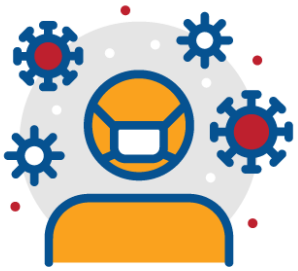
Nutrition and Aging Resource Center

Innovations and Lessons Learned from COVID-19:



A Tip Sheet for the Aging Nutrition Network

Background

Beginning the spring of 2020, older adults were vulnerable to the COVID-19 virus and social distancing forced congregate meal sites to close across the country. At the same time, demand for Older Americans Act meals increased. In 2021, the Administration for Community Living commissioned an exploratory study that used interviews with staff from State Units on Aging (SUAs), Area Agencies on Aging (AAAs), and local service providers (LSPs) from nine states to learn about their experiences providing services during the pandemic. This also included experiences in collecting and reporting data, changes in financial conditions, and staffing challenges. The goal was to gain a better understanding of the impact of the COVID-19 pandemic on aging nutrition programs and identify what programming practices are likely to continue into the future.

Innovations

Aging Nutrition Programs in both urban and rural communities quickly adapted to meet the increased demand for services. Rural programs tended to need a little more time to scale up innovations, but they also updated their services. Three themes occurred among these innovations:

- increased flexibility for participants
- changing service delivery methods due to staff, volunteer, and supply chain shortages
- rethinking emergency planning

The following innovations appeared to be successful and are likely to continue:

Grab-and-Go, Carry-Out, and Drive-Through Meals

Congregate nutrition sites closed and reopened in response to local COVID-19 transmission rates. In some cases, sites closed and opened repeatedly or never reopened. Providers offered participants the option to pick up multiple meals at a time or pick up meals daily from a congregate meal site to eat at home. See Title III C1 and C2 Service Delivery Decision Tree.

More Meal Choices

The use of frozen and shelf-stable meals increased, and providers used funds to offer more culturally-specific meals. This provided greater flexibility and choice for participants and better access to services.

Reduced Frequency of Meals

Reducing the frequency of meal pickup and delivery helped providers with staffing and volunteer challenges. Some providers were able to offer volunteers more flexible schedules to better manage workforce shortages. Many then conducted more safety and wellness checks by phone. Home delivered nutrition programs delivered more meals at one time using less frequent delivery schedules (often once or twice weekly).

Senior Centers without Walls

Many AAAs planned to transition to "Senior Center Without Walls" models. This included either grab-and-go meals with virtual congregating options or partnerships with restaurants. "Senior Centers without Walls" provide more virtual health, wellness, and educational programming. It was found that younger older adults age 60-69 are less interested in congregate nutrition services offered at senior centers and other "typical" locations. This new group of participants want more community-inclusive environments (i.e., restaurants), more meal options and activities reflective of better health. The state of Georgia provides examples of this work.

Restaurant Voucher Models

Restaurant partnerships also offer program benefits: they help diversify the food source supply chain, offer meals in less stigmatizing settings, are more resilient than traditional congregate settings because participants have other options if a site has to close, and support local economies. Review Guide to Working with Restaurants and Grocery Stores for Meals for more information about partnering with foodservice establishments.

Virtual Programming

Social distancing led the Aging Nutrition network to innovate delivery of programming that would have normally been offered in-person at congregate nutrition sites. Virtual programming helped provide opportunities for socialization, nutrition education and evidence-based programming. Expanded virtual programming in the Aging Nutrition network provides increased flexibility for participants and increased opportunity to mitigate workforce and volunteer shortages. The network also identified the need to increase technology literacy offerings to improve participants' access and to support participants in taking full advantage of virtual programming. Review Tele or Virtual Nutrition Education for Older Adults for more information. Review this Title III C1 and C2 Service Delivery Decision Tree to learn more about how virtual programming and other innovative service delivery models fit into congregate nutrition service delivery and funding.

New Partnerships

Study participants reported increasing food insecurity and socialization needs nationally. In response, the Aging Nutrition network developed or expanded partnerships with other food insecurity stakeholders, such as food banks, food pantries and other state and community agencies. Review Partnerships with Food Banks and Other USDA Programs for more information.

Lessons Learned

How to manage increased cost and supply chain challenges

The aging nutrition network reported a dramatic increase in the cost of and reduced access to food and supplies due to supply chain shortages and shipping delays. There were major challenges in sourcing proteins, prepared and frozen meals, and packaging and distribution supplies. Providers reported costs that exceeded negotiated reimbursement rates and cited long lag times (often two years) between agreement and reimbursement.

It appeared that larger organizations and groups who negotiated with vendors collectively were more successful in leveraging their purchasing power to reduce cost and availability pressures. States, AAAs and LSPs may find that collective negotiation (e.g., contracting, joining group purchasing organizations) is a mutually beneficial approach to help manage costs and source necessary products. Review Contracting Tips for Purchasing Meals for more information.

How to rethink emergency plans for a long-term crisis

The pandemic led the aging nutrition network to rethink emergency planning for longer service disruptions and ongoing supply chain disruptions. Existing emergency plans at the beginning of the pandemic were found to be primarily designed for short-term or isolated disruptions and were expanded or adjusted to manage a longer crisis. Many participants were used to more socialization prior to the pandemic compared to older adults who were homebound. This increase in isolation caused an increase in support needs for participants and more complex cases. Lessons learned included:

1. Acquire and reserve meals for distribution during a crisis (often frozen or shelf-stable food);
2. Plan for additional storage and distribution supplies (to-go boxes, cutlery, equipment and packaging to maintain holding temperatures) to adapt to changing delivery systems and manage longer emergencies;
3. Develop lists of "high risk" participants who may need additional support; and
4. Add emergency planning requirements to LSP requests for proposals (RFP).

Review FAQ Managing Senior Nutrition Programs During Emergencies for more information.

How to gather data in an emergency

AAAs and LSPs shifted to gathering data questions by phone. This shift is likely to continue past the pandemic. Well-checks were conducted over the phone to accommodate social distancing and increase safety for participants, staff, and volunteers. Some SUAs provided more assistance to their AAAs and LSPs by developing data collection guidance, adjusting the frequency of programmatic monitoring, and increasing the frequency of data collection monitoring. SUAs that were able to take a flexible approach and maintain alignment with ACL guidance may have been able to better support services changing at the local level. Review Funding Flexibilities for Senior Nutrition Programs for more information.

Some providers expressed concern about potential dissatisfaction among participants when prioritization becomes necessary. Several SUAs reported that they anticipated finding missing Activities of Daily Living and instrumental Activities of Daily Living (ADL/iADL) data as older adults who would typically participate in congregate nutrition services utilized more grab-and-go and home delivered nutrition services. See ACL OAA Performance System (OAAPS) Title III State Performance Report Technical Resources for more information related to collecting and reporting data.

In planning for future emergencies, it may be helpful for the network to consider gathering more ADL/iADL data at intake and update points. Depending on state, AAA and LSP policies, this approach may help providers leverage virtual programming and other innovative service delivery models into congregate nutrition services delivery as shown in this Title III C1 and C2 Service Delivery Decision Tree. Investing in gathering data upfront may also create more flexibility to assign different service delivery methods depending on a participant's immediate needs (e.g., congregate or grab-and-go). Gathering additional data may support improved targeting of services to evaluate how effective services are reaching those in greatest need. This approach is similar to the suggestion of implementing prioritization systems to meet the needs of participants at highest risk first. While the administrative burden may be higher upfront, it may save administrative time during future emergencies. Review SNP Guide to Prioritizing Clients for more information.

Disclaimer. During an emergency, senior nutrition programs will need to adapt their services, activities, and events to continue safely supporting their communities. This tip sheet provides information to help programs plan for, and adapt to, some of the most common emergencies that they may face. The strategies and suggestions in this guide are not exhaustive and should be adapted and modified to meet your situation. In addition, a prudent program administrator will develop emergency plans, policies, and procedures well in advance and review the plans annually. Review FAQ Managing SNPs During Emergencies for more information.

This project was supported in part by grant number 90PPNU0002 from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official ACL policy.