American Dietetic Association
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Medicaid Commission
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW; Suite 450G
Washington, DC 20201

Dear Chairman Sundquist, Vice Chairman King, and Members of the Medicaid Commission;

On behalf of the American Dietetic Association (ADA), thank you for the opportunity to provide comments on nutrition and health issues that arise in Medicaid "rebalancing." As you review and discuss Medicaid initiatives to support elderly and disabled beneficiaries' transition from institutional to home and community-based long-term services, ADA offers comments, concerns, and suggestions which will better serve beneficiaries and help achieve Medicaid's goals and desired outcomes.

The American Dietetic Association represents more than 65,000 registered dietitians (RDs) and other food and nutrition professionals. The Commission on Dietetic Registration, an associated but separate credentialing organization, currently credentials more than 75,000 RDs, the majority of whom provide clinical nutrition care services. In addition, members of ADA are now legally recognized healthcare providers in 46 states the District of Columbia and Puerto Rico.

Uninterrupted access to quality nutrition care services is vitally important. Beneficiaries at risk nutritionally due to either socioeconomic status or physical limitations, and who have benefited from nutritionally balanced and complete meals or from technology-dependent nutrition support such as parenteral and enteral nutrition, and from other nutrition care intervention services of a licensed RD, may not have access to a continuum of nutrition care when transitioned from institutional to home and community-based long term care services. In the case of older adult and disabled beneficiaries, it has also been shown that family caregivers have multiple unmet task-related training needs and low overall preparedness for caregiving.[1]

With respect to nutrition, there are two essential and fundamental types of services that should be included. Already, most states have good resources in both types, but access and coordination of these two kinds of services to address the needs of this population,

[1] Silver HJ, Wellman NS, Galindo-Ciocon D, Johnson P. Family caregivers of older adults on home enteral nutrition have multiple unmet task-related training needs and low overall preparedness for caregiving. *J Amer Diet Assoc*. 2004;104:43-50.

whose needs have been addressed in licensed and regulated institutions and programs, will now bring to the community needs for which it has not had to previously address on a large scale. These two types of services include:

- Access to nutrition care services—including, nutrition screening and if necessary, medical nutrition therapy (MNT). MNT involves assessment, development of a nutrition care plan with appropriate follow-up and measurement and analysis of patient outcomes for ongoing improvement of care. Patients should be screened for level of nutritional risk at discharge from the hospital, long-term nursing facility, or other residence.
- Access to safe, healthful food (i.e. congregate or home-delivered meals) if it is determined the patient is food insecure. Food insecure means the person may not always have access to enough food to meet basic needs[2] or to manage their chronic condition.[3]

There is a need for coordination between community-based food assistance and nutrition care services, including nutrition assessment, medical nutrition therapy and monitoring of nutritional status. Access to a licensed registered dietitian is especially critical for persons who require technology-dependent enteral (tube) or parenteral nutrition (delivered by vein)**.**

The prevention of unintentional weight loss, maintenance of blood glucose control in diabetic beneficiaries, adequate hydration and ongoing consumption of appropriate amounts of calories and nutrients to sustain health and manage chronic diseases are important for emotional, mental and physical well-being and are associated with better health outcomes, including decreased utilization of more expensive medical interventions and less frequent admissions to hospitals and other higher, more expensive institutional-based care.

Thank you again for the opportunity to share ADA's comments and concerns. Following my signature is a list of more detailed recommendations. In closing, however, there are three that warrant particular attention:

- Federal and state long-term care facility certification conditions and licensing rules need to be revisited for better discharge planning or "hand off" requirements to support continuity of care and for ensuring access to qualified registered dietitians.

- Registered dietitians are trained to specifically assess patient nutrition needs and to translate them into understandable food terminology. RDs are the only healthcare professionals trained and possessing comprehensive knowledge of nutrients and food, and thus should be included as part of the interdisciplinary healthcare team in the rules. ADA's analysis of current federal and state rules reveals a wide variation in definitions and responsibilities for nutrition care, ranging from no rules to clear, concise and appropriate requirements.

- Caretakers need support and training to be able to implement nutrition care plans that sustain beneficiary health and manage optimally chronic conditions. RDs can provide that support and conduct educational in-service programs for other staff.

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[2] Gollub EA, Weddle DO. Improvements in nutritional intake and quality of life among frail homebound older adults receiving home-delivered breakfast and lunch. *J Amer Diet Assoc.* 2004;104:1227-1235.
[3] Sharkey JR. Longitudinal examination of homebound older adults who experience heightened food insufficiency: Effect of diabetes status and implications for service provision. *The Gerontologist* 2005;45:773-782.

Please contact me for additional information, further discussion of these and the attached comments, or for assistance in identifying RD experts in any of the fifty states, DC or other territories.

Best regards,

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Specific Recommendations for Essential Program Elements

The American Dietetic Association recommends that "rebalancing" initiatives and proposals submitted to CMS for funding consider and include the following.

- The infrastructure should be developed in a way to ensure coordination of the following two types of services, client access to safe, healthful food and oversight of emergency preparedness related to access to sources of food and clean water.
    - Access to nutrition care services—including, nutrition screening and if necessary, medical nutrition therapy (MNT). MNT involves assessment, development of a nutrition care plan with appropriate follow-up and measurement and analysis of patient outcomes for ongoing improvement of care. Patients should be screened for level of nutritional risk ideally at discharge from the hospital or long-term nursing facility or residence.
    - Access to safe, healthful food (i.e. congregate or home-delivered meals) if it is determined the patient is food insecure. Food insecure means the person may not always have access to enough food to meet basic needs.
- To provide oversight of nutrition services, the proposals should include a qualified nutrition services coordinator. Studies have shown that greater community linkages and strategies are needed to integrate nutrition services into the medical care plan—particularly with at-risk older adults[4].
- Evidence-based quality indicators and a process to measure, collect and enter baseline and ongoing beneficiary data on a regular basis to analyze and determine how well home and community-based services met beneficiary needs, including clinical outcomes, and a mechanism for tracking utilization of the new benefit needs to be included. If such quality indicators do not already exist, a proposal to identify and test the validity of new indicators should be included.
- States should establish an oversight board with stakeholders and other resources. This board must include one state licensed, registered dietitian.
- There is little consensus on what codified and uniform standards for nutrition services are necessary and appropriate in these settings[5]. An assessment of the kinds of medical and social support needs of these special populations must be considered.
- States should engage in a review of its rules for home health, assisted living facilities, day care and any other facility to ensure that nutrition care is safe and of adequate quality so that beneficiaries continue to have access to qualified, dietetics health professionals (licensed, registered dietitian).
- CMS hospital conditions of participation require that discharge planning include the appropriate members of the interdisciplinary team. The guidance for surveyors in the State Operations Manuals, in fact, includes an example of an appropriate team, which includes the qualified dietitian. Research shows, however, that this does not always occur in practice; resulting in patients not receiving the kinds of food assistance and nutrition care they need to prevent rehospitalization.[6]
- CMS long-term care facility conditions of participation requirements for discharge planning do not address the important role of an interdisciplinary team assessment of beneficiary acuity of condition or level of risk.

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[4] Sharkey JR. Longitudinal examination of homebound older adults. *The Gerontologist* 2005; 45(6): 773-782.
[5] Chao S, Dwyer J. Food and nutrition services in assisted living facilities. Boon or big disappointment for elder nutrition? *Generations* 28(3): 72-77.
[6] Baker EB, Wellman NS. Nutrition concerns in discharge planning for older adults: A need for multidisciplinary collaboration. *J Am Diet Assoc* 2005; 105(4): 603-607.