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SENIOR HUNGER AND THE OLDER AMERICANS ACT

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BEFORE THE

SUBCOMMITTEE ON PRIMARY HEALTH AND AGING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

ON

EXAMINING SENIOR HUNGER AND THE "OLDER AMERICANS ACT"

JUNE 21, 2011

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C O N T E N T S

STATEMENTS

TUESDAY, JUNE 21, 2011

SENIOR HUNGER AND THE OLDER AMERICANS ACT

TUESDAY, JUNE 21, 2011

U.S. SENATE,
SUBCOMMITTEE ON PRIMARY HEALTH AND AGING,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:02 a.m. in Room 430, Dirksen Office Building, Hon. Bernard Sanders, chairman of the subcommittee, presiding.

Present: Senators Sanders, Hagan, Franken, and Paul.

OPENING STATEMENT OF SENATOR SANDERS

Senator SANDERS. Good morning and welcome to a hearing of the Committee on Health, Education, Labor, and Pensions Subcommittee on Primary Health and Aging. Today's hearing is addressing a very important issue and I want to thank everybody for being here, especially our panelists.

I don't have to tell anybody in this room that our country today faces some enormously serious problems, and one of them is that, in a time of severe recession, high unemployment, and increased poverty, how do we make certain that all of our people, especially the most vulnerable, those unable to take care of themselves, are able to maintain at least a minimal standard of living.

In my view, the problem that we are discussing today, food security among seniors, is both a moral issue and it is a financial issue. So we're going to be going over both of those aspects of the problem this morning. From a moral perspective, it is clear to me that in this great Nation no one should go hungry, especially those who are old and frail and unable to take care of themselves. From a financial perspective, what is also clear—and we will hear testimony about this this morning from our panelists—is that investing in senior nutrition and in well-designed senior programs in general saves money. Let me repeat that: Saves money for the government, because when we do that, when we make sure that our seniors have adequate nutrition, among other things, at the end of the day those seniors are not going to be ending up in a emergency room, those seniors are not going to be ending up in a hospital when they should not be in a hospital, and in many cases they're not going to be ending up in a nursing home.

I think one of the main points that I want to make this morning and we'll pursue with our panelists, is that investing in seniors, making sure that seniors have the nutrition that they need, is not

only the right and moral thing to do; it is the financially smart thing to do.

Today the situation in our country with regard to hunger among seniors is not anything that we should be proud of and is something that must be significantly improved. As the baby boom generation transitions into their senior years, an ever-expanding number of our Nation's seniors grapple with issues of food insecurity and malnutrition. In fact, the hunger rates for lower income seniors have more than doubled in recent years.

In the wake of the recession, there is a growing demand for both home-delivered and congregate meal programs, and there is evidence indicating that some of our poorest and most functionally limited seniors are simply not getting the nutrition they need.

Sometimes here on Capitol Hill, in this beautiful room, it is hard to imagine that right now all over this country there are hundreds of thousands, if not millions, of seniors sitting alone, perhaps suffering from one or another degree of dementia, confused about the medications they are taking, not able to prepare the food that they need in order to take care of themselves. But that is a reality that is going on in our country and a reality that we as Americans have got to address.

It is estimated today that 5 million seniors face the threat of hunger, 3 million seniors are at risk of hunger, and 1 million seniors go hungry because they cannot afford to buy food. But in some cases it's not just money. In some cases it's having the transportation to get to the store. In some cases it's the ability to think through, when you're 85 or 90 and alone, what kind of food you need and how you purchase it.

This issue is important again not only from a moral perspective, but from a financial one as well. Persistent hunger and malnutrition leads to multiple chronic diseases, resulting in extended hospital stays and premature nursing home placements. There are some studies out. They're not quite sure about what percentages of seniors today who are in nursing homes, and might not need to be in that expensive care, if they had good nutrition and somebody visiting them on a regular basis. That seems to me to be pretty dumb, not a good way to spend Federal money.

Medicaid is paying for 70 percent of nursing home residents' care in this country. At a time when we face skyrocketing deficits, we must dedicate our efforts to funding and finding inexpensive preventative measures to deal with these issues. We, as a nation, do not do well with prevention. We waste huge sums of money by taking care of people at the end, at the end when they're in the hospital, when they're very sick, rather than keeping them from getting sick.

In today's hearing we will also be discussing the simplest of common sense solutions, ensuring that older Americans have access to a prepared and nutritious meal. I have visited many senior centers in Vermont and I just want to thank—not just in Vermont, but all over this country, there are tens and tens of tens of thousands of volunteers who are driving their cars, delivering Meals on Wheels, taking care of seniors, doing all kinds of wonderful things as volunteers, and I want to make it clear that we are very, very appreciative of their efforts.

Today we have a wonderful panel. We're going to take a comprehensive look at this issue, at the severity of the problem, what makes sense, common sense solutions to that problem. So I again want to conclude by thanking all of you for being here and thanking our panelists for the presentations they will shortly make.

Now I'd like to introduce Senator Rand Paul.

Senator Paul.

STATEMENT OF SENATOR PAUL

Senator PAUL. Thank you, Chairman Sanders.

As a physician who's cared for the elderly and impoverished patients, I have a very real and personal concern for those without the resources or the ability to provide for themselves. It would be a great burden and motivation on every American's heart that elderly individuals, however few, are in need. Ensuring that no senior citizen goes hungry is an important goal for our country. The consequences of malnutrition are devastating. In addition to personal hardships, senior hunger also costs taxpayers in the form of higher health costs.

Unfortunately, it's not as simple as waving a magic wand of government and poverty's gone or hunger is gone. We've been doing this a long time, with some success and some failure. The Older Americans Act of 1965 was originally passed as part of LBJ's Great Society war on poverty. Since 1965 the Federal Government has invested over $51 billion in noninflation-adjusted dollars in the Older Americans Act programs. We must ask ourselves, if government is capable of ending poverty for seniors why haven't we succeeded?

We should ask if private charity is also capable of feeding the hungry and do government programs crowd out private charity? We should ask why we have 70 duplicate Federal programs for nutrition.

Today we are focusing our discussion on senior hunger and nutrition services within the Older Americans Act. Nutrition programs make up $818 million out of the $2 billion spent on this program. We will be discussing multiple nutrition programs, including the congregate meals program, home-delivered meals program, nutrition services incentive grants, etc. These programs are just a few of the dizzying array of Federal programs related to domestic food assistance.

The GAO recently issued a report finding that there are over 70 duplicate programs, 70 duplicate Federal programs, dealing with nutrition. Eighteen of these duplicate Federal programs are primarily dealing with nutrition and six of these duplicate Federal programs are for seniors.

We have a chart here that gives you an idea of how we do nutrition assistance. Like so much of government over the last several decades, we just add more to it. We've got program after program, a dizzying array, through this algorithm.

We must ask, what if this program didn't exist tomorrow? Would people still get food from the government? Probably from 69 other programs they'd get food. For example, what if we did food stamps, made the food stamps cover those that they're not covering, give the money to States, let the States administer it and get it to hungry people? It would be a heck of a lot simpler.

The thing is that administration of programs, any program, is notoriously inefficient the farther it is away from the people. The closer it is to the people through the States, the more efficient the program is. We should feed hungry people, but we shouldn't feed people who have the resources to feed themselves. We should feed hungry people that private charity is not feeding, but we shouldn't feed hungry people that private charity is feeding.

We should try not to duplicate ourselves? Why? Because we spend $2 trillion we don't have, so we're having to borrow money from China, borrow money from Japan, borrow money from Russia. The list goes on and on. We do not have unlimited resources, so we have to rethink what we've been doing for the last 50 years.

We're in a big mess as a country. It doesn't mean we cannot help those who need help, but we should be helping only those who truly do need help.

Are we advertising these services? How much money do we spend advertising? In my town there's somebody going all around the State, they're advertising in the newspaper. You know, if people need assistance, let them know where the assistance is, but do we have to promote the programs and have a promotional budget to promote the programs?

But I think we need to simplify these things. As a whole, the government spent over $90 billion on food nutrition assistance in 2010. This isn't including Medicaid. We are spending an enormous amount of money and we need to spend it more wisely. We need to cut out the duplication.

Meals on Wheels has a great history. My grandmother delivered Meals on Wheels to people for most of her adult life. When she could barely walk up the steps in Pittsburgh, she was still taking meals to others who she thought were less fortunate than herself.

There are good programs, but we must ask how many of these programs can exist and might exist if we get the government out of their way. MIT researchers Jonathan Gruber and Daniel Hungerman have written an excellent paper finding that for every dollar of Federal spending, there was a corresponding 3 percent reduction in charitable giving by the churches. Overall they found that government or Federal spending led to an overall 30 percent decline in charitable church giving.

There are many great programs out there. For example, Wal-Mart Foundation made a $2 billion commitment to hunger relief efforts in the United States through 2015, almost equal to these Federal programs.

You have to ask yourself, if you had $100 who would you give it to? Would you give it to the Federal Government to say, "will you help some people with my $100," or would you give it to the Salvation Army or to a private charity that does a much better job, that's much more efficient, and gets people and does help people in your area, and you can go and see the help directly?

You have to ask the difference also, is there a difference between charity, private charity, and the nobility of private charity, and then sort of the bureaucratic malaise of a transfer program that involves transferring wealth from one group to another.

In the remarks that we will hear today, we will find out that only 13 percent of the people getting assistance from the OAA are

said by the group who is making this determination, which may or may not be the most objective, that only 13 percent of them would not be able to get this without OAA's assistance. In other words, 87 percent of them could, either through food stamps or through other programs or, since there really doesn't seem to be a financial indication for why you get this assistance, they could be affording to get their food on their own.

The question is really, do we need duplicate programs? Should we not be trying to get rid of duplication at the Federal Government level? Should we not be simplifying these programs? Should we not be sending these programs back to the States so they can have better oversight, so we can have less bureaucrats in the middle, less overhead, and more efficient distribution of services?

These aren't questions that are just philosophic questions. These are questions that have to and will have to be answered because we as a country are out of money and we cannot just keep adding on program after program.

Thank you, Mr. Chairman.

Senator SANDERS. Thank you.

Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. I want to get to our witnesses and don't want to take too long, but make no mistake about it, the Older Americans Act saves money. It leverages money. It saves money. It allows seniors to stay in their homes who wouldn't otherwise be able to stay in their homes.

So when we're talking about duplicative programs, Meals on Wheels and congregate dining aren't duplicative; they're part of the same program. Let's not get too confused here. I was a member of the Special Committee on Aging last Congress, and because I'm a member of the HELP Committee—I'd like to thank the chairman for holding today's hearing on this very important issue to Minnesota seniors and across the country, and the ability to participate—I'm not a member of this subcommittee, but I'm a member of the HELP Committee and I was a member of the Special Committee on Aging, and as such I asked my staff to start going around the State and doing listening sessions on the Older Americans Act, because I knew we were going to be reauthorizing it. And I personally have done six or seven. I did one this last weekend in Burnsville, MN, at a great place called Ebenezer Ridge's.

I cannot tell you how important this is to those seniors. I would ask the Ranking Member, have you been to listening sessions with these seniors? Because—and I thank your grandmother for doing what she did. Your grandmother was volunteering.

This is leveraging volunteers, and they are—Meals on Wheels is a wonderful program. I think we'll have witnesses speaking about what it costs to deliver Meals on Wheels. Your grandmother was probably reimbursed for travel.

It is sometimes the only point of contact that these seniors have during the day and breaks their isolation and how many Meals on Wheels volunteers have found a senior in actual dire trouble and saved their lives?

I love the volunteers that I've met in the listening sessions that I've done. I also loved the professionals who implement the program.

What I'd like to emphasize is the actual savings that this program creates. There are seniors who are able to live in their homes as they would prefer, rather than have to go to a nursing home, and but for this program—but for Meals on Wheels, but for congregate dining, but for those who provide eldercare, many of whom are seniors themselves, like your grandmother, Senator Paul, who are very moving in their testimony, who say that this is a spiritual thing that they do, providing care for other seniors who need it—this is a program that saves and leverages money to save the Federal Government money, and it is a very successful program and I'm pleased to be participating in today's hearing.

Senator SANDERS. Thank you very much, Senator Franken.

Now we're going to hear from our first witness. Kathy Greenlee is the Assistant Secretary for the Administration on Aging, U.S. Department of Health and Human Services. Assistant Secretary Greenlee served as Kansas's Secretary of Aging and State Long-Term Care Ombudsman. She also recently served on the board of the National Association of State Units on Aging.

Ms. Greenlee, thank you very much for being with us this morning.

STATEMENT OF KATHY GREENLEE, ASSISTANT SECRETARY, ADMINISTRATION ON AGING, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. GREENLEE. Thank you, Chairman Sanders. It's good to see you again. I appreciate you holding the hearing. I also want to acknowledge Senator Paul. I'm very glad that your subcommittee is paying particular attention this morning to hunger, a very important subject.

I would also like to say, "hi" to Senator Franken. I commend you. I know of the work that you've been doing in Minnesota as you've gone around the State to gather information, and I just want to thank you for that work as well.

I appreciate the opportunity to testify at this hearing about hunger, the senior nutrition programs, and the Older Americans Act. The Older Americans Act plays a critical role in helping many of our most vulnerable seniors maintain their health, their well-being, and independence, avoiding more costly hospital or nursing home placement, as you mentioned, Senator Sanders.

Hunger and food insecurity is a serious problem among many older Americans. Research that was sponsored by the Meals on Wheels Association found that nearly 6 million seniors faced the threat of hunger in 2007. We know that, through science-based research, that adequate food and nutrition is vitally important for promoting health, decreasing the risk of chronic disease, maintaining functionality, and helping older adults maintain their independence at home and in their communities.

The Older Americans Act nutrition programs have been one of the core elements of our national strategy for reducing food insecurity among the elderly for nearly 40 years. As you have mentioned, there are three different food programs that we administer at the

Administration on Aging, three different strategies for dealing with senior hunger.

One is the Congregate Nutrition Service. This provides meals in a group setting, such as senior centers. In my experience, many elected officials at every level are familiar with senior centers, have seen the valuable services that are provided, not just the food, but also other wellness and other activities, and companionship for seniors as they participate. In fiscal year 2009, more than 92 million meals were provided to nearly 1.7 million seniors in a congregate senior center setting.

The second program is, of course, the home-delivered meals program. Some people know this as the Meals on Wheels program. Meals on Wheels is certainly a critical partner in our attack against senior hunger. There are also other home-delivered meals programs, and all of the meals programs that are providing to home-bound individuals do so to individuals who are home-bound due to illness, disability, or geographic isolation. The home-delivered meals is often the first in-home service that someone requests and serves as the primary access point to other critical home and community-based services.

In fiscal year 2009, nearly 149 million home-delivered meals were delivered, 149 million, to more than 880,000 home-bound individuals.

Our third strategy and nutrition program, I think, is not as well known as the congregate meals or home-delivered. That's the Nutrition Services Incentive Program. This is an incentive program that is distributed based on performance the year before, number of meals served the year before. It gives the area agencies on aging and the meal providers access to commodities programs administered at the U.S. Department of Agriculture, either cash to purchase commodities or commodities themselves.

It's important to note that our programs and the older adults who participate in these nutrition programs are low income, but income itself is not the only objective. It's not the only measure of need for nutrition services. We certainly target programs to people who are low income, but there are many seniors who are functionally impaired, meaning they can no longer drive to a grocery store, they can no longer physically carry their groceries, they can no longer see, they can no longer actually prepare the meal, which makes this program very different from a program that provides access to groceries. This is a program that provides access to prepared meals, because at some point many people can no longer cook for themselves. They have physical inability to prepare their own food.

Our services through the Older Americans Act are targeted and they have always been meant to serve people who are older, poorer, more likely to live alone, more likely to be minorities, in poor health, in poor nutritional status, functionally impaired, and at higher nutritional risk.

Our performance data indicates that the Older Americans Act programs are effective. Fifty-eight percent of congregate and ninety-three percent of home-delivered meal recipients say that the meals enable them to live in their communities longer. The major-

ity of nutrition program recipients receive more than half of their total food intake for the day from our programs.

As much as we love the nutrition program, I believe it's also important that in many instances nutrition alone is not a sufficient support. There are other individuals who need other kinds of support that we provide in order to help them maintain their health and stay out of hospitals and nursing homes.

Older Americans Act programs help older Americans with severe disabilities remain independent. The programs are efficient and they build system capacity. For every Federal dollar the Older Americans Act funds, communities and States leverage nearly $3 in other funding.

As a former Secretary of Aging in Kansas and finishing my second year as the U.S. Assistant Secretary for Aging, I have seen firsthand how these programs support the values we all share, supporting independence, maintaining health, helping people that are the most vulnerable among us, and providing respite care for families as they continue to take care of their loved ones.

Chairman Sanders, I look forward to continuing to work with you as we talk about this program and other programs that we administer at the Administration on Aging, and to continue to engage with members of your committee as we talk about the reauthorization of the Older Americans Act.

Thank you.

[The prepared statement of Ms. Greenlee follows:]

PREPARED STATEMENT OF KATHY GREENLEE

Thank you, Chairman Sanders, Ranking Member Paul, and members of the Subcommittee on Primary Health and Aging, for the opportunity to testify at this important hearing on hunger, senior nutrition programs and the role of the Older Americans Act (OAA) in helping some of our most vulnerable seniors maintain their health and well-being in their homes and communities, avoiding more costly hospital and nursing home care.

Hunger and food insecurity is a serious problem among many older Americans. Research sponsored by the Meals on Wheels Association of America in 2008 found that nearly 6 million seniors faced the threat of hunger in 2007.[1] Half of these at-risk seniors had incomes above the Federal poverty line. These individuals and households, at some time during the year, had difficulty providing nutritionally adequate and safe foods due to a lack of resources. Yet, study after study show that adequate food and nutrition is vitally important for promoting health, decreasing the risk of chronic disease, maintaining functionality, and helping older adults remain independent at home, and in their communities.

OAA nutrition services programs have been one of the core elements of our national strategy for reducing food insecurity among the elderly for nearly 40 years. These vital community-based programs, which serve persons aged 60 and over, provide access to meals in a group setting or delivered to the home, a service that is not provided by other Federal nutrition programs.

As currently authorized, OAA nutrition services programs include:

• *Congregate Nutrition Services (Title III–C1)*: Provides funding for the provision of meals and related services in a variety of congregate settings, which help to keep older Americans healthy and prevent the need for more costly medical interventions. Established in 1972, the program also presents opportunities for social engagement and meaningful volunteer roles, which contribute to overall health and well-being. In fiscal year 2009, more than 92 million meals were provided to nearly 1.7 million seniors in a variety of community settings.

[1] "The Causes, Consequences, and Future of Senior Hunger in America." James P. Ziliak, Ph.D., Gatton Endowed Chair in Microeconomics and Director of the Center for Poverty Research, University of Kentucky; Craig Gundersen, Ph.D., Associate Professor, Department of Human Development and Family Studies, Iowa State University. Sponsored by the Meals on Wheels Association of America. March 2008.

• *Home-Delivered Nutrition Services (Title III–C2)*: Provides funding for the delivery of meals and related services to seniors who are homebound due to illness, disability or geographic isolation. Established in 1978, home-delivered meals are often the first in-home service that an older adult receives, and serve as a primary access point for other home and community-based services. In fiscal year 2009, nearly 149 million home-delivered meals were provided to more than 880,000 homebound individuals.

• *Nutrition Services Incentive Program (NSIP) (Title III–A)*: Provides additional funding to States, Territories, and eligible tribal organizations that is used to provide meals. Funds are awarded to States and Tribes based on the number of meals served in the prior Federal fiscal year. States and Tribes have the option to purchase commodities directly from the U.S. Department of Agriculture with any portion of their award if they determine that doing so will enable them to better meet the needs of the older persons they serve.

Although many of the older adults who participate in both the congregate and home-delivered programs are low-income, income alone is not an adequate measure of need for nutrition services. Many of the recipients of this assistance are functionally impaired, meaning that they may not be able to drive to a grocery store, carry their groceries, stand for even short periods of time, or they may have hands that are too affected by arthritis to prepare a meal. In other words, provision of groceries is not sufficient to eliminate food insecurity and hunger in this population.

In sum, each year the OAA nutrition services programs help more than 2.5 million older adults, many of whom are functionally impaired and are at risk of serious health consequences, receive the meals they need to stay healthy and decrease their risk of disability.

OAA Nutrition Programs Effectively Target Those With Special Needs. The OAA does not require that all people be served, nor is it means tested, but it does require that services be targeted. The OAA nutrition programs are generally targeted to those with the greatest levels of food insecurity, including those who are poor or near poor, socially isolated, functionally impaired, and in poor health. *Serving Elders at Risk*, a national evaluation of the Administration on Aging's (AOA) nutrition program clients, found that recipients of this assistance are older, poorer, more likely to live alone, more likely to be minorities, in poorer health and nutritional status, more functionally impaired, and at higher nutritional risk than older individuals in the general population.[2]

Based on data gathered through fiscal year 2009 and via the 2009 National Survey of Older Americans Act program participants, we know the following about the participants in the OAA nutrition programs:

For the home-delivered meals programs:

• 4 percent are in poverty and 52 percent are at high nutritional risk;
• 24 percent do not have enough money or food stamps to purchase enough food to eat;
• 63 percent rely on their home-delivered meal for one-half or more of their total food for the day;
• 17 percent report they choose between purchasing food and medications;
• 55 percent of white, 63 percent of African-American and 38 percent of Hispanic home-delivered meal participants report their health as fair to poor.

For the congregate meals programs:

• 34 percent are in poverty and 19 percent are at high nutritional risk;
• 13 percent do not have enough money or SNAP benefits to purchase enough food to eat;
• 58 percent rely on their congregate setting meal for one-half or more of their total food for the day;
• 27 percent of white, 38 percent of African-American and 26 percent of congregate meal participants report their health as fair to poor.

AOA's annual performance data further demonstrate that these programs are an efficient and effective means for helping seniors remain healthy and independent in their homes and in the community. Ninety-one percent of home-delivered meal clients rate service as good to excellent. In addition, the number of home-delivered meal recipients who have severe disabilities (those with three or more impairments of activities of daily living) totaled more than 357,000 in fiscal year 2009. This level of disability is frequently associated with nursing home admis-

[2] *Serving Elders at Risk—National Evaluation of the Elderly Nutrition Program, 1993–95,* pp. 117–18.

sion, and demonstrates the extreme frailty of a significant number of persons served by the home-delivered meals program.

Additionally, data from AOA's 2009 national survey of elderly program participants show that the nutrition services programs are effectively helping seniors improve their nutritional intake and remain at home: 73 percent of congregate and 85 percent of home-delivered meal recipients say they eat healthier meals due to the programs, and 58 percent of congregate and 93 percent of home-delivered meal recipients say that the meals enabled them to continue living in their own homes.[3]

For the majority of program participants, the program provides more than one-half or more of their total food intake and enables them to continue living in their own homes.

AOA continues to build upon the successes of the senior nutrition programs and further increase their effectiveness by implementing a multi-year, comprehensive evaluation. In addition to providing detailed information on how the nutrition programs currently operate at the State and local levels, the evaluation is designed to measure the programs' effects on food insecurity and hunger, social isolation and the health and well-being of program participants. AOA is working with the Centers for Medicare and Medicaid Services (CMS) to identify an appropriate comparison group of non-participants and measure healthcare utilization and cost. The evaluation will answer how and why program results are achieved.

The OAA nutrition programs are a good investment in reducing food insecurity. To help address hunger and food insecurity among older Americans during the economic downturn, $100 million in funding was provided as part of the American Recovery and Reinvestment Act of 2009 to the OAA senior nutrition programs. Since March, 2009, this supplemental funding has provided more than 22 million meals to help combat food insecurity among more than 1.1 million older Americans.

The nutrition programs help to support family caregivers, who provide most of the care for older adults. The provision of a home-delivered meal, which includes not only a meal, but also a mid-day contact, may allow a family caregiver to continue to work and provide care for a loved one in the morning before work and in the evening. Home-delivered meals provide a critical service as a part of a formal comprehensive and coordinated service system that individualizes care for older adults and their families.

Congregate meals provide a daily social interaction that is also a gateway to volunteer opportunities and civic engagement, other home and community-based services, and a meal that promotes health and reduces the risk of chronic disease. Nutrition services are not simply access to food, but to a system that meets social service, health, and food security needs.

Nutrition services are but one component of a larger system of both formal and informal supports authorized by the OAA that help older individuals maintain their health at home and out of hospitals and nursing facilities. In fiscal year 2009, nearly 11 million older Americans and their family caregivers have been supported through the OAA's comprehensive home and community-based system. These services include: transportation; case management; information and referral; in-home services such as personal care, chore, and homemaker assistance; community services such as adult day care; support for family caregivers; protections against elder abuse; nursing home ombudsmen who serve as advocates for residents of long-term care facilities; legal assistance; pension counseling and assistance programs; prevention and reporting of waste, fraud and abuse in the Medicare and Medicaid programs, and a host of other supports that are tailored to meet individual needs.

This nationwide network of community-based assistance complements medical and health care systems, helps to prevent hospital re-admissions, provides transport to doctor appointments, and supports some of life's most basic functions, such as assistance to elders in their homes by delivering or preparing meals, or helping them with bathing.

This assistance is especially critical for the nearly three million seniors who receive intensive in-home services, half a million of whom meet the disability criteria for nursing home admission but are able to remain in their homes, in part, due to these community supports. An analysis of the OAA's program data reveal that, through fiscal year 2009 (the most recent year data are available), most indicators have steadily improved.

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[3] 2009 National Survey of Older Americans Act Participants. *http://www.data.aoa.gov*, select AGID.

• **OAA programs help older Americans with severe disabilities remain independent and in the community:** One approach to measuring the value of OAA's programs is the newly developed nursing home predictor score. The components of this composite score are predictive of nursing home admission based on scientific literature and AOA's Performance Outcome Measurement Project (POMP) which develops and tests performance measures. The components include such items as percent of program recipients who are transportation disadvantaged and the percent of congregate meal individuals who live alone. As the score increases, the prevalence of nursing home predictors in the OAA service population increases, meaning AOA is reaching those most in need of help. In 2003, the nursing home predictor score of program participants was 46.57. In fiscal year 2009, this score increased to 61.0.

• **OAA programs are efficient:** The national aging services network—comprised of 56 State and territorial units on aging, 629 area agencies on aging, 246 Indian tribal and native Hawaiian organizations, nearly 20,000 direct service providers, and hundreds of thousands of volunteers—is providing high-quality services to the neediest elders, and is doing so in a prudent and cost-effective manner. AOA and the national aging services network have significantly increased the number of persons served per million dollars of OAA funding. Without controlling for inflation, OAA programs have increased efficiency by over 36 percent between fiscal year 2002 and fiscal year 2009, serving 8,524 clients per million dollars of funding in fiscal year 2009 compared to 6,103 clients served per million dollars of AOA funding in fiscal year 2002. This increase in efficiency is understated, since the purchasing power of a million dollars in 2009 is significantly less than in 2002 due to inflation.

• **OAA programs build system capacity:** One of the main goals of OAA program funding is to encourage and assist State agencies and area agencies on aging to concentrate resources in order to develop greater capacity, and foster the development and implementation of comprehensive and coordinated systems. This capacity-building at the State and community level is evidenced by the fact that for every dollar of Federal OAA funding provided, States and communities leverage nearly $3 in other funding from other sources.

Taken as a whole, AOA's performance measures and indicators form an interconnected system of performance measurement akin to the three legs of a stool (efficiency, outcomes and targeting) holding up AOA's mission and strategic goals that include:

1. Empowering older people, their families, and other consumers to make informed decisions about, and to be able to easily access, existing health and long-term care options;
2. Enabling seniors to remain in their own homes with a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers;
3. Empowering older people to stay active and healthy through Older Americans Act services and the preventative care benefits under Medicare;
4. Ensuring the rights of older people and prevent their abuse, neglect and exploitation; and
5. Maintaining effective and responsive management.

As the former Secretary of Aging in Kansas, and now having the honor to serve as the U.S. Assistant Secretary for Aging and listening to individuals and families in a variety of settings, I have seen firsthand how the OAA reflects the American values we all share:

• Supporting freedom and independence;
• Helping people maintain their health and well-being so they are better able to live with dignity;
• Protecting the most vulnerable among us; and
• Providing basic respite care and other supports for families so that they are better able to take care of loved ones in their homes and communities for as long as possible, which is what Americans of all ages overwhelmingly tell us they prefer.

For more than a year, we have received reports from more than 60 listening sessions held throughout the country, and received online input from interested individuals and organizations, as well as from seniors and their caregivers, about the reauthorization of the OAA. This input represented the interests of thousands of consumers of the OAA's services. We continue to encourage ongoing input and discussions.

During our input process we were consistently told that, as it is currently structured, the OAA is very helpful, flexible and responsive to people's needs. We also heard a few themes, I will mention two today:

FIRST: *Improve program outcomes by*:

- Embedding evidence-based interventions in disease prevention programs;
- Encouraging comprehensive, person-centered approaches;
- Providing flexibility to respond to local nutrition needs; and
- Continuing a strong commitment to efforts to fight fraud and abuse.

SECOND: *Remove barriers and enhancing access by*:

- Extending caregiver supports to parents caring for their adult children with disabilities;
- Providing ombudsman services to all nursing facility residents, not just older residents; and
- Using Aging and Disability Resource Centers as single access points for long-term care information to public and private services.

Let me give three brief examples of areas we would like to discuss as you consider legislation:

- **Ensuring that the best evidence-based interventions for helping older individuals manage chronic diseases are utilized.** These have been effective in helping people adopt healthy behaviors, improve their health status, and reduce their use of hospital services and emergency room visits.
- **Improving the Senior Community Service Employment Program (SCSEP) by integrating it with other seniors programs.** The President's 2012 budget proposes to move this program from the Department of Labor to the Administration on Aging at HHS. We would like to discuss adopting new models of community service for this program, including programs that engage seniors in providing community service by assisting other seniors so they can remain independent in their homes, while also continuing to support community organizations that rely on SCSEP participants for their valuable work contributions.
- **Combating fraud and abuse in Medicare and Medicaid by making permanent the authority for the Senior Medicare Patrol Program (SMP) as an ongoing consumer-based fraud prevention and detection program**—and by using the skills of retired professionals as volunteers to conduct community outreach and education so that seniors and families are better able to recognize and report fraud and abuse.

The Older Americans Act has historically enjoyed widespread, bipartisan support. One of its great strengths is that it does not matter if an individual lives in a very rural or frontier area, or in an urban center—the programs and community-based supports it provides are flexible enough to meet the needs of individuals in diverse communities and settings. Based in part upon the extensive public input we received, we believe that the reauthorization can strengthen the OAA and put it on a solid footing to meet the challenges of a growing population of seniors, while continuing to carry out its critical mission of helping elderly individuals maintain their health and independence in their homes and communities. We look forward to working with this subcommittee as the reauthorization process moves forward.

Thank you again, Chairman Sanders and members of the subcommittee for your leadership on these important issues and for your invitation to testify today. We look forward to working with this subcommittee as the reauthorization process moves forward. I would be happy to answer any questions.

Senator SANDERS. Ms. Greenlee, thank you very much for your testimony.

Let me begin the questioning in two ways. No. 1, it seems to me that if we provide nutrition, if we provide socialization, if we are monitoring the well-being of people who are frail and elderly, that at the end of the day we save money by keeping people out of the emergency room, out of the hospital perhaps, out of nursing homes. Is that true?

Ms. GREENLEE. Yes, sir. Our evidence shows that to be true.

Senator SANDERS. Do you want to comment on that in general? Why does it in your judgment make sense to invest in these programs as a way in fact to save Federal money at a time of a huge deficit?

Ms. GREENLEE. Almost every person as they age will need supports of some sort to remain independent. The data shows between two-thirds and 75 percent of all of us will need help to stay inde-

pendent. As I said in my testimony, often the first type of support that's requested is nutrition. But there are other supports that individuals need. By and far—by overwhelming evidence, the least expensive place to deliver services is in someone's home. People will need services. Staying in the home is least expensive.

The Older Americans Act programs are far more effective and efficient than a Medicaid home and community-based waiver or very expensive congregate care, such as a skilled nursing home. They are a good investment. As you mentioned, it's also what people want. I think the fiscal policy and the people policy are aligned to support in-home services.

Senator SANDERS. Let me stay on that theme. My understanding is that there are many seniors who are in nursing homes today because they are not able to get the nutrition they need if they stayed at home. Is that your understanding?

Ms. GREENLEE. Senator, yes, but I'd like to qualify and expand your statement. As you said in your opening, lack of nutrition often leads to other chronic disabling conditions. What we find is that people who have multiple chronic conditions, disabling conditions, are more likely to enter a nursing home. It's a contributing factor among other contributing factors that leads to frailty and poor health, which is a predeterminant for nursing home admission.

Senator SANDERS. Let me ask you this. Can you give us a rough estimate as to how many seniors today as we speak are not getting the nutrition that they need?

Ms. GREENLEE. Senator, I've seen some recent studies that I could provide your staff—I think we have—that shows the amount of food insecurity varies by State, from as much as 12 percent of seniors in a State to as little as 3 percent of seniors in a State. There are millions and millions—the numbers I have seen are 8 or 9 million—seniors who are without food, food insecure.

But there are also increasing categories that expand from there, to people who have instability and inability to get food. There are many, many million seniors who don't have enough to eat or have access to the resources.

Senator SANDERS. Let me stop at that point. Senator Paul.

Senator PAUL. Thank you for your testimony, Ms. Greenlee. In your testimony you cite that only 13 percent of participants in the congregate meals program don't have enough money or food stamps to purchase enough food to eat. I guess the converse of that is 87 percent of the participants that you're helping already have enough money to buy their own food?

Ms. GREENLEE. Senator, we do find that the people who participate in congregate meals usually have more resources, are less frail. All of the people who participate, both home-bound and in the congregate, are encouraged to provide contributions, and our total client contributions for the meals programs always exceeds on average more than the third program that I mentioned. $170 to $180 million a year we get from seniors themselves as we encourage them to participate, and most do.

Senator PAUL. Meals on Wheels originally was a private program?

Ms. GREENLEE. Not to my understanding, Senator. It was passed in the 1972 amendments to the Older Americans Act.

Senator PAUL. Actually, I think there were originally Meals on Wheels programs that were private and relied on private funding from churches and other groups. There was an example actually in the 1980s from the Twin Cities area, Meals on Wheels of Benton Harbor, MI. After operating for 4 years with small monthly deficits offset by charitable donations, the program was forced to close once a duplicate OA program siphoned off half of its clients. Meals on Wheels was operating on people paying for their meals and OAA came in with free meals and competed actually with the private Meals on Wheels program.

I think there is some crowding-out phenomenon. The other thing is we all have sympathy for the elderly. I mean, we're all going to be old some day and we hope that there will be someone there to help us. Is part of your eligibility questioning—I guess income is not part of the eligibility?

Ms. GREENLEE. That's correct, it's not a means-tested program.

Senator PAUL. Eligibility is not dependent on whether any of your family members live near you? You don't ask them if their daughter lives down the street or anything like that?

Ms. GREENLEE. No, sir, I don't believe that's done.

Senator PAUL. I mean, I would think that the thing is that if three of your kids live in town and one's a doctor, one's a lawyer, and one's an accountant, maybe they ought to help you before the taxpayer helps you. These are just common sense things, if I ran a welfare program in my little town in Kentucky, that I would ask. I would also probably ask if you've got a million dollars in the bank.

It's the same way when you go to a nursing home. Sure we have sympathy for people, but should the government be the first one lining up so the kids can get the million dollars that granddad has?

So there's a lot of things. These questions have to be asked. You should ask, and if you want to help people who cannot help themselves by all means let's do it, but let's help them with one program. Let's not have program after program after program, and let's not have a program that helps 87 percent of people who can help themselves. We can't afford it.

Basically, this is a small program with regard to Federal programs, but it's still $818 million that we don't have. We've got to borrow it from somewhere. We've got to pay interest to China to borrow this money. It's not really a matter of whether or not we have sympathy. We all have sympathy. We just have different ideas of how to go about addressing the sympathy.

While I want to help people, I want to also have programs that ask questions: Do you have money in the bank, do you have kids that could be doing this? And is the government replacing the idea of what families should do? Is government replacing the idea of what charities should do? These are fundamental questions and not idle questions, in the sense that we have to ask these questions because we're out of money.

Do you have a comment?

Ms. GREENLEE. Yes, sir, I have a couple of comments, both with regard to your statement and your opening comment. Two things I would suggest as we talk about duplication and the value of this program, that I'd be glad to work with you on for consideration. Of

the various Federal programs that provide food assistance to seniors, this is the only one that provides prepared meals. I think that's an important component to understanding the value of the program.

The second observation that I have is that the structure of this program from the Federal level to the local level is very different from any other Federal program that I'm aware of. We have a very small Federal agency that administers money directly to the States and the territories, 250 tribal organizations, 650 area agencies on aging, providing services to thousands of providers and tens of thousands of volunteers. It's a pyramid, and the broad base is the community.

The design of the Older Americans Act for this program and all the other services is community integration to support faith organizations and other local organizations. It was never designed to be an entire and overwhelming Federal response to nutrition, but an important component of a Federal ally, which is what I believe we have demonstrated that we are.

Senator SANDERS. Thank you, Senator Paul.

Senator Franken.

Senator FRANKEN. Let me ask you about this, because again I've done a lot of listening sessions around the State of Minnesota and so many testified to the effect of this program in allowing people to stay in their homes. There are other parts of the Older Americans Act—respite care you mentioned, which is relieving a daughter who is taking care of a parent who is staying in the home and the daughter is taking care of her dad or her mom who is very old and would have to go into a nursing home were it not for the daughter taking care of her or him. And then there's respite care, like 4 hours a week of respite care that actually makes it possible for this child to do this. That keeps a parent out of a nursing home.

I think that, Senator Paul, you should understand the leveraging here and what this does, what this program does, because if it weren't for this program we'd have to borrow more money from the Chinese.

Let me ask you this. Would it be cost-efficient for the Older Americans Act to hire bureaucrats to track down daughters and sons who live within—what mile radius would it be effective? Would it be a 3-mile radius? Would it be a 5-mile radius? Would we have to put rules and regulations in order?

How would you do that? Do you think that would be cost-effective, if the Older Americans Act got into hiring a big bureaucracy to find out exactly how much each senior who is trying to stay in their home, what resources they had available to them? How would you do that?

Ms. GREENLEE. Senator, if I can make a couple of points. Eighty percent of the long-term care in this country is provided by the family. That has not ever changed. There are always family members around, at least for most people that are fortunate. Eighty percent have family support.

The Older Americans Act was not designed to be a means-tested entitlement program. It was always designed to be flexible and to provide only the services that an individual needed at that point in time and as they became more frail.

We have met those targets. We have reached people who are older, who are poorer. We have reached a higher percentage of people of color than the average population and people in worse health. So we know that the targeting is effective, that we can get to the people for whom the services are best designed.

We do not do a comprehensive assessment in order to give people eligibility for services. We target the services to the people who most need them instead.

Senator FRANKEN. Do you think other programs in the Federal Government can learn from the Older Americans Act and from what you guys do?

Ms. GREENLEE. Certainly, because I think this is a cost-effective way to help provide supports. It's a light touch rather than a huge Federal program. It provides the supports that someone needs. We actually are the people who have always done house calls, who go to someone's home and make an assessment and give them just that amount of support.

Senator FRANKEN. Well, I so compliment what you do. I again believe that this is a program that saves the taxpayers money by leveraging what you do and by allowing seniors to stay in their home, which they want to do. And if not for your program, they wouldn't be able to.

So I would only recommend to members of our body who aren't familiar with the Older Americans Act to do some research actually on the ground in their States, instead of relying on statistics provided for them by various groups, and to actually see this as it works on the ground, because I can't tell you how inspiring it is, not only to see the help that is provided, but to hear from those people who you are leveraging, the volunteers, what it means to them and how it keeps them involved—many of them are seniors—and what they get out of it.

It is a program that is a pyramid and at the bottom is the community. And I want to thank you for your work.

Ms. GREENLEE. Thank you, Senator.

Senator SANDERS. Thank you, Senator Franken.

Senator Paul.

Senator PAUL. I had one follow-up question. I think it's curious that only in Washington can you spend $2 billion and claim that you're saving money. Here's a thought: Perhaps the $2 billion we spend on OAA, if we subsumed that into another program and didn't spend it, that might be saving money. But to simply say that we're taking money and saving money that would be spent otherwise—I think the idea or notion that spending money in Washington somehow is saving money really kind of flies past most of the taxpayers.

Now, what I would say, though, is that—or the question I actually have is, with food stamps can you buy these home-delivered meals, Ms. Greenlee?

Ms. GREENLEE. I always think of food stamps as primarily buying groceries, but I'm understanding——

Senator PAUL. Apparently you can.

Ms. GREENLEE [continuing]. You can buy some home-delivered meals.

Senator PAUL. You can. The USDA fact sheet in your binder says that you can take food stamps and you can buy home-delivered meals. So if the sole purpose of this is to have prepared meals and nobody else is providing them, we could privatize Meals on Wheels and let food stamps buy the thing and save $2 billion, and then we really would be saving money.

Thank you.

Senator SANDERS. Let me just make a comment and maybe ask you a question. Senator Paul has suggested that only in Washington can people believe that spending money actually saves money. I think that is the kind of philosophy which results in us spending almost twice as much per person on health care as any other country on Earth. Because we have millions and millions of Americans who can't get to a doctor on time, some of them die, some of them become very, very ill. They end up in the emergency room, they end up in the hospital, at great cost, rather than making sure they have access to a doctor.

The point is—and I think we have a bit of a difference here—I believe—I think Senator Franken has spoken to the fact—that prevention, keeping people healthy, taking care of their needs at home, does actually save money; and that if you deny those resources you're leaving a senior citizen home today alone, isolated, confused about medicine, not getting the nutrition they need, you know what happens to that person? That person collapses. That person ends up in emergency room, that person ends up in a nursing home, at much greater cost to the system.

My own belief is, Ms. Greenlee, we have got to do a lot more. Our goal should be that no senior in this country goes hungry, that we do everything that we can to keep seniors out of nursing homes and in their own homes if that's what they choose by making sure that we have people visiting them, making sure they're doing well with their medications, making sure that they're getting the nutrition and the food that they need.

I happen to believe that intelligently investing in the needs of our people does in fact save us substantial sums of money.

Ms. Greenlee, yes.

Senator FRANKEN. I just want to say one thing. I want to make it very narrow, very narrow. Does the Older Americans Act save the American taxpayer money by allowing—and I'm going to say it as clearly as I can, because I don't think this is—I think Minnesotans understand this, and when I was in Minnesota—and again, I would urge any Senator who has their doubts about this to actually go to a senior center and actually go on the ground and ask about this.

Here is my very precise question: Does the Older Americans Act save taxpayers money by allowing seniors to stay in their homes, as opposed to going to nursing homes?

Ms. GREENLEE. Yes, Senator.

Senator FRANKEN. Thank you. Do you want to expand on that?

Ms. GREENLEE. I guess my expanded answer would be that I believe the program from the very inception was designed to target outreach to individuals who were most at risk for spend-down to Medicaid and most at risk for nursing home admission, and everything that we can do to help invest in the community and less ex-

pensive services, help people stretch their own assets, help people avoid Medicaid, is a wise investment, because once they receive Medicaid services, regardless of their setting, they're much more expensive.

Senator FRANKEN. Are there people in actual other places besides Washington, DC, that understand that, like in the States where this is administered?

Ms. GREENLEE. I think in Kansas we have figured that out, yes.

Senator FRANKEN. Yes. In Minnesota, too.

Senator SANDERS. Senator Paul wanted to make another comment.

Senator PAUL. I appreciate the great and very, I think, collegial discussion, and we do have different opinions. Some of us believe more in the ability of government to cure problems and some of us believe more in the ability of private charity to cure these problems.

I guess what I still find curious is, though, that if we are saving money with the $2 billion we spend, perhaps we should give you $20 billion. Is there a limit? Where would we get to—how much money should we give you in order to save money? So if we spend Federal money to save money, where is the limit? I think we could reach a point of absurdity.

Thank you.

Senator FRANKEN. I think you just did.

Senator SANDERS. I would suggest, Senator Paul, that when you have seniors in this country who are dealing with food insecurity who are not getting the nutrition that they need, my guess is that the government is wasting substantial sums of money by not taking care of those seniors, who will end up in emergency rooms, in hospitals, and in nursing homes.

So you asked that question. My answer is I don't want to see one senior in this country go hungry. It's the morally right thing to do, and from a fiscally conservative point of view saving government money in my view, it is the right thing to do.

Thank you very much for your testimony.

Ms. GREENLEE. Thank you. Thank you, Senators.

Senator SANDERS. If we can have our second panel.

Let me thank all of the panelists for being with us. Each and every one of you are working hard on this issue and we appreciate the work that you do.

Let's begin with Robert Blancato. Mr. Blancato is the executive director of the National Association of Nutrition and Aging Services Programs. Mr. Blancato is also the national coordinator of the Elder Justice Coalition and was appointed by President Clinton to serve as executive director of the 1995 White House Conference on Aging. He was subsequently appointed to serve on the Policy Committee for the 2005 White House Conference on Aging.

Mr. Blancato, thank you very much for being with us.

STATEMENT OF ROBERT BLANCATO, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF NUTRITION AND AGING SERVICES PROGRAMS, WASHINGTON, DC

Mr. BLANCATO. Thank you, Chairman Sanders, Senator Paul, Senator Franken. Thank you for the opportunity to testify. My

name is Bob Blancato, executive director of the National Association of Nutrition and Aging Service Programs.

We appreciate this first hearing being focused on the nutrition programs, the largest and most visible in the Older Americans Act, serving 2.6 million older adults daily with more than 236 million meals each year. Next year we celebrate their 40th anniversary. This year we want to see these programs strengthened, their dollars protected, and continue to achieve their three purposes: reduce hunger and food insecurity, promote the health and well-being of older individuals, and promote socialization to prevent isolation.

Senior hunger is a growing reality. The Leadership Council of Aging Organizations estimates hunger among older people increased by 20 percent in the past decade. The Meals on Wheels Foundation says there were nearly 6 million seniors facing the threat of hunger in 2007. Feeding America estimates 3 million food-insecure older adults. The American Dietetic Association Journal notes 2.5 million older Americans are at risk of hunger. And an AARP paper notes that between 2006 and 2008 the number of poor and near-poor older adults, who did not know where their next meal would come from, doubled, from 5 to 10 percent.

The Older Americans Act is one solution as the largest national food and nutrition program specifically for older adults. One in ten in the congregate program today has more than three IADLs, which can be a precursor to a senior going hungry.

The second purpose is to promote the health and well-being of older adults. The dangers of poor nutrition are well-documented. Risks include premature nursing home admission and increased and longer stays in hospitals. Eighty-seven percent of older adults have one or more of the most common chronic diseases: hypertension, coronary heart disease, and diabetes. In those aged 45 to 64, diabetes alone more than triples the risk of nursing home admission. These three diseases can be prevented or treated through access to appropriate nutrition services. The Older Americans Act is one solution. Its meals must and do provide at least one-third of the dietary reference intakes for older adults. In about 60 percent of participants this meal is one-half or more of their total food for the day, and for minority older adults the percentage is even higher.

Further, more than one-third of home-delivered meals participants today have three or more limits of activities of daily living, which is a precursor for nursing home placement. Each day they remain in the home-delivered program, we potentially save money in Medicare and Medicaid.

The final purpose of this act is to promote socialization, to try and prevent isolation and loneliness.

Nutrition programs run well because of the millions of hours of service provided by volunteers, which in turn produce savings. Almost 25 percent of seniors in the CSET program help other seniors, mostly in nutrition and senior center programs.

But these programs are in tough shape today. Based on a survey we did, higher energy, especially gas, and food prices and loss of volunteers is causing cutbacks in services. Wayne County, MI, just started its first waiting list in 31 years. Fiscal year 2012 funding for nutrition programs must grow above fiscal year 2011 levels. If

not, there will be real consequences involving our most vulnerable older adults.

Let me offer a few recommendations for the reauthorization: A 5-year extension with sufficient authorization levels to allow the programs to meet current and future need. Let's add seniors susceptible to hunger into the targeting language which directs resources to the neediest older adults. Let's protect our nutrition dollars, rethink the existing transfer authority, since almost $40 million came out of nutrition for other services, some not related to nutrition. We cannot afford that any more.

Let's enhance the current flexibility in how local decisions are made about funds used in the nutrition program, but preserve the integrity of the separate, congregate, and home-delivered meal program. Let's have a nutrition resource center to improve the work in the field. Let's provide greater access to fresh fruits and vegetables and greater flexibility for meal planning to reflect cultural considerations.

Let's integrate the aging network, especially nutrition providers, into the community-based care transition programs that are evolving.

Finally, let's increase the opportunities for communities to serve meals to seniors and children in community facilities.

I have more in my written statement of recommendations. But let me put a face on this issue to close with. Theresa is 83 years old. She went to a congregate program when she became a widow. She became a volunteer, has been in the program now for 17 years. A 68-year-old man in the congregate program for 7 years that has allowed him to stretch his dollars and still get prescription drugs that he needs. Mary at 92 is home-bound, has vertigo, and cannot stand up to cook, and she's been receiving home-delivered meals for 6 years. Claudette, age 67; her husband had a heart attack. Home-delivered meals for him allows her to continue to work.

Mr. C was at San Antonio senior center since August 2010. He was well-dressed and engaged with others. Suddenly, a dramatic decline in his appearance. Staff asked and he admitted he was now homeless, living in his car. He was connected to adult protective services and now lives in an apartment, has gained 8 pounds, and has his friends and a safe haven.

The Older Americans Act nutrition programs are all about value, to those it serves and to the volunteers who work in its program. An emerging value is how much it has and will save Medicare-Medicaid costs in the future.

A final thought: The act enjoys a long and bipartisan history in this body and in the House. We hope it will continue. Take time to visit the nutrition programs in your State and see for yourself why this is such a good investment that provides countless returns.

Thank you.

[The prepared statement of Mr. Blancato follows:]

PREPARED STATEMENT OF ROBERT BLANCATO

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; and
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 any 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, MI 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 fiscal year 2012 funding for the OAA nutrition programs be allowed to grow from fiscal year 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 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 United States. 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 U.S. 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 10 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 percent and in West Virginia and Iowa the percentage exceeds 80 percent. Having three 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 5-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 fiscal year 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, CA—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 led 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 the 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, MI 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 three 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.

Senator SANDERS. Thank you.

Mr. BLANCATO. Thank you very much, Mr. Blancato.

Our next panelist is Ken Gordon. I have known Ken for many, many years. Ken is the executive director of the Area Agency on Aging for Northeastern Vermont, what we call the Northeast Kingdom, which is in fact one of the most rural and lowest income areas in the State of Vermont.

Ken serves on the boards of the Community of Vermont Elders, the Northeastern Vermont Regional Hospital, and the National Association of Area Agencies on Aging.

Mr. Gordon, thanks very much for being with us.

STATEMENT OF KENNETH E. GORDON, EXECUTIVE DIRECTOR, AREA AGENCY ON AGING FOR NORTHEASTERN VERMONT, ST. JOHNSBURY, VT

Mr. GORDON. Thank you, Chairman Sanders, Ranking Member Paul, and members of the subcommittee, for the opportunity to testify today. I am honored to be able to speak on behalf of those who depend upon the senior meal programs authorized by the Older Americans Act and the thousands of staff and volunteers who make these programs possible.

My name is Ken Gordon. I do serve as the executive director for the Area Agency on Aging for Northeastern Vermont. We're a small nonprofit organization serving older adults in Vermont's remote Northeast Kingdom. While the back country of Vermont is beautiful, it's a difficult place to grow old. The winters are harsh, food and fuel costs are high, and, like elsewhere in the country, senior hunger remains a vexing problem.

The disturbing reality we face is that hunger is a growing problem among seniors, affecting nearly 6 million older adults each year. The seniors who are served by this program have worked hard throughout their lives. They've paid taxes, they've responded to the call for military service, they've volunteered in their commu-

nities, and they've made possible the quality of life that we all enjoy today. And now, at the end of their lives, they are struggling to make ends meet.

Increasingly, we see many seniors being forced to choose between paying for food, fuel, rent, or prescription medicines. Seniors on fixed incomes are particularly vulnerable, as food is often the first expense to be cut when prices rise.

In Vermont and across the country, Older Americans Act nutrition programs play a critical role in combating senior hunger. In 2008, the act's nutrition programs served over 240 million meals to approximately 2.6 million older adults and family caregivers. These programs work well because they are collaborative in nature. Participants contribute according to their means. Donors provide supplemental funding. State and local governments match Federal dollars. Churches and other community groups allow the use of their facilities, and volunteers provide much of the labor that makes these programs so successful.

One of our senior meal recipients, a 92-year-old widow and retired teacher from St. Johnsbury, VT, by the name of Maybell Peck, has described the home-delivered meals she received as a real lifesaver, and for many, many people across the country they are precisely that. Senior meals provide life-sustaining nutrition for hundreds of thousands of older adults each day. Without this service, many seniors would be left hungry and alone. Often these programs provide the only true meal of the day for many older adults.

The volunteers and staff who deliver these meals also perform a valuable check-in service to ensure the safety of the senior and are sometimes the only human contact that the senior may have all day.

It is absolutely critical that we invest in these programs as they serve as an important lifeline for some of the most vulnerable, isolated, and frail people living in our communities.

Ms. Peck also told us that the meals give her a sense of power, and in many respects these meals do empower older adults to remain living at home. The programs help older adults and family caregivers to remain in control of their own lives. They help the Medicare and Medicaid programs to avoid the cost of unnecessary hospital care and nursing home placements, and they serve as the foundation upon which our Medicaid waiver home and community-based care programs rest. They also serve an important role in the management of chronic disease.

While the Older Americans Act nutrition programs have made a meaningful difference in the quality of life for millions of older Americans, the programs face enormous challenges and are operating under extraordinary stress. Demand for these programs, particularly in the category of home-delivered meals, has grown significantly in recent years. Funding for these programs has not increased in relation to the sharp rise in food and fuel costs we have all experienced, nor has it reflected the increased demand that these programs are contending with.

In response to these challenges, additional Federal support for the act's Federal nutrition programs is vital. Greater flexibility within the act to develop innovative approaches to service delivery

and that provide the flexibility to address local priorities is also critical to sustaining these programs.

Last, while the Older Americans Act nutrition programs address a critical need, in the view of many they represent something far more important. They reflect the sacred obligation that many of us learned early in our lives to honor and respect our elders. These are the people that made our lives possible and whose labor and sacrifice led to the quality of life that we all enjoy today. Collectively, we share in the obligation to ensure that our elders' basic needs are met and that our country's senior citizens are able to live their lives with the independence and dignity that all Americans deserve.

Thank you.

[The prepared statement of Mr. Gordon follows:]

PREPARED STATEMENT OF KENNETH E. GORDON

Thank you Chairman Sanders, Ranking Member Paul and members of the Subcommittee on Primary Health and Aging for the opportunity to testify at today's hearing regarding the issue of senior hunger and the reauthorization of the Older Americans Act (OAA). I am deeply honored to be able to speak on behalf of both the older adults and family caregivers who depend upon the senior meal programs authorized by the Older Americans Act, and the thousands of staff and volunteers who make these programs possible throughout our country.

My name is Ken Gordon. I have the privilege of serving as the executive director of the Area Agency on Aging for northeastern Vermont. We're a small, non-profit social service organization serving older adults and family caregivers in the far northeastern corner of the State, an area bordering Canada to the North, and the State of New Hampshire to the East. It's a rural and heavily wooded area that is home to about 10,000 senior citizens.

While the back country of Vermont is beautiful, it's a difficult place to grow old. The winters are harsh, food and fuel costs are high, and public transportation is often lacking. And, like elsewhere in the country, senior hunger remains a vexing problem for older Vermonters. Despite the extraordinary progress we have made in this country over the past 75 years in combating poverty and poor health among older adults, we still face the startling reality that nearly 6 million seniors (or over 11 percent of all older adults) from across the United States face the threat of hunger each year.

Unfortunately, hunger among senior citizens is a growing problem. According to the U.S. Census, senior hunger in Vermont and many other States has risen dramatically in recent years. Seniors at the greatest risk of hunger are individuals age 60–64 and those living alone in rural areas. Front-line providers are reporting even greater rates of food insecurity since the onset of the economic downturn because family members are less able to help.

The seniors we serve come from all walks of life, both rich and poor. Aging has a way of humbling us all to the realities of birth, death and our short time on this earth. But the majority of the people we serve are older adults of modest means who have played by the rules. They've worked hard throughout their lives, paid taxes, responded to the call for military service, volunteered in their communities and made possible the quality of life we enjoy today. And now, at the end of their lives, they are struggling to make ends meet.

Increasingly, as gasoline, home heating fuel and food prices continue to rise, we see many of the seniors we work with being forced to choose between paying for food, fuel, rent or prescription medicines. Seniors on fixed incomes are particularly vulnerable to price increases. Because food is often the most flexible part of a household budget, it is frequently the first expense to be cut when prices rise.

Hard times are also forcing many of the seniors we work with to choose foods that have limited nutritional value in place of fruits, vegetables, whole grains, low fat dairy products and lean proteins. As we know, there are important consequences associated with the food choices we make, and this is particularly the case for older adults. Over 90 percent of seniors have one or more nutrition-related chronic conditions such as heart disease, diabetes, or high blood pressure that makes their food choices a critical factor to their health and well-being.

In Vermont, and across the country, Older Americans Act nutrition programs play a critical role in combating senior hunger. In concert with the Supplemental Nutri-

tion Assistance Program (SNAP), food commodity programs, community food shelves and other initiatives, they form a hunger "safety net" for older adults and their families. In 2008, the act's congregate and home-delivered meal programs served over 240-million senior meals to approximately 2.6 million older adults and family caregivers. The Older Americans Act nutrition programs are extraordinarily popular among seniors because there is little, if any, stigma associated with them, and the eligibility determination process is straight forward and relatively easy to negotiate.

As those of you who have visited the senior nutrition programs in the communities you serve already know, the programs work well because they are collaborative efforts that rely on a partnership between the individuals receiving services, families, private donors, the State and Federal Governments, faith-based organizations and the community at-large. Participants are asked to contribute according to their means through a system of anonymous, voluntary contributions, and they do. In 2009, seniors and their families in Vermont contributed more than $800,000 towards the cost of operating these programs. Private foundations and corporate donors regularly provide supplemental funding to support these programs, State and local governments provide their "match" to Federal dollars, churches and other community groups lend their facilities to the cause, and volunteers provide much of the labor that makes these programs so successful.

As an aside, I'd like to invite you all to visit the Area Agencies on Aging, senior centers and meal programs in your home communities, to learn for yourselves about these programs and to meet the individuals they serve.

One of our senior meal recipients, a 92-year-old widow and retired homemaker from St. Johnsbury, VT, by the name of Maybell Peck, has described the home-delivered meals she received as a real "life saver". And for many, many people across the country, home-delivered meals are precisely that.

Senior meals provide life-sustaining nutrition for hundreds of thousands of older adults each day. Without this service, many seniors would be left hungry and alone. Often, these programs provide the only true meal of the day for many, if not most, of those individuals participating in the program. The volunteers and staff who deliver meals also perform a valuable "check-in" service to ensure the safety of the senior, and are sometimes the only human contact that a person may have for long stretches of time. It is absolutely critical that we invest in these programs, as they serve as an important lifeline for some of the most vulnerable and frail people living in our communities.

It is also important for policymakers to understand who is being served by these programs. In our case, the majority of those being served are older men and women, age 75+, who are living alone on very modest incomes. Many of these seniors are unable to drive, have disabilities, suffer from multiple chronic health conditions, and do not have the physical ability to shop or prepare a meal. Often, they literally have no other way to feed themselves, and are completely reliant upon this service in order to remain living at home.

Mrs. Peck also told us that the meals she received gave her a sense of "power," and in many respects these meals do empower older adults to remain independent and living at home. Senior nutrition programs help older adults and family caregivers to remain in control of their own lives, while helping the Medicare and Medicaid programs avoid the significant costs of unnecessary hospital care and nursing home placements.

It's been said that an army marches on its stomach. And, to a large degree, the same can be said about our efforts to manage chronic health conditions and to provide seniors and people with disabilities with alternatives to nursing home care. The Older Americans Act senior nutrition programs form the foundation upon which our Medicaid Waiver home and community-based care programs rest and are essential to these programs' continued success. They are also an important part of the chronic care initiatives that have been initiated in recent years by the Centers for Medicare and Medicaid Services that have been proven to enhance the quality of life for those who participate in them and save taxpayer dollars, too.

CHALLENGES

While the Older Americans Act nutrition programs have made a meaningful difference in the quality of life for millions of older Americans, the programs face enormous challenges and are operating under extraordinary stress.

Demand for these programs, particularly in the category of home-delivered meals, *has grown significantly in recent years* as the population ages, and a growing number of States turn to more cost-effective and consumer-preferred home and community-based alternatives to nursing home care.

Increasingly, because of the rising cost of living, *seniors are less able to support these programs* via their contributions. Declining participant contributions are the norm for most senior meal programs in the area we serve. A similar trend has been reported nationally.

Funding for these programs has not increased in relation to the sharp rise in food and fuel costs in recent years, nor has it reflected the increased demand that these programs are experiencing as a result of the economic downturn. Additionally, providers in r*ural and frontier communities face particular challenges* in the face of rising gasoline prices.

In response to these challenges, continued Federal support for the Older Americans Act senior nutrition programs is critical. Additional funding to ensure the viability of these programs in the future as the number of older adults grows dramatically is essential to the well-being and security of the Nation's older adults and family caregivers. Additional flexibility within the act to develop innovative approaches and that provides States and Area Agencies on Aging with the flexibility to address local priorities is also critical to sustaining these programs in the future.

Lastly, while the Older Americans Act nutrition programs address a critical need, and they pay for themselves many times over in the form of avoided health care costs, in the view of many, these programs represent something more important. They reflect the sacred obligation that many of us learned early in our lives to honor and respect our elders. These are the folks who made our lives possible and whose labor and sacrifice led to the quality of life that we enjoy today. Collectively, we share in both the obligation and the responsibility to ensure that our elders' basic needs are adequately addressed, and that our country's senior citizens are able to live their lives with the independence and dignity that all Americans deserve.

Senator SANDERS. Thank you very much, Mr. Gordon.

Our third witness is Kay Brown. Ms. Brown is a director in the Government Accountability Office's Education Workforce and Income Security Team. Throughout her 25-year career at GAO, Ms. Brown has focused on improving government performance in delivering benefits and services to low-income people and vulnerable populations.

Ms. Brown, welcome.

STATEMENT OF KAY E. BROWN, DIRECTOR, EDUCATION, WORKFORCE AND INCOME SECURITY, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Ms. BROWN. Chairman Sanders, Ranking Member Paul, and Senator Franken, I'm pleased to be here today to discuss our recent work on food insecurity among older adults and the nutrition programs available to assist them. These programs play a vital role in the health and well-being of one of our Nation's most vulnerable groups.

I will cover two points: the prevalence of food insecurity and receipt of nutrition assistance; and second, the extent to which nutrition assistance programs show signs of inefficiency or overlap.

First on food insecurity and receipt of assistance: About a fifth of low-income older adults, those with incomes of less than $20,000 per year, were food insecure in 2009. These adults were uncertain of having or unable to acquire enough food because they lacked resources. A smaller but still significant number had their eating patterns disrupted and their food intake reduced because they couldn't afford enough food.

Some of these older adults received help to alleviate food insecurity, but many did not. For example, in 2008 only about 11 percent reported receiving home-delivered or congregate meal services.

Based on our work, we know that requests for elderly nutrition assistance have grown, particularly since the recession, and are ex-

pected to continue to grow. Requests for home-delivered meals are growing faster than those of congregate meals.

For my second point, I'd like to step back and look more broadly at the network of the Nation's nutrition assistance programs. Last year the Federal Government spent more than $90 billion on domestic food assistance programs to serve not only older adults, but other vulnerable populations as well. There are 18 different programs administered by three separate Federal departments. The benefits are delivered through a complex network of multiple State offices, local governments, and nonprofit organizations. These 18 programs emerged piecemeal over the last several decades to address a variety of needs, often to target benefits to specific groups at high risk of malnutrition.

Having multiple food assistance programs has some benefits. The programs provide various points of entry to help increase access and provide a range of choices for recipients. However, this arrangement can also result in overlap among programs and inefficient use of resources, as similar people access similar benefits from different programs.

For example, the elderly nutrition program, as we've heard, provides home-delivered and congregate meals primarily to individuals aged 60 and older. But low-income older adults can also access programs offering similar benefits that are administered by USDA. They might receive commodities from the commodity supplemental food program, the emergency food assistance program, or the senior farmers market program. They might receive meals through the adult and child care food program. And many are eligible for electronic benefits redeemed in authorized stores through the largest program, SNAP, which was formerly called food stamps.

Most of the Nation's 18 programs each have their own specific and often complex administrative procedures that Federal, State, and local organizations must follow to receive funding. Further, program eligibility rules often require applicants who seek assistance from multiple programs to submit separate applications for each one.

Finally, not enough is known about the effectiveness of many of these programs. Research suggests that participation in 7 of the 18 programs, and that includes the elderly nutrition program and SNAP, is associated with positive health and nutrition outcomes consistent with the program goals. However, little is known about the effectiveness of the remaining 11 programs because they have not been well-studied.

In conclusion, many older adults benefit from these programs. However, given the growing demand and the current constraints on our Nation's resources, it is vital to take steps to ensure that benefits and services go to those most in need, as efficiently as possible, and through programs that we know work.

We have made recommendations to HHS, focused on identifying those most in need, and to USDA, focused on improving efficiencies. But continued oversight will be critical.

This concludes my prepared statement.

Thank you.

[The prepared statement of Ms. Brown follows:]

PREPARED STATEMENT OF KAY E. BROWN

Mr. Chairman, Ranking Member Paul, and members of the subcommittee, we appreciate the opportunity to discuss our recent work on food insecurity among older adults and the nutrition assistance programs available to assist them, including nutrition assistance programs authorized under the Older Americans Act of 1965 (OAA).[1] This work can help inform government policymakers as they address the needs of one of our Nation's most vulnerable populations while ensuring the efficiency and effectiveness of Federal programs given rapidly building fiscal pressures facing our national government. While the economy is still recovering and in need of careful attention, widespread agreement exists on the need to look not only at the near term but also at steps that begin to change the long-term fiscal path as soon as possible without slowing the recovery. Our recent work can help with this by identifying potential inefficiency and overlap among programs. At the same time, there is recognition that the services provided by the OAA can play an important role in helping older adults remain in their homes and communities. As the Congress takes steps to address the fiscal challenge, it will be important that these steps are balanced with efforts to ensure the health and well-being of older adults.

My testimony today is based on two recent reports, our April 2010 report on domestic food assistance[2] and our February 2011 report on the unmet need for services under the OAA.[3] My testimony highlights key findings from each of these reports related to: (1) the prevalence of food insecurity and the receipt of nutrition services among older adults; and (2) the extent to which nutrition assistance programs show signs of inefficiency or overlap. This statement will discuss some of the challenges related to ensuring the most efficient provision of services, and suggest how better information could help policymakers address overlap and duplication among programs while ensuring those most in need have access to services.

To address the objectives, we drew upon our April 2010 report and our February 2011 report. In this work, we employed an array of methodologies including analysis of administrative data on program expenditures and participation and national self-reported data on food security status; a nationally representative survey of local agencies that administer nutrition assistance programs funded by OAA[4]; an analysis of studies on program effectiveness; a review of relevant Federal laws and regulations and agency documents; and interviews with relevant experts, Federal officials, and staff of local agencies. We conducted our work in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence we obtained provides a reasonable basis for our findings and conclusions.

On March 1, 2011, we issued a report outlining opportunities to reduce duplication across a wide range of Federal programs raising attention to these issues.[5] That report was prepared in response to a new statutory requirement that GAO identify and report annually on Federal programs, agencies, offices, and initiatives—either within departments or governmentwide—that have duplicative goals and activities.[6] In that work, we also considered fragmentation and overlap among government programs or activities as these can be harbingers of unnecessary duplication. Fragmentation of programs exists when programs serve the same broad area of need but are administered across different Federal agencies or offices. Program overlap exists when multiple agencies or programs share similar goals, engage in similar activities or strategies to achieve them, or target similar beneficiaries. Unnecessary duplication of program services can occur when two or more programs are engaged in the same activities or provide the same services to the same beneficiaries, and this can in turn result in inefficient service delivery and unnecessary program costs. Reducing or eliminating duplication, overlap, or fragmentation could potentially save bil-

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[1] Pub. L. No. 89–73, 79 Stat. 218 (codified as amended at 42 U.S.C. §§3001–58ff).

[2] GAO, *Domestic Food Assistance: Complex System Benefits Millions, but Additional Efforts Could Address Potential Inefficiency and Overlap among Smaller Programs*, GAO–10–346, (Washington, DC: April 15, 2010).

[3] GAO, *Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services,* GAO–11–237, (Washington, DC: February 28, 2011).

[4] We conducted a survey of 125 local agencies, with 99 agencies (79 percent) responding. The percentages cited from this survey are subject to margins of error no more than plus or minus 12 percentage points at the 95 percent confidence level.

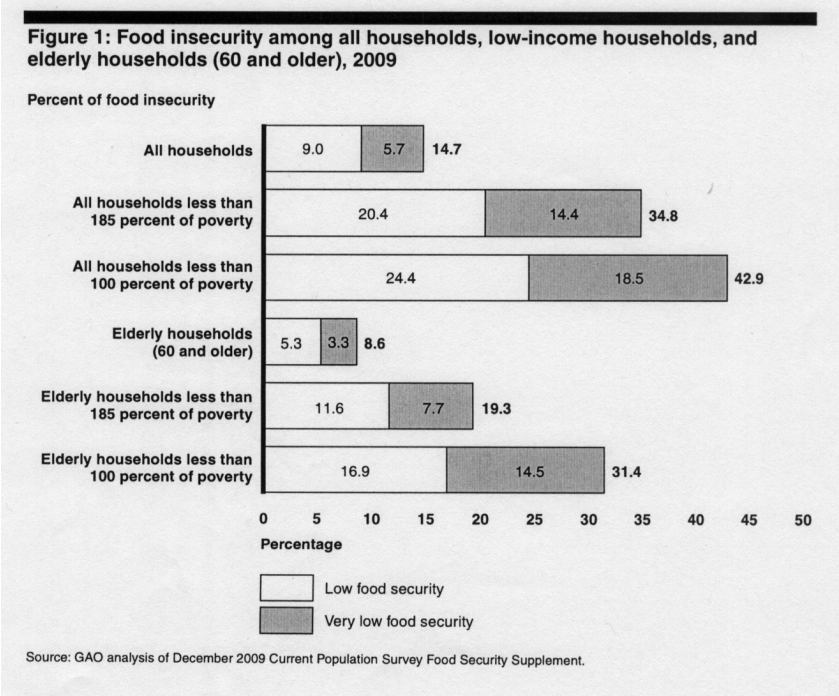
[5] GAO, *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue*, GAO–11–318SP, (Washington, DC: March 1, 2011).

[6] Statutory Pay-As-You-Go Act of 2010, Pub. L. No. 111–139, §21, 124 Stat. 8, 29–30 (codified at 31 U.S.C. §712 note).

lions of tax dollars annually and help agencies provide more efficient and effective services. These actions, however, will require some difficult decisions and sustained attention by the Administration and Congress.

IN RECENT YEARS NEARLY A FIFTH OF LOW-INCOME OLDER ADULTS WERE FOOD INSECURE AND MOST DID NOT RECEIVE ASSISTANCE FROM MEALS PROGRAMS DESPITE INCREASED DEMAND

Analysis of data from the Current Population Survey's (CPS) Food Security Supplement shows that in 2009, about 19 percent of households with adults ages 60 and over with low incomes—under 185 percent of the poverty line—were food insecure. These adults were uncertain of having or unable to acquire enough food because they lacked resources. In comparison, slightly less than 15 percent of all households were food insecure. A small but significant portion of households with older adults had very low food security in 2009—about 8 percent of those with households under 185 percent of poverty and about 14.5 percent of those with incomes under the poverty line. In these households, one or more household members' eating patterns were disrupted and their food intake reduced, at least some time during the year because they could not afford enough food. (See Figure 1.)



Older adults can and do access a number of resources to help alleviate food insecurity; however, many low-income older adults likely to need assistance from meals programs did not receive it, according to 2008 data. Through our analysis of information from the CPS, we found that in 2008 approximately 9 percent of an estimated 17.6 million low-income older adults [7] received home-delivered or congregate meals services including those provided by the OAA Elderly Nutrition Program:

[7] Our analysis of meal program recipients and non-recipients was limited to those living in households below 185 percent of the poverty threshold because the CPS did not collect generalizable information for individuals with higher incomes. In addition to people age 60 and over, younger spouses living with people age 60 and over and people with disabilities of all ages in housing facilities occupied primarily by older people where congregate meals are served or who live with someone age 60 and over are also eligible for meals services through title III. 42 U.S.C §3030g-21(2)(I). Our estimates of older adults who are likely to need meals services also include these additional individuals. An estimated 31 percent of people age 60 and over were below 185 percent of the poverty threshold.

Home-Delivered and Congregate Meals Services (Elderly Nutrition Program)[8] and other organizations such as churches or nonprofits.[9] However, many more older adults did not receive these meals services, but likely needed them due to food insecurity, difficulties with daily activities, and/or limited social interaction, as shown in table 1.[10]

Table 1: Percentages of Low-Income Older Adults With Each Characteristic of Likely Need and Percentages Who Did and Did Not Receive Meals Services

Characteristics of likely need	Have each characteristic	Received home-delivered meals	Did not receive home-delivered meals	Received congregate meals	Did not receive congregate meals	Received either type of meal	Received neither type of meal
Food security:							
Food secure	81.4	3.3	96.7	5.7	94.3	8.3	91.7
Food insecure	18.6	7.4	92.6	4.9	95.1	11.1	88.9
Number of impairments [1]:							
None	65.2	2.3	97.7	5.1	94.9	6.9	93.1
One	18.0	3.6	96.4	6.3	93.7	8.8	91.2
Two or more	16.8	11.5	88.5	6.4	93.6	16.7	83.3
Social isolation [2]:							
Less isolated	31.8	2.5	97.5	6.1	93.9	7.9	92.1
More isolated	41.4	5.0	95.0	5.0	95.0	9.0	91.0
Missing [3]	26.8	4.5	95.5	5.8	94.2	9.7	90.3

Source: GAO analysis of 2008 CPS data.

[1] To identify older adults likely to need meals programs based on potential difficulties preparing or obtaining food, we used four CPS questions that identified functional impairments, such as difficulty doing errands alone, serious difficulty walking or climbing stairs, or difficulty dressing or bathing.

[2] We defined likely need for more social interaction as answering ''no'' to all of the questions in the CPS civic engagement supplement that asked about the older adult's participation in social activities. However, such survey data do not capture more qualitative aspects of an individual older adults' likely need for social interaction such as personality and individual preference. The data also do not allow us to identify individuals who may interact socially outside of organized groups and activities.

[3] CPS questions related to social isolation were asked at a different time in the survey cycle than questions about receipt of meals services. Therefore, approximately 27 percent of the older adults with low incomes in our sample provided information about participation in meals programs, but not about participation in social groups. As a result, we could not measure whether they were more or less socially isolated.

It should be noted that there are many reasons why older adults may not receive nutrition assistance through the Elderly Nutrition Program. They may not know about the available services, may not have access to services due to limited supply in their area, may receive informal assistance from family or neighbors, or may choose to remain self-sufficient rather than request government benefits. In addition, some older adults may choose to participate in a separate program instead, such as the Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps, where they can purchase their preferred foods.

Requests for Elderly Nutrition Program services have increased and demand will likely continue to grow. Through our survey of area agencies on aging (local agencies) conducted during the summer of 2010, we found that an estimated 79 percent of agencies had seen increased requests for home-delivered meals, and 47 percent had seen increased requests for congregate meals since the start of the economic downturn. Further, requests for OAA services are increasing as more seniors stay in their homes longer rather than move to assisted living facilities or nursing homes, according to agency officials. According to U.S. Census data, more than 9 million more Americans were 60 years and older in 2009 than in 2000, and the Census Bureau projects that population group will continue to grow.

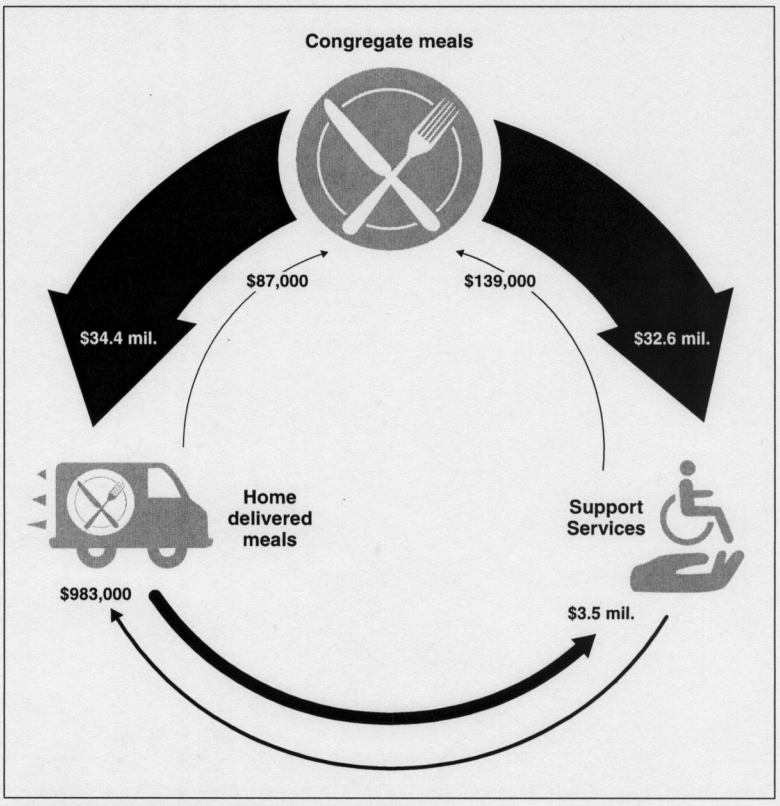
[8] 42 U.S.C. §§3030e and 3030f. Nutrition services authorized under Title III Part C of the OAA are designed to provide balanced and nutritious meals at home or in a congregate setting. Home-delivered meals, commonly referred to as "Meals on Wheels," are typically provided to individuals who have health difficulties that limit their ability to obtain or prepare food. Congregate meals are served at a variety of sites, such as schools and adult day care centers, and serve older adults' social interaction needs, in addition to nutrition.

[9] The CPS asked seniors whether they received home-delivered or congregate meals, but did not specify the source of the meals.

[10] We aligned our definition of likely need with two of the three key purposes of the Elderly Nutrition Program as described in the OAA: (1) reducing hunger and food insecurity and (2) promoting socialization. 42 U.S.C. §3030d-21. Given available data, we could not estimate the number of older adults likely to need services based on the third purpose of promoting health and well-being. Unless otherwise noted, our estimates of low-income older adults likely to need or receive meals services have a maximum confidence interval of +/−3.2 percentage points of the estimate.

Further, demand for Elderly Nutrition Program home-delivered meals is growing compared to congregate meals. In our 2010 survey, an estimated 22 percent of agencies reported they were generally or very unable to serve all clients who request home-delivered meals, compared to an estimated 5 percent of agencies who were generally or very unable to serve all clients who requested congregate meals. To adjust to these changes in requests for services, most State and some local agencies utilized the flexibility provided by the law to transfer OAA funds among title III programs.[11] Agencies most commonly transferred funds from congregate meals to home-delivered meals or other title III services. Nationally, from fiscal year 2000 through fiscal year 2008, States collectively transferred an average of $67 million out of the congregate meal program each year (see Figure 2).

Figure 2: Average Yearly Fund Transfers among Title III Programs, Fiscal Years 2000 through 2008



Source: GAO analysis of AoA Fiscal Year 2000-2008 State Program Reports.

[11] OAA title III authorizes a supportive services and senior centers program that covers, for example, health, transportation, ombudsman, nutrition, and education services, as well as home-delivered and congregate meals programs. 42 U.S.C. §3030d. The OAA provides states with some authority to transfer Federal funding allocations among programs. A state may transfer up to 40 percent of allocated funds for the home-delivered meals programs to the congregate meals program, or vice versa, and the Assistant Secretary of Aging can grant a waiver for a State to transfer an additional 10 percent. 42 U.S.C. §3028(b)(4). In addition, a state may transfer up to 30 percent of allotted funds for Part B support services (such as transportation and home-based care) to the meal programs and vice versa, and the Assistant Secretary may grant a waiver of the 30 percent limit. 42 U.S.C. §§3028(b)(5) and 3030c-3(b)(4).

ACTIONS NEEDED TO REDUCE ADMINISTRATIVE OVERLAP AMONG DOMESTIC FOOD ASSISTANCE PROGRAMS

In part because food insecurity is a national problem that affects not only older adults but also many other vulnerable groups, the Federal Government spent more than $90 billion on domestic food assistance programs in 2010. This represents an increase of approximately 44 percent over 2008 spending, driven largely by increased spending on the SNAP. We identified 18 different Federal programs that provide nutrition assistance, programs that emerged piecemeal over the past several decades to address a variety of needs. Agency officials and local providers have indicated that the multiple food assistance programs work together and provide various points of entry to the system to help increase access to food for vulnerable or target populations at high risk of malnutrition or hunger. Those officials and providers told us that, since no one program alone is intended to meet a household's full nutritional needs, the variety of food assistance programs can help households fill gaps and address the specific needs of individual members. However, we have previously reported signs of overlap and inefficient use of resources in the delivery of benefits through these programs. In addition to the Departments of Agriculture (USDA), Health and Human Services (HHS), and Homeland Security (DHS) multiple State and local government and nonprofit organizations work together to administer a complex network of programs and providers.

We have found that some of these programs, including those serving older adults, provide comparable benefits to similar or overlapping populations. For example, the Elderly Nutrition Program administered by the Administration on Aging (AOA), provides home-delivered and congregate meals primarily to individuals 60 years and older. Separately, other programs administered by USDA, including the Commodity Supplemental Food Program, targets a similar population, providing food to older adults, as well as women, infants and children who are also served by the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program. In addition, individuals eligible for groceries through the Commodity Supplemental Food Program or services through the Elderly Nutrition Program may also be eligible for groceries through the Emergency Food Assistance Program and for targeted benefits that are redeemed in authorized stores through the largest program, SNAP. In fact, a recent AOA report conducted by Mathematica [12] found that 7 percent of congregate meal recipients and 16 percent of home-delivered meal recipients were also receiving SNAP benefits. The availability of multiple programs with similar benefits helps ensure that those in need have access to nutritious food, but can also increase administrative costs, which account for approximately a tenth to more than a quarter of total costs among the largest of these programs. In addition, our previous work has shown that overlap among programs can lead to inefficient use of Federal funds, duplication of effort, and confusion among those seeking services.

We have found in previous work that despite the potential benefits of varied points of entry, program rules related to determining eligibility often require the collection of similar information by multiple entities.[13] For example, an older adult might apply for congregate meals through the Elderly Nutrition Program at their local area agency on aging, electronic benefits through SNAP at the Health and Human Services office, and vouchers for fresh fruit and vegetables through the Senior Farmers' Market Nutrition Program at a local food bank. Most of the 18 programs have specific and often complex administrative procedures that Federal, State, and local organizations follow to help manage each program's resources. According to our previous work and State and local officials, rules that govern these and other nutrition assistance programs often require applicants who seek assistance from multiple programs to submit separate applications for each program and provide similar information verifying, for example, household income. This can create unnecessary work for both providers and applicants and may result in the use of more administrative resources than needed.

Moreover, not enough is known about the effectiveness of many of these programs. Research suggests that participation in 7 of the 18 programs—including the Elderly Nutrition Program and SNAP—is associated with positive health and nutrition out-

[12] Allison Barrett and Jody Schimmel, Mathematica Policy Research, "Multiple Service Use Among OAA Title III Program Participants," September 2010 (Research Brief).

[13] GAO, *Domestic Food Assistance: Complex System Benefits Millions, but Additional Efforts Could Address Potential Inefficiency and Overlap Among Smaller Programs*, GAO–10–346, (Washington, DC: April 15, 2010).

comes consistent with programs' goals.[14] For example, studies on the Elderly Nutrition Program found that the program increases socialization and may have a positive effect on food security. In addition, research suggests the program improves participants' dietary and nutrient intake—an outcome related to the program's goal of promoting the 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. However, little is known about the effectiveness of the remaining 11 programs because they have not been well-studied.

Agencies do regularly collect performance and other data on nutrition assistance programs but these data are not sufficient to determine program effectiveness and do not always provide all the information needed to effectively and efficiently manage their programs. Agency data show that the 11 less-studied programs provide food and nutrition assistance to millions of individuals and households each year—an outcome related to their goals—however, this alone does not demonstrate the overall effectiveness of these programs. Other data—such as on need and unmet need for services—could help agencies better target limited resources and more efficiently serve their target populations but agencies often do not have this information. For example, while the OAA requires AOA to design and implement uniform data collection procedures for States to assess the receipt, need, and unmet need for title III services,[15] AOA does not provide standardized definitions or measurement procedures for need and unmet need that all States are required to use. Instead, AOA provides States with non-binding guidance on these issues and an assortment of tools and resources that they can use to evaluate need and limited information about measuring unmet need. States use a variety of approaches to measure need and measure unmet need to varying extents, but no agencies that we spoke with fully estimate the number of older adults with need and unmet need in their service area. Such information could help providers make informed decisions about serving those most in need as the number of older adults increases and resource constraints are likely to continue.

In April 2010, we recommended that USDA, as the principal administrator of the Federal Government's food assistance programs, identify and develop methods for addressing potential inefficiencies among food assistance programs and reducing unnecessary overlap among its smaller food assistance programs while ensuring that those who are eligible receive the assistance they need. These methods could include conducting a study as a first step; convening a group of experts; identifying which of the lesser-studied programs need further research and taking steps to fill the research gap; or identifying and piloting proposed changes.

Further, in February 2011 we recommended that, to help ensure that agencies have adequate and consistent information about older adults' needs and the extent to which they are met, the Secretary of Health and Human Services partner with other government agencies that provide services to older adults and, as appropriate, convene a panel or work group of researchers, agency officials, and others to develop consistent definitions of need and unmet need and to propose interim and long-term uniform data collection procedures for obtaining information on older adults with unmet needs for services provided from sources like title III.

In addition to our specific recommendations to USDA and HHS, we have also noted in prior work that agencies can reduce program inefficiencies by broadening their efforts to simplify, streamline, or better align eligibility procedures and criteria across programs to the extent that it is permitted by law. Consolidating or eliminating overlapping programs also have the potential to reduce administrative costs but may not reduce spending on benefits unless fewer individuals are served as a result. More broadly, essential to all these efforts is collaboration among many entities. Achieving meaningful results in many policy and program areas, including food and nutrition services, requires some combination of coordinated efforts among various actors across Federal agencies with other governments at State and local levels and nongovernmental organizations.

CONCLUSION

In conclusion, as I have outlined in my testimony, opportunities exist to streamline and more efficiently carry out these important domestic food assistance programs. Specifically, addressing duplication, overlap, and fragmentation could help to

[14] The other programs that show outcomes consistent with many of their program goals include: WIC, the National School Lunch Program, the School Breakfast Program, Nutrition Assistance for Puerto Rico, and the Special Milk Program.

[15] 42 U.S.C. §3012(a)(26).

minimize the administrative burdens faced by those entities—including States and localities as well as nonprofit organizations—that are delivering these programs' services. Such administrative burdens range from eligibility requirements and the application process to costs associated with carrying out the program and reporting requirements. Improving consistency among these various requirements and processes as well as considering how multiple agencies could better coordinate their delivery of programs could result in benefits both for those providing and those receiving the services. In addition, collection of adequate and consistent information about older adults' needs and the extent to which they are met could help providers make informed decisions about serving those most in need. It is particularly important to use resources efficiently given that the need for meals programs among low-income older adults will likely continue to outpace available services given the growing older population and continued economic constraints.

Careful, thoughtful actions will be needed to address issues involving potential duplication, overlap, and fragmentation among Federal programs and activities. These are difficult issues to address because they may require agencies and Congress to re-examine within and across various mission areas the fundamental structure, operation, funding, and performance of a number of long-standing Federal programs or activities. Continued oversight will be critical to ensuring that unnecessary duplication, overlap, and fragmentation are addressed.

Thank you, Mr. Chairman, Ranking Member Paul, and members of the subcommittee. This concludes my prepared statement. I would be pleased to answer any questions you may have.

APPENDIX I: SELECTED FEDERAL FOOD AND NUTRITION ASSISTANCE PROGRAMS, BY AGENCY

Item no.	Program Name
USDA	
1.	Child and Adult Care Food Program
2.	Commodity Supplemental Food Program
3.	Community Food Projects Competitive Grant Program [1]
4.	Food Distribution Program on Indian Reservations
5.	Fresh Fruit and Vegetable Program
6.	National School Lunch Program
7.	Nutrition Assistance for Puerto Rico
8.	School Breakfast Program
9.	Senior Farmers' Market Nutrition Program
10.	Special Milk Program
11.	Summer Food Service Program
12.	Supplemental Nutrition Assistance Program (SNAP)
13.	The Emergency Food Assistance Program
14.	WIC
15.	WIC Farmers' Market Nutrition Program
DHS Federal Emergency Management Agency	
16.	Emergency Food and Shelter National Board Program
HHS Administration on Aging	
17.	Elderly Nutrition Program: Home-Delivered and Congregate Nutrition Services
18.	Grants to American Indian, Alaska Native, and Native Hawaiian Organizations for Nutrition and Supportive Services

Source: GAO, Domestic Food Assistance: Complex System Benefits Millions, but Additional Efforts Could Address Potential Inefficiency and Overlap among Smaller Programs, GAO–10–346 (Washington, DC: Apr. 15, 2010).

[1]The Community Food Projects Competitive Grants Program is administered by the National Institute of Food and Agriculture (formerly the Cooperative State Research, Education, and Extension Service, CSREES) of USDA. All other USDA programs listed above are administered by the Food and Nutrition Service. Community Food Projects Competitive Grants Program participation information is from CSREES Update: September 17, 2009, Office of the Administrator, CSREES, USDA.

Senator SANDERS. Ms. Brown, thank you very much.

Our final witness is Dr. Mary Jane Koren, vice president for the Picker/Commonwealth Long-Term Quality Improvement Program at the Commonwealth Fund, a health policy foundation. Dr. Koren, an internist and geriatrician, began her career in geriatrics at Montefiore Medical Center, where she started the geriatrics fellow-

ship program and was assistant medical director for the Montefiore Home Health Care Agency.

Dr. Koren, thanks for being with us.

STATEMENT OF MARY JANE KOREN, M.D., M.P.H., VICE PRESIDENT, PICKER/COMMONWEALTH FUND LONG-TERM QUALITY IMPROVEMENT PROGRAM, THE COMMONWEALTH FUND, NEW YORK, NY

Dr. KOREN. Thank you, Mr. Chairman, for inviting me to testify today. I'm Dr. Mary Jane Koren and as a geriatrician I have made many home visits to patients living in the Bronx. In my experience, these nutritional programs, those supported by Title III C of the Older Americans Act, are undoubtedly some of the most cost-effective interventions yet devised to combat nutrition and hunger in seniors, keeping them healthier, longer, so they stay out of hospitals, they stay out of nursing homes, and they remain in their own homes.

Let me tell you why this is the case. Against a backdrop of physiologic changes associated with aging—such as the anorexia of aging, poor dentition, difficulty swallowing—there are multiple medical conditions that compromise an elder's ability to maintain nutritional status. Older adults have multiple chronic conditions, such as diabetes, depression, heart failure, kidney disease, and arthritis. Fifty percent of people over the age of 65 have two to four chronic conditions. Likewise, the prevalence of dementia rises with age, affecting almost half of those 85 years or older.

The interplay of these factors, both physiologic and pathologic, means that many seniors experience often insurmountable odds with shopping and meal preparation. They're at high risk for hunger and consequently high users of health care services.

Social issues also play a major role in hunger and food insecurity for elders with limited means and forces them to choose between buying food and paying the rent. Further, as I can attest from my own experiences making home visits in the South Bronx, many elderly patients are reluctant to leave their own apartments. They've learned the hard way that the denizens of that urban jungle view them as easy prey. Others of my patients were just as trapped at home when they could no longer drive. All too often, my patients were subsisting on a protein-deficient tea and toast diet.

As a geriatrician, I can tell you that hunger only makes things worse and drives up health care costs. Yet a low-cost simple intervention such as home meal delivery or congregate meals can reduce hospitalization and delay nursing home placement, thus significantly lowering the costs of what is otherwise an extremely high-cost population and a major driver of health expenditures.

Why are these programs effective? When older people don't eat enough good food, bad things happen. Research findings show that undernutrition causes any or all of the finding: muscle wasting, pressure ulcers, apathy, increased susceptibility to infections, anemia, delirium, increased frailty, functional decline, and fall. Any one of these negative health outcomes have enormous implications for service utilization.

Take falls. A third of people over 65 and a third of them suffer moderate to severe injuries from falls, leaving them disabled or un-

able to live independently. In 2000 the health care costs of falls exceeded $19 billion. Malnourishment increases the rate of falls and it worsens the outcomes. We know from research and from experience that providing nutritional support to vulnerable elders works.

If home-delivered and congregate meal programs could save even a fraction of what falls cost Medicare and Medicaid, they'd pay for themselves. Multiply that by the costs of treating all these other health consequences of hunger and the value of these programs is off the chart.

Not only that, people really love these programs, because they not only provide something to eat, they provide a reason to eat. Make no mistake, social isolation kills people, too. The socialization provided by these programs is a godsend for those who've outlived their friends and who because of illness, frailty, and dysfunction their life has been reduced to a couple of rooms.

This happened to my father. After a head injury in a car accident, he couldn't drive, he couldn't shop, and he couldn't do much in the way of meal preparation for himself. All he knew is he wanted to stay home. Meals on Wheels played a critical role in keeping him in his own home for the last years of his life. The volunteer's visit was the high point of his day.

Meals on Wheels also helped me, too, as his long-distance caregiver. They became my early warning system. Time and again, they alerted me to a problem before it was escalated to a catastrophe.

The bottom line is these programs help seniors stay healthier, which keeps them out of emergency rooms, decreases the rate of hospitalization, shortens lengths of stay and re-admissions, and keeps them out of expensive nursing homes.

In conclusion, I would make several recommendations for things that might be done at the Federal level. First, I would urge not only the reauthorization of funding for title III nutrition programs, I would strongly suggest they be expanded. They work.

I would also advise there be support for demonstrations, pilots, and applied research on how the programs could better serve our diverse population, and test creative strategies for improving outcomes even further.

Third, I would recommend that the requirements for the nutrition programs should ensure the caloric adequacy and key nutrients in meals. For many seniors these meals are their main source of daily food intake. Target specific highly vulnerable groups for receipt of enhanced services. Tailor the programs' services to increase its effectiveness for people with particularly high burdens of illness. Enhance the nutritional education and counseling given to caregivers and to their patients, and give the program the flexibility it needs to better accommodate regional and ethnic food preferences and improve palatability and taste.

I thank you for your attention and for providing the opportunity of addressing the committee.

[The prepared statement of Dr. Koren follows:]

PREPARED STATEMENT OF MARY JANE KOREN, M.D., M.P.H.

Thank you, Mr. Chairman, for inviting me to testify today. I am Dr. Mary Jane Koren and a geriatrician by training. Most of my career has been devoted to serving the elderly, particularly those with serious chronic conditions. I have taken care of

residents living in nursing homes, made home visits as the assistant medical director of the Montefiore Home Health Agency to patients living throughout the Bronx and later was appointed to be the director of New York State's Bureau of Long Term Care Services. Currently, I am vice-president at the Commonwealth Fund, an independent private foundation working toward a high performing health system which is located in New York City. The grant-making program I manage is aimed at improving long term services and supports particularly for people covered by both Medicare and Medicaid, also called the "dual eligibles", and for those transitioning from one level of care to another.

No matter which hat I'm wearing—geriatrician, policymaker or grantmaker—my goal has been, and is, to help frail older adults maintain their independence and well-being. The program I would speak to today, Title III–C of The Older Americans Act, Nutrition Services, is probably one of the simplest, yet most effective programs yet devised to help low-income seniors stay in their homes and stay out of hospitals and nursing homes. You have heard today from both Federal and State policymakers and from those who administer these programs. I will therefore try to give you a somewhat different perspective. Based on my professional background and front-line experience caring for elderly patients I'll briefly cover four areas: First, I'll say a bit on exactly why hunger, or under-nutrition, is so common in this population; second, talk about the consequences of under-nutrition both for patients and for rising health care expenditures; third, describe how home delivered and congregate meals can help low-income seniors, their families, health care providers and policymakers, especially in a time of constrained resources; and lastly, make several recommendations to strengthen these programs.

First, some information about aging: because of the way our bodies age, older people have a heightened risk of "hunger". The aging process itself predisposes a person to under-nutrition—physiologically, it's a stacked deck. These physiologic changes make it extremely difficult for even healthy older adults to stay well nourished. Here are some examples. There is what's termed the "anorexia of aging", a natural phenomenon in which the desire for even adequate quantities of food declines commensurate with the decline in physical activity seen in the very old. This means that seniors don't feel as hungry as you or I do at meal times and so there is the tendency to only eat a little bit or even to skip a meal. Compounding that, stomachs "shrink", or become less compliant, as people age so they feel "full" faster. This sensation of satiation is further mediated by the release of such hormones as cholecystokinin, leptin and dynorphin which act both on the brain and on the gut. The senses of smell and taste likewise diminish with age—food loses its savor making meals less interesting and enjoyable so people tend to eat less. Oral problems, such as poor dentition, ill-fitting dentures, or decreased saliva production are common in old age which can make eating a misery. It has been estimated that dental problems alone may decrease food intake by up to 100 kcal/day—not a lot, perhaps, for 1 day but cumulatively, over weeks and months, enough to cause an insidious and inexorable loss of weight.[1] Swallowing problems, or dysphagia, can make mealtimes a source of stress, not enjoyment. People who've experienced difficulty swallowing may be reluctant to eat very much or be very selective about what they try to eat because of their fear of choking. In addition, older adults don't get as thirsty as young people, which, especially in hot weather or for people with congestive heart failure on diuretics, can cause dehydration with its serious complications including dizziness, delirium and falls.[2] In a word, the aging process itself sets the stage for inanition or energy-protein malnourishment.

On top of this, there are a whole host of medical problems and social issues common to low-income older adults that further compromise an elder's ability to maintain optimum nutrition. Far and away the most common cause of under-nutrition is depression. Research has shown that depressive symptoms are associated with insufficient food intake and nutritional deficiencies, especially in poor elderly people living at home[3] because of loss of appetite, diminished enjoyment of food, difficulty

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[1] "Nutrition" ch2, p9. Merck Manual of Geriatrics, Second Edition, (Whitehouse Station, NJ: Merck & Co., Inc. 1995).

[2] Up to 2 percent of falls in elderly patients result in hip fractures and up to another 5 percent result in other fractures. These types of injuries account for about 5 percent of hospitalizations for patients over 65 years old. About 5 percent of elderly hip fracture patients die while hospitalized, while overall 12-month mortality ranges from 12 to 67 percent. See N. Alexander, "Falls" in Merck Manual of Geriatrics, Third Edition. (Whitehouse Station, NJ: Merck & Co., Inc. 2000).

[3] German L, Kahana C, Rosenfeld V, Zabrowsky I, et al. "Depressive symptoms are associated with food insufficiency and nutritional deficiencies in poor community-dwelling elderly people." J Nutr Health Aging. 2011; 15(1):3–8, cited in Morley JE. "Undernutrition: a major problem in nursing homes." J Am Med Dir Assoc. 2011 May; 12(4):243–6. Epub 2011 Mar 23.

with food preparation and consumption of a less varied diet.[4] A vicious circle gets started where depression leads to poor intake, which worsens depressive feelings, and so on. It can be a hard circle to break especially in the homebound elderly who tend to become lonely, withdrawn and apathetic. One study, for example, found that depressive symptoms, which were more common among women in the study, were linked with diminished mobility and social interaction.[5] I would also note that social isolation is one of the major risk factors for elder abuse, most commonly perpetrated by family members.[6] Encouraging those delivering meals to look for signs of elder abuse would help enormously in the detection of what's often a hidden problem and in getting help for an elder, who may have no other contact with people outside the home.

In addition to the impact of depression on food intake, older people have multiple chronic conditions, such as diabetes, heart failure, kidney disease, stroke and arthritis. The prevalence for those over age 65 of two to four chronic illnesses is about 50 percent. For those over age 75 almost 20 percent have five or more chronic illnesses[7] which take a huge toll on normal function, including even basic actions like being able to stand or lift things which compromises the ability to shop, prepare a meal and sometimes even the ability to eat. The presence and perceived effect of individual diseases and conditions on daily activities is termed the "the burden of disease"[8]—and the more illnesses a person has, the higher that "burden" becomes. When people don't feel well, appetite is often the first thing to go which leads to insufficient energy-protein intake and weight loss.

But treating people's illnesses may actually worsen the situation as far as nutrition is concerned. National surveys show that more than 9 of 10 older adults are taking prescription medications. According to the National Health and Nutrition Examination Survey, 64 percent of adults ages 60 and older are taking three or more prescription drugs per month. Almost 40 percent are taking five or more prescription medications per month[9]—and that's the average! In a population with such a high burden of illness, the likelihood that people will be on multiple medications is all but certain. Some drugs, like digitalis, a common medication for those with heart problems, directly suppress appetite. Others, like medications for arthritis or antibiotics, can cause stomach upset.

Then, there is another group of medications that can cause malabsorption, i.e. the medicines inhibit the uptake of nutrients from the intestinal track.

Another disease that is a major factor in under-nutrition in the elderly is dementia, a slowly progressive disease found in almost 50 percent of people over the age of 85. It is the fifth leading cause of death for those over 65.[10] Data shows that it strikes women with far greater frequency than men, with ⅔ of the cases being women, who according to census data are far more likely than men to be poor and live alone. So here we have people who may not feel hungry, who may quite literally forget to eat and, even if they do remember, may be unable to figure out how to prepare even the most rudimentary of meals. In this all too common scenario the probability of admission to a nursing home rises exponentially. Yet a low cost, simple intervention such as home meal delivery or congregate meals can reduce hospitalization and delay nursing home admissions thus significantly lowering the costs of what is otherwise an extremely high cost population and a major driver of health care expenditures.

Aside from these common medical problems however there are many social factors that play a vital role in the health and well-being of the elderly. Compared to the

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[4] Sharkey JR, Branch LG, Zohoori N, Giuliani C, et al. "Inadequate nutrient intakes among homebound elderly and their correlation with individual characteristics and health-related factors." Am J Clin Nutr. 2002 Dec; 76(6):1435–45.

[5] Penninx BW, Leveille S, Ferrucci L, van Eijk JT, et al. "Exploring the effect of depression on physical disability: longitudinal evidence from the established populations for epidemiologic studies of the elderly." Am J Public Health. 1999 Sept; 89(9):1346-52, cited in Sharkey JR, Branch LG, Zohoori N, Giuliani C, et al. "Inadequate nutrient intakes among homebound elderly and their correlation with individual characteristics and health-related factors." Am J Clin Nutr. 2002 Dec; 76(6):1435–45.

[6] "Who Are the Abusers?" National Center for Elder Abuse, Administration on Aging. Accessed June 17, 2011 *http://www.ncea.aoa.gov/NCEAroot/Main__Site/FAQ/Basics/Abusers.aspx*.

[7] "Chronic Care: A Call to Action for Health Reform." AARP Public Policy Institute. Accessed June 17, 2011 *http://assets.aarp.org/rgcenter/health/beyond__50__hcr.pdf*.

[8] Ibid. 4

[9] Gu Q, Dillon CF, Burt VL. "Prescription Drug Use Continues to Increase: U.S. Prescription Drug Data for 2007–8." NCHS Data Brief. 2010 Sept; (42):1–8. Accessed June 17, 2011. *http://www.cdc.gov/nchs/data/databriefs/db42.pdf*.

[10] "2011 Alzheimer's Disease Facts and Figures, Fact Sheet." March 2011, p1-2. Accessed June 17, 2011 http://www.alz.org/documents__*custom/2011__Facts__Figures__Fact__Sheet.pdf*.

under 65 population, almost 9 percent of the elderly live at or below poverty.[11] Data from numerous studies shows that poverty and hunger go hand in hand in the elderly. This is a problem that will only get worse. A recent survey by AARP's Public Policy Institute [12] reported that one quarter of those surveyed who were ages 50 and over, said they had already exhausted all their savings during the recession and over a third who were having difficulty making ends meet had to stop or cut back on saving for retirement. Food insecurity is a problem that will grow as more and more old people are faced with having to choose between food, rent or medicine. Addressing hunger through title III's nutrition programs will help seniors stay independent in their own homes.

Physical disability, frailty and dementia separately and in combination mean that many seniors experience difficulty with shopping and meal preparation. For example, people who've "aged in place" either in rural or suburban areas may find themselves living miles from a grocery store and, unable any longer to drive, dependent on the good will of neighbors, friends or relatives to get out to shop for food. Even in areas with reasonably good public transportation, buses and subways may be difficult for the frail and disabled especially if trying to lug groceries or maneuver a small shopping cart. Furthermore, as I can attest from my own experiences making home visits in the South Bronx, many patients are afraid to venture beyond their apartments. They learned the hard way that denizens of the urban jungle saw them as "easy prey". I cannot tell you how many of my patients ended up defaulting to a "tea and toast" diet, essentially devoid of nutritional benefit because they were trapped in their own apartments and couldn't or wouldn't risk a trip to the store for food. For them, meals on wheels was central to their survival.

But does "under-nutrition" or "hunger" really matter? Absolutely—and here's why. Under-nutrition leads to any one of several types of nutritional deficiencies. Whether it's not enough calories to maintain weight, insufficient protein to maintain muscles and other vital organs or deficiencies of vitamin and micronutrients, such as zinc, unless older people eat enough "good food" bad things happen. These include:

- Weight loss—and at least two longitudinal studies suggest that weight loss in later life predicts mortality [13];
- Skin problems, such as the development of pressure ulcers and decreased wound healing, especially of the skin tears that are such a common occurrence with the papery skin seen in the oldest old. Unhealing wounds leave people vulnerable to infections of the surrounding skin, soft tissues and underlying bone;
- Loss of muscle mass, or sarcopenia, causes loss of strength and function which predisposes to increased falls leading to hospitalization, nursing home placement and death [14];
- Suppressed immune function, which makes people more susceptible to infections and less able to mount a defense against otherwise minor infections;
- Fatigue which exacerbates depressive symptoms and saps any energy an individual might have to stay engaged with their communities and wider social network;
- Increased frailty, which has been described as loss of physiologic reserve that increases the risk of disability, which is a sort of precursor state to being dependent on another individual to compensate for functional deficits [15];
- Functional decline and impairment, which means people have trouble with their own personal care, e.g. bathing, as well as things like ambulation, thus increasing the risk of falls and gradual loss of the capacity to independently manage routine household tasks such as grocery shopping and meal preparation;

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[11] "A Profile of Older Americans: 2010", p. 1. Administration on Aging (AOA), U.S. Department of Health and Human Services. Accessed June 17, 2011 *http://www.aoa.gov/aoaroot/aging_statistics/Profile/2010/docs/2010profile.pdf*.

[12] "Recovering from the Great Recession: Long Struggle Ahead for Older Americans." May 2011, p. 3. Sara E. Rix, AARP Public Policy Institute. Accessed June 17, 2011. *http://assets.aarp.org/rgcenter/ppi/econ-sec/insight50_recovering.pdf*.

[13] "The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population." 2000, p. 67. Institute of Medicine. National Academy Press. Washington, DC.

[14] Fielding RA, Vellas B, Evans WJ, Bhasin S, et al. "Sarcopenia: an undiagnosed condition in older adults. Current consensus definition: prevalence, etiology, and consequences. International working group on sarcopenia." J Am Med Dir Assoc. 2011 May; 12(4):249–56. Epub 2011 Mar 4.

[15] Buchner DM, Wagner EH. "Preventing frail health." Clin Geriatr Med. 1992 Feb; 8(1):1–17, cited in Rockwood K, Fox RA, Stolee P, Robertson D, et al. "Frailty in elderly people: an evolving concept." CMAJ. 1994 Feb 15; 150(4):489–95.

• Higher complication rates and more severe complications from underlying chronic conditions or acute inter-current illnesses, such as pneumonia, and longer lengths of stay when hospitalized;
• Depression, loneliness and sometimes a condition known as pseudodementia;
• Falls which may arise from altered function brought about by any number of vitamin deficiencies such as Hypovitaminosis D, Vitamin B12 deficiency or from unrecognized dehydration;
• Delirium, which even when transient, has been shown to have long-term sequellae;
• Anemia from deficiencies of B6 (sideroblastic anemia) or B12 (megaloblastic anemia) which leaves people feeling exhausted and can even worsen heart failure.

Any of these negative health outcomes have enormous implications for service utilization. For example, as was mentioned above, many of the consequences of malnutrition increase the risk of a fall. Already, according to the CDC [16]:

• One in three adults 65 and older falls each year.[17] [18]
• Of those who fall, 20 percent to 30 percent suffer moderate to severe injuries that make it hard for them to get around or live independently and increase their chances of early death.[19]
• Older adults are hospitalized for fall-related injuries five times more often than they are for injuries from other causes.[20]

These statistics translate into real money:

• In 2000, the total direct cost of all fall injuries for people 65 and older exceeded $19 billion: $0.2 billion for fatal falls, and $19 billion for nonfatal falls.[21]
• By 2020, the annual direct and indirect cost of fall injuries is expected to reach $54.9 billion (in 2007 dollars).[22]
• In a study of people age 72 and older, the average health care cost of a fall injury totaled $19,440, which included hospital, nursing home, emergency room, and home health care.[23]

If home delivered services and congregate meal programs could reduce by even a fraction of what just this one preventable event costs the health care system, the program would pay for itself. Multiply that by the number of items in the list above and the value of these title III–C Nutritional programs is manifest. Especially since we know, from research studies and from experience, that providing nutritional support to vulnerable elders works. For example, in one study nutritional support of malnourished elderly individuals after a hospitalization actually improved their function.[24] Translation? It reduced the likelihood of nursing home placement.

This discussion would not be complete however without asking what the impact of these programs is for the elderly themselves. Ensuring that old people have a balanced, nutritionally complete diet, can reverse many of the consequences of malnutrition or outright prevent them. People feel better, stronger, and more able to care for themselves. Which is good. However the other real "take away" is that the importance of these programs transcends food—they not only give people something to eat, they give people a reason to eat. They are a life-line out to the community for low-income older people whose world has often been reduced to a couple of rooms due to frailty, illness and dysfunction. The nutrition programs are a source of socialization which is so often missing for the old. Knowing that someone's coming by is often the only reason for them to get out of bed. Forming a relationship with the person delivering the meal so they have someone to talk to or getting out to a lunch

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[16] "Costs of Falls Among Older Adults." Centers for Disease Control and Prevention. Accessed June 17, 2011, *http://www.cdc.gov/HomeandRecreationalSafety/Falls/fallcost.html*.
[17] Hausdorff JM, Rios DA, Edelberg HK. "Gait variability and fall risk in community-living older adults: a 1-year prospective study." Arch Phys Med Rehabil. 2001 Aug; 82(8):1050–6.
[18] Hornbrook MC, Stevens VJ, Wingfield DJ, Hollis JF, et al. "Preventing falls among community-dwelling older persons: results from a randomized trial." Gerontologist. 1994 Feb; 34(1):16–23.
[19] Alexander BH, Rivara FP, Wolf ME. "The cost and frequency of hospitalization for fall-related injuries in older adults." Am J Public Health. 1992 Jul; 82(7):1020–3.
[20] Ibid. 19.
[21] Stevens JA, Corso PS, Finkelstein EA, Miller TR. "The costs of fatal and nonfatal falls among older adults." Inj Prev. 2006 Oct; 12(5):290–5.
[22] Englander F, Hodson TJ, Terregrossa RA. "Economic dimensions of slip and fall injuries." J Forensic Sci. 1996 Sept; 41(5):733–46.
[23] Rizzo JA, Friedkin R, Williams CS, Nabors J, et al. "Health care utilization and costs in a Medicare population by fall status." Med Care. 1998 Aug; 36(8):1174–88.
[24] Neelemaat F, Bosmans JE, Thijs A, Seidell JC, et al. "Post-discharge nutritional support in malnourished elderly individuals improves functional limitations." J Am Med Dir Assoc. 2011 May; 12(4):295–301. Epub 2011 Feb 11.

program where they'll see friends a couple of times a week is as important as the food itself.

I saw this with my father. He received home delivered meals after an automobile accident at age 82 left him with a traumatic brain injury. He could no longer drive, his higher executive functions were impaired and gradually his short-term memory eroded but his desire to live in his own home stayed strong. I live 75 miles away from where he lived and don't own a car. I can assure you that had he not had Meals on Wheels, which came by 5 days a week, he would have been in a nursing home for the last 14 years of his life. I also know how much he valued the volunteer's visit, which was the high point of his day. That volunteer was his audience for an all too brief but important few minutes a day, relieving some of the tedium and loneliness of his life out there in his house in the country.

Meals on Wheels did something for me too in my role of long distance caregiver: it was my early warning system if something was going wrong. Over the course of several years I'd get a call that either he appeared bruised from having fallen, or "wasn't himself" or the heat didn't seem to be working. Meals on Wheels were my eyes: they got to know my father and alerted me about "a problem" before it became "a catastrophe".

The bottom line is title III–C funds are amazingly effective at helping seniors help themselves by feeding not only the body but the person. Having social connections and having enough to eat fulfills several basic human needs and keeps people healthier, longer. Healthy people, even when they are very old, don't need and don't use as many health care services as sick people do. Without a strong program of home delivered meals and congregate dining the really big ticket items go up: more trips to the emergency rooms, more frequent hospitalizations with longer stays, more re-admissions, and more years in a nursing home.[25] As a nation, it behooves us to start spending smart. Providing funding for these programs is the way to do just that. Nutritional programs are low cost solutions for high cost problems.

In conclusion I would make several recommendations for things that can be done at the Federal level. **First**, I would urge not only the reauthorization of funding for the nutritional programs covered under Title III–C of the Older American's Act, I would suggest they be expanded. The elderly use more health care services than any other age cohort and the low-income elderly, or dual eligibles, even more so. Therefore, while there is no single "silver bullet" to rein in costs for Medicare these title III programs come about as close as you will ever get to a simple, low-cost, low-tech intervention that's very popular with patients and their families with an incredible pay back. **Second**, I would advise that there be support for demonstrations, pilot programs, evaluations and applied research aimed at better understanding the needs of the populations served and testing creative strategies for improving outcomes. **Third**, I would recommend that certain elements of the program be strengthened to make it even more cost-effective. Specifically, the requirements for the Nutrition Programs under the Older American's Act should:

- Ensure the nutritional completeness and adequacy of key nutrients in delivered or served meals. For many seniors these meals are their main source of daily food intake. Therefore, they need to have sufficient calories, high quality protein from meat, fish or poultry, green, leafy vegetables and fresh fruit. Research has shown that nutritional supplements are unnecessary if people are eating a well-balanced diet.
- Target specific highly vulnerable groups, such as women, African-Americans and the homebound for receipt of enhanced services.
- Tailor the program's services to increase effectiveness for people with particularly high burdens of illness or high energy (caloric) requirements, such as those with Parkinson's Disease, who burn through calories because of tremors.
- Include nutritional education and counseling to patients and caregivers.
- Give the program flexibility to accommodate regional, ethnic and racial food preferences and improve palatability and taste.

I thank you for your attention and providing the opportunity of addressing the committee.

Senator SANDERS. Dr. Koren, thanks very much for your testimony.

Let me begin the questioning with Ken Gordon. Ken, you live and I used to live years ago in one of the most rural parts of a

[25] Yang Y, Brown CJ, Burgio KL, Kilgore ML, et al. "Undernutrition at baseline and health services utilization and mortality over a 1-year period in older adults receiving Medicare home health services." J Am Med Dir Assoc. 2011 May; 12(4):287–94. Epub 2010 Oct 27.

rural State. We got a lot of snow in the wintertime. People are isolated. Talk for a moment about the impact of Meals on Wheels among elderly, frail people in a very rural part of America?

Mr. GORDON. They are incredibly important to people's well-being. Social isolation is in fact a huge problem, particularly so in rural environments, where there's little social interaction, and apartment buildings or other settings. So not only do they provide essential nutrition for individuals who may have difficulty being able to travel to a senior center or to a grocery store to pick up food, but they help on the social end as well.

Senator SANDERS. Thanks.

Dr. Koren, let me ask you a question. I read your testimony with great interest, and I think the thrust of what you are saying, which I would like you to elaborate on, is that if seniors are not getting the nutrition that they need, in a dozen different ways it ends up costing us as a society and costing the government substantially more money to address needs that result from lack of nutrition.

Do you want to elaborate on that point, please?

Dr. KOREN. Yes. As I mentioned, there are a lot of physiologic problems with aging and also medical conditions. But undernutrition, malnutrition, causes in and of itself even further conditions. As I mentioned, you have muscle wasting, which causes people to be weak. They fall more. You have—

Senator SANDERS. So you're saying—I'm sorry to interrupt you—is that people who do not have adequate nutrition are more likely to sustain injuries falling?

Dr. KOREN. Yes.

Senator SANDERS. And what is the cost of taking care of people who fall?

Dr. KOREN. The 2000 costs were $19 billion.

Senator SANDERS. Let me just mention. That's falls.

Dr. KOREN. That's falls; it's a single condition.

Senator SANDERS. The cost of this entire bill that we're talking about nutrition and nonnutrition, is $2 billion, compared to $19 billion addressing just the issues relating to falls.

Please continue.

Dr. KOREN. The $19 billion was in 2000. The estimated costs for falls in 2020 is $54 billion. The costs for this are going up. So even that one condition alone, which is worsened by the other problems that come with malnutrition—anemias, depression, and wasting of muscles—all of these things are things that can be prevented, and they also make the underlying medical conditions far worse for people. So it worsens things.

For example, anemia can worsen heart failure. That's one of the major drivers of health costs in this country today, is caring for people with congestive heart failure. So the interplay of the problems that occur from undernutrition make underlying medical conditions far worse.

Senator SANDERS. Mr. Blancato, say a few words, if you will, about the unmet need in this country? What we've heard from Dr. Koren is that in fact as a nation we are unnecessarily spending many, many billions of dollars because seniors are incurring a number of illnesses and problems because of poor nutrition.

Could you tell us what you perceive to be the unmet needs in terms of nutrition and seniors?

Mr. BLANCATO. I think a lot of it is reflected in the numbers that we provided in the statements about the number of food-insecure people, that could range between 3 and 6 million, the 87 percent of older people who have those common three chronic diseases. The one on diabetes in particular stood out as one that indicates that for them they have a three times higher rate of being placed in nursing homes.

Again, the idea with the Older Americans Act was to catch the problem early, to find when the person was assessed as being at risk and potential institutionalization it was because of many reasons, and because of nutritional needs. So the idea of the intervention early was intended to save the dollars that are down the road.

I think that this program has proven itself over and over again through the work that's been done and, as pointed out by the GAO, by the evaluation that is done of this program on a regular basis to ensure it's meeting its goals.

Senator SANDERS. Thanks very much.

Senator Paul.

Senator PAUL. Thank you, Senator Sanders.

I still can't get over how we're going to spend more money and we're going to save money by spending more money. This idea that for some—people are going to get less injuries from their falls. Dr. Koren just said people are still falling and their costs are rising. The rising nutritional costs, all the statistics seem to show that we're getting worse, not better. We're spending more, not less.

If we're going to make this argument that somehow providing nutrition is going to make the injuries less from falling, shouldn't we have some data? It sounds like the data argues the opposite. The data argues we're spending more on injuries from falls as a percentage, we're spending more on nutrition as a percentage, we have more problems, not less problems.

You have to have data that proves your points. You have to argue somehow that we are making progress, that we're saving money. You can't just say that we're going to spend $2 billion, why not spend $4 billion or why not spend $10 billion to save more money? You have to prove what we're actually asserting.

Now, one of the things I was curious about—I don't have arguments against Meals on Wheels. I like Meals on Wheels. I do have an argument against a multimillionaire getting Meals on Wheels. I do have a question in my mind when Dr. Koren says her father benefited from it. I have no question her father benefited from it, but my question is should a guy or a fellow working at McDonald's be paying taxes to provide Meals on Wheels for the father of a physician? Is there not anybody else who has that question, whether or not we should target people, those who are in need or whether everybody—does Warren Buffett need Meals on Wheels? If Warren Buffett's father or his daughter lives nearby, do they need Meals on Wheels? Should we not ask these questions, whether or not there is someone else to provide or what the means of the people are before we give these programs? We don't have unlimited programs.

I really think there are questions about this. I guess my question to Dr. Koren would then be, if the health care costs related to falls, are going up, how is that an argument that nutrition is somehow helping the health care costs related to falls?

Dr. KOREN. One of the reasons that costs are going up are there are more old people. But another reason is that what nutrition can do is slow the trend. What we want to do is not eliminate every fall—that will never happen—but what you want to do is slow the rate of falls and decrease the incidence of falls, which can happen from better nutrition.

I also want to improve the odds of a better outcome if people fall. And if malnourished older people fall, they're going to stay in the hospital longer and they're going to end up in a nursing home.

Senator PAUL. But basically you'd have to look at some statistics. And we aren't talking about numbers here; we're talking about percentages. So you'd have to look at percentage of old folks getting hip fractures and tell me you're getting less hip fractures because you're feeding them better through these poverty programs. I think you'll find those statistics don't exist.

Most every group that comes up here wants to tell us how much worse the problems are because they can get more money because the problems are worse. I don't see anybody coming forward to any of these committees saying, "oh, the problems are getting better, the war on poverty is really working, we have less poverty now."

We're not looking at numbers, raw numbers. Everybody understands the population's growing. But if you look at percentages, what everybody who comes before the committee says: "Things are worse, things are worse; give us more money." Well, things are worse; what happened to the money we already gave you?

We have 70 programs doing the same thing. I think we need to ask the question, how do we get rid of duplicate programs? My question to Ms. Brown would be: Do you have any suggestions for how we would get rid of duplicate programs in nutritional assistance? Thank you.

Ms. BROWN. Just for the record, we're not recommending there be a change in any single program. We are, in view of the dire fiscal condition of the country, suggesting that we need to step back and look across the number of different programs that we're offering right now and see if we can find ways to increase the efficiencies, especially as we expect the demand to grow.

It's not a simple issue, and all of these programs were created because there was some kind of need. If we were to step back and look across the programs, the things that we would have to keep in mind are what any effects of any change would be on the recipients and those who need the services and also what the cost-effectiveness would be.

The actual decisions about how programs would be changed, combined, many different options, would be policy decisions.

Senator SANDERS. Thank you.

Senator Franken.

Senator FRANKEN. Ms. Brown, Senator Paul asked for actual research. It sounds like you have done research on the Older Americans Act, the nutritional programs in that. Is that true?

Ms. BROWN. With the 18 programs that we identified that existed ought to provide nutrition, we looked at each of those programs to see what kind of research was available to tell us whether the programs achieved their goals, the specific goal of the program. For 11 of the programs, there wasn't enough research; and for the remaining, there was research and, yes, this program, the senior nutrition program, is one of the ones that is achieving its goals.

Senator FRANKEN. So by achieving its goals, do you mean that it saves money and that by providing these nutritional programs, it allows people to stay in their homes and therefore cuts the costs to the taxpayer in what we would pay and to everyone in terms of what they pay in terms of going into nursing homes?

Ms. BROWN. When I say that they met their goals, we looked at the explicit goals of the program as they're laid out in the law and in the regulations. The two most clear are related to food insecurity, and there is some evidence that these programs help address food insecurity, and the other is to address isolation of older adults, and there's some evidence that the programs have an effect on that, too.

Senator FRANKEN. Mr. Gordon, the clear inference of those results would be the ability to stay out of nursing homes, wouldn't it, and be able to stay at home, if you reduce isolation and increase nutrition?

Mr. GORDON. Yes, Senator, we see evidence of that every day.

Senator FRANKEN. Now let me ask you this. Senator Paul had questioned how only people in Washington could see the relationship between spending money in that way and that actually spending money could save money. Do people in Vermont see that relationship, because people in Minnesota do and we've learned that people in Kansas do. So it's not only in Washington, is that correct?

Mr. GORDON. That's correct. The Vermont legislature and several Vermont governors have also recognized that relationship.

Senator FRANKEN. Let me ask you this, too. Senator Paul brought up the idea of Warren Buffett being a recipient of Meals on Wheels. I think that's very unlikely. But he makes the point that there are probably some people who in some way or another could either contribute to the Meals on Wheels. And some people do, right, or the congregate dining? Some seniors do, right?

Mr. GORDON. Correct.

Senator FRANKEN. OK. But I think what he's suggesting is that if we do this program at all, and since Ms. Brown seems to say that it achieves its goals, if we do this program at all, what he is I think suggesting is that the Older Americans Act set up a large bureaucracy to determine whether any recipient of either congregate dining or Meals on Wheels has a little bit too much money to qualify.

He also talked about absurdity. Do you think that it would be absurd to set up that kind, really in a cost-benefit analysis, to set up a vast bureaucracy to make sure that Warren Buffett doesn't take too much advantage of the Meals on Wheels program?

Mr. GORDON. Well, the intent——

Senator FRANKEN. Is that absurd?

Mr. GORDON. In my mind, yes. As I understand it, the intent of Congress was that this program not be means-tested. I can also tell you that we worked carefully with individuals to talk about family

supports and how family can help them remain independent in the community, and that's a part of our work with every senior that we engage.

Senator FRANKEN. Ms. Brown, I was a little confused, because you talked about 18 different programs and Senator Paul talked about 70 programs. Do you have any idea—I know the Senator has left, but do you have any idea where that discrepancy comes from?

Ms. BROWN. Yes, Senator. When we started our work to review all the domestic nutrition assistance programs, we went through the catalogue of many, many Federal programs. First we identified any programs that could provide food assistance or provided funding that would support food assistance. After we identified those 70, then we narrowed it down to those 18 programs that existed solely to provide nutrition assistance. And looking at the available research and the administration of those 18 programs was plenty for us to do.

Senator FRANKEN. Thank you.

Thank you, Mr. Chairman.

Senator SANDERS. Thank you, Senator Franken.

Senator Hagan.

STATEMENT OF SENATOR HAGAN

Senator HAGAN. Thank you, Mr. Chairman. I really appreciate you holding this hearing today. In my State of North Carolina, we have an aging population. In fact, the 65-year-old population is expected to double in the next 20 years to 2.1 million people. Currently close to 30 percent of the seniors 65 and older are living alone and 25 percent of those have an income between 100 to 200 percent of the poverty level.

I know that the congregate and the home-delivered meals provided to our seniors, particularly our low-income seniors, really provide the vital nutrition to keep them alive. It's a very important program to millions of elderly people across the country, so I appreciate you holding this hearing.

Mr. Blancato, you spoke of cutbacks in services and volunteers because of rising gas prices and food prices. Can you explain in more detail how the nutrition programs that rely on volunteers and provide also more information on the impact that such cutbacks in services have on seniors trying to access these programs.

Mr. BLANCATO. Yes, Senator. Thank you. I point out, I have a brother who's aging in Winston-Salem, so he's in one of your populations there.

The volunteers are impacted by the rising cost of gasoline in their ability to provide their volunteer service when the prices go up and end up having them being unable to continue to do volunteer work. So they are cutting back on their volunteer hours in these programs.

We did a survey, and I'd be happy to share it for the record, but some of the things we learned were that programs ought to be cut back, the number of meals would have to be scaled back, waiting lists would start for people who applied. This is all because of rises in gas prices, food prices, particularly the food that's most important that's provided daily in these programs—beef and meat and bread and things of that nature.

We're finding that the responses we're getting from our members run the gamut of what these cutbacks are really doing for their day-to-day services.

Senator HAGAN. I've been hearing that a lot, too, with rising gas prices, that the volunteers can't afford it.

Mr. Gordon, in your testimony—and I know it was brought up already, too—we talked upon the issue about seniors who live in rural areas. North Carolina has a large population in the rural areas and many of them, according to your testimony, are at the greatest risk of hunger. Can you discuss some of the solutions that would target this vulnerable population?

Mr. GORDON. It's a challenging area because of the logistics and the miles that need to be traveled. One of the promising areas of practice that we've begun to see around the country is merging our senior meal programs with the local food movement. We're seeing more and more attention being paid to growing food locally, to rely on local agricultural economies and distribution systems that are a part of that. I think particularly in rural communities, that is a solution to look for as we move forward.

Senator HAGAN. Thank you.

Dr. Koren, in your testimony you make some recommendations for strengthening the nutrition programs. In particular, you recommend that we ensure the nutritional completeness and adequacy of key nutrients in delivered or served meals. Can you speak to the current nutritional components of the meals? I'm just curious, who determines the caloric, the macro and the micronutrient content of the meals, and does it vary State by State?

Dr. KOREN. I can't give you the exact statistics. I do have them in some of the materials I used to prepare my testimony. You also might be able to find that from Ms. Greenlee. Usually it is my understanding that the delivered meals provide about one-third of the recommended daily allowances for proteins, calories, and nutrition. But as I said, these meals are very often the primary food intake for people during the day.

Also, with some of the cutbacks it's been harder to have high quality protein, such as meat, fish, poultry, and so forth, and also to have green, leafy vegetables and fresh fruits, which are really key for delivering the kinds of nutrients that elderly people need.

Senator HAGAN. So what is your recommendation on how to address that?

Dr. KOREN. I think some of the ideas that we've heard from Mr. Gordon, and also to really look carefully at these programs and see, are there ways of enhancing these. There have been questions about the provision of nutrient supplements, vitamin pills, things like that, with people. But also, if we can sort of think about these programs and enhance them so that the food itself is nutritious and can really deliver the kind of nutrient content that people require.

Mr. BLANCATO. Senator Hagan, if I may, there's another point, too, and that is if we more closely enforce the provision of the law now that allows for consultation with dieticians with the nutrition programs, I think that would also address that issue, and we should look at that.

Senator HAGAN. Thank you.

Ms. Brown, in your testimony you discuss how some seniors might receive assistance through the alternative means other than the elderly nutrition program. You mentioned that some seniors might choose to participate instead in the Supplemental Nutrition Assistance Program, or SNAP. Did you look at why some seniors might choose SNAP over the elderly nutrition program and, if so, what were the reasons?

Ms. BROWN. I think the specific thing with SNAP is that because it's an electronic benefit transfer, you can swipe a card in a supermarket, and you have the option to buy the food that you prefer and what you'd like to have. I think that's the main thing. There are people who also participate in the congregate meals or home-delivered meals and SNAP.

Senator HAGAN. Are there restrictions on what they can purchase with the SNAP card, the SNAP benefit?

Ms. BROWN. Yes, there are, and it's just primarily nonfood items, no alcohol, tobacco, that kind of thing.

Senator HAGAN. You also discuss that the GAO found overlap in these 18 nutritional programs for seniors run by the USDA, HHS, and DHS. However, when I look at the list of these 18 programs, some of the programs don't appear to be geared toward the elderly. For example, the school breakfast program and the national school lunch program. Do all 18 of these programs that you've cited have an elderly component, and if not which of the 18 could realistically be coordinated to ensure that services are provided for seniors needing nutritional assistance?

Ms. BROWN. I can explain the 18. That work was done at a request to look at the total domestic nutrition assistance programs in the United States.

Senator HAGAN. Not just for the elderly?

Ms. BROWN. Correct. Then for this testimony we stepped back and highlighted the ones that we know are available to the elderly. I can tell you, there's the commodity supplemental food program, the child and adult care food program. There's an emergency food program that provides commodities, and several others which I'd have to find.

Senator HAGAN. Thank you, Mr. Chairman.

Senator SANDERS. Thank you, Senator Hagan.

Let me conclude the hearing by, first, thanking all of the panelists for excellent presentations without exception; and second of all, saying that I think that this discussion that we've had this morning raises a very fundamental issue about this country. Today in America we have the most unequal distribution of wealth and income of any major country on Earth. Some people are doing phenomenally well, a lot of people are doing very, very badly economically, and those numbers are growing.

We've got to address that issue from a moral perspective, what do we do when millions of senior citizens do not get the nutrition that they require. Are we happy with that as a nation?

The second issue—and I think Dr. Koren went into that at some length—is whether or not that is good economics, whether it makes sense that at a time when health care costs are escalating and we spend much, much more per person on health care than any other industrialized Nation on Earth, and that maybe one of the reasons

is that we do a pretty bad job in terms of prevention in general, and maybe it does not make a whole lot of sense to see increased costs, health care costs, because of excessive emergency care utilization, nursing home utilization, hospital utilization, because people are not getting the nutrition they need.

Is that good economics? I think not. So that's where we are, and I want to thank you all for commenting on this issue and for your excellent presentations. Thank you very much.

The hearing is now adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF AARP

AARP is a nonprofit, nonpartisan organization with a membership that helps people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. We appreciate this opportunity to offer some preliminary ideas on the reauthorization of the programs and services of the Older Americans Act (OAA), pending formal legislative language. Our interest is to ensure that the act maintains critical service and information roles, and promote greater responsiveness to the needs of mature and older Americans, including those facing nutritional risk aggravated by advancing age.

Today nearly 6 million older Americans experience hunger and this number will only increase as the aging population grows. Between 2006 and 2008, the percentage of poor and near-poor elderly struggling with hunger or lacking sufficient nutrition and food resources more than doubled—from 4.7 percent to 10.1 percent. It is projected that by 2025, this number will reach 12.6 million Americans 50+, or 14.9 percent of this population. Based on recent studies, more than 5 million seniors, or 11.4 percent of all seniors, experienced some form of food insecurity in the mid-2000s, and the number is increasing. Further, a recent study by NASAUD and the AARP Public Policy Institute reported that although demand for meals has increased substantially since the beginning of the recent recession, State funding for these programs has not kept pace and in several areas has decreased. The dimensions of the senior hunger problem are clearly growing as solutions appear to evade the grasp of our policy reality.

In this period of economic downturn, AARP is most concerned that programs, authorities and partnerships that have already proven effective in meeting the needs of vulnerable older Americans be maintained and strengthened. We believe that older persons would be best served if Congress works expeditiously to reauthorize the program, with only minor changes in existing programs to improve efficiency. As related to combating senior food insecurity and nutritional risk, AARP believes that better coordination of existing OAA nutrition programs with other Federal, State and local programs holds great promise and merits the support of the Administration and Congress.

I. REINFORCING CAPACITY FOR DELIVERY OF HOME AND COMMUNITY-BASED NUTRITION SERVICES

Helping people to grow older in their communities with independence and dignity is a bedrock goal of the Older Americans Act. All too often, advancing age and increasing frailty threaten the ability of older persons to remain healthy, nutritionally secure and independent in their own homes. The fear of having to enter a nursing home due to vulnerabilities aggravated by nutritional risks and other aging-related circumstances weigh heavily on the minds of many older persons and their families.

AARP is open to potential new initiatives that complement existing caregiver and service programs with innovative and effective approaches to expanding nutrition program access through the existing and evolving network of home and community-based nutrition services. Newly adopted nutrition initiatives, however, often require additional funds be provided through the annual OAA appropriations process. AARP urges that no OAA nutrition or other OAA services activities be sacrificed to pay for new programs. This would require real commitment and creativity given Federal budget constraints. In the past, OAA has not traditionally received significant new increases in funding.

Over the past two decades, States have made great strides in improving the nutrition options for nutritionally at-risk older persons, especially for those who want to remain in their own homes and communities for as long as possible. However, the weak economy has reduced funding availability and has forced reductions or elimination of nutrition services in many instances for our members and other older Americans. Advocates in States across the country are working to preserve access to vital nutrition services for older adults in these tough economic times and to prevent or minimize the potential harmful impacts that cuts in services or benefits could have on these individuals. Successful State delivery strategies that AARP could support may include:

- better coordination of Federal and State nutrition program funding (e.g., State-only funded programs, USDA nutrition programs, and public-private nutrition initiatives) with the existing network of OAA nutrition programs and other OAA home and community-based services;

• streamlining administrative operations that will permit a designation of central points of coordination for nutrition services for seniors; and
• adopting nutrition assessment and eligibility management practices that allow targeting of resources to the persons most in need, especially those traditionally underserved. Aging and Disability Resource Centers (ADRCs) might be a source of help in providing individuals and their families with one-stop nutrition information and other assistance to enhance coordination of the range of home and community services.

AARP also believes, however, that it is preferable to retain the current separation between the assessment of eligibility and the actual provision of nutrition services, so that the agency that conducts eligibility assessments does not have a financial interest in the type and amount of services authorized. Any potential and actual conflicts of interest by agencies authorizing or providing services should be avoided to ensure that older adults receive the services they need.

The use of existing authorities under the OAA could also be explored to enhance nutrition and other community-based services under the Older Americans Act. Some examples could be the use of volunteers, support for innovative and proven intergenerational programs, and partnerships with National and State Title V Grantees to increase opportunities for Senior Community Service Employment Program enrollees to participate in the delivery of nutrition services.

The aging network should consider where it can add real value and provide assistance to older adults at nutritional risk or experiencing food insecurity by leveraging partnerships and exploring new opportunities and coordination with Federal, State, local or public-private programs and initiatives, especially if there is evidence-based data to support such efforts.

II. TARGETING OF OAA NUTRITION SERVICES

Administration of the programs and services provided under the OAA is more critical in these days of austere budgets than ever before. It is important to direct resources to areas that achieve the most impact while aiming to meet the goals of the act. Toward this end, the AARP supports uniform data collection procedures and definitions that permit evaluation of program effectiveness, especially regarding gaps in service to rural, frail, low-income and minority older persons. This is critical for addressing those elders who are food insecure and nutritionally at risk.

Years of studies show pockets of under-service to certain older populations by the programs of the act. The Administration on Aging (AOA) has improved its ability to collect participant data in recent years. However, there are not adequate measures of the unmet need for services. Broadening the rigor and scope of data collection for title III nutrition programs could help demonstrate their impact on special populations and should be pursued. Toward that end, AARP continues to be concerned about the potentially harmful effect of mandatory cost sharing because of its undetermined impact on food insecure and nutritionally at-risk elders in target communities.

For many years, AARP has advocated targeting OAA services to persons with the greatest social and economic need and, in particular, to low-income, older minorities. AARP continues to strongly support retention of the targeting provisions of the act. The flexible nature of the OAA programs is one of its strengths because it helps to garner broad public and political support. However, historically there have been problems in achieving adequate service delivery to older minority individuals. It is critical that new participation data collected by AOA be disseminated, so that the adequacy of current nutrition service delivery to older minorities can be evaluated. By tracking results, it is possible to ensure that more funding goes to those programs that achieve the best results with the targeted populations. Better tracking would also enhance ability to assess delivery of nutrition services to other underserved target populations, such as rural elders, and enable more effective allocation of OAA nutrition dollars.

III. AARP AND AARP FOUNDATION ANTI-HUNGER EFFORTS

As such, AARP and its affiliated charity, AARP Foundation, are making a long-term commitment to help older Americans get nutritious food on the table so they will no longer have to make the devastating choice between basic needs like food and prescription drugs or food and housing. **Drive to End Hunger** is a national multi-year initiative designed to provide solutions to feed people today and prevent hunger among older Americans tomorrow.

Drive to End Hunger aims to build national awareness about the issue of hunger among 50+ individuals. One platform for this is AARP's sponsorship of four-time NASCAR® Sprint Cup Series Champion Jeff Gordon's No. 24 **Drive to End Hun-**

ger Chevrolet. As part of this collaboration, Gordon and Hendrick Motorsports are engaging the NASCAR fan base, corporations, and charitable organizations through track engagement events across the country. AARP and AARP Foundation have also created a new online resource—*www.drivetoendhunger.org*—where anyone interested in learning more about the issue of hunger among older Americans can obtain information on the causes and consequences of hunger, as well as access resources to help eligible persons receive assistance.

Drive to End Hunger aims to provide short-term support to people in need and to organizations serving the 50+ low-income segment, such as food banks, food pantries, and home meal service providers. AARP Foundation support comes in the form of both food and monetary donations. In only 6 short months since AARP and AARP Foundation launched **Drive to End Hunger**, we have provided the equivalent of 2.18 million meals to local service providers in Alabama, Arizona, California, Colorado, Florida, Kansas, Michigan, North Carolina, Pennsylvania, South Carolina, Tennessee, and Virginia.

Drive to End Hunger aims to increase participation in the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps) by utilizing AARP State Offices, volunteers, partners and existing AARP Foundation program infrastructure to educate and enroll eligible older Americans. While over 7 million 50+ individuals are eligible to receive benefits, only one-third are currently enrolled in the program. Participation in SNAP is low for many reasons including, but not limited to, misinformation about eligibility criteria, complexity of the application for benefits, and stigma associated with receiving public assistance. Not only will SNAP enrollment help nourish older Americans, increased participation will also help boost local economies as every $5 in SNAP benefits expended, generates $9.00 in local economic activity.

Drive to End Hunger aims to develop sustainable solutions to hunger. Next month, AARP Foundation will launch a grant program and offer $1 million to fund projects that address the food needs of older adults experiencing hunger and focus on improving food access, adequacy, affordability, and appropriateness for 50+ Americans. State and local governments as well as national and community-based organizations will be eligible to apply.

Drive to End Hunger aims to further thought leadership and research on hunger, paying particular attention to key research gaps that could lead to systemic solutions for 50+ older Americans.

CONCLUSION

Again, AARP appreciates the opportunity to address the critical issue of senior hunger, especially in the context of the OAA reauthorization as the Nation experiences a rapidly expanding older population. AARP believes that the economic climate demands a very targeted and reasonable approach to addressing the nutrition needs of older persons under the act while laying a foundation on which to build and direct future nutrition investments when the opportunity permits. We look forward to working with the groups in the aging network, Congress and the Administration to advance the interests, independence, and well-being of older Americans during this reauthorization process.

PREPARED STATEMENT OF FEEDING AMERICA

INTRODUCTION

Chairman Sanders, Ranking Member Senator Paul, and members of the U.S. Senate Committee on Health, Education, Labor, and Pensions, Subcommittee on Primary Health and Aging, thank you for the opportunity to submit this statement for the record on behalf of Feeding America and for holding this hearing. We look forward to hearing testimony from the witnesses and from committee members on the issue of senior hunger as well as the upcoming reauthorization of the Older Americans Act, particularly its impact on nutrition policies that impact the health and welfare of our Nation's increasing numbers of seniors.

Feeding America is the Nation's leading domestic hunger-relief charity with a network of more than 200 food banks serving all 50 States through over 61,000 local food assistance agencies. Feeding America food banks, as well as the food assistance agencies they serve, rely on a variety of public and private funding streams to feed 37 million Americans, one out of eight, every year.

During the worst economic downturn since the Great Depression, the number of American families struggling to make ends meet has increased significantly. Data being reported by the Federal Government mirrors what food banks across the country are seeing. In November 2010, the U.S. Department of Agriculture (USDA) re-

leased a report showing that more than 50 million Americans were at risk of hunger during the 2009 calendar year. This number was an increase of nearly 14 million people since the economic recession began in 2007. With unemployment still hovering near 9 percent, the need for food assistance continues to grow and food banks continue to be pressed to meet the need in their communities. Last year, 37 million people, including 14 million children and nearly 3 million seniors, received emergency food assistance through the Feeding America network. This represents an increase of 46 percent since 2006.

Many Feeding America food banks offer programs designed to meet the special nutritional needs of certain segments of the population, including children and seniors. Currently, 116 Feeding America food banks offer senior programs. The Federal Commodity Supplemental Food Program (CSFP) and the private Brown Bag (Food Box) delivery program are the most common program models. Combined, these programs account for 61 percent of the senior programs operated in the network and 87.6 percent of the food distributed by senior programs. The other program models that food banks operate include senior home delivered meals and targeted mobile pantries. In total, more than 86.5 million meals are provided to seniors through these programs.

THE GREAT RECESSION, SENIOR POVERTY, AND HUNGER

According to the U.S. Census Bureau, there are currently 38 million individuals in this country aged 65 and older. As the Baby Boom generation continues to age, this number is projected by the U.S. Department of Health and Human Services' Administration on Aging to increase by one-third by 2020, reaching nearly 55 million individuals. And, by 2030, the number of Americans aged 65 and older is projected to grow to 70 million people. At that time, seniors will comprise nearly one out of every five Americans.

While the challenge that the aging of the Baby Boom generation—those born between 1946 and 1964—would place on nutrition assistance programs has long been anticipated, the prolonged recession and its adverse impact on older American's financial security has made the challenge of meeting increased need more urgent. In addition to significant declines in retirement nest eggs, according to a 2009 report by the Urban Institute, about 2 million adults age 55 or older were unemployed in August 2009, double the number in that age group who were unemployed just prior to the recession. Additionally, according to AARP, the average duration of unemployment rose for older job seekers from 20.2 weeks at the beginning of the recession to 29.9 weeks at the end. Moreover, the percentage of adults age 55 or older who were among the long-term unemployed (27 or more weeks out of work) rose from 23 percent at the beginning of the recession to 38 percent at the end.

Health and housing costs are a strain on the budgets of low-income older Americans, making it extremely difficult to afford other basic necessities such as food. According to a 2010 Feeding America study, 30 percent of client households with seniors indicated that they have had to choose between food and medical care and 35 percent had to choose between food and paying for heat/utilities. Providing low-income seniors with nutrition assistance allows them to stretch their food budget and eases the burden of having to choose between buying food or other necessities, such as medicine and rent.

Currently, one in six persons aged 65 and older lives in poverty, and another nearly one in three lives in near poverty. This is extremely troublesome given that seniors living below or near the poverty line are more likely to be at risk of food insecurity, and therefore at risk from the serious health consequences of not having proper nutrition. The prevalence of food insecurity among older Americans is a serious and growing problem in America. Given that the number of food insecure seniors is projected to increase by 50 percent in 2025, the demand for nutrition services among older Americans will continue to increase in the coming decades.

It is particularly important that we address the nutritional needs of food insecure seniors. According to analysis of data from the 1999–2002 National Health and Nutrition Examination Survey, seniors over the age of 60 who are experiencing some form of food insecurity are significantly more likely to have lower intakes of major vitamins, significantly more likely to be in poor or fair health, and more likely to have limitations in activities of daily living. Additionally, adequate nutrition is essential for preventing and managing chronic medical conditions. Without the proper nutrients seniors are at risk of the following: deterioration of existing health conditions, increased disability, decreased resistance to infections, lengthening of hospital stays, deteriorating mental health, increased risk of underweight, and at risk for diabetes.

As the number of older Americans living in poverty and facing food insecurity continue to increase as a result of the fallout from the prolonged and severe recession, it is critical that we ensure that these seniors have access to the food they need to maintain a healthy lifestyle. While there are many effective programs working to address senior hunger in local communities across this country, there is still an unmet need that must be addressed. A report issued in February 2011 by the General Accountability Office (GAO) estimates that only 10 percent of low-income seniors that were food insecure in 2008 received meals through congregate or home delivered meal programs. As this report shows, it is critical that we not only fill these current gaps, but also proactively prepare to meet the future increased demand for nutrition services among the senior population.

FEDERAL NUTRITION/FOOD ASSISTANCE PROGRAMS AND FEEDING AMERICA RECOMMENDATIONS

Feeding America's emergency food assistance and other targeted efforts to fill the gaps in nutrition services for low-income, older Americans cannot do the job alone. Instead, these charitable efforts are complimented by several key Federal food assistance programs, including: the Elderly Nutrition Program, the Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps), the Commodity Supplemental Food Program (CSFP), and The Emergency Food Assistance Program (TEFAP). These Federal programs are each a critical component in helping to ensure that food assistance reaches all seniors across the continuum of need—from seniors who are not homebound and can cook or access meals to seniors who are homebound and can cook to seniors who are homebound and can't cook. Different interventions are required to reach seniors throughout this continuum of need, and the continuation of each of these valuable programs helps to ensure that low-income seniors in need of food assistance continue to have access to healthy foods no matter where they are located on this continuum. And, while each of these programs is effective at helping to combat senior hunger, each could be expanded and improved to better meet the needs of an increasing number of food insecure seniors and fill the gaps in food assistance.

Elderly Nutrition Program: The Elderly Nutrition Program, administered by the Department of Health and Human Services Agency on Aging (AOA), is a compliment to the broader nutritional safety net programs for low-income seniors administered by the USDA. The Elderly Nutrition Program is designed to: reduce hunger and food insecurity, promote socialization of older individuals including meaningful volunteer roles, and promote the health and well-being of older individuals and delay adverse health conditions through access to nutrition and other disease prevention and health promotion services.

The nutrition program for seniors operated by the Agency of Aging is delivered in two ways, through congregate feeding sites and through home-delivery. According to the AOA, in fiscal year 2008, Congregate Nutrition Services provided more than 94.8 million meals to more than 1.6 million seniors in a variety of community settings while Home-Delivered Nutrition Services provided 146 million meals to more than 909,000 individuals. These nutrition services help millions of older adults receive the meals they need to stay healthy and be food secure.

Recommendations for the Older Americans Act: As the boomers retire and more Americans are living longer, it will be critical to ensure that seniors have access to the food and nutrition they need to maintain a healthy lifestyle. According to a report published by the American Dietetic Association, nutrition is one of the major determinants of successful aging. Food is not only critical to a senior's physiological well-being but also contributes to their social, cultural, and psychological quality of life. In addition, research from the Centers for Disease Control and Prevention (CDC) has shown that behaviors such as eating a healthy diet, taking part in physical activity, and not using tobacco are more influential than genetic factors in helping individuals avoid the deterioration associated with aging.

Unfortunately, current levels of funding provided to AOA through the Older Americans Act are not sufficient to meet the increasing demand for senior nutrition. In order for the AOA to continue serving seniors in need of food and nutrition assistance, Feeding America recommend that Congress increase funding for these critical Nutrition Services programs. Additionally, to ensure that food insecure seniors participating in the Nutrition Services programs are better able to access other Federal food assistance programs available to them, Congress should consider requiring the dissemination of materials about other Federal food assistance programs.

Supplemental Nutrition Assistance Program (SNAP): While Feeding America food banks and the 61,000 local agencies we support—including food pantries, soup kitchens, and emergency shelters—are often the first place older Americans

turn to for emergency food assistance when they fall on hard times, the Supplemental Nutrition Assistance Program (SNAP) administered by the USDA is the cornerstone of the nutrition safety net. SNAP helps ensure struggling Americans have adequate resources for food until their household economic conditions stabilize and improve. In addition to providing emergency food assistance, many of our food banks conduct outreach to inform clients about their potential eligibility for SNAP and connect them with the long-term benefits they need. Incorporating SNAP application assistance and/or outreach into other senior food programs provides food banks with a venue to discuss the benefits of SNAP, dispel myths about the program, and assist seniors with the SNAP application process.

SNAP is the Nation's largest Federal nutrition program, providing over 44 million participants with monthly benefits in the form of an electronic benefit (EBT) card that they can use like cash at most grocery stores to ensure access to an adequate diet. Nearly 80 percent of SNAP households include a child or an elderly or disabled person.

SNAP benefits can be redeemed at any of the more than 200,000 retail stores nationwide that are authorized to participate in the program. Almost 80 percent of SNAP benefits are redeemed within 2 weeks of receipt, and 97 percent are spent within a month. Because the benefits can be quickly and efficiently delivered to recipients via EBT cards, and recipients are likely to spend the benefits quickly, many economists view SNAP as one of the most effective forms of economic stimulus during an economic downturn. The USDA estimates that every $1.00 spent on SNAP benefits generates $1.79 in local economic activity.

SNAP is an important resource that helps low-income seniors buy the food they need to maintain a healthy lifestyle. However, the SNAP participation rate among eligible seniors is much lower than the general population. According to the USDA, in 2008 a little over one-third of eligible seniors participated in SNAP, compared to about two-thirds of the eligible general population.

Many seniors, especially those that are in need of assistance for the first time, are not aware of SNAP and the application process can be confusing for older Americans. According to a survey conducted by USDA's Economic Research Service, misinformation and confusion about the program's eligibility rules and benefit levels was cited as a major reason eligible seniors chose not to apply for SNAP benefits.

Other seniors may choose not to apply for SNAP due to the perceived stigma associated with the program. According to the same Economic Research Service survey, many seniors felt that participation in SNAP might be degrading or embarrassing if others in their families or communities found out they were receiving SNAP benefits. Additionally, some seniors who had worked most of their lives and had never needed government assistance felt that asking for help from the FSP was a sign of failure or weakness.

Recommendation to Improve Access and Participation: Congress should continue to strengthen SNAP's ability to meet need by breaking down access and participation barriers. Not all seniors who are eligible for SNAP participate in the program, because of stigma, misinformation about eligibility and potential benefits, or cumbersome enrollment procedures. While SNAP has made steady improvement in senior participation rates over the last several years, still only about one-third of those eligible are served. Continued outreach is needed to make sure all who are eligible and in need of assistance are informed of and enrolled in the program.

Congress should take steps to improve program education and outreach targeted to seniors, streamline the application and eligibility-determination process, and increase coordination with SNAP across other programs serving seniors. For example, categorical eligibility has been shown to both improve program access while at the same time allowing States to reduce administrative costs and simplify administration. Congress should strengthen categorical eligibility and encourage States to take advantage of the expanded option.

Commodity Supplemental Food Program (CSFP): Administered by USDA, the Commodity Supplemental Food Program leverages government buying power to provide nutritionally balanced food packages to more than 604,000 people, most of whom are low-income seniors 60 years or older in 39 States, 2 tribal organizations, and the District of Columbia. For many of these seniors, CSFP may be the only nutrition assistance program readily accessible to them.

CSFP is an efficient and effective program. While the cost to USDA to purchase commodities for this package of food averages $20 per month, the average retail value of the foods in the package is $50. For the seniors participating in this program, CSFP provides more than just food and nourishment, it also helps to combat the poor health conditions often found in seniors who are experiencing food insecurity and at risk of hunger. CSFP food packages are specifically designed to supplement needed sources of nutrients typically lacking in participants' diets like protein,

iron, zinc, and vitamins B-6 and B-12. CSFP plays an important role in addressing the nutrition needs of low-income seniors.

Despite the clear benefits of CSFP to low-income seniors and the long waiting lists that many States have of seniors who need this program, H.R. 2112, the fiscal year 2012 Agriculture Appropriations bill, has targeted CSFP for deep cuts. While this program will require a funding level of $176.8 million in fiscal year 2012 in order to sustain the current caseload, H.R. 2112 proposed cutting funding for this program by $38 million. As a result, if a cut of this magnitude were to be enacted, an estimated 150,000 low-income seniors would immediately be dropped from this vital program. Although the $20 monthly CSFP food package may not seem like much, to a low-income senior it can mean the difference between putting food on the table and not having enough to eat.

Recommendations for CSFP: Recognizing the role that this program plays in the lives of vulnerable, low-income seniors, Feeding America recommends that this program be reauthorized in the 2012 Farm bill and expanded to all 50 States. Additionally, Feeding America recommends that the income threshold for seniors wishing to participate in CSFP be raised to 185 percent of the Federal Poverty Line, bringing it in line with the threshold already applied to women and children participating in this program. Further, Feeding America recommends that the Senate provide $181.8 million for CSFP in fiscal year 2012 to maintain current caseloads and allow CSFP to expand into six additional States with USDA-approved State plans (Connecticut, Hawaii, Idaho, Maryland, Massachusetts and Rhode Island).

The Emergency Food Assistance Program (TEFAP) Commodities: TEFAP is a means-tested Federal program that provides food commodities at no cost to low-income Americans in need of short-term hunger relief through organizations like food banks, pantries, soup kitchens, and emergency shelters. Healthy and nutritious food commodities provided through TEFAP are essential resources that enable Feeding America food banks to meet the need in their communities.

TEFAP commodities currently account for approximately 25 percent of the food moving through Feeding America food banks nationwide. In most instances, local food banks supplement TEFAP commodities with privately donated foods to extend TEFAP program benefits beyond the budgeted amount for the program. As the unprecedented demand for food continues at food banks across the country, TEFAP commodities are essential for the provision of a steady emergency food supply. However, the level of commodities USDA provides is projected to drop off in fiscal year 2011 and fiscal year 2012.

In fiscal year 2010, TEFAP provided approximately $655 million worth of nutritious foods to low-income Americans. This figure includes commodity purchases mandated by the 2008 Farm bill as well as bonus commodity purchases that were appropriated for in fiscal year 2010 Agriculture Appropriations and those bonus purchases made by USDA when necessitated by market conditions.

In fiscal year 2011, even as the need for food assistance remains at unprecedented levels, the agricultural markets remain very strong. As a result, there is little need for USDA to intervene in the markets to make additional bonus commodity purchases. Without additional bonus purchases in fiscal year 2011, TEFAP spending levels will fall by about 45 percent to approximately $360 million. This $295 million decrease in TEFAP commodity spending for fiscal year 2011 will significantly impact efforts to address the growing need for emergency food assistance throughout the country. Without additional funding for commodities, too many seniors who rely on the commodities they receive from emergency food distributions may go without adequate access to the nutritious foods they need.

Recommendation for Increasing the Supply of Emergency Food: With agriculture commodity markets projected to remain strong in the coming years thereby driving a marked decline in the availability of bonus TEFAP commodities, Feeding America recommends that the amount of annual funding for mandatory TEFAP purchases be increased in the 2012 Farm bill. In addition, with respect to TEFAP commodities available in fiscal year 2011, Feeding America recommends that members of the committee make a request to the Secretary of Agriculture that he use his administrative authority to direct funds for the purchase of additional TEFAP commodities this fiscal year.

CONCLUSION

As the committee begins to engage in debate on the reauthorization of the Older Americans Act, we greatly appreciate the opportunity to submit testimony today on behalf of Feeding America, our over 200 member food banks, and the 37 million Americans our food banks fed last year. For a growing number of Americans—including more than 3 million seniors—food banks are truly the first line of defense,

and many times the only resource standing between them being able to put food on the family dinner table or going to bed with an empty stomach. However, our food banks and the charitable food assistance network cannot meet the needs of these families alone. It is only through our partnership with the public sector and the sustained support the Federal Government provides through programs like SNAP, CSFP, TEFAP, and congregate and home delivered meals that we can make real strides in the fight against hunger.

PREPARED STATEMENT OF THE GERONTOLOGICAL SOCIETY OF AMERICA

The Gerontological Society of America (GSA) is the Nation's oldest and largest interdisciplinary organization devoted to research, education, and practice in the field of aging. The primary purpose of the Society—and its 5,400+ members—is to advance the study of aging and disseminate information among scientists, decision-makers, and the general public. GSA would like to thank the HELP subcommittee on Primary Health and Aging for hosting a hearing on the important topic of nutrition for older adults, and the fundamental role of nutrition programs in the Older Americans Act.

The Older Americans Act oversees congregate and home-delivered meals that bolster nutrition in older adults, allowing them to live healthily and age in place within their communities. According to the 2005 White House Conference on Aging final report, physical changes that take place during aging can result in different nutritional needs, contributing to decreased food intake, unintentional weight loss, malnutrition, and/or obesity. These changes can lead to chronic diseases, such as diabetes and heart disease that ultimately cause individuals to seek costly hospital stays and placements in nursing homes. The cost of 1 day of hospitalization would more than cover the cost for an older person to receive 365 days of home-delivered meals. With this preventative approach, Older Americans Act nutrition programs not only provide crucial services to older Americans, but represent an important investment in keeping older adults healthy and costs down.

Although organizations like the Meals on Wheels Association of America (MOWAA) collect data on the services they provide and self-reported outcome measures, more research needs to be done on the need, current services, and outcomes. GSA supported the Leadership Council of Aging Organizations (LCAO) 2011 OAA Consensus Document, including the following recommendations for evidenced-based research:

1. Improve data collection in the title III C nutrition programs, particularly 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.
2. 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.

In addition to improving the research on older adult nutrition, GSA supports strengthening the volunteering component of Older Americans Act nutrition programs. Roles for volunteers of all ages can include delivering meals, providing nutrition counseling, and organizing education activities or congregate meals. Benefits of engagement for older adults include self-reported quality of life, lower rates of dementia, reduced risk of depression, improved recovery from illness, and reduced mortality. Continuing to develop the connection between volunteering and older adult nutrition helps both groups, and reduces the cost burden on agencies.

The Gerontological Society of America recognizes the importance of nutrition for older adults, and the great work accomplished by Older Americans Act programs to keep older adults healthy and in their communities. Every year, GSA hosts an Annual Scientific Meeting that brings together more than 3,500 top researchers in the field of aging for over 400 scientific sessions. The theme of GSA's 2011 meeting is "Lifestyle Leads to Lifespan." Indeed, this year's program includes a public policy symposium, developed in partnership with the Tufts University USDA Human Nutrition Research Center on Aging, focused on the critical role nutrition plays in healthy aging. Once again, thank you for making this topic a priority.

PREPARED STATEMENT OF HUNGER FREE VERMONT

Hunger Free Vermont, formerly the Vermont Campaign to End Childhood Hunger, is an education and advocacy organization with the mission to end the injustice of hunger and malnutrition for all Vermonters. Incorporated in 1993, we are a statewide nonprofit organization dedicated to hunger prevention through expanding access to nutrition programs that nourish Vermont's children and families. Hunger

Free Vermont committed to expanding advocacy efforts to the senior community in 2010 in response to low participation among seniors in Federal nutrition programs, and the increase in senior hunger and malnutrition in Vermont.

Vermont is considered the ninth hungriest State in the Nation, because we have seen a sharp rise in the more severe form of hunger known officially as "very low food security." When asked about the causes of such an increase, Hunger Free Vermont points to Vermont's particular challenges as a State: relatively low incomes coupled with high housing and heating costs, plus the added burden of transportation costs as the most rural State in the country.

At the same time, Vermont's older population is growing at a rapid pace; the fastest growing segment of the population is now 85 years and older with projections for 2030 showing a 149 percent increase over 2000 census numbers. While the cost-of-living, particularly housing, food and fuel in Vermont, continue to rise, seniors on fixed incomes struggle to afford the necessities. Food tends to be the most flexible item in the household budget and is often cut first when funds are limited, particularly as seniors' appetites and desires to cook are waning. From our experiences working with front lines service providers, Hunger Free Vermont has come to understand that senior hunger is a very real problem in our State.

Seniors are more likely to be at risk of hunger if they are living near or below the poverty line, between the ages of 60 and 64, divorced, separated, or living with a grandchild, or are a renter. Good nutrition is critical to maintain health and independent living when aging. Food insecurity and hunger have serious consequences on the health and well-being of elders. Seniors experiencing food insecurity are significantly more likely to have lower intakes of calories and major nutrients, significantly more likely to be in poor or fair health, and more likely to have limitations in activities of daily living. All these direct results lead to a sicker, less independent and less economically stable aging population.

The 2010 USDA Food Security Report revealed that 14 percent of all Vermont households are food insecure. Food insecurity is defined as the lack of access to enough food to fully meet basic needs at all times due to lack of financial resources. Multiple national organizations, such as the Meals on Wheels Association, the AARP Foundation and Feeding America have documented an increase in senior food insecurity across the country. We see the effects of this increase in Vermont every day as usage of Federal nutrition programs rises and agencies report of more clients' in need of food.

- 11,115 seniors ate meals at congregate meal sites in 2010, a 2 percent increase in meals and 8 percent increase in participants from 2009.
- 736,514 meals were delivered to 4,357 seniors' homes in 2010, a 5 percent increase in meals served from 2009.
- In 2010 there were over 5,000 calls to the statewide Vermont Senior Helpline regarding help with food and nutrition.
- Agencies on Aging report that they are seeing more people eating alone, and more young seniors (age 60–64) signing up for home delivered meals.
- While many home delivered meal programs request a suggested donation, programs often average a much smaller donation amount (for example, the suggested donation in the Lamoille Valley is $3 per meal; the average donation received is $.90 per meal).
- Agencies on Aging and Vermont Kin as Parents report that there are more grandchildren living with grandparents, and because financial support for kin is limited, delivered meals are sometimes being given to the children rather than the elders.

Given the challenge of rising senior hunger in Vermont, the nutrition programs within the Older Americans Act are increasingly important as part of the social safety net to help seniors remain healthy and independent. In working with our partners across Vermont, Hunger Free Vermont sees the following challenges in reaching seniors in need via congregate and home delivered meal programs:

- **Funding:** Funding is limited and meal programs must do significant fundraising to be able to continue serving seniors at their current capacity. Nutritional meals cost much more to make than the Federal reimbursement provides. Agencies report that as seniors live longer, they are now serving multiple generations in their meal programs, from 60 years to 100-plus, presenting new challenges for serving meals, especially as more seniors have special diets and changing health needs. Transporting meals throughout rural Vermont is expensive, especially as gas prices continue to rise. Some programs risk losing their drivers unless they offer a mileage reimbursement or stipend.
- **Access:** Due to limited funding and capacity, congregate meal programs in Vermont are dispersed geographically and rarely serve meals more than a couple

days a week. Seniors need access to good nutrition every day no matter where they live. Even in locations where meals are served daily, without low-cost public transportation options, seniors have difficulty accessing these meals.

• **Structure:** A one-size-fits-all prepared meal may not be the most cost-effective or flexible source of nutrition for every senior in need. In order to qualify for home delivered meals, a senior must be homebound, unable to cook, and/or nutritionally at risk. For some seniors, the problem is not inability to cook, but rather they are homebound due to loss of ability to drive or access public transportation. For others the issue is limited income; they need food but not necessarily a hot prepared meal.

It is critical that the nutrition programs that serve food to insecure older Vermonters are able to do so both efficiently and effectively. These nutrition programs play a pivotal role in ensuring that seniors are able to live and age successfully and independently in their own homes and communities. By investing in proven, cost-effective programs now, Congress can ensure that seniors' nutritional needs are met, health care costs are reduced, and tax payer dollars are used wisely well into the future.

Given the on-the-ground realities in Vermont, Hunger Free Vermont recommends the following improvements to congregate meal and home delivered meal programs:

• **Increase Funding for Good Nutrition:** Increased funding for both congregate meal programs and home delivered meal programs will allow programs to serve high quality meals to more food insecure seniors. As food and fuel prices continue to rise, additional funding will allow meal programs to meet the bottom line and meet the need.

• **More Flexibility to Serve More:** A more flexible home delivered meal program will allow funds to be used more efficiently and effectively while serving more seniors. Programs will have options for kinds of foods to be delivered and in what form (for example, as groceries or as prepared meals) to stretch funds and maintain independence as much as possible while still meeting the needs of seniors.

In conclusion, to emphasize the importance of these programs, we will share a quote from one local advocate who visited a senior in rural Vermont. She said that,

> "This senior had only one squash in her house and no money in her bank account with 2 weeks to go before receiving her next Social Security payment. Without access to the available services and programs, such as 3SquaresVT, home delivered meals, congregate meals and commodity boxes, she and many other seniors in Vermont would go hungry."

Thank you for the opportunity to submit this statement for the record. Hunger Free Vermont looks forward to the successful reauthorization of the Older Americans Act as we work towards the day when Vermont is hunger free.

PREPARED STATEMENT OF MEALS ON WHEELS ASSOCIATION OF AMERICA

Chairman Sanders, Ranking Member Paul and members of the subcommittee. The Meals On Wheels Association of America (MOWAA) commends you on beginning your hearings related to the reauthorization of the Older Americans Act by focusing on senior hunger in America and on the role of Older Americans Act (OAA) Senior Nutrition Programs (SNPs) in addressing it. We thank you for the opportunity to present testimony for your consideration as you work to improve the OAA's effectiveness in delivering needed nutrition services to those seniors who otherwise would not have access to nutritious food.

The Meals On Wheels Association of America (MOWAA) is the oldest and largest national organization representing local, community-based Senior Nutrition Programs—both congregate and home-delivered (commonly referred to as Meals On Wheels)—and the only national organization and network dedicated solely to ending senior hunger in America. While we have traditionally used and continue to use the term "community-based" to describe these programs, it is important to understand that the community has a much greater role in them than simply being the location in which these SNPs operate. It is more accurate to call these individual programs not only community-based but also community-focused, -reliant, -reflective, -informed, -supported, -dependent and -directed. So when MOWAA employs the term "community-based" we intend for it to carry all those meanings, and we believe the concept is an important one. Each SNP is unique, and while they all comply with certain uniform OAA-prescribed standards as related to things like the nutritional content of meals, for example, there is tremendous diversity among programs from community to community and State to State. This is the strength of our network, and it is one of the characteristics that distinguishes Senior Nutrition Programs from the majority of so-called Federal or federally funded food or feeding programs with which SNPs are often associated. In fact, there are more differences between

SNPs and those programs than there are similarities. As the name SNP implies, these programs—which are also often referred to as senior meal programs—are nutrition programs that provide complete, well-balanced meals; and many of those meals are delivered to the homes of individuals who need them. Food programs are not necessarily either nutrition programs or meal programs. Again, the distinction is significant.

Another hallmark of SNPs, which separates them from other Federal food programs, is that they are strong public-private partnerships. SNPs could not exist and operate without the majority of their funding coming from other, diverse sources, such as States and localities, foundations, corporations, individual donors and clients themselves or their families. The Administration on Aging (AOA) often notes that every $1 of Federal support made available through OAA leverages another $3.35 from other sources. As impressive, and distinctive from other food programs, as that figure is, we believe it significantly underestimates the leveraging power of these Federal funds. It fails to take into account the monetary value of the free labor contributed by the vast volunteer army—numbering between 800,000 and 1.7 million nationwide—as well as the donation of the use of personal vehicles to deliver meals. In an effort to calculate this additional value, we interviewed MOWAA Members representing rural, suburban and urban and small, medium-sized and large SNPs to derive the average per meal value of volunteer labor. We used $10 an hour, about half of the generally accepted value as calculated by the Independent Sector ($21.36 for 2010). We also assumed that volunteers drove an average of 2 miles per meal delivery on average, again deliberately under estimating the distance. Using these numbers we found that volunteer labor and vehicle usage (calculated at $0.50 per mile) contributed about $2.75 for each home delivered meal. In fiscal year 2009, when 149 million meals were provided, that equates to additional leveraged, non-Federal funds of almost $410 million. Again, we stress that this grossly underestimates the actual value of the volunteer labor contribution and does not even take into account such labor associated with meals served at congregate sites.

Not all MOWAA Member programs throughout the United States receive OAA (Title III) funds. There are numerous programs nationwide that are entirely privately funded. These programs work in many, if not most, communities side-by-side with their peers partially title III-funded programs; and the relationship is a symbiotic one. Both types of programs acknowledge the value and necessity of the other and both are necessary to the community's goal of providing meals to all the seniors who need them. Some of the private programs are also "private pay," which means simply that clients who can afford them must pay for their meals; other private programs operate in the same way that title III programs do, often utilizing a sliding scale based on self-declared income and suggesting a voluntary contribution from clients. Where both types of programs exist, they clearly complement each other and expand the community's ability to provide nutrition services to seniors in need. But the reality is that not all communities have such private programs, for a variety of reasons, including the location and size of the community and the lack of human and financial resources to sustain any regular, appropriate and reliable nutrition services.

Another critical distinction between OAA SNPs and Federal food programs is that OAA programs are not means-tested. The criteria is need, and that is, as it should be, much broader than income alone. Need can include disability or frailty or immobility or inability to carry out the Activities of Daily Living or social isolation. More and more we are witnessing the emergence of food deserts—that is, communities where there is not one single food source other than the SNP—even in those rural areas that once were the Nation's food basket. Lack of access to food and lack of ability to obtain it certainly constitute need. And if the need gaps, regardless of their cause, are not addressed, then seniors are hungry.

MOWAA's mission, which is shared by our MOWAA Member programs, is clear and straightforward—"to end senior hunger by 2020." Our singular vision is driven by conviction. It is also compelled by the tragic fact that the number of seniors facing the threat of hunger in this great land is not only unacceptably high, but also—and this is despite the heroic efforts of some 3,500 senior nutrition programs funded through the Older Americans Act and their private peers—it is growing. Yes, growing. MOWAA believes that several factors account for this increase in senior hunger and hunger risk. Some of them are frequently discussed . . . like the significant growth in the number of individuals age 60 or older, fueled by the Baby Boom; or ever-increasing costs of food and gasoline; or the state of the economy in general. Like SNPs themselves, this subcommittee has no control over these. But there are other factors that you can mitigate. Some of these "controllable" are factors that, MOWAA believes, may be unintended consequences of the Older Americans Act in its current state. Let me reiterate what I just said, because it may be both a new

concept and a provocative one: the current structure of the Older Americans Act may be contributing unintentionally to the rise of hunger risk among seniors in America.

We can back up that bold statement not with emotion and anecdote, but with data. Then we will propose changes to the Older Americans Act that MOWAA is convinced will enable Senior Nutrition Programs across the United States to serve more meals to more seniors. Doing so will begin to shift the trend, even if only incrementally, toward fewer, not more, hungry seniors. The two major recommendations that we will put forth are simple, and are simply designed to reduce hunger risk among our Nation's vulnerable elderly.

Before we describe them, we want to articulate some assumptions, which we trust can be universally accepted:

1. Food is a basic necessity;
2. There is a direct, and scientifically demonstrable, relationship between nutrition and health;
3. Good nutrition contributes to the prevention, treatment and/or delay of onset of many of the most common chronic medical conditions in the elderly, such as hypertension, diabetes, and obesity, for example; and
4. Hunger is a disease, and we have the cure for it today.

If we agree on those four fundamental points, then we hope that we can agree that the Older Americans Act should be one of the primary vehicles through which we deliver the cure to the deleterious disease called hunger—and prevent so many other diseases as well. We hope the subcommittee will agree that specific changes need to be made to the act during reauthorization in order to enable America to move more effectively and deliberately toward the eradication of senior hunger.

Let us provide brief background about the basis for MOWAA recommendations for change, as well as the data sources that support those recommendations. We have based our recommendations on data, because data are impartial and in this case tend to be extraordinarily straightforward. In 2007 the MOWAA Foundation commissioned outstanding researchers from the University of Kentucky's Center for Poverty Research and Iowa State University to conduct a study entitled "The Causes, Consequences and Future of Senior Hunger in America." That groundbreaking study was released at a hearing of the U.S. Senate Special Committee on Aging in March 2008. The findings were helpful to our understanding of the extent of senior hunger in the United States. They were also discouraging. The researchers found that in 2001, 1 in 9 seniors, or 5 million older individuals, faced the threat of hunger.

The next year we engaged the same researchers again and asked them to update the national study with 6 additional years of data, as well as to give us a state-by-state look at the incidence of senior hunger in America. The second study was released in November 2009 at a briefing of the House Hunger Caucus. To say that those findings were dispiriting is an understatement. They were, and are, morally unacceptable. By 2007, there had been a 20 percent increase in the number of seniors facing the threat of hunger, with the number growing from 5 to 6 million seniors.

What is the relevance of this to the reauthorization of the Older Americans Act? Taken in isolation, probably nothing. Put in a context, quite a lot. MOWAA took the state-by-state data from the study and then overlaid specific program information and results taken from the National Aging Program Information System (NAPIS). This NAPIS data is available on the AOA Web site.

Here is what we found. In fiscal year 2007, the year that corresponds with the study's hunger numbers, 21 of the top 25 Senior Hunger States—that is, those States with the highest rates of senior hunger—transferred funds from title III C, senior nutrition, to title III B. By contrast, only 12 of the bottom 25 Senior Hunger States made such transfers. In fiscal year 2008, 17 of the top 25 senior hunger States increased the amount of funds transferred from title III C nutrition to unspecified title III B services; and in fiscal year 2009, 16 of the top 25 senior hunger States again increased the transfer from nutrition [see Appendix I].

MOWAA believes the evidence is compelling and clear. Allowing transfer of funds from title III C to title III B is having a serious adverse impact on the health and well-being of vulnerable seniors across this great land. It must be stopped. MOWAA's first recommendation for reauthorization is to eliminate the authority to transfer funds from title III C to title III B. This is not a new position for MOWAA, but it is one for which we are advocating with renewed vigor—because what was once a surmise is now a fact, clearly supported by the data.

In the past those groups that opposed this anti-transfer recommendation primarily raised two arguments against it. The first was that the amount of transfer

nationally had remained relatively constant over time. We did not understand the relevance of that statement; even if it were relevant, it is no longer true. Over the course of the most recent 4 years for which we have data, net transfers into title III B from III C have grown significantly from approximately 9.6 percent, or just over $33 million, to about 13.4 percent or nearly $48 million [see Appendix II]. That is real growth and that lost nutrition funding could have furnished hundreds of thousands of additional meals at a time when hunger risk is growing.

This trend of increasing transfer should be alarming to Congress, because both the House and the Senate are on record in report language as strongly warning States, particularly those with high incidences of senior hunger, not to transfer funds from nutrition to other services as long as needed for nutrition services existed. Below is an excerpt of House Report 109–493. That document is the only source by which to determine legislative intent, as the Senate bill was preconferenced with the House, so that there were no Senate or Conference Reports. The House Report reads in part:

> "The committee cautions States from transferring funds from nutrition services to non-nutrition supportive services unless such transfers support, facilitate, or foster participation in senior nutrition programs. In particular, States with a high prevalence of food insecurity are strongly discouraged from diverting funding provided for food services to non-food expenditures and should do so only as a last resort. Further, the committee strongly encourages States to use general and administrative dollars provided in the specific line item or category for which the funds were intended. The committee believes strongly that . . . title III C dollars should not be used by States to pay the administrative cost associated with managing title III B services."

Clearly the committee's "caution" was not taken seriously by the States and in fact, many States' actions were in diametric opposition to the House's intent. The following year, the Senate expressed its agreement with the House authorizing committee's warning by adopting report language to accompany the Senate's Departments of Labor, Health and Human Services, Education and Related Agencies appropriation bill (Senate Report 110–107). That language read:

> "The committee is aware that proper nutrition is essential to the health and wellness of older Americans. A healthy diet can prevent weakness and frailty, improve resistance to illness and disease, and lead to better management of chronic health problems. All of these in turn lead to greater independence and quality of life for older persons. The recent reauthorization of the Older Americans Act recognized the important role that nutrition plays in promoting the health and well-being of seniors. In addition to reducing hunger and promoting socialization, the nutrition services program was reauthorized with the purpose of assisting older Americans in accessing nutrition and other disease promotion services that can delay the onset of adverse health conditions. The act also added greater emphasis on nutrition education, nutrition counseling and other nutrition services. Despite increased recognition of nutrition's importance to the health and well-being of our seniors, the funding level for the nutrition services program has stagnated in recent years, while at the same time the population of older Americans continues to increase. The committee notes that the number of meals provided under the nutrition services program has declined by more than 8 percent from fiscal years 2000 to 2005. The committee is aware that flat funding, along with higher food and transportation costs, has forced many programs to implement waiting lists and consolidate meal sites in order to cut costs. The committee hopes that the funding increase provided will help alleviate the fiscal strain affecting these programs and will allow them to continue to provide meals services that are essential to our seniors. The committee recognizes that the recent reauthorization of the Older Americans Act (Public Law 109–365) continues to allow States to transfer funds between title III B, which funds supportive services, and title III C, which provides funding for nutrition services. While such transfers have remained relatively stable over time, amounting to approximately $35,000,000 per year transferred from nutrition programs to supportive services, *the committee is concerned by the decrease of funds available for nutrition services. The committee believes that the specific funding increase provided for nutrition services in this bill should be used to directly support, facilitate, or foster nutrition programs, and should not be transferred for non-nutrition-related supportive services."*—[emphasis added]

Opponents to our proposal will likely attempt to argue that the transfer of funds have, in fact, been used to "support, facilitate, foster nutrition programs." But that argument is in no way supported by the facts. There is not a shred of evidence to corroborate the fact that in fiscal year 2009 $48 million was spent on such activities.

In fact, the data clearly show that was not the case. The single largest expenditure within the title III B spending is for a category entitled "Other Services." Other services do not include transportation, assisted transportation, nutrition education, nutrition counseling or case management.

These activities all have their own discrete line items. AOA data gathered through the National Aging Program Information Services (NAPIS) system shows that the Federal portion title III B expenditures for "Other Services" in fiscal year 2008 was greater than $105 million. Federal spending on title III B transportation and assisted transportation combined was less than $72 million. By fiscal year 2009 Federal spending had risen to more than $110 million for other services, while spending for the two transportation lines remained relatively stable at just over $72 million. The most disturbing element of this transfer and spending activity is that the AOA data show absolutely no service units and no persons served attached to this "Other Services" spending. That data, either persons or units or both (as is the case with meals), is recorded for every other category of title III spending. We should not have to imagine where and how that money is being spent, but we can be certain that it is not "to directly support, facilitate, or foster nutrition programs" [see Appendix III].

The voluntary compliance regarding the use of nutrition funds to furnish nutrition services that the Congress has sought in the years since the last OAA reauthorization simply has not materialized. To the contrary, the opposite has occurred. The result has been increasing numbers of vulnerable older persons going without the meals and nutrition support they need to age healthily, prevent or improve chronic illness, recover from acute illness, avoid institutionalization. More have suffered hunger or faced its threat. It is time to stop the funding hemorrhage from title III C nutrition funds. We appeal to you, on behalf of the thousands of SNPs across America and the more than 6 million seniors needing services, to amend the Older Americans Act to prohibit the transfer of funds from title III C to title III B. It is a simple change that could have a monumental impact of the health and well-being of our seniors as well as a positive impact on the bottom line of the Federal budget. We will address that point in more detail below, after we offer MOWAA's second major reauthorization recommendation.

MOWAA's second recommendation for changes in the OAA is also related to the issue of transfer. We propose the consolidation of titles III C 1 and III C 2 into a single title III C. This would eliminate the administrative burdens of intra-section transfers. States, Area Agencies on Aging and Senior Nutrition Programs could more easily direct nutrition dollars to areas of greatest need. There would be no change in what entities are eligible for funding, who could receive services, how clients are served, etc. Both congregate and home-delivered meal programs would continue to have access to these dollars, and the process of directing them where they need to go would be simplified. The administrative burden would be significantly reduced and time and energy could be directed to the provision of services.

The adoption of these two recommendations would entirely eliminate transfer within the act by removing the only two provisions that allow it. MOWAA believes this change would benefit not only nutrition programs but also every other program and service funded under title III. It dispels long-held myths associated with transfers that have held us all captive—namely, that the resources provided to programs under the act have been sufficient, and that transfer authority allows States and localities to direct surplus funds from one service to another. There are no surpluses.

Our first assumption, among the four principles we articulated earlier, was that food is a basic necessity. We believe that it is our moral imperative as a nation to make this basic necessity accessible and available to every citizen who needs it, particularly those who are vulnerable. We hope that this subcommittee agrees with that principle and trust that you do, judging from your decision to hold the first of your reauthorization hearings on the issue of senior hunger. As the architects of the legislation that governs SNPs you have the ability to profoundly improve the lives of those individuals who depend on us, and their communities, for the vital life supports. We know that Congress faces extraordinarily difficult decisions relating to spending and that the deficit must be addressed. We also know that this subcommittee has the power to direct millions of "additional" dollars to providing nourishing meals to seniors in need without spending 1 additional cent. That, we believe, should be an easy choice in this time of fiscal austerity. Had transfer from title III C to title III B been statutorily prohibited in fiscal year 2009, those $48 million of nutrition funds that were siphoned off for other services would have been available to provide a basic necessity to those in need. Ethically, it is the right thing to do. Practically, it makes eminently good sense.

Our second and third assumptions focused on the connection between nutrition and health. They are indisputably linked. Good nutrition promotes and supports good health. Poor nutrition on the other hand leads to poor health, and poor health is extremely costly not only in personal terms for the individuals who suffer from it but also for the Nation and our economy. If we leave frail seniors languishing in their homes without proper nutrition, their health will inevitably fail. If they survive, they will end up hospitalized or institutionalized at a cost to the government that far exceeds the cost of providing adequate funds to Senior Nutrition Programs to enable them to furnish seniors meals in the homes and other settings. Senior Nutrition Programs can provide meals for nearly a year for roughly the cost of one Medicare day in the hospital. MOWAA can quantify, using actual health spending data, the savings that can accrue when seniors receive nutritious meals immediately following a hospital stay for an acute condition.

Our evidence in this regard is based on 2006 data (in 2006 dollars) from a special project that MOWAA carried out in partnership with a major national insurance company. The findings were presented in December 2006 in Washington at a Leadership Summit sponsored by AOA. Through the special partnership, the private insurer's Medicare Advantage patients in select markets across the United States were offered without additional cost to the enrollees 10 nutritionally balanced meals, delivered by local Meals On Wheels programs, immediately following discharge from the hospital for an acute condition. Participation in the program was purely voluntary, and those individuals who chose to receive the service were typically sicker than those who declined it. Despite this fact, the insurance data show that those seniors who received just 10 meals had first month post-discharge health care costs on an average of $1,061 lower than those seniors who did not. The beneficial affects were also lasting. The third month after receiving those meals, the average per person savings to the insurer were $316.

Individuals who did not receive meals had both more inpatient hospital days and more inpatient admissions per 1,000 than those who did receive meals. According to PricewaterhouseCoopers, preventable hospital re-admissions cost the Nation approximately $25 billion each year. One out of every five Medicare patients discharged from a hospital is re-admitted within 30 days at an annual cost to Medicare of $17 billion. Given these facts, providing adequate funds for Senior Nutrition Programs can only be regarded as a strong and demonstrable value proposition.

Let us suppose that slightly less than 5 percent of traditional Medicare enrollees, or about 1.8 million seniors, received those 10 meals after an acute illness. And let us suppose that providing meals for those seniors achieved only half the savings, that is, $688, that the Medicare Advantage insurer realized. That still would amount to savings to Medicare of approximately $1,238,400,000. The cost to the Federal Government of furnishing those meals would be less than $500,000. Simple subtraction makes clear the savings: $1,237,900,000. Is our scenario here hypothetical? Yes. Is it based on real world data and real life experience. Yes. Does furnishing vulnerable seniors meals make good fiscal sense and actually save Federal dollars? Absolutely Beyond that, from a human and humane perspective, and from the perspective of the value of individuals and their liberty—principals on which this Nation was founded and for which it still stands—it is the acceptable and right thing to do.

All this leads to our principle No. 4, namely that hunger is a disease and one for which we have a cure today. Meals On Wheels and other SNPs throughout the United States deliver that cure to hundreds of thousands of seniors everyday. But, with additional resources, they could reach more. In closing, we ask you to give careful and serious consideration to the two primary recommendations that we presented to you today. We have others, but we believe that making these two relatively simple changes to the Older American Act are the place to begin our collective effort of reducing senior hunger and improving America's elders physical and emotional health at the same time that we improve our Nation's financial health.

We thank you for your attention to this most critical issue and express our appreciation once again for the opportunity to present testimony to the subcommittee.

Appendix I

An Examination Senior Hunger Rank* in the States and Net Percentage of transfer of Older Americans Act funds to Title III B from III C (Nutrition)

State	Senior Hunger Rank	FY 2007 Net % change to III B from III C	FY 2008 Net % change to III B from III C	FY 2009 Net % change to III B from III C	State	Senior Hunger Rank	FY 2007 Net % change to III B from III C	FY 2008 Net % change to III B from III C	FY 2009 Net % change to III B from III C
MS	1	16.05	20.94	17.56	KS	26	0.00	0.00	0.00
SC	2	17.15	21.80	48.73	NY	27	B to C	B to C	B to C
AR	3	6.78	5.64	7.26	OR	28	11.04	19.57	17.54
TX	4	9.01	10.28	13.84	AK	29	0.00	0.00	B to C
NM	5	12.05	0.00	0.00	WA	30	21.09	22.70	29.28
GA	6	10.91	17.81	0.00	MT	31	B to C	B to C	B to C
AL	7	0.00	0.00	1.03	WV	32	0.00	0.00	0.00
LA	8	14.09	20.88	0.59	UT	33	0.00	0.00	0.00
NC	9	37.34	42.68	42.05	NJ	34	B to C	B to C	0.62
OK	10	0.00	0.00	0.00	VT	35	1.84	5.75	3.20
AZ	11	29.98	20.16	41.75	NV	36	11.98	12.09	20.70
IN	12	20.02	B to C	0.00	PA	37	29.44	33.37	32.59
MO	13	B to C	B to C	4.49	MA	38	8.88	8.03	8.86
MD	14	2.31	0.41	3.33	CO	39	10.83	11.95	25.04
ID	15	16.90	21.36	22.33	IA	40	B to C	B to C	B to C
TN	16	7.39	13.31	15.46	SD	41	0.00	0.00	0.00
ME	17	5.58	7.35	8.92	WY	42	0.00	0.00	0.00
CA	18	1.52	5.67	8.02	IL	43	17.33	19.95	17.86
RI	19	9.66	15.89	17.61	DE	44	18.86	17.15	16.70
KY	20	10.22	12.02	12.25	CT	45	0.74	0.74	0.74
VA	21	32.56	34.13	37.13	WI	46	2.62	2.62	2.60
HI	22	16.83	19.10	13.55	NE	47	0.00	0.00	0.00
FL	23	17.43	19.45	26.03	MN	48	36.07	24.43	23.48
MI	24	B to C	1.13	3.43	NH	49	0.00	0.00	0.00
OH	25	11.96	14.03	13.88	ND	50	B to C	B to C	B to C

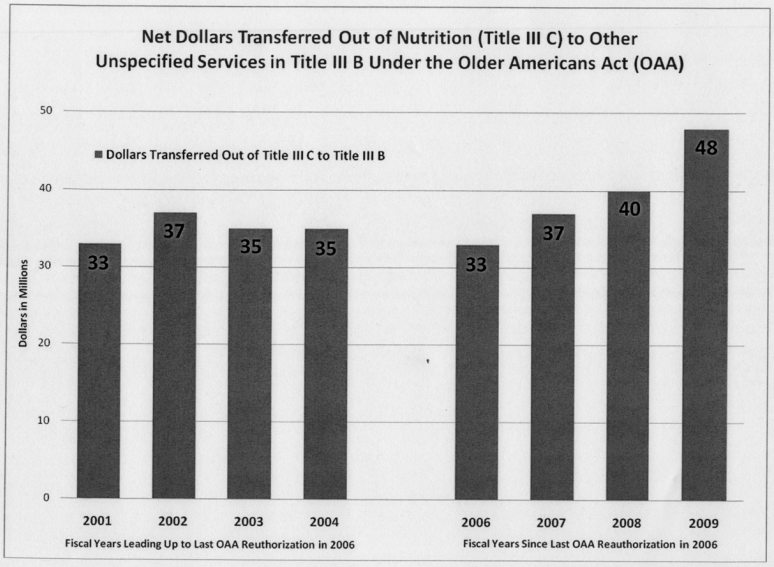
Data on State senior hunger (food insecurity) rankings. Source: *Senior Hunger in the United States: Differences across States and Rural and Urban Areas* , Co-Principal Investigators James P. Ziliak, Ph.D., University of Kentucky and Craig Gundersen, Ph.D., University of Illinois. Released November 19, 2009, briefing of the House Hunger Caucus, U. S. House of Representatives. Ranking of States by Rates of Food Insecurity among Senior Americans, 2001-2007 * (Order from Highest to Lowest)

FY 2007, FY 2008, FY 2009 transfer data. Source: Administration on Aging.

In fiscal year 2007, of the top 25 senior hunger States, 21 transfer funds from nutrition (title III C) to title III B. Of the bottom 25 senior hunger States, only 12 transfer funds from nutrition (title III C) to title III B. In fiscal year 2008, 17 of the top 25 top senior hunger States *increased* the amount of funds transferred from nutrition (title III C) to title III B. In fiscal year 2009, 16 of the top 25 senior hunger States *increased* again the amount of funds transferred from nutrition (title III C) to title III B.

Appendix II

ANNUAL LOSS OF FUNDING FOR SENIOR NUTRITION PROGRAMS



Source: Administration on Aging (AoA) State Program Reports 8

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Appendix III

FY 2009 Profile of State OAA Programs (NAPIS)

Services	Persons Served	Service Units	Title III Expenditures	Total Service Expenditures	% Title III of Total	Total Providers	AAA Providers	Prog. Income Earned
Personal Care	108,887	14,833,984	$ 11,194,758	$ 270,336,077	4.1%	3,648	73	$ 5,219,041
Homemaker	160,510	12,660,912	$ 28,222,264	$ 239,661,872	11.8%	3,512	152	$ 11,047,029
Chore	39,266	1,213,920	$ 5,751,464	$ 21,061,578	27.3%	4,316	44	$ 1,010,000
Home Delivered Meals	880,135	149,188,917	$ 224,389,216	$ 790,488,570	28.4%	976	251	$ 91,827,546
Adult Day Care/Health	23,547	7,909,015	$ 11,720,328	$ 84,376,141	13.9%	1,093	43	$ 6,627,288
Case Management	491,481	3,941,408	$ 31,251,465	$ 264,708,053	11.8%	1,626	315	$ 1,866,348
Assisted Transportation	38,103	1,421,668	$ 3,551,476	$ 15,143,273	23.5%	748	49	$ 741,097
Congregate Meals	1,686,093	92,492,669	$ 263,999,420	$ 643,914,615	41.0%	4,644	268	$ 96,977,174
Nutrition Counseling	23,900	58,193	$ 1,368,862	$ 3,124,931	43.8%	376	80	$ 14,637
Transportation		26,175,683	$ 68,731,181	$ 199,084,035	34.5%	3,133	216	$ 12,354,333
Legal Assistance		931,776	$ 25,159,733	$ 50,491,019	49.8%	821	125	$ 1,208,256
Nutrition Education		1,988,487	$ 3,914,260	$ 6,819,616	57.4%	1,687	161	$ 339,437
Information and Assistance		12,406,397	$ 56,153,108	$ 151,056,286	37.2%	2,684	8,749	$ 1,317,565
Outreach		4,225,060	$ 10,524,273	$ 23,870,849	44.1%	1,901	1,790	$ 443,656
Other Services			$ 110,946,638	$ 628,075,076	17.7%			$ 16,321,180
Total Home &Community-Based Services			$ 856,878,447	$3,392,211,990				$ 247,314,587
Caregiver Counseling/ Support Groups/Training	147,963	456,537	$18,411,299	$26,218,407	70.2%			
Caregiver Respite	69,017	6,406,159	$56,258,419	$94,572,799	59.5%			
Caregiver Supplemental	47,426	1,322,241	$13,779,929	$21,124,526	65.2%			
Caregiver Access Assistance	614,891	1,024,447	$31,921,849	$44,716,538	71.4%			

Source: Administration on Aging (AoA) State Program Reports

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AN OVERVIEW OF SENIOR HUNGER IN THE UNITED STATES—JUNE 13, 2011

(By James P. Ziliak—University of Kentucky; and Craig Gundersen—University of Illinois)

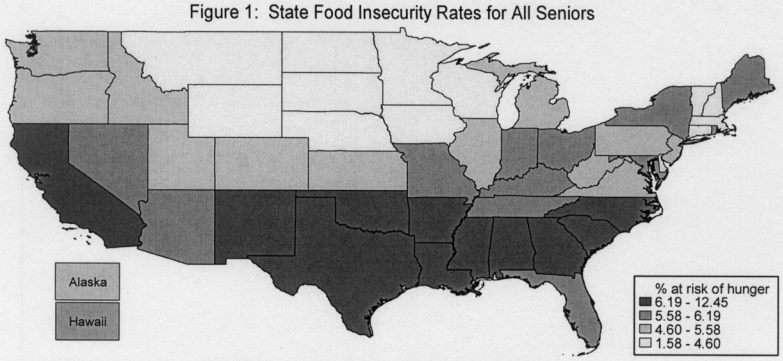
Food insecurity is one of the leading public health challenges facing the United States today. In 2009 alone, over 50 million Americans lived in food insecure households, i.e., households that were uncertain of having, or unable to acquire, enough food for all household members because they had insufficient money and other resources for food. The experience of food insecurity manifests itself across the lifespan in the United States. In recent years, increased attention has been paid to the experience of senior Americans and, in this overview, we consider the extent and determinants of food insecurity among senior Americans, the health consequences associated with food insecurity, and the influence of the recent economic downturn. This overview is based on our research reported in Ziliak, Gundersen, and Haist (2008), Ziliak and Gundersen (2009), and Gundersen and Ziliak (2011).[1]

The extent and determinants of food insecurity among seniors. Based on data from the Current Population Survey (CPS), a nationally representative survey of over 50,000 households per year, we have characterized the extent of food insecurity among seniors over the past decade. The CPS contains the Core Food Security Module (CFSM), which is the data used to characterize food insecurity in the annual report from the USDA (Nord, et al, 2010). On average, between 2001 and 2009 about 3 million seniors were food insecure in any year. Along with those experiencing food insecurity, another 2.9 million seniors are marginally food secure, i.e., they are experiencing some level of food hardship, albeit not enough to be fully food insecure.

Insofar as food insecurity is closely tied to economic constraints, it is not surprising that certain groups of seniors are at greater risk of food insecurity. In particular, seniors with limited incomes, African-Americans, Hispanics, never-married individuals, renters, and younger seniors are all more likely to be food insecure. One other group that is at especially high risk of food insecurity are seniors raising grandchildren. We find that households with a grandchild present are on average about two and a half times as likely to be food insecure as households without a grandchild present.

Along with income and demographic characteristics, there is a great deal of geographic diversity across the United States in food insecurity rates. This diversity is evident in Figure 1 which displays food insecurity rates for all 50 States plus the District of Columbia. The range of food insecurity rates is enormous from 1.6 percent in North Dakota to a rate over 7 times higher in Mississippi (12.5 percent).

Figure 1: State Food Insecurity Rates for All Seniors



Source: Authors' Calculations using the Current Population Survey, 2001-2009

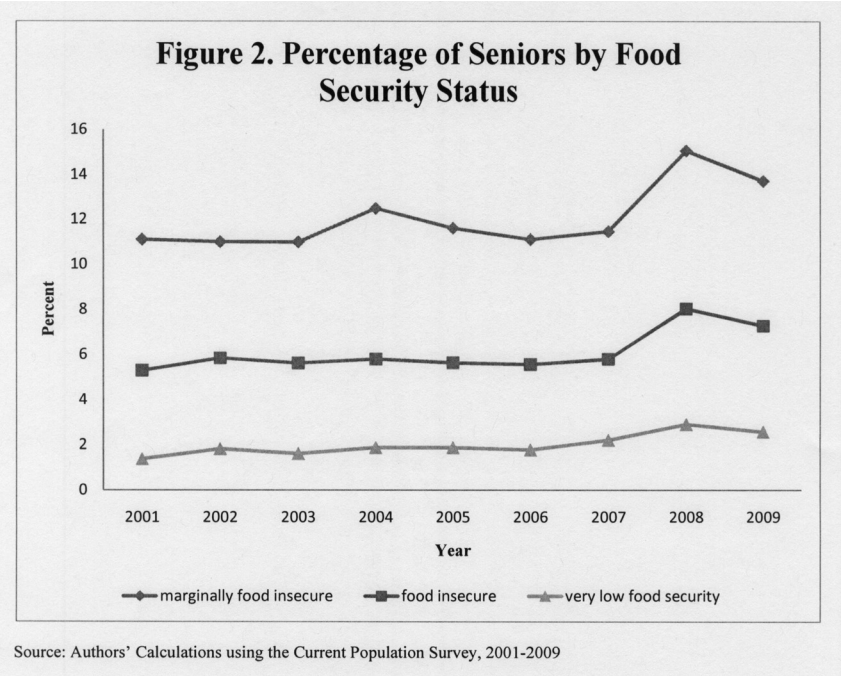
While certain groups of seniors are at greater-risk of food insecurity and there are States with especially high rates of food insecurity, food insecurity cuts across the income spectrum. For example, over 50 percent of all seniors who are at-risk of hunger have incomes above the poverty line. Likewise, it is present in all demographic groups. For example, over two-thirds of seniors at-risk of hunger are white.

[1] Funding for the research in Ziliak, et al. (2008) and Ziliak and Gundersen (2009) was made possible by a grant from the Meals On Wheels Association of America Foundation and, in Gundersen and Ziliak (2011), by a grant from the Merck Foundation.

The consequences of food insecurity among seniors. The mere existence of food insecurity among seniors is of concern to policymakers and program administrators in the United States. What makes food insecurity among seniors an even more pressing concern is that it may lead to numerous negative health outcomes. We examined whether or not food insecurity does lead to worse health outcomes among seniors through the use of data from the 1999–2006 waves of the National Health and Nutrition Examination Survey (NHANES), a nationally representative data set with numerous questions on health and nutrition outcomes.

Controlling for other factors, we found that, as in the general population, food insecure seniors have worse health outcomes than food secure seniors. With respect to nutrient intakes, food insecure seniors are significantly more likely to have lower intakes of energy and major vitamins. The effects are very strong; for example, across all the measures, the effect of being marginally food insecure is over twice as large (and generally much larger) than a move in income from one-to-two times the poverty line. With respect to broader measures of well-being food insecure seniors are significantly more likely to report being in poor or fair health and report limitations in activities of daily living (ADL). For the latter, the effects are especially strong—for example, being marginally food insecure is roughly equivalent to being 14 years older.

Recent changes in food insecurity among seniors. The recent economic downturn has been associated with unprecedented increases in the extent of food insecurity among seniors in the United States. As seen in Figure 2, derived from Ziliak and Gundersen (2011), across all three measures there was an increase of over 30 percent in food insecurity from 2007 to 2008. While food insecurity rates did decline somewhat from 2008 to 2009 for seniors, in comparison to earlier in the decade, the proportions of food insecure seniors are markedly higher. And for the more vulnerable group of seniors raising grandchildren, food insecurity continued to rise through 2009. Overall, then, by 2009, 23 percent more seniors were marginally food insecure, 37 percent more were food insecure, and an astonishing 88 percent more were very low food secure. Translating into estimates of the numbers of seniors involved, by 2009 7.5 million seniors were marginally food insecure, and of those 4 million were food insecure and 1.4 million were very low food secure. Despite another decade of efforts to address food insecurity among seniors, the scale of food insecurity remains stubbornly high.



Source: Authors' Calculations using the Current Population Survey, 2001-2009

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JEFF GORDON INC.,
JUNE 20, 2011.

Hon. BERNARD SANDERS, *Chairman,*
Subcommittee on Primary Health and Aging,
428 Dirksen Senate Office Bldg.,
Washington, DC 20520.

DEAR CHAIRMAN SANDERS: It's an honor to be invited to speak before the committee—what a great opportunity to share all the work we are doing in NASCAR. Unfortunately, I am not able to travel to Washington, DC on the requested date due to other obligations previously scheduled.

Below, please see information detailing the 2011–13 program. In addition to our objectives, we have partnered with International Speedway Corporation (ISC), the owners of Daytona International Speedway, and other tracks we race at to donate left over event food to local food banks.

CONCORD, NC (Oct. 27, 2010)—Hendrick Motorsports and four-time NASCAR Sprint Cup Series champion Jeff Gordon have teamed with AARP and AARP Foundation on the Drive to End Hunger (*www.DriveToEndHunger.org*), an unprecedented 3-year initiative to address the growing problem of hunger among older Americans, including 6 million over the age of 60. Drive to End Hunger will be the majority sponsor of Gordon's No. 24 Hendrick Motorsports team in 2011, 2012 and 2013, with primary paint schemes in 22 Sprint Cup races annually. The No. 24 Drive to End Hunger Chevrolet, which will be unveiled at a later date, will race in the next three Daytona 500 events.

"This is a truly unique opportunity to help people, and it's a completely new, cause-driven approach to sponsorship," said Gordon, 39, winner of 82 career Sprint Cup races.

> "Every single day, millions of older Americans arc forced to make a choice between food, medicine and utilities. It's going to be a team effort, and it's not going to be easy, but we can solve this problem."

With Gordon as its spokesperson, Drive to End Hunger will help the millions of older Americans who are facing hunger across the United States. The effort will engage the NASCAR fan base, corporations and charitable organizations via a text-to-donate program; activation at racetracks across the country; further research on the causes and consequences of hunger in older Americans; and an innovative national grant program that will provide resources to address the problem at a local level.

Donations from Drive to End Hunger will benefit the hunger programs of AARP Foundation.

"Hunger is a hidden problem that millions of older Americans are battling silently. In fact, between 2006 and 2008, the percentage of seniors struggling with hunger more than doubled," said Jo Ann Jenkins, AARP Foundation president.

> "NASCAR fans are among the most charitable, community-minded sports fans in the country, and they have a track record of commitment. With the help of Jeff and the Hendrick team, we will make the most of this unprecedented opportunity to end the struggle that so many older Americans have with hunger."

Drive to End Hunger will build on the hunger initiative *launched earlier this year* by AARP Foundation, including volunteer-led food drives, individual and corporate fundraising campaigns, and online hunger resources at *www.aarp.org/hunger*.

> "It's exciting to see a new organization engage with our sport and our fans through such an innovative approach," said Rick Hendrick, owner of Hendrick Motorsports. "Having seen firsthand what the NASCAR community is capable

of accomplishing, I know the program will help a lot of people in our country who desperately need it. Success ultimately will be measured by how many lives we can impact, and that's a truly unique and special opportunity for everyone involved."

DARLINGTON, SC—Four-time NASCAR Sprint Cup Series Champion Jeff Gordon, International Speedway Corporation's ("ISC") Chief Executive Officer Lesa France Kennedy and Darlington Raceway President Chris Browning today announced that, on behalf of Drive to End Hunger, Americrown, ISC's food and beverage concessions operator, will donate all extra food items from the NASCAR Sprint Cup Series races it services to the local food bank that serves the race track area.

Drive to End Hunger is AARP and AARP Foundation's national effort to end hunger for older Americans. Donations are expected to include breads, produce and other food items and will be prepared for delivery by Americrown on Mondays following ISC's NASCAR Sprint Cup Series races.

"This commitment is a huge opportunity to help people who are struggling with hunger in the communities around the ISC tracks," Gordon said.

"Fifty-one million Americans struggle with hunger and six million of them are over 60. This is a problem that if we all work together, we can solve. We're really thrilled that ISC has joined us in this important fight."

"Providing food to those who need help is a cause that positively impacts each community in which we operate," said France Kennedy.

"We are privileged to collaborate with Jeff Gordon and AARP's Drive to End Hunger effort. Through our collective efforts, we can make a difference in the lives of many in need."

Today's announcement follows ISC's donations at Daytona International Speedway of more than 7,000 pounds of excess food to the Second Harvest Food Bank of Central Florida following the 2011 Daytona 500; Talladega Superspeedway, which donated the extra food from its Aaron's Dream Weekend to the Community Food Bank of Central Alabama; and Richmond International Raceway Central which donated to the Central Virginia Food Bank.

"We are pleased that Darlington Raceway, through AARP's Drive to End Hunger, can make a significant difference for people in our community," Chris Browning said.

"In South Carolina alone, more than 22 percent of people reported not having enough money to buy food in the last year. Almost 10 percent of seniors in South Carolina are at risk of hunger. Particularly in these economic times, we want to do everything we can to support the folks in communities around ISC tracks. They are important to us, they are important to the sport, and solving this problem should be important to everyone in America."

Donations will be made at these ISC tracks for the remainder of the 2011 NASCAR Sprint Cup season, including:

Daytona International Speedway (Daytona Beach, FL)—July 2d—Coke Zero 400; Homestead-Miami Speedway (Homestead, FL)—November 20th—Ford 400; Kansas Speedway (Kansas City, KS)—June 5th—STP 400; and October 9th—Hollywood Casino 400; Martinsville Speedway (Ridgeway, VA)—October 30th—TUMS Fast Relief 500; Michigan International Speedway (Brooklyn, MI)—June 19th—Heluva Good! Sour Cream Dips 400 and June 19th—Michigan 400; Phoenix International Raceway (Avondale, AZ)—November 13th—Kobalt Tools 500; Richmond International Raceway (Richmond, VA)—September 10th—Last Race to Make the Chase; and Watkins Glen International (Watkins Glen, NY)—August 14th—Heluva Good! Sour Cream Dips at The Glen.

Once again, I would like to thank you for this opportunity.

Sincerely,

JEFF GORDON.

[Whereupon, at 11:36 a.m., the hearing was adjourned.]

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