

Thirty years of the Older Americans Nutrition Program

This month marks the 30th anniversary of the Older Americans Act Nutrition Program, the largest and most visible federally funded community-based nutrition program for older persons. It began in 1968 as a 3-year demonstration project and was officially established in 1972 when Congress enacted the National Nutrition Program for the Elderly as Title VII in the Older Americans Act (OAA). In 1978, it was consolidated under Title III (Title IIIC-1 Congregate nutrition services and Title IIIC-2 Home-delivered nutrition services), and Grants to Indian Tribes were added under Title VI. The program provides congregate and home-delivered meals, nutrition screening, education and counseling, and an array of other supportive and health services. While frequently called "meals-on-wheels," that term refers to home-delivered meals only.

This nutrition program is available to all individuals age 60 and over. However, it is targeted to those in greatest economic and/or social need, with particular attention paid to low-income minorities and rural individuals. To receive home-delivered meals, an individual must be assessed to be homebound or otherwise

isolated. Because OAA services are not means-tested, the nutrition program is a primary source of support for many older adults who would not receive services under other income-based programs. Indeed, it is the chief service system for individuals who may be slightly over the poverty line.

The nutrition program is administered by the US Department of Health and Human Services Administration on Aging, through an "aging network" that includes 57 state units on aging, 655 area agencies on aging, thousands of local providers under Title III, and 233 tribes and tribal organizations of American Indian and Alaskan Natives and 2 organizations of Native Hawaiians under Title VI.

Historically, almost half of the OAA annual budget has supported the nutrition program. In 1975, the appropriation was about \$125 million, or 49% of total OAA funds. Of the 48.5 million meals served in 1975, home-delivered meals (HDMs) were limited to approximately 10% of the total. In 2002, the appropriation is \$592.2 million, or 54% of the \$1.1 billion budget. Today, about 250 million congregate and HDMs are served to approximately 2.6 million older adults annually. Home-delivered meals have grown to 54% of all meals served, and at least 41% of programs have waiting lists for them (1).

The OAA funds 44% of the cost of congregate and 30% of the cost of HDM services. These federal funds are highly leveraged by state and local monies and services. In addition, the US Department of Agriculture Nutrition Services Incentive Program provides \$150 million in financial support and commodities. Participants themselves contribute 20% toward the cost of congregate and home-

delivered meals. The average cost of a Title III meal, including donated labor and supplies, was \$5.17 (congregate) and \$5.31 (home-delivered). For Title VI, comparable costs were \$6.19 and \$7.18, respectively (1,2).

AN INTEGRAL PART OF HOME- AND COMMUNITY-BASED CARE SYSTEMS

With the aging of the US population, federal, state, tribal, and local public and private agencies are increasing health and related services in the community to promote successful aging (ie, maintain cognitive and physical functioning, prevent or delay chronic disease and disease-related disabilities, and maintain active social engagement with life) (3). For the past 30 years, the OAA Nutrition Program has been an integral component of a comprehensive and coordinated system of home- and community-based services (HCBC) (eg, transportation, health screenings, wellness and fitness programs, in-home services) that did not exist before the OAA was enacted. Previously, only limited social and nutrition services were available through federal programs.

Today, the nutrition program is closely linked to HCBC systems through cross-referrals and the coordination of service delivery by the aging network. Since older adults are being discharged earlier from hospitals and nursing homes, many require a plan of care that includes HDMs and other nutrition services (eg, nutrition screening, assessment, education, counseling, and care planning). Many states are enrolling Medicaid beneficiaries in HMOs, using Medicaid HCBC waivers, and creating state-funded programs to provide necessary HCBC medical, so-

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cial, and supportive services including home-delivered meals and nutrition education and counseling services (4,5).

Interestingly, the original OAA language (Public Law 92-258, sec 701) emphasized the multiple causes of nutritional risk in later years:

Many elderly persons do not eat adequately because (1) they cannot afford to do so; (2) they lack the skills to select and prepare nourishing and well-balanced meals; (3) they have limited mobility which may impair their capacity to shop and cook for themselves; and (4) they have feelings of rejection and loneliness which obliterates the incentive necessary to prepare and eat a meal alone. These and other physiological, psychological, social and economic changes that occur with aging result in a pattern of living which causes malnutrition and further physical and mental deterioration... there is an acute need for national policy which provides older Americans, particularly those with low-incomes, with low-cost, nutritionally sound meals served in strategically located centers such as schools, churches, community centers, senior centers, and other public or private nonprofit institutions where they can obtain other social and rehabilitative services. Besides promoting better health among the older segment of our population through improved nutrition, such a program would reduce the isolation of older age, offering older Americans an opportunity to live their remaining years in dignity.

Thus, the original purposes of the nutrition program were never limited to simply providing a meal, but were always envisioned as providing "more than a meal" and are as applicable today as when the original legislation was passed. Those purposes are: decreasing malnutrition, preventing physical and mental deterioration, promoting health, reducing social isolation, linking older adults to social and rehabilitative services, and providing low-cost, nutritionally sound meals.

At congregate sites, the nutrition program is a foundation service that provides access and linkages to other community-based services. It is the primary

source of food and nutrients for many program participants and it presents opportunities for active social engagement and meaningful volunteer roles. Home-delivered meals are among the most critical and necessary in-home services provided to vulnerable older adults. Such services may be even more critical for the homebound, who are usually older, poorer, more likely to be women, are significantly functionally impaired and usually have several chronic illnesses or disabling conditions that may be managed by nutrition interventions (1,2).

PROGRAM SERVES THE NEEDY, HOMEBOUND

Because inadequate nutrient intake affects approximately 37%–40% of community-dwelling individuals 65 years of age and older (5), the OAA Nutrition Program is important in reaching the *Healthy People 2010* goals, which are to improve the quality and years of life and to reduce health disparities that exist because of differences in gender, race or ethnicity, income or education, disability, or living location (6). Substantial disparities in cause of death exist among racial and ethnic groups and between genders (7). The OAA Nutrition Program successfully targets individuals at nutritional risk, including those who are of advanced age, of poor income status, and live alone, as well as racial/ethnic minorities (1,2). About 25% of participants are minorities—almost twice the national percentage of minority adults over age 60 (1).

The need for and the success of the OAA Nutrition Program is based on scientific evidence that indicates adequate nutrition is necessary to maintain cognitive and physical functioning; to prevent, reduce, and manage chronic disease and disease-related disabilities; and to sustain health and quality of life (3,8). Millions of older adults lack access to adequate amounts of quality food necessary to sustain health and decrease the risk of disability. Providing meals helps older adults maintain their health (9) and minimize their out-of-pocket food expenses so they can purchase other necessities such as medications, utilities, and shelter. The nutrition program provides an opportunity to implement interventions that address obesity and chronic diseases such as diabetes, heart disease, stroke, hypertension, osteoporosis, osteoarthritis, cancer, and hypercholesterolemia through healthy meals, nutrition education and counseling, and

access to physical activity and wellness programs.

The *National Evaluation of the Elderly Nutrition Program 1993-1995* found that 64% of congregate and 88% of homebound participants are at moderate to high nutritional risk, using an approximation of the *Nutrition Screening Initiative Checklist* (1). Approximately two-thirds of the participants were either under- or overweight, placing them at increased risk for nutritional and health problems. More than 50% of participants usually ate alone and about 25% ate fewer than 3 meals per day. One in three had an illness/condition that required a special diet. Forty-one percent of the homebound could not prepare meals. Approximately 25% of the congregate group and more than 75% of the homebound group have difficulty doing everyday tasks (1). About 50% of persons over 60 years consume less than 1 serving of dairy products and about 33% eat less than 1 serving of fruit daily (10). Participation in the nutrition program may improve intake of these food groups.

PROGRAM EFFECTIVENESS

The OAA Nutrition Program has not received the research and evaluation attention a program its size deserves. The most recent *National Evaluation* showed the positive impact of the nutrition program. Participants had higher daily intakes of key nutrients than similar nonparticipants. The nutrient-dense meals provided high ratios of key nutrients to calories. Each meal supplied more than 33% of the 1989 RDAs (an OAA requirement) and provided 40%–50% of daily intakes of most nutrients (1,2). Women in the congregate program had mean intakes of energy and nutrients that generally exceeded those over 60 in the US population (1). Sodium, total fat, and cholesterol intakes reflected the *Dietary Guidelines* (1,2).

Other studies show that the meals improve the nutritional status of the homebound (11-13), minorities (14), and persons with diabetes (15). Participants who ate at the congregate program 3 or more days per week thought the meal was better than what they would eat elsewhere and ate more food at the congregate site than at home (16). Although national data showed that 10%–16% of participants reported one or more circumstances of food insecurity during the past month (1), New York participants had fewer days without enough or any food than those on waiting lists and also

ate more foods recommended in the *Dietary Guidelines* than nonparticipants (17). Homebound New York participants were hospitalized less frequently than those on waiting lists (17). They had shorter lengths of stay and reduced hospital costs, possibly due to improved immunity in these chronically ill older adults (18). A pilot project suggested that home-delivered nutrient-dense meals may promote healthy serum albumin levels and reduce the risk of rehospitalization (19). One study showed the positive social significance of food and eating in the lives of participants (20).

THE FUTURE

The number of older adults will double to some 70 million in 2030, reflecting an increase from 12.4% today to 20% of the US population in 2030. Minorities will account for 25.4% of the older population in 2030, up from 16.4% today (21). The changing demographics suggest greater and different demands for nutrition program services, particularly for the homebound. Service expansion must include providing culturally and ethnically appropriate services, greater attention to customer wants, more options or choices in meals, more than one meal a day, weekend meals, and modified and therapeutic diets. Customizing services will require individualized care planning, including nutrition therapy. Hence, more dietitians will be needed to provide primary, secondary, and tertiary prevention services in people's later years (22).

The future for OAA Nutrition Programs is to become full-service community programs rather than meal programs. They will be expected to offer more varied and improved services to fill gaps in health care and social services, particularly in rural areas and inner cities. Broadening the service base to include more full-pay clients can expand service options and improve quality and customer satisfaction. The program may also need to increase its focus on supporting caregivers, who are now recognized to be at increased nutrition and health risk (23). Access to transportation and shopping assistance, wellness and exercise programs, medical and case management, and respite care and caregiver support, are essential to maintaining independence at home—a common goal of all persons.

To continue or expand such services, including nutrition services, requires more money and other resources. Today's economic downtrend threatens program

funding at all levels. Other funding sources for nutrition therapy, such as Medicaid waivers for home and community-based care (24), Medicare coverage of nutrition therapy for all nutrition-related conditions (5), and private insurance, must be tapped. More applied research in home and community-based nutrition programs will show the value of investing additional resources in nutrition in later years.

Today's shortage of dietitians in the aging network, as well as in adult day care, nursing and assisted living facilities, and home health care, must be remedied if the profession is to do its part in helping Americans age successfully. The OAA Nutrition Program will continue to address the challenges of enhancing health, functionality, and quality of life, while helping avoid unnecessary and costly institutionalization. Dietitians are invited to join the campaign for successful aging by promoting better nutrition in later years.

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