Testimony of
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In behalf of the
Meals On Wheels Association of America

Before the
Senate Special Committee on Aging

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Chairman Craig, Senator Breaux and Members of the Committee. I am Linda Netterville, President of the Meals On Wheels Association of America for whom I am testifying today. The Meals On Wheels Association of America, or MOWAA as we call our organization, represents senior meal programs from every state. Our member programs provide nutrition services to older adults to improve their dietary intakes, provide nutrition and health education, provide opportunities for social interaction, provide a link to informal and formal community support systems, and provide opportunities for active living. I am joined here in the audience by the Board of Directors of MOWAA. We, on behalf of all MOWAA-member programs from across the country, thank you for holding this hearing and for giving us an opportunity to testify.

Before I begin to address the issue of the role of nutrition in healthy aging, I want to note briefly a couple of important milestones. Later this month, we will commemorate the 31st anniversary of the inclusion of senior meal programs in the Older Americans Act – a congressional action that has literally changed for the better the lives of millions of older Americans over the years. To date, over 6 billion – that is billion with a B – meals have been served through the Act, and senior meal programs are adding to that total each and every day. As part of their commemoration of this, senior meal programs in communities throughout the country will be participating in MOWAA's "March For Meals" campaign. "March For Meals" is a national initiative, carried out individually by local senior meal programs throughout the month of March. The campaign is designed to (1) raise public awareness about senior meal programs and their needs; (2) raise funds to enable the provision of services locally to meet those needs; and (3) recruit volunteers to assist in the delivery of services…"*so no senior goes hungry."* I know that this is quite familiar to you, Senators Craig and Breaux, as the chairmen of our Honorary Congressional Advisory Committee and as Senators who helped us kick-off this now-annual event here in Washington last March at a press conference with race car drivers A.J. and Larry Foyt. But some of your colleagues, particularly those new to the Senate, might not be aware of your leadership and involvement in Meals On Wheels' behalf. So, remembering that anniversary, we want to thank you again publicly and to encourage your colleagues to get involved as well. "March For Meals" is just one of the ways that MOWAA is working to help

individual meal programs enhance the public-private partnerships that are essential to the past and current success, as well as to the future growth, of senior meal programs.

Senior meal programs – some 4000 plus across America – are as diverse as the communities in which they operate and as the seniors they serve. They are urban and suburban and rural; some furnish congregate meals in places like senior or community centers, others provide home-delivered meals, and still others provide both types; some programs serve as few as 30 meals a day, while others serve as many as 3000 daily meals. But all programs share one common commitment. That is the commitment to the regular provision of healthy, nutritious meals to America's elderly who need them. And by doing so, all of these programs are important partners – senior partners, we might even want to call them – with President Bush and Lynn Swann in their efforts to promote a healthier lifestyle for America's seniors. The *HealthierUS* Initiative identifies four keys to improving health: (1) being physically active each day, (2) eating a nutritious diet, (3) getting preventive screening, and (4) making healthy choices and avoiding risky behaviors.

It will not surprise you, I am sure, when I tell you that MOWAA would reverse that order slightly and put "eating a nutritious diet" first. That is precisely what our programs endeavor to do – to put healthy nutrition *first* in the lives of seniors, in order to enable them to do the other three things the *HealthierUS* Initiative promotes.

There is no question that scientific evidence supports the relationship between good nutrition, health and functionality among older adults.
For example, adequate intake of:

- Calcium and Vitamin D are linked to bone health and mobility.
- Vitamins B6, B12, and folic acid help to keep the mind alert and the nervous system performing at its best. These nutrients are also linked to reducing the risk of coronary artery disease.
- Vitamin E, beta-carotene and other carotenoids, and ascorbic acid help to prevent the damaging effects of oxidation in the body-one of which may induce cataracts or macular-degeneration.
- Vitamins E and B_6 and the mineral Zinc will help to strengthen the body's ability to combat infection and chronic disease.

- Fiber helps to ensure that the digestive system stays healthy and reduces the risk of colon cancer.

The majority of our MOWAA member organizations provide nutrition services under the Older Americans Act. Nutrition services provided by MOWAA member organizations target the same objectives enacted nearly 40 years ago under the Older Americans Act, which includes "[t]he best possible physical and mental health which science can make available." Meals served under the Older Americans Act must provide 1/3 of the Recommended Dietary Allowance (RDA) established by the Food and Nutrition Board of the National Academy of Sciences-National Research Council. The meal must also follow the Dietary Guidelines for Americans. These Guidelines include three broad messages:

- Aim for fitness,
- Build a healthy base, and
- Choose food sensibly.

This encourages healthy eating habits and physical activity as a regular part of life.

Although 1/3 RDA is the minimum requirement for a meal, our program's meals contribute 40-50% of the daily nutrients needed by older adults. In addition, the meals provide on average more than half of the recipient's total daily food intake. According to the Performance Outcomes Measures Project, the congregate meal contributes more than ½ of the total daily food intake in 48% of the participants; the home-delivered meal contributes more than ½ of the total daily food intake in 56% of the participants. Our outcome is two-fold. By providing a nutritious meal, we address malnutrition and hunger.

Our programs also encourage physical activity. Congregate programs provide important opportunities to engage in community life. Attending the senior center promotes, in itself, a kind of physical activity that enhances quality of life and improves physical and mental health. In many cases seniors come to the center primarily for meals and end up participating in a variety of other programs, including exercise. Even home-delivered meal programs can contribute in the area of helping seniors increase their physical activity. Most home-bound seniors are not bed-bound. Senior meal programs make it possible for them to stay in their homes and thereby to continue some level of physical activity that may be lacking in institutions or other settings. I am referring here to such simple things as walking from room to room, caring for and interacting

with pets, or even tending to plants and small gardens. I believe that Mr. Swann would agree with me that every movement counts.

Meal programs also help direct seniors to the other key recommendations of the *HealthierUS Initiative's*, namely screening and making healthy choices. Meals are not the only thing provided by senior meal programs. Programs conduct a nutrition screening at intake. A simple "Determine Your Nutritional Health" checklist identifies warning signs of poor nutritional health and assigns appropriate nutrition interventions. Nutrition programs also provide nutrition education, which stresses the importance of nutrition and health. It equips older adults with the knowledge they need to make healthy food choices on their own. For some older adults, general nutrition education may not be enough. Many programs employ a dietitian to provide individualized nutrition counseling to translate a person's nutritional needs into better personalized food choices. These healthy food choices can have a measurable effect on health status.

I would like to elaborate on just who it is who benefits by home-delivered meal services. Home-delivered programs address two distinct participant bases: (1) the frail elderly in long-term need of support and (2) those in need of short-term intervention. The first group is the one which, I believe, most generally comes to mind when we talk about home-delivered meals. In fact, the average home-delivered meal recipient is an elderly woman in her very late seventies or eighties; she is more than twice as likely as her contemporaries to live alone, apart from family and friends. She is likely to be functionally impaired (have trouble walking, for example) and have three or more diagnosed chronic health conditions. In addition, she probably has an income below 200% of poverty. Whatever the reason, she cannot shop, cook, or prepare meals for herself. In other words, she relies on senior meal programs to ensure she gets proper nutrition. Because of the Older Americans Act's targeting of limited services to those in greatest economic and greatest social need, with an emphasis on the low-income population, these are the most likely to be served by ours programs. That is as it should be.

But the other group – those with short-term needs -- merit attention as well. The last national survey, conducted almost a decade ago now, found that 41 percent of all home-delivered meal programs have waiting lists. The median time on the waiting list was one month, with some programs having wait times as long as three months. As a result, particularly in some areas, those in need of short-term intervention may have to go unserved. This group is comprised of

individuals who are recently discharged from the hospital, for example, or who are recovering from an acute illness or have short-term mobility impairment from a broken bone. Without access to community-based services, they may have to be institutionalized or return home to fend for themselves. Regrettably, that can result in a deterioration of nutritional, and concomitantly, of health status; such deterioration, in turn, can result in re-hospitalization. MOWAA believes that this is unnecessarily costly in both human and financial terms. Our programs can feed an individual for a year for the approximate cost of one Medicare day in the hospital ($840 in 2003). Whether or not this worst case scenario occurs, the lack of services most certainly does nothing to contribute positively to our shared goal of promoting healthy aging – a process that rests on the foundation of good nutrition and appropriate physical activity.

While we did not come before the Committee to beg the case for increased funding for our programs, we would be foolish and irresponsible if we did not make the point that the population needing our services is increasing dramatically at the same time that funding from all sources – both public and private – is shrinking. And that, simply put, is not acceptable. So we respectfully request that you continue to advocate on behalf of the country's seniors to ensure that their fundamental needs are met.

The very fact that you have convened these witnesses here today demonstrates once again your concern about and support of America's seniors. We thank you for focusing on this important issue. You are bringing national attention to these facts: Senior nutrition programs are a lifeline for millions of Americans. They are essential to achieving, maintaining, improving or restoring healthy aging. MOWAA and MOWAA member programs take our roles seriously. We remain committed to continuing to put seniors' nutritional needs first; and we look forward to continuing to work with the Committee, the Administration, the private sector and other organizations like the ADA in finding even better ways to enhance, improve and expand the provision of nutrition services to all who need them.

Thank you, Mr. Chairman. That concludes my testimony, but I would be pleased to answer any questions you or other members of the Committee may have.

APPENDIX
Overview of Older Americans Act Nutrition Services
And Participant Profiles

Congregate Nutrition Services

During 2001, 112,000,000 congregate meals were served to 1,750,000 older adults.

Services provided in addition to meals:
- Nutrition assessment
- Nutrition education and counseling when appropriate
- Social activities

Profile of a Congregate Participant:
- 80% are at 200% of poverty
  60% live alone
- 70% women
- 28% rural
- 25 % minority
- Average age 76 years

Mobility:
- 5% are unable to walk of have much difficulty walking without assistance
- 91% get out of the house at least once per week
- 73% get out of the house 5 or more days per week
- 72% have some leisure time physical activity during the past month

Home-delivered

During 2001, 143,000,000 home-delivered meals were served to 927,000 older adults.

Services provided in addition to meals:
- Nutrition assessment
- Nutrition education and counseling when appropriate

Profile of a Congregate Participant:
- 90% are at 200% of poverty
- 57% live alone
- 69% women
- 16% rural
- 27 % minority
- Average age 78 years

Mobility:
- 37% are unable to walk of have much difficulty walking without assistance
- 46% get out of the house at least once per week
- 15% get out of the house 5 or more days per week
- 42% have some leisure time physical activity during the past month