Academy of Nutrition and Dietetics

Older Americans Act Reauthorization

About Us

Registered dietitian nutritionists work to improve the health of all Americans through access to healthy food and nutrition services. The Academy of Nutrition and Dietetics is a nonpartisan organization representing more than 75,000 members nationwide. We are the world's largest organization of food and nutrition professionals.

Key Points

- OAA nutrition programs provide critical services, including healthy meals, to older adults who might otherwise be at risk for malnutrition.
  - Approximately 2.5 million older adults received meals in 2012 from OAA nutrition programs.
- Nutrition therapy and interventions are cost-effective:
  - The cost of one day in a hospital is roughly the same cost as providing an older adult with one year of meals through OAA nutrition programs.
- Medical nutrition therapy delivered by RDNs as part of OAA nutrition programs lessens chronic disease risk and addresses nutrition problems that can lead to more serious and costly conditions and adverse events.

We Ask You to Support the Older Americans Act Re-authorization of 2015

The Older Americans Act (OAA) was first enacted in 1965 to address inadequate community social services for older adults. The current re-authorization lapsed in 2011. On January 20, 2015, Senators Lamar Alexander, Patty Murray, Bernie Sanders and Richard Burr introduced S. 192, the Older Americans Act Reauthorization of 2015. The bill would re-authorize the OAA for three years, through 2018. The language builds on S. 1562, sponsored by Senator Sanders in the 113th Congress, which the Academy also supported. The bill updates the language to reflect the "utilization" of registered dietitian nutritionists in nutrition programs and encourages the use of locally grown fresh foods in nutrition programs.

Older American Act Nutrition Programs Are Essential for Older Americans

In FY 2012, OAA nutrition programs provided 223 million meals to approximately 2.5 million older adults, of which over 60 percent were home delivered.[1] Today, the majority (80 percent) of older adults live with at least one chronic condition, with more than 2/3 having multiple chronic conditions – including hypertension, diabetes, and coronary heart disease – all of which are preventable or treatable in part by access to appropriate nutrition services.[2] Participation in OAA nutrition programs can benefit vulnerable older adults in the following ways:

- **Fewer health care acquired infections:** Older adults with strong nutritional status are less likely to acquire infections if they require hospitalization or other facility care, which means shorter hospital stays and lower healthcare costs.[3]
- **Fewer falls:** Proper nutrition including protein, vitamin D and calcium helps keep muscles stronger and prevents brittle bones that can easily be broken during a fall. Additionally, older adults who eat a variety of food and get enough folate in their diets are less likely to fall than malnourished older adults.[4,5]

- **Enough money for medications:** Many older adults are forced to choose between using their limited resources to purchase medications or food, and often they choose to purchase food instead of medications. Inability to purchase medications results in poor health and increases the number of disease complications that older adults may experience.[6]

Importance of Registered Dietitian Nutritionists in Title III Nutrition Programs

The OAA authorizes providers of congregate and home-delivered meal programs to offer nutrition education and screening, assessment and nutrition counseling. When provided by registered dietitian nutritionists, nutrition counseling and other forms of medical nutrition therapy (MNT), including nutritional assessment and nutritional therapy services, can slow the progression and reduce symptoms of chronic diseases.[7]

Given the positive impact of nutritional assessment and counseling, both on health outcomes for older adults and on health care costs, we support the inclusion of language in the reauthorization of OAA that ensures that qualified nutrition staff, including registered dietitian nutritionists, is included at the local, regional, state and federal levels of the aging network so that cost-effective nutrition services and evidence-based programs result.

Cost-Effectiveness of Title III Nutrition Programs

The cost of a hospital stay is equal to almost seven years of meals through OAA nutrition programs; in 2011, for example, the average expenditure in the United States for a home-delivered meal was $7.[8,9] The cost of one month in a nursing home is the same cost as providing mid-day meals, five days per week, for more than four years.[10] In 2002, OAA programs served 6,103 clients per $1 million of federal funding, while in FY 2012, that figure increased to 9,206 clients per $1 million of funding.[11,12] OAA programs are rooted in state and local efforts and contributions; in fact, for every federal dollar spent, OAA programs generate an average of three dollars more.[13]

Priorities of the Academy of Nutrition and Dietetics for OAA Reauthorization

1. Support the passage of the Older Americans Act Re-authorization Bill of 2015, S. 192.
2. Ensure language that qualified nutrition staff, including registered dietitian nutritionists, is included at the local, regional, state and federal levels of the aging network so that cost-effective nutrition services and evidence-based programs result.
3. Include language that supports a strong evidence-based nutrition and health component through programs that include targeted nutrition screening, assessment, counseling and education.

1 http://www.acl.gov/Newsroom/blog/2014/2014_03_03.aspx. Accessed February 5, 2013.
2 Centers for Disease Control and Prevention (2011). Healthy Aging at a Glance 2011: 1--4. Retrieved January 22, 2015.
3 Gamaletsou MN, et. al. (2012). Nutritional risk as predictor for healthcare--associated infection among hospitalized elderly patients. Hosp Infect Vol. 80(2):168--72.
4 Coin A, P,et. al (2008). Predictors of low bone mineral density in the elderly: the role of dietary intake, nutritional status and sarcopenia. Eur J Clin Nutr. Vol. 62(6): 802--9. 5 Shahar D, et. al. (2009). Nutritional status in relation to balance and falls in the elderly: a preliminary look at serum folate. Ann Nutr Metab. Vol 54(1):59--66.
6 Bengle R., et al. (2010). Food insecurity is associated with cost--related medication non--adherence in community--dwelling, low--income older adults in Georgia. J Nutr Elder Vol. 29(2):170--91. 7 Position of the American Dietetic Association, American Societyfor Nutrition and Societyfor Nutrition Education: Food and Nutrition Programsfor Community--Residing Older Adults(2010). J Am. Diet Assoc. Vol. 110:463--472.
8 www.hcup--us.ahrq.gov/reports/statsbriefs/sb146.pdf. Agency for Healthcare Research and Quality. Costs for Hospital Stays in the U.S. 2010. Accessed January 23, 2015. 9 Meals on Wheels Association of America. Where Your Dollars Go. Accessed January 23, 2015 from www.mowaa.org/yourdollars.
10 MetLife Mature Market Institute.MetLife market survey of Long--Term Care Costs. 2012.
11 Testimony of Assistant Secretary Kathy Greenlee, U.S. Dept of HHS' Admin on Aging, before the Senate HELP subcommittee on Primary Health and Aging. June 21, 2011.
12 Dept. of HHS. Fiscal Year 2015 Administration for Community Living--Justification of Estimates for Appropriations Committees.
13 National Academy of Sciences (2012). Nutrition and Healthy Aging in the Community: Workshop Summary. Sheila Moats and Julia Hoglund, Rapporteurs; Food and Nutrition Board, IOM. Page 9.