[Considering the Costs of Senior Hunger and the Benefits of Federal Nutrition Programs in Washington, D.C.]

[Why Investment in Senior Food Programs Is More Important Now Than Ever]

February 2010

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Executive Summary

The recognition of food insecurity—commonly known as hunger—has been at the forefront of public dialogue as the nation struggles to recover from rising unemployment rates, mass foreclosures, and rising prices. Anecdotal accounts of swelling lines at soup kitchens, food pantries, and Food Stamp offices across the U.S. were confirmed when the United States Department of Agriculture's Economic Research Service (ERS) released its annual survey on domestic hunger rates for 2008 and found that food insecurity had peaked, as demonstrated by the highest reported rates since the report was first developed in 1995. In 2008 and 2009, two landmark studies were released by the Meals of Wheels Association of America Foundation (MOWAAF) highlighting the prevalence, trends, and consequences of food insecurity among individuals 60 and older, prompting the MOWAAF to initiate its own campaign to end senior hunger by 2020. Using the information provided within this investigation, roughly 5 million people age 60 and older were estimated to have experienced some form of food insecurity in 2005, and based on national patterns, this figure is actually expected to be much higher to date. The application of this information led to an inquiry on how the overlapping effects of the recent economic crisis, aging Baby Boomers reaching Medicare eligibility, and the budgetary crunch facing government agencies would impact senior food insecurity trends now and in the District's near future.

This report aims to uncover the connections between the sociological causes of limited food access among older Washingtonians, the development of nutrition-related chronic illnesses, and the potential savings to be garnered by the District by investing in senior-serving nutrition programs, paperless benefits administration, and developing a system of nutritional assessment and referral to address the needs of elderly clients who are increasingly choosing to remain in the community after retirement or, "age in place." Testimony by the Long Term Care Ombudsman to the Committee on the Whole, which is charged with the District's budgetary affairs, claimed that, "The Ombudsman Program is not convinced that the District of Columbia is seriously focused, or ready to meet the upcoming demand on its current senior service network (July 24, 2009)," and, as noted by the declining participation rates of some senior food programs, there is a lot of work left to be done to address the needs of the District's older, hungry adults.

Acknowledgements

This report was made possible by the generous support and technical assistance from the staff at the Congressional Hunger Center (CHC), D.C. Hunger Solutions (DCHS), and Food and Action Research Center (FRAC). I would like to extend my gratitude to the staff and volunteers from the following organizations who shared their time and knowledge with me: Arthur Capper Senior Center, CSFP sites at Carver Terrace and East Capitol Street, D.C. Department on Aging, Iona Senior Services, and the Meals on Wheels sites. Special thanks go out to the following individuals who provided invaluable feedback, encouragement, and guidance on this report, as well as in the field research that informed it: Alexandra Ashbrook, Dara Cooper, Rachel Cooper, Robert Egger, Wanda Flibbonds, Gregory Foy, Amy Johnson, Kimberly Perry, Joni Podschun, Kristin Roberts, Katie Vinopal, and Ayanna Williams.

Selected Facts on the Factors Associated with Senior Food Insecurity in the District

- (2008) Washington, D.C. tied with Mississippi for the highest elderly poverty rate in the nation.
- (2001-2007) At least 5,000 elderly District residents have experienced some form of food insecurity.
- (2001-2007) Older Washingtonians who are Hispanic, employed, and rent tend to have higher food insecurity rates than the 5.37 percent average for all people ages 60 and older.
- (2001-2007) Local trends observing senior hunger show that certain groups—African-Americans, females, widows, and people who did not complete high school—tend to be disproportionately impacted by food insecurity.
- (2008) More than half of District residents ages 60 and older spent 30 percent or more of their annual income on rent, the level used to determine affordable housing.
- (2008) More than one-in-ten Washingtonians between ages 50 and 64 lack health insurance.
- (2009) Residents of Wards 5, 6, 7, and 8 live in areas with limited access to grocery stores and purveyors of affordable, fresh food and have higher Body Mass Index and diabetes levels than the average for the rest of the city.
- (2007) Seniors with nutrition-related illnesses tend to spend up to six times more on health care than older adults of the same age in excellent or very good health spend annually.
- (2007) In the District, total health care costs for seniors with nutrition-related diseases, particularly diabetes and cardiovascular disease, which are prevalent among the general adult population, are predicted to cost the city approximately $172.8 and $245.1 million dollars, respectively.

Part I: A Call to Action—Considering the Costs of Senior Food Insecurity

Introduction

In an age of rapid technological innovation and disease eradication, life expectancy rates for people in the United States have been steadily increasing, as men and women have the potential to live an average of at least 20 years longer than people born 100 years ago. However, for the millions of older people struggling to acquire food that satisfies their nutritional needs, the fruits of aging are difficult to reap. As of 2005, over five million U.S. citizens ages 60 and older have experienced some form of food insecurity or have been at-risk of this in their later years. Considering the prevalence of health problems among this cohort, coupled with increasing fuel, food, and housing costs, many elderly people, especially those living on fixed incomes, are struggling to meet the demands of the rising costs of living. The impact of not being able to access quality and nutritious food spans beyond the palpable effects on health, such as obesity and under-nutrition, as hunger can also lead to depression for affected individuals, premature displacement from the community, and inflict excessive burdens on the general health care system. Older adults make up a significant proportion of emergency food recipients but have been historically underrepresented in Food Stamp Program. This summary aims to explore the demographics of this often overlooked population and characteristics associated with heightened vulnerability to hunger. As noted by the President of the American Society on Aging and UCLA Professor, Dr. Fernando M. Torres-Gil (1996), the impact of senior hunger is ultimately felt by everyone:

> Malnutrition costs. It costs older people by exacerbating disease, by increasing disability, by decreasing their resistance to infection, and by extending their hospital stays. It costs caregivers by increasing worry and caregiving demands. The entire country pays health care costs related to this increase in complication

> rates, increasing hospital stays, and increasing mortality rates. Malnutrition costs people and it costs dollars (S7-S8).[1]

In light of the substantial expansion of the senior population in the coming years and escalating health care costs in the U.S., the impetus to be proactive in addressing elderly hunger and, thus, preventable health care utilization now and in the future, is both urgent and essential.

What is Food Insecurity?

For the purposes of this report, food insecurity, is observed along a continuum, ranging from (a) having to rely on socially unacceptable methods of acquiring food, such as stealing, scavenging, or obtaining the services of food pantries and soup kitchens; (b) feeling anxious about or deprived of nutritious food due to access limitations; to (c) exhibiting involuntary, recurrent, or prolonged disrupted eating patterns because the household lacks the necessary resources for food.[2] The United States Department of Agriculture (UDSA) uses the term "food insecurity" to describe the condition of a household facing food scarcity intermittently. This terminology replaced the phrase "hunger," which, though applicable, is more apt for describing the physical pain and health deficiencies resulting from an individual's experience of prolonged food scarcity due to a lack of resources. Throughout this report, a variety of terms will be used to describe seniors' diminished food access, and "food insecurity" and "hunger" will be used interchangeably. As of 2006, the USDA has replaced its usage of the term "hunger" with "food insecurity," thus acknowledging the causes and effects that the availability of food can have on households: [3]

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[1] Torres-Gil, F.M. (1996). "Malnutrition and Hunger in the Elderly." *Nutrition Reviews*, 54 (1), S7-S8.
[2] See Holben, D.H. "The concept and definition of hunger and its relationship to food insecurity" at http://www7.nationalacademies.org/cnstat/Concept_and_Definition_of_Hunger_Paper.pdf for further explanation of this topic and the measurement of food insecurity for different purposes.
[3] ERS/USDA. (2009). "Food Security in the United States: Measuring Household Food Security" http://www.ers.usda.gov/Briefing/FoodSecurity/measurement.htm.

- **High food security**—Households had no problems, or anxiety about, consistently accessing adequate food.
- **Marginal food security**—Households had problems at times, or anxiety about, accessing adequate food, but the quality, variety, and quantity of their food intake were not substantially reduced.
- **Low food security/at risk for hunger**—Households reduced the quality, variety, and desirability of their diets, but the quantity of food intake and normal eating patterns were not substantially disrupted.
- **Very low food security**—At times during the year, eating patterns of one or more household members were disrupted and food intake reduced because the household lacked money and other resources for food.

How Many Seniors Are or Are at-Risk of Being Food Insecure? [4,5]

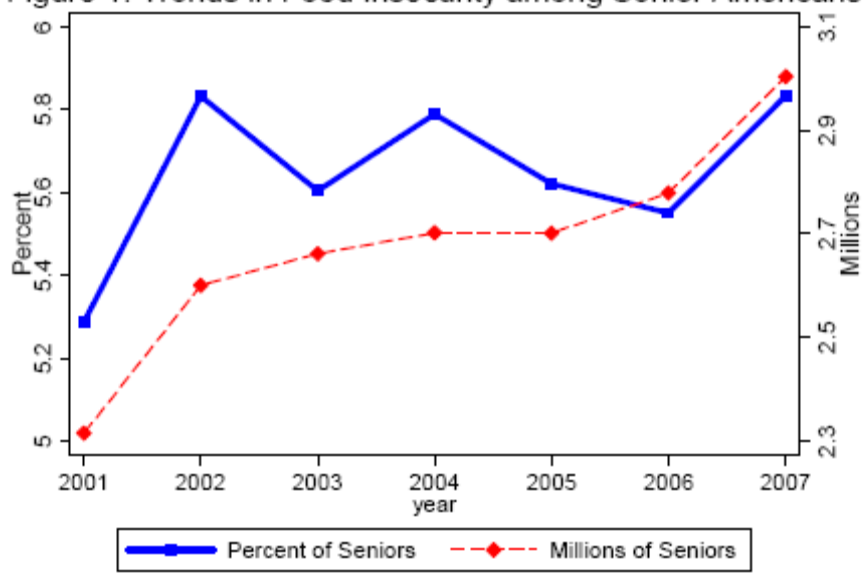
Using data from the national Current Population Survey (CPS) and the Core Food Security Module, two groundbreaking reports released in 2008 and 2009, revealed the depth and severity of senior food insecurity across the United States. Over 11 percent of people over age 60, which describes **more than five million older adults**, experienced periods where their food supply was uncertain. Of these, approximately **2.7 million** seniors were "**at-risk of hunger**", and roughly **750,000** of those sampled **"suffered from hunger"**. According to the updated study that analyzed CPS data from 2001-2007, the incidence of food insecurity rose markedly. As the

[4] This report relies on CPS data from 2001-2005. Ziliak, J.P., Gunderson, C. (2008). "The Causes, Consequences, and Future of Senior Hunger in America." Prepared by the Center for Poverty Research at the University of Kentucky for the Meals on Wheels Association of America, Inc. 1-79, available at http://216.235.203.153/Document.Doc?id=13.

[5] This updated report uses CPS data from 2001-2007. Ziliak, J., Gunderson, C. (2009) "Senior Hunger in the United States: Differences across States and Rural and Urban Areas." Prepared by the Center for Poverty Research at the University of Kentucky for the Meals on Wheels Association of America, Inc. 1-153, available at http://www.mowaa.org/Document.Doc?id=193.

decade progressed, an **additional 700,000** seniors had **"low food security"** by 2007, bringing the total estimation of seniors at-risk for hunger to around **three million older adults**. Although reports from the USDA purport that older citizens are less vulnerable to hunger and more likely to be food secure than nonelderly citizens,[6] this cohort is highly diverse and dynamic. For example, as the left y-axis of Figure 1 portrays, although the proportion of seniors facing hunger demonstrated periods of growth and decline between 2001 and 2007, societal factors, such as first generation "Baby Boomers" reaching age 60 in 2006 and the economic recession in 2007, have led to a **consistent increase in the actual number of seniors at-risk for hunger**, as depicted on the right y-axis.

Figure 1: Trends in Food Insecurity among Senior Americans



Source: Excerpted from Ziliak, J., Gunderson, C. (2009), p.15.

[6] See Nord, M. (2003). "Measuring the Food Security of Elderly Persons," Family Economics and Nutrition Review Special Issue: Elderly Nutrition. 15 (1), 33-46, available at http://www.cnpp.usda.gov/Publications/FENR/V15n1/fenrv15n1.pdf.

What Are the Health Outcomes Associated with Senior Hunger? [7]

Health consequences associated with inadequate nutrition include: **diminished immune response**, **longer hospital stays**, **impairment in physical function**, **premature institutionalization**, **reduced activity levels**, and **higher risks of coronary heart disease, obesity, and diabetes.** Even seniors who are marginally food secure, the category indicating less severe food access limitations, face health threats, such as: **increased likelihood of being in poor or fair health, greater limitations in activities of daily living, higher chances of suffering from depression, and diminished energy due to lower intakes of major vitamins**.

> *"…**social isolation** has an effect size on the likelihood of being at-risk of hunger that is of **comparable magnitude to living in poverty**."*
> (Ziliak, et. al., 2008, p.41)

What Characteristics Put Seniors at-Risk for Being Food Insecure?[8,9]

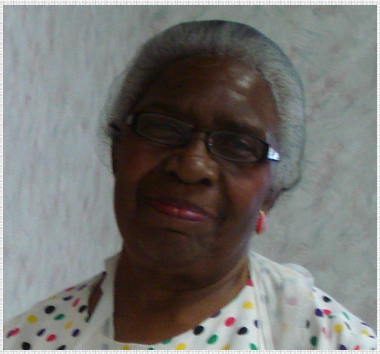
Nationally, most food insecure seniors are white, Non-Hispanic, under age 70, women, retired or disabled, live in metro areas, do not receive Food Stamps, and do not have a grandchild living within the home. All other factors remaining constant, the risk of hunger among seniors increases for people with the following attributes: **ages 60-64, living below the poverty line**, **African-American** or **Latino**, **never completed high school**, **disabled** or **unemployed, divorced** or **separated**, **renting**, **living with a grandchild**, **socially isolated**, **holds less than $25,000 in liquid wealth**, and **has a net worth less than $50,000.** However, the risk of hunger is not unique to these groups and tends to be evident across demographic categories. These

[7] See note 3
[8] See note 3
[9] See note 4

factors are significant when considering the barriers facing national and local anti-hunger organizations who wish to target seniors with unpredictable access to nutritious food.

Example of a hypothetical high risk profile for a metropolitan resident living below 100% of the poverty line:

No grandchild in the home
Renter
Living alone
Widowed



<12 years of formal education
Age 65-69
Disabled
African-American, Non-Hispanic

49 percent probability of being food insecure*

Is There a Connection between Hunger and Income?[10,11]

Clearly, an individual's purchasing power exerts a great deal of influence on their ability to meet his or her nutritional needs for an active, healthy, sustained life. Senior households living in poverty are **three times as likely to be marginally food secure** relative to the average household over ages 60 and older, and **at least two times as likely to be food insecure** or **near hunger.**

But food insecurity is not limited to seniors living below the federal poverty line, which was $10,210 for a household of one in 2007:

- **More than 62 percent** of food insecure seniors have **incomes above the poverty line** (Ziliak, et. al, 2009, p.4).

[10] See note 3
[11] See note 4
* calculated in Ziliak, et. al, (2008), p. 39

- **One in seven** food insecure households with seniors have annual **incomes above twice the poverty line** (Ziliak, et. al, 2009, p.4).

However, accessible financial resources can help buffer an individual from food insecurity:

- The **probability** of being marginally food insecure **decreases by almost 66 percent** for people **with net worth in excess of $100,000** (Ziliak, et. al., 2008, p.55).

Other factors also associated with elderly malnutrition range from systemic gaps, such as the tendency for health care providers to overlook administering regular nutritional screenings for elderly patients, to issues unique to individuals, including difficulties absorbing nutrients due to prescription drug interactions, refusal to eat, and abuse.

National Senior Trends

In many states, the anticipated expansion of the elderly population is expected to exceed the growth of other age groups, and, nationally, the number of people ages 65 and older in 2030 will double what was recorded in the year 2000. This means that, in the not so distant future, one in every five people in the U.S. will be an older adult.[12] Contemporary seniors, with access to the advantages of recent medical and technological innovations, have the opportunity to participate fully in society as community-dwelling citizens throughout their lives. The Partners for Livable Communities and the National Area Agencies on Aging have joined forces with communities to actualize and expand policies and programs geared towards meeting the needs of older adults who wish to remain independent and avoid unnecessary institutionalization. Coined as "aging in place," this nationwide initiative has resonated with organizations that serve elderly clients, such as the D.C. Office on Aging, as well as maturing adults planning for an uncertain future. In response to this social and commercial demand, community-based food options will be necessary

[12] "The Maturing of America—Getting Communities on Track for an Aging Population" http://www.aginginplaceinitiative.org/index.php?option=com_content&task=view&id=19&Itemid=48.

to accommodate the needs aging adults, especially those with physical limitations. Unless policy makers and program administrators make intentional provisions to ensure that services are equally available to all seniors, accessibility to these resources will be greatly determined by socioeconomic factors. Although the Baby Boomers are considered to be one of the most educated and wealthiest generations of our time[13], it is also important to remember the historical exclusion of low-income, non-native and people of color from venues of social elevation and asset accumulation and how these factors influence current demographic attributes associated with food insecure seniors.

Projections of Senior Hunger

By 2030, the number of elderly citizens in the U.S. will reach unprecedented levels, growing at over four times the rate of the population as a whole (Houser et. al 2009).[14] Similarly, the number of elderly people without the means to acquire a consistent supply of food is also likely to increase rapidly. When assessing the future of senior food security rates, Ziliak, et. al (2009) estimates that

> "in the absence of significant changes in economic growth and/or significant policy interventions, the number of seniors in each of the of the latter three groups [categories of food security] will increase by 75 percent, 50 percent, and 33 percent, respectively, by the year 2025" (p.9).

[13] Brandon, E. "Ten Things You Didn't Know about Baby Boomers" January 15, 2009. *U.S. News and Report.*http://www.usnews.com/money/blogs/planning-to-retire/2009/1/15/10-things-you-didnt-know-about-baby boomers.html.

[14] Houser, et. al (2009). "Across the States: Profiles of Long-Term and Independent Living." AARP Public Policy Institute, Eighth Edition, http://assets.aarp.org/rgcenter/il/d19105_2008_ats.pdf

This grim prediction affirms the importance of swift and comprehensive measures to address hunger affecting our elderly citizens and identify barriers to food access that may disproportionately limit the nutrition, health, and longevity of our community members.

> *"…these [projections] are intended to be solely illustrative of the **powerful influence of demographics** on food insecurity across states, and the resulting **great heterogeneity of need for well targeted policies** across the states."*
> (Ziliak, et. al, 2009, p.43)

Part II: National Response to Senior Hunger

Trends in Elderly SNAP Participation and Food Stamp Receipt[15,16]

Designed to bolster the purchasing power of low-income households, the Supplemental Nutrition Assistance Program (SNAP), also known as the Food Stamp Program, has been proven to enhance both the capital and nutritional resources available to households who enroll. People over age 60 tend to have lower participation rates than other eligible demographic groups, as illustrated below in Table 1. In FY 2007, the SNAP participation rate for all eligible older individuals was only 32 percent versus the 66 percent participation rate of all eligible people (Cunnyngham, 2009, p.3). However, due to efforts by the USDA to target seniors eligible for SNAP, such as the Elderly Demonstration Project, providing SNAP outreach grants, and the allowance of Combined Application Projects, the number of SNAP participants ages 60 and older has risen by nearly 40 percent (Cunnyngham, 2009, p.5). The seemingly lower monthly Food Stamps allotment among this population is seen as a significant deterrent to senior SNAP enrollment. The average monthly Food Stamp benefit for all households was $222 in FY 2008. Households with elderly members, on the other hand, received less than half this amount, averaging of $94 in Food Stamp benefits per month (Wolkwitz et. al., 2009, p. 18). Compared with other demographic groups (i.e. households with children, non-elderly disabled individuals, single-person households, and households not containing children, seniors, or disabled persons), SNAP households with elderly participants receive the lowest average monthly Food Stamp allotment, a trend that persists on the individual level as well.

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[15] Cunnyngham, K. (2009). "State Trends in SNAP Participation rates among Elderly Individuals." Mathematica Policy Institute, 1-20.

[16] See Wolkwitz, K. and Trippe, C. (2009). Characteristics of Supplemental Nutrition Assistance Program households: Fiscal year 2008. Mathimatica Policy Institute/Food and Nutrition Service. 1-120. http://www.fns.usda.gov/ora/MENU/published/SNAP/FILES/Participation/2008Characteristics.pdf.

Table 1: Comparison of Selected Characteristics between Older Adults and All SNAP Participants, FY 2008					
	Average Values				
Households with:	**Gross Monthly Countable Income (Dollars)**	**Net Monthly Countable Income (Dollars)**	**Monthly SNAP Benefit (Dollars)**	**Household Size (Persons)**	**Monthly SNAP Benefit Per Person (Dollars)**
Children	839	422	329	3.3	104
Elderly	762	375	94	1.3	75
Disabled Nonelderly Individuals	885	463	159	2.0	79
Households Not Containing Children, Elderly, or Disabled Individuals	219	68	158	1.1	147
Single-Person Households	507	205	105	1.0	105

Source: Adapted from Wolkwitz, K. and Trippe, C. (2009), p. 18.

*SNAP households with elderly participants tend to have **higher incomes**, **smaller households**, and **fewer deductions** than the average SNAP household. Consequently, many senior households typically **receive lower than average monthly benefits**.*

These efforts demonstrate the USDA's commitment to improving outcomes for food insecure older adults though Supplemental Nutrition Assistance Program:

- Changing the name and design of the program to highlight nutrition, reduce stigma
- Boosting the minimum benefit from $10 to $16, the first revision in 30 years
- Increasing the standard deduction and indexing it to inflation
- Excluding elderly households from the cap on shelter deductions
- Permitting elderly household to deduct itemized medical expenses in excess of $35
- Disregarding resources, such as retirement accounts and educational funds, which may have formerly prevented enrollment
- Indexing the standard deduction, which affects 60 percent of elderly SNAP participants[17]
- Facilitating phone, in-home, online, and off-site SNAP applications and interviews, thus catering to applicants who cannot travel to the enrollment office
- Extending recertification periods to a maximum of 24 months rather than 6 months

[17] USDA Food and Nutrition Service (2008). "Supplemental Nutrition Assistance Program: Putting Healthy Food within Reach." Webinar/PowerPoint. Oct. 23, 2008 http://www.fns.usda.gov/FSP/outreach/coalition/102308/farm_bill_changes.pdf.

Part III: Survival of the Fittest—Economic and Food Security among Seniors in D.C.

Introduction

The previous section serves to illustrate the extent, characteristics, and outcomes of senior hunger trends across the United States. By identifying the barriers to elderly economic security, this portion of the report will bridge how and why certain elderly demographic groups are more vulnerable to food insecurity and its effects than others. Given the tremendous variation within this population, it has been difficult to assign a "one-size-fits-all" solution to senior hunger, but through targeted measures aimed at the problems that prevent high-risk seniors from acquiring food, policymakers, administrators, and organizations that serve aging Washingtonians, can develop effective, localized strategies to eradicate senior hunger in the District.

A report issued by the Population Reference Bureau highlighting migration trends of elderly people in the Washington metropolitan region revealed that the number of people ages 65 and older will double between 2000 and 2030 with the entrance of the Baby Boomer generation, beginning when those born in 1946, reaches age 65 in 2011.[18] As the District's population ages, awareness of elderly household food insecurity and senior poverty is crucial for government agencies, nonprofit organizations, and community groups who struggle to serve to an expanding, needy, and, at times, hard to reach population. Roughly 5,000 people ages 60 and older within the District of Columbia meet the USDA's criteria for being food insecure—meaning they do not have access to an adequate amount of food throughout the year to lead healthy and active lives. In the general population the cause of this deficiency is primarily attributed to a deficiency in financial resources, but, there are various factors specific to the elderly population (such as

[18] For a full analysis of selected physical ability and economic characteristics of the elderly population by Ward, see http://www.prb.org/pdf0e7/elderlymigration.pdf

living with a grandchild, diminished physical/mental health, and level of socialization) that tend to influence food access almost as strongly as liquid wealth. This section aims to (a) explore why certain older demographic groups disproportionately experience or are at-risk for food insecurity in the District (b) contextualize how rising costs impact senior food expenditures, and (c) demonstrate the connections between food access and senior wellness, both on the individual and the community-levels.

Food Insecurity

What Is the Extent and Distribution of Food Insecurity among Seniors in D.C.?

There has been no comprehensive study assessing individual-level food insecurity within the District of Columbia; however, by analyzing descriptive data highlighting the prevalence of food insecurity among seniors and demographic information about residents ages 60 and older, Tables 2 and 3 provide informed estimations of the scope and extent that hunger, in its various manifestations, impacts senior citizens within the District. Out of the 99,856 older people recorded as residing within the District in 2008, roughly more than five percent are food insecure. Many of the 5,000-plus adults who struggle with hunger are African-Americans, women, renters, and retirees. More than one-in-ten elderly residents who have completed less than 12 years of formal education have limited access to food. Nearly two-thirds of food insecure seniors are younger than age 70. As previously mentioned, elderly people living above the poverty line compose a significant portion of the sample of food insecure adults, but since 15.73 percent of the sample's income information is not reported, it cannot be conclusively determined whether most food insecure seniors in the District live above or below the poverty line.

Table 2: Demographic Factors Associated with Food Insecurity Among Seniors in D.C.[19]					
Characteristic	**Population Count**	**Percent of Population 60 and Over**	**Rate of Food Insecurity[20]**	**Approximate Count of Food Insecure Seniors**	**Potential Extent of Food Insecurity**
Hispanic	4,693	4.7 percent	11.66	547	200-700
Employed	31,665	33.0 percent	11.29	3,576	3,300-3,700
Renter	25,884	39.3 percent	11.20	2,899	2,600-3,000
Disabled	28,486	29.8 percent	10.56	3,008	2,800-3,200
People 60 and Older	**99,856**	**100 percent**	**5.37**	**5,362**	**5,100-5,500**

Table 3: Distribution of Food Insecurity Among Seniors for Selected Demographics					
Characteristic	**Rate of Food Insecurity Distribution**	**Approximate Count of Food Insecure Seniors**	**Potential Extent of Food Insecurity**	**Estimated Food Insecure Percent of the Total Demographic**	**Total Population within the Demographic**
African American	91.93	4,930	4,700-5,100	7.74 percent-8.4 percent	60,712
Female	73.77	3,956	3,700-4,100	6.22 percent-6.90 percent	59,414
Widowed	41.33	2,216	2,200-2,400	8.96 percent-9.77 percent	24,565
Less than a High School Education	47.21	2,531	2,300-2,700	10.61 percent-12.46 percent	21,669
People 60 and Older	5.37	5,362	5,100-5,500	5.10 percent-5.51 percent	99,856

Methodology

Food insecurity rates originate from the *Senior Hunger in the United States* special report (Ziliak, et.al, 2009), which determines the rate and distribution of elderly food insecurity among District residents based on data averaged from the 2001-2007Community Population Survey. Population estimates were derived from the American Community Survey's (ACS) 2008 summary of "Population 60 Years and Over in the United States" for the District of Columbia. Because the ACS lists the demographic profiles as percentages, the estimates used in the chart had to be calculated by multiplying these percentages by the total population of people 60 and older, which was 99,856 in 2008. This number was rounded to the nearest whole number and

[19] Demographic information extracted from the U.S. Census 2008 American Community Survey (ACS) http://factfinder.census.gov/servlet/STTable?_bm=y&-state=st&-context=st&-qr_name=ACS_2008_1YR_G00_S0102&-ds_name=ACS_2008_1YR_G00_&-tree_id=308&-redoLog=true&-_caller=geoselect&-geo_id=04000US11&-format=&-_lang=en

[20] Rates and distribution figures derived from Ziliak, et. al (2009) "State Profile of Food Insecurity for Seniors, 2001-2007: District of Columbia."

shown in the last column of Table 3. The resulting product (while retaining the decimals) was then multiplied by the "rate of food insecurity" to determine the approximate count of food insecure seniors. The "Potential Extent of Food Insecurity" is meant to take into account the imprecision of the previous figure. Finally, this number is divided by the total (estimated) population of the demographic population to gauge the proportion of people within the selected demographic who are food insecure.

Financial Insecurity

What are the Factors Preventing Food Insecure Older Adults from Acquiring Food?

In addition to having one of the highest general and child poverty rates in the nation, according to data compiled by Kaiser Family Foundation (2007-2008), the District of Columbia also tied with Mississippi for the highest elderly poverty rate in the U.S., at 19 percent. [21] This means that nearly one- in-five older District residents faced economic instability that year. Recurring themes, such as the rising costs of housing expenses, energy, food, transportation, and health care expenditures in recent years has continued to affect people across all income brackets, but the gravity of this situation tends to weigh heaviest on the District's low-income residents, as described in a recent *Washington Post* article, "The High Cost of Poverty: Why the Poor Pay More" (May 2009).

> ***Jeanette Reed, who is retired and lives on a fixed income, sold her blood when she needed money. 'I had no other source to get money,' she says. 'I went to the blood bank. And they gave me $30. I needed the money. I didn't have the money and no source of getting money. No gas. No food. I have to go to a center that gives out boxes of food once a month...'***
>
> **— Brown, D. *Washington Post*, 5/18/2009**

Despite the depth and diversity embedded within the District's older population, common stories relate the perilous position of seniors living on a fixed income. According to a 2005 study

[21] See the brief from the AARP's Public Policy Institute "Poverty Rate by Age, states (2007-2008), U.S. (2008)" at http://jn.nutrition.org/cgi/reprint/136/11/2939

by the Center for Retirement Research analyzing the expenditures of older adults after retirement, married and unmarried older adults typically spend 84 percent and 92 percent, respectively, of their net income. Considering that this leaves approximately 8 to16 percent of their annual funds available in the event of emergencies, it is evident that having supplementary resources, such as savings or assets, is essential to cope with costly, unexpected expenses such as losing a home to fire, long-term hospitalization of a spouse, or, as many seniors will attest, incurring a combination of several, seemingly minor, expenses in the midst of steady inflation.

The Erosion of Retirement Savings

Many households still have not recovered from the losses triggered by inflation, unemployment, and depreciating financial and real estate investments in recent years. A report by the AARP Public Policy Institute (2009) analyzing the impact of the economic recession on the household net worth for U.S. residents found that the collective net worth of households across the country was approximately 17 percent lower in 2009 than it was in 2007. [22] Some households with the means to invest in stock portfolios and retirement packages witnessed their savings evaporate in the stock market's collapses in 2002 and 2008. Without many prospects of reentering the formal economy, many unemployed seniors, especially those without other savings, must rely on Social Security to meet their basic needs. From October 2008 to May 2009, Social Security claims exceeded projected estimates for the year by 9 percent, [23] which could signify that applicants' existing resources are insufficient to maintain their current standards of living, a desire to stave off savings depletion, or an increasing economic need within the elderly population.

[22] See the AARP Public Policy Institute brief on describing the impact of the recessions on Social Security recipients http://www.aarp.org/aarp/presscenter/pressrelease/articles/importance_of_COLA.html

[23] Statistic mentioned in a summary by the AARP's Economic Team based on data from the Social Security Administration http://www.aarp.org/research/ppi/econ-sec/Other/articles/Older_Americans_and_the_Recession.html

Despite numerous reports of price inflation across the board, older people receiving Social Security will not receive a Cost of Living Increase (COLA) in 2010, as the Administration announced that it would not be able to finance the annual raise in Social Security. While this supplemental entitlement is not intended to serve as a sole source income, the National Academy of Social Insurance estimates that this is the case for more than one-in-five recipients ages 65 and older (21 percent), and elderly minorities are disproportionately represented. At least 43 percent of people of Latino origin, 40 percent of African Americans, and 28 percent of Asian and Pacific Islanders solely rely on these monthly checks to pay for their expenses, [24] even though the average benefit nationwide barely buffers an individual from poverty, annually amounting to about 120 percent of the poverty guideline for a single person (or roughly $13,000). [25] When considering the nebulous future of Social Security in conjunction with aging Baby Boomers entering retirement between 2011 and 2030 (when these individuals reach age 65), maintaining and providing auxiliary social and financial support to low-income and at-risk seniors should be a high priority for policy makers in the prevention of food insecurity.

The Cost of Housing[26]

Studies documenting expenditure patterns of elderly adults have found that people in the U.S. spend a disproportionate share of their income on housing as they age. Considering the rising cost of rent for many people in the District, as illustrated below in the Figure 2, having income in addition to federal entitlement funds is essential for people to afford housing. The National Low Income Housing Coalition (NLIHC) deems affordable housing as no more than 30

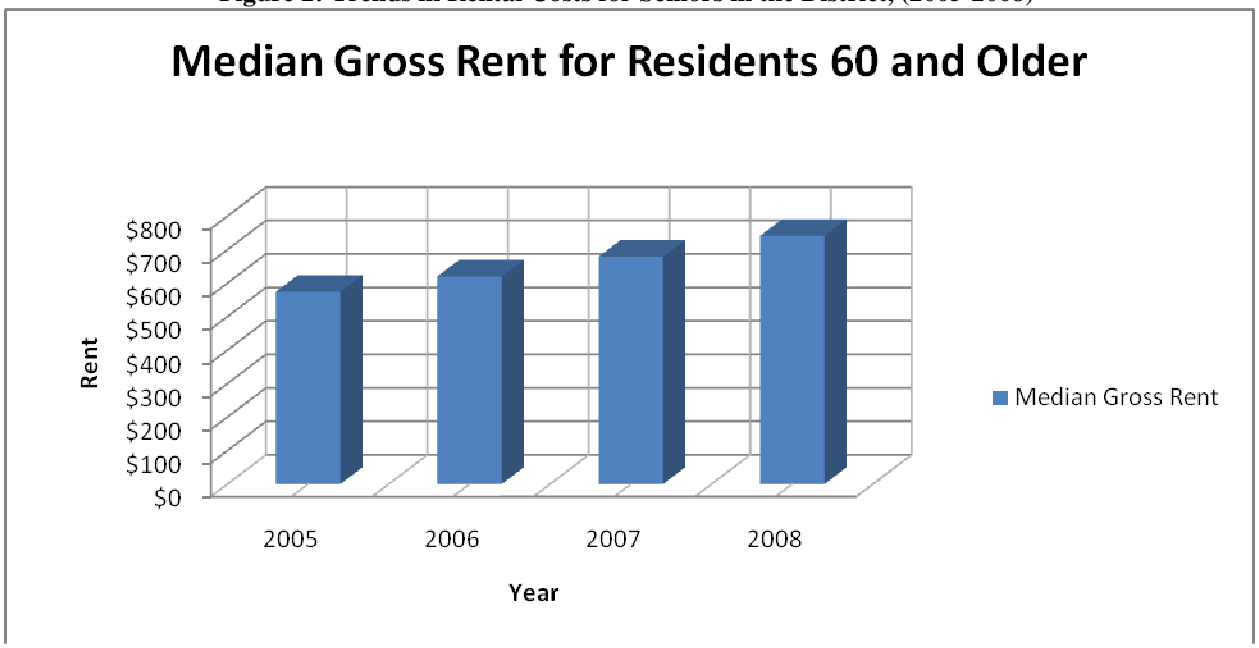
[24] See "The Role of Benefits in Income and Poverty" by the National Academy of Social Insurance http://www.nasi.org/learn/socialsecurity/benefits-role

[25] For further discussion on the role of retirement, pensions, and Social Security in the financial stability of older Americans, see MacKenzie, S. and Wu, K. (2008) "The Coverage of Employer-Provided Pensions: Partial and Uncertain" http://assets.aarp.org/rgcenter/econ/d19108_pensions.pdf

[26] Gómez, M. and Ranney, C. (2002). "Effects of Food and Health Spending Patterns on the Health of the Elderly." Agricultural and Applied Economics Association, No. 19608

percent of a person's income, but even in the District's low-income senior apartment complexes, which provide subsidized housing for elderly residents, rental costs may exceed this figure. Seniors aged 65 and older who are determined to be in economic need can receive monthly stipends known as, Supplemental Security Income (SSI). The monthly payment for an individual in the District is $637, and in 2009, the monthly rent (including utilities) at a local subsidized senior housing complex rose to $190, slightly more than the $181 affordable rental price determined by NLIHC. [27] Low-income seniors[28], on average, devote a greater percentage of their resources on housing than middle-income and more than twice as much as high-income persons.

Figure 2: Trends in Rental Costs for Seniors in the District, (2005-2008)



Prepared by the author. Source: American Community Survey (2008). Population 60 Years and Over for the District of Columbia

In 2008, over half—54.6 percent—of the District's seniors spent 30 percent or more of their annual income on rent, which is considered the threshold for affordable housing. That year, the median gross rent was $741.

[27] The rent at Arthur Capper was obtained through personal observation and the statistic on affordable housing was provided by the National Coalition for the Homeless in this brief http://www.nationalhomeless.org/factsheets/Elderly.pdf.

[28] Butricia, B.A., Goldwyn, J.H., and Johnson, R.W. (2005). "Understanding Expenditure Patterns in Retirement." Center Retirement Research at Boston College. 1-37 at http://crr.bc.edu/images/stories/Working_Papers/wp_2005-03.pdf.

In Parts I and III, which describe national and local trends in senior food insecurity, renters are identified as vulnerable to insufficient food access but they are not solely at-risk. Older African Americans and Latinos homeowners were found to devote a higher percentage of their income towards mortgage because their payments tend to be higher. This phenomenon may be attributed to a variety of discriminatory lending practices that unfairly disadvantage minority homeowners, such as racialized redlining,[29] the absence of mainstream credit institutions in low-income communities, and predatory and subprime lending by mortgage companies, who also target their services towards seniors. In a 2007 testimony before the D.C. Committee on Public Services and Consumer Affairs regarding the Home Equity and Protection Act, Peter Tatian, Senior Research Associate at the Urban Institute, corroborates this occurrence with local observations, "The data show that levels of subprime lending are not uniform across the city. Wards 4, 5, 7, and 8 had the highest shares of subprime lending in 2004; levels of subprime lending in Ward 7 were ten times higher than in Ward 3 (Tatian, 2)" where Caucasians and more affluent persons make up the majority of the population. [30]

In addition to mortgage payments, another significant concern for both homeowners and renters in the District is the cost of utilities. According to a report by the Alliance to Save Energy, residents of Washington, DC typically spend 14 percent more to heat their homes than the nationwide average, and from 2008-2009, households that relied on natural gas and electricity paid $90 and $135 more than in the previous winter, respectively. [31,32] The cost of heating and cooling is of particular concern for senior citizens as many may not have energy

[29] For an overview of redlining see http://public-gis.org/reports/red1.html.
[30] See the complete testimony and frequency tables of subprime home mortgage lending, including data segregated by race and Ward at http://www.urban.org/UploadedPDF/901058_Tatian_Mortgage.pdf.
[31] For a comparison of home heating costs between 2007 and 2009 in Washington, DC see the fact sheet from the Alliance on Energy http://ase.org/extensions/state_facts/fact_sheets/DC.pdf
[32] See the press release, issued January 2010 from the Alliance on Energy highlighting typical home energy costs http://ase.org/content/news/detail/6360

efficient appliances or sufficient weatherization, thus placing residents and their budgets under considerable pressure during high heating and cooling seasons. A 2006 report issued by the ERS has recorded the association between these expenses and food insecurity among low-income elderly households. Low-income elderly residents living in areas where heating expenditures significantly increase during the winter [33] —such as the District— typically experience very low security, the most severe classification, at a rate of 43 percent more than during the summer.

Gaps in Health Care

As in the case of housing, medical expenses have not subsided in recent years, increasing 2.8 percent in 2008 and again, by 3.4 percent, as affirmed by the Bureau of Labor Statistics summary of the Consumer Price Index in 2009. The rising costs associated with health care can pose a significant burden to aging households with high medical expenses due to chronic illness, unplanned hospitalization, being diagnosed with conditions that require expensive prescriptions, or a host of other maladies that may afflict food insecure seniors in poor health. The District of Columbia offers free health care to residents who do not qualify for health insurance through DC Healthcare Alliance; [34] yet, for hundreds of older Washingtonians, the benefits of healthcare are out of reach. The D.C. Office on Aging estimates that more than one-in-ten (10.8 percent) of residents ages 50 and 64 lack health insurance[35] (DCOA, 2009, p.5) and, in the BRFSS(2007)[36] assessment of health indicators within the District, 4.9 percent of residents aged 65 and older could not afford to go to the doctor, despite the provision of Medicare.[37] These are crucial

[33] See the full report by Nord, M. "Seasonal Variation in Food Insecurity Is Associated with Heating and Cooling Costs among Low-Income Elderly Americans" http://jn.nutrition.org/cgi/reprint/136/11/2939
[34] For more information about DC Healthcare Alliance see http://ssc.rrc.dc.gov/ssc/cwp/view,a,1218,q,455339.asp.
[35] D.C. Office on Aging State Plan on Aging, 2009
[36] See more detailed statistics about demographics and health status by Ward in the District of Columbia Behavioral Risk Factor Surveillance System 2007 Annual Report.
[37] Medicare is a federally subsidized healthcare program for citizens aged 65 and older

periods within the elderly cohort, as scholars have observed higher food insecurity rates for elderly people below the age of 70 (Gómez and Ranney, 2002; Ziliak et.al. 2008; 2009).

The Price of Food[38,39,40]

After Hurricane Katrina in 2005, the United States experienced a drastic spike in the cost of oil that revealed how our country's reliance on an inefficient, transportation-dependent system of food delivery, impacting consumers from the parking lot to the checkout kiosk. In his testimony before the Senate Select Committee on Aging, James Weill, Executive Director of the Food and Research Action Center (FRAC), upheld that, when elderly consumers are faced with rising costs without a successive increase in income, their nutrition is the first to suffer from deficient funds. [41] Gómez and Ranney (2002) corroborate this finding in their analysis of how food spending impacts the health of seniors, concluding that

> "even though food is a necessity, food spending declines 1 percent for each year of age of the elderly, while increasing by 1 percent for each year of age of the non-elderly, indicating that food expenditures might be crowded-out by other expenditures as income decreases with age (p. 4)."

In a survey administered by the AARP in June 2008 to customers ages 45 and older, nearly half of the respondents, 49 percent, claimed that the current food prices had caused them economic hardship, with almost 20 percent responding by consuming fewer meals and 41 percent scaling back on meals with meat. [42] Between 2007 and 2008, inflation drove consumers to spend an

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[38] See the USDA Economic Research Service brief at "Food CPI and Expenditures: Analysis and Forecasts of the CPI for Food" at http://www.ers.usda.gov/Briefing/CPIFoodAndExpenditures/consumerpriceindex.htm for an overview of CPI and its measurement

[39] See the USDA ERS analyses of food prices for specific commodities in 2009 and the forecasts for 2010 at http://www.ers.usda.gov/Briefing/CPIFoodAndExpenditures/Data/cpiforecasts.htm

[40] See the most recent summary of CPI generated by the Bureau of Labor Statistics and released January 15, 2010 at http://www.bls.gov/news.release/cpi.nr0.htm and take note of the updates the BLS will apply to their reporting methods in subsequent reviews

[41] Weill, J. "Addressing Hunger Among America's Elderly Population: Testimony before the Senate Select Committee on Aging," March 5, 2008 http://aging.senate.gov/events/hr189jw.pdf.

[42] See the full questionnaire and responses at "AARP Bulletin Survey on Rising Food Costs—Executive Summary" at http://www.aarp.org/research/surveys/stats/surveys/public/articles/bulletin_foodcosts.html.

average of almost 6 percent more for food prepared within and outside of the home, as the price of staples, such as cereals and baked goods, rose more than 10 percent over prices the previous year. In 2009, consumers experienced an increase of nearly three percent for all foods, a trend which is unlikely to abate in 2010.

As in the case of housing, increasing food prices represent an incredible burden on households with minimal assets in comparison to households in higher income brackets. Low-income households typically spend more than a quarter of their annual income after taxes on food—nearly twice as much and more than four times as much than middle and high-income households, respectively.[43] Although there are a host of societal and individual-level aspects that influence this phenomenon, a growing body of work and recognition from the USDA (Ver Ploeg et. al. 2009) has linked the high prices that low-income households tend to spend on food to the types of retail food outlets adjacent to these neighborhoods and the limited availability of wholesome foods, such as fresh fruits and vegetables. In the event that fresh food is available, it often is sold at higher prices than what would be demanded at full-service grocery stores, which are often located further away.

Transportation and Food Access [44]

Another alarming trend related to food prices is the cost of gasoline, which, according the Consumer Price Index for All Urban Customers (CPI-U) climbed 53.5 percent in 2009, well in excess of the moderate 43.1 percent decline in 2008. Riders on public transportation in the District also face mounting prices, as demonstrated by the recent approval of a 10-cent fare hike

[43] See note 7
[44] Information on the prevalence of food deserts in the District, contact D.C. Hunger Solutions for the upcoming report, "When Healthy Food Is Out of Reach: An Analysis of the Grocery Gap in the District of Columbia."

on Metrobus, Metrorail, and MetroAccess systems.[45] The increasing cost of transportation is particularly taxing to low-income seniors who shop for groceries in the District and may have fewer transportation options, be incapable of carrying groceries for long distances, or may not feel safe travelling alone in their communities.

Aside from the distance many food products have to travel before reaching the shelf, consumer food access is similarly compromised by escalating transportation costs due to the inequitable distribution of markets throughout the District, an issue referred to as a "grocery gap." Both nationally and within the District, research has suggested that the deficiency of supermarkets, which offer a wide selection of food choices at affordable prices, is related to the prevalence of obesity, diabetes, and other nutrition-related diseases. The affected areas, often called "food deserts," predominately affect lower-income neighborhoods and disproportionately impact people of color. [46]

> ***…I'm also diabetic, but sometimes I love to get outside, I go places, but sometimes my body don't allow it. So what about when I want to go to Safeway or Giant, why can't it be someplace, like on the corner where I can go? We don't have those types of stores in our neighborhood. Only corner stores, and very, very high...***
> ***I mean, why can't they have a Safeway and Giant in that neighborhood right there? And a CVS/Pharmacy? Where these people are? Where we, the needy people cannot get around too far, that don't drive or anything, that have to use public transportation. Why can't they have someplace close to them? Why do we always have to go out to another neighborhood just to get what you need?***
>
> —GH in interview with Amy Johnson, Bread for the City

In an upcoming study from D.C. Hunger Solutions and Social Compact documenting the distance between full-service grocery stores and District residents, a profound grocery gap

[45] For details on the how the fare increases will impact riders see the January 29, 2010 story in the Washington Post http://www.washingtonpost.com/wp-dyn/content/article/2010/01/28/AR2010012803788.html.
[46] Zenk, S., et. al. (2005). "Why Are There No Supermarkets in My Neighborhood?: The Long Search for Fresh Fruit, Produce, and Healthy Food."

emerges, revealing areas where community members must travel greater than average distances in order to reach a supermarket, and several Wards are deemed food deserts. This indicates that residents in these neighborhoods are underserved by grocery stores and may spend more money travelling to stores in other parts of the city or in neighboring states. Older individuals with diminished mobility may have to rely on nearby convenience and corner stores, which tend to have a smaller selection (if not an absence) of fresh produce and often charge higher prices than full-service grocery stores. On average, District residents must travel .52 miles to reach a full-service grocer, but in Wards 4, 5, and 7, whose residents have to travel further, the combined average distance is about .66 of a mile. Based on 2007 data from the American Community Survey, each of these Wards is home to more older adults than the District's average.

Furthermore, in Wards 5 and 6, the percentage of low-income residents is also greater than the city average.[47] While the difference in distance between the Wards underserved by supermarkets may seem nominal, these distances do not necessary reveal peripheral costs and, ultimately, one's access to adequate markets, such as proximity to train and bus stations (and having places to sit while waiting for the bus), availability of personal transportation, the prevalence of sidewalks, and having money to pay for shuttle services or roundtrip taxi fare. Additionally, the estimated distances are averages, and some residents may have to travel further. As the authors note, this requirement, and the alternative of paying convenience store prices is especially burdensome for District residents already coping with rising prices: "Low-income people, whose budgets are stretched to meet basic needs, often do not have extra money to pay for additional transportation costs and are most affected by long distances to the grocery store (D.C. Hunger Solutions, upcoming, p.13)." While the majority of the District's Wards—five out of eight—contain communities that meet the criterion which signify a gap in grocery services,

[47] See note 36

only half of city's Wards—5, 6, 7, and 8—can be accurately designated as containing food deserts, due to the low median income of residents in these underserved communities.

Table 4: District Health Indicators by Ward (for Adults)				
	Heath Status		Demographics	
Ward	**Overweight or Obese**	**With Diabetes**	**African-American**	**Caucasian**
Ward 1	48 percent	6 percent	43 percent	35 percent
Ward 2	39 percent	5 percent	30 percent	56 percent
Ward 3	38 percent	3 percent	6 percent	84 percent
Ward 4	62 percent	10 percent	78 percent	10 percent
Ward 5	61 percent	10 percent	88 percent	8 percent
Ward 6	58 percent	9 percent	69 percent	27 percent
Ward 7	65 percent	12 percent	97 percent	1 percent
Ward 8	71 percent	11 percent	92 percent	6 percent
Washington, D.C.	55 percent	8 percent	60 percent	31 percent

Source: D.C. Hunger Solutions. "When Healthy Food is Out of Reach: An Analysis of the Grocery Gap in the District of Columbia.

Part IV: Health Outcomes Related to Senior Hunger and Health Care in the District

What are the Connections between Senior Food Insecurity and Community Health?

The identification of food deserts is of particular significance when examining senior food insecurity because of the correlations among social environment, food access, consumption patterns, and the incidence of nutrition-related diseases. While the research on food insecurity has not come to consensus as to whether living in a food desert is necessarily an indication or an outcome of poverty and diminished life expectancy at the community-level, the disproportionate impact of food insecurity on individuals of color living in economically disadvantaged neighborhoods with less access to resources and greater vulnerability to poor health, illustrate the intimate relationship between nutrition and wellness, even though the intricacies of these connections are unclear. This section will draw attention to the interactions of the individual, household and sociological dynamics impacting the health outcomes of senior and aging

residents whose nutritional needs are infrequently and inadequately met, as exhibited through the development of chronic disease.

Table 5: Essential Components of a Measure of Food Insecurity at the Individual, Household, and Community Levels of Study			
Component	**Individual level**	**Household level**	**Community level**
1. Quantity	Energy sufficiency of intake	Repleteness of household store	Physical access to and sufficient number of sources of food required to maintain an adequate diet
2. Quality	Nutrient adequacy of intake	Quality and safety of on-hand food	Consistent access to affordable, healthy foods and beverages
3. Psychological acceptability	Feelings of deprivation or restricted choice	Anxiety about food supplies	Greater incidence of diet-related diseases
4. Social acceptability	Normal meal patterns	Conventional sources of food	Safe and culturally appropriate meal options

Source: Adapted from Campbell, C. "Food Security: A Nutritional Outcome or a Predictor Variable?" January 1991.

Consumption Patterns Associated with Household Food Insecurity and Chronic Disease

Nutrition-related chronic diseases, such as heart disease, certain cancers, hypertension (high blood pressure), and diabetes, are responsible for more than half of the District's recorded mortalities for people ages 60 and older, according to the D.C. Office on Aging.[48] Food insecure adults, particularly the 5,000 plus seniors residing in the District, are at high-risk for nutrition-related illnesses. A study exploring the incidence of chronic disease in food insecure households, which sampled adults living at 200 percent or less of the poverty line, found that the risk of developing high blood pressure was 21 percent higher than that of adults in food secure households, but this pattern was not observed in a similar study that did not segregate the sample by income.[49,50] The disparate conclusions may stem from lower-income participants' inability to

[48] See the D.C. Office on Aging, Customer Service and Community Affairs Unit. "A Snapshot of the Elderly Population in Washington, DC," July 2009.
[49] Terrell, A., et. al. (2009). "Is Food Insecurity Associated with Chronic Disease and Chronic Disease Control?" *Ethnicity and Disease,* Summer 2009. (19), S3- 3-S3-6.
[50] Seligman, H.K., et. al. (2010). "Food Insecurity Is Associated with Chronic Disease among Low-Income NHANES Participants." *The Journal of Nutrition*, 2010: 304:310 at http://jn.nutrition.org/cgi/reprint/121/3/408

afford or have the physical capacity necessary to travel long distances in order to obtain and preserve groceries. Subsequently, if households routinely sustain themselves and their families with the food that is convenient and locally available, similar patterns of nutrition-deficient consumption tend to arise, as indicated by the high frequencies of diabetes and high Body Mass Index (BMI) in affected Wards. A growing body of participant-driven, community-based research has investigated the correlations between nutritionally lacking neighborhood food options and the consumption patterns of residents, as observed in a community food assessment in a low-income neighborhood in East Harlem, New York City: [51]

> "The lower percentage of stores selling basic low-fat, high-fiber, low-carbohydrate, and low-calorie food items in East Harlem may explain sociocultural disparities in diet and overweight found in other research… In comparison with food-sufficient, White, and more affluent persons, adults from food-insufficient families, African Americans, and the poor are more likely to have diets higher in fat and lower in fiber, fruits, and vegetables (Horowitz et.al., 1549)."

The phrase, "you are what you eat," is apt to describe how environmental coping mechanisms and subsequent desperate diets shape the future and quality of life of persons living food deserts as they feed themselves and their families.

Obesity

An unlikely indicator of malnutrition is obesity, which is defined as having a body mass index (BMI) of least 30.0. This condition and its precursor, being overweight, affects more than half of the District's residents, according to recent studies, and has comorbidity with an array of other life-threatening chronic diseases, including stroke, respiratory issues, and certain

[51] Horowitz, C. R., et. al. (2004). "Barriers to Buying Healthy Foods for People with Diabetes: Evidence of Environmental Disparities." American Journal of Public Health, September 2004 at http://ajph.aphapublications.org/cgi/reprint/94/9/1549.pdf

cancers.[52,53] In addition to its association with other health risks, obesity in older people also interferes with the ability to engage in physical activity and has been linked to premature institutionalization, disability development, muscle mass depletion, and untimely death.[54] More recently, research has found a correlation between higher BMI and the development of Alzheimer's disease, which is estimated to affect 15 percent of the District's seniors in 2010.[55] Overweight and obese people actually stand a higher risk of an Alzheimer's diagnosis than individuals with a parent or sibling with the disease.[56] This fact is of particular interest to women, who tend experience obesity more acutely than men, live longer on average, and compose the majority of District's senior food insecure population. While one cannot definitively state that all of the seniors in the District who are obese or overweight are malnourished, it is a gravely misguided assumption to validate food security based on weight.

Because obesity, in addition to physiological, genetic, and other individual-level attributes, is a consequence of diet, understanding the process through which older adults acquire this condition is significant in understanding and addressing its subsequent health impacts, many of which disproportionately impact low-income, food insecure, and limited-mobility, older residents. Many of the survival strategies employed by food insecure individuals, beyond reducing the quantity of food purchased, include adjustments to the quality and variety of the diet. These changes may range from purchasing white bread over whole grain or drinking fruit juice substitutes, to buying the most food possible at the nearest store with the money that is available, as discussed in Seligman, et. al. (2010): "These energy-dense foods, including refined

[52] Lurie, et.al. (2008) "Assessing Health and Health Care in the District of Columbia—Phase 2 Report." RAND Health Working Papers Series, 1-196, http://www.rand.org/pubs/working_papers/2008/RAND_WR579.pdf.
[53] See note 35
[54] Stenholm, S., et.al. (2008). "Sacropenic obesity—definition, etiology, and consequences." National Institute of Public Health, November 28, 2008.
[55] See note 14
[56] Whitmer, et.al "Central Obesity and Increased Risk of Dementia More Than Three Decades Lateer." *Neurology.* March 2008.

grains, added sugars, and added saturated/trans fats, tend to be of poor nutritional quality and less-expensive calorie-for-calorie than alternatives (p. 304)." Over time, the accumulated lack of key nutrients for older adults can levy charges well in excess of the up-front fees associated with healthy grocery purchases, but, without concurrent support from business, community groups, and the government to provide incentives for more competitive food prices or subsidies to purchase healthy foods at market price throughout the year, the choices available to the District's seniors and aging population will always yield the same results.

Diabetes

The less frequent but equally alarming incidence of diabetes in the District is another nutrition-related chronic disease that poses a considerable threat to the lives of seniors and older adults, in addition to the public health care system. As previously discussed, obese food insecure adults have a greater likelihood of contracting Type II diabetes. In 2006, the self-reported average of diabetes among adults in the District reached 8.1 percent, while residents in Wards 7 and 8 responded at appreciably higher rates, 12.2 percent and 11.0 percent, respectively. [57] Though startling as these observations are, it is also important to note that food insecure adults frequently underreport contracting diabetes when compared with clinical diagnoses, suggesting that the rate of diabetes in the District could be higher. [58] Research analyzing the correlation between diabetes and food insecurity established that adult households with severe food insecurity have higher diabetes rates than their food secure counterparts, even after adjusting for socioeconomic factors and BMI, with one report estimating an enhanced risk of roughly 50 percent. [59]

[57] See note 36
[58] See note 49
[59] See notes 49, 50, 51

Based on the tendency for adults to be diagnosed with diabetes between the ages of 45 and 59 (prior to reaching the age for Medicare eligibility), addressing the health care needs of older adults before they reach 65 is a critical need for economically disadvantaged seniors in the District and food is an accessible point of intervention. Unlike some chronic diseases, diabetes has a strong correlation with diet, and as described below, many of the conditions that typify the experiences of food insecure adults increase vulnerability to this diagnosis:

> "…peripheral insulin resistance, a precursor to diabetes, may be adaptive in association with food insecurity insofar as it allows for the preservation of muscle tissue during food restriction…food insecurity is a highly stressful state, both emotionally and physiologically. The elevated cortisol associated with such stress is frequently linked to adiposity, particularly the visceral adiposity that is a strong risk factor for diabetes. Finally, replacement of dietary fruits and vegetables with relatively inexpensive carbohydrates, such as refined starches, increases dietary glycemic load and may increase the risk of developing diabetes in predisposed individuals (Seligman et. al., 2010, p. 308)."

However, the dietary concerns of people determined to have diabetes do not cease after confirmation; rather, their nutritional needs become more specific and, in some cases their options become more limited. For older diabetics unaccustomed to change, education and nutritional support is necessary in order to prevent complications stemming from insulin deregulation, such as blindness, coma, and death. Some economically and nutritionally insecure older diabetics, particularly those living in food deserts, report difficulty managing this illness. Rather than citing ignorance concerning their disease, many attribute their state to the lack of locally available, affordable, and healthy food in their neighborhoods, rather than insufficient education on how to control their disease. [60]

[60] See note 51

The Economic Impact of Senior Food Insecurity on the District of Columbia [61,62]

The District's aging population offers a wealth of potential benefits, not limited to cultural diversity, experience, and education. According to the AARP Public Policy Institute, the District of Columbia ranks among the top states with older adults who have attained advanced degrees and the percentage of persons taking care of grandchildren. Other studies highlight that elderly adults contribute to efforts that bolster their local economies, as they tend to spend, even during recessions. This fact is even more significant within Washington, D.C., where seniors have one of the highest median incomes in the country. Yet, despite the resources embedded within this generation, the excessive rate of elderly poverty and other indicators of economic hardship portend the potential challenges faced by the city's public health system in the wake of budget cuts, pockets of poor community health, and the aging of the District's food insecure adult population.

> *"The **high cost of medical care and the Boomer population reaching older age** is a **'bomb waiting to explode'** and is expected to have a **negative impact** on the already **scarce caregiver resources and services for older persons**."*
> (DCOA, 2009, p.7)

To estimate the public expenditures necessary to serve adults as they enter the Medicare system, the Mayor's Commission on Food and Nutrition commissioned a report by the Urban Institute in 2007, which compared the public health care expenditures utilized by seniors with nutrition-related diseases in comparison to older adult without these illnesses based on their self-reported health status. For the purposes of this study, the nutrition-related illnesses under examination were cancer, diabetes, and cardiovascular disease, and while these syndromes are not solely diet driven, it is widely acknowledged that adhering to recommended nutritional

[61] See note 28
[62] Ormond, B. "Predicted Health Care Expenditures for a Simulated DC Population Age 65 and Older." September 28, 2007

guidelines and wellness practices greatly reduces their incidence. As expected, elderly people with chronic diseases generated higher annual, per capita, out-of-pocket, and public expenses than individuals without these illnesses. In terms of public health care (mainly Medicare) expenditures, annual per capital costs ranged from $5,592 for individuals with cardiovascular disease to $10,443 for people with diabetes, in comparison with $4,197 and $2,402 spent to care for persons with average and above average health (see Table 6).

Table 6: Predicted Annual Public Health Care Expenditures Per Individual by Age and Condition (for simulated DC population, total in 2007 dollars)

	People with Nutrition-Related Illness				*People without Nutrition Related Illness by Reported Health Status*	
Age Group	**Diabetes**	**Cancer**	**Cardiovascular Disease**		**Good, fair, or poor health**	**Excellent or very good health**
65-69	$10,024	$4,830	$5,171		$2,869	$1,653
70-74	$9,847	$6,024	$4,813		$2,954	$1,760
75-79	$10,082	$7,693	$5,099		$3,627	$2,129
80-84	$10,763	$9,479	$5,928		$4,894	$2,759
85+	$12,854	$9,433	$7,041		$7,298	$4,528
All Elderly	$10,443	$7,811	$5,592		$4,197	$2,402

Source: Ormond, B. "Predicted Health Care Expenditures for a Simulated DC Population Age 65 and Older." September 28, 2007.

Table 7: Predicted Relative Annual Public Expenditures on Health Care for Individuals with Nutrition-Related Illness, by Condition, Relative to Individuals in Excellent or Very Good Health (for simulated DC population)

	Nutrition-Related Illness		
Age Group	**Diabetes**	**Cancer**	**Cardiovascular Disease**
65-69	6.1	2.9	3.1
70-74	5.6	3.4	2.7
75-79	4.7	3.6	2.4
80-84	3.9	3.4	2.1
85+	2.8	2.1	1.6
All Elderly	4.3	3.3	2.3

Source: Ormond, B. "Predicted Health Care Expenditures for a Simulated DC Population Age 65 and Older." September 28, 2007

Similar trends are also evident when comparing the rate of annual expenditures for adults with nutrition-related diseases to those in excellent and very good health. According to Ormond's report (see Table 7), which segregated simulated respondents by age, people ages 85 and above with cardiovascular disease spent 160 percent more than the comparison group (the least), while seniors ages 65 to 69 spent the most, 610 percent. Based on the data collected for this study, while people with diet-related chronic diseases still incurred more out-of-pocket expenses, overall, the per capita range across all groups was less, with diabetics spending approximately 46 percent more—$1,066—than seniors with above average health. However, this judgment is not intended to dismiss the significance of this amount on a household with limited resources. Rather, when contrasted to the predicted annual public health care expenditures, the disparities in cost reveal that the financial costs associated with responding to the health care needs of seniors with nutrition-related chronic diseases is a burden borne by primarily by the District's budget (see Table 8). In comparison to seniors with less than optimal health, chronically ill seniors amass much larger health care expenditures, ranging from an excess of approximately $22.1 million for cancer patients to $96.5 million in additional health care costs accumulated by people diagnosed with diabetes. Health care costs for chronically ill seniors also exceed the expenses of the comparison group of seniors reporting average health, ranging from roughly $32 million to $125.8 million, with residents diagnosed with a form of cardiovascular disease (due to the prevalence among the District's elderly) incurring the most overall, despite the less expensive per capita cost.

Table 8: Predicted Total and Excess Health Care Costs Associated with Selected Conditions in 2007 (for simulated DC population, age 65 or older)				
			Predicted Excess Total Cost Relative to:	
Condition	**Predicted per Capita Cost**	**Predicted Total Cost for DC population**	**People Reporting Good, Fair, or Poor Health**	**People Reporting Excellent or Very Good Health**
Excellent or very good health (estimated population = 11,090)	$3,999	$44,350,068		
Good, fair, or poor health (estimated population = 5,336)	$6,336	$33,809,317		
Diabetes (estimated population = 12,043)	$14,349	$172,796,671	$96,492,223	$124,636,714
Cardiovascular disease (estimated population = 29,826)	$8,215	$245,029,326	$56,051,790	$125,755,152
Cancer (estimated population = 4,199)	$11,610	$48,754,405	$22,149,541	$31,962,604

Source: Ormond, B. "Predicted Health Care Expenditures for a Simulated DC Population Age 65 and Older." September 28, 2007

Part V: Federal and Community-Based Senior Food Programs Available in D.C.

Introduction

As Dr. Torres-Gil observes at the beginning of this report, the societal impact of senior hunger is felt far beyond individual affected households, and the long-term costs associated with prolonged nutritional deficiency inflicts a considerable burden on the public health care system. Considering the direct and indirect correlations between food and economic security, it is equally important to assess the existing options available to people with limited economic means to obtain sustainable sources of food and barriers that prevent their utility. Given the limitations of the formal, private food market in addressing the nutritional requirements of an increasing population of older adults struggling to make ends meet, the programs listed below are designed to fill the gaps that currently prevent more than 5,000 of the District's 60 and older population from attaining food security. While the nutritional content of most of these programs were created based on the special nutritional requirements seniors have, most are not intended to provide complete, comprehensive, nutritional satisfaction to beneficiaries and can only offer food relief to households and individuals seeking these services. With the exception of the Elderly Nutrition Program, all of the federally funded food programs have stipulations on participation, including income/asset limits, enrollment caps, or both. Similarly, the local and discounted food options listed at the conclusion of this section—with the exception of Food and Friends—require monetary contributions, although some organizations may accept Food Stamps in lieu of legal tender.

Supplemental Nutrition Assistance Program/Food Stamps (SNAP)[63]

Background

The Food Stamp program offers special rules for seniors due to the high rate of eligible seniors not applying. According to a 2008 report by the Center on Budget Policy Priorities, approximately 60-70 percent seniors who are rightfully entitled to these benefits do not obtain them[64]. Various surveys, studies, and personal accounts have shed some light on the barriers to senior SNAP participation, and national and local efforts are in place to alleviate some of the real and perceived drawbacks seniors face when applying for Food Stamp benefits. Most grocery stores in the District accept Food Stamps. Here are some incentives and recent changes to the Food Stamp Program that may encourage seniors to participate:

More Interview Options

Some older adults, particularly those who are disabled or homebound, cite the trip to the IMA office and the perceived duration and stress of waiting to be seen as major barriers to applying. However, people 60 and older have several application options, and it is possible for someone to receive food stamps without ever stepping into an IMA office.

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[63] D.C. Hunger Solutions "Getting Food Stamps in the District of Columbia" Date of Access: October 16, 2009 http://www.dchunger.org/pdf/get_foodstamps_dc08.pdf

[64] Dean, S. (2008). "Strengthening the Food Stamp Program to serve low-income seniors." Center on Budget Policy, March 8, 2008. http://www.cbpp.org/files/3-5-08fa.pdf

- Proxy interviews for people who wish to authorize someone trusted to interview with the IMA on their behalf
- Phone interviews and in-home interviews for people experiencing hardship that are unable to travel to the IMA office
- Aging and Disability Resource Center offers comprehensive benefits screening and application assistance for people over 60, and SNAP applications can be submitted there on Thursdays and Fridays
- Social Security office offers SNAP application assistance for all elderly clients and will turn in applications for SSI recipients (only)
- Longer recertification periods of up to 24 months for households where all members are at least 60 years old

Increased Minimum Benefit

With the 2008 reauthorization of the Farm Bill, the minimum SNAP benefit in D.C. increased from $10 to $16 per month. Nationally, the average monthly Food Stamp allotment for people over 60 in 2006 was $74, and, contrary to popular belief, only 17 percent of elderly SNAP recipients received the minimum benefit. [65,66] While the enhancement of the minimum benefit may not sound encouraging to some, many people are unaware that their EBT benefits can rollover up to 12 months. The IMA will not take away benefits that are not immediately spent. Caseworkers are required by law to notify recipients if their benefits are expunged and must reinstate food stamps within 48 hours upon recipients' requests.[67] By the end of the year, accrual of the minimum benefit over the course of a year can total at least $192.

Higher Asset Limits

Some older people who consider applying for SNAP are discouraged due to anecdotal accounts that seniors aren't eligible for food stamps because they own assets (such as a house, personal vehicle, etc.) or make "ten cents over" the gross income limit. While this may be true in some cases, most people are not aware that the asset limit for households with elderly members is $1000 higher ($3000) than households without seniors. Additionally, households including an elderly member are exempted from meeting the Gross Income test.

More Deduction Opportunities

It is important to communicate recent changes to SNAP that have expanded eligibility requirements, particularly to elderly people who many be dissuaded from applying because their gross income may just barely exceed the gross income limit. In addition to the pre-existing opportunities to more accurately reflect one's net income, such as the standard deduction (which recently increased) and earned income deduction, there are other provisions to help reflect expenses that maximize the potential for people 60 and older to receive food stamps.

- Excess Medical Expenses: There is an automatic deduction of $35 for disabled people and adults over 60 and over who pay for health care costs out-of-pocket. If the applicant's

[65] See note 16

[66] Accius, J. (2008). "The Food Stamp Program and Older Americans." AARP Public Policy Institute, October 2008. http://assets.aarp.org/rgcenter/il/fs20r_food_stamps.pdf

[67] See "New Food Stamp Rules" (2009) at http://www.gettingfoodstamps.org/newrules.htm

expenses exceed this amount, then the IMA is obligated to subtract an individual's payments for related expenses, such as transportation, attendant care, and supplement purchases, incurred within a month upon proper verification. Deductions for future costs are also accepted in certain cases with proof.

- Excess Shelter Deductions: This was created to account for shelter-related expenses (e.g. taxes, utilities, rent/mortgage, condo fees, etc.) in cases where these costs exceed more than half of the household's income. Elderly and disabled people are allowed deductions exceeding the $459 cap on this category.

- Elimination of the Child/Dependence Care Deduction: Previously capped at $175-200 per month, this recent change has the potential to help households who may pay for day and/or home care for an elderly member and grandparents raising children.

Other Accommodations for Senior SNAP Applicants

- Seniors are exempted from the Food Stamp Employment and Training requirement.
- Washington Elderly Handicapped Transportation Service (WEHTS) provides curb-to-curb service for residents 60 and older, including those who require wheelchairs, for a nominal contribution
- Facilitating the enrollment of seniors by allowing satellite enrollment at special locations, such as the Aging and Disability Resource Center

Fast Facts on SNAP

- Amount of federal funding (FY 2008): $112,324,800
- Total USDA bonus awards for excellence in SNAP administration (2009): $836,305.
- Rate of SNAP enrollment among participants 60+ (2008): 10.2 percent
- Rate of elderly poverty (65+) in the District: (2008): 19 percent
- Number of participants 60+ (FY 2009 Monthly Average): 6,723
- Number of people ages 60+ below the poverty line (2008): 13,832

Locations of District Food Stamp Offices[68]

Anacostia 2100 Martin Luther King Avenue, SE Washington, DC 20020 Phone: (202) 645-4614 Fax: (202) 727-3527 Monday, Tuesday, Thursday, Friday: 8:15 AM-4:45 PM Wednesday: 8:15 AM-8 PM	**Fort Davis** 3851 Alabama Avenue, SE Washington, DC 20020 Phone: (202) 645-4500 Fax: (202) 645-6205 Monday, Tuesday, Thursday, Friday: 8:15 AM-4:45 PM Wednesday: 8:15 AM-8 PM
Congress Heights 7001 South Capitol Street, SW Washington, DC 20032 Phone: (202) 645-4546 Fax: (202) 645-4524 Monday, Tuesday, Thursday, Friday:	**Taylor Street** 1207 Taylor Street, NW Washington, DC 20011 Phone: (202) 576-8000 Fax: (202) 576-8740 Monday, Tuesday, Thursday, Friday:

[68] D.C. Hunger Solutions. (2009). "How to Get Food in the District of Columbia: A Food and Nutrition Resource Guide."

8:15 AM-4:45 PM Wednesday: 8:15 AM-8 PM	8:15 AM-4:45 PM Wednesday: 8:15 AM-8 PM
H Street 645 H Street, NE Washington, DC 20020 Phone: (202) 698-4350 Fax: (202) 724-8964 Monday, Tuesday, Thursday, Friday: 8:15 AM-4:45 PM Wednesday: 8:15 AM-8 PM	

Commodity Supplemental Food Program (CSFP) [69,70]

Background

In 1969, when CSFP began in the District, eligibility was strictly limited to pregnant/postpartum women, breast-feeding mothers, and children under the age of 6 who met the income guidelines. However, with the development of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) in 1974, which absorbed many potential applicants, enrollment expanded to include low-income seniors in FY 1986. Prior to the passage of the most recent Farm Bill in 2008, which authorizes the program until 2012, children and their caretakers had priority over seniors in the event the caseload cap exceeded demand. While the participation of caregivers and children decreased, senior registration steadily grew and, eventually, surpassed that of the program's original target group. Unlike SNAP, which has guaranteed funding as an entitlement program, CSFP is discretionary and its federal budget, which determines the amount of state participants, fluctuates depending on agricultural appropriations. Although the federal government pays for commodities at-cost and issues grants to the District to cover administrative costs, the District contributes a significant portion of local money to the program as well. Consequently, the USDA Food and Nutrition Service (FNS) issues a cap on the number of people each state/tribal organization can serve, and the District has been exploring several options to facilitate the efficient administration of this program and reduce expenses. Most notably, as of February 2009, the Department of Health (DOH), following the model of other states and tribal organizations administering CSFP nationwide, decided to contract CSFP's community services to the Greater Washington Urban League, a community-based agency, which will oversee day-to-day operations for the program, such as storage, distribution, education, and certification. In August 2009, the enrollment of infants under the age of one was terminated and these cases were referred to WIC.

Enrollment

The following documents are necessary to determine eligibility: photo identification with date of birth, address, and income verification. Recertification usually occurs every six months. Once enrolled, participants (or their proxies) pick up free food packages (valued at approximately $50) at one of the three regular service centers throughout the city or at one of the "bulk sites" (unofficial distribution locations where at least 25 participants are served). Total distribution is roughly split between official and bulk locations. Home-delivery of packages is

[69] "Commodity Supplemental Food Program" Date of Access: October 14, 2009 http://app.doh.dc.gov/services/special_programs/csfp/index.shtm

[70] Interview at DOH: November 24, 2009

possible but it is limited to homebound clients. SNAP—ED, also under the DOH, offers nutritional education, such as a cooking demonstration, on site. [71] Food packages include a variety of nutritious foods, including cereal, canned staples (fruits, vegetables, and meats), and dry/evaporated milk, depending on the needs of the participant and the cost of food. Internal records estimate that CSFP distributes 3,868,200 pounds of food to participants each year.

Special Accommodations for Senior CSFP Participants

Although participants can go to one of the three official locations around the city to collect their packages at any time during the month, many bulk sites and Carver Terrace solely distribute during the third week of the month, a time frequently cited by SNAP and Social Security beneficiaries as when food and monetary resources have diminished. Following the passage of the five-cent bag tax in 2010, the DOH distributed food in free cloth bags and will require participants to bring them when picking up monthly packages. CSFP is one of the few programs that receives outreach assistance from the Social Security Administration (SSA), through which potential beneficiaries receive letters with information on CSFP eligibility. Staff members at East Capitol Service Center make courtesy calls at the end of the month to participants who may have forgotten to collect their food. One site, Carver Terrace, is volunteer-run and serves a high-need population, far from other official/bulk distribution points.

Amount of federal/local funding for CSFP

Year	Federal Grant	Local Funding
2007	**$432,715**	**$1.6 million**
2008	**$434,945**	**$1.6 million**

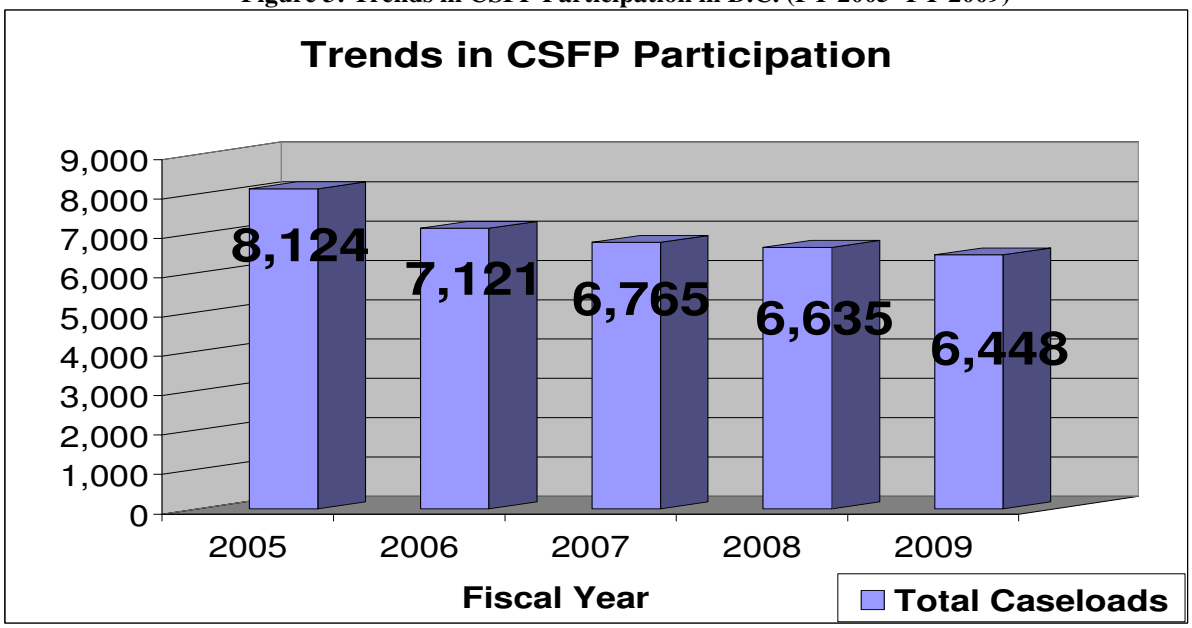
Caseload ceilings for CSFP

Year	Caseload
2007	**7,121**
2008	**6,880**
2009	**6,647**

The annual ceiling for CSFP is determined by the USDA based on the number of participants in the fiscal year prior to the dispensation of federal grant funds. When participation exceeds that of the previous year, the DOH has the option to apply for an increased caseload capacity, and, thus higher federal grant allotment. Conversely, when participation does not meet the ceiling, grant monies decrease; however the DOH can request to maintain the caseload with sufficient justification. In FY 2009, senior participants composed approximately 94 percent of CSFP beneficiaries.

[71] Finegold, K. et. al. (2008). "The Role of the Commodity Supplemental Food Program (CSFP) in Nutritional Assistance to Mothers, Infants, Children, and Seniors." The Urban Institute/USDA ERS, 1-71. http://www.ers.usda.gov/publications/CCR48/CCR48.pdf

Figure 3: Trends in CSFP Participation in D.C. (FY 2005- FY 2009)



Prepared by the author. Source: D.C. Department of Health

Senior Farmers' Market Nutrition Program (SFMNP)[72]

Background

This program has a tri-mission to (a) provide healthy, unprepared produce and herbs to low-income seniors, (b) aid in the expansion and capacity-development for farmers' markets, roadside stands, and community supported agriculture programs, and (c) increase domestic consumption of agricultural commodities. Individuals who meet the income guidelines for CSFP also qualify for "Get Fresh" checks distributed on-site. "Get Fresh" checks can be redeemed as currency at authorized farmers' markets, and seniors are encouraged to visit one of the three area markets (H Street, Silver Spring, and Vermont Avenue) that offer Double Dollar programs. Coupons may only be used between May 1st and November 16th. Participants in the District of Columbia currently receive $30 worth of coupons, the maximum federal allowance. Despite declining participation records , possibly due to fluctuations in CSFP enrollment, the rate of seniors acquiring coupons has decreased 10 percent since FY 2004 (See Table 3). Federal funding has not been impacted, grant for this program has been increasing since FY 2009 (see Table 4). Similarly, the number of farmers' markets accepting vouchers is gradually improving. More than half, 56.5 percent, of the District's farmers' markets participate, well above the national average, 28.2 percent[73] This sustenance could be an indication of its efficacy. In FY 2008, approximately 87 percent of participants utilized the vouchers.

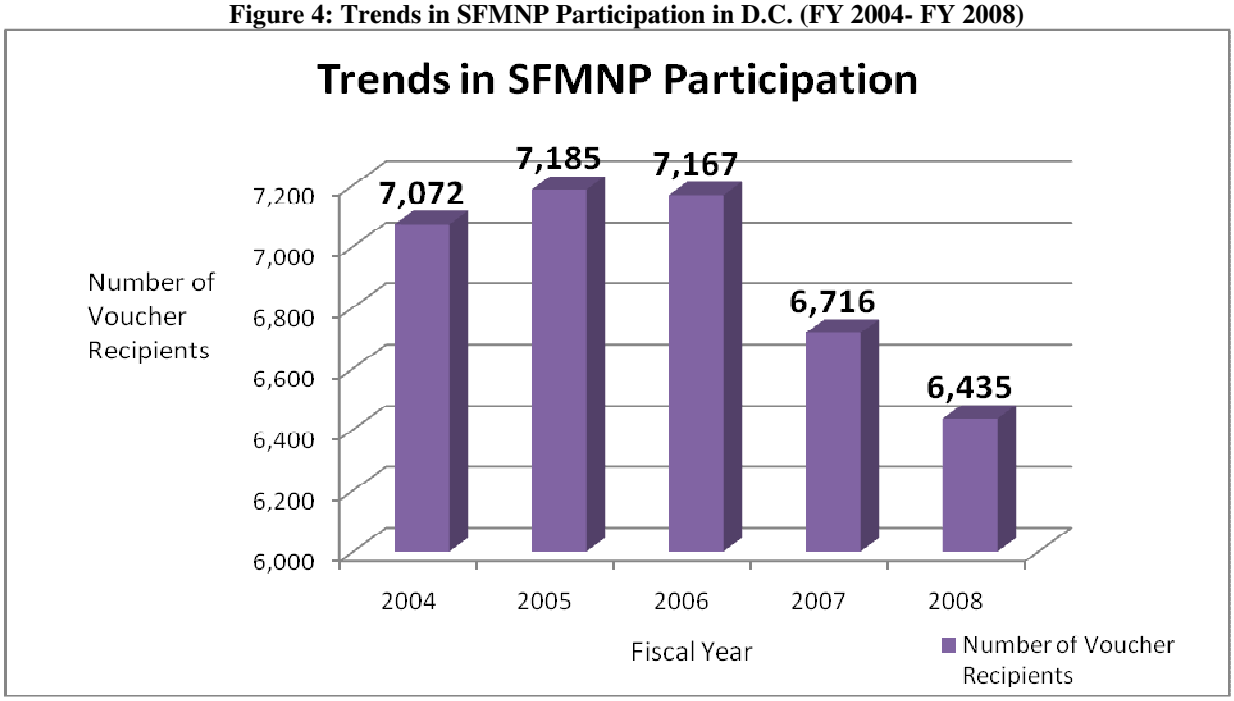
Table 9: Trends in Federal SFMNP Funding (FY 2004-FY 2009)						
	FY 2004	**FY 2005**	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Federal Grant Funding	$142,394	$129,695	$136,989	$139,926	$154,926	$160,312

Prepared by the author. Source: USDA FNS http://www.fns.usda.gov/wic/SeniorFMNP/SFMNPgrantlevels.htm

[72] Food and Nutrition Service "Senior Farmers' Market Nutrition Program" http://www.fns.usda.gov/wic/SeniorFMNP/SeniorFMNPoverview.htm

[73] See a 50 state comparison of fruit and vegetable access here http://www.statehealthfacts.org/comparereport.jsp?rep=53&cat=2&rgnhl=1.

Figure 4: Trends in SFMNP Participation in D.C. (FY 2004- FY 2008)



Prepared by the author. Source: D.C. Department of Health

Locations of CSFP enrollment/SFMNP voucher pick-up sites: [74]

14 Street Service Center 2217 14th St. NW (202) 535-1980 Mon-Fri 8:30 AM-4 PM Enrollment ends at 3 PM	**East Capitol Service Center** 5601 East Capitol St, SE (202) 645-6087 Mon-Fri 8:30 AM-4 PM Enrollment ends at 3 PM
Congress Heights 3720 Martin Luther King Avenue (202) 715-7695 Mon-Fri 8:30 AM-4 PM Enrollment ends at 3 PM	**Carver Terrace** 1115 21st Street, NE (Open the 3rd week of the month ONLY) 3rd Wed., Thurs., and Fri. of the month 8:30 AM - 2:00 PM

Elderly Nutrition Program[75,76]

Background

Administered through the D.C. Office on Aging and funded by Title III (Grants for State and Community Programs on Aging) of the Older American Act (OAA), the Elderly Nutrition Program provides congregate and home-delivered meals to all D.C. residents at or above 60 years of age, regardless of income and served nearly 29,000 clients in 2008.[77] Although seniors

[74] "Distribution Site Phone Numbers" http://doh.dc.gov/doh/cwp/view,a,1373,q,582711,dohNav_GID,1801,dohNav,|33183|33186|,.asp

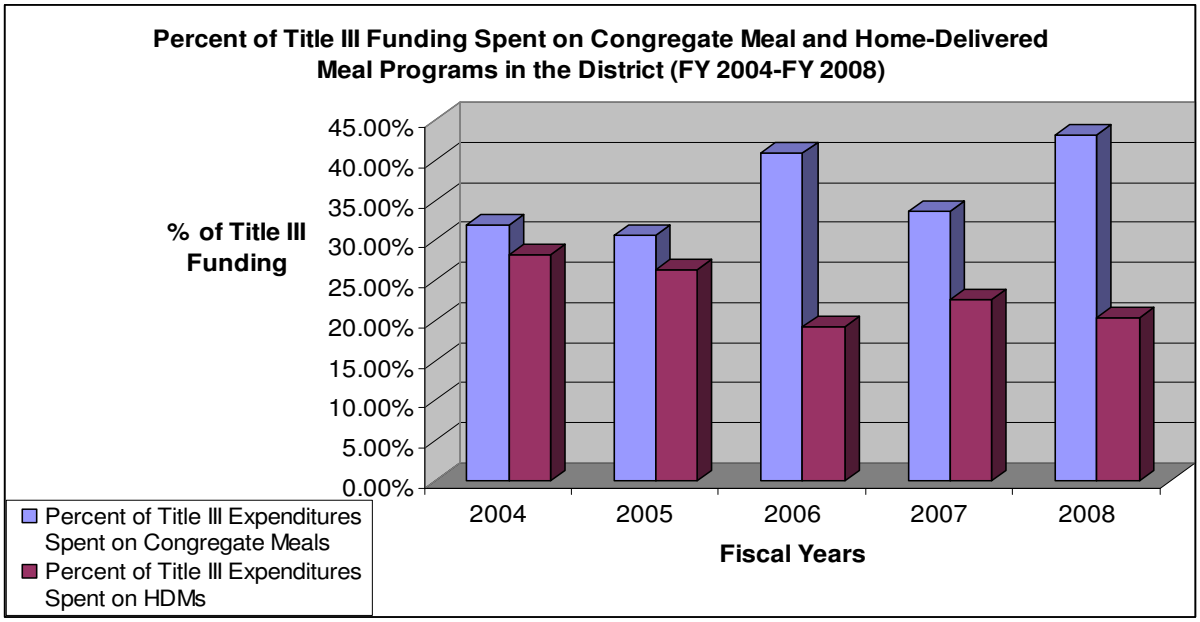
[75] U.S. Department of Health and Human Services—Administration on Aging "Elderly Nutrition Program Fact Sheet." Last modified June 16, 2009 www.aoa.gov/AoARoot/Press_Room/Products.../fs_**nutrition**.doc.

[76] D.C. Office on Aging "Meals and Nutrition" http://dcoa.dc.gov/dcoa/cwp/view,a,3,q,524380,dcoaNav,%7C31411%7C.asp

[77] For links to annual State Reports visit http://www.aoa.gov/AoARoot/Program_Results/SPR/2008/Index.aspx#state.

are the focus of the program, spouses of seniors, some disabled residents, and other special population receive meals through the ENP. Federal guidelines mandate that meals meet at least one-third of the USDA's recommended dietary allowances; however, many consumers actually obtain 40-50 percent of their required nutrients through this service, according to the Administration on Aging. In addition to providing nutritional benefits, counseling, and education, one of the goals of this program is to increase social opportunities for participants by providing community-based services, thus facilitating seniors who wish to age in place. While these services are available to all elderly people, the OAA recommends targeting these programs to those who are in need of extra social and economic support—that this, those with limited English proficiency, members of ethnic/racial minority groups, residents of rural communities, people with limited financial resources, and seniors at-risk for institutionalization.[78] Research on the effectiveness of these programs has found that, compared with nonparticipants, seniors who take advantage of these services are better nourished and more socialized.[79] Unlike the Food Stamp Program, ENP is not an entitlement program, and potential clients may be denied immediate service and fielded to waiting lists based on demand and the availability of resources. In addition to local contributions, additional resources is also leveraged through the Nutrition Services Incentive Program, authorized under section 311 of the Older Americans Act, which allocates annual grants to states based on the amount of meals they report. Grants are dispensed as cash or as USDA commodities, based on the state's request, and, for FY 2009, the District received $645,836.[80]

Figure 5: Title III Funding (%) for the Congregate Meal and HDM Programs in D.C. (FY 2004- FY 2008)



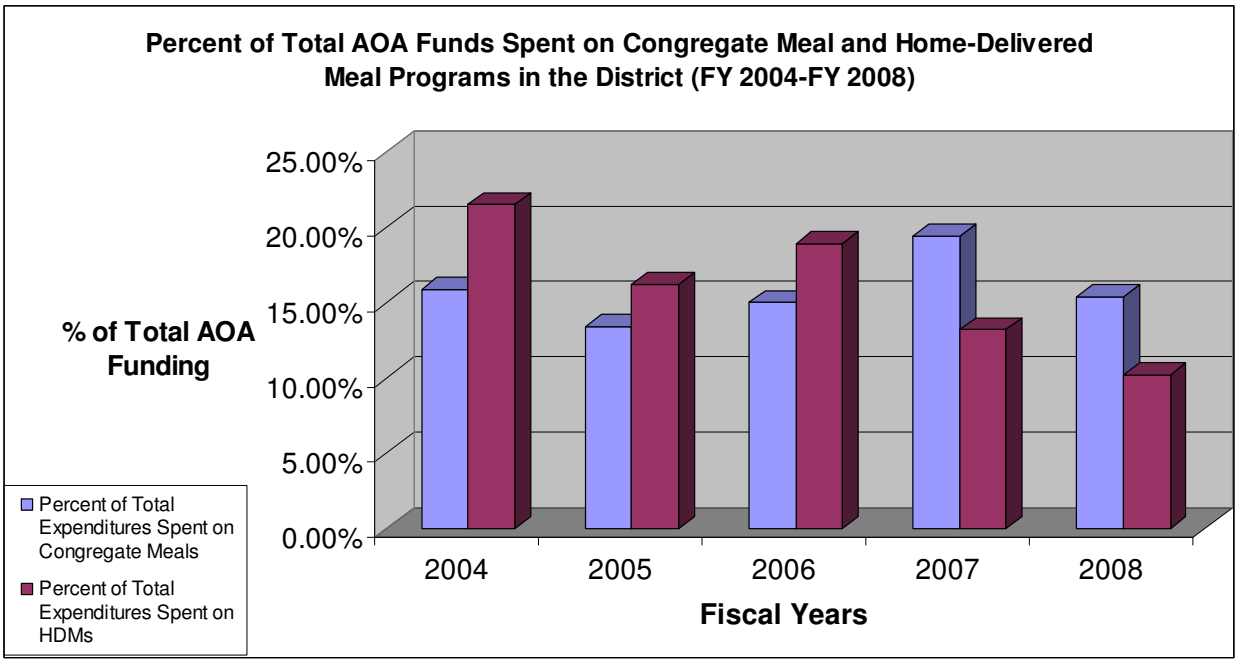
Prepared by the author. Source: AOA records compiled on the Aging Integrated Database www.agidnet.org/

[78] U.S. Department of Health and Human Services—Administration on Aging "Nutrition Services" Last modified: November 29, 2009. http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/Nutrition_Services/index.aspx

[79] Millen, B., et. al. (2002). "The Elderly Nutrition Program: An Effective National Framework for Preventative Nutrition Interventions." *Journal of the American Dietetic Association. 102* (2): 234-240.

[80] For a list of all NSIP grantees and grant allocations for 2009 see http://www.aoa.gov/AoARoot/AoA_Programs/OAA/Aging_Network/State_Allocations/docs/FY2009NSIPStateAwards.pdf.

Figure 6: Total AOA Funding (%) for the Congregate Meal and HDM Programs in D.C. (FY 2004- FY 2008)

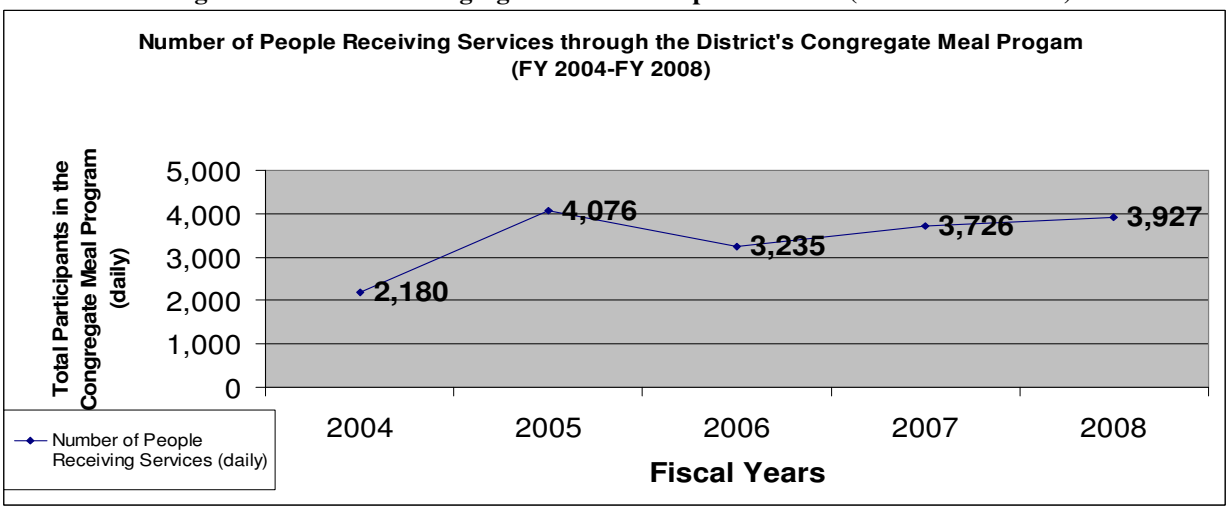


Prepared by the author. Source: AOA records compiled on the Aging Integrated Database www.agidnet.org/

"Meals with Friends" (Congregate Meals)

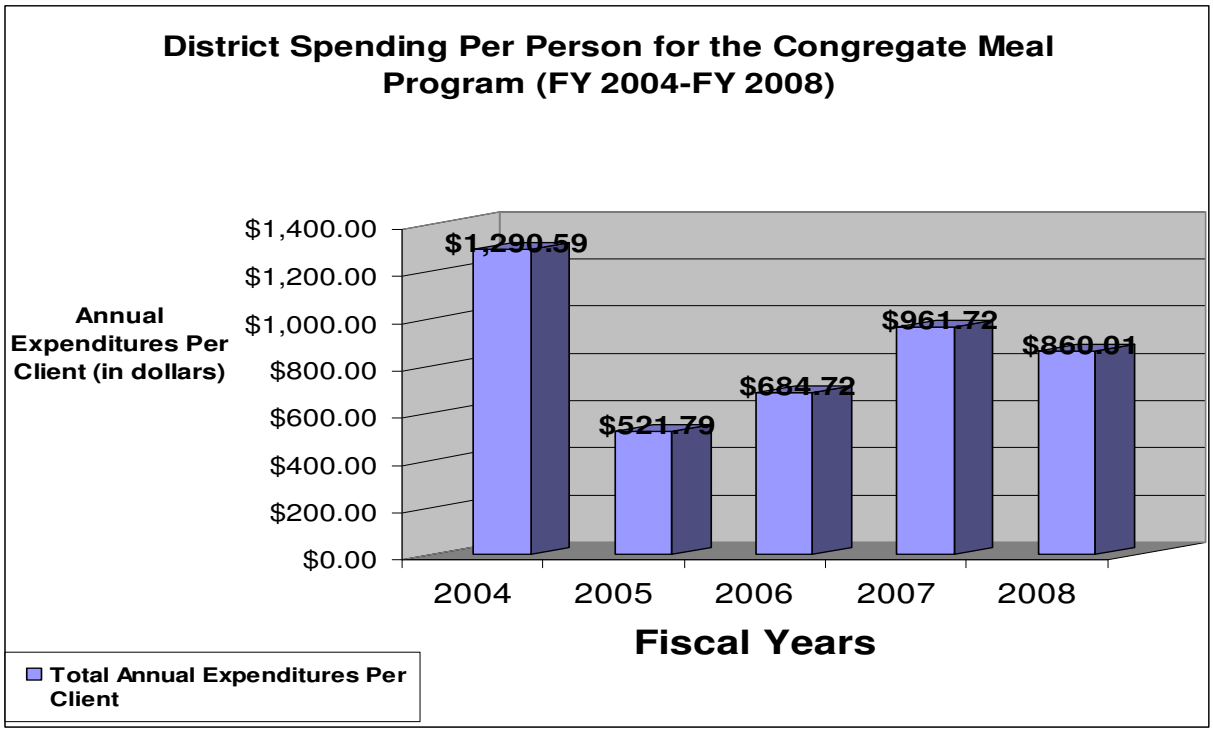
From 2007-2008, approximately $878,000 was allocated towards Congregate Meal services in the District. Serving meals to nearly 4,000 seniors daily, the D.C. Office on Aging coordinates this distribution to roughly 50 community sites around the District through Nutrition, Inc., a private organization hired to oversee meal preparation and delivery. Typically served around mid-day, these hot meals are available at a variety of locations where seniors can eat in community and glean advice about their nutritional needs. Older adults who wish to join should contact the D.C. Office on Aging Lead Agency in their respective Ward to find a nearby site. While there are sites that offer lunch during the weekend, most locations only serve food five days a week at no cost, but contributions are encouraged.

Figure 7: Number of Congregate Meal Participants in D.C. (FY 2004- FY 2008)



Prepared by the author. Source: AOA records compiled on the Aging Integrated Database www.agidnet.org/

Figure 8: Local Funding for the Congregate Meal Program in D.C. (FY 2004- FY 2008)



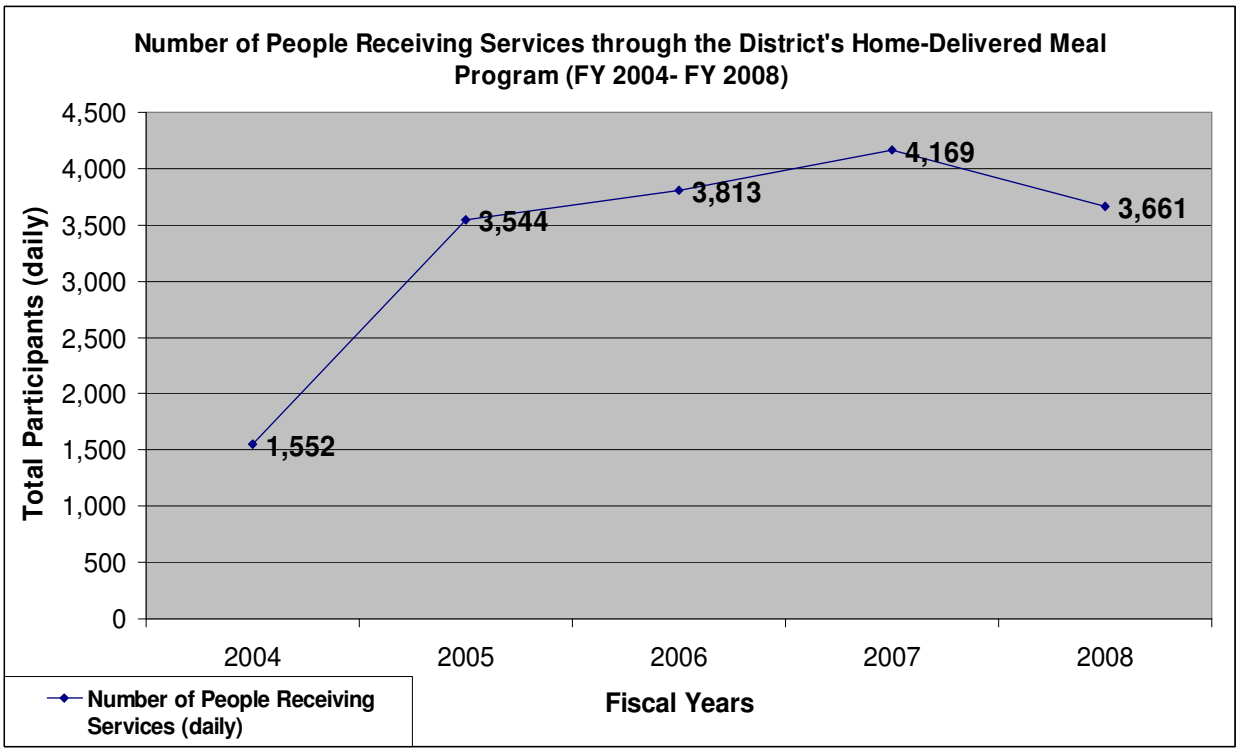
Prepared by the author. Source: AOA records compiled on the Aging Integrated Database www.agidnet.org/

Home-Delivered Meals(HDMs)

The D.C. Office on Aging also subsidizes the delivery of free hot and cold meals to elderly and disabled people who are homebound or may be unable to shop and cook for themselves. Enrollment is arranged through DCOA Lead Agencies listed below. As in "Meals with Friends," while payment is not required, voluntary monetary contributions are accepted. Eligibility is determined through a nutritional screening and assessment, which establishes clients' dietary needs and whether they should receive weekend and/or weekday meal service. Due to the amount of requests for the program (one site serves approximately 300 people), and the number of social workers on site (typically one), there may be a gap between the time that participants request services and when meals are actually delivered. Iona Senior Services has addressed this barrier by conducting intake interviews over the phone to reduce delays in service. According to a 2003 evaluation of ENP, this program has demonstrated effectiveness in reaching high risk populations, as 73 percent of clients served were at high risk for malnourishment. Furthermore, based on health care costs, this preventative service has proven to be more cost-effective than the alternatives of non-treatment—one day of hospitalization costs more than the amount annually spent to feed an individual though the Home-Delivered Meal program. In recognition of the impact of this program on relieving residents and caregivers in need, the DCOA invested in three additional meal delivery trucks with the capacity to serve up to 192 elderly people.[81]

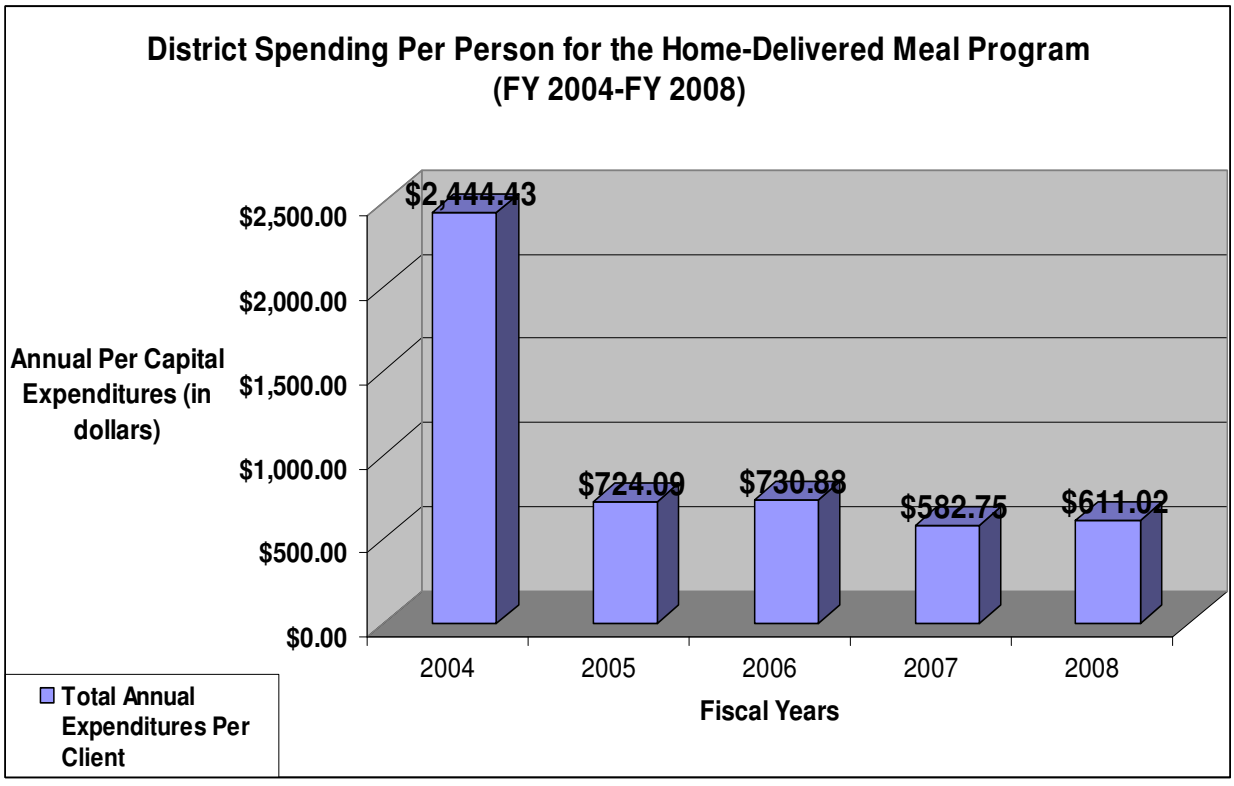
[81] DCOA news release "Fenty Launches Long-Term Care Campaign." October 23, 2009 http://newsroom.dc.gov/show.aspx/agency/dcoa/section/2/release/18412.

Figure 9: Number of HDM Participants in D.C. (FY 2004- FY 2008)



Prepared by the author. Source: AOA records compiled on the Aging Integrated Database www.agidnet.org/

Figure 10: Local Funding for the HDM Program in D.C. (FY 2004- FY 2008)



Prepared by the author. Source: AOA records compiled on the Aging Integrated Database www.agidnet.org/

D.C. Office on Aging Lead Agencies[82]

Wards 1 and 4 Barney Neighborhood House Senior Program 504 Kennedy Street, NW Phone: (202) 939-9020 Fax: (202) 939-5755	**Ward 2** Emmaus Services for the Aging Fleming Nutrition Center 1426 9th Street, NW Phone: (202) 745-1200 Fax: (202) 745-1246	**Ward 3** (West of Rock Creek Park, Foggy Bottom and Dupont Circle) Iona Senior Services 4125 Albemarle Street, NW Phone: (202) 966-1055 Fax: (202) 895-0244
Ward 5 Episcopal Senior Ministries 2900 Newton Street, NE, 1st Floor Phone: (202) 529-8701 Fax: (202) 832-0127	**Wards 6** South Washington West of the River Family Strengthening Collaborative Capitol Hill Towers 900 G Street, NE, 4th Floor Phone: (202) 608-1340 Fax: (202) 698-0529	**Ward 7** East of the River Family Strengthening Collaborative 3732 Minnesota Avenue, NE Phone: (202) 397-7300 Fax: (202) 397-7882
Ward 8 Downtown Cluster's Aging Services 2447 Good Hope Road, SE Phone: (202) 610-6103 Fax: (202) 610-6108		

- *Non-government Food Programs*

In addition to the plethora of soup kitchens, food pantries, and food banks located throughout the Capitol, there are many other meal programs and low-cost grocery opportunities available for seniors seeking to enhance their access to nutritious and age-specific food.

Name	Type	Description	Cost	Contact Information
Angel Foods Ministries	Low-Cost Groceries	National program that offers a variety of monthly food packages available at discounted prices though local host sites, includes heat and serve meals for seniors	**Accepts Food Stamps** Packages range from $18 (10lb chicken wing box to $35 (6lb seafood); Senior package costs $28	Sophia Carter 202-484-3184 Bethel Pentecostal Tabernacle 60 I St SW Washington, DC 20024 202-484-0730 www.bethelatcapitolhill.org To find other sites around D.C., call 1-888-819-3745

[82]D.C. Office on Aging "Role of the Lead Agency" http://dcoa.dc.gov/dcoa/cwp/view,a,1209,q,523372.asp

D.C. Produce Cooperative & Healthy Solutions	Low-Cost Groceries	Offers organic, fresh fruit and vegetables year round	Individual item costs can vary; "Freggie boxes" can range from $15-$65 depending on size	Healthy Solutions Group 1-888-415-COOP (2667) http://producecoop.com/ info@producecoop.com
Food and Friends	Meal/ Grocery Delivery	For people living with HIV/AIDS, cancer, and life-challenging illnesses; Services include meal and grocery delivery in addition to nutritional counseling	None	219 Riggs Road, NE Washington, DC 20011 Main number: 202-269-2277 Fax: 202-635-4265 info@foodandfriends.org
Meals on Wheels	Meal delivery	Brings hot and cold meals to homebound seniors and disabled adults; Not available in all areas	Range from $25-$44/week; Discounted or free meals are limited but available at certain sites for low-income participants	**New York Avenue** 1313 New York Avenue, NW 202-393-3949 Service area: Northwest D.C., parts of Wards 1, 2, 3 **Parishes United** Providence Hospital 4520 12th Street, NE (202) 635-8985 Service area: Parts of Northeast D.C., Ward 5 **Upper Northwest** 6100 Georgia Avenue, NW 202-723-5617 Service area: Upper Northwest, Ward 4 **Ward Circle—Georgetown Meals on Wheels** 4101 Nebraska Avenue, NW 202-966-8111 Service area: Dupont Circle, Western Avenue, west of Rock Creek Park

SHARE Food Program	Low-Cost Groceries	Located and many host sites throughout the Metro area, this program provides monthly discounted grocery package in exchange for volunteer service	**Accepts Food Stamps** Value package ranges from $20-$40, depending on size; Offers specialty packages during holidays	To locate a host site nearby, call 301-864-3115 or toll free at 1-800-217-4273 http://www.sharedc.org/

Table 10: Evaluation of Senior-Serving Nutrition Programs in the District

Federal Nutrition Program	Number of Clients 60+	Barriers to Utilization	Opportunities for Growth
Supplemental Nutrition Assistance Program (SNAP)	(2009) 6,723	• Lack of awareness about program changes, accessibility accommodations, and transportation options available through the DCOA • Perception that most seniors qualify for the minimum benefit • Need for application, recertification assistance	• Implementing an online application, document imaging, and other paperless system technology to improve efficiency, timeliness, and customer service • Offer SNAP enrollment training to senior service providers and discount grocery purveyors that accept Food Stamps
Commodity Supplemental Food Program (CSFP)	(2009) 6,448	• Discretionary federal program whose budget is capped and future is uncertain • Limited budget, staff, and resources for outreach and marketing • DC CARES, the current client information database and tracking system, is closed-in and unable to share information with other systems within the DC Health and Human Services network	• Feature Food Stamp information at CSFP sites • Add D.C. Hunger Solutions Food Resource Guides to the packages of new enrollees • Adopt a different client tracking system, such as the DCOA's Harmony, in order to share client info. between agencies • Target nutritional education towards participants with nutrition-related chronic illnesses • Modify food packages of high-risk clients to adapt to their special dietary needs • Develop a referral system for health care providers who identify seniors at-risk for malnutrition
Senior Farmers' Market Nutrition Program (SFMNP)	(2008) 6,435	• Eligible but non-participants in CSFP cannot obtain SFMNP coupons • Coupons only valid during late summer and fall	• Increase D.C. farmers' markets participation to 100 percent • Expand eligibility to seniors outside of CSFP

Elderly Nutrition Program (ENP)	(2008) Congregate Meals 3,927 Home-Delivered Meals 3,661 Nutrition Counseling 423	• Unexplained fluctuations in participation • Serves a relatively low proportion of the senior population	• Conduct nutritional screenings over the phone to reduce service gaps among home-delivered meal clients • Adopt evidence-based, outcome-driven models of service, such as comparing ENP participants' health versus that of non-ENP users, evaluating client satisfaction, and similar business strategies, to better target nutritionally at-risk individuals • Improving coordination between DCOA Public Health Nutritionist and Meal Coordinators to enhance targeting of food insecure seniors, communicating and sharing effective approaches to service delivery, and recommend improvements • Continue monitoring the nutritional status of clients with high and moderate-risk to determine if additional nutritional assistance is needed, and offer SNAP enrollment assistance

Part VI: How Nutrition Programs and Strategic Outreach Can Relieve Senior Hunger in the District

1. Improve SNAP Access for Senior Households in the District

- **Design a Combined Application Project (CAP)**

  The purpose of this demonstration is to increase SNAP usage among single-person, elderly, and disabled households that qualify for SSI and SNAP without the requirement of an in-office interview, and has been proven effective for many states. Sanctioned through an initial trial in South Carolina during 1994, as of October 2009, over 20 states were in the process of implementing a CAP project[83]. While clients applying through the Social Security Administration do not have the option to apply deductions to determine their benefits, they do receive a set amount of benefits per month and an annual cost of living increase. Through the exemption of dual-applicants from compulsory Food Stamp

[83] USDA Food and Nutrition Service (October 2009) "CAP Status Report" http://www.fns.usda.gov/FSP/government/pdf/2009_CAP-status.pdf

interview and separate application, the final product is a simplified, streamlined approach to reach a population at high-risk for food insecurity and typically reports low participation rates in national evaluations. SSI clients with high shelter, medical, or other expenses that may enhance their Food Stamp receipt, have the option to apply separately.

- **Adopt a simplified application for seniors with the implementation of categorical eligibility**

  Some states also offer different applications for special populations. A common reason for not applying cited among many older non-participants is the perceived burden involved in filling out lengthy forms and acquiring the documents necessary to initiate the application process. Yet, many of the questions on the current SNAP application utilized by the IMA do not apply to most elderly clients and should be reevaluated as categorical eligibility comes into effect. Several other states (such as South Carolina[84], Rhode Island[85], and Massachusetts[86]) have condensed their applications to three pages or less, versus the six-page general application currently available in the District. Additionally, initial and recertification applications should include provisions for elderly applicants, such as the right to waive face-to-face interviews for clients facing hardship and providing a space to indicate the absence of earned income. [87] Other SNAP policy options that improve outcomes for elderly clients include, Simplified Housing Costs (minimizes deduction errors for homeless seniors) and the Simplified Determination of Deductions (disregards changes certain in costs, such as medical expenses, which could cause unnecessary payment errors and case complications).[88]

- **Expanding the use of Food Stamps to purchase prepared food through Meals on Wheels programs and approved restaurants**

  While SNAP is beneficial in helping older adults who are independent or have assistance in shopping and preparing food, the advantages of this program may not be accessible to older residents with physical or mental limitations that prohibit the conventional use of SNAP benefits. Similarly, homeless Washingtonians, some of who are seniors, without access to cooking space could benefit from additional food options. The state of California has taken advantage of a provision of the Food Stamp Program that allows authorized restaurants to accept EBT benefits from people 60 and older, disabled, and homeless individuals. The USDA also advertises expanding the use of Food Stamps to buy prepared food through Meals on Wheels programs, a service that may currently be too expensive for some low-income seniors in the District.

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[84] To view an example of the South Carolina Elderly Simplified Application Project (ESAP) visit https://dss.sc.gov/content/library/forms/files/16176.pdf

[85] To view an example of the Rhode Island SNAP application visit http://www.dhs.ri.gov/Portals/0/Uploads/Documents/FormsApps/SNAP_app_elders.pdf

[86] To view an example of the Massachusetts SNAP application visit http://www.mass.gov/Eeohhs2/docs/dta/c_snapapp_elderly_eng.pdf

[87] 7 CFR 273.2(e)(2)

[88] To review the options available to states with SNAP programs see http://www.fns.usda.gov/fsp/rules/Memo/Support/State_Options/8-State_Options.pdf

2. Coordinate and Expand Benefits for Seniors by Leveraging Existing Resources

- **Promote the Child and Adult Care Food Program (CACFP) among adult day care centers and address barriers to participation**

Background

Primarily serving children up to 18 years of age, the Child and Adult Care Food Program (CACFP) also provides monthly reimbursement for snacks and meals served by licensed or approved adult day care facilities that provide non-residential care to low-income, functionally-impaired adults so that their clients can receive healthy food, based on the USDA's Food Pyramid Guide. Nationally, this program offers affordable nutrition options to 86,000 older adults. Despite its proven efficacy in child care centers, none of the adult facilities in the District have adopted the program. National payment rates are adjusted annually to reflect changes in the Consumer Price Index. Different rules for non- and for-profit institutions apply. Approval for CACFP is contingent on centers offering an individualized plan of care intended to cater to the unique health, social, and related needs of their clients. Qualifying centers are also eligible for a variety of supplemental benefits, including training, technical assistance, and education on nutrition and food safety.

Qualifications

Eligibility is excluded to individuals who reside at an institution, regardless of income, and facilities that receive Title III funding. Tier I rates apply to home-based centers located in low-income areas or when the sponsor's income is below 185 percent of the federal income poverty guideline. Tier II rates apply when the center is not eligible for Tier I but client's income falls within 185 percent of the federal poverty guideline, thus enabling the recipient to qualify for free or reduced-price meals that would be reimbursed to the center.

Table 11: CACFP Reimbursement Rates/Meal for Day Care Centers, Effective from July 1, 2009-June 30, 2010[89]

	Breakfast	**Lunch and Supper**	**Snack**
Paid	0.26	0.25	0.06
Reduced Price	1.16	2.28	0.37
Free	1.46	2.68	0.74

Adapted from the USDA FNS, http://www.fns.usda.gov/cnd/Care/ProgramBasics/Rates/cacf09-10t.pdf

Table 12: Reimbursement Rates/Meal for Day Care Homes, Effective from July 1, 2009-June 30, 2010[90]

	Breakfast		**Lunch and Supper**		**Snack**	
	Tier I	Tier II	Tier I	Tier II	Tier I	Tier II
Reimbursement rates	1.19	0.44	2.21	1.33	0.66	0.18

Adapted from the USDA FNS, http://www.fns.usda.gov/cnd/Care/ProgramBasics/Rates/cacf09-10t.pdf

[89] These rates do not include agricultural commodities or cash-in-lieu of commodities offered to participating CACFP sites

[90] While all home care providers qualify for Tier II rates, some may be eligible for enhanced reimbursements under Tier I for some or all of the meals based on the income of the provider and/or the clients

- **Explore an auto-enrollment agreement between the IMA and the Department of Energy to enroll SNAP clients in utility discount programs and stem the seasonal spikes elderly food insecurity**

  Mark Nord's (2006) article[91] describing seasonal variations of senior hunger attributed this occurrence to the increase in heating and cooling utility expenses and their detriment to limited food budgets. As with many of assistance opportunities available to older adults, many potentially eligible recipients are not aware of that they can qualify. The state of Massachusetts has taken the lead to address this issue by relaying client information to utility companies that serve SNAP households. Additional permission from the applicant is not necessary as this agreement is automatically conferred through a waiver included with the client's application for SNAP benefits.

- **Utilize the Aging and Disability Resource Center (ADRC) as a site for benefits outreach and enrollment**

  With the support of the National Center for Benefits Outreach and Enrollment, several state Agencies on Aging have adapted their local ADRC into a hub for interested seniors and community partners to refer clients in need of extra assistance. Because many of the senior nutrition programs are operated by different agencies, and some community organizations only know about emergency food services, hungry residents may not be have access to the program most appropriate for their needs. Since the ADRC is expected to serve as a referral point for difficult to reach populations, this center has the potential to inform other senior-serving agencies seeking to target their services to underserved elderly clients. Finally, as some clients encounter issues in claiming, using, or reapplying for benefits, such as SNAP, the ADRC can serve as a clearinghouse for benefits disputes and resolution. Currently, the ADRC works in collaboration with the Department of Health Care Finance and the Income Maintenance Administration but not the Department of Health. Providing comprehensive benefits outreach, enrollment, and nutritional screening during the intake process helps cultivate informed decision-making for clients as well as the agencies that serve them.

- **Use data-matching to enhance nutritional, economic, and health care outcomes among low-income seniors through more efficient and targeted outreach**

  In these trying economic times, the efficient utilization of scare resources is a high priority for both seniors living on fixed incomes as well as the agencies that serve them. Research and existing participation rates already indicate demographic groups that under-participate in nutrition programs, such as SNAP. According to estimates from 2006, only 42 percent of eligible District residents aged 60 and older received Food Stamps.[92] To address this gap in service, the District of Columbia should explore data matching models applied in other states, namely New York and Massachusetts, to determine how to balance the competing interests of maintaining client privacy while maximizing the accessibility of useful services to residents in need. Based on the level of client consent

[91] See note 28
[92] See note 7

the District deems appropriate, using data-matching strategies can identify specific households and send pre-populated applications to potential enrollees, or simply identify geographic areas using GIS mapping to designate targeted outreach campaigns. When the New York City Council finished a data-matching project to pinpoint Medicaid recipients who are eligible food stamps but not enrolled, 600,000 citizens received notice of their possibility for enrollment.[93] It would also be wise to coordinate with other programs already within the DCOA Senior Service Network to facilitate data collection, outreach, and targeting potential clients

- **Develop a referral system for care providers who identify community-dwelling seniors at-risk for under-nutrition**

  As more older adults choose to "age in place," or utilize community-based services to prevent institutionalization, it is important to train staff members who work with older adults to identify signs of under-nutrition and provide a system for all senior-serving organizations to report and manage cases of seniors who are not eating, particularly in cases where poverty is the cause. Additionally, even though malnutrition has been linked to longer hospital stays and increased in-hospital health complications, including death, some health care providers do not administer nutrition screenings to their older patients.[94] Through the integration of a system of under-nutrition identification and intervention, the District can facilitate better outcomes for both older Washingtonians and the public health care system.

- **Adding nutritional screening questions to applications used to enroll seniors in nutrition programs**

  Currently, Elderly Nutrition Programs receiving Title III funding administer nutritional screenings when determining in the appropriate services for incoming clients. Based on this ongoing assessment the D.C. Office on Aging identified and 953 clients at nutritional risk thereby enabling providers to tailor services to respond to client needs and make appropriate interventions. This model has proved highly effective and should be expanded to other sites that aim to assist seniors in overcoming barriers to nutritional health.

- **Implement a District Fresh Food Access Initiative to address the grocery gaps in Wards 5,6,7, and 8**

  Elderly Washingtonians with limited financial resources and means of transportation are currently suffering from the dearth of nutritious food options in the District's food deserts. The introduction of a Fresh Food Access Initiative, a public/private strategy to draw grocers and fresh food vendors to underserved communities, has the potential to enhance food security and health outcomes for seniors as well as the community as a

[93] For the official press release describing this initiative, see http://council.nyc.gov/html/releases/pdfs/054_061608_FSDataMatch.pdf

[94] Hajjar, H.H., et.al. (2004) "Malnutrition in Aging." The Internet Journal of Geriatrics and Gerontology. http://www.ispub.com/ostia/index.php?xmlFilePath=journals/ijgg/vol1n1/malnutrition.xml

whole. Other states, namely Pennsylvania (Fresh Food Financing Initiative) and New York (Food Retail Expansion to Support Health), have already experienced success though this pilot and found creative ways to alleviate initial start-up costs by enlisting private and philanthropic financial support. In addition to bringing/retaining employment, promoting community revitalization, and encouraging local spending, adapting this program to the District could play a vital role in addressing the city's high rates of obesity, diabetes, and other nutrition-related chronic illness, which drain public health care coffers and diminish human capital.

The Benefits of Senior Nutrition—How Investment in Senior Nutrition Programs Enhances Long-Term Outcomes for Elderly Washingtonians

Conclusion

The economic crisis of late 2007 has continued to wreak havoc on the financial stability of older citizens, and the District's government has not been spared from the hardship. Many factors, not limited to declining sales, lower income tax revenues, and a rising need for public assistance, have brought about considerable strain on limited state and local governments that is anticipated to persist through the next fiscal year. According to projections from the Center on Budget and Policy Priorities, the District of Columbia experienced a 10.8 percent budget shortfall, totaling $679 million in FY 2009, and can expect to incur another $100 million gap in FY 2011.[95] In a survey of national State Units on Aging (SUAs), one-in-four expressed that scaling back services had become a top priority.[96] Fortunately, the Obama Administration's American Recovery and Reinvestment Act, attempted to cushion SUAs from the mounting costs of delivery by allocating $100 million for the administration of home-delivered and congregate meals, key senior nutrition programs. Yet, as these funds expire on December 30, 2010, this short-term relief will not alleviate the crunch faced by agencies charged with overseeing the food security for a rapidly expanding segment of the District's population.

The District of Columbia should react proactively—immediately—not only to maintain nutrition programs for seniors with limited resources, but to expand these services in order to meet the demands of the aging Baby Boomers, the children they take care of, and adult caregivers responsible for them. Senior nutrition programs benefit community-dwelling seniors

[95] McNichol, E. and Johnson, N. (2010). "Recession Continues to Batter State Budgets; State Responses Could Slow Recovery." Center on Budget and Policy Priorities. Updated January 28, 2010, http://www.cbpp.org/files/9-8-08sfp.pdf.

[96] National Association of State Units on Aging "The Economic Crisis and Its Impact on State Aging Programs—Results of All-State Survey." November 2009, http://www.hapnetwork.org/assets/pdfs/hen/nasua-economic-crisis-report.pdf.

by addressing immediate food needs, increasing social opportunities, and offering tools, such as nutrition education and screening that help older residents enhance their quality of life and maintain independence. Momentarily overlooking the non-economic impact of alternate outcomes for vulnerable older populations (e.g. nursing home/hospital admission, the development of chronic illnesses, and death), the costs of treating the effects of elderly malnutrition inflict a much stronger fiscal detriment on the District's resources than preventative measures. According to the AARP, the Washington, D.C. has the highest proportion of nursing facility residents, approximately 80 percent, citing Medicaid as their primary payer.[97] Furthermore, under-nourished older adults have weaker immune systems, higher risks of disability, typically longer hospital stays, and accrue greater public health care expenses. As frequently referenced by Administration on Aging, it costs less to feed seniors for a year than it does to hospitalize a patient for a day. Investment in nutrition and the agencies that oversee these services can reintroduce money into the economy through local food purchasing, promoting the District's long-term care campaign, and stem mounting public health care expenditures through the prevention of premature nursing home enrollment, hospitalization, and health-related complications. Because the senior-serving nutrition programs described in this report have demonstrated success in enhancing access to positive nutritional and, thus, health outcomes for thousands of older Washingtonians, the District must (a) eliminate gaps in benefits, access, and service, that prevent the full utilization of these programs; (b) maintain and enhance funding to senior-serving programs that have proven effective in promoting nutrition; and (c) collaborate with community partners and leverage public and private resources to expand food access opportunities to all food insecure populations within the Capitol.

[97] See note 48