The Older Americans Act Nutrition Program: Providing Consumers and Caregivers with Food and Nutrition Choices for Healthy, Independent Long Term Living

A Challenge Brief (Draft)

Introduction

The Older Americans Act (OAA) Nutrition Program is a cost effective service that assists older persons to fully engage in society and community life, maintain their health and independence, and stay in their own homes and communities for as long as feasible.[1,2] The Nutrition Program supports the OAA vision and meets performance outcomes and indicators established by the US Administration on Aging (AoA).

Food and good nutrition are key factors in successful aging.[3,4] Together, they help reduce disease related disability, promote health and support increased mental and physical functioning and active engagement with life.[3,5,6,7,8] Research shows that consuming a healthy diet and being physically active are more important than genetic factors in avoiding declines associated with aging.[3] The role of nutrition in maintaining the health of older adults involves both the prevention of malnutrition and the management of common chronic conditions.[5] Nutrition therapy is cost effective.[5]

The Role of Nutrition in Keeping Older Adults Healthy

Nutrition keeps older adults healthier by reducing the risk of chronic diseases and related disabilities. Nutrition is central to chronic disease treatment and management. All top nine chronic health conditions in older persons have dietary and nutritional implications. These in turn influence one's ability to remain independent in the community.[5,6,9,10,11] Further, all are greatly exacerbated by malnutrition, either as obesity or undernutrition.[5]

The conditions[6] and related roles of nutrition are described below.

Heart Disease, Hypertension and Stroke: Strong evidence associates dietary modification with reduced risk and successful disease management including prevention of clinical episodes of coronary heart disease and stroke.[5] Dietary intervention includes reduction in cholesterol and fat intake and reduction in sodium intake to control hypertension, limited alcohol consumption and weight reduction if needed. The Dietary Approaches to Stop

Hypertension diet (DASH) and the American Heart Association Guidelines emphasize a healthy diet high in fruits, vegetables and low fat dairy products.[9,11]

Emphysema, Asthma, Chronic Bronchitis: These chronic lung diseases are associated with airflow blockage and breathing problems.[11] Chronic Obstructive Pulmonary (Lung) Disease (COPD) includes Emphysema and Chronic Bronchitis. Although its etiology is tobacco related and asthma may play a causal role, nutrition therapy is critical in managing the disease. The older person may be physically inactive and may appear to consume an adequate diet. However, COPD causes an increase in metabolism resulting in unintentional weight loss, although on the surface, dietary intake appears adequate. Nutrition status and therapy is very important to its management. Nutrition screening and risk assessment must consider appetite, breathing difficulties and hormonal changes. Dietary intake must be monitored for nutrient adequacy and quality. Intervention strategies may include calorie dense foods, altered mealtimes, snacks and nutritional supplements.[9,10] Nutrition intervention must be pro-active, given the frequent hospitalizations and need for post discharge home care. Nutrition therapy is frequently incorporated into a comprehensive rehabilitation plan that includes strength training and exercise.[9,10]

Cancer: Diet is important in reducing cancer risk and in managing the nutritional problems associated with the disease or its treatment.[9] Increased intake of fruits and vegetables are associated with reducing the risk of some cancers. Current recommendations are to maintain a healthy weight through diet and physical activity and to limit consumption of alcohol which is associated with increased risk of oral, esophageal, liver and breast cancers.[9,10] Obesity is associated with increased risk of colon cancer and, in post-menopausal women, breast cancer[9]. Many older persons who have cancer have serious nutritional problems caused by the disease itself or its treatment. These include poor appetite, inadequate nutrient intakes and unintended weight loss. The development of a person/family centered individualized nutrition treatment plan and maintenance of optimal nutrition status for the individual can result in improved tolerance to treatment, recovery and quality of life.[9,10]

Diabetes: The evidence is clear that dietary modification including carbohydrate control and caloric control when weight loss is warranted, successfully manages the disease and reduces the risk of other chronic conditions including cardiovascular disease.[9,10] Further, research has shown that development of diabetes is delayed in obese individuals with impaired glucose tolerance when they achieve a 5-7% reduction in weight.[9,10] Although it is ideal to begin nutrition intervention when a person is first diagnosed, its effects are proven

beneficial at anytime during the disease process and refresher interventions are also effective.[5] Medicare provides reimbursement for individualized nutrition therapy when it is part of a comprehensive multidisciplinary management approach that includes diet, exercise, medications, and blood glucose monitoring.[5]

Arthritis: A leading cause of disability among older adults, risk factors for arthritis include obesity, being over age 50 and being female, post menopausal. Knowledge is limited about the direct nutrition/arthritis relationships. There are reports that weight loss when indicated has alleviated symptoms. Medications should be evaluated to determine drug nutrient interactions which may affect nutritional status. Improved nutritional status and food intake can be accomplished through the use of adaptive devices to assist with meal preparation and eating.[9,10,11]

Of these nine chronic conditions, heart disease, stroke, cancer and diabetes are among most common and costly diseases[6]. These chronic conditions coupled with obesity have been behind almost all Medicare spending over the past 15 years.[12] Diet modification and nutrition therapy help control the high costs of disease treatment and hospitalizations through risk reduction, delayed disease onset and symptom management. In doing so, nutrition improves the efficacy and effectiveness of the associated medical, pharmaceutical, and rehabilitative treatments.

Relationship between nutritional status, malnutrition and functionality

Nutritional status is closely associated with an older person's functionality and ability to remain independent. There is no single "norm" or standard definition of acceptable nutritional status given the vast heterogeneity among older persons and the variety of settings in which they live. Thus, the goal of improving nutritional status through adequate dietary intake and quality is to prevent the occurrence of malnutrition from obesity and underweight.[5] These two serious conditions have the greatest impact on health and also impede functionality and independent living. Functional status is often measured by the ability to ambulate, grip strength, lift heavy objects and perform Activities of Daily Living (ADLs, e.g., eating, dressing, walking across a room), and Instrumental Activities of Daily Living (IADLs, e.g., preparing meals, shopping).[6,13] Malnourished older adults have limited muscle strength, more exhaustion and reduced physical activity placing them risk for falls and hip fractures.[6,13] This increases healthcare costs and threatens independence.

Obesity, the most common nutritional disorder, is a risk factor for age related chronic conditions described earlier.[5,12] Obesity in the Medicare population grew from 11.7% in 1987 to 22.5% in 2002.[12] Healthcare spending for this population grew from 9.4% of the federal

budget in 1987 to 24.8% in 2002. Obese older adults are more likely to become disabled[14] and report difficulties with ADLs and IADLs that impact their functional independence. They also report more feelings of hopelessness and sadness.[15]

Undernutrition in older adults is far more problematic to resolve. Some chronic diseases are risk factors (e.g., cancer, COPD, Alzheimer's). Unintended weight loss that goes undetected contributes to frailty. Research shows an independent relationship between the amount and quality of dietary intake and frailty.[16,17] Without the appropriate nutritional therapies and other long term care services to support recovery, individuals are at risk for premature nursing home placement. Unaddressed, undernutrition and frailty may result in costly long term care services. Malnutrition, unintentional weight loss and inadequate hydration are serious risk factors for the development of pressure ulcers. Depending upon level of progression, pressure ulcers need aggressive nutrition therapy, medication management, nursing care and sufficient time to heal.[18]

A nutrition screening, assessment and intervention process will detect and prevent malnutrition.[5] The Nutrition Screening Initiative (NSI), a national partnership consisting of health and social service organizations, promotes routine screening and intervention as a cost effective way to promote health and manage disease in older adults. Nutrition screening and targeted interventions help keep older adults in their communities and reduce the costs associated with medications, hospital care and nursing home stays.[15]

Caregivers and nutritional status

Informal, unpaid family caregivers play an important role in improving or maintaining the nutritional status of their care recipients. Informal caregivers provide the majority of care for underserved populations, including those residing in rural settings, those suffering from dementia, and those receiving hospice care. Caregivers prepare meals, assist with eating, and when necessary administer and monitor home enteral nutrition. Caregivers may not have the skills and information needed to encourage eating, modifying food consistency, or to evaluate the appropriateness of nutritional supplements. Nutrition education or individualized nutrition counseling for specific diseases and conditions (e.g., Alzheimer's disease, hip fracture recovery) may be needed[3]. The responsibility for providing nutrition care and sustenance that will impact the health and life of the care recipient adds to caregiver burden. The informal caregiver must be concerned with his or her own nutritional status as well. The stress of caregiving may place the caregiver at malnutrition risk through skipped or unhealthy meals and inattention to management of his or her own chronic diseases or conditions. The OAA National Family Caregiver Support Program provides

caregivers with resource information and referrals, caregiver training in decision making and problem solving and respite care for temporary relief from caregiving.[1]

The Changing Long Term Care System and Impact on Nutritional Health:

The OAA is long recognized as the cornerstone for provision of cost effective, comprehensive, coordinated, high quality, long term home and community based services. It and the AoA continue to embrace innovation to meet the changing needs of older persons. The different needs of the current fast growing, heterogeneous, multi-racial and ethnic population of adults aged 60+ and those of the baby boomers raise questions about the cost effectiveness of the current long term care system. Of the Medicaid funds spent on older adults, 69% is for long term care. Facility based long term care accounts for 70% of Medicaid spending.[19]

AoA, in its national leadership role, is participating in debates and decisions to rebalance the system away from the nursing home and facility based long term care model to a more cost effective home and community based model offering a full array of programs to remain in their homes.[20] Older adults and families will be empowered to choose from a full array of home and community options, services and providers to support their long term living.[2,20,21] Such models have shown to increase consumer satisfaction and save money through lowered use of high cost emergency rooms and institutional care.[19] In fact, preliminary data from recent state project demonstrated home delivered and congregate meals help reduce hospital admissions and emergency room visits for Medicare and Medicaid enrollees.[22]

AoA has a very proactive strategic direction to better empower and assist seniors to remain functionally independent at home. AoA's *Choices for Independence*[20,23] initiative will: 1.) Empower consumers to make informed decisions about choices for long term living; 2.) Target high risk, nursing home appropriate, non-Medicaid individuals and delay institutionalization through *Choices* for home and community care to meet their individualized needs and preferences without the current OAA service categories or titles restrictions;[23] and 3.) Build prevention into community living through a variety of evidence based health promotion and disease prevention programs designed for older adults.[23]

Challenges and opportunities lie ahead. A philosophical and operational shift must be made from a provider/service driven model to one where consumers, families and caregivers are empowered and make their own long term care decisions. They will choose

from a menu of long term care options and service providers. AoA will provide guidance to assist SUAs and AAAs with *Choices* implementation.

Participants and caregivers are very satisfied with today's OAA services.[21] The OAA has the experience, network and programs in place to effectively serve as the model for a rebalanced home and community service long term care system. It is visible, creditable and trusted. Older adults and families turn to it for top quality, accurate information; appropriate, safe services; and competent providers to serve long term living needs.

Implications for nutrition services

Nutritional services will differ as SUAs, AAAs and providers balance the needs of today's older adults including the fast growing numbers of those 85 years and older with those of a more independent, mobile and younger group. Clients will be increasingly diverse with respect to severity of impairments, information and referral needs, mix of therapeutic nutrition, health/medical, and social services and array of health promotion and disease prevention community programs.[24,25]

SUAs, AAAs and local nutrition providers should be cognizant of the implications for malnutrition risk in older adults and be prepared to address it. The Aging Network is now and will continue to target and serve an increasingly frailer, impaired and more underserved population. For example, had it not been for their OAA services, about 30% of participants receiving home delivered meals were impaired to the extent that they were eligible for more costly nursing home placement.[21] If these individuals had been in nursing homes, regulations would require they be carefully monitored for malnutrition risk, any decline in nutrition status evaluated, and a documented care plan developed to prevent deterioration. For example, malnutrition, unintentional weight loss and dehydration lead to pressure ulcers and there are national guidelines in place for screening, staging, prevention and treatment.

Although they may have serious impairments and chronic conditions, older adults would prefer to be at home rather than in a nursing facility. Thus, the OAA Aging Network (including registered dietitians at state and local levels) becomes the first line of defense in monitoring malnutrition risk and implementing a care plan to improve nutritional status and prevent obesity and unintended weight loss. The development of state and local area plans should include nutrition expertise and provide for the range of diverse nutritional needs of consumers and their families as the rebalanced long term living system is brought into place.

The OAA Nutrition Program: A Model that Promotes Health and Independence in Home and Community Based Long Term Care

The popular, grassroots, consumer-oriented OAA Nutrition Program can serve as a model program for implementing AoA's *Choices* Initiative for the aging network. The highly rated Nutrition Program is a key foundation service with a history of well documented, substantial contributions to the health and social well being of its participants.[26,27] The Nutrition Program is well integrated into home and community settings through coordination with community partners and a care planning process incorporating social service and medical care components.[26,28]

The Nutrition Program must comply with the latest edition of the *Dietary Guidelines for Americans*[7] (*DGA 2005*) and is required to use the newest nutrient requirement knowledge and guidance. The *DGA 2005* makes specific quantitative recommendations regarding nutrients and food components, and emphasizes maintaining a healthy weight and participation in physical activity. The Dietary Reference Intakes[29] (DRIs) reflect findings that older adults have specific nutrient requirements due to the aging process. The DRIs help prevent nutritional deficiency, reduce the risk of chronic diseases and improve health over the long term.

There is broad access for participation, anyone aged 60+ may enjoy a meal at a senior center or congregate site. Older persons and their families can call the national elder hotline for information and referral. Unfortunately, given the demand, access to home delivered meals and other home care immediately may require being on a wait list.

The *Second National Pilot Survey of Older Americans Act Title III Service Recipients*[27] shows that the Nutrition Program successfully targets the vulnerable and frail including the underserved, those of minority status, those residing in rural areas and those with limited access to food. The Home Delivered Nutrition Program serves the frailest and most functionally impaired. It is an important social community link and helps delay institutionalization. Participants age 75 and older comprise 73% of home delivered and 62% of congregate Nutrition Program clients. Over half of all participants live alone, including 61% of the homebound. About 70% of the homebound have difficulty with one or more ADLs and 30% have three or more ADL limitations. The latter qualifies them as needing nursing home level of care--a care level that indicates significant frailty.

The mid-day meal provides half or more of the day's total food intake for 66% of home delivered and 56% of congregate Nutrition Program participants. Program meals improve dietary intakes of fruits, vegetables, and dairy products. Participants have healthier

diets in comparison to other older adults. However, the meal is often the sole source of nutrients from key food groups for one- to two-thirds of participants. For example, the Program meal provides 51% of home delivered and 46% of congregate clients their only serving of meat, poultry or fish on any given day. The only two servings of grain foods eaten come from the daily meal for 67% of home delivered and 62% of congregate clients. Participants value the Program because it enables them to eat more balanced meals and avoid sodium and fat. Almost 95% rate meals good to excellent and about 90% are satisfied with the food taste and its on-time delivery at home. Over half of congregate clients participate in fitness activities, use health screening and have increased social opportunities.[27] The Congregate Nutrition Program helps participants remain independent and engaged though meals, culturally appropriate nutrition education and physical activity and social interaction.

The Nutrition Program has a grassroots approach and an infrastructure in place to offer a comprehensive array of popular consumer-driven nutrition services/intervention to meet needs of the complete older adult. They include:

1.) Meals: tasty and nutritionally dense to enhance food/nutrient intake;

2.) Congregate meal site participation: provides interaction and improves active social engagement;

3.) Nutrition education: empowers consumer and caregiver behavioral change and provides information about the latest nutritional buzz;

4.) Nutrition counseling: enhances chronic disease management for consumers and caregivers;

5.) Referrals and coordination: connects consumer and caregiver to community partners for health promotion/disease prevention services, to in-home services, to food and nutrition assistance programs, to facility based discharge planners for post discharge meals, to Medicaid Waiver home and community based services to delay nursing home placement.[30]

The Nutrition Program adheres to a continuous quality improvement process to maintain adherence to the latest scientific evidence and highest performance standards. Mechanisms are in place to measure customer satisfaction, analysis of dietary intake, assurance of nutritional quality and safe food, assurances for families, and adherence to consistency of standards. It also provides appropriate training and guidance on nutritional aspects to case managers as they assess for need for services, training for homemakers and personal care assistants in appropriate shopping and meal preparation and

modification, and for family primary caregivers to help them provide adequate nourishment for their care recipient and themselves. This assures older adults, their families, federal, SUA and AAA decision makers and funders that a process is in place to provide services that are safe, comprehensive and scientifically accurate.

In addition to empowered consumers and families, the AoA *Choices* initiative requires a full array of home and community services that support long term living. The Nutrition Program has a long history of providing consumers and families with a wide variety of nutritional choices. These include the following *Choices*:

1.) Service model including congregate sites and restaurant vouchers targeted for specific purposes;

2.) Menu and food selection including culturally appropriate meals, menu choices including soup and salad bars or food items;

3.) Home Delivered Meals including specialized therapeutic meals (e.g., renal diets or modified consistency) and meals served hot or frozen and delivered or weekly or meals for older caregiver;

4.) In-depth individualized nutrition counseling for disease management for consumer and caregiver (e.g. diabetes, cancer); and

5.) Educational sessions including caregiver needs, guidance for healthy eating, and tips for physical activity.

Choices and the OAA Nutrition Program

Choices offers opportunities for a seamless, coordinated, comprehensive home and community based system. This system can help the aging network overcome challenges due to service gaps. Gaps occur when many federal, state and local agencies offer different services and levels of intensity, with different eligibility requirements and diverse funding mechanisms.

The *Choices* initiative extends the OAA Nutrition Program's health and independent living services to new groups of older adults, families and caregivers. *Choices* will help end the challenge posed by a gap in nutrition services. Many in the aging network view food and nutrition as two separate non-intersecting parallel systems: 1.) food as part of a social and supportive services system; and 2.) nutrition as part of a medical problem-oriented treatment. The Nutrition Program holistically addresses both as they impact consumers and families.

Choices allows states and communities the flexibility to provide information and referral services, long term living options, and health promotion and disease prevention programs specific to their residence needs. SUAs, AAAs and OAA Nutrition Program providers can collaboratively develop state, area and local plans around consumer driven nutrition outreach, messages and services. *Choice* models need to be supported through in-service programs by OAA Nutrition Program registered dietitians to train case managers and other service professionals, including homemakers and personal assistants, regarding the provision of safe food and acceptable nutrition practices.

Older adults are willing to make nutrition related lifestyle changes when information relevant to their needs is available and they understand how to make the changes.[31] Some examples of *Choices* in an integrated coordinated OAA Nutrition Program component follow.

1.) Empower consumers to make informed *Choices* for long term living:

- One-Stop-Shopping to reduce nutrition risk and promote healthy eating through availability of consumer-tested informational brochures, list information about congregate dining sites,
- Prioritize service referrals to reduce malnutrition risk by including 2-3 key questions about inadequate nutrition and health on the uniform I&R form[5], and
- Reduce nutrition risk and food insecurity through information and referrals to agencies and programs that increase access to food (e.g., Food Stamp Program, food banks, Senior Farmers Market Nutrition Program);

2.) Target high risk, nursing home appropriate, non-Medicaid individuals and delay institutionalization through *Choices* for home and community care to meet their individualized needs and preferences without the current OAA service categories or title restrictions:[21,23]

- Provide training to case managers and other assessors to help them understand nutrition related needs and when nutrition services might be needed for consumers and their families including nutrition screening, assessment, problem identification, individualized intervention and follow-up evaluation,
- Provide *Choices* in home delivered meals including specialized therapeutic meals, meals modified for consistency, choice of hot or frozen meals and service daily or weekly, and
- Provide *Choices* in discharge planning and array of nutrition services to be provided including meals, individualized nutrition counseling for disease management;

3) Build prevention into community living through a variety of evidence based health promotion and disease prevention programs designed for older adults:[23]

- OAA Nutrition Program can provide information and referrals for consumers and families about evidence based HPDP programs in area,
- Work with evidence based HPDP to build components into senior centers and congregate dining sites, and
- Offer *Choices* among HPDP programs offered to homebound consumers.

Science increasingly supports the direct role of food and nutrition in promoting health, managing chronic disease and reducing its risk, maintaining functional independence and protecting quality of life for older adults. The Nutrition Program has a nutrition care process and infrastructure in place. Its infrastructure is built around grassroots community based partners and consumers facilitating coordination and integration of various nutrition related services. The OAA Nutrition Program has successfully met client and caregiver needs through coordination of different philosophies, services and funding mechanisms including aging network, training and partner coordination issues. The AoA can use the Nutrition Program as a model to facilitate implementation of *Choices for Independence*.

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CHOICES FOR INDEPENDENCE

MODERNIZING THE OLDER AMERICANS ACT

MARCH 9, 2006

Choices for Independence

Reauthorization of the Older Americans Act includes a proposal to pilot Choices for Independence, a $28 million demonstration project to promote consumer-directed and community-based long term care options. Choices aims to strengthen the nation's capacity to promote the dignity and independence of older people and meet the challenges associated with the aging of the baby boom generation. It also aims to supplement the President's New Freedom Initiative and the Administration's policy for modernizing Medicare and Medicaid by strengthening the Act's role in promoting consumer choice, control, and independence in long-term care.

The Older Americans Act supports a Federal, state, tribal and local partnership known as the national aging services network, which includes 56 state units on aging, 655 area agencies on aging, 243 tribal organizations, 29,000 community-based organizations, and over 500,000 volunteers. The network uses $1.4 billion in federal funds each year to leverage an additional $4 billion from other public and private sources to provide home and community-based services to over 8 million elderly individuals. Services include home-delivered meals, nutrition services in congregate settings, transportation, adult day care, health promotion, and support for family caregivers.

Choices for Independence builds on the mission and success of the Older Americans Act. It also builds on recent HHS initiatives, including: the Aging and Disability Resource Center Initiative; the Own Your Future Long Term Care Awareness Campaign; the Cash & Counseling Demonstration Program; and, the Evidence-Based Disease Prevention for the Elderly Program. Choices integrates best practices from these initiatives into a three-pronged strategy focused on: empowering individuals to make informed decisions about their long-term support options; providing more choices for individuals at high-risk of nursing home placement; and enabling older people to make behavioral changes that will reduce their risk of disease, disability, and injury.

The Older Americans Act is uniquely positioned to advance these changes. It has a statutory focus on keeping older people independent and living in their own homes and communities for as long as possible, and a successful history of providing low-cost, non-medical supports through a federal, state and local partnership under a capped federal appropriation.

Empowering Individuals to Make Informed Choices

Choices aims to empower individuals – both those in immediate need and those who have the ability to plan ahead for their long-term care – to make informed decisions about their support options. To promote ownership over long-term care planning, Choices will conduct a public education campaign and provide individual support through "one stop" resource centers, known as Aging and Disability Resource Centers. These resource centers will be "visible and trusted" sources that people can turn to for information on all available

support options, including private financing options such as long-term care insurance and home equity instruments. This will reduce the confusion and frustration consumers and their families often face as they explore long-term care options. It will also improve government efficiency by integrating the multiple eligibility forms and procedures for various public programs that help finance long-term support options.

Providing More Choices for High-Risk Individuals

Choices will give states and communities greater flexibility under the Older Americans Act to help moderate and low-income individuals to remain in their homes and delay their premature entry into nursing homes. Choices will provide flexible funding that will be targeted at individuals, not at service categories as with the current titles under the Act. This will make it easier for states to respond to people's individualized needs and preferences. It also will promote the use of consumer-directed approaches, including "cash and counseling" models which give consumers more control over the care they receive.

Building Prevention into Community-Living

Choices will empower older individuals to make lifestyle changes that will reduce their risk of disease, disability, and injury. There is a growing body of scientific evidence on the efficacy of low-cost programs that can empower older individuals, including functionally impaired individuals, to better maintain their health. These programs focus on interventions such as chronic disease self-management, falls prevention, exercise, and nutrition. Choices will strengthen the role of the Older Americans Act in translating research into practice by promoting the use of evidence-based health promotion and disease prevention programs at the community-level through local aging services provider organizations such as senior centers, nutrition programs, senior housing projects, and faith-based groups. The nation-wide deployment of these programs will improve quality of life, reduce health care costs, and complement the increasing focus on prevention in our health care system.

Implementing the Choices Demonstration

Choices will provide competitive matching grants to states and will entail a rigorous program evaluation. Participating states will be required to track outcomes based on performance measures that will be established by AoA. Such measures may include promotion of consumer health and well-being, and reductions in the unnecessary use of costly hospital and nursing home care. AoA will establish a national technical assistance program for Choices to support state implementation activities. Finally, AoA will involve the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, the National Institute on Aging, the Agency for Healthcare Research and Quality, and other HHS agencies in the implementation of Choices.

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