We are pleased to provide you with the report "A Population at Risk: Current Findings and Future Needs - The Nutrition Program for the Elderly". The purpose of this report is to review the information available on the nutritional status and needs of New York State's older adults, especially those participating in the Nutrition Program for the Elderly. The report examines the ability of nutrition services providers to meet the needs of our growing elderly population and presents program strategies as a framework for dialogue among service providers, program managers and policy makers to meet these needs.

Program advocates may use the information in this report (in addition to local program information) to inform policy makers, administrators and constituents of:

- Who the Nutrition Program for the Elderly is serving
- What nutrition services are currently being provided
- The growth of the elderly population in New York State
- The need for more and new sources of funding
- Suggested strategies for meeting current and future needs

This report is being distributed to AAA Directors, Nutrition Directors, Advocates and State Legislators. Additional copies are available from the Bureau of Operational Standards and Systems Development (OSSD).

*An Equal Opportunity Employer*
Current Findings • Future Needs
Nutrition Programs for the Elderly in New York State

at risk
A POPULATION AT RISK

CURRENT FINDINGS AND FUTURE NEEDS
NUTRITION PROGRAM FOR THE ELDERLY

NEW YORK STATE OFFICE FOR THE AGING
Mario M. Cuomo, Governor
Jane G. Gould, Director

Division of Local Program Operations
Bureau of Operational Standards and Systems Development

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EXECUTIVE SUMMARY

New York State faces a significant challenge in its efforts to evaluate and address the nutritional needs of its growing number of frail elderly. Satisfying even their basic requirements for food and sustenance will require more funds from both existing and alternative sources. Along with nutritionally appropriate foods, this population also needs expanded supportive services such as nutrition education, nutrition counseling and shopping assistance. Local agencies and service providers must maximize physical, human and financial resources to best serve the elderly. The nutrition program must be seen as an integral part of the community based care system, including long term care, offering the most appropriate and cost-effective services based on an individual's needs and resources.

Those who plan and provide all these services must rely on timely and accurate information from surveillance and evaluative efforts. Ultimately, the expanding needs of our older citizens will demand new strategies to ensure that they maintain their health, independence and quality of life.

The purpose of this report is to review the information available on the nutritional status and needs of New York State's older adults, especially those participating in the Nutrition Program for the Elderly. The report examines the ability of nutrition services providers to meet the needs of our growing elderly population and presents program strategies as a framework for dialogue among service providers, program managers and policy makers to meet these needs.

This report discusses:

- Who the Nutrition Program for the Elderly is serving
- What nutrition services are currently being provided
- The growth of the elderly population in New York State
- The need for more and new sources of funding
- Suggested strategies for meeting current and future needs

BACKGROUND

In New York State, nutrition programs for the elderly are administered by the 59 Area Agencies on Aging (AAA) designated by the New York State Office for the Aging (SOFA) to receive funds to provide nutrition and related services to eligible individuals. AAAs either provide the services directly or through contractual arrangements. Since 1974 the federal Older Americans Act has provided funding for the nutrition program for the elderly.
In State Fiscal Year 1984-85, Governor Cuomo proposed in his State of the State address, a new nutrition program targeted to several high-risk population groups. This program, called the Supplemental Nutrition Assistance Program (SNAP), provided funds to the New York State Department of Health (NYSDOH) for three component programs (1) the Elderly Nutrition Program, (2) the Women, Infant and Child Nutrition Program (WIC) and (3) nutrition services for the homeless.

Because of the experience of SOFA and its provider network in administering the federal nutrition program, the Elderly component of SNAP is administered by SOFA, in collaboration with NYSDOH, through a Memorandum of Understanding. SNAP funding has been used to expand and enhance nutrition services to unserved and underserved individuals determined to be most vulnerable to nutrition related problems. SNAP and the Older Americans Act through Titles III C-1 (congregate meals) and III C-2 (home delivered meals), provide the majority of funds for the Nutrition Program for the Elderly in New York State.

INFORMATION SOURCES

This report uses a variety of sources to present information on the nutritional needs of program participants. The primary sources come from NYSDOH's Nutrition Surveillance Program and SOFA's Consolidated Area Agency Reporting System (CAARS). When available, participant information is compared to national or state survey results, such as the 1990 Population Census and the National Health and Examination Survey.

The Nutrition Surveillance Program, funded by SNAP, is administered by NYSDOH in cooperation with SOFA and its provider network. The purpose of surveillance is to provide timely information needed for program administration and management, program evaluation and for the formulation of nutrition policy.

Between 1984 and 1989, the Nutrition Surveillance Program conducted a series of studies of the frail elderly participating in these nutrition programs. Each study, conducted under contract between NYSDOH and Cornell University's Division of Nutritional Sciences, was designed to fill gaps in information regarding the characteristics of those frail elderly being served and the impact of the nutrition program on assisting participants to obtain an adequate diet. The clients selected in each study were sampled to represent participants receiving meals funded by SNAP and thus the information pertains primarily to SNAP home delivered meal clients. However, when
available, information on congregate and other home delivered meal participants and services was included. Unless otherwise noted, the term "participants" will refer to those receiving home delivered meals.

A number of other organizations provide meals in conjunction with the SOFA network, but from funding sources not administered by SOFA. This report does not contain information on these "private" meal programs.

SERVING THOSE AT NUTRITIONAL RISK

New York State's older population is growing and older people are confronting a variety of nutritional problems and needs. These problems result from the interaction of many diverse environmental, social and economic factors and are compounded by physiologic changes and health conditions that occur at greater rates as individuals age.

Previous studies, including those conducted by the Nutrition Surveillance Program and the national Nutrition Screening Initiative, have consistently shown that poverty, advanced age, living alone, minority status, the prevalence of chronic diseases, the use of multiple medications, poor oral health, difficulties with food preparation and shopping, along with undesirable weight levels, are strongly associated with the risk of poor nutrition among the elderly. Inappropriate dietary intakes and chronic disease or disability place a substantial number of older persons at high risk of poor nutrition. The outcome of unrecognized or untreated nutrition inadequacies is often considerable dysfunction and disability, reduced quality of life, and in some instances, premature or increased morbidity and mortality.¹

The intent of the nutrition program is to locate individuals who have one or more of the above characteristics and then determine what nutrition services are needed. To be eligible for home delivered meals funded by SNAP and Title IIIC, persons must be age 60 or over and assessed to be homebound and incapacitated due to accident, illness or frailty; lack support; and be unable to prepare meals adequately. In addition to these eligibility requirements, SNAP targets the non-institutionalized elderly persons at nutritional risk. Indicators of nutritional risk include individuals with the following characteristics: (1) disabled, (2) low income, (3) live alone, (4) over 75 years of age, and (5) a chronic medical condition that limits activities of daily living.

This section of the report compares nutritional risk factors of home delivered meal participants with the known risk factors for poor nutrition in the elderly. The findings demonstrated that the Nutrition Program for the Elderly in New York State is serving a population at nutritional risk.
Socio-demographic Characteristics of Participants

The Nutrition Program for the Elderly is serving individuals who are more impoverished and live alone more often than the general population of seniors in New York State. Participants also have a high prevalence of chronic diseases, take multiple medications, experience poor oral health and, due to functional impairments, need assistance to shop for and/or prepare food—all factors associated with high nutritional risk.

Figure 1 compares statewide and New York City data from the Nutrition Surveillance Program, CAARS, and 1990 Census information.

Figure 1: Demographic Characteristics

- 44% of participants were below 125 percent of the poverty level. Lower income may limit access to food and reduce food choices.
- 64% were over age 75. Age increases the likelihood of having conditions which contribute to nutritional risk.
58% lived alone. Living alone generally has a negative impact on the way one cares for oneself, including a diminished desire to prepare and consume nutritious meals, which contributes to nutritional risk.

11% were minorities. Minorities, particularly blacks, have a higher incidence of hypertension, heart disease, cancer, diabetes and obesity and require particular attention to obtain good nutrition intervention.

Health, Weight and Disability Characteristics

Participants often reported chronic conditions such as diabetes, arthritis, hypertension and heart disease as shown below.

- 27 - 37% had arthritis
- 25 - 41% had hypertension
- 25 - 41% had heart disease
- 14 - 24% had diabetes

Nutritional support, or the lack of it, has a role in disease causation, risk reduction and treatment of these chronic degenerative diseases. The presence of one or more of these diseases often requires that the elderly person follow a prescribed, therapeutic diet. The need for modified diets due to these conditions was reported by 36% of participants. Of those participants requiring special diets, 89% were able to receive a home delivered meal that met their therapeutic diet prescription. Note that therapeutic diets, although necessary for the treatment of many chronic conditions, may also place the elderly person at nutritional risk because food procurement or food preparation and eating becomes more complex and difficult.

Pharmaceutical treatment of disease is commonplace for elderly individuals. Thirty-five percent of participants took four or more medications while 63% had taken one to three. Side effects and drug-nutrient interactions associated with some medications may cause malabsorption of nutrients, weight loss, anemia, dehydration, low or high blood sugar, fatigue and depression, all of which may lead to poor nutrition and other serious health complications.

Twenty-one percent of participants experienced poor oral health. Fourteen percent were without teeth or did not use dentures and 83% were not receiving dental care. Poor oral health may limit the type, quantity and consistency of food eaten, increasing one's nutritional risk.
Eighteen percent of participants were underweight (Figure 2) which was significantly more than the five percent underweight found in a national sample (National Health and Nutrition Examination Survey, NHANES II 1976-1980). Being underweight often indicates an inadequate dietary intake and is associated with frailty and, possibly, underlying illness.

![Figure 2: Weight Status of HDM Participants](image)

Weight Status of Home Delivered Meal Participants Compared to National Sample

- **UNDERWEIGHT**: 18.4%
- **IN NORMAL WEIGHT RANGE**: 77.9%
- **OVERWEIGHT**: 3.7%


Although information regarding an individual's weight change over time is not available for this report, any unexpected or undesirable change in weight, particularly weight loss, is an indication of nutritional risk. Only four percent of participants were overweight compared to five percent in this national sample.
More participants were "frail", and unable to perform basic self care or home management activities such as shopping and/or preparing food than the general aged population. Program participants were often dependent on others for assistance and without such support would likely be at greater nutritional risk.

- 35 - 45% had impaired mobility or were unable to go outdoors on a regular basis. 6
- 76 - 89% depended on assistance with shopping activities. 7,8
- 58 - 82% depended on someone else to prepare meals. 4,8
- 5 - 8% needed assistance with feeding themselves. 4,8
- 20 - 28% had visual impairments. 7,9

National statistics from the U.S. Department of Health and Human Services (1984) indicated that 23% of those aged 65 and over had health related difficulties with one or more personal care activities and 27% had difficulty with one or more home management activities. The greater percentage of participants with impaired abilities compared to the general aged population was consistent with the eligibility criteria for the home delivered meals program.

NUTRITION INTERVENTION

Effective nutrition interventions are critical to maintaining or improving the health and functional abilities of the elderly and to controlling medical conditions such as diabetes and hypertension. Such interventions include the provision of home delivered and congregate meals, nutrition education and counseling, shopping assistance and transportation.

All meals served by nutrition service providers administered by the 59 AAAs meet dietary standards such as the Recommended Dietary Allowance (RDA) and Dietary Guidelines for all Americans and generally meet the individual elderly's special dietary needs. 2

Nutrition providers administered by 54 AAAs provided a regular diet with substitutions for diabetics. A regular diet with substitutions for high sodium foods was available from 34 AAA providers. Thirteen AAA providers offered a 2 gram low sodium diet, 12 a 40 gram low fat diet, 16 a calorie controlled diet and 13 a soft diet. 10
**Home Delivered Meals:** Almost 10 million home delivered meals were provided at least five days a week to over 51,000 participants during SFY 1990-91. These meals built upon the informal and formal caregiver supports, delayed or prevented inappropriate institutional care, facilitated early hospital discharge and reduced social isolation.

Within the planning and service area for which each of the 59 AAAs are responsible, 35 AAAs administered programs that provided two home delivered meals five days per week, 32 provided one or more meals seven days per week and five provided three meals five days per week.

Despite program efforts to meet the nutritional needs of their participants, the Nutrition Surveillance Program identified that those participants surveyed were not consuming a diet adequate to their health or nutritional need. In addition, almost half of the participants saved or divided up their home delivered meal for later use. Saving parts of their meal reduced the adequacy of their diet, particularly for those served only one meal a day (although such a practice was not uncommon for those also getting two or more meals a day).

These findings may indicate that there is a need to provide additional meals to those underserved, nutrient-dense food products and supplements to those who find it difficult to consume the meals provided and/or more individualized menus to those with food intolerances or special preferences.

**Congregate Meals:** 14.5 million congregate meals were provided to over 128,000 participants during SFY 1990-91. Such meals were available at least five days a week at 85% or 823 of the 998 sites administered by AAAs. Twenty-one sites were open more than five days a week and 149 were open less than five days a week.

These nutrition sites provided participants with the opportunity for social interaction and a focal point for supportive services such as health screening, nutrition education and counseling, financial counseling and recreational activities. Many of these sites are within multi-purpose senior centers which also provide an array of supportive services.

**Nutrition Education and Counseling:** Under the direction of a registered dietitian, nutrition education presentations/information were provided at all congregate sites and provided to home delivered meal participants. Counseling services were provided to individuals assessed to be at high nutritional risk. About six percent of all program participants, who were primarily the home bound, received nutrition counseling.
Outreach and Access Services: All AAAs provided some form of outreach to locate elderly at nutrition risk or to inform individuals and/or other agencies of available services. Area Agencies and their providers referred participants for other benefits and services such as Food Stamps, Energy Assistance, SSI, home care, etc. Transportation and shopping assistance were provided in many areas to get seniors to meal sites and community agencies, grocery and drug stores and medical and other support services.

IMPACT OF NUTRITION INTERVENTION

Information on the impact of nutrition programs for the elderly on the participant's nutrition and health status is limited. Those outcomes, identified from the Nutrition Surveillance Program, are described below. Some of the findings illustrated a positive impact when comparing participants in the home delivered meals program with those on waiting lists. Future studies are needed to more closely examine the role of the nutrition programs and other community based services in improving the health and well being of this population.

As illustrated in Figure 3, home delivered meal participants reported going fewer days without enough or any food than those on waiting lists. A greater number of persons on waiting lists reported going days without enough food or any food than participants.6

Figure 3: Persons Reporting Days without Enough Food

Days Without Enough Food

<table>
<thead>
<tr>
<th>% OF UPSTATE</th>
<th>% OF NEW YORK CITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOME DELIVERED MEAL PARTICIPANTS</td>
<td>8% 23%</td>
</tr>
<tr>
<td>PERSONS ON HDM WAITING LISTS</td>
<td>16% 36%</td>
</tr>
</tbody>
</table>

6 Oneida, Monroe and Tompkins. Source: Cornell University, Final Report 1988

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As shown in Figure 4, participants consumed more foods recommended in the Dietary Guidelines including fish, chicken, broccoli, carrots, mixed vegetables and sweet potatoes than non-participants. The frequency of eating these foods was 4 - 32% greater for participants than those on waiting lists for NYC and upstate respondents.

Figure 4: Selected Foods Eaten in the Past Three Days

<table>
<thead>
<tr>
<th>Selected Foods Eaten In &quot;Past Three Days&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>% OF HOME DELIVERED MEAL PARTICIPANTS WHO CONSUMED ITEM</td>
</tr>
<tr>
<td>% OF UPSTATE RESPONDENTS*</td>
</tr>
<tr>
<td>----------------------------</td>
</tr>
<tr>
<td>66%</td>
</tr>
<tr>
<td>64%</td>
</tr>
<tr>
<td>63%</td>
</tr>
<tr>
<td>50%</td>
</tr>
<tr>
<td>73%</td>
</tr>
<tr>
<td>69%</td>
</tr>
</tbody>
</table>

* Oneida, Monroe and Tompkins. 

Participants had less frequent hospital stays than older adults on waiting lists for home delivered meals. Twenty-two percent of New York City and 19% of upstate participants reported one or more hospital visits during the three months prior to this study compared to 32% and 61% (respectively) of those on waiting lists. However, this finding needs further exploration before a clear conclusion can be drawn.
THE GROWING ELDERLY POPULATION AT NUTRITIONAL RISK

During the 1980s, New York State's over 60 population increased by six percent, and those over age 85 increased by 29%. These groups continue to grow faster than the population as a whole.¹¹ Every five years it is expected that the over 60 population will increase by more than two percent, those over age 75 by close to 10% and those aged 85 and over by as much as 20%. Older minorities and women will continue to make up a large part of this population. (Figure 5)
As many as 650,000 of the State's elderly are impaired by chronic health conditions and require some level of assistance in performing basic activities of daily living according to SOFA, NYSDOH, and Cornell University estimates. These projections also predict that current programs are only able to meet the needs of 29% of the frail elderly population at nutrition risk and 14% of those in immediate need of home delivered meals. Figure 6 shows, by county, the number of individuals requiring but not receiving home delivered meals based on these estimates.

At this time, families provide the vast majority of assistance to their impaired family member(s). However, many, and particularly the most frail, require community based long term care to remain in their homes.

Figure 6: State Map of Unmet Need

**Elderly (60-plus) Persons Eligible BUT NOT Receiving Home Delivered Meal Services in Fiscal Year 1990-'91**

- **NEW YORK STATE** - 161,651
- **NEW YORK CITY** - 71,829
- **REST OF STATE** - 89,822

Legend:

- LESS THAN 250
- 250 TO UNDER 500
- 500 TO UNDER 1,000
- 1,000 TO UNDER 1,500
- 1,500 TO UNDER 2,500
- 2,500 OR MORE

Note: Aggregate Area Agency on Aging data shown for the counties of the New York City and Warren/Hamilton Area Agencies.

Source: Based on CAARS data and DoH Bureau of Nutrition estimates of the number of eligible at-risk elderly persons.
A goal of the Nutrition Surveillance Program is to develop and validate methods to provide better estimates of the number of elderly needing nutrition services. This information is essential to determine effective program targeting and coverage and for efficient allocation of scarce resources.

RESOURCES AND SERVICE NEEDS

Level SNAP funding and modest increases in Title IIIC funds (as illustrated in Figure 7), along with escalating operating costs, has undermined the nutrition program's ability to meet service needs. In fact, AAAs transferred three million dollars (11% of the $26.4 million Title IIIC-1 congregate program FFY91 allocation) to the Title IIIC-2 home delivered meals program to meet the great demand for home delivered meals.

Figure 7: SNAP and Title IIIC Allocations to Area Agencies

<table>
<thead>
<tr>
<th>FISCAL YEAR</th>
<th>SNAP</th>
<th>IIIC-2 Home Delivered Meals</th>
<th>IIIC-1 Congregate Meals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1985</td>
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<td></td>
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<td>1990</td>
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<tr>
<td>1991</td>
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</table>

Allocations in millions of dollars:
- $21.73
- $13.51
- $9.13

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Multiple funding sources and other forms of assistance are used by AAAs and nutrition providers to support the provision of nutrition and supportive services (Figure 8). These significant revenue sources include the U.S. Department of Agriculture (USDA), Community Services for the Elderly (CSE) Program (State), the Long Term Home Health Care Program (Medicaid), County and provider matching funds, voluntary participant contributions, and individual and corporate donations. Non-cash assistance has come from adult and student volunteers, senior volunteers through the Retired Senior Volunteer Program (RSVP), older workers under Title V of the Older Americans Act and Green Thumb, local food banks, farm product donations and the availability of facilities with reduced or no rent charged. It is important to realize that reductions or the elimination of other non-nutrition programs (e.g. CSE) and funding resources may effect the availability of personnel, facilities and other resources currently used to operate nutrition programs.

Figure 8: Funding Resources

<table>
<thead>
<tr>
<th>Expenditures for Nutrition and Supportive Services by Source</th>
<th>FiscAl Year 1990-'91: 100% = $84.0 Million*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>U.S. Department of Agriculture</strong></td>
<td><strong>State Suppermental Nutrition Assistance Program (SNAP)</strong></td>
</tr>
<tr>
<td>$13.6 million -- 16.1%</td>
<td>$13.4 million -- 15.9%</td>
</tr>
<tr>
<td><strong>Federal OAA Title III-C-2</strong></td>
<td><strong>State Community Services for the Elderly Program</strong></td>
</tr>
<tr>
<td>$8.4 million -- 10.0%</td>
<td>$2.1 million -- 2.5%</td>
</tr>
<tr>
<td><strong>Federal OAA Title III-C-1</strong></td>
<td><strong>Participant Contributions</strong></td>
</tr>
<tr>
<td>$21.3 million -- 26.4%</td>
<td>$13.7 million -- 16.3%</td>
</tr>
<tr>
<td><strong>Medicaid (LTHHCP)</strong></td>
<td><strong>County and Local Support</strong></td>
</tr>
<tr>
<td>$1.4 million -- 1.7%</td>
<td>$10.2 million -- 12.1%</td>
</tr>
</tbody>
</table>

* Does not include value of time and expenses contributed by volunteers in delivering nutrition and supportive services. Based on CAARS data.
Despite the nutrition program's access to a variety of funding and other sources of assistance, programs have been forced to implement changes and reductions in services just to maintain the current level of participation. Figure 9 shows how inflation and inadequate funding have eroded the level of congregate and home delivered meals served.

Figure 9: Congregate and Home Delivered Meals Served

Programs were unable to provide for the nutritional needs of participants currently being served and those individuals estimated to be unserved according to a 1990 survey of 55 of the 59 AAAs.

An estimated six million more meals would have been needed annually to meet the nutritional needs of 28,400 current home delivered meal participants who were not able to receive the number of meals they required and of the 18,000 individuals estimated to be unserved.
An estimated nine million more meals were needed annually to meet the nutritional needs of 54,800 congregate participants who were not able to receive the number of meals required and the 37,000 individuals estimated to be unserved.

An estimated 9,750 participants were not able to receive the nutrition counseling services they required. 7,800 participants would benefit from shopping assistance if it were available. 7,700 seniors were unable to attend a congregate program because transportation was not available.

$33.6 million in additional funds had been requested by AAAs in order to provide for the additional meals and other supportive services.

PROGRAM STRATEGIES TO MEET CURRENT AND FUTURE NEEDS

Recognizing how critical nutrition services can be to an individual’s survival and independence, programs have been engaged in aggressive and imaginative cutback planning for several years. To cope with inflation, programs have adopted a variety of practices to increase efficiency and contain costs including:

- Implementing waiting lists for home delivered meals
- Alternating delivery days (one hot meal for the first day and one frozen meal to be consumed the next day)
- Limiting the availability of additional meals for the day
- Closing or consolidating congregate sites and/or reducing the number of days of service.
- Curtailing or limiting shopping assistance, outreach and transportation services.
- Instituting the use of central kitchens

Beyond such cost-saving measures, other broad-ranging strategies must be employed to continue to respond to the current and future nutritional needs of the elderly.

Local agencies and service providers must maximize physical, human and financial resources to best serve the elderly. The nutrition program must be seen as an integral part of the community based care system, including long term care, offering the most appropriate services based on an individual’s needs and resources.
Providers need more funding from traditional resources such as Title IIIIC and SNAP as well as other public and private resources such as USDA, Medicaid, local fund raising and increased participant contributions.

Providers must accommodate individual participant physical and health needs through a range of services for both the active and healthy seniors and those with debilitating conditions in the congregate setting. When coordinated with other community-based and long term care services, such programs can assist in maintaining an individual's independence and health and provide support to caregivers.

Programs must accommodate participant needs and preferences related to their racial and ethnic background offering special foods and activities of cultural importance. Outreach efforts must be designed to reach these individuals and provide them with the services they need.

Advocates and providers must ensure that nutrition counseling, education, shopping assistance and other access services are provided to those in need to enhance the impact of the meal service.

The Nutrition Surveillance Program must provide timely information that meets the needs of service providers and policy makers who wish to improve the nutrition condition of the elderly. Future nutrition surveillance must be coordinated with other state and national activities to enable comparisons of the elderly at nutritional risk in New York State with those in the rest of the nation. In addition, information is needed to more adequately describe the multiple dimensions of nutritional risk experienced by the frail elderly and the connection of nutrition services with the continuum of home and community based care and other aging services. Nutrition Surveillance must also evaluate the impact of the program on the participant's nutrition and health status by examining the outcomes of program participation, including the cost and health benefits of proving nutrition and supportive services.
REFERENCES

Information for this report comes primarily from a series of studies of the elderly conducted by Cornell University's Division of Nutritional Sciences (between 1984 and 1989) under contract with NYSDOH, reporting information (SFY 1990-91) from the State Office for the Aging's Consolidated Area Agency Reported System and other references listed below.

2New York State Office for the Aging, Consolidated Area Agency Reporting System statewide program information for the period April 1, 1990 to March 31, 1991.
   Purpose: To document the nutritional problems and needs of these elderly, to identify select indicators of nutritional risk. Methodology: A baseline assessment form was administered to each SNAP eligible homebound elderly person prior to receiving HDM service between October 1, 1984 and January 30, 1985. Staff from 22 upstate Area Agency programs and the New York City Department for the Aging collected socioeconomic and health information from 2164 elderly participants.
   Purpose: To document the nutritional problems and needs of these elderly, to identify select indicators of nutritional risk, and compare these findings from this population with those in the 1984-85 survey. Methodology: A baseline assessment form was administered to each new SNAP homebound elderly person prior to receiving HDM service between November 15, 1985 and February 28, 1986. Staff from New York City Department for the Aging programs collected socioeconomic and health information from 258 participants.
   Purpose: To compare the health and nutritional status of HDM participants and those on waiting list and evaluate the relative impact of the program on health and nutrition status between minorities and non-minorities and between rural versus urban participants. Methodology: A case control study was conducted in which SNAP HDM participants were cases, and controls were elderly on waiting lists for the program. The New York City sample surveyed 172 HDM recipients and 98 on waiting list from programs in East Harlem, the Bronx and Bayside, Queens. The upstate sample surveyed 121 HDM recipients and 49 on waiting lists from programs in Oneida, Monroe and Tompkins counties.
Purpose: (1) To determine differences in organizational behavior and mode of SNAP program delivery between six upstate county programs and those in East Harlem and the Bronx; (2) To survey HOM participants as to the extent to which their food needs are being met by the program; (3) To determine whether clients can be characterized according to the duration of program continuance; (4) To determine whether there are community networks which exist whereby there is interagency coordination on definition of needs of the frail elderly with respect to providing for their nutritional as well as non-nutritional needs. Methodology: A field investigator interviewed staff from the eight programs (Cortland, Chautauqua, Oneida, Broome, Monroe, Chenango, East Harlem and the Bronx) and examined menus and delivery methods; (2) 1355 surveys were collected from HOM participants in the eight programs and Tompkins county; (3) Information from a total of 371 HOM client record were reviewed form Oneida, Cortland, Chautauqua, East Harlem and the Bronx: (4) 100 surveys were collected form staff of agencies providing services to the homebound elderly in the first eight programs.

8 New York State Office for the Aging, SNAP Annual Report 1990-91.
9 New York State Office for the Aging, SNAP 1990-91 Funding Applications.
10 New York State Office for the Aging, Listing of congregate sites, 1991.
11 New York State Office for the Aging, Proposed Interstate Funding Formula Under Title III of the Older Americans Act (91-IM-61) 1991 and 1990 Census STF-1A (91-TAM-10) 1991.