Design for a mobile meals program through home health care

Terry L. Thomas

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A Design For A Mobile Meals
Program Through Home
Health Care

by
Terry L. Thomas

A research report
submitted in partial fulfillment
of the requirements for the degree of
Master of Science in Health Administration
Cardinal Stritch College
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We approve the thesis of Terry L. Thomas.

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ABSTRACT
A Design For A Mobile Meal Program Through Home Health Care

The purpose of this project was to establish criteria for design and implementation of a mobile meals program. Mr. Carmel Home Health Care decided to develop such a program to service patients and other individuals within the community who were unable to prepare or obtain meals themselves. Mobile meal programs through other agencies provided a valuable community service, yet the development of a program would eliminate referrals to these competitive services. The program was feasible, because many resources were available for use through Mt. Carmel Health Care Center. The program went into effect after the following was accomplished:

1. Researching literature and existing meal programs.
2. Establishing criteria for delivery of meals.
3. Establishing program policies and procedures.
4. Establishing patient costs for the service.
5. Obtaining necessary materials to set up the program.
6. Orienting all staff to program mechanics.
7. Implementing the service to home health patients.
8. Establishing evaluation criteria to monitor the program's success.
9. Making appropriate revisions.

The pilot study was a determining factor for this project. The researcher considered the feedback and when appropriate, incorporated information into the final design. Mt. Carmel
Home Health Care's administration approved the final program draft and home-delivered meals began to patients receiving services from the agency. The final success criterion was a desire by patients and families to have home-delivered meals, indicating that the program filled a void which existed on the south side of the community.
CHAPTER 1
RESEARCH PROJECT

Purpose of the Project

The purpose of this project was to design and implement a mobile meals program through Mt. Carmel Home Health Care. This program would serve patients receiving services from the home health care agency and eventually expand to service individuals in the surrounding community. The program would include specific guidelines for eligibility to receive meals, provide services at competitive costs to the patient and supply nutritionally balanced meals plus specialty diets to persons who meet program criteria.

With assistance of Mt. Carmel Health Care Center a number of resources were available. These resources included a dietary department which agreed to prepare and package all meals and a volunteer service which was called upon for distribution of meals. Administrative staff from the health care center and the home health agency felt that the project was worthwhile, as it would expand services and assistance into the community. An evaluation of the project, using patient questionnaires and periodic home visits, was planned after implementation.

Problem

Since 1985, the home health industry experienced enormous growth (United States Senate, 1976, p. 1). In February of that year Mt. Carmel Home Health Care began to operate.
The agency delivered highly skilled and supportive care to patients referred for services. The patient caseload steadily increased due to vigorous marketing strategies. With the increase in patient census, the researcher found patients to have various needs and that they might benefit from a wider variety of services. A mobile meals program was one service to assist the homebound patient. This type of patient made up the largest percentage of clientele.

The majority of patients using Mt. Carmel Home Health Care were over the age of 65 years. Due to chronic illness, disability, lack of others to provide meals, and living alone, it was the elderly population who requested home-delivered meals and fostered the idea that Mt. Carmel Home Health Care provide such service.

Other than direct benefits to the patients, there were many reasons for the home health care agency to develop such a program. One reason was to help the agency grow in terms of referrals. An economic motive also existed in that additional programs would be a valuable marketing tool for the agency. The major influence to initiate a mobile meals program came from the fact that resources, such as dietary, volunteer services, and van shuttles, were readily available for use through Mt. Carmel Health Care Center.

Title, Location and Duration

The title of the project was A Design For A Mobile Meals Program Through Home Health Care. The design of the
The project occurred at Mt. Carmel Home Health Care in Milwaukee, Wisconsin. Data collection was consolidated in the Home Health Office. The duration of the project was seven months. Project coordination began on June 1, 1987 with the program being implemented on December 1, 1987.

Participants

The researcher, who was also the Director of the agency, became the coordinator of the project. The responsibilities of the researcher included: program development, marketing agency services, determining staffing needs, and purchasing power. Other staff members from the agency participated in data collection. The Assistant Director of the agency helped by providing information based on her experience of developing a similar program at an area hospital. A staff nurse assisted by collecting information from existing agencies that had home-delivered meal services. The dietitian from the health center gathered information about supplies and materials needed to begin delivery of meals. The administrator of the home health agency was kept abreast of the entire program development.

THEORETICAL FRAMEWORK

Psycho-social

The elderly population utilizing home-delivered meal services did so for a number of reasons which the researcher considered to be psychological or social in nature. Some of these reasons were:
1. Many older persons lacked the skills to select and prepare nourishing, well-balanced meals.
2. The homebound aged had limited mobility which hindered their capacity to shop and cook for themselves.
3. Many older persons did not eat adequately because they could not afford to do so.
4. Many elderly had feelings of loneliness and rejection which obliterated the necessary incentive to prepare and eat a meal alone (United States Senate, 1976, p. 6).

Loneliness and isolation were descriptions of the problems faced by a large majority of the elderly population. Factors contributing to isolation were poverty, ill health, inadequate transportation, feelings of rejection, apathy, and loss of their role in the family or within the entire social structure (United States Senate, 1976, p. 11). Home-delivered meal programs have alleviated social problems of patients by providing, on a daily basis, significant social contact and possibly the incentive to prepare meals (United States Senate, 1976, p. 12).

Political

A study by the United States Senate indicated that nutritional efforts, funded by the Federal Government through Title VII of the Older American Act, have achieved growth of home-delivered meal programs. Established in
In 1972, this act led to the Elderly Nutrition Program, designed to serve most meals at congregate sites. In addition, these congregate meal programs provided various levels of home-delivered meals (United States Senate, 1976, p. 4). In 1976, a selected committee on nutrition conducted a study sponsored by the United States Senate. It was at this time that the United States Senate introduced the National Meals on Wheels Act. This act alleviated some of the nutritional, psychological, and social problems which faced many home-bound elderly who received services (United States Statutes at Large, 1982, p. 1536).

In October 1978, Title III, Part C (P.L. 95-487) allowed grant monies for state and local agencies to establish and implement home-delivered meal programs. Since that time the number of home-delivered meal programs increased considerably (United States Statutes at Large, 1982, p. 1537).

**Physiological**

Many physiological changes occurred in the elderly which had a direct effect on their appetite, eating habits, and nutritional requirements. These changes included loss of metabolizing body tissue, lowered body temperature, decreased saliva secretion, impaired circulation, loss of bone density, and loss of lean body mass (D. Raab & N. Raab, 1985, p. 24). Any of these conditions could increase in severity if the older adult did not eat properly. Nurses
working in home health and public health care were aware of these changes and encouraged older adults to consume nutritionally balanced meals through community meal programs.

The meals prepared and supplied to individuals had to contain the Recommended Daily Allowance (RDAs) established by the Food and Nutrition Board of the National Academy of Sciences. The Board judged the RDAs adequate to meet the known nutritional needs of practically all health persons (United States Senate, 1976, p. 19). They specified these allowances according to age, sex, and certain average criteria for height and weight.

Economic

There were a wide range of factors that contributed to the actual cost of a mobile meal program. Factors included the actual cost of the food itself, an item which increased substantially in price over the past several years, and various other expenditures. Such expenditures were the initial costs of purchasing kitchen equipment and containers to keep food warm during delivery (United States Senate, 1976, p. 59). There were also costs in hiring additional kitchen personnel for packaging of meals and a professional nutritionist who arranged special dietary needs. Incidental expenses could add up and increase the need for a substantial cash income from the program.

Many agencies set fees for home-delivered meal programs
based only on the cost of the food itself. These fees, of course, made it easier for the senior citizen to afford home-delivered meals, but could leave an automatic deficit for the agency which provided the service. A review of initial service costs was necessary in the development of this program.

Summary

The purpose of this program was to design and implement a mobile meals program through Mt. Carmel Home Health Care. The decision to implement mobile meals came from the Director of the agency who along with health center administration recognized benefits of the program such as increasing service ability, establishing marketing power for the agency and eliminating referrals to competitive facilities for this service. One limitation recognized was the economical deficit which may occur because of the initial set up costs for the program.

Chapter 1 provided the purpose, problem, scope of the project and theoretical framework. Based on the draft proposal, Mt. Carmel Home Health Care developed the mobile meals program.

In Chapter 2, the researcher reviewed literature from selected areas of nursing, public health files, management literature, government publications, and from existing mobile meal programs. The literature addressed the following questions: What were the specific components of a
mobile meal program? What criteria qualified patients for meal services? What are the advantages or disadvantages of such a program to recipients and to the agencies that provided these services?
CHAPTER 2
REVIEW OF THE LITERATURE

Introduction

The purpose of this project was to design and implement a mobile meals program through Mt. Carmel Home Health Care. This program was important to Mt. Carmel Home Health Care in that the agency could make these services available to patients receiving other home care services and foster the agency's ability to expand services into the surrounding community. Development of the program stemmed from the fact that the agency repeatedly made referrals to competitive agencies when patients required mobile meals. Mt. Carmel's administration recognized the feasibility of a mobile meal program as resources were readily available for use through Mt. Carmel Health Care Center, a 692 bed skilled nursing facility. Resources included a dietary department, volunteer services, and a van service for delivery of meals.

Research on major issues included examination of program components, eligibility of an individual to receive mobile meals, and advantages or disadvantages to either the agency or recipient of such service. Mt. Carmel Home Health Care found information in various sources of nursing literature, public health files, management literature, government publications, and from already existing mobile meal programs.
Major Issue #1: What are the specific components of a mobile meal program?

In 1972 the Federal Government through Title VII of the Older Americans Act, funded efforts to improve nutrition through meal programs (Turner & Armstrong, 1984, p. 37). The 1978 Amendment to this act established separate authorization for home-delivered meals. This amendment, found as Public Law 95-478, October 18, 1978, developed minimal components of efficiency and quality for the furnishing of home-delivered meal services (United States Statutes at Large, 1982, p. 1536). Based on determination of need, area agencies provided home-delivered meals at least five or more days per week. Agencies served meals hot, cold, frozen, dried, canned, or any other type of supplemental food with a satisfactory storage life. The providing agency gave preference in the purchasing of home-delivered meals to the public, private, non-profit, and voluntary organizations that demonstrated their ability to supply home-delivered meals efficiently and reasonably and in compliance with regulations set by the Older Americans Act.

In addition, the Food and Nutrition Board of the National Academy of Sciences required prepared meals to contain Recommended Daily Allowances (RDAs) (United States Department of Health and Human Services, p. 14). Sanitation and temperature control standards had to be met.
regardless of the size of the program, meal preparation method or geographical region. These standards ensured that all food was microbiologically safe for consumption (United States Senate, 1976, p. 19). Every area of program operation required planning by agency administration. These areas were food costs, labor, food preparation, supplies and equipment.

Major Issue #2: What criteria were used for qualifying patients for meal services?

Delivery of meals to the homebound elderly population became the concept for early home-delivered meal programs. A clear consensus among experts at local, state, and national levels indicated that meal support for the homebound elderly was woefully inadequate (Human Development Services, 1981, p. XVI).

Two age groups were of relevance to understanding the problems of the homebound aged. First the 60 to 64 age group received recognition because they were eligible under the authority of the Title VII Elderly Nutrition Program. Second, the age group 75 years and above was important since most disabilities which cause mobility limitations were often related to this group (United States Senate, 1976, p. 4).

From a sociological perspective, older adults often did not eat properly, because they could not afford to do so. They lacked skills to select or prepare meals. Many elderly
also lived alone and often did not have incentive to cook for themselves, thus at meal times they did not eat at all (United States Senate, 1976, p. 5).

Criteria eligibility for services depended on the facility that provided the meals. The agency created its guidelines on whom to serve. For example, the Federal Government defined eligibility for Milwaukee County's home-delivered meal program as follows:

1. An individual sixty years of age or the spouse of a person sixty years of age was able to receive home-delivered meals.
2. The individual must have been homebound, meaning that he or she did not leave home under normal circumstances.
3. The person must be unable to participate in congregate meal programs because of physical or mental impairment.
4. There could be no other living adult in the same building, house, or living area who was willing or able to prepare meals for the individual.
5. Individuals must be able to tolerate a regular diet. Special diets which require modification or therapeutic restrictions would not be provided.
6. The individual must have been able to feed him or herself.
7. The individual must have a physical or mental impairment which made them unable to prepare or obtain food.

8. Each individual must have agreed to be home when the meals were delivered or notify the program if absence was unavoidable.

9. The individual could not receive meals from any other source or agency (United States Senate, 1976, p. 6).

The length of time an individual would receive the meals was also very important. If a person were to utilize the service on a short term basis, a physician's statement indicating the need for home-delivered meals was required. If the person were going to utilize the service on a long term basis, the request for the meal program would have to come from a health or social service agency that had assessed the patient's situation and offered other supportive services (State of Wisconsin, 1980, p. 9).

A registered nurse employed by the Visiting Nurses Association (personal communication, July 10, 1987) specified eligibility as being, homebound residents who were unable to shop for food, cook their own meals or who had to rely on someone else to shop and cook for them on a daily basis. In addition, the Visiting Nurses Association provided meals to those individuals needing special diets or help in preparation until that person learned to manage his
or her own diet. In these cases there was a need for additional services such as in-home counseling to help people learn to adjust to special dietary requirements. A registered dietician was available to visit the home and teach individuals how to incorporate their special diet with nutritional needs of the entire family.

American Medical Services (personal communication, July 10, 1987) also provided home-delivered meals to Milwaukee County residents. A spokesman for the agency explained that to be eligible for home-delivered meals, a recipient need not be of a special age. However, a patient must exhibit decreased mental capabilities or disability which limited their ability to cook for themselves.

Manor Home Care, a home health care agency associated with Methodist Manor Nursing Home, provided Manor Mobile Meals (personal communication, July 10, 1987). A representative of Manor Home Care stated their meal program was a "nutritional link to the community." They serviced specific boundaries in Milwaukee which the agency outlined. Manor Home Care did not state eligibility requirements such as age, homebound status, physical disability or illness.

A social worker at Jewish Vocational Services (personal communication July 10, 1987) described their home-delivered meal program. Like Manor Home Care, Jewish Vocational Services did not specify age group or illness in order for individuals to receive the service. A patient's
physician needed to authorize the provision of meals at least 48 hours prior to expected meal delivery. This program also supplied meals to the disabled and ambulatory elderly at some Milwaukee County congregate sites. Community care organizations and Milwaukee's Department of Social Services supported most meal programs.

West Allis Memorial Hospital (personal communication, July 10, 1987) was another facility that had a community home-delivered meal program. The Director of the meal program stated that eligibility required the beneficiary of services to be a resident of the city of West Allis, plus have an appropriate physician's order for meals to be delivered. The individual must be homebound and have access to refrigeration facilities. The Director did not specify an age for service, however, they served primarily the older adult. West Allis Memorial Hospital supplied special diets to the patient if ordered. A discharge planner from the hospital arranged the patient's meal delivery and was responsible for follow-up on the client's condition.

Major Issue #3: What were the advantages or disadvantages of this service to the agency or recipient of home-delivered meals?

Delivery of meals to the homebound patient played a large role in reducing the cost of institutionalization. Homebound elderly did not necessarily require institutional
care, but sought some support to maintain themselves at home. Often nutritional support was the major obstacle. Shopping and meal preparation have been extremely difficult for someone confined to bed or limited in mobility. Home Health Care agencies, who have provided this service, offered their patients the additional benefit of meal delivery and assisted them with their overall recovery from disease or illness.

 Agencies that offered a great number of services used mobile meal programs as a marketing approach to obtain referrals. For a program to be of benefit to a company or agency, the following operational concepts needed to be enacted:

1. Establishment of a comprehensive source of policies and procedures.
2. Facilitation of consistent administrative personnel policies.
3. Promotion of continuity in management style throughout the organization.
4. Identification of problems before they arise in order to minimize "crisis management."
5. Reduction in the number of emotional decisions encouraging a businesslike climate of objectivity.
6. Definition of clear lines of authority and distribution of responsibility evenly.
7. Establishment of a training tool for employees
   (Chane, 1988, p. 42).

In any growing company top management must personally endorse a project and provide leadership to keep it moving. Functions of top management are to formulate all existing policies and procedures and to conference with all levels of management and staff regarding problem solving. This interaction ensures that all ongoing service needs are covered. Program revisions and one appointed individual in top management should approve all proposals for change. This individual responsible for change eliminates any overlap, duplication or confusion in program management. Finally, top managers should complete a program review, at least yearly, because by its very nature, a growing competitive company experiences rapid change (Chane, 1988, p. 41).

In addition, throughout the business industry top management has continued to seek and implement new programs which improved product quality and enhanced productivity. It was imperative that any business or agency become a "world class competitor" by expansion of their service market to keep them from closing their doors (The Appliance Line, 1988, p. 7).

Mobile meals was probably best known and the most widely respected community service in Australia. There, this service was basically "a neighborhood service."
Providing meals to people who had difficulty caring for themselves offered them a sense of security and independence rather than having to admit these individuals to an institution. Australia reported that some communities had saved considerable expenditures on institutional care. Rather than charity, communities recognized this program as a caring and sharing human experience (Pudney, 1982, p. 11).

Mobile meal programs had a number of circumstances which limited their capacity to serve more than a small portion of those in need of in-home nutritional services. Those circumstances have existed because of the very nature of the program rather than any failure on the part of the person who managed them. Food costs, meal preparation, and incidental expenses had to be taken into account. Compounding the problem, meal programs based the fees on the patient's ability to pay. Every time fees decreased for a particular patient, the program lost money on food costs alone. Therefore, too many lower income patients made it difficult for an agency to sustain itself financially. The acute dilemma that occurred was more and more low income elderly applied for the program. For an agency whose goal was to serve everyone eligible for the service, they found it an increasingly difficult task (United States Senate, 1976, p. 59).

Community resources have been very supportive of
mobile meal programs, but funding available for these programs has been limited. In short, although these programs played an exceptionally vital role in providing a necessary nutritional service to the homebound elderly, these programs have never been able to meet more than a small portion of the need that existed within the community (United States Senate, 1976, p. 60).

Summary

Mobile meal programs have become an important community service to reach the frail homebound elderly individual who, in most instances, had no other means of nutritional support. Mt. Carmel Home Health Care discussed three management issues. These issues were program components, qualifying criteria for services, the advantages or disadvantages to the recipient and the agency. Comparing existing meal programs provided Mt. Carmel Home Health Care with important service guidelines. The literature referred to throughout this chapter provided evidence regarding the standards for meal programs. Although these standards existed, area agencies individually decided whom to service. The objective of every program was to provide this health-related service in a safe, efficient manner.

Literature also supported the necessity of mobile meal programs, especially for agencies or groups that involved caring for the elderly population. The home-
bound elderly were in the greatest need of home-delivered meals for they were the population most vulnerable to malnutrition. In Chapter 3 the researcher outlined the methodology used as Mt. Carmel Home Health Care began to set guidelines, goals and objectives for its own mobile meal program.
CHAPTER 3
METHODOLOGY

Purpose

The purpose of this project was to design and implement a mobile meals program through Mt. Carmel Home Health Care. The program would be available to patients receiving home care services and foster expansion of the agency's services throughout the community. Mt. Carmel Home Health Care researched existing home-delivered meal programs in the community to obtain service guidelines from their current operation. This information assisted us to evaluate and incorporate and appropriate aspects into the design of Mt. Carmel Mobile Meals.

Mt. Carmel Health Care Center was a licensed 692 bed skilled nursing facility which incorporated a home health agency. Mt. Carmel Home Health Care offered a variety of skilled and supportive services to individuals residing in Waukesha, Milwaukee, and Racine counties. The agency was progressively expanding by constantly working to stay abreast of community health needs and practices.

The sharing of information among committee members in regard to mobile meal programs was essential in the planning of the project. Mt. Carmel’s administration was interested in coordinating available resources within the health center to set up the program. The mobile meal program involved the dietary department, volunteer services
and Mt. Carmel's transportation service. Designing and implementing the mobile meals program which met certain requirements was the major objective of this project.

Participants

The researcher, who was the Director at Mt. Carmel Home Health Care, actually succeeded in setting the home health care agency into operation in 1984. The scope of the researcher's experience ranged from providing direct patient care to various levels of nursing administration. Assisting the researcher with recommendations and suggestions were the Assistant Director, the Director of Dietary (a registered dietitian), and two registered nurse staff members of the agency. Mt. Carmel Home Health Care selected forty older individuals for the survey process basing their decision on the number of patients the agency was serving at the time. Other participants included home health aides, the Administrator of the agency, and the Assistant Administrator of the health care center. In addition, six other agencies that had existing mobile meal programs provided information as to their service guidelines.

Research Design

The project initially began on June 1, 1987 with an anticipated implementation on December 1, 1987. The researcher outlined the program after extensive study of information on existing meal programs. Mt. Carmel Home Health Care contacted local vendors to scrutinize equipment
costs and purchase necessary items. Various staff members provided input for the project and both agency and health center administration approved the program.

The home health project committee began inspection of its current case-load to see who would accept the service and who would benefit from the program. The committee selected patients and familiarized them with the mobile meals concept by describing the type of meals to be provided, the time the meals would be delivered, the cost of the meals per day, and extent of service per week. Following patient suggestions and recommendations, the administrative staff approved the final program draft on August 4, 1987. Extensive meetings by health center department directors preceded implementation of the program.

There were some unforeseen problems which made keeping the timeline impossible. The timeline remained intact regarding the program design, orientation of agency staff, marketing strategies and program goals. The Director of the dietary department took a medical leave from Mt. Carmel Health Care Center on September 1, 1987 until November 1, 1987 which delayed development of plan decisions until that time.

Evaluation Design

In studying six area agencies with existing mobile meal programs, Mt. Carmel Home Health Care obtained both positive and negative information about meal programs.
The planning committee incorporated this information into the final design for a mobile meals program.

The survey tool given to patients consisted of a questionnaire to obtain information about meal preferences, time of delivery, and expectations about the quality of meals. On September 28, 1987 and October 15, 1987, Mt. Carmel Home Health Care staff mailed the questionnaires to community residents. In absence of the dietary director, the planning committee could not finalize meal preparation and packaging guidelines. Instead, the committee formed preliminary objectives in regards to dietary instructions. Evaluation of another objective required that home health staff and ancillary members be kept informed on the development of this program.

**Evaluation Question 1**

Did the mobile meal program implemented at Mt. Carmel Home Health Care meet the needs of the patient's served?

The objective was to design a program through Mt. Carmel Home Health Care which would facilitate meal delivery to our patients within the community. Based on the study of literature and existing mobile meal programs, the project committee developed criteria and identified components for implementing a functioning program. These components were to:

1. Designate clearly the personal responsibilities for preparation and delivery of meals.
2. Market services to the population in need of home-delivered meals.

3. Provide a nutritious variety of meals to be served to patients on a regular basis.

4. Provide patients with meal options for example, the number of meals offered per day.

5. Have resources for equipment, meal preparation, and delivery of meals.

Both nursing and administration verbalized interest in development of a mobile meal program through Mt. Carmel Home Health Care. The agency needed program criteria in order to begin serving patients. The project committee was responsible for establishing such criteria. This committee also clarified the developmental issues involved and suggested that a mobile meal program could be a viable and valuable tool in which to expand home health community services. The committee developed policies and procedures to outline the responsibilities of each department. Committee members hoped specific guidelines would provide support to those individuals, such as dietary and volunteer staff members involved in the program's implementation.

Early in the development of this project, strategies for introduction of this new program were laid out. The strategies included:

1. Involving staff from various departments to promote a commitment to the final program.
2. Piloting the program to twenty-five elderly patients receiving home health care services.

3. Realizing that achievement of the researcher's goal requires a shift in working habits and attitudes necessitating education in program mechanics.

4. Implementing the program to additional patients who may benefit from mobile meals and possibly expanding the program to all individuals within a certain service area.

Mt. Carmel Home Health Care did not anticipate that these strategies would eliminate completely the apprehension toward any new program; however, the project committee hoped that these strategies would decrease staff anxieties at the time of the pilot program.

Evaluation Question 2

Were the attitudes of the program participants adequately developed to ensure that meals were delivered to each recipient of the meal program?

Successful implementation of the program depended on Mt. Carmel Home Health Care's educational efforts. The agency developed programs on patients' nutritional needs, and their home environment. One representative of the project committee held the responsibility for this phase of the program. Staff participants attended educational programs to gain knowledge and develop positive attitudes
about community health practices.

Procedures

To fulfill program goals, objectives and implementation of the pilot program, the project committee outlined specific responsibilities for each department. Major departmental responsibilities included the following:

**Home Health Care**

1. Determining patient eligibility and assessing patients need for home-delivered meals. Mt. Carmel Home Health Care stated eligibility as receiving other home care services from the agency. Spouses or other family members were also eligible to receive meals. At this time no age limit for service was set, however, the majority of meals served the elderly population.

2. Contacting the physician to obtain orders for type of diet or modified dietary requirements.

3. Coordinating the meal service with the dietary department and specifying type of diet and patient likes and dislikes.

4. Collecting fees and recording the number of patients receiving the service.

**Dietary Department**

1. Preparing meals with two-thirds of the recommended daily allowances.
2. Storing food and properly packaging meals for delivery.
3. Providing modified dietary needs.
4. Maintaining any and all equipment used in meal preparation and delivery.
5. Ensuring proper temperature of all prepared meals.

Volunteer Services
1. Supplying an adequate number of van drivers to deliver meals Monday through Friday.
2. Providing all drivers with their delivery routes.
3. Scheduling use of the vans between 11:00 a.m. and 1:00 p.m.

Instruments Materials and Equipment

Mt. Carmel Home Health Care outlined the main objective and specific goals for the project in the initial program proposal for mobile meals. Our objective was to establish a meals on wheels program as an integral part of the agency.

Goals included:
1. Overseeing the establishment of the program and coordinating information.
2. Sharing information among all disciplines involved.
3. Working closely with the dietary department at Mt. Carmel Health Care Center as to meal preparation, meal delivery and cost.
4. Investigating initial set-up costs along with establishing a present and future financial plan.
5. Identifying patients who would participate in the pilot program.
6. Assessing staffing needs.
7. Reviewing services and referring operational matters to appropriate personnel to ensure quality of the program.
8. Reviewing effectiveness and efficiency of the program through a retrospective audit on an annual basis or as the program committee deemed necessary.

When the home health care agency formed the program committee on June 12th, 1987, committee members received an outline of their duties in relation to their involvement with the project. At that time committee members approved the proposal.

The actual preparation and delivery of meals required adequate personnel from the departments involved. In addition, the dietary department needed specific equipment for packaging of meals and purchased food carriers especially designed for the delivery of hot meals. All other equipment and utensils were available for our use through Mt. Carmel Health Care Center.

The project committee developed a patient questionnaire which was sent to forty elderly individuals to determine patient needs and viability. The questions were as follows:
1. Are patients currently receiving home-delivered meals or have they ever received home-delivered meals?
2. Was the individual able to feed himself?
3. Was the individual on any special diet?
4. What delivery time was convenient for the recipient of home-delivered meals?
5. Was there a desire for family members or a spouse to receive home-delivered meals?

The main objective of this questionnaire was to find out if there was a need in the community and an interest by patients to receive home-delivered meals. Based on responses to the questionnaire the project committee selected patients to participate in the pilot program.

Summary

The purpose of this project was to design and implement a mobile meals program through Mt. Carmel Home Health Care. The agency planned home-delivered meals to foster expansion of the agency's services throughout the community and provide nutritional assistance to patients already receiving home care services.

The agency developed program guidelines and departmental responsibilities before implementation of mobile meals. The development of criteria was related to admitting patients to this service along with criteria for the preparation and packaging, offering types of meals and
ensuring appropriate delivery of meals. Mt. Carmel Home Health Care staff mailed questionnaires to forty patients to determine the need for such service. The project committee planned a pilot study to check program mechanics. In Chapter 4, the researcher described the findings of the patient questionnaire, reported on the success of the pilot program, and specified necessary revisions or changes in the program's format.
Mt. Carmel Home Health Care staff in Milwaukee, Wisconsin designed, implemented and completed a mobile meals program titled Mt. Carmel Mobile Meals. Prior to the development of this program, Mt. Carmel Home Health Care referred many patients in need of this service to other existing meal programs. The number of patients served during the pilot program totaled six. The patients consisted of older adults over the age of sixty years who were receiving either skilled or supportive services from our agency. Through investigation of local meal programs and based on information collected from various nursing and management literature, the project planning committee coordinated the data and developed the program format. With finalized program objectives, the committee approved delivery of one or two meals per day Monday through Friday to the patient's home between 11:00 a.m. and 1:00 p.m.

Preparation and packaging of meals was the responsibility of Mt. Carmel's dietary department that would also have capabilities to prepare special diets. Directors of both the dietary department and volunteer services gave involved staff members directions on proper packaging of meals and delivery routes. Patients received meals hot, appetizing, and pleasing in appearance. Staff provided assistance to the patient with meal set up if needed.
This goal was met on December 1, 1987 when the delivery of meals started.

An objective of this project was to gain acceptance and affirmation of the program by Mt. Carmel's administration as well as a commitment by patients for its use. The agency sent forty home health care recipients questionnaires on our mobile meal program. The committee tallied a 60% (n=24) response as of November 10, 1987. The project planning committee conducted a detailed analysis of patient responses to describe the viability of the service and identify patient needs (Table 1).

Based on program elements the committee concluded that a majority of patients were presently not receiving home-delivered meals. The figure of 87.5% did not necessarily mean these patients needed home-delivered meals, but simply patients did not receive this service. This finding was important to the agency concerned with developing an area in the community to target the program. One valuable element of the survey was that 98.8% of the individuals were able to feed themselves. The agency adopted this element as one criteria in providing individuals with home-delivered meals.

In addition, a little under one half of the patients ate special diets. Special diets were an important element for meal programs in that providers of home-delivered meals had to be capable of preparing such diets and knowledgeable
Table 1

Evaluation of Patient Response to Questionnaire for Mobile Meal Program (n=24)

<table>
<thead>
<tr>
<th>Program Element</th>
<th>Patient Response</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presently receiving home-delivered meals</td>
<td>yes*a</td>
<td>3</td>
<td>12.5</td>
</tr>
<tr>
<td>Ability to feed self</td>
<td>no*b</td>
<td>21</td>
<td>87.5</td>
</tr>
<tr>
<td>Special diets</td>
<td>1</td>
<td>4.2</td>
<td></td>
</tr>
<tr>
<td>Convenience of meal delivery</td>
<td>yes*a</td>
<td>12</td>
<td>50.0</td>
</tr>
<tr>
<td>Desire for family member or spouse to receive meals</td>
<td>no*b</td>
<td>12</td>
<td>50.0</td>
</tr>
<tr>
<td>TOTAL PATIENT INTEREST IN PROGRAM</td>
<td>yes*a</td>
<td>17</td>
<td>70.9</td>
</tr>
</tbody>
</table>

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*a yes indicates a patient need regarding the meal program is met.

*b no indicates the patient need has not been met.

*c value greater as patient may live alone or have meals brought in by other individuals.
about nutrition in order to properly provide service to patients. Convenience of meal delivery was split 50/50 resulting in delivery time of meals to remain between 11:00 a.m. and 1:00 p.m. A high percentage of individuals responded negatively to the desire for family or spouse to receive home-delivered meals. This element had variables, such as meals, already being provided to the patient by friends or family, or the patient resided with the family, who assisted with meal preparation, or this element did not apply to patients who lived alone. Based on a patient's home situation, the agency believed that if requested, spouses and/or family members would be eligible to receive meals through the program.

The most important element of the program was patient interest. Over 70% of the patients in this category indicated to the agency that a need existed within the community. Patients who participated in the survey raised further comments about specific procedures, such as payment, delivery method, and exact time of delivery. The planning committee addressed each issue individually and accommodated each patient's request.

Following the meeting on November 16, 1987 the researcher met with agency administration and the administrator from Mt. Carmel Health Care Center to discuss implementation issues and receive feedback on the mobile meals program. The administrators expressed concern that
various delays in the transportation schedule might occasionally cause meals to arrive later than the patient's requested time. The researcher agreed to develop a policy of notification in case delays occurred. At the administrators urging, volunteer services would be responsible for following the policy and contacting patients in the event meals would be in excess of thirty minutes late. Administration posted the policy along with the procedure in the Volunteer Office and in the Home Health Care area.

Finally during the administrators' meeting the researcher agreed to prepare a special brochure for patients and families defining the program, enrollment procedure, extent of meal services, and contact number for questions or concerns about the program. Placement of these brochures throughout Mt. Carmel Health Care Center was in such areas as the nursing office, individual patient units, and within the Department of Social Services. These brochures also went to physicians' offices to introduce and explain our new program. Distribution of these brochures not only promoted the program to patients but also marketed the service to the community.
Conclusion

The delivery of meals to the sick, disabled, or elderly was not a new idea. Many people having such conditions found it difficult to care for themselves at home, yet maintained their wish to remain at home and often opposed any type of institutionalization. After analyzing literature and investigating existing home-delivered meal programs, the researcher found that this service played an important role in the community by supplying proper nutrition to individuals who could not prepare or obtain meals.

Mt. Carmel Home Health Care, a home health agency offering both skilled and supportive services to elderly homebound patients, was without such a program. The agency made frequent referrals for this service to competing agencies which had home-delivered meal programs. The researcher noted that resources needed for the implementation of home-delivered meals were available through Mt. Carmel Health Care Center. These resources included a dietary department, volunteer services and van shuttles for meal delivery.

Along with the growing concept of in-home meals, Mt. Carmel Home Health Care found that a number of patients would benefit from this service. In addition, supplying meals to patients in need fostered expansion of services
into the community and provided the agency with a marketing approach for which to obtain referrals.

Implications and Recommendations

One priority for the program committee was to provide patients in need of home-delivered meals with meal delivery at the time requested on the questionnaire. The researcher and project committee agreed that meal delivery would be from 11:00 a.m. to 1:00 p.m. The researcher also accepted responsibility for documenting all meals served per month and creating brochures in which to market the program.

Recommendations for Mt. Carmel Home Health Care included regular follow-up visits to patients in order to evaluate meal satisfaction and the need for expansion of meal delivery to more than five days per week. The project committee assigned home health nursing personnel to make these follow-up visits. Clinically, a skilled nursing assessment of the patient's physical status showed benefits of proper nutrition. The researcher advocated that the project committee, based on policy guidelines, review the referral for service procedure at least annually. This review would be beneficial as the home-delivered meal program expanded within the community and patient caseload increased.

To ensure project efficiency, effectiveness, and ultimately the program's success, a periodic retrospective audit of all patients who have received the meal program
would be performed. This audit would provide all department directors with valuable data about the program's operation. The basis of any changes in the program format were the results of the audit.

Expansion

The mobile meal program served only those patients receiving home health care services and did not serve all patients throughout Milwaukee County. Expansion of services could include all residents of Milwaukee County, however, this would depend on the financial status of the program. The project committee suggested, for program expansion, meal delivery would increase to perhaps seven days per week. For meal delivery to increase several factors needed consideration. These factors included staff availability to deliver weekend meals and a substantial demand from patients to receive weekend service.

The goal of the research project was to design and implement a mobile meals program through Mt. Carmel Home Health Care. With achievement of this goal, the researcher looked forward to the program's growth and success.
BIBLIOGRAPHY


APPENDIX A
The National Meals-on-Wheels Act of 1976
IN THE SENATE OF THE UNITED STATES

June 17, 1976

Mr. McGovern (for himself, Mr. Breaux, Mr. Kassemer, and Mr. Proctor) introduced the following bill, which was read twice and referred to the Committee on Labor and Public Welfare.

A BILL

To amend the Older Americans Act of 1965 to provide a national meals-on-wheels program for the elderly and for other purposes.

1. Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

2. That this Act may be cited as the "National Meals-on-Wheels Act of 1976".

3. Sec. 2. Section 506(a)(1) of the Older Americans Act of 1965 is amended by inserting "(A)" immediately after "(1)", by inserting after the semicolon the words "and, or", and by adding after such section the following new sub-

paragraph:
"(B) to establish a project (referred to herein as a "nutrition project") for the elderly, blind, and disabled which, five or more days per week, provides at least one home-delivered meal which satisfies a minimum of one-third the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Sciences-National Research Council: Provided, That any nutrition project which elects to serve such meals more than five days a week must assure, at a minimum, an amount of commercially available ready-to-eat nutritionally balanced liquid product or light snack, or both, which provide at least 25 per centum of such recommended dietary allowances for each day in which no home-delivered meal is provided. Preference, where feasible, should be given to the use of organizations, such as meals-on-wheels groups, which have demonstrated an ability to operate such services efficiently and reasonably."

Sec. 3, Section 708(a) of the Older Americans Act of 1965 is amended by striking out "(and)" at the end of paragraph (10), by redesignating paragraph (11), and all references thereto, as paragraph (13), and by inserting immediately after paragraph (10) the following new paragraphs:

"(11) to operate an information and referral system for homebound individuals receiving meals under this title by——

(A) training the delivery personnel so that such personnel may make informed judgments about the additional service needs of meal recipients; and

(B) reporting the additional service needs to agencies, groups, or individuals who might be of assistance in meeting such needs;

(12) to seek and utilize volunteer personnel for the provision of home-delivered meals to the maximum extent possible and to compensate such personnel when appropriate for transportation expenses incurred in the delivery of such meals; and.

Sec. 4, (a) (1) Section 708 of the Older Americans Act of 1965 is amended by inserting "(a)" after the section designation.

(2) Section 708(a) of such Act (as redesignated by paragraph (1) of this subsection) is amended by inserting "and paragraph (1) (B), (11), and (12) of section 706 (e)" after "section 707 (e)" in the parenthetical.

(b) Section 708 of such Act is amended by adding at the end thereof the following new subsection:
"(b) In addition to the sums authorized by subsection
(a), there are authorized to be appropriated $60,000,000
for the fiscal year 1977, and $100,000,000 for the fiscal year
1978 for the purpose of providing home delivered meals
pursuant to section 706(a) (1) (B): Provided, That not
more than 20 per centum of such funds shall be used for ad-
ministrative expenses and supportive services. Same ap-
propriated pursuant to this section to carry out the provi-
sions of this title shall remain available for such purposes
until expended."

"NATIONAL AERONAUTICS AND SPACE ADMINISTRATION
MESS SYSTEM FOR THE ELDERLY DEMONSTRATION
PROJECTS"

"Sec. 710. (a) The Commissioner shall conduct a
demonstration project involving at least three States to
determine the feasibility of using the meals system designed
by the National Aeronautics and Space Administration for
the elderly as a component of or as a substitute for regular
nutrition projects assisted under this Act particularly in
areas where normal delivery services under such a nutrition
project are not feasible or practicable or are too costly. Each
such demonstration project shall include a medical evalua-
tion."
APPENDIX B
Patient Questionnaire
PATIENT QUESTIONNAIRE

MT. CARMEL HOME HEALTH CARE

Mt. Carmel Home Health Care is in the process of developing a mobile meal program. Your cooperation in completing this questionnaire will assist us in arranging a program that will meet your needs. Please check the appropriate response to each question and return promptly in the envelop provided.

1. Have you ever had an agency deliver meals to your home?
   yes 10 (41.7%)   no 14 (58.3%)

2. Do you presently receive home-delivered meals?
   yes 3 (12.5%)   no 21 (87.5%)

3. Do you prepare any meals yourself?
   yes 18 (75%)   no 6 (25%)

4. Are you on any special diet?
   yes 10 (41.7%) If so what is your diet?
   no 14 (58.3%)

5. Can you feed yourself?
   yes 23 (95.8%)   no 1 (4.2%)

6. When do you eat your main meal?
   Breakfast 0   Lunch 7 (29.1%)   Supper 17 (70.9%)

7. Is having meals delivered between 11:00 a.m. and 1:00 p.m. convenient for you?
   yes 12 (50%)   no 12 (50%)

8. If meals were delivered to your home would you prefer a hot meal 13 (54.2%) a cold meal 3 (12.5%) both 8 (33.3%)?

9. Do you have a family member or spouse who would like home-delivered meals?
   yes 5 (16.7%)   no 20 (83.3%)

10. Would you be interested in more information regarding home-delivered meals?
    yes 17 (70.9%)   no 7 (29.1%)

Comments

40 questionnaires were sent out with a 60% (n=24) return.
The basis of the above percentages is on 24 questionnaires.
APPENDIX C

Mobilt Meal Program Proposal
MT. CARMEL HOME HEALTH CARE

PROPOSAL
MOBILE MEAL PROGRAM

DEVELOPED BY: TERRY THOMAS RN, BSN
JEAN KARLS RN
OBJECTIVE

To establish a Mobile Meals program as an integrated part of Mt. Carmel Home Health Care. Home Health Care nursing has led us to recognize patients problems and identify factors that will influence our care provided in the home. The need for proper and adequate nutrition is a necessary element for progression toward optimum health.
I. Philosophy

It is the goal of Mt. Carmel Home Health Care to provide a comprehensive health care program. A mobile meal service shall be instituted to further that goal by providing more emphasis on the personal needs of the client.

II. Purpose

1. To provide nutritious meals to patients on a regular basis.
2. To expand on the agency's community services.
3. To provide a comprehensive health care program.
4. To ensure the effectiveness and response of the program, a project committee will be established.
THE MOBILE MEALS COMMITTEE

PURPOSE

To research and develop the program to meet the philosophy and purpose established. The process will focus on providing an economical and appropriate resource to improve the health and nutrition within the community.

GOALS AND DUTIES

1. To oversee the establishment of the program and coordinate all information.
2. To share information and data among all service disciplines.
3. To investigate initial set-up costs, present and future financial planning.
4. To work closely with Mt. Carmel Health Care Center’s Dietary Department as to the feasibility, delivery, meal preparation, and cost.
5. To identify area and/or patients to be included in the pilot program.
6. To assess staffing needs.
7. To review services and refer matters to appropriate personnel to ensure cost containment without reduction in the quality of the program.
8. To review effectiveness of the Mobile Meals Program on an annual basis or as deemed necessary, through a retrospective audit.