Aging at home: more research on nutrition and independence, please1,2

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As highly as Americans prize independence, older Americans fear dependence even more. Yet nutrition’s effect on independence in later years is often overlooked as a research focus and is under-appreciated by older adults themselves and by those working with them. Nutrition scientists can and should play a greater role in prolonging independence by focusing more attention on the health promotion and prevention aspects of nutrition (1).

To rectify this research and service oversight and given the federal cost-containment policy to rebalance long-term care away from nursing homes to the ballooning area of home- and community-based services, the American Society for Nutrition with the American Dietetic Association and the Society for Nutrition Education recently issued a position statement that stated the following (2):

... all (community-residing) older adults should have access to food and nutrition programs that ensure the availability of safe, adequate food to promote optimal nutritional status. Appropriate ... programs include adequately funded food assistance and meal programs, nutrition education, screening, assessment, counseling, therapy, monitoring, evaluation, and outcomes documentation to ensure more healthful aging. The growing number of older adults, the health care focus on prevention, and the global economic situation accentuate the fundamental need for these programs (p 463).

An article in this issue of the Journal (3) shows that delivery of 7 DASH (Dietary Approach to Stop Hypertension) meals per week to participants in the Older Americans Act (OAA) Nutrition Program (commonly called Meals-on-Wheels) increased compliance with dietary recommendations among noncompliant older adults with cardiovascular disease. Whereas there have been innumerable studies on the DASH diet with diverse populations over the years, this is the first study in the Nutrition Program, even though its last national evaluation (1996) found participants had 2–3 chronic health problems (4). More translational research is needed for the Nutrition Program to fulfill one of its purposes (5), which is “to promote the health and well-being of older individuals by assisting (them) to gain access to nutrition and other disease prevention and health promotion services.”

Nutritional research on the OAA Nutrition Program, our nation’s largest food and nutrition assistance program specifically targeted to older adults (5), is relatively sparse. About 241 million congregate and home-delivered meals were served to 2.6 million older adults in 2008. The 2008 State Program Report shows that the program reaches <5% of older Americans, and those served average <3 meals/wk (6). Participants are poorer, older, sicker, frailer, more likely to live alone, be members of minority groups, and live in rural areas (6). Participants’ body mass indexes are two-thirds more likely to be abnormal, with those who are home-bound more likely to be underweight and those who are able to leave the home more likely to be overweight or obese (7).

An eligibility requirement for the program is age ≥60 y; there is no means testing (ie, eligibility is not based on income). The 2008 National Survey of OAA participants (6) stated that 53% of congregate and 67% of home-delivered respondents were aged ≥75 y, 16% and 28% of congregate and home-delivered meal respondents, respectively, had annual incomes of ≤$10,000, and 35% and 48% of congregate and home-delivered meal respondents, respectively, lived alone. Strikingly, 58% and 60% of congregate and home-delivered meal recipients, respectively, said that the one program meal provided half or more of their total daily food intake. Food insufficiency and insecurity, low nutrient intakes, and multiple comorbidities are not uncommon in homebound older women receiving meals (6, 8). Participation in food assistance programs reduces or prevents food insecurity outcomes and improves quality of life, reduces health care expenses, and helps meet nutritional needs (9).

Home-delivered meal recipients are especially frail, and 33% qualify as nursing home appropriate by the need for assistance with ≥3 activities of daily living (eg, bathing, dressing, eating, toileting). Almost all (84%) recipients need assistance with one or more instrumental activities of daily living (eg, shopping, housework, mobility). Half are at high nutrition risk (6).

With adjustment for inflation, total appropriations for OAA Nutrition Services decreased substantially in the past 2 decades [$941.7 million for fiscal year (FY) 1990 to $819.5 million for FY 2010] (10). Concomitantly, total meals declined by 3.9 million from FY 1990 to FY 2008 (most recent data; 6). To offset these reductions, the number of congregate meals decreased, but those delivered to homes have been protected. Home-delivered meals now account for 61% of total meals served.

The sparseness of outcomes research on the OAA Nutrition Program is one of the reasons why federal funding has grown

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only 6-fold since its inception in the 1970s, whereas the plethora of research on the Supplemental Food Program for Women, Infants, and Children (WIC) has helped WIC grow its federal funding 332-fold in the same time period (2). The OAA Nutrition Program lacks nutrition capacity (infrastructure and staff; eg, only one national nutritionist, no nutrition expertise in about half of the states). There are minimal federal nutrition regulations, the most recent being issued in 1988, and limited guidance compared with all other heavily regulated food assistance programs. Gaps in nutrition capacity have likely minimized attention to and funding for nutrition services beyond the provision of meals (2, 10) and are partially responsible for the relatively high meal expenditures (6, 10). Is there not some irony in that the OAA Nutrition Program is the sole nutrition assistance program housed in the US Department of Health and Human Services, with the better documented and better funded programs housed in the US Department of Agriculture?

As federal, state, and local agencies struggle to contain Medicaid and Medicare expenditures by moving from institutional care to home and community care (2), it is imperative that nutrition researchers document outcomes to ensure the inclusion of nutrition as home- and community-based services expand. The American Society for Nutrition’s position on community nutrition programs for older adults (2) is a first step in the research-worthy area linking aging at home, nutrition, and independence.

The author had no conflicts of interest in writing this editorial, either with the original study or studies that are discussed, nor did she have other potential conflicts that might bias this editorial.

REFERENCES