S. HRG. 116–548

THE OLDER AMERICANS ACT: PROTECTING AND SUPPORTING SENIORS AS THEY AGE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

WASHINGTON, DC

MAY 8, 2019

Serial No. 116–06

Printed for the use of the Special Committee on Aging

Available via the World Wide Web: http://www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

47–481 PDF WASHINGTON : 2022

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THE OLDER AMERICANS ACT: PROTECTING AND SUPPORTING SENIORS AS THEY AGE

WEDNESDAY, MAY 8, 2019

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 2:56 p.m., in Room 562, Dirksen Senate Office Building, Hon. Susan Collins (Chairman of the Committee) presiding.

Present: Senators Collins, McSally, Hawley, Braun, Casey, Blumenthal, and Rosen.

OPENING STATEMENT OF SENATOR SUSAN M. COLLINS, CHAIRMAN

The CHAIRMAN. The Committee will come to order.

Good afternoon. Let me begin with an apology. We had two votes that were unexpectedly scheduled, and as someone who has never missed a vote in all the time I have been privileged to serve in the U.S. Senate, I did not want to start with that today.

Senator Casey will be on his way, but since we are behind schedule, I thought that I would begin with my opening statement, and again, my apologies to those who have been waiting for us to begin.

In 1965, President Lyndon Johnson signed into law the Older Americans Act. This landmark legislation represented a vision well ahead of its time. With reauthorization efforts currently underway, I am committed to ensuring that the Older Americans Act continues to match the goals we set to permit seniors to age with dignity, respect, and community.

The Older Americans Act focuses on the well-being and social needs of our seniors. Providing nutritious food, installing grab bars, and giving rides cost far less than taking pills, undergoing surgeries, and moving to nursing homes. In Maine, the average cost of serving one senior Meals on Wheels is $1,854 for an entire year. By contrast, a single day in a hospital is $2,262, on average, and just 10 days in a nursing home is approximately $3,100. What we have learned from the past decade of public health research is that maintaining one's health at home is efficient and cost-effective and compassionate.

For 54 years, the Older Americans Act has targeted the social determinants of health, even before the field that links social and medical outcomes was fully recognized. The act expires on September 30th, so along with my colleagues I am working to sponsor

its reauthorization. The bipartisan coalition includes Ranking Member Casey, Senator Enzi, Senator Sanders, and HELP Committee Chairman Lamar Alexander and Ranking Member Patty Murray.

My chief goal is to get across the finish line, on time, a robust and bipartisan Older Americans Act that will strengthen support for its bread-and-butter programs, while providing more flexibility for States to meet local needs. I have focused on five priority areas as we draft our bill: one, family caregivers; two, nutrition; three, social isolation; four, transportation; and, five, elder justice.

Last year, the National Family Caregiver Support Program served more than 700,000 caregivers, but with 10,000 Americans turning 65 each day, this program has not kept pace with our changing demographics, so I am working with my colleagues to increase the funding authorization. Senator Casey and I are also proposing to increase flexibility for States to better meet the needs of older adults in their communities, from those caring for their fellow seniors to those caring for their grandchildren.

Last year, through home-delivered nutrition programs, the Older Americans Act provided seniors across this country with 358 million meals. That includes meals to 4,600 seniors in the State of Maine. In many States, however, the need for Meals on Wheels is growing. In my State, for example, there is a chronic wait list of 400 to 1,500 people, depending on the time of year. Increasing funding for this critical program to close the gap is another of my priorities.

In addition to reducing food insecurity, Meals on Wheels combats social isolation, too. Carol Kotal, a former data entry specialist from Portland, Maine, receives Meals on Wheels. She lives alone and is unable to walk or stand for long periods, so when a volunteer comes by once a week with meals for her and a can of food for her cat, she is so grateful to see a friendly, familiar face. While increasing resources for this community-building program, I am also working on new policies specifically geared toward reducing social isolation.

One such solution is transportation to help seniors get to more community activities. What works in one place is different from what works in another, so I am working to build on a grant program that ranges from supporting public transit to on-demand and volunteer-based services for seniors. We also need new tools to help seniors obtain information about rides and bus routes more easily.

In rural Maine, transportation is a major barrier for our older Americans. Tailored options for seniors from rural to urban America will go a long way toward helping older Americans stay home in their communities.

Finally, at the core of the Older Americans Act is respect for our seniors and preventing neglect, exploitation, and abuse. States are spearheading initiatives to raise awareness, to train law enforcement officers and health care providers, and to support prevention efforts.

Elder abuse, however, remains far too prevalent. In this year's reauthorization, I am including a provision that would help to equip communities with the skills and resources that they need to

stem the tide of abuse. This has been a major focus of our Committee. Protecting seniors is a mark of a just society.

The Older Americans Act is a shining example of a Federal policy that works. Every $1 invested into the Older Americans Act generates $3 to help seniors stay at home through low-cost, community-based services.

At today's hearing, we will hear from Federal, State, and local administrators, as well as seniors, about how this bedrock system works and what opportunities exist to build on its strengths as we extend and improve this important law.

By enriching the lives of our seniors, the Older Americans Act improves the lives of all Americans.

I am now please to turn to our Ranking Member, Senator Casey, for his opening remarks.

OPENING STATEMENT OF SENATOR ROBERT P. CASEY, JR., RANKING MEMBER

Senator CASEY. Thank you, Chairman Collins, for holding this hearing on the reauthorization of the Older Americans Act.

As the Chairman mentioned, this hearing today will serve as an important step in congressional efforts to reauthorize this important legislation and the programs connected to it. I am pleased that the Aging Committee will be playing such an integral role in shaping this reauthorization.

The Older Americans Act reminds us who we are as a country. It represents our commitment to the generations who made us who we are today, and it lifts up the seniors who need our help the most. This act serves over 11 million Americans each year, including about 400,000 seniors throughout Pennsylvania.

That is why I am pleased that 34 Area Agencies on Aging, which represent about 60 percent of the counties in my home State, answered two questions for us recently. Number one, "How is the Older Americans Act currently working?" The second question we asked that they answered was, "How should this important law be strengthened?" We are grateful for that kind of feedback.

In every city and every town, the aging network said that there is no match for the high-quality services that senior centers and Area Agencies on Aging provide to older Pennsylvanians. The Older Americans Act programs support Pennsylvanians and their caregivers by providing meals, respite, and protection from fraud and abuse, and importantly, the Older Americans Act helps seniors age in the location of their choice, which, of course, is most often their homes and their communities.

Our witnesses today will echo much of the comments made by the Pennsylvania aging network. Yet we must always strive to improve as we always do in reauthorization.

It is for this reason that I am pleased that aging service providers in Pennsylvania also shared very concrete recommendations on how to make the Older Americans Act work better. They suggested that we do more to support grandparents raising grandchildren and improve programs designed to fight social isolation, and they said that we need to strengthen innovation to better show the worth of the Older Americans Act programming throughout the country.

We also need to do more to ensure that Area Agencies on Aging are prepared to meet seniors where they are—in their homes and communities, and they believe it is important that we invest in data collection to show how successful these services are at keeping seniors healthy and out of the hospital.

I am pleased we will have the opportunity today to learn more about the successes of the Older Americans Act and to hear recommendations for how the law can be improved. I look forward to continuing working with Chairman Collins, members of the Aging Committee, and members of the Health, Education, Labor, and Pensions Committee on this important reauthorization.

Thank you, Chairman Collins.

The CHAIRMAN. Thank you very much, Senator Casey.

We are now pleased to turn to our witnesses. On our first panel is Assistant Secretary for Aging, Lance Robertson. Secretary Robertson, I am very pleased to welcome you today.

As Assistant Secretary for Aging and the Administrator for the Administration for Community Living—that may be one of the longest titles in the Federal Government—Mr. Robertson spearheads the implementation of the Older Americans Act. Assistant Secretary Robertson's leadership in the field of aging began in Oklahoma, where he served for 10 years as the Director of Aging Services within the State's Department of Human Services. Prior to that he spent 12 years at Oklahoma State University where he co-founded the Gerontology Institute and served as the executive director of the Nation's largest regional gerontology association. Assistant Secretary Robertson, we are delighted to have you. Please proceed with your testimony.

STATEMENT OF LANCE ROBERTSON, ADMINISTRATOR AND ASSISTANT SECRETARY FOR AGING, ADMINISTRATION FOR COMMUNITY LIVING, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C.

Mr. ROBERTSON. Thank you, Chairman Collins.

Chairman Collins, Senator Casey, and members of this Committee, thank you for an opportunity to discuss with you today the Older Americans Act. I am honored to represent the HHS Administration for Community Living, which was created in 2012 around the fundamental principle that older adults and people with disabilities should be able to live where they choose, with the people they choose, and to fully participate in their communities. By funding services and supports and advancing research, education, and innovation, ACL helps make this principle a reality for millions of Americans.

For more than 50 years, the Older Americans Act has provided critical services that have enabled millions of older Americans to live independently, with dignity, in their homes and communities. Its programs are highly successful because they are flexible, they meet the unique needs of each State and community, and because they require the input of each individual served.

This work has never been more important. Every 7 seconds, one of America's 78 million Baby Boomers celebrates their 60th birthday. That is 10,000 people every day—the equivalent of a small town in America.

Now, I may be a rare breed because I have had the privilege of working in Older Americans Act programs at every level. Before I was appointed to this role, I led these programs for the State of Oklahoma, and I was also very involved in work at the local level in my 12 years at Oklahoma State University, so based on my experience, I believe the Older Americans Act is one of the Nation's greatest success stories.

The act has a limited Federal presence that establishes broad policies and guidance. It works in partnership with States, tribes, area agencies, volunteers, and service providers at the community level with appropriate flexibility to assess and respond to local needs based on the input of consumers. It is a model based not on Federal prescriptiveness, but instead on "bottom-up planning."

Our programs support some of life's most basic functions such as bathing and preparing meals. They also include transportation services, adult daycare, senior and wellness center activities, homemaker and chore services, to name a few. The programs address elder abuse and assist with the practical considerations such as home modifications. They also include services adapted to the unique needs of Native Americans.

They also support family caregivers who provide the majority of long-term support to older family members and without whom far more people would need care in institutional settings.

In 2017, the act provided services to over 11 million people—one out of every six older adults. In addition, it provided critical caregiver support, such as respite care, to over 716,000 people.

Given that Medicaid is the primary payer for nursing homes, supporting community-based options, which usually cost less, will continue to be an important tool in managing public and private expenditures.

However, the act did not create a stand-alone system, and it did not intend to cover all costs associated with serving older Americans. Rather, its funding is used strategically to advance changes in our overall system of care and to fill gaps in services. The aging services network has done an outstanding job in meeting this intent. As the Chairman mentioned, for every Federal dollar, these programs typically secure about $3 from other sources.

Now, the effective prevention role that our programs play is pivotal to one of Secretary Azar's top priorities, and that is, transforming health care to a value-based health care system—one that focuses on sustaining health to avoid the need to treat disease. Such a system will pay providers based on outcomes rather than on procedures performed. The goal is to lower costs while also improving outcomes for Americans.

Addressing these social determinants of health, which, of course, are factors that are not specifically about health but which have a direct impact on health and well-being, is critical to that goal. The social determinants include things like having enough nutritious food options, having a safe place to live, and having access to education, medical care, social support, and employment—the very things our network provides.

As you have been working on reauthorizing this important legislation, we have been pleased to provide information about the significance of its programs as well as technical assistance on par-

ticular policy proposals that are being considered. HHS has developed three proposals for your consideration which also enhance flexibility. We have made tremendous progress in advancing the goals and objectives of the act through the combined efforts of the aging services network. This network literally has built a foundation of this Nation's formal system of home and community-based care, and we have done it in partnership with older Americans and their families. I believe keeping the people we serve front and center is the best way to ensure continued success.

Thank you for this opportunity to participate in today's hearing. I have appreciated the Committee's support of the Older Americans Act and the national aging services network, and I look forward to our continued work together. I am happy to answer any questions.

The CHAIRMAN. Thank you very much, Mr. Secretary.

I want to take up where you just left off about the social determinants of an older person's health. Traditionally, improving the health of older adults has focused on the health care system. Are they getting to the doctor often enough? Are they being treated for diseases that they might have? But there is increasing recognition that improving health requires a broader, more holistic approach that addresses the social determinants of health.

Our Committee has had hearings on the effect of prolonged loneliness and isolation of seniors on their health, and the fact that one expert gave us that has stayed with me because it was so startling is that the impact of prolonged isolation on the senior's health was the equivalent of smoking 15 cigarettes a day. I mean, just think about that.

I think we do need to take a broader look at the picture. The World Health Organization defines these social determinants as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping conditions of daily life.

Could you address two questions? First, how does the Older Americans Act currently address the social determinants of health for older adults? And, second, what more should we be doing now that we have a broader understanding of how important those factors are?

Mr. ROBERTSON. Thank you, Madam Chairman. Chairman Collins, again, I cannot thank you enough for your support around the conversation of social determinants of health. You are absolutely right. When I think about the Older Americans Act and I think about all the programs that are offered through the Administration for Community Living, it is all about meeting people where they are at, really finding the lowest-cost and most preferred way of taking care of their needs.

When I think about some of the services, whether it is transportation or case management, certainly homemaker services and nutrition being the biggest service, all of that points toward a lower-cost, most preferred way of taking care of someone's needs and also combats social isolation, which, as you said, is really a growing conversation around better care for older Americans.

Again, I think to your first question, certainly the Older Americans Act I believe is framed around supporting social determinants of health, community-based services, making sure that those are

provided to Americans each and every day in communities all across our country.

I think to your second question, what more can be done, I think you kind of alluded to it at the beginning of your question. It is about better integration between the social services side of the conversation with the health care conversations that are happening.

I am really honored, of course, to be working for Secretary Azar. This is one of his four priorities, transforming that health care system. You know, he talks about how can we make sure that we are paying for value? How can we support health? How can we look at the lowest-cost settings? What can we do to avoid hospitals, nursing facility stays, readmissions, things that cost all of us a lot, both as taxpayers and as a Federal Government? That balance, as you just alluded to, Chairman Collins, is certainly evident, I think, to most all of us, and that is the future State must include much more advanced conversations around integrating, again, the social services aspects and the services that our networks offer each and every day with that higher cost health care conversation.

The CHAIRMAN. How difficult is it for an Area Agency on Aging, which frequently is administering these programs, to alter a program? For example, if there is someone who wants to participate in Meals on Wheels because they are homebound and yet may be above the income level, can they buy into the program? Or are there ways to have co-pays that may help more people who are struggling, cannot really afford someone to come in and cook for them, and yet may not qualify under the traditional criteria?

Mr. ROBERTSON. Chairman Collins, again, a great question. I think there is sort of a balance in answering that question because I think you are also sort of alluding to folks that are in the more formal acute-care cost system-—Medicaid, if you will—and, yes, there are qualifiers, financial eligibility, those sorts of things that may determine their access to particular services.

Within the Older Americans Act, if you take the nutrition example you just cited, there actually is no means testing, so anyone over 60 is eligible for a meal. I really have to give a shout-out because at the local service level with the AAAs and then the providers that we are honored to work with and support at ACL, they are really, I think, trying to think through how do you, to the extent that you can, make that service delivery the most affordable but also person-centered? Because I think in some instances, as you pointed out, there may be some people that need assistance beyond what may traditionally be provided, and again, I think for ACL, for the work that we are doing at HHS, we are about how do we continue to drive decisions that could be made more at a State and local level. It is about that flexibility.

It is silly for us to believe that one particular position on meal delivery that works in Maine may work in Pennsylvania or some other State across the country, so to the extent that we can, we certainly, as with the three proposals we have advanced on the Older Americans Act reauthorization, want to continue to push more State and local level decisionmaking control and flexibility.

The CHAIRMAN. I think you will hear, when you hear from Larry Gross, who runs the Southern Maine Area Agency on Aging, some really innovative ways, but I am unclear how difficult it is to get

permission to alter some of the programs, and we will explore that further, but I want to yield to my colleague.

Senator CASEY. Thank you, Chairman Collins.

Assistant Secretary Robertson, we are grateful you are here. Thanks for your work. We all know, as we have said several times now, that something on the order of 11 million people are served by this act every year. Whether it is meals or transportation or support for caregivers, it is a big deal for lots of Americans.

These same Americans who benefit from the Older Americans Act also, of course, are most often Medicare and Medicaid beneficiaries.

The services provided through the Older Americans Act that help people age in their homes and communities are also reducing spending in both Medicare and Medicaid by providing the supports to keep people healthy and out of the hospital, and Mr. Secretary, you made reference to that in your opening comments.

It is important we raise the capacity of the aging network to show the return on investment of the act and the programs in the act that provide this kind of support.

The first question I have is: What are the lessons learned, in your judgment, from the aging network's current partnerships with programs like Medicare Advantage, for example? Second, how can these lessons learned be translated into the fee-for-service and Medicaid space?

Mr. ROBERTSON. Thank you, Senator Casey, for that question. That certainly in my mind pushes us toward a conversation around business acumen, and I think within our networks—and I understand the history. Really the business acumen work we are involved in started with a public-private partnership and the SCAN and Hartford Foundations sort of funding that effort, which from there sort of blew up.

Your point is a great one. We have been investing now pretty heavily since 2012 at ACL in the area of business acumen. Obviously, the success of the Older Americans Act program is going to be driven by how well the local service provider can do its job, the level of business acumen they bring to those conversation, the sophistication with which they can partner and contract.

So you are absolutely right. It is one of my five pillars, Senator Casey, and certainly aligns with our support of the network pushing us toward really efficiency and effectiveness in all the work that we do.

We also, of course, work with our national organizations, some of whom are in the room today, to really help make sure we keep an accurate pulse on what those CBOs need. There are, as you know, thousands of them across the country that we are honored to support and work with.

When it comes to specifically some of the different payment models that they are exploring, we try to walk right alongside them, so at ACL we recently funded some States, some programs, actually, to do innovation work and payment models around Medicaid Advantage, so your reference to that-—or Medicare Advantage, so your reference to that is a very good one.

We, of course, want to continue to encourage partnerships, and then, most importantly, we want to share best practices. There are

some, you know, with States like Indiana and many others, that are doing some pretty innovative things around that CBO contracting work. Our goal is to really push out that information so that it is an encouragement and really an educational opportunity for other CBOs that are interested in taking that next step.

Senator CASEY. Thanks very much, and I am sure we can talk more about those lessons learned.

Assistant Secretary, I notice in some of the material we have that you have some organizational changes that you are proposing, the administration is proposing, and I am holding in my hand a document here from the Federal Register, which is scheduled to be published tomorrow, and it seems like rather substantial changes. I was surprised you did not make reference to it, but I wanted to ask you some questions about those changes.

In particular, I wanted to get a sense of the consultation that would undergird these kinds of changes. One organization I am curious about is the Consortium for Citizens with Disabilities, so-called by the acronym CCD, which, for the benefit of everyone here, is a coalition of 115 organizations representing individuals with disabilities, including the Arc of the United States, a major organization that we well familiar with, the American Association of People with Disabilities, and the National Council on Independent Living, so my question about this organization, CCD, is: Prior to your decision to undertake this reorganization, did you hold meetings with or consult with CCD?

Mr. ROBERTSON. Thank you, Senator Casey, and you are right. With an FRN announcement now available publicly, we are moving forward with some reorganization plans at ACL. I can reassure you and everyone that we are actually not eliminating any programs. We are not reducing staff. We are actually really just striving to be better in what we do and how we do it.

Of course, I think any organization, public or private, should regularly look at continuous quality improvement, and while there is never a good time, I know ACL is a very young operating division, just formed in 2012, so I believe this season really was our first opportunity to really take a good look at things and say, What can we do, again, in a way that is the most effective for future stays?

You are correct, sir, and I also recognize that change always creates anxiety, and that is probably the worst part of any of those conversations, is the initial anxiety that creates, but as we have been trying to do recently in messaging with folks, again, no program is going away. We are not reducing staff. Programmatically, nothing of significance will interrupt the core mission that each and every day we plan to fulfill.

Specifically to CCD, we are honored to meet pretty regularly with CCD, as we actually do with most stakeholder groups. In my 19 months here, I have met with over 350 different organizations, spoken at conferences, really tried to lean in, plug in, to just get public feedback about every possible way we can——

Senator CASEY. I just want to interrupt. I am just running out of time.

Mr. ROBERTSON. Yes, sir.

Senator CASEY. I just want to know, did you meet with or consult with CCD about these organizational changes?

Mr. ROBERTSON. Thank you, sir. Fair question. Just to be honest, I have to tell you when it comes to restructuring, reorganization conversations, we are not actually permitted to get into that level of detail prior to the package being approved through the formal process.

Senator CASEY. The answer to my question is no. I take it that is a no.

Mr. ROBERTSON. That is correct, sir.

Senator CASEY. Okay. The last one—and I know I am over time, Madam Chairwoman. I just want to ask about another group. The Leadership Council on Aging Organization, so-called LCAO, is a member organization of 70 groups representing aging networks, including AARP, the National Association of Area Agencies on Aging, the National Council on Aging. Did you meet with or consult with them prior to this change, proposed change?

Mr. ROBERTSON. Thank you, Senator. Again, just to be short in answering your question, specific to reorganization proposals, no, sir.

Senator CASEY. Okay.

Mr. ROBERTSON. Have we, of course, over the years been involved in dialogs about better ways of serving their needs and making them be supported and successful? Absolutely.

Senator CASEY. Thanks. I might have a followup, but thanks for the extra time.

The CHAIRMAN. Thank you.

Senator ROSEN. Thank you. Thank you, Madam Chair and Ranking Member Casey, for bringing such an important hearing to us.

The Older Americans Act is so very important to us all, and as a person who was a caregiver for my parents and in-laws for many years, a lot of these issues I have experienced firsthand, as well as so many of my friends.

Earlier this year, I visited the William Pennington Life Center in Fallon, Nevada. It is a rural senior center, serves over 70,000 meals in their congregant dining room. Now, mind you, we only have 3 million people in the State of Nevada. Northern Nevada is not the central population of our State, so 70,000 meals is a big deal. They deliver meals to over 200 homebound seniors each year.

Last year, I was able to join our Meals on Wheels volunteers in Boulder City, southern Nevada by Hoover Dam, and my own mother, when she became homebound due to illness, received Meals on Wheels herself.

I know that I have seen firsthand what community groups are delivering meals to frail seniors and the services that the OAA provides are nothing short of spectacular, life-changing in so many ways. My mother, I would say, "You do not need those meals." She goes, "No. I want someone to feed me besides you and come over and visit." And so it was a conversation for other people and talking about other things. I say it as a joke now. She is no longer with us, but it was really important to her to have that.

Two home meal delivery programs in Nevada have reported wait lists, the city of Henderson, Catholic Charities, and there are more than 60 eligible individuals who have to be put on a wait list, and throughout Nevada, nearly 600 older adults are on wait lists, and so it is my understanding that we have enough volunteers to de-

liver the food and do all of that. What we do not have is the actual food, and seniors are going hungry.

Secretary Robertson, we know an increase in funding is your principal recommendation for addressing these wait lists. Do you have other additional suggestions that maybe we can take here?

Mr. ROBERTSON. Absolutely. Thank you, Senator, and you are absolutely right. The real bedrock program within the Older Americans Act is a nutrition program, and like you, I have had many professional and personal experiences where it just reinforces for me that that is so much more than a meal.

Senator ROSEN. Right.

Mr. ROBERTSON. It is the ability to really do a wellness check and to engage older adults, so you are absolutely correct. We actually are funding innovation grants on the meals side to really help drive conversations around what can we do to make sure that that service is as efficient and as effective as it can be. I did bring a couple of examples of some innovation work that is happening around the meal program, and——

Senator ROSEN. Does this help our rural communities as well? Because we have the urban area, of course, in southern Nevada, Las Vegas, but when you drive across northern Nevada and around rural Nevada, the distances are vast.

Mr. ROBERTSON. Absolutely.

Senator ROSEN. It is difficult, so they face some challenges in rural communities as well.

Mr. ROBERTSON. You are right, Senator. You know, food insecurity exists everywhere, even in urban settings, but undoubtedly, where conversations are the toughest is rural service delivery. How do you make sure that those cost variables balance out for those CBOs, and many of whom, as Senator Casey was really referencing, that critical CBO network and how frail some are in terms of fiscal resources, how do they continue to serve people in rural parts of America?

You know, some of the options, for instance, I was briefed on a situation in Texas where they are doing weekly deliveries, which, again, is not the most preferred option, but it is an efficient way of making sure seniors get food.

Senator ROSEN. They are getting food. At least they have the food.

Mr. ROBERTSON. That is important. We also were talking about in Missouri AAAs that are using kind of some technology options to partner with local providers on making sure that more——

Senator ROSEN. Are you spreading the word amongst organizations to let them know that people are trying different things?

Mr. ROBERTSON. Yes, ma'am, absolutely. As a matter of fact, even if they are programs that we do not fund, we try to amplify and share that message across the country, because I think that struggle is common in every State. Most every State has that same rural challenge, and I guess a bigger challenge are a few States that face frontier issues where the distance is so enormous that it is almost an impractical feat.

Senator ROSEN. Right, very, very difficult.

Mr. ROBERTSON. Absolutely, we do all we can to share that information through just the public marketing work that we do and how we push that message out.

Senator ROSEN. Thank you. I have one other question. It is my understanding on the ground from people in Nevada that greater coordination between Federal agencies such as HUD and the OAA programs, we could really work together. You talk about amplifying and producing better results, and so tell me what silos you see between Federal agencies and what suggestions you might have for us to make things better for seniors, especially affordable housing. We have lots of issues besides food insecurity, so that would be hot, and the OAA perhaps.

Mr. ROBERTSON. You are absolutely right, Senator. I think there are a lot of opportunities that still exist for Federal coordination. I will tell you, and this is my own personal claim, but I think we are a collaborating machine at ACL. We are always looking for ways that we can partner with other Federal agencies, both within HHS as a big Federal agency and across the Federal Government, so you know, we are doing things. When we talk about meals with USDA, certainly housing with HUD, some of those conversations. I would draw as a couple quick examples, though, where——

Senator ROSEN. Do you have suggestions of how we can help you create those—or do we need to help you in some ways create those partnerships?

Mr. ROBERTSON. Rather than prescribing it, I just love to hear that you would continue to encourage it, resting assured that we are all about that, and, you know, again, a couple quick examples. I know when it comes to elder justice, one of Chairman Collins' priorities, it really is a good day when we have the Elder Justice Council, which we chair, 14 Federal agencies that are all at the table really talking about what we can do to move the needle in that area. I also think about the work we do with veterans on the VA side and how that crosses over so many of these conversations.

I would just say, Senator, that, you know, rest assured we are going to walk right alongside you in championing really the message of collaborating and working together, leveraging resources and being more innovative in how services are delivered. I would not have any prescriptive recommendations at this point, but, again, maybe for QFRs or some way to followup, if there was something specific you were looking for.

Senator ROSEN. I think it is important that we get it right. I appreciate the hearing because none of us are getting any younger, so I would like to get it right before maybe we need it.

Mr. ROBERTSON. Absolutely.

Senator ROSEN. Don't we all have some skin in the game in this one, that is for sure.

Mr. ROBERTSON. Absolutely.

Senator ROSEN. Thank you.

The CHAIRMAN. Thank you, Senator.

Mr. Secretary, in the last Congress, we passed the RAISE Family Caregivers Act, which I co-authored with Senator Baldwin. Now, I know that the National Family Caregivers Support Program has existed for nearly 20 years, but the RAISE Family Caregivers Act comes directly out of hearings that we have had, and it would cre-

ate a new council. I am a little disappointed that it has not been set up yet. Can you give us some idea of when you expect that to happen?

Mr. ROBERTSON. Chairman Collins, I am very happy to give you an update and to reassure you that throughout the last 6 months or so, we have worked as expeditiously as possible to get this up and running. We anticipate the first meeting happening of that council this summer.

What I learned was how laborious a process it is to kind of get these things stood up, so I am proud to say, though, that at every juncture, as we kind of walked through that process, we really were able to shrink timelines and push things through.

I want to thank, of course, you and Senator Baldwin for championing the conversation and Congress for providing that authority in the appropriations. We again have been working through that process. I was also pleased to see that we had hundreds of nominations, folks that were willing to raise their hand and say, "Yes, I would like to be a part of the RAISE or the SGRG Committee."

We are in the process now of having now sent out the invites for the people to serve, and we are getting their responses back. They then go through that final vetting for financials and all that sort of thing, but that is why I do believe this summer we are on track to have that first meeting. We have had a meeting with our internal Federal partners to make sure that everybody is on the same page. We have got our services contract aligned, so I hope to use that here very soon, we will get off and running. As you well know, those support the key things that we do at ACL. It is about supporting caregivers. It is one of my pillars, and it has absolutely from day one remained a priority. I want to thank Senator Casey and so many others that just kept encouraging and saying let us get this done. I just wanted to reassure you it is a priority, and we are doing all that we can to push that across the finish line and get those committees stood up. Like you, we are excited to see what feedback we get and how we can advance the conversation in America around caregivers.

The CHAIRMAN. I am very glad to hear that. In the State of Maine, for example, in the past, I believe, 5 years, we have seen a 24-percent increase in the number of grandparents who are taking care of their grandchildren due, sadly, to the opioid and heroin epidemic that is gripping our State, and they have very different needs from other kinds of caregivers.

We also are seeing people who have been diagnosed with early onset Alzheimer's disease, and the burden and difficulty for their spouse or other child is also great.

There are so many, but the final category that I will mention where we have worked very closely with former Senator Elizabeth Dole is military caregivers, and a lot of these families are going to be in the caregiving for a wounded warrior for decades.

Mr. ROBERTSON. Absolutely.

The CHAIRMAN. It is not just going to be the last few years, so I think the caregiving picture in the United States has really changed, and that is why we are very eager to get this set up and be able to identify best practices, for example.

Let me just ask one final question, and that is on elder abuse, neglect, and exploitation. That is a principal objective—preventing exploitation is a principal objective of the Older Americans Act. It is right there in Title I where the other objectives are listed, and yet our work on this Committee has found that we are having a real epidemic in elder abuse as well. The GAO estimates that seniors lose $3 billion a year to unscrupulous individuals, to scams, and I think that is the tip of the iceberg.

Mr. ROBERTSON. I agree.

The CHAIRMAN. I think the problem is far bigger than that, because particularly when it involves a family member, the senior is very reluctant to report.

Just last month in Maine, a securities agent was sentenced to 10 years in prison for defrauding two older widows out of more than $3 million. That was one of the worst cases of financial abuse that we have had, and in that case, fortunately, the perpetrator was caught and brought to justice, but in most cases, we know that does not happen. In fact, the estimate is that only one out of every 25 cases is ever reported.

What more through the Older Americans Act—and I know about the Elder Justice Council, but what more can we do to raise awareness so that seniors do not fall victim to these relentless scams?

Mr. ROBERTSON. You are right, Chairman Collins. It is so heartbreaking to hear so many stories about abuse and exploitation, even neglect that occurs and how we should be a country free from that worry. People should not wake up in the morning and wonder, "Am I going to be abused, exploited, or neglected today?"

You absolutely hit upon one of my pillars. Again, at ACL, I have five elder justice, elder abuses. One, we are certainly proud of the work again we are doing with the Elder Justice Coordinating Council, which I have to point out the enormity of all 14 agencies leaning in on this is unprecedented. We have added a couple. We added USDA and also Bureau of Indian Affairs, so we have a really comprehensive conversation happening around all angles. You are right, though. The data is scary. The direction that the trend line is going still does not make us happy at all, but I think we are really starting to see some return on a lot of the investment programmatically that we are putting into the work around this space.

You know, the Older Americans Act, of course, calls out the Ombudsman Program. We also, of course, are very honored to be working as the Federal agency that helps fund Adult Protective Services. I think really that answer is kind of an all-in agreement that we have got to make this a priority. Does it involve funding? Sure, absolutely. I think in just leaving a conference this morning where I talked about this topic, I also think part of how we eradicate elder justice is to make it a personal issue and to really begin to make sure that household by household we do what we can to make sure that people are aware when they see or sense that something is happening afoul, that they report that.

You are right. It is difficult because so many perpetrators are family members, so it is a matter really of making it a human rights, a human dignity sort of conversation to say that sort of behavior cannot be tolerated. We as the Federal Government and

Federal programs are ready to aid families all across the country in addressing that.

The CHAIRMAN. Thank you.

Senator CASEY. Thank you, Chairman Collins. For the record, I wanted to put two concerns on the record in light of my last question.

Mr. ROBERTSON. Yes, sir.

Senator CASEY. I just have one question/request. The two concerns—and these concerns we may add to them as we go further into the detail of this reorganization, but one is—and I will just state it as a concern, and we can talk about it later, but one is: What happens to regional offices? That is something I would want to know more about.

Mr. ROBERTSON. Yes, sir.

Senator CASEY. Then also there is among many administrations, as you know, in an organization like this, right now we have the Administration on Intellectual and Developmental Disabilities. I am told or as I can read here in the proposal that that would be renamed to an office as opposed to an administration. I am concerned that that is a downgrade. That is something we can walk through.

Here is my question or my request. Would you meet with me and the members of my office that work on these issues very soon, in the next week or two, if that is possible?

Mr. ROBERTSON. Senator, we would be happy to sit down with members of your team and talk through some of these changes. I am happy to address both of those that you just referenced specifically and even beyond that should you have any other questions, sir.

Senator CASEY. Thanks very much.

Mr. ROBERTSON. Absolutely.

The CHAIRMAN. Thank you, Senator.

Senator HAWLEY. Thank you, Madam Chair, and thank you for calling this important hearing.

I want to start by doing a little bit of bragging on the Area Aging Agencies in Missouri whom I am awfully proud of and just put in the record some of the great work that they have been doing. Last year, they delivered almost 6 million meals to seniors across my State and served over 2 million congregate meals. They have also provided over 30,000 seniors with information and assistance services, given over 15,000 seniors transportation to medical appointments or errands, and helped to involve 7,000 of our elders in recreation programs, and these Area Aging Agencies, backed, of course, by OAA resources, are really an essential part of our community fabric in Missouri, and I am very, very grateful for their hard work.

Let me just mention one other thing, the exciting innovations happening in Missouri. In west-central Missouri, which is where I grew up, a Care Connection for Aging Services, based in Warrensburg, has been providing services in 13 rural counties for 45 years, and they recently pioneered a program called "Seniors Fit and Fun," which I think is great. It was recognized with an Aging Achievement Award by the National Association of Area Agencies on Aging, and this activity, what they did is they used a fair con-

cept with vendors leading interactive health activities for those who attended rather than just setting up tables, and also educated seniors on Medicare preventative care benefits. It has been a very effective way to improve health by encouraging seniors to stay active. It has been a big hit, and, again, I am very proud of all the work that they are doing.

With that, Mr. Secretary, let me ask you this: I was hoping that you might elaborate on the point that you make in your written testimony about value-based care and how OAA programs can help address the social determinants and components of health. What part do you think does OAA play in helping us move to a value-based system?, and how are you incorporating aging networks into the overall health care system to achieve value-based care?

Mr. ROBERTSON. Well, thank you, Senator, and thank you for bragging on your Missouri programs. I think that is wonderful. You probably have some listeners whose chests are sticking out right now. That is great.

We did have a slightly earlier conversation around, again, just the value of this conversation for social determinants and how we are overdue as a country to talk through what does it mean to really better integrate the social services side of all these services that are offered to Americans throughout every community into that higher-cost health care conversation, so it is one of Secretary Azar's four priorities about transforming health care, and really in some of his more recent conversation, he has talked about, hey, we need to better use the aging and disability networks, because the social determinants work they do, as we all know, often can fend off higher costs, and when we think about one example after another, you know, a $4.50 meal can sometimes keep a person out of a nursing home, or a very low cost home modification can really, again, enable someone to stay in their community, so all those things have tremendous value.

Like you, I am very proud of our network. All across the country, we have nearly 22,000 CBOs who are working every day to sort of continually get better at what they do. In some cases, they are expanding into more of that health care space and doing some really creative things around payment models. That is not something yet we have prescribed or necessarily offered directly at the Federal level, although I am really proud of the conversations we are having with CMS, because the key driver behind a lot of that is going to be Medicare and Medicaid, and some of the innovations that they are interested in, the conversations they are having, and I am just convinced that our network is primed and ready to really take that next step and to really begin to better appreciate payment models of how those lower costs in the setting that we all prefer, how those services delivered can really, again, hold off higher costs that Americans, as all of us managing budgets, would be appreciative of.

Senator HAWLEY. Thank you very much.

Thank you, Madam Chair.

The CHAIRMAN. Thank you, Senator.

Thank you very much, Mr. Secretary. We look forward to working further with you as we put together the reauthorization and

hope that we can count on your office for technical assistance as well as for policy guidance.

Mr. ROBERTSON. Absolutely. Thank you, Chairman Collins. Thank you.

The CHAIRMAN. Thank you.

I would now like to turn to our second panel of witnesses, and while I am giving them a moment to get settled, I will introduce them.

Our first witness on the second panel is Richard Prudom, the secretary of the Department of Elder Affairs in Florida. The secretary has served with this department since 2011 and in various roles in the government of Florida for more than 30 years, so he brings a wealth of information to us.

I am particularly pleased that our second witness is Laurence Gross, the chief executive officer of the Southern Maine Agency on Aging. Mr. Gross has been with the Southern Maine Agency on Aging for 41 years, all but the first 5 years of its existence. During his tenure he has championed efforts to address social isolation among our seniors and to pursue innovations to expand the reach of core programs, so we are delighted to have you with us today.

Finally, I will turn to our Ranking Member to introduce our witness from the Commonwealth of Pennsylvania.

Senator CASEY. Thanks, Chairman Collins. I am pleased to introduce Faith Lewis from Simpson, Pennsylvania. We live in the same region, and Faith and I were together recently talking about many of these issues.

Faith is a mother, a grandmother, and, it is hard to believe, a great grandmother. We do not have many great-grandmothers testify in front of the Senate, so this might be a first, so Faith, we are grateful you made the trip here to do this and to tell us what we need to know about a lot of these issues that you confront every day.

Faith is a caregiver for her 5-year-old great-granddaughter, Xziylan—is that how you pronounce it? I want to make sure I did that right, and Faith's sister, Lois, and Xziylan made the trip from northeastern Pennsylvania to be here today and, I am told, are watching today's hearing on television, so we want to say hello to both of them and thank them for being here and coming all the way to Washington.

Faith is one of 11 million people who benefit from the Older Americans Act each year. She attends a grandparents support group at her local Area Agency on Aging, and she also receives resources through the National Family Caregiver Support Program to help with some of the costs of caring for her great-granddaughter, who is watching her on television now, so Faith, thank you for being with us today. We look forward to your testimony.

The CHAIRMAN. Thank you very much, and we will start with Secretary Prudom.

STATEMENT OF RICHARD PRUDOM, SECRETARY, DEPARTMENT OF ELDER AFFAIRS, TALLAHASSEE, FLORIDA

Mr. PRUDOM. Chair Collins, Senator Casey, members of the Committee, thank you for the opportunity to be here today to discuss

the importance of the Older Americans Act and what we are doing in Florida to meet the needs of our growing senior population.

I was honored to be recently appointed Secretary by Governor Ron DeSantis. The Governor has taken bold actions and shown great leadership on issues affecting Florida seniors, including Alzheimer's disease and related dementias and also making Florida an age-friendly State. The Governor has charged me with working to improve the lives of older Floridians—a responsibility I do not take lightly—and it is my pleasure to work with him in service to our 5.5 million seniors.

The Department of Elder Affairs serves as the State Unit on Aging for Florida and oversees more than $330 million in State and Federal funding, including more than $112 million in funding from the Older Americans Act. We partner with 11 Area Agencies on Aging, over 50 lead agencies, and many direct service providers across Florida to keep seniors in their own homes and communities as they age. It is our mission to keep our older residents healthy, safe, and independent for as long as possible.

Florida has the highest population percentage of 65-plus in the Nation. In fact, our senior population of 5.5 million outnumbers the senior populations of 20 other States combined. In the next decade, this senior population will increase by more than 38 percent to 7.6 million.

There are challenges in promoting the health and well-being of this growing and increasingly diverse older adult population. Population aging, especially when the Baby Boomers reach ages 85 and older, signals a likely surge in the use of long-term-care services, so clearly, Florida's aging network is tasked with an important challenge: to ensure that we are meeting and will continue to meet the needs of our frail elders.

The major focus of our programs is to provide home and community-based services as an intervention for those elders who are at risk of being placed into a long-term-care facility because of their degree of frailty. As the Older Americans Act is a primary mechanism for these services, it should be considered the foundation for this aging-in-place concept, which is not only preferred by older Floridians, but the higher costs associated with nursing home placement are avoided.

For the last fiscal year, Florida received nearly $106 million in OAA Title III funds and served approximately 200,000 clients throughout the State. The OAA services most utilized by Florida's seniors and their caregivers were transportation, meals, medication management assistance, and respite for caregivers.

Before I highlight a couple of these programs, I do want to stress to the Committee that we do not take these funds for granted, recognizing they are provided by taxpayers and are essential to the overall health of Florida families. We consider the funding an investment in the future of Florida, being ever mindful of both the societal and economic returns on that investment.

We consistently seek innovative ways to deliver services and explore additional funding sources to supplement and complement those services. Many of these are fully highlighted in my written statement.

In the last fiscal year, we provided nearly 11 million meals in Florida, and more than half—over or 6.3 million—were served through OAA. As we have heard today already, a meal is more than just a meal to those who receive it. Home-delivered and congregate meals are also an opportunity for socialization and engagement, which helps combat another critical issue facing our elders: loneliness and social isolation.

Medication management is a highly utilized OAA service in Florida, and, Chairman, you mentioned about the opioid crisis, and, obviously, this is something in line with that. Studies show that the inappropriate management of medication has been proven to be one of the highest indicators of nursing home placement, so this 3D program is essentially helping us to achieve our goals of help seniors age in place.

In the last fiscal year, Florida received nearly $15 million in funding for caregiver support, serving more than 91,000 family caregivers. Respite is one of the most important services offered because it is vital that our caregivers are healthy and can continue to provide care. Many caregivers face burnout, illness, exhaustion, and financial distress, so it is crucial that we support their well-being and health.

The Older Americans Act also provides more than $1.6 million to help fund the Ombudsman Program, which Secretary Robertson alluded to earlier on. It is a statewide volunteer-based program that works to protect, defend, and advocate on behalf of those living in long-term-care facilities. It also helps fund our abuse prevention coordinators through whom we educate the public on preventing abuse, neglect, and exploitation as well as on how to report abuse.

Before I close, I would like to give you an example of a recent innovation that we introduced. Last August, in consultation with the ACL, we initiated a Disaster Recovery Reserve, a DRR, which obligates the State's 11 AAAs to designate a predetermined amount of Older Americans Act funds to serve elders affected by a disaster. It is important to note that the DRR funds would not be used if a disaster did not occur.

In October 2018, Hurricane Michael hit the Florida Panhandle as a Category 5 hurricane. The DRR innovation allowed us to transfer designated funds to AAAs that housed those affected counties, thereby providing additional services to older adults after the storm. We are repeating the DRR this year as well and obviously hope that we do not have to use them. I shared this innovation with my counterparts from 13 other States at the ACL meeting in Atlanta last week.

As I said at the beginning of my testimony, there are challenges in promoting the health and well-being of Florida's growing and increasingly diverse older population, but I share Governor DeSantis' vision for Florida to be a place where seniors are not just living but living well. An aging population is an opportunity to use our social and technological ingenuity to develop solutions to our changing needs that can move us all forward. The Older Americans Act is essential to our ability to meet those challenges; in that regard, it is the major vehicle we use in Florida to support and protect Floridians as they age in place—helping, among other things, to improve senior nutrition, support family caregivers, advance elder

justice, and helping older adults to age well in their communities. These are all essential pieces that enable current and future seniors to live and live well, which is our ultimate goal in Florida.

Thank you, and I am available to answer any questions.

The CHAIRMAN. Thank you very much.

Mr. Gross.

STATEMENT OF LAURENCE W. GROSS, CHIEF EXECUTIVE OFFICER, SOUTHERN MAINE AGENCY ON AGING, SCARBOROUGH, MAINE

Mr. GROSS. Senator Collins, Senator Casey, members of the Special Committee on Aging, I am Laurence Gross. For 41 years, it has been my honor to serve older adults at Southern Maine Agency on Aging, the past 36 years as chief executive officer. Our service area includes Maine's largest city and one-third of the State's elder population living in 2,000 square miles of suburban and isolated rural settings. SMAA staff and volunteers touch the lives of more than 20,000 people annually. I want to thank Senator Collins for inviting me to speak with you today.

During my tenure at SMAA, I have seen the Older Americans Act evolve to become a solid foundation for the future of aging services in this Nation. Today I will share my experience as a veteran on the front line of the act's evolution in the "oldest" State in the Nation.

Maine is the "canary in the coal mine" when it comes to the field of aging in America. Of necessity, Maine has built a national reputation as a laboratory for innovation, testing, and proving policies and practices that will serve our country well in the decades to come. I am proud of the many national awards SMAA has received in recognition of our contributions to Maine's legacy, most recently as the first recipient of the Business Innovation Award from the John A. Hartford Foundation.

SMAA offers the core of OAA services: home-delivered and community-based meals; information and assistance; family caregiver support, training, and respite; Medicare counseling; fraud prevention; and health promotion activities. We operate a day center for adults with dementia, the Sam L. Cohen Center, where I was delighted to host Senator Collins after it opened in 2016. Our 600-plus volunteers provide invaluable human capital resource: nearly 4,000 hours of program services annually.

Senior nutrition programs are a hallmark of the OAA. However, by the early 2000's our traditional congregate dining model was languishing. Flat funding, rising inflation, and demographic shifts of interest had reduced participation and increased operating costs. Our clientele was "aging out" to home-delivered meals. In response, we made the strategic decision to replace our legacy delivery design with a voucher model. We called the program "As You Like It." Initially set in a hospital cafeteria, As You Like It offered our diners menu choices in an attractive multigenerational setting that was open 7 days a week. The program was an instant hit. We soon expanded to other local hospital and college cafeterias and eventually to a network of small restaurants.

In its first 5 years, As You Like It grew our congregate program by 55 percent and increased the number of diners from rural areas

by 61 percent while increasing the number of people and meals served per dollar of funding.

SMAA then restructured our home-delivered meals program to increase its relevance to the changing needs of our clients. We introduced flash-frozen meals, a dramatic transformation. Flash freezing greatly increased the nutritional density and quality of our meals, reduced waste, and changed our meal delivery paradigm to allow evening and weekend meals. We now offer a variety of menu choices: vegetarian, gluten-free, pureed, renal, and traditional comfort foods every day, very different from the one-size-fits-all single item menus of the past. Consumers loved the change because it offered them choice and convenience. A serendipitous benefit was the ability of our meal delivery volunteers to conduct informal wellness checks and spend more time with clients for whom they were often the only visitor of the day.

Using the updated menu and delivery options, we rebranded our home-delivered offerings as "Simply Delivered Meals" and conducted a pilot study within a 4-year Medicare demonstration designed to reduce hospital readmission rates of high-risk patients. We provided a week of Simply Delivered Meals to patients when they left the hospital and documented a 38-percent reduction in readmission rates and a 387-percent return on investment from avoided readmissions. Our results were peer-reviewed and published in the American Journal of Managed Care in 2018.

These two examples show how the Older Americans Act can become a new platform for addressing what medicine calls the "social determinants of health." Poor nutrition, lifestyle choices, limited access to safe funding and isolation, exacerbate most chronic health conditions, but are nearly impossible for the medical community to influence alone. Area Agencies on Aging are ready to help.

As SMAA has shown, a nimble and innovative AAA can make a quantifiable difference in both quality of life and cost of care.

I conclude with several recommendations to modernize the Older Americans Act, really strengthen the Older Americans Act:•First, I would encourage you to explicitly encourage State and Agencies on Aging to leverage Older Americans Act funds through private-pay and contractual relationships with health care;•Second, modify the act to increase the value in adding cost-and revenue-sharing options beyond individual client donations; and•Third, increase funding. Older Americans Act funding has woefully lagged growth in the aging population. At SMAA, after inflation, we receive less Older Americans Act funding today than we did in 2010. Please increase funding to a level that restores the service capacity we have lost in the past decade. Then index authorizations to keep up with the growth of the older population and inflation.

In 3 months, I will be retiring from my position at the Southern Maine Agency on Aging. I have had a fulfilling career with many unique opportunities and satisfying achievements thanks to the Older Americans Act. Testifying to this Committee and sharing my insights with you is a wonderful capstone. Thank you very much.

The CHAIRMAN. Thank you very much for all those years of service. I can somehow envision you as going from your paid position now to being a volunteer delivering some of those meals.

Mr. GROSS. That might just happen.

The CHAIRMAN. Ms. Lewis, welcome.

STATEMENT OF FAITH LEWIS,
GREAT-GRANDPARENT, SIMPSON, PENNSYLVANIA

Ms. LEWIS. Chairman Collins and Mr. Casey, I want thank you for inviting me today on behalf of the grandparents raising their grandchildren across the country.

I am currently caring for a 5-year-old. Her name is Xziylan, and she is quite the child. She loves to run, and, you know, a 5-year-old is no small defeat, but she is a good kid. She loves to eat. She is a fruit eater. She is a vegetable eater, and when we go shopping, I let her pick out the stuff that she wants, and her favorite is watermelon. I never knew a kid that liked watermelon so much. She loves to go to the park, and for Christmas she got her bike, so she cannot wait for the really nice weather to come so she is able to go outside and do what she wants to do—play—well, of course, with help.

It is important to me that Xziylan is a happy child. Xziylan's mom has been in prison on drug-related charges for the past 3 years, and if I did not step up to help, my daughter, Xziylan's grandmother, would have taken her, and she has two already of her daughter's children, and it would be very hard for her to take care of three, so my son helps a little bit, my neighbor, and yes, my sister, Lois, she helps me, too.

I have strong support. It is very important. Every couple weeks I go out to dance, an old great-grandma out there dancing. I go to Wilkes-Barre with my friends, and we just—I am not a drinker, so we go out just to dance and have a little fun and laugh and joke around.

I rely on my Social Security check to make ends meet. Some months are harder than others, but, you know, I have been watching children since I was 13 years old, when my Mom died, so I figure out how much really what to spend. I used to go shopping, too, for her. I get $35 each month in food stamps, but with a kid who likes to eat such healthy food, it does not stretch very far. Sometimes I go to the food pantry in St. Rose in Carbondale. Sometimes, you know, that helps. I bought a new car, but I do drive Xziylan back and forth to school, and with the cost of the car, and our housing is $500, the insurance is expensive, I have insurance, and I do buy her some clothing when needed. She is starting to grow. She went from a binky to a little girl.

Last year, I joined a grandparents support group called "Parents a Second Time." It is run by the Lackawanna County Area Agency on Aging. It meets regularly, and if the support group did not exist, I would not have anyone to talk to who would understand what is the meaning of caring for a child in the golden years. The issue that we discuss most often is the financial strain of raising our grandchildren.

The National Family Caregiver Support Program helps because I get reimbursed some of the costs of raising Xziylan. It helps me afford clothing that fits her, and she is growing. Next year, she is going to go to kindergarten, so I will have to buy her uniforms, and it helps me pay for a membership to the YMCA for the activities

that she wants to go to. They will reimburse me when I go, and they are helping me with the YMCA.

I think it would be good if more grandparents raising grandchildren would be served through the program. Every little bit helps, and on behalf of the grandparents who cannot get the help like I can, I would like to thank Senator Casey and Senator Collins for trying to help make sure that more grandparents raising grandchildren can participate in the program.

My grandchild is not the only person who got caught up in the opioid crisis. There are many more, and even more people who are unable to care for their children because of sickness or accidents. Grandparents and even great-grandparents like me are the next line of support. I hope that the National Family Caregiver Support Program will be able to help all older caregivers, and I hope that you continue to improve all of the programs funded by the Older Americans Act so that my Area Agency on Aging will continue to be around for me and my family.

Again, Chairman Collins and Mr. Casey, thank you for the opportunity to testify before the Committee, and I look forward to answering any questions.

The CHAIRMAN. Thank you very much, and how fortunate your little great-granddaughter is that you were able to step up and take care of her and raise her. I think it is wonderful that you do so, but also it is really saintly of you to do so. She is a lucky little girl. Thank you.

Mr. Gross, let me start my questions with you. First, I am so impressed with the innovations that you came up with, the As You Like It program, which gave the opportunity for seniors to have more choice and also addresses the isolation problem by bringing them out of their homes, and yet rather than having one set meal at a congregate eating place, they are going to even restaurants, so I love also the choice and convenience of your Simply Delivered Foods program.

Let me ask you, was it difficult to get—did you have to get permission to establish these programs from the Federal Government? Or is there flexibility in the law? Or did you just go ahead and do it?

Mr. GROSS. Thank you, Senator Collins, for that question. Let me say I live in the gray area, and I sort of do not ask for permission but maybe beg forgiveness as an operating approach, and so if the law provides an opportunity to provide a straight answer or answer the question with a straight face, I will make an effort to try to bend the rules, so yes, we just went ahead and did it.

I will say that we initially did get some pushback from the regional office of the Administration on Aging at that time, even though the concept of the Simply Delivered program and the As You Like It program was built into the long-range plan of the Older Americans Act of increasing more meals served per million dollars of Older Americans Act funding, so we just went ahead and did it, and we got some pushback. We had to defend ourselves a little bit about not discriminating against rural communities and that type of thing, but the data that we collected documented that the program was actually what people were looking for, and we were able to make it available to them.

The CHAIRMAN. That is overwhelmingly the case from the statistics that you have given us, and you are treating seniors as they want to be treated, and I think what you are doing is wonderful, and I want to make sure as we put in the reauthorization bill that we specifically provide the kind of flexibility so that you can pursue those kinds of alternatives to better serve your clientele, and I just think both of those programs are really terrific.

I am impressed by the data that you provided us showing that the Simply Delivered Meals given to patients upon discharge from a hospital reduced hospital readmissions by more than a third. That is truly extraordinary. Could you describe on an individual level what impact this had not only in keeping a patient from being readmitted to the hospital but on their lives?

Mr. GROSS. Yes, thank you again, Senator Collins. What we heard from people, particularly around the Simply Delivered Meals program, were a couple things. One, people went to the hospital, did not expect to come home and find their food in the refrigerator was no longer edible. We heard from caregivers comments like, "I never realized how much trouble it was going to be to take care of my spouse when I went home." "The meals were such a wonderful relief for me. It was one less thing that I had to keep track of, one less thing that I had to do when I brought my family member home."

Those are the kinds of comments that we saw that were really unexpected but really point to the quality-of-life considerations in addition to the cost savings that come from reducing readmissions.

The CHAIRMAN. My final question for you has to do with the issue of co-pays. I did not word my question as well as I should have with the Assistant Secretary, but, in fact, haven't you implemented some cost-sharing programs that allow individuals who are on the waiting list to be able to purchase your foods until they qualify because of coming up on the waiting list?

Mr. GROSS. Yes, that is what we did do. We basically offered our Simply Delivered Meals as an alternative to the traditional home-delivered program but for people who can afford to pay them, and so by allowing them to pay privately, they can sort of receive meals, as you said, until their name comes to the top of the list. That is another area that may be a little bit gray in the Older Americans Act under past—it depends on who is in the State Unit on Aging, but in the past, there has been concerns about mixing private-pay dollars in a donation-only program, and there were some prohibitions about using—leveraging your Older Americans Act funds with those private-pay dollars.

We found that, again, we are kind of forced into the corner. We have 250 people on our waiting list right now, and when we take them off, we find that many have gone to higher levels of care or in cases died before we could get to them. They had been on the list since January of this year, so this is one way that we can at least make it available for some people to get off and get nutrition they need.

The CHAIRMAN. That makes all the sense in the world. If there is a waiting list and people have the ability to pay and you can produce the food for them, why not do it so that they are not in a situation where they are not getting the nutrition that they need,

which is going to worsen their health problems? So I really commend you for that as well.

Mr. GROSS. Thank you. I should also mention that there is a slight profit in providing that meal, which then allows us to put the money back in to help other people come off the waiting list sooner.

The CHAIRMAN. That is great. Thank you.

Senator CASEY. Thanks very much.

Faith, I will start with you. I really appreciate your testimony both in terms of helping us better understand the benefits of programs like the National Family Caregiver Support Program, but also for giving us an insight into the reality of your own experience. It is very helpful for us.

I was noting in your testimony one brief sentence in, I guess, your fourth paragraph where you talked about the work you are doing and the work others in your family are doing, and you said, "We help each other out." A simple statement but so important when we talk about what you are doing and what a lot of families are doing around the country. We are told that 2.6 million children—just imagine that, 2.6 million children—are being raised by grandparents or other extended family or friends across the country, and obviously, you know that a big share of that are grandparents, and in your case a great-grandparent.

The role of coming a full-time caregiver comes unexpectedly, and that is probably an understatement. For some, we have heard so many stories it happens literally in the middle of the night. Most grandparents do not even know where to turn for help. Senator Collins and I got legislation passed last year to provide a resource to give grandparents information. We still have a long way to go on that and other priorities.

It is not just an action you take as a grandparent. It is an act of love, and your act of love saves our Government a lot of money, so we must continue to support in a much more robust way grandparents who take on this role because they want to help someone that they care about.

I wanted to ask you, Faith, about the Caregiver Support Program, if you can tell us how that helps you in the difficult task that you have.

Ms. LEWIS. I was trying to get other people to come to the Caregiver Program, but I am out there like pushing, and now I just go to the programs, and what I do is—I am a little startled on the question now. You have to ask me that later.

Senator CASEY. Well, I know you indicated in your testimony, you talked about the fact that because you have these opportunities you are able to share ideas with others.

Ms. LEWIS. Well, right now the Area on Aging——

Senator CASEY. The Area Agency?

Ms. LEWIS. Yes, in Scranton, Rebecca Munley, she and Jason, they help set up programs where we do not have to pay. They pay it for us and set the program up, which I already took Xziylan to two of them, one at Nay Aug Park and one at the Ritz in Scranton, which was very nice, and they set that one up in the Ritz. You could drop your children off and go for like 3 hours and go to dinner or shopping or something, but I did not do that because I will not leave her alone. I did not know—it was more for a couple, but

she said she was still invited, and she enjoyed it. She painted butterflies, and they are hanging—everyone painted butterflies, and they are going to hang them in the courthouse of Scranton.

Senator CASEY. That is great.

Ms. LEWIS. Which I thought is going to be very nice.

Senator CASEY, It does give you a little respite, a little break?

Ms. LEWIS. Yes. They are the nicest people I ever met, and all the people in the group really talk about them and say how nice they are. They are very helpful to everyone, and they do not look down at no one. They are very nice, and I think that is nice, so we all have issues, but we all seem to talk about it and try to see if we could get together and figure out something.

Senator CASEY. Well, you have given us a lot to reflect on in terms of the value of these programs, and I know that in addition to the fact that you have got a substantial responsibility, it also is a responsibility that brings you a lot of joy, and that is also inspiring for us, so thanks.

Ms. LEWIS. I listened to these people here about the aging, and I think, wow, am I lucky or what that I am able to take care of the children and help my daughter out, too. She helps me, like I said, and I help her, so it works out.

Senator CASEY. Faith, thanks very much.

Ms. LEWIS. Thank you.

Senator CASEY. Sorry I am over time a little.

The CHAIRMAN. You are fine.

Senator BLUMENTHAL. Thank you, Madam Chair, and thank you for having this hearing. Thank you to our witnesses for being here today and for your good work, all of you, on behalf of our aging Americans.

I am a strong supporter of the Older Americans Act, and we most certainly need to reauthorize it. I am from Connecticut where our population is composed of about 575,000 people who are seniors, about 16 percent of our population. We are growing older, like the rest of America, and a lot of the discussion so far has been about nutrition and meals and about, Ms. Lewis, how you take care of your great-granddaughter, which is really an inspiring story.

I want to ask you about taking care of the seniors in protecting them from elder abuse, which is one of the key objectives of the Older Americans Act. To what extent do you think this problem is rising in frequency and severity? Let me ask all of you.

Mr. PRUDOM. I will go first, if that is OK, Senator, but that is a really great question, and yes, we are seeing an increase in that, obviously with the aging demographics we are seeing in Florida. People do not understand that even—I mentioned earlier about the number of elder adults moving to Florida. Not all of those are in need. A lot of them actually have a lot of disposable income. Someone at the University of Florida calculated a net economic impact of retirees in Florida, they contributed $2,900 more to the economy than in consuming public services, and people over the age of 50 are driving the longevity economy, so we are seeing older adults who actually have substantial resources, and they are becoming obviously economic contributors to their local economies.

Unfortunately, as they get older, we are seeing some of the vulnerabilities exhibit themselves, and people come and prey on

them, and it is unfortunate, because I was talking to law enforcement and some of the prosecutors, and they say they are adequately resourced for things like murder and for drugs, but for things like abuse, neglect, and exploitation, it is not quite as cool, it is not quite as sexy, it is not quite as—it is more detached from that, and so, you know, we have been talking in Florida about how do we really address this, not only as a State but as a Nation, and I think the secret lies with communities. The Older Americans Act was ahead of its time in considering the value of communities in addressing the needs of their citizens, and I think a lot of emphasis needs to be put on this at the community level where everyone gets to the table and says, "What is important for our citizens to live in our community, to be protected from this?"

We hear a lot of stories about the bad guys that are caught and are put away, but the damage has been done, and that is the bad thing. A lot of people—we are not talking-—it may not be a certain amount, but the actual act of exploiting someone has a terrible physical health cost, and many times they will die within 18 months of that trauma.

Senator BLUMENTHAL. It is an emotional consequence.

Mr. PRUDOM. Most definitely, sir, and I think that is what communities need to step up, and we can help them both on the State and Federal level in equipping them to being proactive and preventing this from happening in the first place, and I think right now there are too many silos out there, and I think those silos could be broken down by having communities step up and demand better for their own citizens and have them at the table to assist in that discussion.

Senator BLUMENTHAL. Thank you.

Mr. Gross?

Mr. GROSS. Thank you, Senator. In addition to the comments that Secretary Prudom has made, I would highlight the importance of keeping family members out of the checkbook. We have a program that we developed at the Agency on Aging that we call "Money Minders," which uses bonded volunteers to go in and help people once or twice a month to sort of sort through their bills and pay their bills that need to be paid, help them to organize their finances.

The client still makes the choices as to how to spend the money, but they preserve their privacy, they make choices that they want to make, and our volunteers are there just to kind of help them understand what the consequences might be if they make this very big donation, let us say, but they have a rent check that is due next week that they will not have the cash to cover that, so that is one example.

I think you might also want to look at some of the work that we have done in Maine actually around what is prosecutable in terms of intent and what levels or degree of evidence that needs to be done. There is some presumptions in the law that something that is—that improvident transfers are a problem, and, again, Maine is sort of the canary in the coal mine. We are the oldest State. We have done a lot of work in those areas to try to identify that.

I would also say that one of the things we have heard from some prosecutors is that they are reluctant to bring elder abuse criminal

proceedings because the reliability of the witness is always at question, and it is very difficult sometimes to convict a person who does not remember the facts and does not have all their faculties around them, and so in some cases, there is a higher priority to chase convictions that are easier to get than they are with the resources that are applied to prosecuting elder crime.

Senator BLUMENTHAL. Some of the victims may be reluctant to come forward out of shame or embarrassment or because the crimes are committed against them by relatives or caregivers whose affection means a lot to them.

Mr. GROSS. Absolutely, and there is also the threat of saying, "If you do something like that, you know, you are going to have to go into a nursing home, and I am not going to be able to support you." That psychological abuse is just as important as physical or financial abuse.

Senator BLUMENTHAL. Good points. I am out of time. Thank you very much.

The CHAIRMAN. Thank you, Senator, for bringing up that issue. We have held, as you know, a lot of hearings on senior scams, and I am proud that Maine led the Nation in passing the Senior$afe Act, which we were able—Claire McCaskill and I working together were able to get enacted on the Federal level, and the Department of Justice is also paying much more attention to this issue than ever before, which I think is progress, and I think our Committee can take some credit for that.

Senator BLUMENTHAL. I know you have had a number of hearings on this issue. The folks from Maine and Pennsylvania and Ms. Lewis should know that you have really been a leader, and I thank you.

The CHAIRMAN. Thank you, and thank you for your work.

Secretary Prudom, across the Nation, and especially in Maine and in Florida, age-friendly communities are starting to emerge as a natural solution to isolation. We held a hearing on this issue as well and found that sometimes very small changes can make a huge difference, such as the timing of traffic lights to allow people more time to cross the street, curb cuts to allow people to not have to step up, restaurants giving senior citizen discounts on a certain day of the week.

Would it be valuable for the Older Americans Act to recognize and support age-friendly communities? Because right now they are not recognized in the act, I think because it has really been only in the last few years that we are starting to see this development. What suggestions would you have?

Mr. PRUDOM. Thank you for that question, Chairman. My suggestion is to do exactly what you just said. I really think this age-friendly initiative is going to be part of the future. We are proud to be the fourth State that has just embraced the age-friendly designation, but it is more than that. It is about livable communities, livable for all, so we can all live and live well, and I think that is the important thing, and you are right, Senator. They actually address the social determinants of health.

The beauty about this initiative, it is community-owned, initiated, and driven, and the success lies up to the community because they know what is important to their citizens, whether it is, like

you said, for the older citizens being able to cross the street safely to go to a restaurant or to go and visit somebody or whatever. Each community needs to address that separately. Then you understand what is important to that community and to get together to address how that should be done.

You talked earlier on about housing, you know, appropriate and affordable housing. That is an important thing that needs to be addressed at the community level.

I think the exciting thing about this age-friendly initiative is that, you know, as a State, we are embracing that, and with the Older Americans Act to further encourage communities to embrace the social determinants of health and help their communities become livable communities is the right way to go.

A lot of times when I talk about this, I tell people there are both societal benefits and economic benefits from becoming a livable community. You talked about the fact of socialization. If you create a community where people are no longer socially isolated and they are interacting with each other as human beings, all of a sudden—as you said, the 15 cigarettes a day—people who are not socially isolated are incurring or can incur more physical and mental health expenditures. The older adults as well in our communities, they volunteer. You mentioned that earlier on. That is huge in our State. Last year, it was 200 million hours the older adults volunteered. At 15 bucks an hour, that is $3 billion in cost avoidance. If you create a community where older adults want to go and live, they will volunteer, and that pays things back.

It is really important, I think, for communities to understand the value of this. It is not some sort of Sociology 101 exercise. It actually makes economic sense, too, and I think once people understand that—and the main thing is they define this on their own terms. They decide how they want to become livable. They decide what their social determinants of health care, which ones to adopt and which ones that do not really matter to them anymore, but I think the big ones are what you mentioned: transportation and housing and outdoor parks and buildings. I think those are the big ones that we are sort of seeing where you can make the most—get the most bang for your buck.

I think, you know, Chairman, I think that would be great to encourage communities by placing incentive in the Older Americans Act to do that, ma'am.

The CHAIRMAN. Thank you very much. That was very helpful.

Senator Casey.

Senator CASEY. I do not have any additional questions. I just want to thank our witnesses. Mr. Secretary, you have given us a lot to think about, and if the State of Maine is the canary in the coal mine on some of these issues, Florida and Pennsylvania are not far behind, and I know you are wrestling with them every day, so I appreciate the work you are doing and the public service.

Mr. Gross, you are, I know, at the end of your career. I am sure you have a second one lined up somehow, but we hope it is in this field or something related, and we are grateful you are here for this testimony, and, Faith, thank you for bringing your story here. It is critically important that we hear from people who are actually

in the trenches every day and working on these issues and, in your case, as a great-grandparent, so thanks very much.

The CHAIRMAN. Thank you very much, Senator Casey.

I, too, want to thank all of our witnesses for your very valuable testimony today. You have helped us better understand the extraordinary benefits of the Older Americans Act, and as we start to write the reauthorization bill, the input that you have given us is extraordinarily helpful. That feedback will help us produce a bill that will even better serve our older Americans in every State and also our tribal communities as well.

We do need to modernize the act to reflect the changing demographics of this country and great new ideas that are out there. At the same time, we want to make sure that we preserve the core programs that support nutrition, wellness, caregivers, elder justice, and really focus on the social determinants of health that can change the trajectory of aging for older adults.

I applaud the work that you are all doing, each in your own way, whether it is on the family level, the regional level, or the State level. I am very grateful for that. As we soon will surpass half a century of success, we celebrate the Older Americans Act, and we look forward to writing an even stronger, better law, and we will be in touch with you as we do so.

I want to also thank the staff of the Committee, which has worked very hard on this issue. Senator Casey, any final remarks?

Senator CASEY. Just a few closing comments. Thank you, Chairman Collins, for the hearing. It is very important to have this hearing as we do this, engage in this reauthorization work. As we heard today, the Older Americans Act is critical to helping seniors age in place, age in their homes and in their communities. We heard that more grandparents are raising grandchildren, as we know, and that those grandparents who have access to Older Americans Act programming and that multigenerational engagement should be expanded to help combat isolation.

We learned that it is crucial to show how the act creates a significant return on investment in terms of savings for both Medicare and Medicaid, and based on the testimony and answers to our questions, I hope that we are able to make these key improvements, and I am sure we will be able to, as well as other ideas to the law this year as we reauthorize the Older Americans Act.

I look forward to continuing to work with Chairman Collins, our colleagues on this Committee, and those on the Health, Education, Labor, and Pensions Committee. We are, obviously, members of both Committees, and that is in furtherance of the goal, which is a strong reauthorization of the Older Americans Act that supports our aging loved ones.

Faith, let me just say the last words about you. It is a pretty remarkable story that that 13-year-old who lost her Mom is now a great-grandmother raising a 5-year-old. That is a great American story. Thanks.

The CHAIRMAN. It is indeed.

Committee members will have until Friday, May 17th, to submit questions for the record. If we get any, we will pass them along to you. Again, my sincere gratitude to each of you for being here today. You added immensely to our understanding.

This hearing is now adjourned.
[Whereupon, at 4:40 p.m., the Committee was adjourned.]

APPENDIX

Prepared Witness Statements

STATEMENT BY

LANCE ROBERTSON
ADMINISTRATOR AND ASSISTANT SECRETARY FOR AGING
ADMINISTRATION FOR COMMUNITY LIVING
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

OLDER AMERICANS ACT: PROTECTING AND SUPPORTING SENIORS AS THEY AGE

MAY 8, 2019

Chairman Collins, Senator Casey, and Members of the Committee, thank you for the opportunity to discuss the important and successful programs made available by Older Americans Act (OAA).

For more than 50 years, the OAA has provided critical services that have enabled millions of older Americans to live independently, with dignity, and in their homes and communities. OAA's programs are highly successful because they are flexible, meet the unique needs of each state and community, and because they require the input and participation of each individual served.

Every seven seconds, one of America's 78 million Baby Boomers will celebrate their 60th birthday. That's a rate of 10,000 people – the equivalent of the population of a small town in America – joining the "senior" ranks every day. Put another way, the census estimates that the number of Americans age 60 and older will increase by over 8.9 million older adults between 2016 and 2020, to reach a total of 77.6 million.[1] During this period, the number of Americans age 65 and over with severe disabilities (defined as three or more limitations in activities of daily living), who are most likely to receive nursing home admission and qualify for Medicaid, will increase by 15 percent.[2]

The OAA has been at the foundation of my entire career. Before I was appointed to serve as the Assistant Secretary for Aging within the Department of Health and Human Services (HHS), I had the privilege of administering OAA programs at the state level for a decade (serving two very different governors) in Oklahoma. During my 12 years as an administrator at Oklahoma

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[1] U.S. Census Bureau, Population Division. Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2016. Release Date: June 2017. Accessed January 2018. U.S. Census Bureau. Population Division. Table 9. Projections of the Population by Sex and Age for the United States: 2015 to 2060 (NP2014-T9). Release Date: December 2014. Accessed January 2018.

[2] Ibid and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 Medicare Current Beneficiary Survey. [Data tables 2.5a and 2.6a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html Accessed January, 2018.

State University, which included co-founding the University's Gerontology Institute, I was very involved in OAA work. In addition, we were the Area Agency on Aging (AAA) subgrantee for the Title III-E Caregiver program. Based on my experience, I believe the OAA is one of our nation's great success stories.

For these reasons, I am honored to have this opportunity to present information and answer questions about this visionary and successful piece of legislation, which created our country's infrastructure for home and community-based care. In addition, I am honored to represent the federal agency that leads the national aging services network of states, tribes, area agencies on aging, local service providers and thousands of dedicated volunteers who work tirelessly to enhance the health, independence and dignity of our country's senior citizens.

The Administration for Community Living (ACL) was created in 2012 around the fundamental principle that older adults and people of all ages with disabilities should be able to live where they choose, with the people they choose, and with the ability to fully participate in their communities. ACL currently funds services and supports provided by networks of community-based organizations, and through our work to advance research, education, and innovation, helps make this principle a reality for millions of Americans.

As part of this important mission, ACL's Administration on Aging (AoA) advocates for the interests of older people and works with and through the national aging services network to promote the development of comprehensive and coordinated systems of home and community-based care that are responsive to the needs and preferences of older people and their caregivers. Authorized under OAA, AoA's core programs help older adults remain at home for as long as possible and advocate for individuals who live in long-term care facilities (nursing homes, board and care, assisted living, and similar settings).

OAA Vision

Over five decades ago, the OAA charted a bold vision for building a nationwide network of

public and private agencies and organizations focused on one common mission -- to ensure the dignity and independence of older people. The OAA has a limited federal presence that establishes broad policy and guidance. It works in partnership with states, tribes, area agencies, volunteers, and service providers at the community level with appropriate flexibility to assess and respond to local needs based on the input of consumers. It is a model based not on federal prescriptiveness, but instead on "bottom-up planning." This approach is recommended by global leaders[3] as the most effective model for aging policy planning.

The OAA created the national aging services network, which today includes 56 state and territorial units on aging (SUAs), 618 AAAs, 274 Tribal and Native Hawaiian organizations, more than 20,000 direct-service providers, and hundreds of thousands of volunteers. The OAA then charged this network with responsibility to promote the development of a comprehensive and coordinated system of home and community-based services that would enable our seniors to remain independent in their own homes and communities for as long as possible.

In passing the OAA, Congress intentionally did not create a stand-alone system; nor did it intend to cover all costs associated with serving every older American. Rather, OAA funds are to be used strategically to advance changes in our overall system of care and to fill gaps in services. The aging services network has done an outstanding job in meeting this intent. These programs have strong partnerships with state and local governments, philanthropic organizations, and private donors that also contribute funding. Many program participants also contribute. For every federal OAA dollar, the programs typically secure about three dollars from other sources, significantly exceeding the programs' match requirements.[4]

As a result of our investments in the OAA, we now have a nationwide infrastructure that reaches every community in this country. OAA-funded programs complement efforts of the nation's public health networks, as well as existing medical and health care systems. While each

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[3] United Nations "Guidelines for review and appraisal of the Madrid International Plan of Action on Ageing; Bottom-up participatory approach," 2006
[4] AoA's FY 2017 State Program Report.

program or service is valuable, the goal of helping older people remain in their own homes and communities instead of entering nursing homes or other types of institutional care often requires a combination of supports tailored to the needs of the individual.[5]

OAA programs include information and personalized assistance, as well as access to a broad array of benefits and services. Those services support some of life's most basic functions, such as bathing and preparing meals. They also include case management, specialized transportation services, congregate and home-delivered meals, adult day care, senior centers and activities, personal care, homemaker and chore services, health promotion, and disease prevention. The programs assist with practical considerations such as home modifications; issues of exploitation, neglect, and abuse of older adults; and services adapted to the unique needs of Native Americans. They also support family caregivers, who provide the majority of long-term support to older family members and without whom far more people would need care in institutional settings – generally at much higher costs.

In fiscal year (FY) 2017, AoA and the national aging services network provided services to over 11 million individuals age 60 and over (one out of every six older adults), including nearly three million clients who received intensive in-home services. In addition, it provided critical support, such as respite care, to over 716,000 caregivers.

In more than half of the states, the SUA has responsibility for managing one or more of their Medicaid waivers, and the aging network has been charged with serving other populations, including people of all ages with all types of disabilities.

OAA programs are especially critical for the nearly three million older adults who receive intensive in-home services, more than 485,000 of whom meet the disability criteria for nursing

[5] Brock, D et al. "Risk Factors for Nursing Home Placement among OAA Service Recipients: Summary Analysis from Five Data Sources" Westat; U.S. Administration on Aging Contract No. 233-02-0087. http://www.aoa.gov/AoARoot/Program_Results/POMP/docs/Risk_Factors.pdf

home admission.[6] These services help to keep these individuals from joining the 1.9 million older adult residents who live for extended periods of time in nursing homes.[7] This is particularly important given the limited long-term coverage under Medicare and constrictions in the long-term care insurance market, many Americans with few resources will continue to rely on Medicaid to furnish their long-term care. Supporting less costly community-based options will continue to be an important tool in managing federal expenditures.

Our OAA network is making a real difference in the lives of people every day all across this nation. However, if we are to continue to be successful, we must evolve to meet the growth in demand and the increasingly complex combinations of needs of the people we serve. We also must keep pace with the changes occurring in the larger policy environment.

Transformation of Health Care

The effective prevention role that our programs play through the provision of critical services and supports to often vulnerable individuals is pivotal to one of Secretary Azar's top priorities: transforming health care to a value-based healthcare system – one which focuses on sustaining health to avoid the need to treat disease. Such a system will pay providers based on outcomes, rather than on procedures performed. The goal is to lower costs, while also improving outcomes for Americans.

The value-based transformation has multiple components, and one of them is providing care in the lowest-cost appropriate setting. That means avoiding hospitalization and nursing home admissions, shortening duration of stays when they happen, and preventing readmissions after discharge, whenever possible.

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[6] Ibid.

[7] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 Medicare Current Beneficiary Survey. [Table 1.2 Demographic and Socioeconomic Characteristics of Medicare Beneficiaries, by Age and by Gender and Age, 2013]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html. Accessed January 2, 2018.

Addressing the social determinants of health – factors that are not specifically "about" health, but which have a direct impact on health and well-being – is critical to that goal. The social determinants include things like having enough nutritious food options, having a safe place to live, and having access to education, medical care, social support, and employment. As the Secretary recently remarked, "Social determinants of health is an abstract term, but for millions of Americans, it is a very tangible, frightening challenge: How can someone manage diabetes if they are constantly worrying about how they're going to afford their meals each week?"[8]

Considering the depth and breadth of services and supports ACL provides to millions of Americans through programs that target the social determinants of health, Secretary Azar has pointed out that we need to better incorporate the aging and disability networks into the overall health care system if we are going to achieve the goal of a value-based system.

I am pleased to be working closely with the Secretary and his team to realize that goal. We are putting significant effort into building our relationships across HHS – and in particular, with the Centers for Medicare & Medicaid Services (CMS) – to enhance systems to better address the issues of Medicare and Medicaid beneficiaries. Together, Medicare, Medicaid, and programs under the OAA, all of which were signed into law in 1965, form one of the cornerstones of a national effort to support the health and well-being of our older citizens and people of all ages with disabilities. These programs are designed to complement one another, so it is critical that ACL and CMS coordinate our efforts.

Key provisions of the OAA

The OAA authorizes a wide array of service programs, including:

Home and Community-Based Supportive Services (HCBSS)

The services provided through the HCBSS program include access services such as

[8] https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the-root-of-the-problem-americas-social-determinants-of-health.html

transportation; case management and information and referral; in-home services such as personal care, chore, and homemaker assistance; and community services such as adult day care and physical fitness programs. In addition, HCBSS also funds multi-purpose senior centers, which coordinate and integrate services for the elderly.

Data from AoA's national surveys of elderly clients show that HCBSS are helping older adults remain in their own homes. For example, over 82 percent of clients receiving case management reported that as a result of the services arranged by a case manager they were better able to care for themselves.[9] In addition, a study published in the *Journal of Aging and Health*[10] shows that assistance provided through the "personal care services" component of HCBSS are the critical services that enable frail seniors to remain in their homes and out of nursing home care.

These programs are particularly important to people who live alone (a key predictor of nursing home admission), especially for those who do not have an informal caregiver to assist with their care. Research has shown that childless older adults who live in a state with higher home and community-based services expenditures had significantly lower risk of nursing home admissions.[11] HCBSS programs serve a disproportionate number of people who live alone. For example, 67 percent of transportation clients live alone.[12] In contrast, nationally, 24 percent of individuals 60 and older live alone.[13]

Nutrition Programs

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[9] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov

[10] Chen, Ya Mei and Elaine Adams Thompson. Understanding Factors that Influence Success of Home- and Community-Based Services in Keeping Older Adults in Community Settings. 2010. Journal of Aging and Health. v22:267. Accessed March 23, 2018 at http://jah.sagepub.com/cgi/content/abstract/22/3/267.

[11] Muramatsu, Naoko. "Risk of Nursing Home Admission Among Older Americans: Does States' Spending on Home and Community-Based Services Matter?" May 2007. Journal of Gerontology: Psychological Sciences.

[12] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov

[13] Administration for Community Living, http://www.agid.acl.gov/DataGlance/. Data-at-a-Glance: American Community Survey (ACS) Public Use Microdata Sample (PUMS) 1-Year Files (2015), accessed January 2018.

Half of older Americans are malnourished or at risk of being malnourished[14], and nearly 5 million Americans lack consistent access to enough food for a healthy life. With food insecurity and malnutrition associated with a variety of negative health outcomes, including more frequent and longer hospitalizations, the nutrition programs play an important role in helping older adults remain healthy and independent.

Nutrition programs under OAA help approximately 2.4 million older adults receive meals in order to stay healthy and decrease their risk of disability.[15] The federal funding provided through the OAA is combined with state and local funding, as well as private donations, to assist 5,000 community-based providers in serving nearly 1.5 million meals a day to older adults across the country in both group (congregate) meal settings and through home-delivered meals.[16]

All local service providers serve a meal at the lunch hour, but more than one in ten also serve breakfast or dinner as well. Fifteen percent are open on the weekend.[17]

OAA nutrition programs provide more than just food – they also address other health-related issues. The program's goal is to decrease hunger and food insecurity, decrease isolation, and offer health promotion activities, such as lifestyle modification programs and evidence-based nutrition education and counseling.

This combined approach is particularly important given that older adults who participate in these programs are more likely than the general Medicare population to have chronic health conditions. Overall, 76 percent of community-living Medicare beneficiaries age 65 or older

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[14] Hamirudin AH, et al Outcomes related to nutrition screening in community living older adults: a systematic literature review Arch Gerontol Geriatr 2016 62 9-25
[15] AoA's FY 2017 State Program Report.
[16] Ibid.
[17] Mabli et al. Final Report: Process Evaluation of Older Americans Act Title III-C Nutrition Services Program. Report prepared for Administration for Community Living. September 30, 2015.

have multiple chronic conditions.[18] AoA's FY 2017 National Survey of OAA Participants found that 95 percent of participants in the meals programs have multiple chronic conditions; 47 percent of congregate and 64 percent of home-delivered participants have six or more. Over 21 percent of congregate and 40 percent of home-delivered participants take more than six medications per day and some take more than 20. They also are older – the average age is 77 – and more frail than the general Medicare population.

Increasingly, the issue of social isolation – among older adults and the population in general – has been gaining more traction in the field of public health. As one of the earliest programs authorized by Congress under the OAA, the nutrition programs have been at the forefront of tackling social isolation, and participants in both the congregate and home-delivered meals programs report increases in social interaction as a result of the programs. In fact, sometimes the person delivering the meal is the only person the older adult sees regularly; without the meal delivery, the older adult could be completely isolated.

These programs are making a critical difference. In the recent program evaluation[19], 63 percent of congregate meal recipients and 93 percent of home-delivered meal recipients have reported that the meals allowed them to continue living in their own homes. Participants in the congregate meals program also had fewer emergency room visits and fewer hospital admissions than their non-participant peers.

Preventive Health Services

These programs provide states and territories with the flexibility to allocate resources among the preventive health programs of their choice to best meet local needs. Priority has been given to providing services to those elders living in medically underserved areas of the state or who have

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[18] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 Medicare Current Beneficiary Survey. [data tables 2.5a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html. Accessed 02 January 2018.

[19] Mabli et al. Final Report: Process Evaluation of Older Americans Act Title III-C Nutrition Services Program. Report prepared for Administration for Community Living. September 30, 2015.

the greatest economic need.

Evidence-based programs empower older adults to take control of their health by increasing knowledge, changing behavior, and improving self-efficacy and self-management techniques. They are established activities, inputs, and resources for implementing health interventions that have been tested in a controlled trial setting and have been shown to be effective at improving health and/or reducing disease, illness, or injury. The more common programs include Chronic Disease and Diabetes Self-Management Education, behavioral health, and falls prevention programs.

Caregiver Services

Family and other informal caregivers are the backbone of America's long-term care system, and their numbers are growing. Like many of you, I have personally been a caregiver and I appreciate the enormity of what they do and the critical role they play.

A recent National Alliance for Caregiving and AARP research report indicated that approximately 34.2 million adult caregivers provided uncompensated care to those 50 years of age and older.[20] In other words, approximately 14.3 percent of all adults provided care to someone age 50 years and older.[21] AARP estimated the economic cost of replacing unpaid caregiving in 2013 to be about $470 billion, an increase from $450 billion in 2009 (cost if that care had to be replaced with paid services).[22] Another recent study by the Rand Corporation[23] estimated the economic cost of replacing unpaid caregiving to be about $522 billion annually.

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[20] Research Report: Caregiving in the U.S. 2015: A Focused Look at Caregivers of Adults Age 50+. National Alliance for Caregiving and AARP Public Policy Institute. June 2015. http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Care-Recipients-Over-50_WEB.pdf. Accessed February 15, 2018.

[21] Ibid.

[22] Valuing the Invaluable: 2015 Update, The Growing Contributions and Costs of Family Caregiving. AARP Public Policy Institute. July 2015. http://www.aarp.org/ppi/info-2015/valuing-the-invaluable-2015-update.html. Accessed February 15, 2018.

[23] The Opportunity Costs of Informal Elder-Care in the United States. Rand Corporation. http://www.rand.org/pubs/external_publications/EP66196.html.

On a daily basis, these individuals, the majority of whom are women, assist relatives and other loved ones with tasks ranging from personal care and homemaking to more complex health-related interventions like medication administration and wound care. Data from the 2017 National Survey of OAA Participants show that over 20 percent of caregivers are assisting two or more individuals.[24]

Support for caregivers is critical because often it is their availability that determines whether an older person can remain in his or her home. Caregiving is a labor of love, and most report finding it incredibly rewarding. However, it also can create challenges. Many caregivers report difficulty managing physical and emotional stress and balancing work and family responsibilities.

For example, caregivers often experience conflicts between work and caregiving. Among working caregivers caring for a family member or friend, 60 percent report work impacts due to caregiving such as having to rearrange their work schedule, decrease their hours, or take unpaid leave in order to meet their caregiving responsibilities.[25] In addition, over 70 percent of caregivers are themselves 60 or older, making them more vulnerable to a decline in their own health, and over 30 percent describe their own health as fair to poor.[26] Approximately 11 percent of caregivers report that caregiving has caused their physical health to decline.[27]

In the recent survey of participants in the OAA National Family Caregiver Support Program (NFCSP), caregivers reported that the types of support provided through the NFCSP can enable

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[24] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov

[25] Research Report: Caregiving in the U.S. 2015- A Focused Look at Caregivers of Adults Age 50+. National Alliance for Caregiving and AARP Public Policy Institute. June 2015. http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Care-Recipients-Over-50_WEB.pdf.

[26] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.

[27] Center on Aging Society. (2005) How Do Family Caregivers Fare? A Closer Look at Their Experiences. (Data Profile, Number 3). Washington, DC: Georgetown University.

them to provide care longer (77 percent) while often continuing to work,[28] thereby avoiding or delaying the need for their loved ones to move to more costly institutional care. Another study indicates that counseling and support for caregivers of individuals with Alzheimer's disease can permit the care recipient to stay at home at significantly less cost for an average of an additional year before being admitted to a nursing home.[29]

Tribal Programs

Between 2000 and 2010, the number of older American Indian and Alaska Native (AI/AN) adults increased by 40.5 percent, a growth that is 2.7 times greater than that of the overall population of older adults over the same 10-year period.[30] In addition, this rapidly growing population is also experiencing some of the highest rates of disability,[31] chronic disease, and poverty[32] in the United States. Because of the combined factors of an aging population and high disability rates, AI/ANs have a great need for access to home and community-based services in their communities.

Grants from the Native American Nutrition and Supportive Services program support a broad range of services to older Native Americans, including adult day care, transportation, congregate and home-delivered meals, information and referral, personal care, help with chores, and other services. Currently, the OAA's congregate meals program reaches 42 percent of eligible Native American seniors in participating tribal organizations, home-delivered meals reach 12 percent of such persons, and supportive services reach 30 percent of such persons.[33] These programs,

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[28] 2017 National Survey of Older Americans Act participants. http://www.agid.acl.gov.

[29] Mittelman, M., Ferris, S., Shulman, E., Steinberg, G., Levin, B. (1996). A family intervention to delay nursing home placement of patients with Alzheimer's disease - A randomized controlled trial. *The Journal of the American Association*, 276(21), 1725-1731.

[30] Administration on Aging, U.S. Population by Age: 65+ Minority Population Comparison using Census 2000 and Census 2010 (July 1, 2011).

[31] National Council on Disability, "Understanding Disabilities in American Indian and Alaska Native Communities: Toolkit Guide" (2003).

[32] Centers for Disease Control and Prevention, "CDC Health Disparities and Inequalities Report – United States" (2013).

[33] ACL's OAA Title VI Program Performance Report, PY 2017. Title VI of the Older Americans Act permits tribes to establish age of eligibility for services below age 60. Calculation based on eligible population as reported in grantee applications

which can help to reduce the need for costly nursing home care and medical interventions, are responsive to the cultural diversity of Native American communities and are an important part of each community's comprehensive services.

Grants assist American Indian, Alaska Native, and Native Hawaiian families who are caring for older relatives with chronic illness or disability and help grandparents care for their grandchildren. The program provides a variety of direct services that meet a range of caregiver needs, including information and outreach, access assistance, individual counseling, support groups and training, respite care, and other supplemental services. Annually, tribal grantees provided over 100,000 hours of respite care, delivered just over 23,000 hours of caregiver training, and assisted 16,000 caregivers to access needed services.[34]

Reports from the people we serve through these programs have been very positive. I have been very involved in the HHS Secretary's Tribal Advisory Council and those national leaders are very pleased with the services we provide through OAA Title VI as well as other ACL tribally-directed programming.

Elder Rights Protections

The most reliable data on the prevalence of elder abuse tells us that 1 in 10 older people are abused, neglected, or exploited each year, and as many as 4 in 10 are the victims of financial exploitation[35]. Two studies show that about half of people with dementia will be abused or neglected by their family caregivers[36].

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[34] Ibid.

35 Lachs, M., & Pillemer, K. (2015). Elder abuse. *New England Journal of Medicine, 373*, 1947–56. doi: 10.1056/NEJMra1404688

[36] Quinn, K., & Benson, W. (2012). The states' elder abuse victim services: a system in search of support. Generations 36(3), 66–71 and Cooper, C., Selwood, A., Blanchard, M., Walker, Z., Blizard, R., & Livingston, G. (2009). Abuse of people with dementia by family carers: representative cross sectional survey. British Medical Journal, 338, b155.

To combat elder abuse, neglect, and exploitation in America, ACL's goal is to establish a comprehensive system to provide a coordinated and seamless response for helping adult victims of abuse, to prevent abuse before it happens, and to develop new and innovative approaches to preventing, detecting, and responding to abuse, neglect, and exploitation. ACL, along with the National Center on Elder Abuse, the National Long-Term Care Ombudsman Resource Center, and legal systems development and assistance programs, create an interconnected framework for carrying out the OAA's Vulnerable Elder Rights Protection activities under Title VII. Among other things, these programs provide a full array of services that effectively address complaints of abuse, neglect, or violation of rights; advocate for system improvements; and support innovation. The Elder Justice Coordinating Council, which ACL leads on behalf of Secretary Azar, helps ensure that this work spans the whole of government.

The aging services network plays a critical role in this work. For example, the AAA network in Massachusetts builds and promotes partnerships with community colleges, long-term care facilities, adult protective services agencies, law enforcement organizations, area community centers, Long-Term Care Ombudsman programs, financial institutions, housing advocacy groups, and many others to ensure that elder rights are prioritized across the state. In building strong partnerships, the AAAs and community organizations join forces to advocate for and ensure that elders have necessary information available to access community resources for services and care decisions.

Through educational efforts, exposing problems that would otherwise be hidden from view, and providing a voice for those who cannot act for themselves, the program helps ensure that all older Americans are able to age with dignity in a safe environment.

Long-Term Care Ombudsman Program

State Long-Term Care Ombudsman programs work to resolve problems related to the health, safety, welfare, and rights of individuals who live in long-term care facilities (i.e., nursing homes, board and care, assisted living, and other residential care communities). Ombudsman

programs promote policies and consumer protections to improve long-term services and supports at facility, local, state, and national levels and play an important role in elder justice networks.

Ombudsman programs respond to a wide variety of problems faced by residents of long-term care facilities, including discharge and eviction, inadequate care, rights violations, and quality of life concerns. In FY 2017, they addressed over 200,000 complaints and resolved 73 percent of these complaints to the full or partial satisfaction of the resident or complainant.

Inappropriate discharge or eviction from a nursing home or assisted living continues to be the most common complaint (over 14,000 in FY 2017) and Ombudsman programs employ a number of strategies to support residents to remain in their facility, which is their home. Strategies include informal complaint resolution to address the causes and to find solutions to rescind the discharge, collaboration with legal services to support residents to request an administrative hearing, and calling upon the state survey agency to conduct a regulatory compliance investigation. Ombudsman programs also use systemic approaches such as developing task forces, training both hospital social workers and long-term care facility staff on relevant requirements, and educating residents and their families about their rights.

Reauthorization –

As you know, the current authorization of the OAA expires at the end of September 2019. ACL has been engaged, along with many national organizations, in providing to members of Congress and their staff information about how the OAA programs work and their effectiveness, as well as providing technical assistance related to specific policy proposals being considered.

HHS has developed three proposals for your consideration. For the development of our proposals, we looked at hundreds of comments and the information we received over the past three reauthorizations through formal listening sessions, online submissions, and from engagements at conferences and meetings where we listened intently to the issues raised. When reviewing all of this information, we discovered that about 90 percent of the comments were

related to appropriations, not authorizations. The balance of the items mentioned related to issues that confirmed what we have heard previously:

- That the Act is not "broken" and doesn't need major restructuring – instead, it can use some tinkering to make it consistent with current needs and changing environments;
- It has been effective in achieving the goals established by Congress; and
- It has been the glue in the community that knits together the components that comprise a comprehensive system of supports and services – regardless of funding source.

As a result, it was not necessary to conduct a series of formal listening sessions around the country and we instead used a variety of opportunities to hear stakeholders about their needs and what they believe should be considered as we address reauthorization.

The Administration is advancing the following proposals:

1) Eliminate the Right of First Refusal;
2) Eliminate Older Relative Caregivers Support Services Limit; and
3) Increase Limit on Use of Allocated Funds for State Administrative Costs.

Eliminate the Right of First Refusal

We have heard from states – and I can attest from my time as the administrator of these programs in Oklahoma – that this is needed to enhance their flexibility and to promote greater degrees of federalism.

Currently, the statute prescribes that whenever a state is designating a new AAA that a preference be given to units of local government over other agencies, including established offices of aging. This provision was first added to the Act in 1984 as a means of enhancing the involvement of local government in aging programs. Today, the need to attract the interests of local government in aging programs does not appear to exist to the same degree. As a result, states looking to consolidate AAAs and create efficiencies may wish to offer the role to units of local government, but do not see the need for a mandatory preference.

Eliminate Older Relative Caregivers Support Services Limit

This proposes to remove the 10 percent limit that states can spend out of funding appropriated to the National Family Caregiver Support Program in support of grandparents raising grandchildren. The cap was added in 2000 when the NFCSP was first established. At the time, needs were not known and considering that the initial intent of the program was to serve caregivers supporting older individuals, a cap was placed on the amount that could be used to support care for younger individuals. Since that time, there has been growing awareness of grandparents raising grandchildren, as well as a growing recognition of the need to support them. Unfortunately, this population also is growing, due in part to the opioid crisis. This proposal is consistent with the Administration's budget proposal to afford states maximum flexibility in administering their programs.

Increase Limit on Use of Allocated Funds for State Administrative Costs

Our third proposal is to update and increase the amount that states can use to administer OAA programs. The administration allowance in the statute was last increased from $300,000 to $500,000 in 1992. Over the 27 years since that reauthorization, the older adult population and inflation have risen as well as the costs of administering the State Plan on Aging. Currently, 16 states and DC are limited to $500,000: AK, DE, HI, ID, ME, MT, NE, NH, NM, ND, RI, SD, UT, VT, WV, and WY. The proposal would also impact states that are currently above the limit of $500,000, but below the proposed $750,000: AR, CT, IA, KS, MS, NV, and OK.

Conclusion

Our strategy focuses on empowering our consumers by giving them more choices and greater control over their own health and long-term care, including more control over the types of benefits and services they receive, and the manner in which those benefits and services are delivered. We also are empowering seniors to make evidence-based behavioral changes that will improve their health and well-being and avoid the risk of chronic disease and injury.

Additionally, we are looking at new ways of targeting our limited resources at seniors most in need.

We have made tremendous progress in advancing the goals and objectives of the OAA through the combined efforts of the aging services network. This network literally has built the foundation of this nation's formal system of home and community-based care, and we have done it in partnership with older Americans and their families. I believe keeping consumers front and center is the best way to ensure our success in our OAA programs and the aging services network for the balance of the 21st century.

Thank you for the opportunity to participate in today's hearing. I have appreciated the Committee's support of the OAA and the national aging services network and I look forward to our continued work together. I am happy to answer any questions that you may have.

US Senate Special Committee on Aging

Hearing: The Older Americans Act: Protecting and Supporting Seniors as they Age
Wednesday, May 8, 2019; 2:30 p.m.

Written Testimony of Richard Prudom, Secretary for the Florida Department of Elder Affairs

Introduction and Demographics

Chair Collins, Ranking Member Casey, members of the committee… thank you for the opportunity to be here to discuss the importance of the Older Americans Act and what we are doing in Florida to meet the needs of our growing senior population.

I am proud to have served at the Florida Department of Elder Affairs (DOEA) for the past eight years and was honored to be appointed Secretary by Governor Ron DeSantis. The Governor has taken bold actions and shown great leadership on issues affecting Florida seniors, including Alzheimer's disease and related dementias and making Florida an Age-Friendly State. Governor DeSantis has charged me with working to improve the lives of older Floridians – a responsibility I do not take lightly, and it has been my pleasure to work with him in service to our 5.5 million seniors.

DOEA serves as the State Unit on Aging for Florida and oversees more than $330 million in state and federal funding – including more than $112 million in funding from the Older Americans Act. We partner with 11 Area Agencies on Aging (AAAs), Lead Agencies, and direct service providers across Florida to assist seniors through OAA, other federally funded programs, and state-funded programs that all aim to keep seniors in their own homes and communities as they age. In leading Florida's Aging Network, it is our mission to keep our older residents healthy, safe, and independent for as long as possible.

Florida continues to be a popular place for seniors. We have the highest population percentage of 65+ in the nation. In fact, our senior population outnumbers the senior populations of 20 other states, as well as the **total population** of Alaska, Delaware, North Dakota, Rhode Island, South Dakota, Vermont, and Wyoming **combined**. More than 450 people over the age of 60 move to Florida each day, and throughout the next decade, our senior population will increase by more than 38% to 7.6 million.

There are challenges in promoting the health and well-being of this growing and increasingly diverse older adult population. Population aging, especially when the baby boomers reach ages 85 and older, signals a likely surge in the use of long-term care services, so clearly, the Aging

Network is tasked with an important challenge – to ensure that we are meeting and will continue to meet the needs of our frail elders.

The major focus of our programs is to provide home and community-based services as an intervention for those elders who are at risk of being placed into a long-term care (LTC) facility because of their degree of frailty. This way, they are able to remain in their own homes and communities with some assistance. The OAA should be considered as the foundation for this aging in place, which is not only preferred by older Floridians in need of services, but taxpayers also avoid the higher costs associated with nursing home placement.

This is not a criticism of the long-term care industry, which plays a very important role in providing health care in the community, but LTC placement should occur only after all other options have been exhausted.

LTC placement is the leading cause of catastrophic out-of-pocket costs for families and involves substantial government spending, primarily through Medicaid and Medicare. Few people have insurance coverage against the high costs of long-term care. After impoverishing themselves, most people must turn to Medicaid to pay for their long-term care services.

Connecting the Age Friendly Initiative and the OAA

It is equally important that we engage community leaders as partners and challenge them to take a more proactive role in the well-being of older adults.

Everything points to the fact that the communities that fare best in the 21st century will be those that both tackle the challenges and embrace the positive possibilities that an aging population creates – essentially becoming Livable Communities. The amenities of a Livable Community help to maximize the independence and quality of life of older adults, while also enhancing the economic, civic, and social vitality of the community.

Accordingly, I am proud to share with you that Florida has just been designated as an Age-Friendly State by AARP through their Age-Friendly Network of States and Communities. We are the first state in the South and, in fact, across the entire Sun Belt, as well as the largest state to accomplish this. Governor DeSantis envisions a Florida where seniors are not just living but living well.

Tasked with the responsibility for planning, coordinating, and advocating for aging services at the community level, DOEA and the Aging Network are in a unique position to integrate individual and community interests to facilitate aging in the community; in fact, the Older Americans Act mandates that we do so.

Solutions to complex social problems do not emerge from the activities of a single individual, social service agency, or sector, but rather from the activities of multiple entities including businesses, non-profits, local governments and the general public. Therefore, it is important to note that the State is working with communities to ensure that they achieve the goals that are relevant and specific to the needs of **that** community.

The Age-Friendly designation is a process that is and will always be community initiated, community driven, and community owned. Neither the state or AARP will be dictating exactly how communities will become Age Friendly/a Livable Community, rather we will work with communities to ensure that they achieve the goals that are relevant and specific to the needs of that community. We will facilitate, we will encourage, and we will reassure, but ultimately success lies with the community. In that regard, it is a true grassroots effort and cannot be achieved without the funding provided through the OAA.

An Age-Friendly/Livable Community example – Creating Dementia-Caring Communities

We are all living longer thanks to twentieth century medicine's assault on infectious diseases. However, that longevity was also accompanied by the growing prominence of chronic illnesses, such as dementia, osteoporosis, heart disease, and stroke, as well as their associated disabilities.

With over 560,000 individuals currently living with Alzheimer's disease, Florida has the second highest incidence of Alzheimer's in the nation. This is projected to increase to more than 720,000 individuals by 2025. That number does not include the tens of thousands more with other forms of dementia, nor does it include the informal caregivers of these individuals which is estimated to be well over 1 million.

Rather than adopt the "woe is us" mantra, we believe these statistics put the state in a unique position to become a national model for how state and local entities leverage resources and state-of-the-art research and treatments to assist individuals living with dementia.

In 2016, the DOEA created the Dementia Care and Cure Initiative (DCCI) – a statewide effort to bring awareness to, education on, and sensitivity regarding the needs of those affected by dementia throughout local communities. While we work toward a cure, our goal is to break down barriers and reduce the stigmas associated with dementia to help communities become more dementia aware, more dementia caring. Our Dementia Care and Cure Initiative (DCCI) fits well into these efforts to make communities become livable for all.

DCCI is gaining momentum, and we have established Dementia-Caring Communities across the state. We have buy-in from community businesses and law enforcement as well. They are taking dementia sensitivity training to implement better communications tactics when engaging with individuals and families affected by dementia and to provide important referrals to Memory

Disorder Clinics and other resources. Recently, in Tallahassee, five popular restaurants have taken the training and received Dementia-Caring Business decals that they proudly display. Now local dementia and caregiver support groups and facilities that care for those with memory disorders have been visiting those restaurants. They know that they will have a supportive and engaging experience.

Working with the federal government, Florida can implement new, innovative, and bold programs that can drastically improve the quality of life for persons living with dementia, as well as their caregivers. Although the OAA and state funds provide significant funding towards caregiver respite, we recognize that more could and should be done.

On December 31, 2018, President Donald Trump signed into law the "Building Our Largest Dementia Infrastructure for Alzheimer's Act," creating a new public health framework within which individuals living with the disease and their caregivers can find support. Previous federal initiatives largely focused on providing funding for drug research, as opposed to what Sen. Susan Collins called for when sponsoring the BOLD Act: "a multi-pronged public health approach that will create a modern infrastructure for the prevention, treatment, and care of Alzheimer's and related dementias."

In order to maximize the opportunities presented in the new BOLD Act, Governor DeSantis has directed Florida's Department of Health (DOH) to include Alzheimer's disease and related dementias as a standalone priority in the State Health Improvement Plan (SHIP), which "… sets out goals for Florida's public health system, with the ultimate goal of efficient and targeted collective action to improve the health of Floridians."

Each of the top 10 leading causes of death in Florida were represented in the SHIP, except Alzheimer's and related dementias. In addition, other chronic conditions/diseases, such as heart disease, cancer, stroke, kidney disease, liver disease, and mental disorders, are all recognized in the SHIP.

Having Alzheimer's disease and related dementias placed onto the Florida SHIP positions DOH to apply for the BOLD Infrastructure for Alzheimer's grants. Recognizing Alzheimer's disease as a top health priority in Florida also aligns with the CDC Public Health Road Map's "Healthy Brain Initiative" – which charts a course for state and local public health agencies and their partners. The Road Map prepares all communities to act quickly and strategically by stimulating changes in policies, systems, and environments.

Governor DeSantis also directed DOH to apply to the CDC to become an Alzheimer's Center of Excellence, which will enable them to draw down federal funding for evidence-based approaches to treatment and prevention.

After demonstrating success with these programs, Florida will be in a position to leverage additional resources, perhaps from the National Institute of Health, to expand what would be evidence-based approaches that increase the quality of life for both patients and caregivers. This would not have been possible without the significant funding provided by the OAA. However, although the resources available under the OAA are a critically important support system for older individuals with Alzheimer's, we must recognize the expanding nature of this terrible disease and also make OAA resources available to individuals with younger-onset Alzheimer's and other dementias as well.

Older Americans Act Funding

The Older Americans Act (OAA) Title III-funded programs enhance the well-being of Florida's seniors and their caregivers, enabling them to live healthier and engaged lives through supportive services like transportation, health and wellness, congregate meals, home-delivered meals, and nutrition services. For FFY 2017-18, Florida received nearly $106 million in OAA Title III funds and served approximately 200,000 clients throughout the state. The OAA services most utilized by Florida's seniors and their caregivers were transportation (III-B), congregate meals (C1), home-delivered meals (C2), HomeMeds – a medication management evidence-based program (III-D), and in-home respite to support caregivers (III-E).

IIIB – Supportive Services

We look to the OAA, not only for the programs and services made possible through the Act, but also for the objectives the act seeks to advance. Legal services funded under the Older Americans Act are critical aging resources that preserve the rights and independence of older Floridians and are a vital part of the Aging Network. In Florida, IIIB funding supports a collaborative statewide program and network of AAAs and legal providers working together to serve the legal needs of seniors in greatest economic and social need. In 2018, OAA-funded legal services were provided by 20 providers across the state, reaching nearly 10,000 older Floridians. Legal assistance in housing is central to seniors but especially those with low incomes who are seeking to maintain their independence. Housing is the largest category for Title III-B funding cases.

Another OAA service, transportation, is essential for elders to avoid isolation and institutionalization. The service facilitates seniors' access to health care, as well as opportunities for social engagement.

III CI and III C2 – Congregate and Home-Delivered Meals

In FFY 2017-18, we provided nearly 11 million meals, and more than half – or 6.3 million – were served through OAA. Unfortunately, 13% of Florida elders report not being able to afford food. Many seniors are just one meal away from a crisis, so these services are essential. And, as we all

know, a meal is more than just a meal to those who receive it. Recently, I was able to participate in a Meals on Wheels route with some of my team – something I greatly enjoy doing. Talking with our clients, learning more about what the services means to them, and identifying how we can further assist them is rewarding. Please know that these programs are truly making a difference in the lives of our older residents. Home-delivered and congregate meals play an important role in promoting the well-being of seniors – even beyond improving their physical health. Through eating at community meal sites or engaging with those delivering meals to their homes, it is an opportunity for socialization and engagement, which helps combat another critical issue facing our elders – loneliness and social isolation. This is so important for the social, behavioral, and mental health of older adults. We have more than 400 congregate meal sites in Florida where thousands of meals are served daily, and elders can socialize and remain engaged with others.

Innovations in Nutrition Programs and Services

Currently, the Department is in the process of applying for the Innovations in Nutrition Grant offered by ACL. The proposal for this grant is to address the changing palate of elders and increase congregate meal site participation. Client satisfaction surveys have revealed elders, especially younger more technologically savvy elders, are less willing to leave their home to attend congregate meal sites as they have more option of meal delivery services. The goal of the grant is for nutrition providers to work directly with their vendors and farmers to incorporate a "farm to senior" aspect to congregate meal sites, thereby enhancing III C1 services. Elders repeatedly voice their desire for fresh fruits and vegetables. Providing a farm to senior platform will increase the variety and quality of food at congregate meal sites and allow for more input from the clients regarding their meals.

III D – Health and Wellness

Title IIID programs are designed to educate seniors and their caregivers to adopt interventions that make a difference in their health and well-being and, ultimately, to increase the overall health of older Floridians. Statewide, approximately 8,000 older adults participated in 19 types of evidenced-based programs, including Home Meds Medication Management, which I mentioned earlier as a highly-utilized OAA service in Florida. Studies show that the inappropriate management of medication has been proven to be one of the highest indicators of nursing home placement, so this IIID program is essentially helping us to achieve our goals of keeping older Americans in their own homes and communities where they want age. Our disease prevention and health promotion programs have been proven to be effective in the prevention and symptom management of chronic health conditions.

In Florida, we are proactive in seeking out additional grants to serve more through this program. In fact, this month we were awarded two grants from ACL for capacity development of falls prevention in rural areas and chronic disease self-management education in under-served areas. These funds will provide $150,000 for each program over a three-year period to reach individuals in counties that currently have no access to falls prevention programs and no access to chronic disease self-management programs. We are proud of our efforts to keep seniors safe from falls. Florida now has the second lowest rate of falls (25.3% according to America's Health Rankings Senior Report, 2018).

III E – Caregiver Support

Through OAA Title III E, Floridians are able to get assistance for their roles as caregivers for their loved ones, whether it is a grandparent or non-parent relative who is caring for a child or someone providing care for an individual 60 or over. During Federal Fiscal Year 17-18, Florida received nearly $15 million in funding and served more than 91,000 family caregivers. Services most utilized were respite and adult day care. Respite is one of the most important services offered for caregivers because caregiver burnout is real and acute. It is important that we support our caregivers and help keep them well. OAA has been essential for us to accomplish this. In a 2016 report, more than 90% of the OAA caregivers self-reported being "very confident in their ability to continue to provide care" after receiving OAA services.

In Sarasota, IIIE programs give grandparents who have "re-entered" parenting to care for their grandchildren the opportunity to learn from each other, share ideas on how to best care for their grandchildren, and provide emotional support. Being able to talk with others in the same boat, so to speak, is important because other friends cannot relate. One client of ours said, "It helps me to deal with the stressful situation I am in by sharing, laughing, encouraging others, and taking some advice."

V- Employment: Senior Community Service Employment Program (SCSEP)

The Senior Community Service Employment Program (or SCSEP) serves low-income Floridians age 55 and older who have poor employment prospects. By providing useful opportunities in community service job training, the goal is to move participants into unsubsidized employment to achieve economic self-sufficiency and remain a vital part of the workforce. In 2017-18, DOEA received $4.6 million in Title V funding, creating the opportunity for 574 Floridians to participate in the program and work more than 360,000 hours.

VII – Elder Justice: Elder Abuse Prevention Program and LTCOP

Elder abuse prevention and elder justice should also be highlighted. Through approximately $2 million in Title VII funding, both the Long-Term Care Ombudsman Program and the Elder Abuse

Prevention Program are in place to protect our seniors from abuse, neglect, fraud, and exploitation. In Florida, the Department does not investigate abuse complaints as that responsibility lies with our partners at the Department of Children and Families, but we house the abuse prevention and education components. Through our abuse prevention coordinators in 11 Planning and Service Areas across the state, we work to educate the public on preventing abuse, neglect, and exploitation, as well as how to report abuse. The Long-Term Care Ombudsman Program is a statewide volunteer-based program that works to protect, defend, and advocate on behalf of those living in long-term care facilities, and they investigate complaints made by or on behalf of the residents. More than 335 volunteers contributed nearly 50,000 hours in the last fiscal year and traveled more than 300,000 across the state in service to long-term care residents.

Abuse prevention is a top priority of DOEA and actually extends beyond our OAA programs into our Office of Public and Professional Guardians (OPPG) and the federal SHINE Program, which also houses the Senior Medicare Patrol responsibilities to empower Medicare beneficiaries to prevent, detect, and report Medicare exploitation and fraud. Through OPPG, we are now able to investigate complaints made against professional guardians, including allegations of abuse and/or financial exploitation. Following a thorough investigation and the appropriate adjudication process, we have recently revoked the registration of a "bad actor" guardian for the first time since being given this authority. I certainly hope that it sends the message that we will not tolerate abuse of our seniors. We are also working on abuse prevention with the Governor's Office and Florida's Attorney General, who just launched the Senior Protection Team to focus on elder abuse.

Innovations

In August of 2018, in consultation with the U.S. Administration for Community Living (ACL), the Department initiated a Disaster Recovery Reserve (DRR), which contractually obligates the state's 11 Area Agencies on Aging (AAAs) to designate a predetermined amount of OAA Title III B, III C1, an III C2 funds for serving elders affected by a disaster. These DRR funds may be used when services are provided because of a President-declared disaster and would not have been provided had the disaster not occurred. In October 2018, Hurricane Michael hit the Florida Panhandle as a category five hurricane. The DRR innovation allowed the Department to transfer designated funds to the AAA that housed the effected counties and clients, thereby enabling the AAA to provide services after the storm. Services included delivery of food and supplies, transportation, debris removal, case management, and case aid used for call-downs to verify client safety and needs, fuel purchases for generators, and the distribution of thousands of meals and water. Though the Department did not plan to use the DRR within two months of inception, it worked, and many clients were provided with provisions and services they would not have without the DRR. This is an innovation within the OAA that Florida will continue to use and is happy to share its blueprint with other State Units on Aging.

The Older Americans Act is our primary source of funding for older Floridians, and it is essential that we utilize the funds as intended. Targeting potentially vulnerable elders is an important component of that, so our Planning and Evaluation Team has instituted a number of innovative solutions and best practices in Florida that uniquely equip our program staff and partners in the Aging Network.

For instance, they created custom client-based and Census population-based GIS maps that are utilized to achieve targeting goals set by the OAA. The census-based maps allow DOEA and our partners to locate concentrations of seniors needing assistance, and the client-based maps are used to illustrate our AAA's performance in serving older individuals with greatest economic or social need, prioritize their targeting, and even support disaster preparedness and recovery efforts before and after events like Hurricane Michael. Many OAA clients are uniquely vulnerable during natural disasters, especially the hurricanes that recently hit Florida. The maps also enable us to accurately predict those clients who will most seriously be affected by storms, effectively plan for their relocation before an event, and arrange for the possibility of extended care after the fact.

We are utilizing OAA funding and services to its fullest potential. We are also implementing innovative practices to serve even more elders. For example, DOEA administers the adult portion of the national Child and Adult Care Food Program, which is a USDA-funded nutrition program that supports the nutrition status of seniors, enabling them to prolong living in their own community. **Florida is the only state in the nation** that bifurcates the child and adult portions into two separate programs administered through two separate state agencies. USDA often highlights the accomplishments of Florida's Adult Care Food Program and encourages other states to consult with us regarding the successful administration of the program. In the last federal fiscal year, this program received nearly $7 million and served more than 2.6 million meals/snacks to elders in Florida. This is a 96% funding increase over the last five years because of its success and the growth of the program.

Summary

As I said at the beginning of my testimony, there are challenges in promoting the health and well-being of Florida's growing and increasingly diverse older adult population, but I share Governor DeSantis' vision for Florida to be a place where seniors are not just living but living well. Our society has a long tradition of finding innovative approaches to challenges. An aging population is an opportunity to use our social and technological ingenuity to develop solutions to our changing needs that can move us all forward. As we live longer and healthier lives, the longevity and productivity of our society and communities will also expand. The OAA is essential to our ability to meet those challenges; in that regard, it is the major vehicle we use in Florida to support and protect Floridians as they age in place – helping, among other things, to improve senior nutrition, support family caregivers, advance elder justice, and help older adults to age well in

their communities. These are all essential pieces that enable current and future seniors to live and live well, which is our ultimate goal in Florida.

Thank you.

Testimony before the United States Senate Special Committee on Aging

May 8, 2019

Laurence W. Gross

Senator Collins, Senator Casey, Members of the Senate Special Committee on Aging:

I am Laurence Gross. For 41 years, it has been my honor to serve older adults at Southern Maine Agency on Aging,(SMAA), the past 36 years as Chief Executive Officer. Our service area includes Maine's largest city (Portland) and one-third of the State's elder population living in 2,000 square miles of suburban and isolated rural settings. SMAA staff and volunteers touch the lives of more than 20,000 people annually. I want to thank Senator Collins for inviting me to speak with you today.

During my tenure at SMAA, I have seen the Older Americans Act evolve to become a solid foundation for the future of aging services in this nation. Today, I will share my experience as a veteran on the front line of the Act's evolution in the "oldest" state in the Nation.

Maine is the "canary in the coal mine" when it comes to the field of aging in America. Of necessity, Maine has built a national reputation as a laboratory for innovation, testing, and proving policies and practices that will serve our country well in the decades to come. I am proud of the many national awards SMAA has received in recognition of our contributions to Maine's legacy, most recently, as

the first recipient of the Business Innovation Award from the John A. Hartford Foundation.

SMAA offers the core of OAA services: home-delivered and community-based meals, information and assistance, Family Caregiver support, training, and respite, Medicare counseling, fraud prevention, and health promotion activities. SMAA operates an adult day center for older adults with dementia, the Sam L. Cohen Center, where I was delighted to host Senator Collins when it opened in 2017. Our 600+ volunteers provide invaluable human capital resource: nearly 40,000 hours of paraprofessional and technical services annually.

Senior Nutrition programs are a hallmark of the OAA. However, by the early 2000s our traditional congregate dining model was languishing. Flat funding, rising inflation and shifting demographic interests had reduced participation and increased operating cost. Our clientele was "aging out" to Meals on Wheels. In response, we made the strategic decision to replace our legacy delivery design with a voucher model. We called the program "As You Like It". Initially set in a hospital cafeteria, As You Like It offered our diners menu choices, in an attractive multigenerational setting that was open seven days a week. The program was an instant hit. We soon expanded to other local hospital and college cafeterias and eventually to a network of small local restaurants.

In its first five years, "As You Like It" grew our congregate program by 55% and increased the number of diners from rural areas by 61% while exceeding AOA goals to increase the number of people and meals served per dollar of funding.

SMAA then restructured our Meals on Wheels program to increase its relevance to the changing needs of our clients. We introduced flash frozen meals, a

dramatic transformation. Flash freezing greatly increased the nutritional density and quality of our meals, reduced waste, and changed our meal delivery paradigm to allow evening and weekend meals. We now offer a variety of menu choices: vegetarian, gluten-free, pureed, renal, and traditional comfort foods every day, very different from the "one size fits all" single item menus of the past. Consumers loved the change because it offered them choice and convenience. A serendipitous benefit was the ability of our meal delivery volunteers to conduct informal wellness checks and spend more time with clients for whom they were often the only visitor of the day.

Using the updated menu and delivery options, we rebranded our new Meals on Wheels offerings as "Simple Delivered Meals" and conducted a pilot study within a four-year Medicare-funded demonstration designed to reduce hospital readmission rates of high-risk patients. We provided a week of Simply Delivered Meals to the patients when they left the hospital, and documented a 38% reduction in readmission rates and a 387% return on investment from avoided readmissions. Our results were peer-reviewed and published in the American Journal of Managed Care in 2018 (included with my testimony). Simply Delivered Meals received an Aging Innovation Award from the National Association of Area Agencies on Aging.

These two examples show how the Older Americans Act can become a new platform for addressing what medicine calls the "social determinants of health". Poor nutrition, lifestyle choices, limited access to safe housing and isolation exacerbate most chronic health conditions, but are nearly impossible for the medical community to influence alone. Area Agencies on Aging are ready to help.

As SMAA has shown, a nimble and innovative AAA can make a quantifiable difference in quality of life and cost of health care.

I have several recommendations to "modernize" the Older Americans Act:

1) Explicitly encourage State and Area Agencies on Aging to leverage OAA funds through "private pay" and contractual relationships with healthcare;
2) Modify the Act to recognize the value in adding cost and revenue sharing options beyond individual client donations;
3) Remove restrictions on Area Agencies on Aging delivering direct services without first obtaining a waiver from their State Units on Aging;
4) Increase OAA funding! OAA funding has woefully lagged growth in the aging population. At SMAA, we receive less Older Americans Act funding today than we did in 2010. Please increase funding to a level that restores the service capacity we have lost in the past decade. Then index authorizations to keep up with the growth of the older population and inflation.

In three months, I will be retiring from my position at SMAA. I have had a fulfilling career with many unique opportunities and satisfying achievements thanks to the Older Americans Act. Testifying to this Committee and sharing my insights with you is a wonderful capstone. Thank you.

Faith Lewis
Testimony before the
United States Senate Special Committee on Aging
May 8, 2019

Chairman Collins, Ranking Member Casey and Members of the Committee, thank you for the honor to testify before you today on behalf of grandparents raising their grandchildren across the country.

My name is Faith Lewis and I live in Simpson, Pennsylvania. I am proud to say that I have 4 grandchildren and 4 great grandchildren. I was invited here today to explain to you why the National Family Caregiver Support Program is so important to me, and why it—and all of the programs funded through the Older Americans Act—are so important to older Americans.

I am currently caring for my five-year-old great-granddaughter, Xziylan. At 69 years old, running around after a five year old is no small feat, but she is a good kid. She is a good eater. She loves fruits, vegetables and yogurt. When I take her to the grocery store with me, she picks out what she wants and it is always watermelon. I didn't know anyone could love watermelon so much. She loves going to the park and got a bike for Christmas. She can't wait for the weather to be nice enough to be outside all of the time. She is a happy kid.

It is important to me that Xziylan has a happy childhood. Xziylan's mother has been in prison on drug-related charges for the past three years. And, if I did not step in to help, my daughter, Xziylan's grandmother, would be taking care of three kids under 11. That is a lot to ask of one person. We help each other out. My son helps when he can, too. And, so does a neighbor when I ask.

Having a strong support network is so important. Every couple of weeks I go out dancing at the VFW in Wilkes-Barre with a friend. That's how I envisioned my retirement. Dancing with friends and traveling with the money I saved.

Now, I rely on my Social Security check to make ends meet. Some months that is harder than others. But, like I have been doing since my mom passed away when I was 13 years old, I figure it out. I get $35 every month in food stamps, but with a kid who likes to eat such healthy food, that doesn't stretch very far. Sometimes I go to the St. Rose Food Pantry. That helps. I had to buy a new car because I drive Xziylan to and from school. Car insurance is expensive. My housing costs are $500

each month. And, I feel like I am always needing to buy her more clothes. You can see how it all adds up.

Last year, I joined a grandparent support group, called 'Parents a Second Time', run by the Lackawanna County Area Agency on Aging. It meets regularly. And, if the support group did not exist, I would have nobody to talk to who would understand what it means to be caring for a kid in your golden years. The issue that we discuss most often is the financial strain of raising our grandchildren.

The National Family Caregiver Support Program helps because I can get reimbursed for some of the costs of raising Xziylan. It helps me afford clothes that fit her. She is always growing. Next year, she is going to kindergarten, so I will have to buy her a uniform. And, it helps me pay for a membership to the YMCA so that she can attend some of the activities for kids. Every kid deserves to have playtime. She loves going to the Y and I would not be able to afford that if I could not get reimbursed from the Area Agency on Aging.

I think it would be so good if more grandparents raising grandchildren could be served through the program. Every little bit helps. And, on behalf of the grandparents who can't get the help like I can, I'd like to thank Senator Casey and Senator Collins for trying to help make sure that more grandparents raising grandchildren can participate in the program.

My granddaughter is not the only person who got caught up in this opioid crisis. There are many more. And, even more parents who are unable to care for a child because of an illness or accident. Grandparents and even great-grandparents are the next line of support. I hope that the National Family Caregiver Support Program will be able to help all older caregivers. And, I hope that you continue to improve all of the programs funded by the Older Americans Act so that my Area Agency on Aging will continue to be around for me and my family.

Again, Chairman Collins and Ranking Member Casey, thank you for the opportunity to testify before the Committee. I look forward to answering any questions.

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