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D.C. MEDICAL CARE ADVISORY COMMITTEE (MCAC)
Sub-Committee Proposal Form

All MCAC sub-committee proposals must be submitted for consideration by the MCAC using this form. Proposals must come from the respective sub-committee chair to MCAC Liaison Trina Dutta (trina.dutta@dc.gov) at least two weeks in advance of the next scheduled MCAC meeting.

1. **Proposal Title**: Support of the proposed FY19 addition of Home Delivered Meals to the list of approved services covered under the Elderly and Persons with Disabilities (EPD) Waiver Program

2. **Submitting Sub-Committee** *(choose one)*

☒Long Term Services and Supports
☐Health Care Re-Design
☐Enrollment & Eligibility
☐Access

3. **Abstract**

In 100 words or less, explain the proposal being submitted for MCAC's consideration.
Currently, 46 states fund nutrition services, such as Home Delivered Meals, through their Medicaid waiver funding. According to Mom's Meals Nourish Care, a current meals provider in many states including DC, approximately 50% of waiver individuals in other states receive Home Delivered Meals as an approved waiver service. Home Delivered Meals are a cost-effective, critical factor that allows more waiver-eligible people to live in their homes and communities, instead of in an institution. A standard benefit is one meal daily but several states approve up to 2 meals a day. In the majority of states, meal and delivery costs are around $6.50 - $7.50 per meal. In addition to Home Delivered Meals, some states provide additional nutrition risk reduction services through their waiver programs, such as medical nutrition therapy (MNT) by a licensed dietitian nutritionist, and high calorie/high protein liquid nutrition supplements for the frailest.

4. **Proposal**[1]

In 1000 words or less, explain the problem being addressed and propose a discrete and actionable solution for the MCAC's consideration. Include any scheduling and/or budget implications, along with risk and mitigation strategies of this proposal.

[1] All supporting documents should be provided as attachments to this proposal.

This year advocates representing the DC Coalition on Long Term Care and the Senior Advisory Coalition suggested that DHCF expand the EPD Waiver Program to include home delivered meals based on data collected by the DC Office on Aging's (DCOA) Lead Agencies was matched with Department of Health Care Finance (DHCF) data. Results showed that approximately 326 (16%) of the 2,050 seniors enrolled in the DCOA Home Delivered Meals program were concurrently enrolled in the EPD Waiver program. If EPD Waiver clients were able to receive Home Delivered Meals through the EPD Waiver instead of through the DCOA senior nutrition programs, hundreds of additional non-EPD Waiver frail, isolated, or homebound DC seniors at high nutrition risk would be able to receive nutritious meals. Adding Home Delivered Meals to the list of FY19 approved services on DC's EPD Waiver will help alleviate the high rate of senior hunger and malnutrition in DC seniors. EPD Waiver Home Delivered Meals would also provide a valuable food resource for EPD Waiver individuals aged 18-59, who is currently ineligible for any prepared meal services.

At the beginning of the FY17budget process we were informed that there was funds included for home delivered meals in the EPD Waiver Program at approximately $650,000. Rose Clifford, Iona Nutrition Program Manager, testified at the FY18 Committee on Health Budget Hearing. (See testimony attached). According to a question asked by Committee Chair Gray, Director Turnage indicated that the $260,000 was actually a quarterly cost as opposed to being an annual figure. Because of this miscalculation the funds the expansion was deferred to the FY19 Budget. To insure that this error is not repeated we are urging a more transparent and robust cost benefit analysis.

5. Supporting Documentation

Any supporting documents should be provided as attachments to this proposal, and referenced in the Q4 Proposal above. List these below.

Testimony on District of Columbia Department of Health Care Finance Budget Hearing
Before the District of Columbia City Council
Committee on Health
Chairperson Vincent C. Gray
May 10, 2017
Presented by Rose Clifford, RDN, MBA

Good afternoon. My name is Rose Clifford and for the past eight years, I've been the Nutrition Program Manager at Iona Senior Services. I'm also currently the Co-Chair of the Nutrition Subcommittee of the DC Senior Advisory Coalition. I'm here to testify in support of the proposed FY18 addition of Home Delivered Meals to the list of approved services covered under the Elderly and Persons with Disabilities (EPD) Waiver Program in Washington, DC. Currently, 46 states fund nutrition services, such as Home Delivered Meals, through their Medicaid waiver funding. According to Mom's Meals Nourish Care, a current meals provider in many states including DC, approximately 50% of waiver individuals in other states receive Home Delivered Meals as an approved waiver service. Home Delivered Meals are a cost-effective, critical factor that allows more waiver-eligible people to live in their homes and communities, instead of in an institution. A standard benefit is one meal daily but several states approve up to 2 meals a day. In the majority of states, meal and delivery costs are around $6.50 - $7.50 per meal. In

addition to Home Delivered Meals, some states provide additional nutrition risk reduction services through their waiver programs, such as medical nutrition therapy (MNT) by a licensed dietitian nutritionist, and high calorie/high protein liquid nutrition supplements for the frailest, underweight participants.

Last year, data collected by the DC Office on Aging's (DCOA) Lead Agencies was matched with Department of Health Care Finance (DHCF) data. Results showed that approximately 326 (16%) of the 2,050 seniors enrolled in the DCOA Home Delivered Meals program were concurrently enrolled in the EPD Waiver program. If EPD Waiver clients were able to receive Home Delivered Meals through the EPD Waiver instead of through the DCOA senior nutrition programs, hundreds of additional non-EPD Waiver frail, isolated, or homebound DC seniors at high nutrition risk would be able to receive nutritious meals. Adding Home Delivered Meals to the list of FY18 approved services on DC's EPD Waiver will help alleviate the high rate of senior hunger and malnutrition in DC seniors. EPD Waiver Home Delivered Meals would also provide a valuable food resource for EPD Waiver individuals aged 18-59, who are currently ineligible for any prepared meal services.

While no one should go hungry or lack access to sufficient healthy food, older adults are particularly vulnerable to the effects of food insecurity, hunger, and sub-optimal nutrition. The National Foundation to End Senior Hunger's June 1, 2016 release of the State of Senior Hunger in America 2014 annual report found that 1 in 5, or 20% of DC seniors overall face the threat of hunger. DC is ranked #7 in terms of the worst states/communities in the United States for the threat of senior hunger.

Nationwide, food insecurity among older adults is increasing. Senior hunger is a health issue with very high personal and economic costs, especially for seniors who qualify for EPD Waiver services. Senior malnutrition is often a "hidden secret" with devastating individual suffering and societal consequences. The estimated annual cost of disease-associated malnutrition in older adults in the US is $51.3 Billion (Snider, JT, et al. JPEN, 2014). Astoundingly, marginal food insecurity in older adults is functionally equivalent to being 14 years older (Academy of Nutrition and Dietetics, 2010). Food and nutrition issues are so important to good health and life quality for older adults, but are often poorly understood or go unrecognized. According to the DefeatMalnutrition.Today coalition, up to 1 out of 2 older adults are at risk for malnutrition and up to 60% of hospitalized older adults may already be malnourished. Malnutrition increases the length of hospital stays, and leads to more complications such as falls and readmissions. Eighty-seven percent of older adults have one of more chronic diseases with nutritional implications, and based on the Healthy Eating Index, 83% of older adults do not consume a good quality diet.

It's also important to understand that hunger and malnutrition are complex, and are often access issues. Factors such as poor appetite, unintentional weight loss and frailty, isolation, decreased mobility, cognitive decline, psychosocial and mental health issues, nutrient deficiencies, poor oral health, and lack of transportation are common contributing factors to senior food insecurity and malnutrition. For these and other reasons, EPD Waiver-eligible older adults or their caregivers are often unable to plan, procure, or prepare adequate, fresh, nutritionally balanced meals.

Take for example, an Iona client who is a 68 year old low-income individual with a debilitating, progressive neurological disorder. Initially, they were referred to me by their social worker because they lived alone with no help (they were on the wait list for Waiver services for a home health aide and other services). They looked haggard, weak, and underweight. Their dentition was really poor, and they had difficulty walking and very limited use of their hands. My client hadn't been able to wash their hair in three months, and they somehow managed a special kind of urinary catheter with a once a week visiting nurse. They had a very difficult time shopping for or preparing any food. It was even difficult for my client to feed themselves or get enough to drink to stay hydrated. Imagine their anxiety level and distress, just trying to survive each day in this weakened state. I wish this was an unusual situation or referral, but in Iona's work, it's common.

Such a simple, basic human need and right – to have sufficient good-quality food to eat in order to maintain health and a good quality of functioning and life. Yet, here is an older adult who is physically unable to do this for themselves. For this client and many other Waiver-eligible individuals like them, hunger and malnutrition is a health issue with very high personal costs – they were suffering daily and declining.

How did Iona step up to the plate to help this client? First, they were enrolled in DCOA's home delivered meals program, and received 10 fresh Mom's Meals delivered every two weeks. They also participated in our Weekend Meals program, receiving one hot and one cold meal delivered by our wonderful volunteers every Saturday. They received several cases of a high calorie/high protein Ensure Plus liquid nutrition supplements per month, courtesy of the DC Office on Aging nutrition supplement program and donations from the community. Their amazing social worker got them new dentures, and also took them regular deliveries from Iona's food pantry.

Putting an end to senior hunger and food insecurity in Washington, DC requires a coordinated effort by multiple stakeholders – please help us in our tireless efforts to set the table for our seniors. Please approve funding to add home delivered meals as a reimbursable service under the EPD Waiver for FY18.

Rose Clifford, RDN, MBA
Nutrition Program Manager

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MALNUTRITION: AN OLDER-ADULT CRISIS

$51.3 Billion
Estimated annual cost of disease-associated malnutrition in older adults in the US[1]

Up to 1 out of 2 older adults
are at risk for malnutrition[2,4]

Up to 60%
of hospitalized older adults may be malnourished[4]

300%
The increase in healthcare costs that can be attributed to poor nutritional status[5]

4 to 6 days
How long malnutrition increases length of hospital stays[3]

Chronic health conditions
lead to increased malnutrition risk

Malnutrition leads to more
complications, falls, and readmissions[6]

Just 3 steps can help improve older-adult malnutrition care

Screen
all patients

+

Assess
nutritional status

+

Intervene
with appropriate nutrition

Focusing on malnutrition in healthcare helps:

- ✓ Decrease healthcare costs[7]
- ✓ Improve patient outcomes[7]
- ✓ Reduce readmissions
- ✓ Support healthy aging
- ✓ Improve quality of healthcare

Support policies across the healthcare system that defeat older-adult malnutrition.

Learn more at www.DefeatMalnutrition.Today

References: 1. Snider JT, et al. *JPEN J Parenter Enteral Nutr.* 2014;38(2 Suppl):775-85S. 2. Kaiser MJ, et al. *J Am Geriatr Soc.* 2010;58(9):1734-1738. 3. Izawa S, et al. *Clin Nutr.* 2006;25(6):952-957. 4. Furman EF. *J Gerontol Nurs.* 2006;32(1):22-27. 5. Correia, et al. *Clin Nutr.* 2003;22(2):235-239. 6. Norman K, et al. *Clin Nutr.* 2008;27(1):5-15. 7. [illegible] et al. *Am J Manag Care.* 2013;19(2):121-128.

b.

Opportunities to Improve Nutrition for Older Adults and Reduce Risk of Poor Health Outcomes

Jane Tilly, DrPH

Administration for Community Living, Center for Policy and Evaluation

March, 2017

The views expressed in this paper are those of the author and not necessarily those of the Administration for Community Living or the U.S. Department of Health and Human Services.

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