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THE OLDER AMERICANS ACT: THE LOCAL IMPACT OF THE LAW AND THE UPCOMING REAUTHORIZATION

Thursday, May 23, 2024

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

The Committee met, pursuant to notice, at 9:30 a.m., Room 106, Dirksen Senate Office Building, Hon. Robert P. Casey, Jr., Chairman of the Committee, presiding.

Present: Senators Casey, Gillibrand, Blumenthal, Kelly, Fetterman, Braun, Rick Scott, Vance, and Ricketts.

OPENING STATEMENT OF SENATOR ROBERT P. CASEY, JR., CHAIRMAN

Chairman CASEY. Good morning. The Senate Special Committee on Aging will come to order. Welcome to today's hearing, which is entitled, ″The Older Americans Act: The Local Impact of the Law and the Upcoming Reauthorization.″ we call it around here—just like, everything has an acronym—OAA, that this act has on communities all across the country.

OAA was passed into law in 1965, to establish a network of social services to support older Americans, complementing Medicare and Medicaid. By all measures, the Older Americans Act has succeeded.

Since its passage, OAA has served as the foundation for community social services for older adults, providing nutrition services, legal support, and social networking, among other services. The Act has a tangible impact on local communities. Funding flows from the federal government to states and to communities to allow programs to be delivered in a way that works best for the locality.

This law supports countless older adults and nearly 20,000 service providers around the country, 20,000. In Pennsylvania, an estimated 27 percent of older adults served by OAA are under the federal poverty line. The Law's nutrition programs alone serve approximately 85,000 older Pennsylvanians.

Today, I am releasing a brochure, which I am holding up and you would not be able to see from the distance of your seats, but it is a brochure that highlights the impact of the Older Americans Act on Pennsylvanians. This brochure is entitled ″Federal Policy on a Local Level: The Impact of the Older Americans Act Across Pennsylvania,″ and it just has some examples of the individuals from different parts of our State and the services that are provided to

them. It provides information on those eight Pennsylvanians who are receiving services from Older Americans Act programs across nine different counties.

Over time, the OAA has evolved to meet the unique challenges that older adults face. In recent years, by way of work that I have done and others, Congress added language to expand support to grandparents raising grandchildren.

Flexibility, of course, is the key. The COVID–19 pandemic required programs to innovate service delivery. We should be learning from this innovation as we move forward.

This year, I am privileged once again to be the leader in negotiations to reauthorize the Older Americans Act. I am committed to building on my work in the last reauthorization to bolster support for older adults throughout Pennsylvania and throughout the Nation. I will be prioritizing both funding and programming that helps the Older Americans Act keep pace with our rapidly aging population.

Just to name a few of my priorities: I am working to pass the Strategic Plan for Aging Act along with Senator Gillibrand to incentivize states to bolster public-private partnerships and build communities that work for the older adults of today and for future generations.

In addition, I am dedicated to uplifting the tireless work of long-term care ombudsmen. As the Committee has shown throughout its history, some older adults experience tremendous hardship in nursing homes and assisted living facilities. Long-term care ombudsmen are advocates for residents in nursing homes and other long-term care facilities, dealing with everything from no-notice evictions and theft to serious neglect.

However, the program is stretched very thin, operating on a grossly inadequate budget, struggling to recruit and retain staff and volunteers. In some cases, one ombudsman may be serving 10,000 beds, well exceeding national recommendations of one to every 2,000 beds. Today, the GAO is releasing a report, which I requested, that shows the real impact these funding challenges have on residents.

We will hear today from Mairead Painter, the State Ombudsman from Connecticut, who can discuss these struggles in much more detail. We will also hear today from two Area Agency on Aging directors, including Leslie Grenfell representing Washington, Greene, and Fayette Counties in Southwestern Pennsylvania, who will discuss the very real challenges they face in delivering services to rural communities with limited funds. The Aging Services network deserves to be elevated and supported by the federal government.

I am especially looking forward to hearing today from Janet Billotte, a meal delivery recipient from Clearfield County, in central Pennsylvania. I am so grateful she is using her voice here today to share how OAA has helped her.

Finally, May is Older Americans Month, a time when our Nation comes together to honor the contributions of older Americans. I want to be clear. I will not support any attempts to undermine vital programs that support older adults in Pennsylvania and across the country. Our Nation's older adults have fought our wars,

raised our children and our grandchildren, they have built our communities, and they deserve support as they age.

I will now turn to Ranking Member Braun for his opening comments.

OPENING STATEMENT OF SENATOR MIKE BRAUN, RANKING MEMBER

Senator BRAUN. Thank you, Chairman Casey, and to all the witnesses who have come here today.

Under the current Administration, we have seen sky-high inflation, and probably 20 percent higher now than it was when the Administration came in. That is an invisible but yet very palpable tax that makes everything we are talking about here even more difficult.

All Americans are struggling, but perhaps no one more so than Older Americans, finding it harder and harder to stretch their dollars to afford even basic groceries.

The spending of borrowed money, almost anything we do new here, is 100 percent borrowed, and it is now averaging into what we already do, 30 cents on every dollar we spend is borrowed. It is a bad business plan for the younger Americans, who are going to have to shoulder that burden, and especially for older Americans, so we need to do something about that, Republicans and Democrats guilty of it.

This reckless spending is forcing more and more seniors to seek support to make ends meet, while simultaneously making the programs that are there for them even harder to be effective.

The Older Americans Act provides this support, including nutrition, transportation, health promotion, and many other things. We need to make sure they stay vital.

As a member of the working group leading the reauthorization of the Older Americans Act, I am committed to preserving flexibility for localities and states, because they generally do things with more effectiveness, and they make sure the bills get paid without borrowing the money.

Every community is different. Seniors are best served, I think, when providers on the ground can be entrepreneurial. You do not want a one size fits all. You do not want it being dictated from the top down. That does not work anywhere. I was an entrepreneur for 37 years, and I can tell you in the real world, in a business, that never works. You want choice, you want transparency, you want new ideas to accomplish the same old thing.

Every community is different, like I said. The Biden Administration, though, has put rules out there that want to try to make everyone adhere to the same guidelines. Some of the final rules are being looked at and litigated currently. All I can tell you is when it happens, it removes flexibility from local area agencies, adds administrative burden, more cost, changes the definition of greatest social need to prioritize certain social groups for OAA's nutrition programs. That just does not make sense to me.

I am working to push back against some of these things they want to do. This includes ensuring that any senior in need of a meal has a fair chance, regardless of which social group they belong to. That should not be a parameter. I am also working on new

proposals to empower AAAs and senior centers to serve older Americans without the need for additional funding. We have got to find a way to spend less than we take in and get more bang for our buck if this place is going to be around and be part of the solution.

We should allow states and local service providers to innovate to meet growing nutrition needs, encourage business acumen in the aging network, and invest in cost-effective, evidence-informed programs.

I would like to bring much needed transparency by requiring the Administration to summarize state ombudsman long-term care annual reports for Congress and publish a list of all resource centers that it funds. This will allow Congress to have better oversight over long-term care facilities and ensure that tax dollars are being stewarded effectively.

Finally, a recurring theme I hear when traveling throughout Indiana—I visit all 92 counties every year; they all are trying to find those best practices, that right mix—is the lack of broadband access in rural communities, and Indiana, for example, is a state that is putting a high priority on it, investing in state funds, not waiting for the Feds to do it, and we are now getting that into every nook and cranny. Other states need to be enabled in the same way. They ought to probably look to see how they do that themselves rather than the cumbersome way of maybe involving this place.

I hope that we can address this issue by doing more to connect existing resources to these communities.

I look forward to working with my colleagues and stakeholders to advance these priorities in the Older Americans Act.

I yield back.

Chairman CASEY. Thank you, Ranking Member Braun, and I want to thank the Ranking Member for his work on the reauthorization that we are working together on.

I will introduce our witnesses now. I will introduce each of our witnesses before their testimony. I will start with our first witness, Janet Billotte. Janet, thank you for being here. She is from West Decatur, in Clearfield County in the middle of our State, kind of the northcentral part of our State, and she receives meal deliveries and other services from her Area Agency on Aging. She will share how meaningful the meals and services she receives have been for her.

I want to thank you, Janet, for being here today and for making the trip from Clearfield County. It is not an easy ride.

I will turn to Ranking Member Braun to introduce our second witness.

Senator BRAUN. It is my pleasure to introduce Laura Holscher. She is the Executive Director and Assistant VP of Generations, which is an Indiana's Area 13 Agency on Aging, located in Vincennes, Indiana, very near where I live. In fact, we are rivals, I think, in a lot of sporting events and so forth, so it is that close.

She has served with Generations for almost 30 years, including the past 14 years as Executive Director. Under her supervision, her team has received the highest level of accreditation through the National Committee on Quality Assurance. Kudos to you for that. She has served as a Board President of the Indiana Association of

Area Agencies on Aging, and now serves as the Chairman of the Public Policy Committee.

Thank you for making the trip to D.C. to be here today.

Chairman CASEY. Thank you, Ranking Member Braun. Our third witness is Leslie Grenfell. Leslie is the Executive Director of the Southwestern Pennsylvania Area Agency on Aging, or AAA as we call them. She will share her experience as the AAA's Executive Director, the challenges they face, and the innovative ways that AAAs handled service delivery during the COVID–19 pandemic.

Ms. Grenfell, thank you for being here and thanks for your service to older Pennsylvanians and sharing your experiences with us today.

Our fourth and final witness, I will turn to my colleague from Connecticut, Senator Blumenthal, to introduce that witness.

Senator BLUMENTHAL. Thanks, Mr. Chairman, and thank you for having this hearing on this very important topic. I am very honored to introduce Mairead Painter, of Connecticut. She is Connecticut's Long-Term Care Ombudsman, and she has done really magnificent work in that job. I am very proud to be here with you.

Ms. Painter was appointed to this position of Connecticut Long-Term Care Ombudsman in 2018. She has had this position during some of the worst times in our long-term care facilities, during COVID. She promotes and protects the quality of life for older adults and individuals with disabilities across the State. She serves more than 30,000 Connecticut residents in skilled, long-term care nursing facilities, residential care homes, and assisted living and managed care residential communities. She also oversees the program's advocacy work and is committed to furthering person-centered care and informed choice for all individuals.

Recently, she received the Administration for Community Living's first Community Living Director Care Award, highlighting the work that she and her team have done in advocating and protecting the rights and well-being of individuals in long-term care facilities.

I want to thank Ms. Painter for all you have done to protect those 30,000 people in facilities across the State of Connecticut, and especially you making the trip down here to D.C. and sharing your thoughts on this very important topic with us. I know you have a lot of experience, a lot of insight, and we really welcome and express our thanks to you. Thank you.

Chairman CASEY. Thank you, Senator Blumenthal. We will turn to our first witness, Ms. Billotte.

STATEMENT OF JANET BILLOTTE, HOME-DELIVERED MEAL PARTICIPANT, WEST DECATUR, PENNSYLVANIA

Ms. BILLOTTE. Chairman Casey, Ranking Member Braun, and members of the Committee, thank you for having me here today at your Older Americans Act hearing. My name is Janet Billotte. I live at the Village of Hope. I am 78 years old, and I live in West Decatur, Pennsylvania, which is a rural town in Clearfield County. Before retiring, I worked as a nursing aide. I am here to share my experiences as a recipient of Meals on Wheels and other services from the Clearfield County Area Agency on Aging.

I have been receiving Meals on Wheels for four years. My husband Richard and I started receiving meals in August 2020, when he had five stents placed in his heart and two years later open-heart surgery, during the pandemic. I was very happy to receive these meals. Every time I received a meal, it always feels like I am getting a present each meal. I would like to invite you to have lunch with me today. The meal is kielbasa, mashed potatoes, sauerkraut, a fruit cup, brown bread, and it is a special day—we get strawberry shortcake.

Last year, I was diagnosed with Stage three colon cancer, and I was also caring for my husband Richard, who had been sick with many issues for a long time. I also just had an operation for my cancer and had chemotherapy three times every other week. Many days, I did not feel well, and it was very helpful to have these meals delivered to us.

I love talking to Fred. Fred is my meal delivery person. Every day he comes he asks me how I am. Lots of times I don't see anyone except Fred to see or talk to each day, so I am thankful when he checks in on me. If he doesn't hear from someone, he calls the Area Agency on Aging and asks to make sure we are okay. A lot of older people don't have family. I don't have family. I have a son, Clint, who is autistic, a daughter, Sarah, who passed away, and my husband recently passed away. Now the Area Agency on Aging has become my family.

Today, my cancer is in remission. I am still receiving deliveries from Meals on Wheels and other services from the Area Agency on Aging. I am very glad that they give us vouchers through the Senior Farmers Market Nutrition Program run by the Agriculture Department so that we can go to the farmer's market, and I can get fresh produce. I can get tomatoes, lettuce, and all kinds of fresh foods from the market. It is good nutrition, and it is helpful in preventing cancer.

During bad weather, they also receive ″blizzard boxes″, where they send us a box of frozen and shelf-stable food so we have something to eat when we are stuck in bad weather to prepare. I am thankful for these services, and I'm not sure what I would do without them.

Beyond meal deliveries, I also participated in events at the senior center. They took us on a field trip to a mushroom farm, where we learned about all the different types of mushrooms and how to prepare them, how bees pollinate herbs, and we went to a flower garden. I love flower gardens and gardens.

The Area Agency on Aging also helped coordinate transportation for me when I had to go to the clinic to get chemotherapy. I had to get chemotherapy and blood work every week, and this was not good, because I live in a rural area, it was very hard to find transportation to the clinic, but Adam was very kind to help drive me to my doctor's appointment and to chemotherapy.

I was very grateful to receive these services, and grateful for the friendship I have with my Area Agency on Aging. Kathy Gillespie, who is with the Area Agency on Aging, is like family to me. I know many older adults receive Meals on Wheels are thankful like I am. I also understand that there are many more older adults on the

waiting list for these services. I ask you to please help more people get into the program and be able to receive these great services.

Thank you again for the opportunity to share my story.

Chairman CASEY. Ms. Billotte, thanks so much for your testimony and for sharing your own personal experience. We are grateful.

Ms. Holscher, you may begin.

STATEMENT OF LAURA HOLSCHER, EXECUTIVE DIRECTOR/ASSISTANT VICE PRESIDENT, GENERATIONS, AREA 13 AGENCY ON AGING, VINCENNES, INDIANA

Ms. HOLSCHER. Senator Braun, Chairman Casey, and members of the Senate Special Committee on Aging, I am Laura Holscher. For 30 years it has been my honor to serve older adults at Generations Area Agency on Aging. Generations is a program of Vincennes University and is designated by the Indiana Division of Aging's Commission on Aging as the Area 13 Agency on Aging and as the Aging and Disability Resource Center. I want to thank Senator Braun for inviting me today.

Under the Older American Act, Generations' role is to develop, fund, and implement a broad range of programs and services to meet the needs of older adults and caregivers. We serve six counties in southwestern Indiana—Daviess, Dubois, Greene, Knox, Martin, and Pike Counties. We impacted the lives of more than 35,000 individuals last year. Our entire planning and service area is considered rural. We have four hospitals, but in some of our cities there is not even one primary care physician and 22.7 percent of the population in our service area is living below 150 percent of the federal poverty level.

Some of the challenges we face as a rural community include lack of broadband internet and limited access to transportation, both of which limit access to health care and social opportunities. Under Title III-B of the Act, our AAA offers in-home services for frail older adults, senior transportation, information and referral/assistance, options counseling, home modification and repair, legal services, the Long-Term Care Ombudsman Program, and other person-centered approaches.

The flexibility of this funding stream gives AAA the means to meet the needs of older adults in the community, eliminating the need for expensive nursing home care.

Our Older Americans Act clients inform our work. Since many have cognitive impairments, we pulled together a dedicated action team to help form partnerships like the one with Mi Patio, a local restaurant, to provide dementia-friendly dining hours. This was achieved by using some of our Title III-B funding and supplementing it through our University of Southern Indiana Geriatric Workforce Enhancement Program workforce development grant. I am proud to say this county was recently designated as a Dementia Friendly Community by Dementia Friendly America.

Another essential part of Older Americans Act is Title—C nutrition services. In the past, Generations has provided daily hot and home-delivered meals to homebound older adults. As the economy shifted, gas prices rose, and the cost of food increased, it became apparent that our operations would need to shift from daily hot,

home-delivered meals to frozen meals. As we made the shift to frozen meal providers we searched locally for partners who would be willing to contract with us to provide hot meals. We now have partnership with a nursing home and two senior centers to provide hot meals in their surrounding area.

Today, we operate a hybrid program. A client can choose from up to six different frozen, home-delivered meal service providers or from a hot meal if they live in a covered area. Last year we provided over 106,000 meals to nearly 1,000 older adults.

Our hope was to expand these local partnerships for hot meal delivery, but the funding is not sufficient. Need is growing in our community. Over the past two years, we have seen a 20 percent increase in calls for meals and have more people accessing our services because they just cannot afford groceries or other necessities. Due to the continued rising cost of food, freight, delivery, and labor costs, the same amount of money simply cannot stretch to meet higher costs.

In addition, donations, grant support, and community support are down as donors themselves are tightening up their purse strings and prioritizing their own budgets. This has forced us to triage calls and provide meals only to the most at-risk individuals and put others on a waiting list. In the meantime, our trained counselors work with clients to provide alternatives, such as enrollment assistance for Supplemental Nutrition Assistance Program, referrals to food banks, food pantries, and local churches.

Under Older Americans Act Title III-D we run several evidence-based health and wellness programs, such as A Matter of Balance, Bingocize, and the Chronic Disease Self-Management Program. Through additional partnerships we have more than doubled in what we were able to offer.

There are also ways to make these dollars go further. Generations and other rural AAAs around the country would benefit from flexibility to use Title III-D moneys to fund evidence-informed programs, which are lower in cost and more adaptable.

Generations was created as a result of the Older Americans Act. These are just a few examples of how we innovate and adapt to meet the needs of older adults in our rural area. Please keep the Act's inherent flexibility and locally driven structure in mind as you update the law this year.

I have four recommendations for the reauthorization.

First, increase Older Americans Act funding, which has not kept pace with the growing number of older adults or inflation.

Second, continue some of the nutrition flexibilities that were extended to AAAs during COVID or allow for the flexibility to fund innovative ideas in the nutrition program.

Third, allow Title III-D health and wellness programs to be evidence-informed, and finally, we support USAging's recommendations for reauthorization.

Thank you for the opportunity to testify today.

Chairman CASEY. Ms. Holscher, thanks for your testimony and for being here today.

Ms. GRENFELL. Thank you.

STATEMENT OF LESLIE GRENFELL, EXECUTIVE DIRECTOR, SOUTHWESTERN PENNSYLVANIA AREA AGENCY ON AGING, CHARLEROI, PENNSYLVANIA

Ms. GRENFELL. Chairman Casey, Ranking Member Braun, and members of the Senate Special Committee on Aging, thank you for the opportunity to testify before you today to discuss the Older Americans Act.

My name is Leslie Grenfell. I am the Executive Director of Southwestern Pennsylvania Area Agency on Aging, serving older adults residing in Fayette, Greene, and Washington Counties. It has been an honor for me to serve as the Executive Director for the past 23 years.

In terms of population, our agency is the largest rural Area Agency on Aging in the Commonwealth. Its service and planning area encompasses 2,223 square miles. The agency acts as a community focal point, providing information and assistance, protecting vulnerable older adults, assisting caregivers and their families, reducing food insecurity, and empowering older adults to live independently and to age well.

The Nutrition Program is the cornerstone of the Older American's Act, and includes congregate, home-delivered, and grab-and-go meals, which were introduced during the COVID–19 pandemic. The flexibility of the grab-and-go meal option, where older adults can pick up a meal to take home, has been well-received by our consumers.

Our home-delivered meal providers, however, are struggling. High costs, long distances between homes, and traveling on winding back-country roads, can make delivery difficult. One of our most demanding routes is in the Laurel Highlands of Fayette County, which requires travel through State Game lands and is 32 miles long.

Although challenging, providers have successfully developed and sustained a service delivery system using volunteers who not only deliver hot, well-balanced nutritious meals five days a week, but also provide wellness checks to each older adult, ensuring their safety and well-being. Last fiscal year, approximately 700 dedicated volunteers delivered over 400,000 in-home meals to at-risk consumers.

The challenges identified by our 34 home and community-based agencies who provide personal care services in rural communities are the costs associated with transportation due to the distance between consumer homes, the recruitment and retention of direct care workers, and the need for increased reimbursement.

Last fiscal year, our agency received $591,073 in American Rescue Plan Act funds, which provided a necessary infusion of financial support, permitting us to help a growing number of older adults.

Despite the growing number of older adults and the corresponding need for services projected to increase, no appreciable amount of additional Older Americans Act funding has occurred for over a decade.

Increasing Older Americans Act funding and increasing its flexibility is a cost-effective financial investment which would enable older adults to stay healthy longer, living in their own homes and

communities where they want to be, whereby reducing the need for more costly long-term care interventions, such as skilled nursing care.

In 2023, the Pennsylvania Department of Aging began development of a 10-year Multisector Plan for Aging called Aging Our Way, PA. It is a state-led and stakeholder-driven strategic plan designed to help transform the infrastructure and coordination of services for older Pennsylvanians and persons with disabilities. The network of AAAs was essential to the stakeholder process, which yielded over 20,000 responses from across the State. Each AAA engaged their local communities, encouraged community participation, and facilitated listening sessions, at least one in each of the 67 counties and over 200 sessions in total.

The AAAs are integral to many of the recommendations developed through this process, and we are looking forward to working with the Pennsylvania Department of Aging in implementation.

In conclusion, I would like to especially thank Senator Casey for inviting me to provide testimony today. On August 5th, I will be retiring after 48 years in the Aging Network. It has been an honor and a privilege for me to share my insights with you and it is truly a wonderful capstone of my career. Thank you.

Chairman CASEY. Well, Ms. Grenfell, thank you, and thanks for those—you said 48 years?

Ms. GRENFELL. Yes, sir.

Chairman CASEY. You started in second grade.

Ms. GRENFELL. Thank you.

Chairman CASEY. You have dedicated your life to this work. Thanks so much for that.

Ms. GRENFELL. You are welcome.

Chairman CASEY. Ms. Painter, you may begin.

STATEMENT OF MAIREAD PAINTER, CONNECTICUT STATE LONG-TERM CARE OMBUDSMAN, STATE OF CONNECTICUT, HARTFORD, CONNECTICUT

Ms. PAINTER. Thank you, Chairman Casey, Ranking Member Braun, and distinguished members of the Senate Special Committee on Aging for inviting me here today, and Senator Blumenthal for that welcome.

My name is Mairead Painter, and I am honored to serve as the State Long-Term Care Ombudsman in Connecticut. As long-term care ombudsman, we serve as independent advocates for older adults and individuals who reside in residential care settings.

The Long-Term Care Ombudsman Program was established in the 1970's by President Nixon in response to widespread concerns over pervasive abuse, neglect, and mismanagement of nursing homes. Over the following years, the program was statutorily formalized as part of the Older Americans Act, or the OAA.

My team in Connecticut, although small, is dedicated and strong. It is comprised of 12 staff members, including myself, and we serve approximately 30,000 residents in about 400 long-term care facilities. The ombudsman's activities are performed on behalf of, and at the direction of, residents, and is strictly confidential. We provide direction for services, information about residents' rights, including consultation, investigation, and complaint resolution.

Our non-mandated reporter status reassures residents that their communication with us is confidential. This is encouraging to them because they can speak to us and get our guidance without fear of reprisal.

Our office frequently receives complaints concerning general care issues. These complaints can be adversely affecting to them, about their basic care needs. For example, in some cases residents are informed that they must choose what days they can get out of bed because they lack available staff to assist them. Other complaints might pertain to involuntary discharges, where residents receive notices that they are being discharged from the facility or instructed that they might have to leave immediately, and that they are being sent to a homeless shelter or a hotel. In these cases, our team works closely with the residents to try to ensure that their rights are upheld and that proper procedures are followed.

Despite an increase in care settings over the years, ombudsman programs have not seen the corresponding increase in funding. Many programs receive minimal state funding, and some programs, like in Tennessee, only receive enough funding to pay for the state ombudsman's salary. This lack of investment in the state funding, coupled with stagnant funding at a federal level, hampers our ability to meet increased demand.

Half of the states do not have adequate staff to meet the 1995 Institute of Medicine staffing ratio, which recommends one ombudsman for every 2,000 long-term care beds. This report, while outdated, provides the most reliable staffing standard for the program to date. Connecticut's program currently operates with one regional ombudsman to almost every 3,800 long-term care beds. Additionally, the increased number of residents with complex care needs who depend on our advocacy underscores the necessity for ombudsmen to be able to responsive.

The original program relied heavily on volunteers, but today demands often exceed what volunteers feel equipped to handle. We need to reevaluate our reliance on volunteers while adding more trained and paid ombudsmen across the Nation.

Most critical is funding limitations impede our ability to educate individuals, respond promptly to complaints, and monitor facilities before crisis happens. This critical funding would also result in cost savings to the greater health care system. Although ombudsmen may work as state employees, our roles require independence.

In addition to monitoring and responding to complaints, our program engages in education and outreach, both at a facility level and in the broader community. We also undertake rigorous systemic and legislative advocacy.

Once I got to know other state ombudsmen I began to realize that in Connecticut, while federally mandated under the Older Americans Act to have autonomy, it is not upheld in all the other states. Many of my peers cannot speak out about the interference that they experience as it might jeopardize their jobs. This is unsettling because ombudsmen must have the autonomy to advocate in a bipartisan way in order to advocate on behalf of the people that we serve.

This leads me to one of the reasons that it is essential that the National Director position for Long-Term Care Ombudsman be re-

filled. It is necessary to have that independent voice advocating for our role. As a representative of the state ombudsmen across the country, I strongly urge you to reinstate the National Director for the Ombudsman Program.

I want to thank you for allowing me to offer you this testimony today, as many individuals are still unaware of our role, their rights, and the standards of care that they should expect when receiving long-term services and supports. As ombudsmen our goal is to continue to protect the health, safety, welfare, and rights of all individuals receiving long-term services and supports. Thank you.

Chairman CASEY. Ms. Painter, thanks very much for your testimony and for your good work.

We will turn next to questions, and I often say at this point in the hearing how challenging Thursdays can be around here with a lot of conflicting hearings. That challenge applies to me today, so I am going to have to step out to get to a hearing and then come back, but the Committee will be in the capable hands of the Ranking Member, and I think we will start with, in my place for questions, we will start with Senator Blumenthal, and then we will turn to Ranking Member Braun. Thank you.

Senator BLUMENTHAL. Thank you, Mr. Chairman, and I appreciate your yielding to me, and I want to thank all the witness for your excellent, insightful testimony.

Ms. Painter, I am particularly interested in your comments about the need for autonomy and independence, and also adequate funding. Connecticut may be doing better than other states, but still your point about needing additional resources I think is extremely important, and perhaps you can tell us how those resources would be used in Connecticut and by other similar ombudsmen or offices around the country.

Ms. PAINTER. Yes. Thank you, so the staffing that we need is trained, paid staff in order to meet the demand when the calls come in. We do not want to have to triage calls. We want to be able to answer the calls when individuals say that there is a need. We want to be able to go out and meet with them directly. It is important that they have the confidentiality and the ability to meet with us face to face.

When you are talking about having to choose or only being able to represent some of the residents, my team right now is almost double the amount of individuals that they serve. We try to get out to everybody within two to three days, but sometimes that is taking up to a week, and like I said, we have one of the better staffing ratios in the country. For some I think it was, Senator Braun brought up, it was almost 10,000. We are almost 4,000; some are 10,000, so that is a major difference there.

Senator BLUMENTHAL. I understand your point about the need for independence so you can speak out.

Ms. PAINTER. Yes.

Senator BLUMENTHAL. At the same time, it is important, is it not, that ombudsman offices be supported by the Administration in Connecticut and around the country. Do you find that support less robust than it should be?

Ms. PAINTER. I have the support at a state level, so different ombudsmen offices are set up differently. They are either housed

within a state agency, which is centralized, or decentralized, which is outside of a state agency, so I am within a state agency. However, I am independent, so I have autonomy. They support me in the ways of a fiscal office and HR. However, I can advocate on behalf of the residents in the way that the residents or family members direct me to do so.

It is challenging for my peers because when something, for instance staffing levels or other issues, come up at a federal level for them to be able to testify either at a state or federal level. They do not always have the ability, or there may be a manager if they are decentralized, or someone that tells them they are either not able to speak out against that or to speak to a reporter. I am able to independently speak to reporters, the media, anyone who contacts me, and I do not have interference at a state or federal level.

Senator BLUMENTHAL. Do you have authority to go to court, to take action in court?

Ms. PAINTER. If I see necessary, yes, I do.

Senator BLUMENTHAL. Do you do that commonly, or is it a rare instance?

Ms. PAINTER. It is a rare instance.

Senator BLUMENTHAL. Would you do more of it if you had more resources?

Ms. PAINTER. Potentially. If there was a need and I felt I needed to, yes.

Senator BLUMENTHAL. That would provide a stronger deterrent as well as remedies for the individuals who may be suffering unfairly or painfully in facilities that are not doing their job right.

Ms. PAINTER. Potentially, if we had the ability to work on the cases and to have the staff out there to work the cases in those ways, we may have the ability to get the information necessary to move cases forward.

Senator BLUMENTHAL. You mentioned a couple of instances that you found where perhaps residents or patients were not treated well, being unable to get out of bed when they wanted to do so, involuntary discharge. Are those the two most common kinds of complaints? What are the most common kinds of complaints that you receive?

Ms. PAINTER. I believe the two highest complaints that we heard this past year were related to individuals' care plans being honored, some of them having a say in their individual plans of care and those being honored, and that was directly linked back to staffing. When we really looked at why their care plans were not being honored it was because they did not have the staff to be able to do that. It was not that the staff did not want to. They were not able to complete those things that the residents wanted done because the staff were not there to do that and the other highest area is involuntary discharge.

Senator BLUMENTHAL. Thank you. My time has expired. This area is of great interest to me and very important in the State of Connecticut. Again, I appreciate your very significant work and the need for more resources. Thank you.

Senator BRAUN. Thank you, Senator Blumenthal. We will go next to Senator Ricketts.

Senator RICKETTS. Great. Thank you, Ranking Member.

As the Nation's population ages, communities face increasing demand and challenges in providing comprehensive systems for the care of older Americans. The Older Americans Act funds programs and services that enable older adults to enjoy healthy, productive, and independent lives in their homes and communities.

Services authorized by the OAA include, but are not limited to, family caregiver support, health and wellness promotion, job training, nutrition programs, transportation, and programs to prevent and address elder abuse, neglect, and exploitation. The OAA provides states not only to target services to people with the greatest social or economic need but also to make programs available to all people in the community.

The Older Americans Act has been the primary federal legislative source supporting social and nutrition services to Americans aged 60 and older since 1965. OAA programs are vital for seniors who are at significant risk of hunger, isolation, and losing their ability to live independently. We have heard about the Meals on Wheels and the great work they do providing home-delivered nutrition services to older Americans, and the Older Americans Act helps fund this critically important program.

When considering care for older Americans, loneliness if often overlooked. Studies undertaken during the COVID–19 pandemic demonstrated significant increase in reported loneliness among older adults. A study conducted at the University of Nebraska Omaha found that 39 percent of older Nebraskans reported feelings of loneliness, and 35 percent reported feeling lonelier due to the impacts of the pandemic.

That was my experience as Governor of Nebraska. One of my concerns was in our skilled nursing facilities and assisted living facilities due to the restrictions that were placed on those facilities. There was concern about the folks in those facilities being isolated and the loneliness that goes along with that, not being able to get access to their families, and that sort of thing.

As a result, last November I introduced the Improving Measures for Loneliness and Isolation Act with my First District Congressman Mike Flood. This would direct the Secretary of Health and Human Services to establish a working group to formulate recommendations for standardizing the measurements for loneliness and isolation.

Ms. Holscher, you mentioned in part of your remarks that lack of broadband actually limited social interactions. In general, what are your thoughts with regard to loneliness and finding a way to come up with uniform measurements for loneliness? Would this be something potentially beneficial? I mean, everybody, I think, mentioned about the wellness checks that the Meals on Wheels do.

Tell me a little bit, what are kind of your thoughts on this?

Ms. HOLSCHER. During COVID obviously we did the wellness checks, as you mentioned. Some of the other activities that we engaged in during COVID included porch drop of activities. We created a manual, so to speak, that had activities and games and trivia, and we were able to porch-drop those to individuals that we were concerned about, that we knew were at high risk of social isolation and loneliness. We continued that for a while with the

COVID relief funding, but since that money is gone we are struggling to be able to continue that.

We have done some other things to get folks out of their houses since COVID kind of opened back up. We are providing Coffee and Canvas programs. They are art programs, and we provide those in senior centers, and they are a more relaxed activity than an evidence-based program, because you can come, you can participate in the activity, and it is just a lot more relaxed than a classroom type activity.

We have done some of that. Again, funding is an issue, and we would like to be able to continue that.

One of the other things that we think is very important is we would like to see the National Resource Center for Engaging Older Adults codified in the Act. This is a valuable resource for AAAs. It provides training and technical assistance on social engagement.

Senator RICKETTS. Would you think it would be helpful, because you mentioned the evidence-based programs and flexibility to use that, would it be helpful then to have some way to measure loneliness, for example, to be able to determine who is most at risk, establish baselines, who would be the folks that you would need to focus on, as a first priority for some of the programs you talked about?

Ms. HOLSCHER. I think that it would definitely be helpful, but I would not want to add an additional mandate to what we are already doing. We have been doing this for 50 years, and we are able to recognize those individuals that we think are most at risk. That does not mean that we will not miss some, but I think what would be helpful—I would not want an additional mandate, because when you add a mandate, it increases our costs.

Senator RICKETTS. Finding a way to be able to maybe establish a baseline but do it in a way that is not going to impact, or mandate you do extra stuff without actually providing the funding to be able to do it.

Ms. HOLSCHER. Right.

Senator RICKETTS. Right. We tend to do that a lot in government. Okay, great.

Hey, well, my time is up but thank you very much, Ms. Holscher. I appreciate your insights on it.

Ms. HOLSCHER. Thank you.

Senator BRAUN. Thank you, Senator Ricketts. Senator Gillibrand.

Senator GILLIBRAND. Thank you, Mr. Chairman.

State and local governments need resources and planning assistance to comprehensively address the needs of our aging loved ones. I am proud to lead the Strategic Plan for Aging Act, with Chair Casey, which would establish a grant program for states, territories, and Tribes to create or continue developing a Multisector Plan to transform the infrastructure and coordination of services for their aging population.

Ms. Grenfell, thank you for your testimony and your 48 years of work in the aging network. Could you please describe the ways in which legislation like the Strategic Plan for Aging help a state like Pennsylvania with continuing to develop its 10-year Multisector Plan for Aging?

Ms. GRENFELL. Thank you, Senator. That is an excellent question. Regarding Pennsylvania's work, there was considerable effort to ensure that we received input from a multiple number of stakeholders. There was effort made also to have a vast majority of older people, as I mentioned.

I think that legislation that you are referring to would be extremely helpful, not only to the work that we are continuing to do in Pennsylvania but to incentivize other states to possibly move into a direction of a Multisector Plan. I think it would be extremely helpful. I think what we are hearing today is that states and local Area Agencies on Aging are struggling, and if there would be a way to incentivize such planning on a national level. We already know that other states have implemented such plans, and Pennsylvania is in the implementation stage. I think it would go a long way to ensuring that older adults across the Nation receive that same type of respect in terms of the planning process, so I thank you for that question.

Senator GILLIBRAND. What, Ms. Grenfell, do you think is most misunderstood or overlooked as part of the Older Americans Act, and what does Congress need to know about it?

Ms. GRENFELL. Well, I think what is most misunderstood is the provision about the state units on aging having oversight over contracting that local Area Agencies on Aging are involved in to help ensure that the constituents that live in their geographic area are able to receive a number of services. There seems to be some confusion on whether or not the state units are to have oversight over all types of contracting or just the contracting that would leverage potentially Older Americans Act funds, as opposed to non-Older Americans Act funds.

In Pennsylvania, we are very involved in the level of care determinations, so that contract, for us, the Southwest Area Agency on Aging, allows us to bring over $1 million. That funding then helps to reduce other funding that we might need but allows us to use more services and programs, provide more services and programs, if you will, to the population that we serve.

Senator GILLIBRAND. Great. Since 1972, the Older Americans Act Nutrition Program has been successfully meeting its purpose to reduce hunger, promote socialization, and support health amongst older adults. During Fiscal Year 2025 appropriations process I am proud to have called for $1.8 billion in funding for this vital program to fund congregate and home-delivered food services for older adults.

Ms. Billotte, thank you for sharing your story. It is vital that older Americans can age in place. Could you please explain the ways in which home delivery food services impacts your ability to live in the setting of your choice?

Ms. BILLOTTE. It is helpful for me to receive services at home because that way I don't have to go to the nearest grocery store, which would be eight miles to Philipsburg, 10 miles to Clearfield for my doctor's appointments. It helps me to be in my home and be secure that I can have Fred, my deliveryman, deliver Meals on Wheels to me, and also that I can receive someone to take me to my doctor's appointments, and for the nutrition part, I believe that

through the Senior Farmers Nutrition Act that also is very helpful for my cancer.

Senator GILLIBRAND. What would happen to you if you were unable to receive home-delivered meals?

Ms. BILLOTTE. I would have to go to someone and hire them to take me to the grocery store, and then to learn how to cook all over again.

Senator GILLIBRAND. Yes. It is a lot. Well, I just want to thank all of our panelists for their dedication and their strong support for our older Americans. Thank you for all the hard work you have done and thank you for your testimony.

Chairman CASEY. Thank you, Senator Gillibrand. We will turn next to Ranking Member Braun.

Senator BRAUN. Thank you, Mr. Chairman. I want to start with Ms. Holscher. In the OAA Final Rule the Administration expanded the definition of ″greatest social need.″ These criteria are used to determine which seniors should get priority for meals. With waiting lists and challenges in food delivery is it justified to expand the definition of greatest social need?

Ms. HOLSCHER. I think the definition needs to remain broad and allow the local AAA to determine who is in the greatest need through their local area plans and their needs assessment. My area does not look like Juneau, Alaska, or Indianapolis, Indiana, for that matter, and we need the flexibility to plan for and meet the needs of the older adults at the local level.

Senator BRAUN. We have heard about how partnering with other aging service providers can magnify your reach while making each dollar go further. I applaud this local entrepreneurship. Our national debt, as I said earlier in my opening statement, is ballooning to the tune of a trillion dollars every six months. To put that in perspective, that was just, well, it is a lot of zeroes after a one. It was a trillion dollars annually just five and a half years ago. We are now $35 trillion in debt, and five and a half years ago, 18, which was approaching a record.

What steps should we take to support entrepreneurship in the aging network, and do you think this will bring costs down and yet still be more effective?

Ms. HOLSCHER. We would ask that the flexibility and control of business arrangements, such as contracting with health care entities to deliver home and community-based services under Medicaid be restored to the local AAA level. We have been charged with building comprehensive systems of services by leveraging local and private funding, and we need to be nimble to do that without delay.

We have a long history of preventing conflict of interest and managing multiple funding sources, and it is important that we maintain our independent status without the restrictions or barriers.

Senator BRAUN. One more question for you. In your testimony you called for more flexibility in the Older American Act's Health and Wellness Programs. Currently, and by the way, health and wellness and prevention and all that is what I wove into my health care plan, back many years ago, in my company, and pretty well, when you do that right you can halt your health care costs and insurance costs, so it can be done, and I know that it hurts in places

where you have got communities that are already strapped for resources.

Can you explain how allowing evidence-informed programs would expand the reach and effectiveness of services?

Ms. HOLSCHER. The flexibility in Title III-D to incorporate evidence-based programs would allow the network to reach older adults with emerging innovations and enhance our ability to stretch the limit on Title III dollars and reach more people.

In my area we would like the opportunity to try a program called Building Better Caregivers. It is a six-week, online workshop for caregivers of veterans, and this flexibility would allow us to do that. Right now that is not a program we would be able to offer because we do not have the funding.

Senator BRAUN. Thank you. Ms. Painter, the Long-Term Care Ombudsman Program exists to identify, investigate, and resolve complaints made at long-term care facilities. State ombudsmen submit reports to the Administration on the cases they handled each year. However, it is unclear how this information is being utilized. How would summarizing this data and making it public improve transparency at long-term care facilities?

Ms. PAINTER. We agree that this information should be available to the public and to policymakers. We think that it is important that transparency is available to everyone.

There are millions, billions of dollars going out to long-term care facilities, and that in many cases individuals are spending down their private dollars and going on Medicaid, and if it is federal dollars that are being spent in these facilities that there should be good policies for oversight and transparency about how those dollars are being spent, and if it is our programs that are looking at those cases and doing those investigations, and by you all having access to that information and what we are seeing would give you better ability to make policies, then that should be available.

Senator BRAUN. Yeah, an ombudsman service is a portal of feedback, and I think any business, any entity ought to welcome it. In your experience, do you get a lot of it, and do you learn a lot from it?

Ms. PAINTER. Yes, we do have a lot of information. We would, of course, want to make sure that it remains confidential—people's names, information in that way—so that they continue to feel confident in giving us that information, but the actual data related to cases of mistreatment, abuse, neglect, the amount of times that people go to the hospital, involuntary transfers and discharges, because I do believe that that directly impacts cost savings, and when individuals are not given information about informed choice, to return a less restrictive setting or encouraged to stay in the nursing home versus go to a less restrictive setting, I think that is very costly to our long-term care system.

Senator BRAUN. It makes sense. Thank you. I yield back.

Chairman CASEY. Thank you, Ranking Member Braun. I will do my questions now that I am back.

I wanted to start with Ms. Billotte. Janet, I am noting in your testimony you shared how not only that you have enjoyed receiving a meal but you also have enjoyed seeing your meal delivery driver,

Fred, and you have become friends, and that is just such an important part of the services, as you made reference to.

A critical piece of the home-delivered meals, the program itself and OAA programs, in general, not only are you receiving important services but you are able to make friends and build relationships. In fact, toward the end of the first page of your testimony you say, ″The Area Agency in Aging is my family,″ which I think speaks volumes of what we are talking about.

In this brochure that I made reference to earlier about these Pennsylvanians, one of them is from Erie, Pennsylvania, Doris Philhower, and she talks about her experience, and I am quoting her here from the brochure, she says, ″It has filled my life with new friends over the years. It's my home away from home.″ I think that says it all, so this is obviously an important part of the benefit that you derive from these services. Can you share more about the social connections you have been able to build through the Clearfield County AAA?

Ms. BILLOTTE. With the AAA services I have been able to receive doctor's appointments, and we become friends with many people that deliver the Meals on Wheels and also that we can depend on those people checking in on us each day, so that we have someone to support us and that will know how we are and what we are doing that day, so I think it is very important to do that.

Chairman CASEY. It is obviously part of life that we have relationships and we are able to see people. I think one of the more remarkable pieces of evidence the last number of years, especially during COVID, was sometimes when someone was receiving a meal, that person delivering the meal was the only person they saw——

Ms. BILLOTTE. Right.

Chairman CASEY [continuing]. for days at a time, if not to include, as well, the Postal Service worker, but I think we all understand what you are talking about.

Ms. Grenfell, I wanted to make reference to your testimony, as well, that Pennsylvania is currently working to develop and implement a so-called Multisector Plan for Aging. These plans help states and localities come together to collaborate on ways to make communities work for older adults. The response throughout our commonwealth from community stakeholders is really impressive. You have lived this, and I want you to know how important it is for us to try to pass the Strategic Plan for Aging Act, Senator Gillibrand and I and others, to incentivize states to start their own planning processes. How can we ensure that state governments are hearing the voices of older adults and nontraditional aging partners across the state?

Ms. GRENFELL. Thank you, Senator. The process that Pennsylvania undertook involved multisector planning, as I mentioned, so what we attempted to do was to reseed the nontraditional type of input from departments, state departments, as well as local planning areas, as well as the elected officials that were local, the American Legions, all the infrastructures that were available locally, so the plan that we are developing will entail the opportunity to have diverse input and will allow Pennsylvanians to have the breadth of a larger plan that takes all of their considerations and

their input into practice, so we are really excited about moving forward on this plan.

It is very transparent. That is the other important part of the plan, and as I said, we are looking forward to its implementation stage, which is coming up.

In terms of having any incentives to do that, if that is an opportunity for other states, I think it would be well received. Pennsylvania could certainly use additional funding if it was available and thank you for presenting that opportunity as a legislation attempt. We appreciate it.

Chairman CASEY. Well, I think funding is a big part of this equation. We appreciate you making reference to that.

I will turn next to Senator Kelly.

Senator KELLY. Thank you, Mr. Chairman, and thank you for having this hearing today.

Since I have been in the Senate three and a half years now I have been very grateful for my senior advisories, my seniors advisory group that I meet with often to discuss issues impacting Arizona seniors, and most of the group is made up by representatives of the Arizona Area Agencies on Aging, and because of that I have gotten to understand the essential role that the Area Agencies on Aging play in their communities, from providing meals to helping somebody find a direct care aide, to connecting older adults to benefit programs, to make the most out of a fixed income.

These organizations are, in many areas of my State, the backbone of the aging services community, and they call themselves the best-kept secret in Arizona until folks turn 60, so I want to make sure we all understand why it is so important that we successfully reauthorize and fund programming in the Older Americans Act.

Ms. Painter, your role is authorized under the OAA, but you are also deeply immersed in the rest of the aging network. Could you speak to how the OAA and Area Agencies on Aging fit into the aging ecosystem and why they are so important, not only to Arizonans but to all Americans?

Ms. PAINTER. Thank you. That is a great question. I think working in partnership in order to support individuals at the lowest level of need, so that they are able to age in a healthy way, and to support them before they have the highest level of need. That way we are giving them—we spoke about good nutrition, access to programming, information about health and wellness, and we want to encourage individuals to be a part of their communities.

Senator KELLY. Would those be examples of the lowest level of need?

Ms. PAINTER. Those are the lowest level of need, and doing that on an individual level, so the Area Agencies on Agencies—I can speak for Connecticut, that I know—they meet with their communities and they talk to the individuals that they serve about the programs that they want in their areas, and so it is really about ensuring that they are meeting the needs of the individuals that they serve, because it could be different district to district, and so we want to make sure that if it is an ombudsman program that is decentralized they may also house some ombudsmen within the Area Agency on Aging, so they could be having information about what services are needed from the Ombudsman's Office, they could

be speaking about what they are seeing related to long-term care, home and community-based services, as well as meal delivery services or even transportation services. We know that comes up a lot for individuals and how they are reaching doctor appointments or access to food and other resources.

I think if we are not able to do that we would see people needing higher levels of care, which is more expensive, more quickly.

Senator KELLY. All right. That is true, I think, in a lot of areas of health care, as well, is trying to tackle the problem earlier can be less costly.

Ms. Billotte, thank you for being here today and thank you for sharing your story, and I am sorry for your loss. Your testimony about your local Area Agency on Aging, about how they made sure you were fed and looked after during your illness was very powerful. You mentioned your interaction with Fred, who delivers your meals.

As we work to reauthorize the OAA, Arizona's Area Agencies on Aging have requested that we allow them one unified nutrition program so they can determine how best to split the congregate meals and home-delivered meals to folks who qualify, and the Arizona agencies have said that that would make it easier to fill the needs of their local communities. Nearly all of them have a waitlist for home-delivered meals, but they are not seeing the same demand for in-person congregate meals.

I think some folks up here are a bit hesitant to create one single nutrition program because socialization is such an important part of the meal program within the OAA.

Ms. Billotte, do you feel like your home-delivered meals were the right fit for you when you needed them, both for your physical and mental health?

Ms. BILLOTTE. They were. It was very helpful when my husband was sick and I also was sick that we received these meals and we were able to understand that they were nutritional and that they did help us, that we were able to receive them.

I also understand that there were many more Americans that are on this waiting list for the Meals on Wheels and would appreciate that you would speak to people that would be able to put this program into service so that we could receive services, and I think that it is very helpful to us, as American citizens.

Senator KELLY. Right. Well, thank you, Ms. Billotte, and thank you, Mr. Chairman.

Chairman CASEY. Thank you, Senator Kelly. We turn next to Senator Fetterman.

Oh, I am sorry. Senator Vance.

Senator VANCE. Thank you, Mr. Chairman. I appreciate Senator Fetterman for pushing back against your Pennsylvania bias there, but thanks to both of you, and thanks to you and the Ranking Member for hosting this hearing, and thanks to all of you for being here and giving us some sense of what you are working on and how we can make things a little bit easier for people.

You know, I come at this with some personal experience with Meals on Wheels program. My grandmother, who I lived with for a very long time, benefited from the program. It was a very, I

think, critical part of keeping her healthy and happy during a pretty tough time for our family.

I want to sort of direct my questions to Ms. Holscher—am I pronouncing that right? Okay, great. I am sort of interested in the two sort of meal programs in the Older Americans Act and how they sort of can provide flexibility or take some away if we do not do this right way, so maybe, Ms. Holscher, given your extensive work in Indiana, what factors inform seniors when they are choosing between congregate meals, going to a place for a meal, versus things like Meals on Wheels?

Ms. HOLSCHER. Well, some of it has to do with transportation and if they have access to a senior center. In some of our very rural areas there are not senior centers, so there is no choice. They would have to access home-delivered meals.

Some of it has to do with some of our senior centers have been around for 50 years, and they are in older buildings, in basements, and they are outdated, and the seniors today want choices, and they want places that they can go that will engage them in activities. We have one senior center that is in the basement, and I personally feel like it is haunted, and I have heard that from other older adults.

They want choices, not just, ″Here is the senior center.″ They want places that they can go where they can engage in today's activities, such as like our Coffee and Canvas project that we do, and sometimes it is about, just because you are isolated does not mean you are lonely, and some older adults prefer to eat at home, alone, but we still try to find ways to engage them in other activities.

I hope that answered your question. Thank you.

Senator VANCE. It does, and I guess on this, if I understand it correctly, and please correct me if I am wrong, is that you saw, understandably, during COVID especially, in that summer of 2020 time period, a really massive increase in demand for things like Meals on Wheels. We are now close to, well, it is exactly four years after that. Where do you think we stand? Has demand fallen? Has it stayed the same? Are we seeing seniors less interested or more interested in that service?

Ms. HOLSCHER. In our area we have seen a 20 percent increase in requests for services, nutrition services, so while I think it has stabilized a little bit after COVID, the increase is definitely there in the last two years, a 20 percent increase that probably has more to do with they can't afford their basic necessities and so they are reaching out to us for help with nutrition to offset some of those other costs.

Senator VANCE. Got it, and could you just explain to me, when the money is coming to an agency like yours, that I believe you have worked with for close to 30 years, right, does it come in as—are there separate buckets?

Ms. HOLSCHER. Yes.

Senator VANCE. There is money for congregate, there is money for Meals on Wheels, and am I correct, you have flexibility in moving them between the two programs, depending on the demand for seniors in your area?

Ms. HOLSCHER. We do not. We had that flexibility during COVID and it was very helpful, obviously because most of our congregate

sites were closed during COVID, but since the public health emergency has ended we no longer have that flexibility.

Senator VANCE. I see, and so I guess I am probably asking the obvious here, but am I right that you would prefer to have more flexibility in how you actually provide these services?

Ms. HOLSCHER. We would definitely prefer to have more flexibility at the local level. We want to meet the needs in our area, and we can only do that with flexibility between funding sources.

Senator VANCE. Yes, and I can imagine, too, just between rural and urban areas, you could have a small town that might have one set of preferences, you could have a bigger city that might have a different set of preferences. Obviously, maybe a little easier to get to a senior center if you are in Indianapolis or Columbus or Cincinnati.

I appreciate your testimony here and I certainly share your view that flexibility would be a good thing here, and maybe we can work on that. Thank you.

Ms. HOLSCHER. Thank you.

Chairman CASEY. Thank you, Senator Vance. I am sorry about the mess-up in the order. I will now turn to my colleague from Pennsylvania, Senator Fetterman, with that long buildup.

Senator FETTERMAN. Thank you, Mr. Chairman. Ms. Grenfell, can you speak to the barriers that exist to the LGBTQ+ older adults and aging individuals with HIV in accessing programming established through the OAA?

Ms. GRENFELL. Thank you for that question, Senator. As we know, the LGBTQ+ community has faced many barriers over the years—discrimination, difficulty accessing health care. The Older Americans Act programs are based on need, and so our job is to ensure that we are creating an inclusive environment that is welcoming to all communities. Our agency is certified platinum, stays informed, and so our staff has made sure that we are all in the position to be able to understand exactly what their history has been, how we can ensure that we have welcoming senior centers, how we can ensure that we have services and programs that meet their particular needs and are sensitive and inclusive of their needs.

Senator FETTERMAN. You are able to confirm that the special kinds of needs and other issues to those kinds of communities are being fully addressed?

Ms. GRENFELL. Well, Senator, to the extent that we are able to include, and are welcoming——

Senator FETTERMAN. Sure, so that language seems specific. What are you referencing then?

Ms. GRENFELL. Well, I am specifically referencing the training that our staff has undergone, and that there are particular questions that are part of the assessment process that are identifying if the individual is willing to self-identify. That is not necessarily everybody is willing to do that, but those that will, then we are able——

Senator FETTERMAN. In other words, somebody might be—they might not be—not comfortable to identify as a member of that community. They would be actually missing those kinds of critical services then, right?

Ms. GRENFELL. They could, yes. Yes, they could. Yes, they could. However, I think that, in general, it is important that there be adequate training for staff and that Area Agencies on Aging are well-informed of the need to be inclusive, to have environments, have policies in place, which allow for all types of individuals to receive the services at that level.

Senator FETTERMAN. Okay.

Ms. GRENFELL. Thank you, Senator.

Senator FETTERMAN. Okay and now, currently the OAA is up to serve Americans 60 and older. Other federal programs do not kick in until 65. There are a lot of Pennsylvanians between 60 and 65 who rely on these critical programs. OAA bridges this gap.

Ms. Painter, can you speak about the importance of offering these programs before the eligibility kicks in on the other federal programs?

Ms. PAINTER. Thank you. Yes, I believe, again, the earlier we can intervene and support individuals and offer them the ability to stay healthy, have access to supports, the better we will be able to maintain their health and well-being and enhance their wellness in order to prevent them from needing higher levels of care at earlier ages and stages of their life.

Senator FETTERMAN. Finally, ensuring Pennsylvanians can have food on the table, I mean, that is a top priority, personally for me, but of course, for the commonwealth as well, and about five percent of older Pennsylvanians are food insecure. Recipients of OAA-provided meals report that this is half or more of the food for that day.

Ms. Billotte—is that correct? How important are these kinds of home-delivered meals for overall, and for your nutritional meals?

Ms. BILLOTTE. I believe that our Area Agency of Clearfield County has obtained a chef that will help each individual meal be characterized, like what the need is. We all have a menu we go through each day, and they provide meals to us. The nutrition meal, for me, for my cancer, was very helpful to help me get through cancer.

Senator FETTERMAN. Mr. Chairman, about 30 more seconds?

Chairman CASEY. Sure.

Senator FETTERMAN. It is also another point of contact for some seniors that may not have any other kinds of contact, essentially a well check on there, like making sure everything is still okay.

Ms. BILLOTTE. That is very correct, because my meal deliveryman, Fred, is my only contact during the day many times to talk to and to see each day, so that is very helpful that he checks in on me to see how things are.

Senator FETTERMAN. Yes, and also my own grandmother, she fell, and she did not have a situation like this, and she was not able to get contact for several days, so the horror of all of that, so only the critical food but just also just kind of that interaction, but also like it is a well check, just how critical it is to make sure that everyone is going to still be okay.

Ms. BILLOTTE. That is correct, and with my transportation issue it was for my cancer, to go to the chemotherapy and to my doctor, and it was very critical because there is no Ubers, no taxis, and no transportation in my area because we live in a rural county, so that is very helpful if I can have transportation to and from my doctors.

Senator FETTERMAN. That seems almost beyond helpful. I mean, that is critical to maintain your health and your way of life.

Ms. BILLOTTE. At that time, I did not drive while I had cancer for the year, so not driving for a year it is critical in finding someone to help.

Senator FETTERMAN. Thank you, all of you. Thank you. Mr. Chairman.

Ms. BILLOTTE. Thank you.

Chairman CASEY. Thank you, Senator Fetterman.

I just have maybe two more questions and then we will have to wrap up. I wanted to ask a question of Ms. Painter. In your testimony you spoke about the Long-Term Care Ombudsman Program desperately needs more federal funding to account for the sheer number of older adults who are now residing in long-term care settings, especially assisted living facilities. Many of these residents may worry about retaliation if they raise issues themselves. Others may not have the ability to self-advocate. That is why the Long-Term Care Ombudsman Program is so important in your voice for older adults who may be both uncomfortable or unable to advocate for themselves.

However, you cannot do this essential job without the funding. I released a report last year entitled ″Uninspected and Neglected.″ The report revealed that lack of investment in ombudsmen and nursing home surveyors leave nursing home residents at risk. Today, at my request, the GAO is releasing new findings on the increased complexity of cases and the impact that limited budgets have on ombudsmen. In fact, Connecticut is one of five states highlighted by GAO. Based on this data, I am advocating to triple the amount of funding for Long-Term Care Ombudsmen Programs in the Older Americans Act reauthorization, so here is the question. If it is clear that additional funding would help ombudsmen stay afloat, can you describe how additional funding would directly impact and improve the lives of older adults living in long-term care facilities?

Ms. PAINTER. Yes. Well, thank you for advocating for us to have that increased stable funding. We so appreciated the funding that we received during COVID, and realized how much we could do. Even though we were not able to access the buildings initially, once we had that funding and we were able to do more outreach that we were seeing an increase in cases, and we have seen a steady increase in cases.

I think with additional funding that would continue, because when we were able to meet that mandate of being in long-term care facilities on a regular basis it is not necessarily that individuals know to reach out to us. As I said in my testimony, individuals do not know what their rights are always related to quality of care, and so when you have the access to regular ombudsman who is in the building, on at least a quarterly basis, going around, introducing themselves to people, explaining their rights, and ensuring that they know what quality of care looks like, talking with them, explaining to them the grievance process, explaining to them that they have the right to transfer to a less restrictive environment, to attend a care plan meeting with them and talk to them about what their plan of care can look like and what they should

be expecting, that they do not have to just decide to get out of bed every other day. The expectation should be that they get out of bed when they want to get out of bed. They should be able to get to the bathroom or have nutritional support when needed.

I think that is when we will see those changes, and I think that will impact cost savings as well, because we will not have those visits to the hospital, where people have wounds or infections and those types of things, because the interventions that the ombudsmen are able to provide one-to-one with the nursing homes, when residents allow us to, and sometimes it means multiple visits. When you have that rapport with a resident, sometimes initially they do not want us to do anything. We just have to go back a few times and reassure them that we can have that conversation with the long-term care community, and when we talk with them they put those interventions in place, and the resident sees that benefit, and I think that is where we will see the biggest change in care.

Chairman CASEY. Ms. Painter, thanks for that response.

The last question I have is really for the panel, but I may ask Ms. Grenfell and Ms. Holscher to address it first, but if anyone else wants to add to the conversation.

As I mentioned earlier we have got a bipartisan group of Senate colleagues that are leading the effort to reauthorize the Older Americans Act. We are not only working to reauthorize the Act, we are also working to modernize it, to make sure that we are meeting the needs of today's older adults and the needs of future generations of older adults.

The reauthorization provides us with an opportunity to look at what has changed in the last four years since the 2020 reauthorization, what innovations were critical throughout the COVID–19 pandemic, and what needs are still not being met.

How have you seen the needs of older adults evolve over your careers, and where is modernization needed most within the Older Americans Act? Maybe Ms. Holscher, and then we can go from there.

Ms. HOLSCHER. The needs have changed, I guess over the years, is today's older adults want choices. They want to be able to choose from a list of meals. They do not want, here is a cookie-cutter meal, everybody gets it, and that is true in all six counties that we serve, so what the folks in Pike County might want is different than what the folks in Dubois County, and they want those choices, and we need the flexibility to be able to provide those choices to them.

As well as we need the flexibility to come up with new ideas. We need to be able to pilot programs, and the funding right now does not really allow for us to get out of our box, so to speak, so we would really like to see more flexibility so that we can implement new ideas, emerging innovations, and be more entrepreneurial.

Chairman CASEY. That is great. Thank you. I might reframe the question a little bit for Ms. Grenfell because of her impending retirement, so I guess the question for you would be what is your hope for the Older Americans Act moving forward?

Ms. GRENFELL. Well, I certainly agree with my colleague, Laura, from Indiana, because those are critical issues for the Older Americans Act.

I would also say that our national USAging organization has really spent a lot of time and effort with the Older Americans Act and has excellent recommendations for moving forward and I think for modernizing it.

It is not always just about money either. I mean, money is important, and we have all mentioned that, but it also, as Laura mentioned, it is really important that we are able to do some innovation. Southwestern Pennsylvania has certain meals that they love, and they do not necessarily meet the nutritional requirements exactly.

I think we have to update a lot of that in terms of the whole nutrition program to make it more available. The COVID–19 grab-and-go meals have been extremely successful. We are finding that our population likes the fact that they are available, and they are flexible, and they can come to the center when they have time, or if they are caring for somebody at home then they can pick up a meal for their loved one and them and get a little bit of respite.

We are also looking at trying to do some innovation, because of the ruralness of our service area, of a cafe, a pop-up cafe, where we would be able to take the meals in more rural parts of our service area and have them available as opposed to an infrastructure like a senior center that is a lot more costly, so we are looking for innovation and cost-efficient ways to provide the program. That type of innovation is what I think both Laura and I are looking for, and that would be something I would hope for.

Thank you, Senator.

Chairman CASEY. We are grateful for that, and I think that innovation is going to be important, and obviously giving seniors choices is also important. Who wants to be locked into one choice for a meal? That should be part of the opportunities we provide.

I will move to our closing statement. I will have a closing statement and then I will turn to Ranking Member Braun, and then we will have to wrap up.

As we heard today from our witnesses, the Older Americans Act is a landmark piece of legislation that has been providing lifesaving services to older adults for nearly 60 years. To put it simply, these programs authorized through the Older Americans Act are working well. The Area Agencies on Aging, senior centers, Meals on Wheels programs, and other provide services tailored to the unique needs of their communities.

The individuals who make up the aging network are dedicated to this work, with many having devoted their entire careers to improving the quality of life for many older adults. Ms. Grenfell, I am making reference to you here. They are the trusted partners in our communities.

I think everyone on both sides of the aisle can recognize the importance of the Older Americans Act in preventing chronic diseases and reducing social isolation and loneliness, and enabling older adults to remain at their home, in their communities, where they would like to be.

However, we cannot expect the aging network to continue to work for older Americans and their communities if we are not willing to provide the programs with adequate funding. As we heard today, due to funding limitations there are thousands of older

adults waiting—waiting—for services across the country, from meal services to ombudsman assistance. Waitlists and wait times will only grow of Congress fails to act.

Folks like Janet should not be forced to wait for needed meals and services, and that is why, through the reauthorization I will be pushing for increased funding for Older Americans Act programs, and I encourage my colleagues to join me. I will also continue to advocate for changes to the statute that will better enable AAAs and local service providers to do their work.

The Older Americans Act plays a critical role in the health and success of older adults in local communities from Pennsylvania to Connecticut to Indiana, and everywhere in between. It is critically important the Senate invest the necessary resources to fulfill the intent of the Act.

I will now turn to Ranking Member Braun for his closing remarks.

Senator BRAUN. Thank you, Mr. Chairman. We always have prepared remarks that we can default to. Since I have been here, I like to listen, hear what everybody says, and then sometimes just chuck the prepared remarks.

This is a Committee that I had to be recruited to get onto, back when I came to the Senate, and it is one that we cannot legislate out of, but for the time I have been here we have had more pertinent discussions in this Committee that other committees end up legislating off of, and in this place it is always frustrating in that we have all heard what we need. We have got future older Americans that have to pay all the bills and shoulder the debt, so we are kind of between that rock and hard place, and it is not only here. It is across our government. You know, sure, we need more funding. Everybody needs more funding, but when you are borrowing 100 percent of it, remember, we are asking our kids and grandkids to pay for it. We have got to get smarter than that. No other place does that work, and that is why being entrepreneurial, maybe turning more of the responsibility over to all the places that have to live within their means.

It was refreshing to hear from Ms. Grenfell that maybe it is not all about money. Federal level, that is what this place is about. That is okay if you have it. If we are borrowing it from our future older Americans, our kids and grandkids, we have to step back and figure out how to be smarter and better, because then we are defeating the whole purpose of what this is about in this discussion.

Thank you all for coming in. It is food for thought. Maybe we will find a way to have our cake and eat it too, be smarter about it in the long run. Thank you.

Chairman CASEY. Well, thanks everyone for being here today. We are grateful for the witnesses, for your testimony, and for bringing your own life experience as well as your professional experience to bear.

If any Senators have additional questions for the witnesses or statements to be added, the hearing record will be kept open until May 30th.

Thank you all for participating today. Have a great rest of your day.

[Whereupon, at 11:10 a.m., the hearing was adjourned.]

APPENDIX

Prepared Witness Statements

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE OLDER AMERICANS ACT: THE LOCAL IMPACT OF THE LAW AND THE UPCOMING REAUTHORIZATION"

MAY 23, 2024

PREPARED WITNESS TESTIMONY

Janet Billotte

Chairman Casey, Ranking Member Braun, and Members of the Committee, thank you for having me here today at your Older Americans Act hearing. My name is Janet Billotte, I am 78 years old. I live in West Decatur, Pennsylvania, which is a rural town in Clearfield County. Before retiring, I worked as a nursing aide. I am here to share my experiences as a recipient of Meals on Wheels and other services from the Clearfield County Area Agency on Aging.

I have been receiving Meals on Wheels for four years. My husband, Richard, and I started receiving meals in August of 2020, during the pandemic. Let me tell you, it is so nice to receive these meals. Every time I get a box, it always feels like I get a little present. You always get milk, sometimes cookies, and if it was summer, sometimes we get a strawberry shortcake. Last year, I was diagnosed with Stage three colon cancer and I was also caring for my husband who had been sick with many issues for a long time. I also just had an operation for my cancer and had chemotherapy three times a week. Many days, I didn't feel well and it was very helpful to have these meals delivered to us.

I love talking to Fred, the meal delivery person. Every day he comes in and always asks me how I am. Everywhere he delivers, he checks on everyone it is wonderful that he does these check ins. If he doesn't hear from someone, he calls the Area Agency on Aging and they make sure we are okay. A lot of older people don't have family around. I don t have family around. I had two brothers, but they passed away and my husband just passed recently. The Area Agency on Aging is my family.

Today, my cancer is in remission. I am still receiving deliveries from Meals on Wheels and also use other services from the Area Agency on Aging. They do this very nice thing where they give us vouchers through the Senior Farmers Market Nutrition Program run by the Agriculture Department so that we can go to the farmer's market and I can get fresh produce. I get tomatoes, lettuce, and all kinds of fresh foods from the market. It is good nutrition, and it's good for preventing cancer. During bad weather, they also do a blizzard box, where they send you a box of frozen and shelf-stable food so we have something to eat when we are stuck in bad weather. I really am thankful for these services because I'm not sure what I would do without them.

Beyond meal deliveries, I also participated in events at the senior center. One time, I went on a field trip to a mushroom farm, where we learned about all the different types of mushrooms. We also went to a flower farm. I love flowers and have always had a flower garden. The Area Agency on Aging also helped coordinate transportation for me when I had to go to the clinic to get chemotherapy. I had to get chemo and blood work every week, and that was terrible, because I live in a rural area, it was very hard to find transportation to the clinic but they were very kind to help drive me to my doctor's appointment.

I'm very grateful to be receiving these services, and grateful for the friendship I have with my Area Agency on Aging. Kathy Gillespie, who is with the Area Agency on Aging, is like family to me. I know many older adults who receive Meals on Wheel are thankful like I am. I also understand that there are many more older adults on the waiting list for these services. I ask you to please help more people get into the program and be able to receive these great services. Thank you again for the opportunity to share my story.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE OLDER AMERICANS ACT: THE LOCAL IMPACT OF THE LAW AND THE UPCOMING REAUTHORIZATION"

MAY 23, 2024

PREPARED WITNESS TESTIMONY

Laura Holscher

I am Laura Holscher. For 30 years it has been my honor to serve older adults at Generations Area Agency on Aging, the past 14 years as the Executive Director. Generations is a program of Vincennes University and is designated by the Indiana Division of Aging's Commission on Aging as the Area 13 Agency on Aging serving Daviess, Dubois, Greene, Knox, Martin and Pike counties in southwestern Indiana. Generations is also designated as the Aging and Disability Resource Center (ADRC). I want to thank Senator Braun for inviting me to speak with you today on a topic that I am very passionate about, the Older Americans Act (OAA) programs and services that support older adults and caregivers in Indiana and nationwide.

As an Area Agency on Aging, Generations' role is to develop, fund and implement a broad range of programs and services to meet the needs of older adults and caregivers, all of which are based on demonstrated need in the communities we serve. We develop an area plan that is based on those identified needs, the changing preferences of older adults and the input of local stakeholders, such as our provider partners. As a AAA, we also leverage additional local dollars to support the Act's efforts, operate an information and referral/assistance system so that consumers can access resources, select community providers to deliver services and then provide oversight, and much more.

Generations serves six counties in southwestern Indiana. Our entire planning and service area is considered rural. We have four hospitals, but in some of our cities, there is not even one primary care physician. Our public transportation system runs Monday through Friday between the hours of 6:00 a.m. and 6:00 p.m. with reservations requiring at least 24-hour advance notice. Additionally, 22.7% of the population in the Generations planning and service area is living below 150% of the federal poverty level.

Some of the challenges we face as a rural community include lack of broadband internet and limited access to transportation, both of which lead to increased risk of social isolation. Broadband internet is nonexistent in some rural areas or unaffordable. This limits access to online opportunities that our AAA offers such as social engagement activities or virtual evidence-based classes on healthy aging.

Through our work with community partners and contracted providers Generations staff and volunteers impacted the lives of more than 35,000 individuals last year. To respond to the needs of older adults and caregivers in our planning and service area, we offer all the core OAA services.

Under Title III B of the Act, our AAA is able to offer in-home services for frail older adults, senior transportation programs, information and referral/assistance services, options counseling, home modification and repair, legal services, the Long-Term Care Ombudsman Program and other person-centered approaches to helping older adults age well at home. Services provided through Title III B are a lifeline for older adults living in the community, and they also connect older adults to other OAA services-for example, transportation services funded by Title III B ensure older adults can reach congregate meal sites funded by OAA Title III C.

The critical flexibility of this funding stream gives AAAs greater means to meet the needs of older adults at home and in the community, thereby eliminating the need for more expensive nursing home care-which usually leads to impoverishment and a subsequent need to rely on Medicaid to meet critical health care needs.

Many of our OAA clients have cognitive impairments, including those living with dementia, and so this informs our OAA work as well as other projects we take on. Recently one of our counties was designated as a Dementia Friendly Community by Dementia Friendly America. This was achieved by using some of our Title III B funding and supplemented through our University of Southern Indiana (USI) Geriatric Workforce Enhancement Program (GWEP) workforce development grant. A dedicated action team was pulled together that consists of a diverse group of community members who volunteer their time and energy to create an inclusive commu-

nity that is welcoming, mindful and inspirational for people living with dementia (PLWD) and their caregivers through education and action. Our action team membership includes representation from the faith community, local nursing facilities, local United Way, Chamber of Commerce, several local nursing facilities and, most importantly, Genevieve and Carmen (someone who is living with dementia and her caregiver daughter). A few of the highlights from our team's dementia friendly work include partnering with Mi Patio, a local restaurant, to provide dementia friendly dining hours. These hours are set aside specifically for people living with dementia and their care partners; a special menu was created for these dining hours which includes a limited menu, to make decision making less stressful, and pictures of each food item so that these customers can see what they are ordering. Other events/activities include Coffee and Crafting activities for PLWD and their caregivers; these activities provide opportunity for fun quality time for the person living with dementia and their caregiver.

In the near future we will be reaching out to first responders in our service area in an effort to provide dementia education and awareness to these individuals who are often first on the scene in the event of an emergency. By educating this group to be able to recognize the signs and symptoms of dementia and instructing them on techniques to interact with someone living with dementia, we hope to reduce stress in an already stressful situation for both the person living with dementia and the first responder.

The flexibility of OAA Title III B also allows AAAs to meet new and emerging needs in their communities. During the COVID-19 pandemic, we were able to transition to new and modified programs such as wellness checks for homebound older adults, activity packets that we were able to porch drop to help older adults stay socially engaged, and a new virtual version of our evidence-based programs. This was in addition to our work supporting vaccine outreach and assistance. To further support older adults' access to social engagement and healthy aging opportunities, we have also started offering basic technology classes geared toward older adults. However, years of eroded funding prior to COVID-19 have resulted in local rural AAAs like my own losing ground in their ability to provide critical Title III B Supportive Services. Without bold investment in FY 2025, the expiration of the COVID-relief funding will create gaps and elimination across a range of OAA programs, but especially Title III B and Title III C.

Another essential part of the OAA is Title III C Nutrition Services. In the past, Generations had provided daily hot home delivered meals to homebound older adults for many years. Under our old model of services, meals were prepared out of our centralized kitchen, plated, packaged and delivered on hot or cold trucks door to door to nearly 1,000 older adults five days a week. Generations prioritized this service by diversifying funding with local donors to ensure that all individuals who met qualifications were provided a daily hot meal. As the economy shifted, gas prices rose and the cost of food increased, it became apparent that our day-to-day operations were going to have to change. We slowly made minor changes such as reducing routes, reducing delivery days, reducing food costs by changing vendors, and closing some of our sites. Ultimately by 2016, we had to make the very difficult decision to shut down local meal production and secure partnerships with home delivered meal providers for frozen/cold meals. We could no longer support the cost of providing daily, hot meals to all the rural communities in our six-county area due to stagnant federal funding that hasn't kept up with inflation-nor the growing need as our country's aging population has grown.

As we were progressing to the shift to frozen meal providers and Fed Ex/UPS meal delivery, we searched locally for partners who would be willing to contract with us to continue to provide hot meal preparation and delivery, even if we couldn't cover all of our planning and service area. We looked at hospitals, community centers, senior centers, long-term care providers, and restaurants. We were fortunate that three local organizations shared our passion for serving older adults in their community. We now have partnerships with a nursing home and two senior centers to provide hot meals in their surrounding area. All three of these sites offer home cooked, hot meals prepared daily to local residents who are homebound and over age 60.

Today we operate a hybrid program that is person centered and designed to meet the needs of the individual. A client can choose from up to six different frozen/cold home-delivered service providers, or, if they live in an area covered by a hot meal provider, they have that option as well. Last year, we provided over 106,000 nutritious meals to nearly 1,000 older adults in our planning and service area.

Our hope was to expand these local partnerships for hot meal delivery, but the funding isn't sufficient. This is even though need is growing in our community: over the past two years, we have seen a 20% increase in calls for meals and have more people accessing our services because they just can't afford groceries or other necessities.

Due to the continued rising cost of food, freight, delivery, and labor cost, it became apparent that we would need to increase reimbursement to our providers by 30% if they were going to continue to provide meals to our current clients. Increasing the reimbursement rate to keep qualified providers decreases our overall budget for the number of clients we can serve. The same amount of money simply cannot stretch to meet higher, necessary costs without reducing the numbers of people served, and it certainly cannot meet the increased need.

In addition, donations, grant support, and community support is down as donors themselves are tightening up their purse strings and prioritizing their own budgets. This has forced us to triage calls and provide meals only to the most at-risk individuals and put others on a waiting list, which is not something we have had to do historically. When older adults sit on a waiting list for nutrition services, it increases the risk of malnutrition, health deterioration and social isolation, in addition to the continued pain of hunger.

In the meantime, our trained and skilled AAA options counselors work with callers to provide alternatives to OAA home delivered or congregate meals, such as offering enrollment assistance for Supplemental Nutrition Assistance Program, or SNAP, benefits and referrals to food banks, food pantries, and local churches and other charities. However, those latter community resources are also under financial strain given increased need, leaving few options for the older adults in our area.

As a way to supplement the work we were doing with evidence-based health and wellness programs under Title III D we entered a partnership with USI on a GWEP grant which covers 12 counties in southern Indiana designated as a Health Profession Shortage area, rural and medically underserved. Other partners included three Deaconess primary care clinics, a family medicine residency program, two AAAs and two chapters of the Alzheimer's Association. Goals included to improve health outcomes for older adults through information, education, support and medical services. Falls, chronic illness, increasing incidence of dementia with longer longevity, nutrition, and mobility issues majorly affect this population.

As a result of the partnership, we have expanded our outreach for evidence-based programs under OAA Title III D. Programs such as A Matter of Balance (MOB) and the Chronic Disease Self-Management Program (CDSMP) have more than doubled in what were able to offer prior to the partnerships. We have increased the number of master trainers for both programs to five and lay leaders to almost 70. This has allowed us to provide education to more than 500 participants in the last five years. Outcomes from MOB analyzed in May 2023 show significant improvements, with individuals stating they are steadier, are walking more and have decreased fear of falling, which is in alignment with national statistics. CDSMP outcomes from post surveys indicated that all individuals had increased knowledge from the program and would refer a friend.

We also added another evidence-based fall prevention program, Bingocizer, which successfully reaches a different older adult audience. While we are proud to be able to offer these evidence-based programs through Title III D, the partnership with USI has allowed us to increase the scope of the programming. As the grant with USI comes to an end though, we are concerned that we will not be able to continue all the programs with the very limited funds we receive through Title III D. Generations and other rural AAAs around the country would benefit from new flexibility to also use Title III D monies to fund evidence-informed programs, which have the benefit of being lower in cost to operate and more adaptable to community needs or cultural factors.

Generations was created as a result of the Older Americans Act for the purpose of planning, pooling resources and coordinating services at the grassroots level. These are just a few examples of how we innovate and adapt to meet the needs of older adults in our rural area. As an organization, we encourage active participation in our communities. We live where we work and that makes a real difference in terms of local access and networking abilities, and that's true of our fellow AAAs and our service providers nationwide. Please keep the Act's inherent flexibility and locally driven structure in mind as you update the law this year.

To that end, I have several recommendations for the reauthorization of the Older Americans Act.

1. Increase OAA funding, both authorized funding levels and actual funding for FY 2025 and beyond. OAA funding has not kept pace with the growing number of older adults or inflation and funding is inadequate to meet even a fraction of the needs of those older adults most at risk.

2. Continue some of the flexibilities that were extended to AAAs during COVID such as flexibility between Congregate and Home Delivered meals which allowed AAAs to use the funding provided based on client needs. Or allow for the flexibility to fund innovative ideas in the nutrition program that meet the needs at the local level.

3. Allow Title III D health and wellness programs to be evidence-informed-not just evidence-based-to expand the Aging Network's ability to reach older adults with emerging interventions and to extend the reach especially in rural areas and other areas which have limited funding for this important work.

4. We also support USAging's reauthorization recommendations.

Thank you for the opportunity to testify today.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE OLDER AMERICANS ACT: THE LOCAL IMPACT OF THE LAW AND THE UPCOMING REAUTHORIZATION"

MAY 23, 2024

PREPARED WITNESS TESTIMONY

Leslie Grenfell

Chairman Casey, Ranking Member Braun, and members of the Senate Special Committee on Aging, thank you for the opportunity to testify before you today to discuss the Older Americans Act.

My name is Leslie Grenfell. I am the Executive Director of Southwestern Pennsylvania Area Agency on Aging, Inc., serving older adults residing in Fayette, Greene and Washington Counties. It has been an honor for me to serve as the Executive Director for the past twenty-three years.

In terms of population, Southwestern Pennsylvania Area Agency on Aging is the largest rural Area Agency on Aging, or AAA, in the Commonwealth. Its three-county service and planning area encompasses 2,223 square miles. The Agency acts as a community focal point providing information and assistance about services and programs, protecting older adults who are most vulnerable, assisting caregivers and their families, reducing food insecurity, and empowering older adults to live independently and age well.

Having worked in the Area Agency on Aging Network since 1976, I have witnessed the transformation and development of the Older Americans Act Programs and Services which have evolved from its early days as a nutrition program into a comprehensive and coordinated service delivery system for older adults who may be at risk of losing their independence.

Older Americans Act Programs

The Older Americans Act Nutrition Program is the cornerstone of the Older Americans Act and includes congregate, home-delivered, and grab-n-go meals, which were introduced during the COVID-19 pandemic. The flexibility of the grab-n-go meal option, where older adults can pick up a meal to take home, has been well-received by our consumers, especially those who are providing caregiver services to a loved one.

Our home-delivered meal providers are struggling. High costs, due to the increased cost of food, supplies, packaging, and staffing, the long distances between homes, and traveling on winding back-country roads or in mountainous areas, especially during inclement weather, can make delivery difficult. One of our most demanding routes is in the Laurel Highlands of Fayette County, called Kentuck Knob, which requires travel through State Game lands, is 32 miles long, and takes 54 minutes to complete.

Although challenging, the home-delivered meal providers have successfully developed and sustained a service delivery system utilizing dedicated volunteers who not only deliver hot, well-balanced nutritious meals five days a week, but also provide wellness checks to each older adult ensuring their safety and well-being. Last fiscal year, a total of 691 volunteers provided 97,638 hours of service and delivered 434,872 in-home meals to at-risk consumers.

The major challenges identified by our thirty-four home and community-based agencies who provide personal care services in rural communities are the costs associated with transportation due to the distance to consumer homes, the recruitment and retention of direct care workers, and the need for increased reimbursement.

Funding

Last fiscal year, the Southwestern Pennsylvania Area Agency on Aging received $591,073 in American Rescue Plan Act (ARPA) funds which provided a necessary infusion of financial support for the OAA nutrition program and the home and community-based program, permitting us to help a growing number of older adults.

With the number of older adults projected to continue to increase, there will be a corresponding growth in the need for services, and yet, no appreciable amount of additional Older Americans Act funding has occurred for over a decade. Increasing Older Americans Act funding and increasing its flexibility is a cost-effective finan-

cial investment which would enable older adults to stay healthy longer, living in their own homes and communities, whereby reducing the need for more costly long-term care interventions.

Looking Ahead

In 2023, the Pennsylvania Department of Aging began development of a 10- year Multisector Plan for Aging called Aging Our Way, PA. It is a state-led and stakeholder-driven strategic plan designed to help transform the infrastructure and coordination of services for older Pennsylvanians and persons with disabilities to reflect the needs and preferences of this population to live where they choose and to access the supports they need to thrive and age in place.

The network of AAAs was essential to the stakeholder process, which yielded over 20,000 responses from across the state. Each Area Agency on Aging engaged their local communities, encouraged community participation, and facilitated listening sessions at least one in each of the 67 counties and over 200 sessions in total.

From that engagement and those 20,000 responses, state government agencies, state experts in different areas of livability, and members of the Long-term Care Council developed Aging Our Way, PA's five priorities, and a number of strategies, and tactics. The AAAs are integral to many of the recommendations developed through this process and are looking forward to working with the Pennsylvania Department of Aging and other stakeholders.

In conclusion, I would like to especially thank Senator Casey for inviting me to provide testimony today. On August 5th, I will be retiring after 48 years in the Aging Network. It has been an honor and a privilege for me to share my insights with you and it is truly a wonderful capstone of my career!

Attachment to Testimony:

Aging Our Way, PA is Pennsylvania's ten-year Multisector Plan for Aging (MPA). This Plan is designed to address the needs and preferences of older adults and their caregivers in Pennsylvania and support the Commonwealth's preparedness as this older adult population grows dramatically over the next 15 years.

On May 25, 2023, Governor Shapiro signed Executive Order 2023-09, which directed the Pennsylvania Department of Aging (PDA) and agencies under his jurisdiction to develop this 10-year strategic plan that has been designed to help transform the infrastructure and coordination of services for Pennsylvania's older adults. Aging Our Way, PA defined by six key traits including:

•Necessary: The investments and improvements outlined in the Plan are needed for Pennsylvania to grow alongside its aging population.

•Stakeholder-Driver: community members were invited from across the state including Pennsylvanians over 60, caregivers, families, subject-matter experts, and community members to recommend improvements to the services and infrastructure in their communities.

•Collaborative: Drawn from stakeholder input, state agencies and community expert partners worked together to articulate the priorities, strategies, and tactics (initiatives) included in the plan.

•Achievable: To guarantee achievability, each Tactic has been refined in active partnership with the agencies responsible for its implementation.

•Responsive: The Plan is designed to adapt alongside shifting needs and resources over its ten-year timeframe.

•Effective: The Plan presents an opportunity for Pennsylvania's government to work smarter.

Pennsylvania's network of Area Agencies on Aging (AAAs) was essential to the stakeholder process that yielded over 20,000 responses from across the state. The AAAs engaged their local communities, encouraged community participation, and facilitated listening sessions at least one in every county and over 200 sessions in total. The AAAs structured these listening sessions around the AARP's eight Domains of Community Livability. These domains organize the holistic older adult experience related to transportation, engaging with government, volunteerism, employment, the need for navigation and getting information from trusted sources, respect and having a sense of belonging, social engagement and the challenges of social isolation and loneliness, access to health care including behavioral health and

long-term care, and most broadly, challenges with housing. From that engagement and those 20,000 responses, state government agencies, state experts in different areas of livability, and members of the Long-term Care Council drew out Aging Our Way, PA's five priorities, strategies, and tactics. The AAAs are integral to many of the recommendations developed through this process and are eager to work with the PDA and other Commonwealth agencies. The Plan's five priorities include:

•Unlocking Access: Eliminate barriers preventing equitable ability of older Pennsylvanians to live healthy, fulfilling lives.

•Aging in Community: Enable older Pennsylvanians to maintain secure housing, active community involvement, and familiar surroundings.

•Gateways to Independence: Promote older adults unhindered mobility and safe, convenient, and autonomous use of transportation.

•Caregiver Supports: Provide support, training, respite, and navigation tools to paid and unpaid caregivers.

•Education and Navigation: Streamline the resolution of complex problems faced by older adults through improvements to the connection, reach, and delivery of the services network.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE OLDER AMERICANS ACT: THE LOCAL IMPACT OF THE LAW AND THE UPCOMING REAUTHORIZATION"

MAY 23, 2024

PREPARED WITNESS TESTIMONY

Mairead Painter

Thank you, Chairman Casey, Ranking Member Braun, and distinguished members of the Senate Special Committee on Aging for inviting me here today. My name is Mairead Painter, and I am honored to serve as the State Long-Term Care Ombudsman for Connecticut. I appreciate the opportunity to offer this testimony to you regarding the critical role of Long-Term Care Ombudsman programs in protecting the health, safety, welfare, and rights of residents' in long-term care settings.

The term "ombudsman" originates from Sweden, where it means "representative." This concept has been adopted by several countries, including the United States, to ensure transparency and accountability within the government and organizations. As Long-Term Care Ombudsmen, we serve as independent advocates for older adults and individuals with disabilities who reside in nursing homes, assisted living facilities, and other small home settings, such as residential care homes many of whom cannot advocate for themselves.

My team in Connecticut, though small, is dedicated and formidable. It includes eight Regional Ombudsmen, two Intake Coordinators, one Administrative Assistant, and myself as the State Ombudsman, serving approximately 30,000 residents in 209 nursing homes and about 200 board and care facilities these are inclusive of residential care homes and assisted living communities. Additionally, we have recently expanded our program with state funding to serve approximately 50,000 individuals receiving home and community-based services. This expansion includes one Manager and one Regional Ombudsman.

Looking back, the Long-Term Care Ombudsman Program was established in the 1970s by President Nixon in response to widespread concerns over the conditions in nursing homes. Media reports and investigations at that time revealed pervasive abuse, neglect, and mismanagement. President Nixon's plan aimed to improve the quality of care in these facilities and address systemic issues such as inadequate care, poor conditions, and lack of accountability. From this initiative, the Long-Term Care Ombudsman Program was born in 1972 as a demonstration program.

In 1973, authority for the long-term care ombudsman demonstration was transferred to the Administration on Aging (AoA), which oversaw the project in several states, and in 1978, the long-term care ombudsman program was statutorily formalized through amendments to the Older Americans Act. In the following years, the ombudsman program was provided a separate authorization of appropriations, incorporated into Title VII of the Older Americans Act, and expanded to cover additional long-term care facilities.

In 2016, nearly 40 years after the functions of the LTCOP were delineated in the Older Americans Act, final regulations went into effect, providing more clarity and additional authority to the Long-Term Care Ombudsman Program in several areas.

All Ombudsman activities are performed on behalf of and at the direction of residents, with strict confidentiality. We provide direct services, including consultation, information about residents' rights, and investigation and resolution of complaints, contingent upon residents' consent. Additionally, we serve as a continuous resource for support. Our non-mandated reporter status reassures residents that their communications with us are confidential encouraging them to seek our guidance without fear of reprisal.

Our office frequently receives complaints concerning general care issues arising from insufficient staffing, which adversely affects residents' ability to have their basic needs met, such as assistance with getting out of bed to use the bathroom. In some cases, residents are informed that they must rotate which days they can get out of bed at all due to the lack of available staff to assist them daily.

Other complaints pertain to involuntary transfers and discharges. Residents may receive notices indicating they are being discharged from the facility or are instructed to leave immediately and are sent to a homeless shelter or hotel. Additionally, there

are instances where residents are sent to the hospital, and when the hospital is ready to discharge them, the facility refuses to readmit them.

In all these cases, our team works closely with the residents to ensure their rights are upheld and that proper procedures are followed. We strive to ensure that any discharge is conducted safely and appropriately. If residents wish to remain in the facility, we attempt to resolve the issues to maintain their facility as their home.

Despite an increase in additional care settings and models over the years, the Ombudsman program has not seen the corresponding increase in funding to manage this new workload. Many programs receive minimal state funding some programs, like Tennessee s, only receive enough state funding to pay the state ombudsman salary. This lack of investment on the state level, coupled with stagnant federal funding, hampers our ability to grow and meet increased demand resulting from older adult population growth and additional care settings. Without sufficient and stable funding, our capacity to fulfill the program's original intent identified as a critical need since its establishment in 1972 continues to decline.

Inadequate resources directly impact our ability to support and protect hundreds of thousands of older adults living in our communities and to respond to complaints. For example, half of the states do not have adequate staffing to meet the 1995 Institute of Medicine staffing ratio, which recommended one ombudsman per 2,000 beds. This report, while outdated, provides the most reliable staffing standard for the program to date. Although Connecticut is fortunate to have a relatively higher level of state support, our team members still manage caseloads nearly double the recommended standard. Currently, our program operates with approximately one Regional Ombudsman for every 3,800 long-term care beds. Despite these financial constraints, Ombudsman programs have expanded services to cover additional settings like assisted living facilities and small homes, further straining our resources.

Additionally, the increasing number of residents with complex care needs who depend on our advocacy underscores the necessity for Ombudsmen to be present and responsive. The original program relied heavily on volunteers, but today's complex care demands and cases often exceed what volunteers feel equipped to handle. Consequently, many volunteer-based programs have been diminished or eliminated. It is no longer feasible to run Ombudsman programs using volunteers as the program's backbone. We need to reevaluate our reliance on volunteers and how to best utilize their skills while adding more trained, paid Ombudsmen across the nation. Sufficient funding is required to make these staffing changes.

Most critical: funding limitations impede our ability to educate individuals, respond promptly to complaints, and monitor facilities to prevent crises

To begin to properly fund Ombudsman programs, we respectfully request the following funding for Fiscal Year 2025 for the benefit and safety of long-term care residents across our nation: $65 million for ombudsman services in assisted living facilities under Title VII of the Older Americans Act and $70 million for our current core funding under Title VII of the OAA. Increased and stable funding would enable us to hire additional staff, enhance our education and outreach programs, and provide stronger protections for elder justice.

This critical funding would not only improve residents' quality of life and well-being but also results in cost savings to the greater health care system. The Long-Term Care Ombudsman Program reduces the risk of individuals requiring Medicaid preemptively and reduces unnecessary trips to the hospital emergency room. Significant data show that when individuals feel they have a high quality of life, they report being in an overall better medical condition.

Although Ombudsmen may work as state employees or under the direction of a state Agency Director, our role requires independence and autonomy to effectively advocate on behalf of residents. This includes the ability to speak out on residents' behalf, regardless of where the program is housed, whether within a state agency or decentralized outside of one.

In addition to monitoring and responding to complaints, our program engages in education and outreach both at the facility level and within the broader community. We undertake rigorous systemic and legislative advocacy at state and federal levels to continuously improve and expand long-term care services and supports for your constituents. Our goal is to empower residents to have a direct voice in policies and legislation that affect them. When this is not feasible, we advocate on their behalf before governmental agencies or policymakers.

Until I became the State Ombudsman in Connecticut, I did not realize how fortunate I was to be part of this ombudsman program. Once I got to know other state ombudsmens, I began to realize that I have an independence and autonomy that is not only federally mandated under the Older Americans Act but is not possible for some of my peers in other states. For example, at a recent conference, as a Board Member of the National Association of State Long-Term Care Ombudsman Programs, I raised questions related to interference with the Ombudsman office. This inference directly impacts state ombudsmen's efforts to advocate for changes to state or federal laws, comment to the media, or talk with legislators about concerns constituents face.

I can ask these questions because in my state I have the autonomy and support to speak freely on behalf of the individuals I serve. However, the conference was being livestreamed, and I know other state ombudsmens would be concerned someone from their state might see them ask the question; it could result in consequences when they return to their home state. Some State ombudsmen have reported that in their state, their comments are controlled by their managers or senior officials, or they are told they cannot make comments to the media or speak to legislators independently at all. This is unsettling because Ombudsmen must have the independence and autonomy this position was intended to have and advocate in a bipartisan way on behalf of the people we serve and truly be their voice. This is foundational to our position as State Ombudsmen, which was created to represent them and inform all of you.

This leads me to one of the reasons it is essential that the National Director position for the Long-Term Care Ombudsman Program be refilled. Although the current leadership at the Administration for Community Living has been extremely supportive of the program, it is necessary to have an independent voice advocating for our role and needs without any conflict of interest. At the state level, Ombudsmen are not able to be housed within the same agency as Adult Protective Services due to concerns over conflict of interest. However, at the federal level, we report to the same Director. This inherently creates a conflict when trying to advocate for the interests of both programs related to funding and support. As the representative of state ombudsmen across the country, we strongly urge you to reinstate the National Director of the Ombudsman Program. It is crucial that we have an independent national director who can represent ombudsmen without any potential conflicts of interest.

I want to thank you for allowing me to offer this testimony. Many individuals are still unaware of our role, their rights, or the standards of care they should expect when receiving long-term services and supports. As Ombudsmen, our goal is to continue to protect the health, safety, welfare, and rights of all individuals receiving long-term services and supports.

Respectfully,
/s/
Mairead Painter,
Connecticut State Long Term Care Ombudsman

Questions for the Record

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE OLDER AMERICANS ACT: THE LOCAL IMPACT OF THE LAW AND THE UPCOMING REAUTHORIZATION"

MAY 23, 2024

QUESTIONS FOR THE RECORD

Janet Billotte

Senator Raphael Warnock

Question:

According to research from 2020, Georgia ranks in the top 10 worst states for food insecurity among seniors.[1] However, in the most recent government funding bill, the Older Americans Act's (OAA) Title III nutrition programs were funded at $8.1 million less than the previous year.[2] We owe it to our seniors to increase funding and strengthen nutrition programs.

Ms. Billotte, how have nutrition programs authorized under the OAA, like Meals on Wheels, helped you?

Response:

I would be happy to answer questions of the nutrition balance of the Meals on Wheels. For protein, chicken, fish, ham, pork, and turkey are on a monthly menu. A balance of vegetables like broccoli, brussels sprouts, carrots, green beans, potatoes and sweet potatoes, spinach and tomatoes are delivered with meals. Wheat bread or a muffin or a dinner roll. Fruit or pudding or cookies. Milk of 2% is delivered with each meal.

[1] Key Statistics on Seniors Hunger, Georgia Department of Human Services Division of Aging Services, https://aging.georgia.gov/key-statistics-senior-hunger.

[2] Kirsten Colello and Angela Napili, Older Americans Act: Overview and Funding, Congressional Research Service, (May 6, 2024), https://www.crs.gov/Reports/R43414.

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MAY 23, 2024

QUESTIONS FOR THE RECORD

Laura Holscher

Chariman Robert P. Casey, Jr.

Question:

In 2021, Democrats passed the American Rescue Plan Act, which provided significant funds and flexibility for federal programs, including those authorized through OAA. This funding was critical to the success of Area Agencies on Aging (AAAs) during the pandemic. It was especially crucial because funding through annual appropriations has not matched the levels authorized in the 2020 reauthorization of OAA. In fact, in Fiscal Year 2024, Older Americans Act programs should have received $450 million more in funding than was appropriated.

Ms. Holscher, how did the American Rescue Plan funds assist service delivery at your Area Agencies on Aging? How does the expiration of those funds affect the older adults you serve and the people you employ?

Response:

As a result of the American Rescue Plan funds, we were able to provide over 18,000 additional meals ensuring no one would go on the waiting list, and we provided 8,000 additional respite hours for caregivers; we doubled the number of evidence-based programs we were able to offer and provided some much-needed one-time services such as home modifications, durable medical equipment and pest control services allowing older adults to remain safely in their homes. We used the funds to kick off some new projects such as technology 101 classes, art programs for people living with dementia and activity packets for those that are homebound and at risk of becoming socially isolated.

We have used all the additional funds made available through the American Rescue Plan and are now looking at scaling back these programs. We are currently only providing meals and respite to the most at-risk individuals, and the waiting list is growing. We have scaled back our new initiatives and may have to eliminate one or more of the evidence-based programs we provide. Finally, we had to decrease our workforce by three FTEs to accommodate the loss of funds.

Allowing AAAs to pilot new projects such as online payments to Uber Eats or partnering with local food trucks to set up in rural communities would enhance our ability to meet the needs of older adults in small communities. We need the flexibility to come up with new ideas that allow us to make the best use of the dollars to meet the needs that best serve our communities.

It goes without saying we could use funding at the same levels we received from the American Rescue Plan, but continuing the flexibility in Older Americans Act TIII-C that was extended to the AAA's during the public health emergency would increase our ability to utilize current funding to best meet the needs in our local communities.

Question:

The Older Americans Act is intended to target those with the greatest social need and greatest economic need, which includes many rural older adults. However, rural populations, while older, poorer, and sicker, are often left out of many social safety net programs, including OAA meal programs. This is a population that has seen a lot of other supports in their community move away-including hospitals, grocery stores, and community centers. There is a need to provide targeted support, particularly nutrition services and transportation, to rural older adults.

Ms. Holscher, what are some of the challenges that rural providers face when trying to reach rural older adults? What can we do within OAA to ensure this population has access to the same services as urban and suburban older adults?

Response:

Some of the challenges we face as a rural community include the lack of broadband internet and limited access to transportation, both of which limit access to healthcare and social opportunities.

While TIII-B is the most flexible of the Titles under the Older Americans Act, additional funding and/or increased flexibility would go a long way to help us address the challenges of rural communities. Increased flexibility would allow us the opportunity to subsidize service connectivity, provide digital literacy training and increase access to telemedicine for older adults.

Affordable, accessible transportation has always been a challenge in rural communities, and in many areas, public transportation systems such as buses, subways etc. will never be an option. We would like the flexibility to include reimbursement for ride-share services and mileage expense for privately owned vehicles as an eligible activity under TIII-B services.

Additionally, we would benefit from the flexibility of using TIII-D for evidence-informed programs which are lower in cost and more adaptable to our local communities.

To sum it up, I would recommend an increase in OAA funding, which has not kept pace with the growing number of older adults or inflation. I would also strongly encourage enhanced flexibility in transfers between Titles and allowable services within the Titles.

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MAY 23, 2024

QUESTIONS FOR THE RECORD

Leslie Grenfell

Chariman Robert P. Casey, Jr.

Question:

In 2021, Democrats passed the American Rescue Plan Act, which provided significant funds and flexibility for federal programs, including those authorized through OAA. This funding was critical to the success of Area Agencies on Aging (AAAs) during the pandemic. It was especially crucial because funding through annual appropriations has not matched the levels authorized in the 2020 reauthorization of OAA. In fact, in Fiscal Year 2024, Older Americans Act programs should have received $450 million more in funding than was appropriated.

Ms. Grenfell, how did the American Rescue Plan funds assist service delivery at your Area Agencies on Aging? How does the expiration of those funds affect the older adults you serve and the people you employ?

Response:

The American Rescue Plan Act (ARPA) funds were critical to meeting the needs of older adults in our planning and service area as we began recovering from the COVID-19 pandemic. Serving as a lifeline, the ARPA funds provided the flexibility needed to ensure local needs such as increased requests for home-delivered meals and community-based services were met during those uncertain and challenging times. However, Area Agencies on Aging continue to struggle with the recruitment and retention of staff and providers, cost inflation and the rapidly growing elderly population who are in need of OAA services and programs. With the ARPA funds expiring, additional OAA financial support is now critical to offset staff reductions in force, long waiting lists for in-home services and the creation of a waiting list for home-delivered meals. While funding levels have not increased over the past two decades, the cost of labor, food, supplies and infrastructure has continued to escalate. Significant increases in authorized funding levels is urgently needed to meet the rising costs of service delivery.

Question:

The Older Americans Act is intended to target those with the greatest social need and greatest economic need, which includes many rural older adults. However, rural populations, while older, poorer, and sicker, are often left out of many social safety net programs, including OAA meal programs. This is a population that has seen a lot of other supports in their community move away-including hospitals, grocery stores, and community centers. There is a need to provide targeted support, particularly nutrition services and transportation, to rural older adults.

Ms. Grenfell, what are some of the challenges that rural providers face when trying to reach rural older adults? What can we do within OAA to ensure this population has access to the same services as urban and suburban older adults?

Response:

By highlighting the challenges that rural older adults face in accessing necessary services in the OAA, we can work to ensure that rural older adults have the same access as their urban and suburban counter parts. The Older Americans Act places emphasis on prioritizing populations with the greatest economic and/or greatest social need. According to the Office of Policy Development and Research, rates of poverty among rural older adults is higher than metro and suburban areas. This exemplifies the need for highlighting rural older adults as part of those in greatest economic need.

The federal final rule assisted in clarifying what should be considered for the "greatest social need", including physical and mental disabilities, language barriers and cultural, social or geographical isolation. Providing a definition of social isolation as it relates to rural older adults and greatest social need would encourage

State Units on Aging to reevaluate their intrastate funding formulas (IFF) to prioritize rural populations that have often been forgotten. By underscoring the importance of addressing rural older adult population in the Older Americans Act, state units can begin to focus on some of the disparities seen between urban and rural communities and provide the access rural older adults need to quality services and programs.

A significant challenge that rural providers face is difficulty recruiting direct care workers. While challenging in any setting, recruitment in rural communities is especially difficult due to many direct care workers not having access to a vehicle to reach remote areas or the inability of providers to reimburse for mileage and other expenses, making rural service provision cost prohibitive. As a result, many rural elders are not receiving the care they need, leaving them socially isolated and at increased risk of self-neglect. Others are not obtaining consistent care, resulting in frequent and costly emergency room visits, hospital admissions and nursing facility stays.

Any efforts to strengthen the direct care workforce through the OAA will increase rural older adult access to these much needed services and also enhance support to rural caregivers of older adults. A suggestion is to support the National Council on Agency's Direct Care Workforce Strategies Center.

Question:

The National Family Caregiver Support Program, authorized through Title III-E of the Older Americans Act, provides critical support to family caregivers across the Nation. Many of these caregivers include older adults caring for a grandchild, great-grandchild, or other loved one-this is especially true as a result of the COVID-19 pandemic and the ongoing opioid crisis. In the last reauthorization of the Older Americans Act, I ensured the resources provided through the National Family Caregiver Support Program would reach those families.

Ms. Grenfell, as a AAA director, what additional supports within OAA would be most helpful for the older adults you serve who are also raising grandchildren, other relatives, or close family friends?

Response:

Over the last several years, our Agency has encountered, but has not been able to serve, many elders caring for related children who are younger than the minimum eligible age of 55. I recommend consideration of lowering the minimum age of eligibility in the National Family Caregiver Support Program (NFCSP) for older adults caring for related children to 50 years old.

In our experience, some children receiving support from older adult relatives enrolled in the NFCSP have aged out of the program while they are still in need of assistance.

I recommend extending the age limit to twenty-one or twenty-two years of age in extenuating circumstances such as:

•If the child is enrolled in the school system with an Individualized Education Plan (IEP) and can remain in the school system until age 21.

•If the child has an intellectual disability, is physically disabled, or has a behavioral health diagnosis that limits their ability to obtain employment.

Question:

Ms. Grenfell, throughout your career, you've helped tens of thousands of older adults, maybe even more, access services that enable them to live healthy, independent, and full lives. You've seen the direct impact that OAA programs have on older adults in your community. One of the defining factors of the Older Americans Act is the age of eligibility. Older adults ages 60 and older, and for some programs, ages 55 and older, can receive the services they need.

Ms. Grenfell, why is it so important, especially in rural communities like yours, that Older Americans Act programs continue to serve those 60 years and older?

Response:

As previously noted, rural older adults face unique challenges in accessing the same services as their urban counterparts. Older Americans Act programs are vital to ensuring rural older adults continue to live in their homes and communities.

With the number of rapidly growing older adults, it is important that the OAA continues to be primarily focused on the needs of older adults aged 60 and older especially in rural areas where there is a lack of community resources and the OAA funding is often necessary to fill the service gap.

Senator Raphael Warnock

Question:

According to research from 2020, Georgia ranks in the top 10 worst states for food insecurity among seniors.[1] However, in the most recent government funding bill, the Older Americans Act's (OAA) Title III nutrition programs were funded at $8.1 million less than the previous year.[2] We owe it to our seniors to increase funding and strengthen nutrition programs.

Ms. Grenfell, how can Congress modernize the Title III C nutrition funding stream[3] to improve meal services for seniors?

Response:

Obtaining adequate nutrition can be challenging for rural seniors due to limited financial resources and the lack of available transportation, as well as access and proximity to a grocery store.

Congress has the opportunity to modernize the Title III C Nutrition Program by consolidating the funding streams to enable increased flexibility at the local AAA level. Such an action would increase innovation and creativity necessary to revitalize the nutrition program to address the requests of current consumers for more culturally appropriate menus and to serve the next generation of elders who are seeking more person-centered service options such as medically tailored meals.

One overreaching goal of the OAA is that the services for older persons must be delivered through a comprehensive plan which is based upon an assessment of the local planning and service area and its resources. Toward that end, the aging network should have the flexibility necessary to determine the programs and supports that most effectively and efficiently address the needs of older adults and caregivers in their communities.

Question:

Area Agencies on Aging (AAAs) offer critical services for seniors across the country. Georgia's 12 AAAs do exceptional work providing resources and care to older Georgians.[4] However, the aging population is growing rapidly, and AAAs across the country may need increased funding to meet the real and urgent needs of their community.[5]

Ms. Grenfell, can you explain how AAAs could benefit from increased funding levels in this year's OAA reauthorization?

Response:

The fastest growing segment of the older adult population is older adults aged 85 and older. In our planning and service area, the number of older adults aged 85 and older is predicted to nearly double between 2030 and 2050. These older adults are the most likely to need the services and supports provided by AAAs in order to continue to live independently in their own homes and communities. Already, about 45% of the older adults our Agency serves are aged 80 and older. Many AAAs, including ours, are forced to maintain a waiting list for in-home services. Increased funding levels would allow AAAs to increase the number of older adults served and the amount of services provided, which would allow older adults to ″age in place″ and prevent or delay costly institutionalization.

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[1] Key Statistics on Seniors Hunger, Georgia Department of Human Services Division of Aging Services, https://aging.georgia.gov/key-statistics-senior-hunger.

[2] Kirsten Colello and Angela Napili, Older Americans Act: Overview and Funding, Congressional Research Service, (May 6, 2024), https://www.crs.gov/Reports/R43414.

[3] See Nutrition Services, Administration for Community Living, https://acl.gov/programs/health-wellness/nutrition-services.

[4] Aging & Disability Resource Connection, Georgia Department of Human Services, https://dhs.georgia.gov/aging-disability-resource-connection.

[5] Becky Kurtz, Request for Information - Older Americans Act Reauthorization, Atlanta Regional Commission (Mar. 21, 2024).

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE OLDER AMERICANS ACT: THE LOCAL IMPACT OF THE LAW AND THE UPCOMING REAUTHORIZATION"

MAY 23, 2024

QUESTIONS FOR THE RECORD

Mairead Painter

Chariman Robert P. Casey, Jr.

Question:

Ombudsmen are uniquely positioned to understand resident needs and to get to know the residents they serve and the facilities they monitor. This, in turn, allows ombudsmen to effectively identify issues and to advocate for their needs.

Ms. Painter, can you explain why ombudsmen are unique in providing this service? How does their status allow them to identify issues more easily than other agencies?

Response:

Residents direct the actions of an Ombudsmen. All conversations with ombudsmen are completely confidential unless the resident grants consent to proceed with taking action. This confidentiality allows residents to speak freely, gain perspective on their concerns, and decide how they wish to address issues without fear of real or perceived retaliation. Additionally, ombudsmen regularly visit long-term care facilities to engage with residents who may be unaware of the program. These visits provide an opportunity to inform residents of their rights and address issues before they escalate and to help individuals learn how to make their needs known and advocate for themselves. This support offered by ombudsmen is unparalleled by any other agency. As the only oversight agency that has a regular presence in facilities, ombudsmen can identify systemic concerns through their observations and resident interactions. These issues can then be addressed directly with the facility by the ombudsman and resolved in a timely manner. When this occurs, resident care and satisfaction can be quickly improved, while potentially lessening the risk of costly citations. Ombudsman intervention and support helps to improve the quality of care and quality of life for individuals living in long term care and can be a cost saving on many levels of the greater health care system by resolving care concerns before they escalate.

Question:

The Older Americans Act reauthorization process provides us with an opportunity to look at what has changed in the last four years since the 2020 reauthorization, what innovations were critical throughout the COVID-19 pandemic, and what needs are still not being met.

Ms. Painter, how have you seen the needs of older adults evolve over your careers and where is modernization needed most within the Older Americans Act?

Response:

Over my career, I have observed many ways in which the needs of older adults have evolved but believe there are three significant areas where modernization is necessary in relation to the Older Americans Act.

First, the complexity of care needs for older adults has increased. Advances in modern medicine have led to longer lifespans, resulting in more complex health needs. Additionally, there has been a rise in individuals facing health-related conditions due to lifestyle choices, substance use diagnosis or seeking mental wellness as they age. This trend is evident not only in the broader community, where issues such as loneliness and poor health are prevalent, but also within long-term care facilities. We are also seeing an increase in residents diagnosed with traumatic brain injuries, cognitive related deficits, mental health diagnoses, and physical limitations resulting in the need for staff that are highly skilled and trained to serve a population with complex physical and psychosocial needs.

Second, the Olmstead Act has brought positive changes by allowing individuals to choose where they receive their long-term services and supports. Many ombudsman programs spend a great deal of time supporting individuals working to transition to the least restrictive environment. It is crucial to ensure that these individuals

have access to the protection of their rights regardless of where they choose to receive their long-term services and supports. Currently, the Older Americans Act does not permit Ombudsman funding to support individuals who opt for long-term services and supports in the greater community beyond six months after transitioning from a nursing home. Only a few states even offer this level of support individuals, so this identifies a significant gap in rights protections while resulting in a potential significant cost savings to states and the federal government.

Ombudsmen oversee Residential Care Facilities for older adults, and individuals with disabilities that are often not regulated or licensed to the same level of Skilled Nursing Facilities. In these facilities there are no minimum staffing requirements, training requirements are weak, and in these communities, ombudsmen often identify cases of significant abuse and neglect. Examples of people who live in residential care facilities could be individuals who want to stay in their local community but require either financial or independent living support but are not in need of a skilled nursing facility. They could be a veteran or other community members, for example in CA there are over 8,000 residential care facilities that house over 200,000 residents and members of their community on a daily basis.

Third, the Elder Justice Act has introduced additional protections for older adults, including many individuals served by Ombudsmen. However, the expansion of these protections has increased the demands and scope of work for our program. The OAA should be modernized by authorizing funding at levels proportionate to the numbers of older Americans in need so that we are able to provide services to all eligible older Americans without delay. When we don't respond quickly to complaints and routinely monitor resident care, residents are at risk of dangerous outcomes.

Senator Raphael Warnock

Question:

Georgia has some of the highest rates of people living with human immunodeficiency virus (HIV) in the country.[1] In 2021, nearly 32 percent of Georgians living with HIV were over the age of 55.[2] Because of advancements in treatment, people with HIV are living longer.[3] We must invest in services for the aging population of those with HIV.

Ms. Painter, can you elaborate on the unique health needs of the aging population of people with HIV? How could new investments in the OAA benefit this population?

Response:

The ombudsman program supports individuals residing in long term care facilities, residential care homes and assisted living communities and individuals with HIV most likely live in these communities that we serve. HIV, like any other infectious diseases, requires long-term care providers to be inclusive of the person, meet their individual needs, have knowledge of and apply good infection prevention and control practices.

I think it is important that all members of our community know that they are welcome, that they deserve and are entitled to high quality care, not matter where they receive it. For this reason, I think that it is important that the OAA provide access to programs that reduce isolation and loneliness, keeping people connected to their greater community and providing education and outreach. Individuals with HIV who live in long-term care facilities or residential care communities would benefit from ombudsmen with adequate stable funding to hire staff ombudsmen that are highly skilled and trained to help them achieve this. No matter what an individual's diagnosis is, Ombudsmen need to be able to serve anyone with complex physical and psychosocial needs, offering them support when needed and protecting their rights.

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[1] Sofia Gratas, Georgia Has Some of the Highest HIV Rates in the Country, but Treatment Has Never Been Easier, Georgia Public Broadcasting (Jul. 1, 2022), https://www.gpb.org/news/2022/07/01/georgia-has-some-of-the-highest-hiv-rates-in-the-country-treatment-has-never-been.

[2] Local Data: Georgia, AIDSVu, https://aidsvu.org/local-data/united-states/south/georgia.

[3] Brian Altman, Older Adults with HIV/AIDS: A Growing Population, Administration for Community Living (Sept. 18, 2021), https://acl.gov/news-and-events/acl-blog/older-adults-hivaids-growing-population.

Statements for the Record

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE OLDER AMERICANS ACT: THE LOCAL IMPACT OF THE LAW AND THE UPCOMING REAUTHORIZATION"

MAY 23, 2024

STATEMENT FOR THE RECORD

National Council on Aging Testimony

Introduction

Chairman Casey, Ranking Member Braun, and members of the Senate Committee, thank you for convening this hearing to highlight the local impact of the Older Americans Act (OAA) as you engage in this year's reauthorization process.

The National Council on Aging (NCOA) is the nation's oldest organization focused on serving older adults. For nearly 75 years, we have worked to improve the lives of older Americans, especially vulnerable and underserved populations. From advocating for passage of the original Older Americans Act, Medicare, and Medicaid, to helping end mandatory retirement, NCOA has operated under the principle that aging well in America should be a right for all, not a privilege for a few.

NCOA's goal is to improve the health and economic security of 40 million older adults by 2030, especially women, people of color, LGBTQ+, low-income, and rural individuals. Working with thousands of national and local partners, we provide resources, tools, best practices, and advocacy to ensure every person can age with health and financial security. Every day, our team works to help individuals secure job training and placement, enroll in programs that help with the cost of food and medicine, better manage their chronic conditions like diabetes and hypertension, and prevent falls. All our insights from our direct service delivery inform our reauthorization recommendations.

The OAA is integral to achieving NCOA's vision of a just and caring society in which each of us, as we age, lives with dignity, purpose, and security. First enacted in 1965, the OAA establishes priorities and operations for key programs and services that help keep our nation's adults ages 60 and older healthy and independent.

The OAA is the designated vehicle to plan for and provide professional assistance to older Americans and their families, providing the many nonmedical care services that older adults often need and complementing the support provided by Medicare, Medicaid, and Social Security. The Act provides the blueprint that encompasses the full range of services and supports that address vital social determinants of health and allow all of us to age well in community and at home as desired. Further, OAA-funded services and supports have been shown to reduce health care costs and delay nursing home placement.[1] Given that greater than 90% of older adults live in communities,[2] we must recognize the OAA's critical role in supporting family caregivers who are the backbone of long-term care for older adults.
different-residential-settings-data-sourcestrends-0#exhibit2

Today's realities demand that we examine the OAA with fresh eyes and with innovation at the forefront. The OAA must be modernized to better address the needs of the diverse and growing older adult population, which includes not only the Silent Generation and Baby Boomers, but also Generation X, whose members start to turn 60 in 2025.

NCOA Reauthorization Priorities

Investing in the Aging Services Network, including the thousands of multipurpose senior centers and other community organizations, is crucial to the Act's success now and in the future. While demand for OAA services is growing and diversifying, OAA funding is not keeping pace. This financial reality has made it increasingly difficult for the Aging Network to maintain existing services, let alone expand. The supplemental funding Congress provided to the Aging Network during the COVID-19 pandemic was critical to helping older adults most at risk and in greatest need and sharply underscored the value of and critical need for additional investment in OAA programs. Ten leading national advocates for the OAA have praised bipartisan

[1] https://www.liebertpub.com/doi/10.1089/pop.2017.0199
[2] https://aspe.hhs.gov/reports/understanding-characteristics-older-adults-

efforts to reauthorize the statute in 2024 and called for authorizing increased funding for these critical programs at the highest possible levels to ensure that all older people can thrive.[3]

NCOA has several additional priorities that we believe should be included in this year's OAA reauthorization. Our proposals focus broadly on senior centers, healthy aging, and economic security.

Seniors Centers

For more than 80 years, senior centers have provided access to support services and opportunities for healthy aging in a highly social setting in towns and neighborhoods across the nation. The OAA has recognized their importance for 50 years by including multipurpose senior centers in 1973 and by establishing the senior nutrition program. In the establishment of the Aging Network, senior centers were to be given special consideration as community focal points to deliver OAA services on a local level. Today, an estimated 11,000 senior centers operate locally, sometimes hyper-locally, as gathering places for generations of older adults to stay active, healthy, and connected.

Research shows that older adults who participate in senior center programs experience better mental health across several measures compared to non-participants, including perceived social and health benefits,[4] depression,[5] friendship,[6] and stress levels.[7] Compared to their peers, senior center participants have higher levels of health, social interaction, and life satisfaction.

Senior centers are a time-tested model to deliver on the promise of the Older Americans Act. They provide for the -maximum co-location of services, which differentiates them from other community-based organizations. A visitor to a senior center can come to exercise and also get screened for benefits, take an art class and get a hot meal, or learn a new language and find purpose through volunteering. At their core, senior centers are places that foster social connection and belonging, addressing the epidemic of loneliness[8] identified by the U.S. Surgeon General.

Senior centers also serve as critical lifelines for many older adults in the community. This was never more evident as during the pandemic that brought a disproportionately harsh impact on older adults. Senior centers across the country sprang into action, ensuring that older adults, especially the most vulnerable, had credible information; access to nutrition through meal delivery, grab-and-go meals, and grocery shopping services; and social engagement through online programs, parking lot parties, drive-through programs, and thousands upon thousands of phone calls. With deep knowledge of their communities, senior centers creatively pivoted to meet ever-changing needs. Many moved programs from in-person to virtual. Today, their in-person participation is rebounding, and those with capacity continue to offer virtual options for older adults who cannot attend the center due to transportation or health issues. When vaccines became available, senior centers stepped in to facilitate appointments, provide transportation, and host clinics.

While they provide these critical services, senior centers, in general, are chronically underfunded. They rely on municipal dollars, philanthropy, and fundraising. While some are operated by Area Agencies on Aging (AAAs), especially when the AAA is part of county government, most are not. They are part of municipal government or nonprofit community-based organizations. In 1978's Older Americans Act reauthorization, senior centers were placed in the consolidated Title III-B, Supportive Services and Senior Centers. In the allocation of scarce resources and without a requirement that any percentage of the appropriation for III-B be directed to senior centers, senior centers generally are not funded by the OAA. They might receive funding on a service unit reimbursement rate (e.g., for meal delivery) but not for general programs, operations, or facility needs. Senior centers that received investments from the American Rescue Plan (ARPA) saw innovations that were not pos-

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[3] https://www.ncoa.org/older-americans-act-reauthorization

[4] Gitelson, R., McCabe, J., Fitzpatrick, T., & Case, A. (2005). Factors that influence perceived social and health benefits of attendance at senior centers. Activities, Adaptation & Aging, 30, 23-45.

[5] Choi, N., & McDougall, G. (2007). Comparison of depressive symptoms between homebound older adults and ambulatory older adults. Aging Mental Health, 11, 310-322.

[6] Aday, R., Kehoe, G., & Farney, L. (2006). The impact of senior center friendships on aging women who live alone. Journal of Women & Aging, 18, 57-73.

[7] Farone, D., Fitzpatrick, T., & Tran, T. (2005). Use of senior centers as a moderator of stress-related distress among Latino elders. Journal of Gerontological Social Work, 46, 65-83.

[8] https://www.hhs.gov/sites/default/files/surgeon-general-social-connection-advisory.pdf

sible before. ARPA was an infusion of funding that supported innovations like grab-and-go meals, allowed communities to make renovations or purchase equipment (for exercise, technology, kitchens, etc.), and shored up the senior nutrition program. ARPA showed us what was possible with better support. However, once ARPA funds are expended, those innovations will not likely be funded, and the programs that were supported will, again, face budget shortfalls.

NCOA has been the national voice for senior centers for more than 50 years. We have over 2,300 senior centers in our affiliate network and, through a three-year cooperative agreement with the U.S. Administration for Community Living (ACL), we have established a Resource Center for the modernization of senior centers. Through this work, we see some senior centers that are modernizing and thriving with new or renovated facilities that support today's technological needs, fitness programs, evidence-based programs, meal options, and services to address complex issues like homelessness and behavioral health. These centers also provide support for economic security through information and referral and benefits enrollment. They have collaborative partnerships with organizations and businesses in their communities, with aging network partners like AAAs, and with community partners like libraries, parks and recreation, and public health. New models of senior centers, including public/private partnerships, wellness centers, and intergenerational centers have been developed.

2023 Programs of Excellence

Among the senior centers receiving a 2023 Programs of Excellence award from NCOA is the Veterans Coffee Club administered by the Muncie/Delaware County Senior Citizens Center in Muncie, Indiana.[9] This special military suicide prevention program was created with support from the VA Delaware County Indiana. The goal is not only to create and design a program to help prevent military suicides, but to develop, with the cooperation of the Veterans Administration, a suicide prevention program that can be introduced to the 10,000+ senior centers across the country.

Initiated in response to staggering rates of suicide, the program started out with four veterans from the center, and currently, there are 237 registered members. A wives support group meets at the same time for those veterans who will only attend if their wife goes, and for Gold Star and Blue Star wives. The program continues to grow, with a club established in Anderson, Indiana, and two more clubs in the works one in Marion and one in New Castle.

All these efforts aim to find a way to reach veterans where they are, not just reach out and hope they come get help. Typical attendance is 80-100 veterans on the first Saturday of every month, and several of the veterans now attend programs at the senior center on a regular basis, but not all senior centers are thriving. NCOA conducted an environmental scan, which identified the successes and challenges of senior centers today. Inadequate support, both in recognition of their value and in the allocation of resources, is at the top of the list of challenges.[10] Centers do not have the funding and direction needed to upgrade their facilities, to access technology, and to ensure a skilled workforce. The centers that struggle the most are those in areas of greatest need.
challenges-and-opportunities

Through OAA reauthorization, Congress has an opportunity and obligation to provide the focus and funding that will ensure that a modern senior center one that addresses the needs of current and future generations of older adults in a way that is culturally meaningful is available in every ZIP code.

Senior centers are also an integral part of the OAA senior nutrition program. The OAA created two delivery systems for nutrition congregate meals (Title III-C1) and, for those unable to access a congregate meal, home-delivered meals (Title III-C2). The pandemic demonstrated the importance of elevating both home-delivered meals and congregate meals as equally important vehicles for fighting senior hunger and addressing social isolation. These proven and effective community-based programs have more than 50 years of experience, expertise, and trust to serve those in greatest need. However, with rising costs and increasing demand, merely maintaining current funding levels is not enough. We need to increase the authorization level and provide greater parity to support both approaches at scale.

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[9] https://www.ncoa.org/article/nisc-programs-of-excellence-veterans-coffee-club
[10] https://www.ncoa.org/article/the-state-of-todays-senior-centers-successes-

Senior centers are the most common site for congregate meals. During the pandemic, we saw innovation in meal delivery such as grab-and-go meals and virtual options for dining with friends. The flexibility to implement innovative solutions should be maintained and encouraged, as should local flexibility, with limits, to shift funds to the most-needed services. However, the OAA should continue to recognize and prioritize them as distinct programs and fund each one adequately. Sharing a meal is one of the most treasured traditions of social connection. We must support the modernization of the congregate meal, in conjunction with senior centers, to ensure current and future generations of older adults have this opportunity.

OAA reauthorization should:

•Address lessons learned from the pandemic related to promoting equitable access to senior center services, addressing diverse needs, and pursuing innovation in nutrition programs.

•Ensure strong congregate settings in the community by reinstating a separate title for senior centers and updated language that retains the special consideration of senior centers as designated focal points and by strengthening support for multipurpose senior center infrastructure and services, while allowing for the flexibility capacity for virtual connections.

•Strengthen the authorization for modernizing senior centers.

•Increase the authorization level of senior nutrition programs to allow for greater parity for both home-delivered meals and congregate meals approaches to be equally funded at scale.

Healthy Aging

Title III-D Health Promotion

Chronic conditions are the leading cause of frailty, disability, and death in the United States. They lead to declining activities of daily living (ADLs), causing affected individuals to lose their independence, require help from family and/or paid caregivers, and need long-term services and supports. Yet, there are evidence-based health promotion and disease prevention programs that we know can help and work.

NCOA has been a leader in expanding access to health promotion and disease prevention programs, many of which have been shown through research to reduce or delay expensive hospital or nursing home admissions. Through education, outreach, and community programs, NCOA provides older Americans with the tools and resources they need to age well physically, cognitively, and mentally. Through our ACL-funded National Chronic Disease Self-Management Education and Falls Prevention Resource Centers, NCOA provides broad support and technical assistance to state agencies and community-based organizations delivering these programs.

These health promotion and disease prevention programs result in positive health outcomes related to managing chronic disease, preventing falls, increasing physical activity, and reducing symptoms of depression and social isolation. These well-researched programs have resulted in health care cost savings for participants:[11]
saving-money-infographic

•A Matter of Balance, a falls prevention program, reduces total annual medical costs by $938 per participant.

•The Otago Exercise Program reduces falls by 35%, resulting in net savings of $429 per participant.

•The Community Aging in Place Advancing Better Living for Elders Program (CAPABLE) provides home modifications to reduce falls risks resulting in more than $30,000 in medical costs savings.

•The Chronic Disease Self-Management Program (CDSMP) shows participants saved $714 in emergency department visits and hospital utilization. If 10% of Americans with one or more chronic conditions were reached by CDSMP, there is potential for $6.6 billion in savings.[12]

Given that 80% of older adults experience two or more chronic conditions, NCOA believes CDSMP should be offered in every ZIP code across the U.S. in an effort to save lives and decrease health care costs. CDSMP is a workshop for adults with

[11] https://www.ncoa.org/article/falls-prevention-programs-saving-lives-

[12] Lorig K, Ritter P, Stewart AL, et al. Chronic Disease Self-Management Program: 2-Year Health Status and Health Care Utilization Outcomes. Medical Care. 2001;39:1217-1223.

at least one chronic health condition, which may include diabetes, heart disease, or arthritis. Given that chronic conditions are the primary drivers of health care costs and disability, as well as declines in quality of life, we must ensure that anyone with a chronic illness has access to this program. CDSMP focuses on critical disease management skills, including decision making, problem solving, and action planning. The program increases confidence, physical and psychological well-being, knowledge of ways to manage chronic conditions, and motivation to manage challenges associated with chronic diseases. Interactive educational activities include peer discussions, brainstorming, action-planning and feedback, behavior modeling, problem solving techniques, and decision making. The program also results in behavior change, such as more exercise and relaxation, better communication with health care providers, healthy eating, medication management, and better management of fatigue.

The delivery of these programs to older adults is funded by OAA Title III-D. Funding amounted to $26.3 million in the FY23 federal budget; this funding is shared across all states, territories, and the District of Columbia. Beginning in 2012, ACL required that programs funded by Title III-D meet strict evidence-based criteria defined as proven effective for improving the health and well-being or reducing disease, disability, and/or injury among older adults; and proven effective with older adult population, using experimental or quasi-experimental design; and results published in a peer-review journal; and fully translated in one or more community site(s); and includes developed dissemination products that are available to the public.

However, not all these programs are reaching older adults in need, especially in rural and diverse communities. This lack of access is due in part to inadequate funding under OAA Title III-D, which has not kept pace with growing needs and costs to deliver evidence-based programs. Congress and the Administration must address lessons learned from the pandemic related to promoting equitable access to services, addressing diverse needs, and expanding healthy aging programs that are offered both in-person and virtually. For example, the costs associated with delivery of virtual programs are significantly higher in most cases than in-person programs due to greater technology and staffing needs.

NCOA recognizes that evidence-based programs have some implementation challenges and inequities. Most have not been tested with a full diversity of populations, communities, or contexts. Some communities struggle to implement them as designed. Therefore, we advocate for expanding the continuum of programs funded under the OAA to include those that are evidence-informed, defined as an approach in which practitioners are encouraged to be knowledgeable about findings coming from all types of studies and to use them in an integrative manner, taking into consideration experience with a program or intervention and judgment, clients' preferences and values, and context of the interventions.[13]

NCOA is proud to be leading the Innovation Lab through funding from ACL's Center for Performance and Evaluation. We are partnering with researchers to take a core-components approach to identify what is truly necessary to achieve the ultimate goal better outcomes for people and communities. This broader approach gives communities the flexibility to deliver programs that match their capacity and meet the needs of their culturally diverse populations. This core components methodology is being applied to falls prevention interventions, and we believe it has significant potential across other areas of aging services such as nutrition and chronic disease management.

[13] Adapted from: Nevo, I., & Slonim-Nevo, V. (2011). The myth of evidence-based practice: towards evidence-informed practice. British Journal of Social Work, 41(1), 1-22.

OAA reauthorization should:

•Double authorized funding levels for OAA Title III-D to support the licensing, training, technology, and other costs required for implementation of evidence-based programs.

•Expand the continuum of programs funded under the OAA to include those that are ″evidence-informed.″

Jane's Story

One of our participants, a 76-year-old woman, initially relied on a walker for mobility. However, as she diligently engaged in the exercises taught in our sessions, her progress was remarkable. By the third session, she entered class confidently using only her cane, brimming with pride at her newfound ability. Her excitement was palpable as she shared how these exercises had significantly improved her mobility and daily activities. Her husband, who accompanied her to class, echoed her joy, thrilled to engage in activities together that had been out of reach for a while.

Direct Care Workforce

Between 2021 and 2031, the direct care workforce is projected to add more than one million new jobs, resulting in a total of 9.3 million direct care jobs need to be filled,[14] according to PHI. Low wages, lack of full-time employment, and the pandemic have caused fewer workers to enter direct care at the exact time the need for their services is growing.
key-facts-2023/

Funded by ACL, the Direct Care Workforce Strategies Center, housed at NCOA, is addressing this challenge by supporting state systems change through the provision of resources, technical assistance, and training to state systems, providers, and stakeholders to improve direct care workforce recruitment, training, and retention.

This Center addresses the charge of OAA and its National Family Caregiver Support Program (enacted as part of the 2000 OAA reauthorization) to build and strengthen the care infrastructure needed to address the pressing challenges that threaten the independence, health, and economic security of older adults who rely on the support of family caregivers.

OAA reauthorization should:

•Strengthen authorities for sustained funding for the Direct Care Workforce Strategies Center beyond five years to increase dissemination of state technical assistance and training opportunities to ensure an adequate and well-trained direct care workforce.

Economic Security

Older adults are more likely to face economic insecurity as they age. In 2023, poverty among older adults rose for the third consecutive year to 14%.[15] An analysis conducted by NCOA and the LeadingAge LTSS Center at the University of Massachusetts, Boston found that of people age 60 and older, 80% (47 million) do not have the financial resources to cover long-term care services or another financial shock, nearly 20% of older households have no assets to draw upon to withstand a financial shock, and 21-80% of older adults have modest assets but would still be unable to afford more than two years of nursing home care or four years in an assisted living community.[16]

An important factor in determining older adults? Economic security is the geographic location of their primary residence. Regions such as the Northeast and the West Coast have a higher cost of living compared to states in the Sunbelt region. NCOA urges Congress and the Administration to modernize and increase flexibility in the determination of economic need with proven tools such as the Elder Index[17], which is a more accurate measure of the income older adults need to meet their basic needs and age in place with dignity. It includes household size, geographic location, housing, and health status in determining costs of living. The Elder Index is updated annually to include the latest Consumer Price Index data to account for

[14] https://www.phinational.org/resource/direct-care-workers-in-the-united-states-
[15] https://www.ncoa.org/article/older-adult-poverty-continues-upward-trend-reaching-an-unacceptable-14-percent
[16] https://www.ncoa.org/article/80-percent-of-older-americans-cannot-pay-for-long-term-care-or-withstand-a-financial-shock-new-study-shows
[17] https://elderindex.org/

inflation costs. Elder Index data show that nearly half of older adults live alone, and one in five older couples is economically insecure and cannot pay for necessities.[18] The costs of necessities in every state exceeds the federal poverty thresholds used in eligibility requirements for benefits programs.

The Elder Index also shows that the average Social Security benefit does not cover the cost of basic expenses. Researchers from the University of Massachusetts, Boston reported that the average Social Security benefit only covers 68% of the costs for basic necessities for a single person living alone and 81% for couples living together.[19] This gap identifies the reality that many older adults must use other means to cover their basic costs either by working, withdrawing from savings and other retirement accounts, or relying on social safety net programs such as the Supplemental Nutrition Assistance Program (SNAP) or Medicare Savings Programs.

OAA reauthorization should:

•Modernize and increase flexibility in the determination of economic need with proven tools such as the Elder Index to ensure the local cost of living are addressed as future generations are expected to age with limited financial resources.

Christian's Story

Christian, 61, lives with disabilities and relies on a fixed income of $1,156 monthly. He relocated to Windsor, Vermont, to assist his 93-year-old father with his care. Christian previously paid $148.50 for Medicare, along with co-pays for medications, without receiving assistance for food, fuel, or prescriptions. Unfamiliar with available resources in Vermont due to being a nonnative, Christian faced financial strain when prescribed a new medication with a $500 copay. With the help of a local benefits enrollment center, Senior Solutions, Christian received a tablet for telehealth, facilitating his connection with family in New York and easing access to medical services. Additionally, Christian applied for food benefits, fuel assistance, and pharmacy aid programs, promptly receiving a SNAP card with $202 for food, $56 for fuel assistance, and relief from his Medicare Part B premium, qualifying him for Medicaid after a $60 spend-down. Thrilled by these benefits, Christian anticipates saving for a car, resulting in monthly savings exceeding $500. These supports allow Christian to continue to care for his father and himself, both remaining independent.

Older Workers

For millions of Americans, aging well means having the opportunity to work in the years leading up to and beyond the traditional retirement age. The reasons older adults want or need to work are the same as at any age. Work provides meaning, social connections, and much needed income to pay for daily needs. As longevity continues to climb and many Americans struggle to save enough for retirement, work is also essential to affording a longer life. This is especially true for older adults of color, who experience higher rates of poverty than white older adults, and among rural and LGBTQ+ older adults who face access barriers and discrimination in employment.

Since 1968, NCOA has served as one of several national administrators for the Senior Community Services Employment Program (SCSEP). Today, we provide SCSEP services in 11 states and Puerto Rico, including Georgia, New York, North Carolina, and Pennsylvania. This work has given us clear insight into the value older workers contribute to our economy.

A Department of Labor program that is authorized and funded under OAA, SCSEP is the only federal job training program focused exclusively on helping older Americans return to the workforce. It prioritizes services to veterans, individuals with disabilities, those living in rural communities, and other most-in-need older adults who have low job prospects and significant barriers to employment. Significant majorities of participants have incomes below 125% of the federal poverty line, are women, and are people of color. The program enables them to develop new skills and add work experience through subsidized community training assignments with local nonprofit organizations.

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[18] Mutchler, Jan; Su, Yan-Jhu; and Velasco Roldan, Nidya, ″Living Below the Line: Economic Insecurity and Older Americans, Insecurity in the States, 2022″ (2023). Center for Social and Demographic Research on Aging Publications. 66.

[19] https://kffhealthnews.org/news/article/elder-index-aging-costs-seniors-basic-necessities/

SCSEP incorporates benefits coordination and access to wraparound services. Older workers particularly low-income individuals with significant barriers to employment have traditionally been left behind by public workforce systems and strategies. Many have been out of the workforce due to caregiving responsibilities, health and disability challenges, and age discrimination. For many, the traditional 40-hour week and year-round employment placement envisioned in Workforce Innovation and Opportunity Act (WIOA) and other public workforce programs are not appropriate. These systems lack the targeted, one-on-one counseling and assistance many older workers require for successful training and re-employment.

However, the impact on ageism starts much before age 55. We advocate for lowering SCSEP eligibility to age 50, so we can broaden the impact of the program by helping people retool their skillset earlier in life. Similarly, we recommend broadening the income eligibility to at or below 200% of the federal poverty level to recognize that those who are slightly over the current cap still need the help of a program like this. If we focus on younger individuals with slightly more income initially, we will be able to further decrease the curve of individuals falling into a position that requires federal benefits and Medicaid.

OAA reauthorization should:

- Update SCSEP eligibility to make it available to adults 50 years and older.
- Adjust income eligibly guidelines to allow for individuals with incomes at or below 200% of the federal poverty level to improve access for older workers struggling with financial security and employment.

Susan's Story

At age 75, Susan learned of the NCOA SCSEP program while waiting at her doctor's office. Unsure of what to expect, but in dire need of work, she took a chance and dialed the number listed on the flyer, hoping for assistance. At the Crawford County Read Program, Susan found fulfillment in helping people of all ages improve their literacy and basic math skills. However, when the program faced closure due to funding issues, Susan feared returning to financial uncertainty.

Thankfully, another opportunity arose swiftly, and Susan embarked on training as a receptionist at an organization dedicated to mental health awareness. As Susan's tenure in the program approached its conclusion, her colleagues recognized her value and advocated for her to join the team permanently. In a remarkable show of support, Susan's coworkers collectively urged management to hire her full-time.

Now secure in her job and an active taxpayer, Susan expresses a newfound sense of relief, stating that she can finally relax knowing she has stable employment. She passionately shares her experience with others, emphasizing the vital role of SCSEP in assisting older adults facing employment obstacles, noting that the program can be a lifeline for many.

Conclusion

The OAA provides our nation with a blueprint for ensuring we have the infrastructure in place to support individuals across the full spectrum of domains related to aging in community and at home as we all desire. The various titles of the Act intentionally and thoughtfully support an ecosystem for deploying services and supports that reflect the needs of states and communities, prioritizing the most vulnerable.

With nearly 12,000 people turning 65 each day this year and for the next several years, we applaud ACL's leadership in updating the Act with the recently released OAA regulations, largely building upon lessons of the pandemic, and we also recognize that demographic trends require us to further align Federal, State, and local programs with the needs of today and tomorrow. We appreciate this opportunity to offer our priorities to reauthorize, modernize, and fund the Older Americans Act to ensure every American can age well.

For more information, please contact: Marci Phillips marci.phillips@ncoa.org.

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE OLDER AMERICANS ACT: THE LOCAL IMPACT OF THE LAW AND THE UPCOMING REAUTHORIZATION"

MAY 23, 2024

STATEMENT FOR THE RECORD

American Association of Retired Persons Testimony

AARP, which advocates for the more than 100 million Americans age 50 and older, thanks the Committee for holding the hearing, "The Older Americans Act: The Local Impact of the Law and the Upcoming Reauthorization." We appreciate the opportunity to work with you to advance support for older adults and their family caregivers through the Older Americans Act (OAA). The OAA has a powerful legacy. Since 1965, the OAA has supported older adults so they can live at home with independence and dignity, deferring or eliminating more costly institutional services and hospitalizations. Our research shows that people overwhelmingly want to age at home in their own communities, but as the population of older adults rises exponentially, it puts a greater strain on services provided by OAA.

Meeting this increasing demand is a significant challenge. In 2000, adults age 65 and older made up approximately 12 percent of the US population; today, the proportion is estimated at 17 percent and is expected to rise to 23 percent by 2050. The number of people age 80 and older, who are the most likely to need help to live independently in their homes and communities, is projected to nearly double from 2023 to 2040.

America is on the brink of a serious national crisis. Right now, nearly 48 million family caregivers are filling in the gaps, providing $600 billion in uncompensated care to their loved ones. Many, especially women, are dropping out of the workforce or cutting back hours to care for their loved ones, exacerbating labor shortages across the economy. As the population ages, the number of family caregivers is not likely to keep up with the demand.

As OAA's funding levels have declined relative to the population demanding these services, more and more is falling on the backs of these caregivers - and they are already at the brink. When adjusted for inflation, total OAA funding has declined by 18 percent since 2001. Without sufficient funding, critical OAA programs are often unable to meet rising demand, and many have been forced to implement waiting lists. For example, according to Meals on Wheels, one in three of their programs currently have a waitlist, with older adults waiting an average of three months for vital meals.

In a typical year, thanks to the OAA, 11 million older adults receive help to stay in their homes, receive congregate and home-delivered meals, case management, family caregiver support, transportation, adult day care, legal services, elder abuse prevention, and job training and employment opportunities for low-income older adults. Additionally, OAA Native American programs provide nutrition, support and caregiver services to older American Indian, Alaska Native and Native Hawaiian people. The OAA plays a critical role in making sure people in this country can age at home, where they want to be. OAA programs are cost-effective investments that serve the needs of older Americans while deferring or eliminating the need for costly institutionalization. Now more than ever, OAA is essential for our country.

As we approach OAA reauthorization, we look forward to continuing to work with you to improve upon OAA's many existing programs. Our recommendations for ways OAA can be improved to meet the needs of our aging population are outlined below.

OAA Reauthorization Priorities

AARP supports a number of proposals that will help to improve OAA, including:

- Strengthening support for family caregivers;
- Improving food security and social isolation through the Nutrition Services Programs;
- Supporting housing stability among older adults;
- Addressing direct care workforce shortages; and
- Protecting and strengthening the reach of OAA programs.

Strengthen Support for Family Caregivers

•Connect Caregivers to the needed resources through caregiver assessments

OAA's National Family Caregiver Support Program (NFCSP) includes a range of services to support family caregivers and older relative caregivers. One of AARP's 2019 OAA reauthorization priorities was to ensure caregivers were being connected to the right resources and support for their particular caregiving situation. The final bill included provisions to allow for and encourage the use of caregiver assessments under NFCSP, which AARP supported, but it did not require their use as we had urged. The Administration for Community Living (ACL) furthered this effort in their recently finalized OAA regulations by including language to allow ″an evidence-informed or evidence-based caregiver assessment.″

We understand that due to the COVID-19 pandemic and availability of resources, some caregiver assessment-related provisions have not been completed or fully implemented at this time. This includes the technical assistance to promote and implement the use of caregiver assessments, an analysis and report on the use of caregiver assessments by the Aging Network, the inclusion of caregiver assessments used in the states in data and reports from states to ACL, and identifying and making available best practices relating to NFCSP and Native American Caregiver Support Services. It is important for these activities to be completed as soon as possible so family caregivers, the Aging Network and others can benefit. We understand that agreements awarded by ACL to provide technical assistance and capacity building to support the aging and tribal services networks with implementing the National Strategy to Support Family Caregivers will help with implementation of some of these provisions.

In addition to completing work from the last reauthorization period, it is important to strengthen caregiver assessments and expand their use so that more caregivers can get the support they individually need. The assessments should be used to provide a no wrong door approach to help connect caregivers with any supports they may need - including programs outside of OAA authority.

We recommend multiple improvements to the current OAA caregiver assessment provisions that AARP supported and were successfully enacted in 2020, including:

•Ensure caregiver assessments are:
  *culturally appropriate;
  *person-and family-centered; and
  *evidence-informed or evidence-based.

•Amend OAA so that services provided under the NFCSP must be informed by a caregiver assessment starting two years after the date of enactment. Currently, this is permitted but not required. The two-year timeframe would allow time to complete caregiver assessment activities from the 2020 reauthorization and build on those activities.

These changes are consistent with the National Strategy to Support Family Caregivers. We note that Outcome 2.2 in the National Strategy is, ″Where appropriate, identifying services and supports needs for caregivers consistently starts with a review of family caregiver strengths and preferences using evidence-based assessments.″ The Strategy also states, ″Accurately assessing the needs of family caregivers with evidence-based tools and protocols is critical to providing services that make a difference for the caregiver and empower them to better meet the needs and preferences of the person they are supporting.″

•Increase awareness of and education about existing family caregiver supports

Too often, family caregivers are not aware of support in their communities and how to find it. To help make it easier for caregivers to learn about existing available support, we propose adding language to OAA Sections 305, 306, and 373 to help increase awareness of and education about existing family caregiver supports.

•Improve Counseling in the National Family Caregiver Support Program (NFCSP) and Native American Caregiver Support Services

To help improve consistency, improve OAA family caregiver counseling services, and incorporate an element from the National Strategy, we recommend adding language to help ensure that counseling under NFCSP and within Native American Caregiver Support Services is person-centered and trauma-informed. This could also help increase caregiver engagement with caregiver support services, consistent with the National Strategy.

•Measure the caregiver navigation experience and impact of caregiver supports

Caregivers say they are stressed emotionally (72%), overwhelmed by responsibilities (60%), and financially strained (55%). Time is also a top challenge for them. They do not have the time to spend unnecessary and inefficient efforts navigating to get the help, information, and support they need. To help ensure that family caregivers receive the navigation support/customer service experience they need and deserve, we recommend requiring ACL to develop and implement family caregiver experience and outcome measures for the NFCSP, Native American Caregiver Support Services, and Aging and Disability Resource Centers (ADRCs) within two years of enactment.

This would help focus additional attention on caregiver experience and outcomes, as measures have traditionally been more focused on the number of people served or processed. There are measures, such as ″Maintain at 75% or higher the percentage of caregiver services clients who report that services enabled them to provide care for the care recipient for a longer time than would have been possible without these services″ and ″Increase the likelihood that the most vulnerable people receiving Older Americans Act Home and Community-based Supportive Services and Caregiver Support Services will continue to live in their homes and communities.″ However, more outcomes and experience measures can help improve caregivers' overall experience.

•Ensure access to flexible respite services that meet the specific needs of each family caregiving situation

As with other recommendations to the NFCSP, AARP recommends authorizing language be added to ensure a person- and family-centered approach to respite care. Ensuring flexible options will help meet the specific needs of individual family caregiver situations.

According to a 2024 AARP report, while family caregivers often feel their role provides meaning in their lives, they also face significant challenges. Caregivers can feel stressed, overwhelmed, and lonely. They may also have physical and financial stressors related to taking care of children, keeping up with their jobs, and managing finances. Some care recipients, especially those with cognitive impairment or dementia, need a caregiver to be on call 24 hours a day.

Many family caregivers need respite care-that is, short breaks from their responsibilities. Respite is most often defined as care provided to an older adult or person with disabilities so that their family caregiver can get a short break from their care responsibilities.

OAA provides respite services through the Title III National Family Caregiver Support Program. These supports help family caregivers balance caregiving with other responsibilities which, in turn, helps ensure more older adults can remain in their homes and communities. Evidence shows that respite services are helpful to family caregivers, including those who care for people with dementia.

AARP research shows tailored communications, flexible and accessible services, and trained staff delivering high-quality care are important and respite programs that take this into account will be better able to meet the needs of family caregivers and their care recipients. Family caregivers could benefit from a range of services that are tailored to their needs, as different caregiving situations may necessitate different types of respite services.

Improve Food Security and Reduce Social Isolation by Ensuring Flexibility in the Nutrition Services Programs

In 2022, nearly 11.8 million (or about 1 in 10) Americans age 50 and older faced food insecurity and the threat of hunger. Food insecurity among this age group increased 25 percent between 2021 and 2022, reversing a decade-long decline. While only part of the solution, OAA nutrition programs are a critical component of addressing senior hunger.

Congregate nutrition services and home-delivered nutrition services provided by the OAA Nutrition Services Program reduce hunger and support older adults' health and independence, including their ability to remain in their homes. A 2017 evaluation found that 42 percent of congregate meal participants and 61 percent of home-delivered meal participants reported they would skip meals or eat less without the program. The majority of participants report that the program helped them to eat healthier and continue to live independently.

Furthermore, OAA-funded senior nutrition programs also provide more than a meal; they provide opportunities for social engagement, offer nutrition screening and counseling, and link participants to other home- and community-based supports. A 2017

AARP Public Policy Institute study found social isolation costs Medicare $6.7 billion per year. Congregate meals participants report seeing friends more often due to the meals and the home-delivered meal program is associated with reduced loneliness among new participants, with delivery individuals often being the only human contact of the day for homebound clients. The improved social connections among participants can lead to improved health and lower associated health care costs among program participants.

We recommend permanently implementing several COVID-era flexibilities for the nutrition services program. AARP believes the following changes would improve efficiency and allow local providers to tailor services to best meet the needs of their communities.

•Grant nutrition service providers funding flexibility to meet the specific needs of their individual communities

Title III-C Nutrition Programs are currently funded separately, meaning providers have limited flexibility to transfer funds from one to another should demand or need differ between the programs. Local providers say combining the home-delivered meals and congregate meals programs into one funding stream or allowing the transfer of funds between the two programs, will improve efficiency and allow the providers to better tailor services to the needs of their participants.

AARP recommends agencies within the Aging Network be given the funding flexibility to offer services based on the needs of the participants and communities, while ensuring they continue to address the program's three goals of reducing hunger, promoting socialization, and promoting the health and well-being of older adults. While this flexibility is key, participants must continue to have the option to receive either congregate or home-delivered meals.

•Codify flexible nutrition service models allowed during COVID-19 and included in the most recent OAA Regulations

Pandemic flexibilities allowed for alternative meal options, such as carry-out, grab-and-go and drive through meals, through the congregate meals program. While included in the most recent OAA regulations, these flexibilities should be permanently extended in statute not only to address hunger but to reach older adults struggling with social isolation.

Protect and Strengthen the Reach of OAA Programs

OAA is a major delivery system of a variety of services for older adults and their family caregivers. In addition to the policy areas addressed above, we are also focused on finding ways to strengthen other critical OAA programs, including - but not limited to - the following:

•The Senior Community Service Employment Program (SCSEP)

SCSEP is the only federal program specifically created to assist low-income workers age 55 and older to regain entry into the workforce. The program provides part-time community service assignments for low-income persons age 55 or older who would otherwise have poor employment prospects because older jobseekers continue to face barriers to employment, often due to age discrimination. SCSEP-funded services are available in nearly all 3,000 U.S. counties and territories.

Grantees include public workforce agencies and national nonprofit organizations. Participants are unemployed, disadvantaged older workers who work an average of 20 hours a week at minimum wage. Work experience is gained typically in community service activities at nonprofit and public facilities, serving as a bridge to unsubsidized employment opportunities. SCSEP has helped thousands of older jobseekers into jobs providing them work-based training and the opportunity to use their skills. According to the recent Department of Labor Workforce GPS survey, participants strongly believe that the program helped prepare them for success in the workforce (8.4 on a 10-point scale). SCSEP adds needed value as the only federal program targeted at lower income older jobseekers.

•The Long-Term Care Ombudsman Program (LTCOP)

LTCOP is the most effective program to advocate and act as a resource for older adults and people with disabilities who live in nursing homes, assisted living, and other licensed adult care homes. Every state - plus Puerto Rico, Guam and the District of Columbia - has a long-term care ombudsman office. These offices work to resolve problems related to the health, safety, welfare, and rights of individuals who live in long-term care facilities, and help residents understand and exercise their

rights to good care in an environment that promotes and protects their dignity and quality of life.

Data from the 2022 National Ombudsman Reporting System (NORS), shows that LTCOP's nearly 2000 full time staff and approximately 4000 certified volunteers investigated more than 182,000 complains nationwide and provided assistance to more than 400,000 individuals looking for information about long-term care.

The COVID-19 pandemic highlighted the critical role these ombudsmen play in the long-term care system and the challenges they face, including significant workload with limited staff and funding.

Support Housing Stability Among Older Adults

Through nutrition assistance, in-home care services and support to family caregivers, OAA is providing a vital resource for millions of older adults who want to age in their homes. In addition to food and caregiving assistance, OAA also provides assistance for home repair and modifications to ensure the home is safe and updated with accessibility features to make the home easier to navigate. However, rising costs to remain in the home, everything from rent and insurance to taxes, is also making it harder for older adults to age in place. According to the Department of Housing of Urban Development's (HUD) recent 2023 Annual Homelessness Assessment Report, there has been a 12 percent increase in homelessness in the last year, with eight percent of all people experiencing homelessness over the age of 64, and almost 30 percent elderly or near elderly (55 years or older).

OAA could play a larger role in supporting local partnerships between Area Agencies on Aging (AAA) and housing providers and enabling access to services and supports for older adults residing in HUD-assisted housing, as well as funding, to support housing stability with service coordination and delivery.

Strengthen the Direct Care Workforce

AARP supports efforts to bolster the direct care workforce, including through additional support and investments in the OAA Direct Care Workforce Demonstration.

Around 12.6 million adults in the US need long-term services and supports (LTSS). Despite the increased demand for direct care workers as the population continues to age, job quality for all members of the direct service workforce remains low. About 38 percent of direct service workers leave their positions in less than six months, and approximately 21 percent leave within six to 12 months. According to a 2023 AARP report on the direct care workforce, major challenges contributing to a high turnover rate within the direct care workforce include:

- low wages and lack of benefits;
- minimal or insufficient training and career development opportunities;
- physically and emotionally demanding positions, with high rates of occupational injury;
- high rates of burnout; and
- racial and gender discrimination that causes, compounds, and/or exacerbates other challenges.

OAA's Direct Care Workforce Demonstration provides funding for a national technical assistance center for federal, state, and private entities to access model policies, best practices, and training materials for recruiting and retaining direct care workers.

Conclusion

AARP appreciates the opportunity to share our OAA reauthorization priorities with the Committee. We look forward to working with you on a bipartisan basis to build upon the success of the OAA as the 2024 reauthorization process moves forward. If you have additional questions, feel free to contact me or have your staff contact Lauren Ryan on our Government Affairs team at lryan@aarp.org or (202) 434-0351.

Sincerely,

/s/
Bill Sweeney
Senior Vice President
Government Affairs

U.S. SENATE SPECIAL COMMITTEE ON AGING

"THE OLDER AMERICANS ACT: THE LOCAL IMPACT OF THE LAW AND THE UPCOMING REAUTHORIZATION"

MAY 23, 2024

STATEMENT FOR THE RECORD

Meals on Wheels Testimony

Dear Chairman Casey, Ranking Member Braun, and Members of the Senate Special Committee on Aging:

Thank you for the opportunity to submit this statement for the record for the recent hearing, "The Older Americans Act: The Local Impact of the Law and the Upcoming Reauthorization." On behalf of Meals on Wheels America, the nationwide network of more than 5,000 community-based senior nutrition providers and the older adults they serve, we urge you to prioritize our recommendations to strengthen and improve the Older Americans Act (OAA) Nutrition Program. Please reference the provided materials for detailed information about Meals on Wheels America's priorities and recommendations for the OAA reauthorization:

- Ellie Hollander, President and CEO of Meals on Wheels America, Testimony before the Senate HELP Committee hearing, "The Older Americans Act: Supporting Efforts to Meet the Needs of Seniors" on March 7, 2024
- Meals on Wheels America's response to the Request for Information from the HELP Committee, submitted March 21, 2024
- Meals on Wheels America's Older Americans Act priorities

We look forward to continuing to work together toward the successful reauthorization of the Older Americans Act. The reauthorization process presents an important opportunity to strengthen and preserve the Act's original intent and core purpose to reduce hunger, promote socialization and improve health and well-being for older adults in greatest social and economic need.

We hope that you will consider Meals on Wheels America a trusted partner as we collectively address the growing issues of senior hunger and social isolation. Please don't hesitate to reach out whenever we may be of service.

/s/
Ellie Hollander
President and CEO

Contact Information:
Josh Protas
Chief Advocacy and Policy Officer
Josh.Protas@mealsonwheelsamerica.org

Good morning, Chairman Sanders, Ranking Member Cassidy, and esteemed Members of the Committee. Thank you for the opportunity to testify before you at this critical hearing. I'm Ellie Hollander and am proud to present before you as the President and CEO of Meals on Wheels America. Meals on Wheels America is the national leadership organization representing over 5,000 local nutrition programs committed to addressing senior hunger and isolation in virtually every community across the country and working toward a vision in which all seniors live nourished lives with independence and dignity.

With the support of hundreds of thousands of committed volunteers and staff members, local community programs deliver nutritious meals in a variety of ways, including in group and/or grab-and-go settings, as well as to individual homes, where they also provide friendly visits and social interaction, safety checks, and connections to other health and wellness services to support older Americans in greatest need, and the underpinning of all this work and impact is a direct result of the support, policies and funding provided through the Older Americans Act (OAA).

For more than 50 years, the OAA has supported millions of our nation's seniors and caregivers through a network of state, regional and local community-based programs. The local providers that we represent at Meals on Wheels America serve as a direct lifeline to those struggling with food insecurity, malnutrition, mobility, loneliness, and countless other difficulties of aging. We frequently say the service starts with the meal and opens the door to so much more. It's the purposeful and unique combination of nutritious meals and social connection that fosters a relationship with the individual senior, enabling Meals on Wheels providers to identify and deliver valuable services that promote independence and well-being. The impact not only saves lives but also saves taxpayer dollars by ensuring that our nation's seniors live safer, longer and more nourished in their own homes and out of other more costly healthcare settings. In fact, we can serve a senior Meals on Wheels for an entire year for roughly the same cost as one day in the hospital or ten days in a nursing home.[1]

The OAA is considered the gold standard of a successful public-private partnership, having delivered on its original intent and shown great resiliency and adaptability through challenging times, including a global pandemic. As its reauthorization approaches, Meals on Wheels America is focusing on several key legislative recommendations that further enhance the support and services provided to older adults. Given the significant need, changing demographics, and inflationary pressures, we are pushing for increased authorized funding levels across all OAA programs, with an emphasis on closing the existing needs gap for nutrition services and establishing incentives and funding for medically tailored and culturally appropriate meals. An important strategic proposal we are recommending involves unifying the Congregate and Home-Delivered Nutrition Services with the Nutrition Services Incentive Program (NSIP) under a single Title III-C Nutrition Program and funding stream. This shift would improve efficiency at all levels of the aging network and enable local service providers to tailor their offerings to meet the diverse needs of seniors in their community far more easily. Additionally, we believe there should be a concerted effort to prioritize community-based organizations for nutrition services contracts, as local providers are delivering a holistic service and not just a meal. Finally, this reauthorization is also an opportunity to continue to modernize the OAA to incorporate innovations, flexibility, and successful practices that were leveraged during the pandemic, ensuring that the Act is adaptable and responsive to the evolving needs of America's older population.

The Foundation of the Older Americans Act

As we look toward this year's reauthorization of the OAA, we first and foremost want to protect the core purposes of the Act and underscore the significance of it as a solution to ending senior hunger and social isolation in our country and why it must be sufficiently resourced.

The Older Americans Act of 1965 (OAA) was signed into law on July 14, 1965, as an answer to improving access to social services and supports for older adults living

[1] Meals on Wheels America (2024), special analysis of ACL and Mathematica's estimated meal cost (OAA Nutrition Programs Evaluation: Meal Cost Analysis), Kaiser Family Foundation's daily hospital expense data (State Health Facts: Hospital Adjusted Expenses per Inpatient Day), and Genworth's cost of semi-private nursing home room (2021 Cost of Care Survey) adjusted for inflation. Sources and methods available at: https://www.mealsonwheelsamerica.org/docs/default-source/fact-sheets/2023/what—we—deliver—2023—national—snapshot—sources—methods.pdf

in the community. Since then, the Act has served as the primary federal legislation supporting community-based social services for adults 60 and older and the bedrock of federal support to the nationwide network of senior nutrition programs that rely on federal funding.

The OAA has evolved and grown over time through prior reauthorizations and consists of seven titles today. Of the seven titles, all but one is administered by the Administration on Aging (AoA), a federal sub-agency established by the OAA within the U.S. Department of Health and Human Services (HHS) Administration for Community Living (ACL). At the state and local levels, OAA activities are carried out by 56 State Units on Aging (SUA), over 600 Area Agencies on Aging (AAA), and thousands of community-based organizations. AoA, housed within ACL, is tasked with advocating for older adults and persons with disabilities and supporting them in securing and maintaining their health, well-being, and independence in the community.

The largest title of the Act, accounting for 72% of the OAA's total funding in FY 2023, is Title III Grants for State and Community Programs, which provides grants to states to help carry out a variety of supportive service and health promotion programs for older adults and their caregivers.[2] The Title III Nutrition Program, which includes congregate (Title III-C1) and home-delivered (Title III-C2) nutrition services, and the Nutrition Services Incentives Program (Title III-C), is a federal program that supports the health and well-being of older adults through nutrition services. We are proud and thankful and want to underscore the significance of the OAA Nutrition Program, which is the only federal program designed specifically to meet older adults' nutritional and social needs. The OAA Nutrition Program is a successful public-private partnership, with the critical federal dollars provided leveraging an impressive funding match of approximately three to one, from additional state, local, and private sources.[3]

Again, we believe that the Act successfully fulfills its purpose, and that reauthorization efforts and modifications should be primarily focused on improving the ability to reach more seniors.

The Pervasive Problem of Senior Hunger

Since its inception, the OAA Nutrition Program has provided billions of meals to seniors in need, improved countless lives, and saved considerable taxpayer dollars through well-established trust built at both the community and national levels. While this program has worked as it was designed for decades, it is not reaching all those in need. Eight out of ten (80.3%) low-income, food insecure older adults are not receiving the congregate or home-delivered meals that they are eligible for and likely need.[4] From a national survey, we found that one in three local Meals on Wheels programs maintain waiting lists, with seniors waiting on average three months for vital meals-an increase of 10% for program waitlists from 2021.[5] The same survey found an overwhelming majority of programs, 78%, have already or would need to add seniors to waitlists due to funding cuts. These are only the individuals we are aware of and know that it is an underrepresentation of the true need across the country. In fact, 97% in our survey indicated they believe that there is unmet need in their communities.

Additional research has found that older adults who seek Meals on Wheels services are already more vulnerable than the average American seniors, with poorer self-reported health, higher levels of depression and anxiety, greater fears of falling and more.[6] Simply put, while older adults are on waiting lists and struggling to have their nutritional and social needs met, their health is continuing to decline and are

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[2] Congressional Research Service (2023), Older Americans Act: Overview and Funding. https://crsreports.congress.gov/product/pdf/R/R43414

[3] ACL (2019), Written Statement by Administrator and Assistance Secretary for Aging Lance Robertson for the Senate Special Committee on Aging. https://acl.gov/news-and-events/announcements/asa-robertson-testified-senate-hearing-oaa-today

[4] U.S. Census Bureau (2022), Current Population Survey (CPS) Food Security Supplement, Meals on Wheels America calculation of dataset available at: https://www.census.gov/data/datasets/time-series/demo/cps/cps-supp—cps-repwgt/cps-food-security.html

[5] Meals on Wheels America (November 2023), #SaveLunch Member Pulse Survey. Internal report.

[6] Meals on Wheels America (2015), More Than a Meal Pilot Research Study, commissioned report prepared by Thomas & Dosa. https://www.mealsonwheelsamerica.org/learn-more/research/more-than-a-meal/pilot-research-study

more likely to end up in a hospital or nursing home prematurely and at significantly higher cost to the individual and taxpayers.

The OAA Nutrition Program is an essential linchpin in supporting the healthy aging process for millions of Americans, but its effectiveness in making a dent in the national dual crises of senior hunger and social isolation depends on being adequately funded. The reality of senior hunger and isolation in our country is sobering. 12 million older adults aged 60+ worry about having enough food (i.e., are marginally food insecure). This was an increase of 2.2 million over 2021.[7]

While daunting, even one individual struggling with hunger is far too many. With the issue being pervasive in American communities and additional challenges fast approaching with the growth of our senior population, there is no time to wait for action. The number of OAA meals and seniors we are able to serve nationwide, however, has failed to keep pace with demographic shifts, growing demand, and the rising costs of food, transportation, and other expenses. While we currently serve 251 million nutritious home-delivered and congregate meals annually to the 2.2 million older adults facing hunger and isolation, we have the infrastructure and know how to reach millions more, especially through increased appropriations and a strong and timely reauthorization.[8]

The Costs and Consequences of Senior Hunger and Social Isolation

Today, millions of seniors are experiencing some degree of food insecurity and/or social isolation, leaving them at risk for a multitude of adverse health issues. Food-insecure older adults experience worse health outcomes than food-secure seniors, with greater risk for heart disease, depression, and decline in cognitive function and mobility.[9] 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. 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, local, community-based organizations serve a critical role in addressing the nutritional and social needs of our nation's older adults. The impact of these services on seniors' lives is powerful.

Most seniors receiving OAA nutrition services from senior nutrition programs consistently report that participating in the program helps them feel more secure, helps them eat healthier foods, prevents falls or fear of falling, and allows them to stay in their own homes. In turn, this helps avoid preventable emergency room visits, hospital admissions and readmissions, and extended rehab stays, preventing premature institutionalization and ultimately reducing our nation's health care costs. The cost of not providing these services and increasing funding is clear.

Currently, almost 95% of older adults have at least one chronic condition, while nearly 80% have two or more chronic conditions.[10] Increasingly, older adults need access to nutritious meals and comprehensive services that can help them manage their chronic conditions.

Malnutrition, senior falls, and social isolation tell a similar story. The economic burden of senior malnutrition alone costs $51.3 billion annually (in 2010 dollars), while senior falls account for $50 billion (in 2015 dollars).[11],[12] Studies show the highest rates of social isolation are found among older adults, putting seniors at risk for high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline, Alzheimer's disease, and even death. Research dem-

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[7] See note 4.

[8] Administration for Community Living/Administration on Aging (2023), State Program Report (SPR) 2021, available on ACL's Aging, Independence, and Disability Program Data Portal (AGID) at: https://agid.acl.gov/

[9] Ziliak and Gunderson (2021), The Health Consequences of Senior Hunger in the United States: Evidence from the 1999-2016 NHANES, report prepared for Feeding America. www.feedingamerica.org/research/senior-hunger-research/senior

[10] National Council on Aging (April 2022), Chronic Inequities: Measuring Disease Cost Burden Among Older Adults in the U.S. A Health and Retirement Study Analysis. https://ncoa.org/article/the-inequities-in-the-cost-of-chronic-disease-why-it-matters-for-older-adults

[11] Snider, et al. (2014), Economic Burden of Community-Based Disease-Associated Malnutrition in the United States. Journal of Parenteral and Enteral Nutrition, 38(2S), 77S-85S. https://doi.org/10.1177/0148607114550000

[12] Thomas, et al. (2018), Home-Delivered Meals and Risk of Self-Reported Falls: Results From a Randomized Trial. Journal of Applied Gerontology, 37(1), 41-57. https://doi.org/10.1177/0733464816675421

onstrates that social isolation among older adults leads to an extra $6.7 billion in Medicare spending a year (in 2012 dollars) similar expenditures to that of having high blood pressure or arthritis.[13]

The Case for Meals on Wheels and the Older Americans Act

As noted throughout this testimony, Meals on Wheels is a proven solution that addresses the escalating issues of senior hunger and isolation. We know this not only through the daily anecdotes we hear of how Meals on Wheels has impacted people's lives, but through decades of research. Our recently released report, The Case for Meals on Wheels: An Evidence-Based Solution to Senior Hunger and Isolation, showcases consistent findings that Meals on Wheels improves senior health, safety, social connection, and more while saving taxpayer dollars.13

The Case for Meals on Wheels analyzed a total of 38 studies, spanning 1996 to 2023, and found they consistently reported that Meals on Wheels programs reduce healthcare utilization and costs, falls, nursing home use, social isolation and loneliness while improving food security, diet quality, and nutritional status and seniors' ability to age in place. These remarkable outcomes, highlighted below, underscore the life-changing impact that Meals on Wheels services have on the lives of the older adults we serve:

1. Reduced use of costly health care services: Several studies found Meals on Wheels program participants needed fewer visits to the emergency room or experienced fewer hospital stays or readmissions.

2. Reduced nursing home use and increased ability to age in place: Access to medically tailored and home-delivered meals allowed individuals to stay in their homes rather than transfer to a nursing facility for nutritional support. Nearly all (92%) home-delivered meal participants said the meals help them continue to live independently, according to the 2022 national survey of Older Americans Act Title III home-delivered meal participants.

3. Reduced health care costs attributed to reduced hospital and nursing home spending: In line with outcomes one and two, their reduced health care and nursing home use also meant Meals on Wheels participants spent less on health care. One study found that among individuals receiving medically tailored meals, average medical expenditures were 40% lower per month for those receiving meals than for a matched group not receiving meals ($843 vs. $1,413).

4. Increased food security: Several studies concluded that home-delivered meal participants worried less about having enough to eat. Those individuals who received breakfast and lunch deliveries, rather than just lunch, benefited even more.

5. Improved diet quality: Home-delivered meals led to higher-quality diets among participants, as measured by nutrient intake, calories, vitamins, and other indicators. Participant feedback reinforced that meal delivery helped them eat healthier, more nourishing foods.

6. Reduced or slow decline in nutritional risk: Program participants threatened by malnutrition saw improvement in their nutritional risk scores. Individuals benefited from both improved dietary intake and improved food security.

7. Reduced social isolation and loneliness: Several studies found a link between home-delivered meals and reduced social isolation or loneliness, particularly among participants who lived alone. These benefits resulted from contact with drivers during meal deliveries and opportunities for social connection via other Meals on Wheels programs.

8. Reduced falls and increased home safety: Several studies found Meals on Wheels participants experienced fewer falls and minimized exposure to hazards in the home, outcomes attributable to safety checks provided at meal delivery, and a reduced need to cook in the kitchen.

This research alone cannot bring these evidence-based programs to the older adults who desperately need them. Seniors' access to these critical services is only possible with the support of Congress and sufficient federal funding. This report illuminates the impact that Meals on Wheels has and the necessity to protect and increase federal funding to meet the current needs of our growing senior population.

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[13] Meals on Wheels America (September 2023), The Case for Meals on Wheels: An Evidence-Based Solution to Senior Hunger and Isolation. https://www.mealsonwheelsamerica.org/learn-more/research/the-case-for-meals-on-wheels-sept23

Older Americans Act Reauthorization Priorities

While the need for far greater federal funding is the primary key to serving more seniors, especially in the years following the COVID-19 pandemic, there are opportunities to ease administrative burdens and improve our insight into the performance and operations of the network at all levels. The Act, including the Nutrition Program, must continue to be robust and successful and fulfill its original intent and core purpose to reduce hunger, promote socialization, and improve health and well-being for older adults in greatest social and economic need. Any policy changes must, first and foremost, do no harm to the aging services network and the seniors they support. Instead, they must address the pervasive and growing challenges of senior hunger and social isolation. We believe reauthorization should also build on the newly updated OAA regulations by modernizing the law and reflecting the on-the-ground needs of service providers, older adults, and their families and caregivers. Accordingly, Meals on Wheels America urges Congress to enact the following recommendations:

1. Increase authorization funding levels for all OAA programs and provide additional resources for enhanced nutrition services.

•Increase authorized funding, including sufficient funding for Title III Nutrition Services, to address existing waiting lists and reach the ever-growing number of older adults who would benefit from OAA programs.

•Authorize new funding streams and establish incentives for senior nutrition programs to offer medically tailored and/or culturally appropriate meals and expand reach in underserved areas.

•Improve and clarify authorization of funding for senior nutrition programs to maintain and invest in the infrastructure and resources needed to prepare and deliver services, including kitchen equipment, delivery vehicles, labor, etc.

2. Unify OAA Congregate, Home-Delivered and the Nutrition Services Incentive Program into a single Title III-C Nutrition Program.

•Create one authorized funding stream to remove administrative burden, improve efficiency, and enable community-based organizations to tailor nutrition services to seniors' needs more easily.

•Codify alternative nutrition services models, such as grab-and-go and drive-thru meals, proven to reach more older adults struggling with hunger and social isolation.

•Modernize the Nutrition Services Incentive Program through enhanced partnership and coordination with USDA, HHS, states, Area Agencies on Aging (AAA), and local providers to procure commodity foods for preparing OAA meals and coordinate other important federal benefits and programs for seniors.

3. Prioritize community-based nutrition programs and experienced network providers in OAA grant awards and contracts.

•Encourage states and AAAs to partner more closely with and leverage senior nutrition programs' established infrastructure, dedicated volunteer base, and experience serving their communities to deliver nutritious meals, socialization services, and safety checks to more older adults.

•Ensure timely payment and reimbursement processes for nutrition services provided.

4. Expand senior nutrition program capacity and infrastructure support for further integration into the health care system.

•Reduce administrative and regulatory burdens on local nutrition and aging services providers seeking to establish contracts and partnerships with health care providers and payors.

•Provide additional resources and promote incentives for the aging services network to build the capacity, including infrastructure and technology, to meet the compliance and privacy standards for providing covered health care benefits.

5. Promote innovations and successful practices learned during the COVID-19 pandemic.

•Facilitate continued innovation and implementation of many successful practices leveraged during the COVID-19 public health emergency, including new partnerships, programming, emergency preparedness and outreach.

•Support the expansion of evidence-informed and/or technology-based solutions that can help meet the needs of seniors, including their preferences for meals and social connectedness.

In addition to improvements through reauthorization, our organization and network of senior nutrition providers are pleased with the recent effort to update federal regulations for OAA policies and programs for Titles III, VI, and VII for the first time in 36 years.[14] As a result, they are now better aligned with language and additions from recent reauthorizations and better reflect the needs of today's growing and diversifying older adult population.

Among the several updated policies we look forward to being implemented, we remain supportive of the following nutrition-related provisions that are included and/or clarified per ACL's final rule (effective Friday, March 15, 2024):

•Home-delivered meals - and a certain amount of congregate meals - may be provided via home delivery, pick-up, carry-out, or drive-through.

•Eligibility for home-delivered meals is not limited to people who are ″homebound;″ criteria may depend upon many factors (including ability to leave home unassisted, ability to shop for and prepare nutritious meals, mental health, degree of disability or other relevant factors about their need for the service, including social and economic need).

•Requirements regarding the use and transfer of funding for Title III programs, including clarification under Title III C-1 and C-2 that funds can be used for nutrition education, nutrition counseling, and other nutrition services, as well as cautioning against transitioning money away from Title III-B and Title III-C services for which they were appropriated and intended by Congress.

•States have the option to receive NSIP allocation grants as cash, commodities or a combination of both, and that funds can only be used to purchase domestically produced foods used in meals.

We are encouraged to see much consideration and modernization of OAA regulations through this regulatory process. Nonetheless, regulatory updates and guidance can only achieve so much and look forward to addressing remaining policy priorities and making further legislative improvements during this OAA reauthorization process.

Conclusion

Thank you for holding this timely hearing and inviting me to testify before you. I appreciate the chance to share how the OAA improves the lives of senior citizens, communities, and our nation. I would like to extend a special thanks to Chairman Sanders for his leadership on the OAA in past reauthorizations and in seeking increased funding, and I want to thank all members of the Committee for sharing the belief that no senior in America should be left hungry or isolated. I hope the information I provided today is helpful as you consider the next reauthorization and look forward to working together to make this vision a reality for our older adults. Thank you again for your time, and I am pleased to answer any questions you might have.

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[14] ACL (February 2024), Final Rule [89 FR 11566]: Older Americans Act: Grants to State and Community Programs on Aging; Grants to Indian Tribes and Native Hawaiian Grantees for Supportive, Nutrition, and Caregiver Services; Grants for Supportive and Nutritional Services to Older Hawaiian Natives; and Allotments for Vulnerable Elder Rights Protection Activities. https://www.federalregister.gov/documents/2024/02/14/2024-01913/older-americans-act-grants-to-state-and-community-programs-on-aging-grants-to-indian-tribes-and

Dear Committee Chairmen Sanders and Casey, Ranking Members Cassidy and Braun, and Senators Kaine, Collins, Markey, and Mullin:

On behalf of Meals on Wheels America, the nationwide network of community-based senior nutrition programs and the seniors they serve, thank you for the opportunity to provide input and submit responses to this bipartisan Request for Information (RFI) regarding the upcoming Older Americans Act (OAA) reauthorization. There is a great urgency for strong legislation that meets our aging population's current and future needs. The upcoming reauthorization deadline comes during a critical period of rapid growth in the senior population. With this population boom comes an even greater need for long-term care solutions like Meals on Wheels - a trusted, tested, and cost-effective solution to senior hunger, malnutrition, isolation and loneliness - instead of costly and preventable health care utilization among the 60+ population.

Responses to the general and targeted questions identified in the RFI are below:

Question:

1. What are the biggest challenges currently facing the older adult population? How have OAA programs performed historically in addressing these challenges? How can OAA programs be improved upon to better address these challenges?

Response:

Our nation is ill-prepared for the massive growth in the older adult population. The in community services and supports necessary to enable seniors' independence, health, well-being and dignity are not keeping pace with need. However, if properly resourced, the OAA network is poised and ready to deliver lifesaving services to America's seniors.

Biggest Challenges:

Unmet Need and Population Increase

The reality of senior hunger and isolation in our country is sobering. 12 million older adults aged 60+ worry about having enough food (i.e., are marginally food insecure). This is a devastating increase of two million over 2021. While daunting, even one individual struggling with hunger is far too many. With this pervasive issue affecting so many American communities and additional challenges fast approaching due to the growth of our senior population, there is no time to wait for action. The number of OAA meals and seniors we are able to serve nationwide fails to keep pace with demographic shifts, growing demand, and the rising costs of food, transportation, and other expenses. While we currently serve 251 million nutritious home-delivered and congregate meals annually to the 2.2 million older adults facing hunger and isolation, we have the infrastructure and know-how to reach millions more, especially through increased appropriations and a strong and timely reauthorization.

While this program has worked as designed for decades, it is not reaching all those in need or who would benefit due to the lack of adequate funding. Eight out of ten (80.3%) low-income, food insecure older adults are not receiving the congregate or home-delivered meals for which they are eligible and likely need. These are only the individuals we are aware of, and we know it is an underrepresentation of the true unmet need across the country. Nearly all (97%) programs in our national survey indicated they believe there is an unmet need in their communities.

Unmet Need and Waitlists

Due to insufficient funding, our local programs have regrettably been forced to place some older adults on waitlists. From the aforementioned national survey, we found one in three local Meals on Wheels programs maintain waiting lists, with seniors waiting an average of three months for vital meals. The same survey found an overwhelming majority of programs (78%) have already or would need to add seniors to waitlists due to funding cuts. In 2023, 33% of programs reported having a waitlist for their home-delivered meal services, higher than the 23% of programs that reported maintaining a waitlist in 2021.[15] In response to the surge in demand and growing unmet need among seniors exemplified by increased program waitlist for services, our Meals on Wheels network is urging increased funding for the OAA as part of its reauthorization.

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[15] Meals on Wheels America (November 2023), #SaveLunch Member Pulse Survey. Internal report.

Additional research has found that individuals who seek Meals on Wheels services are already more vulnerable to adverse health outcomes than the average American older adult, with poorer self-reported health, higher levels of depression and anxiety, greater fears of falling, and more. Simply put, while seniors on waiting lists struggle to have their nutritional and social needs met, their mental and physical health declines, and they are at greater risk of hospitalization or premature nursing home placement-at a significantly higher cost to the seniors, their families, and taxpayers.

Cost of Food Insecurity, Malnutrition and Social Isolation

Today, as millions of seniors are experiencing food insecurity and/or social isolation, they are at greater risk of serious health issues. Food-insecure older adults experience worse health outcomes than food-secure seniors, with a higher risk for heart disease, depression, and decline in cognitive function and mobility. Almost 95% of older adults have at least one chronic condition, while nearly 80% have two or more.[16] Some of the most vulnerable seniors the OAA serves - those who are frail, homebound, and socially isolated - rely on the home-delivered meal program. Increasingly, older adults need access to nutritious meals and comprehensive services that can help them manage their chronic conditions and ease the economic burden for our clients and taxpayers alike.

The economic burden of senior malnutrition alone costs $51.3 billion annually (in 2010 dollars), while senior falls account for $50 billion (in 2015 dollars). Studies show the highest rates of social isolation are found among older adults, putting seniors at risk for high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline, Alzheimer's disease and even death. Research demonstrates that social isolation among older adults leads to an extra $6.7 billion in Medicare spending a year (in 2012 dollars), similar expenditures to that of having high blood pressure or arthritis.

Meals on Wheels Historical Impact and Ways to Face these Challenges:

For more than 50 years, the OAA has consistently demonstrated how access to nutritious food and regular socialization have enabled millions of our seniors to remain healthier, safe, and independent in the comfort of their homes. Despite such cost-effective interventions, these basic human needs are out of reach for hundreds of thousands of American seniors. Community-based organizations are critical to addressing the nutritional and social needs of our nation's older adults-and keeping our healthcare costs in check-but they can only reach their full potential when they have the resources to do so. Nationally, research shows that participation in home-delivered meal programs is associated with lower medical spending and emergency department visits.

In addition to decreasing health care costs, home-delivered meal clients consistently self-report positive and improved health outcomes as a result of participating in the program:

- 92% say services help them live independently
- 77% say meals help improve their health
- 79% say meals help them eat healthier foods
- 85% say services help them feel more secure

As discussed below, Meals on Wheels is an intervention to reduce these kinds of costs. The local providers Meals on Wheels America represent serve as a direct lifeline to those struggling with food insecurity, malnutrition, mobility, loneliness, and countless other difficulties of aging. The Meals on Wheels service begins with the meal and opens the door to so much more. The purposeful and unique combination of nutritious meals and social connection fosters a relationship with the individual senior, enabling Meals on Wheels providers to identify and deliver valuable services that promote independence and well-being. The impact not only saves lives but also saves taxpayer dollars by ensuring that our nation's seniors live safer, longer, and more nourished in their own homes and out of other more costly healthcare settings. In fact, we can serve a senior through Meals on Wheels for an entire year for roughly the cost of one day in the hospital or ten days in a nursing home.[17]

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[16] National Council on Aging (April 2022), Chronic Inequities: Measuring Disease Cost Burden Among Older Adults in the U.S. A Health and Retirement Study Analysis. https://ncoa.org/article/the-inequities-in-the-cost-of-chronic-disease-why-it-matters-for-older-adults

[17] Meals on Wheels America (2024), special analysis of ACL and Mathematica's estimated meal cost (OAA Nutrition Programs Evaluation: Meal Cost Analysis), Kaiser Family Foundation's daily hospital expense data (State Health Facts: Hospital Adjusted Expenses per Inpatient Day), and Genworth's cost of semi-private nursing home room (2021 Cost of Care Survey) ad-

The Case for Meals on Wheels

Meals on Wheels is a proven solution to the escalating issues of senior hunger and isolation. We know this through decades of research and the daily anecdotes we hear about how Meals on Wheels has impacted people's lives. Our recently released report, The Case for Meals on Wheels: An Evidence-Based Solution to Senior Hunger and Isolation, showcases consistent findings that Meals on Wheels improves senior health, safety, social connection, and more while saving taxpayer dollars.[18]

This analysis of 38 studies, spanning 1996 to 2023, found that Meals on Wheels programs are consistently reported to reduce healthcare utilization and costs, falls, nursing home use, social isolation, and loneliness while improving food security, diet quality, nutritional status, and seniors' ability to age in place. The significant outcomes of this research highlighted below underscore the life-changing impact that Meals on Wheels services have on the older adults we serve:

1. Reduced use of costly health care services: Several studies found Meals on Wheels program participants needed fewer visits to the emergency room or experienced fewer hospital stays or readmissions.

2. Reduced nursing home use and increased ability to age in place: Access to medically tailored and home-delivered meals allowed individuals to stay in their homes rather than transfer to a nursing facility for nutritional support. Nearly all (92%) home-delivered meal participants said the meals help them continue to live independently, according to the 2022 national survey of Older Americans Act Title III home-delivered meal participants.

3. Reduced health care costs attributed to reduced hospital and nursing home spending: In line with the first and second outcomes identified above, the reduced health care and nursing home use by Meals on Wheels participants also meant less was spent on health care. One study found that among individuals receiving medically tailored meals, average medical expenditures were 40% lower per month for those receiving meals than for a matched group not receiving meals ($843 vs. $1,413).

4. Increased food security: Several studies concluded that home-delivered meal participants worried less about having enough to eat. Those individuals who received both breakfast and lunch, rather than just lunch, benefited even more.

5. Improved diet quality: Home-delivered meals led to higher-quality diets among participants, as measured by nutrient intake, calories, vitamins, and other indicators. Participant feedback reinforced that meal delivery helped them eat healthier, more nourishing foods.

6. Reduced or slower decline in nutritional risk: Program participants threatened by malnutrition saw improvement in their nutritional risk scores. Individuals benefited from both improved dietary intake and improved food security.

7. Reduced social isolation and loneliness: Several studies found a link between homedelivered meals and reduced social isolation or loneliness, particularly among participants who lived alone. These benefits resulted from contact with drivers during meal deliveries and opportunities for social connection via other Meals on Wheels programs.

8. Reduced falls and increased home safety: Several studies found Meals on Wheels participants experienced fewer falls and minimized exposure to hazards in the home, outcomes attributable to safety checks provided at meal delivery, and a reduced need to cook in the kitchen.

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justed for inflation. Sources and methods available at: https://www.mealsonwheelsamerica.org/docs/default-source/fact-sheets/2023/what—we—deliver—2023—national—snapshot—sources—methods.pdf

[18] Meals on Wheels America (September 2023), The Case for Meals on Wheels: An Evidence-Based Solution to Senior Hunger and Isolation. https://www.mealsonwheelsamerica.org/learn-more/research/the-case-for-meals-on-wheels-sept23

Improvements to the OAA:

Despite such remarkable improvements to health and well-being as the evidence-base shows, not the chasm is widening between those who need access to these critical services and those we are able to reach. That's why we are imploring Congress to boost federal funding to sufficient levels to not only maintain current utilization but also to expand and bridge the growing gap of unmet need. Additional resources are essential to enable the Meals on Wheels network to meet the evolving needs of our growing senior population and continue delivering the powerful and proven return on investment their services provide. The OAA is a foundational law that continues to function exceptionally well, consistent with its original, intended purposes. It has withstood the test of time. Any changes made to the legislation through the reauthorization process should maintain the integrity of the enacted OAA and support community-based aging programs as the backbone of service provision to older adults across the country. Especially as the older adult population skyrockets, the next reauthorization must allow the OAA network to evolve and expand in tandem with the increasing need/demand that will occur through this authorization period. In the following question, our priorities and improvements for the OAA are listed in greater detail.

2. What are your top priorities for OAA reauthorization? Please explain why.

Response:

As reauthorization approaches, Meals on Wheels America is focusing on several key legislative recommendations that further enhance the services and supports provided to older adults. Given the significant need, changing demographics, and inflationary pressures, we are pushing for increased authorized funding levels across all OAA programs, with an emphasis on closing the existing needs gap for nutrition services and establishing incentives and funding for medically tailored and culturally appropriate meals.

To ensure that any changes enacted through the upcoming OAA reauthorization do not harm older adults or the existing aging network, Meals on Wheels America has developed legislative priorities based on input from our diverse senior nutrition network. This network has decades of experience delivering services in their communities, in addition to Area Agencies on Aging (AAAs) and several State Units on Aging. We believe reauthorization should improve efficiencies and remove administrative burdens - such as complex funding transfer protocols and requirements - in the implementation of funding. As well, it should also build on the newly updated OAA regulations by reflecting the on-the-ground needs of service providers, older adults, and their families and caregivers. Ultimately, the goal is to continually address the growing, pervasive issues of senior hunger and isolation.

Top Priorities:

Meals on Wheels urges Congress to enact the following recommendations:

1. Increase authorization funding levels for all OAA programs and provide additional resources for enhanced nutrition services.

•Increase authorized funding, including sufficient funding for Title III Nutrition Services, to address existing waiting lists and reach the ever-growing number of older adults who would benefit from OAA programs.

•Authorize new funding streams and establish incentives for senior nutrition programs to offer medically tailored and/or culturally appropriate meals - which are more costly to prepare/procure - and expand reach in underserved areas.

•Improve and clarify authorization of funding for senior nutrition programs to maintain and invest in the infrastructure and resources needed to prepare and deliver services, including kitchen equipment, delivery vehicles, labor, etc.

2. Unify OAA Congregate, Home-Delivered and the Nutrition Services Incentive Program into a single Title III-C Nutrition Program.

•Create one authorized funding stream to remove administrative burden, improve efficiency, and enable community-based organizations to tailor nutrition services to seniors' needs more easily.

•Codify alternative nutrition services models, such as grab-and-go and drive-thru meals, which have been proven to reach more older adults struggling with hunger and social isolation.

•Modernize the Nutrition Services Incentive Program through enhanced partnership and coordination with USDA, HHS, states, Area Agencies on Aging (AAAs),

and local providers to procure commodity foods for preparing OAA meals and coordinate other important federal benefits and programs for seniors.

3. Prioritize community-based nutrition programs and experienced network providers in OAA grant awards and contracts.

•Encourage states and AAAs to partner more closely with and leverage senior nutrition programs' established infrastructure, dedicated volunteer base, and experience serving their communities to deliver nutritious meals, socialization services, and safety checks to more older adults.

•Ensure timely payment and reimbursement processes for nutrition services provided.

4. Expand senior nutrition program capacity and infrastructure support for further integration into the health care system.

•Reduce administrative and regulatory burdens on local nutrition and aging services providers seeking to establish contracts and partnerships with health care providers and payors.

•Provide additional resources and promote incentives for the aging services network to build the capacity, including infrastructure and technology, to meet the compliance and privacy standards for providing covered health care benefits.

•Promote innovations and successful practices learned during the COVID-19 pandemic.

•Facilitate continued innovation and implementation of many successful practices leveraged during the COVID-19 public health emergency, including new partnerships, programming, emergency preparedness and outreach.

•Support the expansion of evidence-informed and/or technology-based solutions that can help meet seniors' needs, including their preferences for meals and social connectedness.

3. The demographics of the older adult population are changing rapidly: Please describe changing needs and how the aging network (including area agencies on aging, senior centers, state units on aging, aging and disability resource centers, centers for independent living, etc.) plans to address them?

Response:

The OAA Nutrition Program is the essential linchpin to supporting the healthy aging process for millions of Americans. While this program continues to make inroads in addressing the national dual crises of senior hunger and social isolation, its ability to scale to the magnitude of the need and have the impact that is warranted (and that it is capable of) requires a concomitant level of investment.

As the population diversifies further, the types of meals and how meals are provided are also changing and adapting. More programs are offering medically tailored and culturally appropriate meals. They are tailoring nutrition to meet the unique health needs of their clients, treating food as medicine. Enabling seniors to have flexibility in when and where they enjoy their meals is yet another evolving trend borne out of the pandemic. There are key ways the aging network through the OAA is addressing the growing and changing needs of older adults.

Since its inception, the OAA Nutrition Program has provided billions of meals to seniors in need and improved countless lives. Our local programs do this through the more than a meal service model, such as daily safety checks, opportunities for socialization to prevent loneliness, phone calls to ensure the well-being of the most isolated individuals, monitoring of change of condition, caregiver support and connections to other critical community services that support the health and well-being of seniors. One of the ways our local programs are adapting to the changing needs of older adults is by offering medically tailored and culturally appropriate meals, which allow for increased access to nutritious meals.

4. What changes could Congress make to improve the efficiency and effectiveness of OAA services and programs?

Response:

While greater funding is the primary key to serving more seniors and improving the efficiency and effectiveness of the OAA, especially in the years following the COVID-19 pandemic, the OAA Nutrition Program must also continue to evolve and fulfill its original intent and core purpose to reduce hunger, promote socialization, and improve health and well-being for older adults in greatest social and economic need.

Unifying the Congregate and Home-Delivered Nutrition Services with the Nutrition Services Incentive Program (NSIP)

An important strategic proposal we recommend for the upcoming reauthorization, which we mentioned earlier, involves unifying the Congregate and Home-Delivered Nutrition Services with the Nutrition Services Incentive Program (NSIP) under a single Title III-C Nutrition Program and funding stream. This shift would improve efficiency at all levels of the aging network and would provide local service providers with the flexibility they require to tailor their offerings to meet seniors' preferences and the diverse needs of individuals across local communities far more easily. The OAA Nutrition Program is effective at supporting healthy aging because of the combination of proper nutrition and social connection that enables older adults to remain healthier and independent in their own homes, where they want to be; however, the current structure of the OAA Nutrition Program has inevitably contributed to disproportionate funding between different types of delivery models and creates a fragmented approach to delivering the spectrum of service offerings. Local nutrition programs consider the currently set percentage limits and reporting requirements on transfer authority between the nutrition services to be arbitrary and unnecessarily burdensome as they further complicate the movement and use of resources for nutrition providers to meet seniors' needs and preferences to age at home.

While we believe this legislative priority could be achieved in various ways and statutory language, we are recommending a proposal to restructure the program similarly to Sec. 321 of the Act, where allowable activities that are eligible and funded under Title B Supportive Services are outlined in a codified list of services. Further, funding traditionally allocated to NSIP would be redistributed into the consolidated Title III Nutrition Program funding. As a recommended example, under an amended section for a unified program, state and local agencies could have the flexibility to allocate nutrition service funds towards any of the following activities without caps limiting funding distribution of various subprograms/allowable services currently authorized under Title III-C of the Act and per the finalized regulations:

1. Congregate meals
2. Home-delivered meals
3. Grab-and-go, carry out and/or curbside meals
4. Nutrition counseling, assessments, and education related-services (provided in tandem with congregate, home-delivered, and/or eligible alternative meal

Encouraging and Incentivizing Greater Partnership and Coordination

We believe there is further opportunity to modernize NSIP by encouraging and incentivizing greater partnership and coordination in the OAA Nutrition Program among USDA, HHS, states, and Area Agencies on Aging (AAAs). The envisioned collaboration between these entities would allow them to be better poised and connected to help local providers procure the commodity foods needed to prepare and provide balanced Title III meals.

As these federal departments and agencies and their state and local affiliates are heavily involved with the administration and implementation of many other benefits and direct services that support seniors, we propose language and/or requirements encouraging greater partnership in connecting local providers with commodities to reduce procurement costs and connect eligible older adults with all of the federal nutrition, social and financial support from which they may benefit.

Prioritize Community-Based Organizations

Additionally, we believe there should be a concerted effort to prioritize community-based organizations for nutrition services contracts, as local providers deliver a holistic service, not just a meal. The Act has the potential to go further in supporting the long-serving community-based senior nutrition programs that are experts in addressing these interconnected issues by prioritizing them for limited federal grant funding and the OAA contracting process. Nonprofit community-based organizations (CBOs) are uniquely positioned to meet the needs of individuals in their own community as they understand the interplay of resources and connection to other local services and coalitions. Encouraging contracts with these entities helps ensure that the services provided include the more than a meal service model, such as daily safety checks, opportunities for socialization to prevent loneliness, phone calls to ensure the wellbeing of the most isolated individuals, monitoring of change of condition, caregiver support and connections to other critical community services that

support the health and well-being of seniors. Currently, many long-time OAA providers risk or face the loss of critical resources to contracts being awarded to for profit nutrition services as the lowest cost meal provider. These company models may not provide the same level and breadth of service and coordination that Meals on Wheels provides to holistically meet the needs of seniors living independently at home.

There is also wide variation in the amount reimbursed for each meal provided through OAA funding between states and geographic regions and limited information on the processes used to determine this per meal reimbursement. The overwhelming majority of reimbursement rates do not cover the total cost of the meal and services provided, and many have not increased in years. Further, better public information on reimbursement rates would help to improve understanding of how reimbursement rates are determined and the role they might play in creating waiting lists and exacerbating unmet need in local communities.

This recommendation helps ensure that funding explicitly appropriated to the OAA Nutrition Program assists the seniors it is designed and intended to serve. It continues to support the community-based organizations that have built the community's trust and are the ″eyes and ears″ for those they serve.

Finally, as we expand upon our responses to the Targeted Questions below, this reauthorization is also an opportunity to further modernize the OAA by incorporating innovations, flexibility, and successful practices that were leveraged during the pandemic and ensuring that services authorized under the Act remain adaptable and responsive to the evolving needs of America's older population.

Targeted Questions:

A. Legislation passed by Congress in response to the COVID-19 pandemic made temporary changes to some OAA programs, including flexibility for nutrition services funding and adjustments to eligibility for home-delivered meals.

1. What impact did these changes have on older adults and program operations?

Response:

Enhanced flexibility has been extremely beneficial and remains a top priority for many OAA nutrition service providers.

During the pandemic, the flexibilities enabled local programs to adjust on the fly, as they encountered situations they never faced before and needed the space to innovate and reach as many people as possible. In particular, the ability to transfer 100% of funding between Congregate and Home-Delivered meals during the Public Health Emergency was essential. It allowed OAA nutrition providers to serve each person individually and ensure the strategic and cost-effective use of federal funding to provide people with the services they required as needs evolved.

As one senior nutrition program representative recently noted to us regarding the ACL's final rule:

> ″[OAA policies] must include as much flexibility as possible for funding of congregate and home delivered funds. The 'boots on the ground' who are providing services should be allowed to make decisions based on the people they serve.″

2. How should Congress consider these changes outside of a public health emergency?

Response:

We would like Congress to make permanent the ability to direct nutrition funding to where it is needed most in each community, rebalancing and streamlining to accommodate flexibility is critical. As previously noted, we consider the authorized percentages and limits on transfer authority between the nutrition services to be arbitrary and unnecessarily burdensome as they further complicate the movement and use of resources for nutrition providers at the state and local levels. As such, we strongly support a permanent combination of the C1 and C2 nutrition programs and the Nutrition Services Incentives Program (NSIP) into a single Title III-C program (or at a minimum, permanently allow 100% transfer authority between the nutrition funds).

Currently, State Units on Aging have the ability to transfer up to 40% of allocated funding between Title III C1 (Congregate) and Title III C2 (Home-Delivered). However, our network of community-based providers reports that the rationale for the levels and timing of transfer at the state level is not always clear, and the reporting

and administrative requirements to initiate and complete funding transfers between their funding services can be onerous.

We have long advocated for greater parity in budget allocations between the congregate and home-delivered meal programs. In FY 2023, only 40% of the total nutrition funding was appropriated to home-delivered meals. To allow full flexibility of transfer between these programs or by eliminating the separate subparts entirely, programs with limited capacity and resources at their disposal will be able to direct funding toward the specific needs and preferences of older adults in their communities.

Further, in our proposal to eliminate NSIP and redirect appropriations toward the unified Title III-C Nutrition Program, we believe the program's resources would be better utilized as direct funding for the network.

3. What changes made during the COVID-19 pandemic but not mentioned above should Congress examine for this reauthorization?

Response:

Supplemental funding provided through the various emergency COVID-19 relief packages in 2020 and 2021 was absolutely critical. It allowed organizations to respond rapidly with the reassurance that resources were coming and that seniors in communities would not be going without nutritious meals. It also allowed our network to begin addressing the services and unmet needs gap before the pandemic started.

While it's our understanding that only a few states have expended all COVID-relief funding, a growing majority (75%) have expended half or more. Under the statute, states have until September 30, 2024, to expend American Rescue Plan Act funds. Our hypothesis is that resources are not flowing to local service providers more quickly due to fears about annual appropriations cuts that could occur because of what is happening right now in Congress. The Aging Network again needs reassurance that more funding will be coming so that older adults don't begin services and then be forced off the program when there's no longer adequate funding.

Investments in the Older Americans Act had declined well before the COVID-19 pandemic and has neither kept pace with a rising age 60+ population nor inflation. Adjusted for inflation, regular federal funding (excluding emergency supplemental funding) appropriated to the OAA Nutrition Program decreased by $20 million (1.9%) between FY 2019 and FY 2023. Before the influx of emergency supplemental funding in FY 2020-2021, about 18 million fewer OAA meals were served in 2019 than in 2009 due to inflation, rising costs, and inadequate funding. Without increasing both the authorization and appropriation levels on which these programs depend, local programs must attempt to fill the ever-growing gap in other ways. Or worse, Meals on Wheels programs will be forced to reduce services, add more food insecure seniors to wait lists or turn them away altogether.

4. How should Congress consider the impact of the pandemic when working to reauthorize OAA?

Response:

Increased federal funding and extended flexibility within the nutrition program following the COVID-19 pandemic are essential to help ensure that programs have the resources needed to continue providing a wide range of services that meet the unique needs of their communities. Local senior nutrition providers recognize the importance of providing a range of appropriate nutrition options to older individuals and should be used as experts in this field, but they need more resources to do so. The response of the senior nutrition program network in the wake of COVID-19 proved that this model of service is not only effective at working with limited resources but also highly adaptable and able to address unmet needs as they arise.

B. During the COVID-19 pandemic, OAA partners, including congregate meal providers, adapted to new ways of delivering services, such as providing grab-and-go meals.

1. In the absence of a public health emergency, is it appropriate to retain flexibility in meal delivery services for the congregate meals program? If so, why? What effect would changes in meal delivery services have on older Americans?

Response:

Since the onset of the pandemic, local senior nutrition providers have experienced a drastic increase in demand for home-delivered services and alternative delivery

models such as grab-n-go, carry-out, and curbside meals. Greater flexibility in providing these alternative delivery methods in the OAA statute would provide greater balance and flexibility for programs to tailor their services better and support older adults in the coming years. We believe it is important to give local programs the freedom to respond to their diverse and evolving local needs.

Meals on Wheels programs also play a critical role in providing regular meals and socialization opportunities. For countless individuals participating in the program, the staff members and peers at a congregate dining facility, or the volunteer delivering a meal and visit to the home, may be the only person(s) an older adult sees that day, providing critical occasions for social connection. Therefore, we believe that any flexibility in service delivery must be assured not to reduce and/or prevent access to opportunities for vital social connection provided through the nutrition program. In any capacity and especially through home-delivered meal services, Meals on Wheels volunteers and/or staff are additional eyes and ears in seniors' homes, often serving as first responders if an emergency has occurred or preventing them from occurring altogether. As many local programs have described, without greater flexibility to provide home-delivered and alternative delivery models, older adults' safety and well-being would be at greater risk:

″We consistently hear from HDM [home-delivered meal] clients that our driver is the only individual they see each day. Social isolation is a crisis in our country, and we are battling it on a daily basis, one delivery at a time. In addition, delivery drivers frequently find clients in distress and needing immediate assistance. Clients have fallen and have been lying on the floor for hours, unable to get up on their own. Clients have been found on the verge of a diabetic coma or having breathing problems. Without our safety check, we can only imagine the outcome.″ - Meals on Wheels program in Ohio

″One example of how important the home-delivered meals program is a driver found a female who had fallen out of her wheelchair and was stuck between it and a table. She was unable to call for help and he was able to call 911. She had been in that situation for approximately two hours.″ - Meals on Wheels program in West Virginia

The consequence of not allowing flexibility and the ability to provide nutritious meals and meet the needs of the community include harm, loss of quality of life, and financial cost to our clients, their families, and taxpayers for preventable healthcare costs incurred.

2. Should Congress consider any requirements related to different ways of providing congregate meals?

Response:

Our primary position and recommendation regarding congregate meals is to unify the nutrition services under one Title III-C program so that providers have the flexibility to deliver services in a way that meets the needs of their communities. Again, this reauthorization should modernize the OAA by consolidating the OAA Nutrition Program, which would simplify operations and increase the local programs' abilities to provide person centered services that still focus on enhancing nutrition and reducing social isolation. By unifying the nutrition services under a single program and line item, this modification would protect the core purpose of the OAA Nutrition program, which is to reduce hunger, promote socialization, and promote health and well-being. Furthermore, it would better help programs respond to seniors' evolving and diverse needs across communities and enable more decision-making at the local level, which is best positioned to address their communities' needs.

Without full 100% transfer authority between all service delivery models or a consolidated Title III-C Nutrition Program, we believe the congregate meal program should be established as the prioritized/mandated funding stream for grab-and-go, take out and/or curbside meals. As this level of flexibility within the nutrition program was not achieved in the newly finalized regulations, we maintain the urgent need to address the disproportionate budget allocations between congregate and home-delivered nutrition programs. Similarly, while we strongly support flexibilities established and granted through the regulations, terms like ″grab-and-go,″ ″carry-out″ or ″drive through″ are not technically home-delivered meal models in name or practice, so we urge careful consideration of terms - as well as the appropriate funding streams - that are selected so that it is not confusing to the people for whom it is designed to serve.

C. Congress made several changes to OAA through the Supporting Older Americans Act of 2020, including adding caregiver assessments to the National Family Caregiver Support Program as well as efforts to improve social isolation.

1. Have these policies better informed resources needed by caregivers or older Americans? Please explain why or why not, and if yes, how.

Response:

We are supportive of the several provisions, including requiring a report on social isolation and the effect of the OAA program included in the last reauthorization to increase focus and understanding of social isolation and the evidence-based practices to prevent and address loneliness, The final reauthorization's provisions to expand and improve screening of and long-term planning and coordination to address social isolation are especially beneficial for older adults receiving these services as these issues and the negative outcomes associated with them are historically overlooked and under-addressed.

The importance of focusing on social isolation and loneliness in the last reauthorization was realized almost immediately upon enactment during the COVID-19 pandemic.

2. How can Congress improve these efforts?

Response:

Leveraging the network of senior nutrition providers to combat social isolation and loneliness is a crucial focus at Meals on Wheels America. While we believe these OAA amendments have brought much-needed awareness of the issues and strengthened the capacity for OAA programs and resources to address them better, additional support is necessary beyond the critical work already done to ensure the safety and social connectedness of our nation's seniors. As with other OAA services and programs, these activities remain underfunded, and much more investment of resources to address social isolation and loneliness among older adults is urgently needed.

As recommended above, we believe the Act can further support the long-serving community based senior nutrition programs that are experts in addressing these interconnected issues by prioritizing them for limited Federal Grant Funding and the OAA contracting process. For decades, and now more than ever, seniors are relying on Meals on Wheels programs to provide services, including essential socialization, through various creative and resourceful ways that meet the growing needs in their communities. Below are a few examples of these activities that programs are able to offer to support social connection and wellness among participants:

•Telephone reassurance services are designed to have a volunteer or staff member make consistent phone calls to isolated older adults.

•Friendly visitor or senior companion programs designed to offer human connection by providing companionship and emotional support to older adults who are socially isolated or lonely.

•Pet assistance and food delivery programs often leverage partnerships with shelters, veterinarians, pet food stores, and/or boarding and sheltering services to provide holistic animal care and encourage animal companionship. Seniors with pets are less likely to exhibit depression, report feelings of loneliness and experience illness.

Unfortunately, many long-time OAA providers are at risk of losing critical resources to contracts with for-profit nutrition services. Meals on Wheels provides a more holistic, service-oriented approach to meeting the needs of seniors living independently at home than many for-profit models. When these models are selected and prioritized for OAA meal service delivery over traditional local Meals on Wheels programs and senior nutrition providers, far fewer individuals receive the social connection they need with their meals. For this reason, we have long advocated for greater prioritization, utilization, and support for the network of community-based programs that specialize in nutrition services and are already delivering nutritious meals with trusted human connection.

3. What changes made in the Supporting Older Americans Act of 2020 but not mentioned above should Congress examine for this reauthorization?

Response:

We remain highly supportive of changes in the last reauthorization that highlighted the importance of addressing and mitigating the negative impact of issues per-

taining to senior hunger and nutrition, such as malnutrition, chronic diseases, older adult falls, and home safety, as well as social isolation and loneliness described above.

We believe this reauthorization can build upon the advances made in the Supporting Older Americans Act of 2020 with language and authority regarding Food is Medicine (FIM) and medically tailored meals, which are burgeoning practices in the nutrition and healthcare field. Health providers and insurers are increasingly looking to work with the aging services network and Meals on Wheels providers to support and execute their FIM/medical meal strategies; however, many barriers remain in forming and sustaining these partnerships, including restrictive policies and resources.

Several state Medicaid plans offer Home- and Community-Based Services (HCBS) waivers to provide home-delivered meals as a covered service, which is particularly relevant to elderly and disabled beneficiary populations. Additionally, with guidance under the Centers for Medicare and Medicaid Services (CMS), Medicare Advantage (MA) Special Need Plans (SNP) for beneficiaries with chronic conditions are now able to cover additional supplemental benefits, including meals delivered to the home, that are tailored specifically to the patient's conditions and health needs. Greater contracting with Meals on Wheels programs that can also provide efficient, cost-effective health monitoring in the home setting is critical, though, to scale and unlock the true cost-saving advantages of these benefits. To be able to offer many of these services through healthcare partnerships, additional investments must be made to enable senior nutrition programs to meet the requirements and protocol for such infrastructure and operations.

Similarly, we often hear from local senior nutrition providers how special meals, such as medical or cultural meals, are more costly to produce and deliver and may differ based on the community. As evidence shows promising outcomes for these types of special meals in certain communities and in certain healthcare interventions, we believe the next reauthorization should recognize the value of and appropriately resource these enhanced nutrition services. By providing additional targeted funding that is structured in a way that allows for flexible, age-appropriate implementation and promoting opportunities for programs to access alternative revenue streams for special meals, the aging network will be better supported and have the capacity to cater to the health and medical needs and/or preferences of older adults they serve. For example, securing more resources for senior nutrition programs to establish and manage partnerships with local farms would assist older adults actively seeking out easily peelable and digestible fruits and vegetables.

D. ACL recently finalized regulations regarding OAA. Should Congress consider any changes in response to the new rule?

Response:

Our organization supports the recent effort to update federal regulations for OAA policies and programs for Titles III, VI, and VII for the first time in 36 years.[19] We appreciated the opportunity to provide comments on the rule and ACL's partnership. As a result, they are better aligned with language and additions from recent reauthorizations and better reflect the needs of today's growing and diversifying older adult population.

We are especially supportive of the final rule as it contains clarifying language around the home-delivered meals for seniors, including clarification that eligibility for home-delivered meals is not limited to people who are ″homebound″ and that criteria for home-delivered meals may depend upon many factors (including ability to leave home unassisted, ability to shop for and prepare nutritious meals, mental health, degree of disability or other relevant factors pertaining to their need for the service, including social and economic need.

While we are encouraged to see much consideration and modernization of OAA regulations through this process, regulatory updates and guidance can only achieve so much, and we look forward to addressing remaining priorities and making further legislative improvements during reauthorization. Federal level, these include:

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[19] ACL (February 2024), Final Rule [89 FR 11566]: Older Americans Act: Grants to State and Community Programs on Aging; Grants to Indian Tribes and Native Hawaiian Grantees for Supportive, Nutrition, and Caregiver Services; Grants for Supportive and Nutritional Services to Older Hawaiian Natives; and Allotments for Vulnerable Elder Rights Protection Activities. https://www.federalregister.gov/documents/2024/02/14/2024-01913/older-americans-act-grants-to-state-and-community-programs-on-aging-grants-to-indian-tribes-and

•Unifying - or authorizing permanent 100% funding transfer authority between - the home delivered, congregate, and NSIP into a single Title III Nutrition Program.

•Increasing funding authorization levels for all OAA programs, particularly as current funding and reimbursement rates are not keeping pace with increasing demand for nutrition services and sustained higher operating costs.

•Providing additional resources for enhanced nutrition services and requiring that state agencies, AAAs, and local providers be aware of the definitions, uses, and importance of culturally appropriate meals, medically tailored meals, fresh produce, and locally sourced food, as included in the statute.

•Prioritizing community-based organizations and public entities, such as AAAs, county governments, tribes, nonprofit service providers, or volunteer organizations, to receive grant awards and/or enter contracts to provide Title III services.

Thank you again for the opportunity to submit these comments and for considering our concerns and recommendations for the forthcoming OAA reauthorization. A strong reauthorization of the Act is critically needed to improve the delivery, access, and long-term sustainability of services and supports for seniors. Local Meals on Wheels and other OAA programs are essential, effective, and work well to meet the nutritional, health, and social needs of older adults, but they need more support from Congress to better serve older adults in need. Please do not hesitate to reach out with any questions as you continue this critical work for older Americans, their families, and caregivers.

Sincerely,

/s/
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MEALS ON WHEELS AMERICA

OLDER AMERICANS ACT REAUTHORIZATION

PRIORITIES AND RECOMMENDATIONS

The reauthorization of the Older Americans Act (OAA) is an opportunity to strengthen and preserve the Act's original intent and core purpose to **reduce hunger, promote socialization, and improve health and well-being for older adults in greatest social and economic need.**

Any policy changes must first and foremost do no harm to the aging services network and the seniors they support. Rather, they must address the pervasive and growing challenges of senior hunger and social isolation. We believe reauthorization should also build on the newly updated OAA regulations by continuing to modernize the law and reflect the on-the-ground needs of service providers, older adults, and their families and caregivers. Accordingly, Meals on Wheels America urges Congress to enact the following recommendations:

1. **Increase authorization funding levels for all OAA programs and provide additional resources for enhanced nutrition services.**
   - Increase authorized funding, including sufficient funding for Title III Nutrition Services, to address existing waiting lists and reach the ever-growing number of older adults who would benefit from OAA programs.
   - Authorize new funding streams and establish incentives for senior nutrition programs to offer medically tailored and/or culturally appropriate meals and expand reach in underserved areas.
   - Improve and clarify authorization of funding for senior nutrition programs to maintain and invest in the infrastructure and resources needed to prepare and deliver services, including kitchen equipment, delivery vehicles, labor, etc.
2. **Unify OAA Title III-C Program**
   - Create one authorized funding stream to remove administrative burden, improve efficiency and enable community-based organizations to more easily tailor nutrition services to seniors' needs.
   - Codify alternative nutrition services models, such as grab-and-go and drive-thru meals, proven to reach more older adults struggling with hunger and social isolation.
3. **Prioritize community-based nutrition programs and experienced network providers in OAA grant awards and contracts.**
   - Encourage states and AAAs to partner more closely with and leverage senior nutrition programs' established infrastructure, dedicated volunteer base and experience serving their communities to deliver nutritious meals, socialization services and safety checks to more older adults.
   - Ensure timely payment and reimbursement processes for nutrition services provided.
4. **Expand senior nutrition program capacity and infrastructure support for further integration into the health care system.**
   - Reduce administrative and regulatory burdens on local nutrition and aging services providers seeking to establish contracts and partnerships with health care providers and payors.
   - Provide additional resources and promote incentives for the aging services network to build the capacity, including infrastructure and technology, to meet the compliance and privacy standards for providing covered health care benefits.
5. **Promote innovations and successful practices learned during the COVID-19 pandemic.**
   - Facilitate continued innovation and implementation of many successful practices leveraged during the COVID-19 public health emergency, including new partnerships, programming, emergency preparedness and outreach.

- Support the expansion of evidence-informed and/or technology-based solutions that can help meet the needs of seniors, including their preferences for meals and social connectedness.

For more information, please contact the Meals on Wheels America Advocacy Team at advocacy@mealsonwheelsamerica.org.

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