

Older Americans Act Home-Delivered Nutrition Program

The unmet need for services

Introduction

Adequate nutrition is a key component to living a healthy, independent, and high-quality long life. Many studies have shown that poor nutrition among older adults exacerbates diseases, increases risk for infections, delays wound healing, and intensifies functional impairments. These issues lead to long-term care admissions, longer hospital stays, and more readmissions, which increases national health care expenditures – the annual cost of malnutrition for adults 65+ in 2014 was estimated to be roughly \$51.3 billion (Snider et al. 2014).

The changing demographics of the 65+ population is having profound impacts on people's nutrition and the demand for food services. Protecting oneself from hunger, malnutrition, and food insecurity is becoming more difficult for older adults with chronic conditions who are living below the poverty line than for the general population. Currently, for the 65+ population, 1 in 6 struggles with hunger (MOW 2016), 1 in 4 are at risk for malnutrition due to reduced meal sizes or skipping meals

(NCOA 2016), approximately 8 percent of households living with older adults and 9 percent living alone experience food insecurity (Feeding America 2016), and 63 percent of households report having to make a decision between paying for food and paying for medicine (Feeding America 2016).

Research has shown that many older adults prefer to age in place. Their ability to do so depends partly on the availability of home and community based-services provided by the federal government, and state and local agencies. This issue brief discusses the Older Americans Act Home-Delivered Nutrition Program (HDNP) with a focus on its effectiveness in providing services to home-bound older adults.

Older Americans Act Nutrition Programs

Since the Older Americans Act Nutrition Programs (OAANPs) were enacted into law in 1978, millions of vulnerable older adults have relied on the services provided as they age. The programs authorized under OAA Title III-C provide congregate meals and home-delivered

meals, which target the 60+ population with the greatest social and economic need – low-income minorities, rural communities, limited English proficiency, and risk of institutional care. According to the Administration on Aging (AoA), the purpose of the OAANPs is to:

- Reduce hunger and food insecurity among older individuals,
- Promote socialization of older individuals,
- Promote the health and well-being of older individuals, and
- Delay adverse health conditions for older individuals.

The nutrition programs are funded partially by the Administration on Aging (AoA). The AoA allots grants to State Units on Aging (SUAs) to support the delivery of daily meals and related nutrition services in either congregate or home settings. Funds are distributed according to a formula that is largely based on the state's share of the population aged 60 or older. SUAs then allocate the funds to Area Agencies on Aging (AAAs) on the basis of state-determined formulas that reflect the proportion of older people in their particular planning and service areas (PSAs). The AAAs manage the nutrition services program within their PSAs and award grants/contracts to Local Service Providers (LSPs) to deliver nutritional and supportive services in their planning areas.

The nutrition programs are also funded by state and local governments, foundations, direct

payment for services, fundraising, community organizations, and program recipients' voluntary contributions. Currently there are over 5,000 nutrition programs and more than 3,500 home-delivered meal providers.

Home-Delivered Nutrition Program

The HDNP offered through Title III-C2 is the *largest* funded program of the Older American's Act. Since its establishment in 1978, the HDNP has served as a primary access point for home and community-based services and is typically the first in-home service that an older adult receives. The program prioritizes deliveries based on whether a person is home-bound, meets the Activities of Daily Living impairments minimums, is geographically isolated, or has low income (Mabli et al. 2015).

Recent data from the 2014 National Survey of Older Americans Act Participants on HDNPs (http://www.aoa.gov/AoA_programs/HPW/Nutrition_Services/index.aspx) illustrates that they are effective at targeting services:

- 69% of individuals served by this program are 75 years or older
- The average age of a participant is 79 years old
- 63% of participants indicate that the single home-delivered meal provides one-half or more of their total food for the day

- 93% of participants indicate that the HDNP helps them to stay in their own home
- More than half of all participants live alone
- 95-96% of participants would recommend the program to a friend.

The nation's most common home-delivered meal program is Meals on Wheels (MOW). In the 2016 MOW fact sheet, 83 percent of older adults who receive meals from them said it improved their health, 92 percent said it enabled them to remain living at home, and 87 percent said it made them feel more safe and secure. Further findings suggests that the MOW program decreases the rate of falls, which costs our nation \$34 billion each year, and providing meals for one year per individual costs roughly the same as one day in a hospital.

Overall, these findings suggest that HDNPs have positive outcomes for those who receive the services by providing a wholesome meal plus a safety check in certain states, and sometimes the only opportunity for face-to-face contact or conversation. However, multiple reports from the Government Accountability Office (GAO) show that the majority of those in need never receive services.

GAO Findings on the HDNP Services Provided to Older Adults

The GAO analyzed data on the Title III programs in 2008 and 2013. The analysis of the 2008 data found that only around 9 percent of an estimated 17.6 million low-income older adults received meals like those provided by the Title III program. In addition, 18.6 percent of low-income older adults were food insecure (the state of being without reliable access to a sufficient quantity of affordable, nutritious food) and 92.6 percent of these individuals did not receive home-delivered meals. When taking a more detailed look at demographics, 88.5 percent of individuals with two or more ADL impairments, 95 percent of socially isolated people, 93.2 percent of older adults on food stamps, and 93.6 percent of individuals living alone did not receive home-delivered meals.

In the updated 2013 report, the findings were similar to the 2008 results. According to the analysis of the 2013 data, only around 10 percent of an estimated 16.6 million low-income older adults received meals like those provided by the Title III program. There were more low-income older adults who were food insecure in 2013 than in 2008 (23.5% compared to 18.6%), and 90.2 percent of these individuals did not receive home-delivered meals. After examining the characteristics of low-income older adults, 88 percent with two or more ADL impairments, 89.8 percent of individuals on food stamps, and 93.6 percent of older adults living alone did not receive home-

delivered meals (information on social isolation was not provided).

If the main goals of the OAANP is to reduce hunger and food insecurity, promote socialization and well-being, and delay adverse health conditions for older adults, then why is there such a large unmet need for this population? The following section discusses the possible reasons.

Table 1: Estimated Percentages of Low-Income Older Adults with Certain Characteristics that **Did Not** Receive Home-Delivered Meals

Characteristics	2008	2013
2 or more ADL impairments	88.5	88
Social Isolation	95	N/A
Food Stamps	93.2	89.8
Living Alone	93.6	93.6

Reasons for Unmet Need of Home-Delivered Meals

From the organizational level, there are various reasons for the high amount of unmet need. First, the need for home-delivered meals is larger than the number of meals that they are able to fund. In the GAO 2008 data, 22 percent of agencies were unable to serve everyone in need who requested home-delivered meals due to a deficiency of funds. The local service agencies have responded to the funding problem in different ways. Some agencies were forced to reduce services to compensate for cost increases (such as labor, fuel, and food costs), while others created waitlists. One study found that roughly 51 percent of the LSPs that

arrange or provide home-delivered meals reported having a waiting list for applicants (Mabli et al. 2015). Many agencies reduced staff or staff hours (47%), and the frequency of home-delivered meals (32%). Agencies also reported modifying menus or increasing the use of frozen meals (Mabli et al. 2015: 52).

Another reason unmet need occurs is because the AoA does not provide standardized definitions and procedures for states to use when measuring need for services (GAO 2011). Information on services nationally or consistently across states could help make the allocation of their limited resources more effective. Without uniform definitions and procedures, the extent of need is difficult to obtain. Currently, “many programs have no way of knowing whether they are serving those who have the greatest need because they do not have information about those in need who do not receive or request services” (GAO 2011: 34).

There are also reasons for unmet needs on the community level. The Gerontological Society of America study on malnutrition (2015) found that many older adults and caregivers do not receive referrals for available services. For example, 17 percent were referred to educational materials (brochures or websites) with specific nutritional information, 9 percent were referred to a dietitian, 7 percent were recommended to take oral nutritional supplements, 6 percent were referred to the

SNAP program, and only 3 percent were referred to congregate meals or home-delivery meal programs.

Overall, much more should be done to maximize program resources on the organizational and community level as a way to help reduce the number of older adults who are not receiving the services they need to ensure healthy aging.

Concluding Remarks and Recommendations

Persons 65 years or older numbered 46.2 million in 2014 (the latest year for which data is available), or 14.5 percent of the U.S. population (AoA website). The total number of individuals served by MOW home-delivered program in 2016 was 830,187 (MOW fact sheet), which breaks down to approximately .02 percent of the 65 plus population. Clearly, more needs to be done to reach a larger proportion of older adults.

In order to ensure adequate funding, resources, and regulations that can improve the current situation, federal and state policy makers, administrators, and program providers should have a more comprehensive understanding of the current unmet need/demand status, challenges, and opportunities the nutritional program is facing (Lee et al. 2011). Studies have suggested several recommendations on the organizational level that could help maximize program resources and ensure that agencies have

sufficient information on the unmet needs of older adults.

First, a formal process is needed to help standardize the way the states collect data and measure need and ensure the program is not duplicating its efforts. To do this, the Secretary of Health and Human Services (HHS) should partner with other agencies and develop standardized definitions and measurement procedures to assess the receipt, need, and unmet need for services (GAO 2011). Second, there needs to be a policy to define how frequently participants' service needs should be reassessed (Mabli et al. 2015). Third, the Department of HHS should develop a cross-agency federal strategy to help increase the efficient use of resources from all of the federal agencies that fund home and community-based services for older adults (GAO 2015).

Recommendations have also been made for improving the community level outreach efforts to older adults and their caregivers regarding nutrition. First, including prevention campaigns and awareness weeks to support the educational programs already available to the public. Second, routine screening and intervention skills should be taught to all healthcare professionals. Lastly, nutritional screening should be incorporated into quality initiatives and care models (GSA 2015).

Provided that optimal nutrition is a major part of older adults' ability to preserve their independence and delay disease and disability,

it is critical to improve the capacity and targeting of the HDNP to the 65 and older population in need. The currently low percent of older adults who are receiving services from the largest funded federal program of the Older American's Act is unacceptable, and will grow with the aging of the U.S. population unless program funding is substantially increased.

References available upon request.



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