

# MODELS OF GERIATRIC CARE, QUALITY IMPROVEMENT, AND PROGRAM DISSEMINATION

## Leveraging Home-Delivered Meal Programs to Address Unmet Needs for At-Risk Older Adults: Preliminary Data

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**BACKGROUND:** Home-delivered meal programs serve a predominantly homebound older adult population, characterized by multiple chronic conditions, functional limitations, and a variety of complex care needs, both medical and social.

**DESIGN:** A pilot study was designed to test the feasibility of leveraging routine meal-delivery service in two home-delivered meal programs to proactively identify changes in older adult meal recipients' (clients') health, safety, and well-being and address unmet needs.

**INTERVENTION:** Meal delivery personnel (drivers) were trained to use a mobile application to submit electronic alerts when they had a concern or observed a change in a client's condition. Alerts were received by care coordinators, who followed up with clients to offer support and help connect them to health and community services.

**RESULTS:** Over a 12-month period, drivers submitted a total of 429 alerts for 189 clients across two pilot sites. The most frequent alerts were submitted for changes in health (56%), followed by self-care or personal safety (12%) and mobility (11%). On follow-up, a total of 132 referrals were issued, with most referrals for self-care (33%), health (17%), and care management services (17%). Focus groups

conducted with drivers indicated that most found the mobile application easy to use and valued change of condition monitoring as an important contribution.

**CONCLUSION:** Findings suggest that this is a feasible approach to address unmet needs for vulnerable older adults and may serve as an early-warning system to prevent further decline and improve quality of life. Efforts are underway to test the protocol across additional home-delivered meal programs. *J Am Geriatr Soc* 67:1946-1952, 2019.

**Key words:** care navigation; home-delivered meal programs; social needs; vulnerable older adults

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Accumulating evidence suggests that social determinants of health (SDOHs), or the conditions in which people are born, grow, live, work, and age,<sup>1</sup> exert a strong influence on health and well-being.<sup>2-7</sup> Taken together with health behaviors, these social, economic, and environmental conditions are associated with up to 80% of one's health and health outcomes, including mortality.<sup>4,8,9</sup> Health-related social needs, including a lack of community supports, transportation barriers, food insecurity and housing instability, are associated with poor health outcomes and increased healthcare costs.<sup>9</sup> This association may be particularly pronounced among vulnerable populations, such as homebound older adults (ie, persons 65 years and older), who, in addition to being medically complex,<sup>10,11</sup> often have a variety of unmet health-related social needs and may require additional assistance to maintain their functional independence.<sup>12-14</sup>

Community-based organizations have a critical role in identifying and addressing SDOHs for older adults with complex care needs.<sup>15-17</sup> For example, home-delivered meal

programs, such as Meals on Wheels (MOW), provide an important food resource for homebound older adults and adults with disabilities across the United States, with over 850 000 individuals served in 2017.<sup>18</sup> Home-delivered meal programs not only improve older adults' nutritional intake,<sup>19</sup> but can also reduce social isolation, falls, hospitalizations, and potentially nursing home placement.<sup>20-27</sup> Meal recipients (clients) indicate the service helps them eat healthier foods, improves their overall health, and allows them to live independently and remain in their own home.<sup>28</sup> Many of the benefits are hypothesized to derive from the daily interaction between the meal delivery person (driver) and the client.<sup>29</sup> This is especially important given that many older clients are isolated, and interactions with drivers may be their only point of socialization each day. In addition to a friendly visit, drivers serve as the “eyes and ears” for clients, providing a daily wellness check as part of the meal delivery service. This provides an opportunity to standardize routine interactions to systematically identify and address unmet needs that, if missed or ignored, could result in preventable adverse health outcomes and costly healthcare utilization.<sup>29</sup>

This article describes a pilot study of a technology-supported meal-delivery service, which included change of condition monitoring and care navigation support, developed and tested at two MOW programs to assess feasibility. This study was conducted with MOW volunteer and staff drivers who used a mobile application to report changes of condition in clients' health, safety, and well-being observed during meal delivery via an electronic alert. Care coordinators, embedded within the MOW programs, responded to alerts and provided care navigation support to connect clients with health and community services to address unmet needs. We report on the feasibility of the approach, describing the number and types of alerts made by meal-delivery drivers and the follow-up response by care coordinators. In addition, we characterize the experiences of drivers who implemented the technology-supported meal-delivery service.

## METHODS

### Setting

Two MOW programs, located in California (site 1) and Ohio (site 2), participated in the study. Site 1 is composed of four meal delivery service centers, with over 3000 volunteer drivers delivering meals to more than 3000 clients on more than 100 routes across urban, suburban, and rural areas in one county. Site 2 is a Senior Center that operates a home-delivered meal program composed of 18 staff drivers delivering meals to more than 600 clients on 16 routes across several rural counties. The care coordinator position was a new position within the programs and did not require specialized training. The care coordinator at site 1 was an external hire. Existing staff was utilized to fill the position at site 2. Neither coordinator had a background in social work. The pilot sites were selected to maximize variation (eg, rurality, number of clients served, staff vs volunteer drivers) and determine the ability to implement the change of condition monitoring and care navigation support protocol across two distinct MOW programs.

Pilot sites implemented the protocol (described below) across two staggered dates beginning in mid-2017 through mid-2018, and included a total of 21 routes, 53 drivers, and 867 home-delivered meal clients (site 1:  $n = 220$  clients; site 2:  $n = 647$  clients). Implementation at site 1 began in April 2017, with six drivers in three test routes, and was expanded to include a total of 35 drivers in five test routes over 4 to 5 months. Implementation at site 2 began in August 2017 and was expanded program-wide over 3 to 4 weeks to include a total of 18 drivers in 16 test routes.

Mobile routing and change of condition monitoring were introduced on Accessible Solutions, Inc, ServTracker Mobile Meals Application (heretofore, Mobile Meals app), a Health Insurance Portability and Accountability Act-compliant routing and tracking software application.<sup>30</sup> In addition to providing global positioning system (GPS) navigation and electronic delivery confirmation, the Mobile Meals app, with its “Change in Condition” feature, enabled drivers to submit electronic alerts on a mobile device, such as a smart phone or tablet, when they had a concern or noticed a change in a client's health, safety, or well-being during a meal delivery. Alerts were maintained and managed within the ServTracker Nutrition Services Module desktop application for managing clients, services, and billing. Designated MOW care coordinators used the system to document follow-up actions and service referrals. The study protocol was reviewed and deemed exempt from full-board review by the Western Institutional Review Board.

## Protocol

### *Change of Condition Monitoring*

Drivers used the Mobile Meals app to navigate their meal delivery route and communicate delivery status (ie, incomplete, complete) to MOW staff. On delivery confirmation, drivers were automatically prompted with the following message: “Is there a change in condition?” If the driver selected “no,” he/she was prompted to continue to the next client's meal delivery. If the driver selected “yes,” the driver was then prompted to select the appropriate change in condition from a set of seven wellness categories. Wellness categories were developed through cross-disciplinary expert opinion and a review of the literature to identify commonly used categories of health and social needs.<sup>4,31,32</sup> Wellness categories included (1) physical/mental health, (2) self-care/personal safety, (3) mobility, (4) nutrition, (5) home environment, (6) social engagement, and (7) emergency/911. Drivers were informed that they could submit alerts for multiple wellness categories. Drivers were also informed that submitting an alert for emergency/911 would not generate a call to emergency services and were instructed to follow standard operating procedures for all emergency situations, as indicated by the MOW program. When the driver was finished making the appropriate selections, the driver would press “submit” to send the alert(s) electronically to the ServTracker system.

### *Care Navigation Support*

Alerts were received by an on-site care coordinator who followed up with the client or designated emergency contact

(eg, family member) within 24 to 48 hours via telephone. During this follow-up, the care coordinator referenced the alert(s) (eg, nutrition alert, self-care alert) and engaged in a discussion with the client (or family member) to better understand his/her situation and determine if assistance was needed. If additional assistance was needed, the care coordinator worked with the client to identify possible interventions or referrals to address any unmet needs and helped connect him/her with the appropriate health and community services. If it was determined that the client was in the process of resolving the issue (eg, a family member had already been contacted or arrangements had already been made for a service), the care coordinator would ask if any additional assistance was needed and provided his/her contact information in case the client needed assistance later. The agreed on course of action was then facilitated by the care coordinator, and follow-up actions (ie, unable to reach client, referral needed, no referral needed) and referrals for health and community services were documented in the ServTracker system.

Figure 1 provides an overview of the change of condition monitoring and care navigation support protocol. A brief scenario illustrating the protocol is provided below:

Mrs Smith, who is in her late 70s and lives alone, has been a meal recipient for over a year. During meal delivery, the driver observed that Mrs Smith's living room appeared more cluttered than usual. Based on this, the driver submitted an alert for "home environment." On follow-up with the care coordinator, the client reported that she had been struggling with housekeeping. With permission, arrangements were

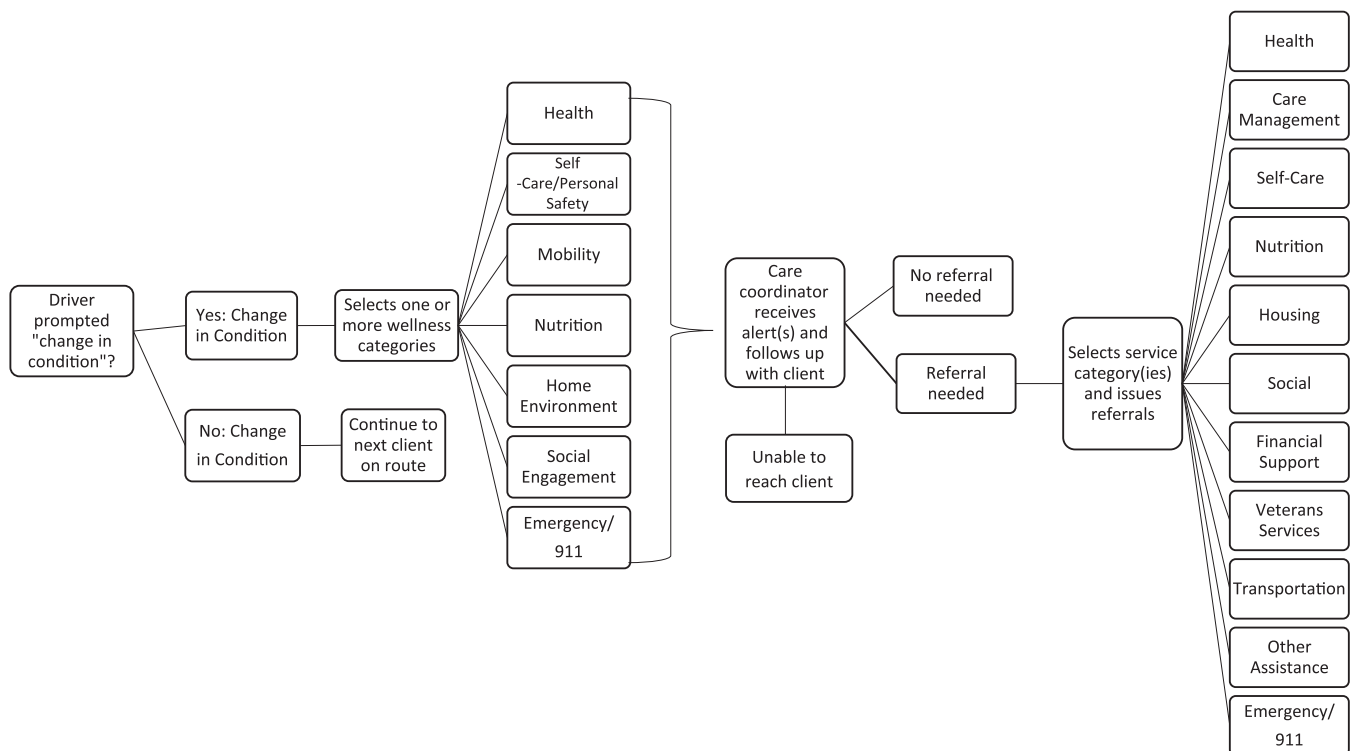
made for a personal care assistant to help 1 day a week, which allowed her to better care for herself.

## Training

Prior to implementation, each pilot site received training on the change of condition monitoring and care navigation support protocol. Training materials were developed and tested at site 1 and provided to site 2 to inform and expedite implementation.

Drivers were provided with a "wellness support training packet" developed by the project team, designed to assist drivers in identifying and reporting concerns or changes in a client's condition observed during meal delivery. In addition to an overview of the protocol, the training packet included an "alert cheat sheet" with examples of key observations associated with each wellness category (eg, health: new bruises, confusion; mobility: unsteady on feet, takes longer than usual to answer the door; nutrition: uneaten meals, visible weight loss or gain) and a set of sample scenarios drivers could use to practice and test their knowledge of the most appropriate wellness category or categories to select, given the hypothetical situation. Drivers also received detailed instruction on how to submit alerts using the Mobile Meals app on a hand-held mobile device. Additional assistance to help drivers practice using the application on their delivery route was provided on request. Drivers were able to ask questions and received support throughout training and implementation.

Care coordinators were provided with a care navigation toolbox developed by the project team, designed to facilitate the receipt of and response to client alerts. The



**Figure 1.** Overview of "change of condition" monitoring and care navigation support protocol for home-delivered meal program clients.

toolbox included a detailed flowchart of the care navigation support protocol, as well as information on how to build rapport with clients and assess unmet needs through a series of probing questions corresponding to each wellness category. Care coordinators were also provided with sample scenario scripts; information on how to find health and community programs, services, and providers for older people; and additional resources on motivational interviewing and communication techniques.

**Data Collection**

**Change of Condition Monitoring and Care Navigation Support**

Data on the number of alerts and referrals were collected from the two pilot sites across a 12-month period between April 2017 and March 2018 (12 months at site 1; 7 months at site 2). Sociodemographic information, including age, sex, and living arrangement, was collected for all clients served along the test routes.

Deidentified client data were shared with the project team for evaluation purposes via a secure online data encryption and transfer platform (CrushFTP). Data were cleaned and analyzed using Alteryx Designer x64<sup>33</sup> and SAS Studio 3.71. Frequencies and means of client demographic characteristics were calculated. Frequencies of alerts and referrals were also calculated across wellness, health, and community service categories. Referrals for health and community services were collapsed into 11 broad service categories: (1) health (including healthcare services, nonemergency, primary care physician, and medical equipment and supplies), (2) self-care (including safety/welfare check, abuse of older people/self-neglect, personal care, homemaker assistance, and caregiver support), (3) care management, (4) nutrition, (5) housing (including housing and home repair/modifications), (6) social (including civic engagement and volunteer opportunities), (7) financial (including financial assistance and utility assistance), (8) veterans assistance, (9) transportation, (10) emergency, and (11) other (including legal assistance and pet care). Data were aggregated across sites.

**Focus Groups**

Focus groups were conducted at each site (site 1: n = 6 drivers; site 2: n = 13 drivers) after 2 months to document the site’s experiences with training, change of condition monitoring, and the Mobile Meals app. In addition, we aimed to understand drivers’ level of comfort with reporting concerns and understanding of their role and to elicit suggestions for improvement.

**RESULTS**

**Change of Condition Monitoring and Care Navigation Support**

**Sample Characteristics**

Table 1 presents demographic characteristics of clients on test routes, stratified by those who had an alert generated on their behalf compared to all clients served on the test

**Table 1. Demographic Characteristics of All Home-Delivered Meal Program Clients on Test Routes and Clients with at Least One Alert, Aggregated Across Sites**

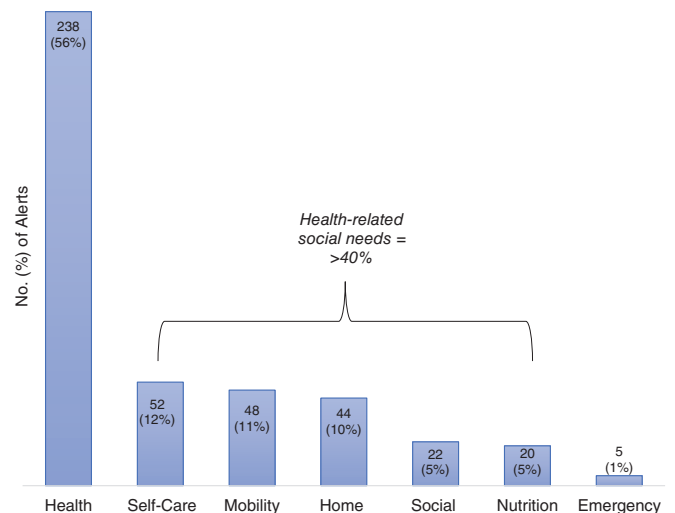
Characteristics	Total across pilot sites	
	All clients served on test routes (N = 867)	Clients with alerts on test routes (N = 189)
Age, y	77.4 (10.5)	77.5 (11.0)
Lives alone		
Yes	467 (53.8)	111 (58.7)
No	383 (44.2)	78 (41.3)
Unknown	17 (2.0%)	
Sex		
Male	324 (37.4)	56 (29.6)
Female	543 (62.6)	133 (70.4)

Note: Data are given as mean (SD) or number (percentage).

routes. Across the two sites, a total of 59% of clients with alerts lived alone, 70% were female, and 90% were 65 years or older, with an average age of 77 years. Clients with alerts and total clients served on the test routes were comparable in terms of living status, sex, and age.

**Alerts**

Over the study period, the two pilot sites reported a total of 429 alerts for 189 clients of 867 clients served on the test routes. Of the 22% of clients with alerts, 58% had one alert, 22% had two alerts, and 20% had three or more alerts over the course of the study. The frequency of alerts across the seven wellness categories varied (Figure 2). The most frequent alerts (56%) were submitted for a client’s physical/mental health (eg, confusion or apparent change in mood or behavior, unusual breathing, swelling, or fatigue), followed by alerts for self-care/personal safety (12%),



**Figure 2. Frequency of alerts for home-delivered meal program clients by wellness categories, aggregated across sites (n = 429 total alerts).**

mobility (11%), and home environment (10%). Only 1% of alerts were for submitted for emergency/911.

### Referrals

On follow-up with care coordinators from each pilot site, a total of 132 referrals were initiated for health and community services (Figure 3). For example, on follow-up for a health alert, if it was determined a client was experiencing painful leg swelling, a referral may be issued for transportation to a medical appointment and self-care for help bathing, dressing, and toileting. Although all alerts resulted in follow-up actions from the care coordinator, approximately 14% of clients were unable to be reached during the study, despite repeated attempts. In addition, following verification of the alert(s), it was determined that approximately 50% of clients did not need a referral (eg, client already in process of resolving issue or issue was resolved without a referral). Across the 11 service categories, referrals were most frequently initiated for self-care (33%), health (17%), care management (17%), and transportation (9%).

### Focus Groups

Focus groups revealed that most drivers found the application easy to use and valued the electronic wellness checks as an “important contribution” to their meal delivery.

Overall, drivers reported that they felt positive about MOW. They appreciated the training they received and expressed approval for the change of condition monitoring. Although drivers noted some initial minor technical difficulties using the mobile application (eg, problems logging in and with GPS routing), difficulties generally reduced over time through familiarity with the application. Related to training, several drivers reported some confusion about whether they should continue submitting alerts for ongoing

problems for which they had already placed an alert. In general, drivers felt that observing clients and reporting concerns fit in well with their role. However, some drivers expressed fears about liability if they failed to report a client problem. Drivers also noted they would like to receive information regarding what happened to clients after submitting an alert.

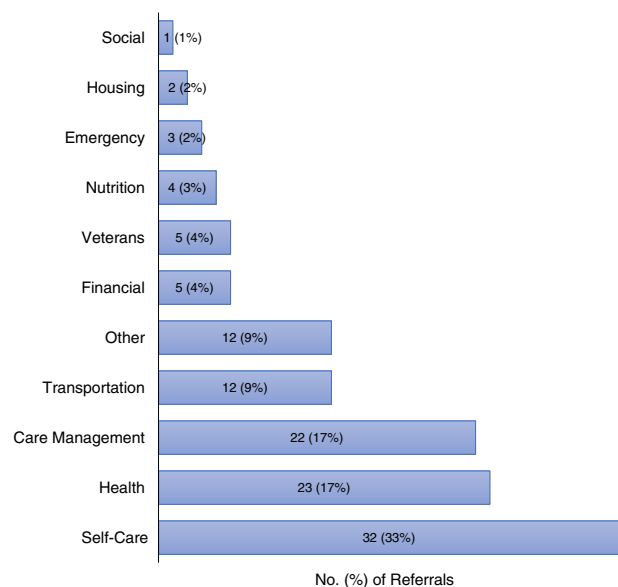
### DISCUSSION

In this study, we demonstrated the feasibility of implementing a technology-supported meal-delivery service that included change of condition monitoring and care navigation support in two MOW programs. Drivers were engaged to use a mobile application to identify and report observed changes in older meal recipients. According to focus group findings, most drivers were not only willing to use mobile technology to report concerns, but also saw value in daily client monitoring.

More than one of five older clients on the participating test routes had at least one alert for a change of condition over the course of the study. Although over half of alerts were for health concerns, alerts were submitted across all wellness categories. When combined, nearly half the alerts were submitted for concerns related to self-care, mobility, nutrition, home environment, and social engagement, underscoring the importance of monitoring or screening for broader health-related social needs.

On follow-up, we found that not all alerts required a referral to address the identified need(s). This could be because the client only needed information from the care coordinator or was already in the process of obtaining services. However, for clients who needed a referral, at times it was necessary to provide multiple referrals to various service providers to address a single unmet need. At other times, a single referral could address multiple unmet needs. Additionally, the type of referral may not be directly tied to the original alert. For example, although an alert may be issued for a health concern, the solution may include referrals to a variety of community services, such as nutrition and transportation services and social engagement opportunities. This may partially explain why the largest volume of referrals was for self-care services, followed by health-related services. We also found that there was a relatively high need for care management services. This is not surprising given that MOW clients are largely homebound and often characterized by multiple chronic conditions and functional limitations.<sup>10,11</sup> Although client satisfaction was not directly assessed, feedback from care coordinators suggests clients were receptive to assistance and that connections were made with outside resources who may have been able to meet clients' needs and enable them to retain their independence.

The purpose of the study was to test the feasibility (ie, “proof of concept”) of leveraging existing home-delivered meal programs to proactively identify and address the unmet needs of vulnerable older adults across two geographically and operationally diverse MOW programs. Although some differences were observed between sites in terms of the proportion of alerts and referrals made, the study design did not allow for meaningful cross-site comparisons. Instead, pilot sites were selected to maximize



**Figure 3.** Frequency of referrals for home-delivered meal program clients by health and community service categories, aggregated across sites (n = 132 total referrals). [Color figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]

variability and ensure that the approach was feasible, regardless of site-specific characteristics.

## CONCLUSION

Using a proactive standardized approach to identify changes in health, safety, and well-being in older home-delivered meal clients was shown to be feasible across two distinct programs. As the approach was designed to be a low-cost solution, it uses software frequently used by MOW programs, can utilize existing staff, and provides free training materials and support for volunteers and staff. Providing care navigation support to address unmet needs may serve as an early-warning system to potentially mitigate risk for an adverse health event and enable vulnerable older adults to maintain their functional independence and remain in their homes and communities.

While findings from this pilot are promising, additional research is needed to determine the impact of the intervention on patients' health outcomes, as well as healthcare utilization and costs. Further research is also needed to demonstrate the ability to sustain and scale the technology-supported meal-delivery service. As such, it will be important to assess for variation in reporting by drivers' characteristics (eg, staff vs volunteer, age, level of engagement). Efforts are underway to disseminate the learnings, protocol, and training across additional home-delivered meal programs to enable an in-depth evaluation.

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**Conflict of Interest:** The authors have no conflicts of interest to disclose.

**Author Contributions:** A.M.: study concept and design, data analysis and interpretation of data, and preparation of the manuscript. J.E.: data analysis and interpretation of data and preparation of the manuscript. B.S., D.D., E.G., R.S., U.K., K.T.: study concept and design and preparation of the manuscript.

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### ***Editor's Note***

A few years ago, our healthcare system handed off our Meals on Wheels program to another community, a not-for-profit organization. The rationale was that the Meals on Wheels program was not a part of “our core business.” Perhaps we were wrong.

This pilot study by Dr Andrea Morris and colleagues is particularly of interest to geriatrics health providers and leaders of health systems. Their model tests a process of identifying vulnerable, community-dwelling, older adults who have a change in their health, safety, and well-being. The Meals on Wheels drivers used an alert system that was integrated into their mobile application tools. The electronic wellness check signaled a champion who offered appropriate follow-up and services to those who had a change in condition.

As healthcare systems struggle to address the social determinants of health, this innovative Meals on Wheels model may provide part of the solution. As leaders in geriatric medicine, we should champion social programs (such as Meals on Wheels) that meet the needs of vulnerable individuals in our communities. In retrospect, our core business is to help the whole person, whose healthcare needs are intertwined with his/her social needs.

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