Position of the American Dietetic Association, American Society for Nutrition, and Society for Nutrition Education: Food and Nutrition Programs for Community-Residing Older Adults

ABSTRACT
Given the federal cost-containment policy to rebalance long-term care away from nursing homes to home- and community-based services, it is the position of the American Dietetic Association, the American Society for Nutrition, and the Society for Nutrition Education that all older adults should have access to food and nutrition programs that ensure the availability of safe, adequate food to promote optimal nutritional status. Appropriate food and nutrition programs include adequately funded food assistance and meal programs, nutrition education, screening, assessment, counseling, therapy, monitoring, evaluation, and outcomes documentation to ensure more healthful aging. The growing number of older adults, the health care focus on prevention, and the global economic situation accentuate the fundamental need for these programs. Yet far too often food and nutrition programs are disregarded or taken for granted. Growing older generally increases nutritional risk. Illnesses and chronic diseases; physical, cognitive, and social challenges; racial, ethnic, and linguistic differences; and low socioeconomic status can further complicate a situation. The beneficial effects of nutrition for health promotion, risk reduction, and disease management need emphasis. Although many older adults are enjoying longer and more healthful lives in their own homes, others, especially those with health disparities and poor nutritional status, would benefit from greater access to food and nutrition programs and services. Food and nutrition practitioners can play a major role in promoting universal access and integrating food and nutrition programs and nutrition services into home- and community-based services.


POSITION STATEMENT
Given the federal cost-containment policy to rebalance long-term care away from nursing homes to home- and community-based services, it is the position of the American Dietetic Association, the American Society for Nutrition, and the Society for Nutrition Education that all older adults should have access to food and nutrition programs that ensure the availability of safe, adequate food to promote optimal nutritional status. Appropriate food and nutrition programs include adequately funded food assistance and meal programs, nutrition education, screening, assessment, counseling, therapy, monitoring, evaluation, and outcomes documentation to ensure more healthful aging. The growing number of older adults, the health care focus on prevention, and the global economic situation accentuate the fundamental need for these programs.

For 60 years, the United Nation's Universal Declaration of Human Rights (1) has had an enduring relevance. In Article 25.1, this document states:

“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”

Greater attention to older persons in food assistance programs, food safety initiatives, health-promoting nutrition education and intervention services, as well as nursing home diversion and transition programs, will help improve nutritional status and successful aging (2). Of particular concern are the widespread under-recognition of the importance of nutrition for more healthful aging and the historic underfunding of some programs. Diet quality and quantity play major roles in preventing, delaying onset, and managing chronic diseases associated with aging (3). Escalating health care costs are largely related to chronic diseases in which nutrition interventions have proven effective. About 87% of older adults have diabetes, hypertension, dyslipidemia, or a combination of these chronic diseases (3). These costly conditions, as well as their roles as predisposing factors for nursing home placement, may be ameliorated with appropriate nutrition services.

Since the mid-1970s, funding has not kept pace with inflation and the dramatic growth in aging populations. Shifting federal and state funding...
priorities, especially in recessionary times, regularly threaten eligibility criteria and service availability. To maximize older adult participation in such programs, special consideration is needed to address the diverse reasons for nonparticipation (ie, benefit underestimation, welfare stigma, burdensome application processes, and lack of outreach and program awareness, as well as confusing eligibility requirements).

The 37 million US residents aged 65 years and older account for 12.6% of the total population. They are living longer and growing in absolute numbers, with those aged 85 years and older the fastest-growing segment (4). Projections for 2030 estimate an increase to 72 million or 20% of the population (4,5). The American Dietetic Association position paper on nutrition across the spectrum of aging details the importance of nutrition for successful aging, including relationships to health and disease (6). This position paper focuses on access to safe and adequate food in communities.

Health care costs are a major consideration today. Food assistance programs may help reduce these costs by helping people stay in their homes. The cost of 1 day in a hospital equals the cost of 1 year of Older Americans Act Nutrition Program meals, based on 2007 reported total expenditures and number of home-delivered meals provided by states (7). Although skilled nursing facilities provide comprehensive health care services beyond a noon meal, it is interesting to note that the cost of 1 month in a nursing home equals that of providing mid-day meals 5 days a week for about 7 years (8). On average, Medicaid can support three older adults and adults with disabilities in home- and community-based settings for every person in a nursing facility (9).

Enabling older adults to remain at home is public policy at federal and state levels and home- and community-based care is replacing institutional care (10). The federal government established the Home- and Community-Based Service (HCBS) waiver program under Section 1915(c) of the Social Security Act. While HCBS may include home-delivered meals and nutrition counseling, only 29 states have chosen to do so as part of the Medicaid waiver program. With 95% of health care spending for those aged 65 years and older attributable to chronic conditions (11), an opportunity exists to expand the benefits of health promotion programs to them. Evidence-based health promotion programs show cost savings (12). The American Dietetic Association position on health promotion and disease prevention identifies primary prevention as the most cost-effective course of action for preventing and reducing risk for chronic disease throughout the life cycle (13). There is evidence that older adults benefit from health promotion and nutrition education (14). Food and nutrition practitioners need to advocate for funding and expansion of nutrition services for older adults in community programs and policy initiatives.

Those working with older adults often do not understand the effect of adequate food and nutrition on older adults’ ability to remain at home with a good quality of life. Food and nutrition programs for children and adolescents have improved dietary intakes, reduced low-birth-weight incidence, and provided useful information to families at risk (15). Their success is attributable in part to increases in funding over time. This has enabled programs to keep pace with increased demand, evolve appropriately to meet diverse nutrition needs, and evaluate effectiveness at achieving outcomes. The same funding support is needed for food and nutrition programs for older adults.

With limited information on food insecurity of older adults in other position papers (6,16), this paper addresses issues related to food insecurity, hunger, and malnutrition as well as food and nutrition programs serving older adults in community settings.

PREVALENCE OF FOOD INSECURITY, HUNGER, AND MALNUTRITION

The US Department of Agriculture (USDA) describes the degree of food security in the United States as high, marginal, low, or very low. There is no mention of hunger and its association with food insecurity (17). However, the Institute of Medicine clearly makes a distinction between hunger and food insecurity (18):

“... hunger should refer to a potential consequence of food insecurity that, because of a prolonged, involuntary lack of food due to lack of economic resources, results in discomfort, illness, weakness, or pain that goes beyond the usual uneasy sensation.”

The Institute of Medicine suggests research to find an appropriate national assessment of the hunger of individuals rather than the hunger of households.

Food Insecurity

Nearly 10% of older adults live below poverty and 26% are considered low-income (4,19). The lowest quintile annual income is $11,519, including 8% from public assistance. With 32% of income going to housing, 17% to transportation, 13% to food, and 11% to health care, it is understandable that the poorest of the oldest have inadequate means to meet their food and nutrition needs (4). Their decreased earning potential and lack of access to food leaves the already vulnerable at increased risk (20). Those experiencing food insecurity have lower intakes of micronutrients and energy, more health problems, and functional limitations related to loss of independence (21). Marginal food insecurity is equivalent to being 14 years older (22).

About 11% of all older Americans are marginally food insecure, 6% are food insecure, and 2% are very low food secure. This translates into about 2.5 million at risk for hunger and about 750,000 suffering from hunger due to financial constraints (21). Nearly 28% of households in the lowest economic group (incomes ≤130% of poverty guidelines) experience low or very low food security. The 35% of food insecure older adults with incomes >130% of poverty guidelines are ineligible for some food and nutrition assistance programs (21). Based on the Healthy Eating Index (23), 83% of older adults do not consume a good quality diet and those in poverty have lower scores than those not in poverty.

Many factors affect food insecurity in older adults. Those most likely at-risk of hunger are those aged 60 years and older, living at or below poverty, high school drop outs, African Americans or Hispanics, divorced or separated or living with a grandchild, and renters (21). Living alone is associ-
are for 34% higher Medicare costs for obese vs nonobese older adults (33). Relationships between BMI and mortality form a U-shaped graphic distribution, with the greatest risk for poor functional outcomes at the lowest and highest BMIs (34).

Older adults eating convenient low-nutrient-dense foods have higher energy and lower nutrient intakes (35). One explanation for the greater prevalence of obesity in low-income households is that less-expensive foods (typically energy-dense, nutrient-poor) are more commonly eaten. Access to healthful foods is limited in poorer neighborhoods because stores are less likely to carry nutritious foods (36) and those for special dietary needs. In addition, physical disability, transportation problems, and limited finances contribute to food insecurity and lower nutrient intake (20,21). Caregivers’ role in ensuring adequate intakes of nutrient dense foods is crucial (37). Obesity and physical limitations may lead to earlier nursing home admissions (38).

Sarcopenia, the age-related loss of skeletal muscle mass, is most often associated with underweight. But sarcopenic obesity can be more severe as muscle loss may be greater due to immobility in addition to increasing age (39). In both weight situations, sarcopenia affects strength and accelerates functional decline.

Polypharmacy increases the risk for malnutrition. Many medications directly affect food intake due to side effects. Food–drug interactions can be problematic for those taking vitamins, minerals, and other supplements with medications (40). Some medications also increase the need for specific nutrients.

Problems in the oral cavity are a nutrition risk indicator. Declining weight and subsequent increased morbidity and mortality can result from periodontal disease and other oral problems. Effective screening, education, and intervention programs can enable older adults to maintain their health, enjoy food, and have a higher quality of life (41).

Functionality has a direct effect on food security, diet quality, weight status, and ultimately independence and nursing home placement. Inability to do physical tasks necessary for shopping and food preparation increases the likelihood of inadequate food intake. These functional limitations affect 42% of people aged 65 years and older (4). Older adults’ independence may progressively decline as measured by diminished abilities in activities of daily living or instrumental activities of daily living (34).

Psychosocial issues and mental and cognitive impairment can lead to undertreatment, overnutrition, food insecurity, and dependence. Depression due to social isolation, financial difficulties, loss of autonomy, or impaired cognition is common and often leads to a loss of motivation to eat or to eat unhealthful meals (42). Treatment of depression is one of the most effective means of achieving weight improvement in older adults with anorexia (42). Decreased food intake and associated weight loss can also result from bereavement of a spouse, alcoholism, late-life paranoia or mania, abuse, pain, use of multiple medications, and even nursing home admission (43).

Malnutrition and chronic illnesses can depress the immune system and increase susceptibility to infection and foodborne illness. Unsafe food handling contributes to infirmity in older adults. Compared to younger adults, mortality rates are higher for older adults who come in contact with Listeria monocytogenes, particularly when immune function is impaired (31). Invasive Salmonella infections cause the highest hospitalization and death rate among older adults (31). Those living in their own homes are also at risk for foodborne illnesses as 13% admit to not washing their hands or cutting boards after touching raw meats, with men and individuals living alone having significantly worse food-handling skills (31).

**OVERVIEW OF FOOD AND NUTRITION PROGRAMS FOR OLDER ADULTS**

The Figure summarizes current features and funding levels of federal food and nutrition assistance programs. Each program is further described below.

**US Department of Health and Human Services**

The Older Americans Act (OAA) Nutrition Program. The purpose of the OAA is:

> “…to reduce hunger and food insecurity; to promote socialization of older individuals; and to promote the..."
<table>
<thead>
<tr>
<th>Program</th>
<th>Purpose</th>
<th>Appropriation</th>
<th>Target population</th>
<th>Services</th>
<th>Eligibility</th>
<th>Eligible older adults served</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>US Department of Health and Human Services—Administration on Aging</strong>&lt;br&gt;Older Americans Act&lt;br&gt;Titles I-VII</td>
<td>Grants to state, tribal, and community programs on aging (eg, research, demonstration projects)</td>
<td>$1.49 billion total Fiscal Year (FY) 2009</td>
<td>Age ≥60 y in greatest economic and/or social need, with particular attention to low-income minorities, those in rural areas, those with limited English proficiency</td>
<td>Nutrition, array of other supportive and health services, protection of vulnerable older Americans</td>
<td>Age is sole requirement (see also Target population column)</td>
<td>18.5%</td>
</tr>
<tr>
<td><strong>Older Americans Act&lt;br&gt;Titles I-VII</strong></td>
<td>Nutrition services to older adults</td>
<td>$649 million FY 2009</td>
<td>Age ≥60 y; age ≥60 y and disabled living in elderly housing, disabled living at home and eating at congregate sites or receive home delivered meals with older adults, volunteers during meal hours</td>
<td>Congregate and home-delivered meals; nutrition screening, assessment, education, counseling</td>
<td>Same as above but only homebound eligible for home-delivered meals</td>
<td>5.1% of all eligible older adults</td>
</tr>
<tr>
<td><strong>Older Americans Act&lt;br&gt;Titles I-VII</strong></td>
<td>Tribal and native organizations for aging programs and services</td>
<td>$36 million FY 2009</td>
<td>Age requirement determined by Tribal organizations or Native Hawaiian Program</td>
<td>Congregate and home-delivered meals; nutrition screening, education, counseling; array of other supportive and health services</td>
<td>Age is sole requirement Not available</td>
<td>Not available</td>
</tr>
<tr>
<td><strong>Nutrition Services Incentive Program</strong></td>
<td>Provides proportional share to states and tribes of annual appropriation based on number of meals served prior year</td>
<td>$161 million FY 2009</td>
<td>Same as Title III</td>
<td>Cash and/or commodities to supplement meals</td>
<td>Same as Title III Not available</td>
<td>Not available</td>
</tr>
<tr>
<td><strong>US Department of Agriculture—Food and Nutrition Service</strong>&lt;br&gt;Supplemental Nutrition Assistance Program</td>
<td>Assists low income families to buy food that is nutritionally adequate</td>
<td>$40 billion FY 2008</td>
<td>US citizens and legal residents who are most in need, gross income ≤130% federal poverty level; up to $2,000 countable resources, $3,000 if age 60 y or disabled</td>
<td>Coupons or electronic benefits to purchase breads, cereals, fruits, vegetables, meats, fish, poultry, dairy products; Seeds and plants that produce food for households</td>
<td>≥130% of the federal poverty guidelines</td>
<td>30% of eligible older adults participate; 75% of these live alone. 8% of all Supplemental Nutrition Assistance Program participants are older adults</td>
</tr>
<tr>
<td><strong>Commodity Supplemental Food Program</strong></td>
<td>Food and administrative funds to states and tribes to supplement diets. Available in 33 states and two tribes</td>
<td>$140 million FY 2008</td>
<td>Pregnant and breastfeeding women, mothers up to 1-y postpartum, infants, children up to age 6 y</td>
<td>Participants receive a monthly food package</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td><strong>Seniors’ Farmers Market Nutrition Program</strong></td>
<td>Grants to states and tribes to provide fresh foods and nutrition services while providing the opportunity for farmers to enhance their business</td>
<td>$20 million FY 2008</td>
<td>Low income older adults: at least aged 60 y and who have household incomes of not more than 185% federal poverty</td>
<td>Coupons or vouchers to be exchanged for fresh fruits and vegetables at local farmers markets</td>
<td>≤185% federal poverty guidelines</td>
<td>Not available</td>
</tr>
<tr>
<td><strong>Child and Adult Care Food Program</strong></td>
<td>Healthy, Nutritious meals for children and adults in day centers</td>
<td>$2.4 billion FY 2008</td>
<td>Children &lt;12 y, Homeless children, migrant children &lt;15 y, Disabled citizens regardless of age, Age ≥60 y, functionally impaired, reside with family members</td>
<td>Nutritional meals and snacks</td>
<td>≤185% federal poverty guideline</td>
<td>Not available</td>
</tr>
</tbody>
</table>

**Figure.** Summary of federal food and nutrition assistance programs for older adults.
health and well-being of older individuals by assisting such individuals to gain access to nutrition and other disease prevention and health promotion services to delay the onset of adverse health conditions resulting from poor nutritional health or sedentary behavior" (44).

The OAA Nutrition Program is the largest national food and nutrition program specifically for older adults. The US Administration on Aging is responsible for policy development, planning, and funding the delivery of supportive home and community-based services to older persons and their caregivers. The US Administration on Aging works through an Aging Network (45) to deliver an array of supportive services including transportation, protection of vulnerable elders, and nutrition. This national network consists of 56 state units on aging, providing services through 655 area agencies on aging; 241 tribal and Native American organizations representing 244 American Indian and Alaskan Native tribal organizations and two organizations serving Native Hawaiians; and thousands of service providers, which include adult care centers, caregivers, and volunteers and an estimated 12,000 senior centers throughout the nation. Programs and services are targeted to low-income, minority, and rural older adults (44).

Under Title IIIC of the OAA, adults aged 60 years and older are eligible for congregate or home-delivered meals, nutrition screening, nutrition education, counseling, and other health services. Meals must provide at least one third of the Dietary Reference Intakes for older adults and must meet the most recent Dietary Guidelines for Americans (46). The program is not means-tested (eligibility is not based on income), and participants may make voluntary confidential donations for meals (47). At present, about 236 million congregate and home-delivered meals are served to 2.6 million older adults annually. The OAA Nutrition Program reaches less than one third of older adults in need of its program and services and those served receive on average only three meals per week (44). Those receiving congregate or home-delivered meals are twice as likely to live alone than those not receiving them. A larger proportion of participants are minorities compared with nonparticipants of the same age. Participants tend to have two to three chronic health problems. BMIs of participants are two thirds more likely to be abnormal than nonrecipients, with those able to leave the home more likely to be overweight or obese and those who are homebound more likely to be underweight (48).

The Title VI OAA program provides nutrition, supportive services, and caregiver support services to Native American, Alaskan Native, and Native Hawaiian elders (44). These programs help reduce the need for costly institutional care and medical interventions. They are responsive to the cultural diversity of Native American communities and represent an important part of the communities’ comprehensive services.

Ryan White Comprehensive AIDS Resources Emergency Act. This 1990 act was created to help states, communities, and families cope with the growing human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) epidemic. Although HIV/AIDS is considered a disease of the young, older Americans make up >10% of the HIV/AIDS cases. The Centers for Disease Control and Prevention report that from 2001-2004 the number of people aged ≥65 years living with HIV/AIDS increased 60%, from 6,674 to 10,861 (49). Nutrition services include clinical services (medical nutrition therapy, education, and counseling) and food assistance (home-delivered meals, groceries, food vouchers, and liquid nutritional and other dietary supplements).

USDA
Supplemental Nutrition Assistance Program (SNAP). SNAP is the largest federal food assistance program. Through this entitlement program, eligible participants receive electronic benefit transfer cards to buy food at 152,500 authorized stores nationwide. There are few restrictions on food purchases, but alcohol, tobacco, and other nonfood items are excluded. Eligibility requires that gross monthly income not exceed 130% of the federal poverty guidelines and meet assessed limits (50). Each state has the option to provide nutrition education to participants regarding food choices, but guidance does not specify targeting older adults (51). State and local governments share in program cost and administration. Historically, the primary SNAP goal was to decrease hunger in the United States.

One measure of SNAP’s success is determined by the number of eligible participants who make use of the benefits. Historically, fewer than three of 10 eligible older adults receive benefits (52,53). Compared to all demographic groups, older adults have the lowest participation rates. Among those eligible under age 60 years, participation rates are 67%. Only 5% of all recipients receive the minimum $14 per month and 89% of these households include older adults or individuals with disabilities. Older adults living alone on average receive $65 per month and $152 per month if they live with others (54).

Reasons for low participation rates include the belief that the benefit amount will be significantly smaller than the trouble it takes to apply, feeling stigmatized as a welfare recipient, mistrusting electronic benefit transfer cards, lack of outreach, fearing the process is overly intrusive, and confusion regarding eligibility (55,56). USDA pilot tested three approaches to reduce application barriers and encourage food stamp participation among eligible persons aged 60 years and older. When eligibility determination rules were simplified, there was a 20% increase; when one-on-one application assistance was offered, a 31% to 37% increase; and when a commodity alternative was offered, a 36% increase. Thus small procedural changes can affect large changes in benefit use (55).

Commodity Supplemental Food Program. This food distribution program provides nutritious commodity foods to those aged 60 years and older with incomes ≤130% of poverty. Eligibility for others is determined by state and local agencies. Food and nutrition education is provided at local levels. Nutrition education is intended to improve dietary intake and health while preventing nutrition-related problems. Explanations regarding the importance of eating the supplemental foods must be included in the education as well as sensitivity to the special needs of participants possibly residing in a home without running water, electricity, or limited cooking and refrigeration facilities. Local agencies determine how and by whom
the nutrition education is provided. They are not required to employ reg-
eristered dietitians (RDs) or nutrition 
educators for educational purposes 
(57). Though limited in variety, foods 
include cereal, canned fruits and vege-
tables, nonfat dry and evaporated 
milk, cheese, juices, rice, pasta, egg 
mix, peanut butter, dry beans or peas, 
and canned meat, poultry, or tuna. 
This program operates in a limited 
number of states, so the benefits are 
not available to older adults in all 
areas of the country. A limitation of 
this program has been the awkwardly 
large package sizes for one- to two-

Senior Farmers’ Market Nutrition Program. 
This nutrition and education program 
provides fresh fruits and vegetables from 
farmers markets, community-
supported agriculture programs, and 
roadside stands to older adults with 
income ≤185% of the poverty level. 
Grants are made to states, territories, 
and recognized Indian Tribal Organiz-
tions. Funding nationally varies 
greatly and benefits are available 
only during harvest seasons. The pro-
gram helps farmers enhance their 
business by creating a nontraditional 
customer base of community-residing 
and homebound older adults who may 
not normally frequent these markets. 
This program increases the number of 
fruits and vegetables consumed by 
older adults for a few months a year 
and taps into novel markets through 
the coordination of community agen-
cies (59). Unfortunately, the nutrition 
benefit of this program is unknown. 
With an average monetary benefit of 
$25 per year per participant during a 
limited growing season, the Senior 
Farmers’ Market Nutrition Program’s 
impact on diets and food security is 
also unknown.

The Emergency Food Assistance Program. 
Food is distributed to individual states 
with allocations dependent on numbers 
of low-income and unemployed resi-
dents. States administer distribution 
of foods to local food banks, soup kitchens, 
and food pantries. Eligibility criteria is 
set by each state using information 
regarding consumption, income stan-
dards, and participation in other exist-
ing federal, state, or local food pro-
grams (60).

The Child and Adult Care Food Program. 
This program provides nutritious 
meals and snacks to eligible adults 
aged 60 years and older at ≥130% of 
the poverty level who are enrolled in 
adult day centers. Community-resid-
ing adults who live with family mem-
bers are also targeted. To participate, 
a center must be licensed to provide 
day care and sign an agreement with 
a sponsoring organization. Low-in-
come older adults may receive free 
meals; there is an income-dependent 
sliding scale for meals for others. 
Meal patterns vary depending on par-
ticipant age and type of meal served 
but all meals must meet federal di-
teritory guidelines (61). In fiscal year 
2008, the Child and Adult Care Food 
Program served 86,000 older adults 
(62).

DISCUSSION OF FEDERAL FOOD AND 
NUTRITION ASSISTANCE PROGRAMS

A poignant comparison can be made 
between two food and nutrition pro-
grams begun in the 1970s. Congress 
recognized the urgent unmet nutri-
tional needs of special populations 
and authorized the OAA Nutrition 
Program and the Special Supplemen-
tation Nutrition Program for Women, 
Infants, and Children (WIC), with ini-
tial appropriation levels being $125 
million and $20.6 million, respec-
tively. As of 2008, WIC funding has 
grown to $6.20 billion, a 332-fold in-
crease, whereas OAA funding is cur-
rently $784 million, a sixfold increase 
over the same time period. WIC 
serves more than 60% of the needy 
women and children, 98% of eligible 
infants, or 45% of all babies born in 
the United States, whereas OAA Nu-
trition Program reaches <5% of all 
older adults. Among OAA Nutrition 
Program participants, some need 
multiple meals daily, weekend meals, 
dietary supplements, and nutrition 
education or counseling. These needs 
are often unmet in part due to insuf-
ficient funding and/or transferring 
Title III-C funds into other program 
services. As a result, functions such 
as nutrition service needs assess-
ment, planning and development, as 
well as nutrition education and as-
essment, goal setting, and evalua-
tion, are minimal.

WIC has a strong emphasis on tar-
geted and effective nutrition educa-
tion; the direct provision of nutritious 
foods and essential resource informa-
tion for health care and other needed 
support. With sufficient funding, WIC 
has become a model nutrition in-
tervention program able to demon-
strate effectiveness through system-
atric evaluation and reporting. RDs 
and trained nutritionists throughout 
the WIC network provide quality 
care, along with the essential docu-
mentation necessary to ensure future 
funding (44).

The Aging Network employs few 
RDs and nutritionists. Most state 
units on aging do not employ an RD or 
qualified nutritionist to provide tech-
ical support and guidance to the 
Area Agencies on Aging and local pro-
viders. Although some Area Agencies 
and providers have staff RDs or nu-
tritionists, many rely on consultants 
whose time is often limited to menu 
development. As a result, functions 
such as nutrition education, assess-
ment, and counseling, as well as goal 
setting and evaluation, are minimal 
(2).

Although nutrition education is 
recommended in most federal food 
and nutrition programs for older 
adults, it is not routinely offered 
or is its effectiveness well docu-
mented. The availability of food and 
nutrition practitioners, including Ex-
tension agents in USDA programs 
(other than WIC), varies consider-
ably. States have the option of provid-
ing nutrition education to SNAP par-
ticipants, being reimbursed for 50% of 
the allowable costs. Nutrition educa-
tors teach participants about health-
ful food choices on a budget and how 
to follow the 2005 Dietary Guidelines 
for Americans (44). However, SNAP 
nutrition education generally does 
not focus on diseases. This may limit 
the effectiveness of these educational 
programs for older adults in that 
about nine in 10 (87%) have nutrition-
related chronic conditions (3). For 
some USDA programs, little or no 
data are available on older partici-
pants regarding their nutritional sta-
tus, food security, and need for nutri-
tion-related services. Whereas older 
adults may need less total energy, 
food costs are not necessarily lower 
because they need more nutrient-
dense foods and these can be more 
costly, especially given the rising cost 
of foods overall. Also their physical 
limitations (eg, stamina, vision, and 
immune function) may require buy-
ing pre-prepared foods or having food 
delivered—both of which are more 
costly.
FOOD AND NUTRITION IN HOME- AND COMMUNITY-BASED SERVICES

US Department of Health and Human Services Centers for Medicare and Medicaid Services

Federal policy today seeks to ensure that individuals in need of long-term care (LTC) have access to a wide range of noninstitutional options. To rebalance Medicaid’s reliance on nursing homes, the Deficit Reduction Act of 2005 was amended to add new community-based LTC options and to offer states financial incentives to move Medicaid-enrolled individuals back into the community (10). This change was based on almost 25 years of experience in the Medicaid Waiver program wherein nursing home appropriate older adults were provided HCBS. Medicaid Waivers, established under Section 1915(c) of the Social Security Act in 1981, were a means for states to prevent or decrease nursing home or LTC institutionalization.

Medicaid, the country’s single largest purchaser of LTC, paid more than $101 billion for LTC in 2005 (63). The one third of older Medicaid LTC enrollees accounted for 86% of all Medicaid spending on older adults. Of the 1.9 million older Medicaid beneficiaries using LTC services, two thirds used institutionalized services and averaged $38,780 annually per enrollee. The remaining who used Medicaid HCBS waivers averaged less than half this amount ($17,176) (64). Each state determines what needs are most urgent and allows the waiver of rules for an array of HCBS based on broad national guidelines (65). For those at or near poverty relying on the government to subsidize their income, cost containment measures and decreases in benefits have had serious consequences (66). Adequate and sustained support for these programs and services is essential if older adults are to remain healthy and in their own homes for as long as possible.

The Social Security Act of 1965 created the Medicare program to cover the health care costs of those aged 65 years and older and persons with disabilities. Medicare has traditionally not covered primary prevention services, such as community-based and outpatient nutrition services. The 2003 Medicare Prescription Drug, Improvement, and Modernization Act shifted this strategy and addressed the importance of preventive care by providing coverage of diabetes and nondialysis kidney disease counseling by RDs. The Medicare Improvements for Patients and Providers Act of 2008 (67) improves beneficiary access to preventive services and leads the way to expanding the medical nutrition therapy considered reasonable and necessary for prevention of an illness or disability.

RATIONALE FOR INCREASED ACCESS, INTEGRATION, AND RESEARCH

Older adults deserve access to a healthful diet, yet not all are afforded this right. Growing older generally increases nutrition risk; illnesses and diseases; physical, cognitive, and social challenges; racial, ethnic, and linguistic differences; and low socioeconomic status can further complicate the situation. Equally important are beneficial effects of nutrition for health promotion, risk reduction, and disease management (3). Although many older adults are enjoying longer, more healthful lives in their own homes, others, especially those with health disparities and poor nutritional status, would benefit from greater access to food and nutrition programs and services.

Nutritional status affects functionality, independence, and quality of life (3,4). Active life expectancy is used to determine the number of years that older persons can expect to live without functional limitations (68,69). Eating foods in a social, comfortable, safe, and stable environment enhances not only food intake but health-related quality of life (24,25). Healthy People 2010 defines health-related quality of life as “factors that affect the physical or mental health of individuals or communities” (27).

Inappropriate energy and inadequate nutrient intakes and health problems associated with malnutrition in homebound persons is related to nutrition-related chronic diseases and higher food insecurity (70). Food assistance program participation reduces or prevents poor outcomes of food insecurity and improves older adults’ quality of life, saves on health care expenses, and helps to meet nutrition needs (71). Older adults receiving home-delivered meals have higher daily intakes of key nutrients compared to those who do not (72). Their reported weekend nutrient intake is significantly higher than their weekend intake when meals are not provided. Improvement in nutritional status by eating a nutrient-dense breakfast was shown in homebound older adults (73). A two-meal program decreases risk of malnutrition and improves depression symptoms in homebound persons (73).

Public health resources for health promotion, risk reduction, and disease management should target older adults (74). Screening and referral systems, culturally appropriate educational materials, behavioral strategies, and comprehensive care management are needed to improve outcomes. Yet, few intervention programs include nutrition care despite the fact that many older participants in community programs have nutrition-related chronic conditions (3). Establishment of an effective screening and referral system is particularly timely as coverage of individualized nutrition counseling becomes more available through Medicare and Medicaid.

CONCLUSIONS

Regardless of how successful aging is defined, poor nutritional status and poor health status are detrimental and costly. They lead to loss of independence, lower quality of life, increased morbidity and mortality, increased caregiver burden, and greater health care utilization.

Malnutrition, underweight, overweight, obesity, food insecurity, and hunger are linked to decreased quality of life, increased morbidity, and premature mortality (6). Because an inability to achieve and maintain good nutritional status places older adults at risk for numerous poor outcomes, access to food and nutrition assistance programs and nutrition services in home and community-based services must be a high priority for federal, state, and local governments and championed by food and nutrition practitioners.

Roles and Responsibilities of Food and Nutrition Practitioners

Roles and responsibilities of food and nutrition practitioners regarding older
older adults on nutrition and food and nutrition practitioners providing home- and community-based services; and

adequate and sustained funding for food and nutrition programs at local, state, and federal levels, as well as for surveillance efforts to document the need for and effectiveness of these publicly funded programs for older adults.

Participate in:

- programs that provide food assistance, meals, nutrition education, nutrition screening, nutrition therapy, and care management for older adults;

- efforts to provide technical assistance to food and nutrition programs to improve cost-effectiveness and efficiency;

- the provision of routine nutrition assessments that include weight status, food security, meal preparation skills, and dietary and fluid intakes, and advocate for routine assessment of functional status, cognitive status, depression, oral health, and polypharmacy;

- development and implementation of nutrition education programs designed specifically for older adults and caregivers and that emphasize the importance of nutrition for health, risk reduction, and disease management; and

- outcomes research regarding the effectiveness of food and nutrition programs for older adults.

Educate:

- physicians, discharge planners, and other health/social service professionals, agencies, and organizations that provide services to older adults regarding the importance of food and nutrition for healthful aging; and

- older adults on nutrition and food safety to promote health, reduce risk, and manage diseases, which in turn will improve/maintain health, independence, and quality of life.

Recommendations

To promote healthful aging and optimal nutritional status, the following recommendations are made regarding access to food and nutrition programs and services in home and community services, and the availability of a safe, adequate, healthful food supply:

- food and nutrition services in most home- and community-based programs, as well as in many social service, health care, public health, food safety, and food security systems serving older adults;

- practice guidelines for food and nutrition practitioners providing home- and community-based services; and

- lack of cultural competency among those working with older adults given the increasing diversity of the aging population.

Increase the:

- nutrition capacity (staff, infrastructure) in all food and nutrition programs, especially the OAA Nutrition Program;

- general awareness about successful aging through nutrition, food safety, and food security in relation to independence, quality of life, functionality, and disease management; and

- funding for basic and translational nutrition and aging research.

Document the:

- effects of food and nutrition services, including home-delivered meals, as a part of an individualized package of HCBS that can help older adults remain at home; and

- program outcomes on food and nutrient intakes, food security, health care utilization, health status, and quality of life on specific groups of frail, disabled older adults.

Continue to:

- oversample older adults and analyze nutrition-related data using more discrete older age categories in all program evaluations and in national surveys such as the National Health and Nutrition Evaluation Surveys.

Through the life span, dietary intake, health, and quality of life are interrelated. Food and nutrition programs are important safety nets. Our resource-rich nation should support the dignity and health of all its citizens. Older adults should have access to food and nutrition programs that promote successful aging. As our nation shifts from institutional care for older adults to home and community care, nutrition services, including meals, must become integral parts of home- and community-based services.

References


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