EXAMINING THE OLDER AMERICANS ACT: PROMOTING INDEPENDENCE AND DIGNITY OF OLDER AMERICANS

HEARING

BEFORE THE

SUBCOMMITTEE ON CIVIL RIGHTS AND HUMAN SERVICES

COMMITTEE ON EDUCATION AND LABOR U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, MAY 15, 2019

Serial No. 116–23

Printed for the use of the Committee on Education and Labor

Available via the World Wide Web: www.govinfo.gov
or
Committee address: https://edlabor.house.gov

U.S. GOVERNMENT PUBLISHING OFFICE
36–598 PDF WASHINGTON : 2020

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C O N T E N T S

EXAMINING THE OLDER AMERICANS ACT: PROMOTING INDEPENDENCE AND DIGNITY OF OLDER AMERICANS

Wednesday, May 15, 2019
House of Representatives
Committee on Education and Labor,
Subcommittee on Civil Rights and Human Services
Washington, DC.

The subcommittees met, pursuant to notice, at 10:18 a.m., in room 2175, Rayburn House Office Building. Hon. Suzanne Bonamici [chairwoman of the subcommittee] presiding.

Present: Representatives Bonamici, Schrier, Hayes, Trone, Lee, Comer, Thompson, Stefanik, and Johnson.

Also present: Representatives Scott, and Foxx.

Staff present: Nekea Brown, Deputy Clerk; Ilana Brunner, General Counsel Health and Labor; Brutrinia Cain, HHS Detailee/ Health Fellow; Emma Eatman, Press Aide; Alison Hard, Professional Staff; Carrie Hughes, Director of Health and Human Services; Ariel Jona, Staff Assistant; Stephanie Lalle, Deputy Communications Director; Katie McClelland, Professional Staff; Richard Miller, Director of Labor Policy; Max Moore, Office Aide; Veronique Pluviose, Staff Director; Banyon Vassar, Deputy Director of Information Technology; Cyrus Artz, Minority Parliamentarian, Courtney Butcher, Minority Director of Member Services and Coalitions; Bridget Handy, Minority Communications Assistant; Amy Raaf Jones, Minority Director of Education and Human Resources Policy; Kelley McNabb, Minority Communications Director; Jake Middlebrooks, Minority Professional Staff Member; Casey Nelson, Minority Staff Assistant; Brandon Renz, Minority Staff Director; Mandy Schaumburg, Minority Chief Counsel and Deputy Director of Education Policy; Meredith Schellin, Minority Deputy Press Secretary and Digital Advisor; and Heather Wadyka, Minority Operations Assistant.

Chairwoman BONAMICI. The Subcommittee on Civil Rights and Human Services will come to order. I note a quorum is present. This meeting will hear the testimony on examining the Older Americans Act, promoting independence and dignity for older Americans.

Pursuant to committee rule 7c opening statements are limited to the Chair and ranking member. This allows us to hear from our

witnesses sooner and provides all members with adequate time to ask questions.

I recognize myself now for the purpose of making an opening statement.

We are here today to examine the Older Americans Act, a critically important pillar of our efforts to improve the quality of life for older Americans and their families.

In 1965, Congress passed the Older Americans Act, or OAA, to provide basic supports to aging Americans. Since then, Congress has repeatedly updated and strengthened the OAA in a bipartisan manner to fulfill its mission of helping more Americans live independently and age with dignity.

OAA programs have been consistently successful, which has led to a gradual expansion of the services it provides. The Act now supports a range of community-based programs that target assistance to those who need it most.

Of the many vital OAA programs, one of the most recognized is nutrition assistance offered through both congregate meal sites and home-delivered programs such as Meals on Wheels. OAA's nutrition assistance programs provide more than 900,000 healthy meals to older Americans each day.

OAA also supports elder justice activities and funds programs to prevent elder abuse. Additionally, the Act offers community service employment opportunities to low-income seniors, allowing them to access part-time work that both supports them economically and provides purpose and social engagement.

OAA also provides family caregivers with much needed training, respite, and support. And based on my own experience caring for my 90-year-old mother, who has Alzheimer's, I can particularly appreciate the importance of the National Family Caregiver Support Program.

Collectively, OAA programs serve about 11 million older adults, 3 million of whom regularly look to OAA services for basic needs. Importantly, OAA programs work together to make sure that aging adults retain independence and avoid costly institutionalized care for as long as possible.

Despite the success of the Older Americans Act, in recent years our investment has not kept pace with inflation and has not recognized the rising number of older Americans and the challenges they continue to face.

Although the population of Americans age 60 and over has grown more than 60 percent since 2001, OAA funding has only grown by roughly 20 percent. And, accounting for inflation, OAA funding has steadily declined by 16 percent.

The disinvestment has weakened OAA programs at a time of growing demand for the services they provide. Nearly 1 in 10 Americans over the age of 65 lives in poverty, and they are not getting the support they need. A 2015 Government Accountability Office study found that 83 percent of food insecure, low-income older Americans did not receive any meal services, and 2 in 3 older Americans who struggle with daily activities received limited or no home-based care.

As the number of older Americans continues to increase, Congress must strengthen our support for OAA's proven, long-standing

programs. We must recommit to providing basic services and compassionate care to vulnerable members of our communities.

Not only is this the right thing to do, but the economics also make sense. OAA allows older Americans to delay or altogether avoid costlier care by promoting healthier—healthy behaviors, such as chronic disease management, and by providing the supportive services that allow seniors to age in place.

That is the responsibility and the opportunity facing this committee and the 116th Congress. We are in a position to advance a reauthorization of the Older Americans Act that will allow millions of Americans across the country to age with dignity.

This hearing is an important first step. Today, we will discuss the challenges facing older Americans, what OAA programs look like across the country, and how the OAA supports millions of seniors and their families.

Today we are also continuing the law's tradition of strong bipartisan support. I was honored to be involved in the 2016 reauthorization when both the House and Senate unanimously supported the legislation and I look forward to once again working with Ranking Member Comer, Ranking Member Foxx, and of course Chairman Scott, and all my colleagues on both sides of the aisle to advance a robust Older Americans Act reauthorization bill this year.

Thank you to the distinguished witnesses for being here today. I look forward to this discussion.

And I now recognize the distinguished ranking member for the purpose of an opening statement.

[The statement of Chairwoman Bonamici follows:]

Prepared Statement of Hon. Suzanne Bonamici, Chairwoman, Subcommittee on Civil Rights and Human Services

We are here today to examine the Older Americans Act, a critically important pillar of our efforts to improve the quality of life for older Americans and their families.

In 1965, Congress passed the Older Americans Act, or O-A-A, to provide basic supports to aging Americans. Since then, Congress has repeatedly updated and strengthened OAA in a bipartisan manner to fulfill its mission of helping more Americans live independently and age with dignity. OAA programs have been consistently successful, which has led to a gradual expansion of the services it provides. The Act now supports a range of community-based programs that target assistance to those who need it most.

Of the many vital OAA programs, one of the most recognized is nutrition assistance offered through both congregate meal sites and home-delivered programs such as Meals on Wheels. OAA's nutrition assistance programs provide more than 900,000 healthy meals to older Americans each day. OAA also supports elder justice activities and funds programs to prevent elder abuse. Additionally, the Act offers community service employment opportunities to low-income seniors, allowing them to access part-time work that both supports them economically and provides purpose and social engagement. OAA also provides family caregivers with much-needed training, respite, and support. And based on my own experience caring for my 90-year-old mother, who has Alzheimer's, I can particularly appreciate the importance of the National Family Caregiver Support Program.

Collectively, OAA programs serve about 11 million older adults 3 million of whom regularly look to OAA services for basic needs. Importantly, OAA programs work together to make sure that aging adults retain independence and avoid costly institutionalized care for as long as possible.

Despite the success of the Older Americans Act, in recent years our investment has not kept pace with inflation and has not recognized the rising number of older Americans and challenges they continue to face.

Although the population of Americans age 60 and over has grown more than 60 percent since 2001, OAA funding has only grown by roughly 20 percent. And, accounting for inflation, OAA funding has steadily declined by 16 percent.

This disinvestment has weakened OAA programs at a time of growing demand for the services they provide. Nearly one in ten Americans over the age of 65 lives in poverty, and they are not getting the support they need. A 2015 Government Accountability Office study found that 83 percent of food insecure, low-income older Americans did not receive any meal services. And two in three older Americans who struggle with daily activities received limited or no home-based care.

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As the number of older Americans continues to increase, Congress must strengthen our support for OAA's proven, long-standing programs. We must recommit to providing basic services and compassionate care to vulnerable members of our communities.

Not only is this the right thing to do, but the economics also make sense. OAA allows older Americans to delay or altogether avoid costlier care by promoting healthy behaviors, such as chronic disease management, and by providing the supportive services that allow seniors to age in place.

That is the responsibility and the opportunity facing this Committee and the 116th Congress. We are in a position to advance a reauthorization of the Older Americans Act that will allow millions of Americans across the country to age with dignity.

This hearing is an important first step. Today, we will discuss the challenges facing older Americans, what OAA programs look like across the country, and how the OAA supports millions of seniors and their families. Today we are also continuing the law's tradition of strong bipartisan support. I was honored to be involved in the 2016 reauthorization when both the House and Senate unanimously supported the legislation. I look forward to once again working with Ranking Member Comer, Ranking Member Foxx, Chairman Scott, and all my colleagues on both sides of the aisle to advance a robust Older Americans Act reauthorization bill this year.

Thank you to the distinguished witnesses for being here today. I look forward to this discussion and now yield to the Ranking Member, Mr. Comer, for the purpose of an opening statement.

Mr. COMER. Thank you, Madam Chairman, for yielding.

Today's life expectancy in our Nation is at a historic high, which is great news and it means we need to be doing all we can to ensure that Americans have access to quality, timely services which allow them to live in their homes as long as possible.

This hearing will help us better understand what might be done to ensure the law is aging as well as the people it saves.

Since 1965 the Older Americans Act, or OAA, has governed the organization and delivery of services for senior citizens throughout the country. With more than 41 million Americans 65 and older, the social and nutritional programs offered by OAA are critical to helping them maintain independence. The reach of this law is substantial and covers many aspects of elder care.

In addition to well known programs like Meals on Wheels, OAA support services provided by more than 300 State, tribal, and native Hawaiian organizations and approximately 200,000 local providers. Some of these services include nutrition programs, providing meals for senior citizens, schools, and churches, care to prevent the abuse, neglect, and exploitation of seniors, family care giver support systems, and community service employment opportunities for older Americans.

These types of programs offer valuable assistance for American seniors and the Federal Government should continue to support them. I know that I do.

As our committee considers reauthorization of OAA, I am confident that we can work together on bipartisan legislation to support our Nation's seniors through effective policy.

I thank the witnesses for being here today and hope today's discussion will offer insights into how we can build upon OAA's flexible policies to promote consumer driven independent living for older Americans.

Madam Chairman, I yield back.

[The statement of Mr. Comer follows:]

Prepared Statement of Hon. James Comer, Ranking Member, Subcommittee on Civil Rights and Human Services

Thank you for yielding.

Today's life expectancy rate in our Nation is at a historic high, which is great news, and it means we need to be doing all we can to ensure that Americans have access to quality, timely services which allow them to live in their homes as long as possible. This hearing will help us better understand what might be done to ensure the law is aging as well as the people it serves.

Since 1965, the Older Americans Act, or OAA, has governed the organization and delivery of services for senior citizens throughout the country. With more than 41 million Americans 65 and older, the social and nutritional programs offered by OAA are critical to helping them maintain independence.

The reach of this law is substantial and covers many aspects of elder care. In addition to well-known programs like Meals on Wheels, OAA supports services provided by more than 300 State, Tribal, and Native Hawaiian organizations and approximately 20,000 local providers. Some of these services include: nutrition programs providing meals at senior centers, schools, and churches; care to prevent the abuse, neglect, and exploitation of seniors; family caregiver support systems; and community service employment opportunities for older Americans. These types of programs offer valuable assistance for America's seniors, and the Federal Government should continue to support them.

As our committee considers a reauthorization of OAA, I am confident that we can work together on bipartisan legislation to support our Nation's seniors through effective policy. I thank the witnesses for being here and hope today's discussion will offer insights into how we can buildupon OAA's flexible policies to promote consumer-driven, independent living for older Americans.

Chairwoman BONAMICI. Thank you very much to the ranking member.

Without objection, all other members who wish to insert a written statement into the record may do so by submitting them to the committee clerk electronically in Microsoft Word format by 5 p.m. on May 29, 2019.

I will now introduce our witnesses. I am honored to introduce Lee Girard, who is the director of Multnomah County Aging, Disability, and Veterans Services Division, the federally designated Area Agency on Aging, or AAA, from Multnomah County, Oregon, and the largest AAA in the State of Oregon. Multnomah County Aging, Disability, and Veterans Services Division serves approximately 40 percent of the State's caseload in long-term services and supports.

The Division operates Older Americans Act programs, State funded programs, adult protective services, and Medicaid eligibility for long-terms services and supports for older adults, people with disabilities, and veterans. Lee has a staff of 465, with 10 community centers and 11 meal sites, reaching more than 136,000 consumers annually.

Lee currently serves as the chair of the Oregon Association of Area Agencies on Aging, the member association representing the

area agencies in the State of Oregon. She is also a board member of the National Association of Area Agencies on Aging, or n4a.

We are going to come back to Ms. Archer-Smith.

Next is Christina Grace Juno Whiting. She is the president and chief executive officer at the National Alliance for Caregiving, where she continues her tenure from previous roles, including chief operating officer and the director of strategic partnerships.

Grace led the launch of the Caregiving in the U.S. 2015 research study with AARP and directed the first national public policy study of rare disease caregivers with Global Genes.

She has contributed to several national reports on caregiving, including Cancer Caregiving in the U.S., with the National Cancer Institute and Cancer Support Community, and Dementia Caregiving in the U.S., with the Alzheimer's Association.

She is also a member of the American Society on Aging and the Gerontological Society of America.

Next we have Patty Ducayet. She is a licensed master social worker. She became the State long-term care ombudsman at the Texas Department of Health and Human Services in January of 2007. As the State long-term care ombudsman, Patty oversees 28 local ombudsman programs, certifies and trains ombudsmen, and advocates for policy and legislative change to positively impact Texans living in nursing and assisted living facilities.

Patty has served on the Board of the National Association of State Long-term Care Ombudsman Program since 2009, including serving as president from 2014 to 2018. She currently serves as chair of the Association's advocacy committee.

Mr. Trone is not here, so. Mr. Trone was going to introduce Ms. Archer-Smith, but I am going to introduce her.

She is from his home State of Maryland. Stephanie Archer-Smith is executive director of Meals on Wheels of Central Maryland, a community based, nonprofit organization providing congregate and home-delivered meals and support services to individuals primarily age 60 and older through the Older Americans Act nutrition program in Baltimore City and County, as well as six surrounding counties.

Ms. Archer-Smith has 35 years of experience working with vulnerable populations through the life cycle in private, public, and not for profit human services organizations. Stephanie has served on the board of directors for the Baltimore Homeless Services and was a contributing author to Journey Home, Baltimore's 10-year plan to end homelessness.

We appreciate all of the witnesses being here today and we look forward to your testimony.

Let me remind the witnesses that we have read your written statements and they will appear in full in the hearing record. Pursuant to committee rule 7d and committee practice each of you is asked to limit your oral presentation to a 5-minute summary of your written statement.

Let me remind the witnesses that pursuant to Title 18 of the U.S. Code section 1001, it is illegal to knowingly and willfully falsify any statement, representation, writing, document, or material fact presented to Congress or otherwise conceal or cover up a material fact.

Before you begin your testimony please remember to press the button on the microphone in front of you so it will turn on and the members can hear you. As you begin to speak the light in front of you will turn green. After 4 minutes the light will turn yellow to signal that you have 1 minute remaining. When the light turns red your 5 minutes have expired and we ask that you please wrap up.

We will let the entire panel make their presentations before we move to member questions. When answering a question, please remember once again to turn your microphone on.

I will first recognize Ms. Girard.

STATEMENT OF LEE GIRARD, DIRECTOR, MULTNOMAH COUNTY AGING, DISABILITY AND VETERANS SERVICES

Ms. GIRARD. Chair Bonamici, Ranking Member Comer, and members of the subcommittee, I am Lee Girard, Director of Multnomah County Aging, Disability, and Veterans Services.

Thank you for this opportunity to share our experiences and recommendations for the Older Americans Act as you work toward reauthorization.

In Oregon, we have set forth in statute the values of independence, dignity, and choice as the foundation of our work in supporting older adults. These values are also foundational in the Older Americans Act. Area Agencies across the Nation have worked to build a strong and dynamic network of services and supports that allow older adults to have the kinds of choices we all wish for, living in the communities of our choosing in ways that are responsive to our diverse needs and preferences.

When my agency conducted our last area plan community needs assessment we talked to almost 500 older adults from diverse communities across our county. The need for flexibility in planning local services was highlighted by the variety of needs that were raised in these community sessions. Based on these listening sessions, our agency has continued to prioritize expansion of services for older adults with the greatest economic and social needs, with particular focus on LGBT and racial and ethnic communities in our area.

Oregon is no different than the national trend. We now enjoy a longer lifespan than previous generations. By 2025, it is estimated that 20 percent of Oregon's population will be age 65 and over. Oregon's person-centered system prioritizes the needs of the individual to provide better care, lower costs, and a better quality of life for older adults and people with disabilities.

Information and assistance and person-centered options counseling are foundational services within the Older Americans Act. As an individual finds that they need more help to remain independent, these services provide the support to meet that goal.

Several recent studies in Oregon have demonstrated the impacts of this work. A recent business case study found an 11:1 return on investment for these services. The benefits that were found included finding and keeping long-term services and supports and housing, helping with basic needs to remain independent, avoiding homelessness—which is a growing issue for older adults—preventing abuse, and averting falls and other debilitating situations.

A second study also found a distinct correlation between avoiding preventable hospitalizations and the availability of Older Americans Act funded information assistance and options counseling services. These are significant numbers and demonstrate the high value and return on investment for the services provided via the Older Americans Act. Social determinants of health can influence up to 60 percent of an individual's health.

The Older Americans Act funds health promotion programs, elder justice and abuse prevention, family caregiving support, and nutrition services. It really is this holistic approach that made the Older Americans Act truly "ahead of its time" when it was created in 1965.

As you begin your work on reauthorization, we encourage you to consider important adjustments that could be made to the Act to bring it into this new era of services and supports. We also know that the needs of older adults' experiences can vary widely and be significantly impacted by a variety of factors and barriers. The Older Americans Act is founded on targeting services to individuals with the greatest social and economic needs. We ask that LGBT communities be specifically recognized as one of those populations to be targeted.

Local flexibility is also a key program strategy for the Older Americans Act. This provision has enabled Area Agencies to meet the needs of their local communities in ways that makes the most sense with the most efficient use of funds.

Supporting innovation and best practices must also be another key priority. The Aging Network continues to evolve through local planning and development efforts to expand a network of services focused on interventions that lower the overall cost curve in long-term care and healthcare.

Finally, a commitment for bipartisan support to increase authorization levels as well as reauthorizing the Older Americans Act is absolutely necessary to meet the goals of the Older Americans Act going forward.

I would like to thank you for your time today and would be happy to answer any questions later from the committee.

Thank you.

[The statement of Ms. Girard follows:]

Department of County Human Services

Multnomah County

Aging, Disability & Veterans Services Division

Testimony before the United States House Subcommittee on Civil Rights and Human Services

May 15, 2019

Lee Girard

Chair Bonamici, Ranking Member Comer and members of the Subcommittee on Civil Rights and Human Services, I am Lee Girard, Director of Multnomah County Aging, Disability & Veterans Services, Chair of O4AD, the Oregon Association of Area Agencies on Aging & Disabilities. O4AD is the member association representing the Area Agencies on Aging serving older adults and people with disabilities in our state, and a Board member of N4A, the National Association of Area Agencies on Aging. Thank you for this opportunity to share our experiences, perspective and recommendations for the Older Americans Act as you work towards reauthorization. We appreciate your time and consideration.

Multnomah County Aging, Disability and Veterans Services operates Older Americans Act programs, State-funded programs, Adult Protective Services and Medicaid eligibility and long term services and supports for older adults, people with disabilities, veterans and their families. I have a staff of 465 with 10 community centers, 11 meal sites and reaching over 136,000 consumers annually.

In Oregon, we have enshrined the overarching values that are our north star in serving older adults. Independence, dignity and choice are the foundation of our work and are set forth in Oregon statute. These values, along with the safety of the consumer, are also foundational in the Older Americans Act. Area Agencies across the nation have worked to build a strong and dynamic network of services and supports that allow older adults to have the kinds of choices we all wish for – living in the communities of our choosing in ways that are responsive to our diverse needs and preferences.

When my agency conducted our last Area Plan community needs assessment we talked with almost 500 older adults from diverse communities across our County. Sixty-eight (68) percent were non-English speakers and 89 percent were from diverse communities, including the LGBT community. The need for flexibility in planning local services was highlighted by the variety of needs that were raised in these community sessions. Based on these listening sessions, our agency has continued to prioritize expansion

of services for older adults with the greatest economic and social needs, with a particular focus on LGBT and racial and ethnic communities.

Innovation in service delivery has helped to meet the needs of a rapidly growing population. Oregon is no different than the national trend – we now enjoy a longer lifespan than previous generations. Yet this also requires a new look at investments in the services that are needed to meet that growth. By 2025, it is estimated that fully 20% of Oregon's total population will be age 65 and over. Oregon's person-centered system prioritizes the needs of the individual to provide better care, lower costs and a better quality of life for older adults and people with disabilities.

Information and Assistance and Person-Centered Options Counseling are foundational to the Older Americans Act. As an individual finds they need more help to remain independent, these services provide the information and navigation to meet that goal. A recent Social Return on Investment study in Oregon demonstrates the impact of this work. When looking at Options Counseling and Information and Assistance, this business case study by Compelling Reason[1] found an 11:1 return on investment for these services. The benefits include:

- Finding and keeping long-term services and supports and housing
- Helping with basic needs to remain independent
- Avoiding homelessness
- Preventing abuse
- Averting falls

We are happy to share this report on request.

HMA, Health Management Associates, also completed a study[2] on a variety of long-term services and supports in Oregon to determine impacts. HMA found a distinct correlation between avoiding preventable hospitalizes and readmissions and Information and Assistance and Options Counseling services. HMA noted, "avoidable hospitalizations cost $4 billion per year, nationally. Oregon's share is almost $50 million per year, even more when you include the cost for people who end up needing more intensive care and

[1] Compelling Reason/Oregon Department of Human Services. 2018

[2] Health Management Association. "Making a Data Driven Case for Oregon's Area Agencies on Aging and Disabilities." 2017

must go on Medicaid." HMA went on to share that is just 1 in 5 people leaving a hospital received assistance including the services through an Area Agency, the savings could be $10 million per year.

Avoiding preventable hospitalization and readmissions requires support to be present for an individual including in-home visits, nutrition, medical management and transportation. Helping not only an individual but their family know what services exist and how to access them offers the opportunity to 'land safely'.

Information and Assistance, Person-Centered Options Counseling and Case Management have been a part of the Older Americans Act for many years, and the health care world is now catching onto the importance.

These are significant numbers and demonstrate the high value and return on investment for the services provided via the Older Americans Act. Through health care transformation, we are now fully aware that medical care is not the only factor that helps improve health. Social determinants of health can influence up to 60 percent of an individual's health. The HMA study referenced before also found that is just 5% of Oregonians with chronic conditions participated in a health promotion program such as the Stanford Living Well Self-Management program, the savings could have been over $142 million in health care costs.

The OAA brings necessary resources to health promotion programs as well as the focus on elder justice, abuse prevention, family caregiver support and nutrition services. It is this holistic approach that made the Older Americans Act truly "ahead of its time" when it was created in 1965 and demonstrates why the need not only for reauthorization, reinvestment and increased appropriation are more critical now than ever before.

As you begin your work on this reauthorization, we encourage you to consider important adjustments that should be made to the Act to bring it into this new era of services and supports. In Oregon, we see that not only is our older population increasing in numbers, but the needs of those consumers are changing. More older adults are aging without family nearby or the natural supports that we all previously counted on, those with family members in the state need to work to support their own family and are unable to serve as a caregiver and the complexity of needs for consumers seeking help is increasing.

We also know the needs that older adults experience can vary widely and be significantly impacted by a variety of factors and barriers. The Older Americans Act is founded on targeting services to individuals with the greatest economic and social needs. We ask that LGBT communities be specifically recognized as a required population in addressing social and economic needs.

Local Flexibility has been a key program strategy for the Older Americans Act. This provision has enabled Area Agencies to meet the needs of their local communities in ways that makes the most sense and is the most efficient use of funds. Enabling that flexibility to reach into the nutrition programs specifically will allow the network to provide services where they are most needed - in seniors' homes. Working with Aging advocacy organizations to maximize local flexibility within the OAA for Area Agencies is an important task going forward in this reauthorization period.

Supporting innovation and best practices must also be another key priority. The Aging network continues to evolve through that local flexibility we spoke about previously and is working to implement wellness tools and evidence based programs to promote healthy aging and disease self management. Bring more funds and resources to these programs will continue to help the network focus on intervention and prevention, which lowers the overall cost curve in long-term care.

Finally, a commitment for bipartisan support to not only reauthorizing the Older Americans Act but moving to adequate and stable funding is absolutely necessary to continue to meet the needs coming to our nation as our older population continues to increase. The Older Americans Act is the first line in the overall goals of improving the quality of life, improving health outcomes and bending the cost curve in long-term services and supports.

I would like to sincerely thank you for your time today and would be happy to answer any questions from the Committee.

Chairwoman BONAMICI. Thank you for your testimony.

And next I will recognize Ms. Archer-Smith for 5 minutes for your testimony.

STATEMENT OF STEPHANIE ARCHER-SMITH, EXECUTIVE DIRECTOR, MEALS ON WHEELS OF CENTRAL MARYLAND, INC.

Ms. ARCHER-SMITH. Good morning, Chairwoman Bonamici, Ranking Member Comer, and members of the subcommittee. Thank you for the opportunity to testify today.

My name is Stephanie Archer-Smith and I am the executive director for Meals on Wheels of Central Maryland, a community-based nonprofit that provides congregate and home-delivered meals through the Older Americans Act nutrition program.

Each year we serve over a million nutritious meals; 800,000 of those are delivered to the door of nearly 3,000 homebound seniors in Baltimore City and the surrounding counties. Federally supported senior nutrition programs like ours are leading the fight to improve senior health by combating hunger and isolation. This unique combination of nutritious meals, companionship, and other person-centered services is only made possible by the Older Americans Act.

Title III-C of the Older Americans Act, the nutrition program, is the only Federal program designed specifically to meet both the nutritional and social needs of older adults in order to reduce hunger and food insecurity, promote socialization, and improve the health and wellbeing of older individuals. In 2017 the Older Americans Act delivered on that promise to 2.4 million seniors nationwide.

The Older Americans Act nutrition program is perhaps the best example of the power of a successful public-private partnership. At Meals on Wheels of Central Maryland, the Older Americans Act funding we receive makes up 60 percent of our budget. The remaining 40 percent is comprised of private donations, other private and local government grants, and other healthcare partnership programs. We mobilize more than 1,800 volunteers who provide over $2 million of in-kind contribution annually to support our daily operations.

The reality of senior hunger and isolation in our country is sobering. In Maryland more than 140,000 seniors face the threat of hunger each day, often making difficult choices between eating properly or paying for medication. Nationwide nearly 9 million seniors struggle with hunger, and almost twice as many live alone, leaving them at risk for negative health outcomes associated with food insecurity, malnutrition, and social isolation. Feelings of loneliness in particular are associated with negative health effects comparable to smoking 15 cigarettes a day.

The economic burden associated with senior malnutrition costs $51 billion annually, while senior falls account for $50 billion in medical costs. The good news is the infrastructure to address these consequences already exists through the Older Americans Act network. The majority of seniors receiving Older Americans Act nutrition services report that participating in the program helps them feel more secure and prevents falls, avoiding hospitalization and re-

ducing healthcare costs. One year of Meals on Wheels services can be provided for the approximate cost of 1 day in the hospital.

In Maryland the impact is clear. Ninety-four percent of our participants report increase food security, ninety-eight percent believe our services have extended the length of time they can remain living at home, ninety-four percent report that Maryland Meals on Wheels has improved their quality of life, and one hundred percent report better medication compliance.

But it is best illustrated by the story of the seniors themselves. Frederick, who is a 69-year-old Navy veteran, lives alone in a mobile home in Harford County. He has been receiving Meals on Wheels since 2015 because of his limited mobility. Frederick also receives food for his dogs, who are always by his side when we deliver.

During his annual home assessment, something all Meals on Wheels clients receive, it was discovered that he had a roof leak so severe that he was no longer able to use his bedroom and mold was growing. Our case management team immediately intervened, identifying resources for his roof replacement.

Today Frederick enjoys his home free of leaks and dangerous mold due to a complete roof replacement, which was finished earlier this month at no cost to him.

Ruth lives alone on a narrow street in Baltimore. During a big snow storm last winter she wondered how the mobility van that picks her up for dialysis would make it down her narrow street. Despite the snow, her Meals on Wheels volunteer was there. The Meals on Wheels team reached out to the police to ask for their help in getting Ruth safely to her treatment.

Ruth shared her gratitude with me, stating "I thought my life depended on dialysis, but that day my life depended on Meals on Wheels."

Were it not for Meals on Wheels these seniors would be hungry and alone and disconnected from their community. The unacceptable truth is that for these seniors we are unable to serve this is their reality.

A 2015 Government Accountability report found that 83 percent of low-income food insecure adults are not receiving the meals they need. We currently have 186 people waiting for space on the Older Americans Act funded program. How do you tell a senior who needs your help that you cannot help them?

I urge this committee to keep a strong and on-time reauthorization of the Older Americans Act a priority and support local nutrition providers like me as we work tirelessly to meet the unmet needs of seniors today and in the future.

Again, I thank you for holding this timely hearing during Older Americans Act month, and for the opportunity to testify. I stand ready to support this process in any way I am able and look forward to answering any questions you might have.

[The statement of Ms. Archer-Smith follows:]

Testimony of Stephanie Archer-Smith
Executive Director, Meals on Wheels of Central Maryland

Subcommittee on Civil Rights and Human Services
Committee on Education and Labor
United States House of Representatives

Hearing on "Examining the Older Americans Act: Promoting Independence and Dignity for Older Americans"

May 15, 2019

Chairwoman Bonamici, Ranking Member Comer, and distinguished Members of the Subcommittee, good morning. Thank you for the opportunity to testify before you today at this important hearing. I am Stephanie Archer-Smith, the Executive Director for Meals on Wheels of Central Maryland.

Meals on Wheels of Central Maryland is a community-based nonprofit organization providing congregate and home-delivered meals and support services to individuals primarily age 60 and older through the Older Americans Act (OAA) Nutrition Program in Baltimore City and County, as well as six surrounding counties. Each year we serve over a million meals, 800,000 of which are delivered to the door of nearly 3,000 homebound Marylanders. Since our founding in 1960, our services have helped seniors and individuals with disabilities live safely and independently at home, reduce isolation, and improve health and overall quality of life.

I am also proud to join you today as both a member and partner organization with Meals on Wheels America – the national nonprofit membership organization working to support the network of 5,000 senior nutrition programs located in virtually every community across the country and the millions of seniors who rely on them as a lifeline.

Each day, independently-operated senior nutrition programs are leading the fight to improve senior health by combatting hunger and isolation. The combination of nutritious meals, companionship, and other person-centered support services we provide to our nation's most vulnerable seniors are only made possible by the federal funding and support authorized by the OAA. This foundational and successful legislation not only delivers a strong social and economic return on investment for the individuals it serves, but also to taxpayers by averting unnecessary hospitalizations and premature nursing home placement often paid for through Medicare and Medicaid. In fact, we can provide Meals on Wheels in Maryland and across the country to a senior for an entire year for less than one day in a hospital or a week in a nursing home.

The Older Americans Act: A Lasting Legislative Achievement

Since 1965, the OAA has been the principle piece of federal legislation supporting vital nutrition services and supports for older adults age 60 and older, as well as their families and caregivers. The law has grown and evolved over the years since its enactment, but its purpose remains the same: create a strong national aging network that offers social services and other essential supports to seniors in their communities. No doubt, the data speaks for itself. The OAA is meeting this goal each and every day.

The OAA established the Administration on Aging (AoA), which was to be led by the Assistant Secretary for Aging. Today, the AoA is housed within the U.S. Department of Health and Human Services' Administration for Community Living (ACL) and is tasked with supporting older adults and persons with disabilities in order to maintain their health, and keep them living safely and independently in their homes and communities. At the state and local levels, programs and activities are carried out by 56 state agencies, over 600 Area Agencies on Aging (AAAs) and thousands of community-based organizations, like ours, who are in the field personally interacting with your constituents daily. For context, the state agency overseeing OAA programs in Maryland is the Department of Aging. As the largest Meals on Wheels program in Maryland, my organization serves a wide geographic region, reaching multiple counties with contracts and partnerships established in eight of the 19 AAAs across the state.

The OAA contains seven separate titles. Title III – Grants for State and Community Programs – is the largest title of the Act and provides grants to states to help carry out a variety of supportive service and health promotion programs for older adults and their caregivers. The largest of these programs is the Title III-C Nutrition Program, which includes congregate and home-delivered nutrition services. The OAA Nutrition Program is the only federal program that is designed specifically to meet both the nutritional and social needs of older adults and represents over 40% of all OAA funding for FY 2019. The stated purpose of the program is "to reduce hunger and food insecurity, to promote socialization of older individuals, to promote the health and well-being of older individuals by…access to nutrition." It fulfills these objectives day-in and day-out. In 2017, the program helped the senior nutrition network deliver on that promise to 2.4 million seniors.[1]

Furthermore, the OAA Nutrition Program is an example - perhaps the best example - of the power of a successful public-private partnership. Critical federal dollars provided by the OAA leverages additional sources of funding from state, local and private sources to help meet the rapidly growing need. At Meals on Wheels of Central Maryland, the OAA funding we receive through contracts with our partnering AAAs makes up 60% of our budget. The remaining 40% is comprised of private donations, other private and local government grants, payments through the Maryland Medicaid Waiver and other healthcare partnership programs. We also mobilize an army of more than 1,800 volunteers, who provide over $2 million of in-kind contributions to support our daily operations annually.

In short, the OAA has not only withstood the test of time but has continuously adapted to meet the needs of seniors and families it serves. After more than 50 years, this legislation remains a strong and essential piece of aging policy. Everyday my colleagues and I witness how the Act successfully fulfills its purpose. Any modifications made through the reauthorization process must be focused on improving the ability to reach more seniors and to serve them better. There remains too many seniors who need nutritious meals but are not currently receiving services, primarily due to lack of funding.

The Older Americans Act: Its Role in Addressing Senior Hunger and Isolation

The reality of senior hunger and isolation in our country is sobering. Today, millions of seniors are experiencing some degree of food insecurity and/or social isolation. In Maryland, more than 140,000 seniors face the threat of hunger each day, often making difficult choices between eating properly or paying for medication. Nationwide, nearly 9 million seniors struggle with hunger – representing an increase of almost 90% since 2001 – and almost twice as many live alone, leaving them at risk for a multitude of negative health outcomes associated with food insecurity, malnutrition, and social isolation.[2]

Food insecure older adults experience worse health outcomes than food secure seniors, with greater risk for heart disease, depression, decline in cognitive function and mobility.[3] Feelings of loneliness, in particular are associated with negative health effects comparable to smoking 15 cigarettes per day.[4] The economic burden of senior malnutrition alone costs $51 billion annually, while senior falls account for $50 billion in medical costs.[5,6] Despite the well-founded inextricable link between healthy aging and access to nutritious food and regular socialization, millions of seniors struggle to meet these basic human needs.

The infrastructure and cost-effective interventions to address these consequences already exist through the OAA network. As stated above, the congregate and home-delivered programs serve a critical role in addressing the nutritional and social needs of our nation's older adults. The OAA Nutrition Program effectively meets the needs of older adults who face challenges in living independently at home as a result of advanced age, including physical and/or cognitive impediments to one or more activities of daily living, management of multiple chronic conditions, and taking several medications daily.[7,8] Some of the most vulnerable seniors that the OAA serves – those who are frail, homebound, and socially-isolated – rely on the home-delivered meal program.

The impact of these services on seniors' lives is powerful. The majority of seniors receiving OAA nutrition services consistently report that participating in the program helps them feel more secure, prevent falls or fear of falling, and allows them to stay in their own home.[9,10] In turn, this helps avoid preventable emergency room visits, hospital admissions and readmissions, as well as extended stays in rehab, preventing premature institutionalization and ultimately reducing our nation's health care costs.

In Maryland, we see the vital need for the OAA firsthand, and the impact is clear. In FY 2018:

- 98% of Meals on Wheels of Central Maryland clients believe Meals on Wheels services have extended the length of time they will be able to remain living at home in the community
- 94% believe Meals on Wheels services have improved their nutrition and food security
- 94% report that Meals on Wheels programs have improved their quality of life
- 72% report that Meals on Wheels has decreased their social isolation and feelings of loneliness
- 94% reported increased food security
- 72% reported improved mental health
- 100% reported better medication compliance
- 61% reported improved health literacy
- 78% reported increased feelings of home safety, security, and independence in their home

In addition, the first year results of a three-year demonstration project with a community healthcare partner showed a 33% reduction in hospitalizations, post participation in the program.

Above all, the importance of these services can be best defined by those who use them. Seniors like:

Curry, who is 80 years old and acts as the sole caregiver for his wife Barbara, who lives with Parkinson's Disease. They would be forced to leave their home were it not for Meals on Wheels.

Judy, who can no longer cook her own meals due to a back injury — a true personal struggle for someone who made all her Kosher meals from scratch prior to her injury. Were it not for Meals on Wheels, she tells us she simply would not eat.

Ms. M., who is blind, and although she has memorized how to prepare her favorite meals, can no longer shop for the groceries needed to do it. She would not have groceries in her home, were it not for our volunteers.

And I would also like to tell you more about two people whose service exemplifies the "more than a meal" philosophy—the added value of the program beyond every meal.

Doreen, who is 92 years old, lives alone in what was a lovingly cared-for home, but now can only move around by using a walker. She finds it difficult to get to the door and is unable to carry her food trays herself. Every day, our volunteers, who she delights in talking with, let themselves in, carry her food to her table, and unwrap the meal for her. Were it not for Meals on Wheels, I am not sure what Doreen would eat. I know it would not be a healthy meal, and she would sorely miss that daily human connection and visit each day.

And Frederick who is a 69-year old veteran and lives in a mobile home in Harford County. He served in the Navy and spent time in Vietnam. He has been receiving Meals on Wheels since September of 2015 because of limited mobility due to spine and lung problems, which has helped to sustain him at home for the last four years. In addition to receiving meals, he is a Kibble Connection client so that he can receive food for his two dogs who are always by his side when we deliver. Otherwise, he would likely be sharing his food with them. During his annual home assessment, it was discovered that he had a roof leak so severe that he was no longer able to use his bedroom and mold was starting to grow. Our Case Management team got to work identifying resources for his roof replacement. Today, Frederick enjoys his home free of leaks and dangerous mold due to a complete roof replacement, which was finished earlier this month.

Simply put, were it not for Meals on Wheels and the dedicated volunteers who prepare, serve and deliver meals, these seniors and millions more across the country would be hungry and disconnected from the community they love. And the unacceptable truth is that for the seniors we are not currently able to serve, this is their reality.

The Older Americans Act Reauthorization: An Opportunity to Serve More in Need

Reauthorization of the OAA provides an important legislative opportunity to evaluate the Act's programs and services, and build upon the improvements made in the past. Since its inception, the OAA Nutrition Program has provided billions of meals to seniors in need, improved countless lives and saved considerable taxpayer dollars with well-established trust, at both the community and national level.

While this program has worked as it was designed to for decades, it is not reaching all of those in need. A 2015 Government Accountability Report found that 83% of low income, food insecure older adults are not receiving the congregate or home-delivered meals that they are eligible for and likely need.[11] At our program, we currently have 186 clients waiting for a space on the OAA-funded program. These are only the individuals we are aware of and know that it is an underrepresentation of the true need in our community. And I know many of my colleagues across the county have to manage waiting lists for vulnerable older adults in their communities in desperate need of services, as well. How do you tell someone who needs your help that you cannot help them?

One individual struggling with hunger is far too many. And with the issue being pervasive in American communities and additional challenges fast-approaching with the growth in our senior population, there is no time to wait for action. The population of adults age 60 and older is projected to nearly double by 2060, yet the number of meals and seniors we are able to serve nationwide is decreasing.[12] Nearly 21 million fewer meals were served in 2017 than in 2005, attributable mainly to stagnant federal funding levels which have failed to keep pace with demographic shifts, growing demand, and the rising costs of food, transportation, and other expenses.[1]

Such a large gap between the number of seniors who could benefit from these meals, and the actual number receiving them, indicates the need to improve and increase our network's capacity to serve more seniors. I urge this Committee to keep a strong and on-time reauthorization of the OAA a priority to support local nutrition providers like me as we work tirelessly to meet the unmet needs of seniors in their communities today and evolve to adequately serve those in the years to come.

The Older Americans Act Reauthorization: Recommendations

While the need for far greater federal funding is the primary key to serving more seniors, there are opportunities to ease administrative burdens and improve our insight into the performance and operations of the network at all levels.

As a local provider, OAA reauthorization impacts me directly. Making certain that the federal support and funding for our programs are secure is of utmost importance. The Act, including the Nutrition Program, must continue to be robust, successful and fulfill its purpose.

So, in this reauthorization, I hope we can find ways to better:

- Capture more data, including unmet need, to further understand the experience and community-focused nature of these services
- Enhance and expand services through investment in evidence-based aging services research, evaluations and innovations; such as medically-tailored and culturally appropriate meals, and other supportive services
- Serve more seniors in need of nutrition services by simplifying and clarifying the ability for local nutrition providers to transfer dollars between congregate and home-delivered meals
- Reinforce how the OAA Nutrition Program – the only federally-supported program designed specifically to meet the social and nutritional needs of seniors – is delivering so much more than a meal

In closing, I thank you again for holding this timely hearing during Older Americans Month and the opportunity to testify before you to share the impact that the OAA makes in the lives of your senior constituents and for our communities, as a whole. I would like to extend special thanks to you, Chairwoman Bonamici, for your leadership on the OAA both in past reauthorizations and in seeking increased funding. Most recently, we sincerely appreciate you and Congresswoman Stefanik, along with your colleagues Congressman Loebask and Deutch, for recognizing the importance of OAA programs and once again leading a letter calling for a

10% appropriations increase for the OAA Nutrition Program. This was included in the House Labor-Health and Human Services-Education Appropriations Bill passed by the full Committee last week, and we would urge all Members of this Committee to support it, as well. I am hopeful the information provided today is helpful as you consider reauthorization and that it remains a priority. I stand ready to support this process in any way I am able and look forward to answering any questions you might have.

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[1] Administration for Community Living (ACL) Aging Integrated Database (AGID), Data Source: *State Program Reports (SPR) 2005-2017*, available at https://agid.acl.gov/DataGlance/SPR/

[2] Ziliak & Gunderson. *The State of Senior Hunger in America 2016*, a report prepared for Feeding America and The National Foundation to End Senior Hunger (Chicago, IL: Feeding America, May 2018), available at https://www.feedingamerica.org/sites/default/files/research/senior-hunger-research/state-of-senior-hunger-2016.pdf

[3] Ziliak & Gundersen, *The Health Consequences of Senior Hunger in the United States: Evidence from the 1999-2014 NHANES*, a report prepared for Feeding America and the National Foundation to End Senior Hunger (Chicago, IL: Feeding America, August 2017), available at https://www.feedingamerica.org/sites/default/files/research/senior-hunger-research/senior-health-consequences-2014.pdf

[4] Hold-Lunstad, Smith & Layton, *Social relationships and mortality risk: a meta-analytic review.* PLoS Medicine (Vol. 7(7): e1000316; 2010), available at https://www.ncbi.nlm.nih.gov/pubmed/20668659

[5] Snider et al., *Economic burden of community-based disease associated malnutrition in the United States.* Journal of Parenteral and Enteral Nutrition (Vol. 38(2S):77S-85S; 2014), available at https://www.ncbi.nlm.nih.gov/pubmed/25249028

[6] Florence et al., *The medical costs of fatal falls and fall injuries among older adult.* Journal of the American Geriatrics Society (Vol. 66(4):693-698; 2018), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6089380/

[7] Mabli et al., *Evaluation of the Effect of the Older Americans Act Title III-C Nutrition Services Program on Participants' Food Security, Socialization, and Diet Quality*, report prepared for Administration for Community Living by Mathematica Policy Research (Cambridge, MA: Mathematica Policy Research, April 2017), available at https://acl.gov/sites/default/ files/programs/2017-07/AoA_outcomesevaluation_final.pdf

[8] Mabli et al., *Evaluation of the Effect of the Older Americans Act Title III-C Nutrition Services Program on Participants' Health Care Utilization*, report prepared for Administration for Community Living by Mathematica Policy Research (Cambridge, MA: Mathematica Policy Research, September 2018), available at https://acl.gov/sites/default/files/programs/ 2018-10/NSPevaluation_healthcareutilization.pdf

[9] Thomas & Dosa, *More Than a Meal Pilot Research Study*, report commissioned by Meals on Wheels America, (Arlington, VA: Meals on Wheels America, 2015), available at https://www.mealsonwheelsamerica.org/docs/default-source/News-Assets/mtam-full-report---march-2-2015.pdf?sfvrsn=6

[10] ACL, AGID, Data Source: *National Survey of OAA Participants, 2017,* available at https://agid.acl.gov/CustomTables/

[11] U.S. Government Accountability Office (GAO), *Older Americans Act: Updated Information on Unmet Need for Services* (Washington, DC: GAO, June 2015), available at https://www.gao.gov/products/GAO-15-601R

[12] U.S. Census Bureau, *2017 National Population Projections Tables, Table 3: Projected 5-Year Age Groups and Sex Composition of the Population, Projection for the Unites States 2017-2060*, available at https://www.census.gov/content/census/en/data/tables/2017/demo/popproj/2017-summary-tables.html

Chairwoman BONAMICI. Thank you for your testimony.

And I recognize Ms. Whiting for your 5 minutes for your testimony.

STATEMENT OF C. GRACE WHITING, J.D., PRESIDENT AND CEO, NATIONAL ALLIANCE FOR CAREGIVING

Ms. WHITING. Thank you so much, Chair Bonamici and Ranking Member Comer, and members of this subcommittee. Chair Bonamici, thank you especially for sharing your own personal experience as a caregiver for your mother. We need champions like you on these issues.

I appreciate the time today to talk about the Older Americans Act, Title III-E, National Family Caregiver Support Program.

My name is Grace Whiting and I am the President and CEO of the National Alliance for Caregiving, a 501(c)(3) nonprofit organization dedicated to advancing family caregiving through research, innovation, and advocacy. We believe that OAA programs, including the National Family Caregiver Support Program, support our long-term care ecosystem in three key ways.

First, healthcare providers rely on caregivers to fill gaps in care and Older Americans Act's programs help caregivers become better care providers.

Second, employers who face productivity losses due to caregiving can use OAA programs as a resource to help caregivers who are in the work force.

And, third, OAA programs can protect the health, wealth, and wellbeing of aging caregivers themselves.

We believe that family caregiving is a public health issue. In national research with AARP we estimate that there are approximately 44 million people caring for older adults and people with disabilities across a lifespan. That is one in five Americans, roughly the same size as the population of the country of Argentina. And when supported, caregivers can improve the quality of care offered to individuals. They support activities of daily living, such as helping people eat and bathe, instrumental activities of daily living, such as managing finances, and more than half are conducting medical nursing tasks that would normally be provided through formal care providers. Activities like giving injections, tube feedings, catheters, and colostomy care, often without any prior education on how to do these activities and no prior support. Most help with transportation, which helps address social isolation and allows people to stay engaged in their communities longer. And we know that when supported, caregivers can improve the health of populations and reduce health system costs.

When surveyed, program participants in the Administration for Community Living program, almost nine out of 10 caregivers said that these services help them to be a better caregiver, and more than half said that if they did not have the National Family Caregiver Support Program, the person they care for would be in a nursing home. In fact, if we replaced every caregiver in America with a direct care worker, it would cost our economy $470 billion a year. Health care providers are aware of this cost savings and

emerging trends in managed care rely on caregivers to bridge gaps, to reduce health system costs, and to improve shared savings.

In our written testimony we speak to the impact of caregiving on the work force, including an estimated $36.5 billion a year in productivity losses to employers. Title III programs can help employers offset the cost of caregiving. For example, nutrition programs provide support when a caregiver may not be available to make dinner, senior centers offer an additional form of respite. Transportation support for seniors can make it possible for caregivers to use that time for other needs.

As family size shrinks, the number of available people to care is shrinking too, meaning that we must act now to protect caregivers.

More than half of the caregivers in America are 50 years old or older, 7 percent are 75 years old or older, and caregivers of adults with disabilities are aging too. Think, for example, of the aging parents of an adult child with Down Syndrome, or the aging wife of a wounded warrior from Desert Storm. Yet the current program only supports 700,000 caregivers. Based on our prevalence estimate, this means that the current program serves only 2 percent of America's caregivers.

One quick personal story before I end. About 6 years ago I had the honor of being invited to the White House for a ceremony to celebrate caregivers of veterans, the Hidden Heroes Initiative, led by former Senator Elizabeth Dole. And I was standing in the green room talking to this caregiver whose husband had been wounded in Iraq and I said I grew up in Louisiana, I went to High School in Mississippi, I never in a million years thought that I would be standing in the White House looking outside at the tourists. And she looked at me, at this celebration to honor the work that she was doing for her husband, in a room that most Americans are never going to have the chance to be able to stand in, and she said all I can think about is my husband back at his hotel room and whether he is OK without me. That is the type of person that this program serves, people who are too tired, too overwhelmed, and too busy to advocate for themselves. We know that family is the basic unit of society, and our society needs these families to survive.

Thank you.

[The statement of Ms. Whiting follows:]

United States House of Representatives
Committee on Education and Labor
Subcommittee on Civil Rights and Human Services
Examining the Older Americans Act:
Promoting Independence and Dignity for Older Americans
Wednesday, May 15, 2019, 10:15 A.M.
2175 Rayburn House Office Building, Washington, D.C.

Written Testimony of
C. Grace Whiting, J.D., President and CEO, National Alliance for Caregiving

Good morning, Chair Bonamici, Ranking Member Comer, and members of this Subcommittee. Thank you for your time today to talk about the Older Americans Act's (OAA) Title III(e), National Family Caregiver Support Program – a necessary cornerstone to supporting the dignity and independence of older adults, adults with disabilities, and the friends or family who provide care to them.

My name is Grace Whiting, and I am the President and Chief Executive Officer of the National Alliance for Caregiving (NAC). NAC is a 501(c)(3) nonprofit organization dedicated to improving the quality of life for friends and family who provide unpaid caregiving to millions of Americans across the lifespan. Our core work includes public policy research on caregiving, national advocacy on federal caregiving initiatives, and support for a state network of grassroots caregiver coalitions. We are also the founder and Secretariat for the International Alliance of Carer Organizations, a multi-national coalition of 16 non-governmental entities around the world who are working to build a global understanding and respect for the role of caregivers.

Family caregiving is a public health issue. Millions of Americans are providing high-touch, high-impact activities to support older adults and adults living with disabilities. In a nationally representative research study conducted in partnership with AARP, we estimated that there are 34.5[1] million people caring for older adults and adults 18 – 59 with disabilities. If we add to this the number those who care for children with disabilities, that estimate rises to 44 million Americans. One in five Americans. For reference, forty-four million people is roughly the same size as the entire population of Argentina.[2]

Many of your Congressional colleagues share in the challenges of caregiving. We applaud the Members of the Assisting Caregivers Today Caucus, and champions such as U.S. Representatives Jan Schakowsky, Debbie Dingell, Jacky Rosen, Jim Langevin, and other leaders who have spoken openly about their caregiving journey.[3]

The Older Americans Act, including the National Family Caregiver Support Program, supports our long-term care ecosystem in three key ways:

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[1] National Alliance for Caregiving and AARP Public Policy Institute, Caregiving in the U.S. 2015 (June 2015), www.caregiving.org/caregiving2015.
[2] Current population estimate is 43,847,430; see United Nations Department of Economic and Social Affairs, Population Division. World Population Prospects: The 2017 Revision (2017). Available at https://population.un.org/wpp/DataQuery/.
[3] See Congressional Stories of Family Caregiving (November 2017), https://www.caregiving.org/wp-content/uploads/2018/02/GSA-Congressional-Stories-of-Caregiving-briefing-paper.pdf

1. **Health care providers can rely on caregiver supports in the OAA to improve the ability of friends and family to provide informal care.**

2. **Employers who face productivity losses due to caregiving can use OAA programs as a resource to support caregivers in the workforce.**

3. **OAA programs can protect the health, wealth, and well-being of aging caregivers.**

For the purposes of today's testimony, we use the term "caregiver" as it is defined in the recently enacted RAISE Family Caregivers Act. A caregiver is "an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation."[4]

Health care providers can rely on caregiver supports in the OAA to improve the ability of friends and family to provide informal care.

In 2008, Dr. Donald Berwick, of the Institute for Healthcare Improvement and a former Administrator of the Centers for Medicare and Medicaid Services (CMS)[5], challenged health policy experts to rethink the framework for health reform. He identified three key pillars of successful reform typically described as the "Triple Aim." The framework posits that reform should (1) improve the quality of individual health, (2) improve the health of populations, and (3) reduce the cost of health care. Family caregivers support these three pillars, and health care providers have started to take note.

We know from research and personal experience that family caregivers improve the quality of care offered to individuals by providing personalized care:

- Caregivers provide support for activities of daily living such as help with bathing or eating, instrumental activities of daily living such as managing finances, and medical/nursing tasks such as giving injections.

- More than half (57%) of America's caregivers provide medical/nursing tasks individual patients, through medical/nursing tasks such as giving injections, tube feedings, catheter and colostomy care, and other complex care responsibilities often without prior education or support. Nearly half of caregivers help with managing medication (46%).[6]

- The majority of caregivers help with transportation (78%), which reduces social isolation and allows older adults to stay engaged in the community.

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[4] From P.L. No: 115-119, available at https://www.congress.gov/bill/115th-congress/house-bill/3759. In research and in advocacy, "caregiver" may be described as: informal caregiver, care partner, caretaker, and related terminology. In an international context, the term "carer" is often used. It should be noted that an estimated 1.4 million children in the U.S. are unpaid caregivers (NAC and United Hospital Fund, Young Caregivers in the U.S. (2005) at https://www.caregiving.org/data/youngcaregivers.pdf).

[5] Donald M. Berwick, Thomas W. Nolan, and John Whittington. The Triple Aim: Care, Health, and Cost. Health Affairs (Vol. 27, No. 3, May/June 2008). Available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.27.3.759.

[6] See n. 1; see also Susan Reinhard, Heather Young, Carol Levine, Kathleen Kelly, Rita Choula and Jean Accius. AARP Public Policy Institute. Home Alone Revisited: Family Caregivers Providing Complex Care (April 2019). Available at https://www.aarp.org/content/dam/aarp/ppi/2019/04/home-alone-revisited-family-caregivers-providing-complex-care.pdf.

- Nearly one-third of caregivers (32%) are "high intensity" and provide care for at least 21 hours a week, on average providing 62.2 hours of care each week.

- Caregivers play the role of advocates, with a majority advocating with health care providers, coordinating services, and navigating health care systems such as insurance.

Caregiving is a constant balance between activity and worry, as one caregiver describes:[7]

> *"No matter how good things are, you are always on pins and needles... You worry about a possible relapse, you worry about him not being able to get his medication on time, you worry he will stop taking his medicines..."*

We know from research that family caregivers, when supported, can improve the health of populations. Research has shown that caregivers can help avoid unnecessary hospital readmissions as individuals are discharged from hospital to the home, reducing admissions by 25% at 90 days and 24% at 180 days.[8] When it comes to Alzheimer's and dementia, caregivers can help an older adult to live longer in the community and delay the cost of institutionalization.[9]

And we know from economic analysis that family caregivers can reduce overall health system costs. AARP has estimated that if we replaced each family caregiver of an adult with a direct care worker, it would cost our economy $470 billion[10] a year. Providers are aware of this cost savings, and emerging trends in managed care rely on caregivers to bridge gaps, reduce health system costs, and improve shared savings.[11]

Although caregivers offer these services without pay, these services are not free. In many cases, caregiving can strain an individual's finances, their health, their social connections and relationships, and even their overall wellness. If we are asking families to take on $470 billion worth of care with little support, they need education, respite, and support to be effective. Providers in some spaces have noticed this, providing assessment of caregiver needs through programs like the Home- and Community-Based Waivers Program under Medicaid. Yet this use of assessment is not universal, and in many cases, there are no standard assessment tools to identify caregiver needs and refer caregivers to services.[12]

The National Family Caregiver Support Program offers an entry point for identifying caregiver needs and can help to address the need for caregiver education, respite, and support. Since 2000, the program

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[7] National Alliance for Caregiving in partnership with Mental Health America and the National Alliance on Mental Illness. On Pins & Needles: Caregivers of Adults with Mental Illness (February 2016). Available at https://www.caregiving.org/wp-content/uploads/2016/02/NAC_Mental_Illness_Study_2016_FINAL_WEB.pdf.

[8] Rodakowski, et al. "Caregiver Integration During Discharge Planning for Older Adults to Reduce Resource Use: A Metaanalysis," Journal of the American Geriatric Society (April 2017), at http://onlinelibrary.wiley.com/doi/10.1111/jgs.14873/full

[9] See e.g., Mittleman, et al. "An intervention that delays institutionalization of Alzheimer's disease patients: treatment of spouse-caregivers," Gerontologist (1993), https://www.ncbi.nlm.nih.gov/pubmed/8314099

[10] Reinhard, S., Feinberg, L. F., Choula, R., & Houser, A., Valuing the Invaluable 2015 Update: Undeniable Progress, but Big Gaps. (2015), at https://www.aarp.org/ppi/info-2015/valuing-the-invaluable-2015-update.html

[11] See e.g., Richard Schulz, National Academies for Science, Engineering, and Medicine, Families Caring for an Aging America, "Family Caregivers' Interaction with Health Care and Long-Term Services and Supports." (2016). Available at https://www.ncbi.nlm.nih.gov/books/NBK396396/.

[12] See Kathleen Kelly, Mary Jo Gibson, Lynn Feinberg. AARP Public Policy Institute, Listening to Family Caregivers: The Need to Include Family Caregiver Assessment in Medicaid HCBS Waiver Programs (December 2013). Available at https://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/the-need-to-include-family-caregiver-assessment-medicaid-hcbs-waiver-programs-report-AARP-ppi-ltc.pdf

has provided grants to states and territories to help older adults and people with disabilities stay in the home as long as possible.

There are five types of services offered under the program:

- Information about available services
- Assistance to gain access to services
- Individual counseling, organizational of support groups, and caregiver education
- Respite care, to allow caregivers to take a break, and
- Supplemental services.

The Administration for Community Living has noted that these programs can enable caregivers to provide care longer, which can help older adults and people with disabilities to delay or even avoid the need for institutional care.[13] Nearly two thirds (74%) of caregivers who evaluated the program indicated that services enabled them to provide care longer than would have been possible otherwise. Almost nine out of ten (88%) reported that the services they received helped them to be a better caregiver, and more than half (62%) indicated that without the services they received, the person receiving care would be living in a nursing home.

Employers who face productivity losses due to caregiving can use OAA programs as a resource to support caregivers in the workforce.

As of the 2016 Reauthorization of the Older Americans Act, four key populations are served by the National Family Caregiver Support Program:

- Adults who care for people age 60 or older
- Adults who care for people of any age with Alzheimer's disease and related disorders
- Relatives age 55 and older, excluding parents, who care for children under age 18; and
- Relatives age 55 and older, who care for adults with disabilities between ages 18 and 19.

People in each one of these groups are at least ten years shy of being eligible for retirement. Our research has shown that as many as six out of ten caregivers are balancing work and care.[14] We have estimated that caregivers age 50 or older who step out of the workforce to care for aging parents lose just over $300,000 in lost wages, pension, and Social Security income.[15]

Employers also face losses as America ages. Employers with caregiving employees must make workplace accommodations for caregivers in the workforce. Many employers face caregiving costs including retention, rehiring, absenteeism, crisis in care, workday interruptions, additional time to manage employees, unpaid leave, and reduced hours. In total, these costs total an estimated $33.6 billion a year for employers.[16]

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[13] See https://acl.gov/programs/support-caregivers/national-family-caregiver-support-program.
[14] See n. 1.
[15] National Alliance for Caregiving. The MetLife Study of Caregiving Costs to Working Caregivers (June 2011). Available at https://www.caregiving.org/wp-content/uploads/2011/06/mmi-caregiving-costs-working-caregivers.pdf.
[16] National Alliance for Caregiving. The MetLife Caregiving Cost Study: Productivity Losses to U.S. Businesses (July 2006). Available at https://www.caregiving.org/pdf/research/Caregiver%20Cost%20Study.pdf.

In addition to work, many juggle multiple care responsibilities, as shared by caregivers in a forthcoming study on Crohn's disease and ulcerative colitis:

> *"I have been my husband's caregiver and confidant since he was diagnosed in 1993. Our oldest daughter was also diagnosed at the age of 18, my experience with her was far different from the one with my husband. She was allergic to every medication that was tried and spent most of that summer in the hospital."*

> *"My house is always a disaster because all my time goes to cooking and transportation to and from appointments. My younger child has not had the benefit of participating in sports or extracurricular activities because I no longer have time to take her to those activities, and instead of having a typical childhood, her young years are being spent visiting her brother in the hospital."*

Employers and human resources experts have taken notice of the need to address caregiving and work. The U.S. Equal Employment Opportunity Commission has issued guidance for "Employer Best Practices for Workers with Caregiving Responsibilities" including eldercare.[17] An analysis of family responsibilities discrimination from the UC Hastings College of Law found in 2016 that employee lawsuits involving eldercare had increased by 650%, with "further growth expected to continue as the population ages."[18] Innovators have partnered with AARP and the Respect a Caregiver's Time Coalition to identify promising best practices for corporate eldercare.[19] Public and private sector leaders alike are looking for solutions to keep caregivers at work and to improve the balance between our work lives and our family responsibilities.

In addition to the supports in the National Family Caregiver Support Program, the OAA offers services to older adults that can supplement the care provided by working caregivers. Title III programs provide states with grants to support case management and information and referral for the older adult who needs care. Nutrition programs provide support when a caregiver may not be available to make dinner; senior centers may offer an additional form of respite; and transportation support can make it possible for the older adult to stay independent and the caregiver to use that time for other needs. These services enable employers to meet caregivers where they are and protect employers from having to cover all the social care needs that are required to help older adults and people with disabilities stay independent.

OAA programs can protect the health, wealth, and well-being of aging caregivers.

The United Nations has noted that globally, populations aged 60 or older are growing faster than all younger age groups.[20] In Europe, one out of four people is over 60 as of 2017. The United States is not far behind, with one out of five over 60. As family sizes shrink, the number of available people to care is shrinking too—meaning that we must act now to protect caregivers.

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[17] EEOC. Employer Best Practices for Workers with Caregiving Responsibilities (January 2011). Available at https://www.eeoc.gov/policy/docs/caregiver-best-practices.html.

[18] Cynthia Thomas Calvert. Caregivers in the Workplace: Family Responsibilities Discrimination Litigation Update 2016 (2016). Center for WorkLifeLaw, UC Hastings College of the Law. Available at https://worklifelaw.org/publications/Caregivers-in-the-Workplace-FRD-update-2016.pdf.

[19] ReACT and AARP. Supporting Working Caregivers: Case Studies of Promising Practices (2017). Available at https://respectcaregivers.org/wp-content/uploads/2017/05/AARP-ReAct-MASTER-web.pdf.

[20] United Nations. Work Population Prospects (2017 Revision). Available at https://esa.un.org/unpd/wpp/Publications/Files/WPP2017_KeyFindings.pdf.

In the United States, more than half of our caregivers are 50 or older. Seven percent (7%) are 75 years old or older.[21] We see the same trends in other studies of caregiving across the lifespan. More than one in four caregivers of adults with disabilities under age 60 are themselves aged 50 or older—think the aging parents of adults with down syndrome, the aging wife of the wounded warrior from Desert Storm. Over a third of people who reported that they care for someone with a rare disease, condition, or disorder are over 50.[22] In mental illness, almost six out of ten caregivers are over age 50 and four percent (4%) are 75 or older.[23]

Yet the current National Family Caregiver Support program supports only 700,000 older adults as of the last estimate from the Administration for Community Living; if we use the most conservative estimate of the number of caregivers of adults (17.7 million via RAND Corporation in 2014), that means this program only serves four percent (4%) of caregivers in our country. We believe that the number is closer to two percent (2%).[24]

These services can reduce caregiver depression, anxiety, and stress, enabling caregivers to provide care longer and thereby avoiding or delaying the need for costly hospital and institutional care. They offer a way for family and friends to take a break from care and to be present with the people they love.

One personal story before I end. About six years ago, I had the honor of being invited to a celebration at the White House for caregivers of Veterans. The event was part of a bipartisan program led by Senator Elizabeth Dole to recognize the hidden heroes who care for wounded warriors when they return from combat. I was standing in the Green Room, talking to one of the Elizabeth Dole Fellows, a young woman who was caring for her husband who had been wounded in Iraq.

I said to her, "Can you believe this? I grew up in rural Louisiana, I went to high school in southern Mississippi, I never in a million years thought I'd be standing in the White House looking out at the tourists." She looked at me, and at this celebration to honor her commitment as a caregiver, in a room that most Americans will never have the chance to visit, she said, "All I can think about is my husband back at the hotel and whether he's okay."

That's the type of person that this program serves. Caregivers who are too tired, too overwhelmed, and too busy to advocate for themselves. People who need your voice to support them and the role they play in supporting our health care, social care, and long-term care systems. Family is the "basic unit of society." And our society needs these families to survive.

Thank you.

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[21] See n. 1.
[22] National Alliance for Caregiving in partnership with Global Genes. Rare Disease Caregiving in America (February 2018). Available at https://www.caregiving.org/wp-content/uploads/2018/02/NAC-RareDiseaseReport_February-2018_WEB.pdf.
[23] See n. 6.
[24] See https://acl.gov/programs/support-caregivers/national-family-caregiver-support-program; RAND Corporation, Hidden Heroes (2014), https://www.rand.org/pubs/research_reports/RR499.html; NAC and AARP, *Caregiving in the U.S. 2015*, n. 1.

Chairwoman BONAMICI. Thank you for your testimony.

And now I recognize Ms. Ducayet for 5 minutes for your testimony.

STATEMENT OF PATRICIA DUCAYET, LMSW, TEXAS STATE LONG-TERM CARE OMBUDSMAN, TEXAS HEALTH AND HUMAN SERVICES

Ms. DUCAYET. Thank you, Chair Bonamici and Ranking Member Comer, thank you to the subcommittee. It is my pleasure to testify today on behalf of the Texas State Long-Term Care Ombudsman Program.

Title VII of the Older Americans Act authorizes State ombudsman programs to protect the health, safety, welfare, and rights of residents, people who live in nursing facilities and assisted living facilities.

In Texas over 92,000 people live in a nursing home and over 45,000 live in an assisted living facility. Last year we resolved 78 percent of our complaints that we received; that was over 16,000 complaints in the State of Texas. We did that through the use of 100 staff and over 400 volunteers in our program.

Today you recognize the ombudsman program and the work we do to prevent abuse and protect residents' rights. And you see that as part of the system to protect independence and promote dignity. Many Americans don't think of an assisted living as a place where you can be independent, but it should be. And many Americans don't think of a nursing facility as a place where you can live a dignified life, but it must be.

Our program volunteers and staff are onsite in facilities to the maximum extent possible, to ensure that residents have independence and to address instances of indignity. Essential elements of the ombudsman program include our confidentiality provisions, systems advocacy, resolving complaints, and preventing abuse and neglect. Confidentiality requirements are specifically outlined in the Act and include strict confidentiality of our ombudsman program records, so no resident identifying information can be released by our program without the permission of the person to which it pertains.

Based on the problems we observe in facilities our program represents the interests of residents to decisionmakers in Congress, to the State legislatures, and to Federal and State agencies. We make recommendations and provide comments, which we call systems advocacy, and aim to improve quality of life and quality of care for residents, most of whom are Medicare and Medicaid eligible.

In 2017, State ombudsman programs across the Nation investigated almost 200,000 complaints, complaints ranging from the use of chemical restraints to neglect to insufficient staffing in facilities. But the most common complaint we receive is about discharge. Because a nursing home is a person's residence, a resident has a right not to be discharged without cause. To protect this right, a resident can appeal to the State Medicaid agency and nursing homes are required to notify every resident and the ombudsman each time there is a discharge. Ombudsmen help residents who want to stay in their home file an appeal and represent them in

a hearing. Ombudsmen also negotiate with the facility to find solutions that are other than discharge.

So as an example, I want to share with you a brief story from Texas. A resident in a dementia unit was issued a discharge notice for being a threat to others. The resident had recently fallen, had limited mobility and vision, and had a diagnosis of dementia. The facility was discharging him for one incident of disrobing in public, which is a relatively common symptom of dementia. His guardian appealed the discharge, and while awaiting the hearing received a call at 6 p.m. on a Friday night from the nursing home informing the guardian that the resident had been discharged to a behavioral health hospital.

The nursing facility refused to take the resident back. So the resident remained in this behavioral health hospital for a month before being transferred to a new nursing facility and living only 1 week longer.

While the resident's case prevailed in the fair hearing, because it was an improper discharge, the result came too late to benefit him. So the guardian has given us permission to share his story to honor him and to inform you of the effects of improper discharge.

To prevent abuse, neglect, and exploitation, ombudsmen train residents, family members, and facility staff on how to prevent, identify, and report abuse. Each onsite visit that we make also prevents abuse. And 2017 nationwide, ombudsman programs made over 29,000 routine visits for that purpose. Ombudsman programs also investigated over 5,000 cases of abuse, neglect, and exploitation in an assisted living facility and over 11,000 cases of abuse, neglect, or exploitation in a nursing home.

Thank you for preserving the independence and dignity of older Americans across the continuum, thank you for recognizing that people who live in institutions and victims of abuse also need dignity and independence.

On behalf of the Texas Ombudsman Program and my colleagues around the country, I want to thank you. Thank you for your support of the Older Americans Act and with it, ombudsmen will be here in the future and are here today to prevent harm and protect residents' rights.

Thank you very much.

[The statement of Ms. Ducayet follows:]

Testimony of Patricia Ducayet

Texas State Long-Term Care Ombudsman

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**Prepared for the House Committee on Education and Labor,
Subcommittee on Civil Rights and Human Services**

Examining the Older Americans Act: Promoting Independence and Dignity for Older Americans

May 15, 2019

Chair Bonamici and Ranking Member Comer, Chair Scott and Ranking Member Foxx, and members of the subcommittee, I am pleased to present this testimony on behalf of the Texas Long-Term Care Ombudsman Program (Ombudsman Program) and in collaboration with the National Association of State Long-Term Care Ombudsman Programs (NASOP). Thank you for your ongoing support of state long-term care ombudsman programs, authorized by Title VII of the Older Americans Act, which addresses Vulnerable Elder Rights Protection Activities.

As you know, the Older Americans Act authorizes state long-term care ombudsman programs to protect the health, safety, welfare, and rights of some of our nation's most vulnerable citizens who live in nursing homes and assisted living facilities. Some amazing people

live in facilities in your communities. Residents are rocket scientists, industry leaders, teachers, religious leaders, truck drivers, grocers, plumbers, politicians, veterans of World War II, Korea, Vietnam, and Gulf wars, and people from all walks of life. They are also our grandparents, parents, aunts and uncles, sisters and brothers, neighbors, and friends.

It is my privilege to have served as the Texas state ombudsman for 12 years, and for three years prior as a local ombudsman in Dallas County. The Texas Ombudsman Program operates independently within the Texas Health and Human Services Commission, which is the agency designated as the state unit on aging. For decades, our program has operated in conjunction with 28 area agencies on aging, which house the local operations so that ombudsman services are delivered quickly and effectively. This system works for us to ensure that ombudsmen can be in facilities throughout the state to interact with as many residents as possible, and to observe, investigate, and resolve complaints on behalf of residents.

Most other states operate similarly to ours – an office of the state long-term care ombudsman is located within the state unit on aging, and the office contracts with area agencies on aging or non-profit organizations to operate local ombudsman offices. Some states have the office located within the state unit on aging, but do not contract with other agencies to operate local offices, and other states are operating in an independent agency or a state agency that is not the state unit on aging. Flexibility in the location of a state long-term care ombudsman program is necessary to ensure the program is in the best organization to operate independently of functions that may conflict with the ombudsman's role as a resident advocate and to ensure that state and federal funds are used efficiently and effectively.

The need for long-term care is growing as the population of older Americans grows. By 2030, adults age 65 and older are projected to make up more than 20 percent of the total U.S. population, and a significant portion of that population will need care in a facility. Over 92,000 older Texans live in a nursing home and over 45,000 live in an assisted living facility. Title VII of the Older Americans Act ensures that the voices of these citizens are heard, and their rights are protected.

In 2018, with about 100 staff and 400 volunteers, the Texas Ombudsman Program investigated 16,544 complaints and resolved 78 percent of them to the satisfaction of the resident. Volunteers donated over 31,000 hours to the program. That donated time consists of training, visiting residents, and resolving complaints. As you might imagine, the role of a volunteer ombudsman is challenging and meaningful. Volunteer and staff ombudsmen must engage in conflict and deal with complicated and emotional issues, including the loss of many residents.

Today, I appreciate that the Ombudsman Program, with our work to protect residents' rights and prevent abuse, is recognized among our Older Americans Act colleagues as part of the Act's system to promote independence and dignity. I imagine, however, that many Americans don't think about an assisted living facility as a place where a person can be independent, but it can and should be. I imagine that many don't think a nursing home is a place where a person lives a dignified life, but it must be. Program staff and volunteers are onsite in facilities to the maximum extent possible to ensure facilities are creating opportunities for residents to have independence, and to call out instances of indignity and hold a facility accountable to correct its mistakes.

Nationally the most common complaint ombudsmen receive is about discharge from a facility. Because a nursing home is a residence – that is, an individual's home – a resident has a right not to be discharged except for certain valid reasons. And, to protect that right, a resident has a right to appeal to the State Medicaid agency and nursing homes are required to notify the resident and the ombudsman of the discharge. Ombudsmen help residents who want to stay in their home file an appeal and represent the resident in an appeal. We can also negotiate with the facility to find a solution other than discharge.

I want to provide an example of why protection from discharge is so important and why ombudsmen are so passionate about protecting rights. A resident in a secure dementia care unit was issued a discharge notice for being a "threat" to others in that facility. The facility provided no evidence of what that "threat" was. The resident had recently fallen, had limited mobility, limited vision, and dementia. The facility pointed to one incident of his disrobing in public, a common symptom associated with dementia, as the reason they were pursuing discharge. The guardian appealed the discharge, and while awaiting the hearing, got a phone call from the facility at 6pm on a Friday to say the resident had been discharged to a behavioral hospital. The facility had gotten a court order to involuntarily commit him without contacting the guardian. The hospital conducted an assessment, determined the resident posed no danger to anyone and was not appropriate for placement in the hospital because he was experiencing the effects of dementia, not a mental illness. The facility refused to take the resident back and the resident remained in the behavioral hospital for a month before being transferred to a new nursing home where he died a week later. The guardian believes the stress of the discharge contributed to a quick decline in his condition, and while the resident's case prevailed in the fair

hearing, the result came too late to benefit the resident. With permission from his guardian, we share this story to honor the resident and inform our lawmakers about the effects of improper discharge.

Confidentiality

Confidentiality is a core principle of individual rights and the ombudsman program, and confidentiality is fundamental to the program's ability to carry out its mission and mandate. Confidentiality requirements are explicitly set out in the Older Americans Act, including strict confidentiality of ombudsman program records. To preserve the fundamental inviolable trust relationship between the resident and the ombudsman that enables residents to feel safe in reaching out with their problems, no resident-identifying information is released without the consent of the resident. For this reason, ombudsmen cannot be mandated reporters of abuse, neglect, or exploitation. With a resident's permission, ombudsmen can and do report abuse, as most residents reveal a problem to us because they want our help to report and keep the resident safe. Ombudsmen also consistently strive to help residents understand the value and importance of reporting abuse. When a resident does not consent to disclosure, the ombudsman seeks resolution approaches that protect the resident's identity, monitors the situation, and works to end the abuse. Ombudsmen also remind facility staff and family members of their status as mandated reporters of abuse.

Federal law requires ombudsman programs to share aggregate program data and other information in an annual report and upon request. Sharing of non-confidential information regarding long-term care issues and trends is consistent with the program's systems advocacy and community education role.

Preventing Abuse, Neglect, and Exploitation

Long-term care ombudsmen serve residents, advocating for quality care that ranges from basic needs like the right to nutritious food to serious issues of abuse. Ombudsman programs coordinate with law enforcement, the Centers for Medicare and Medicaid Services, state licensing and regulatory agencies, adult protective services, provider associations, and others to advocate for quality care for all residents, which includes that residents are protected from abuse, neglect, and exploitation. We train residents, family members, and facility staff on how to prevent, identify, and report abuse. Put simply, ombudsmen are eyes and ears in a facility. Each onsite visit made – which in 2017 was over 29,000 visits nationwide – prevents abuse. Each visit is an opportunity for residents to speak up about abuse or for an ombudsman to witness subtle signs of abuse that can be addressed with residents and the facility.

Nationally in 2017, ombudsman programs investigated over 5,000 cases of abuse, neglect, or exploitation in assisted living facilities, and over 11,000 cases in nursing homes. This year in Houston, Texas, a volunteer ombudsman was the first person a nursing home resident told about sexual abuse she experienced while being bathed by a staff member. The ombudsman worked as her advocate to help the resident report to the administrator and law enforcement, which led to the termination and prosecution of the employee. Ombudsmen are on the front lines of preventing abuse in facilities, because we build trust with residents and are someone residents can turn to for a person-centered response to any problem.

Fear of retaliation is prevalent in long-term care facilities. If you rely on someone to take you to the bathroom and you complain about how staff treated you – how will you be treated the next time you need help? Will you be left longer and forced to go to the bathroom on

yourself? These are real questions that one resident told his ombudsman keeps him from reporting some problems. Our role is to respect the choices of each resident and stay resident-centered because, at the end of the day, we go home to the safety and security of our own homes, and residents stay in theirs. Choice and control are essential to protection of a resident's right to dignity.

As a resident advocate, it's important to empower the resident, especially in abuse circumstances. This is similar to the role of a victims' services advocate, giving the resident – and not the ombudsman program – the authority to make the decision about when, where, and how the resident's information can be disclosed by the ombudsman program. Therefore, ombudsmen are an important part of the elder justice system. We educate the public about residents' rights and reporting requirements, respond to and support the resident when abuse happens, and inform the public and law makers about what needs to change in the system.

Systems Advocacy

Based on the problems we observe in facilities, our program is also charged with the responsibility to represent the interests of residents to decision-makers in state and federal agencies and legislatures. We are charged with making recommendations and providing comments and context to policies, explaining the impact a policy or action has on residents themselves. Efforts at efficiency, provider burden reduction, and even rule-making can have unintended negative consequences that decision-makers need to know. Our efforts to act as a voice for residents – which ombudsmen call systems advocacy – is aimed at quality of care and quality of life and provides the government and its citizens with an accountability service for residents, most of whom are Medicare and/or Medicaid eligible. The field of advocates for

older adults is relatively small, but the work is important to improving the systems in long-term care. Long-term care ombudsmen are – and need to be – at the forefront of advocacy for long-term care residents, many of whom can't advocate for themselves. And when a resident can advocate, it's our responsibility to help the resident's voice resonate.

Assisted Living Advocacy

The Older Americans Act added responsibilities to state long-term care ombudsman programs in 1981 to include advocacy for residents of assisted living, board and care, and similar community-based long-term care settings. Since then, the assisted living facility industry has boomed, with nursing facility numbers in some states being overtaken by assisted living facility numbers. While the mandate to serve residents in assisted living facilities was added to our mission in the Older Americans Act, there have been no appropriations for this function. As a result, state programs are unable to adequately serve residents in assisted living, and that's evidenced by the difference in our national data of facility visits. While ombudsman programs make routine onsite visits (one every three months) to 70 percent of nursing facilities, programs only visit 31 percent of assisted living facilities with the same frequency. Without ombudsmen in these buildings, residents are at greater risk of abuse, neglect, and exploitation, and other rights violations. As validation of the risks to residents of assisted living facilities, the Government Accountability Office released a study in 2018 about the severity of quality of care

problems in assisted living facilities. The study revealed that abuse, assault, and even unexpected or unexplained deaths are not well monitored or reported.[1]

Conclusion

Finally, I'd like to acknowledge the importance of the National Ombudsman Resource Center. The National Ombudsman Resource Center, which is modestly funded, provides valuable and reliable technical assistance and support to state and local ombudsman programs, and is more important than ever as the Administration for Community Living reorganizes and adapts to the needs of the aging network. State ombudsmen rely on our resource center for its research and training services. We need Congress and the Administration for Community Living to continue to support and strengthen the role and availability of resources through the National Ombudsman Resource Center.

Thank you for the opportunity to participate in today's hearing. Again, I thank this Subcommittee and the Committee on Education and Labor for its past and future support of the Older Americans Act. Thank you for preserving the independence and dignity of older Americans across the continuum of long-term services and supports, including when living in an institution and when victimized by abuse, neglect, or exploitation. On behalf of the Texas Long-Term Care Ombudsman Program and my colleagues in every state, with the Older Americans Act, we will be here for residents now and in the future to protect residents' rights and prevent their harm.

[1] https://www.gao.gov/products/GAO-18-179

Chairwoman BONAMICI. Thank you so much to each of our witnesses for your excellent and comprehensive testimony.

Under committee rule 8a we will now question witnesses under the 5-minute rule. As chair I will go first and then yield to the ranking member. We will then alternate between the parties.

And I yield myself 5 minutes.

Ms. Girard, you discussed research that has been conducted in Oregon regarding the return on investment for OAA programs. I ask you unanimous consent to enter into the record the 2018 report commissioned by the Oregon Department of Human Services.

So how have you been able to achieve—you talked about an 11:1 return on investment you mentioned. And based on this research and from your professional experience, are OAA programs a good investment for the Federal Government and the taxpayer?

Ms. GIRARD. Yes, I would say that they are an excellent investment. The foundation for the return on investment that was studied in Oregon is really person-centered options counseling, and that really entails individuals who have been trained on how to do motivational interviewing and really person-centered care planning and work with individuals, meet with individuals, and really focus in on their long-term services and support needs, and really develop a very focused plan that is person-centered to what that person and individual needs and the very unique needs that they have.

Through the study what we were able to do is actually do both a qualitative and quantitative analysis really looking at what were the outcomes that were gained for each individual. And then we used either State or national data around things like if we were shown that we were able to prevent future falls, we could—you can actually cost that out. You know what the cost is when somebody falls and breaks a hip and ends up in the hospital. And we were able to show that we were reducing hospital readmissions. We know what the cost of that is in our community.

And then able to do other things like helping somebody to avoid homelessness. We know what the expense is for somebody being homeless. So doing that we were able to really show that this is a comprehensive service that really helps to connect people to just a wide variety of very person-centered services that results in a significant cost savings.

Chairwoman BONAMICI. Thank you for that work. And continuing, Ms. Girard, you discussed tailoring your department's services and supports to meet the distinct needs of individuals from diverse communities, including the LGBT community. We know that LGBT older adults often face structural inequalities, including greater social isolation and higher rates of poverty. But they also encounter barriers to accessing culturally competent aging services and supports and in many cases are less likely to have supportive family members and more likely to face discrimination.

So I want to ask you, and then I will ask the others, how does your department address the unique needs of the LGBT community and why should LGBT older adults be designated a population of greatest social need?

Ms. GIRARD. Thank you, Chair Bonamici.

One of the things that is really a challenge for us locally is that there are not really good data sources around what is the preva-

lence of folks that are LGBT in our community. And there is actually a fear for people reporting. So one of the things that we have done is we have a great network in our area,—we do, we actually participate in both regional and Statewide advocacy coalition to really raise awareness and to really try to identify what the needs are. And one of the things we really have done is we have actually met one-on-one with individuals in our communities. We have done things like we know that there are specific types of social events, so we actually go and meet. We went to a dinner party with a group of folks and really sat down and talked about what are the unique issues and needs that you are experiencing. And when we did some of that as part of our area plan, what we really found was that the needs do differ across different populations.

Chairwoman BONAMICI. And what would the designation of greatest social need mean? And I am going to ask the others as well.

Ms. GIRARD. I really think it helps to—one of the things that it does is it really focuses our area plan efforts. So we have to do—it makes us really reach out into the community, hear from communities, and then really be conscientious about how we program for those needs.

Chairwoman BONAMICI. Thank you.

Does anybody else—please weigh in on that issue. Ms. Whiting, did you have—

Ms. WHITING. So I would second the recommendation that there needs to be more research. We know that there is approximately 9 percent of caregivers in America identified as LGBT and I have heard from the field that particularly people who are transgender sometimes feel that the people they care for get worse care from formal providers because of biases. So, for example, a gentleman who is transgender said that his mother received worse care in the nursing facility she was at because the staff was uncomfortable with him and his identity.

So I think it is an area that needs more research. We had in our written testimony, included some recommendations for OAA reauthorization and one piece of that is to collect more data in particular on caregiving and these OAA programs broadly.

Chairwoman BONAMICI. My time is expired, so I am going to ask the others—well, we will submit a question for the record.

And I now yield to Dr. Foxx, the ranking member of the full committee for 5 minutes for your questions.

Ms. FOXX. Thank you, Madam Chairman. And I want to thank our witnesses for being here today to discuss this important subject.

Miss Girard, I was pleased to hear that you appreciate the value of local flexibility in the Older Americans Act. Can you give us some examples of the differences between services you provide to seniors in Portland versus some of the more rural areas of Oregon?

Ms. GIRARD. Thank you, Representative Foxx.

I think probably a really key example is the provision of transportation. We hear from older adults across Oregon that it is a significant need, but it looks very different in Portland than it does out in places like Ontario or Malheur County.

In our area we have a robust transit system and we can purchase transportation services through that network. In rural counties, the AAA is the transportation network. So that is probably a really good example.

Ms. FOXX. Great.

This question is for all of you, and I will start on this end of the panel so you are not always last. One of the purposes of the Older Americans Act is to help people age 60 and older maintain independence in the home. Why is this important and how does this goal potentially save taxpayer dollars? And do keep in mind there are four of you to answer, so.

Ms. DUCAYET. Well, as the representative of providing services to people who live in an institutional setting, I will make my answer quick to you and say I know that people want to live in their home and prefer to. There will be a need continuously for long-term care facilities, but emphasis does need to be where people want to get their services at home.

Ms. WHITING. I would say it is in the title of the hearing today, it is about dignity and independence. Our family sizes are getting smaller, we have got I think roughly one out of five Americans are over 60, and so we want people to be able to thrive and to be cared for by their families in the setting they choose.

Ms. FOXX. Ms. Archer-Smith.

Ms. ARCHER-SMITH. Yes, I would echo that the people that we work with want to stay—they want to stay in their home and in their communities, they want to age in place. It is more economical to age in your home and I would argue that intergenerational communities are stronger.

Ms. FOXX. All right.

Ms. GIRARD. In our community only 14 percent of people getting long-term services and supports are in a nursing facility. The Older Americans Act is the foundation of helping people identify and figure out what additional kinds of resources and services are available so that they don't have to rely on nursing facility services unless it is absolutely necessary.

Ms. FOXX. And let me ask a clarifying question, because I have for years—I think, Ms. Archer-Smith, you mentioned that it is less expensive—one of you mentioned it is less expensive for people to remain in their homes. And I have also read over the years that people are healthier, more alert, and in better—generally in better health and better able to be involved with activities the longer they are able to stay in their home.

I am sure there is associations with having the ability to do it, but also using the facility that you have while you are in your home. Does the research continue to show that?

Any of you can respond.

Ms. WHITING. Especially in Alzheimer's and dementia, where someone who is changing settings but might have mild cognitive impairment, it can be very hard for both that person and the family to continue to care for them.

Ms. GIRARD. And I would just add that in Oregon, because we do have such a broad array for people that are often at the same level of need, we are able to show that people can function quite

well at home and have pretty significant care needs as long as you have a system that supports them.

Ms. FOXX. Great. Thank you all.

I yield back, Madam Chairman.

Chairwoman BONAMICI. Thank you, Dr. Foxx.

I now recognize Representative Lee from Nevada for 5 minutes for your questions.

Ms. LEE. Thank you, Madam Chair, for hosting this important hearing on such an important issue.

Having a father who passed away after spending 4 years in a nursing home and now dealing with a mother who is suffering from—is an assisted living facility and having experienced her struggles as a caregiver, I think that addressing these issues is incredibly important.

I appreciate the question that Representative Foxx just asked about the benefits the tax benefit and financial benefit of allowing people to age in place.

I wanted to ask Ms. Girard, you know, as we know, these supportive services and preventative health programs are essential for older Americans in need of care. And in Nevada, my home State, $3.5 million went to support that.

Can you please elaborate on how home healthcare services can serve as preventive healthcare for older Americans?

Ms. GIRARD. Yes. We have had—In Oregon we have had a foundation of both State and Older Americans Act funded in-home service supports for older adults since 1981. Well, the Older Americans Act actually before that. And we have been able to show that it really helps people to avoid further decline, it helps them to avoid spending down to have to go on Medicaid and use more expensive Federal supports, and actually keeps them more engaged in their communities.

Ms. LEE. Thank you.

Miss Whiting, one of your recommendations was to develop a national resource center for caregiving. Can you explain what the benefit of establishing that would be?

Ms. WHITING. Absolutely. And that recommendation builds on some of the language in the RAISE Family Caregivers Act that was enacted last year, which talks about finding efficiencies between different Federal agencies. So, for example, there is the VA Caregiver Support Program, there is the National Family Caregiver Support Program under Older Americans Act, there were supports across CMS, looking at different types of caregiver supports within Medicaid and community-based service models.

So the idea here is let us put all that information in one place and make it more efficient for caregivers to navigate across these different centers, as well as identify other community-based supports that might be available to families across the country.

Ms. LEE. Yes that—Speaking from a personal point of view, my father broke his hip and because of Medicare requirements and Medicaid requirements, was really forced—you know, they quit—we quit rehab, which led him to unfortunately go into a nursing home. So I find that sort of looking across all of these issues and doing as much as we can to keep someone in home is really important.

So I look forward to working with you on that.

I wanted to turn real quickly to nutrition. In Nevada 80,000 older Americans were deemed to be food insecure in 2016. Estimated by 2025 17,000 more older Nevadans will need nutrition services than those today, totaling almost 100,000 older Nevadans.

And we all know the great work that Meals on Wheels accomplishes carrying out home-delivered services.

I would like to ask Ms. Archer, can you please speak a little bit about the other option, congregate nutrition option, and how it is important to fulfilling the social needs of many of our older Americans?

Ms. ARCHER-SMITH. Yes, thank you.

The congregate meal program as I see it, it is kind of a continuum of service. So the congregate meal program is really good for people who might be able to get to it, either they have transportation provided for them or they are still a little bit more mobile. So they don't quite need the home-delivered meal program yet. So it is a good continuum of service. That opportunity to socialize with your peers is invaluable. And what often happens is they come for the meal and then they engage in other programs and other activities that will keep them healthier, more mobile, stronger, things like that. So it is a really important part of the continuum of service.

Ms. LEE. Great.

I will yield the rest of my time. Just thank you all for the important work you do.

Chairwoman BONAMICI. Thank you for your questions. And as I am yielding to Ranking Member Comber, I want to encourage all of my colleagues to do what I have done, which is to deliver Meals on Wheels and to visit a congregate meal site, because I think you will really appreciate everything that happens there.

And now I yield to Ranking Member Comer for 5 minutes for your questions.

Mr. COMER. And I agree with that, Madam Chair. I have done that as well.

Miss Ducayet—did I pronounce that right? I am from rural Kentucky, it is hard for me to pronounce a name like that, but so glad you are here. You mentioned the importance of flexibility in the location of a State long-term care ombudsman program. Can you expand on what factors might play into this decision?

Ms. DUCAYET. Thank you for the questions. And, yes, I know I have a difficult last name and career name as well—it is hard to pronounce.

Yes, so we are in, in Texas, the State unit on aging, a pretty traditional setting for the State Ombudsman Program. And we coordinate with the Area Agencies on Aging in our State to deliver ombudsman services locally. That is a fairly standard practice in many States, but not all States operate in the same manner, and they do so successfully. The flexibility is needed because of different State structures and the different jobs that are done in a State unit on aging, or in an Area Agency on Aging, because ombudsman programs need to be free of any conflicts of interest so that we are sure we are assured that we are serving the needs of

the resident first and foremost and that none of our work is compromised by the location that we operate within.

And so my placement within my State agency, for example, ensures that I have independence from other functions that are performed by the State Medicaid agency, for example. And it works very well for us.

Mr. COMER. Great.

Ms. DUCAYET. Thank you.

Mr. COMER. Great.

Miss Girard, how do the agencies on aging, senior citizens, and other providers of elderly services work together to deliver services?

Ms. GIRARD. I think the foundation is we start with our area plan. Every Area Agency on Aging needs a robust area plan that really engages all of the community. And then we actually in our area have an aging and disability resource connection network, and so we really are able to have a no wrong door system. We fund a wide variety of services out in community-based organizations, some of which are culturally responsive, some are culturally specific, and it is really that aging and disability resource connection network that allows the consumer—it doesn't really matter where they show up, we are going to be able to help them.

Mr. COMER. Great.

This question is for everyone on the panel. As Ms. Foxx said, we have limited time, but are there any provisions in the current law or regulations that are particularly burdensome to your efforts that we in Congress need to address this year? Can anyone think of anything?

Well, I will—before I yield back I will say this, of all the government programs that I am aware of, and there are many, in my opinion in my district there is nothing more popular that Meals on Wheels. Very popular district and anytime there is mention of potential cuts to that we get a lot of calls and messages in my office on that. So I appreciate everything that you all do and we look forward to working with you as we continue to try to make life better for you and for the great people that you serve.

Madam Chairman, I yield back.

Chairwoman BONAMICI. Thank you very much, Mr. Comer.

I now recognize Representative Hayes from Connecticut for 5 minutes for your questions.

Ms. HAYES. Good afternoon, everyone, and thank you for having this very important hearing and for you all coming here.

I am struggling a little this morning because I have this lovely binder with these prepared questions and all I can think about is my grandma right now. And so I really have to shift gears and just go in a different direction just for a minute, if you would indulge me.

I was raised by my grandmother. My mom struggled with addiction and my grandmother raised my brother and I, and really was the backbone of our family. And I would say that, you know, this is over 30 years ago, but in my experience, recently as a teacher and even seeing it every week in my church, there are so many aging adults who are over 60 who are now raising their grandchildren. So I know we are talking a lot about, you know, our elder-

ly community receiving care, but there are so many of them that are still giving care.

So I guess what I want to first start with, the Senate held a similar hearing last week and they talked about the National Family Caregiver Support Programs.

I guess, Ms. Whiting, has the opioid crisis impacted the rate of aging Americans, especially grandparents, who are having to be the de facto guardians and in fact raising their grandchildren?

Ms. WHITING. Thank you for the question. It is incredibly—something that has been on our minds as we look out at the field and we interact with people, that the rate of substance abuse—even I would say other populations, such as military veterans where you have wounded warriors coming home and they are not able to care for their own children and so sometimes their parents take on care of those minor children. So I think you have hit on something that is critically important and, of course, is recognized within the Older Americans Act program overall.

I would say that some have proposed flexibility in allowing States to, you know, put some of the caregiver funding into the kinship care, the grandparents raising grandchildren. We would just encourage you to think about expanding authorization and appropriations for the program as a whole, because there are many people over 50 who are also caring for other adults and kids with disabilities.

Ms. HAYES. Thank you. And I think that is exactly where I was going, because currently there is a proposed 10 percent cap on the NFCSP programs that fund older adults caring for children in this country. And I don't want to us to get caught up addressing one problem, but not addressing the flip side of that problem because fast forward 30 years and the same grandmother who I just told you was the backbone of our family went through stages of dementia, Alzheimer's, hospice, at home in bed. My aunt didn't leave the house for a year because she had to take care of my grandmother.

So I want to make sure that we are addressing all aspects of this problem. It is not just about providing nutrition and supports and getting health care services, but really the entire family is affected when this happens. You know, whether they are the children, who now the only reliable person in their life can no longer care for them, or the adults who are now tasked with caring for their parents and have to put their careers on hold, their families, their lives on hold.

So I guess my question for—and this is the same thing that everyone here has kind of said—how can we provide supports to—what is it that we need to be asking for when we are legislating programs to ensure that we are touching all of those needs and not just pinpointing one area? Because I recognize how broad those things are.

Ms. DUCAYET. Thank you for the question and your personal story.

One thing that occurs—

Ms. HAYES. Everything is personal here, I swear.

Ms. DUCAYET. One thing that occurs to me is the need for person-centered services. And the Older Americans Act actually does an incredible job of emphasizing that. But I think there is always

room for improvement in terms of how we coordinate those person-centered services across the different Older Americans Act services. So that is something I would recommend to look at and see if that is a point where we could improve upon.

Ms. WHITING. I would also just thank you for your personal story and for talking about that. My grandmother had dementia and my aunt was her primary caregiver, and it was very difficult for her to access services because some of the restrictions in these laws around ages. So, for example, in the caregiver program, you know, it is caring for people over 60 and then caring for people with dementia of any age. And it is sometimes difficult for people to understand how those programs could be administered. So that is an area where, you know, thinking about how the program aligns and making sure people understand at the State level how the program can be administered.

Ms. HAYES. Thank you, Madam Chair. That is all I have.

Chairwoman BONAMICI. Thank you very much, Representative.

I now recognize Representative Thompson from Pennsylvania for 5 minutes for your questions.

Mr. THOMPSON. Chairwoman, thank you so much. Thank you for this session. As someone who worked a career for almost 30 years serving mostly older adults, therapists, previously a licensed nursing home administrator, the Older Americans Act is incredibly important.

I was pleased when a few years back here we did the last reauthorization, we made some really good improvements, tried to focus on some of the chronic and disabling conditions, did some investment in our senior centers. A lot of good things. But this is the reason we do periodic reauthorizations, so we make sure that we are always getting it better and getting it right.

And thank you for what each of you do and the perspectives that you bring here. You know, one of the covered—and this was mentioned briefly—one of the covered populations under the Older Americans Act obviously are those who are living with Alzheimer's disease. I experienced that. My mother lived with Alzheimer's for 10 years. It stole her identity, her memories, and then her life eventually. You know, these individuals receive the vital care and assistance needed to help maintain their independence. However, there is an estimated 200,000 Americans under the age of 60 that are now living with Alzheimer's disease, or more commonly referred to as early onset Alzheimer's. Kind of an area I worked on when I practiced rehabilitation.

Now, those with early onset Alzheimer's face difficult challenges when it comes to family and work and finances. Things kind of compound. It is almost like an accelerated aging to some extent.

So starting with Ms. Whiting, you know, what are your thoughts as we look forward to reauthorization—and I know that we have got an age group of 60 that we define with the Older Americans Act, but quite frankly, when you look at things like Medicare, we do make accommodations for certain disabling conditions, end State renal disease—there may be more—you know, where folks are younger than that normal eligibility age. Any thoughts on what we should do in terms of early onset Alzheimer's? Any revisions or

thoughts for changes as a result of the next reauthorization of the Older Americans Act?

Ms. WHITING. So under the current Family Caregiver Support Program my understanding is that if you are caring for someone with Alzheimer's or related dementias of any age that you can receive services. But I would say when we look at other places in the Federal Government where they are providing support to caregivers, this is an area that is definitely underserved.

So, for example, there is an estimated 5.5 million people caring for military veterans and the support for those programs is over $1 billion. Likewise, with Alzheimer's and dementia, you know, that community was able to reach an appropriation and authorization level to support it.

I think the other piece, though, is just looking at research and where is it that we don't know what we don't know.

Mr. THOMPSON. And there was an early onset bill that has been introduced in the House and the Senate that I think would be perfect to incorporate into any future Older Americans Act reauthorization.

I want to kind of revisit just briefly, to anyone that wants to comment further, on the whole issue of just everywhere I go, you know, obviously the public health crisis of our lifetime is substance abuse. Maybe it is opioids, maybe it is crack, maybe it is prescription drugs—it changes based on a host of factors, but it is the underlying substance abuse. And a tremendous number of—I don't want to call them older adults because I put myself in that category of, you know, grandparents who find themselves now back in a primary care role. And there is a reason we have our kids when we are younger, we have the endurance for it. And when you, you know, assume those roles say in your 50's and 60's and 70's, it is a challenge.

And I heard some general responses, but are there any concrete, any specific at this point recommendations that you would have for—I am not one that just likes to throw money into a program and hope that good people do good things, I like to have clear direction. And maybe it is more study that we need to do to figure out what are the supports that folks—I guess technically it would be 60 and older because the Older Americans Act, of how can we help those grandparents that find themselves in a parenting role once again?

Ms. GIRARD. I think That is a really, really great question. There are—I think there are some really good evidence-based programs that some communities are really starting to utilize that are helping to destigmatize and bring resources for older adults who are experiencing many behavioral health issues, including substance use disorders, because they are often co-occurring with other issues. And I know in our State we have actually been looking at studying what some of the barriers are for people getting the support that they need. And it is actually more challenging for somebody that is older, somebody 65 and older to get the supports that they need because of issues around how Medicare is structured. So if we can be looking at ways that we can use evidence-based programs, that we can use peer supports, where peers can actually

support other people that are going through the same thing, I think that would be excellent.

Mr. THOMPSON. Thank you, Madam Chair.

Actually, let me just say if any other witnesses have any thoughts on inputs or specific strategies, if you wouldn't mind forwarding to the committee. I think that would be very helpful, how do we help these grandparents who find themselves in—

Chairwoman BONAMICI. Yes, Representative Thompson, if you put that in writing as a question for the record we will make sure that happens and we have a full record.

Thank you.

I now recognize Representative Trone from Maryland for 5 minutes for your questions.

Mr. TRONE. Thank you, Madam Chairman. Thank you all for coming out today. This is a really important subject.

I want to talk a little bit about social determinants of health, SDOH. It is a new term in health. I wasn't that familiar with it whatsoever. For the Older Americans Act, has been way ahead of the curve in recognizing the importance in addressing the social determinants of health through community interventions. Category under the SDOH that is starting to get more attention is loneliness and social isolation. It is a growing concern and one that has serious health consequences.

A 2010 study at Brigham Young University found that loneliness can shorten a person's life by 15 years. Another at Rush University found connection between loneliness and a whole wide range of health problems, especially increased risk of Alzheimer's.

So Ms. Archer-Smith, first of all I want to thank you again for coming out. You are a—You work in my district in Montgomery County, so it is great. You serve over 40,000 seniors throughout Maryland, and we really appreciate the help with Meals on Wheels. But a quarter of our seniors are living alone. And, you know, I know the fantastic volunteers are serving many of these seniors nutrition, and that is the only human interaction they get often, and those connections are so important to have during the day.

So you spoke about the benefits of home-delivered meals and reducing isolation among these homebound adults. Can you share some examples of individuals who particularly benefit from social contact provided by the program and how this program is doing more than just substance, but performing other duties on isolation?

Ms. ARCHER-SMITH. Yes, and thank you for the question.

So I can give countless examples of volunteers who tell us about the person who they wait for the end of the route so that they can spend more time with them, play cards with them, talk with them about, you know, what is in the news.

I can share with you a personal experience that was in my written testimony of a woman named Doreen who was 92 years old and lived alone. And I actually delivered to her personally. I was covering for someone and I liked to do that periodically to, you know, engage with our clients. And she didn't know me when I came in, but her face was so excited to see me and her eyes lit up so, you know, so wide and she wanted to know everything about me, what was my name and what did I do at Meals on Wheels and why was I there today and where was her other volunteer. And those are the

questions. She was just hungry for someone to talk to. And I think is true of many of the people that we serve, but many of the things that we do, we call ourselves more than a meal because we are delivering more than just a meal, and that goes beyond that interaction with the volunteer. We also have other services that act as other touch points for them. So if it is a companion visit or if it is a phone pal, or something like that. That is another touch point. If it is someone to help them with some grocery shopping and household things that we don't deliver, those are other touch points and those are opportunities for them to interact more. And we have many, many stories of people who receive our full offering of services.

Mr. TRONE. Yes, I was with a friend of mine last night, he has worked with Meals on Wheels for probably four or 5 years and he had a lot of similar stories about, you know, saving one person toward the end of the route to spend some time with them and one-on-one, and that made their day.

So I think it is really great work that you guys are doing.

What are the limitations that you are facing right now to be able to cover everybody appropriately, and, you know, what are the barriers?

Ms. ARCHER-SMITH. So the barriers obviously are the funding. I mean, you know, that is the easy answer. But, you know, there are so many other things that our clients need. So being able to create those services and a plan for them that is unique to their individual needs is important. So being able to be creative about how we can deliver those services, whether it is grocery shopping through volunteers or companion visits, or whether it is professional case management and care coordination services.

Mr. TRONE. And what is your volunteer stream? Do you have an adequate number of volunteers?

Ms. ARCHER-SMITH. We have an aging group of volunteers, so we have some very, very loyal volunteers that have been with us for many, many years. And so we are able to recruit a lot of volunteers by way of word of mouth because they are so loyal to us and they tell their friends about it.

But we are struggling to keep volunteers with growth. So there needs to be a more intentional approach with that, which we are addressing.

Mr. TRONE. Well, it is very rewarding work. Thank you.

Ms. ARCHER-SMITH. Thank you.

Chairwoman BONAMICI. Thank you, Mr. Trone.

I now recognize Mr. Johnson from South Dakota for 5 minutes for your questions.

Mr. JOHNSON. Thank you, Madam Chair.

Ms. Ducayet, maybe start with you. Of course, as we talk about reauthorizing the Act we want to make sure that it is well positioned for the future. I feel like I have read in a number of different places that number of older Americans, seniors, will double like in the next 30 or 40 years. And I think despite our best efforts to help people age in place, I assume that will mean a lot more folks who will call nursing homes, long-term care facilities, home.

No. 1, is my assumption right about the data from what you know?

And then, No. 2, will that place a burden on the ombudsman—ombudspeople across the country?

Ms. DUCAYET. Thanks. Yes. So absolutely we know that the numbers are really skyrocketing in terms of our aging population, and that is going to affect our need for long-term care facilities.

Where we are really seeing the biggest boom, and it has really been happening for decades now, is in assisted living facilities. If we can make those affordable everywhere, and that is a big question in all States, then people will choose assisted living facilities instead of a nursing home if they could at all possibly have it. It gives you more freedom and independence. It is less expensive to provide services in that setting. That boom has completely overwhelmed our ombudsman programs across the country.

And so we hope to see a new appropriation for us to serve people in assisted living facilities, frankly because we have never seen that given to us in reauthorizations before and we have been very overwhelmed by the addition of assisted living facilities to our responsibilities.

Mr. JOHNSON. Yes, of course, resources are a big part of the equation. I mean nationally do we see a change in how services are deployed in a way that provides for more efficiency or effectiveness in meeting the mission?

Ms. DUCAYET. Well, I think big States like mine tend to use localized services and don't have a State operation hub for all services to be provided, and that makes sense for us to have localized offices of our program so that we can get to the residents quickly and visit facilities frequently. We need to use volunteers and we are allowed to use volunteers. That is a cost savings to the government. Our volunteers do a lot for our program, but our volunteer work force is aging as well and that has been a challenge for us too as we need to replenish those services.

So another thing that would help the ombudsman program with volunteers is to be able to recognize the role of the volunteer more specifically in the Act, be able to reimburse volunteers specifically for mileage costs and training costs that are associated with it. Because volunteers save money for the Older Americans Act, but it isn't entirely free to have a volunteer in your program either. You have got to have a well trained force.

Mr. JOHNSON. So I just want to make sure I am tracking, more specific language making it clear that those volunteer expenses could be reimbursed as a part of the program would be helpful?

Ms. DUCAYET. Yes, yes. Yes, it would.

Mr. JOHNSON. Okay, very good.

So then, Ms. Whiting, as we look at—we talked about aging in place, and I thought you did a nice job of outlining the value proposition. When we have effective caregivers that allows people to maybe put off going to a long-term care facility or assisted living.

So a similar question, if we have this many more older Americans in the future, and you mentioned that we are only providing supports to 2 percent of the caregivers out there, are there ways that we should be looking nationally to deploy services in a different way that can help meet the goals, meet the mission?

Ms. WHITING. I think, Congressman, the ultimate goal here is that we would have people taking care of each other and we would

be fostering that, not just through the appropriations process and expanding the program, but just to bring to your attention the RAISE Family Caregivers Act advisory council has yet to meet and it is on a 3-year sunset and will end in 2021. And that council, you know, proposes an opportunity to examine those exact kind of questions. And so we would encourage you to think about extending the life of that so we can actually get a plan that has employers, providers, older Americans, and others putting in what they really need, and where there could be more efficiencies in the system.

I think the other piece of this is—if I can respectfully call it the Golden Girls model—where we have peers living together because increasingly we have younger generations of caregivers who are not having as many kids, they are more isolated, and so how can we help people age in healthy ways, using things like respite and senior centers and these other types of OAA programs so that they can care for each other as peers.

Mr. JOHNSON. Yes. So and then Ms. Archer-Smith, Ms. Girard, I just wanted to give you an opportunity briefly to comment on anything it is we are talking about, increasing number of seniors and if there are different deployment mechanisms to provide supports, allow for aging in place. Any other thoughts?

Ms. GIRARD. Well, I don't know if it is an opportunity, it is definitely a challenge. One of the things that families need is they need respite care and they actually often can be a better caregiver if somebody else is coming in to do caregiving, like giving somebody a bath. And what we are really experiencing is a challenge in the availability of the work force.

So I think work force development for people so that there are people that view this as a viable option for them for employment would be really, really beneficial. And I know that there are both many State and national efforts looking at work force issues, but that is going to be a big one.

Mr. JOHNSON. Thank you very much.

Madam Chair, I yield back.

Chairwoman BONAMICI. Thank you very much.

I now recognize Representative Stefanik from New York for 5 minutes for your questions.

Ms. STEFANIK. Thank you, Chairwoman, and thank you to our panelists for being here today on such an important topic.

I represent New York's 21st district, which is one of the most rural districts on the East Coast, but it is also one of the most aged districts if you look at the percentage of seniors that I represent. So your programs and the great work that you do has a direct impact on my constituents.

I wanted to followup on Mr. Thompson's line of questioning related to Alzheimer's. As we know, there are approximately 200,000 Americans suffering from early onset Alzheimer's disease and too often people living with this disease in their 30's, 40's, and 50's can have young children, new homes, or growing careers. They are shut out of vital services just because they are young and the disease hits them earlier.

Alzheimer's forever changes people's lives. It has impacted my family and we have heard from stories on both sides, both individuals in the audience here today, witnesses, as well as Members of

Congress who have been impacted. I introduced the Younger Onset Alzheimer's Act this year, that was the legislation Mr. Thompson was referencing, that would amend the Older Americans Act to ensure the availability of programs and services for those impacted by Alzheimer's by allowing patients younger than 60 to access them.

So my question, Ms. Whiting, this legislation would allow the National Family Caregiver Support Program and the Long-term Care Ombudsman Program to serve this population, but can you shed more light on how expanding these programs to those under the age of 60 would greater support family caregivers, especially those in the work force or those caring for young children? I am really interested in the caregiver piece aspect of this.

Ms. WHITING. Thank you for that question.

I think Alzheimer's is probably one of the biggest threats, for lack of a better word, facing us. In particular for caregivers, we know from research that it impacts their health, it impacts their ability to stay engaged in the work force, and we know that employers are starting to think about the impact of Alzheimer's. So actually in Kentucky the ranking member's home State, the Louisville Healthcare CEO Council has been trying to come up with business solutions for caregivers at work.

I think where Older Americans Act programs can be most helpful to people with Alzheimer's, one would be respite, expanding the availability of respite. The second is, you know, really being a State laboratory to test Alzheimer's interventions that work. So, for example, the REACH intervention is an amazing intervention in New York, Mary Mittelman's program that she has done, hospital to home, that helps educate caregivers at discharge is also an excellent program. So thinking about how the AAA network can test that in different types of communities and then use that to spread those best practices.

Ms. STEFANIK. Thank you.

Ms. Girard, I wanted to followup on your recommendation about work force development when it comes to caregivers. The issue of caregivers is something that not only I have engaged on this committee, but also on the House Armed Services Committee when it comes to military caregivers. There was a program through the VA for military caregivers, but they did not anticipate just how many applications there would be. So it was underestimated.

You talk about work force development specifically for caregivers. What can we do to ensure that we have a trained, qualified, and well paid work force when it comes to caregiving?

Ms. GIRARD. That is a really great question as far as what kind of infrastructure is needed. I think we need to be looking at making sure that it is seen as a viable career, that it pays a living wage. That can be a challenge where sometimes the in-home caregivers are actually receiving public benefits. So the more we can promote a living wage for folks where they might be able to get some benefits.

I had the opportunity to be on our Oregon Home Care Commission and they really have developed Statewide a strategic plan. So I think encouraging communities to develop strategic planning that really looks at their work force and how they can really boost it,

because really we are funding that work force in our area through both Medicaid, through State funds, and Older Americans Act funds. And it impacts really all the individuals getting those services. So it is a real vital thing.

Ms. STEFANIK. Absolutely. Any other feedback on those questions from other panelists? Ms. Archer-Smith?

Ms. ARCHER-SMITH. Yes. I would just encourage the reauthorization at levels that help meet the unmet need, because when you are providing the meal for the person with Alzheimer's, you are supporting that caregiver. When you are bringing other resources into the home, you are supporting that caregiver.

We have stories, of you know, people that we have been able to help navigate a very complicated system of resources that are out there. And without the support of a case manager or a client support specialist, they may not have known how to get that, those extra hours of in-home care that they were eligible for. So making sure that we are meeting the unmet need is serving both the participant and the caregiver.

Ms. STEFANIK. Thank you.

My time has expired.

Chairwoman BONAMICI. Thank you. I now recognize the chairman of the full committee, Representative Scott from Virginia, for 5 minutes for your questions.

Mr. SCOTT. Thank you.

Miss Whiting, I wanted to followup on one of the things you talked about, respite care. Can you talk about the value of respite care, both to the senior and to the caregiver?

Ms. WHITING. Absolutely, and thank you for the question.

So respite care is one of those evidence-based benefits that we know improves the ability of the caregiver to actually be a provider of care and it provides the individual who is receiving care a chance to essentially take a break. I mean one of the challenges is we think about caregiving in these real tactical terms, but there is research coming out that shows that if you are going to improve the relationship and the way that the caregiver and recipient communicate with each other, you cannot only improve the health of the older person or the person with disabilities, but you can improve the health of that caregiver as well.

So being able to give people a break from each other and a chance to just be the sister, the wife, the brother, the friend, has a tremendously positive benefit on families.

Mr. SCOTT. Thank you.

Ms. Girard, you talked about the cost of caregiving. Is it realistic to think that you could provide funding for caregivers without subsidy?

Ms. GIRARD. Well, I do know a good example. I am probably actually a good example because I am doing caregiving for my father. He lives about 30 miles from me and I have been searching for a caregiver that I am willing to pay in my community and I can't find anybody. So it is a struggle. I mean there are many families who are willing to cover the cost of that, and especially when you look at a return on investment of they get a break if you can have somebody come in 5 hours a week to just do some of the really heavy work.

So I think looking at how we can encourage families to do that, individuals to do that. But then also I do think we have to look at a bit of a safety net for people that really can't afford to pay for caregiving and if you look at the return on investment.

Mr. SCOTT. If you are going to pay the caregiver a living wage, most of the seniors can't pay someone else a living wage because they are hardly making it themselves.

Ms. GIRARD. That is true. So that is where really we do have to subsidize that. But if you look at the cost of the in-home caregiving and compare it to the cost of either a community-based care, like assisted living or a nursing facility, it is still much, much cheaper. We have some State funded programs where it is really only costing the State, and Older Americans Act actually, about $300 a month. But if that person was in an assisted living, it would be probably $3,000 a month. And if they were in a nursing home it would be closer to $6–8,000 a month. So if you look at it that way, it is actually very cheap.

Mr. SCOTT. Thank you.

The Older Americans Act supports a number of evidence-based health interventions. Ms. Girard, one of these is fall prevention, where evidence shows that fall prevention programs can reduce problems. Can you say a word about that?

Ms. GIRARD. Yes. For our Area Agency on Aging we look at the development of those programs at multiple levels. We participate in a network that includes us, it includes public health, it includes health care providers, and it includes our community partners, like our nutrition programs. We develop a plan in our area and then we look at different ways that we can all pool funding to start really developing a network of fall prevention programs, evidence-based fall prevention programs. And some of the funding is coming from Older Americans Act, but some of the funding is coming from other sources. And we really try to embed it in local community-based organizations because then it is more likely to get out to the folks that actually need it.

Mr. SCOTT. When you talk about evidence-based, do the fall prevention programs prevent falls?

Ms. GIRARD. Yes, the evidence-based—they have been studied, they have been compared to control groups where people have not been getting the program, and has shown a really significant return in reduction of falls. And I know that in our area falls is actually, for older adults, one of the biggest disease injury kind of issues in our county.

So it is something that our whole health network is really looking at.

Mr. SCOTT. Thank you.

And, finally, Ms. Ducayet, can you say a word about the ombudsman model addressing problems of elder abuse?

Ms. DUCAYET. Yes, thank you. So I would say that our model includes surprise visits, frequent visits to facilities where our eyes and ears are in those buildings. And I think that absolutely prevents abuse. It is something different far and away from a regulatory function that is there to cite a facility and bring them into compliance. Our focus is on the resident and being person-centered

and finding a resolution that the resident wants and seeks to feel safe and secure after abuse, neglect, or exploitation.

I think those are really key factors. We resolve 73 percent of complaints to the satisfaction of the resident or the decisionmaker of the resident every year.

Mr. SCOTT. Thank you.

Ms. DUCAYET. Thanks.

Mr. SCOTT. Thank you, Madam Chair.

Chairwoman BONAMICI. Thank you, Mr. Chairman.

And I see no other members.

I want to remind my colleagues that pursuant to committee practice, materials for submission for the hearing record must be submitted to the committee clerk within 14 days following the last day of the hearing, preferably in Microsoft Word format. The materials submitted must address the subject matter of the hearing. Only a member of the committee or an invited witness may submit materials for inclusion in the hearing record. Documents are limited to 50 pages each. Documents longer than 50 pages will be incorporated into the record via an internet link that you must provide to the committee clerk within the required timeframe, but please recognize that years from now that link may no longer work.

So, again, I want to thank the witnesses for their participation today. What we have heard is incredibly valuable and I know members of the committee may have some additional questions for you. We ask the witnesses to please respond to those questions in writing. The hearing record will be held open for 14 days to receive those responses.

And I remind my colleagues that pursuant to committee practice, witness questions for the hearing record must be submitted to the majority committee staff or committee clerk within 7 days. Questions submitted must address the subject matter of the hearing.

I now recognize the distinguished ranking member for his closing statement.

Mr. COMER. Thank you, Madam Chairman. And I just want to again thank the witnesses for being here today and thank you for everything that you do in the people that you serve. Your knowledge and experience and testimony today will help us better serve older Americans as we move forward.

It is crucial that we hear from people on the front lines, like yourselves, and I think this committee hearing has been very beneficial to us. We must acknowledge the challenges facing the Older Americans Act given the rapidly growing senior population and constraints of a limited Federal budget.

As we explore ways to further empower seniors, we must enhance coordination within the program to effectively serve those with the greatest social and economic needs. A critical aspect of this is maintaining and strengthening the local flexibilities within the law to meet the needs of individual communities.

We have the opportunity today to begin the committee's process of improving the law to better provide care for older Americans.

Again, thank you for being here today and I look forward to working with you in the future.

Madam Chairman, I yield back.

Chairwoman BONAMICI. Thank you.

I now recognize myself for making a closing statement.

Thank you, again, to the witnesses for providing such insightful testimony. And I think I also want to thank my colleagues who shared—and you heard the intensely personal stories—because this is an issue that affects us all and affects our constituents.

People in the United States of America should be able to retire and age with dignity. And by passing the Older Americans Act in 1965, Congress did make a commitment to provide Americans the support they need to age independently in their homes and communities for as long as possible. And today, as our witnesses testified, the Older Americans Act programs empower millions of adults every day to remain independent while avoiding or significantly delaying costly institutionalized care.

The population of older Americans continues to grow, but unfortunately commitments—investments by Congress in OAA programs have not sufficiently kept pace. And this has reduced our ability to meet the increased demand for these effective and widely used services.

Just Monday at home in Oregon I heard about an 80-year-old woman who was living in the back seat of her car. And I think far too many Americans continue to live in poverty across our districts, face discrimination, face barriers to basic necessities in part because OAA programs are underfunded and not well enough supported.

So today's hearing has underscored our responsibility. We can help stop this cycle of disinvestment which is eroding the original purpose of the Older Americans Act and creating additional challenges for too many older Americans, and actually costing us more in higher cost care.

As this committee considers the OAA reauthorization I hope we can work together so its programs have the support and resources needed to provide essential services and compassionate care to all aging Americans.

Just 3 years ago both parties came together in each chamber of Congress to reauthorize and improve the OAA programs. Today, I appreciate my colleagues joining me in renewing that commitment to honoring the promise made to older Americans more than a half a century ago. By continuing the Older Americans Act tradition and bipartisan support we can make clear that this committee and this Congress will continue to stand up for older Americans.

So thank you, again, to the witnesses for being here. I look forward to working with you and all of my colleagues on both sides of the aisle as we move forward.

And if there is no further business, without objection, this committee stands adjourned.

[Additional submission by Chairwoman Bonamici follows:]

ADRC Business Case: Final Report

Intermediate Procurement #4340

Presented by Compelling Reason, LLC
ORPIN Supplier Number 71360

JUNE 19, 2018

Contents

Figures, Tables, and Narratives

The Bottom Line: The Business Case for ADRC

In the private sector, "making a business case" means analyzing whether an endeavor offers a product customers want to buy while providing a positive return on investment (ROI) for investors.

We applied the business-case idea to the State of Oregon's Aging and Disability Resource Connection (ADRC). A positive business case for ADRC would mean it offers services of value to consumers while costing less than the value it provides. Comparing value to costs is called *social return on investment*.

SROI: Social Return on Investment

ROI and SROI both measure whether value-provided exceeds costs-incurred. However, private-sector ROI differs from public-sector SROI.

In business, ROI means people invest money and the same people receive money if their investment pays off; that is, if the business returns money to its investors. SROI is different. "Social return" means that the benefits accrue to a group (e.g., a state and its inhabitants). Those in the group who receive the benefits may or may not pay for the costs (the investment). The benefits may be wholly monetary, partly monetary, or not monetary at all.

Social return on investment measures how much "good" comes from a given effort. It is the ratio of quantified benefits (the social return) to quantified costs (the investment). We express it as, for example, 3.0 to 1, which means $3.00 of quantified benefits relative to $1.00 of quantified costs.

Table 1: SROI ratios

SROI ratio	Meaning
Above 1.0 to 1	Case made. The activity produces more benefit than it costs.
Equals 1.0 to 1	Breakeven. You pay $1 for services worth $1.
Below 1.0 to 1	Case not made. The activity costs more than it's worth.

THE ADRC BUSINESS CASE

Our estimate of ADRC's SROI:

11.1 to 1

That SROI, for fiscal year 2016-17, covers the subset of benefits we could quantify and directly attribute to ADRC. Benefits totaled $39.8 million and came at a cost of $3.6 million.

About This Report

This is the comprehensive report on our analysis of Oregon's ADRC. It contains confidential information proprietary to Compelling Reason LLC and the State of Oregon. **This report is not intended for publication.**

A separate report, covering the highlights of our analysis, is suitable for publication. It is available from ADRC.

This report presents our analysis of Oregon ADRC's social return on investment.

We conducted our analysis from September 2017 through May 2018. We relied on the guidance, assistance, and contributions of many people in Oregon's Department of Human Services.

Our job was not to presume the ADRC business case; that is, it was not to search for positive evidence. Rather, our job was to analyze, with the best data available, whether the business case could be made.

METHODOLOGY

We present our methodology at a high level: how we collected data, how we kept our analysis conservative, and what we quantified and what we didn't.

RESULTS

We describe the results of our analysis. We focus on the numbers that make up ADRC's 11.1 to 1 SROI.

RECOMMENDATIONS

We offer suggestions for ongoing ADRC analysis.

RESOURCES

The people who participated in the analysis.

SOURCES

We tapped government databases and academic studies for various statistics. We reference others for additional reading.

TECHNICAL APPENDIX

The Technical Appendix details how we quantified both benefits and costs of ADRC. It also contains comments on our analytical model.

Methodology

In this section we discuss:

- Why make the business case? The key question and key goal underlying the project.
- How and why we were conservative with our analysis.
- The SROI equation.
- Which ADRC benefits we did, and didn't, quantify.
- How we collected data.
- How we adjusted our data sample to reflect state-wide numbers.
- Calculating the total benefits and costs of ADRC assistance.

Why make the business case?

Social services for seniors and people with disabilities have been offered by numerous non-governmental organizations and government agencies with federal, state, and local sponsorship. Consumers could reach these agencies directly or, in recent years, through referral programs (Information and Assistance, Information and Referral, 211, etc.).

Before ADRC, people needing services had to navigate their own way through myriad social-service agencies. Help was there for those in need but it was not easy to find, given the numerous agencies and services. Age and disability posed additional challenges precisely for those who most needed help.

ADRC brought all such programs under an umbrella that coordinated Information Assistance/Referrals. It also introduced professional options counselors who assess needs and match consumers to services.

ADRC innovations enhance access to social services by:

- Funding and training options counselors and referral specialists.
- Building and maintaining a database of support services and agencies.
- Reporting options counselor activities.
- Enabling options counselor follow-up with consumers.
- Providing uniform, statewide access to ADRC and its services through the Internet, toll-free phone, and printed documents.
- Expanding capabilities and coordination with services for Information and Assistance and Referral
- Connecting to professional statewide leadership from a central office directed by the Oregon Department of Human Services.

Table 2: The key question and the key goal

The key question	Do the ADRC enhancements provide significant benefits to consumers and the agencies that support them?

The key goal	Establish the business case for Oregon's ADRC ■ Quantify the value and potential savings created by ADRC. ■ Estimate ADRC's current social return on investment. ■ Develop an ongoing framework to track and evaluate program benefits.

How and why we were conservative with our analysis

A guiding principle in our work with SROI: be conservative with numbers. That's not "conservative" on a conservative/liberal spectrum; it's conservative on a solid/speculative spectrum. When conservative analysis shows a strong SROI (as ours does) for ADRC, we can (and do) have reasonable faith that ADRC's contribution is real.

We made our analysis conservative by following these rules:

1. Count only what we can quantify and attribute to ADRC.
2. Use published studies where possible.
3. Don't depend on any single number.
4. Use sensitivity analysis as needed.
5. When in doubt, leave it out.

Precision. Conservative analysis and precision are not the same thing. By its nature, SROI analysis cannot be precise and SROI will vary from year to year. ADRC's high SROI, though, makes it highly unlikely that imprecision or variation will unmake the business case.

When numbers get close to a threshold — for example, breakeven SROI of 1.0 to 1 — sensitivity analysis (rule 4) can help show whether it'd be easy to tip SROI to a less-enthusiastic value. We made provisions in our model for sensitivity analysis in case ADRC's SROI turned out low (see the Technical Appendix). ADRC's SROI, though, is far above such a threshold, and so we did not conduct extensive sensitivity analysis. (See the Technical Appendix for an example of a sensitivity analysis.)

The SROI equation

We calculate ADRC's SROI by:

- Comparing the benefits received by seniors and people with disabilities with ADRC, versus the status quo, to
- The incremental costs borne by the state to operate the ADRC program.

As an equation, ADRC's SROI looks like this:

$$SROI = \frac{Benefits\ (with\ ADRC) - Benefits\ (status\ quo)}{Cost\ (of\ ADRC) - Cost\ (status\ quo)}$$

We quantified only those benefits and costs that accrue directly from options counseling since it is the most-notable enhancement created via ADRC. By focusing on options counseling, we ensure that our

analysis gives SROI credit only to activities clearly due to ADRC. Information and Assistance/Referral (I&A and I&R) and Care Transitions are critical functions that work synergistically with options counseling but their costs and benefits are excluded from the analysis.

Table 3: Focus on options counseling

Function	Costs	Benefits
Options counseling	Included	Included
Information & Assistance, Information & Referral	Excluded	Excluded
Care Transitions	Excluded	Excluded
ADRC Central Office cost	Allocated by FTE (61% to SUA, 39% to ADRC)	Not applicable

Benefits we did, and didn't, quantify

ADRC provides many kinds of benefit to its consumers. "Benefits", in the equation above, is the sum of all the benefits we quantified. The benefits we quantified fall into five categories.

Table 4: Five categories of benefits from options counseling

Benefit category	Description
Making suitable long-term care and housing decisions	Options counselors (OCs) help consumers identify and understand their needs and assist them in making informed decisions about appropriate long-term service and support choices. They encourage consumers to remain at home with home health care or in another institution instead of the more-costly choice of nursing homes.
Assisting with financial aid, food, health, transportation	OCs assist consumers obtain financial aid, food or food stamps, health-related products and services, transportation, or other items of value.
Preventing homelessness	OCs discuss housing options with consumers who are homeless or facing eviction. Counselors help prevent homelessness by providing assistance for options such as low-income housing or rent assistance.
Preventing abuse	OCs identify consumers who are at risk of abuse and neglect and take preventive actions. Examples include helping to safeguard funds and referrals to Adult Protective Services.
Preventing falls	OCs encourage consumers with a history or risk of falls to attend fall-prevention programs (e.g., Tai Chi, Matter of Balance, Otago) that are proven to reduce hospitalization and other costs.

It's clear that ADRC provides benefits in addition to those in Table 4. We didn't quantify those benefits, though, because reliable data were unavailable or because benefits were only partially due to ADRC.

We did not quantify the benefits below.[1]

- Broader, faster access to services via a well-maintained database of service providers.
- More-efficient and -appropriate support by coordinating I&A, I&R, and options counseling.
- Better, more-consistent service due to ADRC training, professional support, and management.
- Lower expenditures by avoiding repeated and extended use of services.
- Employment (and related tax payments) for program beneficiaries and family caregivers.
- Improved quality of life[2] from better health, lower stress, etc.

How we collected data

We collected benefit and cost data through interviews, literature search, and surveys.

Table 5: Calculating benefits and costs

Identify benefit categories	Develop methodology	Calculate benefits	Calculate costs
■ Interviews with Steering Committee (senior executives; subject matter experts) ■ Literature search	■ Find available outcomes data ■ Design and test survey for options counselors	■ Options counselor survey ■ Confirm data with OCs ■ Convert outcomes to benefits ■ Scale and weight to sample mix	■ Cost survey ■ Meeting with ADRC accounting staff

Four segments. We surveyed options counselors throughout the state. They were based in AAAs (Area Agency on Aging) and CILs (Center for Independent Living). Each AAA or CIL could be in an urban or rural area. Thus, we had four segments: AAA | Urban, AAA | Rural, CIL | Urban, and CIL | Rural.

Options counselors graciously provided data on 971 consumers served in 2017. The 971 is 21.5% of the 4,506 consumers served by ADRC that year. We did not receive data on all 4,506 consumers because:

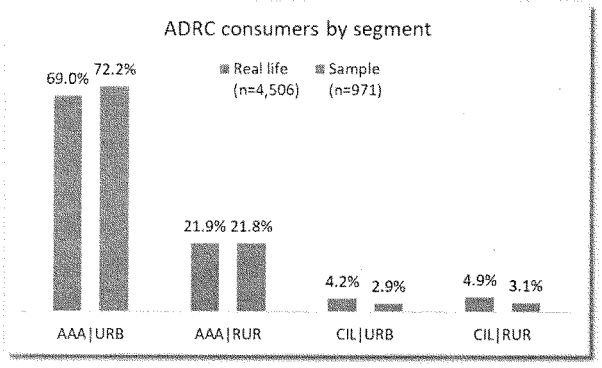
[1] If we could have quantified them, ADRC's SROI would go up. That's because we've already included the costs of providing those benefits (see Total costs) through options counseling, so quantifying those additional benefits would add frosting to the analytical cake.

[2] Quality Adjusted Life Year (QALY) analysis commonly uses values of $50,000 to $100,000 per year, or more. See also Sources 63 and 64.

- Some OCs had heavy caseloads and did not have time to provide information on all the consumers they helped. We asked those OCs to send us data on a subset of their cases. Some had caseloads too demanding even to send that subset.
- Some consumers were helped by OCs who left their jobs and thus were not available to record their experiences with those consumers.
- Some OCs simply did not respond, either by choice or as directed by their supervisors.

How we adjusted our data sample to reflect state-wide numbers

The graph below shows the distribution of consumers by segment. The left columns represent all consumers served by ADRC in 2017; the right columns represent the consumers in our data sample.



Source: Compelling Reason SROI model

Figure 1: ADRC consumers by segment

Broadly speaking, the consumers in our sample mirror the population of consumers served by ADRC in 2017. However, AAA|URB is slightly overrepresented and CILs are slightly underrepresented.

We adjusted our SROI analysis to the population by giving a little less weight to each AAA|URB consumer and a little more weight to each CIL|URB and CIL|RUR consumer.

The scaling factor. We also scaled our findings from our weighted sample (the benefits to 971 consumers) to the entire state (4,506 consumers). We multiplied benefits by a scaling factor of 4.641, which is the ratio of total consumers to sample consumers in 2017. Scaling the benefits from our sample approximates the state-wide benefit from ADRC.[3] Of course we used total, state-wide numbers for ADRC costs.

[3] It is possible that our sample is biased. (That's true of any survey sample.) Perhaps the options counselors who responded were those who had the best results, which they were proud to report. Or perhaps the OCs who responded were those with the worst results, because those who didn't respond were out creating even greater benefits.

Calculating the total benefits and costs of ADRC assistance

TOTAL BENEFITS

We calculated the total benefits — i.e., the financial outcomes — with the same three-step process for each of the five benefits we quantified.

Table 6: Process to calculate benefits from outcomes

STEP 1 ADRC outcomes	STEP 2 Outcome benefits	STEP 3 Total benefits
■ Determine outcomes for ADRC consumers ■ Calculate differences between "before ADRC" and "after ADRC"	■ Determine benefits for various outcomes	■ Difference, before vs. after, *times...* ■ $ value of outcome, *times...* ■ # of consumers in survey, *times...* ■ Scaling factor

Table 7: Calculating total benefits

Benefit categories	STEP 1 ADRC outcomes	STEP 2 Outcome benefits	STEP 3 Total benefits
Long-term care	% delayed entry to nursing homes	Δ cost: nursing home versus home care	■ Difference, before vs. after, *times...* ■ $ value of outcome, *times...* ■ # of consumers in survey, *times...* ■ Scaling factor
Financial aid, food, health, transport, etc.	% receiving assistance	Δ value of assistance	
Preventing homelessness	% facing eviction or continued homeless	Average cost x duration of homelessness	
Preventing abuse	# of financial abuse case prevented	Average value of abuse prevented	
Preventing falls	% enrolling in fall prevention programs	Net benefit per fall prevented	

So, if our sample is biased, we don't even know in which direction... which suggests biases, if any, are likely to cancel out. And again, our sample would have to be massively biased to lead us to a different conclusion about ADRC's manifest value to the State of Oregon.

TOTAL COSTS

We calculated ADRC annual program costs by 1) isolating the costs of options counseling and 2) allocating the portion of costs for ADRC options counseling from Central Office costs. To do so, we met with ADRC accounting staff and asked regional offices to complete a brief cost survey.

We estimated the total cost of ADRC as

ADRC = Central Office + AAAs + CILs
= $5,328,854

We focused on the costs of options counseling. We excluded the costs of I&A and I&R. We did so to align the benefits part of SROI (in this case, solely the result of options counseling) with the costs part of SROI. The other programs — I&A, I&R, Care Transitions — are clearly of great value. But since we didn't calculate the benefits of those programs, it isn't analytically correct to include the costs of those programs ir SROI.

So, the total cost of ADRC options counseling in 2017 was:

ADRC OC = OC costs at Central Office[4] + AAA OC costs[5] + CIL OC costs[6]
= $377,531 + $3,054,312 + $141,573
= $3,573,416.

[4] Total cost of Central Office x 39% ADRC-related x 33% options counseling-related. Central Office costs include the costs of maintaining the resource database.
[5] From cost survey.
[6] From cost survey.

Results

In this section we focus on the numbers that make up ADRC's 11.1 to 1 SROI. You'll find:

- Key observations from our analysis.
- Why the SROI calculations are conservative.
- The big picture for the business case.
- Details of benefit results and calculations.
- Commentary on the benefits.

Key observations

ADRC's SROI of 11.1 to 1 is terrific. Economists call that productivity: one dollar spent produces more than eleven dollars of value. Venture capitalists call that a wonderful venture worthy of capital.

Benefits from options counselors alone pay for ADRC. We estimate total benefits of $39.8 million just from options counseling in 2017. The total cost of ADRC in 2017 was $5.3 million.

Benefits from the options counselors in our survey handily exceeded their costs. The options counselors who responded to our survey created benefits of $8.6 million[7] in 2017. The total cost of the options counseling program that year was $3.6 million.

Why the SROI calculations are conservative

We understand that SROI is unfamiliar to most people as a concept and as a calculation. As data skeptics and decision analysts ourselves, we want to ensure our numbers are as solid as possible. That means we take care not to "stretch" interpretations, not to make rosy assumptions, and so on.

Here's why we think the SROI calculations are conservative.

- We included only the five categories of benefits we could quantify.
- We excluded other benefits that we could not quantify with existing data. That's highly conservative since it's highly unlikely they have no benefit at all, as excluding them implies. We excluded:
  - Options counselors enrolling consumers in Care Transition programs.
  - Preventing non-financial abuse and neglect.
  - Identifying high-risk individuals and channeling them to appropriate programs.
  - Avoiding duplication of services.
  - Increasing efficiency in tracking and organizing information.

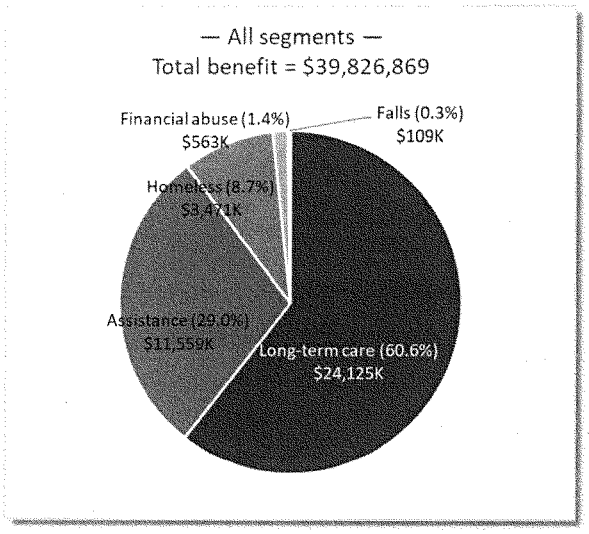
[7] The $8.6 million comes from benefits from the 51 options counselors who served the 971 consumers in our survey. (They served more than 971 consumers. They reported results on a subset of their caseload.) The difference between the $8.6 million from those OCs and the $39.8 million for ADRC options counseling overall is due to the scaling factor (see page 7) we used to adjust from our sample to the entire OC force and caseload.

- Helping people maintain or improve their health, independence, and quality of life.[8]
- Helping people obtain and maintain employment.

- Options counselors responded to the benefits survey based on their records and memories, which may not have included all consumers that they assisted.
- We used conservative estimates to translate outcomes to benefits:
  - We assumed the cost of home health care to be 75% of the cost of assisted living.[9]
  - We used $6.5K as the average value of financial abuse prevented, compared to published averages of $10K or more.

The big picture for the business case

We quantified key benefits of ADRC's options counseling for the entire state.[10]

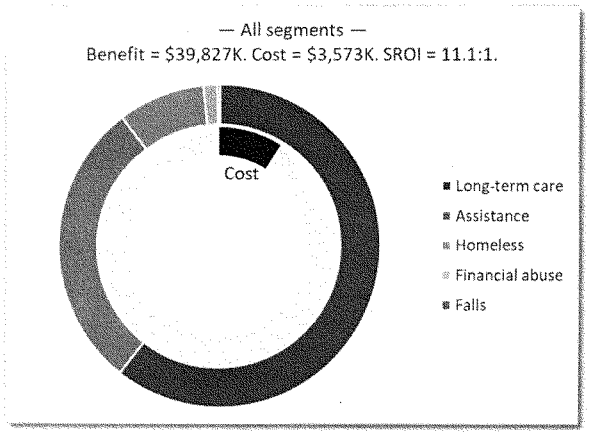


Source: Compelling Reason SROI model

Figure 2: State-wide benefits of ADRC options counseling

[8] See Quality Adjust Life Years (QALY) in footnote 2, page 6.
[9] According to Source 22 (Genworth 2015 Cost of Care Survey Oregon), the median annual rate for assisted living facilities in Oregon is $46,560 and the median annual rate for adult day health care is $23,010. Costs for home health care vary greatly but are likely to be between these two figures (>50% and <100% of the assisted living cost).
[10] Table 4, page 5, defines the benefits in the graph. "All segments" refers to the four segments listed on page 6.

We calculate ADRC's social return on investment (SROI) to be 11.1 to 1. In other words, ADRC's benefits are 11.1 times its costs.



Source: Compelling Reason SROI model

Figure 3: The SROI big picture

Note that the value of *each* of the three top benefits — long-term care, financial assistance, and preventing homelessness — exceeds the *total* cost of ADRC options counseling.

Details of benefit results and calculations

LONG-TERM CARE

Table 8: Benefits for long-term care

Assistance with long-term care and living decisions					
$24,125,329		ALL SEGMENTS: 2,886 of 4,506 consumers			
Benefit	**Savings per month ($)**	**Freq.**	**# Con.**	**Months**	**Benefit ($)**
Avoid nursing home (home)	5,970	14.5%	418	7.2	18,051,381
Avoid nursing home (institution)	4,953	2.8%	81	6.3	2,521,668
Avoid institution (home)	1,017	16.9%	488	7.2	3,552,279
No change	0	65.8%	1,899	#N/A	0
Total		100.0%	2,886		24,125,329

Source: Compelling Reason SROI model. Numbers in this table and others may not add perfectly due to rounding.

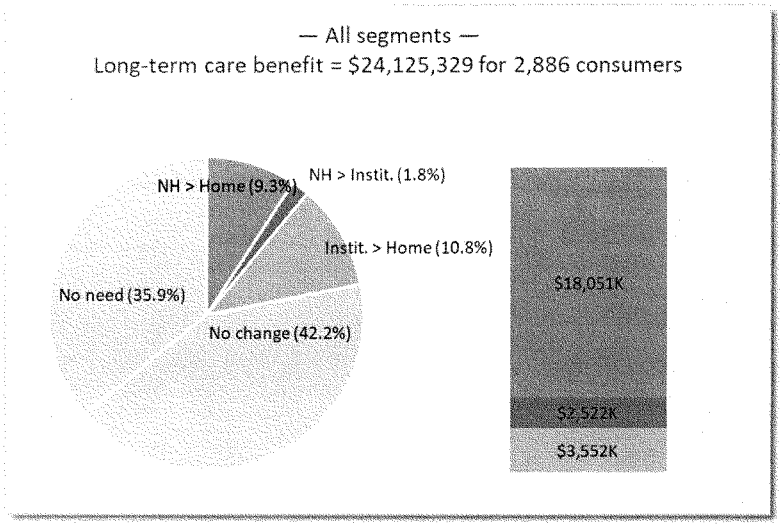
State-wide, options counselors helped 2,886 consumers with long-term care and living decisions. (The 2,886 is a weighted, scaled number. See Adjusting our data sample to reflect state-wide numbers.)

Of the 2,886 consumers:

- OCs helped 418 stay home rather than move to a nursing home. On average, that saved each consumer $5,970 per month for 7.2 months, for a total benefit of $18,051,381.
- OCs helped 81 move to a less-costly institution (e.g., assisted living or a foster home) rather than to a nursing home. That saved each consumer $4,953 for 6.3 months, totaling $2,521,668.
- OCs helped 488 stay home rather than move to an institution other than a nursing home. That saved each consumer $1,017 for 7.2 months, totaling $3,552,279.
- OCs did not lead to changes for the remaining 1,899 consumers.

The total benefit due to assistance with long-term care and living decisions
= $18,051,381 + $2,521,668 + $3,552,279
= $24,125,329.

The savings per month numbers came from Source 22.



Source: Compelling Reason SROI model

Figure 4: Long-term care details

ASSISTANCE WITH FINANCIAL AID, FOOD, HEALTH EQUIPMENT, ETC.

Table 9: Benefits for assistance with financial aid etc.

Assistance with financial aid, food, health, and transportation					
$11,558,919					
	Savings per	ALL SEGMENTS: 2,262 of 4,506 consumers			
Benefit	year ($)	Freq.	# Con.	Years	Benefit ($)
Financial aid	2,273	27.3%	617	1.2	1,636,879
Food aid	1,853	42.7%	965	2.1	3,726,032
Health-related	1,844	40.0%	904	2.2	3,611,274
Other (>$1,000/yr)	5,465	7.7%	174	2.2	2,064,269
Transportation	388	27.3%	618	2.2	520,465
Total					11,558,919

Source: Compelling Reason SROI model

State-wide, options counselors helped 2,262 consumers (weighted and scaled) with financial aid, food aid, health equipment and services, other items, and transportation. Some consumers received more than one kind of aid, so the "frequency" column totals more than 100%.

Of the 2,262 consumers:

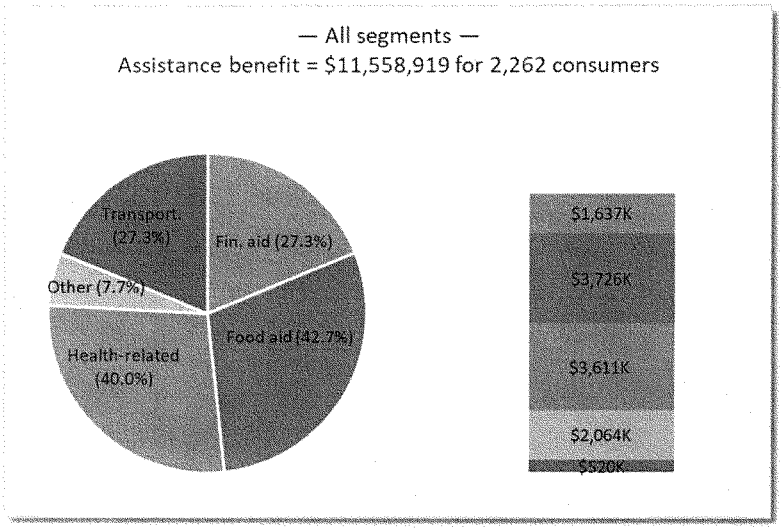
- OCs helped 617 with financial aid. On average, that saved each consumer $2,273 per year for 1.2 years, for a total benefit of $1,636,879.
- OCs helped 965 with food aid. That saved each consumer $1,853 per year for 2.1 years, totaling $3,726,032.
- OCs helped 904 obtain health equipment and services. That saved each consumer $1,844 for 2.2 years, totaling $3,611,274.
- OCs helped 174 with other items worth at least $1,000 per year. That averaged $5,465 per year for 2.2 years, totaling $2,064,269.
- OCs helped 618 with transportation. That saved each consumer $388 per year for 2.2 years, totaling $520,465.

The total benefit due to assistance with financial aid, food aid, etc.

= $1,636,879 + $3,726,032 + $3,611,274 + $2,064,269 + $520,465

= $11,558,919.

The savings per month numbers came from the OC survey. Question 5B of the survey asked for the OC's estimate of the average approximate value of assistance per year in each assistance category. The average number of years of assistance for each category came from Source 13.



Source: Compelling Reason SROI model

Figure 5: Assistance details

PREVENTING HOMELESSNESS

Table 10: Benefits for preventing homelessness

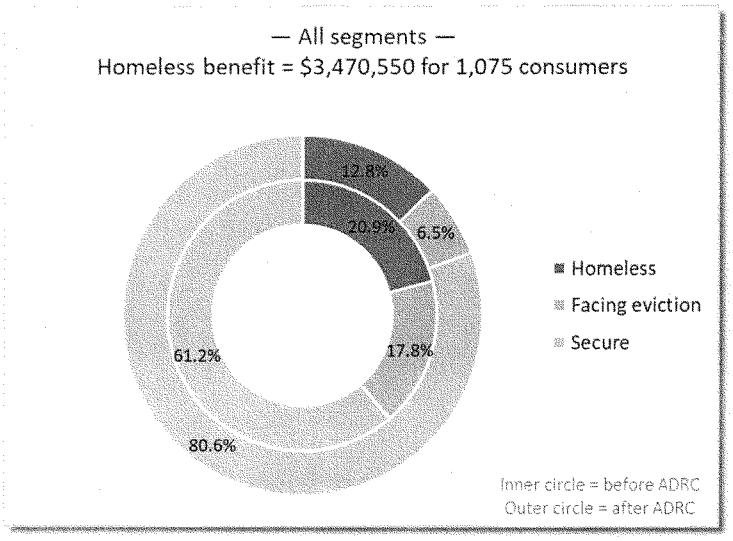
Preventing homelessness					
$3,470,550					
	Savings per	ALL SEGMENTS: 1,075 of 4,506 consumers			
Benefit	month ($)	Freq.	# Con.	Months	Benefit ($)
Continued homelessness		20.9%	225		
Facing eviction		17.8%	192		
Housing insecurity without ADRC		38.8%	417		
Continued homelessness		12.8%	138		
Facing eviction		6.5%	70		
Housing insecurity with ADRC		19.4%	208		
Improvement in housing security	3,700	19.4%	208	4.5	3,470,550

Source: Compelling Reason SROI model

State-wide, options counselors helped 1,075 consumers (weighted and scaled) with inquiries about housing options.

- Before talking with OCs, 417 of the 1,075 consumers faced housing insecurity. Of the 417, 225 faced continued homelessness and 192 faced eviction.
- After assistance from OCs, 208 of the 1,075 consumers faced housing insecurity. Of the 208, 138 faced continued homelessness and 70 faced eviction.
- Assistance from OCs reduced housing insecurity by 50%, from 417 to 208 consumers. On average, that saved $3,700 per month for 4.5 months, for a total benefit of $3,470,550.

The savings per month number came from Source 12. The average number of months of homelessness came from Source 32.



Source: Compelling Reason SROI model

Figure 6: Homelessness details

PREVENTING ABUSE AND NEGLECT

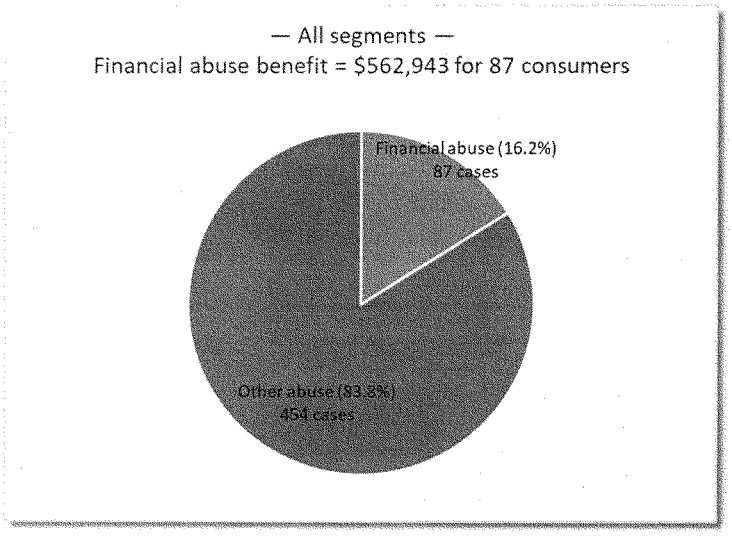
Table 11: Benefits of preventing financial abuse

Preventing abuse and neglect			
$562,943	ALL SEGMENTS: 87 of 4,506 consumers		
Benefit	**Save/con.**	**# Con.**	**Benefit ($)**
Financial abuse prevented	6,494	87	562,943
Other abuse		460	
Total			562,943

Source: Compelling Reason SROI model

State-wide:

- OCs helped 87 consumers prevent financial abuse. The OCs estimated an average savings per consumer of $6,494, for a total benefit of $562,943.
- OCs helped 460 consumers prevent other, non-monetary forms of abuse.



Source: Compelling Reason SROI model

Figure 7: Abuse details

PREVENTING FALLS

Table 12: Benefits of preventing falls

Preventing falls					
$109,128					
	Savings per	ALL SEGMENTS: 868 of 4,506 consumers			
Benefit	**event ($)**	**Freq.**	**# Con.**	**Falls**	**Benefit ($)**
Expected falls/person (comparison)		1.0	868	868	
Plan fall prevention without ADRC		14.4%	125	50	
Plan fall prevention with ADRC		48.9%	425	170	
Falls prevented	910			120	109,128

Source: Compelling Reason SROI model

State-wide, options counselors helped 300 of 868 consumers (weighted and scaled) to enroll in fall-prevention programs. Preventing falls means preventing trips to the emergency room.[11]

- OCs reported that 14.4% of the 868 consumers they assisted who had had falls, or 125, had planned to attend a fall-prevention program prior to contacting ADRC.
- OCs reported that 48.9% of those consumers, or 425, planned to attend a fall-prevention program after contacting ADRC.
- The benefit of avoiding a fall-related trip to the ER is, on average, $910.[12]
- Based on the 60% success rate of classes at preventing falls, 40% of the 125 (50) and 40% of the 425 (170) would fall and require a trip to the ER. The difference — 170 minus 50, or 120 — represents falls prevented by OC advice.

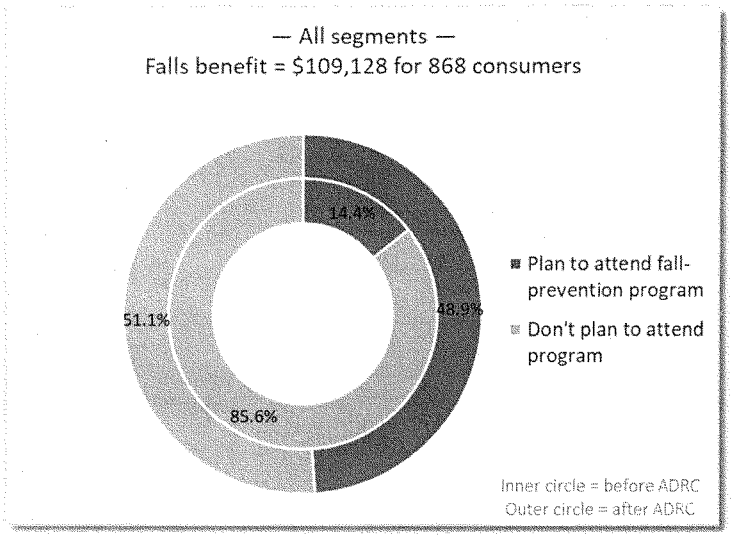
The total benefit due to recommending fall-prevention programs

= 910 x (170 – 50)

= $109,128

[11] Preventing falls also means preventing pain and suffering. We did not quantify the benefit of less pain and suffering. Analysis using QALY, quality-adjusted life years, might be possible in a future study.

[12] Fall-prevention programs have a net benefit of $364 per *person*, taking into account the savings from hospital admissions and other medical expenses, minus the cost of the program itself. The programs have a 60% success rate at preventing falls, so 40% of people who take fall-prevention programs will fall anyway. The benefit per *fall* is, then, $364 ÷ 40%, or $910. See Sources 8, 9, and 34.



Source: Compelling Reason SROI model

Figure 8: Fall-prevention details

Recommendations

ADRC has expressed a desire to update the SROI analysis and business case periodically. We recommend that ADRC continue to use the same benefit categories and metrics to maintain consistency and track improvements.

We offer three suggestions to improve the quality of data and to streamline data collection in ongoing ADRC analysis. We also offer three suggestions to enhance the value produced by ADRC.

Ongoing ADRC analysis

#1: ADD THESE QUESTIONS TO THE RTZ TRACKING SYSTEM[13]

- Did this consumer **delay entering a nursing home** and live at home or another institution after receiving your guidance? If so, where will the consumer live, and how many months of delay?
- Did you assist this consumer to **avoid eviction or homelessness**?
- Did this consumer plan to attend a **fall prevention program** (e.g., Tai Chi, Matter of Balance, Otago) after receiving your guidance?
- Was this consumer likely to receive **financial aid, food, health equipment or services, transportation, or other items of value** after receiving your guidance? If so, what type of assistance were they likely to receive, for how long, and for what approximate value?
- Did you help prevent **abuse or neglect issues** for this consumer? If there was risk of financial abuse, about how much was at risk?

#2: EXPAND THE CONSUMER SATISFACTION SURVEY WITH THESE QUESTIONS

We thank Diana White, PhD, Senior Research Associate at the institute on Aging at Portland State University, for her work on the ADRC Customer Satisfaction survey and her recommendations to expand that survey.

Delay entering a nursing home

- New question: Q45A – Agreement/disagreement with this statement: *The services or information has helped me avoid moving to a nursing home.*
- If you agree with the previous statement, how long do you expect to avoid moving into a nursing home?

Avoid eviction or homelessness

- New Q4A (need) – *worries about eviction or homelessness*
- New Q42 (services received) – *help with housing to prevent eviction or homelessness*

[13] ADRC's software program for tracking options counselor and I & A/R activities as provided by RTZ Associates Inc.

Fall-prevention program

- New Q4A – *worries about falling*
- New following Q42 items – *Did you attend a program to prevent falls (e.g., Tai Chi, Matter of Balance, Otago) as a result of guidance from ADRC? How long/often do you (did you) attend?*
- New Q47A. Agreement/disagreement with this statement: *I believe I am less likely to fall*

Assistance received

- New Q4A - *help getting medical equipment or assistive devices*
- New questions for all assistance received: *What did you receive as a result of ADRC guidance and what was the approximate value? If it is a recurring item, how often and how long do you expect to receive assistance?*

Abuse and neglect

- New Q4A – *worries about abuse or neglect*
- New Q42 – *received services to address abuse or neglect*
- New: *If you received guidance to avoid financial abuse, what was the approximate value of abuse prevented?*

#3: IMPLEMENT A SYSTEM FOR PERIODIC UPDATES

Document all data sources needed for updates

- New RTZ questions
- New ADRC Customer Satisfaction survey questions
- ADRC cost survey
- Government and literature sources to convert outcomes to benefits

Collect and analyze the data periodically and consistently

- Need consistency to compare results over time

Quantify additional benefits

- Example: Life satisfaction's effect on QALY (quality adjusted life-years), which use a globally recognized concept to put a value on health, lack of stress, etc.

Use data to spread expertise

- Close the loop: involve options counselors in SROI results
- Differences from OC to OC suggest opportunities to share ideas

Enhancing ADRC value

#1: INCREASE MARKETING TO CREATE ADDITIONAL AWARENESS FOR ADRC

Use marketing communications to educate

- Increase the use of public service announcements for radio and television to inform consumers and caregivers of ADRC resources
- Utilize Internet search-engine optimization techniques to promote ADRC to consumers seeking support for aging- and disability-related situations

#2: ESTABLISH ADRC CONTRIBUTIONS TO SOCIAL DETERMINANTS OF HEALTH

Analyze cost reductions and health improvements facilitated by ADRC

- ADRC services such as the Care Transitions program reduce expenditures for high-cost medical care, especially emergency room visits and nursing-home utilization. Additional research could analyze these benefits.
- Additional research could also estimate the value of ADRC helping consumers to maintain healthy lifestyles and avoid other costly medical interventions. An analysis (not ours) of ADRC consumers found a 70% match with Oregon Medicaid enrollment, a clear indication that ADRC services provide value to the Medicaid program.
- Establishing ADRC's contributions to social determinants of health could lead to closer cooperation between ADRC and the Oregon Health Authority and with local healthcare providers.

#3: CONSIDER MEASURING THE CONTRIBUTIONS OF INFORMATION AND REFERRALS

Measuring benefits beyond options counseling

- In 2017, *over 37,000* referrals were made in the five benefit categories, so Information and Assistance/Referrals contributions are significant. We did not include those benefits in this study because they existed prior to the introduction of the ADRC program and thus were not unique to ADRC.
- In the future, follow-up analysis could measure this value. Given the impressive SROI for ADRC established through options counseling, however, one wonders whether counting the additional benefits of I & A/R would be useful.

Resources

ADRC management

Kristi Murphy	Communications and management oversight
Dawn Rustrum	Project coordination
Lacey Hanson	RTZ data analysis

ADRC Steering Committee

Angie Albee	Aging and People with Disabilities Legislative Coordinator, Advocacy /Political Perspective
Jon Bartholomew	ADRC Advisory Council and Advocacy Political Perspective
Mary Jo Carpenter	Community Connection of Northeast Oregon
Tanya Dehart	NorthWest Senior and Disability Services
Shelly Emery	State Independent Living Council
Lee Girard	Multnomah County
Shannon Hunter	Aging and People with Disabilities Field ADRC Operations Manager
Mike Marchant	Aging and People with Disabilities Field District Manager
Elizabeth O'Neil	Aging, Disability & Veterans Services Division, Multnomah County
Jordan Purdy	Aging and People with Disabilities Data – Office of Business Intelligence
Greg Sublett	Abilitree
Kati Tilton	Clackamas Country
Kirt Toombs	Eastern Oregon Center for Independent Living
Tina Treasure	Disability Consumer rep

Compelling Reason, LLC

The Compelling Reason team designed and conducted the business-case analysis.

KELLY T. JENSEN, MANAGING CONSULTANT WITH COMPELLING REASON

Kelly is a business leader and management consultant with over 25 years' experience introducing new technologies and management practices at public and private companies of all sizes, government agencies, and not-for-profit organizations. His industry background includes healthcare (providers, suppliers, payers), application software, high tech, government (federal, state, local), and athletic equipment & apparel.

In work related to the ADRC Business Case, Kelly helped launch software applications and consulting services for hospital market analysis at Baxter Healthcare. This data-intensive effort required the identification and integration of multiple sources of healthcare demographics and utilization. The resulting software models assisted healthcare providers in optimizing the allocation of scarce resources to maximum community benefit.

hrough his work with healthcare providers, the Oregon Department of Human Services, and the Oregon lealth Authority, Kelly is familiar with data sources used for CCO Incentive Metrics, Medicare quality neasures, and other performance assessment approaches related to the ADRC business case.

elly is past president of the Harvard Business School Association of Oregon and a founding member of its ommunity Partners program that introduced the concept of Social Return on Investment to the Oregon onprofit community. He is currently board chair of The FACES Foundation whose surgical teams repair acial abnormalities for impoverished children in Peru. He also serves on the Program Committee of the)regon Health Forum that brings together government, community, and business leaders to examine the nost pressing issues in healthcare.

elly earned his MBA and AB degrees at Harvard, and was an adjunct faculty member for the Illinois Insti-ute of Technology in Chicago.

BRUCE HAMILTON, PE, PMP, SENIOR CONSULTANT WITH COMPELLING REASON

ruce Hamilton is also a co-founder and Partner of Benefitics, LLC, which provides objective, impartial, nd cost-effective evaluations of the social return on investment (SROI) of nonprofit organizations. He has ed or contributed to SROI projects for a range of Oregon-based nonprofits since 2009.

ruce has more than 30 years of experience in leadership positions in the energy industry where he has emonstrated success in policy analysis, strategic planning, operations, asset management, and project nanagement associated with power generation projects, particularly wind power. Bruce has led strategic tudies for power generation equipment manufacturers, electric utilities, developers, owner/operators, nvestors, trade associations, and governments. He served as the Principal Investigator for three major ffshore wind studies for the U.S. Department of Energy and NYSERDA. He has provided expert witness estimony for investor-owned electric utilities, wind turbine manufacturers, and wind developers. As a esult of this experience, Bruce understands the multiplicity of variables to be considered in calculating eturns on investment for complex initiatives.

ruce has previous experience as VP-Independent Power Operations of LG&E Energy (a Fortune 500 com-any) as well as with major energy participants GE, Exxon, and Iberdrola. Bruce is past president of the larvard Business School Association of Oregon, which conducts pro bono SROI projects as part of its ommunity Partners program. He holds Professional Engineer and Project Management Professional li-enses, a BS in chemical engineering from the University of California at Berkeley, and an MBA from the larvard Graduate School of Business Administration.

MARK CHUSSIL, SENIOR CONSULTANT WITH COMPELLING REASON

Mark Chussil is also Founder of Advanced Competitive Strategies, Inc. He's consulted for four decades vith *Fortune 500* companies on six continents about competitive strategy and quantitative decision-

making. He's a pioneer in business war-gaming and strategy simulation, helping add billions to companies' bottom lines, and he's taught thousands of executives and students to think more strategically.

Mark is also an Adjunct Instructor in the Pamplin School of Business at the University of Portland. He's lectured in executive education at The Wharton School, presented seminars for the Harvard Business School and the Indian School of Business, and led workshops on strategic thinking and decision-making at conferences, companies, and graduate schools.

Along with Bruce Hamilton, Mark co-founded Benefitics, LLC, focusing on social return on investment.

Mark has written two books and chapters for five others. His numerous articles and case studies have appeared in the *Harvard Business Review* online, *Sloan Management Review*, *The Journal of Business Strategy*, *The PIMS Principles* (Buzzell and Gale), *Wharton on Dynamic Competitive Strategy* (Day and Reibstein), and elsewhere. He's been quoted in *Fast Company*, *The New York Times, The Wall Street Journal*, and more. He has a patent in simulation technology.

Mark served for seven years on the Board of Directors of Friends of the Children and chairs the Community Partners pro bono consulting program for the Harvard Business School Association of Oregon. He holds an MBA from Harvard and a BA from Yale.

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51	The National Association of States United for Aging and Disabilities (NASUAD)	Colorado senior services data study	SEP 2016
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53	Treasure, Tina, State Independent Living Council	Aging and Independent Living Networks	MAR 2013
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#	Source	Title	Date
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67	ADRC Central Office Cost	2/21/18
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#	Title	Date
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73	Caseload count by Options Counselor.xlsx	1/29/18
74	Client Custom Export Report Mapping.xlsx	11/27/17
75	Final Oregon ADRC April 2013 – September 2013	10/31/13
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77	Final Oregon ADSSP October 2012 – March 2013	4/25/13
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81	Health Promotion for Older Adults and People with Disabilities (2015-2017)	SEP 2017
82	Map of Oregon Centers for Independent Living	JUN 2107
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86	Oregon ADRC State Plan (2011)	JUN 2011
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Technical Appendix

SROI thresholds

Social Return on Investment (SROI) analysis tells us whether a program adds value relative to its cost.

Table 13: Making decisions with SROI thresholds

Not worth it	The further SROI falls below 1.0, the more the program adds cost that doesn't produce offsetting benefit. Daily street-sweeping would make for good-looking streets but at very high cost in equipment, inconvenience, fuel, etc.
Uncertain	The closer SROI is to 1.0, the less sure you are whether to continue the program. To make a solid decision when SROI falls near 1.0: Refine the analysis by including additional costs or benefits, or consider criteria other than costs and benefits.
Worth it	The further SROI rises above 1.0, the more-enthusiastic decision-makers should be about the program. Examples of (presumably) high SROIs include vaccination, free public schools, and traffic lights.
Just do it	If benefits are positive, and if costs are zero or negative, then SROI is meaningless but the program is a just-do-it good idea. Example: technology that improves results and reduces costs, such as smartphone navigation versus stand-alone devices.[14]

TIMING

Benefits may quickly follow costs. Sometimes, though, benefits take years or even decades to arrive.[15] We've encountered that issue in SROI analyses for programs, for example, focused on at-risk children. Some ADRC benefits may continue to accrue for years after the costs were incurred.

OBJECTIVITY

Outcomes such as happiness and life satisfaction aren't objective but they are easy to measure with surveys. They even have hard-to-measure ripple effects, such as spreading the word that Oregon is a great place to live and thus boosting the state's growth. We've encountered similar issues in previous analyses. How to deal with those issues depends mostly on whether an SROI falls into the "uncertain" category in Table 13. If "uncertain", analyze further. If "worth it" or "just do it", further analysis may refine the SROI number but it will not change the recommendation.

---

[14] SROI calculations don't work in the "just do it" scenario because they divide by zero or generate a negative SROI.
[15] Think about switching the USA to the metric system, which was begun in 1975 and abandoned in 1982. There are clear long-term benefits, but even clearer short-term costs. By contrast, fixing the Y2K bug, had clear short-term benefits. Only two other countries have not adopted, or begun to switch, to metric: Myanmar and Liberia.

Narratives and details

These narratives present our calculations step by step in words and numbers.

We show them in descending order of total benefit.

Narrative 1: Long-term care and living decisions

BENEFIT CATEGORY: ASSISTANCE WITH LONG-TERM CARE AND LIVING DECISIONS		
STEP 1: DETERMINE OUTCOMES FOR ADRC CONSUMERS		
Out of a weighted sample of 971 consumers, OCs assisted 622 consumers on this subject. 622 consumers x 4.641 scaling factor = 2,886 consumers assisted statewide. Outcome A: 14.5% delayed entry to a nursing home by staying at home 7.2 months longer. Outcome B: 2.8% delayed entry to a nursing home by staying in an institution 6.3 months longer. Outcome C: 16.9% delayed entry to another institution by staying at home 7.2 months longer.		
STEP 2: DETERMINE BENEFITS FOR VARIOUS OUTCOMES		
OUTCOME A	OUTCOME B	OUTCOME C
Cost of nursing home = $9,023/month Cost of home health care = 75% of other institution = $3,053/month Difference = $5,970/month	Cost of nursing home = $9,023/month Cost of other institution = $4,070/month Difference = $4,953/month	Cost of other institution = $4,070/month Cost of home health care = 75% of other institution = $3,053/month Difference = $1,017/month
2,886 consumers x 14.5% x $5,970/month x 7.2 months = $18,051K	2,886 consumers x 2.8% x $4,953/month x 6.3 months = $2,522K	2,886 consumers x 16.9% x $1,017/month x 7.2 months = $3,552K
STEP 3: DETERMINE TOTAL BENEFIT		
Total benefit to all ADRC consumers = $18,051K + $2,522K + $3,552K = $24,125K		

Source: Compelling Reason SROI model

Narrative 2: Assistance with financial aid, food, health, and transportation

BENEFIT CATEGORY: ASSISTANCE WITH FINANCIAL AID, FOOD, HEALTH, AND TRANSPORTATION				
STEP 1: DETERMINE OUTCOMES FOR ADRC CONSUMERS				
Out of a weighted sample of 971 consumers, OCs assisted 487 consumers on this subject.				
487 consumers x 4.641 scaling factor = 2,262 consumers assisted statewide.				
Assistance	% Assisted	Avg. increm. value/year	Months assisted	Years assisted
Financial aid	27.3%	$2,273	1.2	0.10
Food aid	42.7%	$1,853	2.1	0.17
Health-related	40.0%	$1,844	2.2	0.18
Other (>$1,000/yr)	7.7%	$5,465	2.2	0.18
Transportation	27.3%	$388	2.2	0.18
STEP 2: DETERMINE BENEFITS FOR VARIOUS OUTCOMES				
BENEFITS THAT CONSUMERS RECEIVED DUE TO ADRC ASSISTANCE				
Financial aid	= 2,262 x 27.3% x $2,273 x 0.10	= $1,637K		
Food aid	= 2,262 x 42.7% x $1,853 x 0.17	= $3,726K		
Health-related	= 2,262 x 40.0% x $1,844 x 0.18	= $3,611K		
Other (>$1,000/yr)	= 2,262 x 7.7% x $5,465 x 0.18	= $2,064K		
Transportation	= 2,262 x 27.3% x $388 x 0.18	= $520K		
STEP 3: DETERMINE TOTAL BENEFIT				
Total benefit to all ADRC consumers = $1,637K + $3,726K + $3,611K + $2,064K + $520K = $11,559K				

Source: Compelling Reason SROI model

Narrative 3: Preventing homelessness

BENEFIT CATEGORY: PREVENTING HOMELESSNESS		
STEP 1: DETERMINE OUTCOMES FOR ADRC CONSUMERS		
Out of a weighted sample of 971 consumers, OCs assisted 232 consumers on this subject.		
232 consumers x 4.641 scaling factor = 1,075 consumers assisted statewide.		
	Before ADRC	After ADRC
A: Continued homelessness	20.9%	12.8%
B: Facing eviction	17.8%	6.5%
C: Other	61.2%	80.6%
STEP 2: DETERMINE BENEFITS FOR VARIOUS OUTCOMES		
MOVING FROM OUTCOMES A OR B TO OUTCOME C		
Number of consumers avoiding homelessness = 1,075 x (80.6% - 61.2%) = 208 consumers		
Cost of homelessness = $3,700/month		
Average months of homelessness = 4.5 months		
STEP 3: DETERMINE TOTAL BENEFIT		
Total benefit to all ADRC consumers = 1,075 consumers x $3,700/month x 4.5 months = $3,471K		

Source: Compelling Reason SROI model

Narrative 4: Preventing abuse and neglect

BENEFIT CATEGORY: PREVENTING ABUSE AND NEGLECT		
STEP 1: DETERMINE OUTCOMES FOR ADRC CONSUMERS		
Out of a weighted sample of 971 consumers, OCs assisted 19 consumers on this subject.		
19 consumers x 4.641 scaling factor = 87 consumers assisted statewide.		
	# Consumers	Avg. $ abuse
Financial abuse	87	$6,494
Other abuse	460	n/a
STEP 2: DETERMINE BENEFITS FOR VARIOUS OUTCOMES		
FINANCIAL ABUSE PREVENTED		
Number of financial abuse cases prevented = 87		
Average value of abuse prevented = $6,494 per consumer		
STEP 3: DETERMINE TOTAL BENEFIT		
Total benefit to all ADRC consumers = 87 consumers x $6,494 per consumer = $563K		

Source: Compelling Reason SROI model

Narrative 5: Preventing falls

BENEFIT CATEGORY: PREVENTING FALLS		
STEP 1: DETERMINE OUTCOMES FOR ADRC CONSUMERS		
Out of a weighted sample of 971 consumers, OCs assisted 187 consumers on this subject.		
187 consumers x 4.641 scaling factor = 868 consumers assisted statewide.		
	Before ADRC	After ADRC
% planning to attend class	14.4%	48.9%
STEP 2: DETERMINE BENEFITS FOR VARIOUS OUTCOMES		
ATTENDING CLASSES TO REDUCE FALLS AND ER VISITS		
Incremental consumers planning to attend = 868 x (48.9% - 14.4%) = 300		
Percentage decrease in ER visits from fall-prevention classes = 40.0%		
Savings per ER visit prevented = $910		
Comparison-group ER visits per year = 1.0		
STEP 3: DETERMINE TOTAL BENEFIT		
Total benefit to all ADRC consumers = 300 x 40.0% x $910 x 1.0 = $109K		

Source: Compelling Reason SROI model

The SROI model

The figures, the narratives, and the tables with numbers come from the Compelling Reason SROI model. Built using Microsoft Excel and the VBA programming language, the model comprises:

- Over 18,000 cells containing formulas, numbers, or words.
- 16 pages that range from data entry to intermediate calculations to graphs and analysis.
- Over 4,000 lines (about 70 pages) of computer code.

Sensitivity analysis

Any SROI analysis involves uncertainty in its data. None of the data in the model can be known with absolute precision, not even at a single point in time.

The purpose of the SROI analysis, though, is not to measure with precision; it is to determine whether the business case can be made for ADRC. It doesn't *matter* whether SROI is 11.1 to 1 or 12.03 to 1 or 8.27423 to 1. Any value materially above 1.0 to 1 — see SROI thresholds — makes the business case.

We believe our analysis is conservative. Here's what would have to happen for ADRC's business case to go down toward breakeven, even beyond that conservative analysis:

- *Multiple* numbers from *multiple* sources would have to be overestimated by an order of magnitude.
- Few or no other numbers, from *any* source, could be underestimated.

In other words, for ADRC's business case to go down toward breakeven, a lot would have to go wrong... and all of the going-wrong would have to be in one direction.

We can test the business case: what if data did go wrong?

The SROI model's sensitivity analysis deliberately varies some data, within a range of reasonable uncertainty, to see whether ADRC's SROI changes enough to challenge its business case.

Our base-case assumption says that home health care costs 75% of what institutions (other than nursing homes) cost. (See footnote 9 on page 11.) We think that's conservative. But what if we're seriously wrong? What if home health care is just as expensive as health care in other institutions?

Of course, changing that (or any other) number will change ADRC's SROI. The question is whether changing that number will change ADRC's SROI *enough* to challenge our conclusion that ADRC's SROI makes the business case.

SCENARIO 1: BASE CASE

This is the scenario we used throughout the report. In it, the cost of one month of health care is:

- $9,023 in a nursing home.
- $4,070 in another institution.
- $3,053 at home (75% of the $4,070).

In that scenario, we get an SROI of 11.1 to 1.

Table 14: Base-case sensitivity scenario

Segment to analyze:	All segments		
Benefit	Source	Social Return on Investment	
$24,125,329	Assistance with long-term care and living decisions	$39,826,869	Total benefit
$11,558,919	Assistance with financial aid, food, health, and transportation	$3,573,416	Total cost
$3,470,550	Preventing homelessness	11.1 to 1	**SROI = Benefit ÷ Cost**
$562,943	Preventing abuse and neglect		
$109,128	Preventing falls		

SCENARIO 2: SENSITIVITY TO HIGHER HOME HEALTH-CARE COSTS

In this scenario, we changed the $3,053 home health-care costs to $4,070. In other words, we made a month of health care at home equally expensive to a month of health care in an institution other than a nursing home.

In that scenario, we get an SROI of 9.3 to 1.

Table 15: High home health-care costs

Segment to analyze:	All segments		
Benefit	Source	Social Return on Investment	
$17,497,965	Assistance with long-term care and living decisions	$33,199,505	Total benefit
$11,558,919	Assistance with financial aid, food, health, and transportation	$3,573,416	Total cost
$3,470,550	Preventing homelessness	9.3 to 1	**SROI = Benefit ÷ Cost**
$562,943	Preventing abuse and neglect		
$109,128	Preventing falls		

Of course, SROI changes, and of course it goes down, but it goes down only to 9.3 to 1. An SROI of 9.3 to 1 is still excellent — benefits over $9 for every $1 spent — so we conclude the business case is strong.

[Questions submitted for the record and their responses follow:]

COMMITTEE ON EDUCATION
AND LABOR
U.S. HOUSE OF REPRESENTATIVES
2176 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100

May 30, 2019

Ms. Stephanie Archer-Smith
Executive Director
Meals on Wheels of Central Maryland, Inc.
515 South Haven Street
Baltimore, MD 21224

Dear Ms. Archer-Smith:

I would like to thank you for testifying at the May 15, 2019, Committee on Education and Labor Subcommittee on Civil Rights and Human Services hearing entitled "*Examining the Older Americans Act: Promoting Independence and Dignity for Older Americans*" in Washington, D.C.

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later than Friday, June 14, 2019, for inclusion in the official hearing record. Your responses should be sent to Ali Hard of the Committee staff. She can be contacted at the main number 202-225-3725 should you have any questions.

We appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Committee on Education and Labor
Civil Rights and Human Services Subcommittee Hearing
"Examining the Older Americans Act: Promoting Independence and Dignity for Older Americans"
Wednesday, May 15, 2019 at 10:15 a.m.

Chairwoman Suzanne Bonamici (OR)

1. You mentioned the need for flexibility in funding and recommended a greater ability to transfer funds between congregate and home-delivered nutrition programs. Will you please elaborate on what that flexibility would mean and how agencies might use the authority to transfer funds?

COMMITTEE ON EDUCATION
AND LABOR
U.S. HOUSE OF REPRESENTATIVES
2176 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100

May 30, 2019

Ms. Patricia Ducayet, LMSW
Texas State Long-Term Care Ombudsman
Texas Health and Human Services
701 W. 51st Street, MC-W250
Austin, Texas 78751

Dear Ms. Ducayet:

I would like to thank you for testifying at the May 15, 2019, Committee on Education and Labor Subcommittee on Civil Rights and Human Services hearing entitled "*Examining the Older Americans Act: Promoting Independence and Dignity for Older Americans*" in Washington, D.C.

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later than Friday, June 14, 2019, for inclusion in the official hearing record. Your responses should be sent to Ali Hard of the Committee staff. She can be contacted at the main number 202-225-3725 should you have any questions.

We appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Committee on Education and Labor
Civil Rights and Human Services Subcommittee Hearing
"Examining the Older Americans Act: Promoting Independence and Dignity for Older Americans"
Wednesday, May 15, 2019 at 10:15 a.m.

Chairwoman Suzanne Bonamici (OR)

1. How do ombudsmen interact with family caregivers, and how are caregivers affected by placing a family member in a long-term care facility?

2. What changes are needed to the Older Americans Act to ensure that state long-term care ombudsman programs can serve those in long-term care facilities?

3. What effects, if any, has the opioid crisis had on people living in long-term care facilities?

4. What is the greatest challenge facing residents in long-term care facilities and the long-term care ombudsman program?

COMMITTEE ON EDUCATION
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WASHINGTON, DC 20515-6100

May 30, 2019

Ms. Lee Girard, MPA:HA
Director
Multnomah County Aging, Disability and Veterans Services
209 SW 4th Street
Portland, OR 97204

Dear Ms. Girard:

I would like to thank you for testifying at the May 15, 2019, Committee on Education and Labor Subcommittee on Civil Rights and Human Services hearing entitled "*Examining the Older Americans Act: Promoting Independence and Dignity for Older Americans*" in Washington, D.C.

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later than Friday, June 14, 2019, for inclusion in the official hearing record. Your responses should be sent to Ali Hard of the Committee staff. She can be contacted at the main number 202-225-3725 should you have any questions.

We appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Committee on Education and Labor
Civil Rights and Human Services Subcommittee Hearing
"Examining the Older Americans Act: Promoting Independence and Dignity for Older Americans"
Wednesday, May 15, 2019 at 10:15 a.m.

Chairwoman Suzanne Bonamici (OR)

1. We know that OAA funding is currently not enough to reach all older adults in need of services. Approximately what percentage of the older adults in your community are you currently reaching with your services, and how would you use additional resources to better fulfill the mission of your agency?

COMMITTEE ON EDUCATION
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May 30, 2019

Ms. C. Grace Whiting, J.D.
President and CEO
National Alliance for Caregiving
4720 Montgomery Lane, Suite 205
Bethesda, MD 20814

Dear Ms. Whiting:

I would like to thank you for testifying at the May 15, 2019, Committee on Education and Labor Subcommittee on Civil Rights and Human Services hearing entitled "*Examining the Older Americans Act: Promoting Independence and Dignity for Older Americans*" in Washington, D.C.

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later than Friday, June 14, 2019, for inclusion in the official hearing record. Your responses should be sent to Ali Hard of the Committee staff. She can be contacted at the main number 202-225-3725 should you have any questions.

We appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Committee on Education and Labor
Civil Rights and Human Services Subcommittee Hearing
"Examining the Older Americans Act: Promoting Independence and Dignity for Older Americans"
Wednesday, May 15, 2019 at 10:15 a.m.

Rep. Kim Schrier (WA)

1. Ms. Whiting, Washington State's Family Caregiving Support Program is a model program that, research shows, provides positive impacts for caregivers it supports. It uses a three-tiered model of increasing services to assist family caregivers. In each tier, family members are screened to determine if additional supports are needed. Studies on Washington State's model have found that caregivers remain part of the program for longer periods of time and are consistently engaged, even when caring for their family member becomes more time intensive.

    a. Would you talk more about what you mentioned in your testimony regarding who the National Family Caregiving Support Program and other OAA services help caregivers provide effective care for older adults with special health needs, like individuals with dementia?

    b. You mentioned also that a lot of these caregivers are part of the "sandwich generation." They are caring for both their children and their parents. What are the unique needs of these family members and how can OAA services provide support?

    c. I imagine family caregivers also help prevent increased healthcare costs and usage by ensuring their family members receive nutritious meals, routine care so there is less need for hospital and dental visits, and the assistance necessary to prevent placement in long-term care facilities. Are you aware of how much savings might come from decreased Medicaid and Medicare costs because of their dedication?

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Chairman Robert C. "Bobby" Scott
Committee on Education and Labor
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, DC 20515

June 14, 2019

Dear Chairman Scott,

Thank you for the opportunity to testify before the Committee on Education and Labor Subcommittee on Civil Rights and Human Services hearing entitled "*Examining the Older Americans Act: Promoting Independence and Dignity for Older Americans*" held on May 15, 2019. It was my honor to speak on behalf of older Americans whose voice often goes unheard.

Thank you also for the follow up question regarding congregate meals programs from Chairwoman Suzanne Bonamici (OR):

1. You mentioned the need for flexibility in funding and recommended a greater ability to transfer funds between congregate and home-delivered nutrition programs. Will you please elaborate on what that flexibility would mean and how agencies might use the authority to transfer funds?

Below is my response to the question:

Attendance at congregate meal programs can be affected by any number of outside forces including planned as well as unexpected building maintenance closures, and most notably inclement weather closures. As an example, in Maryland last winter there were several inclement weather closures resulting in meals not served and funds unspent. At the same time, there remained a waiting list for home delivered meals. While some counties are at times able to find additional funds to serve those on the waiting list, money is generally not able to shifted until late in the contract year as it often comes from other sources. This not only results in longer waits, but often creates a back log for new applications because we must finish the remaining federal fiscal year, and begin the next year with a census supported solely by the federal funds for that contract year.

In addition, if the other sources are from state funds, often they need to be spent quickly, often less than 30 days, to comply with the state fiscal year. This precludes using the funds for wait

list participants and generally results in funding to support program enhancements such as new thermal bags. While important, this does not get at the root problem of the 'underserved' population.

Therefore, increased flexibility and clarity for local programs about transferring funds between congregate and home-delivered meal programs would allow us to use funding where and when it is needed most to serve individuals/seniors in our community.

Again, it was my honor to testify on behalf of our aging network for this important work. Please do not hesitate to contact me should you have any additional questions or need further clarification.

Very Truly Yours,

Stephanie Archer-Smith, MS
Executive Director

Cc: Katie Jantzi, LCSW
Director, Government Affairs
Meals on Wheels America

Erika Kelly
Chief Membership and Advocacy Officer
Meals on Wheels America

June 11, 2019

Committee on Education and Labor
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, D.C. 20515-6100

Dear Chair Scott:

Thank you for the opportunity to testify before the Civil Rights and Human Services Subcommittee in the Older Americans Act reauthorization hearing, "Examining the Older Americans Act: Promoting Independence and Dignity for Older Americans." Below are responses to questions received on May 30, 2019, from Chair Bonamici of the Civil Rights and Human Services Subcommittee.

1.How do ombudsmen interact with family caregivers, and how are caregivers affected by placing a family member in a long-term care facility?

Federal law requires a nursing facility to inform a resident representative, who is most often a resident's family member, of a resident's rights, facility responsibilities, and the role of a long-term care ombudsman. Among the responsibilities of a nursing facility is a requirement to allow residents to have visitors and for family members and friends of residents to form a family council at the facility. States may or may not have similar requirements of an assisted living facility and other types of board and care facilities. Ombudsmen interact with family members and friends of residents by way of face-to-face encounters at a facility, phone calls, and emails and social media contacts. With permission from the resident, including when a person acts as a resident's representative through an advance directive, ombudsmen work with family caregivers to identify, investigate, and resolve problems about a resident's quality of life and quality of care.

Moving a family member into a long-term care facility is a painful decision that typically triggers feelings of guilt. Ombudsmen observe that family members experience grief in this setting, but few caregivers acknowledge their grief or seek help to process it. With a highly mobile society and fewer residents with family members who live nearby, fewer family councils are operating and many family caregivers must resolve concerns from long distance. It is imperative that the public understand that family members of long-term care facility residents <u>are</u> family caregivers who need supports like other caregivers of older Americans.

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2. What changes are needed to the Older Americans Act to ensure that state long-term care ombudsman programs can serve those in long-term care facilities?

The following changes are needed to ensure that our program can serve residents.

A. Update the reference year from 2000 to 2019 in sections 306(a)(9), 307(a)(9), and 703(a)(2)(C). This revision will ensure that state and federal funds for the Ombudsman Program continue to be dedicated to the protection of long-term care facility residents and that the future minimum allotment for states is based on the most recent budget year.
B. Amend section 702 to include a separate authorization of $20 million for ombudsmen to serve in assisted living facilities, and update the authorization for long-term care ombudsman services to $35 million.
C. Acknowledge the role and costs of volunteer ombudsmen by allowing program funds to reimburse costs of volunteer training, management, and facility visits.
D. Clarify that an ombudsman has access to a resident's records in situations where residents are transferred or discharged and no longer "residing" in the facility that discharged them. This is necessary to help a resident appeal a discharge and prepare a defense for the resident's fair hearing.

3. What effects, if any, has the opioid crisis had on people living in long-term care facilities?

There are two ways that the opioid crisis has created challenges for long-term care residents and facilities. First, is the effect on residents' access to opioids for pain management. When education for prescribers increased to address concerns about over-prescribing practices, many physicians stopped prescribing opioids. This had an immediate effect on some nursing facility operations, and led to some residents needing to travel to specialty pain clinics for opioid medications. This travel is a barrier for residents with certain medical conditions. Facility staff have, at times, labeled residents who are prescribed opioids as "drug seeking", which dehumanizes and distances residents from staff. Ombudsmen work to ensure that long-term care facility staff continue to provide good pain management.

Second, is the effect of adults with opioid addiction who move into long-term care facilities. Facility staff are not trained on the treatment of addiction, and long-term care facilities are generally not equipped to competently provide addiction treatment. At the same time, if the person has a medical condition that requires 24-hour nursing, the person may qualify for nursing facility services and may not be appropriate for in-patient addiction treatment. This has placed considerable strain on long-term care facility operations and is a problem that has not been considered or addressed by current policy and practice.

4. What is the greatest challenge facing residents in long-term care facilities and the long-term care ombudsman program?

Based on Ombudsman Program data and experience, involuntary discharge is the greatest challenge facing residents. Too often residents are "dumped" in a hospital or homeless shelter, and too rarely are facilities held accountable for their improper discharge planning or failure to respond with care interventions other than discharge. One root cause of this problem is insufficient direct care staffing. If facilities were adequately staffed, then caring for residents with complicated medical needs and responding to resident behaviors associated with dementia would be manageable and involuntary discharge would be avoidable.

The greatest challenge facing Ombudsman Programs is demand for our services in assisted living facilities and similar board and care settings. The program foes not receive adequate funding to routinely visit and respond to complaints in nursing facilities, and the boom of the assisted living facility industry has multiplied these challenges.

Again, thank you for opportunity to testify on this important subject for older Americans. Please contact me if you have any additional questions.

Sincerely,

Patty Ducayet

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Department of County Human Services
Aging, Disability & Veterans Services Division

June 21, 2019

Representative Scott, Chairman
Committee on Education and Labor
U.S. House of Representatives
2176 Rayburn House Office Building
Washington DC 20515-6100

Dear Representative Scott:

It was a privilege to testify before the Subcommittee on Civil Rights and Human Services on May 15, 2019, regarding the importance of the Older Americans Act in local communities. Following is my response to an additional question from Representative Bonamici, Chairwoman for the Subcommittee.

Question: We know that OAA funding is currently not enough to reach all older adults in need of services. Approximately what percentage of the older adults in your community are you currently reaching with your services, and how would you use additional resources to better fulfill the mission of your agency?

We estimate that we are providing services to approximately 15% to 18% of older adults in Multnomah County, Oregon. These services include transportation, in-home care , senior nutrition services, caregiver support and respite, and care planning and coordination. Our first priority for use of additional resources would address services that have been prioritized by older adults in our community, some of which also have wait lists for new applicants.

These include, in priority order:

1. Transportation services to assist people to get to medical appointments, shopping, pharmacy, and senior centers and meal programs (OAA Title III B);
2. In home care to provide housekeeping and personal care (bathing, dressing, etc.) to help people remain at home and avoid more restrictive and expense levels of care (OAA Title III B);

3. Culturally-specific congregate senior meals for culturally diverse communities to reduce hunger and food insecurity, promote socialization, and promote health and well-being (OAA Title III C1);
4. Home delivered meals for older adults in our community who are confined to their homes and at high risk both nutritionally and health-wise (OAA Title III C2); and
5. Development of new evidence-based services to address social isolation for older adults who are living alone (28% nationally), experiencing a dementia or other risk factors (OAA Title III B).

Thank you for the opportunity to share information regarding the needs of older adults in our community.

Sincerely,

Lee A Girard

Lee Girard, Director
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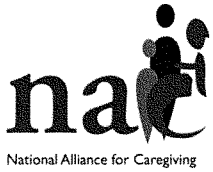

June 14, 2019

About the National Alliance for Caregiving

Established in 1996, the National Alliance for Caregiving is a non-profit coalition of national organizations focusing on advancing family caregiving through research, innovation, and advocacy. The Alliance conducts research, does policy analysis, develops national best-practice programs, and works to increase public awareness of family caregiving issues. Recognizing that family caregivers provide important societal and financial contributions toward maintaining the well-being of those they care for, the Alliance supports a network of more than 80 state and local caregiving coalitions and serves as Secretariat for the International Alliance of Carer Organizations (IACO).

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Chairman Robert C. "Bobby" Scott
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RE: Committee on Education and Labor Civil Rights and Human Services Subcommittee Hearing: *Examining the Older Americans Act: Promoting Independence and Dignity for Older Americans*

Dear Chairman Scott,

Thank you for this opportunity to provide additional insights into the needs of America's family caregivers. Our additional answers in response to Congresswoman Kim Schrier's written questions are below. Should you have any additional requests, please do not hesitate to reach out to me or to my advocacy team. Thank you.

1. Ms. Whiting, Washington State's Family Caregiving Support Program is a model program that, research shows, provides positive impacts for caregivers it supports. It uses a three-tiered model of increasing services to assist family caregivers. In each tier, family members are screened to determine if additional supports are needed. Studies on Washington State's model have found that caregivers remain part of the program for longer periods of time and are consistently engaged, even when caring for their family member becomes more time intensive.

a. Would you talk more about what you mentioned in your testimony regarding who the National Family Caregiving Support Program and other OAA services help caregivers provide effective care for older adults with special health needs, like individuals with dementia?

Caregivers can have a varied and broad range of needs, barriers and existing supports from which to draw upon. The National Family Caregiver Support Program can be a tool to help care providers learn how to tailor services for caregivers based on their individual strengths and challenges. The best way to determine what services caregivers would benefit from most would be to require providers in the Aging Network to conduct a needs assessment of caregivers to identify their specific needs and existing supports. This strategy is currently used under the Medicaid Home- and Community-Based Services Waiver program and has been an effective means of connecting families to the services they need.[1] The information gathered from the needs assessment can then be used to appropriately target support services and provide referrals to gain access to needed services.

These assessments do not only help caregivers access services, they can also be used to determine best-practices offered and performed via the OAA. It would be appropriate for the Assistant Secretary of HHS to identify best-practices related to the use of procedures and tools offered to caregivers, to monitor and evaluate the performance of programs carried out and determine other relevant issues pertinent to promoting best-practices. Then the Assistant Secretary can disseminate findings to inform the Aging Network of determined best-practices via the website of the Administration.

b. You mentioned also that a lot of these caregivers are part of the "sandwich generation." They are caring for both their children and their parents. What are the unique needs of these family members and how can OAA services provide support?

Caregivers who fall into the category commonly referred to as "sandwich caregivers" do face some unique challenges and have some unique needs. We see the challenges typically involve financial hardship and the ability to be present and available to those whom they are providing care. A significant portion of these caregivers are juggling work and caregiving responsibilities. With the lack of available and affordable long-term care supports and services caregivers are dedicating their financial resources to provide expensive and extensive care needs.

Caregivers are spending their time providing medical and nursing tasks, providing transportation to and from doctor's appointments, and providing the other basic functions related to caring for other members of the family. This often results with caregivers facing the decision to choose between career advancement and being there for those in need of care.

[1] K. Kelly, M. Gibson, and L. Feinberg. AARP Public Policy Institute. Listening to Family Caregivers: The Need to Include Family Caregiver Assessment in Medicaid HCBS Waiver Program (December 2013); available at https://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/the-need-to-include-family-caregiver-assessment-medicaid-hcbs-waiver-programs-report-AARP-ppi-ltc.pdf.

OAA support can address these challenges most directly by focusing on two specific actions:

- Engaging with the employer community to ensure that employers are aware of the challenges their caregiving employees are facing and raise awareness of the support that OAA programs can provide.
- OAA can enhance the provision of services that promote caregiver financial stability, such as programs like the National Resource Center for Women and Retirement and the provision of grants that promote health, independence and longevity for older adults, individuals with disabilities, individuals with serious illness and their caregivers.

c. I imagine family caregivers also help prevent increased healthcare costs and usage by ensuring their family members receive nutritious meals, routine care so there is less need for hospital and dental visits, and the assistance necessary to prevent placement in long-term care facilities. Are you aware of how much savings might come from decreased Medicaid and Medicare costs because of their dedication?

Yes, it is estimated that caregivers in total save our healthcare system nearly $470 billion[2]—the cost of what it would take to replace the care they provide were they not able to do so. Much more analysis is needed to determine not only the cost savings caregivers provide, but also how family caregivers can contribute to improved health outcomes across systems of care. While there is a body of research that indicates that caregivers, when properly supported with training, respite, and other evidence-based interventions, there is still a need for more consistent research.[3] Federal agencies can be part of the solution by making it easier to track data on the health of the person receiving care and the caregiver, too.

This type of analysis would likely require a modernizing of interagency coordination of those federal agencies which focus on improving healthy aging, age-friendly communities and population health. Interagency coordination should address the various components needed to support the ability of older individuals to age in place and access preventive healthcare, promote age-friendly communities, address the ability of older adults to access long-term care supports—including access to caregivers and home and community-based health services.

Factors other than cost savings should also be taken into consideration when collecting data on caregivers and the value they provide. Research is needed to better under how programs such as OAA can reduce social isolation among older adults and caregivers.

One way to tackle this need is to include an extension of the Recognize, Assist, Include, Support, and Enhance (RAISE) Family Caregivers Act in the current reauthorization efforts.

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[2] S. Reinhard, L. Feinberg, R. Choula, and A. Houser. AARP Public Policy Institute. Valuing the Invaluable: Undeniable Progress, but Big Gaps Remain (July 2015); available at: https://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf.

[3] See, e.g., J. Giffin, et al. Effectiveness of Caregiver Interventions on Patient Outcomes in Adults with Dementia or Alzheimer's Disease: A Systematic Review. *Gerontology & Geriatric Medicine* (Jan. – Dec. 2015); available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5129450/pdf/10.1177_2333721415595789.pdf.

The RAISE Act, which will sunset in 2021, will establish an Advisory Council to examine and better understand how caregivers can be supported through public and private partners across the country, and how government services can be more efficiently streamlined to meet the need. OAA should further prioritize, invest in, implement, and evaluate innovation and demonstration programs involving multigenerational engagement, including support for caregivers caring for individuals of any age and community-based partnerships designed to support families of those with serious conditions, advanced illness, or medical complexity.

Again, thank you for your time and consideration and please call on us should you need additional support in your work on behalf of America's families.

Kind regards,

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[Whereupon, at 11:49 p.m., the subcommittee was adjourned.]

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