Nutrition Services Program Outcomes Evaluation

September 14, 2017

Responses to attendees questions posed during webinar:

Question	Response
Are there any data available or collected on malnutrition?	The survey includes information on unintentional losses of weight and on food insecurity. The analyses conducted using the 24-hour dietary recall data can also provide insight into malnutrition and participants' nutritional status. For example, the evaluation examined the percentage of participants whose usual diets met recommendations for key vitamins, minerals, and macronutrients (Table III.11). The evaluation also assessed how well participants' diets conform to key recommendations of the Dietary Guidelines (using the Healthy Eating Index-2010; Table III.13). However, the survey did not include questions from malnutrition screening tools and did not formally measure malnutrition.
Was there a mix of rural and urban participants? Did you see any difference between these two groups?	Yes, there was a mix of urban and rural participants. 72 percent of congregate meal participants and 75 percent of home-delivered meal participants live in urban areas (Table III.1) We did not examine findings by urbanicity.
It has been reported that underutilization of these CM and HDM programs increases risk of malnutrition in the older adult population. Is there research being conducted on how we can increase utilization while the Federal funding of these programs are being reduced?	The evaluation examined program participation patterns and frequency of use of the program among congregate and home-delivered meal participants (Tables III.14-16). However, it did not assess how to increase program use.
How is activity levels considered in the study?	The survey included a question asking whether participants took part in an exercise or fitness class offered by the meal site. However, the evaluation did not assess activity levels more generally.

I realize the survey numbers aren't huge, but it would be great to see some of this data broken out a bit more – e.g., by race/ethnicity, urban vs. rural, and maybe some other groupings. Any chance this will be possible?	The evaluation report presents program impacts separately for congregate meal participants and nonparticipants and for home-delivered meal participants and nonparticipants. The analyses of the effect of congregate and home-delivered meal participation on outcomes measuring food security, socialization, and diet quality were also conducted separately for two important household and economic subgroups: by monthly household income relative to poverty and according to whether individuals lived alone or with other family members. The design of the outcomes evaluation began with the design of the process and cost studies (which collected data from agencies such as SUAs, AAAs, and LSPs). This allowed the evaluation team to link the person-level data from the outcomes evaluation to the agency-level data from the process and cost studies. These findings are not available in the report, however. The agency-level data include the type of meal site (private/public), whether the LSP is a stand alone organization, whether the LSP offers special or therapeutic diets, whether various services are offered (such as nutrition education, nutrition counseling, transportation, and case management), types of social activities offered, number of volunteer hours, and the total and component costs of providing meals.
Did you get data on percent who had dietary intakes ABOVE recommended levels for fat and sodium? (vs non-participants)	Yes, the evaluation did estimate the percentage of participants and nonparticipants with usual intakes that exceeded recommendations for total fat and sodium (Table IV.7). For total fat, 46 percent of congregate meal participants exceeded the recommendation for total fat compared with 50 percent of nonparticipants. 40 percent of home-delivered meal participants exceeded the recommendation for total fat compared with 52 percent of nonparticipants. For sodium, 94 percent of congregate meal participants and 63 percent of nonparticipants exceeded the recommendation. 69 percent of home-delivered meal participants and 62 percent of nonparticipants exceeded the recommendation for sodium.

When you looked at the number of meals delivered and the effect on loneliness, did you look at the number of individual deliveries? For example, did you compare daily hot meal delivery vs. a once a week delivery of 5 or more meals?	The survey collected information on the number of days in a typical week the participant received delivered meals from the nutrition program. It did not contain information on whether the meals were hot or frozen, or the number of meals provided in a single delivery.
How did you recruit nonparticipants, and how do you know they are equivalent in food news?	To estimate the effect of congregate or home-delivered meal participation on outcomes, we compared outcomes for participants with a matched comparison group of eligible nonparticipants. We surveyed participants, obtained their Social Security Number, obtained Medicare administrative records for them and obtained Medicare administrative records for all older adults in the same small geographic area (either the residential zip code or the service area in which the participant received meals). Using this information, we identified a long list of potential nonparticipants with similar demographic, economic, and health-related characteristics as the participant and that lived in the same small geographic area. We used a matching algorithm to rank the potential nonparticipants from best to worst match. We contacted the nonparticipants, confirmed they met the eligibility criteria and were not participating in the program, and administered the survey. Despite this rigorous matching technique, several differences remained between participants and nonparticipants, so we also used econometric and statistical methods to control for these differences when estimating program effects.
Regarding food security among CM and HDM participants, is there data broken out by some risk factors - i.e. poverty, isolation, marital status, etc.?	The report presents food security status for all program participants, separately by congregate and home-delivered meal participation status, and separately by income and age.

What is your hypothesis on why diabetes was reported as an issue for 1/3 of participants, yet 60 percent of respondents reported being on a diabetic diet?	The percentage of participants that reported having been diagnosed with diabetes or high blood sugar was 33 percent for congregate meal participants and 36 percent for home-delivered meal participants (Table III.4). The percentage that reported being on a special diet for diabetes was 60 percent for each program group. However, the question about the specific type of diet was asked only of those participants that reported being on any special or therapeutic diet (27 percent of congregate meal participants and 34 percent of home-delivered meal participants reported being on any special or therapeutic diet). Thus, the percentage of all congregate meal participants that reported being on a diabetic diet was smaller than the percentage that reported ever being diagnosed with diabetes—16 percent (equal to 27%*60%) versus 33 percent. Similarly, the percentage of home-delivered meal participants that reported being on a diabetic diet was smaller than the percentage that reported ever being diagnosed with diabetes—20 percent (equal to 34%*60%) versus 36 percent. We do not have information on why some participants that reported having been diagnosed with diabetes did not report being on a special diabetic diet.