INNOVATIONS IN NUTRITION PROGRAMS AND SERVICES

APRIL 21, 2020
Challenges: Osteoporosis
What is stopping you?
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
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

1. Jefferson primary care team (JPCT) identifies patient, confirms eligibility and consent, and refer to Family Food LLC.

2. FFLLC verifies health insurance MNT coverage, contacts patient and schedules RD and HC visit.

3. RD and HC conduct dietary assessment and nutrition education.

4. RD provides meal planning.

5. RD adjusts meal plan and provides support.

6. Ongoing JPCT, HPC, and FFLLC support/communication.

7. Case Closure.

Process outcomes:
- Increased program satisfaction
- Increased program retention

Patient-reported outcomes:
- Increase knowledge
- Increase behavior
- Complete action plan

Clinical outcomes:
- Decrease ER visits
- Decrease HbA1c
- Increase medication adherence
- HC conducts shopping/cooking skill building session. Repeated 2-3 times.

The National Resource Center on Nutrition & Aging

@NRCNA_engAging
ACL TAKING CHARGE OF DIABETES PROGRAM RESULTS

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

# patients contacted  **105**

- 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%**

Completed ACL Taking Charge Program:  **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.
**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
INNOVATION STORY

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

Site Closures

Lack of awareness of AAA in Iowa’s 2\textsuperscript{nd} largest metro area
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
"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

FY2017 | FY2018 | FY2019
---|---|---

Congregate Meals
Linn County

FY2017 | FY2018 | FY2019
---|---|---

Encore Café Participant Age

- Age 60-69: 43.06%
- Age 70-79: 43.06%
- Age 80-89: 23.33%
- Age 90-99: 0.83%
- Age 100+: 4.72%

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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

with 46 participants!
six evidence-based programs offered

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 REPLICAION

• Collaborate in unconventional ways
• Grand Opening events and marketing
• Quality and choice for different generations
ADVICE TO PEERS

• Allow for flexibility
• Make project partners a priority
THANK YOU!

TIM GETTY, MBA
REGIONAL NUTRITION PROGRAM COORDINATOR
HERITAGE AREA AGENCY ON AGING
TIM.GETTY@KIRKLAND.EDU

ALEXANDRA BAUMAN, RD LDN
NUTRITION, HEALTH & WELLNESS DIRECTOR
IOWA DEPARTMENT ON AGING
ALEXANDRA.BAUMAN@IOWA.GOV
MARYLAND INNOVATIONS IN NUTRITION PROJECT

MARYLAND DEPARTMENT OF AGING

April 21, 2020
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.
### Malnutrition Pathway Toolkit

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

<table>
<thead>
<tr>
<th>Care Planning Components</th>
<th>AAA Referral Programs and Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food and Nutrition Z594</td>
<td>- Senior Center Congregate Meals</td>
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<tr>
<td></td>
<td>- Home-Delivered Meals</td>
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<tr>
<td></td>
<td>- Nutrition counseling, MNT, nutrition education, and care planning</td>
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<tr>
<td></td>
<td>- Commodity Supplemental Food Program (CSFP)</td>
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<tr>
<td></td>
<td>- Community food resources (Food Bank, etc.)</td>
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<td></td>
<td>- Senior Farmers Market Nutrition Program</td>
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<td></td>
<td>- Stepping Up Your Nutrition</td>
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<td>- Post-discharge, medically-tailored meals</td>
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<tr>
<td>Housing Z590</td>
<td>- Assisted Living (Including SALGHS)</td>
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<tr>
<td></td>
<td>- Ramp Assistance</td>
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<tr>
<td></td>
<td>- Horse Modification</td>
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<td>- Assistive Technology</td>
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<tr>
<td></td>
<td>- Durable Medical Equipment</td>
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<tr>
<td></td>
<td>- Congregate Housing Services Program</td>
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<tr>
<td>Transportation Z650</td>
<td>- County or Regional Transit</td>
</tr>
<tr>
<td></td>
<td>- Cab/Bus Vouchers</td>
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<tr>
<td></td>
<td>- Senior Village</td>
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<td></td>
<td>- Community for Life</td>
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<tr>
<td>Financial Z690</td>
<td>Application assistance for financial aid:</td>
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<tr>
<td></td>
<td>- SNAP</td>
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<td></td>
<td>- Medicaid</td>
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<td></td>
<td>- State Health Insurance Program (SHIP)</td>
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<tr>
<td></td>
<td>- Energy-assistance programs</td>
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<td></td>
<td>- Income-tax assistance</td>
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<td></td>
<td>- Medicare Part A, B, C, D</td>
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<td>- Medicare Billing, Appeals, Denials, Grievances</td>
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<tr>
<td></td>
<td>- Medicare Fraud Assistance</td>
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<td></td>
<td>- Oral nutritional supplements (Ensure, etc)</td>
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<td></td>
<td>- Prescription assistance</td>
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<tr>
<td></td>
<td>- Assistance for dental, eye care, hearing aids</td>
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<tr>
<td>Utilities Z690</td>
<td>- Low-Income Home Energy Assistance Program (LIHEAP)</td>
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<tr>
<td></td>
<td>- Electric Universal Service Program (E-USEP)</td>
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<td></td>
<td>- Universal Service Protection Program (USPP)</td>
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<td></td>
<td>- Utility Assistance (other)</td>
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<tr>
<td>Personal Safety Z590</td>
<td>- Hider Abuse</td>
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<td>- Legal Assistance</td>
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<td></td>
<td>- Emergency Response Systems</td>
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<td></td>
<td>- Falls Prevention (Stepping On, Master of Balance, Tai Chi for Better Balance)</td>
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<tr>
<td></td>
<td>- Arthritis foundation classes (Walk with Ease)</td>
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<tr>
<td>In-Home Care Z602</td>
<td>- Sliders and in-home care services (personal care, chore service)</td>
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<td></td>
<td>- Home Care agencies</td>
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<td>- Community First Choice</td>
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<td>- Senior Care</td>
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<td></td>
<td>- Home-delivered meals</td>
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<td>- Dietitian referral</td>
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<td>- Senior Village</td>
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<td></td>
<td>- Senior Center (exercise, socialization, Congregate Meals)</td>
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<td></td>
<td>- Telephone Reassurance</td>
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<tr>
<td></td>
<td>- Support Groups: Caregivers, Renal, Stroke, A.L.S, Parkinson’s</td>
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<td></td>
<td>- Adult Day Care</td>
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<tr>
<td></td>
<td>- Volunteer opportunities</td>
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<td>- PEARLS: Program to Encourage Active, Rewarding Lives</td>
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<td></td>
<td>- Enhance Wellness</td>
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<td>- Healthy IDEAS</td>
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<td>- Behavioral Health Referral (Core Service Agency or Health Department)</td>
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<td>- Primary Care Physician</td>
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<td></td>
<td>- Clinics: Dental, Eye, Physical Therapy</td>
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<td>- Community Health Worker</td>
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<td>- Adult Medical Day Care</td>
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<td>- Local health department</td>
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<td></td>
<td>- Home care agencies</td>
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<td></td>
<td>- Medical supplies</td>
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<td></td>
<td>- Senior Employment</td>
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<td></td>
<td>- AAA volunteer coordinator</td>
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<td></td>
<td>- Community volunteer opportunities</td>
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<tr>
<td></td>
<td>- Diabetes Self-Management (Spanish version available)</td>
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<td></td>
<td>- Chronic Disease Self-Management (Spanish version available)</td>
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<td></td>
<td>- Chronic-Pain Self-Management</td>
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<td></td>
<td>- Cancer Thriving and Surviving</td>
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<td></td>
<td>- Falls Prevention (Stepping On, Matter of Balance, Tai Chi for Better Balance)</td>
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<td></td>
<td>- SAIL (Stay Active and Independent for Life)</td>
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<td></td>
<td>- Aging Mastery</td>
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<td>- Enhance Fitness</td>
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<td>- Lifelong Learning</td>
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<td>- Medication Management</td>
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<td>- Wellness Center Gym</td>
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</tbody>
</table>
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 affect 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.

**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!

**Eye 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.

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

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

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>RECOMMENDED ACTION</th>
<th>POSSIBLE ADDITIONAL OR ALTERNATIVE SERVICES</th>
</tr>
</thead>
</table>
| 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](https://nfsc.umd.edu/extension/expanded-food-security-screener)
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.
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

Nutrition Barriers and Meal Isolation
• 17% “never/rarely” eat with someone daily
• 17% “often/sometimes” ran out of food
• 53% “often/sometimes” skipped meals

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”
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](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/](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
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
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.

Website: https://nutritionandaging.org/innovation-services-hub/
RESOURCE HUB OVERVIEW

ABOUT US
Health Promotion Council of Southeastern Pennsylvania (HPCSEP) is a non-profit organization dedicated to improving community health outcomes. HPCSEP was a part of a national hypertension control effort (NHBC), which led to additional disease prevention and control initiatives.

PROJECT PURPOSE
- To address patient care beyond the clinical setting, which improves health outcomes at the patient level.

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, and personalization of health and disease resources out of the clinical setting.
- Number of staff/FTEs dedicated to innovation: 1
- Total grant funds received: $250,000
- Total project length: Two years (2017-2019)
- Total funding leveraged from organization: $0

PROJECT COMPONENTS
- Partnership between two hospitals (The Children’s Hospital of Philadelphia Health Promotion Council)
- Provision of nutrition services including education and support
- Establishment of a referral network encompassing health and social services, e.g., Food Stamps, emergency food services

SUMMARY BRIEF

ABOUT US
- The Iowa Department on Aging strives to improve the quality of life and care of older Iowaans through advocacy, planning, policy development, and the administration and support of statewide programs and services that promote health, safety, and long-term independence.

-Agency context: The Heritage Agency is 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 services counseling.

PROJECT PURPOSE
- To develop an innovative, replicable service delivery model for congregate meals titled “Encore Café.”
- A concept designed to encourage older adults to participate in congregate meal programs.
- Specifically, 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
- Utilizing local providers to adhere to required nutritional guidelines
- Managing unintended consequences of intervention – larger than anticipated client turnover, heightened unrealistic participant expectations
- Meal site purpose confusion for participants and others
- Aligning new initiatives (i.e., chef-led demonstrations) with interests of participants.

Prepared by: Laura Sena

The National Resource Center on Nutrition & Aging
THANK YOU

PLEASE COMPLETE THE EVALUATION