Nutrition and Aging
Resource Center

Insights from State Units on Aging on Combating Malnutrition through OAA State Plans

August, 24, 2023

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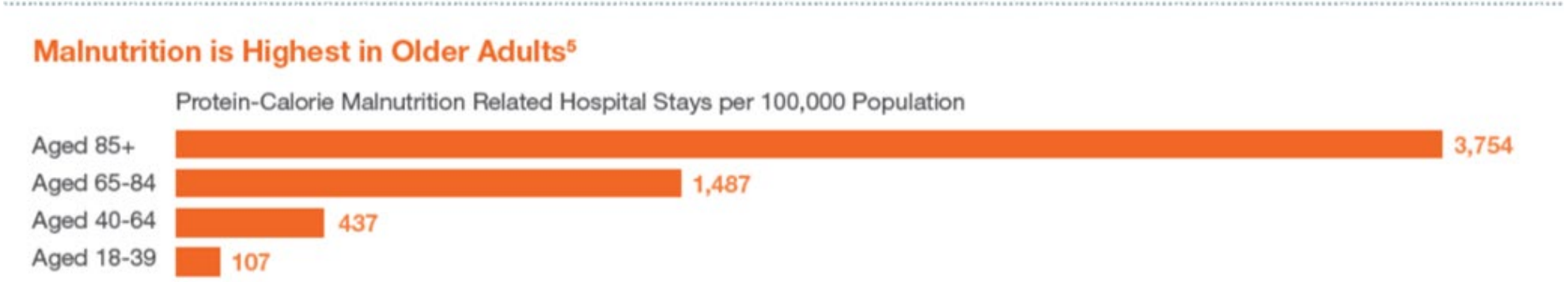
Agenda

- Background on Malnutrition and State Units on Aging (5 min)
- Malnutrition Learning Collaboration overview (5 min)
- Technical Experts share their approach (20 min)
- Learning Collaborative Members share their experience (20 min)
- Questions (10 min)

Malnutrition Is a Public Health Issue that Disproportionately affects older adults



The Malnutrition Quality Collaborative. National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update. Accessed August 9, 2023. https://defeatmalnutrition.today/blueprint

DEFEAT MALNUTRITION TODAY. THE NATIONAL BLUEPRINT: ACHIEVING QUALITY MALNUTRITION CARE FOR OLDER ADULTS, 2020 UPDATE.

Malnutrition impacts functionality and health

The Malnutrition Quality Collaborative. National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update. Accessed August 9, 2023. https://defeatmalnutrition.today/blueprint

Incidence of malnutrition and food insecurity in 2022 National Survey of Older Americans Act Participants

NSOAAP is an annual survey of older adults who participate in OAA programs and seeks to answer important questions: are OAA programs serving at-risk populations and how well are they doing it?

OAA Program	Screen positive malnutrition risk MST (>=2)	Screen positive Food insecurity risk
Homemaker	23%	23%
Case Management	22%	29%
Transportation	21%	19%
Home Delivered Meals	19%	29%
Congregate	17%	17%

Source: agid.acl.gov

NSOAAP Screening Questions

Malnutrition Screening Questions

- 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)
- Have you been eating poorly because of decreased appetite?
  - No (0)
  - Yes (1)

Food Insecurity Screening Questions

- In the last 12 months,
- How often was this statement true for your household: the food that we bought just didn’t last and we didn’t have money to get more?
- How often was this statement true for your household: we couldn't afford to eat balanced meals?
- Did you or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food? How often?
- Did you ever eat less than you felt you should because there wasn't enough money for food?
- Were you ever hungry but didn't eat because there wasn't enough money for food?

Older Americans Act Nutrition Programs and role in addressing malnutrition

Celebrate the Senior Nutrition Program

- Purpose of the OAA Nutrition Programs is to reduce hunger, food insecurity and malnutrition
  - Malnutrition was added in 2020 Update and programs may include malnutrition screening in OAA-funded programs
- OAA requires multi-year State Plans on Aging (SPAs)
- Baseline research of SPAs in 2020, before malnutrition was added to purpose, found 33% of plans mentioned malnutrition but only 8% as goals/objectives and 15% as strategies/actions
- Federal requirement to screen with DETERMINE Checklist
- Malnutrition screening authorized but not required

Resource: https://pubmed.ncbi.nlm.nih.gov/35963994/

The DETERMINE checklist-self assessment for participant nutritional intake

The warning signs of poor nutritional health are often overlooked. Use this checklist to find out if you or someone you know is at nutritional risk.

Determine Your Nutritional Health

Read the statements below. Circle the number in the yes column for those that apply to you or someone you know. For each yes answer, score the number in the box. Total your nutritional score.

	YES
I have an illness or condition that made me change the kind and /or amount of food I eat.	2
I eat fewer than two meals per day.	3
I eat few fruits or vegetables, or milk products.	2
I have three or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take three or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last six months.	2
I am not always physically able to shop, cook and/or feed myself.	2
TOTAL	

Total your nutritional score. If it's --

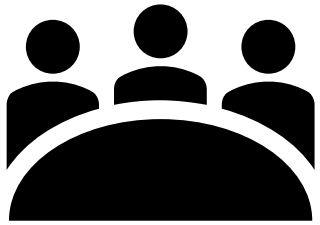
0-2 **Good!** Recheck your nutritional score in 6 months.

3-5 **You are at moderate nutritional risk.** See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in 3 months.

6 or more **You are at high nutritional risk.** Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

Remember that warning signs suggest risk, but do not represent diagnosis of any condition. Turn the page to learn more about the Warning Signs of poor nutritional health.

Source: Nutrition Screening Initiative



Malnutrition Learning Collaborative Including Malnutrition in State Plan on Aging

- Learning collaborative formed to assist SUAs in adding malnutrition language to their state plan and implementing malnutrition actions
- 9 states participated
  - 4 focused on writing malnutrition into their state plan
  - 5 focused on executing malnutrition plans
- 6 technical experts

Group 1-Plans due in 2023/24

Participants

- Maureen Brown, Bureau of Elderly and Adult Services, NH
- Amanda Stoess, KT Dept for Aging and Independent Living
- Kelly Wright, VA Department for Aging and Rehabilitative Services
- Aleatha Dickerson, RI Office of Healthy Aging
- Kristin Cox, State of AK Senior and Disability Services

Technical Experts

- Carmen Clutter, OH Department of Aging
- Mary Beals-Luedtka, NACOG AAA (AZ)
- Mary Beth Arensberg, Abbott Nutrition
- Adam Mosey, ADvancing States

Group 2-plans due after 2024

Participants

- Lesley Farmen, SD Department of Human Services
- Elizabeth Fridley, IA Department on Aging
- Julie Craigo, WV Bureau of Senior Services
- Johanna Schneider, Community Living, Aging and Protective Services/OK Human Services
- Sara Koenig, WI Bureau of Aging and Disability Resources
- Kristie Garner, IN Family & Social Services Administration Division of Aging

Technical Experts

- Shirley Chao, MA Executive Office of Elder Affairs
- Pam VanKampen, Greater WI Agency on Aging Resources
- Jaime Gahche, NIH
- Ryann Hill, SCAN Health Plan

Technical Experts Weigh in

Shirley Chao
Former Director of Nutrition, MA Executive Office of Elder Affairs
Principal, FoodPolicy Insights

Why Include Malnutrition in the State Plan

- Community malnutrition screening is important, malnutrition is preventable and treatable if identified early
- Malnutrition prevention and treatment in the community can help seniors reduce hospitalizations, promote wound healing, improve recovery and reduce readmissions.
- Reduce caregiver and health care cost burden.
- ***Screening is unethical unless those at risk will then be further assessed and treated***
- Assessment and treatment ***empower and enhance*** AAA's capacity building for food and nutrition services, and further generates revenue and other resources for the organization.

Important Steps to Include Malnutrition in the State Plan

There are many risk factors that cause Malnutrition in older adults: food insecurity, limited income; lack of services/access, food deserts, lack of medical tailored meals, oral health, etc.

- Identify the most needed/challenge areas in the state that can reduce malnutrition risk or raise malnutrition awareness
- Study the state geography, the cultural and ethnic diversity, and the number of AAAs; it makes difference if it is a single state AAA or multiple AAAs
- Weigh the SUA relationship with each AAA, and the working relationship with other state agencies including SNAP, public health or agriculture agencies.
- Assess the nutrition capacity of each AAA. Are they able to conduct nutrition assessment, counseling and intervention?

Buy-In

What Health Care Facilities (e.g., hospitals, ACOs) want from Community Nutrition Programs (AAAs)

Risk factors

1. Chronic health conditions
2. Malnutrition
3. Metabolic conditions, other - malnutrition, obesity
4. At risk for a nutritional deficiency or imbalance due to food insecurity

Goods and Services

1. Medically Tailored meals
2. Food boxes
3. Food vouchers
4. Intake, assessment, coordination, and nutrition counseling
5. Nutrition Referral Coordination & Education

Source: Housing, Transportation, And Food: How ACOs Seek To Improve Population Health By Addressing Nonmedical Needs Of Patients.2016
https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0727

Other Goods and Services AAA Can Offer Through Malnutrition Prevention/Treatment Programs

- **State/AAA level has RD** –
  - Nutrition standards for a healthy diet
  - Nutrition education, nutrition counseling
  - Malnutrition screening, nutrition assessment, documentation of malnutrition diagnosis, and development of a nutrition care plan.
- Technology
  - Computerized recipe and menu reporting
- Collaborate with other resources
- Medical nutrition therapy
  - Medicare advantage, Medicare MNT
- Medically tailored meals, grocery box prescription, Food is Medicine

MA Commission on Malnutrition Prevention Among Older Adults

Est. November 29, 2016

2018-2022

https://www.mass.gov/lists/commission-on-malnutrition-prevention-among-older-adults

Massachusetts Commission of Malnutrition Prevention for Older Adults

1. Consider strategies to improve **data collection and analysis** to identify malnutrition risk, health care cost data and protective factors for older adults;
2. **Assess the risk and measure the incidence of malnutrition** occurring in various settings across the continuum of care and the impact of care transitions;
3. **Identify evidence-based strategies that raise public awareness** of older adult malnutrition including, but not limited to, educational materials, social marketing, statewide campaigns and public health events;
4. **Identify evidence-based strategies, including community nutrition programs**, used to reduce the rate of malnutrition among older adults and reduce the rate of re-hospitalizations and health care acquired infections related to malnutrition;
5. Consider strategies to **maximize the dissemination** of proven, effective malnutrition prevention interventions, including community nutrition programs, medical nutrition therapy and oral nutrition supplements, and identify barriers to those interventions;

2018

- Baseline survey of 280 targeted long term care facilities on their use of malnutrition screening tools.
- Research to determine best methods for raising awareness

2019

- SUA added the Malnutrition Screening Tool (MST) to the Nutrition Intake Assessment for all new clients.
- OAA nutrition programs started CMS Medical Nutrition Therapy (MNT) pilot programs.
- The Commission introduced PatientPing, This technology can be used to identify patients/consumers with malnutrition or risk factors for malnutrition upon hospital discharge and allow for timely interventions. In 2019, 70 hospitals in Massachusetts (95%), 400 post-acute facilities, 30 provider groups, and some AAAs were a part of the PatientPing network. https://bamboohealth.com/

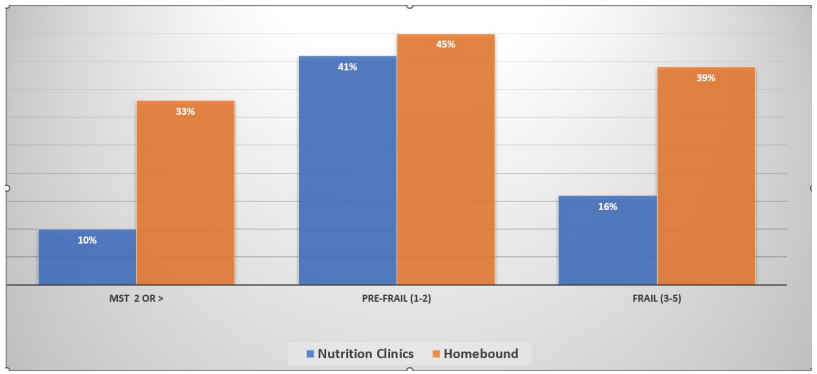
2019

Malnutrition week promoted during Older Americans Month (May 2019).

> "Whereas critical programs such as ***the Senior Nutrition Program, and the work of the Commission on Malnutrition Prevention Among Older Adults, are key to the Commonwealth's efforts to prevent malnutrition and improve the health, wellbeing and independence of older adults***." – Gov. Charlie Baker

Conduct Statewide Community Malnutrition Prevention clinics and screenings

- ***82 senior nutrition clinics held statewide;***
- ***3,000 participants and 1,000 were screened (200 homebound) were screened*** during ASPEN Malnutrition Week™
  - Screening tools : Malnutrition Screening Tool (MST)
  - FRAIL Scale score (Fatigue, Resistance, Ambulation, Illnesses,
  - Weight Loss)



- 10% of community living seniors, and 33% of home bound seniors at risk.
- Findings in line with literature on community-dwelling seniors
- Community homebound seniors at higher risk of malnutrition and frailty

2020-2021 (COVID-19)

True Challenge for Malnutrition Among Older Adults

In 2021, the Malnutrition Prevention Commission (MPC) continued to ***meet challenges*** exacerbated by the COVID-19 pandemic. At the same time, both the food insecurity rate and SNAP enrollment rate in Massachusetts were rising.

Many MPC member's agency participated in the Governor's ***Food Security Task Force (FSTF)*** to **incorporate the FSTF actions into the MPC work to raise the awareness of malnutrition among older adults.**

MPC recognized the adverse impact to older adults both physically and mentally and selected key areas and encouraged the membership organizations to maximize initiatives in those key areas

Community response to prevent malnutrition during COVID-19

- Reducing food insecurity
- Increasing socialization
- Promoting community nutrition services (OAA programs, farmer's market program, and other community nutrition programs)
- *Raising malnutrition prevention awareness*
- Promoting nutrition education and disease management

2020-2021

Raising malnutrition prevention awareness

1. ***#Doacovidcheck*** There were more than 15,000 followers on these postings
2. Statewide Food Assistance Decision Tree #Covid19MA -Need groceries or meals this week? You are not alone. Find the right program for you. Visit Mass.gov/FindFoodHelp ***#Covid19MA***
3. ***#BeaNutritionNeighbor*** -The campaign had 32 engaged groups who posted the campaign message over 100 times, resulting in close to 110,000 impressions

2022

MPC participation:

- White House Conference on Hunger, Nutrition and Health
- CMS the Global Malnutrition Composite Score (GMCS)
- Food is Medicine Inventory Advisory Panel

Statewide survey demonstrates encouraging results

Promote Food Security

- Over 1/3 of home delivered meal respondents reported they would have a shortage of food in the house if it were not for the program.
- 69% of home delivered meal respondents reported it is their main meal of the day.

Promote Quality of Life

- 81% of home delivered meal recipients reported that the meals help them to live independently.
- 80% of respondents receive at least one daily meal, some of them receive three meals a day plus weekend meals.
- Sixty-one of the participants who completed surveys were 100-yearsold or older.

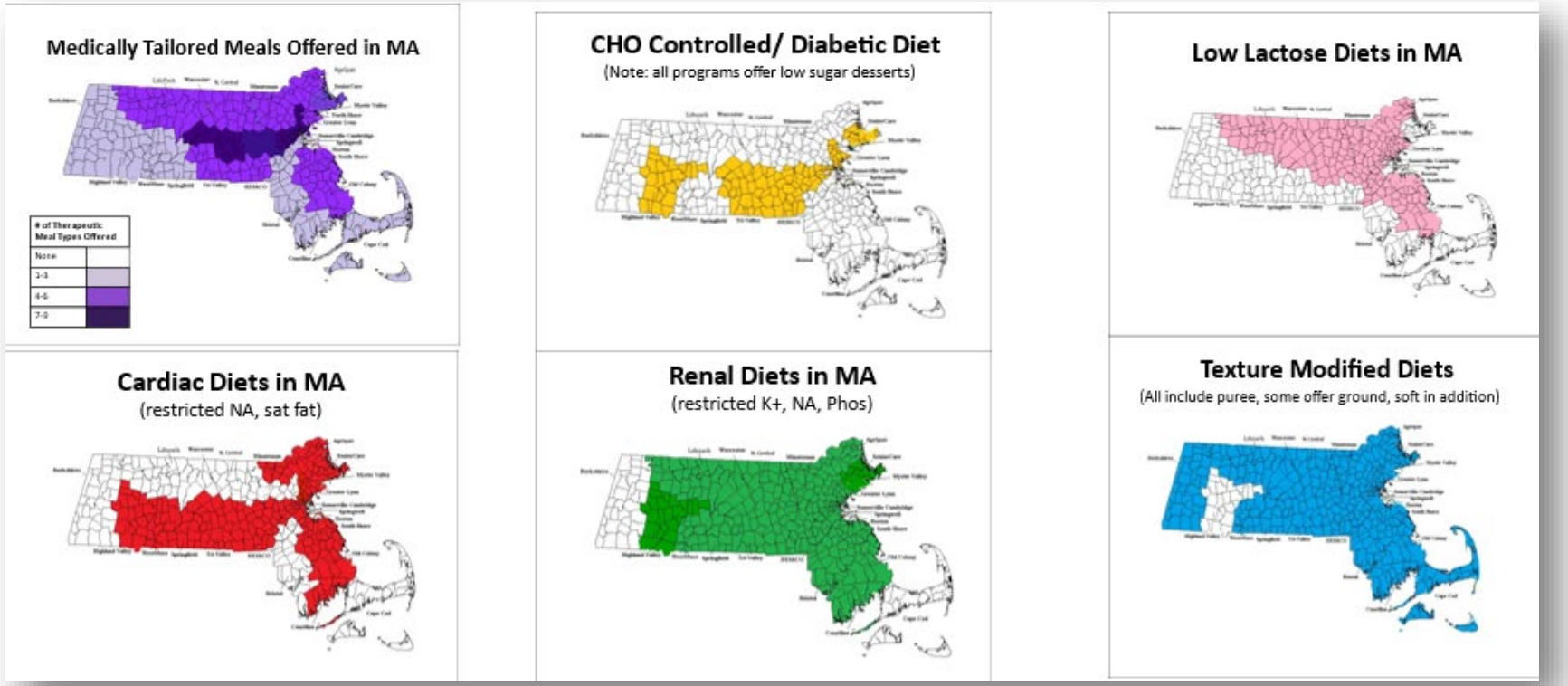
2022

Promotes Nutritional Health and Wellness

- 90% reported eating healthier, 81% maintained weight and improved health,
- 50% of the respondents successfully maintained their blood pressure and blood sugar levels.

Medical Tailored Meals (Food as Medicine)

- While all meals meet nutrition standards, *96%* of the programs also offer medically tailored meals (e.g., cardiac, renal, diabetic).



Chao 2022

OHIO'S 2023-2026 STATE PLAN ON AGING

CARMEN CLUTTER, MS, RDN, LD

Chief | Elder Connections Division

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Ohio Department of Aging

Department of Aging

MALNUTRITION PREVENTION COMMISSION REPORT

Key Findings

- The **Population** in Ohio is **Shifting**
- The **Risk** for Malnutrition is **High**
- Malnutrition is **Costly**

Recommendations

- Education and Awareness
- Data and Evaluation
- Prevention Models: Team-Based Care

2023-2026 STATE PLAN ON AGING

Comprehensive roadmap to **advance elder justice and equity** and **achieve optimal health and well-being** for older Ohioans

Ohio Department of Aging

ACHIEVING THE GOAL AND VISION

The State Plan on Aging lays a foundation to ensure that all partners in the aging network are rowing in the same direction to improve the health and well-being of older Ohioans.

Figure 1. **Multi-Sector Partnerships to Achieve the State Plan Goal and Vision**

Ohio Department of Aging

2023-2026 State Plan on Aging Framework

VISION | Ohio is the best place to age in the nation.

GOAL | All Ohioans live longer, healthier lives with dignity and autonomy, and disparities and inequities are eliminated.

Ohio's 2023-2026 State Plan on Aging Priorities

Community Conditions	Social Connectedness
Healthy Living	Population Health
Access to Care	Preserving Independence

PRINCIPLES | Elder Justice | Equity | Federal Priorities

Ohio Department of Aging

Overarching Goal

2023-2026 State Plan on Aging

All Ohioans live longer, healthier lives with dignity and autonomy, and disparities and inequities are eliminated.

Outcome 1: Increase Life Expectancy	
Objective 1.1	Increase the average life expectancy for all Ohioans at birth from 76.5 years (2017) to 77.6 years (2029). (Data source: ODH)
Outcome 2: Reduce Premature Death	
Objective 2.1	Reduce the years of potential life lost before age 75, per 100,000 population, from 8,227 years (2018) to 8,000 years (2029). (Data source: ODH)
Outcome 3: Improve Health Status	
Objective 3.1	Reduce the percent of adults, age 65 and older, with fair or poor health from 26.1% (2018) to 23.7% (2029). (Data source: Behavioral Risk Factor Surveillance System [BRFSS])
Outcome 4: Reduce Elder Abuse, Neglect, and Exploitation	
Objective 4.1	Reduce the number of reports of elder abuse, neglect, or exploitation for adults, age 60 and older, living in the community from 32,072 reports (2020) (monitor only; target not set at this time). (Data source: ODJFS)

Strategy Categories

Healthy Living

Outcome	Strategy Categories
Improve Nutrition	• SNAP enrollment • Community-based healthy food access (=) • Retail-based supports and incentives (=) • Healthy eating incentives (=) • Workplace supports • Disease management (=) • Malnutrition prevention and treatments (=)
Improve Physical Activity	• Community fitness (=) • Transportation and land use • Physical activity programs • Workplace supports • Home modifications • Disease management

Note: The strategy categories labeled with this symbol **(=)** include strategies that are likely to reduce disparities and inequities based on research

Specific policies, programs, and services within each strategy category are listed in **Attachment E**

ATTACHMENT E: DETAILED STRATEGY TABLES

Malnutrition prevention and treatments Across strategies, meals should be adjusted for cultural considerations and preferences and medically tailored to the maximum extent practicable	• Community gardens **SHIP** • Mobile produce markets **(=)** Expand access to nutrition services, such as SNAP, Comm… Supplemental Food Program*, The Emergency Food Assistance Program*, and The Ch… Adult Care Food Program* • Nutrition service programs for older adults, including congregate, grab-and-go (pick… home-delivered meals • Expand nutrition education through the Supplemental Nutrition Education Program … Education (SNAP-Ed)* and The Abbott Nutrition and Health Institute* • Increase malnutrition screening, assessment, diagnosis, intervention, and monitorin… evaluation , such as nutrition counseling*, medical nutrition therapy*, and emphasizi… nutrition in care coordination* • Improve discharge planning for malnourished patients, such as Meals on Wheels* • Stepping Up Your Nutrition (SUYN)

Additional Resources

ATTACHMENT E
Detailed Strategy Tables

Healthy Living

The table on the following page list specific strategies to advance the goal and achieve the objectives of the Healthy Living goal of the State Plan.

Strategies to Improve Nutrition

Strategies	Examples Include
Supplemental Nutrition Assistance Program (SNAP) enrollment	• Strengthened outreach and advocacy to maintain or increase enrollment in federal food assistance programs, such as (SNAP) SHIP • Streamline the SNAP application and certification process through the Elderly Simplified Application Project (ESAP)
Community-based healthy food access	• Healthy food initiatives in food pantries and banks (=) SHIP • Fruit and Vegetable Gleaning Initiatives (=) • Cultivate Safety Net Services • Adult Day Services (ADS)*
Retail-based supports and incentives	• Farmers' markets SHIP • Electronic Benefit Transfer (EBT) payment at farmers' markets* (=) SHIP • WIC & Senior Farmers' Market Nutrition Programs (=) SHIP • Healthy food in convenience stores (Ohio example: Good Food Here Program) (=) SHIP • Incentives to bring healthy food retailers to underserved communities, such as the Healthy Food Financing Initiative*
Healthy eating incentives	• Fruit & vegetable incentive programs (=) (Ohio example: Produce Perks) SHIP • Point-of-purchase prompts for healthy foods SHIP • Competitive pricing for healthy foods SHIP
Workplace supports	• Worksite obesity prevention programs SHIP • Workplace Chronic Disease Self-Management Program • Financial rewards for employee healthy behavior
Disease management	• Combined diet and physical activity promotion programs to prevent Type 2 Diabetes among people at increased risk (such as the National Diabetes Prevention Program) SHIP • Disease management / health promotion programs to prevent or manage chronic health conditions, such as CDC Diabetes Prevention Program (DPP), Chronic Disease Self-Management Program (CDSMP), and Diabetes Self-Management Program (DSMP). • Multi-component obesity prevention interventions SHIP • Eat Smart, Move More, Weigh Less, virtual classes teaching evidence-based strategies for weight loss and maintenance • Nutrition prescriptions* (=) SHIP • Food insecurity screening and referral* SHIP • SNAP Education
Malnutrition prevention and treatments Across strategies, meals should be adjusted for cultural considerations and preferences and medically tailored to the maximum extent practicable	• Community gardens SHIP • Mobile produce markets (=) Expand access to nutrition services, such as SNAP, Commodity Supplemental Food Program*, The Emergency Food Assistance Program*, and The Child and Adult Care Food Program* • Nutrition service programs for older adults, including congregate, grab-and-go (pick-up) and home-delivered meals • Expand nutrition education through the Supplemental Nutrition Education Program – Education (SNAP-Ed)* and The Abbott Nutrition and Health Institute* • Increase malnutrition screening, assessment, diagnosis, intervention, and monitoring/ evaluation , such as nutrition counseling*, medical nutrition therapy*, and emphasizing nutrition in care coordination* • Improve discharge planning for malnourished patients, such as Meals on Wheels* • Stepping Up Your Nutrition (SUYN)

Additional Resources

- Combating Food Insecurity: Tools for Helping Older Adults Access SNAP, AARP and Food Research and Action Center, FRAC
- Creating Healthy Communities, ODH
- Dietary Guidelines for Americans 2020-2025, The Departments of Agriculture, HHS
- Food Assistance for Older Adults, National Council on Aging (NCOA)
- Malnutrition Prevention Commission Report, ODH
- Meals on Wheels reports and other information, Meals on Wheels
- Nutrition and Aging Resource Center, ACL
- Ohio Food and Beverage Guidelines Toolkit, ODH
- Senior Nutrition Guide, Feeding America
- The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables, CDC

(=) = Likely to reduce disparities, based on review by WWFH, or health equity strategy in Community Guide

SHIP = Included in 2020-2022 State Health Improvement Plan

*Strategy is rated as "expert opinion" in WWFH, or evidence of effectiveness is emerging

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ATTACHMENT F: DETAILED OBJECTIVE TABLES

Improve Nutrition

Indicator #1 (source)	Baseline (2019)	Progress (2020)	Short-term target (2023)	Intermedi target (2026)
Unintentional weight loss Percent of Ohioans age 65 and older who recently lost weight without trying (Behavioral Risk Factor Surveillance System) [BRFSS]	12.7%	12%	11.6%	10.6%

Healthy Living

Improve Nutrition

Indicator #1 (source)	Baseline (2019)	Progress (2020)	Short-term target (2023)	Intermediate target (2026)	Long-term target (2029)
Unintentional weight loss Percent of Ohioans age 65 and older who recently lost weight without trying (Behavioral Risk Factor Surveillance System) [BRFSS]	12.7%	12%	11.6%	10.6%	9.5%
Older adult priority populations based on data					
This indicator does not allow for disaggregation of data. Feedback from expert stakeholders was utilized to identify priority populations. Ohio can work toward improved data collection in this area with special attention toward collecting data to identify priority populations.					

Indicator #2 (source)	Baseline (2017)	Progress (2019)	Short-term target (2023)	Intermediate target (2026)	Long-term target (2029)
Fruit consumption Percent of Ohioans age 65 and older who consume fruit(s) one or more times per day (BRFSS)	66.4%	63.8%	66.8%	67.2%	67.6%
Older adult priority populations based on data					
Other race	59.9%	72.2%	62.5%	65%	67.6%
People with a high school education or less	61.7%*	59.9%*	63%	65.3%	67.6%
People with annual household incomes below $15,000	58.5%	51.7%	61.5%	64.6%	67.6%
Males	61.9%	61.0%	63.8%	65.7%	67.6%

Indicator #3 (source)	Baseline (2017)	Progress (2019)	Short-term target (2023)	Intermediate target (2026)	Long-term target (2029)
Vegetable consumption Percent of Ohioans age 65 and older who consume vegetables one or more times per day (BRFSS)	82.9%	79.9%	83.3%	83.7%	84.1%
Older adult priority populations based on data					
Black, non-Hispanic	78.8%	71.30%	80.6%	82.3%	84.1%
People with a high school education or less	80.1%**	77.4%**	81.4%	82.8%	84.1%
People with annual household incomes below $25,000	76.4%***	73.4%***	79%	81.5%	84.1%
Males	81.2%	76.6%	82.2%	83.1%	84.1%

Call to Action

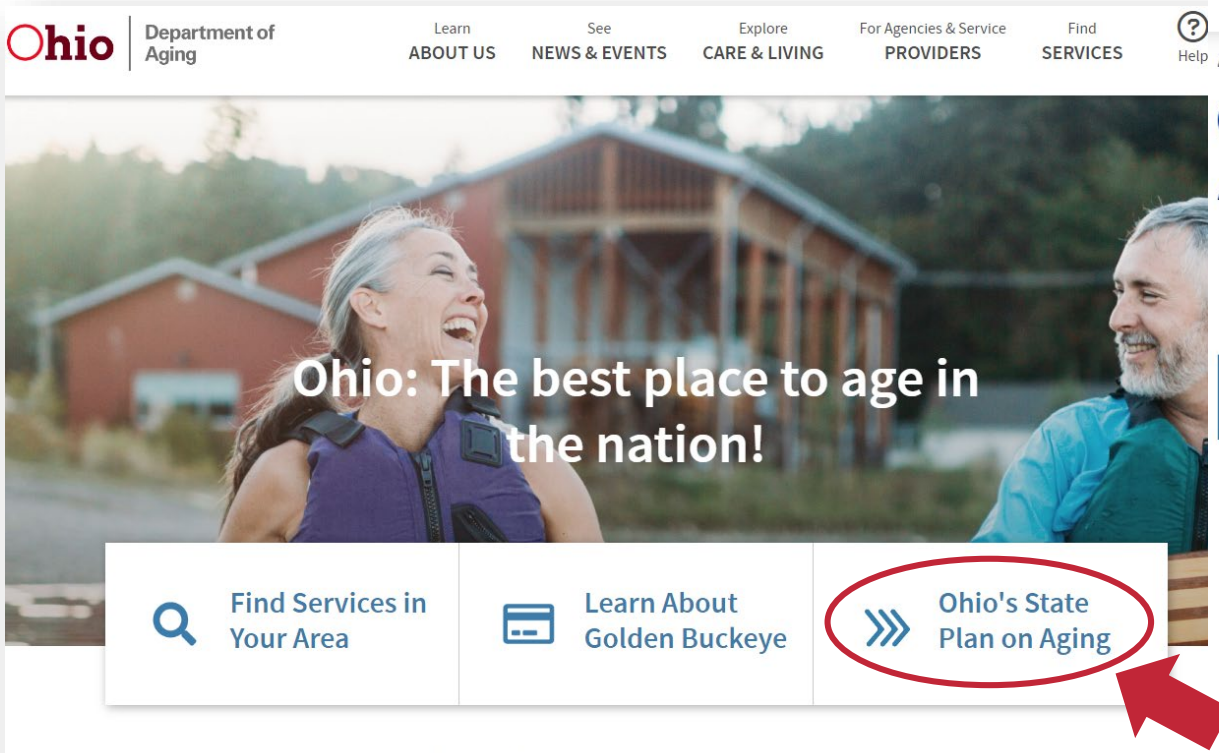
6 Action Steps to Achieve Ohio's Vision and Goals

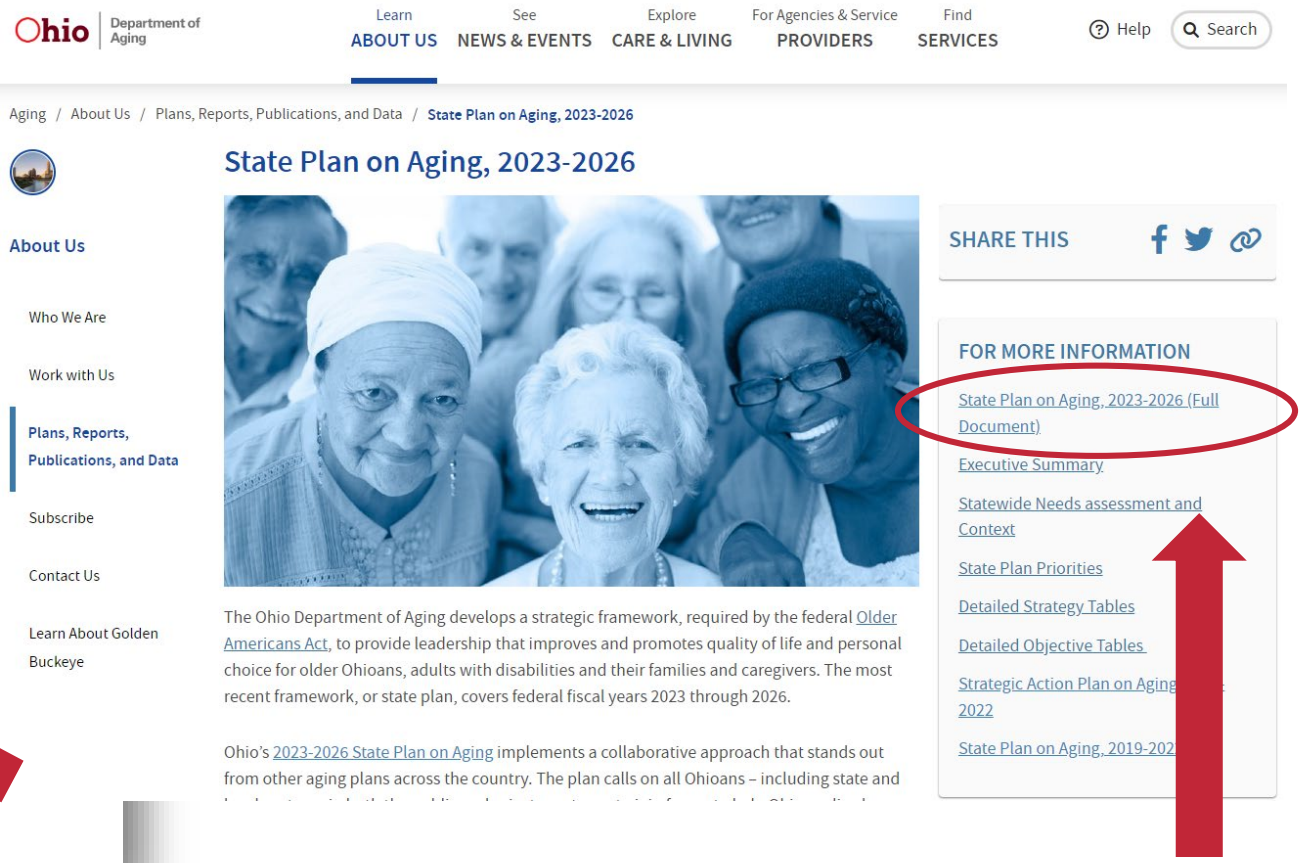
ALIGN	Align with and focus on one or more of the goals, outcomes, and/or priority populations identified in the State Plan.
ADVOCATE	Advocate for funding and policy change to address the State Plan priorities.
FUND	Fund evidence-informed strategies identified in Attachment E of the State Plan.
IMPLEMENT	Implement one or more of the evidence-informed strategies identified.
PARTNER	Partner and collaborate within and across sectors to improve the State Plan outcomes.
EVALUATE	Evaluate progress on the State Plan objectives and the impact of the evidence-informed strategies.

IMPLEMENTATION TOOLKIT

The Toolkit provides **guidance, best practices, tools,** and **resources** that state and local partners can use to **ACT**.

2023-2026 STATE PLAN ON AGING





Department of Aging

Malnutrition Learning Collaborative Participants Weigh in

Elizabeth Fridley

Health Promotion Director

Iowa Department of Health and Human Services

Division of Aging and Disability Services

IOWA HHS

Approach

- Review state plans than have already included malnutrition
- Look at current state plan's goals and objectives to find where malnutrition might naturally fit
  - Example: "Improve the reach of nutrition education and counseling to older Iowans at high nutrition risk or at risk of malnutrition"
  - Current plan runs 2022-2025, planning for 2026 plan
- Connect with technical experts
  - Utilize shared resources as a starting point
  - Toolkit

Strategies

- Discuss malnutrition with AAA nutrition and health promotion directors
  - Defined malnutrition
  - Reviewed differences between nutrition risk and malnutrition
  - Shared estimated cost of malnutrition using Defeat Malnutrition Today infographics
  - Reviewed validated screening tools for malnutrition
  - Identified where AAAs are already screening for malnutrition
  - Discussed interventions and referrals to address malnutrition and malnutrition risk factors
- Identified opportunities to pilot malnutrition screening
- Worked with database administrator to get the Malnutrition Screening Tool (MST) added in Wellsky for optional use
- Ongoing meetings with the planning and performance evaluation team to create a malnutrition dashboard

Challenges

- Developing comprehensive intervention and referral pathways to utilize in response to a consumer screening positive for malnutrition
- Finding ways to measure and capture the impact OAA services have on malnutrition and malnutrition risk factors

Maureen Brown, RDN
Nutrition Consultant
Bureau of Elderly and Adult Services
New Hampshire Department of Health and Human Services

Approach for SPOA 2024-2027 with submission deadline of June 30, 2023

Background: What informed our approach ?

What we learned during PHE

- Need for continuation of grab-n-go meals post PHE
- Need to respond to changes in service method needs/preferences → Restaurant Voucher Program (RVP) initiated
- ↓ Trends in participation in CSFP and enrollment of SNAP eligible participants-ongoing post PHE
  - Recent data: revealed start of a slight but first upward trend in SNAP participation –awaiting specifics on OAs
- Under-representation of older adults in programs/coalitions/advocacy groups
- Need for age-specific nutrition & health-related data inclusive of older adults

Asking, What was already happening in NH?

- **New Hampshire Hospital Association's Healthcare (NHHA)priorities include**
  - Implementation of Food Insecurity screening in hospitals and primary care settings
- **NH Hospital (NHH) state psychiatric hospital SFY 2024 strategic plan development was underway**
- **Continuance of NH inter-departmental Food Insecurity Work Group (started during PHE)**
- **Presence and growing number of stakeholder groups focused on food access/ending hunger/nutrition health equity and advocacy**

Approaches - general

1. Gather information regarding current state plans that contained malnutrition or those that were planning to
2. Reviewed state plans that contained malnutrition
3. Seek support of technical experts in the field of nutrition, advocacy, and data collection
4. Ongoing education and advocacy for nutritional health of OAs

Strategies - general

1. Utilize listserve to connect with states whose plans contained malnutrition or were in process of adding malnutrition
2. Compare NH state plan for similarities in structure and content to facilitate updates
3. MLC participant
   DPHS (data)
   NH Center for Justice & equity (data & advocacy)
   NH Hunger Solutions (data & advocacy)
4. Continue and expand active representation of OAs in statewide/local food and nutrition work groups to advocate and inform re: needs of OAs; as well as receive input and support for OAs.

Strategies - specific	Challenges/Outcomes
1. Achieve uninterrupted continuation of grab-n-go post PHE 2. Maintenance and expansion of RVP to meet ongoing needs/ preferences of participants & staffing challenges of programs 3. Promote greater awareness of need and understanding of food and nutrition services for OAs	1. Adopt Administrative Rule (TIII) prior to end of PHE - achieved 2. Survey: 65% of participants are new to program; reconnecting w/neighbors, friends and churches; joining other community activities 3. Sustain collaboration w/state & local food programs and work & advocacy groups to expand awareness and participation in nutrition programs

Strategies - specific (continued)

1. Educate and Inform research and data collection for better representation of OAs

2. Establish evaluation methods to show effectiveness of Grab-n-Go and RVP in: maintaining and expanding participation; and reducing risk of food insecurity and malnutrition

Challenges/Outcomes (continued)

1. Initiate review of SPR data collection; Work with NHHA, DPHS, BFA, and other data collection sources for inclusion

2. In process – demonstrating effectiveness of expanding participation is proving doable, however challenge will be demonstration of the latter

Strategies - specific (continued)	Challenges/Outcomes (continued)
1. Leverage opportunities to expand participation in pilot: create and implement Universal screening, intervention, and referral process to reduce food insecurity and malnutrition risk in OAs	1. Maintain active participation (in pilot) of NHH Food & Nutrition Services, Adult Protective Services case workers, and contracted nutrition program staff; Foster ongoing relationship with research and data collection/ outcomes of the NHAH; Developing new partnerships; Consistent tracking of interventions and outcomes/impact.

Resources

- Nutrition and Aging Resource Center- Malnutrition Page
  - https://acl.gov/senior-nutrition/food-insecurity-malnutrition
- State Plans on Aging
  - http://www.advancingstates.org/initiatives/aging-policy-and-programs/map-state-plans-aging
- ACL Guide to Prioritizing Participants with DETERMINE
  - https://acl.gov/sites/default/files/programs/2020-12/SNPGuidetoPrioritizingClients.pdf

How to Self Register CPE for RDNs

- A RD/DTR can earn 1 CPE credit for this program under CPE Activity Type 170 – Lectures/Seminars or Type 171 - Teleseminars/Webinars
  - **Only available for the live presentation**
  - Can use the agenda or request certificate of completion
- Helpful Resource: https://secure.eatright.org/CGI-BIN/lansaweb?wam=LOGFAQ2&webrtn=entrywr&ml=LANSA:XHTML&part=PRD&lang=ENG#175a

Thank you

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Nutrition and Aging Resource Center

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