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# Demonstrating the Process of Doing Applied Research: The Missoula Senior Nutrition Program User Profile

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Demonstrating the Process of Doing Applied Research:
The Missoula Senior Nutrition Program User Profile

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The process of researching, constructing, administering, compiling and reporting the results of a 41 item questionnaire assessing the social, medical and economic characteristics of the program's current participants is examined. Organizational, political and methodological issues of program definition, client identification, questionnaire co-optation and results presentation are specifically addressed.

The client profile and needs assessment was funded by the District XI Human Resource Council was to assess the social, medical and economic status of the current Missoula Senior Nutrition Program participants. Individuals who were recorded as clients of either the congregate mealsite or home delivered meals program during the period of June 10 through June 24, 1985 became the potential pool of interviewees for this survey. Of the 129 clients identified during this timeframe, 100 (77.5%) participated in the study. Congregate mealsite participants completed self administered questionnaires. For those clients who were physically unable to complete the survey questionnaire, the questions and responses were read to them and their answers were recorded by the mealsite coordinator or the author. Home delivered meal clients were interviewed by telephone by the nutrition program coordinator.

Profile results indicated two distinct groups of seniors having differences in three areas: personal and social mobility patterns; chronic or serious health issues; and age. The results support the continuation of two service delivery programs addressing the differing needs of user groups. The second issue, the ability of the clients to assist in the financial support of the Missoula Senior Nutrition Program through financial contributions, was explored. Seniors in both programs indicated that a donation should be made for the meal, but it should be based on an individual's ability to pay. Fifty eight percent of the mealsite participants and 52% of the home delivered meal participants indicated an annual income which placed them below the State poverty level guidelines (income of less than $5250).

The challenges of doing research in the applied setting are considered.

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## PROJECT OVERVIEW

What started as a basic research project for a local senior service delivery program has become the basis of this paper, a discussion of the process of doing applied research in the community setting. The Missoula Senior Nutrition Program (MSNP), at the instigation of the District XI Human Resource Council (HRC) and the District XI Area Agency on Aging (AAOA) requested assistance in conducting a client profile and senior needs assessment. This program, created to be a service provider for a federally mandated service, found itself being squeezed by cutbacks in service delivery legislation and allocation. To justify revenue maintenance (and hopefully, revenue enhancement) the program had to document client need. As most small, grassroot organizations, the program had no in-house research or planning unit personnel. Due to the potential importance of the outcome of the study, and the desire for outside validation of the findings, assistance from a sociologist from the University of Montana was requested.

The sociologist's basic training in methodology, analysis and problem solving develops a foundation of skills suitable to address the study of organizational goals and outcomes service based agencies require. While conducting the participant survey, the complex nature of the community interorganizational network, as well as the struggle of an agency to survive and serve its' intended clientele became apparent. The unspoken agendas of power, turf and autonomy, not addressed in the

survey process, were in fact real issues facing the program's continued existence.

This paper will address two sets of issues, the process of conducting the senior user study as well as the challenges for the consultant in applied settings. The first issue is a review of the process of researching, constructing, administering, compiling and reporting the results of a 41 item questionnaire assessing the social, medical and economic characteristics of the program's current participants. The second issue is an analysis of the problems of organizational, political and methodological issues of program definition, client identification, questionnaire co-optation and results presentation.

Sociologists doing applied research in program assessment and evaluation face a number of issues not addressed by basic social research methodology. The researcher must respond and accommodate a variety of issues not normally encountered in basic or "pure" research. Three important areas that must be considered are the organizational framework of the agency, political issues surrounding the program, and the unique methodological problems that the organizational framework and issues present. All of these factors will influence the study and may necessitate methodological accommodations. Definitions of service, clients success and recordKeeping techniques determine the basic framework of the applied research process. Additional issues of resources, cost, time and personpower may further impact research considerations.

Most programs conduct studies to meet mandated reporting requirements or to provide justification for continued support and existence (Sze and Hopps, 1974). Thus, the organizational framework of the agency as well as the program's history become the first area of study for the researcher. Definitions of the purpose of the program, its' clientele, goals and strategies for survival must be understood in order to define the parameters of the study. Research needs to take into account state and federal regulations, funding source requirements, mandated goals or objectives, and client and public expectations. In this information-gathering process, researchers will often encounter political issues including both overt and covert agendas, competing programs, client ownership or turf defense and program survival strategies.

Chapter 2 is a brief overview of the Federal legislation authorizing and mandating the delivery of services (in particular, nutrition) to seniors. This review clarifies many of the issues that were to be addressed in the study. Included in this discussion is the rationale for the nutrition program mandate of service to seniors. Chapter 3 introduces the Missoula Senior Nutrition program, identifying the social service agency, and its relationship to other senior service providing agencies in the community. The issues that are the focus of the study are also addressed in this chapter. Chapter 4 is the excerpted Senior User Profile, including a discussion of the methodology, the sample and the survey instrument, as well as selected results from the profile. Chapter 5 is a review of applied research

techniques as well as a discussion of the problems of doing applied research in the community setting, concluding with a discussion of the role of the consultant in community settings.

# CHAPTER 2

## INTRODUCTION

For most of human history, support of the aged had been a private concern, shouldered by the family, tribe or clan (Fischer, 1977). The extended family, religious and cultural beliefs as well as inheritance and property transfer laws helped to insure the care of the elderly. As societies diversified, ethnic and religious groups became concerned with caring for elderly in need. The attitude of private responsibility was represented by the development of voluntary and charitable sources to assist individuals, including the aged, in need. The secularization of private responsibility continued into the nineteenth century.

The late 1800's produced a major turning point as problems of the needy, young and old, became a public concern (Hudson and Brastock, 1976). The Civil War left many seniors, white and black, without family or means of economic support. Industrialization and the growth of the urban community isolated and fractured family and ethnic communities. The Westward expansion left aged parents on depleted family homesteads, to run neighborhood shops or to fend for themselves in a hostile world. The changing times and society all contributed to economically and socially isolated seniors in need of assistance.

The progressive era and the social justice movement of the early 1900's set the stage for society's accepting attitude toward public assistance. Settlement houses, orphan trains, poor farms, and soldier's

and widow's pensions were early forms of public charity. Today, in an era that believes that all persons in the society have a right to basic necessities, many state and federal agencies and local programs have been established to meet this objective. Through legislative action and federal and state taxing structures, a number of services have been instituted to meet needs once defined as private responsibility have been instituted. A growing population targeted for services is senior citizens.

The Federal Mandate

The development, from a national perspective, of social programs to assist seniors has evolved over the past 50 years. This is illustrated by the enactment of Social Security legislation in 1935 establishing the first national income security program for older persons, and the subsequent development of a number of programs to help meet the need of the growing aging population. While the first comprehensive federal program for older Americans wasn't passed until 1965, the state of Connecticut established the Commission on the Care and Treatment of the Chronically Ill, Aged and Infirmed in 1945 (Administration an Aging, 1979, p.159). This state unit on Aging became the model for the establishment of such agencies in all states.

From a national perspective, the White House Conference on Aging in 1961 and the 1963 address to Congress "Elderly Citizens of Our Nation" by President Kennedy set the stage for the development of a network of federal program assistance for the elderly. Until the middle 1960's few

specialized services for aged people besides nursing homes existed (Gelfand, 1982, p. 59). President Kennedy recommended a coordinated Federal program of assistance to state and local agencies and organizations for planning and developing services for the elderly. Also included in his recommendations was the provision for research, demonstration and training projects in aging. During the past twenty years, new programs and services have been devised to meet emergent perceived needs of the elderly.

The centerpiece of federal legislation on behalf of the older population is the Older Americans Act (OAA) of 1965. This legislation created the Administration on Aging (AoA) and seven million five hundred thousand dollars was appropriated to fund its first year. By 1983, the OAA budget was nearly $1 billion and it served 3.2 million persons (Newcomer, Estes and Benjamin, 1983). The coordination of delivery services is channeled through an "aging network" of State and Area Agency on Aging programs. This localization of senior programs for older people can help them to live more autonomous, useful lives for as long as possible in their own homes and communities.

A considerable variety of programs were created to address the needs of older people (Gelfand and Olson, 1980, Lowry, 1980, Kutza, 1981). In addition to the early programs that included income maintenance, other programs addressed the issues of health care (Medicare, Medicaid), housing (low rent public housing, construction and rehabilitation loans), and nutrition. In 1972, additional programs were enacted to address the needs of older persons in the area of social

services. These included multipurpose senior centers, homemaker and homehealth services and daycare. Additionally, legislation was enacted to add a new Title VII to the Act, establishing a "Nutrition Program for the Elderly" a large-scale, direct service nutrition program for the elderly.

The next major legislative change came when Congress consolidated the administration of many social services for seniors with "The Comprehensive Older Americans Act Amendments of 1978." A major result was the refocusing of the mission of the Administration on Aging (AoA), stressing State's development of community-based services for older persons (US Dept. of Health and Human Services, 1980, p.1). The Amendments of 1978 also funded and stimulated a broad spectrum of social services, some of these programs are directly aimed at improving the lives of older people by mandating and funding services, such as authorization for congregate mealsites and home delivered meals, others seek to encourage various benefits and safeguard the elderly, such as legislation regulating pensions.

## The Aging Population

The issues affecting senior citizens in America are changing. The older population itself is getting older. In 1983, the 65-74 age group (16.4 million) was over 7 times larger than in 1900, but the 75-84 group (8.5 million) was 11 times larger and the 85+ group (2.5 million) was 20 times larger (American Association of Retired Persons, 1984). Inevitable life changes coincide with the process of aging, such as

altered or changed family social roles, death of spouse and friends, changes in living arrangements, limited mobility, decreased income and physiological changes.

Of the nation's elderly, the vast majority live in households and only 5% are institutionalized (Riley and Foner, 1968). The rate of living alone among the elderly population in the United States has escalated in recent decades. In 1960, 19.7% of persons aged 65 and older lived alone, compared to 27.7% in 1980 (U.S. Bureau of the Census, 1963; 1983a; 1983b). However, among the single, widowed and divorced the shifts are more dramatic. By 1980, 52.6% of unmarried persons aged 65 and over lived alone, but only 38.8% did so in 1960 (Krivo, 1989, p. S54). While many seniors live alone by choice, the aging individual may at times have little control over his or her choice of living arrangements. This may lead some seniors to become isolates and others desolates (Edwards, 1983; Soldo, 1981). These changes are relevant because dietary patterns of seniors are affected by stressful life changes (Wan, 1982).

One of the major life changes faced by the elderly is living alone. Death, divorce and longevity can leave seniors facing the last years of their lives without an network of intimates. There are several responses to the situation of living alone, that of adaptation, isolation or desolation (Hooyman and Kiyak, 1988). Those seniors who have family, religious, ethnic or personal resources are frequently able to relocate into new patterns of integrative living. For others, social isolation, whether self imposed or the result of a loss, can have

serious consequences for their quality of life (Davis and Randall, 1984).

Isolates are people who live alone by choice. For example, they have lost a spouse but choose to remain alone. Among the aging populations, more women than men tend to be isolates. Health issues and cultural traditions influence this outcome. Women on average outlive men, and women tend to marry men older than themselves. A result of these patterns is that women's spouses frequently die before they do, leaving them alone. While more than 70% of men over the age of 65 are married and living in a household with their spouse present, only 36% of women over the age of 65 have this arrangement. Older women have fewer opportunities to remarry, but women are seen as more likely to be capable of caring for themselves due to their past experiences (O'Leary, 1977). The increasing proportion of women, especially in the older age categories, has significant implications for the nutrition programs since the majority live alone and on fixed low incomes.

Desolates are people who live alone, but not by choice. The elderly who are desolates may not have found a replacement for a family member or friend they have lost. Men and blacks who are 75 years and over seem to be at risk for becoming desolates (U.S. Dept. of Health and Human Services, 1985). Low income men who are not living with a spouse are at the highest risk of poor dietary intake (Chevan and Korson, 1972). These living arrangements are relevant because dietary patterns of older men when compared to older women are strongly associated with type of living arrangement and income.

As disengagement of the elderly from their social network and changes in living arrangements creates social isolation or desolation, eating patterns and habits of the elderly may be affected. Undernutrition in the elderly is frequently related to social isolation, since loneliness may decrease appetite (McIntosh and Shifflett, 1984). Isolated and desolated people who are often lonely are less likely to secure proper nourishment regardless of the amount or quality of available food because eating alone is emotionally distasteful (Krivo, 1989). Thus a major problem facing today's elderly and a focus of this paper is adequate nutritional maintenance.

The Social Context of Food

Food is a major element in social relationships. It can not be thought of simply as a source of nutrition or as a means to avoid hunger. Food helps to define the social identity of the individual. It is also vested with wide ranging symbolic meanings that are part of the fabric of daily life. The rituals, meanings and importance of food as a cultural expression begins at birth and develops throughout life. The sharing of a meal, the atmosphere of the room, table setting, and the conversation are all part of the dining process. Meals are social events, a time for social interaction, so the social connotation of dining, not just eating must be a consideration in nutrition programs for the elderly (Sadalla and Borroughs, 1981).

Social isolation, which affects how the elderly use food, may result in overeating and overweight rather than undernutrition (U.S.

Department of Health and Human Services, 1985). At least 20% of older people have conditions that require sodium restriction, weight control or drug therapy in their management indicating a need for dietary counseling and supervision (Rozovski, 1984). Among the other physical contributions to inadequate nutrition are ill fitted dentures, troubles with swallowing, diminished sense of taste and smell and the inability to shop or prepare food (Hooyman and Kiyak, 1988; Wan, 1983). All are contributing factors that seem to characterize the lives of many older people.

Living alone not only increases isolation, but may also lead to decreased economic, physical or psychological resources to travel the streets, to do the marketing and to make proper food choices (Harbert and Ginsberg, 1979). For the older person living alone, nutrient intake can be severely reduced on days when usual activities must be curtailed, due to illness or injury, if neighbors or family are not available to provide meals. On the average, older people have 40 restricted activity days and 14 bed rest days each year (U.S. Dept. of Health and Human Services, 1985).

Finally, poverty may be one of the most important sources of nutrition problems among the elderly (Riley, Hess and Bond, 1983). Poverty alone does not precipitate a nutritional deficiency, but it may affect the ability to obtain an adequate diet. It may also reduce the ability to obtain the health care needed to diagnose, treat and manage chronic illnesses linked to nutrition (Rozovski, 1984). Despite a radical decrease in income after retirement, that leaves one in every

five American retirees with incomes less than the current federally established minimums, very few attempt to claim the public assistance benefits for which they qualify (Hendricks and Hendricks 1977).

Only a little over 10% of those receiving Social Security payments also obtain public assistance benefits - that is, state and federally administered Supplemental Security Income payments - although government estimates suggest 66% of those receiving only Social Security payments are attempting to live on incomes less than the minimum set by the Federal government (Atchely, 1976, U.S. Dept. of Health Education and Welfare, 1975, Hendricks and Hendricks, 1977). The failure to claim benefits may arise from ignorance of their availability, but it may also stem from a sense of pride. Many people in their sixties and seventies hold strongly to an ethic of individual responsibility that views governmental assistance programs, and sometimes even Social Security payments as charity that self-respect prevents them from accepting (Gelfand, 1982; Senate, 1974, Ward, 1984).

The Title VII nutrition program (congregate and home delivered meals) focus on the problems experienced by many older Americans to maintain an adequate diet. These problems may be caused by economic, physical or emotional issues faced by them. The term congregate refers to meals served at a site where participants come to eat. For those individuals who are unable to come to a community mealsite, due to health or mobility problems, meals are delivered to their homes on either a regular or emergency basis (US Dept of Health and Human Services, 1981). The nutrition program's exploiting the social function

of dining also attempt to provide seniors with access to other available community services. And in many communities it is the cornerstone of the local senior service delivery system.

# CHAPTER 3

## THE MISSOULA SENIOR NUTRITION PROGRAM

The nutrition program for Missoula's senior citizens has undergone a difficult transition in the last several years. The program, following the mandate of the Older Americans' Act Amendments of 1978, was organized to maintain local seniors in the community and enhance the quality of their lives. The Missoula Senior Center had been the Nutrition Program subcontractor for a number of years. After District XI Human Resource Council bid and became service contractor in 1983, the Missoula Senior Nutrition Program (MSNP) was created to operate as the service provider of the congregate mealsite and home delivered meals program.

Because of the importance of the congregate meal program, both for the food provided as well as the pleasurable social interaction of dining with others, the transition to new mealsite locations and personnel has proven difficult for many seniors. The change in service providers and location have resulted in a change in client population and a reduction in the dollar amount of client donations to the program.

Another problem facing the subsidized nutrition program is that the former nutrition mealsite provider, the Missoula Senior Center, has continued a noon time meal program, charging participants for the actual cost of the meal. Those seniors who prefer to eat at the Senior Center and can afford the cost (on average, $2.00, as reported by seniors at the Human Resource Council mealsite) have left the nutrition program.

Some seniors participate in both meal programs, but the majority of current Nutrition program clients attend only the government subsidized nutrition program.

While the main issue in the nutrition program mandate is to provide 1/3 of the required daily allotment of nutrition for senior participants, opportunities for sociability is an underlying facet of the program. Home delivered meals, a non-profit program (not to be confused with the profit making Meals on Wheels Program) was instituted to provide nutrition program services to those who are considered physically or mentally unable to attend the mealsite program. A doctor, public health nurse or nutrition program coordinator must recommend an individual for the home delivered meals program. Since the goals of the nutrition program are to provide seniors opportunities for social interaction with peers, acquire information about other senior services and programs and to make contact with the larger senior service providing community, not just meals, only those who are deemed unable to utilize the congregate mealsite program are provided with home delivered meals. (The exception to this rule is to allow seniors who are service providers to homebound seniors to share in the home delivered meals service.) While the cost of home delivered meals is higher than mealsite meals, the mandate to provide services to help maintain seniors in their own homes make the extra cost and effort worthwhile.

At the present time, the Missoula Senior Nutrition Program does not charge a fixed amount or even have a suggested donation recommendation for the participating seniors. They are able to contribute cash or

foodstamps. The current, average free will donation is $.57 per congregate participant and $.61 per home delivered meal. The overall average contribution is $.60 for each meal served. Income collected from these free will contributions are used to increase the number of meals served by the local project.

Based on past experience and projection of future client need, nutrition services are contracted. By provisions in the Nutrition services contract, if any quarter exceeds its pro-rated meal count by 2% or more, there is to be a program review and, if necessary, contract modifications made. The current nutrition program contract specifies that 35% of the total funds for the nutrition program is to address the congregate mealsites, and 65% is for home delivered meals. Record checks over a six month period of nutrition service delivery, demonstrated a decline in mealsite attendence and an increase in home delivered services. At present, the clients are evenly divided between the two programs.

The Study

The issues that the Missoula Senior Nutrition Program officials had to address were initiated by both concerns of the program director and coordinators, as well as issues motivated by potential changes initiated by the program grantor, District XI Area Agency on Aging. The study was designed to assess a variety of personal characteristics including economic, health and social interaction patterns; living arrangements; transportation; and program utilization. Additionally, it would address

the specific issues of program support and financial contribution to the nutrition program.

Finally, the study would allow the individual participants to provide comments or suggestions for program improvement. Previous studies conducted for MSNP focused specifically on the program itself and not the larger social context of the senior's lives and the role or impact of the nutrition program in improving the quality of life of the senior participants. Copies of previous questionnaires can be found in Appendix B.

Beyond the general questions of interest about the seniors' conditions and issues, the study was to assess specific issues including client group definitions and long-term program funding patterns. One of the intended outcomes was to help the program director and coordinators to determine if the two current client groups were significantly different enough to warrant the present client program assignments. Since client distribution affects funding patterns, it was also hoped that the information gathered during the course of the study would identify what could be done to help home delivered meals pprogram seniors crossover to the more comprehensive congregate mealsite nutrition program.

Particular concern was voiced by regional administrators about the increasing number of home delivered meals clients and the decrease of congregate mealsite participants from the projected expectations based on previous program utilization. The problem of higher cost of the home delivered meals program operations, are focused in the next issue,

client ability to financially support the program.

Clients are currently supporting the two nutrition programs with donations averaging $.60 per meal. The Area Agency on Aging had recommended mandatory donations to offset costs of the program. The suggested contribution was $1.50 per meal received. Funds generated would be used to support the inclusion of more seniors in the meal programs. The Missoula Senior Nutrition Program is currently paying $2.20 per congregate meal and $2.38 for each home delivered meal prepared by the subcontractor. The price does not include the cost of program administration or operation, nor an offset for inkind contributions.

Missoula Senior Nutrition Program Participants

All senior citizens in the city of Missoula are able to use the senior nutrition program since there is no income eligibility standards affecting participation. Due to this fact, the number of seniors in the nutrition program is limited only by the budget allocated for the program by the Area Agency on Aging. The home delivered meals portion of the senior nutrition program does have a handicap requirement, but the definition of handicap (physical, mental or social) has been broad enough to include any senior who insisted on home delivered meals.

Seniors who would like to eat at Missoula Senior Nutrition Program must call a day in advance to reserve a space (and so MSNP can notify the meal preparation contractor with the attendence number for the next day). Upon the first contact with the new program client, a short

intake form is completed. (A copy of the intake form can be found in Appendix C.) The monthly reporting requirements of the State of Montana Department of Social and Rehabilitation Services direct the tabulation of new client totals for each month and cumulative client totals for the year to date. Additionally, records are kept on the number of meals served, both for the month and cumulatively, however, no official record is kept of the number of different clients served in a month (Appendix D). The actual number of clients was determined by counting the number of individuals requesting even one reservation to either program during the timeframe of the study. Appendix E contains site and consumer evaluation forms.

# Chapter 4

## SUMMARY OF THE MISSOULA SENIOR NUTRITION PROGRAM USER PROFILE AND SENIOR NEEDS ASSESSMENT

### The Interview Schedule

A questionnaire was designed to assess client history in the nutrition program, as well as social, medical and economic background of the congregate nutrition program participants. This questionnaire was modified to be relevant for the home delivered meal program participants. All questions used in this survey were approved by the Director of the Senior Nutrition Program, the Director of the District XI Human Resource Council and reviewed by the Area XI Agency on Aging prior to the interviewing.

The mealsite program questionnaire consists of 41 questions. The questions in the survey cluster around five variables; client/program compatability, program support, social interaction, and a health profile. The first 13 questions concerned the nutrition program and the senior's participation history in the program. The next 7 questions were concerned with the senior's recreation and activities while 6 questions developed a medical problems/illness profile of the respondent. Additionally, there were 6 questions on nutrition and 8 demographic questions. Finally, the last question asked for suggestions to improve the nutrition mealsite program.

Once the interview had been completed, the responses were computer coded in the spaces on the left column of the schedules. A discussion and debriefing session was conducted by the author during and after the interviewing had taken place to ensure consistency in the coding of responses. Following a check of the schedules for coding errors, the data were entered into the computer, verified for accuracy and processed using the Statistical Package for the Social Sciences, Version X. The data was compiled to produce frequency distributions at the request of the contracting agency. A copy of each of the questionnaires with frequency distributions for all relevant variables are presented in Appendix A.

The Sample

The time frame of the survey required interviewing in the early summer. The data for this study were collected during the two week period of May 13-26, 1985 at the Missoula Senior Nutrition Program. This does affect the configuration of the client population of both programs. Short term, more mobile seniors are more likely to be omitted from the survey. The most consistent (and possibly most needy) seniors would be interviewed. With the assistance of the nutrition program coordinators, a list of all clients participating in the nutrition programs, June 10 through June 24, 1985 was developed. This list yielded a total of 129 participants, 61 in the congregate mealsite program and 68 in the home delivered meal program. This list became the potential pool of interviewees for this survey. Based on the definition

of client utilized by the Nutrition Program, the participants during the two week study would be the total population of seniors in the program. Logistical and manpower limitations made it impossible to interview all senior nutrition clients to date, especially since even one participation in the nutrition program includes an individual as a client.

Because of limited funds, it was decided that the mealsite program survey would be self administered. Of the 61 potential clients in the congregate mealsite program, 50 individuals, (82%) completed self administered or face to face interviews. (For those clients who were physically unable to complete the survey questionnaire, either the author or the mealsite coordinator read the questions and answers to those clients and recorded their responses on the interview schedule.)

Due to the fragile nature of the majority of the home delivered meal clients, their interviews were conducted by telephone. For those seniors with no telephone, face-to-face interviews were attempted. Of the 68 potential clients in the home delivered meal program, 50 individuals (73%) answered the interviewer's questions. (The lower completion rate for this group of respondents was directly influenced by the physical or mental condition of clients served in the home delivered meals program. Many of the seniors participating in this program were too severly handicapped either physically or mentally to complete even a telephone or face-to-face survey.) The telephone interviews were conducted by the nutrition program coordinators. There were no refusals by any of the clients in either group to participate in the senior

opinion profile.

## Results

The purpose of this study was to accomplish two goals. The first was to develop a general profile of current clients utilizing the program services. The second goal was to investigate the two issues that guided the format of the study, client/program compatibility, and client ability to contribute to the financial support of the program.

### Client/ Service Compatibility

One of the primary goals of this study was to determine if there were in fact two distinct nutrition program client populations requiring different types of service. There are no discrete set of criteria that can objectively determine which individuals should be clients of what program. Intake supervisors, based on client responses to a set of questions, personal observation and external evidence (professional referral) attempt to guide senior clients to the appropriate meal program service. No single measure can substitute for this subjective decision making process. Indeed, upon review of individual variables, there is a great deal of similarity between congregate and home delivered meal participants. However, when the issues are clustered together to make a composite profile it is evident that there are two groups of seniors who have major differences in three areas: personal and social mobility patterns; chronic or serious health issues and age.

The clients of both programs were asked why they participated in their nutrition program. The results are presented in Table 1. The results indicate that the social aspects of dining are most important for the congregate participants, 72% of the seniors at the congregate sites indicated that they enjoyed eating with others. Additionally, 54% of the congregate seniors indicated that they enjoyed the food. For those seniors utilizing the home delivered meals program, 88% indicated that the inability to cook for themselves was the most compelling reason for home delivered meals. The second most frequent reason cited for using the program was the inability to shop for food (56%).

TABLE 1

REASON FOR COMING (USING) THE NUTRITION PROGRAM

| | Congregate | Delivered |
|---|---|---|
| enjoy eating with others | 72% | * |
| save money | 22% | 12% |
| no cooking facilities | 8% | 2% |
| enjoy visiting with others | 34% | * |
| like the food | 54% | 16% |
| can't cook for self | 18% | 88% |
| unable to shop for food | ** | 56% |

*only asked of congregate clients.
**only asked of home delivered clients

The freedom to move about independently is one of the major differences demonstrated by the seniors of the two nutrition programs.

The inability to shop or prepare food does not and should not, in and of itself, be the sole determinant for home delivered meal service. Other seniors who also have these challenges use the congregate mealsite program. Transportation to the mealsite nutrition program is available from Senior Transportation, seniors only need to request service to come to the nutrition program. However, community mobility, or its lack, is another subtle measure of program designation. Several questions to assess the seniors' general community mobility were investigated.

TABLE 2

AUTOMOBILE OWNERSHIP AND OPERATION

| | Congregate | Delivered |
|---|---|---|
| Automobile ownership | 48% | 44% |
| Currently Drive | 48% | 18% |

The ownership of a car and the ability to drive are symbolic signs of independence, adulthood and autonomy. As can be seen in Table 2, 48% of the congregate mealsite participants and 44% of the home delivered meals participants own their own cars. However, while all of the congregate mealsite seniors who indicate automobile ownership drive their cars, only 18% of the home delivered meals participants consider themselves able tc drive and actually do so.

TABLE 3

PERCENTAGE AND TYPE OF VISITORS IN THE HOMES OF NUTRITION PROGRAM PARTICIPANTS LAST MONTH

| | Congregate | Delivered |
|---|---|---|
| Company | 74% | 90% |
| family | 54% | 60% |
| friends | 50% | 50% |
| nurse/aide | 8% | 2% |
| salesman | 8% | 0% |
| clergy | 6% | 4% |

Mobility is also demonstrated by socializing outside of one's home. Table 3 shows that 90% of the home delivered meals clients and 74% of the congregate mealsite participants had had company in their own homes in the last month indicating that they were not so isolated that they would have not had a place to go, if they wished to visit. However, only 62% of the home delivered meals clients as compared to 70% of the congregate clients visited outside of their homes (Table 4).

TABLE 4

VISITING OUT OF THE HOME BY NUTRITION PROGRAM PARTICIPANTS IN THE LAST MONTH

| | Congregate | Delivered |
|---|---|---|
| Gone to visit | 70% | 62% |
| family in town | 26% | 24% |
| family out of town | 14% | 2% |
| neighbor | 54% | 12% |
| others | 26% | 4% |

In the area of chronic or serious health issues, four percent of the congregate mealsite participants claimed that they had a chronic debilitating condition, while 36% of the home delivered meals participants claimed to be ill all of the time. When asked more specifically, if their doctor had told them that they had a chronic illness, 42% of the congregate mealsite participants and 58% of the home delivered meals participants had been told that they had a chronic illness. Table 5 lists the illnesses of the two participant groups.

TABLE 5

CHRONIC ILLNESSES REPORTED BY SENIOR NUTRITION PROGRAM PARTICIPANTS

| | Congregate | Delivered |
|---|---|---|
| Chronic illness | 42% | 58% |
| high blood pressure | 8% | 2% |
| heart | 2% | 22% |
| arthritis | 4% | 8% |
| ulcers | 4% | 4% |
| lung | 2% | 6% |
| cancer | 0% | 4% |
| parkinsons | 0% | 8% |

The differences in the two groups are further demonstrated in frequency of hospitalization. Twice the number of home delivered meals participants were hospitalized in the last year compared to the congregate mealsite participants (52% and 26% respectively).

The third major factor that differentiated the two groups was age. Fifty four percent of the senior congregate mealsite participants are under the age of seventy five, while 68% of the home delivered meal participants are over the age of seventy five. The age breakdown can be seen in Table 6.

TABLE 6

AGE OF SENIOR NUTRITION PROGRAM PARTICIPANTS

| | Congregate | Delivered |
|---|---|---|
| under 60* | 8% | 0% |
| 61-65 | 28% | 10% |
| 66-70 | 8% | 20% |
| 71-75 | 18% | 8% |
| 76-80 | 10% | 22% |
| 81-85 | 10% | 22% |
| 86-90 | 6% | 4% |
| 91-95 | 0% | 10% |
| 96-100 | 0% | 2% |
| missing | 18% | 2% |

* handicapped residents of Vantage Villa and Native Americans over the age of 55 are eligible to participate in the nutrition program.

## Client's Ability to Donate to the Nutrition Program

The second issue that this study addresses is the ability of the clients of the current senior nutrition program to assist in the financial support of the Missoula Senior Nutrition Program through financial contributions. Nutrition program meals are subsidized by federal, state and local contributions. There is no means test requirement to participate in the Nutrition Program, however, the agency sponsoring the program may, based on community standards, authorize a suggested or mandatory contribution. Contributions can be

cash or foodstamps and this income generated becomes available to support increased service delivery. Increased demand for service from eligible community members, as well as reductions in federal assistance for social programs in general has motivated a greater shift to consumer support for services provided in the public sector.

While contributions to the Missoula Senior Nutrition program are not mandatory for eligible participants, they are encouraged. As shown in Table 7, seniors in both programs indicated that a donations should be made for the meal, but that the amount of the donation should be based on an individual's ability to pay.

TABLE 7

OPINION ON DONATIONS TO SUPPORT NUTRITION PROGRAM

| | Congregate | Delivered |
|---|---|---|
| participants should donate | 86% | 94% |
| donations based on ability to pay | 90% | 88% |

Nutrition program records indicate that the average contribution per meal served is $.60. This amount is comparable to national average senior nutrition participant contribution of $.57. Table 8 shows current levels of financial support for the nutrition program as reported by the current participants.

TABLE 8

REPORTED PER MONTH DONATION AMOUNT FOR NUTRITION PROGRAM MEALS

| | Congregate | Delivered |
|---|---|---|
| $0.00 - $5.00 | 52% | 50% |
| $6.00 - $10.00 | 6% | 10% |
| $11.00 - $15.00 | 0% | 10% |
| $16.00 - $20.00 | 18% | 8% |
| $21.00 - or more | 10% | 4% |

It has been recommended by the Area Agency on Aging that there be a required donation of $1.50 per meal received. As demonstrated in Table 9, 48% of the congregate participants and 52% of the home delivered meals clients felt that they would have to limit their participation if they were required to make a mandatory donation of $1.50 per meal.

TABLE 9

"IF YOUR WERE REQUIRED TO DONATE $1.50 PER MEAL, COULD YOU CONTINUE TO PARTICIPATE IN THE NUTRITION PROGRAM?"

| | Congregate | Delivered |
|---|---|---|
| no, would stop completely | 48% | 52% |
| no, would participate less | 18% | 4% |
| yes, would continue at present level | 26% | 40% |

Seniors were asked what they felt would be an appropriate level of financial participation. While 50% of the congregate mealsite participants indicated that $1.00 per meal would be an appropriate contribution, 52% of the home delivered meal participants believed that the individual's ability to pay should set the amount of the contribution. The responses are indicated in Table 10.

TABLE 10

DONATION AMOUNT SUGGESTED BY SENIOR NUTRITION PARTICIPANTS

| | Congregate | Delivered |
|---|---|---|
| one dollar per meal | 50% | 12% |
| two dollars per meal | 10% | 14% |
| ten dollars a month | 2% | 10% |
| ability to pay | 8% | 52% |

A factor that has to be taken into consideration before any required donation can be authorized, is the income level of the participants. For many individuals and families, $1.50 would be an extravagant sum to spend for one person for one meal. The seniors who are currently participating in the nutrition program were asked to indicate their income level. Table 11 illustrates their general income categories. At least 58% of the congregate mealsite participants and 52% of the home delivered meals participants indicated an annual income which places them below the State 100% poverty level guidelines (income of less than $5250. for one person).

TABLE 11

INCOME RANGE OF SENIOR NUTRITION PROGRAM PARTICIPANTS

| | Congregate | Delivered |
|---|---|---|
| $0.00 - $ 5250 | 58% | 52% |
| $5251 - $ 6563 | 10% | 8% |
| $6564 - $ 7050 | 4% | 0% |
| $7876 - $ 8813 | 2% | 10% |
| $8814 - $10575 | 6% | 4% |
| $10576 or more | 0% | 12% |

One way for many seniors to participate in the nutrition program and not spend any of their current income would be to apply for assistance from the Foodstamp program and donate their foodstamps for the contribution for their nutrition program meals. Historically, there

has been great resistance by senior citizens to utilize the federal nutrition supplemental programs. The perceived social stigma, bureaucratic intrusion and required forms, as well as pride, deprive many seniors from these life enhancing programs. Given the income levels reported by the senior participants, it can be estimated that at least 50% are eligible for foodstamps. As Table 12 shows, fewer than twenty percent of the congregate participants and only six percent of the home delivered meals participants are currently receiving foodstamps. The utilization of the commodities program by significant numbers of seniors in both the congregate mealsite program (62%) and the home delivered meals program (24%), may be understandable due to the fact that the commodities are distributed by the Human Resource Council (the parent agency of the Senior Nutrition Program) at the senior mealsite locations.

TABLE 12

NUTRITION ASSISTANCE PROGRAMS UTILIZED BY SENIOR NUTRITION PARTICIPANTS

| | Congregate | Delivered |
|---|---|---|
| use other food programs | 72% | 32% |
| food stamps | 18% | 6% |
| commodities | 62% | 24% |
| food bank | 30% | 2% |
| Poverello | 2% | 0% |
| family/friends | 4% | 8% |
| Meals on Wheels | 2% | 0% |

Summary

A self administered questionnaire was completed by 50 participants (82%) of the Missoula Senior Nutrition Congregate Mealsite program. A questionnaire, modified to be appropriate for the Home Delivered Meal Program was conducted by telephone or in person with 50 (73%) of the current clients of the program. The questionnaire sought information regarding seniors nutrition program participation and financial donation history, general health status, community contacts, recreational interests, community services utilization, income level, age and current housing status.

The responses of the participants of each program created two profiles, each demonstrating the need for and the value of the nutrition programs in the lives of these senior clients. Those seniors who felt independent and self sufficient utilized the congregate mealsite program with its' opportunities for recreation, information and socialization. Further, they indicated fewer sick days and in general a greater sense of well being than home delivered meals clients, even though they indicate similar patterns of chronic illness. Home delivered meals clients who lacked independent mobility, as indicated by the inability to drive or prepare meals, were provided a life enhancing service with the nutrition project.

The ability of the senior participants to financially assist in the funding of the nutrition program was explored. While the voluntary contribution patterns of the local senior nutrition program participants

compared favorably with national contribution averages, program contractors had considered mandatory contributions to offset the costs of the program. Over half of the seniors of both programs indicated income levels that would place them at the 100% poverty level. The majority of seniors of both programs indicated that they would have to change their utilization of the nutrition program if a mandatory charge was imposed.

Conclusion

The the number and quality of community resources available to senior citizens will have to increase to meet the demand for services created by the increase of independent elderly households (Soldo, 1981). For example, appropriate types of available housing, supportive healthcare, financial assistance, demographic composition or normative social support may be necessary to make independent living feasible for many seniors (Krivo, 1989). Policy makers and program directors will have to become sensitive to the varied needs of the aging population and strive to meet these needs in the least restrictive ways possible.

The physical ability differences between congregate and home delivered meals participants, as demonstrated by their responses to questions in the user survey, highlight the different outcomes and potential losses for each group of seniors if administrative changes force their curtailment of program utilization. While the congregate meal site program provides needed nutritional and socializational opportunities for its clients, the freedom of mobility provides options

for those seniors if the cost of participation in the program becomes prohibitive. While the increased cost of participation could prove an economic hardship on both client groups, lack of alternatives for nutrition enhancement could become a serious personal hardship for the homebound seniors.

Home delivered meals participants indicated that their program participation was not recreational, but borne out of physical necessity. Their options to access other nutrition programs is limited. The community currently has no other low cost, long term feeding program for home bound seniors. With no other viable alternative, those seniors who could not afford the mandatory contribution, might be forced to leave their less restricted home environment and move to an institutional setting.

# CHAPTER 5

# APPLIED RESEARCH ISSUES

All human service programs face the problems of planning and accountability. It is not enough to have a worthwhile goal or even day to day success. To remain viable in the competition for philanthropic and governmental financial support, human service programs have to demonstrate "bang for the buck" - the effectiveness of their intervention in the lives of the individuals they serve in relation to the cost of operation. Many funding agencies require compliance with guidelines and regulations that include: client composition, cost containment, and public expectation. Most records detail only detached numeric tallies, and do not reflect the true nature of the program, nor its impact on the lives of its clients.

## Role of Research in Public Programs

Funding agencies and various federal and state regulations require records keeping and timely reporting of aggregate totals for financially sponsored programs. Most reporting forms require monthly and quarterly totals, services to date, ie., information that can objectively demonstrate that regulations are being met. Reporting forms do not subjectively demonstrate the quality of the program, nor the impact that the program makes on the lives of the people that it serves. Many agencies, due to the demands of everyday service delivery and lack of professional researchers, do not quantify the intrinsic or social value

of the services provided or the impact that programs have on the quality of life of their clients.

It is the emotive, human dimensions of programs that are frequently the most compelling and that bring programs and their services to the attention of the public. During times of fiscal responsibility and program cutbacks, this non-commercial form of advertising may prove to be the most beneficial to a program's survival. This was one of the reasons for the participant profile for the Missoula Senior Nutrition Program. A small agency, contracting a federally mandated service, the Missoula Senior Nutrition Program found itself being squeezed by cutbacks in service delivery legislation and allocation. To justify revenue maintenance (and hopefully revenue enhancement) they had to document client need.

The decision by the program directors to do the study was motivated by external pressures and issues, which is consistent with many of the current programatic research strategies. The post-hoc nature of the research provided many challenges for the researcher. There was little or no control over what observations were made before the program was begun or while the research was in progress. Researchers are frequently not contacted until a program is underway or completed. The researcher may find little agreement about the goals or aims of the program. Even if the goals are agreed upon, they are so broad that it is difficult to devise a measure to demonstrate if the goals are being achieved (Saslow, 1982, Trela and O'Toole, 1974, Weiss, 1972).

The Competitive Environment of Service Delivery

Every program takes place in a setting that has consequences for its effectiveness. A single program may have widely diverse meanings for the participants in various community context and the researcher must respond sensitively to the complex nature of the program's mission (Shostak, 1974; Trela and O'Toole, 1974). An organization is located in a network of other organizations, some of which are essential not only to its service mission but to its very survival. Other organizations in that same network may attempt to subvert and claim clients in a battle of turf and funding dollars.

Human service programs function primarily in relationship with the organizations that sponsor and oversee the program (Weiss, 1972). For the Missoula Senior Nutrition Program this included the District XI Area Agency on Aging and the District XI Human Resource Council. Its relationship with these organizations may be alternatively viewed as competitive or cooperative. In the case of the Area Agency on Aging, the Missoula Senior Nutrition Program had to justify contract changes as well as their ability to best serve the user population of senior citizens. Because of the direct physical and programatic relationships with the Human Resource Council, the daily dynamic was more cooperative and less threatening.

The complex nature of community interorganizational networks, power, and the struggle for an agency to survive and serve their intended clientele necessitates a thorough understanding of the value of the intervention program in the larger community. Additionally, an

understanding of the history and dynamic of the various service providers in an area is important. The District XI Human Resource Council had bid successfully to become the senior nutrition congregate and home delivered meals provider for Missoula County. The agency created the Missoula Senior Nutrition Program to coordinate the program. The previous contractor, the Missoula Senior Center continued to serve a noon meal program, though no longer subsidized by federal funding.

Concerns about exclusiveness and the "Country Club" atmosphere of the Senior Center had been part of the reason for the Human Resource Council to bid for the Senior Nutrition Contract. Complaints about segregation and not meeting the needs of the most "at risk" population were common. But, these types of concerns about senior centers are not just local or a rural phenomenon. As Frankfather (1977) found, senior centers frequently resemble closed societies, made up of middle-class women who were intolerant of deviance and forced "outsiders" to withdraw from involvement (Ward, 1984, p. 307).

In the 18 months that the Missoula Senior Nutrition Program had been in existence, there had been a dramatic change in the client population. Utilization of the home delivered meals program had increased, as had the number of seniors coming to the congregate mealsite by the Senior Transportation Program. While from casual observation, the program seemed to be reaching the most needy and at risk seniors, there was no official demographic profile of the client population. However, another more ominous indication of meeting the intended client population was also seen. The amount of client contributions for the meals programs

had dropped. While the local program was exceeding national donation averages for free will contributions (U.S. Dept. of Health and Human Services, 1981), the program grantor, District XI Area Agency on Aging was considering mandatory contributions to offset the cost of the program and to be able to provide more funds for meals. This potential change in service delivery and its presumed hardship on the senior participants motivated the decision for a study of the user population.

Human service delivery systems evolve strategies which are designed to achieve multiple program objectives, some of which are clearly stated and some are latent or implied (Neuber, 1980). The program goals, frequently defined at multiple levels of administration often conflict and are products of competing ideologies, attaching different values to the end product (Sze and Hopps, 1974). This can be clearly seen with the Missoula Senior Nutrition Program. From the perspective of the Area Agency on Aging, program success was a statistical formula of cost vs units served. For the Human Resource Council, aquisition and maintenance of a revenue generating program that increased their control of the human service delivery market was important. For the the Missoula Senior Nutrition Program Directors, finding and feeding needy seniors and bringing them into the larger senior services network was the goal. In a real sense, all the goals were met, but the impact and effectiveness of community human service programs are hard to demonstrate (Cox et al., 1984). To remain viable in today's service provider arena, the program must be accountable for its' work.

Basic vs Applied Research

Research has two major divisions, basic and applied. Just as the meaning of research is highly elastic, the distinction between basic and applied research is often difficult to articulate. Nevertheless, the distinction is an important one in settings where the research role is not clearly defined. Research of immediate problems, may, or course, have both basic and applied implications, but in most cases, a general orientation can be identified. The significant difference between basic or nonevaluative research and applied or evaluative research is one of purpose and not of method (Suchman, 1971, p.45).

Basic research is not intended to solve the problems or answer the questions of host organizations. It is thought that findings will ultimately benefit society, explain how things happen in general, develop or test a theory. Basic research is intended to increase understanding rather than to solve specific problems. Basic (pure) research involves developing and testing hypotheses and theories that relate to sociological principles or perspectives of interest to the researcher. Pure research deals with questions that are intellectually challenging to the researcher but may or may not have practical applications at the present (Bailey, 1982).

Applied research, on the other hand, focuses on problems posed by the host organization and is intended to contribute to the solutions of organizational problems (Vollmer, 1972). It is more immediate in its concern and applications, responding to specific issues or problems presented to the researcher with the aim of finding an immediate

solution to a practical problem (Berstein and Freeman, 1975). Toward that end, applied research techniques can vary from project to project (Saslow, 1982). Applied research techniques used to review programs include descriptive studies and performance assessments.

Descriptive studies generate a user profile providing base line information about the clients of a given program or service. Performance assessments focus on the process of service delivery. There are different types of performance assessment including: monitoring, contract compliance and outcome evaluation (Azarnoff and Seliger, 1982). Monitoring is the name for on-site inspections of programs that agencies operate and focuses on the process of service delivery (Ginsberg, 1983). In contract compliance, research measures the degree to which process objectives slated in the contract are achieved and evaluation. Performance outcome evaluation is the assessment of the effectiveness of social programs that were designed as tentative solutions to existing problems (Smith, 1981, p. 241).

Sampling Strategies

While most basic research strategies utilize probability or quota sampling, the demands and limitations of applied research frequently require different strategies of determining the sampling frame (Phillips, 1985). With probability sampling, the probability that an element will be chosen from the universe is known. In quota sampling each stratum is represented in proportion to the general population. Many studies (generally smaller ones) use non-probability sampling.

This can include purposive sampling, interviewing those who best meet the needs or purposes of the study or even the "snowball" or referral sampling techniques. In the snowball or referral sampling approach, individuals with the requisite characteristics are interviewed and then they are used as informants to identify the next wave of respondents. While there is the obvious disadvantage that the research can not be considered representative of the larger population, nonprobability sampling is much less complicated, much less expensive and is able to take advantage of available respondents. A nonprobability sample may prove perfectly adequate if the researcher has no desire to generalize his or her finding beyond the sample (Bailey, 1982, p.97).

Questionnaire Design

The heart of a user profile is the questionnaire. It is one of the most economical, efficient ways of collecting a quantity of comparable data. The questionnaire format, if carefully and thoughtfully constructed can elicit quality information about the nature and characteristics of a population. The self-administered questionnaire allows the respondent privacy as well as the time to formulate and select appropriate answers. Due to the need for fewer project staff, its use reduces the overall cost of research. However, certain difficulties may arise when interviewing special populations.

With older respondents, in addition to a general skepticism of research or a perception of intrusion, there may be physical difficulties or mental confusion that can create special challenges for

the research enterprise. It is important, therefore, to anticipate the need for the interviewer assisted questionnaire for those participants who are unable (for a variety of reasons) to complete an interview schedule on their own. Left on their own to complete an interview schedule, older people who may have more difficulty understanding questionnaire forms are more likely to state "no opinion" (Riley et al, 1972). It is also a common observation that older people give more favorable evaluations of their life circumstances than seems warranted by objective conditions, and such denial or defense may depend on the wording of the question (Carp and Carp, 1981).

For either form of questionnaire, self administered or interviewer completed, the researcher must recognize the role of the language and experience of the participants to further guarantee a successful outcome (Sudman and Bradburn, 1982). The question wording needs to be clear, the meaning of words precise and familiar to the respondents. The schedule format must be logical, and the response categories inclusive. The questions should be direct, to the point and convey the nature of the appropriate response. They should follow a sequence that is orderly and builds on the previous responses. Individuals are more likely to participate and respond truthfully if they can see that the survey has the ability to address some of their interests and concerns.

Finally, without sacrificing the quality of the end product, the questionnaire should be as short as possible. Researchers frequently ask more questions than are immediately necessary to the completion of the research act (Saslow, 1982). This propensity can be multiplied if

there is outside co-optation of the research project.

Research Project Co-optation

One problem in evaluation research is that there are often conflicting interest groups involved in the program, each with different vested interests and different program goals (Coleman, 1972). When a program is not autonomous, or when the cost of research has been allocated from an outside source, there is great temptation from those outside interests to include "just a few more questions" on the survey form. The nature of survey research generates the desire to ask questions. The respondent holds an untold wealth of information just waiting to be mined by the ardent researcher. The research process can be further compromised with "piggybacking" or the co-optation of the questionnaire instrument by other agencies or programs.

These additional questions may obscure the true nature of the original study, complicate the question sequencing and tax the patience of the individuals trying to respond to a series of questions that seem to have no purpose or value to those researchers whom they have consented to help.

Co-optation was a major problem for the Missoula Senior Nutrition Program User Study. The District XI Area Agency on Aging, as grantor of the senior nutrition program, was interested in the outcome of the user study. It would provide statistical information about the current nutrition program user population. It would also provide other information about a senior population, many of whom fit the proposed

profile of clients that might benefit from a new program that the AAOA was considering sponsoring. It was requested that several questions about seniors recreational and social outlets as well as telephone use be included in the user study.

The District XI Human Resource Council, underwriters of the study were interested in information that could document senior's use of supplemental programs as well as their general health status and medical needs. Again, the Nutrition Program questionnaire was amended to include the additional questions of interest. What originally started out as a 23 item questionnaire about nutrition program clients' participation history and their perceived ability to financially assist with the cost of the program became a 40 item questionnaire. Questions that were submitted by the AAoA and HRC assessed a variety of personal characteristics of the participants as well as a number of senior issues. All of the questions were appropriate to address senior concerns, and the additions did not significantly impact the quality of the responses of the senior participants. However, the co-optation and overlapping turf did make itself evident and had to be managed.

The Research Consultant

The sociologist's basic training in methodology and analysis sets a foundation of skills suitable to address the study of organizational problems and evaluations that any service based agency requires. Even though most sociologists are competent to define, interpret and analyze any organization from the sociological perspective, many organizations

seen hesitant to utilize the services of trained professionals. The problem seems to be based in not what should be studied, nor even the need to study agencies and their service delivery, but rather, the results that are produced from studies by sociologists.

In the attempt to gain greater precision, thus greater predictive qualities from data analysis, sociology has created a product that at times is valuable only to other sociologists. A major complaint from many service providers who are recipients of sociological diagnostic and evaluative services is the inability of the providers to understand and utilize the sociological results. To make applied sociology useful to those who request and need the services, sociologists must be willing to forgo some academic rigor and recognize the need for utility in the world of the service provider. At the same time, agency professionals have to understand that all research represents a compromise between what is ideally desired and what realistically can be done (Bernstein and Freeman, 1975).

The tension between the applied researcher and the service organization professional may be due to the relatively new relationship between the two. There is often little interaction between service organizations and various scientific disciplines and hence role definitions and standards of role performance have not been firmly developed for persons who cross over the boundaries of their experience (Trela and O'Toole, 1974). In the last 20 years there has been a tremendous increase in interest in evaluation research and program evaluation (Bailey, 1982). Policy makers, funding organizations,

planners and program staff need answers to a number of questions that in the past were not asked. Due to funding cuts and changes in Federal legislation, accountability is mandated. The role of research in an organization must be developed, and this development must take into account the various perspectives and interests of the organization's administrators, practioners and the researcher.

The early view of research centered on the feedback process within an ongoing program management system. There has been a move to view the role of evaluation as an integral part of the policy decision making and research process (Cronbach et al., 1980). The researcher can help the policy maker or program manager define the information needs and the decision options available for the program. The issues raised about program review or evaluation for what, for whom, and with what impact on whom are the primary questions. Providing the answers to program and policy questions is at the heart of evaluation research (Cox et al., 1984; Rossi et al., 1979; Weiss, 1972).

The role of program research in an organization as well as the role of the professional consultant to perform agency research are major areas of concern and confusion for sociologists. Working in the community setting involves issues not always considered or recognized in academia. There must be negotiation, and defining of roles and expectations between the contracting agency and the professional (Trela and O'Toole, 1974). The decision maker, not the researcher, determines the areas of interest. In a service organization, the problems of the host take precedence over what may be intellectually intriguing to the

researcher. The researcher has to understand and work around the limitations or problems in gathering dependable information. The researcher may discover that the decision-maker needs very basic information about the way his program operates or how services are delivered - not a complex theoretical model or a social phenomenon based on tenuous assumptions and limited data (Sze and Hopps, 1974, p.19).

Conclusion

Evaluations are initiated for many purposes - sometimes conflicting ones (Cronbach et al., 1980). Program administrators, facing shrinking budgets may need to choose the best innovation among several proposed lines of action. Programs already in existence need to adapt long running operations to reflect the needs of a changing clientele. Many programs routinely perform evaluations to maintain quality control. Other program officials use evaluation as a tool or threat, forcing subordinates to comply with instructions. Evaluations can provide documentation that a program's funding is well founded. They can be used to demonstrate support for a pet proposal, or cast doubt on a policy favored by political opponents. The evidence to be sought in each instance is that which will produce the greatest difference in social thought and action (Cronbach et al., 1980, p.14).

What becomes clear for the sociologist who does work for hire (ie. applied sociology) is that there must be an interpretive process performed to transform "sociologese" into something understandable for the general consumer. While the basic abstract principles and theories

of sociology and its methodology apply to the product of community research, the end product of "classic" sociological inquiry may be foreign and intimidating to non-sociologists, making the information as well as the consultant suspect. While performing services in the consultant role, the demand for simple practicality must be stressed. This flies in the face of most "basic training" in sociology where research can, at times, be best defined as an end unto itself.

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# APPENDIX A

## SENIOR NUTRITION PROGRAM

## SENIOR OPINION PROFILE

SENIOR NUTRITION PROGRAM
SENIOR OPINION PROFILE

Please help us by answering these questions. We need to know a little bit about you and your feelings about the nutrition program so we can try to get more money for more meals for more seniors. Thank you very much.

Mealsite Program

1. How long have you have you been coming to the mealsite program?

__8%_ less than one month
_10%_ 1 - 3 months
__6%_ 4 - 6 months
_10%_ 7 - 12 months
_10%_ 13 - 18 months
_14%_ 19 - 24 months
_42%_ more than two years

2. How often do you come to the mealsite program?

_62%_ 5 days a week
__8%_ 3 - 4 days a week
_26%_ 1 - 2 days a week
__4%_ less than 4 times a month

3. How do you get to the mealsite program?

_12%_ walk
_40%_ drive yourself
_14%_ ride with a friend
_12%_ take the Mountain Line bus
_22%_ special transportation
_____ other:_____

4. How did you find out about the nutrition program?

__2%_ newspaper
_24%_ social workers/service providers
_12%_ meals on wheels
_50%_ friends/family
__8%_ other:_____

5. Why do you come to the Nutrition program? (check all that apply)

_72%_ I enjoy eating with others
_22%_ I save money on my food budget
__8%_ I don't have cooking facilities
_68%_ I like to visit with people
_54%_ I like the food
_18%_ I am unable to cook for myself

6. Do you know of someone who should be receiving meals, but aren't getting them?

_82%_ no
_18%_ yes

7. Should there be a donation made for the meal?

_10%_ no
_86%_ yes

8. Should the donation be based on the ability to pay ($.50 to $2.00 depending on income)?

__8%_ no
_90%_ yes

9. In the average month, about how much do you donate for the meals you eat?

_52%_ $ -0- - $ 5.00
__6%_ 6.00 - 10.00
_18%_ 11.00 - 15.00
_10%_ 16.00 - 20.00
_14%_ 21.00 - or more

10. If you were required to donate $1.50 per meal, could you continue to come to the mealsite program?

_48%_ no, I would have to stop coming to the mealsite program
_18%_ no, I would have to come less often to the mealsite program
_26%_ yes, I could continue to come as often as I do now

11. What amount would you suggest for a donation? $_____

12. Has there been a time when you stopped coming to the meal program?

_46%_ no
_52%_ yes (if yes, why?)_____

13. Have you ever used the home delivered meals program?

_74%_ no
_26%_ yes (check all that apply)
_12%_ nutrition program home delivered meals
__6%_ Meals on Wheels

Recreation/Activities

14. In the last month, have you attended any of the following? (Check all that apply)

_48%_ church service
_46%_ senior center
_18%_ club or organization meeting (what club or organizations)

_____

15. What are your favorite hobbies or interests?

sewing_26%
fishing_16%
bingo_12%
reading_10%

16. In the last month, have you had any visitors to your home?

_26%_ no
_74%_ yes (check all that apply)
_54%_ family members
_50%_ friends
__8%_ nurse/home aide
__8%_ salesman
__6%_ clergyman
__4%_ other: _____

17. In the last month have you gone to someone's home to visit them?

_30%_ no
_70%_ yes (check all that apply)
_26%_ family member in town
_14%_ family member out of town
_54%_ neighbor
_26%_ other: _____

18. Do you visit with friends and family by telephone?

_20%_ no, I don't have a phone
_10%_ no, I don't visit by telephone
_40%_ yes, I visit by phone every day
__6%_ yes, I visit by phone 3 to 6 times a week
_14%_ yes, I visit by phone 1 to 3 times a week
_10%_ yes, I visit by phone less than 4 times a month

19. Do you own a car?

_52%_ no
_48%_ yes

20. Do you drive your car?

_52%_ no
_48%_ yes

Medical Problems/Illness

21. Have you had a health check-up in the last six months?

_12%_ no
_38%_ yes, this month
_20%_ yes, last month
__6%_ yes, 2 months ago
__4%_ yes, 3 months ago
_20%_ yes, more than 3 months ago

22. Have you been ill for more than three days in the last month?

_72%_ no
_26%_ yes

if yes, how long were you ill? _____

23. Have you had a serious illness in the last 6 months?

_66%_ no, I haven't been sick
__2%_ yes, sick for 1 - 3 days
_12%_ yes, sick for 4 - 7 days
__4%_ yes, sick for 8 - 14 days
_12%_ yes, sick for 15 - 30 days
__4%_ yes, sick for more than a month

24. Were you hospitalized within the last year?

_74%_ no
_26%_ yes

25. Has a doctor told you that you have a chronic illness?

_56%_ no
_42%_ yes, I have _____

26. Do you have medical insurance?

_22%_ no
_72%_ yes (check all that apply)
_64%_ medicare
_16%_ medicare suppliment
_16%_ medicaid
_18%_ private insurance
__2%_ other_____

Nutrition

27. How many meals do you normally eat in a day?

__8%_ 1
_44%_ 2
_42%_ 3
__4%_ 4 or more

28. Has a doctor or a nurse told you in the past year that you should:

__4%_ eat more
_24%_ eat less
_24%_ take vitamins

29. Has a doctor or a nurse told you that you need a special diet?

_64%_ no
_32%_ yes (check all that apply)
_22%_ low salt
_20%_ low fat
_22%_ low sugar
__0__ low fiber
__4%_ high fiber
__0__ soft foods
__0__ other _____

30. Do you cook for yourself?

_10%_ no, spouse does the cooking
__4%_ no, eat out
_10%_ no, family, friend does the cooking
_72%_ yes

31. In addition to the meals from the nutrition program, do you have food assistance from other programs?

_24%_ no, I only use the nutrition program
_74%_ yes (check all that apply)
_18%_ foodstamps
_62%_ commodities (cheese, butter, rice, etc.)
_30%_ foodbank
__2%_ Poverello
__4%_ family, friends
__2%_ Meals on Wheels
__4%_ other:_____

32. Would you be interested in attending programs about nutrition or cooking?

_80%_ no
_14%_ yes

Background

33. How long have you lived in Missoula?

__8%_ less than 1 year
__2%_ 1 - 2 years
_86%_ 3 - 4 years
__2%_ 5 or more years

34. Are you currently married?

_10%_ no, single never married
_24%_ no, divorced
_50%_ no, widowed
_14%_ yes

35. Do you have any family members living in Missoula?

_44%_ no
_52%_ yes (check all that apply)
__8%_ spouse (husband/wife)
_10%_ sister/brother
_36%_ son/daughter
_18%_ grandchildren
_10%_ other

36. Where are you currently living?

_44%_ own my own home
_16%_ rent my home
_14%_ rent an apartment (not in senior housing)
_16%_ rent an apartment in senior housing
__4%_ live with family or friends

37. Your sex?

_38%_ male
_62%_ female

38. Your age? _____

39. Your income range is

_58%_ $ -0- - 5250
_10%_ 5251 - 6563
__4%_ 6564 - 7050
__0__ 7051 - 7875
__2%_ 7876 - 8813
__6%_ 8814 - 10575
__4%_ 10576 - or more

40. How many people are living on your income? 1 - 84%
2_-_12%_

41. What are your suggestions to improve the nutrition mealsite program?

SENIOR NUTRITION PROGRAM
SENIOR OPINION PROFILE

Please help us by answering these questions. We need to know a little bit about you and your feelings about the nutrition program so we can try to get more money for more meals for more seniors. Thank you very much.

Home delivered Meal Program

1. How long have you have you been receiving home delivered meals?

__2%_ less than one month
_24%_ 1 - 3 months
_10%_ 4 - 6 months
_12%_ 7 - 12 months
_10%_ 13 - 18 months
_12%_ 19 - 24 months
_30%_ more than two years

2. How did you find out about the nutrition program?

__0__ newspaper
_36%_ social workers/service providers
__0__ meals on wheels
_42%_ friends/family
_14%_ other:_____

3. Why do you get home delivered meals? (check all that apply)

_12%_ I save money on my food budget
__2%_ I don't have cooking facilities
_16%_ I like the food
_88%_ I am unable to cook for myself
_56%_ I am unable to shop for food

4. Do you know of someone who should be receiving meals, but aren't getting them?

_78%_ no
_22%_ yes

5. Should there be a donation made for the meal?

__6%_ no
_94%_ yes

6. Should the donation be based on the ability to pay ($.50 to $3.00 depending on income)?

_12%_ no
_88%__ yes

7. In the average month, about how much do you donate for the meals you eat?

_50%_ $ -0- - $ 5.00
_10%_ 6.00 - 10.00
_10%_ 11.00 - 15.00
__8%_ 16.00 - 20.00
__4%_ 21.00 - 25.00
__0__ 26.00 - 30.00
__0__ 31.00 - 35.00
__0__ 36.00 - 40.00
__0__ 41.00 - 45.00
__0__ 46.00 - 50.00
__0__ 51.00 - or more

8. If you were required to donate $1.50 per meal, could you continue to get home delivered meals?

_52%_ no, I would have to stop getting home delivered meals
__4%_ no, I would have to get fewer home delivered meals
_40%_ yes, I could continue to get home delivered meals as often as I do now

9. What amount would you suggest for a donation? $_____

10. Has there been a time when you stopped receiving home delivered meals?

_58%_ no
_40%_ yes (if yes, why?)

away 10%
hospital 26%

11. Have you ever come to the mealsite program?

_72%_ no
_28%_ yes

12. Have you ever used the Meals on Wheels program?

_90%_ no
_10%_ yes

Recreation/Activities

13. In the last month, have you attended any of the following? (Check all that apply)

_22%_ church service
_22%_ senior center
__6%_ club or organization meeting (what club or organizations)

14. What are your favorite hobbies or interests?

reading 12%
sewing 12%
gardening 8%
watching television 6%
collecting 6%
music 2%

15. In the last month, have you had any visitors to your home?

_10%_ no
_90%_ yes (check all that apply)
_60%_ family members
_50%_ friends
__2%_ nurse/home aide
__0__ salesman
__4%_ clergyman
__4%_ other: _____

16. In the last month have you gone to someone's home to visit them?

_36%_ no
_62%_ yes (check all that apply)
_24%_ family member in town
__2%_ family member out of town
_12%_ neighbor
__4%_ other: _____

17. Do you visit with friends and family by telephone?

__4%_ no, I don't have a phone
_12%_ no, I don't visit by telephone
_24%_ yes, I visit by phone every day
_22%_ yes, I visit by phone 3 to 6 times a week
_12%_ yes, I visit by phone 1 to 3 times a week
_26%_ yes, I visit by phone less than 4 times a month

18. Do you own a car?

_56%_ no
_44%_ yes

19. Do you drive your car?

_82%_ no
_18%_ yes

Medical Problems/Illness

20. Have you had a health check-up in the last six months?

_26%_ no
_38%_ yes, this month
_14%_ yes, last month
_12%_ yes, 2 months ago
__2%_ yes, 3 months ago
__8%_ yes, more than 3 months ago

21. Have you been ill for more than three days in the last month?

_46%_ no
_52%_ yes

if yes, how long were you ill? _____

22. Have you had a serious illness in the last 6 months?

_44%_ no, I haven't been sick
_10%_ yes, sick for 1 - 3 days
__2%_ yes, sick for 4 - 7 days
__6%_ yes, sick for 8 - 14 days
__8%_ yes, sick for 15 - 30 days
_30%_ yes, sick for more than a month

23. Were you hospitalized within the last year?

_48%_ no
_52%_ yes

24. Has a doctor told you that you have a chronic illness?

_40%_ no
_58%__ yes, I have_____

25. Do you have medical insurance?

_18%_ no
_82%_ yes (check all that apply)
_72%_ medicare
__0__ medicare suppliment
_10%_ medicaid
_22%_ private insurance
__6%_ other_____

Nutrition

26. How many meals do you normally eat in a day?

_10%_ 1
_32%_ 2
_56%_ 3
__0__ 4 or more

27. Has a doctor or a nurse told you in the past year that you should:

_10%_ eat more
_10%_ eat less
_30%_ take vitamins

28. Has a doctor or a nurse told you that you need a special diet?

_50%_ no
_48%_ yes (check all that apply)
_32%_ low salt
_12%_ low fat
_10%_ low sugar
__2%_ low fiber
__8%_ high fiber
__2%_ soft foods
__6%_ other _____

29. In addition to the meals from the nutrition program, do you have food assistance from other programs?

_66%_ no, I only use the nutrition program
_32%_ yes (check all that apply)
__6%_ foodstamps
_24%_ commodities (cheese, butter, rice, etc.)
__2%_ foodbank
__0__ Poverello
__8%_ family, friends
__0__ Meals on Wheels
__2%_ other:_____

30. Do you cook for yourself?

_18%_ no, spouse does the cooking
_16%_ no, only eat home delivered meals
__8%_ no, family, friend does the cooking
_56%_ yes

31. Would you be interested in attending programs about nutrition or cooking?

_84%_ no
_14%_ yes

Background

32. How long have you lived in Missoula?

__0__ less than 1 year
__4%_ 1 - 2 years
_10%_ 3 - 4 years
_86%_ 5 or more years

33. Are you currently married?

_12%_ no, single never married
_12%_ no, divorced
_50%_ no, widowed
_24%_ yes

34. Do you have any family members living in Missoula?

_26%_ no
_70%_ yes (check all that apply)
_20%_ spouse (husband/wife)
_10%_ sister/brother
_46%_ son/daughter
_10%_ grandchildren
_12%_ other

35. Where are you currently living?

_66%_ own my own home
_12%_ rent my home
_12%_ rent an apartment (not in senior housing)
__6%_ rent an apartment in senior housing
__4%_ live with family or friends

36. Your sex?

_32%_ male
_64%_ female

37. Your age? _____

38. Your income range is

_52%_ $ -0- - 5250
__8%_ 5251 - 6563
__0__ 6564 - 7050
__0__ 7051 - 7875
_10%_ 7876 - 8813
__4%_ 8814 - 10575
_12%_ 10576 - or more

39. How many people are living on your income? _____

40. What are your suggestions to improve the nutrition mealsite program?

# APPENDIX B

## MEALSITE SURVEY FORMS

Missoula Area Agency on Aging

## SURVEY OF MEAL SITE PARTICIPANTS

LOCATION: _____ DATE: _____

THE TASTE AND TEXTURE OF MY MEAL IS USUALLY:

_____ EXCELLENT _____ FAIR

_____ GOOD _____ POOR

THE AMOUNT OF FOOD IS USUALLY:

_____ TOO MUCH _____ TOO SKIMPY

_____ ABOUT RIGHT

THE FOOD IS USUALLY SERVED:

_____ HOT _____ COLD

_____ WARM

THE SITE MANAGER IS USUALLY:

_____ PLEASANT _____ INDIFFERENT

_____ HELPFUL _____ CRANKY

THE COOK IS USUALLY:

_____ PLEASANT _____ INDIFFERENT

_____ HELPFUL _____ CRANKY

CHECK THE STATEMENT YOU BELIEVE TO BE TRUE:

_____ MEALS COST $2.50

_____ MEALS ARE FREE

_____ I CAN DONATE TOWARDS THE COST OF THE MEAL.

A CONTRIBUTION OF $1.50 IS:

_____ TOO LOW _____ TOO HIGH

_____ ABOUT RIGHT

EATING AT THE MEAL SITE REGULARLY:

_____ SAVES ME MONEY ON MY FOOD BILL

_____ COSTS ME MONEY ON MY FOOD BILL

_____ HAS NO EFFECT ON MY FOOD BILL

_____ I DON'T KNOW

MEALS ARE IMPORTANT TO ME BECAUSE:

_____ THEY HELP ME EAT PROPERLY

_____ IT'S CONVENIENT

_____ I ENJOY EATING WITH OTHERS

_____ THEY HELP ME REMAIN INDEPENDENT

_____ THEY ARE NOT IMPORTANT TO ME.

I EAT AT THE SITE:

_____ REGULARLY(4 OR MORE TIMES A WEEK)

_____ OFTEN (2-3 TIMES PER WEEK)

_____ OCCASIONALLY (3-4 TIMES A MONTH)

_____ SELDOM (2 OR LESS TIMES A MONTH)

MY INCOME IS:

_____ BELOW $3,000

_____ BETWEEN $3,601 TO $7,000

_____ BETWEEN $7,001 TO $10,000

_____ BETWEEN $10,001 TO $15,000

_____ OVER $15,0000

HOW MANY TIMES DURING THE PAST MONTH DID YOU SPEND TIME WITH FAMILY, FRIENDS, OR NEIGHBORS (NOT COUNTING YOUR VISITS TO THE MEAL SITE)?

_____ ALMOST EVERY DAY

_____ A FEW TIMES A WEEK

_____ ONCE A WEEK

_____ SEVERAL TIMES A MONTH

_____ ONCE THIS MONTH

_____ NOT AT ALL

IN GENERAL MY HEALTH IS:

_____ GOOD _____ POOR

_____ FAIR

FOR CONFIDENTIALITY
DO NOT SIGN

PLEASE FOLD!!

DESCRIBE WHAT IS DONE WITH LEFTOVERS AT YOUR SITE: _____

SUGGESTIONS FOR IMPROVING THE MEAL PROGRAM ARE: _____

FOR CONFIDENTIALITY - DO NOT SIGN - PLEASE FOLD

# DISTRICT XI HUMAN RESOURCES COUNCIL
# REPORT ON LOW-INCOME NEEDS

1. WE WOULD LIKE TO KNOW YOUR AGE:

- ☐ less than **22**
- ☐ **23 - 29**
- ☐ **30 - 49**
- ☐ **50 - 59**
- ☐ **60 - 69**
- ☐ **70 - 79**
- ☐ **80** & Older

2. IF YOU ARE ☐ **MALE** or ☐ **FEMALE?**

3. ARE YOU A WOMAN WHO IS THE HEAD OF HOUSEHOLD? ☐ **YES** ☐ **NO**

4. HOW MANY PERSONS ARE THERE USUALLY IN YOUR HOUSEHOLD? _____

5. WE WOULD LIKE YOU TO CHECK UP TO **4 PROBLEM** or **NEED** AREAS THAT ARE MOST IMPORTANT OR OF GREATEST CONCERN TO YOU.....

- ☐ FOOD
- ☐ CLOTHING
- ☐ FAMILY PROBLEMS
- ☐ CHILD CARE
- ☐ TRANSPORTATION
- ☐ NEED A JOB
- ☐ HIGH MEDICAL COSTS OR LACK OF MEDICAL SERVICES
- ☐ HANDICAP OR HEALTH PROBLEMS
- ☐ CRIME OR FEAR FOR SAFETY
- ☐ LONELINESS OR LACK OF FRIENDS
- ☐ EDUCATION AND TRAINING
- ☐ HAVE A JOB BUT WAGES ARE TOO LOW
- ☐ HIGH RENT, LACK OF AFFORDABLE HOUSING OR CROWDED HOUSING
- ☐ HELP WITH HOME REPAIR OR INSULATION
- ☐ HIGH ENERGY BILLS
- ☐ NEED BETTER V.A., SOCIAL SECURITY OR S.S.I. BENEFITS
- ☐ NEED BETTER WELFARE BENEFITS
- ☐ NEED HELP TO MOVE OUT OF THE AREA

Write in any of your concerns that we have left out and any ideas that you have for District XI Human Resource's programs:

**THANK YOU!**

# APPENDIX C

## SERVICE PROVIDER INTAKE FORM

Missoula Area Agency on Aging — Service Provider Intake Form

CRITERIA AND TARGETING MEASURES

Provider Agency: _____ Intake by: _____ Date _____

Client (First name only): _____ Date of Birth _____

City or Town _____ Urban ( ) Rural ( )

**********

MOBILITY (outside of the home/within the community).

Mobility is limited as a result of
( ) confinement to a wheelchair
( ) use of crutches, walker, cane, braces
( ) visual impairment
( ) requires companion's assistance
( ) other (describe) _____
Limitation is ( ) Temporary ( ) Permanent ( ) Seasonal

Current access to transportation
( ) own and drive a vehicle
( ) relative or friend will transport
( ) public transportation (live on route)
( ) specialized transportation

Describe difficulties accessing these modes of transportation _____

**********

SUPPORT FROM RELATIVES AND FRIENDS

( ) lives with compatible and helpful spouse or relative
( ) lives with incompatible spouse or relative
( ) lives alone but can get help from a relative, friend, neighbor or other
( ) neighbors and friends visit - How often? _____

Names of family members in local area:

_____ Phone _____ Working ( ) Yes ( ) No

_____ Phone _____ Working ( ) Yes ( ) No

_____ Phone _____ Working ( ) Yes ( ) No

Whom do you contact in case of emergency?

_____ Phone _____

_____ Phone _____

_____ Phone _____

Participates in supportive and recreational facilities; which ones? How often participating?

( ) member of a club or organization _____ _____
( ) member of a church or synagogue _____ _____
( ) visits library _____ _____
( ) visits park, movies, etc. _____ _____
( ) other _____ _____

**********

ECONOMIC

Are you eligible for or using

( ) Medicare
( ) Medicaid
( ) Health Insurance
( ) Family financial support

1/85 MAAA

How many people are living on your income?

( ) 1 Your income range is
( )$ -0- - $4,310 (100)
( ) 4,310 - 5,387 (125)
( ) 5,387 - 6,465 (150)
( ) 6,465 - over

( ) 2 Your income range is
( )$ -0- - $5,690 (100)
( ) 5,690 - 7,112 (125)
( ) 7,112 - 8,535 (150)
( ) 8,535 - over

**********

FUNCTIONAL

| Physical | Needs Indep | Assist | Depen. | Activities of Daily Living | Needs Indep | Assist | Depen. |
|---|---|---|---|---|---|---|---|
| Dressing | | | | Reads & writes letters | | | |
| Toileting | | | | Uses phone | | | |
| Restricted diet | | | | Banking & shopping | | | |
| Personal hygiene | | | | Prepares meals | | | |
| Hearing | | | | Uses public transport. | | | |
| Vision | | | | Housework | | | |
| Mobility about house | | | | Medications | | | |

( ) Hospital admission within past six months. _____ Date last visit to M.D.

Mental

| | | | |
|---|---|---|---|
| Shows common sense in making judgments | ( ) Yes | ( ) No | ( ) Unknown |
| Able to handle major problems in life | ( ) Yes | ( ) No | ( ) Unknown |
| Finds life exciting and enjoyable | ( ) Yes | ( ) No | ( ) Unknown |
| Widowed within past six months | ( ) Yes | ( ) No | |
| Living alone within past six months | ( ) Yes | ( ) No | |

**********

COMMUNITY SUPPORT

| Services Available | Rec'd 6 Mo. | Still Rec'd | Needs Refrl | Comments |
|---|---|---|---|---|
| Transportation | | | | |
| Shopping | | | | |
| Living Quarters (Housing) | | | | |
| Personal Care | | | | |
| Visitation or Respite | | | | |
| Meal Preparation, Delivery or Group Site | | | | |
| Home Chore or Homemaker | | | | |
| Protective Services | | | | |
| Social/Recreational | | | | |
| Mental Health | | | | |
| Nursing Care or Therapies | | | | |
| Medical Services | | | | |
| Supportive Devices and Protheses | | | | |
| Relocation and Placement | | | | |
| Case Management or Coordination | | | | |
| Financial Assistance | | | | |

**********

COMMENTS _____

_____

_____

# APPENDIX D

## MONTHLY PROGRAM REPORT FORM

ew 10/82)

STATE OF MONTANA
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
MONTHLY PROGRAM REPORT

For _____
(Contract Number)

rvice Delivery for the Month of March 1985

Number of clients served this month by service(s):

| SERVICE | NUMBER OF NEW CLIENTS SERVED THIS MONTH | TOTAL NUMBER OF CLIENTS SERVED TO DATE |
|---|---|---|
| $C_1$ Congregate | 3 | 106 |
| $C_2$ Home Delivery | 9 | 107 |
| | | |
| | | |
| Total | 12 | 213 |

Number of units of service provided to all clients for each service during this month:

| SERVICE | NUMBER OF UNITS OF SERVICE PROVIDED THIS MONTH | TOTAL NUMBER OF UNITS OF SERVICES PROVIDED TO DATE |
|---|---|---|
| $C_1$ Congregate | 1,046 | 6,398 |
| $C_2$ Home Delivery | 2,136 | 12,268 |
| | | |
| | | |
| Total | 3,182 | 18,666 |

March Contributions:

| | |
|---|---|
| $C_1$ | $.57/meal |
| $C_2$ | $.61/meal |
| Total | $.60/meal |

# APPENDIX E

## CONSUMER EVALUATION FORM

Missoula Area Agency on Aging Program _____

Consumer Evaluation

Interviewer: _____ Date of Visit: _____

Name of Client: _____ Phone: _____

Address: _____
Street or Box Number City State Zip

Marital Status: _____ Age: _____ Sex: _____ Census Tract: _____

A. Quality of Service

1. How do you feel about receiving this service?

2. Why do you use this service?

3. Does this service meet your needs?

4. If not, what more is needed?

5. How could this service be improved?

6. How do you feel toward the people who provide this service?

7. What would you do if this service was not available?

8. Do you receive any other services available to senior citizens?

9. Other comments?