STATEMENT OF

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AOA LISTENING FORUMS ON THE REAUTHORIZATION OF THE

OLDER AMERICANS ACT

ON BEHALF OF

THE NATIONAL ASSOCIATION OF STATE UNITS ON AGING

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Assistant Secretary Greenlee, I appreciate the opportunity to appear before you today on the first day of your important journey to receive input on the Reauthorization of the Older Americans Act. I am James Toews, and I am here today on behalf of the state of Oregon as well as representing the National Association of State units on Aging. Currently, I am the Assistant Director of the Oregon Seniors and People with Disabilities, Department of Human Services. I also serve as the Vice President of the National Association of State Units on Aging. NASUA's mission is to design, improve and maintain state systems delivering home and community based services and supports for the elderly and individuals with disabilities.

NASUA members believe strongly in the important role that prevention and wellness play in ensuring that seniors and individuals with disabilities will be able to live in their home and community. Today I am here to present on a number of programs that the aging services network is currently working on that help to promote prevention and wellness. This presentation shall provide an overview of several aspects to these programs, and their importance within the aging network and the OAA. Specifically, I will focus on two key aspects of healthy aging: nutrition programs and evidence-based health promotion and disease prevention. The OAA's nutrition programs are crucial to the Act, and to the health of the seniors who depend on these meal programs in their daily lives. Evidence-based programs are also key to the OAA's efficacy, due to the disproportionate number of seniors whose daily lives are affected as they struggle to live with manageable, if not preventable conditions such as chronic disease and injuries attributable to falling. With the number of seniors entering the aging network increasing dramatically in future years, investing in scientifically proven evidence-based programs will operate to decrease future health care costs, given the large amount of healthcare dollars currently being spent to treat the results of inadequate prevention programs.

As Slide 2 shows, experts estimate that chronic diseases are responsible for 83% of all health care spending.[i] Additionally, 96% of Medicare spending and about 83% of Medicaid spending is for people with chronic conditions.[ii] This means that 96 cents of every Medicare dollar and 83 cents of every Medicaid dollar are spent on patients with one or more chronic disease. Health care spending for a person with one chronic condition is, on average, two and a half times greater than spending for someone without any chronic conditions.[iii] If we are going to effectively bend the health care cost curve, we must act to drive down the incidence of chronic disease. Slide 3 illustrates the most common conditions that are attributed to chronic disease. As you can see, among the most frequently occurring chronic conditions is arthritis, with nearly 50% of individuals living with the disease. Additionally, around 40 percent of individuals are suffering from hypertension, while 31 percent of all chronic conditions are attributed to heart disease, over 20 percent to cancer, and nearly that many to diabetes and sinusitis.[iv]

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To decrease both the cost and prevalence of chronic disease and the conditions seen here, states, area and agencies on aging and the Administration on Aging have been in partnership for the last several years developing a wide array of evidence-based health promotion and disease prevention programs. It is important to note that we are adhering to rigorously tested and proven programs that have been proven over time to improve health outcomes, quality of life for the individual as well as to reduce health care costs. Today I would like to talk about a few of the programs that the states are working on towards that end.

First, NASUA believes that the number one prevention and wellness program that states administer is the Nutrition program. In 1972, when a nutrition component was first put into the Older Americans Act, it was done so under the premise that in order to delay the onset of health issues, proper nutrition is required. That is, nutrition was, and is, considered to be a vital component in overall health, and access to meals and socialization opportunities by older Americans was, and is, considered to have barriers. You can see in the slide that according to the statute, the express purpose of the OAA Nutrition Program is to: Reduce hunger and food insecurity, promote socialization of older individuals, and to promote the health and well-being of older individuals and delay adverse health conditions through access to nutrition and other disease prevention and health promotion services.[v] Thus, the nutrition program was designed to provide assistance to those in need, and in so doing, to prevent or delay the onset of health deterioration. With the causal link between nutrition and health widely recognized, the OAA nutrition program is is arguably the most well recognized of all of the services that the aging network provides. The programs are so visible and widespread that many individuals who are unfamiliar with the full scope of programs and services available through the aging network have certainly heard of "meals on wheels." Thus, just as these nutrition programs can provide participants with first step into the network's available assistance, they can also provide all Americans with an opportunity to become more involved in the aging network. There are a variety of programs that the Older Americans Act currently funds, and today I would like to discuss with you the Congregate Nutrition and Home Delivered Meal Programs.

Slide five depicts a congregate meal setting, with seniors having the opportunity to socialize and to receive a nutritionally sound meal. OAA Title III C1 authorizes meal provision and related nutrition services in congregate settings, for the purpose of keeping older Americans healthy, which prevents the need for more costly medical interventions in the future. The next slide has a graph representing the 94.2 million meals that were served at congregate nutrition sites to 1.6 million participants in FY08. This is just under 40 percent of the total number of meals served in the entire OAA nutrition program program. To be eligible for participation in the congregate program, you must be 60 or older, with exceptions for spouses, volunteers, and certain individuals with disabilities.[vi]

Regarding anticipated funding for the program in the next fiscal year, we look to President Obama's FY11 proposed budget, released earlier this year. Though not a binding law, the President's budget request is a good way to to discern both the Administration's goals for the coming year, and the levels of funding various programs may receive at the conclusion of the Appropriations process in Congress. Accordingly, the President requests $446 million for the congregate nutrition program for FY11. The program received $440 million in appropriations in FY 10, so this looks like a $6 million funding increase for congregate nutrition. The reality, however, is that the nutrition programs received quite a bit of funding, $65 million to be specific, through ARRA in FY10, and this $440 million does not reflect these stimulus funds, it only reflects the money that the program received through appropriations. The slide illustrates that to accurately calculate the congregate program funding in FY10, the stimulus funds and the appropriations should both be considered. Combining these separate funding streams swells the congregate meal funding in FY10 to $505 million, significantly more than the President's $446 million FY11 budget request. With the remainder of the $65 million in ARRA funds set to expire at the end of September 2010, if they are not extended, , the congregate nutrition program will most likely operate at a relative loss in the coming year.

The second nutrition program I would like to go over today is the OAA's Home-Delivered Meals Program, an example of which is depicted on this slide. The Older Americans Act Title III C2 authorizes meal provision and related nutrition services to older, home bound individuals. This program is often the first in home service that a consumer receives, and serves as the primary access point for other home and community-based services, designed to keep the individual in the setting of his or her choice by promoting health and wellness. Like the congregate meal program, services available under this portion of the OAA include nutrition screening, education, assessment and counseling. Home-delivered meals also assist caregivers in maintaining their health and well-being by providing them with a nutritionally balanced meal, as well as social interaction.

As you can see on slide nine, in FY08, slightly fewer than 150 million meals were delivered to just under 1 million American seniors. Home delivered meals are increasing in their popularity and just over 60 percent of all nutrition program meals were served in that setting. The existing statute states that home delivered and congregate meal services are to be available to individuals who are 60 or older and homebound, and the spouse of such a person regardless of age, with exceptions for some individuals with disabilities under age 60, if they reside with a homebound older individual.

In President Obama's FY11 budget request, the Home-Delivered Nutrition Services Program receives an increase of $4 million in funding over the levels in the FY10 enacted budget, for a total FY11 request of $221 million. However, as the graph shows, this figure is somewhat illusory, as the President's budget focuses on appropriated dollars only, and therefore, like the congregate program request we discussed

earlier, does not reflect the $32 million in ARRA funds that home-delivered nutrition programs received in FY10. If this ARRA funding is not extended through FY11, these programs will receive less total funding in the next fiscal year than they received in FY10.

The cost of providing a home delivered meal has an average cost of $5.14 and the congregate setting meal has a slightly higher per meal cost average of $6.75. Measure these small costs in terms of savings to the overall health care system. According to a recent Mathematica study, the home-delivered meals program had large impacts on the lives of recipients. Over 90 percent of the clients served indicated that the home-delivered meals allowed them to continue to live in their own home.[vii] The same study indicated that on delivery days, two in three clients indicated that the home delivered meal represented at least one-half of their total food intake for the day.[viii] As the graph illustrates, the relative cost of $5 or $6 per meal is much more cost effective than the $219 cost per day for institutionalized care.

Regrettably, while the Older Americans Act does state that individuals 60 and older are eligible for a meal, the nutrition program is not an entitlement and states have had to target specific high risk populations for nutrition services rather than serve all. As a result, only about 6 percent of all eligibles are being served under this program. In a NASUA survey that was conducted after an additional $100 million in stimulus funding was added to the program, states still indicated that they were unable to meet the demands of the requests for services.

I would now like to focus on the second prong of this prevention and wellness presentation by highlighting the importance of evidence-based programming. According to NASUA's State Perspectives report, released in October 2009, ***State of Aging: 2009 State Perspectives on State Units on Aging Policies and Practices***, nearly 80% of states are administering the evidence based disease management and health promotion programming component of NASUA's Project 2020 initiative. Under Project 2020, these programs would build upon the current Healthy Aging Program, and would give states the flexibility to choose among various chronic disease self management programs, falls prevention, and other initiatives. Evidence-based programs are interventions based on evidence that is generated by scientific studies published in peer-reviewed journals. Since 2006, AoA has awarded $22 million in grants to support evidence-based programs in 27 states, to develop and deliver these programs to seniors.[ix] This slide shows the percentage of states administering various evidence based programs, such as programs on nutrition, depression, and substance abuse prevention. The two most common programs that the states are using include the falls prevention program, a Matter of Balance, and the chronic disease program, Chronic Disease Self Management Program. States report savings for the evidence-based prevention and health promotion programs on reduced hospital admissions, emergency room visits, and other medical cost savings associated with injury. As the next slide shows, one key aspect of the prevention and wellness programs is to continue to build the capacity of the network by

developing partnerships. Currently, states are partnering with AAAs, housing sites, grocery stores, meal sites, churches, libraries, and clinics to provide these services.

Since older Americans are disproportionately affected by chronic diseases and conditions, with 90% of older Americans living with at least on chronic condition, and over 70% having at least two, there is a need for evidence-based disease and disability prevention programs (EBDDP) to empower older adults to take control of their health.[x] The Stanford University Chronic Disease Self Management Program (CDSMP) does just that. This program is a series of workshops, or patient education courses, led by specially trained leaders, at least one of whom has a chronic illness. The programs are conducted in community-based settings and concentrate on patients' self-defined needs and self-management options for common problems and symptoms. Through this process, patients learn skills that help them to maximize their functioning and ability to carry out normal daily activities. the program has been effective in helping people with chronic conditions change their behaviors, improve their health status, and reduce their use of hospital service. [xi]

The cost associated with this program is estimated to be $197 per person in 2009 based on currently funded AoA initiatives, which is a worthy investment given that the annual cost to health care for treatment of chronic diseases and conditions is $1.7 trillion, as the slide shows.[xii] Additionally, the cost per participant in a CDSMP could be reduced once a newly designed online version of the program is fully operational. This would also allow for greater accessibility of the program, increasing participant level and decreasing cost.

There is also evidence that CDSMP generates enough savings in healthcare costs within the first year of its implementation to pay for the program. This is possible because the program effectively utilizes healthcare resources by addressing the patients needs, which, if unaddressed would probably lead to hospital admission, in outpatient settings, rather than waiting until the patient is already hospitalized. In so doing, the patient's overall health is enhanced, and the costly healthcare resources the patient utilizes is reduced, rendering the program cost-neutral.[xiii] Such data underscores the basic evidence-based program tenet that expending prevention efforts upfront, such as teaching patients to identify and correct negative patterns, can result in cost savings to the patient and the system by avoiding expensive medical interventions that may have otherwise been necessary.

Evidence-based programs such as Matter of Balance provide individuals with a plan designed to help minimize elders' fear of falling. More than one third of elders over 65 fall each year, and in half of the cases the falls are recurrent. [xiv] The cost associated with this program averages $87 per participant, based on the costs of the Matter of Balance Program currently in operation, while the average hospitalization cost for a fall injury is around $17,500.[xv] Based on a 2003 study by economists at the Research Triangle Institute in North Carolina in conjunction with the CDC, direct medical treatment costs

from elder falls are expected to total almost $55 billion annually by 2020. Direct costs are what patients and insurance companies pay for treating fall-related injuries, and they include fees for hospital and nursing home care, doctors and their professional services, rehabilitation, community-based services, use of medical equipment, prescription drugs, changes made to the home and insurance processing.[xvi] Significantly, direct costs do not account for the long-term effects of these injuries, such as disability, dependence on others, lost time from work and household duties, and reduced quality of life. In 2000, direct medical costs for fall injuries, both fatal and non-fatal, exceeded $19 billion, $12 billion, or 63%, of which paid for hospitalizations. You can see from this slide that if these trends continue, as the 65 and older population continues to grow, the cost of treating fall-related injuries is projected to swell dramatically in the coming years, as older adults are hospitalized for fall-related injuries five times more often than they are for injuries from other causes.[xvii] According to a November 2006 CDC report, fall-related death rates for men and women 65 and older increased significantly from 1993 to 2003. In 2003, more than 13,700 seniors died from falls, making this the leading cause of injury deaths among people 65 and older.[xviii]

As we look to the future of the Older Americans Act, not just in terms of how to reduce costs but also in terms of how to enhance the quality of life of older Americans, I hope the importance of the Act's nutrition programs, and the evidence-based health promotion and disease prevention initiatives the Act supports, will be sustained. I would like to thank Secretary Greenlee for all that you do for older Americans , and for the opportunity to speak with you all here today. As we move ahead and work with the Administration on Aging, and our partners in the aging network and beyond, I look forward to our continued partnership.

END NOTES

[i] Partnership for Solutions, Chronic Conditions: Making the Case for Ongoing Care. September 2004 update.
[ii] Ibid.
[iii] Ibid.
[iv] Ibid, p.12
[v] OAA Section 330
[vi] http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/Nutrition_Services/index.aspx
[vii] *Results from the Administration on Aging's Third National Survey of Older Americans Act Program Participants*, Final Report, March 12, 2008, p. 42
[viii] Ibid.
[ix] http://www.aoa.gov/AoARoot/Press_Room/Products_Materials/pdf/fs_EvidenceBased.pdf
[x] ibid
[xi] http://www.aoa.gov/AoARoot/AoA_Programs/HPW/Evidence_Based/index.aspx
[xii] Partnership to Fight Chronic Disease 2009 Almanac Executive summary, accessed here: http://www.fightchronicdisease.org/resources/almanac.cfm
[xiii] http://patienteducation.stanford.edu/research/Review_Findings_CDSMP_Outcomes1%208%2008.pdf
[xiv] Tinetti ME, Speechley M, Ginter SF, Risk factors for falls among elderly persons living in the community, New England Journal of Medicine, 1988, 319: 1701-7.
[xv] Roudsari BS, Ebel BE, Corso PS, Molinari, NM, Koepsell TD. The acute medical care costs of fall-related injuries among the U.S. older adults. Injury, Int J Care Injured 2005;36:1316-22.
[xvi] Englander F, Hodson TJ, Terregrossa RA. Economic dimensions of slip and fall injuries. Journal of Forensic Science 1996; 41(5): 733-46.
[xvii] Alexander BH, Rivara FP, Wolf ME. The cost and frequency of hospitalization for fall-related injuries in older adults. American Journal of Public Health 1992; 82(7): 1020-3.
[xviii] http://www.cdc.gov/ncipc/duip/adultfallsfig-maps.htm

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