Addressing and Understanding Food Insecurity

Approaches from Local to National

NCI·AD
NATIONAL CORE INDICATORS
PEOPLE DRIVEN DATA

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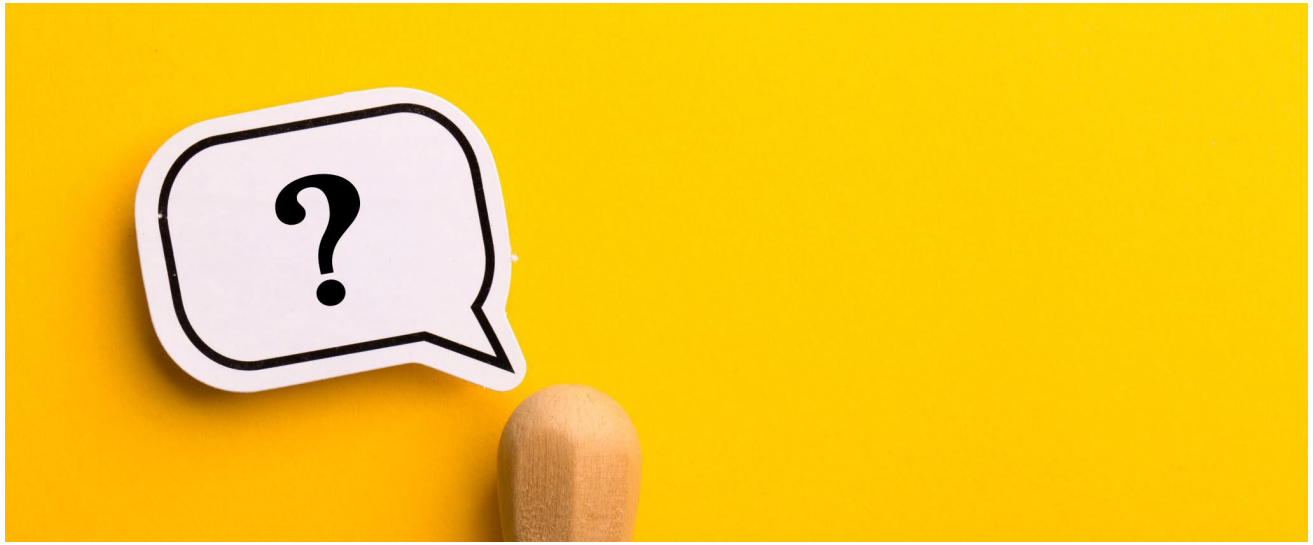
Abstract

Food insecurity is estimated to affect one in every 14 people aged 60 and older living in the United States according to the most current *State of Senior Hunger,* and its effects are disproportionately felt by historically underserved populations. Food insecurity and malnutrition have particularly determinantal effects on older adults by exasperating preexisting conditions, increasing risk of falls, leading to a greater likelihood of hospitalizations.

Using data from National Core Indicators—Aging and Disabilities® (NCI-AD), we will explore the relationship between those who report they have to skip meals due to financial concerns and the effect that has on SDOH and other quality of life outcomes. Innovations within states and federal policy will be shared that improve access to nutrition and wellness.

Who is here today?

How do you see SDOH impacting your work and the people you serve?



Background – SDOH and Older Adults

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 3/14/24, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Social Determinants of Health
Copyright-free
Healthy People 2030

Social Factors Impact Health Outcomes

What Determines Health?

Genetics	Health Care	Social, Environmental, Behavioral Factors
20%	20%	60%

Setting the Stage

Food insecurity puts older adults at particular risk for declining health and can put seniors out of their home or community to placement in residence centers (e.g., assisted living or nursing facilities) that offer regular nutritional and health services.

Food insecurity is not a new issue; however, the impact has been exasperated particularly for vulnerable populations since COVID-19 and the PHE unwinding.

The Aging Services Network:

Addresses SDOH

Provides services to the most socially and economically vulnerable older adults

Has experience developing, coordinating, and delivering services addressing SDOH needs of older adults

By providing nutrition, transportation, in-home services and other supports, the Aging Services Networks help older adults — many of whom live with multiple chronic conditions and disabilities — remain in their homes and communities for as long as possible

SDOH Category	Aging Services	SDOH Category	Aging Services
Healthcare Access and Affordability	Care Transitions, Case Management DME, Healthcare Counseling Home Health, Medication Management	**Financial Strain**	Benefits Assistances, Financial Assistance, Household Assistance Material Assistance, Utility Assistance
Personal Health Practices and Coping	Support groups, Fall Prevention Services, Recreation and Exercise Wellness Education	**Food Security**	Food, Groceries, Congregate Meals Home Delivered Meals, Nutrition Education
Clothing	Clothing	**BH Support**	Counseling
Education	Kinship, Summer Camps	**Childcare**	Childcare Respite, Kinship Care
Employment	Employment, SCSEP	**Safe Communities**	APS, Legal Services
Housing	Home Repair, Housing Assistance Home Assessments	**Social Isolation and loneliness**	Home Visits, Friendly Visiting Senior Centers
Social Supports	Adult Day Health, Adult Day Care Caregiver Supports, Escort Services Personal Care, Respite Care	**SDOH Access**	Information and Referral Aging and Disability Resource Centers
Transportation	Senior Center Transportation Older Driver Training, Vouchers		

Food Insecurity in Older Adults – Incidence and Time

For older adults, these detrimental effects may cause speedier health declines by further exasperating preexisting physical and emotional health concerns.

Impact on the wellbeing of people who face food insecurity are many – including elevated stress, emotional distress, and decreased physical wellbeing, and increase cognitive decline.

Following some of the highest recorded levels of food insecurity in the United States between 2011 and 2014 (mainly attributed to the recession), food insecurity decreased significantly.

However, in 2020 COVID-19 renewed issues of food insecurity due to loss of income (among other issues) and projected to remain at heightened levels.

PHE unwinding is likely to increase incidence of food insecurity.

Across the U.S. 78 m individuals are 60 and over

- 7.1% or 5.5m are food insecure
- 2.7% or 2.1m are very food insecure

Disproportionally impacts people who are vulnerable, including:

- low-income,
- disability, and
- medically fragile.

Additionally, food insecurity is disproportionately felt by non-white populations.

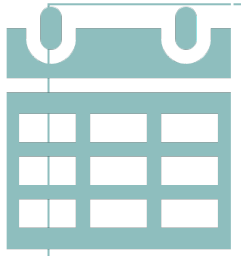
https://www.feedingamerica.org/research/state-senior-hunger

SDOH Discussion

How do you see these factors impacting your work?

What are you doing in your work to support people who experience food insecurity?

NCI-AD: An Overview

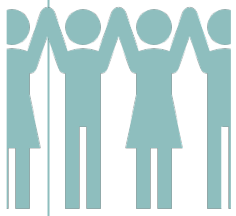


Established

- 2015
- Grew out of NCI-IDD

Participating states

- 23
- 30 throughout project



Population addressed

- Older adults and people with physical disabilities

Covers multiple domains

- AD domains and indicators
- **New** State of the Workforce Survey – Aging and Disabilities

Adult Consumer Survey (ACS) A Person-Centered Approach

- **Standardized survey with a sample of individuals receiving services**
  - No pre-screening procedures
- **Survey includes:**
  - Demographic and service-related characteristics typically from existing records
  - Main survey section conducted with person receiving services
  - Some questions may be answered by a proxy respondent
- **Survey conducted in-person, via video conference, over the phone**
- **Standardized surveyor training**
- **Allows questions to be reworded or rephrased using familiar names and terms**
- **Survey portions take 50 minutes on average**
- **Minimum sample ~400**

Data can help measure disparities

Individual characteristics of people receiving services	Where people live
	Gender
	Race/Ethnicity
	Disability
The nature of their experiences with services	Interaction with staff and case managers
	Self-direction
	Choice and Control
The context of their live	Involvement with family and friends
	Access to community involvement
	Safety
Health and well-being	Utilization of health services
	Ability to manage chronic conditions
	Mental healthcare

For this analysis…

Data are from 2022-23

Analysis criteria:

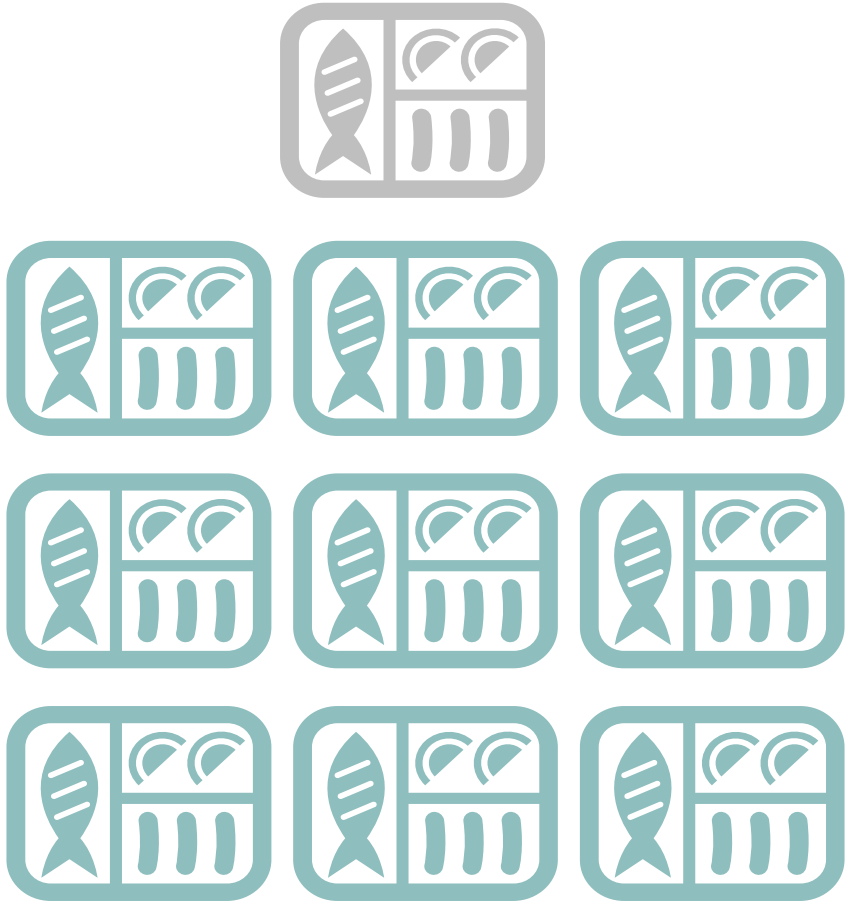
- People 60 and older
- Those *not* living in a nursing facility
- Answer question: Do you ever have to skip a meal due to financial worries?
- Total 8,189 respondents

Comparison groups are based on question:

- **Do you ever have to skip a meal due to financial worries?**
  - Yes, often or sometimes (N= 906)
  - No (N= 7,283)

Findings between groups are significant at .01

One in Ten
older adults sometimes or often had to skip meals due to financial worries.

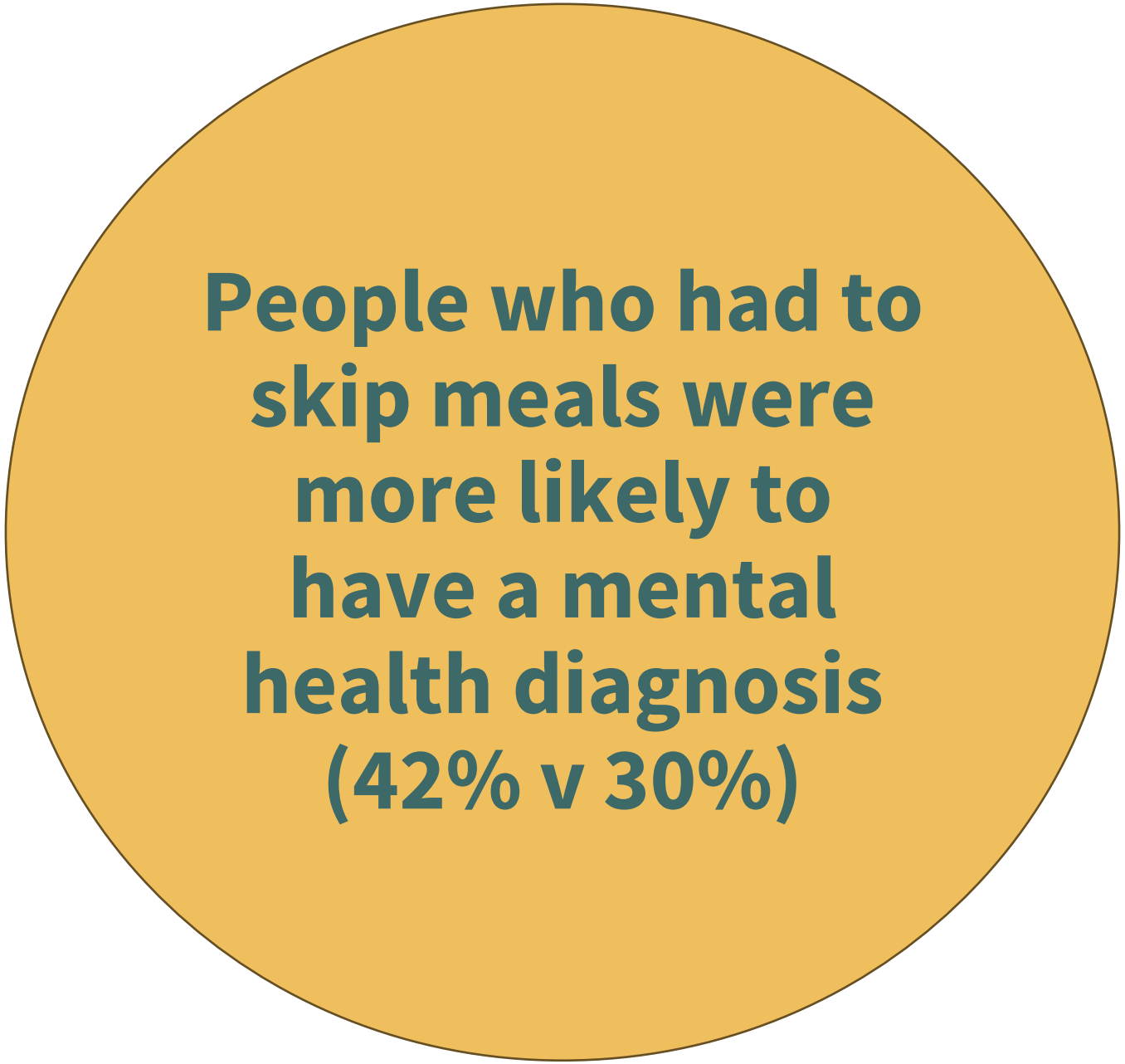


31%
of older adults who skipped meals received home delivered meals

Those who reported having to skip a meal were more likely than those who did not to live in zip codes with an average annual income under $30,000

People who had to skip meals were more likely to have

Heart disease	44% v 37%
Diabetes	43% v 39%


People who had to skip meals were more likely to have a mental health diagnosis (42% v 30%)

Older adults who had to skip meals had less access to healthy foods (53% v 90%)

Black respondents were more likely to have had to skip meals due to financial worries.

Asian and Hispanic respondents were less likely to report having to skip meals.

Home

Older adults who reported having to skip meals were less happy with where they live

People in their own or a family home were more likely than those living in a group setting to report they had to skip meals

- They were also more likely to live alone

Those who had to skip meals were…

Less likely to like where they live
(86% v 94%)

And more likely want to live somewhere else (38% v 26%)

Of those who wanted to live somewhere else, similar rates wanted to live in a different kind of home. But those who had to skip meals were…

- More likely to want to live in another neighborhood (23% vs 17%)
- And less likely to report wanting to live with or closer to family (11% vs 15%)

Relationships and Community

Older adults who reported having to skip meals reported lower rates of close relationships and less access to their communities

Those who had to skip meals were less likely to report:

- Having family or friends they do not live with who are involved in their life
(87% v 93%)
- And being able to see or talk to friends and family they do not live with when they want (91% v 96%)

People who reported that they had to skip meals were more than *twice as likely* as those who did not have to skip a meal to report they *often* feel sad or depressed (33% v 14%)

People who had to skip meals reported lower rates of access to their community. They were less likely to…

Have transportation to get places they wanted to go

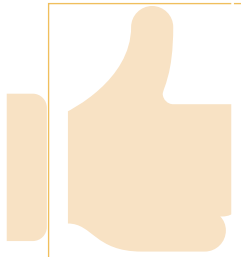
- 79% v 91%

Participate in groups with others as much as they wanted (in-person or virtually)

- 45% v 64%

Get to do things in the community as much as they want

- 47% v 68%



Like how they spend their day

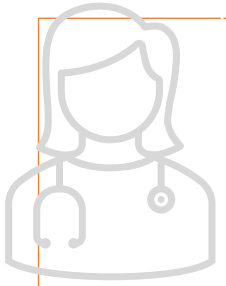
- 45% v 65%

Health

Older adults who reported having to skip meals reported lower healthcare utilization

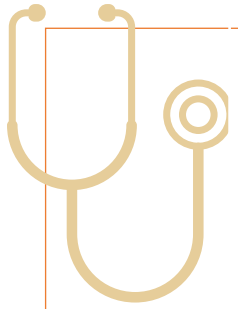
People who skipped a meal were more likely to report being in poor health (24% v 15%)

Overall, those who reported they had to skip a meal also reported lower healthcare utilization. They were less likely to…



Be able to see a PCP when needed

- (75% v 87%)

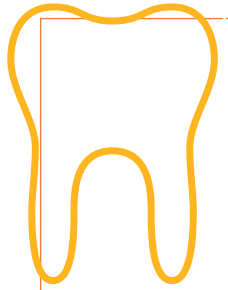


Have had an annual physical exam in the past year

- (82% v 88%)

Have had a hearing exam in the past five years

- 43% v 50%



Have had a dental visit in the past year

- 39% v 43%

People who had to skip meals were more likely to use emergency services. They were more likely to…

- Have had an emergency room visit in the past year (45% v 40%)
- More went to the ER because they could not see a PCP when needed (12% v 7%)
- Have been admitted to a hospital or rehab facility for an overnight stay in the past year (32% v 29%)

Services and Supports

Older adults who reported having to skip meals reported lower access to needed supports

Similar rates reported having a case manager. However those who had to skip meals were…

More likely to report their case manager ***changed too often***
(36% v 28%)

Less likely to report they ***could contact their case manager*** when needed
(90% v 94%)

Less likely to report their ***case manager talked to them about services*** to help meet their needs and goals
(50% v 61%)

People who skipped meals were more likely to need some or a lot of support with everyday activities…

…but less likely to report they always have the support they need for everyday activities

(60% v 84%)

53%
of those who had to skip meals reported the services and supports they receive meet all of their needs and goals.

That’s compared to 76% of those who did not have to skip meals.

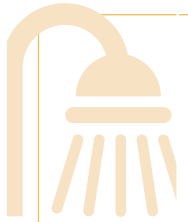
The top service needs among people who had to skip meals were…

Homemaker/chore services

- 44%

Transportation

- 38%



Personal care assistance

- 36%

Housing assistance

- 32%

Home delivered meals

- 30%

People who had to skip meals were less likely than those who did not to feel that supports and services help them live a better life
(77% V 91%)

Thoughts? Questions? Reactions?

What is being done?

State and Federal Action

OAA Rulemaking

Historic Update

- This rule marks the first update to OAA regulations since 1988, apart from changes made to the Long-Term Care Ombudsman Program (LTCOP) regulations.

Application:

- The final rule applies to OAA Titles III, VI, and VII.
- It does not specifically apply to Title IV or V.

OAA Final Rule Update

States must be compliant with the final rule by October 1, 2025
This allows states approximately 18 months for implementation.

ACL will accept corrective action plan (CAP) requests beginning April 1, 2024

States must review and approve AAA contracts and commercial relationships

ADS is working with ACL and USAging to develop some tools to support this effort.

Nutrition Services: Grab & Go Meals

§ 1321.87(a)

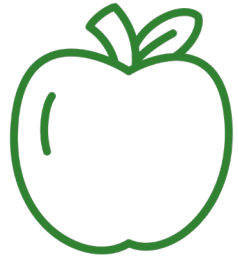
Title III, Part C-1 Funds

The final rule allows states to use Title III, part C-1 (congregate meals) funds for grab & go meals.

Parameters for Use of Part C-1 Funds

- Must provide information in the State Plan about the use of Part C-1 funds.
- Funds expended must not exceed **25%** of total C-1 funding at the state or AAA level.
- Meals should complement the congregate meal program

Nutrition Services (cont.)



§ 1321.87(a)

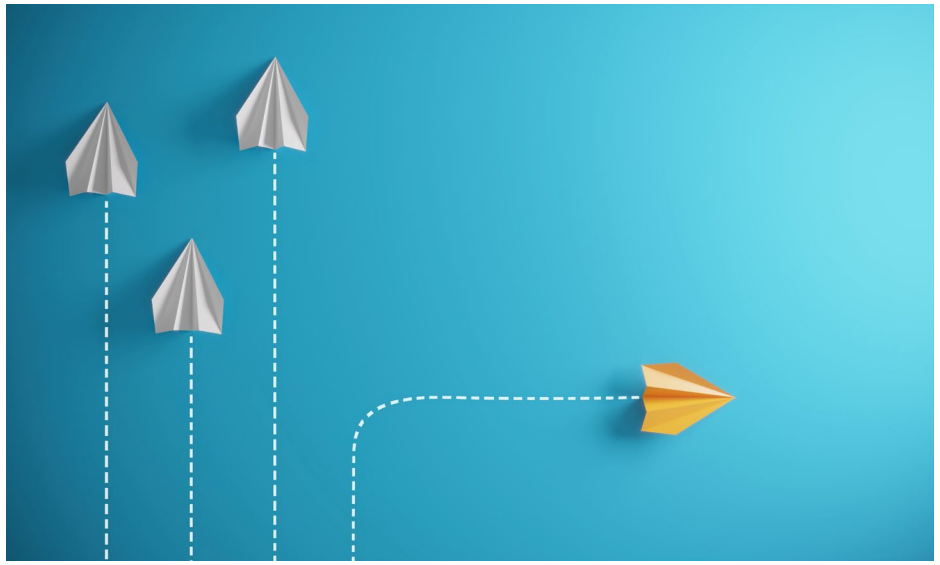
Eligibility for Home-Delivered Meals (HDM)

- Eligibility criteria may consider multiple factors.
- Eligibility is not limited to individuals identified as “homebound.”

Nutrition Education and Nutrition Counseling

- Nutrition education, nutrition counseling, and other nutrition services may be provided using Title III, Part C-1 and C-2 funds.
- Funds must be distributed through an approved IFF or funds distribution plan.

Medicaid Interventions



Expanding the Menu: Opportunities for Medicaid to Better Address Food Insecurity – CHCS, https://www.chcs.org/resource/expanding-the-menu-opportunities-for-medicaid-to-better-address-food-insecurity/

- In Lieu of Services (ILOS)
- 1115, Dec 2022
- HSRN Framework, Nov 2023
- Food is Medicine
  - Movement and Summit
- HCBS Quality Set, Jan and April 2024
  - Experience of Care Surveys
  - Adding State Specific Questions to NCI-AD Survey Tool

MFP Grantee States and Territories –

HCBS Quality Measure Set Implementation

MFP grant recipients are required to report in Fall 2026 on the HCBS Quality Measure Set every other year for their section 1915(c), (i), (j), and (k) programs and section 1115 demonstrations that include HCBS

- For the initial implementation of the measure set, MFP grant recipients can opt to, but are not required to, stratify data for MFP participants and by demographic or other characteristics of their HCBS participants
- Federal funding available to support costs

MFP Grantee States and Territories – HCBS Quality Measure Set Implementation

First year of reporting will be 2026, using performance data from 2025

For NCI participating states, data reported would be from 2024-2025 survey cycle

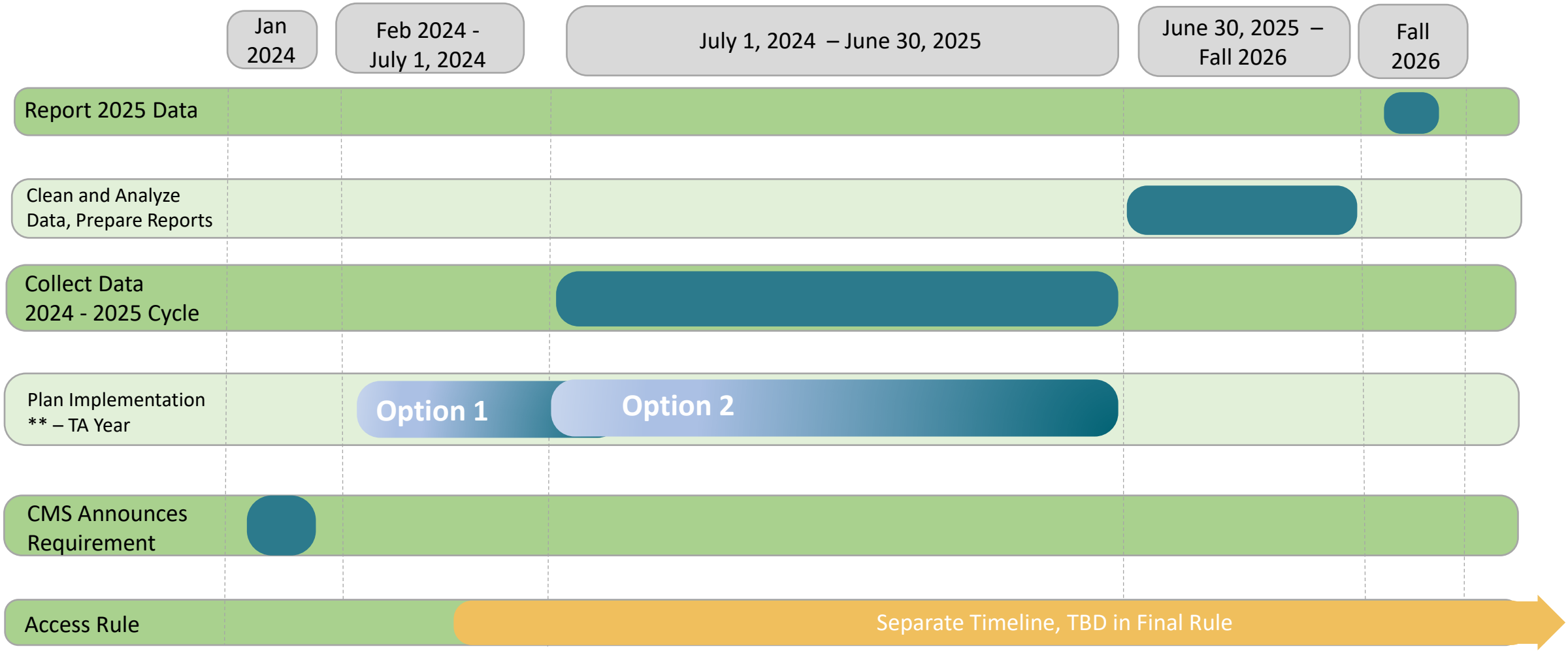
New reporting forms in the Medicaid Data Collection Tool are under development

CMS expects that reporting in 2026 will be no earlier than

September 1, 2026

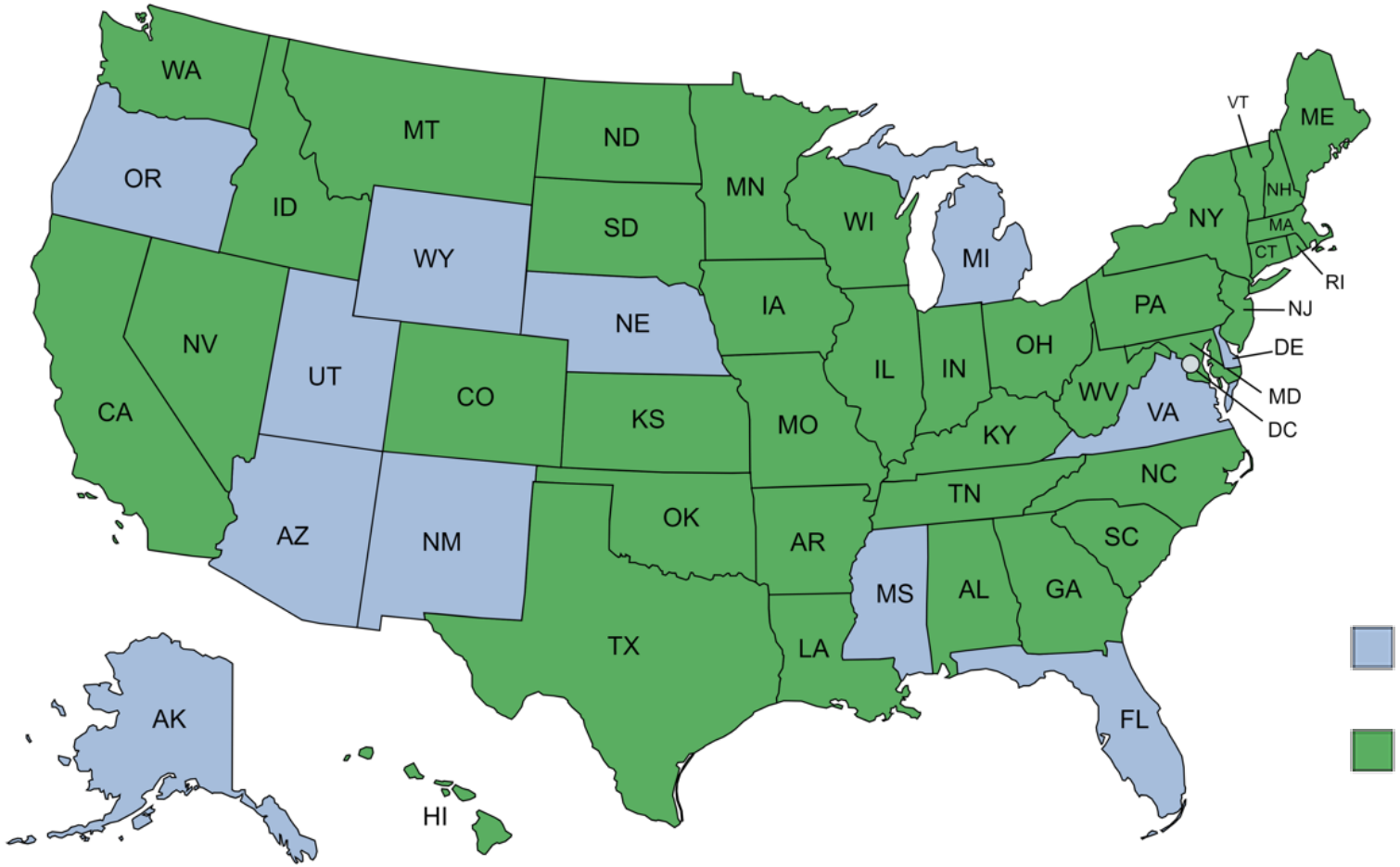
For the initial implementation of the HCBS Quality Measure Set, MFP grant recipients will be expected to report on a subset of the measures in the measure set and to develop a quality improvement plan related to two measures of their choice

Data Reporting Timeline



** includes any state procurement and contracting requirements for survey vendor

MFP Grantee States and Territories



MFP Grantee Territories:
American Samoa
Puerto Rico

not current MFP grantee

current MFP grantee

Access NPRM and Quality Measure Set Background

1915(c) waiver assurance: Service Plans	1915(c) waiver assurance: Health and Welfare
Access	Rebalancing
Community Integration	

If a measure addresses more than one of these topics, they are indicated as such.

- States must report on all of their section 1915(c), (i), (j), and (k) programs and section 1115 demonstrations

Access NPRM and Quality Measure Set Background

Source

Vast majority of measures are drawn from surveys of people with lived experience

Flexibility

CMS permits states flexibility to determine which survey tool they implement (from the following):

- NCI®-IDD
- NCI-AD™
- HCBS CAHPS®
- POM®

Access NPRM and Quality Measure Set Background

Requires adoption of HCBS Quality Measure Set

- Originally shared as guidance in CMS State Medicaid Director Letter #22-003
- Applies to all HCBS authorities (except state plan personal care) and all delivery systems as well as self-directed programs
- Requires stratification and sampling phase-in
- HCBS Quality measure set updated every other year by the Secretary
  - Process includes soliciting public comment

States must establish performance targets, reviewed and approved by CMS, of mandatory measures

- Performance targets must include quality improvement strategies states will pursue to achieve the performance targets

Several operational changes likely required of states to meet compliance

Discussion:

How could these federal interventions make a difference?

Do you work in a state that has implemented any of these strategies? What changes have you seen?

Other thoughts?

Thank you!

Contact us:

NCI-AD

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Learn more about NCI-AD

- Welcome | NCI-AD (National Core Indicators-Aging and Disabilities)