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Testimony of Bob Blancato
Hearing of the Senate HELP Subcommittee on Primary Health and Aging
Chairman-Senator Bernard Sanders (VT)
Ranking Member-Senator Rand Paul (KY)

Chairman Sanders, Senator Paul:

Thank you for the opportunity to testify before your Subcommittee. My name is Bob Blancato and I am the Executive Director of the National Association of Nutrition and Aging Services Programs, NANASP. We are a national membership organization representing community-based providers of congregate and home-delivered nutrition services for the elderly as well as other professionals in the aging network.

Our more than 600 members along with many others in the national aging network, including registered dieticians, appreciate your dedicating this first Older Americans Act hearing to the nutrition programs. They are the largest and most visible programs in the Act. They operate in every state. They serve more than 2.6 million older Americans daily with more than 236 million nutritious meals served each year. A critical component; whether the meal is delivered to one's home or served at a congregate site, is the daily personal contact with the older adult.

Nutrition services in the Older Americans Act include the congregate and home-delivered meals programs along with NSIP, the Nutrition Services Incentive Program. Congregate meal programs operate in a variety of sites, such as senior centers, community centers, schools, and adult day care centers. Besides meals, services include nutrition screening and education and nutrition assessment and counseling as appropriate. The program also presents opportunities for social engagement and meaningful volunteer roles, which contribute to overall health and well-being. Home-delivered meals provide meals and related nutrition services to older individuals that are homebound. Home-delivered meals are often the first in-home service that an older adult receives, and the program is a primary access point for the other home and community-based services. NSIP provides additional funding to States, Territories and eligible Tribal organizations that is used exclusively to purchase food, and may not be used to pay for other nutrition-related services or for state or local administrative costs. States may choose to receive the grant as cash, commodities or a combination of cash and commodities.

Next year, we will celebrate the 40th anniversary of the signing into law of the Nutrition Program for the Elderly Act as the 1972 amendments to the Older Americans Act. Our goal for the 2011 reauthorization process is making the nutrition programs stronger, by protecting its federal dollars and ensuring the programs address all three of its main purposes which are to:

1) Reduce hunger and food insecurity;
2) Promote the health and well being of older individuals by assisting them to access nutrition and other disease prevention and health promotion services to delay the onset of adverse health conditions resulting from poor nutritional health;
3) Promote socialization, community service and prevent isolation of older individuals.

Before we look to the future, we find nutrition programs across the country confronting tough times because of this economy. A recent survey we did of our membership indicated that for many of them, either rising gas or food prices is causing cutbacks in services and is contributing to loss of volunteers. I was informed that Wayne County Michigan was recently forced to start its first waiting list for home-delivered meals in 31 years.

It was only 2 years ago when the Older Americans Act nutrition programs received an additional $100 million from the ARRA bill when the programs were confronting these same challenges. We can readily see the challenges have not gone away. It is critical that FY 2012 funding for the OAA nutrition programs be allowed to grow from FY 2011 levels or else there will be real consequences involving older and frailer adults.

Returning to the purposes, the first of which is to reduce hunger and food insecurity, I testified at a Senate Special Committee on Aging hearing on this topic in March of 2008. The crisis of food insecurity continues. The terms used to describe the crisis include hunger, food insecurity, food insufficiency and malnutrition. No matter what term is used, it is harmful to the older person it impacts.

The Leadership Council of Aging Organizations (LCAO) estimates that hunger among older persons increased by 20 percent in the past decade. The Meals on Wheels Association of America Foundation states that as of 2007, there are nearly 6 million seniors facing the threat of hunger, 1 million more than in 2001. Another estimate from Feeding America indicates there are 3 million food insecure seniors in the US. According to an article in the March 2010 *Journal of the American Dietetic Association*, about 2.5 million older Americans are at risk of hunger and 750,000 suffer from hunger due to financial constraints. A brief issued by the Food Security Institute of the Center on Hunger and Poverty at Brandeis University indicates that national estimates of food insecurity among older Americans range from 5.5 to 16 percent. A more recent study on hunger among older adults in New York City done by the Council of Senior Centers and Services points to a 35 percent rate of food insecurity. Separate work done by the United States Department of Agriculture points to especially high rates among those ages 60 to 64. This is important since eligibility for Older Americans Act Title III programs is 60. In addition, the *USDA Food Insecurity Report* found that 884,000 households with older persons living alone are food insecure and older persons living alone represents one of the fastest growing populations in our nation.

The important point is that while the Older Americans Act is not the only solution; it remains the largest national food and nutrition program specifically for older adults. Also, according to the American Dietetic Association (ADA), these programs reach less than one third of older adults in need of its program and services. Those it reaches tend to live alone, tend to be minorities and tend to have two or more chronic health problems. These are all elements along with lack of transportation and living in food deserts of what are the common causes of hunger among older adults.

In addition, according to AoA data, more than one out of every ten seniors served in the congregate program have more than three impairments of activities of daily living(IADLs) which can be a precursor to a senior going hungry since two of the most commonly reported limitations is the inability to cook meals or shop. The number climbs to over 70 percent for home-delivered meal program participants.

A fundamental outcome of the reauthorization must be to better target the resources of the nutrition program to ensure it is reaching those older Americans most susceptible to hunger.

What does hunger and food insecurity mean to our nation and the federal government? It means that older adults who are malnourished and often isolated are more likely to end up with more expensive and unnecessary hospital and nursing home stays. It means more doctor visits, home health care and other services. It also means we are letting members of our greatest generation suffer in their golden years.

The second purpose of the nutrition programs is to promote the health and well being of older individuals to delay the onset of adverse health conditions which can lead to placement in nursing homes and long-term care facilities.

Consider that 87 percent of older adults have one or more of the most common chronic diseases--hypertension, coronary heart disease and diabetes. According to a 2006 American Medical Association article, in those aged 45-64, diabetes more than tripled the risk of nursing home admission.

According to the ADA, these three common chronic diseases are preventable or treatable in part through access to appropriate nutrition services including meals, nutrition screening and assessment, counseling and education.

Again, the OAA nutrition programs are not the only solution but the meals it provides every day must provide at least one third of the Dietary Reference Intakes for older adults.

As we look to reauthorize the OAA, we should consider the potential cost savings that could be achieved for Medicaid and Medicare if we invest more in programs like the nutrition programs. According to the AoA 2009 State Program Reports on Home-delivered Meal Clients, the average percent of clients who have three or more ADL (Activities of Daily Living) impairments is 35.19% and in West Virginia and Iowa the percentage exceeds 80 percent. Having 3 or more ADLs is normally a precursor for being admitted to a nursing home. The difference in cost between a home-delivered meal and a day in a nursing home is dramatic. If we are able to keep these individuals in their homes, we will achieve genuine savings. An investment in the nutrition programs today most certainly can produce a strong return on the investment in terms of savings to Medicare and Medicaid in the future.

The final purpose of the nutrition programs is the promotion of socialization of older individuals. When older adults tell us stories about the importance of the congregate nutrition program, they tell it in the context of the program providing nourishment for the body and the soul. One of the fastest growing segments of the older population is those who live alone. In fact, according to AoA, 48 percent of all women over the age of 75 now live alone. The OAA nutrition program provides seniors, especially those who live alone, with an opportunity to interact each day with other older adults. This can help to avert greater isolation and loneliness for these older adults.

There are many other outstanding cost savings outcomes from the Older Americans Act nutrition programs. The programs are targeted to the older person in their own communities. They rely very heavily on volunteers who commit millions of hours of service which mean millions of dollars in savings. In addition, the nutrition programs have a critically important relationship with low-income seniors employed by SCSEP (Senior Community Service Employment Program) which do their community service work in nutrition programs. In fact in the case of one of the larger national SCSEP contractors, Senior Service America, 24 percent of all the community service hours were in service to the elderly with about half of these hours being provided to senior centers and nutrition programs.

The programs provide more than just a meal. Programs include engaging and actionable nutrition education programs intended to educate and inform older adults on how best to ensure proper nutrition when they are not at the programs.

This reauthorization is important to both strengthening the core service programs in the Act as well as to modernize the Act for the future. In addition to our call for a five year reauthorization of the Act with sufficient authorization levels to allow the program to meet current and future needs, we recommend the following:

- Protect nutrition dollars. It is time to rethink the transfer authority currently in the statute. The authority has been a one way street. Most all of the money transferred comes from one program, the congregate nutrition program. Based on FY 2009 data, more than $78 million was transferred out of the congregate program. Half of this went for the home-delivered meals program. We think that is appropriate so communities can direct their nutrition programs to where older adults need them. The other half went for Title III B services. Some, but not all of these funds were used to support services not related to nutrition. That has to change. In these difficult fiscal times, we cannot afford to take $39 million in funds intended for nutrition and have them go elsewhere. Only services that relate directly to nutrition, including transportation or senior centers should be funded under the transfer authority. Otherwise the transfers between B and C should be eliminated entirely.

- As the Leadership Council of Aging organizations recommends, we should enhance the current flexibility in the allocation of senior nutrition program funding in local communities while preserving the integrity of the separate congregate and home-delivered meals programs.

Additional recommendations, some of which are included in the Leadership Council of Aging Organizations (LCAO) 2011 OAA Consensus Document include:

- Building the link between nutrition and health, and establish a set aside of funds under Title III D for nutrition related evidence-based health promotion programs.

- Authorize a Nutrition Resource Center that will identify ways to increase cost effective food and nutrition services in home and community-based social and long-term care systems serving older adults. We see this as a public private partnership.

- Better enforce existing law that State Units on Aging solicit the expertise of a registered dietitian and work to have more RDs on the staff of SUAs.

- Provide greater access to fresh fruits and vegetables through senior farmers markets, urban gardening and farm to table programs.

- Promote greater flexibility for meal planning including cultural considerations and preferences while maintaining current requirements on meal requirements being met.

- Look for and provide support for best practices in nutrition programs that have succeeded in recruiting and retaining first wave boomers who are at risk for malnutrition in addition to existing clientele.

- Invest in the opportunity to use Title III C funds not only to serve the current population in need but also to transform congregate home-delivered nutrition services to meet the nutrition needs of the burgeoning numbers of older individuals seeking to remain healthy in their communities.

- Improve data collection in the Title III C nutrition programs, particularly measures of unmet need, such as waiting lists. Currently, according to a report by the National Health Policy Forum, data on the unmet need for nutrition services are elusive and national data on waiting lists does not exist.

- Better recognize the essential role of transportation in the provision of nutrition services.

- Develop through language a stronger role for the nutrition programs to aid in the fight against elder abuse, especially in the areas of education, raising awareness and helping to detect and report elder abuse.

In addition, NANASP supports:

- Aging and Disability Resource Centers (ADRCs)-nutrition screening questions and routinely making appropriate referrals for full nutrition assessments for those determined to be at nutritional risk.

- A study that can determine how many seniors who are served by the Act are at risk of being institutionalized without the nutrition program, determine the savings to Medicaid and based on this evidence then direct a portion of the dollars saved to be reinvested in the OAA. It is possible that some of this information might be included in the ongoing evaluation of the nutrition programs being conducted by AoA. The exact parameters of this proposed study could await the release of the evaluation.

- Build the capacity of and funding for the Native American Nutrition Programs in order to better strengthen their ability to serve the complex and urgent needs of elders in Indian Country.

- In advance of the 2012 reauthorization of the Farm bill, consider conducting joint hearings with the Agriculture Committee on the nutrition programs in each Act that benefit older adults and work for better coordination.

- Expand the definition of nutrition education to include screening, assessment and counseling and extend this education to caregivers of older adults served by the OAA.

- Finally, we recognize that one of the more promising elements of the Affordable Care Act is the Community Based Care Transitions Program to support community-based organizations partnering with eligible hospitals to help patients safely transition between settings of care. A commitment of $500 million was announced recently by HHS. We believe some of these community-based organizations should be from the existing aging network in programs which feature nutrition services which are viewed as being important to a successful transition of care from a hospital back to the community.

We hope this Subcommittee might consider a broader hearing that could examine approaches that could strengthen the aging network's future role, responsibility and resources in home and community-based care, especially through the Medicaid program.

The success of the OAA nutrition programs is often best captured by what seniors themselves say. I have recently obtained a few of these stories either by visiting a program or through those sent in by NANASP members.

This first story was provided by our NANASP President Paul Downey:

- San Diego, California-*Peggy Shannon, 63, was laid off from her job as an administrative assistant during the economic downturn in 2008. It was the first time since she turned 16 that she was without a job. Eventually her unemployment ran out forcing Peggy to take early retirement (with penalty) which put her income at about $850 -- below the Federal Poverty Level. She made drastic cuts in spending and was having to choose between paying for medications or food. Peggy was extremely worried about having regular, nutritious, meals because of her severe diabetes. The stress of the situation caused her to lapse into a deep depression where she isolated herself in her apartment and cried most of the time. Her deep pride and embarrassment over her situation prevented her from reaching out to family and friends.*

  Finally, in desperation with her blood sugar at dangerous levels, she came to Senior Community Centers for food after reading an article about the agency's new Gary and Mary West Senior Wellness Center. The center serves two meals per day, 365 days per year. Peggy began coming every day for the food and to have her blood sugar levels checked by the facility's nurse. Because of her limited income, Peggy was not able to make the donation for the meals. She insisted on "paying" for them by volunteering to assist with clerical work. That lead to her becoming an active member of the Civic Engagement program where she mentors other seniors facing similar challenges. It also connected her with one of Senior Community Centers' collaborative partners, San Diego State University, which provides interns and faculty in the West Center. Peggy was able to secure a job working 15 hours a week for SDSU.

  Peggy emphatically states that Senior Community Centers saved her life and credits the meals for motivating her to come in for help. This is a classical it is "more than just a meal" story.

Another story I was told by an I&R/A (Information and Referral/Aging) specialist from Wayne County Michigan when I presented at the annual conference of the Alliance of Information and Referral Systems (AIRS). She found a voicemail on a Monday morning from an 88 year old man who had left the message on a Sunday. He said he needed food, had no friends or family

and only had enough food to last the day. The response on Monday was to provide him with a chore worker who could go to the grocery store, but the man's condition worsened and an ambulance was called. The man ended up first in the hospital and after 3 days, a doctor's recommendation was to transfer the man to a skilled nursing home. According to the I&R/A specialist, if the man "had access to this crucial service, he may have had a better chance at avoiding placement in a skilled nursing facility."

The I and R specialist also noted, "Then to show how older people through voluntary contributions value the nutrition programs comes this hand written note just signed Meg."--

> *I have been in rehab for 2 months after falling and fracturing my hip so I have lost contact with the outside world almost. My husband said he had 3 pickups but he did not give me the paper that accompanied the delivery. If I have shortchanged you on this check, I apologize and will catch up on the next check.*

Another story provided by one of our members involved an 87 year old man who had normally called once a month for transportation services so he could come to town and pay his bills. On his most recent call he said "I don't think I am long for this world." When asked why, the man said he was starving. He was invited to the congregate site and initially showed up weighing 109 lbs but standing 6 feet tall. He finally agreed to attend the center 3 times a week during which time he was advised of other benefits for which he might be eligible. According to the program director, "The congregate meal program helped to improve the man's nutritional health; however, it did much more by opening the door to so many other benefits that will continue to benefit him and help him to live independently. He is more than just units of service provided and dollars spent. His life has been forever changed."

I appreciate the opportunity to present this testimony and these testimonials on the value of the Older Americans Act and especially its nutrition programs. That is the story of this Act throughout its history. It is about the value it provides to those it serves. It is about the value of the volunteers who work in the program and perhaps most importantly; it is about the value it represents to our present and future federal budgets. The Older Americans Act enjoys a long bipartisan history in this body and in the House. We hope that can continue to allow a strong reauthorization bill to be enacted which does more than just extend the program but also modernizes it to meet today and tomorrow's needs.

Respectfully Submitted,

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