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HEALTHY AGING IN RURAL AMERICA

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

WASHINGTON, DC

MARCH 29, 2001

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HEALTHY AGING IN RURAL AMERICA

THURSDAY, MARCH 29, 2001

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 9:32 a.m., in room SD–562, Dirksen Senate Office Building, Hon. Larry E. Craig, (chairman of the committee) presiding.

Present: Senators Craig, Burns, Ensign, Breaux, Kohl, Lincoln, Carper, and Carnahan.

OPENING STATEMENT OF SENATOR LARRY E. CRAIG, CHAIRMAN

The CHAIRMAN. Good morning, everyone. I will convene this Special Committee on Aging hearing.

I want to thank all of you for attending the hearing this morning. I would first of all like to thank the witnesses for agreeing to testify before our committee today on "Healthy Aging in Rural America."

As the new chairman of this old and well-established committee, I chose "Healthy Aging in Rural America." as our hearing topic today because it is a very important issue in my State of Idaho as well as many other States across the country. It is time we stopped thinking of aging as end of life, but as a continuation of living. Most of us are living longer, healthier, and more productive lives, and I am looking forward to hearing testimony that will ensure that these opportunities are available to older Americans in rural communities.

Some of the challenges facing the elderly in rural communities are: transportation, nutrition, access to health care, employment, and housing. Questions and testimonies today will focus on each of these challenges. My priority is to look at constructive ideas that address the challenges of older Americans in rural communities and what they face on a day-to-day basis.

Ideas that allow our senior citizens the option of remaining in their communities and living out vigorous and productive lives ought to be a goal of this committee.

Again, I would like to thank the witnesses for sharing their expertise, and I would particularly like to thank Melinda Adams, from my great State of Idaho, who made a detour, I understand, to Washington today from her commitment with her daughter, who is visiting colleges.

Our ranking member, Senator John Breaux of Louisiana, is off on a phone call at the moment, but he will be back, so let me turn

to my colleague from Montana, Senator Conrad Burns, for any opening comments he may have.

Senator Burns.

OPENING STATEMENT OF SENATOR CONRAD BURNS

Senator BURNS. Thank you, Mr. Chairman, and thank you for holding this hearing, and I want to thank the witnesses.

I will put a statement in the record, but I will say that in the State of Montana, we are getting older, as all States are, to be quite honest with you. The percentage of older people is becoming a bigger part of our population and our demographics.

We started a center in Billings, MT, at Deaconess Medical Center, using telemedicine and new technologies, because we are going to manage our older populations in rural areas in a different way. I have 13 counties that have no doctors.

I can remember my father, who died at the age of 86 back in 1992, telling me just a week before he died—we were a farm family, a very close family—but my father said, "You know, I was never afraid to grow old, but I was always afraid to get too old."

And that Monday night I flew back to Washington, and I said, "I will see you this weekend"—I would go back through Missouri on my way to Montana—and he said, "I will not be here, because I am not going to get too old." And by gosh, he wasn't there the next weekend.

We are going to use new technologies. We have a doctor in geriatrics at Deaconess now who designed these programs for rural Montana using telemedicine and broad band services for interacting visibly with the patient and via computers and telephones and a lot of things, and we use that same system in our distance learning. We also use it in the ways of rural doctors, because as soon as they graduate from college—I have a daughter who is a doctor—her education stops, and she wants to practice in a rural setting, in that venue. That is her only way of continuing education.

So we have to start thinking about this. Instead of moving people, we have got to find those technologies that move us closer to them from a major medical center so that we can manage our aging and our health care for our aging in a different way.

So we thank you for coming today, and I look forward to your testimony. But I will tell you as chairman of the Communications Subcommittee over in Commerce, new and exciting technologies are coming out, and we should be setting the environment where these new technologies can be used, and then get out of the way and let the people who really have the imagination to put them into use.

So thank you all for coming today, and I thank you, Mr. Chairman.

[The prepared statement of Senator Burns follows:]

PREPARED STATEMENT OF SENATOR CONRAD BURNS

Mr. Chairman, thank you. I'm excited to get the hearings of the Special Committee on Aging kicked off today. I look forward to working with you and the great staff you have assembled for the betterment of senior citizens across America.

I'd like to start off by thanking today's witnesses for taking time out of their schedules to share their knowledge and experiences with the Committee today. The Chairman and we have brought you here to learn from you so that we may better legislate.

By the year 2025, Montana will have the third highest concentration of senior citizens in America, behind Florida and your State, Ms. Heady, West Virginia. At the present time, Montana is not ready for this demographic shift. Montana's health care system is not merely challenged by rural areas, it is DEFINED by rural and frontier settings. Difficulties in transportation are exacerbated by tremendous distances and Montana's own version of inclement weather. This hearing is especially pertinent, therefore, to the concerns of my constituents.

As I mentioned earlier, we up here are here to learn from you, so I will keep this short. But I am certain, however, that I will have some questions for you after your testimony.

The CHAIRMAN. Conrad, thank you.

Senator Breaux is not back yet, and we have a vote at 9:45, so we are going to start taking testimony, and Senator Breaux can make his opening comments when he returns. We understand that our first witness is time-sensitive—he is going to talk about transportation, but he needs to catch some transportation, which makes him time-sensitive.

With that, let the committee turn to Jon E. Burkhardt, who is Senior Study Director at WESTAT, who will be talking to us about transportation.

Jon, welcome before the committee. Please proceed, and I will ask the committee to stay at the 5-minute limit, if you would, please.

STATEMENT OF JON BURKHARDT, SENIOR STUDY DIRECTOR, WESTAT, ROCKVILLE, MD

Mr. BURKHARDT. Thank you very much. It is a pleasure to be here. I have prepared written testimony that I would like to submit for the record.

I am here to tell you that rural transportation is one of the best investments that this country can make. It keeps people off of welfare; it keeps them out of nursing homes; it breaks down isolation; it allows volunteers to volunteer; it connects people to health care, commerce, and to each other; and it is especially important for healthy aging in rural America.

I would like to point out four items today. One is that transportation is a key concern to elderly persons in rural areas. Travel demands of older persons will increase significantly. Our current Federal programs have offered a great deal of inspiration and assistance for both specific riders and our society. We need some improvements, and I would like to ask the committee's assistance in this.

The primary challenges in rural areas are the large proportions of older persons and elderly poor who have few transportation options and have critical needs for long-distance transportation, particularly for treatments like dialysis and chemotherapy.

The numbers of our elderly are growing quite rapidly—this is true for rural areas as well as our urban and suburban areas. Most elderly in the future will live in areas that are now not well-served by public transportation.

In the year 2030, we need to think about driving. Most of us drive, and we have to start talking about transportation by talking about driving. In 2030, the number of drivers 65 and older is going to double. The proportion of older drivers on the roads will triple, and one of the possibilities is that the number of fatalities involving older drivers will go up by three to four times what it is now.

That will make it greater than the current level of alcohol-related fatalities, and we know that that is unacceptable.

In my grandparents' era, few people expected to retire from working; in today's era, not many of us think that we are going to retire from driving. I would bet that a lot of people in this room think that they will drive to their own funerals. This is not going to happen.

A recent letter to Ann Landers said, "I have had two bypass surgeries, a hip replacement, new knees, fought breast cancer and diabetes. I am half-blind and cannot hear anything quieter than a jet engine. I take 10 different medications that make me dizzy, windy, and subject to blackouts. I have had bouts of dementia, poor circulation, I can hardly feel my hands and feet anymore. I am 85 or 87, but I do not know, and no one can tell me—all my friends are dead. But thank God I still have my Florida driver's license."

People do not want to give up driving. Driving is important. We have had people tell us: "Driving is my life. If I lose my driver's license, I will curl up and die."

We need better options. We need better programs. In rural areas, we have the Federal Transit Administration's Section 5311 program; we have the Administration on Aging's Title III Program, and we have Medicaid. Those are the three big programs. They work best when they work together.

In particular, the FTA's 5311 program is a program that has had great success in recent years in attracting many more riders and doing this actually at a lower cost per ride, which is wonderful.

We did some studies of the economic benefits of rural public transportation. It is a factor of three to one, and that is not even counting all that we really could count.

The people who get this transportation tell us things like: "It is a blessing to have the bus. "Thank God, you have helped us out." "This is what keeps me out of that nursing home." It feels like letting a bird out of a cage." These are very powerful testimonials from older people.

We have many transportation services around the country that serve as sparkling examples of what can be done to assist older persons. In particular I would encourage people to look at the Independent Transportation Network in Portland, Maine, as a highly customer-friendly and service-oriented operation.

I am running out of time, but I would like to say that we very much appreciate the committee highlighting these issues, and we look forward to the committee's support for full and enhanced funding for current programs, activities like the Coordinating Council on Access and Mobility. And I would like to ask that you look into some changes in the current Medicare transportation provisions. This is perhaps a $2 billion expenditure this year. It is not being done as cost-effectively as it might be, and this is an area where the committee could be of great assistance.

We need new kinds of vehicles, new forms of transportation services, and if we do that, we do not have to look at the isolation of our older citizens and risks and avoidable traffic fatalities.

Thank you very much.

[The prepared statement of Mr. Burkhardt follows:]

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TRANSPORTATION SUPPORT FOR HEALTHY AGING AMONG THE RURAL ELDERLY

Draft

by
Jon E. Burkhardt

March 29, 2001

Testimony Prepared for Hearings on

Healthy Aging in Rural America
Special Committee on Aging
United States Senate

TRANSPORTATION FOR THE RURAL ELDERLY

Modern society offers a wide range of life-enriching activities, ranging from sophisticated health care options to fascinating entertainment possibilities. Transportation is the key that unlocks access to these activities. High levels of mobility mean high levels of access, choice, and opportunity, which can lead to self-fulfillment and enrichment. Low levels of mobility can lead to isolation and cultural impoverishment.

Obtaining sufficient transportation can be a significant challenge for some persons, including those who are elderly or poor, those who live in rural areas, and persons with disabilities. Older persons who live in rural areas face some particular challenges in obtaining the transportation they need to maintain their independence and quality of life.

With the support and assistance of a number of key Federal programs, transportation has become less of a problem and more of an opportunity for rural residents who are older. Still, much remains to be done before the rural elderly can be assured of access to society's key benefits.

Four key factors need to be emphasized:

- Transportation is a serious concern for older persons in rural areas.
- Travel demands among rural seniors will increase significantly in the future.
- Federal programs that offer transportation assistance for healthy aging have created substantial inspiration and benefits.
- Significant improvements to rural transportation services for older persons are both needed and possible.

TRANSPORTATION DEMANDS FOR SENIORS IN RURAL AREAS

OVERALL TRAVEL PATTERNS AMONG THE ELDERLY

Because of our expanding elderly population, personal transportation will become a much more important issue in the future for the United States, particularly in rural areas.

Projected Numbers of Older Persons

The numbers of persons 65 years of age and older are projected to grow dramatically in the near future. People 65 and older comprised 13 percent of the population in 2000; this is projected to grow to 18 percent in 2020 and 20.4 percent in 2030. The fastest growing age group in the U. S. is persons 85 years of age and older. The U. S. Census projects that, by the year 2050, the number of persons in the population 65 and older will more than double, the number of persons 75 and older will triple, and the number of people 85 and older will quintuple.

Changes in the size of the elderly population between now and the year 2020 also will vary considerably from one part of the country to another. Increases are expected to be greatest in the West and South, and lowest in the Northeast and Midwest. The following figure illustrates these different growth patterns.

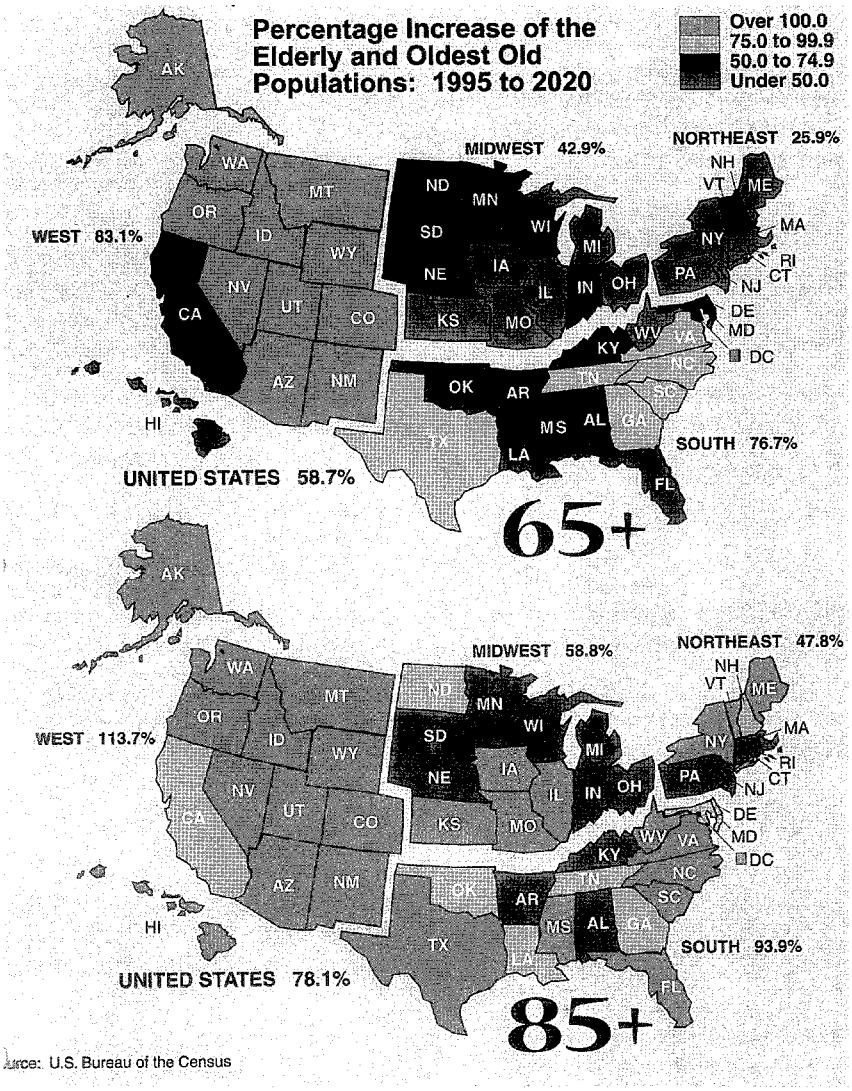
Automotive Travel

Autos currently play a large part in the travel patterns of older persons, accounting for about 90 percent of all the trips made by older persons. The numbers and percentages of older people who are drivers could increase significantly in the near future. These changes can be expected to have important consequences.

The numbers of drivers 65 years old and older will at least double over the next 30 years. If, as expected, older women drive more than they do now, the numbers of older drivers could exceed 2.5 times the 1996 levels within 30 years. The proportion of older drivers on our streets will also increase significantly, and older drivers will be driving more (taking more trips and driving more miles) than before.

The total amount of travel that older drivers will undertake will be much greater in 30 years, increasing from 400 to 500 percent. The proportion of all driving done by older drivers will nearly triple by 2030 even according to conservative estimates.

With no changes to current crash-related fatality rates, the number of fatalities involving elderly drivers in 2030 could be three to four times greater than in 1995. If this expected increase occurs, the number of elderly traffic fatalities in 2030 will be 35 to 71 percent greater than the total



Source: U.S. Bureau of the Census

number of alcohol-related traffic fatalities in 1995 – a fatality number now viewed by policymakers and the public as cause for serious concern.

Travel Safety

As the aging of our society creates **more** older drivers, we also see larger numbers of older persons who are unable to safely operate motor vehicles, because the usual consequences of the aging process include an increase in functional disabilities and a reduction in the skills and abilities needed to drive an automobile.

When people with diminished capabilities continue to drive, an increased safety risk is created for all members of society. However, older drivers facing the prospect of reducing or terminating their driving expect substantially reduced mobility with undesirable consequences. These include a loss of personal independence, social isolation, and a reduction or lack of access to essential services. The vast majority of older Americans have grown up in a culture that strongly depends on automotive transportation for mobility, and driving occupies a central role in the lives of many older adults (as, indeed, it does for most of us). Thus, it is not surprising that no longer driving is a major loss for many older individuals. It has even been called "a major life crisis." The central values of American life, autonomy and independence, are reflected in the difficulties older people have in relinquishing their driving privileges. Most seniors expect their lives to be more difficult and less happy after they stop driving.

For older adults facing the imminent or immediate end of their driving career, their choices are usually new modes of travel, changing established travel patterns, reducing activities and expectations, relying on some combination of formal and informal transportation alternatives, relocating to a community with more densely located services, or moving in with family members. When it is not possible to maintain previous connections established by our elderly citizens, society suffers from the lack of access to the expertise of these older adults as well as from the loss of their productivity as workers and volunteers. Thus, there are many reasons to take steps to reduce the potential mobility losses associated with the reduction or cessation of driving.

Decisions by older drivers about driving also have consequences for their families and

friends. Family and friends of an ex-driver often are faced with the issue of providing transportation and its associated costs, including their own loss of time and, perhaps, income. There may be serious disruptions to work and family schedules to care for an older parent.

Alternatives to Driving

Automotive travel is a difficult "habit" to break because of the nearly unfettered mobility it offers and because of the psychic and symbolic rewards that have been associated with it. Public mass transit services are more limited than auto travel in both the spatial and the temporal dimensions of service. Individuals who are accustomed to the high level of mobility and the psychic rewards of driving may find it more difficult to adapt to life without a car than are those people who have never been drivers. Ways to improve mass transit include upgrading its services, upgrading its image to that of first-class service, and increasing its consumer orientation. To achieve these goals, efforts on each may have to be undertaken simultaneously.

The concept that "life depends on driving" is less prevalent when other travel options are available. Persons who had access to a well-developed public transportation system and could live in close proximity to the kinds of shopping and recreational opportunities that appeal to seniors felt that a car was not a necessity to live an active life. They could control their own mobility choices, and make reasoned choices about driving or not driving.

Public Transportation

Transit is used by about 11 percent of older persons. Fifty-four percent of the older population could but doesn't use public transit, and 34 percent report that no public transit service is available to them.. (In non-metropolitan areas, 73 percent report that no public transit service is available to them..) Transit trips represent about three percent of all trips of older persons. Transit usage is closely related to residential location, with older center city residents using transit much more frequently than elders residing elsewhere. Transit currently has problems serving older persons who are in the oldest age groups, have multiple travel options, live outside of central cities, and have multiple impairments. The large numbers of persons who do not drive and do not use public

transportation should be considered as potential riders for new or improved transit services, which could help older people continue to live independently in their own homes for longer periods of time, thus benefitting both the older persons and society as well.

CHARACTERISTICS OF RURAL AREAS

In the 1990 Census, it was reported that one in 14 households in rural America had no car. Forty-five percent of the rural elderly and 57 percent of the rural poor had no car. Despite such obvious transportation needs, 38 percent of the nation's rural residents live in counties with no public transit service and 28 percent live in areas in which service is less than 25 trips per year for each household without a car. Many small areas have no taxi service; intercity and interstate bus, train, and air service to rural areas has greatly diminished.

Rural areas have larger proportions of elderly residents than do urban areas. This leads to an older age structure in non-metropolitan than metropolitan areas: in 1998, the median ages were 36.0 in nonmetro areas and 34.0 in metro areas.

Non-metropolitan populations are both increasing and becoming older. The combination of the out-migration of younger segments of the population and the aging in place of those people who remain has dramatically increased the average age of the rural population in certain areas (for example, central Iowa). The in-migration of retirees has increased the overall age of the populations in other rural areas, particularly those classified as "retirement destinations." Nonmetro retirement communities, primarily located in the South and the West, are expected to continue their rapid growth. While these counties total just nine percent of all nonmetro counties, they accounted for 25 percent of the nonmetro population growth from 1990 to 1998.

In 1997, 18 percent of the rural population was elderly, compared to 15 percent of the urban population. The majority of non-metro counties with an elderly population of 20 percent or more are located in the Great Plains subregion, often in the states of Nebraska, North Dakota and South Dakota, but also in Iowa, Kansas, Missouri, and Texas (Fuguitt, 1995). These states have experienced a large out-migration of younger persons, and have a large population that is aging in place.

The oldest old (over 85) are more concentrated in rural areas. Non-metropolitan elderly are significantly more likely to be poor or near-poor than their metropolitan-area counterparts.

Many rural areas have fewer transportation options than their urban or suburban counterparts. By the year 2000, almost three-fourths of people over the age of 65 will live in suburban or rural areas in the United States, where alternatives to the automobile are often scarce or nonexistent. One reason that transportation issues are particularly important for older persons is because most rural areas have fewer medical services available than in comparable urban areas. Rogers lists the medical problems of rural communities as a narrower range of health care services for elders, fewer alternatives available, less accessible and more costly health service in rural areas, and fewer health care providers offering specialized services in rural areas.

FEDERAL ASSISTANCE FOR TRANSPORTATION

At the moment, there are three key sources of Federal support for rural transportation services for older persons: the Federal Transit Administration's Section 5311 Non-Urbanized Area Formula Assistance Program, the Administration on Aging's Title III Grants for State and Community Programs on Aging, and the Health Care Financing Administration's Medicaid program. FTA's Section 5311 program, with FY 2000 funding of over $203 million, often serves as the nucleus for transportation services in rural areas.

AoA's Title III program, with $68 million in transportation expenses in FY 1999, has often served to initiate transportation services in rural areas without any other form of public or specialized human service transportation operations. AoA-sponsored transportation services are used primarily to access meal sites and health care. For older rural Americans, long-distance travel to specialized medical services (such as dialysis and chemotherapy) remain a significant unmet need.

HCFA's Medicaid program is authorized by Title XIX of the Social Security Act. It pays for medical and health-related services for certain vulnerable and needy individuals and families with low incomes and limited resources. Medicaid will probably spend about $840 million for transportation services in FY 2000, and has often been the major funding source for many Section

5311 operations. HCFA funding typically provides reimbursements to individuals after travel is completed.

Other funding sources are crucial for rural transportation operations, but these three key programs provide the vast majority of funds that benefit older riders, especially those living in rural areas.

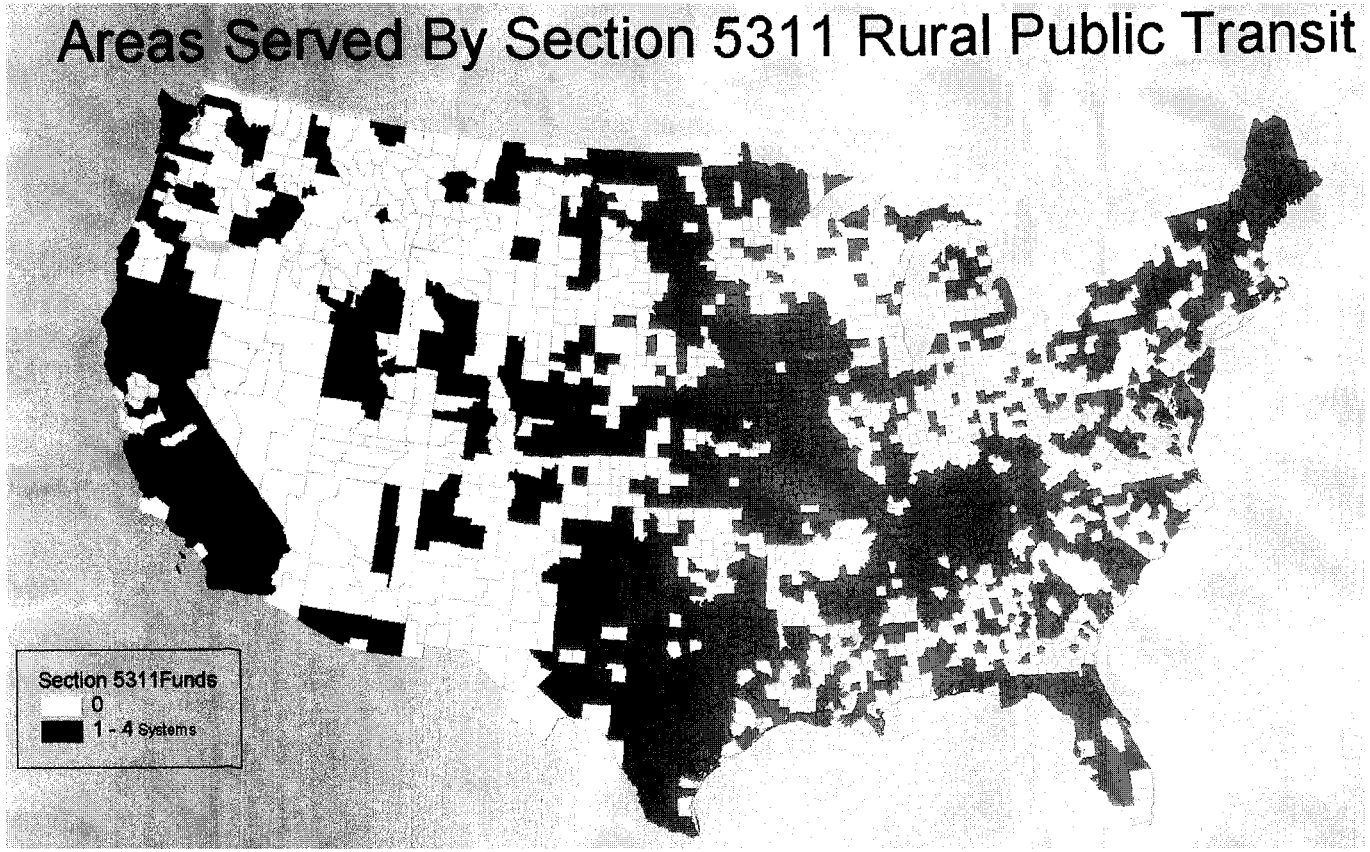
THE GROWING RURAL TRANSIT INDUSTRY

About 1,250 public transportation systems are supported by Federal, state, and local funding in rural communities across the United States. Many of these systems have been in operation since the 1970s and 1980s. The areas served by rural public transit systems in 1998 are shown on the following page.

Ongoing Federal funding for rural public transportation was authorized by the Surface Transportation Assistance Act of 1978. Now the Section 5311 program, funds from this program may be used for capital, operating, and administrative transportation expenses. From fiscal years 1981 to 1996, the appropriations for this program grew from $72.5 million to $115 million. The new spending ceiling authorized by Congress under the Transportation Equity Act for the 21st Century (TEA-21) for the Section 5311 program now exceeds $203 million.

Like rural communities, rural transportation systems are quite diverse in many ways, including type of service provided and in size of operations. Rural transit systems very often feature demand responsive service. Thirty-six percent of these systems are demand-responsive only; 32 percent are demand responsive and fixed route; 23 percent are demand-responsive and other than fixed route; 9 percent are fixed route only; and 4 percent are other types. Most rural transit systems are relatively small in terms of annual operating expenses — 40 percent have annual operating expenses of $111 thousand or less — and a few systems that are quite large — 20 percent have annual operating expenses of $500 thousand to $8.4 million.

There has been a substantial growth in rural public transportation services in communities across the U. S. in recent years. Comparing 1998 figures to those of 1993, there was


Areas Served By Section 5311 Rural Public Transit
Section 5311Funds
0
1 - 4 Systems

- a 10 percent increase in the number of rural public transportation systems,
- a 34 percent increase in the average fleet size,
- a 79 percent increase in trips on these systems,
- a 55 percent increase in system budgets, and
- a 10 percent decrease in the average cost per trip.

On average, costs per trip actually declined, indicating that rural public transportation systems are operating at higher levels of efficiency than before.

These figures are indicators of substantial improvements in the rural transportation industry. More trips are being taken and more funds are being applied to rural public transportation. More vehicles are in service, and there are more riders per vehicle than before. Best of all, the overall cost-effectiveness of these systems — measured in terms of cost per trip — has improved. The overall picture is one of more service being delivered more professionally.

The larger systems have often recorded major increases in fleet size, numbers of riders, and funding. The smaller systems have usually maintained their previous service levels.

THE ECONOMIC IMPACTS OF RURAL PUBLIC TRANSPORTATION

Like large urban public transit systems, rural public transit systems have real benefits for the communities that they serve. Prior to 1998, the contributions that rural transit systems have made to the economic health and well-being of the communities they serve was largely undocumented. At that time, a report (prepared by Ecosometrics, Incorporated, for the Transportation Research Board) — **Assessment of the Economic Impacts of Rural Public Transportation** (TCRP Report 34, 1998) — for the first time measured the economic benefits of rural transit operations. Using benefit estimates from 22 case studies of rural transit systems and from national transportation and economic data, large economic benefits were found, demonstrating that public transportation is a good investment for rural communities:

- The average net earnings growth differential between rural counties with transit and rural counties without transit systems was 11 percent.
- The average annual economic impact per rural county from public transit was calculated to be more than $1 million dollars.

- Comparing the estimated overall national economic impacts to the total Federal investment provided an estimated leveraged impact of Federal funds from the Section 5311 program of approximately 13.5 to one from 1975 through 1994.
- The national annual economic benefit from rural public transit systems for fiscal year 1997 was estimated at **$1.26 billion**, compared to federal-state-local rural transit expenses of **$375 million**. This gives a benefit to cost ratio of **3.35 to 1.0.**
- According to FTA's FY 2000 Section 5311 report, the total of the annual operating budgets of all Section 5311 systems is now about $1 billion, with FTA providing less than 12 percent of that total.

This is a significant level of benefits. The ratio of 3.35 to one exceeds by a large margin the returns for many governmental programs that are considered successful. This indicates that investments in rural public transportation have unusually high returns, and that conclusion supports the notion of at least continuing, if not actually increasing, the current level of investments in rural public transportation services.

The study also examined eight rural transit systems in depth and conducted desk audits on another 14 operations. The 22 case studies were

- Aberdeen Area Ride Line, Aberdeen, South Dakota
- Ames Transit Agency (Cy-Ride), Story, Iowa
- Aroostook Regional Transportation, Presque Isle, Maine
- Blacksburg Transit, Blacksburg, Virginia
- Coordinated Transportation System, Gainesville, Florida
- County Express, Sterling, Colorado
- County Commuter, Hagerstown, Maryland
- County of Lee Transit System (COLTS), Sanford, North Carolina
- Delta Area Rural Transportation System (DARTS), Clarksdale, Mississippi
- East Central Arkansas Transit (ECAT), Crittenden, Arkansas
- El Aguila, Laredo, Texas
- Eureka Springs Transit, Eureka Springs, Arkansas
- JAUNT, Charlottesville, Virginia
- North Idaho Community Express (NICE), Coeur D'Alene, Idaho
- Pee Dee Regional Transportation Authority, Florence, South Carolina
- Pullman Transit, Pullman, Washington
- Sweetwater County Transit Authority (STAR), Rock Springs, Wyoming
- Tri-County Community Council, Bonifay, Florida

- Upper Cumberland Human Resource Agency, Cookeville, Tennessee
- Village of Angel Fire Transit, Colfax, New Mexico
- Western Iowa Transit System (Region XII COG), Carroll, Iowa
- Zuni Entrepreneurial Enterprises, Zuni Reservation, New Mexico.

Among the in-depth case studies, the benefit cost ratios ranged from 4.22 to one (two systems) to 1.67 to one. The relative consistency of these ratios is notable. Four of the eight systems had benefit/cost ratios in the narrow range from 3.03 to 3.55 to one.

The average ratio of benefits to costs among the eight systems studied in depth was 3.12 to one. Because the approach focused on the primary types of benefits for each transit system and did not attempt to exhaustively quantify all benefits, **it is likely that the calculations slightly understate the actual benefits of these systems.** Thus, both the case study and the national approach produced benefit-cost ratios for rural public transit systems that exceed three to one.

Table 5:

BENEFIT/COST RATIOS FOR CASE STUDY SYSTEMS

SYSTEM'S NAME	ANNUAL OPERATING EXPENSE	NUMBER OF VEHICLES	NUMBER OF TRIPS/YEAR	BENEFIT ESTIMATE	BENEFIT/ COST RATIO	DATA YEAR	PRINCIPAL BENEFIT TYPES
Blacksburg Transit, Virginia	$1,677,975	33	1,470,000	$2,819,350	1.67/1	FY 96	Traffic Reduction Parking
COLTS (Lee County), North Carolina	$258,986	15	54,339	$1,093,316	4.22/1	FY 95	Dialysis Welfare to work Nutrition Training
County Commuter, Maryland	$1,089,201	12	290,000	$3,462,717	3.18/1	FY 94	Employment Medical Training
Delta Area Rural Transportation System, Mississippi	$800,350	21	109,930	$2,843,880	3.55/1	FY 96	Employment Dialysis
JAUNT, Inc., Virginia	$1,641,710	60	209,799	$3,040,500	1.85/1	FY 96	Employment Disabled Empl. Dialysis/medical
Pee Dee Regional Transportation Authority, South Carolina	$3,808,025	89	531,455	$12,362,423	3.25/1	FY 96	Employment Welfare to work Dialysis Emergency
STAR, Sweetwater County, Wyoming	$554,859	14	83,659	$1,681,287	3.03/1	FY 96	Employment Medical Indep. Living
Zuni Entrepreneurial Enterprises, New Mexico	$115,726	4	15,998	$488,880	4.22/1	FY 96	Education Employment

SUMMARY OF ECONOMIC IMPACTS

Public transit is a good investment for rural communities. The major local economic goals that rural transit systems help achieve are

- allowing local residents to live independently (instead of on welfare or in nursing homes),
- increasing the level of business activity in the community,
- allowing residents to live more healthy lives, and
- making more productive use of scarce local resources.

Achieving these goals can create returns on investment of greater than 3 to 1, as shown by both national and local analyses. Other economic impacts that were not measured in the above study but will be of interest to local communities will include the salaries and wages paid to transit system employees, the transit system's purchases from local businesses and suppliers, cost efficiencies for the system's riders (less expensive travel; better access to more cost-effective services), and the multiplier effects of all of the above expenditures in the local economy.

WHAT DOES IT MEAN TO SENIORS TO HAVE MOBILITY?

For the Administration on Aging, WESTAT is assessing the performance outcomes of a variety of service programs for the elderly, including transportation services. Surveys of client satisfaction with services are being conducted. Using telephone and mail surveys, State Units on Aging and Area Agencies on Aging in Arizona, Florida, Hawaii, Indiana, Iowa, Kentucky, and Ohio assessed client satisfaction with transportation services provided through AoA-funded programs. A total of 941 interviews were conducted. Initial tabulations showed that

- older consumers are, in general, highly satisfied with the AoA-funded transportation services they have received,
- while about half of those interviewed use these services for just a few of their trips, one-fifth of the respondents used the services for nearly all of their trips,
- on average, riders of these services make about six trips per month on these services, primarily for medical purposes, for shopping, and trips to senior centers,
- the most frequent recommendation for transportation service improvements, reported by half of the respondents, was to increase the hours of service, and
- 60 percent of the riders reported that they traveled more now than before they had access to these AoA-sponsored transportation services.

Seniors in these seven states were asked how their lives had changed since they started using AoA-sponsored transportation services. Their responses included the following:

> For many of us it is indeed a blessing to have bus services provided for us. I don't feel like a shut-in anymore. I gives me the freedom and liberty of being able to come and go and do for myself, while I'm able to. We pray that this transportation service will continue on.
>
> I feel very independent not bothering any of my family for transportation.
>
> I am still alive — I would be dead without this service.
>
> Life has been better for me because I don't drive and [now] I can volunteer at the Medical Hospital. By helping others I'm helping myself.
>
> Good to get out, and if the service was not available, I would not be able to get to medical appointments or shopping. I appreciate this service very much.
>
> Quality of life is better. Made new friends — got to go places and to things and enjoy life. Thank you!
>
> I depend on your bus, now that my husband went to heaven, and I don't drive. Most people my age group (97) need this. When my husband left, I wondered how was I going to get around. I need not have worried — our county is taking good care of us.
>
> I am so thankful and happy that I have found this services. It has really changed my life entirely cause I don't drive and I don't have to depend on my family. I don't know what I would have done without your service. I know that God loves those who help themselves.

My life has greatly changed because of this wonderful service. I depend my life on this service. I don't drive like I used to anymore because of my age and my eyesight. So this transportation service really, really gets me to feel whole and complete again.

A sense of dignity that you are able to secure transportation for your basic or urgent needs.

It helps me keep my functions and independent living style.

The transportation program has plenty to do with my well-being. It surely made my life richer and happier.

This is what keeps me out of that nursing home.

It's like letting a bird out of a cage.

EXAMPLES OF HIGH-QUALITY TRANSPORTATION SERVICES

An impressive number of rural communities have created innovative transportation services that provide significant benefits to older residents. A small sample of these services are described below.

BIG STONE GAP, VIRGINIA

Since 1974, Mountain Empire Older Citizens (MEOC) has provided Area Agency on Aging transportation and general public transportation to the City of Norton (population 4,427) and the counties of Lee, Wise and Scott in Southwestern Virginia. The service area is rural and mountainous, with a population of just over 90,000, 15 percent of which are over the age of 65. For many years, coal mining was the dominant industry in this part of the State. The long-term effects of coal-mining and coal dust exposure are evident in the frail nature of the elderly population in this area, and it is no coincidence that a regional cancer treatment facility recently chose the City of Norton for its location.

In addition to general public transit, MEOC provides a variety of services tailored to the individual requirements of anyone in their service area. Able-bodied persons without cars can get

a ride wherever they need to go, using the general public demand-responsive system. Persons requesting a higher level of service meet with caseworkers, who determine the level of need and report back to MEOC. For example, persons who are determined to be too frail to ride a bus for several hours are eligible for the MEOC "One on One" service. For this service, a driver picks up one client, takes him or her to their appointment, waits for them to finish, takes them to the pharmacy (if necessary) and then takes them home. In some situations, a driver will pick up a blank check and a shopping list from a client, and do that person's grocery shopping for them. In other cases, drivers will actually move a client in a MEOC vehicle, packing all of their belongings and transporting them to an elderly care facility or apartment. Mountain Empire Older Citizens prides itself on making extra efforts to meet the needs of the elderly clients in their service area. If a caseworker identifies a need, MEOC will meet it.

PENNSYLVANIA'S TRANSIT PROGRAMS FOR SENIORS

Pennsylvania pays for two special transportation programs for older citizens: the Free Transit Program for Senior Citizens and the Shared-Ride Program for Senior Citizens. Established in 1973 and 1980, respectively, both programs are funded through the Pennsylvania State Lottery. Together, these two programs fund transportation for older persons in all of the state's 67 counties using public transportation systems. The lottery-funded programs involve substantial coordination between the state Departments of Transportation and of Aging, seven other state agencies, local governments, and local public transportation operators. Other state agencies work closely with the Pennsylvania Department of Transportation (PennDOT) and local public transit providers to minimize duplication and overlap and to maximize cost-effectiveness of specialized transportation services.

Through the Free Transit Program for Senior Citizens (primarily for urban areas), persons 65 years of age and older can ride free on local fixed-route bus, trolley, commuter rail, and subway elevated systems during off-peak hours on weekdays and all day on weekends and on designated holidays. There are no trip purpose restrictions.

The Shared-Ride program is a paratransit program providing substantial assistance in rural areas. Persons 65 and above must register with the shared-ride transit operator to use the Shared-

Ride program. Trips must be reserved at least one day in advance. Anyone using this service must be willing to share the vehicle with other passengers. Door-to-door service is usually available. Riders generally pay 15 percent of the fares charged to the general public. Some local Area Agencies on Aging will pay the rider's portion of the paratransit fare. There are no restrictions on trip purpose or time of day of travel during regular system service hours.

Older riders have reported substantial economic benefits; in addition to saving the costs of the fares, older ridersreported being more able to shop around and take advantage of lower-priced goods and services. The Free Transit Program increased mobility and decreased dependency on friends and families for rides. Human service programs with elderly clients have also benefited from lower transportation costs.

CENTRAL VIRGINIA

Based in Charlottesville, Virginia, JAUNT is a nonprofit public service corporation that provides rural public transportation, complementary ADA paratransit service, and consolidated human services transportation for central Virginia. JAUNT has become the coordinator of both public transportation and human services transportation by actively seeking contracts to provide human services transport. Almost one-half of JAUNT's riders are 65 years of age and older. A key factor in the success of the venture has been that the local transportation planning agency has a written policy stipulating that human service agencies are to coordinate transportation services with JAUNT. The planning agency oversees implementation of this requirement through the metropolitan planning review process. JAUNT's coordination has resulted in service expansions to geographic areas and consumers not served previously, more service options, fewer limits on trips purposes and destinations, and lower trip costs for consumers.

SWEETWATER COUNTY, WYOMING

The Sweetwater County Transit Authority (STAR) serves a very large and sparsely populated rural county. Initiated in 1989, STAR replaced a large number of client-based, agency-operated transportation services with a single coordinated demand-responsive public transit system. STAR

substantially reduced per trip costs for agencies and increased the number of trips provided, while also extending service hours and boundaries, creating new services where none had existed, and providing rides for members of the general public. This system's features include providing one-stop transportation shopping for riders, emphasizing data collection and technology, and offering high quality, dependable service. The system's primary economic benefit, at about $720,000 per year, has been enabling local elderly residents to continue living independently in their own homes instead of moving to nursing homes.

GREAT FALLS, MONTANA

Great Falls Transit District provides an interesting example of a multi-faceted marketing program that pays special attention to older riders. The system directly operated fixed-route and demand-response service (via contract with Diamond Cab) within the Transit District service boundaries. Service is provided between 5:15am and 7:15pm Monday through Friday, and 9:00am to 6:30pm on Saturdays.

The State of Montana has the fourth fastest-growing senior population in the United States, with an annual 23 percent increase in the State's elderly population. In response to this dramatic increase, the State Legislature recently passed a bill requiring the State Department of Health and Human Services to report annually on the aging population. Cascade County, which contains the City of Great Falls and the entire Great Falls Transit District, has a population of over 78,000 (according to 1999 Census estimates) of which 14 percent are over the age of 65.

Elderly persons do not automatically qualify to ride the Great Falls paratransit system. They must fill out an application, have a doctor verify their disability, and complete an interview with the GFTD staff. Because of these restrictions, many seniors ride the regular fixed route service. Great Falls Transit District officials estimate that between 11% and 15% of their fixed-route riders are over the age of 65. Because the maximum length of the GFTD fixed routes is only 30 minutes, it may actually be easier for some older persons to ride the bus, rather than using the dial-a-ride service.

In order to assist elderly persons with riding fixed route service, Great Falls has several programs in place. GFTD officials will bring a bus to Senior Centers and retirement facilities, and

demonstrate how easy it is for them to ride. They will take large groups of seniors on trips with a group leader, helping them to overcome any fears or apprehensions. They have also made their route maps easier to understand, added an indoor transfer station, and made improvements in their bus shelters. In addition, drivers have received extra training in assisting elderly passengers. All of this effort adds up to massive cost-reduction for GFTD, as every elderly fixed route passenger saves the system $15.00 in paratransit costs. With an estimated annual elderly ridership of over 50,000, that amounts to well over $500,000 in annual cost-reduction.

Great Falls officials point to extensive community involvement as the key component of their success. They have worked closely with local civic and social groups, kept in close contact with local political officials, attended numerous neighborhood council meetings, and spent a lot of days visiting nursing homes and retirement centers. Instead of responding to new housing developments and projects, Great Falls is involved from the inception, and has time to plan accordingly. Instead of waiting for people to express needs, Great Falls actively seeks them out and asks them. This proactive approach has helped them integrate themselves in every aspect of community transportation.

THE INDEPENDENT TRANSPORTATION NETWORK — PORTLAND, MAINE

Several transportation operations have attempted to broadly address the special transportation needs of certain segments of the older population. One service that has been more ambitious than most in addressing customer-oriented issues of acceptability, accessibility, adaptability, affordability, and availability by offering a new service alternative is the Independent Transportation Network in Portland, Maine.

The Independent Transportation Network (ITN) is a non-profit organization that uses on-demand automobiles to provide customer-oriented transportation for older persons. Trips are also provided for visually impaired persons. Services are available 24 hours a day, 7 days a week, 365 days a year with no restrictions on trip purpose. There are no income or other restrictions on who can receive service. Among this program's innovations are the following features:

- Services are demand-responsive, from any origin to any destination, for any purpose, within the service area. Door-to-door service is standard; door-through-door service and hands-on assistance are provided as needed.

- Fares charged vary according to the level of responsiveness. Customers become "members" of the ITN, and pay into their own account. Customers are encouraged to call 24 hours in advance and share rides with others; in such cases, they pay low fares. Single-occupant trips on short notice require premium fares. The system intends to achieve financial viability through a combination of fares and donations, not dependent on public subsidies.

- A variety of innovative payment plans are in place or proposed, including trip cost sharing by merchants and professionals visited by the riders and an auto trade-in program, whereby program participants can donate their cars to the program in exchange for trips equal to the total value of the car. Gift programs, through which children and others can provide rides for older persons, are widely promoted. Transportation credits for volunteer services can also be obtained.

- The system relies heavily on volunteers for drivers and other positions. ITN uses a "100 Famous Persons" volunteer program as a means of attracting volunteers and publicizing the program. Corporate sponsorships and community donations are actively sought.

- Close attention is paid to the expressed needs of the riders. Riders are involved in a variety of research programs that test and evaluate service components. The system emphasizes the dignity and desires of the participants.

- The system pays rigorous attention to cost-saving measures.

- The service is highly data-oriented, with files on each individual participant, their travel needs, and their account status. The system is moving to implement automated dispatching software.

- Community leaders are encouraged to participate on the ITN Board of Directors, both to guide the system and promote its value to the community. A Board of Advisors includes national experts in transportation and other services.

- Pilot replication sites are under consideration in Arizona and Texas.

While this service is still in its experimental phase, its ridership growth is significant. It has been consciously configured as a service to meet the travel needs and desires of seniors that are not being met by other services.

AN INTRIGUING NEW SERVICE MODEL

A concept that originated in Sweden but is now applied much more widely is that of the **family of services**. This recognizes that there is no single solution to the mobility of a whole population. For example, services that provide for larger sectors of the population can provide wider coverage, higher frequency and lower cost, but will not be usable by some groups. Services that become more specialized to meet the needs of small groups will be less flexible to use and more expensive to supply.

The full range of options appears likely to consist of accessible fixed route public transport (for example, low floor transit buses) for those who can reach bus stops; customized service routes for people who need a little more care than public transport can provide, and who do not need a very frequent service; subsidized taxis for people who need transport door to door, but do not need specialized care during the journey; dial-a-ride for the most severely disabled people who need considerable assistance or care; and subsidized private automobiles for those disabled people who are physically able to drive and who live far from public transport services or who are able to work if they have an automobile available.

CONSIDERATIONS FOR THE SPECIAL COMMITTEE ON AGING

Despite substantial progress in recent decades, one still has to conclude that living in rural America makes it harder to meet transportation needs, especially for older persons. Long-distance medical trips for dialysis and chemotherapy are crucial needs for older Americans in rural areas, but even local travel for shopping, routine health care, and other activities of daily living can be difficult to accomplish for some elderly persons.

There are a number of ways in which the U. S. Congress could measurably improve transportation services in rural areas and thus promote healthy aging. These include the following:

1. **Make transportation services a priority issue.** The pace of change in transportation services is often dismally slow, but the "age wave" of very large numbers of older adults will be upon us very soon. Improved transportation options for all of us as we age should be made a key Congressional priority. With safe mobility, for life, our entire society benefits.

2. **Support innovation and associated data.** Much good work is being done around the country but is often poorly reported. Funding innovative services and disseminating key data about them should receive increased energy and attention.

3. **Supporting full and enhanced funding of existing programs.** This is particularly important for FTA's Section 5311 rural transportation efforts and AoA's Title III transportation programs.

4. **Simplify grant procedures and reporting requirements.** Many rural transportation efforts receive funding from multiple Federal sources, but these sources often require unique, cumbersome, and expensive procedures. Administrative simplification would create great benefits for rural transportation services.

5. **Change the transportation provisions of the Medicare legislation.** Allowing Medicare funding for non-emergency trips would allow a much more rational allocation of resources within this important program. At the moment, Medicare transportation is restricted by law to emergency services by ambulance transportation only, yet many serious health care needs, such as dialysis, do not require Basic Life Support or Advanced Life Support services requiring skilled medical professionals and ambulance transportation. Congress should take up this matter as a key means of promoting cost-effective solutions to increased health in rural America.

CONCLUSION

The concept of "safe mobility, for life" needs much greater emphasis. One of the most significant findings of this study is the nearly universal lack of planning — by those now elderly or those of us who hope to be older one day — concerning travel options once driving is no longer viable. Several generations ago, few people planned to retire from work, and now many people can look forward to 25 years of active life after their careers. We need to educate people to consider how they will get around if and when they don't drive, and to encourage that financial and residential decisions be made with mobility issues in mind. The counterpart of such planning, of course, is that

our society also must recognize a social responsibility to ensure that mobility options are available when and where needed.

The very real losses that can result when mobility is reduced to minimal levels need to be addressed by society. Elders who have been accustomed to high levels of mobility may experience the most profound losses if they become unable to drive. Therefore, some of them continue to drive beyond that time when it is safe or wise for them to do so. Adequately serving both older drivers and society as a whole requires a premise of empowerment that encourages appropriate personal decision making regarding driving safely and using other choices when necessary.

Our society is not yet prepared for the increased numbers and proportions of elderly travelers expected in the future. Additional public and private sector responses will be necessary to provide for the safe mobility of all our citizens, including new kinds of vehicles, new designs for roadways, and new forms of transportation services. The costs of not responding to these challenges will include the increasing isolation of our oldest citizens and the loss of their potential contributions to our society — and may include avoidable traffic injuries and fatalities. We need to understand that the mobility needs of senior citizens are vital to all of us, whether we are now elderly or expecting to get there.

Successful programs for healthy aging will be those that provide not only rides, but also a sense of security, independence, and dignity. They will provide mobility and will also address the satisfactions that seniors now receive from cars in addition to transportation, including perceptions of pride and ownership. They will change the limited and restricting perception that "If you can't drive, you can't go."

We need to start making mobility improvements **now**. We need a combination of individual responsibility and social responsibility to adequately address the concept of **safe mobility, for life**.

The CHAIRMAN. Jon, thank you very much.

We are going to allow questioning of Jon now, so that he can have the flexibility of leaving before we go on with our panelists. But first, another one of our committee members has joined us, Senator Carnahan, so let me turn to her at this moment for any opening comments she would like to make before we start the questioning of Jon.

Thank you.

STATEMENT OF SENATOR JEAN CARNAHAN

Senator CARNAHAN. Thank you, Mr. Chairman.

I am pleased to be here as a new member of this committee and look forward to working with the committee to address issues that affect seniors in Missouri and across the country.

From personal experience, I am happy to say that of all my committee assignments, aging is the subject I know the most about.

Mr. Chairman, the demographics of the United States are changing. We are an aging population. My home State of Missouri has the 14th-largest population of senior citizens. We are experiencing the effects of this change. The growth of Missouri's 60-and-over population now outpaces all other age categories. This group is expected to exceed 20 percent of Missouri's total population by the end of the decade. Even more rapid growth is expected in the 85-and-over age group. By the year 2020, this group will comprise more than 2 percent of the State's population.

When looking at public policy, though, statistics are helpful, but they do not tell the whole story. Behind the statistics are real people with real concerns about the future—seniors who suffer from chronic illnesses without access to reliable and affordable health care; seniors on fixed incomes who struggle with the escalating cost of prescription drugs; adults who worry what the future holds for an aging parent who can no longer live independently.

I believe these concerns affect us all, as they did me during the 8 years that I cared for my father, who was asthmatic and diabetic and lived in our home during that time. So it is from that perspective that I will be approaching my work on this committee.

As policymakers, we have a responsibility to ask ourselves whether our social infrastructure is prepared to meet the demands on the horizon. There are two fundamental questions. First, how can people maintain quality of life as they age, and second, how can the Federal Government most effectively help seniors achieve that quality of life? We cannot answer the second question without keeping the larger context of the Federal budget in mind.

Decisions that we will make this year about taxes and the budget could affect our ability to support our senior citizens 5 years or 10 years or even 30 years down the road.

As a member of this committee, I intend to examine these questions closely. I have a particular interest in exploring how we can help seniors stay in their own homes and communities as they get older.

The challenges that seniors face with aging in place are multiplied for those in rural areas. One critical issue in rural areas is adequate transportation so that seniors can live independently, be

able to travel to the grocery store or to the doctor's office or to the community center or to church.

In Missouri, we have two programs that provide door-to-door van service. The vans are very helpful to many of our seniors. However, some of Missouri's area agencies on aging are reporting a decrease in the use of these vans. There is a demand for more individualized service, particularly among seniors in rural areas who are frail or have a disability. For these seniors, it can be difficult to sit in a van for a long period of time as the driver picks up other people in neighboring small towns, towns that could be as much as an hour away. The time that it takes a driver to pick up several passengers, deliver them to doctors' appointments and return them to their homes is just simply too long for some seniors.

However, individualized service is expensive. The area agencies on aging have been relying on volunteers to assist with the driving. But with the rising cost of gasoline, they have lost most of the volunteers.

The transportation example illustrates just one of the challenges for rural seniors in Missouri. It underscores the importance of revising our understanding of the needs of today's seniors. Once we have explored the issues, we can adjust our public policy accordingly.

I applaud Chairman Craig for holding these hearings, and I am optimistic that our panel today will educate us and guide us as we develop a policy that meets the needs of our seniors in rural Missouri and throughout the Nation.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Carnahan, thank you.

I have watched my wife's parents care for their aging parents—and I think any of us who have done that bring a unique perspective to this committee, and I thank you for that contribution.

Let me turn now to our ranking member on the committee, John Breaux of Louisiana. I think we have a vote starting in 3 or 4 minutes, John, so you can proceed with your opening comments, and then, Senator Lincoln has joined us. The moment the vote starts, I will step out, run and vote, so that we keep the committee functioning.

Please proceed, John, and I will turn it over to you at this time.

STATEMENT OF SENATOR JOHN B. BREAUX

Senator BREAUX. Thank you, Mr. Chairman.

We all welcome you as our new chairman. We sort of traded in the old chairman for a new chairman who is a little younger, and we look forward to having you at the leadership of our committee. I think we start with a very important panel, talking about aging particularly in rural America.

I think all of us on this committee share the common goal of not only helping people extend their lives and live longer but also, an equally important goal is to allow people to live better, not just longer. All the issues that we will be discussing are really very important in ensuring that people live a better quality of life and not just a longer life. So we are delighted and look forward to working with you on a number of other issues throughout the year that will

make a major contribution toward our aging population which is so important to this country.

So I look forward to working with you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Breaux.

Now, let me turn to Senator Lincoln.

Blanche.

STATEMENT OF SENATOR BLANCHE L. LINCOLN

Senator LINCOLN. I too, Mr. Chairman, want to congratulate you on your new role as our committee chairman.

These are exciting and challenging times for us as we attend to the care needs of our seniors in this Nation, and I look forward to working with you on these matters that are very near and dear to my heart. As many have expressed here, caregiving is also a very real experience that I am going through with my family as well.

Arkansas ranks fifth-highest for its population of 55-plus seniors and first for the number of seniors living in poverty. And although we do have the Donald W. Reynolds Center on Aging, which has been a wonderful tool for us in Arkansas, out of 125 medical schools in this country, we only have three that offer a residency program in geriatrics. I do not know about you, but that tends to make me a little paranoid about how ill-prepared we are in this Nation for the increasing number of seniors who will come in with the baby boomers.

Although we have the center, and it has been a great advantage to us in Arkansas, I would also be delinquent in my duties if I did not acknowledge the tireless efforts of our most fierce trailblazers, the State's Area Agencies on Aging. We have a very dynamic director in the State of Arkansas. His name is Herb Sanderson and he, along with all of the county directors, is really clearing the way for some truly outstanding services for the seniors of Arkansas. I have thoroughly enjoyed my working relationship with Herb, and he brings a great deal to this job.

Thinking out of the box is second nature for these State directors, as they are charged with creating aging programs that attend to the very basic needs of one of our most precious populations. Oftentimes, in rural States like Arkansas, they really do have to be creative.

I believe that if there were a message to take from this hearing today, it would be that in spite of the great challenges that face rural States, they remain our most fierce trailblazers when it comes to the development of creative care delivery systems. I hope that we can all talk about that; as we look forward to the testimony.

In addition, given the magnitude and volume of challenges that are facing Congress, I believe that a balanced approach for Government would be to continue our support for the creative programming that the States have initiated while the Federal debate continues.

I really look forward to your testimony here today, and thank you all for participating in this discussion and certainly the opportunity to share some of Arkansas' struggles as well as their successes. As Senator Breaux mentions we are striving—not just to

provide a longer life to our seniors, but a quality of life for them in their own homes and in their own communities.

Thank you, Mr. Chairman.

The CHAIRMAN. Blanche, thank you.

Now let us turn to our first witness, who has already given his testimony in the area of transportation.

Jon, I suspect my greatest sense of freedom came the day that I got my driver's license. And out in rural Idaho, uniquely, that came at 12 years of age, because I lived out on a rural ranch, and the sheriff gave a special permit to let us kids drive—especially when you had to drive 27 miles one way to school. That is just the way it was.

At the same time, about 10 years ago, I was forced into the very difficult situation, because of a close relationship with an elderly aunt, where no one wanted to tell her that she should not drive anymore. After three or four crashes, I was the one chosen to tell her that she should not and could not. I can remember the look on her face and the discussion we had. She was worried about her freedom, her access—how would she do this, how would she do that?

So your testimony today is most appropriate, and that is one of the greatest hurdles if our citizens want to continue to live in rural America where they would like to live, where oftentimes their life style is much more acceptable to them than having to migrate toward urbanism, where they had never lived before.

In your testimony, you have cited a variety of programs, and you have highlighted a couple of them and mentioned one that I believe you said was not being cost-effective in the area of Medicare in general. Now can you be specific and give us some examples of your concerns and your suggestions as to how those might be improved in those program areas.

Mr. BURKHARDT. Thank you, Senator Craig.

I am concerned that under Medicare provisions, the only transportation authorized by law is by ambulance. This is for emergency situations. We know from an Inspector General's report from HHS that this is not exactly what is happening in the world these days. A very large concern is rural elderly persons who need dialysis treatment. Clearly, if you do not get many dialysis treatments, you will die. So that is a critical medical condition, but it generally does not fall under what is considered emergency transportation, and it does not require advanced life support, and it does not require basic life support services that are provided by ambulances.

These trips to and from dialysis could be provided much more cost-effectively by the kinds of rural public transportation services and services from area agencies on aging that exist now. This is not currently permitted under Medicare legislation, but we know that it exists. I would encourage the committee to encourage the Health Care Financing Administration to come up with a much more comprehensive transportation policy; for them to do that, it will require a change in the law.

The CHAIRMAN. You had mentioned the area of planning, and your testimony acknowledges that there seems to be a lack of planning in the area of transportation services for the elderly. I too am astounded by statistics in aging and where we are going to be 20,

30, 50 years out. There was a gentleman in my office the other day whose name I do not recall, but he is a renowned geriatrics doctor in New York who has an aging clinic, and he said that at the end of this century, and that seems to be plenty of time to plan, but usually is not—we are going to have 5 million centenarians. That is a bit mind-boggling for all of us, and as we bring about these new health care applications that make our lives better and extend that life, obviously, what you are talking about is very clear. You mentioned a few number of accidents on roads and deaths that might be caused by elderly people less capable of driving.

What kind of planning do you envision as it relates to communities and to the programs?

Mr. BURKHARDT. I envision planning that would focus on access and mobility. When we interview older persons about driving, they say two words to us—freedom and independence. These are both very cherished American values.

I would like to believe that the automobile is not the only way to achieve mobility and independence, but in fact in many communities that is true today. You have the operator of a very successful service in Iowa saying, "I hope I never have to depend on my own service." Now, he is doing well, but what he is saying is that these services are often 9 a.m. to 5 p.m., Monday through Friday; they do not let you go to a movie; they do not get you to visit your wife in the nursing home on Christmas Day; they do not provide lots of really critical transportation services. And then, some people who really need these services drive when they should not. By having more choices, I believe we could improve the safety and health and well-being of rural Americans by a substantial amount.

The CHAIRMAN. Jon, thank you.

Let me now turn to my colleague, Senator Breaux.

Senator BREAUX. Have the other panelists testified yet?

The CHAIRMAN. No, they have not, but Jon has a transportation problem, so we are going to question him and then move to the rest of the panel and then to questions and follow-up.

Senator BREAUX. I was just looking over the testimony, Mr. Burkhardt, and I find it very interesting because you know, a lot of times, we spend a great deal of effort trying to provide better facilities, but we never follow up to find out how you get from one place to another. I think your testimony has been very helpful in having us look into the whole question of transportation from one facility to the next. It is a real challenge.

I know there will be more and more older people driving, which creates safety problems. I am a big believer in one being able to drive as long as he or she is capable of doing so. Let us test them and make sure they are capable, but not have an arbitrary cutoff date. So you raise some really interesting points that I think will allow us to focus in on transportation problems, which we really have not done a lot of as far as this committee is concerned.

Senator Lincoln, do you have questions or comments?

Senator LINCOLN. Yes, just briefly. We are preparing in Arkansas for a forum that we have entitled, "Caring Across the Continuum," to look at all of the needs of seniors. We plan to address service delivery and barriers to access. Transportation has been a huge

factor for some of our most frail seniors in areas like the delta which is one of the highest poverty areas in the Nation.

Can you address any creative ways that you have seen through public-private partnerships helping with rural transportation needs? Is there anything specific there that comes to mind?

Mr. BURKHARDT. I think there are a number of solutions that would lend themselves to the area that you are speaking of. One of the best approaches is to look at transportation services that serve everybody, that serve welfare-to-work clients, that serve older people, that serve the general public, that serve kids getting home after basketball practice—all very, very different kinds of clientele. The funds are put together in a coordinated way so that no one agency is responsible for all of the resources, and they operate cooperatively. Sometimes it is what we call a "brokerage," where there is a central information number to call and then, perhaps, they will assign the trip to a taxi company or perhaps to an Area Agency on Aging or to a developmental disability program or to a public transportation provider. A brokerage often works very, very well.

We should include car-pooling and van-pooling, we should include volunteer services, and we should caste as broad a net as possible to solve these problems.

Senator LINCOLN. Most of the solutions that you have mentioned are public agencies or something under public auspices, other than taxi services. Do you see any private entities playing a role in that, or have you seen anything that stands out?

Mr. BURKHARDT. We have seen some wonderful efforts by corporations like FedEx to get their employees to work, and a number of other large corporations have also been involved. I think we want to reach out to private enterprise, but one of the important points about planning is to have a focal point, and in particular one point of access, especially for older persons, but let us say an 800 number that you can call. So it does not really matter what color the van in which you ride is, and it does not matter so much what it says on the side; what matters is that you get a ride.

This is what is called the new paradigm in freight transportation—the U.S. Postal Service buying services from FedEx, FedEx shipping packages on UPS airplanes, and so on. We need to look at this kind of approach for rural public transportation.

Senator LINCOLN. Thank you. I appreciate your comments.

Senator Breaux [presiding.] Senator Carnahan.

Senator CARNAHAN. Yes, clearly, access to transportation is a major concern in our rural areas. In your testimony, you have listed several ways that you think Congress could improve transportation in the rural areas, including the sharing of information on best practices.

Is there a clearinghouse for best practices that would be available to people?

Mr. BURKHARDT. The real focal point at the moment is the Coordinating Council on Access and Mobility, which is jointly staffed by the U.S. Department of Transportation and the U.S. Department of Health and Human Services.

I will tell you that this is a voluntary effort, and it would help that Council if its status were elevated and if it had some more

funding. At the moment, it does not have a telephone number that you can call, and it does not have stationery. It does have a web page.

Also, I would like to point out the Rural Transportation Assistance Project from the Federal Transit Administration and the Community Transportation Assistance Project from the Department of Health and Human Services. They are both staffed by the Community Transportation Association of America, and they have a large amount of information available.

Senator CARNAHAN. Thank you.

Senator BREAUX. Mr. Burkhardt, we will excuse you. If you commuted in from Rockville this morning on 270, you understand what transportation problems are all about. [Laughter.]

Thank you for your testimony.

Mr. BURKHARDT. Thank you, Senator Breaux. I appreciate the committee's assistance in my travel problems.

Senator BREAUX. We will now take testimony from our other distinguished panelists, and we will start with Ms. Hilda Heady.

Ms. Heady, we are pleased to have you before the committee.

STATEMENT OF HILDA HEADY, EXECUTIVE DIRECTOR, WEST VIRGINIA RURAL HEALTH EDUCATION PARTNERSHIPS, MORGANTOWN, WV, ON BEHALF OF THE NATIONAL RURAL HEALTH ASSOCIATION

Ms. HEADY. Thank you, Senator.

I am also pleased to be here. I appreciate the committee's invitation to testify. I am representing the National Rural Health Association as a member of their policy board. I am also the Executive Director of a State-funded program in West Virginia where we require all of our health professions students to train in rural communities for at least 3 months before we let them out of the State with their degree. Early on we had some resistance to the requirement but most students come out of it much wiser and much happier.

We have a lot of exciting opportunities and challenges, as you know, in rural America. West Virginia achieved the distinction last year of becoming the oldest State in the Nation. We got older than Florida. We are using our own rural values around collaboration and partnerships to try to deal with some of these issues, but we expect in the next 10 years in our own State that one out of every four people will be over the age of 65.

The congressional fixes that have been instituted to the Balanced Budget Act present hope for us, but one of the greatest impacts which represents our short-term challenge, is in the area of home health. We have had 24 agencies close and a 48 percent drop in the number of home health visits. That presents challenges to our local communities with existing providers and their need to collaborate and to develop other stopgap measures.

One example that I want to use is the system of free clinics that we have in our State. We have nine free clinics that provide $13 million worth of free drugs to elderly who are on Medicare and do not have a prescription benefit. So we know that we have a number of rural elderly who could use a prescription drug benefit in Medicare.

There are other examples of collaborations and partnerships in our State and in others that I would like to highlight. These are also included in my written testimony. In West Virginia we have a program called Aging Well in Calhoun County. There are 8,000 people in that county, and the program was started by a group of people who wanted to volunteer to transport elderly clients to health care facilities both in and out of the State; but before they started that program, they knew that they needed to be trained in how to care for the elderly and deal with circumstances if they came up during transportation.

Another program is the Integrated Health and Service Council of Ritchie County, that has the senior citizens' program, the nutrition site, and a child day care center in the same facility with an adult day care center. I was there last week with an Alzheimer's patient and two other seniors, playing dominoes, and one of the elders was 101-year-old Nellie. Her 55-year-old grandson had taken her to the doctor that morning, and she was telling me stories about living in her trailer on her grandson's buffalo farm.

One of the exciting opportunities I have is working with students when they are out on rural rotation, working with the elderly and learning skills to work with this population. Our program last year served 185,000 rural citizens. We had medical students, nursing students, a variety of students, working with that many people in health promotion activities.

Another program that I would like to mention is the Partnership for Rural Elderly in Dahlonega, GA. This is a collaborative of a number of different health and social service agencies, and all of these programs have the objective of trying to keep the elderly healthy and in their home communities.

One of the prime examples that we have in the Federal Government for the elderly that do require this type of collaboration and use of local resources is through the Federal Office of Rural Health Policy and their Rural Outreach Grants. It is one of the most flexible funding streams and allows communities to innovate as much as possible to be creative to meet their challenges.

I would also like to bring up a topic that we rarely see when we talk about the aging or even in rural health circles, and that is the problems we are seeing with the aging rural veteran. I am a member of a support group, the Significant Others Support Group of Vietnam Wives, at our Vietnam Readjustment Center in Morgantown, WV. That center serves 18 counties in West Virginia and Southern Pennsylvania, and more than 50 percent of the people who come to the center come from rural areas.

One thing we do know—Vietnam was always called "the war that was fought from Harlem to the hollows"—so we do know that we have a disproportionate share of aging veterans who are poor and that a significant number of them are rural.

In preparing my testimony, I called all the veteran outreach centers in the States of Iowa, Idaho, Louisiana, and West Virginia, and every one of them reported that anywhere from one-third to two-thirds of their clients come from rural areas.

We also know that 50 percent of all veterans who get services from the Veterans' Administration get them from these outreach centers. They are concerned about long-term care, particularly for

the World War II veteran. Every center needs a family therapist, because there currently is not one in the Veterans' Administration to staff them.

Among the things that the Federal Government can do at this point are to look seriously at the prescription benefit for all Medicare recipients; improve home health care and community-based services; develop more funding streams for partnerships with States to train health professionals in rural areas that focus on rural content for the rural elderly; fund a national study on the aging veteran—the last time we looked at this population was in 1988; and provide increased funding for transportation.

Thank you so much for your time and your attention. I want to let you know that the National Rural Health Association is very ready to work with you.

Thank you.

The CHAIRMAN. Thank you very much.

Mr. Sykes.

[The prepared statement of Ms. Heady follows:]

Testimony of

THE NATIONAL RURAL HEALTH ASSOCIATION

Hearing on

Healthy Aging in Rural America

Senate Special Committee on Aging

U.S. Senate

Thursday, March 29, 2001

Good morning. My name is Hilda Heady and I am Executive Director of the West Virginia Rural Health Education Partnerships. I am here today representing the National Rural Health Association (NRHA). I want to thank Chairman Craig, Ranking Member Breaux and the members of the Special Committee on Aging for the opportunity to testify before you on the topic of healthy aging in rural America.

My remarks will focus on access to health care for the elderly in rural communities. I will comment on both success stories, as well as areas in which the Federal government can become partners in our efforts to improve both access and quality for rural elderly.

The NRHA is a national nonprofit membership organization that provides leadership on rural health issues. Through discussion and exploration, the NRHA works to create a clear national understanding of rural health care, its needs, and effective ways to meet them. The association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research.

The NRHA membership is made up of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health. Individual members come from all disciplines and include hospital and rural health clinic administrators, physicians, nurses, dentists, non-physician providers, health planners, researchers and educators. Organization and supporting members include hospitals, community and migrant health centers, state health departments, state offices of rural health and university programs.

It has been widely noted that the U.S. population is aging, with 77 million baby-boomers poised to enter the Medicare system in the coming years. The rural population of our nation is aging more rapidly because of elderly people aging in place, younger residents leaving rural areas for metro areas and elderly citizens returning home to rural communities as they age. There are approximately 9.2 million people in rural America aged 65 and older. Rural elderly are less likely to have a high school education and more likely to be poor. Because rural residents tend to have lower lifetime incomes than their metropolitan counterparts, their Social Security benefits are subsequently less in many cases.

As you are well aware, rural areas are unique. They differ from urban areas in their geography, population mix and density, economics, lifestyle, values and social organization. Rural areas are viewed as vulnerable to reduced access to health care for a variety of reasons. These reasons include limited numbers of providers, poorly developed health care systems, high prevalence rates of chronic illness and disability, socioeconomic hardships, and geographic and transportation issues.

Rural areas also differ from urban areas in the way that health care services are delivered to residents. Small, rural hospitals, in addition to being the only source of emergency care, are often a community's only resource for health care services such as long-term care, home health services, and outpatient services. Rural residents tend to have access to a narrower and more costly range of health care services and to be served by fewer health care providers. Rural people and communities require programs appropriate to their individual characteristics and needs and often utilize innovative and creative collaborations to meet their health care needs.

General Needs of the Rural Elderly

The major issues for the rural elderly are access to health and other services, housing, and transportation (not only for health care services but for needs of daily living such as shopping, recreation, etc.) My home state, West Virginia, has become the oldest country in the nation. One of our fastest growing segments of the population is women over the age of 85. These elderly women cannot maintain their homes so housing and a safe household environment become critical. Younger people migrate from rural areas leaving their elderly relatives on their own to try to maintain the homestead.

Telemedicine

One of the recent innovations seen in rural communities is the increased use of telemedicine, or care provided remotely via telecommications equipment from a specialist at an urban center. Last year's Medicare, Medicaid & S-CHIP Benefits Improvement and Protection Act (BIPA) allowed Medicare reimbursement for telemedicine at the same rate that would be reimbursed for in-person provision of services. This change makes telemedicine a more viable option for seniors living in rural areas. However, it remains to be seen how effective telemedicine will be

and how it will impact access in rural areas. Telemedicine should be seen as a part of an access solution, but it does not negate the need for a viable rural health care infrastructure. Telemedicine and telehealth approaches can provide much needed linkages services for rural facilities and providers; however, the training on the use of this technology for health providers and students is essential to ensure the use of this technology in the future.

Medicare

Because the elderly make up a larger proportion of the rural population, Medicare assumes a greater role as a source of financing for health care in rural areas. However, Medicare spends more on urban than rural beneficiaries and in many cases, pays less for the same service provided in a rural as opposed to urban setting. In 1996, Medicare paid an average of $4,400 per beneficiary in rural areas compared to $5,300 in urban areas. Taking into account all of the Medicare rate adjustments, average rural hospital payments are 40% less than urban hospital payments and 30% less for physician payments. Medicare managed care, or Medicare+Choice, has seen slight penetration of rural markets, with 2.45% of rural beneficiaries enrolled in managed care versus 20% of urban beneficiaries enrolled. It is unclear whether Medicare+Choice is a workable solution to the challenge of access to health care in rural areas, as 101 plans pulled out of rural counties last year. Legislation passed during the 106th Congress attempted to solve the problem of Medicare+Choice plan non-renewals by raising payments per beneficiary.

Post-Acute Care

Research has shown that the rural elderly make greater use of home health and skilled nursing services, often substituting such services for care that may otherwise be provided in a hospital inpatient setting. Therefore, rural Medicare beneficiaries have experienced a greater impact from reductions in payment rates for home health care in recent years and are more adversely affected by closures of home health agencies and skilled nursing facilities than their metro counterparts.

A lack of rehabilitation options in rural communities has led rural hospitals to diversify and provide a broader range of services to its patients. In 1982, the swing bed program was implemented to allow rural hospitals to receive payments under Medicare Part B to increase the

availability of rehabilitation services in rural areas. Isolation due to geography or distance and a lack of rural home care or assisted living services creates a problem for rural residents with access to rehabilitation care after a hospital stay. Swing beds allow patients to stay in the hospital beyond the end of their acute care stay and receive the nursing and rehabilitation services they need. Sixty percent of rural hospitals participate in the swing bed program, and 47% of patients are discharged directly home after their swing bed stay.

The precarious nature of the rural health care delivery system has the result of creating instability and insecurity for the rural elderly. The lower Medicare reimbursement rates for rural hospitals mean that these providers are constantly at risk and forced to make hard choices about what services they can afford to provide to beneficiaries. A hospital that eliminates health care services may find that it is unable to keep its doors open, and once a hospital closes, other parts of a community's health care infrastructure are endangered as well. The National Rural Health Association continues to advocate for an equalization of payment rates for rural and urban Medicare beneficiaries, thereby expanding access to health care services for the rural elderly and ensuring that the benefits of health care are available to all Americans, regardless of where they live.

Partnerships and Collaboratives

Partnerships, networks, collaboratives, and other cooperative approaches among rural providers can address some of the fragility of the rural health care landscape and can engage rural consumers in health care and policy development. These approaches have been used extensively to create wellness and health promotion programs for the elderly and other rural populations. The strategies of engagement, equanimity, and empowerment makes sense to rural people for these reflect the rural values of working together for the common good in the face of adversity. Any federal approaches which advocate and support the development of partnerships for rural health education, and for wellness and health promotion should be given serious consideration as a viable mechanism to address the health care problems of the rural elderly.

The Aging Rural Veteran and their Families

We know that a significant number of combat veterans live in rural areas and while the Veterans' Administration supports systems of health care for these veterans, we need to give great consideration to the long term care needs that are growing as this population ages. The need for more readjustment outreach centers and their services for the aging Vietnam era baby boomers is increasing. The average age for this vet is now 53. The 1988 National Vietnam Veteran Readjustment Survey found that 15.2% of male and 8.5% of female Vietnam veterans (approximately 486,500) currently have PTSD. Readjustment Centers around the country are experiencing and increase in the number of vets seeking help for acute on set of PTSD related symptoms as they age. I am a member of a women's group in a local Vet Readjustment Center in West Virginia. In that small group over half the women have reported that their husband's acute episodes of PTSD behaviors have occurred after the age of 50 and are increasing as they age. Adding in all the veterans who suffer from partial PTSD, and recognizing that PTSD by definition is a delayed response, the numbers of veterans with full or partial PTSD in need of help and support could be 1.5 million. Knowing that the character of the disease impacts not only the veteran but also his or her loved ones as well, the number of people now suffering with the impact of PTSD from the Vietnam and other wars is staggering. More research is needed to study the needs of the aging veteran and the impact and relationship of PTSD on domestic violence, child abuse, divorce, suicide, and elder and substance abuse.

Examples of Successful Models and Practices for the Rural Elderly

Programs that promote local innovation and development of local resources, engage the elderly in planning, implementing, and dissemination, and build partnerships among resources and citizens are generally the most successful. Among the most important factors in assuring access to services in rural areas are identification and maximization of existing resources. Local volunteers are a valuable potential resource in every community. With specialized training they can provide nearly every population with basic needs and support services. Such an arrangement benefits both the volunteers and the service recipients and can strengthen the community bonds of both parties.

Volunteers in Calhoun County, West Virginia, prior to providing transportation to services for older people in remote areas, requested education and training in coping with sudden health problems that might occur in the course of a journey. After such education and training they provide the volunteer service on a daily basis. Last week while engaged in a service-learning experience with health professions students in our state, I was fortunate to attend the morning session of the Adult Day Care program of the Integrated Health and Services Council in Ritchie County, West Virginia. One hundred and one year old Nellie was there for the morning and for lunch and shared with me stories about her life in a comfortable trailer on her 55-year-old grandson's buffalo farm. This extended family uses the services of the Adult Day Care program for respite and for social activities for this dear woman.

Many kinds of health-care providers can also be a valuable resource in rural communities but as yet are underutilized. For instance, as patient loads increase and fewer physicians venture into rural practice, pharmacists can serve as a vital link for health information and for education and support of patients. The West Virginia Rural Health Education Partnerships is a collaboration of over 670 individuals across the state. This program trains 10 disciplines of health profession students in rural underserved areas of the state. Our state higher education system requires these students to complete three months of their training in these areas and to engage in service-learning, interdisciplinary case management and community based research while in these rural communities. Last year students completed 1,339 rotations for 6,145 weeks of training and served 185,000 rural residents, many of them elderly, in health promotion and disease prevention activities. This is a state funded program and the other West Virginia programs cited are funded both with local, state, and federal funds

The Federal Office of Rural Health Policy through its Rural Health Outreach Grants has fostered innovation in the use of local resources for services to the elderly. Three such programs, in Idaho, Iowa, and Georgia are also examples of best practices in the use of local resources. In Moscow, Idaho the Adult Day Health Program provides a continuum of appropriate health and therapeutic services, recreational activities, nutritional services, psychosocial support, and educational activities in a safe, caring, stimulating environment. The primary target populations for this program are African American (1%), American Indian (3%), Caucasian (90%), and

Hispanic (5%). A collaboration of regional health and human services agencies provides additional support, expertise, and ancillary services. The program's targeted population is the frail elderly, the developmentally disabled, and severely impaired adults of the service area. The overall goals of the center are to maintain and improve the physical health status and activity level, improve the psychosocial health status and activity level, and improve participants' ability to perform activities of daily living and remain in the home community with an optimum level of independence. To achieve these goals the center extends services to geographically and socially isolated residents; coordinates services with other providers; provides transportation and well-trained staff escorts to allow participants to attend appointments for other services; and provides assistance, education, and psychosocial support to family members and caregivers of the targeted population.

The North Iowa Mercy Health Center in Mason City provides expanded health care services to seniors in 15 counties in northern Iowa. The project recycles and repairs assistive technology equipment to clients who are unable to afford new durable medical equipment or the repair costs of their existing equipment. The project also develops a multiprovider clinic to ensure local access to physician, therapy, and dental services. This site also provides the focal point for the equipment outreach that is done both at the clinic and in the homes of needy seniors. The project is also developing an education initiative to promote the project and the equipment and health care services available to local residents.

The Partnership for Rural Elderly in Dahlonega, Georgia is a collaborative interdisciplinary effort committed to providing direct rehabilitation, consultative, and educational services to rural, low-income elderly citizens in the North Georgia region who do not otherwise have access to such care. This community is primarily Caucasian (96%). This program provides services within this underserved community to bridge the gap between medical care and quality of life. County Senior Center, Programs Assisting Community Elderly, Dahonega Habitat for Humanity, Gainesville Aid Project, Georgia AHEC, and the Lumpkin County Commissioner.

The federal government can be helpful in the following ways:

- Provide a prescription drug benefit under Medicare

- Improve reimbursement to home health and other community-based services that seek to keep the elderly healthy and at home.
- Develop funding partnerships with state governments to encourage state to train health professional students in rural communities and engage in service-learning with the elderly while they train.
- Fund a national study on the rural aging veteran and their families with a focus to improve the outreach and readjustment center services in rural areas.
- Improve funding to local communities who engage local resources to renovate the homes for the rural elderly.
- Provide increased funding for transportation programs that serve the rural elderly.

On behalf of the NRHA, I wish to thank Chairman Craig and members of the Committee again for the opportunity to testify here today. As my testimony to you today indicates, good things are happening in our rural communities to help seniors obtain quality health care. I want you to know that the NRHA stands ready to work with your Committee and the Congress to ensure improved access to essential health care services for the elderly in rural and frontier communities. I would be happy to take any questions you may have.

STATEMENT OF JAMES SYKES, SENIOR ADVISOR FOR AGING POLICY, DEPARTMENT OF PREVENTIVE MEDICINE, UNIVERSITY OF WISCONSIN MEDICAL CENTER, MADISON, WI

Mr. SYKES. Thank you, Senator. It is a real pleasure for me to be before the committee to speak about something that has been the heart and soul of my life for 30 years.

Where one lives is simply the most important daily fact of one's life. When that place is supportive, familiar, navigable, that is a good place to live, and people who have that have high levels of life satisfaction. Those for whom their housing situation is not good live each day with a series of problems that housing itself, the shelter, makes more onerous.

In my brief time here, Senators, I would like to mention three programs—one, a community program; one, a State policy; and third, a HUD policy—that are critical to the well-being of people living in rural America. And I would like to very briefly mention lessons from each of these.

Let me go first to Sun Prairie, WI where, some years ago, a group of people with some leadership from the corporate world, local government, religious groups, decided that the elders in their community needed some place to go, something to do, and out of that, the corporation gave leadership to the development of a senior center and provided the money.

With the partnership of others in the community, that program evolved into an exciting program with a whole range of services including, later on, adult day care as a freestanding facility, the meals, the transportation, the counseling, and opportunities for personal growth.

From that experience, which is sustainable through a wide range of support, initially brought into being by a very small Older Americans Act grant that was important, the Colonial Club continues to make life in a relatively small community in Northeast Dane County livable and provides a great deal of support to the people, knowing that in their community, they are cared for. And for the children, it provides a great deal of confidence that their parent or parents are cared for.

Under every good local program, there needs to be a policy, a program that sustains it, and in this respect, Wisconsin again provided very important leadership, including support when Senator Feingold was one of our State Senators in Wisconsin, when we developed a Community Options Program which simply said that everyone in the State was entitled to an assessment of functional capacity, that they were entitled to some effort to devise a care plan so that they could be cared for in the least restrictive setting, in the most effective way, and that, using Medicaid waiver moneys and State general-purpose revenues, the State had both an obligation and an opportunity to enable people to continue to live in the community and in their homes.

It was not the principal goal of the program, but it certainly has been a favorable consequence, that there has been serious diversion from nursing home placements because of this program, and it is in place.

So a little program like this one in Sun Prairie and many other towns throughout rural Wisconsin has under it a foundation of

public support through the Community Options Program, and there are some lessons to be drawn from that.

Third, in each of the programs that I have seen across this country, something had to make it start, something had to get it going. In many of the communities during my tenure as chair of the State's Housing, Finance, and Economic Development Authority, we found that what it took was somebody coming into that town, listening to the people talk about what they wanted to do for their citizens, but with the knowledge and the ability to access the funds, to show how other programs have developed and have been successful.

So in the whole area of technical assistance, including the Rural Housing and Economic Development Assistance Program and other HUD technical assistance moneys, there is now the capacity within an organization like ours, the Wisconsin Partnership for Housing Development, to in fact pay for the technical assistance, but that it is spent and allocated to a particular community with its own goals.

Those are three very small and very brief examples of a community development that needs some assistance, some catalytic agents, some partnership at the local level. The second is that we do need a State policy that really provides financial assistance and enables communities to build, finance, and sustain the kind of infrastructure that is necessary for people to live a good life and to move ahead on many fronts. We need people who are knowledgeable, who can provide technical assistance, and help communities move from where they are to where they want to be.

Across this Nation, I have not seen a religious organization, a civic group, a local government, or others that has not had as a part of its intention to serve their elders well. They have had lots of problems making it happen, and we know through examples how it can happen, how it can be successful, and how it can be sustained.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Sykes, thank you very much.

[The prepared statement of Mr. Sykes follows:]

Statement

of

Mr. James Sykes

Senior Advisor for Aging Policy
Department of Preventive Medicine
University of Wisconsin Medical Center
and
Board Member, National Council on the Aging

before the

Senate Special Committee on Aging

on

"Healthy Aging in Rural America"

Thursday, March 29, 2001

Good morning. Thank you, Mr. Chairman, for the opportunity to share my ideas, based on hands-on experience with housing and services in rural Wisconsin, and to express my conviction that, while we have made tremendous strides in improving the well-being of the nation's elders, we have major challenges to achieve the goal of decent, affordable, appropriate housing with services for those living in rural areas.

I am Jim Sykes. While primarily presenting my own opinions from my work in the field for thirty years, I will also share insights and experience from members of the National Council on the Aging, especially NCOA's National Coalition on Rural Aging and the National Institute of Senior Housing. My long association with the Wisconsin Partnership for Housing Development has broadened my views. Colleagues within the Rural Wisconsin Health Cooperative and the Coalition of Wisconsin Aging Groups have provided valuable information and my graduate students and faculty at the University of Wisconsin have sharpened my understanding of the complexities of developing sound practices and enlightened policies.

Over the years I have been privileged to chair Wisconsin's Board on Aging, the Wisconsin Housing and Economic Development Authority, the Dane County Housing Authority and the National Council on the Aging. I was the leader of the "housing with services" track at the 1995 White House Conference on Aging—a poignant time in which elders from across the nation expressed their concerns and voted on policy priorities for America to improve the quality of life of older citizens. In addition, my work with the Elderly Housing Coalition here in Washington has provided a foundation for my judgment about what needs to be done to increase the probability that older persons may continue to live active, healthy lives and to receive the care they need when infirmities associated with advanced years become all too onerous.

I would like to highlight some of the problems that make this hearing so timely and important. Then, I'll describe a case on point—one small town's efforts to provide affordable, appropriate, attractive housing for older persons. I'll suggest certain solutions to the problems almost inherent among older persons living in rural areas. Briefly, I will describe Wisconsin's Community Options Program, a creative effective response to those who

require long term care due to their isolation, frailty, and the lack of appropriate, affordable shelter and services.

One needs only to live in rural America to experience what demographers and health policy specialists describe as the consequences of living to advanced years in an aging society. As we age we experience
The decline of our health and capacity for self-care,
The decline of supportive networks as our friends move, our children age,
The decline of our communities due to shifting populations,
The decline of health facilities and sustainable services,
The decline of our housing stock due to costly repairs and maintenance.

In short, while we continue to prefer to age in places we know, among those with whom we have worked and nurtured, and to remain independent, we find ourselves increasingly unable to cope with decline—our own and our community's. Fortunately, we have examples of communities that have brought together needed resources, governmental and private, to enable those least able to care for themselves to live satisfying lives and to receive the care they require. Permit me to describe what citizens of Sun Prairie, Wisconsin, have done to improve the chances that the community's elders will live secure, satisfying, independent lives.

The Sun Prairie story began—in a manner of speaking—when the owners of a local corporation, The Wisconsin Cheeseman, decided that they had an obligation and an opportunity to assist those community leaders who recognized increasing problems among their fellow citizens and determined to act responsibly. The Cheeseman asked me, an officer of the company, to investigate what was needed and what should be done to improve the lives of older citizens. With others, I facilitated a community planning process that led to the establishment of a senior center and, later, to the development of independent and supportive housing. From the outset, we gave equal attention to the healthy and active and to those facing problems associated with their advanced age, limited income, and their lack of personal support. The Corporation, and its Foundation which I headed, provided grants to build a center with and for the elders of Northeastern Dane County. With a small grant from Wisconsin's Older Americans Act resources, our group

organized the Colonial Club, a non-profit center, and began to offer a wide array of programs and services built on a solid base of volunteers, personal contributions and a few corporate gifts. The center was an immediate success—by the number of participants and the range of services provided.

It became evident to the Center leadership and to the owners of The Cheeseman, that a large number of area residents lived in inappropriate housing—too large for some, too costly for others, too isolated for still others. We provided the leadership for a local housing authority to meet the need for affordable housing; unfortunately, our application for public housing was added to a long list of unfunded community programs. The community tried again for funding under another Federal program, but met the same fate. The Cheeseman decided that we would build the housing utilizing the skills and knowledge of our employees. We set rents that were below fair-market rates. These units that surround the senior center provide the residents with not only independent, attractive, affordable shelter, but also with easy access to comprehensive programs and services. The Cheeseman continues to provide financial support along with grants from the City, Dane County, the United Way and individual contributions of cash and hundreds of hours of volunteer time, energy and creativity. Later, the Foundation and Corporation funded a center expansion and an adult day care facility. To the 98 privately owned units we developed initially, we built another facility with 56 apartments providing supportive services.

The Colonial Club, with a HUD Section 202 loan, built a 94 unit congregate housing facility on its site. With Section 8 subsidies, the residents were able to have supportive, affordable housing. I'd love to continue this story in detail; however, suffice to say, the partnership that developed in one small Wisconsin town among government, private corporations, older people and their families resulted in a program that works, and an environment that supports an increasing number of frail elders. Largely because we decided to establish within one neighborhood the center, housing, adult day care various meal, transportation, counseling, health promotion, rehabilitation, socialization, education, information and employment opportunities—paid and unpaid—a synergism has been achieved that sustains, albeit always at the margin, a comprehensive, community-based care system, a community.

Another example of a rural community responding to the need for supportive housing may be found in Franklin, Vermont, a town of about 1000. By creatively combining private, local government, HUD, Medicaid and Tax Credits, the community developed 40 units of supportive housing. Services to residents are also available to community dwellers proving again the importance of flexibility when combining various grant, loan and support services to serve both frail and less frail citizens; efficiencies achieved from higher density provide important savings and ensured higher quality services. (For information, contact Sarah Carpenter, Executive Director, Vermont Housing Finance Agency, 802-864-5743.)

The Wisconsin Partnership for Housing Development, utilizing diverse resources, including a Historic Preservation designation, totally rebuilt an old hotel in Richland Center to provide quality housing for this small town's aging population and to save a landmark (For information, contact William Perkins, Executive, Wisconsin Partnership for Housing Development, 608 258-5560 x23.)

In Prairie du Chien, Wisconsin, the Memorial Hospital has utilized its limited resources and dedicated staff to create independent housing and, somewhat later, an assisted living facility by converting a Catholic convent into attractive, affordable assisted living for residents who now have an average age of 88. The natural ties between people with declining health and the competent professional staff of a small rural hospital ensures that residents receive timely, appropriate attention as and when they need help. (For information about ways rural hospital are involved in community housing with services programs, contact Tim Size, Executive Director, Wisconsin Rural Hospital Cooperatives, 608 643 2343.)

In small towns across the nation, there may be found religious congregations, hospitals, corporations, citizen groups, local and county governments that sincerely want to improve the quality of life for their members, patients, customers and citizens. With the guidance of organizations such as the Wisconsin Partnership, with a HUD technical assistance grant, affordable housing projects can be developed at a scale appropriate to a small town, with a range of services essential for elders

facing chronic illness and declining personal support. Building the facilities is only half the problem.

Rural communities in Wisconsin and Vermont—indeed, throughout the country—have found creative ways to develop and maintain affordable, attractive, appropriate housing for community elders, not only to divert frail residents from nursing homes, but also to improve the quality of their lives and their sense of security. In rural America, neighbors, religious congregations, small hospitals, and other voluntary groups are providing services to elders who need a meal delivered, a ride, someone to visit, some help with home maintenance or housekeeping. Unfortunately, nearly every rural project about which I have information is facing the problem of sustaining their services for an increasingly frail population. In addition, thousands of rural elders remain alone, unserved, afraid.

In Wisconsin, the Community Options Program (COP) provides resources for frail elders and disabled people of any age to enable them to receive the support they need, in settings of their choice, and with the assurance that as their conditions change they will have additional, cost-effective services. The Community Options Program provides resources for the effective coordination of services, for assessing functional capacity and threats to independence, for determining one's eligibility for governmental resources and for monitoring care plans. Utilizing Federal and State funds, the Community Options Program enables frail persons to continue to live in their homes and communities.

The Community Options Program, through care management agencies and the recently developed Aging and Disability Resource Centers, provides essential support and guarantees that people in need will be served. COP is a policy solution to the challenge for urban and rural communities and individuals determined to care for fellow citizens in need in a dignified, appropriate, effective manner. Wisconsin's Community Options Program has been a tremendous success in providing individuals at risk of institutionalization with the ability to purchase various services they need—not more than they require, but not less than they need. (For information about Wisconsin's Community Options Program and "phase two," Aging

and Disability Resource Centers, see www.state.wi.us/ltcare/ or call Janet Zanger at 715-346 1401.)

Systemic problems require systemic solutions. The nation's rural elders are living with uncertainty--about their health, their homes, their financial condition and, especially, their capacity to live independently. We have replicable models of how communities have joined forces with government, business, religious congregations and neighbors to remove obstacles to a good old age for the elders of their communities by developing and supporting sustainable programs.

A little over a year ago the Elderly Housing Coalition, comprised of national organizations, developed a policy paper, "Toward a National Continuum of Care," that calls for the integration and rationalization of various funding sources to enable those living in subsidized housing to remain where they prefer with services they need. We urged then, and I do today, a partnership between HUD and HHS to coordinate and maximize the benefits for vulnerable residents for both shelter and services whether they live in organized projects or in their individual homes or apartments. We urged then, and I do today, that we strengthen such programs as service coordinators, meals programs, and those services often associated with assisted living as a way not only to avoid premature or unnecessary institutionalization or an unwelcome move of any kind, but also as a way to increase the quality and security of their lives. (See the May-June, 2000 issue of Health Progress, a publication of The Catholic Health Association.)

We know who needs care. We know where they prefer to live. We know how to provide appropriate and quality care to people no matter where they live. An integrated system of health and support services provided to rural elders is within our means; it is certainly consistent with our goals for a civil, caring society. The question we must answer is whether we will move beyond the rhetoric of caring to ensure that we, if I may steal a phrase, leave no elder uncared for.

The CHAIRMAN. Before I turn to the next witness, do either of my colleagues who have joined us here have an opening statement?

Now let me turn to Melinda Adams, who is the Older Worker Coordinator at the Idaho Commission on Aging. She will be talking to us about employment of our elderly.

Melinda, again, welcome to the committee.

STATEMENT OF MELINDA M. ADAMS, OLDER WORKER STATEWIDE COORDINATOR, IDAHO COMMISSION ON AGING, BOISE, ID

Ms. ADAMS. Senator Craig, thank you for your kind welcome. I appreciate this opportunity to testify.

To start, a few words about our home State's work force initiatives. Idaho's older worker programs have been regarded as models of coordination and have achieved excellent results. For 7 of the past 10 years, the U.S. Department of Labor has ranked Idaho's Senior Community Service Employment Program first in the Nation for success in placing low-income seniors in jobs.

I am also pleased to report that, with the able leadership of our former State Aging Director, now Staff Director Lupe Wissel, Governor Kempthorne's Workforce Council approved second-year funding for our Statewide Workforce Investment Act Project. Since the elimination of Federal set-aside money for older workers, Idaho was the first State to designate State-level WIA funding for older job-seekers. Other States are finally beginning to follow. That should not be the case in an economy where the numbers of disadvantaged older workers are growing far faster than any other age group and where low-income older workers constitute the most computer-illiterate group of workers in a labor market where 70 percent of jobs require computer literacy.

Also, the need for dislocated worker resources for older workers is on the increase. Idaho's rural areas have an above-average share of older people who can no longer depend on agriculture, timber, and mining for their support. The Sunshine Mine closures in the Silver Valley, and the impending Boise Cascade closures, announced in recent weeks, are unfortunate examples of the devastation caused by layoffs in our small communities.

Idaho is not unique in this respect. These dynamics are at play throughout rural America with the demise of the family farm, the decline of other natural resource-based industries, and the impact of global economics.

The data clearly show that older persons who lose their jobs experience far more difficulty than other age groups in becoming reemployed. At both the Federal and State levels, rural older worker employment should be a focus in economic and dislocated worker initiatives.

Accordingly, as Congress reconsiders reauthorization of the Workforce Investment Act, we urge added emphasis on older workers.

New opportunities to serve our most geographically isolated seniors are finally presenting themselves, thanks to the new technologies. An older worker in Salmon, Idaho can now support herself as a medical transcriptionist, operating out of her home, with the right training and the right equipment. Thus, our recommenda-

tion for expanded flexibility and increased funding to use Title V funds for self-employment and cottage-based entrepreneurial activities.

Similarly, expanded flexibility to use these funds for private sector work experience will allow us to better serve our most rural seniors who reside in locales with few, if any, eligible host sites.

Distance learning innovations also offer hopeful solutions to the rural senior in need of training. Many rural communities have limited public transportation systems; the more remote areas have none at all. As a solution, we challenge our educational system to expand lifelong and affordable distance learning opportunities.

We also support policy changes that eliminate disincentives to work—the removal of provisions in pension plans that penalize individuals for working after retirement; the encouragement of phased retirement and tailored benefit packages to facilitate the hiring of mature workers in flexible work arrangements.

In closing, both job-seekers and incumbent workers need a voice. It is ironic that, at the very time that aging workforce issues should be a focus, Federal legislation eliminated dedicated funding for mature workers.

Strategies on how to address the physical, educational and training needs of disadvantaged older workers should be a focus now. For these reasons, we urge the U.S. Department of Labor to establish a position at the assistant secretary level for oversight of workforce issues impacting older individuals and employers.

Thank you for this opportunity to testify.

The CHAIRMAN. Ms. Adams, thank you very much for that valuable testimony.

[The prepared statement of Ms. Adams follows:]

Testimony of Melinda M. Adams

On behalf of the

Idaho Commission on Aging

And the

National Association of Older Worker Employment Services

Before

The United States Senate Special Committee on Aging

Regarding

Workforce Issues Impacting Mature Workers in Rural States

Washington, DC

March 29, 2001

Mr. Chairman and Members of the Committee on Aging, I welcome this opportunity to testify on workforce issues impacting rural states.

I have administered older worker employment and training programs for the Idaho Commission on Aging for the past fourteen years. I currently manage Idaho's Senior Community Service Employment Program and our statewide Workforce Investment Act Older Worker Demonstration Program.

I serve as Chair of the National Association of Older Worker Employment Services, and am on the board of the National Council on the Aging. I am also a member of the Workforce Committee of the National Association of State Units on Aging.

Idaho's Older Worker Programs have been regarded as models of service provider coordination and have achieved excellent results. For seven of the past ten years, the U. S. Department of Labor ranked Idaho's Senior Community Service Employment Program **first** in the nation for success in placing low-income seniors in jobs off the Program. Our Idaho Job Training Partnership Older Worker Project also consistently exceeded national performance standards.

I am pleased to report that just last week Governor Kempthorne's Workforce Development Council approved the Idaho Commission on Aging's request for second-year funding for our statewide Older Worker Workforce Investment Act (WIA) Project. Since the elimination of JTPA set-aside money for older workers, Idaho was the first to designate state-level WIA funding for older job seekers. Other states are finally beginning to follow.

That should not be the case in an economy where the numbers of disadvantaged older workers are growing far faster than any other age group. That should not be the case where low-income older workers constitute the most computer illiterate group of workers in a labor market where 70% of jobs require computer literacy (U. S. Bureau of Labor Statistics).

We must communicate that State and Local Workforce Investment Boards can and are designating funds for older workers. Employment and training programs that meet a workforce need and have proven effective should be supported and enhanced – not eliminated in the devolution of decision-making from the Federal level to the State level.

The need for dislocated worker resources for older workers is also on the increase. Idaho's rural areas have an above average share of older people who can no longer depend on agriculture, timber, and mining for their support. The Sunshine Mine closures in the Silver Valley, and the Potlatch mill downsizing, and the impending Boise Cascade closures, announced in recent weeks, are unfortunate examples of the devastation caused by layoffs in our small communities.

Idaho is not unique in this respect. These dynamics are at play throughout rural America with the demise of the family farm, the decline of other natural resource based industries and the impact of global economics.

The data clearly shows that older persons who lose their jobs experience far more difficulty than other age groups in becoming re-employed (U. S. Bureau of Labor Statistics). At both the federal and state levels, rural older worker employment should be a focus in economic and dislocated worker initiatives.

Accordingly, as Congress considers reauthorization of the Workforce Investment Act of 1998, we urge added emphasis on older workers and the re-instatement of "Long-term Unemployed" as a criterion for Dislocated Worker Services. *(Note: An individual who was unemployed at least 15 of the preceding 26 weeks was considered "Long-term Unemployed" and eligible for Dislocated Worker Services under the Job Training Partnership Act; a large percent of unemployed, older individuals qualified under this eligibility factor.)*

New opportunities to serve our most geographically isolated seniors are finally presenting themselves, thanks to the new technologies. An older worker in Salmon, Idaho can now support herself as a medical transcriptionist, operating out of her home, with the right training and the right equipment.

Thus, our recommendation for expanded flexibility (and increased funding) to use SCSEP funds for self-employment and cottage-based entrepreneurial activities. Similarly, expanded flexibility to use SCSEP funds for private-sector work experience will enable us to better serve our most rural seniors who reside in locales with few, if any, eligible work experience host sites (government entities and non-profit organizations having 501 C-3 IRS status).

Distance learning innovations also offer hopeful solutions to the rural senior in need of training. Many rural communities have limited public transportation systems; the more remote areas have none. As a solution, we challenge our educational system to expand life-long and affordable distance learning opportunities (occupational skill training, adult basic education, English as a Second Language, etc.).

We also support policy changes that eliminate disincentives to work:

- Remove provisions in pension plans that prevent retirees from working for the companies from which they retired or otherwise penalize older individuals for work beyond retirement.

- Explore innovative ways to avoid career stagnation for long-tenure employees and pursue phased-retirement as an alternative.

- Encourage greater use of "cafeteria-style" benefit packages to facilitate the hiring of mature workers in flexible work arrangements.

Seriously consider the recommendations of the Research & Policy Committee for Economic Development to:

- Eliminate the Social Security Earnings Test; and
- Remove the Employer First Payer provision in Medicare.

In closing, older workers (both job seekers and incumbent workers) need a voice. It is ironic that, at the very time aging workforce issues should be a focus, federal legislation eliminated dedicated funding for mature workers.

Strategies on how to address the specific physical, educational, and training needs of disadvantaged older workers should be a focus now ("The Aging Baby Boom: Implications for Employment & Training", The Urban Institute).

For these reasons, we urge the U. S. Department of Labor to establish a position, at the Assistant Secretary level, for oversight of workforce issues impacting older individuals and employers.

I thank you for this opportunity to comment.

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The CHAIRMAN. Now let me turn to Jane White, President of the American Dietetic Association, who will be talking to us about diet and nutrition.

Jane, welcome before the committee. We are pleased to have you.

STATEMENT OF JANE V. WHITE, PRESIDENT, AMERICAN DIETETIC ASSOCIATION, WASHINGTON, DC

Ms. WHITE. Thank you, Chairman Craig.

I am pleased to be here to discuss nutrition and its importance to healthy aging in rural America. I represent the largest association of food and nutrition professionals in this country. Our 70,000 members serve the public through the promotion of optimal nutritional health and well-being.

I live and work in rural East Tennessee. As a registered dietitian, professor of family medicine, and a member of the ADA's Nutrition Screening Initiative, I see the difference that optimizing nutrition status makes in the lives of older Americans.

The Institute of Medicine has observed that poor nutritional status is a major problem among our Nation's elderly. Inadequate intake is estimated to affect 37 to 40 percent of free-living elderly. Diet quality ratings in these people show that about 80 percent have diets that need improvement or that are poor. Among hospitalized and nursing home elderly, undernutrition is especially prevalent. In addition, 86 percent of older Americans have one or more chronic diet-related diseases, including hypertension, diabetes, and dyslipidemia, singly or in combination. Adverse health outcomes are prevented or reduced with appropriate nutrition intervention.

Healthy aging requires adequate nutrition. However, rural America offers some unique challenges due to distance, topography, and limited availability of health care options that are widely present in more urban settings. Seniors who routinely eat nutritious food and drink adequate amounts of fluids are less likely to have complications from chronic disease or to require care in a hospital, nursing home, or other facility. It makes sense to emphasize routine nutrition screening for all Americans, but especially for seniors living in rural areas.

Isolated individuals are more susceptible to poor control of chronic disease states due to difficulty in accessing available nutritional care. Nutrition screening can identify seniors at increased risk for poor nutritional status and can facilitate intervention to improve health. The Determine Check List and Nutrition Care Alerts developed by ADA's Nutrition Screening Initiative were designed for this purpose.

Take the Nevada Division of Aging Services' pilot program. It provides 120 at-risk seniors with nutrition screening and intervention that includes medical nutrition therapy, home-delivered meals, and dietary supplements. A homebound older gentleman was screened after spending 2 weeks in the hospital to treat a sore on his foot. The healing process was impaired by poorly controlled diabetes. His doctor was concerned that if the wound did not heal, amputation might be necessary. Medical nutrition therapy, in this case, meal planning and food selection and preparation education provided by a registered dietitian, and home-delivered meals

helped this man control his diabetes, resulting in the rapid healing of his foot wound.

The total cost of this nutrition intervention was $350—far less than the cost of even one day in the hospital, not to mention the additional costs in health care and support services had the man's foot been amputated.

Meals programs and other nutrition-related services offered through the Administration on Aging are vital to maintaining the health and well-being of our Nation's elderly. These programs do a good job. Between 80 and 90 percent of participants have incomes below 200 percent of poverty level. Two-thirds of participants are either over-or underweight, placing them at increased risk for nutrition and health problems. Those receiving home-delivered meals have more than twice as many physical impairments compared to the general elderly population. But the wait time to access these services is 2 to 3 months in many areas, and the lines are long. Funding for these programs are at 50 percent of 1973 levels.

Seniors must be able to access dietitians who can determine what will best meet their needs and who can teach them how to apply that knowledge in their daily lives. Programs like the National Health Service Corps could help bridge the gap between need and access. ADA believes that dietetics professionals should again be included in this program.

Recognition of telemedicine technology as the vehicle for nutrition services delivery also could facilitate access to dietitians when none is available in the immediate area.

HCFA requires nursing homes to have a dietitian. However, in many States, they set a minimum of 3 hours per week for dietetic presence in a facility. Most facilities comply with the bare minimum. Considering the widespread nutrition-related problems so prevalent in nursing homes, 3 hours per week is not enough time for dietitians to oversee the paperwork that is required, let alone to fulfill the active role of facilitator and manager of nutrition and hydration care.

Research indicates that the more time dietitians spend in nursing homes, the less time the nursing home residents spend in hospitals. It is critical to have a dietitian in every nursing home full-time.

Chairman Craig, nutritional well-being is critical in assuring quality of life for our seniors. We hope that Congress will pass your legislation, the Medical Nutrition Therapy Amendment Act, so that nutrition services for cardiovascular disease, the leading cause of death in men and women in this country, may be covered. This will ensure access to life-enhancing and life-saving therapy for seniors who suffer these debilitating conditions.

To summarize, frail elderly living in rural areas face unique and difficult challenges, not the least of which is accessing a nutritious meal daily and accessing preventive and curative nutrition services.

Thanks for the opportunity to testify. I would be pleased to answer any questions.

[The prepared statement of Ms. White follows:]

Testimony of
Jane V. White, PhD, RD, LDN
President, American Dietetic Association
on
Healthy Aging in Rural America
before the
Senate Special Committee on Aging
March 29, 2001

Mr. Chairman and members of the Committee, it is my pleasure to discuss nutrition and its importance for healthy aging in rural America. As president of the American Dietetic Association (ADA), I represent our nation's largest organization of food and nutrition professionals with nearly 70,000 members. We are dedicated to serving the public through the promotion of optimal nutritional health and well being. Our work is based on information drawn from peer-reviewed nutrition research and resources representing significant scientific consensus.

I live and work in East Tennessee. As a Registered Dietitian, Professor of Family Medicine and member of the Nutrition Screening Initiative's Technical Review Committee, I have seen firsthand the critical difference that optimizing nutritional status can make in the lives of older Americans. The Institute of Medicine has observed that poor nutritional status, excessive or inadequate intake of nutrients, is a major problem in older Americans. Inadequate intake is estimated to affect 37-40 percent of community dwelling individuals over age 65. Dietary quality ratings of free-living Americans age 65 years and older, as measured by the Healthy Eating Index, show that roughly 80 percent had diets that were ranked as needing improvement or that were poor. (AOA) Among hospitalized and nursing home elderly, undernutrition is especially prevalent. In addition, 86 percent of older Americans have one or more of the chronic diet-related diseases including hypertension, diabetes, and dyslipidemia, singly or in combination. These conditions have adverse health consequences that could be prevented or reduced with appropriate nutrition intervention.

Healthy aging for all Americans requires adequate nutrition to maintain health, prevent chronic diet-related disease, and treat existing disease. However rural America offers some unique challenges due to distance, topography, and limited availability of the wide array of health care options that are present in more urban settings. Those seniors who routinely eat nutritious food and drink adequate amounts of fluids are less likely to have complications from chronic disease or to require care in a hospital, nursing home or other facility. Thus, it makes sense to emphasize nutrition screening for seniors in rural areas.

↑ routine

Isolated individuals frequently are more susceptible to poor control of chronic diet-related disease states due to difficulty in accessing available medical and/or nutritional care. Nutrition screening can identify seniors at increased risk for poor nutritional status and facilitate intervention to improve health.

A good example of the importance of nutrition screening comes from a Nevada Division of Aging Services pilot program started in January 2001. The program provides 120 at-risk seniors with nutrition screening and intervention that includes medical nutrition therapy, additional meals and dietary supplements. In one instance, a homebound older gentleman was screened after spending two weeks in the hospital to treat a sore on his foot. The healing process was impaired by poorly controlled diabetes. The gentleman's physician was concerned that if the wound did not heal, amputation might be necessary. Medical nutrition therapy provided by a registered dietitian along with home delivered meals through the Meals on Wheels program helped this man to control his diabetes, resulting in the rapid healing of his

foot wound. He also was able to lose ten pounds. This was accomplished with Medical Nutrition Therapy that included nutrition counseling related to meal planning, food preparation, and diet enhancement using protein and vitamin supplements. The total cost of this nutrition intervention was $350 – far less than the cost of even one day in the hospital, not to mention the additional costs in health care and support services had the man's foot been amputated.

The meals programs and other nutrition-related services offered through the Administration on Aging are vital in maintaining the nutritional health and well being of our nation's elderly. These programs do a good job! Between 80 and 90 percent of participants have incomes below 200 percent of the DHHS poverty level, which is twice the rate for the overall elderly population in the United States. Approximately two-thirds of participants are either over- or underweight placing them at increased risk for nutrition and health problems. Those receiving home-delivered meals have more than twice as many physical impairment compared to the general elderly population. To underscore how these programs fill a need: 9 percent of congregate and 41 percent of home-delivered meals programs have waiting lists greater than 2 months in duration with an average of 52-85 people on the list at any given time. In contrast, only 22 percent of other programs (for example homemaker, transportation and home health aid service) have waiting lists, which average 2 months in duration.

Seniors must be able to access dietitian/physician teams who can determine what will best meet their needs and who can teach them how to apply that knowledge in their daily lives. Unfortunately, seniors in rural areas often have limited access to qualified health professionals capable of providing information and guidance needed to make proper nutrition a priority. Programs like the National Health Service Corps, which encourages health professionals to practice in under-served rural areas, could help bridge the gap between need and access. Unfortunately, this program no longer includes dietetics professionals in its list of eligible participants. ADA believes that dietetics professionals should again be included in this program. Recognition of telemedicine technology as a vehicle for nutrition services delivery also could facilitate access to dietitians when none are available in the immediate area.

Nutrition services accessibility in other areas of our nation's health care system should also be examined. In response to a congressional request, the Institute of Medicine recommended that "HCFA as well as accreditation and licensing groups reevaluate existing reimbursement systems and regulations for nutrition services along the continuum of care (acute care, ambulatory care, home care, skilled nursing and long-term care) to determine the adequacy of care delineated by such standards."

HCFA requires nursing homes to have a dietitian as a full-time employee, part-time employee or consultant. However, many states set a minimum number of hours for dietitians to be present in a facility each week. In multiple states, this is as few as three hours weekly. As often happens, most facilities comply with the bare minimum. Considering the widespread nutrition-related problems so prevalent in nursing homes, three hours per week is not enough time for dietitians to give or even to oversee the clinical care that is required, let alone fulfill the active role of facilitator and manager of nutrition and hydration systems and programs. Research indicates that the more time dietitians spend in nursing homes, the less time residents spend in hospitals. The Administration on Aging's report on nutrition and hydration care underscores that in order to provide adequate feeding assistance to every resident it is critical to have a dietitian in every nursing home full time.

Attached to my statement are other examples of programs established under the Older Americans Act showing remarkable success in providing essential nutrition to at-risk seniors. The American Dietetic Association also requests the opportunity of providing a more detailed statement concerning healthy aging in rural America for the hearing record.

Chairman Craig, nutritional well being is critical in assuring quality of life for our seniors. The American Dietetic Association is appreciative that the 106th Congress recognized the role nutrition could play in the prevention and treatment of disease. Medical nutrition therapy will soon be covered under Medicare Part B for individuals with diabetes and renal disease. We hope that Congress will pass your legislation, the Medical Nutrition Therapy Amendment Act, so that nutrition services for cardiovascular disease, the leading cause of death in men and women in the United States, also may be covered. This will ensure access to life enhancing/life saving treatment for those seniors who suffer these debilitating conditions.

To summarize, frail elderly living in rural areas face unique and difficult challenges – not the least of which is accessing a nutritious meal, daily. Thank you for the opportunity to discuss some of the nutrition programs and services that can make such a huge difference. I'd be pleased to respond to any questions the committee might have.

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Administration on Aging. Older Americans 2000: key Indicators of Well-Being. www.aoa.gov/agingstats/chartbook2000/default.htm

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Other Examples and Challenges:

Ways the Older Americans Act Makes A Difference in Seniors' Nutrition

- In Bannock County, Idaho, three centers provide the opportunity for seniors to receive a good meal, nutrition education and social contact. The Southeastern Idaho Community Action Agency Meals on Wheels provides meals to 175 homebound seniors five days a week. In many cases, these meals are providing one third of a senior's nutritional needs. The Meals on Wheels program in southeastern Idaho expanded service from 118 to 175 people each day without adding additional staff or vehicles.

  However, one of the biggest problems facing the nutrition programs is transportation. Serving rural areas requires vehicles and staff for transporting seniors to congregate centers or delivering meals to remote areas. The agency expects demand to increase another 10 percent this year, but are unsure how to meet the need without additional resources. This is a common problem for programs across the country that provide a necessary service in the face of increasing demand that is outpacing funding.

  The Leadership Council of Aging Organizations recommends a 10 percent increase in funding for Older Americans Act programs to help address the increasing need. This funding would help to serve many of the individuals that currently are not receiving and assistance or are on a waiting list. The aging population is growing and is set to increase dramatically when the baby-boomers become seniors. It is critical to start enhancing the capacity of programs like feeding programs in anticipation of the impending demand.

- The Elderly Nutrition Program in Knox County, Tennessee is celebrating its 30th anniversary. Over the last four years the number of home-delivered meals served by this program has doubled from 400 to 800 per day. This has been accomplished with no increase in federal funds; with community support and local fund raising efforts. But volunteerism in many parts of America has been stretched to the limit. The program has 450 volunteers per year, 55 volunteers per day, who deliver meals. However, 75 per day are needed. Eight of the 45 daily routes are filled by paid staff. More funding for transportation is needed.

  The waiting list for home delivered meals in this East Tennessee County, my county, is three to four months duration. At any given time 75 people are waiting for meals. Because of funding and staffing constraints, only those who are most debilitated are served, thus the death rate for program participants is high. The turnover rate for this program is 60 percent annually.

  If the mobile meals program is to do what it should and could do – delay the onset of chronic disease, prevent deterioration, promote independent living -- we must be able to reach those in need earlier, so that health is restored/maintained and quality of life enhanced.

Looking into the Faces of the Invisible: Aging in Rural Communities

by Anne McKinley

"People who have problems in rural areas are not always well heard, and because they are not always well heard, they are not always well served."

Leon H. Ginsburg, 1977, Social Work in Rural Communities

This statement could easily have been written today rather than 21 years ago. It could easily have begun, "the elderly who have problems in rural areas...." The rural elderly are a barely visible population that is aging along with the rest of America. Data from the 1990 census tells us that compared to the elderly who live in metropolitan areas, the rural elderly have less income, poorer health, less adequate housing, less access to health care, and less access to transportation. In short, there is an abundance of scarcity.

Anne McKinley comforts a senior with dementia at the Prescott Adult Day facility, which serves a rural community in Prescott, Arizona.

More of the rural elderly live alone, enter institutions earlier, and have a higher incidence of depression with the highest percentages of elder suicide. Another asset they have less of, but need more of, is a significant political power base to provide an equitable distribution of resources. The listing of the "have's and have not's," is not meant to "catastrophize," but rather to give a picture of a reality that is shown over and over in rural aging research. To provide a broader context and frame of reference for rural America, it helps to start with definitions and numbers. There is confusion about what rural is and is not. And there is a general lack of knowledge about how many people are out there, where they live, and who they are.

Defining Rural

There is a reason that the term "rural" is confusing—there are more than 40 working definitions. The definitions seem to stem from governmental entities that need to develop formulas for funding streams or from the Bureau of the Census, which needs parameters for demographic characteristics.

For our purposes, think simplistically. Think low population density rather than economic base (most people think "rural" means farm). Remember that

"if you have seen one rural community, you have seen one rural community." The diversity in rural America and the ambiguity of definition are parts of the challenges we face as we work with and represent rural people and their communities so they can live and not just survive.

While rural communities and rural people share similar problems, there is no one answer or solution for all of them. Nor is there any assurance that rural solutions in one part of the country will work in another part of the country (just as it is very clear that what works in an urban/metropolitan setting rarely works in a rural setting). The lack of acknowledgment of this fact by policymakers and planners is one of the biggest barriers we face. To raise awareness about the problems rural elders face, we need advocacy to help create an informed and interested political power base. We also need to inform both the public and private sectors that funding decisions in research and demonstration projects cannot be primarily based on numbers served.

The Communities

According to the Bureau of the Census, there were 10,484,192 people who were age 60 and over living in rural America in 1990. This is 25 percent of the rural population. In a metropolitan area, the elderly may make up 11 percent of the population. But in many small towns of 25,000, the elderly may be 33 percent of the total population. In most of the small towns with which I am familiar, the population is likely to be 50 to 65 percent elderly. A town near my home has 750 people, and the average age is 83.

These people are at highest risk for falls, complications from chronic disease, and age-related traumatic illness. All of these conditions suggest a need for a variety of rehabilitative and long-term care services that are unavailable in rural areas. Also, these are people who are more likely to live alone or with an impaired spouse, and whose children and other family members may only be able to give care and support from a distance.

> After an acute health need, rural elders are much more likely to go into a nursing home before going home, if they ever can, for there are no resources for follow-up care.

Where do they turn? To their communities, and most of these communities do not have adequate health and social service infrastructures. Neither do they have the funding sources to create them. They are unincorporated, with no tax base of their own, and primarily dependent on public funding from the state and the federal governments for developing support services for their elderly people.

The Rural Southwest

My part of rural America is the Southwest, and I include in my rural world the Rocky Mountains, deserts, dry river beds, and vast distances between towns. There are stands of pine trees, aspen, Joshua trees, and suagharo cactus. There are Indian reservations and Native American people who add the richness of their culture. The climate has both low desert temperatures that hit 110 degrees in the summer and high desert, mile-high elevations with snow in the winter. Some towns that are just 35 miles apart have an hour and a half of driving time between them.

There are communities of no growth where the old economic bases are gone and where new economies have not been developed. There are communities of rapid growth where the basic service infrastructure, like sewers and electric lines, is only a dream waiting for tax revenue. In these communities, there are older people aging in place after having lived there for a long time. They are being displaced by new growth and experiencing a state of anomie, helpless to stop the change, losing their culture, tradition, and mores, losing their communities.

Today, it is important to profile rural communities so we can understand how the past and present intersect and so we can better plan for the future. Some of our communities are literally becoming ghost towns because of outmigration; some are figuratively ghost towns because in-migration has brought such growth that all that remains of the original community is a memory. There is a third kind of community, too. These are born today much as in earliest western times: A group of people find an attractive empty space, park their recreational vehicles (RVs) there, and soon others follow.

These communities have similar profiles. There is usually no health provider, no large grocery store, no pharmacy, maybe one organized community church. The businesses are likely to be a restaurant, a gas station, and a hardware store. Interestingly, there is frequently a civic organization and a small library. Two of the most dependable services in rural communi-

ties are the rural fire departments, which may be volunteer or county staffed, and the representative from the county sheriff who is likely responsible for a large geographic area.

Nutrition, Transportation

There also may be a nutrition program funded by the Area Agency on Aging (AAA) and staffed by a person who is employed under Title V of the Older Americans Act. If there is a nutrition program, it probably is trying to serve four or five communities, all of which may be 20 or 25 miles away. There is little resemblance to the idea of a focal point senior center. A general or community hospital may be 40, even 70 miles away, and secondary and tertiary care may be 100 to 180 miles away. After an acute health need, rural elders are much more likely to go into a nursing home before going home, if they ever can, for there are no resources for follow-up care. Families are separated, and visiting is an infrequent option.

With this kind of profile, is it any wonder that transportation is a number-one issue that always arises? Next time you are on vacation and enjoying the quaint towns, winding roads, and wide vistas, think of the people who live there. Think of the communities as havens for the elderly. Think of them in the spring storms, summer heat, and ice and snow of winter. Think of the elderly friend or spouse who is trying to get someone to the hospital, perhaps driving with impaired vision, weakness from stroke, or beginning dementia. Think of the automobile as the mode of transportation, one that may be old and in ill repair because there is neither money nor a mechanic to make it better.

Remember that the deregulation of transportation brought to a halt buses stopping in small towns. Buses may go through there, but they just don't stop. People were virtually cut off from the single public transit option that had been available for them. I still remember the transportation planner who told me that the town I lived in was not isolated because there was a shuttle that could take people to the airport 120 miles away.

The People

There needs to be a wall for the names of the aging, ageless heroes who live in rural America and give so much of themselves to their elderly neighbors. It is the elderly who are helping each other.

So many times we write about rural elderly people as statistics. I once read that "statistics are people with their tears wiped off." Sometimes that's true. Sometimes, however, when I am with the people in the rural communities, I see those statistics with smiles and determination on their faces. Many of them are living fulfilling, productive lives. Many of them are the corps of volunteers who are trying to make a "place" a "community." Many of them are the people with whom the volunteers work: the frail, the ill, the alone.

Sometimes they volunteer for people like Virginia. Virginia is 75 and has serious mobility problems because of arthritis and complications from congestive heart failure. She tries to do her own personal care, but she has trouble keeping her tiny house clean. She can no longer go to the nutrition site for socialization and a hot meal. Volunteers see that she has some help with her housework and that she has a home-delivered meal. Personal care and personal hygiene are issues, but difficult for a volunteer to handle. There is only one hour of service available every other week from an agency 40 miles away, but Virginia is determined to stay at home.

Some of the people are like John whose wife, Alice, is diagnosed with Alzheimer's disease. A neighbor comes in sometimes so he can go shopping or go gold panning with a friend. John wants to keep Alice at home as long as possible. He says, "She gave me happy years, I need to keep her here and be here for her." Two immediate problems, personal-care needs for her and respite care for him, could be alleviated with the option of adult day care. There is none. Friends are concerned for John and for Alice. John's stress is beginning to show as a short temper, and he has considerable pain from his back with a loss of mobility. Other issues are fundamental: lack of organizational support, limited financial resources, and the distance to a place where she could live safely and where the caregivers would understand her disease.

And then there was Bob. Bob was 84 years old when I met him. He lived with his dog and his horse in a small trailer on a dirt road called Walden's Pond. It was very unlike the place of

Buses may go through there, but they just don't stop. People were virtually cut off from the single public transit option that had been available for them.

Thoreau. Bob was a cowboy who had driven cows from Arizona and Texas to Montana, and except for the time he served in World War II, he had always been on a ranch. He had diabetes, glaucoma, and hypertension. He needed personal care and meals. It wasn't possible to give him the level of service he required because staff was not available, and his needs were greater than the service a volunteer could provide. He became acutely ill. He went to the hospital where it was decided that he could no longer live alone without home-care support. But there was no home-care support available, so his only option was entering a nursing home. He was allowed to return to his trailer for his personal belongings. While there, he took his dog and his gun and went out and fed and watered his horse. There he shot his dog and then himself and left his horse for a nephew.

What Can We Do

The first thing we need to do is strengthen the network of care that is already out there in rural America. We need to help make them more visible, better heard, and better served. We need to act as advocates with and for the elderly who live there. With our aging populations now, and with the aging population projected for the future, we are headed toward problems of critical concern and potentially crisis proportions.

As we strive to meet the challenges, we cannot overlook that greatest resource of all—the people who are there. They are the storehouse of information about what the service gaps are, where the people who need help are located, and how to tap potential volunteers. They best understand the unique characteristics of their town or hamlet, or the scattered clusters of houses that make up their communities. In my world, the population may change seasonally as people seek refuge in a different climate (those who are well and who have the funds do so.) Those who are left behind are those with fewer funds and poorer health.

We have to decide what we mean by "community. The word itself is derived from "com," which means come together, and "munio," which means to fortify. Let us come together and build a safe place where the rural elderly can age with quality of life, dignity, and a will to live long and well.

What do the people need? They need support and education about how to advocate for themselves. They need to let the policymakers and planners know the harsh realities of aging in place in rural areas. They need to inform policymakers that if funding were made available, they could draw on the strengths in the community to make the communities better. They also need to put an economic value on the work they do. If these concerned community members were not there, it would prove costly indeed, both economically and emotionally, for the elderly and their families, and costly indeed for the taxpayers.

Formal organizations in nearby towns and cities need to make a commitment to these rural people. They also need to find and use funding to help ensure that the elderly in need are well served. Networking, consortium building, collaborative educational efforts, and respect are all necessary ingredients.

Another priority is technology for rural areas. While even phone service is limited or non-existent on some areas, we must press ahead for greater technological advances in rural communities.

Finally, we have to decide and define what we mean by "community." The word itself is derived from "com," which means come together, and "munio," which means to fortify. Let us come together and build a safe place where the rural elderly can age with quality of life, dignity, and a will to live long and well. Let us include our elders who live on Indian reservations, which are among the most rural areas in the U.S.

I have a favorite quote that I use often. It is credited to Charles Kettering. "Nothing ever rises to meet the sky unless someone dreams it should, and someone believes it could." I add my own line to this: ". . . and someone is willing to do the work."

Anne McKinley is a National Social Work Fellow in the office of U.S. Senator John McCain, of Arizona. She is also past chair of NCOA's National Coalition on Rural Aging. The views expressed in this article do not necessarily reflect Sen. McCain's views.

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SPECIAL SECTION: CATHOLIC SPONSORED HOUSING

Toward a National Continuum of Care

Only by Integrating Healthcare, Housing, and Services Can the U.S. Prepare for the Coming Wave of Frail Elderly

By the Elderly Housing Coalition

The Elderly Housing Coalition is made up of national organizations (including CHA), agencies, and individuals who work together to influence federal policies concerning suitable and affordable housing for the elderly. The following is a working document intended to provide recommendations to the U.S. Department of Health and Human Services (HHS) and the Department of Housing and Urban Development (HUD). It was distributed at a national meeting on elderly housing sponsored by HUD in early May. The Elderly Housing Coalition is grateful to James T. Sykes, assistant director, Institute on Aging, University of Wisconsin—Madison, who contributed greatly to the development of this report.

America's population is rapidly aging, with the fastest growth occurring among people 75 years and older. This is particularly true of residents of federally assisted housing, elderly people who are especially vulnerable because they are also frail and poor and have often outlived their informal support networks.

The demographics of our aging society are startling:

- Today there are 34.1 million Americans who are 65 and older; in 2010 the number will be 39.4 million.
- Two-thirds of elders living alone are widows. (In 1997 there were 143 older women for every 100 older men.) Researchers predict that, by 2020, poverty among the elderly will be confined primarily to women living alone.
- A growing number of Americans are reaching age 85. In 1992, 10 percent of the 65-and-older population group had reached 85. Between 1992 and 2000, this group increased by 50 percent; by 2010 the number of people over 85 will increase by another 29 percent.
- Those who live a long time face not only increasing disability but also a reduced income. The 1996 median income of households of people over 65 was $20,535, while that for households of people 85 and over was only $16,000. The incomes of residents of federally assisted housing fall far below even the latter figure.

The importance of these data is clear: Care in a nursing facility–although appropriate for persons recovering from an acute illness or having long-term, complex medical

and nursing needs–is neither appropriate nor cost-effective for most frail older people. The rapid growth of the assisted living industry for those who can afford such accommodations has demonstrated the merits of supportive services and healthcare assistance in residential settings. Unfortunately, the cost of assisted living facilities is too high for elderly residents of federally assisted housing.

Nevertheless, the nation's need is growing for shelter with services for older persons who face illness, poverty, or the loss of family caregivers. A national long-term care policy that incorporates both health and housing polices is urgently needed to:

- Integrate health and housing programs
- Facilitate the retrofitting of federally supported housing
- Fund service coordinators
- Utilize federal, state, and local resources to pay for shelter, healthcare, and supportive services
- Create a "one window" access system for assisted living

Barriers to Affordable Continuum of Care

In this era of rapid growth of the aging population, there has been accompanying development of such services as home health, meals on wheels, transportation, congregate meals, and adult day care programs, and of such vocational roles as care managers, service coordinators, and personal aides. Although these services may not be available in all communities, most basic services are now widely available, thanks largely to Older Americans Act* funding and the ingenuity and dedicated service of nonprofit organizations. Nonetheless, there are barriers that keep the poor elderly in federally assisted housing programs from gaining access to a continuum of care essential to their independence, autonomy, and dignity.

Cost Cost is the major barrier, with the median market rate for assisted living facilities over $2,500 per month. Poor and frail residents of federally assisted housing simply cannot afford most assisted living facilities and many cannot afford the essential health and supportive services they need.§

Cost also poses a barrier to service providers trying to design housing and service programs for this population. Without government subsidies, the cost of developing and operating these programs exceeds the reach of those for whom the programs are intended.

Varying Eligibility Criteria Different service and entitlement programs have different eligibility criteria, which often makes it difficult for housing residents to access the services and programs intended for them and for providers to coordinate and deliver those services. An older person eligible for Medicare, Medicaid, Older Americans Act programs, and subsidized housing is treated by the government as four different entities. Most of these programs have discrete eligibility requirements, income limitations, disability criteria, regulations, and payment vehicles (Medicare has no limitations on income). The result is not only frustrating for the individuals involved; it also makes for inefficient and ineffective service delivery.

Fragmented Services Elderly residents of federally assisted housing who need health and social services, information on services, transportation, and medical care must turn to multiple sources for help. Although nearly everyone agrees that frail elderly persons benefit greatly from a holistic approach that includes a

comprehensive and seamless continuum of care, this ideal is rarely achieved. Instead, we see fragmented services in which a provider knows neither which other services are being delivered nor whether needs are being met. This leads to duplication, major gaps in services, and an inefficient use of resources. Such a nonsystem of care is especially difficult to navigate for aged persons with cognitive or physical limitations.

Lack of Family Care Providers The oldest residents of federally assisted housing, with few exceptions, live alone. Many have outlived their informal support systems and have no family or close friend to whom they can turn for help. Lacking such support, many poor elderly people must choose between moving to a nursing facility or being neglected. The cash equivalent of the care provided to the elderly by kin and other volunteers is estimated to be about $200 billion a year; unfortunately, residents of federally assisted housing seldom have family members or others who might provide such care.

Regulations The complexities of licensure and the cost of meeting regulations can create barriers to the effective development and delivery of support services by facilities serving the frail elderly. Regulations established by different agencies confound what should be a comprehensible and efficient system. For example, regulations that are appropriate for nursing facilities add to the cost of care and create an institutional atmosphere when applied to housing facilities. Although we of the Elderly Housing Coalition recognize that regulations are necessary to ensure high-quality care, we believe that those regulations should be appropriate for each setting in the continuum.

Space Limitations Residential facilities built for persons fully capable of independent living do not accommodate the needs of those who have physical limitations and need personal assistance, wheelchairs, or other assistive devices. Such facilities were not designed for persons needing nutritional or social supports; they lack adequate space for community kitchens, dining facilities required by health and safety codes, and for group recreation and socialization areas. Persons aging in place in federally assisted housing programs could benefit from on-site clinics, adult day care, PACE programs, and other co-located services that would help keep them well and minimize transportation needs.

HUD's policies requiring the building of as many residential units as the capital budgets could provide resulted in projects with little common space. To add spaces such as communal kitchens and dining rooms, small clinics and offices may require converting residential units into program spaces. A comprehensive plan to enable residents to age in place may require that apartments be converted to common space in order to accommodate new services.

Lack of a Systems Approach Barriers to a coordinated, comprehensive, comprehensible continuum of care are the result of decades of piecemeal legislation. Although each legislated component has a specific function, together they are haphazard and uncoordinated. In an era devoted to reinventing government and containing healthcare costs, it is apparent that an interagency and interdepartmental effort must be employed to develop a continuum of care. Innovative efforts by various states and the federal government have been successful in overcoming some of the barriers described here. Some of these innovations are discussed in the sections below.

Federal Initiatives: Housing

The three HUD programs described here emphasize the fact that, for more than 20 years, the department has administered programs promoting independence among

frail residents. The Congregate Housing Services Program, Service Coordinator Program, and HOPE for Elderly Independence Demonstration Program, although modest in their reach, provide evidence of the effectiveness of strategies that enable frail elders to age in place.

Congregate Housing Services Program (CHSP) Since 1978, CHSP has made modest grants to public housing agencies and other federally assisted housing projects to cover the costs of meals and supportive services for frail elderly and nonelderly disabled persons. Eligibility is based on a functional assessment that identifies those residents who are eligible for assistance. Services include one meal per day, housekeeping, personal assistance, social programs, transportation, and the support of a service coordinator.

Evaluations of CHSP indicate that the program reaches residents seriously in need, providing services that enable them to age in place. It thus directly addresses the needs of a large and growing number of frail elderly residents. HUD's administration of CHSP demonstrates that it can effectively administer, and local authorities can competently manage a services component to a housing program.

However, as a grant program with minimal funds, CHSP fails to serve most of the people who could benefit substantially from it. A CHSP grant covers only 40 percent of its services' costs. Unfortunately, most resource-poor public housing authorities and other sponsors of federally assisted elderly housing projects are unable to provide the remainder. The few projects that are awarded CHSP grants must therefore develop substantial local resources to sustain the program.

The CHSP program shows what can be achieved, at a relatively low cost in a federally assisted elderly housing project, to enable elders to age in place. Meals, housekeeping, and personal assistance constitute the minimal services that should be available to low-income, at-risk residents when age-related infirmities compromise their ability to live independently. We believe that lessons learned from CHSP should be applied to a national strategy for developing a continuum of services for elderly residents in federally supported housing.

Service Coordinator Program (SCP) This is another example of an effective strategy to assist residents to remain independent. In it, service coordinators are hired by projects to help frail residents gain access to supportive services in the community and to help them manage their care, especially in times of stress. The program is an approved expense in all federally subsidized housing programs serving older persons and younger persons with disabilities. In addition, the Supportive Services Program in Senior Housing, a demonstration funded by the Robert Wood Johnson Foundation through state housing finance authorities, allows certain private sector elderly housing projects–those developed with tax exempt bonds but without direct federal support payments–to employ service coordinators.

Service coordinators in elderly housing projects make it possible for frail residents to get services that enhance their independence. Knowledgeable about community resources and state and federal programs, the service coordinator is a confidant and friend of residents, a key actor in a continuum of care strategy.

Unfortunately, SCP, like CHSP, is underfunded. Although the number of coordinators across the nation is growing, the gap between the number in place and the number needed is huge. We believe that service coordinators–a first line of support for the nation's frail residents of subsidized housing–should be funded for every senior housing project.

HOPE for Elderly Independence (HOPE IV) This is another well-conceived HUD

initiative carefully targeted to a specific population within public housing. Unfortunately, it is no longer funded.

HOPE IV incorporated essential elements of supportive services and individual resident care management to enhance the quality of life of frail, very low-income residents in an independent living environment. The target recipients were primarily women over 75, living alone, impoverished, in poor health, and without close friends or family to care for them.

Evaluations of HOPE IV reported that the program helped frail persons remain in their public housing apartments. The program's most helpful services, evaluators found, were housekeeping, home health aides, meals, and transportation. A care manager was identified as an important key to the success of the program. Unfortunately, local housing authorities had some difficulty in finding candidates for the program.

Federal Initiatives: Healthcare

Several federal initiatives promote healthcare for the low-income elderly outside nursing homes.

Medicaid Waivers In a limited number of states, the Health Care Financing Administration (HCFA) grants waivers for exploring improved ways to finance services for low-income elderly persons. There are two types of waivers:

- *1115 Waivers* These allow the states that have them to use Medicaid resources to "assist in promoting the objectives" of Medicaid. Projects usually include a research methodology and an independent evaluation. Most projects run for a period of several years, after which they may be renewed.
- *2176 Waivers* These, which are also known as 1915(c) and 1915(d) waivers, allow the states that have them to offer community-based, long-term care services to persons who would otherwise require nursing home care or other forms of institutional care. Programs using these waivers provide a broad range of home and community-based services to elderly, mentally retarded, disabled, and chronically ill persons. (See also **Box**.)

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a national demonstration model integrating care for frail elderly persons who, although eligible for nursing facility care, prefer to live in the community. To enable them to do so, the program uses case management, adult day-care and other community-based services. Evaluations show that PACE reduces hospital and nursing facility use while improving the quality of life of participants. The program's sites receive monthly capitation payments from Medicare and Medicaid.

Several PACE programs have been located in federally assisted housing sites, including HUD 202 buildings. These are often developed in partnership with hospitals or other healthcare organizations, which thereby take responsibility for the medical aspects of participants' care. As a result of the Balanced Budget Act of 1997, PACE became a permanent program and the number of potential sites was greatly increased. This will make it possible to extend access to PACE to residents of federally assisted housing programs throughout the nation.

Older Americans Act The Older Americans Act (OAA) provides limited funds for various programs and services that are important to residents of federally assisted

housing programs. These funds, funneled through state offices, have been used to provide elderly people with congregate meals, companions, housekeeping, transportation and escort services, health promotion and disease prevention programs, and access to information and referral services.

Responsibility for identifying the needs to be met by such funds lies with local officials. They then develop a plan and submit it to the state and the Administration on Aging. Contracts with local agencies–including senior centers, home health agencies, and transportation providers–ensure that limited resources are effectively distributed. Nearly all OAA-funded agencies use volunteers, thereby providing maximum services to targeted populations. Whether those services reach residents of subsidized housing depends on local assessments of needs, service capacities, and delivery priorities.

These HUD- and HHS-sponsored national programs are focused on those in greatest need, administered at the state or local level, and sustained through modest federal grants or budget allocations. They are highly successful in what they attempt to do, providing evidence that HUD and HHS effectively manage important health, shelter, and social service programs.

Unfortunately, these programs are also limited in scope and funding and have almost always operated in isolation from each other. Nevertheless, evaluations of them persuasively suggest that we know what to do to enable frail elderly to age in place–the goal articulated by members of Congress and succeeding administrations for more than 20 years.

State Initiatives

States have provided laboratories for testing ways to advance the goal of independence for frail persons. Most states have been pushed by the dramatic increase in their Medicaid budgets as larger numbers of frail, medically indigent older persons were destined for nursing homes. Some states began years ago to identify ways to divert persons from costly nursing home beds into community programs.

The wisdom of using Medicaid waivers to fund community initiatives spread from state to state. Two states, Wisconsin and Oregon, have pioneered programs that created community options to reduce, or at least slow, the rate of nursing home admissions. Florida, faced earlier than the rest of the nation with this profound demographic shift, has examined policy options and is planning for the growing needs of its aging residents.

Wisconsin For more than 20 years, Wisconsin has sought answers to the questions: How, where, and at what cost should state governments provide care for those least able to care for themselves?

In 1981 the state developed the Community Options Program (COP). The program's two central concepts are, first, placing eligible frail persons at the program's center and, second, bringing the services and support they need, tailored to their special needs, to their homes. Key features of COP include an assessment of the recipient's needs and capacities and a care plan developed and executed with the participation of the recipient himself or herself.

COP is a partnership between the state and county governments, between federal Medicaid funds and state general-purpose revenues, and between recipients and care providers. Support for the program has grown through different administrations, both liberal Democratic and conservative Republican, and changing leadership in the

houses of the state legislature. This long-term care program proves that older persons can be well served when they are put in charge of their own care, when community resources are mobilized, and when agencies make the commitment to care for those in greatest need. In addition, COP has delivered impressive savings over the cost of other alternatives.

Oregon Oregon's leadership in integrating shelter, services, and healthcare into a simple comprehensible, effective program for low-income elders has been widely acknowledged. Faced with a rapid increase in the demand for nursing home beds, Oregon decided to pursue alternatives to the institutional bias found in the allocation of Medicaid and other funds. The state developed what is called the Oregon Plan, which provides needy elderly with financial assistance for shelter, support, and services–with, in short, assisted living.

An analysis of Oregon's long-term care expenditures and its use of Medicaid waiver funds is instructive. A Lewin Group analysis of Oregon's experience reports the following:

- In 1994, through its use of home- and community-based care rather than nursing home facility care, Oregon saved $49 million. Since receiving its Medicaid waiver, the state has had total cost savings of $278 million.
- Oregon spends $638 per person aged 65 and older, compared with a national average of $1,047.
- The number of persons Oregon serves in community settings has increased from 6,000 to 17,000–in less than 10 years.
- Despite an increase in its elderly population, Oregon's nursing home census declined by 15 percent among persons aged 75 and older between 1981 and 1994.

A state strategy to improve the quality of life of elderly poor persons by offering them shelter with services has paid huge dividends–for older persons, for their care providers, and for the state's taxpayers. With this strategy Oregon has, since 1987, tripled the number of persons receiving less expensive community-based services in settings of their choosing. In the process, Oregon has developed a long-term care infrastructure and policy base that promises high-quality care and lower costs for more persons in the years ahead. A close examination of Oregon's policies and experience provides strong evidence that a long-term care policy that integrates shelter, services, and healthcare into one system makes good sense for all involved.

Florida This state offers, first, a compelling case for integrating shelter with services for low-income elderly impaired persons, and, second, a strategy for achieving it.

With over 18 percent of its population aged 65 and older, Florida is a snapshot showing the rest of the nation how it will look in the near term. The state urgently needed a long-term care system filling three needs:

- High-quality, affordable, appropriate shelter with services for those least able to care for themselves
- Support for their care providers
- Relief for those who pay, directly or indirectly, for the care

Florida encouraged the state agencies involved to study models of care developed in

other states and create demonstration projects that would test concepts and practices based on them. The agencies then made six recommendations that have met wide approval from rent-subsidized housing organizations and service providers. Florida was urged to:

- Fund additional service coordinators within rent-subsidized facilities
- Create incentives for rent-subsidized facilities to provide services that help older tenants to age in place
- Develop partnerships to expand supportive services to elder residents in rent-subsidized facilities
- Articulate the state's commitment to the development of a well-organized and comprehensive long-term care system featuring the growth of home and community-based programs
- Integrate and expand medical care (through the use of home health nursing and home health aides) into home- and community-based programs
- Expand its Extended Congregate Care program to absorb those who would otherwise be placed in nursing homes

Toward a National Policy for a Continuum of Care

Having examined several national and state strategies, we find that there is a significant body of thought, experience, and knowledge to guide our nation in its response to older persons who face the triple jeopardy of poverty, chronic illness, and living alone. For the segment of the population living in federally assisted housing, a continuum of care that brings together shelter, social services, and healthcare is a sensible, cost-effective solution.

We now know *who* needs care. We know *where* they prefer to receive it. We know *which services* are needed. And we know *how* to provide them--through an integrated, comprehensive, affordable system.

The Elderly Housing Coalition is recommending the adoption of a national policy that will ensure the right of elderly low-income persons to decent, safe, affordable housing with appropriate services. This would translate core values of the American people into a policy that protects vulnerable elders with appropriate and affordable shelter, supportive services, and health care to enable them to live independently in their homes and communities.

Achieving this goal will require the development of a continuum of care: an integrated system of housing, health, and support services. A continuum of care includes an array of services that are accessible, affordable, and coordinated for older persons who live in federally supported housing. It would be developed utilizing the experience of past successes and demonstrations which show that federal, state, and local services and funding must be coordinated to achieve results and efficiencies, and to ensure quality health and housing programs for the nation's vulnerable elderly persons.

For more information contact Julie Trocchio, 202-721-6320.

* The Older Americans Act of 1965 established the Administration on Aging as an agency of the U.S. Department of Health and Human Services. The agency administers programs that, among other things, provide supportive services to

vulnerable older people who want to remain in their own homes.

§ This article focuses on those vulnerable older persons who reside in federally assisted housing or are eligible for Section 8 vouchers. But millions of others face the same cost barrier.

The Coalition's Findings in Brief
From their long experience in developing appropriate housing for older people, the members of the Elderly Housing Coalition have reached the following conclusions: • Elderly residents of subsidized housing and recipients of housing vouchers are at risk of institutionalization or neglect because of declining health and the loss or absence of support and timely interventions. Residents who are in great need but possess few resources constitute a group to which supportive services can be delivered in an efficient and effective manner. • Service coordinators in elderly housing projects have successfully assisted frail persons to access information, programs, benefits, and connections that promote their well-being and enrich the quality of their lives. • The success of HUD's Congregate Housing Services Program and HOPE for Elderly Independence provide the foundation on which the nation could base supportive housing programs for its elderly. • Delivery of services in federally subsidized housing is often fragmented because of multiple funding streams, conflicting regulations, and overlapping state and federal agencies. This fragmentation is not just costly; it also leaves serious gaps in the meeting of needs. • HUD, HHS, and the various states participating in demonstration programs have creatively addressed problems associated with declining health, frailty, and poverty among the nation's elders. The use of Medicaid waivers to support community-based programs has been innovative and successful in serving frail citizens where they live and, thus, in reducing nursing home placements.

The Coalition's Recommendations

The Elderly Housing Coalition urges the federal government to:

- Create a partnership between HUD and HHS to coordinate and maximize the benefits of federal housing and health programs for vulnerable residents. The government should authorize, finance, and administer programs that bring together shelter, healthcare, supportive services, and social services to help elderly residents remain independent as long as possible.
- Develop a continuum of care that offers supportive services to low-income elderly people whether they live in federally assisted housing projects that provide such services, or they receive a subsidy for their shelter and service needs.
- Give incentives and resources to federally assisted housing programs that encourage them to provide services and outreach not only to elderly residents but also to frail elderly people living in the neighborhood.
- Offer assisted living to frail elderly residents of federally assisted housing programs. Financial and other resources are needed to both add services and cover the structural modifications necessary to make affordable assisted living an option for elderly residents of subsidized housing.
- Find other funding sources for the conversion of federally supported housing to assisted living. Such funds should no longer be taken from allocations vital to the expansion of the Section 202 program, as they are at present.
- Establish HUD's Service Coordinator Program as an essential service authorized and adequately funded to ensure that every elderly resident of subsidized housing has access to a staff person knowledgeable about community services and sensitive to the needs of older people, especially the frail.

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The CHAIRMAN. Thank you very much, Ms. White. We appreciate your testimony.

I am going to adhere to a 5-minute round of questioning for all of us, and of course, we can repeat as often as is necessary to complete; so if staff would take care of the lights for us, that would be appreciated.

I apologize, Ms. Heady. I did not get a chance to hear your testimony. I will read it, and I do have some questions that I would like to start with you on.

You mention in your testimony that several obstacles prevent the elderly from accessing quality health care in rural areas. What do you think is the single biggest obstacle that is the challenge out there that we should be tackling?

Ms. HEADY. I think there are two things—transportation and providers; having the appropriate level of care and services as close to the elderly as possible, and their transportation to even get to it.

One thing that we see happening, particularly with some of our primary care centers—in West Virginia, we have some of the most per capita—we have 102 primary care centers right now in our State. And when reimbursement to those centers becomes a problem, and they have to close some of their satellite operations, we see that the elderly are the ones who suffer the most, because they are most of the population who patronize those service centers.

The CHAIRMAN. Are you experiencing in West Virginia something similar to what we are experiencing in Idaho—and Ms. Adams mentioned it—that when we lose employment that is traditional to the region that oftentimes provides the economics that maintain the infrastructure of health care—hospitals—the seniors who are staying there, or living there still, oftentimes are tremendously disadvantaged because the younger worker has lost his or her job and moves elsewhere, and the economy changes?

Ms. HEADY. Exactly. In fact, that is one reason why West Virginia is getting as old as it is, because we have the generation of workers who can support that population, and the younger population is actually leaving our State to find employment.

The other thing that is unique in rural areas is that in many, many rural communities, the health care industry, if it is not the first employer is the second or third-largest employer in that particular county. Just for example, with the 24 closures of home health agencies that we have had in our State, we lost 1,000 jobs, and those 1,000 jobs are in predominantly rural communities. So it is a domino effect; we not only impact the direct services to the elderly, but long term, we impact it even greater when we impact the economy of the health care delivery system. So it is true that we are experiencing the same thing in our State.

The CHAIRMAN. Thank you.

Mr. Sykes, again, thank you for your testimony. You have been working with the elderly and housing for 30-plus years. From your own experience, what do you see as the benefit of keeping seniors in their own homes and in their own communities?

Mr. SYKES. I am delighted to say that as a gerontologist over these years that we have come to the conclusion that the benefits

are so substantial that we have to use all of the energy and policy and resources that we can find to accomplish that goal.

First and foremost, it is where most elders want to be; it is what gives them emotional support as well as the feeling that they can retain their independence for as long as possible.

It is not simply, in my judgment, a diversion from skilled care. There comes a time in people's lives when they need that level of care. But we have also discovered to an extraordinary degree in Wisconsin and elsewhere that with certain kinds of supports, timely supports at the right time in the individual's life, with careful assessment, with a care plan that works, and with the monitoring of the quality of the care that one is receiving, people who just 5 and 10 years ago in our own independent housing would have had to move out are now able to stay in their homes.

Part of this is due to medical advances, but far more of it is because we have made policy commitments to support those persons who are in fact providing the care that individuals need.

The CHAIRMAN. We have been joined by Senator Carper. He does not have an opening statement. We are pleased, Senator, that you could spend some time with the committee this morning.

Senator Carper. Thank you, Mr. Chairman.

Mr. Sykes, do you have an example of best practice that highlights the type of community partnership that you described with a combination of Federal, State, local governments, private corporations, religious groups, hospitals—and then again, in all of that, what are the greatest challenges of these kinds of collaborations, and how do we overcome those challenges?

Mr. SYKES. I am pleased to say that in many parts of our State and country, we have found ways to bring together the kinds of resources that we are talking about. I am thinking of a low-income housing tax credit project where the private sector is putting up the funds necessary to do the construction of the project; I am looking at some of the community development block grant moneys that become available for programs that are serving people in transition of one kind or another, another channel of resources. There is private fundraising, either with or around the United Way; efforts to bring those programs.

Your question had to do with best practices. I cannot look at a project across the State of Wisconsin that I have had some role in in my State Housing Finance chairmanship that does not reflect the kind of partnership of a variety of sources. Frequently, it is the donation of a piece of land that gets it started in the right place at the right time, and then come, with some careful planning, the resources to sustain it.

Terribly important to most of the lowest-income people in both rural and other parts of America is the Section 8 subsidy, a sufficient subsidy to enable somebody to pay whomever owns or manages that property a fair market rate so that that property, that program, can be sustained.

It takes all of the above to make a good project, and we have lots of wonderful examples, whether they were begun by churches or a trade union or a rural hospital or a corporation, as in the case of the Sun Prairie story.

The CHAIRMAN. Thank you.

Let me turn now to Senator Kohl.

Herb.

Senator KOHL. Thank you very much, Senator Craig.

Mr. Sykes, you have highlighted several examples of Wisconsin businesses and hospitals that took the initiative to address the needs of the elderly in their communities. Ideally, we would like to see more businesses take a more active role in this area. Is there anything that the Congress or the Government can do to encourage this?

Mr. SYKES. That is a tough one, and speaking as a corporate officer myself for many years, I realize that there was not a particular program that induced us to start building elderly housing.

I think that what is needed is a public awareness campaign that says that to be successful, a corporation—especially a large company in a small town—the responsibility goes beyond adequate pay to the workers, adequate retirement benefits to the workers, but to help create within that community the kinds of conditions and environment in which people can grow old, can live comfortably, can have a high level of satisfaction.

Most of the successful corporations in the country have either a foundation or have reasonable pots of resources that they can make available within their community.

So I do not see, other than programs that generally encourage—obviously, the 5 percent write-off that we get as a cost of doing business is an initial kind of incentive—but I think it is going to take a good effort at public information.

HUD's Best Practices Program highlights a lot of successful projects. I think that when we show other corporations that they can do what we have done in a community, that is the single best thing. I am sorry, I do not have a good answer for what the Government's role should be to help the private sector take the initiatives that my company did.

Senator KOHL. Mr. Sykes, as you know, the Senate will take up the budget next week. In your opinion, which programs affecting housing for the elderly in rural areas should we continue to make a priority in this year's budget?

Mr. SYKES. Thank you. That is a really important question.

First, let me say that working with the Elderly Housing Coalition here in Washington and the National Council on Aging in that group, we clearly came to the conclusion that right now, with approximately 1.5 million elders in subsidized housing, and with that population growing old very rapidly and becoming increasingly frail, the most cost-effective and humane policy for the Government is to support such initiatives as I will mention one quick moment that will enable those people to stay where they are and not to move.

The first is the whole idea of service coordinators within subsidized housing. That has shown that we can connect people who are frail with resources extant in the community to enable them to stay in their homes. That is an important program; it is in the budget at $50 million. It should be expanded. It should be available to every housing project, even some of the small ones that do not seem to support that level of responsibility.

Second, I think we need to use the resources of both HHS and HUD to be certain that people who are in or need to be in subsidized housing have those benefits brought together. That requires some level of flexibility; it has required funds from more than one place. But when they come together—and my example would be the HUD Congregate Housing Services Program that has been funded and revised, but it has always been so marginal that it is a token program, very much as the Title V program is a token program—we know how many people could benefit from this. If we could just move it ahead another $50 million for service coordinators, another $50 million for the Congregate Housing Services Program, we will be making important steps toward enabling people to remain in their homes.

And third, we have a lot of projects that need retrofitting. Where there are already 24 people living in a rural area or community, by just some modifications in that facility itself, we can provide the community spaces, we can collocate community service providers in that facility that will enable those people to continue to live in their homes longer.

Those are important initiatives. They are not new. We certainly need substantially more resources to make them effective across the country.

Senator KOHL. Thank you.

My last question is for all the members of the panel. What are the most critical programs for our rural elderly that need additional Government support? What are one or two of the most critical programs, in your opinion, that we need to focus on this year in terms of supplying resources?

Ms. Heady.

Ms. HEADY. I would say any of the Federal programs, and particularly the rural health outreach grants, should fund groups to do partnership services in other words, to go into an area where you have low density numbers who are participating in the program—and require those groups to come together to make available their unduplicated services. This approach is probably the smartest thing that we can do with what money we have available for rural communities.

Programs that provides for existing health care providers to be much more innovative, to go out of their dependency on their reimbursement stream and to really innovate and try to do "push the envelope" for rural seniors should be supported.

Senator KOHL. Thank you.

Ms. Adams.

Ms. ADAMS. I would have to say that the recent wave of layoffs and business closures both in Idaho and throughout many other States is something that we really need to take a hard look at now.

We need to look at the past and take some preventive action based on that. About 14 years ago, when the bottom fell out of silver, smelters and mines shut down in Northern Idaho; there were widespread layoffs. The incidence of suicide among older males in the Silver Valley section of our State skyrocketed.

We cannot let unemployment do that to our seniors again. Reemployment can be a very, very difficult problem in rural America. You cannot just pick up and leave when your life savings are tied

up in your house, and homes are not selling. Even though you have a lifetime of very substantive experience, let us say in refrigeration systems for mining, how can you transfer that when the industry is so very depressed?

On top of that, many of our older people are very entrenched in their rural communities—they are third- and fourth-generation families.

Dr. Barbara McIntosh at the University of Vermont is a business professor who is looking into the whole issue of older workers being dislocated from their jobs, and what she is finding is that those older people who succeed in getting reemployed are those who get connected with the dislocated worker initiatives that are triggered now, when there are massive layoffs.

That is a long answer to your question, but what we need to do is make sure that there is legislative emphasis on older worker service within the dislocated worker section of the Workforce Investment Act. That is sorely missing right now.

Unfortunately, when this new legislation was passed in 1998, it even removed as an eligibility criterion long-term unemployed, and that is how, in previous legislation, we made many of our older individuals eligible for those very services.

So I would encourage legislative emphasis in the Workforce Investment Act.

Senator KOHL. Thank you.

Ms. White.

Ms. WHITE. I think it is critical that we fund elderly nutrition programs at an appropriate level. Many of the communities—for example, the one in Knoxville—have doubled the number of people they serve with home-delivered meals over the last 4 years, with no increasing in funding, and funding is at 50 percent of 1973 levels.

I also think it is critical that elders have access to nutrition services through Medicare, particularly for cardiovascular disease, hypertension, congestive heart failure, and the dyslipidemias, which are major contributors to poor health and limited functional status in our elderly.

Senator KOHL. Thank you.

Thank you, Senator Craig.

The CHAIRMAN. Thank you.

Senator Ensign.

Senator ENSIGN. Thank you, Mr. Chairman.

I have a few questions, first for Mr. Sykes. I have dealt a lot in the past with the low-income housing tax credit, and one of my first experiences with it was when I was on the Ways and Means Committee in the House, and we were trying to eliminate the low-income housing tax credit because there had been a lot of problems with it in the past.

After doing a lot of research, I actually became a big supporter of the low-income housing tax credit because I realized what an efficient use of Government tax dollars it is versus normal public housing.

It was an experience with senior housing with the low-income housing tax credit that really turned me around. At the opening of one of these projects, in Las Vegas there were a lot more people

there who wanted to get into the place than there were available units.

This brings me to the point that I would like you to comment on. We talked about Section 8 and some of the other types of things that the elderly utilize, and some of our public housing things with the elderly do seem to me to be the most successful parts of our public housing. Additionally, the tax credits seem to be the most efficient use of the money.

In rural and in fast-growing areas, however, the tax credit seems to be totally inadequate. That is why I have sponsored legislation in the past and will continue to do so. To expand the tax credit and to look for other ways to make more affordable housing for people, especially our senior population, who need it the most, and for those in rural areas where it is going to be critical.

I would just like your comments on that.

Mr. SYKES. First, in candor, I must say that any effort to meet a substantial major national problem by using tax expenditures as opposed to budget outlays is not efficient. As one who has used tax credits and as one who is part of a profitable corporation, to be able to make a community investment, if you will, and also pay in effect less taxes by doing good within the local community is a very attractive alternative. Certainly all the housing bonds that I signed during my years on the State Housing Finance Agency, it was always with a little bit of difficulty in my hand, because it just seemed to me like a less direct way to bring the resources of our Nation to bear on a very large problem.

However, in the meantime, it does work, and one reason why the low-income housing tax credit works efficiently is because it does target a population that really needs support; it puts them in a project which is not only built for the poorest of the poor, but it provides for some market-rate rents as well. So the result is a more habitable environment for those who live in a low-income housing tax credit program.

Equally important to me is that in order for one of those to go up, you have already to have achieved a very high level of cooperation among many people within the community—not only the Government, but also private business, with personal contributors, to those who are supporting the programs that the people who live in that housing need as well.

So it is an effort to really bring the community together, and to that extent I think has worked very well. I am frankly distressed with the amount of resources, when they are finally added up, that go to accountants and lawyers and bankers to comply with all the provisions of it. There is a better way to do it, and it is called outlays. It is not a politically achievable thing, so I am just going to wish for a better time.

Senator ENSIGN. Thank you.

Ms. White, I would like to address quickly—because when I was in the House, I was very involved, as Senator Craig was here on the Senate side—the Medical Nutrition Therapy Act. Having a lot of experience in our family with a diabetic and seeing the horrible things that diabetes can do to a person, but also seeing over the years how much dietitians have helped her, there is no question that more of these kinds of things are going to be important. But

even if we have the Medical Nutrition Therapy Act, where Medicare is paying for some of these diseases—and obviously, we are happy that they are now paying for kidney and diabetes treatments, but there are a few other diseases like heart diseases and cancer that we still need to be paying for—what about rural Nevada? Are there adequate supplies of registered dietitians to be able to meet the needs, even through Medicare?

Ms. WHITE. Again, that is why I was talking about ways to increase access of dietitians in rural areas. An example is the National Health Service Corps that dietitians were a part of in earlier years and are now excluded from. I think that is one way.

I think that distance learning modalities that are interactive, that would allow individuals to access nutrition services via computer or telemedicine—we are using telemedicine in our family practice program with resident education and the delivery of some types of health care services—just think what we could do if we could utilize this technology to provide nutrition education and counseling to people in remote areas.

I also think that we have to recognize that the meals programs through the Older Americans Act do offer medical nutrition therapy as well as food. In urban areas, they are required to provide five meals a week home-delivered, but in rural areas, it may be only two or three meals a week that are provided.

I think we have to expand the opportunities for our seniors not only to receive home-delivered meals—and now, with the waiting lists 2 months, 3 months, 4 months in Knox County, and with 85 or more individuals on that list, only the most critical are being served. We are not preventing; we are just putting a bandaid on food needs in this population.

Senator ENSIGN. Thank you.

Ms. Heady.

Ms. HEADY. I would like to comment on your question as well. My mother, who lives in rural North Alabama, was just diagnosed with diabetes, and from West Virginia, I attempted to find a registered dietitian or a certified diabetes educator to work with her in her home, because she is currently not driving. The closest person I could find who would actually make a home visit—and my mother is fortunate—she has kids who can pay for it—was 3 hours away in Tennessee. She could get a diabetic class, and she could receive instruction at the local hospital, but not follow-up care. That is part of the problem with the reimbursement that we have seen with home health agencies that can only take the very ill, as Ms. White was saying.

Ms. WHITE. That is right, and there is no provision for medical nutrition therapy services in home health. I think that if we had that option, dietitians could go out, either with home health agencies or even through the local health department, and provide some of these services.

Senator ENSIGN. When you were talking about the telemedicine and some of the things via computer, that might be one thing we will have to look at utilizing in places like senior centers. In Nevada—and I am sure that all of us on the campaign trail learn where the senior centers are—every small community has a senior

center, and a lot of the seniors go to those places, and that might be a place to provide some of these services.

Ms. WHITE. Right. And the congregate meals at the senior centers do offer the opportunity for elders to get together and socialize. The problem is that those areas of the elderly nutrition program really have not been able to grow because the demands are so high for home-delivered meals, and transportation is so difficult in these areas.

Senator ENSIGN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Breaux.

Senator BREAUX. I want to thank the panel for the very important and educational statements from each and everyone of you. As we try to get this committee to concentrate on helping to provide quality of life for seniors, everything that you all are involved in is part of that equation.

Ms. White, the whole area of nutrition is so critically important. Why is it that the Meals-on-Wheels are unable to provide more services in rural areas than they do in urban areas? Is it just a funding problem?

Ms. WHITE. It is a funding issue; it is an issue of access, transportation, volunteers needed to deliver the meals. For example, in Knox County, we have 450 volunteers a year, 55 per meal delivery, period. But we need 75 in order to reach the number of people who need to be served.

Senator BREAUX. So it is more expensive in rural areas.

Ms. WHITE. Oh, yes, it is more expensive because of the transportation costs involved. If we could bring people to the senior centers, we have screening, and we could have dietitians available to work with them.

Senator BREAUX. I imagine that for many of the seniors who are living alone and who depend on Meals-on-Wheels, it may be just about the only contact they have with the outside world and perhaps the only meal they get.

Ms. WHITE. Absolutely. I have a number of examples from Houma, LA, which is where I was born and where I cared for my parents, showing that for very elderly individuals who have lost their spouses and have no living family members, this meal is a lifeline for them both from the standpoint of social contact and just from the standpoint of food.

The one meal a day with the senior nutrition program supplies two-thirds of the calories and nutrients that those individuals need. It is an incredible boon and really allows folks to live in their own homes.

Senator BREAUX. Which is a savings in the long term by a big margin. I wonder what it would take if we wanted to make a commitment that the Government would ensure that we would fully fund or help to fund a Meals-on-Wheels program for rural America. I think it would be a good investment, because in the long-term, if a person is not adequately fed with a Meals-on-Wheels program, he is going to end up in a nursing home or a hospital, and it is going to cost us a lot more per day to have him served there than to spend another year or two in his own home, receiving food.

Ms. WHITE. Absolutely. Food helps to maintain function, it helps to maintain quality of life. Appropriate food really helps to prevent some of the complications associated with many of the chronic diet-related diseases that are killers.

Senator BREAUX. We just have to be smarter, I think, Mr. Chairman, on how we spend money in order to be more efficient and more effective. I am a firm believer that sometimes a little bit of money spent up front saves us a lot of money in the long term down the road. Adequate health care in the beginning for children prevents us from spending a great deal more because they do not have health care and we wait until it becomes an emergency in the emergency room. Something as simple as Meals-on-Wheels in a home setting could save us a lot of money in nursing home costs and hospital costs if we do not provide that.

So I think we need to really be looking at the budget in that regard as an investment and as a long-term savings. I do not think anybody on the Joint Committee on Taxation could give us a scoring on this, but common sense would give us a scoring that says that we save money by keeping people in their own home settings and adequately feeding them instead of putting them in a nursing home at $1,000 per week or more.

I thank all of you. It has been very helpful, and everything that you have said will be very important to this committee.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, John.

Ms. White, you kept using the figure 50 percent of 1973 funding levels. Could you expand on that for us? That is a fairly alarming statement.

Ms. WHITE. Right. That figure comes directly from information provided by the Administration on Aging regarding funding levels for these programs.

The CHAIRMAN. Is that an aggregate figure, or is that specific to nutrition programs?

Ms. WHITE. That is specific to the elderly nutrition programs.

The CHAIRMAN. OK.

Ms. WHITE. In Knox County, I have been very involved with the feeding program there, and we have only been able to increase numbers served from 400 to 800 through an aggressive community funding outreach program. And again, the waiting list in Knox County is 4 months. We have 85 people on that list. I work with family physicians in the area to try to get an elderly person who is being released from the hospital on that meals program, and it is almost impossible, even if they can pay for the cost of the meal. We simply do not have the resources transportation-wise and volunteer-wise to get the meals there.

The CHAIRMAN. And as you have mentioned, any of us who spend time in the senior centers of our communities in our States see a phenomenal stretching of the dollar—I am absolutely amazed—and a very large voluntary effort to do what they get done. They have truly taken the dollar available and stretched it probably more than they ever thought they could or would.

Ms. Adams, let me turn to you for a couple of questions before I come back to Ms. White. Recent data indicates that staying active in the workplace keeps seniors healthier longer and can contribute

to a higher quality of life. Because of this new data, I am especially interested in ways that employers can help those seniors who still want to work. From your experience, how does employer behavior affect seniors working, and are there ways for this relationship to improve?

Ms. ADAMS. Those employers who show that they value the experience of older workers make a huge difference in terms of that older worker wanting to stay employed and working longer.

Those employers who will take a look at their fringe benefit packages and structure those packages to better meet the needs of an older employee as opposed to just a younger employee who might have a need for child care and other kinds of benefits, those employers who really look at the needs of an older worker and offer flexible work arrangements that meet the older person's need to visit their grandchildren in the summer or work part-time or work half a year as opposed to a full year, those are the employers, I think, who are really the employers that older workers want to stay with.

There are a number of large corporations, too, that are beginning to actually look at their pension plans and restructure them to make them more older-worker-friendly, to encourage older workers to work beyond normal retirement age.

Polaroid Corporation has done some very interesting things in terms of phased retirement, allowing an older individual to take 6 months off and then come back and work the remainder of the year.

There is much that employers can do to encourage a longer work life.

The CHAIRMAN. You mentioned in your testimony that the loss of traditional jobs in rural areas—and you have highlighted several in Idaho in logging, agriculture, and mining—is forcing workers out of work, or at least, certainly, older workers. What types of programs are working in Idaho to retain these displaced workers, and do you think these applications would work in other States?

Ms. ADAMS. We do have a very effective dislocated worker program in Idaho. Rapid response teams are put together around plant closures and layoffs, and those response teams consist of labor and management and worker representation as well as our State Department of Labor. We need to make sure that older worker staff are looped into those kinds of rapid response teams so that they can focus on the needs of the older dislocated worker who has a much more difficult time getting reemployed.

We also need more Senior Community Service Employment Program funds to help serve this need. We have been at flat funding for years, and the current program only serves 2 percent of the eligible population. So if we had more funds, we could focus more emphasis on these dislocated people.

The CHAIRMAN. Thank you.

Ms. White, the Senator from Nevada mentioned, and we worked cooperatively together, both the House and Senate, last year on legislation to provide for medical nutrition therapy and coverage for diabetes and kidney disease. This year, I am working to expand coverage for people with cardiovascular disease, and I am enlisting the support of my colleagues to get this done.

Can you briefly discuss the types of benefits that nutrition therapy provides to seniors? You have already highlighted some, but I am always amazed to see the role of good nutrition in both the quality of life of the individual senior but also the extension of life and the vibrancy of the life that they have.

Ms. WHITE. Absolutely. Good nutrition, particularly for people with diabetes or the dyslipidemias, can No. 1 reduce complications. We know that if you normalize blood sugar, if you get lipid levels to less than 200 total, and for people with established disease less than 100 LDL, you can significantly reduce complications, you can reduce the need for medications, you can reduce readmission rates to acute care systems, you can reduce length of stay in acute care settings, you can improve wound healing and enhance immune function.

Nutrition is integral to life, and you can just improve all of these factors. There is a lot of evidence to show—some people think that older people really are not motivated to change life styles—but in fact, older people are probably more receptive than any other age group. They would much rather modify diet and life style than add another drug to an already often very complicated drug system. Again, this saves money.

The CHAIRMAN. Thank you.

Senator Kohl.

Senator KOHL. Thank you, Senator Craig.

Well, you have made it very clear that there is a desperate need for increased funding to improve the quality of life of people who live in the rural areas of our country and who are elderly, and that there would be a significant improvement in their lives if we could get just 5 or 10 percent more funding. It is not like you are suggesting that there is so much funding out there that there is not much more we can do—it is to the contrary—that there are enormous things that could be accomplished if we could get just a little bit more funding.

So when we look at our Federal budget as citizens, and read about what it is we are proposing to do, and how we are thinking about spending the surplus, and just for example, spending $1.6 trillion over 10 years on tax cuts—which I am not quarreling with, and I am not being critical about—but you wonder whether we should be able to find some additional funding for some of these needs that you are talking about this morning. Do you think that if you had a chance to work on that budget, you might be able to figure out how we can use our resources here at the Federal level to do a better job with the rural elderly in our country, Ms. White?

Ms. WHITE. Absolutely. Food is such a basic need, and we have such an abundance of food in this country; it is a shame that we cannot find the funds and the means to get this food to the people who are in desperate need of it and to whom it would make an enormous difference in health and in quality of life.

Senator KOHL. Ms. Adams.

Ms. ADAMS. I think that we probably need to do a better job of looking at the return on investment that these programs really provide and communicate that to lawmakers. When you look at our older worker programs in terms of those people who get jobs off the program, and when you look at how much money those people are

generating via paychecks that they earn, taxes that they pay—I know that our Idaho older worker programs pay for themselves in just 11 months.

So this is a very wise investment of tax dollars. Furthermore, we also need to look at the value that the Senior Community Service Employment Program brings to our communities in the form of public service; they also provide infrastructure support for all of the aging programs that you have heard described today.

So maybe we need to do a better job of communicating the value of these programs, again, to decisionmakers like yourselves.

Senator KOHL. Thank you.

Mr. Sykes.

Mr. SYKES. I do not want to be cynical in regard to the last point, but during the time when I was on the Federal Council on Aging, we did a very major study of the Title V program, and the evidence was overwhelming that the purposes were being fulfilled, the eligibility was carefully targeted, the results were incredible. And we barely kept from losing the program totally, and it has been flat-funded for years despite that reality.

So yes, Melinda, we do need to deliver those facts. I would go to housing quickly and show the 202 program. There is none within the housing area that has wider public support, and we who have put 202 programs together have daily evidence of a program that works, and it works well. It is expensive, but it works, and it keeps people from laying out money in another way.

We could easily and effectively double or triple the number of units in the 202 program, and communities across this country would be beneficiaries, and many elders would find alternatives to either neglect, which is all too often the situation, or institutionalization.

I would like to join the force and help to figure out some ways not simply to divert from a tax refund, but I know in terms of the elders of America and rural elders that there will be a much higher return on investment, if you will, and a much greater benefit for doing things to increase the likelihood that that local environment will support them in their homes, with the services they need, than any amount of money that will pass to me or to my rich children in terms of a tax children.

Senator KOHL. Thank you, Mr. Sykes.

Ms. Heady.

Ms. HEADY. Thank you.

I would like to offer something that would be a mere drop or even less than a drop in the Federal budget, and that is to look at studying the next generation, the rural aging veteran. We have a window of opportunity right now to start looking at and preventing some serious, serious problems in the future. Right now, we have 1.5 million elderly who are in subsidized housing, and right now, we have diagnosed 1.5 million veterans with PTSD, and these are guys whose families are disintegrating, they are winding up on park benches, and they are becoming part of the rural homeless as well.

We have outreach centers, and if we can get some better knowledge about what they need, how to survey that population—we

have not even looked at that population since 1988—we can gear ourselves up.

One thing that I find most frustrating about this issue is that whenever I say the word "veteran," everybody immediately sends everything to the Veterans' Administration. They think that that is where it all belongs. But that is not true. Particularly in rural communities, when these veterans are spread out among the rural population—and we do know that there are more aging Vietnam-era veterans in rural areas than any place else in the country—it is an issue that we really do need to look at. And unfortunately, we do not even know enough about it to talk about it intelligently in a policy arena. Only those of us who have been personally affected by it and have tried to get services for either the veteran or his family through the outreach centers can really see the tip of the iceberg.

From what I have learned personally—and I know women who now, for 30 years, have slept every night with a man who keeps a loaded weapon under his bed because that is the only way he can sleep—we really have a serious problem that we need to look at.

Senator KOHL. Say that again, please.

Ms. HEADY. I personally know women whose veteran husbands sleep with loaded weapons. They feel that they need to have that level of security to be able to get whatever sleep they can get for the night—and that has been going on in their relationships for 30 years.

Senator KOHL. Well, thank you. You have been a great panel.

The CHAIRMAN. Let me extend that thanks, too. You have all been a great panel. There are a good many more questions that we could ask, but time is not going to allow that to happen.

We will leave the record open for several days, and we may extend to you some questions in writing to complete the record and would appreciate your cooperation there.

Again, we have obviously just surfaced the tip of the iceberg on this issue, and as it grows and as our communities grow older, we would hope that the programs that we can make available will be well-funded and flexible enough to adjust to the changes occurring out there with an aging America.

I am fascinated by the sheer numbers and the length of health. I tell this story because it is real, and I think it well-illustrates it. My wife's parents are in their eighties and are alive and healthy, going strong, living in a retirement center in Tucson. We visit them as often as we can, and during the holidays of this past winter, we were down there. They live in a very lovely retirement center, and they are fully active, so they can still interact well with their community.

We were sitting in the dining room having dinner, and two fellows walked through—you are only allowed to use canes in that dining room; you cannot access it with wheelchairs or walkers—and they came roaring through on their canes, and as they passed by, my father-in-law said, "There is 100 and so many months and another 100 and so many months." There were two living, active members of that immediate community who were 100 years old or better.

It kind of washed over me—oh, my goodness—and that is happening everywhere else in America, and it continues to increase. So we have a job to get done.

Thank you all very much for being with us this morning. We appreciate it.

The committee will stand adjourned.

[Whereupon, at 11:17 a.m., the committee was adjourned.]

APPENDIX

April 13, 2001

The Honorable Larry E. Craig, Chairman
Special Committee on Aging
Washington DC 20510-6400

Dear Mr.Chairman,

During the Senate Special Committee on Aging's hearing on "Healthy Aging in Rural America," Senator Herb Kohl asked me what incentives could the federal government provide to encourage the private sector to play an active role in developing affordable housing for older persons. His question warranted a more thoughtful reply than I gave and therefore, I would like you to consider adding this letter to the record of the hearing.

First, housing development requires predevelopment financing and working capital. Developers must spend money for site options, market analyses, financial feasibility studies, architectural and site planning, environmental reviews, and to obtain zoning and other approvals—costs that must be met prior to their obtaining construction or permanent financing. Projects also require working capital for site development before housing can be built. Conventional construction lenders are willing to lend only part of the cost of site development and construction of units leaving developers to rely on their own equity or to seek subordinated loans.

Nonprofit developers who have developed many outstanding affordable housing projects usually have very limited funds for such expenses as noted above. For-profit developers are reluctant to use their own capital for affordable housing when they can invest in more expensive housing with a higher potential profit margin. Expanding the availability of predevelopment financing and working capital could significantly increase the amount and quality of affordable housing that could be developed.

Were the federal government to provide at attractive rates predevelopment and working capital loans to for-profit developers willing to build housing for persons with low income, it is reasonable to assume that such incentives would encourage the private sector to become active in this endeavor. Such funds could be managed by national nonprofit intermediaries such as the Housing Partnership Network, Local Initiatives Support Corporation and the Enterprise Foundation and locally based intermediaries such as Community Development Financial Institutions. Federal funds could leverage private investments and, depending on the loan requirements, lower the overall cost of predevelopment and working capital loans, especially if federal funds were to be provided to intermediaries at low or no cost. The presence of federal funds in a loan pool would help offset the risk that now keeps private capital from being made available for

predevelopment and working capital loans.

Second, if the federal government were to adopt legislation with significant allocations to increase the supply of affordable housing and were the government to encourage the private sector to become active in this mission, then the government will need to partner with intermediaries who have the capacity and competence to facilitate the production of affordable housing. Such an arrangements will result in the efficient development of affordable housing, especially in rural America where the need is great and the number of potential developers few. Unfortunately, while we know about the effectiveness of programs utilizing HUD technical assistance monies, the recent record is disappointing. Permit me to cite the Wisconsin experience.

In 1994, HUD made available $693,000 for training and technical assistance to Community Housing Development Organizations ("CHDOs") in Wisconsin under the HOME Program, to be used over a three-year period. In 1998, the same amount was made available to technical assistance providers to be used in one year. The Wisconsin Partnership for Housing Development, on whose board I serve, effectively utilized those funds to help Wisconsin CHDOs produce affordable housing. However, in 1999, HUD offered only about $108,000 for the same purpose, and annual funding for the technical assistance program remains today at that inadequate level.

Private lenders and investors need incentives to invest in the development of affordable housing. They need the technical assistance of competent professionals to assist them through the development steps and to guide them through the maze of governmental regulations. Private foundations are reluctant to fund technical assistance because its value, already demonstrated, is not a new idea. If the federal government is responsive to the critical need for more affordable housing and wants to encourage private-sector financial partners to help meet that need, then it needs to increase allocations for technical assistance services. I believe a relatively small public investment could produce big returns in affordable housing.

Third, the federal government should substantially simplify its two primary housing production programs, HOME and Low Income Housing Tax Credits, if it expects to increase private-sector involvement in producing affordable housing. Although simplifying federal programs is not easy, less complex programs will save money and encourage potential investors and developers to engage in helping to meet the serious national shortage of affordable housing. The money that now is spent on legal and accounting fees, often as much as $50,000 even for a fairly straightforward project, to make certain that the project complies with complicated federal rules could be better spent to produce more housing. Private lenders and investors are discouraged from

making capital available to projects because when developers, owners and managers are unable to follow the complex rules, their investment may be jeopardized. To offset those risks, they demand higher rates of return than they would expect if the programs were governed by simpler rules.

The primary reason we should want to attract lenders, investors, employers and developers is, simply, to produce not only more affordable housing but also housing of high quality. We can't do that without public funds to make up the difference between what households with modest incomes can afford to pay and the cost of producing housing. Even if the private sector expands its involvement in affordable housing, it will not replace the need local housing authorities and nonprofit organizations to continue their efforts to develop attractive, affordable housing especially for those least able to pay for adequate shelter and appropriate services. If the federal government wants private-sector partners, and I believe that it should, then it will have to provide important incentives and remove some of the barriers for that partnership to produce results.

Thank you for the opportunity to offer additional comments.

Sincerely,

James T. Sykes
Director, NCOA Board of Directors
Director, Wisconsin Partnership for Housing Development

CC Senator John Breaux, Ranking Member
Senator Herb Kohl
Senator Russ Feingold

Questions from Senator Carnahan

Mr. Sykes, in rural areas, many seniors live in farmhouses. Some of the houses are over 50 years old. They are expensive to maintain, too expensive for many seniors. They have strong family and emotional ties to the farms and do not want to give them up.

What initiatives or strategies are you aware of that could help these seniors remain in their homes?

Senate Hearing

Thank you, Senator Carnahan. Missouri has been a leader in efforts to enable elders to remain in their homes—as has Wisconsin. Let me mention a few state and Federal programs that have proven successful in enabling elders to stay put where they prefer. The programs fall into two categories—those designed to assist homeowners with the cost of repairs and improvements for their homes and those developed to help the resident with staying in their homes despite disabling conditions.

First, such programs as reverse mortgages permit residents to access funds from the equity of their homes for repairs and maintenance or retrofitting their environment to support those with certain disabilities. Another is the Older Americans Act that provides funds for programs such as home repair or chore services and with assistance for housekeeping and property maintenance. The problem here is to find people to do minor repairs, housekeeping and to help with ramps, bathroom modifications and other interventions that make one's home safer and supportive. Homestead property tax relief frees residents from the onerous cost of property taxes, depending, of course, on one's income and assets.

The other set of programs are clearly directed at helping one to navigate one's home and that includes physical and occupational therapy, such as provided for under Wisconsin's Community Options Program, transportation, telephone reassurance, home delivered meals—actually the entire menu of supportive services supported in part by Medicaid waivers and through projects funded with Older Americans Act funds or state tax-supported initiatives.

Permit me to add that a key to enabling people to remain in their homes, whether farmhouses or small flats in town, in assessment. An assessment of both the residents and her housing permits an agency to help the person, especially one at risk of having to move, to appreciate what is needed to maintain her independence and when the requirements for independent living exceed what is reasonable or safe. I applaud all of the programs that extend the time one is able to live independently where one prefers, I also recognize that for many, especially those who reach age eighty and older, a more appropriate living arrangement must be found.

And that leads me to this point. HUD and HHS as well as State and local governments must develop a wide range of alternatives for frail elders that support individuals as long as practicable in independent living arrangements, but also provide supportive housing that is affordable when that move is clearly in the individual's and the community's best interest.

Response to question posed by
Senator Jean Carnahan

"Ms. Heady, an obstacle to providing in-home and home health care services to seniors is the absence of sufficient staff. What recommendations do you have in recruiting, training, and retaining these individuals?"

The recruitment and retention of any health care professional and other professionals in rural areas is always challenging and particularly challenging in the health care industry. The Medicare reimbursement system uses a salary wage index that pays less for health care employees in rural facilities who do the same work as their urban and suburban counterparts. As long as these disparities remain, recruitment and retention challenges will remain.

There are two three areas, that can assist in recruitment and retention of home health care workers:

1. Improved reimbursement
2. Education and training
3. Financial incentives

The fixes of the BBA have not yet impacted the home health industry and the results have been devastating to many rural communities. In WV alone, we have lost 1000 home health jobs statewide. When the reimbursement is cut services and staffs are cut and the benefits to these staff members are cut. Benefits to staff can be great recruitment and retention tools and less costly than salary raises. These benefits such as low-cost medical care and health insurance, eye and dental insurance, prescription discounts through the provider or coverage, child-care, housing allowances or sign on bonuses for house down payments and job-sharing, could help with recruitment and retention.

Community based education and training in rural areas can better prepare workers for the challenges of rural health care and provide them the skills and cultural competence needed for practice with rural low-income and elderly consumers. There are many local and national models of community partnerships of local agencies, community leaders, and health profession schools whose sole purpose is to train health professionals to better serve vulnerable populations through clinical training and service-learning as a means to increase their interest in practice in these areas.

Recruitment and retention is increased and more successful when community based training is coupled with financial incentives programs in exchange for a period of service obligation. West Virginia has a nine-year-old partnership of this nature and has had considerable success in recruiting doctors, nurses, pharmacists, dentists, etc. to rural areas of the state. (See reports at www.wvrhep.org) These incentive programs could be extended to all levels of nurses, nurses' aids, social workers, physical and occupational therapists in exchange for their contracted obligation to home health agencies.

Another suggestion from a rural senior provider is to develop Home Care Worker programs in local high schools and vocational and technical training centers, again. These programs could offer a Health Care or Home Care Mentor program, utilizing current providers as mentors for older teens during the summer or even during the school

year, so that they can get a feel for the job, all geared toward retaining graduates in the home county. The values in rural communities are ones in which families want to remain in their home counties, but young people have to leave the rural community to find work and more specialized training. The rural elderly are much more comfortable with "one of their own" providing their care.

Senator Carnahan, thank you for your question and your interest in this area of need for the rural elderly. It has been a pleasure to respond to your inquiry.

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May 14, 2001

The Honorable Larry Craig
Chairman
Special Committee on Aging
G31 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Craig:

Thank you again for the opportunity to appear before the committee on March 29,2001. The hearing helped to bring much needed attention to the issue of maintaining the health and independence of older Americans in rural settings. We hope to continue working with you and the committee to further investigate the role of nutrition in the aging population and ways that we can ensure the nutritional well-being of seniors in all settings.

During the hearing, a couple of questions arose related to my testimony. I respectfully request the opportunity to submit the following responses to those questions for the hearing record.

> **Question:** In my statement, I stated that the level of funding for Older Americans Act programs is at about 50% of 1973 levels. Chairman Craig asked whether that number is for all programs or just nutrition services.
>
> **Response:** The attached section of the FY 1997 Administration on Aging State Program Report shows the disparity between actual Older Americans Act appropriations and what the amounts should have been if adjusted for inflation and increases in the population over age 60. The chart clearly indicates that funding is about 50% less than 1973 when these factors are considered.
>
> It should be noted that states have done a tremendous job in leveraging the decreasing appropriations with funds from other sources. State data indicates that Older Americans Act funds provide only about 44% of the cost of a congregate meal and 29% of a home-delivered meal. Unfortunately, there is still significant unmet need, especially in rural areas where costs can be higher and access to other funding sources may be more limited.
>
> **Question:** After the hearing concluded, Aging Committee Staff Director Lupe Wissel asked what percentage of Area Agencies on Aging are performing nutrition screening and who is performing that service.

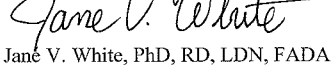
Response: The Administration on Aging (AoA) requires nutrition screening as part of its program reporting system. All states require that their Area Agencies on Aging (AAA) or local providers report on the number of individuals at high nutrition risk. The Nutrition Screening Initiative (NSI) DETERMINE Your Nutritional Risk Checklist is used for congregate meals, home-delivered meals, nutrition counseling, and case management. The AoA has not examined how AAAs or local provider use the information that it collects in actual service provision. Unfortunately, we know that in many cases information obtained from the screening is often used only to meet reporting requirements and not to trigger provision of nutrition counseling or medical nutrition therapy services or to help in planning designing, targeting or prioritizing services to meet needs. Programs simply collect the report the data.

Who performs the screening depends on how services are provided in a state. For instance, in congregate meals programs the screen may be self-administered once a year. In home-delivered meals, it may be administered in-person or over the telephone. Depending on the state and service system (e.g. single-entry point system), it might be administered by a social worker, a case manager, a registered nurse, a dietitian, or the manager of the local meals program.

Older Americans Act nutrition services including congregate and home-delivered meals, nutrition screening and assessment, and nutrition education are essential to keeping high risk older adults independent and in their communities. Delivery of services in these programs improves nutrient intake and increases active social engagement that is essential for healthy, successful aging. Adequate funding to maintain and increase these services is essential. Additionally, nutrition programs could benefit from changes to allow more flexibility in how services are offered and increased staffing of registered dietitians.

Thank you for the opportunity to provide additional information on this very important issue.

Sincerely,



Jane V. White, PhD, RD, LDN, FADA
President

Attachments: ADA Position Paper: Nutrition, aging and the continuum of care
Administration on Aging State Program Report – FY 1997 (appropriations chart)

Answer submitted for the record from Jane V. White, PhD, RD, LDN, FADA
Question for the record from Senator Jean Carnahan
Hearing of the Senate Special committee on Aging
March 29, 2001

Thank you Senator Carnahan for your question. Educating about good nutrition requires providing useful information and practical tools and skills to seniors in a manner that is interesting, convenient and sensitive to their personal preferences and mental and physical limitations. Successful nutrition education requires providing resources and instruction to caregivers including health care professionals and family members.

The American Dietetic Association (ADA), as a partner in the Nutrition Screening Initiative (NSI) -- http://www.aafp.org/nsi/index.html, has helped to develop and support the use of the NSI DETERMINE Your Nutritional Health Checklist and the Nutrition Care Alerts. I have provided copies of these tools for the committee. The DETERMINE Checklist is a simple questionnaire that can be completed by individuals or caregivers to screen for nutrition risk. This tool is recommended by the Administration on Aging and is widely used by Area Agencies on Aging and local senior nutrition programs for nutrition screening efforts. The Nutrition Care Alerts are targeted at nursing assistants and other caregivers in the nursing and home care environments. The Alerts identify warning signs and action steps for caregivers in identifying and addressing unintended weight loss, dehydration, pressure ulcers and complications from tube feedings.

As part of the Clinton Administration initiative to improve the quality of nursing home care, the ADA worked with Health Care Finance Administration (HCFA) to develop best practice guidelines to prevent malnutrition dehydration, and bedsores. HCFA has since incorporated resources developed by ADA and NSI into a Fact Pac on nutrition and hydration care that provides nursing assistants with handy tools to help identify warning signs and appropriate interventions.

There is now broad acknowledgment that seniors too, have nutrition needs that vary from other segments of the population. The ADA has developed a Nutrition & Health for Older Americans Toolkit that includes a special Food Guide Pyramid for Persons 50 Plus. Recognizing the strong link between nutrition and physical activity, ADA also created a Physical Activity Pyramid for Persons 50 Plus. These are valuable tools for educating seniors about making food choices appropriate to their stage in life.

The NSI is also developing educational materials for physicians and consumers on nutrition for older adults with chronic diseases that will be released later this year. The materials will include healthy eating tips with special emphasis on dietary modifications for seniors with chronic disease.

In addition to nutrition screening efforts, there are numerous examples of creative initiatives developed for use in state and local senior nutrition programs. Many of these activities are provided in congregate meal locations and senior centers and include group nutrition counseling, cooking classes and demonstrations, assistance with meal preparation and instruction regarding specific disease conditions (e.g. hypertension, diabetes).

Attachments:
- NSI Nutrition Care Alert
- NSI DETERMINE Your Nutritional Health Checklist
- ADA Food Guide Pyramid for Persons 50 Plus
- ADA Activity Pyramid for Persons 50 Plus

Position of the American Dietetic Association: Nutrition, aging, and the continuum of care

ABSTRACT

Scientific evidence increasingly supports that good nutrition is essential to the health, self-sufficiency, and quality of life of older adults. With the population of the United States living longer than ever before, the older adult population will be more diverse and heterogeneous in the 21st century. The oldest-old and minority populations will grow more quickly than the young-old and non-Hispanic white populations, respectively. For the current 34 million adults 65 years of age and older living in the United States, there are about 12 million caregivers who provide formal or informal care. A broad array of culturally appropriate food and nutrition services, physical activities, and health and supportive care customized to accommodate the variations within this expanding population of older adults is needed. With changes and lack of coordination in heath care and social-support systems, dietetics professionals need to be proactive and collaborate with aging-services and other health care professionals to improve policies, interventions, and programs that service older adults throughout the continuum of care to ensure nutritional well-being and quality of life. The American Dietetic Association supports both the provision of comprehensive food and nutrition services and the continuation and expansion of research to identify the most effective food and nutrition interventions for older adults over the continuum of care. *J Am Diet Assoc. 2000;100:580-595.*

Nutritional well-being contributes to the health, productivity, self-sufficiency, and quality of life of all older adults from the young-old to the oldest-old (Figure 1). Emerging scientific evidence, demographic information about the burgeoning older adult population, especially within minority populations (Tables 1 and 2) (1-3), changing concepts of aging itself, and dramatic changes in health care delivery all accentuate the importance of food and nutrition for health and disease prevention and management.

Many people, as they age, remain fully independent and actively engaged in their communities. Others fare less well and need more support within the community. Positive and productive aging promotes quality of life and accommodates variation in independence and health (4-6). The aging process is a continuum that extends from independence to intervention to interdependence. Meaningful involvement—such as remaining involved in the community and keeping active, a positive mental outlook, and relationships with others—contribute to an individual's positive aging over this continuum (6). Medical and supportive services, including culturally sensitive food and nutrition services that are appropriate to levels of independence, diseases, conditions, and functional ability, are key components of the continuum of care (Figure 1).

POSITION STATEMENT

The American Dietetic Association supports both the provision of comprehensive food and nutrition services and the continuation and expansion of research to identify the most effective food and nutrition interventions for older adults over the continuum of care.

fat-free snacks among participants with a high school education compared with those with at least some college, and females were more than twice as likely to be heavy consumers compared to males.

Future research should clarify whether diet quality improves when consumers substitute non fat for full-fat snacks

On average, heavy eaters of high-fat snacks consumed 40% of energy from fat, almost 13% of energy from saturated fat, and 2.2 servings of fruits and vegetables per day (Table 2). After statistical adjustment for age, sex, race, education, and BMI, there were still strong and statistically significant trends of higher DQI scores (indicative of a poor diet) with increasing consumption of high-fat snacks. In contrast, increasing fat-free snack consumption was significantly associated with diets containing less total and saturated fat, and more fruits, vegetables, and fiber. After adjustment for participant characteristics, there were no other differences in DQI scores across categories of fat-free snack use.

Composite measures of diet quality such as the DQI and the Healthy Eating Index (14,16,21-24) can serve as an indicator for risk of chronic disease. Our data indicate that consumption of high-fat savory snacks independently contributed to poor diet quality. Previously published studies have reported inverse associations between consumption of nutrient-poor foods and important nutrients such as calcium, vitamin C, and folate, and positive associations with fat intake. Randall et al (25) found that men who were heavy consumers of sweet and salty snacks were less likely to follow heathful dietary behaviors such as trimming fat from meat. Kant and Schatzkin (26) reported that consumption of "other foods" (eg, fats, sweets, and alcohol) was inversely associated with adequate nutrient consumption among respondents in the Second National Health and Nutrition Examination Survey.

APPLICATIONS

As noted above, most Americans consume savory snacks at least occasionally. Although occasional use of these foods or use of nonfat varieties is not detrimental, heavy consumption of full-fat snacks is associated with poor diet quality and increased risk of chronic disease.

- Future research should clarify whether diet quality improves when consumers substitute nonfat for full-fat snacks.
- Dietitians should encourage their clients to practice moderation with foods of limited nutritional value such as savory snacks.

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AGING AND THE CONTINUUM OF CARE

Today, older adults and their caregivers want choices among living situations and health-related services (Figure 1) to optimize independence, productivity, and quality of life. The term "aging in place" (Figure 1) has many definitions and does not necessarily mean living in one setting or one home for a lifetime. Ideally, aging in place offers choices from a spectrum of living options and medical and supportive services customized to accommodate those who are fully active and have no impairments, those who require limited assistance, and those with more severe impairments who require care in long-term–care facilities. Payment for these options may come from private funds, public monies, or a combination of public and private sources.

Living arrangements that enable older people to continue residing in the community include private residences, adult continuing care (or life care) retirement communities, assisted-living facilities, group housing, and adult day care. The social and supportive services necessary to help older adults remain in the community may be delivered through informal networks of families and friends or more formal networks of community, civic, tribal, and religious organizations (7). The National Aging Services Network mandated by the Older Americans Act of 1965 delivers supportive in-home and community-based services to delay or prevent placing people with impairments in nursing facilities (8) (Figure 1). These services vary nationwide and are usually charged on a sliding fee scale or a combination of public and private funds (9).

At present, though it is needed, a well-coordinated delivery system of medical and supportive services across acute, home, community, and long-term–care sites does not exist (10). Frequently, medical and social supportive needs are provided through 2 separate, parallel delivery systems—medical services and social supportive services—resulting in fragmented service and limited continuity of care (11). Because these systems frequently function separately, duplication of effort and unmet needs often result (12). Dietetics professionals and interdisciplinary aging-services providers can address this problem by working together to improve service planning and coordination (12). Outreach and service expansion should target older adults isolated in urban and rural areas and underserved minority populations including Asians and Pacific Islanders, African-Americans, Hispanics, and Native Americans.

NUTRITION, PHYSICAL ACTIVITY, AND QUALITY OF LIFE ACROSS THE CONTINUUM OF CARE

Enjoyment of food, along with its social and nurturing aspects, contributes to quality of life for older adults (Figure 2) (6). Food and nutrition services belong in the interdisciplinary continuum of care because they are unique in both medical and social contexts. Within this continuum, the psychosocial aspects of food and meals must be combined with the preventive/therapeutic aspects of medical nutrition therapy to promote or maintain well being, independence, and disease prevention and management for all segments of this heterogeneous population. Dietetics professionals should consider each older adult holistically, including personal goals, overall prognoses, benefits and risks of intervention and treatment, and, most importantly, quality of life (13). Maintaining the desire to eat and the enjoyment of food minimizes the risks of weight loss and undernutrition, especially in elders in long-term care. For these people, a more liberalized nutrition intervention, rather than a therapeutic diet, may be warranted to maintain quality of life (13). Nutrition interventions should be monitored and diets modified appropriately. Nutrient needs for people 60 or 80 years of age are unlikely to be the same.

Table 1
Estimated life expectancy at birth and age 65 by race/ethnicity and gender, 1999 and 2050[a]

Life expectancy	At birth, y		At age 65, y	
	Men	Women	Men	Women
1999				
All races/ethnic groups	72.9	79.7	15.8	19.4
Non-Hispanic white	74.2	80.4	16.0	19.5
African-American	64.3	74.4	13.6	17.7
Hispanic	75.1	82.7	19.0	22.3
American Indian	71.9	80.5	18.1	22.7
Asian/Pacific Islander	79.7	85.2	19.0	23.1
2050				
All races/ethnic groups	79.7	84.3	20.3	22.4
Non-Hispanic white	81.9	85.3	20.9	22.7
African-American	69.5	78.8	15.7	19.6
Hispanic	84.4	89.6	25.6	27.9
American Indian	78.3	85.0	21.6	25.1
Asian/Pacific Islander	83.9	88.1	21.8	25.3

[a]Source: reference 2.

Physical activity and fun are essential components for health promotion and chronic disease management in all older adults; they also enhance quality of life (6). Quality of life and quality of health are positively related (Figure 2) (14).

Many of the chronic conditions prevalent among the older adult population are modifiable by lifestyle changes (ie, changes in diet and physical activity) (15,16). These conditions include cardiovascular disease, diabetes mellitus, hypertension, obesity, and osteoporosis (17). The majority of older adults in the United States rate their health as excellent to good (Table 2) despite the high prevalence of disease among this population group (17). Older adults are willing to make lifestyle changes when they understand the benefits (18).

Aerobic exercise and resistance weight training can improve the functional ability of older adults to perform the activities of daily living (Figure 1) (19,20). Even frail elderly people may benefit from progressive resistance training that can help preserve bone density and increase muscle strength and potentially improve agility and balance (20). Both independent and frail elders can gain meaningful functional benefits from physical activity (19,21).

Recognizing the importance of physical activity in health promotion and disease prevention, the Expert Committee of Nutrition and Health for Older Americans developed "Exercise Guide for Older Adults" (16). This guide provides suggestions for activities such as walking, tai chi, and gardening. Although physical activity has been shown to improve a person's functioning and decrease health care costs, approximately two thirds of the population older than 65 years do not exercise regularly (22).

Physical activity and social interactions exert independent effects on functional performance and independence (23). Recent evidence shows that social and productive activities (eg, church attendance, group socialization) may be acceptable alternative interventions to more rigorous exercise in frail

Table 2
Demographic profile of older adults in the United States by race/ethnicity and gender

Characteristic and age	Non-Hispanic white		African American		Hispanic	
	Men	Women	Men	Women	Men	Women
Percent in poverty[a]						
65+ years	5.6	11.5	21.8	28.8	20.3	26.3
Living arrangements, 65-74 y[a]						
Living alone	13.4	30.4	21.6	37.6	12.8	21.7
Living with spouse	79.0	55.8	60.3	29.7	70.9	44.0
Living with other relative	4.5	12.1	12.4	30.4	10.7	32.1
Living arrangements, 75-84 y	3.1	1.8	5.8	2.1	5.4	2.2
Living alone	20.0	51.9	28.1	44.9	14.6	37.7
Living with spouse	72.7	33.3	50.2	19.8	65.8	29.2
Living with other relative	5.7	13.4	15.6	31.8	17.1	31.3
Living arrangements, 85+ y	1.6	1.4	6.4	3.2	2.0	1.4
Living alone	34.7	64.6	35.3	47.1	20.8	34.3
Living with spouse	49.1	11.2	23.2	7.4	37.7	8.6
Living with other relative	11.3	22.9	27.6	41.4	35.8	58.6
Living with nonrelatives	4.9	1.3	13.8	3.4	5.7	—
Fair or poor health status[b,c]						
65-74 y	23.7	22.5	38.4	40.7	31.3	31.5
75-84 y	30.6	28.3	43.6	44.7	40.3	40.7
85+ y	32.7	33.6	55.0	44.0	49.1	44.9

[a]Source: Kramarow E, Lentzner H, Rooks R, Weeks J, Saydah S. Health and Aging Chartbook. *Health, United States, 1999.* Hyattsville, Md: National Center for Health Statistics; 1999.
[b]Source: Census report—Marital Status and Living Arrangements: March 1998. (P20-514) (Table 7. Marital status of persons 15 years and over, by family status, age, sex, race, and Hispanic origin: March 1998). Available at: http://www.census.gov/population/www/socdemo/ms-la.html. Accessed November 2, 1999.
[c]Self-reported.

individuals and are equal to physical exercise programs in lowering mortality from all causes (24). Such factors as having more than one instrumental activity of daily living limitation, more than 2 activities of daily living dysfunctions, no social support in times of emergency, and lack of regular exercise are associated with elevated mortality (25).

Depression in older adults can increase risk for disability in the activities of daily living (26). This increased risk is partly explained by less physical activity and fewer social interactions among depressed people. Physical activity also appears to improve psychological well-being, relieving the symptoms of depression and anxiety (27). Research has also shown that physical activity and social interactions buffer the effects of the loss of a spouse on functional decline, especially among men (23).

Dietetics professionals and their interdisciplinary colleagues can incorporate the appropriate dietary and health recommendations, physical activities, and social interactions in programs to accommodate levels of independence throughout the continuum of care, thereby enhancing quality of life. Scientific evidence increasingly confirms the relationship nutrition has with health, independence and well being for older people (6,15,28). When this evidence is translated into policy and program development, older people benefit. Dietetics professionals must use scientific information to advocate at all levels of government to assure that policies and programs result in improvement in health, disease management, and preservation of function through proper nutrition (15,16,29). In addition, older adults themselves must actively participate in the planning and implementation of new policies and programs to ensure their needs are met.

NUTRITION OUTCOMES OF CARE

The relationships among appropriate nutrition services, positive health outcomes, and reduced health care costs for older adults continue to be established (29-33). Good nutritional status and personal well-being in older adults benefit both the individual and society: health is improved, dependence is decreased, hospitalization stays and time required to recuperate from illness are reduced, and utilization of health care resources is contained (34-36). Nevertheless, in very frail older adults, improving or maintaining quality of life may be the more viable outcome measure associated with nutritional factors (6,14).

Government agencies and third-party payers continue to adopt outcomes-based practices and make funding allocations based on client and program improvements (37,38). Program performance and quality improvement mechanisms must evaluate client satisfaction and document positive health, independence, or quality of life outcomes. Research in this area is needed to establish the vital nature and cost-effectiveness of appropriate food and nutrition services (29). Collaborations between dietetics practitioners working in older-adult programs and researchers could result in powerful evidence that may influence decisions concerning policy and resource allocations.

FOOD, NUTRIENT, AND SUPPLEMENT NEEDS OF OLDER ADULTS

Physiologic and functional changes during aging result in changes in nutrient needs (39-42). Specific dietary recommendations for several essential nutrients and food components, such as dietary fiber, have not yet been delineated for the older adult (43). The 1989 Recommended Dietary Allowances (RDAs) did not provide separate recommendations for people older than 51 years because of a lack of sufficient data (44). Research has shown that older adults do have specialized requirements for a variety of nutrients because of aging effects on absorption, utilization, and excretion (41,45).

For brevity, not all essential nutrients will be discussed. The nutrients selected were those for which new evidence of their role in disease prevention has been reported since this position paper was published in 1996. For example, although vitamin A needs decrease with age because of increased absorption, other nutrient needs may increase. Researchers have shown that older adults require greater intakes than those recommended in the 1989 RDAs for folic acid and vitamins B-6 and B-12 to prevent some decline in cognitive function associated with aging (46) and to reduce risk for coronary artery disease by keeping homocysteine levels to within normal ranges (47); more calcium is needed to reduce risk for osteoporosis. Lower blood levels of vitamin B-12 and folate may be attributable to age-related hearing loss (48). In addition, protein requirements for older adults exceed the 1989 RDAs (1.0 to 1.25 g/kg vs 0.8 g/kg body weight, respectively) (49).

The Dietary Reference Intakes (DRIs) are replacing the previous RDAs for healthy people. These new references consist of 4 levels of intake values: Estimated Average Requirements, RDAs, Adequate Intake, and Tolerable Upper Intake Limit (50). The DRIs, unlike the 1989 RDAs, divide the adult population older than 50 years into 2 life-stage groups: 51 through 70 years and older than 70 years. To date, the DRIs for calcium and related nutrients (phosphorus, magnesium, vitamin D, and fluoride), and for folate and B vitamins (thiamin, riboflavin, niacin, vitamins B-6 and B-12, panthothenic acid, biotin, and choline) have been released (51,52). The new reference values for calcium, folate, and vitamin B-12 are higher than the 1989 RDAs (Table 3). The 1989 RDAs are considered the best guide for evaluating dietary intakes of nutrients with unavailable DRIs (53).

The antioxidants a-tocopherol (vitamin E), beta carotene, and ascorbic acid may affect cataract formation (54-56) and age-related macular degeneration (56-59), leading causes of visual impairment in older adults. Dietary carotenoids, lutein and zeaxanthin, may act to protect the retina from ultraviolet phototoxicity and may serve as antioxidants to quench active oxygen species formed in the retina, thereby reducing the risk for age-related macular degeneration (41). Vitamin E may also have a potential role in the prevention of central nervous systems disorders such as Alzheimer's and Parkinson's disease (60-64) and of atherosclerosis (65). The use of vitamin E supplements may reduce risks for coronary heart disease. Although some cohort studies have shown a 40% reduction in risk among people who used vitamin E supplements containing more than 100 IU per day for 2 years, the research has not resolved the controversy of causality (66-69). The use of vitamin E in amounts above the RDAs by older adults requires further study.

Ascorbic acid is essential to wound healing due to its role in collagen synthesis (70). Vitamin A and zinc are also important in wound healing (71,72). Older individuals with diets deficient in these nutrients may have impaired wound healing (73). Additional research is needed to determine whether increased ascorbic acid intake before and after surgery can result in faster recovery of skin integrity and strength across the wound (74,75).

Vitamin K plays an essential role in carboxylation of bone glutamate residues (76). This function is especially important to older adults. An age-related decline in vitamin K status is associated with reduced carboxylation of osteocalcin and reduced bone density (77). Studies have reported a relationship between vitamin K status and risk of osteopenia (78,79). Unfortunately, information on vitamin K requirements and food intakes of older adults is limited (80). Atrophic gastritis may also influence the absorption of vitamin K by older adults (40). More research is needed to better define the roles of vitamin K in bone health and dietary recommendations for older adults.

There is a declining need for energy with age because of a reduction in lean body mass (sarcopenia) and a more sedentary lifestyle. However, energy requirements of older adults may be underestimated in the 1989 RDAs for older adults (81). When overall energy intake is low, dietary quality is difficult to ensure. The role of diet in promoting health and reducing chronic disease for such conditions as cardiovascular disease, type 1 or type 2 diabetes mellitus, and selected cancers has been well-established (15). A Food Guide Pyramid was developed by the Expert Committee of Nutrition and Health of Older Americans to assist older adults in making wise food choices (16). A unique feature of this pyramid is that the base rests on water to emphasize the critical importance of fluid intake and the prevention of dehydration.

Dehydration is a major problem in older adults, especially the oldest-old and the institutionalized, and is responsible for 6.7% of hospitalizations (42,82). Dehydration is associated with swallowing impairment and feeding dependency in hospitalized elders (83). Dehydration risk increases because of the kidney's decreased ability to concentrate urine-blunted thirst sensation, decreased renin activity and aldosterone secretion, relative renal resistance to vasopressin, changes in functional status, delirium and dementia, medication side effects, and mobility disorders (84). Fear of incontinence and increased arthritic pain resulting from numerous trips to the toilet may also interfere with consumption of adequate fluid intake. In elders, dehydration can result in constipation, fecal impaction, cognitive impairment, functional decline, and death (85).

Consuming a wide variety of foods is considered the best way to ensure balance of nutrients and consumption of appropriate amounts of healthful food components. When dietary selection is limited, nutrient supplementation with low-dose multivitamin-mineral supplements can be useful for meeting Recommended Dietary Intakes (86). In relatively healthy, community-dwelling older people, multivitamin supplementation improved lymphocyte function and reduced the incidence of clinical infection (87). Vitamin D can significantly impact bone mineral, fracture risk, and muscle strength (88,89). The best food sources of vitamin D include fatty fish, fluid milk, and fortified breakfast cereals. Older adults who limit intake of fluid milk and sunlight exposure may not be receiving sufficient vitamin D. For these people, low-dose supplementation of vitamin D in the range of 10 µg/d (400 IU) may be advised (90,91). It has been shown that individuals receiving vitamin D supplementation within physiological limits had a significant reduction in fractures, compared with controls, whether they were free-living or institutionalized (45,92,93). Vitamin D supplementation may also improve muscle strength and decrease disability in older people (94).

Aging in place The term has many definitions and does not necessarily mean aging in one setting or in one's own home until death (11, p 1150).

Assisted living An industry term that describes many forms of multi-unit housing with different levels of personal and congregate services. As a rule, assisted living units do not offer health care services as part of their operations. Facilities require that residents have a basic level of independence such that they can evacuate their living quarters in the event of an emergency[a].

Caregivers of older adults Approximately one fourth of all US households is home to least one adult who provides assistance to another adult at least 50 years of age. Almost all of these caregivers are female. The older the care recipient, the older the caregiver. A spouse is most likely the primary or only caregiver and is just as likely to be male as female. Children are the next most likely caregivers, with daughters more likely to be providing care than sons. Friends and neighbors tend to be supplemental sources of care providers. Data have shown that, generally, caregiving is not a shared activity; rather, one person tends to provide the majority of informal care. The survey showed that 20% of the caregivers share a household and another 55% live less than 20 minutes from the care recipient. The most recent national data profiling the caregiver for people age 50 and older was obtained from a 1996 nationwide telephone survey conducted by the National Alliance for Caregiving (NAC) and the American Association of Retired Persons[b] (AARP).

This NAC/AARP survey reported a higher incidence of caregiving among Asian American (31.7%), African-American (29.4%), and Hispanic (26.8%) households than in the general population. Caregivers in these 3 minority groups are more likely to provide care for more than one person. They were also more likely than white caregivers to live with the care recipient and to receive help from other people[c].

Case/care management A system for assessing, planning treatment for, referring, and monitoring older adults to ensure provision of continuous service that is coordinated with payment and reimbursement for cost of care (8[d]).

Continuum of care A coordinated array of settings, services, providers, and care levels in which health, medical, and supportive services are provided in the appropriate care setting (eg, acute, subacute, ambulatory, community, and day care; hospice; respite retirement and continuing care communities; and group housing, assisted-living, home care, and traditional nursing home facilities). Ideally, the older person moves, according to need, to different sites and services with strong continuity within the system. Depending upon the individual setting, the goal may be to assist the older person receiving services from the most intensive (restrictive) to the least[e].

Food security Describes the situation in which the individual has access at all times to a nutritionally adequate, culturally compatible diet that is not obtained through emergency food programs. In older adults, food insecurity could be due to physical, mental, or financial impairments (125[f]).

Functional assessment measures to determine functional status

- Activities of daily living: A series of basic self-care activities that include bathing, dressing, eating, walking, transferring, and toileting. The level at which a person performs these activities (eg, unaided, with help) is used as a measure of functional status.
- Instrumental activities of daily living: A series of more complex skills needed to live independently. These include housekeeping, meal preparation, use of transportation, use of telephone, shopping, managing money, and taking medications. The level at which a person performs these activities is used as an additional measure of functional status[g].

In the population of community-dwelling adults 70 years of age and older, 34% received help with at least one assisted activity of daily living or instrumental activity of daily living (17). Of this group, approximately 25% of the dependents received help with walking, 33% with bathing or showering, 56% with transportation, 58% with shopping, and 80% with heavy housework (17).

Integrated medical and social services demonstration projects Federal and state demonstration projects underway to integrate acute and long-term care into a single capitated managed-care package that combines medical and supportive services to reduce fragmentation, duplication, and cost of care. Federal demonstration projects include the Social Health Maintenance Organization and the Program of All-inclusive Care for the Elderly programs (136).

Long-term care Assistance provided over a long period to people with chronic health conditions or physical disabilities who cannot care for themselves without the help of another person (136).

Medicaid A health insurance program for certain low-income and needy people, including people who are aged, blind, or disabled, and people eligible to receive federally income assistance. Medicaid is a jointly funded, federal–state program that serves more than 36 million individuals[h]. There are waivers to traditional Medicaid to facilitate expansion of home and community setting long term care.

- 1115 (a) Medicaid waiver: Waiver under the Social Security Act allowing demonstration projects for eligibility standards and reimbursement mechanisms in providing acute-care and long-term care services under Medicaid (136).
- 1915 (c) Home and community-based Medicaid waiver: Waiver under the Social Security Act allowing states to use Medicaid funds to provide in-home and community-based services previously not covered by Medicaid to individuals who are aged, disabled, or nursing-facility certified (136).

FIG 1: Definitions and descriptions related to services for older adults.
[a] *Source: http://www.aoa.dhhs.gov/NAIC/Notes/assistedliving.html. Accessed March 14,2000.*
[b] *Tennstedt S. Family caregiving in an aging society. Available at: http://www.aoa.dhhs.gov/caregivers/FamCare.html. Accessed March 14, 2000.*
[c] *Source: Longevity in the new American century. Paper presented at: US Administration on Aging Symposium: Longevity in the New American Century; March 29, 1999; Baltimore, Md.*
[d] *Additional source: Position of the American Dietetic Association: nutrition services in managed care.* J Am Diet Assoc. *1996;96:391-395.*

Medicare The nation's largest health insurance program, providing coverage to people age 65 years or older and to people with permanent kidney failure and certain disabilities regardless of age. Medicare is managed by the Health Care Financing Administration and serves more than 39 million Americans[i]. Selected nutrition services for older adults, such as diabetes counseling, are now reimbursed under Medicare (33), and recommendations for third-party payment for medical nutrition therapy have been made (29). Third-party payers offer use of managed-care delivery systems, including health maintenance organizations (HMOs), to contain escalating health care costs for older people[d]. Older adults may benefit from risk screenings and health promotion programs offered by these plans but may receive fewer medically intensive and thus costlier services. Although the current congressional emphasis is to encourage more HMOs and private participation in Medicare-Plus-Choice, many HMOs are decreasing Medicare contracts or reducing service areas, thus decreasing options for many older people[j].

Older adults category subgroups Young-old: people 65 to 74 years of age; old: people 75 to 84 years of age; oldest-old: people 85 years of age and older—the fastest growing segment of the older population (3).

Older Americans Act, Administration on Aging and National Aging Services Network The Administration on Aging administers the Older Americans Act through a National Aging Services Network (Aging Network) of more than 225 Native American and Pacific Islander organizations (Title VI), approximately 57 state and territorial units on aging, 655 area agencies on aging, and thousands of local service providers that provide direct services to older people[k]. The Aging Network is mandated by the Older Americans Act to establish a system and provide comprehensive, coordinated in-home and community-based supportive services to delay or prevent placing people with impairments in nursing facilities (8). Title III and Title VI for Native Americans, including Alaskan Natives and Native Hawaiians, authorizes the Elderly Nutrition Program and other supportive services (ie, homemaker support, home health aides, counseling or referral services, personal care, shopping assistance, chore maintenance, adult day care, in-home respite care, assisted transportation, disease prevention, and health promotion). The Elderly Nutrition Program provides congregate and home-delivered meals, nutrition education, and nutrition screening and nutrition counseling (8,109). Availability of nutrition and non-nutrition services created by the Older Americans Act varies nationwide. Title IV of the Older Americans Act authorizes and funds training, research, and discretionary projects and programs. The National Policy and Resource Center on Nutrition and Aging at Florida International University, Miami, is the only Title IV grantee focused on nutrition issues[l]. Another example is The Native Elder Health Care Resource Center, whose purpose is to develop and disseminate culturally competent health care for Native American elders and promote relevant health materials to Indian communities nationwide[m]. Although authorization of the Older Americans Act lapsed in September 1995, it has continued to be funded through the annual appropriations process. Reauthorization for fiscal year 2000 remains uncertain.

The older population As of 1997, 13% of the US population was 65 years of age or older. This was composed of 15% of the non-Hispanic white population, 8% of the African-American population, 7% of the Asian or Pacific Islander population, 7% of the American Indian or Native Alaskan populations, and 6% of the Hispanic population. In the United States, the elderly population is growing more rapidly than the population as a whole, the proportion of people older than 85 years is growing more rapidly than the overall elderly population, and the proportion of non-Hispanic whites is growing more slowly than the other racial/ethnic populations. (18).

Socioeconomic status affects health and, in 1997, 10% of people 65 years of age and older was living in a family at or below poverty. More older women live in poverty than older men. This is true for whites (13% vs 7%), African-Americans (29% vs 22%), and Hispanics (26% vs 21%). (18).

The overall death rate for older men is greater than for older women, although these rates tend to converge at approximately 95 years of age. For ages 65 to 84 years, African-Americans have a higher death rate than whites, Asians or Pacific Islanders, American Indians or Alaska Natives, or Hispanics. The leading cause of death in older men and women 65 to 74 years of age is cancer; in those 75 or more years of age, it is heart disease. The most prevalent chronic disease among men and women 70 or more years of age is arthritis. (18).

FIG 1. Definitions and descriptions related to services for older adults.
[d] *Practice report of the American Dietetic Association: home care—an emerging practice for dietetics.* J Am Diet Assoc. *1999;99:1453-1459.*
[f] *Additional source: http://www.fiu.edu/~nutrelder/Elder_insecurities.htm. Accessed March 14, 2000.*
[g] *Source: The Nutrition Screening Initiative. Nutrition interventions manual for professionals caring for older Americans, 1992. Washington, DC: Nutrition Screening Initiative; 1992.*
[h] *Source: http://www.hcfa.gov/medicaid/medicaid.htm. Accessed March 14, 2000.*
[i] *Source: http://www.medicare.gov/whatis.html. Accessed March 14, 2000.*
[j] *Source: Archer D. Forum: Redefining Medicare: Getting back to basics.* Aging Today, *January/February 2000)*
[k] *Source: http://www.aoa.gov. Accessed March 14, 2000.*
[l] *Source: http://www.fiu.edu/~nutreldr/htm.*
[m] *Source: Jackson MY. Administration on Aging programs and services for Indian elders.* IHS Primary Care Provider. *1999;24:79-81.*

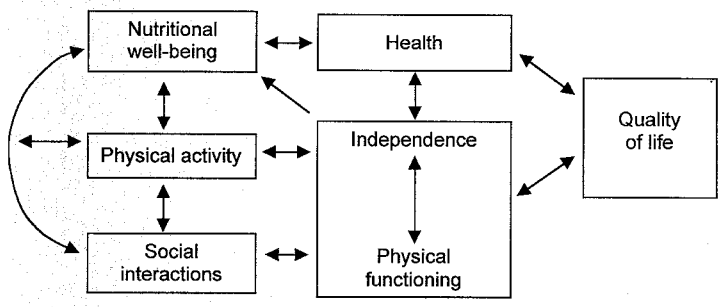

FIG 2. Simplified model of the relationship of nutrition, physical activity, and social interactions on quality of life

Altered ability to taste and smell, poor oral health, dysphagia, and failure-to-thrive syndrome (ie, nonspecific symptoms associated with deteriorating mental status and functional ability, social isolation, and decreased food intake) can contribute to decreased nutrient intake, involuntary weight loss, and malnutrition (95-101). Insufficient intake of vitamin C and riboflavin, as well as inadequate intakes of vitamins B-12 and B-6 and folate, may result in poor memory (46). Likewise, immune function affected by nutritional status may be improved by supplementation of protein, vitamin E, zinc, and other micronutrients (39,46).

Weight loss is common among older adults and significant loss is associated with increased mortality. Many older adults, especially the oldest-old and those in institutions, do not consume enough food at meals to meet their energy and nutrient requirements. An energy- and nutrient-dense supplement provided between meals can benefit these older adults. Research has shown that between-meal medical nutrition supplements do not displace energy and nutrient consumption at meals (102). Morbidity and mortality also increase with protein-energy undernutrition (ie, no overt clinical signs of malnutrition), low serum levels of albumin and thyroid hormones, and hypothermia. Older adults with weight loss and no improvement in serum albumin 1 month after hospitalization are at higher risk for hospital readmission (103). Very low cholesterol levels (<4.16 mmol/L[1]) can be predictive of mortality (104).

Therapeutic nutrient supplementation would be indicated to treat or prevent nutrient deficiency when nutrient requirements are increased; nutrient consumption, absorption or utilization is decreased; or nutrition excretion is increased (86). For instance, the DRIs stipulate that people 51 years of age and older should consume foods fortified with vitamin B-12 or take a supplement containing vitamin B-12, as 10% to 30% of older adults have protein-bound vitamin B-12 malabsorption (105). In older adults there can also be a decreased capacity to absorb calcium because of reduced estrogen levels, low circulating 25(OH)D, partial intestinal resistance to 1,25(OH)2D, and impaired renal conversion of 25(OH)D to 1,25(OH)2D (92). Calcium bioavailability can also be impaired because of atrophic gastritis and increased fiber intake for laxation (41). Clinical trials with daily calcium supplementation of 1.0 to 1.7 g calcium, along with vitamin D supplementation, have significantly reduced the rate of age-related bone loss and the incidence of hip fractures (41,106).

NUTRITION RELATED RISK FACTORS AFFECTING OLDER ADULTS

Many older adults undergo changes in their lives (eg, physiological, social, family, environmental, economic) that could affect their nutrition intake (Figure 3). This section provides an overview of the nutrition-related risk factors that can influence the well-being, health, and independence of older adults. These factors, often multiple and synergistic, include hunger; poverty; inadequate food and nutrient intake; social isolation; depression; dementia; dependency; functional disability; poor dentition and oral health, chewing, and swallowing problems; presence of diet-related acute or chronic diseases or conditions; polypharmacy; minority status; urban and rural geographic areas; advanced age; and living alone (107-109). Left unchecked, these risk factors could weaken nutrition status, increase medical complications, and result in loss of independence.

The most frequent nutritional risk factors identified in a population of 5,373 community-residing, rural, predominately white, older people were polypharmacy and inadequate consumption of recommended food groups (30). Furthermore, poor appetite, eating problems, low income, eating alone, and depression were significantly associated with functional limitations (30). Similarly, a study with an urban, homebound, predominately African-American population found tooth pain and problems with chewing food to be significantly associated with a lower body mass index (BMI) (95). A study of 2,655 older adults in a semirural community found that women rather than men and African-Americans rather than whites were more likely to have inadequate intakes for most nutrients.

[1] To convert mmol/L cholesterol to mg/dL, multiply mmol/L by 38.7. To convert mg/dL cholesterol to mmol/L, multiply mg/dL by 0.026. Cholesterol of 5.00 mmol/L=193 mg/dL.

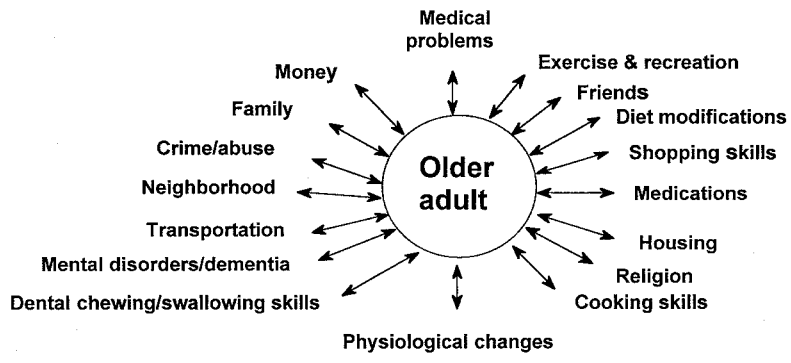

FIG 3. Multiple interrelated factors affecting nutritional status for older adults.

In particular, over 40% of African-American women were estimated to have had inadequate intakes of the key nutrients vitamin B-6, vitamin E, calcium, and zinc (110). A study of 604 rural African-American older adults reported similar findings of low intakes of calcium, energy, and fiber and high intakes of fat and cholesterol. They consumed fewer servings of fruits/vegetables, bread/cereals, and milk/cheese, and increased servings of meat/fish/poultry (111). Another study determined that rural Hispanic older adults were more at risk than their non-Hispanic white counterparts for inadequate intakes. Factors included inadequate consumption of vegetables, tooth problems affecting the ability to chew, problems preparing meals, and lack of money to buy food (112). A study of 309 urban dwelling Chinese, Korean, and Japanese older people living in senior-citizen housing found underweight to be more of a problem than obesity. Intake of dietary calcium was inadequate, and more than 23% of the Korean sample consumed less than two thirds of the RDA for protein, phosphorous, and vitamin C (113).

Compared with African-American, Hispanic, and Asian and Pacific Islander populations, Native American people, aged 51 to 61 years, have the highest relative risk of chronic disease. These diseases include, but are not limited to, type 1 or type 2 diabetes, cancer, heart problems, broken bones after age 45, and arthritis (114). The prevalence of type 1 or type 2 diabetes in Native Americans and Alaska Natives is 3 to 5 times that of the general population. Among Native Americans and Alaska Natives aged 65 years and older who have type 1 or type 2 diabetes, 63% are women and 37% are men (115).

One third of the Native American elders living in Los Angeles (n=283) rate their health as fair and 15% as poor. Compared with the elderly men, the women in this demographic reported significantly higher frequencies of hypertension and heart disease. Approximately 40% of these women lived alone. Despite the fact that some urban elders volunteered as peers and intergenerational counselors, social isolation was identified as a risk factor (114).

The community-based Older Americans Act Elderly Nutrition Program targets minority populations and those who are poor. It too has reported serious nutrition-related problems, especially among the frail, homebound older adult (109). Many older adults have 2 to 3 diagnosed chronic health conditions; 26% of participants in congregate meal programs and 43% of those who receive home-delivered meals had a hospital or nursing-facility stay in the previous year. In addition, almost two thirds of respondents had a weight outside the healthful range, and 18% to 32% had involuntarily gained or lost 10 lbs within the 6 months before the survey (109).

Obesity in older adults is a serious nutritional risk and has profound functional and psychosocial consequences. In addition, obesity is associated with increased risk of chronic diseases and increased use of health care resources (30,116). In the general population, the annual direct costs of type 2 diabetes mellitus, coronary heart disease, hypertension, and gallstones for people with a BMI of >30 was estimated at $23 billion in health care, compared with $6 billion for people with a BMI of 23 to 24.9 (116). The most appropriate range of BMI reflective of healthy body weight for older adults is controversial. The National Heart, Lung and Blood Institute clinical guidelines define overweight as a BMI of 25 to 29.9 and obesity as a BMI of 30 or greater (117). However, data from the Longitudinal Study of Aging, a prospective longitudinal cohort study of over 7,000 people, found that a relatively high BMI (30 to 35 for women and 27 to 30 for men) was associated with minimal risk for mortality in adults older than 70 years of age (118). Findings from the Cardiovascular Health Study, a cohort study of over 4,000 nonsmoking men and women aged 65 to 100 years, also found that the association between higher

Table 3
Dietary reference intakes for older adults

Nutrient	Men		Women	
	51 to 70 years	>70 years	51 to 70 years	>70 years
Calcium (mg/d)[a]	1,200	1,200	1,200	1,200
Phosphorus (mg/d)[a]	700	700	700	700
Magnesium (mg/d)[a]	420	420	320	320
Fluoride (mg/d)[a]	3.8	3.8	3.1	3.1
Vitamin D (μg/d)[a]	10	15	10	15
Thiamin (mg/d)[b]	1.2	1.2	1.1	1.1
Riboflavin (mg/d)[b]	1.3	1.3	1.1	1.1
Niacin (mg/d)[b]	16	16	14	14
Vitamin B-6 (mg/d)[b]	1.7	1.7	1.5	1.5
Folate (μg/d)[b]	400	400	400	400
Vitamin B-12 (μg/d)[b]	2.4	2.4	2.4	2.4

[a]Source: reference 51.
[b]Source: reference 52.

BMI and mortality seen in middle aged adults was not observed to be a risk factor for 5-year mortality in this age group (119).

Alcohol abuse and dependence among older adults is often undetected (120). It is estimated that 2.5 million older adults are affected by alcohol abuse. Approximately 10% of those older than age 65 are binge drinkers, consuming more than 5 drinks in one sitting (120); 25% of those who drink do so on a daily basis. Screening for alcohol abuse is important because the extent of the true problem is unknown. Alcohol abuse may impede independence because it contributes to accidents, falls, nutritional deficiencies, and diseases (120). Alcohol alters the storage, mobilization, utilization, and metabolism of several nutrients including thiamin, riboflavin, folate, and vitamins A, C, and B-6 (121).

POVERTY AND ECONOMIC UNCERTAINTY

Poverty is a strong indicator of nutrition risk and food insecurity (17,122). Approximately 17% of older adults (1 in every 6) were poor or near-poor in 1998 (17) (Table 2). In 1998, 26.4% of elderly African-Americans, 21% of elderly Hispanics, and 8.9% of elderly whites were poor. Older women experienced almost twice the poverty rate (12.8%) than men (7.2%). Older adults living alone or with nonrelatives were more than 3 times (20.4%) as likely to be poor than those living with families (6.4%). Older African-American women living alone had the highest poverty rate (49.3%).

Older people who are not poor may live on a fixed income. As expenses increase, those older adults may opt to reduce food intake, thereby placing themselves at risk for malnutrition (11). For example, when physical and mental impairments interfere with grocery shopping and cooking, older adults may balance the resulting increase in food-related costs from delivery charges, use of more-costly convenience foods and other special foods, and the higher price of restaurant meals by eating fewer meals (11). In addition, many older adults take an extensive number of costly medications; money spent for medications often reduces the amount of money available to purchase food (11).

Older adults have major economic uncertainties in terms of health care expenditures and longevity. Access to affordable and continuous health care becomes a concern as individuals approach retirement and beyond. Although the majority of older people has access to health care through Medicare, Medicare does not pay all their health care costs. Older people meeting specific income and asset requirements are also eligible for Medicaid benefits. A recent study analyzing data from the 1995 Medicare Current Beneficiary Survey determined that older adults with chronic health conditions and who do not have employer-subsidized supplemental insurance coverage or Medicaid bear the highest out-of-pocket payments. More than half of the out-of-pocket payments for health services were for prescription medicines and dental care (123).

An episode of poverty, despite safety net protections of Social Security or Supplemental Social Security, looms for many older individuals. A 1999 study estimated age-specific and cumulative proportions of older adults who will experience poverty at some point in their later years (124). These findings—developed from the Panel Study of Income Dynamics, different from commonly used, yearly, cross-sectional information—found that at some point between ages 60 to 90 years, 40% of older adults will encounter one year below the poverty line and 48% will experience poverty at the 125% level. Those who are African-American, not married, or have less than a 12th-grade education are at particular risk (124).

FOOD SECURITY

Maintaining food security by ensuring access to enough food that is nutritionally adequate, safe, and obtained through normal channels is important to alleviate hunger and nutrition risk. Limited income and poverty affect the ability to purchase nutritious foods in adequate quantities. In addition, lack of physical mobility to shop and prepare food and lack of transportation and proximity to food stores also contribute to food insecurity (125). Unfortunately, approximately 5.9% to 16% (1.6 to 4.9 million) of older adults are food insecure, as reported in 2 studies (126,127). One study found that older adults from food-insecure households were more likely to be from a minority group. This group consumed a mean energy intake of 58% of the recommended daily allowance and less than two thirds of the recommended daily allowance for calcium, vitamins E and B-6, magnesium, and zinc (128). A study of 192 older residents in rural Appalachia found 24% had one or more food insecurity indicators. The strongest food insecurity indicators in this population were: taking 3 or more prescription drugs, eating alone, and living on an income less than 150% of poverty level. Except for food stamps, this population did not use government-funded nutrition programs to lessen food insecurity (129).

Federal programs to combat hunger and food insecurity reach only one third of needy older adults (127). The congregate and home-delivered meal programs and the US Department of Agriculture (USDA) Food Stamp Program reach those with the highest rates of food insecurity. Yet, 41% of home-delivered meal programs established by the Older Americans Act have waiting lists (109). An older adult may not meet income guidelines for food stamps (127). The minimal amount of food stamps provided may deter many from applying. For example, older adults may find the application process to acquire food stamps invasive, demeaning, and difficult, especially for those with limited English proficiency as well as debilitating conditions.

Older adults who are food insecure manage using a variety of mechanisms influenced by their life experiences (125). Some use food stamps, whereas others do not because of their connotation as welfare. Many use the Elderly Nutrition Program because of its "senior" and local community appeal. The confidential donation system allows them to adjust their contributions depending upon money available (125). One study reported food pantries to be well accepted by older people in rural areas (125). Community characteristics also influence the availability of programs and willingness of the older population to use them. Traditionally, older adults have not been a primary focus of hunger advocacy groups, food banks, food pantries, and soup kitchens.

Dietetics professionals should encourage food and nutrition assistance programs to include older adults in their outreach efforts. Those professionals, engaged in wellness and health promotion activities, should include use of food-assistance programs in culturally sensitive and aging-sensitive ways.

Dietetics and aging-services professionals working with older adults should encourage routine screenings (108,130,131) to detect the presence of these interrelated nutrition risk factors and offer referrals for appropriate assistance. They should compile and use the information from the screenings to advocate for new or expanded home and community services to meet the needs of the older population. They must pay particular attention to the needs of minority populations, especially those who are poor, living alone, or located in underserved rural and urban areas. For example, the out-migration of the younger population, large travel distances, and lack of health, social, and transportation services may leave rural older adults isolated at a time when they are growing more frail (111,132,133). Little is known about the social-service needs of the growing population of older Asians. A study of 18 Asian senior centers in a large metropolitan city determined that clients were predominately female, older, and on social security income. Services needed but not provided included home-delivered meals, emergency psychiatric care, home assistants, legal services, protective services, and medical services (134).

INTEGRATION OF FOOD AND NUTRITION SERVICES INTO THE CONTINUUM OF CARE

The lack of a coordinated delivery system of medical and supportive services across acute, home, community, and long-term-care sites has implications for providing older adults with appropriate food and nutrition services. Older people receive medical care for acute and chronic diseases in a variety of settings—acute, subacute, skilled nursing, rehabilitation, community health, home care, adult day care, life care, assisted-living, and nursing facilities—and not necessarily in a particular order (135). Older adults are being discharged earlier from acute-care and long-term-care facilities, possibly without a plan for home and community follow-up care including home-delivered meals and other supportive services (11,29). Because medical and social supportive needs are often provided through separate systems, it is not uncommon for each system or program to have different eligibility requirements, funding streams and varying types and amounts of services. As a result, provision of the necessary array of food and nutrition services and availability of dietetics professionals across this continuum varies widely (109).

Federal and state agencies are adopting home and community options because of the high costs of health and nursing facilities (136). Many states are seeking ways to delay placing older adults in nursing facilities by enrolling Medicaid beneficiaries in health maintenance organizations (136), using Medicaid Home and Community based waivers, and creating state-funded programs to provide necessary home- and community-based medical, social, and supportive services (137). Some states include home-delivered meals and medical nutrition therapy as part of these services (9).

The environments and services that compose the continuum of care on a remote tribal reservation community may seem different from those in an urban community. However, the key to obtaining, organizing, and accessing the vital services for older American Indians is cooperation and coordination of

Clinical Setting
- Assist caregivers with implementation of nutritional interventions
- Collaborate with other health professionals to develop, implement, monitor and evaluate interventions that improve care of elders and maintain or enhance quality of life.
- Evaluate the benefits of medical nutrition therapy.
- Develop case management guidelines
- Advocate legislative change

Community Setting
- Assist caregivers with implementation of nutritional interventions
- Initiate nutrition screening of older adults
- Collaborate with industry and non-profit organizations to promote nutrition and health education activities
- Collaborate with older adult organizations to develop programs that ensure quality of life
- Work with other health professionals to expand services to elders, especially minority elders
- Advocate legislative changes

Research Setting
- Conduct multidisciplinary research in the following areas:
  - Identification of the predictors of malnutrition
  - Determination of essential nutrient requirements
  - Establishment of references for the evaluation of nutritional status assessment data
  - Exploration of relationship of lifestyle changes to quality of health and life for all racial ethnic groups, especially minority elders
  - Exploration of relationships between nutritional status and health of all racial ethnic groups
  - Evaluation of the impact of food assistance and feeding programs, especially on minority elders.
- Communicate research findings

Academic Setting
- Mentor students about the opportunities available working with elders
- Design curriculum that develops critical thinking and effective listening and written and oral communication skills
- Design curriculum that addresses nutrition in aging throughout required courses for dietetic majors or develop independent courses focused on nutrition and older adults.
- Develop multidisciplinary continuing education/distance learning courses for dietitians and other health professionals to disseminate the current information about effective nutrition support and/or education programs targeted to older adults.
- Educate students on the legislative process.

FIG 4: Actions for dietetics professionals

professionals in varying health disciplines. Interdisciplinary elder-care teams are in place for American Indian populations (138). Collaboration between the Zuni Wellness Center and the Zuni Senior Citizens Center demonstrates how limited resources can be brought together to benefit the elders in the community. The tribal wellness center coordinator goes to the senior center to lead exercise classes several days a week (139).

Dietetics professionals have the expertise to provide continuity of nutrition-related services and bridge the gap across the continuum of care. Proactively, these professionals should work and advocate within their institutional, home, and community networks. Dietetics professionals can develop mechanisms that expand the types of food and nutrition services available, ensure it is targeted appropriately, improve service coordination and continuity, and take the lead in measuring the effectiveness of programs and services (Figure 4). Professionals can initiate linkages among the vast array of public, not-for-profit, or for-profit community agencies and health care facilities that provide complementary services to older adults. Examples exist for improving the nutrition care provided to older adults in underserved areas. A nutrition managed-care model built upon risk screening and case management has demonstrated outreach to rural elders (133). A pilot telemedicine nutrition consultation service for use in rural areas has shown success. The system consisted of audio and visual transmitting to conduct nutritional assessments, interviews, and provision of nutrition recommendations to 20 participants. Participants reported the service to be positive, more convenient, and cheaper than in-person visits (140).

Dietetics professionals can establish linkages with the National Aging Services Network (Figure 1) to coordinate provision of the Elderly Nutrition Program congregate and home-delivered meals and other Older Americans Act services. Such coordination of services is demonstrated by the fact that many older people recently discharged from acute-care settings receive home-delivered meals (109). The benefits of home-delivered meals on nutritional status and reduced hospitalization has been demonstrated (32). Unfortunately, many Elderly Nutrition Programs have waiting lists for home-delivered meals (109) because of high volume and insufficient funding.

The Elderly Nutrition Program is particularly beneficial for populations like low-income and ethnic minorities who are more likely to be at nutritional risk. Participants have statistically significantly higher intakes, as a percentage of the Recommended Dietary Allowances, for energy, calcium, zinc, and vitamin B-6 than nonparticipants (109). Congregate meals contributed 40% to 50% of the daily intakes of these nutrients (109). Approximately one third of the congregate meal participants and about one half of the home delivered meal participants have incomes below the US Department of Health and Human Services poverty threshold. Research has demonstrated that Hispanic seniors, especially men, who participate in congregate meal programs have significantly higher intakes of energy and 11 essential nutrients than nonparticipants (141).

However, in the Elderly Nutrition Program, additional nutrition services including screening, assessment, and counseling are not consistently provided (109), nor is the availability of dietetics expertise in the network at the federal, state, and local levels (109). Through their involvement in service coordination, dietetics professionals can ensure appropriate nutrition services are available and targeted more cost-effectively to the most needy and will result in improved program and client outcomes (32).

Anecdotal information provides areas in which dietetics professionals can establish effective linkages, outreach, and service coordination to improve the nutritional status and well-being of older people. For example, USDA Cooperative Extension provides nutrition education for older adults in many communities; fire–rescue departments conduct blood pressure screenings; schools may participate in intergenerational activities; shopping malls organize walks; hospitals offer health screenings; and public health departments offer immunizations and flu shots.

CUSTOMIZED FOOD AND NUTRITION SERVICES ACROSS THE CONTINUUM OF CARE

Dietetics professionals must use evidence-based practice to improve the nutritional well being of older adults. A customized array of food and nutrition services is required to meet the changing physiological, mental, functional, and socioeconomic capabilities of this heterogeneous older adult population (16). Dietetics professionals should customize food, fun, and fitness to promote quality of life and positive aging.

Older adults may use complementary or alternative medicine therapies (142-145), although very few studies have specifically focused on this population. A recent study of 728 older people enrolled in a Medicare plan offering acupuncture and chiropractic found that 41% reported using complementary or alternative medicines. The most frequently reported therapies used included herbs, chiropractic, massage, and acupuncture. Complementary and alternative medicine users were younger; more educated; reported arthritis, anxiety, or depression; exercised; used meditation; and made more physician visits. However, they did not inform their physicians of complementary or alternative medicine use. There were no observed changes in self-reported health status associated with usage of complementary or alternative medicine, although 80% reported receiving substantial benefit from use (146). Alternative medicine has potential to reduce health costs and provide more effective care (142,146).

The use of alternative medicine is common among Navajo older adults; almost 40% use native healers on a regular basis. In a survey of Navajo Indians (n=300), 31% of those aged 66 to 90 years reported using a native healer within the past year. The use of native healers was highest for the conditions of arthritis, abdominal pain, depression/anxiety, and chest pain. It was not uncommon for this population to use both a conventional medical provider and native healer for a wide range of health problems, particularly for arthritis and diabetes. Unlike the characteristics of individuals using alternative medicine, there was no correlation with education and lifetime or recent use of native healers. Cost was a main barrier to seeking native–healer care (147). Further research is needed to elucidate how conventional care and alternative-medicine care, such as native–healer care, can be combined to increase overall effectiveness of care provided to the elder patient.

Dietetics professionals can customize culturally appropriate nutrition and health promotion programs to meet the diverse needs of older people (Figure 4). Culturally appropriate activities include those suggested by American Indian elders living in Los Angeles who wanted to enhance the quality of their lives through potlucks, powwows, crafts, games, and recognition of American Indian history (114). There is also a need to develop culturally sensitive restorative care services in long-term–care nursing facilities to prevent decline in functional status. Within

the American Indian population, approximately 71% have difficulty in performing the activities of daily living. Indian elders are often placed in non-American Indian nursing homes because of limited availability of tribal long-term–care facilities. Geography influences long-term–care decisions. In these facilities, elders may encounter staff unfamiliar with American Indian ways, traditional foods, and native language, causing feelings of loneliness, dissatisfaction, and decreased quality of life. Lack of access to a traditional American Indian medical practitioner is another source of discomfort (148).

MEDICAL NUTRITION THERAPY INCLUDING NUTRITION SCREENING AND ASSESSMENT ACROSS THE CONTINUUM OF CARE

Medical nutrition therapy is a 2-phase process: assessment of nutritional status and development of an individualized intervention plan (34). Medical nutrition therapy applies to all settings from home and community to hospitals and long-term–care facilities. Nutrition education—though it is not medical nutrition therapy per se—is appropriate across all settings of the continuum to promote healthful eating and safe food-handling practices. More intensive medical nutrition therapy interventions are appropriate after the initial screening and assessment phase. Dietetics professionals must be ready to develop care plans and initiate more intensive treatments in home and community settings.

Nutrition screening, the process of identifying individuals at nutritional risk or with malnutrition, is critical not only to cost-effective medical nutrition therapy (149), but also to helping community-dwelling older adults maintain their independence and personal well being. Once a person has been flagged or identified to be at nutritional risk, a comprehensive nutrition assessment is then used to probe further into the person's anthropometric, biochemical, clinical, dietary, psychosocial, economic, functional, mental health, and oral health status. The complete assessment is the basis for the development of a care plan (149). This care plan coordinates appropriate treatments and maintains continuity of care through periodic review and modification.

Several instruments, such as the DETERMINE your nutritional health checklist, the Mini Nutritional Assessment (MNA), and SCALES, have been used in different settings to screen the older adult population for nutrition risk (108,130,131). The DETERMINE checklist was designed to increase elders' awareness about nutrition and health. Unlike the MNA and SCALES, this tool has not been clinically validated. SCALES has demonstrated high specificity and sensitivity in detecting older individuals at nutritional risk, especially protein energy undernutrition (130). The MNA is a validated instrument composed of anthropometric measurements, global assessment of lifestyle, medication and mobility, questions about diet, and self-perception of health and nutrition. The MNA can be used to distinguish those elders with adequate nutritional status, those at risk for malnutrition, and those with malnutrition. Sensitivity of the MNA was found to be 96%, specificity 98%, and predictive value 97% for malnutrition, taking clinical status as the reference (150). The MNA is a useful tool, not only to screen but to monitor changes in nutritional status following intervention. However, more extensive validation is needed before it is adopted for widespread use (29).

More older adults will require an array of intensive services, including requisite medical nutrition therapy, in home and community settings, given the shift in medical service delivery (29). These comprehensive clinical, social, and nutrition services encompass the management of transition feedings, enteral and parenteral therapies, feeding complications, dysphagia, and hydration (151). The effectiveness of medical therapy in speeding wound healing related to pressure ulcers (152), recovery from hip fractures (153), and management of type 1 or type 2 diabetes mellitus (31) are documented. Multidisciplinary practice guidelines are critical to the success of medical nutrition therapy and to improved quality of care of elders (34,154). The multidisciplinary care plan synthesizes all risk indicators and factors to identify desirable outcomes. Appropriate interventions must be selected, prioritized, and implemented. Food and nutrition interventions include congregate or home-delivered meal programs; nutrition education; diet modification and nutrition counseling; and specialized medical nutrition therapies, including supplementation with medical foods and enteral and parenteral nutrition. Monitoring nutritional status and periodic reevaluation of the plan by the multidisciplinary team will ensure continuity of care and achievement of the desired outcome.

Medical nutrition therapy has been integrated into the treatment guidelines for cardiovascular disease, type 1 or type 2 diabetes mellitus, hypertension, obesity, and osteoporosis (90,155). These diseases are usually treated with pharmacotherapy. For example, for the treatment of osteoporosis and alendronate, and vitamin D and calcium supplementation have clearly demonstrated an antifracture efficacy (reduction in fracture risk) (156,157). For cost-effective medical nutrition therapy and pharmacotherapy, a multidisciplinary approach is essential (153,155,158,159).

Osteoporosis afflicts about 25 million people in the United States at a cost of $13.8 billion per year. The economic cost of osteoporosis is expected to rise to $50 billion by 2040 because of the increased number of older adults. In addition to the economic expense, people with osteoporosis suffer loss of independence and decreased quality of life. Medical nutrition therapy involving a physician, nurse specialist, physical therapist, and registered dietitian could decrease morbidity and mortality in people with fractures and retard future bone loss (90).

Maintenance of health through medical care and maintenance of quality of life are the 2 goals for care of older adults who reside in long-term–care facilities (13). The role of medical nutrition therapy in long-term care has been delineated (13). For long-term-care residents, a liberalized nutrition intervention can increase the desire to eat and enhance the enjoyment of food, while decreasing the risk of weight loss and undernutrition. Nutrition Care Alerts are used in long-term–care facilities to detect the occurrence and, if found, implement treatments for unintended weight loss, dehydration, pressure ulcers, and tubefeeding (160).

INTERDISCIPLINARY CASE/CARE MANAGEMENT AND SERVICE DELIVERY

Today, continuity of care is provided through interdisciplinary case or care management. Nutrition support helps improve outcomes most effectively when it is integrated into comprehensive interdisciplinary care management. In case management, costs are overseen and services are coordinated from different funding streams (161,162).

The interdisciplinary process often uses care conferences and includes older people themselves, families, and caregivers. Case management plans must be sensitive to geographic location, such as urban or rural setting (163), and to culture and accul-

turation (164). Nutrition screening and assessment and food and nutrition services are integrated into the process (165). Selected nutrition services for older adults, such as type 1 or type 2 diabetes counseling and therapy, are reimbursed under Medicare (33). Cross-functional and interdisciplinary teams minimize duplication of tasks and improve decision-making, access, delivery of services, and outcomes (151,166). Outpatient geriatric evaluation and management has not only received satisfactory ratings from older adults and their primary-care physicians (167,168) but has also improved physical and cognitive function and reduced admissions to institutions (169).

Although it is not case management per se, discharge planning also coordinates institutional and noninstitutional care. Comprehensive discharge planning and home follow-up intervention has been shown to reduce hospital readmissions, lengthen the time between discharge and readmission, and decrease the cost of health care (170). Many interdisciplinary opportunities exist to merge food and nutrition services into continuity of care. Similar to the 1996 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards for nutrition services in long-term–care settings (135), the 1995 JCAHO accreditation process for home health agencies offering nutrition services specifies that nutrition screening of patients must occur before or at admission and that screening must be followed by coordinated food and nutrition services for those at nutritional risk (171).

FUTURE DIRECTIONS FOR DIETETICS PROFESSIONALS

Currently, people aged 55 to 70 years are globally healthier and less disabled by chronic conditions such as cardiovascular disease, hypertension, and chronic obstructive pulmonary disease than were similarly aged people born approximately 17 years earlier (172). Dietetics professionals can improve the nutritional status and well-being of older adults through customized, culturally appropriate nutrition practices and standards of practice matched to the home, community, and institutional care settings (Figure 4) (108,154,173). They must contribute to and/or use new research findings and technological advances to improve nutrition care, types of needed nutrition-related services, and how they are best provided. They should use data collected to document client outcomes and the value and cost effectiveness of food and nutrition services. They must develop integrated plans while knowing that nutrition-related services for older adults are funded by different grants, titles, and funding streams, yet recognizing the importance of and including non-nutrition services. Dietetics professionals must be aware of rapid public and private policy changes and participate in the process by building coalitions. Because minority groups are the fastest-growing segment the aging population, those working in this domain must become competent in cultural mores. Dietetics professionals and students must be prepared to practice effectively in an interdisciplinary environment that is undergoing change. They must pool their resources with others, ally to exploit opportunity, and link systems into interdisciplinary partnerships and networks.

Today's challenge is to do more with less; dietetics professionals must look outward and inward for strategies to realistically and flexibly position food and nutrition services within the continuum of care for older adults and:

- Advocate for third-party coverage of medical nutrition therapy for Medicare beneficiaries (29);
- Engage in out-of-the-box thinking to identify new and different approaches (Figure 4);
- Establish standards of professional practice to ensure older adults receive adequate and appropriate nutrition care that is integrated into the rapidly changing delivery of medical, health, and supportive services (108,154,173) across the continuum;
- Position dietetics professionals as lifestyle agents;
- Work (and volunteer) to alleviate elder poverty, hunger, and malnutrition in communities and through legislative processes;
- Network in communities across dietetics specialties and with interdisciplinary aging–network colleagues to develop broad scale community interventions across the continuum;
- Acquire new skills for a multi-skilled approach;
- Develop more effective listening, communication, and observation skills to better interpret the spoken and unspoken needs of older adults;
- Conduct research to document outcomes that establish the vital nature and cost-effectiveness of the provision of appropriate nutrition services to quality of life and independence of older adults (see Figure 4).

Dietetics professionals, together with older adults, caregivers, and advocates, should take the lead in translating the evidence into sound practices and programs at federal, state, and local levels that promote nutritional well-being, health, independence, and quality of life.

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■ ADA position adopted by the House of Delegates on October 26, 1986, and reaffirmed on October 24, 1991, September 15, 1995, and September 28, 1998. This position will be in effect until December 2003. The American Dietetic Association authorizes republication of the position, *in its entirety*, provided full and proper credit is given. Requests to use portions of this position must be directed to ADA Headquarters at 800/877-1600, ext 4896, or ppositions@eatright.org.

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PERIODICALS

Periodical articles of special interest to nutrition professionals are cited or abstracted in this section. Articles that have been abstracted are marked with a darkened box (■).

Literature abstracts and citations are prepared by the *Journal* editors. Articles are selected from scientific and professional publications chosen to convey fundamental knowledge in nutritional science and to span the specialty practice fields of readers. A list of the publications reviewed for this section is published each year in the January issue. The current list, which includes contact information for each title, appears on page 133 of the January 2000 issue. Readers who want information about any article or publication appearing in New In Review should use this directory to locate the authors or editors of the original article or publication.

THE AMERICAN JOURNAL OF CLINICAL NUTRITION

Vol 70, December 1999

□ Are olive oil diets antithrombotic? Diets enriched with olive, rapeseed, or sunflower oil affect postprandial factor VII differently. L.F. Larsen, J. Jespersen, and P. Marckmann. 976-982.

□ Modified milk fat reduces plasma triacylglycerol concentrations in normolipidemic men compared with regular milk fat and nonhydrogenated margarine. H. Jacques, A. Gascon, J. Arul, A. Boudreau, C. Lavigne, and J. Bergeron. 983-991.

■ HDL-subpopulation patterns in response to reductions in dietary total and saturated fat intakes in healthy subjects. L. Berglund, E.H. Oliver, N. Fontanez, et al, for the DELTA investigators. 992-1000.

■ Dietary saturated fats and their food sources in relation to the risk of coronary heart disease in women. F.B. Hu, M.J. Stampfer, J.E. Manson, et al, for the Nurses' Health Study. 1001-1008.

□ High-monounsaturated fatty acid diets lower both plasma cholesterol and triacylglycerol concentrations. P.M. Kris-Etherton, T.A. Pearson, Y. Wan, R.L. Hargrove, K. Moriarty, V. Fishell, and T.D. Etherton. 1009-1015.

■ Longitudinal changes in adult fat-free mass: influence of body weight. G.B. Forbes. 1025-1031.

■ Effects of an omnivorous diet compared with a lactoovovegetarian diet on resistance-training-induced changes in body composition and skeletal muscle in older men. W.W. Campbell, M.L. Barton Jr, D. Cyr-Campbell, S.L. Davey, J.L. Beard, G. Parise, and W.J. Evans. 1032-1039.

■ Efficacy of a green tea extract rich in catechin polyphenols and caffeine in increasing 24-h energy expenditure and fat oxidation in humans. A.G. Dulloo, C. Duret, D. Rohrer, L. Girardier, N. Mensi, M. Fathi, P. Chantre, and J. Vandermander. 1040-1045.

■ Dietary factors in relation to rheumatoid arthritis: A role for olive oil and cooked vegetables? A. Linos, V.G. Kaklamani, E. Kaklamani, Y. Koumantaki, E. Giziaki, S. Papazoglou, and C.S. Mantzoros. 1077-1082.

□ Receiver operating characteristic analysis of body mass index, triceps skinfold thickness, and arm girth for obesity screening in children and adolescents. L.B. Sardinha, S.B. Going, P.J. Teixeira, and T.G. Lohman. 1090-1095.

Dietary total and saturated fat and HDL subpopulations This study investigated the effect of reductions in total fat and saturated fatty acid (SFA) intakes on high-density lipoprotein (HDL) subpopulations. Reduction in total fat and SFA intakes was associated with a decrease in levels of large (HDL_2 and HDL_{2b}) and small, dense (HDL_{3a}, HDL_{3b}, and HDL_{3c}) HDL subpopulations, although decreases in HDL_2 and HDL_{2b} were most pronounced. Men and women (n=103, aged 22 to 67 years, 77 whites and 26 blacks) who participated in the Dietary Effects on Lipoproteins and Thrombogenic Activities Study ate 3 diets for 8 weeks each in random order. The 3 diets were a typical American diet (34.3% of energy intake from total fat and 15.0% from SFAs), an American Heart Association step 1 diet (28.6% of energy as total fat and 9.0% as SFAs), and a diet low in saturated fat (25.3% of energy as total fat and 6.1% as SFAs). HDL_2 levels were significantly positively related to dietary intake of total fat and SFAs; the association was less strong for HDL_3. Dietary total fat and SFAs were positively related to proportions of the larger HDL_{2b} subpopulation and significantly negatively related to proportions of the smaller HDL_{3a}, HDL_{3b}, and HDL_{3c} subpopulations. For all 3 diets, HDL_{3a}, HDL_{3b}, and HDL_{3c} levels were positively correlated with serum triglyceride (TG) levels; HDL_2 and HDL_{2b} levels were negatively correlated with serum TG levels; and diet-induced changes in serum TG levels were negatively correlated with changes in HDL_2 and HDL_{2b} levels.

Sources of dietary saturated fatty acids and risk of CHD in women A distinction between stearic acid (C18:0) and other saturated fatty acids does not appear to be important in dietary advice to reduce risk of coronary heart disease (CHD), partly because levels of stearic acid and other saturated fatty acids are highly correlated in typical diets. Subjects were 80,082 women (aged 34 to 59 years) who participated in the Nurses' Health Study. Subjects had no known CHD, cancer, hypercholesterolemia, or diabetes, and they completed validated food frequency questionnaires in 1980. During 14 years of follow-up, 939 subjects experienced major CHD events. After control for age, cigarette smoking, and other covariates, intakes of short- to medium-chain saturated fatty acids (C4:0 to C10:0) were not significantly associated with risk of CHD. However, intakes of longer-chain saturated fatty acids (C12:0 to C18:0) were each separately associated with a small increase in risk of CHD. The multivariate relative risk (RR) of CHD for a 1% increase in energy intake from stearic acid was 1.19. The ratio of dietary polyunsaturated to saturated fatty acids was strongly inversely associated with CHD risk (multivariate RR for subjects with ratios in the highest vs the lowest decile = 0.58). Ratios of intake of red meat to poultry and fish and of high-fat to low-fat dairy products were significantly positively related to risk of CHD.

Effect of longitudinal changes in body weight on fat-free mass Loss of fat-free mass (FFM) is not inevitable during adulthood, at least up to age 81 years. The magnitude and direction of change in FFM are strongly influenced by change in body weight. Whole-body potassium counting was used to estimate FFM in adult university personnel (15 men and 5 women) over 21 to 38 years. No advice was given about diet or exercise. Changes in FFM over time varied considerably among subjects. Some subjects lost FFM over time; others gained FFM. Adults who maintained their body weight lost a mean 1.5 kg FFM per decade and so gained an equal amount of fat; those who lost weight lost even more FFM, whereas those who gained weight either gained FFM or lost it more slowly than the others. Data from the literature confirmed this trend.

Omnivorous vs vegetarian diet and resistance training–induced changes in body composition Older men who

ADMINISTRATION ON AGING STATE PROGRAM REPORT

A Summary of State and Community Programs under Title III of the Older Americans Act of 1965, as amended

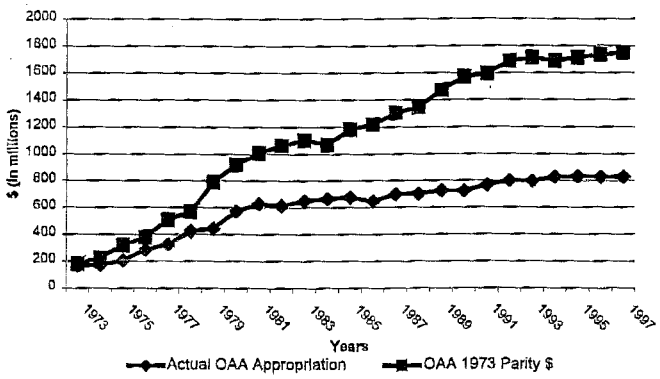
Federal Fiscal Year 1997

U.S. Department of Health and Human Services
Administration on Aging
330 Independence Avenue. SW
Washington, DC 20201

July 2000

Figure 1 shows how OAA funds have remained relatively static in recent years and have actually fallen in real terms. The graph displays the actual annual appropriations under the OAA, as the bottom line, and the amount of increase that would have been required just to keep pace with inflation and the increase in the size of the elderly population, as the top line. Adjusted for inflation and the rise in the 60+ population, the actual appropriations have decreased about 50 percent since 1973.

Figure 1. The Shortfall between Actual and Inflation-Adjusted Older Americans Act Appropriations Since 1973



DETERMINE YOUR NUTRITIONAL HEALTH

The Warning Signs of poor nutritional health are often overlooked. Use this Checklist to find out if you or someone you know is at nutritional risk.

Read the statements below. Circle the number in the "yes" column for those that apply to you or someone you know. For each "yes" answer, score the number in the box. Total your nutritional score.

	YES
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2
TOTAL	

Total Your Nutritional Score. If it's –

0-2 Good! Recheck your nutritional score in 6 months.

3-5 You are at moderate nutritional risk. See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Recheck your nutritional score in 3 months.

6 or more You are at high nutritional risk. Bring this Checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

Remember that Warning Signs suggest risk, but do not represent a diagnosis of any condition. Turn the page to learn more about the Warnings Signs of poor nutritional health.

These materials are developed and distributed by the Nutrition Screening Initiative, a project of:

AMERICAN ACADEMY OF FAMILY PHYSICIANS
THE AMERICAN DIETETIC ASSOCIATION
THE NATIONAL COUNCIL ON THE AGING, INC.

The Nutrition Screening Initiative • 1010 Wisconsin Avenue, NW • Suite 800 • Washington, DC 20007
The Nutrition Screening Initiative is funded in part by a grant from Ross Products Division of Abbott Laboratories, Inc.

The Nutrition Checklist is based on the Warning Signs described below. Use the word DETERMINE to remind you of the Warning Signs.

DISEASE

Any disease, illness or chronic condition which causes you to change the way you eat, or makes it hard for you to eat, puts your nutritional health at risk. Four out of five adults have chronic diseases that are affected by diet. Confusion or memory loss that keeps getting worse is estimated to affect one out of five or more of older adults. This can make it hard to remember what, when or if you've eaten. Feeling sad or depressed, which happens to about one in eight older adults, can cause big changes in appetite, digestion, energy level, weight and well-being.

EATING POORLY

Eating too little and eating too much both lead to poor health. Eating the same foods day after day or not eating fruit, vegetables, and milk products daily will also cause poor nutritional health. One in five adults skip meals daily. Only 13% of adults eat the minimum amount of fruit and vegetables needed. One in four older adults drink too much alcohol. Many health problems become worse if you drink more than one or two alcoholic beverages per day.

TOOTH LOSS/MOUTH PAIN

A healthy mouth, teeth and gums are needed to eat. Missing, loose or rotten teeth or dentures which don't fit well, or cause mouth sores, make it hard to eat.

ECONOMIC HARDSHIP

As many as 40% of older Americans have incomes of less than $6,000 per year. Having less -- or choosing to spend less -- than $25-30 per week for food makes it very hard to get the foods you need to stay healthy.

REDUCED SOCIAL CONTACT

One-third of all older people live alone. Being with people daily has a positive effect on morale, well-being and eating.

MULTIPLE MEDICINES

Many older Americans must take medicines for health problems. Almost half of older Americans take multiple medicines daily. Growing old may change the way we respond to drugs. The more medicines you take, the greater the chance for side effects such as increased or decreased appetite, change in taste, constipation, weakness, drowsiness, diarrhea, nausea, and others. Vitamins or minerals, when taken in large doses, act like drugs and can cause harm. Alert your doctor to everything you take.

INVOLUNTARY WEIGHT LOSS/GAIN

Losing or gaining a lot of weight when you are not trying to do so is an important warning sign that must not be ignored. Being overweight or underweight also increases your chance of poor health.

NEEDS ASSISTANCE IN SELF CARE

Although most older people are able to eat, one of every five have trouble walking, shopping, buying and cooking food, especially as they get older.

ELDER YEARS ABOVE AGE 80

Most older people lead full and productive lives. But as age increases, risk of frailty and health problems increase. Checking your nutritional health regularly makes good sense.

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The Nutrition Screening Initiative is funded in part by a grant from Ross Products Division of Abbott Laboratories, Inc.

NUTRITION CARE ALERTS

Warning Signs and Action Steps for Caregivers in Nursing Facilities

Proper nutrition care is vital to the health and well being of nursing facility residents. This guide, developed by nutrition and long term care experts, can help caregivers learn more about the warning signs of poor nutrition and the practical steps to maintain and improve residents' nutritional health. It is designed to be used every day with every resident.

This guide addresses four common nutrition-related conditions: unintended weight loss, dehydration, pressure ulcers and complications from tube feeding. Warning signs are on the left. Action steps for nursing assistants are in the center. Action steps for other care providers like physicians, nurses, dietitians and pharmacists are on the right.

Please share this guide with your coworkers, friends, volunteers and your residents' family members. Together, you can help maintain or improve the nutritional health of your residents.

UNINTENDED WEIGHT LOSS

WARNING SIGNS

The following are some signs that a resident may be at risk for or suffer from unintended weight loss:

- Needs help to eat or drink
- Eats less than half of meals/snacks served
- Has mouth pain
- Has dentures that don't fit
- Has a hard time chewing or swallowing
- Has sadness, crying spells, or withdrawal from others
- Is confused, wanders, or paces
- Has diabetes, COPD, cancer, HIV or other chronic disease

ACTION STEPS

Below are some action steps to increase food intake, create a positive dining environment, and to help residents get enough calories:

Nursing Assistant

- Report observations and warning signs to nurse and dietitian
- Encourage resident to eat
- Honor food preferences
- Offer many kinds of foods and beverages
- Help residents who have trouble feeding themselves
- Allow adequate time to finish eating
- Notify nursing staff if resident has trouble using utensils
- Record meal/snack intake
- Provide oral care before meals
- Position resident correctly for feeding

Other Members of the Interdisciplinary Care Team

- Monitor weight
- Provide higher calorie food, beverages, or oral supplements
- Give high calorie liquids with medications
- Incorporate increased fluid into resident's diet plan
- Assess cultural, ethnic preferences
- Reassess resident's dietary restrictions
- Modify food texture or temperature to increase intake
- Assist the resident to develop an advance directive regarding feeding/hydration issues
- Consider tube feeding, if indicated, and in accordance with advance directive
- Consider medications to improve mood or mental status
- Consider a dental consultation

DEHYDRATION

WARNING SIGNS

The following are some signs that a resident may be at risk for or suffer from dehydration:

- Drinks less than 6 cups of liquids daily
- Has one or more of the following:
  - dry mouth
  - cracked lips
  - sunken eyes
  - dark urine
- Needs help drinking from a cup or glass
- Has trouble swallowing liquids
- Frequent vomiting, diarrhea, or fever
- Is easily confused/tired

ACTION STEPS

Most residents need at least 6 cups of liquids each day to stay hydrated. Below are some action steps to help residents get enough to drink:

Nursing Assistant

- Report observations and warning signs to nurse and dietitian
- Encourage resident to drink every time you see the resident
- Offer 2-4 ounces water or liquids frequently
- Be sure to record fluid intake
- Offer ice chips frequently
- Offer sips of liquid between bites of food at meals and snacks
- Drink fluids with the resident, if allowed
- Make sure pitcher and cup can be lifted by resident
- Offer the appropriate assistance as needed if resident cannot drink without help

Other Members of the Interdisciplinary Care Team

- Monitor fluid intake
- Incorporate increased fluid into resident's diet plan. For example: popsicles, juice bars, gelatin, ice cream, sherbet, soup, broth, fruit/vegetable juices, lemonade, flavored water
- Offer a choice of liquids at meals and snacks
- Assist the resident to develop an advance directive regarding feeding/hydration issues
- Consider oral rehydration or IV hydration treatment if enteral intake fails to meet needs
- Consider tube feeding, if indicated, and in accordance with advance directive
- Assess medications and revise prescriptions that contribute to dehydration
- Give medications with 1 cup (240 cc) water or other liquid

PRESSURE ULCERS

WARNING SIGNS

The following are some signs that a resident may be at risk for or suffer from pressure ulcers:

- Patient subject to:
  - incontinence
  - moisture
- Needs help:
  - moving arms, legs or body
  - turning in bed
  - changing position when sitting
- Weight loss
- Eats less than half of meals/snacks served
- Dehydration
- Has discolored, torn, or swollen skin over bony areas

ACTION STEPS

Below are some action steps to help residents who are at risk for or suffer from pressure ulcers:

Nursing Assistant

- Report observations and warning signs to nurse and dietitian
- Check and change linens as appropriate
- Handle/move the resident with care to avoid skin tears and scrapes
- Reposition frequently and properly
- Use *"unintended weight loss action steps"* so resident gets more calories and protein
- Record meal/snack intake
- Use *"dehydration action steps"* so resident gets more to drink

Other Members of the Interdisciplinary Care Team

- Initiate wound management protocol
- Consider nutritional supplementation based on a resident's needs
- Assist the resident to develop an advance directive regarding feeding/hydration issues
- Use *"unintended weight loss action steps"* to improve calorie/protein intake
- Use *"dehydration action steps"* to improve fluid intake

RESIDENTS WHO ARE TUBE FED

WARNING SIGNS

The following are some signs that a resident may be at risk for or experiencing tube feeding complications:

- Has one or more of the following:
  - nausea/vomiting/diarrhea
  - swollen stomach
  - constipation/cramping
- At the site where the feeding tube enters the body, there is:
  - pain, redness, heat, or swelling
  - crusty or oozing fluid
- A cough, wet breathing or a feeling of something "caught" in the throat

ACTION STEPS

Below are some action steps in cases where residents may be at risk for or experiencing tube feeding complications:

Nursing Assistant

- Report observations and warning signs to nurse and dietitian
- Maintain position of resident with head elevated 30 degrees or more as tolerated during feedings and for at least 30 minutes after feedings

Other Members of the Interdisciplinary Care Team

- Assess pain and other complaints to rule out non-tube feeding causes
- Assess/revise medications to minimize complications/pain, if indicated
- Check placement of tube and residual prior to each feeding
- Check tube for obstructions
- Flush tube regularly
- Modify tube feeding administration, rate, strength, and formula, if necessary
- Reassess need for tube feeding; transition to oral feedings if appropriate
- Assist the resident to develop an advance directive regarding feeding/hydration issues

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INITIATIVE FUNDED IN PART THROUGH A GRANT FROM ROSS PRODUCTS DIVISION, ABBOTT LABORATORIES INC.

NUTRITION & HEALTH FOR OLDER AMERICANS

FATS, OILS AND SWEETS
Eat sparingly

jelly
candy
gelatin
mayonnaise
salad dressing
margarine/butter

MILK, YOGURT, CHEESE	MEAT, POULTRY, FISH, DRY BEANS, EGGS, NUTS
1 cup milk	1/2 cup tuna
1 cup yogurt	2 oz meatloaf
1 cup pudding	chicken leg/thigh
1 cup milkshake	2 fish sticks
1 1/2 cups ice cream	2 eggs
1 1/2 oz Swiss cheese	1 cup baked beans
2 cups cottage cheese	4 tbsp peanut butter

VEGETABLES *Eat 3–5 servings daily*	FRUITS *Eat 2–4 servings daily*
1/2 cup corn	1 orange
1/2 cup carrots	1 banana
two spears broccoli	3/4 cup fruit juice
1 cup salad greens	1/2 cup applesauce
1/2 cup green beans	5 prunes
3/4 cup vegetable juice	1/2 cup fruit cocktail
1/2 cup mashed potatoes	1/2 cup strawberries

1/2 bagel	1/2 English muffin
1/2 cup cooked rice	1/2 cup cooked noodles
1/2 cup cooked hot cereal	1 slice bread
1 dinner roll	2 to 3 graham crackers
1 small muffin	1 oz ready-to-eat cereal

Foods are indicated with amount equal to one serving.

WHAT ABOUT WATER?

Adults need six to eight 8-ounce cups of water or liquid a day. Sources of liquid, in addition to water, are fruit and vegetable juices and milk. Caffeine-free coffees and teas and herbal teas are also good sources.

Food Guide Pyramid

FOR PERSONS 50 PLUS

The Most Frequently Asked Questions About the Older Americans* Food Guide Pyramid

NUTRITION & HEALTH FOR OLDER AMERICANS

WHAT IS THE FOOD GUIDE PYRAMID?

The Pyramid, developed by the United States Department of Agriculture, is a general guide that lets you choose a healthful eating plan that's right for you. The Pyramid calls for eating a variety of foods to get the nutrients you need with the right amount of calories to maintain a healthy weight.

IS ONE FOOD GROUP MORE IMPORTANT THAN ANOTHER?

All foods are important. Foods in one group can't replace those in another. Most Americans need to eat more foods from the lower three sections (vegetables, fruits and grain products) of the Pyramid. For good health, you need to choose a wide variety of foods.

HOW DO NUTRITION NEEDS CHANGE AS I AGE?

Enjoying a variety of nutritious foods is important at any age. You need at least the same amounts of vitamins and minerals as you did when you were younger. Healthful food choices keep you strong and energetic and may even help prevent some diseases. Did you know that your need for calories decreases with age? Because of reduced physical activity and a slower metabolism, calorie needs may decrease by as much as 25 percent.

Physical changes that occur with aging may influence how well the body digests and absorbs food. Many medications can also affect digestion and absorption of nutrients, as well as decrease appetite. Even though you may need fewer calories, vitamin and mineral requirements don't decline. Planning your meals to provide all the nutrients of value with fewer calories can be quite a challenge! Following the Food Guide Pyramid makes it easier to invest in your future health.

Depending on your individual requirements, it may be helpful to consume foods that are lower in sodium, fat and/or calories, such as low-sodium crackers or low-fat cheese. Learn to use herbs instead of salt or margarine to flavor your foods – you'll love the results.

WHAT ABOUT THE TOP OF THE PYRAMID WHICH SHOWS FATS, OILS AND SWEETS?

Salad dressings, cream, butter, margarine, sugars, soft drinks, candies, sweet desserts, and alcoholic beverages belong to this group. These foods provide calories but few vitamins and minerals. Most people should go easy on foods from this group.

Some fat or sugar is also found in the other food groups. When choosing foods for a healthful eating plan, consider that fats and sugars are in all the food groups, not just in the Pyramid tip.

WHAT SHOULD I DO TO ENSURE I AM EATING WELL?

As you grow older, you must carefully select foods high in vitamins and minerals while lower in fat, calories and sodium. Follow these guidelines to ensure a helpful eating pattern:

- Eat a balanced diet, chosen from a variety of the most nutritious foods.
- Drink plenty of water: 6-8 cups daily.
- Keep your calories at a level that allows you to maintain a healthy weight.
- Choose a diet lower in fat, saturated fat and cholesterol.
- Choose a diet with plenty of vegetables, fruits and grain products.
- Consume salt and high-salt foods sparingly.
- Drink alcoholic beverages in moderation, if at all.

ARE THERE OTHER FACTORS I SHOULD CONSIDER?

Yes, **fiber and roughage** are very important for your eating plan. Fiber and roughage are found in whole-grain breads, cereals, crackers, beans, fruits and vegetables. It is important to eat foods with fiber in them every day. As you increase fiber in your diet, remember to increase liquids at the same time. Fiber increases should be made gradually, as a large increase may cause gas, bloating or diarrhea.

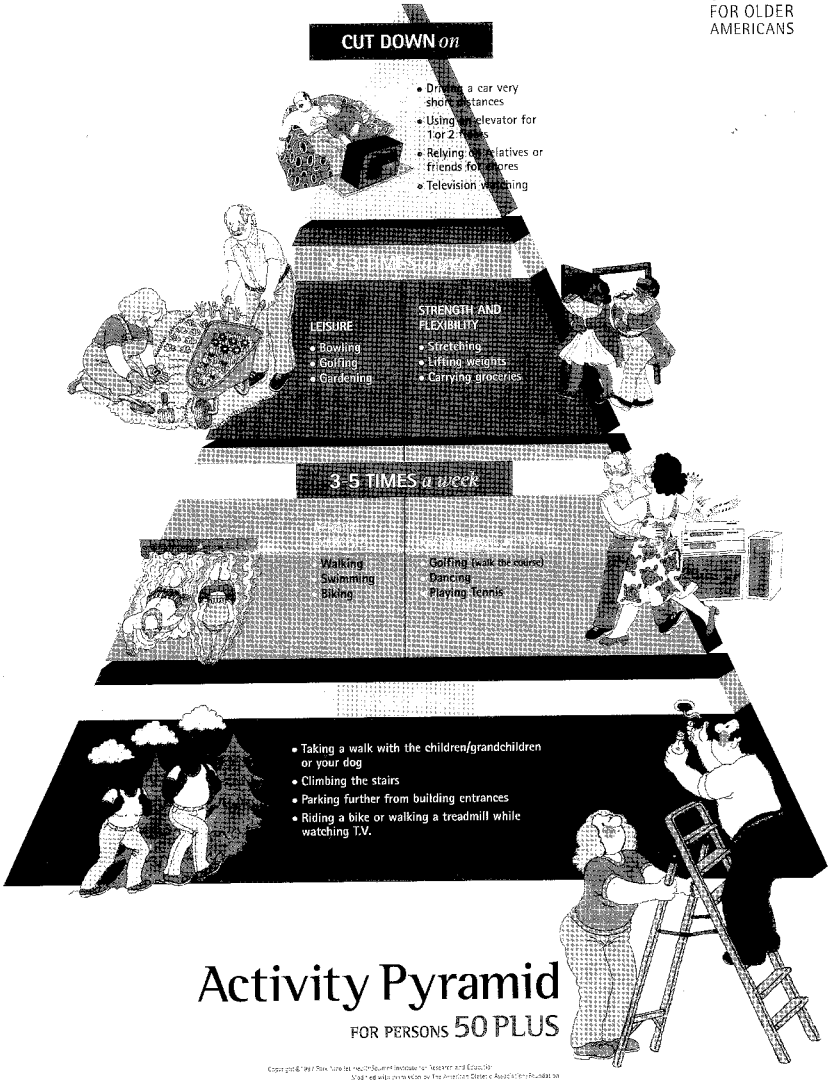
Your **calcium** intake remains important even as you age. In order to maintain your bone mass or reduce the rate of loss, you need regular exercise and adequate amounts of calcium-rich foods. Remember, all forms of milk contain the same amount of nutrients and calcium, but low-fat and nonfat contain less fat.

Water is a very important nutrient that is often overlooked. In fact, water is so important that it might be said to be the true base of the Pyramid of healthy eating. Adults need six to eight cups of water or liquid a day. Other good sources of liquid are fruit and vegetable juices and milk. Regular tea and coffee are not good sources of water because the caffeine in them causes your body to lose water. Caffeine-free coffees and teas and herbal teas are fine. To "dress up" plain water, add a splash of lemon or other fruit juice for a refreshing beverage.

SPECIAL NOTE: If you are on a special (therapeutic) diet, follow the advice of your physician and/or registered dietitian. Check with your physician for special nutrient needs you may have because of any medication you may be taking.

* The AIA/F Nutrition and Health for Older Americans program has been designed to address the needs of Americans age 60 and over.

NUTRITION
& HEALTH
FOR OLDER
AMERICANS



Activity Pyramid

FOR PERSONS 50 PLUS

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