January 4, 2016

Centers for Medicare & Medicaid Services,

Department of Health and Human Services

Attention: CMS-3317-P

P.O. Box 8016

Baltimore, MD 21244-8016

Re: Comments on Proposed Discharge Planning Rule for Hospitals, Critical Access Hospitals, and Home Health Agencies (80 Fed. Reg. 68126).

Dear Reviewer:

On behalf of the thousands of Meals on Wheels programs across the country that provide nutrition services to nearly 2.5 million seniors each year, Meals on Wheels America is pleased to submit comments to you on the above-referenced proposed discharge planning rule for hospitals and other healthcare settings. We applaud the Department for its work in proposing measures to ensure that discharge planners more routinely and thoroughly develop discharge plans and communicate and connect with community-based organizations (CBOs), a national network which was built in large part by your Department over the past fifty years but which is not fully integrated into the community healthcare system as an essential part of the continuum of care that supports health and well-being. From the research and other work undertaken by Meals on Wheels America, we know that engaging our local programs can substantially reduce readmissions and other post-discharge costs, but that referral to these programs upon discharge has been inconsistent and largely ad hoc.

While there is much in this proposed rule with which we agree, we would like to focus our comments on the following three key points:

1. Meals on Wheels America believes that a nutritional assessment, including an assessment of a discharged patient’s ability to access nutritious food prior to discharge, should be a necessary requirement of the discharge process. Nutrition is essential to health and recovery, from patient strength to pharmaceutical efficacy, and can have a dramatic impact on achieving the goals of reducing post-discharge readmissions and other healthcare-related costs. Yet, despite its importance, the word “nutrition” is not even mentioned in this proposed rule.
2. Meals on Wheels programs have the unique ability to cross the threshold into the home on a daily basis, providing home-delivered meals, social interaction, and a safety check to vulnerable seniors. Accordingly, they should be specifically identified as one of the CBOs that hospital discharge planners should consult as part of the discharge planning process. In addition, many of our programs may also provide a variety of other in-home supportive services that could significantly benefit a discharged senior, such as transportation, nutrition counseling and minor home repairs.
3. Finally, and perhaps most importantly, physicians and hospital discharge planners should have the ability to order Meals on Wheels services upon discharge and have designated funding available to pay for them. Often, there is a misconception that these services are entitlements paid for by some other funding stream, such as the Older Americans Act. The truth is that many Meals on Wheels programs are at their service capacity based on funds available through traditional funding sources. Despite their mission and desire to serve more seniors in need, these programs cannot do so without additional third party payer funding, which should be made available because of the clear evidence supporting the fact that seniors receiving meals upon discharge experience significantly less readmissions and notable healthcare expense savings.

## ABOUT US

Meals on Wheels America is the oldest and largest national organization supporting the more than 5,000 community-based senior nutrition programs across the country that are dedicated to addressing senior hunger and isolation. This network exists in virtually every community in America and, along with more than two million volunteers, delivers the nutritious meals, friendly visits and safety checks that enable America’s seniors to live nourished lives with independence and dignity. By providing funding, leadership, research, education and advocacy support, Meals on Wheels America empowers its local member programs to strengthen their communities, one senior at a time.

Because Meals on Wheels programs are trusted and invited to cross the threshold and enter the homes of seniors, there is much they can do to assist recently-discharged individuals during their recoveries and to provide feedback to hospitals, insurers, physicians and/or case workers. In addition to the daily provision of nutritious meals, Meals on Wheels volunteers and staff are the eyes and ears inside the home, offering direct, ongoing personal interaction, caring conversations, and observations that cannot be practically achieved or effectively replicated through other means, such as telephone calls or even visits by persons affiliated with insurance companies or hospitals. Meals on Wheels providers are poised to help and need to be an essential link in the healthcare continuum for those individuals who can benefit from the services they offer.

### NUtrition planning is essential Upon discharge

*“Nutrition plays a critical role in preventing hospital readmissions,*

*and it’s imperative to have initial screening and nutrition interventions in*

*place to enable recovery during care transitions. It’s important to remember*

*that older adults are at risk for malnutrition across the care continuum and*

*may become more vulnerable to malnutrition during recovery.” [[1]](#endnote-1)*

All too often, seniors discharged from the hospital return home, alone, to food which has perished or is stale, if not to an empty refrigerator altogether. Having no ability to shop, prepare, or access food, they often face further health decline and end up back in the hospital. Returning home from a hospital stay is when these vulnerable individuals need help the most, and Meals on Wheels, given the resources to provide services, is the intervention that can assist them most expeditiously and cost-effectively.

Malnutrition among seniors is already a serious national problem. It is estimated that 50% of the seniors who enter the hospital are already malnourished when they arrive.[[2]](#endnote-2) It is also estimated that more than 85% of seniors have one or more chronic conditions that could be improved by nutrition.[[3]](#endnote-3) Poor nutrition among older adults has serious negative health impacts, including slower healing rates, three times the risk for surgical infection, extended in-patient stays, increased readmissions and post-discharge costs, as well as increased mortality, among other adverse consequences.[[4]](#endnote-4)

Despite its critical importance to the well-being and recovery of patients, nutrition planning is not routinely considered as part of discharge planning. For example, a 2014 poll taken among nurses in the Academy of Medical Surgical Nurses (“AMSN”), found that 43.5% of the respondents do not consistently incorporate nutrition into the discharge plan, and 84% lack nutrition information in the discharge plan. Further, 55% stated that they do not have clear methods of identifying and referring at risk patients who develop nutrition issues, and 44% of AMSN members do not have nutrition embedded into their discharge planning process.[[5]](#endnote-5)

We believe that §482.43(b) “Applicability” and/or §482.43(c) “Discharge planning process” should be amended to require a nutrition assessment and a 30 day post-discharge nutrition plan. This assessment is particularly important for individuals who showed evidence of malnutrition or dehydration during their inpatient stay (such as not eating or only partially eating meals provided) and for individuals who are being discharged to home and who may not have a dependable care network. Nutrition support (meals or nutrition supplements) should be available immediately upon return to the home so there is no lapse in availability. We applaud the Department’s goal of encouraging the start of the discharge planning process early so that services will be available upon discharge. Meals on Wheels programs, if provided sufficient notice and resources, can provide meal services immediately following discharge.

Further, Meals on Wheels programs can help discharge planners and hospitals with the development of nutrition assessments and protocols since they routinely undertake nutrition assessments as part of their intake process for new clients and have access to protocols for these kinds of services.

In many respects, nutrition is as critical to a person’s recovery as medication (even more so if the medication is required to be taken with food). In several places in the proposed rule, the Department emphasizes the need for medication education for patients and

caregivers as part of the discharge planning process. However, we believe that education on food and medication interaction, as well as good nutrition generally, is equally as important and should be included as a part of the discharge plan.

### Meals on Wheels programs are important community-based organizations to include in the discharge planning process

*Engagement of Meals on Wheels programs in the*

*healthcare discharge process will help to substantially*

*reduce post-discharge costs and readmissions.*

Meals on Wheels programs – both congregate and home-delivered – across the country have been serving meals, providing social interaction and encouragement, and observing conditions in the homes of tens of millions of individuals for more than forty years under the Older Americans Act, and others have been in existence longer. This network, which includes government-sponsored programs administered by your Department as well as Meals on Wheels providers that receive no governmental funding whatsoever, is comprised of thousands of providers and over two million volunteers and staff, who collectively and effectively reach seniors in communities, large and small, and in rural parts of America from coast to coast. Since it built it in the first place, the Department should assign priority to the utilization of this network as part of the healthcare continuum, particularly for that segment of the older population who has little support to assist them following a hospital discharge.

Meals on Wheels programs are particularly important because they have the ability to quickly initiate daily visits to vulnerable discharged seniors where conditions can be observed, most critically during the days immediately following discharge. Many professionals speak of Post-Hospital Syndrome, a period of vulnerability following discharge of generalized risk for a wide range of adverse events. The 30-day period following discharge is the time when seniors in particular have the accumulated risks associated with recovery from the original illness or injury along with the other forms of stress acquired while in the hospital such as sleep deprivation, pain, discomfort, inactivity and other factors. During this time, Post-Hospital Syndrome dramatically increases the risk of readmission, often for reasons other than the original diagnosis.[[6]](#endnote-6)

Engagement of Meals on Wheels can substantially help to improve health status and reduce post-discharge costs and readmissions. A ground-breaking 2015 study entitled *More Than a Meal* conducted by Meals on Wheels America in conjunction with Brown University and AARP Foundation ([www.mealsonwheelsamerica.org/mtam](http://www.mealsonwheelsamerica.org/mtam)), showed that compared to an average senior, respondents receiving daily-delivered meals were more likely to exhibit:

* Improvement in mental health (i.e., less anxiety)
* Improvement in self-rated health
* Reductions in the rate of falls
* Improvement in feelings of isolation and loneliness
* Decreases in worry about being able to remain in home

Further, Meals on Wheels is a proven way to reduce readmissions and post-discharge costs. One engagement we undertook with a national insurer eventually covering over 135,000 Medicare Advantage seniors post-hospital discharge over a five-year period involving just a one-time delivery of ten frozen meals and follow-up phone calls, alone produced:

* Overall healthcare savings averaging 31% per member per month (PMPM) for the first month following discharge (based on a study of the first project year, 2006) [[7]](#endnote-7)
* Fewer post-discharge costs, including fewer hospital inpatient days and inpatient admissions per 1,000
* Referral opportunities for about 30% of recipients for ongoing meal and other community services, and
* Positive impacts for patients with higher intensity inpatient stays.

Subsequent engagements have shown that daily meal delivery over a longer period of time (30 days – 6 months or more) produces even more favorable health outcomes and longer term cost savings when compared to national readmission risks:

* Compared to national 30-day readmission risk rates ranging from 15% - 33%
  + Community SeniorServ, CA:
    - Participants received meals within 72 hours of hospital discharge. Each was given one meal per day. Of 203 clients, only 6% had been readmitted within 30 days.
  + Johnson County Meals on Wheels, KS:
    - Participants received a seven day frozen meal pack within 72 hours of hospital discharge and additional information of other supportive community services available to them. Of the 138 clients, only 6.5% had been readmitted within 30 days.
  + Senior Services, Inc., NC:
    - Participants received 2-4 week delivery of meals (hot or frozen as assessed) beginning at discharge and a connection to other supportive community services. Of the 60 clients, only 6% had been readmitted within 30 days.
* Compared to national-90 day readmission rate of 34%
  + Tarrant County Meals on Wheels, TX:
    - All participants received at least one hot meal within two weeks of hospital discharge. Of 86 clients, 24.4% had been readmitted within three months.

Therefore, in proposed modifications to the re-designated §482.43(c)(5) and the new §482.43(d), “Discharge to home,” we encourage the Department to specifically include Meals on Wheels as one form of community-based care for patients. We are also pleased about the encouragement provided from the Department for hospitals “to develop collaborative partnerships with providers of community-based services to improve transitions of care that might support better patient outcomes.” We believe that for certain at-risk patients, nutrition needs to be included into the discharge plan of care and further development of collaborative partnerships (with feedback loops) with Meals on Wheels should be required for the in-home observations and other reasons cited above. Partnerships do not need to be defined only at the local level; Meals on Wheels America would also consider national or regional partnerships with hospital networks.

Further, we agree wholeheartedly with the purposes and rationale for the proposed requirement under the new §482.43(d)(4) to establish a post-discharge follow-up process for patients discharged to home. It is valuable to note that Meals on Wheels programs routinely do this, reporting on the health circumstances and conditions observed during meal delivery. For example, Meals on Wheels drivers are trained to report a lack of response to their knock on the door, or other unusual conditions or circumstances facing their homebound clients.

Meals on Wheels is a proven client-centered solution that already does what you are proposing to require of hospitals in post-discharge follow-up, by helping to “improve patient safety and patient satisfaction,” and decrease “the likelihood of post-discharge adverse events and hospital readmission.” Furthermore, Meals on Wheels visits can help to identify problems in follow-up care and complications of recovery early, resulting in quicker intervention, improved outcomes, and reduced re-hospitalization.

### PROVIDING RESOURCES TO SUPPORT Meals on wheels and other COMMUNITY-BASED PROGRAM INTERVENTION IS ESSENTIAL

*Meals on Wheels can provide good nutrition, social interaction and*

*safety checks to a person for an entire year for roughly the same*

*cost of caring from them just one day in the hospital.*

Meals on Wheels America is committed to helping reduce healthcare costs associated with unnecessary readmissions and post-discharge expenses. We offer a proven program that is cost-effective, improves health and saves lives, and has the ability to expand available services if provided the resources to do so. We very much want to be a part of the healthcare continuum and are working toward that goal.

All too often, discharge planners and even physicians seek to make referrals to Meals on Wheels programs without considering how those meals will be paid for. Meals on Wheels is not an entitlement, and funding under the Older Americans Act is limited in meeting the current needs of the burgeoning senior population in this country, much less the additional requirements of assisting with hospital-discharged seniors. Many Meals on Wheels programs have waiting lists of seniors to be served through traditional Older American Act funding sources. In fact, a Government Accountability Office report released last summer found that about 83% of food insecure seniors and 83% of physically impaired seniors did not receive meals [through the Older Americans Ac], but likely need them.[[8]](#endnote-8)

Physicians should be able to prescribe, and hospital discharge planners should be able to order, Meals on Wheels services to vulnerable seniors discharged to home. Although we recognize that this suggestion may be beyond the scope of this proposed rule, identifying a mechanism for the payment of community-bases services is essential to the effective utilization of this existing network. Hospitals and third-party payers such as insurers, not to mention CMS itself, benefit by reductions in readmissions and post-discharge costs, and they should be willing to step up to cover the short-term costs of meals, particularly given the enormous savings that would result. Hospital discharge staff should know in advance how the meals will be paid for and should be able to make arrangements with the provider to bill, as necessary.

The Meals on Wheels network exists in communities all across the country and is trusted to provide essential services to vulnerable individuals in a cost-effective manner. As mentioned previously, funding is critical to the successful utilization of this network or likely, that of any other CBO. Meals on Wheels America stands ready to engage in discussions with the Department about how its national network can be more readily and effectively integrated into the healthcare continuum.

## COnclusion

Meals on Wheels America supports the strengthening of the hospital discharge process but as mentioned above, believes that the proposed rule needs to go further to include the crucial role that nutrition plays in expediting recovery upon discharge, as well as mention of the existing Meals on Wheels community-based network as an invaluable nationwide support infrastructure. The proposed rule will certainly enhance communication between hospitals and community-based programs and hopefully lead to a better understanding by those in the healthcare field of the services and benefits offered by our programs. Many older adults already rely on community-based resources to maintain health and independence, but the opportunity to leverage them needs to be expanded through Medicare and Medicaid because Older Americans Act funding is limited and waiting lists are high. Nutrition is central to disease management, and it is proven that instituting an effective nutrition program upon hospital discharge will lead to better patient outcomes. This needs to be done across the continuum of care.

Thank you for your consideration of our comments, and please let us know if we can provide additional information to you.

Sincerely,



Ellie Hollander

President and CEO

1. *Nutrition to Reduce Hospital Readmissions for Older Adults*. Brenda Richardson. Nutrition & Foodservice Edge, September 2015. <http://www.anfponline.org/docs/default-source/legacy-docs/docs/nc_092015.pdf?sfvrsn=2> [↑](#endnote-ref-1)
2. *Role of Nutrition in Discharge: A Nursing Perspective.* Andie Melendez. <http://anhi.org/conference-summaries/integrated-role-of-nutrition-post-hospital-discharge-a-scientific-rountable-discussion/role-of-nutrition-in-discharge-a-nursing-perspective> [↑](#endnote-ref-2)
3. *Nutrition concerns in discharge planning for older adults: A need for multidisciplinary collaboration.* Nancy Wellman; Etty Baker. Journal of the American Dietetic Association. May 2005. [↑](#endnote-ref-3)
4. Melendez, Wellman, *op cit*. [↑](#endnote-ref-4)
5. Richardson, *op. cit*. [↑](#endnote-ref-5)
6. Richardson, *op. cit*. [↑](#endnote-ref-6)
7. *Humana – Meals On Wheels Association of America Foundation (MOWAAF) Meals On Wheels Program.* Gail Miller. Presentation made at Administration on Aging’s Choices in Aging Conference, December 5, 2006. [↑](#endnote-ref-7)
8. *Older Americans Act: Updated Information on Unmet Need for Services.* Charles A. Jeszeck. U.S. Government Accountability Office, June 2015. <http://www.gao.gov/products/GAO-15-601R> [↑](#endnote-ref-8)