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SERVING SENIORS THROUGH THE OLDER AMERICANS ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON HIGHER EDUCATION AND WORKFORCE TRAINING

COMMITTEE ON EDUCATION AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

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SERVING SENIORS THROUGH THE OLDER AMERICANS ACT

Tuesday, February 11, 2014
House of Representatives,
Subcommittee on Higher Education
and Workforce Training,
Committee on Education and the Workforce,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:03 a.m., in Room 2175, Rayburn House Office Building, Hon. Virginia Foxx [chairwoman of the subcommittee] presiding.

Present: Representatives Foxx, Petri, Thompson, Walberg, Salmon, Guthrie, Heck, Hudson, Hinojosa, Tierney, Bonamici, and Wilson.

Also present: Representatives Kline and Gibson.

Staff present: Janelle Belland, Coalitions and Members Services Coordinator; Lindsay Fryer, Professional Staff Member; Amy Raaf Jones, Deputy Director of Education and Human Services Policy; Rosemary Lahasky, Professional Staff Member; Nancy Locke, Chief Clerk; Daniel Murner, Press Assistant; Krisann Pearce, General Counsel; Jenny Prescott, Staff Assistant; Nicole Sizemore, Deputy Press Secretary; Emily Slack, Professional Staff Member; Alex Sollberger, Communications Director; Alissa Strawcutter, Deputy Clerk; Tylease Alli, Minority Clerk/Intern and Fellow Coordinator; Kelly Broughan, Minority Education Policy Associate; Jody Calemine, Minority Staff Director; Jamie Fasteau, Minority Director of Education Policy; Melissa Greenberg, Minority Staff Assistant; Scott Groginsky, Minority Education Policy Advisor; Julia Krahe, Minority Communications Director; Brian Levin, Minority Deputy Press Secretary/New Media Coordinator; Leticia Mederos, Minority Director of Labor Policy; and Megan O'Reilly, Minority General Counsel.

Chairwoman Foxx. A quorum being present, the subcommittee will come to order. Good morning, and welcome to today's hearing.

I would like to start by thanking our panel of witnesses for joining us to discuss serving our nation's seniors through the Older Americans Act.

Enacted in 1965, the Older Americans Act was established to help older individuals continue living independently in their homes and remain active in their communities. The Act combines federal, state, and local resources to support programs and services that ad-

dress the needs of the senior population, now estimated at more than 41 million Americans.

At the federal level, the Older Americans Act established the Administration on Aging, now known as the Administration for Community Living, to oversee most of the law's programs. However, the Act largely relies on a national network of 56 state agencies on aging, 629 Area Agencies on Aging, and nearly 20,000 service providers to plan, coordinate, and deliver services to local seniors.

Using formula-based grants authorized under Title III of the law and other funding sources, state and Area Agencies on Aging develop programs tailored to meet the needs of local seniors. These programs provide supportive services such as transportation to and from doctors' offices and pharmacies, financial support for senior centers and family caregivers, and disease prevention and health promotion activities.

But the Older Americans Act is perhaps best known for supporting key nutrition services, such as group and home delivery meal programs, the latter being more commonly known as Meals on Wheels. States match 15 percent of their federal grant to ensure local agencies can provide nutritious meals to the elder population most in need. In fiscal year 2011, the most recent data available, more than 223 million meals were served to approximately 2.5 million people.

The Older Americans Act plays a vital role in helping seniors access services that promote health, independence, and longevity. In fiscal year 2010 alone the law's programs served nearly 11 million older Americans and their caregivers.

As we work toward reauthorizing the Older Americans Act, we must acknowledge the law faces challenges. The population of senior citizens has changed dramatically since the law was first drafted in the 1960s.

U.S. Census projections estimate the number of Americans age 65 and over will increase from 40 million in 2010 to 72 million in 2030. This means that for the next 19 years roughly 10,000 baby boomers will turn 65 every day.

As a result, many are concerned that the Older Americans Act cannot effectively meet the needs of the rapidly growing senior population, especially amid current fiscal constraints.

As we explore ways to strengthen the law, it is critical we seek to enhance program coordination and efficiency so that we may better serve those with the greatest social and economic needs. Equally important is preserving the law's federalist structure, which balances a national framework of programs and funding with significant local flexibility in order to effectively meet the needs of local seniors.

Last year the Senate Committee on Health, Education, Labor, and Pensions approved the Older Americans Act Reauthorization Act of 2013. Today we have the opportunity to begin the committee's process of exploring the best ways to improve the law's flexible policies and targeted programs that are essential to providing care for America's seniors.

I look forward to working with my colleagues in a bipartisan effort to reauthorize the Older Americans Act and help seniors age with dignity and comfort.

With that, I yield to my colleague, Mr. Rubén Hinojosa, the senior Democrat member on the subcommittee, for his opening remarks.

[The statement of Chairwoman Foxx follows:]

Prepared Statement of Hon. Virginia Foxx, Chairwoman, Subcommittee on Higher Education and Workforce Training

Good morning and welcome to today's hearing. I'd like to start by thanking our panel of witnesses for joining us to discuss serving our nation's seniors through the Older Americans Act.

Enacted in 1965, the Older Americans Act was established to help older individuals continue living independently in their homes and remain active in their communities. The Act combines federal, state, and local resources to support programs and services that address the needs of the senior population – now estimated at more than 41 million Americans.

At the federal level, the Older Americans Act established the Administration on Aging, now known as the Administration for Community Living, to oversee most of the law's programs. However, the Act largely relies on a national network of 56 state agencies on aging, 629 area agencies on aging, and nearly 20,000 service providers to plan, coordinate, and deliver services to local seniors.

Using formula based grants authorized under Title III of the law and other funding sources, State and Area Agencies on Aging develop programs tailored to meet the needs of local seniors. These programs provide supportive services such as transportation to and from doctor's offices and pharmacies; financial support for senior centers and family caregivers; and disease prevention and health promotion activities.

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As we work toward reauthorizing the Older Americans Act, we must acknowledge the law faces challenges. The population of senior citizens has changed dramatically since the law was first drafted in the 1960s. U.S. Census projections estimate the number of Americans age 65 and over will increase from 40 million in 2010 to 72 million in 2030. This means that, for the next 19 years, roughly 10,000 Baby Boomers will turn 65 every day. As a result, many are concerned that the Older Americans Act cannot effectively meet the needs of the rapidly growing senior population – especially amid current fiscal constraints.

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I look forward to working with my colleagues in a bipartisan effort to reauthorize the Older Americans Act and help seniors age with dignity and comfort. With that, I yield to my colleague, Mr. Rubén Hinojosa, the senior Democrat member of the subcommittee, for his opening remarks.

Mr. HINOJOSA. Thank you, Chairwoman Foxx.

Today's hearing will focus on the vital importance of the Older Americans Act in serving our nation's older adults. Our distinguished panel of witnesses includes Dr. Yanira Cruz, executive director of the National Hispanic Council on Aging.

I personally want to thank Dr. Cruz for bringing a very unique perspective to this hearing and for sharing her expertise on the Hispanic elderly and the many diverse populations you have worked with.

Over the next 20 years the proportion of the U.S. population over age 60 will dramatically increase, as our chairwoman pointed out, as 77 million baby boomers reach traditional retirement age. According to the U.S. Census Bureau, by 2030 more than 70 million Americans—twice the number in 2000—will be 65 and older. Older Americans will comprise 20 percent of the U.S. population, representing one in every five Americans.

Our nation's aging populations is also becoming increasingly diverse, with Latinos; African-Americans; Asian-Americans; Native Americans; and lesbian, gay, bisexual, and transgender seniors comprising a larger segment of the elder population.

In light of these significant demographic shifts, the committee must work together to continue to improve the law and to adequately fund OAA programs.

As you know, OAA was passed in 1965 to address concerns over the lack of community and social services for the elderly. Today a range of services, including health, nutritional, and social supports, and job training provided through the OAA programs remove the barriers to economic and personal independence for older adults.

In recent years the Act has been expanded to cover long-term care ombudsman and family caregiver support. OAA programs reduce costly institutional care and medical intervention by focusing on in-home and community-based long-term care. Targeted spending on programs authorized by OAA makes it possible for older adults to stay in their homes, helping to reduce those costs.

While OAA programs are available to all Americans 60 years or older and require no income eligibility for services, OAA programs also target resources to seniors with the greatest economic and social need. Notably, a 2012 GAO report found that low-income, limited English-speaking, minorities, and very elderly populations had higher need for OAA services than their counterparts.

Finally, despite bipartisan support for these OAA programs and the sharp increases in the aging population, OAA programs have been inadequately funded for several years. What is more, in my congressional district in Deep South Texas there are older adults who are victims of elder abuse and financial scams that many times go unreported.

Low-income seniors in South Texas also experience food insecurity. This is clearly unacceptable to me and to members of our committee. In my view, adequately funded OAA programs and better financial literacy programs for seniors could help to address these issues.

As this committee considers the reauthorization of OAA, I ask my colleagues to put our nation's seniors first. OAA programs have had longstanding bipartisan support and older Americans deserve nothing less.

With that, Madam Chair, I yield back.

[The statement of Mr. Hinojosa follows:]

Prepared Statement of Hon. Rubén Hinojosa, Ranking Minority Member, Subcommittee on Higher Education and Workforce Training

Thank you, Chairwoman Foxx.

Today's hearing will focus on the vital importance of the Older Americans Act (OAA) in serving our nation's older adults. Our distinguished panel of witnesses includes Dr. Yanira Cruz, Executive Director of the National Hispanic Council on Aging (NHCOA). I personally want to thank Dr. Cruz for bringing a unique perspective to this hearing and for sharing her expertise on the Hispanic elderly and diverse populations.

Over the next 20 years, the proportion of the U.S. population over age 60 will dramatically increase, as 77 million baby boomers reach traditional retirement age. According to the U.S. Census Bureau, by 2030, more than 70 million Americans – twice the number in 2000 – will be 65 and older. Older Americans will comprise nearly 20 percent of the U.S. population, representing one in every five Americans.

Our nation's aging population is also becoming increasingly diverse, with Latinos, African Americans, Asian Americans, Native Americans, and Lesbian, gay, bisexual, and transgender (LGBT) seniors comprising a larger segment of the elderly population.

In light of these significant demographic shifts, this committee must work together to continue to improve the law and to adequately fund OAA programs.

As you know, OAA was passed in 1965 to address concerns over the lack of community and social services for the elderly. Today, a range of services, including health, nutritional, and social supports and job training provided through the OAA programs remove barriers to economic and personal independence for older adults. In recent years, the Act has been expanded to cover long-term care ombudsmen and family caregiver support.

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While OAA programs are available to all Americans 60 years or older, and require no income eligibility for services, OAA programs also target resources to Seniors with the greatest economic and social need. Notably, a 2012 GAO report found that low income, limited English speaking, minorities, and very elderly populations had higher need for OAA services than their counterparts.

Finally, despite bipartisan support for OAA programs and the sharp increases in the aging population, OAA programs have been inadequately funded for years.

What's more, in my congressional district, there are older adults who are victims of elder abuse and financial scams that many times go unreported. Low-income Seniors in South Texas also experience food insecurity. This is clearly unacceptable.

In my view, Adequately funded OAA programs and better financial literacy programs for Seniors could help to address these issues.

As this committee considers the reauthorize of OAA, I ask my colleagues to put our nation's Seniors first. OAA programs have had long-standing bipartisan support, and older Americans deserve nothing less!

With that, I yield back.

Chairwoman Foxx. Thank you, Mr. Hinojosa.

Pursuant to committee rule 7(c), all subcommittee members will be permitted to submit written statements to be included in the permanent hearing record. And without objection, the hearing record will remain open for 14 days to allow statements, questions for the record, and other extraneous material referenced during the hearing to be submitted in the official hearing record.

It is now my pleasure to introduce our distinguished panel of witnesses.

Ms. Carol O'Shaughnessy is a principal research associate with the National Health Policy Forum at George Washington University in Washington, D.C. Mrs. Lynn Kellogg is chief executive officer of the Region IV Area Agency on Aging in Southwest Michigan.

Dr. Yanira Cruz is the president and CEO of the National Hispanic Council on Aging. Mrs. Denise Niese serves as the executive

director of the Wood County Committee on Aging in Bowling Green, Ohio.

Before I recognize you to provide your testimony, let me briefly explain our lighting system.

You will have five minutes to present your testimony. When you begin the light in front of you will turn green; when one minute is left the light will turn yellow; when your time is expired the light will turn red. At that point I ask that you wrap up your remarks as best as you are able.

After you have testified, members will each have five minutes to ask questions of the panel.

I now recognize Ms. Carol O'Shaughnessy for five minutes.

STATEMENT OF MS. CAROL V. O'SHAUGHNESSY, PRINCIPAL POLICY ANALYST, NATIONAL HEALTH POLICY FORUM, WASHINGTON, D.C.

Ms. O'Shaughnessy. Good morning, and thank you, Chairwoman Foxx, Ranking Member Hinojosa, and members of the subcommittee. I am pleased to appear before you today to talk about the Older Americans Act of 1965.

As you mentioned, the purpose of the Act is to help people age 60 and older maintain maximum independence in their homes and communities and to provide a continuum of care for the vulnerable elderly. The 1965 law authorized generic service programs, but in successive amendments Congress has authorized more targeted programs under various titles.

In 1973, Congress extended the reach of the Act by creating authority for sub-state Area Agencies on Aging. This decentralized planning and service model has meant that state and area agencies are largely in control of their aging agendas and can be responsive to state and local needs within federal guidelines and priorities. The major function of these agencies is to advocate for, plan, and coordinate, and promote a coordinated service system for older people.

Under its seven titles, the Act supports the aging services network, comprised, as you mentioned, of 56 state Agencies on Aging; over 600 Area Agencies on Aging; thousands of service providers and volunteers; and research, demonstration, and training initiatives. Total federal funding is about $2 billion.

Title III, the largest component of the Act, representing over 70 percent of funding, creates authority for four service programs.

The first, the elderly nutrition program, the oldest and perhaps most well-known of the Act's services, is intended to address inadequate nutrition by providing meals in congregate settings and to frail older people in their homes. The supportive services program provides home care, adult day health care, and transportation services, among others, to help impaired older people live independently.

The family caregiver program provides grants to develop caregiver support programs, such as family counseling and respite care. The smallest of Title III programs authorizes disease prevention and health promotion activities, such as nutrition counseling, Medicaid management consultation, and immunizations.

Title III services are available to all older people who need assistance, but the law requires that services be targeted to those with the greatest economic and social need. Compared to all older people, Title III participants are the most vulnerable, such as those with advanced age, those who have income below poverty, live alone, or have multiple chronic conditions and impairments, making Title III services important and critical for older people and their families.

States receive Title III funds according to their relative share of the total U.S. population age 60 and older. States allocate funds to area agencies based on state-determined formula, and then area agencies determine how to best serve the target populations defined by law.

Participants are encouraged to make voluntary contributions for the services they receive, and states may implement cost-sharing policies on a sliding fee scale for certain services. Means testing is prohibited.

Title VII of the Act provides grants to support the long-term care ombudsman program. About 10,000 paid and volunteer ombudsman work to improve the quality of life for residents of nursing homes and other residential facilities.

The Act authorizes other programs, such as elder abuse, neglect, and exploitation prevention; community service employment; aging and disability resource centers; and grants to Native American organizations.

Over the years, many state and area agencies have broadened their responsibility beyond the administration of the Act's funding—for example, administering the Medicaid state and finance long-term services and supports programs.

The law was not intended to meet all the community needs of older people. Its resources are meant to leverage other funds.

States are required to match other funds, as you mentioned, and aging services network agencies garner other federal and nonfederal funds to support aging services. Also, voluntary contributions match state and local funds. According to AOA, states typically match two or three dollars for every federal dollar.

In conclusion, the mission of the aging services network is designed to meet many competing needs of older people. Even with its modest funding, the Act has encouraged the development and provision of multiple and varied services over the last 49 years.

Nationwide, state and area agencies connect thousands of providers with people who need assistance. The law allows flexibility to state and area agencies to develop programs where they see the greatest need.

Even though the Act's funds reach relatively limited numbers of older people, programs are targeted to the most vulnerable. Efforts by state and area agencies to act as planning, coordination, and advocacy bodies have improved policies that affect broader groups of older people.

As the U.S. population rapidly ages, as you mentioned, the sheer number of elderly will continue to present challenges to communities across the nation and to the aging services network.

Thank you, and I would be happy to answer any questions you may have.

[The statement of Ms. O'Shaughnessy follows:]

"Serving Seniors Through the Older Americans Act of 1965"

Hearing before the Committee on Education & the Workforce

Subcommittee on Higher Education & Workforce Training

U. S. House of Representatives

February 11, 2014

Carol V. O'Shaughnessy

National Health Policy Forum

George Washington University

"Serving Seniors Through the Older Americans Act of 1965"

Testimony of
Carol V. O'Shaughnessy
Principal Policy Analyst
National Health Policy Forum
George Washington University
Before the
Subcommittee on Higher Education & Workforce Training
Committee on Education & the Workforce
U.S. House of Representatives
February 11, 2014

Good morning, Chairwoman Foxx, Ranking Member Hinojosa and members of the Subcommittee. My name is Carol O'Shaughnessy and I am a policy researcher at the non-partisan National Health Policy Forum at George Washington University. I am pleased to appear before you today to talk about the Older Americans Act programs.

The purpose of the Older Americans Act of 1965 is to help people age 60 and older maintain maximum independence in their homes and communities, with appropriate supportive services, and to promote a continuum of care for the vulnerable elderly. The Act represented a turning point in financing and delivering community services to the elderly.

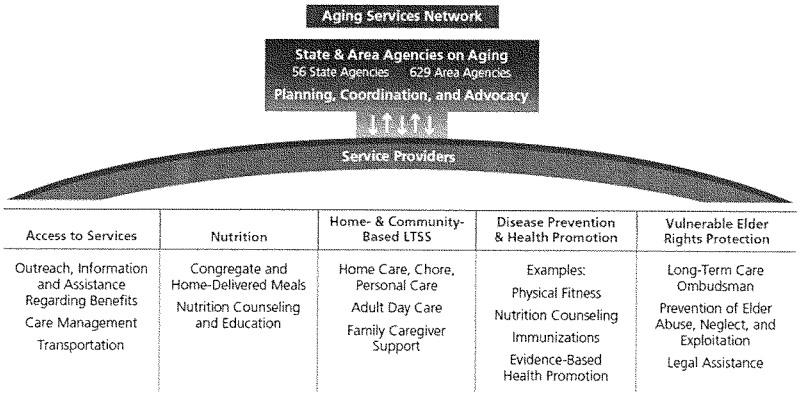
The 1965 law authorized generic social service programs, but in successive amendments Congress has authorized more targeted programs under various titles of the Act. In 1973 Congress extended the reach of the Act by creating authority for sub–state area agencies on aging. This decentralized planning and service model has meant that state and area agencies, working collectively within a state, are largely in control of their aging agendas and can be responsive to state and local needs, within federal guidelines and funding priorities. Since their inception, the major function of state and area agencies has been to advocate for, plan, and coordinate programs that promote comprehensive and coordinated services systems and maximum independence and dignity in a home environment for older people.

Under its seven titles, the Act and its programs support the "aging services network," which is comprised of 56 state agencies on aging; over 600 area

agencies on aging; over 250 Indian Tribal and Native Hawaiian organizations; nearly 20,000 service providers; thousands of volunteers; as well as research, demonstration, and training initiatives in the field of aging. Total federal funding for the Act's programs in fiscal year (FY) 2014 is about $2 billion.

Title III, the largest component of the Act representing over 70 percent of funding, creates authority for state and area agencies and various service programs.

Major Services Authorized by the Older Americans Act



Title III authorizes four service programs:

- The elderly nutrition program, the oldest and perhaps most well-known Older Americans Act service, is intended to address inadequate nutrition of older people by providing meals in congregate settings and to promote socialization, as well as meals to frail older people in their homes. The program aims to reduce hunger and food insecurity and delay the onset of adverse health conditions through proper nutrition. Indirectly, the program acts as income support for many poor and near-poor older people by providing food that they would otherwise purchase in grocery stores or restaurants. The program represents about 44 percent of the Act's total

funding. In FY 2011, about 2.6 million people received 228 million meals (60 percent of meals were provided to home-bound elderly).

- The supportive services program is aimed at helping impaired older people remain independent in their own homes by providing services such as home care, adult day health care, and transportation.
- The family caregiver program provides grants to states to develop caregiver support programs, such as individual counseling, education, and respite care.
- The smallest of Title III programs authorizes disease prevention and health promotion activities. Grants may support a wide range of activities, such as diabetes and arthritis control education, and individualized services, such as medical screening, nutrition counseling, medication management consultation, and immunizations.

Title III services are available to all people age 60 and over who need assistance, but the law requires that services be targeted to those with the greatest economic or social need. In successive amendments, Congress has added specific groups of older people to be targeted: those with low incomes, members of minority or ethnic groups, older people living in rural areas, those at risk for institutional care, and those with limited English proficiency. Research has shown that Title III participants are among the most vulnerable populations, such as those of advanced age, who have income below the federal poverty level (FPL), live alone, or have multiple chronic conditions and functional impairments in comparison to all older people. These characteristics make Title III services extremely important to helping vulnerable older people maintain their independence at home.

Data from the U.S. Administration on Aging (AoA) for FY 2010 show that about three million people received Title III services on a regular basis. Almost 8 million people received other services, such as transportation, information and assistance, or congregate meals, on a less-than-regular basis.

States receive Title III funds according to their relative share of the total U.S. population age 60 and older. States allocate funds to area agencies based on state-determined formulae, generally a combination of factors such as age, income and minority or ethnic status of the older population. Although the distribution of Title III funds to states is determined on age-based factors, state and area agencies determine how to best serve the target populations that are defined by federal law.

A variety of methods are used to target services, including location of services in areas where vulnerable people reside, as well as strategic outreach to low-income and minority older people.

Participants are encouraged to make voluntary contributions for services they receive. States may implement cost-sharing policies for certain services (such as homemaker, personal care, or adult day care services) on a sliding fee scale, based on income and the cost of services. Means testing—considering a person's income and assets as a condition of receiving services—is prohibited.

Title VII of the Act provides grants to states to support the long-term care ombudsman program and for elder abuse, neglect, and exploitation prevention activities.

- About 10,000 paid and volunteer ombudsmen work to improve the quality of life and care for the 2.5 million residents of almost 67,000 nursing and other residential care facilities by investigating and resolving complaints about their care and to protect their rights. Ombudsmen complement efforts of federal and state staff who are required to review and enforce federal nursing home quality-of-care requirements.
- States also receive grants to help make the public aware of ways to identify and prevent abuse, neglect, and exploitation and to coordinate activities of area agencies on aging with state adult protective services programs.

Other titles of the Act authorize grants to Native American organizations for supportive and nutrition services; research, training, and demonstration activities; community service employment; and aging and disability resource centers.

The law was not intended to meet all the community service needs of older people. Its resources are meant to leverage other federal and nonfederal funding sources. In addition to a requirement that states match federal funds, states and area agencies garner other federal, state and local funds to support aging services. Also, voluntary contributions from older people to pay part of the costs of some services, especially for the congregate and home-delivered meals programs, augment federal, state, and local funds. According to the AoA, states typically match 2 or 3 dollars for every dollar funded by the Act.

Over the years, many state and area agencies have broadened their responsibilities beyond the administration of Older Americans Act funds. For example, many state and area agencies on aging manage home- and community-based long-term services and supports (LTSS) programs financed by Medicaid and state funds. Federal and state agencies have increasingly looked to the aging services network to help administer new programs and services. For example, in implementing the Medicare Part D prescription drug benefit, the Centers for Medicare & Medicaid Services (CMS) drew heavily on the outreach and assistance capabilities of the aging network. Also, in recent years, some health care systems have used the expertise of the network to help patients make successful transitions from hospitals to post-acute care settings and from nursing facilities to their own homes.

Conclusion

In conclusion, the mission of the aging services network is aimed at addressing many competing needs of older people. Even with its modest funding, the Act has encouraged the development and provision of multiple and varied services for older people over the past 49 years. State and area agencies have relationships with tens of thousands of service providers offering a wide range of services across the nation. In addition, the Act allows flexibility to state and area agencies to develop programs where they see the greatest need.

Even though Older Americans Act funds reach relatively limited numbers of older people, programs are targeted to the most vulnerable. Efforts by state and area agencies to act as planning, coordinating, and advocacy bodies have improved policies that affect broader groups of older people by integrating complex programs funded by multiple financing sources. As the U.S. population rapidly ages, the sheer numbers of elderly will continue to present challenges to communities across the nation and to the aging services network.

A National Health Policy Forum publication on the Act is attached as background for the record (http://www.nhpf.org/library/details.cfm/2880).

Thank you and I would be happy to answer any questions you may have.

Chairwoman Foxx. Thank you very much.

I now recognize Mrs. Lynn Kellogg for five minutes.

STATEMENT OF MRS. LYNN KELLOGG, CHIEF EXECUTIVE OFFICER, REGION IV AREA AGENCY ON AGING, ST. JOSEPH, MICHIGAN

Mrs. KELLOGG. Good morning. It is my honor to share how the Older Americans Act uses AAAs—Area Agencies on Aging—to fulfill its mission.

The core mission of the Act is to develop comprehensive coordinated systems of care. How? Let me reduce the roles of AAAs into three core areas, then provide examples of how this spurs innovation.

First role: planning and program development. AAAs are charged by the Act with developing a system of home and community-based services. It can't be done by the Act alone.

Beyond administering service dollars, AAAs drive development of aging as an economic sector. Leveraging resources has resulted in a three-for-one return on every OAA dollar spent. The AAA role in bottoms-up local planning identifies need areas, which are also potential business markets.

AAAs encourage private and public businesses to expand services into need areas using OAA dollars as a catalyst. The impact on expansion is robust. A schematic of this is included in written testimony.

Home and community-based service dollars—the services are critical for a raft of in-home support services to help with daily activities, such as dressing and bathing and eating. The Act requires AAAs to identify, assess, and wrap around other services in order to target OAA to gap areas.

AAAs end up connecting disparate services to create a local system. The vision of the Older Americans Act to create a national means through AAAs to direct services to flexibly fill gaps left by other federal, state, and local initiatives is genius. It works.

Caregiver support is the third area. The Act includes the National Family Caregiver Support Program, a mechanism to support family and friends caring for loved ones. Services include caregiver classes on how to cope and provide care without toppling one's own health, and provision of respite and adult day care, which temporarily provide relief, enabling caregivers to go on.

The Older Americans Act mission to create systems spurs many innovations and business startups. Let me give you three examples from my own AAA; more are in written testimony.

Person-centered contracting is one. AAAs provide information and care planning. Region IV AAA developed person-centered contracting within its care management service. Rather than awarding a large sum to a single service provider to provide X number of units of a predesignated service, available funds are placed in a purchasing pool and used on a person-by-person basis.

This allows diversity in scope of services purchased and the numbers of providers participating. Ability to tailor services is enhanced, and impact is based on whether the needs of the person are met rather than whether contractual obligations are met. The innovation went statewide and quickly spread to other states.

Business startups are common. Recently, AAA—my AAA started a PACE, PACE Program of Southwest Michigan, now co-located with the Area Agency on Aging.

Another innovation is working with a hospital and federally qualified health clinic to create an interagency care team to help patients with high recurrent use of hospital emergency departments. Problems at home impact directly patient health outcomes. By incorporating the AAA as a partner with the medical team, solutions occur and readmissions decrease. Though the project is just starting, positive outcomes are already reported as a result of planning.

Using the mission of the Older Americans Act as a springboard to systems development, such as my agency has done, is not an aberration; it is common. Area agencies operate complex local service delivery systems augmented by a range of other funders.

In addition to nine core services required by the Older Americans Act, the average AAA offers more than 12 non-mandated services. How? Leveraging and partnerships.

In 2010, AAAs secured funds from an average of seven sources other than the Older Americans Act. While the Older Americans Act funding remains the critical unifying structure, this forms the base, not the breadth.

Other funding streams view the AAA structure as key. Common sources of funding coming through AAAs are state, local, Medicaid waiver, grant funds, cost-sharing, and private.

Collaborations abound. On average, area agencies have 11 informal partnerships and five formal partnerships.

The Older Americans Act is about independence and personal empowerment. AAAs are engines of change to do this, and the existing structure of the Act is well-suited.

Some concluding observations, considering reauthorization:

Administrative leanness: With the growth of responsibility, it is notable that AAAs remain administratively lean compared to virtually all other national systems. The Older Americans Act limits administrative dollars, and targeting is done with minimal bureaucracy so no change is needed.

Linkage potential: The Older Americans Act is a not-well-understood gem that should be paired with other initiatives. For example, AAAs stabilize complex, home-based needs in a low-cost, person-centered ways. If those needs aren't met, other goals, like health outcomes, suffer.

It is imperative that reauthorization recognizes and strengthens the role of AAAs wherever feasible to bridge the medical or health interventions with the social human service side of needed supports. Other acts should be encouraged to reach to AAAs as a go-to partner.

Finally, local flexibility: The core structure of the Act to provide bottoms-up planning and local flexibility in systems design is the genius of the Older Americans Act. To safeguard this flexibility, the transfer authority between all relevant Title III service subtitles within the Act must be maintained.

Thank you for letting me come today.

[The statement of Mrs. Kellogg follows:]

Offering Choices for Independent Lives

U.S. House Education and Workforce Committee
Subcommittee on Higher Education and Workforce Training
Hearing:

Serving Seniors Through the Older Americans Act

February 11, 2014

Testimony presented by
Lynn Kellogg, CEO, Region IV Area Agency on Aging
St. Joseph, MI

Good morning, Chairman Kline, Chairwoman Foxx and Members of the Committee. The impact of Area Agencies on Aging (AAA) at the local level has been profound. It is my honor to testify before you to share how the Act fulfills its mission and manifests change. The result is an incredibly effective system for planning, developing and delivering vital supports and services to older Americans. I am Lynn Kellogg, CEO of the Region IV Area Agency on Aging in St. Joseph, Michigan. I have had the honor of working in this endeavor for 37 years. My region is a relatively rural area in the extreme southwest corner of Michigan, bordered on the west by Lake Michigan and to the south by Indiana. The area is comprised of small cities and towns, vineyards and farm country. It's comparable to many locales across the nation.

Introduction

Since its inception in 1965, the Older Americans Act (OAA) has been the foundation of our national system of home and community-based services for older Americans. The OAA provides funding to states for a range of community planning and service programs to older Americans at risk of losing their independence. Since its enactment, the OAA has been amended 15 times, most recently in 2006, to expand the scope of services, increase local control and responsibility, and add more protections for the elderly.

I'd like to use my time this morning to discuss how the Act uses AAAs to effectively develop local delivery networks to serve more than 8 million older adults and family caregivers.

To ensure that this federal program meets the wide array of needs of older adults and caregivers across the country, the OAA establishes a critical level of authority and leadership within each state, then turns over key planning and service development roles to AAAs to customize services according to local needs and preferences. This "bottoms-up" planning results in a wide range of services and provider efforts being administered under Act which allows consumers to select service choices that best meet their individual needs.

How does this work? The Act designates entities to serve as Area Agencies on Aging (AAAs) to plan and develop services within specifically designated sub-state geographies called "planning and service areas." All states and territories are covered with no duplication. The core mission of the Act is to develop comprehensive and coordinated systems of care so that older adults can live independently in their homes for as long as possible. In particular, AAAs play a pivotal role in assessing community needs and developing programs that respond to those needs. They often serve as portals to care, assessing multiple service needs, determining eligibility, authorizing or purchasing services and monitoring the appropriateness and cost-effectiveness of services. AAAs assess the adequacy and quality of myriad provider agencies. They have become experts in long term care.

I'm pleased to convey both the core services and common activities of every AAA established by the Act, as well as how AAAs have used their role to progress forward, revealing significant innovation and variation - the building blocks of the comprehensive and coordinated system of care envisioned in the Act's creation.

Core Services - Permit me to truncate and categorize the many roles of AAAs into three areas.

Planning & Program Development

AAAs are charged by the Act with developing a system of home and community-based services that citizens of all communities need when facing challenges due to age or disability. This cannot be done solely with resources from the OAA. Beyond administering dollars for services at the local level, the program development role of AAAs is a driver for the development of aging as an economic growth sector. The partnerships and leveraging of resources by AAAs has significantly grown the impact of the OAA. It's been documented that for every OAA federal dollar invested, three additional dollars are leveraged at the state and local level towards high-need service areas. Local planning and needs assessment identifies these high-need areas, which are also essentially potential business markets. In addition to using OAA service money to fill a gap in available services, AAAs play a key role in encouraging both private and public businesses to expand services into need areas, often using the OAA service dollars as a catalyst. A schematic of how this works is included at the end of this testimony. The impact on expansion of service can be robust. Given AAAs' role as a trusted local broker of services, many AAA directors, me included, sit on local Economic Development Boards.

Home and Community-Based Services

The Act comes with dollars (Title IIIB,C & D) for critical services such as objective assessment and consultation, (e.g., case management), transportation, nutritional meals and a raft of in-home support services that help older adults with Activities of Daily Living (ADLs), such as dressing and bathing. These flexible supportive services are critical as such assistance is often what makes it possible for older adults to age safely and successfully at home and in the community. The Act requires AAAs to identify, assess, and wrap around all other possible funding streams existing in an area in order to target OAA service dollars to critical gaps. In this regard OAA services become the gold standard for connecting

disparate local services into a system for it is the only national funding source with flexibility enough to target resources where gaps in local services exist. AAAs are the only national vehicle with a consistent charge to target resources to gaps in service and build comprehensive services. States and locales vary tremendously in what they are able to provide their populace. *The vision of the OAA to create a national means through AAAs to direct services to flexibly fill whatever gaps are left by other federal, state and local initiatives is genius. And it works.*

Caregiver Support

The Act includes the National Family Caregiver Support Program (NFCSP, Title III E). Again allowing local flexibility through AAAs, the OAA provides a national mechanism to support and maintain the role of family and friends who provide the bulk of long-term support for people needing help on a daily basis. According to Pew Research Center, 39 percent of U.S. adults care for someone with significant health issues; up from 30 percent in 2010. Examples of caregiver support services include evidence-based caregiver classes on how to cope and provide care without toppling one's own physical or mental health, and provision of services such as respite and adult day care, which provide temporary relief for caregivers, enabling them to stay engaged longer. A lifesaver for many families struggling to continue their support for loved ones, the NFCSP is also a wise use of taxpayer dollars. Contributions by family and other informal caregivers save the nation billions in long-term care costs, including savings to Medicaid.

Innovation Examples

The OAA's mission, not to just administer dollars but rather to create comprehensive state and local systems, has been the origin of many innovations and business start-ups. Let me offer a few examples from my own AAA to give you a better sense of how the Act breeds innovation, enhances coordination with other systems, and is ever-changing to better meet the needs of today's older adults and caregivers.

1) *Person-Centered Versus Agency-Centered Contracting* – AAAs are a trusted source of objective information. This manifests in telephonic information and assistance services and in-home assessments, consultation and care planning—referred to as case management within the OAA and nowadays often referred to as care management or options counseling. In the early 1980s, Region IV AAA developed person-centered contracting as a component of its care management service. In person-centering contracting, rather than awarding a large sum to a single service provider to provide "X" number of units of a pre-designated service over the course of a year, available funds are placed in a purchasing pool. Services are then targeted to those most in need and ordered on a person-by-person basis. This allows more diversity both in the scope of services being purchased and the number of providers participating in delivery. The ability to tailor services to complex needs is enhanced and impact is based on whether the needs of the person needing assistance were met rather than whether contractual obligations were met; a significant improvement in quality assessment. Service providers are also very uneven in their geographic and cultural capacity to

serve people, particularly in rural areas. Person-centered contracting allows flexible design of service rather than being limited to the scope of an individual service provider. This innovation went statewide through all AAAs in Michigan and quickly spread to other states.

2) *Coordination with Medicaid & Medicare* – Region IV AAA's person-centered contracting through the OAA became the basis for Michigan Medicaid's initial investment in Region IV AAA to run a voluntary preadmission screening demonstration for people seeking nursing home care. This demonstration in turn became the basis for Michigan's adult home and community-based service waiver, called MIChoice, which serves nursing home eligible adults age 18 and up. The coordination of MIChoice with the OAA is close, allowing callers seamless entry into whichever system is most appropriate. Michigan AAAs are currently pre-paid ambulatory health systems for the 18 and over Medicaid population, maintaining seamless coordination with the OAA for those not eligible for Medicaid.

   Additionally, Michigan is working to be a demonstration state for integrated care for people who are dually eligible for Medicaid and Medicare. Region IV AAA is again part of a demonstration start-up site for this initiative. Details are not yet finalized.

3) *Custom Care/Private Pay* – When an adult son from California called about his mother living in St. Joseph, he asked if the AAA would work with his mother, package services from varied agencies for him, assure they were delivered correctly to his mother and then bill him. We did it for the OAA and Medicaid, why not a family? So we leveraged the administrative structure established by the Act to package services for private pay clients such as this adult son. *Custom Care* was started to bridge the availability of service from private pay to Medicaid.

4) *PACE of Southwest Michigan* – Region IV's program development role has included multiple independent business start-ups. The most recent is the development of a Program of All-Inclusive Care for the Elderly (PACE) project. Seeking investor and donor partners, the AAA created PACE as an independent entity and expanded its AAA-owned building to create a destination, 2900 Lakeview, in which PACE is co-located with the AAA and the AAA's other tenant, Disability Network Southwest Michigan.

5) *Technology Use* – Technology can assist in maintaining independence through online shopping, bill paying, consumer research and staying in touch with family and friends. Many seniors retired before heavy use of computer technology began. Also at the AAA is a computer classroom, staffed by volunteers who teach ten students at a time with one instructor and multiple coaches. Spin-offs have included expanding OAA information services to hold workshops on www.Medicare.gov to help new 65-year-olds understand their Medicare Part D options, training older job seekers to be comfortable with today's common office computers, provision of class scholarships to low-income seniors and distributing refurbished computers to them, and multiple spin-offs in staff training and special projects.

6) *211& Other National Information Systems* – OAA-funded information services have often formally linked with 211 information services. Calls to 211 in Region IV's geography link automatically with the AAA call center for all callers requesting information on aging or disability. Similarly, calls from adult children to the national ElderCare Locator can be patched through to local AAA information lines to secure information on services for loved ones living away from them. These are only a sample of the type of coordination and streamlining of information services that AAAs are driving locally.

7) *Inter-Agency Care Team [ICT]* – One of Region IV AAA's newest innovations is working with the local hospital and federally qualified health clinic to create an Inter-Agency Care Team, or ICT, to create a holistic approach for patients whose circumstances result in high recurrent use of the hospital emergency department. Increasingly medical providers realize that mitigating problems at home impact directly patients' health outcomes. By incorporating the AAA's knowledge of in-home and community services and bringing in the AAA as a partner with the medical team, it's expected stabilization will occur and readmissions decrease. Though the project has just begun seeing its first patients, the hospital is already reporting decreased emergency department usage on an individual basis as a result of project planning. Both AAA-based hospital-to-home transition coaching services and ongoing care management are designed to become fundable components of the effort. The local Health Department is involved to oversee evaluative aspects of the project which include measurable outcomes such as hospital use patterns, no-shows at physician offices, and indicators of self-empowerment. The project is seen as an important program development piece in bridging medical and socially based services, a critical part of the OAA's mission to create a comprehensive and coordinated system for those in greatest social and economic need.

8) *CMS Partnerships* - The Centers for Medicare and Medicaid Services has tapped the structure of the OAA and the Aging Network for multiple initiatives in addition to Medicaid waivers. Some of these include:

   a) State Health Insurance Assistance Programs (SHIPs): one-on-one volunteer counseling for consumers. In Michigan this is called Medicare/Medicaid Assistance Program (MMAP). Nearly two-thirds of AAAs nationwide run or serve a vital role in the SHIP program in their state. Consumer outreach, engagement and education is what AAAs do well.

   b) Community-Based Care Transitions Program (CCTP): evidence-based post hospital coaching to assure a successful transition home following discharge from a hospital. The majority of sites selected for this demonstration are led by AAAs and constitute another example of the importance of bridging medical and socially-based in-home services and supports.

9) *Evidence-based consumer training* - AAAs have been in the forefront of developing and expanding evidence-based Health Promotion and Disease Prevention programs. OAA Title IIID

requirements for the provision of such efforts have spawned an army of certified trainers in local classes that empower people in a host of topics endorsed by the Center for Disease Control and Prevention and the Administration on Aging. AAAs routinely form local partnerships to expand these health and wellness options based on local demand. By providing critical tools to improve health, reduce the risk of disease and disability, and manage chronic disease, these programs have been proven to have both an immediate impact on the life of the older person, as well as the potential for significant reductions in health care costs. In Region IV chronic disease self-management trainings, caregiver trainings and fall prevention classes are becoming commonplace. Feedback from participants underscores the life-changing nature of results. Nationwide, more than 90 percent of AAAs deliver at least one evidence-based health promotion program or service.

Scope of Innovations

I want to reinforce that using the mission of the OAA as a springboard to systems development as Region IV AAA has done is not an aberration. Surveys conducted by the Administration of on Aging (AoA) through the National Association of Area Agencies on Aging (n4a) in concert with Scripps Gerontology Center of Miami University at Ohio give us a window into the scope of work AAAs currently undertake.

While the mission has not changed, over time AAAs have broadened the scope of core services provided locally. Gradually, these have been augmented by a range of other services financed by various sources. Today AAAs operate complex local service delivery systems that provide access, community-based, in-home and elder rights services. In addition to the nine core services required by the OAA, the average AAA offers more than twelve non-mandated services.

How do AAAs do this? Simply - leveraging and partnerships. The limited amount of funding provided through the OAA means that AAAs must leverage additional sources of funding to meet the health and long-term care needs of older adults in their communities. In 2010, virtually all AAAs secured funds from an average of seven sources other than the OAA. To be sure, OAA funding provides the critical, unifying structure for the Aging Network. Nationally the average AAA receives 41 percent of its budget from OAA, but it should be noted that this forms the base and not the breadth. Increasingly other funding streams have seen the structure of the OAA, using AAAs to determine local need and develop services, as an advantageous construct for the distribution of resources [see referenced schematic on page 9]. The prevalence of states tapping the AAAs as a hub for the management of Medicaid home and community-based services is a common example. In Michigan the state passed the Older Michiganians Act to clone the OAA as a means of disbursing state funds. Nationwide, the most common sources of additional funding or service development through AAAs are: state general revenue funding, local funding, Medicaid Waiver programs, grant funds, and cost-sharing by consumers.

As well as an increasingly diverse funding pool, AAAs form collaborations with other community-based entities. On average, AAAs have 11 informal partnerships and 5 formal partnerships. The most common formal partnerships (i.e., those with a contract or memorandum of understanding) are with: State Health

Insurance Assistance Programs (68.8% of AAAs have a formal partnership); transportation agencies (52.4%); Medicaid (51.9%); disability service organizations (34%); and Adult Protective Services (32.0 %). The most common informal partnerships are with long-term care facilities (65.5%), emergency preparedness agencies (59.1%), advocacy organizations (57.3%), public housing authorities (57%), and faith-based organizations (55.5%).

Observations of Pertinence to OAA Reauthorization

The primary theme of the OAA is one of independence and personal empowerment. AAAs are the engines of change to assure that community infrastructures have the choice and range of service that people need to age well with dignity and as much independence as possible. *The existing structure of the Act is well-suited to this end.* Some observations may be helpful as you consider reauthorization.

Administrative Leanness - With the growth of responsibility and significant leveraging of funds, it's important to note that the OAA and AAAs remain administratively lean as compared to virtually all other national systems. The structure within the OAA itself sets in place a process for state review and the award of funds to the AAA level that limits strictly the amount of administrative dollars to be used. State and AAAs are required to match that amount. This encourages partnerships. Also, the ability of AAAs to successfully target resources to those in greatest social and economic need with minimal bureaucracy creates a lean and efficient system. AAAs devise mechanisms to successfully target persons in need. The system works.

Linkage Potential – The OAA is a not-well-understood gem that should be paired with other initiatives. AAAs have become experts at stabilizing the home environment in a low-cost, person-centered way. Industries associated with medical outcomes increasingly recognize that the stability of the home environment is critical to achieving health outcomes. If older adults struggle to complete routine activities of daily living such as dressing, toileting and eating, as well as the errands and chores associated with an independent life, health outcomes become a secondary priority and suffer. Local experience has shown that rather than trying to re-create a focus on non-medical issues through a medical lens, AAAs should be a go-to partner in integrating long-term supports and services in the home, particularly when bridging medical and social services. This has the potential of providing a cost effective, non-medicalized means of providing holistic care and keeping costs down.

It is imperative that the reauthorization recognize and strengthen the role of AAAs, wherever feasible, to integrate or bridge medical and the social or human service side of long-term services and supports at the community level. Common roles to consider include the many different roles associated with long-term services and supports such as those related to health, wellness (both physical and behavioral health), and care management. Other Acts should be encouraged to reach to AAAs for expertise on home based services and supports. Strengthening the AAA role in these endeavors is also a means of supporting the myriad service providers supported by the OAA, particularly those reaching to rural America, a critical consideration for the future as many larger health entities may consider recreating direct service provision

from an in-house basis, significantly changing the flow of dollars, potentially away from existing providers. In rural America these are often small businesses piecing together the ability to provide service from a variety of funders, not the least of which are AAAs.

Local Flexibility – The core structure of the Act to provide "bottoms-up" planning and assuring local flexibility in systems design is the genius of the OAA and must be safeguarded. Without this local emphasis and flexibility, AAAs cannot achieve the greatest degree of wrap around and intersection with other systems, resources and funding in their communities. This ability is core to crafting services to meet a wide variety of individual needs, critical to achieving the goals of independence and personal empowerment. To safeguard this flexibility, the transfer authority between all relevant Title III service subtitles within the Act must be maintained.

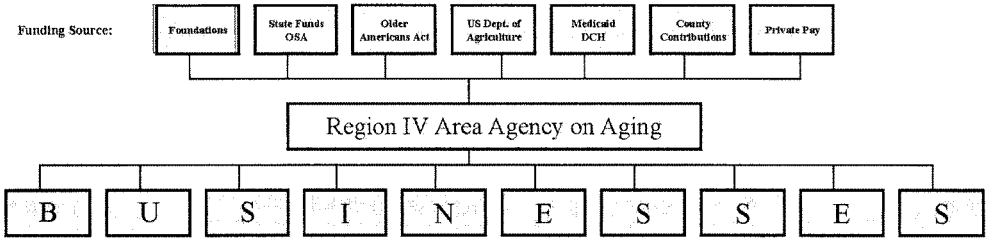
Final Thought

I hope that my testimony today has helped expand your understanding of *how* the Act works, and works well. But we must not lose sight of the reason *why* the Act exists in the first place: the older adults who are trying to age in place in their homes and communities but need a little help. We serve the most vulnerable first and foremost, but another value of the Act is that it supports the development of the community infrastructures, resources and engagement that nearly everyone needs as they age.

Thank you for inviting me to testify today about the value and future of the Older Americans Act. I stand ready to answer any questions you may have and support your work on this reauthorization going forward.

Area Agency on Aging, Inc.
SPECIALISTS IN AGING

Aging of America: Growth of an Economic Sector



Area Agency on Aging market/needs analyses channel age and disability related supports and services into high need areas. This saves the state money in health related costs while fostering private sector development to meet the growing demands of an aging population.

Chairwoman Foxx. Thank you.

I now recognize Dr. Yanira Cruz for five minutes.

STATEMENT OF DR. YANIRA CRUZ, PRESIDENT AND CEO, NATIONAL HISPANIC COUNCIL ON AGING, WASHINGTON, D.C. (DEMOCRAT WITNESS)

Dr. CRUZ. Thank you for the opportunity to testify at this hearing.

I am president and CEO of the National Hispanic Council on Aging, the leading national organization working to improve the lives of Hispanic older adults, their families, and caregivers. We are a member of the Diverse Elders Coalition, a coalition of five organizations advocating for aging policies that improve the lives of racially and ethnically diverse Americans, including American Indian, Asian American, and LGBT communities.

Though the particular needs of each community differ, maintaining health and economic security is something all seniors strive for, and the Older Americans Act helps them achieve this. We know that the OAA and its services work.

Older adults experiencing the threat of hunger tell us that oftentimes their only meal is through a local senior center. We also hear stories about selfless caregivers who have received training and respite as part of the National Family Caregiver Support Program.

Across the nation older adults are learning new skills and going back to work because of training received from the Senior Community Services Employment Program. The OAA also helps seniors to receive the services and support they need to maintain their health and independence, as well as avoid more expensive forms of care.

Sequestration harms the Older Americans Act's ability to fulfill its mission. Every day 10,000 people turn age 65. Yet, OAA funding has not increased enough to meet this new demand.

On the contrary, some of its programs have been cut. This means that millions of meals are not being delivered to senior centers or homes, hundreds of thousands of seniors are losing access to daily living assistance, and thousands of low-income older adults who are eager to learn new skills are turned away from job training.

Although the OAA has been successful, it is in need of an update because the demographics of the seniors it serves are changing. Currently there are about 8 million diverse seniors, and these numbers will only increase as the general U.S. population ages.

The OAA must respond to these demographic changes. In general, diverse older adults experience health inequities and disproportionate levels of economic insecurity.

The American Community Survey estimates that around 5 percent of Hispanics over age 65 lack health insurance. In comparison, less than 1 percent of non-Hispanic seniors lack health insurance. This makes the health community services offered through the OAA particularly important for Latino seniors.

Similarly, the American Community Survey finds that 19 percent of American Indian older adults live in poverty. African-American seniors—currently the largest group of diverse seniors in the country—endure diabetes at disproportionately high rates. We know that the Older Americans health education and nutrition programs can help reduce these inequities.

At our regional community forums I hear from our older adults struggling to access OAA services because of cultural and linguistic barriers. A Hispanic older adult in Los Angeles explained to us, "Many of the services do not have employees that have the capacity or the patience to help us. There is a huge lack of respect—there is a huge lack of respect seniors." A report by Hispanics in Philanthropy entitled "The Latino Age Wave" found that there is a lack of places Latino seniors can go to access aging services.

Cultural factors form a barrier to services for LGBT older adults as well. Many LGBT seniors have endured a lifetime of discrimination based on their sexual orientation and gender identity. As a result, many feel uncomfortable seeking out services from mainstream providers.

We strongly support the reauthorization of the Older Americans Act. And I know that we are currently in a challenging budgetary situation, but the OAA needs more funding. The cuts of sequestration are harming the ability of our country to care for our older adults.

Additionally, in recognition of current demographic changes, the provision of services in a culturally and linguistically competent manner should be made a priority of the law. LGBT older adults and people with HIV/AIDS should be identified as a population in greatest social need.

Thank you for the opportunity to testify. I am happy to answer any questions you may have.

[The statement of Dr. Cruz follows:]

Written Testimony of
Dr. Yanira Cruz, President and CEO
National Hispanic Council on Aging

Before the House of Representatives Education and Workforce Committee
Subcommittee on Higher Education and Workforce Training
Tuesday, May 11, 2014

Thank you Chairman Foxx, Ranking Member Hinojosa, and Members of the House of Representatives' Subcommittee on Higher Education and Workforce Training, for the opportunity to testify at this hearing. It is an honor to be here to underscore the great need to reauthorize the Older Americans Act (OAA).

I am president and CEO of the National Hispanic Council on Aging (NHCOA), the leading national organization working to improve the lives of Hispanic older adults, their families, and caregivers. NHCOA is a member of the Diverse Elders Coalition, a coalition of five organizations advocating for aging policies that improve the lives of racially and ethnically diverse Americans, including the American Indian, Asian American and LGBT communities. Though the particular needs of each community differ, maintaining health and economic security is something all seniors strive for, and the OAA helps them achieve this.

Enacted in 1965 as a partner to Medicare and Medicaid, the OAA provides services and programs that allow seniors to age independently in their communities. Specifically, the OAA provides home-delivered and senior center meals, transportation services, caregiver support, job training, long-term care protections, and a number of other services.

We know the OAA and its services work. Older adults experiencing the threat of hunger tell us that often times their only meal is through a local senior center. We also hear stories about selfless caregivers who have received training and respite as part of the National Family Caregiver Support Program. Across the nation, older adults are learning new skills and going back to work because of training received from the Senior Community Services Employment Program. The OAA also helps seniors receive the services and support they need to maintain their health and independence, as well as avoid more expensive forms of care.

Sequestration harms the OAA's ability to fulfill its mission. Every day, 10,000 people turn age 65.[1] Yet, OAA funding has not increased enough to meet this demand. On the contrary, some of its programs have been cut. This means that millions of meals aren't being delivered to senior centers or homes, hundreds of thousands of seniors are losing access to daily living assistance, and thousands of low-income older adults who are eager to learn new skills are turned away from job training.[2]

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[1] Cohn, D., Taylor, P. *Baby Boomers Approach 65 – Glumly.* Pew Research Social and Demographic Trends. December 20, 2010. Accessed from http://www.pewsocialtrends.org/2010/12/20/baby-boomers-approach-65-glumly/

[2] Leadership Council of Aging Organizations. *Issue Brief: NDD Sequestration Hurts Vulnerable Seniors*. October 2012. Accessed from http://www.lcao.org/files/2013/02/LCAO-Sequestration-Issue-Brief-Oct2012.pdf

Although the OAA has been successful, it is in need of an update because the demographics of the seniors it serves are changing. Currently, there are 3.3 million African American seniors, 2.9 million Hispanic seniors, 1.4 million Asian American seniors, 1.5 million openly lesbian, gay, bisexual, and transgender seniors, and 235 thousand American Indian and Native Alaskan seniors.[3] And these numbers will only increase as the general U.S. population ages. The OAA must respond to these demographic changes. In general, diverse older adults experience health inequities and disproportionate levels of economic insecurity. The American Community Survey estimates that around 5% of Hispanics over age 65 lack health insurance. In comparison, less than one percent of non-Hispanic seniors lack health insurance.[4] This makes the health community services offered through the OAA particularly important for Latino seniors. Similarly, the American Community Survey finds that 19% of American Indian older adults live in poverty.[5] African American seniors— currently the largest group of diverse seniors in the country— endure diabetes at disproportionately high rates.[6] We know that the OAA's health education and nutrition programs can help reduce these inequities.

At NHCOA's regional community forums, I hear from older adults struggling to access OAA services because of cultural and linguistic barriers. A Hispanic older adult in Los Angeles explained to us, "Many of the services do not have employees that have the capacity or the patience to help us. There is a huge lack of respect to seniors." A report by Hispanics in Philanthropy, entitled *The Latino Age Wave*, found there is a lack of places Latino seniors can go to access aging services.[7] Cultural factors form a barrier to services for LGBT older adults as well. Many LGBT seniors have endured a lifetime of discrimination based on their sexual orientation and gender identity. As a result, many feel uncomfortable seeking out services from mainstream providers.[8]

Effectively reaching and serving diverse older adults requires cultural and linguistic competence. In practice, this entails more than merely translating. Rather, outreach materials should be adapted and targeted to the community they are intending to reach. Service providers should keep in mind that levels of education, English proficiency, and seniors' past experiences differ and affects their ability to understand and receive services through the OAA.

NHCOA strongly supports the reauthorization of the OAA. And I know that we are currently in a challenging budgetary situation, but the OAA needs more funding. The cuts of sequestration are harming the ability of our country to care for our older adults. Additionally, in recognition of

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[3] Administration on Aging. *Minority Aging– Statistical Profiles.* Accessed from http://www.aoa.gov/AoARoot/(S(2ch3qw55k1qylo45dbihar2u))/Aging_Statistics/minority_aging/Index.aspx and Services and Advocacy for GLTB Elders. *General Facts.* Accessed from http://www.sageusa.org/issues/general.cfm

[4] National Hispanic Council on Aging calculations based on data from the 2010-2012 American Community Survey 3-Year Estimates.

[5] U.S. Census Bureau. "Poverty Status in the Past 12 Months by Sex by Age (American Indian and Alaskan Native Alone). 2008-2012 American Community Survey 5-Year Estimates.

[6] Administration on Aging. *Minority Aging– Statistical Profiles.* Accessed from http://www.aoa.gov/AoARoot/(S(2ch3qw55k1qylo45dbihar2u))/Aging_Statistics/minority_aging/Index.aspx

[7] Global Policy Solutions. *The Latino Age Wave.* Hispanics in Philanthropy. February 2011. Accessed from http://www.hiponline.org/storage/documents/HIP_LatinoAgeWave_FullReport_Web.pdf

[8] Services and Advocacy for GLBT Elders, *LGBT Older Adults and the Reauthorization of the Older Americans Act: A Policy Brief.* March 2011. Accessed from: http://www.sageusa.org/resources/publications.cfm?ID=15

current demographic changes, the provision of services in a culturally and linguistically competent manner should be made a priority of the law. Additionally, LGBT older adults and people with HIV/AIDS should be identified as a population in greatest social need. Once again, thank you for the opportunity to testify. I am happy to answer any questions you may have.

Chairwoman Foxx. Thank you, Dr. Cruz.

I now recognize Mrs. Denise Niese for 5 minutes.

STATEMENT OF MRS. DENISE NIESE, EXECUTIVE DIRECTOR, WOOD COUNTY COMMITTEE ON AGING, INC., BOWLING GREEN, OHIO

Mrs. NIESE. Thank you.

Chairman Kline, Chairwoman Foxx, Ranking Member Hinojosa, and subcommittee members, on behalf of the governing board of the Wood County Committee on Aging and the older adults that we serve, I appreciate this opportunity to appear before the subcommittee.

As a nonprofit organization with the mission to provide older adults with services and programs which empower them to remain as independent as possible and to improve the quality of their lives, we support and we advocate for the Older Americans Act reauthorization.

We operate seven designated multipurpose senior centers throughout Wood County and a centrally located production kitchen from which all meals for the senior centers and home-delivered clients are prepared. As a direct service provider at the local level, we work closely with our local Area Agency on Aging. While entities such as ours are in local communities delivering programs and services, we look to them for technical assistance and to best serve our client base.

In 1977, the Older Americans Act represented 61.6 percent of our budget. In 2014, Older American Act funds account for 9 percent of our total agency budget.

The remaining 91 percent of our budget are comprised of other sources, including a countywide property tax dedicated to senior services and donations for meals. As you can see, the majority of funds for programs and services in Wood County, Ohio, are nonfederal.

Each component of the Act impacts local communities. With this structure from the federal level, with the guidelines and accountability inherent, the Act also allows for states, local Area Agencies on Aging, and providers like us to have the flexibility to develop and implement programs and services that meet the needs of our local constituency.

The flexibility to collaborate with businesses, schools, institutions of higher learning, and other partners allow us to expand our programs and services to meet local needs. Some of the local needs that we are addressing, totally local-funded or sponsored, include Club Fit. This is an exercise program we do throughout the county and we collaborate with local nursing homes who provide and sponsor the physical therapists and occupational therapists who come in and lead the exercise classes.

We also do Title IIIB medical escort—nonmedical—nonemergency transportation. But the unique component that we do with this and with these Title IIIB funds, it is a door-through-door service. So if the older adult needs someone to help them out to the car, into the doctor's office, back into their home when we get back, it is provided.

But we also make sure that the level of assistance is in keeping with what the older adult wants. We don't impose aid if it is not requested.

Nutrition services are by far the largest program that we operate. It continues to grow in participants for both the congregate and home-delivered meal service. We are able to provide and continue to meet the demand through the use of volunteers in the production kitchen as well as delivering meals.

Our staff process all home-delivered meal intakes. The client must be 60 years of age and over, live in Wood County, and be considered homebound.

In addition to receiving a hot lunch Monday through Friday, each client also benefits from a midday safety check from our home-delivered meal drivers. In many instances in our rural county, the home-delivered meal driver is the only face-to-fact contact with someone on a regular basis.

We were serving an average of 567 meals per day in 2004 and identified that we were nearing capacity of production. It was anticipated that within three years it would be necessary to create a waiting list for meals—not because of funding, but because of production capacity.

It was at this point that we approached our then-State Senator Randy Gardner and then-State Representative Bob Latta, who many of you know, to secure state capital funding for a construction project. Today we are serving an average of 746 meals daily, and that is coming from the new production kitchen.

We were fortunate and our community partner, the Bowling Green State University, agreed to be the fiscal agent for processing the state funds. This official relationship has also benefitted BGSU greatly, as the placement of interns, capstone projects, and research by graduate and doctoral candidates has drastically increased.

The Older Americans Act has a significant impact on the lives of older adults. Impact is measured with established standards and measurements for services and annual monitoring conducted by the Area Agency on Aging. Pre-and post-testing is also conducted for evidence-based programs.

There are multiple levels of assessment for programs and services provided by multipurpose senior centers, including accreditation by the National Council on Aging. WCCOA became the first senior center in Ohio to receive this designation.

As the reauthorization process of the Act moves forward, please maintain the flexibility that is an integral part of the success of this Act. The flexibility permits service providers to meet the unique needs of our communities while maintaining the high standards of the Act.

In honoring the genuineness of the Older Americans Act of 1965, focus on opportunities for the Older Americans Act to be used as seed money that will allow service providers to leverage other dollars to further develop needed services.

I hope to inspire you today to consider the legacy that you will impart to the senior citizens of today and those that will age into the reauthorized Older Americans Act. Thank you.

[The statement of Mrs. Niese follows:]

Testimony of Denise Niese
Executive Director, Wood County Committee on Aging, Inc.
before the House Education and the Workforce Subcommittee
on Higher Education and Workforce Training
February 11, 2014

INTRODUCTION

Chairman Kline, Chairwoman Foxx, Ranking Member Hinojosa, and subcommittee members, on behalf of the Governing Board and older adults served by the Wood County Committee on Aging (WCCOA), I appreciate the opportunity to appear before the subcommittee on the important issue of the reauthorization of the Older Americans Act. I am Denise Niese, Executive Director of the Wood County Committee on Aging, a self-incorporated non-profit organization with the mission to provide older adults with services and programs which empower them to remain independent and improve the quality of their lives. Our service area is located in Ohio's 5th District, represented by Congressman Robert Latta.

As a 501(c)(3), a self-incorporated non-profit, the corporate powers, property, and affairs of WCCOA are vested in, exercised, conducted, and controlled by the Governing Board. This Governing Board operates with a membership of 35. These members are representative of the entirety of Wood County and include liaisons to the Wood County Job and Family Services, Health District, Board of Developmental Disabilities, Alcohol Addictions and Mental Health Services Board, Social Security Administration and Bowling Green State University. While this is a large group, it is a working Board. With nine (9) committees with assigned responsibilities, they make recommendations to the full Board for action. The philosophy of this Governing Board is that "committees propose and the Governing Board disposes". Along with this Governing Board, we work closely with County Government keeping them apprised of activities of this organization.

The Wood County Committee on Aging operates seven (7) designated multipurpose senior centers throughout Wood County, Ohio, and a centrally located Production Kitchen from which all meals for the senior centers and home-delivered clients are prepared. With this designation we are responsible for the planning, development and implementation of services for older adults. As a direct service provider at the local level, WCCOA works closely with our local Area Agency on Aging (Area Office on Aging of Northwestern Ohio) to provide comprehensive and coordinated service systems to serve older individuals as defined in the Area Plans. While entities such as WCCOA are in the local communites delivering programs and services, we look to the Area Agency for information and technical assistance to assist the aging network to best serve our client base. Since 1977 WCCOA has developed programs and services ranging from medical escort and adult day care to recreation and exercise to congregate and home-delivered meals. In 2013, WCCOA served more than 6500 unduplicated individuals. In 1999 the WCCOA became the first Senior Center in the State of Ohio (25th Nationally) to receive accreditation by the National Council on Aging / National Institute of Senior Centers. This accreditation recognizes the professionalism

and structure of this organization as well as our programs and services. WCCOA has been successful in maintaining our national accreditation status by successfully completing the process in 2006 and 2011.

Without a doubt, the Older Americans Act (OAA) has been instrumental in the creation of a wide array of programs and services intended to enhance the well-being of older adults. This chief piece of legislation was designed to be the focal point of federal government policy on aging and it established the Administration on Aging, state units on aging, and area agencies on aging. The programs and services provided through the OAA are needed now more than ever before as the "graying of the population" is most evident with 10,000 Baby Boomers turning 65 each day.

How Do Older American Act Funds Leverage Local Dollars

In 1977, the operating budget of the Wood County Committee on Aging, Inc., was $42,089, which included $25,928 in Older Americans Act funds (61.6% of the total budget). The first award of Title III was made to the organization in 1977 to fund supportive services and nutrition at two locations in Wood County (Bowling Green and Rossford). In 2014, Older Americans Act funds awarded to the WCCOA total $257,282 of our projected revenues of $2,711,610 (9% of our total budget).

These funds, which are administered through our local Area Agency on Aging, support direct costs associated with congregate meals (C-1), home-delivered meals (C-2) $187,612 (with 133% cash match), and Medical Escort (Transportation 9) and Minor Home Repair $69,671 (with 100% cash and in-kind match). An additional $62,860 is provided through NSIP and $19,386 from Ohio Senior Community Service Block Grants.

The remaining 91% of our operating budget is comprised of the following sources:

- 74% Senior Services Levy (.7 mil county-wide property tax passed 11/2011 by 69.32% of vote)
- 8.4% Program Income (donations for meals)
- 5% Medicaid Waiver contract for medical transportation and home-delivered meals
- 3.6% Cost Share contributions, program fees, sponsorships, private grants, and other miscellaneous income

As you can see, the majority of funding for programs and services in Wood County, Ohio, is non-federal.

In looking at each component of the Older Americans Act, you can truly appreciate the impact that each title can make in local communities. With this structure from the federal level, with guidelines and accountability, the Older Americans Act also allows for States, local Area Agencies on Aging, and providers such as WCCOA, to have the flexibility to develop and implement programs and services that meet the needs of our local constituency. The credibility that these regulations provide enables WCCOA to demonstrate the effectiveness and accountability of these services to our Board of County Commissioners and to the voters of Wood County, who have supported County-wide senior services funds through the property tax levy since 1986.

While WCCOA receives Older Americans Act funding only to supplement nutrition services (26,320 congregate and 35,663 home-delivered meals annually), along with 371 home-delivered meal assessments, and transportation (2,142 units annually), WCCOA utilizes standards defined in the OAA for non-funded programs and services.

One of the most positive aspects of a multipurpose senior center is the ability to provide the *"front door"* for services for older adults in their community. Senior Centers are an inviting presence where older adults find a "one stop shop" for services and resources. In a non-threatening, non-institutional environment, we can assist with a multitude of issues and concerns. If staff cannot solve the situation directly, we can assist in connecting the senior (or their family and/or caregiver) with the appropriate entity.

The flexibility to collaborate with businesses, corporations, K-12 schools (including career centers), institutions of higher learning, and other community organizations allows us to expand our programs and services to meet the needs of our constituency. WCCOA is constantly exploring our options to meet the needs of our older adults while being frugal with our resources.

At our local level these offerings and collaborations include:

- **Delay the Disease*** - "Delay the Disease" is a fitness program designed to empower people with Parkinson's Disease (PD) by optimizing their physical function and helping to delay the progression of symptoms.
- **Matter of Balance*** – Matter of Balance emphasizes practical strategies to reduce fear of falling and increase activity levels. Participants learn to view falls and fear of falling as controllable, set realistic goals to increase activity, change their environment to reduce fall risk factors, and exercise to increase strength and balance.
- **Club Fit** – This is a local initiative which meets the needs of older adults who want to remain healthy and flexible through a 1-hour exercise session which focuses on flexibility with light weight training. *This offering is a collaboration between WCCOA and 5 local nursing facilities. The facilities provide their Physical Therapist/Occupational Therapist to lead the exercise. As an outreach effort for the rehab units of these facilities, these sessions are offered at no cost to the participants.*
- **Chronic Disease Self-Management – Diabetes*** - Subjects covered include: 1) techniques to deal with the symptoms of diabetes, fatigue, pain, hyper/hypoglycemia, stress, and emotional problems such as depression, anger, fear and frustration; 2) appropriate exercise for maintaining and improving strength and endurance; 3) healthy eating; 4) appropriate use of medication; and 5) working more effectively with health care providers. Participants will make weekly action plans, share experiences, and help each other to solve problems they encounter in creating and carrying out their self-management program. *This program is provided locally by staff from our Area Agency on Aging.*
- **Healthy IDEAS*** - Healthy IDEAS is a depression self-management program that includes screening and assessment, education for clients and family caregivers,

referral and linkages to appropriate health professionals, and behavioral activation. *This program was developed by Baylor College of Medicine and was made available through grant funding provided by the Toledo Community Foundation.*

- **Project LifeSaver** - is an active response to the problem of locating people who may not be able to find their way home – before they become victims. The average rescue time is less than 30 minutes. A lost person with any kind of dementia or a developmental disability is unaware of his or her situation. They do not call out for help and do not respond to people calling out to them. The Project Lifesaver team is trained to approach a person with Alzheimer's disease or a developmental disability, gain their trust, and put them at ease for the trip home. *This is a collaborative project with the Wood County Sheriff's Office.*
- **Durable Medical Equipment Loans** – WCCOA has a variety of assistance equipment available for loan to 60+ residents of Wood County. Available equipment may include, but is not limited to: Grab Bars, Bed and Toilet Rails, Commodes, Canes and Quad Canes, Walkers, Crutches, Wheelchairs (6 week loan limit), Shower Seats, Kitchen Seats, Transfer Boards, Stepstools, Portable Ramps, There is no charge for the use of this equipment, but we do accept monetary donations.
- **OSHIIP** – Provides information and assistance specifically for those enrolled or eligible for Medicare. We will answer your questions about any of the following matters: Medicare health coverage for seniors and for people under age 65 with disabilities, Medicare prescription drug plans, Medicare Advantage Plans (example: HMOs and PPOs), Medicare supplemental insurance, Financial assistance programs for people with limited income, and Long-term care insurance.
- **Non-Emergency Medical Transportation / Escort** - The Title IIIB funds received by the WCCOA are used to supplement local funds for transportation of older adults to medical appointments, grocery shopping and into their local Senior Center. A unique component of the transportation is that we provide door through door service. What this means is that whether the older adult is being transported for a medical appointment (lab work, a doctor appointment, dialysis, etc.), or coming into a multipurpose senior center for lunch, the driver will assist them from their threshold into the vehicle and then into their destination. The level of assistance is in keeping with the need and choice of the older adult.

*Denotes an evidence-based program

Local Efforts which enable expansion of services

Nutrition services are by far the largest program operated by the WCCOA. And it continues to grow in participants for both the congregate and home-delivered meals service. We are able to continue to meet the demand through use of volunteers to assist in the production kitchen as well as to deliver meals to our "in-town routes".

In 2004 WCCOA was serving an average of 263 congregate and 304 home-delivered meals per day (total 567) and identified that WCCOA was nearing capacity for meal production at the 400 square foot kitchen in our Bowling Green location where all meals

for 5 seniors centers and home-delivered meals were prepared (since 1981). It was anticipated that within 3 years it would be necessary to create a waiting list for meals, not because of funding but due to capacity.

It was at that point the WCCOA Governing Board members and administrative staff approached our then State Senator Randy Gardner and then State Representative Bob Latta for consideration of a capital funding project as part of the SFY 2004/05 State of Ohio Capital Budget. State Senator Gardner and State Representative Latta were successful in securing $500,000 for use toward this project. Over the course of 2005, the WCCOA Governing Board, staff and the community raised an additional $800,000. to fund the balance of the project. The Wood County Board of County Commissioners provided the property where the kitchen would be located. Ground was broken March 31, 2006, and the new 5400 square foot, state of the art Production Kitchen went into operation on January 3, 2007. Since that time average daily meals produced are at 850+ and WCCOA has never had to resort to a waiting list for nutrition services.

Since 2007, we have continued to develop meals which comply and exceed standards of the OAA. Not only are we licensed and inspected by our local health district for food service, we are also inspected and licensed by the Ohio Department of Agriculture. With the Ohio Department of Agriculture licensure and inspection, including compliance with the Seafood HAACP requirement in order to serve dishes such as tuna salad and tuna noodle casserole, we are also licensed to prepare, package and freeze meals prepared in this production kitchen. This means that we are able to prepare frozen meals for our clients who require 2 meals per day and weekend meals. When compared to commercially prepared meals, our locally produced meals are lower in sodium and can be made at a lower unit cost.

A component of the capital budget funds requires a State fiscal agent to serve as the conduit for the State money for the project. We were fortunate that our community partner, the Bowling Green State University, agreed to be the fiscal agent for processing the State funds. They generously allowed the percentage set aside for their administrative costs to be used for the building project. Additionally, the State funds required the development of a formal agreement, a "joint use agreement", between the WCCOA and BGSU. This official agreement is in place for a 15-year period (through 2022). This official relationship has also benefitted BGSU greatly as the placement of internships, capstone projects, and research by graduate and doctoral candidates has drastically increased.

In 2013, the Wood County Committee on Aging served 186,510 meals to 3,017 older adults throughout the County. It should be noted that 749 of these people are home-delivered meal clients (who received 96,037 meals, 57% of the total served).

WCCOA Social Services Department processes all Home-delivered Meal (HDM) intakes. When staff receives a call about the meals, we explain the program and our criteria for the meals to see if the client is eligible. The client must be 60 years of age or

over, live in Wood County and be considered "homebound" (meaning they do not leave the house under normal circumstances or without assistance from others). A spouse of an eligible client may also be on our meal program as a caregiver.

If the client meets eligibility, we then collect the following information on the assessment form: if the client is a diabetic (they will get a sugar free dessert), client's name, DOB, age, street address, city, zip, gender, phone number, homebound status, last 4 digits of social security number, number of persons in household, primary care physician, and two emergency contacts. We also write in the date we are registering them and who referred them to us.

Once we take a new HDM start, we are able to start delivering them the meals within 2 business days. We are able to begin services sooner if there is an emergency. We also collect from the client any pertinent directions and/or descriptions of the house or what door to use for the driver delivering the meals.

We then determine if the client is going to get 5 hot meals or 5 hot and 2 frozen meals for the weekends. Frozen meals are available upon request. We will also ask the client for a brief health history.

All clients are reassessed annually. If it is determined that situations have changed in the household during the course of the year, staff will reassess on more frequent intervals.

In addition to receiving a hot lunch Monday through Friday, each client also benefits from a mid-day safety check from our home-delivered meal drivers. In many instances, in our rural County, the home-delivered meal driver is their only face-to-face contact with someone on a regular basis.

Real Life Impact
The support of the Older Americans Act has a significant impact on the lives of the older adults served by the Wood County Committee on Aging. We measure impact with established standards and measurements for services and annual monitoring conducted by the Area Agency on Aging, and pre- and post-testing that we conduct for the evidence-based programs. We also use other methods, such as the client satisfaction evaluations and questionnaires completed by the participants to measure impact and client satisfaction. We also have tools to survey for programming ideas and for modifications. There are multiple layers of assessment for programs and services provided by multipurpose senior centers.

Following are two real life examples of how we are making a difference in the lives of our most vulnerable clients:

Just last week, on Monday, February 3, 2014, at 12:30 pm, our driver Nikki arrived at a residence in Luckey, Ohio, to find our client on the floor. The 77 year old widow, who lives alone, had fallen during the morning and was unable to get up or to a phone. She

was alert when Nikki arrived and "911" was called. Staff waited with the client until the ambulance arrived and transported the client to the hospital. While awaiting the ambulance, Nikki contacted her supervisor who in turn alerted the client's daughter of the situation, and the daughter was able to meet her mother at the hospital. These situations are the ones with the positive outcome. Clients in this situation often comment that they were not afraid because they know their home-delivered meal driver would be coming to their door soon.

There is also the potential for home-delivered meal drivers to find a client who has expired during the night. As family members have shared with us, at least "Mom" was found quickly. In situations like this we work with the Wood County Sheriff's office to summon the coroner and notify the family.

Summary

As the Reauthorization process of the Older Americans Act moves forward, I would encourage Congress to strive to maintain the flexibility that is an integral part of the success of the Act. The flexibility permits service providers such as WCCOA to meet the unique needs of our communities while maintaining the high standards set by the Act.

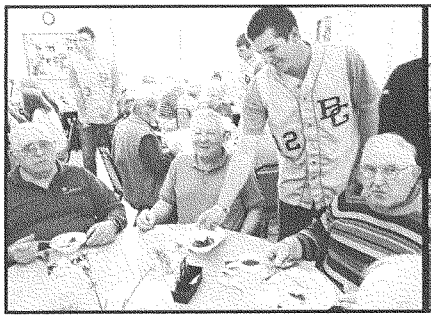
In honoring the genuineness of the Older Americans Act of 1965, focus on opportunities for the Older Americans Act to be used as the seed money for programs that will allow service providers to leverage other dollars to further develop services to meet the needs of the older adults in their communities.

As I developed this testimony, I have had an opportunity to reflect upon the legacies of Lyle Fletcher, Harold Siek, Ann Baty, Nellie Garner, and other visionary community members who identified the need for organized and comprehensive programs for the older adults of Wood County back in 1973.

As this sub-committee begins the process of the Reauthorization of the Older Americans Act, which will affect seniors and their families throughout our Country. I hope to inspire you to consider the legacy that you will impart to the senior citizens of today and those that will age into our Older Americans Act programs over the life of this reauthorization.



Seniors from around the area enjoy lunch at the Wood County Senior Center.



Athletes from Bowling Green State University volunteer to serve lunch at the Wood County Senior Center.



Staff at the Production Kitchen work hard to prepare nutritious meals for the home-delivered meal clients.



A local senior enjoys her 90th birthday at the Wood County Senior Center.



Seniors work with children to complete fun projects on Intergenerational Day.



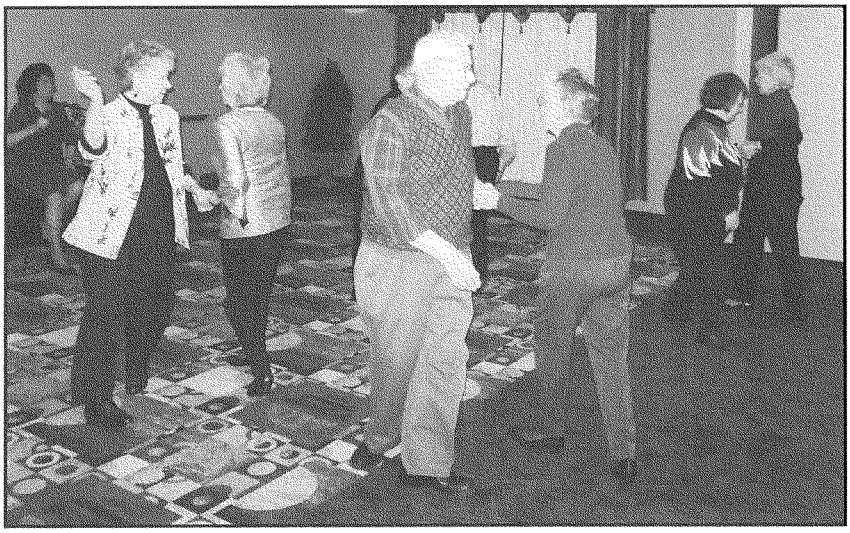
Seniors learn about tablet computers with help from Bowling Green State University students.



A participant in the *Jam Session* has fun playing his guitar.



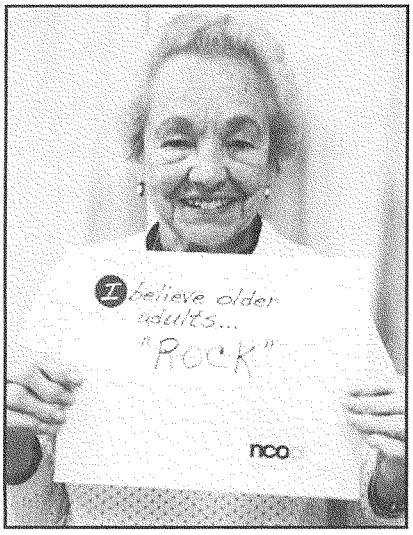
Seniors like playing the piano for all to enjoy.

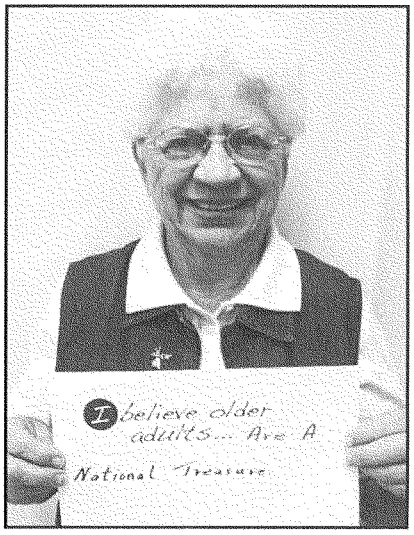


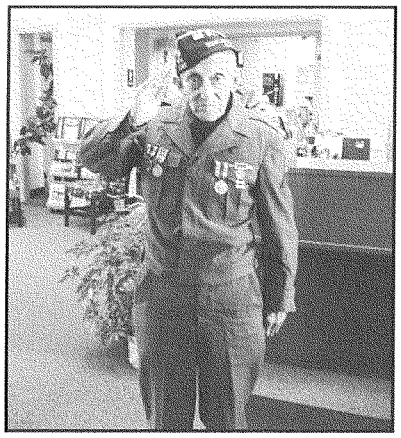
Seniors have fun moving to their favorite tunes at a dance.



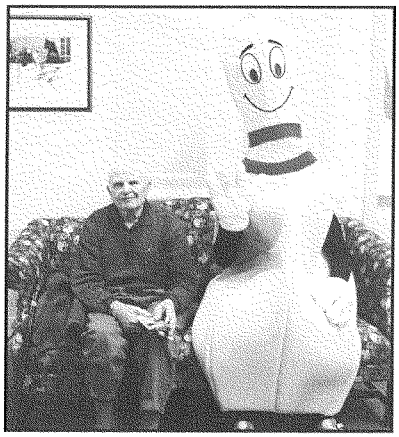
Top: Participants in the *Great Decisions* program show off their certificates of achievement.
Bottom: Seniors show what being an older adult means to them.



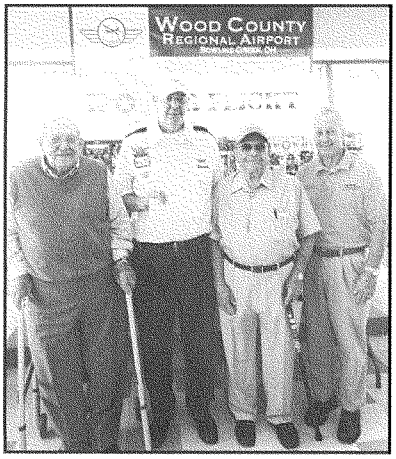


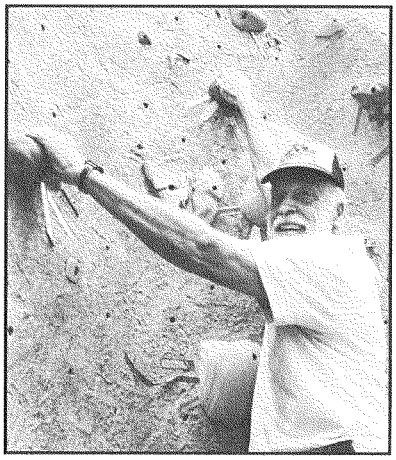


Top: A local senior proudly shows off his military outfit and medals.
Bottom: A group of veterans take part in the *Honor Flight* program.



Top: 'Pin Boy' takes time to meet with seniors participating in a Wii Bowling Tournament.
Bottom: A participant in the *New Adventures* group tries rock climbing.





Chairwoman Foxx. Thank you very much.

I now recognize Mr. Walberg for five minutes for questioning.

Mr. WALBERG. I thank the chairman.

And I thank the panel for being here and for the work that you do.

Mrs. Kellogg, delighted to see that you broke out of the subfreezing cold and snow drifts of western Michigan.

Mrs. KELLOGG. Counted my blessings when the skies were blue.

Mr. WALBERG. Yes. And here in the balmy climes of Washington, D.C., for at least a while.

Your testimony talks about Area Agencies on Aging being experts in stabilizing the home environment for seniors in a low-cost, person-centered way, ultimately enabling—and I think this is important where possible, and would hope even more possibility—enabling seniors to stay in their own homes. We had the privilege of having my mother stay in her home—own home on our property for 13 years, which impacted her and us very well, and hopefully the taxpayer also in that process.

If you could add some examples of the expertise of the AAA you operate, I would appreciate that. And also maybe you could comment on other networks and systems, what they could benefit from utilizing the expertise of the AAAs so as to avoid specifically duplicative services and costs.

Mrs. KELLOGG. Certainly. When we go into the home, I think we are one of the few networks that has truly life in the home and stabilizing how to live, with the things we all take for granted—dressing, eating, running errands, doing chores—is our core competency. There are many other—and we send—we have nurses and social workers that specialize in that, and then have to be aware of everything else that exists in the community.

There are the major federal streams of resources—Medicaid, Medicare, so forth—but to know the limits of all those as well as what else is being provided locally so that you don't leave gaps and try to—that is what I meant by creating a system, I think, is a particular expertise.

I think nowadays, and perhaps this is where you are going, with so many people realizing that if people are overwhelmed by their—the barriers they face just living daily in the home, they sometimes can't focus on other things that might need to happen, and I think this happens in the health professions and health industries sometimes. So there is a natural reach to—we have to work in the home. We have to reach out to the home.

And we have had many partnerships locally with PACE, with the Medicaid waiver through the Older Americans Act is a great gap-filler. Explaining to people how those gaps should be filled. Many of our colleagues in the health and medical professions have a hard time seeing home-based services beyond the required follow up, maybe, from a hospitalization, to go in and provide short-term, in-home—and that is kind of their entire world of in-home.

And many people need assistance without having a presenting health issue. That is the expertise of the area agencies and their whole network of providers.

I think that is what I meant, an unused—not fully utilized gem, I think, linking that entire system that understands the basis of

people just trying to live and what can be fostered to maintain life and independence. It is the American dream: independence for as long as possible in life, to the end of life. And capping that rather than recreating a new system of home supports, perhaps through a different, more medical lens is critical. I think there is a great potential there for the Older Americans Act.

Mr. WALBERG. Can you talk about any relationships you form with private businesses to do some of those services?

Mrs. KELLOGG. Yes. Local businesses have been major partners in some of our initiatives because I think many of them recognize—one, they are good corporate citizens locally, but also recognize the increasing reality of the aging society. What we have realized for years is now becoming well-known everywhere, and they are in—

Mr. WALBERG. Some examples of that?

Mrs. KELLOGG. Employees that are struggling with caregiving. People think of caregiving as hands-on and giving someone a bath, but an employee who is also trying to remember to leave early to run by the store to pick up something for someone or to remember to remind somebody of appointment, or maybe to stop by and shovel some snow because they are worried about somebody slipping are also caregivers.

And I think the awareness of how important that is in a community and how they, as corporate citizens, are—on a different note, they are becoming very involved with us in what we call—it has many names nowadays—livable communities for all ages, universal design. Every municipality, every corporation is spending some funds as corporate citizens or local planning entities.

It is important that they recognize the challenges people face as they grow old and embrace them for universal design in all investments. In that way, some of our larger corporations have become major partners with us in championing that cause of awareness of aging and reaching to—our largest employer is very multifaceted and they are very aware of cultural issues, as well, so they have become our champion.

Mr. WALBERG. Thank you.

My time is expired.

Chairwoman Foxx. Thank you very much.

Ms. Wilson, you are recognized for five minutes.

Ms. WILSON. Thank you, Madam Chair.

I believe that the most critical time in our lives—happens when we begin to get older, and I think that with dementia on the rise and Alzheimer's on the rise this is an extremely important topic. I have a couple of questions.

This question is for Ms. Cruz: When you consider the positive outcomes of OAA programs, such as increased tax revenues and spending power from working seniors, reduced emergency visits, and Medicare and Social Security costs, can you quantify how much OAA programs benefit both the economy and the taxpayer?

Dr. CRUZ. We know that the Older American Act reduces complications resulting from chronic illnesses, for example, and prevents unnecessary hospitalizations that can be very costly.

So one example is that the cost of providing annual meals through the Older Americans Act is approximately $1,300 per year. That would be the equivalent probably of a day of hospitalization,

so that is one example that I can offer you that speaks to the value of prevention that comes through the Older Americans Act, prevention that can reduce high hospitalizations, high complications that are very costly not only for the individual, the family, but also for the overall society.

Ms. WILSON. Thank you.

Would all of you agree that it makes sense to spend more money to feed seniors and fund the OAA than to pay much more for the emergency health care costs that arise when people are hungry?

Do you agree with that, Mrs. Niese?

Mrs. NIESE. I think when you look at preventative measures, they have a large impact, so, yes.

Dr. CRUZ. We are very concerned with the levels of hunger in the community, particularly older adults of diverse background, and so I would say that is absolutely critical to ensure that everyone is aging with dignity.

Mrs. KELLOGG. I think you are spot on in prevention and recognizing that preventative quality of all of these services. I think meals are critically important.

In every household it will be a balance. Sometimes you have an adult son who is willing to prepare a meal but not give a bath, so the issue that presents will vary, so the flexibility to respond for all of those needs in a prevention mode is critical.

Ms. WILSON. Thank you.

Ms. O'Shaughnessy. I think it is very difficult to come up with numbers in terms of tax savings or dollars saved through the Older Americans Act. However, I would say that when you are dealing with a frail older person who prefers to live in a home and community-based environment, the services that the Older Americans Act provides, such as home care, the meals programs, adult day care, is less expensive for most people, unless you are totally impaired and need 24-hour care, than going in a nursing home. And that is where we have the clearest sort of research evidence that there is a savings.

In addition to that, when you have an older person who is being cared for at home, you have family caregivers who are, you know, providing the most care. They are the primary caregivers for people with many impairments, and that is a cost that is not realized. It is a savings that is not realized by the federal budget. It is an, you know, unexpended or not able to be quantified number, so I think we have to take that into account when we are looking at cost-benefit issues.

Ms. WILSON. Thank you.

I am very familiar with the PACE program, and we are starting a brand new sort of outreach for PACE with veterans. And I think it is important for us to understand that it is not so much that people are poor that they don't eat; it has a lot to do with them, sometimes, remembering to eat and knowing how to prepare the food and having the strength, because they have to remember to take their medication, they have to remember all sorts of things. So if someone brings them a meal it is there and they will eat it.

So it is important. I especially am a champion for Meals on Wheels.

Thank you.

Chairwoman Foxx. Thank you, Ms. Wilson.

Dr. Heck, you are recognized for five minutes.

Mr. HECK. Thank you, Madam Chair.

And thank all of you for being here today. You know, obviously the Older Americans Act appropriately prioritizes individuals with greatest economic need and greatest social need to receive services to age in place in their homes and communities, and, Dr. Cruz, you listed a long list of the varying and diverse senior demographics that we face.

One that was missing, and one that represents a big part of my constituency, is Holocaust survivors who are minorities at risk of isolation. For them, institutionalization has potentially devastating traumatic consequences, due to the loss of control and autonomy over their daily life.

Ms. O'Shaughnessy, if you could tell me how we are doing from a national perspective, and perhaps, Mrs. Kellogg, if you could tell me from a AAA perspective, how we are doing to ensure that the survivors, especially the ones who are living in poverty who continue to teach us the most valuable lessons about humanity, diversity, perseverance, and the strength of the human spirit—how we are doing in making sure they have access to the services and supports to enable them to age in place with dignity, comfort, and security?

Ms. O'Shaughnessy. Well, the national data is very clear on this in terms of the three million people who receive intensive services under the Older Americans Act, and 11 million to 12 million who receive less intensive services, those services such as home care, adult day care, the meals programs, are very well targeted to people who have the greatest social and economic need, so I think that we do have a well-targeted, and the state and area agencies have been known to, you know, take that provision under advisement and do outreach strategies to make sure that those who are the most vulnerable get services.

However, research has shown that there are many people who need services who are not getting them, either because they don't know about the services or there is not enough funding to expand services. So that is an issue of concern in terms of unmet need among the elderly population that we have to always be concerned about. And that is an issue of using resources more wisely, but obviously it is also a resource-based issue to contend with.

Mr. HECK. Mrs. Kellogg?

Mrs. KELLOGG. I would agree with that. If your question is how do people respond locally, when we target resources there are various criteria or discussion points that you talk about with someone as to whether they would receive the—basically support through—directly through Older Americans Act resources. It could be based on age, income self-declaration, whether or not they have any support in the home, whether they are able to do their daily routines in the home.

You work through that, and we set—because we receive so many calls from people we have a priority system set that no one is denied, but when people presenting issues hit into very high criteria of high priority, they will be targeted ahead of someone who maybe

has some concerns but they might be more worries than manifesting real in the day to day.

Mr. HECK. As a AAA, do you interact much with the local social service agencies that target specific segments of a diverse community to help identify those in needs of service?

Mrs. KELLOGG. Yes. Yes. My area is mostly rural and quite diverse culturally, so we have variety of—one of the roles of AAAs is also education, so we have tapped for cultural sensitivity for providers, and outreach as to how to communicate and message the availability of resources, as well as language barriers.

Mr. HECK. Great. Thank you.

Thank you, Madam Chair. I yield back.

Chairwoman Foxx. Thank you very much.

Mr. Tierney, you are recognized for five minutes.

Mr. TIERNEY. Thank you very much.

And I want to thank all of our witnesses here this morning, as well, for your testimony.

Let me try to just cover a couple of areas quickly on that. One is respite care.

I would be appreciative to hear your comments on the importance of respite care, whether or not we are putting enough resources in that area, because I continually hear from people about how difficult it is to continually be responsible for a person that is under their care on that, and yet have a possibility—a chance to have any respite at all. So if we would just quickly go through whoever wants to respond to that from my left to right?

Ms. O'Shaughnessy. Well, respite care is a very important service for family caregivers who, as I said, are the primary caregiver—primary source of support for impaired older people. Respite services can be provided by Title III, and it is a Title III-funded service. It comes into play not only in the supportive services allotments that states get, but also in the family care giving program because there are limited funds for respite services.

But to be honest, I think that, you know, one could always do more because of the enormous strains that there are on caregivers who might have to care for a person 24/7, you know, 7 days a week. So that is an important consideration.

Mr. TIERNEY. Are we not funding the program in the aggregate enough, or are we not allocating resources that exist to that priority as opposed to others?

Ms. O'Shaughnessy. Well, when states get their supportive services allotment they decide, you know, what is the most—what are the most important services that they want to provide. Under the Family Care Giving Program it is an identifiable service, but under the supportive services allotment there is a laundry list of services that people—that area agencies can provide and they have to choose among them.

There are certain priority services, and home care services are one of the priority services under Title III, so there might be some spending. But again, it is up to the local agencies to decide how much to devote to respite care.

Mr. TIERNEY. Thank you.

Mrs. Kellogg?

Mrs. KELLOGG. It is hard to say from the national level whether there is enough because it does wrap around other resources. In Michigan, we have state funds also targeted specifically for respite and day care because of the tremendous need for caregiver relief.

There is also an interesting dichotomy because, although I believe that those are incredibly valuable services and they are out there, convincing caregivers to use them—people work themselves into physical or mental decline, and it is a major challenge to have them understand the value of respite day care. I think it is an up-and-coming, and will continue to be an up-and-coming, growth area because it is hugely prevention-oriented services to help these caregivers.

Mr. TIERNEY. Thank you.

Dr. Cruz?

Dr. CRUZ. Just to say that as I hear you, I echo what you say and say that dementia and Alzheimer's is on the rise, and we are very concerned that the demand for caregiving will continue to increase, and so not to lose sight of that and to keep that in mind as we—you know, as the law gets reauthorized.

Mr. TIERNEY. Thank you.

Mrs. Niese?

Mrs. NIESE. As a direct service provider and working in all the county communities that we have, one of the things that I see are the senior centers are the front door for respite care. You have many families, the husband and wife are coming in, the wife is using the time at the senior center for her respite; the husband is there with her, but she can be engaged in other activities, she can be socializing. He is safe; he is doing his activities and programs.

I think one of the things we have to focus on, too, is the education for the caregiver, that it is our right to seek help. Because that continues to be a challenge with my staff, to get caregivers to embrace the opportunities that they have.

Mr. TIERNEY. Thank you.

Thank you all for that.

And then just quickly, should we be listing LGBT adults as a group in largest need?

Ms. O'Shaughnessy. Well, I think that all people who have need for services should have equal access to the services under the Older Americans Act. I think that, you know, the Act lists a number of groups already, in terms of those people with low income, minority status, at risk of institutionalization.

One of the issues, as I mentioned earlier, was that people who need services now are not getting them, so I think it is an issue of, you know, do you add another target group to the—

Mr. TIERNEY. Well, I am just wondering whether or not you are seeing enough particularities with that group as they age that they need that special listing on that.

Mrs. Kellogg, what is your view?

Mrs. KELLOGG. Well, I think in Michigan our State Office on Aging has required area plans to include focus on that population. In my region, we have conducted sensitivity trainings in partnerships with those groups.

Whether or not something was listed in the Act, I don't think—I tend to think a broad sweep is probably the most appropriate be-

cause it is hard to respond to what are you specifically doing for one if you are already becoming active in a certain area.

Mr. TIERNEY. Fair enough.

Dr. Cruz?

Dr. CRUZ. Yes. Our research is showing that LGBT elders are not fully accessing the current system. They feel isolated, and we need to review that.

Mr. TIERNEY. Thank you.

And Mrs. Niese?

Mrs. NIESE. I think we have to look at it at a local level and make sure that we are welcoming and we are doing the outreach. I think even if it were in the Act, if we as service providers are not providing opportunities and making a safe place and a welcoming place, even if it is in the Act it is not going to be successful.

Mr. TIERNEY. Thank you.

Thank you, Madam Chairman, for your time.

Chairwoman Foxx. Thank you.

Mr. Salmon, you are recognized for five minutes.

Mr. SALMON. Thank you, Madam Chairman.

The older I get, the more up close and personal this becomes, and let me say what I mean. I mean, obviously we are all going to be in that situation in the not-so-distant future, but right now, dealing with that with my own parents. My father, World War II veteran, a hero in my estimation, passed away about four years ago. My mom, 92, has been living by herself for the last four years since he passed away, and she is in the hospital right now with some issues and has finally acquiesced and will be—when she comes out of the hospital, she will be moving in with my brother and his wife, who are empty nesters.

In about three weeks—well, let me go on. My in-laws, my father-in-law was diagnosed about a year ago with Alzheimer's disease; he is 84. And my mother-in-law, 84, is kind of at wit's end because, you know, she is frustrated and scared and doesn't know how to cope completely.

And in three weeks, they are going to be moving in with my wife and I, and we will be caring for them. I know it is a big challenge ahead, and in a lot of ways I am kind of frightened.

But I have got to say, in my younger days I served a mission for my church in Taiwan, and one of the things that I really loved about that culture—the Chinese culture—is their reverence to their elders and their love for the parents, and the idea that the responsibility for their parents is equal to the responsibility their parents had for them when they were children.

And I am glad we have these programs. They are good. And I think that taking care of the most elderly and vulnerable in our society is a good function of government.

I would love to see some kind of a public awareness campaign in this country to try to encourage families to be families and step up and, you know, to take care of their parents and not neglect them and not just forget about them.

I think a lot of parents who—you mentioned, Dr. Cruz, some of them feel really isolated. Maybe they wouldn't feel so isolated if their kids would give them a phone call or if their kids would visit them once in a while.

And I know that is not a broad brush. There are a lot of good, you know, children that take care of their parents and watch out for them, but government is no substitute for the love that comes from families. It is great to take care of the basic needs, but it is no substitute for love of families.

And I would really like to see some kind of a, you know, a public awareness campaign go across this country to remind people that, you know, your family responsibilities continue, you know, when your children are grown, and it reverses maybe a little bit to the people that loved you and nurtured you and brought you into this world.

And so I am not trying to just sermonize. I get really frustrated because I have gone to old folks' homes, and I have visited folks that are lonely and abandoned, and I would just really like to see all of us maybe focus a little bit more on, you know, the family and keeping that together.

I would like any thoughts that any of you have on that, on roles that we can play and maybe making that happen.

Ms. O'Shaughnessy. Well, so many families are going through what your family is going through now, and it is a very difficult and stressful time because you see your parents who are declining, and it is a very sad thing to watch.

I do think some of the national organizations have done a good job in recent years to try to focus on the family, and I just saw an ad, actually, a few days ago. It was an AARP ad that had a picture of an older woman and her daughter, who was performing different roles in sort of a photo montage, and here she was preparing meals, and then she was coordinating her doctors' appointments, and she was doing the housecleaning, and she was, you know, being a comfort to her mother.

So I think it was a very telling ad because it speaks to what you are talking about, and I do think that some of the national organizations—and even in the Older Americans Act, by recognizing family caregiving as a—as one of the funded services was a big step forward in 2000 when Congress added that new program.

So I think that there—the research shows, you know, that families are primary caregivers, despite, you know, kind of—we hear about families moving so far away, but eventually—and I think most people live within a certain geographic range of their family so they are available. It is just the stress that happens when you are—you have multigenerational families like your own there.

Chairwoman Foxx. Thank you very much.

Mr. Hudson, you are recognized for five minutes.

Mr. HUDSON. Thank you.

And I thank the witnesses for your testimony today and the time you have given us. Very informative.

I have a question for Ms. O'Shaughnessy. I understand the Older Americans Act Title III funding formula generally distributes funds to states based on the population of older Americans in the state. However, the previous reauthorization back in 2006 included a "hold harmless" provision that prevents states from falling below their 2006 funding levels. This does not take into account current populations; in fact, it is based on the 2000 population—2000 census.

What formula changes would you suggest to ensure that states are receiving their fair share of available funds while recognizing the current fiscal challenges we face, and what are some of the issues we need to consider?

Ms. O'Shaughnessy. Well, Mr. Hudson, that is a very difficult and complicated question, and whenever you change a formula that has sort of been a longstanding formula, there are winners and losers. And usually there was a change in the 2006 amendments to the formula, so a "hold harmless," as you mentioned, was added. And a "hold harmless" is always a compromise because you don't want to negatively affect certain states while certain states are being positively affected. So it is a balancing issue.

I think in the past there have been various proposals to change the formula to look at, for example, a function of need of older people, how many individuals within a state have limitations in activities of daily living, or, you know, disability issues. There have been proposals to look at a state's low-income and minority older population. You can look at age as a proxy for disability, for example.

All those things have tradeoffs because some of the southern states have higher proportions of people with disabilities, and you kind of get into—not to overgeneralize, but you get a Rust Belt, Sun Belt kind of issue. You have growing populations in certain states, maybe like North Carolina and other states in the South and the Southwest, versus other states in the North-Northeast who have higher proportions of the old population, as people have migrated.

So what you have to really do is look at the numbers and do formula runs that would look at the numbers. I am making work for my colleague in the audience here, who works for CRS, but it—you really have to look at the numbers and see where people come in, and it becomes a very divisive issue in some cases when you change a formula.

So a "hold harmless" is a way to kind of moderate that—those influences. I don't know if that helps, but—

Mr. HUDSON. It does. And obviously the concern of a state like North Carolina, with a growing population, the—you know, the "hold harmless" seems to penalize states that have a growing seniors population, and certainly I want to assure that North Carolina seniors are not being shortchanged because of, you know, shortsighted errors in Washington or the way we are doing the formula.

Well, how important is it for states and Area Agencies on Aging to have maximum flexibility in how they serve seniors? Are there areas where your organization could benefit from increased flexibility?

I guess Mrs. Kellogg?

Mrs. KELLOGG. You are asking if there are areas that we should have increased flexibility?

Mr. HUDSON. Yes.

Mrs. KELLOGG. It is a hard issue because I tend to believe maximum flexibility is best, and you have—at the same time, there are specific needs that people want to make sure are addressed. So right now the Act does look at some areas of categorical limits or recognition of a need area and then stop.

That is why I mentioned the construct of the Act right now is probably okay the way it is. It provides some categories of very important need—legal, meals, other things—number of—percentages of in-home, different things. But if you start drilling down too much—because they are all real and people really have those needs—you end up losing the flexibility to wrap around what is happening in the community in the local level. And I truly believe that is paramount to really making the whole Act efficient of how it can do its job.

So in a perfect world, I don't think there should be hardly any limits. The way it is now, it points out high-need areas, sets some limits, and leaves it alone at that point. I think that is probably a good way to continue and allowing maximum flexibility within the different service titles as they are now.

Mr. HUDSON. Great. Thank you.

Madam Chair, I yield back.

Chairwoman Foxx. Thank you.

Ms. Bonamici, you are recognized for five minutes.

Ms. BONAMICI. Thank you very much, Chair Foxx, and thank you for scheduling this hearing about this important issue.

I apologize that I wasn't here for your testimony. We are trying to do two things at once this morning. But I have reviewed the testimony.

I want to start by saying that during the past year a bipartisan Senate coalition has worked with diverse stakeholders to report language that makes important updates to the Older Americans Act. And I have been honored to work with them and our ranking member, Mr. Hinojosa, and we will soon be introducing legislation that builds on what the Senate has started and includes other key updates about our most vulnerable populations. And it is my hope that as this committee moves forward with the reauthorization of the Older Americans Act that we can work together on both sides of the aisle to make important targeted updates to ensure that this law continues to serve our seniors.

And I want to start by asking Dr. Cruz—thank you for your testimony today, especially for advocating for aging policies that meet the needs of diverse elders. You note in your testimony that diverse seniors generally experience disproportionate levels of economic insecurity, and unfortunately this seems to be true for many LGBT elders.

Indeed, advocates point out that LGBT elders face higher poverty rates than heterosexual elders. They are also twice as likely to be single, three to four times as likely to be without children.

This is an important issue and Representative Hinojosa and I are working on our legislation, and we have provisions that will strengthen services and access for LGBT seniors. Specifically, the bill will designate LGBT seniors as a population in greatest social need to ensure that they can get culturally competent care that addresses their needs.

Can you explain how the Older Americans Act falls short currently in serving LGBT elders and how designating LGBT seniors as a population in greatest social need would expand access to services for this group of Americans? Thank you.

Dr. CRUZ. Thank you for your comments and for your service.

I think the current situation, what our research is showing is that LGBT elders are not fully accessing services. The infrastructure that is currently in place—clinics, for example, or community centers—are not providing culturally competent services for LGBT populations, and so therefore, they are delaying services, they are delaying preventive services that could, you know, reduce costly complications, chronic diseases down the road.

So that is the—what our research is showing us. And we have looked at California, we have looked at New York, D.C., and Florida.

Ms. BONAMICI. Thank you.

And I have a follow-up question, too. I think we can all agree that preventing the mistreatment of elders should be a priority of the Older Americans Act.

The National Center on Elder Abuse found that despite current reporting laws, many cases of elder abuse and neglect go unreported. And the center cites several recent studies estimating that up to 10 percent of respondents have been abused in the past year.

The bill that Representative Hinojosa and I are developing would establish a unified database to collect information on elder abuse, exploitation, and neglect, and it would also ensure that those who work directly with older adults receive training in elder abuse prevention and detection. What steps can we take to prevent elder abuse, neglect, and exploitation, and are there particular programs that have been successful—I am a big supporter of evidence-based programs—at preventing elder abuse and that may be worth expanding?

And I would be interested in hearing from the other witnesses on this, as well.

Dr. Cruz, do you want to start, or—

Ms. O'Shaughnessy. Well, as you say, there are many cases—and plus, we don't know exactly how many cases go unreported. There are two segments in the Older Americans Act. There is a small program for elder abuse, neglect, and exploitation prevention. It is one of the smallest programs in the Act.

However, there is also the Elder Justice Act that was enacted as part of the ACA, and part of that program, although I don't think it has 2014 funding. It did receive a couple of years of funding, but one of the components of that Act is to provide training to local officials about being aware of elder abuse issues, and I think you might want to look at building on that program for your legislation.

Ms. BONAMICI. Thank you.

Mrs. Kellogg?

Mrs. KELLOGG. It is ironic. In Michigan, we have been championing over the last year a package of 11 bills that would not bring money but policy and process changes to raise awareness of elder abuse in Michigan, and I think we have got now eight of the 11 passed.

And I would echo Carol's comments in that has brought together—we do training for—and education. That is one thing.

But then bringing together the different emergency responders as well as the services providers and those—the dialogues across systems have been very, very helpful. So it is just a matter of doing

that and then making sure you have policies in place that can put teeth in laws if you find issues.

Ms. BONAMICI. Thank you.

And I see that my time is expired, but I would be interested in hearing from the other two witnesses perhaps in writing after the hearing. Thank you very much.

I yield back. Thank you, Chair Foxx.

Chairwoman Foxx. Thank you, Ms. Bonamici.

Mr. Guthrie, you are recognized for five minutes.

Mr. GUTHRIE. Thank you, Madam Chairman. I appreciate that. And thank you all for being here.

I want to point out, it was mentioned about sequestration and the programs, and 10,000 people who are—a day who are 65 or—are turning 65 every day, and just note that we are going to spend hundreds of billions of dollars over the next budget—within this next budget on people 65 and older. As a matter of fact, when my daughter is my age in 30 years, 100 percent of federal revenues, under the current budget if we don't do anything different,- will be Social Security, Medicare, and Medicaid, and a substantial Medicaid goes to the seniors. So that is squeezing out these programs and that is what we need to address when they work that way.

First, Mrs. Kellogg the Areas on Aging—the agencies—you said you do needs assessment and then you try to put your services to what your needs are. What tools do you do to do needs assessment? Is it roundtables, discussions, surveys?

Mrs. KELLOGG. We started off in our agency doing a series every three years of random digit dialing in partnership with the university. We knew if we talked solely to one constituent group we would get that perspective, so we went with a kind of a more of a approach that looked at barriers to independence rather than asking about specific services and really quizzed people on what kind of barriers were they having.

Over a sequence of years, and doing that three—I think three or four times—it pointed us directly towards the whole array of long-term supports and services that were needed. After that direction was firmly entrenched, we ended up getting involve, because we have been around awhile in information services. We have a very robust call center as well as care management that goes out to the home and talks to people.

Nowadays you look at what is the nature of those calls coming in? What needs are able to be met and what aren't? We get I think it is close to 15,000 reached through that call center every year, and we talk about what are the unmet needs, what are people having?

So that becomes that kind of cold call, as well as when we send people out to the home, maybe in a care management-type mode, what are the things that you can find solutions for? What can't you? And now they have become our drivers.

Then the individual help with a person becomes much more of an individual process: What is that person facing? And that is the person-centeredness of today's world, just hearing what they view their barriers are rather than trying to craft a pigeon hole for them.

Mr. GUTHRIE. Exactly. Thank you.

And, Mrs. Niese, in your testimony you talked about you have flexibility to collaborate with businesses, corporations, and K–12. Could you give an example of a collaboration—or one or two—that has worked and been successful?

Mrs. NIESE. Well, the collaboration with the local nursing homes, where we can offer exercise programs with the certified P.T.s—physical therapists and occupational therapists. Other things that we do—again, people realize the market of the baby boomers hitting 60 and 65 and they are a whole new client base. And so we have many organizations—home health care agencies, pharmaceuticals, all of that are wanting to educate on their programs and services. We are not letting them sell.

But in order for them to provide that education, we are asking them to contribute and support. Maybe they are going to sponsor one of our events so that we can have seniors there who could otherwise not afford to participate in cholesterol screenings and that. So they are underwriting services that older adults who don't have the financial means can actually participate in.

Mr. GUTHRIE. Well, thanks.

That leads to Ms. O'Shaughnessy. In your testimony, you mentioned that participants in Title III are encouraged to make voluntary contributions for services they receive and states may implement cost-sharing policies for certain services. Do you know how many states have implemented cost-sharing policies and how successful they have been?

Ms. O'Shaughnessy. Well, from the latest survey information that we have, about 16 states have, you know, formal, written cost-sharing policies, and when states cost-share they—generally they are for the more high-cost individualized services like home care, personal care, adult day care. I think why have more states not done—established cost-sharing policies? So, voluntary contributions are a part of the Act. I mean, people do contribute on a voluntary basis, generally generating income through the nutrition programs.

Mr. GUTHRIE. Do people contribute for their own service, or could it be, like, you could have a pharmaceutical contribute to the program and have access to educate on their—

Ms. O'Shaughnessy. Yes, you could have, I think, you know, as witnessed by some of the other speakers today, that, you know, they are seeking out businesses to help contribute toward services that are provided in the community.

With respect to the cost-sharing, some states have found it very administratively difficult, because even if you have cost-sharing policies, the law says that you cannot deny services if someone cannot contribute. So it becomes sort of a catch-22: You might have the policy, but if someone cannot contribute, will not contribute, you still have to provide the service, especially if they are in the greatest social and economic need. So it becomes a little bit of an administrative difficulty.

Mr. GUTHRIE. Thank you. Thanks for those answers.

My time is expired. I yield back.

Chairwoman Foxx. Thank you.

Mr. Thompson, you are recognized for five minutes.

Mr. THOMPSON. Madam Chair, thanks for this hearing.

Thank you to the witnesses for being here.

As someone who has spent basically almost 30 years working with older adults—started out as a certified therapeutic recreation specialist, rehab services manager, and I guess somewhat out of self-defense, a licensed nursing home administrator towards the end of my career. You know, meeting the needs of older adults—and I think thankfully today, with science and lifestyle, we—most older adults, my observation, age with dignity and independence in place. But for those who don't, because of health, illness issues, it is important to have these services that you all are in one way or another connected with.

And so, Ms. O'Shaughnessy—or Ms. O'Shaughnessy—I wanted to—as the committee begins to reauthorize the Older Americans Act, you know, what key principles should guide us how we review and reform programs serving older Americans?

Ms. O'Shaughnessy. I think you have heard from other witnesses today in terms of maintaining the flexibility that the Act currently has. The decentralized structure of the Act is somewhat elegant in the sense that you have agencies that have feet on the ground, ears on the ground, hands on the ground to provide and to develop services for older people.

I think you might want to be careful about adding any new requirements in this time of fiscal constraint. We may have some issues in terms of if you add new requirements on an already burdened network, which is trying to serve the needs of the growing elderly population, it becomes very difficult.

I think that one might look at some evaluations that the Administration on Aging is conducting now. They have some results from various component parts of the network, so I think you might want to look at some of the evaluative information that is coming out of there—out of the administration.

Also, I think that—some people have mentioned it, too—I think that, you know, we have to think about new ways of garnering resources, so making state and area agencies, or at least area agencies, more entrepreneurial, looking at being trained on business outlooks, and I think that the administration has taken the step by awarding to the National Association of Area Agencies on Aging a grant so that they can help area agencies become more competitive, and to garner, you know, outside, private sector resources, as someone just mentioned. I think those are the kinds of things you might want to look at.

The other areas, I think, that—the administration has even suggested this, that you might want to look at ways to increase efficiency and performance across the board, and by perhaps having incentive grants for high-performing agencies that might, you know, have a little competition going on, but reward people for doing, you know good things and—on evidence-based research. I think those are the kinds of things I would suggest maybe looking at.

Mr. THOMPSON. Thank you.

Speaking of evidence-based research, one of my certifications in the past had to do with working with individuals with disturbing behaviors—dementia, such as Alzheimer's. And this is my observation, and so I was curious to just get an affirmation whether I am right or wrong—and I am okay either way because people tell me

every day that I am right and wrong on the same issue, actually—but how significant an issue is the increasing evidence and prevalence of disturbing behaviors related to dementia, such as Alzheimer's—and obviously there are other disorders in that family—for this older adult reauthorization, compared to even just in 2006, and what should we consider to address this rising incidence and the impact on individuals and families?

I don't have much time but we will start with Mrs. Kellogg, and then when we don't get if, if you would submit in writing that would be great. I appreciate it.

Mrs. KELLOGG. I was thinking of the other representative's comments about his family and involvement. When we put out an education or a seminar in our community saying, "You and Your Aging Parent," it is flooded every time.

And when that happens, I think we just need to help people be aware and not be so afraid of the disease, and recognize the reality so that they can take preventative steps to live life even with the disease, as well as people, because they are sometimes fearful to come forward, miss the tips—and the benefit of each other. We are doing a lot with creating confident caregivers, evidence-based caregiver training that focuses on dementia, and the "aha" moments among participants that they are not alone and they can still live life, and how do you manage this? I think that is a critical task for us all.

Mr. THOMPSON. Thank you, Madam Chair.

Chairwoman Foxx. Thank you, Mr. Thompson.

I would now like to welcome to the committee our distinguished colleague from New York, Congressman Gibson. Without objection, Congressman Gibson will be permitted to participate in our hearing today.

I hear no objection, so I recognize Mr. Gibson for five minutes.

Mr. GIBSON. Well thanks, Madam Chair.

And I thank the ranking member and all the members of the distinguished committee here.

I thank the panelists for their tremendous testimony today.

The resources, the support programs that come with the Older Americans Act, critical to my district. And it is a very popular program. In fact, really the only criticism I hear about the program is the name of the Act, and I wonder—but it may be something to think about going forward.

But, you know, as I have worked the issues across the 11 counties in upstate New York, and listening to seniors, seniors' advocates, family members, and caregivers, and then meeting with the directors of the Office of the Aging in my area, it was clear to me that we needed to push for this reauthorization that puts the programs at risk without the authorization.

So, and I worked with my colleagues, Betty McCollum, Tom Reed, and we have authored and introduced H.R. 3850, which is a 5-year reauthorization of the Older Americans Act. And that is why I greatly appreciate the Chair allowing me to be here today. Our staffs have been working together.

I also want to mention some of the organizations, I think, that were instrumental in authoring the reauthorization: AARP, the National Association of Area Agencies on Aging, the National Council

on Aging, the Meals on Wheels Association of America, Experience Works—and that is, you know, the work that they do in our district I think is critically important, and I think important for generations working together. So many seniors who have just remarkable wisdom and the desire to impart that on younger Americans, and I think this is a great program that helps with that—Easter Seals.

And so all these advocacy groups working with my colleagues and I to get this reauthorization. And so I look forward to what I hope is a fruitful set of hearings so that we can get to this reauthorization.

And, you know, I had one question for Mrs. Niese, and it is really based on our experiences in upstate New York. I am curious to hear your best practices of how you deal with this challenge.

I have a county on the western trace of my district—Delaware County. The village is Sidney, and Sidney sits right on the western edge, and it—you know, within a rock's throw you are in Chenango County. And the orbit within 10 miles or so pulls everyone to Sidney, but it is a different county.

And so we have had a challenge because there is a wonderful senior center right in Sidney and they service people in another county, and so they find a way. They have voluntary contributions. But it has been a bit challenging for the administration of the program.

I am curious to know, do you have similar challenges, and what you have done about it?

Mrs. NIESE. I certainly do, and a large part of that is because we are a bedroom community of Lucas County, Toledo, Ohio, and we have many people who live in Lucas County who come across into Wood County to one of the senior centers there. We also, in our southern part of our county, have folks coming in from Hancock County for programs and services.

Because of the Older Americans Act funds coming in, my governing board, our county commissioners allow for that. They are treated as everyone else. So it doesn't matter where you are coming from. You are a U.S. citizen, it is Older American Act dollars, you are welcome to come in.

Now, since the majority of our funds are raised through our senior services levy, there are different call centers associated. If someone wants a newsletter and they are out of county, they pay more. If someone wants to—well, we cannot do medical escort for someone out of county. But if they want to go on a trip or an activity they are welcome to come into the site and then they can participate as a county resident.

So you have to work together.

Mr. GIBSON. Yes. So the flexibility in the Act, I think, is highlighted—

Mrs. NIESE. Flexibility is phenomenal.

Mr. GIBSON. Yes. Well, thank you. And thank you again for all your great work and leadership.

And, Madam Chair, I will yield back the balance of my time. Thank you.

Chairwoman Foxx. We like guests like you who yield back the balance of their time. Thank you.

Well, I want to thank all of the members of the panel who are here today, and because I am chairing and am here the entire panel I usually wait till last to ask my questions. And when that happens most of my questions get asked ahead of time, but you have prompted some issues and some questions for me.

I appreciated, Ms. O'Shaughnessy, your talking about the fact that there are some efforts being made to make the programs more efficient and to measure performance and to do evidence-based research.

All of you have mentioned the fact that funds are scarce, and people here know that I am a big proponent of accountability and efficiency and effectiveness.

This is a program that, it appears, has done a good job of leveraging local and state money. It can be, I believe, a model program for the federal government to be involved.

So I would like to ask—and you don't have to go into great detail, and I am hoping you will give me some information in writing, so I am not asking for great detail here. I would like to give Ms. O'Shaughnessy and Mrs. Kellogg, Mrs. Niese some—an opportunity to quickly answer.

How are ways that you are measuring efficiency, client outcomes, and how services are targeted to the most vulnerable of the populations? And can we export these metrics to programs that aren't using them now? How can we do that? And how can we set up a program of reward to help those who aren't doing the kinds of things that should be done based on evidence-based research?

So, Ms. O'Shaughnessy, if you could very quickly respond?

Ms. O'Shaughnessy. I do think that, you know, performance standards are a good thing, and at this moment I don't believe that there are performance standards. It is very difficult in the social service world to have performance standards, but I think that you can have a goal and objectives—excuse me.

So I do think that, you know, as you mentioned, working on evidence-based research is absolutely very important, and perhaps, you know, developing the performance standards and having technical assistance to state and area agencies to make sure that those standards are being used. You can't really cut off their funding if they don't do it, but you can have, as you mentioned, an incentive program, perhaps, to offer the high-performing agencies in order for them to compete for additional funds. I do think that is an option you may want to consider.

Chairwoman Foxx. Thank you.

Mrs. Kellogg?

Mrs. KELLOGG. Yes. Obviously one measure, by shifting almost everything we do to evidence-based practice is kind of copping out to one degree, but building on our research to make sure that you are only doing evidence-based practice. When I talked about the person-centered contracting, it did raise our impact analysis significantly because you actually order a service based on a need and then follow up to see if that exact service did the need or not, so that is a very direct measure for us.

I do believe that there is a body in—somewhat in the academic community studying performance standards for satisfaction and empowerment-type issues. People, if they truly know—they have

overturned every rock and understand their situation in life, it does bring peace. And how to measure that in today's world is a toughy, so I am glad there are people smarter than I am tackling it.

But I do think that becomes a standard when you are talking about programs that at one point are serving people with very severe needs that you do not expect to get better.

Chairwoman Foxx. Mrs. Niese?

Mrs. NIESE. One of the things that we have established internally is that all of our locations have a set of standards that we have developed that they have to adhere to so that residents throughout our service area are receiving equitable services. That is very important to us.

Another thing that we have done is we have collapsed administrative costs, in that we have staff at our central office that are shared at all seven of those senior centers. And so we have two R.N.s and one MSW on staff. Those three ladies are running around this county at all the seven senior centers and are being as efficient as possible working one-on-one with those seniors, going into the homes for assessments, helping with home repairs.

So again, sometimes we have to step back and look at our own administrative operations and maybe have an economy of scale by readdressing that.

Chairwoman Foxx. Thank you very much.

I want to thank our distinguished panel of witnesses for taking the time to testify before the subcommittee today.

Mr. Tierney, do you have some closing remarks?

Mr. TIERNEY. Just very brief, and to echo your comments, I want to thank all of the witnesses for their testimony. It is refreshing to see all of us be able to come together on an issue and in a matter that I think obviously reflects the concern that members of Congress have.

And thank you for adding your insight into it. It will be very useful as we move forward.

Thank you.

Chairwoman Foxx. Thank you.

And as you all said, and others have said here today, we know that we have scarce resources. However, we know the population—the elderly population—is growing. There is just some givens there that we have.

But I think the—you have raised some really important points today that we need to pay a lot more attention to, and that is to getting out the information to which programs are effective, and to making sure that the hard-earned taxpayer dollars are being spent as efficiently and effectively as they can be. We do want to take care of our elderly, and it is important that we do so in the best manner possible.

So I will look forward to looking at some of the research that has been done and talking to folks who are doing more research, and hopefully seeing people go in the direction that will help us set up guidelines, set up performance measures that would help the money be spent better.

And I applaud all of you, particularly those of you working at the local community to deliver the services, for making stone soup, as we said before, taking scarce resources and putting them together,

because I do think that this is an example of good partnerships at the local level. So thank you all very much for being here today and getting us started on this discussion.

There being no further business, the subcommittee stands adjourned.

[Additional Submissions by Mr. Bonamici follow:]

THE ELDER JUSTICE COALITION
A NATIONAL ADVOCACY VOICE FOR ELDER JUSTICE IN AMERICA

February 21, 2014

Testimony of the Elder Justice Coalition
Hearing of the House Education and the Workforce Subcommittee on Higher Education and Workforce Training
Chairwoman: Rep. Virginia Foxx (NC)
Ranking Member: Rep. Ruben Hinojosa (TX)

Chairwoman Foxx, Ranking Member Hinojosa:

On behalf of the Elder Justice Coalition, I thank you for providing an opportunity to submit testimony. The Elder Justice Coalition is a 3000-member coalition of individuals and organizations working to prevent and combat elder abuse, neglect and exploitation.

Elder abuse is a growing problem in our country. According to the Department of Justice, one out of every 10 older adults is a victim of elder abuse. 1 in 2 of those with dementia will be victims. A 2011 study on elder abuse prevalence indicated that out of 23.5 elder abuse cases, only 1 is reported. For financial exploitation, the ratio is an astounding 43.9 to 1 reported. $2.9 billion is lost to financial exploitation every year. With 10,000 people turning 65 every single day, this epidemic will only continue.

The Older Americans Act is critical to the fight against elder abuse. Title VII of the Older Americans Act, Vulnerable Elder Rights Protection, is one of the most crucial sources of funding for the prevention and combating of elder abuse. Created in 1992, Title VII funds programs such as the State Long Term Care Ombudsman Program which investigates allegations of abuse and neglect made by residents of nursing homes and long term care facilities and which is the only OAA program to focus on institutionalized persons. The Title also contains a provision to require states to carry out activities to raise public awareness of elder abuse, neglect and exploitation and to coordinate the activities of area agencies on aging with states' Adult Protective Services programs.

The goals of the Elder Justice Coalition for the 2014 reauthorization of the Older Americans Act are to strengthen Title VII and include other provisions in the Act that would complement Title VII's programs:

- **Elder justice federal database:** Language should be included in the Act that establishes a unified federal database for the collection of data and statistics on the incidence and prevalence of elder abuse, neglect and exploitation with assistance from federal, state, and local agencies and other private and public organizations. This database should be updated annually. This is not a new program; it simply enhances the existing language in the Act to make it consistent with the forthcoming expected Elder Justice Coordinating Council recommendations.

- **Elder abuse training for staff who work with older adults:** All staff and volunteers working in OAA-funded programs should receive training in elder abuse prevention and detection. This training already happens in most programs and this provision would ensure consistency.

1612 K STREET, NW SUITE 400 WASHINGTON, D.C. 20006
PHONE: 202-789-0470 ♦ FAX: 202-223-2099
WWW.ELDERJUSTICECOALITION.COM ♦ INFO@ELDERJUSTICECOALITION.COM

THE ELDER JUSTICE COALITION
A NATIONAL ADVOCACY VOICE FOR ELDER JUSTICE IN AMERICA
JOHN B. BREAUX, HONORARY CHAIR ◆ ROBERT B. BLANCATO, NATIONAL COORDINATOR

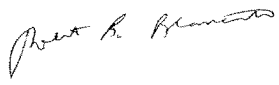
- **Support for resident and family councils:** A section should be added to Title VII supporting and encouraging resident and family councils, which have been successful in protecting the rights of elders in long term care facilities. The current program has not provided resources to the ombudsmen program in Title VII to support these councils. There is no additional cost for this provision—the money is already present in the Family and Caregiver Support Program.

- **Greatest social need including victims of elder abuse:** Older Americans Act programs are designed to target those in "greatest social need." This category should include those who are victims of abuse, neglect, and financial exploitation. This amendment would ensure that victims of elder abuse receive adequate support.

- **Abuse sensitivity services for caregivers:** Caregivers are often perpetrators of elder abuse; providing training will reduce abuse and provide them with options to reduce their fatigue and seek respite care.

The Elder Justice Coalition appreciates this opportunity to provide testimony on behalf of the Older Americans Act and especially its elder abuse prevention programs. The Older Americans Act is crucial to protecting some of our most vulnerable seniors. It has a long bipartisan history and we are hopeful that this history will continue and allow a strong bill to be passed that will meet the needs of our growing senior population, both today and tomorrow.

Respectfully Submitted,



Robert B. Blancato
National Coordinator
Elder Justice Coalition

1612 K STREET, NW SUITE 400 WASHINGTON, D.C. 20006
PHONE: 202-682-4140 ◆ FAX: 202-223-2099
WWW.ELDERJUSTICECOALITION.COM ◆ INFO@ELDERJUSTICECOALITION.COM

Written Statement of
Shane Snowdon
Director, Health and Aging Program
Human Rights Campaign

To the
Subcommittee on Higher Education and Workforce Training
Committee on Education and the Workforce
United States House of Representatives
"Serving Seniors Through the Older Americans Act"
February 11, 2014

Ms. Chairwoman and Members of the Committee:

My name is Shane Snowdon, and I am the Director of the Health and Aging Program at the Human Rights Campaign, America's largest civil rights organization working to achieve lesbian, gay, bisexual and transgender (LGBT) equality. By inspiring and engaging all Americans, HRC strives to end discrimination against LGBT citizens and realize a nation that achieves fundamental fairness and equality for all. On behalf of our over 1.5 million members and supporters nationwide, I am honored to submit this statement into the record for this important hearing on the Older Americans Act.

Congress passed the Older Americans Act recognizing the significant role that community social services play in the lives of American elders. The Older Americans Act touches seniors across the country through 20,000 service providers every day. These services lift many seniors out of isolation, support vital nutrition programs, and provide much-needed support for caregivers. At this juncture, it is critical that Congress take steps to ensure that every senior is served through the Older Americans Act, including those who are LGBT.

There are an estimated 1.5 million LGBT seniors in America today. As the Baby Boomer generation ages, the number of LGBT older adults is expected to grow exponentially. By 2030, the number of LGBT seniors is expected to reach 3 million.[1] LGBT seniors are an extremely vulnerable population. Many will be forced to navigate significant and unique barriers to successful aging. Discrimination in housing, employment, and healthcare has made many LGBT older adults subject to an increased risk for social isolation and higher poverty rates. In fact, lesbian couples over the age of 65 are twice as likely to be living in poverty as heterosexual

[1] *Improving the Lives of LGBT Older Adults*, 2010. Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE) and the Movement Advancement Project. Available at: http://www.sageusa.org/specialevents/home.cfm?ID=71.

married couples.[2] This increased risk for poverty, coupled with lifelong discrimination, silences many LGBT older adults and their families. Too often, they find themselves excluded from the programs and services designed to support them.

Fear of discrimination deters many LGBT seniors from seeking the help they need, often urgently. Thirty percent of LGBT seniors in a recent survey reported that they believed discrimination in a long-term care facility was inevitable.[3] This well-founded fear makes many LGBT seniors go to great lengths to avoid being admitted to a care facility. Fearing harassment and discrimination at the hands of home health aides and other care providers, LGBT seniors are also less likely to seek out and use supportive services that could help them age in place. This fear extends to programs funded by the Older American Act, including those provided through Area Agencies on Aging (AAAs). Without these services, LGBT seniors, especially those who are low-income or living in rural areas, are at an even higher risk of social isolation, poor health outcomes, and early death.

In 2012, the Administration on Aging (now the Administration on Community Living, or "ACL") published clarifying guidance recognizing that LGBT older adults can and should be served by the programs funded by the ACL. This guidance broadened the current definition of "greatest social need"--which allows communities to identify populations in their service area that experience isolation for cultural, social, or geographic reasons—to include older adults with heightened needs based on sexual orientation and gender identity. This informal guidance reminds aging networks serving LGBT older adults that receive ACL funding to consider this vulnerable population as one with a "greatest social need." However, it is only a first step in protecting LGBT older adults from discrimination and ensuring equal access to ACL-funded programs.

The Human Rights Campaign urges Congress to address these issues and this growing need in the reauthorization of the Older Americans Act. For over five decades, the Older Americans Act has been a lifeline for aging Americans and the programs that serve them. Congress must act now to ensure that these programs and services are available to every elder, and that LGBT seniors are afforded the same level of dignity, respect, and self-determination as their peers.

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[2] *Poverty in the Lesbian, Gay, and Bisexual Community*, March 2009. Randy Albelda, M.V. Lee Badgett, Alyssa Schneebaum,, Gary J. Gates; The Williams Institute. Available at: http://williamsinstitute.law.ucla.edu/wp-content/uploads/Albelda-Badgett-Schneebaum-Gates-LGB-Poverty-Report-March-2009.pdf.

[3] *Metlife, Out and Aging: The Metlife Study of Lesbian and Gay Baby Boomers* (2006). Available at: http://www.metlife.com/FileAssets/MMI/MMIStudiesOutAndAging.pdf.

National Association of Nutrition and Aging Services Programs
1612 K Street, NW Suite 400 Washington, DC 20006
(202) 682-6899 (202) 223-2099 fax
www.nanasp.org

February 19, 2014

Testimony of the National Association of Nutrition and Aging Services Programs
Hearing of the House Education and the Workforce Subcommittee on Higher Education and Workforce Training
Chairwoman: Rep. Virginia Foxx (NC)
Ranking Member: Rep. Ruben Hinojosa (TX)

Chairwoman Foxx, Ranking Member Hinojosa:

On behalf of NANASP, the National Association of Nutrition and Aging Services Programs, I thank you for providing an opportunity to submit testimony. NANASP is a national not-for-profit membership organization of 1,100 members who provide older adults with healthful food and nutrition through community-based services, many through the Older Americans Act nutrition programs.

The Older Americans Act Title III-C nutrition services programs are the largest and most visible programs in the Act. They operate in every state. They serve more than 2.6 million older Americans daily with more than 236 million nutritious meals served each year.

Nutrition services in the Older Americans Act include the congregate and home-delivered meals programs along with NSIP, the Nutrition Services Incentive Program. Congregate meal programs operate in a variety of sites, such as senior centers, community centers, schools, and adult day care centers. Besides meals, services include nutrition screening and education and nutrition assessment and counseling as appropriate. The program also presents opportunities for social engagement and meaningful volunteer roles, which contribute to overall health and well-being. Home-delivered meals provide meals and related nutrition services to older individuals that are homebound. Home-delivered meals are often the first in-home service that an older adult receives, and the program is a primary access point for the other home and community-based services. NSIP provides additional funding to States, Territories and eligible Tribal organizations that is used exclusively to purchase food.

Our goal for the 2014 reauthorization process is making the nutrition programs stronger by protecting its federal dollars and ensuring the programs address all three of its main purposes which are to:

1) Reduce hunger and food insecurity;
2) Promote the health and well-being of older individuals by assisting them to access nutrition and other disease prevention and health promotion services to delay the onset of adverse health conditions resulting from poor nutritional health;

3) Promote socialization and community service and prevent isolation of older individuals.

Reducing hunger and food insecurity

The Meals on Wheels Association of America Foundation states that as of 2011, there are 8.8 million seniors facing the threat of hunger and that from 2001 to 2011, the number of seniors experiencing the threat of hunger increased by 88%. In addition, the *USDA Food Security Report* found that 9.1% of all households with older persons living alone are food insecure and older persons living alone represent one of the fastest growing populations in our nation. While the Older Americans Act is not the only solution, it remains the largest national food and nutrition program specifically for older adults. According to the Academy of Nutrition and Dietetics, this program reaches less than one-third of older adults in need of its program and services.

What does hunger and food insecurity mean to our nation and the federal government? It means that older adults who are malnourished and often isolated are more likely to end up with more expensive and unnecessary hospital and nursing home stays. It means more doctor visits, home health care and other services. It also means we are letting members of our greatest generation suffer in their golden years. A fundamental outcome of the reauthorization must be to better target the resources of the nutrition program to ensure it is reaching those older Americans most susceptible to hunger.

Promoting the health and well-being of older individuals

The second purpose, promoting the health and well-being of older individuals by assisting their access to nutrition and health promotion services to delay the onset of adverse health conditions resulting from poor nutritional health, will not only save the health of our seniors but also save our taxpayers and our health care systems money.

87 percent of older adults have one or more of the most common chronic diseases: hypertension, coronary heart disease and diabetes. According to a 2006 American Medical Association article, in those aged 45-64, diabetes more than tripled the risk of nursing home admission. These three common chronic diseases are preventable or treatable in part through access to appropriate nutrition services including meals, nutrition screening and assessment, counseling and education. Again, the OAA nutrition programs are not the only solution, but the meals it provides every day must provide at least one-third of the Dietary Reference Intakes for older adults.

As we look to reauthorize the OAA, we should consider the potential cost savings that could be achieved for Medicaid and Medicare if we invest more in programs like the nutrition programs. In the congregate and home-delivered meal programs, a senior can be fed for a year for about $1,300. This $1,300 is the same as the cost of six days in a nursing home or one day of hospitalization. If we are able to keep these individuals in their homes, we will achieve genuine savings. An investment in the nutrition programs today most certainly can produce a strong return on the investment in terms of savings to Medicare and Medicaid in the future.

Promoting socialization and preventing isolation

The final purpose of the nutrition programs is the promotion of socialization of older individuals. When older adults tell us stories about the importance of the congregate nutrition program, they tell it in the context of the program providing nourishment for the body and the soul. One of the fastest growing segments of the older population is those who live alone. In fact, according to AoA, 48

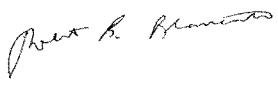
percent of all women over the age of 75 now live alone. The OAA nutrition program provides seniors, especially those who live alone, with an opportunity to interact each day with other older adults. This can help to avert greater isolation and loneliness for these older adults.

We feel that the Older Americans Act, while already a critical part of the tools used by the aging services network to provide services for older adults, could be strengthened further by the addition of a few key provisions that would update the Act's nutrition provisions.

- Under Title III of the Act, all OAA nutrition programs should provide for nutrition screening, education, assessment, and counseling. Doing so will maximize the impact of OAA nutrition programs by making sure that participants have the knowledge and information they need to attend to their nutritional needs.
- Aging and disability resource centers (ADRCs) created under Title I of the Act should provide incoming clients with information on nutrition and nutrition education. This change would help older adults understand their nutrition options.
- Finally, also in Title III, a study should be conducted to measure the outcomes of programs headed by registered dieticians. This study would help determine the extent to which nutrition professionals make a measurable difference in improving health outcomes and reducing costs in area- and state-level OAA nutrition programs. This information will help inform the structure of these programs in the future (i.e. whether employing a registered dietician can help a state reduce costs in senior nutrition programs).

NANASP appreciates the opportunity to provide this testimony on the value of the Older Americans Act and especially its nutrition programs. This Act is about the value it provides to those whom it serves. It is about the value of the volunteers who work in the program, and perhaps most importantly, it is about the value it represents to our present and future federal budgets. The Older Americans Act enjoys a long bipartisan history in this body and in the Senate. We hope that will continue and that will allow a strong reauthorization bill to be enacted that does more than just extend the program—that also modernizes it to meet today and tomorrow's needs.

Respectfully Submitted,



Robert B. Blancato
Executive Director
National Association of Nutrition and Aging Services Programs (NANASP)

National Indian Council on Aging, Inc.

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Navajo

February 21, 2014

Testimony of the National Indian Council on Aging
Hearing of the House Education and the Workforce Subcommittee on Higher Education and Workforce Training
Chairwoman: Rep. Virginia Foxx (NC)
Ranking Member: Rep. Ruben Hinojosa (TX)

Chairwoman Foxx, Ranking Member Hinojosa:

The National Indian Council on Aging (NICOA), the only national organization dedicated to the well-being of American Indian and Alaskan Native (AI/AN) Elders, is pleased to submit this written statement for the record on the House Education and the Workforce Subcommittee on Higher Education and Workforce Training hearing entitled "Serving Seniors through the Older Americans Act."

In the spirit of contributing to the understanding of the Older Americans Act (OAA), we want to present some information on its Title VI Grants for Services for AI/ANs.

Under the Act, grants are awarded under Title VI to Indian tribal organizations, Alaskan Native organizations and non-profit groups representing Native Hawaiians. Grants are used to fund supportive and nutrition services for older Indians. Grants are awarded to more than 250 tribal organizations and 2 Native Hawaiian organizations. In addition, family caregiver grants have been awarded to 218 Title VI organizations.

According to the 2010 Census, the American Indian/Alaskan Native population increased at a rate faster than the total population, rising from 4.1 million to 5.2 million. In addition there are approximately 325,00 persons age 60 and over that have identified themselves as AI/AN, and another 267,000 persons age 60 and over identified themselves as part AI/AN.

As an organization which works on a daily basis with older AI/ANs, we know the critical importance of the programs and services which the OAA provides. It is for this reason that we strongly support the reauthorization of the OAA in this session of Congress.

As is the case with all other Older Americans Act titles, Title VI suffers from chronic underfunding at a time when demand for services is growing. Our members endure higher rates of poverty, geographic isolation and low education levels. The services provided both under Title VI and nutrition services under Title III-C can and do make a critical difference in their health status. We hope that a reauthorized Older Americans Act will send an important message to the Appropriations

10501 Montgomery Blvd. NE, Suite 210 • Albuquerque, NM 87111
Telephone 505-292-2001 • Fax 505-292-1922 • www.nicoa.org

Committee that it makes good fiscal sense to invest in the Older Americans Act and its services so we can achieve savings in Medicare and Medicaid in the future.

The National Indian Council on Aging wishes to offer these specific recommendations to the Subcommittee:

- We call for increased training for Title VI service providers that include new and innovative ways to improve Indian elder access to social services. These should be separate funds from service dollars.
- We also call for renewal of and for first time funding for Subtitle B of Title VII of the Older Americans Act which authorizes a program for Tribes, public agencies or non-profit organizations serving Indian elders to assist in prioritizing issues related to elder rights and to carry out activities in support of these priorities.
- Elder abuse is a growing problem in Indian country as it is across the nation and we hope the Older Americans Act can be strengthened to improve the federal response.
- Finally, we want to offer our ongoing support for Title V, the Community Services Employment for Older Americans program of the OAA (also known as SCSEP). We are proud to serve as a national sponsor and believe the program operates well under the Department of Labor. We also urge that the community service focus of the program be continued, especially since it often benefits other older individuals in communities to be provided services by these low-income seniors.

The Older Americans Act is a good and proven program which deserves to be reauthorized, modernized and strengthened for all the millions of older adults it serves every day. We look forward to working with you and your colleagues to reauthorize this important legislation.

Respectfully submitted,

Eddie L Tullis

Eddie L. Tullis
NICOA Chairman

10501 Montgomery Blvd. NE, Suite 210 • Albuquerque, NM 87111
Telephone 505-292-2001 • Fax 505-292-1922 • www.nicoa.org

[Additional Submissions by Mr. Holt follow:]

The Jewish Federations of North America
Washington Office

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Gerrald B. Silverman
PRESIDENT/CEO

1720 I Street, NW
Washington, DC 20006-3736

Phone 202.785.5900
Fax 202.785.4937
JewishFederations.org/washington
jfederations @jfederations

William C. Daroff
Senior Vice President for Public Policy & Director of the Washington Office
The Jewish Federations of North America

"Serving Seniors Through the Older Americans Act"
Hearing Date: February 11, 2014
Statement for the Record submitted February 24, 2014

Education and the Workforce Committee
Subcommittee on Higher Education and Workforce Training

Background

The Jewish Federations of North America (JFNA) strongly supports the Older Americans Act (OAA) as a vehicle for providing home and community-based services to older adults in need. The Jewish Federations of North America represents 153 Jewish Federations and over 300 Network communities, which raise and distribute more than $3 billion annually for social welfare, social services, and educational needs. JFNA partners with the Association of Jewish Family & Children's Agencies (AJFCA) and its network of 125 social service providers to provide direct services to vulnerable populations of all faiths and backgrounds.

According to data from the recent Pew Research Center report, "A Portrait of Jewish Americans," 24 percent of American Jewish adults is age 65 or older, compared with 18 percent of the general adult population. Accordingly, aging services is high on the communal agenda. Jewish Federations care for older adults through a vast network of community centers, family service agencies, synagogues, and senior centers, many of which host programs funded in part by the Older Americans Act. Jewish community centers host health, nutrition, and social programs, and family service agencies offer accessible transportation to help prevent isolation. Our affiliated agencies partner with state and local governments, community businesses, and other nonprofit organizations.

The Jewish Federations of North America is pleased that the Senate Committee on Health, Education, Labor and Pensions approved the bipartisan reauthorization of the Older Americans Act on October 30, 2013. This legislation makes modest improvements to the law.

JFNA supports inclusion of the following priorities in the Older Americans Act.

- Inclusion of the RUSH Act to assist Holocaust survivors with services and assist all seniors with culturally appropriate meals.
- TITLE IV – Activities for Health Independence, and Longevity, in particular the Community Innovations for Aging in Place program and a return to innovative community-based demonstration grants.
- Nutrition services provided in senior centers and delivered to seniors' homes to promote well-being and reduce social isolation.
- Technical assistance and support for multipurpose senior centers including best practices for modernization and the promotion of intergenerational models.

- National Family Caregiver Support Program to assist caregivers who pay a high price physically, socially, emotionally, and financially to care for loved ones.
- Training and best practices to respond to elder abuse, neglect, and exploitation.
- The Senior Community Service Employment Program to train and place low-income adults, age 55 years and older, to work for community service programs.

Title IV of the OAA

With an expanding older adult population, community-based providers need to prepare by modernizing systems of care that provide consumers with more control over their lives, and improve the overall quality of life for older adults to ensure that they remain at home as long as possible. This is a predominant principle within the Administration on Aging, and until recent fiscal cycles, it was advanced in significant part through Title IV of the OAA.

In the preceding decade, Title IV was an important gateway for the promotion of research, development, and the demonstration of innovations and improvements in community-based aging services and programs. The title enabled the nation to expand its knowledge and understanding of the older population and the aging process; provided opportunities for the public and nonprofit Aging Services Network to design, test, and promote the use of innovative ideas and best practices in programs and services for older individuals; helped to meet the needs for trained personnel in the field of aging; and increased awareness of the need to assume personal responsibility for one's own longevity.

Important initiatives in family caregiver support and community-building models (such as NORC Supportive Services Programs and the Community Innovations for Aging in Place program) emanated from Title IV to assist older adults to age in place and safely forestall costly and unwanted institutionalizations.

In recent years, commencing in FY2010, Title IV has been severely impacted by budget cuts and austerity measures that have forced innovative Title IV programs to fold outright and opportunities for new initiatives to cease. This has occurred just as the first Baby Boomers reached retirement age in January 2011. With the aging tidal wave still before us and growing, we believe strongly that Congress should utilize the opportunity of OAA reauthorization to reinstate Title IV as an essential part of the Act and to include a strong message opposing the wholesale cuts that have hurt and hindered Title IV.

OAA and Holocaust Survivors

Our members assist older adults of all backgrounds to live independently in their communities. For Holocaust survivors, this is critical. For survivors, removal from one's home results in the loss of autonomy, independence, and control over one's daily life, which has the potential to trigger psychological impacts from experiences in the Holocaust. For example, when placed in an institution, some Holocaust survivors may resort to hiding food in their rooms, insecure about when their next meal will come, and

how much food will be available. Some survivors learned long ago to fear and mistrust doctors, white coats, or uniforms because of their terrifying experiences with Nazi soldiers and medical experiments. Unfamiliar showers are particularly traumatic to survivors of concentration camps, some of which contained gas chambers disguised as showers. Even socially adjusted survivors who have adapted well their entire lives in America may experience these triggers later in life, especially if compounded by dementia or Alzheimer's.

Of the approximately 120,000 Holocaust survivors currently in the United States, it is estimated that about a quarter are living in poverty, placing them at higher risk of isolation and potentially traumatic institutionalization. Poverty is most pervasive in the population of survivors that immigrated to the United States after 1965 from countries of the former Soviet Union. These survivors have had less time to integrate into the American workforce. Many of them do not speak English. About half of the survivors who are in this group are suffering from poverty, while survivors who immigrated earlier, before 1965, are at a socioeconomic level comparable to the general population of seniors.

The targeting of services in the OAA would assist this vulnerable population to remain safely in their homes. JFNA strongly endorses the bipartisan Responding to Urgent needs of Survivors of the Holocaust, or the "RUSH" Act, H.R. 2064, which among other provisions, designates Holocaust survivors as a population of 'greatest social need' in the OAA. Additionally, the RUSH Act encourages nutrition programs to meet dietary requirements stemming from religious or cultural requirements.

JFNA supports the bipartisan OAA legislation approved by the Senate Committee on Health, Education, Labor and Pensions on October 30, 2013. This reauthorization included a requirement for the Administration on Aging to consult with organizations serving Holocaust survivors and issue guidance on outreach to the survivor population for Older Americans Act programs. We urge the House of Representatives to include this language in the OAA reauthorization.

The Jewish Federations of North America looks forward to continuing our work to ensure that Holocaust survivors and all vulnerable older Americans are able to live in dignity, comfort, and security in their homes and communities. JFNA is pleased to serve as a resource on these issues. JFNA thanks the Education and the Workforce Committee and the Subcommittee on Higher Education and Workforce Training for their focus on the Older Americans Act.

Contact: Shelley Rood, Senior Legislative Associate, (202) 736-5880,
Shelley.Rood@JewishFederations.org

[Additional Submissions by Mr. Miller follow:]



STATEMENT FOR THE RECORD

SUBMITTED TO THE

Committee on Education and the Workforce

Subcommittee on Higher Education and Workforce Training

House of Representatives

on

"Serving Seniors Through the Older Americans Act"

February 11, 2014

AARP
601 E Street, N.W.
WASHINGTON, DC 20049

For further information, contact:
Ariel Gonzalez
AARP Government Affairs
(202) 434-3770

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 support for reauthorization of the programs and services of the Older Americans Act (OAA). The straightforward mission of OAA is to provide a vital array of programs and services that assist, protect, nourish and sustain the nation's seniors with maximum dignity and independence. In the House, AARP has endorsed bipartisan, straight reauthorization legislation introduced by Representative Gibson, along with Reps. Reed and McCollum (H.R. 3850) as the best approach to building and maintaining bipartisan support for this critical source of services for the nation's rapidly expanding aging populations. AARP has urged the bipartisan leadership of authorizers in the House and Senate to move the legislative process forward with a simple reauthorization of the OAA. We intentionally chose the expression "simple reauthorization" to indicate that some minor changes to improve coordination could be embraced. While there are many positive ideas worthy of consideration during any OAA reauthorization discussion, our interest is to ensure that the Act maintains its critical service and information roles, while promoting responsiveness to the needs of mature and older Americans in a difficult economic climate.

In this period of economic downturn, AARP is most concerned that programs, authorities and partnerships 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.

Since 2010, AARP has consistently stated we support a reauthorization with minor changes whose goals are to strengthen and improve coordination of existing core services. This is based on the current fiscal climate, especially after years of essentially frozen funding for core existing OAA programs.

While AARP has supported various packages of positive OAA reauthorization legislative improvements, we have consistently noted that expansion of the program does not appear to be conducive at this time. Whenever possible, AARP is interested in program improvements, but at minimum, we ask that its existing programs be maintained. AARP has urged Congress to enact a core bill that at minimum does no harm to existing core programs and services. While AARP looks forward to future opportunities to support new provisions that may contain additional authority or spending, we do not support the elimination of any of OAA's existing programs.

AARP supports H.R. 3850 and applauds its sponsors and supporters, but we remain concerned about the potential negative effect of any proposals to eliminate existing programs. We also have concerns about undermining programs that have successfully operated since the Act became law in 1965 and have been sustained with overwhelming bi-partisan support.

To be clear and consistent with Congress, AARP regards the following as essential for our support of any final OAA reauthorization vehicle:

- Maintains core existing programs and services;
- No major new spending initiatives that compete with core existing programs;

- Only minor changes to improve coordination and efficiency needed since all agree that the current Act works; and
- Authorization levels are fiscally sound and provide needed guidance on what is essential to preserve and maintain core programs of the Act. While "such sums" could work for some smaller programs, guidance on appropriate funding levels to maintain major OAA programs as the age 60+ Boomers increase through 2030 is critical.

AARP remains willing to support a more expansive bill if it advances the OAA reauthorization process to successful conclusion.

Conclusion

Again, AARP appreciates the opportunity to address the important issues of OAA reauthorization, especially as those programs and services relate to serving 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.

[Additional Submissions by Ms O'Shaughnessy follow:]

"Serving Seniors Through the Older Americans Act of 1965"

Hearing before the Committee on Education & the Workforce

Subcommittee on Higher Education & Workforce Training

U. S. House of Representatives

February 11, 2014

Resources for the Record

Carol V. O'Shaughnessy

National Health Policy Forum

George Washington University

NATIONAL HEALTH POLICY
FORUM

The Aging Services Network:
Serving a Vulnerable and Growing Elderly Population in Tough Economic Times

BACKGROUND PAPER NO. 83

CAROL V. O'SHAUGHNESSY, *Principal Policy Analyst*

DECEMBER 13, 2011

Anticipating consideration of proposals to reauthorize the Older Americans Act during the 112th Congress, this publication updates a background paper published by the Forum in 2008.

OVERVIEW — *In 1965, Congress enacted the Older Americans Act, establishing a federal agency and state agencies to address the social services needs of the aging population. The mission of the Older Americans Act is broad: to help older people maintain maximum independence in their homes and communities and to promote a continuum of care for the vulnerable elderly. In successive amendments, the Act created area agencies on aging and a host of social support programs. The "aging services network," broadly described, refers to the agencies, programs, and activities that are sponsored by the Older Americans Act. The Act's funding for services is supplemented by other federal funds, such as Medicaid, as well as state and local funds. As the number of older people increases with the aging of the baby boom population, the need for a wide spectrum of services is expected to place pressure on the aging services network. Research has shown that the Act's programs serve vulnerable older people, yet many more are likely to need, but not receive, certain services important to help them to live in their own homes. Whether the aging services network will be able to sustain its current capacity and fully realize its potential will depend on its ability to attract and retain additional resources. Its challenges have been heightened by the continuing budget constraints faced by state and local governments during stressed economic times.*

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON DC

National Health Policy Forum

2131 K Street, NW
Suite 500
Washington, DC 20037

T 202/872-1390
F 202/862-9837
E nhpf@gwu.edu
www.nhpf.org

Judith Miller Jones
Director

Sally Coberly, PhD
Deputy Director

Monique Martineau
Director, Publications and Online Communications

The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at www.nhpf.org.

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In 1965, when Medicare, Medicaid, and the Older Americans Act were enacted, people age 65 and older represented slightly more than 9 percent of the nation's population. By 2010, the number of elderly had more than doubled, reaching over 40 million people and 13 percent of the U.S. population. The first wave of the baby boom generation began to turn age 65 in 2011. By 2020, one in six people will be age 65 and older. The growing elderly population is a recurrent and persistent theme in policy deliberations on the future of federal health, long-term services and supports (LTSS), and income security programs. In addition to concern about the fiscal pressures affecting Medicare and Medicaid, policymakers and practitioners have expressed concern about whether resources available under the Older Americans Act will keep pace with the growing elderly population, especially given its broad mission and scope of responsibilities. Budgetary pressures on domestic discretionary programs may place strain on aging services programs at the same time that some cohorts of the baby boom population are expected to create more demand for services.

This paper discusses the historical development, functions, and governance of the Older Americans Act aging services network. It also discusses its service programs and populations served as well as selected service programs administered by the network but financed by other sources. (The Appendix summarizes selected aging service network service programs.)

THE OLDER AMERICANS ACT: THE FOUNDATION OF THE AGING SERVICES NETWORK

The purpose of the Older Americans Act is to help people age 60 and older maintain maximum independence in their homes and communities, with appropriate supportive services, and to promote a continuum of care for the vulnerable elderly. The 1965 Act represented a

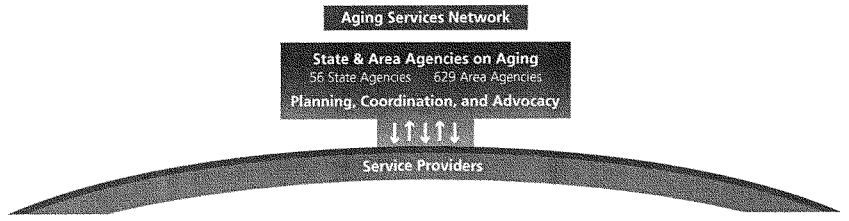
turning point in financing and delivering community services to the elderly. Before then, federal and state governments played a limited role in providing social services and LTSS to older people.

The Act's reach has evolved significantly through the years. Initially, it created authority for a then-new Administration on Aging (AoA) within the U.S. Department of Health and Human Services (HHS)[1] as well as state agencies to be responsible for community planning for aging programs and to serve as catalysts for improving the organization, coordination, and delivery of aging services in their states. It also created authority for research, demonstration, and training projects in the field of aging. Over the succeeding years, Congress expanded the scope, authority, and responsibilities of these agencies. The original legislation authorized generic social service programs, but in successive amendments Congress authorized more targeted programs under various titles of the Act to respond to specific needs of the older population. In 1973, Congress extended the reach of the Act by creating authority for sub-state "area agencies on aging" to be responsible for planning and coordination of a wide array of services for older people, as well as serving as advocates on their behalf.

Today, the "aging services network" is comprised of 56 state agencies on aging, 629 area agencies on aging, 246 Indian Tribal and Native Hawaiian organizations, nearly 20,000 service provider organizations, and thousands of volunteers.[2] These agencies are responsible for the planning, development, and coordination of a wide array of social, LTSS, and health-support services within each state (Figure 1). The Older Americans Act provides a framework for the delivery of a range of services for older people funded not only by the Act but also by other federal programs. For example, state and area agencies on aging, at a state's option, administer Medicaid LTSS programs as well as services funded by the Social Service Block Grant (SSBG), the State Health Insurance Program (SHIP), and the Public Health Service Act Alzheimer's Disease Supportive Services Program, as well as state and local funds. In addition, many state agencies on aging are responsible for administration of LTSS and other programs for younger people with disabilities.

While the infrastructure created by the Older Americans Act laid the foundation for the current aging services network, the law was not intended to meet all the community service needs of older people. The resources made available under the Act are intended to leverage other federal and nonfederal funding sources to serve older people.

FIGURE 1
Major Services Authorized by the Older Americans Act



Access to Services	Nutrition	Home & Community-Based LTSS	Disease Prevention & Health Promotion	Vulnerable Elder Rights Protection
Outreach, Information and Assistance Regarding Benefits	Congregate and Home-Delivered Meals	Home Care, Chore, Personal Care	Examples:	Long-Term Care Ombudsman
Care Management	Nutrition Counseling and Education	Adult Day Care	Physical Fitness	Prevention of Elder Abuse, Neglect, and Exploitation
Transportation		Family Caregiver Support	Nutrition Counseling	Legal Assistance
			Immunizations	
			Evidence-Based Health Promotion	

Prepared by the National Health Policy Forum.

Note: In addition to Older Americans Act programs, state and area agencies on aging manage services authorized by other federal programs. See text.

A relatively small proportion of the older population receives services directly funded by the Act. However, the infrastructure created by the Act can influence service programs that reach a far larger proportion of the older population. Mandates given to state and area agencies on aging to act as planning, coordinating, and advocacy bodies can impact policies that affect broader groups of older people. For example, state agency on aging efforts to develop LTSS have the potential to change service patterns for older people and for younger people with disabilities who do not directly receive services funded by the Act. In addition, the advocacy functions embedded in the Act's programs can make other programs' activities more accountable. For example, actions taken by Older Americans Act-funded long-term care ombudsmen to assist nursing home residents can improve nursing home care financed by Medicaid and Medicare.

As federal and state governments strive to meet growing needs, they have increasingly looked to the aging services network to administer new programs and services and to expand the scope of their responsibilities. For example, in implementing the Medicare Part D prescription drug benefit, the Centers for Medicare &

Medicaid Services (CMS) drew heavily on the outreach and assistance capabilities of aging services network agencies. Also, in recent years, some health care systems have used the expertise and resources of the network to provide assistance to help patients make successful transitions from hospitals to post-acute care settings and from nursing facilities to their own homes.

Considering the broad sweep of its mission, the reach of the Act itself is constrained by limited resources. Whether the aging services network can sustain its current capacity and fully meet its potential in the face of growing demand by an increasing older population will be influenced by its ability to attract and retain additional resources and by policy decisions of federal, state, and local officials. As a result of the economic downturn in recent years, activities of many aging services network agencies have been affected by shrinking state and local resources. A 2010 survey of state agencies on aging found that state programs were experiencing increasing demand for services at the same time they were facing budget reductions.[3] Similarly, a 2010 survey of area agencies found that many agencies have seen increased client caseloads, instituted waiting lists for services, and restricted the number of clients served, as a result of funding reductions.[4]

Historical Development: Expanding Responsibilities of the Aging Services Network

The original 1965 law and subsequent legislation in the 1970s emphasized the planning, coordination, and needs-identification functions of state and area agencies that continue as major functions today. The functions of state and area agencies on aging were designed to be carried out through a "bottom-up" planning process. The development of the aging services infrastructure in the early 1970s was partially influenced by national political trends toward decentralization of decision-making to state and local governments, exemplified by the New Federalism of the Nixon administration.[5] It was believed that state and area agencies were in the best position to assess the needs of the elderly and to plan and coordinate services at their respective levels without federal directives on what services to provide. While the program goals were determined nationally, the program was to be state-administered with a great deal of state and local flexibility.

During the early years of implementation, Congress authorized limited dollars for social services and intended that federal funds were to act as catalysts, or "seed money" to draw in state and local (that is, non-Older Americans Act) funds to benefit the elderly. The decentralized planning and service model has meant that state and area agencies, working collectively within a state, are largely in control of their aging agendas and can be responsive to state and local needs, within federal guidelines and funding priorities. However, the flexibility given to state and area agencies on aging has also led to wide variability in the design, implementation, and scope of aging services programs they administer, outside the federally authorized Older Americans Act programs. Moreover, the aging services network's success in securing additional resources depends on both the political and economic circumstances in individual states and localities and its ability to leverage private sector funds.

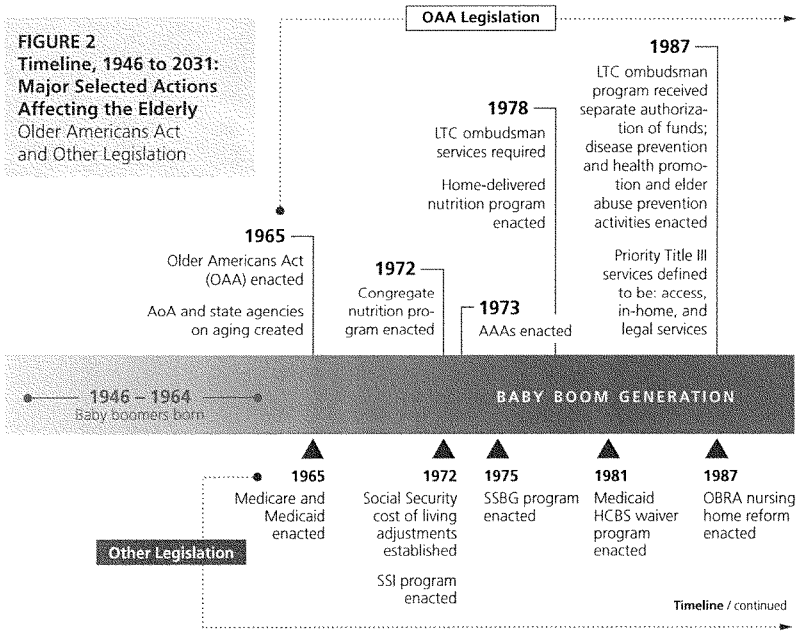
As state and area agencies implemented the planning process during the 1970s and 1980s, the needs of older people became more identified and differentiated. As a result, Congress began to authorize targeted programs to respond to specific needs. (See Figure 2, next page, for a timeline of major events in the evolution of the Older Americans Act and related legislation affecting the elderly.) The congregate and home-delivered nutrition services programs, created to address issues of nutritional inadequacy among the elderly, were added to the Act in 1972 and 1978, respectively. The long-term care ombudsman program to address quality of care for residents of long-term care facilities was added in 1978. In 1987, Congress required states to devote a portion of Title III services funds to certain "priority" services: (i) access services, defined as transportation services, outreach, information, and assistance to help older people obtain services, and case management; (ii) in-home services; and (iii) legal assistance. Also in 1987, the disease prevention and health promotion program was authorized. In 2000, the family caregiver support program was enacted. In the last amendments in 2006, Congress recognized the role that the aging services network can play in promoting home and community-based LTSS for people who are at risk for institutional care. These amendments required AoA to implement Aging and Disability Resource Centers (ADRCs) in all states to serve as visible and trusted sources of information on LTSS

options and to coordinate and streamline consumer access to services (see below for more information on ADRCs).

STRUCTURE AND FUNDING OF THE OLDER AMERICANS ACT

The Older Americans Act contains seven titles and authorizes myriad service programs. Total federal funding for the Act's programs in fiscal year (FY) 2011 is $1.9 billion. Title III, which authorizes activities of state and area agencies, and various service programs, is the major component of Older Americans Act funding, representing 70 percent of the Act's FY 2011 appropriation. Figure 3 (p. 10) shows a description of each title and the breakdown of federal funding by title.

FIGURE 2
Timeline, 1946 to 2031: Major Selected Actions Affecting the Elderly
Older Americans Act and Other Legislation



Timeline / continued

State and Area Agencies on Aging: Functions, Governance, and Staffing

Since their inception, the major functions of state and area agencies on aging have been to advocate for, plan, and coordinate programs that will promote "comprehensive and coordinated services systems" and "maximum independence and dignity in a home environment with appropriate support services" for older people. These agencies are also charged with developing a "continuum of care" for vulnerable older people and to help them remain as independent as possible in home and community-based settings.[6]

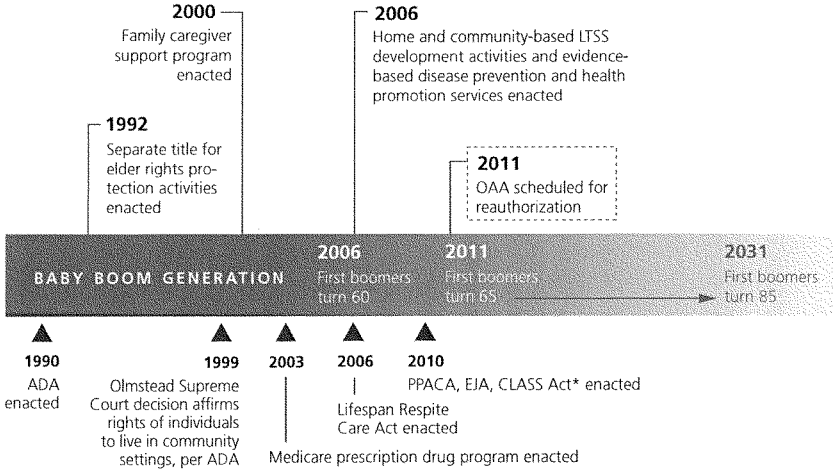
Each state has an agency designated by its governor to plan and coordinate services for older people, develop a statewide plan on aging,

FIGURE 2: Acronyms Defined

AoA	Administration on Aging
AAA	Area Agencies on Aging
ADA	Americans with Disabilities Act
CLASS	Community Living Assistance Services and Supports Act*
EJA	Elder Justice Act
HCBS	Home and Community-Based Services
LTSS	Long-Term Services and Supports
OBRA	Omnibus Budget Reconciliation Act
PPACA	Patient Protection and Affordable Care Act
SSBG	Social Services Block Grant
SSI	Supplemental Security Income

FIGURE 2 — Timeline / *continued*

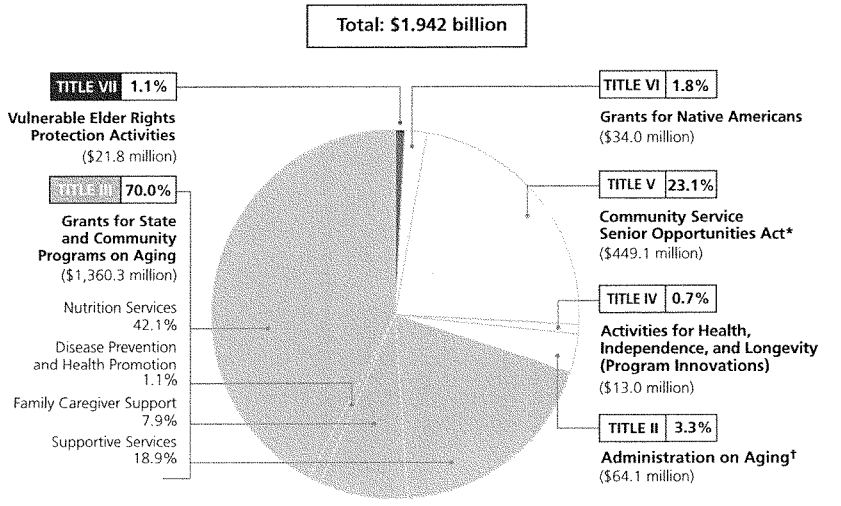
OAA Legislation



** As of fall 2011, HHS has suspended work on implementation of the CLASS Act.*

and administer Older Americans Act programs. State agencies on aging are required to divide the state into planning and services areas (PSAs), and, for all PSAs, designate area agencies on aging that develop area plans on aging. (A few state agencies operate as area agencies due to their small geographic size or population density.[7]) State and area agency plans on aging are to reflect how they will meet the needs of older people, using Older Americans Act funds as well as other funding resources.

FIGURE 3: Older Americans Act, FY 2011 Appropriations



** Also referred to as the Senior Community Service Employment Program (SCSEP) for Older Americans.*

† Also referred to as Aging Network Support Activities. Includes funds for AoA administration and for health and LTSS programs, including $10 million appropriated by the Patient Protection and Affordable Care Act (Section 2405 of P.L. 111-148) for Aging and Disability Resource Centers (ADRCs). ADRCs are authorized under Section 202 of the Older Americans Act. Also includes funding for national resource centers for elder abuse prevention and long-term care ombudsman programs, the national eldercare locator, and other activities.

Note: Not included in this chart is funding appropriated by Section 3302 of PPACA for various AoA programs to conduct outreach and assistance to low-income elderly. Section 3302 appropriated $15 million for area agencies on aging for fiscal years 2010–2012; $10 million for ADRCs for fiscal years 2010–2012; and $5 million for the National Center for Benefits and Outreach Enrollment for fiscal years 2010–2012.

Source: Prepared by the National Health Policy Forum, based on appropriations data provided by the U.S. Administration on Aging and the U.S. Department of Labor.

In addition to their advocacy, planning, and coordination roles, area agencies provide, or contract with other agencies and organizations to provide, a set of service programs. Functions considered "core" functions and generally provided directly by area agencies are information, referral, assistance, and outreach services to help older people determine their service needs and options; long-term care ombudsman programs that help residents of care facilities resolve complaints about their care; and family caregiver and support services. Other services generally provided directly by area agencies are case management and assessment and development of care plans to assist vulnerable older people get the support services they need, and benefits counseling to help older people apply for and receive benefits from income, health, and LTSS programs. Area agencies generally contract with other agencies or organizations to provide a number of other services; these are congregate and home-delivered nutrition programs, medical and non-medical transportation, legal assistance, homemaker, chore, respite care, personal care assistance, and adult day care services.[8]

The majority of state agencies on aging are located in umbrella human service and/or health services agencies; the remainder are

At a Glance: Older Americans Act Structure

Title I	**Declaration of Objectives.** Sets out broad social policy objectives oriented toward improving the lives of all older people.
Title II	**Administration on Aging (AoA).** Establishes AoA within the Department of Health and Human Services (HHS) as the chief federal agency advocate for older persons and sets out the responsibilities of AoA and the Assistant Secretary for Aging. Establishes aging network support activities.
Title III	**Grants for State and Community Programs on Aging.** Authorizes activities of state and area agencies on aging and funds for supportive and nutrition services, family caregiver support, and disease prevention and health promotion activities.
Title IV	**Activities for Health, Independence, and Longevity.** Authorizes research, training, and demonstration projects in the field of aging.
Title V	**Community Service Senior Opportunities Act.** Authorizes funds to support part-time employment opportunities for unemployed low income people age 55 and older who have poor employment prospects.
Title VI	**Grants for Native Americans.** Authorizes grants for supportive and nutrition services to American Indians, Alaskan Natives, and Native Hawaiians.
Title VII	**Vulnerable Elder Rights Protection Activities.** Authorizes funds for the long-term care ombudsman program and services to prevent elder abuse, neglect, and exploitation.

independent departments or commissions of state government.[9] The governance of area agencies varies widely. About 42 percent are independent non-profit agencies, about 30 percent are part of city or county governments; and about 23 percent are part of councils of government or regional planning and development agencies. The remainder are located in colleges, community action agencies, and other organizations.[10]

Staffing patterns of state and area agencies vary considerably based on each state's older population and the type and budgets of programs they administer. The staffing of state agencies on aging cluster around two ranges: about 33 percent of state agencies report between 21 and 75 full-time equivalent (FTE) staff and 41 percent, 126 or more FTEs.[11] Staffing of area agencies range from small staffs of just a few people, especially in rural states or rural areas within a state, to very large staffs of one-hundred or more in major metropolitan areas. In part, this reflects state policy decisions regarding geographic distribution of area agencies, the dispersion of the elderly population within a state, and funding. In FY 2010, the 629 area agencies on aging were staffed by over 23,000 paid staff in total; volunteers working in aging services programs numbered over 29,000 people.[12]

Variation on a theme — While all state and area agencies carry out advocacy, planning, and coordination functions, and administer core service programs, some observers have pointed to the wide variability in the design, implementation, and scope of aging services available to older people among states and across communities. The variation in the governance as well as the staff and resources available contribute to wide differences in capacity among these agencies. For many social service programs, national standards or guidelines for best practices do not exist.[13] This can present challenges to state and local aging services administrators who may seek to achieve or approximate effectiveness as measured by any defined standards. To address this variability AoA has, in recent years, encouraged state and area agencies to use evidence-based programs that have been proven by objective data to be effective, including in areas of health promotion and education and services to help older people transition from hospitals to post-acute care. (See sections below on Disease Prevention and Health Promotion and Aging and Disability Resource Centers.) However, evidence-based programs do not exist for many aging services programs.

Targeting the Vulnerable Older Population

Older Americans Act services are available to all people age 60 and over who need assistance, but the law requires that services be targeted to those with the greatest economic or social need.[14] (In certain instances people under the age of 60 may receive services.[15]) In successive amendments, Congress has added specific groups of older people to be targeted: those with low-income, members of minority or ethnic groups, older people living in rural areas, those at risk for institutional care, and those with limited English proficiency.[16]

Means testing—considering a person's income, assets, savings, or personal property as a condition of receiving services—is prohibited.[17] Participants are encouraged to make voluntary contributions for services they receive. In addition, states may implement cost-sharing policies for certain services (such as homemaker, personal care, or adult day care services) on a sliding fee scale, based on income and the cost of services. Where such policies exist, older people may not be denied services due to failure to make voluntary contributions or cost-sharing payments.

Although the distribution of Title III funds to states is determined on the basis of age alone, state and area agencies determine how to serve the target populations that are defined by federal law. A variety of methods are used to target services, including location of services in areas where vulnerable people reside, as well as strategic outreach to low-income and minority older people. Some services are targeted to vulnerable groups by definition. Examples of these, the long-term care ombudsman program, family caregiver support services, and home and community-based LTSS, are discussed below.

Population served — For FY 2010 AoA data show that about 5.1 percent of the 57.8 million people age 60 and older, or almost 3 million people, received services funded by the Act, such as home-delivered meals, home care, personal care, or case management services, on a regular, or intensive, basis.[18] A larger proportion—about 14 percent of the older population, or almost 8 million people—received other services, such as transportation, information and assistance, or congregate meals, on a less-than-regular or -intensive basis.[19] Even though a small number overall receives services, vulnerable older people are more likely to receive Title III services, as measured by poverty and minority status. Of all people served under Title III programs in FY 2010, 30 percent of those who received services on a regular or intensive basis had income

below the federal poverty level (FPL), compared with 9.5 percent in the U.S. population age 60 and over. About 25 percent of clients were members of a minority group, compared with about 22 percent in the U.S. population age 60 and over.[20]

Title III participants are more likely to be among the oldest population groups and to have multiple chronic conditions and functional impairments. Analysis of AoA data by Mathematica Policy Research, Inc., found, for example, that 37 percent of Title III congregate nutrition participants, and 36 percent of transportation participants were in the oldest age category (age 75-84 years) compared with only 24 percent in that same age group in the overall national population. Participants in selected Title III services, such as homemaker services, home-delivered meals, and case management programs, were more likely to have multiple chronic conditions and limitations in activities of daily living (ADLs), than other older people.[21]

SERVICES AUTHORIZED BY THE OLDER AMERICANS ACT

Title III authorizes four service programs: supportive services, nutrition services, family caregiver support, and disease prevention and health promotion activities (see also Appendix for a summary). Title VII authorizes the long-term care ombudsman program, and activities to prevent elder abuse, neglect, and exploitation. The following section discusses selected major services programs, including available data on participant characteristics.

Evaluation studies, where they exist or are underway, are briefly described under individual service programs. With a few exceptions, however, evaluations are limited to overviews of program implementation, or are dated.

Distribution of Funds and Non-Federal Matching Requirements

AoA distributes Title III and Title VII funds to states according to population-based formulae. Except for family caregiver support services, each state receives Title III allotments for services proportionate to its population age 60 and over, compared with the total U.S. population age 60 and over. Family caregiver support program funds are allotted based on states' proportionate population age 70

and over. States allocate Title III funds to area agencies on aging based on a state-determined formula, which is generally a combination of population factors such as age, income, and racial or ethnic status of the older population throughout the planning and service areas of the state.

In general, states are required to provide matching funds to use federal Older Americans Act services funds.

In general, states are required to provide matching funds to use federal Older Americans Act services funds. For supportive and nutrition services grants, states are required to provide 15 percent and for family caregiver grants, 25 percent, in state matching funds, as a condition of receiving federal funds. States may support long-term care ombudsman services with Title III and Title VII funds; in the case of Title III, a 15 percent state matching amount is required and, for Title VII, no matching amount is required. State and local communities often provide additional funds, above the federal requirements, to spread Older Americans Act funds more widely. In addition, voluntary contributions from older people to pay part of the costs of some services, especially for the congregate and home-delivered nutrition programs, augment federal, state, and local funds.

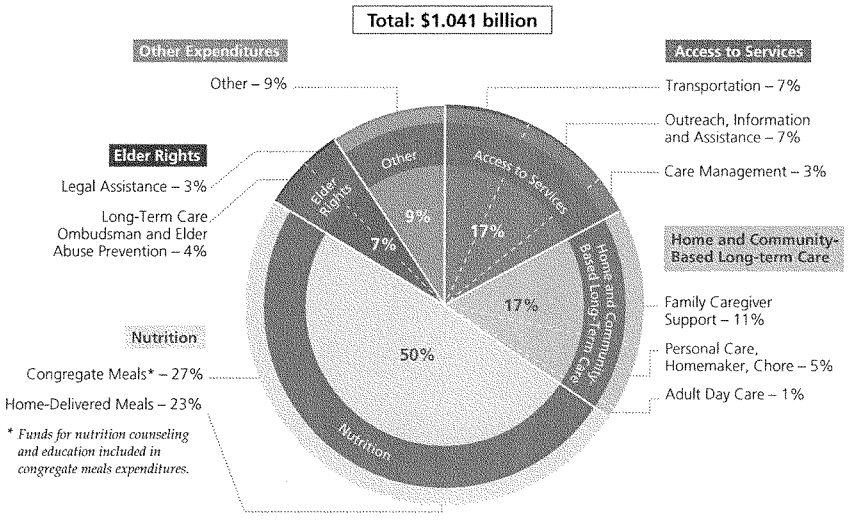
Supportive Services: Helping Older People Remain Independent in Their Communities

The supportive services program funds social services aimed at helping older people remain independent in their own homes and communities. Unlike other programs under the Older Americans Act that target a specific service, this program funds a wide range of services. These include services to help older people access services (such as information and assistance and transportation) as well as home and community-based LTSS (such as personal care, homemaker, chore, and adult day care services). Due to its limited funding, the amount of services the program can buy is relatively small.

Figure 4 (next page) shows FY 2010 federal expenditures for major services funded by the supportive services funding stream—access services and home and community-based LTSS —and other services funded by Title III and Title VII. (Note: Federal expenditures shown differ from appropriations for individual programs in part because states can transfer appropriated funds between programs.[22])

Information, assistance, and outreach — Central to the mission of the state and area agencies on aging is their role in providing information, assistance, and outreach services in order to act as access

FIGURE 4
Older Americans Act: Federal Expenditures for Services Authorized by Title III and Title VII, FY 2010



Note: Expenditures for disease prevention and health promotion not readily available. In 2009, this spending was 2 percent of the total. Also, federal expenditures shown differ from appropriations for individual programs in part because states can transfer appropriated funds from some programs to others.

Source: Prepared by the National Health Policy Forum, based on AoA data on federal expenditures for services reported by state agencies on aging. Does not include other federal or state and local funds.

points for aging services programs for older people and their families. Area agencies on aging are tasked with providing convenient and direct access to information and referral services to help older people identify, understand, and effectively use services available in their communities. According to AoA data, about 2,700 information and referral and assistance organizations across the country are supported by Title III supportive services funds.[23] In FY 2010, total expenditures for information, assistance, and outreach by aging network agencies were $178 million, with $67 million, about 38 percent, from Title III funds.[24]

A 2010 survey of area agencies found that over 90 percent provide information and assistance directly, rather than contracting with another agency.[25] Other data indicate that almost half of area agencies provide toll-free telephone lines. On average, each area agency

handles over 13,000 information and assistance calls annually, and most screen clients for their eligibility for home and community-based services programs.[26] Area agency information and assistance providers are sometimes recruited to assist in special outreach efforts. For example, they devoted considerable effort to provide Medicare beneficiaries information and assistance to help them enroll in the Medicare Part D prescription drug benefit.

Transportation services — Transportation services is the largest category of Title III supportive services spending, accounting for almost $74 million in FY 2010. Title III funds constitute a little more than a third of all transportation funding managed by area agencies.

An analysis of Title III FY 2009 data show that transportation service recipients are in the oldest age categories and are more likely to live alone than their peers nationally. For example, although only 8 percent of older people nationally were age 85 and older, more than one-quarter of Title III transportation recipients were age 85 and older. More than two-thirds of recipients lived alone, compared with a little more than one-quarter nationally. Recipients also tended to have numerous health problems: more than 80 percent had four or more chronic conditions.[27] Other data show that over half of recipients said they had no vehicle available in the household, and 43 percent reported that they relied on these services for virtually all their local transportation needs. About one-third of recipients used Title III-funded transportation more than 12 times per month.[28]

Focus groups with area agency staff, conducted as part of a supportive services program evaluation, found that transportation services were in short supply in certain areas, especially inner cities and rural areas, and that volunteers and waiting lists were being used to manage demand.[29] A 2011 GAO report found that the need for transportation services by older people is significant, especially among women, those who are age 80 or older, or those living below the poverty threshold. GAO reported a substantial need for transportation that cannot be met by state and local programs.[30]

Home care services — State agencies on aging are required to devote some of their Title III funds to home care services, including homemaker, chore, and personal care services. Almost 300,000 people received Title III-funded personal care, homemaker, or chore services in FY 2010.[31] Recipients are a particularly vulnerable group. An analysis of Title III FY 2009 data show that about 91 percent of homemaker

service recipients had four or more or chronic conditions; of those with multiple chronic conditions, about 42 percent had three or more limitations in ADLs. Almost 70 percent of homemaker services recipients lived alone and almost three-quarters were age 75 or older.[32]

In FY 2010, total expenditures for home care services by aging network agencies were $527 million, with about $51 million, or almost 10 percent, from Title III funds. Most of the funding for home care services comes from other sources, primarily Medicaid home and community-based waiver funds. Although the amount of funding devoted to home care is a small fraction of the amount spent under Medicaid and Medicare, the Title III program has the flexibility to serve people who may not otherwise be served under those programs. Because Older Americans Act services may be provided without the income and asset restrictions required under Medicaid, and without the restriction that beneficiaries need skilled care under Medicare, Title III funds may be used to fill gaps left by these other programs.

Evaluation — A 2006 evaluation of the supportive services program that primarily used AoA data concluded that the program serves a particularly vulnerable population. Moreover, analysis of data over a four-year period showed that for some services, such as home care and transportation, the proportion of vulnerable elderly (as measured by activity limitations and living alone status) increased. The evaluation also pointed out that agencies on aging use federal funds to leverage a substantial amount of non–Older Americans Act funds. According to this study and AoA data, for every $1 in federal funds, state and area agencies on aging supplement with more than $2 from other funding sources.[33]

Nutrition Services Program: Serving an At-Risk Population

Many older people are at high risk for hunger and food insecurity. Food insecurity is defined as being uncertain of having, or unable to acquire, enough food for all household members because of insufficient money or other resources for food.[34] Using data from the Current Population Survey's Food Security Supplement, a GAO analysis reported that almost one-third of elderly households with income less than the poverty level, and about 19 percent of households with income less than 185 percent of poverty, were food insecure.[35] Other research shows that in recent years, the number of elderly facing

poor nutrition and hunger has been increasing.[36] Being poor, having low education, and living alone are indicators of risk for poor nutrition. Older people lacking adequate nutrition are more likely to suffer from poor health and to have functional limitations.[37]

The elderly nutrition program, the oldest—and perhaps most well-known Older Americans Act service—is intended to address the nutritional problems of older people by providing meals in congregate settings, such as senior centers and churches (the "congregate meals" program), and meals to frail older people in their own homes (the "home-delivered meals" program). The purposes of the program are to reduce hunger and food insecurity, promote socialization among older people, provide meals to the homebound, and delay the onset of adverse health conditions among older people that result from poor nutritional health or sedentary behavior. Indirectly, the program acts as income support for many poor and near-poor older people by providing food that they would otherwise purchase (in groceries or at restaurants). The program has the potential to improve older people's health by offering nutritionally adequate meals in compliance with USDA guidelines.[38] It also can offer nutrition counseling and education, though access to these services is quite limited.

AoA has recently awarded funds to establish a National Resource Center on Nutrition and Aging, which is tasked with building the capacity of the aging services network to provide nutrition services for both current and future older adult populations. The Center is expected to provide training and technical assistance to the aging services network, including scientific and clinical evidence that support nutrition services.[39]

Funding and meals provided — The program represents about 42 percent of the Act's total FY 2011 funding. In FY 2010, about 2.6 million people received 242 million meals; 60 percent of meals were served to frail older people living at home, and 40 percent were served in congregate settings.[40] In recent years, the growth in the number of home-delivered meals has outpaced congregate meals. A number of reasons account for this trend, including efforts by states to transfer funds from their federal congregate services allotments to home-delivered services (as allowed by the law), state initiatives to expand services to frail older people living at home, and successful leveraging of nonfederal funds for home-delivered meals services. In some cases, due to state or local budget reductions, home-delivered meals

The nutrition services program represents about 42 percent of the Older American Act's total FY 2011 funding.

programs have been preserved at the expense of congregate meals programs.

Recipients — As shown in Table 1, recipients are older, more likely to live alone and have income below or near poverty, compared to all adults age 60 and over. Nutrition recipients are also very likely to suffer from multiple chronic conditions, with home-delivered meals recipients frequently experiencing three or more ADL limitations.[41]

Unmet Need for Nutrition Services — Until recently data on the unmet need for nutrition services generally have been elusive. However, a 2011 GAO report has shed some light on the issue of unmet need. It found that about 9 percent of low-income older adults received Older Americans Act meals services but many more were likely to

TABLE 1: OAA Nutrition Service Recipients: Age, Income, and Health Status, FY 2009

Recipient Characteristics	Congregate Nutrition Recipients	Home-Delivered Nutrition Recipients	U.S. Adults Age 60 and Older
Age 75 or Older	57%	70%	32%
Living Alone	48%	56%	27%
Income Below, At, or Near Poverty*	33%	52%	15%
Four or More Chronic Conditions	71%	83%	N/A
Three or More ADL Limitations and Presence of Chronic Conditions	9%	31%	N/A

* *Income below, at, or near poverty refers to households in $5,000 income bands that include or are below the federal poverty guideline. This includes households for one- or two-person households with income less than $15,000 per year in 2009.*

Source: Based on an analysis of a sample of randomly selected Title III recipients in 2009: Norma Altshuler and Jody Schimmel, Mathematica Policy Research, Inc. "Aging in Place: Do Older Americans Act Title III Services Reach Those Most Likely to Enter Nursing Homes?" Research Brief No. 1, July 2010, www.aoa.gov/aoaroot/program_results/docs/2010/AoA_1_NursingHomes_041311.pdf; *Rebecca Kleinman and Leslie Foster, "Multiple Chronic Conditions Among OAA Title III Program Participants," July 2011,* www.aoa.gov/AoARoot/Program_Results/docs/2011/AoA4_Chronic_508.pdf.

need them due to financial constraints or other difficulties. About 89 percent of low-income older adults who were considered food insecure did not receive either congregate or home-delivered meals. The report also indicated almost 90 percent of older people who were limited in two or more ADLs did not receive home-delivered meals. A number of factors may contribute to non-receipt of needed services. Some older people may not know these services exist or that they might be eligible, and, especially in the case of home-delivered meals, agency budgets do not allow expansion of services to meet identified needs.[42]

While national data on waiting lists for nutrition services do not exist, recent surveys of state and area agencies on aging have indicated that the requests for these services have increased in some areas.[43] Even with increased requests, the national economic downturn has caused many aging service providers to reduce services.[44] For example, GAO found that since the beginning of the economic downturn almost 80 percent of local aging service providers have experienced increased requests for home-delivered meals.[45]

Evaluation — The most recent major evaluation of the nutrition program is dated. Completed in 1996 by Mathematica, it found that the program is an important part of participants' overall nutrition, and that meals consumed were the primary source of daily nutrients. Participants were more likely than the general older population to have health and functional limitations that placed them at nutrition risk.[46] AoA has another national evaluation underway, also being conducted by Mathematica, that will include a participant outcome study, a cost analysis of meal services, and a review of program administration by state and area agencies and local service providers. The participant outcome study will include a matched comparison group and will measure nutrition, health and well-being, food insecurity and hunger, and socialization outcomes. Meals cost data will be measured by labor, food, and supplies costs and method of meal production.[47] The evaluation is not expected to be completed for several years.

Family Caregiver Services: Serving Multiple Generations Through One Program

The vast majority of the elderly with long-term supportive care needs receive care from their families and other informal, unpaid caregivers. Millions[48] of caregivers provide informal, unpaid care to older

people and younger adults who need assistance due to a physical, cognitive or mental impairment. The aging of society is expected to exacerbate demands on family caregivers and increase the number of families who will be called on to provide care. Because caregiving responsibilities often lead to physical and emotional stress, and because of the increasing numbers of caregivers, many people consider the stress of caregiving to be a health issue of growing concern.

Services provided — The National Family Caregiver Support Program (NFCSP), authorized under Title III of the Act, provides grants to state agencies on aging that award funds to area agencies on aging for caregiver support.[49] Services authorized include information and assistance about available services, individual counseling, organization of support groups and caregiver training, respite services to provide families temporary relief from caregiving responsibilities, and supplemental services (such as home care and home adaptations) on a limited basis to complement care provided by family and other informal caregivers. Aging network funding for family caregiver support in FY 2010 totaled $188 million, with most (63 percent) from Title III. Almost half of all funding was spent on respite care, with the remainder spent on access assistance, counseling, support groups, caregiver training, or other assistance.[50]

Recipients — The number of caregivers served is small compared with the estimated number of caregivers nationwide. Annually about 600,000 caregivers receive assistance through the program. In 2009, about 80 percent of caregivers served received information about, or help receiving, services; 60 percent received supplemental goods or services, such as canes or walkers, emergency response systems, or nutritional supplements for care recipients; half received respite services; and one-third participated in training, counseling or support groups.[51]

The program supports caregivers of all ages. About 47 percent of caregivers are adult children caring for a parent; 39 percent are spouse caregivers; and 14 percent are grandchildren, or other relatives or friends. Spouse caregivers are a particularly vulnerable group; most are older than 70, in fair or poor health, and have a health condition or disability that affects their ability to provide care. The majority of caregivers provide care to people who have significant physical or cognitive disabilities.[52]

Program results and evaluation — A 2004 survey regarding the initial years of implementation conducted with state officials found that the program had increased the range of caregiver support that state and area agencies on aging offer. However, programs were found to be uneven across and within states. While states and area agencies have set up initiatives to coordinate the program with other home and community-based LTSS programs, a major barrier cited was differing eligibility requirements and administrative authorities. State officials interviewed pointed to the need for better coordination of caregiver services with social services programs, the importance of developing methods to uniformly assess caregiver needs and provide caregiver training, and the need for additional funding for respite care services.[53]

Other than the 2004 survey, little evaluative information is available. Some information is available in a survey of Title III recipients; it found that 80 percent of caregivers rated services they received very highly, most saying that the services allowed them to provide informal care longer than they otherwise would have, and that the support they received helped them deal with the strain and difficulties involved in caregiving.[54] AoA has a national evaluation underway. A design contract was awarded to the Lewin Group, Inc., and the design phase is in process.

Disease Prevention and Health Promotion Activities: Straining to Have Broader Reach

At least 60 percent of the elderly have multiple chronic conditions,[55] and most health care spending is for people with chronic conditions.[56] Although the primary way the Older Americans Act addresses disease prevention and health promotion activities is through the nutrition services program, Congress has authorized specific funds for these activities as part of Title III (under subpart D). Appropriated at $21 million in FY 2011, disease prevention and health promotion activities are one of the smallest Older Americans Act programs. States use these funds to support health promotion activities at various community venues, such as senior centers and congregate nutrition sites, among others.

The types of activities that state and area agencies support with these funds vary widely. According to an assessment of eight programs completed for AoA, aging services network health promotion

Although the Older Americans Act is intended to provide seed money for its programs, state and area agencies sometimes find it difficult to sustain funding for programs after they are initiated.

activities include both group services, such as physical fitness and diabetes control classes and arthritis and nutrition education, as well as more individualized services, such as medical and dental screening, nutrition counseling, medication management consultation, and immunizations. Area agencies work with a range of public and private health and social services organizations in planning and delivering these services.[57]

According to an AoA program assessment, providing these services presents a number of challenges. Although the Older Americans Act is intended to provide seed money for its programs, state and area agencies have found it particularly difficult to leverage other funding for health promotion and disease prevention activities. In addition, not being able to sustain funding is a major impediment to continuing programs once they are initiated.[58] In recent years, some state agencies on aging have been working with state Medicaid programs to use Medicaid matching funds to help sustain their disease prevention and health promotion initiatives.

To complement its formula-based grant program for disease prevention and health promotion, in recent years AoA has awarded discretionary grants funds to states and community agencies to help them develop programs based on evidence-based disease protocols. In part, these programs have been developed using research supported by the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Disease Control and Prevention (CDC). The aim of the projects is to implement low-cost interventions that have proven effective in reducing the risk of disease, disability, and injury among older people. Programs are focused on a number of areas, including chronic disease self-management, falls prevention, physical activity, and depression. Through this grant program, state and area agencies are developing collaborative relationships with a variety of entities such as community agencies, public health departments, universities, physicians, and health plans. AoA has awarded its discretionary grants to states and community agencies to implement evidence-based health promotion programs, such as the Chronic Disease Self-Management Program (CDSMP),[59] and falls prevention programs, such as A Matter of Balance,[60] among others. A survey of area agencies indicated that about 82 percent are involved in implementation of these types of programs.

Even with these steps, increased support for health promotion and disease prevention initiatives may be needed as policymakers discuss ways to control costs for older people with chronic illnesses. As with other aging services network programs, a key issue is to identify effective and self-sustaining strategies.

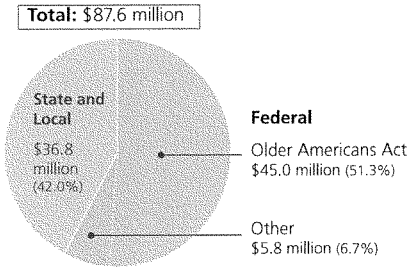
Long-Term Care Ombudsman Program: Protecting Resident Rights

For many years, policymakers have been concerned about the quality of care in various types of residential care facilities. While most attention has been directed at nursing home quality, Congress has also been concerned about care in other residential facilities, such as assisted living facilities and "board and care" homes. The primary way the federal government oversees quality of care in Medicare- and Medicaid-certified nursing homes is through enforcement of a series of requirements enacted in the Omnibus Reconciliation Act of 1987 (OBRA 1987) and subsequent amendments. Licensure and/or certification of residential care facilities other than nursing homes are the province of state government.[61]

A complementary way to address quality of care in nursing facilities is through protection of resident rights and consumer advocacy, which Congress established through the Older Americans Act. In 1978, Congress enacted a requirement that state agencies on aging establish an ombudsman program to advocate for, and protect the rights of, residents of long-term care facilities. In the 1987 Older Americans Act amendments, Congress gave more prominence to the program by adding a separate authorization of appropriations for the program. And in 1992, Congress added a new title to the Act for vulnerable elder rights protection activities. Facilities that come under the purview of ombudsmen include not only nursing homes but also assisted living facilities, board and care homes, and other similar adult residential care settings. All states, the District of Columbia and Puerto Rico, administer an ombudsman program. In most states the program is administered by state agencies on aging; in eight states, program administration is contracted to entities outside state government.[62]

The functions of the ombudsman program are quite broad and include investigating and resolving resident complaints; providing services to protect resident health, safety, welfare, and rights;

FIGURE 5 | **Long-Term Care Ombudsman Spending, 2010**



Source: Prepared by the National Health Policy Forum based on data in AoA, 2010 National Ombudsman Reporting System Data Tables, table A-9, available at www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/National_State_Data/2010/Index.aspx.

representing the interests of residents before governmental agencies; seeking administrative and legal remedies to protect their rights; and providing consumer education. Funding for the program is rather modest considering its broad responsibilities, and the program relies on citizen volunteers to carry out its mission.[63] Some observers have raised concerns about the capacity of the program to meet its legislative mandate, given the low level of federal funding and paid staffing.

In FY 2010, total program support was $87.7 million with 51 percent from the Older Americans Act. (see Figure 5). Significant support—42 percent—comes from state and local sources, well over the amount required by federal law to receive federal matching funds.[64] Because of the significant contributions of unpaid ombudsman volunteers, the program's effective resources are higher. The amount spent by the program nationally from both federal and state sources in FY 2010 is the equivalent of about $30 per bed annually.[65]

(For an in-depth analysis of the ombudsman program, see Forum background paper, "The Role of Ombudsmen in Assuring Quality for Residents of Long-Term Care Facilities: Straining to Make Ends Meet," by Carol V. O'Shaughnessy, December 2, 2009, available at www.nhpf.org/library/details.cfm/2767.)

BEYOND THE OLDER AMERICANS ACT

Over the years, many state and area agencies have broadened their responsibilities beyond the administration of Older Americans Act funds. This is exemplified especially in their management and redesign of home and community-based LTSS financed by Medicaid and state funds. In addition, many aging services network agencies administer Social Service Block Grant (SSBG) funds for elder abuse prevention, the State Health Insurance Program (SHIP), Public Health Service Act funds,[66] and state general revenue funds for myriad services for older people, and programs for younger people with disabilities. (See Appendix for examples of other aging services programs.)

Management and Redesign of LTSS

As a result of the planning efforts undertaken by state agencies on aging during the 1970s and 1980s, it became clear to state aging administrators that home and community-based services for vulnerable older people were underdeveloped and that a "continuum of care," as envisioned by the Older Americans Act, did not exist. At the same time, the federal government had been giving more policy attention to "alternatives to institutional care" through various demonstration programs.[67] Moreover, states were concerned about growing Medicaid and state spending for nursing home care and wanted to place more attention on reducing—or at least controlling—the rate of increase in expenditures for institutional care. They also wanted to become more responsive to the preferences of the frail elderly and other adults with disabilities for care in home and community-based settings rather than in institutions. As a result, some states to begin to focus more attention on developing home and community-based care options that could prevent or delay institutional care.

Calls by advocates and policymakers for greater access to a wider range of home and community-based care led Congress to enact the Medicaid section 1915(c) home and community-based waiver program in 1981. The program permits the Secretary of HHS to waive certain Medicaid statutory requirements, thus allowing states to provide a wider range of home and community-based services for the elderly and other groups than were otherwise available for Medicaid reimbursement. The waiver program allows states to control the budget for these services by targeting specified groups and by providing services on a less-than-statewide basis. Implementation of waivers during the 1980s and 1990s began to change the fabric of LTSS as states developed a broad span of services, such as care management, home care, adult day care, and respite care, to meet the needs of vulnerable populations living in the community. The program provides an opportunity to alter what some refer to as Medicaid's "institutional bias." Prior to the waiver program, care in Medicaid-financed nursing homes and other institutions was often the only option for elderly and other groups with LTSS needs and limited income and resources.

Administrators and advocates for the elderly recognized that their ability to provide home and community-based services could be significantly augmented by access to Medicaid funds. The aging infrastructure proved to be a ready-made network for waiver

implementation. Many state governments began to assign responsibility for administration and day-to-day management of the Medicaid waiver services program to state agencies on aging. Often, state agencies on aging designated area agencies on aging to deliver waiver services, including case management, assessment of individuals' care needs, and development of care plans. Medicaid now represents a significant part of funding for both state and area agencies on aging. A 2010 survey of state agencies on aging found that, after the Older Americans Act and state appropriations, Medicaid represented their third largest source of funding.[68] A similar finding was made by GAO with respect to funding for area agencies. Forty-two percent of area agency funds were from Older Americans Act sources; 24 percent from state funds; and 10 percent from Medicaid home and community-based waivers; and the balance from other federal, state, local, and private funds.[69]

Throughout most of the aging network, administration of Medicaid waiver programs is now a core component of aging services. According to a 2010 survey, state agencies on aging in 32 states were the designated operating agencies for one or more Medicaid home and community-based waiver program. About half of state agencies on aging also administer state-only funded home and community-based services for the elderly.[70]

In addition to management of Medicaid waiver programs, some state agencies on aging have been instrumental in redesigning their state LTSS programs by making broad policy changes, using Medicaid funds for home and community-based services in combination with Older Americans Act and state funds. LTSS redesign has taken various approaches including (i) consolidating administrative structures and financing with the aim of redirecting service delivery toward home and community-based services from institutional care, and (ii) restructuring the delivery of LTSS to help consumers more easily access services.

Some states have redesigned their systems by consolidating policy, financing, and administration into one single state agency that has control of, and is accountable for, all LTSS resources. In these cases, one agency is responsible for not only planning and development of LTSS policy, but also administration of eligibility determination, financing, regulation, service delivery, and quality for both institutional and home and community-based services. Consolidation allows state administrators to balance resources among all services

and to shift funds from institutional care to home and community-based services.

Aging and Disability Resource Centers — Navigating the care system, with its complex range of services and differing eligibility requirements for each program, is often a challenge for older people and their families. Over the past decade, an increasing number of states have restructured the delivery of LTSS through the development of single points of entry/no wrong door (SPEs)/NWD. SPEs/NWD are intended to provide consumers smooth access to LTSS through one agency or organization which considers the range of care alternatives and helps people make decisions about the best and most feasible care alternative.

Over the past decade, an increasing number of states have restructured LTSS delivery by offering single points of entry or "no wrong door" systems.

These initiatives have been spurred on through the use of AoA and CMS discretionary grants to states to create Aging and Disability Resource Centers (ADRCs). The purpose of the ADRC program is to help people of all ages, disabilities, and income levels more easily access LTSS through SPEs/NWD, and make more efficient use of care options, and maximize choice of available services. In 2006, Congress formally recognized the ADRC program in amendments to the Older Americans Act (P.L. 109-365). The law requires AoA to implement ADRCs in all states. ADRCs are tasked with providing personalized counseling to assist individuals and their families with care choices; developing a single integrated approach to LTSS intake, assessment, assessment and eligibility determination; and serving as convenient entry points for all public and private LTSS programs.

Some ADRCs are also involved in care transition services, that is helping people transitioning from one setting of care to another or from one public program payer to another. The purpose of care transition programs is to help people avoid unnecessary placement in nursing facilities or other institutions or readmission to hospitals, and to provide for continuity of care through the transition process. AoA has specified that state ADRC grant recipients involved in care transition services must use an evidence-based care transition model; choices include the Care Transitions Intervention,[71] the Transitional Care Model (TCM),[72] Guided Care,[73] and Geriatric Resources for Assessment and Care of Elders (GRACE),[74] among others.

(For more information on the ADRC program, see NHPF background paper, "Aging and Disability Resource Centers (ADRCs): Federal and State Efforts to Guide Consumers through the Long-Term Services

and Supports (LTSS) Maze," by Carol V. O'Shaughnessy, November 19, 2010, www.nhpf.org/library/details.cfm/2835.)

Prevention of Elder Abuse, Neglect, and Exploitation

Abuse, neglect, and exploitation of older adults in their own homes and other non-institutional settings is a largely unrecognized, but growing, problem. Types of abuse or neglect include physical, emotional, or sexual abuse; neglect (or self-neglect); financial exploitation; and abandonment.[75] Although data on the full extent of the problem nationally are elusive, in a 2011 report GAO found that the most recent study on abuse estimated that 14.1 percent of non-institutionalized older adults had experienced physical, psychological, or sexual abuse, neglect, or financial exploitation in the past year. This study and others do not provide a full estimate of the extent of abuse, and many cases of potential abuse may go unreported to officials.[76]

Data on abuse have not been measured consistently.[77] Various reports, however, have pointed to increases in the extent of the problem. A recent study of the impact of the economic downturn on state aging programs found that states had received increased calls for adult protective services, and many of these were reporting instances of financial exploitation.[78] GAO interviews with state officials confirmed this trend, and these reports have confirmed earlier studies.[79] Increasing numbers of cases are an indicator of growing demand for services, either for investigation by state personnel or intervention on behalf of abused clients. Data showing an increase in the number of cases could be due to an increase in abuse of the elderly, or to increased awareness by the public thus generating additional reports of abuse.[80] Despite increased reporting of potential cases, GAO indicated that adequate funding for staffing, training, and public awareness is difficult to maintain, especially in the face of state budget constraints.

Federal and state role — Three federal statutes define federal and state roles in addressing elder abuse, neglect and exploitation in domestic settings. The *Social Service Block Grant* (SSBG; Title XX of the Social Security Act) authorizes funds to states for a wide array of social services, including prevention of abuse, neglect, or exploitation of adults unable to protect their own interests. States decide how much of their block grant funds they will spend on protective services as well as many other service categories. The *Older Americans Act*

authorizes formula grants to states to develop and strengthen programs for the prevention, detection, and assessment and treatment of abuse, and to develop public education and outreach services to promote awareness of instances of abuse. The *Elder Justice Act* (EJA), enacted by the Patient Protection and Affordable Care Act of 2010 (PPACA), authorizes grants to state adult protective service programs under the SSBG.

Medicare and Medicaid statutes govern investigation of abuse in facilities that receive reimbursement under those programs, and the long-term care ombudsman program, discussed above, is responsible for investigating and resolving complaints of residents in long-term care facilities. (For more information on the EJA, see the Forum report, "Elder Justice Act: Addressing Elder Abuse, Neglect and Exploitation," by Carol V. O'Shaughnessy, November 30, 2010, available at www.nhpf.org/library/details.cfm/2836.)

Each state has developed its own statutory, regulatory, and administrative authorities to address elder abuse issues. Most states have designated agencies, known as Adult Protective Services (APS) agencies, to administer services to protect adults from abuse, neglect, or exploitation. State agencies on aging in 22 states administer APS programs.[81] In most states, APS programs are considered the first responders to reports of abuse, neglect, or exploitation.[82]

Funding — Funding to prevent elder abuse, neglect, and exploitation comes from a variety of sources but is primarily from state and local sources. To the extent that federal funding supports APS, it is primarily from the SSBG. In FY 2009, of the $1.9 billion[83] SSBG funding for all services, states spent $216 million for APS programs, about 12 percent of their total allotments.[84] In most states, SSBG funding far outweighs funds under the Older Americans Act.[85] Congress has appropriated a little more than $5 million for the Title VII elder abuse prevention program for each of the past several years. No funds have been appropriated under the EJA, as of the fall of 2011.

In 2011, AoA awarded funds to a national APS Resource Center to help state and local adult protective services systems respond more quickly and intervene more effectively in cases of adult abuse, neglect, and exploitation. The Center is tasked with identifying evidence-based practices for APS programs and interventions, compiling research relevant to APS programming, and providing technical assistance to state and local APS programs.[86]

Program assessment — Congressional hearings and reports over the years have pointed to the need for greater federal-level attention on prevention of elder abuse, neglect, and exploitation. Among other things, experts have recommended improved national level data collection that would estimate and track the extent of the problem and increased funding to states to address prevention, detection, and investigation of abuse incidence, as well as to fund public awareness programs. Congressional concern and actions by advocates culminated in the enactment of the EJA in 2010. The law authorizes several grant programs including a new state formula grant program for APS under the SSBG.[87] It also establishes requirements for reporting of crimes in long-term care facilities, and creates advisory bodies on elder abuse with the Department of Health and Human Services (HHS).

In addition, GAO found that federal leadership on elder justice issues is lacking. It stated that the Older Americans Act requires AoA to develop a long-term plan to establish federal guidelines for state-level uniform data collection on abuse, but the agency has taken only limited steps to do so. According to GAO, state APS agencies face numerous challenges in preventing, identifying, and resolving elder abuse issues. Even though some agencies, such as AoA and the Department of Justice, have taken some steps to assist states, their activities have had a "limited impact on the elder justice field" and have been hampered by limited funding. The EJA, if funded, could assist federal and state agencies improve their efforts to address elder abuse.[88]

State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP), created by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) and administered by CMS, provides grants to states for counseling, information, assistance, and outreach programs for Medicare beneficiaries and their families regarding health insurance. The program was originally established to help older people choose Medicare supplemental insurance (Medigap). It has expanded to provide counseling and information to beneficiaries on a wide range of Medicare and Medicaid issues, as well as Medigap, Medicare Advantage plans, long-term care insurance, and resolution of claims and billing problems.[89] A major program focus is to help older people choose prescription drug plans under Medicare Part D and enroll in Medicare

Savings Programs that help low-income beneficiaries pay for Medicare, premium, copayment and deductible amounts.

Of the 54 SHIP state grant programs, two-thirds are administered by state agencies on aging and the remainder are administered by state insurance commissions. The SHIP program recruits and trains counselors (primarily volunteers) to conduct one-on-one counseling to Medicare beneficiaries through over 1,300 local sponsoring agencies. In 2008, over 12,000 counselors served more than 4.8 million beneficiaries through one-on-one, in-person, and telephone counseling and assistance, as well as through public education programs. At the community level, most SHIPs are operated through area agencies on aging. As more people become eligible for Medicare, demand for counseling and assistance on Medicare issues is likely to increase.

(For more information on the SHIP program, see Forum report, "The State Health Insurance Assistance Program (SHIP)," by Carol V. O'Shaughnessy, March 29, 2010, available at www.nhpf.org/library/details.cfm/2778.)

Funding for the Act's core programs has remained relatively flat despite reports of increasing demand.

THE OLDER AMERICANS ACT IN A CHANGING SERVICE DELIVERY ENVIRONMENT

In recent years, AoA has taken steps to modernize and strengthen the aging services network through targeted use of discretionary funds. It has helped states make system changes aimed at improving the coordination of LTSS delivery by implementing ADRCs, and, through application of evidence-based programs (see Aging and Disability Resource Centers, p. 29), address the risk of chronic illnesses among older people and improve transitions across care settings. While new or reprogrammed funding has made it possible for these efforts to take place, funding for the Act's core programs has remained relatively flat despite reports of increasing demand. Thus, efforts to modernize or improve the core programs, and to bring others to scale, have lagged.

Some observers have indicated that the quality of Older Americans Act programs should be assessed to determine what effect they have on the lives of older people. Limited evaluative information on the core programs is available, in part because variability in program models across states and sometimes within states makes it difficult to evaluate programs or draw conclusions that could inform national and state policy development. Although AoA is in the process of a

number of program evaluations, results will not be available for several years. Most observers applaud the increasing use of evidence-based models for application to aging services in efforts to improve quality programming. However, evidence-based models do not exist for many social services programs; without national guidance or availability of information on proven models, quality of services is unlikely to be assessed.

GAO has suggested a number of improvements in AoA's data collection procedures on the need and unmet need for services by older people. Although AoA issues standardized definitions and measurement procedures for collecting information on the receipt of Title III services to state agencies, states have not been required to use uniform and standardized measures for assessing need and unmet need. According to GAO, this has made it difficult for state and area agencies to make decisions about how to prioritize services to those most in need. GAO recommended that the Secretary of HHS work with other agencies to (i) develop consistent definitions of need and unmet need and (ii) propose interim and long-term uniform data collection procedures for obtaining information on older people with unmet service needs. In response to the GAO recommendations, AoA cautioned that data collection is hampered by problems in defining need and unmet need across multiple services funded by different federal, state, and local sources. Also, additional reporting burdens on states during a time of fiscal constraints may not be feasible.[90] Despite the difficulties surrounding data collection, available AoA data has shown that programs are well-targeted and those older people who are served are among those in the lowest income groups and have characteristics, such as presence of multiple chronic conditions and limitations in daily living activities, that make them most vulnerable.

Some programs that have been central to the Older Americans Act are in the process of transformation. For example, the congregate nutrition program, in operation for almost 40 years, provides venues for nutrition and socialization for many older people. Expenditures for the congregate nutrition program are still higher than for the home-delivered nutrition program (53 percent and 47 percent, respectively, of total FY 2010 nutrition expenditures). However, given the rising numbers of frail homebound older people, states have increasingly transferred congregate nutrition services funds to bolster support for home-delivered nutrition services. As a result, some communities

have seen downsizing of their congregate programs. Other communities are developing innovative ways to modernize their congregate nutrition programs, for example, by placing nutrition sites in fitness and wellness centers for people of all ages. Nutrition administrators may need to seek ways to attract private sources of support by improving meal quality, choice, and types, and by diversifying socialization activities at congregate sites, as well as partnering with nontraditional community service providers.

In addition, some observers indicate that the baby boom population may demand improvements or modernization of particular services. For example, senior centers that offer Older Americans Act core programs may need to develop additional, privately supported programs that appeal to broad cross sections of older people in order to attract and sustain the interest and support of baby boomers who are able to pay for services. Some publicly funded senior center facilities may need capital improvements and additional professional staff to attract clientele. As with other aging services, an important goal will be to develop sustainable sources of revenue.

Constrained public resources may spur aging services network agencies to assess how to become social entrepreneurs by broadening their base of financial support. They may need to develop a full range of revenue streams, from private pay and cost-sharing services, as well as public funds, donations, and no-fee services, to help increasing numbers of retirees who need and can pay for supportive services. They may also need to conduct marketing to retirees who seek civic engagement, volunteer opportunities, or leisure activities. In doing so, area agencies may need to become competitive with private sector organizations that see the aging of society as a source of new business revenue and opportunities. This direction is not without some controversy. While some observers indicate that greater efforts should be made to develop private sector markets, others believe that doing so and serving those older people with resources to pay for the full cost of services is not the within network agencies' mission that calls for targeting programs to those who are most in need. Regardless, it appears that many area agencies have not pursued business development or marketing plans. This has been attributed, in part, to inadequate public sector resources that could be devoted to efforts to engage the private sector.[91] Moreover, the Act allows state agencies to develop cost-sharing policies so that older people who can afford to pay for specified services do so; still, many

state agencies have not developed such policies, citing administrative burden and limited likelihood of collecting enough funds to be worthwhile.[92] While these trends play out, AoA is helping area agencies develop a more entrepreneurial approach to aging programming and operations by providing support for an Aging Business Academy operated by the National Association of Area Agencies on Aging. The Academy provides learning opportunities to help area agencies build knowledge and skills in strategic and business planning, resource development, innovation, and performance management.[93] Several state agencies are developing business tools and training protocols targeted at empowering them to leverage new partnerships with the private sector.[94]

Finally, an emerging trend that will affect aging services providers is the interest by some state Medicaid agencies in shifting from traditional fee-for-service arrangements to pay for LTSS for aging and disability populations to managed care arrangements whereby the state makes capitated payments to managed care organizations (MCOs) that arrange for and coordinate these services. While only a handful of states operate Medicaid managed LTSS programs now, it is expected that more states will move in this direction in the next few years. The interest by states is being spurred by state budgetary concerns with the hope that managed LTSS programs can save money and improve consumer outcomes through coordination of care.

Most area agencies on aging have been providers of LTSS for many years and, recently, some have become involved in care transition programs. States' movement toward Medicaid managed LTSS and other care coordination services, such as management of care transition programs, could potentially require those area agencies that have not operated under managed care arrangements to adopt new business models that will support their viability in a more competitive environment. While it may be too early to determine what impact these trends will have, federal and state policymakers may want to focus on what steps may be necessary to help aging network providers to operate under Medicaid managed LTSS arrangements.

BROAD MISSION, LIMITED RESOURCES: SUMMARY OF CHALLENGES FOR THE FUTURE

The mission of the aging services network set out by law is expansive and is aimed at addressing many competing needs of older

people across a wide spectrum of services. Despite its broad mandate and sweep of services, Older Americans Act resources are relatively limited. Some have observed that funding has always been small and not kept pace with increasing demands from a growing elderly population. As a result, some programs have grown very slowly over time, or have not been brought to scale. Some programs' capacity depends heavily on volunteers, thereby masking any need for additional staff resources to carry out program functions. Moreover, the aging services network's decentralized planning and service model has led to variability in program implementation across states and communities.

The aging services network's decentralized planning and service model has led to variability in program implementation across states and communities.

Nevertheless, despite its funding constraints and variability in implementation, over the last 40 years, the Older Americans Act has encouraged the development and provision of multiple and varied services for older people. State and area agencies have relationships with tens of thousands of service providers offering a wide range of services across the nation. Older Americans Act funds reach limited numbers of older people, but AoA data and other research suggests that they are well targeted to vulnerable older people. Because of the mandates that state and area agencies have to coordinate services and act as advocates, they have the potential to improve access to services for older people by integrating complex programs funded by multiple financing sources.

To create an expanding service delivery system and to complement limited federal Older Americans Act dollars, state and area agencies on aging have leveraged other federal and state funding sources. Thus, aging services network agencies have evolved from planning and coordination entities to managers of multiple sources of funds. The ability of the aging infrastructure to adapt to changing demands has led to added responsibilities and resources. In addition to the aging services network administration and management of Medicaid LTSS programs discussed above, a range of participant-directed home and community-based services are provided by area agencies on aging under an agreement between the Department of Veterans Affairs and AoA. Policymakers may want to consider other ways to build on the aging services network.

As the population ages, the sheer numbers of elderly will have significant impact on the nation's largest entitlement programs, Social Security, Medicare, and Medicaid. This growth will also test the strength of the fabric of social and health-support services in communities

across the nation and will affect families who care for older family members. Aging service providers will face increasing challenges in financing and delivering a wide range of community services for vulnerable elderly, such as assisted transportation, home care, adult day care, nutrition, elder abuse prevention services, and access and information about benefit programs.

In the future, policymakers may need to focus on actions that will enable communities to sustain services in the face of growing demand of the coming baby boom population. Many observers warn that challenges to aging services network programs have been heightened by the continuing budgetary constraints faced by state and local governments. In an environment where there is more competition for public resources, policymakers and practitioners in the field of aging may be forced to develop new advocacy, planning, and sustainability models. The increasing numbers and heterogeneity of the older population may demand more varied service models including those that will be able to attract increased private resources and support. All of these issues are more salient as Congress reviews the Older Americans Act for its scheduled reauthorization during the 112th Congress.

ENDNOTES

1. At the time the U.S. Administration on Aging (AoA) was created, it was located in the U.S. Department of Health, Education and Welfare (HEW).

2. AoA, "FY 2012 Budget Justifications," www.aoa.gov/AoARoot/About/Budget/DOCS/FY_2012_AoA_CJ_Feb_2011.pdf.

3. Jenna Walls *et al.*, "Weathering the Storm: The Impact of the Great Recession on Long-Term Services and Supports," AARP Public Policy Institute, January 2011, available at www.nasuad.org/documentation/nasuad_materials/weathering_the_storm/weathering_the_storm.pdf.

4. National Association of Area Agencies on Aging and the Scripps Gerontology Center (NAAAA and SGC), "Area Agencies on Aging: Advancing Health and Long-Term Services and Supports," July 2011, available at www.n4a.org/pdf/2011_AAA_Survey_Report.PDF.

5. Carroll L. Estes, *The Aging Enterprise: A Critical Examination of Social Policies and Services for the Aged* (San Francisco: Jossey Bass, 1979).

6. Older Americans Act of 1965, as amended, 45 USC 3025.

7. These states or jurisdictions are Alaska, Delaware, the District of Columbia, Nevada, New Hampshire, North Dakota, Rhode Island, and Wyoming.

8. NAAAA and SGC, "Area Agencies on Aging."

9. Preliminary findings from a 2010 survey of state agencies on aging by the National Association of States United for Aging and Disability (NASUAD), e-mail communication with author, November 15, 2011.

10. NAAAA and SGC, "Area Agencies on Aging."

11. Preliminary findings from a 2010 survey of state agencies on aging by NASUAD, e-mail communication with author, November 15, 2011.

12. AoA, National Aging Program Information System (NAPIS), "2010 Reports," available at www.aoa.gov/AoARoot/Program_Results/SPR/2010/Index.aspx.

13. For example, national standards for home and community-based services do not exist. The Deficit Reduction Act of 2005 directed the Agency for Healthcare Research and Quality (AHRQ) to develop quality measures for these services, covering performance and client function and measures of client satisfaction. AHRQ, "Medicaid Home and Community-Based Services Measure Scan: Project Methodology," updated May 2007; available at www.ahrq.gov/research/ltc/hcbsmethods.htm#purpose.

14. "Greatest social need" is defined in law as those with low income and whose racial or ethnic status may heighten the need for services, as well as those who have needs related to social factors, such as those with a physical or mental disability or who experience cultural, social, or geographic isolation that restricts their ability to perform normal daily tasks or threatens their capacity to live independently. "Greatest economic need" is defined as having an income below the official federal poverty level (FPL).

15. In certain instances, people under the age of 60 may receive services. For example, younger spouses of nutrition services recipients, and younger people with disabilities who reside in elderly housing facilities where congregate meals are served, may receive nutrition services. Caregivers age 55 and older who are caring for children may receive caregiver services under certain circumstances.

16. Some Older Americans Act service programs have specific eligibility requirements. For example, in order to receive home-delivered meals, people must be homebound. Long-term care ombudsman services are available to all residents of nursing and other residential care facilities, regardless of age.

17. The exception is Title V of the Older Americans Act, which provides opportunities for low-income older people to work in subsidized employment. In order to participate, individuals must be age 55 or older and have income below 125 percent of the FPL. Title V is outside the scope of this publication.

18. AoA collects Title III data on total clients and "registered" clients, that is, those who receive services on "regular or intensive basis," such as home-delivered meals, and home care or personal care services. Others receive services, such as transportation and information and assistance, on a less-than-regular or -intensive basis.

19. NAPIS, "2010 Reports."

20. NAPIS, "2010 Reports."

21. AoA Research Briefs done by Mathematica Policy Research, Inc.: Norma Altshuler and Jody Schimmel, "Aging in Place: Do Older Americans Act Title III Services Reach Those Most Likely to Enter Nursing Homes?" Research Brief No. 1, July 2010, www.aoa.gov/aoaroot/program_results/docs/2010/AoA_1_NursingHomes_041311.pdf; Allison Barrett and Jody Schimmel, "OAA Title III Services Target the Most Vulnerable Elderly in the United States," August 2010, www.aoa.gov/AoARoot/Program_Results/docs/2010/AoA_2_HealthStatus_041311.pdf; Allison Barrett and Jody Schimmel, "Multiple Service Use Among OAA Title III Program Participants," September 2010, www.aoa.gov/AoARoot/Program_Results/docs/2010/AoA_3_Multiple-Services_041311.pdf; and Rebecca Kleinman and Leslie Foster, "Multiple Chronic Conditions Among OAA Title III Program Participants," July 2011, www.aoa.gov/AoARoot/Program_Results/docs/2011/AoA4_Chronic_508.pdf.

22. Within federally prescribed limits, states are allowed to transfer funds between supportive and nutrition services and between congregate and home-delivered nutrition services. States also use funds appropriated for prevention of elder abuse, neglect, and exploitation to support the long-term care ombudsman program.

23. NAPIS, "2010 Reports."

24. NAPIS, "2010 Reports."

25. NAAAA and SGC, "Area Agencies on Aging."

26. Donna J. Rabiner *et al.*, "Draft Final Report for the Evaluation of Select Consumer, Program, and System Characteristics under the Supportive Services Program (Title III-B) of the Older Americans Act," AoA, Final Report, June 2007; available at www.aoa.gov/aoaroot/program_results/docs/Program_Eval/III-B%20Final%20Report_6_26_07.pdf.

27. Analysis for AoA: Altshuler and Schimmel, "Aging in Place" and Kleinman and Foster, "Multiple Chronic Conditions Among OAA Title III Program Participants."

28. Jody Beauchamp and Lisa Trebino, Mathematica Policy Research, Inc., "Results from the Administration on Aging's Third National Survey of Older Americans Act Program Participants," Final Report, March 12, 2008, available at www.aoa.gov/AoARoot/Program_Results/docs/3rd_NPS_Final_Report_Mar2008_final.pdf.

29. Rabiner *et al.*, "Draft Final Report for the Evaluation of Select Consumer, Program, and System Characteristics."

30. U.S. Government Accountability Office (GAO), "Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services," GAO-11-237, February 2011, available at www.gao.gov/new.items/d11237.pdf.

31. NAPIS, "2010 Reports."

32. Analysis for AoA: Altshuler and Schimmel, "Aging in Place" and Kleinman and Foster, "Multiple Chronic Conditions Among OAA Title III Program Participants."

33. Rabiner *et al.*, "Draft Final Report for the Evaluation of Select Consumer, Program, and System Characteristics."

34. The Current Population Survey measures food security and insecurity by asking respondents to comment on a number of statements and questions including: "We worried whether our food would run out before we got money to buy more." "The food we bought just didn't last and we didn't have money to get more." "We couldn't afford to eat balanced meals." "In the last twelve months did you or other adults in the household ever cut the size of your meals or stop meals because there wasn't enough for food?" See Mark Nord *et al.*, "Household Food Security in the United States, 2009," U.S. Department of Agriculture, Economic Research Report No. 108, November 2010, p. 3, available at www.ers.usda.gov/Publications/ERR108/ERR108.pdf.

35. GAO, "Nutrition Assistance, Additional Efficiencies Could Improve Services to Older Adults," GAO-11-782T, testimony by Kay E. Brown before the Committee on Health, Education, Labor and Pensions, U.S. Senate, June 21, 2011, available at www.gao.gov/new.items/d11782t.pdf.

36. James P. Ziliak and Craig Gunderson, "Senior Hunger in the United States, Differences Across States and Rural and Urban Areas," report prepared for Meals on Wheels Association of America, September 2009, available at www.mowaa.org/document.doc?id=193.

37. James P. Ziliak, Craig Gunderson, and Margaret Haist, "The Causes, Consequences, and Future of Senior Hunger in America," report prepared for Meals on Wheels Association of America, March 2008, available at www.mowaa.org/document.doc?id=13.

38. Congregate and home-delivered meals must comply with the U.S. Department of Agriculture's "Dietary Guidelines for Americans" and provide the minimum dietary intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences.

39. AoA, "Administration on Aging Announces New National Resource Center on Nutrition and Aging," press release, October 3, 2011, available at www.aoa.gov/AoARoot/Press_Room/For_The_Press/pr/archive/2011/October/2011_10_03.aspx.

40. NAPIS, "2010 Reports."

41. Analysis for AoA: Altshuler and Schimmel, "Aging in Place" and Kleinman and Foster, "Multiple Chronic Conditions Among OAA Title III Program Participants."

42. GAO, "Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services."

43. NAAAA and SGC, "Area Agencies on Aging"; Walls *et al.*, "Weathering the Storm."

44. Walls *et al.*, "Weathering the Storm."; NAAAA and SGC, "Area Agencies on Aging."

45. GAO, "Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services."

46. AoA, "Serving Elders at Risk, The Older Americans Act Nutrition Programs – National Evaluation of the Elderly Nutrition Program, 1993-1995," completed by Mathematica Policy Research, Inc., Michael Ponza *et al.*, available at www.aoa.gov/AoARoot/Program_Results/Nutrition_Report/eval_report.aspx. For an overview of the results, see www.mathematica-mpr.com/nutrition/enp.asp.

47. AoA, "Evaluation of Title III-C Nutrition Services and Title VI Native American Nutrition, Supportive and Family Care Services Programs," available at www.aoa.gov/AoARoot/Program_Results/docs/Program_Eval/III_C_Assessment/Evaluation_Status_Report_11_09.html.

48. Due to lack of consistency in definitions of caregiving, estimates of the number of informal, unpaid caregivers vary widely and depend on the type and duration of care provided, and the disability and health status and the living arrangements of the care recipient. For example, the type of care may range from daily hands-on personal care to intermittent help with shopping or bill-paying. Care recipients in various estimates may include all those age 18 and over living in community settings, or those age 65 and over living in community-based settings, or other combinations. Activities of daily living (ADLs) refer to eating, bathing, using the toilet, dressing, walking, and getting in or out of bed. Other activities necessary for community living, or instrumental activities of daily living (IADLs), include preparing meals, managing money, shopping, performing housework, and doing laundry. Estimates from the 1999 National Long-Term Care Survey (a nationally representative survey of elderly Medicare beneficiaries; see www.nltcs.aas.duke.edu for more information on NLTCS). William D. Spector *et al.*, "The Characteristics of Long-Term Care Users," Agency for Healthcare Research and Quality, AHRQ Publication No.00-0049, January 2001, available at www.ahrq.gov/RESEARCH/ltcusers, showed that 7 million caregivers provide ADL or IADL assistance. Other estimates indicate that there are over 42 to 62 million caregivers. See Lynn Feinberg *et al.*, "Valuing the Invaluable: 2011 Update. The Growing Contributions and Costs of Family Caregiving," AARP Public Policy Institute, 2011, available at http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf.)

49. The primary groups served are caregivers of people age 60 and older, but the law allows grandparents or other individuals who are relative caregivers of children to be served under the program.

50. NAPIS, "2010 Reports."

51. Leslie Foster and Rebecca Kleinman, "Supporting Family Caregivers through Title III of the OAA," Mathematica Policy Research, Inc., for AoA, Research Brief No. 5, September 2011, available at www.aoa.gov/AoARoot/Program_Results/docs/2011/AoA5_SupportFamilyCaregvrs.pdf.

52. Foster and Kleinman, "Supporting Family Caregivers through Title III of the OAA."

53. Lynn Friss Feinberg *et al.*, *The State of the States in Family Caregiver Support: A 50 State Study, National Center on Caregiving, Family Caregiver Alliance,* in collaboration with the National Conference of State Legislators, 2004, available at www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=1276.

54. Foster and Kleinman, "Supporting Family Caregivers through Title III of the OAA."

55. Jennifer L. Wolff, Barbara Starfield, and Gerard Anderson, "Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly," Archives of Internal Medicine, 162, (November 11, 2002): pp. 2269–2276, available at http://archinte.ama-assn.org/cgi/reprint/162/20/2269.pdf.

56. Gerard Anderson, "Chronic Conditions: Making the Case for Ongoing Care," Johns Hopkins University, November 2007.

57. Joshua M. Wiener *et al.*, "Assessment of Title III-D of the Older Americans Act: Disease Prevention and Health Promotion Services," AoA, Final Report, January 2006; available at http://www.aoa.gov/aoaroot/program_results/docs/Program_Eval/Final_Report_DPHP_Assessment.pdf.

58. Wiener *et al.*, "Assessment of Title III-D of the Older Americans Act."

59. Stanford University School of Medicine, Chronic Disease Self-Management Program, http://patienteducation.stanford.edu/programs/cdsmp.html. See also, AHRQ, "Preventing Disability in the Elderly with Chronic Disease," Research In Action, Issue #3, April 2002, available at www.ahrq.gov/research/elderdis.pdf. The CDSMP is a 17-hour course taught by trained lay people that teaches patients with chronic disease how to better manage their symptoms, adhere to medication regimens, and maintain functional ability.

60. Maine Health, "What is a Matter of Balance?" available at www.mmc.org/mh_body.cfm?id=432.

61. A wide range of terms is used to describe residential care facilities that are not nursing homes. These include assisted living facilities, board and care homes, adult foster care homes, personal care homes, congregate care homes, among others. Generally, there is lack of consistency among states in the use of terminology and the requirements these facilities must meet in order to be licensed.

62. These states or jurisdictions are Colorado, District of Columbia, Maine, Rhode Island, Vermont, Virginia, Washington, and Wyoming.

63. Jo Harris-Wehling, Jill C. Feasley, and Carroll L. Estes, Eds., *Real People, Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act* (Washington, DC: Institute of Medicine, 1995), p. 44, available at www.nap.edu/openbook.php?isbn=NI000028.

64. States are required to match federal Title III funds with 15 percent in matching funds. There is no required match for Title VII funds.

65. In FY 2010, AoA data reported a total of 2.9 million beds in both nursing facilities and board and care homes and similar facilities.

66. As shown in the Appendix, the Alzheimer's Disease Demonstration Grants to States authorized under Section 398 of the Public Health Service Act are administered by AoA. These grants fund home and community-based services to Alzheimer's patients and their families.

67. The largest and best known of these demonstrations was the National Long-Term Care Channeling Demonstration begun in the early 1980s. About a dozen other demonstration projects were funded by the then-Health Care Financing

Administration and the then-National Center for Health Services Research (now, the Centers for Medicare & Medicaid Services and the Agency for Healthcare Research and Quality, respectively) to test the cost effectiveness of adult day care and homemaker services compared to institutional care. Pamela Doty, "Cost-Effectiveness of Home and Community-Based Long-Term Care Services," U.S. Department of Health and Human Services, June 2000; available at http://aspe.hhs.gov/daltcp/reports/2000/costeff.htm.

68. Preliminary findings from a 2010 survey of state agencies on aging by NASUAD, e-mail communication with author, November 15, 2011.

69. GAO, "Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services."

70. Preliminary findings from a 2010 survey of state agencies on aging by the NASUAD, e-mail communication with author, November 15, 2011.

71. The Care Transitions Program, University of Colorado Denver, "The Care Transitions Intervention," www.caretransitions.org/overview.asp; "Program Structure," www.caretransitions.org/structure.asp; and University of Colorado Denver, "Definitions," www.caretransitions.org/definitions.asp.

72. "Transitional Care Model," available at www.nursing.upenn.edu/media/transitionalcare/Documents/Information%20on%20the%20Model.pdf.

73. Johns Hopkins University, "Guided Care," available at www.guidedcare.org.

74. Steven R. Counsell *et al.*, "Geriatric Care Management for Low-Income Seniors: A Randomized Controlled Trial," Journal of the American Medical Association (JAMA), 298, no. 22 (December 12, 2007): pp. 2623–2633, available at http://jama.ama-assn.org/cgi/reprint/298/22/2623.

75. AoA, National Center on Elder Abuse, "What is Elder Abuse?" www.ncea.aoa.gov/ncearoot/Main_Site/FAQ/Questions.aspx

76. GAO, "Elder Justice: Stronger Federal Leadership Could Enhance National Response to Elder Abuse," GAO-11-208, March 2011, available at www.gao.gov/new.items/d11208.pdf.

77. GAO, "Elder Justice: Stronger Federal Leadership Could Enhance National Response to Elder Abuse,"

78. Walls *et al.*, "Weathering the Storm."

79. Adult Protective Services (APS) agencies received almost 566,000 reports of suspected abuse of adults of all ages in 2003, an increase of almost 20 percent from 2000. About 192,000 reports of abuse were substantiated after investigation by APS agencies, an increase of almost 16 percent from 2000. Pamela B. Teaster *et al.*, "The 2004 Survey of State Adult Protective Service: Abuse of Adults 60 Years and Older," National Center for Elder Abuse, February 2006, available at www.ncea.aoa.gov/NCEAroot/Main_Site/pdf/2-14-06%20FINAL%2060+REPORT.pdf.

80. Erica F. Wood, "The Availability and Utility of Interdisciplinary Data on Elder Abuse: A White Paper for the National Center on Elder Abuse," National Center for Elder Abuse, May 2006, available at www.ncea.aoa.gov/NCEAroot/Main_Site/pdf/publication/WhitePaper060404.pdf.

81. GAO, "Elder Justice: Survey of Adult Protective Services Program Administrators, GAO-11-129SP, March 2011, an E-Supplement to GAO-11-208," available at www.gao.gov/special.pubs/gao-11-129sp/index.htm.

82. Pamela B. Teaster *et al.*, The 2004 Survey of State Adult Protective Service."

83. The SSBG received supplemental funding of $600 million in FY 2009, not included in these data.

84. Administration on Children and Families (ACF), "SSBG Focus Reports, 2009: Adult Protective Services," table 1, available at www.acf.hhs.gov/programs/ocs/ssbg/reports/ssbg_focus_2009/adult_protective_services.html. (Not all states reported using SSBG funds for APS.)

85. ACF, "SSBG Focus Reports, 2009," table 1.

86. AoA, "Administration on Aging funds first national adult protective services resource center," press release, October 13, 2011, available at www.aoa.gov/aoaroot/Press_Room/For_The_Press/pr/archive/2011/October/2011_10_13.aspx.

87. The law is less expansive than originally contemplated in previous congressional proposals. For a chronology of various legislative actions of the U.S. Senate Committee on Finance over the years, see http://finance.senate.gov/search/?q=elder+justice+act&access=p&as_dt=i&as_epq=&as_eq=&as_lq=&as_occt=any&as_oq=&as_q=&as_sitesearch=&client=finance&sntsp=0&filter=0&getfields=title&lr=&num=15&numgm=3&oe=UTF8&output=xml&partialfields=&proxycustom=&proxyreload=0&proxystylesheet=default_frontend&requiredfields=&site=finance&sitesearch=&sort=date%3AD%3AS%3Ad1&start=0&ud=1.

88. GAO, "Elder Justice, Stronger Federal Leadership Could Enhance National Response to Elder Abuse," GAO-11-208, March 2011, p. 34.

89. Centers for Medicare & Medicaid Services (CMS), "State Health Insurance and Assistance Programs," updated December 14, 2005.

90. GAO, "Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services."

91. NAAAA and SGC, "Area Agencies on Aging."

92. GAO, "Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services."

93. NAAAA, e-mail communication with author, November 4, 2011.

94. In-person interview with staff of the NASUAD, November 11, 2011.

APPENDIX: Selected LTSS and Health-Support Services Managed by the Aging Services Network

PROGRAM / SERVICE CATEGORY	Federal Legislative Authority, or, if applicable, Other Authority	Services Provided	Administrative Agency
Home and Community-Based LTSS	Older Americans Act *(Titles III and, for Native Americans, Title VI)*; Medicaid home and community-based services programs *(Section 1915(c) of the Social Security Act and other Medicaid state plan options)*; Social Services Block Grant (SSBG)	Wide range of services, including home care (for example, homemaker, home health, personal care), transportation, adult day care	AoA CMS ACF
Outreach, Information, and Assistance	Older Americans Act *(Titles III and, for Native Americans, Title VI)*; SSBG; Medicaid *(state plan options)*; state and local funds	Connecting older people and their families to information about programs and services	AoA ACF CMS
Care Management for Home and Community-Based LTSS	Older Americans Act *(Titles III and, for Native Americans, Title VI)*; Medicaid home and community-based services programs *(Section 1915(c) of the Social Security Act and other Medicaid state plan options)*; SSBG	Needs assessment, care planning, monitoring of services provided	AoA CMS ACF
Nutrition Services (Congregate and Home-Delivered Meals)	Older Americans Act; SSBG; Medicaid home and community-based waiver programs for home-delivered meals *(Section 1915(c) of the Social Security Act)*; state and local funds	Meals in congregate settings, or in a person's home; nutrition counseling and education; socialization	AoA ACF CMS

AoA — U.S. Administration on Aging
ACF — U.S. Administration on Children and Families
CMS — Centers for Medicare & Medicaid Services
DOL — U.S. Department of Labor
HHS — U.S. Department of Health and Human Services

APPENDIX *(continued)*

PROGRAM / SERVICE CATEGORY	Federal Legislative Authority, or, if applicable, Other Authority	Services Provided	Administrative Agency
Family Caregiver Services	Older Americans Act *(Titles III and, for Native Americans, Title VI)*; SSBG; state and local funds	Information and assistance to caregivers about available services, individual counseling, organization of support groups and caregiver training, respite services to provide families temporary relief from caregiving responsibilities, and supplemental services (such as home care and adult day care) on a limited basis that complement care provided by family and other informal caregivers.	AoA ACF
Prevention of Elder Abuse, Neglect, and Exploitation / Adult Protective Services	Older Americans Act *(Titles III and, for Native Americans, Title VI)*; SSBG; state and local funds	OAA program provides support for outreach and education campaigns to increase public awareness of elder abuse, neglect and exploitation and prevention strategies; for example, support to elder abuse prevention coalitions. The SSBG provides funds for adult protective services.	AoA ACF
Disease Prevention and Health Promotion Services	Older Americans Act *(Title III)*; SSBG; state and local funds	Health promotion services, such as screening for blood pressure, cholesterol, hearing, nutrition counseling, immunizations, exercise programs.	AoA ACF
Long-Term Care Ombudsman Program	Older Americans Act *(Titles III and VII, and, for Native Americans, Title VI)*; SSBG; Medicaid in certain instances; state and local funds	Investigation of complaints of residents of long-term care facilities (nursing homes, assisted living facilities, board and care homes, similar adult care homes) and protection of residents' rights.	AoA CMS

APPENDIX *(continued)*

PROGRAM / SERVICE CATEGORY	Federal Legislative Authority, or, if applicable, Other Authority	Services Provided	Administrative Agency
Senior Community Service Employment Program	Older Americans Act *(Title V)*; state and local funds	Part-time community service employment for unemployed people age 55 and over who have poor employment prospects.	DOL
Aging and Disability Resource Centers (ADRCs)*	Older Americans Act *(Title II)*; PPACA of 2010; Medicaid in certain instances; state and local funds	Single point of entry for consumers to receive information on available public and private LTSS programs; personal counseling to assist individuals in assessing LTSS, and development and implementation of a plan to meet their needs; and help to consumers to access publicly supported LTSS programs for which they may be eligible.	AoA CMS
Alzheimer's Disease Supportive Service Grants	Public Health Service Act *(Section 398)*; SSBG; state and local funds	Delivers supportive services and facilitates informal support for people with Alzheimer's Disease and Related Disorders (ADRD) and their family caregivers using proven models and innovative practice; translates evidence-based models that have proven beneficial for persons with ADRD and their family caregivers into community-level practice; and advances state initiatives toward coordinated systems of home and community-based care–linking public, private, and non-profit entities that develop and deliver supportive services for individuals with ADRD and their family caregivers.	AoA ACF

* *For more information on ADRCs, see "Aging and Disability Resource Centers (ADRCs): Federal and State Efforts to Guide Consumers Through the Long-Term Services and Supports Maze," by Carol V. O'Shaughnessy, Background Paper No. 81, November 19, 2010, available at* www.nhpf.org/library/details.cfm/2835.

APPENDIX *(continued)*

PROGRAM / SERVICE CATEGORY	Federal Legislative Authority, or, if applicable, Other Authority	Services Provided	Administrative Agency
State Health Insurance Program (SHIP)	Centers for Medicare & Medicaid Services *(Omnibus Budget Reconciliation Act (OBRA) of 1990)*; SSBG; state and local funds	Counseling, information, assistance, and outreach programs for Medicare beneficiaries and their families regarding health insurance issues.	CMS ACF
Lifespan Respite Care Act	Public Health Service Act *(Title XXIX)*	Temporary relief for caregivers of children and adults with special needs.	AoA
Community Living Assistance Services and Supports (CLASS) Act†	Public Health Service Act *(Title XXXII)*	Federally administered voluntary insurance program to help adults age 18 and over with disabilities pay for LTSS, enacted March 23, 2010. Subsequent to passage of the law, HHS analyzed possible CLASS implementation options that are consistent with the statutory requirements that the program be actuarially solvent over the next 75 years and that it be self-funded. After a 19-month period of analysis, HHS officials stated in testimony before the House Committee on Energy and Commerce on October 26, 2011, that it had suspended work on the CLASS Act.	AoA

† *For more information on CLASS, see "The Community Living Assistance Services and Supports (CLASS) Act: Major Legislative Provisions," by Carol V. O'Shaughnessy, The Basics, June 9, 2010, available at* www.nhpf.org/library/details.cfm/2790.

[Additional Submissions by Mr. Petri follow:]

WE ARE
Meals On Wheels
ASSOCIATION OF AMERICA
So no senior goes hungry.

Statement for the Record

Submitted to the

Subcommittee on Higher Education and Workforce Training

House Committee on Education and the Workforce

Hearing on

"Serving Seniors Through the Older Americans Act"

February 11, 2014

Submitted by

Meals On Wheels Association of America
413 N. Lee Street
Alexandria, VA 22314

703-548-5558
www.mowaa.org

Chairman Foxx, Ranking Member Hinojosa and Members of the Subcommittee, we commend you for your leadership and for initiating the Older Americans Act (OAA) reauthorization process by focusing your attention on its core functions, including the home-delivered and congregate nutrition programs. The Meals On Wheels Association of America is grateful for the opportunity to present testimony for your consideration as you work to improve the Act and bolster its efficiency and effectiveness to serve the escalating number of seniors in need.

We recommend two OAA modifications that will make a significant dent in senior hunger by serving millions more nutritious meals to thousands more seniors ***without expending an additional federal dollar***. These recommendations are presented on pages 6 - 9.

As background, the Meals On Wheels Association of America (MOW) is the oldest and largest national organization comprised of and representing Meals on Wheels programs in all 50 states and U.S. territories. Some of these programs serve meals at ***congregate*** locations like senior centers, and some deliver meals directly to the homes of seniors whose mobility is limited (most commonly referred to as ***Meals on Wheels***). However, the overwhelming majority of our members provide both.

As a national organization, we work each day to support local programs by:

- Providing education, training and professional development for Meals on Wheels staff and volunteers to equip them with the specific skills and tools they need to improve operations and meet the ever-growing demands of the seniors in their communities;
- Securing financial and other resources to assist local programs in keeping their revenue streams diverse and their programs sustainable;
- Identifying and sharing successful practices that may be replicated and scaled elsewhere;
- Funding and conducting timely and relevant research on senior nutrition, including the social and economic impact of the entire Meals on Wheels package—the nutritious meals, friendly visits and safety checks; and,
- Raising awareness about the issue of senior hunger and the tireless work undertaken every day across the country by local programs and their dedicated army of 2 million plus volunteers.

For over 40 years, OAA nutrition programs in communities large and small, urban and rural, have been serving our country's most vulnerable, frail and isolated seniors. What started as a demonstration project has grown into a highly effective community-based, nationwide network of more than 5,000 local programs. While not all programs receive OAA funds, the majority rely, in part, on the federal dollars authorized under Title III as a foundation on which to leverage other funding. This enables a very successful public-private partnership to help raise the remaining resources needed to provide daily nutritious meals and social contact to seniors 60 years of age or older who are at significant risk of hunger and losing their ability to remain independent in their homes.

The objectives of the congregate (Title III C1) and home-delivered/Meals on Wheels (Title III C2) nutrition programs are to reduce hunger and food insecurity, promote socialization and improve health and well-being. Nutrition services under the OAA are targeted to those with the greatest economic and social need, including most at risk for nursing home placement. The evidence demonstrates that these programs are not only saving lives and taxpayer dollars every day, but they are doing precisely what they were designed to do by effectively reaching our nation's most vulnerable seniors, including those who are functionally impaired and in poor health.

Of those receiving Meals on Wheels:

- The majority are women who are over 75, live alone, and are homebound;
- 63% have between 6 - 15 serious health conditions, such as heart disease, hypertension, arthritis, and diabetes;
- 61% take between 6 - 26 medications; and,
- 39% live in poverty.[1]

The profile of those seniors who are able to make it out of their homes and into a congregate setting, such as a senior center, is slightly better:

- The majority are also women who are over the age of 75 and nearly 40% live alone;
- 40% have between 6 -15 serious health conditions, such as those listed above;
- 31% take between 6 - 26 medications;
- 26% live in poverty; and,
- 72% need help going outside.[2]

For both Meals on Wheels and congregate meal clients, an overwhelming majority need help bathing, dressing, going to the bathroom, and managing their medications.[3] On top of these sad realities, many of the basic necessities of daily life that many of us take for granted, such as interacting with others and having access to nutritious food, are simply not options without OAA nutrition programs. In short, these programs are a lifeline, enabling more than 2.5 million seniors[4] to live at home, independently and in better health.

It is often said that if you have seen ***one*** Meals on Wheels program, you have in fact, seen only ***one*** Meals on Wheels program. This is due to the inherent nature of the OAA. Congress' original intent was to design a community-driven model that could easily adapt to the changes seniors need over time. As highlighted earlier, OAA nutrition

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[1] National Survey of Older Americans Act Participants. U.S. Department of Health and Human Services, Administration on Aging. 2011. http://www.agid.acl.gov/
[2] Id.
[3] Id.
[4] 2011 Older Americans Act State Program Reports. U.S. Department of Health and Human Services, Administration on Aging. March 2013. http://www.agid.acl.gov/

programs are one of the best, if not ***the*** best, example of a successful public-private partnership model because they started in the community, were built by their community, and continue to be supported by their community.

However unique in terms of individual program origin/history, daily operations, facilities, volunteers, geographic location, and funding structure; the current challenges they face are nearly uniform. It is clear that the Act needs to be reauthorized and funded at far more appropriate levels that take into consideration inflation, demographic shifts, and the growth in senior hunger and poverty rates. Let us delve deeper into the challenges our programs face, the opportunities and recommendations for improvement, and the economic case for taking urgent action.

THE CHALLENGES

The need is severe. We are merely scratching the surface on meeting the needs of an exponentially increasing hungry senior population as the gaps widen between need/demand and availability/affordability. Nationally, there are 8.8 million seniors[5] currently struggling with hunger. Yet, through the OAA, we are providing nutritious meals to ***only*** 2.5 million.[6] The gap is incomprehensible, with over 6 million American seniors still in need of reliable, nutritious meals.

In 2011, a Government Accountability Office (GAO) report also painted a grim picture, one that has assumedly worsened due to sequestration, year-after-year declines in funding, and an aging population. The GAO (GAO-11-237) found that "*. . .approximately 9 percent of an estimated 17.6 million low-income older adults received meal services like those provided by Title III programs. However, many more older adults likely needed services, but did not receive them. . .For instance, an estimated 19 percent of low-income older adults were food insecure and about 90 percent of these individuals did not receive any meal services. Similarly approximately 17 percent of those with low incomes had two or more types of difficulties with daily activities that could make it difficult to obtain or prepare food.* ***An estimated 83 percent of those individuals with such difficulties did not receive meal services.***"[emphasis added] While the infrastructure and network exists to fill the senior hunger and need gap, the financial resources fall substantially short.

The demand is increasing. The demographic swing to an aging population is already in motion. Baby Boomers are turning 65 at a rate of 10,000 a day. By 2030, the senior population will double to over 70 million.[7] With one in nearly six seniors struggling with hunger today in America – the most affluent country in the world – it is overwhelming to imagine that in a mere 16 years more than 10 million will be.

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[5] Ziliak, James & Craig Gundersen. *Senior Hunger in America: 2010.* University of Kentucky and University of Illinois. August 2013. http://bit.ly/MIEbCM

[6] 2011 Older Americans Act State Program Reports. U.S. Department of Health and Human Services, Administration on Aging. March 2013. http://www.agid.acl.gov/

[7] Aging Statistics. U.S. Department of Health and Human Services, Administration on Aging http://www.aoa.gov/Aging_Statistics/

Funding is not keeping pace. "Real" funding levels (adjusted for inflation)[8] for OAA nutrition programs have decreased 18% from 1992 to 2012.[9] At the same time, the population over 60 has increased 34%. Atop this widening gulf have been increasing food and transportation costs, and fewer private donations have yet to rebound to pre-recession levels.

THE R.O.I – THE CASE FOR GREATER INVESTMENTS

There is an unrecognized but substantial return on investment. OAA nutrition programs can be a major part of the solution to our nation's fiscal challenges, and there is increasing and irrefutable evidence that improving and bolstering them for seniors will substantially reduce long-term healthcare costs. A recent report from the Center for Effective Government found that for every $1 invested in Meals on Wheels, up to $50 could be saved in Medicaid alone.[10] Brown University conducted a recent study which found that by investing more in home-delivered meals, more seniors can be kept out of nursing homes. Specifically, the research found that for every additional $25 a state spends on home-delivered meals each year, per person over 65, the low-care nursing home population—seniors who are nursing home eligible but could remain in their homes with only a little outside support—decreases by a percentage point.[11] One percentage point can translate to billions of dollars in savings.

OAA nutrition programs effectively leverage federal funding to raise more. Older Americans Act funding provides on average about 31% of home-delivered and 44%[12] of congregate programs' total annual budget. These programs could not exist and operate without the majority of their funding coming from other, diverse sources, such as states and localities, foundations, corporations, individual donors and clients themselves and/or their families. The Administration on Aging (AoA) often notes that every $1 of federal support made available through Title III C leverages another $3.35 from other sources.[13] However, as impressive and distinctive from other federal nutrition programs as it is, we believe it significantly underestimates the leveraging power because it fails to take into account the monetary value of in-kind labor contributed by the vast volunteer army—numbering 2 million—as well as the donation of the use of personal vehicles to deliver meals.

OPPORTUNITIES EXIST WITHOUT INCREASING FUNDING

Our Association's first and primary OAA reauthorization recommendation would enable this Subcommittee, as an authorizing committee, to provide funding that would make

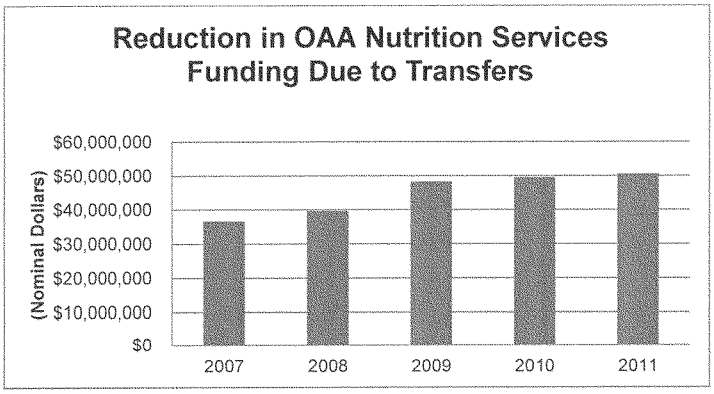
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[8] U.S. Department of Labor, Bureau of Labor Statistics. http://1.usa.gov/1dMfWyM
[9] U.S. Department of Health and Human Services, Administration on Aging. http://1.usa.gov/1ckEBW8
[10] Schieder, Jessica & Lester, Patrick. Sequestering Meals on Wheels Could Cost the Nation $489 Million per Year. The Center for Effective Government. April 2013. http://bit.ly/16jmmRU
[11] Thomas, Kali & Mor, Vincent. *The Relationship between Older Americans Act Title III State Expenditures and Prevalence of Low-Care Nursing Home Residents.* Brown University. December 2012. http://bit.ly/16wl0B2
[12] 2011 Older Americans Act State Program Reports. U.S. Department of Health and Human Services, Administration on Aging. March 2013. http://www.agid.acl.gov/
[13] U.S. Department of Health and Human Services, Administration on Aging. http://1.usa.gov/1lfptBz

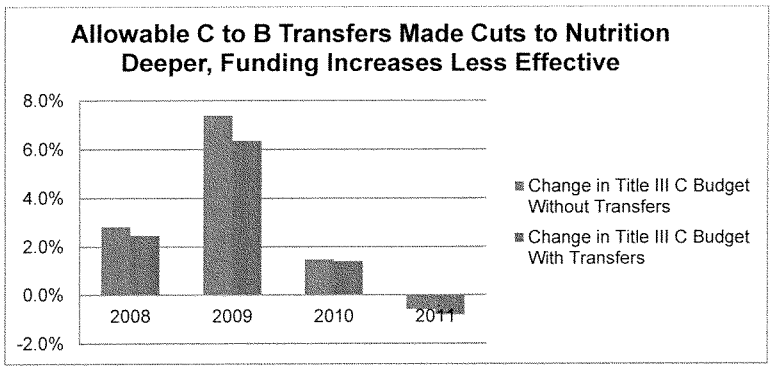
literally millions of additional meals available to vulnerable and frail seniors who need them to maintain or improve their health and independence. And, **it would do that without requiring the expenditure of one more dollar of federal money**.

Our recommendation **is to eliminate the ability to divert Title III C nutrition dollars**—dollars that are appropriated by Congress specifically for nutrition services for seniors—**to other non-nutrition related services** allowable under the Act. Specifically, we believe that eliminating the ability to transfer funding between Title III B, Supportive Services and Title III C, Nutrition Services is critical to ensuring that our seniors have a greater likelihood of receiving the meals they need to remain healthier, independent in their homes, and out of nursing homes and more costly health care settings.

Based on the latest data available from AoA, in 2011 alone, $50.5 million in already appropriated funding for OAA nutrition programs was transferred out of Title III C and into Title III B, Supportive Services. This represents a cut to nutrition funding larger than sequestration itself and approximately 7.8% of the entire budget for these programs for the 2011 program year. The following graphic illustrates the escalating dollars transferred from Title III C1 and C2, Nutrition Services into Title III B, Supportive Services.



From 2007 to 2011, the amount of money transferred out of Title III C into Title III B rose from $36,653,547 to $50,547,587, a 38% growth over five years. In contrast, the annualized expenditures for Title III C programs only grew by 11.4%. This is a significant growth in transfers—the equivalent loss of this diversion is approximately 8 million meals. At a time when the number of seniors struggling with hunger is growing exponentially, this lost federal funding to nutrition could have furnished millions of additional meals and addressed the senior hunger gap we referenced earlier.



This trend of increasing transfers of nutrition funding should be alarming to Congress because both the House and the Senate are on record in report language as strongly warning states, particularly those with high incidences of senior hunger, **not** to transfer funds from nutrition to other services as long as the need for nutrition services exists. Below is an excerpt from House Report 109–493, which reads in part:

"*The Committee cautions States from transferring funds from nutrition services to non-nutrition supportive services unless such transfers support, facilitate, or foster participation in senior nutrition programs. In particular, States with a high prevalence of food insecurity are strongly discouraged from diverting funding provided for food services to non-food expenditures and should do so only as a last resort. Further, the Committee strongly encourages states to use general and administrative dollars provided in the specific line item or category for which the funds were intended. The Committee believes strongly that . . . Title III–C dollars should not be used by states to pay the administrative cost associated with managing Title III–B services.*"

The following year, the Senate expressed its agreement with the House authorizing Committee's warning by adopting report language to accompany the Senate's Departments of Labor, Health and Human Services, Education and Related Agencies appropriations bill (Senate Report 110–107). That language read:

"*The Committee is aware that proper nutrition is essential to the health and wellness of older Americans. A healthy diet can prevent weakness and frailty, improve resistance to illness and disease, and lead to better management of chronic health problems. All of these in turn lead to greater independence and quality of life for older persons. The recent reauthorization of the Older Americans Act recognized the important role that nutrition plays in promoting the health and well-being of seniors. In addition to reducing hunger and promoting socialization, the nutrition services program was reauthorized with the purpose of assisting older Americans in accessing nutrition and other disease promotion services that can delay the onset of adverse health conditions. The act also added greater emphasis on nutrition education, nutrition counseling and other nutrition*

services. Despite increased recognition of nutrition's importance to the health and well-being of our seniors, the funding level for the nutrition services program has stagnated in recent years, while at the same time the population of older Americans continues to increase.

The Committee notes that the number of meals provided under the nutrition services program has declined by more than 8 percent from fiscal years 2000 to 2005. The Committee is aware that flat funding, along with higher food and transportation costs, has forced many programs to implement waiting lists and consolidate meal sites in order to cut costs. The Committee hopes that the funding increase provided will help alleviate the fiscal strain affecting these programs and will allow them to continue to provide meals services that are essential to our seniors. The Committee recognizes that the recent reauthorization of the Older Americans Act (Public Law 109–365) continues to allow States to transfer funds between title III–B, which funds supportive services, and title III–C, which provides funding for nutrition services. While such transfers have remained relatively stable over time, amounting to approximately $35,000,000 per year transferred from nutrition programs to supportive services, ***the Committee is concerned by the decrease of funds available for nutrition services. The Committee believes that the specific funding increase provided for nutrition services in this bill should be used to directly support, facilitate, or foster nutrition programs, and should not be transferred for non-nutrition-related supportive services****.'*[emphasis added]

This data clearly demonstrates that transfers are increasing at a national level over time. And there is **no transparency** in how federal dollars transferred are being utilized. The public should know that their hard-earned tax dollars are being used to support proven and effective programs offering the greatest return. Taking into account the leveraging power of these programs, had this transferability not occurred in 2011, an additional $150 million would have been spent on proven nutrition programs; thus providing tremendous savings in health care costs and remaining consistent with congressional intent outlined in the aforementioned Committee reports.

Our second recommendation is **to consolidate Title III subparts C1 and C2 into a single Title III Part C.** This division in separate OAA nutrition programs resulted from the historical fact that the home-delivered meal program was created ***after*** the congregate program and through a different reauthorization bill.

As noted earlier, the overwhelming majority of the members of our Association—approximately 70%—provide both congregate and home-delivered meals. Unfortunately, the separation of these two nutrition programs causes situations where there are large carryover funding in one nutrition program or another. This end result encourages Title III C to Title III B transfers at a time when the need for nutrition services has never been greater.

Furthermore, if this second recommendation were accepted, states, area agencies on aging and local nutrition programs would improve efficiency and could more easily direct

nutrition dollars to areas of greatest need within their community. There would be no change in which entities are eligible for funding, who could receive services, nor how clients are served, etc. Both congregate and home-delivered meal programs would continue to have access to these dollars, and the process of directing them where they need to go would be simplified and streamlined. The administrative burden would be significantly reduced, and time and energy could be directed to the provision of nutritious meals.

IN CLOSING

As a national organization representing Meals on Wheels and congregate programs, we believe that no senior should go hungry. It is our moral imperative as a nation to ensure that the basic necessity of nutritious food is accessible and available, especially to our most vulnerable citizens. As the architects of the legislation that governs the OAA, you have the ability to not only improve the lives of those individuals who depend on us, and their communities, for these vital life supports, but also save substantial taxpayer dollars in avoided hospital, nursing home and other health care expenses.

We know that Congress faces extraordinarily difficult decisions relating to federal spending and that the deficit must be addressed. However, we also know that this Subcommittee has the power to reauthorize and improve the OAA and direct millions of "additional" dollars to providing nourishing meals to seniors in need without spending one additional cent. As you work to reauthorize and improve the Act, we urge you to:

- 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 state and local levels by giving communities the ability to target funds to best meet the specific needs of their older adults; and,

- Close the loophole that allows nutrition dollars to be spent on non-nutrition related expenses by eliminating the authority to transfer funds from Title III, C to Title III, B. Had transfers from Title III C into Title III B been statutorily prohibited in FY 2011, the $50.5 million of nutrition funds that were siphoned off for other services would have been available to provide a basic necessity to those in need, and potentially saving billions in Medicare and Medicaid costs.

We believe these should be easy choices, and especially so in this time of fiscal austerity. Ethically, it is the right thing to do. Practically, it is good economics.

Again, we thank you for the opportunity to submit this statement for the record and look forward to working with every Member of the Subcommittee and the full House to find solutions to improve, strengthen, and reauthorize the OAA.

[Additional Submissions by Mr. Thompson follow:]

Public Policy Division
1212 New York Ave NW
Suite 800
Washington, DC 20005

202.393.7737 **p**
866.865.0270 **f**
www.alz.org

alzheimer's association®

February 21, 2014

The Honorable John Kline
Chairman
House Education & the Workforce Committee

The Honorable George Miller
Ranking Member
House Education & the Workforce Committee

The Honorable Virginia Foxx
Chairwoman
Subcommittee on Higher Ed and Workforce Training
House Education & the Workforce Committee

The Honorable Rubén Hinojosa
Ranking Member
Subcommittee on Higher Ed and Workforce Training
House Education & the Workforce Committee

Dear Chairman Kline, Ranking Member Miller, Chairwoman Foxx and Ranking Member Hinojosa,

On behalf of the Alzheimer's Association, thank you for your leadership on issues important to Americans with Alzheimer's disease and other dementias, as well as their families and caregivers. The Alzheimer's Association proudly supports the efforts of the Committee to move forward with the reauthorization of the Older Americans Act (OAA), which provides essential support for older Americans in need. The programs supported by the OAA provide funding and assistance for many critical programs and services vital to the Alzheimer's disease and dementia community. We look forward to working with you in a bipartisan fashion to reauthorize these essential programs during the 113th Congress.

The Alzheimer's Association is the leading voluntary health organization in Alzheimer's care, support and research. As you know, more than 5 million Americans are currently living with Alzheimer's disease and other dementias. In addition, more than 15 million friends and family of those with Alzheimer's disease are also acting as uncompensated caregivers. In 2012, these individuals provided 17.5 billion hours of care, valued at more than $216 billion. Alzheimer's disease was recently identified by the New England Journal of Medicine as the costliest disease in the United States, as care costs exceeded $200 billion in 2013. As the baby boom generation continues to age, one-in-nine above age 65 will develop Alzheimer's disease or another dementia. By 2050, the number of people with Alzheimer's disease in the United States is expected to balloon to nearly 14 million, representing a cost to the nation of nearly $1.2 trillion.

The OAA provides for federal funding and the necessary infrastructure to deliver vital support programs and social services to our nation's seniors, including those with Alzheimer's disease and other dementias. These critical programs are used by millions of Americans and provide for such services as nutrition programs, senior centers and caregiver supports. Furthermore, nearly one-third of older individuals with Alzheimer's disease and other dementias that have Medicare are also eligible for Medicaid, underscoring the need within the Alzheimer's community for such programs as the National Family Caregiver Support Program, which help support low-income seniors with dementia. Additionally, reauthorization of the OAA would help support the implementation of the Department of Health and Human Services' *National Plan to Address Alzheimer's Disease (National Plan).* The *National Plan* is an annually-updated strategic plan to address the rapidly escalating Alzheimer's crisis that was required by the National Alzheimer's Project Act (NAPA). This bipartisan legislation was signed into law in 2010, after unanimous approval by Congress. Successful implementation of the *National Plan* relies on many entities and programs authorized under the OAA,

including initiatives to increase knowledge of available resources, caregiver education and training, and elder abuse awareness activities.

The Alzheimer's Association appreciates your leadership on this important issue, and we look forward to continuing to work with you and your colleagues to improve care and support for individuals and families affected by Alzheimer's disease. If you have any questions, please contact Rachel Conant, Director of Federal Affairs, at RConant@alz.org or at 202-638-7121.

Sincerely,



Robert Egge
Vice President, Public Policy
Alzheimer's Association

[Additional Submissions by Mr. Tierney follow:]

ALZHEIMER'S FOUNDATION OF AMERICA

Our mission is "to provide optimal care and services to individuals confronting dementia, and to their caregivers and families—through member organizations dedicated to improving quality of life."

"Serving Seniors through the Older Americans' Act of 1965"

Hearing before the

Committee on Education & the Workforce

Subcommittee on Higher Education & Workforce Training

U. S. House of Representatives

February 11, 2014

Statement for the Record Submitted by:

Honorable Charles J. Fuschillo, Jr.

Chief Executive Officer

Alzheimer's Foundation of America

322 Eighth Avenue,7th Floor, New York, NY 10001
(866) AFA-8484 • Fax: (646) 638-1546
info@alzfdn.org • www.alzfdn.org

Chairwoman Fox, Ranking Member Hinojosa and Members of the Subcommittee on Education and Workforce Training:

On behalf of the Alzheimer's Foundation of America (AFA), a national nonprofit organization that unites more than 1,600 member organizations nationwide with the goal of providing optimal care and services to individuals confronting dementia, and to their caregivers and families, I appreciate the opportunity to present testimony in support of reauthorization of the Older Americans' Act (OAA). This action will ensure that vital and necessary supports for people with Alzheimer's disease and their family caregivers will remain in place and expand in line with the increasing needs of our aging population.

Alzheimer's disease in the U.S. is at crisis proportions. As our population ages, incidences of the number of persons affected by this brain disorder are expected to triple by 2050[1]. Costs associated with Alzheimer's disease are also growing at an unsustainable rate. A recent RAND study of adults aged 70 and older found that total economic cost of dementia in 2010 was estimated to be $109 billion for direct care—higher than heart disease and cancer; and $159 billion to $215 billion when cost of informal care is included[2].

People with Alzheimer's disease tend to have multiple co-existing medical conditions, such as coronary artery disease, diabetes, congestive heart failure, and chronic obstructive pulmonary disease. Thus, they tend to have higher rates of health care use than others without the disease. For example, hospital stays are more frequent among people with Alzheimer's disease than among those without this brain disorder[3]. In addition, avoidable hospitalizations are more common among Medicare beneficiaries with Alzheimer's disease than for diabetes (short-term and long-term complications of diabetes) and hypertension, COPD or asthma, and heart failure[4]. These results suggest that Alzheimer's disease creates additional challenges in managing certain comorbidities, resulting in higher costs.

Since its inception, OAA has been providing necessary care supports and promoting best practice tools to family caregivers that allow individuals with Alzheimer's disease to live safer in their home and community-based environment, delaying nursing home placement and helping to avoid costly avoidable hospitalizations and emergency room visits.

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[1] Alzheimer disease in the United States (2010–2050) estimated using the 2010 census, Neurology (March, 2013).
[2] *Monetary Costs of Dementia in the United States*, N. Engl. J. Med. 2013; 368:1326-1334 (April 4, 2013) (www.nejm.org/doi/full/10.1056/NEJMsa1204629).
[3] Zhanlian Feng, PhD, et.al., Hospital and Emergency Department Use by People with Alzheimer's Disease and Related Disorders: Final Report (August 2013) (http://aspe.hhs.gov/daltcp/reports/2013/ADRDhed.shtml#execsum).
[4] Ibid.

OAA programs like Alzheimer's disease education, adult day services, caregiver training, senior nutritional services, and legal assistance help alleviate some of the physical, financial and emotional toll of Alzheimer's disease, both for the rising number of diagnosed individuals and their overwhelmed family caregivers. Proposed OAA initiatives to fund new models of care coordination and advanced aide deployment, and efforts to shield elders from abuse, neglect and exploitation are worthy initiatives that would further extend OAA's reach and protections.

Absent these supports, the dementia population and their families would face increased hardships, greater challenges, and higher costs. As well, the majority of people would find it difficult if not impossible to carry out the much-desired goal of continuing to live at home and in their community for as long as possible.

Caring for a loved one with Alzheimer's disease or a related dementia poses enormous and life-changing challenges for families and caregivers. Alzheimer's disease is a mind-robbing, progressively debilitating brain disorder for which there is no cure. This chronic condition makes it more and more difficult for the person with Alzheimer's disease to remember things, think clearly, and communicate with others; and dramatically changes a person's personality and behaviors. The very nature of dementia, therefore, requires reliance on caregivers, both families and professionals, as the individual's brain functions spiral downwards and the ability to perform everyday tasks and vital activities of daily living (ADLs) become compromised. Ultimately, persons with dementia are totally dependent on their caregivers. OAA programs help provide caregivers the necessary tools and essential services to effectively care for an individual with dementia.

In particular, these core OAA programs are critical to individuals with Alzheimer's disease and their caregivers:

- National Family Caregiver Support Program (NFCSP): NFCSP provides grants to states and territories, based on their share of the population aged 70 and over, to fund a range of supportive services that assist family and informal caregivers in caring for their loved ones at home for as long as possible, thus providing a more person-friendly and cost-effective approach than institutional care. **AFA urges that $192 million be appropriated in FY 2015 to support this important program.**

- Lifespan Respite Care Program (LRCP): LRCP provides competitive grants to state agencies working with Aging and Disability Resource Centers and non-profit state respite coalitions and organizations to make quality respite care available and accessible to family caregivers regardless of age or disability by establishing State Lifespan Respite Systems. **AFA urges a commitment of $50 million to LRCP in FY 2015.**

- Alzheimer's Disease Supportive Services Program (ADSSP): Existing resources for the Alzheimer's population and their caregivers are already tapped out, at a time when demand is continuing to rise in line with the skyrocketing incidence of this disease. **AFA supports funding of $9.5 million for this program.**

- Alzheimer's Disease Initiative (ADI): Services such as support for caregivers in the community, improving health care provider training, and raising public awareness are essential toward improving quality of life for families affected by the disease. Research shows that education, counseling and other support for family caregivers can delay institutionalization of loved ones and improve a caregiver's own physical and mental well-being—thus reducing costs to families and government. **AFA supports $15.5 million for this program.** In addition, AFA supports an **additional $4.2 million for funding a necessary and vital awareness campaign.**

OAA programs are vital to the health and well-being of the ever-growing number of American caregivers. As our nation ages, the number of people with Alzheimer's disease is expected to triple in the next 40 years. Researchers project that the total number of people with Alzheimer's dementia in 2050 will be 13.8 million, up from 4.7 million in 2010[5]. About seven million of the people with the disease will be 85 or older[6]. As a result, the family caregiving population—many of them older adults themselves—will catapult accordingly.

Family caregivers, often called the "invisible second patients," are critical to the quality of life of individuals with dementia. The effects of being a family caregiver, though sometimes positive in terms of building character and strength, are generally negative; caregivers face high rates of burden and psychological morbidity as well as social isolation, physical ill-health, financial hardship,[7] and premature death.

Caregivers of individuals with Alzheimer's disease report experiencing health issues as a result of providing care[8]. Overall, there was a 25 percent increased use of all types of health services by family caregivers, with the median cost of healthcare for family caregivers providing care for someone with Alzheimer's disease averaging $4,766 more per year than non-caregivers[9].

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[5] Alzheimer's disease in the United States (2010–2050) estimated using the 2010 census, www.neurology.org/content/early/2013/02/06/WNL.0b013e31828726f5.abstract.

[6] Ibid.

[7] Family caregivers of people with dementia, Dialogues in Clinical Neuroscience, Volume 11(2); June 2009 (www.ncbi.nlm.nih.gov/pmc/articles/PMC3181916/).

[8] CAREGIVING COSTS: Declining Health in the Alzheimer's Caregiver as Dementia Increases in the Care Recipient, National Alliance for Caregiving, Nov, 2011 (www.caregiving.org/pdf/research/Alzheimers_Caregiving_Costs_Study_FINAL.pdf).

[9] Ibid.

As the nation's population grows older, the "aging in place" movement has been gaining ground. According to AARP, nearly 80 percent of adults 65 and older want to stay in their homes as they age[10]. More than 7 of 10 people with Alzheimer's disease live at home[11] Holding steadfast to this desire, many families are only able to keep loved ones home with the assistance of family, friends, volunteers or paid professionals, as well as by taking advatange of community and national support services. The need for outside help is often prompted by situations such as a loved one's need for assistance with ADLs or emergence of behavioral problems. When such behavioral issues start to impact the caregiver's physical or mental health, caregivers are somewhat more receptive to hiring a paid professional.

Reauthorization of OAA is clearly in sync with a growing movement in our nation to attack the Alzheimer's disease crisis head-on. A major goal of the historic "National Plan to Address Alzheimer's Disease" calls for expanding supports for people with Alzheimer's disease and their family caregivers. Action steps under this goal include: increasing dementia training for direct and indirect caregivers; enabling caregivers to continue to provide care while maintaining their own health; and assisting families in planning for future care needs.[12] OAA programs provide many of these vital supports and services. Without reauthorization of these essential programs, any gains in long-term care services and supports as articulated in the national Alzheimer's plan will be quickly erased, and other recommendations in the plan will not be realized.

For all of the reasons stated above, the *status quo* is inadequate to meet the growing needs anticipated by the "silver tsunami" as our population ages. OAA supports and services are a lifeline to the millions in our nation with this devastating brain disorder, and to their families. On behalf of those Americans affected by the disease currently or in the future, AFA urges the Subcommittee to support the reauthorization and proper funding of OAA as outlined in this testimony.

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[10] Aging in Place: A State Survey of Livability Policies and Practices," AARP (2011)(http://assets.aarp.org/rgcenter/ppi/liv-com/aging-in-place-2011-full.pdf).

[11] Alzheimer's Research & Prevention Foundation, Alzheimer's Info (www.alzheimersprevention.org/alzheimers-info).

[12] See, National Plan to Address Alzheimer's Disease, Goal 3; action steps A-C.

[Questions submitted for the record and their responses follow:]

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MARK POCAN, WISCONSIN

March 12, 2014

Mrs. Lynn Kellogg
Chief Executive Officer
Region IV Area Agency on Aging
2900 Lakeview Avenue
St. Joseph, MI 49085

Dear Mrs. Kellogg:

Thank you for testifying before the Subcommittee on Higher Education and Workforce Training at the hearing entitled, *"Serving Seniors through the Older Americans Act"* on Tuesday, February 11, 2014. I appreciate your participation.

I have enclosed additional questions for inclusion in the final hearing record. Please provide a written response **no later than March 26, 2014**. Responses should be sent to Lindsay Fryer or Jenny Prescott of the committee staff who can be contacted at (202) 225-6558.

Thank you again for your important contribution to the work of the committee.

Sincerely,

Virginia Foxx
Chairwoman
Subcommittee on Higher Education and Workforce Training

Chairwoman Virginia Foxx (R-NC)

- How have state and Area Agencies on Aging broadened their responsibilities to serve more seniors beyond those mandated by the Act? What role do they play in their communities in serving seniors, and how have they worked with others in the community to achieve this goal?

- How do you measure the impact of your programs on those served? What specific metrics do you use in determining effectiveness? Do you target funding only to those initiatives proven effective to ensure that federal and other dollars are being used wisely to support things that work?

[Mrs. Kellogg's response to questions submitted follows:]

March 26, 2014

***"Serving Seniors through the Older Americans Act"* - original testimony: February 11, 2014**
Additional questions - asked of Lynn Kellogg, CEO/Region IV Area Agency on Aging, St. Joseph, MI
U.S. House of Representatives / Subcommittee on Higher Education and Workforce Training
Chairwoman: Virginia Foxx

Questions: Set #1

1) How have state and Area Agencies on Aging broadened their responsibilities to serve more seniors beyond those mandated by the Act?

The Older Americans Act [OAA] charges AAAs with developing a *system* of home and community-based services that fosters independence for as long as possible. This cannot be done solely with resources from the OAA. It's a common misnomer to see services funded directly from OAA funds as the extent of AAA influence. The vast majority of AAAs follow the broader mission of system development embodied in the OAA. In this sense they become sources of information; catalysts for change and business development. Beyond administering dollars for services at the local level, the program development role of AAAs becomes a driver for the development of aging as an economic growth sector. Their OAA foundation of objective planning and assessment, coupled with their national reach into all communities, regardless of geography, makes them a go-to resource for additional funders with purposes complimentary to the OAA. The aging of communities is a national phenomenon. In 2010, virtually all AAAs secured funds from an average of seven sources other than the OAA.

2) What role do they play in their communities in serving seniors, and how have they worked with others in the community to achieve this goal?

Local roles played directly by AAAs are multifold. Common examples include:

Information – Virtually all AAAs serve as trusted sources of information about local services. Many operate call centers. Region IV AAA's *Info-Line for Aging & Disability* is a composite of a local toll-free line, two state toll-free lines, the federal ElderCare Locator, and a specialty patch for 211 calls. Thousands of calls are received annually.

Planning & Service Development – In addition to planning and targeting OAA resources, AAAs have leveraged many sources of additional dollars towards the mission of the OAA. They typically target and administer dollars from the Medicaid home and community-based waiver, state funds, local sources, private foundation(s), private payers, and donors. The range of services developed varies by community. Many parallel those mandated by the OAA such as meals and in-home services, others may address localized needs. In this regard AAAs are major funders of local services.

Care Management/Options Counseling – The same objective quality that makes an AAA ideal for assessing and developing services for a community or region also serves well at the individual level. From private pay to Medicaid you'll find AAAs involved in consulting individuals and families on their options for maintaining independence. Many AAAs now use

this role as a vehicle for funding service providers by purchasing services on an individual person-centered basis rather than a traditional agency-centered basis.

Program Development – AAAs use their knowledge and expertise to spur interest in aging and encourage growth in services. Based on their knowledge of needs, AAAs often encourage service providers to expand existing services or consider starting a new service. AAAs sit on local boards such as an economic development board, a chamber of commerce, a hospital board, or a private foundation to share expertise with the goal of increasing involvement and investment in making communities easier to live in. AAAs participate in a myriad of human service councils and committee exploring solutions to local issues.

AAAs have commonly been responsible for a host of local business start-ups. An AAA will pursue funding for an entirely new endeavor or business related to an identified need because there is no one else taking to the lead to do it. Region IV AAA has established several independent operations including transportation providers, a meals provider, volunteer programs, a senior center, and mostly recently, a PACE program.

Education – AAAs routinely conduct evidence-based classes designed to empower and promote independence. For example, Region IV AAA offers: a) a volunteer run computer class with set curriculum designed to help seniors become functional and comfortable using the computer as a tool, b) caregivers classes help those caring for loved ones maintain that role without physical or mental collapse, c) fitness and/or balance classes designed to prevent falls, and d) chronic disease management classes help individuals self-manage an unlimited array of chronic conditions.

In all of these roles the AAA becomes a major community collaborator. Their role on boards, council and committees, and their leadership in program development, is all part of successfully having other entities recognize the value of the older population and the importance of finding solutions to their continued independence. These collaborative efforts is how AAAs are able to leverage other resources towards the mission of the OAA.

Questions: Set #2

1) How do you measure the impact of your programs on those served? What specific metrics do you use in determining effectiveness?

Impact is measured in several ways:

Evidenced-based constructs: The shift in recent years to local development and expansion of proven service modalities has been profound. Beyond the requirements of the OAA, AAAs look to certified solutions that have been studied and certified at the university level. This is true in the educational classes provided as well as the protocols developed for specific services.

Individual Feedback: Through Care Management type services, AAAs are able to talk directly to the person receiving service about the impact of services provided rather than relying solely on monitoring of contractual standards at an agency level. For persons in functional decline, the

opinion as to what is needed and whether needs were met is an individualistic measurement best measured on a person by person basis.

Benchmarks: Whether focusing on prevalence of pain, volume of medication, frequency of falls, use of an emergency room, indicators of social isolation, or waiting times for everything from call backs to transportation service, benchmarks and studies abound. The advent of the internet for research and sharing and the need to assure efficacy of effort results in a plethora of benchmarking measures. Metrics vary by service.

2) Do you target funding only to those initiatives proven effective to ensure that federal and other dollars are being used wisely to support things that work?

The short answer is "yes". That's not to say that every service is scientifically tested, though many are. The flexibility of the OAA allows services to be tailored to local or individual need(s). This flexibility is key to the OAA as it allows a national vehicle to meeting needs not otherwise met. The "proven" impact of a service tailored to meet an individual need is reported in the Individual Feedback described earlier.

I would be happy to provide any further explanations or clarifications that may be helpful.

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U.S. HOUSE OF REPRESENTATIVES
2181 RAYBURN HOUSE OFFICE BUILDING
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March 12, 2014

Mrs. Denise C. Niese
Executive Director
Wood County Committee on Aging, Inc.
305 N. Main Street
Bowling Green, OH 43402

Dear Mrs. Niece:

Thank you for testifying before the Subcommittee on Higher Education and Workforce Training at the hearing entitled, *"Serving Seniors through the Older Americans Act"* on Tuesday, February 11, 2014. I appreciate your participation.

I have enclosed an additional question for inclusion in the final hearing record. Please provide a written response **no later than March 26, 2014**. Responses should be sent to Lindsay Fryer or Jenny Prescott of the committee staff who can be contacted at (202) 225-6558.

Thank you again for your important contribution to the work of the committee.

Sincerely,

Virginia Foxx
Chairwoman
Subcommittee on Higher Education and Workforce Training

Chairwoman Virginia Foxx (R-NC)

- How do you measure the impact of your programs on those served? What specific metrics do you use in determining effectiveness? Do you target funding only to those initiatives proven effective? How do you ensure that federal and other dollars are being used wisely to support initiatives that work?

[Mrs. Niese's response to question submitted follows:]

Subcommittee on Higher Education and Workforce Training
"Serving Seniors through the Older Americans Act"
Submission for the Final Hearing Record
Denise C. Niese, Executive Director
Wood County Committee on Aging, Inc.
March 26, 2014

Chairwoman Virginia Foxx (R-NC)

- How do you measure the impact of your programs on those served? What specific metrics do you use in determining effectiveness? Do you target funding only to those initiatives proven effective? How do you ensure that federal and other dollars are being used widely to support initiatives that work?

Organizations today are striving to deliver more and more with less. Achieving this objective is highly dependent upon how efficient operations are. Efficiency depends upon the ability to provide programs and services with the desired outcome using the least resources (funding) possible. The key to an organization's ability to achieve this goal rests with the flexibility found within the language of the Older Americans Act.

In 2014, of our projected revenues of $2,711, 610, Older Americans Act funds awarded to the WCCOA total $257,282 (9% of our total budget). Older Americans Act funds are used for direct costs associated with nutrition, transportation, and home repair.

These funds which are administered through our local Area Agency on Aging, support direct costs associated with congregate meals (C-1), home delivered meals (C-2) $187,612. (with 133% cash match) and Medical Escort (Transportation 9) and Minor Home Repair $69,670 (with 100% cash and in-kind match). An additional $62,860 is provided through NSIP and $19,386 from Ohio Senior Community Service Block Grants.

The remaining 91% of our operating budget is comprised of the following sources:

- 74% Senior Services Levy (.7 mil county-wide property tax passed 11/2011 by 69.32% of vote)
- 8.4% Program Income (donations for meals)
- 5% Medicaid Waiver contract for medical transportation and home delivered meals
- 3.6% Cost Share contributions, program fees, sponsorships, private grants, and other miscellaneous income

As you can see, the majority of funding for programs and services in Wood County, Ohio is non-federal. Aside from the services that are supplemented by the Older Americans Act (congregate meals, home delivered meals, transportation, and minor home repair), all other programs and services are supported through the county-wide property tax levy, fees for service, and/or donations and sponsorships.

With the diverse programs offered by the Wood County Committee on Aging (WCCOA), multiple tools are used to measure impact and effectiveness.

Since 2006, WCCOA has contracted with our Area Agency on Aging (AAA) for Older Americans Act (OAA) funds to support direct costs associated with Title IIIC Nutrition (congregate and home delivered meals), and Title IIIB Supportive Services (non-emergency medical Escort and minor Home Repair). All of these

delivered services are reported via the National Aging Program Information System (NAPIS) and entered into the Harmony Information Systems SAMS software (as required by the Area Agency on Aging and the Ohio Department of Aging (ODA). It is our understanding that this system allows the local AAA, the ODA and the Administration on Community Living (ACL) to review performance, efficiencies and effectiveness in relation to the OAA funded services.

In addition to those measurements, WCCOA also conducts annual client satisfaction surveys for these services. In order to garner additional input specific to our menu development (for both the congregate and home delivered participants), the WCCOA Food Service Director is on-site at all seven senior centers each Spring / Summer to facilitate "Menu Talk." This provides an opportunity for participants to voice their comments, concerns, complements, ideas, and any other input (including recipe suggestions) directly to the staff involved in the program. Home-delivered meal participants receive a detailed evaluative survey (annually) which they complete and return. In addition, if a homebound participant would like to speak directly with the Food Service Director, he/she is invited to do so on a regular basis. Conducting program evaluations is an integral part of operating and managing a program because it helps to examine whether you are meeting the needs of your client base and achieving the overall goals of the program.

For non-OAA fund services the WCCOA utilizes a variety of tools to measure impact and effectiveness. All services are evaluated in some manner. For example, in an exercise class the range of motion is tracked. Blood sugar, cholesterol, and blood pressure clinics are held frequently to measure the changes that routine monitoring and education have had on the participants. Under the Healthy IDEAS program, decreases in functional ability associated with depression are measured and evaluated.
WCCOA uses its three year strategic plan to address local needs and initiatives. The strategic plan is updated regularly and is used to prioritize agency goals and objectives and for evaluation. It is also used to deal with needs of seniors in cooperation with other service organizations. This enables all organizations involved to avoid duplication of services, to coordinate services for the benefit of those receiving the services, and to reduce costs for all involved. Using the strategic planning process allows the agency to determine which services or programs have met their goals and are no longer needed and can be phased out or eliminated. This process also identifies services and programs that can be developed and/or strengthened.

Without a doubt, the Older Americans Act (OAA) has been instrumental in the creation of a wide array of programs and services intended to enhance the well-being of older adults. This chief piece of legislation was designed to be the focal point of federal government policy on aging and it established the Administration on Aging, state units on aging, and area agencies on aging. The programs and services provided through the OAA are needed now more than ever before as the "graying of the population" is most evident with 10,000 Baby Boomers turning 65 each day.

As the Reauthorization process of the Older Americans Act moves forward, I would encourage Congress to strive to maintain the flexibility that is an integral part of the success of the Act. The flexibility permits service providers such as WCCOA to meet the unique needs of our communities while maintaining the high standards set by the Act.

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U.S. HOUSE OF REPRESENTATIVES
2181 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100

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MARK POCAN, WISCONSIN

March 12, 2014

Ms. Carol V. O'Shaughnessy
Principal Policy Analyst
National Health Policy Forum
2131 K Street, NW, Suite 500
Washington, D.C. 20037-1882

Dear Ms. O'Shaughnessy:

Thank you for testifying before the Subcommittee on Higher Education and Workforce Training at the hearing entitled, *"Serving Seniors through the Older Americans Act"* on Tuesday, February 11, 2014. I appreciate your participation.

I have enclosed additional questions for inclusion in the final hearing record. Please provide a written response **no later than March 26, 2014**. Responses should be sent to Lindsay Fryer or Jenny Prescott of the committee staff who can be contacted at (202) 225-6558.

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Subcommittee on Higher Education and Workforce Training

Chairwoman Virginia Foxx (R-NC)

- How have state and Area Agencies on Aging broadened their responsibilities to serve more seniors beyond those mandated by the Act? What role do they play in their communities in serving seniors, and how have they worked with others in the community to achieve this goal?

- We have heard that the aging network established under the *Older Americans Act* to serve seniors is strong and should not be completely rethought or changed during reauthorization. Can you provide some examples of how the Act's structure contributes to the strength of the aging network and comment on your thoughts about maintaining this structure in *OAA* reauthorization? How does the network promote a continuum of care for the vulnerable elderly?

[Mrs. O'Shaughnessy's response to questions submitted follows:]

- **How have state and Area Agencies on Aging broadened their responsibilities to serve more seniors beyond those mandated by the Act? What role do they play in their communities in serving seniors, and how have they worked with others in the community to achieve this goal?**

Over the years, many state and area agencies have broadened their responsibilities beyond the administration of Older Americans Act funds. This is exemplified especially in their management and redesign of home and community-based LTSS financed by Medicaid and state funds.

As a result of the planning efforts undertaken by state agencies on aging during the 1970s and 1980s, it became clear to state aging administrators that home and community-based services for vulnerable older people were underdeveloped and that a "continuum of care," as envisioned by the Older Americans Act, did not exist. As a result, some states to begin to focus more attention on developing home and community-based care options that could prevent or delay institutional care. Calls by advocates and policymakers for greater access to a wider range of home and community-based care led Congress to enact the Medicaid section 1915(c) home and community-based waiver program in 1981. Implementation of waivers during the 1980s and 1990s began to change the fabric of LTSS as states developed a broad span of services, such as care management, home care, adult day care, and respite care, to meet the needs of vulnerable populations living in the community. The program provides an opportunity to alter what some refer to as Medicaid's "institutional bias." Prior to the waiver program, care in Medicaid-financed nursing homes and other institutions was often the only option for elderly and other groups with LTSS needs and limited income and resources.

Administrators and advocates for the elderly recognized that their ability to provide home and community-based services could be significantly augmented by access to Medicaid funds. The aging infrastructure proved to be a ready-made network for waiver implementation. Many state governments began to assign responsibility for administration and day-to-day management of the Medicaid waiver services program to state agencies on aging. Often state agencies on aging designate area agencies on aging to deliver waiver services, including case management, assessment of individuals' care needs, and development of care plans. Medicaid now represents a significant part of funding for both state and area agencies on aging.

In addition to management of Medicaid waiver programs, some state agencies on aging have been instrumental in redesigning their state LTSS programs by making broad policy changes, using Medicaid funds for home and community-based services in combination with Older Americans Act and state funds. LTSS redesign has taken various approaches including (i) consolidating administrative structures and financing with the aim of redirecting service delivery toward home and community-based services from institutional care, and (ii) restructuring the delivery of LTSS to help consumers more easily access services. Some states have redesigned their systems by consolidating policy, financing, and administration into one single state agency that has control of, and is accountable for, all LTSS resources. In these cases, one agency is responsible for not only planning and development of LTSS policy, but also administration of eligibility determination, financing, regulation, service delivery, and quality for both institutional

and home and community-based services. Consolidation allows state administrators to balance resources among all services and to shift funds from institutional care to home and community-based services.

Beyond their work in management of both federally- and state-funded LTSS programs, many aging services network agencies administer Social Service Block Grant (SSBG) funds for elder abuse prevention, the State Health Insurance Program (SHIP), Public Health Service Act funds, and state general revenue funds for myriad services for older people, and programs for younger people with disabilities.

- **We have heard that the aging network established under the *Older Americans Act* to serve seniors is strong and should not be completely rethought or changed during reauthorization. Can you provide some examples of how the Act's structure contributes to the strength of the aging network and comment on your thoughts about maintaining this structure in *OAA* reauthorization? How does the network promote a continuum of care for the vulnerable elderly?**

The purpose of the Older Americans Act is to help people age 60 and older maintain maximum independence in their homes and communities, with appropriate supportive services, and to promote a continuum of care for the vulnerable elderly. The mission of the aging services network set out by law is expansive and is aimed at addressing many competing needs of older people across a wide spectrum of services. The Act's reach has evolved significantly through the years. The original legislation authorized generic social service programs, but in successive amendments Congress authorized more targeted programs under various titles of the Act to respond to specific needs of the older population. The creation of agencies on aging that are responsible for planning and coordination of a wide array of services for older people, as well as serving as advocates on their behalf, has proven to be an impetus for the development of locally-based aging programs that would not exist without the framework envisioned by the Act. As federal and state governments strive to meet growing needs, they have increasingly looked to the aging services network to administer new programs and services and to expand the scope of their responsibilities.

The infrastructure created by the Act can influence service programs that reach a far larger proportion of the older population. Mandates given to state and area agencies on aging, to act as planning, coordinating, and advocacy bodies can impact policies that affect broader groups of older people. For example, state agency on aging efforts to develop LTSS have the potential to change service patterns for older people and for younger people with disabilities who do not directly receive services funded by the Act. In addition, the advocacy functions embedded in the Act's programs can make other programs' activities more accountable.

Despite its broad mandate and sweep of services, Older Americans Act resources are relatively limited. Some have observed that funding has always been small and not kept pace with increasing demands from a growing elderly population. As a result, some programs have grown very slowly over time, or have not been brought to scale. Some programs' capacity

depends heavily on volunteers, thereby masking any need for additional staff resources to carry out program functions. Moreover, the aging services network's decentralized planning and service model has led to variability in program implementation across states and communities. Despite these constraints, the basic structure of the Act is strong. The Committee may review findings of various program evaluations that the Administration on Aging has underway for ways to improve and strengthen the Act.

In the future, policymakers may need to focus on actions that will enable communities to sustain services in the face of growing demand of the coming baby boom population. The increasing numbers and heterogeneity of the older population may demand more varied service models than those that now exist including those that will be able to attract increased private resources and support aging programs. All of these issues are more salient as Congress reviews the Older Americans Act for reauthorization.

[Whereupon, at 11:37 a.m., the subcommittee was adjourned.]

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