NEW YORK STATE OFFICE FOR THE AGING

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George E. Pataki, Governor Walter G. Hoefer, Director

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PROGRAM INSTRUCTION **Number: 98-PI-25**

DATE: October 9, 1998

TO: Area Agencies on Aging Directors

SUBJECT: Guidelines for Conducting Short Term Home Delivered Meal Assessments

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PURPOSE: The purposes of this Program Instruction are to: transmit the subset of Minimum Data Set (MDS) questions (Attachment A) that must be asked as part of an assessment for short term Home Delivered Meals (HDMs); provide a tool (Attachment B) which can be used to conduct short term assessments; specify the guidelines that apply; and discuss the results of the questionnaire attached to 98-IM-38, Short Term Home Delivered Meal Assessments.

Area agencies have the option to use a shorter set of questions than the complete MDS to assess individuals seeking short term HDMs. In deciding if such a process will be implemented, this PI, including the requirements associated with the short term HDM option should be reviewed.

BACKGROUND: Recognizing the inherent differences between short term HDMs and other community based long term care services and in exploring ways to relieve AAAs of undue administrative effort related to performing comprehensive assessments, this Office drafted a minimum set of information to target and turn on short term HDM service while ensuring that the needs of the clients are met appropriately. This set of information was field tested by four AAAs in the fall of 1997. Subsequently, the set of information was sent to all the AAAs as part of 98-IM-38 for review and comment.

Questionnaire Responses

Twenty-nine AAAs responded to the IM. The AAAs were divided in their opinions regarding the assessment questions. Some expressed strong views that a full evaluation was essential to providing all clients with appropriate services, while others felt that the shorter set of questions was not short enough. Among AAAs who reported having experience with a briefer assessment for short term HDM assessments, few had available data on the length of time the short term clients actually remained on the program. Those reporting such data indicated that only one-third or fewer of those seeking short term meals terminated within the expected time. Therefore, we were not able to identify reliable criteria through this process to predict who will be a short term client.

The following is a brief summary of the AAA responses regarding short term HDM assessments:

Total number responding - 29

Number wanting fewer questions than the entire MDS to assess people needing short term meals - 16

Number indicating that based on their experience, the ideal period to define as short term is:

- o up to 15 calendar days -- 2
- o up to 30 calendar days -- 6
- o up to 45 calendar days -- 3
- o up to 60 calendar days -- 7
- o up to 90 calendar days -- 1
- o six to 8 weeks -- 1

Note: Of the respondents that specified an ideal short term period, the median response was 45 days.

Number indicating experience with a short term meal component - 13

Number indicating experience with a short term meal assessment having fewer questions than assessments for other individuals seeking HDMs - 4

Note: One additional AAA is currently conducting a short term pilot using a set of fewer questions.

Number indicating experience with a short term meal component which had available data on length of client participation - 4

Percent of time the above 4 AAAs reported client seeking short term meals who then terminated within the expected period of time:

- 3 AAAs reported that clients terminated as expected 10% of the time.
- 1 AAA said the clients terminated as expected 33-1/3% of the time.

Note: Only two of the above programs continue to have a short term component; both use the same assessment tool for all clients seeking HDMs.

Discussion

Face-to-Face Visits

While this Office has not specified criteria for identifying short term home delivered meal clients (aside from self-identification), it is clear that most area agencies which have such criteria expect the majority of the clients to be recovering from an acute health episode, most likely coming from a hospital or nursing home rehabilitation program.

Information from the Nutrition Screening Initiative about the prevalence of high nutritional risk suggests that perhaps as many as 50% of elderly hospital patients and 40% of nursing home residents are malnourished. We believe that such a potentially vulnerable population should be accorded the benefit of having the individual's appearance and environment observed by a trained assessor . After weighing this information and the comments of respondents, it was determined that phone interviews should not be substituted for a face-to-face visit.

Timing for Assessments

Please note that individuals seeking any community based long term care services should be assessed prior to having services initiated. However, in recognizing that emergencies exist which require the immediate provision of services the Nutrition Standards provide the flexibility to conduct HDM assessments within ten days of starting service. AAAs should not routinely enroll individuals prior to assessments.

Required Questions

The set of required information in Attachment A reflects, to the extent feasible, the comments of respondents. Nine AAAs cited questions they believed to be unnecessary or particularly difficult to ask prospective short term clients. There was little consensus among the AAAs as to which questions should not be asked, except

for income, which was identified by all nine of the AAAs. Income has been deleted from the required set of questions. Also omitted is the client's night phone number, which is not included in the MDS.

Four AAAs said that information about ADL and IADL impairments were not needed; however the specific ADL and IADLs which are listed are related to HDM eligibility and/or service issues, e.g., eating. This information is retained.

Five AAAs said some additional questions need to be asked. One question which generally addresses the suggestions was added: "Are there any other services you need?" Of course, AAAs may add any additional questions to the assessments that they wish, including the complete MDS.

Tracking Length of Participation

Based on the information provided by the pilot test and comments of AAAs which have implemented a short term component, **tracking the length of client participation is critical**. For effectiveness and efficiency, AAAs will want to know if they are successfully predicting short term participation since clients who turn out to need services for a longer period will have to be reassessed using the full MDS. We will continue to follow individual AAA's efforts to implement short term components to learn more from their experiences.

ACTION REQUESTED: Area agencies electing to implement a short term HDM component must adhere to the following guidelines:

For the purpose of conducting short term HDM assessments, **short term is defined as a period of up to 45 calendar days**. Individuals requesting meals for a period of time up to 45 days, or individuals for whom referral sources request such meals, may be considered short term clients.

<u>Guidelines specific to conducting short term HDM assessments</u>

AAAs implementing a short term HDM component must meet the following guidelines:

1. Assessments for short term meals must be conducted face-to-face with the person prior to initiating service. In the event of an emergency (e.g., referral from a hospital) meals may begin prior to the assessment, with the assessment completed within ten days.

2. The assessment information should include, at a minimum, the set of questions listed in Attachment A of this PI. (Attachment B provides a tool which incorporates all of the questions.)

3. The assessor must possess the same qualifications as other staff who perform assessments for community based long term care services.

4. Follow-up contact with the client is required within five calendar days of service initiation regardless of when the assessment is done to check the adequacy of services. Similarly, before short term HDM service is terminated because the arranged time period is expiring, client contact must be made to alert/remind the client of the termination of the HDMs. This contact must be recorded in the client's record.

5. If there continues to be a need for meals beyond 45 days, a comprehensive in-home assessment meeting the full MDS must be completed.

PROGRAMS AFFECTED:	[] Title III-B	[] Title III-C-1	[x] Title III-C-2
[] Title III-D	[] Title III-F	[x] CSE	[x] SNAP	[] Energy
[] EISEP	[] Cash-in-Lieu	[] Title V	[] HIICAP	[] LTCOP
[] Other:			

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Attachment "A"
September, 1998

MINIMUM DATA ELEMENTS REQUIRED FOR SHORT-TERM HOME DELIVERED MEALS CLIENT ASSESSMENTS

I. INTAKE INFORMATION

A. Date of Referral
B. Referral Source (Specify Name, Agency, Phone)
C. Presenting Problem/Person's Concern(s)
D. Estimated length of time home delivered meals are needed: ___days.

II. CASE IDENTIFICATION

A.Client Case #
B.Assessment Date
C.Assessor Name
D.Assessment Agency

III. CLIENT INFORMATION

A. Person's Name
B. Address (including zip code)
C. Telephone No.
D. Birth Date
E. Race/Ethnicity: American Indian/Native Alaskan; Black Non-Hispanic; White, Non-Minority; Asian/Pacific Islander; Hispanic
F. Living Arrangement: Alone; With Spouse; With Relatives; With Non-Relative(s)
G. Emergency Contact: Name; Address; Relationship; Phone (Home/Work)

IV. HEALTH STATUS

A. Primary Physician; Clinic/HMO; Hospital; Other
B. Does the person have a self-declared chronic illness and/or disability: Alzheimers, anorexia, arthritis, cancer, colitis, colostomy, congestive heart failure, constipation, dehydration, dental problems, diabetes, diarrhea, digestive problems, diverticulitis, fractures(recent), gall bladder disease, hearing impairment, heart disease, hiatal hernia, high blood pressure, hypoglycemia, liver disease, low blood pressure, osteoporosis, Parkinson's, renal disease, respiratory problems, smelling impairment, speech problems, stroke, swallowing difficulties, taste impairment, ulcer, urinary tract infection, visual impairment, other(Specify)
C. Hospitalizations in the last 6 months; reason and date(s)

V. NUTRITION

A. Person's height
B. Person's weight
C. Body Mass Index
D. Are the person's refrigerator/freezer and cooking facilities adequate?
E. Is the person able to open containers/cartons and cut up food?
F. Does the person have a physician-diagnosed food allergy? Describe.
G. Does the person use nutritional supplements? Specify who prescribed and describe the supplements.
H. Does the person have a physician prescribed modified/ therapeutic diet? If yes, indicate what the diet is.

I. Nutritional Risk Status
1. Person has an illness or condition that changes the kind and/or amount of food eaten Y(2)/N
2. Eats fewer than 2 meals/day Y(3)/N
3. Eats fewer than 2 daily servings of each of the following food groups: Fruits, Vegetables, Milk Products Y(2)/N
4. Has three or more drinks of beer, liquor or wine almost every day Y(2)/N
5. Has tooth or mouth problems that make it hard to eat Y(2)/N
6. Does not always have enough money to buy food needed Y(4)/N
7. Eats alone most of the time Y(1)/N
8. Takes three or more prescribed or over-the-counter drugs/ day Y(1)/N
9. Without wanting to, lost or gained 10 pounds in the past six months Y(2)/N
10. Not always physically able to shop, cook and/or feed self Y(2)/N
Score by adding the numbers of those factors that were answered Y. A score of 6 or more indicates "High" nutritional risk, 3-5 indicates "Moderate" nutritional risk and 2 or less indicates "low" nutritional risk.

VI. PRESCRIBED AND OVER THE COUNTER MEDICATIONS CURRENTLY TAKEN;

Name; Dose/Frequency; Reason Taken

VII. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs) STATUS/UNMET NEED

Status must be noted: Totally Able, Needs Some Assistance, Unwilling to Perform.
A. Shopping Y/N
B. Prepare and Cook Meals Y/N

VIII. ACTIVITIES OF DAILY LIVING (ADLs) STATUS/UNMET NEED

Status must be noted: Totally Able, Needs Some Assistance, Unwilling to Perform.
A. Mobility Y/N
B. Eating Y/N

IX. INFORMAL SUPPORT STATUS

A. Does the person have family, friends and/or neighbors who help or could help with care? Identify primary and secondary informal supports. Name; Address; Relationship; Phone No.; Involvement: (Type of help/frequency)

X. CARE PLAN

Staff Preparing; Date
Person's Name; Person's Phone; Address

A. Is the person self directing/able to direct care?
B. Goals; Care Plan Objectives; Proposed Time Frame
C. What are the person's preferences regarding type of diet and/or services?
D. Are there any other services the person needs (beyond HDMs?)
E. Types of services to be provided; Frequency; Start Date; Projected End Date; Formal Informal/Provider
F. Referred to;
G. Information/special instructions that have direct bearing on implementation of the care plan:
H. Has the person been placed on waiting list for any service need? If Yes, list.
I. Plan has been discussed and accepted by client and/or informal supports?
J. Signature and Title of individual approving plan; date; phone

IX. SERVICE/CARE PLAN TERMINATION

A. What is being terminated? Service(s); Care Plan
B. Termination Date
C. Reason for termination: Goal Met; Independence; Client Request; Client Relocated; Hospitalization; Nursing Home; Death; Other
D. Service or Care Plan Related Client Outcome(s) Statements
E. Signature and Title of staff; Date; Phone

Attachment "B"
September, 1998

ASSESSMENT FOR SHORT-TERM HOME DELIVERED MEALS CLIENTS

The client information contained in this assessment instrument is confidential and may be shared with others only as necessary to implement the client's care plan and comply with program requirements, including but not limited to, monitoring, research and evaluation.

INTAKE INFORMATION

A. Date of Referral:_____

B. Referral Source (Specify Name, Agency, Phone):_____

_____

C. Presenting Problem/Person's Concern(s):_____

_____

D. Estimated length of time home delivered meals are needed: ___days.

CASE IDENTIFICATION

Client Case #: _____

Assessment Date:_____

Assessor Name: _____

Assessment Agency:_____

I. CLIENT INFORMATION

A. Person's Name :_____

B. Address (including zip code):_____

_____

C. Telephone No:_____

D. Birth Date: _____

E. Race/Ethnicity (Check one): ☐ American Indian/Native Alaskan; ☐ Black Non-Hispanic; ☐ White, Non-Minority; ☐ Asian/Pacific Islander; ☐ Hispanic

F. Living Arrangement: (Check all that apply)
☐ Alone ☐ With Spouse ☐ With Relatives
☐ With Non-Relative(s)

G. Emergency Contact:

Name:_____

Address:_____

_____

Relationship:_____

Phone (Home/Work): _____

II. HEALTH STATUS

A. Primary Physician:_____

Clinic/HMO:_____

Hospital: _____

Other: _____

B. Does the person have a self-declared chronic illness and/or disability? (check all that apply)
☐ alcoholism ☐ Alzheimers ☐ anorexia ☐ arthritis ☐ cancer*
☐ colitis ☐colostomy ☐congestive heart failure ☐ constipation
☐ dehydration ☐ dental problems* ☐ diabetes* ☐ diarrhea
☐ digestive problems* ☐ diverticulitis ☐ fractures(recent)
☐ gall bladder disease ☐ hearing impairment ☐ heart disease*
☐ hiatal hernia ☐ high blood pressure* ☐ hypoglycemia ☐ liver disease ☐ low blood pressure ☐ osteoporosis ☐ Parkinson's
☐ renal disease ☐ respiratory problems ☐ smelling impairment*
☐ speech problems ☐ stroke ☐ swallowing difficulties ☐ taste impairment* ☐ ulcer ☐urinary tract infection ☐ visual impairment
other(Specify)
* May indicate need for assessment by nutritionist

C. Has the person been hospitalized in the last 6 months?
☐ Yes (If Yes, describe the reason for the recent hospitalization) ☐ No

Month:_____ Year:_____

_____

_____

Comments:_____

III. NUTRITION

A. Person's height:_____ Source:_____
B. Person's weight:_____ Source:_____
C. Body Mass Index:_____ (calculated from height and weight as follows: weight in pounds x 705:divide this number by height in inches; then divide by height in inches again, Healthy older adults should have a BMI between 22 and 27. *A BMI outside of this range may indicate the need for a referral to a dietitian.)

D. Are the person's refrigerator/freezer and cooking facilities adequate? ☐ Yes ☐ No (If no, describe)

E. Is the person able to open containers/cartons and cut up food?
☐ Yes ☐ No (If no, describe)

F. Does the person have a physician-diagnosed food allergy?
☐ Yes (If yes, describe) ☐ No

G. Does the person use nutritional supplements? ☐ Yes* (If yes, specify who prescribed and describe the supplements) ☐ No

H. Does the person have a physician prescribed modified/therapeutic diet? ☐ Yes* ☐ No
(**If yes**, check all that apply)
☐ Texture Modified ☐ Calorie Controlled Diet
☐ Sodium Restricted ☐ Fat Restricted ☐ High Calorie ☐ Renal ☐

Other(Specify)_____
(**Other**, check all that apply)
☐ Regular ☐ Special Diet
☐ Ethnic/Religious (Specify)_____
☐ Vegetarian

I. Nutritional Risk Status
Check all that apply and circle corresponding number at right:

☐ 1.	Person has an illness or condition that changes the kind and/or amount of food eaten	2
☐ 2.	Eats fewer than 2 meals/day	3
☐ 3.	Eats fewer than 2 daily servings of each of the following food groups: Fruits Vegetables Milk Products	2
☐ 4.	Has three or more drinks of beer, liquor or wine almost every day	2
☐ 5.	Has tooth or mouth problems that make it hard to eat	2
☐ 6.	Does not always have enough money to buy food needed	4
☐ 7.	Eats alone most of the time	1
☐ 8.	Takes three or more prescribed or over-the-counter drugs/day	1
☐ 9.	Without wanting to, lost or gained 10 pounds in the past six months	2
☐ 10.	Not always physically able to shop, cook and/or feed self	2

Score____

NSI Score: A Score of 6 or more indicates "High" nutritional risk, 3-5 indicates "Moderate" nutritional risk and 2 or less indicates "Low" nutritional risk. Conclusion: Based on the NSI score, this person is at (check one) ☐ High Risk* ☐ Moderate Risk ☐ Low Risk

*** MAY INDICATE THE NEED FOR A REFERRAL TO A DIETITIAN**

IV. PRESCRIBED AND OVER THE COUNTER MEDICATIONS CURRENTLY TAKEN

A. MEDICATIONS:

NAME	DOSE/FREQUENCY	REASON TAKEN

V. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs) STATUS/UNMET NEED

ACTIVITY: What can the person do? Enter person's activity status.
Activity Status: 1. Totally able (with or without equipment 2. Limited, participates but does not complete task fully (needs some assistance) 3. Unable to participate at all (needs maximum assistance) 4. Unwilling to perform

A. Shopping ___

B. Prepare and Cook Meals ___

Comments: Describe limitations, parts of tasks to be done, and responsibilities of informal supports and formal services

VI. ACTIVITIES OF DAILY LIVING (ADLs) STATUS/UNMET NEED

ACTIVITY: What can the person do? Check person's activity status.

A. Mobility

☐ 1. Walks with no supervision or assistance. May use adaptive equipment.
☐ 2. Walks with intermittent supervision. May require human assistance at times.
☐ 3. Walks with constant supervision and/or physical assistance.
☐ 4. Wheels with no supervision or assistance, except for difficult maneuvers, or is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.

B. Eating

☐ 1. Requires no supervision or assistance.
☐ 2. Requires intermittent supervision and/or minimal physical assistance.
☐ 3. Requires continual help and/or physical assistance.
☐ 4. Person does not manually participate. Totally fed by hand, or tube or parenteral feeding for primary intake of food.

Comments: Describe limitations parts of tasks to be done and responsibilities of informal supports and formal services.

VII. INFORMAL SUPPORT STATUS

A. Does the person have family, friends and/or neighbors who help or could help with care? ☐ Yes (If yes, identify) ☐ No

Primary Informal Support

1. Name:_____

   Address:_____

   _____

   Relationship:_____

   Home Phone: _____ Work Phone:_____

   Involvement: (Type of help/frequency)_____

   _____

Secondary Informal Support

2. Name:_____

   Address:_____

   _____

   Relationship:_____

   Home Phone:_____ Work Phone:_____

   Involvement: (Type of help/frequency)_____

   _____

VIII. CARE PLAN Date:_____

Prepared by: _____

Person's Name:_____ Person's Phone:_____

Address:_____

A. Is the person self directing/able to direct care? ☐ Yes ☐ No (If no, who will provide direction?)

B. Problems to be Addressed	Goals	Care Plan Objectives	Proposed Time Frame

C. What are the person's preferences regarding type of diet and/or services?

D. Does the person need any other services (beyond HDMs?)

E. Types of services to be provided	How Much? When? Frequency	Start Date	Projected End Date	Informal/ Formal	Provider

F. Problems to be referred | Referred to | (Reminders- some possible referrals) Hospital, Nursing Home, Adult Home, Health Assessment, Personal Care Program, Certified Home Health Agency, Protective Services for Adults, Housing Assessment, Long Term Home Health Care Program, Mental Health Assessment, Other

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G. Information/special instructions that have direct bearing on implementation of the care plan:

H. Has the person been placed on waiting list for any service need? ☐ Yes (If Yes, list) ☐ No

Service	Provider	Date placed on List

I. Plan has been discussed and accepted by client and/or informal supports? ☐ Yes ☐ No
(If No, explain)

J. Plan approved by (if applicable):_____ Date:_____ Phone:_____
Signature and Title

IX. SERVICE/CARE PLAN TERMINATION

A. What is being terminated? ☐ Service(s) ☐ Care Plan

If Service, specify which one(s)_____
_____
_____

B. Termination Date:___/___/___

C. Reason for termination: (Check all that apply)

☐ Goal Met: (specify)_____
_____
_____

☐ Independence

☐ Client Request

☐ Client Relocated

☐ Hospitalization

☐ Nursing Home

☐ Death

☐ Other: (specify)_____
_____
_____

D. Service or Care Plan Related Client Outcome(s) Statements:_____
_____
_____
_____
_____
_____
_____
_____

E. Terminated by:_____
Signature and Title

Date:___/___/___ Phone:_____