



**The National
Resource Center on
Nutrition & Aging**

INNOVATIONS IN NUTRITION PROGRAMS AND SERVICES

APRIL 21, 2020

Challenges Question
Why?

What stops you



The National
Resource Center on
Nutrition & Aging

**WELCOME AND
INTRODUCTIONS**



**The National
Resource Center on
Nutrition & Aging**

ACL Innovation Grant Funding Opportunities

ACL INNOVATIONS IN NUTRITION GRANT OPPORTUNITIES

Demonstration

- Funding opportunity number:
HHS-2020-ACL-AOA-INNU-0404
- Application closing date:
May 26, 2020
- Funding amount: \$250,000 for each year of the 3-year project period

Research

- Funding opportunity number:
HHS-2020-ACL-AOA-INNU-0403
- Application closing date:
May 26, 2020
- Funding amount: \$300,000 for each year of the 3-year project period



ACL INNOVATION CALL FOR GRANT REVIEWERS

What is the responsibility of a grant reviewer?

- Reviewers will independently review and score each of their assigned applications from their home or office and be compensated for each application reviewed.
 - An individual review can take approximately 3 hours per application.
- Each reviewer will have approximately two weeks to review all assigned applications.
- Reviewers will also be compensated for participating in 1 reviewer training and 1 panel call. The panel call will be scheduled for 3 hours and include discussion of strengths and weaknesses from each reviewer
- Selected reviewers should have nutrition programming experience in the aging network and resumes or CVs should be submitted to annotate experience. We will train all reviewers in being equipped to handle this task, so don't worry if you have not previously served as a reviewer for a discretionary grant program.
- Please contact Mr. Phantane Sprowls at phantane.sprowls@acl.hhs.gov by **Monday, May 4, 2020** with your resume if interested in becoming a reviewer for this grant program.



POLL QUESTION

- What brought you here today?
 - I want to be more innovative in my program.
 - I want to learn from my peers.
 - I want to get new programming ideas.
 - I want to do more with technology.





TAKING CHARGE OF DIABETES

Presenter: Susan Hayes, RD, LDN
Clinical Program Manager, Nutrition and Active
Living, Health Promotion Council
April 21, 2020

INNOVATION STORY

- Taking Charge addresses the **gap** in care transitions for older adults (65 and older), by offering a multi-component, home-based intervention to improve health outcomes at the patient level and reduce health care costs at the system level for adults 65+ with Type 2 Diabetes.

- Project Partners:

Health Promotion Council

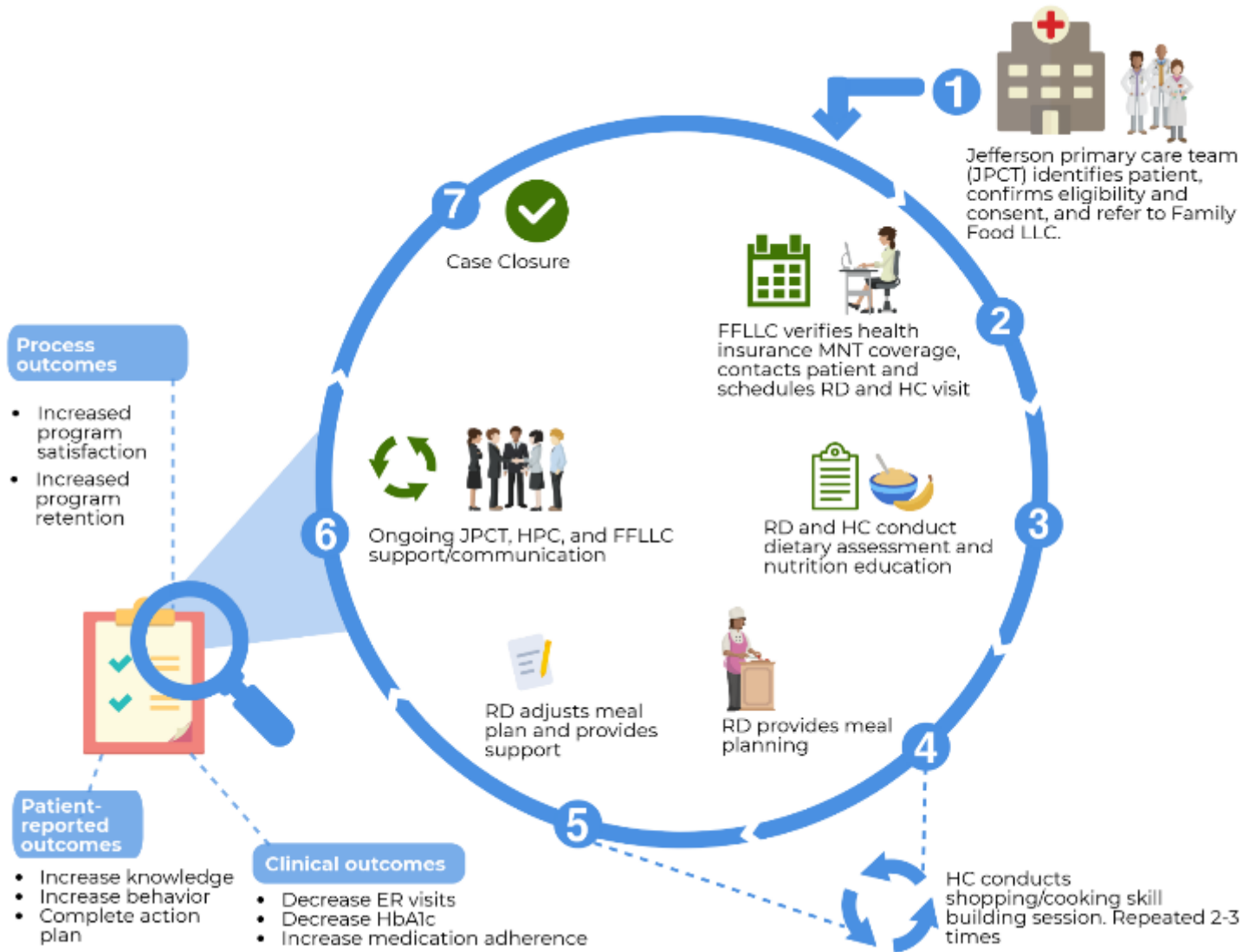
Thomas Jefferson University Hospital Primary Care

Thomas Jefferson University Center for Urban Health

Family Food LLC



IMPROVE HEALTH OUTCOMES AND QUALITY OF LIFE OF ADULTS AGE 65+ WITH TYPE 2 DIABETES BY ESTABLISHING AN INNOVATIVE COMMUNITY-CLINICAL INTEGRATION MODEL



ACL TAKING CHARGE OF DIABETES PROGRAM RESULTS



2018 78 eligible patients
2019 167 eligible patients
Total **245** eligible patients



patients contacted
105



patients enrolled in program
28



Completed ACL Taking Charge Program:
3 patients 11%



- ❑ Completed RD MNT1 sessions:
10 patients 36%
- ❑ Completed RD MNT2 & Health Coach Nutrition sessions:
7 patients 25%
- ❑ Completed HC Cooking Shopping sessions:
3 patients 11%

PROGRAMMATIC OUTCOMES

- 100% of JPCT, HPC and CUH reporting satisfaction with the care coordination system.
- Among Taking Charge participants who completed the program, 100% reported satisfaction with the overall program.
- 80% of Taking Charge program participants attended 40% of scheduled sessions.
- Utilizing the tracking tools, referral protocol and forms approved by IRB, 100% of Taking Charge participants seen by the Health Coach were offered referral services



PATIENT CENTERED OUTCOMES

- Eight patients out of thirteen who received medical nutrition therapy through Taking Charge reported to visit the ED at least once after being enrolled in the program.
- 100% of Taking Charge participants demonstrated increased knowledge and self-efficacy related to healthy eating and diabetes management.
- 67% of Taking Charge participants reported positive behavior change related to healthy eating and diabetes management.



PATIENT CENTERED OUTCOMES CONT.

- Due to restrictions and limitation in accessing medical records, Taking Charge was unable to assess medication adherence as prescribed.
- 56% of Taking Charge patients (whose data was available to assess) showed a reduction in hemoglobin A1c within 12 months as noted in their medical record.
- Utilizing the tracking tool, protocol and instruments approved by IRB, 67% of Taking Charge participants achieved at least one of their personal action plan goals (included major dietary changes to better manage diabetes).



KEY CHALLENGES

- ❖ Participant Enrollment
- ❖ Patient Interest in Taking Charge
- ❖ Social Determinants of Health
- ❖ Data Access and Billing
- ❖ Partnerships



SUGGESTIONS FOR REPLICATION/ADVICE TO PEERS

Funding:

If justifying a budget to cover the **planning period** is an issue, factor into overall budget or consider applying for additional funding elsewhere. Start up time can be significantly long depending on legal, contracts, IRB and other institutional restrictions.

Technology:

Consider providing **in-home health education using telehealth**. Technology can potentially be used to do both individual and group activities/classes.

Consider having a **robust system to access medical records and billing system** for all partners involved in the project to facilitate referral, scheduling and loop back to provider.



SUGGESTIONS FOR REPLICATION/ADVICE TO PEERS

Partnership:

Partner with an organization or health care institutions that has **RDs** who can provide MNT and capability for billing services already in place.

Partner with a **local community organization** as they are deeply connected with the community and understand the needs, challenges, and resources available to patients.

Staffing:

Staffing would **require a program coordinator** to manage the communication needed for all the moving pieces and partnerships involved as well as ensuring services are provided as proposed.



THANK YOU

Susan Hayes, RD, LDN
suhayes@phmc.org



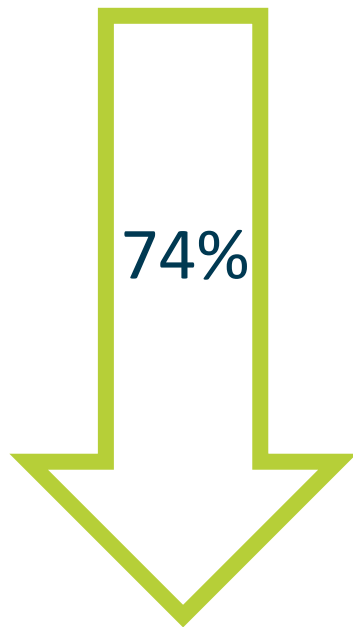
LINN COUNTY INNOVATIONS IN NUTRITION
PROGRAM
ENCORE CAFÉ

TIM GETTY, MBA
HERITAGE AREA AGENCY ON AGING

April 21, 2020

INNOVATION STORY

Heritage AAA experienced
74% decline in congregate
meal participation 2011-
2017



Site Closures



Lack of awareness of
AAA in Iowa's 2nd largest
metro area



PROJECT DESCRIPTION



ENCORE CAFE

A Second Call to Enhance Your Health

- Four pop-up, catered sites in community buildings
- Library, Senior Center, Church, and Parks Building
- Salad Bars & Choice Menus
- Flexible Serving time 11:30am-12:30pm
- Evidence-Based Programming and Nutrition Education offered
- 2.0 Total FTEs and 12 active volunteers
- Successful Project Partners



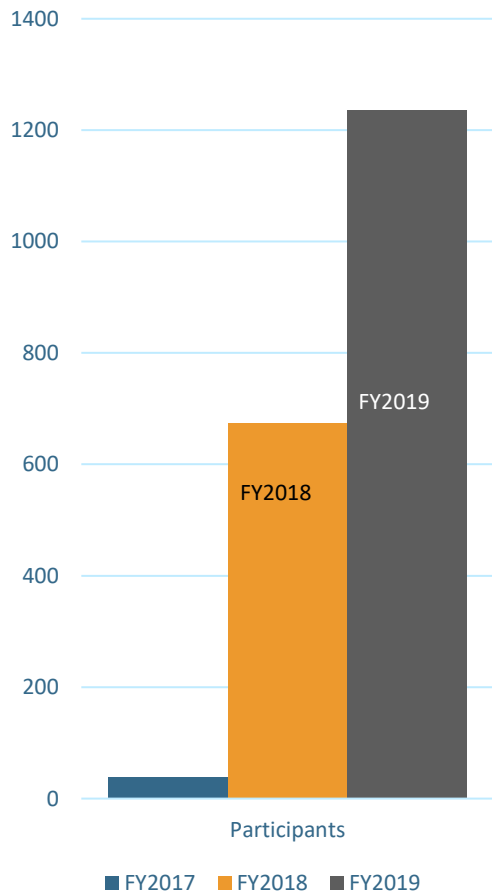
KEY LEARNING(S)

“The food has been tasty with generous portions. The ladies have been very helpful and friendly. I appreciated the fresh produce to take home. Nice visit with Steve and his service dog Peyton. Eating is great at Encore Café. Catering by Hy-Vee has been exceptional.”

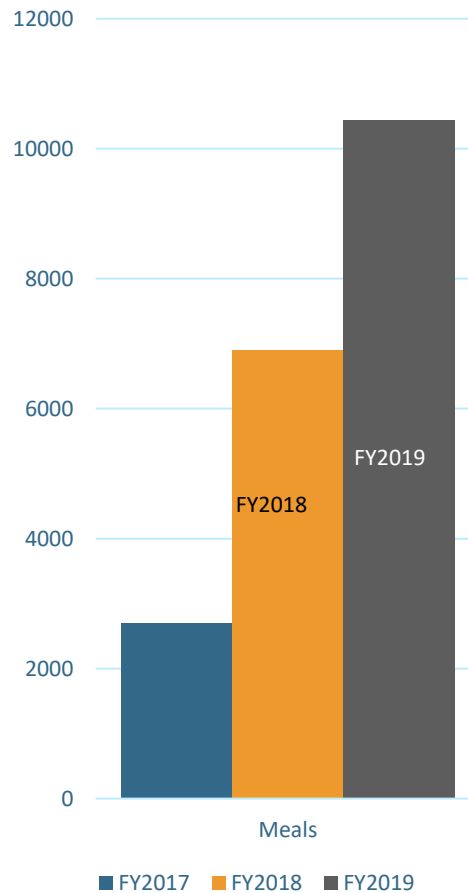


DATA

Congregate Participants Linn County

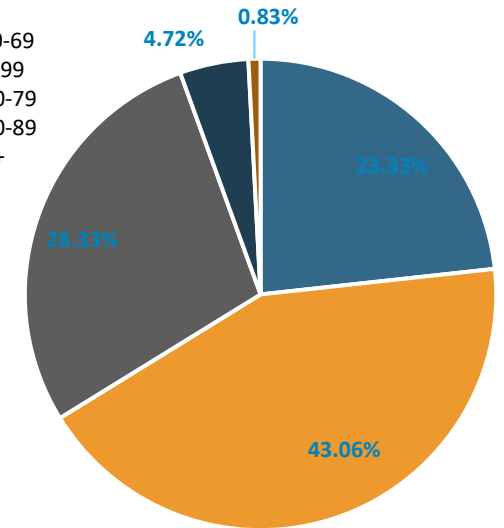


Congregate Meals Linn County



Encore Café Participant Age

23.33% age 60-69
 4.72% Age 90-99
 43.06% Age 70-79
 28.33% Age 80-89
 .83% Age 100+



■ Age 60-69 ■ Age 70-79 ■ Age 80-89 ■ Age 90-99 ■ Age 100+



DATA

Resources

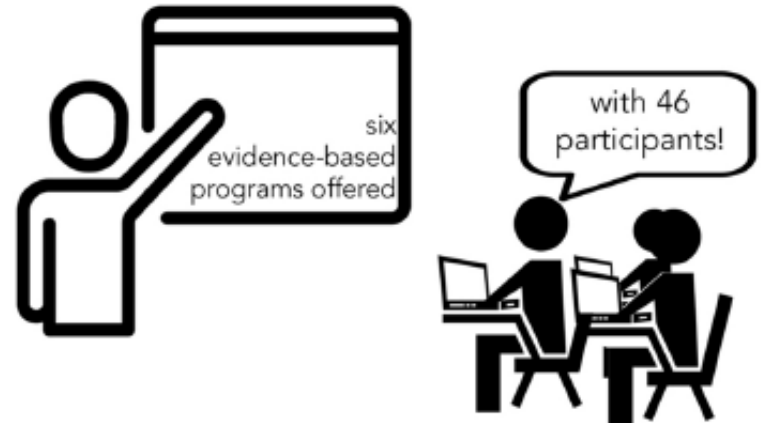


- 1) Lowest Daily Average: \$3.33
- 2) First Year Average: \$3.90
- 3) Second Year Average: \$3.95
- 4) Highest Daily Average: \$5.00

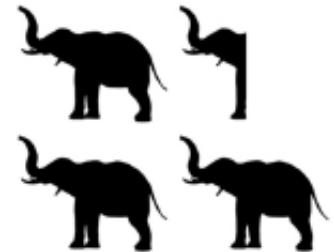


Volunteer Hours: 1,993
 Volunteer Hour Match: \$33,598
 Total In-Kind Match: \$118,298
 Total Financial Match: \$151,896

Beyond the Meal



708 participants in food distribution



19,693 lbs of food distributed equal to 3.3 adult elephants

NOTE:  50 consumers

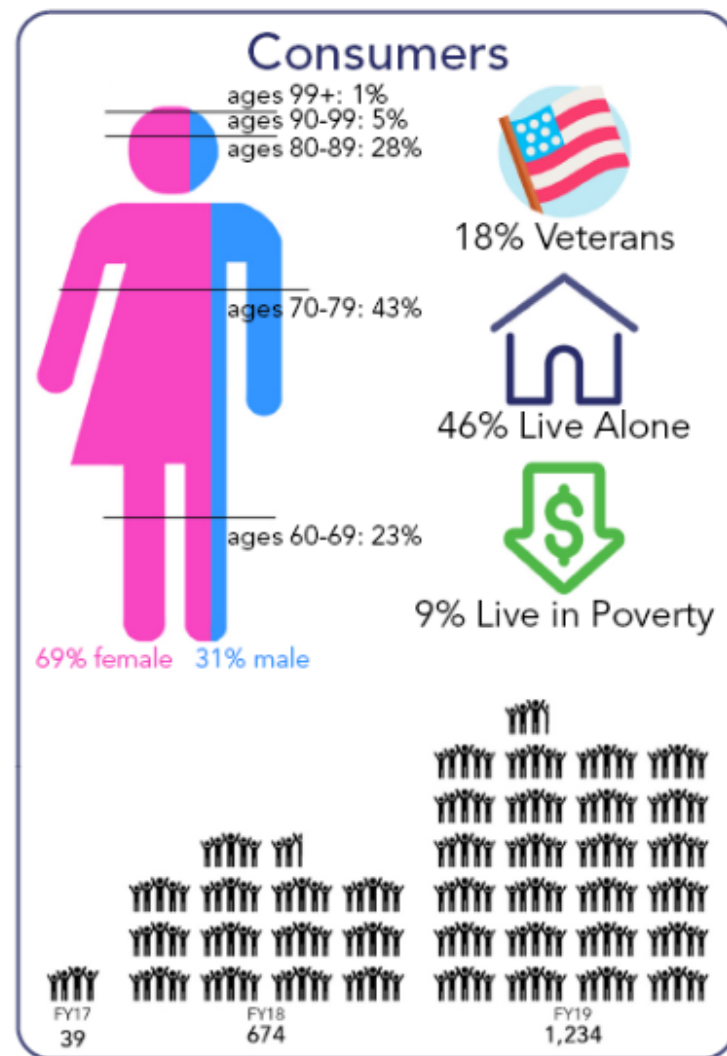
KEY CHALLENGES OVERCOME

- Staff turnover
- Catering through regional grocery store and nutrition requirements
- Attendance outgrew sites
- Meal site purpose confusion for participants and others
- Chef demonstrations and the audience



PROJECT IMPACT

- Increased participation
- Increased awareness/community partnerships
- Replicable service model



SUGGESTIONS FOR REPLICATION

- Collaborate in unconventional ways
- Grand Opening events and marketing
- Quality and choice for different generations

Marion State of the City recognizes growth in jobs, quality of life

by Eva Andersen | Thursday, January 31st 2019

A



ADVICE TO PEERS

- Allow for flexibility
- Make project partners a priority



THANK YOU!

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NUTRITION, HEALTH & WELLNESS DIRECTOR
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MARYLAND INNOVATIONS IN NUTRITION PROJECT

MARYLAND DEPARTMENT OF AGING

April 21, 2020

INNOVATION STORY

Purpose: Transform Senior Nutrition Program using the epidemic of older adult malnutrition as the catalyst to introduce:

- evidence based practices
- cost-cutting measures
- innovative meal products, and
- efficient service delivery methods

To forge new health care linkages and expand service to older adults in the community.



PROJECT DESCRIPTION

- Design a replicable model for a hospital post-discharge malnutrition care pathway.
- Create meal packages for older adults transitioning from hospital to home.
- Enhance an existing Home Delivered Meal Priority Screening tool.
- Evaluate the effectiveness of a community malnutrition awareness workshop.

PROJECT DESCRIPTION

Table 2: Sample Referral Table - Social Determinants of Health with ICD-10 codes.

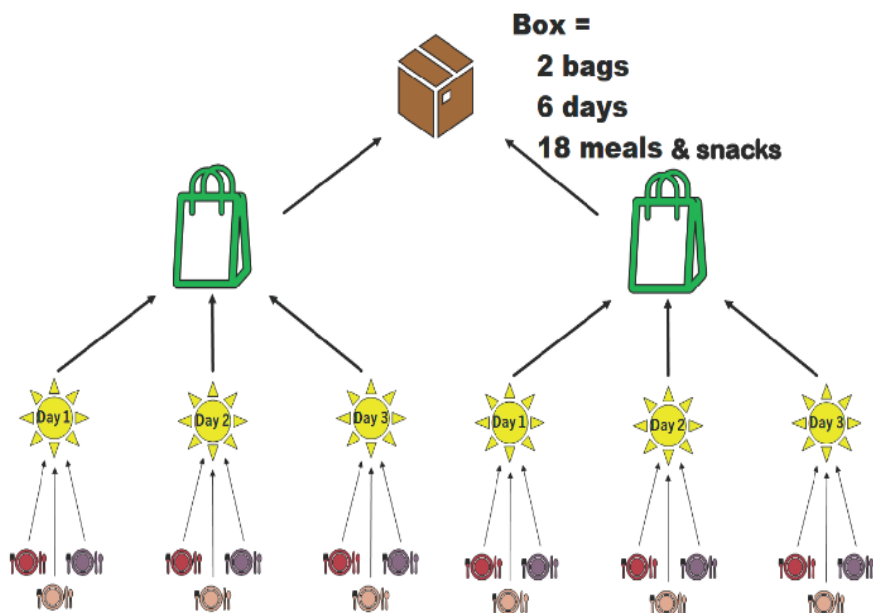
Care Planning Components	AAA Referral Programs and Services
Food and Nutrition Z594	<input type="checkbox"/> Senior Center Congregate Meals <input type="checkbox"/> Home-Delivered Meals <input type="checkbox"/> Nutrition counseling, MNT, nutrition education, and care planning <input type="checkbox"/> Commodity Supplemental Food Program (CSFP) <input type="checkbox"/> Community food resources (Food Bank, etc.) <input type="checkbox"/> Senior Farmers Market Nutrition Program <input type="checkbox"/> Stepping Up Your Nutrition <input type="checkbox"/> Post-discharge, medically-tailored meals
Housing Z590	<input type="checkbox"/> Assisted Living (Including SALGHS) <input type="checkbox"/> Ramp Assistance <input type="checkbox"/> Home Modification <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Durable Medical Equipment <input type="checkbox"/> Congregate Housing Services Program
Transportation Z650	<input type="checkbox"/> County or Regional Transit <input type="checkbox"/> Cab/Bus Vouchers <input type="checkbox"/> Senior Village <input type="checkbox"/> Community for Life
Financial Z590	Application assistance for financial aid: <ul style="list-style-type: none"> <input type="checkbox"/> SNAP <input type="checkbox"/> Medicaid <input type="checkbox"/> State Health Insurance Program (SHIP) <input type="checkbox"/> Energy-assistance programs <input type="checkbox"/> Income-tax assistance <input type="checkbox"/> Medicare Part A, B, C, D <input type="checkbox"/> Medicare Billing, Appeals, Denials, Grievances <input type="checkbox"/> Medicare Fraud Assistance <input type="checkbox"/> Oral nutritional supplements (Ensure, etc) <input type="checkbox"/> Prescription assistance <input type="checkbox"/> Assistance for dental, eye care, hearing aids
Utilities Z590	<input type="checkbox"/> Low-Income Home Energy Assistance Program (LIHEAP) <input type="checkbox"/> Electric Universal Service Program (EUSP) <input type="checkbox"/> Universal Service Protection Program (USPP) <input type="checkbox"/> Utility Assistance (other)
Personal Safety Z600	<input type="checkbox"/> Elder Abuse <input type="checkbox"/> Legal Assistance <input type="checkbox"/> Emergency Response Systems <input type="checkbox"/> Falls Prevention (Stepping On, Matter of Balance, Tai Chi for Better Balance) <input type="checkbox"/> Arthritis foundation classes (Walk with Ease)
In-Home Care Z602	<input type="checkbox"/> Sitters and in-home care services (personal care, chore service) <input type="checkbox"/> Home Care agencies <input type="checkbox"/> Community First Choice

Malnutrition Pathway Toolkit

In-Home Care Z602 (con't)	<input type="checkbox"/> Senior Care <input type="checkbox"/> Home-delivered meals <input type="checkbox"/> Dietitian referral <input type="checkbox"/> Senior Village
Social Supports Z600 or Z630	<input type="checkbox"/> Senior Center (exercise, socialization, Congregate Meals) <input type="checkbox"/> Telephone Reassurance <input type="checkbox"/> Support Groups: Caregivers, Renal, Stroke, Al.S, Parkinson's <input type="checkbox"/> Adult Day Care <input type="checkbox"/> Volunteer opportunities
Mental Health Z640 or Z650	<input type="checkbox"/> PEARLS: Program to Encourage Active, Rewarding Lives <input type="checkbox"/> Enhance Wellness <input type="checkbox"/> Healthy IDEAS <input type="checkbox"/> Behavioral Health Referral (Core Service Agency or Health Department)
Health Care Referral ICD-10 code dependent on root cause	<input type="checkbox"/> Primary Care Physician <input type="checkbox"/> Clinics: Dental, Eye, Physical Therapy <input type="checkbox"/> Community Health Worker <input type="checkbox"/> Adult Medical Day Care <input type="checkbox"/> Local health department <input type="checkbox"/> Home care agencies <input type="checkbox"/> Medical supplies
Employment Z560	<input type="checkbox"/> Senior Employment <input type="checkbox"/> AAA volunteer coordinator <input type="checkbox"/> Community volunteer opportunities
Health Education Z550	Self-management workshops: <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes Self-Management (Spanish version available) <input type="checkbox"/> Chronic Disease Self-Management (Spanish version available) <input type="checkbox"/> Chronic-Pain Self-Management <input type="checkbox"/> Cancer Thriving and Surviving <input type="checkbox"/> Falls Prevention (Stepping On, Matter of Balance, Tai Chi for Better Balance) <input type="checkbox"/> SAIL (Stay Active and Independent for Life) <input type="checkbox"/> Aging Mastery <input type="checkbox"/> Enhance Fitness <input type="checkbox"/> Lifelong Learning <input type="checkbox"/> Medication Management <input type="checkbox"/> Wellness Center Gym



PROJECT DESCRIPTION



Carb-Controlled, Heart-Healthy

Meal Packages

The Carb-Controlled, Heart Healthy meal package is designed to provide you with the food you need to help you recover after your visit to the hospital.

Balanced carbohydrates

Carbohydrates (carbs) from the food you eat effect your blood sugar. These meals and snacks are balanced with the right amount of carbs to keep your blood sugar under control throughout the day.

Low salt

Getting too much sodium (salt) can raise your blood pressure and be bad for your heart health. These meals are low in salt to keep your heart healthy and your blood pressure under control.

Pro Tip

Be sure not to add any salt to these foods. Try other seasonings, like garlic powder, dried herbs, Mrs. Dash Salt-Free seasoning, or other salt-free seasonings.



Picture source:
<http://www.mrsdash.com/products/seasoning-blends/MC27AB-original-blend>

Easy to prepare

These foods were chosen because they are single-serve, easy to prepare, and can be kept at room temperature for up to six months.

We want you to stay healthy once you leave the hospital. Enjoy these foods on us!

In addition to these meal packages, you may also need:
Water, bowls & plates, forks, knives & spoons, can opener, microwave, scissors

Grant funds from the Administration for Community Living (ACL), Grant Number 90NN0002 and the Maryland Department of Aging assisted in the development of this material. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the ACL or Department.



PROJECT DESCRIPTION

Nadine Sahyoun, PhD, RD
 Professor of Nutritional Epidemiology
 Department of Nutrition and Food Science
 University of Maryland
 nsahyoun@umd.edu

TRAINING MANUAL



COLLEGE OF
 AGRICULTURE &
 NATURAL RESOURCES

DEPARTMENT OF NUTRITION
 AND FOOD SCIENCE

LEVEL	RECOMMENDED ACTION	POSSIBLE ADDITIONAL OR ALTERNATIVE SERVICES
A	NWL: Home Delivered Meals WL: Highest priority on wait list	Home-delivered meals are the most appropriate support for these clients Further inquiries to the applicant may reveal additional beneficial supports
B	NWL: Home-delivered meals and suggest additional services WL: Second highest priority on wait list, suggest alternative services	Financial-based nutrition support services such as SNAP Help with getting groceries, such as grocery delivery or transportation services
C	NWL: Home-delivered meals and suggest additional services WL: Third highest priority on wait list, suggest alternative services	Financial-based nutrition support services such as SNAP
D	NWL: Home-delivered meals and suggest additional services WL: Fourth highest priority on wait list, suggest alternative services	Help with getting groceries, such as grocery delivery or transportation services
E	NWL: Home-delivered meals and suggest additional services WL: Lowest priority on wait list, suggest alternative services	Further inquiries to the applicant may reveal the type of support required

NWL = No Existing Wait List **WL** = Existing Wait List

Available at: <https://nfsc.umd.edu/extension/expanded-food-security-screener>



PROJECT DESCRIPTION



MEASURING MALNUTRITION RISK LEVEL



High Nutrition Risk: Score > 50

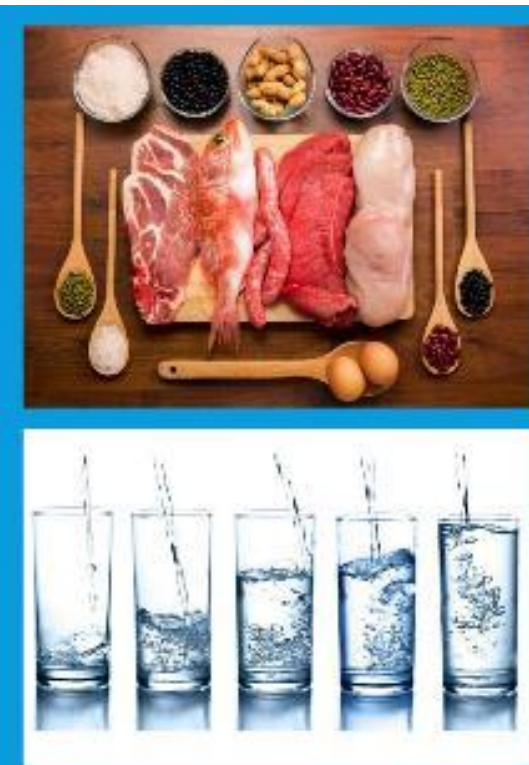
Consult with healthcare team as soon as possible to address the areas of nutrition concern and improve nutrition status

Moderate Nutrition Risk: Score 50 to 54

Take action to improve nutrition health. Discuss options with healthcare team and identify resources to help reduce risk

No/Low Nutrition Risk: Score 55+

Continue current eating habits to keep healthy and strong



Available at: <http://www.mdlivingwell.org/programs/stepping-up-nutrition/>



KEY LEARNING(S)

- Community Based Malnutrition Pathways Toolkit
 - useful as nationally-replicable model
- Meal packages
 - highly accepted, feasible
 - may have impact on reducing readmissions
- Revitalized products
 - valued by AAAs
 - impact on consistent training and implementation
- Use of a proven, award winning tool can strengthen a new project's outcomes and success



KEY CHALLENGES OVERCOME

- Working with consultants.
- Greater than expected internal workload.
- Delays in learning curve, capturing data and receiving outcomes.
- Universities and the aging network work at different paces, affecting deliverable timeliness.



DATA



STEPPING UP YOUR NUTRITION Risk at baseline (n =429)

SCREEN II – Nutritional Risk

- Average risk score 44.1 (± 8.4)
 - 70% **high** nutrition risk
 - 20% **moderate** nutrition risk
 - 10% **no/low** nutrition risk

Fall-Related Risk

- 21% reported a recent fall
 - 48% of those who fell reported an injury
- 16% fearful of falling “a lot”
 - 27% fearful of falling “somewhat”

Nutrition Barriers and Meal Isolation

- 17% “never/rarely” eat with someone daily
- 17% “often/sometimes” ran out of food
- 53% “often/sometimes” skipped meals



DATA

POST-DISCHARGE, MEDICALLY-TAILORED SHELF STABLE MEALS

- Health Care Utilization: 54% reduction in 30-day readmissions.
- Client surveys:
 - 95% - packages helped them recover.
 - 92% - packages met their nutritional needs based on their health condition.
 - 89% - easy to get the packages at hospital discharge and at the follow-up visit
 - 85% - packages helped them manage their health condition.
 - 82% - packages provided them with food otherwise unable to buy or shop for.
 - 82% - packages provided food when they had difficulty preparing their own meals.
 - 86% - packages helped them eat healthier food.



PROJECT IMPACT

- Promising healthcare impact data for meal packages. A separate Department grant (ADRC) is offering the meal packages with subgrantees.
- All components of the grant are replicable across US.
- Grant significantly impacted the spread of a malnutrition awareness Session 0 across the state.
- AAA has received grant funding for consultant to implement the malnutrition pathway.
- Post-discharge meal peer network group continues.



SUGGESTIONS FOR REPLICATION

- The RD consultants continue offering the meal packages. <https://sites.google.com/bnws.co/bnws-meals/home>. It is being used in projects with hospitals, physicians' offices and AAAs.
- The Stepping Up Your Nutrition program is sustainable and is offered nationally via <https://www.steppingupyournutrition.com/>
- Toolkit: “Addressing Malnutrition in Community Living Older Adults: A Toolkit for Area Agencies on Aging.”
- HDM Priority Screening Tool: Training Manual, embedded excel, Paper screening tool, and instructions to access the “app” . Contact nsahyoun@umd.edu.



ADVICE TO PEERS

- Limit the scope of projects, as each component requires oversight, management and data collection. Focus applications on grant requirements.
- Ensure adequate personnel to run day-to-day tasks.
- Don't work in isolation - reach out to others. Many thanks to everyone who shared with us!



THANK YOU!
JUDY SIMON, MS, RD, LDN
JUDY.SIMON@MARYLAND.GOV



**The National
Resource Center on
Nutrition & Aging**

ROUND ROBIN

ROUND ROBIN QUESTIONS

- Describe how your project was in fact 'innovative'?
- How will your innovation project(s) be sustained?
- What new partner(s) did your organization engage/does your organization plan to engage with going forward to grow or sustain the new nutrition programs/services you have established?
- Discuss any COVID-19 changes to how your innovation project is being currently implemented.



QUESTIONS AND ANSWERS



POLL QUESTION

- Please select the areas below that you feel it easiest for your organization to be innovative (select all that apply):
 - Partnerships
 - Technology
 - Service delivery
 - Marketing





**The National
Resource Center on
Nutrition & Aging**

2017


**ACL INNOVATIONS IN
NUTRITION PROGRAMS
AND SERVICES HUB**

RESOURCE HUB OVERVIEW



In 2017, the Administration for Community Living awarded six grantees funding for innovative projects that will enhance the quality, effectiveness, and outcomes of nutrition services programs provided by the national aging services network. The six grants totaled \$742,872 for the two-year project period. Through this grant program, innovative and promising practices that can be scaled across the country have been identified with a goal to increase use of evidence-informed practices within the nutrition programs.

The Innovations in Nutrition Programs and Services Resource Hub contains documents for senior nutrition programs to understand and replicate the inventive programs and services piloted by the 2017 ACL grantees.

 **BRIEFS AND RESOURCE COMPENDIUM** ↓

 **KEY ARCHIVED NRCNA WEBINARS** ↓

 **ADDITIONAL RESOURCES** ↓

Website: <https://nutritionandaging.org/innovation-services-hub/>



RESOURCE HUB OVERVIEW

ADMINISTRATION FOR COMMUNITY LIVING INNOVATIONS IN NUTRITION PROGRAMS AND SERVICES CAPSTONE SERIES

ORGANIZATION: Health Promotion Council of Southeastern Pennsylvania

TAKING CHARGE OF

ABOUT US
Health Promotion Council of Southeastern Pennsylvania to implement community-based hypertension and Pennsylvania High Blood Pressure Control Program as part of a national hypertension control effort (NHLBI). When NHLBI disease control effort on these additional disease prevention control name accordingly.

PROJECT PURPOSE
To address patient care beyond the clinic to improve health outcomes at the patient with Type 2 Diabetes.

PROJECT LENGTH
Two years

KEY PARAMETERS


- Population targeted: Adults age 65+ with hypertension
- Geographic setting: Urban
- Service delivery setting: Clinical and community
- Services offered: Medical nutrition therapy education in the form of personalized self-management resources out of the clinical setting, into the community
- Number of staff/FTEs dedicated to implementation
- Total grant funds received: \$250,000
- Total project period: Two years (2017 – 2019)
- Total funding leveraged from organization: \$500,000

PROJECT COMPONENTS

- Partnership between two hospitals (The University of Pennsylvania and the Health Promotion Council)
- Provision of nutrition services including medical nutrition therapy
- Provision of an evidence-based self-management program
- Establishment of a referral network established (i.e., Food Stamps, emergency food support)

ADMINISTRATION FOR COMMUNITY LIVING INNOVATIONS IN NUTRITION PROGRAMS AND SERVICES CAPSTONE SERIES

ORGANIZATION: Iowa Department on Aging in partnership with Heritage Area Agency on Aging



LINN COUNTY INNOVATIONS IN NUTRITION PROGRAM

SUMMARY BRIEF

ABOUT US

- The Iowa Department on Aging strives to improve the quality of life and care of older Iowans through advocacy, planning, policy development and the administration and support of statewide programs and services that promote health, safety and long-term independence.
- The Heritage Agency has been a department of Kirkwood Community College since 1973 and was designated by the Iowa Department on Aging to serve Benton, Cedar, Iowa, Johnson, Jones, Linn and Washington counties. Heritage serves people age 60 and above as well as their families, communities, and governments. In addition, The Heritage Agency serves as an Aging and Disability Resource Center (ADRC) serving adults 18 years of age and older with a disability through advocacy and options counseling.

PROJECT PURPOSE

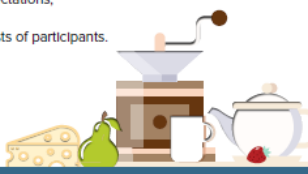
- To develop an innovative, replicable service delivery model for congregate meals titled "Encore Café." This café concept was designed to encourage older adults to participate in congregate meal programs. In particular, the project aimed to attract the younger sub-population of older adults called "Baby Boomers" who had a smaller percentage of participation in recent years.

PROJECT LENGTH

- Two years

KEY CHALLENGES OVERCOME

- High turnover in key senior center coordinator position;
- Upskilling local providers to adhere to required nutritional guidance;
- Managing unintended consequences of intervention – larger than anticipated client turnout, heightened/unrealistic participant expectations;
- Meal site purpose confusion for participants and others;
- Aligning new initiatives (i.e., chef-led demonstrations) with interests of participants.



The National Resource Center on Nutrition & Aging | ACL Administration for Community Living | nutritionandaging.org

This project was supported, in part by grant number 90PPM0001 from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201



MEAL PACKAGE PEER NETWORK: LEARN ABOUT SLACK



Prepared by: Laura Sena

AVAILABLE NRCNA/COVID-19 RESOURCES

The National Resource Center on Nutrition & Aging

COVID-19 SUGGESTIONS

States and localities can use the flexible procedures. While States may seek [Community Living's Nutrition Services](#) offers more flexibilities), States may

Align the suggestions below with your

Home Delivered Meal Programs (such as Meals on Wheels)

- Offering drive-through or pick-up in call.
- Prioritizing congregate participants or an online screening procedure.
- Offering congregate nutrition services through UPS, Fed Ex or other known carriers.
- Distributing a week's worth of groceries to check on people's well-being.
- Collaborating with local restaurants.

Maintaining a Congregate Nutrition Program

- Setting up lunch friend programs.
- Coordinating virtual sites to meet.

Ways to Increase Meals/Food Delivery

- Providing seven meals a week.
- Providing two meals a day.
- Providing breakfast as one meal can provide more variety, especially dry cereals made of bran, but:

 - Providing breakfast earlier in the day, a less expensive.
 - Providing breakfast freezer space to store.

- Collaborating with multiple providers for your participants.

URGENT CALL FOR CHANGE A CALL FOR THE NETWORK

The National Resource Center on Nutrition & Aging

SPRING 2019

Written by: Jean L. Lloyd, MS Nutrition Consultant

eat right. Academy of Nutrition and Dietetics

The National Resource Center on Nutrition & Aging




Medical Nutrition Therapy for Seniors

A Resource Guide for Registered Dietitians and Senior Nutrition Program

The National Resource Center on Nutrition & Aging

The National Resource Center on Nutrition & Aging




Spring 2020

CAREGIVER NUTRITION EDUCATION TOOLKIT

Commissioned by: NRCNA
Written by: Linda Netterville, MA, RDN, Nutrition Consultant

This project was supported, in part by grant number 90PPNU0001 from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201





**The National
Resource Center on
Nutrition & Aging**

THANK YOU

**PLEASE COMPLETE
THE EVALUATION**