

Older Americans Nutrition Program Toolkit

Chapter 1:
Introductions

Chapter 2:
Definitions

Chapter 3: Meal
Service

Chapter 4: Menu &
Nutrient
Requirements

Chapter 5: Food
Safety & Sanitation

Chapter 6:
Food Service
Operations

Chapter 7:
Nutrition & Health
Promotion
Services

Chapter 8: Site
Administration

Chapter 9:
Personnel
Requirements

Chapter 10:
General State &
Area
Responsibilities

Chapter 11:
Evaluation

Chapter 12:
Reporting & Fiscal
Management

This project is supported, in part, by a grant, number 90AM2390, from the Administration on Aging, Department of Health and Human Services, Washington, DC 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Health and Human Services policy.

Guest Author

Mary Podrabsky, RD

Staff Authors

Barbara Kamp, MS

Stacey Reppas, MS, RD

Lester Rosenzweig, MS, RD

Heidi Silver, PhD, RD

Technical Review Committee

Shari Baker, RD, LD, Nutritionist

Ohio Department of Aging, Columbus, OH

Laura Hudspeth, MSc, RD, Nutritionist

Wyoming Department of Health, Aging Division, Cheyenne, WY

Jennifer Keeley, MS, RD, Nutritionist

Wisconsin Bureau on Aging and Long Term Care Resources, Madison, WI

Linda Netterville, MA, RD, Nutrition Program Manager

Johnson County Nutrition Program, Olathe, KS

Sarah Strawn, RD, Nutritionist

Alabama Department of Senior Services, Montgomery, AL

Susan Wenberg, MPH, RD, Nutritionist

Minnesota Board on Aging, St. Paul, MN

Jean Lloyd, MS, RD, Nutritionist

Administration on Aging, Washington, DC

Floristene Johnson, MS, RD, LD, Nutritionist

Administration on Aging, Region VI, Dallas, TX

JoAnn Pegues, MPA, RD, LD, Nutritionist

Administration on Aging, Region VIII, Denver, CO

Joseph Carlin, MS, RD, LDN, FADA, Nutritionist

Administration on Aging, Region I, Boston, MA

Nancy S. Wellman, PhD, RD, FADA, Professor and Director

Dian O. Weddle, PhD, RD, FADA, Associate Professor and Co-Director

National Policy and Resource Center on Nutrition and Aging

Additional Reviewers of Introduction and Chapter II

Sheila Belle, MA, RD

Department of Senior Program and Services, Westchester County, NY

Bertha Hurd

City of Los Angeles Department of Aging, Los Angeles, CA

Barbara Morrison, MS, RD

Southwest 8 Senior Services, Council Bluffs, IA

Chapter 1

Introduction

Contents

Background

Purpose

1998 Collection of SUA Documents

Organization of the Toolkit

Additional Resources

References

BACKGROUND

Under the Older Americans Act (OAA), the Older Americans Nutrition Program (OANP) is the largest and most visible, federally funded community-based nutrition program for older adults. The Nutrition Program is administered by the US Department of Health and Human Services, Administration on Aging (AoA) who provides leadership, coordination and support to an Aging Network that includes 57 State Units on Aging (SUAs), 655 Area Agencies on Aging (AAAs) and thousands of local providers under Title III. The AoA provides Title III-C funds to SUAs to provide congregate and home-delivered meals, nutrition screening, education and counseling, as well as an array of other supportive and health services.

To carry out the responsibilities mandated by the OAA, SUAs are responding to the demographic changes in the U.S. population of older adults. The proportion of older adults is expected to double to about 70 million by the year 2030, reflecting an increase from 12.4% today to 20% (1). The year 2030 represents the demographic milestone when many Baby Boomers

National Aging Services Network



will attain the ranks of the "oldest old" (age 85 and older) and large numbers of Gen Xers will themselves reach age 65 (1). All may be eligible for or in need of nutrition services. Furthermore, food insecurity, chronic diseases, and functional disabilities are common to many older adults. At the same time, changes in the health care system and public policy have resulted in earlier discharge of ill older adults from hospitals to home and community-based care. As a result, nutrition service providers need to expand and enhance the delivery of food and nutrition services to meet the increased demand for their services.

PURPOSE

The goal of the *Toolkit* is to assist SUAs in revising and updating their nutrition-related regulations, policies, procedures, and guidelines. The objectives of the *Toolkit* include:

- To provide technical assistance and guidance to the Aging Network
- To identify best practices and emerging areas for planning new approaches to implementing the OAA
- To identify mechanisms for collaboration and partnership building
- To identify resources to improve methods of service delivery
- To provide continuous, up-to-date information and resources (The *Toolkit* will be updated regularly).

1998 COLLECTION AND USE OF SUA DOCUMENTS

To begin developing the *Toolkit*, the AoA regional offices requested all U.S. states and territories to send copies of all current documents pertaining to state policies, procedures, rules, regulations, operational manuals, guidelines and standards for administering OANPs to the Center. A list of 19 topics, along with 103 subtopics (Appendix), was provided to suggest content areas of documents submitted. Forty-four states and the District of Columbia, Guam and Puerto Rico responded, submitting files of existing documents ranging from 50 to about 800 pages, each. The Center maintains the *SUA Policies and Procedures: 1998 Collection of Information* and requests that new documents be sent as they are revised or developed.

A manual (page by page) content analysis of each states' documents was conducted to code each portion of each SUA document into categories represented by the topic and subtopic list. Descriptive statistics, such as frequencies and percentages, were

used to summarize the topics and subtopics.

Limitations in the method of collecting and analyzing State documents for this *Toolkit* were that some topics or subtopics may not have been identified and counted in the survey or SUAs may not have submitted all pertinent documents. Given these limitations, the *SUA Policies and Procedures: 1998 Collection of Information* represents a more general, broad-based summary of current Nutrition Program practices. While this *Toolkit* contains sample SUA policies and procedures, there is the possibility of error or omission of other best practices.

ORGANIZATION OF THE *TOOLKIT*

The *Toolkit* is organized into the following chapters:

Chapter I: Provides a brief history and explains current issues of the Older Americans Nutrition Program; Describes the purpose of the *Toolkit* and a summary about the 1998 Collection of SUA Policies and Procedures.

Chapter II: Contains definitions of terms commonly used throughout SUA documents. Many are provided verbatim from Title I of the OAA to provide a framework for using and understanding OANP terminology.

Chapters III-XII: Each chapter is divided into sections that address the main components of the OANP. The following is included in each section:

- Citations from the 2000 OAA that provides the legislative foundation for each section and its subsections.
- Sample SUA policies and procedures that correspond to the OAA regulations.
- Links to additional resources (articles, internet websites, catalogs, state booklets) that SUAs can use to help plan, develop, implement, monitor, and evaluate their nutrition service systems.

Additional Resources

Additional Older Americans Act Aging Services Network Resources are available at:

http://www.fiu.edu/%7Enutreldr/Aging_Network/aging_network.htm

PowerPoint Presentations from the AoA Nutritionists / Administrators Conference (June 2-4, 2002):

- [Administration on Aging and Nutrition Services \(Edwin Walker\)](#)

- [Older Americans Act Fundamentals \(Jean Lloyd, Floristene Johnson, Jo Ann Pegues, Joesph Carlin\)](#)

References

(1) Wellman NS, Rosenzweig LY, Lloyd JL. Thirty years of the Older Americans Nutrition Program. J Am Diet Assoc. 2002;102:348-350.

(2) Wellman NS, Smith J, Alfonso M, Lloyd J. (1999) Report: The Nutrition 2030 Grassroots Survey. Florida International University, Miami, FL

SELECTED DEFINITIONS FROM THE OLDER AMERICANS ACT OF 2000 (Sec. 102)

The following definitions are selected terms that relate to the Older Americans Act (OAA) Nutrition Program. These definitions are listed verbatim and in the order they appear in Title I of the OAA.

Assistive Technology

(10) The term "assistive technology" means technology, engineering methodologies, or scientific principles appropriate to meet the needs of, and address the barriers confronted by, older individuals with functional limitations.

Information and referral

(11) The term "information and referral" includes information relating to assistive technology.

Disease Prevention and Health Promotion Services

(12) The term "disease prevention and health promotion services" means--

(A) health risk assessments;

(B) routine health screening, which may include hypertension, glaucoma, cholesterol, cancer, vision, hearing, diabetes, bone density, and nutrition screening;

(C) nutritional counseling and educational services for individuals and their primary caregivers;

(D) health promotion programs, including but not limited to programs relating to prevention and reduction of effects of chronic disabling conditions (including osteoporosis and cardiovascular disease), alcohol and substance abuse reduction, smoking cessation, weight loss and control, and stress management;

(E) programs regarding physical fitness, group exercise, and music therapy, art therapy, and dance-movement therapy, including programs for multigenerational participation that are provided by--

(i) an institution of higher education;

(ii) a local educational agency, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801); or
(iii) a community-based organization;

(F) home injury control services, including screening of high-risk home environments and provision of educational programs on injury prevention (including fall and fracture prevention) in the home environment;

(G) screening for the prevention of depression, coordination of community mental health services, provision of educational activities, and referral to psychiatric and psychological services;

(H) educational programs on the availability, benefits, and appropriate use of preventive health services covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

(I) medication management screening and education to prevent incorrect medication and adverse drug reactions;

(J) information concerning diagnosis, prevention, treatment, and rehabilitation concerning age-related diseases and chronic disabling conditions, including osteoporosis, cardiovascular diseases, diabetes, and Alzheimer's disease and related disorders with neurological and organic brain dysfunction;

(K) gerontological counseling; and

(L) counseling regarding social services and follow-up health services based on any of the services described in subparagraphs (A) through (K).

The term shall not include services for which payment may be made under titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq., 1396 et seq.).

Aging network

(14) The term "aging network" means the network of -

(A) State agencies, area agencies on aging, title VI grantees, and the Administration;

(B) Organizations that

(i) are providers of direct services to older individuals; or

(ii) are institutions of higher education; and

(iii) receive funding under this Act.

Area agency on aging

(17) The term "area agency on aging" means an area agency on aging designated under section 305(a)(2)(A) or a State agency performing the functions of an area agency on aging under section 305(b)(5).

Case management

(21) The term "case management service"-

(A) means a service provided to an older individual, at the direction of the older individual or family member of the individual-

(i) by an individual who is trained or experienced in the case management skills that are required to deliver the services and coordination described in subparagraph (B); and

(ii) to assess the needs, and to arrange, coordinate, and monitor an optimum package of services to meet the needs, of the older individual

(B) includes services and coordination such as-

(i) comprehensive assessment of the older individual (including the physical, psychological, and social needs of the individual);

(ii) development and implementation of a service plan with the older individual to mobilize the formal and informal resources and services identified in the assessment to meet the needs of the older individual, including coordination of the resources and services-

(I) with any other plans that exist for various formal services, such as hospital discharge plans; and

(II) with the information and assistance services provided under this Act;

(iii) coordination and monitoring of formal and informal service delivery, including, coordination and monitoring to ensure that services specified in the plan are being provided;

(iv) periodic reassessment and revision of the status of the older individual with-

(I) the older individual; or

(II) if necessary, a primary caregiver or family member of the older individual; and (v) in accordance with the wishes of the older individual, advocacy on behalf of the older individual for needed services or resources.

Frail

(26) The term "frail" means, with respect to an older individual in a State, that the older individual is determined to be functionally impaired because the individual -

(A) (i) is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision;

or (ii) at the option of the State, is unable to perform at least three such activities without such assistance

(B) due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual.

Greatest economic need

(27) The term "greatest economic need" means the need resulting from an income level at or below the poverty line.

Greatest social need

(28) The term "greatest social need" means the need caused by non-economic factors, which include -

(A) physical and mental disabilities

(B) language barriers

(C) cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that-

(i) restricts the ability of an individual to perform normal daily tasks; or

(ii) threatens the capacity of the individual to live independently.

Information and assistance

(29) The term "information and assistance service" means a service for older individuals that-

(A) provides the individual with current information on opportunities and services available to the individuals within their communities, including information relating to assistive technology;

(B) assesses the problems and capacities of the individuals;

(C) links the individuals to the opportunities and services that are available;

(D) to the maximum extent practicable, ensures that the individuals receive the services needed by the individuals, and are aware of the opportunities available to the individuals, by establishing adequate follow-up procedures; and

(E) serves the entire community of older individuals, particularly -
(i) older individuals with greatest social need; and
(ii) older individuals with greatest economic need.

Multipurpose senior center

(33) The term "multipurpose senior center" means a community facility for the organization and provision of a broad spectrum of services, which shall include provision of health (including mental health), social, nutritional, and educational services and the provision of facilities for recreational activities for older individuals.

Older individual

(35) The term "older individual" means an individual who is 60 years of age or older.

Planning and service area

(37) The term "planning and service area" means an area designated by a State agency under section 305(a)(1) (E), including a single planning and service area described in section 305(b)(5)(A).

Additional Definitions

Administration on Aging (AoA)

The Older Americans Act (OAA) established the AoA under the U.S. Department of Health and Human Services. AoA is the federal focal point and advocacy agency for older persons, as mandated by the OAA, and administers most OAA programs at the federal level. These programs provide assistance to older persons and their caregivers, as well as critical support services, such as nutrition and transportation, for older persons at risk of being prematurely or unnecessarily institutionalized.

State Units on Aging

AoA awards funds for Title III to the 57 State Agencies on Aging which are located in every State and Territory. Program funding is allocated to each State Agency on Aging, based on the number of older persons in the State, to plan, develop, and coordinate systems of supportive in-home and community-based services. Most States are divided into Planning and Service Areas (PSAs) so that programs can be effectively developed and targeted to meet the unique needs of older adults residing in that area. States establish planning and service areas of the State (AAAs) or designate a State to be a single planning and service area .

Area Agencies on Aging

Nationwide some 655 Area Agencies on Aging (AAA) receive funds from their respective State Agencies on Aging to plan, develop, coordinate and arrange for services in

each PSA. In rural areas, an AAA may serve the needs of older adults living in a number of counties, while other AAA's serve the elderly living in a single city. AAA's contract with public or private groups to provide services. There are some 27,000 service provider agencies nationwide. In some cases, the AAA may act as the service provider, if no local contractor is available. There are approximately 4000 nutrition service providers in the country.

Adult Day Care/Adult Day Health

Provision of personal care for dependent adults in a supervised, protective, congregate setting during some portion of a twenty-four hour day. Services offered in conjunction of adult day care/adult day health typically include social and recreational activities, training, counseling, meals for adult day care and services such as rehabilitation, medications assistance and home health aide services for adult day health.

Assisted Transportation

Provision of assistance, including escort, to a person who has difficulties (physical or cognitive) using regular vehicular transportation.

Congregate Meals

Provision, to an eligible client or other eligible participant at a nutrition site, senior center or some other congregate setting.

Home Delivered Meals

Provision, to an eligible client or other eligible participant at the client's place of residence.

Native Americans

Grants for Native Americans are provided under Title VI of the Older Americans Act. It is the purpose of this title to promote the delivery of supportive services, including nutrition services to American Indians, Alaskan Natives, and Native Hawaiians that are comparable to services provided under Title III. A tribal organization of an Indian tribe is eligible for assistance if (1) the tribal organization represents at least 50 individuals who are 60 years of age or older; and (2) the tribal organization demonstrates the ability to deliver supportive services, including nutrition services. The terms "Indian Tribe" and "tribal organization" have the same meaning.

Nutrition Counseling

Provision of individualized advice and guidance to individuals, who are at nutritional risk, because of their health or nutritional history, dietary intake, medications use or chronic illnesses, about options and methods for improving their nutritional status, performed by a health professional in accordance with state law and policy.

Nutrition Education

A program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants or participants and caregivers in a group or individual setting overseen by a dietitian or individual of comparable expertise. [Note: this is the only service of the 14 listed services in the SPR where the unit measure (one session) refers to either an individual or group service. In this case, for example, a group of people attending a session on nutrition issues for the elderly would count as one unit of "Nutrition Education".

The Nutrition Services Incentive Program (NSIP)

NSIP is the new name for the United States Department of Agriculture (USDA) cash or commodity program, known as the Nutrition Program for the Elderly (NPE). The NPE is administered by the Administration on Aging (AoA), but receives commodity foods and financial support from USDA's Food and Nutrition Service (FNS). The program is funded through an appropriation to USDA and administered by the FNS. For additional information, refer to AoA's website, *Nutrition Frequently Asked Questions, #36, What is the Nutrition Services Incentive Program?*

Registered Dietitian / Diet Technician / Licensed Dietitian

Registered Dietitians (RDs) are food and nutrition experts who have met the following criteria to earn the RD credential:

- Complete a minimum of a bachelor's degree at a US regionally accredited university or college and course work approved by the [Commission on Accreditation for Dietetics Education \(CADE\)](#) of [The American Dietetic Association \(ADA\)](#).
- Complete a CADE-accredited or -approved supervised practice program at a healthcare facility, community agency, or a foodservice corporation, or combined with undergraduate or graduate studies. Typically, a practice program will run six to twelve months in length.
- Pass a national examination administered by the [Commission on Dietetic Registration \(CDR\)](#).
- Complete continuing professional educational requirements to maintain registration.

Some RDs hold additional certifications in specialized areas of practice, such as pediatric or renal nutrition, nutrition support, and diabetes education. These certifications

are awarded through CDR, the credentialing agency for ADA, and/or other medical and nutrition organizations and are recognized within the profession, but are not required. In addition to RD credentialing, many states have regulatory laws for dietitians and nutrition practitioners. Frequently these state requirements are met through the same education and training required to become an RD. The ADA provides a number of resources concerning State Professional Regulation.

Registered Dietetic Technicians (DTRs) are trained in food and nutrition and are an integral part of health care and foodservice management teams. DTRs have met the following criteria to earn the DTR credential:

- Complete at least a two-year associate's degree at a US regionally accredited college or university.
- Complete a dietetic technician program approved by the Commission on Accreditation for Dietetics Education (CADE) of the American Dietetic Association (ADA), including 450 hours of supervised practice experience in various community programs, health care, and food-service facilities.
- Pass a national, written examination administered by the Commission on Dietetic Registration (CDR).
- Complete continuing professional educational requirements to maintain registration.

Rural

Any area that is not defined as urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories with a combined minimum population of 50,000) and (2) an incorporated place or a census designated place with 20,000 or more inhabitants.

Transportation

Provision of a means of going from one location to another. Does not include any other activity.

Additional Resources

Additional resources concerning the Administration on Aging, U.S. Department of Agriculture, Centers for Medicare and Medicaid, and OAA Aging Network Organizations are available at http://www.fiu.edu/%7Enutrelldr/Aging_Network/aging_network.htm

Chapter 3

Meal Services

Contents

Congregate Nutrition Services

- Older Americans Act
- Sample SUA Congregate Services Standards
- Improving the Congregate Nutrition Program

Home Delivered Nutrition Services

- Older Americans Act
- Sample SUA Home Delivered Nutrition Services Standards

Meal Service Options

- Multiple Meals
- Weekend Meals
- Frozen Meals
- Shelf-stable/
Emergency Meals
- Sample SUA
Emergency Meal
Standards

CONGREGATE NUTRITION SERVICES

Scientific evidence confirms that good nutrition helps older adults remain healthy and independent in their communities. Under the older Americans Act (OAA), congregate meals help increase the nutrient intake of participants. Hot or other appropriate meals are served five or more days per week, where feasible. These meals are offered in a variety of settings, such as senior centers, community and faith-based facilities, schools, and adult day care facilities. In these settings, participants are given the opportunity to form new friendships and to interact in a social environment. A variety of nutrition services may also be provided, such as nutrition screening, assessment, education and counseling. Supportive services, such as transportation, assisted transportation, shopping assistance, physical activity programs, health screening, health promotion and other services are also often available. These services help participants identify their nutrition needs as well as enhance their health and well-being. In 1998, the Older Americans Nutrition Program (OANP) served 147.2 million meals at congregate nutrition sites. However, for the last 12 years, both the number of congregate participants and meals served has been steadily declining nationwide (1). The *1995 National Evaluation of the Elderly Nutrition Program* found that congregate nutrition services targeted individuals who were at greater health and nutritional risk than the general older adult population. Because congregate sites offer many benefits to participants, it is important for service providers to increase participation, particularly to those at nutritional risk, and to maintain and/or improve the nutritional health of program participants (2). The National Evaluation found that OANP participants were:

- significantly poorer than the general U.S. population,
- primarily women who live alone,

Nutrition Services Incentive Program and Commodities

- Older Americans Act
- Sample NSIP Standards

- **Additional Resources**
- **References**

- 76 years old on average,
- likely to be minorities (~27%),
- hospitalized or in a nursing home in the past year (26-43%),
- have 2-3 chronic conditions on average,
- have 3 or more functional impairments (41%),
- at moderate to high nutritional risk (64-90%) (2).

Older Americans Act 2000 Nutrition Requirements

PART C--NUTRITION SERVICE SUBPART 1--CONGREGATE NUTRITION SERVICES PROGRAM AUTHORIZED SECTION 331

The Assistant Secretary shall carry out a program for making grants to States under State plans approved under section 307 for the establishment and operation of nutrition projects...

(1) which, 5 or more days a week (except in a rural area where such frequency is not feasible (as defined by the Assistant Secretary by regulation) and a lesser frequency is approved by the State agency), provide at least one hot or other appropriate meal per day and any additional meals which the recipient of a grant or contract under this subpart may elect to provide;

(2) which shall be provided in congregate settings, including adult day care facilities and multigenerational meal sites; and

(3) which may include nutrition education services and other appropriate nutrition services for older individuals.

Sample SUA Congregate Nutrition Services Standards / Guidelines

From Connecticut

- *Provide at least one hot or other appropriate meal in a congregate setting at least once a day, five or more days per week.*
- *When necessary (in case of illness, injury, etc.) make home delivered meals*

available to congregate meal participants.

- *Serve a minimum of 98% of all meals to eligible participants and their spouses.*
- *Develop procedures for responding to emergency situations for all congregate sites and provide ongoing training on emergency procedures to all site managers and other site staff.*
- *Make nutrition education available to meal site participants at a minimum of once each quarter.*
- *Nutrition education subjects shall be based on the needs of the participants.*
- *Nutrition information and visual educational materials shall be available to the participants on a continuing basis.*
- *Each congregate nutrition site shall be open for at least three hours per meal-time unless a waiver is received from the Area Agency on Aging.*
- *Each congregate nutrition site shall be neat, clean and have adequate lighting, ventilation, and temperature control.*

From New York

- *To the maximum extent possible, sites are open at least five days a week in recognition of the greater impact on the nutritional status of participants.*
- *All sites are open at least one hour before and after the meal to permit all participants to eat a leisurely meal, enjoy social contact, and take advantage of other services at the site.*
- *To the maximum extent possible there is space available for supportive, educational and/or recreational services and activities.*

Improving the Congregate Nutrition Program

There has been a steady decline in both the number of congregate participants and meals served (2). It is important that service providers identify means by which their congregate meal services can be expanded and improved. Ask the Experts Topics: *Addressing the Image of Older Americans Congregate Nutrition Programs, Increasing Participation at Older Americans Act Title III Funded Congregate Meal Sites, and Res-*

restaurant-based Congregate Nutrition Sites and Restaurant Voucher Programs offer guidance and suggestions, some of which are included below.

SUAs should have policies and procedures in place to help nutrition providers enhance their programs. The following are some examples to consider:

- Increase flexibility, provide food choices and culturally proficient services.
- Have programs at different times during the day, such as breakfast or dinner.
- Provide a variety of activities, transportation to sites, and linkages to other nutrition and social services.
- Expand outreach activities and improve marketing.
- Use a restaurant as an alternative site to provide ethnic meals or food choices.
- Provide vouchers for individuals to redeem at participating restaurants, cafeterias (hospital or school lunchroom), grocery stores, food courts, etc.

The National Policy and Resource Center on Nutrition and Aging conducted a survey of nutrition providers, the *Nutrition 2030 Grassroots Survey*. Providing outreach and improved marketing were the top-ranked items in the congregate section.

HOME DELIVERED NUTRITION SERVICES

As with congregate meals, home-delivered meals (HDM) (sometimes called meals on wheels) help increase the nutrient intake of older adults at nutrition risk. HDM participants tend to have more health problems than congregate participants. The HDM service is associated with decreased hospital stays and allows participants to remain in their homes. The OAA allows much flexibility in the type of HDMs provided to older adults. Such meals may be delivered hot, cold, frozen, dried, canned or as supplemental foods. In addition, breakfast, lunch or dinner, or a combination of 2 or 3 meals, may be provided 5 days per week, but can also be provided on weekends.

A case manager often plays an integral role in the cross-referral and coordination of service delivery of home and community-based care services (HCBC). Since older adults are being discharged earlier from hospitals and nursing homes, many require a care plan that includes HDMs and other nutrition services, ie, nutrition screening, assessment, education, and counseling. Many states enroll Medicaid beneficiaries in Health Maintenance Organizations, use Medicaid HCBC waivers, and create state-funded programs to provide necessary HCBC medical, social, and supportive services

including HDMs and nutrition education and counseling services (4). In contrast to congregate meals, the number of HDMs has been steadily increasing each year. In FY 1988 there were 94.7 million HDMs served compared to 130 million in FY 1998, a 27.2% increase (1). The demand for HDMs will continue to increase due to health care cost containment and rapid hospital discharge. States need to evaluate funding sources to maximize the availability of HDMs as well as expand and enhance their nutrition services in response to the diverse and burgeoning number of older Americans.

Older Americans Act 2000 Nutrition Requirements

SUBPART 2--HOME DELIVERED NUTRITION SERVICES PROGRAM AUTHORIZED SECTION 336

The Assistant Secretary shall carry out a program for making grants to states under State plans approved under section 307 for the establishment and operation of nutrition projects for older individuals which, 5 or more days a week (except in a rural area where such frequency is not feasible (as defined by the Assistant Secretary by regulation) and a lesser frequency is approved by the State agency), provide at least one home delivered hot, cold, frozen, dried, canned, or supplemental foods (with a satisfactory storage life) meal per day and any additional meals which the recipient of a grant or contract under this subpart may elect to provide.

Sample SUA Home Delivered Nutrition Services Standards / Guidelines

From Connecticut

- *Provide a nutritious home delivered meal at least once a day, 5 days a week. Meals may be hot, cold, frozen, dried, or canned foods with a satisfactory storage life.*
- *With the consent of the older person, or his/her representative, bring to the attention of appropriate officials for follow up conditions or circumstances which place the older person or the household in imminent danger.*
- *Make arrangement for the availability of meals to older persons in weather related emergencies.*

From Oklahoma

- *The Home Delivered Meals may be hot, cold, frozen, dried or canned with a*

satisfactory storage life, and must conform to procurement standards.

- *The Home Delivered Meals service may include the delivery of more than 1 meal for each day's consumption provided that proper storage and heating facilities are available in the recipient's home.*

The *Nutrition 2030 Grassroots Survey* found that increasing and maintaining volunteers and performing needs assessments were the top-ranked issues in the HDM section. The difficult challenge of deciding who has priority as a potential meal recipient when resources are limited is indicated by the emphasis on needs assessment as the second ranked item. There were differences by funding source for increasing and maintaining volunteers with privately-funded respondents giving that a higher ranking than did public or public/private, indicating that volunteers play even more important roles in privately-funded organizations.

MEAL SERVICE OPTIONS

Multiple Meals

It is common to provide a combination of two or three meals including breakfast, lunch and/or dinner, to participants receiving HDMs. Multiple meal packages are typically delivered with the noon meal. Breakfast, a popular meal with older adults, contributes to their health and well being by increasing intakes of critical nutrient dense food groups associated with positive health outcomes: cereals and grains, complex carbohydrates, fruits, fiber, milk, and milk products (5). Written eligibility requirements can help determine a participant's need to receive one or more meals. A best practice is to conduct periodic reassessments to determine the continued need for HDMs and the number of meals per day. Congregate nutrition programs may also serve breakfast and/or dinner in addition to or instead of lunch. Such services reflect the needs of a particular community or group and may only be provided on a limited basis during the week or month (e.g., 1 day per week or month).

Weekend Meals

Many homebound participants have functional impairments that make it difficult for them to shop and prepare meals. A number of nutrition programs offer weekend meals to frail, homebound participants receiving home-delivered meals. Weekend meals help contribute to a nutritionally adequate diet for these individuals and provides respite for family and friends. Written eligibility requirements, as noted above, would assist in determining a participant's need to receive weekend meals. Congre-

Frozen Meals

Frozen meals are often used in areas where daily delivery is limited, for weekend meal services, or to enable home delivered meal programs to offer more menu choices. The participant's kitchen (having appropriate appliances to store and reheat meals) and functional ability (can handle and/or heat meals) must be carefully considered when providing frozen meals. Frozen meals may also be used at congregate sites in rural areas where participation is small and other food service options are not feasible. Such meals would be heated and served at the site.

Shelf-stable / Emergency Meals

Emergency meals are generally shelf-stable ready to eat food products. Meal packages are generally provided to participants determined to need such food products if the program is unable to deliver meals due to weather or other problems. A best practice is to instruct participants on when and how they should use their emergency meal packages or to provide written suggestions for preparing their own emergency food stores. Program emergency preparedness is covered in Chapter X.

Sample SUA Emergency Meal Standards / Guidelines

From Massachusetts

All Nutrition Projects must offer all home delivered meals clients, at the time of assessment, a shelf stable emergency meal package, available for use during inclement weather or other emergency situations, when the Project is unable to deliver meals.

- The case manager may identify current clients who may require an emergency meals package.*
- Congregate meals participants should be advised to keep an emergency foods shelf at home in case of inclement weather.*
- The emergency meal package for home delivered meals participants shall be delivered to clients by November 1 of each year.*
- The package should consist of two to three days of shelf stable foods and shall be replenished by the Nutrition Project.*
- It is recommended that the emergency meal package contain one-third RDA; the package should, as much as possible, match the regular menu pattern.*

- *The no added salt policy is waived for these meals, however, low sodium items are encouraged.*
- *Persons requiring unsweetened foods must be provided with appropriate items.*

NUTRITION SERVICES INCENTIVE PROGRAM AND COMMODITIES

Nutrition Services Incentive Program is the new name for the U.S. Department of Agriculture (USDA) cash allotment or commodity program. The OAA authorizes the USDA to provide state agencies with either a cash allotment or commodities to encourage the effective and efficient delivery of meals funded through Titles III and VI of the OAA. States have latitude regarding whether they offer one or both of these options to nutrition projects. Although very few area agencies or nutrition projects use the additional option to use commodities, this is part of the program. Most SUAs do not use the commodity option and only a cash allotment is available. About 98.5% of the USDA funding is distributed as cash; 11 states use commodities. Examples of commodities are frozen or chilled beef or poultry, cheese, pasta, rice, canned or frozen vegetables, flour, vegetable oil, and butter.

Nutrition projects equipped to handle commodities may find them more cost effective than cash in lieu of commodities. Furthermore, additional commodities are available for state or area agencies on aging that take at least 20% of their program benefits as commodities.

States need written policies and procedures for use of cash and commodities, as well as reporting the number of meals served. Accepting USDA assistance is a necessary component of maintaining solvency of the OANP.

Older Americans Act 2000 Nutrition Requirements

SECTION 311 NUTRITION SERVICES INCENTIVE PROGRAM

(a) The purpose of this section is to provide incentives to encourage and reward effective performance by States and tribal organizations in the efficient delivery of nutritious meals to older individuals.

(b)(1) The Secretary of Agriculture shall allot and provide in the form of cash or commodities or a combination thereof (at the discretion of the State) to each State agency with a plan approved under this title for a fiscal year, and to each grantee with an application approved under the title VI for such fiscal year, an amount bearing the same ratio to the total amount appropriated for such fiscal year under subsection (e) as the

number of meals served in the State under such plan approved for the preceding fiscal year (or the number of meals served by the title VI grantee, under such application approved for the preceding fiscal year), bears to the total number of such meals served in all States by all title VI grantees under all such plans and applications approved for such preceding fiscal year.

(2) For purposes of paragraph (1), in the case of a grantee that has an application approved under title VI for a fiscal year but that did not receive assistance under this section for the preceding fiscal year, the number of meals served by the title VI grantee for the preceding fiscal year shall be deemed to equal the number of meals that the Assistant Secretary estimates will be served by the title VI grantee in the fiscal year for which the application was approved.;

(c)(1) Agriculture commodities and products purchased by the Secretary of Agriculture under section 32 of the Act of August 24, 1935 (7 U.S.C. 612c), shall be donated to a recipient of a grant or contract to be used for providing nutrition services in accordance with the provisions of this title.

(2) The Commodities Credit Corporation shall dispose of food commodities under section 416 of the Agricultural Act of 1949 (7 U.S.C. 1431) by donating them to a recipient of a grant or contract to be used for providing nutrition services in accordance with the provisions of this title.

(3) Dairy products purchased by the Secretary of Agriculture under section 709 of the Food and Agriculture Act of 1965 (7 U.S.C. 1446a091) shall be used to meet the requirements of programs providing nutrition services in accordance with the provisions of this title.

(d)(1) In any case in which a State elects to receive cash payments, the Secretary of Agriculture shall make cash payments to such State in an amount equivalent in value to the donated foods which the State otherwise would have received if such State had retained its commodity distribution.

(2) When such payments are made, the State agency shall promptly and equitably disburse any cash it receives in lieu of commodities to recipients of grants or contracts. Such disbursements shall only be used by such recipients of grants or contracts to purchase United States agricultural commodities and other foods for their nutritional projects.

(3) Nothing in this subsection shall be construed to authorize the Secretary of Agriculture to require any State to elect to receive cash payments under this subsection.

(4) Among the commodities delivered under subsection (c), the Secretary of Agriculture shall give special emphasis to high protein foods. The Secretary of Agriculture, in consultation with the Assistant Secretary, is authorized to prescribe the terms and conditions respecting the donating of commodities under this subsection.'

(e) There are authorized to be appropriated to carry out this section (other than subsection (c)(1)) such sums as may be necessary for fiscal year 2001 and such sums as may be necessary for each of the 4 succeeding fiscal years.'

(f) In each fiscal year, the Secretary of Agriculture and the Secretary of Health and Human Services shall jointly disseminate to State agencies, area agencies on aging, and providers of nutrition services assisted under this title, information concerning-
(1) the existence of any Federal commodity processing program in which such State agencies, area agencies on aging, and providers may be eligible to participate; and
(2) the procedures to be followed to participate in the program.

Sample SUA Nutrition Services Incentive Program Standards / Guidelines

NOTE: Because these SUA policies were collected prior to the 2000 reauthorization of the OAA, authorizing Nutrition Services Incentive Program (NSIP) SUAs are revising policies to accommodate NSIP changes.

From Colorado

- *Nutrition providers shall accept and use all commodities, including bonus commodities, made available by the state agency and funded by the USDA.*
- *Nutrition projects shall store commodities as prescribed in the "Donated Food Standard Agreement".*
- *The nutrition project shall accept only the quantity and type of food stated on the invoice. If the quantity is less than shown on the invoice, the nutrition project shall note this on the invoice, and request the deliverer to initial.*
- *Nutrition projects shall report any irregularities in the commodity shipping invoices to Food Assistance.*
- *Area agencies shall promptly and equitably disburse all USDA cash in lieu of commodities payments to nutrition providers that are funded with OAA funds.*
- *The distribution of such funds to the nutrition service provider(s) shall be in proportion to the number of meals served by each provider.*
- *Area agencies shall ensure that payments received by nutrition providers are used solely for the purchase of United States agriculture commodities and other foods produced in the United States; or Meals furnished under contractual arrangements with food service management companies, caterers, restaurants, or*

institutions, provided that each meal contains United States produced commodities or foods at least equal in value to the per-meal cash payment which the nutrition service providers have received.

From Montana

- *The nutrition provider shall ensure that adequate inventory records are maintained on commodities received. The inventory must show commodities received, used and on-hand.*

From Massachusetts

- *The provider shall receive, handle, store and utilize USDA commodities made available for Title III-C, in accordance with State Policy and Procedure for Distribution and Control of Commodity Foods. The provider agrees to comply with these regulations around the proper use, storage, loss or damage of commodities and recording/accounting procedures involved. The provider will be responsible to the Nutrition Project and the State Distributing Agency in the outlined areas of responsibility.*
- *The provider recognizes the following responsibilities to be its own:*
 - *The provider will make use of available USDA commodity foods made available by the Nutrition Project. The provider shall submit monthly credit vouchers for commodity foods received. The provider must use a minimum of \$0.13 per meal for commodities for the month.*
 - *To confer with the Nutrition Program manager and nutritionist in the ordering of commodities in accordance with an accepted utilization rate and to work with the nutritionist in designing menus to incorporate the available commodities.*
 - *The provider shall properly store and mark for easy identification all commodity foods.*
 - *To sign for receipt of shipment of commodities and notify the Nutrition Project of such in writing.*
 - *The commodities to be credited will be the total value of the commodities received. Credit will be made on the month that the commodities are received.*

A number of nutrition projects may also participate in the USDA Commodity Supplemental Food Program (CSFP). This program works to improve the health of low-income pregnant and breastfeeding women, infants, children up to age six, and people at least 60 years of age, by supplementing their diets with nutritious USDA commodity foods. It provides food and administrative funds to States to supplement the diets of these groups.

Additional Resources

Research/Reports and Resources concerning OAA Meal Services are available on the Center's website at: http://www.fiu.edu/~nutreldr/SubjectList/O/Older_American_Act_Nutrition_Programs.htm

OAA Aging Services Network Programs and Organizations

References

1. Administration on Aging. 1998 State Performance Reports. Available at: <http://www.aoa.dhhs.gov/napis/98spr/tables/default.htm>. Accessed September 7, 2001.
2. Mathematica Policy Research, Inc. [*Serving Elders at Risk, the Older Americans Act Nutrition Programs: National Evaluation of the Elderly Nutrition Program 1993-1995, Volume I: Title III Evaluation Findings.*](#) Washington, DC: US Department of Health and Human Services; 1996.
3. Wellman NS, Smith J, Alfonso M, Lloyd J. (1999) Report: The Nutrition 2030 Grass-roots Survey. Florida International University, Miami, FL.
4. Weddle DO, Faneelli-Kuczmariski M. Position of the American Dietetic Association: Nutrition, aging, and the continuum of care. *J Am Diet Assoc.* 2000;100; 580-595.
5. Weddle DO, Gollub E, Stacey SS, Wellman NS (1998) Final Report: The Morning Meals on Wheels Program Pilot Program: The Benefits to Elderly Nutrition Program Participants and Nutrition Projects. Florida International University, Miami, FL.

Chapter 4

Menu & Nutrition Requirements

Contents

Background

- Nutritional Needs of Older Adults
- National Evaluation of Nutrition Program Meals

Nutrient Recommendations

- Federal Nutrition Policy
- Dietary Reference Intakes (DRIs)
- Dietary Guidelines
- Older American Act
- Issue Panel and Recommendations
- Nutrient Values for Menu Planning and Evaluation

Menu Planning

- Menu Planning Process
- Nutrient Analyses Software
- Meal Patterns
- Updated Sample Meal Pattern
- Suggested Food Group Components and Serving Size

INTRODUCTION

Planning nutritious, appetizing, economical meals is a complex, multifaceted task. Menu planning plays a critical role in the delivery of quality services in Older Americans Nutrition Programs (OANPs). There are many factors to take into consideration in developing menus. The elements of menu planning noted below include suggested Best Practices.

BACKGROUND

Nutritional Needs of Older Adults

Scientific evidence increasingly supports the positive role nutrition plays in good health, self-sufficiency, and quality of life of older adults. Many older adults undergo changes in their lives (e.g., physiological, social, family, environmental, economic), which may affect their dietary intake. Nutrition-related risk factors include hunger, food security, poverty, inadequate food and nutrient intake, social isolation, depression, dementia, dependency, functional disability, chewing and swallowing difficulties, presence of diet-related acute or chronic diseases or conditions, polypharmacy, minority status, urban and rural geographic areas, advanced age, and living alone. If ignored, these risk factors could weaken nutritional status, increase medical complications, and result in loss of independence (1,2).

Malnutrition and dehydration are associated with delayed healing, altered immune response and increased risk of infections, increased severity of coexisting diseases, altered drug metabolism, decreased muscle strength, and behavioral symptoms such as confusion, apathy, depression, and memory loss. For the homebound, lack of transportation, weak family and social networks, physical barriers, and inadequate funds for food also contribute to inadequate nutrition (3).

-
- Enhancing the Nutritional Quality of the Meal: Key Nutrients
- Sources of Key Nutrients
- Nutrition Labeling / Daily Values

Special Dietary Needs

- Sample SUA Modified and Therapeutic Diet Standards
- Nutrition Supplements
- Sample SUA Use of Nutrition Supplements Standards
- Texture Modified Meals
- Ethnic and Religious Meals

Menu Review and Approval

- Sample SUA Menu Approval Standards
- Menu Substitutions

Meal Service Options

- Multiple Meals
- Weekend Meals
- Frozen Meals
- Shelf-stable/ Emergency Meals
- Supplements
- Definitions
- Additional Resources
- References

Physiologic function gradually declines with age and may result in decreased taste, smell, and appetite. In addition, polypharmacy, functional impairment, and multiple medical and social problems all place older persons at higher risk than the general population. Malnutrition leads to increased difficulty with activities of daily living and decreased quality of life (4).

The need for and the success of the OANPs is based on the scientific evidence that indicates that adequate nutrition is necessary to maintain cognitive and physical functioning, to prevent, reduce, and manage chronic disease and disease-related disabilities, and to sustain health and a good quality of life (5,6). Millions of older adults lack access to adequate amounts and quality of food necessary to sustain health and decrease the risk of disability. The provision of meals helps older adults maintain their health (7) as well as minimize their out-of-pocket food expenses so they can purchase other necessities such as medications, utilities, and shelter. The OANP provides an opportunity to implement interventions to address obesity, multiple chronic diseases such as diabetes, heart disease, stroke, hypertension, osteoporosis, osteoarthritis, cancer, and hypercholesterolemia through healthy meals, nutrition education and counseling and linkages to physical activity and wellness programs.

National Evaluation of Nutrition Program Meals

The [National Evaluation of the Older Americans Nutrition Program 1993-95](#) (8) found that the average OANP meal provided more than 50% of the 1989 Recommended Dietary Allowances (RDAs) for many nutrients based on adult male values. The *National Evaluation* concluded that both congregate and home-delivered meals contributed significantly to participants' daily nutrient intake, and therefore, their nutritional status. When comparing the nutrient content of OANP meals at the time of the *National Evaluation* to newer Dietary Reference Intakes (DRIs) (including RDA and other values described below), the meals would have been deficient in vitamins D, E, folate, and magnesium.

Other nutrients met or exceeded the newer DRI/RDA values. See [Table 2 Nutrient Availability of an Older Americans Nutrition Program Meal Relative to the Dietary Reference Intakes and Recommended Dietary Allowances](#) compiled by the National Policy and Resource Center on Nutrition and Aging (Center).

The use of the newer DRI/RDA values to plan and evaluate OANP meals was addressed by an Issue Panel convened by the Center in February 2002 (reviewed later in this chapter). Recommendations from this and future Issue Panels will continue to shape OANP practice and guidelines.

NUTRITION RECOMMENDATIONS

Federal Nutrition Policy

Congress reauthorized the Older Americans Act (OAA) in 2000 for 5 years. OAA Section 339 requires that nutrition projects meet the Dietary Guidelines for Americans (9), published by the Secretaries of Health and Human Services and Agriculture and the RDAs (which are now included in the DRIs) established by the Food and Nutrition Board, Institute of Medicine of the National Academy of Sciences. The National Nutrition Monitoring and Related Research Act of 1990 (Public Law 101-445) requires that the Secretaries of Health and Human Services and Agriculture contract with a scientific body, such as the National Academy of Sciences, to publish reports on nutrient requirements and status of the United States on a 2 to 5 year basis and to develop Dietary Guidelines every 5 years. The Act requires that all federal food, nutrition, and health programs promote the Dietary Guidelines. Thus, the most recent versions of the DRIs and Dietary Guidelines serve as the cornerstone for federal nutrition policy.

Dietary Reference Intakes

The new DRIs (10-15) provide values for men and women aged 51-70 and over 70 years. The DRI values include an RDA or an Adequate Intake for nutrients with no established RDA, and a Tolerable Upper Intake Level. Refer to Table 1 Dietary Reference Intakes for Older Adults compiled by the Center for current nutrient values established by the Food and Nutrition Board.

The RDA is the average daily dietary intake level that is sufficient to meet the nutrient requirement for nearly all (97-98%) healthy individuals of a specified age range and gender.

The Adequate Intake (AI) is the daily dietary intake level of healthy people assumed to be adequate when there is insufficient evidence to set an RDA. It is based on observed mean nutrient intakes and experimental data. The National Academy of Sciences recommends that the Adequate Intake be used if an RDA is not available.

The Tolerable Upper Intake Level (UL) is the highest daily dietary intake that is likely to pose no risk of adverse health effects to almost all individuals of a specific age range.

The Estimated Energy Requirement (EER) is defined as the dietary energy intake that is predicted (with variance) to maintain energy balance in a healthy adult of defined age, gender, weight, height and level of activity, consistent with good health.

An Acceptable Macronutrient Distribution Range (AMDR) is defined as a range of intakes for a particular energy source (i.e., carbohydrates, proteins, fats) that is associated with reduced risk of chronic disease while providing adequate intakes of essential nutrients. The AMDR is expressed as a percentage of total energy intake because its requirement is not independent of other energy fuel sources or of the total energy requirement of the individual.

The newer DRIs include RDAs for older adults that are higher than the 1989 RDAs for vitamins B-12, C, D, E, K, folate, calcium, and magnesium. The DRIs provide equations to calculate an individual's energy requirements based on activity level (the EER). To meet the body's daily nutritional needs while minimizing risk for chronic disease, an AMDR was established for carbohydrate to be 45-65% of total calories, for fat, 20-35% of total calories, and for protein, 10-35% of total calories. The DRIs also suggests that no more than 25% of total calories come from added sugars (those incorporated into foods and beverages during production and processing). The DRIs now emphasize the importance of physical activity and recommends that adults strive for an "active" lifestyle that is equivalent to 60 minutes of moderately intense physical activity throughout each day (15).

Dietary Guidelines for Americans

The 2000 Dietary Guidelines for Americans (5th ed.) are the most current guidelines to be followed when planning and serving OANP meals. These guidelines are incorporated in the selection of foods and serving sizes for meals as well as the basis for nutrition guidance for individuals and groups. The 3 main themes are:

1. Aim for Fitness

Aim for a healthy weight. Choose a lifestyle that combines sensible eating with regular physical activity. To be at their best, adults need to avoid gaining weight, and many need to lose weight. Being overweight or obese increases your risk for high blood pressure, high blood cholesterol, heart disease, stroke, diabetes, certain types of cancer, arthritis, and breathing problems. A healthy weight is key to a long, healthy life. Be physically active each day (a new recommendation). Being physically active and maintaining a healthy weight are both needed for good health, but they benefit health in different ways. Children, teens, adults, and the elderly—all can improve their health

and well-being and have fun by including moderate amounts of physical activity in their daily lives.

2. Build a Healthy Base

Let the pyramid guide your choices. Different foods contain different nutrients and other healthful substances. No single food can supply all the nutrients in the amounts you need. For example, oranges provide vitamin C and folate but no vitamin B12; cheese provides calcium and vitamin B12; but no vitamin C. Choose the recommended number of daily servings from each of the five major food groups. If you avoid all foods from any of the five food groups, seek guidance to help ensure that you get all the nutrients you need.

Choose a variety of grains, especially whole grains. They provide vitamins, minerals, carbohydrates (starch and dietary fiber), and other substances that are important for good health. Whole grains differ from refined grains in the amount of fiber and nutrients they provide, and different whole grain foods differ in nutrient content, so choose a variety of whole and enriched grains. Eating plenty of whole grains may help protect you against many chronic diseases.

Choose a variety of fruits and vegetables daily. Eating plenty of fruits and vegetables of different kinds may help protect you against many chronic diseases. It also promotes healthy bowel function. Fruits and vegetables provide essential vitamins and minerals, fiber, and other substances that are important for good health. To promote your health, eat a variety of fruits and vegetables—at least 2 servings of fruits and 3 servings of vegetables—each day.

Keep food safe to eat (a new recommendation). Foods that are safe from harmful bacteria, viruses, parasites, and chemical contaminants are vital for healthful eating. Safe means that the food poses little risk of foodborne illness. Farmers, food producers, markets, food service establishments, and other food preparers have a role to keep food as safe as possible. However, we also need to keep and prepare foods safely in the home, and be alert when eating out.

3. Choose Sensibly

Choose a diet that is low in saturated fat and cholesterol and moderate in total fat. Fats supply energy and essential fatty acids, and they help absorb the fat-soluble vitamins A, D, E, and K, and carotenoids. Some kinds of fat, especially saturated fats, increase the risk for coronary heart disease by raising the blood cholesterol. In contrast, unsaturated fats (found mainly in vegetable oils) do not increase blood cholesterol. Eating lots of fat of any type can provide excess calories.

Choose beverages and foods to moderate your intake of sugars. Sugars are carbohydrates and a source of energy (calories). Dietary carbohydrates also include the complex carbohydrates starch and dietary fiber. Sugars and starches occur naturally in

many foods that also supply other nutrients.

Choose and prepare foods with less salt. Many people can reduce their chances of developing high blood pressure by consuming less salt. Many studies in diverse populations have shown that a high sodium intake is associated with higher blood pressure. At present, the firmest link between salt intake and health relates to blood pressure. High salt intake also increases the amount of calcium excreted in the urine. Eating less salt may decrease the loss of calcium from bone. Loss of too much calcium from bone increases the risk of osteoporosis and bone fractures.

If you drink alcoholic beverages, do so in moderation. Alcoholic beverages supply calories but few nutrients. Current evidence suggests that moderate drinking is associated with a lower risk for coronary heart disease in some individuals. However, higher levels of alcohol intake raise the risk for high blood pressure, stroke, heart disease, certain cancers, accidents, violence, suicides, birth defects, and overall mortality (deaths). Older adults have a decreased ability to metabolize alcohol due to physiological changes and as a result may be at greater risk of adverse consequences.

Older Americans Act 2000 Nutrition Requirements

SECTION 339 Nutrition

A State that establishes and operates a nutrition project under this chapter shall

(1) solicit the advise of a dietitian or individual with comparable expertise in the planning of nutritional services, and

(2) ensure that the project --

(A) provides meals that --

(i) comply with the Dietary Guidelines for Americans, published by the Secretary and the Secretary of Agriculture,

(ii) provide to each participating older individual

(I) a minimum of 33 1/3 percent of the daily recommended dietary allowances as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, if the project provides one (1) meal per day,

(II) a minimum of 66 2/3 percent of the allowances if the project provides two (2) meals per day, and

(III) 100 percent of the allowances if the project provides three (3) meals per day, and

(iii) to the maximum extent practicable, are adjusted to meet any special dietary needs of program participants.

(B) provides flexibility to local nutrition projects in designing meals that are appealing to program participants, ...

Issue Panel on Dietary Reference Intakes and Dietary Guidelines in Older Americans Act Nutrition Programs

The Center convened an Issue Panel: Dietary Reference Intakes and *Dietary Guidelines* in OANPs in February 2002. Panelists included nutrition and aging-related researchers, individuals involved in policy development, persons working at the federal, state, and local program level, and representatives from food industries. The [Issue Panel Report](#) includes a summary, backgrounder and working documents, and a directory of Issue Panelists (16).

The Issue Panel focused on the rationale for and the use of the most recent DRIs and *Dietary Guidelines* in the provision of OAA nutrition services, including nutrition education, nutrition counseling, and congregate and home-delivered meals. The *Issue Panel Report* was provided to the US Administration on Aging for consideration. These recommendations will assist in the development of guidance and technical assistance related to implementation of the DRIs and *Dietary Guidelines* in the OANP. State Units on Aging (SUAs), Area Agencies on Aging (AAAs), local service providers, and Title VI grantees can use these recommendations in the development of guidance and assistance for implementation. Recommendations from the report are included in applicable sections of the *Older Americans Nutrition Program Toolkit*.

The OAA states that a project shall provide a meal that complies with the *Dietary Guidelines* and a stated percentage of the RDAs which varies with the number of meals served to a participant. Because it is the responsibility of the SUA to implement the OAA, SUAs have incorporated these standards into their policies and procedures.

Issue Panel Recommendations for Meeting Nutrition Requirements

1. OANP meals should meet the current RDAs and AIs, and the 2000 Dietary Guidelines for Americans, as these reflect the most recent scientific evidence and provide the best-known guidance for meeting the nutrition needs of older adults in America.
2. OANPs should strive to ensure that each meal is reasonably well-balanced nutritionally and reflects the 2000 Dietary Guidelines since the meals provide a positive nutrition education model for participants. To best serve the nutrition and educational needs of participants, OANPs that serve 1 meal per day should ensure that each meal offers at least 33 1/3% of the RDAs/Adequate Intakes. OANPs that serve two meals per day should ensure that the sum of the two meals offers at least 66 2/3% of the RDAs/Adequate Intakes (but each meal itself does not have to be 33 1/3%) and those serving three meals per day should ensure that the sum of these three meals offers

100% of the RDAs/Adequate Intakes.

3. In addition to providing meals that meet the 2000 Dietary Guidelines and 1/3 of the RDAs/Adequate Intakes, OANPs should emphasize foods high in fiber, calcium, and protein. To the extent possible, programs should continue to target vitamins A and C, with vitamin A provided from vegetable-derived (carotenoid) sources. However, targeting specific nutrients such as those mentioned in this recommendation should not be misinterpreted as permission to ignore other nutrients. More specific recommendations regarding targeting nutrients should be addressed at a future Issue Panel.
4. OANPs should plan and evaluate meals for meeting the 2000 Dietary Guidelines and 1/3 RDA/Adequate Intake standards by computer-assisted analysis. Furthermore, Registered Dietitians (or individuals with comparable expertise) should be available at the SUA, AAA, and local provider level to assure nutrient adequacy of meals. If a meal pattern is used, it should be based on the food servings delineated in the Food Guide Pyramid that combined would meet 1/3 the RDAs/Adequate Intakes and the 2000 Dietary Guidelines, be tested for meeting standards, and include increased servings of fruits, vegetables, and whole grains.
5. Assuming culturally appropriate meals, OANPs should accommodate specific dietary needs to the extent possible. To better serve defined groups and individuals who require customization or therapeutic diets, OANPs would benefit from the availability of Registered Dietitians (or individuals with comparable expertise) -- who could also conduct needs assessments of the populations their programs serve.

Nutrient Values for Meal Planning and Evaluation

The table below presents the most current DRIs and other nutrient values to use when planning and evaluating meals. Values are provided for serving 1, or a combination of 2 or 3 meals for 1 day's consumption for the average older adult population served by the OANP. The nutrients selected include those recommended for emphasis by the Issue Panel and those found in a number of studies to be deficient or of concern in the diets of older adults. (See "Enhancing the Nutritional Quality of the Meal" section of this chapter). Refer to [Table 1 Dietary Reference Intakes for Older Adults](#) compiled by the Center for all DRI values and footnotes.

Nutrient Values for Meal Planning and Evaluation			
	1 meal/day 33% RDA/AI	2 meals/day 67% RDA/AI	3 meals/day 100% RDA/AI
Macronutrients			
Kilocalories (Kcal)(1)	685	1369	2054
Protein (gm)(2,3) [20% of total Kcal (gm)] (4)	19 34	37 69	56 103
Carbohydrate (gm) (5) [50% of total Kcal (gm)] (4)	43 86	87 171	130 257
Fat (gm) [30% of total Kcal (gm)] (6)	23	46	68
Saturated Fat (<10% of total Kcal) (7)	Limit intake (8)		
Cholesterol (<300 gm/day) (7)	Limit intake (8)		
Dietary Fiber (gm)(3)	10*	20*	30*
Vitamins			
Vitamin A**(ug) (3)	300	600	900
Vitamin C (mg) (3)	30	60	90
Vitamin D (ug) (3)	5*	10*	15*
Vitamin E (mg)	5	10	15
Thiamin (mg) (3)	0.40	0.80	1.20
Riboflavin (mg) (3)	0.43	0.86	1.30
Vitamin B6 (mg) (3)	0.57	1.13	1.70
Folate (ug)	133	267	400

Vitamin B12 (ug)	0.79	1.61	2.4
Minerals			
Calcium (mg)	400*	800*	1200*
Copper (ug)	300	600	900
Iron (mg)	2.70	5.30	8.00
Magnesium (mg) (3)	140	280	420
Zinc (mg) (3)	3.70	7.30	11.00
Electrolytes			
Potassium (mg) (9)	1167	2333	3500
Sodium (mg) (7)	<800	<1600	<2400

* RDAs are in **bold type** and Adequate Intakes (AIs) are in ordinary type followed by an asterisk (*).

**Vitamin A should be provided from vegetable-derived (carotenoid) sources. See [Issue Panel Report on Dietary Reference Intakes and Dietary Guidelines in Older Americans Act Nutrition Programs](#).

(1) Value for 75 year old male, height of 5'7", " low active" physical activity level (PAL). Using Table 5-22 Estimated Energy Requirements (EER) for Men and Women 30 Years of Age, calculated the median BMI and calorie level for men and subtracted 10 kcal/day (from 2504 kcal) for each year of age above 30.

(2) The RDA for protein equilibrium in adults is a minimum of 0.8g protein/kg body weight for reference body weight.

(3) Used highest DRI value for ages 51+ and male and female.

(4) Acceptable Macronutrient Distribution Ranges (AMDRs) for intakes of carbohydrates, proteins, and fats are expressed as percent of total calories. The AMDR for protein is 10-35%, carbohydrate is 45-65%, total fat is 20-35%.

(5) The RDA for carbohydrate is the minimum adequate to maintain brain function in adults.

(6) Because the percent of energy that is consumed as fat can vary greatly while still meeting daily energy needs, an AMDR is provided in the absence of an AI, EAR, or RDA for adults.

(7) Recommendations from the *Dietary Guidelines for Americans 2000*.

(8) *Saturated fats, trans fatty acids, and dietary cholesterol have no known beneficial role in preventing chronic disease and are not required at any level in the diet. The recommendation is to keep intake as low as possible while consuming a nutritionally*

adequate diet, as many of the foods containing these fats also provide valuable nutrients. Institute of Medicine, Food and Nutrition Board. Dietary Reference Intakes for Energy, Carbohydrates, Fiber, Fat, Fatty Acids, Cholesterol, Protein, and Amino Acids. Washington, DC: National Academy Press; 2002.

(9) National Research Council, Food and Nutrition Board. Recommended Dietary Allowances. 10th ed. Washington, DC: National Academy Press; 1989.

Issue Panelists generally agreed that there might be circumstances when it is not always necessary for a single meal to meet the 1/3 requirement for every nutrient for which an RDA or Adequate Intake has been established. The idea of averaging nutrients over a longer period of time, such as a few days, or week was discussed. However, averaging was rejected overall by Panelists for periods longer than 1 day for the following reasons:

- The OANP meal can provide a good example of healthy food choices and balanced eating for participants, as well as demonstrate to federal policy makers the best that the OANPs offer;
- The availability of water-soluble nutrients, such as vitamin C, in foods may be reduced over long cooking or transporting times. Thus, participants may not be consuming the level of these nutrients that is planned; and
- The needs of congregate and home-delivered meal participants may not be equally met. Individuals who receive home-delivered meals five days per week may have better nutrient intakes over time than congregate participants that do not receive meals daily. Data indicate that only 60% of congregate participants attend a dining center 5 days a week. It is possible that participants might come on days when the meal contains less than requirements (16).

The Center plans to hold another Issue Panel (2003) regarding implementation of the DRIs. It is expected that the Panel will develop more specificity for energy (calories), the percentage of carbohydrate, protein, and fat to total calories, and key nutrients that should be included in computer-assisted menu analyses. The Issue Panel recommendations will be included in future modifications of the above table and other sections of this chapter.

MENU PLANNING

Menu Planning Process

In order to ensure nutrient quality for the health of older Americans and to comply with the requirements of the OAA, SUAs establish written standards and guidelines detailing the specific requirements for menu planning and approval. Planning menus that includes input from participants is a best practice. Information may be obtained through focus groups, advisory councils, suggestion boxes, or surveys. Suggestions may also come from food production staff, site managers, home-delivered meal drivers, and food purveyors. SUAs, AAAs, and local providers should rely on professionals, preferably registered dietitians or nutritionists, to assist in the development, implementation, and approval of menus for OANPs. (Chapter 2 provides a description of a registered dietitian). Ideally, the menu will reflect local food preferences, provide variety in shape, color, temperature, texture, and flavor, consider food availability (foods in season), and costs. Well planned menus improve meal quality and increase client satisfaction (17).

The Issue Panel recommended that OANPs plan and evaluate meals for meeting nutritional requirements using computer-assisted nutrient analysis and that Registered Dietitians (or individuals with comparable expertise) be available at the state, area, and local provider levels to assure nutrient adequacy of meals (16).

Nutrient Analysis Software

A variety of nutrient analysis and meal production software products are available and used by SUAs, AAAs, and providers. Some simply provide analysis of foods, recipes, and menus. Others offer food production, inventory, and costing capabilities. The National Policy and Resource Center on Nutrition and Aging surveyed SUAs (12/02) concerning their use and requirements to use nutrient analysis software. (Click here for complete survey). Below is a summary of some of the responses. Additional responses are included in the "Menu Review and Approval" section of this chapter. State Unit on Aging Respondents (N = 33)

- 10 SUAs use computer software to analyze the nutrient content of meals. These include Food Processor (6 SUAs), Nutritionist Pro (2 SUAs), FoodWorks (1), Compu-trition (1), and Nutritionist V (1).
- Factors influencing the selection of Food Processor software were cost, ease of use, ability to add to the data base, completeness of the database, and technical support. Nutritionist Pro and Foodworks were selected for similar reasons. Nutritionist V

was selected because it provided quantity recipes. Computrition was used by a large vendor to do forecasting, inventory control, etc.

- 6 SUAs recommended a particular brand of nutrient analysis software for AAA and provider use: Food Processor (4 SUAs), NutritionistPro (1), and Nutritionist IV or more (1). Several SUAs indicated they provide no specific recommendations.
- SUAs identified nutrient analysis software commonly used by AAAs and providers: Food Processor (9 SUAs), Nutritionist IV or V (5), Nutritionist Pro (4), Computrition (4), and Master cook (2).

The following list of nutrition software products was compiled by the Center:

- CALCMENU www.calcmenu.com/
- Computrition www.computrition.com/
- Dave Johnson Nutrition www.djsoft.com/
- DietAid www.shannonsoft.com/
- DietMaster www.lifestylestech.com/
- Dine Healthy www.dinesystems.com/
- Food Processor, Esha Research www.esha.com
- Food Smart www.food-smart.com/
- FoodWorks, Nutrition Company www.nutritionco.com
- Fuel Nutrition Software www.logiform.ca/fuel/pro_an.htm
- Mealformation Software www.mealformation.com/
- Nutribase 2001 Clinical, CyberSoft, Inc. www.nutribase.com
- Nutritionist Pro, First Databank www.firstdatabank.com
- SureQuest Software www.surequest.com/products.htm

Meal Patterns

A meal pattern is best used as a menu-planning tool (ensuring food plate coverage, and as a component of a catering contract) rather than as a standard for nutritional adequacy or as a compliance tool. Use of computerized nutrient analysis rather than a meal pattern helps ensure nutritional adequacy of meals and increases menu planning flexibility. Many SUAs require documentation that menus meet nutrient requirements using computer-assisted nutrient analysis. Some SUAs specify that meals must follow a meal pattern with no deviation.

Additional guidance is often provided for accompaniments such as desserts, condiments including margarine, salad dressings, and relishes, and beverages other than milk. Specific guidance is frequently included to ensure that foods high in key nutrients are provided. Recommendations for inclusion of foods high in vitamins A and C and fiber are common. In addition, information is typically provided in SUA guidelines to ensure that menus incorporate foods that are lower in sodium, fat, saturated fat, and cholesterol.

The 1972 meal pattern (still used by many OANPs today) first appeared in the *Guide to Effective Project Operations, The Nutrition Program for the Elderly* (the Oregon Guide, 1973). It was assumed that if a variety of foods were provided daily in the amounts indicated and proper food preparation and handling was practiced, the meal would provide at least 1/3 of the 1968 RDAs. The pattern became the quick checklist for determining the nutritional adequacy of a meal. Some SUAs added requirements that meals provide foods high in specific nutrients, such as vitamins A and C, as well as some others. This pattern does not ensure that the new DRI requirements are met for calories, carbohydrates, magnesium, folate, vitamin E, and fiber as noted in the [Issue Panel Report: Table 4.1 Nutrient Composition of the 1972 Meal Pattern \[page 53 of 62\]](#) (16). These variations in menu planning may be addressed in state guidelines.

Updated Sample Meal Pattern to Meet New DRIs

The updated sample meal pattern below is based on the newer DRIs for energy as calculated for the table above, "Dietary Reference Intakes for Meal Planning and Evaluation." It provides approximately 685 calories per meal. The number of servings for each food group are based on USDA's *Food Guide: Background and Development, Table 5 Nutrient profiles for food groups and subgroup composites*. These profiles represent the quantities of nutrients and other components that one would expect to obtain on average from a serving of food in each group (18). Information from *Table 5 Nutrient profiles...* and from USDA's Agricultural Research Service, [Home and Garden Bulletin No.72 \(Revised October 2002\)](#) was used to determine the appropriate

number of food group servings to best meet the new DRIs. See table, "[Nutrient Composition of a Sample Meal Pattern](#)."

The updated sample meal pattern includes 1 additional serving of bread or bread alternate and another serving of vegetable or fruit compared to the 1972 meal pattern. Serving sizes are based on the *Food Guide Pyramid*. The number of servings reflects an appropriate distribution of foods for the day, particularly for lunch or supper. Servings from a food group may be combined as one larger serving. For example, 2 servings from the bread or bread alternate food group may include 2 slices of bread for a sandwich or 1 cup of pasta or rice or it may include 1/2 cup pasta and 1 slice of bread. Likewise, 2 servings of vegetable may be 1/2 cup mashed potato and 1/2 cup green beans or 1 cup of either vegetable. The pattern provides the option for substituting 1 fruit serving for a vegetable serving and vice versa.

This updated sample meal pattern, although based on the food servings recommended in the *Food Guide Pyramid*, does not assure that meals meet 1/3 the DRIs and the *2000 Dietary Guidelines*. Meals are likely to require specific types of fruits and vegetables, whole grains, and high fiber foods. Based on the information used from USDA's *Food Guide: Background and Development, Table 5 Nutrient profiles for food groups and subgroup composites*, the updated meal pattern may be deficient in vitamin E, requiring extra care in the selection of foods that are good sources of this nutrient (see "Sources of Key Nutrients" section of this chapter). Because of the increased nutrient requirements, it may be difficult for some participants to eat the amount of food for 1 meal at 1 sitting. The use of nutrient dense foods as well as fortified and enriched products should be a priority. In addition, calories from carbohydrates, fats, and/or proteins will require adjustment for underweight or overweight individuals. As appropriate for the weight status of participants, the provision of food supplements and modifications in serving sizes of particular food groups may be needed.

Suggested Food Group Components and Serving Size

The food group information below generally follows the *2000 Dietary Guidelines* and *Food Guide Pyramid*. Although some foods are classified in more than 1 food group, a serving of a food can only be counted in 1 food group within the same meal. For example, dried beans may be counted as either a meat alternate serving or as a vegetable serving but not both in the same meal. Likewise, cottage cheese may be counted as either meat alternate serving or milk alternate serving but not both.

Compiled from the *Dietary Guidelines for Americans 2000* and Florida, Massachusetts, and Ohio standards:

1. Bread or Bread Alternate

- A serving of bread is generally 1 slice (1 ounce); ½ cup pasta or grain product; or 1 ounce of ready-to-eat cereal. Bread and bread alternates include:
 - 1 small 2 ounce muffin
 - 2" cube cornbread
 - 1 biscuit, 2.5" diameter
 - 1 waffle, 7" diameter
 - 1 slice French toast
 - 1/2 English muffin
 - 1 tortilla, 6" diameter
 - 2 pancakes, 4" diameter
 - 1/2 bagel
 - 1 small sandwich bun
 - 1/2 cup cooked cereal
 - 4-6 crackers
 - 1/2 large sandwich bun
 - 3/4 cup ready to eat cereal
 - 2 graham cracker squares
 - 1/2 cup bread dressing/stuffing
 - 1/2 cup pasta, noodles, rice
- A variety of enriched and/or whole grain bread products, particularly those high in fiber, are recommended.
- Bread alternates do not include starchy vegetables such as potatoes, sweet potatoes, corn, yams, or plantains. These foods are included in the vegetable food group.

2. Vegetables

- A serving of vegetable (including dried beans, peas and lentils) is generally $\frac{1}{2}$ cup cooked or raw vegetable; or $\frac{3}{4}$ cup 100% vegetable juice; or 1 cup raw leafy vegetable. For prepacked 100% vegetable juices, a $\frac{1}{2}$ cup juice pack may be counted as a serving if a $\frac{3}{4}$ cup pre-packed serving is not available).
- Fresh or frozen vegetables are preferred, canned vegetables.
- Vegetables as a primary ingredient in soups, stews, casseroles or other combination dishes should total $\frac{1}{2}$ cup per serving.

3. Fruits

- A serving of fruit is generally a medium apple, banana, orange, or pear; $\frac{1}{2}$ cup chopped, cooked, or canned fruit; or $\frac{3}{4}$ cup 100% fruit juice. For prepacked 100% fruit juices, a $\frac{1}{2}$ cup juice pack may be counted as a serving if a $\frac{3}{4}$ cup pre-packed serving is not available).
- Fresh, frozen, or canned fruit will preferably be packed in juice, light syrup or without sugar.

4. Milk or Milk Alternates

- One cup whole, low fat, skim, buttermilk, low-fat chocolate milk, or lactose-free milk fortified with Vitamins A and D should be used. Low-fat or skim milk is recommended for the general population. Powdered dry milk ($\frac{1}{3}$ cup) or evaporated milk ($\frac{1}{2}$ cup) may be served as part of a home-delivered meal. (Some states restrict serving reconstituted powdered milk.)
- Milk alternates for the equivalent of one cup of milk include:
 - 1 cup yogurt
 - $1\frac{1}{2}$ cups cottage cheese
 - 8 ounces tofu (processed with calcium salt)
 - $1\frac{1}{2}$ ounces natural or 2 ounces processed cheese
 - $1\frac{1}{2}$ cups ice milk/ice cream

5. Meat or Meat Alternate

- Three ounces of meat or meat alternate should generally be provided for the lunch or supper meal. Meat serving weight is the edible portion, not including skin, bone, or coating.
- 1 egg
- 1 ounce cheese (nutritionally equivalent measure of pasteurized process cheese)

cheese food, cheese spread, or other cheese product)

- ½ cup cooked dried beans, peas or lentils
 - 2 tablespoon peanut butter or 1/3 cup nuts
 - ¼ cup cottage cheese
 - ½ cup tofu
 - A one ounce serving or equivalent portion of meat, poultry, fish, may be served in combination with other high protein foods.
-
- Except to meet cultural and religious preferences and for emergency meals, avoid serving dried beans, peas or lentils, peanut butter or peanuts, and tofu for consecutive meals or on consecutive days.
 - Imitation cheese (which the Food and Drug Administration defines as one not meeting nutritional equivalency requirements for the natural, non-imitation product) cannot be served as meat alternates.
 - To limit the sodium content of the meals, serve no more than once a week cured and processed meats (e.g., ham, smoked or Polish sausage, corned beef, wieners, luncheon meats, dried beef).

Accompaniments

Include traditional meal accompaniments as appropriate, e.g., condiments, spreads, garnishes. Examples include: mustard and/or mayonnaise with a meat sandwich, tartar sauce with fish, salad dressing with tossed salad, margarine with bread or rolls. Whenever feasible, provide reduced fat alternatives. Minimize use of fat in food preparation. Fats should be primarily from primarily vegetable sources and in a liquid or soft (spreadable) form that are lower in hydrogenated fat, saturated fat, and cholesterol.

Desserts

Serving a dessert may or may not be required by the SUA. Healthier desserts generally include fruit, whole grains, low fat products, and/or limited sugar. States may limit the number of times a high sugar or high fat item is provided (e.g., cakes, cookies, pies). Fresh, frozen, or canned fruits packed in their own juice are often encouraged as a dessert item in addition to the serving of fruit provided as part of the meal.

Beverages

Fluid intake should be encouraged as dehydration is a common problem in older adults. It is a good practice to have drinking water available. Other beverages such as juices, coffee, tea, decaffeinated beverages, soft drinks, and flavored drinks, may be served. Nonnutritive beverages do not help meet nutrition requirements but can help

with hydration. Alcoholic beverages should not be provided with OAA funds.

Enhancing the Nutritional Quality of the Meal: Key Nutrients

The Issue Panel recommended that OANPs emphasize foods that are high in fiber, calcium, and protein, and continue to target vitamins A and C, with vitamin A provided from vegetable-derived (carotenoid) sources. Targeting specific nutrients mentioned in this recommendation should not be misinterpreted as permission to ignore other nutrients (16). A number of studies found specific nutrients to be deficient in diets of older adults (8,19,20). While the *National Evaluation* revealed that OANP meals supplied over 33% of the 1989 RDAs for key nutrients. When compared to the newer DRIs, meals were inadequate in vitamins D and E, folate, calcium, and magnesium (8). *The Continuing Survey of Food Intakes by Individuals 1994-1996* found older adults' dietary intake to be low in calories, total fat, fiber, carbohydrate, vitamin E, folate, calcium, and magnesium (19). *The Third National Health and Nutrition Examination Survey* (NHANES III) found older adults' dietary intake to be low in calories, total fat, fiber, calcium, magnesium, zinc, copper, folate, and vitamins B6, C and E (20). Therefore, the following require special attention: vitamins A, B-6, C, D, E, and folate; calcium, copper, magnesium, zinc; and calories, carbohydrates, total fat, protein, and fiber. More definitive guidance concerning targeting key nutrients will be developed as part of the next Issue Panel on the implementation of the DRIs.

Sources of Key Nutrients

Foods considered good sources of specific nutrients are shown in the following table prepared by the Center. Information provides "good" and "high" food sources of specific nutrients. A "high source" is defined as providing 20% or more of the Daily Value for a given nutrient per serving. A "good source" is federally defined as providing 10-19% of the Daily Value for a given nutrient per serving. See summary of the use and meaning of Daily Values that follows the table. Foods selected for the table meet the above parameters using typical serving sizes.

The USDA's [National Nutrient Database for Standard Reference, Release 15 Nutrient List](#) was used to develop the table (21). The database contains reports of selected food items and nutrients sorted by food description or in descending order by nutrient content in terms of common household measures. The food items and weights are adapted from *Home and Garden Bulletin No. 72, Nutritive Value of Foods*.

Nutrient	Food	Serving Size	Amt	% DV c
Calcium			mg	
High	Yogurt, plain, low fat	8 oz	345	35
	Milk 1% w/ added Vit A	1 cup	300	25
Good	Cheddar cheese	1 oz	204	17
	Collard greens, cooked	1/2 cup	179	15
	Turnip greens, cooked	1/2 cup	125	10
	Spinach, cooked	1/2 cup	123	10
Magnesium			mg	
High	Finfish, Halibut	1/2 fillet	170	40
Good	Spinach, cooked	1/2 cup	79	19
	Soybean, cooked	1/2 cup	74	18
	Beans, white, canned	1/2 cup	67	16
	Beans, black, cooked	1/2 cup	60	14
	Artichokes, Cooked	1/2 cup	51	12
	Beet greens, cooked	1/2 cup	49	12
	Lima beans, cooked	1/2 cup	47	11
	Okra, frozen, cooked	1/2 cup	47	11
	Oat bran, cooked	1/2 cup	44	10
	Brown rice, cooked	1/2 cup	42	10
Vitamin B12			mg	
High	Yogurt, plain. low fat	8 oz	0.49	37
	Milk 1%, w/ added vit A	1 cup	0.41	31
	Egg whole, scrambled/hard-boiled	1 Lg	0.27	21
Good	Soybeans, cooked	1/2 cup	0.25	19
	Ricotta cheese, whole milk	1/2 cup	0.24	18
	Mushrooms, cooked	1/2 cup	0.23	18
	Spinach, cooked	1/2 cup	0.21	16
	Beet greens, cooked	1/2 cup	0.21	16
	Cottage cheese, low fat	1/2 cup	0.19	14
Folate			ug	
High	Lentils, cooked	1/2 cup	179	45
	Pinto beans, cooked	1/2 cup	147	37
	Chickpeas, cooked	1/2 cup	141	35
	Okra, frozen, cooked	1/2 cup	134	33
	Spinach, cooked	1/2 cup	132	33
	Asparagus, cooked	1/2 cup	122	30

	Turnip greens, cooked	1/2 cup	85	21
	Brussels sprouts, frozen, cooked	1/2 cup	78	20
Good	White rice, long-grain, cooked	1/2 cup	77	19
	Broccoli, frozen, cooked	1/2 cup	52	13
	Mustard greens, cooked	1/2 cup	52	13
	Green peas, frozen, cooked	1/2 cup	47	12
	Orange	1 med	39	10
Vitamin E			mg	
High	Vegetable oil, sunflower linoleic (>60%)	1 tbsp	6.88	46
	Tomato products, canned, puree	1/2 cup	3.15	21
	Vegetable oil, canola	1 tbsp	2.93	20
Good	Turnip greens, frozen, cooked	1/2 cup	2.39	16
	Peaches, canned	1/2 cup	1.86	12
	Tomato products, canned, sauce	1/2 cup	1.72	11
	Broccoli, frozen, cooked	1/2 cup	1.52	10
Fiber			gm	
High	Pears, Asian, raw	1 pear	9.9	28 <i>d</i>
	Beans (pinto, black, kidney)	1/2 cup	7-8	20-23 <i>d</i>
	Dates, dry	1/2 cup	7.0	20 <i>d</i>
Good	Chickpeas, cooked	1/2 cup	6.0	17 <i>d</i>
	Artichokes, cooked	1/2 cup	4.5	13 <i>d</i>
	Green peas, Frozen, cooked	1/2 cup	4.4	13 <i>d</i>
	Raspberries, raw	1/2 cup	4.2	12 <i>d</i>
	Vegetables, mixed, frozen, cooked	1/2 cup	4.0	11 <i>d</i>
	Apple, raw, with skin	1	3.7	11 <i>d</i>

a High Source: 20% or more of Daily Value (DV) for given nutrient per serving.

b Good Source: 10-19% of Daily Value (DV) for given nutrient per serving.

c Daily Values (DV) for each nutrient based on RDA/AI.

d Based on DV for fiber of 35gm.

A number of SUAs and service providers have developed lists of foods considered good sources of specific nutrients but do not necessarily follow the federal food labeling definitions of good and high sources above. Such lists are commonly available for food sources of calcium, vitamins A and C, and fiber. [An example from Colorado SUA is available.](#) A number of websites provide lists of foods that are good sources of selected nutrients. Resources include [Room 42 Health Tools](#), [Nutrition Tools](#), [Fitness Tools Resource Center](#) and [Healthcheck Systems](#).

Nutrition Labeling/Daily Values

Federal law requires that nutrition label information enable the public to readily comprehend the information and to understand its relative significance in the context of a total daily diet. [Daily Values](#) is the dietary reference labeling standard developed by the Food and Drug Administration (FDA) to help consumers plan a healthy overall diet. For various nutrients, it allows consumers to determine the percentage of the Daily Value provided by a serving of a food. It also provides a basis for defining descriptor terms, such as "high fiber" and "low fat" (22).

Daily Values include 2 sets of reference values for nutrients: Daily Reference Values (DRVs) and Reference Daily Intakes (RDIs). DRVs are for nutrients for which no set of standards previously existed, such as fat, saturated fat, cholesterol, carbohydrate, protein, fiber, sodium, and potassium. DRVs for the energy-producing nutrients (fat, carbohydrate, protein, and fiber) are based on the number of calories consumed per day. For labeling purposes, 2,000 calories was established as the reference for calculating percent Daily Values in 1990.

Because of the links between certain nutrients and certain diseases, DRVs for some nutrients represent the uppermost limit that is considered desirable. Eating too much fat or cholesterol, for example, has been linked to an increased risk of heart disease. Too much sodium can heighten the risk of high blood pressure in some people.

DRV Label Values for Fats and Sodium

- ✦ total fat: less than 65 g
- ✦ saturated fat: less than 20 g
- ✦ cholesterol: less than 300 mg (milligrams)
- ✦ sodium: less than 2,400 mg

RDIs replaced the term "US RDAs" (Recommended Daily Allowances). The US RDAs are a set of values, based on the 1968 RDAs, that are used as the food labeling standard by the FDA. These nutrient values are approximately equivalent to the highest number recommended in the 1968 RDAs for each of the included nutrients. US RDAs should not be confused with RDAs. The latter are short for Recommended **Dietary** Allowances, which are set by the National Academy of Sciences, and revised periodically. Food label definitions and nutrient values used generally lag behind the latest scientific knowledge. Plans are underway to revise the Nutrition Facts portion of the food label to comply with the newer DRI values.

SPECIAL DIETARY NEEDS

Today, menu planning is more challenging due to changes in the nutrient requirements as well as the need to accommodate the growing diversity of older adults. Increasing the number and variety of meal choices can help meet both the personal preferences of program participants and nutritional or special health needs. Meals should be adjusted to meet special dietary needs of program participants to the maximum extent possible (OAA, Section 339). The definition of "maximum extent practical" takes into consideration factors such as characteristics of the older adults served in the community, number of people with a specific need, capacity and capability of the provider, availability of different caterers/vendors, requirements of different funding sources, provider expertise, etc.

The term "special dietary needs" has been variously interpreted to mean: providing meals to meet cultural or ethnic preferences, i.e., culturally appropriate; tailoring menus to conform to religious requirements (e.g., Kosher, Hallal); and the provision of therapeutic or meals that are modified for health conditions (e.g., 2 gm sodium, diabetic, renal, texture-modified). Other interpretations include meals that provide client "choice" or selection of different meal components (e.g., 2 different entrees or 3 different vegetables, choice of milk).

To better serve defined populations and individuals who require menu customization or therapeutic diets, the Issue Panel recommended that OANPs utilize Registered Dietitians in conducting needs assessments of the program population and in developing appropriate interventions (16). The American Dietetic Association addressed the use of dietetics professionals in the assessment, planning and provision of liberalized diets for older individuals. When appropriate, such diets can enhance both quality of life and nutritional status, thus increasing the participants satisfaction with the meals provided and reducing noncompliance to their special dietary needs as well as any risks of malnutrition and weight loss (23).

Sample SUA Modified and Therapeutic Diet Standards/Guidelines

Wisconsin

Using the knowledge and expertise of a consultant dietitian or qualified nutritionist, programs should determine the need, feasibility, and cost effectiveness in establishing a service for special menus using the following criteria:

- *there are sufficient number of persons who need the special menus to make this service a practical and cost effective use of funds;*

- *the food and skills necessary to prepare the special menus are available in the planning and service area; and*
- *the type of special diet considered for service can be produced and delivered safely and cost effectively.*

Modified meals meet the regular menu pattern, but contain modifications to one or more menu items. The types and amounts of all items must conform to the regular menu pattern. A health professional's authorization is not needed for a participant to receive a modified meal. However, a nutrition program may wish to prioritize the requests for modified meals. The following are examples of modified meals that a nutrition program may provide:

- *meal with a lower sodium entrée if the regular entrée is of significantly higher sodium content than usually served;*
- *meal with fresh fruit, or juice-packed canned fruit in place of a concentrated sweet dessert;*
- *a modified meal may have an altered texture to accommodate the needs of an individual with problems chewing or swallowing. Examples of such meals include ground meat, thickened liquids or all pureed foods. "Clear liquid" meals are not allowed.*
- *A therapeutic meal changes the meal pattern significantly by either limiting or eliminating one or more menu items, or by limiting the types of foods allowed and resulting in a meal that does not meet the nutrition guidelines of the Program.*
- *Nutrition programs may obtain complex therapeutic meals from a local hospital or other facility under the supervision of a registered dietitian.*

New York

General modifications to the regular menu should be provided (e.g., substitutions for high sodium foods, substitutions for high concentrated carbohydrates, and texture modifications) for those individuals who do not require a more defined therapeutic diet.

Therapeutic diets, such as two grams sodium, 40 grams protein, 1200 Calories, and/or 40 grams fat, may be provided, if feasible, under the supervision of a registered dietitian. A written physician's order may be required to provide such diets. Overly restrictive diet prescriptions with less than these amounts or with multiple restrictions should be discouraged.

Nutrition Supplements

The use of medical foods, foods for special dietary uses, dietary supplements and functional foods is increasing. See definitions of "Supplements" at the end of this chapter. These products can play a positive role in people's health and may help improve the poor nutritional status of needy older adults. Many older adults are at nutrition risk because of low calorie intakes, poor food choices, economic reasons, chronic diseases (e.g., osteoporosis), and/or special needs (e.g., dysphasia). Also, many congregate and home delivered meal participants are unable to consume a complete meal when served or delivered. Therefore, greater flexibility in what constitutes a meal and other ways to provide meals that, to the maximum extent practical, are adjusted to meet special dietary needs of program participants may be allowed when prescribed by a registered dietitian (RD) or physician in conjunction with an individualized nutrition care plan.

Dietary supplements encompass a wide range of products, including vitamins, minerals, amino acids, herbs, and other botanicals. Although some older adults may need dietary supplements for health enhancement and/or to assist in meeting daily nutrient needs, the OAA cannot be used to pay for them. Funds from the OAA can be used for food as a part of a conventional meal.

The use of medical foods, foods for special dietary uses, and/or functional foods may allow OANPs to appropriately address individual nutrition needs in a comprehensive individualized nutrition care plan under the direction of an RD or MD. By using functional foods, the OANP may be able to more directly address public nutrition issues commonly seen in later years, such as osteoporosis. Functional foods should not be used as a replacement for important conventional foods, for example, replacing dairy products with calcium-fortified orange juice. Because of interrelationships among DRIs, *Dietary Guidelines for Americans*, and the *Food Guide Pyramid*, meals should include appropriate numbers of servings from each food group. To appropriately address the use of medical foods, foods for special dietary uses, and/or functional foods, SUAs and/or AAAs need to establish policies and procedures for their use. Such policies may reflect different program and funding requirements such as the Medicaid Waiver program.

Sample SUA Use of Nutrition Supplements Standards/Guidelines

New York

Nutrition supplements (e.g., canned formulas, powdered mixes, food bars) may be made available to participants based on documented, assessed need as determined

by a registered dietitian. Such products cannot replace conventional meals unless a physical disability warrants their sole use.

Wisconsin

Follow-up by health professionals is essential to follow progress, monitor nutrient intake, and to measure the success of the therapy. Health professionals who may make a written referral to the nutrition program for supplement meals include physicians, registered or certified dietitians, nurses, and public health nurses. A nutrition program participant's diet order may require a nutrition supplement to:

- *replace a meal for an individual with profound dietary needs. The professional making the referral, or program dietitian must determine how much supplement would constitute 1 meal;*
- *in addition to a complete meal, or to replace 1 item in the meal pattern. (This is counted as 1 meal.); and*
- *provide a supplement-only meal in addition to a regular meal (To be counted as 2 meals, together they must provide 66% of the RDA).*

Products not to be funded under the OAA include those used for weight loss and have reduced calories and/or fat; single or multiple vitamin or mineral supplements in tablets, capsules, liquids or any form, whether prescribed or over-the-counter; herbal remedies, teas, medicinal oils, laxatives, fiber supplement, etc; and products that require preparation such as powdered mixes or concentrated liquids.

The following products are not allowed for use in the OANP:

- *Liquid supplement products which are used for weight loss, have reduced calories and/or fat. Examples include "SlimFast", "Ensure light", "Boost", and "Carnation Instant Breakfast".*
 - *Single or multiple vitamin or mineral supplements in tablets, capsules, liquids or any form, whether prescription or over-the-counter. Examples include "One-A-Day", "Geritol", vitamin B-6 and iron supplement.*
 - *Herbal remedies, teas medicinal oils, laxatives, fiber supplements, etc...*
- Supplemental nutrition products that require preparation such as powdered mixes or concentrated liquids.*

Texture Modified Meals

Modifying food texture and consistency may help older adults with chewing and swallowing problems. Chopping, grinding, pureeing or blending foods are common ways to modify food textures. Texture modified food has the same nutritive value of solid foods and it can be just as tasty and appealing. Serving sizes should account for any dilution to the food item during the preparation process. Texture modified foods can be purchased in a variety of forms, may be prepared by the production kitchen, or may possibly be modified in an older adult's home. Thickened liquids are often required for individuals with dysphasia. The provision of such foods should be planned and prepared under the advice of a Registered Dietitian or other appropriate professional, such as an Occupational Therapist or Speech Pathologist.

Ethnic and Religious Meals

Meeting the food preferences of program participants can be challenging. Nonetheless, making adaptations to menus is essential. Today's menus often contains common ethnic foods like spaghetti and lasagna, chow mein and stir-fry beef and broccoli, corned beef and cabbage, and fried chicken and sweet potatoes. However, there may be many entrees and side dishes representative of other cultures that are often overlooked. The good feeling that participants have when served favorite ethnic foods partly comes from the recognition that their cultural preferences are important and respected. Providing culturally appropriate, nutritious, high quality, and tasty meals can be effective as outreach to bring in the target population, improve customer satisfaction, promote health and reduce health disparities.

An Ask the Experts: [*Providing Food Services to Meet the Needs of Your Culturally Diverse Participants*](#) offers guidance and suggestions such as:

- Include community input when developing programs and planning menus.
- Target outreach to specific ethnic, cultural, or religious communities. Many programs have an advisory or community council with participants of various ethnicities to assist with menu planning.
- Employ staff and volunteers who reflect the diversity of the community served. Use bilingual staff, volunteers and/or interpreters to solicit menu and program ideas.
- Provide authentic ethnic cuisine. Although programs may do their best to provide ethnic meals, providing authentic ethnic cuisine may be difficult for cooks without such native experience. Having a cook "experienced" with traditional ethnic cooking be a

"guest" cook or use an ethnic restaurant in the community as a caterer. This is particularly important during special occasions and holidays to carry on cultural traditions.

- Use an ethnic caterer or restaurant to serve specific ethnic and/or religious communities. The restaurants follow a meal pattern provided by the nutrition provider and the caterer develops the actual menu based on the known preferences of the group.
- Offer a variety of meals and/or foods from different ethnic groups. Introduce new foods to coincide with ethnic and religious holidays and nutrition education activities. Offer cultural food items as side dishes, desserts, or snacks, if not the entrée on a regular basis.

MENU REVIEW AND APPROVAL

Reviewing menus at State, AAA, or local levels involves verifying that they conform to nutrition standards and menu policies. Computer analysis ensures that menus conform to the *Dietary Guidelines* and provide at least minimal levels of RDAs for older adults. Reviews may also include recommending changes when menus contain errors, discouraging the use of extra items to avoid added food costs, and commenting on the variety of foods, color appeal, texture, consistency, and use of seasonal foods. States may or may not require submission of menus for review at that level, but no matter what level, a registered and/or licensed dietitian (or individual of comparable expertise) is usually required to complete the review and approval of menus or certify the menus (17).

Sample SUA Menu Approval Standards/Guidelines

New York

The AAA shall ensure that menus are certified by a Registered Dietitian that each meal offers at least 33 1/3% of the RDAs, for two meals per day, the sum of the two meals is at least 66 2/3% of the RDAs (but each meal itself does not have to be 33 1/3%) and for three meals per day the sum of these three meals is 100% of the RDA; a nutrient analysis is available for all meals provided to participants; any deviation from the planned menu is noted and approved by a Registered Dietitian, project director or other designated person(s).

Massachusetts

Programs that prepare their own meals (and not using a set of rotating menus) must submit the nutrition analysis for three days meals once per fiscal year quarter to the SUA. Programs that use a set of rotating menus (such as frozen meals under state contract, catered Kosher or ethnic meals), must submit the nutrition analysis for all menus once per year to the SUA. (edited)

A complete nutritional analysis of the menu shall contain a minimum of: macronutrients:

- macronutrients: calories, protein, fat (including the % of total calories from fat).*
- vitamins: A, B-6, B-12, C, and D, thiamin, riboflavin, niacin, and folate.*
- minerals: calcium, iron, zinc, and magnesium.*

The nutritional analysis form or equivalent computer analysis sheet should be used for the submission of the nutritional analysis. Nutrition projects are encouraged to utilize the nutritional information of the actual food products. However, if sources of food products vary, an average nutritional analysis may be used (i.e., USDA Handbook No. 8).

If a 2nd (and 3rd) meal is provided to any clients for consumption on the same day as the meals mentioned above, nutrient analysis shall be performed on the same Nutritional Analysis Form. For example, if an evening, multiple meal or breakfast menu is provided to clients in addition to a noon, regular meal, the 2nd (and 3rd) meal(s) should be submitted along with the "main" meals even if these meals are considered limited selection.

The specific meals that are analyzed may be chosen by the Nutrition Project. Different meals should be selected each quarter (i.e., analyzed meals may not be identical to those chosen previously). The SUA may request that a nutritional analysis be performed on any meal which appears not to meet State requirements or for "spot-checking" purposes.

Nutritional analysis and/or full product descriptions for individual items used within Title III meals must be provided or made available by caterers. For consortium or joint menus, only one menu/nutritional analysis is required per menu cycle. It is the decision of the Nutrition Projects which agency(s) shall submit this information to Elder Affairs. If more than one Nutrition Project provides the same frozen/limited selection meal, only one nutritional analysis needs to be submitted. It is the decision of the Nutrition Projects which agency(s) shall submit this information to the SUA.

Menu Substitutions

Menu substitutions should be comparable in nutrient content to the original menu item. SUAs often provide guidance as to the type of substitutions allowed, number of

substitutions allowed during a given period of time, and the process to approve such menu changes by nutrition projects and caterers. Some states require that the nutrition program and/or a dietitian approve substitutions before they are served. Other states may also require that menu changes not only be documented and on file with the program but be submitted to the SUA within a certain time after the meal was served. Alabama requires that all menu deliveries to a dining center include an official notice of a menu change. Otherwise, the item must not be served for food safety reasons.

Some States or AAAs have written lists of acceptable food substitutions for each food group on a meal pattern. These lists are similar to those in this Chapter: "Suggested Food Group Components and Serving Size," "Some High and Good Sources of Selected Nutrients," and those developed by SUAs and service providers. For example, substitute a high vitamin C source for a fruit; use a high vitamin A source for a vegetable substitute; and replace a meat with cottage cheese or peanut butter. Using a substitution list limits the need for staff to contact the dietitian each and every time there is a need to make a menu change.

MEAL SERVICE OPTIONS

Multiple Meals

It is common to provide a combination of 2 or 3 meals including breakfast, lunch and/or dinner, to participants receiving home-delivered meals. Multiple meal packages are typically delivered with the noon meal. Breakfast, a popular meal with older adults, contributes to their health and well being by increasing intakes of critical nutrient-dense foods associated with positive health outcomes: cereals and grains, complex carbohydrates, fruits, fiber, milk, and dairy products (24). Congregate nutrition programs may also serve breakfast and/or dinner in addition to or instead of lunch.

Weekend Meals

A number of nutrition programs offer weekend meals to higher risk congregate participants or to frail, homebound participants receiving meals on weekdays. Table IV.9 of the Mathematica Report indicates that 11% of congregate nutrition programs offer weekend meals and 35% of home-delivered nutrition programs offer weekend meals.

Frozen Meals

Frozen meals are often provided in areas where daily delivery is limited, for weekend meal services, or to enable home delivered meal programs to offer more menu choices. Frozen meals may also be used at congregate sites in rural areas where participation is low and other food service options are not feasible. Such meals are heated and served at the site.

Menu Choice

Menu choice using a selective menu can increase participant satisfaction by offering choices for 1 or more food items. For example, nutrition programs may offer 1 entrée but several vegetable or dessert choices. There may be ethnic and religious-based alternatives to choose from or a choice of hot, cold, or ready-to-heat entrees. Home-delivered meal participants may be offered choices of hot meals or frozen meals delivered in advance. Menu choices may also be provided by offering participants a choice of 2 distinct and complete menus. The menus may vary in their ethnic offering (i.e., choice of an American or Asian menu), be based on religious custom (e.g., Kosher or Hallal), or vegetarian observance.

Shelf-stable/Emergency Meals

Emergency meals generally consist of shelf-stable items. Meal packages are provided to participants determined to need at times when the program is unable to deliver meals due to weather or other problems.

Definitions of "Supplements"

Medical food, as defined in Public Law 100-290, The Orphan Drug Amendment of 1988, is food which is formulated to be consumed or administered enterally under supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

Medical foods are known by a variety of names, such as nutrition supplements, "liquid meals," and oral supplements. However, the most appropriate statutory term is medical food. It is interesting to note that the very same product, depending on where it is used (and how it is labeled), may at times qualify as a medical food (e.g., in an institutional setting) and at other times, if purchased at retail, does not qualify as a medical food. "Non-medical" foods sold at retail always have the mandatory "Nutrition Facts" label.

Food for special dietary uses, according to Section 201 of the Federal Food, Drug, and Cosmetic Act, as the term is applied to food for humans, means particular (as distinguished from general) uses of food, as follows: (i) uses for supplying particular dietary needs which exist by reason of a physical, physiological, pathological or other condition, including but not limited to the conditions of diseases, convalescence, ... underweight and overweight; (ii) uses for supplying particular dietary needs which exist by reason of age, ...; (iii) uses for supplementing or fortifying the ordinary or usual diet with any vitamin, mineral or other dietary property.

Food for special dietary uses are often useful when there are chewing and swallowing problems and to speed recovery when there is illness-related cachexia and/or to halt unintended weight loss.

A **dietary supplement** is defined in Section 201 of the Federal Food, Drug, and Cosmetic Act as a product (other than tobacco) intended to supplement the diet that bears or contains one or more of the following ingredients: (A) a vitamin; (B) a mineral; (C) an herb or other botanical; (D) an amino acid; (E) a dietary substance for use by man to supplement the diet by increasing the total dietary intake; or (F) a concentrate, metabolic, constituent, extract, or combination of any ingredient described in clause (A), (B), (C), (D), or (E).

In the *2000 Dietary Guidelines for Americans*, older adults are mentioned specifically as a group who may benefit from dietary supplements to meet specific nutrient needs. Older adults and people with little exposure to sunlight may need a vitamin D supplement. People who seldom eat dairy products or other rich sources of calcium need a calcium supplement, and people who eat no animal foods need to take a vitamin B12 supplement. The Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences recommends that adults over age 50 get their vitamin B12 from a supplement or from fortified foods.

Functional foods have no universally accepted definition. However, 2 definitions provide insight into this category. The American Dietetic Association broadly defines functional foods to include whole foods and fortified, enriched, or enhanced foods that have a potentially beneficial effect on health when consumed as part of a varied diet on a regular basis (25). The Institute of Medicine defines functional foods as those foods in which the concentrations of one or more ingredients have been manipulated or modified to enhance their contribution to a healthful diet (26).

Additional Resources

Menu Planning Resources listed by the Center

Use of Medical Food and Food for Special Dietary Uses In Elderly Nutrition Programs: Background. Prepared for the AoA by the Center, May 1996.

PowerPoint Presentations from the AoA Nutritionists / Administrators Conference (June 2002):

- Dietary Reference Intakes & Dietary Guidelines in Older Americans Act Nutrition Programs (Nancy Wellman and Jean Lloyd)
- Dietary Reference Intakes and Dietary Guidelines: Nutrition Standards for Today's Older Americans (Nancy Wellman and Jean Lloyd)
- Computer-assisted Menu Analysis for the Elderly Nutrition Program (Kathy Stroh)

American Dietetic Association: Related Position Statements

Brewer MS, Kendall P. Biotechnology and the future of food -- Position of ADA. *J Am Diet Assoc.* 1995;95:1429-1432. (reaffirmed and update to be published, 2000).

Dorner B, Niedert KC, Welch PK. Liberalized diets for older adults in long-term care -- Position of ADA. *J Am Diet Assoc.* 2002;102:1316-1323.

Duffy VB, Anderson GH. Use of nutritive and nonnutritive sweeteners -- Position of ADA. *J Am Diet Assoc.* 1998;98:580-587.

Hunt J, Dwyer J. Food fortification and dietary supplements. *J Am Diet Assoc.* 2001;101:115.

Marlett JA, McBurney MI, Slavin JL. Health implications of dietary fiber -- Position of ADA. *J Am Diet Assoc.* 2002;102:993-1000.

Mattes RD. Fat replacers -- ADA position. *J Am Diet Assoc.* 1998;98:463-468.

Messina VK, Kenneth I, Burke KI. Vegetarian Diets -- Position of ADA. *J Am Diet Assoc.* 1997;97:1317-1321.

Thomson C, Bloch AS, Hasler CN. American Dietetic Association Position Paper: Functional foods. *J Am Diet Assoc.* 1999;99:1278-1285.

Weddle DO, Fanelli-Kuczmarski M. Position of the American Dietetic Association: Nutrition, aging, and the continuum of care. *J Am Diet Assoc.* 2000;100;580-595

References

1. National Academy of Sciences, Institute of Medicine (1999). The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population. Executive Summary, Washington, DC.
2. Weddle DO, Fanelli-Kuczmarski M. Position of the American Dietetic Association: Nutrition, aging, and the continuum of care. *J Am Diet Assoc.* 2000;100;580-595.
3. Webber CB, Splett PL. Nutrition risk factors in a home health population. *Home Health Care Services Quarterly.* 1995;15;97-110.
4. Ryan C. Role of the dietitian in home care of the elderly. *Home Healthcare Consultant.* 1998;5;8-15.
5. Rowe JW, Kahn RL. Successful Aging. New York, NY: Pantheon; 1998.
6. Vailas LI, Nitzke SA, Becker M, Gast J. Risk indicators for malnutrition are associated inversely with quality of life for participants in meal programs for older adults. *J Am Diet Assoc.* 1998 May;98(5):548-53.
7. Smith R, Mullins L, Mushel M, Roorda J, Colquitt R. An examination of demographic, socio-cultural, and health differences between congregate and home diners in a senior nutrition program. *J Nutr Elder.* 1994;14(1):1-21
8. Mathematica Policy Research, Inc. *Serving Elders at Risk, the Older Americans Act Nutrition Programs: National Evaluation of the Elderly Nutrition Program 1993-1995, Volume I: Title III Evaluation Findings.* Washington, DC: US Department of Health and Human Services; 1996.
9. *Dietary Guidelines for Americans, 2000.* USDA. USDHHS. 5 Ed, 2000. Home and Garden Bulletin No. 232.
10. Institute of Medicine, Food and Nutrition Board. *Dietary Reference Intakes for Calcium, Phosphorus, Magnesium, Vitamin D, and Fluoride.* Washington, DC: National Academy Press; 1997.
11. Institute of Medicine, Food and Nutrition Board. *Dietary Reference Intakes for Thiamin, Riboflavin, Niacin, Vitamin B6, Folate, Vitamin B12, Pantothenic Acid, Biotin, and Choline.* Washington, DC: National Academy Press; 1998.

12. [Institute of Medicine, Food and Nutrition Board. *Dietary Reference Intakes for Vitamin C, Vitamin E, Selenium, and Carotenoids*. Washington, DC: National Academy Press; 2000.](#)
13. [Institute of Medicine, Food and Nutrition Board. *Dietary Reference Intakes: Applications in Dietary Assessment*. Washington, DC: National Academy Press; 2000.](#)
14. [Institute of Medicine, Food and Nutrition Board. *Dietary Reference Intakes for Vitamin A, Vitamin K, Arsenic, Boron, Chromium, Copper, Iodine, Iron, Manganese, Molybdenum, Nickel, Silicon, Vanadium, and Zinc*. Washington, DC: National Academy Press; 2001.](#)
15. [Institute of Medicine, Food and Nutrition Board. *Dietary Reference Intakes for Energy, Carbohydrates, Fiber, Fat, Protein and Amino Acids \(Macronutrients\)*. Washington, DC: National Academy Press; 2002.](#)
16. [Dietary Reference Intakes and Dietary Guidelines in Older Americans Act Nutrition Programs: An Issue Panel Report. \(2002\) Florida International University, Miami, FL.](#)
17. Rhodes SS, ed. *Effective Menu Planning for the Elderly Nutrition Program*. Chicago, IL: American Dietetic Assoc.; 1991.
18. US Department of Agriculture, Human Nutrition Information Services. *USDA Food Guide: Background and Development*. Table 5. Nutrient profiles for food groups and subgroup composites. Misc. Pub. No. 1514; Hyattsville, MD: US Government Printing Office; 1993.
19. [US Department of Agriculture, Food Survey Research Group. \(1998\) Continuing Survey of Food Intakes by Individuals 1994-1996.](#)
20. National Center for Health Statistics. (Series 11, #1, SETS Version 1.22a) [CD-ROM]. Washington, DC: US Government Printing Office; 1997.
21. [US Department of Agriculture *National Nutrient Database for Standard Reference, Release 15 Nutrient List*.](#)
22. [US Food and Drug Administration. Kurtzweil P. Daily Values' Encourage Healthy Diet.](#)
23. [Dorner B, Niedert KC, Welch PK. Liberalized diets for older adults in long-term care -- Position of ADA. *J Am Diet Assoc*. 2002;102:1316-1323.](#)

24. [Weddle DO, Gollub E, Stacey SS, Wellman NS. Final Report: The Morning Meals on Wheels Program Pilot Program: The Benefits to Elderly Nutrition Program Participants and Nutrition Projects. Florida International University, Miami, FL. 1998.](#)
25. [Thomson C, Bloch AS, Hasler CN. American Dietetic Association Position Paper: Functional foods. *J Am Diet Assoc.* 1999;99:1278-1285.](#)
26. [Committee on Opportunities in the Nutrition and Food Sciences, Food and Nutrition Board, Institute of Medicine. Thomas PR, Earl R, eds. *Opportunities in the Nutrition and Food Sciences: Research Challenges for the Next Generation of Investigators.* Washington, DC: National Academy Press; 1994.](#)

Chapter 5

Food Safety and Sanitation

Contents

Background

- National Food Safety Issues
- Older Americans Act 2000 Requirements

Management and Personnel

- Model Food Code
- SUA Standards/ Guidelines: Food Handling
- Food Safety Training and Education
- SUA Standards/ Guidelines: Food Safety Training

Food

- Food Safety
- HACCP
- SUA Standards/ Guidelines: Food Safety
- Food Recalls
- SUA Standards/ Guidelines: Food Recall
- Foodborne Illness Outbreaks

BACKGROUND

National Food Safety Issues

Food safety and sanitation is an important public health concern. In the United States, it is estimated that 76 million illnesses, 325,000 hospitalizations, and 5,000 deaths are attributed to foodborne illness each year. The annual cost of foodborne illness is estimated to be from \$10 to \$83 billion (1). For some individuals, foodborne illness may result in a mild, temporary discomfort. Because older adults are a highly susceptible population, foodborne illness may have serious or long-term consequences, and may be life threatening. Older adults are vulnerable to foodborne illness for several reasons. Some of these include (2):

1. **Weakened immune systems:** As part of the aging process, the ability of the immune system to function at normal levels decreases. A decrease in the level of disease-fighting cells is a significant factor in making the average older adult highly susceptible to harmful microorganisms in food.
2. **Inflammation of the stomach lining and a decrease in stomach acid:** The stomach plays an important role in limiting the number of bacteria that enter the small intestine. During the natural aging process, an older person's stomach tends to produce less acid. The decrease or loss of stomach acidity increases the likelihood of infection if a pathogen is ingested with food or water.
3. **Decline in sense of smell and taste:** Many contaminated foods do not smell or taste bad. However, for foods like spoiled milk, a person who does not no-

Food <ul style="list-style-type: none"> SUA Standards/ Guidelines: Foodborne Illness
Equipment/Water/ Physical Facilities
Compliance and Quality Improvement <ul style="list-style-type: none"> SUA Standards/ Guidelines: Food Safety Monitoring
<ul style="list-style-type: none"> Additional Resources References

tice "off" odors and flavors is more likely to eat the food and more likely to become ill.

4. **Living on their own:** For an older person, preparing meals may pose special challenges. A widower who has not cooked for himself may not know how to prepare food safely. A person receiving home-delivered meals may not be familiar with safe handling and storage practices for meals and leftovers.

The causes of foodborne illness are multifaceted. Some major risk factors of foodborne illness are related to employee behaviors and preparation practices in food service establishments. The principle known risk factors include:

- Improper holding temperatures,
- Inadequate cooking, such as undercooking raw shell eggs,
- Contaminated equipment,
- Food from unsafe sources,
- Poor personal hygiene, and
- Others (such as, pest and rodent infestation and improper food storage).

There are a number of foodborne disease organisms, toxins, and chemicals that affect the public health. It is important for SUAs to provide the OANP with general information about new emerging concerns that relate to foodborne diseases. For example, Noroviruses are the most common cause of gastroenteritis in the US. They cause an estimated 23 million cases of acute gastroenteritis (AGE) annually (3). The [Norwalk](#) virus has received recent attention as a number of outbreaks of AGE were reported on cruise ships sailing into US ports between June and December 2002 (3). Since October 2002, several states have noted an increase in outbreaks of AGE consistent clinically and epidemiologically, with norovirus infection, particularly in institutional settings such as nursing homes (CDC, unpublished data, 2002). Although attention has been drawn recently to outbreaks of norovirus on cruise ships, an estimated 60%-80% of all AGE outbreaks occur on land, particularly in institutional settings, through nonfoodborne modes of transmission (4-6). CDC's Emerging Infections Program Foodborne Diseases Active Surveillance Network (FoodNet) collects data on

about 10 foodborne diseases in nine US sites to quantify and monitor foodborne illnesses (7). Some other common foodborne infections are those caused by the bacteria [Campylobacter](#), [Salmonella](#), [Listeria](#) and [E. coli O157:H7](#). It is important for SUAs to inform OANPs about the emergence of these foodborne diseases and provide the necessary resources to assist OANPs in minimizing the risk of foodborne illness outbreaks.

The following resources provide additional information on foodborne diseases:Bad Bug Book: <http://www.cfsan.fda.gov/~mow/intro.html>
CDC Division of Bacterial and Mycotic Diseases: <http://www.cdc.gov/ncidod/dbmd/diseaseinfo/default.htm>

The 2001 Model *Food Code* (8) released by the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) of the US Department of Health and Human Services (DHHS) and the Food Safety and Inspection Service of the US Department of Agriculture (USDA), provides practical and science-based guidance for foodservice establishments. The *Food Code* (<http://www.cfsan.fda.gov/~dms/fc01-toc.html>) addresses controls for risk factors. It established 5 key public health interventions to protect consumer health:

- Demonstration of knowledge,
- Employee health controls,
- Controlling hands as a vehicle of contamination,
- Time and temperature parameters for controlling pathogens, and
- Consumer advisory.

The 2001 *Food Code* is a model code, which FDA regularly updates. It provides a scientifically sound, legal basis for regulating the retail food market at the state and local level. The 2001 *Food Code* is neither federal law nor federal regulation and does not preempt state and local food law. It and its predecessor have been written so that it is easy to adopt at state and local levels. Through the years, state and local jurisdictions have adopted some of the model food code. A list of jurisdictions that have adopted the 2001 *Food Code* is available at <http://www.cfsan.fda.gov> under Federal/State Food Programs-Retail Food Safety References.

Food safety is a priority action area of *Healthy People 2010*. Priority action areas include: reducing infections caused by foodborne pathogens, reducing outbreaks of

foodborne illness, and improving food employee behaviors and food preparation practices that directly relate to foodborne illnesses in retail food establishments (9).? The FDA, USDA, US Environmental Protection Agency, and CDC maintain a collaborative website on national food safety programs at: <http://vm.cfsan.fda.gov/~dms/fs-toc.html>. It contains a variety of government-generated information on food safety for the food industry and food consumers. The website www.FoodSafety.gov is the gateway to government food safety information. Medline Plus also provides access to current food safety information: <http://www.nlm.nih.gov/medlineplus/foodsafety.html>

The OAA emphasizes the importance of food safety and sanitation in nutrition projects. It requires them to comply with state or local laws regarding the safe and sanitary handling of food, equipment, and supplies. SUAs are encouraged to use the 2001 Model *Food Code* and the objectives in *Healthy People 2010* as reference documents to assist in developing policies and procedures that comply with state and local food laws.

It is important that SUAs examine the food safety and sanitation requirements in their current policies and procedures and take the necessary steps to ensure that OANPs comply with their state and local food law.?It is equally important for OANPs to ensure that their caterers and vendors comply with state and local food law.Rather than review 56 different state and territory food laws as well as hundreds of local regulations and ordinances, this chapter reviews the provisions in the 2001 *Food Code* upon which many state and local jurisdictions base their food statutes, regulations, and ordinances.?The chapter addresses the following:

- B. Management and Personnel,
- C. Food,
- D. Equipment/Facilities/Supplies, and
- E. Compliance and Enforcement.

Older Americans Act 2000 Requirements

SECTION 339 Nutrition

(2) ensure that the project ---

(3) (C) encourages providers to enter into contracts that limit the amount of time meals must spend in transit before they are consumed.

(F) comply with applicable provisions of State or local laws regarding the safe and sanitary handling of food, equipment, and supplies used in the storage, preparation,

service, and delivery of meals to an older individual.

MANAGEMENT AND PERSONNEL

Management primary responsible is to provide safe food to consumers. All levels in the network, whether at a state, AAA, or local provider level, have a management function of assuring safe food in the OANP. To ensure food safety, management has the responsibility and duty of demonstrating knowledge of foodborne disease prevention and implementing Hazard Analysis Critical Control Point (HACCP) principles and requirements of the Model *Food Code*. Other important responsibilities referenced the Model *Food Code* include:

- Complying with the state and local food codes,
- Minimizing liability issues,
- Dealing with crises, such as food recalls, food illness outbreaks, equipment breakdowns, and other emergencies,
- Ensuring personnel follow appropriate food safety and hygiene practices,
- Being a certified food handler,
- Providing a safe place to work,
- Keeping equipment in good operating order,
- Publishing rules for good safety, and
- Training employees in proper food safety principles

Food safety is achieved in a foodservice establishment when both employees and management properly perform their duties. Below are additional examples of management responsibilities from the 2001 Model *Food Code* and SUA policies and procedures.

2001 Model Food Code

Supervision (Part 2-1):

- It is recommended that the *supervision* of the foodservice establishment shall

be designated to management or an individual in charge who has the re-
sponsibility and duty of ensuring that personnel follow appropriate food safety
and hygiene practices. Management or person(s) in charge shall also dem-
onstrate knowledge of foodborne disease prevention, application of the Haz-
ard Analysis Critical Control Point principles, and the requirements of the
Model *Food Code*.

Employee Health (Part 2-2):

- Management or person in charge shall require *foodservice personnel* (applicants to whom a conditional offer of employment is made and current *foodservice employees*) to report information about their health and activities as they relate to diseases that are transmissible through *food*.

Personal Cleanliness (Part 2-3) and Hygienic Practices (Part 2-4) :

- Good hygienic practices are important to ensuring that food is not contami-
nated with bacteria, foreign objects or chemicals. It is important that all food-
service workers maintain a high standard of personal hygiene and cleanli-
ness. Some hygienic practices that every foodservice worker should follow
include:
 - frequent hand-washing,
 - personal hygiene
 - hair restraints
 - wearing appropriate attire (clean clothes, aprons, closed-toe shoes)
and limited jewelry
 - keeping fingernails trimmed, filed, and maintained
 - abstaining from smoking, chewing gum and other unhygienic practices
in food handling areas, and
 - covering all wounds on hands or arms.

Sample SUA Food Handling Standards/Guidelines

California

- *All food handlers and servers shall be free of communicable disease. If an employee or volunteer is believed ill or a carrier of a communicable disease, she/he shall be restricted from performing food preparation and service activities. Clearance from a physician may be requested by the provider prior to permitting the employee to return to work.*

- *All food handlers and servers shall wear clean, washable clothing, close-toed protective footwear, and hairnets, caps, or other suitable hair coverings to prevent contamination of foods, beverages and/or utensils.*
- *All food handlers and servers are prohibited from using tobacco in any form while preparing, handling, or serving food or beverages. Tobacco shall not be used in any form in any room or space used primarily for the preparation or storage of food. Projects shall post and maintain No Smoking signs in such rooms or places.*
- *All food handlers and servers shall use tongs or other implements while serving food. If hand contact with the food is unavoidable, disposable hand coverings shall be worn.*
- *All food handlers and servers shall thoroughly wash their hands prior to beginning work, after using the toilet and every time hands are soiled.*
- *Hand washing facilities in good repair and equipped with hot and cold running water shall be provided for employees within or adjacent to the food preparation area.*
- *A permanently installed detergent or soap dispenser and single use paper towels or hot air blowers shall be provided at or adjacent to all hand washing facilities.*
- *Legible signs shall be posted in each toilet room directing employees that they shall wash hands with soap before returning to work.*

Food Safety Training and Education

Providing OANP staff and participants with information and educational materials for food safety is important in reducing the risk of food-borne illness. Because there are large numbers of volunteers who work in OANP dining centers and who deliver meals to homes, providing them with food safety training is important. It is recommended that either SUAs or AAAs indicate in their policies and procedures that OANP providers, including caterers, train staff in food safety and that this recommendation be included in any service contract.

The 1995 *National Evaluation of the OANP* found about 36% of SUAs reporting state certification for food service sanitation in their state. The Evaluation also found that sanitation and food safety training was mandatory for different program personnel in a number of states. Such training was most frequently mandatory for food service

aides, site managers, and nutrition project directors. Thirty-three percent of the SUAs reported that training was not mandatory at the project or site levels (10).

Training of OANP staff and volunteers is an important component to ensure food safety. Managers and/or supervisors must assume a primary responsibility for food safety and sanitation training in a food establishment. Some SUAs require training for all program personnel. For example, food service managers and other staff members may be required to complete a course provided by their local Health Department to be certified as a Food Handler. Certification of specific food service personnel is often required by the State Health Department.

Foodservice Certification Courses

Below are some programs that provide certification for food protection managers. For certification requirements, contact the local regulatory agency. A list of State health agencies can be found at: www.fda.gov/oca/sthealth.htm

ServSafe

A comprehensive food safety education and training program developed by the Educational Foundation of the National Restaurant Association that is widely recognized by many federal, state and local jurisdictions. The program combines thorough training in all areas of food safety. The ServSafe certificate verifies that an individual has successfully passed the ServSafe Food Protection Manager Certification Examination. www.edfound.org

Certified Food Protection Professional (CFPP)

The Dietary Managers Association's CFPP credential is geared toward the food-service professional. Options for the food protection course are a 16-hour classroom food safety training course, independent study via print materials, or independent online study. www.dmaonline.org

National Certified Professional Food Manager (NCPFM)

Experior Assessments™ administers the NCPFM exam, which tests knowledge, skills, and abilities related to food protection, and the ability to organize and supervise employees within the work environment. The NCPFM exam is appropriate for site supervisors, managers, or first line supervisors in establishments that prepare and serve food. www.experioronline.com

Certified Food Safety Manager

This certification, offered by the National Registry of Food Safety Professionals, Inc., serves the foodservice industry, regulatory agencies, and academia. The Food Safety Manager Certification Examination is designed to be used with any food safety training program available on the market.? www.nrfsp.com

Food Safety Information and Training Resources for Professionals

A number of food safety and sanitation training resources are available. Below are several websites that provide training information:

Office of Regulatory Affairs Training & Human Resource Development:

http://www.fda.gov/ora/training/course_ora.html

Foodborne Illness Education Information Center: Provides a multiplicity of food safety education information and materials.

<http://www.nal.usda.gov/foodborne/index.html>

Foodborne Illness Education Information Center: Provides links to information on distance learning, on-line courses and curriculums.

<http://www.nal.usda.gov/foodborne/fbindex/032.htm>

Many resources are also available in languages other than English. A few sources are listed below:

Food Safety Foreign Language Materials

<http://www.nal.usda.gov/foodborne/fbindex/037.htm>

Food Safety Training Materials in Foreign Languages

<http://peaches.nal.usda.gov/foodborne/fbidb/forlang.asp>

The National Food Service Management Institute: Food Safety Mini Posters:

<http://www.nfsmi.org/Information/postindx.htm>

Food Safety Information and Material for Consumers/OANP Participants

Food safety education for OANP participants, especially those receiving home delivered meals, helps prevent foodborne illness. Studies show that home-delivered meal participants often save food from their meals to eat later in the

day (11-13). Most home-delivered meal participants do not consume their meal immediately upon delivery (13). Therefore, it is important that OANPs educate participants and their caregivers about proper storage and heating of meals not immediately consumed and/or if portions of the meal are saved to eat later in the day. Dining center participants should also be educated about the risks associated with taking food out from the dining site.

Resources and materials for consumers and older adults include:

- Food Safety Publications: www.fsis.usda.gov/oa/pubs/consumerpubs.htm
- The Foodkeeper: A Consumer Guide to Food Quality and Safe Handling <http://www.fmi.org/consumer/foodkeeper/foodkeeper.pdf>
- Food Safety Education and Consumer Information <http://www.fsis.usda.gov/OA/consedu.htm>
- To Your Health! Food Safety for Seniors <http://www.foodsafety.gov/~fsg/sr2.html>
- Seniors and Food Safety. Preventing Foodborne Illness <http://vm.cfsan.fda.gov/~dms/seniors.html>
- Seniors Need Wisdom on Food Safety <http://www.fsis.usda.gov/OA/pubs/seniors.htm>

Sample SUA Food Safety Training Standards/Guidelines

California

- *Quarterly in-service training shall be provided for all paid and volunteer food service personnel, including home-delivered meal personnel.*
- *At least two of the quarterly in-service training sessions shall include the prevention of foodborne illness and all food service personnel as defined in Subsection 147.5c. shall attend.*
- *Prevention of foodborne illness training shall include the principles of Hazard Analysis Critical Control Point (HACCP).*

Connecticut

- ***Appropriately instruct clients or their caregivers on the following safe practices for handling delivered food, as they may apply:***
 - ***to eat hot food within 1 hour of delivery.***
 - ***to eat cold foods immediately or place them in the refrigerator.***
 - ***to eat fast chilled meals within 3 days of delivery and to store them at 40 degrees or less (edited).***
 - ***to eat frozen meals within 1 month of delivery and to store them at 10 degrees or less.***
 - ***to have an accurate thermometer in their refrigerator if they store fast chilled meals, and one in their freezer if they store frozen meals.***

FOOD

Food Safety

Inadequate food temperature controls are common factors contributing to foodborne illness. Unless food is properly handled when purchased, stored, prepared, and served, contamination may occur. Proper food handling practices help prevent foodborne illness. Written guidelines should reflect the type of foodservice operations in place. There are different requirements to prepare and serve hot meals at dining centers and to the homebound than for meals prepared and delivered from a central kitchen. Likewise, the preparation and/or service of frozen meals require specific procedures. Regardless of the type of congregate or home delivered meal prepared and/or served, a critical element in maintaining food safety is to cook foods to appropriate temperatures and to keep perishable food products out of the temperature danger zone (between 41 and 140 degrees Fahrenheit).

Food and other products such as utensils and dinnerware must be packaged and delivered in a manner that prevents contamination and maintains proper food temperatures. State of the art food carrier and transport systems can safely deliver cold and hot food items and/or meals at proper temperatures within acceptable time frames. Protecting food from contamination is dependent upon the development of suitable standards and procedures and ensuring that these guidelines are followed. The Partnership for Food Safety Education's Fight BAC! formed in 1997, is a public-private coalition dedicated to educating the public about safe food handling to help reduce foodborne illness. Members represent industry, government (including USDA, FDA, CDC) and consumer groups, as well as alliances with corporate America. Below are four steps (verbatim) for keeping food safe developed for the Fight BAC! campaign (<http://www.fightbac.org/foursteps.cfm>). The website has many other resources and links. Also refer to Chapter 3 in the Model *Food Code* for additional guidance.

Step 1. Clean: Wash hands and surfaces often

According to food safety experts, bacteria can spread throughout the kitchen and get on to cutting boards, knives, sponges and counter tops. Here's how to Fight BAC:

- Wash hands in hot soapy water before preparing food and after using the bathroom, changing diapers and handling pets. For best results, consumers should use warm water to moisten their hands and then apply soap and rub their hands together for 20 seconds before rinsing thoroughly. Twenty seconds is the same amount of time it takes to sing two choruses of Happy Birthday. After hands are washed, they should be dried with a paper towel or with an air hand-drying device.
- Wash cutting boards, knives, utensils and counter tops in hot soapy water after preparing each food item and before going on to the next one.
- Use plastic or other non-porous cutting boards. Cutting boards should be run through the dishwasher or washed in hot soapy water after use. Consider using paper towels to clean up kitchen surfaces. Or, if using cloth towels, consumers should wash them often in the hot cycle of the washing machine.

Step 2. Separate: Don't cross-contaminate

Cross-contamination is how bacteria spread from one food product to another. This is especially true for raw meat, poultry and seafood. Experts caution to keep these foods and their juices away from ready-to-eat foods. Here's how consumers can Fight BAC!:

- Separate raw meat, poultry and seafood from other food in the grocery-shopping cart.
- Store raw meat, poultry and seafood on the bottom shelf of the refrigerator so juices don't drip onto other foods.
- If possible, use one cutting board for raw meat products and another for salads and other foods that are ready to be eaten.
- Always wash cutting boards, knives and other utensils with hot soapy water after they come in contact with raw meat, poultry and seafood.

- Never place cooked food on a plate which previously held raw meat, poultry or seafood

Step 3. Cook: Cook to Proper Temperatures

Food safety experts agree that foods are properly cooked when they are heated for a long enough time and at a high enough temperature to kill the harmful bacteria that cause foodborne illness. The best way to Fight BAC is to:

- Use a meat thermometer, which measures the internal temperature of cooked meat and poultry, to make sure that the meat is cooked all the way through.
- Cook roasts and steaks to at least 145°F. Whole poultry should be cooked to 180°F for doneness.
- Cook ground meat, where bacteria can spread during grinding, to at least 160 degrees Fahrenheit. Information from the Centers for Disease Control and Prevention (CDC) links eating undercooked, pink ground beef with a higher risk of illness. If a thermometer is not available, do not eat ground beef that is still pink inside.
- Cook eggs until the yolk and white are firm, not runny. Don't use recipes in which eggs remain raw or only partially cooked.
- Cook fish until it is opaque and flakes easily with a fork.
- Make sure there are no cold spots in food (where bacteria can survive) when cooking in a microwave oven. For best results, cover food, stir and rotate for even cooking. If there is no turntable, rotate the dish by hand once or twice during cooking.
- Bring sauces, soups and gravy to a boil when reheating. Heat other leftovers thoroughly to 165 degrees Fahrenheit.

Step 4. Chill: Refrigerate promptly

Food safety experts advise consumers to refrigerate foods quickly because cold temperatures keep most harmful bacteria from growing and multiplying. So, public health officials recommend setting the refrigerator at 40°F and the freezer unit at 0°F and oc-

asionally checking these temperatures with an appliance thermometer. Then, Americans can Fight BAC by following these steps:

- Refrigerate or freeze perishables, prepared food and leftovers within two hours.
- Never defrost (or marinate) food on the kitchen counter. Use the refrigerator, cold running water or the microwave.
- Divide large amounts of leftovers into small, shallow containers for quick cooling in the refrigerator.
- With poultry and other stuffed meats, remove the stuffing and refrigerate it in a separate container.
- Don't pack the refrigerator. Cool air must circulate to keep food safe.

Other Guidelines include:

From Health Services Agency-County of Santa Cruz Environmental Health Services. Available at: http://www.co.santa-cruz.ca.us/eh/consumer/food/holding_temperatures.pdf

Correct holding temperature

- Keep hot foods hot and cold foods cold.
- Hot foods keep at 140°F or above.
- Cold foods refrigerate at 41°F or below.
- Use a calibrated probe thermometer to check internal food temperatures.

Holding hot foods

- Transfer hot foods directly to an oven, steam table, or other holding unit. Do not heat foods in a steam or holding unit.
- Reheat leftover foods to 165°F prior to placing in a holding unit. If possible, avoid cooking foods more than one day ahead of time.

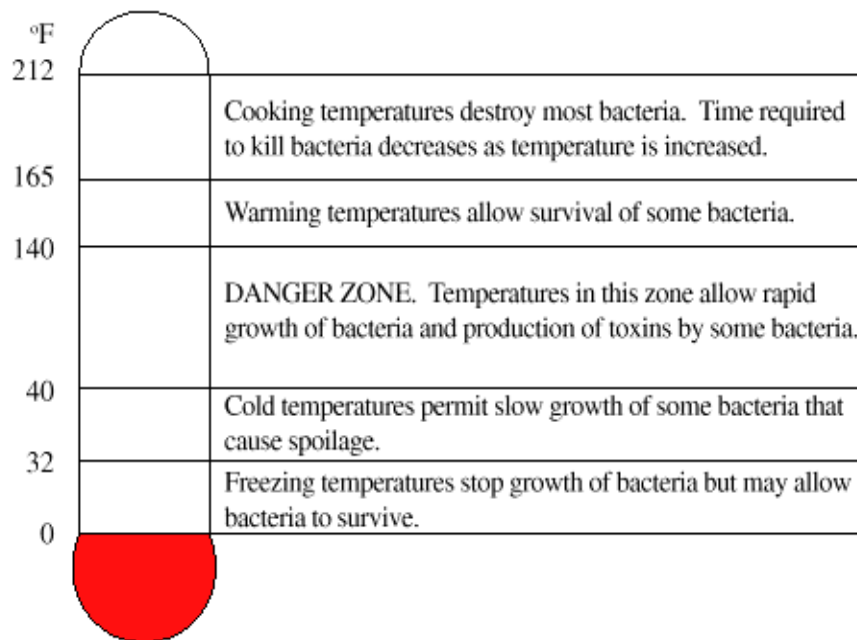
- Stir foods at frequent intervals to evenly distribute heat. Keep a cover on foods to help maintain temperatures. Break the chain of possible food contamination.
- Never combine an old batch of food with a new batch. Check the temperature of the foods on a frequent and regular basis. Use a clean and sanitized thermometer.
- Don't rely solely on the thermostat gauges of the holding equipment. They may not accurately indicate the internal temperature of the food.

Holding cold foods

- Keep foods in cold-holding tables, commercial refrigerated display cases, and refrigerators.
- Keep food in salad bars and display units, set the food containers in ice to keep them below 41°F.
- Keep a cover on foods held in cold holding units to help maintain temperatures.
- Check the temperature of the foods on a frequent and regular basis. Use a clean, sanitized thermometer.

Calibrating a thermometer using the ice method

Immerse the temperature probe at least two inches into a glass of finely crushed ice. Add cold tap water to remove air pockets. Wait at least 30 seconds. The gauge should read 32°F; if not, adjust it accordingly.



Thermy, developed by the USDA, Food Safety and Inspection Service, is an educational site (<http://www.fsis.usda.gov/thermy/>). It focuses on cooking temperatures needed to ensure food safety. It discusses the different types of thermometers and why food color does not indicate that the minimum internal temperature has been reached.

Hazard Analysis Critical Control Point (HACCP)

The HACCP system, developed by the FDA, Center for Food Safety and Applied Nutrition, should be applied throughout any foodservice operation. HACCP is a proactive, comprehensive, science-based food safety system that allows operators to continuously monitor their establishments and reduce the risk of foodborne illness. The successful application of HACCP requires the responsibility, commitment, and involvement of management and every employee and volunteer involved in the handling, delivery, and service of congregate and home-delivered meals. Following HACCP guidelines allows for a thorough monitoring of meals that will help ensure food safety. The HACCP system comprises seven principles:

1. Conduct a hazard analysis. Potential hazards associated with a food and measures to control those hazards are identified. The hazard could be biological, such as a microbe; chemical, such as a toxin; or physical, such as ground glass or metal fragments.

2. Determine Critical Control Points (CCPs). These are points in a food's production--from its raw state through processing and shipping to consumption by the consumer--at which the potential hazard can be controlled or eliminated. Examples are cooking, cooling, packaging, and metal detection.

3. Establish critical limits. For a cooked food, for example, this might include setting the minimum cooking temperature and time required to ensure the elimination of any harmful microbes.

4. Establish monitoring procedures. Such procedures might include determining how and by whom cooking time and temperature should be monitored.

5. Establish corrective actions when monitoring shows that a critical limit has not been met. For example, reprocessing or disposing of food if the minimum cooking temperature is not met.

6. Verification procedures to confirm that the system is works. For example, testing time-and-temperature recording devices to verify that a cooking unit is working properly.

7. Establish record keeping and documentation procedures. This would include records of hazards and their control methods, the monitoring of safety requirements and action taken to correct potential problems. Each of these principles must be backed by sound scientific knowledge: for example, published microbiological studies on time and temperature factors for controlling foodborne pathogens.

To assist foodservice operations in applying HACCP principles a draft document entitled: *Managing Food Safety: A HACCP Principles Guide for Operators of Food Service, Retail Food Stores, and Other Food Establishments at the Retail Level* is available

<http://www.cfsan.fda.gov/~dms/hret-toc.html>

<http://www.nal.usda.gov/fnic/foodborne/haccp/index.shtml>

Sample SUA Food Safety Standards/Guidelines

Arizona

All foods shall be of good quality and shall be obtained from sources which conform to federal, state and local regulatory standards for quality, sanitation, and safety.

The following shall not be used:

- *Foods prepared or canned in the home,*
- *Cans which are bulging, dented, leaking, rusty or which spurt liquid when opened,*
- *Foods with an off odor, and*
- *Foods which show signs of mold.*

The following may be used:

- *Donated bakery products, and*
- *Donated fruits and vegetables*

All other food contributions shall be cleared, prior to serving, with Local County Sanitarian or the Department consulting Registered Dietitian or Nutritionist.

California

- *Food in hermetically sealed containers shall be processed in a licensed establishment. No home-prepared or home-canned food shall be used.*
- *Food from broken containers, unlabeled, rusty, or leaking cans or cans with side seam dents, rim dents, or swells shall not be used.*
- *Adequate and suitable space free from dirt, vermin and contamination or adulteration shall be provided for the storage of food, beverages, and cooking, serving, and eating utensils.*
- *The dry storage area shall be cool, dark, well ventilated, clean, orderly, and free from leakage, insects, rodents, and vermin, or other contamination. It shall have at least 10 foot-candles of light. It is recommended that the temperature of the dry storage area be maintained at 50-70 degrees Fahrenheit.*
- *All foods shall be stored at least 6 inches above the floor, 18 inches from the ceiling and away from the wall to permit free circulation of air and prevent contamination.*
- *All food and non-food items shall be clearly labeled so that their contents are easily identifiable.*
- *All chemicals and cleaning supplies shall be stored in an area separate from food.*

- *Opened packages of foods, such as sugar, flour and noodles shall be stored in tightly closed containers and clearly labeled on the main part of the container.*
- *Refrigerators and freezers shall be kept clean and in good repair.*
- *All refrigerators shall maintain a maximum temperature of 40 degrees Fahrenheit.*
- *All freezers shall maintain a maximum temperature of 0 degrees Fahrenheit.*
- *An accurate and readily visible thermometer shall be installed in all refrigerators and freezers.*

Georgia

- *Food must be attractive, palatable, and appealing to the older persons to assure maximum individual consumption.*
- *All raw food used in the preparation of meals shall be high quality. The following minimum standards must be met:*
 - *Canned fruits and vegetables: USDA Grade A*
 - *Fresh fruits and vegetables: #1 Quality*
 - *Poultry: USDA Grade A or better*
 - *Beef: USDA Choice or better*
 - *Pork: USDA #1 or better*
 - *Eggs and dairy products: USDA Grade A or better*
 - *Salt: Iodized*
 - *Milk: Grade A Pasteurized*
- *Food items used in the preparation/serving of nutrition program meals must meet the expiration date usage requirements. Food items beyond the indicated expiration date on the package are not allowed.*
- *Preparation methods designed to conserve the nutritive value of food should be followed at all times. Specific attention should be given to short cooking periods and minimum use of water in preparation of vegetables.*

Iowa

- *All satellited or catered meals shall be delivered to the site(s) by the project or caterer at an agreed upon time, in good condition and at temperatures of at least 140°F for hot foods and 40°F or below (edited) for cold foods.*
- *Appropriate temperatures shall be maintained throughout the period of meal service. In order to retain maximum nutritional value and food quality, foods should be served as soon as possible after preparation. Holding time between the completion of cooking and beginning of food service shall not exceed two hours.*

Massachusetts

Food storage systems shall ensure a First-In, First-Out use of foods. All foods stored in freezers shall be dated and labeled.

Minnesota

- *The AAA reserves the right to inspect such foods to determine compliance with the specifications and to reject any food not meeting such specifications.*
- *Insulated containers or other appropriate materials that are easily cleaned and sanitized each day must be used to maintain acceptable temperatures during the transport of bulk foods to serving centers, and for home delivered meals on delivery routes.*
- *Insulated containers or other appropriate materials that are easily cleaned and sanitized each day must be used to maintain acceptable temperatures during the transport of bulk foods to serving congregate dining centers, and for home delivered meals on delivery routes.*

North Carolina

All food shall be packaged and transported in a manner to protect against potential contamination including dust, insects, rodents, unclean equipment and utensils, and unnecessary handling.

Tennessee

- *Foods purchased for use in the nutrition program shall be of good quality and shall be obtained from sources, which conform to federal, state and local regulatory standards.*
- *Each food carrier must be tightly closed after each meal is removed.*
- *From the time of packaging of home delivered meals to the receipt by participants, hot food shall be kept at 140°F or above, and cold foods at 40°F or below (edited).*
- *Frozen meals shall be maintained in a frozen state during delivery. When the meal has completely thawed, it shall not be refrozen for later use.*
- *All meals must be individually portioned. Cold and hot foods must be packed in separate insulated food carriers with tight fitting lids and transported immediately.*
- *No food with the exception of fresh fruit and milk shall be taken from the congregate meal site after it has been served.*
- *Nutrition service providers shall have a written policy posted regarding the removal of food from the congregate meal site.*

Utah

- *All food transported to sites which becomes leftover, except unopened pre-packed food, must be properly disposed of at the meal site or the main food preparation site in compliance with local Health Department regulations.*
- *AAAs shall develop policies and procedures to minimize leftover meals to 1.5% or less.*
- *Leftovers (which should be minimal) shall be offered to all participants as second helpings at those congregate settings which do not have on site cooking facilities or methods to preserve leftover food to meet the nutritional standards for later consumption (approved by the local Health Department).*
- *The AAA shall cause to have placed at each nutrition site, in a location that is easily visible to patrons, a disclaimer which shall state: For Your Safety: Food removed from the center must be kept hot or refrigerated promptly. We cannot be responsible for illness or problems caused by improperly handled food. No food shall be taken*

from the site by staff.

Food Product Recalls

All OANPs need to pay attention to food product recalls and be familiar with the appropriate steps for handling food recalls. A food recall is a voluntary action by a food manufacturer or distributor to protect the public from products that may cause health problems and even death. The type of food product determines which federal agency is responsible for regulation (14). The USDA Food Safety and Inspection Service (FSIS) inspects and regulates meat and poultry products, as well as pasteurized egg products (eggs that have been removed from their shells for further processing) produced in federally inspected plants. The FDA regulates all other food products, including fruits, vegetables, dairy, fish, grains, and nuts. FDA is responsible for ensuring that foods are safe, wholesome, and correctly labeled. However, because FSIS is the primary agency for USDA commodity foods, it is the liaison agency in all recalls of USDA commodity foods including those regulated by the FDA.

The FDA has guidelines for companies to follow with respect to their voluntary removal or correction of marketed violated products under the Agency's jurisdiction. These guidelines are published in [Title 21 of the Code of Federal Regulations, Part 7](#). FDA expects companies to take full responsibility for product recalls, including follow-up checks to assure that recalls are successful. FDA's role under the guidelines is to monitor company recalls and assess the adequacy of a firm's action. After a recall is completed, FDA makes sure that the product is destroyed or suitably reconditioned and investigates why the product was defective.

When a food product is recalled, FSIS and FDA are responsible for determining a recall classification based on the health risk to consumers. A recall classification is always listed in the recall notification. FSIS and FDA use a code to help consumers know the seriousness of the effects of consuming the product. The following is a list of definitions of the classification of a food recall:

Class I: A health hazard situation with a reasonable probability that consuming the product will cause serious health problems or death.

Class II: A health hazard situation with a remote probability of health problems from consuming the product.

Handling Food Product Recalls

It is recommended that SUAs and/or AAAs implement policies and procedures that include information on responding to a Food Recall Notice. OANPs should be aware of the standard food recall procedures in their state. Important procedures to consider include:

- Completing a food recall action checklist.
- Identifying the recalled food product.
- Counting the recalled product in inventory.
- Identifying where and how to segregate the recalled food product.
- Placing warning labels on the segregated food product.
- Notifying site staff not to use the segregated food product.
- Counting the amount of the recalled food product used.
- Accounting for the entire recalled food product by consolidating counts for product used and product in inventory.
- Obtaining information needed for public communications: whether the product was served, to whom it was served, and date served

The following are some resources regarding handling a food product recall:

Print Materials:

- Responding to a Food Recall Manual (PDF): <http://www.nfsmi.org/Information/recallmanual.pdf>
- Leader Guide (PDF): <http://www.nfsmi.org/Information/recalllg.pdf>
- Brochure (PDF): <http://www.nfsmi.org/Information/recallbrochure.pdf>
- Poster (PDF): <http://www.nfsmi.org/Information/recallposter.pdf>

Consumer Information and Education:

- What to Do If You Have a Problem with Food Products (FSIS): <http://www.fsis.usda.gov/oa/pubs/illness.htm>
- Recall Information Center (FSIS): http://www.fsis.usda.gov/OA/recalls/rec_intr.htm
- US Food and Drug Administration Recalls and Safety Alerts: <http://www.fda.gov/opacom/7alerts.html>

Sample SUA Food Product Recall Standards/Guidelines

Alabama

- *A designated individual at the Contractor's corporate offices will maintain a current vendor listing for food purchases made at the corporate or the local level. Information will be readily available for identifying the product lines purchased by manufacturer, brand, and item number.*
- *The Contractor shall require, as a condition of purchase, that all vendors (food brokers, wholesalers, distributors, manufacturers, etc.) immediately alert the Contractor in the event that notification of a food recall is received from a manufacturer, the Health Department, or other governmental agency.*
- *Upon receiving notification of a food recall, the Contractor will take the necessary steps to determine if the recalled product was a brand and item purchased for meals served in the State of Alabama. In that event, the Commission and the appointed representative of the Commission will be immediately advised of the potential problem.*
- *The Contractor will also (a) check purchasing records to determine which production units, if any, received the recalled lot numbers and the date and amounts received (b) check production unit records to determine the recent history for serving the recalled product line and (c) check all storage, production, and service areas to locate any recalled products. The Commission will be advised of these determinations. If a recalled product has been or may have been served within the State of Alabama, the Commission will advise the Area Agencies on Aging of the potential problem and will consult with officials at the Alabama State Department of Public Health to determine the appropriate course of action. If the product recall results in meals or portions of meals not being served or injury to persons consuming the contaminated food, the Contractor will bear the loss and will be liable for all damages.*

Foodborne Illness Outbreaks

Data from the Foodborne-Disease Outbreak Surveillance System (15) indicate that the most commonly reported factors that contributed to foodborne disease between 1993-1997 were improper holding temperature and inadequate cooking of food. The annual number of outbreaks reported ranged from 477 to 653. Objectives 10-1 and 10-2 in *Healthy People 2010* aim at reducing the number of foodborne illness cases and foodborne illness outbreaks by 50% respectively.

A foodborne illness outbreak is when a group of people consumes the same contami-

nated food and two or more of them come down with the same illness. This may occur when a group eats the same contaminated meal together at a foodservice establishment, or it may occur among a group of people who do not know each other, but who all happen to buy and eat the same contaminated food from a grocery store or restaurant. Usually a number of factors contribute to a foodborne illness outbreak. Many are local in nature. For example, a food item can become easily contaminated when it is inadequately cooked or when it is left out at room temperature for many hours. Foodborne illness outbreaks are often recognized when a group of people realizes that they all became ill after a common meal, and someone calls the local health department. For example, a common local outbreak might occur after eating a catered meal at a reception or a meal at an understaffed restaurant on a particularly busy day. Cases of foodborne illness can either be confirmed through laboratory analysis of the patients' stools or remain probable or suspect. Reports of outbreaks to local health departments usually come from individuals who are ill or health care providers and hospitals. Local health departments investigate reported outbreaks and report the results to the state Department of Health, which subsequently reports them to the US Centers for Disease Control and Prevention (CDC). The CDC: Foodborne Infections provides up-to-date information about foodborne infection on their website: http://www.cdc.gov/ncidod/dbmd/diseaseinfo/foodborneinfections_g.htm.

It is important for SUAs to provide AAAs and OANPs with the appropriate guidance on responding to foodborne illness outbreaks. While there have been instances of foodborne illnesses associated with the OANP, the reported incidence of such outbreaks has been relatively low. The 1995 National Evaluation found that among the 400 AAAs surveyed (which represent 60% of the AAAs in the country), there were only six incidents of illness associated with the OANP in the past three years. The AAAs reported that 175 older persons became ill from these six incidents. Meat and poultry products were associated with the reported food-borne illnesses (10).

If a foodborne disease outbreak occurs in an OANP, the impact can be devastating for the program and its participants. The following are some examples from the Idaho Food Safety & Sanitation Manual (<http://www2.state.id.us/dhw/behs/FoodSafety/Sec6.htm>) on what to do if a foodborne disease outbreak takes place:

- Staff and/or volunteers should direct all calls and/or complaints from a customer claiming that they became sick from a food and/or beverage they consumed to the manager or person in charge immediately. The following information should be obtained from the caller:
 - Name, address and telephone number of person calling;

- Who became ill and what were their symptoms;
 - Was the illness diagnosed by a physician (get physician's name if diagnosed);
 - What foods and/or drinks were consumed;
 - What was the day and time the food was consumed;
 - Who was the person who served or provided the food, if any;
 - Other information that may seem important at the time.
- Write the information down. Include the date and time the person called. Inform the caller that the complaint will be investigated immediately, and the management will call back within a specified period of time.
 - The information needs to be promptly evaluated and a decision made on the likelihood that an outbreak has occurred. There are no clear cut guidelines. The best rule of thumb is to consider that a foodborne disease outbreak may have occurred when two or more persons experience a similar illness, usually gastrointestinal, after eating a common food. 4. After giving the matter proper consideration and the management has reason to believe that a foodborne disease outbreak may have occurred, the following contacts are important:
 - Health Department. Contact your local health department immediately.
 - Your Attorney. Advise your attorney of the situation and the action taken. Although your attorney will most likely recommend that you cooperate fully with the health department, he or she may want to be included in the investigation to ensure that the rights of all concerned are properly respected.
 - Your Insurance Agent. Depending on the nature and the extent of the outbreak, your insurance company may become involved. It is advisable to inform your agent at the beginning of an official investigation.
 - Once an official foodborne disease outbreak investigation has begun, the management needs to be aware of the following health department activities:
 - Interviews. Investigating a foodborne disease outbreak is a lot like detective work. Health department staff will be asking a lot of questions, not only of

food establishment employees, but also of people who allegedly have become ill. Two fundamental questions need to be answered:

- ✦ What food caused the illness; and
 - ✦ What went wrong to cause the illness
- Isolating the Disease. Depending on the nature of the foodborne disease outbreak, preventing additional cases is paramount. Such control measures that may need to be implemented immediately are as follows:
 - ✦ Excluding sick employees from food-contact work,
 - ✦ Using alternate food processing or preparation methods, and/or
 - ✦ Closing the establishment.
 - Sampling. Collecting food and environmental samples is an important activity during a foodborne disease outbreak investigation. Finding or not finding the suspected organism or agent in a specific food is significant in determining the cause of the outbreak. Also, it is not uncommon to obtain stool, vomitus and/or blood samples from victims and employees.
 - Embargo. Suspected foods in foodborne disease outbreak investigations may be placed under embargo until a determination can be made as to its safety or status. Such foods will be properly identified, and the food must remain undisturbed until the embargo is lifted.
 - Reports. Several reports are generated as a result of the investigation. A special inspection report is generally completed during the course of the investigation. It is similar to a regular inspection but only addresses conditions relating to the outbreak. Also, case investigation reports are generated.

Sample SUA Foodborne Illness Standards/Guidelines

Alabama

- *The Contractor will make reasonable effort to avoid problems with food product contamination, natural or otherwise, and with foodborne illnesses through the food purchasing specifications and buying practices; the product receiving and storage procedures; and the food handling and delivery practices. In the event of a problem or suspected problem, the Commission, the appointed representative of the Commission, and the affected Area Agency (ies) will be notified. The Contractor will cooperate with the Commission and any officials of the Alabama Department of Public Health investigating the incident(s). Client notification will be as recommended by the Alabama Department of Public Health and the Commission. Any and all media communications will be coordinated with the Commission; both the Commission and the Contractor will have designated spokespersons for handling the media communications.*
- *The Contractor will develop plans for handling food product recalls; food contaminants; and outbreaks/suspected outbreaks of foodborne illnesses or other reported injury from food contaminants. A copy of said plans shall be submitted with the Invitation to Bid. At the beginning of the contract year, the Contractor will provide copies of the plans to each Area Agency on Aging and to the appointed representative of the Commission.*
In the event of a problem, the Contractor will aim to identify the source of the contamination and take any needed steps to avoid future problems. The Contractor will be liable for all medical expenses and damage claims resulting from a medically documented foodborne illness.

New York

- *Outbreaks of suspected foodborne illness are reported to the local Health Department and SUA immediately.*

EQUIPMENT/WATER/PHYSICAL FACILITIES

EQUIPMENT

Contaminated equipment is one of the major causes of foodborne disease outbreaks. Thus, it is crucial that the foodservice facility and its equipment are properly maintained, cleaned, and sanitized to prevent the transmission of foodborne diseases. Effective cleaning and sanitization of equipment and utensils serve two primary purposes. They:

- Reduce chances for contaminating safe food during processing, preparation, storage, and service by physically removing soil and bacteria and other microorganisms; and
- Minimize the chances of transmitting disease organisms to the consumer by achieving bacteriologically safe eating utensils.

The task of choosing equipment designed for sanitation has been simplified by organizations such as the National Sanitation Foundation (NSF) International. NSF International develops and publishes standards for sanitary equipment design. A clean and sanitary food establishment is a prerequisite to an effective food-safety program. A routine cleaning program must be established and monitored.

WATER SUPPLY SYSTEM

Proper sanitary controls for the water supply system and sewage and liquid waste disposal systems are necessary in food establishments to prevent the food contamination and the creation of public health hazards.

Because water is so common in place for food establishments, its availability, purity, and safety are taken for granted. The protection of water is provided through compliance with local and state regulations of public drinking water systems and plumbing codes. However, hazards through repairs, emergencies, changes, and/or alterations in the water delivery system and distribution system within the establishment may occur. Therefore, the water supply systems in a food establishment also need special attention and must be monitored to prevent food, equipment, and supplies from becoming contaminated.

PHYSICAL FACILITIES

Well-designed, constructed, installed, operated and maintained physical facilities of a

foodservice establishment are important to ensure adequate food safety and sanitation. Other key considerations in helping keep food safe include adequate hand-washing and toilet facilities and prohibiting pets and other animals on the premises of the foodservice establishment. Pests such as insects and rodents can also pose serious problems for establishments. The greatest danger from pests comes from their ability to spread disease, including foodborne illness. Developing policies and procedures to ensure that the physical facilities of the establishment are maintained in good repair and implementing a pest management program will help prevent contamination and pests from infesting foodservice establishments.

Sample SUA Equipment/Water/Physical Facilities Standards/Guidelines

Idaho

Equipment

WAREWASHING CYCLE

The following numerated list and comments pertaining to the wash cycle of food contact surfaces will help supervisors and managers appreciate why there is a particular order in the process:

1. Equipment and Utensils Clean Prior to Use. Properly cleaned and sanitized equipment and utensils should be bacteriologically safe prior to use. Should contamination be suspected, the equipment and/or utensils should not be used, but re-cleaned and sanitized.
2. Soiled Equipment and Utensils. During use, equipment and utensils become soiled and contaminated with bacteria.
3. Scrapping, Preflushing and Presoaking. Scrapping, preflushing and presoaking, as necessary, are methods for removing gross amounts and stubborn soil from equipment and utensils.
4. Cleaning. There are two steps in the cleaning process - washing and rinsing:
 - Washing, when using proper detergents, cleaners, chemicals and abrasives, remove the remaining soil from equipment and utensils. This is a physical and a chemical process. The soil and bacteria, as well as cleaning compounds, are suspended in the wash water; and

- Rinsing removes most of the suspended soil, bacteria and cleaning compounds from the equipment and utensils. Although the equipment and utensils look visibly clean at this point, they are still contaminated with many bacteria.
5. Sanitizing. Sanitizing kills the remaining pathogenic organisms on the equipment and utensils. Sanitization will occur when certain specific chemical concentrations, temperature requirements, time requirements and water conditions are satisfied. These conditions are crucial for effective sanitization. Therefore, precise measurements of the sanitization process are made periodically. **NO RINSING OR ANY OTHER CLEANING PROCESS SHOULD TAKE PLACE AFTER THE SANITIZING PROCESS.**
 6. Air Drying. The only acceptable method of drying equipment and utensils is air drying. The use of towels for drying, polishing or any other purpose re-contaminates equipment and utensils with bacteria.
 7. Proper Storage and Handling. Proper storage and handling of cleaned and sanitized equipment and utensils is very important to prevent recontamination prior to use. Cleaned and sanitized equipment and utensils must be:
 - stored on clean surfaces, and
 - handled to minimize contamination of food contact surfaces.

SANITIZATION PROCEDURE

Chemical sanitization requires greater controls than hot water sanitization. The following factors must be considered in order to obtain effective sanitization by chemical sanitization methods:

- Amount of water used;
- pH of the water;
- Hardness of the water;
- Temperature of the water; and
- Contact time.

The pH and hardness needs to be determined. Should the water supply be from a municipal supply, the water company may already have this information. If not, the water will need to be tested periodically.

MANUAL SANITIZATION

The following table provides information pertaining to minimum and maximum chemical sanitization requirements for manual operations (in parts per million-ppm)

Chemical Solutions	Temp (°F)	pH		Maximum Allowed	Contact Time
		≤8.0	≥8.1		
Chlorine	120? o: p>	25	25	200	10 sec
	100? o: p>	50	50	200	10 sec
	75? o: p>	50	100	200	10 sec
	55? o: p>	100	100	200	10 sec
≤5.0*					
Iodine	75?	12.5As specified by manufacturer, see label; hardness 500 ppm or less*		25	30 sec
Quats**	75?			200	30 sec

* unless container label specifies a higher pH and/or water hardness limit

** Quaternary ammonium compounds

OBTAINING PROPER SANITIZATION

All chemical sanitizer instructions call for a given amount of sanitizer per gallon of water. The following are two methods of determining the amount of water used for sanitization:

- Use a gallon container and pour a gallon of water at a time into the sink until the water is at a suitable depth; or
- Use the following formula:

$$\text{width} \times \text{length} \times \text{water depth} = \text{total gallons}$$

231 (cu. in. in one gallon)

The following will serve as an example:

Length of sink - 24" Width of sink - 24" Depth of sink = 16"

$$24 \times 24 \times 16 = 9,216 = 40 \text{ gallons}$$

231 ???231

- Use the test kit each time and adjust water amount or sanitizer amount until proper concentration is obtained.

In the first two methods, the same amount of water must be used each time, unless the amount is recalculated.

Another problem in measuring the right amount of sanitizing chemical is the method of measure stated on the label. The following table provides equivalents of various measurements:

	drops	ml.	tsp.	tbsp.	f.o.
1 ml.	20	-	-	-	-
1 tsp.	60	5	-	-	-
1 tbsp.	-	15	3	-	-
1 f.o.	-	-	6	2	-
1 cup	-	-	-	16	8





ml. = milliliter tbsp. = tablespoon
 tsp. = teaspoon f.o. = fluid ounce

Household bleach is often used as a sanitizer. When used, only pure bleach (without additives) is acceptable. The amounts of bleach (which contains 5.25% sodium hypochlorite) needed to obtain certain concentrations are as follows:

Concentration	Amount of bleach/gallon(s) water
25 ppm	3/4 teaspoon/2 gallons 1 1/2 teaspoons/4 gallons 1 tablespoon/8 gallons
50 ppm	3/4 teaspoon/1 gallon 1 1/2 teaspoons/2 gallons 1 tablespoon/4 gallons 1/4 cup/16 gallons
100 ppm	1 1/2 teaspoons/1 gallon 1 tablespoon/2 gallons 1/2 cup/16 gallons
200 ppm	1 tablespoon/1 gallon 1 cup/16 gallons

MANUAL WAREWASHING METHODS





Three-Compartment Sink Method (hot water sanitization)

Scrap 	Detergent 	Clear Water 	Chemical 	Air Dry
	Wash - 95°F ¹	Rinse	Sanitization 170°F ²	

1 Or as specified on the manufacturer's label

2 Immersed for at least 30 seconds

Three-Compartment Sink Method (chemical sanitization)

Scrap 	Detergent 	Clear Water 	Chemical 	Air Dry
	Wash - 95°F ¹	Rinse	Sanitization ²	

1 Or as specified on the manufacturer's label

2 According to chemical sanitization schedule

When a two-compartment sink cleaning method is used, a special sanitization formulation must be used in both sink compartments.

SPECIAL CLEANING AND SANITIZATION

Food processing equipment and some vending equipment that requires in-place cleaning shall be designed and fabricated so that:

1. Washing and sanitizing solutions can be circulated throughout a fixed system using an effective cleaning and sanitizing procedure, and
2. Cleaning and sanitizing solutions will contact all food contact surfaces,
3. The system is self-draining or capable of being completely evacuated, and
4. The procedures utilized result in thorough cleaning of the equipment,
5. Equipment used in production-line food processing shall be cleaned and sanitized according to the following schedule:
 - Each time there is a change in processing between types of animal products (consider exceptions),
 - Each time there is a change from raw to ready-to-eat foods,

- After substantial interruptions,
- Throughout the day as necessary, and
- After final use each working day.

Water Supply

With improved water system technology, monitoring and regulatory control, water supplies are safer than ever. However, contamination does occur as a result of system failure or cross-connections. Give special attention to the following:

- **Water Status Notices.** Be alert to public notices that pertain to your water supply. To ensure a safe water supply for food establishment operations and for drinking purposes during such notices, contact your local health department for assistance.
- **Changes in Water Quality.** Be aware of changes in water quality such as taste, odor, or clarity or changes in water pressure. Such changes may be an indicator of a possible cross-connection.
- **Cross-connections.** Check your establishment for cross-connections mentioned above.
- **Repairs and alterations to the water system or equipment connected to a water system** must be done only by a licensed plumber who is familiar with cross-connection prevention.

Physical Facilities

Adequate Handwashing Facilities. Handwashing facilities shall be adequate. Adequacy pertains to the following design requirements:

- Provided with hot and cold or controlled temperature water (90°F to 105°F) through a mixing valve or combination faucet;
- Self-closing, slow-closing or metering faucets shall provide a continuous flow of water for at least fifteen seconds without reactivating the faucet; and
- Steam mixing valves shall not be used.

In addition, handwashing facilities shall be provided with a continuous supply of:

- Hand soap or similar hand cleanser; and
- Individual disposable sanitary paper towels; or
- A continuous towel system supplied with a clean towel; or
- A heated air hand-drying device.

COMPLIANCE AND ENFORCEMENT

The key to food safety is controlling time and temperature throughout the flow of food, practicing good hygiene, preventing cross contamination, and purchasing food supplies from approved suppliers. In addition to being monitored by health inspectors, it is also important that each foodservice operation inspects its own facilities.

The number of problems identified by SUAs during site inspections stresses the importance of meal site sanitation and food safety monitoring. The 1995 National Evaluation of the OANP (10) found that about 28% of SUAs reported sanitation and food safety problems in their last assessments of AAAs or projects. According to the Evaluation, 73% of SUAs require all sites, both OANP production and service sites, be inspected. However, only 18% of SUAs require only sites preparing food be inspected. Dining centers that serve meals should also be routinely monitored to ensure the maintenance of appropriate food temperatures and safe handling practices. It is also important that vendors and caterers be monitored. Sample [Dining Center](#) and [Kitchen](#) monitoring tools are available from Florida. The National Evaluation found that only 75% of SUAs require vendor sites to be monitored.

Below is a list of common violations from actual inspections, along with suggestions for correcting them (16):

Violation #1: Potentially hazardous food at room temperature.

Suggestions: Monitor the receiving area and be sure perishable food deliveries are reaching refrigerators and freezers promptly. Evaluate whether delivery times are coordinated with staffing, and make any needed adjustments. In the kitchen, watch for overzealous employees who may be removing products for preparation too far in advance. In serving areas, be sure that cold food is going directly into cold holding units, and hot food is going directly into hot serving units ?no pans on counters.

Violation #2: Bare hands are contacting food.

Suggestions: Train all employees about the need to use a barrier between food and hands. The barrier may be a utensil or a clean plastic glove (changed regularly) or a sheet of deli paper. Then, be sure that sanitary utensils are available in all areas.

Sometimes it takes planning to match the utensil to the job. Employees given utensils that are awkward to work with often give up and use bare hands.

Violation #3: No thermometers in use.

Suggestions: Recognize thermometers as one of the chief controls for keeping food out of the hazard zone. In cold storage areas without a built-in thermometer, a hanging thermometer can be secured inside. Then, check and log the temperature regularly. For food preparation and holding areas, be sure everyone who needs one has and uses a calibrated thermometer. In holding, emphasize that cold holding below 41 is just as critical as hot holding above 140°F. FDA researchers noted this year that many foodservice professionals have done a great job of paying attention to endpoint cooking temperatures, but are overlooking holding and storage issues with cold food.

Violation #4: Improper thawing.

Suggestions: Use one of the approved methods for thawing food: thaw in the refrigerator, or under cold running water, or in the microwave (and then begin cooking immediately). What really goes wrong with thawing? Sometimes it is a matter of last-minute efforts to get food ready. A reminder to transfer frozen ground beef to the refrigerator two to three days before it will be cooked can help a great deal.

Violation #5: Food not protected from dirt.

Suggestions: Check all storage areas to be sure food is at least 6 inches off the floor. This includes in refrigerators and freezers. Elevation protects food from dirt as you sweep floors, and also makes food slightly less accessible to pests. Meanwhile, when serving and transporting food, be sure all food is covered. Again, a close look at the tools provided to employees can help. Do they have to tear off sheets of plastic wrap one-by-one to cover food? Are there snug-fitting lids available that you could use instead?

Violation #6: Employees are eating in preparation and/or service areas.

Suggestions: To change this practice, first establish policies clearly. Then, monitor all areas and remind employees as needed. It's helpful to explain the rationale behind this policy: Eating makes your own hands unclean, and facilitates transfer of pathogens to the food that others will eat. The irony of this policy is not to encourage cooks to taste their own food and take responsibility for ensuring quality. Is there a solution? Some managers set up a taste panel in a controlled area every day, inviting employ-

ees to taste the food and comment.

Violation #7: Improper dishwashing.

Suggestions: Review dish-machine maintenance plan as recommended by the manufacturer. Inspectors say they often find heavy lime build-up, clogged rinse jets, or broken temperature gauges. Each of these violations is preventable with some attention to maintenance.

Violation #8: Chemical sanitizers not tested.

Suggestions: Whether in the pot and pan sink or in a bucket of solution used for wiping tables, the concentration of chemical sanitizer must be correct. Explain to employees that too low a concentration may not work, and too high a concentration may not be safe. Also, explain that sanitizing solutions lose their strength over time. Finally, be sure that test kits are available where needed, and spend the time to show employees how to use them.

Violation #9: Wiping cloths improperly handled.

Suggestions: Sometimes, an employee will use a cloth for tables to grab a spill on the floor. Encourage employees to use separate cloths for separate purposes, and keep wiping cloths in the sanitizing solution between uses. Of course, cloths should be changed as they become soiled, and every time you make a fresh solution of sanitizer.

Violation #10: Walls, ceiling or floor in disrepair.

Suggestions: Continue to monitor the condition of these surfaces to ensure integrity is intact. This may mean patching and finishing a crumbling spot on a wall, or replacing loose or chipped tiles on a floor. All of this protects food in two ways: It prevents the physical hazard of having loose construction fragments enter food, and it ensures that these surfaces are cleanable.

Violation #11: Lighting is not shielded.

Suggestions: Recognize broken glass as another physical hazard to food. Check to be sure that fixtures are shielded.

Violation #12: Employees are promoting cross contamination.

Suggestions: Cross contamination is the transfer of pathogens from one food to another.

It can happen in the refrigerator when an employee places raw meat above fruit and the drippings contaminate the fruit. It can happen in the kitchen when a cook slices turkey on the slicer and then slices roast beef without sanitizing the equipment in between. It can happen in the serving area when an employee wearing plastic gloves

picks up a hamburger to place it on the grill, and then picks up deli meat for a sandwich to order without changing gloves in between. Explain to employees that utensils, equipment, gloves, and even hands can all boil down to a personalized taxi service for harmful bacteria and viruses.

Internal monitoring procedures are critical in ensuring that appropriate sanitation standards and food handling procedures are followed. Best practices include the regular monitoring and documentation of compliance and that corrective actions are completed appropriately. Participant satisfaction surveys, focus groups, and other consumer-oriented meal service evaluations on a regular basis also provide information on program compliance and need for quality improvement.

Sample SUA Food Safety Monitoring Standards/Guidelines

Massachusetts

- *Every kitchen utilized for the preparation of Title III-C meals shall be inspected twice per year by the Nutrition Project/Area Agency on Aging using the Elder Affairs Kitchen inspection form. Inspections shall occur at approximately six-month interval.*

Minnesota

- *Nutrition contractors must utilize temperature probes for checking food temperatures. In addition, refrigerators and freezers located at food preparation and service sites must have thermometers.*

Ohio

- *A provider cited for critical items during the local health department inspection must furnish a copy of that inspection report and the follow-up report to the AAA within five working days of receipt from the inspecting agent.*
- *A provider cited by the Ohio Department of Agriculture or USDA Regulatory Agents must furnish a copy of the findings and corresponding corrective plans within five working days of receipt from the regulatory agent to the AAA.*
- *These aspects of provider operations require monitoring:*
 - *Food temperatures during storage, preparation, transport and delivery*

- o *of food to the dining site; holding food before and during the meal service.*
 - o *Food packaging and transporting systems.*
 - o *Preparation, holding, and delivery practices; ensuring retention of food quality and characteristics (e.g., flavor and texture).*
- *A provider must monitor all aspects of the operation and take immediate action to improve practices. Aspects that require monitoring are:*
- *Client satisfaction by eliciting their comments about dining environment, type of food, portion size, temperatures, meal delivery, meal service schedules and staff professionalism.*

Tennessee

- *Food temperatures shall be recorded by the name of each specific food item. Exceptions are bread products, crackers, cake and fresh fruit. Temperature reports must be kept on file for three years plus the current year.*
- *Temperature checks of hot and cold food must be taken and recorded at least one time per week on selected routes. The last meal delivered on the route shall be the one checked to assure that hot food is delivered at a minimum of 140°F and cold food is delivered at 40°F or below (edited). Records of temperatures shall be maintained and kept on file by the provider.*
- *Temperature retention problems involving the entire meal shall be monitored on a daily basis until the problems are identified and corrected.*
- *Temperature retention problems with individual food items shall be followed up immediately in order to correct the problems.*
- *Each nutrition project shall establish a monitoring schedule that insures that standards are met on all routes.*
- *A sample of all food items shall be saved at each food preparation site at least 72 hours for checking purposes should food borne illness occur.*

Additional Resources

- Training Toolkit: <http://www.fsis.usda.gov/OA/pubs/fstea.pdf>
- Food Safety Education. Improving Public Health: <http://www.fsis.usda.gov/>

[OA/background/fseducation.pdf](http://www.fda.gov/oc/background/fseducation.pdf)

- Food Protection Connection: <http://www.dmaonline.org/fppublic/connect.html>
- Research/Reports and Resources concerning food safety and sanitation are available on the Center website at: http://www.fiu.edu/~nutreldr/SubjectList/Food_Safety_Sanitation.htm

References

1. Mead PS, Slutsker L, Dietz V, McCraig LF, Bresee JS, Shapiro C, Griffin PM, Tauxe RV, 1999. Food-related Illness and Death in the United States. Emerg. Infect. Dis. Vol. 5, No. 5, in: <http://www.cdc.gov/ncidod/EID/vol5no5/mead.htm>.
2. US Food and Drug Administration. Center for Food Safety and Applied Nutrition. Seniors and Food Safety. Preventing Foodborne Illness. Why Are Seniors at Risk of Foodborne Illness? Available at: <http://vm.cfsan.fda.gov/~dms/seniorsb.html>.
3. Mead PS, Slutsker L, Dietz V, et al. Food-related illness and death in the United States. Emerg Infect Dis. 1999;5:607-625.
4. Bureau of the Census, Economics and Statistics Administration, US Department of Commerce. Population estimates. Available at: <http://eire.census.gov/popest/estimates.php>.
5. Frome, EL. The analysis of rates using Poisson regression models. Biometrics 1983;39:665-674.
6. Voetsch A, Angulo F, Rabatsky-Ehr T, et al. Laboratory practice in FoodNet sites, 1995--1999. Conference on Emerging Infectious Diseases. Atlanta, Georgia, March 2002. Available at http://www.cdc.gov/foodnet/pub/iceid/2002/voetsch_a.htm.
7. [CDC. Preliminary FoodNet Data on the incidence of foodborne illnesses---selected sites, United States, 2000. MMWR 2001;50:241-246.](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm2102a.htm)
8. US Department of Health and Human Services Public Health Service Food and Drug Administration. 2001 Food Code. Available at: <http://www.cfsan.fda.gov/~dms/fc01-toc.html>.
9. Health People 2010. Food Safety Objectives. Available at: <http://www.health.gov/>

healthypeople/document/HTML/Volume1/10Food.htm

10. Mathematica Policy Research. Serving Elders At Risk. The Older Americans Act Nutrition Programs. National Evaluation of the Elderly Nutrition Program, 1993-1995. US Department of Health and Human Services. Available at: <http://www.aoa.gov/aoa/pages/nutreval.html>
11. Fogler-Levitt E, Lau D, Csima A, Krondl M, Coleman P. Utilization of home-delivered meals by recipients 75 years of age or older. J Am Diet Assoc. 1995;95:552-557.
12. Asp E, Darling M. Home-delivered meals: Food quality, nutrient content, and characteristics of recipients. J Am Diet Assoc. 1988;88:55-65.
13. Lau D, Coleman P, Krondl M. Delayed consumption of home-delivered meals by elderly recipients 75+. J Am Diet Assoc. 1994;94(suppl):A-61. Abstract.
14. Food Safety And Inspection Service. US Department Of Agriculture. Recall Information Center. Available at: http://www.fsis.usda.gov/oa/recalls/rec_intr.htm
15. Olsen SJ, MacKinon LC, Goulding JS, Bean NH, Slutsker L. Surveillance for food-borne disease outbreaks --United States, 1993-1997. MMWR. 2000;49(SS01):1-51. Available at: <ftp://ftp.cdc.gov/pub/Publications/mmwr/ss/ss4901.pdf>
16. What health inspectors know: common violations & how to avoid them. Dietary Manager. 2001. Available at: <http://www.dmaonline.org/fppublic/connect14.html>.

Chapter 7

Nutrition and Health Promotion Services

Contents

Background

- Nutrition and Health Concerns of Older Adults
- Evidence for Nutrition and Health Promotion Services

Home and Community-Based Care

- Caregivers', support, assistance and respite care
- OAA 2000 requirements

Nutrition Screening and Assessment

- Nutrition Screening Initiative and Mini Nutritional Assessment
- Performance Outcomes Measures Project
- OAA 2000 Requirements
- Sample SUA Screening and Assessment Standards

BACKGROUND

Nutrition and Health Concerns of Older Adults

Evidence confirms that good nutrition is important in maintaining the health and functional independence of older adults. It can reduce hospital admissions and delay nursing home placement. The aging of the US population has heightened the interest in developing effective and efficient nutrition and health services for older people. Service networks that a continuum of home and community-based services have become especially important because they allow older adults to preserve their independence and ties to family and friends.

The nutritional status of older adults can be easily compromised given their number of chronic conditions and functional impairments. About 87% of older adults in the US have diabetes, hypertension, dyslipidemia or a combination of these chronic conditions (1). These can be successfully managed with appropriate nutrition interventions that will improve health and quality of life outcomes. Left unchecked, these conditions result in poorer health, dependence, and increased costs, especially among minorities (2).

Although many older adults remain fully independent and actively engaged in their communities, many need additional nutrition and health services (2). Three of the AoA's top priorities include:

1. Make it easier for older people to access an integrated array of health and social supports.
2. Help older people to stay active and healthy.

Nutrition Counseling/Medical Nutrition Therapy

- Insurance Coverage for MNT
- Registered and Licensed Dietitian Credentials
- OAA 2000 Requirements
- Sample SUA Nutrition Counseling Standards

Nutrition Education

- OAA 2000 Requirements
- Sample SUA Nutrition Education Standards

Care Management

- OAA 2000 Requirements
- Sample SUA Case/Care Management Standards

Health Promotion/Disease Prevention and Wellness Activities

- OAA 2000 Requirements
- Examples of Wellness and Physical Activity Programs
- Sample SUA Health Promotion/Wellness Standards

- Additional Resources
- References

3. Support families in their efforts to care for their loved ones at home and in the community.

Older Americans Act (OAA) Nutrition Programs provide supportive in-home and community-based services to improve quality of life of community residing individuals as follows:

- Home-delivered and congregate meals,
- Nutrition education and counseling,
- Care (Case) management services,
- Care plan development and implementation, and
- Health promotion and disease prevention activities such as exercise, diabetes management, medication management, and smoking cessation programs.

It is important for OAA Nutrition Programs to be aware of health trends, so that nutrition and health promotion services are targeted. Accordingly, SUAs need to be familiar with trends in:

- Mortality and the leading causes of death in older adults,
- Health disparities,
- Quality of life including measures of illness and disability,
- Factors associated with healthy aging, and
- The cost of illness (3).

[Chartbook on Trends in the Health of Americans. Health, United States, 2002.](#)

The [Older Americans 2000: Key Indicators of Well-Being](#) report focuses on a number of key areas effecting older adults.

They include population, economics, health status, health risks and behaviors, and health care. By understanding current health trends and indicators, effective nutrition and health promotion services can be developed and/or enhanced in the OANP.

Evidence for Nutrition and Health Promotion Services

- The [*Health and Aging Chartbook, 1999*](#) provides important data on the population, health status and health care access and utilization from national data sources. The *Chartbook* supports the importance of nutrition and health promotion services and addresses many risk factors that contribute to nutritional concerns.
- The Institute of Medicine (IOM) report, *The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population* (1), examined the nutrition services that older adults receive along the continuum of care, the role of nutrition therapy in the management of diseases, and the expertise needed to provide appropriate nutrition therapy. The following recommendations pertain to home and community based care:

Recommendation 1: Nutrition therapy, upon referral by a physician, be a reimbursable benefit for Medicare beneficiaries. This is based on the high prevalence of individuals with conditions for which nutrition therapy was found to be of benefit. Eighty-six percent of Medicare beneficiaries over 65 years of age have diabetes, hypertension, and/or dyslipidemia alone.

Recommendation 2: Registered dietitians be directly reimbursed as providers of nutrition therapy. In addition, a registered dietitian should be involved in educating other members of the health care team regarding nutrition interventions and practical aspects of nutrition. This is of particular importance in the areas of home care, ambulatory care, and care given in skilled nursing and long-term care facilities, where basic nutrition advice or reinforcement of nutrition plans will likely be provided by other health professionals.

Recommendation 4: The Centers for Medicare and Medicaid Services (formally the Health Care Financing Administration) as well as accreditation and licensing groups should reevaluate existing reimbursement systems and regulations for nutrition services along the continuum of care to determine the adequacy of care delineated by such standards. The committee found numerous inconsistencies with regard to regulations and reimbursement systems related to the provision of nutrition services across the continuum of care.

Recommendation 4.2: The availability of nutrition services be improved in the home health care setting. Both types of nutrition services are needed in this setting: nutrition education and nutrition therapy. A registered dietitian should be available to serve as a consultant to health professionals providing basic nutrition education and follow-up, as well as to provide nutrition therapy, when indicated, directly to Medicare beneficiaries being cared for in a home setting.

In summary, the IOM committee found that expanded coverage for nutrition therapy would be economically beneficial to participants and Medicare. Nutrition therapy in the context of multidisciplinary care has potential short term cost savings for populations with hypertension, dyslipidemia, and diabetes. In addition to decreased mortality and morbidity, nutrition therapy can have impact quality of life in less tangible ways that cannot be measured quantitatively. Meals provide the social context for many experiences across the course of life, including holidays. Because food is central to an individual's social attachment and role, dietary problems that require significant behavior change or interfere with long-established social relationships can have a significant impact on well-being independent of their impact on mortality or morbidity. Nutrition therapy translates the care plan into daily life skills such as grocery shopping, food preparation, and menu selection. Nutrition therapy that assists homebound individuals to participate in family meals may have a greater impact on subjective well being than many other interventions that have an equal impact on physical health (1).

- [Healthy People 2010](#) is a set of disease prevention and health promotion objectives for the Nation to achieve during the first decade of the new century. The national health objectives are designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. *Healthy People 2010* has two goals:
 - 1) Increase quality and years of healthy life, and
 - 2) Eliminate health disparities.

Focus Areas of *Healthy People 2010*

1. Access to Quality Health Services	15. Injury and Violence Prevention
2. Arthritis, Osteoporosis, & Chronic Back Conditions	16. Maternal, Infant, and Child Health
3. Cancer	17. Medical Product Safety
4. Chronic Kidney Disease	18. Mental Health and Mental Disorders
5. Diabetes	19. Nutrition and Overweight
6. Disability and Secondary Conditions	20. Occupational Safety and Health
7. Educational & Community-Based Programs	21. Oral Health
8. Environmental Health	22. Physical Activity and Fitness
9. Family Planning	23. Public Health Infrastructure
10. Food Safety	24. Respiratory Diseases
11. Health Communication	25. Sexually Transmitted Diseases
12. Heart Disease and Stroke	26. Substance Abuse
13. HIV	27. Tobacco Use
14. Immunization and Infectious Diseases	28. Vision and Hearing

Leading Health Indicators of *Healthy People 2010*

1. Physical Activity	6. Mental Health
2. Overweight and Obesity	7. Injury and Violence
3. Tobacco Use	8. Environmental Quality
4. Substance Abuse	9. Immunization
5. Responsible Sexual Behavior	10. Access to Health Care

- Each health indicator has one or more objectives in *Healthy People 2010* associated with it. Of the 467 objectives in *Healthy People 2010*, 76 specifically related to older adults can be found at: <http://www.healthypeople.gov/hpscripts/KeywordResult.asp?n270=270&Submit=Submit>
- *Healthy People 2010* can be used as a framework to guide nutrition and health promotion activities. By using the national objectives, OAA Nutrition Programs can develop appropriate nutrition and health promotion programs to help improve health and prevent disease in older adults. OAA Nutrition Programs are encouraged to integrate *Healthy People 2010* into their current community programs, special events and publications.

The USDA Food and Nutrition Service (FNS) developed [Promoting Healthy Eating: An Investment in the Future—A Report to Congress](#). It focused on issues that require congressional action and concludes that the Nation must enhance the investment in nutrition education in order to promote food security, avoid preventable deaths, eliminate nutrition-related health disparities, and address the obesity epidemic. The needed changes can only be achieved through a sustained, integrated, long-term nutrition education effort.

HOME AND COMMUNITY BASED CARE

Home and community-based care (HCBC) refers to a variety of services and settings available to older and disabled people living in their own homes or in residential care settings. Basic community services available through an HCBC system include:

- Information and assistance
- Personal care, homemaker and chore services
- Congregate and home-delivered meals
- Adult day care
- Rehabilitative care
- Transportation assistance
- Home health care
- Caregivers' support, assistance and respite care
- Housing options, including assisted-living arrangements
- Consumer protection and advocacy.

Frequently older and disabled persons often have multiple and changing health and social service needs. Therefore, effective HCBC programs facilitate services at a consolidated location for comprehensive assessment, care planning or case management, pre-nursing home admission screening, and/or referrals to medical care providers.

The network of SUAs and AAAs are in position to provide a full range of HCBC services and administrative systems to meet the needs of the older adults and their caregivers. Many AAAs, through state allocations of Older Americans Act funds, state and local revenues, Social Services Block Grant funds, and other resources, fund local service providers to deliver basic HCBC services.

Caregiver Support, Assistance and Respite Care

A caregiver is a person who provides assistance to someone else who experiences limitations in activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs). Informal and/or family caregivers are unpaid individuals such as family members, friends, neighbors and volunteers who provide help or arrange for help. They may be primary or secondary caregivers, full time or part time, and may or may not live with the person recipient. Caregivers may assist with household chores, finances, or with personal or medical needs (5). Family caregivers provide ongoing assistance to allow loved ones to remain in the comfort of their own home and community. Caregivers require respite and such assistance should be available. Respite care services provide temporary relief to family caregivers and include in-home respite, adult day care, and overnight respite (6).

The 2000 amendments to the OAA established the National Family Caregiver Support Program (NFCSP). Funded at \$125 million in fiscal year 2001, approximately \$113 million was allocated to states to work in partnership with AAAs and local providers. The NFCSP is a significant addition to the OAA because it enables the aging network to develop caregiver support programs. It provides an opportunity for the aging network to develop services and programs to respond to the needs of our Nation's caregivers. The basic services for family caregivers are:

1. Information to caregivers about available services,
2. Assistance to caregivers in gaining access to supportive services,
3. Individual counseling, organization of support groups, and caregiver training to assist the caregivers in making decisions and solving problems relating to their caregiving roles,
4. Respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities, and
5. Supplemental services, on a limited basis, to complement the care provided by caregivers.

The following link to AoA provides helpful information, resources and tools on implementing caregiver services: <http://www.aoa.gov/carenetwork/>

A number of states that provide innovative services and programs for caregivers are described in the following reports:

- **Survey of Fifteen States' Caregiver Support Programs:** <http://www.caregiver.org/issues/execsum9910.html>
- **Helping the Helpers: State Supported Services for Family Caregivers:** http://research.aarp.org/health/2000_07_help.pdf
- **Building Multifaceted Systems for Caregivers: A Variety of State Efforts** <http://www.aoa.dhhs.gov/carenetwork/NFCSPConf01-Papers/state-efforts.html>

Older Americans Act 2000 Requirements

SEC 321

PART B-SUPPORTIVE SERVICES AND SENIOR CENTERS PROGRAM AUTHORIZED

(5) services designed to assist older individuals in avoiding institutionalization and to assist individuals in long-term care institutions who are able to return to their communities, including--

(A) client assessment, case management services, and development and coordination of community services;

(B) supportive activities to meet the special needs of caregivers, including caretakers who provide in-home services to frail older individuals; and

(C) in-home services and other community services, including home health, home-maker, shopping, escort, reader, and letter writing services, to assist older individuals to live independently in a home environment.

Part E--National Family Caregiver Support Program

[Sections 371, 372, 373, and 374 of the Older Americans Act of 1965, as Amended \(P.L. 106-501\), Grants for State and Community Programs on Aging](#)

SECTION 373 PROGRAM AUTHORIZED

(a) IN GENERAL- The Assistant Secretary shall carry out a program for making grants to States with State plans approved under section 307, to pay for the Federal share of the cost of carrying out State programs, to enable area agencies on aging, or entities

that such area agencies on aging contract with, to provide multifaceted systems of support services--

(1) for family caregivers; and

(2) for grandparents or older individuals who are relative caregivers.

(b) SUPPORT SERVICES- The services provided, in a State program under subsection (a), by an area agency on aging, or entity that such agency has contracted with, shall include--

(1) information to caregivers about available services;

(2) assistance to caregivers in gaining access to the services;

(3) individual counseling, organization of support groups, and caregiver training to caregivers to assist the caregivers in making decisions and solving problems relating to their caregiving roles;

(4) respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; and

(5) supplemental services, on a limited basis, to complement the care provided by caregivers.

(c) POPULATION SERVED; PRIORITY-

(1) POPULATION SERVED- Services under a State program under this subpart shall be provided to family caregivers, and grandparents and older individuals who are relative caregivers, and who--

(A) are described in paragraph (1) or (2) of subsection (a); and

(B) with regard to the services specified in paragraphs (4) and (5) of subsection (b), in the case of a caregiver described in paragraph (1), is

providing care to an older individual who meets the condition specified in subparagraph (A)(i) or (B) of section 102(28).

(2) PRIORITY- In providing services under this subpart, the State shall give priority for services to older individuals with greatest social and economic need, (with particular attention to low-income older individuals) and older individuals providing care and support to persons with mental retardation and related developmental disabilities (as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001)) (referred to in this subpart as 'developmental disabilities').

(d) *COORDINATION WITH SERVICE PROVIDERS-* In carrying out this subpart, each area agency on aging shall coordinate the activities of the agency, or entity that such agency has contracted with, with the activities of other community agencies and voluntary organizations providing the types of services described in subsection (b).

NUTRITION SCREENING AND ASSESSMENT

Nutrition Screening Initiative Checklist and Mini Nutritional Assessment

Nutrition screening is a first step in identifying individuals at nutritional risk or with malnutrition. Screening tools, such as the Nutrition Screening Initiative (NSI) and the "Mini Nutritional Assessment" (MNA) have been used in different settings to screen older adults for nutrition risk. The [NSI Checklist](#) was designed to increase older adults' awareness about nutrition and health. The [Mini Nutrition Assessment \(MNA®\)](#) was designed to identify older adults (>65 years) at risk of malnutrition. Both help differentiate among adequate nutritional status, malnutrition risk, and malnutrition.

Title III, Section 339 of the OAA requires that nutrition projects provided nutrition screening. The AoA as part of its reporting requirements in the State Performance Report requires that states report on nutrition risk status of individuals who receive home-delivered and congregate meals, nutrition counseling, and/or case management. The *NSI Checklist*, was initially developed as a public awareness tool. AoA does not require that the *NSI Checklist* be used verbatim. States can organize the questions in their own client assessment instruments or add to the 10 checklist questions. However, AoA requests that States report, through NAPIS, the 10 questions and the related score for consistency from state to state.

Under ideal circumstances when an older adult is identified as being at nutritional risk, it is recommended that a referral be made to a dietitian. A dietitian then conducts a nutrition assessment to obtain more specific information regarding the individual's anthropometric, biochemical, clinical, dietary, psychosocial, economic, functional, mental health, and oral health status. Nutrition screenings and/or assessments may be administered at a individual's home, congregate dining center, health fair, doctor's office, etc. Such information is necessary to develop a care plan that will best meet the needs of the individual and his/her situation. Care plans include interventions, expected outcomes, and monitoring strategies.

Although there are nutrition programs that refer to the dietitians they employ, many nutrition programs do not have dietitians and thus have to refer to a dietitian in their local communities. These referrals may be made to dietitians in outpatient clinics, hospitals, health clinics, home health agencies or dietitians in private practice.

The [National Evaluation of the Older Americans Nutrition Program 1993-95](#) (7) found that only 25% of Title III congregate dining sites offered nutrition screening and that a registered dietitian administered the screening at about half of those sites. The *National Evaluation* found 64% of congregate and 88% of homebound participants at moderate to high nutrition risk, using an approximation of the *NSI Checklist*. About 66% were either under- or overweight, placing them at increased risk for nutritional and health problems. Over 50% of participants usually ate alone and about 25% ate fewer than 3 meals per day. One in 3 had an illness/condition that required a special diet. Forty-one percent of the homebound clients could not prepare meals. About 25% of congregate participants and more than 75% of the homebound clients had difficulty doing everyday tasks (7).

Today, nutrition screening of congregate and homebound participants is routine at most OAA Nutrition Programs. The National Aging Program Information System (NAPIS) reporting requirements are being revised. Once the revision is complete, this section will be updated. It is anticipated that nutrition screening will be included in the revision.

[Title III and Title VII State Program Reports Definitions](#)

[Questions and Answers About the National Aging Program Information System \(State Performance Reports\)](#)

Performance Outcomes Measures Project (POMP)

The AoA continues to develop and field-test a core set of performance measures for state and community OAA programs. Called the Performance Outcomes Measures Project (POMP), this project will help SUAs and AAAs address their own planning and reporting requirements, while assisting AoA to meet the accountability provisions of the Government Performance and Results Act (GPRA). POMP developed measures for 8 client-service domains. The nutritional risk performance measure can be used to determine whether a nutritional service, such as home delivered meals or congregate meals, helps to sustain or improve the nutritional status of clients over time. The Nutrition Performance Indicator and other performance indicators are available at: <http://www.gpra.net/main.htm>

Older Americans Act 2000 Requirements

SECTION 339 Nutrition

(2) *ensure that the project ---*

(J) provide for nutrition screening and, where appropriate, for nutrition education and counseling.

SUA Standards/Guidelines: Screening and Assessment

Utah

The State developed a screening system using the NSI DETERMINE Checklist as part of a complete process to identify needs and make appropriate referrals ([link to this document](#)).

Delaware

- At least once a year, all homebound clients will complete a nutrition screening checklist provided by the Delaware Division of Services for Aging and Adults with Physical Disabilities. Appropriate counseling, nutrition information and/or referrals will be offered to all high-risk clients. Clients designated as high-risk will be contacted within six months of the screening.*
- All congregate clients will be offered the opportunity to complete a nutrition screening checklist provided by the Delaware Division of Services for Aging and Adults with Physical Disabilities (DSAAPD). At least once a year, clients will complete the checklist and be provided with appropriate counseling, information or other interventions. Those designated as high-risk will be contacted within six months of the nutrition screening.*

Nutrition Screening Tasks

Homebound Clients

- Provide copies of a DSAAPD-approved checklist to all homebound clients at least once. All new clients should complete a checklist as well as all current clients, on an annual basis.*
- Checklists will be scored and separated according to risk status*
- All high-risk clients will be provided with appropriate nutrition education materials, dietary counseling or other interventions) as deemed necessary.*
- Those clients identified as high-risk must be contacted within six months to re-evaluate their status and provide necessary counseling/referrals.*
- All clients receiving nutritional supplements must be visited at least once a year to assess their, status. If possible, weight should be determined.*

- *Clients receiving nutritional supplements must be contacted by telephone at least every four months. A home visit may substitute for this phone contact.*
- *Printed nutrition education topics should be developed, based on responses to the checklist.*
- *Accurate records of screening activities will be maintained.*
- *Quarterly reports of screening activities will be prepared and sent to the Delaware Nutrition Screening Program (DNSP) Coordinator. Information will be forwarded to the DSAAPD Nutritionist.*

Congregate Clients

- *Provide copies of a DSAAPD-approved checklist to all congregate clients at least once a year.*
- *Contact high-risk clients within six months of screening to reevaluate nutritional status.*
- *Score checklists and separate according to risk status.*
- *Provide all high-risk clients with appropriate nutrition education materials, dietary counseling or other intervention as deemed necessary.*
- *Contact clients receiving adult nutritional supplements every four months.*
- *Develop group nutrition education topics based on responses from the nutrition screening checklists.*
- *Provide on-going support groups for diabetes and other relevant topics.*
- *Maintain accurate records of activities.*
- *Prepare quarterly report of screening activities and send to the Delaware Nutrition Screening Program (DNSP) Coordinator. Information will be forwarded to the DSAAPD Nutritionist.*

Documentation of Nutrition Screening Activities

- *Completed and scored checklists will be kept on file at the agency.*
- *Educational materials mailed and/or nutritional counseling provided will be noted on the client's checklist.*

- *Where possible, contacts related to nutrition screening will be noted in the client's chart.*
- *Number of total and high-risk clients will be calculated.*
- *Contacts made with non-risk and high-risk clients will be documented.*
- *Attendance at support groups and nutrition programs must be maintained.*
- *Quarterly reports must be submitted to the DNSP Coordinator*

North Dakota

All congregate and home-delivered meals clients must be screened for nutritional risk using the Nutrition Screening Checklist, which is part of the Adult Services Intake Form.

- *The screenings should be conducted a minimum of one time during the contract agreement.*
- *Data on the number of clients screened 'at high nutritional risk' will be reported on the Adult Services Intake Form.*

NUTRITION COUNSELING/MEDICAL NUTRITION THERAPY

"Eighty-seven percent of older Americans have either diabetes, hypertension, dyslipidemia, or , or a combination of these chronic diseases" (1). These can be successfully managed with appropriate nutrition interventions that will improve health and quality of life outcomes. Nutrition counseling or medical nutrition therapy (MNT) is the provision of individualized comprehensive guidance to persons who are at nutritional risk because of their health or nutritional history, dietary intake, medications use, or chronic illnesses. It takes into consideration the client's desires, health, cultural, socio-economic, functional, and psychological factors, as well as home and caregiver resources. Nutrition counseling is provided in accordance with state law and policy. It provides individuals with options and methods for improving their nutritional status. The Institute of Medicine recommended that MNT be provided by registered dietitians as part of the health-care team (1). In 2000, Medicare coverage was expanded by Congress to include registered dietitians providing MNT to diabetes and renal disease patients.

Insurance Coverage for Medical Nutrition Therapy (MNT)

The availability of nutrition services under Medicare, Medicaid, and private insurers is expanding. Increasing health care and consumer demand for MNT provides dietitians an opportunity to expand nutrition counseling services. Understanding funding sources for nutrition services by [Medicare](#), [Medicaid](#), [managed care organizations](#) (MCOs), and in [alternate care settings](#) is essential. Obtaining payment from these insurers involves learning the language of reimbursement, including [coding systems](#) and [billing essentials](#). Selected reimbursement resources are highlighted in a [reimbursement bibliography](#). Each affiliate and several Dietetic Practice Groups (DPGs) have a reimbursement representative. For the name of your state's affiliate/DPG reimbursement representative, contact the affiliate/DPG directly or e-mail reimburse@eatright.org for the name and for answers to specific reimbursement questions.

Registered and Licensed Dietitian Credentials

A number of States require nutrition education and/or counseling (MNT) to be provided by or under the direction of a registered and/or licensed dietitian/nutritionist. [Registered dietitians](#) (RDs) are food and nutrition experts who have completed a minimum of a bachelor's degree at a US regionally accredited university or college and course work approved by the Commission on Accreditation for Dietetics Education (CADE) of the American Dietetic Association (ADA), completed a CADE-accredited or -approved supervised practice program at a healthcare facility, community agency, or a foodservice corporation, or combined with undergraduate or graduate studies, passed a national examination administered by the Commission on Dietetic Registration (CDR), and complete continuing professional educational requirements to maintain registration (8). Medicaid and Medicare nutrition services often require the use of a registered and/or licensed dietitian/nutritionist. The ADA provides a number of resources concerning [State Professional Regulation](#) (9).

The ADA defines licensing as statutes that include an explicitly defined scope of practice. Performance of the profession is illegal without first obtaining a license from the state. Statutory certification limits the use of particular titles to persons meeting predetermined requirements, while persons not certified could still practice the occupation or profession. Registration is the least restrictive form of state regulation. As with certification, unregistered persons may be permitted to practice the profession if they do not use the state-recognized title. Typically, exams are not given and enforcement of the registration requirement is minimal (9).

Older Americans Act 2000 Requirements

SECTION 339 Nutrition

(2) ensure that the project ---

(J) provide for nutrition screening and, where appropriate, for nutrition education and counseling.

Sample SUA Nutrition Counseling Standards/Guidelines

Kansas

Provision of individualized advice and guidance to individuals who are at nutritional risk because of their health or nutritional history, dietary intake, medications use or chronic illnesses, about options and methods for improving their nutritional status, performed by a health professional in accordance with state law and policy.

Nebraska

- *A more specialized activity which may be included as a component of the nutrition education program is dietary screening and counseling.*
- *Dietary screening and counseling is the process of providing individualized and group professional guidance to assist people in adjusting their daily food consumption to meet their health needs. The objective is modification of behavior. This objective is accomplished when individuals understand how to make wise food choices.*
- *Dietary screening and counseling is a component of a nutritional care program in which a Registered Dietitian gives professional guidance to an individual, working with the individual's physician as appropriate. The service includes:*
 - *Assessing present food habits, eating practices and related factors.*
 - *Developing a written plan for appropriate dietary screening and counseling. Translating the written plan into a daily meal plan with the individual.*
 - *Planning follow-up care and evaluating achievement of objectives.*

Florida

Individuals to receive counseling may be identified through a screening/intake process, self-referred, or referred by a caregiver or other concerned party. A licensed dietitian/nutritionist (LD/N) or a Registered Diet Technician (RDT) under the supervision of

a LD/N evaluates the participants nutritional needs, conducts a comprehensive nutrition assessment, and develops a nutrition care plan in accordance with Chapter 64B8-43, Florida Administrative Code. Based on the individual's needs and with appropriate contact with the individual's physician and caregiver, the LD/N develops and implements or supervises the development and implementation of the nutrition care plan.

Nutrition counseling shall be provided by a Licensed Dietitian (LD/N) (Chapter 468 Part X, Florida Statutes, Dietetics and Nutrition Practice, Chapter 468.504, Florida Statutes) who is covered by liability insurance. A Registered Dietetic Technician may assist the LD/N in the screening and assessment process.

Licensed Dietitians/Nutritionists shall keep applicable written participant records that shall include the nutrition assessment, the nutrition counseling plan, dietary orders, nutrition advice, progress notes, and recommendations related to the participant's health or the participant's food or supplement intake, and any participant examination or test results, in accordance with Chapter 64B8-44, Florida Administrative Code.

NUTRITION EDUCATION

Nutrition education helps promote health and prevent disease. Research confirms that well-designed, behavior-focused interventions can effectively improve diets and nutrition-related behaviors. OAA Nutrition Programs provide unique opportunities to deliver nutrition and healthy lifestyle messages to older adults. Nutrition education is essential for helping older adults achieve and maintain optimal nutrition status. Older adults are eager for health information and tend to be active in community health promotion programs. Therefore, nutrition education activities are well received by older adults especially if these activities are developed according to their needs, behaviors, motivations, and desires.

Nutrition education, by a dietitian (or individual of comparable expertise), provides accurate and culturally sensitive nutrition, physical fitness, and health (as it relates to nutrition) information and instruction to participants and/or their caregivers in groups or individually. (See [Chapter II: Definitions](#)). Nutrition education programs must go beyond providing information alone. To be effective, programs must incorporate methods for creating behavior change (10). To do so, nutrition education must be provided on a continuous basis to OAA Nutrition Program participants. As the OAA does not specify the frequency of providing nutrition education, the SUAs may specify this in their policies and procedures.

Although nutrition education is a fundamental OANP component, there are few nutri-

tion education tools for older participants and there has been minimal assessment of their effectiveness. Older adults are willing to change their eating habits when they understand the benefits. They are more receptive to the positive messages of health promotion and disease prevention through better nutrition (11-13). Many older adults are in the pre-contemplation stage of change for losing weight and exercising (14). Nutrition education based on appropriate behavior change and adult learning theories is more likely to be effective. It is recommended that resources be allocated to develop and evaluate nutrition materials and methods. OAA Nutrition Programs can take the lead in demonstrating how to effectively reach older adults in congregate sites and homes with important nutrition information that helps maintain independence and quality of life. Topics could include eating healthy to prevent or treat disease(s), interpreting nutrition messages in the media (15), hydration (16,17), avoiding unintended weight loss, changing nutrient needs with age, drug/nutrient interactions, keeping caregivers nutritionally healthy, etc.

The 1995 *Journal of Nutrition Education* Special Issue included a chapter on the effectiveness of nutrition education in older adults (18). The extensive search revealed only 14 nutrition education intervention studies that had acceptable evaluation criteria and measured behavioral outcomes. The authors attributed this lack of evaluation "partly due to the fact that, although nutrition education is mandated as part of some federal food programs for older adults, evaluations of such efforts are not required." The lack of clarity and ambiguity regarding the goals for nutrition education for older adults was also noted. Consortiums in several states, such as Kansas (19), Ohio (20), and Georgia (21), have recently developed nutrition education programs for older adults and there is interest in evaluating their effectiveness. Many more are needed, especially those that are culturally and ethnically diverse.

There are a variety of theoretical framework models (see below) that can be used to develop nutrition education strategies to achieve a change in nutrition-related behaviors (22). These include:

- Knowledge-attitude-behavior model: A gain in new knowledge leads to changes in attitude, which, in turn, result in improved dietary behavior or practices. The knowledge provided must be motivational for changing attitudes and behaviors.
- Health belief model: Emphasizes perceived threat as a motivating force and perceived benefits as providing a preferred path to action.
- Social learning theory: Emphasizes the interactive nature of the effects of cognitive and other personal factors and environmental events on behavior.

- Marketing model: An aggregate of functions involved in moving goods from the producer to the consumer.
- Social marketing model: The use of marketing concepts and tools to increase the acceptability of social ideas or practices.
- Social action model: Uses conflicting and advocacy approaches to change powerful interests and defend victims (22).

Nutrition education needs to be culturally appropriate. The Ask the Experts [Cultural Diversity as Part of Nutrition Education and Counseling](#) helps guide to individuals providing nutrition services to ethnic and cultural groups. A "one size fits all" program is not usually effective. To target diverse participant groups, use print and broadcast media, nutrition contests, table tents in the dining room, group nutrition education classes, clinic based programs, food taste testing sessions, nutritious potluck dinners, etc. Other innovative approaches include nutrition-through-gardening and computerized programs. Many ideas and suggestions could be successfully implemented with various groups, including home-delivered and congregate meal participants. Refer to the [American Dietetic Association](#), [Cooperative Extension Services](#) including the [University of Nebraska Cooperative Extension](#) and [Nutrition for Older Adults Health](#) (NOAHnet from the University of Georgia) for nutrition education resources as well as those on the Center's Resources section online.

Measuring the Success of Nutrition Education and Promotion in Food Assistance Programs: <http://www.usda.gov/cnpp/FENR%20V11N3/fenrv11n3p68.PDF>

Older Americans Act 2000 Requirements

SEC. 214. NUTRITION EDUCATION.

The Assistant Secretary and the Secretary of Agriculture may provide technical assistance and appropriate material to agencies carrying out nutrition education programs in accordance with section 339(2)(J).

Sample SUA Nutrition Education Standards/Guidelines

Florida

Nutrition and related client and health instruction or information is provided by or under the direction of a licensed dietitian at each congregate site and distributed to each home-delivered meal participant a minimum of two times per year, with at least 3 months between each session.

Congregate Nutrition Education is a formal program of regularly scheduled health promotion presentations on culturally sensitive nutrition, or physical fitness, or health as they relate to nutrition information and instruction to participants in a group setting. Home Delivered Nutrition Education is a formal program of regularly scheduled individual distribution of health promotion information on culturally sensitive nutrition, or physical fitness or health as they relate to nutrition topics.

Nutrition education shall be planned and directed by a licensed dietitian/nutritionist (LD/N) (Chapter 468.504, Florida Statutes) who is covered by liability insurance. Under the direction of the dietitian, individuals with comparable expertise or special training, e.g., Cooperative Extension agents or trained Meal Site Coordinators, may provide such education activities. An individual with comparable expertise is defined as a person who has a Bachelor's or Master's degree in Home Economics, Family and Consumer Sciences, or Human Sciences with an emphasis in Nutrition and Dietetics. An annual nutrition education plan/schedule is developed. Participants' needs, comments and requests are considered when planning programs. Teaching methods and instructional materials must accommodate the older adult learner, e.g., large print handouts, demonstrations. Other resources are used to enhance programming as appropriate, e.g., Dairy Council, Cooperative Extension.

Kansas

A program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants or participants and caregivers in a group or individual setting overseen by a dietitian or individual of comparable expertise.

Nevada

- *Nutrition education services shall be provided no less than semi-annually to congregate and home-delivered meal participants*
- *The goal of nutrition education is to provide older persons with information that will promote improved food selection, eating habits and health related practices.*
- *Documentation shall include:*
 - *date of presentation or distribution of materials*
 - *name and title of presenter or title of materials distributed*
 - *topic discussed (if applicable)*
 - *number of persons in attendance*

If materials are delivered to homebound participants, documentation shall include date of distribution, copy of distributed material, and number of participants receiving the information.

Nebraska

- *Nutrition education is the process by which individuals gain the understanding, skills, and motivation necessary to promote and protect their nutritional well-being through their food choices.*
- *Each congregate and home-delivered meal nutrition project shall provide nutrition education a minimum of twice each year as an important and integral part of providing nutrition services to older individuals.*
- *It is recommended that nutrition education be provided quarterly to congregate and home-delivered meal participants.*
- *Nutrition education services shall be planned for congregate and home-delivered participants in accordance with AAA nutrition policy.*
- *All nutrition education plans, activities, and materials shall be approved by the nutrition coordinator and/or dietitian prior to presentation.*
- *Nutrition education services shall be provided by a dietitian or by someone of comparable expertise.*

Nutrition Education Goals

- *To create positive attitudes toward good nutrition and provide motivation for improved dietary practices conducive to promoting and maintaining the best attainable level of wellness for an individual.*
- *To provide adequate knowledge and skills necessary for critical thinking regarding diet and health so the individual can make appropriate food choices from an increasingly complex food supply.*
- *To assist the individual to identify resources for continuing access to sound food and nutrition information.*

Nutrition Education Content

- *Food, including the kinds and amounts of food that are required to meet one's daily nutritional needs.*
- *Nutrition, including how it relates to successful aging.*
- *Behavioral practices, including the factors which influence one's eating and food preparation habits.*
- *Consumer issues, including eating alone, cooking for one, and how to eat well on a limited income.*
- *Diet and disease relationships including risks for high blood pressure, heart disease, stroke, certain cancers, and diabetes.*
- *Examples of nutrition education activities include: cooking classes, food preparation demonstrations, field trips, plays, lectures, panel discussions, planning and/or evaluating menus, debates, food tasting sessions, question and answer sessions, gardening, physical fitness programs, motion pictures,*

CARE MANAGEMENT/CASE MANAGEMENT

Care management is often referred to as "case" management, but the more socially acceptable phrase is care management. Care management provides an important framework for assessing participant needs and arranging for the delivery of services. For this reason, care management often transcends the boundaries of OAA services and assist participants in accessing other programs and services such as housing assistance, the Low Income Home Energy Assistance Program (LIHEAP), Medicaid, Social Security Income (SSI), and the Food Stamp Program.

Care management in the community setting aims to incorporate the range of medical, social, nursing, psychological and supportive services to maintain older adults in their homes and communities, i.e., to avoid both acute and long-term institutionalization (23). Through care management, the needs of each individual are assessed, a plan of services to meet those needs are developed, the delivery of services are arranged and monitored, and the effectiveness and need for continuation of services are evaluated.

Care managers work with clients to ensure that a care plan matches needs, values, and preferences. It is preferred that care managers refer older individuals at nutritional risk to a dietitian/nutritionist. This is a comprehensive way of providing nutrition

assessment and appropriate interventions rather than simply referring for meal services. Nutrition care management identifies the specific nutritional needs of participants and arranges for nutrition interventions, such as home-delivered meals, nutrition education, diet modification, adaptive eating devices, and medical nutrition therapy.

Nutrition care management of an older person helps prevent or delay chronic diseases and their complications, maintain or improve immune function and resistance to infection, shorten hospital stay, decrease surgical risk and postoperative complications, speed wound healing and recovery, and ultimately decrease health care utilization and costs (23).

Older Americans Act 2000 Requirements

SEC 321

PART B-SUPPORTIVE SERVICES AND SENIOR CENTERS PROGRAM AUTHORIZED

(5) services designed to assist older individuals in avoiding institutionalization and to assist individuals in long-term care institutions who are able to return to their communities, including--

(A) client assessment, case management services, and development and coordination of community services;

(B) supportive activities to meet the special needs of caregivers, including caretakers who provide in-home services to frail older individuals; and

(C) in-home services and other community services, including home health, homemaker, shopping, escort, reader, and letter writing services, to assist older individuals to live independently in a home environment.

PART E-NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM

SEC 373 Program Authorized

(b) SUPPORT SERVICES- The services provided, in a State program under subsection (a), by an area agency on aging, or entity that such agency has contracted with, shall include-

(3) individual counseling, organization of support groups, and caregiver training to caregivers to assist the caregivers in making decisions and solving problems relating to their caregiving roles.

SEC 373 (b) SUPPORT SERVICES- The services provided, in a State program under subsection (a), by an area agency on aging, or entity that such agency has contracted with, shall include-(5) supplemental services, on a limited basis, to compliment the care provided by caregivers.

Sample SUA Care/Case Management Standards/Guidelines

Tennessee

A service designed to help older individuals to assess the needs, and to arrange, coordinate, and monitor an optimum package of services to meet the needs of the older individual.

The program must individualize the situation of persons being served by such means as case assessment or diagnosis, periodic reassessment and, sometimes, counseling or, at least, effective communicative relationships between a worker and a client. The program should provide continuity and comprehensiveness of service to special subgroups of multi-problem clients through such activities as assigning a case manager or service team, maintaining a client-oriented tracking system, or arranging case conferences. While such case coordination also needs to occur within a single agency with multiple services to offer, this definition is restricted to those case coordination efforts which must involve other agencies in providing services on a client-by-client basis in a harmonious way by referral, purchase of service, written agreements, case advocacy, or appeals.

SERVICE ACTIVITIES: (REQUIRED)

Comprehensive assessment of the older individual - Administering structured assessment instruments) which has been approved by the state agency to gather information about a participant to determine need and/or eligibility for services. Information collected must include health and nutritional status, financial status, activities of daily living status, physical environment, and social support system.

Development and implementation of a service plan with the older individual to mobilize the formal and informal resources and services identified in the assessment to meet the needs of the older individual, including coordination of the services and resources. Includes technical review and analysis of facts concerning an individual's social, psychological and physical health problems for the purpose of determining the types of services needed and resulting in a written plan for services and assistance. Purchasing services and/or arranging services with formal and informal service providers, including family, friends, and volunteers to perform services needed by the participant is also included.

Coordination and monitoring of formal and informal service delivery including activities to ensure that services specified in the plan are being provided.

Periodic reassessment and revision of the plan based on changes in the status of the individual or his/her circumstances. Consists of evaluating the appropriateness and/or

effectiveness of service in meeting individual participant needs, includes the convening of case conferences and the joint review of care plans, when necessary.

Intake Screening

Each case management program must have uniform intake procedures and maintain consistent records. Intake may be conducted over the telephone. Intake records for each participant must include at a minimum:

Individual's name, address, and telephone number;

Individual's age or birthday;

Physician's name, address, and telephone number;

Name, address, and phone number of person, other than spouse or relative with whom individual resides, to contact in case of emergency;

Handicaps, as defined by Section 504 of the Rehabilitation Act of 1973, or ether diagnosed medical problems;

Perceived supportive service needs as expressed by individual or his/her representatives;

Race;

Sex;

Whether or not the individual has an income at or below the poverty level for intake and reporting purposes.

If intake indicates that needs can be met by a single service, the individual should be provided Information and Referral Services. When intake suggests multiple service needs, a comprehensive individual assessment of need must be performed within ten (10) working days of intake.

Assessments

All assessments and reassessments must be conducted in person. Each assessment should provide as much of the following information as is possible to determine:

(Note: Caseworkers must attempt to acquire each item of information listed, but must also recognize and accept the client's right to refuse to provide requested items)

Basic Information

- Individual's name, address, and telephone number;*
- Age, date, and place of birth;*
- Gender*

- *Marital status;*
- *Minority status (African American, Hispanic, American Indian/Alaskan, Asian/Pacific Islanders, Non-minority)*
- *Living arrangements; (living alone or with others)*
- *Condition of environment;*
- *Income and other financial resources, by source (including SSI);*
- *Expenses; and,*
- *Religious affiliation, if applicable.*

Functional Status

- *ADL/IADL Status -- number and type of limitations in activities in daily living and instrumental activities of daily living;*
- *Cognitive impairment;*
- *Vision;*
- *Hearing;*
- *Speech;*
- *Oral status (condition of teeth, gums, mouth, and tongue).;*
- *Prostheses;*
- *Psychosocial functioning;*
- *History of chronic and acute illness;*
- *Nutrition Screening risk status and diet restrictions, if any; and,*
- *Prescriptions, medications, and other physician orders.*

Supporting Resources

- *Physician's name, address, and telephone number;*
- *Pharmacist's name, address, and telephone number;*
- *Services currently receiving or received in past (including identification of those funded through Medicaid);*
- *Extent of family and/or informal support network;*
- *Hospitalization history;*
- *Medical/health insurance available; and,*
- *Clergy name, address and telephone number, if applicable.*

Need Identification

- *Participant/family perceived;*
- *Assessor perceived and/or identified from referral source/professional community; and,*
- *Each participant is to be reassessed every six months, or as needed, to determine the results of implementation of the care plan. If reassessment determines the participant's identified needs have been adequately addressed, the case should be closed.*

Care Plan

A written care plan must be developed for each person determined in need of and eligible for case management. The care plan must be developed in cooperation with and be approved by the participant (or participant's guardian or designated representative, if applicable). The care plan must contain at a minimum:

- *statement of the participant's problems, needs, strengths, and resources;*
- *Statement of the goals and objectives for meeting identified needs;*
- *Description of methods and/or approaches to be used in addressing needs;*

- *Identification of services to be provided by other agencies and the service schedules;*
- *Treatment orders of qualified health professional, when applicable.*
- *Participants with unmet health needs (physical or mental) are to be referred to appropriate health care provider(s).*
- *Each program must have a written policy/procedure to govern the development, implementation, and management of care plans.*

Record Keeping

Each program must maintain comprehensive and complete case files which include at a minimum:

- *Details of participant's referral to case management program;*
- *Intake records;*
- *Comprehensive individual assessment and reassessment;*
- *Care Plan (with notation of any revisions);*
- *Listing of all contacts (dates) with participants (including units of service per participant);*
- *Case notes in response to all participant or family contacts (telephone or personal);*
- *Listing of all contacts with service providers on behalf of participant;*
- *Comments verifying participant's receipt of services from other providers and whether service adequately addressed participant need; and,*
- *Record of release of any personal information about the participant and copy of signed release of information form.*
- *In order to maintain confidentiality, all case files must be stored in controlled-access files. Each program must use a standardized release of information form, which is time limited and specific as to the information being released.*

HEALTH PROMOTION/DISEASE PREVENTION and WELLNESS ACTIVITIES

Health promotion and disease prevention programs are key to helping improve the health of Americans. National programs such as the [President's Healthier US Initiative, USA on the Move: Steps to Healthy Aging](#) and *Healthy People 2010* recognize the importance of activities that promote health and address the relationship between nutrition, physical activity, and chronic disease (1). Health promotion and disease prevention programs help minimize health-related risk factors associated with aging. The programs can help older adults understand the factors associated with optimal psychosocial and physical well-being and provide resources to help them cope with the psychological and physical changes of aging (24).

Health promotion programs for older adults focus on increasing control over and improving their health in a variety of areas; for example, nutrition, physical activity, mental health, alcohol and substance reduction, tobacco use. Wellness programs--a type of health promotion program--involve all aspects of the individual: mental, physical, and spiritual. Both types of programs provide structured opportunities to increase knowledge and skills in specific areas, such as stress management, or environmental sensitivity. The supportive environment nurtures the emotional and intellectual aspects of participants, and helps them become increasingly responsive to their health needs and quality of life (7). These programs are usually short-term and educational rather than therapeutic in nature.

A sedentary lifestyle, due to age, depression, obesity, arthritis, stroke or respiratory diseases, is a major risk factor for disability in older adults (25-28). Research supports the importance of physical activity in reducing the risk of these debilitating conditions (26-32). The well documented benefits of physical activity include increased appetite, increased mobility and flexibility, and improved muscle strength and aerobic capacity (33). Active participants have better dietary intakes, improved functional capacity to perform activities of daily living, reduced risk for falls, improved bone health, and improved responses to coronary heart disease, hypertension, diabetes, and osteoarthritis than their non-active counterparts (26-31).

According to *National Evaluation*, 80% of nutrition sites that provided recreation and social activities (or 67% of all congregate sites) offered these activities at least twice per week (7). Physical activity programs were included in this category but were not listed as a separate activity. The Surgeon General, supported by American Association of Retired Persons (AARP), the American College of Sports Medicine, the American Geriatrics Society, the National Institute on Aging, the Center for Disease Control and Prevention, and the Office of the Assistant Secretary for Planning and Evaluation

in the US Department of Health and Human Services, recommend community-based physical activity programs or community activities that include physical activity opportunities to achieve health benefits in older adults (31,34,35). Some congregate nutrition programs offer resistance training (e.g., strength training via free-weights or machines), endurance training (e.g., aerobics, walking, swimming), flexibility training (e.g., stretching, yoga), and balance training (e.g., Tai-chi). These help older adults in their pursuit of a healthy lifestyle (33,36).

The [2000 Dietary Guidelines for Americans](#) (DGs) is an essential health promotion/disease prevention document that focuses on the relationship between nutrition, food, health, and physical activity. The *Dietary Guidelines* provide consumers and professionals good information about nutrition and physical activity. Because the OAA requires compliance with the *Dietary Guidelines*, this document can assist states, AAAs, and local providers to address nutrition and physical activity in their programs.

A [National Survey of Health and Supportive Services in the Aging Network](#), by the National Council on the Aging (Summer 2001) describes the impact of organizations in improving health outcomes and supporting older people in their homes (37). It shows the vitality and diversity of agencies and services in the aging network. It illuminates the range of innovative services in diverse settings and geographic areas. For example, these programs operate in clinics, churches, community centers and in residences of the homebound in inner cities, urban, suburban and rural areas. It identifies the resourcefulness of agencies in recruiting and employing certified professionals and engaging well-trained volunteers. The study reports successes in measuring program outcomes via positive changes in health status, health practices, and quality of life. These high quality programs make extensive use of partnerships to leverage funding and meet participant needs. More than 50% partner with health care providers. Others partner with universities, public agencies, and local businesses. Cost sharing is common with 67% reporting fees and donations as important funding sources.

Examples of Wellness and Physical Activity Programs

[Steps to Healthy Aging: Eating Better and Moving More](#) is a two-part program designed to improve nutrition and physical activity in older adults. It is sponsored by AoA and the National Policy and Resource Center on Nutrition and Aging. Simple, modest increases in daily activities can improve overall health, prevent disease and disability, and reduce health care costs for our nation. The *Steps to Healthy Aging: Eating Better and Moving More Guidebook* will be available in late 2003.

The *Ask the Experts* [Wellness Activities for Older Adults](#) has examples from a wide variety of organizations and agencies. It summarizes objectives and activities of specific programs. It includes topic suggestions and additional resources such as state and county health departments, cooperative extensions, hospitals and health clinics, colleges and universities, health care practitioners, federal and state public health agencies, and other agencies, organizations, and businesses in relation to specific diseases, services, and/or products.

Information from the National Policy and Resource Center on Nutrition and Aging:

[Hotlinks: Nutrition / Health Information](#)

[Resources: Education and Health Promotion](#)

[Bibliographies: Education and Health Promotion](#)

The Role of Dietitians/Nutritionists in Health Promotion and Disease Prevention

It is the position of the American Dietetic Association that health promotion and disease prevention endeavors are the best population strategies for reducing the current burden of chronic disease. Dietetics professionals should be actively involved in promoting optimal nutrition in community settings and should advocate for the inclusion of healthy eating, in addition to other health-promoting behaviors, in programs and policy initiatives at local, state, or federal levels (13).

There is an increasing need for nutrition services in OAA Nutrition Programs because so many older adults have chronic conditions which can be managed with appropriate nutrition interventions. Dietitians and nutritionist are the primary information resource regarding the relationships among diet, health, and disease prevention. When OAA Nutrition Programs integrate *Healthy People 2010* into their programs, dietitians and nutritionists are vital to helping meet these objectives. They can contribute significantly to the design, delivery, and evaluation of health programs and services in the OAA Nutrition Program.

Older Americans Act 2000 Requirements

Part B-Supportive Services and Senior Centers Program.

Section 321

(a) The Assistant Secretary shall carry out a program for making grants to States under State Plans approved under section 307 for any of the following supportive services:

(1) health (including mental health), education and training, welfare, informational,

recreational, homemaker, counseling, or referral services:

(7) services designed to enable older adults to attain and maintain physical and mental well-being through programs of regular physical activity, exercise, music therapy, art therapy, and dance-movement therapy;

(8) services designed to provide health screening to detect or prevent illnesses, or both, that occur most frequently in older individuals;

(17) health and nutrition education services, including information concerning the prevention, diagnosis, treatment, and rehabilitation of age-related diseases and chronic disabling conditions...

Part D - Disease Prevention and Health Promotion Services Program

Section 361

(a) *The Assistant Secretary shall carry out a program for making grants to States under State Plans approved under section 307 to provide disease prevention and health promotion services and information at multipurpose senior centers, at congregate meal sites, through home-delivered meals programs, or at other appropriate sites. In carrying out such programs, the Assistant Secretary shall consult with the Directors of the Centers for Disease Control and Prevention and the National Institute on Aging.*

(b) *The Assistant Secretary shall, to the extent possible, assure that services provided by other community organizations and agencies are used to carry out the provisions of this part.*

Sample SUA Health and Wellness Standards/Guidelines

Pennsylvania

Primetime Health Program: Philosophy and Goals:

PrimeTime Health is unique in that it is the first substantial effort by the national aging network to increase efforts at disease prevention. Providing support and education to older people before they become ill is a creative and cost-effective way to reduce the demand for medical treatment. The Department believes this affords an important opportunity for the network to attract a new, sometimes younger and healthier clientele into the aging services system. As such, PrimeTime Health can play an especially significant role in senior community center revitalization.

The Department's primary intent was, and is, to creatively assist AAAs to develop their local programs. Paperwork and reporting requirements remain minimal. The major source of PrimeTime Health funding comes from the Federal Older Americans Act which provides overall direction on the use of health promotion funding. The Department has the responsibility to insure that PrimeTime Health operates within these

guidelines.

PROGRAM REQUIREMENTS:

Each AAA is responsible for the continued delivery of a local PrimeTime Health Promotion program. Each AAA must:

(A) Retain one or more individuals to provide local health promotion services. Staff may or may not be attached to the AAA complement. In fact, attaching such staff senior centers or other appropriate community organizations is encouraged. AAAs with large grants are encouraged to dedicate a portion of their PrimeTime funds to pay for a health promotion specialist to concentrate on the coordination of health promotion activities.

(B) Establish a PrimeTime Health Advisory Committee consisting of older adults, representatives from community health organizations, senior community center directors, physicians and other health care providers, agencies serving older adults, local businesses, local, community clubs and associations, the PrimeTime Health Coordinator and other interested individuals. This committee should meet at least twice a year to discuss goals and plans for the program. This committee may be a subcommittee of an existing AAA advisory committee.

The purpose of this advisory committee is to create a sense of community ownership for this program so that the community sees this as something they are doing for older adults. Committee members should be encouraged to make their resources available to the program. This committee is to be advisory in nature. The AAA maintains policy control of the program.

Establish yearly program goals within one or more of the allowable state?level priority areas including activities outlined in the Federal Older Americans Act. These activities include: health risk assessments; routine health screening; nutritional counseling; health promotion programs, including programs relating to chronic disabling conditions such as alcohol and substance abuse reduction, smoking cessation; weight loss and control, and stress management; physical fitness including group exercises, music, art, dance movement programs and multi-generational health and fitness programs; home injury control services; screening for prevention of depression and coordination of community mental health services; medication management screening and education; information on age?related diseases and chronic disabling conditions; education programs, including programs on the appropriate use of preventative health services; counseling regarding social services and follow?up services; and gerontological counseling.

AAAs may wish to reference *Healthy People 2000* goals, state and local demographic data and consumer interest when establishing goals.

PrimeTime Health funds are not to be used for programs that are purely social or recreational in nature.

(C) Conduct all health promotion activities offered through the aging network under the name *PrimeTime Health*, regardless of how they are funded. We strongly encourage the use of *PrimeTime Health* marketing materials to create a consistent *PrimeTime Health* look and message across the State, so that the name "*PrimeTime Health*" will become well known by older people throughout the Commonwealth. We recognize that there may be times this may be difficult because of funding by outside sources or because an activity has a long standing history under another name. In this case, we ask that, somewhere within the advertisement for the program, a reference be made to *PrimeTime Health*. For example: "*Golden Achiever*, a *PrimeTime Health* Program." Please insure that AAA staff and volunteers who answer the phone are aware of the name and refer calls to the appropriate person? the designated *PrimeTime Health* Coordinator.

(D) Offer activities without charge to participants, if those activities can be directly traced to older Americans Act funding. Voluntary contributions which respect the privacy of each older person may be collected as long as no older person is denied a service because of unwillingness or inability to contribute.

(E) Submit a report at the end of each fiscal year reflecting progress on the AAA goals for the year (see section C above), and the AAA's plans for the following year. The format will be supplied to the AAAs by mid-May of each year, beginning in May, 1998. In reporting activities and persons served during the program year, AAAs are to be guided by the most current SEY reporting document used by the Department.

South Carolina

Disease Prevention and Health Promotion Services

Purpose: To improve the quality of life for older adults and prevent premature institutionalization by:

1. *Maintaining and/or improving health status*
2. *Increasing years of healthy life by minimizing period of morbidity/disability*
3. *Reducing risk factors associated with illness, disability or disease*

4. *Delaying onset of disease*
5. *Preserving functional abilities*
6. *Managing chronic diseases*

The following Disease Prevention and Health Promotion Services have been designated as priority services by the State Unit on Aging:

1. *Routine Health Screening with Counseling and Referral as a component*
2. *Nutrition Risk Assessment Counseling and Follow-up*
3. *Health Promotion Programs*
4. *Physical Fitness Programs*
5. *Home Injury Prevention and Control Services*

Service Activities: All activities shall be performed according to the State Unit on Aging Quality Assurance standards for disease prevention and health promotion services:

1. *Programs and services, appropriate to the client population, consist of planned, progressive activities with measurable client outcomes.*
2. *Programs and/or individual client goals designed to maintain/improve the participants' health status and/or reduce risk of disease are established and progress toward those goals is measured.*
3. *Disease prevention and health promotion services are offered in addition to other program activities conducted in congregate nutrition centers.*
4. *Disease prevention and health promotion services are scheduled at times and in places that allow participation by individuals in need of these specific services.*
5. *Disease prevention and health promotion services are designed and carried out to maintain and/or improve participant health or to reduce risk factors in the targeted population.*

Additional Resources

Nutrition screening, assessment, education, and counseling [Resources](#) and [Bibliographies](#) compiled by the National Policy and Resource Center on Nutrition and Aging.

[Nutrition management and restorative dining for older adults: practical interventions for caregivers. Chicago, IL: American Dietetic Association, 2001.](#)

[Nutrition Care of the Older Adult: A Handbook for Dietetics Professionals Working Throughout the Continuum of Care](#)

<http://www.cdhcf.org/products/index.htm>

[Links to nutrition and health information websites listed by the Center.](#)

PowerPoint Presentations at the AoA SUA Nutritionists/Administrators Conference (June 2002):

- Why Wellness Programs? Jean Friend
- Nutrition Interventions In Wisconsin. Jennifer L. Keeley, WI
- What Do We Do After We Screen? Medical Nutrition Therapy & Other Cutting Edge Nutrition Interventions. Nancy Wellman, Center, Jennifer Keeley, MN, Suhda Reddy, GA, Bonnie Athas, UT.
- Nutrition Can Maintain Function at any Age. Mary Ann Johnson, UGA.

American Dietetic Association: Position Statements

[Total diet approach to communicating food and nutrition information -- Position of the ADA. *J Am Diet Assoc.* 2002;102:100](#)

[Nutrition education for health care professionals -- Position of ADA. *J Am Diet Assoc.* 1998;98:343-346.](#)

[Cost-effectiveness of medical nutrition therapy -- Position of ADA. *J Am Diet Assoc.* 1995;95:88-91.](#)

[Nutrition education for the public -- Position of ADA. *J Am Diet Assoc.* 1996;96:1183-1187.](#)

The role of dietetics professionals in health promotion and disease prevention -- Position of ADA. *J Am Diet Assoc.* 2002;102:1680-1687

Liberalized diets for older adults in long-term care -- Position of ADA. *J Am Diet Assoc.* 2002;102:1316-1323.

References

1. Institute of Medicine (1999). The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population. Executive Summary, Washington, DC.
2. Weddle DO, Fanelli-Kuczmariski M. Position of the American Dietetic Association: Nutrition, aging, and the continuum of care. *J Am Diet Assoc.* 2000;100:580-595.
3. Pastor PN, Makuc DM, Reuben C, Xia H. Chartbook on Trends in the Health of Americans. Health, United States, 2002. Hyattsville, Maryland: National Center for Health Statistics. 2002.
4. Report. Promoting Healthy Eating: An Investment in the Future—A Report to Congress. USDA Food and Nutrition Service. 1999.
5. Members of the HHS New Freedom Initiative Caregiver Support Workgroup. Care-giver Compendium. 2003.
6. Zarit SH. Respite Services for Caregivers. Implementing the National Family Care-giver Support Program (NFCSP). Caregiving Resources for the Aging Network.
7. Mathematica Policy Research, Inc. *Serving Elders at Risk, the Older Americans Act Nutrition Programs: National Evaluation of the Elderly Nutrition Program 1993-1995, Volume I: Title III Evaluation Findings.* Washington, DC: US Department of Health and Human Services; 1996.
8. Becoming a Registered Dietitian: A Food and Nutrition Expert, American Dietetic Association
9. State Professional Regulation, American Dietetic Association. Government Relations Team. Updated January 2002.
10. Position of the American Dietetic Association: Total diet approach to communicating food and nutrition information. *J Am Diet Assoc.* 2002;102:100.

11. Rowe JW, Kahn RL. *Successful Aging*. New York, NY: Pantheon Books; 1998.
12. Maibach E, Parrott RL. *Designing health messages: Approaches from communication theory & public health practice*. Thousand Oaks, CA: Sage Pub; 1997.
13. Position of the American Dietetic Association: The role of nutrition in health promotion and disease prevention programs. *J Am Diet Assoc*. 1998;98:205-208.
14. Nigg CR, Burbank PM, Padula C, Dufresne R, Rossi JS, Velicer WF, Laforge RG, Prochaska JO. Stages of change across ten health risk behaviors for older adults. *Gerontologist*. 1999;39:473-482.
15. Earl R, Wellman NS. Nutrition news may sidetrack the elderly in their nutrition efforts. *J Nutr Elderly*. 1997;16(4):27-36.
16. Kleiner SM. Water: an essential but overlooked nutrient. *J Am Diet Assoc*. 1999;99:200-206.
17. Vogelzang J. Overview of fluid maintenance/prevention of dehydration. *J Am Diet Assoc*. 1999;99:605.
18. Contento I, Balch GI, Bronner YL, Lytle LA, Maloney SK, Olson CM, Swadener SS. Nutrition education for older adults. *J Nutr Ed*. 1995;27:339-346.
19. *Senior Nutrition and Activity Program*; Senior Services, Inc. Wichita, Kansas.
20. *Staying Well: Teaching Tools for Older Adults*. Columbus, OH: Ross Products Div Abbott Laboratories; 1998.
21. *Take Charge of Your Health: The Active Older Adult Speaker's Kit*. Duluth, GA: Wellness Inc., 1999.
22. Contento I, Balch GI, Bronner YL, Lytle LA, Maloney SK, Olson CM, Swadener SS. The effectiveness of nutrition education and implications for nutrition education policy, programs, and research: A review of research. *J Nutr Educ*. 1995;27(6):277-422.
23. [Johnson F. The Role of Nutrition in Home and Community-Based Long Term Care.](#)
24. [Older Adults and Mental Health: Issues and Opportunities, Chapter 4 - Supportive Services and Health Promotion. Administration on Aging. January 10, 2000.](#)

25. Kramarow E, Lentzner H, Rooks R, Weeks J, Saydah S. Health and Aging Chartbook. Health, United States, 1999. Hyattsville, MD: National Center for Health Statistics. 1999.
26. Rader MC, Vaughen JL. Management of the frail and deconditioned patient. *South Med J*. 1994;87(5):S61-65.
27. Vorhies D, Riley BE. Deconditioning. *Clin Geriatr Med*. 1993;9:745-763.
28. Blumenthal JA, Babyak MA, Moore KA, Craighead WE, Herman S, Khatri P, Waugh R, Napolitano MA, Forman LM, Appelbaum M, Doraiswamy PM, Krishnan KR. Effects of exercise training on older patients with major depression. *Arch Intern Med*. 1999;159:2349-2356.
29. [American College of Sports Medicine Position Stand. Exercise and physical activity for older adults. *Med Sci Sports Exerc*. 1998;30:992-1008.](#)
30. Hurley BF, Roth SM. Strength training in the elderly: Effects on risk factors for age-related diseases. *Sports Med*. 2000;4:249-268.
31. [US Dept of Health and Human Services. Physical activity and health: A report of the Surgeon General. Atlanta, GA: US Dept of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion;1996.](#)
32. Yates SM, Dunnagan TA. Evaluating the effectiveness of a home-based fall risk reduction program for rural community-dwelling older adults. *J Gerontol A Biol Sci Med Sci*. 2001;56:M226-230.
33. Carlson JE, Ostir GV, Black SA, Markides KS, Rudkin L, Goodwin JS. Disability in older adults 2: Physical activity as prevention. *Behav Med*. 1999. 24(4):157-168.
34. [The Robert Wood Johnson Foundation. National Blueprint: Increasing physical activity among adults age 50 and older.](#)
35. [US Dept of Health and Human Services. Physical activity fundamental to preventing disease. Office of the Assistant Secretary for Planning and Evaluation; June 20, 2002.](#)
36. Jette AM, Lachman M, Giorgetti MM, Assmann SF, Harris BA, Levenson C, Wernick M, Krebs D. Exercise-it's never too late: the strong-for-life program. *Am J Public*

Health. 1999;89:66-72.

37. [National Survey of Health and Supportive Services in the Aging Network](#). National Council on the Aging. 2001.

Additional References

Barrocas A, Bistrain BR, Blackburn GL, Chernoff R, Lipschitz DA, Cohen D, Dwyer J, Rosenberg IH, Ham RJ, Keller GC, Wellman NS, White JV. Appropriate and effective use of the NSI Checklist and Screens. *J Am Diet Assoc*. 1995;95:647-648.

[Older Adults and Mental Health: Issues and Opportunities, Chapter 4 - Supportive Services and Health Promotion. Administration on Aging. January 10, 2000.](#)

Posthauer, ME, Dorse, B, Foiles, RA, Escott-Stump, S, Lysen, L, and Balogun, L. Identifying patients at risk: ADA's definitions for nutrition screening and nutrition assessment. *J Am Diet Assoc*. 1994;94: 838-839.

Chapter 8

Site Administration

Contents

Background

Facility Compliance with Fire, Building, & Health Codes

- Older Americans Act
- Sample SUA Facility Standards

Facility Selection & Operations Guidance

- Older Americans Act
- Sample SUA Facility Standards

Facility Agreements

- Sample SUA Facility Agreements

Center Management

- Sample SUA Center Management Standards

Emergency Preparedness

- Sample SUA Emergency Preparedness Standards

BACKGROUND

The congregate dining center is often the focal point for older adults in the community. The facility may be an older adult's first contact with the "Aging Network" and the many resources provided by the service provider and Area Agency on Aging. From this location meals may be prepared and/or served to participants and meals may be packaged for delivery to the homebound in the area. How the center is managed can boost or doom participation in the Older Americans Nutrition Program (OANP). A well run center depends on clear guidance on its operation in respect to compliance to the Older Americans Act (OAA), local fire, building, and health codes, the Americans with Disabilities Act, and service plans and contracts. Individuals responsible for center operations must be knowledgeable about OANP policies and procedures concerning the topics listed below.

Successful dining centers attract older adults and provide a warm and welcoming environment where they can enjoy a nutritious meal, socialize with their friends and peers, participate in classes and wellness activities and have access to information and other services which help them stay healthy, active and engaged in their community. Staff and volunteers who are trained in the operational policies and procedures described in this chapter, and who also have the people-skills to help create such an environment are essential to the success of the program.

FACILITY COMPLIANCE WITH FIRE, BUILDING, AND HEALTH CODES

The wide variety of facilities used as congregate dining centers reflects the diversity and flexibility of the program. Dining centers may be free standing structures or co-located in a senior center or community center. They may be located

Participant Contributions

- Older Americans Act
- Sample SUA Contributions Standards
- Food Stamps Collections and Processing as Contributions

- Additional Resources
- References

within schools, religious-affiliated or health care facilities, restaurants, and service oriented club facilities such as those of the local Rotary or Veterans organizations. The use of any facility for the purpose of serving older adults requires that it be safe and accessible, and have adequate space and equipment/furnishings to accommodate participants and staff, program operations and services. All should have permits to occupy the building, fire safety apparatus, and access for individuals with disabilities.

Older Americans Act 2000 Requirements

SECTION 339 Nutrition

A State that establishes and operates a nutrition project under this chapter shall (1) solicit the advise of a dietitian or individual with comparable expertise in the planning of nutritional services, and

(2) ensure that the project -

F) comply with applicable provisions of State or local laws regarding the safe and sanitary handling of food, equipment, and supplies used in the storage, preparation, services, and delivery of meals to an older individual.

AoA Regulation, Sec. 1321.75 Licenses and safety.

The State shall ensure:

(a) That, in making awards for multipurpose senior center activities, the area agency will ensure that the facility complies with all applicable State and local health, fire, safety, building, zoning and sanitation laws, ordinances or codes; and

(b) The technical adequacy of any proposed alteration or renovation of a multipurpose senior center assisted under this part, by requiring that any alteration or renovation of a multipurpose senior center that affects the load bearing members of the facility is structurally sound and complies with all applicable local or State ordinances, laws, or building codes.

Sample SUA Facility Standards / Guidelines

Pennsylvania

Senior Community Center and Satellite Center Buildings

Area Agencies on Aging and senior community centers must ensure that senior community center and satellite center buildings are conducive to their purposes and goals to maximize program performance and participation.

Building Requirements

At a minimum, the following standards must be achieved by the senior community center and satellite center and monitored by the Area Agency on Aging:

- Centers must be located in areas accessible to older persons with the greatest social and economic needs with particular attention to low-income and/or minority individuals.
- Centers must have on file, a Certificate of Occupancy from the Department of Labor and Industry ensuring that the building meets the requirements of the State Fire and Panic Code. A copy of the certificate must be visibly displayed at the site. In Philadelphia, Pittsburgh and Scranton where Labor and Industry certification is not applicable, a Certificate of Compliance with local building codes is required.
- Centers must be accessible to persons with disabilities in accordance with Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794, the Americans with Disabilities Act of 1990 (42 U.S.C. §§12101-12213) and the Pennsylvania State Handicapped Code, Public Law 235 as amended. (71 P.S. §§1455.1 .3b).
- Each center shall provide toilet facilities equipped for use by persons with disabilities.
- Temperatures in winter months (October 15 through April 15) must be maintained at a minimum of 70 degrees F to prevent hypothermia. This requirement must be included as a part of the written agreement for the use of the building. Every attempt should be made to maintain temperatures at a level to ensure the comfort and health of consumers throughout the year.
- Each center shall have a sign of a size that is clearly visible and which clearly states its name or identifies it as a senior community center or satellite center. It is not required that the words "senior," "community," "center," or "satellite" are included on the sign. If a permanent fixed sign is not possible because of dual occupancy, (e.g., church building, high rise, etc.) a portable or removable sign is acceptable. The AAAs, centers or satellite centers may consider including the days and/or hours of operation on the signs.
- Center buildings, which are renovated with funds from the Department of Aging, shall have written leases for a period of one year for each \$5,000 worth of renovations performed at the center up to a maximum of ten years.

In addition, senior community centers should make every effort to achieve the following standards:

- There should be a designated non smoking area, which may comprise all, or part of the senior community center facility. Through consultation with consumers, a senior community center or the AAA may have the discretion to establish a center as a non-smoking building.
- The building should be of adequate size and design to carry out all senior community center activities and services; senior community centers should provide for:
 - Spaces for group activities, which are large enough to avoid crowding, and rooms located and designated so that meetings and other programs can be conducted without interruption.
 - Sufficient office space to permit staff to work effectively and without undue interruption.
 - Adequate locked storage space for program and operating supplies.
 - Illumination levels in all areas, which are adequate and compensate for visual losses experienced by many older people.
 - Adaptive devices or telephones to accommodate the hearing impaired.
 - An area where an ill person may lie down. The area should be private if possible.
 - A private area where confidential discussions may be held.

Furnishings and Equipment

Furniture and equipment for use by participants when purchased with Department of Aging funds shall be selected for comfort and safety and shall compensate for visual and mobility limitations.

Safety

The senior community center or satellite center should be designed, constructed and maintained in compliance with all applicable Federal, State and local building, safety and fire codes. In addition, the center shall make arrangements for:

- The clear identification of hazards such as high steps, step grades, etc.
- A safe and secure interior and exterior with well-lighted areas and paved exterior walkways free of debris and snow and ice in winter months.
- At least one fire extinguisher with a minimum of 2A rating for each floor including the basement. The AAA and centers should give consideration to the number of fire extinguishers as compared to the size and layout of the senior community centers' area and rooms divisions.
- An annual on-site fire safety inspection by the local fire department or any other fire safety authority. If this is not possible, the AAA must provide assistance with arranging for an annual fire inspection to be done by a person trained in fire safety. Documentation of the date, source and results of the fire safety inspections must be kept on file.
- Emergency exits, which are unobstructed, unlocked and clearly marked.
- All fire extinguishers must be inspected and approved annually by the local fire department or other fire safety authority. The date of the inspection shall be marked on the extinguisher.
- Adequate supplies and equipment for emergency first aid.

Maintenance and Upkeep

Responsibility for maintenance and upkeep must be part of the written lease or agreement. There shall be sufficient maintenance and housekeeping to assure that the building is clean, sanitary and safe, when the center is open. In addition, the center shall make arrangements for the following:

- Maintenance and housekeeping shall be done on a regular basis and in conformance with generally acceptable standards.
 - Provision shall be made for frequent, safe and sanitary disposal of trash and garbage.
 - Painting and redecorating shall be done as appropriate.
 - Provision should be made for equipment maintenance, repair and replacement.
- Senior community centers or satellite centers must adhere to requirements

pertaining to all aspects of food service, e.g. receiving, storing, preparing, serving, and cleaning/sanitizing in accordance with the policies established by the Pennsylvania Department of Aging and local health departments.

Oklahoma

The grantee agency arranges for all applicable health, fire, safety and sanitation inspections for project offices and congregate meal sites in the following manner:

- In the absence of local standards, standards developed and adopted by the Department of Human Services with the cooperation of the State Fire Marshal and the Oklahoma State Department of Health are applicable.
- A sufficient number of exits must be made available. Any space providing seating for 50 or less must have at least one exit, which goes directly outside. Any space providing seating for more than 50 must have two exits remotely located from each other. Exit doors must swing in the direction of travel. Exit doors must remain unlocked during hours of operation of the Title III program. Exit signs must be illuminated. If the exit door is not visible from inside the space, directional exit signs must mark the path of travel to the exit.
- Panic hardware shall be installed on exit doors for occupant loads of 100 or more persons. An evacuation plan shall be posted.
- Pathways must be accessible and clear of obstructions.
- The building in which the program is housed must be clearly numbered and the exterior well-lighted. The building number shall be visible from the street.

FACILITY SELECTION AND OPERATIONS GUIDANCE

Guidance for the operation of congregate dining centers includes determining their location and the services to be provided. Consideration to locate a facility goes beyond compliance to building, fire, and health codes, and would include accessibility to the target population, the availability of space for a variety of services and staff offices, and cost. Such guidance may specify the types and frequency of services that should be offered, the hours of program operations, and when meals are to be served.

Older Americans Act 2000 Requirements

Section 339 Nutrition

(2) ensure that the project -

(E) provides that meals, other than in-home meals, are provided in settings in as close proximity to the majority of eligible older individuals' residences as feasible,

Part B - Supportive Services and Senior Centers

Section 321 (b) (1) The Assistant Secretary shall carry out a program for making grants to States under State plans approved under section 307 for the acquisition, alteration, or renovation of existing facilities, including mobile units, and where appropriate, construction of facilities to serve as multipurpose senior centers.

(2) Funds made available to a State under this part may be used for the purpose of assisting in the operation of multipurpose senior centers and meeting all or part of the costs of compensating professional and technical personnel required for the operation of multipurpose senior centers.

Sample SUA Facility Selection and Operations Standards / Guidelines

Pennsylvania

Prohibition of Sectarian Use

Buildings altered, acquired, renovated or constructed using Department of Aging funds may not be used for sectarian instruction or as a place for religious worship during center operation hours.

Wisconsin

New or Relocated Meal Sites: To open a new or relocated meal site the aging unit must demonstrate that the program has sufficient resources necessary to support the site and the need for the new site. This information must be included in the county/tribal plan or as an amendment to the current county/tribal plan submitted to the area agency on aging and Bureau on Aging for review and approval.

Closing Meal Sites: Prior to closing a meal site permanently, written rationale for the closure and written approval by the local Commission on Aging and Advisory Council must be provided to the area agency for review and to the Bureau on Aging for approval. A form will be provided.

Temporary Closings of Meal Sites: Nutrition programs must also identify for area agencies those days, which they expect that a site will be closed for one or more days due to cleaning, repair, redecoration, problems with the caterer, etc. A form will be provided for programs to identify the days and to explain how they will meet the participant's nutritional needs.

District of Columbia

Nutrition Site Criteria

A needs assessment must be conducted to support the need for, and interest in, having a nutrition site within the proposed service area. The prospective nutrition site sponsor and the Lead Agency must work in conjunction to document the need.

Operation

- The site should serve a minimum of 25 eligible persons each day for the congregate meal. Exception to this target size must be justified by documentation that the target population is less than 25 persons and that there are no other sites available nearby to accommodate the customers.
- The nutrition site must be available for a minimum of four (4) hours daily, 10 a.m. to 2 p.m., five (5) days a week, Monday through Friday.
- The site must operate under the Office on Aging's Nutrition and Supportive Services Grantee, i.e. the Lead Agency responsible for the service area.
- The sponsor's specific role is defined by the Lead Agency in its project plan.
- The site must have a plan of operation describing coordination with other community resources and programs.
- The older population in the area should support the site location by participating, volunteering, or helping to sponsor the site. The recipients of services should be involved as much as possible in assisting the site manager in planning and developing relevant programs and neighborhood outreach.
- The sponsor of the site, in cooperation with the Lead Agency, shall contribute program support by developing neighborhood awareness, involving churches, organizations, and other interested persons. Sponsorship includes providing space, utilities, maintenance, incidental expenses, recruitment of volunteers, and programming activities.
- The site must maintain a system of meal reservations to allow for orderly planning by the Lead Agency and the DC Office on Aging's Caterer.
- Meals must be served by 12:30 pm, within two (2) hours after delivery, if catered, or within two (2) hours if prepared on-site. Hot food must be maintained at 140°F or higher and cold food at 45°F or colder until served.

- Meals must be served as planned and delivered; the nutrition site may not add or subtract food items.
- Specific menus, where feasible and appropriate, will be provided at each congregate meal site for meeting the particular dietary needs arising from the health requirements, religious requirements or ethnic backgrounds of the customer majority. For sites served by different caterers, the same requirements exist.
- Two activities or more must be conducted each day in addition to the meal. Nutrition Education, overseen by a Dietitian, will be conducted twice annually.
- Components of a nutrition site must include, but are not limited to the following:
 - Conducting intake process annually to determine each customer's eligibility;
 - Conducting nutrition screening annually to determine those at nutritional risk;
 - Arranging transportation for customers to sites (see transportation to sites and activities definition);
 - Serving a complete mid-day meal to eligible individuals in a group setting;
 - Ordering and maintaining service supplies (e.g., napkins, utensils, etc.);
 - Maintaining an adequate participant reservation system;
 - Maintaining paid/ volunteer staff needed to provide congregate meal service;
 - Providing information about other programs and services for which the meal service customer might be eligible;
 - Referring the customer to the proper services as necessary;
 - Providing assistance to the participant in gaining public benefits; and

- Maintaining records, collecting contributions, preparing reports and other administrative efforts necessary to provide congregate meal service.
- The nutrition site shall be visible and recognizable as a part of the Office on Aging Senior Network.
- To the extent possible, identification signs shall be attractive with large, lettering using the Office on Aging Logo.

Location and the Space

- The selection of a nutrition site shall be based on the needs of the elderly in the service area, the advice of the Lead Agency for the Ward, and other organizations and institutions serving the elderly and handicapped individuals in the Ward.
- The following factors shall be given consideration in selecting a nutrition site:
 - Demographic information and projections over a one-year period, i.e., Census Bureau Information, DC Office of Planning and Development;
 - Accessibility to the greatest number of elderly persons;
 - Proximity to other services and facilities; and
 - Centrally located in the target area preferably within walking distance or on a public transportation route.
 - When possible, the facility shall be located on the street level.
 - The facility shall have sufficient space to accommodate at least two program activities daily in addition to lunch.
 - The facility shall be flexible and adaptable for large and small groups as well as for individual activities and services.
 - The facility shall include sufficient toilets, at least one per gender, accessible and equipped for use by mobility-limited (physically challenged) persons.

- There shall be sufficient, private office space to permit staff to work effectively, without interruption.
- There shall be adequate secured storage space for program and operating supplies.

FACILITY AGREEMENTS

Congregate dining centers often exist in facilities owned and operated by other entities such as local or county government, community organizations, religious organizations, schools, or individuals. Regardless of the financial arrangement for the use of the facility (i.e., no-cost or rent), a best practice includes a written agreement that clearly articulates the responsibilities of each party.

Sample SUA Facility Agreement Standards / Guidelines

New York

The Area Agency on Aging shall ensure that there are written site agreements between the provider and all sites serving meals. The site agreements must address as appropriate:

- Agreement on utility/rent payment
- Specific areas and square footage
- Hours opened, days opened, days closed, and seasonal variations
- Responsibility for care and maintenance of the facility (i) sanitation of restrooms and common areas, (ii) cleaning range hoods, fans, furnace vents, etc., and (iii) snow removal on walks
- Responsibility for fire inspections
- Obtaining Health Department permits
- Insurance coverage for items owned by the project
- Personnel liability insurance

- Compliance with all federal, state and local laws
- Security for site equipment and food
- Responsibility for replacement of equipment

Alabama

Contracts/Subgrants

Contract/Subgrant Development: Area Agencies on Aging must execute contracts/subgrants with service providers and contractors under their Area Plan in sufficient time to assure no interruption in service delivery between budget periods. The development of all contracts for the provision of services or goods under Older Americans Act programs or which receive financial assistance through the State Agency must adhere to the requirements outlined in the "Procurement Policies and Procedures" section of this Manual.

Minimum Contract Requirements: Actual service delivery may be carried out by organizations, which contract with the State Agency and Area Agencies on Aging. While the State Agency does not mandate a prescribed format that all contracts must follow, there are certain items that grantees must incorporate in any proposed contract format. Such a contract must:

- indicate all parties to the contract;
- define the effective dates) of the contract;
- state the purpose of the contract;
- reference all applicable laws and regulations;
- describe the services to be provided and any related conditions (i.e., quantity, quality, etc.);
- specify the compensation (attach a budget), including a detailed description of costs, and the amount, method of payment, and required match to be provided;
- indicate that the contractor assures its capability to perform the specified services;

- list the types of information and data that may be required of the contractor and the records that must be maintained;
- describe the review, monitoring, and audit rights of the grantee and authorized state and federal agencies or authorities;
- prevent any unlawful benefits from accruing to individuals associated with the contractor as a result of the contract;
- assure that equal employment opportunities will exist and that no discrimination on the basis of age, race, color, religion, sex, handicap, or national origin will result;
- provide for a method of modifying, suspending, or terminating the contract, if necessary;
 - include indemnification clause of the State Agency;
 - include standard assurances, such as civil rights, confidentiality, etc.;
 - describe the disposition requirements for any equipment purchases authorized through each contract or subgrant; and
 - address other conditions, as appropriate.

Contract Execution

- All contracts must be signed only by duly authorized representatives of the contracting parties and dated. Funds may not be expended until a contract has been properly executed, unless specific written authorization has been obtained from the State Agency.
- If revisions in a contract or related project application will result in a substantive change under the Area Plan, the Area Agency on Aging must follow the Area Plan amendment process outlined in this Manual in order to make the change.
- **Prior Approval of Contracts with Profit-Making Organizations:** Contracts to be executed with a profit making organization must receive approval from the State Agency and be in compliance with federal, state and local bid laws. Such proposed contracts should be submitted to the Alabama Commission on Aging at least thirty days in advance of the planned execution date, if possible. The State Agency may approve the

contract only if the Area Agency demonstrates the profit making organization would provide services in a manner clearly superior to other available public or private, non-profit organizations, with exceptions as provided in state, federal and local bid laws.

CENTER MANAGEMENT

Regardless of its location, the management of the congregate dining center is key to effective and efficient program and fiscal operations. The center's success is often measured by the number of individuals who participate, the degree of diverse program offerings, and fiscal accountability. SUAs vary as to the extent to which they provide guidance or establish standards for the operation of congregate dining centers.

Sample SUA Center Management Standards / Guidelines

Pennsylvania

Senior Community Center and Satellite Center Management Responsibilities

The senior community center or satellite center shall manage its programs and services in a manner which is consistent with the philosophy of the senior community center or satellite center.

These facilities will also be operated utilizing accepted management practices as determined by the Department, the AAA or the parent organization where applicable. In order to perform this function, the senior community center or satellite center shall be managed by a responsible competent individual, who is either a paid or volunteer staff person. This, designated individual will be responsible for the coordination of all center activities and will encourage communication between the center, the consumers, the AAA and other community organizations which offer services to older adults.

Minimum Staff Qualifications

There shall be a sufficient number of competent paid and/or volunteer staff, to effectively carry out the programs and services provided at a senior community center or satellite center. AAAs and centers should consider involving older people as paid and/or volunteer staff. While this APD does not mandate a staffing ratio or specific qualifications for the senior community center or satellite center staff, AAAs and subcontract agencies should consider alternative staffing patterns and specific qualifications in order to reflect the complexity of demands on the center. All staff shall exhibit positive, supportive behavior toward consumers at the senior community center or satellite center.

Training of Staff

To the extent that current funding levels permit, an ongoing program of training and development should be provided for all staff. This program should be consistent with procedures established by the Area Agency on Aging and should include:

- Ongoing in-service training that will: improve skills, foster the development of positive behavior toward older persons, assist in center program development and provide skills necessary for adequate facility and fiscal management.
- Encouragement of participation in conferences, seminars, training sessions and other professional development opportunities sponsored by the Department of Aging and its subcontractors within prevailing budgetary restraints.
- First aid and cardiopulmonary resuscitation (CPR) certification and recertification courses for senior community center and satellite center staff.
- Training for center staff related to the special needs of center consumers with physical or mental disabilities.
- Training for staff related to marketing strategies appropriate to reach the diverse populations within their communities.
- Diversity training for center staff working with minorities, including older persons who may be Hispanic/Latino, African American, Asian/Pacific Islanders, other immigrant populations and Native Americans.
- Training for center staff related to confidentiality.

EMERGENCY PREPAREDNESS

State Units on Aging and AAAs play critical roles in disaster response. SUAs must facilitate the flow of information, provide technical assistance and maintain momentum in service delivery and development of funding to support the needs at the local level and older adults in the community affected. For example, the SUA must assure that the AAA knows when shelters are going to be open and their locations so that AAA staff can be present to facilitate assistance for older adults. The SUA must coordinate the flow of information so that appropriate state organizations, including the State Emergency Management Agency and the Administration on Aging know the status of older victims and assistance needs. (From the Administration on Aging's Emergency

Preparedness Manual for the Aging Network, 1995)
<http://www.aoa.dhhs.gov/disaster/manual/atitltoc.html>

At the local level, AAA and provider staff may be responsible to coordinate emergency procedures with their respective Emergency Management Office (EMO) and be included in their local EMO plan. This may mean keeping staff and participants informed of the nature of the disaster and response. Congregate dining centers and other facilities operated by an AAA or provider may become a temporary shelter and/or food preparation site serving people of all ages. Plans for such assistance should be in place that includes the facility's capacity to become a shelter, the type of food items to be available (e.g., soups, sandwiches, and beverages), and the responsibilities of staff and volunteers. It is important to be familiar ahead of time with the agencies that provide financial or material assistance and their reimbursement and documentation requirements. These agencies include the SUA, the State agency that administers USDA commodities, the Red Cross, and others. Such required documentation may include a log of food and disposable items used, a record of the number of meals provided and to whom, a telephone log, and a list of workers and volunteers and their time involved in an emergency.

The Ask the Experts [Emergency Preparedness](#) article provides information, resources, and examples from a wide variety of organizations and agencies.

[AoA Disaster Assistance Resources for the Aging Network](#)

[Ready.gov](#) website from the Department of Homeland Security is geared to the general public to learn about potential threats, including biological, chemical, nuclear and radiological weapons, and how to be prepared.

Sample SUA Emergency Preparedness Standards / Guidelines

Pennsylvania

Area Agency on Aging Responsibility: Each senior community center or satellite center must be considered in the Area Agency on Aging's emergency preparedness plan as part of the county emergency management agency's master plan. Senior community centers or satellite centers shall be instructed on their role and responsibilities in community emergency situations.

Senior Community Center and Satellite Center Responsibility: Emergency arrangements shall be made by the senior community centers and satellite center staff in consultation with relevant organizations such as the fire department for addressing in-

house emergencies affecting the center. At a minimum, the following components of an emergency plan shall be developed:

- Specific personnel within the senior community center or satellite center shall be designated and trained to take charge during emergencies at the senior community center.
- Written notices shall be posted in conspicuous locations throughout the center; notices must include:
 - Telephone numbers for the fire department, police and ambulance services; and
 - Center evacuation procedures.
- Fire drills shall be held at least semi-annually, in cooperation with the fire department. If it is not possible to perform fire drills in conjunction with the fire department, centers must conduct their own fire drills. Policies on how fire drills are conducted must be developed (in writing) and implemented. Quarterly fire drills are suggested for large centers with multiple floor levels or a complicated physical layout. Exit maps for senior community centers and satellite centers should be written in a clear, concise manner and posted in areas so they can be referenced easily. Fire drill trainings should include an explanation and review of building exits and evacuation.
- Accommodations for people with disabilities must be prearranged should an emergency occur and evacuation of the center is necessary. This plan must be implemented during fire drills and must be part of the written policies.
- A written record of all consumer injuries occurring at the senior community center or satellite center shall be properly documented in a manner prescribed by the AAA and transmitted in a timely manner to the AAA and insurance carriers as appropriate.
 - When the Area Agency on Aging provides State or Federal funds for the purchase of property, and such property is stolen, lost, vandalized or otherwise damaged or destroyed for reasons other than normal wear and tear, a written record must be submitted to the AAA and the appropriate insurance carrier in a timely manner.

PARTICIPANT CONTRIBUTIONS

The provision to accept contributions for nutrition services, particularly congregate and home delivered meals, is fundamental to the financial integrity of the program. Nationally, contributions provide about 20% of the funds used to operate OANPs. The OAA, the AoA, and SUAs provide specific guidance on the voluntary nature of contributions for nutrition services, as well as guidance in enhancing the level of contributions received. Best practices include offering sliding scales with suggested contribution amounts, providing participants with information on the total cost of the service, the use of reminder letters for home bound participants, "gift certificates" for meals, and the acceptance of Food Stamps. OANPs under the OAA do not have the option to use cost sharing as a method to collect contributions, as is the case of some OAA funded services.

A fair voluntary contribution system, which is clearly communicated, allows older adults to maintain their dignity and to have ownership of their local program. The perception of the OANP as a program where all older adults are welcome, regardless of their income or ability to make a contribution, is a unique strength. An appropriate contribution system helps to promote this perception and keeps the program from being characterized as a "welfare" program only for the poor.

Contributions must be used to expand the services for which the contributions were given. Contributions cannot be used to meet the non-federal share or match requirement (Section 315(b)(4)(e)).

Other types of contributions and revenue-generating activities are covered in Chapter 12: Reporting and Fiscal Management.

Older Americans Act 2000 Requirements

SECTION 315 Consumer Contributions

(b) Voluntary Contributions-

(1) In general - Voluntary contributions shall be allowed and may be solicited for all services for which funds are received under this Act provided that the method of solicitation is non-coercive.

(2) Local decision - The area agency on aging shall consult with the relevant service providers and older individuals in agency's planning and service area in a State to determine the best method for accepting voluntary contributions under this subsection.

(3) Prohibited acts - The area agency on aging and service providers shall not means test for any service for which contributions are accepted or deny services to any individual who does not contribute to the cost of the service.

(4) Required acts - The area agency on aging shall ensure that each service provider will -

(A) provide each recipient with an opportunity to voluntarily contribute to the cost of the service;

(B) clearly inform each recipient that there is no obligation to contribute and that the contribution is purely voluntary;

(C) protect the privacy and confidentiality of each recipient with respect to the recipient's contribution or lack of contribution;

(D) establish appropriate procedures to safeguard and account for all contributions; and

(E) use all collected contributions to expand the service for which the contributions were given.

AoA Regulation, Sec. 1321.65 Responsibilities of service providers under area plans.

As a condition for receipt of funds under this part, each area agency on aging shall assure that providers of services shall:

(c) Provide recipients with an opportunity to contribute to the cost of the service as provided in Sec. 1321.67;

AoA Regulation, Sec. 1321.67 Service contributions.

(a) For services rendered with funding under the Older Americans Act, the area agency on aging shall assure that each service provider shall:

(1) Provide each older person with an opportunity to voluntarily contribute to the cost of the service;

(2) Protect the privacy of each older person with respect to his or her contributions; and

(3) Establish appropriate procedures to safeguard and account for all contributions.

(b) Each service provider shall use supportive services and nutrition services contributions to expand supportive services and nutrition services respectively...

(c) Each service provider under the Older Americans Act may develop a suggested contribution schedule for services provided under this part. In developing a contribution schedule, the provider shall consider the income ranges of older persons in the community and the provider's other sources of income. However, means tests may not be used for any service supported with funds under this part. State agencies, in developing State eligibility criteria for in-home services under section 343 of the Act, may not include a means test as an eligibility criterion.

(d) A service provider that receives funds under this part may not deny any older person a service because the older person will not or cannot contribute to the cost of the service.

From Joe Carlin, AoA Regional Nutritionist presentation at SUA Nutritionist Conference June 2002.

Are donations the same as contributions? While the words "voluntary contributions" are used in Section 315 of the OAA, people may also use the word "donations." For the purposes of the OAA both of these words have the same meaning. Older people understand "donation" to mean that they have the power to determine what, if anything, they will voluntarily contribute toward the cost of meal. Furthermore, they want to make that donation in a private way and have their confidentiality protected.

Confidential does not mean anonymous. The OAA does not forbid the use of receipts if receipts are used in an appropriate manner in compliance with protecting the privacy of the older adult.

Donations are not "fees." Fees are perceived as mandatory devoid of privacy and confidentiality. It has been the experience of AoA since the beginning of the OANP that if very poor elderly participants perceive that there is a fee for the meals they will stay away from the program. Fees are understood as "charges" in our society. Programs should review their voluntary donation system to insure that pressure (in the wording on signage, procedures, collections systems, etc.) is not being placed on older Americans to pay a charge instead of making voluntary donations. Of course, older people need to be fully informed of cost associated with provision of a meal so they can make an informed decision about their voluntary donation.

Sample SUA Contribution Standards / Guidelines

Wisconsin

3.2 Contributions

OAA Section 307(a)(13)(C)(i). Each project will permit recipients of grants or contracts to solicit voluntary contributions for meals furnished in accordance with guidelines established by the Commissioner, taking into consideration the income ranges of eligible individuals in local communities and other sources of income of the recipients of a grant or contract; and such voluntary contributions will be used to increase the number of meals served by the project involved, to facilitate access to such meals, and to provide other supportive services directly related to nutrition services.

Since enactment in 1965, the Older Americans Act has emphasized regard for the dignity of older persons by requiring that opportunities be provided to older persons to participate not only in the planning and administering of aging programs, but also in the cost of services. Therefore, each provider of Title III services must provide each

older person with an opportunity to voluntarily contribute to the cost of service. These contributions must be used to expand meal services, to maintain the service level, to provide outreach, and to provide nutrition education and dietary counseling.

- Each county and tribal nutrition program must develop a contribution schedule for Title III services provided. In developing a contribution schedule, the program must consider the income ranges of older people in the community. Means tests may not be used.
- Contributions collected at individual meal sites must be returned to the county or tribal aging unit to be used in the planning and budgeting for the county-wide or reservation-wide nutrition program.

3.21 Contribution Options

Programs with the advice and consent of nutrition advisory groups and the commission on aging and taking into consideration the income range of the area may choose to do one or more of the following options:

- Set a suggested donation and post it at the meal site;
- Set a range of donation levels and post at sites; or
- Provide participants with meal costs and ask them to decide their own contribution.

3.22 Contribution Requirements

Programs must:

- Provide each older person with an opportunity to voluntarily contribute to the cost of the service;
- Protect the privacy of each older person with respect to his or her contributions;
- Establish appropriate procedures to safeguard and account for all contributions; Use all nutrition contributions to expand or maintain the program, to provide outreach, nutrition education, and dietary counseling;
- Not deny an older person a service because the older person cannot or will not contribute to the cost of the service;
- Allow for the collection of food stamps for meal services; and
- Develop procedures for contributions collected at individual meal sites to be returned to the county or tribal aging unit for redistribution, such as, setting up a checking system where the county can draw a check on the local account.

3.23 Contribution Signs and Brochures

At each meal site, there must be a sign (and in the case of home-delivered meals a

brochure or letter) which includes meal costs, source of funds used for programs, and the stipulation that no participant may be denied a meal along with the contribution option the program has decided upon. The signs, brochures or letters should be in large print.

3.24 Non-differentiation

Regard for dignity not only entails an opportunity to contribute by persons who are able, but also freedom from embarrassment for those who cannot. Accordingly, the methods for receiving contributions must be handled in a manner that does not publicly display the differing contributions of participants. Confidentiality as to contribution level is required.

3.25 Gift Certificates

Gift certificates may be sold by the nutrition program to relatives or friends of a participant. Gift certificates may be sold for a single meal or for several. The price of the certificates would be equal to the full price per meal, as determined by the program, times the number of certificates.

3.26 Contributions as Program Income

Contributions made by older people are considered program income. Contributions from local civic groups, businesses, etc. are also considered program income. Program income must be planned for and spent by the county/tribal aging unit on behalf of the nutrition program.

District of Columbia

A written policy must be posted, in large print, at each nutrition site. The policy shall include methods used to give each older person an opportunity to contribute, methods taken to prevent loss, theft, or misuse of contributions and methods of accountability. Specifically, the policy is to include the following:

- Protection of privacy of each individual with respect to his/her contribution.
- Contributions counted by two individuals, one of which is a senior customer.
- Receipts for contributions to be signed each day by counters and signed receipts forwarded with contributions when collected by the grantee agency.
- Contributions safe-guarded by keeping in a locked box, file, safe, etc., until deposited or collected.

- Contributions collected are deposited with the Lead Agency within five (5) days after the end of each week.
- Copy of receipts for contributions are forwarded to the DC Office on Aging by the tenth of each following month.
- Customers, family members, and/or caretakers must be informed of the cost of providing congregate meal service and must be offered the opportunity to make voluntary contributions to help defray the cost, thereby making additional service available to others. Persons under 60 years of age are considered special guests and must pay the cost of the meal. Any volunteer is entitled to a meal.

Alabama

Contributions for Services Under An Area Plan. Each service provider must:

- Spend contributions during the budget year in which they are generated, prior to the expenditure of any other type of funds.
- Each service provider may develop a suggested contribution schedule for services. In developing such a schedule, the provider must consider the income ranges of older persons in the community and the provider's other sources of income. However, means tests may not be used.

Food Stamps Collection and Processing as Contributions

The [Food Stamp Program](#) serves as the first line of defense against hunger. It enables low-income families and older adults to buy nutritious food with coupons and Electronic Benefits Transfer (EBT) cards. Food stamp recipients spend their benefits to buy eligible food in authorized retail food stores. Older adults participating in the OANP may also use their Food Stamps for meal contributions.

South Dakota

Food Stamps may be applied to congregate or home-delivered meals using a 20 punch meal ticket. C1 - site managers call in or in the main cities with several sites the participant may take to the main office for call in.

For HDM's some of the projects have received permission to not have the HDM participant sign. Either the site manager at in the smaller communities or the HDM coordinator in larger communities handle the vouchers for the HDM participants.

Oklahoma

"Access Oklahoma" Debit cards are used for Food Stamp purchases. All participants (to ensure confidentiality) are given manual vouchers. They can fill out the voucher with their card number and the amount they wish to give. Vouchers are placed in an envelope and given to persons who deliver the meals. The envelopes are returned to the nutrition site, sent to the nutrition project, and then the project calls them in. This is a difficult process due to time restraints. The time of signing to Food Stamp office cannot exceed 10 days.

Since inception of the debit card, we have had fewer participants use them. The HDM participant must contact the Food Stamp Program in their district. The HDM participant writes a letter asking for an "authorized representative". The authorized representative must go to the Food Stamp office for an interview with their own personal ID and the ID of the HDM person who needs the food stamps.

All congregate dining centers in Oklahoma must accept Food Stamps. Centers that do not have electronic debit card machines must handle the "Access Oklahoma " card manually. This process may limit confidentiality as manual forms are placed at all donation boxes. Those that handle the contributions at each center are told to keep such information confidential. Such manual vouchers must be submitted to the Food Stamp office within ten days for processing. Most Centers send the manual vouchers to the Nutrition Program office and the office calls them in or hand delivers them to meet the time frame.

Washington

An authorized representative is an adult who is not a member of the food assistance unit [the person, or group of people who live together, and whose income and resources are considered for eligibility and benefit amount] but has the knowledge and consent of the assistance unit to act on their behalf. A responsible member of the food assistance unit can name, in writing, an authorized representative. An authorized representative has authority to: (1) apply for food assistance on behalf of the food assistance unit; (2) redeem the food coupon authorization (FCA) card for the unit; and (3) purchase food for the food assistance unit using the unit's authorized benefit allotment. A responsible member of the food assistance unit can name in writing an emergency authorized representative to transact a particular FCA card when no responsible member is able to transact the card. Both the responsible member of the food assistance unit and the person named must sign the written statement. The food assistance unit members are liable for any over-issuance that may result from information supplied to the department by the authorized representative. An authorized representative may act on behalf of more than one food assistance unit when approved by the

CSO administrator.

Wisconsin

If you are applying for Food Stamp benefits, you have the right to: (1) have an adult who knows your circumstances apply for you if you cannot get to the Food Stamp Office yourself; (2) have a home visit or a telephone interview if you cannot get to the Food Stamp Office or find someone to go for you; and (3) choose an authorized representative to use Food Stamp benefits on your behalf. The authorized representative would receive a QUEST card with his/her name on it. You would not receive a QUEST card. The Food Stamp Program: A Help Guide How to Apply for Food Stamp Benefits: YOUR RIGHTS AND RESPONSIBILITIES IN THE FOOD STAMP PROGRAM.

Additional Resources

- Design Suggestions for Senior Center, Sarah S. Strawn, MS, RD, Director, Commission on Aging Project, Auburn University (link to file)
- Pennsylvania Standards for Senior Community Center and Satellite Center Programs (link to file)
- Ask the Experts: [Addressing the Image of Older Americans Congregate Nutrition Programs](#)
- Ask the Experts: [Emergency Preparedness](#)
- Ask the Experts: [Restaurant-based Congregate Nutrition Sites and Restaurant Voucher Programs](#)
- Ask the Experts: [Increasing Participation at Older Americans Act Title III Funded Congregate Meal Sites](#)
- [Senior Center Resources online from the National Aging Information Center.](#)
- [Senior Center accreditation by the National Institute of Senior Centers](#) (NISC), a unit of the National Council on the Aging, Inc. (NCOA). · Add sample contribution letters
- [Food Stamp Materials for Older Adults from USDA Food and Nutrition Service](#)
- Emergency Preparedness in Congregate and Home-delivered Meal Programs PPT from SUA Conference

Chapter 9

Personnel Requirements

Contents

Introduction

Federal Employment Laws

- Employee Benefit Plans
- Safety & Health Requirements
- Wage, Hour & Other Workplace Standards
- Requirements Applicable to Employers who receive Government Contracts, Grants or Financial Assistance

Staffing Levels

- OAA 2000 Requirements
- Sample SUA Standards/Guidelines
- Other Requirements

Volunteers

Staff & Volunteer Resources

Training

- Sample SUA Standards/Guidelines

INTRODUCTION

Determining the specific personnel needs of an organization and matching the right people to the job are among the most challenging and important decisions made by leadership. Whether paid or volunteer, professional or skilled labor, employees are important organizational assets. As with any business, having motivated, qualified, well-trained, and effectively-managed staff is critical to the successful operation of the OANP.

While nutrition programs typically have a director and while most utilize volunteers, staffing patterns vary across the country depending on the size, location and scope of the nutrition program, the type of foodservice, and the goals and structure of the host organization.

FEDERAL EMPLOYMENT LAWS

More than 180 federal laws govern the variety of workplace situations throughout the country. Employers rely on human resource and employment experts for direction and oversight regarding implementation, reporting and compliance of appropriate employment laws. Federal employment laws are administered and enforced by the Department of Labor (DOL), the Equal Employment Opportunity Commission (EEOC) and the National Labor Relations Board (NLRB).

In addition to federal employment laws and regulations, most states have additional laws that govern employment practices within their state. These may include minimum wage requirements, background checks, employer and employee rights, and other requirements that govern the hiring and termination practices of employers in the state.

Staff Evaluation

Additional Resources References

Some of the major federal labor laws include:

Employee Benefit Plans

Employee Retirement Income Security Act (ERISA): governs certain activities of most employers who have pension or welfare benefit plans.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA): provides for the continuation of health care benefits under an employer's health plan to separated participants, at their own cost and for a limited period of time.

Health Insurance Portability and Accountability Act of 1996 (HIPPA): improves portability and renewability of provisions of group health plans as well as improved access to insurance, protection against discrimination on the basis of health status, and privacy protection of health information.

Safety and Health Requirements

Occupational Safety and Health Act (OSHA): regulates safety and health conditions in most workplaces.

Wage, Hour and Other Workplace Standards

Fair Labor Standards Act (FLSA): prescribes minimum wage and overtime pay standards as well as record-keeping and standards for work conducted in the home.

Immigration and Nationality Act (INA): allows foreign workers to work in the United States.

Family and Medical Leave Act: requires that employers of 50 or more employees (and all public agencies) provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the birth and care of a child, for placement with the employee of a child for adoption or foster care, or for the serious illness of the employee or a family member.

Uniformed Services Employment and Reemployment Act: ensures that those who serve in the armed forces have a right to reemployment with the employer they were with when they went into service, including those called up from the Reserves or National Guard.

Employee Polygraph Protection Act (EPPA): prohibits most use of lie detectors by employers on their employees.

Consumer Credit Protection Act: regulates the garnishment of wages by employers.
Labor-Management Reporting and Disclosure Act (LMRDA): also known as the Landrum-Griffin Act deals with the relationship between a union and its members.

Requirements Applicable to Employers who receive Government Contracts, Grants or Financial Assistance

Non-Discrimination and Affirmative Action: prohibit discrimination and require affirmative action with regard to race, sex, ethnicity, religion, disability and veteran status.

Wage, Hour, and Fringe Benefit Standards: determines benefit standards for employees of federal contractors under the Davis-Bacon and Related Acts (for construction); the Contract Work Hours and Safety Standards Act; and the McNamara-O'Hara Service Contract Act (for services). Safety and health standards are also issued unless they have been superseded by OSHA standards.

STAFFING LEVELS

OAA language specifically related to nutrition project personnel is as follows:

Older Americans Act 2000 Requirements

SEC. 339 NUTRITION

A State that establishes and operates a nutrition project under this chapter shall-

(1) solicit the advice of a dietitian or individual with comparable expertise in the planning of nutritional services

States are responsible for determining what education, skills and expertise are comparable to those of a dietitian when an individual with comparable expertise is utilized instead of a dietitian.

Dietitians are utilized throughout the aging network at the State, Area Agency and local provider level. Some serve as consultants, while others are full-time or part-time staff members. Roles at the State level may include:

- Policy development (interpretation of legislation, regulation, policy and procedures, standards/guidance, budget);
- Program development (needs assessment, planning, implementation/management, contracting, monitoring, coordinating interagency linkages, building capacity, assessment/evaluation, quality improvement);

- Training and technical assistance (materials, conferences, consultation, research and dissemination);
- Research (demonstration, pilot testing, outcome measurement, focus groups);
- Grant writing;
- Consumer needs (satisfaction/service assessment, publication, outreach campaigns);
- Evaluation (program, outcome, quality); and
- Advocacy.

Roles at AAA and local provider level may include these some of responsibilities, but may be focused on more direct service functions such as overall program direction; nutrition education, assessment, screening and counseling; policy development; food-service operations; menu oversight; program and service planning and evaluation.

Sample SUA Standards/Guidelines: Advice of a dietitian or individual with comparable expertise

Wisconsin

Nutrition Program Nutritionist

Each nutrition program shall employ or retain the services of a qualified dietitian or nutritionist who is responsible to the nutrition program director and available to the program for no less than eight hours per month. This may include time of a nutritionist provided by a caterer's contract.

Program nutritionist responsibilities include:

- (1) Approve all menus served.
- (2) Assist the program director in the development and provision of staff training in proper sanitation.
- (3) Assist the program director in the development of sanitation policies and procedures.
- (4) Assist the program director in the selection of food service equipment.
- (5) Assist the program director in the development of food contracts.
- (6) Assist the program director in the provision of nutrition screening.

- (7) Oversee nutrition education programming and approve materials.
- (8) Annually monitor each nutrition services provider and dining center to evaluate the provision of nutrition services. At a minimum, this annual monitoring shall include verification that:

- (A) Meals comply with the nutrition requirements of menus.
- (B) Food safety standards are in accordance with the Wisconsin Food Code.
- (C) All nutrition education services comply with state policy.
- (D) Nutrition screening scores are accurately collected from all participants in compliance with state policy.

Other duties and responsibilities may include:

- (1) Assist the program director in the development and implementation of a nutrition education plan.
- (2) Review all nutrition screening forms of participants.
- (3) Coordinate and provide nutrition counseling to participants who are nutritionally at risk.
- (4) Coordinate and provide supportive nutrition services.

For the purpose of the Wisconsin elderly nutrition program, a "qualified nutritionist" shall have one or more of the following qualifications:

Certified Dietitian

A certified dietitian is an individual who holds a current certification with the State of Wisconsin Department of Regulation and Licensing and is certified as a dietitian under the Wisconsin State Statutes (1997), Chapter 448, "Medical Practices", Subchapter IV, Dietitians Affiliated Credentialing Board. This person uses the C.D. credential. Verification of certification can be done online at the web site for the Wisconsin Department of Regulation and Licensing

Registered Dietitian

A registered dietitian is an individual who holds a current registration with the Commission on Dietetic Registration. This person uses the R.D. credential. Verification of whether or not a person is a registered dietitian or if s/he is registration-eligible may be done by contacting the Commission on Dietetic Registration of the American Dietetic Association.

Registered Dietetic Technician

A registered dietetic technician is an individual who holds a current dietetic technician registration with the Commission on Dietetic Registration. This person uses the D.T.R.

credential. Verification of whether or not a person is a registered dietetic technician or if s/he is registration-eligible may be done by contacting the Commission on Dietetic Registration of the American Dietetic Association.

Comparable Education / Experience and Authorization

Comparable education and/or experience requires the authorization in writing from the Area Agency on Aging's dietitian or the BADR nutrition coordinator. Those not likely to receive approval include nurses, dietary managers, dietary supervisors, and cooks, unless they can prove an extensive, well-rounded education and experience in the major areas of dietetic practice.

Pennsylvania

Utilization of the Services of a Dietitian

1. An approved dietitian must review and approve all menus served within a PSA prior to meal service. Although menu review meets the Department's minimum requirements for approved dietitian services, it is recommended that the AAA consider utilizing the dietitian for other functions where a clinical and administrative background in nutrition would be appropriate and beneficial. Some of these other duties could be preparation and monitoring of catering contracts, instruction on cooking and serving techniques, supervision of food and equipment purchasing, nutrition education, diet counseling and nutritional needs assessment. The role of the dietitian can vary between AAA and the duties should be based on the needs of the agency and the community.
2. All menus utilized for meals in the nutrition program shall be reviewed and determined acceptable in writing by an approved dietitian in order to meet requirements for DHHS meal reimbursement. The review of meal selections by an approved dietitian serves to uphold the nutritional adequacy (1/3 RDA and The Dietary Guidelines) of meals provided through programs funded by the Older Americans Act. A dietitian's approval can also reduce problems by eliminating the use of substandard and unappetizing food combinations, the failure to follow the dietary guidelines in planning and the failure to make seasonal adjustments in menu cycles.
3. Review and approval of modified diet menus by an approved dietitian is essential to ensure that such meals are nutritionally adequate, as well as responsive to the special dietary needs of the client.
4. An approved dietitian's name and registration number or indication of master's degree shall appear on the menu submission forms (Attachment V, page 1 and Attachment VI, page 1) used for menu submission. A copy of this document including the approved dietitian's signature, attached to a copy of the menu cycle, must be kept on file at the AAA office. The dietitian may also submit to the AAA a letter accompanying the menu cycle indicating which menus have been re-

viewed/approved, including the time period for which the menus will be served, the meal service locations, and the dietitian's registration number.

5. The approved dietitian must indicate the amount of protein, Vitamin C, Vitamin A, calcium, sodium, calories, fiber and fat for each menu to be used. This information is to be included on the menu submissions to the Department. It is recommended that a computer-assisted nutrient analysis be completed on all menus to ensure nutritional adequacy. Copies of the computer-assisted nutrient analysis shall be maintained on file at the AAA office. Note that while the nutrients listed above are targeted and respective values included on the menu form, other nutrients should also be given attention.

North Carolina

Nutrition programs are not required to employ a licensed dietitian or nutritionist, but arrangements must be made for a qualified dietitian/nutritionist to certify nutrition program menus.

Washington

The staffing pattern should include:

- Registered Dietitian or Individual with Comparable Expertise (ICE): The Older Americans Act requires CNS and HDNS to be carried out with the advice of "a dietitian or individual with comparable expertise." For the purpose of these standards, a dietitian shall be defined as a dietitian registered by the Commission on Dietetic Registration (Registered Dietitian or RD). An individual with comparable expertise (ICE) is defined as a nutritionist according to RCW 18.138, which requires a master's or doctorate degree in one of the following areas: human nutrition, nutrition education, foods and nutrition, public health nutrition, or nutrition sciences. It is recommended that the RD or nutritionist be certified by the State of Washington in accordance with RCW 18.138.
- An RD or ICE must be available to the service provider for the planning and provision of nutrition services, either on staff, under contract, or in a volunteer capacity.
- The required responsibilities of the RD or ICE are:
 - A. assist in the development of menus;
 - B. certify that all meals meet the nutrient requirements as defined in the section on menu planning;
 - C. provide consultation on food quality, safety, and service;
 - D. plan meals prepared to meet special dietary or therapeutic needs, if provided by the program;
 - E. assist with the development of program objectives related to nutrition

education;

F. provide directly or oversee the provision of nutrition education;

G. assist with the development of program objectives related to nutrition therapy services, and provide nutrition therapy, where the nutrition program has allocated the resources to provide the service.

Additional responsibilities may include staff training and other activities based upon the needs and priorities established for the program. These needs and priorities should be jointly established by the AAA and the service provider.

Other Requirements

Current regulations require that State agencies and Area Agencies on Aging “shall have an adequate number of qualified staff to carry out the functions prescribed...

Sample SUA Standards/Guidelines: Staffing Requirements

Wisconsin

Each aging unit shall employ for the nutrition program an adequate number of qualified staff, supplemented as necessary by qualified consultants, to ensure the provision of program leadership, planning, food service management, nutrition services, and other services.

Nutrition Program Director

A nutrition program director is responsible for the day-to-day management and administrative functions of the program. The nutrition program director will be hired on a full-time basis unless the county or tribal aging unit can clearly demonstrate that the size of the program or other conditions indicate that a part-time position is adequate.

The duties and responsibilities may include:

- (1) Recruit, screen, interview, hire, train, and supervise all part-time and fulltime subordinate personnel affiliated with this program;
- (2) Inform, assist, and seek advice from the nutrition advisory council;
- (3) Contract for provision of food stuffs, supplies, and facilities according to the procurement procedures of the designated authority and as described in this manual;
- (4) Develop fiscal procedures for the local dining centers.
- (5) Prepare contract applications, job descriptions, bid specifications and proposals, and budget proposals, in a timely and proper manner as directed;
- (6) Plan, develop, implement, and coordinate all programs and services included within the nutrition program;
- (7) Coordinate the development and provision of supportive services for this program;
- (8) Maintain all accounts and records required by this program and submit reports as

directed;

(9) Develop and maintain good working communication with the awarding agency for all aspects of this program;

(10) Compile, organize, and prepare written reports and materials for the aging unit and other key agencies as directed (this includes the county or tribal aging unit, the area agency, and BADR);

(11) Set up auditing controls to measure program effectiveness, feasibility, and costs on a continuing basis;

(12) Identify program problems and recommend remedial measures;

(13) Attend public hearings and meetings relating to legislative proposals for the elderly as directed by the aging unit;

(14) Carry out all other duties and activities assigned to the holder of this position;

(15) Develop and maintain a good public relations program including the use of local newspapers, radio, and public appearances;

(16) Develop training programs for nutrition program staff as needed; and

(17) Recruit, train and recognize volunteers as needed by the nutrition program.

Nutrition Program Dining Center Managers

All congregate dining centers shall be supervised by a designated dining center manager, who is responsible to the nutrition program director, for organizing and supervising the safe and sanitary service of meals and all other related nutrition program activities carried on at the dining center.

Depending on the structure of the nutrition program, job duties for dining center managers may include some of the following:

- greeting and registration of participants;
- record keeping of program data;
- counting and depositing participant donations;
- food safety activities such as testing and recording temperatures of food, washing utensils, and surfaces;
- outreach to new participants;
- quality assurance for food or for food-vendor contracts;
- assessments for home-delivered-meal participants; and
- scheduling and/or supervising volunteers in some of the above activities.

Important skills and qualities to consider when hiring dining center managers include food-handling experience, first aid certification, group leadership experience, problem-solving abilities, and a warm, non-judgmental personality.

Maryland

Employ adequate numbers of qualified staff – The AAA shall provide adequate paid and volunteer staff to operate nutrition services including a Nutrition Services Director, a site manager, and additional staff based on the size of the program, the service area, the method and level of service provided and outreach. In carrying out this function, the AAA shall adhere to local, state and federal equal employment opportunities and fair employment practices.

The AAA shall administer nutrition project with the advice of dietitians or nutritionists licensed in Maryland

Washington DC

Site Manager Requirements

- Special consideration given to those 60 years of age and older;
- Experience and ability in working with people;
- Knowledge of and ability to use public and community resources in planning site services;
- Creative abilities in developing and designing site services for individuals and groups; and
- Motivational skills to encourage site participants to explore other programs and activities and site programs.

Site Manager Responsibilities

- Coordinates the nutrition site under the general supervision of the project director and/or the nutritionist of the Lead Agency;
- Recruits and supervises a corps of volunteers, including participants, to assist with site activities;
- Plans and develops recreational and educational programs, with the help of customers, the site council and the Lead Agency;
- Cooperates with community workers, nutrition workers and the site council in developing supportive and outreach services needed by customers and others in the community;
- Interviews and registers customers of the center;
- Keeps daily and weekly attendance sheets on meals served to customers and guests; and maintains a record of home delivered meals disbursed from congregate site;
- Oversees the collection of contributions by program participants and guests;

- Develops the confidence of the customers, awareness of their needs, and coordinates with project resource persons to meet these needs;
- Maintains time and attendance records for staff and volunteers;

Food Handlers

A minimum of two certified food handlers are required to serve food at each site. Meals that are prepared on-site must certify all cooks and food aides. All servers must be certified by the Department of Consumer and Regulatory Affairs. The servers must practice the essentials of sanitary food handling and food service.

Host/Hostess

Greets and welcomes customers. May assist site manager in record keeping.

Driver

When transportation is provided, the driver transports the customers to and from the site or other location as specified by the project director or site manager.

North Carolina

Nutrition providers must provide enough staff to operate the program, including a nutrition program director and, if funded for congregate nutrition, a site manager. Site managers may not be paid through the Home and Community Care Block Grant for more than 4 hours per day.

Nutrition staff also must recruit, orient, train, and supervise volunteer staff to help with meal service and programming.

Washington

The service provider should employ an adequate number of qualified personnel to assure satisfactory conduct of the program. Preference should be given to persons age 60 or over in the hiring for all positions when other qualifications are equal.

The staffing pattern should include:

Nutrition Program Director: The program director should be empowered with the necessary authority to conduct the day-to-day management and administrative functions of the program. The director may be hired on a part-time or full-time basis, at the discretion of the AAA, as long as the staff time allocated is adequate to fulfill the responsibilities of the position.

Program directors should have management or supervisory experience and a background in food, nutrition, or food service management, which can be fulfilled by education or experience in the food service industry.

Other Personnel: The method used to provide meals, nutrition education, and nutrition outreach will determine the number and type of permanent, consultant, or volunteer personnel required to manage the nutrition program and provide fiscal, administrative and clerical support.

VOLUNTEERS

The delivery of OAA nutrition services depends largely on volunteers-many of who are themselves older adults. Each year, over half a million volunteers work through State and Territorial Units on Aging, Area Agencies on Aging, and more than 20,000 local organizations to help deliver OAA services.

Volunteer activities in nutrition programs include assisting at group meal sites, serving on boards or advisory councils, delivering meals to the homebound, escorting frail older persons to services, counseling older persons in a variety of areas including health promotion and nutrition and assisting with reception and clerical needs.

While almost any work that needs to be done to meet the goals of the program can be done by volunteers, careful assessment of the needs of both the program and the available volunteer workforce should take place. Some of the best program volunteers are often found among older adults participating in services at senior centers or dining sites.

By identifying a range of jobs and different abilities, skills and commitment requirements, the program can attract a more diverse group of volunteers. Often times, former volunteers move on to become outstanding employees within an organization. The following types of volunteers should be considered:

Short-term or episodic volunteers: These volunteers are more likely to take on jobs that are short in duration with definite start and end dates and those that occur at regular intervals-such as fundraising events.

College volunteers and interns: Colleges and universities often sponsor volunteer fairs for recruitment. If interested in volunteers with specific expertise (nursing, public relations, nutrition), initiate contact with the department that is most consistent with the needs.

Virtual volunteers: Many people are looking for opportunities that they can complete from home or work computers and on the internet. Family commitments, time constraints or disability can make volunteering difficult.

Volunteers with disabilities: People with disabilities are an excellent yet often underutilized source of volunteer talent. The Americans with Disabilities Act provides for full participation in and access to all aspects of society, including volunteering. Reasonable accommodations can often be made with little effort and expenditure. Other agencies can sometimes lend adaptive equipment for the use of a specific volunteer.

Volunteers are motivated to offer their services for a variety of reasons such as to improve the quality of life of members of the community; to support something they believe in; to make new friends; to repay what they have received, to learn new skills or to feel like they are needed'. However, common to all is the desire to be successful and the need for recognition for their efforts.

All volunteer jobs have costs and benefits. Costs may include the time commitment and certain aspects of the job that are less appealing than others. Benefits may include special training, the development of new relationships, the fulfillment of personal goals and recognition for the positive results gained from the contribution of time. Developing position descriptions for volunteer jobs is essential to both define the tasks expected and to appropriately match the potential candidate's characteristics, skills and availability. Many states require background checks of volunteers who will be working with vulnerable older adults. This should be clearly spelled out in the job requirements.

Although training of volunteers is as important as training of regular paid staff, it is often done hurriedly or not at all. Once the perfect person is selected for the job, orientation and job-specific training is essential to a successful and rewarding experience for both the volunteer and the program.

Ongoing recognition of volunteers for their efforts will ensure that they continue to volunteer and feel good about their contribution. The knowledge that an organization values and recognizes their volunteers can be a powerful incentive for others to step up and volunteer. Recognition can take place in many ways including an annual volunteer recognition event, thank you cards, gift certificates, plaques and/or award certificates.

STAFF AND VOLUNTEER RESOURCES

Senior Community Service Employment Program ([SCSEP, http://www.doleta.gov/seniors/](http://www.doleta.gov/seniors/))

SCSEP provides part-time employment and training opportunities for low-income adults age 55 or older, and assists older workers in transitioning to unsubsidized employment. Many nutrition programs hire SCSEP employees to perform a variety of jobs in foodservice, office environments, congregate nutrition sites and other settings.

SCSEP is established under Title V of the OAA. Although the SCSEP is authorized by the OAA, it is administered by the US Department of Labor.

The program provides part-time employment and training opportunities for low-income adults age 55 and older. Thirteen non-profit organizations and 56 state and territorial units on aging administer the SCSEP and ensure that more than 100,000 participants receive job training and 20,000 are placed with employers through the 69 grantees.

Wages for SCSEP employees vary depending on a variety of factors including the minimum wage in effect in a state and the specific job being performed. Often, annual physical examinations are provided. The agency employing SCSEP employees typically subsidizes some portion of salary and/or benefits.

Senior Corps Programs (www.seniorcorps.org)

Senior Corps is a network of programs that tap the experience, skills, and talents of older adults to meet community challenges. Through its three programs – Foster Grandparents, Senior Companions, and RSVP (the Retired and Senior Volunteer Program) – more than half a million Americans age 55 and over assist local nonprofits, public agencies, and faith-based organizations in carrying out their missions. The programs are administered by the Corporation for National and Community Service (www.nationalservice.org). RSVP and Senior Companions are utilized extensively throughout the aging network including nutrition programs.

RSVP (www.seniorcorps.org/joining/rsvp/index.html)

Local organizations receive grants to sponsor and operate RSVP projects in their community. These projects recruit older adults age 55 and over to serve from a few hours a month to almost full time, though an average commitment is 4 hours per week. Volunteers are typically paired with local community organizations, like senior nutrition programs, that are already helping to meet community needs.

RSVP volunteers are not paid, but sponsoring organizations often reimburse them for some costs incurred during service. RSVP provides appropriate volunteer insurance coverage, and volunteers receive pre-service orientation and in-service training from the agency or organization where they are placed.

The Senior Companion Program (SCP) (www.seniorcorps.org/joining/scp/index.html)

Senior Companions are healthy individuals age 60 or over with limited incomes. They serve one-on-one with the frail elderly and other homebound persons who have difficulty completing everyday tasks such as grocery shopping. Senior Companions serve 20 hours per week, and also provide short periods of relief to primary caregivers. All applicants undergo a background check and a telephone interview, as well as a pre-service and in-service training on relevant topics such as diabetes, Alzheimer's and issues related to mental health. Local nonprofit organizations and public agencies receive grants to sponsor and operate Senior Companion projects. Community organizations that address the health needs of older persons work with the local SCP projects to place and coordinate the services of the SCP volunteers.

Senior Companions receive an hourly wage (tax free), reimbursement for transportation, annual physical examinations, meals, and accident liability insurance during service.

TRAINING

Training staff and volunteers helps to ensure good performance and is essential to the provision of high quality and dependable services. Training can be formal or informal, in group settings or with individuals. Technology-based training offered on interactive cd-rom or on the internet can help managers address a variety of training needs.

Orientation

The induction of a new staff member or volunteer to his or her job is an important aspect of personnel management. During the orientation, the employee is introduced to the goals and objectives of the organization and is provided with a context for their critical role within the organization. Topics included in an orientation may include:

- tour of the location and introductions
- review of roles and responsibilities
- review of employee handbook and personnel policies
- review of benefits and enrollment as appropriate
- review of job description
- orientation to the agency history, mission and values
- training schedule
- description of evaluation process

Managers should carefully evaluate the training needs of the staff. There are three levels of analysis for determining the needs that training can fulfill:²

Organizational Analysis: focuses on identifying where within the organization training is needed. Examples might include:

- training of all staff regarding the agency policies on harassment.
- training for kitchen staff regarding food safety and sanitation
- training of supervisors regarding appropriate hiring practices
- training for all staff on issues related to cultural diversity
- training for delivery drivers regarding emergency procedures to follow in specific participant situations

Operations analysis: attempts to identify the content of training-what an employee must do in order to perform competently. Examples might include:

- training related to safe food handling practices such as ServSafe
- assessment techniques for home delivered meal participants
- training on administration of the Determine Your Nutritional Health screen.

Individual analysis: determines how well each employee is performing the tasks that make up his or her job. The employee job description provides the basis for identifying the specific tasks to be evaluated. These individual training efforts could be designed to help an individual employee succeed in specific areas where improvement is needed or new skills are required.

After a thorough analysis, a written training plan which is updated regularly and evaluated for effectiveness can help to ensure that ongoing training of staff becomes standard practice. Some states have specific requirements for training such as food handler's permits or other requirements that may address special training needs. These should be included in the training and/or orientation plan.

Sample SUA Standards/Guidelines: Training

North Carolina

Training:

- Nutrition program directors must successfully complete within 12 months of employment at least 15 hours of instruction in food service sanitation and also participate in training on nutrition program management offered by the N.C. Division of Aging. They are responsible for day-to-day management and thus must be knowledgeable about administrative procedures, site operations, record-keeping and reporting requirements, food safety, and food service.
- Site managers must be knowledgeable about site operations and record-keeping requirements, community resources and referral procedures, food safety, and food portioning.
- All staff must be knowledgeable about the aging process.
- All staff must know procedures for fire or disaster evacuations.

Agencies should document that training is provided to staff. This may be done with agendas and sign-in sheets for group training. For individual sessions, documentation might take the form of a list of topics discussed that is signed or initialed and dated by the staff member or volunteer. Agencies also could assemble written information in booklets or binders for site managers and volunteers and then document the date that information is explained and distributed. Documentation may take many forms, but it is important to assure that the nutrition agency has met the requirement for staffers to have the required skills and knowledge. This is usually done by documenting that they have participated in training sessions.

Staff working in food preparation – whether paid or volunteer – must be under the supervision of a knowledgeable person who can assure the application of hygienic techniques and practices in food handling, preparation, and service.

The requirement for the nutrition program director to complete at least 15 hours of instruction in food service sanitation may be met by completing a food sanitation course offered by an accredited college or university or by completing the SERV SAFE, Serving Safe Food Certification course offered through the Education Foundation of the National Restaurant Association.

The N.C. Cooperative Extension Service, local health departments, and community colleges often sponsor courses in communities across the state. To see a schedule of upcoming local food service training courses posted on the NC State University website, go to the following link: <http://www.ces.ncsu.edu/depts/foodsci/agentinfo/>

In addition, the Division of Aging provides a basic orientation to nutrition program management twice a year, required for nutrition program directors but also open to site managers.

Nutrition agencies must assure that site managers are well versed not only in food safety and food portioning, but also in site operations, community resources and methods of referrals, and record-keeping (for example, documentation of client registration information and documentation of meals ordered, received, and served).

Training in site operations should include among other things the agency's requirements for programming and nutrition education, procedures to North Carolina Division of Aging be followed in case of participant illness or injury, provisions for quarterly fire drills, and the agency's procedures for evacuating the site in case of fire or explosion. Not only site managers but all staff should be trained in evacuation procedures in case of fire or explosion. In addition, you would expect that all staff (paid or volunteer) should understand the aging process and apply that awareness to their interactions

and communications with the nutrition program participants.

Certain agency requirements – such as protecting confidentiality, safeguarding the collection of voluntary donations, or refraining from prohibited activities (e.g., giving medications) – may not be listed as training requirements but certainly are a part of program operations.

Some staff and volunteers are responsible for specific tasks that require individual training. For example, the person designated to receive food if food preparation is subcontracted to a caterer has certain responsibilities for documenting arrival time and notifying responsible parties if incomplete meals are delivered. Their training also should involve temperature control after food delivery if it is held prior to serving. Staff or volunteers who assist with food service should be taught how to portion food according to menu specifications.

Congregate site workers may need instruction in how to provide assistance to participants who have difficulty walking or carrying trays.

Home-delivered meal volunteers also need training specific to their role in meal service, such as:

- maintaining temperatures while delivering food,
- procedures for documenting that a meal was delivered to a specific client,
- friendly visiting and providing assistance with opening meals, beverages, or utensils,
- what to do if they encounter an emergency at a client's home,
- how to report changes in a client's status or condition,
- how to report situations that look like the client or the household is in imminent danger,
- procedures for accepting donations, including Food Stamps,
- protecting confidentiality,
- not to leave a meal unless the participant is at home to receive it (unless other arrangements have been made),
- not to conduct financial transactions except those related to meal donations,

- not to administer medical treatment or medications, and
- not to accept gifts from participants.

Agencies must maintain some type of documentation that training has been offered to volunteers.

Wisconsin

To the maximum extent feasible, the nutrition program shall provide training and opportunities for voluntary participation of individuals in all aspects of program operations. Appropriate orientation and training shall be provided by the nutrition program.

Staff/Volunteer Training:

All staff, paid and volunteer, shall be oriented and trained to perform their assigned responsibilities and tasks.

Training shall include food safety, prevention of foodborne illness, the principles of the Hazard Analysis Critical Control Point (HACCP), accident prevention, instruction on fire safety, first aid, choking, emergency preparedness, and other emergency procedures. A minimum of six (6) hours of staff training shall be provided annually for paid staff and regular volunteer food-service staff. Three and one-half hours can come from the regional nutrition program staff training; coordinated by BADR, AAA's, and aging units; and usually held in the fall of every year.

Washington

Training and Other Staff and Volunteer Requirements:

Safe Food Handling Practices

All staff involved in the handling of food must have training on safe food handling practices prior to beginning food handling duties if the worker does not hold a valid food worker card. These staff must receive the required food worker training and obtain a food worker card, according to local health department requirements and WAC 246-217 (Appendix II), within fourteen calendar days of beginning paid or volunteer work. The provider must document the health department requirements relevant to each site and develop its policies in response.

Orientation and In-Service Training

All staff, both paid and volunteer, should receive orientation before providing nutrition program services.

The service provider should provide in-service training on a regular basis for all staff, paid or volunteer, engaged in implementing the program. Such training should be designed to enhance each staff member's performance of his/her specific job responsibilities, take into account requests for training from staff, and be designed to resolve problems identified during the AAA assessment of program performance.

Each service provider should have a written training plan describing the content of orientation and the subject matter expected to be covered during in-service training. The dates and content of training actually provided should be documented.

As allowed by the funding source, nutrition program funds may be used to pay for costs to local, statewide or out-of-state training in accordance with AAA policies.

STAFF EVALUATION

Performance appraisals of paid staff and volunteers serve a twofold purpose: ² (1) to improve employees' work performance by helping them realize and use their full potential in carrying out the organizational mission and program goals and (2) to provide information to employees and managers for use in making work-related decisions.

Most organizations use a combination of methods to accomplish performance appraisals including rating scales, check lists, narrative evaluation or personal conferences. Whatever the method, performance appraisals offer an important opportunity for supervisors to encourage and recognize strengths and identify weaknesses or areas where additional training or support is needed. The purpose and frequency of appraisals should be known and the methods should be consistently applied.

Sample SUA Standards/Guidelines: Employee Evaluation/Performance Appraisal

Louisiana

Performance Appraisal/Evaluation

A performance evaluation is performed on an annual basis on all nutrition personnel. This evaluation will include employees' knowledge of work, quality/quantity of work, dependability and work relationships.

The Individual's immediate supervisor and/or LSP Director complete the evaluation form. The form is then discussed with the employee. The employee and the supervisor date and sign the evaluation form. The employee may have the evaluation reviewed by the Agency Director and/or the Personnel Committee of the Board of Directors.

Additional Resources

ServiceLeader: www.serviceleader.org

Fisher JC, Cole K. Leadership and Management of Volunteer Programs. San Francisco: Jossey-Bass; 1993.

References

1. Levin M. The Gift of Leadership. BAI, Inc; 1997.
2. Cascio WF. Managing Human Resources-Productivity, Quality of Work Life, Profits. 5th ed. Irwin/McGraw-Hill; 1998.

Chapter 10

General State and Area Agency on Aging Responsibilities

Contents

Background

Administration on Aging

State Units on Aging

- OAA 2000 Requirements
- Sample SUA Standards/ Guidelines: State Plans

Area Agencies on Aging

- OAA 2000 Requirements
- Sample SUA Standards/ Guidelines: Area Agency Plan
- Sample SUA Standards/ Guidelines: Advocacy
- Sample SUA Standards/ Guidelines: Grievance Procedures
- Sample SUA Standards/ Guidelines: Coordination of Services

BACKGROUND

With the passage of the Older Americans Act (OAA) in 1965, a partnership of federal, state, tribal and local entities was formed. This partnership, called the Aging Network, consists today of 56 State Units on Aging (SUA); 655 Area Agencies on Aging (AAA); 243 Indian Tribal Organizations (ITO); more than 29,000 service providers; thousands of volunteers and a wide variety of national organizations. Created during a time of rising societal concerns for the poor and disadvantaged, the OAA has been reauthorized 14 times since its original passage in 1965.

Subsequent amendments to the OAA have added grants to AAAs for local needs identification; planning and funding of services; services targeted at low-income minority elders; health promotion and disease prevention activities; in-home services for frail elders; services for caregivers and those services which protect the rights of older persons. Other changes have been made which have provided added flexibility to states.

ADMINISTRATION ON AGING

Title II of the OAA established the Administration on Aging (AoA) within the Department of Health and Human Services (DHHS). The mission of AoA is to develop a comprehensive, coordinated and cost-effective system of long-term care that helps elderly individuals to maintain their dignity in their homes and communities, and to help society prepare for an aging population. The AoA is under the direction of the Assistant Secretary for Aging (ASA)-appointed by the President with the advice and consent of the Senate-and with a direct reporting relationship to the Secretary of DHHS. AoA is the Federal Leader of the Aging Network.

-
- Sample SUA Standards/ Guidelines: Advisory Councils

Federally Recognized Tribes

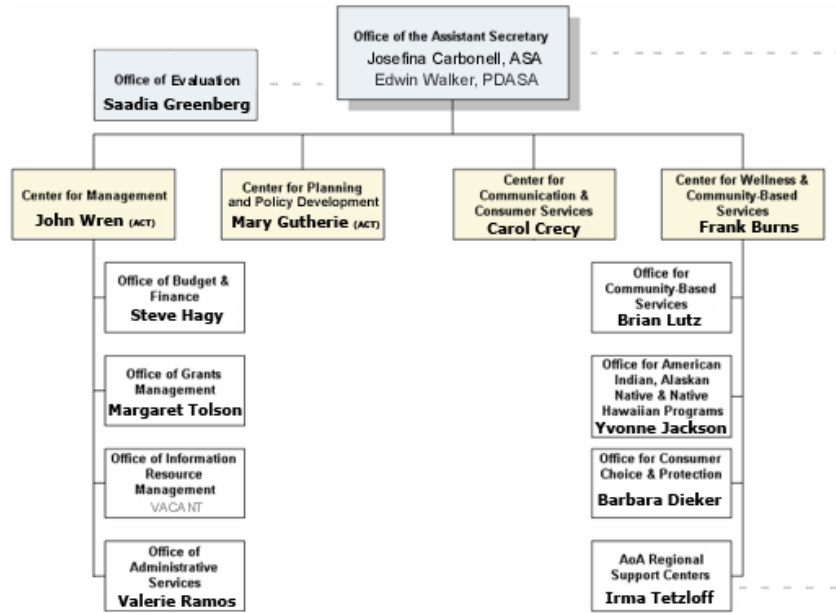
Targeting & Eligibility for Nutrition Services

- OAA 2000 Requirements
- Sample SUA Standards/ Guidelines: Targeting
- Sample SUA Standards/ Guidelines: Eligibility/ Assessment
- Sample SUA Standards/ Guidelines: Termination of Services

Outreach

- OAA 2000 Requirements
- Sample SUA Standards/ Guidelines: Outreach

Additional Resources



Included in AoA's duties and functions are: to serve as an effective advocate for older individuals; collect and disseminate information related to problems of the aged and aging; develop basic policies and set priorities; coordinate and assist in the development and planning of a nationwide network of comprehensive, coordinated services; administer grants; conduct evaluation of programs; provide technical assistance and consultation to states and stimulate more effective use of existing resources. The complete detail of the duties and functions of AoA and of the Assistant Secretary are contained in OAA Section 202.

An AoA Strategic Action Plan for 2003-2008 was developed at the direction of the ASA to guide the AoA as it carries out its statutory mission and provides national leadership on aging issues. Five priorities were established in the plan to ensure that AoA and the Aging Services Network continues to play a leadership role in shaping the evolving health and long term care system on behalf of older people. These priorities are:

- Make it easier for older people to access an integrated array of health and social supports;

- Help older people stay active and healthy;
- Support families in their efforts to care for their loved ones at home and in the community;
- Ensure the rights of older people and prevent their abuse, neglect and exploitation; and
- Promote effective and responsive management.

AoA has ten Regional Support Centers which are responsible for disseminating and providing technical assistance to SUAs, AAAs, ITOs, and nutrition services providers regarding the development of guidelines concerning safety, sanitary handling of food, equipment, preparation and food storage, disseminating information to nutrition service providers about nutrition advancements and developments and defining a long range role for the nutrition services in community-based care systems.

AoA employs a full-time National Nutritionist (OAA Sec. 205(a)(2)(A) who is responsible for the administration of the nutrition services described in subparts 1 and 2 of part C of title III of the OAA. Specific duties of the National Nutritionist include: designing, implementing and evaluating nutrition programs; developing guidelines for nutrition providers regarding all aspects of food handling and safety; disseminating current information regarding nutrition advancements and developments to nutrition service providers; promoting coordinating between nutrition service providers and community-based organizations; developing guidelines on cost containment; defining a long range role for the nutrition services in community-based care systems; developing model menus and other appropriate materials for serving special needs populations and providing technical assistance to the Regional Support Centers.

STATE UNITS ON AGING

The SUA are broadly responsible for the development, implementation and evaluation of comprehensive and coordinated systems to serve older individuals within their state. The OAA provides states with flexibility to meet the differing needs of their own state and so implementation varies from state to state. The result is a variety of program models and systems throughout the country, designed to specifically address the unique issues, concerns and needs of older individuals within the different states.

The wide range of functions of the SUA includes advocacy, planning, coordination, interagency linkages, information sharing, brokering, monitoring and evaluation.

In order for any state to be eligible to receive grants from allotments under OAA, the governor designates a state agency as the sole agency to put forth a plan for developing and implementing a statewide aging program. Once approved by the ASA this multi-year plan (2, 3 or 5 years) represents a legal contract between the state and the federal government for carrying out the programs authorized under the OAA. The plan is revised as necessary.

OAA grant funds received by the SUAs are allotted based on the population of older individuals age 60 or over relative to the population of older individuals in all states, according to the most recent census data along with other factors. This is commonly referred to as the interstate funding formula.

The SUA is responsible for designating planning and service areas (PSAs). A PSA may be any approved unit of general purpose local government, region within a State recognized for area wide planning, metropolitan area or Indian reservation. Once the SUA has divided the State into distinct (PSAs), it is charged with designating an Area Agency on Aging (AAA) for each one of them. There are some exceptions to this requirement and currently there are 13 states or territories which are considered single PSAs. Examples of single PSAs include Alaska, Delaware, Nevada and Wyoming. A SUA must perform the functions of AAA in the case where a state is a single planning and service area.

One critical function of SUAs is the development of a formula for the allocation of its funds to PSAs. This formula, which must first be approved by the ASA, must take into account the geographical distribution of older individuals in the State (with special attention paid to those living in rural areas), the distribution among PSAs of older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older individuals. This is commonly referred to as the intrastate funding formula.

Older Americans Act 2000 Requirements

SEC. 305

(1) the State shall, in accordance with the regulations of the Assistant Secretary, designate a State agency as the sole State agency to-

(A) develop a State plan to be submitted to the Assistant Secretary for approval under section 307;

(B) administer the State plan...;

(C) be primarily responsible for the planning, policy development, administration, coordination, priority setting and evaluation of all State activities...

(D) serve as an effective and visible advocate for older individuals...;

(E) divide the State into distinct planning and service areas (or in the case of a State specified in subsection (b)(5)(A) designate the entire State as a single planning and service area....;

(2) the State agency shall-

(A) ...designate for each such area...a public or private nonprofit agency or organization as the area agency on aging for such area;

(B) provide assurances...that the State agency will take into account...the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan;

(C) in consultation with area agencies...develop and publish for review and comment a formula for distribution within the State of funds received under this title that takes into account-

(i) geographical distribution of older individuals in the State; and

(ii) the distribution among planning and service areas of older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older individuals;

(D) submit its formula...to the Assistant Secretary for approval;

(E) provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need with particular attention to low-income minority individuals and older individuals residing in rural areas...;

(F) provide assurances that the State agency will require use of outreach efforts...;

(G) set specific objectives...for each planning and service area;

SEC. 307 State Plans

(a) ...each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Assistant Secretary a State plan for a two-, three-, or four-year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may be regulation prescribe....Each such plan shall comply with all of the following requirements:

(1) The plan shall-

(A) require each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval....an area plan meeting the requirements of section 306; and

(B) be based on such area plans

(2) The plan shall provide that the State agency will-

(A) evaluate..the need for supportive services...nutrition services, and multipurpose senior centers within the State;

(B)develop a standardized process to determine the extent to which public or private programs and resources ...have the capacity and actually meet such need;

and

(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended...to provide each of the categories of services specified in section 306(a)(2).

(3) The plan shall-

(A) include...the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning intrastate distribution of funds); and

(B) with respect to services for older individuals residing in rural areas-

(i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000;

(ii) identify, for each fiscal year...the projected costs of providing such services....and

(iii) describe the methods used to meet the needs for such services...

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities, with particular attention to low-income minority individuals and older individuals residing in rural areas.

(5) The plan shall provide that the State agency will-

(A) afford an opportunity for a hearing upon request...to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issue guidelines applicable to grievance procedures..

(C) afford an opportunity for a public hearing, upon request, by any area agency on aging, by any provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request...

(6) The plan shall provide that the State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require...

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(8)(A) The plan shall provide that no supportive services, nutrition services, or in-home services will be directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency-

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable

quality, by such State agency or area agency on aging.

(10) The plan shall provide assurances that the special needs of older individuals residing in rural areas will be taken into consideration...

(14) The plan shall provide assurances that, if a substantial number of the older individuals ...are of limited English-speaking ability, then the State will require the area agency on aging...

(A) to utilize in the delivery of outreach services...workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include-

(i) ...to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability...

(ii) providing guidance to individuals engaged in the delivery of supportive services..to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(15) The plan shall...

(A) identify the number of low-income minority older individuals in the State; and

(B) describe the methods used to satisfy the service needs of such minority older individuals.

(16) The plan shall provide assurances that the State agency will require outreach efforts...

(17) The plan shall provide....assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs...

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based long-term care services...for older individuals who –

(A) reside at home and are at risk of institutionalization...

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall-

(A) provide an assurance that the State agency will coordinate programs... under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(23) The plan shall provide assurances that demonstrable efforts will be made-

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities...

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI...

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received...will not be used to pay any part of a cost incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

Sample SUA Standards/Guidelines: State Plans

Oklahoma

Procedures. In order to carry out the policy for State Plan development, the following activities are performed by ASD staff:

- (1) Obtain State Plan development guidelines from the Administration on Aging (AoA) Regional Office;
- (2) Elect to utilize a one, two, three, or four year format, (resource allocation must be submitted annually);
- (3) Outline State Plan development timeline;
- (4) Gather identified priority needs from the area agencies on aging;
- (5) Develop a data profile on older Oklahomans from available census data;
- (6) Conduct statewide needs assessment activities including, but not limited to, public hearings and/or administration of survey instruments to older consumers, service providers, state agencies and other interested parties;
- (7) Analyze the results of needs assessment activities, and outline identified statewide priority needs;
- (8) Outline and evaluate the existing service delivery system, including services, coordination, advocacy, and training activities;
- (9) Present a summary of Needs and Priorities to the State Council on Aging;
- (10) Develop draft summary of State Plan including:

- (A) A summary of the Older Americans Act, as amended,
 - (B) A profile of older Oklahomans (including all pertinent census data),
 - (C) An outline of the identified needs of older Oklahomans,
 - (D) A description of the current service delivery system, and an evaluation of same,
 - (E) State Plan goals and objectives,
 - (F) State Council on Aging membership and responsibilities, and
 - (G) A resource allocation plan;
- (11) Present State Plan summary to State Council on Aging and other interested agencies/organizations two weeks prior to conduct of public hearing(s) on the Plan;
- (12) Publicize public hearing(s) at least two weeks prior to public hearing(s) outlining dates, times, and locations, and assure that older persons, public officials and other interested parties have reasonable opportunities to participate;
- (13) Conduct public hearing(s) and incorporate written and verbal comments into revised Plan, as appropriate;
- (14) Submit revised Plan to the State Council for approval;
- (15) Submit revised Plan to Department of Human Services, Office of Management Services, in preparation for approval by the Oklahoma Commission for Human Services;
- (16) Submit final Plan to Department of Human Services, Executive Division, for approval;
- (17) Submit final Plan to Department of Human Services, Office of Management Services, in preparation for approval by the Governor; and
- (18) Submit final Plan to AoA Regional Office for approval.

SUAs develop written standards and policies designed to assist AAAs and nutrition services providers in meeting specific quality standards and in complying with federal requirements including nutritional content of meals served, compliance with state and local food safety and sanitation code and other requirements of the OAA. The SUA is responsible for ensuring adherence to these policies. Excerpts from samples of these policies and standards which focus on specific topic areas are included throughout the chapters in the Toolkit.

AREA AGENCIES ON AGING

The AAAs are the leaders relative to all aging issues on behalf of all older persons in the PSA. As such, they are responsible for a wide variety of functions including advocacy, planning, coordination, inter-agency linkages, information sharing, brokering, monitoring and evaluation. AAAs award grants or enter into contracts with local provider agencies to furnish services in the community. AAAs may also directly provide services when certain conditions are met.

AAAs must develop and submit for approval by the SUA an area plan for a 2, 3 or 4-year period as determined by the SUA (OAA Sec. 306). The plan must determine the extent of need for services, including nutrition, and evaluate the effectiveness of the use of resources in meeting such need. All activities of the AAA including planning, advocacy and systems development must consider, among other things, the needs of low-income minority older individuals, older individuals residing in rural areas, older individuals with disabilities, older individuals with greatest social needs and the number of older individuals who are Indians residing in such areas.

Older Americans Act 2000 Requirements

SEC.306(a) Area Plans

Each area agency on aging....shall....prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency.....Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1). Each such plan shall-

(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, or construction of multipurpose senior centers.....evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;

(2) provide assurances that an adequate proportion, as required under section 307(a)(2) of the amount allotted for part B...will be expended for the delivery of...

(A) services associated with access to services (transportation, outreach, information and assistance, and case management services);

(B) in-home services...;

(C) legal assistance...;

(3)(A) designate, where feasible, a focal point for comprehensive service delivery in each community....;

(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point...;

(4)(A)(i) provide assurances that the area agency on aging will set specific objectives for providing services to older individuals with greatest economic need and older individuals with greatest social need, include specific objectives for providing services to low-income minority individuals and older individuals residing in rural areas...;

(B) provide assurances that the area agency on aging will use outreach efforts....;

(C) contain an assurance that the area agency on aging will ensure that each activity undertaken...including planning, advocacy, and systems development will include a focus on the needs of low-income minority older individuals and older individuals re-

siding in rural areas;

(5) Provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities...;

(6) provide that the area agency on aging will-

(A) take into account...the views of recipients of services...;

(B) serve as the advocate and focal point for older individuals within the community...;

(C) .where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families....;

(D) establish an advisory council consisting of older individuals consisting of older individuals...who are participants or who are eligible to participate...representatives of older individuals, local elected officials, providers of veterans' health care (if appropriate) and the general public....;

(E) establish effective and efficient procedures for coordination of-

(i) entities conducting programs that receive assistance under this Act within the planning and service area...; and

(ii) entities conducting other Federal programs for older individuals at the local level...;

(G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency....shall conduct outreach activities to identify such individuals...and shall inform such individuals of the availability of assistance...;

(7) provide that the area agency on aging will facilitate the coordination of community-based, long-term care services designed to enable older individuals to remain in their homes...;

(10) provide a grievance procedure...;

(11) provide an assurance that the AAA will to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI;

(12)provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federal assisted programs...

Sample SUA Standards/Guidelines: Area Agency Plan

Montana

Purpose: This rule establishes the requirements that the area agency shall meet to develop or amend and submit an area plan.

(1) The area agency shall develop the area plan in accordance with all applicable federal and state regulations, the uniform plans format and other guidelines issued by the

division.

(2) The area plan shall encompass a planning period as specified by the division. However, fiscal budgets, including allotments/funds for services and planned service delivery shall be amended at least annually or as available allotments/funds change.

Needs Assessment: The area agency shall assess the level of need for congregate and home-delivered meals within the PSA and maintain documentation of the method (s) used to assess level of need and how the results were used to determine levels of services to meet those needs.

Wisconsin

Specific content areas, formats, and timetables will change over time. Those requirements will be addressed in the instructions for the area plans.

All area agency plans shall address the following general requirements:

- Indicate the participation of older people in the development of the plan.
- Show evidence of participation and approval by the board and advisory council.
- Address all required content areas.
- Indicate a significant focus on meeting the needs of aging units.
- Follow the prescribed format.

Sample SUA Standards/Guidelines: Advocacy

Montana

Purpose: This rule requires the area agency to carry out activities to advocate in the interest of the elderly.

(1) The area agency shall serve as the advocate for the elderly in the planning and service area performing at least the following activities:

(A) Monitor, evaluate, and comment on all policies, programs, hearings, levies, and community actions which affect older persons;

(B) Solicit comments from the public on the needs of older persons;

(C) Represent the interest of older persons to public officials, public and private agencies or organizations;

(D) Carry out activities in support of the division's long term care ombudsman program; and

(E) Coordinate planning with other agencies and organizations to promote new or ex-

panded benefits and opportunities for older persons.

(2) The area agency shall develop and implement written policies and procedures that describe how it carries out advocacy activities.

Wisconsin

The Older Americans Act includes advocacy as part of the core mission of the aging network.

Permitted Activities:

(1) The benefit specialist may, with the written consent of the benefit specialist's client, contact a legislator or other elected official, legislative employee, or agency official, to advocate for a change in law, rule or policy that would fix the client's problem.

(2) The benefit specialist may testify about legislation or rules or otherwise communicate with an elected official about some topic if representing a client affected by the topic, which client has provided written consent; or if the official has requested that the benefit specialist testify or respond.

(3) Even without a client or invitation from a legislator, the benefit specialist may testify at any time for informational (educational) purposes. The benefit specialist may only provide information and shall refrain from recommending a position on the matter under consideration.

(4) The benefit specialist may contact legislators or public agency staff to inform them of and make available the results of non-partisan analysis, study or research.

(5) At the written request of a legislator, a benefit specialist may provide in person or in writing a factual presentation of information on a topic directly related to the performance of a grant, contract or other agreement, including the OAA grant agreement provisions for benefit specialist services and contracts for legal backup services.

(6) The benefit specialist may give talks or use communication media to reach older persons and inform them of actions they could, or even should, take to contact elected officials.

(7) As part of her or his job, the benefit specialist may serve on a government sponsored committee.

(8) The benefit specialist may contact the state legislators in whose district she or he resides to advocate on an issue even if the benefit specialist does not have an affected client or a request from the legislator.

(9) The benefit specialist may furnish information to a state agency official in response to a request for information from that state agency official.

(10) The benefit specialist may send communications to "members," Board, clients and constituents of her or his organization regarding legislation of interest to the organization and regarding actions these persons may want to take.

(11) The benefit specialist may appear before or communicate with any legislative body, if related to a possible decision that might affect the existence of her or his organization, its powers and duties, tax-exempt status or the deduction of contributions

to the organization. For example, if the federal government proposes a fifty percent reduction in the Older Americans Act to pay for heated toilet seats on the new FU60 attack aircraft, the benefit specialist may contact federal legislators to remonstrate and may testify before a congressional committee on the matter.

(12) The benefit specialist may engage in activities which would otherwise be considered lobbying if undertaken on behalf of an organization to which she or he belongs (e.g., the Wisconsin Association of Benefit Specialists) when the position taken and the activity are both authorized by the organization under its by-laws, and when the actions are undertaken outside of work time.

(13) The benefit specialist may lobby on his or her own time, speaking for herself or himself, on an issue of her or his choosing.

Note: Except when advocating on one's own time, the benefit specialist should identify herself or himself by her or his position and organizational affiliation. If advocating on behalf of an organization, the benefit specialist should make clear that it is the position of the organization and that the benefit specialist is not speaking for her or his employing agency.

Prohibited Activities

(1) The benefit specialist may not use agency funds, position, title or organizational affiliation to influence any election or to foster or engage in any partisan or political activity. Note that this does not prevent a benefit specialist from inviting all candidates for an office to a forum to discuss relevant issues, provided it is run in an even-handed manner, or from sending out candidate surveys and printing the results in an agency newsletter.

(2) The benefit specialist may not use OAA funds for dues to any organization which has, as a purpose or function, engaging in activities that are prohibited under the Act, unless the amount of dues per person per year is less than \$100. This \$100 limit does not apply to bar association dues.

(3) The benefit specialist may not attempt to influence legislative or administrative action by oral or written communication with any elective official, agency official or legislative employee.

Sample SUA Standards/Guidelines: Grievance Procedures

Hawaii

A grievance procedure shall be established in writing by the AAA for those terminated from the program against their will and for registering complaints regarding the service. The grievance procedure shall assure that both the individual and program staff are given a full hearing.

Wisconsin

Area agencies on aging, aging units, and their subcontractors shall adopt an informal discrimination complaint process that incorporates appropriate due process standards and provides for a prompt and equitable resolution of complaints alleging discrimination on the basis of protected status, including those alleging illegal harassment. Information provided to clients about the complaint resolution process should be in writing or other usable media such as audiotape. In service areas with a significant population of persons with limited ability to read and understand English, the information should be translated and available in the language of the major language groups in that area. Complainants have an informal complaint process available through which to seek resolution at the most immediate level of responsibility within the agency. However, complainants are not required to file an informal complaint with the contractor/subcontractor in most cases. They may choose to file a formal complaint. The informal complaint process of the contractor or subcontractor should attempt early resolution.

Sample SUA Standards/Guidelines: Coordination of Services

Montana

Area Agency Development of a Comprehensive and Coordinated Service Delivery System

Purpose: The rule describes the requirements the area agency shall meet to develop a comprehensive and coordinated system within the planning and service area.

(1) The area agency continuously shall work toward development of a comprehensive coordinated community-based system that shall facilitate access to and utilization of all supportive and nutritional services provided by any source within the PSA. Components of this system may include:

(A) Services that facilitate access such as transportation, outreach, information and referral, escort, individual assessment and service management;

(B) Services provided in the community such as congregate meals, continuing education, health and nutritional education, health screening...

(C) Services provided in the home, such as home health services, ... home delivered meals, and nutritional education

(2) The area agency shall assess the needs of the elderly in the PSA and the effectiveness of resources in meeting identified needs

(3) The area agency shall establish effective and efficient procedures for coordination of planning and service delivery with other agencies and organizations within the PSA...

Advisory Councils

Each AAA must establish an advisory council to continuously advise the AAA on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan. The advisory council must consists of:

- More than 50% older persons, including minority individuals who are participants or who are eligible to participate;
- Representatives of older persons;
- Representatives of health care provider organizations, including providers of veterans' health care (if appropriate);
- Representatives of supportive services providers organizations
- Persons with leadership experience in the private and voluntary sectors;
- Local elected officials; and
- The general public.

Sample SUA Standards/Guidelines: Advisory Councils

Montana

PURPOSE: This rule requires each area agency to have an advisory council and establishes the requirements it shall meet.

(1) Each area agency shall have an advisory council which shall develop and make public written bylaws which specify the role and functions of the advisory council, number of members, procedure for selection of members, term of membership and the frequency of meetings.

(2) The advisory council shall meet at least quarterly.

(3) The composition of the councils shall be more than fifty percent older persons, including older persons with greatest economic or social need, older minority individuals, service recipients, and also shall include representatives of older persons, local elected officials and the general public.(4) The advisory council shall advise the area agency on developing and administering the area plan, conducting public hearings, representing the interest of the elderly and previewing and commenting on community policies and actions affecting the elderly.(5) The area agency shall provide staff and assistance to the advisory council.

FEDERALLY RECOGNIZED TRIBES

Under the laws of the U.S. and in accordance with treaties, statutes, Executive Orders, and judicial decisions, the Federal government has recognized the right of Indian Tribes to self-government and self-determination. Because of this government-to-government relationship and the unique needs and circumstances of American Indians, Title VI of the OAA was established to directly fund ITOs to provide services comparable to Title III services.

The AoA Office for American Indian, Alaska Native, and Native Hawaiian Programs is charged with serving as an advocate on behalf of Native American elders and works closely with States to promote the enhanced delivery and coordination of services and implementation of programs to older American Indians, Alaska Natives and Native Hawaiians. Nutrition services are a major component of the Title VI programs. Services provided under title III are coordinated, to the maximum extent practicable, with the services provided under title VI.

TARGETING AND ELIGIBILITY FOR NUTRITION SERVICES

Although all individuals 60 years of age and older are eligible for services under the OAA, priority attention is given to those in greatest need. This is referred to as “targeting” services. Targeted groups are those in greatest social and economic need with particular attention to low-income minority elderly, Indians, and older individuals living in rural areas.

Older Americans Act 2000 Requirements

SEC 102 Definitions

For the purposes of this Act-

(27) The term “greatest economic need” means the need resulting from an income level at or below the poverty line.

(28) The term “greatest social need” means the need caused by non-economic factors, which include-

(A) physical and mental disabilities

(B) language barriers; and

(C) cultural, social or geographical isolation, including isolation caused by racial or ethnic status, that-

(i) restricts the ability of an individual to perform normal daily tasks; or

(ii) threatens the capacity of the individual to live independently.

(35) The term “older individual” means an individual who is 60 years of age or older.

In addition to focusing on low-income and other older persons at risk of losing their independence, the following individuals are eligible to receive nutrition services under title III Subpart 3-General Provisions, Sec 339 (2)(I)(J):

- A spouse of any age;
- Disabled persons under age 60 who reside in housing facilities occupied primarily by the elderly where congregate meals are served;
- Disabled persons who reside at home and accompany older persons to meals; and
- Nutrition service volunteers

Sample SUA Standards/Guidelines: Targeting

Wisconsin

Targeting of effort is an integral part of the planning and advocacy activities of the aging network. When organizations develop advocacy or service plans, an initial step is an assessment of the needs of the older people in the community. Advocacy strategies and services are then developed to meet the needs of the older population. The needs of the older population drive the plans and activities of the aging agency. Because needs are not uniform within the older population, the activities of the aging unit are naturally more focused on some groups (target groups) than on others. This does not imply a lack of caring for the general elderly population; merely a focusing of efforts.

Targeting is not excluding older people; rather it is a focusing of limited funds and resources on the needs of older people who are, by some standard, most in need. Federally mandated target groups, which are noted in the Older Americans Act, can be seen as representing the sense of the Congress on which groups within the nation's older population require particular attention by the aging network. It is the same process that local aging agencies go through in determining their local target groups.

Washington

To the degree feasible, the provider shall ensure that preference is given to those individuals aged 60 and over who meet the vulnerability criteria in Section IIB3, with further preference given to low-income and minority individuals and to those with the greatest economic and social need.

IIIB3: A person is considered vulnerable if s/he:

- a. Is unable to perform one or more of the activities of daily living (ADL's) or instrumental activities of daily living (IADL's) listed below without assistance due to physical, cognitive, emotional, psychological or social impairment.

Activities of daily living are eating, dressing, bathing, toileting, transferring in and out of bed/chair, walking.

Instrumental activities of daily living are preparing meals, shopping, medication management, managing money, using the telephone, doing housework, transportation; or

Has behavioral or mental health problems that could result in premature institutionalization; or is unable to perform the activities of daily living listed in #1, or is unable to provide for his/her own health and safety, primarily due to cognitive, behavioral, psychological/emotional conditions which inhibit decision-making and threaten the ability to remain independent.

AND

- b. Lacks an informal support system: Has no family, friends, neighbors or others who are both willing and able to perform the service(s) needed, or the informal support system needs to be temporarily or permanently supplemented.

Sample SUA Standards/Guidelines: Eligibility/Assessment

Tennessee

An applicant is eligible to receive home delivered meals if the person meets at least one of the criteria in each of the following five categories:

1. Age is 60 years or older.
2. Physical or mental disability:
 - a. Cannot use public transportation. No public or private transportation available;
 - b. Incapable of walking unassisted outside home: or
 - c. Mental frailty.
3. Inability to prepare meals:
 - a. Cannot prepare meals; or
 - b. Cannot shop for self.

4. Lack of informal supports:

- a. Lives alone or with another dependent person; or
- b. Has no informal help.

5. Unable to receive meal assistance through other formal sources.

PRIORITY

After eligibility is determined, priority rating for meal service is total PAF score as follows:

- (1) High priority/high impairment 65+
- (2) Medium priority/medium impairment 50 to 64
- (3) Low priority/low impairment 35 to 49
- (4) Minimal impairment Below 35

Hawaii

Although all persons aged 60 and over are technically eligible for admission, the program is mandated to give priority to those determined to be in greatest economic and social need. Therefore, each applicant for the congregate and home delivered meals programs should be registered and assessed by a trained assessment member of the program staff or a trained outreach aide employed by the Information and Assistance Service in the PSA. At a minimum, all programs beginning October 1994 shall use the Nutrition Checklist instrument. The program may also elect to use the level I Nutrition Screen. The assessment shall not require a means test.

After assessment is completed, the nutrition program shall determine admission into the program based on the eligibility criteria and the availability of space at a meal site for congregate meals participation or based on the capacity of the program to provide home delivered meals for specific geographic areas. If space is available and there are no persons with greater priority known to be in need of the service at that time, an applicant shall be admitted into the program. If there is no space available at the time of initial referral, the applicant shall be placed on a wait list if that is the individual's desire. Individuals on the wait list shall always be admitted into the program based on prioritization of need and not on the basis of length of time on the wait list.

When an assessment is completed by the trained program staff, a procedure shall be established to inform the I & A/Outreach Program or other appropriate programs within the PSA of the initiation of meal service and any other services which the older person may need. Although it is not the responsibility of the meals program to perform

other social services, coordination with I & A services and other appropriate services such as case management is a responsibility. The nutrition program shall coordinate to the maximum extent feasible. It is in this way that individualized social services can be assured for all congregate and home delivered meals participants.

Participants for the congregate meals program shall be reassessed on a periodic basis by a trained program staff to determine if their needs are being met and if other appropriate services are needed in which case, referrals are in order. Reassessment shall be documented in participants' files.

Likewise, documented reassessment of all home delivered program participants shall be done to avoid fostering dependency on the home delivered meals program for those whose needs may be met in other more appropriate ways and to coordinate the provision of other services, which may be needed by the participants.

All HD participants admitted on a permanent basis shall be reassessed quarterly by a trained staff to reevaluate their eligibility status or via staff conferences to update the team on the participant's current status. Dated documentation shall be made in the participant's record on any changes or lack of changes in the person's circumstances or condition.

All HD participants who were admitted for a limited and specified time period, Le, those convalescing following hospital discharge, shall be reassessed when the estimated length of time for service has expired to determine if the service is still needed and, if so, for how long. Reassessment shall be by a trained staff or via staff conferences to update the team on the participant's current status.

To insure HD reassessments are conducted on a timely basis, the service provider must establish a record keeping system, which indicates assessment, dates to program staff without violating participant's confidentiality.

Montana

Eligible recipients of home delivered nutrition services:

1. A person aged 60 or over who is homebound by reason of a disabling physical, emotional, or environmental condition.
2. The spouse of the older person, regardless of age or condition, if the Area Agency on Aging determines receipt of the meal is in the best interest of the homebound older person.

3. Area agencies on aging shall establish procedures that will allow nutrition project administrators the option to offer a meal, on the same basis as meals are provided to elderly participants, to:

- a. individuals providing volunteer services during the meal hours, and
- b. individuals with disabilities who reside at home with an older eligible individual.

In order to receive home delivered meals in excess of two consecutive weeks, participants must have an initial assessment, and

1. May have a recommendation from doctor, county health nurse, or home health agency; or
2. Are homebound; or
3. Show evident inability to prepare meals for themselves; or
4. Have been recently discharged from the hospital or nursing home and need the help either temporarily or permanently; or
5. Are dependent on a caregiver.

Based upon the initial assessment, at risk participants shall be re-evaluated every 90 days, and non at risk participants shall be reevaluated at a minimum of 180 days.

RESTRICTIONS: If sufficient resources are not available to serve all eligible individuals who request a service, the Area Agency on Aging shall ensure that preference is given to those of greatest social or economic need, with particular *attention to* low - income minorities.

Sample SUA Standards/Guidelines: Termination of Services

South Carolina

Termination of congregate nutrition services shall be a carefully planned process. Indicators:

1. The agency has clearly defined criteria to determine when to terminate a congregate nutrition service.
2. Prior to making a decision, the client and/or the client's family and appropri-

ate agency staff discuss decreasing service levels and the effective date of service termination.

3. All notices of client service termination shall include written procedures to be followed by the client and/or client's family if the service needs to be reinstated.

Hawaii

Each project must establish a system delineating the criteria for termination of a participant from the congregate and home delivered nutrition programs. Once an applicant has been accepted into the program, the participant cannot be terminated without sufficient rationale. Recommendation for termination can be made by the trained program staff and with the approval of the program director.

A. Congregate Nutrition Program Rationale:

1. Non-attendance or continuous erratic attendance without providing adequate notice;
2. Causing or threatening to cause bodily injury to himself or to other participants;
3. Willful damage to property;
4. Anti-social behavior, which disrupts other participants or is detrimental to the program.

B. Home Delivered Program Rationale:

1. Determination that participant is able to care for himself, including procurement and preparation of meals and no longer needs the service;
2. Determination that a member of the participant's household is able to prepare the client's meals without causing undue stress to the household member;
3. Repeated failure of the participant to eat the meals, or to eat the meal on a timely enough basis to insure against spoilage;
4. Repeated failure of the participant to admit the meal delivery person into his/her home; or hostile behavior towards the delivery person, which prevents the delivery person from determining whether the meal is accepted;

5. Successive absence of the participant from his/her home when delivery is made without sufficient notification to the program.

At the time of termination, the project shall document the circumstance for the termination and describe what arrangements have been made by the participant and/or family for meal service. This can be recorded on the assessment form. Notices to interested parties who have indicated or requested a report of the participant's change of status shall be transmitted.

OUTREACH

Outreach activities are emphasized throughout the OAA as an essential means of identifying, reaching and targeting services to older individuals who may not be aware of or who may have difficulty accessing existing services for a variety of reasons. The SUA requires AAAs to arrange for outreach at the community level that identifies individuals eligible for assistance under the OAA and other programs, both public and private, and informs them of the availability of assistance. The outreach efforts place special emphasis on reaching older individuals with the greatest economic or social needs with particular attention to low income minority individuals, older Indians, older individuals with severe disabilities, individual with limited English speaking abilities, and individuals with Alzheimer's disease and their caregivers.

Outreach activities designed to inform the community about resources for seniors may include:

- Speaking engagements;
- Participation in community activities such as health fairs and other events directly related to programs and services for older individuals;
- Distribution of culturally-appropriate brochures and other written materials to community service organizations, churches, hospitals, local businesses, local government offices and physician's offices; and
- Special mailings in utility bills regarding available services.

Outreach activities designed to help older individuals access or obtain a needed service may include:

- Visiting seniors in their homes to determine the help needed;

- Assisting in the completion and submission of forms and applications;
- Arranging services;
- Advocating on behalf of older individuals when access to services from an agency or provider is difficult; and
- Following-up to determine if help was received and if the older individual's needs were met.

Older Americans Act 2000 Requirements

SEC 307 (a)(16) State Plans

The plan shall provide assurances that the State agency will require outreach efforts that will-

(A) identify individuals eligible for assistance under this Act, with special emphasis on-

- (i) older individuals residing in rural areas
- (ii) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (iii) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (iv) older individuals with severe disabilities
- (v) older individuals with limited English-speaking ability; and
- (vi) older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals);

And

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

Sample SUA Standards/Guidelines: Outreach

Hawaii

Outreach for the nutrition program is a necessary supportive service to seek out and identify those persons in need of the program and to provide follow up service for those participants already accepted into the program. Because outreach is such an integral service to the nutrition program, it is an allowable cost of Title IIIC. Outreach efforts may be conducted either by the service provider itself or by the Outreach/ Information and Assistance Service within the PSA. If Title IIIC funds are used by the

general outreach/ Information and Assistance service, they must be used specifically for services for the nutrition project and its participants.

Nebraska

With respect to the provision of outreach services, the Area Agency on Aging will provide outreach that will identify individuals eligible for assistance under the Act, with special emphasis on rural elderly, older individuals in greatest economic and/or social need (with particular attention to low-income minority individuals), and severely disabled older individuals, and will inform such individuals of the availability of assistance. Further, the Area Agency on Aging must assure that if there is a significant number of older Native Americans in the Planning and Service Area, the Area Agency on Aging will conduct outreach to identify, locate, and inform them of the availability of services under the Act.

Washington

Nutrition outreach is an activity designed to seek out and identify, on an ongoing basis, the hard-to-reach, isolated, and vulnerable target group of eligible individuals throughout the program area. Nutrition outreach should be provided as necessary to reach the target population. It may be provided by the AAA, nutrition services provider, or by another contracted provider on behalf of one or more nutrition services providers.

When nutrition outreach is being provided by the nutrition program service provider, all costs associated with the delivery of nutrition outreach services must be budgeted and charged appropriately to that service.

Additional Resources

Disaster Assistance Resources for Practitioners and the Aging Network. AoA.
www.aoa.gov/disaster/network/default.htm

Administration on Aging Strategic Action Plan FY 2003-2008
www.aoa.dhhs.gov/about/strategic/strategic.asp

Community-Based Alternatives for Individuals with Disabilities (Olmstead). AoA.
www.aoa.gov/network/cba/default.htm

Guidance on the Development and Submission of State Plans and Intrastate Funding Formulas. [PROGRAM INSTRUCTION](#) AoA-PI-02-02
www.aoa.gov/pi/pi-02-02.html

State Plan Amendment Procedures for the Older Americans Act, as Amended in 2000

[PROGRAM INSTRUCTION](#) AoA-PI-01-01
www.aoa.gov/pi/pi-01-01.html

Guide to Performance-Based Management: Concepts and Approaches For the National Network on Aging AoA (1996).
<http://www.aoa.gov/network/pbmguide.html>

www.aoa.gov/aoa/pages/splan.html

Consumer Direction in Home and Community Based Services: An Assessment Guide, National Association of State Units on Aging (NASUA), 1999. No Charge. Developed under an "Independent Choices" grant from the Robert Wood Johnson Foundation, the Guide is designed to help states comprehensively assess their system of home and community based services to identify opportunities for increasing consumer choices and control over their services. Ten states are currently using the Guide to develop a state-specific consumer direction reform agenda.

www.nasua.org/bookstore.htm#STATE%20COMMUNITY%20SERVICES%20PROGRAMS

National Association of State Units on Aging Public Policy
www.nasua.org/Public%20Policy.htm

Home and Community-Based Services for Older Adults Policy Paper. National Association of Area Agencies on Aging (PDF format):

Introduction and Executive Summary

www.n4a.org/home_and_communitybased_services_0207.pdf

Older Americans Act

http://www.n4a.org/older_americans_act_0207.pdf

Chapter 11

Evaluation

Contents

Introduction

Types of Evaluation

- Process or Program Implementation Objectives
- Outcomes

Planning for Evaluation

Outcome Measurement Results for OAA Nutrition Programs

- Initial Outcome Measurement
- Performance Outcome Measurement Project (POMP)
- Advanced POMP
- Local Projects

Standardized Health Measures in National Surveys

Older Americans Act 2000 Requirements

SUA Standards/ Guidelines: Planning & Evaluation

INTRODUCTION

The Older Americans Act Nutrition Program (OANP) faces numerous challenges as it evolves to meet the future needs of older adults, their families and caregivers. Evaluation of program operations and outcomes measurement is essential if programs are to efficiently and effectively meet future demands. Evaluation employs systematic methods for collecting, analyzing and using information to answer basic questions about a program-and to ensure that those answers are supported by evidence.

Evaluation and documentation of outcomes is necessary to answer broad questions such as:

- Is the OANP achieving its aim of promoting better health through improved nutrition and contributing to the goal of keeping older Americans independent and functioning in their own homes and communities?
- Is the OANP meeting the needs of increasing numbers of frail elderly including ethnic minorities with health disparities?
- What is the evidence of OANP's effectiveness?
- What array of culturally appropriate nutrition related services and culturally competent professional expertise contributes to this body of evidence?
- Do the OANP and OAA link to the broader health and supportive system including managed care, other home and community care models and specialized home services?

A growing body of scientific evidence has helped us to learn more about interventions that positively impact nutritional status, health and quality of life. Along with this growing evidence has come a parallel trend toward use of this data for decision making at all levels-from the Federal government as

Definitions & Terms	
References	required by the Government Performance and Results Act (GPRA) to local funders such as United Way, private foundations and local government, consumers and tax payers.
Resources	

Results of evaluation can be used to:

- Raise the level of awareness about programs and services by presenting results to elected officials, philanthropic organizations, partnering organizations, and the overall community including older adults, their families and caregivers;
- Identify weaknesses or areas where attention is needed and implement necessary changes in programs and services;
- Assist boards of directors or advisory councils in making and justifying funding decisions;
- Increase funding by presenting results to philanthropic organizations or elected officials both at the local and national levels.

The most successful programs incorporate evaluative measures throughout their operations and view them as critical elements in assuring the provision of effective, efficient and high quality services. An evaluation approach that emphasizes accountability and continued improvement is most useful.

TYPES OF EVALUATION

There is a strong consensus in the scientific community that only randomized experiments are fully capable of providing reliable estimates of a program's impacts(1). The randomized experiment is the "gold standard" of program evaluation. In the simplest randomized design, potential participants are randomly assigned to either an experimental (or treatment) group, which will be subject to the program being assessed, or to a control group, from which the program will be withheld. The program's impact is then estimated by comparing the average outcomes in the experimental group, after sufficient exposure to the program, with control group outcomes measured at the same time.

A randomized evaluation design however would have ethical and possibly legal implications if utilized by OANPs. Therefore, quasi-experimental designs are more commonly utilized. These include:

- comparing participants to non-participants
- comparing participants before and after program participation

- comparing participants vs. non-participants before and after program participation

There are essentially two types of evaluation objectives.

Process or Program Implementation Objectives(2)

Process evaluation includes both qualitative and quantitative information. Process evaluation helps answer questions like what did you do? How much did you do? How did you do it and to whom? What was done compared to what was planned? Process evaluation describes the amount, type and quality of services provided as well as the characteristics of participants served(3).

Examples of components of process evaluation include:

- outputs such as people served, units (meals) served
- cost per unit (such as a meal or nutrition education session) of output or outcome
- cost per person served
- amount of work or units (such as meals) produced by a program or department or other efficiency measures
- demographics of participants (to evaluate targeting efforts, risk factors, etc.)
- participant satisfaction with various aspects of service including meals, staff interaction, timing of delivery and meal site operations
- satisfaction/quality input from other agency partners, community members, family members

Outcomes

Outcome evaluation or measurement is a tangible, quantifiable indicator of the actual results of a program, service or activity(4). Outcomes usually are benefits or changes in participants' knowledge, attitudes, values, skills, behavior, condition or status which result from their involvement with a program(5).

Examples of possible outcomes for nutrition services include:

- increased socialization
- increase in key nutrients consumed
- reduction in nutritional risk
- increase in nutrition knowledge
- increased quality of life
- change in behavior related to diet
- participant perception of increased or maintained health
- increase in participant ability to remain independent
- reduction in hospitalizations and/or medical costs

- increase in access to other supportive services

PLANNING FOR EVALUATION

Measuring and evaluating the success of a program requires planning and effort. Organizations must first define success, and then establish objectives for attaining and measuring it. Most organizations conduct a strategic planning process which provides direction and defines success for the overall organization and its departments—thus establishing broad goals. Many different models exist for strategic planning. From there, departmental and program objectives and measures are defined.

Engaging stakeholders as well as the primary users of evaluation results in all elements of evaluation including the design, preparation, feedback, follow-up and dissemination will help to ensure that the evaluation findings are used, interpreted and distributed properly(8).

A successful evaluation process *must be realistic and balanced, taking into account available resources for collecting and analyzing data*. Program objectives must be clear, specific and *measurable*—that is, sufficient information can be realistically attained to measure the objective using available program resources and the data can be logically interpreted once compiled. The more specific the objectives are the easier program evaluation becomes.

While outcomes measurement is increasingly emphasized, programs still need to monitor and measure process objectives. These include:

- Participant Measures: such as demographics...are the right people being served?
- Adherence to Standards of Service: are standards for areas such as food safety, record keeping, food production, service delivery, and staff training being met?
- Financial Accountability: how is the money being spent? Are costs in line with the budget and with projections?
- Program Outputs: what exactly is the program generating? Are the outputs meeting, exceeding or falling behind projections? Why? What are the implications?
- Participant Satisfaction: are participants satisfied with the food? With the quality of their interactions with staff and volunteers? Are services easily accessed? What services are lacking or needed?

Examples of objectives that may be relevant for process evaluation for nutrition programs include:

- provide services annually to X% of the eligible older adult population within the service area
- provide services annually to X% of the eligible older adult minority population within the service area
- achieve a participant satisfaction rate with at least 90% of participants rating meal quality as high
- maintain a unit cost range of \$X-\$X

Other process-related objectives might relate to staff productivity, levels of service delivery and other quality measures.

Determining Program Outcomes

Outcomes most often represent benefits or positive changes in participants' knowledge, attitudes, values, skills, behavior, condition or status(5). However, in some cases an outcome may be related to maintaining or slowing a decline.

Outcomes also are either proximate (closer in time) and more directly the result of specific program component(s) offered by OANPs, or distal (intermediate or longer in time) and influenced by numerous other factors and programs in addition to the OANP(4).

The contributions of OANPs vary widely depending on the services provided. While some OANPs provide only meals and nutrition education, others provide a full array of nutrition services. The range and quality of nutrition related activities conducted and the availability of professional nutrition expertise most strongly determines the type and amount of outcomes that can be expected(4).

A systems-oriented approach which links allocated resource inputs to activities conducted to outputs to outcomes can provide a useful framework for documentation and evaluation of OANP efforts and outcomes. The model for this approach, referred to as a Logic Model, provides a way of linking planned work to intended results(6). A glossary of terms provided at the end of this chapter provides definition of terms commonly used in outcomes and performance evaluation.

Figure A(4) illustrates the Input-Activities-Output-Outcome framework for the OANP from a theoretical point of view. The framework illustrated in Figure A shows two outcomes boxes to deliberately identify proximate and distal outcomes.

Figure A: A Model to Identify Potential Performance and Outcome Indicators for the OANP (4)

SOCIETAL VALUES		ECONOMIC ISSUES		POLITICAL ISSUES		MEDICAL & HEALTH ISSUES	
INPUTS		ACTIVITIES		OUTPUTS		OUTCOMES	
Resources used by OANP		Service Components		Products		Proximal Altered Status	
Distal Altered Status						Distal Altered Status	
MONEY, STAFF, EQUIPMENT, SUPPLIES, FACILITIES, VOLUNTEERS, PARTICIPANT POOL, COLLABORATION NETWORK, WORK	FOOD PRODUCTION AND DELIVERY; MEALS-CHOICE, TEXTURE, DIET MODIFIED, CULTURALLY APPROPRIATE DINING SITE LOCATION, HOME DELIVERY	APPROPRIATE MEALS TARGETED NUTRITION EDUCATION CLASSES OR MATERIALS TO MAKE CHANGES DIET/STATUS RELATED NUTRITION COUNSELING	DIETARY INTAKE/ NUTRIENTS FOOD ENJOYMENT CUSTOMER SATISFACTION NUTRITION KNOWLEDGE	PARTICIPANT/FAMILY FUNCTIONAL STATUS INDEPENDENCE DISEASE MANAGEMENT/PREVENTION QUALITY OF LIFE & WELL BEING			
QUESTIONS / ISSUES: 1. STAFFING-APPROPRIATE TRAINING & SKILLS FOR OPERATIONAL PROGRAM MANAGEMENT 2. STAFFING-SUFFICIENT INVOLVEMENT OF NUTRITION PROFESSIONALS 3. BALANCE OF COSTS & REVENUES 4. EFFICIENT USE OF VOLUNTEERS & DONATIONS 5. GOOD CONNECTIONS WITH OAA NETWORK	NUTRITION SERVICES: .EDUCATION, .SCREENING & ASSESSMENT, .CARE PLANNING, .COUNSELING COORDINATION AND REFERRAL: CARE PLANNING & COORDINATION FOR HEALTH, SOCIAL, PHYSICAL ACTIVITY PROGRAMS QUESTIONS / ISSUES: 1. MEET DIETARY GUIDELINES & RDA/DRI 2. MEET SAFETY & SANITATION STANDARDS 3. ACCESSIBLE TO MOST NEEDY 4. NUTRITION SERVICES MATCH INDIVIDUAL & COMMUNITY NEEDS	CARE PLANNING FOR COMPLEMENTARY SERVICES SOCIAL, HEALTH/ WELLNESS PROGRAMS QUESTIONS / ISSUES: 1. APPROPRIATE MEALS: # PARTICIPANTS SERVED # HOURS OF SERVICE # MEALS SERVED # MODIFIED DIETS # MEALS PER PERSON 2. TARGETED NUTRITION EDUCATION CLASSES OR MATERIALS TO MAKE CHANGES: # OF SESSIONS 3. DIET/STATUS RELATED NUTRITION COUNSELING: # SCREENED, PRIORITIZED # REFERRALS # COUNSELED	DIETARY/ HEALTHY LIFESTYLE MODIFICATIONS DISEASE MANAGEMENT ACCESS TO FOOD & NUTRITION, FOOD SECURITY ACCESS TO NEEDED HEALTH CARE & SUPPORTIVE SERVICES SOCIAL INTERACTION CARE GIVER SUPPORT RISK: MEDICAL, NUTRITION, SOCIAL, FUNCTIONAL/ PHYSICAL QUESTIONS / ISSUES: 1. AMOUNT OF CHANGE 2. WHO ACHIEVES CHANGE	HOME & COMMUNITY SYSTEM LINKAGES & SERVICE PROVISION WITH HOSPITALS & NURSING HOMES, MAINTANCE AT HOME ECONOMIC COSTS OF SERVICES HEALTH CARE RESOURCE SAVINGS DELAYED NURSING HOME PLACEMENTS, HOSPITAL RE-ADMISSION QUESTIONS / ISSUES: 1. COMBINED CONTRIBUTION OF OANP & OTHERS TO DISTAL OUTCOMES			

Developing Outcome Objectives or Targets

Outcome targets are difficult to establish in a meaningful way until programs have at least one year of baseline outcome data(5). Setting targets without a baseline relevant to the specific program may lead to erroneous interpretation of data and program and/or funding changes that are premature. Using benchmarks, such as those available from the POMP Pilot Survey and other studies listed in this chapter can be helpful in guiding programs as they develop objectives for their own performance. Objectives that may be relevant for outcomes evaluation for nutrition programs include:

- improve nutritional intake of X% of participants by increasing fruit and vegetable consumption by X servings per day
- increase social contacts of X% of participants by X per week
- increase the percentage of congregate participants who also participate in exercise classes by X% per quarter
- increase linkages of X% of participants to other support services as a result of participating in the nutrition program by X%
- reduce hospital admissions of X% of participants by X% per year

The above list of objectives represents *examples*. The actual objectives, as well as the number of objectives chosen for evaluation must be linked to the priorities and goals of the organization.

Outcome Indicators (Performance Measures)

Indicators are chosen which track progress toward the outcome target, showing the degree to which the desired results have been achieved. While there is much that would be “nice to know,” planners should limit indicators to a few essential indicators which are tied to specific outcomes. New data collection methods or tools may be necessary, but not always. Many standardized tools have been developed and tested and often times, agencies are already collecting data that reflects on outcomes. Data collection for indicators can be derived from a variety of sources including interviews, observation, case studies focus groups, surveys or questionnaires, pre and/or post tests or program records such as applications, assessment forms or other tools.

If the development of tools such as interview instruments, assessment instruments or questionnaires is necessary, it is critical to have someone on the evaluation team who is knowledgeable about the development of valid and appropriate evaluation tools.

There are advantages and disadvantages to using existing instruments(2). The primary advantages are that they are often (but not always) standardized and have been established as valid and reliable. The main disadvantages of using existing instru-

ments are that they are not always appropriate for all cultural or ethnic populations and may not be useful for the particular program being evaluated.

Examples:

#1: Outcome: Participants increase their consumption of key nutrients

Indicators:

- Participants report that they have increased their fruit and vegetable consumption by 1 serving per day as a result of consuming the meal
- Participants report that they have increased their intake of 4 key nutrients as a result of participating in the meal program.

Possible Sources of Data:

Participant survey and/or participant interviews

Objective or Target:

- improve nutritional intake of 55% of program participants each year, by increasing fruit and vegetable consumption by an average of 1 serving per day
- increase intake of 4 key nutrients (calcium, fiber, protein, vitamin A) among 55% of participants as a result of consuming the program meal.

#2: Outcome: Participants have more social contacts as a result of participating in the congregate meal program

Indicators: Participants report that they have more social contacts since participating in the congregate meal program.

Possible Sources of Data:

Participant survey

Objective or Target:

- 65% of congregate program participants annually report more social contacts since participating in the program

OUTCOME MEASUREMENT RESULTS FOR OAA NUTRITION PROGRAMS

Initial Outcome Measurement

The results of the most comprehensive evaluation of the OAA Nutrition Program were released in 1996. The results showed that the OAA Nutrition Program accomplished its mission of improving the nutritional intakes of older adults and decreasing their social isolation. The Executive Summary and Volume 1 are available online at www.aoa.gov/prof/aoaprogram/nutrition/program_eval/program_eval.asp.

The USDA ERS 4-volume Report, *Effects of Food Assistance and Nutrition Programs on Nutrition and Health, Volume 1-4, is available at*

www.ers.usda.gov/publications/fanrr19-1/

www.ers.usda.gov/publications/fanrr19-2/

www.ers.usda.gov/publications/fanrr19-3/

www.ers.usda.gov/publications/fanrr19-4/

NOTE: Volume 3 mistakenly refers to the OAA Nutrition Program as Nutrition Services Incentive Program. This is being corrected.

Nutrition and Health Characteristics of Low-Income Populations; Volume IV, Older Adults

www.ers.usda.gov/publications/efan04014-4/

Performance Outcome Measurement Project (POMP)

The AoA POMP projects were designed to develop outcome measures for OAA programs. In addition to individual state projects, the AoA funds a national survey of various programs using POMP that assess individual outcomes. The most recent tools are on the GPRA website at www.gpra.net/. These tools address different services, including congregate and home delivered nutrition services. A report on the National Survey *Highlights from the Pilot Study: First National Survey of Older Americans Act Title III Service Recipients - Paper No. 2* identified outcomes such as the following:

- Home delivered services are effectively targeted to vulnerable populations.
- Home delivered services are successfully targeted to socially isolated.
- Home delivered services provided are high quality and reliable in the perception of the service recipient.
- Home delivered meals are provided to individuals who need them.
- Home delivered meal recipients exhibit much greater levels of impairment or frailty than the entire 60+ population, suggesting that these OAA Services contribute to maintaining individuals in their homes.
- Dietary intake for home delivered meal recipients is as good as or better than the dietary intake for the general population 60+, suggesting that home delivered meals improve dietary intake.

There are similar outcome measures for congregate meals.

Advanced POMP

The AoA is funding 3-year projects that are in the process of finalizing their scope of work. The purposes of the Advanced POMP are to demonstrate:

- the cost avoidance attributed to OAA Program;
- efficiency of OAA Program; and
- effectiveness/benefits of OAA Program and potential economic impacts.

Local Projects

- **MOWAA Community Connections Grant**

The Meals on Wheels Association of America (MOWAA) is conducting a demonstration project titled “Community Connections.” The objective is to demonstrate the effectiveness of short-term home delivered meals and related value-added services. Six demonstration subgrants were provided as part of this project. Information is available at: <http://www.connectowellness.org/index.aspx>

- **Local Quality Assurance**

The Council on Aging of Southwestern Ohio in Cincinnati has an ongoing provider quality and performance project with a number of quality indicators including client satisfaction, service utilization, unit rate, percentage of desired referrals awarded, and number of improvement recommendations. Local providers are assessed yearly and given feedback regarding annual changes. Providers are expected to improve scores. This AAA is in the process of developing best practice models for their area as a means of assisting providers who have not sufficiently improved in performance. The contact is Ken Wilson, 513-721-1025 or kwilson@help4seniors.org

- ***Eat Better & Move More* Multi-site Demonstration Project**

The National Resource Center on Nutrition, Physical Activity & Aging at Florida International University, Miami, with support from the US Administration on Aging, awarded 10 mini-grants to locally implement *Eat Better & Move More*, a community-based nutrition and physical activity program for older adults. Nutrition, health, physical activity, and stages of change outcomes were measured. Instruments used are available at www.fiu.edu/~nutreldr/You_Can/You_Can_firstpage.htm

STANDARDIZED HEALTH MEASURES IN NATIONAL SURVEYS

It may be desirable to incorporate one or more standardized measures from national surveys so the results can be compared with published national data(4). Some standard measures are:

- **Core Healthy Days Measures:** The standard 4-item set of Healthy Days core questions is a direct estimate of people's perceived physical and mental health over time. The Healthy Days Measures have been used in the state-based Behavior Risk Factor Surveillance System (BRFSS) since 1993. In 2000, the Healthy Days Measures were added to the examination component of the National Health and Nutrition Examination Survey (NHANES). Standard Activity Limitation and Healthy Days Symptoms modules have been available since January 1995. When used together, these measures comprise the full CDC HRQOL-14 Measure. Healthy Days core questions are available at www.cdc.gov/hrqol/methods.htm Quality of life trend charts and prevalence estimates for a particular state or nationwide are available at apps.nccd.cdc.gov/HRQOL
- **Health Utility Index (HUI):** The HUI is based on eight attributes: vision, hearing, speech, mobility, dexterity, cognition, emotion, and pain/discomfort. It measures the health related quality of life for chronic disease patients on a scale of 0 (death) to 1 (perfect health) and is used to detect possible associations between HUI system and various chronic conditions. This index allows researchers to assign negative values to a person with a health status considered worse than death. The index has been used in population surveys and clinical studies such as the Action to Control Cardiovascular Risk in Diabetes (ACCORD) study and is found at www.fhs.mcmaster.ca/hug/
- **RAND 36-item Short Form Health Survey:** Commonly referred to as the SF-36, this tool uses 36 questions, eight subscales, and two summary scales to assess key aspects of physical and mental health. Individuals are asked to rate their general health, vitality, pain, limitations (due to physical and emotional problems), functioning (physical and social), as well as psychological distress and well-being. The SF-36 can be used alone or with disease-specific measures in clinical practice, research, and policy analysis. The SF-36 is used by the Centers for Medicare and Medicaid Services (CMS) and the Medicare Health Outcomes Survey which is available at www.cms.hhs.gov/surveys/hos/hosinstrument.asp

- **US Household Food Security Survey Module:** The 18-item US Food Security Survey Module, formerly known as the Core Module, is the basis for national level reports of food insecurity and hunger. It is used in the Current Population Survey (CPS) and NHANES 1999-2000. It is available at www.ers.usda.gov/Briefing/FoodSecurity/surveytools/
- **Six-item Short Form of the Food Security Survey Module:** The “short form” 6-item scale uses a subset of the standard 18 items. It provides a reasonably reliable substitute for surveys that cannot implement the 18-item measure. It is available at www.ers.usda.gov/Briefing/FoodSecurity/surveytools/
- **USDA Food Adequacy Indicator:** Food security status can be categorized in four major groups: enough and kinds of food wanted, enough but not always kinds wanted, sometimes not enough, and often not enough. This allows an indication of adequacy (quality) as well as sufficiency (quantity). The same indicator and follow-up questions are included in NHANES III. Different versions have been used in the Continuing Survey of Food Intake in Individuals (CSFII). USDA expects to refine and improve the food security questions and scale over time. Researchers should obtain the most current version of the questions and scale to maximize comparability with national statistics. For detailed information on how food security and hunger are measured, please visit www.ers.usda.gov/Briefing/FoodSecurity/measurement/
- **Health Eating Index (HEI):** The HEI is a summary measure of overall dietary quality, broadly defined in terms of adequacy, moderation and variety. It provides a picture of the type and quantity of foods that people eat, and the degree to which diets comply with specific recommendations in the *Dietary Guidelines* and the Food Guide Pyramid. Data from the 1999-2000 NHANES and CSFII were used to calculate the HEI. HEI findings are presented in *Older Americans 2004: Key Indicators of Well-Being*, the second comprehensive analysis of the lives of older Americans compiled by the Federal Inter-agency Forum on Aging-Related Statistics. This new document is available at www.agingstats.gov For details on how the HEI is computed, please visit www.cnpp.usda.gov/healthyeating.html
- **Fruit and Vegetable Consumption:** The average frequency of fruit and vegetable consumption per day has been asked in the BRFSS since 1996. Summary data are provided on the BRFSS website at www.cdc.gov/brfss/index.htm by choosing the options “Prevalence Data” and “Trends Data.” By choosing the Nutrition category, the sub-category listed as “Not enough fruits

and vegetables” will provide information on persons eating less than 5 servings of these each day. In the CSFII, mean number of servings of total fruit and vegetable consumed per day are based on intakes reported by individuals 2 years and older on 2 nonconsecutive days. The data are compared to recommendations in the USDA Food Guide Pyramid to provide national probability estimates for the US population.

- **Fruit and Vegetable Screener:** The 7-item fruit and vegetable screener used in the national 5-A-Day for Better Health intervention trials is similar to the BRFSS’s measure of fruit and vegetable consumption frequency. The tool is available at riskfactor.cancer.gov/diet/screeners/fruitveg/

OLDER AMERICANS ACT 2000 REQUIREMENTS

Functions of the Assistant Secretary

SEC. 202 (f)(1) The Assistant Secretary, in accordance with the process described in paragraph (2), and in collaboration with a representative group of State agencies, tribal organizations, area agencies on aging, and providers of services involved in the performance outcome measures shall develop and publish by December 31, 2001, a set of performance outcome measures for planning, managing, and evaluating activities performed and services provided under this Act. To the maximum extent possible, the Assistant Secretary shall use data currently collected (as of the date of development of the measures) by State agencies, area agencies on aging, and service providers through the National Aging Program Information System and other applicable sources of information in developing such measures.

(2) The process for developing the performance outcome measures described in paragraph (1) shall include-

(A) a review of such measures currently in use by State agencies and area agencies on aging (as of the date of the review);

(B) development of a proposed set of such measures that provides information about the major activities performed and services provided under this Act;

(C) pilot testing of the proposed set of such measures, including an identification of resource, infrastructure, and data collection issues at the State and local levels; and

(D) evaluation of the pilot test and recommendations for modification of the proposed set of such measures.

Evaluation

SEC. 206(a) The Secretary shall measure and evaluate the impact of all programs authorized by this Act, their effectiveness in achieving stated goals in general, and in

relation to their cost, their impact on related programs, their effectiveness in targeting for services under this Act unserved older individuals with greatest economic need (including low-income minority individuals and older individuals residing in rural areas) and unserved older individuals with greatest social need (including low-income minority individuals and older individuals residing in rural areas), and their structure and mechanisms for delivery of services, including, where appropriate, comparisons with appropriate control groups composed of persons who have not participated in such programs. Evaluation shall be conducted by persons not immediately involved in the administration of the program.

(c) In carrying out evaluations under this section, the Secretary shall, whenever possible, arrange to obtain the opinions of program and project participants about the strengths and weaknesses of the programs and projects, and conduct, where appropriate, evaluations which compare the effectiveness of related programs in achieving common objectives. In carrying out such evaluations, the Secretary shall consult with organizations concerned with older individuals, including those representing minority individuals, older individuals residing in rural areas and older individuals with disabilities.

(d) The Secretary shall annually publish summaries and analyses of the results of evaluative research and evaluation of program and project impact on effectiveness, including, as appropriate, health and nutrition education demonstration projects conducted under section 307(f)...

Area Plans

SEC.306 (a) Each area agency on aging ...shall...develop an area plan for a planning and service area...Each such plan shall-

(1) provide..for..determining the extent of need for supportive services, nutrition services, and multipurpose senior centers..evaluating the effectiveness of the use of resources in meeting such need and entering into agreements with providers...for the provision of such services..

(4) (A) (i) provide assurances that the area agency on aging will set specific objectives for providing services to older individuals with greatest economic need and older individuals with greatest social need, include specific objectives for providing services to low-income minority individuals and older individuals residing in rural areas, and include proposed methods of carrying out the preference in the area plan;

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will-

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals and older individuals residing

(III) meet specific objectives established by the area agency on aging for providing services to low-income minority individuals and older individuals

residing...

State Plans

SEC. 307(a)

(2) The plan shall provide that the State agency will-

(A) evaluate, using uniform procedures described in section 202(a)(29) the need for supportive services....., nutrition services, and multipurpose senior centers within the State;

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities, with particular attention to low-income minority individuals and older individuals residing in rural areas.

SUA STANDARDS/GUIDELINES: PLANNING AND EVALUATION

North Carolina

Options for Responding to Local Needs – Having the flexibility to develop slightly different nutrition programs in each community means that planners can develop programs that are responsive to local needs, such as the risk of malnutrition, health promotion/disease prevention issues, or the diversity of the population.

Nutrition providers are encouraged to do a self-assessment and see how well their services go beyond meals to offer social interaction, mental stimulation, informal support systems, and volunteer opportunities. Are participants connected, as needed and appropriate, with other health and supportive services, such as transportation and home repairs? Are they referred for other food assistance programs, such as Food Stamps?

Wisconsin

Annual Plan Status Report

A major element in the annual area plan amendment will be the annual plan status report. The purpose of this report will be to give the advisory council, board of directors, and the agency staff an opportunity to review progress toward the completion of the major planned activities. The format, content, and procedures for the development of the status report will be determined by BADR.

There are many ways to engage citizen advisors in reviewing the progress on plans:

-Scorecards: When an area agency develops its area plan, it sets annual performance targets (outcomes). At the time for the annual review of the plan, the agency and citizen advisors/board members compare actual to planned performance. Aging unit staff

can also be invited to assist in this analysis. This helps the agency keep on track. More importantly, it serves as the opportunity to analyze why targets were or were not met and to adjust future actions accordingly.

-Ask the aging units: As the key constituent group of the AAA's, the aging units are in a perfect position to advise the AAA's about "mid-course corrections" they feel might be useful in the area plans.

Keep Your Perspective During Planning

Many people in the aging network spend most of their time "fighting fires" in their communities. Their time is spent realizing and reacting to problems. For these people, it can be very difficult to stand back and take a hard look at what they want to accomplish and how they want to accomplish it.

However, one of the major challenges confronting the aging network is the need to see the broad perspective, to take the long view on what needs to be done now and in the future, and how things will be done.

One of the best ways to develop this approach is through a thorough planning process. The following guidelines may help you to get the most out of your planning experience:

- (1) The real benefit of the planning process is the process itself, not the plan document.
- (2) There is no "perfect" plan. There is doing your best at strategic thinking and implementation; there is also learning from what you are doing to enhance what you do the next time around.
- (3) The planning process is usually not an "a-ha!" experience. It is like the management process itself, a series of small moves that together keep the aging agency doing things right as it heads in the right direction.
- (4) In planning, things usually are not as bad as you fear nor as good as you would like.
- (5) Start simple, but start! A standard planning process can be illustrated by four simple questions:
 - (1) Where are we now?
 - (2) Where do we want to be?
 - (3) How do we get there? and,
 - (4) How will we know that we are making progress?

An agency should tailor its plan to meet its needs. Some of the most frequently included elements are described below:

- (1) Mission statement:
The agency's unique reason for existence.
- (2) Overview of the Plan:

*Discussion of the benefits an agency expects from the process;
Recognition of agency accomplishments;
Brief description of the planning process used and its participants; and
Explanation of the plan's elements and how to use them.*

(3) Summary of Agency Mandates:

Description of the mandates and their sources.

(4) Constituent analysis:

*Description of constituents and their relative priority; and
Discussion of their expectations and the agency's ability to meet them.*

(5) Core Activities:

*Description of the core business activities; and
Discussion of the priority for an agency's activities.*

(6) Situation Assessment:

*Description of the external trends and issues likely to impact the agency;
Discussion of the opportunities and threats;
Analysis of the internal operations of the agency; and
Discussion of the agency's internal strengths and weaknesses.*

(7) Critical Issues:

*Description of the critical issues the agency faces and the challenges they present;
and
Explanation of each issue's priority.*

(8) Strategic Summary:

*Goals the agency desires to pursue;
Objectives that describe the specific outcomes;
Description of how the agency proposes to move in the preferred direction; and
Assignment of responsibility for the actions.*

(9) Tracking and Evaluation:

*Process to monitoring progress;
Role of performance measures; and
Description of key performance measures.*

Major Steps in Measuring Performance

During the first phase, the aging unit defines the results. They set expectations and standards for performance. After they establish the desired results, they identify possible indicators to measure performance and to track movement toward the target. Lastly, program managers, agency managers, policy-makers, and any other interested groups get the information produced from the measurement system. Staff use the information to improve program performance or to verify expected benefits. Successful organizations know where they are headed and they assess their progress. A measurement system plays an important role in this. Public organizations, including aging agencies, find measurement systems most successful when they

consistently apply two practices.

Firstly, they structure their measurement system to have these four characteristics: (1) measures are tied to specific objectives and show the degree to which the desired results have been achieved;

(2) measurement system is limited to an essential few measures that produce useful data for decision making;

(3) measures respond to multiple priorities; and

(4) measures are linked to those responsible for producing the results.

Secondly, these agencies know that they must balance the concept of an "ideal" measurement system against real-world considerations, such as the cost and effort involved in gathering and analyzing data. These agencies try to have data that, to be useful in decision-making, are sufficiently complete, accurate, and consistent; and that can be collected using a reasonable level of resources.

DEFINITION AND TERMS

Some common evaluation vocabulary includes:

Baseline: A single starting point or reference for measuring change over a time period (4).

Benchmarking: A system for comparing performance on a defined set of standardized indicators among similar programs or facilities(4).

Efficiency: Producing the greatest *output* with the resources (inputs) available (e.g., cost/meal)(4).

Effectiveness: Achieving desired outcomes under ordinary circumstances of program operation(4).

Cost-effectiveness: Producing the greatest *outcome* with the resources (inputs)_ available (e.g., change in nutrition risk/dollar spent)(4).

Goal: The general intent of a program, service or activity. Goals are usually stated more broadly and globally than objectives and are usually not measurable or time specific(3). For example: "The goal of the nutrition program is to allow older adults to maximize their nutritional health and functionality."

Indicator: The specific items of information that track a program's success on outcomes. They describe observable, measurable characteristics or changes that represent achievement of an outcome(7). Indicators are also referred to sometimes as

performance measures.

Input: Any resource used which leads to the achievement of program objectives. (7) Examples of inputs include staff, volunteers, financial resources and in-kind support.

Objective: The anticipated outcome of a program, service or activity. Program objectives are generally stated in specific and measurable terms(3). For example: During the first quarter, 35% of participants will report that as a result of reading the nutrition newsletter, they have implemented at least one dietary change; or during the calendar year, 60% of participants will increase their fruit and vegetable consumption by an average of 1 serving per day. An objective could also be called a “target.”

Outcome: The change that occurs in the participants’ behavior, knowledge, skills, attitude, values, condition, status or other attributes. Outcomes can be short term or longer term, and are linked directly to the goals of the program(3). Examples of outcomes related to the nutrition program could be “participants increase their consumption of key nutrients,” or “participants increase their social contacts.”

Output: The products or a program’s activities(7). Outputs are things that can be counted such as meals, referrals or number of clients served. Outputs are sometimes referred to as units of service.

Qualitative Methods: Non-numerical, content-rich data that is collected about a program. Qualitative methods may include interviews, observation, case studies or focus groups(3).

Quantitative Methods: Numerical data collected about a program. Quantitative methods may include surveys or questionnaires, pre or post tests or program records such as applications, assessment forms or other tools(3).

REFERENCES

1. United States Department of Agriculture, Economic Research Service. Effects of Food Assistance and Nutrition Programs on Nutrition and Health: Volume 1, Research Design. Available at http://www.ers.usda.gov/publications/fanrr_19-1/
2. Department of Health and Human Services, Administration for Children and Families, Planning, Research & Evaluation. The Program Manager’s Guide to Evaluation. Available at http://www.acf.hhs.gov/programs/apre/other_resrch/pm_guide_eval/reports/pmguide_toc.html

3. Nunn, Yolanda J. A Practical Introduction to Program Evaluation. Available at <http://www.canonprofits.org/CANAlert/sept.oct.01.practical.html>
4. Splett PL, Weddle DO. *Nutrition 2030: A white paper on measuring outcomes*. Miami, FL: National Policy and Resource Center on Nutrition and Aging; 1999.
5. Plantz, Margaret C, Greenway, Martha T et al. United Way Outcome Measurement Resource Network. Outcome Measurement: Showing Results in the Nonprofit Sector. Available at <http://national.unitedway.org/outcomes/resources/what/ndpaper.cfm>
6. W.K. Kellogg Foundation, Logic Model Development Guide; 2004. Available at www.wkkf.org/Pubs/Tools/Evaluation/Pub_3669.pdf.
7. United Way Outcome Measurement Resource Network. Measuring Program Outcomes; A Practical Approach. Available at <http://national.unitedway.org/outcomes/resources/mpo/glossary.cfm>
8. Center for Disease Control Evaluation Working Group: Steps in Program Evaluation. Available at <http://www.cdc.gov/eval/framework.htm#card>

RESOURCES

Designing Evaluations: www.gao.gov/policy/10_1_4.htm

Evaluation Toolkit: www.projectstar.org

American Evaluation Association: www.eval.org

W.K. Kellogg Foundation, Logic Model Development Guide; 2004. Available at www.wkkf.org/Pubs/Tools/Evaluation/Pub32669.pdf or 1-800-819-9997 and request item 1209

Studies including outcomes of the OAA Nutrition Program which determine the effects of improved nutrient intake or improved social interaction on eating behavior

- Dichiera E, Cotugna N, Vickery C. An outcome evaluation of a senior feeding program. *J Am Diet Assoc.* 2000;100(suppl):A-91. Abstract.

- Gilbride JA, Amella EJ, Breines EB, Mariano C, Mezey M. Nutrition and health status assessment of community-residing elderly in New York City: a pilot study. *J Am Diet Assoc.* 1998;98:554-558.
- Kretser A, Kerr W, Voss T, Ackman A, Squires M, Baker C. Improving nutritional and functional outcomes in homebound elders via an aggressive 21-meal-per-week home delivery programs. *J Am Diet Assoc.* 2000;100(suppl):A-91. Abstract.
- Locher JL, Burgio KL, Yoelds WC, Ritchie CS. Social significance of food and eating in the lives of older recipients of Meals on Wheels. *J Nutr Elder.* 1997;17(2):15-33.
- Neyman MR, Block G, Johns M, Sutherlin JM, McDonald RB, Zidenberg-Cherr S. Effect of participation in congregate-site meal programs on the energy and nutrient intakes of Hispanic seniors. *J Am Diet Assoc.* 1998;98:1460-1462.
- Pluckebaum JM, Chavez N. Nutritional status of Northwest Indiana Hispanics in a congregate meal program. *J Nutr Elder.* 1994;13(3):1-22.
- Stein C, Vozenilek J. A profile of participants in congregate meals. *J Am Diet Assoc.* 2000;100(suppl):A-89. Abstract.
- Vailas LI, Nitzke SA, Becker M, Gast J. Risk factors for malnutrition are associated inversely with quality of life for participants in meal programs for older adults. *J Am Diet Assoc.* 1998;98:548-553.