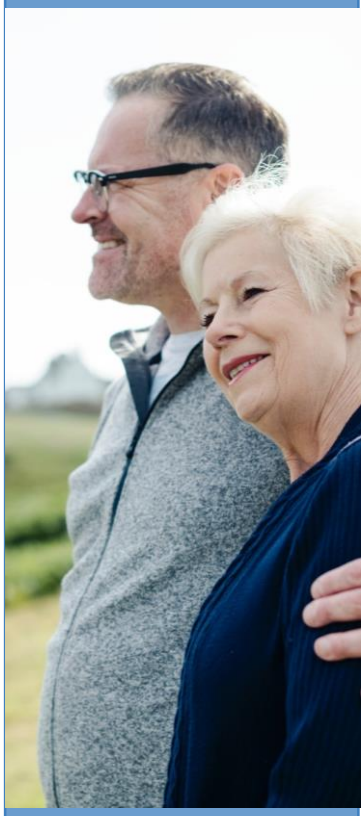
15 – 25 grams per snack

Sodium

1500 – 2000 mg/day

Carb-Controlled, Heart-Healthy

Meal Packages



The Carb-Controlled, Heart Healthy meal package is designed to provide you with the food you need to help you recover after your visit to the hospital.

Balanced carbohydrates

Carbohydrates (carbs) from the food you eat effect your blood sugar. These meals and snacks are balanced with the right amount of carbs to keep your blood sugar under control throughout the day.

Low salt

Getting too much sodium (salt) can raise your blood pressure and be bad for your heart health. These meals are low in salt to keep your heart healthy and your blood pressure under control.

Pro Tip

Be sure not to add any salt to these foods. Try other seasonings, like garlic powder, dried herbs, Mrs. Dash Salt-Free seasoning, or other salt-free seasonings.

Picture source: http://www.mrsdash.com/products/seasoning-blends/%C2%AE-original-blend

Easy to prepare

These foods were chosen because they are single-serve, easy to prepare, and can be kept at room temperature for up to six months.

We want you to stay healthy once you leave the hospital. Enjoy these foods on us!

In addition to these meal packages, you may also need:
Water, bowls & plates, forks, knives & spoons, can opener, microwave, scissors

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MARYLAND Department of Aging

MDMP Maryland Discharge Meal Program

What's in your Bag?

Day 1

Breakfast
Corn Flakes, Mixed Fruit Cup, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch
Premium Chicken **(1/2 can)**, Wheat Crackers, Hearty Chicken Noodle Soup, Diced Carrots, Craisins

Dinner
Barilla Pasta **(1/2 bag)**, Tuna, Green Beans, Mayonnaise To-Go

Snacks
Blended Yogurt, Applesauce, Raisins

Day 2

Breakfast
Mini Wheats, Mixed Fruit Cup, Lowfat Milk

Lunch
Tuna, Classic Tomato Soup, Wheat Crackers, Natural Peanut Butter

Dinner
Premium Chicken **(1/2 can)**, Wheat Crackers, Raisins, Mayonnaise To-Go, Diced Carrots

Snacks
Applesauce, Blended Yogurt, PB & Dark Chocolate Granola Bar

Day 3

Breakfast
Quaker Oatmeal, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch
Brown Rice & Quinoa, Hearty Vegetable Soup

Dinner
Pink Salmon, Barilla Pasta **(1/2 bag)**, Green Beans, Mayonnaise To-Go

Snacks
Blended Yogurt, Fruit Snacks, Chocolate Deluxe Protein Bar

Nutritional Content

Carbohydrates
190 – 220 grams per day

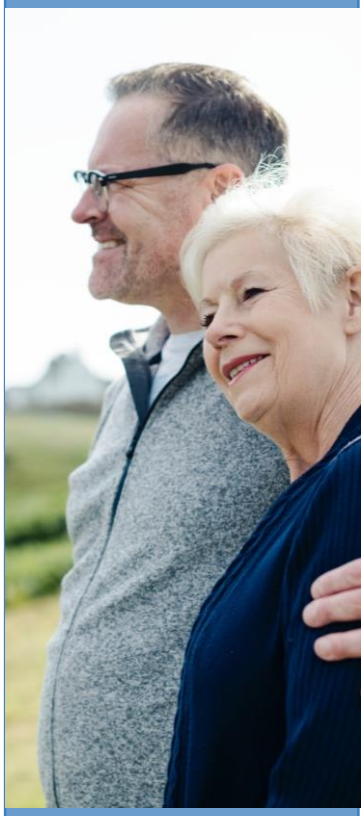
45 – 70 grams per meal

15 – 25 grams per snack

Sodium
1500 – 2000 mg/day

Carb-Controlled, Heart-Healthy

Meal Packages



The Carb-Controlled, Heart Healthy meal package is designed to provide you with the food you need to help you recover after your visit to the hospital.

Balanced carbohydrates

Carbohydrates (carbs) from the food you eat effect your blood sugar. These meals and snacks are balanced with the right amount of carbs to keep your blood sugar under control throughout the day.

Low salt

Getting too much sodium (salt) can raise your blood pressure and be bad for your heart health. These meals are low in salt to keep your heart healthy and your blood pressure under control.

Pro Tip

Be sure not to add any salt to these foods. Try other seasonings, like garlic powder, dried herbs, Mrs. Dash Salt-Free seasoning, or other salt-free seasonings.

Picture source: http://www.mrsdash.com/products/seasoning-blends/%C2%AE-original-blend

Easy to prepare

These foods were chosen because they are single-serve, easy to prepare, and can be kept at room temperature for up to six months.

We want you to stay healthy once you leave the hospital. Enjoy these foods on us!

In addition to these meal packages, you may also need:
Water, bowls & plates, forks, knives & spoons, can opener, microwave, scissors

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MARYLAND Department of Aging

MDMP Maryland Discharge Meal Program

What's in your Bag?

Day 1

Breakfast

Corn Flakes, Mixed Fruit Cup, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch

Wheat Crackers, Tuna, Classic Tomato Soup, Mayonnaise To-Go

Dinner

Barilla Pasta, Premium Chicken **(1/2 can)**, Green Beans, Blended Yogurt

Snacks

Pretzels, Natural Peanut Butter, Chocolate Milk, Ensure Shake, Deluxe Chocolate Protein Bar

Day 2

Breakfast

Quaker Oatmeal, Craisins, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch

Brown Rice & Quinoa, Sweet Corn, Picante Sauce, Deluxe Chocolate Protein Bar

Dinner

Wheat Crackers, Premium Chicken **(1/2 can)**, Raisins, Diced Carrots, Mayonnaise To-Go, Chocolate Milk

Snacks

Pretzels, Natural Peanut Butter, Ensure Shake, Applesauce, Blended Yogurt

Day 3

Breakfast

Mini Wheats, Craisins, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch

Tuna, Sweet Corn, Hearty Vegetable Soup, Wheat Crackers, Natural Peanut Butter

Dinner

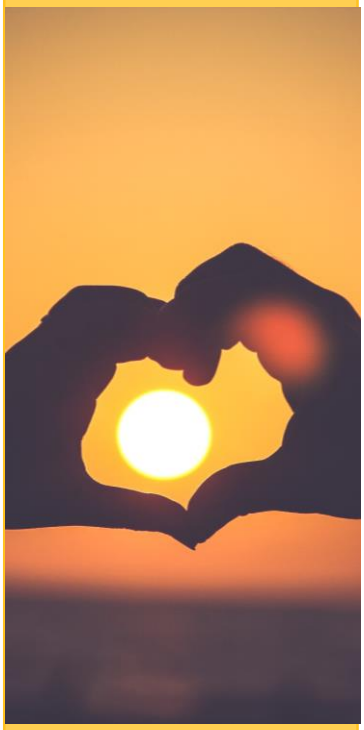
Pink Salmon, Mac & Cheese, Green Beans

Snacks

Mixed Fruit Cup, Blended Yogurt, Deluxe Chocolate Protein Bar, Fruit Snacks, Ensure Shake

Enhanced Healing

Meal Packages



The Enhanced Healing meal package is designed to provide you with the food you need to help you recover and stay strong after your visit to the hospital.

High protein

Protein helps keep your immune system strong, keep you from losing muscle, and helps wounds to heal. These foods give you enough protein to keep your muscles strong and to help you heal and recover after your hospital stay.

High energy

Eating a balanced diet and getting enough energy from your food is very important when you're recovering. It can be hard to get enough to eat when you are sick, so these foods give you more energy in every bite.

Easy to prepare

These foods were chosen because they are single-serve, easy to prepare, and can be kept at room temperature for up to six months.

We want you to stay healthy once you leave the hospital. Enjoy these foods on us!

In addition to these meal packages, you may also need:
Water, bowls & plates, forks, knives & spoons, can opener, microwave, scissors

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MARYLAND Department of Aging

MDMP Maryland Discharge Meal Program

What's in your Bag?

Day 1

Breakfast
Corn Flakes, Mixed Fruit Cup, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch
Premium Chicken **(1/2 can)**, Wheat Crackers, Hearty Chicken Noodle Soup

Dinner
Brown Rice & Quinoa, Tuna, Green Beans, Blended Yogurt, Mayonnaise To-Go

Snacks
Ensure Shake, Applesauce, Deluxe Chocolate Protein Bar, Chocolate Milk

Day 2

Breakfast
Mini Wheats, Mixed Fruit Cup, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch
Tuna, Classic Tomato Soup, Wheat Crackers, Natural Peanut Butter

Dinner
Premium Chicken **(1/2 can)**, Mac & Cheese, Diced Carrots

Snacks
Fruit Snacks, Blended Yogurt, Deluxe Chocolate Protein Bar, Applesauce, Ensure Shake

Day 3

Breakfast
Quaker Oatmeal, Raisins, PB & Dark Chocolate Granola Bar, Lowfat Milk

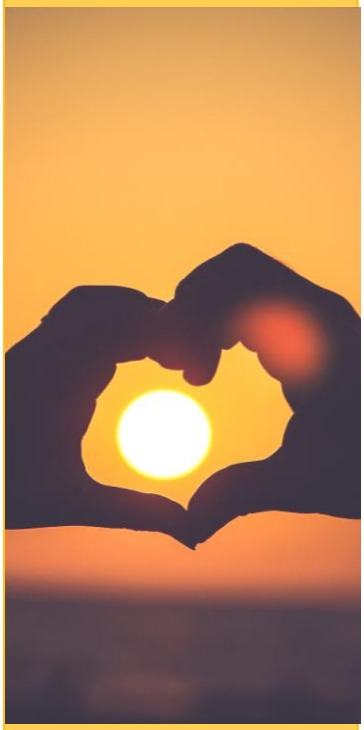
Lunch
Brown Rice & Quinoa, Sweet Corn, Hearty Vegetable Soup, Blended Yogurt

Dinner
Pink Salmon, Barilla Pasta, Diced Carrots, Mayonnaise To-Go

Snacks
Mixed Fruit Cup, Ensure Shake , Deluxe Chocolate Protein Bar, Wheat Crackers, Natural Peanut Butter

Enhanced Healing

Meal Packages



The Enhanced Healing meal package is designed to provide you with the food you need to help you recover and stay strong after your visit to the hospital.

High protein

Protein helps keep your immune system strong, keep you from losing muscle, and helps wounds to heal. These foods give you enough protein to keep your muscles strong and to help you heal and recover after your hospital stay.

High energy

Eating a balanced diet and getting enough energy from your food is very important when you're recovering. It can be hard to get enough to eat when you are sick, so these foods give you more energy in every bite.

Easy to prepare

These foods were chosen because they are single-serve, easy to prepare, and can be kept at room temperature for up to six months.

We want you to stay healthy once you leave the hospital. Enjoy these foods on us!

In addition to these meal packages, you may also need:
Water, bowls & plates, forks, knives & spoons, can opener, microwave, scissors

Grant funds from the Administration for Community Living (ACL), Grant Number 90INNU0002 and the Maryland Department of Aging assisted in the development of this material. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the ACL or Department.

MARYLAND Department of Aging

MDMP Maryland Discharge Meal Program

Maryland Discharge Meal Program Pilot: Feedback Survey

INFORMATION FOR SURVEY ADMINISTOR

(NOT TO BE SHARED WITH PATIENT)

PURPOSE/BACKGROUND:

- The purpose of this survey is to collect feedback from clients participating in the Maryland Discharge Meal Program (MDMP) pilot in order to improve the program for future clients.

- The surveys are anonymous and administered in the following order of preference:

  1) in person

  2) by telephone. If these attempts are unsuccessful, then

  3) by mail.

- Document both successful and unsuccessful survey administration contacts on the MDMP tracking form.

- **Do not** indicate patient's name or any personal information on the forms.

- The hospital MDMP coordinator will ensure proper tracking of the surveys and will fax groups of completed surveys by the 5th business day of each month to the Maryland Department of Aging FAX, to the attention of Laura Sena at 410-333-7943.

INSTRUCTIONS FOR SURVEY ADMINISTRATION:

STEP 1:

Administer survey verbally face-to-face (if possible) at or around day 13 post-admission. Document patient's responses on the attached form.

STEP 2:

If in-person administration is not possible, call the patient to administer the feedback survey verbally by telephone at or around day 13 post-discharge and document his/her responses on the attached form. If calls are unsuccessful, attempt twice more before day 30 post-discharge.

STEP 3:

If 3 phone call attempts do not succeed by day 30 post-discharge, send paper survey along with a stamped return envelope addressed to the Maryland Department of Aging with instructions to return within 2 weeks of receiving to:

Laura Sena, Innovations in Nutrition Programs
Maryland Department of Aging
301 W. Preston Street, Suite 1007
Baltimore, MD 21201

Maryland Discharge Meal Program Pilot: Feedback Survey

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Maryland Discharge Meal Program Pilot: Feedback Survey

This survey contains questions about the meal packages that you received from the Maryland Discharge Meal Program Pilot. Your answers will be kept confidential. For this set of questions, we would like you to think about how the meals may have helped you, compared with how you might have felt if you didn't receive them. Do you feel the meal packages…

1. Helped you recover after being in the hospital?
   - □ Yes
   - □ No

2. Kept you from losing weight?
   - □ Yes
   - □ No

3. Helped you manage your health condition (for example, hypertension, diabetes, etc.)?
   - □ Yes
   - □ No

4. Provided you with food that you wouldn't have otherwise been able to buy or shop for?
   - □ Yes
   - □ No

5. Provided you with something to eat when you had difficulty preparing your own meals?
   - □ Yes
   - □ No

6. Helped you eat healthier food?
   - □ Yes
   - □ No

7. Considering all the meal packages combined, how much of the food did you eat?
   - □ ¼ or less
   - □ ½ or less
   - □ ¾ or less
   - □ Almost all

8. Do you feel the foods met your nutritional needs based on your health condition?
   - □ Yes
   - □ No
   - □ If yes, how? _____
   - □ If no, why not? _____

9. Of the foods you received, what were your top 3 favorites?
   1) _____
   2) _____
   3) _____

Maryland Discharge Meal Program Pilot: Feedback Survey

10. Of the foods you received, what were your 3 least favorite?
    1) _____
    2) _____
    3) _____

11. Did you have any trouble opening the food packages?
    - □ Yes
    - □ No
    - □ If yes, which ones? _____

12. Was it easy to get the meal packages home from your hospital discharge and follow-up visit (if applicable)?
    - □ Yes
    - □ No
    - □ If no, please describe any issues. _____

13. Did the second meal package make it more likely for you to attend your follow-up visit?
    - □ Yes
    - □ No
    - □ Not applicable

14. Did you find the "What's in Your Bag?" menus provided helpful?
    - □ Yes
    - □ No
    - □ If no, why not? _____

15. Did the pilot program help you connect to organization(s) that provide wellness, meals, financial, housing, caregiver supports (or similar services)?
    - □ Yes
    - □ No
    - □ If yes, what organization(s)? _____

16. Did the pilot program help you connect to program(s) that can help you eat better, like senior centers, food pantries, SNAP, etc.?
    - □ Yes
    - □ No
    - □ If yes, what program(s)? _____

IF YOU RECEIVED THIS SURVEY BY MAIL, PLEASE PLACE YOUR COMPLETED FORM IN THE ENVELOPE PROVIDED AND MAIL BACK PROMPTLY.

THANK YOU! WE APPRECIATE YOUR FEEDBACK!

Date Survey Completed: _____

Maryland Discharge Meal Program Pilot:
Summary and Implementation Instructions

***Note to host organization: BEFORE YOU DISTRIBUTE TO STAFF please fill in the underlined, highlighted sections that apply to your hospital.**

PROGRAM SUMMARY

Background

- Your hospital is one of four Maryland hospitals participating in the Maryland Discharge Meal Program Pilot. Congratulations in being part of this innovative project!
- Each hospital will provide medically-tailored meals for 50 patients upon discharge, beginning in March 2019 through approximately May 2019.
- Meals are shelf-stable and require minimal preparation (water, microwave, can opener). Complete nutritional support (3 meals and 2 snacks per day), except for fluid, is provided for 12 days post-discharge. The MDMP pilot offers two diet types.
- The program is funded and overseen by the Maryland Department of Aging via a grant from the federal Administration for Community Living.
- The Maryland Food Bank assembles the meal packages and delivers them to *the hospital and a secondary, follow-up site for distribution*
- Your Hospital Coordinator is: _____, in case you have questions.

Resources – located in Appendices. Please see detailed instructions on the following pages.

Resource	Purpose
A: Tracking Sheet	▪ Required tracking information for outcome data analysis and to keep track of project progress
B: Ordering Instructions	▪ Includes information about meal package dimensions and weight and instructions for placing email orders to the Maryland Food Bank
C: Provider Educational Materials	▪ Explains the two different diet types and what is inside of each box for healthcare providers
D: Patient Selection Flowsheet	▪ Lists circumstances that would make a patient ineligible for this program including certain diet restrictions, living circumstances, etc. ▪ Includes information to help staff ensure a good match between patient and meal package
E: Consent Form	▪ Ensures patient is aware of purpose of project and agrees to terms regarding privacy and liability
F: Community Referral Handout	▪ Provides community based referrals for long-term support services, if needed
G: Patient Educational Materials	▪ Explains the diet provided and how to use the foods to create a daily menu of meals
H: Feedback Survey	▪ Collects anonymous feedback from patients to measure if pilot is meeting goals and objectives and to improve the program for future participants

Maryland Discharge Meal Program Pilot: Summary and Implementation Instructions

IMPLEMENTATION INSTRUCTIONS
TRACKING, ORDERING, MEAL PAKCAGING AND DISTRIBUTION

Tracking the Pilot

Person(s) Involved

- Input tracking information: _____

Details:

- The Tracking Sheet will be used to keep track of patient information for input into CRISP by Alice Chan at the University of Maryland St. Joseph Medical Center as well as pilot progress and logistics (including verification of patient's signing the consent form and hospital administration of feedback survey).
- **Hospital Coordinator - please ensure proper tracking and send the Tracking Sheet to Alice Chan via HIPAA-compliant, secure transmission methods at AliceChan@umm.edu by the 5th business day of each month.**
- There is space for 50 patients on the excel so please continue to add to the same Tracking Sheet throughout the pilot and submit as-is each month.
- The "Referral Criteria" and "Diagnosis" sections as well as the Initial and Follow-Up Package "Location" and "Days of Meals" should be customized to your specific hospital.

Resource:

- Tracking Sheet (Appendix A)

Ordering Meal Packages (as needed, 50 patients per hospital)

Person(s) Involved:

- Place orders:_____

Details:

- Orders are to be provided via email to the Maryland Food Bank, no later than Tuesdays at 10:30AM for deliverers on Thursdays and Fridays. There is a minimum order size of 20 boxes. Orders will be standardized to a 50/50 split of each diet type.
- Email subject line should read "Maryland Discharge Meal Program New Order." Include:
    - Desired delivery date
    - Delivery location
    - Quantity of boxes
- Please send emails to Tracey, the main contact, and cc Jessica, Zak, and Gary.
- Email addresses:
    - Tracey Ivison (Partner Services Supervisor) – tivison@mdfoodbank.org
    - Jessica Corcelius (Partner Services Director) – jcorcelius@mdfoodbank.org
    - Zak Jeffries (Warehouse Manager) – zjeffries@mdfoodbank.org
    - Gary Melvin (Transportation Manager) – gmelvin@mdfoodbank.org
- Phone numbers:
    - Tracey Ivison – 443-297-5080
    - Jessica Corcelius – 443-297-5193
    - Zak Jeffries – 443-297-5207
    - Gary Melvin – 443-297-5149

Resource:

- Ordering Instructions (Appendix B)

Maryland Discharge Meal Program Pilot: Summary and Implementation Instructions

Meal Packaging

The MDMP program offers two diet types including Carbohydrate-Controlled, Heart-Healthy and Enhanced Healing (high-protein, high-energy). Each diet type has an "A" and "B" 3-day menu for increased variety.

Packaging	Ziploc bags (3)	Grocery Totes (2)	Box (1)
# of day of meals	One day/bag	Three days/tote	Six days/box
Weight	3-4 lbs	11-12 lbs	22-24 lbs
Dimensions			15.5" x 11.5" x 11.5"

- Each Ziploc bag contains a one day supply of meals
- 3 Ziplocs are packaged into one grocery tote which will be given to patients (three day supply of meals)
- Two grocery totes are packaged into a box for transportation and storage purposes (six day supply of meals)

Resource:

- Provider Educational Materials (Appendix C)

Meal Distribution

Initial package at discharge → Follow-up package at *follow-up and/or home visit*

- Each patient will receive 4 grocery totes total (12 day supply of meals). Each hospital will determine how many meals patients receive upon discharge and follow-up.
- Patients will receive *1 or 2* grocery totes (a *3 or 6* day supply of meals) at hospital discharge
- Patients will receive *3 or 2* grocery totes (a *9 or 3* day supply of meals) at follow-up after discharge
- Meal packages are delivered in boxes. Hospitals are responsible for removing the grocery totes from the boxes before distribution to patients.

Maryland Discharge Meal Program Pilot: Summary and Implementation Instructions

WHAT YOU NEED TO KNOW: STEP BY STEP

Step 1: Patient Eligibility and Diet Selection

Person(s) Involved:

- Refer patients: _____
- Determine eligibility and meal package type: _____

Details:

- Each hospital has decided which patient types are referred to this program. Typically, referral criteria is related to high risk for re-admission, medical diagnosis (CHF, COPD, and/or diabetes), malnutrition, food insecurity, etc.
- Your hospital's specific referral criteria includes: _____ _____
- Referred patients then are assessed for eligibility based on whether they are appropriate to receive the meals, which is based on their dietary restrictions, discharge destination, and other criteria outlined in the Patient Selection Flowsheet.
- Eligible patients then need to be matched to one of the two diet types. This criteria is also outlined in the Patient Selection Flowsheet. If you have any questions, please contact your inpatient dietitian, as appropriate.

Resource:

- Patient Selection Flowsheet (Appendix D)

Step 2: Obtain Patient Consent

Person(s) Involved:

- Administer consent form:_____

Details:

- Execution of the consent form is required for participation in the pilot program. Hospital staff should administer the consent form to the patient and forms should be retained by the Hospital Coordinator. They should not be sent to the Maryland Department of Aging.

Resource:

- Consent Form (Appendix E)

Step 3: Distribute Initial Meal Package

Person(s) Involved:

- Coordinate distribution at discharge: _____

Details:

- The first meal package will be provided at hospital discharge.
- The patient will receive *1 or 2* grocery totes (a *3 or 6* day supply of meals).
- Patient educational materials will be pre-packaged within the meal package for the patient. These materials will explain the diet provided and how to use the foods to create a daily menu of meals. There will also be a handout with community-based referrals for long-term support services, if needed, including SNAP, Area Agencies on Aging, food pantries, and United Way 211.

Resources:

- Community Referral Handout (Appendix F)
- Patient Educational Materials (Appendix G)

Maryland Discharge Meal Program Pilot:
Summary and Implementation Instructions

Step 4: Distribute Follow-Up Meal Package

Person(s) Involved:

- Coordinate distribution at follow-up: _____

Details:

- The second meal package will be *picked up by the patient at a follow-up visit and/or delivered during a home visit*. The goal is to provide an incentive for the patient to attend their follow-up visit or comply with a home visit.
- The patient will receive the remaining *3 or 2* grocery totes (a *9 or 6* day supply of meals).
- This is an important time to discuss the Community Referral Handout with the patient. We encourage you to connect with your local Area Agency on Aging to identify needed services and programs. Also, Maryland Food Bank and local food pantry information is provided to address food insecurity issues.

Resource:

- Community Referral Handout (Appendix F)
- Patient Educational Materials (Appendix G)

Step 5: Administer Feedback Survey

Person(s) Involved:

- Administer feedback survey:_____

Details:

- An anonymous feedback survey will be administered in the following order of preference by the hospital:

  1) in person at or around day 13 post-admission
  2) by telephone if in-person administration is not possible; at or around day 13-post discharge; if unsuccessful, attempt twice more before day 30 post-discharge
  3) by mail if phone call attempts do not succeed by day 30 post-discharge; send paper survey along with a stamped return envelope addressed to the Maryland Department of Aging with instructions to return within 2 weeks of receiving to:
  Laura Sena, Innovations in Nutrition Programs
  Maryland Department of Aging
  301 W. Preston Street, Suite 1007
  Baltimore, MD 21201

- As you administer the survey in-person or by phone, please complete the survey instrument
- The survey administrator should document both successful and unsuccessful attempts to contact the patient on the Tracking Sheet
- **Hospital Coordinator - please ensure surveys contain no patient information and fax groups of completed surveys to the Maryland Department of Aging, to the attention of Laura Sena at 410-333-7943 by the 5th business day of each month.**

Resource:

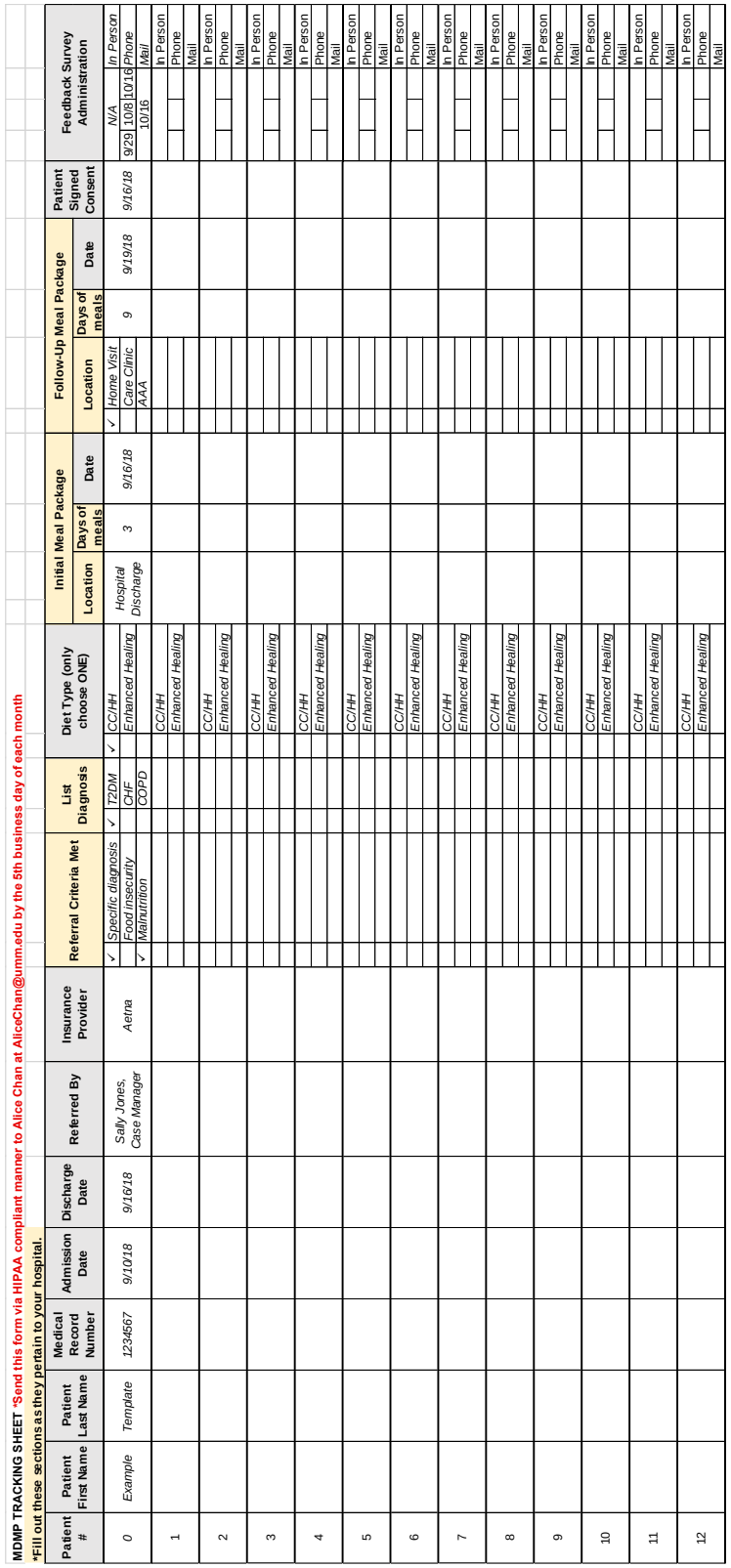
- Feedback Survey (Appendix H)

Maryland Discharge Meal Program Pilot:
Summary and Implementation Instructions

Appendix

A. Tracking Sheet
B. Ordering Instructions
C. Provider Educational Materials
D. Patient Selection Flowsheet
E. Consent Form
F. Community Referral Handout
G. Patient Educational Materials
H. Feedback Survey

Appendix A: Tracking Sheet



MDMP TRACKING SHEET *Send this form via HIPAA compliant manner to Alice Chan at AliceChan@umm.edu by the 5th business day of each month

*Fill out these sections as they pertain to your hospital.

Patient #	Patient First Name	Patient Last Name	Medical Record Number	Admission Date	Discharge Date	Referred By	Insurance Provider	Referral Criteria Met		List Diagnosis		Diet Type (only choose ONE)		Initial Meal Package			Follow-Up Meal Package			Patient Signed Consent	Feedback Survey Administration		
														Location	Days of meals	Date	Location	Days of meals	Date				
0	Example	Template	1234567	9/10/18	9/16/18	Sally Jones, Case Manager	Aetna	✓	Specific diagnosis	✓	T2DM	✓	CC/HH	Hospital Discharge	3	9/16/18	✓	Home Visit	9	9/19/18	9/16/18		N/A	In Person
									Food insecurity		CHF		Enhanced Healing					Care Clinic				9/29	10/8	10/16	Phone
								✓	Malnutrition		COPD							AAA					10/16		Mail
1													CC/HH											In Person
													Enhanced Healing											Phone
																								Mail
2													CC/HH											In Person
													Enhanced Healing											Phone
																								Mail
3													CC/HH											In Person
													Enhanced Healing											Phone
																								Mail
4													CC/HH											In Person
													Enhanced Healing											Phone
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5													CC/HH											In Person
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11													CC/HH											In Person
													Enhanced Healing											Phone
																								Mail
12													CC/HH											In Person
													Enhanced Healing											Phone
																								Mail

Appendix B: Ordering Instructions

MARYLAND DISCHARGE MEAL PROGRAM PILOT: ORDERING INSTRUCTIONS

Package sizes: Outer package dimension – 15.5”x 11.5”x 11.5”
Weight per box – 22-24 lbs. for 6 days box
Weight per bag – 11-12 lbs for each cloth grocery bag
Note: Enhanced Healing package will be slightly heavier than Carb-Controlled/Heart-Healthy

Order processing for the pilot follows:
Deliveries will occur on Thursdays and Fridays, so please place orders no later than Tuesdays at 10:30AM.
Delivery windows: either 8-12PM or 12-4PM
Minimum order size: 20 boxes
Note: Orders will be standardized to a 50/50 split of each of the 2 diet types (½ Carb-Controlled/Heart-Healthy and ½ Enhanced Healing)

Please send email orders to Tracey, the main contact, and cc Jessica, Zak, and Gary.

Email address: Tracey Ivison (Partner Services Supervisor) - tivison@mdfoodbank.org
Jessica Corcelius (Partner Services Director) – jcorcelius@mdfoodbank.org
Zak Jeffries (Warehouse Manager) - zjeffries@mdfoodbank.org
Gary Melvin (Transportation Manager) – gmelvin@mdfoodbank.org

Email is the best and most effective way to contact the team however phones are:
Tracey Ivison – 443.297.5180
Jessica Corcelius 443.297.5193
Zak Jeffries - 443.297.5207
Gary Melvin – 443.297.5149

Email instructions:
Email subject line: Maryland Discharge Meal Program New Order
Email should include:

- Desired delivery date
- Delivery location
- Quantity of boxes

Appendix C: Provider Educational Materials

What's in your Box?

MDMP
Maryland Discharge Meal Program

Boxes either contain:

Carb-Controlled, Heart-Healthy meal plan

or

Enhanced Healing meal plan

Each patient only gets one type of meal plan

Use the Patient Selection Flowsheet to help you determine which meal plan is right for your patient

Your patient will either get a **Carb-Controlled, Heart-Healthy** or a **Enhanced Healing** meal package plan.

Here are the differences between the two:

Carb-Controlled, Heart-Healthy

- Calorie range 1500 – 1700 per day
- Carbohydrates are 45-55% of total calories in accordance with the adult Dietary Reference Intake*
- Carbohydrates are spread evenly between meals.
  - Meals are about 3-4 carb choices each and snacks are 1-2 carb choices.
- Moderate total fat (25 – 33% of total calories)
- Adequate protein for maintaining muscle (18 – 20% of total calories)
- Sodium is under 2,000 mg per day

Enhanced Healing
(high energy & high protein)

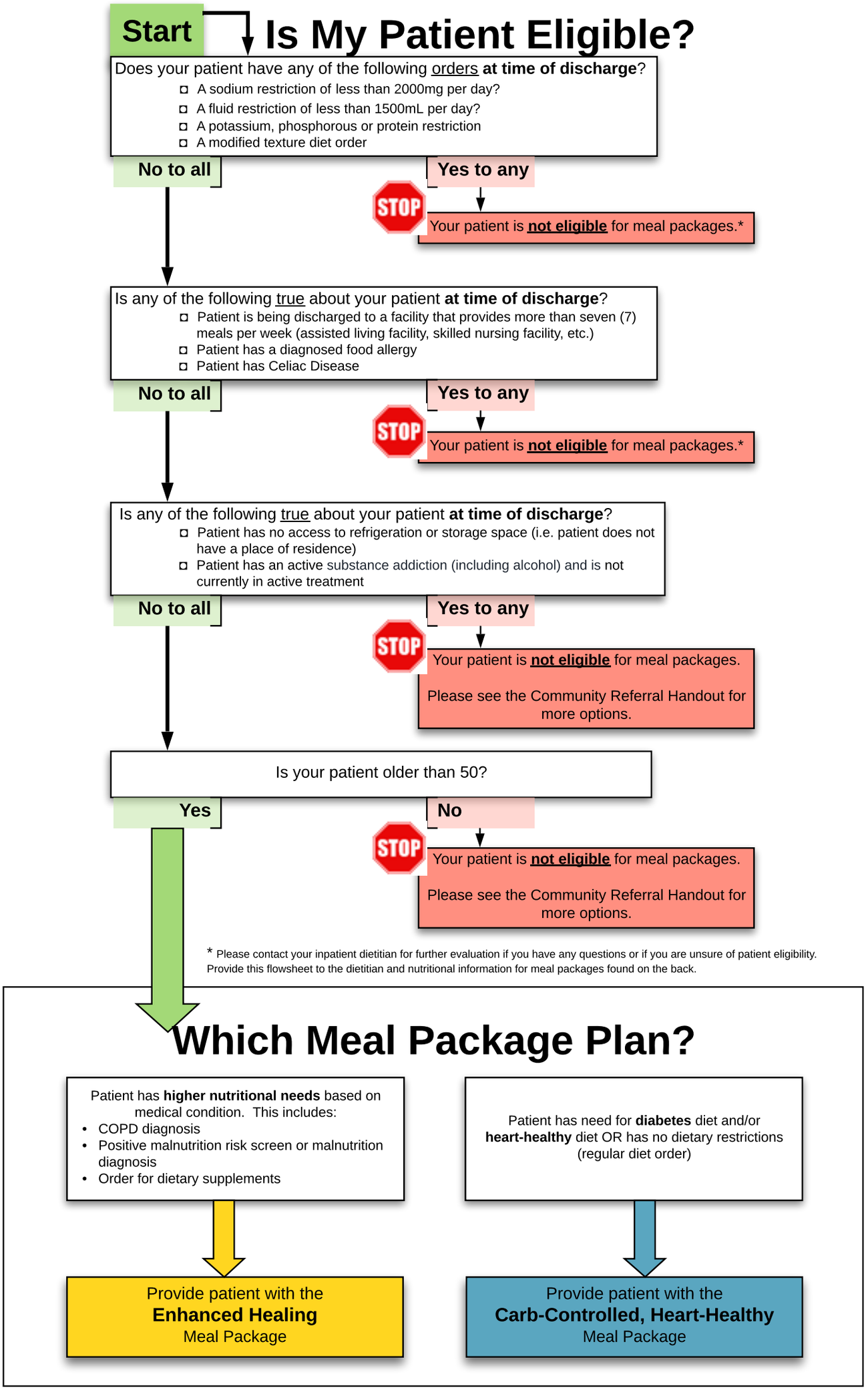
- Higher calories for medical conditions that use more energy (1900 – 2500 Calories per day)
- Adequate protein for maintaining muscle (over 100 grams per day)
- No restrictions on fat, carbohydrates, or sodium

Additional information for both meal package plans:

- Easy to prepare. Requires:
  - Spreading with a knife
  - Opening a can
  - Pulling off a cap
  - Mixing
  - Puncturing with a straw
  - Pulling open a package
- Additional kitchen items required:
  - Water
  - Bowls & plates
  - Forks, knives & spoons
  - Can opener
  - Microwave
  - Optional: scissors (if patient has difficulty opening packages)

Grant funds from the Administration for Community Living (ACL) and the Maryland Department of Aging assisted in the development of this material. Points of view or opinions contained herein are those of the authors and do not necessarily represent the official position or policies of the ACL or Department

*SOURCE: Dietary Reference Intakes for Energy, Carbohydrate, Fiber, Fat, Fatty Acids, Cholesterol, Protein, and Amino Acids (2002/2005). https://www.ncbi.nlm.nih.gov/books/NBK56068/table/summarytables5/?report=objectonly


Start
Is My Patient Eligible?
Does your patient have any of the following orders at time of discharge?
A sodium restriction of less than 2000mg per day?
A fluid restriction of less than 1500mL per day?
A potassium, phosphorous or protein restriction
A modified texture diet order
No to all
Yes to any
STOP
Your patient is not eligible for meal packages.*
Is any of the following true about your patient at time of discharge?
Patient is being discharged to a facility that provides more than seven (7) meals per week (assisted living facility, skilled nursing facility, etc.)
Patient has a diagnosed food allergy
Patient has Celiac Disease
No to all
Yes to any
STOP
Your patient is not eligible for meal packages.*
Is any of the following true about your patient at time of discharge?
Patient has no access to refrigeration or storage space (i.e. patient does not have a place of residence)
Patient has an active substance addiction (including alcohol) and is not currently in active treatment
No to all
Yes to any
STOP
Your patient is not eligible for meal packages.
Please see the Community Referral Handout for more options.
Is your patient older than 50?
Yes
No
STOP
Your patient is not eligible for meal packages.
Please see the Community Referral Handout for more options.
* Please contact your inpatient dietitian for further evaluation if you have any questions or if you are unsure of patient eligibility. Provide this flowsheet to the dietitian and nutritional information for meal packages found on the back.
Which Meal Package Plan?
Patient has higher nutritional needs based on medical condition. This includes:
COPD diagnosis
Positive malnutrition risk screen or malnutrition diagnosis
Order for dietary supplements
Provide patient with the Enhanced Healing Meal Package
Patient has need for diabetes diet and/or heart-healthy diet OR has no dietary restrictions (regular diet order)
Provide patient with the Carb-Controlled, Heart-Healthy Meal Package

Carb-Controlled, Heart-Healthy

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
Breakfast	Corn Flakes, Fruit Cup, Granola Bar, Milk 68g of Carbs	Oatmeal, Granola Bar, Milk 46g of Carbs	Cereal, Craisins, Milk 64g of Carbs	Corn Flakes, Fruit Cup, Granola Bar, Milk 68g of Carbs	Cereal, Fruit Cup, Milk 58g of Carbs	Oatmeal, Granola Bar, Milk 46g of Carbs
Lunch	Crackers, Tuna, Tomato Soup, Mayo Packet 45g of Carbs	Rice & Quinoa, Corn Cup, Salsa, Protein Bar 68g of Carbs	Tuna, Corn Cup, Vegetable Soup, Crackers, Peanut Butter 53g of Carbs	Chicken, Crackers, Chicken Noodle Soup, Carrot Cup, Craisins 57g of Carbs	Crackers, Tuna, Tomato Soup, Peanut Butter 56g of Carbs	Rice & Quinoa, Vegetable Soup 57g of Carbs
Dinner	Pasta, Chicken, Green Bean Cup, Yogurt 60g of Carbs	Raisins, Chicken, Carrot Cup, Mayo Packet, Crackers 48g of Carbs	Salmon, Pasta, Green Bean Cup, Mayo Packet 45g of Carbs	Pasta, Tuna, Green Bean Cup, Mayo Packet 44g of Carbs	Chicken, Raisins, Crackers, Mayo Packet, Carrot Cup 48g of Carbs	Salmon, Pasta, Green Bean Cup, Mayo Packet 45g of Carbs
Snacks	Crackers, Peanut Butter 33g of Carbs	Fruit Snacks, Yogurt, Applesauce 54g of Carbs	Fruit Cup, Yogurt, Granola Bar 46g of Carbs	Yogurt, Applesauce, Raisins 57g of Carbs	Applesauce, Yogurt, Granola Bar 49g of Carbs	Yogurt, Fruit Snacks, Protein Bar 51g of Carbs
Totals[1]	Kcal 1630 / Pro 76 g / Fat 62 g / CHO 206 g / Na+ 2035 mg / K+ 1875 mg	Kcal 1560 / Pro 70 g / Fat 47 g / CHO 216 g / Na+ 1850 mg / K+ 1779 mg	Kcal 1598 / Pro 79 g / Fat 57 g / CHO 208 g / Na+ 1890 mg / K+ 2018 mg	Kcal 1480 / Pro 68 g / Fat 39 g / CHO 226 g / Na+ 1855 mg / K+ 1743 mg	Kcal 1598 / Pro 71 g / Fat 60 g / CHO 211 g / Na+ 1685 mg / K+ 2269 mg	Kcal 1520 / Pro 78 g / Fat 44 g / CHO 199 g / Na+ 1545 mg / K+ 1486 mg

Enhanced Healing (high-protein, high-energy)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
Breakfast	Corn Flakes, Fruit Cup, Granola Bar, Milk	Oatmeal, Craisins, Granola Bar, Milk	Cereal, Craisins, Granola Bar, Milk	Corn Flakes, Fruit Cup, Granola Bar, Milk	Cereal, Fruit Cup, Granola Bar, Milk	Oatmeal, Raisins, Granola Bar, Milk
Lunch	Tuna, Crackers, Tomato Soup, Mayo Packet	Rice & Quinoa, Corn Cup, Salsa, Protein Bar	Tuna, Corn Cup, Vegetable Soup, Crackers, Peanut Butter	Chicken, Crackers, Chicken Noodle Soup	Tuna, Crackers, Tomato Soup, Peanut butter	Rice & Quinoa, Corn Cup, Vegetable Soup, Yogurt
Dinner	Pasta, Chicken, Green Bean Cup, Yogurt	Chicken, Raisins, Crackers, Mayo Packet, Carrot Cup, Chocolate Milk	Salmon, Mac & Cheese, Green Bean Cup	Rice & Quinoa, Tuna, Green Bean Cup, Mayo Packet, Yogurt	Chicken, Mac & Cheese, Carrot Cup	Salmon, Pasta, Carrot Cup, Mayo Packet
Snacks	Pretzels, Peanut Butter, Chocolate Milk, Ensure, Protein Bar	Pretzels, Peanut Butter, Ensure, Applesauce, Yogurt	Fruit Cup, Yogurt, Protein Bar, Fruit Snacks, Ensure	Applesauce, Ensure, Chocolate Milk, Protein Bar	Fruit Snacks, Yogurt, Ensure, Applesauce, Protein Bar	Fruit Cup, Ensure, Protein Bar, Crackers, Peanut Butter
Totals[1]	Kcal 2430 / Pro 123 g / Fat 75 g / CHO 334 g / Na+ 2850 mg / K+ 2789 mg	Kcal 2360 / Pro 99 g / Fat 76 g / CHO 322 g / Na+ 2740 mg / K+ 2895 mg	Kcal 2018 / Pro 110 g / Fat 65 g / CHO 265 g / Na+ 2565 mg / K+ 2507 mg	Kcal 1970 / Pro 105 g / Fat 58 g / CHO 274 g / Na+ 2270 mg / K+ 2684 mg	Kcal 2018 / Pro 106 g / Fat 67 g / CHO 266 g / Na+ 2365 mg / K+ 2499 mg	Kcal 2430 / Pro 105 g / Fat 77 g / CHO 334 g / Na+ 2465 mg / K+ 2750 mg

[1]Nutrition facts are estimates based on most accurate data and may not reflect the exact nutritional makeup of the meal packages. Days 1-3 and Days 4-6 are packaged together and a client may not eat everything in the exact order as described on this page.

Appendix E: Maryland Discharge Meal Program Pilot: Acknowledgement & Authorization

Purpose & Background

The first two weeks following a discharge from a hospital are very important for recovery. Many patients are at high risk for poor nutrition and readmission to the hospital during this time. The Maryland Discharge Meal Pilot Program is intended to help smooth the transition from hospital to home and to improve the nutritional status of the patients selected by the participating hospital for the pilot.

The Program includes 12 days of medically tailored, shelf-stable food paid for by the Maryland Department of Aging via a grant from the federal Administration for Community Living. The Maryland Food Bank assembles the food packs for the Program. The initial pack of food will be provided by the hospital upon discharge and the second pack of additional food will be available for pickup at a follow-up visit or delivered during a home visit. Participating individuals will be asked to reply to an anonymous client feedback survey.

Not all patients are medically eligible for this meal program. Eligibility criteria is included in the Patient Selection Flowsheet.

I understand, acknowledge, and agree that:

1. I am receiving the initial food pack from the hospital discharging me,
2. I will pick up (or if the hospital so provides, receive) the second pack,
3. My discharging hospital has discussed this pilot program with me in detail and explained to me where I have to go and what I have to do to pick up the second pack,
4. I have discussed the eligibility criteria and have disclosed any relevant information to the hospital,
5. This program does not deal with emergency situations and if I need immediate help, I will call 911,
6. This is a voluntary program,
7. At any time, I have the right to revoke my consent to the release of information I have provided below, and that, in any event, my consent will expire one year from the date I sign this acknowledgement, and
8. There is no cost to participate, but the food provided is for my consumption alone and must not be given or sold to others.

Client Authorization for Release of Information

I consent to:

1. The hospital contacting me in person, by telephone, or by mail for a follow up feedback survey,
2. The hospital sending the results of the survey in an anonymous* fashion so that my identity is not disclosed, to the Maryland Department of Aging,
3. My discharging hospital sharing certain anonymous* information with the Maryland Department of Aging so the Department can know what food packs have been provided by hospitals and been picked up by participants, and
4. My discharging hospital sharing certain health information developed by the hospital with the University of Maryland St. Joseph Medical Center so the effectiveness of the pilot can be evaluated.

*Anonymous means no personally identifying information, such as name or address, is reported and all data is reported in a summary format so no individual can be identified.

I have read this and understand it. If there were parts I did not understand, I asked questions and had it explained to me.

_____

Name of Patient (Printed)

_____

Signature of Patient **Date**

_____

Name of Discharging Hospital

If you need food or other support….

Have you applied for SNAP?

- "SNAP" stands for "Supplemental Nutrition Assistance Program" - formerly known as food stamps. SNAP is a government program. You can apply directly to the state or get help with your application. The Maryland State Information/ Hotline Number is 1-800-332-6347.
- Maryland Food Bank has a SNAP Outreach Team that can help with your application. Phone toll-free 1-888-808-7327, Monday-Friday 8am to 5pm.

These resources may help!

Area Agencies on Aging provide a wide array of services to people 60 or older, including hot or cold home-delivered meals and group dining (senior center meals). To get connected with your local Area Agency on Aging, call the Maryland Department of Aging at 410-767-1100.

Maryland Acccess Point (MAP) is a one-stop source of information and assistance for long term services and supports. These include…

- Information on health
- Transportation
- Income and financial aid
- Senior and community centers and clubs
- Nutrition and meals
- Pharmacy assistance
- Housing
- Volunteer opportunities
- And more!

Get connected by calling 1-844-627-5465 or go to www.MarylandAccessPoint.info

Grant funds from the Administration for Community Living (ACL) and the Maryland Department of Aging assisted in the development in this material. Points of view or opinions contained herein are those of the authors and do not necessarily represented the official position or policies of the ACL or Department.

MARYLAND Department of Aging

MDMP Maryland Discharge Meal Program

If you need food or other support….

Food Pantries want to help.

To find a food pantry in your area:

1. Go to the Maryland Food Bank website https://mdfoodbank.org
2. Click on the words “Find Food” in the top right-hand corner.

3. Scroll down, then click inside the grey box below the words “Address or Zip Code”
4. Enter your address or zip code, select the “within” miles and click on “Submit”

These resources may help!

Other services can help by easing emotional or financial burdens in other parts of your life.
The United Way has a free, confidential information and referral service.

To get help, call 2-1-1, 24 hours a day, 7 days a week.
If you can’t reach them by calling 2-1-1, use these numbers:

- Greater Baltimore: 410-685-0525
- Elsewhere in Maryland 1-800-492-0618
- TTY (for hearing impaired) 410-685-2159 (weekdays 8:30am-4:45pm).
- You can also go to the website www.211md.org

What's in your Bag?

Day 1

Breakfast
Corn Flakes, Mixed Fruit Cup, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch
Tuna, Classic Tomato Soup, Wheat Crackers, Mayonnaise To-Go

Dinner
Barilla Pasta **(1/2 bag)**, Premium Chicken **(1/2 can)**, Green Beans, Blended Yogurt

Snacks
Wheat Crackers, Natural Peanut Butter

Day 2

Breakfast
Quaker Oatmeal, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch
Brown Rice & Quinoa, Sweet Corn, Picante Sauce, Chocolate Deluxe Protein Bar

Dinner
Premium Chicken **(1/2 can)**, Raisins, Diced Carrots, Mayonnaise To-Go, Wheat Crackers

Snacks
Fruit Snacks, Blended Yogurt, Applesauce

Day 3

Breakfast
Mini Wheats, Craisins, Lowfat Milk

Lunch
Tuna, Sweet Corn, Hearty Vegetable Soup, Wheat Crackers, Natural Peanut Butter

Dinner
Pink Salmon, Barilla Pasta **(1/2 bag)**, Green Beans, Mayonnaise To-Go

Snacks
Mixed Fruit Cup, Blended Yogurt, PB & Dark Chocolate Granola Bar

Nutritional Content

Carbohydrates
190 – 220 grams per day

45 – 70 grams per meal

15 – 25 grams per snack

Sodium
1500 – 2000 mg/day

What's in your Bag?

Day 1

Breakfast
Corn Flakes, Mixed Fruit Cup, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch
Premium Chicken **(1/2 can)**, Wheat Crackers, Hearty Chicken Noodle Soup, Diced Carrots, Craisins

Dinner
Barilla Pasta **(1/2 bag)**, Tuna, Green Beans, Mayonnaise To-Go

Snacks
Blended Yogurt, Applesauce, Raisins

Day 2

Breakfast
Mini Wheats, Mixed Fruit Cup, Lowfat Milk

Lunch
Tuna, Classic Tomato Soup, Wheat Crackers, Natural Peanut Butter

Dinner
Premium Chicken **(1/2 can)**, Wheat Crackers, Raisins, Mayonnaise To-Go, Diced Carrots

Snacks
Applesauce, Blended Yogurt, PB & Dark Chocolate Granola Bar

Day 3

Breakfast
Quaker Oatmeal, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch
Brown Rice & Quinoa, Hearty Vegetable Soup

Dinner
Pink Salmon, Barilla Pasta **(1/2 bag)**, Green Beans, Mayonnaise To-Go

Snacks
Blended Yogurt, Fruit Snacks, Chocolate Deluxe Protein Bar

Nutritional Content

Carbohydrates
190 – 220 grams per day

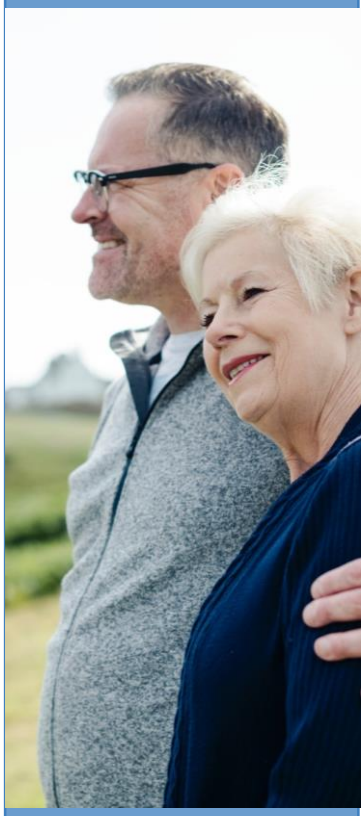
45 – 70 grams per meal

15 – 25 grams per snack

Sodium
1500 – 2000 mg/day

Carb-Controlled, Heart-Healthy

Meal Packages



The Carb-Controlled, Heart Healthy meal package is designed to provide you with the food you need to help you recover after your visit to the hospital.

Balanced carbohydrates

Carbohydrates (carbs) from the food you eat effect your blood sugar. These meals and snacks are balanced with the right amount of carbs to keep your blood sugar under control throughout the day.

Low salt

Getting too much sodium (salt) can raise your blood pressure and be bad for your heart health. These meals are low in salt to keep your heart healthy and your blood pressure under control.

Pro Tip

Be sure not to add any salt to these foods. Try other seasonings, like garlic powder, dried herbs, Mrs. Dash Salt-Free seasoning, or other salt-free seasonings.

Picture source: http://www.mrsdash.com/products/seasoning-blends/%C2%AE-original-blend

Easy to prepare

These foods were chosen because they are single-serve, easy to prepare, and can be kept at room temperature for up to six months.

We want you to stay healthy once you leave the hospital. Enjoy these foods on us!

In addition to these meal packages, you may also need:
Water, bowls & plates, forks, knives & spoons, can opener, microwave, scissors

Grant funds from the Administration for Community Living (ACL), Grant Number 90INNU0002 and the Maryland Department of Aging assisted in the development of this material. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the ACL or Department.

MARYLAND Department of Aging

MDMP Maryland Discharge Meal Program

What's in your Bag?

Day 1

Breakfast

Corn Flakes, Mixed Fruit Cup, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch

Wheat Crackers, Tuna, Classic Tomato Soup, Mayonnaise To-Go

Dinner

Barilla Pasta, Premium Chicken **(1/2 can)**, Green Beans, Blended Yogurt

Snacks

Pretzels, Natural Peanut Butter, Chocolate Milk, Ensure Shake, Deluxe Chocolate Protein Bar

Day 2

Breakfast

Quaker Oatmeal, Craisins, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch

Brown Rice & Quinoa, Sweet Corn, Picante Sauce, Deluxe Chocolate Protein Bar

Dinner

Wheat Crackers, Premium Chicken **(1/2 can)**, Raisins, Diced Carrots, Mayonnaise To-Go, Chocolate Milk

Snacks

Pretzels, Natural Peanut Butter, Ensure Shake, Applesauce, Blended Yogurt

Day 3

Breakfast

Mini Wheats, Craisins, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch

Tuna, Sweet Corn, Hearty Vegetable Soup, Wheat Crackers, Natural Peanut Butter

Dinner

Pink Salmon, Mac & Cheese, Green Beans

Snacks

Mixed Fruit Cup, Blended Yogurt, Deluxe Chocolate Protein Bar, Fruit Snacks, Ensure Shake

What's in your Bag?

Day 1

Breakfast
Corn Flakes, Mixed Fruit Cup, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch
Premium Chicken **(1/2 can)**, Wheat Crackers, Hearty Chicken Noodle Soup

Dinner
Brown Rice & Quinoa, Tuna, Green Beans, Blended Yogurt, Mayonnaise To-Go

Snacks
Ensure Shake, Applesauce, Deluxe Chocolate Protein Bar, Chocolate Milk

Day 2

Breakfast
Mini Wheats, Mixed Fruit Cup, PB & Dark Chocolate Granola Bar, Lowfat Milk

Lunch
Tuna, Classic Tomato Soup, Wheat Crackers, Natural Peanut Butter

Dinner
Premium Chicken **(1/2 can)**, Mac & Cheese, Diced Carrots

Snacks
Fruit Snacks, Blended Yogurt, Deluxe Chocolate Protein Bar, Applesauce, Ensure Shake

Day 3

Breakfast
Quaker Oatmeal, Raisins, PB & Dark Chocolate Granola Bar, Lowfat Milk

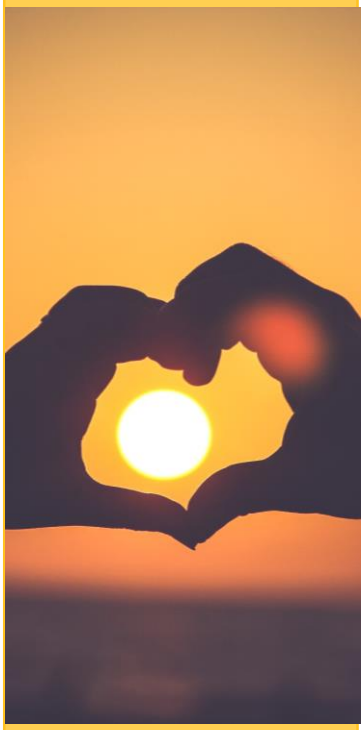
Lunch
Brown Rice & Quinoa, Sweet Corn, Hearty Vegetable Soup, Blended Yogurt

Dinner
Pink Salmon, Barilla Pasta, Diced Carrots, Mayonnaise To-Go

Snacks
Mixed Fruit Cup, Ensure Shake , Deluxe Chocolate Protein Bar, Wheat Crackers, Natural Peanut Butter

Enhanced Healing

Meal Packages



The Enhanced Healing meal package is designed to provide you with the food you need to help you recover and stay strong after your visit to the hospital.

High protein

Protein helps keep your immune system strong, keep you from losing muscle, and helps wounds to heal. These foods give you enough protein to keep your muscles strong and to help you heal and recover after your hospital stay.

High energy

Eating a balanced diet and getting enough energy from your food is very important when you're recovering. It can be hard to get enough to eat when you are sick, so these foods give you more energy in every bite.

Easy to prepare

These foods were chosen because they are single-serve, easy to prepare, and can be kept at room temperature for up to six months.

We want you to stay healthy once you leave the hospital. Enjoy these foods on us!

In addition to these meal packages, you may also need:
Water, bowls & plates, forks, knives & spoons, can opener, microwave, scissors

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MARYLAND Department of Aging

MDMP Maryland Discharge Meal Program

Appendix H: Maryland Discharge Meal Program Pilot: Feedback Survey

INFORMATION FOR SURVEY ADMINISTOR

(NOT TO BE SHARED WITH PATIENT)

PURPOSE/BACKGROUND:

- The purpose of this survey is to collect feedback from clients participating in the Maryland Discharge Meal Program (MDMP) pilot in order to improve the program for future clients.

- The surveys are anonymous and administered in the following order of preference:

  1) in person

  2) by telephone. If these attempts are unsuccessful, then

  3) by mail.

- Document both successful and unsuccessful survey administration contacts on the MDMP tracking form.

- **Do not** indicate patient's name or any personal information on the forms.

- The hospital MDMP coordinator will ensure proper tracking of the surveys and will fax groups of completed surveys by the 5th business day of each month to the Maryland Department of Aging FAX, to the attention of Laura Sena at 410-333-7943.

INSTRUCTIONS FOR SURVEY ADMINISTRATION:

STEP 1:

Administer survey verbally face-to-face (if possible) at or around day 13 post-admission. Document patient's responses on the attached form.

STEP 2:

If in-person administration is not possible, call the patient to administer the feedback survey verbally by telephone at or around day 13 post-discharge and document his/her responses on the attached form. If calls are unsuccessful, attempt twice more before day 30 post-discharge.

STEP 3:

If 3 phone call attempts do not succeed by day 30 post-discharge, send paper survey along with a stamped return envelope addressed to the Maryland Department of Aging with instructions to return within 2 weeks of receiving to:

Laura Sena, Innovations in Nutrition Programs
Maryland Department of Aging
301 W. Preston Street, Suite 1007
Baltimore, MD 21201

Appendix H: Maryland Discharge Meal Program Pilot: Feedback Survey

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Appendix H: Maryland Discharge Meal Program Pilot: Feedback Survey

This survey contains questions about the meal packages that you received from the Maryland Discharge Meal Program Pilot. Your answers will be kept confidential. For this set of questions, we would like you to think about how the meals may have helped you, compared with how you might have felt if you didn't receive them. Do you feel the meal packages…

1. Helped you recover after being in the hospital?
   - □ Yes
   - □ No

2. Kept you from losing weight?
   - □ Yes
   - □ No

3. Helped you manage your health condition (for example, hypertension, diabetes, etc.)?
   - □ Yes
   - □ No

4. Provided you with food that you wouldn't have otherwise been able to buy or shop for?
   - □ Yes
   - □ No

5. Provided you with something to eat when you had difficulty preparing your own meals?
   - □ Yes
   - □ No

6. Helped you eat healthier food?
   - □ Yes
   - □ No

7. Considering all the meal packages combined, how much of the food did you eat?
   - □ ¼ or less
   - □ ½ or less
   - □ ¾ or less
   - □ Almost all

8. Do you feel the foods met your nutritional needs based on your health condition?
   - □ Yes
   - □ No
   - □ If yes, how? _____
   - □ If no, why not? _____

9. Of the foods you received, what were your top 3 favorites?
   1) _____
   2) _____
   3) _____

10. Of the foods you received, what were your 3 least favorite?
    1) _____
    2) _____
    3) _____

11. Did you have any trouble opening the food packages?
    - □ Yes
    - □ No
    - □ If yes, which ones? _____

12. Was it easy to get the meal packages home from your hospital discharge and follow-up visit (if applicable)?
    - □ Yes
    - □ No
    - □ If no, please describe any issues. _____

13. Did the second meal package make it more likely for you to attend your follow-up visit?
    - □ Yes
    - □ No
    - □ Not applicable

14. Did you find the "What's in Your Bag?" menus provided helpful?
    - □ Yes
    - □ No
    - □ If no, why not? _____

15. Did the pilot program help you connect to organization(s) that provide wellness, meals, financial, housing, caregiver supports (or similar services)?
    - □ Yes
    - □ No
    - □ If yes, what organization(s)? _____

16. Did the pilot program help you connect to program(s) that can help you eat better, like senior centers, food pantries, SNAP, etc.?
    - □ Yes
    - □ No
    - □ If yes, what program(s)? _____

IF YOU RECEIVED THIS SURVEY BY MAIL, PLEASE PLACE YOUR COMPLETED FORM IN THE ENVELOPE PROVIDED AND MAIL BACK PROMPTLY.

THANK YOU! WE APPRECIATE YOUR FEEDBACK!

Date Survey Completed: _____

Post-Discharge Meal Distribution Programs Report

Comprehensive review of meal package programs including the Maryland Discharge Meal Program.

Post-Discharge Meal Distribution Programs

Bethesda NEWtrition and Wellness Solutions

Developed for the Maryland Department of Aging

MAY 2019

Grant funds from the Administration for Community Living (ACL), Grant Number 90INNU0002-02-01 and the Maryland Department of Aging assisted in the development in this material. Its contents are solely the responsibility of the authors and do not necessarily represent the official position or policies of the ACL or Department.

Table of Contents

Introduction

Background

Seniors leaving the hospital at risk for malnutrition have a higher rate of readmission and death. Some studies estimate that as many as 30% of hospitalized patients may be malnourished at the time of their admission (Sharma et al., 2017) and as many as 49% of older adults are malnourished after discharge. (Buys et al., 2017) A recent study conducted by Sharma et al has shown that impaired nutrition status upon discharge can increase the incidence of readmission to the hospital both in the short-term (0-7 days) and the longer-term (8-180 days) post discharge. (Sharma et al., 2017)

As the US population gets increasingly older, addressing senior malnutrition is becoming more of a priority. The number of Americans aged 65 and older is expected to almost double by 2050 to 88 million ("World's older population grows dramatically | National Institutes of Health (NIH)," n.d.) and those 85 and older are projected to more than double by 2040 to 14.6 million. (Administration on Aging, 2017)

About the Maryland Discharge Meal Program (MDMP)

The Maryland Discharge Meal Program (MDMP) is part of an initiative put forward by the Maryland Department of Aging (MDoA). The program is funded by an Innovations in Nutrition Programs and Services grant from the Federal Administration for Community Living. The goal of the grant project is: *to transform the Maryland Department of Aging's Senior Nutrition Program (SNP) by using the epidemic of older adult malnutrition as the catalyst to introduce new evidence-based practices, cost-cutting measures, meal products, and service delivery methods that will forge new health care linkages and expand services to older adults in the community.* (language from grant application)

The MDMP is a pilot that will provide shelf-stable, medically-tailored meals to 200 seniors being discharged from four hospitals in Maryland. The program partnered with Maryland Food Bank, which was responsible for purchasing, packaging, and distributing meal packages to the pilot hospitals. Hospital staff will then distribute the meal packages to patients leaving the hospital who meet the criteria for the program. Potential participants will be screened for eligibility based on their age, medical condition(s), and risk for malnutrition upon leaving the hospital. The pilot program will particularly focus on addressing malnutrition risk associated with chronic conditions that have been identified as having high readmission rates for these particular hospitals.

A participant will receive one of two medically-tailored meal packages based on their medical needs. For this pilot, two types of meal packages are included. The Carb-Controlled, Heart-Healthy (CC/HH) meal package is low in sodium, meets the DRI for macronutrients (protein, fat, and carbohydrates), and evenly distributes carbohydrates between meals and snacks. The CC/HH packages are intended to be used for participants with diabetes mellitus, hypertension, and/or congestive heart failure. The Enhanced Healing (EH) meal package is higher in protein and calories and has no restrictions on sodium, carbohydrates or fat. The EH package is intended to be used for participants who have higher energy needs due to their medical condition, such as chronic obstructive pulmonary disease. Table I, below, contains a more specific nutritional summary.

Table I: Nutritional summary of MDMP meal packages					
Meal package type	Nutrition data (ranges)				
	Calories	*Carbohydrates*	*Fat*	*Protein*	*Sodium*
Carb-Controlled, Heart-Healthy (CC/HH)	1500 – 1700 per day	45-55% of total calories per day • 190 – 220 grams per day • 45 – 70 grams per meal • 15 – 25 grams per snack	25-33% of total calories per day	18% - 20% of total calories per day	Under 2,000 mg per day
Enhanced Healing (EH)	1900 – 2500 per day	No restrictions	No restrictions	Over 100 grams per day	No restrictions

Purpose of this Report

With increased awareness of the impact of malnutrition on older adults, several initiatives to address this area of concern have been underway both in the US and abroad. Meal distribution programs similar to the MDMP have provided insight into processes, ideas, and potential collaborations that have been tried—both successfully and unsuccessfully—in the past. Takeaways from these programs informed the development of the MDMP. A review of relevant literature and similar programs/initiatives and their takeaways are profiled in the following pages. For each program reviewed, this report includes a compilation of costs and distribution methodology and what each program may do to ensure meals are culturally appropriate, person-centered, or medically-tailored.

Literature & Program Review

Community and government programs have taken initiatives to tackle senior malnutrition using innovative care models and nutrition programs. Meals on Wheels America ("Meals on Wheels America," n.d.) is one program that has been delivering meals to people's homes for generations, however newer local initiatives are also underway. Table II, below, is a review of some of the programs that have informed the MDMP initiative.

Review of Post-Discharge Meal Programs, Literature, Insurance Company Initiatives, and Other Similar Programs

The MDMP is unique in that it targets *all* seniors who have nutritional risk regardless of socioeconomic status. Several programs in the US provide meals specifically for low-income individuals, such as home delivered meals provided through Medicaid or the Commodity Supplemental Food Program (CSFP) ("Commodity Supplemental Food Program (CSFP) | Food and Nutrition Service," n.d.). Additional programs serve older adults of any income but target those with economic or social needs, including the Older American's Act congregate and home delivered meal programs (Administration for Community Living & Administration on Aging, 2014). While there is clearly a need to specifically address low-income seniors, malnutrition risk for seniors impacts all socioeconomic levels and therefore the MDMP does not have an income criteria for inclusion..

Programs reviewed here have a variety of goals and objectives, all centered around addressing high hospital admission and readmission rates, similar to the goals of the MDMP. For example, the Food is Medicine Coalition of California (CalFIMC) is specifically targeting adults suffering from congestive heart failure who they determined are at highest risk of hospital readmission and worsening health outcomes.

(Trust & Food, 2017) The Philadelphia MANNA project is targeting adults with AIDS or other chronic illness that puts them at high nutritional risk. And Flavor Harvest @Home provides their meal services for community members or recently discharged patients who have specific chronic conditions. Other programs only have an age requirement for eligibility, not subject to medical condition.

The types of meals offered by these programs vary widely, and some programs offer a variety of different meal types depending on the need of the participant. The MDMP meals are unique in that they are entirely shelf-stable. Only a few other programs have focused specifically on shelf-stable meals. One such program is the Metropolitan Interfaith Association (MIFA) No Hungry Senior program, which provided 7 shelf-stable meals to seniors who were deemed capable of light meal preparation. Maintaining Active Citizens' Maryland Malnutrition Model (MDMM) offers shelf-stable emergency food bags and shelf-stable snack bags.

Table II: Review of programs and literature similar to MDMP

	Food Is Medicine Coalition of California (CalFIMC)
Overview	Coalition of meal providers in California; first multi-county and multi-organization study of this kind in the US; members include: Ceres Community Project, Food for Thought, The Health Trust, Mama's Kitchen, Project Angel Food, and Project Open Hand.
Goals	To reduce hospital and emergency department 30-day and 90-day readmissions, to show the cost-effectiveness of including medically-tailored meals as part of Medi-Cal covered benefits, and to inform California policy.
Funding Source(s)	Funded by Senate Bill 97 passed in June of 2017, approved by Governor Jerry Brown and the California Legislature that provides $6 million for a 3-year project period.
Target Population	Medi-Cal insurance beneficiaries who have a diagnosis of congestive heart failure (CHF) and have been discharged from an inpatient stay (at a hospital, emergency department or skilled nursing facility) resulting from exacerbation of CHF. Approximately 1,000 patients to be included. Patients need to be able to refrigerate and re-heat foods.
Meal Types	Medically-tailored meals approved by a Registered Dietitian Nutritionist (RDN) that follow evidence-based practice guidelines. Meals are recommended based on a nutritional assessment or healthcare provider recommendations. 3 meals per day are provided for 12 weeks. Multi-organization and multi-county project—each of the organizations is familiar with the needs and cultural preferences of their target population.
Outcomes	The Cal FIMC is an ongoing project (began in 2018), so outcomes are not available yet. Outcomes will be measured using data collected from Medi-Cal utilization and claims data. Outcomes include changes in hemoglobin A1C, health care utilization (ex: emergency department visits), skilled nursing use, readmissions, overall costs of care, and other measures.
Costs	Costs range, for example Mama's Kitchen was $2.92 per meal.
Distribution Methodology	The multi-centered approach allows for a wide distribution of services to multiple counties in California. This project specifically works with Medi-Cal recipients, but is intended to stand as an example that other projects can imitate.
Sources	(Food et al., n.d.), (*Medi-Cal Medically Tailored Meal Pilot Project*, 1996), (Medicine, n.d.), (Food is Medicine Coalition (FIMC), 2018), (*Free / Medi-Cal Covered Medically Tailored Meals and Medical Nutrition Therapy for Discharged CHF Patients Scope of Intervention How to Refer*, n.d.)
	MANNA (Philadelphia)
Overview	MANNA began as a church-affiliated meal delivery program for Philadelphia residents with AIDS. MANNA expanded its services to anyone at nutritional risk due to critical illness in 2006. The program includes medically-tailored, in-house cooked meals and nutritional counselling.
Goals	Providing nourishment to critically ill neighbors.
Funding Source(s)	MANNA is a non-profit organization funded by donations from individuals, foundations and corporations, special events, and insurance coverage for some services.
Target Population	Residents of Philadelphia suffering from AIDS and other critical illness at risk for undernutrition and isolation. "MANNA clients must currently be battling or in care for a serious illness and, due to that illness, are at acute nutritional risk. Some nutrition indicators include: • Recent unintentional weight loss

	• Recent, extended hospitalization • Start of new medical treatment (ex. chemotherapy, radiation, or hemodialysis) • Recovery from surgery • Wound care" ("Apply for MANNA Services - MANNA," n.d.-a) (Apply for MANNA Services, n.d.)
Meal Types	Fully-prepared, frozen meals, delivered once a week: 7 breakfasts, 7 lunches, 7 dinners, desserts, and fresh fruit. Meals are high in protein, and moderate in carbohydrate, sodium and fat. Offers 11 different dietary modifications, including kidney friendly (low potassium low phosphorous, low sodium), diabetic/heart healthy (carbohydrate and sodium controlled), low lactose, GI friendly (low fiber, mild spice), no pork, no beef, no seafood, mechanical soft, pureed, high protein/high calorie, and children's menu. Adaptations for personal or religious requirements. Can combine up to 3 modifications.
Outcomes	MANNA patients who received medically-tailored meals and medical nutrition therapy (MNT) experienced 50% fewer hospital admissions, were 23% more likely to be discharged to their homes rather than another facility, and had 28% lower monthly health care costs.
Costs	~$4.40 per meal. For the 2017 fiscal year MANNA spent $4,390,043 on meals and services. In their IRS Form 990, MANNA reported serving 995,270 meals in FY 2017. This comes to about $4.40 per meal.
Distribution Methodology	Meals are provided for the greater Philadelphia area, participants are referred to the program.
Sources	("Apply for MANNA Services - MANNA," n.d.-b), (Mccarron, 2017), (Gurvey et al., 2013), (Daugherty, Hoskins-Brown, & Laverty, n.d.), (MANNA, 2017)
	Southern Maine Agency on Aging (SMAA) – Simply Delivered Meals Pilot Study
Overview	This agency is focused on improving social determinants of health by providing corresponding services and support. SMAA conducted a 2-year pilot of home delivered meals with 622 patients at high risk of readmission called "Simply Delivered Meals" in affiliation with Maine Medical Center.
Goals	Reducing 30-day readmission rates post-acute care. Improving emergency department usage and hospital admission rates.
Funding Source(s)	Hospital partners and grant funding.
Target Population	Elderly and Medicare patients (for pilot study).
Meal Types	Meals are frozen, prepared and no bread or milk is given. No information indicates that meals were tailored to be culturally appropriate beyond the different varieties of meals (i.e. vegetarian, gluten-free). Meals were given based on indicated preferences and diagnosis. Meals were specialized (e.g. vegetarian, pureed, regular, gluten free, low sodium, diabetic, renal, other/allergies) and could be packaged to meet multiple needs.
Outcomes	The 2-year pilot conducted at SMAA demonstrated a 387% return on investment, and a 2-point reduction in admission rates. The pilot provided a minimum of 7 meals, with the option to join Meals on Wheels at the end of the 7-day period.
Costs	~$7 per meal. For the pilot study, the costs of providing 7 meals to 622 patients was $43,530.
Distribution Methodology	The pilot was limited to hospital patients being discharged from Maine Medical Center.
Sources	(Martin, Connelly, Parsons, & Blackstone, 2018b), (Martin, Connelly, Parsons, & Blackstone, 2018a), ("Order Simply Delivered Meals," n.d.), ("Southern Maine Agency on Aging," n.d.), ("SMAA/MMC Simply Delivered Meals (SDM) Pilot," n.d.), (Braveman, n.d.)
	Flavor Harvest @Home
Overview	This project was an extension of an existing intervention at Lee Health in Southwest Florida into the primary care setting. Dietitians were trained to identify malnutrition risk in a primary care setting and patients who were at-risk received 4 weeks of medically-tailored meals along with a clinical dietetic consultation.
Goals	Improvement in long-term health status (reduced hospital length of stay, lower readmission rates, improved reimbursement opportunities, reduced operational costs) and quicker recovery for recently discharged patients. Improved clinical status was indicated by measures such as weight gain, grip strength, and functional status.
Funding Source(s)	Grants from Bank of America and The Allen Foundation funded the meals. Funding was for 2 years and supported 60 patients.
Target Population	Patients being discharged from Cape Coral Hospital and Gulf Coast Medical Center that were identified as at-risk for malnutrition. Specifically targeting frail elderly patients with chronic conditions (especially congestive heart failure, chronic obstructive pulmonary disease, acute myocardial infarction, or pneumonia).

Meal Types	Meal options were individualized and approved by a RDN based on the patient's medical condition. Meals were provided for a 7-day period and included 3 meals per day and snacks. Meals were a mix of fresh produce, shelf-stable items and frozen prepared meals.
Outcomes	Patients participating in the program were found to have a reduced length of stay in the hospital, improved fluid status and strength, and reduced readmission rates.
Costs	~$10 per meal. The program estimated that meals would cost an average of $840 per person for 4 weeks. Based on 3 meals per day for 28 days, the cost came to about $10 per meal.
Distribution Methodology	Patients eligible for this program were identified from two area hospitals (Cape Coral Hospital and Gulf Coast Medical Center) using the Flavor Harvest Assessment Screening Tool (FHAST) and a physical exam to identify malnutrition risk. After discharge, Flavor Harvest @Home coordinated the home delivery of meals, using their existing vehicle delivery structure.
Sources	("Flavor Harvest@HOME - AARP Foundation," n.d.), (*Flavor-Harvest-at-HOME.pdf*, n.d.), ("Lee Health – Flavor Harvest@Home | AHA," n.d.)
	Maintaining Active Citizens Maryland's Malnutrition Model (MDMM)
Overview	Maintaining Active Citizens (MAC) is the Area Agency on Aging (AAA) in Salisbury, MD, and serves surrounding counties. Clients receive home visits to establish them for home nutrition services and then are screened for malnutrition risk, food insecurity, and other social determinants of health. Appropriate interventions are put into place based on areas of concern identified in the screening and the client is followed by a community health worker through home visits and follow up calls. Meal packages are provided based on malnutrition and food security risk, and also can be given as "emergency" bags when recently discharged from the hospital.
Goals	Collaborative and encompassing approach to combat malnutrition.
Funding Source(s)	Grant funding.
Target Population	Seniors at-risk for malnutrition.
Meal Types	The program offers different types of meals based on client needs. There are fresh fully-prepared meals, soups, shelf-stable emergency food bags, and shelf-stable snack bags. Meal bags were designed with input from community members about what would be acceptable to members of the population being served. The RDN meets with each participant to determine the best meal package plan for that person. Food items in the meal packages are low in sodium, fat, and added sugar, and are high in fiber. All meals meet the nutritional standards set by the Maryland Department of Aging and provide one-third of the RDI for older adults and 30 grams of protein.
Outcomes	Project is still underway.
Costs	~$3 per meal. Emergency meal bags provide meals for about $3 per meal, coming to about $10 per bag (three meals).
Distribution Methodology	MAC is responsible for packaging and distributing the meal packages to participants homes.
Sources	(Simon, Beardsley, Davidson, Lachenmayr, & Eagle, 2018)
	Metropolitan Interfaith Association (MIFA) No Hungry Senior
Overview	The Metropolitan Inter-Faith Association (MIFA) serves the Memphis, Tennessee metropolitan area with programs for seniors and families. In 2014 MIFA initiated the No Hungry Senior program in partnership with the Aging Commission of the Mid-South (ACMS), Mid-South Food Bank, Catholic Charities of West Tennessee, the Memphis Jewish Federation, the Common Table Health Alliance, Baptist Memorial Health Care, and Methodist Le Bonheur Healthcare. The program began with a pilot in 2014 with 20 clients and was expanded to 35 in 2015 with the receipt of a new grant from the H. W. Durham Foundation.
Goals	The goals of the program are to reduce the number of food-insecure seniors in Shelby County, improve and maintain seniors' overall health, and reduce hospitalizations and emergency room utilization.
Funding Source(s)	Initially, a three-year, $3.98 million grant from the Plough Foundation funded the program. A subsequent $50,000 grant came from the H. W. Durham Foundation for FY2015. Funding also came from the Wal-Mart Foundation and the Jewish Federations.
Target Population	Shelby County residents in Tennessee, 60 years or older. Specifically focusing on those that are homebound, recently discharged from hospitals, or particularly challenged by a lack of transportation. Clients were identified from the agency's Meals on Wheels waiting list.
Meal Types	• 5 home delivered hot/frozen meals delivered M-F by MIFA (for highest need clients) • 7 shelf-stable meal box delivered weekly by MIFA and Catholic Charities (for those who can do some light meal preparation) • 5 home delivered hot/frozen kosher meals per week provided by Memphis Jewish Federation

	• 7 shelf-stable meal box given at discharge by Baptist Memorial Health Care and Methodist Le Bonheur Healthcare
Outcomes	Outcomes from 1-year post-enrollment compared with 1-year pre-enrollment found an overall reduction of healthcare utilization, including a 34% reduction in inpatient admissions. Participants also experienced a significant reduction in feelings of loneliness. There was also a high acceptability of the food and meals. Some of the lessons learned from this program were: • Food waste was an issue; the quantity of food delivered was sometimes too much for the seniors to consume. • The Food Bank had difficulty sourcing low sugar and low salt foods that fit into their meal plans because they were high cost and harder to find. • Effective communication with collaborators required having a dedicated point of contact/team. • Having a 6-month planning period and regular meetings with project partners lead to greater success with project implementation.
Costs	~$7 per meal. Average cost per client (including food costs, delivery, admin) came to less than $7 per day ($1,800 per client per year, one meal per day).
Distribution Methodology	Meals are distributed by volunteers. MIFA produces the meals, Mid-South Food Bank sources the foods, and Catholic Charities manages meal deliveries.
Sources	(*Member Partnership Guide: Keys To Greater Collaboration and Impact to Better the Lives of Older Adults*, 2016), (MIFA, n.d.), ("MIFA - Metropolitan Inter-Faith Association - Home," n.d.)
	Humana Dine Well
Overview	This program provides nutritious meals to eligible Medicare Advantage members recovering from an inpatient stay in a hospital or skilled nursing facility. Meals also are available for some Humana Medicare members who are enrolled in a qualified chronic-condition special needs plan. The chronic conditions supported by this program include diabetes, chronic obstructive pulmonary disorder (COPD), congestive heart failure (CHF) and some other cardiovascular disorders.
Goals	Overall goal is to improve member health and wellbeing. Meals are intended to provide proper nutrition after a long-term illness or condition that may have caused loss of important vitamins and proteins. The program doesn't just serve meals, they keep track of patients and know all about their well-being, so that they can provide the proper meals to their door.
Funding Source(s)	Health plans/membership.
Target Population	Seniors who are Medicare Advantage members.
Meal Types	There are several diets a Humana Member could choose from such as regular, pork-free, fish-free, pureed, diabetic, vegetarian, pureed, renal supportive options and kosher meals. Patients who have been discharged from a hospital or skilled nursing facility (SNF) receive 10 frozen, packaged, low-sodium meals. Patients can receive meals in conjunction with up to four hospital/SNF admissions per year. Patients who are eligible for the chronic condition meals program receive 20 frozen, packaged meals that support the special dietary needs of that chronic condition. Patients with multiple conditions can receive multiple benefits.
Outcomes	Humana Medicare Advantage members who participate in the Well Dine delivery program have fewer hospital readmissions, shorter hospital stays and fewer emergency-room visits.
Costs	No cost to the recipients, cost per meal unreported.
Distribution Methodology	Via health care providers; health care providers send a referral and Humana arranges meal delivery.
Sources	("Humana and Well Dine Deliver Program's One Millionth Meal in Knoxville | Humana Healthcare," 2010), (Humana Inc., 2019)
	Better Meals (Vancouver)
Overview	Established in 1993, Better Meals offers a wide selection of nutritious meals and à la carte food items including breakfast, homemade pies, side dishes, and 3 course dinners (soup, entree, and dessert), fresh sandwiches and wraps, snacks, and à la carte individual dinners. Meals are delivered in the service area of Greater Vancouver, Fraser Valley, Greater Victoria, Mid Vancouver Island and into the Okanagan and Interior.
Goals	Providing natural, tasty and beneficial meals with nutritional value conveniently delivered. They strive to provide meals made from scratch that are: • Cooked using healthy fats and minimal added salt • Provide adequate calories and protein to support health during illness and healing • Evocative of warm memories and feelings of comfort • Culturally appropriate

	• Designed to provide 50-67% of daily nutrition • Tailored to meet the medical and nutritional needs of each client
Funding Source(s)	Money collected for the meals; individuals place orders online and weekly delivery is free.
Target Population	Seniors in the service area of Greater Vancouver, Fraser Valley, Greater Victoria, Mid Vancouver Island and into the Okanagan and Interior.
Meal Types	Regular, diabetic, low sodium, minced, and à la carte. Meals are made with: • No MSG or preservatives are added • Natural spices are used to reduce sodium • Full course and à la carte meals are blast frozen to maintain freshness and preserve nutrients • Salads and sandwiches are prepared shortly before their arrival for a refreshing taste
Outcomes	Not reported.
Costs	~$6.75 per meal. Varies based on type of meal (i.e. regular, special, etc.) and full course dinner and à la carte options; Cost of full course dinner including soup, entrée, and dessert is $6.75. Minimum order per delivery is $30.
Distribution Methodology	Home delivered meals; delivered weekly (free); orders may be placed online.
Sources	("Better Meals," 2019)
	Community Servings
Overview	Community Servings is a Boston-based not-for-profit organization with a 27-year history of providing medically-tailored meals and nutrition services to individuals and their families coping with critical and chronic illnesses. They provide 2 meals per day for 5 days per week to provide 50-67% of daily needs. Eligibility is based on extent of illness, clients' lack of mobility, and factors that make it difficult to cook and shop (food desert, wheelchair, not able to carry groceries). The program also provides nutrition education and counseling for clients who are no longer in need of delivered meals.
Goals	Improve health outcomes for critically ill clients and reduce health care costs.
Funding Source(s)	Funding from charitable financial, in-kind donations from corporations, foundations and individuals.
Target Population	Critically ill individuals including adults and children.
Meal Types	17 medical diets with up to three combinations per patient including bland – mild and low in sodium, children's menu, chopped/soft, diabetic, heart-healthy, low-fat/low cholesterol, low fiber, no citrus/tomatoes, no dairy, no eggs, no fish/shellfish, no nuts, no poultry, no red meat, low vitamin K, renal, vegetarian, and nausea care packages.
Outcomes	Study to look at role of medically-tailored meals on health of clients from the perspective of healthcare workers (case managers, nurses, physicians) who referred patients to Community Servings' services through qualitative interviews and online surveys found improved psychosocial well-being (relieved anxiety so that energy can be focused on treatment); promoted healthy weight (stabilize or gain weight); provided high-quality, holistic care (care for the whole patient); improved adherence to medications and treatments (reduces side effects). 96% reported that the meal program improved their clients' health; 65% believed the program resulted in decreased hospitalizations; 94% believed the program significantly improved patients' access to healthy food; 16% net reduction in average monthly health care costs for patients who received the Community Serving home delivered, medically-tailored meals.
Costs	$350 monthly per person.
Distribution Methodology	Home delivered meals. They deliver to 20 different cities or 300 square miles; clients outside of delivery area can pick up meals.
Sources	(Berkowitz et al., 2018), ("Community Servings Food Heals," 2019), ("Financials | Community Servings," n.d.)
	Diabetes Initiative Food Box – Feeding America
Overview	Feeding America Diabetes Initiative provides diabetes-appropriate food to clients through monthly or bi-monthly food distributions. The Feeding America Diabetes Initiative was piloted at three member food banks that offered tailored services to people with diabetes. These services included nutrition education, blood sugar monitoring, healthy food and referrals to primary care providers.
Goals	Improve diabetes outcomes and reduce food insecurity.
Funding Source(s)	Funding from the Bristol-Myers Squibb Foundation, the Food Bank of Corpus Christi (Corpus Christi, TX), the Mid-Ohio Foodbank (Columbus, OH) and the Redwood Empire Food Bank (Santa Rosa, CA).
Target Population	Individuals with diabetes struggling with food insecurity.

Meal Types	Diabetes-friendly diet box. Food items provided include whole and unrefined grain products, fresh fruits and vegetables, canned fruits in own juice, low-sodium vegetables, sauces, soups, low-fat dairy, lean meats, and beans.
Outcomes	Individuals with diabetes showed improvements in pre-post analyses of glycemic control (hemoglobin A1c decreased from 8.11% to 7.96%), fruit and vegetable intake (which increased from 2.8 to 3.1 servings per day), self-efficacy, and medication adherence. Among participants with elevated HbA1c (at least 7.5%) at baseline, HbA1c improved from 9.52% to 9.04%. Lessons learned from this pilot include: • Clients requested utensils, spices and cooking oil needed to cook items in the food boxes. • Providing recipes and tips was found to be valuable.
Costs	~$0.38 - $0.94 per meal. On average, boxes cost $16 and are intended to support meals for 1-2 weeks. If recipients are averaging 3 meals per day from the contents of these boxes, this comes to approximately $0.38 - $0.94 per meal.
Distribution Methodology	Two general methods of distribution: • Clients coming to food pantries are screened for diabetes, then offered a diabetes-friendly box to help them make good choices for their meals. • Provider referral. Clients without a doctor are referred to a local provider who can make sure they get the healthcare services, including medication and blood sugar testing supplies that they need to manage their disease.
Sources	(Prendergast, 2014), (Seligman, Bindman, Vittinghoff, Kanaya, & Kushel, 2007), (Seligman et al., 2015) (Feeding America, 2019), (Feeding America, n.d.)
	Food & Friends
Overview	Food & Friends provides meals, groceries, nutrition counseling and a two hour cooking class called CHEW to people living with life-challenging illnesses such as HIV/AIDS and cancer. Determination of eligibility is entirely health-based. Food & Friends has no requirements for income or insurance coverage.
Goals	To improve the lives and health of people with HIV/AIDS, cancer and other serious illnesses that limit their ability to provide nourishment for themselves.
Funding Source(s)	Financial support comes from individuals, corporations/foundations, public funding and in-kind donations from corporations and individuals.
Target Population	To be eligible for services, one must have AIDS, cancer, poorly-controlled diabetes or be receiving hospice care, have a compromised nutritional status and a limited ability to prepare his/her own meals. Food & Friends' clients must be referred by a healthcare provider.
Meal Types	11 different meal plans including regular, pureed, diabetic, shelf-stable, renal, no diary, heart-healthy, soft, vegetarian, no fish, and gastrointestinal friendly. Each Food & Friends meal delivery contains 2 days-worth of food including a variety of fresh and frozen components. Each delivery includes food for breakfast, lunch and dinner, along with liquid nutritional supplements, as needed.
Outcomes	858,021 meals served to 2,624 clients in 2017. Health outcomes improved – 72% reported improved health, 76% felt better able to follow their doctor's orders, 73% reported being better able to manage the side effects of their treatment or medications, 66% reported fewer hospitalizations after receiving services, 88% found it less stressful to provide food for themselves and their family.
Costs	No cost/fee for services to clients.
Distribution Methodology	Meals are delivered by volunteers and staff.
Sources	("Food & Friends," n.d.)
	New Opportunities, Inc.
Overview	New Opportunities, a senior nutrition services provider, partnered with Care Transitions, a care management coordination provider to provide high risk hospital patients meals for 30-90 days and nutrition counseling and education.
Goals	To prevent readmission for high risk seniors recently transitioning from hospital to home.
Funding Source(s)	The CT Community Foundation and Meals on Wheels.
Target Population	High risk seniors recently transitioning from hospital to home. For the pilot, 4 individuals were selected from a partner health provider.
Meal Types	2 medically appropriate meals per day.

Outcomes	In a five-month period the program showed a 100% success rate keeping four patients referred to the program at home for 60 days or more.
Costs	The program spent $1,500 for four patients over 60 days.
Distribution Methodology	Home delivered meals. Drivers deliver the meals. The program trained drivers to track health status and send report back to Senior Nutrition Services and they would contact cardiologist if there were red flags.
Sources	(American Society on Aging, 2017)
	God's Love We Deliver (GLWD) –New York
Overview	The program prepares and delivers nutritious, high quality meals to people who, because of their illness, are unable to provide or prepare meals for themselves. GLWD also provides illness-specific nutrition education and counseling to clients, families, care providers and other service organizations. All services are provided free of charge without regard to income. The program provides home delivered meals determined by an RDN and executive chef. Each week clients receive 10 meals, as well as nutrition counseling and education. Clients get their first meal within 1-4 days of signing up. The program also provides nutrition tip guides for HIV, breast cancer, colorectal cancer, and prostate cancer as well as older adults and caregivers.
Goals	GLWDs aim is to improve the health and well-being of men, women and children living with HIV/AIDS, cancer and other serious illnesses by alleviating hunger and malnutrition.
Funding Source(s)	Funding includes government, private including corporations and foundations, and individual giving.
Target Population	Men, women, and children living with HIV/AIDS, cancer, Alzheimer's disease, ALS, Parkinson's disease and other life-altering illnesses throughout the five boroughs of New York City, Westchester and Nassau Counties, and Hudson County, NJ.
Meal Types	Medically-tailored meals with choices that include regular, modified, children's and vegetarian. They follow a four-week menu cycle with each meal containing a soup, entrée, bread and dessert. Clients with special needs work with a RDN.
Outcomes	7000 served annually; 1.2 million home delivered meals; 90% of clients live below the poverty line.
Costs	Free to clients.
Distribution Methodology	Home delivered to 5 boroughs of NYC, Hudson County, and 2 congregate sites in Newark, NJ.
Sources	("How It Works | God's Love We Deliver," n.d.), ("Menu | God's Love We Deliver," n.d.), ("Our Impact | God's Love We Deliver," n.d.)
	Home Plate Meal Program
Overview	The Home Plate Meal Program (HPMP) is administered by the Johnson County Area Agency on Aging. The program is supported by the Older Americans Act and provides short-term meal service to seniors and retired veterans post hospital discharge. Once a patient is discharged from the hospital, they are referred to the HPMP by a discharge planner or social work staff member. Following referrals, staff member at the Johnson County Area Agency on Aging contacts patient within 72 hours of hospital discharge to make arrangements to deliver a meal package. A nutrition assessment is completed within 3 days of discharge and follow-up calls are made to evaluate additional service needs such as a home-visiting nurse, ongoing nutrition services, etc.
Goals	The program goal is to assist seniors and retired veterans in their recuperation, decreasing the incidence of hospital readmission.
Funding Source(s):	Government and clients (donations).
Target Population	Patients age 60+, homebound, and discharging to a home in Johnson County from a participating hospital/rehabilitation facility.
Meal Types	Microwavable 7-day frozen meal package (meat entree, vegetable, fruit, dessert, and whole wheat bread or cornbread, and milk).
Outcomes	Program is currently suspended.
Costs	Donations accepted as payment.
Distribution Methodology	Following a referral to the HPMP, a staff member with the Johnson County Area Agency on Aging will contact the patient to make arrangements to deliver the 7-day frozen meal pack to the patient at home within 72 hours of hospital discharge.
Sources	("Home Plate Meal Program | Johnson County Kansas," n.d.)

	Independent Living Systems (ILS)
Overview	Independent Living Community Services Inc. (ILS) is a non-profit organization in Miami-Dade County, Florida. ILS aims to deliver meals, community-based services that improve the daily living experience for special needs populations from children to the elderly as well as rebalancing costs across the healthcare system. The program offers home delivered meals, nutrition counseling and care coordination. ILS currently delivers 800,000 meals per month through Care Delectable meal delivery.
Goals	The program seeks to improve community-based care transitions, outcomes, and reduce readmissions and overall cost.
Funding Source(s)	Government sponsored and private insurance plans.
Target Population	The elderly, special needs, and at risk-populations in Miami with qualifying health plans.
Meal Types	Offer 10 frozen home delivered meals (regular heart friendly, fish free, pork free, diabetic, gluten free, renal, vegetarian, puree, kosher).
Outcomes	Florida's Experience: Expanding the CMS Care Transition • Community readmission rate: 22.1% • 30-day readmission rate: 13.5% (meals only) • 30-day readmission rate: 7.6% (meals and nurse visit) • Post discharge 10 frozen meal packages, data shows reduced readmission rates • From June 2015- April 2015: readmission rate decreased by 65%
Costs	~$8.90 per meal. The service used is Care Delectables. After discount, Care Delectables meals cost $89.00 for a 10-pack excluding applicable taxes.
Distribution Methodology	Meals are delivered to the home immediately upon discharge from a hospital or nursing home. Care Delectables delivers via 2nd day air freight in dry ice in specially designed packaging. Meals can be heated in a conventional oven or microwave by following simple instructions.
Sources	(Suazo, n.d.), ("Independent Living Systems Launches New "Care Delectables" Nationwide Home-Delivered Meals Service," n.d.), ("Care Delectables - Home Delivered Meals," n.d.)
	Carer Gateway (Australia)
Overview	Carer Gateway provides meal assistance, including but not limited to the following: provisions of meals at a community center or at home, help preparing meals at home, help with shopping for food, help with making meals and storing food in the home, help with learning to cook, and delivering meals to the home. The starting point to accessing the service is My Aged Care, a service funded by the Australian Government.
Goals	To help older people live as independently as possible.
Funding Source(s)	Australian government. The National Disability Insurance Scheme (NDIS) can be used to fund assistance with meal planning, preparation, and cooking as well as delivered meals.
Target Population	Individuals 65 years or older (50 years or older and identify as Aboriginal or Torres Strait Islander person) or 50 years or older (45 or older for Aboriginal and Torres Strait Islander people) and low income, homeless or at risk of being homeless.
Meal Types	Help with shopping for food, help with making meals and storing food in the home, help with learning to cook, delivering meals to the home, and providing meals at a community center.
Outcomes	None available at this time.
Costs	Varies.
Distribution Methodology	Meals can be home delivered and many programs rely on non-government organizations to deliver services.
Sources	("Meals Assistance | Carer Gateway | Australian Government," 2018)
	Seniors Community Care (Australia)
Overview	The Seniors Community Care program offers clients prepared meals that are delivered to the home. The program has an extensive menu that provides both fresh chilled and frozen meals. The nutritious and healthy meals are prepared and home delivered twice a week.
Goals	Seniors Community Care aims to offer services of the highest standard and support independent living for individuals.
Funding Source(s)	Cost of meals paid for by individual(s) ordering the food/meals.

Target Population	Seniors or aged persons; disabled persons; individuals managing at home after an illness, injury or hospital stay or, any individual who likes the convenience of prepared meals.
Meal Types	Meal options include diabetic, low sodium, low fat, vitamised, diced, gluten free or vegetarian options, within the selection of fresh meals also available upon request.
Outcomes	None available.
Costs	~$10.30 - $12.90 per meal. Fresh cooked chilled dinner size small is $10.30 and medium is $12.90.
Distribution Methodology	Meals are delivered fresh, chilled, and frozen on a regular or as needed basis.
Sources	(“Home Delivered Meals | Seniors Community Care,” n.d.), (Home Delivered Meals, 2017)
	Maryann’s Kitchen (Australia)
Overview	Maryann’s Kitchen offers fresh, healthy and home delivered meals for people who are elderly, disabled, and recovering from illness and surgery.
Goals	Meal delivery is their primary goal.
Funding Source(s)	Fee for meals.
Target Population	Elderly, disabled, and those recovering from illness and surgery.
Meal Types	They offer a different meal each day, over a 28 day period, with menus changing every 6 months. They offer a special weekend menu. Meals consist of a main course, with choice of dessert or soup or salad. Meal types include regular and diabetes. They cater to special dietary needs on an individual basis.
Outcomes	None available.
Costs	~$7 per meal. $14.00 per day per 2 course meal or $70.00 per week.
Distribution Methodology	Meals can be delivered daily hot or cold. Daily, weekday and weekend meal plans available. Extra surcharges may apply if ordering less than 5 meals per week.
Sources	(“Home - MARYANN’S KITCHEN,” 2019), (Maryann’s Kitchen, 2018)
	Tender Loving Cuisine (Australia)
Overview	Tender Loving Cuisine (TLC) was established in 1995 and provides meals with a homemade taste at an affordable price. TLC delivers meals frozen.
Goals	TLC aims to improve the quality of life for older people and individuals in need by providing the highest quality meals.
Funding Source(s)	Fee for meals.
Target Population	All ages.
Meal Types	Regular, diabetes friendly, gluten-free, heart friendly, dairy-free, low salt, textured soft, minced moist.
Outcomes	None available.
Costs	~$8.40 to $13.75 per meal. Saver menu cost starts at $8.40 per meal, premium meals start at $13.75; bundle packages can further reduce meal prices.
Distribution Methodology	Delivered to the home, business or senior village.
Sources	(“Our Mission - Tender Loving Cuisine,” n.d.)
	Swedish Municipal Food Distribution
Overview	The program offers two key services, including: (1) The municipal Food Distribution service (FD) which provides services targeting individuals who are unable to do their own grocery shopping, and prepare their own meals and (2) home delivered meals.
Goals	The goal of the program is help elderly people and those with disabilities age in place.
Funding Source(s)	Elder care in Sweden is funded by municipal taxes and government grants. In 2014, the total cost of elderly care in Sweden was SEK 109.2 billion (USD 12.7 billion, EUR 11.7 billion), but patient charges were only 4% of the cost. Healthcare costs paid by the elderly are subsidized; the degree of subsidization is based on specified rate schedules.
Target Population	Persons who are unable to do their own shopping, and prepare their own meals.

Meal Types	Various types – meal boxes which are hot, chilled or frozen with different delivery frequencies.
Outcomes	360,000 meals are served within elderly care.
Costs	Variable – low as government and welfare system covers.
Distribution	Home delivery with different delivery options.
Methodology	
Sources	(“Elderly care in Sweden,” n.d.), (Pajalic, 2013), (Josefsson, 2018)

Impact on the MDMP

Meal Packages

Review of previous and ongoing meal package programs from this report have informed the development of the MDMP meal packages’ menu and design. An example of two menus from programs profiled in this report is found in Appendix A. Familiarity and recognizability of the food items in the meal packages was an important aspect of the menu design. This way, once the meal packages run out participants can recognize and find replacement food items to purchase that also fit their nutritional needs. For example, a patient with heart failure might leave the hospital with an order to follow a low-sodium diet. When they are given the CC/HH meal packages and the accompanying menu they will know that they are eating a low-sodium diet and they will get a better idea of what it is like to follow this type of diet. Once they have consumed all of the MDMP meals, they can then purchase foods that are similar to those found in the meal packages, such as low-sodium soups.

The cost of meals in other programs was scrutinized for reference. Meals from the programs profiled in this report tended to cost an average of $10 or less, with some as low as $3 per meal. The MDMP packages aim to meet or exceed the cost effectiveness of these meals. Many of the food items can be purchased at discount stores such as Walmart and Dollar Tree. These stores are also usually accessible in most locations, even those considered to be “food deserts.” This way, once the participant has consumed the meal packages, they will be able to find replacement items easily and affordably.

The flexibility and cost-effectiveness of prepackaged, shelf-stable foods was determined to be useful for the MDMP. The MDMP meal package food items are entirely shelf-stable, require minimal preparation, and are easy to open. Almost all of the other programs profiled in this report included a component of fresh or frozen, fully-prepared meals. As the MDMP progresses through and beyond the pilot period, it will be important to assess whether including a fully-cooked meal option in the program will be cost-effective, viable and appealing to clients.

Educational Materials

Evaluating other programs illuminated the need for effective educational materials to inform participants as well as staff. A sample of an educational handout can be found in Appendix B. Educational materials are designed to accompany the MDMP meal packages and also to inform the hospital staff/healthcare workers that are providing the meal packages. Other programs’ materials also informed MDMP workflow, including a patient selection flowsheet, ordering protocol, and additional resources for patients who do not meet the criteria or need additional help to access assistance. A sample of workflow and patient selection can be found in Appendix C. Some programs had specific referral forms (seen in Appendix D). The MDMP does not use referral forms but a patient selection flowchart to determine patient eligibility as well as a consent form for the patient to sign.

Target Population

The MDMP is specifically intended to address malnutrition risk in older adults. The program further focuses in on chronic conditions that have the highest rate of readmissions for the pilot hospitals. Many of the other programs that were reviewed were not specific to senior populations, but addressed malnutrition risk for specific sub-populations based on income, disease, or insurance type. Malnutrition risk was sometimes identified using an assessment tool either developed by the program or an established verified tool. However, almost every program focused on specific medical conditions that are highly associated with malnutrition risk. Almost invariably, programs did not approach participant identification using a diagnosis of malnutrition as an eligibility criterion. The MDMP quickly discovered through review of similar programs and through collaborations with pilot hospitals that eligibility assessments needed to focus on specific medical conditions and risk-assessment tools to determine eligibility rather than relying on a diagnosis of malnutrition or referral for malnutrition treatment.

Other Impacts & Considerations

One theme that frequently emerged in this review of similar programs was the importance of inter-institutional collaboration and effective communication between partners. A report on the progress of the MIFA No Hungry Senior initiative (*Member Partnership Guide: Keys To Greater Collaboration and Impact to Better the Lives of Older Adults*, 2016) stated that one of the challenges for the program was the great number of collaborators involved. They found that effective communication would be a key to success for similar programs. As MDMP moves forward and more partner organizations get on board, setting up frequent meetings and having communication platforms to keep everyone apprised and engaged in ongoing efforts will be paramount.

Funding for these programs came from a variety of sources. The meals cost on average $10 or less for the programs profiled in this report. The packages currently being designed for the MDMP pilot average about $11.50 for a full day (3 meals, 2 snacks) or $2.30 per meal/snack (for food costs alone). Although this cost is on par with or less than these other programs, it will still require adequate and ongoing funding to be effective. Federal and State grants can provide financial support from the public sector, but the program can also look to private-sector and healthcare funding sources. For example, if partnering with a non-profit organization the program could take a note from MANNA in Philadelphia and utilize philanthropic donations from individuals and organizations. MDMP can also look to funding from private pay, insurance reimbursement, etc.

Many of these programs relied on volunteers to distribute and package food. Transportation will be required while meals are being distributed to clients in the community and while procuring items for the meal packages. This transportation requires vehicles, gas, and drivers. MDMP is addressing this through several different avenues. In some cases, participant hospitals have community health workers who are visiting discharged patients at home as part of their transitional care. This will provide an opportunity for the packages to be delivered during these visits. In other scenarios, the patient will be returning to the hospital's transitional care clinic for a follow up visit and they will receive the packages there. This has an added advantage of providing an additional incentive to the patient to return for their follow-up visits. However, the issue of transportation and accompanying costs and required resources will be an ongoing issue area to look at while expanding the program.

Continual Network Support and Feedback

As the MDMP pilot progresses, continued support and feedback from a network of groups working on similar initiatives will be essential. As much as previous projects have impacted the MDMP design and process, groups around the US and abroad are concurrently working on initiatives or evaluating results from projects that can continue to help to inform the MDMP pilot and ultimately the expansion of the larger Maryland implementation.

Slack Network

The MDoA has brought together representatives from a variety of programs and initiatives around the country virtually using a Slack network (www.slack.com) to share materials, information and perspectives. Slack is an online networking tool that provides a shared collaborative workspace that combines communication through chat and instant messaging with sharing documents and other resources. MDoA intends to use this online network of collaborators to support the MDMP initiative and, in turn, provide support to other similar ongoing and future programs.

Quarterly Phone Meetings

Once a quarter, members are invited to a telephone conference call hosted by the MDoA MDMP representatives. Members range across acute, post-acute and community-based providers and are from 20 different states across the United States. Each quarter 1-2 programs are highlighted to share details about their initiative, outcomes, and ongoing processes. This collaborative space is yet another way to share ideas, provide feedback, and learn from other programs to provide ongoing support to the MDMP and other initiatives around the country.

Conclusion and Acknowledgements

Maryland, and all states across the US, have an exciting and challenging opportunity to address senior malnutrition and chronic illness with post-discharge meal package programs. The MDMP is a unique example for others to consider, given it is entirely shelf-stable, medically-tailored, and connects patients discharged from hospitals to resources in the community and resources in their doctor's office.

The authors wish to thank and acknowledge similar programs and initiatives around the country and around the globe which have informed the development of the MDMP. We also thank the Maryland Department of Aging's staff, Laura Sena, MSPH, RD, LDN and Judy Simon, MS, RD, LDN for their contributions by editing this material and compiling much of the foundational information presented in this document. The Maryland Department of Aging's work coordinating the national peer network has facilitated cross-organizational discussions and will continue to impact the program as MDMP is implemented and eventually grows to a larger initiative.

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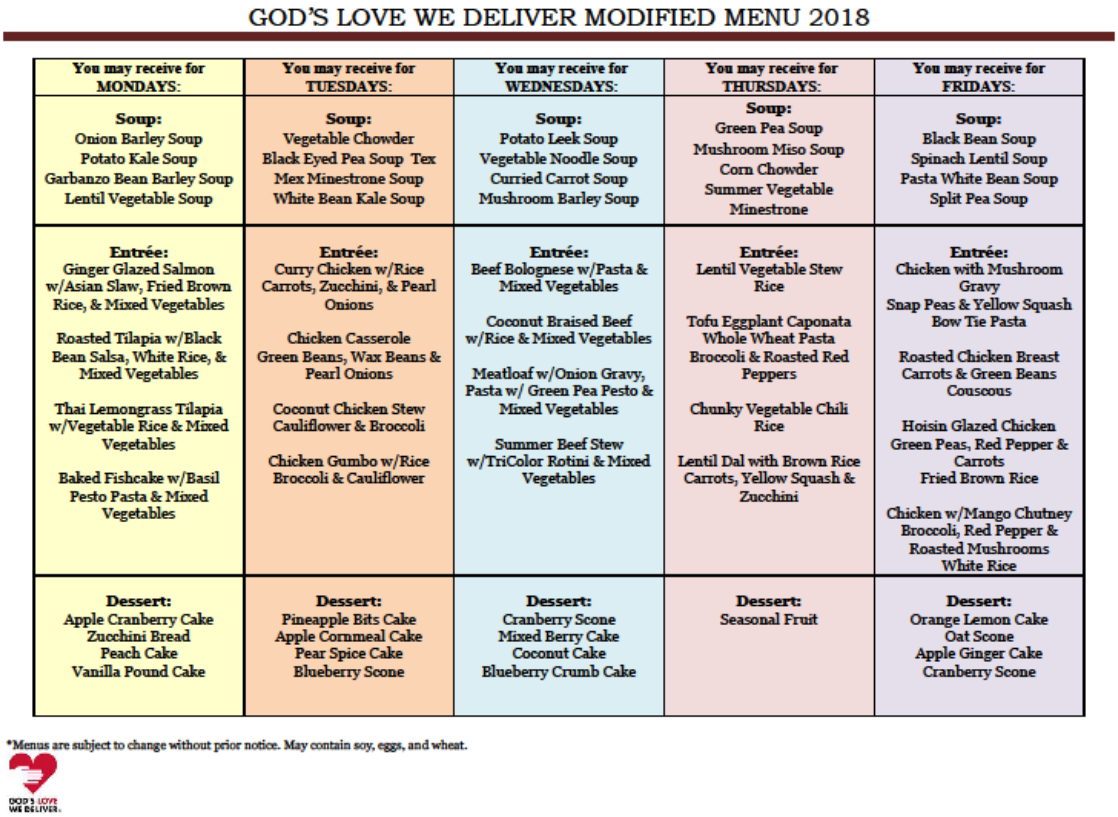
Appendix A: Sample Menus



GOD'S LOVE WE DELIVER MODIFIED MENU 2018

You may receive for MONDAYS:	You may receive for TUESDAYS:	You may receive for WEDNESDAYS:	You may receive for THURSDAYS:	You may receive for FRIDAYS:
Soup: Onion Barley Soup Potato Kale Soup Garbanzo Bean Barley Soup Lentil Vegetable Soup	**Soup:** Vegetable Chowder Black Eyed Pea Soup Tex Mex Minestrone Soup White Bean Kale Soup	**Soup:** Potato Leek Soup Vegetable Noodle Soup Curried Carrot Soup Mushroom Barley Soup	**Soup:** Green Pea Soup Mushroom Miso Soup Corn Chowder Summer Vegetable Minestrone	**Soup:** Black Bean Soup Spinach Lentil Soup Pasta White Bean Soup Split Pea Soup
Entrée: Ginger Glazed Salmon w/Asian Slaw, Fried Brown Rice, & Mixed Vegetables Roasted Tilapia w/Black Bean Salsa, White Rice, & Mixed Vegetables Thai Lemongrass Tilapia w/Vegetable Rice & Mixed Vegetables Baked Fishcake w/Basil Pesto Pasta & Mixed Vegetables	**Entrée:** Curry Chicken w/Rice Carrots, Zucchini, & Pearl Onions Chicken Casserole Green Beans, Wax Beans & Pearl Onions Coconut Chicken Stew Cauliflower & Broccoli Chicken Gumbo w/Rice Broccoli & Cauliflower	**Entrée:** Beef Bolognese w/Pasta & Mixed Vegetables Coconut Braised Beef w/Rice & Mixed Vegetables Meatloaf w/Onion Gravy, Pasta w/ Green Pea Pesto & Mixed Vegetables Summer Beef Stew w/TriColor Rotini & Mixed Vegetables	**Entrée:** Lentil Vegetable Stew Rice Tofu Eggplant Caponata Whole Wheat Pasta Broccoli & Roasted Red Peppers Chunky Vegetable Chili Rice Lentil Dal with Brown Rice Carrots, Yellow Squash & Zucchini	**Entrée:** Chicken with Mushroom Gravy Snap Peas & Yellow Squash Bow Tie Pasta Roasted Chicken Breast Carrots & Green Beans Couscous Hoisin Glazed Chicken Green Peas, Red Pepper & Carrots Fried Brown Rice Chicken w/Mango Chutney Broccoli, Red Pepper & Roasted Mushrooms White Rice
Dessert: Apple Cranberry Cake Zucchini Bread Peach Cake Vanilla Pound Cake	**Dessert:** Pineapple Bits Cake Apple Cornmeal Cake Pear Spice Cake Blueberry Scone	**Dessert:** Cranberry Scone Mixed Berry Cake Coconut Cake Blueberry Crumb Cake	**Dessert:** Seasonal Fruit	**Dessert:** Orange Lemon Cake Oat Scone Apple Ginger Cake Cranberry Scone

*Menus are subject to change without prior notice. May contain soy, eggs, and wheat.

GOD'S LOVE WE DELIVER.

Source: (God's Love We Deliver, 2018)

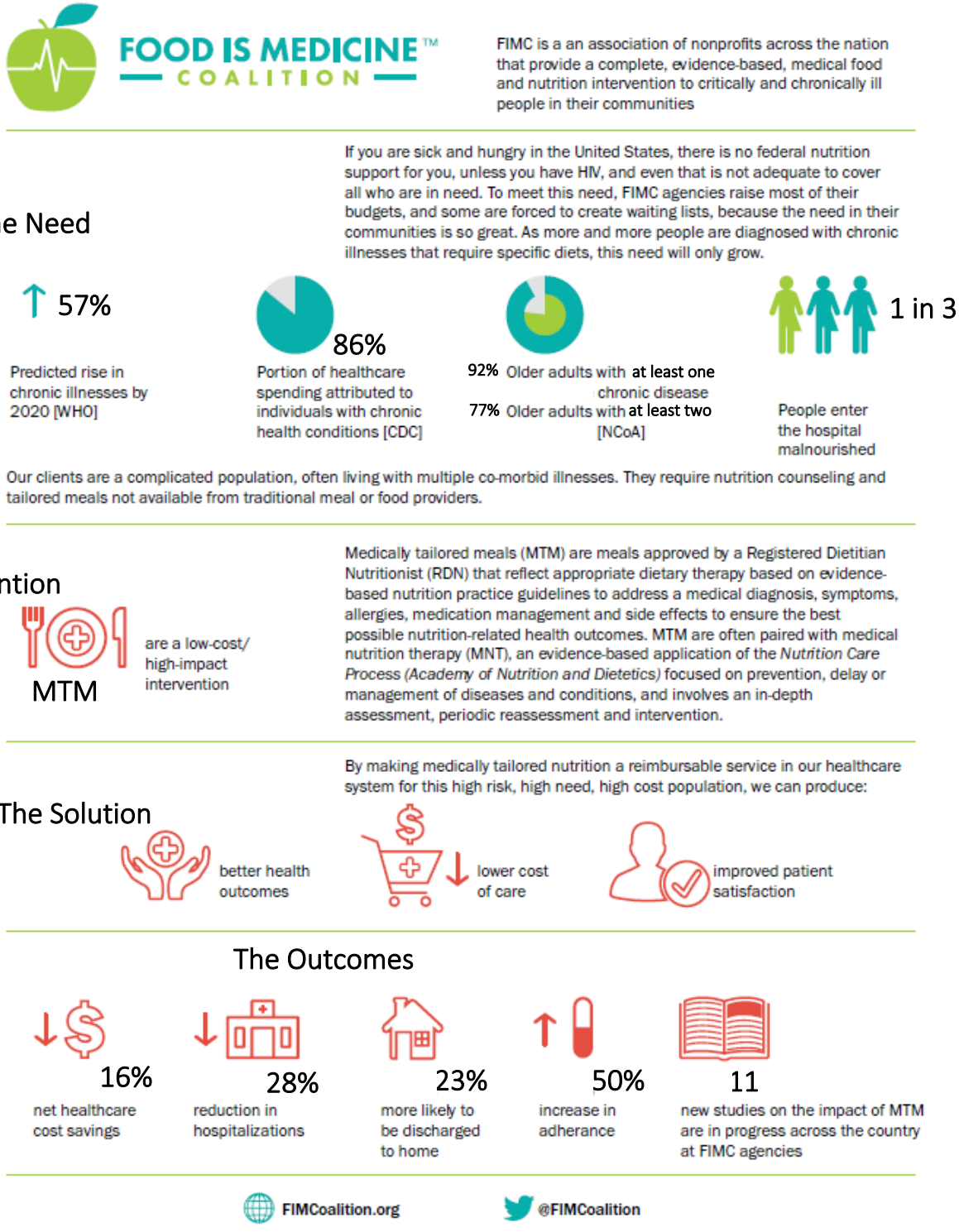
MARCH 2019 WELLNESS MENU

Monday	Tuesday	Wednesday	Thursday	Friday
MARCH is National Nutrition Month			Join us today for a nutritious and balanced meal. Make nutrition a focus of your day, this month and beyond! Project Open Hand	1-Mar Roasted Pork Loin / Mushroom Herb Gravy Bulgur Broccoli & Cauliflower
4-Mar Roasted Chicken Thigh / Mushroom Sage Gravy Penne Peas & Carrots	5-Mar Mongolian Beef Brown Rice Green Beans	6-Mar Baked Tilapia / Basque Sauce Bulgur Glazed Carrots	7-Mar Chicken Tetrazzini Stew Penne Broccoli & Cauliflower	8-Mar Roasted Pork Loin / Sweet & Sour Sauce Brown Rice Broccoli
11-Mar Roasted Chicken Thigh / Marinara Sauce Brown Rice Pilaf Carrots	12-Mar Turkey Bolognese Penne Green Beans	13-Mar Herb Roasted Chicken Thigh / Lemon Mustard Sauce Brown Rice Peas & Carrots	14-Mar Chicken & Eggplant Provencal Brown Rice Pilaf Normandy Vegetables	15-Mar Baked Herb Tilapia / Puttanesca Sauce Penne Glazed Carrots
18-Mar Roasted Chicken Thigh / Paprikash Sauce Brown Rice Broccoli	19-Mar Turkey Meatloaf / Mushroom Sage Gravy Penne Peas & Carrots	20-Mar Roasted Pork Loin / Marsala Sauce Brown Rice Carrots	21-Mar Alma's Chicken Tinga Stew Brown Rice Green Beans	22-Mar Baked Tilapia / Sweet & Sour Sauce Bulgur Normandy Vegetables
25-Mar Roasted Chicken Thigh / French Country Sauce Brown Rice Peas & Carrots	26-Mar Roasted Beef Patty / Onion Gravy Macaroni Carrots	27-Mar Roasted Pork Loin / Salsa Verde Brown Rice Carrots	28-Mar Chicken & Red Bean Stew Spanish Brown Rice Normandy Vegetables	29-Mar Roasted Tilapia / Puttanesca Sauce Penne Broccoli

Source: (Project Open Hand, 2019)

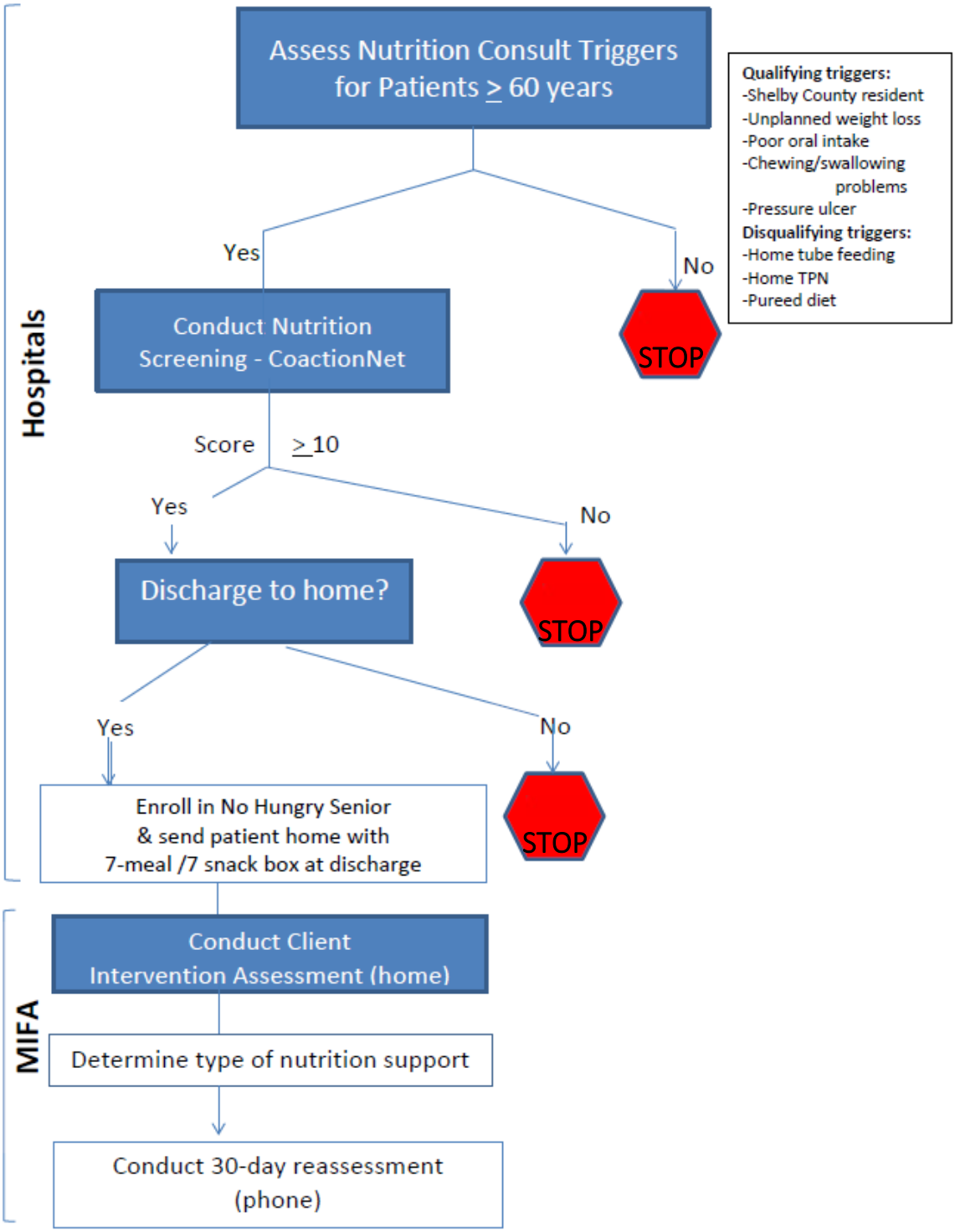
Appendix B: Sample Educational Material

Food is Medicine Coalition (FIMC)



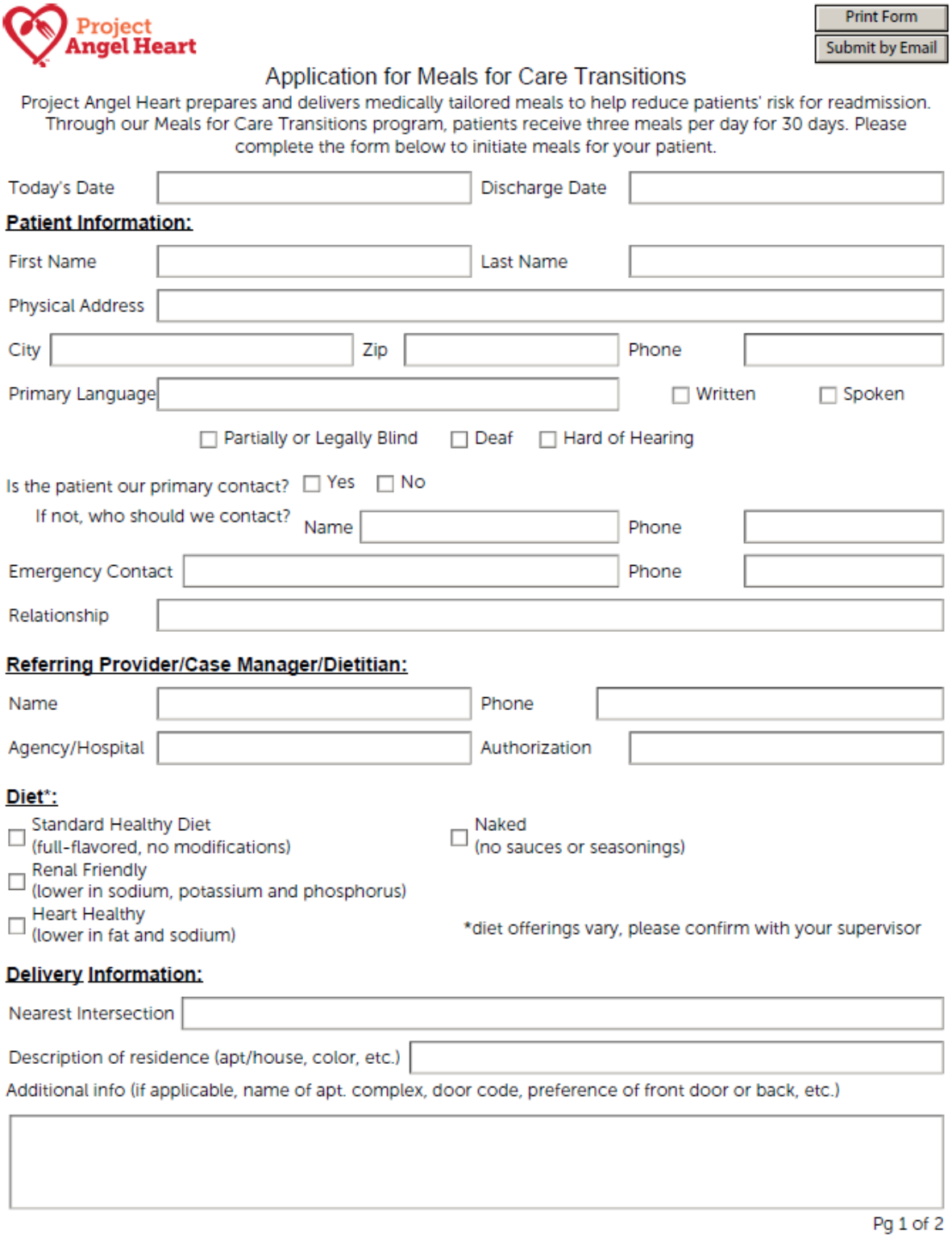
Source: (Food is Medicine Coalition (FIMC), 2018)

Appendix C: Sample Workflow



Source: MIFA No Hungry Senior program

Appendix D: Sample Referral Form



Project Angel Heart

Print Form | Submit by Email

Application for Meals for Care Transitions

Project Angel Heart prepares and delivers medically tailored meals to help reduce patients' risk for readmission. Through our Meals for Care Transitions program, patients receive three meals per day for 30 days. Please complete the form below to initiate meals for your patient.

Today's Date | Discharge Date

Patient Information:

First Name | Last Name

Physical Address

City | Zip | Phone

Primary Language | ☐ Written ☐ Spoken

☐ Partially or Legally Blind ☐ Deaf ☐ Hard of Hearing

Is the patient our primary contact? ☐ Yes ☐ No

If not, who should we contact? Name | Phone

Emergency Contact | Phone

Relationship

Referring Provider/Case Manager/Dietitian:

Name | Phone

Agency/Hospital | Authorization

Diet*:

☐ Standard Healthy Diet (full-flavored, no modifications)
☐ Renal Friendly (lower in sodium, potassium and phosphorus)
☐ Heart Healthy (lower in fat and sodium)
☐ Naked (no sauces or seasonings)

*diet offerings vary, please confirm with your supervisor

Delivery Information:

Nearest Intersection

Description of residence (apt/house, color, etc.)

Additional info (if applicable, name of apt. complex, door code, preference of front door or back, etc.)

Pg 1 of 2

Source: ("Application for Project Angel Heart meals - Project Angel Heart," n.d.)

Summary Brief

Snapshot of project and findings.

ORGANIZATION: Maryland Department on Aging

MARYLAND'S INNOVATIONS IN NUTRITION PROGRAMS AND SERVICES

ABOUT US

The Maryland Department of Aging helps establish Maryland as an attractive location for all older adults through vibrant communities and supportive services that offer the opportunity to live healthy and meaningful lives.

PROJECT PURPOSE

- To transform the Maryland Department of Aging's Senior Nutrition Program using the epidemic of older adult malnutrition as the catalyst to introduce evidence based practices, cost-cutting measures, innovative meal products, and efficient service delivery methods to forge new health care linkages and expand service to older adults in the community.

PROJECT LENGTH

- Two years

KEY PARAMETERS

- **Population targeted:** Age 60 and older, persons at risk of hospital readmission, and/or malnutrition
- **Geographic setting:** Urban, suburban, and rural settings (statewide)
- **Service delivery setting:** Community settings; initial distribution site of meal packages was in the hospital, at discharge
- **Services offered:** Innovative post-hospital discharge meal package services, and development of a malnutrition care pathway approach
- **Number of staff/FTEs dedicated to innovation project:** (paid/unpaid, FTEs): Maryland Department of Aging: 0.75 FTE Project Coordinator, with in-kind support of senior staff, and involvement of Older Americans Act (OAA Nutrition Program Manager (in-kind not counted since the OAA is a federal program and could not be applied for budget purposes)
- **Consulting Registered Dietitian Firm:** procured to assist with specific components
- **Subgrantees:** Maintaining Active Citizens, Inc. (MAC Inc.), a Maryland Area Agency on Aging (AAA) and the Maryland Food Bank. Both were engaged and paid for time and expertise devoted to the project based on executed agreements
- **Total grant funds received:** $245,975
- **Total project period:** Two years (2017 – 2019)
- **Total funding leveraged from organization (cash/in-kind):** $85,236 (State funding)

PROJECT COMPONENTS

- A replicable model for a hospital post-discharge community-based malnutrition care pathway.
- Medically-tailored, shelf-stable meal packages for older adults transitioning from hospital to home.
- University-led cognitive- and validation-testing of the Maryland Home Delivered Meal Screening tool.
- Community malnutrition awareness workshops for seniors at risk for falls entitled, "Stepping Up Your Nutrition".

SUCCESSES AND LESSONS LEARNED

Community Based Malnutrition Pathways Toolkit

- **Successes:** A Community-Based Malnutrition Pathways Toolkit was created and was found to be of value to Area Agencies on Aging across the nation.
- **Lessons Learned:** Plan sufficient time for project staff to manage and be significantly engaged in projects that involve Area Agencies on Aging training, since consultants often will not have the context to develop special needs plan (SNP) applicable materials and trainings independently, even if they are content experts.

Meal Packages

- **Successes:** The meal package project received excellent acceptance and usage by patients and succeeded in its client-centered goals. The project team was able to create the first medically-tailored, shelf-stable meal package for older adults in our state and possibly for the nation.
- **Lessons Learned:** Anticipate delays in the learning curve, capturing data and receiving outcomes. Do not allow subgrantees to put project work plan timeline at risk. Intervene early to address problems.

Home Delivered Meal Screening Tool

- **Successes:** Local AAAs in Maryland now have an "app" for their use and a current manual for implementation of this screening procedure.
- **Lessons Learned:** Universities and the aging network work at different paces. This can affect deliverable timeliness.

Stepping Up Your Nutrition

- **Successes:** Met or exceeded programmatic and health outcomes. The workshops are sustainable and offered nationally via steppingupyournutrition.com.
- **Lessons Learned:** Use of a proven, award winning tool can strengthen a new project's outcomes and success.

PROJECT IMPACT

The department partnered closely with a number of healthcare and AAA partners to fulfill this grant. These relationships continue and enhance each organization's ability to serve clients effectively. Examples of the project's Impact:

- One AAA has received funding to hire a dietitian and implement the malnutrition pathway.
- The Consulting Registered Dietitian Firm will continue offering the meal packages to healthcare providers and AAAs.
- A number of pilot projects have stemmed from our partnership with the hospitals.
- Another Department grant will be implementing the meal packages with subgrantees.

ADVICE TO PEERS

This grant project was very ambitious. The recommendation would be not to put too many projects into one grant proposal and consider what is absolutely critical to achieve project goals and what is manageable within the project's timeframe. The important thing to remember when preparing grant proposals is that they are reviewed and scored based upon clearly defined project goals and objectives and the demonstration of a methodology/approach that is reasonable to achieve them within the project timeframe.

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