Pilot Evaluation of the Home Delivered Meals Program in Improving the Quality of Life Among Homebound Seniors

A graduate project submitted in partial fulfillment of the requirements
For the degree of Master of Social Work

By
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in collaboration with
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May 2016
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Dedication

The researchers dedicate this graduate project to the Santa Clarita Valley Senior Center.
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Abstract

Pilot Evaluation of the Home Delivered Meals Program in Improving the Quality of Life Among Homebound Seniors

By

Kira Reed

Master of Social Work

A pilot evaluation of The Santa Clarita Valley Senior Center’s Home Delivered Meals Program attempted to test the quality of life among homebound seniors before and after implementing the program. The study used secondary data consisting of male and female seniors, sixty years of age and older, deemed medically homebound, and new to the program. Clients were invited to participate in an in-person pre-assessment and telephone post-assessment, which assessed for depressive symptoms and quality of life. After a three-month period of participation, researchers found statistical significance for PHQ9 scores and self reported quality of life ratings. These findings suggest a correlation between the quality of life of homebound seniors and The Home Delivered Meals Program. Future research focusing on larger sample sizes and a more comprehensive assessment tool may provide policy makers and funders with evidence to support further development and creation of programs.
Introduction

The goal of the Home Delivered Meals Program is to address food insecurity, encourage socialization, and promote the health and well-being of elderly individuals through nutrition and nutrition-related services. By focusing on addressing these three goals with homebound seniors, there is an increase in the number of elderly individuals living independently at home, which provides seniors with dignity, and independence that improve their quality of life. (Thomas & Mor, 2013). The study is a pilot evaluation of The Santa Clarita Valley’s Home Delivered Meals Program aimed at improving the quality of life among homebound seniors in the community. This study attempts to test the quality of life and depressive symptoms among homebound seniors before and after implementation of the Home Delivered Meals Program. The study assessed for a correlation between the quality of life among homebound seniors and the Home Delivered Meals Program. Quantitative data was collected in order to answer the following question: Does participation in the Home Delivered Meals Program increase the quality of life among homebound seniors? The researchers hypothesized that the Home Delivered Meals Program would improve the quality of life among homebound seniors. The researchers’ prediction was that they would find a positive correlation between the quality of life among homebound seniors and the Home Delivered Meals Program. In studying the efficacy of the Home Delivered Meals Program, The Santa Clarita Valley Senior Center will have evidence that they are achieving the part of their mission statement regarding the improvement of the quality of life of seniors in the community. The information provided can help to improve and further develop the existing program. The findings of the program evaluation can be used in highlighting the
importance of Home Delivered Meals Programs to improve the quality of life among homebound seniors. The findings can be used in support of funding future home delivered meals programs.
Literature Review & Conceptual Framework

Literature has shown that seniors living alone face economic challenges and tend to be underfed and undernourished as a result of depression and a sense of isolation. Attention is needed to improve the quality of life of low-income homebound seniors in order for them to live a healthy life without ailments and disabilities due to their limited mobility and lack of access to feeding facilities (Lee & Joo, 2012). Lee and Joo (2012) found that seniors living alone are economically disadvantaged, frequently underfed, and easily exposed to undernourishment, due to a sense of isolation and depression. Nutrition is a critical element in the quality of life among seniors and seniors do not want to lengthen their life expectancy without improving their quality of life (Lee & Joo, 2012). Edfors and Westergren (2012) found that according to the Mini Nutritional Assessment (MNA), under-nutrition among home-living seniors was found to be 14.5%. A qualitative content analysis was conducted and found that the following consequences are due to under-nutrition, functional decline or frailty, decreased quality of life, increased health care utilization and costs, higher rates of adverse complications from other health conditions, and increased mortality (Edfors & Westergren, 2012). This is where food delivery services can provide support at the societal level in order for homebound seniors to lead a healthy, independent life (Lee & Joo, 2012). Previous research has found that receiving meals from a formal agency can improve food intake, decrease the risk for under-nutrition, and provides further assistance for those in their own homes who would otherwise not be able to obtain or prepare food (Edfors & Westergren, 2012).

A previous study showed that it was difficult for seniors to accept becoming dependent on others, however dependence on meals from a food distributor could
increase their quality of life (Edfors & Westergren, 2012). Limited or uncertain access to enough food to sustain a healthy lifestyle affects nearly one in twelve seniors living in the United States. Meals on Wheels and other home-delivered meal programs provide a cost-effective method of improving nutritional health and social well-being, therefore, studying the overall efficacy and assessing the nutritional and mental health impact are important to demonstrate the value of these services (Sudduth, Epps, Wright & Vance, 2015). Thomas and Mor (2013) state that the overall goals of food delivery programs are to address food insecurity, which is the difficulty in obtaining nutritionally adequate meals due to a lack of resources, provide socialization, and promote the health and well-being of seniors through nutrition and nutrition-related services. Sahyoun and Vaudin (2014) report that by decreasing seniors’ need to shop and cook by providing a consistent source of affordable, quality food could improve their food security and contribute to their ability to maintain their independence.

Food insecurity in seniors is associated with many unfavorable health outcomes, such as low nutrient intakes, unhealthy body weight and size, poor self-reported health status, anemia, multi-morbidity and disability, lower cognitive function, anxiety and depression, and decreased quality of life (Sahyoun & Vaudin, 2014). This research follows other reports of participants in home-delivered meals programs where more than 92% say the meals enabled them to continue living in their own homes (Thomas & Mor, 2013). Furthermore, Thomas and Mor (2013) reported that home-delivered meals may provide more than just a nutritious meal, they provide dignity and independence which improve the quality of life for many homebound seniors, with recipients reporting that the meals are essential to their independence. In addition, many homebound seniors live in
isolation and the delivery drivers (both paid staff and volunteers) are often the only people seniors see or interact with on a regular basis (Thomas & Mor, 2013).

A descriptive study of a Meal on Wheels program was conducted in Central Florida. The study measured nutritional status, dietary intake, food security, and emotional wellbeing, feelings of loneliness and isolation, and demographic information. The study found that homebound seniors have a high prevalence of malnutrition and nutrition risk and after only two months on the meal program participants’ nutritional status, quality of emotional functioning, and food security level improved (Sudduth, Epps, Wright & Vance, 2015). This study supports the hypothesis that home delivered meals programs improve the quality of life among homebound seniors. The home-delivered meals programs are required to offer at least one meal per day, five or more days per week, with each meal providing a minimum of one-third of the daily Recommended Dietary Allowances (RDAs) (Sahyoun & Vaudin, 2014). Overall, large portions of the seniors surveyed believe that home-delivered meals programs contribute to their independence and remaining in their own homes.

As with all research, limitations exist. A limitation that is presented in the research is the limited number of studies that have been conducted on this topic. Another limitation with the current research is the lack of rigorous study designs and small sample sizes in the current research (Edfors & Westergren, 2012). It has also been found that evaluations of home delivered meals programs are difficult to conduct due to many variables, such as age and complex health status of participants, being compared and considered (Sahyoun & Vaudin, 2014). Future research is needed to help quantify the
improvement in the participants’ quality of life that is a result from receiving home-delivered meals (Thomas & Mor, 2013).

Our hypothesis is congruent with the research findings in the literature; we hypothesize that homebound senior’s quality of life will improve after participating in the Home Delivered Meals Program for a minimum of three months, showing a positive correlation between the quality of life among homebound seniors and the Home Delivered Meals Program. The food security which comes with seniors receiving a home-delivered meal also includes consistent, affordable, quality food, contributing to their ability to live independently in their own homes, an increase in individual’s independence, encouragement of autonomy, which all lead to an individuals’ improved quality of life.

The theory of health empowerment is influenced by the principle of integrality perspective of individuals being integral with their environment in which they live and their health experience. The individual becomes an active participant of their health and health care decisions. (Crawford Shearer, 2009). Health empowerment is a relational process that emerges from the recognition, building, and utilization of personal resources (self-capacity) and social-contextual resources (support from social networks and social services), which leads to purposeful participation in goal attainment, thereby promoting the wellbeing of homebound older adults. (Crawford Shearer, 2009). Home delivered meals programs serve as a social-contextual resource that homebound seniors utilize which promotes their wellbeing. Using the health empowerment theory helps to conceptualize the importance of homebound seniors’ utilization and recognition of their personal and social contextual resource to improve their wellbeing. Health Empowerment
Theory can be used to examine the quality of life among homebound seniors by understanding the impact of home delivered meals programs on their sense of well-being.
Methods

Participants

This study used secondary data in evaluating the Santa Clarita Valley Senior Center’s Home Delivered Meals Program. The evaluation assessed the program’s efficacy in achieving part of the agency’s mission statement regarding the quality of life of seniors in the community. The study population consisted of male and female seniors sixty years of age and older, whom the agency deemed medically homebound, and are new to the program. Care managers from the Supportive Services department conducted initial screenings to identify recipients who meet the program’s eligibility criteria. The care manager described the study and invited clients to participate in an in-person pre-assessment, and a telephone post-assessment. Initially, a total of thirty-seven pre-assessments were collected. However, due to program cancellations and participant deaths only twenty-eight pre-and post-assessments were collected. Secondary data has been used so no recruitment was necessary. There was no deception involved and no consent needed. Both researchers had previously signed confidentiality agreements and had background checks on file with the agency.

Procedure

The Santa Clarita Valley Senior Center welcomed this study and gave permission for the researchers to use their agency data. Secondary data collected by the agency was used and no identifiable information was collected. Agency employees protected subject’s confidentiality by replacing subject’s name with a number based on their acceptance into the Home Delivered Meals Program. The researchers did not have access to any identifiable information and only had access to each subject’s given number.
Agency employees matched the pre- and post-assessments with the subject’s given number. The researchers did not have access to the names and corresponding numbers given to each subject. Researchers only had access to the subject’s pre- and post-assessments, which were stored in a locked filing cabinet with only researchers’ access to by key. Electronic data was stored in a password-protected computer and destroyed upon completion of the study in May 2016. Researchers assessed for a positive correlation between the quality of life of homebound seniors and the Home Delivered Meals Program. The Home Delivered Meals Program has been identified as the independent variable, while the seniors’ quality of life is the dependent variable. The study variables include depressive symptoms, quality of life, and being homebound.

Measures

Depression is measured by the Patient Health Questionnaire (PHQ-9), which is widely used, easy to administer, and has been used reliably by non-psychiatric interviewers in multiple healthcare settings (Sirey, Bruce, Carpenter, Booker, Reid, et al., 2008). A modified version of The World Health Organization Quality of Life Instrument (WHOQOL-BREF) was used to measure quality of life. The WHOQOL-BREF is one of the best well-developed multidimensional instruments that has been developed for cross-cultural comparisons of quality of life (Vahedi, 2010). The WHOQOL-BREF has been widely used in multi-cultural healthcare settings due to its translation in over 40 languages and its easiness to administer (Vahedi, 2010). This instrument is a valid assessment of quality of life, as reflected by its four domains: physical, psychological, social and environment. The agency used twelve specific questions chosen from the WHOQOL-BREF to represent an overall measure of quality of life. This may affect the
reliability and validity for this assessment given that the entirety of the questionnaire was not included. Due to the agency’s preference, specific questions such as, “How much do you need any medical treatment to function in your daily life?”, “How well are you able to concentrate?” “Are you able to accept your bodily appearance?” “To what extent do you have the opportunity for leisure activities?” “How satisfied are you with your capacity to work?” “How satisfied are you with your sex life?” etc. were not included due to the sensitive topic and the population that participated in the study. The WHOQOL-BREF is an extensive measurement with questions that the agency did not find necessary to assess for when assessing the quality of life for this specific population. Work life, sex life, leisure activities, etc. were not included in the assessment due to agency discretion.

Being homebound was determined based on agency qualifications of being sixty years of age or older, frail (older individuals who is determined to be functionally impaired because they are unable to perform at least two Activities of Daily Living) and homebound by reason of illness, disability, or is otherwise isolated.

Each measurement was scored and compared on pre- and post-assessments. Combining the PHQ-9 and the modified WHOQOL-BREF provided a comprehensive assessment tool to specifically measure depressive symptoms and quality of life for this specific population.
Results

Demographic Characteristics

In the sample of 28 participants the mean ($M$) age was 80.82 with a standard deviation ($SD$) of 6.76. More than half of the participants (68%) were females, and (32%) were males. Out of the participants’ self-reported living situation, 14% reported living alone without help from others, 18% reported living with others without help, 14% reported living alone with help 4 hours per day or less, and 54% reported living with others with help. As previously stated, participants’ depressive symptoms were measured on the pre- and post-assessment using the PHQ9 assessment tool. The results show that prior to participation in the Home Delivered Meals Program 36% of participants reported experiencing no depressive symptoms, 36% reported experiencing mild depressive symptoms, 21% reported experiencing moderate depressive symptoms, 7% reported experiencing moderately severe depressive symptoms, and none of the participants experienced severe depressive symptoms. After a three-month period of receiving home delivered meals, participants’ depressive symptoms were reassessed. Scores indicated 39% of participants reported experiencing no depressive symptoms, 43% reported experiencing mild depressive symptoms, 14% reported experiencing moderate depressive symptoms, 4% reported experiencing moderately severe depressive symptoms, and none reported experiencing severe depressive symptoms.

Paired Samples t-test

A paired samples t-test was conducted to compare data scores from pre- and post-assessments of PHQ-9 scores, self reported ratings of quality of life, and the four domains of the modified WHOQOL-BREF: Physical Health, Psychological, Social Relationships,
and Environment. Researchers ran this test in order to compare data from pre- and post-assessments on a continuous dependent variable. The test showed if a correlation exists between quality of life of homebound seniors and the Home Delivered Meals Program.

Over a three month period of participation in the Home Delivered Meals Program, participants’ PHQ9 score significantly reduced from pre-assessment ($M=6.61, SD=4.83$) to post-assessment ($M=5.43, SD=4.19$) $t(28)=5.39, p<.001$. For seniors’ overall rating of quality of life, there was statistical significance between the pre-assessment ($M=3.43, SD=.69$) and post-assessment ($M=3.75, SD=.59$) $t(28)=-3.58, p=.001$, showing an increase in self-reported quality of life ratings. However, the physical health domain of quality of life did not yield any statistically significant change between pre-assessment ($M=5.57, SD=1.40$) and post-assessment ($M=5.50, SD=1.32$) with $t(28)=.81, p=.424$. The psychological domain between pre-assessment ($M=12.14, SD=2.21$) and post-assessment ($M=12.43, SD=2.12$) with $t=-2.30, p=.030$ was statistically significant, showing an increase in the psychological domain of quality of life. In regards to social relationships, no statistical significance was shown between pre-assessment ($M=7.46, SD=1.75$) and post-assessment ($M=7.50, SD=1.67$) with $t=-.57, p=.573$. When looking at the environmental domain, there was no significant difference between pre-assessment ($M=7.43, SD=1.45$) and post-assessment ($M=7.43, SD=1.43$) with $t=.00, p=1.000$. 
### Table A: Characteristics of Demographic Variables (N= 28)

<table>
<thead>
<tr>
<th>Variables</th>
<th>n</th>
<th>%</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients Age</td>
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<td>80.82</td>
<td>6.76</td>
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<tr>
<td><strong>Gender</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>67.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>9</td>
<td>32.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Living Arrangement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone without help</td>
<td>4</td>
<td>14.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With others without help</td>
<td>5</td>
<td>17.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone with help 4hr/ day or less</td>
<td>4</td>
<td>14.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lives with others with help</td>
<td>15</td>
<td>53.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pre PHQ 9 Score</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Depression</td>
<td>10</td>
<td>35.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild Depression</td>
<td>10</td>
<td>35.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Depression</td>
<td>6</td>
<td>21.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderately Severe Depression</td>
<td>2</td>
<td>7.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe Depression</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Post PHQ 9 Score</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Depression</td>
<td>11</td>
<td>39.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild Depression</td>
<td>12</td>
<td>42.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Depression</td>
<td>4</td>
<td>14.3</td>
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</tr>
<tr>
<td>Moderately Severe Depression</td>
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<tr>
<td>Severe Depression</td>
<td>0</td>
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Table B: Paired Samples T-Test (N=28)

<table>
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<tr>
<th>Variables</th>
<th>Pre (n=28)</th>
<th>Post (n=28)</th>
<th>T</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>PHQ9 Score</td>
<td>6.61</td>
<td>4.83</td>
<td>5.43</td>
<td>4.19</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>3.43</td>
<td>.69</td>
<td>3.75</td>
<td>.59</td>
</tr>
<tr>
<td>Physical Health</td>
<td>5.57</td>
<td>1.40</td>
<td>5.50</td>
<td>1.32</td>
</tr>
<tr>
<td>Psychological</td>
<td>12.14</td>
<td>2.21</td>
<td>12.43</td>
<td>2.12</td>
</tr>
<tr>
<td>Social Relationships</td>
<td>7.46</td>
<td>1.75</td>
<td>7.50</td>
<td>1.67</td>
</tr>
<tr>
<td>Environment</td>
<td>7.43</td>
<td>1.45</td>
<td>7.43</td>
<td>1.43</td>
</tr>
</tbody>
</table>
Discussion

After a three-month period of participation in the Home Delivered Meals Program, self-reported levels of depressive symptoms decreased, while self-reported quality of life scores increased. Researchers concluded that participation in food assistance programs has a positive impact on the wellbeing of homebound seniors. This finding is congruent with the findings of Kim and Frongillo (2007), which suggest that food insecurity is related to increased weight and depression in elders. Food assistance programs are able to improve, not only, physical health of homebound seniors, but also emotional and mental wellbeing. In general, participation in the Home Delivered Meals Program was positively related to an increase in the quality of life among homebound seniors. This has been consistently shown throughout previous research. Thomas and Mor (2013), concluded that food assistance programs provide more than simply a nutritious meal for homebound seniors. The ability for seniors to remain in their homes provides prolonged dignity and independence, improving their quality of life overall. In the present study, PHQ9 scores showed a significant improvement after three-months of participation in receiving one meal five times per week, implying that in a short period of time the program had a positive impact in reducing depressive symptoms. Similarly, seniors’ self-reported quality of life scores showed an increase after this period of participation. As shown in the results, participants’ scores from the modified WHOQOL-BREF were broken down into four domains. Physical Health scores decreased after the three-month period of participation. Due to seniors being sixty-five and older and their pre-existing health conditions, it was not unexpected that their physical health would have a decrease over the participation period. Results from the Psychological domain
indicated a rise in psychological wellbeing, which may have been in part due to increased nutrition and a decrease in depressive symptoms. The domain addressing Social Relationships showed a minimal increase in scores, possibly due to the daily interaction with food delivery personnel and support from the agency. Levels of interaction or support were not assessed, however researchers can deduce that by simply having a meal delivered once per day provided some significance. Scores from the Environmental domain showed no change from the start of the program to the three-month assessment. These findings suggest that meal delivery services do not have a direct affect on homebound seniors’ living situations. In answering our hypothesis, researchers found that participation in the Santa Clarita Valley Senior Center’s Home Delivered Meals Program does increase the quality of life among homebound seniors. The research data suggests a positive correlation between homebound seniors’ quality of life and participation in the Home Delivered Meals Program.
Implications

Further research is needed to assess the efficacy and satisfaction of home delivered meals programs among participants. Policymakers and funding sources may want to know more about mental health and functional abilities, secondary health conditions, such as falls or involuntary weight loss, health care utilization, and mortality (Thomas, K., 2015). This information would provide evidence to policy makers and funders of the daily problems faced by homebound seniors, and the need for further programs. In conjunction with Campbell (2015), more research is needed to gain insight into reasons for low utilization in home delivered meals programs, the need for more programs reaching a larger range of older adults, utilization of home delivered meals programs co-occurring with other supportive services, and the need for programs where resources are scarce. Furthermore, research is needed to examine the ways in which community-based services meet the needs of both older persons and their caregivers and the processes by which older persons and their caregivers obtain information and decide whether to use these types of services (Strain, 2002). The results of this study have shown a multifaceted range of benefits from receiving home delivered meals. Creation and implementation of these programs will benefit the growing aging population by possibly decreasing health care costs due to hospitalizations and entering nursing homes. Seniors that are provided with a nutritious meal along with minor socialization and safety “check-ins” five days per week by food delivery personnel are more likely to sustain their health, along with their mental and emotional well-being. The study results provide some evidence of the success of the Santa Clarita Valley Senior Center in achieving part of their mission statement and areas for further development of their program.
Limitations

The pilot study’s small sample size limits the ability to generalize the findings. A larger sample size would better assess for results that could be generalized to other home delivered meals programs. The sample size does not represent a large enough number of participants in the program and, therefore, may not be a good indicator of the program’s effectiveness. Another limitation facing the study was the use of elderly participants as a study subject. Homebound seniors’ pre-existing health conditions are a determining factor for participation in the Home Delivered Meals Program. However, this factor limits research due to seniors canceling the services due to changing health conditions, hospitalizations, living situations, increased family support/intervention, and/or deaths. The quality of life assessment tool provided a limitation in that it did not use the complete list of questions on the WHOQOL-BREF. Using only a selected number of questions affects the reliability and validity of participants’ domain scores. A more comprehensive assessment tool would better assess quality of life.
Conclusion

Researchers hypothesized that a three-month period of participation in the Santa Clarita Valley Senior Center’s Home Delivered Meals Program would show a correlation among quality of life and depressive symptoms among homebound seniors. Results indicated an overall improvement in self-reported quality of life and depressive symptoms. The limitations included a small sample size with a vulnerable population, and the use of a modified assessment tool, which affected its validity. Future research focusing on larger sample sizes and a more comprehensive assessment tool may provide policy makers and funders with evidence to support further development and creation of these programs.
References


Thomas, K., & Mor, V. (2013). The Care Span Providing More Home-Delivered meals is One Way to Keep Older Adults with Low Care Needs Out of Nursing Homes. *Health Affairs*, 32(10), 1796-1802.


Appendix A

ADDENDUM – Pilot Evaluation of the Home Delivered Meals Program in Improving the Quality of Life Among Homebound Seniors

Pilot Evaluation of the Home Delivered Meals Program in Improving the Quality of Life Among Homebound Seniors is a joint graduate project between Kira Reed and Megan Stanman. This document will explain the division of responsibilities between the two parties.

Kira Reed is responsible for all the following tasks/document sections:
- Finalized formatting and layout of the project and poster
- Researched information pertaining to SPSS data input and analysis
- Brainstormed ideas for poster presentation
- Formatted data tables based on APA guidelines

Megan Stanman is responsible for all the following tasks/document sections:
- Liaison with agency staff
- Revised project based on suggestions by Dr. Park
- Edited spelling and grammar throughout the project
- Formatted reference page based on APA guidelines

Both parties shared responsibilities for the following tasks/document sections:
- Communication and follow up with Dr. Park
- Sourced articles for literature review
- Reviewed, analyzed, entered data into SPSS
- Developed all sections of research project

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Student ID ___________________________ Student ID ___________________________

Dr. Hyun-Sun Park, Committee Chair ___________________________ Date __________
Dr. Amy Levin, Graduate Coordinator ___________________________ Date __________

Dr. Jodi Brown, Committee Member ___________________________ Date __________
Dr. Amy Levin, Department Chair ___________________________ Date __________

Dr. Amy Levin, Committee Member ___________________________ Date __________