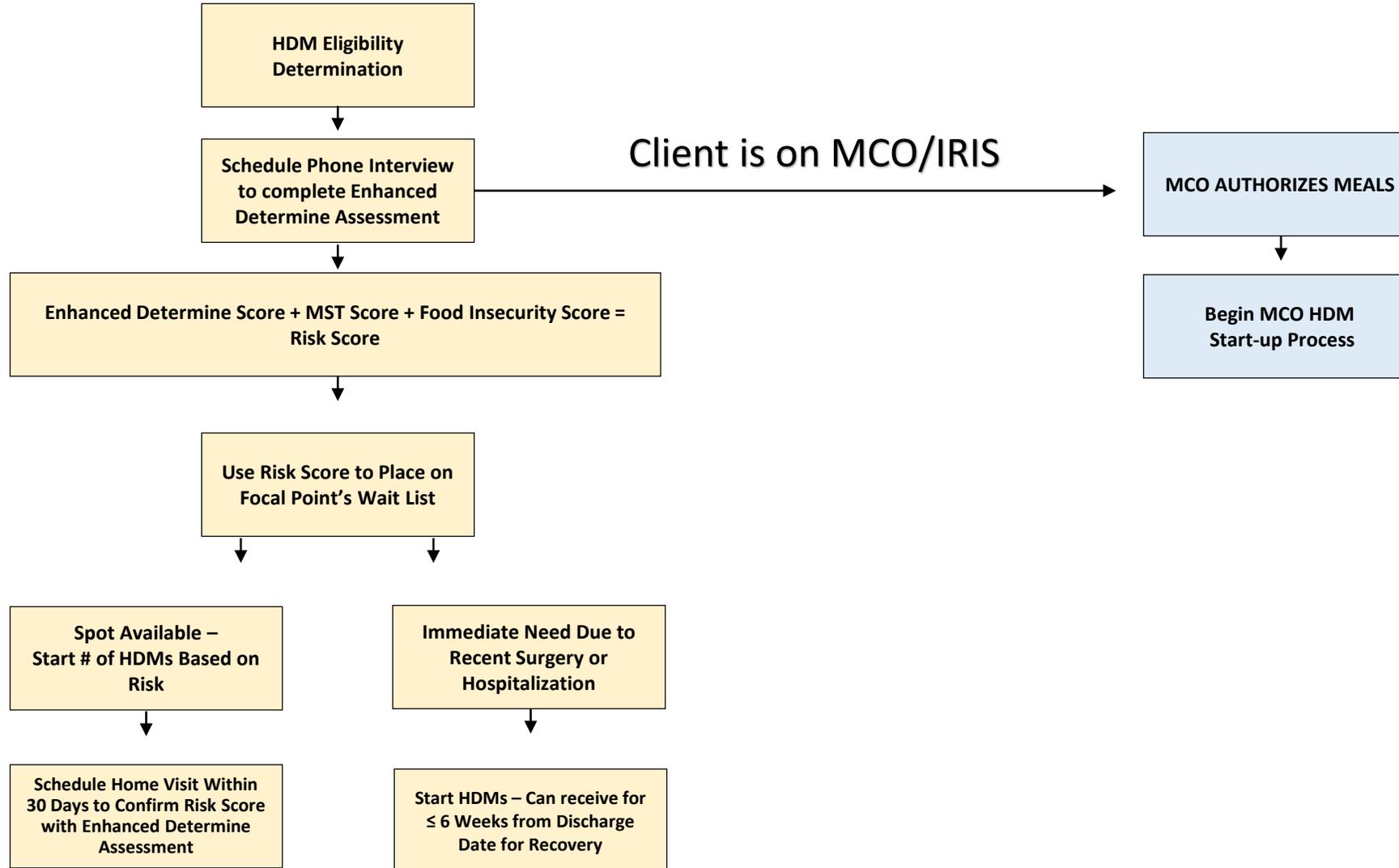


# Title III Meals

# MCO Meals



### Enhanced DETERMINE Questions Pathways

| DETERMINE Question   | If Yes, ask Follow Up Questions  | Referral/Intervention Options (Person-Centered Plan)  |
|--|--|---|
| <p><b><i>I have an illness or condition that made me change the kind and/or amount of food I eat.</i></b></p> <p><input type="checkbox"/> Yes (2)<br/><input type="checkbox"/> No (0)</p>  | <p>What acute or chronic conditions do they have?</p> <p><input type="checkbox"/> Recent falls?<br/><input type="checkbox"/> Recent Surgery?<br/><input type="checkbox"/> <b>Do they follow a special diet?</b></p> <p>If yes, specify:</p>  | <p><input type="checkbox"/> Refer to Registered Dietitian for Nutrition Ed and/or Nutrition Counseling.<br/><input type="checkbox"/> Refer to a Healthcare provider for a special diet or medically tailored meal order.<br/><input type="checkbox"/> Refer to MD for f/u if they didn't go in after a recent fall.<br/><input type="checkbox"/> Refer to Stepping Up Your Nutrition (online or in-person class).<br/><input type="checkbox"/> Refer to <i>Mind Over Matter, Healthy Bowls, Healthy Bladder (MOM)</i>. Evidence-Based Online or In-person program for incontinence<br/><input type="checkbox"/> Refer to Aging Mastery Program (AMP) offered by Focal Points.<br/><input type="checkbox"/> Refer to Healthy Living with Diabetes<br/><input type="checkbox"/> Refer to Living Well w/Chronic Condition<br/><input type="checkbox"/> Other EB Classes: Stand Up-Move More</p>  |
| <p><b><i>I eat fewer than 2 meals a day.</i></b></p> <p><input type="checkbox"/> Yes (3)<br/><input type="checkbox"/> No (0)</p> <p>(If Yes, ask what they typically eat in a day and when. Record below)</p> <p><b>Page 1 Total:</b></p> <div style="border: 1px solid black; width: 50px; height: 50px; margin-top: 5px;"></div> | <p><input type="checkbox"/> No appetite<br/><input type="checkbox"/> Unable to prepare food.<br/><input type="checkbox"/> Unable to shop for food.<br/><input type="checkbox"/> Cannot afford food.<br/><input type="checkbox"/> I sometimes forget to eat.<br/><input type="checkbox"/> Can they open the food?<br/><input type="checkbox"/> Do they have working equipment to cook or reheat food or to store it properly, i.e. working fridge?<br/><input type="checkbox"/> Do they have enough food for their pet?<br/><input type="checkbox"/> Are they raising grandchildren?<br/><input type="checkbox"/> Ask about culture and religious beliefs to see if this is one of the reasons.<br/><input type="checkbox"/> Ask if they feel lonely or depressed. If yes, ask, In general:</p> <ul style="list-style-type: none"> <li>• <b>How often do you feel that you lack companionship?</b> <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often</li> <li>• <b>How often do you feel left out?</b> <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often</li> <li>• <b>How often do you feel isolated from others?</b> <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often</li> </ul> | <p><input type="checkbox"/> Refer to Dietitian for further assessment.<br/><input type="checkbox"/> If concerned about med side effects affecting appetite <a href="https://www.drugs.com/">https://www.drugs.com/</a><br/><input type="checkbox"/> Complete FoodShare Application.<br/><input type="checkbox"/> Provide a list of food pantries and community meals and Senior Dining Sites.<br/><input type="checkbox"/> Provide list of activities to reduce loneliness and Focal Point newsletter.<br/><input type="checkbox"/> Arrange for transportation to the sites/foodpantry.<br/><input type="checkbox"/> Arrange for a proxy food pantry shopper.<br/><input type="checkbox"/> Arrange for grocery delivery.<br/><input type="checkbox"/> Provide a list of online stores that deliver. (Remember Walmart and Aldi-InstaCart)<br/><input type="checkbox"/> Refer to ADRC to explore adaptive equipment.<br/><input type="checkbox"/> Refer to <a href="#">Grand Parents Raising Grandchildren</a> support group and programs.</p> |

|  |   |   |
|--|---|---|
| <p><b><i>I eat few fruits, vegetables or milk products.</i></b></p> <p><input type="checkbox"/> Yes (2)<br/><input type="checkbox"/> No (0)</p>  | <p><input type="checkbox"/> Cannot chew fresh F/V.<br/><input type="checkbox"/> No access to fresh fruits and veggies.<br/><input type="checkbox"/> Cannot peel or cut fresh produce.<br/><input type="checkbox"/> Do not know how to prepare F/V.<br/><input type="checkbox"/> Lactose Intolerant<br/><input type="checkbox"/> Ask what fruits &amp; veggies and dairy products they typically eat and list below.<br/><input type="checkbox"/> Meds limit what they are able to eat.<br/><input type="checkbox"/> Cannot have leafy green veggies</p>   | <p><input type="checkbox"/> Refer to Dietitian for Nutrition Ed and/or Counseling.<br/><input type="checkbox"/> Refer to ADRC for Adaptive Equipment Evaluation.<br/><input type="checkbox"/> Complete FoodShare Application.<br/><input type="checkbox"/> Offer transportation for shopping.<br/><input type="checkbox"/> Recommend Lactaid or Calcium and Vit. D fortified Juice if available.<br/><input type="checkbox"/> Offer Senior Farmers Market Vouchers if available.</p>  |
| <p><b><i>I have 3 or more drinks of beer, liquor, or wine almost every day.</i></b></p> <p><input type="checkbox"/> Yes (2)<br/><input type="checkbox"/> No (0)</p>  | <p><input type="checkbox"/> Are they a widower or live alone?<br/><input type="checkbox"/> Ask about their appetite. (Poor/Fair/Good)<br/><input type="checkbox"/> Ask what meds they take, as many are affected by alcohol.<br/><input type="checkbox"/> Ask if they feel lonely or depressed. If yes, ask, In general:</p> <ul style="list-style-type: none"> <li>• How often do you feel that you lack companionship? <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often</li> <li>• How often do you feel left out? <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often</li> <li>• How often do you feel isolated from others? <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often</li> </ul> | <p><input type="checkbox"/> Refer to Dietitian for further assessment.<br/><input type="checkbox"/> Refer to Stepping On Falls Prevention Class<br/><input type="checkbox"/> Refer to Stepping Up Your Nutrition Class (If available)<br/><input type="checkbox"/> Refer to support group if wanted.<br/><input type="checkbox"/> Provide resources available from <a href="#">the National Institute for Alcohol Abuse and Addiction</a> to help make informed decisions about drinking alcohol, including <a href="#">Rethinking Drinking: Alcohol and Your Health</a>.</p>   |
| <p><b><i>I have tooth or mouth problems that makes it hard for me to eat.</i></b></p> <p><input type="checkbox"/> Yes (2)<br/><input type="checkbox"/> No (0)</p> <p><b>Page 2 Total:</b></p> <div style="border: 1px solid black; width: 50px; height: 50px; margin-top: 5px;"></div> | <p><input type="checkbox"/> Dentures? Full or partial. Do they fit?<br/><input type="checkbox"/> Have their own teeth.<br/><input type="checkbox"/> Edentulous (No teeth)<br/><input type="checkbox"/> Dry mouth?<br/><input type="checkbox"/> Swallowing problems?<br/><input type="checkbox"/> They have visited the dentist in the past year. If no, why? _____<br/><input type="checkbox"/> Ask about brushing/flossing habits.<br/><input type="checkbox"/> If they have a caregiver, ask if any challenges with feeding and oral healthcare.<br/><input type="checkbox"/> They smoke or chew tobacco</p>  | <p><input type="checkbox"/> Refer to dietitian for follow up.<br/><input type="checkbox"/> Rec. healthcare provider review meds to see if they are causing dry mouth.<br/><input type="checkbox"/> Ask if a Veteran? If yes, refer to VA for a dental assessment.<br/><input type="checkbox"/> Provide a list of free or no cost dentists.<br/><input type="checkbox"/> Refer to ADRC for adaptive equipment/<a href="#">easy-grip</a> toothbrush.<br/><input type="checkbox"/> Provide information about good oral hygiene for older adults.<br/><input type="checkbox"/> Ask if interested in quitting tobacco use and make an appropriate referral.<br/><input type="checkbox"/> Review insurance plans that include dental <a href="#">care</a> during open enrollment.</p> |

|  |   |  |
|--|---|--|
| <p><b><i>I don't always have enough money to buy the food I need.</i></b></p> <p><input type="checkbox"/> Yes (4)<br/><input type="checkbox"/> No (0)</p>  | <p><input type="checkbox"/> Ask if they get food from the food pantry, family, neighbors, etc. to make ends meet.</p> <p><input type="checkbox"/> Do they manage their own money?</p> <p><input type="checkbox"/> Do they know the meals are offered on a contribution basis?</p>   | <p><input type="checkbox"/> Refer to dietitian for tips on how to make meals on a budget.</p> <p><input type="checkbox"/> Complete FoodShare Application.</p> <p><input type="checkbox"/> Provide a list of food pantries and community meals.</p>   |
| <p><b><i>I eat alone most of the time.</i></b></p> <p><input type="checkbox"/> Yes (1)<br/><input type="checkbox"/> No (0)</p>   | <p><input type="checkbox"/> Concerned about social isolation or loneliness.</p> <p><input type="checkbox"/> Seems depressed. Why?</p> <p>If yes, ask, In general:</p> <ul style="list-style-type: none"> <li>How often do you feel that you lack companionship? <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often</li> <li>How often do you feel left out? <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often</li> <li>How often do you feel isolated from others? <input type="checkbox"/> Hardly Ever, <input type="checkbox"/> Some of the time, <input type="checkbox"/> Often</li> </ul> <p><input type="checkbox"/> Do they have a pet(s)?</p> <p><input type="checkbox"/> What do they feed the pet?</p> <p><input type="checkbox"/> Do they have a smartphone, tablet, or computer?</p> <p><input type="checkbox"/> Interested in learning how to Skype, Zoom, Facetime, etc.?</p> <p><input type="checkbox"/> Do they have internet access? If no, why not?</p> <p><input type="checkbox"/> Are they a Veteran? If yes, are they interested in the Honor Flight or other programs and services from the VA?</p> | <p><input type="checkbox"/> Refer to dietitian for follow-up</p> <p><input type="checkbox"/> Arrange transport to Senior Dining Site if able and interested on _____ days of the week.</p> <p><input type="checkbox"/> Offer Friendly Visit, phone call.</p> <p><input type="checkbox"/> Refer to community meals and senior dining locations.</p> <p><input type="checkbox"/> Provide information on the free <a href="#">Easy Tablet Help for Seniors App.</a></p> <p><input type="checkbox"/> Tell them about or help them review eligibility for discounted internet and devise at <a href="https://www.everyoneon.org/">https://www.everyoneon.org/</a></p> <p><input type="checkbox"/> Connect with Technology buddy to get them up socially connected.</p> <p><input type="checkbox"/> Provide information about local Senior Center and other community clubs/organizations/communities of faith that align with their interests.</p> <p><input type="checkbox"/> Provide Craft or Coloring Kits</p> <p><input type="checkbox"/> Refer to Volunteer Coordinator or RSVP. There may be things they can do at home to stay engaged.</p> <p><input type="checkbox"/> Refer to Veterans Office for Honor Flight or other services.</p> |
| <p><b><i>I take 3 or more different prescribed or over-the-counter drugs a day.</i></b></p> <p><input type="checkbox"/> Yes (1)<br/><input type="checkbox"/> No (0)</p> <p><b>Page 3 Total:</b></p> <div style="border: 1px solid black; width: 50px; height: 20px; margin-top: 5px;"></div> | <p><input type="checkbox"/> Ask what herbs, supplements, vitamins, and other OTC medicines they take. (List below)</p> <p><input type="checkbox"/> Are they taking their meds as prescribed? If not, why?</p> <p><input type="checkbox"/> Do they understand the instructions of how and when to take meds?</p>   | <p><input type="checkbox"/> Refer to Dietitian for follow-up.</p> <p><input type="checkbox"/> Rec. medication review with pharmacist.</p> <p><input type="checkbox"/> Refer to Pharmacist/healthcare provider to check for drug/nutrient interactions.</p> <p><input type="checkbox"/> Suggest or provide a pillbox to help them manage their meds</p> <p><input type="checkbox"/> Encourage them to tell their MD all the over-the-counter supplements they take.</p> <p><input type="checkbox"/> Review insurance options for prescription drug coverage during open enrollment.</p> <p><input type="checkbox"/> Tell them about Drugs.com if they are interested in knowing more about their meds or supplements.</p>   |

|   |  |  |
|---|--|--|
| <p><b><i>Without wanting to, I have lost or gained 10 pounds in the last 6 months.</i></b></p> <p><input type="checkbox"/> Yes (2)<br/><input type="checkbox"/> No (0)</p>  | <p><input type="checkbox"/> Any change in condition or life event change to help determine the root cause.</p> <p><input type="checkbox"/> Ask about their sleep habits.</p> <p><input type="checkbox"/> Ask about their energy level and strength.</p>  | <p><input type="checkbox"/> Refer to dietitian for follow-up.</p> <p><input type="checkbox"/> Other:</p>   |
| <p><b><i>I am not always physically able to shop, cook, and/or feed myself.</i></b></p> <p><input type="checkbox"/> Yes (2)<br/><input type="checkbox"/> No (0)</p> <p><b>Page 4 Total:</b></p> <div style="border: 1px solid black; padding: 2px;"> <p><b>FINAL DETERMINE SCORE</b> _____</p> </div> | <p><input type="checkbox"/> Does someone else prepare meals for them? Who?</p> <p><input type="checkbox"/> Do they use a lot of convenience foods? What types?</p> <p><input type="checkbox"/> Do they have any adaptive equipment? Know how to use it? Or are interested in about it?</p> <p><input type="checkbox"/> Able to open boxes, packages, cans?</p> <p><input type="checkbox"/> Able to prepare food?</p> <p><input type="checkbox"/> Ask if they exercise? If yes, what and how often.</p> | <p><input type="checkbox"/> Refer to dietitian.</p> <p><input type="checkbox"/> Refer to Evidence based classes as appropriate.</p> <p><input type="checkbox"/> Refer to Stepping Up Your Nutrition Class (if available)</p> <p><input type="checkbox"/> Refer to ADRC for adaptive equipment.</p> <p><input type="checkbox"/> Provide list of exercise or movement classes/programs</p> |

|  |  |  |
|--|--|--|
| <p><b>ASK EVERYONE and enter total score for question 1 and 2.</b></p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p><b>MST TOTAL SCORE:</b><br/>____ (0-5)</p> </div> | <p><b>2 question <a href="#">malnutrition screen MST</a></b></p> <p>1. Have you recently lost weight <b>without trying</b>? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>         If Yes, how much weight have you lost?<br/> <input type="checkbox"/> 2-13 lbs. (Score 1)<br/> <input type="checkbox"/> 14-23 lbs. (Score 2)<br/> <input type="checkbox"/> 24-33 lbs. (Score 3)<br/> <input type="checkbox"/> 34 lb. or more (Score 4)<br/> <input type="checkbox"/> Unsure (Score 1)<br/> <b>Weight loss score</b> _____</p> <p>2. Have you been eating poorly because of a decreased appetite?<br/> <input type="checkbox"/> No (Score 0)<br/> <input type="checkbox"/> Yes (Score 1)<br/> <b>Appetite Score</b> _____</p> <p><b>Total Score for question 1 and 2</b> _____</p> | <p><b>How to Score:</b></p> <p><b>MST = 0 or 1 = NOT At Risk</b><br/>         (Eating well with little or no weight loss)</p> <p><b>MST= 2 or more = At Risk</b><br/>         (Eating poorly and/or recent weight loss)</p> <p><input type="checkbox"/> Ask if ok to refer to Dietitian for follow-up.</p> |
|--|--|--|

|  |   |  |
|--|---|--|
| <p><b>ASK EVERYONE and enter score:</b></p> <p><input type="checkbox"/> Food Secure (0)<br/> <input type="checkbox"/> Food Insecure (1)</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p><b>FOOD INSECURITY TOTAL SCORE:</b><br/>____ (0-1)</p> </div> <p><b>A response of "often true" or "sometimes true" to either question = positive screen for Food Insecurity.</b></p> | <p><b>Two Question Food Insecurity Questions</b></p> <p>I'm going to read you two statements that people have made about their food situation. <b>For each statement, please tell me whether the statement was often true, sometimes true, or never true</b> for your household in the last 12 months.</p> <p>1. "We worried whether our food would run out before we got money to buy more." Was that often true, sometimes true, or never true for your household in the last 12 months?<br/>         _____</p> <p>2. "The food that we bought just didn't last, and we didn't have money to get more." Was that often, sometimes, or never true for your household in the last 12 months?<br/>         _____</p> | <p><input type="checkbox"/> Refer to Dietitian.<br/> <input type="checkbox"/> Complete FoodShare Application.<br/> <input type="checkbox"/> Provide a list of food pantries and community meals.</p> |
|--|---|--|



|   |  |   |
|---|--|---|
| <b>DETERMINE Nutrition Risk Level:</b><br><input type="checkbox"/> Low Risk (0-2)<br><input type="checkbox"/> Moderate Risk (3-5)<br><input type="checkbox"/> High Risk (6 or more) |  | <b>MST Malnutrition Screen Score</b><br><input type="checkbox"/> Not at Risk (0 to 1)<br><input type="checkbox"/> At Risk (2 or more) |
|   | <b>DETERMINE Score (0-21)</b>                                    | <b>Food Insecure?</b><br><input type="checkbox"/> No (0)<br><input type="checkbox"/> Yes (1)  |
|   | <b>MST Malnutrition Screen Score (0-5)</b>                       | <input type="checkbox"/> Record the MST Score and Food Security Response in SAMs Special Use Fields                                   |
|   | <b>Food Insecurity Score (0-1)</b>                               |   |
|   | <b>Total Risk Score (0-27)<br/>(For Assignment on Wait List)</b> |   |
|   | <b>Short-Term Recovery Need for Meals ≤ 6 Weeks</b>              |   |

# FAQs

- 1. What if a in-home caregiver or family member is hospitalized or recovering from a procedure and no longer able to cook meals for the older adult?** Title III Meal Process. Short term meals are not started since they're for the individual that is recovering from a procedure or hospitalization.
- 2. If person needing meals has a caregiver and it is in the best interest of the person needing meals, the caregiver can receive meals, as well.** (That caregiver receives the meals at the same time that the person needing meals becomes eligible (taken off wait list)).
- 3. What if their recovery phase is longer than 6 weeks?** Must have in-home reassessment to continue.
- 4. How often are individuals on the wait list reassessed?** Annually, but if their condition worsens – have the client call to be reassessed.
- 5. How many wait lists are there and who manages it?** One wait list per focal point – managed by that focal point.
- 6. Do I need to complete an in-home assessment prior to placing on the wait list?** No – phone assessment is adequate.
- 7. Do I need to complete an in-home assessment prior to starting meals?** No, completed within 30 days.
- 8. SSM Health:** No existing evening meal recipient can be placed on county funded evening meals until a phone assessment is completed, they are placed on the wait list, and a spot becomes available.
- 9. Private Pay meals are not an option for focal points.**