

**STRENGTHENING OUR COMMITMENT TO
MINNESOTA SENIORS: PROMOTING INDEPENDENT
LIVING THROUGH THE OLDER AMERICANS ACT
REAUTHORIZATION**

HEARING
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

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**STRENGTHENING OUR COMMITMENT TO
MINNESOTA SENIORS: PROMOTING
INDEPENDENT LIVING THROUGH THE OLDER
AMERICANS ACT REAUTHORIZATION**

FRIDAY, SEPTEMBER 10, 2010

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Maple Grove, MN.

The Committee met, pursuant to notice, at 1:30 p.m., in the
Maple Grove Community Center, Hon. Al Franken, presiding.
Present: Senator Franken [presiding].
Index: Senator Franken.

OPENING STATEMENT OF SENATOR AL FRANKEN

Senator FRANKEN. I now call the Special Committee on Aging
Hearing on the Reauthorization of the Old Americans Act to order.
Thank you all for turning out. Thank you to the Maple Grove Com-
munity Center for hosting this event. This is an official hearing of
the Senate Special Committee on Aging, and we'll be hearing from
a number of key experts on aging.

I'm pleased that additional experts have submitted testimony for
the record. I welcome everyone in attendance also to submit any
comments you have about today's hearing to my office using the
form that you received when you came in.

I'm pleased to have the opportunity to discuss this important law
and to hear your recommendations for improving it. I'm proud to
sit on two key Senate committees that oversee senior services and
I want to make sure that we're doing all that we can so that Min-
nesota seniors remain independent and healthy for as long as pos-
sible.

So, thank you all for being here to be part of the Reauthorization
of the Older Americans Act, and to share your expertise on seniors
issues in Minnesota and across the nation.

The Older Americans Act funds many crucial programs for our
seniors, Meals on Wheels, caregiver support, health promotion,
elder abuse prevention, and much, much more. These programs are
cost effective with a high return on investment. In Minnesota we
spend an average of \$4,900 per month for a resident in a care center,
as compared to \$2,700 for those seniors we support to stay at
home. That's real savings, and that's why it's important that we're
not pennywise and pound foolish by underfunding these programs

that help people stay in their homes. Keeping people out of nursing homes saves money and it's what seniors want; it's win/win.

The Older Americans Act became law in 1965 when the country was concerned seniors were not getting the services that they needed. Today, 45 years later, we've made progress in many areas, but we still have a lot to do to ensure that seniors have the resources they need to be independent and the support they deserve at the end of life. These issues are especially salient now because our country's demographics are changing. Next year, the first baby boomers will begin to turn 65. My brother, Owen, will be 65 next August. I can't believe it, because that means I'm older, too.

Thanks to medical advances and to the boomers' commitment to stay active, boomers are expected to live longer than members of any previous generation. By 2030, almost 20 percent of our population is estimated to be over the age of 65. So now more than ever, we need to be ready to help seniors stay healthy and independent as they age.

During the past few months my staff and I have held 17 listening sessions across the State, actually I asked my staff to do 17, and I got a report back from them, I've done three since. I've learned a lot from these conversations and the information is guiding legislation that I will be introducing this fall. I've learned that Minnesotans, Minnesota seniors, want to stay in their homes as long as possible, and to do that they need access to transportation and other support services. They want nursing home care only when they really need it, and even when they're in a nursing home, seniors don't want to be told exactly when they want to eat and sleep, and they definitely don't want to be forced to go to bed before the Twins game is over. [Laughter.]

Especially this year.

The main message I've heard from Minnesota seniors across the State is that they want to remain vital and active in their later years, they want to take their grandkids fishing, go to the State fair, work in the garden, and be as independent as possible. So, how do we make that happen?

Well, the Older Americans Act does a lot—does a lot to keep our seniors in their homes. A little support goes a long way, and that's what the Older Americans Act is all about.

Today we'll hear testimony from Jan Ferrier from Coon Rapids who uses Older American Act services for leaf raking, snow shoveling, and the occasional lunch at the Coon Rapid's Senior Center. As Jan will tell you, just because you can't shovel your driveway any more, or you need help with meals now and then, that does not mean that you should have to move into a nursing home. It doesn't mean that you should have to give up your independence. Just like Jan, more Minnesota seniors are looking for ways to receive services at home so they can continue to live independently. The demand for home and community-based services is increasing and people are actually moving out of nursing homes to receive care at home.

Minnesota has been at the forefront of this national movement, this culture change to support seniors' independence, and that's why it's critical that we seize the opportunity presented by next year's reauthorization of the Older Americans Act, to increase ac-

cess to high quality home and community-based services for all seniors, whether they're down in Dodge county or right here in the metro area.

When lawmakers passed the Older Americans Act 45 years ago, they tried to anticipate the needs of future generations of seniors. They set up a national infrastructure that included the U.S. Administration on Aging, and State units on aging, like the Minnesota Board on Aging, both of which are represented here today. These agencies are vital resources for seniors and have been successful in helping seniors remain independent. However, many Older Americans Act programs struggle to find enough resources to meet the needs of seniors. We need to take steps to ensure that the Older Americans Act is able to deliver on its promise to support our seniors.

As we move forward with the reauthorization, I'm committed to championing legislation that builds on Minnesota's leadership in aging services, like our State's Homecare Bill of Rights, and the report card on quality for home and community-based services. I want to strengthen the Older Americans Act for Minnesota seniors and I'm looking forward to hearing from our witnesses about the opportunities they see for promoting senior independence in the reauthorization.

Thank you all again for being here, and thank you to those who submitted testimony for publication in the Congressional record in connection with today's hearing.

I would like now to introduce Jim Varpness, Regional Administrator for the United States Department of Health and Human Services Administration on Aging. Mr. Varpness is filling in for Assistant Secretary Kathy Greenlee of the Administration on Aging whose flight was unfortunately delayed and unable to join us today. Mr. Varpness was kind enough to fly in today from Chicago to deliver Assistant Secretary Greenlee's testimony and answer questions on her behalf.

Mr. Varpness currently oversees the administration of the Older Americans Act in Minnesota and the Midwest, and has over 28 years of experience with Minnesota's aging services. Prior to his current position at the U.S. Administration on Aging, Mr. Varpness served as the Executive Director of the Minnesota Board on Aging and the Director of the Division of Aging Services at Minnesota's Department of Human Services. He was also Director of Minnesota's Office of the Ombudsman for long-term care. Mr. Varpness holds a Masters in Public Administration from Hamlin University.

Thank you, Mr. Varpness for joining us today on such short notice, and I look forward to hearing your testimony delivered on behalf of Assistant Secretary Greenlee. Thank you.

**STATEMENT OF JIM VARPNESS, REGIONAL ADMINISTRATOR
FOR THE UNITED STATES DEPARTMENT OF HEALTH AND
HUMAN SERVICES ADMINISTRATION ON AGING**

Mr. VARPNESS. Thank you, Senator Franken, and again, I extend Assistant Secretary for Aging Greenlee's apologies for not being able to be here. But as you know, when they tell you there's something wrong with the plane, you don't get on it. So—

Senator FRANKEN. Smart, smart policy.

Mr. VARPNESS. Yeah, she's a very smart lady.

Anyway, thank you, Senator Franken for the opportunity to testify before the Senate Special Committee on Aging hearing on the upcoming reauthorization of the Older Americans Act. We're pleased to discuss our efforts to solicit input from throughout the country and to hear Minnesota's perspective on this important legislation that provides vital home and community-based services to older adults and their caregivers.

At the outset, we would like to commend you, Senator, for your leadership as a member of the Senate Special Committee on Aging, as well as a member of the Committee on Health, Education, Labor and Pensions, Judiciary Committee, and the Senate Committee on Indian Affairs, whose jurisdictions impact many of the Older Americans Act programs and services administered by the Administration on Aging. We are grateful for the support you have provided for Older Americans Act programs and especially for your strong interest in consumer fraud and elder rights issues.

We're impressed by the level of commitment and dedication of Minnesota's aging network as well, and by the interest and enthusiasm of your older citizens and their families. We would like to also recognize Kathleen Harrington, who is Chair of the Minnesota Board on Aging, the local area agencies on aging, the Tribal organizations, and other advocates for seniors here in Minnesota, and commend them all for their continued work on behalf of older citizens here in this State and across this land.

Minnesota is a leader in so many areas related to health and well-being of seniors and soon-to-be seniors, like your brother, and the rest of our Nation has much to learn from your citizens.

On July 14, 1965, as you noted, President Johnson signed the Older Americans Act into law. Sixteen days later, on July 30, he signed legislation creating Medicare and Medicaid. These three programs, along with Social Security created back in 1935, have served as the foundation for economic, health and social support for millions of seniors, individuals with disabilities and their families. Because of these programs, millions of older Americans have lived more secure and healthy and meaningful lives in this country. The Older Americans Act has quietly but effectively provided nutrition and community support to millions of people across Minnesota and across this land. It has also protected the rights of seniors, and in many cases, has been the key to their independence.

In 1965, there were about 26 million Americans age 60 and over. Today, there are 57 million older Americans 60 years and over, with many more on the immediate horizon. Our senior population is not only growing larger, but is also becoming more diverse. The older population, age 85 and older, is also projected to increase significantly. In 1990, the 80-plus population was about 3 million

people. In 2020, that figure is projected to be more than double by about 6.6 million according to the Census. Many will need long-term care, both in the community and when that becomes impossible, in nursing homes and other facilities. Reliance on family members who currently provide 80 percent of long-term care assistance for seniors will also increase.

The historic enactment of the Affordable Care Act by President Obama on March 23rd of this year, provides us with another tremendous opportunity to harness the success and progress of the last four decades to further improve the health and lives of older Americans and support their caregivers. As you know, the Affordable Care Act represents the biggest change in our national health care delivery system since 1965. Just as they were in 1965, the programs of the Older Americans Act and our national aging network of State, tribal and community organizations, senior advocates, volunteers, providers and family caregivers will be called upon to complement, support and enhance these changes. How successfully we weave these multiple responsibilities together will say much for how we will care for seniors in the future.

As part of the process for reauthorizing the Older Americans Act, early this year the Administration on Aging sought input from people all across this Nation in a number of very specific areas. We sponsored three onsite listening sessions, in Washington, Dallas, and San Francisco. We co-led the first of its kind listening webinar with Department of Labor on workforce issues for seniors and the Older American Community Service Employment Program. We encouraged the conduct of State and local listening events throughout the country and we received on-line summaries of the events and we provided online and downloadable individual input forms on its reauthorization website at the administration.

Over 400 individuals from 48 States and Territories have participated in the public input process and sessions. We believe the individuals and organizations that provided input represent the interest and concerns of thousands of Americans and consumers throughout this land.

I am pleased to report that Minnesota was an active participant in this process with input topics including: sustaining aging programs as the older populations expand; providing more flexibility in Title III programs in funding streams; increasing support for family caregivers; simplifying cost-sharing provisions; and supporting direct service workers.

Overall, the types of input we received throughout the country can be grouped into the following general categories: structure administration and service delivery and expansion. Specifically, we heard some of the following recurring themes at these listening sessions. One, the importance of the original Declaration of Objectives in Title I of the Act that establishes the guiding principles and goals of the Act in creating a society that enhances the lives of older persons.

The importance of the role of the assistant secretary in advocacy in coordinating and advocating on behalf of older persons and aging issues within and across Federal agencies and departments. Also, the role of Administration on Aging and the entire aging network

in advocating on behalf of older individuals at the Federal, State, tribal and local levels.

The importance of home and community-based services and the aging network infrastructure for responding to the needs and preferences of older persons, the importance of information and assistance, and the need for consolidated access, such as single points of entry, another area that Minnesota is a national leader through your Senior LinkAge Line and your Minnesota Help Network, the need for flexibility in programming to respond to local and area needs, the need to include a broad range of evidence-based interventions as a component of Health Promotion, Disease Prevention part of the Older Americans Act, the need for greater inclusiveness of various kinds of kinship care and more respite services in the provisions of caregiver services, the unique challenges of providing services and meeting the needs of individuals residing in rural, remote and frontier areas across this country.

The importance of innovation, research, demonstrations and training authority and funding and how it has played a significant role in building the aging network and enhancing the field of aging in this country. The need to restore more of a sense of community services back in the Older American Community Service Employment Program, and to look at ways to distinguish the program from other workforce and job placement programs at the Department of Labor. The need to fully recognize the sovereignty of tribal nations in Title VI and to consolidate programming for Tribes from other parts of the Act to Title VI. The importance of focusing, of course, on elder rights and elder justice issues and to look broadly on building effective infrastructures through enhanced coordination with domestic violence, adult protective services, ombudsman, consumer protection agencies, and other such entities.

Within the Administration, the process for the reauthorization has already begun. We are discussing the input we have received within the Department of Health and Human Services. For the past 45 years, the Older Americans Act has become recognized and highly regarded for stimulating the development of comprehensive home and community-based services system that has enhanced the lives of older persons and their family caregivers. We look forward to the reauthorization process as a means to strengthen and position this important piece of legislation so that its programs and services will continue to carry out the important mission of helping elderly individuals maintain their health and independence in their homes and communities.

Thank you, Senator Franken, and I will be glad to answer your questions.

[The prepared statement of Mr. Varpness follows:]



Testimony of
Kathy Greenlee
Assistant Secretary for Aging
U.S. Department of Health and Human Services

Before the

Senate Special Committee on Aging
Field Hearing on
Reauthorization of the Older Americans Act

Maple Grove, Minnesota
September 10, 2010

Thank you, Senator Franken, for the opportunity to testify before this Senate Special Committee on Aging hearing on the upcoming reauthorization of the Older Americans Act (the Act). I am pleased to discuss our efforts to solicit input from throughout the country and to hear Minnesota's perspectives on this important legislation that provides vital home and community-based services to older adults and their caregivers.

At the outset, I would like to commend you, Senator Franken, for your leadership as a member of the Senate Special Committee on Aging, and as a member of the Committee on Health, Education, Labor and Pensions, the Committee on the Judiciary, and the Committee on Indian Affairs, whose jurisdictions impact many of the Older Americans Act programs administered by the Administration on Aging (AoA). We are grateful for the support you have provided to the Older Americans Act programs and especially for your strong interest in protecting against consumer fraud and supporting elder rights issues.

I am impressed by the level of commitment and dedication of Minnesota's aging network and by the interest and enthusiasm of your older citizens and their families. I would like to commend Jean Wood, Director of the Minnesota Board on Aging, who I understand could not be here today, for the excellent work that she and her agency provide for seniors here in Minnesota and to thank Kathleen Harrington for ably filling in for her today. I also want to express my appreciation for the great work that the local area agencies on aging, tribal organizations, and other advocates provide for seniors in

Minnesota and commend them all for their continued work on behalf of older citizens of your beautiful State. Minnesota is a leader in so many areas related to the health and well-being of seniors and soon-to-be seniors and we have much to learn from the insights and perspectives of your citizens.

On July 14, 1965, President Johnson signed the Older Americans Act into law. Sixteen days later, on July 30, he signed legislation creating Medicare and Medicaid. These three programs, along with Social Security enacted in 1935, have served as the foundation for economic, health and social support for millions of seniors, individuals with disabilities and their families. Because of these programs, millions of older Americans have lived more secure, healthier and meaningful lives. The Older Americans Act has quietly but effectively provided nutrition and community support to millions of people across Minnesota and across the nation. It has also protected the rights of seniors, and in many cases, has been the key to their independence.

In 1965, there were about 26 million Americans age 60 and over. Today, there are 57 million older Americans 60 and over, with many more on the immediate horizon.¹ Our senior population is not only growing larger, but becoming more diverse. The older population aged 85 and over is also projected to increase significantly. In 1990, there were 3.1 million persons 85 and over; in 2020, this figure is projected to more than

¹ Source: Table 12. Projections of the Population by Age and Sex for the United States: 2010 to 2050 (NP2008-T12), Population Division, U.S. Census Bureau; Release Date: August 14, 2008.

double to 6.6 million persons.² Many will need long-term care, both in the community and when that becomes impossible, in nursing homes and other facilities. Reliance on family members, who currently provide 80 percent of the long-term care assistance for our nation's seniors, will increase.

The historic enactment of the Affordable Care Act (ACA) by President Obama on March 23, 2010 provides us with another tremendous opportunity to harness the successes and progress of the last four decades to further improve the health and lives of older Americans and support their caregivers. As you know, the ACA represents the biggest change in our national health care delivery system since 1965. And just as they were in 1965, the programs of the Older Americans Act - and our national aging network of State, tribal and community-based organizations, service providers, volunteers and family caregivers - will be called upon to complement, support and enhance these changes. How successfully we weave these multiple responsibilities together will say much for how we will care for seniors in the future.

As part of the process for reauthorizing the Older Americans Act (now authorized through FY 2011), early this year the Administration on Aging sought input from all interested parties, and offered a wide range of input options. Specifically AoA:

² Source: Figures for 2010 and 2020 projections are from: Table 12. Projections of the Population by Age and Sex for the United States: 2010 to 2050 (NP2008-T12), Population Division, U.S. Census Bureau; Release Date: August 14, 2008. The figure for 1990 is from Appendix Table 5, Census 2000 Special Reports, Series CENSR-4, Demographic Trends in the 20th Century, 2002.

- Sponsored three on-site listening forums (Washington DC - February 25, 2010; Dallas - February 26, 2010; and San Francisco - March 3, 2010);
- Co-led the first of its kind listening webinar with Department of Labor (DoL) Assistant Secretary for Employment and Training, Jane Oates, to focus on workforce issues and the Older American Community Services Employment Program (Title V of the Act administered by the DoL);
- Encouraged the conduct of State/local listening events throughout the country with receipt of on-line summaries of the events; and
- Provided online and downloadable individual input forms on its reauthorization website.

Over 400 individuals from 48 States and Territories have participated in the public input process to date, including 310 who attended one of the three on-site listening forums. A total of 264 individuals have provided written, oral or online input, or panel presentations. In addition, 12 State or local input events sponsored by six different agencies have been conducted. We believe the individuals and organizations that provided input represented the interests and concerns of thousands of consumers throughout the country. I am pleased to report that Minnesota was an active participant in this process with input topics including: sustaining aging programs as the older population expands; providing more flexibility with Title III funding streams; increasing support to caregivers; simplifying cost-sharing provisions; and supporting direct service workers.

The recommendations of the national organizations focused on providing/promoting:

- Single access points for long-term care information and services, evidence-based health promotion and disease prevention activities, and enhanced nursing home diversion/community living programs;
- Person-centered (self-directed) services;
- State/area flexibility to direct nutrition funding where most needed (i.e., consolidation of funding for congregate and home-delivered nutrition services funding);
- Integration of medical and human services-based long-term services and supports (LTSS), particularly in order to promote the aging network's role in health, wellness (both physical and behavioral health) and care management;
- Workforce development, utilization of technology and application of business models; and
- Increased capacity for Title VI Native American aging programs.

Overall, the types of input we received throughout the country can be grouped into two general categories-structure/administration; and service delivery and expansion.

Specifically, we are hearing the following recurring themes:

- The importance of the original Declaration of Objectives in Title I of the Older Americans Act that establish the guiding principles and goals of the Act in creating a society that enhances the lives of older individuals.

- The importance of the role of advocacy of the assistant secretary in coordinating and advocating on behalf of older individuals and aging issues within and across Federal agencies and departments. Also, the role of AoA and the entire aging network in advocating on behalf of older persons at the Federal, State, tribal and local levels was highlighted (Title II).
- The importance of home and community-based services and the aging network infrastructure for responding to the needs and preferences of older individuals to remain, when possible, in their homes and communities (Title III).
- The importance of Information and Assistance and the need for consolidated access, such as Single Entry Points or Aging and Disability Resource Centers (ADRCs).
- The need for flexibility in programming to respond to local and area needs – often mentioned in the context of consolidating congregate and home-delivered meals into one nutrition services allocation and program without prescribed levels of funding for each category from the Federal level.
- The need to include a broader range of evidence-based interventions as a component of Health Promotion, Disease Prevention.
- The need for greater inclusiveness of various types of kinship care and more respite services in the provision of caregiver services.
- The unique challenges of providing services and meeting the needs of individuals residing in rural, remote and frontier areas of the country.

- The importance of innovation, research, demonstrations and training authority and funding and how it has played a significant role in building and enhancing the field of aging. (Title IV)
- The strong encouragement for active collaboration between AoA and DoL to reinforce the dual purpose of the Older American Community Service Employment Program to offer community service opportunities while providing training and employment for low-income seniors (Title V).
- The need to fully recognize the sovereignty of tribal nations in Title VI and to consolidate programming for Tribes from other parts of the Act to Title VI. Also, comments were made to achieve greater parity with Title III.
- The importance of focusing on elder rights and elder justice issues and to look broadly at building an effective infrastructure through enhanced coordination with domestic violence, adult protective services, ombudsman, and consumer protection organizations and entities (Title VII).

Within the Administration, the process for the reauthorization has also begun. We are discussing the input we have received within the Department of Health and Human Services.

For the past 45 years, the Older Americans Act has become recognized and highly regarded for stimulating the development of a comprehensive home and community-based supportive services system that has enhanced the lives of older individuals and their family caregivers. We look forward to the reauthorization process as a means to

strengthen and position this important piece of legislation so that its programs and services will continue to carry out the important mission of helping elderly individuals maintain their health and independence in their homes and communities.

Thank you. I would be happy to answer any questions.

Senator FRANKEN. Thank you, Mr. Varpness. I'm kind of assuming that most of the people here have an understanding and knowledge of the Older Americans Act. But for those who may have come and don't really know the day to day of what it is. You gave us a nice, view from 30,000 feet, and on some of the kinds of areas that need attention in—or need focus on the reauthorization, but having gone through a number of these, I just want to touch on some of the things you said before I ask you questions, because you have so much experience here in Minnesota on this, on what we're really talking about, because you talked about things like employment and nutrition and transportation and respite services.

Nutrition is Meals on Wheels, and is also congregate dining. Now, you know, I've been in these listening sessions where you hear that Meals on Wheels is not just providing nutrition, but it's providing companionship. Sometimes it will be the only time during the day that the senior will see someone. Sometimes it's finding a senior who has gone to their mailbox and collapsed, and Meals on Wheels can be—that person who can save a life. So, I just want to give people a very quick overview because I don't want to take from your time and my time of asking you questions.

Transportation, I want to ask you about transportation in rural areas particularly, this is the one thing I anticipated before I asked my folks to go out there and have these listening sessions, I said you're going to hear most about transportation. I want to get your ideas on what we can do because, I want to ask you about an idea my wife has. But, this is basically so that seniors can go to a doctor's appointment. Sometimes this is like a bus line, you know, sometimes this is volunteers who come out and drive seniors to a haircut or to a senior center or to a congregate meal. When I say nickel and diming, some of these volunteers get reimbursed only for the period of time when the senior is in the car. So if you drive out to where the senior lives, you don't get reimbursed for the gas for that time when you're driving without the senior in the car, that to me is kind of silly.

It's helping with chores, senior companions, these are the kinds of things that we're talking about. So, I think as this hearing continues on, I think we'll hear more and more about these things, but I want to have people get a feel for what the Older Americans Act does, and how it is more than just providing services, it's a human thing and the people that are involved in this field are unbelievably great people, and thank you for your many, many years of service here in Minnesota and nationally.

I want to ask you how you feel Minnesota has been a leader in the Older Americans Act and what we can use from Minnesota in the reauthorization.

Mr. VARPNESS. Thank you, Senator. Minnesota really is truly a leader in so many different kinds of areas. I think Minnesota has a strong policy toward providing assistance for people to age in place, to receive help as much as possible and to stay at home as long as possible. You see that in your waived service programs under the Medicaid program and you see it also—

Senator FRANKEN. Can you explain that for everyone?

Mr. VARPNESS. Under the Medicaid program, Minnesota, of course pays for nursing home care for individuals, but also pays for

home and community-based services. Minnesota is a leader in terms of really trying to redirect its Medicaid dollars toward helping people to stay more at home. It's one of the top five or so States in terms of really moving and serving more and more people in long-term in community-based settings and in their home than in nursing home care. So it's—and Minnesota's been in that area for quite some time and has done so.

Minnesota has done a great job and has really been a national leader in terms of its Senior LinkAge Minnesota Help System, really trying to identify a single place where individuals can go for all kinds of answers, connecting with coaches to help the identify services that might help them, their mom, their dad.

Senator FRANKEN. What you call the single point of entry.

Mr. VARPNESS. Single point of entry types of things, but providing it in a sense of trying to help people find programs they may be in fact eligible, trying to direct them toward places and services that they can pay for and purchase out of their own pockets when they're able to do so, but also to connect them with specialists and people that really understand various kinds of chronic diseases to really help them try to deal with some of those kinds of things. Minnesota has been a great leader, I think, in that particular area as well.

Senator FRANKEN. Jim, I'm being told by my staff that we've got to keep moving on, but I want you to stay and be available for questions when I ask questions of the second panel.

So, thank you, Jim, and please stick around.

Now I'd like to invite the second panel of witnesses to come forward. Joining us today is Sherilyn Moe, on behalf of Deb Holtz. Deb is Minnesota's State Ombudsman for Long-Term Care, and Sherilyn—I'm not sure, we'll find out soon on what basis Sherilyn feels she can fit in— [Laughter.]

For Deb who oversees this important program to protect consumers of long-term care services from abuse and neglect. Ms. Holtz has worked for 30 years in long-term care and she has worked with home and community-based services, nursing homes, and with the Centers for Medicaid and Medicare services, and we'll find out exactly what Sherilyn's history is when she testifies.

Next is Kathleen Harrington. Ms. Harrington serves as Chair of the Minnesota Board on Aging, which is responsible for administering the Older Americans Act funds in Minnesota. Ms. Harrington also works with Carol Corporation, a Minneapolis-based healthcare company that helps healthcare systems transition from a volume-base to value-base model of care, which is a big part of the affordable care Act, a big purpose of it. Ms. Harrington has also worked on healthcare policy in the United States Congress, the Executive Branch, and as Director of External Affairs at the centers for Medicare and Medicaid services. Ms. Harrington also served in senior positions at United Healthcare.

Next is Jan Ferrier, who I spoke of earlier. Ms. Ferrier is a resident of Coon Rapids, where she has lived since 1966. In her forties, Ms. Ferrier suffered from two consecutive strokes that resulted in limited mobility on her right side. She currently received services funded by the Older Americans Act through the Chores and More program. To stay active, Ms. Ferrier enjoys gardening and quilt

making, she holds degrees in Aviation Administration and Aviation Business.

Next is Iris Freeman. Ms. Freeman is Associate Director and a Professor of Law at the Center for Elder Justice and Policy at the William Mitchell College of Law in St. Paul. She has also taught at the University of Minnesota Graduate School of Social Work. Ms. Freeman has directed the Advocacy Center for Long-Term Care, now the Elder Rights Alliance for over 20 years. She was the Staff Director of Public Policy at the Minnesota Dakota's Chapter of the Alzheimer's Association. Since the 1970's, Ms. Freeman has brought the consumer perspective to State and national discussions on long-term care. She holds degrees from Barnard College and the University of Minnesota, and publishes widely in professional and scholarly journals.

Finally, we have Neil Johnson, Executive Director of the Minnesota Homecare Association, which represents homecare agencies across the State. Previously Mr. Johnson served as Administrator of First Choice Homecare in St. Paul. He has 12 years of experience in planning and development, and has served as owner and business administrator of several Twin Cities child development centers. Mr. Johnson is currently co-chair of the Minnesota Leadership Council on Aging. Mr. Johnson is a licensed social worker and holds a Masters of Social Work from the University of Minnesota-Duluth.

Thank you all for being here, and I look forward to hearing all of your testimony.

Let's start now with Ms. Moe.

**STATEMENT OF SHERILYN MOE, OFFICE OF OMBUDSMAN FOR
LONG-TERM CARE, ST. PAUL, MINNESOTA**

Ms. MOE. Good afternoon.

Senator FRANKEN. Good afternoon.

Ms. MOE. My name is Sherilyn Moe, and I work at the Office of Ombudsman for Long-Term Care.

Senator FRANKEN. Can you talk directly into the mic?

Ms. MOE. Yes. I've been with the Ombudsman Office for 20—thank you. That helps.

Senator FRANKEN. It's a very directional mic.

Ms. MOE. That helps. I'll start over.

I have worked at the Office of Ombudsman for Long-Term Care for a total of 23 years, and my position is an Ombudsman Specialist. My specialty is in home and community-based services and elder housing. I oversee our State-wide volunteer program and I coordinate all of our continuing education for Ombudsman and our volunteers.

Senator Franken, thank you for the honor of representing the experiences and concerns of the Ombudsman Office. Most of the people that we represent are not here because they are in nursing facilities or in other settings and are much more vulnerable than the average older Minnesotan and that is why they are in those settings.

The Minnesota Office of Ombudsman for Long-Term Care has a broad Federal mandate to enhance the quality of life and quality

of services for long-term care consumers through advocacy, education, and empowerment.

The Long-Term Care Ombudsman Program was established in 1978 through the Federal Older Americans Act mandating that states establish ombudsman programs that advocate for people living in nursing homes and board and care homes. In the late eighties, Minnesota expanded this role to include Medicare and homecare clients under auspices of Jim Varpness.

Minnesota is one of only twelve other States that their Long-Term Care Ombudsman programs have expanded into the homecare role through additional State funding. But it's important to note that this additional State funding does not meet the needs of the increased calls that we are receiving. There are limitations in having an expanded authority with limited State dollars in this kind of economy.

Ombudsmen investigate complaints, meet personally with customers who have issues with their long-term care services, work to resolve individual concerns, and identify problems and advocate for changes to address them. Ombudsmen promote self-advocacy and the development of problem-solving skills through education and training for consumers, their families, friends, caregivers, providers and the community.

We currently serve persons who live in the State veterans' homes, nursing homes, board and care homes. We also serve persons who receive in-home services and certain community services, tenants in housing with services, Medicare beneficiaries who seek assistance with concerns regarding hospital access, denial of inpatient or outpatient services, or discharge questions and concerns. We also work with many older Minnesotans who live in adult foster care homes, people who will receive hospice services and many other long-term care services and supports.

I feel—it sounds like I am whistling. Does it sound like that to anyone else? Am I too close?

Senator FRANKEN. There might be a little feedback, I don't know.

Ms. MOE. Push it back. Thank you.

One of the main purposes of our office is to ensure that people know what their rights are and make real informed choices about where they want to live and then to live without fear of neglect, abuse, or financial exploitation.

We have many good laws in Minnesota that explain people's rights. Knowledge of these laws and enforcement is key to success. The Minnesota Home Care Bill of Rights is an excellent example of the initiative that Minnesota has taken. In 1987, the Minnesota Homecare Bill of Rights was enacted for people receiving in-home services or homecare services. This, again, is an excellent example of consumer protection that can easily be duplicated on a national level, as there is no national homecare bill of rights. There is under Medicare, of course, for homecare consumers.

This Bill of Rights has many excellent components, including the right to receive information, the right to be free from abuse, the right to take an active part in creating or changing a care plan or a service plan. Included in this information must be the name and address of the long-term care ombudsman.

This Bill of Rights, however, like any other bill of rights, is only as good as the enforcement, and the ability of people to understand choices, and to have real choices. Like all bills of rights, it is also only as good as what people understand and know, and of course, information is power.

We know from experience, unfortunately, that many people will often accept what might otherwise be termed unacceptable assistance in their own home, because the fear of going somewhere else is so high. Or in some minds, there is no choice if the only choice is perhaps a nursing home. So information about choices and options are all good, but they must be real choice and real options.

We must avoid policy by sound bite, “age in place”, “choices”, “live well age well” all sound good, but what do they really mean? Choices are based on feasible choices for the person, choices that allow them to still have control, choices that allow them to keep the relationships in their lives, and choices that enable them to live their days in dignity.

We know that some choices are made because of people not wanting to lose that last connection with family, even if it is a grandson financially exploiting grandma by threatening not to visit if she does not give him some money. We know that choices are sometimes made because vulnerable adults feel too guilty to turn in their abusive daughter or son.

So along with real choices, we know that people also need eyes and ears to voice with them when they are need of strength or help them stand up and voice for those who can not speak for themselves. The ombudsman is that voice. We first seek to provide information to all, so that people know what their rights are and how to stand up for them. We provide eyes and ears so that for those individuals who are in vulnerable situations, we are able to speak for them when they may not be able to.

Finally, we may need to re-think the definition of staying at home and what supports are really needed. As we strive to assist people to stay in their community and live in their own homes as long as possible, we may not always factor in, and adequately fund, the most important part of people’s lives, which is relationships. It does no good to most people to stay in their own homes and then become isolated from everyone including family, friends, their faith community, and social activities. There is so much more to aging than simply being free of maltreatment and having our basic needs met.

It should be a given that we all age without any abuse or neglect, and that our lives will continue to be filled with dignity, real choices and relationships that give our lives meaning.

Senator Franken, thank you so much for taking the leadership to listen to the people of Minnesota as we move to the next year for the renewal of the Older Americans Act. We appreciate your commitment to these issues, and look forward to working with you.

[The prepared statement of Ms. Moe follows:]



**Office of
Ombudsman for
Long-Term Care**

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September 10, 2010
Maple Grove, MN

Reauthorization of the Older Americans Act
Hearing before the U.S. Senate Special Committee on Aging

Written statement of Deb Holtz, J.D.
State Ombudsman for Long-Term Care, Minnesota
A service of the Minnesota Board on Aging

Senator Franken, and members of the U.S. Senate Special Committee on Aging:

Thank you for this opportunity to share the experiences and concerns from the viewpoint of an Ombudsman Office.

The Minnesota Office of Ombudsman for Long-Term Care has a broad federal mandate to enhance the quality of life and quality of services for long-term care consumers through advocacy, education, and empowerment.

The Long-Term Care Ombudsman Program was established in 1978 through the Federal Older Americans Act – mandating that states establish ombudsman programs that advocate for people living in nursing homes and board and care homes. In 1988, Minnesota enacted state law that expanded this ombudsman program to include advocacy for Medicare beneficiaries with complaints about being discharged from the hospital too soon and accessing acute health care. It was the first acute care government-level ombudsman service in the nation. In 1989 Minnesota expanded the ombudsman service also to consumers of home care services. MN is only one of twelve Long-Term Care Ombudsman programs nationally that serve in this expanded role, supported through the addition of state funding with the Older Americans Act funding.

It is important to note that this funding does not meet the needs of the increased calls we are receiving. There are limitations in having an expanded authority with limited state dollars in this current economy.

Ombudsmen investigate complaints, meet personally with customers who have issues with their long-term care services, work to resolve individual concerns, and identify problems and advocate for changes to address them. Ombudsmen promote self-advocacy and the development of problem-solving skills through education and training for consumers, their families and caregivers, providers and the community.

We currently serve:

All veterans in the Minnesota state veterans' homes – over 800 veterans
 32,982 active beds in nursing homes
 1246 active beds in board and care homes
 28,100 people receiving home care
 59,000 tenants in housing with services settings
 749,000 Medicare beneficiaries who seek assistance with concerns re hospital access, denial of inpatient or outpatient services, or discharge questions/concerns.

Our 2009 Annual Report further explains the specific complaints we responded to and resolved.

In addition to providing advocacy services to those who request it, we also provide information re:

- Services options
- Consumer rights
- Regulations for services and settings

One of the main purposes of our office – is to ensure that people know what their rights are, to make informed real choices about where they want to live, and then to live without fear of neglect, abuse, or financial exploitation.

We have many good laws in Minnesota that explain what people's rights are. Knowledge of these laws and enforcement are key to success. The MN Home Care Bill of Rights is a good example of the initiative that MN has taken. In 2007, the Minnesota Bill of Rights was enacted for people receiving Home Care services.

This Bill of Rights has many excellent components, including:

- The right to receive information about care, before that care begins
- The right to take an active role in creating the plan of care and services
- The right to be told in advance of services that will be delivered
- The number of visits to be explained
- Other choices that are available
- The consequences of those choices or consequences of refusing certain services
- The right to know the charges of the services
- The right to be treated with courtesy and respect
- The right to be free from physical and verbal abuse
- Included in this information must be the name and address of the LTC Ombudsman

This Bill of Rights, like any other bill of rights, is only as good as the enforcement, and the ability of people to understand choices, and to have real choices. Like all bill of rights, it is also only as good as what people understand and know. Information is power.

We know from experience, unfortunately, that many people will often accept what might otherwise be termed “unacceptable” assistance in their own home, because the fear of going somewhere else is so high. Or in some minds, there is no choice if the only choice is an institutional model down the street.

So information about choices and options are all good – but they must be real choice and real options.

We must avoid policy by sound bite. Age in place, choices, live well age well – all sound good, but what do they really mean?

Real choices are based on feasible choices for the person, choices that allow them to still have control, choices that allow them to keep the relationships in their lives, and choices that enable them to live their days in dignity.

We know that some choices are made because of people not wanting to lose that last connection with family – even if it is a grandson financially exploiting grandma by threatening not to visit anymore if she does not give him some money to help him for a bit. We know that choices are sometimes made because of vulnerable adults feeling too guilty to turn in their abusive daughter or sons.

So along with real choices – choices that can actually be made – and are not simply a nice phrase in a pamphlet about some services that may or may not be available in the area of the state where you live – that people also need eyes and ears to voice with them when they are in need of a stronger voice to stand up and a voice for those who cannot speak for themselves.

The ombudsman is that voice. We first seek to provide information to all, so that people know what their rights are and how to stand up for them. We also provide eyes and ears so that for those individuals who are in vulnerable situations, we are able to speak up for those who may not be able to.

Finally, we may need to re-think the definition of staying at home and what supports are really needed. As we strive to assist people to stay in their own community and live in their own homes as long as possible, we may not always factor in, and adequately fund, the most important part of people's lives – relationships. It does no good to most people to stay in their own home, then become isolated from everyone including family, friends, faith communities, social activities. There is so much more to aging, than simply being free of abuse and neglect, and having our basic cares met.

It should be a given that we all age without any abuse or neglect, and that our lives will continue to be filled with dignity, real choices and relationships that give our lives meaning.

Senator Franken - Thank you for taking the leadership to listen to the people of Minnesota as we move into the next year for the renewal of Older Americans Act. We appreciate your commitment to these issues, and look forward to working together with you.

Senator FRANKEN. Thank you, Ms. Moe. I have been reminded by staff to ask people to keep their testimony to 5 minutes. We don't have a clock, here, so I don't know how you're going to know whether you're doing it. Oh, we do? Oh, well, I stand corrected. So, we have a clock. So, shame on you to exceed 5 minutes. [Laughter.]
Ms. Harrington.

STATEMENT OF KATHLEEN HARRINGTON, CHAIR, MINNESOTA BOARD ON AGING, ST. PAUL, MN

Ms. HARRINGTON. OK, since I'm on the clock, I will begin by quickly thanking you, Senator Franken, for your—the opportunity to speak to you today, but most importantly for your passionate commitment to the people of Minnesota. The quality of representation you bring, and your obvious interest in your constituents and in seniors, particularly, is greatly appreciated—

Senator FRANKEN. If you want to take more than 5 minutes—
[Laughter.]

No, no. OK. Five minutes starts now.

Ms. HARRINGTON. OK. [Laughter.]

I could go on and on. [Laughter.]

Senator FRANKEN. Why don't you get to the thing— [Laughter.]

Ms. HARRINGTON. OK. All right.

Can I be like Darsen Keeler and just throw my—all right, seriously. Shinatova, and thank you.

Senator FRANKEN. Right.

Ms. HARRINGTON. We also—on behalf of the Minnesota Board, want to thank Jim and Assistant Secretary Greenlee for both of their commitment to—Jim's commitment—long-term commitment to—service, here in Minnesota and the region, and to Assistant Secretary Greenlee's leadership. We already feel her imprint and greatly appreciate the support of the Administration on Aging in helping us in Minnesota to innovate and develop new models to help serve our seniors.

Here in Minnesota, as in states across the country, we are beginning to experience the age wave—it's not just your brother, Senator. Many of our rural counties already have populations with significant proportions of older adults. At the same time, I think Minnesota faces particularly challenging issues with the increase in ethnic diversity, compounding with the aging. The demographic and ethnographic changes real challenges, and opportunities, for our State.

The needs of older Minnesotans are diverse, they are not monolithic, they do not fit into one category. They are dynamic and dependent on geography, income, literacy and health status, to name a few.

Within that context I want to speak with you today about three themes that reflect the Minnesota Board on Aging's work over the past several years and encompass the recommendations we have as you work on the reauthorization of this important statute.

First, supporting our area agencies on aging who have to do more with less, to meet the increasing needs of an aging population. Second, the ability to engage in public and private partnerships to expand our home and community-based service capacity and the social fabrics in our community. Third, strengthening our programs

and services to support self-direction and ensure that the rights of older Minnesotans are protected and enforced.

The mission of the Minnesota Board on Aging is to ensure that older Minnesotans and their families are effectively served by State and local policies and programs in order to age well and live well. We make this mission a reality through our three main roles: Advocacy, advisorship, and administrator. As an advocate, we promoted policies to the State legislature and the executive branch. As an advisor, we provide objective innovation that promote public education on ways to meet the challenges of Minnesota's older population. As administrator, we educate seniors and their families, their caregivers in programs and opportunities to help them do just as I said, live well, and age well.

We operate the Senior LinkAge Line, as you've heard. We work closely with your very dedicated casework staff in meeting the specific needs of constituents when the bureaucracy sometimes fails them, and checks are lost and things are missing. So, we work very closely with staff, and appreciate their commitment, as well. We also operate the Office of the Ombudsman, as you heard, here, and appreciate the incredible dedication of that small staff to accomplish large deeds. So, the accomplishments of the Office are written and articulated in my testimony, so rather than sit here and pat myself on the back, and our staff, let me get to the meat of what you want us to do here today and talk about three areas of recommendations for you to consider as you and your staff do this hard work.

We're looking to see if it's possible to increase the simplicity and flexibility in financing within the Older Americans Act. I know that's a big surprise to you. [Laughter.]

Simplify the Act by—and this may be asking, sir, for a mission impossible, but consolidating its six separate home and community-based services funding streams under Title III into one, might be a way to de-complicate and save administrative time and funds to ensure more flexible service delivery in a person-centered model subservice to older adults whose needs reach beyond any one specific service program.

In my professional life, in healthcare, we often say that, "disease does not recognize the tax year." Similarly, social needs do not recognize program definition. So, the more we can weave things together, we think, the better we can serve our population.

Similarly, and this one may be as difficult, we would like to suggest you think about consolidating the Congregate Meals and the Home-Delivered Meals in order to provide us with greater flexibility in meeting the needs of people. The shift in the current discretionary funding of Aging and Disability Resource Centers, evidence-based self-management and caregiver support programs, and Community Living Programs, to consolidate those—that funding, as well.

Second, strengthen the Ombudsman role in the community—and this really falls under modernization. We are working very hard in your home State to expand the living-at-home opportunities, but the Ombudsman Office does not have the resources or the role scope to help those who stay in their home and helping them in protecting their rights, as well. We ask that this be considered.

Finally, we need to encourage partnerships to expand community service capacity. Strengthening the Act to emphasize the critical need for coordination, particularly in transportation, across Federal, State and local funding streams is really critical to meet the needs of this State and, we think, across the Nation. We seek new opportunities to partner with others across different parts of the government, and we hope that this can be accomplished through the reauthorization.

In conclusion, thank you very much for this opportunity, sir. I appreciate it, I know the Board—my colleagues on the Board do, as well, and thank you for your leadership.

[The prepared statement of Ms. Harrington follows:]



Statement of

Kathleen Harrington

Chair

Minnesota Board on Aging

Before the

Special Committee on Aging

U.S. Senate

Maple Grove, MN

September 10, 2010

Senator Franken thank you for the opportunity to testify on behalf of the Minnesota Board on Aging and to discuss the Older Americans Act, its important impact on older Minnesotans and their families, and opportunities we see with the reauthorization.

Here in Minnesota – as in states across the country – we are beginning to experience the age wave. Many of our rural counties already have populations with significant proportions of older adults. On January 1, 2011 the first of the baby boomers begins turning 65. By 2020, Minnesota will have more retirees than school age children, with this will come a significantly lower labor force growth rate. At the same time, our population is becoming much more diverse. These demographic changes present real challenges – and opportunities for our state. The needs of older Minnesotans are diverse – they do not fit into one category – they are dynamic and dependent on geography, income, literacy and health status to name a few.

Within that context I want to speak with you today about three themes that reflect key areas of our work over the past several years and the recommendations we have for the reauthorization of the Older Americans Act. The themes are:

- Supporting our Area Agencies on Aging to meet the growing needs of an aging population with fewer resources;
- Engaging in public and private partnerships to expand our home and community-based service capacity; and
- Strengthening our programs and services to support self direction and ensure the rights of older Minnesotans.

Minnesota Board on Aging

The Minnesota Board on Aging is the designated State Unit on Aging for Minnesota for the purposes of administering the federal Older Americans Act. Its 25 board members are appointed by the Governor and represent diverse backgrounds, ages, interests and communities across the State. The MBA administers more than \$23.1 million in Older Americans Act funds and an additional \$6.8 million in state funds annually. We work closely with our seven regional Area Agencies on Aging who leverage an additional \$16.7 million in local dollars and resources, ensure local input and accountability for service funding and promote local innovation in problem-solving.

The **mission** of the Minnesota Board on Aging is to ensure that older Minnesotans and their families are effectively served by state and local policies and programs -- in order to age well and live well. We make this mission a reality through our three main roles:

- As an “**advocate**” we promote policies to the State Legislature, the Governor and State Agencies that fairly reflect the needs and interests of older Minnesotans.
- As an “**advisor**” we provide objective information and promote public education on ways to meet the changing needs of Minnesota’s older population to age well and live well. We have been a strong partner with the Minnesota Department of Human Services to implement ***Transform 2010***, to prepare Minnesota for the coming age wave of baby boomers and a permanent shift in the age of our state’s population. We are working towards a vision for Minnesota in which our policies, infrastructures and services are transformed so that we can survive and even thrive as this permanent age shift occurs.
- As an “**administrator**” we, partnering with Area Agencies on Aging and others, administer and oversee the effective use of Older Americans Act and state funds to support older Minnesotans. Last year, we provided a total of **325,000** older Minnesotans and their family caregivers with in-home, community and caregiver supports designed to help them maintain their community living and stay out of the more costly Medicaid program.

We manage the Senior LinkAge Line® which provides thousands of older adults and family caregivers with the information and education necessary to make informed decisions about their health insurance and long-term care options. We also administer the Office of Ombudsman for Long-Term Care. I am very glad that you will be hearing directly from our State Ombudsman for Long-Term Care today, Deb Holtz.

Older Americans Act

The Older Americans Act is the original home and community-based services act. Before Medicaid Waivers there was the Older Americans Act. The Act laid the groundwork for our state’s system of services for older adults and family caregivers. We continue to work towards its vision of “a comprehensive array of community-based long-term care services adequate to appropriately sustain older people in their communities and in their homes, including support to family members and other persons providing voluntary care to older individuals.” This vision cannot be fully realized without relationship building with other service providers and funding organizations to weave a fabric of support for older adults in all circumstances to age well and live well.

We greatly appreciate the leadership of Assistant Secretary Greenlee and the support of the Administration on Aging in helping us – and all state aging networks – to innovate and develop new models to better serve a rapidly growing and changing aging population.

Minnesota Accomplishments

The Older Americans Act has provided Minnesota with significant opportunities to improve our services to older Minnesotans. We are proud of our successes in several critical home and community-based service areas. I want to specifically highlight the great work of our Area Agencies on Aging who effectively ensure that the day-to-day needs of older adults and family caregivers are met while they spearhead dramatic innovations in supportive services to older adults.

- Last year, we provided a total of 325,000 older Minnesotans and their family caregivers with in-home, community and caregiver supports designed to, over time, help them maintain their community living and stay out of the more costly Medicaid program.
- Over 70,000 older Minnesotans and family caregivers received **information and assistance** regarding Medicare, health insurance and long-term care through our toll-free Senior LinkAge Line®. We are extending the reach of our decision-making support through the development of web-based tools including www.minnesotahelp.info. We are expanding our capacity to provide one-on-one long-term care options counseling to older adults. A specific, targeted effort is underway to help individuals **Return to the Community** from the nursing home. These services, together called the MinnesotaHelp Network, are federally defined as **Minnesota's Aging and Disability Resource Center**.
- We are increasingly **targeting** our services to older adults at risk of nursing home placement with incomes above Medicaid eligibility but less than 200% of poverty. We are providing them with flexible service options and support to better manage their risks in order to take control of their health and their lives. We are proud of our new partnership with the Veterans Administration to provide **Veterans Directed Services** to veterans of any age who wish to have more control over the services they receive in their own home.
- Minnesota's Aging Network is taking a lead role disseminating proven interventions addressing falls prevention, chronic disease self-management and memory care. Approximately 1,000 older Minnesotans at risk for falls and struggling to manage multiple chronic conditions are learning how to take more control of their health

through low-cost **evidence-based prevention and self-management programs**. A total of 100 family caregivers of persons with memory loss have improved their ability to manage their caregiving role and maintain their own health through an evidence-based **memory care** intervention.

- The MBA and the Area Agencies on Aging are supporting local efforts to make Minnesota's communities good places to grow up and grow old. Over 45 organizations and 675 community members participated in a recent effort to share proven strategies to promote **Communities for a Lifetime**. This is one example of the important influence of the Area Agencies on Aging **Program Development and Coordination** work in shaping our communities for older adults, family caregivers and all residents.
- In 2009, the **Ombudsman for Long-Term Care** handled more than 2,700 complaints from consumers, family members, friends, social service agency and facility staff related to consumer rights, resident care and quality of life. Over 15,200 visits were made in this process.
- Last year, over 24,000 older adults received **transportation** services to medical appointments, grocery shopping, and to access other critical community services. Without access to these services older adults, especially in our rural communities, would be quite isolated and at risk.

Reauthorization of the Older Americans Act

On behalf of the Minnesota Board on Aging, I submit the following recommendations for changes to strengthen and modernize the Older Americans Act.

Increase simplicity and flexibility in financing...

- Broaden current cost sharing provisions to include services such as homemaker, chore and nutrition. In Minnesota we are increasingly targeting our services to older adults at risk of nursing home placement with incomes above Medicaid eligibility but less than 200% of poverty. Older adults with incomes above 200% of poverty must be given an opportunity to share in the cost of services via sliding fee schedules.
- Simplify the Older Americans Act by consolidating its six separate home and community-based service funding streams under Title 3 into one. This would allow states to offer more flexible, person-centered models of service to older adults whose needs reach beyond any one specific service program.

It is particularly important to consolidate the funding for the Congregate Meals and the Home-Delivered Meals in order to provide us with the flexibility needed to better meet the needs of the older people we serve. We are continuing to see a strong demand for home-delivered meals and a reduced demand for congregate meals.

- Shift the current discretionary funding for the Aging and Disability Resource Centers, evidence-based self-management and caregiver support programs, and the Community Living Program to permanent formula funding. This will generate savings to Medicaid and Medicare at the federal and state levels, while enabling older adults and individuals with disabilities to live well at home.

Strengthen Ombudsman role in the community...

- Expand the program of the State Long-Term Care Ombudsman Program to include, as a voluntary option, providing their services to older adults living in their own homes. We have made significant strides in increasing the number of older adults who, despite functional limitations and a need for assistance, can live safe and healthy lives in their own homes. Funding for the Ombudsman Program has not kept pace with this development. It is critical that we have the capacity to protect the health, safety, welfare and rights of these older adults in the same way that we are able to for older adults living in nursing homes.

Push for funding to be appropriated for the Elder Justice Act provisions authorized as a part of the Affordable Health Care Act. These funds would improve the capacity of the Ombudsman Program, support program innovations and improve training for Ombudsman staff.

Encourage partnerships to expand community service capacity...

- Strengthen the Older Americans Act to emphasize the critical need for coordination of transportation across federal, state and local funding streams. Minnesota believes in the value of coordinating services, especially transportation services, to stretch resources farther and serve as many people as possible. We seek new opportunities to partner with others to meet this important need.

Strengthen Aging Network role in promoting Communities for a Lifetime...

- Modernize the Older Americans Act by strengthening the role of Area Agencies on Aging in helping communities prepare for an aging population, and acknowledging

the impact of OAA programs on the quality of life of all adults. The Area Agencies on Aging are very involved in local Communities for a Lifetime development work.

Conclusion

Thank you for this opportunity to share the perspective of the Minnesota Board on Aging regarding the benefits of the Older Americans Act to the older citizens of our state. As Chair of the Minnesota Board on Aging, I am proud to be able to share our accomplishments in providing home and community-based services to older adults and their family caregivers. We look forward to working with you on the reauthorization of the Older Americans Act.

Senator FRANKEN. Thank you, Ms. Harrington.

Ms Ferrier? Ms. Ferrier, you take advantage of some of the services, both—that you pay for, right, and also that—volunteers help you with, right?

Ms. FERRIER. That's correct.

Senator FRANKEN. Can you tell us a little bit about your story. How's that, for about 5 minutes?

Ms. FERRIER. OK, you want my testimony.

Senator FRANKEN. Yes, I'd like your testimony.

**STATEMENT OF JAN FERRIER, ANOKA, MINNESOTA RESIDENT,
USER OF OLDER AMERICANS ACT SERVICES, COON RAPIDS,
MN**

Ms. FERRIER. Can you hear me?

During 1990, at the age of 49, I had 2 strokes affecting my right side, including loss of my hand, an acute sensitivity to cold and hearing loss. Doctors ruled the underlying cause as Sneddon's Syndrome, which is slowly but progressively disabling. By the way, Sneddon's Syndrome is a form of Lupus. Things became very challenging for me at that time. What a blessing to become aware of the Anoka County Community Action Program called Chores and More. At that time, I began using volunteers to help with spring and fall leaf raking and eventually to help provide lawn moving and snow removal.

When it became medically necessary for me to take an early retirement at the age of 62, I began using the Chores and More Program for other things I was unable to do on my own including tree trimming, gutter cleaning, small carpentry projects, installation of a new mailbox and other things as the needs arise, at a reduced, affordable rate. These services have allowed me to stay in my home where I have lived for the past 44 years.

In addition to lawn and leaf raking, the program has provided me with volunteers who have helped dig up space to put in a vegetable garden, refinish a wooden picnic table, put up curtain rods and much more. With today's ever-increasing costs, the program helps me to be able to continue to live independently in my home.

Other things I have utilized the Coon Rapids Senior Center for include occasional noon lunches, numerous free or low cost seminars and presentations such as Social Security benefits, medical insurance and much, more.

In conclusion, I am deeply grateful for the Chores and More Program and the help it provides aging residents of Anoka County at a fair, affordable rate. Perhaps utilizing television and/or newspapers could make the elderly more aware of the program.

As our United States Senator, I strongly urge you to consider Chores and More Program when making funding decisions for the aging. We need your help and support.

Thank you for allowing me to testify before the Senate Special Committee on Aging regarding the Older Americans Act Reauthorization.

[The prepared statement of Ms. Ferrier follows:]

JAN A. FERRIER 11255 OLIVE STREET N.W. MINNEAPOLIS, MN. 55448
763-755-2444

During 1990, at the age of forty-nine, I had 2 strokes affecting my right side, including loss of my hand, an acute sensitivity to cold and hearing loss. Doctors ruled the underlying cause as Sneddon's Syndrome, which is slowly but progressively disabling.

Things became very challenging for me.

What a blessing to become aware of the Anoka County Community Action Program called CHORES & MORE. At that time, I began using volunteers to help with spring and fall leaf raking and eventually help providing lawn mowing and snow removal.

When it became medically necessary for me to take an early retirement at the age of sixty-two I began using the CHORES & MORE PROGRAM for other things I was unable to do on my own including: tree trimming, gutter cleaning, small carpentry projects, installation of a new mailbox and other things as needs arise, at a reduced, affordable rate. These services have allowed me to stay in my home where I have lived for the past forty-four years.

In Addition to lawn and leaf raking the program has provided me with volunteers who have helped: dig up lawn space to put in a vegetable garden, refinish a wooden picnic table, put up curtain rods and much more. With today's ever increasing costs, the program helps me to be able to continue to live independently in my home.

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Jan A. Ferrier Minneapolis, MN

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Thank you for allowing me to testify before the Senate Special Committee on Aging regarding the Older Americans Act Reauthorization.

Senator FRANKEN. Thank you, Ms. Ferrier. Let me just say that you—it's great to have you here because you put a real human face to this.

When we get back to you, I want to ask you about some of your volunteers—some people who volunteered for you. Because as I have gone around the State, I have met some of these volunteers, and it is really—these are great, great Americans, great Minnesotans, and I think people should hear about them. But thank you so much.

Ms. Freeman.

**STATEMENT OF IRIS C. FREEMAN, ASSOCIATE DIRECTOR,
CENTER FOR ELDER JUSTICE AND POLICY, WILLIAM MITCHELL
COLLEGE OF LAW**

Ms. FREEMAN. Thank you, Senator Franken.

These comments will focus on elder justice issues. [Laughter.]

Supporting independence is at the heart of the Older Americans Act.

Ms. FREEMAN. For some, especially those most frail, independence is a generous and misleading term for isolation. Real independence for older Americans means safety from abuse, neglect and financial exploitation. Moreover, real independence means the ability to access help for the daily care and chores that one can no longer manage. My testimony addresses these two facets of elder justice: protection from that maltreatment, and safety in home and community services.

Elder abuse, neglect, and exploitation are more than personal tragedies. They translate to public costs: medical care to treat wounds, broken bones, and starvation, housing and healthcare for victims left destitute by the swindles of people they trusted. Reported allegations in MN for Fiscal Year 2009 exceeded 25,000, with 39 percent of those alleging caregiver neglect. Reported cases are widely acknowledged to be just a fraction of the reality.

Priority: Address abuse, neglect, and exploitation in home and community settings with increased Title VII funding, while maintaining efforts on behalf of nursing facility residents.

Minnesota receives \$21 million from the Older Americans Act funding. Only \$79,000 of that is Title VII Elder Abuse money; a fraction of a percent. The narrow dollars and ratio promise short-changed services.

Priority: Make uniform national data collection a condition of receiving Federal funds by 2015.

Practitioners and policymakers just do not have the data needed to tackle elder abuse, neglect and exploitation head on. We lag behind that work in the fields of domestic violence and child abuse, but we can learn from their models.

Another priority: Create six coordinating Centers of Excellence on Elder Abuse and Neglect through the Reauthorization.

The Center of Excellence at the University of California at Irvine Medical School is a beacon and a model of medical, forensic, and victim services. But realistically it can not respond to an entire Nation's needs.

Let me turn, now, to consumer protection in home and community-based services and reprise some of the issues and recommendations that you have heard so far.

We are facing a barrel of challenges, and probably two barrels of mysteries. We know that the overwhelming percentage of care is provided by family. But we do not know how sustainable that is into the future. We know that paid caregivers are in such short supply that even one's ability to pay does not promise enough, or good enough, care. We are unwilling to give these jobs livable wages. We know that monitoring the delivery of care for persons inside the walls of private homes makes the challenges of monitoring care in congregate settings seem like small potatoes. Some of the technological possibilities for keeping watch are controversial. Technology may bridge miles and guard against isolation, but I, for one, do not want to wear a wire or line up with a monitor to use the toilet.

Priority: Include a Bill of Rights for Home and Community-based Services in the 2011 reauthorization.

Minnesota's Home Care Bill of Rights applies only in licensed home care services. Similar limits exist in those codified in other states. A Federal bill of rights, across services and regulatory jurisdictions, would promote both professional standards and public expectations.

Priority: Plan for ongoing public awareness efforts to raise people's expectations of good care and individual rights.

Individual rights are intrinsically difficult to monitor, especially in private homes. A few of us remember contract details when we sign up for services, especially in a crisis.

Priority: Expand the mandate and funding of the Ombudsman program to include advocacy for elders in home and community services.

Quality standards and a bill of rights set us on the right path. Ombudsmen explain the complexities, intercede, and use persuasion to repair situations regardless of whether there is a specific violation of law.

Priority: Assure that Ombudsman programs also have the independence in their settings and mandate to provide advocacy at the policy level as well as in individual cases.

Ombudsmen are in an ideal position to use case data, trends, and experiences to advocate for consumer rights and safety. The Older Americans Act must ensure their freedom to represent their constituencies in public decisions about service systems.

Finally, this is a very good time for State Units on Aging, Ombudsman Programs and Adult Protective Services systems to plan strategically for delivering elder justice in the future. None of these systems is uniquely able to handle the growing needs for protective services and consumer safety. Regardless of funding levels, cooperative efforts will promote cost efficiency.

Thank you, Senator Franken and your fellow committee members for your leadership on the Reauthorization of the Older Americans Act. Throughout Minnesota today, there are older people desperately clinging to their homes, some in frighteningly abject circumstances. Ensuring their basic safety while respecting their individuality and privacy requires our steady, shared commitment.

[The prepared statement of Ms. Freeman follows:]

Reauthorization of the Older Americans Act

Hearing before the U.S. Senate Special Committee on Aging

September 10, 2010, Maple Grove, MN

Maple Grove Community Center

Statement of Iris C. Freeman, Associate Director

Center for Elder Justice & Policy, William Mitchell College of Law

Elder Justice

Supporting independence is at the heart of the Older Americans Act. Real independence for those with advanced age or disabilities requires security against maltreatment, namely abuse, neglect, and financial exploitation. For some, especially those most frail, independence is a generous and misleading term for isolation. Furthermore, real independence requires the ability to access help for the daily care and chores that one can no longer manage. This testimony makes recommendations on these two facets of elder justice, protection from maltreatment and consumer protection in home and community services.

Protection from abuse, neglect and financial exploitation

Elder abuse, neglect, and exploitation are more than personal tragedies. They translate to public costs: medical care to treat wounds, broken bones and starvation...housing and healthcare for victims left destitute by the swindles of people they trusted. Reported allegations in MN for Fiscal Year 2009 exceeded 25,000, with 39% alleging caregiver neglect. Reported cases are widely acknowledged to be but a fraction of the reality.

Priority: Address abuse, neglect, and exploitation in home and community settings with increased Title VII funding, while maintaining efforts on behalf of nursing facility residents.

Minnesota receives \$21 million from the Older Americans Act. Only \$79,000 of that is Title VII Elder Abuse money...a fraction of a percent. The narrow dollars and ratio promise short-changed services.

Earlier this year, we celebrated the passage of the Elder Justice Act (EJA). Decisions with respect to the Reauthorization must certainly be made to complement the promises of the EJA. Funds that result from authorized Elder Justice Act provisions are, however, down the road, and that is the best case scenario. Today, the news is not good on appropriations for the Elder Justice Act. Neither the House nor Senate Labor HHS FY 2011 appropriation bills point contain any money for the Elder Justice Act. Passage of the Elder Justice Act was a great milestone. But after the cake and the balloons, it's all about the money. Therefore the Reauthorized Older Americans Act should continue and strengthen its place in protecting vulnerable elders and responding to the needs of victims.

Priority: Make uniform national data collection a condition of receiving federal funding by 2015.

Practitioners, policy makers and lawmakers lack the data they need to address elder abuse, neglect and exploitation effectively and efficiently. We are years behind those developments in the fields of domestic violence and child abuse, but we can learn from their models.

The Assistant Secretary for Planning and Evaluation (ASPE) funded a Congressionally-mandated study addressing the feasibility of collecting such data, and the 2006 OAA amendments contain an unfunded and unimplemented provision requiring data collection. Given the historically microscopic federal commitment to elder abuse services, one can well understand why definitions of abuse, neglect and financial exploitation are state-specific. Nevertheless, the ASPE study illustrates methods that can permit uniform national data collection without disturbing state-specific definitions used, for example, in charging elder abuse crimes.

Priority: Create six coordinating Centers of Excellence on Elder Abuse and Neglect.

The Center of Excellence on Elder Abuse and Neglect at the University of California at Irvine is a beacon and model of medical, forensic and victim services. But its reach cannot be universal nor can it realistically respond to an entire nation's problems. Their recently released study on mistreatment of people with dementia by their caregivers adds to the urgency of our work.

To learn more, visit its website, <http://www.centeronelderabuse.org/> **Center of Excellence on Elder Abuse and Neglect** at the UCI School of Medicine, Program in Geriatrics. From its welcome message: "Locally, the Center of Excellence provides medical, forensic, and victim services to abused and neglected seniors and serves as a "living laboratory" of innovative approaches. Statewide, the Center of Excellence serves as a central source of technical assistance, best practice information, multidisciplinary training, useful research, and relevant policy issues in California."

Consumer Protection in Home and Community Services

We are faced with a barrel of challenges and two barrels of mysteries. We know that the overwhelming percentage of care is provided by family. We do not know how sustainable that is into the future. We know that paid caregivers are in such short supply that even one's ability to pay does not promise enough or good enough care. We are unwilling to give these jobs liveable wages. We know that monitoring the delivery of care for persons inside the walls of private homes makes the challenges of monitoring care in congregate settings seem like small potatoes. And some of the technological possibilities for keeping watch are controversial. Technology may bridge miles and guard against isolation, but I for one do not want to wear a wire or line up with a monitor to use the toilet.

Priority: Include a Bill of Rights for Home and Community Services in the 2011 Older Americans Act.

Minnesota's Home Care Bill of Rights (Minnesota Statutes section 144A.44) is applicable only in licensed home care services. Similar limitations exist in those codified in other states. A federal bill of rights, across services and regulatory jurisdictions, serves both to promote professional standards and public expectations. At minimum, the language should include rights to information, to choices, to privacy, to a routinely updated plan of care, to dignified treatment, to opportunities for resolving problems, and rights to a smooth transition when the provider can or will no longer continue on the job.

Priority: Plan for ongoing public awareness efforts to raise people's expectations of good care and individual rights.

Individual rights are intrinsically difficult to monitor, especially in private homes. And few of us remember the list of promises we are given when we sign up for services, particularly in crisis situations. Regulatory agencies are best at identifying and responding to shortcomings that are physical and measureable. Clients and their family caregivers have to know their rights to seek redress of violations. Public awareness efforts have to be ongoing to be effective. Episodic bursts in response to media coverage of a horrendous case of maltreatment will not serve the long-term need.

Priority: Expand the mandate and funding of the Ombudsman program to include advocacy for elders in home and community services.

Quality standards and a bill of rights set us on the right path. An ombudsman explains the complexities, intercedes, and uses persuasion to repair situations regardless of whether a specific violation of law has occurred. Even better than knowing your rights is knowing whom you can call when you have a problem. Ombudsmen are safety nets. Sometimes they are life lines.

Priority: Assure that Ombudsman programs have the independence in their settings and mandate to provide advocacy at the policy level as well as in individual cases.

Ombudsmen are in an ideal position to use case data, trends, and experiences to advocate for consumer rights and safety. The Older Americans Act must ensure their freedom to represent their constituencies in state and local government decisions. Early on, federal law prohibited Ombudsman programs from being housed in state departments of health and comparable regulatory agencies, because of the inherent conflict of interest that could arise when advocates for nursing home residents answer to the same commissioner who oversees nursing home regulation. That assurance of independence has to follow a wider span of service to vulnerable adults. In the past year, the Nursing Home Ombudsman in Iowa was pressed to be silent in the public arena. While this example caused a stir and turned out well, the phenomenon should be avoided.

Finally, these ongoing conversations about the Reauthorization provide an opportunity for State Units on Aging, Ombudsman Programs and Adult Protective Services systems to plan strategically for the delivery of elder justice in the future. None of these systems is uniquely able to handle the growing needs for protective services and consumer safety. Regardless of funding levels, cooperative efforts will promote cost efficiency.

Additional notes for the Committee and staff:

Existing provisions of the Older Americans Act, dating from prior Reauthorizations, cannot effectively meet the needs of vulnerable older adults without further effort:

1. Promulgate regulations on concerning conflicts of interest, consistent with the call for regulations pertaining to ombudsmen in Title VII, Subtitle A, Chapter 2, Section 713.

2. Develop and implement measures to ensure the existence and effectiveness of state-level elder abuse prevention in Title VII, Subtitle A, Chapter 3, Section 721(h).
3. Ensure that adequate legal counsel is provided for the ombudsman program as required in Title VII, Subtitle A, Chapter 2, Section 712(g)(1).
4. As mentioned earlier, appropriate adequate funding for the elder abuse programming outlined in Title VII, Subtitle A, Chapter 3 including much-needed data collection, training, and victim outreach.
5. Appropriate the funds necessary to implement the legal assistance and legal services developer program authorized in Title VII, Subtitle A, Chapter 4. Although \$10 million was authorized for this purpose, no funds have been appropriated.
6. Appropriate the funds to implement the elder abuse programming for Native Americans outlined in Title VII, Subtitle B. This portion of Title VII has received zero appropriations since enactment in 1992 despite long-recognized need for such programs.

Federal consumer protection laws are additional means for safeguarding vulnerable adults in their household and healthcare purchases. We applaud U.S. House passage of H.R. 3040, the Senior Financial Empowerment Act. Rep. Tammy Baldwin's (D-Wisconsin) bill would authorize \$100 million over 5 years to establish a Justice Department grant program for organizations to conduct outreach to seniors and help them guard against fraud, particularly internet fraud. Financial exploitation is often viewed as less tragic than visible wounds; yet it has the potential to be the trigger for a downward spiral in an elder's health and housing.

The passage of the Elder Justice Act was recognized above. While momentous, most of the justice-system provisions of the original bill were not part of the Act as passed. Therefore lawmakers need to do more than coordinate the decisions made on the Reauthorization and the EJA. Attention must still be paid to enhancing the justice system's capacity to address the problem, to evaluating the efficacy of existing state criminal elder abuse laws, to developing some model state laws, and to establishing victim services that meet the needs of elderly and disabled victims. Elder abuse remains a shadow among human rights issues, causing wounds, deprivation and suffering that too rarely deterred or redressed by the justice system.

Thank you, Senator Franken and Committee members, for your leadership on the Reauthorization of the Older Americans Act. Throughout Minnesota today, there are older people desperately clinging to their homes, some in frighteningly abject circumstances. Ensuring their basic safety while respecting their individuality and privacy, requires our steady, shared commitment.

Senator FRANKEN. Thank you, Ms. Freeman.
Mr. Johnson.

**STATEMENT OF NEIL JOHNSON, EXECUTIVE DIRECTOR OF
THE MINNESOTA HOMECARE ASSOCIATION, ST. PAUL, MN**

Mr. JOHNSON. Thank you, Senator Franken. I also want to praise you and thank you for your work. I also want to thank your staff, as well, Melissa and Lauren did a wonderful job in working with us and preparing us and getting information to us about the hearing today.

In the spirit of full disclosure, I am the past co-chair of the Minnesota Leadership Council on Aging, and probably didn't update my vitae when I sent that to you. But, I wanted to let you know that I'm still a member of that group.

Again, thank you for the opportunity to appear before you today and for your work on these timely topics. I would like to talk about how we can ensure quality in home and community-based services. As you can imagine getting your arms around what quality means can be challenging. Medicare certified home care agencies have measurable outcomes called "Homecare Compare" with which to gauge progress on a number of publicly reported areas such as re-hospitalizations, falls, taking of oral medications, et cetera. Other home and community-based services are measured on the number of services that are provided or the timeframe by which they are delivered. Many programs, like personal care attendant services have no real measures other than to document if the services were delivered.

Oversight by the Minnesota Department of Health and the Department of Human Services for certain licenses provide some measure of quality by documenting compliance with rules and, to some extent, consumer satisfaction.

Do any of these things really ensure quality? I don't think so. Instead, we must start with the consumer. Counties and regional planning agencies annually listen to consumers and do a gaps analysis whereby they identify gaps in needs and services in their community, such as transportation, housing, meals, in-home services, et cetera, as we've heard today. Community needs assessments are very important. Most service providers have some kind of assessment process to determine needs, level of care, and eligibility. In fact, the new MINN CHOICES tool that is being developed and tested by the state of Minnesota will go a long way to ensure some continuity in approaches to a comprehensive assessment process across funding sources and programs.

As we enter the age of the savvy computer—excuse me, consumer—we will need to think—maybe that, too. [Laughter.]

We will need to think of more creative ways to ensure quality. First of all, providers need to be transparent with regard to services and costs. Service agreements and contracts should clearly spell out what are the costs—what services will be provided, and what those services will cost.

Second, we need to make access to services easier to navigate. We have such things as the Senior LinkAge Line and Minnesotahelp.info and they are wonderful resources. But we need to make sure that consumers are given information on available

services, as well as those that are providing quality services and there is follow-through in the form of care coordination to make sure the services were provided in the best way possible.

We have often talked about a report card approach which would be helpful to consumers, but we need to be careful about what we are sharing and how accurate that information is. We also need to embrace technology in order to provide services in the most cost-effective, efficient way possible. Such things as being able to exchange information remotely through TeleHealth, a single repository of information like electronic health records, and assistive technology to help keep seniors in the homes. Internet connectivity can help families track services for their loved ones and remotely participate in their care planning. We need to add broadband width to rural areas of the state in order to take advantage of some of these forms of technology.

What kinds of information would be helpful to know for consumers? How long has the agency been in business? What are the qualifications of the staff? How long have they been there? What is the turnover rate of the staff, including key positions like nurses, home health aides, et cetera? What is the extent of their criminal background study? Have they had a recent survey by the Health Department? If so, what, if any, were the citations? If they have not had a recent survey, when was the last survey? Have they had a substantiated complaint against them? What services do they offer? If I have a problem, who do I call or communicate with? Is there a policy to resolve issues with the consumer? Does that agency have a measurable work plan? What is it? How does the agency communicate with the consumer/family about the Care Plan? If there is a willing and able caregiver in the home how does that person receive support from the agency? What kind of training does the staff receive? If there are changes in the consumer's health or condition how is that handled?

This is a starting list of questions; I am sure there are many more. Advocating for a broader Bill of Rights like we've talked about today, like we have in Minnesota is good and something to build on.

So, in conclusion, quality means different things to different people. If we start with the consumer and listen to their needs we are on the right track. Next, providers of home and community-based services must have practical measures of outcomes across payment sources and programs. We must support family caregivers as the core of home and community-based services through training, coaching, and mentoring. There needs to be regular oversight by regulatory bodies, as long as it does not create undue burdens for providers. We must all collaborate and cooperate to ensure that providers are working toward a goal of helping people stay in their homes, even though they're facing health issues, and provide the highest functioning level possible for the consumer so that they can live in the least restrictive environment possible.

Thank you.

[The prepared statement of Mr. Johnson follows:]

Ensuring Quality in Home and Community-Based Services:

My name is Neil Johnson and I am the Executive Director of the Minnesota HomeCare Association representing about 250 home care agencies throughout the state of Minnesota. I am also a member of the Minnesota Leadership Council on Aging. Thank you for the opportunity to appear before you today and for your work on these timely topics.

I would like to talk about how we can ensure quality in home and community based services. As you can imagine getting your hands around what quality means can be challenging. Medicare certified home care agencies have measurable outcomes with which to gauge progress on a number of publicly reported areas such as rehospitalizations, falls, taking of oral medications, etc. Other home and community based services are measured on the number of services that are provided or the time frame by which they are delivered. Many programs like personal care attendant services have no real measures other than to document if the services were delivered. Oversight by the Minnesota Department of Health and the Department of Human Services for certain licenses provide some measure of quality by documenting compliance with rules and to some extent consumer satisfaction.

Do any of these things really ensure quality? I don't think so. Instead we must start with the consumer. Most programs have some kind of assessment process to determine needs, level of care, and eligibility. In fact the new COMPASS tool that is being developed and tested by the state of Minnesota will go a long way to ensure some continuity in approaches to a comprehensive assessment process across funding sources and programs.

As we enter the age of the savvy consumer we will need to think of more creative ways to ensure quality. First of all providers need to be transparent with regard to services and costs. Service Agreements/contracts should clearly spell out what services will be provided and what those services will cost. Second, we need to make access to services easier to navigate. We have such things as the Senior Linkage Line and Minnesota help.info and they are wonderful resources. But we need to make sure that consumers are given information on available services as well as those that are providing quality services and there is follow through in the form of care coordination to make sure the services were provided in the best way possible. We have often talked about a report card approach which would be helpful to consumers but we need to be careful about what we are sharing and how accurate the information is. We also need to embrace technology in order to provide services in the most cost effective, efficient way possible. Such things as being able to exchange information remotely through telehealth, a single repository of information like electronic health records, and assistive technology to help keep seniors in the homes. Internet connectivity can help families track services for their loved ones and remotely participate in their care planning. We need to add broadband width to rural areas of the state in order to take advantage of some of these forms of technology.

What kinds of information would be helpful to know?: How long has the agency been in business? What are the qualifications of the staff? How long have they been there?

What is the turnover rate of the staff, including key positions like nurses, home health aides, etc.? What is the extent of their criminal background study? Have they had a recent survey by the Health Department? If so what if any were the citations? If they have not had a recent survey, when was the last survey? Have they had a substantiated complaint against them? What services do they offer? If I have a problem, who do I call or communicate with? Is there a policy to resolve issues with the consumer? Does that agency have a measurable work plan? What is it? How does the agency communicate with the consumer/family about the Care Plan? If there is a willing and able caregiver in the home how does that person receive support from the agency? What kind of training do the staff receive? If there are changes in the consumer's health or condition how is that handled? This is a starting list of questions. I am sure there are many more. Advocating for a broader Bill of Rights like we have in Minnesota is good and something to build on.

So in conclusion, quality means different things to different people. If we start with the consumer and listen to their needs we are on the right track. Next providers of home and community based services must have practical measures of outcomes across payment sources and programs. There needs to be regular oversight by regulatory bodies. We must all collaborate and cooperate to ensure that providers are working toward a goal of either restoration or maintenance of consumers of services and can provide the highest functioning level possible for the consumer so that they can live in the least restrictive environment possible. Thank you.

Senator FRANKEN. Thank you, Mr. Johnson.

Thanks to all of you.

I would—Jim, would you come up and join and share a mic, too? Because I'm going to be asking some questions for everyone to weigh in on, and if you have a thought I would appreciate that.

Jan, I want to start with what I was talking about, but first I want to ask you how you heard about the Chores and More Program? Because, Mr. Varpness talked about single point of entry, and I just wanted to know how you heard about Chores and More?

Ms. FERRIER. Oh my goodness, it's been so long ago, I think I probably heard about it from a neighbor, originally.

Senator FRANKEN. OK.

Ms. FERRIER. Then I called Anoka County, and they referred me to the Chores and More Program where I worked with Ann Kusie and——

Senator FRANKEN. So, it was word of mouth from a neighbor?

Ms. FERRIER. Yes.

Senator FRANKEN. OK.

Let me just—because I just wanted to do this, because I've been so struck with the volunteers that I've talked to around the State. Can you tell me what the volunteers—I know you pay for some of the services you get, but talk to me about the people who volunteer?

Ms. FERRIER. They are so amazing. So, so amazing. I have had a whole Boy Scout troop help me with lawn and leaf raking, I have had church groups—incidentally, the people who raked my lawn last year, in the fall—excuse me, in the spring, this past spring—they were a young high school student who needed to earn some credits for a class in school, and his parents came. So, all three of them worked on my lawn.

Senator FRANKEN. Did his parents get any credit? [Laughter.]

Ms. FERRIER. The parents—no.

Senator FRANKEN. From him? [Laughter.]

Ms. FERRIER. The parents came and worked with him on it, and then the neat thing I felt about it, was I spoke with Ann a few days ago—we always sign up on the first of September, for the fall work—and she informed me that they had requested that they work for me again at my home. So I love their volunteer work; they're really great. They did a really good job. Most people do.

I had one—I don't remember what the name of the organization was, although I did send them a thank you letter, because they did such an amazing job, and they are the ones that—and strictly volunteer work—they cleaned my gutters, they refinished my picnic table, including sanding it and restaining it—a lot of work in that area. They raked the leaves, just so much they did.

Senator FRANKEN. Thank you.

Ms. FERRIER. I am really appreciative of volunteers, and what they do.

Senator FRANKEN. We all are.

Ms. FERRIER. I am probably more than likely going to be looking forward to using more things that are available to me down the road, because my medical problem is progressively disabling.

Senator FRANKEN. Thank you.

Ms. Moe, do you favor increased funding and independence for the Ombudsman Program? [Laughter.]

Ms. MOE. Certainly. [Laughter.]

Senator FRANKEN. OK, I thought so. [Laughter.]

Well, because what I'm hearing is, and Ms. Harrington talked about recommendations—increase simplicity and flexibility, consolidate funding streams, strengthen the Ombudsman Office, which I heard, also, from Neil, and I believe from Iris, too; partnerships to coordinate services and transportation—all of this seems desired. Part of my experience is, you all know each other, essentially, right? I mean, except for Ms. Ferrier, but essentially, this is a community, right? All of you are working incredibly hard on behalf of seniors in Minnesota, and Jim on behalf of seniors nationwide. This is a community. You kind of really know what you need.

One thing I heard was these funding streams. You say there were six funding streams under Title III, and you'd like to get it down to one.

Jim, is such a thing possible? How do we do that?

Mr. VARPNESS. Probably with great care.

I think——

Senator FRANKEN. That's how to do it——

Mr. VARPNESS. Yeah, right.

We've certainly heard from others, besides here in Minnesota, about consolidating funding streams. We've heard mostly your comment about C-1 and C-2, which is the home-delivered meal and the congregate meals, and there seems to be a lot of interest in doing those kinds of things, primarily so that, again, getting back to the flexibility comment that Kathleen talked about, so that States and local communities can decide, where do they need the meals money most? Home-delivered meals——

Senator FRANKEN. Right.

Mr. VARPNESS [continuing]. Is growing all over this country.

Senator FRANKEN. Well, I hear this in every facet of government—I hear it in education, you know, sometimes the funding streams dictate the decisions we make, because, “Well, I need money, I can only get it from this funding stream, so I've got to hire this, when what we really need is that.” So, if we can get into more detail about that, I'd really like to do it.

I heard this—Meals on Wheels, or Meals at Home, and Congregate seems to be something that should be done and then I've heard from a number of you in your testimony and some of the other written, submitted testimony.

I want to bring up my wife's idea—— [Laughter.]

Senator FRANKEN. Because if I don't—she'll hear about it.

But, I think this is a good idea, because Ms. Harrington, you brought it up. Which is, partnerships to coordinate services and transportation. Now, here's an idea, and I'm wondering—but take it more of an example of an idea, which is that school buses—are basically used at the beginning of the day and the end of the day, right? Then I hear about lack of transit, transportation for seniors, so her idea was, to coordinate the use of school buses with senior transportation. Is such a thing—has it ever been tried, has it been contemplated? Is it doable? Is it a good idea?

Ms. HARRINGTON. It's a great idea——

Senator FRANKEN. It's a great idea? OK, use the mic.

Ms. HARRINGTON. But it—

I think you can tell your wife it's a great idea. It has been tried—we, in fact, one member of the Board on Aging has discussed it in her local community. We run into—not surprisingly—liability issues, cost-effective issues, willingness of Boards of Education to cooperate with local governments, so it creates a complexity that seems to be unfortunate, but it has been discussed, and I don't think the discussions should cease.

Senator FRANKEN. But, can those barriers be overcome? It seems like, maybe they can.

Ms. HARRINGTON. I think anything can be overcome, yes.

Senator FRANKEN. Yeah.

Ms. HARRINGTON. But, I think we would need leadership in helping make it happen. I think there would be some relief that would be necessary from liability issues. Obviously, the cost-effectiveness of running buses versus individual cars; there's—there are issues, there.

Senator FRANKEN. Well, there are some bus lines that do work—and I was just in Pine City, and they have a bus line up there that really is a life-saver for seniors.

Ms. HARRINGTON. Oh, I think that's true in many States, and obviously many areas in this State. But the issue of getting the various governance jurisdictions to cooperate—and I know there is a very effective task force going on within Minnesota that is making progress, and we could see, you know, if we could get a report—

Senator FRANKEN. So, that would be something for someone in government to do.

Ms. HARRINGTON. In government. Well, I think it helps for—

Senator FRANKEN. Hm, where could we find one of those? [Laughter.]

Check into that, would you? OK.

Iris—sorry, I keep going between last names and first names. Neil talked about quality, a lot about quality. Would effective measures of quality reduce abuse and neglect?

Ms. FREEMAN. Senator, the most important place to start is simply to keep people safe from charlatans. If we can just get the bad actors out of that service, people who—and I say this with great respect to Neil and all of the real angels who work in home care—there are agencies where they're printing the nursing licenses in the trunk of the car. There is a lot that can be done with quality measurement and real—very, very subtle, minute elements of quality.

But for real consumer protection and safety, let's start with getting the bad guys out.

Senator FRANKEN. Yeah, but it's interesting, because again, across anything, there's bad actors and good actors, right?

Ms. FREEMAN. Mm hm.

Senator FRANKEN. Usually, most of the actors are good actors, and there are a few bad actors.

Neil, you headed up, in Minnesota, the Home Care Providers, right?

Mr. JOHNSON. Right.

Senator FRANKEN. Do they know who the bad actors are?

Mr. JOHNSON. Well, that's a good question—

Senator FRANKEN. Or, are they fly by-nights?

Mr. JOHNSON. Well, it's—you know, I think, we mentioned some of the things that you want to look for when you're—particularly your hiring process; hiring is certainly not a perfect science by any means, and we do a background study in Minnesota. The problem is, of course, you're only looking at Minnesota. So, we're looking at, you know, trying to broaden out the background studies so you're looking at other states, for example, you're looking at other types of offenses that may be more prevalent to those going in and ripping off people.

You know, I think, guarding against family members who do it is really difficult, because then you—

Senator FRANKEN. What percentage of care is provided by family members? Because I think it's in the 80-something percent?

Mr. JOHNSON. Yeah, it's probably about 10 percent—I think family caregivers is about 90 percent of the care giving, so it's a small percent.

Senator FRANKEN. I've heard in the testimony about the, I think it was Ms. Moe, who talked about the fear of, "My son won't visit me unless I give him money." So, when we're talking about some of this neglect and abuse—and this is 90-percent of the care, we're talking about a large part of this abuse and neglect coming from family members, is that correct?

Ms. FREEMAN. That is correct, and verifiable, particularly in the area of financial abuse, financial exploitation.

Some of these family members may not be caregivers, per se, but they do have a very emotional hold on the vulnerable individual. The vulnerable individual is rarely willing to press charges.

Senator FRANKEN. Do you need to press charges? I mean, that means, being a witness and being able to bring a case—you can't bring it without the person saying, "I'm willing to testify against my—"

Ms. FREEMAN. Remember, you're asking the social worker at the law school— [Laughter.]

Senator FRANKEN. Well, that's why I'm asking. I did remember that.

Ms. FREEMAN. But, in fact—

Senator FRANKEN. That's why I asked you. [Laughter.]

Ms. FREEMAN. It is true that family members may very well be the perpetrators. But it is also true that when family members are trying to do the good comparison shopping that we would have them do to find out about the staffing characteristics at an agency and their training and what-not, they may be faced with the reality that that is the only service in the area that has a slot open. So we want people to ask the right questions and be diligent, but sometimes the urgency is to get anybody in there, right away. That's just the sad truth of the matter.

Senator FRANKEN. Ms. Harrington, I wanted to ask about the Senior LinkAge Line, and Minnesota Help dot-info Web site. Say I call the Senior LinkAge Line for help after my mom fell and couldn't take care of herself. Walk me through—how that would go? I mean, how would the process of talking with the phone counselor help me figure out which services were available to my mom?

Ms. HARRINGTON. Depending upon the county you called, but I think in general, you would get a well-informed person who could help you understand all of the available services and the connections to those. If it was an emergency situation, it would obviously be done on a rapid-response basis. But, clearly the people who work on the Senior LinkAge Line—the front-line people sometimes do the triage, but then pass them on to people who are quite expert in the resources that are available in the community.

I can speak of this from a previous life when I was not a Minnesotan, and worked in Washington doing the Part D campaign—Minnesota's Senior LinkAge Line was the premiere service line in the entire country, in terms of quality and volume of service that it handled for senior trying to find out about their health insurance.

But, to—I think I answered your question, with a little aside, there, that you would get the full complement of available resources and the directory information.

Senator FRANKEN. Do other States have similar lines?

Ms. HARRINGTON. There is, in this country, a—what's called the State Health Insurance Program, that is a volunteer-based program sometimes run out of the Office of the Insurance Commissioner, sometimes out of the Aging Office that does—is available to help seniors make informed decisions on their Medicare issues, long-term care issues, and—but to say that most of them are as robust as Senior LinkAge Line would not be necessarily true. I think this one is highly developed—and I'm looking to Jim because I want to sound like I'm being a partisan, here—I think it is much more robust than many. Probably the most—

Senator FRANKEN. Jim, you're objective. [Laughter.]

Mr. VARPNESS. This is true, this is true.

Senator FRANKEN. Now that you're working for the Federal Government—

Mr. VARPNESS. Yes, yes, I can speak from the Federal—

Senator FRANKEN. Put on your Federal hat, here.

Mr. VARPNESS. Yeah, it's on, it's on.

Yes, that's actually correct. Minnesota really has probably the most expansive, comprehensive data base of any State. It has approached doing this by bringing together, really, all of the various kinds of departments—it's really a model of partnerships and coalition-building that's brought Children's Services, services for people with disabilities, veterans' services, housing services and even FEMA-type services in this State. So, it's a very robust data base.

What's great about this particular system that some of the other States have, as well, is that you can actually—individuals can actually go through Minnesota Help online and get the information themselves. Some people, frankly, aren't phone people. They want to bring, and pull this stuff together. You can, online, actually chat with people online. It really is a marvelous example—it's a model service, that piece of it.

There are 47 other States that have various approaches, but they're not as robust, and they're not Statewide, they're demonstration projects, and some States have more investments in terms of person capital on the resource side.

Senator FRANKEN. In terms of what?

Mr. VARPNESS. Person capital, putting more people at the local levels and counties to do some of the coaching and some of the triage work. Minnesota, I believe, still does a lot of this through the Network.

Ms. HARRINGTON. Mm hm. Yes.

Mr. VARPNESS. Through the phone system. Yeah.

Senator FRANKEN. OK, I'm wondering in reauthorizing the Older Americans Act, what can you legislate because I would think this is a more efficient system that ultimately saves dollars and saves suffering et cetera. How would you legislate something like that? Or, can you?

Mr. VARPNESS. Well, we've been funding these as innovation projects across the country and demonstration projects. Some States have done it in different ways to meet their specific needs. In the State of Wisconsin, for example, Wisconsin has a different kind of approach, a different model. They fund aging disability resources in each of their 87 counties. It's much more of a—it's much more of a single point that relies on individuals, essentially, coming in, if you will, for different kinds of services. It's a very successful program, too, as Minnesota—

Senator FRANKEN. So, allow each State to figure out their own—

Mr. VARPNESS. I think—

Senator FRANKEN [continuing]. To some extent—

Mr. VARPNESS. In the sense, it works best for States to try to best meet some of the individual needs in their particular areas.

There's also issues that—Neil brought up the issue on broadband width example. Some States are able to really push a lot of technology options and opportunities. Other larger, rural States, that's not a very realistic approach for them to take.

So, we've got to be careful about how we say how it should be done.

Senator FRANKEN. Ms. Freeman, you said that there were 25,000 reported allegations in Minnesota in 2009 of some kind of, abuse or neglect.

Ms. FREEMAN. Or financial exploitation.

Senator FRANKEN. Or exploitation.

Ms. FREEMAN. Yes.

Senator FRANKEN. You said 39 percent alleged caregiver neglect. How does the rest of it break down? You said it was widely acknowledged to just be a fraction of the reality, so explain that.

Ms. FREEMAN. Yes. We have asked the Department of Human Services to go further into their data to be able to break out of the caregiver neglect—how many of those or what percentage of those occur with formal providers, how many of those are family caregivers. That information isn't as readily available as we would want it to be, but they are working on it.

Senator FRANKEN. You asked for more data?

Ms. FREEMAN. That's right. Something more refined than those large categories. So we're hoping to have that. I will see to it that your staff and office have that.

But the issue of reported cases being the tip of the proverbial iceberg is what is reported by national studies done by the National Adult Protective Services, administrators, as well as scholars in the

field. It very much—very much resembles what domestic abuse and child abuse reporting were like when those phenomena were first seen as public issues and not just family tragedies.

Senator FRANKEN. OK.

Ms. FREEMAN. So as awareness grows, there are more individuals who may be willing—either because they're a mandated reporter under law, or because they just have a feeling of civic duty to help—more people will call.

But, one of the things I also hope to see as we improve these services, is greater public awareness about where to call, a more streamlined system for making those reports of abuse, neglect, and exploitation. Because, unless you really work in the field, it is not obvious to anyone, where you call to report a case?

Senator FRANKEN. Thank you. Thank you, all. This concludes the time that we have for today. I really appreciate you all being here—everyone who's here. Especially those who shared your expertise, and your thoughts on the reauthorization of the Older American Act.

I would also like to thank the Maple Grove Community Center for making the space available today, for hosting today's hearing. Our discussion has made it clear that in order to help seniors stay independent, we must do more to provide high-quality services to seniors in their homes. I will soon be introducing legislation—including many of the proposals, we have talked about today, such as a Federal Homecare Bill of Rights to ensure that all seniors who receive care in their homes have similar protections guaranteed in the Minnesota Homecare Bill of Rights.

I will also be working to ensure that Minnesota has the resources we need to protect seniors from abuse and neglect when they receive services in their home. I will work to build on existing resources, like the Senior LinkAge Line, and the Minnesota Help.info Web site, to help seniors and families get information that they need to make informed decisions about their care.

Finally, I will be a staunch advocate for robust funding for the Older Americans Act, and also for increased flexibility and simplicity and of hopefully, more cost-effective use of funding we do have. The Older Americans Act is a cost-effective investment that helps keep our seniors in Minnesota and across the Nation in their homes, so that they can age happily and healthfully.

Once again, thanks to everyone for attending today's hearing. I look forward to continuing to work with you to promote senior independence in the 2011 Older Americans Act.

The hearing is closed.

[Whereupon, at 3 p.m., the hearing was adjourned.]

APPENDIX



Written testimony submitted for the Special Committee on Aging Field Hearing

On The Reauthorization of the Older Americans Act

Maple Grove Minnesota, September 10, 2010

These written comments represent the views of the Minnesota Association of Area Agencies on Aging and are presented for review by Connie J. Bagley, Chair of the Minnesota Association of Area Agencies on Aging.

Older adults and family caregivers in Minnesota are a hearty bunch. Many of us brave long, cold winters our entire lives. Growing old in Minnesota requires fortitude, and often, a little help. We have a strong tradition of pulling together. Families, friends and neighbors form a valuable, informal support network that helps frail older adults live in the community. The essential services provided through the Older Americans Act are also critical to helping older Minnesotans and their caregivers face the challenges of growing older.

Some of our most innovative efforts have been to develop and implement best practice models including evidence-informed or evidence-based services to help family caregivers support their loved ones in the community longer with greater competence and confidence.

For example we have developed a model that provides coaching to caregivers that provides education about community base services and how to access those services. The Coaching services for caregivers are practiced in accordance with established training and standards to help family caregivers set goals, devise strategies and select services that are most likely to result in successful outcomes for their unique situations.

Minnesota has implemented a new statewide model for assisting nursing home residents with transitions called Return to the Community. This program facilitates voluntary transitions for private pay nursing home residents who are at risk of becoming long-stay nursing home residents yet prefer to return to the community and have potential for a successful transition. This increased demand means that Minnesota Area Agencies on Aging need additional funding to help support a growing need for services that will enable more older adults to remain in the community.

Recognizing the importance of effective assessment and support planning for caregivers, AAAs and their community partners have also implemented the Tailored Caregiver Assessment and Referral (TCARE) protocols developed by Dr. Rhonda Montgomery. Utilizing the TCARE screen with caregivers at various entry points to services identifies high-risk caregivers and links them to comprehensive planning and coaching.

As Congress prepares to reauthorize the Older Americans Act, Minnesota's Area Agencies on Aging urge Congress to make expansion of in-homes services for seniors and supportive services for caregivers a priority. In addition Minnesota's AAAs ask consideration for the following:

1. Raise the cap on appropriations for Title IIIB Supportive Services. The demand for chore services, information and assistance, transportation, and services in the home far exceeds the resource capacity of Minnesota's AAAs and service provider partners.
2. Increase the effectiveness of the Older Americans Act by combining Titles B/D and C1/C2. Give AAAs the flexibility to make local funding decisions that best support the independent living needs of the target population. At a minimum, combine Titles IIIC-1 and IIIC-2 funds and allow the maximum in flexibility. Participation levels in Congregate Dining continue to trend downward while demand for services in the home increases.
3. Support innovation and increased flexibility in use of Title IIIC funds for services that help older adults access healthy foods via grocery delivery, grocery shopping assistance, food shelves, and other models.
4. Incorporate the three major elements of Project 2020 into the Older Americans Act.
5. Simplify cost-sharing provisions. Minnesota targets Older Americans Act funds to subsidize services for older adults at risk of nursing home placement with incomes above Medicaid eligibility but generally less than 250% of poverty. Older adults with incomes above 250% of poverty must be given a real opportunity to share in the cost of services.
6. Increase the cap on Title IIIA to fund state-of-the-art management information systems and other technology. Technology is and will become more essential in the function of ADRCs, in using robust data to best target scarce resources, and for communicating with older adults, family caregivers and the public about the value of planning ahead and making informed choices.
7. Establish a new Title in the Older Americans Act for the Ombudsman and related elder rights programs to give them more visibility and autonomy.
8. Strengthen the role of Area Agencies on Aging to provide community planning that spurs service innovation, improves service quality, facilitates integration with the health care system, and engages the broader community. Create stronger emphasis on community planning to ensure that older Americans can live in and contribute to livable communities.

Thank you for the opportunity to submit these comments for your consideration on the reauthorization of the Older Americans Act. We work together to effectively support older adults and family caregivers in alignment with the ideals and spirit of the Older Americans Act.



MINNESOTA ADULT DAY SERVICES ASSOCIATION

Senator Franken, Members of the Aging Committee, thank you for the opportunity today to speak to THE OLDER AMERICANS ACT 2011 REAUTHORIZATION.

The Minnesota Adult Day Services Association is a non-profit organization that promotes and supports adult day services. Our mission is to establish adult day services as a viable option in the continuum of long term care. Our members and the people that we serve thank you and the committee for your legislative efforts in Washington to reauthorize the Older Americans Act on both the Senate Health, Education, Labor & Pensions Committee and the Special Committee on Aging.

Recommended strategies for balancing State long-term care systems include allowing consumers to receive services in the settings of their choice, support for family caregivers, and giving people more choice and control over the services they need. Adult Day Services provides such community-based supportive services in a cost-effective manner. (AARP Public Policy Institute Study-Kassner et al., 2008)

Adult Day Services in Minnesota has grown since the first center opened in the late 1960's to 135 Adult Day Programs licensed by the State of Minnesota with the capacity to serve 4,677 adults who need and want supervised non-institutional care during the day.

Over the past five years there has been a significant increase in counties' ranking of the need for support services for families and informal caregivers. In 2005, the need for respite/companion, **adult day service and evening/week-end care all ranked among the top five, and all three are services that support an older person's family caregivers.** This highlights a growing need for effective strategies to sustain and strengthen the family and informal support. The Area Agencies on Aging have played a critical role by using Older Americans Act funds to fill gaps in local service capacity. (MN Board on Aging)

Adult Day Services have benefited from a portion of the grant funds awarded to 225 Community Services/Service Development projects in 87 counties across Minnesota. The National Adult Day Services Association (NADSA) is encouraging collaborations with adult day providers and the Area Agency on Aging to use adult day services as a means to transition older individuals from nursing homes to the community, as well as helping older individuals age in place in affordable senior housing.

In a literature review that examined studies on adult day health care since 1975 (Gaugler and Zarit 2001) most of the research implied that adult day programs do not appear to serve as alternatives to nursing home care on their own. However, models that incorporated a variety of services with adult day care, appeared effective in reducing institutionalization, particularly if the program effectively targeted those most at risk of nursing home placement.

The Centers for Medicare & Medicaid Services (CMS) adopted the Uniform Data System for Medical Rehabilitation's (UDSMR) FIM® instrument as the basis for the Inpatient Rehabilitation Facility Prospective Payment System (IRF-PPS). Dr. Carl V. Granger, Founder and Executive Director of UDSMR, helped develop the FIM(R) instrument and also created the LIFEware(SM) System to measure and promote functional health and well being and monitor the effects of treatment. **One area of application for the LIFEware(SM) System is in Adult Day programs, which strive to provide daily assistance to frail elders so they may live in their homes for as long as possible.** UDSMR products are widely used for CARF accreditation and meet the Joint Commission's criteria for inclusion in the accreditation process.

Based on anecdotal evidence from Minnesota providers and families, adult day services enable informal caregivers to continue to provide care in the home, thereby delaying or preventing institutionalization:

"... I have found Adult Day Services to be an answer that works for my mother and I, as it relates to home health care for seniors. I use Common Sense Services Adult Day in South St. Paul for my mother. She attends 5 days a week while I'm at work and I care for her at our home in the evenings and on the weekends. My mother requires hands-on personal care throughout the day, yet I never have to worry that she is alone or not being cared for in a healthy and safe environment. My mom has plenty of activities, a good hot meal, caring staff, and most of all she loves seeing her friends every week day. It's a happy alternative for her and for me" – submitted with permission by Lynne Zimmeman, President Common Sense Services

"... Senior Club" (Adult Day Center) has been a saving grace for my mother. It has made it possible for her to remain living in her apartment at Walker. Senior Club is a name that would mean nothing without Betty, her staff and volunteers. They are welcoming, warm and caring. They are very intuitive and quick to understand the needs of each individual. Every day you can count on activities that are stimulating and fun. They adapt the activity for the individual, so they can participate and be part of a group. My mom smiles from the moment they pick her up for Senior Club and all the way through the day. I am so grateful for Betty and everyone at Senior Club. Dementia has taken away so much of my mother. Senior Club brings joy and happiness to her life. Who could ask for more."- submitted with permission by Betty Coleman, Director Walker Senior Club

"... Caring Connection Adult Day Health Program in Redwood Falls is located in rural Minnesota. Caring Connections Adult Day provides medical services to individuals during the daytime hours and serves as the Aging and Disability Resources Center for the County. Located on the Redwood Area Hospital Campus, Caring Connection actively coordinates health care with physicians and home health agencies. Transportation to and from centers can be very costly for many caregivers, especially in rural Minnesota. Funding cuts to transportation systems in our county has caused an increase in rates in order to maintain the service for the elderly and handicapped that can run as high as \$60 a day. For example, George and his wife live 16 miles from our center. His wife brings him to the center in the morning and then returns to pick him up in the afternoon. This drive is becoming a burden. Transportation provided by a volunteer driver costs \$50 a day. George is eligible for a maximum transportation subsidy of \$25 a day. He cannot afford to pay the addition \$25 out of pocket. If George's wife is unable to continue to transport him to the center, he will need to discontinue services and will likely be admitted to an area Nursing Home. Utilizing the Handicapped Bus would be less costly, however funding cuts to Counties and Cities that subsidize such transportation result in too few dollars to meet the transportation needs of elderly and disabled adults who live in rural Minnesota Counties". – Lynn Buckley, Dir.; Chair, Minnesota Adult Day Services Association.

Wives and Daughters: The Differential Role of Day Care Use in the Nursing Home Placement of Cognitively Impaired Family Members is a study that highlights the importance of relationship differences when studying caregiving. Although the current study showed that ADS use clearly had different implications for wives and daughters, the reason why wives and daughters use ADSs remains unclear. Identifying differences in the reasons for use of services such as ADSs may allow policy makers and providers to more appropriately target the needs of caregivers. (Soyeon Cho, PhD, 1 Steven H. Zarit, PhD, 2 and David A. Chiriboga, PhD)

As the American work force ages, the demands of caring for aging relatives increases. Family caregiving often interferes with workplace responsibilities, creating physical, emotional, and financial stress for caregivers. Employers must address the productivity losses created by absenteeism of workers who struggle with work-life issues created by caregiving roles. (Pitsenberger, D.J. "Juggling work and elder caregiving: work-life balance for aging American workers" 2006)

A new study from the MetLife Mature Market Institute® (MMI) reports that the cost to U.S. business due to lost productivity of working caregivers is \$17.1 billion to \$33.6 billion per year

Although families want to take over care of elderly relatives, many families have two full-time workers. Adult day care programs provide families with the support they need to keep seniors living among the family, while also offering seniors opportunities for enriching programs and social interaction during the day.

In a pilot study of women transitioning off welfare, nearly 30 percent of the 32 respondents said they had to leave a job in the past year to care for others, including their mother (17%) grandmother (17%), friend (17%) or father (8%). – (Kneipp et al., 2004).

Recent research on caregiver support services has shown very promising results. In a study investigating patterns of service use for one type of respite service (adult daycare) for caregivers of persons with dementia, **researchers found that the sustained use of adult day services by caregivers of persons with dementia can substantially reduce their levels of caregiving-related stress and improve their mental health.** Zarit, S. H., et al. 1996. "Adult Day Care and the Relief of Caregiver Strain: Results of the Adult Day Care Collaborative Study."

"...Serving nearly a quarter of a million individuals and their families every day, adult day services is a critical community-based long-term care option for individuals with Alzheimer's disease and physical limitations. The number of individuals who need social and health care support from adult day programs will only increase as the number of older persons continues to grow". – Holly Dabelko-Schoeny, PhD, Assistant Professor & Hartford Geriatric Scholar, Ohio State University, Board Member National Adult Day Services Associati

September 8, 2010

Dear Senator Franken:

The National Alliance on Mental Illness of Minnesota is pleased to submit these comments on the reauthorization of the Older American's Act. The axiom that we are getting older is true now more than ever. According to the Minnesota Demographer's office, Minnesota's population is becoming older and Minnesota's older adults are living longer. As people live longer they also become more at risk for developing a chronic illness or a disability and with this comes the increased risk for developing a mental illness such as depression or anxiety. Additionally, people who have a serious mental illness also move from the adult mental health system into the older adult system. A key issue of concern to NAMI Minnesota is how equipped is the older adult system to address the mental health needs of our older adults?

About 75 percent of Minnesotans over age 85 report having a disability, 31 percent reporting that it is a mental disability.^[1] Women are at greater risk for depression, even in this age group. Hormonal changes, greater care-giving responsibilities, more likelihood of living longer—and thus alone—places them at greater risk. Older adults with depression are more likely to be socially isolated.^[2] There are also some conditions that are more associated with depression such as stroke, hip fracture, heart attack and macular degeneration.

In February of 2008, the Minnesota Council of Health Plans released a report on mental health^[3]. Their members reported that 10 percent of people age 65 or older have a mental health diagnosis and they take an average of 3.5 psychotropic medications. People age 80 or older had the highest rate of mental illness—14 percent. The Council found that for those 80+ the rates per 1,000 were 5.03 schizophrenia, 3.44 delusional disorders, 39.07 brief psychotic disorders, 80.43 depression, and 25.18 major depressive episode/disorder. For people 65 to 79, those rates were 4.69 schizophrenia, .91 delusional disorders, 9.80 brief psychotic disorder, 38.11 depression, and 25.05 major depressive episode/disorder. In this report, people with mental illness represented 10 percent of employer-based coverage, 10 percent of Medicare, and 21 percent of state public programs.

Nearly every report states that they expect the number of older adults with mental illness to double in the next 20 years. One of the many hurdles in tackling the target population of older adults is the stigma and misinformation surrounding mental illness. Many people believe that depression is a normal part of aging. Who wouldn't be depressed to lose their spouse or significant others, to see their friends "die off"? Older adults in particular do not understand that mental illness is a biological brain disorder and view depression as a character flaw. Older adults rarely seek treatment for depression.

The symptoms of depression in older adults are different. We typically think of sadness, but in older adults it can be memory problems, confusion, social withdrawal, loss of appetite, inability

^[1] Elderly Minnesotans: A 2000 Census Portrait

^[2] Breaking Ground, Breaking Through: The Strategic Plan for Mood Disorders Research of the NIMH

^[3] Minnesota's Mental Health :A Report from the Minnesota Council of Health Plans, February 2008

to sleep, irritability, and even delusions or hallucinations.^[4] Some health care providers and families mistake the symptoms of depression for dementia. But more likely, the depression is not diagnosed, with primary care settings doing a poor job in detecting depression, partly due to lack of self-reporting of symptoms and to poor training on geriatric mental illnesses. Detection rates are even lower in racial and ethnic communities. Access and quality of mental health care for older adults is another issue. They are not fully accessing the mental health system; they are receiving poor quality of care in the regular health care system and are far more likely to end up institutionalized.

Mental health is a much over-looked factor when addressing quality of life and independence issues in older adults. It is therefore imperative that mental health issues be attended to for older adults. Having a mental illness, including depression, decreases the quality of an older adult's life and increases the likelihood of institutionalization. An article published in July 2009 in *Psychiatric Services* reported on the trends in nursing home admissions. Their study found that while in the past dementia was the number one reason for nursing home admissions, that it had been overtaken now by mental illness, particularly depression.^[5]

It should be noted that the presence of any disability increases the likelihood of depression and that needing help with self-care or having a mental disability increases the likelihood of institutionalization. The prevalence of depression increases among the elderly as they move from the community to institutional care, with estimates of less than one percent in the community, increasing to 13.5 percent in older adults receiving home care, and further increasing to 11.5 percent for those who land in the hospital.^[6]

When looking at the deaths of older adults, a large number are attributable to mental and behavioral disorders: 2,126 for ages 65 and over, with 71 percent being for those over 85; and 71 deaths attributed to suicide, representing 13 percent of all deaths by suicide.^[7] The Surgeon General's report on mental health indicated the presence of depression in 60-75 percent of completed suicides among people age 75 or older. The National Institute on Mental Health (NIMH) reports that older adults are much more likely to die by suicide:

- Although they comprise only 12 percent of the U.S. population, people age 65 and older accounted for 16 percent of suicide deaths in 2004.^[8]
- 14.3 of every 100,000 people age 65 and older died by suicide in 2004, higher than the rate of about 11 per 100,000 in the general population.^[9]
- Non-Hispanic white men, age 85 and older were most likely to die by suicide. They had a rate of 49.8 suicide deaths per 100,000 persons in that age group.^[10]

^[4] Depression in Older Persons, national office of NAMI

^[5] Trends in Mental Health Admissions to Nursing Homes; 1999 – 2005. Fullerton et al. *Psychiatric Services*, July 2009

^[6] Hybels CF and Blazer DG. Epidemiology of late-life mental disorders. *Clinics in Geriatric Medicine*, 19(Nov. 2003)

^[7] Deaths from Selected Causes, Minnesota Department of Health, 2006

^[8] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2005)

^[9] Conwell Y, Brent D. Suicide and aging. I: patterns of psychiatric diagnosis. *International Psychogeriatrics*, 1995

^[10] Conwell Y. Suicide in later life: a review and recommendations for prevention. *Suicide and Life Threatening Behavior*, 2001

In the Minnesota Council of Health Plan's report the found that "seniors who are diagnosed with a mental illness are taking three or more drugs that are potentially dangerous for elderly patients because of their adverse effects in older people." Eighty percent of all prescriptions were prescribed by primary care physicians. The number of individuals age 65+ who were taking anti-psychotics was 6,585; anti-anxiety was 18,348; anti-depressants was 42,689; and lithium was 328.

According to data from the Minnesota Department of Human Services, there were 2,126 people served in the mental health system who were between the ages of 65-74 and 1,299 who were over age 75.^[11] This means that approximately 0.46 percent of people receiving services were over the age of 65 versus three percent of the 18- to 64-year-olds. The American Geriatrics Society (AGS) reports that only four percent of people receiving care at community mental health centers are over the age of 65 and fewer than four percent of the patients seen by private mental health practitioners are elderly. Yet, national figures place the incidence of mental illness generally at 25 percent and at 20 percent for older adults.

A study conducted by Texas A&M Health Science Center found that physicians discussed mental health in about 22 percent of the visits for about two minutes. They also found that "Efforts to treat or provide care for a mental health issue varied widely among the doctors participating in the study. Most fell into one of three patterns of care: 1) listening to the patient for an extended period of time and referring him or her to a mental health care specialist; 2) gathering information but providing inadequate treatment; or 3) being dismissive toward the patient and his or her emotional distress, and failing to follow up."^[12] Additionally, women discussed this topic more than men, and if the woman had a woman physician she was even more likely to discuss this topic.

The American Geriatrics Society (AGS) position statement, while old, clearly states that "mental illness is an important contributing factor to the disease burdens of the elderly...despite substantial rates of morbidity, the proportion of elderly persons recognized as impaired who actually receive adequate treatment is markedly lower than in younger groups."^[13] They cite the significant barrier to treatment being the discriminatory coverage of outpatient mental health treatment under Medicare. This barrier is finally being addressed as the payment rate for outpatient mental health services will increase from 50 percent to 80 percent over several years. However, now CMS is proposing to cut Medicare Part B rates to clinical social workers which will create a huge barrier to finding providers willing to provide mental health treatment.

Dr. Stephen Bartell, Director of Aging Services Research at the Dartmouth Psychiatric Research Center believes that mental illness and aging is an emerging mental health crisis. He has found that depression is common in older adults and that it is associated with worse health outcomes, greater use of medications and greater use of health services—thus more services but worse outcomes. One service that is least likely to be accessed by older adults is psychotherapy, despite that fact that it can very effective. In looking at the barriers, Dr. Bartell cites the fragmentation of

^[11]Uniform Data on Public Mental Health System Basic Tables for 2007 Report

^[12] NIMH Science Update, February 25, 2008

^[13] Mental Health and the Elderly Statement, American Geriatrics Society, January 1993

the mental health and older adult services, providers lack of education on both topics - financial barriers (Medicare) and stigma.

NAMI Minnesota has recently implemented a project on older adult mental health. One of our key findings is that many staff who work with older adults have received little training on mental illness. Conversely many mental health providers know little about meeting the needs of older adults.

As you work on this important legislation, NAMI Minnesota urges you to include measures that would address the mental health needs of all older adults. This includes efforts to include mental health screening in physician's offices and older adult programs, public awareness campaigns, and more integrated delivery of services between older adult and mental health providers. We also recommend that mental health services be included in any home and community-based services.

I appreciate this opportunity to submit these comments.



AARP STATEMENT
OF
MICHELE KIMBALL
SENIOR STATE DIRECTOR
AARP MINNESOTA

REGARDING THE

2011 REAUTHORIZATION OF THE OLDER AMERICANS ACT

ST. PAUL, MN

SEPTEMBER 10, 2010

AARP is a nonprofit, nonpartisan membership organization that helps people age 50 and over improve the quality of their lives. We appreciate this opportunity to offer some preliminary ideas on the reauthorization of the programs and services of the Older Americans Act (OAA), pending formal legislative language. Our interest is to ensure that the Act maintains critical service and information roles, and promotes greater responsiveness to the needs of mature and older Americans.

In this period of economic downturn, AARP is most concerned that programs, authorities and partnerships that have already proven effective in meeting the needs of vulnerable older Americans be maintained and strengthened. We believe that older persons are best served by a simple reauthorization that makes only minor changes in existing programs to improve efficiency. Better coordination of existing OAA programs with other federal programs holds great promise and merits the support of the Administration and Congress.

I. Delivery of Home and Community-Based Services

Helping people to grow older in their communities with independence and dignity is a bedrock goal of the Older Americans Act. All too often, advancing age and increasing frailty threaten the ability of older persons to remain in their own homes. The fear of having to enter a nursing home, with its attendant loss of independence and threat of impoverishment, weighs heavily on the minds of many older persons and their family caregivers.

Older Americans Act funding and home and community-based services under the Act are one of a number of options for services that may be available to help individuals live in their homes and communities. OAA services are an important piece of the patchwork of

services to help older adults live in their homes and communities. AARP is pleased to strongly support the Administration's Caregiver Initiative that proposes \$100 million in increased funding for family caregiver support services and home and community-based services (supportive services) under the OAA, as well as \$2.5 million in additional funding for the Lifespan Respite Care Program. This initiative would provide an increase in funding for important OAA programs that assist older adults living in their homes and support family caregivers, who are the backbone of long-term services and supports in this country.

AARP is open to potential new initiatives that complement existing caregiver and service programs with innovative and effective approaches to expanding access to home and community-based services. Newly adopted initiatives, however, often require higher OAA appropriations and AARP would urge that other important OAA activities not be sacrificed to pay for new programs. This would require real commitment and creativity given federal budget constraints. Also, OAA does not usually receive significant new increases in funding.

Over the past 15 years, states have made great strides in improving the options for older persons with disabilities who want to remain in their own homes and communities for as long as possible. However, the weak economy has reduced funding availability and has forced elimination in some cases of services for our members and other older Americans. Advocates in states across the country are working to preserve access to vital services for older adults and persons with disabilities in these tough economic times and to prevent or minimize the potential harmful impacts that cuts in services or benefits could have on these individuals. Successful state delivery strategies that AARP could support may include:

- expanding home and community-based care programs by better coordination of federal and state funding (such as Medicaid, state-only funded programs, OAA, and Social Services Block Grant);
- streamlining administrative operations that will permit a single state agency to serve as a single point of entry into the long-term care system; and
- adopting assessment and care management practices that allow targeting of resources to the persons most in need, especially those traditionally underserved.

AARP supports the single point of entry approach, and maximizing linkages between various delivery systems is critical in any system, especially access linkages like transportation, elder abuse prevention or legal assistance. Without such coordination, persons who need long-term care must go from agency to agency, trying to locate programs and services for which they are eligible. They also must try to decipher the multiple and often conflicting eligibility requirements of various programs. We note that the new health care law does include investments of \$10 million per year over the next five years for Aging and Disability Resource Centers (ADRCs) that help provide individuals and their families a one-stop shop for information and other assistance regarding long-term services and supports. The proposed additional funding in the Administration's Caregiver Initiative – if enacted – would help ensure that there are OAA services (among others) there for individuals who come to ADRCs seeking services.

AARP also believes that it is preferable to retain the current separation between the assessment of eligibility and the actual provision of services, so that the agency that conducts eligibility assessments does not have a financial interest in the type and amount

of services authorized. Any potential and actual conflicts of interest by agencies authorizing or providing services should be avoided to ensure that older adults receive the services they need.

The use of existing authorities under the OAA could also be explored to enhance home and community-based services under the Older Americans Act, such as the use of volunteers, support for innovative and proven intergenerational programs, partnerships with National and State Title V Grantees to increase opportunities for Senior Community Services Employment Program enrollees to participate in the delivery of HCBS, and incentive grants for capacity building initiatives focused on proven effectiveness in delivery of OAA HCBS and non-OAA HCBS that are coordinated through the OAA aging network. Title IV of the OAA could also be explored, as it has supported a wide range of projects in the past, including those related to long-term care.

Finally, the aging network has also become more involved in efforts such as supporting healthy aging and helping older adults through care transitions, such as under the Community Living Grants Program. The aging network should consider where it can add real value and provide assistance to older adults by leveraging partnerships and exploring new opportunities and coordination with federal, state, or local programs, especially where there is evidence-based data to support such efforts.

II. Long Term Care (LTC) Ombudsman

Finding methods of monitoring and improving quality in the delivery of long-term care services is critical. Comprehensive federal legislation to protect vulnerable seniors from abuse, neglect and exploitation – the Elder Justice Act – has been enacted, but still must

be funded. Regardless, the resources of the OAA remain critical (see our later comments on elder rights protections). Individuals receiving long-term care are particularly vulnerable, and the aging network has a vital role to play in quality assurance. AARP supports adequate funding for the LTC Ombudsman program authorized by the OAA. We strongly support maintenance of the Office of the LTC Ombudsman and the program's authority to be an effective watchdog in nursing homes and other long-term care facilities. We urge retention of provisions that enable the Ombudsman to:

- provide information to the public and lawmakers;
- comment on laws or regulations affecting care institutions;
- execute their mission free of conflict of interest at any level; and
- assure the confidentiality of resident complaints and program records.

III. Targeting of OAA Services

Administration of the programs and services of the Act is more critical in these days of austere budgets than ever before. It is important to direct resources to areas that achieve the most impact while aiming to meet the goals of the Act. Toward this end, the Association supports uniform data collection procedures and definitions which permit evaluation of program effectiveness, especially regarding gaps in service to rural, frail, low income and minority older persons.

Years of studies show pockets of under-service to certain older populations by the programs of the Act. AoA has improved its ability to collect participant data in recent years. However, there are not adequate measures of the unmet need for services. Broadening the rigor and scope of data collection for Title III and VI programs could help demonstrate their impact on special populations and should be pursued.

For many years, AARP has advocated targeting OAA services to persons with the greatest social and economic need and, in particular, to low-income, older minorities. AARP continues to strongly support retention of the targeting provisions of the Act. The flexible nature of the OAA programs is one of its strengths because it helps to garner broad public and political support. However, historically there have been problems in achieving adequate service delivery to older minority individuals. It is critical that new participation data collected by AoA be disseminated, so that the adequacy of current service delivery to older minorities can be evaluated. By tracking results, it is possible to ensure that more funding goes to those programs that achieve the best results with the targeted populations. Better tracking would also enhance ability to assess delivery of services to other underserved target populations, such as rural elders, and enable more effective allocation of OAA service dollars.

IV. Vulnerable Elder Rights Protection, Consumer Protection & Legal Assistance

AARP supports retaining the advocacy functions of the OAA programs. In order to fulfill the Act's mission, it is critical that state and area agencies on aging continue to be effective and visible advocates for older persons. A critical component of this function is allowing for public participation in all aspects of the Act's planning and implementation processes. AARP continues to support efforts by the aging network to improve access to public benefit programs by low-income older persons. Participation by older persons in public benefit programs continues to lag behind participation rates for other age groups. Extensive post-welfare reform barriers to federal benefit access have the lingering effects of creating angst and compounding lack of information for those seniors asked to consider their possible eligibility. The OAA programs can play an important role in helping older persons with low incomes to gain access to other programs for which they are eligible.

Such assistance can make a critical difference in the quality of life for these vulnerable individuals. We also urge that Congress restore the statutory mandate for a majority of citizen consumers and their representatives on all OAA-related policy and service advisory boards to maximize consideration of senior interests and a consumer-oriented approach.

AARP urges that legal assistance be reaffirmed as a required service under the Act unless waived in accordance with guidelines from the Secretary. It is critical that the current waiver process be retained. This process provides that interested parties be notified and a public hearing be held before a waiver can be granted. Without this protection, the vital interests of many of the most vulnerable elders can be waived without recourse. Legal assistance, whether in-person, by phone or other electronic means, helps older persons obtain access to vital medical, insurance, housing, and Social Security benefits as well as providing guidance regarding nursing home and estate issues.

The OAA mandate to provide legal services remains extremely important. This ensures the availability of legal help for at least some of the most critical problems of the neediest older Americans. Requiring services rather than providing discretion in this area is critical because legal services are controversial in some communities. Without the mandate, the fundamental principle of access to justice will be denied to some older persons. For the same reason, area agencies should be required to spend a minimum percentage of their Title IIIB funds, set by the State Unit on Aging, on legal services. Before establishment of the mandate, less than 50% of area agencies funded any legal services. Many others spent insignificant amounts on legal services. A 2002 study of legal services in New Jersey noted among its conclusions that pro bono services are inadequate to make a

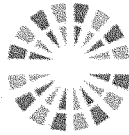
significant difference in access to legal assistance by those who need it. AARP therefore remains opposed to substitute pro bono services for OAA legal assistance without reliable data to affirm that legal needs are being met by such services.

In addition to legal services and the long-term care ombudsman program, the OAA can play an important role in addressing elder abuse, neglect, and exploitation. Such abuse can occur in any setting and individuals who may need help in preventing, detecting, or responding to abuse or potential abuse may contact state or area agencies on aging or other providers of services under the OAA. Additional elder abuse provisions were added to the Older Americans Act in the last reauthorization and OAA programs continue to play an important and complementary role in addressing this important issue.

The Elder Justice Act (EJA) that was passed as part of health care reform promises potential vital, new resources that could aid the detection, prevention and intervention activities of OAA programs aimed at elder abuse, neglect and exploitation, especially the long-term care ombudsman program authorized under Title VII of the OAA and other prevention services under Title III. We encourage that the AoA pursue and assume a vital and active role in the Elder Justice Coordinating Council to be established under the EJA to provide a more comprehensive and coordinated federal commitment to fighting elder abuse, neglect and exploitation.

Conclusion

Again, AARP appreciates the opportunity to address the critical issues of OAA reauthorization, especially those related to the delivery of home and community-based services to a rapidly expanding older population. AARP believes that the economic climate demands a very targeted and reasonable approach to addressing the needs of older persons under the Act while laying a foundation on which to build and direct future investments when the opportunity permits. We look forward to working with the groups in the aging network, Congress and the Administration to advance the interests, independence, and well-being of older Americans during this reauthorization process.



**MN Leadership
Council on Aging**

**Policy Principles for the Reauthorization of the Older Americans Act
Submitted to the Senate Special Committee on Aging
by the Minnesota Leadership Council on Aging
September 7, 2010**

The Minnesota Leadership Council on Aging (MNLCOA) is a coalition of primarily statewide organizations working together on behalf of older Minnesotans and their family caregivers. The Leadership Council on Aging brings together a broad representation of consumer, advocacy, social service and health care organizations. Sixteen leading nonprofit organizations form the Council. Together, Council members advocate for positive system changes that improve the lives of older adults as they age in their communities.

Minnesota seniors depend on the federal Older Americans Act (OAA) to help them maintain their independence as they face the challenges of old age. In Minnesota the Older Americans Act funds essential supports including meals, transportation, homemaker and chore help, caregiver support, and robust information and assistance. Through highly coordinated efforts, Title III-funded service providers, Minnesota Area Agencies on Aging and the Minnesota Board on Aging target services to older adults at risk of nursing home placement with incomes above Medicaid eligibility but generally less than 200% of poverty. Older Americans Act services play a strategic role in Minnesota's long-term care system. Last year more than 325,000 seniors and their family caregivers received critical in-home community and caregiver supports that helped them maintain their community living and stay out of the more costly Medicaid program.¹

Minnesota's Older Americans Act network has an excellent history of innovation and leads the way across the nation with its technology-based strategies to implement Aging and Disability Resource Center services. In addition Minnesota's OAA network and its partners are strong players in developing evidence-based health promotion and chronic disease management services. Family caregivers in Minnesota benefit from interventions that help them care longer, with less burden, and with greater competence and confidence.

As Congress begins its work to reauthorize the Older Americans Act, the MNLCOA finds the following principles essential and requests consideration in the reauthorization process.

- 1. Make the OAA more flexible across the six home and community-based service programs to facilitate direction and use of funds to meet locally defined high priority needs.**

¹ Minnesota Board on Aging, 2010

2. Modernize the OAA across all Titles to maximize resources and services in the context of the economy, technology and generational change.
3. Align reauthorization of the OAA with health care reform related to coordinated care, disease prevention and management, and purchase of long-term care services under the CLASS program.
4. Ensure that services are provided adequately to communities that are disenfranchised with priority focus on addressing language and cultural barriers.
5. Provide ongoing funding under the OAA for successful, cost effective, evidence-based interventions by shifting short-term demonstration funding to formula funding
6. Recognize the reach and value of the nationwide OAA network as one that delivers core services affordably and reliably in communities across the country.
7. Increase investments in the OAA to sustain cost-effective services and to grow the capacity of OAA programs to meet the needs and preferences of a growing population of older adults.
8. Streamline administrative burden for OAA providers and increase investments in management information systems and other technology for efficient service planning, management and delivery. Coordinate administrative requirements with other federal programs that serve older adults.

The Minnesota Leadership Council on Aging looks forward to providing additional consensus recommendations to members of Congress regarding specific policy changes to the OAA.

Respectfully submitted by:

Minnesota Leadership Council on Aging - Policy Committee Co-chairs

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Special Committee on Aging, field hearing
Senator Al Franken
“Strengthening Our Commitment to Minnesota Seniors: Promoting
Independent Living Through the Older Americans Act Reauthorization”
Maple Grove Community Center, Maple Grove, MN
September 10, 2010

Statement of Volunteers of America of MN, Senior Services,
www.voamn.org

“[T]he single greatest category of problems we encounter are those that address the care of decisionally incapable patients...who have no living relative or friend who can be involved in the decision making process.
These are the most vulnerable patients because no one cares deeply if they live or die.”

Nancy Dubler, Hospital Bioethicist, Incapacitated and Alone, ABA, 2003

Senator Franken thank you for providing yet another opportunity to hear of the challenges facing Minnesota’s growing population of older adults to remaining as independent as possible. We welcome this chance to share our expertise in how the Older American’s Act can support this goal.

Volunteers of America-Minnesota, a nonprofit organization founded in 1896, is one of the oldest, largest and most comprehensive human service organizations in the state with more than 60 programs, 900 employees and 8,000 volunteers. We serve over 15,000 seniors each year. We have a rich history of developing innovative programs to meet emerging social needs.

Volunteers of America of MN would like to speak on behalf of a population of seniors whose voice is not heard, those who lack cognitive decisional capacity and lack a social support network of family and friends. These are the older adults who no one wants to believe they will become. These are the older adults who do not attend hearings or write letters to their congressional members. They have no son to take them to the grocery store, no daughter

to make sure they have help with a bath, no niece to be sure they paid the rent and no cousin to be an emergency contact when they are in the hospital. Our staff sees the challenges of the incapacitated and the unbefriended elders through many of our programs on a daily basis.

The Volunteers of America Protective Services program receives over 800 calls annually from county, nursing home and hospital staff, attorneys, bankers and community members concerned about cognitively incapacitated individuals, who are often in crisis and in need of services to remain in the community, but who lack a surrogate decision maker to consent to necessary services and to ensure the older adult's assets are used to pay for these needed services. Approximately 3% of our referrals are Unbefriended Elders. We are in the last stages of a grant from the Minnesota Department of Human Services to meet the needs of this population by addressing their needs for a surrogate and treatment preferences prior to incapacity. Through in-depth assessments and case work, we were able to work with unbefriended older adults to identify treatment preferences and potential surrogates. This grant has preserved independence and provided support for Minnesota's unbefriended older adults.

The National Institute of Health estimates as many as 2.4 million to 5.1 million Americans have Alzheimer's disease. The risk of AD increases with age. The number of people age 65 and older is expected to grow from 39 million in 2008 to 72 million in 2030. Some current estimates indicate that the incidence of dementia in those over age 85 is over 50%. Fortunately, not all of those with the disease lack capacity in the early stages. The National Institute recently concluded that at this time there is nothing known to effectively treat or delay this disease.

One study of long-term care residents found 47% lacked all decision-making capacity and another 26% retained only partial capacity" (Miller & Cugliari, 1990). In Minnesota, we have found that approximately 3% of residents of long-term care facilities fit this definition and in the Twin Cities it is up to 7% of residents. The number of unbefriended elders in the community is unknown.

The Minnesota Commission on End of Life Care identified the development of systems and procedures within the health care systems to work with Unbefriended Elders/Adult Orphans as a "Top Five" public policy recommendation. The Minnesota Department of Human Services

“Transform 2010”, identified the need to support caregivers and “activate networks” to “support individuals who do not have family or other social support” as a theme for action.

Unbefriended Elders are often socially isolated. They are at risk for over or under treatment when admitted to care settings. They often are not eligible for county adult protective services as they do not meet county intervention standards. They may or may not be financially eligible for waived services. Their eligibility for services is often irrelevant, as their disease leads them to lack insight into their impairments and resulting need for services. These older adults do not make their needs known, as they lack the insight or memory to understand they have needs. Not only do they lack family or other social support, they often lack formal decision makers such as a Powers of Attorney, Health Care Agents, Trustees, Conservators or Guardians.

There is no one to advocate to have their needs met or to advocate for the quality of services they may receive. Caught in a perverse situation as a result of their disease, they lack insight into their needs and refuse services, sabotaging their desire to remain independent and leading to premature hospitalization or nursing home placement which is only necessary as they do not understand the need for so will not accept the very community supports that would keep them at home.

One option to meet the needs of the unbefriended population is a court appointed guardian or conservator. Minnesota’s Office of the Public Guardian solely serves citizens with developmental disability. The Minnesota Department of Human Services 2009 analysis of service gaps for seniors identified 13% of MN counties as reporting that guardianship availability is decreased. Need for guardianship was ranked 10th in service decrease by 36% or 30 Minnesota counties.

Using court appointed guardians/conservators is a costly option to meet the needs for cognitively incapacitated unbefriended older adults, due to related court and attorneys fees, as well the need to pay a non-family guardian, or the costs involved in developing high standards, well –supervised, volunteer programs.

A deeper policy issue for Minnesota and the country is whether we want to have the removal of constitutional rights and the appointment of a guardian

for all cognitively incapacitated older adults as public policy. As our population ages, this option has significant ramifications for a country which values freedom. What percentage of our older population do we want to have with rights removed and under the supervision of the court?

Considerations for Addressing the Needs of Unbefriended Elders through the Older Americans Act

1. Alternatives to requirements that an older adult be able to direct their own care, or have a surrogate to do so, in order to receive Medical Assistance waivers or other government funding to remain in the community. Any requirement for a legal surrogate in order to receive services, although on the face of it is to protect the rights of the incapacitated, in practice, as funding for legal surrogates is not available or is inadequate to the point that there are not professional guardians/surrogates willing to serve indigent clients, creates a barrier to services and can be seen as discriminatory to those with cognitive impairment.

2. Admission to a transitional care unit, long-term care facility, hospital or other federally funded service can not be denied on the basis of incapacity and lack of a legal or informal surrogate. Facilities are reluctant to admit the incapacitated who lack a decision maker as they are afraid they will be stuck with an older adult they can't safely discharge due to their own lack of insight into their care needs and refusal to accept necessary care, or due to the older adult's inability to recall or understand and manage their own finances and the provider's fear of being left with an unpaid debt. Who will consent to treatment? Who will do discharge planning? Who can figure out assets and determine if MA is needed? Who will do the MA application? Who will clean out the apartment/house for this person if they can't return home? Who will sign psychotropic medication consent paperwork? Who will be emergency contact? If there is a family, even if they don't have authority, they can still get things done informally, or get authority if needed, so providers will accept the incapacitated with family available with less issue. It is easier not to admit the unbefriended.

3. Funding dedicated to social work case management and advocates for incapacitated, unbefriended, older adults, regardless of income and assets. Social workers are able to assess capacity, respect the rights of older

adults, understand how to balance protection of the incapacitated with their rights and help ensure that the older adults receive the services necessary to remain independent in the community. Requiring cost sharing and fee for services case management does not work with this population as they lack insight into their needs and so will refuse services, they often don't know their income and assets and in practical ways lack the capacity to give informed consent for a service contract. Allowing social workers, advocates and case managers to serve these clients despite their lack of capacity, will allow experienced and capable professionals to develop plans to keep these older adults out of institutions and in the community.

4. Funding for quality, high standards, assessment as to need for guardianship, evaluation and implementation of less restrictive alternatives to guardianship, as well as high quality guardianship services must be available. All of these options, not just guardianship, must be available both to avoid unnecessary guardianship and to meet the needs of unbefriended and incapacitated older adults when there is no alternative to guardianship. Often professionals “jump the gun” on assuming the need for guardianship when less restrictive options could meet the individuals needs. At this time, alternatives are few and funding for professional guardians is insufficient in many areas of the state. Many professional guardians are refusing to accept referrals for indigent unbefriended older adult when their payment for heavy court responsibilities is \$30 per month. Unbefriended indigent older adults end up with no advocates, no decision maker and truly at the mercy of a system that is increasingly underfunded and requiring an advocate to ensure quality care as well as manage the system to ensure services. Our DHS grant to work on health care directives and 30 year history working with this population confirms that good alternatives to guardianship are available and effective.

5. Funding directed to support caregivers to keep older adults in the community, must be balanced to address the needs of those who lack the support of an informal caregiver. Unbefriended elders lose out on equitable funding and services that are available to seniors with caregivers, as well as the chance to be supported in the community when they may need it most.

6. Consideration of statutes which define and fund decision-makers for community services and medical care when the older adult lacks capacity and there is no legal or informal family surrogate. Statutory

options for accomplishing this include development of priority list of those with decisional authority when there is not legal surrogate, language allowing decisions to be made by a family member without legal authority, or by allowing 2 physicians, an ombudsman, a community committee, a case manager, a temporary limited guardian or court authorization of a special procedure or service, under clearly defined limited circumstances.

As a state and as a nation, we must develop alternative supports for those unbefriended older adults who lack informal family decision makers. This can be accomplished through the development of public policy, statutes, funding viable alternatives including community supports and case management, as well as adequate funding for quality guardianship/conservatorship services when there is no alternative to meet the needs of a cognitively incapacitated older adult. These steps will help maintain older adults in the community as well as have the added benefit of avoiding neglect and exploitation of the incapacitated.

Thank you for your consideration.

Minnesota Women's Consortium

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Bonnie Watkins

2009 Seneca

Falls Society
Rev. Katherine
Austin Mahle
Connie Barry
Sharon Bigot
Betty Bredemus
Marilyn Bryant
Lyn Burton
Mary Lee Dayton
Ralph Ebbott
Kay & Bill Erickson
Jeanne M. Fornier
Billie O. Franey
Shelly Franz
Carol J. Freeman
Rhoda Gilman
Francie Glickman
Grace Harkness
Ruth Hayden
Joan H. Higinbotham
Terri Hudoba
Sally Jorgensen
Lorraine Kemmer
Karen & Dave
Kirkwood
Perrin Lilly
Peggy Lucas
Kim Lund
Martha Muska
Ann K. Newhall
Kathy O'Brien
Sally W. Pillsbury
Joyce Prudden
Nina & Ken Rothchild
Nancy Rustad
Marna M. Skaar, M.D.
Mary Jo Skaggs
Patricia & Roger
Sween
Patty Tanji
John Taylor
Mary Tjosvold
Jessica Trites Rolie
Emily Anne Tuttle
Clara Ueland
Susan Vento
Rosalie Wahl
Lauren Weck
Jean M. West
Penny Winton
Lynelle Wood

To: Senator Al Franken
From: Bonnie Watkins, Executive Director, Minnesota Women's Consortium
Date: September 7, 2010
Re: Minnesota Women's Consortium Position on Older Americans Act Reauthorization

Dear Senator Franken,

The Minnesota Women's Consortium is pleased to be connected with your office in conjunction with your recent listening sessions on the reauthorization of the Older Americans Act (OAA), which funds many crucial senior services in Minnesota. We urge you, as a member of two committees that will oversee this reauthorization, to consider our testimony below, and we look forward to your leadership.

The Consortium has been the lead state organization on the Minnesota Elder Economic Security Initiative (MinnEESI, or The Elder-Nomics Project) since spring 2008. The Elder Index research released in February 2009 showed that thousands of Minnesota seniors, primarily women, have incomes that are inadequate to meet the true costs of living, yet are ineligible for government programs. The median retirement income for Minnesota women age 65 and over, from all sources, is about \$12,000, nearly \$7,000 short of the Elder Index cost of about \$19,000.

To help older women prosper, we recommend that rather than simply requesting large increases in funding for programs or services for older people you re-target funding to specific programs that meet the criteria below.

The Minnesota Women's Consortium believes the Older Americans Act must:

- Promote equitable and rational policy by using the Elder Index as a more realistic cost of living measure when evaluating existing policies and developing new policies for older Minnesotans.
- Assist older Minnesotans in moving toward economic security by supporting state-level programs such as Alternative Care and the Property Tax Refund.
- Maintain and expand existing programs which make housing affordable, and develop new ways to assist elders to remain in their own homes and communities. Our member group Golden Girl Homes is one such innovative

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approach, assisting older women in sharing housing assets. Several grassroots Living At Home Block Nurse Programs have endorsed the Minnesota Elder Index, and these programs unique to Minnesota support elders' choice to remain in their homes. Yet neither of these programs receive federal support.

- Encourage employers to provide flexible, non-traditional work configurations so elders who choose to work beyond age 65 can improve their economic status.
- Increase the emphasis on wellness and prevention in health care and long-term care.
- Provide leaders and people of all ages with more and better information related to income adequacy for older Minnesotans, to ensure appropriate use of services.

The Minnesota Women's Consortium is the only one of its kind in the United States. As a statewide collaboration of 160+ member organizations, the Consortium serves as a resource center to enhance equality and justice for all women and children. Since 1981, Minnesota women have come to the Consortium with concerns and proposed solutions. The Consortium has supported and helped many vital organizations that work toward heightened awareness on women's issues, sound public policy, and ultimately, full equality for women.

Women are disproportionately affected by economic insecurity, as the majority of older people, majority of economically vulnerable older people, majority of paid and volunteer caregivers for older people, and a group that has likely been underemployed and underpaid throughout their work-lives, with less access to benefits like pensions. The Minnesota Women's Consortium urges you to consider the testimony above throughout this process. Please consider us a resource, as we are happy to share our expertise with you. Thank you.

Sincerely,

Bonnie Watkins
Executive Director
Minnesota Women's Consortium



Minnesota Field Hearing on the Reauthorization of the Older Americans Act
September 2010

Comments on the Employment of Older Americans
Submitted by Experience Works, Inc.

Experience Works is a national, charitable, community-based organization whose mission is to improve the lives of older people through employment, community service and training. Originally named Green Thumb and chartered in 1965 as a small, rural demonstration program, Experience Works has grown to be the nation's leading provider of training, employment, and community service for low-income older Americans. As such, Experience Works is uniquely qualified to speak to the importance of reauthorizing the Older Americans Act, and strengthening those supports and services under the Act that help this country's older citizens secure and keep the jobs upon which more and more have come to depend.

Last year, through the Senior Community Service Employment Program (SCSEP) authorized through Title V of the Older Americans Act, Experience Works provided training and community service employment opportunities for over 30,000 unemployed people age 55 and over whose income was at or below 125% of the Federal poverty level. Those we served had multiple barriers to employment, including low literacy levels, disabilities, homelessness, and being out of the workforce for an extended length of time. This year, as our nation struggles to recover from the recession, we are facing extraordinary demands for our services in the thirty states (and Puerto Rico) where we operate our SCSEP programs.

SCSEP is a valuable tool to help unemployed older people who are low income or at risk of becoming low income get back on their feet. We have helped thousands of older Americans find work that contributes to their communities and leads them down a path to permanent employment. Older workers who have participated in SCSEP across the country have contributed millions of hours of community service, while serving thousands of local faith- and community-based organizations. Besides helping these people achieve self-sufficiency, SCSEP also provides an economic boost to their communities through wages earned and other direct services provided to such places as senior centers, schools, and health and veterans facilities. This community service improves the quality of life for all of us.

In addition to the economic benefits of SCSEP, the program provides older people the opportunity to continue to be productive and active, which leads to better health, increased longevity, and the feeling that they are still valued and important members of their communities. As the only federally funded employment program for low-income persons 55 or older, SCSEP is an essential part of the Older Americans Act (OAA) and an important vehicle for those older Americans most in need to learn new skills, contribute to their community and obtain gainful employment.

Congress has long recognized the importance of community service employment for older Americans. During the 2006 OAA Reauthorization, Congress affirmed the dual purpose of SCSEP by adding a Sense of Congress, Section 516, to the OAA, which read:

It is the sense of Congress that – (1) the older American community service employment program described in this title was established with the intent of placing older individuals in community service positions and providing job training; and (2) placing older individuals in community service positions strengthens the ability of the individuals to become self sufficient, provides much-needed support to organizations that benefit from increased civic engagement, and strengthens the communities that are served by such organizations.

Because of the aging of the population and the recent economic crisis that has so negatively affected older Americans, the need for a program like SCSEP has never been greater. According to the Bureau of Labor Statistics, there were nearly two million unemployed workers age 55 and older as of January 2010, an increase of 31 percent since November 2008 and the *highest number of unemployed workers in this age group since the Bureau of Labor Statistics has kept age-specific records*. Many of these people have not only lost jobs, but also their dreams of retirement and security.

As unemployment rises, these older workers face unprecedented challenges and barriers when looking for a job because of their age, the need for re-training, and the increased competition for the jobs that are available. With the nation's population continuing to grow older and the 55-to-74 year old cohort projected to increase by an estimated 47 percent over the next decade, SCSEP will be critical for meeting the needs of this country's most vulnerable older workers.

During the reauthorization process for the Older Americans Act, Congress will have the opportunity to examine how some policies have contradicted the intent and the purpose of SCSEP, and create a program that more fully serves the increasing needs of disadvantaged older Americans and their communities. To accomplish this, we recommend the following actions:

- Strengthen and expand Older Worker Programs so that they have a bigger impact on employment and training services for the fastest growing segment of the population.
- Maintain the \$825 million level of funding for SCSEP at a minimum, to meet the growing needs of older individuals and communities in light of demographic, social, and economic challenges of the future.
- Maintain the SCSEP at the U.S. Department of Labor (DOL). With the dramatic aging of the workforce, DOL can build on the long term record of success of the SCSEP to expand communication and coordination with other workforce programs to ensure the needs of older workers are met.

- Eliminate durational limits for SCSEP. In this uncertain economic climate, participants in SCSEP should be allowed to remain on the program rather than be subject to the maximum time extension they would be permitted in the current law.
- Develop performance requirements based on the population served by SCSEP. These would include using different definitions such as: placement rate rather than entered employment; earnings gain rather than average earnings; and a community service measure that reflects the value of community service rather than the number of hours worked by participants.
- Further strengthen the community service mission of SCSEP to maintain community service as a core performance requirement, and ensure that the measure reflects its true value in communities.
- Establish service options that respond to a range of individual circumstances and goals. For example, include provisions for a *community service only* goal for participants when community needs will be furthered and/or employment is not a feasible goal for the participants. Conversely, for those participants who *only need customized employment services* provided by SCSEP to become employed, they should be permitted to take advantage of only those services they need.
- Modify the SCSEP eligibility requirements to allow severely underemployed individuals the opportunity for enrollment.
- Expand services by implementing the OAA *Section 502(e) – Pilot, Demonstration, and Evaluation Projects* to provide new services for SCSEP participants as well as assisting those who are poor but do not quite qualify for SCSEP.
- Create a competitive grant making process that ensures efficiency, fairness, and minimal disruption to customers and is based on experience and performance. Grantees that meet performance expectations should not have territories disrupted every four years, which results in a decrease in services to older workers, at least for the first full year after competition. Absent unusual circumstances, grantees should not be awarded territories for which they have not applied and do not have expertise to serve.
- Provide clarification and streamline the law to eliminate the complicated data validation and data collection requirements. Current data collection requirements result in complicated procedures, which place an inordinate value on compiling information rather than on customer focused service delivery.
- Support the administration of SCSEP through employment and training administrative funds rather than reducing grants to cover the cost of administration.

Thank you for the opportunity to submit these comments on the reauthorization of the Older Americans Act and the importance of the community service employment program for older Americans contained with Title V of the Act. We look forward to working with other stakeholders throughout this process.

Written Testimony
Recommendations for Reauthorizing the Older Americans Act

Submitted to the Office of U.S Senator Al Franken, by
Jeri Schoonover, Vice President for Community Services, Lutheran Social Service of MN
September 7, 2010

Thank you Senator Franken, staff and all parties who are dedicated to assuring the reauthorization of the Older Americans Act (OAA) will grant improvements that will significantly benefit older Americans.

My work with Lutheran Social Service (LSS) is focused on supporting older adults and people with disabilities to achieve a full life in community – with the promise of safety, dignity and hope. I believe the OAA reauthorization can strengthen community based services and ensure they are the first choice to meet the needs of older adults as they age well in place.

Senior Corps, Caregiver Respite, Senior Nutrition, Guardianship and other community based services for older adults are within my area of leadership at LSS. Based on the expert insights offered by staff and the people we support in communities throughout the state of Minnesota, I offer the following recommendations for your consideration as you lead a new chapter in developing an OAA that meets the needs of tomorrow's older adults and communities:

1. A social model of service (non-medical) achieves fundamental OAA goals

Community based services offer countless benefits – from assuring socialization for older adults to accessing vital services that can assure health and wellbeing with little infrastructure. The difference between aging well in place and seeking service from a costly institution can be as simple as having someone help with meal preparation, grocery shopping and attending medical appointments regularly. In addition, one key community-wide benefit of supporting a community member as they age in their home is meeting economic development and community development goals for small and large jurisdictions. We know that community based service, using a social (non-medical) model, is cost-effective, meets needs, and must be creatively expanded as to meet growing needs.

2. Flexibility to implement with clarity of purpose

Meeting local need requires flexibility to adapt approaches to best match culture, opportunity and assure the most efficient use of funds. Responsiveness also requires local input on how to meet formula funding – so that federal, local government, philanthropic and community contributions can be leveraged to the greatest extent for the purpose of meeting the needs of older adults. The value of flexibility should also be seen in defining parameters on participation in the service – both for recipients and for contributors, specifically thinking of flexibility as a key value for tapping the vast resource of volunteers.

Flexibility must be paired with clarity of purpose, so parameters guide service delivery without spelling out the detailed approaches that should be customized for each local region or community. Once clarity of purpose has been established, funds should be channeled to those who can deliver the service with effectiveness, expediency and quality. Evaluation

measures should be standardized and used nationwide to determine the key deliverables being offered in each community.

3. Community based services require basic infrastructure supports to flourish

The often discussed age wave and corresponding needs for care can be met with community based services, if we have the foresight to establish the infrastructure necessary to grow and support key services. This includes sufficient funding to retain staff, appropriate mileage reimbursement to assure access to services for rural and isolated older adults, and support for implementation of technologies that can drive new models for service delivery.

Increasingly, newly retired volunteers are an invaluable resource for delivering community based services. To utilize and retain volunteer supports it is crucially important to that OAA fund technology and staff supervision for their work. Examples of necessary technology include access to phone, computer and business cards. Staff are needed to oversee, coordinate and support the work of volunteers.

The most crucial element for effective service delivery is excellent staffing. Support for effective training for staff, volunteers and community leaders can deepen confidence, quality and overall capacity to meet the needs of older adults. It is imperative to effectively utilize staff time by optimizing and streamlining administrative and reporting functions. Measuring and evaluating key service elements can enhance the quality of the service by informing all key stakeholders of trends, new lessons and emerging best practice to be incorporated to all services.

4. Support the self-directed approach to service

People seeking services are smart, they and their families know what they need to age well in place. Meeting specific need with the exact support being sought out creates an efficient exchange. This is exactly what self-direction of service helps older adults and their families do to, assuring each person's unique individual needs are effectively met. The OAA should glean the learning Centers for Medicare and Medicaid Services has gained as the self-direction clause has been adopted for Medicaid expenditures by older adults and people with disabilities nationwide. This approach and value represent much opportunity and should be incorporated into the new OAA.

Reauthorization of the Older Americans Act represents an important opportunity to drive innovation, and meet anticipated need while tailoring care giving and developing greater capacity to meet need through a community based approach.

If there is any way my staff or I could support your ongoing work please do not hesitate to ask for our assistance – we will do all we can to respond to your areas of interest.

Jeri Schoonover

The mission of Senior Community Services (SCS) is to **develop, coordinate and provide services that help meet the needs of older adults and support their caregivers**. SCS is celebrating its 60th anniversary this year so we have a lot of experience working with senior citizens and their caregivers. This gives us a fairly unique perspective about the value of the Older Americans Act (OAA).

A very high percentage of caregiving is done by family and friends. Conversely, only a small percentage of caregiving is done by 'professionals'. The OAA helps provide a vital safety net for senior citizens by providing funding for programs that support family caregivers. However, more funding is needed, especially as the 'Baby Boomers' enter into and swell the senior citizen ranks.

SCS, in partnership with Independent Home Living (IHL), through a grant from the Margaret A. Cargill Foundation, has developed a new and easy to use web-based resource to assist caregivers. It is completely free to the caregiver and the people they are caring for. By accessing this free tool, caregivers can reduce stress and have more time to attend to their own needs. This online program offers the following:

- Resources and ideas that make it easier for caregivers to start planning services for their loved one
- Community specific service resource information with professional recommendations
- A way to set up, coordinate and communicate with a personalized care team quickly and effectively
- 24/7 access to helpful and local caregiver information
- A place to call for free assistance with an experienced community professional to answer any questions and solve problems

Currently this free web-based tool is available with community specific information for Eden Prairie, Minnetonka, and Plymouth in Minnesota. Here is a link to the Minnetonka program's website: <https://www.ihlcaregiver.com/minnetonka>. This is a wonderful, efficient program that combines a 'high tech' with a 'high touch' approach to caregiving. It is a great example of what can be done with funding and creativity. We hope to expand this program to many other communities in the future.

SCS strongly encourages increased funding for the OAA. Thank you for this opportunity to provide written testimony. Please contact me if you have any questions or need any additional information.

Sincerely,

Don Waletzko

Field Hearing of the Senate Special Committee on Aging

"Strengthening Our Commitment to Minnesota Seniors: Promoting Independent Living Through the Older Americans Act Reauthorization"

Maple Grove Community Center, Maple Grove, MN
September 10, 2010

Written testimony from DARTS
West St. Paul, MN

DARTS is a nonprofit, community-based provider of aging services and resources for older adults and family caregivers. For 36 years, we have responded to the changing needs of the community with solutions, innovation, and a collaborative approach.

Key findings from Senator Franken's statewide listening sessions align with DARTS' core competencies: household services, caregiver support, transportation, and volunteerism. To strengthen the Older Americans Act (OAA) and its effectiveness, we suggest a wide-angle perspective of what an older person both needs and wants:

- Awareness of what's available to help
- Options and choices to meet unique circumstances
- High-quality services from trusted providers
- Easy access to services that are coordinated across providers
- Individual strengths recognized and maximized

This perspective is achieved only by a service system that is flexible and responsive to changing community needs. The community-based long-term care system is broad, and its infrastructure allows the federally defined aging network to function well.

In deliberating reauthorization of the Older Americans Act, we urge you to:

1. Allow flexibility in service definitions so providers can achieve commonality with other funders to streamline outreach, data collection, and reporting efforts and thereby increase service delivery capacity. When all system players buy in to the bigger outcome – increased health and independence among older adults – they all share in the overall results.
 - At DARTS, *we coordinate and multiply resources*. For instance, our homemaking and chore services facilitate the independent living of nearly 500 older adults each year. We piece together a complex combination of multiple public and private funders and other resources to bring some 18,000 hours of service to frail seniors. All government payers are vested in the cost savings that come from non-institutional care alternatives, but each payer "buys" service for only their select segment of the population. DARTS assembles all public funding sources and then adds: private-pay clients; United Way and foundation funding; and a dedicated workforce of staff and volunteers (corporate groups, community groups, and youth fulfilling community service hours). We maximize all investments to the extent possible while also managing the numerous billing, reporting, and accountability requirements.

2. Encourage innovation and access variety alongside selected program models that are informed by practice-based evidence gathering. Services need to have appeal and a personalized connection to be used.
 - At DARTS, *we bring a generalist approach to a very specialized service world.* We listen to needs and try to personalize services accordingly. People seldom need just home-delivered meals, or only chore service, or simply a bit of respite. They often need someone to explore with them their strengths, wishes, and options, and to then aid them in navigating and coordinating services. We understand the continuum of care, offer multiple access points, and provide the service education and coordination that is so needed and so seldom paid for by any source other than the philanthropy nonprofits can attract.
3. Infuse dollars or effort into awareness outreach, especially for caregiver services where self- and issue-identification is still limited.
 - At DARTS, *we provide awareness, education, and access and we are a trusted resource.* We are local and familiar. By having multiple touch points with older adults and family caregivers, we're in a position to tell them about Title III services and other community services available to them. We are their direct link to the programs and opportunities available through the OAA. As an expert in caregiver issues, we are looked to for advice and solutions along the aging and caregiving continuums.
4. Recognize and maximize the assets of older adults
 - At DARTS, *we put volunteers in the community and move their passion to action.* We take a full-circle approach to older adults by meeting their support needs as well as their need for meaningful participation in community life, often through volunteer opportunities.

As critical as OAA funding is, its impact is maximized by the complementary infrastructure built at the local level through organizations like DARTS. Please consider reauthorization of the Older Americans Act a critical priority in ensuring older citizens can access needed services delivered efficiently by local, trusted resources.

Field Hearing of the Senate Special Committee on Aging

**"Strengthening Our Commitment to Minnesota Seniors:
Promoting Independent Living Through the
Older Americans Act Reauthorization"**

Maple Grove Community Center, Maple Grove, MN
September 10, 2010

Written testimony -- Transportation
DARTS, West St. Paul, MN

DARTS is a nonprofit, community-based provider of aging services and resources for older adults and family caregivers. For 36 years, we have responded to the changing needs of the community with solutions, innovation, and a collaborative approach.

While DARTS is not a direct recipient of Older Americans Act funding for transportation, we have 36 years of experience transporting seniors and adults with disabilities. The hallmark of our service has been coordinating several levels of service and integrating various funding sources to provide a quality, shared-ride system aimed at optimal use. We were recognized with the national United We Ride Leadership Award for coordinated transportation in 2005.

As Senator Franken's statewide findings indicate, transportation continues to top the list of needs of seniors. Strengthening the link between transportation and community-based support services is critical in maintaining and improving the quality of life for older Americans and in building more inclusive, livable communities. It's widely recognized that a key component of creating a community for a lifetime is to improve mobility, which includes access to transit, safe and age-friendly roadways, and pedestrian-friendly streets.

Adaptability is one of the five critical A's of transportation. The others are affordability, accessibility, acceptability, and availability. Transportation that adapts to changing circumstances is increasingly important for seniors today and in the future.

First: Aging can be full of complexities. Older adults who need more assistance and support to navigate transit and service systems could get it through mobility management aimed at the individual.

Second: Using transit shouldn't be viewed as a penalty. Age-related issues vary from person to person and transit options vary too. Transitioning from driving to transit use can be difficult, but beneficial when the right options are found.

Record numbers of seniors will make this switch, so we must educate them on transit use and help them adapt well.

Third: Flexibility in transportation funding can address priorities. More transportation funding for seniors is needed. Flexible use community by community – like training volunteer bus drivers – allows adaptability to real needs and maximizes local assets.

Finally: Transportation coordination differs by application and funding source. Coordination between local transit providers and regional, fixed-route transit meets the need of some seniors, but it may not meet the need of those seeking priority rides closer to home. And, to echo the statewide findings, rural areas are challenged by fewer, if any, transit options for getting to services, often at some distance. More incentives for coordination can allow transportation providers to maximize and leverage funding.

DARTS has proven that when you mix transit users, funding sources, infrastructure, and operations to provide mobility for a community, the result is high-quality, efficient transportation. When providers can adapt to changes in needs and changes in demand and funding, we can better support older transit users and make the system less complex for them.

Adaptable, affordable, accessible, and acceptable transportation must be available to older adults. Without it, other resources go unused and people are left unserved. Communities depend on OAA funds to fill transit gaps and coordinate existing resources. Please consider transportation a critical priority in deliberating reauthorization of the Older Americans Act.

Testimony from the Living at Home Network

The Living At Home Network represents a model unique to Minnesota for helping older people stay in their own homes with a coordinated and integrated nonprofit network of local neighborhood and community support - at very low cost to government programs and the seniors themselves. Its formal name is the Living At Home/Block Nurse Program (LAH/BNP). We are not just there for those who are already utterly impoverished and frail, although we put poverty programs to work when our clients happen to qualify. We are there for all older people in each of the 43 geographically-based programs in Minnesota, and in our daily work we are deeply aware that "it's a two way street" with the older people serving as volunteers, board members, and active community members, helping each other and the professional and volunteer staff at least as much as we help them. Because of this work, we are delighted to hear that Senator Franken received the message many times over that "the top concern of Minnesota seniors [is] remaining independent and in their homes as they age."

Because we are grassroots nonprofit community-governed organizations, we see things differently from clinics, insurance companies, nursing agencies, assisted living facilities and hospitals. Many of those programs do not have a priority focus on helping seniors remain independent in their own homes. Many of them require long assessment meetings, filling out long forms, and jumping through hoops to find out if the senior qualifies for the very specific service. Our perspective starts with the individual seniors and their households and families. We offer companionship, social events, community services including help accessing those other services, and home based services including volunteer transportation, volunteer visiting, caregiver support, health promotion, service coordination and assessment, and when needed, home health aides and nurse-managed health care. Many of these services are provided at no cost, and when we have to charge, we keep the costs minimal. We work to build lifelong relationships that recognize the elders' strengths and assets and prevent problems as much as possible, long before the institutions and systems kick in for the health crisis, the "trash house" diagnosis, the family meltdown, or even the yearly clinic checkup. We partner with the seniors, which often means helping fill out voluminous forms and learning reams of rules on how to qualify for a patchwork of programs. And we are the best experts on what relationships and services are available, reliable, and affordable in each neighborhood.

We are proud to be different from the many large institutions which cannot provide the individualized attention and care and relationship-building that our communities offer. Over and over again, older people tell us, "I need a little help - but do not send me to some agency. I don't know them, and I don't want to share financial or personal information, or let people into my home, that I don't know and trust." Our model of care, while outwardly less impressive than the shiny new assisted living facilities, annually serves about 11,000 Minnesota seniors. Annually our services are critical in keeping over a thousand seniors at nursing home level of care out of nursing homes. In just one year, the care for the people we keep out of nursing would have a cost of over 20 millions dollars more if they were in nursing homes. Surely this model is worth a closer look as the Age Wave and accompanying shortage of government dollars makes it more obvious than ever that the current system is not working.

LAH/BNPs are typically small, with an average of only 2 direct staff and budgets averaging [\$100,000] annually. That's one reason you don't see our name on any billboards and we do not have any lobbyists. Yet with our community connections, local donations and private pay clients as well as small state and local government grants (typically about \$50,000 annually), we leverage thousands of hours of social and health services in prevention and "treatment" for older people in our communities and volunteer support services. For example, many of our programs help local Meals On Wheels programs recruit volunteers, undertake assessments and get older people enrolled, and follow up if something goes wrong in the delivery of the meals. With the many government cutbacks of recent years and the Age Wave upon us, the people we serve are ever more frail and impoverished, and our staff resources are stretched to the breaking point. We believe that just a fraction of the money now spent on institutional care and development of senior housing, using the perspective of seniors themselves rather than the large institutions, could make sure that all seniors in Minnesota have access to true community-based care and support, and could increase our capacity while maintaining the "small is beautiful" focus of Living At Home Block Nurse Programs where they do exist.

We strongly support Senator Franken's assessment that "resource constraints can limit access" and that funds are desperately needed to "improve coordination of service delivery." Minnesota could be a shining example to the nation of how to offer this high quality care at the lowest possible cost to the largest number of seniors - but even a demonstration or pilot project would require some additional funds. With a relatively small investment of resources, Living At Home/ Block Nurse Programs can do more and better about preventing elder abuse and ensuring the highest quality of care. We urge you, Senator, to resist the implication that bigger is better and that the large and visible institutions are best positioned to coordinate services and ensure quality in our homes and communities. On the contrary, the vast majority of seniors who govern our programs and donate to our programs and volunteer themselves, keep on telling us that they want to stay home and they are in fact able to stay home, with just a little help from the community. The seniors themselves keep saying that every neighborhood is different and every family is different. When they experience a short term stay in hospital or nursing home, they are grateful for the intensive care but they notice the loss of control over their own lives. We hope you will keep on listening to them.

Respectfully Submitted,

The Living at Home Network Board



1821 University Ave West S112 St Paul MN 55104
www.storetodoor.org

Testimony by Mary Jo Schifsky, Executive Director
 Store To Door
 Older Americans Act, Special Committee on Aging field hearing
 September 3, 2010

Store To Door, serving the seven county metro area of Minneapolis-St Paul MN, has a single program: We shop for and deliver groceries to homebound elderly, allowing them to remain well-nourished in their homes for as long as possible. We've been providing this shopping and delivery service to thousands of seniors for over 26 years. In addition to the groceries, ordered over the phone with the help of dozens of community volunteers and delivered directly into the kitchens of our clients, we provide a personal human connection for many of our isolated clients.

Our typical client is 82 years old and living with one or more chronic conditions, including macular degeneration, osteoporosis or emphysema. Over 75% of the clients served report income levels within 200% of the Federal poverty level. These elderly people are simply unable to get to the store, walk around it and bring groceries home. But they can navigate their home and they can prepare their own food, provided the food is brought to them.

In 2010, the Minnesota Board on Aging presented the results of a survey of age 60+ adults living in the metro area. It showed that 23,000 respondents reported needing help obtaining groceries and of that group, 7,000 had no one to assist them. The service provided by Store To Door can make the difference for an elderly person between having to leave their home and staying within familiar surroundings while still obtaining adequate nutrition.

Currently, Store To Door's receives no funding through provisions of the Older Americans Act. While Title III-B Supportive Services funds could include grocery delivery, the demand for Title B funds far exceeds the resources available to support all the supportive service needs. And, Store To Door is not eligible for any Title III-C funds. Within the Title III-C funding structure, there is no category for grocery shopping and delivery services. Of our active clients, about 15% use a meal delivery service but none of them can take advantage of a congregate dining site unless they happen to live in the building where it's available and have the mobility to get to the dining area.

We do receive funding through State of MN legislative policy actions but these funds are at risk as the State works through budgetary difficulties. Were we to lose these funds, we would be forced to curtail our service at a time when the need is projected to increase.

Store To Door asks the Administration on Aging, with the help of Senator Franken, to make provision of groceries to homebound elders a priority in the reauthorization. Please increase the flexibility of the Title III-C funds to include Store To Door's grocery shopping and delivery services.

There is no way my husband and I can grocery shop outside the home. I am an amputee; he has problems because of strokes. Thank you. Bev C., 2010 client.

To the Office of U.S Senator Al Franken

Written Testimony

Recommendations for Reauthorizing the Older Americans Act

Ruth Hunstiger and Monica Douglas, Co-Chairs,
Minnesota Association of Senior Nutrition Services

Submitted

September 7, 2010

The work being conducted to improve the impact of Older Americans Act (OAA) funding in the lives of Minnesotans is of supreme importance and most appreciated. We thank the office of Senator Franken for your excellent work, and also extend our thanks to the many people in Congress who are committed to assuring this reauthorizing process is one that improves the OAA to more effectively support all U.S. older adults to maximize independence and well being.

The Senior Nutrition Directors Association is a group of service providers who provide Senior Nutrition services to older adults throughout the state of Minnesota. Our Goal is to "Help Older Minnesotans maintain independence through access to healthy foods." All members of this organization receive Title III Older Americans Act dollars that assist us in providing this meaningful service.

Our many years of leadership in service programs to seniors and collaboration with statewide colleague organizations lead us to make the following strong recommendations to your office:

1. Clarity of purpose with federal funding streams.

Funding this area of service should not be so complicated. The goal is to deliver federal funding to the geographic and program areas that can deliver the resource as effectively, efficiently and with a high level of quality to older adults. With that in mind, we recommend that the OAA:

**Consolidate Titles III C1 and III C2 into a single Title III C that will fund both
congregate and home-delivered nutrition services and allow greater flexibility at the**

local project levels to target funds to best meet the needs of older adults at the community level.

Designate dollars in Title III C to congregate and home-delivered nutrition services only.

2. Support innovation to meet local need.

Each local area has its own unique dynamics. Senior nutrition providers should be encouraged to develop innovative methods of service delivery to meet the needs of each community. For example, food and nutrition should be viewed in a holistic system combining nutrition and physical activities into wellness programs and building partnership with services like immunizations, mental health or financial counseling. Other innovations include integrating local resources to best serve older Americans, creative marketing and recruitment of new participants who have a need and would otherwise not be aware of the opportunity to receive nutritious meals. As the funding currently stands providers are paid on a production basis, per meal, so there is no money available to allow time to develop and implement new service delivery models. We recommend that the OAA:

Fully fund Title III C and invest in the opportunity to use funds not only to serve the current population in need but also to transform congregate nutrition sites and home delivered nutrition services into desired models to meet the needs of the growing numbers of older individuals seeking to remain healthy in their communities.

3. Invest in low-cost, high outcome, community based services like Senior Nutrition.

With the numbers of older Americans expected to grow significantly over the short-term, Senior Nutrition and other community based services represent an area where capacity can be developed over the short term to meet need, and by doing so save significant public dollars. When older adults have active socialization opportunity and nutrition as provided by senior nutrition they age well at home longer. With this in mind, we recommend the OAA:

Increase funding for Title III C in order to ensure adequate funds to provide services for older individuals who need them.

**Strengthening Our Commitment to Minnesota Seniors: Promoting Independent Living
Through the Older Americans Act Reauthorization**

Testimony of Robert L. Kane, MD
Minnesota Chair in Long-term Care and Aging
University of Minnesota School of Public Health

Making Better Long-term Care Decisions

The Problem

Almost every American adult will have to make difficult decisions about long-term care (LTC), and they are woefully ill prepared. LTC represents an unrecognized crisis for most American families. Just do the math. A person living to age 65 has about a 40% chance of entering nursing home before they die. That means that each of us will have to make a stressful LTC decision for ourselves or our parents or our spouse.

Unfortunately we make these fateful decisions under the worst circumstances. We have insufficient information. We are in a crisis and we are extremely anxious. Nothing good can come from that recipe for disaster and often bad things do come from it. People unwittingly make poor decisions that set in motion a chain of unfortunate events that can ruin lives.

Many LTC decisions are made as a result of a discharge from a hospital. A discharge planner is told that the elderly patient must be gone by the end of the day. Hence, the most available service is deemed the best one. Families are put under great pressure to choose among limited, poor options. It is hard to make a good LTC decision under the best circumstances; it is virtually impossible under current arrangements.

What is involved in a good LTC decision? We can start with goal identification, what outcome are you trying to maximize? This may involve choosing between several important issues, like function, autonomy, and safety. How risk averse are you? Many family members have a much greater fear of risk than their older relatives. Likely not everyone in the family shares the same priorities about outcomes or risks. These differences deserve to be talked through, but such talk is not compatible with a rushed decision process.

Making a good decision requires structure and guidance. It is basically two-step process. The first step involves deciding what type of care is most suitable, what will produce the best outcomes. The second step then addresses who should provide that type of care. The salient factors for the first question may be quite different from those for the second. A list of salient questions that address what type of care will yield the best outcomes includes the following:

1. What outcome are we trying to achieve?
2. What risks are we willing to accept?
3. What is the array of care options available?
4. How does each option do in terms of achieving the desired outcomes and minimizing the risks?
5. Which options are realistic? Where are there openings now?
6. What are the costs involved in each option? Will third parties pay for some options but not others?
7. Should we think about temporizing by taking a less desired option and getting on the waiting list for what we really want?

Once you have identified the type of care desired, the next question is who should provide it. Questions around choosing a provider for a desired option include:

1. If a nursing home or assisted living, where is it located? Will relatives be more inclined to visit?
2. If a home care agency, what is its capability? Does it staff with a full array of therapists? Does it have policies about weekend care? If your relative has special needs, for example, for a caregiver speaking a particular language, will the agency try to find such a resource?
3. What do you know about the quality of these providers?
4. What does it cost? Total cost? Net costs after third-party payers pick up their share?
5. If it includes a residence, is it somewhere you would want to live? Who are the other residents? Will your relative have privacy?
6. Does it have a philosophy compatible with yours? A religious or ethnic overlay?
7. Are there policies that restrict the residents from doing what they want?

Establishing the conditions for asking these questions and making good decisions as a result is hard. This is generally not a do-it-yourself job. Most families need some sort of referee or councilor to sort through the family dynamics and provide salient information. Most families come to this stage pretty naïve and uninformed. They do not know what kinds of information is available or even what they need to know to understand what works best for whom. Unfortunately they usually turn to hospital discharge planners for this help, but these people are hospital employees whose job is to move people out as quickly as possible. They may not be the family's best advocate.

The Solution

AoA is in a good position to help with this important challenge. Their work can improve the lives of older people and their families. The answer lies in a strategy that includes several steps:

1. Create a structure for making more thoughtful, organized decisions. This may involve providing some sort of decision counselors, who could come from the ranks of case managers already sponsored by AoA but currently more focused on eligibility issues.
2. Create an information base. AoA already funds the creation of Aging and Disability Resource Centers. They offer the platform for structured decision making supports and information that describes the range of LTC services and the attributes of each type of provider. The information can go further, providing pictures and descriptions, much like MLS real estate listings on line. Tools are available to help make more thoughtful decisions and to take stock of people's level of risk aversion. Their ability to be a caregiver. (For a list of tools see RL Kane and J Ouillette, *The Good Caregiver*. Avery: New York, 2011) The ADRCs could offer resources to both guide decisions about how to choose the best type of care and provide quality ratings, pictures, and perhaps user comments on various vendors. Minnesota's well developed ADRC might be a good site for a demonstration of how these tools can be most effectively utilized.
3. What people really need is time to make good decisions. Coming to agreement takes time. AoA cannot address paying of transitional care to provide the protected time needed to do this planning, but it might be able to coordinate a planning effort, and perhaps a demonstration project,

Gayle Kvenvold, President and CEO, Aging Services of Minnesota
Written Testimony
2011 Older Americans Act Reauthorization
September 10, 2010

Thank you, Senator Franken, for your leadership on the Senate Aging Committee and for your hearing in the state on this issue so important to Minnesota's seniors. I would like to thank you for giving us the opportunity to submit testimony on the Older Americans Act (OAA) and the upcoming reauthorization of this critical legislation. I am submitting testimony today on behalf of Aging Services of Minnesota and our national affiliate, American Association of Homes and Services for the Aging (AAHSA). Aging Services of Minnesota represents more than 700 senior services providers across the state of Minnesota, delivering long term care, housing and supportive services to approximately 100,000 seniors every year.

Minnesota has been nation-leading in building a robust home and community-based services system to allow seniors to live in the place they call home for as long as possible. Our state agencies, providers, and consumers have worked together to ensure Minnesota's older adults rely less on nursing homes and more on care in the community. In the past decade alone, we have reduced the number of nursing beds in our state by more than 20%, reduced the average length of stay to well less than a year and median length of stay in a care center to only 26 days. Over 50% of persons who were discharged from a care center last year went *home*. In many cases, "home" is a setting where some service supports are still needed to keep that older person in their house or apartment -- and programs that are funded through the Older Americans' Act, whether meals to adult day, or homemaking, have played a key role in making this possible.

This dramatic change in where and how seniors receive essential service supports has been made possible because our public policy incentives and the desires of seniors are so well aligned -- not only is community living what seniors want for themselves, it is prudent investment of taxpayer dollars. On average we spend \$4,900 per month for a resident in a care center in Minnesota as compared to \$2,700 per month for those seniors we are helping to support in a home and community based setting.

Keeping our seniors independent longer means we must provide them with viable housing options. For those that the median age of residents in Housing and Urban Development senior housing is 74 years old, and 30% of them are age 80 and older. Studies show that subsidized senior renters experience more chronic health conditions than non-subsidized renters and homeowners. Efficiencies and cost savings in service delivery can be obtained when providing services in a congregate housing setting. Nursing home diversion programs provide real options for seniors that can live independently where services are available. Unfortunately relocation out of a nursing home can be hampered by a lack of affordable, accessible, supportive housing options. Please remember that our seniors rely disproportionately on federally assisted housing stock, including the Section 202 elderly housing program. Preservation and rehabilitation of these buildings is a key part of making home and community based services successful. These communities provide a platform for services for OAA service providers. And HUD has begun to actively promote co-location with service providers for everything from health screenings to meals.

Access to programs such as adult daycare and transportation are desperately needed by elderly Minnesotans in order to age in place safely. The Older Americans Acts should expand its focus to these areas by providing resources and directing interagency collaboration. The aging network of professionals that make these programs an important part of our continuum of care must have a commitment at the national level for interagency coordination. Almost every federal agency has programs that are targeted at the elderly. We must promote successful cooperation to deliver the very best opportunities to our elderly. The Older Americans Act already provides for an interagency coordinating committee and we applaud the informal interagency discussions that have taken place thus far. We strongly urge the Administration on Aging to formally convene the committee and provide a forum for identifying service gaps, finding opportunities for reducing or eliminating barriers and reach out to underserved communities.

Aging Services of Minnesota also believes good, accessible information is key to strengthening our state and nation's long-term care system. To achieve this, the Aging and Disability Resource Centers under Title II should have dedicated funding for improvements in public awareness of Older American's Act programs, information and referral technology, and training for single point of entry staff to assure that older adults and caregivers receive all the appropriate long-term services and support options that are available to them in their communities.

AAHSA has also proposed additional grant programs for Affordable Rental Housing with Supportive Services (*see attached draft language*) and demonstration projects that promote the use of technology for medication management, fall prevention, safety, and health and wellness kiosks in senior centers and senior housing developments.

Aging Services Minnesota appreciates your dedication to this issue. On behalf of our members and the residents they serve, we'd like to thank you for this opportunity to submit recommendations.

Whitney Senior Center

I would like to express my sincere appreciation to Senator Franken for holding Listening Sessions around Minnesota and now a Field Hearing of the Senate Special Committee on Aging. As the Director of the Whitney Senior Center in St. Cloud, Minnesota for the past 30 years I have seen the impact a comprehensive Senior Center can have on the daily lives of our nations Older Adults. We see and average of 300-500 people per day coming for multiple reasons. We have many classes to keep both the body and mind active. Our Fitness Center is very popular as well as the Senior Dining program funded through the OAA. Our Center is funded mainly through the City of St. Cloud General Tax Levy, as well as United Way funding, donations and grants. It costs the same to operate Whitney Senior Center for one year as it does to have 5 people in a Nursing Home for one year. We serve thousands of people from 55-101. Our funding is in danger due to cuts in Local Government Aid [LGA] from the State of Minnesota. Our nation needs to put direct funding into keeping its active Senior Centers operating and efficiently serving our rapidly aging population. By the year 2020 the State Demographer predicts that there will be more people over 65 in our state than under 18. Starting January 1st, 2011 our nation will see 10,000 people per day turning 65 for the next 20 years! These type of numbers will overwhelm our current service delivery system. We need to act now to keep people physically, mentally and socially active long into their retirement years. Thank you for the opportunity to share my perspective based on 33 years of experience in the aging field.

Steve Hennes



**Written Statement by Krista O'Connor, Administrator
Eldercare Partners, West St. Paul, Minnesota**

**Older Americans Act Reauthorization Recommendations - Caregiver Support Services
September 10, 2010**

Eldercare Partners serves the seven-county metropolitan area. The organization improves the lives of older adults and their family caregivers by providing high quality, easily accessible, community-based services through the cooperative efforts of our member organizations.

Eldercare Partners started receiving Older American's Act funding in 2002. Today the program is nationally recognized and received the National Alliance for Caregiving and MetLife Foundation 2006 Family Caregiving Award. With the support of the Metropolitan Area Agency on Aging (MAAA) and Title III-E funding, Eldercare Partners has successfully equipped thousands of family caregivers with the tools, resources, and support needed to continue their caregiving journey. Eldercare Partners collaborates with the State, other community-based providers and the health care industry to raise awareness on family caregiving issues and tap alternate funding sources, such as elderly waiver, alternate care or state cssd (community services/service development) grant funding. However, the need is greater than the dollars, and a \$25,000 shortage in 2010 Title III-E funding is projected at year's end.

Caregivers are Vulnerable

The caregiving role is not an easy one. Family caregivers encounter physical strain, disturbed sleep, elevated stress and develop chronic conditions at almost two times the normal rate. Caregivers report lower levels of self care and higher levels of smoking, alcohol use and prescription drug use. Estimates show that between 40 and 70% of caregivers have clinically significant depression.¹ And the ultimate sacrifice of caregiving is earlier death. Spouses, aged 66-96, who experience caregiving related stress, have a 63% higher mortality rate than non-caregivers of the same age.²

¹ Zarit, S., Assessment of Family Caregivers: A Research Perspective. In Family Caregiver Alliance (Eds.), Caregiver Assessment: Voices and Views from the Field. Report from a national Consensus Conference (Vol II). San Francisco: Family Caregiver Alliance.

²National Alliance for Caregiving and AARP. Caregiving in the U.S. Bethesda: National Alliance for Caregiving, and Washington, DC: AARP, 2004.

Although 60% of caregivers are employed full or part-time, they often struggle with balancing family and work. The caregiving role may lead to reduced job responsibility, termination, and interrupted contributions to social security and retirement plans. One study found that women who were caregivers during their working years were 2.5 times more likely to live in poverty as elders than women who had not been caregivers.³

Programs are Effective

Research continues to demonstrate the effectiveness of caregiver support programs. In 2004, Dr. Terry Lum, University of Minnesota, evaluated the Eldercare Partners caregiver coaching service and found that it significantly reduced the level of burden experienced by caregivers and helped them cope and provide care longer.⁴ Another study, released in late 2006, showed that patients whose spouses received counseling, support group participation, and phone support experienced a 28% reduction in the rate of nursing home placement and delayed the median time of institutionalization by 557 days.⁵

The Metropolitan Area Agency on Aging has supported the implementation of evidence-based/evidence-informed programs. Several organizations are using Powerful Tools for Caregivers, which is a six-session education series, or the TCARE process (Tailored Caregiver Assessment & Referral) that assists caregivers in selecting strategies and services that are most likely to lead to successful outcomes. Eldercare Partners supports research and evidence based programs. Eldercare Partners staff participated in Dr. Rhonda Montgomery's National Research Project, which collected data to support her TCARE model. In addition, with Title III-E funding assistance, Eldercare Partners was able to hire Montgomery and her team to conduct an evaluation of the Eldercare Partners caregiver coaching program. The results of the program evaluation are expected in early 2011, and will be used to determine best practice models.

However, every caregiving experience is unique and caregiver circumstances, preferences and abilities vary widely. In order to be most responsive to each and every caregiver, it is important that a variety of service approaches are available. Eldercare Partners requests that consumer choice and continued innovation can be fostered alongside the growing emphasis on select evidence-based models.

³ Wakabayashi, C. and K. M. Donato. 2004. The Consequences of Caregiving for Economic Well-Being in Women's Later Life. Presented at the annual meeting of the American Sociological Association, San Francisco.

⁴ Lum, T. (June 2004). Effectiveness of the caregiver coaching and counseling program: An evaluation report submitted to Eldercare Partners, Metropolitan Area Agency on Aging, St.Paul, MN.

⁵ Mittelman, M. S., Haley, W. E., Clay, O. J., Roth, D. L. 2006. Improving caregiver well-being delays nursing home placement of patients with Alzheimer disease. *Neurology*, 67: 1592-1599.

Family Caregivers Need Continued Support

Supporting family caregivers is a win, win, win scenario. The caregiver increases life balance and health, allowing them to provide care for longer periods of time. The older adult is able to receive needed services, and maintain independence for longer periods of time. And the long-term care system, avoids unnecessary inpatient admissions and the costs associated with premature institutionalization.

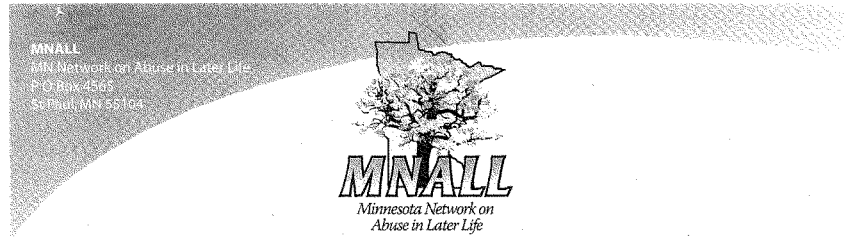
Family caregivers are the backbone of our long-term care system. Their services have an estimated national value of \$306 billion dollars annually.⁶ In 2005, family and friends provided 96% of the long-term care services in Minnesota.⁷ However, that percentage has fallen to 92%.⁸ Research shows that every 1 percent decline in eldercare provided by family and friends costs the Minnesota public sector an additional \$30 million per year.⁹ The 4% decrease carries a \$120 million annual price tag. Minnesota can not afford to continue this downward trend. Family caregivers must be supported with effective services that address their own health and well-being, services that empower and educate, and services that allow them to continue in their caregiving role. Eldercare Partners urges Congress to further strengthen support of family caregivers as it reauthorizes the Older Americans Act.

⁶ National Family Caregivers Association and Family Caregiver Alliance (2006). Prevalence, Hours and Economic Value of Family Caregiving, Updated State-by-State Analysis of 2004 National Estimates (by Peter S. Arno, PhD). Kensington, MD: NFCA and San Francisco, CA: FCA.

⁷ Status of Long-Term Care in Minnesota 2005. A Report to the Minnesota Legislature. Minnesota Department of Human Services Aging Initiative. June, 2006.

⁸ Department of Human Services, Minnesota Board of Aging: "Transform 2010".

⁹ Minnesota Department of Human Services estimate, 2006. The Medical Assistance (MA) program, the name that Minnesota uses for the Medicaid program is the federal/state program that provides health and long term care assistance to individuals who have exhausted their own resources.



September 10, 2010

MINNESOTA NETWORK ON ABUSE IN LATER LIFE (MNALL)

In 2001 the former Older Battered Women's Committee of MCBW found that there was a need for services from many agencies to answer the needs of Older Women (50 and over) that were/are victims of both domestic violence and sexual assault. As a result, several agencies joined together to form the Minnesota Network on Abuse in Later Life to address the many needs of older victims.

- We know that the population is increasingly getting older, and by 2020, there will be more people over the age of 65 than under the age of 18. Currently 1/3 of the population is over age 50.
- It is estimated that only 1 in 24 cases of abuse in later life is reported. This is considered to be the most hidden and underreported crime today.
- Women who have been traumatically assaulted in their lifetimes (no matter at what age) and have not received advocacy and support (and, indeed most have never reported) begin to experience age related health problems 10 to 12 years earlier than those who have not been assaulted, or if assaulted, reported and immediately received advocacy and support.

Mission Statement

The mission of the Minnesota Network on Abuse in Later Life is to promote networks of organizations and individuals statewide, to collectively confront issues of domestic/sexual abuse in later life, advocacy, and perpetrator accountability.

Vision Statement

The vision of the Minnesota Network on Abuse in Later Life is: A MINNESOTA FREE OF ABUSE IN LATER LIFE!

www.mnall.org

The Minnesota Network on Abuse in Later Life is a membership, non-profit organization, which provides resources and training on the dynamics of abuse in later life. Since 2006, we have done this work under a grant received from VAWA OJP/DOJ. The first 3 years were spent preparing and training law enforcement officers, prosecutors, and judges. We trained more than 250 officers along with many prosecutors and were able to send several judges to the federal training provided under our grant. Currently, we are training under a 2nd grant to train advocates, Adult Protection workers, and other service providers to the older population. Our grant allows us to train within the 7 county metro area, but we have extended invitations statewide for those that might possibly be able to attend.

Our grants were both funded as pilot projects and are ending within the next month. We have many requests to take this training "on the road" and train in many other areas of the state. This work is extremely important because the dynamics of working with older victims are so different from working with younger victims. This is due to that fact that they are older and come from different eras that may not have allowed the individuals to report the crimes, are heavy with shame, or do not even recognize the fact of being a victim because of beliefs they have lived with all of their lives.

Over the years, we have applied many times for funding from the Minnesota Office of Justice Programs, but have never been the recipient of funding. We have existed totally on funding from individuals, membership fees, and private donations along with a few small grants from agencies such as the Minnesota Women's Foundation, Bremer Foundation, etc. Unfortunately with all the cuts in available funding, we have not received any grants for a few years. Currently, MNALL is the only program in Minnesota providing training and resources on the dynamics of abuse in later life. In order to keep doing the work we do, MNALL desperately needs to receive funding.

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n4a's Draft Ideas for the 2011 Reauthorization of the Older Americans Act

July 16, 2010

1. Flexibility

Overall Idea 1: Make no change to the Act that unnecessarily restricts the local flexibility and inherent person-centered nature of the OAA's core philosophy and history.

Background: Of top importance to AAAs and Title VI programs is increasing local flexibility in order to provide more customized care for the consumers that they serve. The reauthorization should provide opportunities to determine if strategic reduction of unnecessary restrictions on local flexibility would ultimately provide a more person-centered and successful experience for the older adults and their caregivers, and should be careful not to impose new restrictions that reduce the ability of AAAs/Title VI programs to meet their clients where they are and get them the services and supports they need.

Idea 1-A: Merge Title C-1 and C-2 into one nutrition subtitle C that preserves the infrastructure of these vital programs while allowing for local flexibility in funding distributions. Make room for innovation in reducing hunger among older adults that is not necessarily a home-delivered or congregate site meal.

Idea 1-B: Enhance local transfer authority within the Act, specifically between all Title III subtitles. At the very least, maintain the transfer authority limit of 30 percent between Titles III B and III C.

Idea 1-C: Expand the ability for AAAs and the service providers they contract with to offer cost-sharing for selected OAA programs and services. While some services must remain exempted from cost-sharing (e.g., information and assistance; elder abuse prevention; outreach; and ombudsman), there is a longer list of OAA services that would benefit from enhanced and more formal cost-sharing. Thoughtful re-working of the cost-sharing rules would ideally increase the number of older adults that could be served, provide additional funds to the programs, and strengthen the long-term services and supports delivery system envisioned in the Act.

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Idea 1-D: Simplify the Title III E National Family Caregiver Support Program by lifting unnecessary data collection burdens, restrictions on how funds may be spent at the local level, and restrictions on how funds may be used by the caregivers. Increase authorization levels to meet the tremendous need for these services.

2. Long-Term Services and Supports

Overall Idea 2: Strengthen the role of the Aging Network to integrate medical and human services–based long-term services and supports (LTSS), particularly in order to promote the Aging Network’s role in health, wellness (both physical and behavioral health) and care management.

Background: With the passage of health care reform (The Affordable Care Act, or ACA), there are new opportunities for AAAs and Title VI programs to play a stronger and more enhanced role in promoting Medicare preventive services, transitional care, medical home model, options counseling and community-based/evidence-based health promotion and disease prevention programs. It is imperative that the OAA reflect that new reality and continue to promote the development of comprehensive long-term services and supports systems in every state and community.

Idea 2-A: Reflect the key elements of *Project 2020* (S. 1257/H.R. 2852)—single entry point models, evidence-based health promotion and disease prevention activities, and enhanced nursing home diversion/community living programs.

Background: In 2008, n4a and the National Association of States United for Aging and Disabilities jointly developed *Project 2020*, a legislative proposal which would take three AoA/CMS tested and proven approaches from the Aging Network to scale nationally. *Project 2020* has been introduced in Congress as S. 1257/H.R. 2852. This strategy of providing long-term services and supports will generate savings to Medicaid and Medicare at the federal and state levels, while simultaneously enabling older adults and individuals with disabilities to age in their homes and communities.

While the OAA reauthorization does not offer the funding opportunities that *Project 2020* requires to bring efforts to scale nationally, it will be important to ensure that the Act is updated to reflect the capacity and potential of the Aging Network in these areas.



June 16, 2010

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Idea 2-A-1: Include language in OAA that clarifies the relationship of AAAs and Aging and Disability Resource Centers (ADRCs). Include language and funding authorization that reinforces and supports the role of AAAs/Title VI programs in person-centered access to information, assistance and public education so that older adults, people with disabilities and caregivers have ready access to information on long-term care planning; are connected to community-based long-term services and supports; and have access to options and benefits counseling and case management.

Idea 2-A-2: Strengthen OAA Title III-D Preventive Health programs to incorporate best practices learned through AoA's evidence-based health promotion and disease prevention demonstrations (previously funded through Titles II and IV as well as by CMS), as well as authorized funding levels sufficient to meet the need for these cost-saving and health-boosting programs.

Idea 2-A-3: Build upon the successes of AoA's Community Living demonstration programs by establishing a permanent structure and authorized funding levels for enhanced nursing home diversion programs in the Act.

3. Authorization Levels

Overall Idea 3: Raise or create authorization levels for all of the titles of the OAA to ensure the Aging Network has the necessary resources to adequately serve the projected growth in the numbers of older adults, particularly the increasing ranks of individuals age 85 and older, who are the most frail, vulnerable and in the greatest need for aging supportive services.

Background: The OAA is the major federal categorical social services program for older adults in the United States. For 45 years, it has provided an ideal, well-established, trusted, community-based infrastructure of services responsive to the needs of older people and their caregivers. OAA programs' budgets have eroded over the last several years as federal funding has not kept pace with inflation or the growing population of individuals in need of services. As a result, services funded by these programs have lost considerable service capacity, causing many families to be placed on waiting lists for supportive services, adding to their emotional, physical and financial hardships. A larger federal investment in core OAA services and supports is needed to ensure the Aging Network has the necessary resources in the years ahead to adequately serve the projected growth in the numbers of older adults.



June 16, 2010

4. Building the Capacity of the National Aging Network

Overall Idea 4: Raise the bar on OAA performance by creating capacity-building initiatives to strengthen and enhance the National Aging Network.

Background: We must focus on building the capacity of the National Aging Network infrastructure to meet the challenges ahead. Creating the infrastructure needed to support the aging of the population requires investment in the Aging Network's capacity. Building capacity requires investments on multiple fronts, including developing core competencies, establishing performance standards, performing evaluations, and consistently attending to staff/volunteer development, training and retention. There is a tremendous opportunity in the reauthorization of the OAA to attend to this national priority.

Idea 4-A: Add to the existing Title II evaluation provisions under Section 206 to enhance the capacity of the Administration on Aging (AoA) to perform program evaluations for current OAA and emerging programs. This enhanced capacity would allow AoA to further develop its involvement in evidence-based programming and evaluate the Aging Network's role in providing long-term services and supports and related system change efforts. The enhanced capacity would also enable AoA to adequately evaluate new opportunities associated with the Affordable Care Act. These include the role of state agencies and AAAs in single-point-of-entry systems, options counseling, care coordination, case management services, prevention and wellness programs, and other core competencies of the network. The evaluation activities would be funded through their own authorization under Title II.

Idea 4-B: Create a new training and professional development program under Title III to boost employment efforts in the field of aging services that we as a nation have a strategic interest in growing: ¹ jobs in the provision of aging services and long-term services and supports. This new program would have its own funding authorization so it would not be dependent on other Title III funds or take away from services. The program would include new initiatives aimed at developing students' interest in working in the field of aging; preparing aging professionals already in the Network to become leaders; and enhanced staff and volunteer training through peer-level exchanges in effective leadership skills and management practices.

¹ The need for this investment has been well documented in reports such as the Institute of Medicine, "Retooling for an Aging America: Building the Health Care Workforce," April 14, 2008.

5. Senior Mobility Options

Overall Idea 5: Explore ways to strengthen the Aging Network's role in the coordinated planning activities through greater collaborative efforts between transit, planning and aging agencies and enhancing the role of the network in the growing field of mobility management services.

Background: The OAA reauthorization presents a tremendous opportunity to strengthen the Network's role in meeting the transportation needs of an expanding older population over the next decade, and to build on current efforts the Network has started in the areas of coordinated planning and mobility management services. In addition to the significant amount of transportation the Aging Network has provided as a core service of the OAA, the Network has also become key participants in the development of the coordinated public transit-human services transportation planning process established under the 2005 surface transportation authorization. Given the Network's extensive role in coordinating and providing transportation to older adults and persons with disabilities through the OAA, other human service programs such as Medicaid, and federal transportation programs, we must evaluate how we can best enable the Network to meet the challenges of increased service demands over the next OAA reauthorization period and beyond.

Idea 5-A: Formalize the role of the Aging Network, in particular AAAs, in the coordinated public transit-human services transportation planning process and authorize funding support and technical assistance to support these efforts. Include complementary provisions that reinforce and build upon this role under the pending surface transportation reauthorization.

Idea 5-B: Build on existing provisions in the OAA in Title III to encourage greater collaboration between AoA and the DOT and FTA-funded programs that will help break down funding silos. The Aging Network needs to maximize limited resources through the OAA by working more frequently with local transit agencies and providers. By developing effective partnerships, AAAs will be able to serve more individuals with additional funding available through the FTA's specialized transportation programs.

Idea 5-C: Add new language to the OAA to expand the description of transportation services to include mobility management activities. Providing a broad enough definition of mobility management to include the different facets of this burgeoning approach to providing transportation resources promises to improve both program effectiveness and the responsiveness of services they offer to consumers' needs.

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Idea 5-D: Authorize dedicated funding to implement the Technical Assistance and Innovation to Improve Transportation for Older Americans program under Section 416 of the OAA. This provision, added in the 2006 amendments, authorizes grants to non-profit organizations for demonstration projects or technical assistance to assist local transit providers, AAAs and other groups to encourage and facilitate coordinated transportation services and resources.

6. Title VI Native American Programs

Overall Idea 6: Build the capacity of and funding for Title VI programs to strengthen their ability to serve the complex and urgent needs of elders in Indian country.

Background: Title VI Native American aging programs are especially overdue for an increase in authorized funding. OAA provides the primary authority for funding services to elders in Indian country. Older American Indians are the most economically disadvantaged elders in the nation. Current Title VI funding levels are woefully inadequate to meet the needs of Indian elders; there has long been a lack of proper investment in these programs, which further exacerbates the challenges Indian elders face. Inadequate funding has made it impossible for many tribes to meet the five-days-a-week home-delivered meal requirement and has forced them to serve congregate meals only two or three days a week. Other service delivery needs among Native Americans have also developed that deserve increased attention, in particular transportation which is critical to connecting the Indian elders with other essential services especially in rural areas of the country.

Idea 6-A: Similar to the recommendation for Title III agencies, create a new training, professional development, and technical assistance program under Title VI to boost employment efforts in the field of aging services for Title VI grantees. Current training and technical assistance support to Title VI programs is less than 1 percent of Title VI funding while other Title II and IV training and technical assistance provisions have been unfunded. We propose that this new program would have its own authorized funding to promote a range of capacity building activities including training, professional development, and technology enhancements.

Idea 6-B: Specify authorization amounts for Part A and B of Title VI at a level that reflects the significant underfunding of the program and the need in Indian country for these vital services. Provide a comparable increase in authorization levels in Section 643 for the Part C Caregiver Support Program over the same period.

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Idea 6-C: Establish a new subsection under Title VI to focus on addressing the transportation needs of Native American elders. This new subsection would include its own authorized funding amounts for a range of mobility services including: transportation planning and coordination efforts; collaboration with other transportation programs focused on the Native American population; mobility management services, efforts to address unmet transportation needs; and to develop new and innovative programs to serve elders' transportation needs in rural and frontier communities

7. Promoting Livable Communities for All Ages

Overall Idea 7: Broaden, strengthen and support the unique role of AAAs and Title VI aging programs in strategic community planning to promote the ability of older adults to live successfully and independently at home and in the community for as long as possible.

Background: The country is facing the aging of the largest demographic cohort in its history. The aging of the baby boomers over the course of the next three decades will have a direct and dramatic impact on every community in the nation. The rise in the numbers of aging citizens will impact the social, physical and fiscal fabric of our nation's cities and counties; directly and dramatically affecting local aging, health, human services, land use, housing, transportation, public safety, workforce development, economic development, recreation, education/lifelong learning, volunteerism/civic engagement policies and programs.

Despite the impending demographic forecast, few communities have begun to prepare to address the aging of their population. Given their existing mandated role under the OAA to create multi-year plans for the development of comprehensive, community-based services which meet the needs of older adults, AAAs and Title VI programs are in a unique position to expand their support to communities to assess and assist in coordinating with local agencies to address the challenges and opportunities posed by the growing numbers of older adults.

Idea 7-A: Establish new provisions with dedicated funding authorizations to support AAAs and Title VI programs to assist county, city, and tribal governments across the nation to proactively prepare for the aging of their communities. The provisions would authorize funding and outline the role and activities to be performed by a full-time planner/community organizer position. This new planner/community organizer would take a leading role in working with other agencies and stakeholder organizations in developing a comprehensive livability plan and implementation strategy factoring the range of community policies, programs, and services.



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The authorized funding would be non-formula based, with a minimum level of funding and additional formula-based funding to increase subsidies to more heavily populated service areas and have a 25 percent match requirement. The new provision would include non-formula based funding to State Units on Aging to coordinate state-level planning. The provision would also establish a National Resource Center on Livable Communities for all Ages to provide the necessary guidance, training and technical assistance to AAAs and Title VI programs in their comprehensive planning efforts. Efforts funded under the provision would be evaluated after two years before the next reauthorization.

8. Make the Connection Between Affordable Housing & Services

Overall Idea 8: Expand the Aging Network's role in access to housing that meets the needs of older adults and the coordination of long-term services and supports in housing, in order to maximize older adults' quality of life and to promote livable communities for all ages.

Background: There is a need for increased attention and resources for connecting low-income individuals in subsidized housing facilities with needed supportive services that will allow them to more effectively age in place.

Idea 8-A: Add a new subsection under Title III aimed at connecting supportive services with congregate housing settings, including federally-assisted rental housing and Low-Income Housing Tax Credit Rental Housing. This new subsection would include its own authorized funding amounts for a range of services, including all service categories currently outlined under Title III B and planned for under the Section 305 and 306 planning provisions of the OAA. The new subsection would include provisions focusing on how the programs would coordinate with other Title III programs; interact with HUD Section 202 housing service coordinators; grant allocation; technical assistance; quality assurance; and oversight. In addition, the subsection would also include language encouraging grantees to coordinate with broader initiatives such as the HHS Money Follows the Person Demonstration and the Partnership for Sustainable Communities through HUD, DOT and EPA.



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9. Title V and Older Workers

Overall Idea 9: Improve the Title V Senior Community Service Employment Program while enhancing coordination with the Workforce Investment Act system, which is also up for reauthorization.

Background: Currently, there are two federally supported programs that provide assistance to older workers. The Senior Community Service Employment Program under Title V of the OAA provides low-income job seekers age 55 and older with job training and paid temporary work assignments with non-profit organizations, as well as placement assistance with local employers. This program is invaluable to low-income older adults who want or need to enter or return to the workforce. It also helps prevent the isolation of older adults by allowing them to engage in their communities through community service assignments. The Workforce Investment Act (WIA) contains provisions to assist in older worker job retraining and placement, but in recent years most of the focus for WIA programs has been on finding employment for younger workers. There are a number of provisions both in the OAA and the WIA that encourage coordination between the two systems, however, these provisions unfortunately do not go far enough to spur the necessary linkages and collaboration between the two programs.

Idea 9-A: Expand the Title V Senior Community Service Employment Program to include a greater number of older workers in need of assistance and training who are interested in working for community service organizations. Increase the income eligibility guidelines for the program from 125 percent of the Federal Poverty Level (FPL) up to 175 percent of FPL. This change will increase the ability of local Title V programs in serving older workers in search of employment who are not adequately served by the broader WIA one-stop system. Additionally, consider providing an exemption from these guidelines for higher income older workers, up to 200 percent of FPL, who have been out of work for a consistent period of time during the previous several months and have not been able to gain employment. These changes in eligibility guidelines would be accompanied by a new source of resources through the WIA system to serve the broader population of older workers (see Idea 9-D).

Idea 9-B: Raise the current cap on participation of an average of 27 months in the aggregate to at least 36 months. This change will allow greater time for older workers to gain necessary training and skills from community service positions that will provide them with the experience needed for unsubsidized employment in the future.

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Idea 9-C: Currently, grantees under Title V are required to consult with AAAs in the areas where they will be conducting a project and are required to submit to the state agency and AAAs, in the planning and service area, a description of the project for review and comment in order to ensure coordination with other aging programs under the OAA. However, this provision has not spurred enough collaboration between local Title V projects and AAAs to ensure effective coordination. Therefore, we propose that Title V projects be required to enter into memorandums of understanding (MOUs) with their local AAAs (if the project is not administered by the AAAs), outlining the steps the agencies will take to effectively coordinate their programs, similar to provisions under Section 511 requiring coordination with the WIA system.

Idea 9-D: Consider new provisions to both the OAA and the Workforce Investment Act of 1998 to build on current provisions that require Title V projects to be required partners in local WIA one-stop delivery systems and that require them to be signatories of MOUs outlined in the Section 121 of the WIA. Add provisions to each authorizing bill requiring that state agencies and AAAs have regular representatives on both state and local WIA boards. In addition, include a requirement that the WIA one-stop centers set-aside a portion of their authorized funding under Title I for serving older workers. This change would reinstate a set-aside provision under the Job Training Partnership Act that was dropped from the WIA, which has led to a decline in the number of older workers being served through WIA. This percentage of authorized WIA funding would be used to serve older individuals referred from the local WIA one-stop systems to Title V projects. This increased collaboration and pooling of resources would allow local Title V projects to better serve the growing number of older workers in need of assistance being referred to them from their WIA system partners.

10. Emergency Preparedness

Overall Idea 10: To ensure that older adults' needs are addressed in federal, state and local emergency preparedness efforts.

Background: There are specific steps that can be taken at the federal level that would help to promote coordination between agencies and allow them to better serve the needs of older adults during disasters. The demographic shift resulting from the aging of the baby boomers reinforces the need for communities of all sizes to begin to address a range of emergency preparedness issues that will have a direct impact on the aging population.

Idea 10-A: Promote federal, state, and local information sharing by establishing a consistent policy to ensure that FEMA registration information for the age 60 and older population is shared with state agencies and AAAs in federally declared disaster areas.



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In addition, federal grant funding should be established through AoA to support community-level work by AAAs to implement emergency preparedness registry systems for older adults and special needs populations that utilize geographic mapping technology.

Idea 10-B: Reinforce existing federal policy to formalize coordination plans. Build on the emergency preparedness provisions added to the Older Americans Act in 2006 by requiring that FEMA and local emergency preparedness agencies formalize coordination plans with the Aging Network, and specifically state agencies and AAAs. In addition, direct AoA and the Department of Homeland Security to establish an interagency program that would facilitate cross-agency training opportunities and provide on-the-ground orientation to both networks on how they can more effectively work together and better utilize each others resources during disaster planning, response and recovery efforts.

Idea 10-C: Fulfill the promise of the OAA emergency planning provisions by authorizing dedicated funding to AAAs to support the critical endeavors described under Section 306(a)(17). Reassess the OAA disaster assistance program under Section 310 and consider changes that will allow AoA to provide more substantive and timely aid to the Aging Network in times of disaster. As an example, raise the cap on the amount of total payments during any fiscal year to states, AAAs, and tribal organizations to provide supportive services during disasters, which is currently based on a percentage of total Title IV appropriations.

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June 16, 2010



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Statement on the 2011 Reauthorization of the Older Americans Act

September 10, 2010

The Honorable Herb Kohl, Chair
U.S. Senate Special Committee on Aging
G31 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Al Franken, Member
U.S. Senate Special Committee on Aging
320 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Kohl and Senator Franken:

The two field hearings held this week by the Senate Special Committee on Aging in Milwaukee, WI and Maple Grove, MN, represent the beginning of an exciting conversation about the future of the Older Americans Act (OAA) as Congress looks to reauthorize this important piece of legislation in the coming year. We thank you for your leadership in conducting the hearings as a way to galvanize your colleagues in the Senate and to listen to older adults, caregivers and advocates, in order to start the reauthorization process in a thoughtful and thorough way.

As you know, n4a is proud to represent the nation's 629 Area Agencies on Aging and to be a champion in Washington, DC for the 246 Title VI Native American Aging Programs. We believe that the OAA is the critical cornerstone of aging services in this nation and that the 2011 reauthorization provides us with an opportunity to build on the successes of the Act in order to respond to the needs of today's and tomorrow's older adults and caregivers.

n4a's process to develop our reauthorization recommendations began last winter and has included three focus groups on the eve of AoA's Listening Sessions early this year; a comprehensive survey of our members on the Act this summer; and a "Ramping Up for Reauthorization" interactive discussion forum at our annual conference this July. We are in the process of finalizing our recommendations to Congress and hope to have specific details to share with you later this fall. n4a is committed to working with our AAA and Title VI members and congressional champions—like you—to build momentum for reauthorization in 2011.

National Association of Area Agencies on Aging

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While we do not yet have those final recommendations to bring before the Special Committee on Aging, we have attached the draft set of ideas distributed at our annual conference in July in order to provide a sense of our priorities.

n4a's Board, members and staff look forward to working with you and your staff as the reauthorization process unfolds. Thank you for your leadership on behalf of our country's older adults, people with disabilities and their caregivers.

Sincerely,

Dawn Simonson
President, n4a
Executive Director, Metropolitan Area Agency on Aging, Inc., North Saint Paul, MN

Sandy Markwood
Chief Executive Officer, n4a

cc: Members of the Senate Special Committee on Aging

Attachments:
n4a Draft Ideas Document, July 2010