A PILOT STUDY: AN ASSESSMENT OF THE MOBILE MEALS PROGRAM AND ITS EFFECT ON THE PERCEIVED WELL-BEING OF THE ELDERLY

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CHAPTER I

INTRODUCTION AND STATEMENT OF THE PROBLEM

Introduction

As publicized by the American Association for Retired Persons in 1990, thirteen percent (32.8 million) of the U.S. population was 65 or older, and it has been estimated that by the year 2030, persons in this age category will constitute approximately seventy million (21.1 percent) people (Bagby, Nagy, Jessee, & Beall, 1998).

The increased visibility of hunger and malnutrition pose significant health problems for this explosive population, and are related to morbidity, mortality, and quality of life. Poor nutrition among older adults may be related to illness, functional decline, cognitive impairment, mental illness, and medication usage (Rosenberg, 1994; Silver, 1990). Beyond these, though there are many factors associated with poor nutrition and hunger that are cultural, social, and psychological in nature. The nutritional health of community-dwelling older adults, especially those that are homebound, is of particular concern in our contemporary American society to both researchers and policy makers.

The Nutrition Program for the Elderly, initially established and funded through the Older Americans Act in 1972, was this nation's response to both the nutritional and social needs of this diverse elderly population. The goal of the program during the first year, as stated by the Administration on Aging *GUIDE to Effective Project Operations*, was to "provide 250,000 older Americans, particularly those with low incomes, with daily low-cost, nutritionally sound and satisfying meals served in strategically located group settings where participants could also obtain rehabilitative and social

services."(Administration on Aging, 1973). While home-delivered meals and supportive services could be delivered from such congregate settings, these were not encouraged in the early years and in some cases home-delivered meals were limited to no more than ten percent of the total meals served. According to the above cited Administration on Aging *GUIDE*, "besides promoting better health among the older segment of the population through improved nutrition, such a program is aimed at reducing the isolation of old age, offering older Americans the opportunity to live their remaining years in dignity". (Administration on Aging, 1973).

Within the last decade, a number of significant changes have served to shape the nutrition program of today, both the congregate and home-delivered nutrition services. As the average age of the population of the United States has increased, so too has the average age of congregate meal participants, from seventy-three to seventy-six years of age (Kirshner, 1983; Ponza, Ohls, & Posner, 1995).

Participation levels in the programs have also changed over the last thirteen years. While the overall combined congregate and home-delivered meal number has remained relatively constant, down six percent over a ten year period according to the Administration on Aging, the participation levels by program are much different. In the last year period from 1985 to 1994, congregate meals served went from 149.9 million to 126.7 million meals, a 15.5 percent decrease. Home-delivered meals served went from 75.5 million meals served in 1985 to 113.1 million meals served in 1994, a 49.8 percent increase (O'Shaughnessy, 1990; AoA, 1995).

The Nutrition Program for the Elderly today, while remaining the primary community based nutrition service providing congregate and home-delivered meals for

the elderly, is different from the one with its ancestral beginnings in the early seventies. It is more mature, a part of a larger community of services and no longer a protected "stand alone" program. The program today has mandated services. Separate line item funding for congregate and home-delivered meals is proposed for elimination, giving way to the single funding category of Nutrition Services. The program now must compete with all other community-based services for limited Older Americans Act as well as other funds (Moyer & Balsam, 1996).

Purpose of the Study

The purpose of this research is to gain further insight in the Stillwater Mobile Meals program and its effect on the perceived well-being of its participants. For the population of the frail elderly adults, the main nutrition service available is the meals-on-wheels program. Most studies that have examined the effectiveness of the meals-on-wheels program have noted that the program helped (1) improve the dietary status of elderly client, and that (2) the person delivering the meal provided the homebound person with an important social contact and sense of reassurance (Roe, 1990).

Objectives of the Study

The objectives of this study were to:

(1) Identify to how often the Mobile Meals program had been used by its Stillwater elderly recipients through daily observations and the use of personal interview questions. A pertinent question relative this objective was, "How long have you been a Mobile Meals client?" Also, focus was placed on any other programs offered by the Mobile Meal program.

(2) Examine what effect the Stillwater Mobile Meals program had on the psychological and physical well-being of its clients by using an adapted version of Recker and Wong's Perceived Well-Being scale.

(3) Examine any cultural or social behaviors exhibited by the Mobile Meals clients during meal time by observing their eating habits, the setting in which the meals were eaten, and recording their personal testimonies relative to the act of eating and the Mobile Meals program.

Significance of the Study

Increasingly, the focus of agendas for long-term care initiatives is to enhance the quality of life of older adults living within the community, especially the maintenance of functional independence. Such efforts are often implicitly and explicitly intended to avoid or postpone costly institutionalization (either hospitalization or nursing home placement). The provision of food services, specifically home-delivered meals to older homebound adults living in the community, is one means to this end. Home-delivered meal services have demonstrated to have positive outcomes for recipients (Roe, 1990). The potential benefit of these services, though, may not be fully realized. Cohen, Burt, and Schulte (1993), reporting on survey results from a nationally representative sample, revealed that only 1.5 percent of older respondents participated in home-delivered meal program.

Conceptual Assumptions

Aging and Perceived Health Status. The perception of one's health status is a very important indicator of the manner in which aged persons related to their social world. This situation is particularly evident when it was realized that the subjective well-

being of elderly adults appeared to be related most strongly to their perceived level of health. A review of literature found, for example, that the self-assessment of health was the strongest single predictor of life satisfaction among older people (Larson, 1978; Myles, 1987; Palmore & Luikart, 1972) and this association apparently increased with age (Spreitzer & Snyder, 1974).

Other studies have found that self-ratings of health among elderly adults are valid measures of the respondent's objective health status (Ferraro, 1980; Fillenbaun, 1979; Maddox & Douglas, 1973; Palmore & Luikart, 1972; Tissue, 1972). Whereas it is a biological fact that health deteriorates with age, it might therefore be presumed that elderly people report relatively poor health in general. Such, however, is not the case. Many studies find that both institutionalized and noninstitutionalized elderly persons tend to rate their health positively (Ferraro, 1980; Fillenbaum, 1979; Myles, 1987; Rose, 1965; Shanas, Townsend, Wedderburn, Friis, Milho, & Stehouwer, 1968). Even the oldest among the elderly people over age 75 have been found to express an especially positive view of their own health (Ferraro, 1980).

The Social Significance of Food and Eating

Farb and Armelagos (1980) observed that " in all societies, either primitive or complex, eating is the primary way of initiating and maintaining social relationships (Locher, Burgio, Yoels, & Ritchie, 1997). The services provided by Meals-on-Wheels meets the basic materialist needs of the elderly clients by providing for their physical sustenance, by giving them the currency necessary to engage in mutual reciprocity with other members within the community, and by allowing clients to receive daily contact with other humans they otherwise would not receive.

Definitions of Terms

The Nutrition Program for the Elderly. The Nutrition Program for the Elderly, known as Title III under the Older Americans Act of 1972, was the nation's response to both the nutritional and social needs of a growing population. The goal of the program during the first year, as stated by the Administration on Aging *GUIDE to Effective Project Operations*, was to "provide 250,000 older Americans, particularly those with low incomes, with daily low-cost, nutritionally sound and satisfying meals served in strategically located group settings where participants could also obtain rehabilitative and social services. Besides promoting health among the older segment of the population through improved nutrition, such a program was aimed at reducing the isolation of old age, offering older Americans the opportunity to live their remaining years in dignity" (Moyer & Balsam, 1996).

Meals-on-Wheels. This term is nationally known and is used interchangeably with the term home-delivered meals. For the purpose of this research, the term "mobile meals" will be used.

Stillwater Mobile Meals. The Stillwater Mobile Meals program is sponsored by the United Way Agency and generous contributions from the Stillwater community. The program originated in the Presbyterian Church of Stillwater in 1972 as a pilot program in conjunction with the Stillwater Medical Center. The organization provides hot nutritious noon meals to the convalescing, elderly, and homebound persons of Stillwater. Its goal is to help Stillwater residents maintain their independence and to live in their own homes as long as possible. The program's first clients consisted of 10 participants. Now the Mobile Meals program serves approximately 65 to 70 clients.

Nonprofit Home-Delivered Meals. A nonprofit home-delivered meals program is a community service administered by an official or voluntary health or welfare agency. The service is provided to ill, disabled, and elderly persons, and other persons whose physical, emotional, mental, or social conditions handicap their ability to obtain or prepare adequate meals for themselves. Its purpose is to provide, on a regular basis, nourishing meals(including modified diets), as one factor in assisting such persons to lead healthful, wholesome, and self-sufficient lives. Standards call for meals to be prepared, packaged, and delivered under the supervision of a nutritionist or dietitian. To ensure that home-delivered meals are appropriate to the needs of the individual, the service is initiated and continued on the basis of a medical recommendation, and an evaluation of the individual's situation by a public health nurse or a social worker. The program may prepare and deliver meals or it may purchase the preparation and/or the delivery of meals from a nonprofit or commercial source (Home-Delivered Meal, 1965).

Homebound. The homebound client is defined as one who, though ambulatory in their own environment, and though able at times to leave their home with or without the aid of another person, essentially is confined to their own dwelling and immediate environs for documented health or social reason (Home-Delivered Meals, 1965).

Psychological Well-Being. The presence of positive emotions such as happiness, contentment, joy, and peace of mind and the absence of negative emotions such as fear, anxiety and depression (Reker and Wong, 1984).

Physical Well-Being. Self-rated physical health and vitality coupled with perceived absence of physical discomforts (Recker and Wong, 1984).

The Perceived Well-Being Scale (PWB Scale). The 14-item measure of psychological, physical, and general well-being that was developed by Recker and Wong in 1984. The composite set of items was an index of general well-being based on a 7-point Likert scale. The Perceived Well-Being Scale used in this research is an adapted version of such a scale in that it consists of 12 items on a 5-point Likert scale (1984).

Limitations

This research was restricted to the Stillwater Mobile Meals program and its elderly participants who lived in the Stillwater community. Because this type of research has never been done concerning the program, it was important that enough time was allowed so that the researcher could establish a strong rapport with as many of the Mobile Meals clients as possible. In addition, the researcher chose to become familiar with as many of the 12 delivery routes as possible to encourage participation and curtail any reservations the clients may have had when they were aware that a survey and personal interview was involved. 6 of the 12 routes were successfully completed by the researcher because they were easier to follow.

Aside from health reasons, the main factor for a lack of full participation was that the clients commented that the instruments were confusing. The instruments along with a consent form arrived in a sealed plain envelope. Some of the clients stated that they disregarded the envelope as a part of their daily mail. Often the envelope was left with their other mail and forgotten until they were reminded.

In addition, visits with the clients were dependent on their availability due to health reasons or appointments with their physician. Lastly, some of the clients chose not to participate because they just did not want to do so.

Summary of the Chapter

As stated inn this Chapter One, the purpose of this research was to gain further understanding of the Stillwater Mobile Meals program. The potential benefit of such a service and others may not be fully realized, (Roe, 1990). The objectives intent was examine the relation between the Mobile Meals program and it clients and their perception of the service or services provided by the program. The following chapter introduces the home-delivered and Stillwater Mobile programs beginning with an overview of the Nutrition Program for the Elderly. It will also discuss food choice among the elderly and highlight relevant literature concerning the social significance of food and eating among home-delivered meal recipients. Lastly, it will discuss the self-assessment of personal health by elderly persons.

CHAPTER II

REVIEW OF LITERATURE

Introduction

Society, as a whole, has treated aging primarily as a phenomenon of decline. Although aging and old age are to a large degree determined by bodily characteristics and the biological nature of aging, researchers have demonstrated an alternative perspective that suggests that the future of old age holds more promise than originally presumed (Baltes & Baltes, 1990; Birren & Bengston, 1998). As one attempts to maneuver in to the older population's world of understanding, it is evident that a number of factors have co-mingled to produce a multi-faceted creation – the older adult. Among these factors that contributed to an individual's personal profile is his or her lifelong cognitive and affective developmental pattern, environmental and historical shifts, age-related changes, and inner challenges that might have been interpreted by the person as successful or devastating outcomes (Schulz & Heckhausen, 1996).

Throughout our lives we are encouraged to believe that we are encouraged to believe that we can become and accomplish whatever we envision. A realistic appraisal, however, advanced awareness that this potential might be constrained by genetic contributions, physical limitations, and societal restraints (Schulz & Heckhausen, 1996). Never have these considerations been more apparent than in the later years of life. Increasingly, the focus of agendas for long-term care initiatives is to enhance the quality of life of older adults living within the community, especially the maintenance of functional independence. Such efforts are often implicitly and explicitly intended to

avoid or postpone institutionalization (either hospitalization or nursing home placement). The provision of food services, specifically home-delivered meals to older homebound adults living in the community, is one means to this end (Roe, 1990). The potential benefit of these services, though, may not be fully realized. Cohen, Burt, and Schutle (1993), reporting on survey results from a nationally representative sample, reveals that only 1.5 percent of older respondents participate in home-delivered programs.

The Nutrition Programs for the Elderly

Background. Early program requirements of the program were that the meal be served in a congregate setting, that the program operated at least five days per week, and that the meal met one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Academy of Sciences-National Research Council. In addition, there were eight mandated supportive services to include transportation, information and referral, health and welfare counseling, nutrition education, shopping assistance, recreation, outreach and personal escort services. The program operates on a donation basis and no one can be denied service based on his or her ability or willingness to donate. While the program targets its services to low income and minority individuals, the primary eligibility requirement is that participants be aged sixty or older or the spouse of an eligible participant (Moyer & Balsam, 1996).

The Last Decade

In addition to the changes in terms of participant characteristics and participation/meal levels, federal funding through the Older American Act has changed dramatically over the past decade for the meals program (Moyer & Balsam, 1996). Funding for the congregate meal programs in 1985 was $336 million. In 1994, the actual

funding level, after transfer, was $245.1 million, a loss of real dollars of over 27 percent. If one were to have adjusted these dollars for inflation, the loss in funds would approach 50 percent! The home-delivered program, by contrast, fared better. Home-delivered funding, following transfer, increased form $67.9 million and $128.2 million dollars during the same ten year period, a significant 89 percent increase.

Perhaps the most significant changes of the elderly nutrition program occurred in program operations. The first serious effort to document service innovations and to identify factors associated with such innovations in the elderly nutrition program was done by Balsam and Rogers in 1988. This work identified sixteen service innovations ranging from breakfast, dinner and weekend meal options to contracts with restaurants to meals for the "homeless". Since the study was widely distributed to the field, it served to both summarize such innovations as well as to stimulate thought and further program innovations. The explosion in such service innovations included: a broader range of menu offerings to include special diets, culturally sensitive meal offerings and increased use of nutritional supplements; an expansion of meal service to other populations to include the homeless, persons with AIDS, persons in assisted living, low income housing populations, adult day care programs participants, children in head-start programs and battered women's shelters; and such innovations as offering two and three meals per day, home-delivered groceries, shelf-stable emergency meal packs, food co-ops and home-delivered nutritional support.

Few issues over the last ten years have effected more nutrition programs than the ever present need for fund-raising. This issue has taken a myriad of forms. It has included special event fund-raisers like the "Miles for Meals" pledge walks sponsored

through the National Meals-on-Wheels Foundation, fund-raising dinners, and auctions as well as increased advocacy efforts with national and local public funding entities. It has included such fund development methods as foundation grant writing, the establishment of endowment and trust or ongoing solicitation campaigns. The continuing need to have nutrition programs raise money has led many programs to increase the voluntary contributions of programs participants, reduce staff, cut employee benefit packages and, in some cases, prioritize, reduce, or eliminate service.

The Current Program

Today's program, while remaining the primary community based nutrition service providing congregate and home-delivered meals for the elderly, is different from the one with its ancestral beginnings in the early seventies. It is more mature, a part of a larger community of services and no longer a protected "stand alone" program. The program of today has no mandated services. Separated line item funding for congregate and home-delivered meals is proposed for elimination, giving way to a single funding category of Nutrition Services.

The trends articulated over the last ten years are continuing today. The population being served is older, congregate participation is declining while home-delivered participation is on the rise, and the need for funding presents a constant challenge. Today, nutrition programs across the country are struggling to implement a data collection system to meet the newly revised State Reporting Requirements for Title III and VI of the Older Americans Act. This revised system will require nutrition programs to collect and report the unduplicated count of clients served by service area and report clients characteristics to include: age group, minority status, individual minority group,

sex, rural residence, live-alone poverty status, and in some case of home-delivered participants- assisted daily living/independent assisted daily living status. This data collection system, when fully implemented will, for the first time, portray accurately who is served and what types of services are provide by Title III and VII of the of the Older Americans Act (Moyer & Balsam, 1996).

With regard to meals and supplies, nutrition programs are increasingly cost conscious. The ability to save a few cents per meal often represents thousands of dollars a year in food cost savings. A number of projects are now using nutrient analysis to meet the one-third Recommended Daily Allowance requirement instead of the more traditional menu pattern. This often produces meals smaller in quantity, while maintaining quality and saving dollars. Similar savings are achieved through consortium bidding and multiple year contraction where possible (Moyer & Balsam, 1996).

Moreover, today's nutrition programs are far more customer-sensitive and responsive than ever before. Not only are programs listening to the customer, but also they are changing the definition of the customer. They no longer consider the participant or the Area Agency on Aging as the only customer. Rather, it may be a day care provider seeking a meal service or an emergency shelter that needs shelf stable meals. More options are available today, not only in terms of meals, but also settings. It is not a wish to be all things to all people, but rather to market the same thing to different people. With appropriate management and accounting procedures, such entrepreneurial ventures are not only allowed, but encouraged, and my go a long way in supporting the financial needs of our primary mission-providing nutrition services to the elderly.

Home-Delivered Meals (Meals-on-Wheels)

The formal concept of home-delivered meals, later given the popular designation of Meals-on-Wheels, began early in this century where, in 1905, the invalid kitchens of London began sending hot meals to household patients. The first Meals-on-Wheels program in the United States began in Philadelphia in 1954. The program operated through the Lighthouse, a settlement house serving an area of approximately 5 square miles, and served 50 homebound clients each day (Nutrition in Aging, 1984). (not in ref section)

The services provided by the Meals-on-Wheels program enable older persons to more fully participate in community life in several significant ways. First, the program provides food to homebound persons who otherwise may not be able to obtain or prepare food without assistance from others to facilitate their ability to remain living in the community. Thus, the delivery of food meets the basic materialist needs of the clients by providing for their physical sustenance (Locher, Burgio, Yoels, & Ritchie, 1997). Secondly, and more importantly from a sociological point of view, the food that people receive from the Meals-on-Wheels program give them the opportunity to more fully participate in community life by providing them the currency necessary to engage in mutual reciprocity with other members within the community. This interpretation relies upon the social exchange theory developed by Richard Emerson (1962) and Peter Blau (1964) within the tradition of social psychology. Essentially, the social exchange theory posits that persons enter into relationships based upon their expectations of an exchange of mutual rewards and costs taking place between actors. When mutual reciprocity occurred between individuals and the balance between rewards and costs is roughly

equivalent, the relationship is likely to be maintained. For example, Jeanie Schmit Kayser-Jones (1981) used the social exchange theory in her classic study of older nursing home residents and found that when older persons were able to engage in balanced social relationships with others, dependency on and negative sanctions from others did not occur.

The Stillwater Mobile Meals program

Early Beginnings. The Stillwater Mobile Meals program began in the Presbyterian Church of Stillwater where a study group recognized that not only where there elderly persons living in poverty but found that the physical inability to cook and prepare adequate meals as well as loss of appetite due to medication or social isolation were factors which interfered with receiving good nutrition (personal interview with Mary Beth Ray, 1999).

The Present Program. Operating under the United Way Agency, the Mobile Meals program, under the direction of Mary Beth Ray, continues as it mission to provide the delivery of hot, nutritious noon meals to the convalescing, elderly, and homebound persons within the Stillwater community. Its goal is to help the Stillwater Mobile Meals client to maintain their independence and continue to live in their own homes as long as possible.

Since 1972, the Mobile Meals program has served approximately 318,417 meals. In 1999 14,056 meals were delivered with 4,934 of those meals subsidized. It should be known that since the programs early beginning the cost of each daily meal has only increased by 3% in 28 years. An average of 65 to 70 are meals are delivered by volunteers on any of the 12 routes (with 5 to 6 clients per route) available Monday

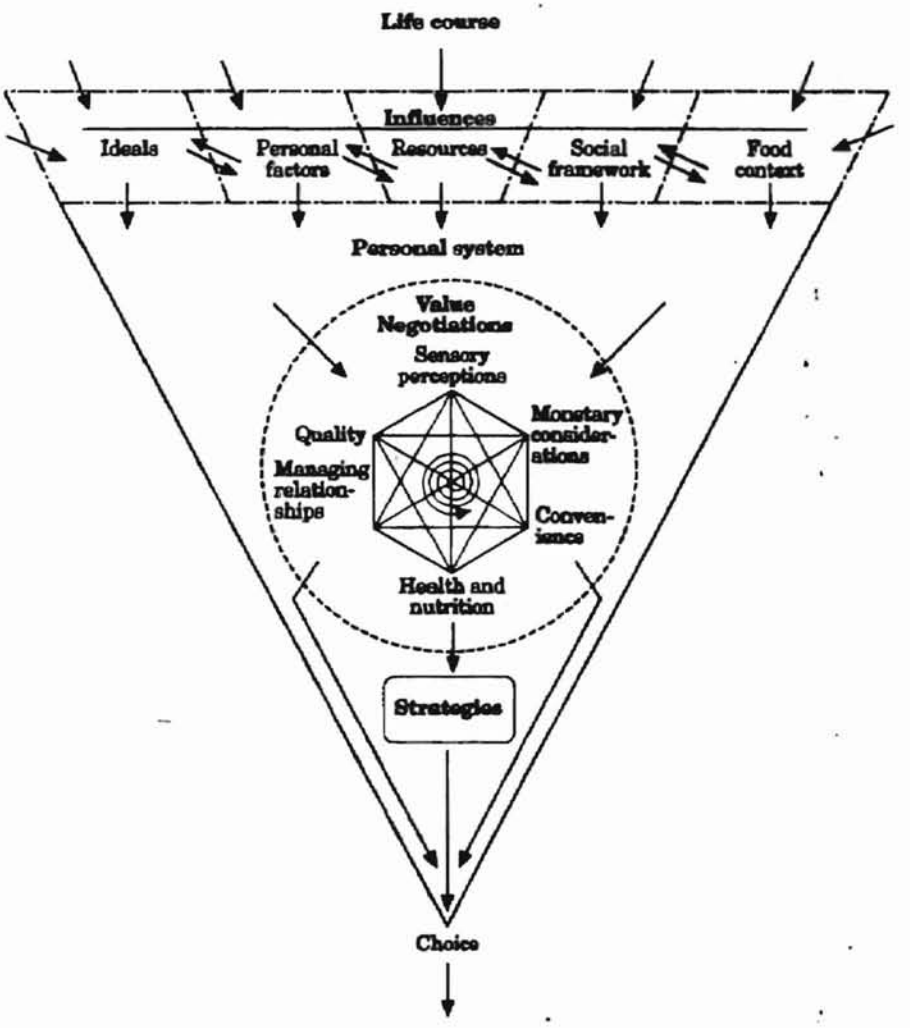
through Friday and on holidays that fall within this weekly time frame. The meals are served daily except in the case of inclimate weather and on those days in which a holiday those not fall during the days of Monday through Friday (Ray, 1999).

It should be reiterated that the Mobile Meals program does not receive any federal funds. Solely supported by the United Way Agency and generous contributions of residents in the Stillwater community, the Mobile Meals is able to provide meals for the elderly and convalescing adults for a year at the cost of one day's stay at the medical center.

Foodways of the Elderly

The Food Choice Process. The choices people make among food determine which nutrients enter the body, and influence food production systems through consumer demand. Specific food choices lay the groundwork for long term food habits. How people consider and select foods and beverages affects their acquisition, preparation or consumption or food in a wide variety of settings including grocery stores, restaurants and vending machines; parties and social events; and meals and snacks at home. Interviews examining the food choice process were conducted with 29 adults in a study of the food choice process by Furst, Connors, Bisogni, Sobal, & Falk (1996) in relation to grocery store shopping. A conceptual model of the food choice process emerged for the data analysis and is shown in Figure 1.

FIGURE 1. A Conceptual Model of the Components in the Food Choice Process.



The model represents the types of factors and the process involved in a single choice event. Factors involved in food choice were grouped into three major components: (1) life course, (2) influences, and (3) personal system. The relationship to

these components to one another generates the process or pathway (indicate by arrows) leading to the point of choice.

A basic and universal factor that provided the groundwork for food choices was the life course. The life course includes the personal roles and social, cultural and physical environments to which a person has been and is exposed. A person's life course generates a set of influences: ideals, personal factors, resources, social framework and food context. These influences inform and shape people's personal systems, including conscious value negotiations and unconsciously operationalized strategies that may occur in a food-related choice situation.

The model's funnel shape illustrates several attributed of the food choice process. First, a single food choice event results from the mixing and separating of the diverse set of personal and environmental inputs. The life course, a major ingredient in the process, gives rise to and shapes the influences that emerge in a food choice situation as well as the manner and extent to which the social and physical settings affect how people construct and execute personal systems of food choice. The value negotiation process within such a personal system is very dynamic, while strategies are more routine. Finally, the boundaries between components and processes are highly permeable, and much mutual shaping occurs between and within components.

The model outlines the general nature of the food choice process and includes five major categories of influences upon food choice. Among these are: ideals, personal factors, sensory perception, and health and nutrition.

The Social Significance of Food and Eating. This research was influenced by an ancillary study done by Locher, Burgio, Yoels, & Richie (1997) designed to evaluate the

nutritional and oral health status of 150 older home-bound adults being served by the Jefferson County Office of Senior Citizens Activities Meals on Wheels Program in Birmingham, Alabama. The research of Locher and et al. (1997) followed the conceptual frameworks for consideration of a "grounded theory" approach by Hendricks, Calsanti, & Turner (1988). In a grounded approach, ongoing analysis consists of coding, data collection, and further refinements and synthesis, all oriented toward understanding how people, not nutritionists, do nutrition. Underlying their discussion was the proposition that eating is a social issue. It is imbued with emotionality not only because it is an act largely done in the company of others, according to learned, shared values, but because food preferences and eating behaviors become part of one's social identity and self-identity throughout life.

The Locher and et al. study focused on those older adults whose limitations necessitated a reliance upon home-delivered meals. The study also relied on the experiences of older adults' perception of themselves-a necessary first step in gaining insight into the social and cultural issues surrounding food and eating in older adults in order to address nutrition related problems in this group. Findings in both of these studies will be further discussed in Chapter IV.

Aging and Perceived Health Status

Self-assessment of personal health by elderly persons seem to be based largely upon how they compare themselves with peers of their age, sex, and perhaps expectations others had of their health (Fillenbaum, 1979; Maddox, 1962; Shanas, Townsend, Wedderburn, Friis, Milho, & Stehouwer, 1968). In a statewide survey of 660 Illinois residents ranging from the age of 18 to 93, Cockerham, Sharp, & Wilcox (1983) found

that one particular characteristic older aged groups is that they tend to perceive their health in a more positive fashion than members of young aged groups when they compare themselves to each other. This tendency most likely stems from two types of rationalization.

First, simply surviving to old age in a state of reasonably free of serious illness or severe disability is evidence of relatively good health. Only among the last few generations has survival to old age without server health problems of disability become fairly common. With increasing numbers of Americans living past age 65, many people in the older age categories are able to feel that their health has indeed been good (1983).

Secondly, Myles (1978) posits that subjective responses to a health problem tend to be a function of how much of a person's life is disrupted by the condition. The extent of the potential disruption is determined by the level of physical and mental functioning required in a particular social environment. Usually elderly people are not required to maintain a highly active level of functioning and thus find it easier to perceive their health as good enough to meet the needs of their environment.

Summary of the Chapter

In Chapter Two, the reader became acquainted with the Nutrition Program for the Elderly. The Meals-on-Wheels program, Mobile Meals respectively, falls under such program. The reader was also introduced to literature relevant to the social significance of food and eating as it pertained to the Meals program and, also, literature on aging and perceived health was covered. Chapter Three will discuss Recker and Wong's Perceived Well-Being Scale and components of the research instrument.

CHAPTER III

METHODOLOGY

Introduction

A number of instruments have been developed to measure perceived physical well-being but these were of a one-item variety such as that previously mentioned study on the perceived health status of the elderly by Cockerham et al., (1983). Moreover, most of the research on perceived health of the elderly is on the predictive relationship between perceived health and life satisfaction (Braun, 1977; Dickie, Ludwig & Blauw, 1979; Larson, 1978; Petrus, 1980; Quinn. 1980; Research & Forecast, 1980) however they recognized that there were two major components of perceived well-being – psychological and physical. As defined earlier, psychological well-being is the presence of positive emotions such as happiness, contentment, joy, and peace of mind and the absence of negative emotions such as fear, anxiety, and depression. Physical well-being is the self-rated physical health and vitality coupled with perceived absence of physical discomforts. The researcher used as a guide Recker and Wong's (1984) Perceived Well-Being Scale because their findings were able to provide an index of one's overall perceived well-being resulting in several advantages over the existing scales.

First, it is better focused than the earlier multidimensional measures in that it is based on only two clearly defined dimensions. These measure include life satisfaction indices (Cantril, 1965; Neugarten, Havighurst, & Tobin, 1961; Spreitzer & Snyder, 1974), morale scales (Kutner, Fanshel, Togo, & Langner, 1956; Lawton, 1975) and scales of happiness (Bradburn, 1969; Kozma & Stones, 1980).

Secondly, it is more global than the recent single factor well-being scales in that it provides an index of one's overall perceived well-being while permitting independent assessments of both psychological and physical well-being.

Thirdly, since the two subscales have a common response format and are validated on the same sample of elderly, they allow the assessment of the relative contribution of the two components to overall well-being and their interaction. Finally, it allowed the indentification of the unique correlations of the subscales as well as the global index.

Contruct of Recker and Wong's Perceived Well-Being Scale (PWB)

Development of the PWB. In the initial construction of the PWB, the authors generated a pool of 72 items judged to measure psychological and physical well-being. twenty psychology faculty and students were asked to indicate whether an item reflected psychological or physical well-being and to comment on the clarity of each statement. All items exceeding 70% agreement among the judges were retained. Logical considerations and suggestions from the judges led to a further screening of items for redundancy and ambiguity, resulting in a 32-item scale (Recker and Wong, 1984).

The 32-item, 7-point PWB was administered to a sample of 80 community and institutionalized elderly ranging from 61 to 93 years of age. Eleven non-contributing items were eliminated following item analysis. The remaining 21 items were factor analyzed with varimax rotation to simple structure. A three factor solution emerged accounting for 50.2% of the variance. Factor I, labeled Psychological Well-Being, accounted for 27.3% of the variance; 10 items of a psychological nature loaded

substantially on this factor. Factor II, labeled Physical Well-Being, accounted for 1.6% of the variance; 9 items of a physical nature loaded of this factor. The third factor was found to be a mixture of both psychological and physical items. In all three factors, some items shared variance with one or tow other factors. By eliminating the third factor, which did not make an independent contribution to the PWB scale, and by removing items that did not load uniquely on any one factor, the scale was reduced to 14 items.

The 14-item, 7-point PWB was then administered to a combined sample of 238 community and institution elderly. The responses were subjected to principal components factor analysis with varimax rotation of all factors with eigenvalues greater than unity. The resulting factor structure is presented in Table I.

TABLE I

Factor structure of the 14-item Well-Being Scale (Recker & Wong, 1984).

	Factor loadings[a]	
	Factor I	Factor II
Psychologicl Well-Being		
2. No one really cares whether I am dead or alive.	.49	.03
5. I am often bored.	.59	.35
7. It is exciting to be alive.	.81	.16
8. Sometimes I wish that I never wake up.	.78	.10
10. I feel that life is worth living.	.82	.14
12. I don't seem to care about what happens to me.	.70	.17
Physcial Well-Being		
1. I don't have many physical complaints.	.17	.56
3. I don't think that I have a heart condition.	-.03	.58
4. I have a good appetite for food.	.23	.45
6. I have aches and pains.	-.06	.66
9. I am in good shape physically.	.21	.70
11. I think my health is deteriorationg.	.21	.64
13. I don't get tired very easily.	.14	.63
14. I can stand a fair amount of physical strain.	.24	.61
Eigenvalues	4.50	1.90
Percent variance	32.10	13.40

[a]loadings > .40 are underscored

Two meaningful factors emerged, accounting for 45.5% of the variance. Factor I (32.1% of the variance) contained high loadings on its measuring psychological well-being. Factor II (13.4% of the variance) was defined by high loadings on the physical well-being items. These two factors are defined by the same items as the first two factors in the 80-subject sample. The items identified as loading substantially on each factor were given unit weights; raw scores were summed to generate factor scores. All reliability and validity data to be reported here are based on the factor scores of the 14-item PWB scale (1984).

Reliability of the PWB. The internal consistency of each dimension of the PWB was computed for the sample of 238 elderly by means of Armor's Theta (1974). Theta coefficients provide an optimal reliability estimate (each item is differentially weighted) for factor scores based on principal component analysis. Theta coefficients of .82 and .78 were obtained for the psychological and physical well-being dimensions, respectively. Internal consistency of the overall well-being index reached .91.

An index of the test-retest of reliability of the PWB was obtained in a study of 34 elderly following a two-year time interval. The stability coefficients were. 79 ($\rho < .001$) for psychological well being; .65 ($\rho < .001$) for physical well-being; and .78 ($\rho < .001$) for general well-being. These results provide strong support for the internal consistency and temporal stability of perceived well-being in diverse groups of elderly. Only two other studies to date have provided evidence of long-term temporal stability of the well-being construct. Palmore and Kivett (1977) found life satisfaction to remain stable over a four-year period; Kozma and Stone (1983) found happiness to remain stable over 18 months.

Empirical Validity. The results of the comparison between community and institution elderly in terms of psychological, physical and general well-being on the PWB are presented in terms of means and deviation in Table II.

TABLE II

Means and standard deviations for community and institution elderly on the perceived well-being scale

Variable		Community (N = 20)	Institution (N = 24)	t
Perceived Well-Being				
Psychological	Mean	36.3	31.2	3.27***
	S.D.	1.7	7.3	
Physcial	Mean	39.6	34.5	2.09*
	S.D	7.4	8.6	
General	Mean	75.9	65.7	3.12**
	S.D	8.4	12.4	

**$\rho < .01$

*$\rho < .05$

Inspection of the means in Table II shows that community elderly rated their psychological, physical, and general well-being significantly higher compared to institution elderly. These findings provide evidence for the construct validity of the PWB (Recker and Wong, 1984).

Like the earlier life satisfaction measures, the PWB provides an index of one's perceived general well-being. But unlike the earlier scales, the PWB offers separate

assessment of two clearly defined and objectively validated dimensions of well-being: psychological and physical. In their study of the 238 community and institution elderly, Recker and Wong found the PWB to have numerous positive measurement properties. The psychological and physical dimensions showed high internal consistency and stability. The validity data deemed sufficiently high to justify its continued use with the elderly. Furthermore, the PWB holds up remarkably well in the author's more recent work with the elderly on perceived efficacy of coping behavior and well-being (Wong and Reker, 1982) and personal optimism, meaningfulness and well-being (Reker and Wong, 1983). In these studies, the PWB is significantly correlated with variables known to affect one's well-being.

The PWB is a short and convenient measure constructed and validated for use with community and institution elderly. It is brief enough to make it a useful screening device to identify the elderly who are either low or high on the wellness/illness continuum. Its ecological validity makes it a useful instrument in longitundinal and intervention studies, regardless of whether the elderly reside in the community or the institution.

The relevant literature concerning Recker and Wong's PWB allowed the researcher to construct and adapted version of the measurement of perceived well-being containing 12-items on a 5-point Likert scale. Through the use of the adapted version of the PWB and information collected from the personal testimonies of the Stillwater Mobile Meals client, the researcher was able to investigate the effect the program had on the perceived well-being of its clients.

Population Sample

The participants in this research were clients of the Stillwater Mobile Meals program who had been on the program for at least one month and who had been readily identified by the program director as mostly likely to participate in the study.

The program provides service to approximately 70 clients daily. The number of daily meals varied because the clients would elect not to receive a meal due to illness, a doctor's appointment, or a previous engagement. On the day of the survey distribution 64 clients had elected to receive meals. Table III shows a breakdown of the clients who chose to participate in the research.

TABLE III

Demographics of Research Respondents

Participant	Age	Gender	Marital Status	Living Arrangements	Program Usage
1	92	Female	Widowed	Elderly Housing, Alone	4 years
2	85	Female	Widowed	Owns Home, Alone	7 months
3	76	Male	Widowed	Elderly High Rise, Alone	10 years
4	85	Male	Widowed	Owns Home, Alone	5 years
5	57	Male	Married	Owns Home with Wife	1 ½ years
6	73	Male	Married	Owns Home with Wife	2 months
7	71	Female	Married	Owns Home with Husband	2 months
8	90	Female	Widowed	Owns Home, Alone	Unsure
9	85	Female	Widowed	Owns Home, Alone	3 years
10	81	Female	Widowed	Owns Home, Alone	10 years
11	97	Female	Widowed	Owns Home, Alone	3 years
12	81	Male	Widowed	Elderly High Rise, Alone	Unsure
13	84	Male	Single	Elderly High Rise, Alone	12 years
14	96	Female	Widowed	Elderly Housing	1 year

Components of the Instrument

The survey was an adapted version of the Recker and Wong's PWB scale. It consist of 12 items on a 5-point Likert scale ranging from strongly agree to strongly disagree. Five items were listed under psychological and seven were listed under physical. The adjusted scale is shown in Appendix A.

The personal interview consisted of two sections: (1) the meal and eating habits and (2) mobile meals-the program. The 3 questions in section one was concerned with the participant's perception of what constituted a meal to them, how often did they eat this perceived meal, and in where did they most often eat. The 5 questions in section two dealt with the client's participation overall perception of the mobile meals program. The questions for the interview are found in Appendix B.

The survey and the questions structured for the personal interview along with a cover letter and consent form were hand delivered in a sealed envelope on each of the twelve routes. The clients were only asked for their consent to participate in the research however the survey and interview questions were distributed so that the clients would know what would be asked of them. All of the clients were contacted by the director of the program to inform them of the study and that the envelope would arrive with their meal. The researcher also contacted the clients to further alleviate and concerns or doubts about the actual purpose of the research. This action was prompted in light of the many schemes that befall the elderly. Moreover, the researcher wanted to clients to feel relatively at ease during the personal interview process.

There was no response after two weeks of the initial administration of the research instrument. The clients were then phoned by the program director and

researcher to further encourage participation. It was only after repeated visits and phone calls that the envelopes began to file in. The main reason for the delay was that the clients saw the envelopes as junk mail. Another reason for the delay is that some of the clients simply could not remember what they did with their envelopes after they had completed the Perceived Well-Being Scale; several of the clients simply could not remember if that had received such an envelope at all.

Special Considerations While Interviewing the Elderly

Hoinville (1984) points out several special characteristics of interviews with the elderly that distinguish them from interviews with the rest of the population:

In general, the interviews will be longer than normal for a variety of reasons. Elderly respondents need more attention at the start of an interview to encourage them to take part, to reassure them, and to help them into their role as respondents. Due to their lack of concentration during the course of the interview, elderly respondents will need more explanation and encouragement from the interviewer. There has to be more social interaction in interviews with the elderly to secure and maintain cooperation.

Some interviews with the elderly will be more stressful for both interviewer and the respondent. Elderly respondents have health, mobility and care problems and needs. They can become distressed and emotional during the course of the interview. The interviewer will have a harder job, too, in keeping respondents on course. .

The interviewer may interfere with the quality of responses given. Because interviewers have a more positive role to play during the interview – more explanation, more encouragement, and more probing, there is a greater opportunity for distortion of the truth.

The quality of responses given by elderly people might be poor for several reasons. They may not be able to read or hear adequately and hide those weaknesses from the interviewer. Even if the interviewer is aware of the problems, he or she might not be able to overcome them without biasing the results. The respondents may simply not understand the questions or some of the concepts that are used in survey questionnaires. They may have difficulty in remembering details and my get confused between events or frequencies. They might try to hide the truth for fear of reprisal, embarrassment, guilt or lack of confidence. Or they might just have difficulty in expressing their views clearly. And of course, at the extreme some elderly will be too senile to give reliable responses. The following chapter will discuss the raw data from the perceived well-being scale and highlight the statements that were recorded in the personal interview sessions.

CHAPTER IV

Results and Discussion

Introduction

The purpose of this research was to gain further insight of the Stillwater Mobile Meals program. Its objectives were to identify how often the program was used by its elderly clients, examine the effect the program had on the psychological and physical well-being of its clients, and to examine any cultural or social behaviors exhibited by the Mobile clients during meal time.

As previously mentioned, the elderly population is rapidly growing in the U.S. On a small scale, this growth can even be seen in Stillwater. Table IV presents a population profile of the different age groups with in the city of Stillwater in a survey done in 1997. The groups were denoted by population count and percentage as they related to those persons 65 and older. During that year, 8.2 percent (3,069) of persons 65 and older were among a total city population of 37,564 (Marketview Comparison Report, 1998). This population equaled or surpassed the percentage of those persons in the age groups which ranged from 30 to 64 years of age.

TABLE IV

Profile of Sample Age Groups for Stillwater, Oklahoma (1997)

Age	30-34	35-39	40-44	45-54	55-64	*65-85
Population Count	3,085	2,706	2,140	3,009	1,735	3,069
Percent	8.2	7.2.	5.7	8.0	4.6	8.2

*denotes the percent of the population for those persons 65-85 years and older
The total median age (in years) for the year 1997 was 25.5
The population for Stillwater, Oklahoma for the year 1997 was 37,564

The comparison of these figures is important because they are a light for the continued existence of the current Mobile Meals program. As the growth of the elderly population increased, Meals program directors will not only need to be aware of the unique dietary needs of their prospective clients, but also what these new food savvy customers are looking for in such a program in the upcoming years. More importantly, learning what the clients are actually saying about the program, program directors will get a better insight on ways to make their programs more appealing and consumer-friendly.

Discussion

Objective One was concerned with the extent of use of the Mobile Meals program and other programs, if any, that were offered. In reference to program usage, the responses to question two of the interview questions: How long have you been a client with Mobile Meals? , were displayed in Table III. Out of the 14 respondents, only two were unsure as to how long they have been clients of mobile meals. When asked how they heard about the program (question 1 of Section II of the interview questions), the

majority of the respondents heard about the program from their physician. Only one member, a widower (76), heard about the program somewhat differently: "I cooked for my wife after the doctor put her on the Mobile Meals program. I cooked everything for her because that's what I liked to do. She was on the program about eight years before her death. Although I enjoy cooking, especially grilling, I don't do much now. The program is a really nice alternative and I eat almost everything."

Prolonged usage of the program is attributed to the various modified diet menu choices such as diabetic and low sodium however most of the respondents stated that they remain on the program because of the Mary Beth Ray, her staff, and the volunteers: " At one time, I knew all of them (the volunteers) by heart," stated a participant who had recently turned 81; the program utilizes approximately 24 to 30 volunteers. "It's not so much the food for me because I'm not much of a big eater," exclaimed a 90 year- old participant. "It's the people (the volunteers) who keep me alive."

Mobile Meals offered more than nutritious hot meals. In 1991, a free book delivery service began in conjunction with the Stillwater Public Library. In 1993, the "Second Helpings" program was created in cooperation with the Stillwater Medical Center Nutritional Services Department, delivering frozen foods to the Mission of Hope (a nonprofit agency that assist the homeless. The program jumpstarted the year 2000 with its continued delivery service to approximately 20 to 30 persons visiting the city's elderly day care center, the Stillwater Life Center. Additionally, 5 to 15 meals were delivered daily to elderly clients who were patrons of Senior Perspectives, a day treatment clinic specializing in elderly depression.

Corresponding to the effect of the program on the psychological and physical well-being of the clients (Objective Two), the raw data output in the following tables is representative of the total 14 responses, include and excluded, to the 12 survey statements used on the adapted PWB of Reker and Wong. Table V shows those variables that were excluded from each survey statement, in particular, participant #14 who chose not to answer the survey but did request to be interviewed. The number which denoted a missing (excluded) variable was recorded as a 9 for the response.

TABLE V

Raw Data Output Representing Excluded Variables

Survey Statements	Cases					
	Included		Excluded		Total	
	N	Percent	N	Percent	N	Percent
Most of the time the only person who knows I'm alive is the Mobile Meals volunteer	13	92.9%	1	7.1%	14	100.0%
I get excited about me and my community	12	85.7%	2	14.3%	14	100.0%
I have no reason to live now that all my friends and loved ones are gone	12	85.7%	2	14.3%	14	100.0%
I'm axcited about living despite world events	13	92.9%	1	7.1%	14	100.0%
My age seldom dictates how youthful I feel	12	85.7%	2	14.3%	14	100.0%
Despite my age I am in good physical health	13	92.9%	1	7.1%	14	100.0%
I am still hungry after eating a Mobile Meals lunch	13	92.9%	1	7.1%	14	100.0%
Most of the time I feel like eating my Mobile Meals lunch	13	92.9%	1	7.1%	14	100.0%
Because of my aches and pains I seldom like to move around	13	92.9%	1	7.1%	14	100.0%
I would say that I am mentally alert	13	92.9%	1	7.1%	14	100.0%
I still attend OSU campus and/or community activities	13	92.9%	1	7.1%	14	100.0%
I don't get out as much becuase I am afraid that I am afraid that I will fall or hurt myself	13	92.9%	1	7.1%	14	100.0%

Table VI represents data output for each participant's response to the survey statements of the PWB. The following statements under the category of psychological well-being are also shown to represent an additional participant who chose not to respond. The excluded response for these variable were also coded with the number 9:

#2. I get excited about me and my community.

#3. I have no reason to live now that all my friends and loved ones are gone.

and

#5. My age seldom dictates how youthful I feel.

TABLE VI

Raw Data of the Perceived Well-Being Scale: Participant Response

Participants	Most of the time the only person who knows I'm alive is the Mobile Meals volunteer	I get excited about me and my community	I have no reason to live now that all my friends and loved ones are gone	I'm excited about living despite world events	My age seldom dictates how youthful I feel	Despite my age I am in good physical health
1	2.00	4.00	1.00	4.00	3.00	4.00
2	1.00	3.00	1.00	3.00	3.00	2.00
3	1.00	2.00	1.00	5.00	5.00	1.00
4	2.00	3.00	1.00	5.00	4.00	1.00
5	1.00	4.00	1.00	5.00	5.00	3.00
6	1.00	4.00	1.00	4.00	3.00	4.00
7	1.00	4.00	1.00	4.00	2.00	2.00
8	1.00	2.00	1.00	4.00	3.00	3.00
9	2.00	5.00	1.00	4.00	2.00	2.00
10	2.00	9.00	9.00	3.00	9.00	2.00
11	1.00	4.00	1.00	3.00	4.00	2.00
12	3.00	4.00	1.00	5.00	3.00	5.00
13	1.00	4.00	2.00	4.00	4.00	4.00
Total N	13	12	12	13	12	13

Participants	I am still hungry after eating a Mobile Meals lunch	Most of the time I feel like eating my Mobile Meals lunch	Because of my aches and pains I seldom like to move around	I would say that I am mentally alert	I still attend OSU campus and/or community activities	I don't get out as much because I am afraid that I am afraid that I will fall or hurt myself
1	2.00	5.00	1.00	4.00	4.00	1.00
2	1.00	5.00	3.00	5.00	1.00	3.00
3	1.00	5.00	1.00	1.00	5.00	1.00
4	1.00	4.00	1.00	5.00	3.00	1.00
5	3.00	4.00	2.00	4.00	5.00	1.00
6	2.00	4.00	2.00	4.00	4.00	2.00
7	2.00	4.00	4.00	4.00	2.00	4.00
8	1.00	4.00	2.00	4.00	1.00	1.00
9	1.00	4.00	1.00	4.00	2.00	2.00
10	1.00	5.00	5.00	5.00	1.00	1.00
11	2.00	2.00	5.00	4.00	2.00	4.00
12	3.00	3.00	3.00	5.00	3.00	5.00
13	2.00	4.00	2.00	4.00	2.00	4.00
Total N	13	13	13	13	13	13

a. Limited to first 100 cases.

Mean and Standard Deviation values are shown in Table VII along with the range of possible responses. 1 = Strongly Disagree (SD), 2 = Disagree (D), 3 = Neutral (N), 4 = Agree (A), and 5 = Strongly Agree (SA).

TABLE VII

Raw Data Output with Means and Standard Deviations

	N	Minimum	Maximum	Mean	Std. Deviation
Most of the time the only person who knows I'm alive is the Mobile Meals volunteer	13	1.00	3.00	1.4615	.6602
I get excited about me and my community	12	2.00	5.00	3.5833	.9003
I have no reason to live now that all my friends and loved ones are gone	12	1.00	2.00	1.0833	.2887
I'm excited about living despite world events	13	3.00	5.00	4.0769	.7596
My age seldom dictates how youthful I feel	12	2.00	5.00	3.4167	.9962
Despite my age I am in good physical health	13	1.00	5.00	2.6923	1.2506
I am still hungry after eating a Mobile Meals lunch	13	1.00	3.00	1.6923	.7511
Most of the time I feel like eating my Mobile Meals lunch	13	2.00	5.00	4.0769	.8623
Because of my aches and pains I seldom like to move around	13	1.00	5.00	2.4615	1.4500
I would say that I am mentally alert	13	1.00	5.00	4.0769	1.0377
I still attend OSU campus and/or community activities	13	1.00	5.00	2.6923	1.4367
I don't get out as much becuase I am afraid that I am afraid that I will fall or hurt myself	13	1.00	5.00	2.3077	1.4936
Valid N (listwise)	12				

Participants and Implementation of the Instruments

On a daily basis, the average number of clients who chose to receive mobile meals was sixty-five; this number does not include the Stillwater Life Center. Initially, sixty-five adapted PWB questionnaires along with questions related specifically to the meal and eating habits and the mobile meals were distributed by the volunteers on all twelve routes, requesting the participants permission to be interviewed. The number of respondents was reduced to fifty-four when eleven of the clients chose not to participate due to health reasons. The total number of respondents was reduced to fifteen. Thereafter, the researcher visited with the clients either in the homes or by phone.

The personal interview had a dual purpose. It not only sought answers to the inquiry surrounding the clients eating habits and their perception of the mobile meals program but it provided the researcher with a real-life experience to the past, present, and future. The adapted Becker and Wong's Perceived Well-Being Scale consisted of twelve questions (five under the heading Psychological Well-Being and seven under the heading Physical Well-Being) each followed by a 5-point Likert scale ranging from Strongly Agree (SA) to Strongly Disagree (SD) with the number 5 representing Strongly Agree. Eight interview questions followed with special attention to #3 under the heading the Meal and Eating Habits:

Question #3. What reasons do you have for eating your meal in a particular setting (the Kitchen, the living, the bedroom)?

Both the Perceived Well-Being Scale and Interview Questions were accompanied by a cover letter in a sealed envelope with the number of the researcher and the director of Mobile Meals, Mrs. Mary Beth Ray inside if there were any questions or concerns. Follow-ups either by phone or in person were conducted for two weeks before analyzing the data. When

The Personal Interview

Before elaborating on the personal interviews, the researcher would like to first expound on the special considerations while interviewing the elderly as highlighted by Hoinville (1984). None of the participants needed to be encouraged to take part in the interview. In fact, the researcher had to make sure that the time did not overlap the next appointment. It was quite an interesting fare to be taken from the Civil War to the beginnings on the town of Stillwater and then to the present day happenings on campus. The researcher would also like to add that among the 15 respondents the youngest was 57 and the oldest was 97 years of age. The results are as follows:

I. The Meal and Eating Habits

Question #1: What constituted a balanced meal for you before you began receiving Mobile Meals lunch?

Although the most of the respondents said that they ate a sandwich or one or all of the combination of a meat, vegetable, and salad a striking response was: "whatever I had". The respondent was 85.

*"What constitutes a balanced meal," inquired a spright respondent of 90. "Eating never *fascinated* me. I guess it would stem from my mother feeling my stomach and telling me that I had one more hole to feel...and she would make me it. " " I'm just to busy to eat". In fact, the respondent was waiting on some friends to eat at an area establishment. "Will you eat something then?" "Only to appease," she replied.

Question #3: What reasons do you have for eating your meal in a particular setting (the kitchen, the living room, the bedroom)?

In the Locher et al. study, most of the respondents who ate in the dining room or the kitchen most often watched the television or listened to the radio. Interestingly enough, most of the respondents ate either in the kitchen or the living room however they did not do so because of the television.

*"I ate in the kitchen because that 's where my flowers are. They grew wild when I lived in Nevada and I would sit on my patio and enjoy the view.

*"I sit in the kitchen because it's near the playground...I love listening to the children."

Indeed, some did eat in the living room or kitchen simply because it was convenient for them to do so.

II. Mobile Meals

Question #1: How did you hear about the Mobile Meals program?

The majority of the respondents were referred to the mobile meals program by their doctor however a few were told by their spouse or loved one.

Question #2: How long have you been a client?

It was difficult to pinpoint the length of usage of the Mobile Meals program because all of the respondents chose to become clients although they were referred by their doctor or loved one. It would depend on what was on the client's schedule. Nevertheless, there was a client who has been receiving mobile meals for 26 years:

*"My wife was on the program because it was more convenient for the both of us. After she died, I just couldn't let that good food go to waste".

The following are responses that did not pertain to the interview questions however the researcher felt that these words of spirit were important to heighten the awareness of a explosive population:

1. (85 year old female)."I've been here in Stillwater for 26 years and I haven't asked much of anyone. I'm a retired ordained minister and from time to time I teach Sunday School at my church. It was only five years ago that I had to stop doing things I wanted to do because I fell of the house when I was painting it; I couldn't afford to hire someone to do it for me. Besides, I figure if I could mow my lawn I could paint my house. When you grow up during the Depression, you learn how to survive.
2. (90 year old female). " My mother lived to be 93 and my father, 94. My grandmother taught school during the Civil War. I'll be 91 soon. I should receive some type of frequent flyer miles just for that, eh?
3. (85 year old male). "I would be interested in age-integrated housing. Everyday there would be something different. Sure, you have health care facilities that provide that atmosphere of community but when you neighbor goes in his or her door after breakfast or lunch, you probably won't see them for the rest of the day or until the next meal.
4. (84 year old male). " I save my lunch for dinner and what I don't eat, I save for the weekend. I always seems to carry me over.

   In fact, every one of the 4 individuals interviewed saved their lunches at one time or another until supper not dinner. They would eat a little or none at all and save it for the evening meal so that they would have something for the evening even though all of them were in accordance with ideal that lunch (dinner) was the heaviest meal and dinner (supper) was one to be eaten lightly.

From their responses, it is evident that this group of individuals should no longer be regarded as a group to be forgotten. Despite their problems with mobility and health care needs, our elderly are continuing to live longer and some are greeting their "golden years" with fervor. The eldest deacon in the researcher's place of worship, 90, still walks a mile each day along with two sister's who are 75 and 79 years old in the community. The researcher's mother who turned 70 this year, still enjoys walking and cooking for the family. "I just can't sit around and do nothing," she scowls.

Despite their seemingly good-natured attitudes and fervor for life, there is still the question as to whether or not the clients of the Mobile Meals are receiving adequate nutrition after the noon meal. The noon meal, aside from a light breakfast, might have been the only nutritionally balanced meal they received. This concern will continue to surface when one hears and elderly say, " I just don't feel like eating anything today" or " I've been on this diet that the doctor has prescribed for me all this time and I still feel good. Why should I change now?" If the source of one's nutrients comes mainly from a piece of fruit and a cup of coffee, there is room for change.

CHAPTER V

SUMMARY

The purpose of this research was to gain a further insight of the Stillwater Mobile Meals program. Because of other programs of informal and formal support, nutritional programs are now fighting to effectively appeal to the growing older adult population. Does the Stillwater Mobile Meals program do such a thing?

CONCLUSIONS

It is evident that the services provided by the Mobile Meals program are beneficial to those in the elderly community. It is also evident that the Mobile Meals volunteer plays an integral part in providing this service. Daily, the researcher would be asked to "stay a little longer". The elderly is a population that is still regarded as poor and feeble despite advancements in medical research and breaks in medical costs.

RECOMMENDATIONS

By becoming an active volunteer in the Mobile Meals program, several recommendations could be inferred concerning a closer look at HACCP measures and encouraging participation and sponsorship.

Anyone may elect to receive mobile meals however when the destination is out of the time-alloted range of the driver, the optimum temperature for the cold and hot sides of the meal is compromised. Although the elderly community of Stillwater continues to grow, there are still those who are not fully aware of the program. The researcher is led to wonder if the present clients would have chosen to become clients if not referred by a doctor. Volunteering with the program would provide an excellent opportunity for

younger adults to tap into reservoir of knowledge which a Mobile Meals client has to offer.

FUTURE RECOMMENDATIONS

Concerning program usage among the Mobile Clients, it would be interesting to compare the responses to the survey statements of the PWB between those who had been with the program for two months and those who have been with the program for five or more years. A look into updated equipment which ensures keeping foods out of the danger zone should be fostered.

Because the program is a non-profit organization, it continually has to find ways to provide an efficient and effective service while remaining cost-conscious. Partnerships with local the local, radio, area television stations could foster awareness and encourage volunteer and sponsor participation.

It is very difficult to please every customer however incorporating innovative to prepared therapeutic diets while providing adequate nutrition could be researched by testing recipes from various sources, such as the American Dietetic Association suitable for therapeutic diets.

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APPENDIXES

APPENDIX A

PILOT STUDY QUESTIONNAIRE (PWB)

APPENDIX A

Please rate the following statements using the following choices: SA = Strongly Agree, A = Agree, N = Neutral, D = Disagree, SD = Strongly Disagree. We would like to ask you about your psychological and physical well-being. Please return the survey to **Mary Beth Ray** or **James Smith.** Thank you for your cooperation.

Psychological Well-Being

	SA 5	A 4	N 3	D 2	SD 1
1. Most of the time the only person who knows I'm alive is the Mobile Meals volunteer.	☐	☐	☐	☐	☐
2. I get excited about things that involve me and my community.	☐	☐	☐	☐	☐
3. I have no reason to live now that all my friends and loved ones are gone.	☐	☐	☐	☐	☐
4. I'm excited about living despite world events.	☐	☐	☐	☐	☐
5. My age seldom dictates how youthful I feel.	☐	☐	☐	☐	☐

Physical Well-Being

	SA 5	A 4	N 3	D 2	SD 1
1. Despite my age I am in good physical health.	☐	☐	☐	☐	☐
2. I am still hungry after eating a Mobile Meals lunch.	☐	☐	☐	☐	☐
3. Most of time I feel like eating my Mobile Meals lunch.	☐	☐	☐	☐	☐
4. Because of my aches and pains I seldom like to move around.	☐	☐	☐	☐	☐
5. I would say that I am mentally alert.	☐	☐	☐	☐	☐
6. I still attend OSU campus and/or community activities.	☐	☐	☐	☐	☐
7. I don't get out as much because I am afraid that I will fall or hurt myself.	☐	☐	☐	☐	☐

APPENDIX B

INTERVIEW QUESTIONS

APPENDIX B

QUESTION MAKE-UP FOR HOME INTERVIEW

Gender ___M ___F

Age _____

Marital Status: _____single _____married _____widowd

I. The Meal and Eating Habits

1. What constituted a balanced meal for you before you began receiving Mobile Meals?
2. How man times during the week did you eat a balanced Meal?
3. What reasons do you have for eating your meal in a particular setting? (the kitchen, the living room, the bedroom)

II. Mobile Meals

1. How did you hear about the Mobile Meals program?
2. How long have you been a client?
3. What do you enjoy most about the Mobile Meals program?
4. Are there any changes that you would like to see made in the Mobile Meals program?
5. Have you told anyone else about the Mobile Meals program?

APPENDIX C

CHARACTERISTICS OF THE MOBILE MEALS SURVEY RESPONDENTS

APPENDIX C

CHARACTERISTICS OF THE MOBILE MEAL SURVEY RESPONDENTS

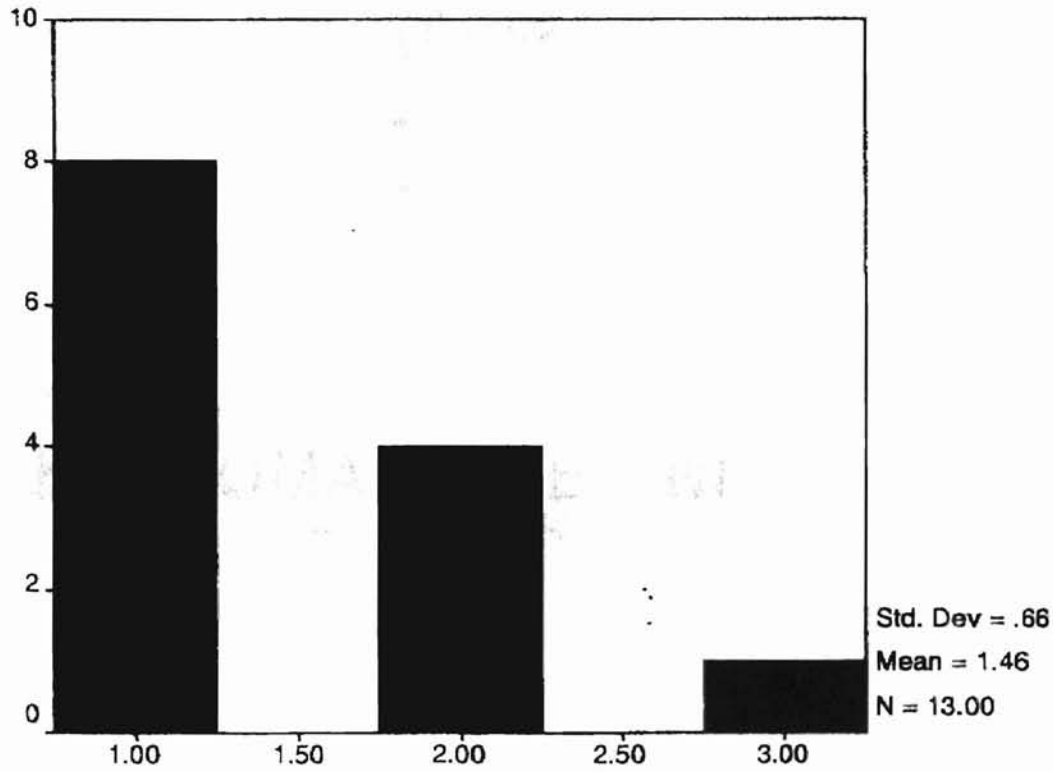
GENDER	AGE	MARITAL STATUS
F	92	Widowed
F	85	Widowed
M	76	Widowed
M	85	Widowed
M	57	Married
M	73	Married
F	71	Married
F	90	Widowed
F	85	Widowed
F	81	Widowed
F	97	Widowed
M	81	Widowed
M	84	Single
F	96	Widowed
F	85	Widowed

APPDENDIX D

RAW DATA: TABLES AND FIGURES

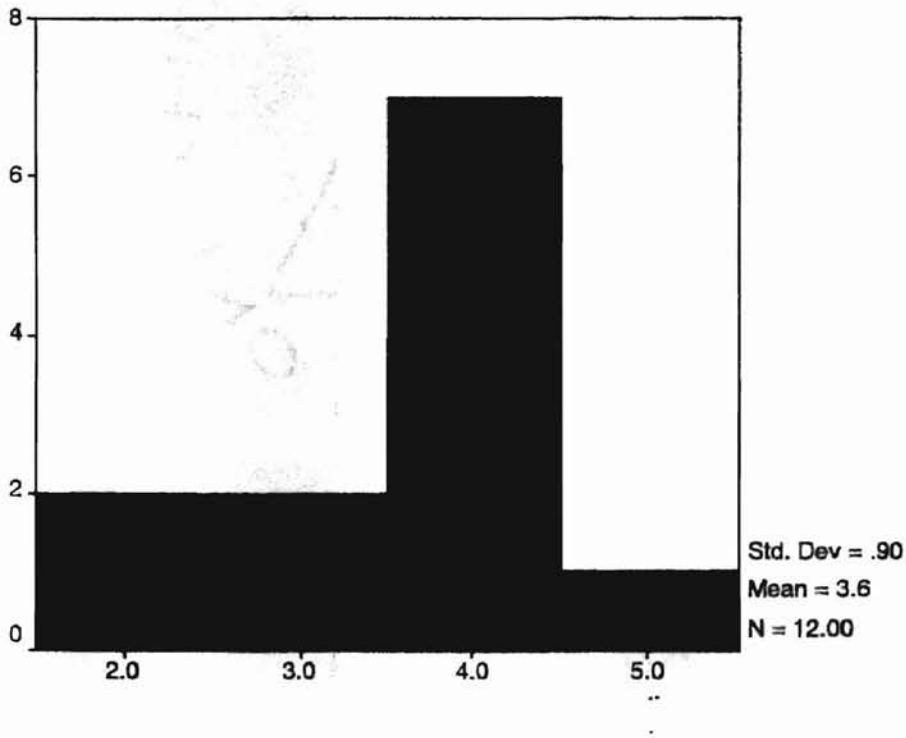
Most of the time the only person who knows I'm alive is the Mobile Meals volunteer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	8	57.1	61.5	61.5
	2.00	4	28.6	30.8	92.3
	3.00	1	7.1	7.7	100.0
	Total	13	92.9	100.0	
Missing	9.00	1	7.1		
Total		14	100.0		



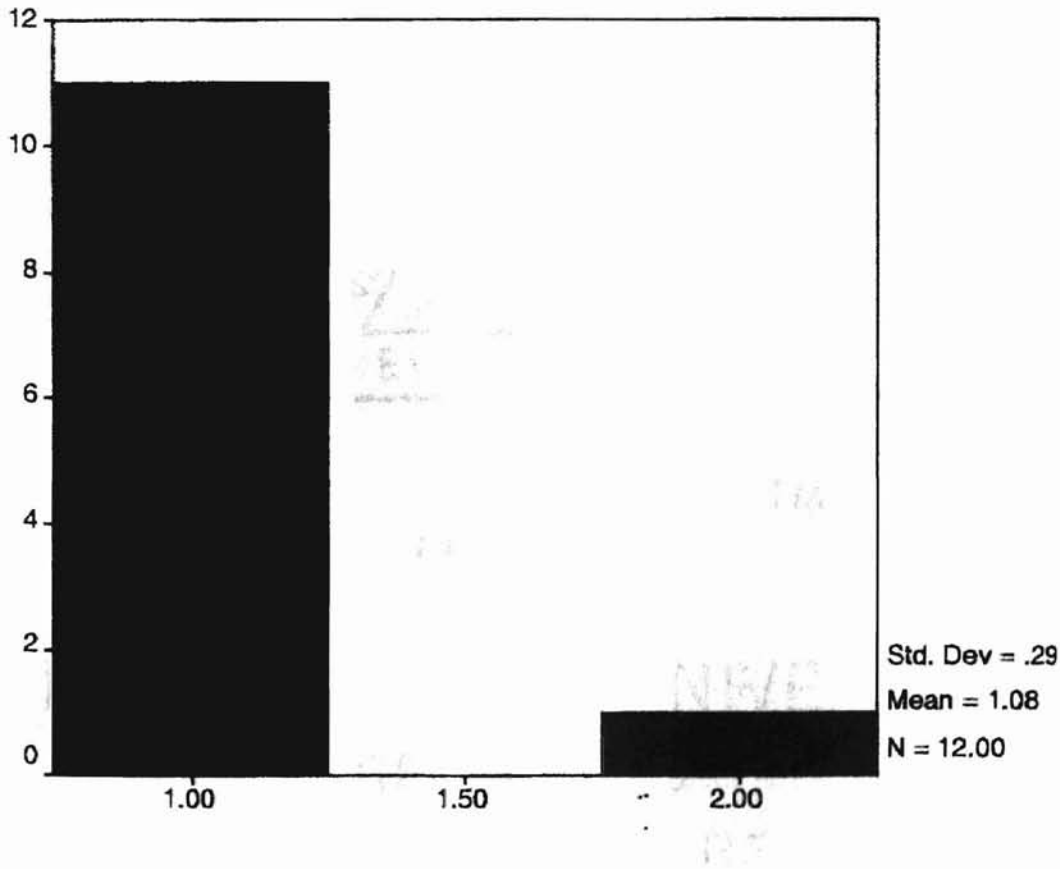
I get excited about me and my community

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2.00	2	14.3	16.7	16.7
	3.00	2	14.3	16.7	33.3
	4.00	7	50.0	58.3	91.7
	5.00	1	7.1	8.3	100.0
	Total	12	85.7	100.0	
Missing	9.00	2	14.3		
Total		14	100.0		



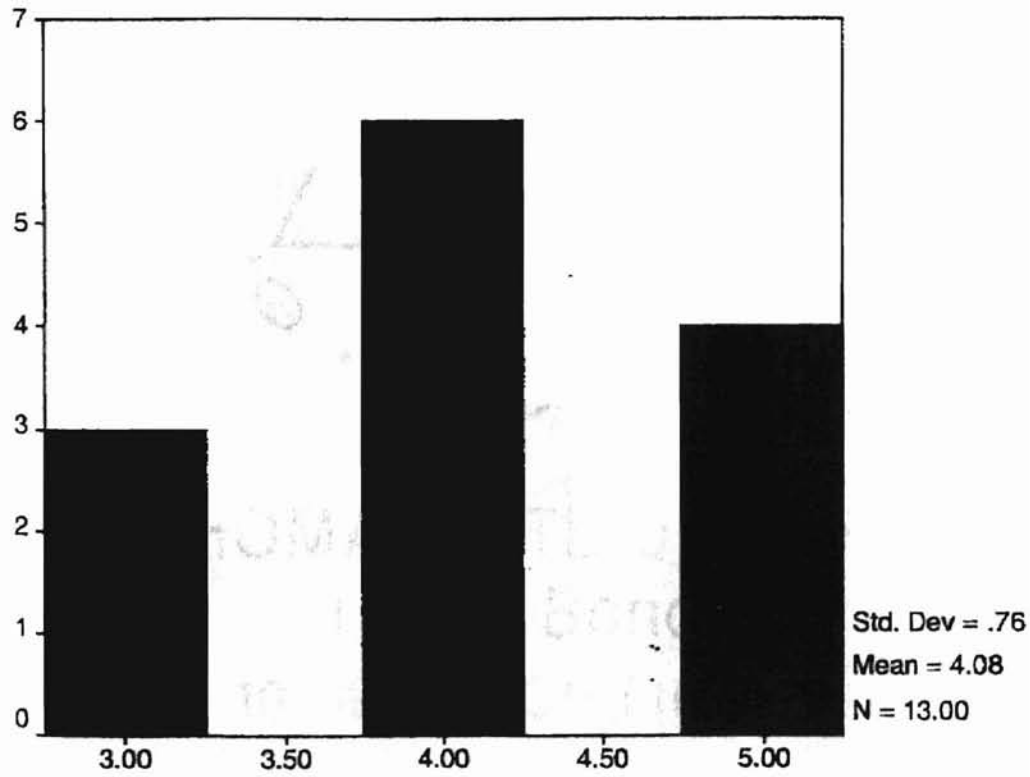
I have no reason to live now that all my friends and loved ones are gone

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	11	78.6	91.7	91.7
	2.00	1	7.1	8.3	100.0
	Total	12	85.7	100.0	
Missing	9.00	2	14.3		
Total		14	100.0		



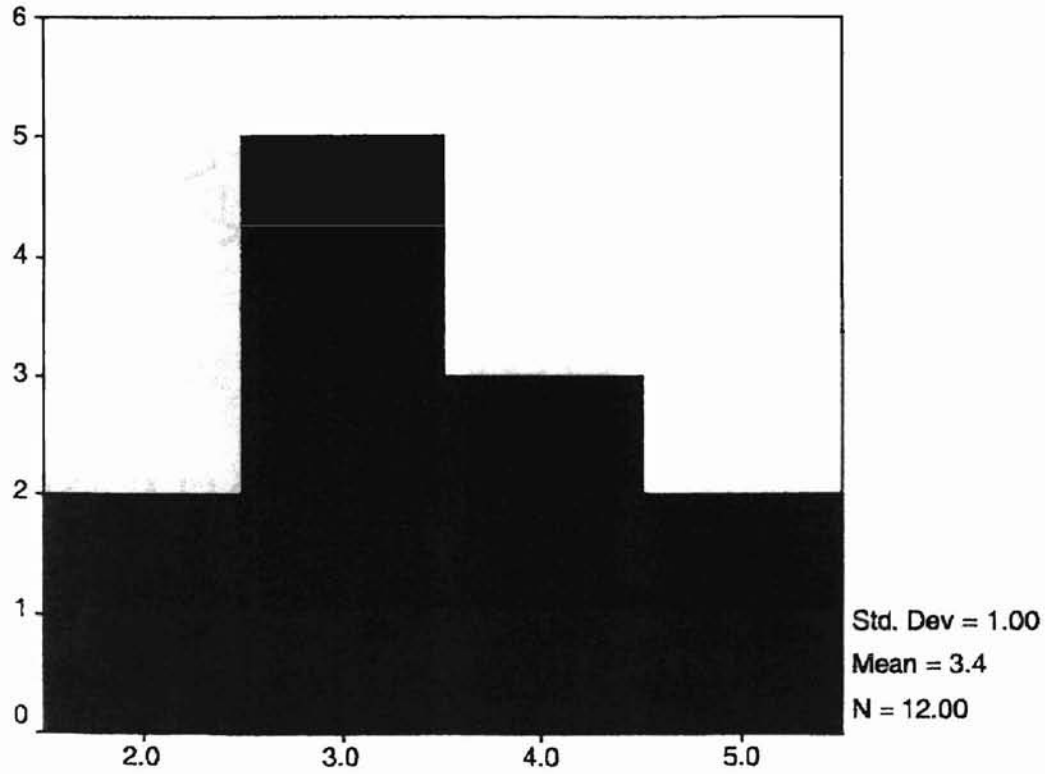
I'm axcited about living despite world events

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3.00	3	21.4	23.1	23.1
	4.00	6	42.9	46.2	69.2
	5.00	4	28.6	30.8	100.0
	Total	13	92.9	100.0	
Missing	9.00	1	7.1		
Total		14	100.0		



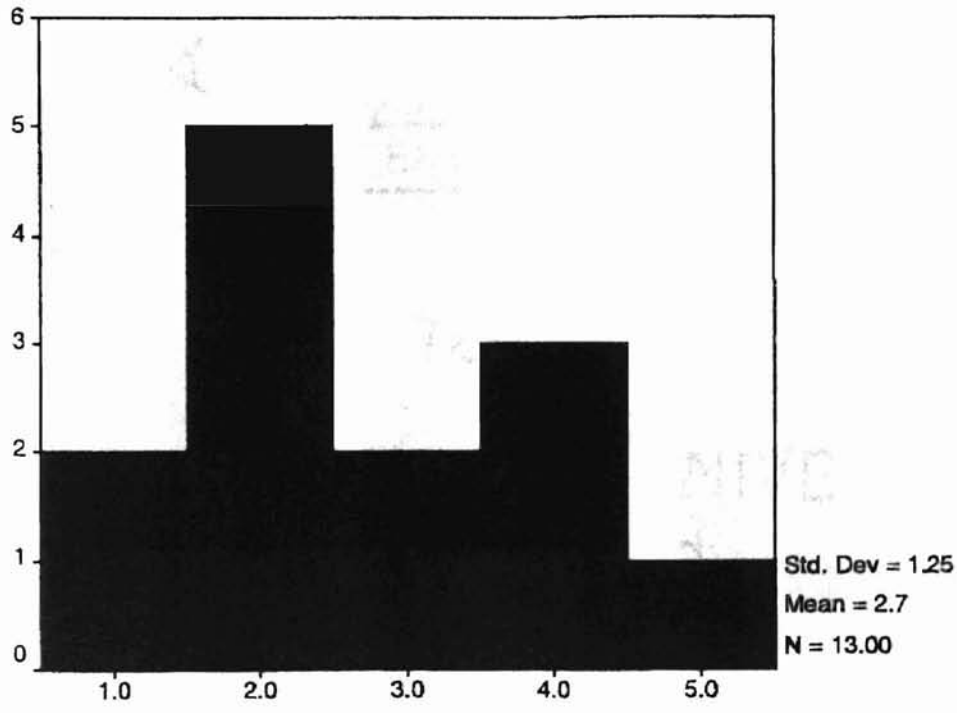
My age seldom dictates how youthful I feel

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2.00	2	14.3	16.7	16.7
	3.00	5	35.7	41.7	58.3
	4.00	3	21.4	25.0	83.3
	5.00	2	14.3	16.7	100.0
	Total	12	85.7	100.0	
Missing	9.00	2	14.3		
Total		14	100.0		



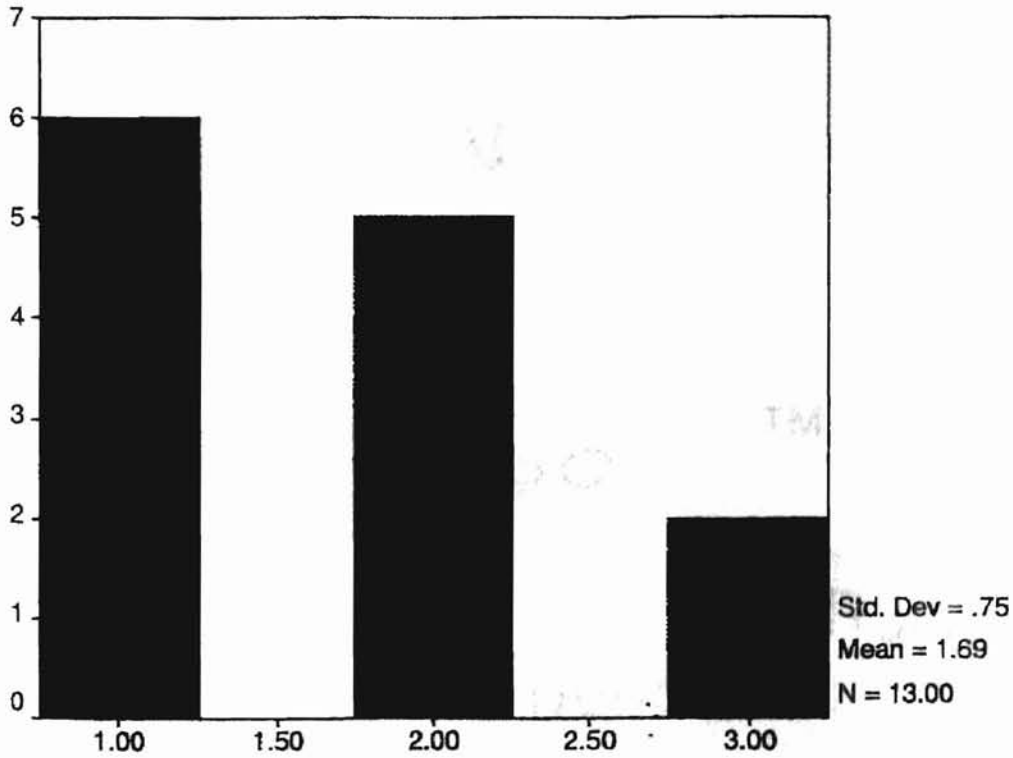
Despite my age I am in good physical health

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	2	14.3	15.4	15.4
	2.00	5	35.7	38.5	53.8
	3.00	2	14.3	15.4	69.2
	4.00	3	21.4	23.1	92.3
	5.00	1	7.1	7.7	100.0
	Total	13	92.9	100.0	
Missing	9.00	1	7.1		
Total		14	100.0		



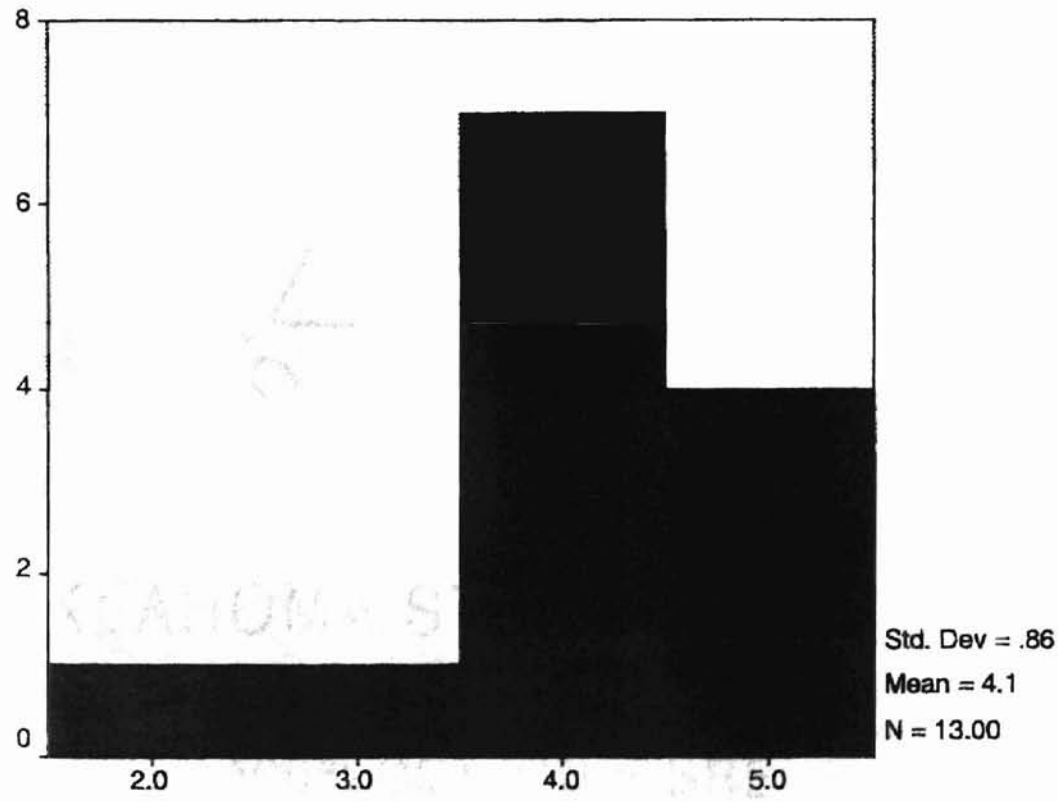
I am still hungry after eating a Mobile Meals lunch

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	6	42.9	46.2	46.2
	2.00	5	35.7	38.5	84.6
	3.00	2	14.3	15.4	100.0
	Total	13	92.9	100.0	
Missing	9.00	1	7.1		
Total		14	100.0		



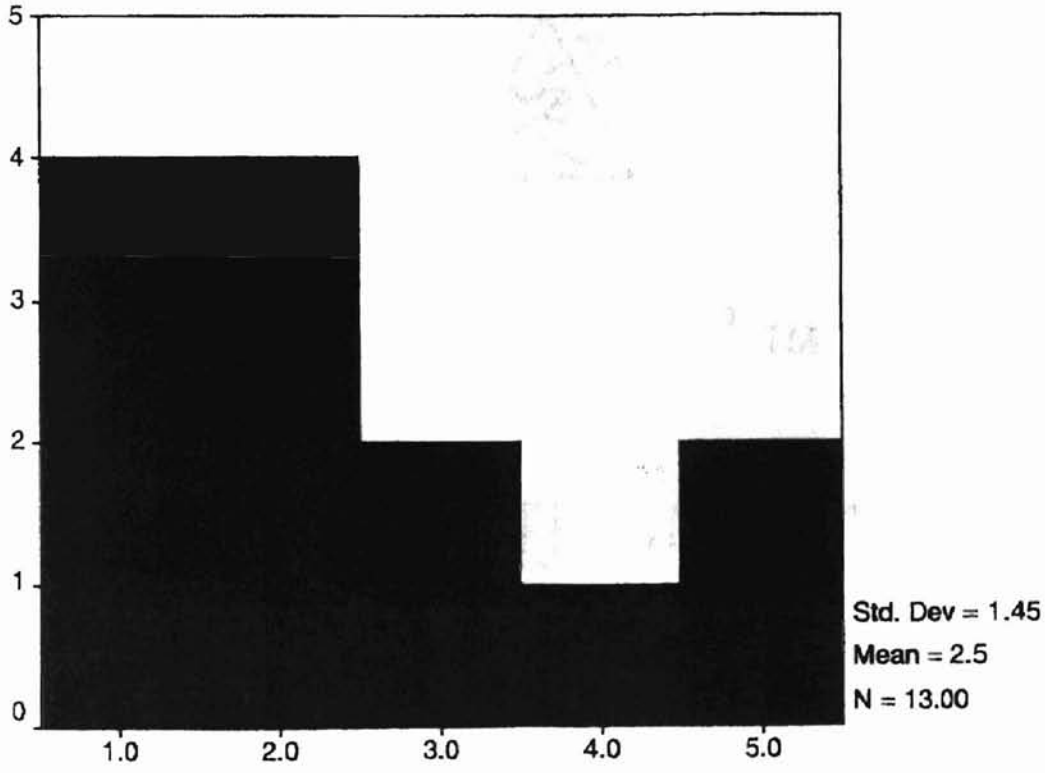
Most of the time I feel like eating my Mobile Meals lunch

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2.00	1	7.1	7.7	7.7
	3.00	1	7.1	7.7	15.4
	4.00	7	50.0	53.8	69.2
	5.00	4	28.6	30.8	100.0
	Total	13	92.9	100.0	
Missing	9.00	1	7.1		
Total		14	100.0		



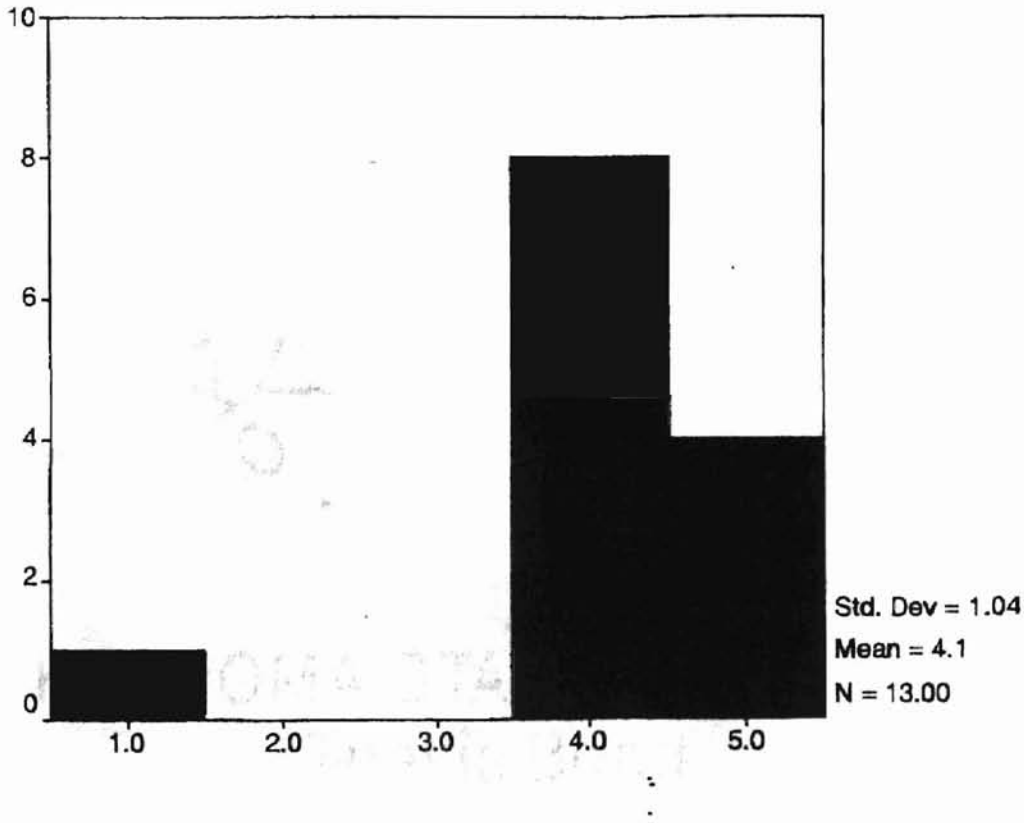
Because of my aches and pains I seldom like to move around

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	4	28.6	30.8	30.8
	2.00	4	28.6	30.8	61.5
	3.00	2	14.3	15.4	76.9
	4.00	1	7.1	7.7	84.6
	5.00	2	14.3	15.4	100.0
	Total	13	92.9	100.0	
Missing	9.00	1	7.1		
Total		14	100.0		



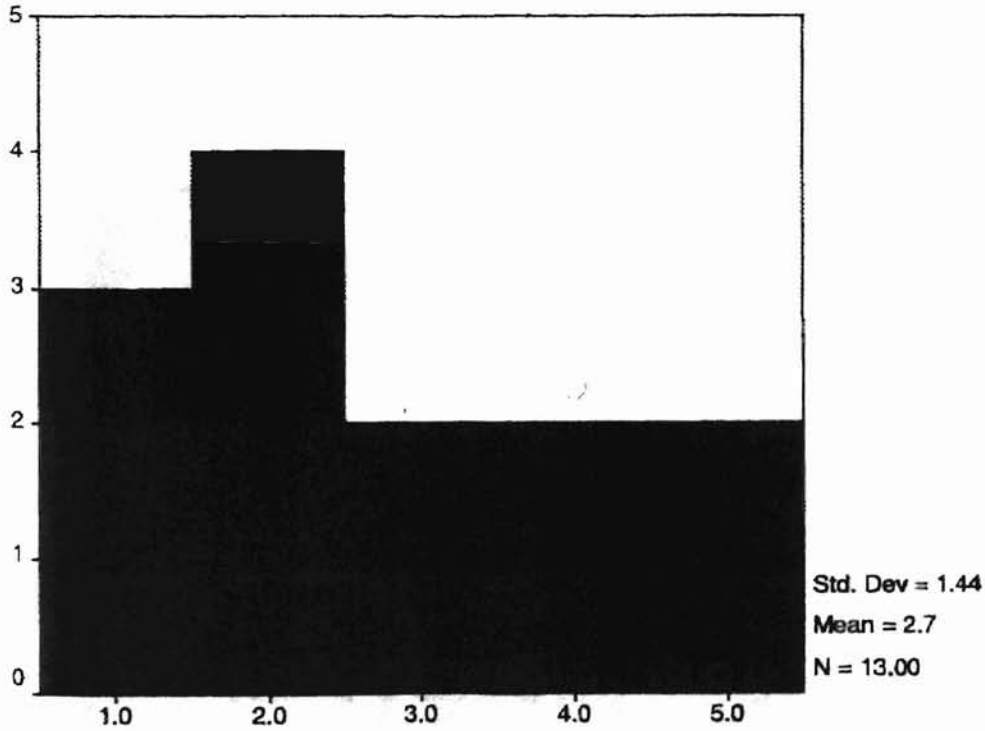
I would say that I am mentally alert

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	1	7.1	7.7	7.7
	4.00	8	57.1	61.5	69.2
	5.00	4	28.6	30.8	100.0
	Total	13	92.9	100.0	
Missing	9.00	1	7.1		
Total		14	100.0		



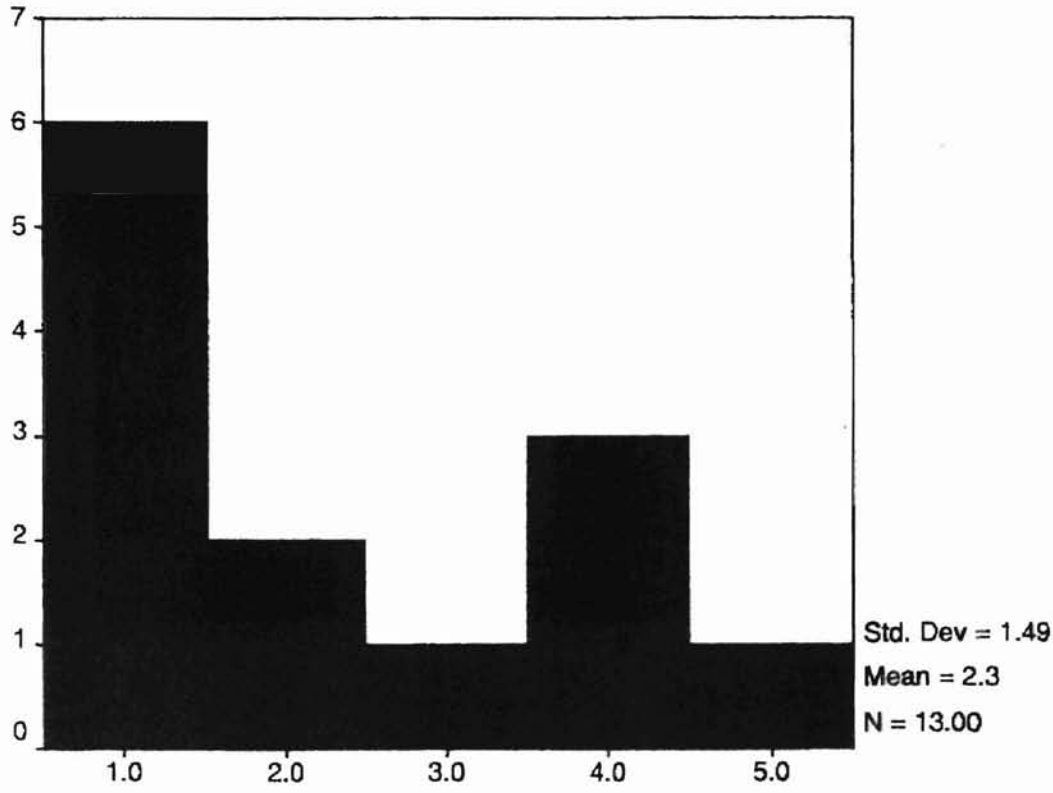
I still attend OSU campus and/or community activities

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	3	21.4	23.1	23.1
	2.00	4	28.6	30.8	53.8
	3.00	2	14.3	15.4	69.2
	4.00	2	14.3	15.4	84.6
	5.00	2	14.3	15.4	100.0
	Total	13	92.9	100.0	
Missing	9.00	1	7.1		
Total		14	100.0		



don't get out as much becuase I am afraid that I am afraid that I will fall or hurt myself

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	6	42.9	46.2	46.2
	2.00	2	14.3	15.4	61.5
	3.00	1	7.1	7.7	69.2
	4.00	3	21.4	23.1	92.3
	5.00	1	7.1	7.7	100.0
	Total	13	92.9	100.0	
Missing	9.00	1	7.1		
Total		14	100.0		



APPENDIX E

INSTITUTIONAL REVIEW BOARD APPROVAL FORM

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

Date: March 23, 2000 IRB #: HE-00-157

Proposal Title: "A PILOT STUDY: AN ASSESSMENT OF THE MOBILE MEALS PROGRAM OF STILLWATER, OKLAHOMA AND ITS EFFECTS ON THE PERCEIVED WELL-BEING OF THE ELDERLY"

Principal Investigator(s): Jerrold Leong, James Smith, Joseph Weber, Linda Martin

Reviewed and Processed as: Exempt

Approval Status Recommended by Reviewer(s): Approved

Signature: Carol Olson

Carol Olson, Director of University Research Compliance — March 23, 2000 (Date)

Approvals are valid for one calendar year, after which time a request for continuation must be submitted. Any modification to the research project approved by the IRB must be submitted for approval with the advisor's signature. The IRB office MUST be notified in writing when a project is complete. Approved projects are subject to monitoring by the IRB. Expedited and exempt projects may be reviewed by the full Institutional Review Board.

VITA

James Smith

Candidate for the Degree of

Master of Science

Thesis: A PILOT STUDY: AN ASSESSMENT OF THE MOBILE MEALS MEALS PROGRAM AND ITS EFFECT ON THE PERCEIVED WELL-BEING OF THE ELDERLY

Major Field: Hospitality Administration

Biographical:

Personal Data: Born in Shreveport, Louisiana, on January 3, 1967 the son of Lonnie Mae Smith of Shreveport, Louisiana.

Education: Graduated from Fair Park High School, Shreveport, Louisiana in May, 1985; received Bachelor of Science degree in Food Production Management from Grambling State University in December 1994. Completed the requirements for the Master of Science degree with a major in Hospitality Administration at Oklahoma State University in July, 2000

Experience: Operated 50-personnel dining facility as chief food specialist, Naval Weapons Stations, Earle, NJ and assistant cook on board The USS Trenton during Operation Solid Shield; Dietary Therapist for the 301st Medical Squadron, Carswell Air Force Base, Fort Worth, TX. Served as student manager for Grambling State University's Dinner Theater and Coordinator for Mission of Hope Fundraiser at Oklahoma State University. Elected as President of the Hospitality Administration Graduate Student Association at Oklahoma State University and graduate Teaching Assistant in the Department of Hospitality Administration at Oklahoma State University.

Professional Membership: Eta Sigma Delta Honor Society