

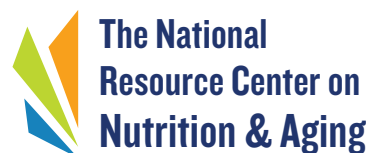
JULY 2019



## CONGREGATE NUTRITION PROGRAMS

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AN EXPLORATION OF CURRENT CHALLENGES AND FUTURE OPPORTUNITIES





# About Us

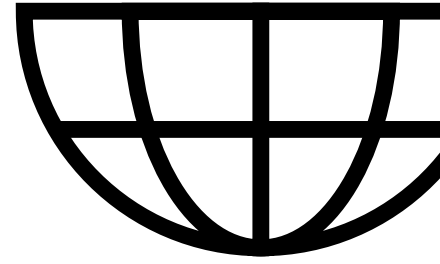
## About NANASP

Founded in 1977, the National Association of Nutrition and Aging Services Programs (NANASP) is proud to be a leading organization advocating for community-based senior nutrition programs and staff. Our member programs represent a wide range of essential services providers who support the nutrition, health and life quality of seniors. With over 1,100 members from across the United States, we are national advocates for senior health and wellbeing who strengthen the policies and programs that nourish seniors. We accomplish this mission through a collective national voice and through local community action. For more information, go to [nanasp.org](http://nanasp.org).

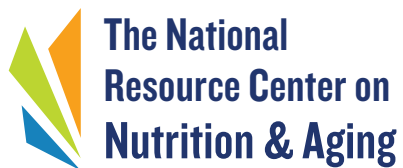
## About NRCNA

Hosted by Meals on Wheels America as part of a cooperative agreement with the Administration for Community Living, the National Resource Center on Nutrition & Aging (NRCNA) is designed to build the capacity of the aging services network to provide nutrition services for both current and future older adult populations integrated into a home- and community-based service system and provide training and technical assistance to the aging network regarding nutrition services. To learn more, visit [nutritionandaging.org](http://nutritionandaging.org).





# What's Inside



**The National  
Resource Center on  
Nutrition & Aging**



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National Voice. Local Action.

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# Executive Summary

The congregate nutrition program is the largest program in the Older Americans Act (OAA). It provides group meals for older adults at senior centers, churches, and other facilities. But, as the older adult population grows and becomes more diverse, this program is experiencing some challenges.

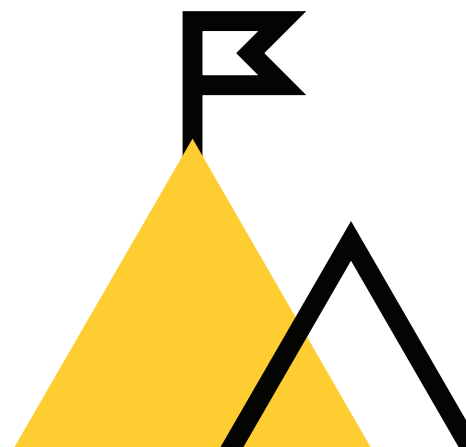
As the older adult population grows and becomes increasingly diverse, congregate nutrition programs face new challenges, including combating rising rates of hunger and food insecurity, increasing rates of chronic disease, funding and program planning issues, demographic shifts, regional issues, and general program perception issues.

However, there are also new opportunities for programs, such as the café model, the “wellness model,” and becoming more culturally competent to serve a newly diverse population.

Ultimately, congregate nutrition programs are supposed to provide three benefits to older adults, as laid out in the Older Americans Act: a nutritious meal, nutrition education, and an opportunity for socialization. Ensuring that programs are offering these benefits to the satisfaction of the local community can be an opportunity to innovate, particularly for smaller programs.

Further, program leaders can and should engage members of their communities in discussions about the future of their local program. This can help program leaders to better understand the needs and desires of their community and in turn to seek out appropriate programming for their sites.

In short, though funding may be limited for some programs, innovations are possible – and ultimately, necessary to the survival of the network.





# Introduction

The congregate nutrition program is the largest program in the Older Americans Act (OAA). It provides group meals for older adults at senior centers, churches, and other facilities. But, as the older adult population grows and becomes more diverse, this program is experiencing some challenges.

## Overview of the Program

The OAA originally became law on July 14, 1965, establishing the Administration on Aging within the Department of Health and Human Services. It also created the aging services network, which currently includes 56 State Units on Aging (SUAs), 622 Area Agencies on Aging (AAAs), 270 Title VI Native American aging programs and more than 29,000 service provider organizations.<sup>1</sup>

In 1972, the OAA added a Nutrition Services Program for older adults, beginning with a congregate program, with funds reserved for home-delivered meals. *(A separate program for home-delivered meals was established in 1978 and the Nutrition Services Incentive Program (NSIP) was established in 1974<sup>4</sup>.)* Today, Title III(C) of the OAA provides Americans over the age of 60 with healthy meals, nutrition education and nutrition counseling.





# Federal Funding

## An Exploration of Current Programs

The Administration on Aging, now contained within the Administration for Community Living (ACL), partially funds the Nutrition Services Program. In FY 2019, the overall program received \$906.7 million in total funding, with \$495.3 million specifically allotted to the congregate nutrition program.<sup>5</sup>

The Nutrition Services Program is also fiscally supported by state and local governments, foundations, direct payment for services, fundraising and participant contributions.<sup>6</sup> (*Eligibility for the Nutrition Services Program is not subject to means-testing, though participants are encouraged to make a monetary donation.*) The Administration on Aging awards states and territories OAA Title III(C) funds for congregate and home-delivered meals according to a funding formula based on states' and territories' share of the population over age 60. States and territories in turn award funds to the 622 AAAs that administer the program in their service areas. States must provide a funding match of 15 percent in order to receive this funding.<sup>7</sup>





# Changing Demographics

OAA services, including the congregate nutrition program, must target those with increased social and economic needs, especially low-income and minority older adults, those with limited English-language skills, rural area residents and those at risk of institutionalization. In 2014, according to ACL's AGID database, the demographics of clients in the overall Title III program (*including nutrition, supportive services, family caregiving, and preventive health services*) were as follows:

## Title III Clients

Data Element	2014
Total Clients	94,298
Total Registered Services Clients	52,381
Total Minority Clients	17,747
Minority Clients as a % of Registered Clients	33.9%
African American Non-Hispanic Clients as a % of Registered Clients	32.8%
Asian and Pacific Islander Non-Hispanic Clients as a % of Registered Clients	0.3%
American Indian and Eskimo Non-Hispanic Clients as a % of Registered Clients	0.3%
Hispanic Clients as a % of Registered Clients	0.4%
Clients Below Poverty Level	16,560
Clients Below Poverty as a % of Registered Clients	31.6%
Minority Clients Below Poverty Level	7,464
Minority Clients Below Poverty as a % of Registered Clients	14.2%
Rural Clients	25,507
Rural Clients as as % of Registered Clients	48.7%
# of Caregivers of Elderly	2,939
# of Grandparents Caregivers	172

Source: National Aging Program Information Systems (NAPIS) State Program Reports (SPR)

2014 demographics of clients in the overall Title III program (*including nutrition, supportive services, family caregiving, and preventive health services*).



# Current Challenges

As the older adult population grows and becomes increasingly diverse, congregate nutrition programs face new challenges, including combating rising rates of hunger and food insecurity, increasing rates of chronic disease, funding and program planning issues, demographic shifts, regional issues, and general program perception issues.

## Hunger and Food Insecurity

The older adult population has experienced heightened rates of food insecurity in the past few decades. Between 2001 and 2012, the percentage of adults age 60 and older who are food-insecure increased by 66%, and the number of food-insecure older adults increased by 130%.<sup>8</sup> Since the start of the most recent recession in 2007, the percentage of older adults experiencing food insecurity rose by 40%, and the number of older adults at risk of hunger increased by 63%.<sup>7</sup>

Congregate nutrition programs are impacted by this increasingly food-insecure population.<sup>9</sup> According to a survey of older residents in Dane County, Wisconsin, respondents who attended a congregate nutrition program once per week or more, as compared to those who attended less than once per week, were significantly more likely to indicate:

- They had skipped a meal during the past month because they had to use the money for other living expenses.
- If they didn't receive these meals, they would not have at least one hot, freshly prepared meal daily.
- They didn't always have enough money to buy the food they need.
- And, of all the food they eat in a day, over half is eaten at a congregate nutrition program.<sup>10</sup>

The OAA Nutrition Program reaches less than one-quarter of older adults in need of its program and services.<sup>11</sup> Only about 9% of the estimated 17.6 million low-income older adults received these services, but many more needed such services and didn't receive them.<sup>12</sup> A 2011 Government Accountability Office report estimated that about 90% of low-income older adults who were food insecure received no meal services through the OAA<sup>13</sup>. Still, the OAA Nutrition Services Program enables 2.5 million older adults to remain in their own homes and communities.<sup>11</sup>





# Funding and Planning Issues

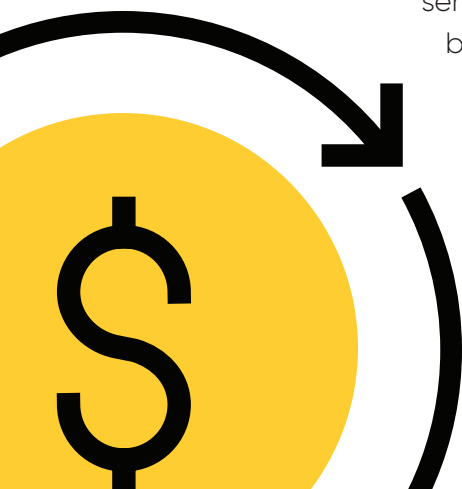
In many communities across the United States, funding for nutrition is decreasing. A 2019 AARP Public Policy Institute Report finds that total OAA funding isn't keeping pace with inflation—and that, when adjusted for inflation, program funding has fallen by 16% since FY 2001. This report finds that if trends continue, the inflation-adjusted appropriation will continue to decrease to \$1.83 billion in 2030 (in 2019 dollars), 25% lower than in FY 2001.<sup>14</sup>

Regarding the nutrition programs, per AARP, FY2019 OAA nutrition program funding levels represent a significant increase from \$680 million in FY 2001. However, AARP found that when adjusted for inflation, total funding appropriated for OAA nutrition services over the past 18 years fell by 8%, a decline of \$80 million in 2019 value.<sup>15</sup>

Based on these declining numbers, many communities are having to change their service delivery methods. For example, in Knoxville, Iowa, a January 2019 proposal was unveiled to close a local senior center's kitchen and halt rent payments to senior centers for the use of their facilities to serve congregate meals.<sup>16</sup>

In response, Roy Richardson, the director of the Knoxville Senior Center said, "Unless we stay open out of the goodness of our heart for them to use as a meal site, they're gonna lose Pleasantville and Knoxville. So then where would the people out in the country have to drive to, to take advantage of it? We're seeing this shrinking of services. If the kitchen isn't here and they don't serve meals here, a lot of the people that frequent here probably aren't gonna stop in, so our numbers are gonna go down and we're gonna struggle to stay open. That's the facts of life."<sup>17</sup>

In other words, congregate nutrition programs will need to diversify their funding sources. "Partnerships and collaborations have always been a foundation for senior centers to be successful, but with less resources available and the budget axe looming in many communities, working with hospitals, parks and recreation departments, local foundations, neighborhood associations, local aging service providers ... and others is imperative to remain sustainable in the future," said Jay Morgan, Crossroads moderator and consultant with the National Council on Aging for the National Institute of Senior Centers.<sup>18</sup>





# Demographic Shifts

As the older adult population grows, it is also becoming more diverse. Per ACL's 2017 Profile of Older Americans, "racial and ethnic minority populations have increased from 6.9 million in 2006 (19% of the older adult population) to 11.1 million in 2016 (23% of older adults) and are projected to increase to 21.1 million in 2030 (28% of older adults)."<sup>19</sup>

ACL data also suggests that between 2016 and 2030, the white (not Hispanic) population age 65 and over is only projected to increase by 39% compared to 89% for older racial and ethnic minority populations, including Hispanics (112%), African-Americans (73%), American Indian and Native Alaskans (72%), and Asians (81%).<sup>20</sup>





According to the Population Reference Bureau, in 2010, more than one in eight (11.9%) of adults in the United States ages 65 and older were immigrants. In fact, the older immigrant population has risen from 2.7 million in 1990 to 4.6 million in 2010, or a 70% increase in 20 years.<sup>21</sup> Depending on how recently these older adults immigrated, they may have a lower level of acclimation to U.S. society and may have less knowledge of available services for older adults.<sup>22</sup> They may also have dietary preferences that differ from what is commonly offered at congregate meal sites.

These shifting population realities are leading to increased awareness of differing needs within communities. Most studies have found that older adults benefit from social support at congregate meal sites, including the 2017 Mathematica Policy Research evaluation of OAA nutrition program participants.<sup>23</sup> However, low-income and African-American subgroups have been found to experience less social support than higher-income and white subgroups.<sup>24 25</sup>

Another growing minority group to consider is the LGBT older adult population. Many LGBT older adults<sup>26</sup> are not likely to participate in mainstream elder services due to past discrimination. Porter and Cahill have found that LGBT aging trainings for elder service providers have been shown effective in improving the professional capacity of staff to serve LGBT older adults. One resource for this training is a toolkit from SAGE (Services and Advocacy for GLBT Elders), an organization focusing on LGBT older adults.<sup>27</sup>

As the U.S. older adult population grows and becomes more diverse, it is incumbent upon aging services providers to meet this diverse population's needs. Even small steps, such as celebrating culturally-specific holidays, including foods in menus that reflect local cultures, and planning programming inclusive of LGBT participants, can go a long way toward making congregate nutrition programs more welcoming environments.



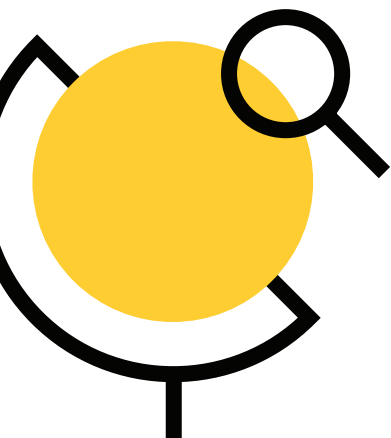
# Local Infrastructure

Congregate nutrition programs differ widely by geography and population. Rural, urban, and suburban programs have unique challenges, for example.

Some research has been done specifically on rural congregate nutrition programs. One article found that certain characteristics of rural areas, “specifically geographic remoteness from food outlets, inadequate infrastructure in communities, and limited food options,” directly affect access to healthy food choices for older adults living in rural areas.<sup>28</sup> This article found that, as a result, “distinct consequences in nutrition-related health behaviors, including lower fruit and vegetable consumption, are correlated with [negative] health outcomes, including higher obesity and chronic disease rates, in rural areas.”<sup>29</sup>

Socially, rural-dwelling older adults indicate that food choices are increased through community support. Food sharing is common; for example, 75% of older adults in one study reported receiving a gift of food during the previous year.<sup>30</sup> A different group of older adults reported that shared mealtimes decreased their social isolation, and social interactions at mealtimes are related to increased dietary quality.<sup>31</sup> Congregate nutrition programs are vital to facilitate these interactions between older adults.

Interestingly, increased development and construction in these areas do not appear to lead to increased food options and programs, just buildings, roads, and population growth. Further, public transportation tends to be unavailable and unreliable.<sup>32</sup> Thus, even as some rural areas grow, they are still lacking both food options for older adults and transportation methods for older adults who cannot drive themselves to meal sites. This in turn puts a strain on some rural programs to remain sustainable and even thrive, as some sites experience decreasing participation even though their older adult population continues to grow.





# Perception of Programs

As a new generation of older adults—the baby boomers—ages, they have different interests than the generations preceding them. Some of these interests are not compatible with a very traditional congregate nutrition program environment.

In Iowa, a focus group of older adults not participating in congregate nutrition programs was consulted to ascertain why they were not participating. Participants in this survey “were asked what the term ‘congregate meal site’ conveyed to them. The major connotation associated with the term congregate meal site was ‘old, poor, and bored.’ Participants considered congregate meal sites as a place with ‘bad food’ where ‘old people’ go.”<sup>33</sup>

Congregate nutrition programs are statutorily required to benefit older adults, and older adults will not receive these benefits if they are not participating in the first place. However, there are ways to modernize congregate nutrition programs and make them more appealing to the “younger old,” including through different tracks of leisure programming.

As Sharon Yager, director of the Shrewsbury, MA Senior Center for 17 years, said in a 2013 *Aging Today* article, “bridge has become the new bingo; Zumba has replaced line dancing; the knitters and quilters are turning to Wii; and recent retirees are arriving early in the morning to partake in tai chi.”<sup>34</sup>

Funding can be an issue for these new program offerings, and some centers are turning to contributory models. (The OAA also allows sites to ask for voluntary contributions from congregate nutrition participants.) For example, as noted in the *Atlanta Journal-Constitution* in 2017:

The stereotypical senior center is changing, with expanded programs and fitness opportunities being offered to a growing population of older adults. But these new models are expensive to operate and, increasingly, those who attend are being asked to help share the cost. Membership fees are already standard in many of the newer government-run active adult centers in metro Atlanta, and at least one county will move from offering free services to a fee schedule in all of their senior centers next year.<sup>35</sup>





New programming options must also consider demographic differences and preferences. For example, at one site, women were twice as likely to participate in group exercise classes at the sites as men.<sup>36</sup> And, according to the findings of one focus group, “older women considered holistic, group activities as important in healthy aging, whereas older men stated competitive physical activity aids healthy aging.”<sup>37</sup>

Some sites have moved to a “café” format, as pioneered by Mather LifeWays’s “Café Plus” model in Illinois.<sup>38</sup> These programs offer meals and snacks in a coffee-shop-like format. They also have programming akin to a community college, with classes on topics such as history, flower arranging, and digital safety. This model has been extensively featured in national outlets such as the *New York Times*.<sup>39</sup>

In short, congregate nutrition programs may be perceived by some older adults as “boring,” but nutrition programs (and senior centers generally) are attempting to dispel these perceptions by modernizing their offerings. Programs still must balance the potentially differing activity and meal preferences of the “younger old” and the “older old,” but there is potential for a middle path forward.

Further, as Jay Morgan, the consultant with the National Council on Aging for the National Institute of Senior Centers, said in *Aging Today*, “Even though there is a perception that boomers may be reluctant to go to a senior center, I predict that once they become 70 and older, with three or more chronic health conditions, they will be more open to going to a center that focuses on their needs in their third chapter.”<sup>40</sup>



# Further Opportunities

Innovations such as the aforementioned “café” model are rapidly changing the stereotypical image of congregate nutrition programs. However, not all programs are able to move to this modernized approach, potentially due to funding issues, regulatory constraints, interest from the local community, or other barriers. What are other ways that programs can stay relevant in an era of many options for older adults’ time and attention, and what are other local issues that programs might address?

## Wellness Model

The “wellness” model is one approach that programs have been using nationwide. Many congregate nutrition programs, particularly those hosted at senior or community centers, offer chronic disease self-management education and other forms of preventive health as part of their programming. This education can involve falls prevention exercises, blood glucose management training, cognitive skills exercises, and other forms of physical and mental wellness activities.<sup>41</sup> Some centers, such as the Gary and Mary West Senior Wellness Center in San Diego, CA, even have health amenities such as on-site doctors, nurse practitioners, counselors, and an oral health program.<sup>42</sup>

## Combatting Hunger and Food Insecurity

As mentioned before, older adults in communities across the United States struggle with hunger and food insecurity, which can lead to malnutrition and exacerbate pre-existing health conditions. Congregate nutrition programs are equipped to help combat these issues in their communities; beyond providing the stereotypical “hot lunch,” programs are now also offering breakfast and dinner options. Access to congregate nutrition programs provides vital nutrition for older adults; according to ACL, 54% of congregate nutrition program participants say a congregate meal supplies 50 percent or more of their total food intake for the day.<sup>43</sup>



# Cultural Competency

Given the United States' significant increasing older minority populations, researchers Porter and Cahill recommend that congregate nutrition and related services be provided in a culturally competent manner, meaning that programs should understand the core needs of the diverse communities they serve and be prepared to address them. They suggest strategies that include:

- Locating meal sites in minority neighborhoods.
- Providing culturally-specific menus based upon the tastes and dietary needs of the local population.
- Using meal sites to celebrate cultural holidays and observe traditions.
- Creating programs in which local languages such as Spanish, Russian, and Chinese are the primary language, along with ensuring that outreach materials and on-site print materials are in the language spoken by the community and that staff are fluent in that language.<sup>44</sup>

These suggestions may not even take additional funding, particularly adapting menus or celebrating non-traditional holidays.





# Conclusions

Congregate nutrition programs must rapidly evolve as the older adult population increases and becomes more diverse, as must all aging services programs.

Congregate nutrition programs are supposed to provide three benefits to older adults, as laid out in the Older Americans Act: a nutritious meal, nutrition education, and an opportunity for socialization. Ensuring that programs are offering these benefits to the satisfaction of the local community can be an opportunity to innovate, particularly for smaller programs.

Further, program leaders can and should engage members of their communities in discussions about the future of their local program. This can help program leaders to better understand the needs and desires of their community and in turn to seek out appropriate programming for their sites, whether in a refreshed menu, new educational materials, or in new classes and activities.

Though funding may be limited for some programs, innovations are possible – and ultimately, necessary to the survival of the network.





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