URGENCY FOR CHANGE

A CALL TO ACTION FOR THE AGING NETWORK

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Table of Contents

Executive Summary

To add value and to survive, senior nutrition programs need to modify and modernize. Senior nutrition program leaders will need to target services more sharply, and rethink how their business models can best mesh with existing systems. Both external and internal environmental changes are confronting nutrition programs.

Urgent changes are needed in senior nutrition programs, who are now competing to provide the right services to the right people at the right time.

In a fast-moving world, familiar services can vanish (goodbye pay phones), longtime stores can shrivel (think Sears), business models can change (hello Lyft, or electric cars), and individual needs evolve (more on-demand convenience).

Senior nutrition programs are not immune to the tide of change.

To add value and to survive, senior nutrition programs need to modify and modernize. Senior nutrition program leaders will need to target services more sharply, and rethink how their business models can best mesh with existing systems. Both external and internal environmental changes are confronting nutrition programs.

Senior nutrition programs must change so they can:

- Serve the demographics of a much more diverse older population,
- Address compelling competition from other private and public service providers,
- Adjust to changes in science, health, technology and media,

- Better integrate within the health and social service systems and
- Become an essential component of the long-term services and supports (LTSS) system.

Other challenges include limited public funding, the need for innovation as food-service delivery mechanisms are changing, and the need for adaptation in serving the multiplicity of participants from the young old to the old old.

Leaders of nutrition programs should be guiding discussions about how to incorporate quality and sustainability into their operations, and how to make services more individualized.

The older population was more homogenous when the OAA Nutrition Program (OAA NP) began, but several decades have created significant demographic challenges. Changes include: the increasing number and percentage of older adults; increasing racial/ethnic diversity, especially population growth among Hispanics; increase in both healthy older adults and less healthy, less functional older adults; increase in those age 85-plus; increase in the percentage of older women; higher rates of poverty for some older adults; and increase in disabilities and chronic health conditions.

Society has changed since 1972, when the OAA NP first was enacted. There

was little competition for the new senior centers and congregate meal programs then. Personal technology barely existed, much less online ordering of personalized restaurant meals delivered to your door within the hour.

Now, competition is everywhere, from soup and salad bars in supermarkets to food kits delivered to your home to make into meals. Private industry is serving and marketing to older adults. Commercial vendors now produce meals that meet the requirements of the OAA and also offer meals for special dietary needs and ones that meet regional/cultural preferences. Commercial vendors are competing with senior nutrition programs on both price and quality.

Local senior nutrition programs need to improve the quality of their meals and services to help older adults actively choose their services. They also will need to better integrate within health and social service systems and ensure that they are an essential component of the emerging LTSS system.

Such changes will help senior nutrition programs meet the demands of a larger, more diverse population—for both congregate and home-delivered meals—and ensure they can provide the right services to the right people at the right time.

Introduction

Both external and internal changes are sparking discussions about how to incorporate quality and sustainability into program operations—and how to do so more quickly. This document highlights the internal and external changes that are influencing implementation of the Older Americans Act Nutrition Program.

"The times...they are changing" may be a cliché, but it is true. People change, things change, programs change, and systems change.

The changing times affect how nutrition programs function every day and how well they can meet current and future needs. To be of value, nutrition programs need to invest in quality, efficient, effective, person-centered changes.

Here are just a few examples of how programs have evolved over the past few decades. The Food Stamp Program was authorized in 1964 to improve the levels of nutrition in low-income households regardless of age. The Older Americans Act (OAA), passed in 1965, did not include any direct services. During the late 1960s, it became apparent that older Americans continued to have food needs that were unmet by the Food Stamp Program. The Administration on Aging then funded pilot nutrition projects to meet these needs.[1]

Based on these pilot projects, congregate meals were the first home- and community-based service[1-2] authorized in the OAA in 1972 (Administration for Community Living. 2019). Designed to meet social and nutrition needs of older adults, particularly those who were low-income, the program also included social activities and connections to other needed services. Home-delivered meals were limited. Over the years, the program was reduced

within the aging services network to meal provision.

In 2016, Congress reiterated the original broader purposes of the OAA Nutrition Program (OAA NP):

1. To reduce hunger and food insecurity;
2. To promote socialization of older individuals; and
3. 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 to delay the onset of adverse health conditions resulting from poor nutritional health or sedentary behavior. (Older Americans Act. 2016. Section 330.)

OAA NP implementation has changed significantly from 1972. What has influenced this? Both external and internal environmental changes.

Urgent external environmental changes include demographics, competition, science and technology, social services, health care, and integration of health and social services as a part of long-term services and supports systems (LTSS).

Pressing internal environmental changes influence whether or not OAA NP can survive. They include limited public funding, limited innovation in service delivery as food-service delivery mechanisms are changing, less adaptation to serving the multiplicity of participants from the young old to the old old, and less focus on quality and changes in the business environment of OAA NP.

Both external and internal changes are sparking discussions about how to incorporate quality and sustainability into program operations—and how to do so more quickly. This document highlights the internal and external changes that are influencing implementation of the OAA NP.

Demographics

Our older population is growing overall, and especially among those over age 85. Its racial/ethnic, income, and health and functional diversity are increasing as well. This is causing an increase in the need for services, different kinds of services and different ways to finance them so that an older adult receives the right service at the right time in the right way.

Growth

The older population (defined as 65 and older) is growing as a percentage of the U.S. population.[3] Over the past 10 years, the older population has increased 33% and will double to 98 million by 2060. By 2035, the number of older adults will outnumber children, a situation that could stimulate competition for public and private funding and services.

Nationally, about 15% of the U.S population is over 65, but the percentage is significantly higher in some places. Although California, Florida, Texas, New York and Pennsylvania have the largest number of older adults, Florida, Maine, Puerto Rico, West Virginia, Vermont and Montana have the highest percentage of older adults at 17% and over. Many rural states have a higher percentage than the national rate but also more limited public spending and social services. Between 2006 and 2016, Alaska (17.3%), Nevada (21.3%), Colorado (19.8%) and Arizona (23%) increased their age 65-plus population by 50%.

Nationally about half of the older population is between the ages of 65 and 74; about 29 percent is between 75 to 84 or about double that of the age 85 and older population.

States with an increased number and percentage of older adults face increased demands for services. However, the needs of these older adults may differ based on their age cohort and other characteristics.

Racial/Ethnic Diversity

The older population continues to be largely white. However, it is becoming more diverse. All minority race/ethnicities (African American, Asian, American Indian/Alaska Natives, and Hispanic Americans) are increasing from 19% in 2006 to 23% of the older population by 2030, with the greatest increase for Hispanic Americans.

Because racial/ethnic minorities will increase, some may expect more culturally appropriate meals, activities, and services as well as services in languages other than English.

Increase in Those Over 85

Although most older adults are under age 85, the age 85-plus population is expected to increase the fastest of the age cohorts, doubling by 2040 and tripling by 2050. About 9% of this population lives in assisted living/nursing homes, and 91% lives at home in the community. As the over age 85 population increases, there will be an increased demand for both home- and community-based services and facility-based services.

Since most of the 85 and older population will continue to live at home in the community, they will need more in-home services and caregiver support services.

Ratios of Women to Men

Women continue to outnumber men, and most older men are married (70%) compared to older women (46%). Over half of older adults lived with a spouse or partner in 2017, but this percentage decreases with age, especially for women. About two times as many women who were 85-plus were widowed compared to men of the same age. In general, women are caregivers for men, who die sooner. The proportion of individuals living alone increases with age, with about 45% of women age 75 and over living alone.

Older women will be a significant portion of the population, possibly with increased social isolation or more caregiver burden, so services may need to adapt by focusing on more services or more intense services to keep them in the community.

Living Arrangements

As people age, they are less likely to live in a family household.[4] About 81% of the U.S. population lived with a family in a household, while 67.6% of those age 65 and older did. By age 85, about half of older adults lived in a family or non-family household, while about 39% lived alone. About 45% of women aged 75 and older lived alone compared to men, who were more likely to live in a family household.

Living alone is a risk factor for social isolation as well as a risk factor for nursing home placement. Targeting services to those who live alone is not only required by the OAA, but also makes sense in terms of promoting health and delaying institutionalization.

Income Diversity

There is increased financial diversity— more higher-income older adults and more poorer older adults. Although the median income of an older person in 2016 was $23,394, it was $31,618 for males and $18,380 for women. For all older persons, 47% reported an income of $25,000 or more.

The age cohorts provide more nuanced insights, however. Since about 49% of households between ages 65 to 74 had some earned income, many younger older adults are still in the work force and may not be ready to access services. This percentage declines with those age 75-plus.

The poverty rate for the older population is lower than the general U.S. population. Using the U.S. Poverty Guidelines, about 9.3% of the older population is below the poverty level of $12,490 for a single person and another 4.9% are at 125% of poverty or "near poor." About 14% reported an income below $10,000.

Both ethnic/racial minorities and women have higher poverty rates. About 7.1% of Whites, 18.8 % of

American Indian/Alaska Natives, 18.7% of African Americans, 17.4% of Hispanics and 11.8% of Asian Americans are below the poverty level. Women (10.6%) have a higher poverty rate than men (7.6%) and Hispanic women who live alone have the highest rate (39.5%). Some states/ territories have the highest poverty rates, such as Puerto Rico (38.1%), District of Columbia (13.4%), Louisiana (13.0%), Mississippi (12.3%), New Mexico (11.5%), New York (11.4%) and Kentucky (11.1%).

Those with higher incomes generally have better health, and are more able to access a wider array of health care and other supports/services from private sources. This higher-income group may also be able to voluntarily contribute more to the cost of publicly funded services that they do access. Those with lower incomes are more in need of diverse public services and have fewer options. Lower-income older adults and those in greater poverty have more food insecurity, poorer health, less functionality and more social isolation. Lower-income older women may be most in need. Needed services include meals, but also community-centered nutrition education, person-centered nutrition counseling and referral to other food assistance, economic security programs, HCBS services and health care options.

Those with greater poverty are more in need of services due to associated issues such as food insecurity, poorer health, less functionality and more social isolation. Targeting services to these people helps fulfill the purposes of the OAA and keeps older adults at home in the community.

Disability and Health

Based on its legislated purposes, the OAA NP is both a social service and health-related nutrition program. So knowledge of health and functionality is essential for appropriate targeting and tailoring of services to meet community and personal needs of older adults.

Disabilities and poorer functionality increase with age. About 35% of the over-65 population has some disability. Although about 44% of those over 75 have some difficulty in physical functioning, about 56% do not.

The most common disability among all older adult age cohorts is difficulty in walking and climbing stairs. About 15% of those age 65 to 74 had these difficulties compared to about half of those age 85-plus. About 8% of those age 65 to 74 had difficulty with independent living, such as shopping or going to the doctor, compared to about 43% of those age 85-plus. As the population ages, the percentages rise of those with more than one type of disability (vision, hearing, cognition, ambulation, self-care and independent living).

Health status also varies. Although most older adults assess their health as excellent or very good, most have at least one chronic condition and many have several. The top

Lower income and poverty are risk factors for premature institutionalization. Those with greater poverty are more in need of services due to associated issues such as food insecurity, poorer health, less functionality and more social isolation. Targeting services to these people helps fulfill the purposes of the OAA and keeps older adults at home in the community.

chronic conditions are hypertension, hyperlipidemia, arthritis, heart disease and diabetes. About 31% of older adults are considered obese. Most of these conditions have nutrition and physical activity components to their management. Men and women and different racial/ethnic groups have differing rates of these conditions. Understandably, adults over age 75 have more health care interactions than younger individuals, whether physician visits, hospitalizations or nursing home stays.

Many older adults, including many over 75, are healthy, functional and socially active, so they will want healthy eating choices, physical activity programs to retain functionality, programs to reduce their risk of chronic disease, and social opportunities. For these people, the congregate programs will want to emphasize their healthy meal choices, health promotion activities, linkages to chronic disease management, and social activities that enhance social connectedness.

Individuals with ambulatory difficulties will need assistance such as transportation to reach congregate services and other services that reduce social isolation. They may benefit from short-term in-home meals after hospitalization or nursing home rehabilitation, so that they can return to the congregate program.

People who are 85-plus are often less healthy, more functionally-impaired, and poorer. At the same time nutrition programs are offering congregate programs to promote health, they need to provide programs to maintain the health and functionality of these high-risk older adults.

For example, older adults with multiple chronic conditions may need meals and snacks at adult day care, home-delivered meals, medically-tailored special diet meals and supplements, specialized nutrition counseling, health coaching, in-home medication management programs and physical activity, in-home assistance for food programs, and other economic benefits and nutrition-related caregiver support.

Health and functionality status influence the different kinds of services that older adults need, as well as what they may expect. A challenge to the aging services network is to provide services that promote health, reduce the risk of chronic disease, and assist in managing chronic diseases and conditions, as well as help maintain health and functionality in populations that are compromised.

The older population was more homogenous when the OAA NP program began and now is undergoing significant demographic challenges. To add value, nutrition programs will need to accelerate change, improve targeting of services, and tailor them to meet the more diverse needs of today's heterogeneous population.

Disabled Population – All Ages

Of all people with disabilities, about 20% are 65 and older, 23% are under age 18 and 57% are between the ages of 18-64.[5] The younger disabled population has different health, employment, food security, and services needs and challenges than older people do. The younger disabled population will continue to increase and may represent a new population to serve. Aging services providers will need to leverage traditional and non-traditional funding sources to serve this population as they age, anticipating that they may be a population that has differing needs than current OAA NP participants.

Summary of Demographic Change and Impact

Urgent demographic factors all influence the services necessary to provide the right services to the right people at the right time. Demographic changes include the increasing number and population percentage of older adults; increasing racial/ethnic diversity; increase in both healthy functional older adults and less healthy, less functional older adults; increase in those age 85-plus; increase in the number and percentage of older women; higher rates of poverty for some older adults; and increase in disabilities and chronic health conditions as people age.

The older population was more homogenous when the OAA NP program began, but several decades have created a new picture. The older population is now undergoing significant change. To add value, senior nutrition programs will need to adjust, modify, modernize and transform to meet the service needs of a diverse, heterogeneous population.

Competition

Significant demographic and societal shifts have occurred since the OAA was first enacted. Most women did not work outside the home then, families stayed in closer geographic proximity, and limited public services were targeted to older adults.

Now, older adults' incomes may be higher, their families more spread out. More women are working outside the home, in a greater variety of occupations. Regardless of their income level, older adults have higher expectations about accessing quality services. Individuals and public and private funders also expect quality services, with participant, patient or customer-focused care spurring competition.

Food Service Competition

In 1972, there was little competition for the new senior centers and new congregate meal programs, nor were there food products in groceries that only required limited preparation except "TV dinners."

Now competition is everywhere, and growing: restaurant early bird specials and senior discount meals; quality frozen food products; ready-to-eat meal components and soup and salad bars in supermarkets; on-demand restaurant deliveries in urban areas that go beyond pizza and Chinese carry-out; food kits delivered to the home to make into meals; and online ordering of frozen meats, meals and other food delivered to a consumer's door.

Besides physical activities at senior centers, there are health clubs, health insurance programs, and hospital and rehabilitation facilities that target special physical activities

to older adults. Health insurance programs may offer discounts for health promotion/disease prevention programs, financial incentives and support groups. Many Medicare Advantage programs pay for Silver Sneakers memberships, which emphasize physical activity, health classes and social interactions.[6]

Senior centers themselves have changed. For example, some senior centers offer different kinds of meals for different populations. They may offer the OAA NP meal to one group and the private pay, for-profit café meal to a more affluent group. These services may operate with different menus, may offer unique foods in varied locations in the same senior center at distinct times during the day - all targeting an array of clients with wide-ranging needs. Or a nutrition provider may operate a for-profit restaurant open to the general paying public, and offer OAA-financed congregate and home-delivered meals and private-pay home-delivered meals.

Private industry is starting to serve and market to the older adult population. While many senior centers once self-produced congregate and home-delivered meals that catered to local tastes, they now have competition. Now, commercial vendors produce meals that meet the

requirements of the OAA and also offer meals for special dietary needs and meals that meet regional/cultural preferences, including choices among entrees, sides and desserts. And because these meals may be delivered to the home and require reheating, older adults may choose when to eat, thus giving them more flexibility.

Commercial vendors are competing with local programs on both price and quality to obtain contracts for congregate meals and home-delivered meals from both traditional funders and new HCBS managed-care organizations.

New Business Models

Since the 1970s, a variety of business social models have emerged that mix for-profit and not-for profit, private and public organizations, private industry and social entrepreneurial models. These models may include practices and concepts common to business, yet not-for-profit nutrition programs are now using them, too. Examples include partnerships of smaller programs to incorporate standards and service areas to appeal to health insurance companies, or not-for-profit nutrition programs that incorporate private for-profit businesses such as catering and cafes.

To add value, local providers need to improve the quality of their meals and services to help older adults actively choose their services from the wider variety of competitive products. To provide the right services to the right people at the right time, providers must meet the demands of a larger, more diverse population, incorporate more social entrepreneurial efforts, enhance their business acumen, and compete with private industry.

Science, Technology and Media

What other factors influence products and service diversity? Nutrition, health and food safety knowledge, behavioral science, health information targeted at professionals and consumers, and health literacy, to name a few. Changes in food, food technology, packaging, production and delivery mechanisms also influence product quality, safety and consumer satisfaction. Changes in computer technology, devices, software and interoperability also influence office operations, resource development, management and interactions with health care organizations, food assistance or other social services and service delivery. Media—whether print newspapers, radio and television, or social media such as YouTube, Facebook, Instagram or Twitter—affect consumers' perceptions of services and products, as well.

Nutrition Science

The OAA requires that meals meet national nutrition standards, state and local food-service laws, be appealing, and if possible, meet special dietary needs of older adults. National nutrition standards include:

- Dietary Guidelines for Americans[7], issued by the departments of Health and Human Services and Agriculture, which are based on the most current science evidence and updated every five years,
- Dietary Reference Intakes[8], published by the National Academy of Sciences, and
- State, tribal and local food-service laws that are based on the model Food Code (2017), published by the Food and Drug Administration and periodically modified to safeguard public health and ensure food is safe and unadulterated.

Evidence-based and evidence-informed behavioral science, health information and health literacy shape health promotion/disease prevention programs (whether disease and medication management programs or caregiver support), nutrition education and individual, person-centered nutrition counseling. Improved food technology is transforming food products and delivery processes.[9] Computer technology is influencing all operations. And media can make or break a program.

None of these factors are on as predictable a schedule as the nutrition and food safety science. As a result, nutrition programs need to incorporate considered changes as soon as economically possible and feasible. **Organizations also need to respond quickly to advances in science, technology and media to ensure quality, sustainable programs.**

Health care and Social Services

According to the Centers for Medicare and Medicaid Services (CMS), health spending will grow from $3.6 trillion in 2018 to $6.0 trillion in 2027, primarily due to the increase in the older population. Increases are expected in Medicare; Medicaid; out-of-pocket costs; prescription drugs; and hospital, physician and clinical services.[10-12]

CMS has been experimenting with ways to support innovative approaches to improving quality, accessibility and affordability, while finding the best ways to use innovative technology to support patient-centered care. The CMS Innovation Center is focused on new payment and service delivery models, including quality and effectiveness. **These innovation programs may affect local delivery systems and the partnership opportunities available to local programs.**

Public health affects community health care. The Community Guide explores what works to promote health for communities, emphasizing integrated community efforts for all ages (The Guide to Community Preventive Services. 2019). These efforts are in part funded by the Department of Health and Human Services, Agency for Health care Research and Quality, and offer opportunities for integrating evidence-informed service approaches.

Social determinants of health (SDOHs) are defined as conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Factors like food insecurity, economic instability, housing transportation, public safety, social cohesion, access to health care, language and literacy and access to

emerging mass media are examples of these SDOHs.[14] To better address SDOH, the social service systems and health care and public health systems are attempting to better integrate. For example, Medicare spends more on socially isolated older adults; being socially connected helps people age better.[15] A purpose of the OAA NP is to promote socialization for both congregate and home-delivered program participants and to coordinate with the HCBS under OAA Title III-B to address some of these essential SDOH. OAA Title-III B funds programs providing in-home and community-based long-term care services, including supportive services such as transportation, information & assistance, outreach, case management, homemaker or chore services, legal service, and adult day centers.

To add value, senior nutrition programs need to better integrate the health, public health and social service aspects of the program, integrating with health care and

collaborating with other agencies that are addressing aspects of **SDOH.** This might mean the provision of meals after hospital discharge; referrals from clinics and physicians for congregate or home-delivered services; provision of culturally appropriate congregate and home-delivered meals for racial/ethnic minorities; collaboration with food assistance programs funded by the U.S. Department of Agriculture; collaboration with transportation services to bring people to a senior center; ensuring access to volunteer activities, enhancing civic engagement; referrals for heating assistance; enhancement of friendly visiting through volunteer programs; and partnering with the public health department to ensure flu vaccinations or referrals for appropriate oral health care. All of these activities address aspects of SDOH and ways to help older adults remain at home, and in the community.
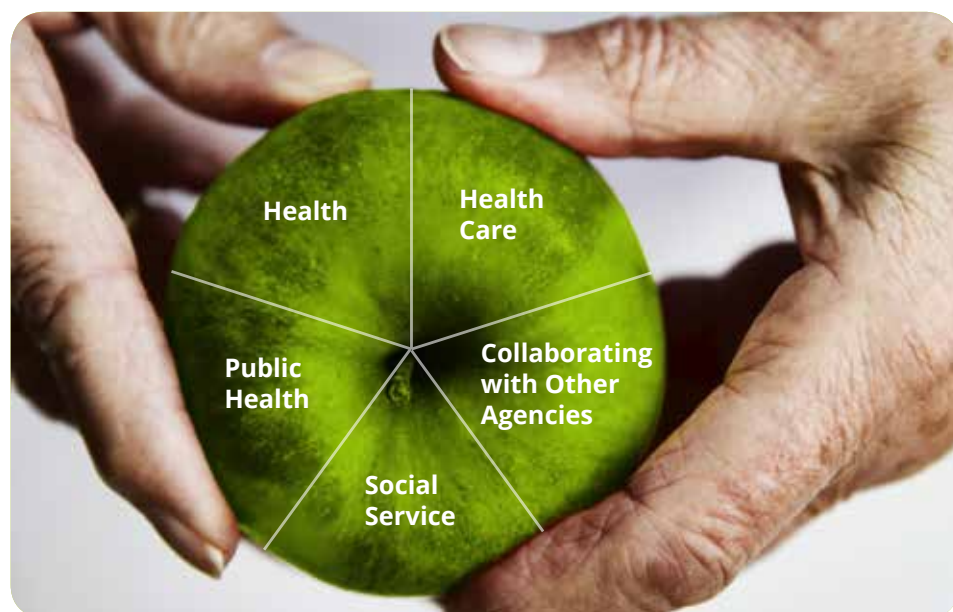
Long-Term Services and Supports (LTSS)

Systems change. The OAA ushered in the development of HCBS such as senior centers, congregate and home-delivered meals, transportation, home-modification, chore support, case management, prevention of elder abuse, and caregiver support, long before the concept of LTSS. The U.S. does not have a consistent state-by-state, formal LTSS system, but does have a variable system including private- and public-funded community and facility-based services.

LTSS include a range of medical and personal care assistance to help people of any age function more easily in daily life. These services can be provided informally by family members or formally by paid providers. Meals in congregate sites and home-delivered meals are essential components of this system.

Congregate meals provide the foundation service connecting people with health promotion/disease prevention services, social opportunities and community services. Home-delivered meals bridge health care and community care. Although many local nutrition programs may not consider themselves part of a broader system, the LTSS will increasingly influence the provision of services, quality and funding.

Over the past 20 years, care has shifted from facility-based services to HCBS. This shift is due to many factors such as personal and family preference, the Supreme Court's Olmstead decision, and the high cost of institutional care. Institutional care costs exceed HCBS service costs.[16]

A 2016 study based on the 2004 National Long-Term Care Survey (NLTCS) found a modest association between the use of paid HCBS and the reduced use of long-stay nursing home care among older adults aged 65 and older. Although the amount of nursing home reduction was not enough to offset the HCBS costs, older adults and their families overwhelmingly prefer HCBS and many states are promoting HCBS in place of nursing home care.[17] Studies have also found that state-funded HCBS programs that are not Medicaid-funded do help low-income adults with care needs to live at home.[18]

In addition, states that invest more in delivering meals to older adults' homes have lower rates of "low-care" seniors (defined as residents who have the functional capacity to live in a less care-intensive environment) living in nursing homes, after adjusting for several other factors. For every $25 per year per older adult that states spend on home-delivered meals, they reduce their percentage of low-care nursing home residents compared to the national average by 1 percentage point.[19]

Although LTSS relies on HCBS services provided by a variety of private and public sources, these services have not kept pace with increasing need. Funding for the OAA NP has remained relatively flat[20]; there is a shortage of home health workers; assisted living and residential care facilities for those who can pay remain limited; and the nursing home population continues to decline. All these factors place increasing pressure on family caregivers and publicly funded programs such as the OAA NP.[21]

A recent analysis of the National Health and Aging Trends Study found that two-thirds of older Medicare beneficiaries living in the community rely on some level of LTSS, but many of these beneficiaries had an unmet need for LTSS, especially those who were lower-income and eligible for both Medicare and Medicaid.[22]

LTSS is financed by both public and private funding with the majority covered by public sources such as Medicaid. Historically within the Medicaid program, there has been a bias toward institutional care. However, in the past two decades there has been significant progress toward rebalancing institutional care in favor of HCBS. Nutrition services (primarily as home-delivered meals but also nutrition counseling, nutrition support and nutrition supplements) are a part of many Medicaid HCBS targeted to older adults. As the multiple efforts funded through CMS to identify, develop and evaluate HCBS quality measures[22] come into common practice, senior nutrition programs that are highly variable may be affected.

As the demand for HCBS increases and there are limited LTSS options outside of Medicaid and little financial support for most older adults needing services, the reform of LTSS policy and financial incentives to care organizations, etc. will need to be considered to support functional independence and enhance quality of life for most older Americans. To keep being of value in a changing, competitive system, senior nutrition programs will need to ensure that they provide quality, effective, efficient and sustainable services within this emerging system.

Conclusion

Senior nutrition programs must provide quality and sustainable nutrition services if they are to survive in a rapidly changing environment. It is urgent to change so they can:

- Meet the exploding demographics of a diverse older population,

- Address the compelling competition from other private and public service providers,

- Adjust to the changes in science, health, technology and media,

- Better integrate within health and social service systems, and

- Ensure they are an essential component of the emerging LTSS system.

References

1. Administration for Community Living, 2019. Historical Evolution of Programs for Older Americans. Available at: https://acl.gov/about-acl/authorizing-statutes/older-americans-act. Retrieved February 26, 2019.
2. Administration for Community Living, 2018. 2017 Profile of Older Americans. Available at: https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2017OlderAmericansProfile.pdf. Retrieved February 26, 2019.
3. United States Census Bureau, 2018. The Population 65 Years and Older in the United States: 2016. American Community Survey Reports. Available at: https://www.census.gov/content/dam/Census/library/publications/2018/acs/ACS-38.pdf. Retrieved April 8, 2019.
4. Federal Interagency Forum on Aging-Related Statistics, 2016. Older Americans: Key Indicators of Well-Being. Available at: https://agingstats.gov/docs/LatestReport/Older-Americans-2016-Key-Indicators-of-WellBeing.pdf. Retrieved February 26, 2019.
5. United States Census Bureau, 2018. Americans with Disabilities: 2014. Current Population Reports. Available at: https://www.census.gov/library/publications/2018/demo/p70-152.html. Retrieved February 26, 2019.
6. Silver Sneakers, 2019. Available at: https://www.silversneakers.com/. Retrieved February 26, 2019.
7. United States Department of Health and Human Services, 2015. Office of Disease Prevention and Health Promotion. Dietary Guidelines for Americans: 2015-2020. Available at: https://health.gov/dietaryguidelines/2015/guidelines/. Retrieved February 26, 2019.
8. Dietary Reference Intakes: The essential Guide to Nutrient Intakes, 2006. Institute of Medicine. Available at: https://www.nap.edu/catalog/11537/dietary-reference-intakes-the-essential-guide-to-nutrient-requirements. Retrieved February 26, 2019.
9. Food and Drug Administration. 2017. Food Code 2017. Available at: https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm595139.htm. Retrieved February 26, 2019.
10. Centers for Medicare and Medicaid Services, 2019. Office of the Actuary. National Health Expenditure Projections. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html. Retrieved February 26, 2019.
11. Centers for Medicare and Medicaid Services, 2019. Innovation Center. Available at: https://innovation.cms.gov/initiatives/Medicare-Health-Care-Quality/. Retrieved February 26, 2019.
12. Centers for Medicare and Medicaid Services, 2019. The CMS Innovation Center. Available at: https://innovation.cms.gov/ . Retrieved February 26, 2019.
13. The Community Guide, 2019. Available at: https://www.thecommunityguide.org/. Retrieved February 26, 2019.
14. United States Department of Health and Human Services, 2010. Office of Disease Prevention and Health Promotion. Healthy People 2020. Social Determinants of Health. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health. Retrieved February 26, 2019.
15. Flowers L, Houser A, Nobel-Miller C, Shaw J, Bhattacharya J, Shoemaker L, Farid M, 2017. Medicare Spends More on Socially Isolated Older Adults. AARP Public Policy Institute. Available at: https://www.aarp.org/content/dam/aarp/ppi/2017/10/medicare-spends-more-on-socially-isolated-older-adults.pdf. Retrieved February 26, 2019.
16. 1Reaves E.L., Musumeci M, 2015. Medicaid and Long-Term Services and Supports: A Primer. Kaiser Family Foundation. Available at: https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/. Retrieved February 26, 2019.
17. Spillman B, 2016. Does Home Care Prevent or Defer Nursing Home Use? Office of the Assistant Secretary for Planning and Evaluation. Department of Health and Human Services. Available at: https://aspe.hhs.gov/basic-report/does-home-care-prevent-or-defer-nursing-home-use. Retrieved February 26, 2019.
18. O'Brien, E. Fox-Grage, W. Ujvari, K, 2019. Home and Community-Based Services Beyond Medicaid: How State-funded Programs Help Low-Income Adults with Care Needs Live at Home. Available at: https://www.aarp.org/content/dam/aarp/ppi/2019/02/home-and-community-based-services-beyond-medicaid.pdf. Retrieved February 26, 2019.
19. Thomas K, Mor V, 2012. The Relationship between Older Americans Act Title III State Expenditures & Prevalence of Low-Care Nursing Home Residents. Health Services Research. 12.3.12. Available at: http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12015/abstract
20. Napili A, Colello K, 2013. Funding for the Older Americans Act and Other Aging Service Programs. RL33880. Congressional Research Service. Available at: www.crs.gov Retrieved February 26, 2019.
21. Houser, A. Fox-Grage, W. Ujvari, K. 2018. Across the States: Profiles of Long-Term Services and Supports. AARP Public Policy Institute. Available at: https://www.aarp.org/content/dam/aarp/ppi/2018/08/across-the-states-profiles-of-long-term-services-and-supports-full-report.pdf. Retrieved February 26, 2019.
22. Willink A, Kasper J, Skeha M.E., Wolff J.L., Mulchany J., Davis L, 2019. Are Older Americans Getting the Long-Term Services and Supports They Need? Commonwealth Fund. Available at: https://www.commonwealthfund.org/sites/default/files/2019-01/Willink_are_older_americans_getting_LTSS_ib.pdf. Retrieved February 26, 2019. Older Americans Act. 2016. Available at: https://legcounsel.house.gov/Comps/Older%20Americans%20Act%20Of%201965.pdf. Retrieved February 26, 2019.