Building a Connection between Senior Hunger and Health Outcomes

EVER SINCE THE FIRST "BABY boomer" aged into Medicare in 2011, there has been a pending "silver tsunami" building in the United States. In 2013, there were 44.7 million Americans aged 65 and older, or one in every seven Americans. It is predicted that by 2060, there will be 98 million Americans over the age of 65 years.[1] At the same time, one issue of nearly unanimous bipartisan agreement in Congress is the need to reform Medicare to make it sustainable for future generations of Americans, even as the senior population rises. However, in the current political environment, there is a lack of consensus on what direction this reform should take.[2] One of the issues that older adults have to face, and a reformed Medicare will have to address, is the challenge of hunger, which includes both food insecurity and malnutrition.

Malnutrition is defined as a nutrition imbalance that affects both overweight and underweight patients. In a consensus statement[3] of the Academy of Nutrition and Dietetics (the Academy) and the American Society for Parenteral and Enteral Nutrition in 2012, malnutrition is diagnosed by the identification of two or more of the following six characteristics:

- insufficient energy intake;
- weight loss;
- loss of muscle mass;
- loss of subcutaneous fat;
- localized or generalized fluid accumulation that may sometimes mask weight loss; and
- diminished functional status, as measured by hand grip strength.

Malnutrition affects an estimated 30% to 50% of adult hospitalized patients in the United States, but only 3.2% of these patients are discharged with a diagnosis of malnutrition.[4] Malnourished patients have worse health outcomes when compared with well-nourished patients, including increased physician visits, longer hospital stays and readmissions, decreased function and quality of life, and increased health care costs.[5-7]

Food insecurity, often thought of as hunger, is defined as limited or intermittent access to nutritionally adequate, safe, and acceptable foods accessed in socially acceptable ways.[8] The US Department of Agriculture describes low food security as situations in which, "households reduced the quality, variety, and desirability of their diets, but the quantity of food intake and normal eating patterns were not substantially disrupted," and very low food security as, "at times during the year, eating patterns of one or more household members were disrupted and food intake reduced because the household lacked money and other resources for food."[9]

In 2014, 3 million households with seniors older than the age of 65 years experienced food insecurity, while 1.2 million seniors living alone were food insecure. Food-insecure seniors are at an increased risk for chronic health conditions; they are 60% more likely to experience depression, 53% more likely to report a heart attack, and 40% more likely to report an experience of congestive heart failure. These numbers will only get worse as the population ages; by 2025, the number of food-insecure seniors is projected to increase by 50%.[10]

HIDDEN HUNGER…MAYBE NOT SUCH GOLDEN YEARS

Why are we seeing more senior hunger:

- People are living longer with the growing escalation of the so-called "old-old" population (those in their mid-80s and beyond).
- Some are outliving their savings as cost of living is higher and interest payments lower. Those relying on investments for income have seen interest payments on their bonds and certificates of deposit wane in recent years.
- Some never recovered from the loss of equity in the housing market crash.
- Social Security checks have increased by <2% annually beginning in 2013. In 2016, there was no annual cost of living adjustment.
- The rates of isolation are high even in some retirement communities.
- May be homebound or disabled, making it more difficult to go to the store or cook for themselves.

HISTORY OF SENIOR NUTRITION PROGRAMS

One tool to relieve senior food insecurity is the Older Americans Act (OAA). The OAA was enacted 50 years ago to "reduce hunger and food insecurity, to promote socialization of older individuals, and to promote 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." This aligns with the Academy's

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position that "all older adults should have access to food and nutrition programs that ensure the availability of safe, adequate food to promote optimal nutritional status."[11] The two primary OAA nutrition programs are home-delivered meals and congregate meals. In 2013, a national survey of OAA participants found that >50% of home-delivered meal recipients and congregate meal recipients relied on these programs for the majority of their total daily food needs; 75.3% of congregate and 83.6% of home-delivered meal participants report eating healthier meals as a result of their participation in the programs. Similarly, 68.4% of congregate meal recipients and 92.2% of home-delivered meal recipients say that the meals enabled them to continue living in their own homes.[12]

Why Does It Matter?

According to Robert Blancato, a strong supporter of Academy public policy issues and board chair of the American Society on Aging, "The Older Americans Act matters because of what it provides and the outcomes it produces. Its programs and services have achieved the main goal of the Act when it was passed—to allow older adults to remain independent, either in their community or in their homes. It is worth noting that the Act, by law, targets its services to those in the greatest economic or social need, with particular attention to low-income minorities, rural residents, and those with limited English proficiency."[13]

Stalled in the House

The OAA expired at the end of fiscal year 2011, and reauthorization has been sputtering in Congress for the last 5 years. There are several theories as why that might be occurring, none of which have risen to the top. However, in 2015, Senators Bernie Sanders (I-VT) and Lamar Alexander (R-TN) were the drivers for the passage in the Senate of the strong and bipartisan OAA reauthorization bill (S. 192). The bill moved to the House, where it is hoped that there will be a vote in 2016.

Funding for OAA nutrition programs has not kept pace with growing need, or with inflation. Cuts to the federal budget due to sequestration have resulted in fewer meals, increased waiting lists, and program closures.[14] The fiscal year 2016 federal budget did restore funding for these programs, but still did not provide the funds required to meet growing need.[15]

Supplemental Nutrition Assistance Program for Seniors

Another critical senior nutrition program is the Supplemental Nutrition Assistance Program (SNAP).[16] However, three out of five seniors, or 5.2 million older adults, who are eligible for SNAP benefits do not participate. Using SNAP has been shown to improve health outcomes, and eases the burden of having to choose between paying for medications or for food. Challenges that seniors face in receiving SNAP benefits include lack of mobility, difficulties with technology, social stigma, and misinformation about the program, among others.[17] Several initiatives across the country are aimed at increasing SNAP enrollment for seniors.

HOW YOU CAN HELP

- Be an active member in the Healthy Aging dietetic practice group (DPG) and the Dietetics in Health Care Communities DPG.
- Volunteer at a food bank or senior center.
- Counsel your senior patients to apply for SNAP benefits.

Collaborating for Success

The Academy recognizes the importance of partnering with like-minded organizations to achieve its advocacy goals. Two coalitions to highlight in the Academy's work on senior hunger are the Food Is Medicine Coalition[18] and the Root Cause Coalition.[19]

The Food Is Medicine Coalition[18] is a national volunteer association of nonprofit medically tailored food and nutrition services providers that have been managing chronic illnesses like human immunodeficiency virus/acquired immunodeficiency syndrome, cancer, cardiovascular disease, renal failure, muscular sclerosis, Alzheimer's disease, and more than 200 others, through nutrition for more than 30 years. The Food Is Medicine Coalition seeks to preserve and expand coverage of food and nutrition services for the critically and/or chronically ill clients served. Many of the food and nutrition services providers in the coalition employ registered dietitian nutritionists (RDNs) to ensure that meals meet the nutrition needs of clients, and to provide medical nutrition therapy to clients when necessary.

The Root Cause Coalition[19] was founded in 2015 to connect health care providers with payers, public health organizations, government officials, and industry, using evidence-based research to address the root causes of food insecurity. The Coalition focuses on research, education, and advocacy to achieve its objectives.

ACADEMY MEMBERS BRIDGING THE GAP WITH GOOD NUTRITION

Connecting Older Adults to Local Farmers Markets

Not all efforts to improve senior nutrition take place on a national scale. Academy member Maria Mahar, RD, helps connect older adults to local farmers markets in Onondega County, New York, through the Seniors Farmer Market Nutrition Program. Onondega County Aging Services has entered into a partnership with the Central New York Regional Market; this partnership allows the Central New York Regional Market to stage a demonstration kitchen, provide access to SNAP benefits, and host Senior Nutrition Days throughout the year.

Preventing and Treating Chronic Disease

At Senior Services of Snohomish County, Academy member Martha Peppones, MS, RD, leads the effort to provide nutrition, wellness, and social services to older adults. Her department provides chronic disease self-management programs and conducts workshops across the country for chronic conditions, chronic pain, and diabetes. Approximately 12 to 15 workshops, lasting 6 weeks each, are conducted each year around the country; they are held at senior centers, senior housing, retirement communities, and a community mental health facility. The program has also established a