

THE NATION'S RURAL ELDERLY

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HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FIFTH CONGRESS

FIRST SESSION

PART 17—CHAMPAIGN, ILL.

DECEMBER 13, 1977



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The Nation's Rural Elderly :

- Part 1. Winterset, Iowa, August 16, 1976.
- Part 2. Ottumwa, Iowa, August 16, 1976.
- Part 3. Gretna, Nebr., August 17, 1976.
- Part 4. Ida Grove, Iowa, August 17, 1976.
- Part 5. Sioux Falls, S. Dak., August 18, 1976.
- Part 6. Rockford, Iowa, August 18, 1976.
- Part 7. Denver, Colo., March 23, 1977.
- Part 8. Flagstaff, Ariz., November 5, 1977.
- Part 9. Tucson, Ariz., November 7, 1977.
- Part 10. Terre Haute, Ind., November 11, 1977.
- Part 11. Phoenix, Ariz., November 12, 1977.
- Part 12. Roswell, N. Mex., November 18, 1977.
- Part 13. Taos, N. Mex., November 19, 1977.
- Part 14. Albuquerque, N. Mex., November 21, 1977.
- Part 15. Pensacola, Fla., November 21, 1977.
- Part 16. Gainesville, Fla., November 22, 1977.
- Part 17. Champaign, Ill., December 13, 1977.

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THE NATION'S RURAL ELDERLY

TUESDAY, DECEMBER 13, 1977

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Champaign, Ill.

The committee met at 9:40 a.m., pursuant to notice, in St. John's Lutheran Church, Hon. Charles H. Percy presiding.

Present: Senator Percy.

Also present: Kathleen M. Deignan, professional staff member; Margaret S. Fayé, minority professional staff member; Lawrence Grisham and Wayne Fletcher, legislative assistants to Senator Percy; Alison Case, assistant chief clerk; and Madonna Pettit, research assistant.

OPENING STATEMENT BY SENATOR CHARLES H. PERCY, PRESIDING

Senator PERCY. I want to welcome all of you to these sunrise services this morning. I am sorry to have been a little late, but I did have a meeting with 30 of the outstanding farmers in the area to hear about the problems of agriculture prior to the proposed national farmer's strike on December 14. I don't think many of those farmers whom I met with are going to be striking.

It is an honor to have all of you here, and inasmuch as we are in this beautiful church where the pastor generally stands at the back of the church and shakes hands, I am sorry I didn't have a chance to meet all of you. But I will go to the back of the room when we adjourn the hearings, and I would like to meet each and every one of you. I want to express my thanks on behalf of the Senate Special Committee on Aging for your attendance this morning.

The format of our meeting will be three panels. At the end of the testimony to be given by each of the separate panels, I will ask for a couple of questions from the audience. I will try to take you in the sequence that I see hands go up. At the end of the three panels, we will take as many questions as we can from the audience, so I will ask our panelists to be as concise as they can. Their full testimony, of course, will go in the hearing record, but we will try to take as many questions as we can from you.

If at the end of the hearing—12 o'clock—you have not had a chance to ask your question, you will find in the back of the room, or maybe you have already picked them up, these green forms addressed to me. If you would be good enough to write out any comments that you

would like to make, we will see that you not only receive a copy of the transcript of the hearing, if you check that off, but also we will see that those comments that you make will be incorporated as a part of the written record of the hearing.¹

This is a hearing of the Senate Special Committee on Aging, and we are very pleased to be in Champaign today. Frequently, hearings are held by our committee in Washington, and we have experts who come to Washington. However, it is a little different when the committee comes out to you because you are in your own home setting. I sometimes feel that people coming to Washington see us sitting in these huge cabinet rooms and get a little stage fright. They don't feel quite as familiar as they are on their own home grounds, talking about things in their own communities. That is why I am so gratified that the committee decided to have hearings out in the country rather than always in Washington. I think it provides an opportunity also for our local media to participate with us because, so many times, we find that many senior citizens simply do not know of programs that are available to them.

SENIOR CITIZENS SAVE COMMITTEE

In the reorganization of the Senate, it was recommended that this committee be abolished, and it was senior citizens who banded together and petitioned the Senate to not abolish this committee. When we decided that every Senator would have to be limited to the number of committee assignments he had, I was faced with the choice of choosing between the powerful Joint Economic Committee on which I had been for 10 years—I took my degree in economics and it was my chosen field, and I love working with Hubert Humphrey as the chairman of that committee—but when given the choice of choosing between that committee and the Special Committee on Aging, I chose without equivocation the Special Committee on Aging. Aging is a subject to which I devoted full time on the only textbook I ever wrote, "Growing Old in the Country of the Young," published by McGraw-Hill. So I come to you with a strong feeling that those who are participants today deserve the gratitude of the Senate for their testimony.

This committee has been charged by the Senate to "make a full and complete study and investigation of any and all matters pertaining to problems and opportunities of older people." In that capacity, the committee has been conducting a series of hearings on "The Nation's Rural Elderly," which is the topic of our hearing today. We are here to look into the unique problems and needs of the rural elderly. Our inquiry will concentrate on the coordination of services provided under the Older Americans Act, transportation and energy-related programs for the elderly, and health care delivery.

We are becoming, in this country, an older society. Presently, 10 percent of our population is age 65 or older, and it is projected that this figure will increase to 17 percent in just 50 years. Such a population shift presents critical questions to Congress and to the American people as a whole as we develop social policies which will enable all

¹ See appendix 3, page 1465.

Americans to lead full and productive lives. The elderly have special needs in all areas of societal concern: Housing, transportation, employment, health, recreation, nutrition, and other social services.

Due to the smaller populations of rural areas, the greater distances between places, the generally smaller economic bases, and the movement of younger persons away from rural areas, the rural elderly have unique problems. In most communities they constitute a very high proportion of the population.

ONE-FOURTH OF ELDERLY LIVE BELOW POVERTY LEVEL

In the 16-county area which comprises the East-Central Illinois Area Agency on Aging, over 15 percent of the population is 60 years of age or older, with the proportions ranging from 8.5 percent in Champaign County, which has the smallest elderly population because of the large university population, to 22.5 percent in Clark County. One-fourth of them live on incomes which are below the poverty level and, in an area where transportation is sparse, almost 60 percent of them have only limited mobility.

These conditions are not unique to east-central Illinois. There are similar problems in rural areas throughout the country. This is the reason why the Senate Committee on Aging is conducting these hearings. We are gathering the information necessary for Congress and the executive branch of the Federal Government to develop and implement a comprehensive national policy on aging. Although tremendous strides have been made toward that goal in recent years—the establishment of senior centers, nutrition programs, and other initiatives designed to assist the elderly that have achieved significant successes—despite all this, we still have a long way to go.

I am very pleased that Mrs. Josephine Oblinger, the director of the Illinois Department of Aging, is with us today. Mrs. Oblinger will make a few remarks before we call the first panel of witnesses. I have known her for a long time. I won't say how long, but I found her to be one of the most dedicated public officials that I know. I am just delighted to open our meeting with a few comments by Jo Oblinger.

STATEMENT OF JOSEPHINE OBLINGER, DIRECTOR, ILLINOIS DEPARTMENT ON AGING, SHERMAN, ILL.

Mrs. OBLINGER. Senator Percy has kindly consented to add a part to the proceedings today so that he can see in action the results of some of the bills they passed in Congress. Most of you are familiar with title V which is for the acquisition, renovation and expansion of multipurpose senior citizen centers. We were given a grant by the Federal Government early this fall, and we then contacted all our area agencies on aging and asked for recommendations on grant proposals, which they sent us. We review them, indicate whether we agree with their priorities or not, and then make the award. Today it is my pleasure to make an award to one of the projects in this area.

I really want to stand because I am so proud of them. This is to the Charleston Area Senior Activities, Inc. They have presented to us one of the most complete, one of the finest, proposals I have ever seen. If

they were all like this, we would not have any work to do. They are taking over the basement of the Elks Club in Charleston, building a ramp and entranceway through a window so they will conform to 504, Senator, and there won't be any person who can't come in.

INTERIOR BEING REDECORATED

Then they are redecorating the whole interior. The space had been given over to some young people, and everything was painted black. They are going to make it more cheery. They told me yesterday they are even going to have red telephones, and I don't know if that is going to be a hotline to the Senator or not, but anyway, they are going to have red telephones.

At this time one of their board members, who is a senior citizen, Mr. Paul Craig, will be asked to come up here and accept our grant. This grant is for \$32,452. The Illinois Department on Aging is pleased to make this award. [Applause.]

Mr. CRAIG. I will accept this grant for the Charleston area, but I didn't come to make a speech. Thank you again.

Mrs. OBLINGER. Thank you.

Senator PERCY. I think we should note that you are putting in \$13,-484 also, so the total project is \$45,936; is that right?

Mrs. OBLINGER. That is right. There has to be a local match and it may be part in time, part cash, and they have both.

Senator Percy, members of the committee and staff, I wish to commend you on holding a hearing on the needs of the rural elderly—on holding it in an area where firsthand testimony can be secured. The Illinois Department on Aging appreciates being asked to present testimony and is cognizant, too, that it offers the department an opportunity to incorporate the testimony given today into our program planning.

As a senior resident of rural Illinois, I live on a working farm myself and have been snowed out for 3 days and my husband has been snowed in. I wish to offer comments on two problems that are of concern to many of us. These are in addition to the testimony offered by Mr. Klage who is speaking on behalf of the Department of Aging.

CONGREGATE HOUSING NOT PRACTICAL

Housing is a problem for Americans in rural areas where it is neither practical nor expeditious to develop congregate housing. However, the program which we call finders keepers leasing program is peculiarly suited to the rural areas. This program which pays 75 to 85 percent of the rent for those who qualify, single person with an income under \$4,100 up to \$13,700 for a family of eight, allows people to remain where they are presently residing, provided that the housing qualifies as "safe, decent, and sanitary," and that the landlord agrees to come into the program. We would like to see this program expanded in the rural areas, with HUD doing a much more intensive and extensive information program on its availability and allocating more money and more slots to the rural counties—slots specifically earmarked for the rural communities.

I have a copy of that program here. You know, in the rural communities we cannot build a 90-unit housing complex. We don't have the money and we don't have the people available in that small area. This program would help rural areas and I have the pamphlet here on it.

A second need voiced by many of the rural elderly is for supportive services in order to keep people in their homes and out of institutions. Homemaker, housekeeper, home chore services and home health programs are more readily available in urban areas where social services are concentrated. Available title XX funds are used for the limited development of these programs in Illinois. States need block grants or a designation of certain amounts of title XX dollars for these purposes. Alternative comprehensive care programs which we are in the process of developing in Illinois have three model projects in existence now, and should be greatly expanded into rural areas where many of the elderly live while the younger people are moving into the cities.

HIGH RATIO OF RURAL ELDERLY

In the 12 counties served by Lincoln Land Community College—and I am from Springfield and have been there for many years—our demographic studies showed that people 60 and over make up over 22 percent of the population, as against 11 percent statewide; of the poverty population, the rural elderly make up 48 percent. Many of these people reside in rural Illinois.

I hope this committee will be the conduit which carries these messages to the U.S. Congress. I appreciate the committee's concern for the well-being of our rural older citizens.

Thank you for allowing me this opportunity to speak for rural senior citizens, because I am one.

Senator PERCY. You speak from knowledge.

Mrs. OBLINGER. Yes; I do.

Senator PERCY. Thank you very much. We appreciate your comments.

We will now call our first panel.

Before we start, I would like to acknowledge our gratitude to those who have made these hearings possible, starting with Rev. Donald Ehlers, who is the pastor of the church; Phyllis Pinkerton, Phil Cunningham, and Sharon Lindsay have also been so very helpful.

Peg Fayé on my left, from the Committee on Aging minority staff; Kathy Deignan, Alison Case, Madonna Pettit of the committee majority staff; Lawrence Grisham, Wayne Fletcher, and Hal Smith of my office. We appreciate them being with us today.

Now our first panel will consist of Richard Klage, Phyllis Pinkerton, and Sharon Lindsay. Will they take their places right here, please?

We can go in the order in which I have called you. Richard Klage is a social service consultant with the Illinois Department on Aging. Mr. Klage is also the title VII coordinator for the State and the representative for the department in this area of the State. He will testify for the department on aging.

Mr. Klage.

**STATEMENT OF RICHARD E. KLAGE, CONSULTANT, DIVISION OF
FIELD SERVICES, ILLINOIS DEPARTMENT ON AGING, SPRING-
FIELD, ILL.**

Mr. KLAGE. Senator Percy, distinguished members of the Special Committee on Aging and staff, the Illinois Department on Aging appreciates the opportunity to comment on the Older Americans Act and possible revisions of that act. I am Dick Klage, consultant, division of field services, Illinois Department on Aging.

The Illinois Department on Aging is the sole State agency designated by the Governor to develop and administer the State plan, review all programs for seniors within other State agencies, and carry out the functions and responsibilities of the State agency as identified in the Older Americans Act, as amended in 1973—Public Law 93-29, 87 statute 36-45. The overall objective of the department on aging is to strengthen or develop, at the community level, a system of coordinated and comprehensive services for the elderly.

GOAL: SOCIAL SERVICE DELIVERY SYSTEM

The department on aging is responsible for planning and monitoring, functioning as an advocate on behalf of the elderly, defining planning and service areas, and designating local area agencies on aging. The department and the agencies are mandated to develop a comprehensive and coordinated social service delivery system including needs assessment, evaluation, and, based on needs, establish sub-contracts with provider agencies for direct services. They are also to establish advisory councils with consumer representation for review of their area plans and programs.

The department on aging is responsible for the five major titles under the Older Americans Act. These are: title III, title IV-A, title V, title VII, and title IX.

Although the committee is currently discussing the Nation's rural elderly, some of the problems with the various titles not only affect the elderly, but the total system. One of the problems is that planning under current Federal and State legislation affecting the rural elderly does not allow sufficient leadtime for the Federal to the State to the area agency unit to adequately identify the needs of the older persons. With limited time to develop programs, prepare applications, and fund these programs, the program may lack a degree of coordination. To develop such coordination after the programs have been funded is much more difficult than to provide for the coordination prior to the time the program is funded.

We feel one of the most useful tools in coordinating services to the elderly is title V of the Older Americans Act of 1965, as amended. That title provides funds for making grants and contracts to pay part of the cost of acquiring, altering, or renovating existing facilities, including the initial equipment of such facilities to serve as multipurpose senior centers. The first allocation within the State of Illinois was during the transitional quarter—July–September 1976—which provided \$277,000, which was a limited amount of funds. For fiscal

1977, title V provided for the State of Illinois an additional amount of \$986,500 for multipurpose senior centers, certainly not a significant amount for the State of Illinois on the whole.

COORDINATION OF FUNDING

Funds under this title have effectively brought together titles III and VII programs in one central facility to provide services to a broad base of elderly persons. Although many title III and title VII services were provided from the same facility, there were a number of places where the original title III facility was not large enough to accommodate the newly funded title VII program. Therefore, quite often there were two focal points for senior citizens in the same community. With funding under title V, facilities can be developed which will accommodate funding under several titles. However, a modest amount of funds available limits the extent which coordinated programs can be developed.

The first funding under this title was for the transitional quarter July 1, through September 30, 1976. The release of the funds and the basic documents needed to complete grant reforms arrived only shortly before the deadline for such grants to be received. Likewise, in fiscal year 1977, the State of Illinois was allocated \$986,500 for title V programs.

Regulations for that program were promised from January 1, 1977, and were not available until the middle of the year. Since this information was available on a last minute basis, it was sometimes difficult to develop a good proposal within the short period of time. We need a longer period than 12 months to properly do a renovation job at title V sites. We are asking that the time limits be expanded or that the time period be related to the local grantee rather than the State agency.

We are also recommending that future funding of this program be substantially higher so that projects which have been operating over the years in makeshift-type facilities can have an appropriate place which can be called the center for services for senior citizens in the community. Such centers would become part of the total network and enhance services provided under title III and title VII.

Under title III of the Older Americans Act, the State has found that they are able to provide a multitude of different services for the elderly. Such services are based on need as identified within the community. States and area agencies do have a concern of the priority services which are set by persons in Washington. In many cases, such services are definitely needed in the local communities; however, the concept of the development of these priority services at the national level defies the principle of developing needs through assessments at the grassroot level.

ELIMINATE 3-YEAR RULE?

Another problem with which we are currently faced in the title III program is that there have been regulations which indicated that funding is for a 3-year period and that such funding should either be discontinued after the third year or a waiver obtained for such services. The seed money concept is valid; however, in a large number of com-

munities, particularly rural communities, there are inadequate funds to continue programs started through title III of the Older Americans Act, even though it has been demonstrated to the community that such programs are vitally needed. We suggest that the 3-year rule be eliminated and that the regulations on this item be left up to the discretion of the individual States as the need arises.

In conjunction with title III programs, one of the priority services at both the national and local level is providing transportation, particularly to those in rural areas. However, in Illinois, as well as in other States, we have experienced dramatic increases in the cost of providing such transportation. Surprisingly, the cost of the vehicle is relatively small compared to the cost of maintenance, personnel, and particularly, insurance for such vehicles. Insurance rates for vehicles providing services to senior citizens have gone as high as \$6,000 per vehicle.

Incidentally, the \$6,000 was in the Chicago area and that amount of money is more than some of the rural projects in downstate Illinois receive in toto under title III funds. That amount of money would probably fund a whole transportation program in southern Illinois, excluding the insurance.

A recent survey of senior citizens projects throughout the State indicates that possibly over \$300,000 is being spent for insurance by programs which are providing transportation services to senior citizens. It is strongly suggested that if the Government cannot develop a self-insurance policy for title III programs which would save considerable amounts of money currently being spent for insurance for transportation, that an alternative plan guarantee against extraordinary liability expenditures so that local insurance companies could reduce their rates significantly.

MANY VANS UNSATISFACTORY FOR RURAL AREAS

The Federal Government has, through the Department of Transportation, provided a source for vehicles to be used by local projects. However, as indicated earlier, this expenditure is generally considered the smallest part of the total expenditure of the transportation program. In addition, many of the vans which are available to the Department of Transportation are specifically designed to use in metropolitan areas and have been found to be very unsatisfactory in rural areas and on rural roads. There needs to be additional emphasis on research and study of rural transportation programs to determine the most effective method of delivery of such services and also the type of vehicles which would be most appropriate.

I might mention in terms of the Department of Transportation vehicle, I saw one 2 weeks ago down at Mount Carmel and, with all of the research they did, they have to tie a motorcycle strap on the door to keep it from opening because when the door opens in the wind, then the bus stops in the middle of the highway. So all of the research and work they put on these vans—there needs to be some more work.

The transportation element is closely tied to the title VII nutrition program. Quite often, in the rural areas, they do need transportation in order to get to a congregate meal site. Such costs can be very expensive, and with a 20-percent limitation on social services under title

VII, it is sometimes difficult to provide adequate transportation to nutrition programs which are located in rural areas. Because of the difficulty in providing transportation for senior citizens in the rural areas, some of the title VII programs have attempted to use their resources to provide home-delivered meals to these rural elderly rather than transporting them to a congregate meal site. However, such a program is directly against the intent of the title VII regulations, which is to decrease isolation and provide a hot meal in a congregate site.

"REINFORCING ISOLATION"

Congress has been looking at a home-delivered meals program which would operate in conjunction with the title VII congregate meal program. We feel this aspect of the nutrition program is important to those individuals who need this type of service and should be supplemented by other social services as determined during review of each participant's needs. I feel that this is very important. Quite often, in a home-delivered meal program, they are only reinforcing isolation rather than helping the elderly person and trying to ultimately get him out of his home.

A number of local not-for-profit organizations have been providing home-delivered meals for many years. They have operated such programs on a sliding scale with those who can afford the cost, paying that cost, and those who can't afford to pay, getting their meals free. If the title VII home-delivered meals program goes into effect with the same regulations as the congregate meal program, it is a distinct possibility that many of the older established programs would be put out of business. If the project must do an evaluation in order to determine if the person is appropriate for home-delivered meals, they will, more than likely, touch on resources which that person may have. The idea behind that statement is the possibility of allowing a sliding scale for home-delivered meals which would be in conjunction with the currently operated home-delivered meals program.

There has been some discussion on who would be responsible for the home-delivered meals component of the title VII program. It is strongly suggested that the current title VII project maintain the responsibility for this new program. If there is a qualified organization currently providing meals to the local community, that service should be contracted to that local organization. If there is no local organization to accept responsibility for meals program, then title VII could incorporate such preparation into the preparation of their meals for the congregate site.

There have also been proposals that the home-delivered meals program include disabled persons as well as elderly. We have a concern that, without an adequate appropriation to cover the handicapped persons and a specific definition on those who are handicapped, it is possible that the program could serve a considerable number of handicapped individuals under 60 years of age. Another concern is that by providing home-delivered meals to the handicapped, such services to the handicapped might well be expanded to persons attending congregate mealsites, and the limited title VII resources which are currently available for the elderly will be greatly inadequate to meet the need of the population.

EFFECTIVE USE OF EXISTING RESOURCES

Under title IV-A of the Older Americans Act, the department receives funds to provide training. Until now, the amount of money available under this act has been relatively modest. This is very important, and it is recognized that one of the functions of the department's responsibilities under the Older Americans Act is to stimulate more effective use of the existing resources and available services for the aged. Such training is highly necessary, particularly for those persons in the rural areas who deal with such problems of the elderly. Adequate training can stimulate these local persons to provide, on their own, many of the services which are required by the elderly located in the rural area.

The department feels that all of the titles have a very important aspect in the total program for the elderly. In order to coordinate such services, particularly to those persons located in the rural areas, requires additional funding in the title V program for multipurpose senior centers and some assistance from the national level in solving problems in conjunction with transportation programs as transportation services are essential in the provision of all services in all areas, specifically in the rural areas.

Thank you.

Senator PERCY. Thank you very much.

It might be a good time to note that as a result already of the hearings that this committee has held on the rural elderly, just a week ago, approximately on December 5, the Administration on Aging issued proposed regulations to relax the 3-year funding rule. It would be left up to the States to decide how long to fund a project, and that provides the added flexibility, I am sure you agree, we need.

Phyllis Pinkerton, director, East-Central Illinois Area Agency on Aging.

STATEMENT OF PHYLLIS PINKERTON, DIRECTOR, EAST-CENTRAL ILLINOIS AREA AGENCY ON AGING, BLOOMINGTON, ILL.

Mrs. PINKERTON. Thank you, Senator. I ask you to especially notice my board members.

As mandated by Federal regulation, the area agencies on aging throughout the Nation are in a leadership role to provide coordination for the delivery of services to the elderly of this Nation. Not only has the role been spelled out in the law, but the local boards and advisory councils consider it a key issue in the provision of services. Coordination takes two forms: that of working with service providers to modify their services to the elderly; and second, to expand their services to the elderly.

In preliminary findings of a study recently completed for the administration on aging on area agencies, which was reported at the November Gerontological Society Convention, service providers report an increase in services by 20 percent and an increase in the median number of persons served from 400 to 500 as a result of area agency on aging coordination. Donald Reilly, Deputy Commissioner on Aging, states

the report shows that in spite of the lack of sufficient tools such as funds and staff, and the lack of any other Government model, the area agencies on aging have been successful in shifting from a grants manager position to that of an influential role in the service delivery system.

TOTAL DELIVERY SYSTEM MUST BE PLANNED

The coordination role of the area agencies on aging is currently hampered severely by the splintering of programs and their funding authority through a number of Government and private agencies. If the area agencies on aging are to be planners and coordinators, they must be allowed to plan for a total delivery system, not just the use of title III funds. When we say publicly that the area agencies on aging are to plan, we aren't being realistic. They cannot plan for all aging services. In our situation, we must refer a community interested in a meal program to the State department on aging. The department of public aid and, in some parts, the department of aging, act as the program agents for title XX services. For ACTION programs, we refer to the regional office of ACTION. For title IX programs, currently we refer to the Illinois Farmers Union as well as to the department of aging at this point. We most certainly have not been given the tools to do planning on any comprehensive basis.

In the provision of services within the 16 counties for which this area agency on aging is responsible, coordination is not a feasible goal in the rural areas in the two previously described forms of coordination. However, we have been successful with rural areas in the formation of county councils on aging in 13 of our 16 counties. Also, we bring together local units of government and the limited service providers to a level of understanding the very special needs of the elderly in their rural county. Service providers come together regularly in many counties to share problems and develop solutions along with their fellow professionals.

I would like to make several comments and recommendations directed to improving the help area agencies on aging can offer to the rural communities.

Since rural counties have no previous experience in the delivery of services to the elderly, the need for assistance is the greatest. Area agencies on aging should be allowed to spend staff time and the necessary amount of funds in the planning, program development which is designed specifically to meet rural needs, in in-depth technical assistance, and followup in the rural areas.

"SHOTGUN APPROACH" DOES NOT WORK

Since in the rural areas there are no or extremely limited sources to coordinate, the Congress, Administration on Aging, and the States must give the area agencies on aging latitude in responding to their special needs. Cost of services will be higher due to the smaller, scattered population and the lack of community cash to sponsor programs. We must be given the opportunity to provide for adequate levels of programing, not just the shotgun approach hoping to reach some of the rural needs.

The seed money concept is impractical for most rural counties who have a limited tax base on which to continually draw. Revenue sharing has been of help in many rural communities but cannot be used as we are all aware to match title III or other Federal funding. The ability of the service providers to raise funds for programs is hampered by the high cost of the delivery of rural services to scattered clients as well as the lack of understanding of the older person's needs by other rural residents.

Much of the current research and model programs are not applicable to rural situations. We urge researchers to respond with service models geared to rural needs.

Other Federal agencies should be urged to place priority on the rural elderly. For example, UMTA funds can be used in rural areas, but there are few sponsors in the rural communities who have the 25-percent cash match for gas, oil, maintenance and drivers' salaries. Farmers Home Administration should be encouraged to develop more elderly housing in rural, scattered sites as these are the natural places for the rural elderly to retire near friends and relatives, not in large urban areas away from all family support. In the development of rural areas, Farmers Home should give consideration to developing community buildings to be shared with seniors as well as business loans to support the economic base. We can certainly go a long way to make our rural areas more desirable for seniors to remain near their families. By creating a place for seniors to stay near their family, it reduces the demand on the social service system.

SPECIAL ASSISTANCE FOR RURAL COMMUNITIES

Formalized programs with all the requirements, regulations, and accountability are neither acceptable nor practical in rural communities. Perhaps the area agency on aging should be allowed to develop a service delivery system with a variety of services under one grantee rather than have to fit into predetermined priorities with a number of nonexistent grantees. Special assistance should be given rural communities in grant writing, technical assistance in setting up programs, and ongoing followup of a more intensive nature.

Appropriations must be made available to allow for compliance with new regulations. An example is that of section 504 compliance for accessibility for the handicapped. Nowhere to my knowledge is there a church which is committing cash to make its building accessible so that a senior center or nutrition program can continue in its donated facility. It will take a major portion of the funds now allocated for social services within an area agency's budget to renovate our current buildings and vehicles.

Particularly in the rural areas it is impossible for the nutrition programs to provide the required services. The services are not existent to tap into nor are the title VII funds sufficient. The nutrition programs should not need to be placed in a position, in my opinion, of planning and funding new social services. When we attempt to coordinate, we find that title III is inadequate due to limited funds to respond to the total needs of the community.

All Older Americans Act funds need to be channeled through one agency and we are suggesting the area agencies on aging for planning

purposes rather than have several State, Federal, and private groups involved. It cannot achieve its goal of a comprehensive system unless it can plan comprehensively for that service delivery. We must get the most from the limited funds available by allowing them to complement each other and to prevent overlap and gaps.

Communities have little confidence in funding sources if they can only plan for 1-year periods. Realistically, programs can achieve organization, community recognition, and some service provision during their first year. Programs should be sustained based on an evaluation of performance. A more realistic plan would be for 3 years. The Older Americans Act should be extended for longer periods of time rather than renewal every 3 years in my opinion.

FINDING ONGOING FUNDS DIFFICULT

In considering the renewal of the Older Americans Act, Congress needs to give the area agency on aging the latitude of local decision-making as to sustained funding and priorities, and I am pleased to hear your comment, Senator. Rural areas, as urban areas, have great difficulty finding ongoing funds for administration program development. Priorities should be established within the framework of the law by local advisory councils not mandated by Federal or State priorities.

Many rural elderly have never had an opportunity to really develop job skills which may be applicable and marketable for entering the labor market as an older worker. Allowances for job training should be taken into account when renewing the older worker programs. We have found in our older worker programs that the families who have farm backgrounds or small-town residents do not come with skills necessary to interpret nursing home regulations, for example, in our nursing home visitor program. They, too, have never had an opportunity to know of services outside their own area to become an informed outreach worker.

Training does not always take place in educational settings. An example of rural needs is the need to train homemakers. The nearest educational institution is 50 to 70 miles away with a formalized 5-day-a-week training program. Why not allow title IV-A funds for training in the local community by the nursing staff who have the experience and expertise in providing homemaking services abiding by the established standards?

The low-income eligibility criteria, in my opinion, is too low for today's cost of living. Individual situations, such as high medical costs, special living situations, dietary needs, et cetera, should be taken into consideration, not an arbitrary dollar figure.

Priority services, as established at the national and State levels, make it difficult to respond to rural needs with title III funds. Rather than design the program to the needs of the rural community, we have to bend the needs into our program categories to allow funding to take place.

Currently, older worker programs are developed at the State level. Area agencies on aging are given, or apply for, part of the programs as established by the State. This buying into already written programs prohibits any opportunity for manpower planning within the total

scheme of services to the elderly. Each grant has its own individual set of eligibility requirements making it extremely difficult to mesh programs. Manpower programs should be a goal within the area plan and the area agency on aging allowed to plan for the use of the funds placing workers within the total delivery system. This would allow for many older workers to be placed in service to other older persons and within service programs currently underfunded for staff.

RURAL ELDERLY BECOMING ISOLATED

For the rural elderly to remain independent, they currently must have the ability and the money to own their own vehicle. It is an obviously unrealistic expectation. As physical status changes, the rural elderly become isolated as there is no possible way for them to reach services, friends, and health maintenance unless transportation can be provided. The extreme limitation of title III funds and with only \$720 in State dollars in our social service budget for this agency, we can provide limited vehicles. The need is illustrated by pointing out that we at best can provide one vehicle serving only a few hundred elderly in counties with thousands in need.

Currently, the best response we have is routed vans in the rural area. Needs are not just for vehicles and the recognition that they need frequent replacement, but also that of sustained funds for gas, oil, insurance, maintenance, and drivers' salaries. Insurance rates have gone up as much as 500 percent when available. Several rural programs received insurance policy cancellations—one twice. Answers from the insurance company as to reasons for cancellation are that the riders are considered too high risk. When attempting to set up a workshop addressing the issue, two major insurance companies refused to participate as they stated it is up to the local agent to determine who can be insured. Within the same company agents differ in their willingness and cost of insuring transportation vehicles to serve the elderly.

Mass transit districts, where there are such districts—in only 4 out of 16 counties—need to expand their authority into the rural areas so that they might provide the leadership and their transit expertise in meeting those specialized needs of the rural elderly. What we are experiencing is that the aging network is meeting the need as best it can without the expertise and sometimes uncoordinated systems developing. It is not the best method but currently the only way to get persons from the rural areas to basic human service needs. We encourage more funding.

RECOMMENDATIONS

Some recommendations as a result of the rural needs would be:

Federal agencies must be charged with addressing the needs of the rural elderly in an adequate manner to allow them to get to necessary services. Funds should also be addressed to maintaining and staffing those programs.

Studies need to be undertaken to determine the most appropriate means of providing transportation to the rural elderly. In urban areas, consolidation and coordination of social service transportation systems must be undertaken.

The necessity of proper insurance coverage needs to be addressed through technical assistance to the aging network and approaches made to the industry for reasonable cost and necessary coverage.

Title III funds must be increased to allow for the provision of those identified priority needs such as transportation. Sustained funds must also be allowed as equipment depreciates and the need for maintenance and drivers is ongoing.

The rural elderly in the Midwest are already suffering severely from the harsh winter. Even those who were fortunate enough to qualify last year for the emergency energy program have still not received credit on their overdue bills. The winter has arrived very early, and it is very harsh as you are experiencing with us today. Utility companies will be hard pressed to continue to extend credit for those outstanding bills.

We have all been asked to reduce our consumption of fuel. The elderly have been doing this for some time due to the continuing spiral of costs. With fixed incomes, what can give? Now, the National Institute on Aging warns us that the elderly must maintain their environment at 65° to avoid a potentially fatal drop in body temperature. How can they once again compensate for this physical need as costs continue to soar?

The concept behind the emergency energy program was indeed a good one, to rebate to those most in need. But the restrictions for eligibility, the need for three forms of five copies each were excessive, the timelag in introducing the program, the task for locating and signing up seniors in such an extremely short 3- to 4-week time frame, the fact that the agent in Illinois had limited contact with the elderly, all meant that the elderly were shortchanged.

AGING NETWORK RESPONDS ADMIRABLY

The program agents were allowed no administrative costs, told that they were to do it within an extremely limited period of time, and that to accomplish this they would have to hire and train new temporary personnel. The aging network was called upon and responded admirably with all possible speed and with all its resources diverted to the effort. Area agency on aging staff trained volunteers took applications and spent weekends in certifying clients. All funded and unfunded aging programs responded by staff spending full time taking applications and certifying need. Even the older workers themselves under title X diverted their total efforts. The area agency on aging alone was responsible through seven community action agencies all having their own set of problems and interpretation of regulations.

As to recommendations relating to the energy status of the rural elderly, they include:

For the low-income elderly, continue the funding of the emergency energy program and the hope that we can learn from our first year's experience. The public needs to be aware of the program through an advanced education campaign.

Registration periods need to be extended. Workers must be trained. Those agencies who will be called upon to help need to be aware of all regulations and allowed to gear up well ahead.

The weatherization portion of the program needs to be advanced in time so that work can take place before winter sets in. The weatherization program can prevent, in many cases, the use and high cost of fuel. We now understand the insulation itself is not available due to the demand of private contractors.

The rural elderly are the most difficult to locate and reach through traditional program methods. Programs of this nature also have a stigma of welfare which is unacceptable. Let us improve upon the ability of the aging network to reach the elderly, make them knowledgeable, and allow them the opportunity to apply for such programs. Older workers can be trained through manpower programs to assist in locating older persons in need and alert them to possible programs.

ALLOCATION METHOD OF FUNDING?

The emergency energy program in several counties in our area had funds committed to other needy persons before the elderly could be reached in the rural areas due to the need to schedule staff and space to take applications. Rather than a first-come, first-served basis, perhaps an allocation method for the elderly to receive their share would be more equitable.

Many small rural distributors of fuel found it impossible to deal with the paperwork required and certification process necessary for the elderly to take advantage of the program. Let's require less paperwork, yet insure accountability.

Congress should consider other alternatives to assist the low-income elderly with rising costs rather than reacting to already incurred bills which adds up to higher costs for the distributor, as well as the consumer. The floor of SSI could be increased as costs rise to offset these spirals to take care of food and housing. It has been advanced that these funds could come from the excess profits of our Nation's energy providers, perhaps not a very popular notion.

Let's increase the income eligibility standards to allow some of those elderly in the gray area to have their homes weatherized. This will lead to the prevention of unnecessary fuel consumption and save them from becoming low income or in need of services from the already overburdened programs.

My last recommendation is that federally assisted housing for the elderly should take advantage of the known fuel saving designs in future construction and renovation effort. Perhaps an "energy impact statement" can be required of builders.

Thank you.

Senator PERCY. That last recommendation is certainly noteworthy. I have talked to several realtors and they tell me that people, when they buy a home, do not ask the question, "How much will it cost to heat it?" We are still unrealistic about that.

Thank you very much, Phyllis.

Our last witness on this panel is a dear friend who helped us set up this hearing. We are very grateful to you, Sharon.

Sharon Lindsay is the director of the Champaign County Office on Aging and will speak about the weatherization program, as well as the relationship of the county office to the AAA.

STATEMENT OF SHARON LINDSAY, DIRECTOR, CHAMPAIGN
COUNTY OFFICE ON AGING, URBANA, ILL.

Mrs. LINDSAY. Thank you.

I am Sharon Lindsay, director of the Champaign County Office on Aging, and this is a county agency designed to identify needs, resources, and gaps in services locally to the elderly. We have one major urban center in which almost all of the social service agencies, nearly all of the medical facilities, and most of the shopping opportunities are located. However, approximately 40 percent of our elderly live outside of this major urban area.

These rural elderly face the same problems that face the urban elderly: Inadequate income, difficulty finding and/or maintaining suitable housing, the "crisis treatment" approach of the health service systems, diminishing work opportunities, and the trauma of role changes. The lack of information about available resources and the inability to reach them when they are based in an urban location are also significant problems for the rural elderly.

The 1977 emergency energy crisis intervention program is an example of how these problems impact the rural elderly. A given amount of money was designated for each county but none was allocated for coordination or outreach. The program was handed to the Urban League, a city-oriented agency, and applicants were to receive assistance on a first-come, first-served basis.

The rural elderly had less opportunity to learn about the program than the urban residents who were already familiar with the Urban League. Many who did learn about it had no way to apply immediately. In our county, the given amount of money was committed before the application period was half over.

FIRST-COME, FIRST-SERVED NOT EFFECTIVE

The first-come, first-served approach is not an effective way to serve the most needy rural elderly. It would be better to devise a formula to provide assistance based on need. Future programs related to the energy situation should provide more long-range benefits than were provided by the crisis intervention grants to be most effective. Money used to weatherize houses against heat loss would reduce fuel usage and, therefore, fuel costs for years to come. Grants offer immediate help but do nothing to prevent the same people from having the same problems meeting fuel costs year after year.

Transportation is a key factor in the elderly's ability to take advantage of resources. Census data and local surveys indicate that only about half of the elderly have a driver's license. Many rural elderly who drive are reluctant to do so in the city where there are traffic and parking problems. Special transportation services for the rural elderly are vital.

I would like to digress just a minute to comment on a letter I just received yesterday from Elderly Housing Associates. The developer says that many times, the fact that an area has its own transportation available can determine when, where, and if this particular area will be approved for elderly housing. So the needs tie together very definitely.

Specialized transportation offers mobility, independence, socialization, and fuel conservation.

Our county developed a rural transportation program about 3 years ago that provides service 2 days a month to riders who can board a conventional van. The service is good but needs to be expanded. The program is made possible through the cooperative efforts of 35 different agencies and groups. The Older Americans Act, title III, provided the vehicle; the American Red Cross operates, insures, and maintains it; the county, via stafftime, coordinates the program and receives calls from riders; 15 rural township boards of auditors reimburse the Red Cross 20 cents a mile toward the operating costs—they use revenue sharing or in some cases other township funds; 15 community senior citizens organizations provide outreach and publicity; the city of Champaign funded Downtown Senior Citizens' Drop-In Center and offers a waiting station; and title III funded TeleCare, which offers backup service via volunteers and staff drivers.

RURAL TRANSPORTATION PROBLEMS

Experiences with the rural transportation program have revealed some problems in both transportation service and in coordination. Funding for a vehicle was not feasible through the Department of Transportation because their primary focus was urban. Insurance and operation costs are constant problems. The total cost of operating the rural service is close to \$8 per person per round trip. Much of this cost is provided as in-kind by cooperating agencies. However, they are contributing to their limit and the service needs to be expanded. The actual cost is so high that the system cannot become self-sustaining. A subsidy from source will always be necessary and the subsidy will grow as the service expands.

Department of Transportation funding is available for capital expenditures for coordinated rural systems and for reimbursement for reduced rates for senior citizens in urban systems. Older Americans Act grants are available on a phaseout basis to help initiate new programs. Maybe that has changed now. That is good to hear. At this time, however, none of these resources can help maintain an existing program that has demonstrated its effectiveness.

Coordination of agencies and groups to provide services efficiently is a desirable goal. My experience in a county agency working to develop programs through coordinated efforts, such as the rural transportation program, has led me to see coordination as an exercise in communication and collaboration. With no funding power and no other means of pressing for the cooperation of agencies that frequently compete with each other for the same funds, it is not possible for coordination to take the form of consolidation and control.

Consolidation and control are not necessary if there is adequate communication and collaboration of service providers around a comprehensive plan. Development of such a plan requires unbiased, paid staff actively to obtain and maintain an up-to-date overview of needs and resources. An overview and plan from the county level can pool the resources to cover the total population.

MULTIPURPOSE SENIOR CENTERS

One method of providing coordination of services for the rural elderly is through multipurpose senior centers. Title V is a welcome funding source to help initiate such centers. There are two problems, however. In some communities there simply is no suitable structure to be purchased or renovated for a center. Funding for new construction where there is no feasible alternative is needed. Also, after the center is developed, there will be an ongoing need for funding for staff and operating costs. In our State it is unclear what funding units can and should be responsible for local funding.

In summary, the Older Americans Act has provided much-needed funding to initiate the development of programs to meet the needs of the elderly. Now it is time for the act to mature to the level where it can provide funding to maintain the operation and coordination of good programs.

I would like to just tack on something that really is not in my written testimony, but it is about older workers whom Mrs. Pinkerton referred to. We find that the Green Thumb, the title IX older workers program, is a very efficient and philosophically good approach for providing employment for older people because it, as much as anything, begins with the needs of the older jobseeker rather than with some job design that comes from an office at a higher level.

Thank you.

Senator PERCY. Thank you very much, Sharon.

You mentioned a letter from the Elderly Housing Associates. Could we have a copy of that letter so that it may be made a part of the record?

Mrs. LINDSAY. Yes.

[The letter follows:]

ELDERLY HOUSING ASSOCIATES,
Urbana, Ill., December 10, 1977.

DEAR SHARON: Just a quick note to let you know we'll be at the hearing for elderly transportation and standing right behind you.

We have been submitting applications to FmHA and HUD and designing, constructing, etc., for elderly for 3 years. A more satisfying and rewarding job, I have never had.

But may I say this: Many times, the fact that an area has their own transportation available can determine when, where, and/or if this particular area will be approved for Elderly Housing.

Personally, I say they have been taking care of us for one long time; let's do all we can for them.

Thank God for you and Phyllis Pinkerton and Marian Ascoli and Josephine Oblinger and all the other beautiful people who care enough to do something.

If we can help in any way (filling out forms for submitting, etc.) please feel free to call upon us.

Good Luck.

Sincerely,

MARJIE MURPHY,
Vice President.

Senator PERCY. Mention was made of revenue sharing funds, that they could not be used for matching funds. The law is now changed on that, and they can be used as matching funds. Could you comment as to whether or not the elderly are getting their fair share now of revenue sharing funds?

NOT RECEIVING FAIR SHARE

Mrs. PINKERTON. I don't think they are getting their fair share, but they are certainly getting a good size. They are very successful and very active with most of the local units of Government attempting to acquire a portion of those in many communities. I think you could point them out specifically which may not have value for the testimony today, but indeed they have received funds to sustain transportation programs, to sustain a TeleCare program in one of our communities.

It is quite a marked amount of money. I mean, there are \$4,000 or \$5,000 chunks coming in from townships which, in their operational level is quite sizable. Indeed, we have not gained through public hearing any additional input. I don't think their limited amount of money will come out from those who have knowledge of programs enough to really speak to the issues.

Senator PERCY. Should the Federal Government change its allocation formula to place a greater emphasis on rural areas, or should the States really do this themselves? Would anyone like to comment?

Mrs. OBLINGER. Yes; I would allocate the title VII Federal dollars on a number percentage of elderly poor within an area and title III funds on a percentage of elderly within an area. Thus, the rural areas get less money. Chicago should get approximately half the money because they have half the elderly, and we do follow this formula.

Senator PERCY. Yet that would seem unfair because transportation costs are obviously so much more in rural areas, much more expensive than doing it in urban areas. Maybe we ought to take a look at that allocation.

Would any of you care to comment further on that?

Mr. KLAGE. I think what the director said in terms of allocation, we always have that dilemma of the small base, mainly elderly people. I think the percentages of elderly which you indicated in the 16 counties here is still high compared to many of these southern Illinois communities where the younger people move out and go elsewhere, earn a living, and retire back in southern Illinois. However, the population base is so small that we cannot develop adequate programs at this point. We do feel that the State agency should have the option of determining allocations to individual areas.

EMERGENCY FUEL ASSISTANCE PROGRAM

Senator PERCY. Last week Congress voted to continue the emergency fuel assistance program for another year at the same funding level as this year—\$200 million. Can you tell us how we can better implement it if it is needed again this year?

Sharon?

Mrs. LINDSAY. I am sorry it has been continued. I personally would like to see that money go to weatherization or something with far more long-lasting results, but as long as it is here, we will spend it.

In my testimony I stated that the first-come, first-served approach just does not allow the rural needy elderly, who most of the time do not have transportation, don't even take a newspaper a lot of times, and don't listen to any of the media—they just are not able to make

it first. So if nothing else, I would like to see that approach changed. I know that probably means a means test of some kind, which is not fun either.

Senator PERCY. No; that is true. I think, however, we will have an energy bill across the board with tax credits for weatherization. That will affect the elderly as well as other parts of the society.

We are running so far behind at this stage that I am going to ask the second panel to take their seats. Let's give a good hand to our first panel. [Applause.]

Our first participant in the second panel is Marian Ascoli, program director for Telecare Family Service of Champaign County. This was one of the first programs in the State to receive an Older Americans Act grant.

I would like to also indicate that Mrs. Ascoli has won the Illinois Social Worker of the Year Award for the last 2 years.

STATEMENT OF MARIAN L. ASCOLI, TELECARE PROGRAM DIRECTOR, FAMILY SERVICE OF CHAMPAIGN COUNTY, URBANA, ILL.

Mrs. ASCOLI. That is a little overstating it, but I have been honored and I appreciate those honors.

I was very glad to hear from Mrs. Oblinger because, as I reviewed the list of panelists, I feared that at 55 I was the oldest person speaking here on aging today.

Senator PERCY. At 58, I still have seniority. [Laughter.]

Mrs. ASCOLI. I do see and hear from persons who ask for and use our programs, so I am going to start with a little aside to those of us who are aging today—age 60 and above. If you have reached the age of 95 and are living in a one-room shack with no phone, no indoor toilet, no means of transportation; or if you live in danger of invasion by stray cats and dogs, which is a house that cannot be secured; or if you and your spouse have had to give up your comfortable home because your adult children cannot find adequate attendant assistance and service for you now that you have arthritis and cataracts.

"OCCUPATIONAL HAZARDS"

If you are in danger of daily beatings from the disturbed relative living with you whom you yet love and care for; or if you have no way of marketing the fine handwork that you have crafted to eke out your meager pension.

If you sometimes stubbornly refuse all forms of State or Federal assistance because you never took charity and don't intend to start now—you may be one among the rural or the urban elderly whom I have known. And if you can cook up a storm when you are invited to a senior potluck; it is a real occupational hazard, I will tell you. I suffer all the time from it. If you volunteer to deliver meals in your old car to your sick neighbor. If you travel the highways of our county bringing music to others who are living in long-term care facilities.

If you live out the meaning of the old Yankee and American adage: "Use it up, wear it out, make it do or do without," you may be one among the rural or the urban elderly. If you are honored in

your community by the city fathers and also if you are knocked down in the street by rude, rushing young who are impatient with your slow step.

If you lie at the bottom of the stairs for a day with a broken hip before someone can find you; or if you alert someone else to the needs of your fallen neighbor after your daily checking call has not answered—if you have had one of these experiences at times you may need the following:

Information, transportation, companionship, a visit at your home or a drop-in center, employment opportunities, housing, homemaking service, home health care, volunteers, counseling, support in your bereavement, financial guidance, retirement planning, your commode carried out to be emptied, a bed bath, home medical care—doctors don't like to make home visits any more and I hope something will change our national ethic in that sense—you may need your children, your grandchildren who live far away, you may need help with and for your even more aging parents.

CHOOSE YOUR OWN LIFE STYLES

You need a sense of worth in your community. You need to be left alone to choose your own life style. The life style of the older American may not necessarily be our average middle-class style, many of them live pioneer style and they want to be left to live that way with help to do things in their own way.

You may need day care, nursing care, the right to die with dignity.

You may need exercise, rest, contact with others, stimulating ideas. In our county we have the happy circumstance that there are resources which might meet some of these needs. But there are many who are never reached at all.

You may need or want some or none of the above, but they should be available at reasonable cost if you can afford to pay, or without cost if you cannot.

So if you have 60 years or more on your frame and you live outside or inside an urban area and you have one or more of the mentioned or many unmentioned needs and wants and characteristics of people anywhere, you are among the elderly, the aging, the senior citizens, the older adults, the long-living—take your pick. If none of you like to be called any of the above, you will have to give me a new name and I will be glad to call you that.

You have the power, however, through you vote and your voice, and you should let your pleasure be known to the public. I hope that today you have spoken through me and that together we can continue to work for a good life for all the long-living.

I am going to summarize a little bit some of my other testimony. I want to reflect on the remarks of the people who preceded us on the panel. I appreciate most of the comments. I am a little bit leary of the emphasis on senior centers.

While I have a real area of agreement with the center concept and our own program has participated through the outreach services in developing many minicenters in a number of communities throughout Champaign County, I am also concerned with the home delivery of

services for those who cannot make it to the center. I wish to see that in any regulations covering the development of multipurpose senior centers that the "multi" really stays in there and it is not just services for those who can make it; the services should be available for those who cannot.

The center site should be a site for a preventive service. Home delivery needs to be an option in protective service for the elderly.

I refer in my written testimony¹ to the many statistics which are available through the census, through the development of our State of Illinois Department of Aging, through the work of Mr. Robert Butler, and also to the book which Senator Percy himself mentioned earlier. The situation has not changed all that much since those books were written. Although I believe in our county, the local newspapers really seem to make an effort to honor and to recognize many fine characteristics of older people. I have been very happy with the participation of the media in that respect. I hope they keep it up and expand considerably. I also hope that this will become really an exciting option throughout the country, because things that older people do are valuable, are beautiful, and are exciting many, many times.

NASW POLICY ON AGING

I have referred to the National Association of Social Workers policy on aging² which was adopted this past spring. It emphasizes the need for policies which will improve the income situation, the employment and retirement situation of older persons. I know we are working on that nationally now—the health needs of the elderly, the mental health needs of the elderly where counseling and assessment services are particularly critical and where many times mental health problems are simply swept into the wastebasket. There is the chronic brain syndrome, but forget that one. I hope somebody will turn that around.

The national association policy emphasizes the needs for a really good emphasis on long-term care, in the regulations thereof, and the provision thereof, and there are many problems in that area.

Housing and possibilities of various living alternatives—we have seen many older people who, in congregate living arrangements, have been able to push back that need for being swept up by maybe 5 years or more simply by the kind of support that their neighbors in the housing area have been able to provide for them. Many people say, "Well, housing facilities for the elderly are just a form of segregation." But also I have seen quite often that the older people who live together in these sites are now much more willing to venture out and tackle the world together in groups than they had been when they were staying in their own homes. So I think that is a very important social policy and it should be available to people who are rural persons as well as those who are urban individuals.

NEEDS OF ELDERLY OUTLINED

I think that the final thing that NASW policy emphasized was transportation which has been, I think, very well covered. The need

¹ See page 1411.

² See appendix 1, item 1, page 1447.

for social services, counseling services, assessment services, financial counseling, management of the system—this is the thing that many, many older people need. They may be that individual with no spouse to help them, who now needs someone to help fill out the form and know when the form is due, to go in to help them argue with the caseworker, the social security office, or the public aid office, who may give them short shrift unless they have a friendly, firm hand beside them. Those services are really essential and people should have them available; whether they want to use them is their choice.

I also made reference to the committee of the document on the need for protective and preventive services for the Nation's elderly. This was a paper which was presented at the National Conference of Social Welfare by Frances Hadley of our local Champaign Health Center and it will be published in the proceedings of that conference from the May 1977 social welfare forum in Chicago. The emphasis there is on the right to choice and the recognition of the agony of choice for older persons and for those who are working with them. It affects particularly the rural elderly who have fewer choices because of limited resources.

In addition, I refer the committee to a very new document¹ which has just been developed by the local district of the National Association of Social Workers, the document on "Recommendations and Guidelines for Provision of Social Services in Long-Term Care." No one here today has mentioned that other 4 percent of the elderly population—the ones who are now in long-term care. These people may well be able to make it back out in the community if a social service and rehabilitative program is in place, but in many instances this kind of program is not in place.

DISTRESSED BY FEDERAL GUIDELINES

We have been particularly distressed by the Federal guidelines which I think were a good attempt at bringing social services into the home. The Federal guidelines for medicaid and medicare asked for social service "consultants." Now, a consultant is anybody from 50 miles away who you pay to do it, and then go back 50 miles away and you don't have to listen to them. That is about the way the consultant services tend to operate in many long-term care facilities.

The second element is they now have something called the social service "designee," which is a way to get around the law of the State of Illinois. It says that anybody who is doing social work should be called a social worker only after having passed the examination put out by our Illinois Department of Registration and Education.

The social service designee in many of these homes is a paper person who does not even know that they have been assigned this task, and when you go in there they are visibly doing their aide work or the recreation work, or whatever, and they have no knowledge, no training, and no background in this social work.

Senator PERCY. Try to wind up in about half a minute. We are not going to have time for any participation by the audience.

Mrs. ASCOLI. I will try to be brief.

¹ See appendix 1, item 2, page 1452.

Senator PERCY. Half a minute.

Mrs. ASCOLI. We have also remarked on the title III, disappearing funds, and particularly we wish to remark on problems under title XX of the abrogation of privacy of the individual where we have to send information to that great computer in the something or other—I won't call it the sky; that is supposed to be heaven—where peoples' personal information is kept for I am not quite sure what purpose. I think that this is to provide checks on programs and that could be done by local audit.

Finally, I want to comment on problems of inflation. The rate increase that the utility company is initiating will now include an account for future expansion and/or development of the utility company. That was commented to me today by one of the members of the audience. It is great to have additional funds for weatherization and maybe grants next summer for the utility bill, but some of the utility bills are perhaps unnecessary.

I hope that the provision of services for the persons in their own home will be the major emphasis of the Committee on Aging.

[The prepared statement of Mrs. Ascoli follows:]

PREPARED STATEMENT OF MARIAN L. ASCOLI

I have been asked to address the dual questions of identifying needs of the rural elderly and planning for the continuation of the Older Americans Act. On both of these subjects I have some information, a few thoughts, and many strong feelings.

From the Bureau of the Census, from the statisticians of the State, from the planning and funding agencies you will no doubt have had a plethora of numbers indicating the size of the rural elderly population, their income, housing, access to medical care, their strengths and their weakness, and many other characteristics. Reams have been written by splendid authorities such as Robert Butler and Senator Percy himself on these subjects, and it hasn't changed all that much over the intervening years. The older adult is more visible now. Our local papers praise and honor them, our local community supports and participates in services for them, tax breaks, housing, nutrition, and many other projects, transportation systems have been developed in response to the growing gray power (and the power of their allies). For this progress the concerned citizen, the participating elder can be truly and duly grateful. But in Champaign County, for every participant there is still the person overlooked; for every individual identified by reaching out, there is the neighbor unknown and untouched. For every county such as ours, blessed in resources and responsiveness, there are many counties where organization and services are still minimal or nonexistent. Ageism, limited employment, artificial barriers to full citizen participation still exist for many of the after-60 crowd.

Rather than repeat the creation of already collected material, I would refer the committee to several attached documents. Included is the recently adopted national policy on aging of the National Association of Social Workers, the development of which I had the honor of participating with many of my local, State, and national colleagues in that association. It deals with the broadest continuum of need of the aging population and the part which the profession of social work and its practitioners should play in addressing and, hopefully, ameliorating the conditions identified. (See appendix 1, item 1, p. 1447.) In addition, I wish to refer the committee to the publication of a paper on protective services for the Nation's elderly which was presented at the National Conference of Social Welfare in May 1978 (coauthored by Frances Hadley, ACSW, of our local mental health center and myself). This paper (somewhat edited) will appear in the proceedings of the May 1977 conference, shortly after the first of the year. It deals with a concern inherent in services for aging persons in urban as well as rural settings, i.e., the critical dilemmas of life and/or death, care or custody, intervention or neglect, personal choice, privacy or privation, which face each individual older person, their family, their friends, and the society, community they live and die in.

GROWING CONCERN OVER LONG-TERM CARE FACILITIES

In addition, I wish to share with the committee a recently developed position statement regarding the provision of social services in long-term care facilities. The history of the statement is the growing concern of a local group of social workers, members of the Illini District, National Association of Social Workers, Illinois chapter, over the inefficient and frequently nonexistent social services provided persons in long-term care and their families under present State regulation in Illinois. This document will be considered by the Department of Public Health Long-Term Care Facility Advisory Board, of which I am a member, and has the endorsement of the NASW State Chapter Board, of the Illinois Welfare Association Board of Directors, and has been reviewed by the Department on Aging, State of Illinois. It addresses the need for a strong advocate role within the long-term care system, whether under medicare, medicaid, or private pay—in private and/or public institutions for resident individuals, and their right to dignity, individuality, and personal expression. (See appendix 1, item 2, p. 1452.)

To convey some of the flavor and some of the specific information concerning older persons in this part of central Illinois, I am attaching a copy of a fine "Profile of the Black Aged in Champaign County, 1975," prepared by Ruppert Downing, et al., of the School of Social Work, University of Illinois, Urbana campus. This study underlines the characteristics of strength and resilience in adversity common to our minority elderly. (See appendix 1, item 3, p. 1454.) In other ways we can demonstrate similar traits among our isolated rural elderly, our urban poor elderly, our University of Illinois annuitants (managing on meager pensions), our current nutrition program participants, the people attending our numerous senior centers, riding our buses and cabs, filling our hospitals and our long-term care homes—and attending this afternoon (December 13, from 1 to 3:30 p.m. at the Downtown Center, Champaign) the Telecare RSVP Christmas party. We urgently hope that members of the special committee, Senator Percy, his staff, and panel members will join us with the throng of older adults celebrating our season together.

To underline the extent and quality of only a few of our local services, I include examples of program materials¹ from the Telecare Program of Family Service of Champaign County, of which I am currently program director. These include the Telecare Volunteer Handbook, the Telecare Annual Report for 1975-76, and brochures from the retired senior volunteer program, and our special self-help group for the bereaved, the Banyan group. (See Appendix E., F., G., H.)

We flatter ourselves in Champaign County that the smorgasbord of resources available offers a reasonable choice to any older person—and for many this is now true. There are problems, however, in maintaining those services (a case in point the gradual erosion of the fine older workers program developed by our county office on aging), in communicating their existence (word of mouth is still the largest source of public information on the programs in a population of 14,000 elders, even though our shared Senior News reaches close to 3,000 individuals and/or interested organizations); and in planning for locally appropriate resources, new and/or continuing in the face of changing allocations, changing and conflicting regulations, continuous need to write and rewrite to present and defined grant requests, as well as the ultimate exhaustion of generally underpaid personnel and community pressures for services which are needed but not funded.

If the above sentence is involved and confusing, it is not a patch on the confusions which the service planner and provider must put up with to design and deliver meaningful useful services to senior citizens in his/her own local area. As a case in point, I will not include the manual for title III projects, nor examples of the minutiae of title XX reporting which, on the one hand, at times interfere in the appropriate policy and procedure setting functions of an agency and, on the other, consume inordinate resources in clerical time and indirectly local cash in a program which hasn't a penny to spare.

MEALS-ON-WHEELS PROGRAM

Locally, we need funds to support an expanded meals-on-wheels program, including subsidy for limited incomes and special diets. We don't need a homogenized surplus commodity, overly regulated, nationally designed, locally un-

¹ Retained in committee files.

responsive monster meals program. Locally, we need a sheltered workshop for older persons to meet and work at employment which will enhance our lives and enrich (if slightly) their pocketbooks.

Locally, to provide for urban and rural elderly, we need stability and continuity in the funding cycle and process. Locally, we need consistent, coherent and reasonable regulation. We need not to have confused interpretations of title III matching fund regulations which turns up supposed over-obligations of Federal cash which need to be repaid 2 or 3 years later—at considerable disadvantage to current programing. Locally, for urban and rural services, we need to have not only funds to develop programs in undeveloped areas, but a basic level of funding for proven programs in areas already being served. We need the support of the Federal Government, the State and local communities. The private citizen, the older adult, must participate in this planning and experience a system which is responsive. To help develop this community responsiveness, we at Telecare have developed a sensitivity training exercise "The Aging Game" used in many settings with some effect.

In Illinois, in Champaign County, or across the Nation, we need to continue to acknowledge the value of our older citizens and to enhance their lives in simple, straightforward, stable, and subtle ways.

Senator PERCY. Thank you very much.

I ask now the cooperation of our other two panelists to summarize as much as possible so that others participate in the discussion.

Michael Strader, director of the title VII nutrition program—Peace Meal. He operates 32 nutrition sites in 12 counties, the largest geographical unit in the State.

STATEMENT OF MICHAEL STRADER, DIRECTOR, PEACE MEAL SENIOR NUTRITION PROGRAM, CHARLESTON, ILL.

Mr. STRADER. Thank you, Senator. It is an honor to be here, although I think I would rather be serving food right now.

I think we need more money for more staff and services, but as a title VII director, I do see the positive aspects of the programs. We are serving right now 800 seniors, or we were until last week's snow storm, serving about 800 senior citizens daily in our program. It is one of the greatest means I feel of reaching and helping the senior citizens. It enables them to maintain better health within their home surroundings. The social needs are being met but, as it was mentioned earlier, we do need other coordination and more money so that we can get more social services through title III or even tied in with title VII, so that we can prolong physical activity which helps delay the physical and mental deterioration of the senior citizen. Physical exercises, recreation, and other social activities all help to alleviate this.

Because of such a program, many seniors are able to supplement their income. We have within our own program some 24 to 30 senior citizens who are employed either because of title VII or the Green Thumb CETA workers, such as this.

Besides being employed, many, many hours of volunteer time are spent working in the program. This gives the senior citizen a sense of accomplishment and really helps improve our program by what the seniors have achieved and accomplished. One thing I like is that it is open to all citizens age 60 and above without a means test for income level. We know our priority is to reach the low income and the minority, but this heterogeneous mixture of senior citizens provides a more stable and stronger program.

TRANSPORTATION DESPERATELY NEEDED

We do have some problems, however. Transportation has been hit. We do desperately need transportation in 12 counties. We have 32 sites, and probably 32,000 or many more towns need a nutrition or a title III program. Within each area of 10 miles around the site, we have probably 10 to 12 other cities, towns, or villages that could also use this program. We do need transportation to get the people there. More outreach, of course. In reality, the outreach is a door-to-door, one-to-one calling basis where we are splintering—each of us going our own way with our own outreach. We need a better trained outreach worker who is familiar with all services available to the seniors.

Home health and homemaker services—we see as we take home-delivered meals to these people a great need for residential repair and renovation. Also, the income level for qualification of participating in many if these programs like the emergency energy relief, so many people who are right on the borderline who are just existing, but still work, and are \$10 to \$15 over the maximum; they need it too.

I know all of these means tests are relating to more Federal funding. However, I also feel that we do have a lot of untapped sources in our revenue funding from the townships and counties. We are finding this when we work for title V sites, such as our senior citizens multipurpose senior center in Charleston. There is money there if you know how you can get it.

I would like to speak just a little bit on the home-delivered meals as part of the meals-on-wheels program. I feel that whatever agency or whatever program gets this, it is still going to have problems. You are still going to need volunteers to deliver these meals; you are still going to need transportation to get there, your special diets, your decisionmaking of handicaps. Many of my site managers—if they were given the job of making a decision, if you got 15 percent who you can work with your physically handicapped—they reach that 15 percent, but they may have 25 percent out there. They are not going to make that decision, so they are going to say "Forget it."

I really feel that the greatest need is greater cooperation and working agreements with the many agencies dealing with the programs—for instance, USDA with the food stamps, Department of Public Aid, and Social Security—some of these. We need to bring these services to the people instead of making the people try to get to the post office for the food stamps or to the county courthouse when they are 25 miles away in another village. I believe, by bringing these services to the people instead of trying to get these senior citizens to the services, you are going to make this a much better program also.

Thank you.

Senator PERCY. Thank you very much. We appreciate your comments. The full text of your testimony will be incorporated in the record.

[The prepared statement follows:]

PREPARED STATEMENT OF MICHAEL STRADER

As a title VII director sponsored by the School of Home Economics, Eastern Illinois University, and serving 12 counties which provide nutrition for senior

citizens daily from 32 sites, I see positive and negative aspects connected with providing services to the older Americans. The positive aspects are as follows:

(1) The nutrition program is one of the greatest means of reaching and helping senior citizens today. The one hot meal per day, meeting the one-third daily nutritional requirement for seniors, enables many to maintain better health within their home surroundings.

(2) The social needs of many are met by the congregate meal sites, thus prolonging physical and mental deterioration of the aged. The physical exercises, recreation, and other social activities all help to alleviate loneliness.

(3) Because of such a program, many seniors are able to supplement their income by employment within the program. (We currently employ 24 seniors.)

(4) Many, many hours of volunteer time are spent working in the program which gives the senior citizens a sense of accomplishment, reduces isolation, and helps to make the program their own by the accomplishments achieved.

(5) It is open to all citizens, age 60 and above, without a means test for income level. Although our priority is to reach the low income and minority, the heterogeneous mixture of senior citizens at the sites provide a more stable and stronger program.

The negative aspects are not detrimental to the title VII programs, but are services that still need to be improved for a more complete program to help all senior citizens:

(1) Transportation for the rural elderly has to be the most important need in our area. We have many rural areas with senior citizens living there who are unable to take advantage of any programs because of lack of transportation. With the high cost of maintaining an automobile, many volunteer drivers are dropping out. Also, if a program tries to run a transportation service, the high cost of insurance, the cost of vehicles, and maintenance of such vehicles makes for a questionable program. Besides transportation to programs, many senior citizens are in need of transportation for maintaining their current living arrangements, such as shopping assistance, rides to professional offices (medical, dental, legal, etc.). This type of transportation would allow many more senior citizens to stay in their own homes and keep them out of nursing homes.

(2) More outreach is needed in all programs for the senior citizens. In reality, it takes several calls, door to door, to reach many seniors and sell them on using such programs that would help them. We are in need of better trained outreach workers who are familiar with all the services available to seniors, instead of each of our programs maintaining our own outreach workers.

(3) Home health and homemaker services need to be greatly expanded. By providing such help from these services, many senior citizens are able to remain there in their own homes and live out their lives among their neighbors and friends with dignity.

(4) Residential repair and renovation for senior citizens should be increased throughout our area again allowing them to stay in their homes.

(5) The income level used for qualification of participating in many of these programs should be reconsidered. With the increase in the cost of living, many senior citizens fall into an area that does not allow them to take advantage of such programs, but their income is too low to adequately maintain their existence.

The items listed above are needs which I feel are most important to help our senior citizens live out their lives in their own environment among friends and neighbors with dignity and purpose.

I realize many of the needs relate directly to more Federal funding; however, if we as people, and we as a nation, are seriously interested in helping others, especially our senior citizens who have brought us to the present, then I see no other alternative.

Some personal thoughts I have concerning the Older Americans Act to be revised are:

(1) Retain title VII senior nutrition programs as a separate title under the Older Americans Act. I feel that the freedom to work directly with the State department on aging has been very beneficial in making Illinois a leader in the nutrition program. If it was to be a part of another program, it would become another agency fighting the system for more money while politics within could halt its growth and improvement.

(2) Home-delivery meals should be a part of title VII; however, I am against the addition of handicapped below the age of 60. I feel it would be detrimental to the aging programs as our senior citizens do not want to be listed with the handi-

capped. It would be a wedge to open all aging programs. It would be a difficult position in which to put many of our nutrition sites in determining who is allowed.

Finally, I feel that we need greater cooperation and working agreements with the many agencies dealing with aging programs. USDA with food stamps, Department of Public Aid, and Social Security are some that come to mind. We need to bring these services to the people instead of trying to get the people to the services. The best way I know to arrange this is with title VII senior nutrition sites. This concern cannot be legislated, I don't believe; however, we should all be aware of the need.

Senator PERCY. Ms. Pat Gunter is the director of Williamson County Programs on Aging, which provides multiservices to over 6,000 different persons a year. She has had 18 years experience in aging—10 years in New York City and the last 8 years in Illinois. A research project of services to the elderly in Williamson County has been completed with a breakdown of unit costs of services. They are higher in rural areas, yet there is no additional funding, I understand, for rural areas.

Ms. GUNTER. That is right.

Senator PERCY. That is a good start for you.

STATEMENT OF PAT L. GUNTER, DIRECTOR, WILLIAMSON COUNTY PROGRAMS ON AGING, HERRIN, ILL.

Ms. GUNTER. Yes.

I thank you, Senator, and the committee members.

As many of you may know from southern Illinois, I am sure that our problems are not unique in any way compared to rural America any place across the country. I can only add, at this particular time, agreement to everything that the other witnesses have said, and to keep it brief. What I am going to do is pick out certain items from my testimony that was submitted which have not been hit upon yet.

The services needed in our area, as surveyed in the southern counties—one of the primary programs is the outreach program. Individuals are isolated in communities. They do not hear well, they do not see well to reach, they are not getting the information as to resources available to them. You can have multipurpose center sites all over the place, but unless you deliver services to people who need them, forget it. Multiservice centers for years have catered to, in many ways, the well-aged—the aged who could get to the site, the aged who could ask questions about services, explain their needs which leads me into the challenging concept as established today of multipurpose centers in Illinois.

"NO TIME FOR EMPIRE BUILDING"

There has to be a key to successful service delivery, and one of those keys is comprehensive planning with all agencies. In any area, particularly in areas with a lack of resources, there is no time for empire building. This is meritorious. These are my people. Don't you dare counsel anybody from across the county line. You will get credit for it and I won't.

I understand, and many of you do, too, the beginnings of these. They began in the social club, small community action groups, and there is a personal pride and personal commitment which is valuable,

but we must go further. There must be professionalism. It could be a light professional, the KBA group of professionals in any one area providing service to individuals, but it must be there. It is lacking now.

Let's take just a random example. In-service training and personal development is lacking. Employees are hired and fired on personal likes and dislikes of administrators. I have seen this over and over again. They are expected to perform service deliveries to the elderly and, without any type of training, they are hired. This is their job description, if they are lucky. If it has not been included in the proposal to the State to meet the guidelines, this is what you do; now, go do it. You will learn—osmosis will get this skill to you and you will be able to offer all types of good services. I have seen this and I think many of you have, too.

Individuals who are administering programs—one program I am thinking of is administering around \$140,000 in funds. There needs to be job qualifications. Their skills must be demonstrated, not for the home people I have coming in. What is actually happening there? They need to be tested, reviewed, and evaluated periodically by people outside of the system.

Growth is dangerous in any social services system and we see it all the time. Counseling services are offered through titles III and XX, yet seven out of eight agencies that offer such services do not have a professional counselor on the staff. This may not be feasible money-wise, we understand. Nor do they have any type of professional supervision of a counselor.

"TOO FAR OUT OF THE MAINSTREAM"

Counseling is a hit-and-miss service; very rarely are there any followups or referrals made because, again, they do not want to cross lines. Staff is neither capable nor qualified to decide if the individual is in need of a service. One agency having a "counselor" on the staff, when asked how he dealt with the problems of the rural elderly, seriously made the response: "It is their problem; they live too far out of the mainstream." I do not think this is unique, I am sorry to say.

Another lack of professionalism is in recordkeeping and the record-keeping process. Agencies do not have confidential files on clients who are screened. Attendance records are kept; counseling records are kept—those provided by the State. I. & R. sheets are kept basically for one reason: To justify funding sources.

Now, I am not saying there was—this is something they have been pushed into, doing with guidelines. I have seen confidential records passed around amongst staff persons for no other reason than just to read them.

Friendly visiting, very much needed in a rural community, is very infrequent, maybe every 3 months. Recently an individual was found after lying on the floor for 4 days. She had been on a friendly visiting list; she was known to the agency. Yet there has not even been an attempt in the agency to develop a network of daily callers.

Outreach is minimal. We have it on the radio; we do all kinds of things. We sent out a newsletter. The problem with that is the newsletter only goes to members, people who donate so much a year. A site

director canceled an outreach program 2 days ago which had been scheduled in a rural community. It had been scheduled for a month and advertised. The outreach worker would work at the site, setting up for a night Christmas party. This party would, again, serve the well elderly.

Now, I ask you, where and what are the priorities? Sometimes they look good on paper, but sometimes it is actually not happy.

Target group—Many times the rural elderly are considered a target group which is a definition to be used by agencies because it sounds good and it looks good in proposals. Very few, if any, agencies concentrate on such groups and have sought to serve this particular population by lack of support and interference from agency staff and directors. I have seen these services often aborted.

ADDITIONAL FUNDING QUESTIONED

In conclusion, I have only touched upon, maybe, some of the outstanding problems that I see that have a direct influence on service delivery. I am a field practitioner and I firmly believe in comprehensive services and planning. I do not say at this time additional funding is the answer. I am sorry.

I say let's straighten out some of the guidelines. Let's get it together. Let's establish those priorities. Let's work within a network of systems. Let's see what we can do with what is available and then let's go all out.

I think area agencies should be the ones in our area that we are responsible to. Title VII is responsible to Springfield. This is confusing and it is very difficult to work with. If it is difficult on the local level, can you think what happens when you are trying to deliver services to individuals?

Service to the rural elderly qualitywise will not be met unless we start now to face some of the challenges. It is a good system. The Older Americans Act is on a sound basis, but before we get into a public aid bureaucratic structure, let's start now and we can do it as practitioners.

All services need to be upgraded and I really want to see concentration ruled wisely on people who are bound to their small communities and are bound in their homes. The situation of ignoring the rural elderly can no longer be tolerated; it is a waste of human resources, it is a waste of tax dollars and, most of all, it is ignoring those who need these services.

Thank you. [Applause]

[The prepared statement follows:]

PREPARED STATEMENT OF PAT L. GUNTER

This testimony is being submitted in the hopes that it will aid in the understanding of the problems faced by the aged rural American today; it holds possible suggestions that might help alleviate a needless waste of human resources.

The statements and suggestions in this testimony are based on my 17 years of field practice in the area of aging both with urban and rural elderly populations.

The facts and figures contained in this testimony are based on personal experiences and a complete survey that was taken in the 13 southernmost counties in Illinois.

THE RURAL ELDERLY—WHERE ARE THEY?

In a State, where 8 out of every 10 older persons live in urban areas (populations of 2,500 and over), there are 2 elderly persons living or residing in rural communities or villages. This growing group of elderly has not really been dealt with in terms of their needs and priorities. The rural elderly somehow have managed to become a definition only and not a reality. Whatever the reasons, both numerous and complex, the needs of many rural Americans are not being met or even recognized. The number of rural elderly Americans is increasing faster than that of the urban population, basically because many city dwellers are returning to small communities after retirement.

Over one-third of the older population, of the southernmost counties (13) in Illinois, reside in communities with less than 1,500 total population. A good portion of these rural elderly actually live outside or on the fringes of these communities. They are geographically isolated, as well as isolated from professional services, and further isolated because of a very human process—aging. They are easily located and identified, and just as easily ignored.

Although the rural elderly have been identified as in need of special services for a number of years, the concern has not been great enough for immediate action. Legislation lags. Social services are spotted and fragmented, and social service providers have far too long catered to the "well aged," providing services to those individuals who are able to seek help and remain active in their communities and in local sites. The providers long have ignored the very poor, the isolated, the mentally distressed, and the physically undesirable. A point has been reached where this can no longer be tolerated. The ineffectiveness of partial service delivery to our rural elderly is a sign of gross neglect. An effort must be made to provide services to this group of elderly. This effort begins in the legislative acts of Congress; it becomes a priority for the Illinois Department on Aging; it becomes a major target area for the area agencies on aging, and it must be provided by the local social service agency. There must be a comprehensive service plan developed to meet the immediate needs of these rural aged.

EXISTING SERVICES TO THE RURAL ELDERLY

There are very few agencies that offer direct services to the rural elderly. Those that do are capable of providing only minimal and partial services. The most common type of services delivered are recreational in nature and do not deal with the real problems. Furthermore, they are site-oriented, compared with the need for complete services and service delivery to the home-bound and to the socially and geographically isolated.

The service providers may be divided into five basic categories: health providers, social service agencies, housing agencies, recreation, education and leisure providers, religious groups, and community action planning agencies. The most active providers in the social services category are those sites funded by the Older Americans Act under titles III and VII. Although limited, the existing CAP agencies offer the most comprehensive service plan to the rural elderly. These, however, are not meeting the basic needs of the rural elderly as well as they could or should.

A basic gap is the obvious lack of any solid interagency referral system. This means a direct referral system, with followup, not just telling the client where he may go for help. Agencies are duplicating services in many areas and not providing the important services in major areas of need.

MAJOR PROBLEMS

The major problem of the rural aged is that of isolation—Isolation from regional and community resources. The geographical isolation leads to a far more distressing type of mental isolation. Increasing isolation, because of ill health, loss of friends and relatives, loss of income, and low feeling of self, breeds a multiple problem situation. Lack of education, transportation, and income add to the total picture of the type of isolation facing the rural elderly.

These people are forced to retreat by circumstance and often become withdrawn, become neglectful of themselves and their homes, giving the appearance of decay. They are difficult to reach, geographically and socially; they are the ones that have been most neglected by social service providers and society as a whole.

These individuals are independent, stoic, and distrustful of "giveaways"; they want to pay their own way as much as possible. They above all, of the aging population, want to remain independent, living in their own homes and making their own decisions. One of their greatest fears is the loss of this independence and eventual institutionalization. Yet, the services that would provide them the means and the methods to remain independent are not being provided.

WHAT ARE THE NEEDS OF THE RURAL ELDERLY?

The special needs of the rural elderly can best be met by a comprehensive service plan and delivered through an outreach network system. Efforts must be concentrated on home delivered services and not on the participant receiving services in a central site, often completely inaccessible to the client.

Outreach is the basic service that must be top on any priority list planning services for the elderly, the initial task being to locate the elderly in need of specialized services. This does not mean a one-time visit and informing the individual of where services are available and letting it go at that. The search must be carried out from community to community, from door to door, and continuously.

Finding the aged and identifying his needs are of little value unless services can be provided to meet those needs. The outreach worker must recognize, identify, and develop a plan for service delivery to meet each client's need. The worker must recognize when services can be performed directly; i.e., friendly visiting, shopping assistance, arranging and providing transportation, filling out forms, and aiding the client in understanding rules and regulations involving other agencies. However, the worker must recognize their own limits in providing help with problems that deal with such areas as counseling, health care, legal aid, and guardianship roles. These special identifiable problems must be handled by, or referred to, trained professionals, whenever possible.

The relationship between the home-bound person and the outreach worker very often is the difference between self-maintenance, with help, and confinement in a nursing home. Although placement in a protective environment is often necessary, a personal relationship with a worker may and should made the transition to protective care easier.

Through the outreach process there is the understanding that needs are identified and solutions provided to meet these needs when possible. Certainly, not all problems of the rural elderly can be solved, but many of the immediate crisis situations of the rural elderly can be prevented and with preventive planning can be almost eliminated in entirety.

SPECIFIC NEEDS OF RURAL ELDERLY

Home-delivered meals: The concept of meals-on-wheels and congregate meal sites have provided needed services to many. Yet, they have not gone far enough in the concept of total service delivery. Home-delivered meals are regulated as to the number and the persons who receive them. For every one person attending a congregate meal site, there are two individuals in need of home-delivered meals.

There are many reasons why individuals will not attend a local title VII site. State and Federal regulations prevent these individuals from gaining a much-needed service. Many older individuals need the security and comfort of remaining in their own homes during meal time and often feel threatened by the group encounter. They are embarrassed by eating without teeth, not being able to take care of their personal hygiene activities, have difficulty with physical mobility, and are plagued by poor eyesight. All of these factors add to the discomfort of a person participating at a congregate site. Other facts that have a tendency to hold them back from participating are the need to make reservations in advance, not knowing how they will feel the next day, and that they must depend on outside transportation at another's convenience. All of these facts create an atmosphere where the individual hesitates to become involved because too much may be asked of them.

A personal objection that many site participants have are the invariable recreational and educational programs presented immediately before the meal. Individuals are transported to the site and find themselves a captive audience. They cannot see well or hear well, and the programs have little interest or value to

them personally. The meal itself should be served without concentration on such recreational programing. Although such programs are valuable on an optional basis to those who choose to participate, they should not be a prerequisite for a nutritious, balanced meal.

The solution to providing a nutritious meal to the isolated elderly is to offer as many home-delivered meals as possible. One way that this can be efficiently handled in a rural setting is to transport prepacked meals from a central site to a local distribution point; i.e., a village hall, local church, etc. Allow individuals to pick up their prepacked meals and take them home to those who cannot get to the distribution site. Also, it would be more convenient for those volunteers who deliver meals to the completely home-bound elderly.

Experts and practitioners agree that one of the major problems of the elderly is malnutrition. The elderly do eat, but not basically balanced meals. Dietary needs change with age. Availability of food supply is limited in a rural area. Also, the elderly do not have the knowledge, desire, or energy to prepare the food that their bodies require. By offering more home-delivered meals, not only would a health problem be handled, but the individual's receiving the meals would have daily contact with a volunteer or site worker. This would be one of the advantages of this type of system.

Home health services are vital and they must be a strong part of any comprehensive service plan to the rural elderly. Most rural communities lack the medical resources to provide basic medical care for any age population. The rural elderly have even a greater burden; the lack of local practitioners interested in aging, lack of adequate medical facilities to meet the problems of aging, and certainly the lack of preventive health planning. The cost of medical care, medication, and an adequate income further contributes to the immediate health needs of the rural aged. A tremendous exploitation of the older population, through medicare and medicaid fraud, is not limited to urban elderly.

The public health departments are limited in staff, limited in funds, and limited in the services they may offer to the rural aged. Currently, the lack of ambulance service to the rural area has compounded the health problems.

Provisions must be made for the training of individuals to serve in the home health aid field. The home health aid, under the supervision of professional health personnel and trained specifically in the health needs of older adults, is a necessary service not to be denied. Many of the rural aged could look forward to a better and healthier future by the development of this one service.

Home chore services and homemaker services are a must if we are to keep individuals independent and functioning in their own housing units. Chore services are identified as those activities that will keep the housing unit habitable and hazard free, in relation to the client's well-being and safety. The cleaning of a house once a week, helping the individual to do laundry, the making of minor repairs and care where indicated on the outside premises, will reduce many of the deplorable housing conditions in which we find the older person residing.

Chore services are an essential ingredient in keeping individuals out of nursing homes and within their local communities. Once removed from familiar surroundings, older adults show evidence of a more rapid rate of mental and physical deterioration. For this reason alone, every effort must be made to keep the individual functioning at their highest possible level within their personal surroundings.

Transportation in rural areas is inadequate, and what does exist is not satisfactory. The rural area is one of black-topped roads, gravel roads, and two-laned highways; they are often impassable during the winter for days at a time. A totally new approach must be found and explored to handle the transportation problems of the rural elderly. Admittedly, this is one of the most expensive services that is needed.

The attempt to provide transportation to the rural elderly has been along the lines of a standard routing system. The long distances combined with their lack of physical mobility make the fixed route system impractical, and the lack of population to be transported daily means miles of travel to pick up few individuals. The vehicles themselves are often too large for the demand and cost more than the actual delivery of the run. A major problem has been the insuring of vehicles for transportation of older adults and the insistence of insurance companies placing these individuals in the high risk category.

Most rural communities have school systems operating vehicles over the entire rural region. These vehicles are not in use except for a small portion of each school day. It seems reasonable that agreements should be worked out to accommodate the elderly adults as well as school children. Various States have regulations prohibiting the use of their school vehicles for any other purpose except for transportation of school children. It will take a mandate on the Federal or State level to change these regulations, and these changes should be strongly encouraged.

To service the special needs of the rural aged, small service vehicles should be considered. These vehicles should be capable of transporting a small number of rural aged as well as equipped to handle the handicapped elderly. These vehicles should be used for transporting a small number of aged adults for such trips as shopping, laundry, doctors, and clinic appointments which would keep larger and more costly vehicles in perspective with their needs.

Transportation needs in the rural areas are clearly in evidence and to meet these needs, many problems must be hurdled. They are not, however, insurmountable, and a concentrated effort must be made to overcome them. This will take specific guidelines and the cooperative efforts of Federal, State, and local departments. The alternative to the transportation problem is to have all services delivered to the client, which would be a far more costly undertaking.

KEYS TO SUCCESSFUL SERVICE DELIVERY

The key to the successful delivery of services is through comprehensive planning programs. This involves the cooperative efforts of all agencies providing services to the elderly on all levels. It must be recognized that many of the social service providers have long depended on Federal funding for the capital to operate their programs. In rural southern Illinois, the majority of these programs are funded through titles III and VII of the Older Americans Act. The outgrowth of these programs have been the senior centers and multipurpose senior centers.

Senior centers and multipurpose centers developed from small community social clubs. Most often they were inadequately staffed and managed. As they grew, and Federal and State guidelines were expanded, quantity and not quality of services has been the mode of operation. Persons administering title III and title VII sites from its inception as a social club to the present now resist any type of outward service delivery and growth. They are lacking in basic social service skills.

Training is a must for all senior center administrative staff. Training in basic office management, personnel development, and policy and procedure practices should be mandatory. Attendance at conferences and seminars are not enough. Skills should be demonstrated, tested, reviewed, and evaluated periodically by qualified persons outside of the site. Specific guidelines and evaluations must be developed to see that senior service providers are qualified, capable, and trained to meet the responsibilities of their task.

On-site or inservice training, as it is defined today, is nonexistent. Untrained center administration cannot be expected to provide adequate inservice training when they themselves do not have either training or the basic understanding of the purposes or guidelines of the program. All staff, regardless of job duties, should have a sound basis in gerontology and its practical application in the field. As an example, a trained outreach worker is particularly invaluable to any site offering services to the home bound. They know the community, the people, and are sensitive and aware of the problems of aging. They are able to deal with the elderly as equals and friends, while referring more complex problems to the appropriate agency. The outreach worker's skills in problem identification, assessment, and interventive planning can make the difference between life and death.

Professionalism is a much-needed ingredient in successful service delivery to the aged. Every senior center should have on staff, or if this is not feasible for funding reasons, then at their disposal, a social worker, a counselor, a health expert, and a legal aid advisor. These individuals should be a specialist in the field of aging in their area. Since it would not be feasible, costwise, for each site to provide this type of expertise, it would, however, be possible for several sites to share the cost and benefits of these specialty individuals. Another position that these individuals might hold, is that of supervisors of lay professionals

that are providing the actual services to the clients. The pooling of resources is the only way that quality services will be delivered to a quantity of rural elderly needing specific supportive aids.

Area agencies on aging are absolutely essential in service delivery plans to the rural elderly; but only if they are functioning as a total working unit. Too many area agency staffs are not qualified to direct the allocations of funds, to supervise site managements, and make program evaluations. At any level in the delivery of services, professional backgrounds are needed—probably most needed on the area agency level. Area agency directors should be required to have adequate staff to meet the needs of the area. There should be a set of guidelines and qualifications for all area agency staff. These should be the same statewide and should be adhered to strictly. Until this type of system is put into effect, supervision and services through the area agencies will not be provided to the utmost capabilities, or provided only on paper as a fulfillment for funding requirements.

Titles are a hazard. One problem that is evident in social service agency structures is the difference between various title programs and their funding process. Currently, the funding of various title programs is creating multiple delivery problems. Many of the Federal guidelines are in direct conflict with sponsoring agencies policies and definitions.

The funding of title III is through the area agency on aging; title VII goes directly through the field representative from the State. Title III reports are monitored through the area agency on aging. Title VII reports directly to the appropriate representative at the department on aging in Springfield, Ill. There must be a single structure responsible for all area funding and reporting.

This agency must be adequately staffed and have a monitoring evaluative system that reports what is actually happening and not what they said would happen. The agency must be visible and attainable; it must be responsible for coordinating all service delivery to the area aged, and the agency must be accountable for following the State mandates.

Funding has been a major handicap to the delivery of services to the rural, isolated aged. Areas are funded on the number of elderly per total population. Two very important items are missing in this funding formula: (1) the larger concentration of elderly in Illinois are located in or near metropolitan areas where there are multiple special services resources available within easy access to the elderly, and there are also more community resources available, i.e., transportation, clinics, laundry, shopping areas, etc., (2) cost per unit of service delivery is less where multiple resources are available.

Rural areas, in contrast, do not have the available resources, and the lack of these resources becomes a major hurdle. It takes time and money to either deliver the service to the client or transport the client to the service providers. The unit cost per service delivery in many cases will triple as compared to unit cost in an urban area. This points to the need for a new funding formula if we are to meet the needs of the rural American elderly. The rural areas do not always have the community resources available to meet the qualifications for matching funds on the local level. Funding formulas must be based on resources and extent of need, rather than on the number of elderly per total population.

Simplification of agency structure and centralization of service directives must be seriously considered. All directives and information dealing with older Americans should be funneled through the Office of the Administration on Aging. Currently, various Federal agencies provide a variety of funding sources and guidelines that affect the ability of local service providers to coordinate and obtain information and funding for their programs. Waste of effort, time, manpower, and money help prevent full utilization of the available resources.

The same problem exists on the State level; in fact, it is even more complex. Such agencies are the Department of Public Aid, Illinois Department of Transportation, Department of Public Health, Department of Mental Health, and the Illinois Department on Aging. If we have a department on aging, does it not stand to reason that all services delivered to the elderly should be funneled through one department? It would simplify the role of the social service providers greatly if this were the case.

If it appears complicated on the State level, by the time information is channeled to the local level the real confusion begins. Agencies are found to be duplicating services while, at the same time, assuming that other agencies are

providing services which they sometimes are not. Literally fighting over territorial rights, they wind up serving only a small part of the population in need. It is all too apparent that without total agency cooperation the rural elderly individual will not get the quality of services of his urban counterpart.

CONCLUSION

The problems of the rural aged are in many ways similar to those of other aged groups: urban, minority, and handicapped. The problems are complex and cannot be solved by simplistic additions to an already inadequate system. Increased funding is not the answer either. Until some of the structural problems are dealt with directly and immediately, there will be no guarantee of adequate services to the rural elderly.

The provisions of the Older Americans Act are valuable in and of themselves; the concepts are solid ones. Now that the beginnings have been made, it is necessary to begin a revamping process immediately. If changes are prolonged and recommendations made that are studied and then restudied, there will be another public aid situation at hand. A situation that can only go from bad to worse, with great cost to the taxpayer and inadequate benefits to the clients, which is why the structure was created to avoid such a public aid catastrophe.

SUMMARY

It is quite evident that the rural elderly in our State are not receiving that which they need nor that to which they are entitled. They are isolated, both geographically and socially, by circumstance. Currently, all forms of public information have not been effective in reaching those target groups of rural elderly that are in need of services. All the newsletters, radio spots, and newspaper coverage have not been able to reach those who are hard of hearing, have poor eyesight, cannot read, and have little contact outside of their limited environment.

The only method to reach these individuals is through a concentrated outreach plan. This must be performed through a network of comprehensive service plans for the rural elderly. It involves the coordination of multiple agencies in any given area and the restructuring of the area agencies on aging.

Training on all levels is a necessity, particularly in the existing senior centers. Training in administration, personnel development, and program management are vital at this stage in the growth of senior centers. If professional services are funded, i.e., counseling, it should be performed by a qualified professional counselor or by a lay counselor under the supervision of a qualified staff person.

Services most needed by the rural elderly are: home delivered meals, home health aid, chore services, and the opportunity to gain these services as quickly and efficiently as possible. Transportation, a definite need, must be examined very closely, and a new approach developed.

Funding processes and allocations must be closely scrutinized and an equitable funding mechanism developed. Accountable, responsible and evaluative systems must be developed that are structured the same for all areas; the same set of rules for everyone must apply. A simplification of the bureaucratic structure would aid in the delivery of services to all older Americans. Do away with all the various titles. The purpose is the same: to provide services where services are needed.

If the concept of the Older Americans Act is to provide the means of keeping older individuals independent and functioning in their environment as long as possible, it is apparent that now is the time to start insuring that the special needs of the rural elderly are met. That their dignity and worth as human beings are preserved, and the quality of their life according to their personal needs is continued. Not all problems of any one population can ever be solved, but those problems created by societal situations are no more complex than the ability, the desire to pool resources and deliver services in an orderly professional manner.

Senator PERCY. Thank you very much.

We appreciate very much this tremendously stimulating panel.

Our third panel consists of Beverly Kofoot and Gladys Kohrt.

Beverly Kofoot is director, Community Resource and Counseling Center, Ford County. I hope you will talk a little about health services.

So that we can have participation by everyone here, can you summarize your testimony in 5 minutes each?

**STATEMENT OF BEVERLY A. KOFOOT, SUPERVISOR, FORD COUNTY
HOMEMAKER PROGRAM, PAXTON, ILL.**

Mrs. KOFOOT. First of all, I have to correct my title. I am not the director of the community resource and counseling center. I am the supervisor of the homemaker program, which is just one of the areas that we do cover in Ford County. Our director, Korman Smith, is here and I am sure he will be glad to know I gave him back his job.

I am representing Ford County which is the second smallest county in Illinois.

Senator PERCY. Is Ford larger than Bureau?

Mrs. KOFOOT. I don't know which is the largest.

The population of Ford County is approximately 16,000, and of this about 3,000 citizens are over 60 years of age. The largest city in Ford County has a population of approximately 4,400, so it is very evident that we are a rural area also.

Homemaker services were established in Ford County by the community resources counseling center in 1975. We obtained grant moneys from title III of Older Americans Act, which provided 80 percent of the total budget. Twenty percent of that budget had to be matching funds from the communities in the county.

DECREASE IN FUNDS HANDICAPS PROGRAM

The yearly decrease in funds of the title III programs has greatly handicapped the growth of the program since we must increase the matching funds each year. This is extremely difficult since the area is so rural and we do not have the large providers as do the more urban counties. Our communities are supportive this year, but there is no future security in this because not only do we have to increase the matching fund amount each year, but these community funding needs will be changing. Consequently, there is always the fear of running out of money and not being able to provide the service at all.

Last year we obtained grant moneys from title XX of the Social Security Act to help support our homemaker service. This grant does not require matching funds, but such a small amount was allotted—only \$4,000—that it did not provide for growth of the program. It did, however, help us to sustain the homemaker program through the fiscal year since we had such a problem obtaining matching funds for title III.

The amount of title XX moneys did not increase this year. Even though the need for growth of the program was proved last year. Because of the small amount of money received in title XX, it is

realized that those present clients who are eligible for title XX money for services will have to be switched to the title III program when the \$4,000 is exhausted.

Under title XX we aren't allowed to ask for donations to help defray the program's operating costs, but under title III programs the clients are asked to make monthly donations if they are able on the sliding-scale basis according to their income. This really poses a problem in that it is very difficult to explain this to these citizens or these clients.

Title XX also, in my opinion, asks for entirely too much personal information about the client. This is an unnecessary invasion of the client's privacy.

MANY SERVICES PERFORMED IN THE HOME

In general, I just would like to go over some of the duties that are performed by the homemakers in our county. They go into the homes of the clients on a part-time basis and give personal care not requiring a professional. They also provide meal planning and preparation, light household duties, emotional support, anything that will help to make the home run more smoothly during a period of stress. The physicians and hospitals have been notified of our services and we are getting referrals from local doctors and hospitals and also from larger institutions such as Mercy and Burnham hospitals in Champaign, Ill.

Our clients have been pleased and extremely gratified for this service because in many cases it has shortened hospital stays. Our homemaker service also limits the necessity of long term institutional care such as nursing homes which not only saves money but also provides the client with the self-esteem and security of remaining in their own home for as long as possible.

While in the process of supervising the homemaker program, I have seen personally the very definite need for home health services in Ford County. There is no public health department representative in the county. All referrals go through Champaign County. They are then referred to our one county nurse who will do initial home evaluation visits. But there is no one in Ford County who will make daily home visits to perform such home health duties such as injections, dressing changes, and so on. This is one area that we at the community resources and counseling center identify and are trying to find the financial support for.

Hopefully, these comments and suggestions that I have presented will aid Ford County and all the other little towns and rural counties in Illinois in continuing to upgrade the services that these citizens are entitled to.

Senator PERCY. Thank you very much indeed.

Now, we turn to a larger county. Gladys Kohrt—I hope we have your title correct. You are administrator of Livingston County Health Department. You can tell us about services that are provided in the larger counties in Illinois.

**STATEMENT OF GLADYS KOHRT, ADMINISTRATOR, LIVINGSTON
COUNTY PUBLIC HEALTH DEPARTMENT, PONTIAC, ILL.**

Ms. KOHRT. Thank you, Senator Percy.

I think, since we are pressed for time, I will push into an area that has hardly been touched, and that is home health care.

Home health care permits the elderly to remain in their own home. It also can reduce their hospital stay, and it can lessen hospital readmission. These services are available locally in my area, but they are limited because of major obstacles in the medicare law and in the department of aging funds.

One of the obstacles is the definition of the word "skilled" in the medicare law. I was talking to one of your agents this morning and she said you were working on that. I feel that this word has had the interpretation changed over the years since 1966, and I have been working with the program since 1968. I believe if that one word were deleted from the law, it would change the intent of the law.

As an example, I can tell you that a registered nurse may go into the home and change a patient's catheter, but if the catheter needs to be irrigated or monitored, then she is to teach someone else to do it. If there is not anyone there to reach, that is not medicare's problem. Quite often it is a skilled service, so I don't think a blanket definition can be applied. We need to change it so that we can maintain these people in their home.

NO BENEFITS FOR CUSTODIAL CARE

The medicare insurance is useless for terminal cancer patients because much of the care is maintaining the patient, and if medicare won't pay it, then other insurance won't pay it either. Our home health agency has maintained cancer patients in their own home until death, and certainly that is less expensive than sending them to the hospital. Then they have been denied because it is custodial care, and they are probably right, it was. We were maintaining them there.

I think that the terminal patient deserves to know that a skilled person is monitoring them and the family that has chosen to care for these people needs the supportive guidance that the nurse gives them to reassure them that they are doing all that is possible. It is important that these people can maintain their dignity. That is something that was mentioned today, and I can very strongly talk about maintaining the dignity of the elderly. You cannot take that away from them. I would suggest that the persons making the determination of payment on whether these are skilled or not would be required to make an occasional field visit to see what is happening out there with their providers and the recipients. This would be much the same as you have done today, and we do appreciate that.

One year ago, our department started a homemaker home health aide program with department of aging funds, and I think you have heard a lot about that. My funding wasn't increased and I should close the program, but to use this opportunity to put the department of aging on guard, I don't intend to close my program down. I intend to fight for that funding and no way am I going to close it in March, which

I will have to do if I don't get some funding. So they have now been alerted that I am going to fight decreased funding in Livingston County.

As far as nursing homes, I don't think much has been mentioned on this, but the narrowness of the pay base deprives them from giving service. If the nursing homes in our area are not providing extended care facilities due to the restrictions imposed, this means that that patient cannot go from home to extended care and then into their home with our home health agency picking them up. They have to go into custodial care homes. I recognize that nobody is going to go out of business due to these limitations, but I think you are forcing a double or triple taxation on these older people who can least afford it. They have paid their social security, they have paid for medicare; if they own any property at all, they are also paying that tax. I think this is spreading it over the elderly while the general economy goes on and you are taxing the few people who are vulnerable to the system and must use that system.

MIDDLE INCOME HAS PROBLEM WITH MEDICINE

Another thing I want to mention is the high cost of medicine. That is another problem with what I call the middle-income elderly. People that are on public aid will get it paid for, and your wealthier people can pay for it, but your middle income has a problem with medicine. We find people not getting prescriptions filled because they cannot afford to pay for it or they do not take it properly, they try to make it last. If it is to be twice a day, they take it once a day, and it is ineffective due to inadequate dosage. I cannot think of an adequate solution to this problem, but I call it to your attention as a problem of the elderly.

When I was given an opportunity to testify, I did place an ad and ask for people to call me with their problems. Those are the ones that I have presented. There was another one that I was asked to call to your attention. It is H.R. 25, a bill to amend the Internal Revenue Code of 1954 to provide a basic \$5,000 exemption from income tax for amounts received as annuities, pensions, or other retirement benefits.

We are concerned in our area about the requirements of the health planning law. We feel HEW is in the process of making rules that will seriously deny access to quality medical care.

The present proposal would reduce the number of hospital beds for our area. I think if you look at the long-range plan of reducing the beds in the area, you reduce the possibility of doctors willing to practice in rural areas. If we do not have full service hospitals in our area, we will not get the doctors there. Again the elderly would have to travel further and you have your transportation problem again, which keeps cropping up today.

I would urge you to help change the medicare benefits to deal with the general health improvement with preventive services. It is difficult to prove the long-term benefit of this type of service whereas the critically ill patient is highly visible. My primary interests are preventive medicine and public health, but I think hospital costs can be reduced effectively if more health care resources are reallocated to the preventive area.

I do thank you for your interest in the Nation's senior citizens.

Senator PERCY. Well, we very much appreciate the testimony.

I would like to point out that there is a bill in the Senate—S. 2009—of which I am a cosponsor, that will take care of some of the problems that have been outlined. It would eliminate the 3-day stay in the hospital, the skilled nursing requirement, and so forth. We are working on some of those problems.

I would like to ask you just a few questions.

MORE SCHOOLS OF GERONTOLOGY?

We have heard testimony previously that there is plenty of medical care, but that the younger doctors like to take on younger patients. Some of them shy away a little bit from the elderly. Do we have a problem, in your judgment, in getting physicians to not only take care of elderly patients, but also become familiar with their special health needs? Do you feel that it is a serious enough problem so that we should advocate that more schools of gerontology be established?

Ms. KOHRT. I feel in our rural area we are caring for the elderly because the doctors have them as patients. So really in our area the younger people who move in—sometimes the doctors in Illinois are not taking new patients. I don't think it is that much of a problem in our rural area.

Mrs. KOROOT. I agree with that.

Senator PERCY. Then would you give us some idea of what proportion of the elderly are not getting adequate medical services today? Is it a serious problem? What type of transportation would be needed, if transportation is a part of the problem, to help the elderly?

Ms. KOHRT. Part of our transportation problem is getting the people from their rural community to the service, our largest town is Pontiac, which is 9,000, and the hospital there for their outpatient services. I receive calls saying, "Can you help me get to my physical therapy appointment?" and that type of thing. We have a transportation service to take these elderly people to their doctor appointments.

Senator PERCY. My last question is provoked by Mr. Strader's testimony. His written testimony indicated that home-delivered meals should be a part of title VII. However, he said, "I am against the addition of handicapped below the age of 60 in the home-delivery meal service." He said the elderly do not wish to be classified with the handicapped.

Could you comment as to whether there is a tendency to fold the handicapped into some of the programs? Would you care to comment on the pros and cons on that?

Anyone who has an opinion in the audience, I would appreciate it. Do any of the panelists want to comment?

Mrs. KOROOT. There may be some from the audience.

Senator PERCY. There is.

Would you care to take the microphone and come up?

Mrs. BENNETTE. I was not prepared to do it in this order. First, Mr. O'Hare from LeRoy is going to make a presentation on your two Senate bills, and in his presentation he includes this and why we

I have a little postscript here on this. We are aware of the fact that the Senate Nutrition Committee is due to be disbanded January 1, 1978, but would appreciate our recommendation being considered by the proper authorities.

I would like to add something else while I am up here, if I may. We are getting transportation for senior citizens. I am from LeRoy, as Mrs. Bennette introduced me. We have three representatives from LeRoy. We have the Peace Meal, we have our senior citizens club, but our biggest problem is transportation to pick these people up to participate in the Peace Meal program and at our senior citizens meeting.

I have had an opportunity to talk to one of our auto dealers. At that time we could have gotten a vehicle, but there, again, the insurance was so outrageous that it just possibly could not be done. Is there any way that the small communities can be helped in getting transportation for their senior citizens?

Thank you.

Senator PERCY. Mrs. Oblinger, do you want to comment on that?

Mrs. OBLINGER. I know the State place, and that is where he needs to be directed. We have just received a \$36,000 grant from the Department of Transportation to do a study of the transportation needs here because we have found out that the rates have increased between 400 and 500 percent. The biggest increase was in Eureka—a 571-percent increase. They are saying it is because, No. 1, our senior drivers have more accidents; No. 2, that we don't properly train them; No. 3, that all the seniors riding on the buses are always falling and breaking their arms and legs and hips. We have asked a number of our area agencies about these allegations and we have not found this to be true, so we are doing a complete study of what actually goes on on every bus we fund, which is around 215 buses. We are taking that to the department of insurance. They have to work with the insurance companies because region V of HEW says that Illinois has the highest rate of insurance for senior vehicles of any State in the Union, so we are working on that.

DISTRIBUTION OF MOTOR TAX FUNDS

The second part is what the Senator referred to. There is \$13 million of motor fuel tax in the Department of Transportation for reimbursement for senior citizens transportation. Up to this point it has gone entirely to mass transit districts on reimbursement. Approximately \$12 million goes to Chicago. I have asked them to redo this and reimburse the transportation programs on the numbers of people transferred and not on the transportation districts. I live near Springfield which has a mass transit district. So my State representative said, "Well, we have one," and I said, "Yes, I live 15 miles out in the country. Am I to walk 15 miles to Springfield and then am I to get on the Springfield bus line which can be reimbursed?" This is not the way it is to be done. We are working, No. 1, to find out why this is so and, No. 2, to get reimbursement for the downstate vehicle claimants.

Senator PERCY. Thank you very much.

May I now see the hands of those in our audience who would like to make a brief statement or ask a brief question of any of the panel-

don't want to be included with the handicapped. So I will let him talk first.

Senator PERCY. All right, fine.

Ms. KOHRT. If I could first make a statement about the handicapped and the elderly. When you added medicare disability to take care of the handicapped, I want to say that this really helped because of the fact that they need the insurance coverage, so I have been speaking for their part.

Senator PERCY. Thank you.

STATEMENT OF JOHN J. O'HARE, LeROY, ILL.

Mr. O'HARE. Senator Percy, ladies and gentlemen, this was a presentation at a speak-out session held in Springfield, Ill., on November 18. The member of the regional III subcouncil of the peace meal senior nutrition program, which is funded by title VII of the Older Americans Act, would like to request the State department on aging to support the following issues which will be determined in Washington in 1978.

The first of these concerns the two Senate bills to provide home-delivered meals. We feel that the Kennedy bill, S. 1283, is superior to the McGovern bill, S. 519, in the following ways:

No. 1, we prefer the title "home-delivered meals for the elderly" as opposed to "national meals-on-wheels."

No. 2, we like the fact that the Kennedy bill was referred to the Committee on Human Resources instead of Labor and Public Welfare. The welfare image is not what senior citizens want.

Senator PERCY. It is the same committee just renamed.

Mr. O'HARE. Beg pardon?

Senator PERCY. It is the same committee just renamed.

Mrs. BENNETTE. We didn't realize that.

Senator PERCY. So you prefer the new name? Good. So do I.

Mr. O'HARE. No. 3, the Kennedy bill is for senior citizens only. It is important that senior citizens not be lumped together with the handicapped.

No. 4, funding preferences should be given to title VII and meals-on-wheels programs. If preference is given solely to meals-on-wheels programs, many rural areas may be left out.

On this we do have another point—that there are more general provisions in the Kennedy bill which we also consider. We strongly urge the State department on aging to consider these points and consider the Kennedy bill.

FAVORS STATUS QUO FOR TITLE VII FUNDING

In addition, we would like to state that we are strongly in favor of maintaining the status quo for title VII funding. It is our understanding that the Senate Nutrition Committee will recommend that title VII not be consolidated with other aging programs. We know that this will be a key issue when Congress takes up extension of the Older Americans Act and we feel very strongly that title VII should remain a very visible, independent program.

ists? Could I see your hands high. I see there are 10. That means that we should limit ourselves to 1 minute each for either a question or a statement and the questions hopefully we could give in 30 seconds so that we can allow 1 minute for an answer.

Now, let's just start right over here. If you will just come up and state your name and your county.

STATEMENT OF RAY SCHROEDER, DWIGHT, ILL.

Mr. SCHROEDER. I am Ray Schroeder from Dwight, Ill.

I have been kind of pushing the bill H.R. 25. I understand that at the last congressional meeting it was turned down. If anybody is not acquainted with it, if you want to present it or else I will present it—what the bill H.R. 25 represents.

Senator PERCY. It applies to our hearings today, does it?

Mr. SCHROEDER. Aging, yes. The bill before the U.S. Congress provides a basic \$5,000 exemption from income tax for moneys received from annuities, pensions, and other retirement incomes. That is the basic element of it.

Now, I would like to know for what reason it has been turned down and if there can be any help that we can promote it again and get it started.

Senator PERCY. It is a House bill that has not been considered in the Senate yet, to my knowledge.

Would you care to answer that directly, Peg?

Mrs. FAYÉ. No.

Senator PERCY. We have no answer to your question at this time. It is a House bill, not yet in the Senate, and turned down apparently by committee. So I don't have an answer now, but if you just leave us your name and address, we will get an answer for you.

Mr. SCHROEDER. Thank you very much.

Senator PERCY. Our next question, let's take one on this side then. Yes, way in the back. I think you had your hand up first.

There are five seats empty right there. Those of you who have questions, it would save us time if you come down and take those five seats.

STATEMENT OF KAY MCGUIRE, PAXTON, ILL.

Ms. MCGUIRE. Senator Percy, I am Kay McGuire. I am also from Ford County. I work at the agency where Beverly does and I am a counselor and I work with older people.

In response to your question about home health care, I have these observations. First of all, I think one problem that the elderly have in their health care is that many doctors are reluctant to go very often to nursing homes. I work in nursing homes and I feel this is a very, very big problem because the staff is very frustrated. They don't want to take responsibility, and they should not.

Another thing, when older people are in their homes they get confused on medication. As the lady stated, they try to stretch it out, and so forth, and unless someone comes in and explains it to them, unless they get up the nerve to ask their doctor, "Why do I need this medication? What does it do?" and so forth and so on, they are not going

to do it and they are not going to take it. So as a counselor when I go in and see them, they have all these questions. I am not medically trained and I try to call on Bev to help me because she is a nurse. This is something that they don't want to ask. They do need that self-esteem and they don't have it. I think that medication is one of the biggest problems that the elderly have, understanding it, getting it, paying for it, and then having it administered.

Thank you.

Senator PERCY. Thank you. That is a very good statement. I saw so many heads going up and down. I know you have expressed the views of many of our audience today. Thank you.

Go right ahead.

Ms. PENTECOST. I am Edna Pentecost from Danville.

Many people say that the older people don't want to be categorized with the handicapped. No one has answered why. I just wondered why we don't want to. [Applause.]

Senator PERCY. Would someone care to respond to that question, please?

Mrs. BENNETTE. I have an answer to that, too, because in our nutrition center program when you admit the physically handicapped, the first thing you are doing, you are getting mentally handicapped. Now, this is purely a personal feeling and I hope you don't think I am prejudiced or narrowminded, but would you like to sit across the table from someone that was drooling?

WIDE BASE FOR SERVICES ?

Senator PERCY. Is there some possibility of developing a guideline that if you developed a program that provides a service—and possibly I am thinking in terms of home-delivery service where you have the vans, you have the funding—we might get more funding for transportation if we included the handicapped? If you try to combine student union centers with senior centers, this would not really work because the students want a place to go with other students. Senior citizens really want a place to go with other senior citizens. So if it interferes with the basic purpose of the program, it possibly should not be combined. But if it would not interfere with the basic purpose of the program, possibly there is no reason not to have the two done together by the Federal Government. It would be certainly more efficient to have the outreach services, health services, and so forth, combined where it clearly does not interfere; in fact, it might strengthen the program for both groups.

Mrs. KOHRT. I think we all have handicaps; on some of us it shows more than others. I think they should be included. [Applause.]

Senator PERCY. Fine. Let the record show that there was much applause. This is a controversial area where there is a difference of opinion and it is wise in this public hearing to have both sides presented. I appreciate that very much.

Our next person.

Mrs. SMITH. Senator, I am Mamie Smith from the Mount Olive site. Mrs. Montgomery could not make it.

Is it possible to take them some food if they don't come in? Could someone take it to them? I mean, those who are sick. They were coming in, but three of them can't come in now.

Senator PERCY. Does someone want to comment on that?

STATEMENT OF STANLEY WEIDNER, CHENOA, ILL.

Mr. WEIDNER. I am Stanley Weidner.

We have money given to us by the city. My question and comment—everybody is talking buses. I think we have to work out something where individuals can pick up these people. The bus cannot get to them. They have difficulties getting to a bus. The liability insurance is too expensive for the volunteers. Now, we have money to give to the volunteers. Everyone talks about this problem.

I took someone 50 miles to Peoria. Well, the gas prices are ferocious and mileage should be available.

I asked a State lady about insurance. Is anything being done to pay the volunteers when they are using their car and not having them insured when receiving mileage payments? That is our big question.

Thank you.

Senator PERCY. I think that is a very good point.

Mrs. OBLINGER. I will answer the question. Title VII has a limit on the percentage of home-delivered meals that you can have. Only 12 percent of your title VII money can be spent for home-delivered meals; therefore, you cannot serve all those who need it.

No. 2, we had volunteers insured through the group in Washington and under ACTION and the National Center for Voluntary Action. They have canceled all car insurance for volunteers.

Mr. WEIDNER. I will have to comment on that. They have insurance that is very cheap for \$3 or \$4 a year, but it insures the driver and not the people you are hauling. That is where we are running into trouble.

Mrs. OBLINGER. It is a liability insurance.

Mr. WEIDNER. Even if a volunteer is paid mileage, taking someone to a meal, the passenger should be covered.

Senator PERCY. Thank you very much indeed.

Mrs. SMITH. I was thinking of taking the meal.

Mrs. OBLINGER. Out of the whole amount you have to take 12 percent to be delivered, the rest to be served in congregate meals.

Senator PERCY. Thank you very much.

STATEMENT OF MAMIE SMITH, CHAMPAIGN, ILL.

Mrs. SMITH. We have it pretty nice. We are getting a pretty nice outreach because they have to pay out—I don't know. She really got working and got one of the things I have been preaching about. We need to have outreach go around. She did a lot of things for me and, just like I said, you need a good outreach and know what is going on. Some don't know where to go, some don't know what is going on, but she is really working with us.

I live at Bradley in Champaign, Ill. We need some things up there. My apartment needs a door fixed. The cold comes in and we can't keep warm. The bugs are bad. The hall doors open—they broke in the apart-

ment the third time. The rug is rotting on the hall—flood. People are noisy; the management does not seem to care. A group of us have tried to get something done about it. I ask, please tell me what can be done. I am losing heat. I have had it rough. I was hurt 7 years ago in a car accident. Now after about a year, they cut the rent, but I have no lights.

Senator PERCY. Thank you very much. We are going to have to limit the questions or statements now to those who are standing there. We just don't have time for any more. I am going to ask each of you to do it in a half minute.

Mr. MATTHEWS. It would take me 3 hours to do it.

Senator PERCY. Well, you will be alone then. You have a half minute and that is all. You can submit for the record any length of statement or question that you would like.

Mr. MATTHEWS. I would like to submit that and give you a copy of that. This is our committee meeting, and we have taken out everything that was said.

Senator PERCY. Very good.

STATEMENT OF HENRY MATTHEWS, CHAMPAIGN, ILL.

Mr. MATTHEWS. I just want to say that I am the Lieutenant Governor's adviser on the aging committee and we have five committees. I am quite surprised that we have people in this area who have not known of this. I happened to read it in the paper. I am the chairman of the housing committee, and at our last meeting we took up everything that had been said here at the meeting. So I would like you to have a copy of that. If anyone wants to know, I say get a hold of the Lieutenant Governor because they have a committee working on this.

I would like to speak on insurance. We have got in our thing there about the insurance that we are going to the director of insurance to have a committee set up to insure, like they do on dangerous—they have to have their turn—about so the insurance company will be taken care of, too. You just read that. I would like to get that back.

Senator PERCY. Very good. Thank you very much.

STATEMENT OF WANDA F. ANDERSON, RESEARCH ASSOCIATE, SOUTHERN ILLINOIS UNIVERSITY, CARBONDALE, ILL.

Mrs. ANDERSON. I am Wanda Anderson from Southern Illinois University where I am a research associate with the gerontology program. I have a background of professional social-work education and practice.

I just have two statements to add. One is complete confirmation of what the panel II speaker from Williamson County, Pat Gunter, had to say, born of my years of experience, not only very short experience in Illinois, but in many parts of the country.

Second, what we in higher education could do to help needs clarification, and I think the question comes my way repeatedly as I go into the field, which I do, is how you define social services and training. In the defense of those people who are manning agencies which are trying to write and draft proposals, I think it would help if Congress

could find some way to define some of the terminology more clearly and, in connection with that, to set certain kinds of standards so that well-intentioned people do not find themselves directing programs when they have had neither program nor management training and/or experience. And, I don't mean sophisticated management, but those who have not had the background to help them in the difficult task that the administration requires.

I also would like to make a personal pitch. My husband is also "handicapped." He is in the audience, and maybe he won't appreciate this, but with a law doctorate, he cannot quite understand the latest words from the medicare people, and he is going to call his local social security representative. I find it sort of sad that we don't have terminology which perhaps might be developed by some of the consumers in some of the forms and some of the materials that are being sent out. Even though most of us in higher education are not responsible for much of the terminology, we cannot interpret it. I think that would be helpful. [Applause.]

[The prepared statement of Mrs. Anderson follows:]

PREPARED STATEMENT OF WANDA F. ANDERSON

The area historically served by Southern Illinois University at Carbondale is poor and it is rural. It has been characterized by one writer as "The Other Illinois" (Brownell, 1958). It does not share in the general prosperity of the State and the Nation. The area loses young people by out-migration. There is a heavy concentration of the aged.

Statistics to document this characterization abound. However, the area is defined for statistical purposes, and whatever measures of age, income, and ruralness are used, the differences between southern Illinois and the rest of the State and the United States are large and dramatic.

The area served by the Carbondale campus of Southern Illinois University is reasonably well approximated by the Illinois 24th Congressional District—22 counties at the southern end of the State. Statistics for the district will serve to illustrate the differences between southern Illinois and other areas. Some of these differences will be described.

The area is rural and it is not growing. While the population of the United States had increased by 13 percent between 1960 and 1970, and that of Illinois by over 10 percent, the southern Illinois area had increased less than 2½ percent.

The rural character of the area is illustrated by the fact that only about 43 percent of the people of the area live in urban places. Compare this to 83 percent for the State as a whole and 73½ percent for the Nation. Over 12 percent lived in rural farm areas, while the corresponding values were about 4 percent for Illinois and for the United States. There is no major metropolitan area in the region. The largest city is Carbondale, where the SIU campus is located (population 23,000). There are only five cities with population over 10,000.

MEDIAN FAMILY INCOME OF \$7,500

The area is poor. Median family income in 1970 was about \$7,500. For the State as a whole, it was nearly \$11,000. For the Nation, it was about \$9,600. While Illinois is among the more prosperous states in the country, southern Illinois is among the least prosperous areas. The same pattern is shown by the median incomes of unrelated individuals and by per capita income levels. Over 15 percent of families of the area live below the officially defined "low-income level," fully twice the percentage of that for the State, and about half again that for the Nation.

The data on housing show that a much higher proportion of southern Illinoisans than of others in the State own their homes. The proportion is also higher than that of the Nation. This indicates a rather stable and immobile population. Also, however, the statistics show that the housing base is older than that of the State and the Nation, that new units tend often to be mobile homes, that a high

percentage lack at least some plumbing facilities, and that the value of the housing in southern Illinois is markedly less than that of the State and of the Nation.

The population of southern Illinois is old. The median age is 32.6, nearly 4 years above that for the whole of Illinois, and over 4 years above that of the Nation. The percent of the people of the area who are 65 and over is nearly 15 percent, contrasted with the approximately 10 percent for the State and for the United States.

Older citizens bear disproportionately the burdens of low income and the isolation that results from being in rural areas. Over 30 percent of residents of the area who are 65 and over are living below the officially designated low-income level, compared to 22½ percent for all of Illinois and only 19 percent for the United States. This low-income level, as officially defined, is a conservative indicator of poverty, which assesses the needs of rural people and old people to be less than that of urban people and young people. For example, the 1969 low-income level for a female unrelated individual 65 or over living on a farm was only \$1,487. However, even by this conservative official definition, nearly one-third of the elderly in the southern Illinois area live in poverty.

Within this general area, older people tend to live in the smaller towns and in rural areas. The major cities in the area tend to have very low proportions of persons over 65. So in addition to being concentrated in the southern Illinois rural area, even within the area the elderly are underrepresented in the cities. This, of course, causes physical isolation. The percent of households having automobiles available is less than that for the State and for the Nation. Public transportation in the area is virtually nonexistent. For example, only about 1 percent of people in the employed labor force use public transportation to get to work, compared to 15 percent in the State as a whole and 9 percent in the Nation. This lack of public transportation is powerful evidence for the physical isolation of the elderly in southern Illinois.

Compared to the State and to the Nation, the population of southern Illinois tends to be old and poor and rural and physically isolated. The differences are not small differences to be discovered only by the trained statistician's eye and manipulation. They are large. They are important. They are dramatic.

The service needs of the elderly in this area are great. It is an ideal laboratory for the study of the rural and poor elderly. It is an ideal situation for the development of models for the delivery of services to the elderly and rural poor.

SKILLED HOME HEALTH CARE SERVICES NOT AVAILABLE

Among the most pressing unmet needs for the elderly poor in southern Illinois would be adequate and accessible health care. Skilled home health care services, for example, are not available in most areas generally, and scarcely ever in the rural sections. This simply implies that few alternatives can be found to institutionalization for the elderly person requiring supportive services to remain at home. It is easily documented that the cost factor is greater when the individual must be placed in a nursing home, both financially and socially.

Another important concern relates to the availability of protective services and legal aid for the elderly poor. Such services are virtually nonexistent with the exception of possibly one or more of the "cities" in southern Illinois. Lack of public transportation would then become complicating to this situation in every instance.

Communication ranks with transportation with regard to service provision to the rural elderly, especially the poor. It is doubtful that the majority of eligible persons ever realize that help may be possible. The characteristic pride and sense of personal dignity found among rural people prohibits most from asking for aid. The tendency, too, to think of any help from "outsiders" as a form of "welfare" further exacerbates the situation. Too often the semilliterate state common to the elderly poor simply prevents discovery of whatever community resources may be in existence. Problems usually become serious, and often beyond solution, before the proper agency or organization is made aware.

Increasingly then, it is evident that a truly accurate and reliable needs assessment is crucial to service provision. Reliance upon the traditional word-of-mouth forms or the appraisals of persons whose self-interest may color their judgments is not only unfortunate, but usually costly in the end. The best intentioned individual is subject to error in assessment of a personal situation. The record speaks

for itself in that large numbers of rural elderly remain unserved in even the most urgent ways while other people receive the available help on a reasonably regular basis. Duplication of efforts and lack of accountability plague most of the agencies struggling to meet service needs which are determined by less than scientific methods at best.

The foregoing rationale represents the major impetus for the effort of Southern Illinois University to join in the struggle to relieve some of the problems most serious in its region. SIU-C has, therefore, begun preparations for the establishment of a center on aging to serve as the focal point for its efforts to ameliorate conditions locally and regionally. The idea of a focus on the needs of the aging is not new at SIU-C, but only in recent years has it reached the stage of an organized, sustained approach.

FUNDING COMMITMENT MADE BY UNIVERSITY

After considerable planning on a universitywide level, four task forces were developed to work toward the establishment of a multidisciplinary research center for the study of aging. Input has been solicited campuswide and preparations are now underway to draft a proposal application for a title IV-C (Older Americans Act) grant from the Administration on Aging. Commitments have also been made by top level university administration officials to set aside funding to supplement the grant and to continue beyond that assistance.

The center on aging at SIU-C will have four main objectives, as follows:

(1) To stimulate, coordinate, and produce basic and applied research related to environmental, biological, psychological, social aspects of aging;

(2) To stimulate the incorporation of information on aging into the educational effort of the university;

(3) To assist and encourage the SIU School of Medicine in its efforts to seriously incorporate geriatrics and gerontology into its teaching, research, and service activities. The SIU School of Medicine has a special mission to train practicing physicians to serve the areas of the State that lack adequate health care service in central and southern Illinois;

(4) To focus and direct research and educational activity toward several specific populations of older adults with which SIU has a special relationship because of its location. Among these special populations would be coal miners and their families. Coal mining is the major industry and miners face special problems as they age, notably respiratory diseases such as black lung. Another special group is found in the two State prisons and a Federal penitentiary located in the region. A large Veterans' Administration hospital facility is at Marion and SIU-C already has close linkage with it.

It is also important to point out the existence of two administrative units within the university which will work closely with the center on aging. The nationally known rehabilitation institute and the coal research center have already been involved in a variety of research projects which include needs of the elderly. The rehabilitation institution provides opportunity for research into the various aspects of disability and the treatment modalities needed to improve functioning in all age groups. Special attention has been devoted to the counseling of special groups such as the elderly nursing home patient and those confined in mental health facilities. The coal research center has sponsored a research project involving a team of health educators to examine the concerns and interests of miners and their families. Health and social needs were among those items of high priority.

Southern Illinois University at Carbondale recognizes the mandate given to all public institutions of higher education is a three-fold one. That mandate calls for the emphasis to be placed upon quality research, service, and teaching. By joining in the overall effort to improve the quality of life for the elderly poor in southern Illinois, SIU-C is demonstrating its allegiance to that mandate in its fullest sense.

SUPPLEMENTAL STATEMENT

Pat Gunter, Williamson County, was accurate in her remarks as a member of panel 2. It is clearly evident that a crucial factor relates to the need for an accurate, reliable need assessment on a statewide basis. Reliance on data gathered by title VII directors is an error. An outside, professional assessment is badly needed.

My own testimony was filed with your staff member, Kathy Deignan. It represents a summary of data collected by Southern Illinois University at Carbondale through its universitywide gerontology council.

Lack of professional standards and in-service training is a major issue. Educational institutions can and should be involved in their area as well as in regard to objective, competent needs assessment and program evaluation.

Senator PERCY. Thank you, Mrs. Anderson, very much.
Yes, sir.

STATEMENT OF RICHARD RYAN, MATTOON, ILL.

Mr. RYAN. I am Dick Ryan from Mattoon, Ill.

In discussing the energy-related programs for the elderly, I would just like to bring out one facet as an input person for the emergency energy program. I have found that many elderly and handicapped were not income eligible for the program; they were short just a few dollars. I would suggest a new formula based on heating cost in relation to income. As an example, if heating costs exceed 8 percent of income, people over 65 and handicapped would be eligible for reimbursement in the sliding percentage scale. These input records would also pinpoint dwellings that need winterization assistance. We need to save energy. If we winterize these homes, they will save us money in our own energy costs and also reduce the elderly individual cost—to more wisely spend our money in the State and National program.

Thank you.

Senator PERCY. Thank you very kindly. I appreciate it.
Yes, sir.

STATEMENT OF JACK HORNING, DIRECTOR, ILLINOIS GREEN THUMB PROGRAM, SPRINGFIELD, ILL.

Mr. HORNING. Thank you, Senator.

My name is Jack Horning. I am the State director for the Green Thumb program. We are operating in 60 counties with 734 workers now working. One of the things we have not been able to come across in Illinois, and I guess across the country, is employment for seniors who want it. We have nearly 300 percent of our applicants who apply who are over income or program guidelines, but they are still looking for employment. We would like to try to help these people. We are talking about the people in the \$4,000 to \$6,000 per year income bracket.

Thank you.

Senator PERCY. Thank you.
Yes, ma'am.

STATEMENT OF JUNE FINN, TITLE VII PROJECT DIRECTOR, DANVILLE, ILL.

Ms. FINN. I am June Finn. I am from Vermilion County.

I am the title VII project director. I am a grassroots person who sees it as it is. Our county supervisors have been almost blind to the home health needs in our county, but our home health needs have been assisted by title III of our area agency on aging. Together with this,

I would like to see a medicaid program—simply stated, a van to be outfitted or several vans to be outfitted, to go out into the community to the rural patients.

I would like to know how we could staff one, or how it could be worked out, or whether it has ever been done. This would bring the doctor to the patient at much less expense and a lot less inconvenience. Possibly an intern program.

Thank you.

[The prepared statement of June Finn follows:]

PREPARED STATEMENT OF JUNE FINN

I would like to address the issue of social services to rural elderly.

The elderly in rural areas are often invisible—they are more solitary because of location and inclination. They are generally more independent and resist help. This resistance is partially due to fear of being found and placed in a nursing home. To almost all seniors, this is the very worst calamity that can happen to them. This attitude should tell us a great deal: (1) That we have a very poor image of nursing homes, (2) that we could keep them in their own homes for a much longer period by providing homemakers, chore service, and home health aides; also a telephone reassurance program.

Many people try to economize by doing without a telephone. Some method should be devised to pick up the cost of a phone as a dire necessity for those who are isolated or living alone. We must not forget that many are living on an income of less than \$200 per month. How would we, you and I, like to try to make it on that?

Transportation is one of the greatest holdbacks for the elderly getting out to available services.

Addressing the problem of transportation for the rural elderly is a real task. The problem is doubly serious in these areas. The distances are great, neighborhood communications break down, and the isolated seniors do not have any method of getting their groceries, going to the doctors, as well as other needed trips.

The distances involved mean that many trips will take a great deal of time and cannot be served by one van in a county.

I also believe that the older citizens should contribute something toward these services so that we are doing with as well as for them.

The meals programs are also not available to these rural seniors. Once again the delivery of the meals, when necessary, or the bringing of the seniors to the meals sites will provide the important links for them. Volunteerism is great, but one cannot rely on that system entirely.

We need an adequate senior transportation system of some type in the rural areas.

The recent State of Illinois emergency energy program, which we just experienced this fall, was frantic. We did not get the go-ahead soon enough; we had only 30 days after training to do the job. We needed more time to publicize the program.

The seniors were also afraid that by taking part they would jeopardize themselves in some way. If the program is to be activated again, we would like time and better publicity, couched in simple terms.

The program was extremely helpful to them. However, I would like to suggest that the gas and light companys should check out the cases that must be cut off. Example: This recent case of the woman who was cut off, who was using kerosene lamps for heat, and burned to death. Had someone checked, or had these people known about the energy program, it might have been a different story. Possibly the utility company could release a list of cutoffs, to be checked by a responsible agency.

In fact, we all are responsible for these tragic cases.

Senator PERCY. Thank you. I will see that the staff looks at the question you cite and responds to you.

Yes, ma'am.

STATEMENT OF LINDA SHARP FLESHER, COORDINATOR, HOME HEALTH SERVICES, CHAMPAIGN COUNTY NURSING HOME, URBANA, ILL.

Ms. FLESHER. I am Linda Flesher.

I am the coordinator of Home Health Services of Champaign County Nursing Home. We are a certified home health agency that deals primarily with rural elderly. I want to emphasize the need in relation to home health services of some funding source for chronic illness care. Our clients are usually above the age of 65. It is a well-known, documented fact that the multiplicity of health problems of older Americans are primarily concerned with chronic illnesses. In most instances, we have adequate funding under medicare and medicaid for acute illness care. We have nothing for chronic illness care.

In addition to that, it is very, very important that home health services across the Nation receive some sort of funding for home health aides and homemakers that is not so restrictive. It does no good to put a professional nurse in the home once a week if there is no one there to prepare meals, to change the linens, to empty the garbage—all these things. So this is a very, very needed thing.

Senator PERCY. Ms. Flesher, we will see that the full text of the testimony you submitted to us is made part of the record at this point.

Ms. FLESHER. Yes, sir.

[The prepared statement follows:]

PREPARED STATEMENT OF LINDA SHARP FLESHER

Home Health Services of Champaign County Nursing Home was established in June of 1976. It is an approved medicare and medicaid provider of home health services. The geographic area served by the agency is the county of Champaign, with particular emphasis on areas of the county which lie outside the city limits of Champaign-Urbana. The population of service is the adult resident of Champaign County who is 45 years of age or older, with special concern for those who are 65 years of age or older. Specific services offered by the agency are skilled nursing, physical therapy, and home health aides. The agency makes about 200 home visits per month, with an approximate unduplicated daily census of 30 clients.

In this presentation I wish to speak to the unmet home health needs of the elderly of Champaign County.

At this time, in this county, the home health care needs of the person 65 years of age or older who is suffering from an acute illness or the acute exacerbation of a chronic illness can be met in the majority of instances with adequate funding sources. Medicare and/or medicaid will reimburse an approved provider for services rendered in most cases of acute illness care. However, Federal health insurance for aged (medicare) and medical assistance under title XIX (medicaid) does not allow for payment of services provided to those persons suffering from chronic illnesses. Health guidance and professional supervision of treatment regimes are, nevertheless, an important aspect of home health care. It is well known and documented that older persons suffer from a multiplicity of health problems—many of a chronic nature.

These problems often require close monitoring, health counseling, and supervision by a home health professional if the physician's medical treatment regime is going to benefit the patient. In our agency alone, we can point to several instances, substantiated by our documented observations as well as those of the physician and other community professionals, where home health care has been successful in prevention of hospitalization of long-term care facility admission.

Health situations which were potential crises were prevented or averted due to the intervention of a home health care professional. These instances involved

persons with diseases which were chronic in nature. In most of the cases, Home Health Services was in the home, receiving payment under medicare or medicaid, for the acute care of another condition.

When the agency must leave that home, discharge that client, and no longer visit regularly, what happens to those chronically ill people suffering from emphysema, diabetes, arthritis, or congestive heart failure? How is the physician alerted in sufficient time to adjust medical care and prevent hospitalization? Who is to monitor the patient's progress under that adjusted medical treatment? Who is there to observe and alert the patient to habits or practices which are potentially hazardous to him? Who is there regularly to observe the reactions and interactions of the many medications many older citizens must take in order to function? Somewhere in the fragmented maze of Federal and State funding for home health care, the elderly citizen of Champaign County needs assistance in paying for health care directed toward chronic illness.

NONPROFESSIONAL HOME HEALTH CARE

In addition to professional chronic illness home care, there is an overwhelming need for a payment vehicle to cover the cost of nonprofessional home health care. When an elderly person is not able to do his grocery shopping or prepare a nutritionally balanced meal or get in and out of the tub or shower, these situations affect his health. When an older person cannot sweep the floor, do the laundry, change the bed linen, dispose of the garbage, these situations affect his health. Yet they do not require the expense and labor of a professional nurse or therapist or social worker.

Medicare and medicaid will not pay for homemaker services. Payment for home health aide services are severely restricted by medicare and medicaid. While it does not cost as much to send a home health aid to make a visit as it does to send a professional nurse, it does cost money. Frequently, more money than the client's private resources will permit him/her to pay on an ongoing basis. The need for payment sources for home health aides and homemakers in Champaign County is great.

It is evident to the professionals in our community that professional services alone will not prevent institutionalization or promote and maintain the independence of family centered living. Professional services must be augmented by home health aide and homemaker services. In addition to aides and homemakers, there exists a need for the provision of meals delivered to the home-bound. In many instances, it seems it would be more economically feasible to centrally prepare 25 meals and deliver them to 25 homes than to employ 25 homemakers to shop for, prepare, and serve 25 different meals. (That is, of course, if we had the 25 different homemakers in the first place.) Professional services plus supportive services is the key to home delivered health care.

In addition, our agency had identified one professional service which is needed in home care and for which, at this time, in this country, there is no known payment source. That need is for therapeutic home nutrition counseling by a registered dietician or nutritionist. Many of the acute and chronic illnesses which have a high incidence among elderly are directly related to or affected by dietary intake. A home health agency would be an ideal provider of this service. Our agency sees a real need for such services, but, because of the nonpayment factor, we are unable to provide them.

In conclusion, I will mention cost effectiveness of home health services and client satisfaction with home health services. Cost effectiveness of home health care as opposed to institutional health care has been documented many times by many people in many places. It is still disputed by many others. Clients who have received home health care speak long and convincingly and unashamedly of their bias in favor of this method of health care delivery. Despite the impressive statistics offered in support of home care, particularly on cost, the best summation of its value was given to me by a 78-year-old man who, in response to my question: "What do you think about home health care?" said this: "If I didn't have anything to eat or a dime to spend, I'd still be happy because I'm home . . . that's what I think it means to me."

ADULT DAY CARE

There is one other mode of health care delivery that I would like to mention briefly. Although adult day care has functioned as an alternative to nursing home

in-patient care for almost two decades in England, this community-based mode of long-term care for the elderly has just come under study in the United States. Much of the cause for this slow growth can be attributed to consequences of medicaid and medicare, which has long favored payment only for institutional care. But health care costs are spiraling, particularly institutional costs. The social security amendments of 1972 (P.L. 92-603, section 222) specified that adult day care would be one alternative form of health care delivery modes considered. Champaign County Nursing Home currently operates a viable adult day care program serving some 28 participants. It has proven to be a satisfying and economical alternative for some individuals to total institutionalization. From its inception to the present, the largest problem has been no public funds to cover the cost of day care. If public funds were available, we are confident the number of participants we would serve would be limited only by the physical limitations of space available in our building.

**STATEMENT OF VERNON L. BARKSTALL, EXECUTIVE DIRECTOR,
URBANA LEAGUE OF CHAMPAIGN COUNTY, CHAMPAIGN, ILL.**

Mr. BARKSTALL. Vernon Barkstall, executive director of the Urban League of Champaign County.

I have prepared a statement so I will try to refrain from going beyond the time limit you asked for.

We have two major kinds of concerns that I addressed in our statement, and that has to do with the fact that we were the administrator of two Federal programs—one being the special crisis intervention program, and the other one is a community service administration-sponsored home weatherization program.

The special crisis intervention program, in our estimation, is a Band-Aid type of operation in that it provides immediate assistance and relief to eligible low-income elderly persons, but it does not address the long-range needs of those persons. The fact that a person may get \$250 of assistance to take care of inflated fuel bills does not speak to his needs on behalf of the home weatherization program. I think they should be taken into consideration jointly. As a matter of fact, those same persons who needed the assistance last winter will also need it again. This does not speak to the 500 or so eligible persons in our community who did not get the assistance for one reason or another, primarily because there was not enough funds to go around, even though we have \$129,000 in this community to take care of that fuel bill program.

The other thing relates to the weatherization program. We are finding it increasingly difficult to get insulation and other building materials in a timely fashion. We cannot get insulation at all, I should say, and we are having a very difficult time getting storm doors and windows to decrease our heat loss. I know you are concerned about the total energy picture, and we believe that it is a much more beneficial kind of program to spend moneys on weatherizing homes. That benefit will be there year after year, rather than the \$250 that has been appropriated because it ends up that the fuel provider becomes the major beneficiary.

[The prepared statement follows:]

PREPARED STATEMENT OF VERNON L. BARKSTALL

The Urban League of Champaign County is one of 109 affiliates of the National Urban League. The urban league is a not-for-profit community organization with a major aspect of its mission being to increase the life-chances of disadvantaged

citizens brought on by low-incomes, low-educational attainment and, among other factors, the special problems of the elderly.

We appreciate the opportunity of participating in this hearing on energy-related problems facing the elderly because we have been able to gain some hard experience in this area as a result of our administration of Federal grants to provide home weatherization and special crisis intervention (fuel bill) services to the economically disadvantaged. We know that you are most cognizant of the newness of energy-related programs; therefore, we will not touch upon problems of operational nature brought on by inexperience, but rather we will briefly note matters over which operators do not have control.

The special crisis intervention program which provided fuel bill assistance to eligible clients is a band-aid type program. Our organization administered a \$129,307 grant in Champaign County and provided assistance to 538 households. The speed with which these funds were applied for (less than 2 weeks) assures us that many eligible clients would have participated had more funds been available. Because of national inexperience, and the relative low level of funding compared to need and logistical problems, many rural elderly persons did not get served in this year's entitlement.

We used the term "band-aid" earlier because these same persons (served and unserved) will need this assistance every winter until economic policies are instituted which will take into consideration the fact that elderly persons and the otherwise disadvantaged exist on fixed and grossly inadequate incomes.

In addition to the logistical problem alluded to in reaching the rural elderly, we have found that some of the most severely disadvantaged—as is usually the case—did not hear of the program in time to be among the early applicants.

We recognize the tremendous relief that the receiving of up to \$250 of fuel bill assistance is to the beneficiary; we suggest, however, that more long-term benefits will accrue if homes of the disadvantaged are weatherized to reduce heat loss.

This comment leads to our second concern:

Our agency has been engaged in the weatherization of homes of eligible applicants in Champaign County. The first phase of our program centered almost exclusively on persons in Champaign and Urbana. Subsequent efforts will be expanded to more adequately include the rural elderly. A prime source of referral will come from among those assisted in the fuel bill program.

There is a critical shortage of building and insulation materials which is making it next to impossible to adequately weatherize homes. With 6 inches of blown-in cellulose insulation, one can decrease heat loss by 30 percent. Nine to twelve inches of insulation can drop heat loss to nearly 50 percent. A corresponding reduction in fuel bills would be of long-term direct benefit to those served. As it is, their bills remain high, their homes stay cold, and the fuel provider becomes the major beneficiary of the \$200 million supplemental appropriation to the Community Services Administration.

We ask that assurances be given nationally that the shortages are real. We have much faith in the free enterprise system, but consideration must be given to the fact that supply and demand alone assures that those most in need can least afford the service and are the most likely not to know where to turn for assistance.

Thank you, sir; the Urban League appreciates the opportunity afforded to make these brief comments.

Senator PERCY. Thank you very much.

Is Bill Cunningham here? Could he stand, please?

Bill Cunningham.

We want to thank you very much for your help with this hearing. Is there anything you want to say from there?

Mr. CUNNINGHAM. No.

Senator PERCY. Thank you very much.

I want to thank every participant for all the support and help you have given us. If any of you who wish a copy of these proceedings would write a letter to me, we will send you a copy when it is printed.

Thank you very much for being with us.

This hearing is adjourned.

[Whereupon, at 12:06 p.m., the committee adjourned.]

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APPENDIXES

Appendix 1

MATERIAL SUBMITTED BY MARIAN L. ASCOLI,¹ TELE-CARE PROGRAM DIRECTOR, FAMILY SERVICE OF CHAM-PAIGN COUNTY, ILL.

ITEM 1. NATIONAL ASSOCIATION OF SOCIAL WORKERS POLICY ON AGING

(Prepared by Task Force on Aging : Midwest Coalition, Eastern Coalition, Western Coalition, Southeastern Coalition)

BACKGROUND AND BASIS FOR CONCERN

NASW's policy on aging is predicated on the following demographic and social characteristics; political and professional concerns.

Demographic characteristics of older persons

Since 1900, the percentage of the U.S. population 65 years of age and older has more than doubled. Today, older Americans constitute approximately 10 percent of the population. By the year 2000, this proportion is expected to reach one in eight.

Social scientists say this growing proportion of elderly people will have a significant impact on America's economic and social institutions. Most older people live in a family setting; but more than one-third (6.3 million; 1.4 million men and 4.8 million women) live alone or with nonrelatives. The proportion living in family settings decreases rapidly with advancing age. A smaller proportion of older versus younger persons live in metropolitan areas (64 percent vs. 69 percent). In such areas, however, 53 percent of the elderly live in the central section of the city. Older women overwhelmingly outnumber older men (143 to 100) and projections indicate that this trend will continue.

On the average, blacks and other minorities have a much shorter life expectancy than whites of about 8 years which accounts for the smaller proportion of blacks among aged persons. To be black, Mexican-American, or Indian, elderly is to be in "double jeopardy" as to survival into old age and to an impoverished existence in later years. In addition, an increasing number of workers 55 and older are anticipating retirement with resultant increases in social adjustments to older age.

Elderly persons living on fixed incomes are helpless in the face of inflation, which includes ever-escalating energy costs. Persons receiving social security benefits who wish to continue working, on a part-time basis, are penalized by reason of deductible features in the social security act.

Social characteristics of older persons

As a group, older Americans often have needs and problems related to their social situations, economic conditions, and physical limitations. As individuals, many remain independent and develop their strengths well into their later years if not prevented from doing so by society's obstacles. It is too often forgotten by the society that aging is a natural developmental process.

Older adults of this Nation are a highly heterogeneous group with a wide range of physical and mental capabilities and disabilities; financial assets and liabilities; likes and dislikes. But even those persons who are most successful in the art of growing old feel the impact of societal changes resulting from the greater

¹ See statement, page 1407.

mobility of individuals and families. In the face of shifting population old communities are being lost. There is strong evidence that families and friends still want to be financially and emotionally supportive but government policies and societal norms including such matters as housing patterns often inhibit such informal initiatives. Employment and retirement practices often discourage the older person from maintaining a meaningful role in society either in paid or volunteer employment. The expenses of illness and inflation often use up savings at a faster rate than planned by the older person.

Vulnerability of older persons

As a group, the elderly comprise one of the highest "at risk" populations in the Nation. The elderly are disproportionately vulnerable compared with younger age groups to such phenomena as income deficiency, chronic illness, functional disabilities, housing deficiencies, victims of crime, loss of spouse, and loss of social role. Moreover, within the overall population of the elderly, the subpopulation aged 75 years and over constitutes a group with extraordinary needs by reason of the frequent association of frailty or functional disability with upper levels of age span.

Response of society

Our society has failed to adequately address the needs of older Americans, although in a number of ways, particularly with respect to income support. Federal social policies provide for the elderly. Thus, some 95 percent of persons over the age of 65 now receive either or both social security and supplemental security income to supplement their private pensions and personal assets. Certain tax benefits accrue to the elderly and not to younger age groups. Medicare and/or medicaid are available to pay for much of the acute health care needs and some of the chronic health care requirements of the elderly. Such benefits as these have resulted in what is essentially an income strategy for older Americans. The premise is that if older people are provided with enough money they can buy whatever services they may require. In addition, services to the elderly have also been made available through the social service titles of the Social Security Act and the Older Americans Act.

The problems and inadequacies of these well-intentioned benefits and services are legend. First of all, funding is insufficient to adequately serve the target groups. Second, targeting itself is poorly determined. This results in confusion for the intended recipients and the planners and deliverers of the programs. In many instances, an increase in one benefit program eliminates eligibility in others. Older persons are frequently unaware that they are eligible for certain benefits and services. With respect to health care services, the most intensive medical technology is all too frequently inefficiently and inappropriately delivered. There is insensitivity to the social and psychological dimensions of illness. The development of long-term care facilities has resulted in a dual system of care: institutionalization versus community based care. Institutionalization is often feared as an end to personal autonomy and to a meaningful social role.

SPECIFIC PROFESSIONAL CONCERNS

Among the professional disciplines, there has been gradual and somewhat reluctant recognition of the status and problems of the elderly which are unique to their development and stage of life. Such professions as education, law, medicine, nursing, psychology, the natural and social sciences are beginning to respond to the elderly as a distinctive group with distinctive desires and needs that are different from the concerns of younger age groups.

Social work has shared in "age-ism" practices against the elderly exhibited by the various professional disciplines. But even more important, social work has failed to recognize its unique contribution among the professions to the improvement of the quality of life for older Americans. The case-by-case intervention in social circumstances and conditions are the means of alleviating problems and promoting positive functioning in individuals and families is an early hallmark of the profession which must be recognized as a key service to the frailest and oldest of the elderly. Social diagnosis and social treatment are missing elements in current national policy formulations be they characterized as improving nursing, home care or alternatives to institutionalization. These unique social work skills are essential to the development of a system of services for those persons who require ongoing personal care services.

STATEMENT OF POLICY

Involvement of the elderly

In the development of programs, older persons should be significantly involved in their planning, policy development, and administration. Older persons in significant numbers should be recruited, trained, and employed in the provision of these services. When programs are implemented which affect the older populations, or program priorities are set by health and social agencies, there should be feedback by the elderly with reference to the quality of programing and the insurance that the policies and programs are not administered in an arbitrary fashion.

Economic security

The aim, as declared by the 1971 White House Conference on Aging, is a minimum standard of income adequacy for the elderly, based upon the intermediate budget as developed by the BLS. Social security should be the universal basic system for providing income upon retirement with which all other programs of retirement should be integrated. The "retirement test" for social security should be liberalized for those older persons who need or wish to augment their incomes.

Government must work to insure the integrity of public, private, and commercial systems of economic security for the elderly. Efforts should be made to examine the merits of increasing, on an actuarial basis, the social security payments of those who retire after 65. Women who have been employed and therefore have contributed to the social security system should be entitled to benefits based upon their own contributions without regard to their spouse's pension. Efforts must be aimed at eliminating the adverse effects of program interactions which often result in an overall loss of benefits to persons assistance from two or more government financed programs having separate and different eligibility requirements.

Employment and retirement

Aging persons should not be discriminated against or, in the case of employment, exploited because of age. Employment should permit the utilization of talents, skills, and experience of older persons for the good of self and community. Compensation should be based upon the prevalent wage scales of the community for comparable work. Flexible retirement policies making available reduced work hours and training or retraining for part-time jobs and volunteer jobs will allow continued employment if desired. Preretirement planning should be readily available to all employees. Based upon generally accepted indices of employment performance and adjustment, no employee should be forced to retire or be denied employment solely because of age.

Mandatory retirement based solely on chronological age should be eliminated.

Health care

An adequate system of health care for the elderly—going beyond medicare, which is essentially a system of insurance for part of the health costs of the elderly and medicaid, which is a system of welfare medicine—must be developed as an integral part of a universal program of comprehensive health care available to all Americans. Such a program should establish health care as a right, coordinate and rationalize health care systems, assure strict quality and cost controls, and eliminate deductibles, coinsurance, and means test. A supplementary medical assistance program will still be required to provide the elderly, with chronic health conditions with certain aide and services. We favor positive and conscious steps toward universal health care. Because the social care and health problems of the elderly are closely related, the social care component of the health delivery system should be given increased prominence. This should include helping the older persons and their families cope with terminal illness.

Mental health

The mental health needs of the elderly should receive proportionate attention through a comprehensive health care system. Community based facilities must assure equal access to mental health services by the elderly. Adequate systems of prescreening for geriatric hospitals should be instituted to assure alternatives to institutional services. Discharge planning and followup services should provide for training of appropriate staff to ensure human care and treatment of the mentally impaired elderly.

Long-term care

This term should encompass a continuum of care, including institutional as well as community settings. The point of entry into either system must be through a psychosocial assessment of the individual, in which a professional social worker plays a worker role. In assisting in the development of the continuum of care, the social worker must address the issues of maintenance of independence, self-determination, appropriate support systems and work toward the provisions of adequate protective services.

The older person should be sustained to the extent possible in his/her own environment. The quality of institutional care, when needed, must be sustained by adequate reimbursement, regular review and monitoring, and a program of community based ombudsmen available to the elderly of nursing homes and board-and-care facilities, as well as to the families of such persons.

Living arrangements

The widest choices of living arrangements should be available, designed and located with reference to special needs at costs which older persons can afford. The housing supply for the lower and middle income older persons must be increased. Funds for housing maintenance and repair should be readily available via a combination of grants, subsidized and conventional loans. Sufficient housing should be available to permit older persons a choice.

A range of supporting health and social services such as: home health, personal care, homemaker services, friendly visiting, and telephone reassurance, should be available to maintain the older American in his/her home and community.

Fire and safety codes should be established, and enforced in all congregate facilities for older persons. Subsidized congregate housing should include social and supportive services.

Transportation

If elderly are to benefit from available health and social services, and other resources in a community, an adequate transportation system is necessary for the transportation disadvantaged.

We should move towards establishing barrier free transportation services in urban and rural communities. Both elements of the transportation system, accessible low cost mass transit and special purpose programs for the elderly should be coordinated in the interests of servicing the mobility requirements of the elderly.

Social and other supportive services

Social services are an integral component of any supportive service system. Isolated, lonely, depressed and/or physically handicapped elderly persons need counseling, advocacy, and outreach in order to use, secure and benefit from programs already identified as essential for the elderly. Both individual and group services should be provided for older persons.

Social workers should have an active leadership role in the planning and provision of social services. Programs should utilize the natural helping network (informal) to the extent possible. We support and encourage the establishment and utilization of multipurpose senior centers as focal points of services and involvement of the well elderly.

Older persons should have the opportunity to participate in the widest range of civic, educational, recreational, and cultural activities.

Rural elderly

Programs addressed to the special needs of the elderly in rural areas of United States should be designed to fit their living style. Since growing old in rural America presents unique problems in service delivery design and outreach, broad service programs of income support, employment, housing, health care, legal and protective services, and transportation, among others must be provided in ways congruent with rural conditions, patterns, and traditions.

Minority elderly

Most aging programs were developed for a nonminority population and therefore do not address the special needs of the minority elderly. Many minority elderly are unable to relate to the system because of linguistic and cultural barriers. The social service system must be expanded to become broad enough and

flexible enough to meet the needs of minority older Americans. Minority representation must be increased at all levels of the system and programs developed must recognize and reflect differences in language, culture and demographic and social characteristics, in order that the minority elderly not be systematically excluded from services.

A differential approach to research of minority elderly must be undertaken and an appropriate data base established.

Research and training

To improve knowledge about aging Americans, the state of the art of working effectively with older people, and increasing the supply of trained manpower in the field, a consortium of the Administration on Aging, the Federal Council on the Aging, and the National Institute on Aging should design and undertake a coordinated and accelerated program of federally funded research and training in gerontology and geriatrics.

A systematic research strategy to benefit the elderly directly should emphasize at least the following areas: (1) Attention to issues of substantive relevance to the elderly, (2) increased attention to policy oriented research, (3) priority given to a multidisciplinary approach, (4) a close working relationship between practitioners and researchers, (5) stimulating improved levels of data gathering and research activities in State units on the aging, (6) establishing a national clearinghouse on major gerontological research findings in the United States and other parts of the world, and (7) accelerate the amount of sound research concerning minority elderly.

To effectively increase the supply of qualified personnel in the fields of gerontology and geriatrics, there should be Federal support for both professional career training and for in-service training of both professional career training and for in-service training of workers currently in the field. A fully developed training program at university and college levels should: (1) Give increased emphasis to improving curricula in the applied field such as social work, allied health professions, particularly for preparing geriatric physicians, planning, law, and architecture; (2) provide adequate funds for recruitment and support of faculty and students, especially for minority students seeking careers in the field; (3) enlarge the number of university based multidisciplinary research and training centers; and (4) utilize retired academicians and professionals for unstructured and field instructional positions.

IMPLEMENTATION

In carrying forward the above policy the following measures are indicated:

- (1) Establishment of a permanent national committee charged with implementation of NASW policy in the field of aging and providing a focal point for NASW concerns in this area. In addition, chapters should be encouraged to establish committees on aging to work cooperatively with and integrate their concerns with the national committee.
- (2) Further refinement of NASW policies relevant to aging.
- (3) Development of national, State, and local information and discussion groups on policy/legislative issues and practice/implementation priorities.
- (4) NASW national and chapter participation in lobbying for enlightened laws and national, State, and local programs in the areas outlined.
- (5) NASW representation on regulatory and planning commissions, local board, and similar bodies.
- (6) Recruitment of older persons, retired professionals from the association for expert testimony, advice or leadership in policy and program development.
- (7) Chapter efforts at self-education and exploration to eliminate attitudes conducive to ageism.
- (8) Chapter efforts at community education with regard to capabilities and contributions of older persons as well as need of services and supports for individuals in their later years.
- (9) Individual and professional emphasis on research, training and direct service standards and skills appropriate to the needs of older persons.
- (10) Collaboration with other social work and human service professional organizations directed toward a coordinated approach to policy and planning in the field of aging. Work on the local level to maintain a comprehensive service delivery network through councils on aging, multipurpose senior centers, and consortium of programs and organizations of, by and for older people.

(11) Where the laws and regulations require or advocate the employment of social workers in consultative roles, local chapters of NASW should endeavor to encourage that the skills of the social worker be fully engaged to the end that residents and their families can be certain that the facility, the individual resident, and his relatives are brought into harmony aimed at the better living and possible improvement of the patient. NASW must develop standards for consultants to such facilities.

(12) In the interest of developing social programs and in light of scarce resources, programs for the elderly and youth should not be pitted against one another.

ITEM 2. RECOMMENDATIONS AND GUIDELINES FOR PROVISION OF SOCIAL SERVICES IN LONG-TERM CARE FACILITIES

Significant progress has been made in recent years in the provision of physical and nursing care for the individuals in long-term care facilities in the State of Illinois. However, in order to meet the total human needs of nursing home residents, much more needs to be done, particularly in meeting their social and emotional needs. Whereas standards relating to the physical plant of an institution have been specific, well defined and mandatory, standards relating to the provision of social services have been kept vague and at a minimum. Standards relating to the provision of physical care of residents are detailed, but standards relating to services to meet the mental health needs of residents are not. It is time to focus on these social and mental health aspects of institutional care; and it is time to assume more responsibility for detailing what is specifically involved in a comprehensive social service program.

Americans are living longer than ever before, but too often the quality of life which is available to them is not adequate. It is estimated that 20 percent of the elderly population will, at some future time, be institutionalized, primarily because of chronic ill health related to aging. Institutionalization for many will mean placement in a nursing home setting. The necessity of such a placement is a traumatic experience for most older persons and their families and brings about a major crisis in their lives. The social changes which result, which are as life-threatening as strokes, hip fractures, and other crises of aging, involve such major changes as the loss of an established social role and the loss of independence and the subsequent reliance on others for all physical care and life sustaining activities.

Other populations currently using long-term care include children and younger adults suffering from neurological disorders and other chronic health or mental health care problems, including the developmentally disabled. These persons and their families also may suffer from similar effects of institutionalization.

Social service programs within an institution which address themselves to meeting the social and emotional needs of residents have been shown to increase residents' active participation, sense of self worth, sense of well-being and sense of independence. It is also possible to prevent or alleviate some of the common mental health problems, depression and regression, by utilizing the knowledge and skills of a trained professional social worker within the institutional setting.

Nursing homes are facilities established to meet the total care needs of their residents: physical, medical, nursing, recreational, rehabilitative, social and psychological. In order to provide total resident care, a professional social worker must work with all disciplines as a member of a team. Working together as a team this group must establish policies, routines and programs which will meet the total care needs of all residents. The objective must be the restitution of the activities of daily social living, the provision of opportunities for functioning at a maximum level, the maintenance of functioning and the social stimulation of residents. This task can be appropriately and effectively performed by professional social workers, working closely with all other staff members within the long-term care facility.

SOCIAL SERVICES IN LONG-TERM CARE FACILITIES

Definitions

A. Social work means the professional activity whose purpose is to help individuals, groups or communities to maintain, enhance or restore their capacity for social functioning within the institution or in return to the community to create conditions favorable to this goal through counseling with individuals, families and groups, community development, and planning and administration of social

service delivery systems. These services include direct service to residents and to their families, indirect services that affect the well being of the residents, staff in-service education and team support, and the use and development of community resources.

B. Social work staff. 1. Certified social worker—"has a degree from a graduate school of social work approved by the department of registration and education and who meets the requirements of section 4." of the Illinois Social Workers Registration Act, III. Rev. Stat. 1967, Ch. 23, Sec. 5301 to 5320.

2. Social worker—"has an undergraduate degree from a 4-year college or university approved by the department of registration and education, who meet the requirements of section 4." of the Illinois Social Workers Registration Act, III. Rev. Stat. 1937, Ch. 23, Sec. 5301 to 5320, and who is currently employed in one of the fields of social work and has at least 2 years experience in one of the fields of social work after receiving that degree.

3. Social work associate—has a BSW (undergraduate degree in social work) from a college or university approved by the department of registration and education.

Staffing

A. All long-term care facilities shall have a social service department directed by a certified social worker appointed by and responsible to the administration of the facility.

B. The director of the department shall be responsible for the setting and implementing of goals, staffing and supervision of staff and the preparation of the departmental budget.

C. The size of the social service department will be directly related to the number of beds contained within the facility and according to the needs and level of care of the residents.

Social service department program

A. Identification and assessment of the social and emotional factors which affect residents or families, including problems relating to preadmission, admission, illness, treatment planning, family relationships, activities of daily living, interpersonal relationships, rehabilitation, transfer and/or discharge planning, followup and other individual concerns.

B. Provision of specific services (as defined in section IV) to meet these needs and to prevent other problems from occurring, and

C. Cooperation with other staff members within the facility, as well as individuals in the community, who share responsibility for the assessment, placement, care and treatment of residents in order to develop a program which will allow residents to attain their maximum level of self care and well-being.

Functions and responsibilities

A. Direct service functions. 1. The social service department staff shall assist with the preadmission or admission procedure and orientation of new residents and their families to the nursing home routine.

2. The social service department shall make an evaluation, within 7 days and based on interviews with the resident, his/her family, other collaterals as well as nursing home staff, of the psychosocial factors associated with the illness and placement of the resident.

The evaluation will emphasize the rehabilitation potential and other potential to cope with the current situation. This assessment will be made in a written professional evaluation to be contained in the medical record.

3. The written professional evaluation will serve as a basis upon which an individualized resident care plan will be formulated. This plan, including goals, treatment approaches and a plan for possible discharge, will: (a) Be developed in conjunction with the resident and his/her family (when possible), the physician, director of nursing and other nursing staff, director of activities, dietician, pharmacist and other appropriate staff or community agencies which are involved in the resident's care; (b) Identify the social, physical, emotional and rehabilitative needs, problems, strengths and coping skills of each individual resident; (c) Identify the approaches and services available to meet these needs and to reinforce strengths.

4. The social service department staff shall provide such services as are necessary to restore the individual to his/her maximum level of social functioning. These services include direct individual counseling of residents and/or group counseling for those with behavioral, emotional, and other adjustment problems.

5. The social service department staff shall provide counseling services, individually or in groups, to families in order to assist them in dealing with specific social and emotional problems and/or to assist them to better understand the social and emotional needs of the aged, the ill, mentally or physically disabled and the dying. Where counseling services are not appropriate, contact shall be maintained with the family members to involve them in the resident's care and progress and to help them to better understand the treatment and its implementation.

6. The social service department staff shall provide discharge coordination and shall work with the resident, family, staff and community resources to develop and implement a discharge plan. The social service staff shall ascertain whether the former resident is managing effectively after discharge.

B. Facility services. 1. The social service director shall develop, in conjunction with the administrator of the facility and directors of other departments, policies and procedures for social service delivery within the facility.

2. The social service director shall assist in the development and maintenance of policies which govern other aspects of the facility including policies, related to admission, discharge, resident rights, staffing, job descriptions and resident care.

3. The social service department shall develop and maintain written reports including pertinent psychosocial information on each resident, periodic progress notes and records of other activities.

4. The social service department staff shall confer with staff members individually or in groups in order that they have a better understanding of a resident's social and emotional needs.

5. The social service department staff shall participate in resident care plan meetings as well as other staff conferences.

6. The social service department staff shall participate in and assist with inservice training programs.

7. The social service director shall have input into other program areas which are directly related to a total social service program, in order to have a comprehensive program of supportive services designed to promote the social and emotional well-being of all residents. This includes programs such as: activity programs, occupational therapy programs, social and religious activities and volunteer programs.

8. The social service department shall maintain confidential records.

9. The social service staff shall work cooperatively with all other staff members to achieve a team approach to resident care.

10. The social service director shall participate in the utilization review committee, and other management committees, as appropriate.

C. Community services. 1. The social service director shall serve as a liaison person between the nursing home and community agencies.

2. The social service director shall compile and keep up-to-date directories and listings of all community resources as well as other important reference materials.

3. The social service department shall participate in interagency programs which enhance the ties between the nursing home and the community and provide current information regarding community programs.

4. The social service department staff as part of their discharge coordination function shall provide those responsible in the community for followup services with an appropriate summary for continuity of care, consistent with principles of confidentiality.

5. The social service department shall maintain ties with existing community services so that these services can be utilized when a facility is unable to provide specific financial, restorative, legal, and other services. The social service staff will make appropriate referrals to these services when necessary.

ITEM 3. A PROFILE OF THE BLACK AGED IN CHAMPAIGN COUNTY, ILL.

(Conducted by title I Black Elderly Project funded by Illinois
Higher Board of Education)

This is a report on inquiry into the conditions of the black elderly persons of Champaign County. The study found that the black elderly in Champaign

County can be characterized as being poor according to income and tend not to receive public services. At the same time, they are a rather stable population as demonstrated by homeownership, meeting transportation needs through private arrangements, length of residence in Champaign County, and length of time at their present address.

The study was undertaken by the title I black elderly project which is administered jointly by the school of social work and the office of continuing education and public service at the University of Illinois. Project funds were obtained from the Illinois Higher Board of Education.

The program was instituted July 1, 1974. The project was designed to identify black elderly residents of Champaign County and through a personal interview, document their need for social services, health care, housing, income, nutrition, transportation, and recreational programs, etc. Efforts were made to examine their awareness of and their use of social services.

To identify the elderly, three methods were used. They were: (1) Canvassing door-to-door, (2) contacting agencies who were currently providing services to the black community, and (3) using black elderly staff members as interviewers/resource persons.

Data from the 1970 Census indicate that approximately 700 black elderly reside in Champaign County. With these three methods, 602 persons were identified as being over 60 years of age. Of that number, 404 persons were interviewed, 55 persons chose not to be involved in the study, 49 persons were unable to be considered in the study because of health reasons, 21 persons could not be located or had moved to other areas, 49 persons were deceased.

Of the 602 persons identified, 364 were women and 238 were men. Of the 404 persons interviewed, 258 were women and 146 men. There were 291 persons interviewed from the city of Champaign, 101 persons from Urbana, and 1 person from outside of the Champaign-Urbana area. Twelve of the persons interviewed lived in nursing homes. A total of 29 persons were identified as living in nursing homes.

The study revealed that the mean age of the black elderly persons interviewed was 72.5. There were 86 percent of the persons in the study who were born outside the State of Illinois, no black elderly persons were born outside of the Midwest or southern States, according to our findings.

The study revealed that only 1 percent of the sample interviewed worked in a professional field before they retired, 27.2 percent worked in domestic work and 5.9 percent in a skilled trade. There are 21 percent of the black elderly persons who are presently working and 19.8 percent indicated that they would accept employment, if it was made available to them.

With respect to health care, it was learned from the study that 50.5 percent rate their health as fair or poor and 49.3 percent good or better. Another important finding was that 52.5 percent of those persons participating in the study had physical ailments which required continuous attention. The ailments consisted of diabetes, high blood pressure, etc.

A large number of the black elderly persons in Champaign County are homeowners, according to the study, 55.4 percent owned their home. It was also found that 32 percent of the black elderly pay some kind of rent for housing.

The sampling also discovered that 52.7 percent of the black elderly in Champaign County have lived at their present address for over 10 years and 32 percent have lived at their address for over 20 years.

A very important finding was in the area of income. It was found that the average black elderly income in Champaign County was \$2,000 to \$2,500. Poverty guidelines set for an individual by the U.S. Department of Labor is \$2,590 per year for one person.

In terms of marital status, 39.4 percent of those persons interviewed were married and 66.6 percent are widowed, single or divorced.

It was found through the study that only 23 percent of the black elderly in Champaign County participate in a senior citizens' club or group. Over 76 percent are not currently participating in a club or group.

It was also learned that 24 percent of those interviewed were involved in church work in their leisure time. Also, 63.1 percent indicated that they were an active member of a church.

Only 21.3 percent of those persons interviewed reported that they were on some type of special diet. There were 92.6 percent who indicated that they felt they were eating a well-balanced diet.

Transportation plays a very important role in the lives of the elderly. Of those persons interviewed, 63.1 percent own a private automobile, 32.7 percent have a driver's license, 64.4 percent do not have a driver's license. Only 12.1 percent of the black elderly have a Champaign-Urbana Mass Transit senior citizen discount identification card.

The following information is a sampling of questions and responses from the study.

AGE

Of the 404 black elderly persons interviewed, 66 persons were between the age of 60-64, 100 between 65-69, 92 between the age of 70-74, 78 were between 75-79, 35 were 80-84, and 33 persons were over the age of 85. The oldest persons interviewed was 102 years old.

PLACE OF BIRTH BY STATE

Findings from this study indicated that a majority of the black elderly persons living in Champaign County were not born here or in the State of Illinois. Only 57 persons indicated that they were born in Illinois, 157 persons were born in the State of Mississippi, 73 in Tennessee, 37 in Kentucky, 18 in Louisiana, 16 in Arkansas, 9 in Georgia, 7 in Alabama, 3 in Virginia, and 1 each from Maryland, West Virginia, and North Carolina. There were 70 persons born in the Midwestern States: 57 in Illinois, 6 in Indiana, 5 in Missouri, and 1 each in Minnesota and Iowa. An additional 14 persons were uncertain as to where they were born.

Based on the study, no black elderly persons were born outside of the Midwest or Southern States.

EMPLOYMENT

Based on the study, the majority of black elderly persons living in Champaign County worked in nonprofessional areas of work before they retired. Only 4 persons had worked in a professional field and all of them were school teachers. 110 persons worked in domestic work, 64 in labor, 57 were cooks, 24 custodial, 24 in skilled trade, 4 were clerks, and 40 worked in other areas. There were 77 persons, who for various reasons, unemployed or did not elect to respond to the question.

Our findings also found that of those black elderly persons presently working, only two persons work in a professional field (school teacher), 19 are involved in domestic work, 12 work as cooks, 11 skilled trade, 8 custodial, 4 in labor, 2 are clerks, and 22 work in other areas. Of the 391 persons responding to the question, "Are you presently employed?", 85 said YES and 306 persons were NO longer working.

HEALTH

The 404 persons interviewed were asked to describe their health as either excellent, good, fair, or poor. Their responses were: 38 black elderly persons rated their health as excellent, 161 rated theirs as good, 133 were fair, and 71 rated their health as poor, and 1 person chose not to rate their health.

The response to the question, "Do you see a doctor on a regular basis?", it was found that 241 persons do and 163 persons said they did not see a doctor on a regular basis.

HOUSING

A large number of the black elderly persons in Champaign County are homeowners according to the study. Of the 404 persons interviewed, 224 were homeowners, 81 persons rent an apartment, 46 rent a house, 21 lived with relatives, 11 rent a room, and 9 had other types of housing arrangements. Of those persons responding to the question, "How much do you pay for rent?", 131 persons indicated that they did pay rent. The average monthly payment for rent of the black elderly was between \$60-\$72 per month.

Over 50 percent of the black elderly in Champaign County have lived at their present address for more than 11 years. Findings from the study indicated that: between 1-20 years that 173 persons have lived at their present address, 178 have lived between 20-40 years, and 35 persons have lived over 40 years or more at their present address.

INCOME

Available financial resources are important factors in the total life situation of the aged, particularly among the black elderly. Of the 404 persons interviewed, over one-half had incomes below the national poverty guidelines (which is \$2,590 per year for one person as designated by the U.S. Department of Labor), 213 persons had earnings of less than \$2,500, 191 persons income was over \$2,500. The average income of the black elderly persons based on the study is between \$2,000-\$2,500 per year, indicating that the average income of the black elderly persons in Champaign County is below the poverty level.

MARITAL STATUS

Having a spouse in the household has often been recognized as one of the more important factors in the well-being in old age. According to our findings, 159 black elderly persons are married, 190 widowed, 35 divorced, and 19 were single. One person chose not to answer.

NUTRITION

It was discovered in the study of the 404 persons interviewed, 374 persons reported that they felt they were eating a well-balanced diet. There were 86 persons who reported that they were on a special diet.

RECREATION

It was found through the study that only 23 percent of the black elderly in Champaign County participate in a senior citizens' club or group. There were 307 black elderly persons who said that they did not participate in a senior citizens' club or group, and 93 persons were involved in either a club or group.

Responses to the question, "How do you spend your leisure time?", found that 100 black elderly persons are involved in some type of church work, 66 persons enjoy sewing in their leisure time, 63 persons enjoyed fishing, 32 gardening, 23 liked working with children, 9 baking, and 101 persons enjoyed other types of activities related to leisure.

TRANSPORTATION

Transportation plays a very important role in the lives of the elderly. Of those black elderly persons who responded to the question, "How do you get about from place to place?", 255 persons got around by using private automobile, 77 by taxi service, 31 used public conveyance, 22 walked, and 7 get about by other means.

Other findings revealed that 143 persons own an automobile and 261 persons are without possession of an automobile. Also, 132 persons have a driver's license, 260 indicated they did not. The other 12 persons did not respond.

Only 49 persons said they had a senior citizen discount identification card for the Champaign-Urbana Mass Transit, and 312 persons were without one.

Appendix 2

LETTERS AND STATEMENTS FROM INDIVIDUALS

ITEM 1. LETTER FROM JOSEPH B. HUDSON, DIRECTOR, GIBSON CITY, ILL., AREA TELECARE SERVICE, INC., TO SENATOR CHARLES H. PERCY

DEAR SENATOR PERCY: The programs and services funded by the Older Americans Act are by far the most productive and useful to ever come out of Washington. They serve a segment of our population that has contributed greatly to our country's well-being—but, because of advancing years and/or discriminations for employment, they are no longer able to provide some of these necessary services for themselves.

I have been engaged as a provider of some of these services for 4 years. During that time I have also served on the corporate board of the East Central Illinois Area Agency on Aging, being a member of its evaluation committee.

Of the services funded under the act, I believe transportation, homemaker/health aide, and outreach to be the most important in the rural area.

Unfortunately, with year-by-year funding, we cannot plan for an extended period of time nor reasonably plan expansion.

The practice of decreased funding over a 3-year period, then none at all, has greatly hampered these programs. Local governments are sometimes reluctant to provide moneys for such programs, so many of the elderly have all they can do to provide shelter, food, and medical needs.

Either specific instructions that so much revenue sharing money be allotted these services or continued fund under the Older Americans Act on at least a 60 to 40 percent basis should be provided for the most vital of these services.

It seems to me the programs of the Older Americans Act have been geared to the urban areas. The rules and regulations, the goals. If in fact just about all the criteria of regulating the programs is based on the urban population.

We have a terrible time bending these regulations and quotes to fit the rural needs and still stay within an acceptable range with the area agencies on aging.

For one thing—the so-called “poverty level” of income (which most of these programs seem to require) is too low.

While the \$2,400–\$2,700 may be realistic in the urban areas \$3,500–\$4,000 will go no farther in the rural areas. There is no enough competition between food suppliers, pharmacists, doctors, and landlords to keep prices within reason.

Housing is inadequate in the rural areas, even for those a little above the poverty level of income. The “highrises” I call “birdcages.” People are not permitted in or out of a lot of them without permission. The apartments I’ve seen there are small; some are a “community within itself,” the residents have little need and little opportunity to get out into the “community at large.”

I wish, sir, that you could take a look at the Ford Villa in Gibson City. We need more such places.

Within the Department of Health, Education, and Welfare, in the State departments on aging, and the area agencies on aging there is a decided trend toward increased bureaucracy. Every time a little more money is available the departments add more people to their staff, this means more regulations, more paperwork, and very little increase for services.

This year Federal regulations require each project in each program to be audited (which is good). But State employed auditors are not acceptable—CPA's are required and the Illinois Department on Aging insists these people be paid out of funds already allotted the area agencies on aging—taking quite a bite out of the money available for services.

Another problem in the rural area is that to provide these services an administrative agency must be established. There is not enough money available to hire qualified people for recordkeeping. We depend upon the federal work programs for most of our help, and qualified people just will not work for the salaries these programs allow.

In spite of these and other faults not bothering us—if you would look back just 10 years and compare the situation of the elderly then with the present, one can readily see the programs of the Older Americans Act have accomplished a great deal.

Respectfully,

JOSEPH B. HUDSON.

ITEM 2. LETTER FROM GLADYS FARTHING, PRESIDENT, AND W. P. ADERMAN, SECRETARY, GOLDEN CIRCLE NUTRITION PROGRAM, EFFINGHAM, ILL., TO ILLINOIS DEPARTMENT ON AGING, DATED DECEMBER 7, 1977

DEAR SIR: During our project council meeting on December 2, several motions were passed regarding home bound meals. This letter is being sent to staff members of the Illinois Department on Aging, and the area agencies on aging stating that more home delivered meals be allowed in the communities than the present ten percent for the following reasons:

- (1) Large numbers of senior citizens are not physically able to attend the nutrition sites.
- (2) Some communities have no meals-on-wheels program.
- (3) If there is a meals-on-wheels program it is too expensive for some citizens.
- (4) At times, some regular participants are ill and unable to attend. They need delivered meals for a limited amount of time.
- (5) There are some senior citizens recently out of the hospital who need home delivered meals.
- (6) During the winter months, some participants are unable to attend because of the danger of falling.

We feel that it is imperative that home delivered meals continue and perhaps be increased so that senior citizens are able to remain in their homes in the community. The title VII policy and procedural manual of the Illinois Department on Aging states that home delivered meals be provided where necessary and feasible to meet the needs of a target group eligible individuals who are home-bound (14.40.210). How can a determination be made on saying no to a senior citizen who needs and asks for a home delivered meal. One of the nutrition sites is the town of Herrick in Shelby County. They state that their population is 536, two-thirds of which is senior citizens and children. They average 55 meals a day, 16-23 meals are delivered and there is a need for 28-30 home delivered meals. There is no meals-on-wheels program and even if there was they could not afford it.

Some of the people involved are the following:

- (1) A lady, 83 years old, has had a stroke, and walks with a walker. Her son-in-law is a disabled vet, age 65. The wife works.
- (2) A lady, age 74, has had a heart attack and a stroke.
- (3) A lady, age 78, has come to the site ever since it began. Has called bingo, served food, and cleaned off tables. Anything she could do to help the center. Even donated bingo prizes. Now she is sick and can't always come to the center. Now they have cancelled her dinner. She is by herself.
- (4) A man, 82, and his wife, 84, are both ill, they are living by themselves. If they could have dinners brought to them they could continue to stay by themselves and will not have to go to a nursing home.

The Golden Circle Nutrition Project Council ask that you consider this information and allow more home delivered meals from the nutrition sites.

Sincerely yours,

GLADYS FARTHING,
W. P. ADERMAN.

ITEM 3. STATEMENT OF JANIE L. BLOOMER, ROCKY BAR FARM, HARDIN, ILL.

The rural elderly have problems which are compounded by their feelings of independence and a strong desire not to be "charity recipients." In the areas I have worked, trying to develop services and programs, both through TeleCare and the older workers program of Champaign County, and based on my observations in my home county of Calhoun, one of the most rural in the State, the

three programs which have proved most popular and most used have been transportation, the nutrition sites, and home-delivered health services.

These three programs provide most of their basic needs—the ability to get out and do their shopping, take care of errands, etc., and get to other senior programs, the opportunity to be with others and to obtain a good meal at a price they can afford, and care in their homes when they are not able to be out.

I would urge that all programs give the older people a chance to contribute, and urge that they do. In fact, I would almost urge that a basic cost be set for the meals at the nutrition sites—low enough that everyone could attend, but high enough that they feel they are helping pay their way.

I would also urge that programs be funded on a longer, on-going basis, so that less time has to be taken up with “dollar-chasing” and justification, and more given to services.

The central problem in all our lives is that of inflation, which continues to eat at savings, which is so constant that people despair of being able to support themselves. A stable economy, with less scare headlines, less emphasis on the crises of the moment, would help most of us to a better frame of mind. The present worry over “What’s going to happen to social security,” the constant changing of eligibility and regulations in the agencies dealing with older people, are most upsetting when they are continually faced with trying to make their dollars stretch from one month to the next.

The ideal program, of course, is one which is adequately funded, reaches all those who need services, has a trained, competent staff who have enough flexibility to be able to institute new or different services as the needs of their clients change. We found here in Champaign County that as the basic needs were provided for, others presented themselves which could only be dealt with by professional persons, the social workers, the nurses, etc.

I have not tried to touch on the energy program, because I feel that our older people are not the ones who waste our fuel reserves. They all had to conserve all their lives, so this is nothing new to them. My main concern is that fuel be available to them as they need it, which again touches on transportation—the ability to travel some of the rural roads in delivery trucks and vans, which is impeded at this stage by the condition of some of the roads. The home insulation program and home repair program have not yet reached enough of the rural elderly to make that much impact. They have concentrated more on the urban areas.

We do appreciate the opportunity to present our ideas to this group, and urge that you continue to be open to new and fresh ideas for dealing with programs which will eventually touch all our lives.

SUPPLEMENTAL STATEMENT

I would like to see more money allocated for jobs for older people. We have been able to start many good programs and were able to furnish staff for existing programs. One of the most popular has been the establishment of “drop-in centers,” in small communities for older people. The communities had resisted establishment or participation in other programs for the aging, but with our funding a half-time person to act as host or hostess, make the coffee, line up groups to furnish goodies, clean up, put out the domino games, the small communities could easily find an empty, accessible store-front building. The township supervisors have been most cooperative by helping with rental, maintenance, and several have picked up the cost of the hostess when the grant expired: (1) Gives a place for older people to congregate, share resources, introduce programs, professional persons, etc.; (2) gives the professional helping persons a place to reach persons who have been reluctant to use services, but who feel more comfortable when they know the person.

A. HEALTH NURSES—PREVENTIVE CARE

Very little money is needed to start up these projects and these places would be reluctant to apply for title V.

One of my biggest quarrels with regulations of the CETA program under which I worked was the limitation of funds to only economically disadvantaged. We have helped isolated persons again become part of the productive community. We have furnished training for persons who had never been part of the labor

force, but were forced to go to work to meet expenses. We have used the talents of qualified persons to develop programs for older people which could not have gotten started without our help:

(1) Volunteers in the schools. Volunteers recruited and placed, coordinator funded by OWP.

(2) Competent and reliable drivers for senior vehicles.

(3) Drop-in centers.

(4) Senior talent employment pools using a senior in smaller communities to recruit persons to furnish home help, home repair, etc., and refer them to persons who need and require the help.

ITEM 4—STATEMENT AND ENCLOSURE OF JEANNE VERMILLION, CHAIRPERSON, CHAMPAIGN COUNTY, ILL., COMMITTEE ON AGING

In our county, there are five hospitals, two large clinics, and nearly 200 physicians. These are impressive numbers. However, four of the hospitals are in the urban Champaign-Urbana areas and the fifth is restricted to military personnel. Both clinics are in the city and all but 10 of the 200 physicians are located in the city. Two of the ten rural doctors have only part-time office hours in the rural communities. There are 16 rural communities with no physician. About 40 percent of our elderly live in this rural area that is badly underserved.

In recent years, efforts have been made to increase home health care services to the rural elderly. Some of the problems have been: (1) The cost is very high because of the distances to be traveled and the variety of care needed; (2) sources of funding for home health focus on crisis treatment and neglect maintenance and ancillary care services; (3) physicians seem to be apathetic about the need to maintain people in their own homes and tend to overuse nursing homes, which are all located in the cities.

Another problem related to the health of the rural elderly is inadequate health education. This influence preventive and health maintenance measures people take. During a year long demonstration project, the county office on aging geriatric home health program determined that of 344 clients served, 170 were naive about symptoms of disorders, indicators of complications, basic hygiene, nutrition, and prevention measures. This indicates that Older Americans Act money would be well used to fund health education programs specially designed to serve the elderly.

Much health education and screening can be offered through title V funded multipurpose centers. However, lack of mobility of the rural elderly and the need for individualized health education and counseling (323 of the 344 clients) indicate that home delivered services are also essential.

Another home-delivered service for which there is a serious need is meals. The demonstration project shows that 172 of the clients are able to do their own cooking. That is only half of them. Many suffer from malnutrition that complicates other health problems. It helps that food stamps can be used to pay for home delivered meals. In rural areas, it is difficult to find a source to provide the meals and the manpower to deliver them, however. Older Americans Act money to fund the operation of rural home delivered lunches would help.

In summarizing her experiences with the geriatric home health project, Mrs. Janice Miller, R.N., submitted the enclosed narrative and recommended that a health care advocacy role be established to supplement the team of service providers for the elderly.

Also enclosed is a statistical report of the data collected from the 344 clients served by Mrs. Miller's project. The data is computerized so cross analysis of it could be available if you have specific questions.

HEALTH CARE ADVOCACY

(Submitted by Ms. Janice K. Miller, geriatric health coordinator, Champaign County, Ill., Office on Aging)

By definition, advocacy is the act of speaking or writing in support of something. An advocate is a person who pleads another's cause. This paper is presented to describe why the elderly need services of an advocate, particularly an advocate for health maintenance and health care.

Our society tends to perceive old people as persons in need of care. Values in American culture of competitive achievement and future orientation make this society especially negative toward aging, and therefore, encourage the aged to disengage or withdraw from life. Disengagement of the elderly has an impact of the health care system as a whole. All too often these people are labeled ill and senile and placed in an institution for their remaining years. Institutionalization is many times due to the fact that no place exists for the person to live and the person is no longer considered useful to society. If we expect the elderly to be isolated, alone and forgotten, might these expectations become rationale for leaving the aged in their plight? Interact only to carry out treatments? Avoid the support of the dying elderly client because death is expected?

Dr. E. Kahn states, "As a person approaches old age and the end of life, he must come to grips with the congruence or incongruence of his achievements and his expectations of himself. At the same time, because of society's expectations, its values, and the occurrence of natural events of living (illness, loss of friends, etc.) the individual finds himself increasingly excluded from the mainstream of life. As he seeks to learn new roles, in an effort both to meet expectations and to find new satisfactions, he still seeks to do so in keeping with his own life-style."

The 1971 White House Conference on Aging recommends that "... the USA must guarantee to all its older people health care as a basic right and a quality of life consistent with that which our Nation should assure to this group who have made invaluable contributions to its development.

"To be comprehensive and systematic, this health care must provide: (a) Assessment of health, (b) education to preserve health, (c) appropriate preventive and outreach services, (d) all physical, mental, social, and supportive services necessary to maintain or restore health, (e) rehabilitation, and (f) maintenance and long-term care when necessary."

Because the major health needs of the elderly are economic and social in nature and are not well served by only a medical model of illness care, we need to assume an advocacy role within the framework of our supportive system.

We need a health worker who can assess health and refer appropriately, who can educate the elderly to conserve and promote their own health, who can promote positive feelings of health of the elderly, who can counsel the elderly to give attention to health when needed before illness develops, who can coordinate health services, who can teach the elderly nutritional requirements, ("Honey, they hadn't invented vitamins yet when I went to school") and who can promote positive feelings of the aged within the medical-nursing system, ("She's an old lady, surgery would be more trouble than it's worth").

Although I was referred to many persons who needed direct nursing care, I also visited persons who had no need for "care." Many people that I visited needed someone to act as their advocate in the health care system. The rest of my paper will give examples of my role as advocate.

When I first started working as health coordinator for senior citizens in April of 1974, I was referred by the Red Cross to Mr. C. M. He was 57 and had been unemployed since October of 1973 when he failed his company's insurance examination for an elevated blood pressure reading. His personal physician prescribed medication which lowered the pressure to safe limits, but Mr. M. began having what he described as "falling-out spells." The doctor told him he could expect this until his body adjusted to the lowered blood pressure. My first visit with Mr. M. revealed no obvious problems other than obesity. He complained of increasing sensations of "falling out." His wife reported that he was not going out at all, refused to drive and was irritable. This was very unlike him as he had been outgoing and good tempered "before." She felt he was depressed because of finances. The township supervisor was able to pay the rent but not utilities or groceries and they had no monies coming in now.

I consulted with Telecare who had also visited upon request of the Red Cross office. They were helping the family submit application forms to public aid. The physician was called and given my report; he felt Mr. M. was "gold bricking" because he did not want to work. No orders were given.

The next week's visit found Mr. M. to be in better spirits. He still had the "spells" but was feeling "pretty good." He had fallen a couple of times and had repeated dizzy spells. He wondered if he should stop taking the blood pressure medicine. We called the doctor who permitted him to stop the medicine for 2 weeks if I would check the pressure twice weekly. On the third check, the blood

pressure was higher but still safe. The fourth check revealed an even higher pressure. Mr. M. reported that he still suffered from the falling out spells and was light headed most of the time. The physician agreed to see Mr. M. and then referred to a neurosurgeon who tested extensively. Mr. M. was found to have obstructed carotid arteries causing lessened blood flow to his brain. The dizziness and falling out spells resulted from an insufficient amount of oxygen and nourishment to brain tissue. Mr. M. was referred back to his physician with the suggestion that he lose weight before attempting surgery. A call to the doctor this time provided orders for a reducing diet and monitoring of vital signs.

Mr. M. lost 32 pounds before the neurosurgeon saw him again. Because of increasing frequency of spells, the surgery was scheduled before another 20 pounds could be lost. Both carotids were opened and removed of plaques which caused the obstruction. This was done in two separate surgeries. No problems resulted during or following the surgeries. Symptoms were immediately alleviated. In 6 weeks, Mr. M. was released from care of the neurosurgeon who referred him to his medical physician. Eight weeks following surgery, Mr. M. returned to work after passing the insurance examination.

It is entirely possible that Mr. M. would have suffered a stroke had this condition not been alleviated. He probably would never have been able to return to work and would have been subsidized by social security disability. The doctor's original theory that Mr. M. was "gold-bricking" may not have changed had not a health care worker been able to act as advocate and encourage the doctor to re-examine the findings.

Mr. R. C. was referred to me from the hospital from which he was discharged following hip surgery after a fracture resulting from a fall. A home visit found him to be recuperating with few problems. A health assessment was also offered Mrs. C. who reported no problems except occasional fatigue resulting from spending most of her day and night caring for her husband. Her blood pressure was found to be quite high and she was encouraged to see her physician. Because Mr. and Mrs. C. had moved to the area 3 years before and had been in good health, they had never obtained care of a physician here. We discussed a number of possibilities and she chose a physician who could see her early the next week. The doctor wanted Mrs. C. to be hospitalized for tests for 3 days because the pressure was dangerously high. Mr. C. could not stay alone though. The physician's nurse called the office to ask assistance for Mr. C. We attempted live-in help but the expense prohibited this plan. Homemaker care during the day and a close neighbor who could spend the night seemed the best alternative. This worked for the 3 days that Mrs. C. had to be in the hospital. Following discharge Mrs. C. was weak and upset. The homemaker was retained for another 2 weeks until Mrs. C. felt strong enough and less nervous. Mrs. C.'s pressure was monitored weekly for 3 months before the physician discontinued the orders.

Six months later I visited the family again. Mr. C. was getting around very well. Mrs. C. complained of chronic fatigue. She had not kept her 6-month check with the doctor as planned because she did not feel well. Her pressure was very low, and her pulse was not regular. Foods containing high amounts of potassium were advised until we could make another appointment with her doctor. In 2 weeks she was seen by the physician who reduced the amount of medication for her blood pressure and prescribed a potassium supplement.

It is possible that Mrs. C. would have become very ill before going back to her physician. Although the doctor was aware that she had missed the appointment, it is not the policy of his office to get in touch with the patient unless the physician feels there might be a problem. He feels that the patient has the right not to come in.

He assumed that his patient would get in touch when necessary. Mrs. C., who was 78 years old, may have been in need of more extensive medical care because of postponing early treatment. An advocate was able to counsel that she obtain early care.

Mr. J. H. was 88 years old when I was asked by his family to visit to make sure he was properly caring for his colostomy. He had 4 week earlier been discharged from the hospital following bowel surgery. Extensive cancer was found and a colostomy performed to relieve a bowel obstruction. He had been taught very well to care for the colostomy. My first nursing note read in part, "Doing very well with colostomy: lonely." I called the physician who gave no orders but thought periodic visits might be wise to follow his condition which was terminal. Mr. H. was not to know according to his children. The oldest

daughter who had called the office was called and assured that her father was getting along well with the colostomy. We agreed to meet at her house when we discussed his condition. Her brother was there also. They were nearly in tears when they talked of their father. Weekly visits were arranged and I assured them that I would notify them of problems. Although they visited almost daily with their father, they felt a great need to be told of his condition often.

After several visits I came to know Mr. H. very well. He had been told that all was well following the surgery but he believed that he was soon to die. He felt weaker than before and had little interest in food. More than anything he complained of loneliness. He talked often of moving back to his home in the country. He did not like living in an apartment in town. I mentioned this to his daughter who felt it would be too difficult for everyone and best not to bring up old memories. But, before my next visit, she and her brother took Mr. H. to the farm. He had brought back several items for his apartment which he proudly showed me. He also talked about his old cat that was no longer on the farm. We talked about the merits of cats and I offered him one of our kittens. Although his children worried about germs because of his colostomy, they were reassured that the cat would cause no harm. The next week he was given a 3-month old tom cat. He seemed pleased and was playing with it in the yard as I left. Following visits proved that he and the kitten had become good friends.

Mr. H. talked more about dying. He felt he should be ready as he did not want to cause problems for his children. He didn't know what to do. He cried easily and lost weight. He began having trouble with the colostomy. He became demanding of the children begging them to stay with him. The son called to discuss nursing home placement which had been avoided as long as possible. I met again with the son and daughter and we discussed Mr. H.'s fears about not being prepared to die and causing problems for his children. The two decided to "level" with him. We all met next week with Mr. H. who appeared in good spirits with everyone there. It was too difficult for either the son or the daughter who could only tell him that they loved him and wanted what was best. Mr. H. replied that he knew he was going to die but that he did not want to go into a nursing home.

We discussed a homemaker staying with him in the daytime and the children taking turns by the week staying the night with him. This worked satisfactorily for 9 days. He was less demanding and once again took care of his colostomy when he was not too ill. The homemaker was discharged on the ninth day and the daughter stayed the next 3 days. Both the son and daughter stayed the last day. He was to die soon and was awake until late in the evening when he went to sleep and died.

The daughter called me the next day to tell me about his death and that she would like to keep the cat for her children.

Acting as an advocate for Mr. H. allowed him and his children to deal more honestly with each other. They did not have to pretend to him that all was well. When he became too sick to pretend, he no longer had to demand their presence and help. Dying is an experience all of us must face. It is a saying of goodbye to all that we know and can be frightening if not dealt with honestly with those we know and love. Dying can be expected when we become old and sick. But the expectation of death should not deny us the experience of support.

Appendix 3

STATEMENTS SUBMITTED BY THE HEARING
AUDIENCE

During the course of the hearing, a form was made available by the chairman to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR PERCY: If there had been time for everyone to speak at the hearing on "The Nation's Rural Elderly," in Champaign, Ill., on December 13, 1977, I would have said:

The following replies were received:

ANONYMOUS

It's too bad more time wasn't allowed for seniors themselves to speak. They are less likely to be able to present you with typed statements than the paid staff persons who were allowed to speak.

STELLA R. BENNETT, BLOOMINGTON, ILL.

One of the questions listed by the community nutrition institute in the weekly report of September 22, 1977 was: "How to increase elderly participation in running the feeding programs." Under the rules and regulations of the nutrition program for the elderly, some advisory responsibility and approval authority is given to the project councils, which includes a stated percentage of more than one-half of the members of this council shall be actual consumers of the nutrition services of the project.

On September 17, 1977, I sent a letter to the Federal Commissioner on Aging regarding the new title VII instructions issued by the Administration on Aging, and to Senator Charles Percy. A reply from Senator Percy states that he is checking into the matter and he will get back in touch with me.

The new title VII instructions appear to decrease the authority of the project councils. As council project members, we feel that this authority should be increased as the participants become more informed of the functions of the program and become more experienced in the use of the funds appropriated by Congress for the program.

We have laid the groundwork for a State organization of the project councils in Illinois. One of the purposes of organizing is to voice opinions and make recommendations on legislation that affect the status of title VII.

I greatly appreciated the opportunity of attending the hearing. The reports read by the directors and others of the various agencies and departments, represented on the panels, were very interesting.

Thank you.

HAROLD Q. BODEEN, CASRY, ILL.

Clark County, Ill. is one of many rural counties with a high percent of elderly—22 percent—where many live on less than \$100 a month.

While there are many programs to help, the very multiplicity is confusing to many elderly; add to this the names of the programs (i.e., circuit breaker, energy crisis, rebate, additional tax, etc.) which are not particularly descriptive. It is essential then for persons to interpret these programs.

Transportation is a problem. Even the towns do not have public transportation. So the workers need to travel in response to requests by elderly for assistance. Also, some have to be searched for (they have not heard of these programs).

Such services as project call and project care—which provide information, counsel, home health care, and housekeeping assistance—should be continued or extended if possible.

Nutrition, especially hot meals to the home-bound, should become permanent through Federal grants.

CAROL S. BOTSCH, NORMAL, ILL.

Half the elderly in McLean County live in rural areas. Greater allocations are needed for RSVP if we are to serve these people. The key is transportation. Rural elderly are even less able to get about than are urban elderly, due to lack of public transportation, isolation from services, and weather conditions that affect even those who drive. Our friendly visitor program could be extended to the rural areas if transportation was available, for example. Many elderly who sit home and vegetate could contribute to the community if there were ways to transport them to the places where volunteers are needed.

I am also somewhat disappointed that so little time was allocated for speakers from the floor, after spending our tax dollars to bring all those people from Washington to the Midwest. It seems to me that the purpose of having a hearing was defeated.

CEFS, EFFINGHAM, ILL.

I question whether or not area agencies are the appropriate bodies through which to channel funds to implement the various title programs. I question this because I see area agencies attempting to first insure their own continuance rather than work in developing local organizations and agencies into adequate program planners who work on the front lines and have firsthand contact with and knowledge of those persons who are program participants—beneficiaries of the Older Americans Act. Due to the number of area agencies within the State of Illinois, I see difficulty in assuring the continuity that a single agency like the department on aging can provide.

MARY CLARKSON, WATSEKA, ILL.

I would like to see a larger portion of time set aside for individual "speak-out." It was good, however, that the agencies had a chance to collect their thoughts and ideas and present them in an orderly and organized way. This helps to avoid omission of important factors. Five minutes was too short a time for individuals. Individuals contribute some very worthwhile ideas—and are many times hesitant or ignorant of passing them on to a helpful source or agency.

I know quite a few individuals who declined attending this speak-out because of the too-limited speak-out.

LAVON CLER, THOMASBORO, ILL.

In our area, we are in need of a senior citizen "drop-in center." We are told that title V, under the Older Americans Act, will not provide funds for a newly constructed building. We do have a lot in mind, but there isn't a building available to remodel. In other words, we need funds made available to construct a new multipurpose center in Thomasboro, Ill., Champaign County.

C. S. DAY, THAWVILLE, ILL.

The senior citizens program on aging, in line of importance, are: (1) Nutrition, (2) transportation, and (3) home health care. Naturally, they are all important.

(1) The nutrition program is handled mostly in urban areas, not reaching the rural areas. Why can't such a program be a part of the school lunch?

(2) Transportation should be principally for those lacking such and their needs to get medical care, groceries, banking, legal aid, etc. Too much money is used for social and recreational programs.

(3) Home health care is again good in urban localities, but a shortage of qualified people is evident.

Communication is the key to success in promoting these programs. The circuit breaker, meals-on-wheels, etc., are obsolete before reaching the volunteer or outreach worker.

All U.S. citizens pay taxes, so Federal grants can be made; therefore, each senior citizen should have an equal opportunity to receive some. Let's get to the needy and dispense with the greedy.

SHEILA A. DUNN, BLOOMINGTON, ILL.

I am in full agreement with Mr. Richard Klage's recommendation that the home delivered meal program be allowed to utilize a sliding scale fee. In addition, I feel strongly that several Older Americans Act programs could so benefit—especially home health care and homemaker services. Not only would this help to generate operational (sustained) funds for the program, but I believe it would also encourage more older people to avail themselves of the services offered. Many rural elderly are too proud to partake of free or nearly free (donate-what-you-can) programs.

JOHN M. HATTEBERG, ELLIOTT, ILL.

More is needed for legal services for the elderly.

In relation to medical expenses not covered by social security benefits—the insurance cost of \$600 to \$700 to cover what is not covered by social security. Medicare benefits—what can be done in this area?

MARCIA H. HEAL, CHAMPAIGN, ILL.

As a direct service worker, I have been called on countless times to provide ex post facto advice on hospital billing of medicare or other insurance. This billing is always unclear and does not direct the patient to disregard the bill—as it should—or say that medicare will cover 80 percent (or whatever) of the account or that the patient is to be responsible for only a minor amount. Without this clarification, patients are repeatedly sent statements, become frightened at the intimidation, borrow funds if possible, or exhaust their savings and tie up these dollars for months, with endless worry. This intimidation and anxiety is inexcusable. The system could provide clearcut information, combined with efficient methods of application to the insurance companies for rapid reimbursement, that would eliminate this whole unnecessary trauma.

Public aid or State welfare departments (I formerly worked in AFDC in Texas) are supposed to have social service staffing and this staff is to provide counseling and guidance, advocacy, information and referral, etc. However, in reality, P.A. workers resent and interfere with any of these services and are not equipped to provide them. P.A. workers are simply technical workers who determine budgetary allowances according to State guidelines. In addition to not offering evaluation of and alternatives to a recipient's circumstances, P.A. workers do not even refer recipients to other social services providers. While we, the social service provider, do constantly use P.A. as a resource, I maintain that P.A. workers should be trained to look for total needs of their (elderly) clients and should at least refer them to agencies such as ours (Telecare) and provide followup.

LULA G. KELLER, URBANA, ILL.

Too many professional staff talking. Let's hear from the participants in the programs. We know they (professionals) are wanting more money, more staff, more control and power.

L. L. LAWHEAD, URBANA, ILL.

I served as township supervisor in Mahomet Township for many years. There are about 250 senior citizens in this rural township and some of them were not able to build up enough savings when they were working to take care of themselves adequately in their old age. I always felt it was the township supervisor's responsibility to see that these people had what they needed in the way of food, shelter, and medicine. Some supervisors are less willing to spend township money on these people. Now, it seems that the responsibility has shifted to the State department of public assistance.

That shift is good because it can provide more fair and even distribution of help. Unfortunately, at this time, the public assistance department does not provide enough money to meet the needs.

Those who have to go to nursing homes have a special problem. The public assistance payment does not cover the cost of care set by the nursing homes so people have a hard time finding a home and are sometimes moved out simply because they are on public assistance.

Something needs to be done to increase the amount of assistance available and to make the procedure as uncomplicated as possible.

DAVID E. LINDSTROM, URBANA, ILL.

Proposal No. 1.—Difficulty to hear requires better facilities to provide adequately for this failure.

Proposal No. 2.—Need to provide home services rather than institutionalization, especially in rural areas.

Proposal No. 3.—Some method of using census techniques to find the elderly and needy, especially those who have no means of making their wants known, and securing needed help. This relates to providing facilities.

Proposal No. 4.—Combine counties for administration; for example, southern Illinois counties to be combined into larger geographical units. We could do with as few as 15 counties in Illinois.

Proposal No. 5.—Team work on the part of professional workers is essential, as are shown in what is now emerging in increasing areas.

Proposal No. 6.—Provide for ease of volunteers with adequate training to develop a sound basis for real concern of people in need, especially those who refuse to go for help; try to avoid help to those trying to falsify need.

LEONA LUCAS, MATTOON, ILL.

I urge the continuation of the emergency energy plan, but feel the base income level should be readjusted to include more rural elderly who could greatly benefit. In implementing the program during the past year, there was not sufficient time allotted to get information to the elderly nor sufficient funds to train workers. I feel transportation should be placed high on a priority list of needed services for rural elderly.

A. D. MULLIKEN, CHAMPAIGN, ILL.

Inflation is the major problem facing every American today, including the Nation's rural elderly. It has its root cause in a government that spends more money than it takes away from them in taxes. It will devour all of the social advances that we feel we have attained unless immediate steps are taken to curb its growth. Therefore, I hope that before any steps are taken to expand services, the funding be secured by elimination of outmoded programs.

Use volunteers more. Too many people working for the aging are being paid. Support programs that are largely provided by volunteers. Support programs that "cure" rather than "serve as a solution." Sharon Lindsay's comment to weatherization versus tax rebate is a good example of the route to take.

In evaluating today's testimony, you must be constantly aware that you have only heard from professionals who have a rebate in continued and expanded programs funded by government. Some of the comments made are not necessarily accurate, particularly with regards to rural transportation needs. Some

of the regular riders (Champaign County Rural Transport) own their own cars, can drive South during winter months, etc. Please note that some fall into this class. I am of opinion that taxi service should be provided for those who need service, rather than a van route that attracts persons who just like to go for a ride.

Comment: You should come to Champaign-Urbana some Sunday and eat a noon meal at Illini Union. You will see as many elderly as students. It is good food at reasonable prices.

MARILYN PLATH, CHAMPAIGN, ILL.

As director of the Champaign County RSVP of Family Service, I strongly disagree with Mrs. Pinkerton that all the granting and monitoring of funds under all titles of the Older Americans Act should be centralized within one agency; i.e., at the most local level, the area agencies on aging. A system of power distributed among several agencies, allowing for diversity, is, in my view, a much more healthy system of implementing and funding service delivery. Coordination of services needs to happen at the most local levels—centralization at the top does not necessarily result in such coordination. We are much better coordinated here at the local level than are our State and/or Federal sponsors.

Some Federal agencies, namely ACTION, do allow the use of Federal revenue sharing funds for match. I had understood from a member of the area agency staff that title III also has begun this year allowing such a match. The philosophy is that the Federal Government collects a portion of the income tax from individuals as an agent of local governments, and that Federal revenue sharing funds represent the per capita return of these funds to the local area. Decisions on use of these funds are made at the local level (though limited by Federal guidelines); therefore, it is appropriate to allow such funds as local match.

CARL RIEMAN, ATWOOD, ILL.

I live in a small town, which is in a location on the line of two counties and one-quarter mile from another county line. Also, I am one of the seniors who is trying to establish a center. It is in a good location and brought in more than 70 seniors many times, with a potential of reaching nearly 500 seniors.

We have run into a problem, no doubt many other clubs have found. The problem is this: We cannot find a suitable building, without spending more for it, or at least as much as a new building. Why should old buildings be considered before a new one? The grant that was presented the day you were in Champaign (I think it was to Charleston), is costing close to \$58,000. A ramp has to be built, it is an old building, with no more guarantee than a new building. I was a carpenter by trade and built new homes as well as working over old ones. I'm 72 years old and retired.

I would like to see the part changed, so senior clubs like ours can have a decent place, on ground level, and fixed up so some office could be located in the building for the health program, home care program, nutrition dinners, meetings for social gatherings, crafts, and many other programs for the elderly. These things could all be accomplished in a community such as ours without as much cost as to have them located in separate places. We seniors could help in something like this, as well as being helped. There is the fact that the younger generation is more willing to help on something new, than on an old worn out building, which they themselves look to use in the future. We, the elderly, know we are not dead yet, and surely deserve as good as others in higher offices.

Thank you Senator Percy for your visit.

RUTH SCHANKIN, CHAMPAIGN, ILL.

I would like to stress the need for Federal funding for adult day care under the medicaid program. Title XX does not provide funds for adult day care with a major medical emphasis. As a provider of long-term care, day care and home health services, I have been able to delay inappropriate admission of elderly to institutions. Also, we have been effective in better utilization of health professionals and paraprofessional staff across the health continuum.

With proper utilization of adult day care services for delaying long-term care admissions, medicaid dollars could be saved.

MYRTLE E. STANTON, DANVILLE, ILL.

I feel that in Danville, Ill., especially in the over-55 age group, a well-adult clinic is needed.

There are so many older persons who are poor, black, white, and others who desperately need this service. I find many elderly are diabetic; they do not see a doctor. If there was a well-adult clinic, these persons could be checked periodically. An outreach program could be set up and used to see these elderly persons and let them know of the well-adult services that would help them. Their feet, urine, blood pressure would be checked on a monthly basis. This, I believe, would cut down on amputees among the diabetics. One could also become aware of the growing arthritics who can't properly care for themselves.

DEAN TARVIN, DECATUR, ILL.

Being a veteran of World War I and knowing the need of many who need a pension, I would appreciate your support for the World War I pension bill. The average age of veterans of World War I is 82 years.

It is becoming increasingly difficult for the veterans of World War I to get medical service in a veterans' hospital.

BRIAN M. TURNER, URBANA, ILL.

The problems of the elderly in rural areas are not particularly unique and are integrally related to larger community problems. Problems of social and physical isolation, transportation, health services, nutrition, housing, and income affect whole communities. The elderly experience the same problems in greater depth.

Currently, service delivery mechanisms are supported to impact upon the elderly only. Federal and State funding support those mechanisms and, in a large sense, define those mechanisms.

Another, perhaps better, director is to put more emphasis upon services which enhance the level of natural self-help networks and which enhance advocacy efforts which contribute to the solution of broader community problems. Federal and State funding can influence the development of these services in important ways.

More emphasis needs to be placed upon strengthening families as they attempt to provide support to their elderly members. Our experience at Family Service of Champaign County has demonstrated that many families would like to provide support to their parents, but are in a quandry as to how to do that. Our family life education groups for middle-aged children of older parents provide solutions. However, supportive funding for aging programs does not support this kind of activity.

Generally, Federal and State funding provided in a social services to the elderly strategy, rather than a community development strategy, may result in an everexpanding social services program which does little to address causative problems.

FLOSSIE E. WILLIAMS, MAHOMET, ILL.

I am 84 years old and need help to get to the grocery store. I don't have much trouble with transportation to the store. Friends in town help me.

I do have trouble getting to Champaign to buy my food stamps. I have to ask a friend to take me; sometimes I cannot go because of my health. I do not like to impose on my friends to help.

Why can't we buy our food stamps in Mahomet? Why are all the other services in Champaign—public aid, social security, etc.?

BJARNE WOLDING, THOMASBORO, ILL.

I would like to congratulate you for your interest in the aging group. I would also add that the elders in the Nation are watching their representatives in Congress and evaluating their statements and their votes on the various issues affecting their health, income, housing, job opportunities, transportation, and how they can obtain needed help from the various agencies involved in the outreach to the elders.

I would assess that the No. 1 priority for the senior group would be how best to stay out of the old folks home. I would think special attention should be given to caring for the elders in their own homes.



THE HISTORY OF THE

of the city of London, and the county of Middlesex, from the year 1713 to the year 1714, in which year the city of London, and the county of Middlesex, were visited by a great plague, which was the first time since the year 1665, that the city of London, and the county of Middlesex, were visited by a great plague. The plague was first discovered in the month of June, and it continued to rage for several months, and it was not till the month of September, that it began to abate. The plague was first discovered in the parish of St. Martin in the Vintry, and it spread from thence to the other parishes of the city of London, and to the county of Middlesex. The plague was first discovered in the parish of St. Martin in the Vintry, and it spread from thence to the other parishes of the city of London, and to the county of Middlesex. The plague was first discovered in the parish of St. Martin in the Vintry, and it spread from thence to the other parishes of the city of London, and to the county of Middlesex.











