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THE OLDER AMERICANS ACT: SUPPORTING EFFORTS TO MEET THE NEEDS OF SENIORS

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

ON

EXAMINING THE OLDER AMERICANS ACT, FOCUSING ON SUPPORTING EFFORTS TO MEET THE NEEDS OF SENIORS

MARCH 7, 2024

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C O N T E N T S

STATEMENTS

THURSDAY, MARCH 7, 2024

THE OLDER AMERICANS ACT: SUPPORTING EFFORTS TO MEET THE NEEDS OF SENIORS

Thursday, March 7, 2024

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 11:03 a.m., in room 430, Dirksen Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders [presiding], Casey, Baldwin, Murphy, Kaine, Hassan, Smith, Hickenlooper, Markey, Cassidy, Collins, Braun, and Marshall.

OPENING STATEMENT OF SENATOR SANDERS

The CHAIR. The Senate Committee on Health, Education, Labor, and Pensions will come to order. Before we get to the Older Americans Act, which is an issue of enormous consequence, I just wanted to say a few words on—briefly on some of the subjects.

First, as all of you know, this Committee has spent a lot of time on the high cost of prescription drugs in America and the fact that in some cases we pay ten times more for the same products that people in other countries pay.

This Committee did an investigation an exhaustive investigation on inhalers. Millions of people have asthma and obesity, and it is very difficult for them to pay for the products that they need.

During the last couple of weeks, among other things, I have talked to the major manufacturers of those inhalers, or four major ones. Two of them were receptive. Two of them not so much.

But I am very happy to mention today that one of those manufacturers, Boehringer Ingelheim, announced that it is substantially lowering the cost of their inhalers in America by making sure that every uninsured or underinsured patient in the country will pay no more than $35 for those devices.

That is a big deal, and I very much appreciate the step forward by Boehringer Ingelheim and we look forward to the other manufacturers following suit. On another issue, I wanted to tell you what all of you know, and that is the minibus that was passed by the House yesterday and will soon, I expect, be passed by the Senate contains new funding for community health centers, the National Health Service Corps, and teaching health centers.

These issues this Committee has worked hard on. The community health center program will go up from $4 billion in mandatory funding to $4.4 billion. The National Health Service Corp will go up from $310 million in funding to $364. And the teaching health center will go up from $126 million to $175 million.

Now, given the dysfunctionality of the U.S. Congress, these are not insignificant steps forward. But given the crisis that we face in primary health care, we are not accomplishing anything near what we have got to do.

The system is completely broken. We waste enormous amounts of money when people end up in the emergency room in a hospital because they don't get the primary care they need. So, my point is, I look forward very much to continuing the work that we have begun on primary health care and seeing if we can do a bit more in the remaining months ahead of us.

Let's get to the subject matter of the day, and that is the Older Americans Act. According to the OECD, 23 percent of seniors in America are living in poverty, compared to just 12 percent in Canada, and 9 percent in Germany, and 4.4 percent in France. Further, one out of every four seniors in America is trying to survive on an income of less than $15,000 a year, and I am not quite sure how anybody can survive on $15,000 a year.

Today, we will be paying attention to the urgent unmet needs of millions of seniors in America and what we should do as a society to reduce the senior poverty rate, to reduce hunger, and to improve the health and well-being of our parents and grandparents, the people who helped build this country.

In America today, 12 million seniors are dealing with food insecurity. Quite unbelievable, but true. Nearly a quarter of our Nation's seniors are considered to be socially isolated, a huge issue. And more than one out of every four seniors suffer from falls, tragic falls, the leading cause of death from injury among our elderly population.

Something we don't pay enough attention to. Nearly 95 percent of adults over the age of 60 have a chronic health condition, and 80 percent have two or more chronic conditions like high blood pressure, arthritis, and diabetes.

Seniors throughout our Country, particularly in rural areas, lack the transportation they need to get to a doctor's office, the grocery store, or the dentist. And that should not be happening in the richest country in the history of the world. In my view, both from a moral and from an economic perspective, we cannot turn our backs on the millions and millions of seniors who are hurting and who desperately need our help today.

Here is the good news. The good news is we have a very effective piece of legislation on the books to address the urgent needs of vulnerable seniors, and that is the Older Americans Act. And I want to thank all of our panelists and so many people around the country who have worked so hard on that piece of legislation.

The Older Americans Act provides Federal funding for many essential services for our Nation's seniors, including helping older adults live at home rather than end up in nursing homes. Sup-

porting our Nation's caregivers' activities to combat loneliness and isolation, preventing disease, job training, protections from abuse, and rides to the doctor's office and grocery store.

Importantly, and this is maybe the main point of today, about 45 percent of funding from the Older Americans Act is used to provide meals to millions of frail and isolated seniors through Meals on Wheels program and through congregate meal programs at senior centers.

When we talk about the Older Americans Act, let's not forget 45 percent of the funding goes to nutrition programs for seniors who need them. And I suspect all of us have been to senior centers and seen the effectiveness of the congregate meal program and the Meals on Wheels program.

Let us be clear, this is a point that needs to be made over and over again, these nutrition programs not only provide good nutrition, but anyone who understands the Meals on Wheels program knows that it is important it is not just the actual meals. Literally it is somebody knocking on the door, saying hello, asking how you are doing, breaking through the isolation.

That is what Meals on Wheels program does, and we thank all the volunteers who are involved in those efforts. But not only does the Older Americans Act save lives and ease human suffering, it saves money.

I am almost thinking, Senator Cassidy, that we should change the name of this Committee to the prevention committee. Because as a Nation, what we do is end up spending a fortune after people end up in the emergency room, in the hospital, rather than keeping them out of it.

We treat kids, we don't get the quality education they need, and they end up in jail. So, we should be focusing on prevention. That is certainly what the Older Americans Act is about. If seniors do not get the nutrition they need and seniors become malnourished, what happens to those seniors?

Well, if you are malnourished, by definition, you are going to get sick more often than you should. If you are old and you are sick, where do you end up? You are going to end up in the emergency room. At great expense to Medicare and Medicaid, you can end up in the hospital. A great expense to our health care system.

Matter of fact, malnutrition among seniors today costs our society over $50 billion each and every year, a rather an incredible amount of money. The truth is, it makes a lot more sense to provide adequate nutrition to frail seniors than to spend money on preventable hospital costs.

In fact, and I love this number here, it costs less to feed a senior, one senior, for an entire year through the Older Americans Act than it does for a senior to spend one night in a hospital. Feed a senior for a year or spend one night in a hospital.

Well, I think it is a better idea to feed that senior. Providing adequate nutrition to seniors, new services for seniors also reduces the need for nursing home care. People would rather stay at home than end up in nursing home—in nursing homes, and that is what Meals on Wheels and other programs do.

Bottom line is here, and what is of concern to this Committee is since 2016, despite increased demand that a massive increase in the number of seniors in America, funding for the Older Americans Act has gone down by nearly 20 percent after adjusting for inflation—20 percent in real dollars.

As a result, seniors who are desperate for nutrition food are being put on waiting lists that can last for months. So, we have a choice, either we are going to respond to the crises facing seniors, adequately fund these programs, or we don't.

My strong hope is that we go forward and do the right thing.

Senator Cassidy.

OPENING STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Thank you, Chairman Sanders. And two things about your opening comments. It is good that Boehringer is going to offer those inhalers at $35, but we have learned is that when the insulin providers say that they provided an insulin at $35, pharmacy benefit managers wouldn't carry it.

I think it is incumbent upon us to say—to get our PBM reform legislation, which we worked on a bipartisan basis in this Committee, signed into law. And that is going to take not just this Committee, but the entire Senate and the House Republicans in the House is to collaborate.

We are not there yet, but anyone that can pick up a phone, call, we need to get that done so that the benefits of that actually occurs as merely being something which just wouldn't it be nice, but it actually doesn't impact someone's life.

Second, just a typo and I am sure is an oversight, it is good that we have increased the funding for the community health centers. It is $4.27 billion, not $4.4, but it shows what can happen when we actually work together with reasonable numbers and try and make things happen, and that is when this Committee is at its best.

Now returning to the Committee at hand and thank our witnesses for being here. Really appreciate it. And one by zoom, which I wonder why everybody isn't by zoom because that would obviously be more efficient.

We are discussing the reauthorization of the Older Americans Act, or the OAA, legislation empowering American seniors to live healthy and independent lives in the settings they choose the lifestyle they choose. One of our Members of the panel just got her hair dramatically cut. Said it was a celebration of her 66 birthday.

We see that seniors can live on the wild side. So, I just want to kind of comment on that right off the bat.

[Laughter.]

Senator CASSIDY. First enacted in 1965, the OAA provides funding to support essential services to aging Americans through nutrition—through programs such as nutrition, caregiver support, and elder abuse prevention.

We have, historically in Congress, come together on a bipartisan basis to reauthorize this, strengthen its support for all seniors.

Post-COVID, we need to look at and make sure the programs that we are authorizing work. If they are not working, improve them. And make sure that those scarce taxpayer dollars are being put to maximum benefit.

How do we build on what works? Replace that which does not. During the pandemic, OAA service providers had to adapt, and I would tour many of those places seeing how are you doing it differently.

My gosh, they were quick on it. We should take lessons learned during the pandemic and use that new knowledge as how we can better serve those whom we intend to serve. The OAA is a foundation, but it was never meant to meet all needs and we have to be clear about that.

It is also important to understand how to use public private, partnerships to leverage this funding to expand services beyond the reach of this funding. Today, we will hear about some of those partnerships. Again, thank you for being here. Maximizing the reach of these dollars requires strong organizations on the state and local level.

We appropriate. It has to be implemented on the state and local level. So how do we support those state units and those local units to maximize their effect? One of our witnesses today, Secretary Michelle Branham, will speak to us about how she has successfully done this in Florida, which I think has one of our old—one of our—probably the largest population of seniors.

She is looking at me. She is making sure that I don't diss Maine. I understand that Maine has got a lot of seniors. Believe me, I know Senator Collins. But anyway, Florida has just got a bigger population than you. You got to walk a tightrope around here, you know what I am saying.

[Laughter.]

Senator CASSIDY. This year, the HELP Committee will need to pass legislation reauthorizing the program, and I am glad to join Chair Sanders in leading a bipartisan working group with Senators Collins, Braun, Mullin, Casey, Kaine, and Markey.

With this group, with our stakeholders, we are going to come forward with a bipartisan reauthorization, improving the lives of all of those who we call senior citizens. I appreciate the Chair for engaging. I look forward to hearing from you.

The CHAIR. Thank you, Senator Cassidy. We have a wonderful panel. Our first witness is Ms. Ramsey Alwin, the President and CEO of the National Council on Aging.

The National Council on Aging has been a national voice and advocate for older adults since 1950 and provides resources and advocacy to ensure that every person can age with health and financial security.

Ms. Alwin, thank you so much for being with us.

STATEMENT OF RAMSEY ALWIN, PRESIDENT AND CEO, NATIONAL COUNCIL ON AGING, ARLINGTON, VA

Ms. ALWIN. Thank you for having us. And thank you to the Chairman and Ranking Member for your support, your leadership

on this important topic today, and the bipartisan workgroup that you have initiated together.

We greatly appreciate that leadership. For nearly 75 years, the National Council on Aging has operated under the principle that aging well in America should be a right, not a privilege for the few.

We applaud the leadership of the Chairman for initiating an effort to ensure the Older Americans Act can reach all Americans with an appropriations letter, with 41 other Senators supporting doubling the support for the program.

Thank you for that important leadership, because we know from our work every day with partners from across the country helping older adults secure jobs, enroll in programs that can help with food and medicine, and learn how to better manage their chronic conditions and prevent falls, there is more need and demand than ever before, and this reauthorization is an opportunity to strengthen and modernize the act to meet those needs.

Before I get started on our recommendations, I would like to share one story of millions that we have collected over the years. Ms. West is a family caregiver in her 60's, and she shared with our team, navigating all the challenges my mom has faced these past few years has been difficult.

The death of my father, moving in with my husband and I, cancer, and surgery, not to mention COVID. Yet after she had a fall, the local senior center connected us to the capable team. The capable team came into our home with fresh eyes and ears, years of experience, and kind hearts.

They helped by offering home modification ideas we hadn't thought of and resources we didn't even know existed. Our home is now better equipped to keep my mom safe, and we have a plan for the future as her needs increase. She has even gotten involved in the senior center and made some new friends.

Ms. West shares, I wish every senior could have the peace of mind all of this has offered us. Stories like this one and so many more informed the recommendations I will share with you today. We know more than 90 percent of older adults live in communities, and the Older Americans Act plays a critical role in providing nonmedical professional services to ensure all can age well at home.

Our priorities for this reauthorization begin with senior centers, which are a time tested model to deliver on the promise of the Act. A visitor to a senior center can come into exercise, get screened for benefits, take an art class, get a hot meal and socialize, learn a new language, or find purpose through volunteering.

Despite all this important work, senior centers face chronic budget shortfalls and are not generally funded by the Older Americans Act. Through reauthorization, Congress has an opportunity to ensure that a modern senior center is available to every American.

We must address lessons learned from the pandemic, reinstate a separate title for senior centers, strengthen the authorization for modernizing them, and increase funding for senior nutrition programs to allow for parity between home delivered and congregate meal settings.

Our second priority is healthy aging. We know that chronic conditions are the leading cause of frailty, disability, and death in the U.S., but we also know there are evidence based programs that make a difference. They save lives and they save money.

For instance, participants in that capable program around home modifications to prevent falls on average save $30,000 to the health system. Participants in the chronic disease self-management program are shown to save $700 per participant in emergency room and hospital visits.

Given that 80 percent of older adults have two or more chronic conditions, we believe that chronic disease self-management program should be offered and available in every ZIP code, which is not the case today.

Title 3(d) of the Act supports this work, but funding has not kept pace with the growing needs and costs. To expand reach, reauthorization should double the authorized funding levels for Title 3(d) and expand the continuum of programs funded to include those that are evidence formed as well as evidence based.

Our third priority is direct care workforce and the desire for home and community based services. Funded by ACL, NCOA leads the Direct Care Workforce Strategy Center, which is working to address the workforce shortage crisis with state systems change.

We ask that reauthorization strengthen authorities for sustained funding for this center to increase technical assistance and training for states that are looking for creative solutions to build that workforce given the increase in demand.

Finally, the Act is critical to ensuring the economic security of older adults, especially those that need and want to continue to work. Since 1968, NCOA has served as a National Administrator of the Senior Community Service Employment Program, or SCSEP.

A Department of Labor program that is authorized and funded under the Act, SCSEP is the only Federal job training program focused exclusively on helping older Americans return to the workforce.

The majority of participants are women and people of color, and the job training provides more than a job. It is dignity, its purpose, its security. We advocate for lowering the eligibility for the program from 55 to age 50 and raising the income eligibility from 125 percent of Federal poverty to 200 percent of the Federal poverty level.

Reaching people earlier, as well as those on the edge, will enable more to benefit from this successful program, providing them the income, the security, the purpose needed to age well, and they will continue to be taxpayers. In conclusion, the Older Americans Act provides a critical blueprint for ensuring we have the infrastructure needed in our Country to support all of us as we age.

Now is the time to modernize and strengthen the Act to meet the needs of today and tomorrow so that every American, including each of us here today, can age well. Thank you, and I am happy to take any questions you may have.

[The prepared statement of Ms. Alwin follows.]

PREPARED STATEMENT OF RAMSEY ALWIN

Introduction

Chairman Sanders, Ranking Member Cassidy, and Members of the Senate Committee, thank you for the opportunity to speak with you today about the vital need to reauthorize, modernize, and fund the Older Americans Act OAA to support the needs of older adults.

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

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

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

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

Reauthorization of the OAA provides a critical opportunity to strengthen and revitalize its many important provisions. Previous bipartisan reauthorization efforts have created innovative new programs that have significantly improved the lives of older adults, their caregivers, and the Aging Network. For example:

- The Supporting Older Americans Act of 2020 created a **Research, Demonstration and Evaluation Center for the Aging Network**. The purpose of the Center is to coordinate research, evaluation, and demonstration projects and increase the repository of information on evidence-based programs and interventions available to the Aging Network.[3] This work will help us understand how the Aging Network can improve the lives of older adults and do its part in slowing the growth in expenditures of programs like Medicare and Medicaid.
- The OAA Amendments Act of 2006 created the **National Center for Benefits Outreach and Enrollment**. The Center supports a network of community-based organizations that find and enroll low-income beneiciaries—generally with annual incomes below $22,000—in benefits programs they are eligible for. Thanks to this work, from 2022–2023, 9.3 million low-income older adults and individuals with disabilities were connected to benefits[4] that enable them to afford prescription drugs and other needed health care, as well as food and energy assistance.

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[1] *https://www.liebertpub.com/doi/10.1089/pop.2017.0199*.

[2] *https://aspe.hhs.gov/reports/understanding-characteristics-older-adults-different-residential-settings-data-sources-trends-0#exhibit2*.

[3] *https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2021/05/Policy-Spotlight-OAA-Research-FINAL-508.pdf*.

[4] *https://www.ncoa.org/article/helping-lower-income-adults-afford-Medicare*.

- The 2000 OAA reauthorization created the **National Family Caregiver Support Program**, which provides grants to states and territories to fund a range of supports that assist family and informal caregivers to care for their loved ones at home for as long as possible. Grantees provide information to caregivers about available services, individual counseling, support groups, caregiver training, and respite care.

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

According to the U.S. Census Bureau, from 2010 to 2020, the 65-plus population experienced its largest-ever percentage-point increase—from 13.0 percent to 16.8 percent of the total population. Before 2010, it took 50 years—from 1960 to 2010—for the older population's share of the total population to grow by the same number of percentage points. [5]

The older population is also increasingly diverse. In 2020, 24 percent of individuals ages 65 and older were members of racial or ethnic minority populations. Over the next two decades, the white non-Hispanic older population is expected to grow by 26 percent, while older racial and ethnic minority populations are expected to increase by 105 percent, as the younger more racially and ethnically diverse generation ages. [6]

While demand for OAA services is growing and diversifying, OAA funding is not keeping pace. This financial reality has made it increasingly difficult for the Aging Network to maintain existing services, let alone expand. The supplemental funding Congress provided to the Aging Network during the COVID–19 pandemic was critical to helping older adults most at-risk and in greatest need. But today, the demand for these services continues, while the relief funds are running out. The pandemic sharply underscored the value of and critical need for additional investment in OAA programs.

NCOA Priorities

As the leading advocate on behalf of older adults and the Aging Network, NCOA has several priorities that we believe should be included in this year's OAA Reauthorization. Our priorities focus broadly on senior centers, healthy aging, and economic security.

Senior Centers

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

Research shows that older adults who participate in senior center programs experience better mental health across several measures compared to non-participants, including perceived social and health benefits, [7] depression, [8] friendship, [9] and stress

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[5] *https://www.census.gov/library/stories/2023/05/2020-census-united-states-older-population-grew.html*.

[6] *https://acl.gov/sites/default/files/Proile%20of%20OA/2021%20Proile%20of%20OA/2021ProileOlderAmericans-508.pdf*.

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

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

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

levels.[10] Compared to their peers, senior center participants have higher levels of health, social interaction, and life satisfaction.

Senior centers are a time-tested model to deliver on the promise of the Older Americans Act. They provide for the "maximum co-location of services," which differentiates them from other community-based organizations. A visitor to a senior center can come to exercise and also get screened for benefits, take an art class and get a hot meal, or learn a new language and find purpose through volunteering. At their core, senior centers are places that foster social connection and belonging, addressing the epidemic of loneliness[11] identified by the U.S. Surgeon General.

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

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

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

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

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

NCOA has been the national voice for senior centers for more than 50 years. We have over 2,300 senior centers in our affiliate network and, through a 3-year cooper-

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

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

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

But not all senior centers are thriving. NCOA conducted an environmental scan, which identified the successes and challenges of senior centers today. Inadequate support, both in recognition of their value and in the allocation of resources, is at the top of the list of challenges.[12] Centers do not have the funding and direction needed to upgrade their facilities, to access technology, and to ensure a skilled workforce. The centers that struggle the most are those in areas of greatest need.

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

OAA Reauthorization should:

- Address lessons learned from the pandemic related to promoting equitable access to senior center services, addressing diverse needs, and pursuing innovation in nutrition programs.
- Ensure strong congregate settings in the community by reinstating a separate title for senior centers and updated language that retains the "special consideration" of senior centers as designated focal points and by strengthening support for multipurpose senior center infrastructure and services, while allowing for the flexibility capacity for virtual connections.
- Strengthen the authorization for modernizing senior centers.
- Increase the authorization level of senior nutrition programs to allow for greater parity for both home-delivered meals and congregate meals approaches to be equally funded at scale.

Healthy Aging

Title III-D Health Promotion

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

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

These health promotion and disease prevention programs result in positive health outcomes related to managing chronic disease, preventing falls, increasing physical activity, and reducing symptoms of depression and social isolation. These well-researched programs have resulted in health care cost savings for participants:[13]

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

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[12] *https://www.ncoa.org/article/the-state-of-todays-senior-centers-successes-challenges-and-opportunities*.

[13] *https://www.ncoa.org/article/falls-prevention-programs-saving-lives-saving-money-infographic*.

- The Otago Exercise Program reduces falls by 35 percent, resulting in net savings of $429 per participant.
- The Community Aging in Place Advancing Better Living for Elders Program (CAPABLE) provides home modifications to reduce falls risks resulting in more than $30,000 in medical costs savings.
- The Chronic Disease Self-Management Program (CDSMP) shows participants saved $714 in emergency department visits and hospital utilization. If 10 percent of Americans with one or more chronic conditions were reached by CDSMP, there's potential for $6.6 billion in savings. [14]

Given that 80 percent of older adults experience two or more chronic conditions, NCOA believes CDSMP should be offered in every ZIP code across the U.S. in an effort to save lives and decrease health care costs. CDSMP is a workshop for adults with at least one chronic health condition, which may include diabetes, heart disease, or arthritis. Given that chronic conditions are the primary drivers of health care costs and disability, as well as declines in quality of life, we must ensure that anyone with a chronic illness has access to this program. CDSMP focuses on critical disease management skills, including decision-making, problem-solving, and action planning. The program increases confidence, physical and psychological well-being, knowledge of ways to manage chronic conditions, and motivation to manage challenges associated with chronic diseases. Interactive educational activities include peer discussions, brainstorming, action-planning and feedback, behavior modeling, problem-solving techniques, and decision-making. The program also results in behavior change, such as more exercise and relaxation, better communication with health care providers, healthy eating, medication management, and better management of fatigue.

The delivery of these programs to older adults is funded by OAA Title III-D. Funding amounted to $26.3 million in the fiscal year 2023 Federal budget; this funding is shared across all states, territories, and the District of Columbia. Beginning in 2012, ACL required that programs funded by Title III-D meet strict evidence-based criteria defined as proven effective for improving the health and well-being or reducing disease, disability, and/or injury among older adults; *and* proven effective with older adult population, using experimental or quasi-experimental design; *and* results published in a peer-review journal; *and* fully translated in one or more community site(s); *and* includes developed dissemination products that are available to the public.

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

NCOA recognizes that evidence-based programs have some implementation challenges and inequities. Most have not been tested with a full diversity of populations, communities, or contexts. Some communities struggle to implement them as designed. Therefore, we advocate for expanding the continuum of programs funded under the OAA to include those that are "evidence-informed," defined as an approach in which "practitioners are encouraged to be knowledgeable about findings coming from all types of studies and to use them in an integrative manner, taking into consideration experience with a program or intervention and judgment, clients' preferences and values, and context of the interventions." [15]

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

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

[15] Adapted from: Nevo, I., & Slonim-Nevo, V. 2011. The myth of evidence-based practice: toward evidence-informed practice. British Journal of Social Work, 411, 1–22.

nificant potential across other areas of aging services such as nutrition and chronic disease management.

OAA Reauthorization should:

- Double authorized funding levels for OAA Title III-D to support the licensing, training, technology, and other costs required for implementation of evidence-based programs.
- Expand the continuum of programs funded under the OAA to include those that are "evidence-informed."

Jane's Story

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

Home Safety and Home Modifications

NCOA also advocates for using OAA reauthorization to enhance resources for home modification screenings and implementation. Older adults are living longer in the community, many with chronic conditions and disabilities that impact their daily function and risk for falls. Across older households, 28 percent have at least one person who has difficulty using some element of the home, such as climbing stairs or bathing.[16] The home's condition affects a person's ability to care for themselves and caregivers' ability to provide care. Home modifications that increase safety and support daily activities play a key role in helping people stay in their homes and communities as they age. Yet, fewer than 4 percent[17] of U.S. homes are suitable for people with moderate mobility disabilities, and only about 1 percent are wheelchair accessible. OAA Title III-B funding can be used to fund home modifications, but it is capped at $150 per person based on a 1988 Federal regulation. In many states, this would not cover the cost to install a grab bar. States can request Federal permission to waive that cap, but this can be time-consuming, and many are not aware of this option or how to go about it.

OAA Reauthorization should:

- Remove the outdated $150 per person home modification cap and give states more flexibility and control to support their older population's ability to age in place.

Direct Care Workforce

Between 2021 and 2031, the direct care workforce is projected to add more than 1 million new jobs, resulting in a total of 9.3 million direct care jobs need to be filled,[18] according to PHI. Low wages, lack of full-time employment, and the pandemic have caused fewer workers to enter direct care at the exact time the need for their services is growing.

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

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

OAA Reauthorization should:

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[16] *https://www.census.gov/library/publications/2013/demo/h150-11.html..*

[17] *https://www.jchs.harvard.edu/research-areas/working-papers/how-well-does-housing-stock-meet-accessibility-needs-analysis-2019.*

[18] *https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2023/.*

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

Economic Security

Older adults are more likely to face economic insecurity as they age. In 2023, poverty among older adults rose for the third consecutive year to 14 percent.[19] An analysis conducted by NCOA and the LeadingAge LTSS Center at the University of Massachusetts, Boston found that of people age 60 and older, 80 percent 47 million do not have the financial resources to cover long-term care services or another financial shock, nearly 20 percent of older households have no assets to draw upon to withstand a financial shock, and 21–80 percent of older adults have modest assets but would still be unable to afford more than 2 years of nursing home care or 4 years in an assisted living community.[20]

An important factor in determining older adults' economic security is the geographic location of their primary residence. Regions such as the Northeast and the West Coast have a higher cost of living compared to states in the Sunbelt region. NCOA urges Congress and the Administration to modernize and increase flexibility in the determination of economic need with proven tools such as the Elder Index,[21] which is a more accurate measure of the income older adults need to meet their basic needs and age in place with dignity. It includes household size, geographic location, housing, and health status in determining costs of living. The Elder Index is updated annually to include the latest Consumer Price Index data to account for inflation costs. Elder Index data show that nearly half of older adults live alone, and one in five older couples are economically insecure and cannot pay for necessities.[22] The costs of necessities in every state exceeds the Federal poverty thresholds used in eligibility requirements for benefits programs.

The Elder Index also shows that the average Social Security benefit does not cover the cost of basic expenses. Researchers from the University of Massachusetts, Boston reported that the average Social Security benefit only covers 68 percent of the costs for basic necessities for a single person living alone and 81 percent for couples living together.[23] This gap identifies the reality that many older adults must use other means to cover their basic costs either by working, withdrawing from savings and other retirement accounts, or relying on social safety net programs such as the Supplemental Nutrition Assistance Program SNAP or Medicare Savings Programs.

OAA Reauthorization should:

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

Christian's Story

Christian, 61, lives with disabilities and relies on a fixed income of $1,156 monthly. He relocated to Windsor, VT, to assist his 93-year-old father with his care. Christian previously paid $148.50 for Medicare, along with co-pays for medications, without receiving assistance for food, fuel, or prescriptions. Unfamiliar with available resources in Vermont due to being a non-native, Christian faced financial strain when prescribed a new medication with a $500 co-pay. With the help of a local benefits enrollment center, Senior Solutions, Christian received a tablet for telehealth, facilitating his connection with family in New York and easing access to medical services. Additionally, Christian applied for food benefits, fuel assistance, and pharmacy aid programs, promptly receiving a tablet for telehealth, a SNAP card with $202 for food, $56 for fuel assistance, and relief from his Medicare Part B premium, quali-

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[19] *https://www.ncoa.org/article/older-adult-poverty-continues-upward-trend-reaching-an-unacceptable-14-percent*.

[20] *https://www.ncoa.org/article/80-percent-of-older-americans-cannot-pay-for-long-term-care-or-withstand-a-inancial-shock-new-study-shows*.

[21] *https://elderindex.org/*.

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

[23] *https://kfhealthnews.org/news/article/elder-index-aging-costs-seniors-basic-necessities/*.

fying him for Medicaid after a $60 spend down. Thrilled by these benefits, Christian anticipates saving for a car, resulting in monthly savings exceeding $500. These supports allow Christian to continue to care for his father and himself, both remaining independent.

Older Workers

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

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

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

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

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

OAA Reauthorization should:

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

Susan's Story

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

Thankfully, another opportunity arose swiftly, and Susan embarked on training as a receptionist at an organization dedicated to mental health awareness. As Susan's tenure in the program approached its conclusion, her colleagues recognized her

value and advocated for her to join the team permanently. In a remarkable show of support, Susan's coworkers collectively urged management to hire her full-time.

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

Conclusion

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

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

[SUMMARY STATEMENT OF RAMSEY ALWIN]

NCOA appreciates the opportunity to discuss the vital need to reauthorize, modernize, and fund the Older Americans Act (OAA) to support the needs of older adults. From advocating for passage of the original OAA to helping end mandatory retirement, NCOA has operated under the principle that aging well in America should be a right for all, not a privilege for a few.

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

While demand for OAA services is growing and diversifying, funding is not keeping pace. This financial reality has made it increasingly difficult for the Aging Network to maintain existing services, let alone expand. The supplemental funding Congress provided during the COVID–19 pandemic was critical to helping older adults most at-risk and in greatest need. But today, the demand for these services continues, while the relief funds are running out.

NCOA has several priorities that we believe should be included in OAA Reauthorization:

- **Senior Centers**: (1) Address lessons learned from the pandemic related to promoting equitable access to senior center services, addressing diverse needs, and pursuing innovation in nutrition programs; (2) Ensure strong congregate settings in the community by reinstating a separate title for senior centers and updated language that retains the "special consideration" of senior centers as designated focal points and by strengthening support for multipurpose senior center infrastructure and services, while allowing for the flexibility capacity for virtual connections; (3) Strengthen the authorization for modernizing senior centers; (4) Increase the authorization level of senior nutrition programs to allow for greater parity for both home-delivered meals and congregate meals approaches to be equally funded at scale.
- **Title III-D Health Promotion**: (1) Double authorized funding levels for OAA Title III-D to support the licensing, training, technology, and other costs required for implementation of evidence-based programs and (2) Expand the continuum of programs funded under the OAA to include those that are "evidence-informed."
- **Home Safety and Home Modifications**: Remove the outdated $150 per person home modification cap and give states more flexibility and control to support their older population's ability to age in place.

- **Direct Care Workforce**: Strengthen authorities for sustained funding for the Direct Care Workforce Strategies Center beyond five years to increase dissemination of state technical assistance and training opportunities to ensure an adequate and well-trained direct care workforce.
- **Economic Security**: Modernize and increase flexibility in the determination of economic need with proven tools such as the Elder Index to ensure the local cost of living are addressed as future generations are expected to age with limited financial resources.
- **Older Workers**: (1) Update SCSEP eligibility to make it available to adults 50 years and older and (2) Adjust income eligibly guidelines to allow for individuals with incomes at or below 200 percent of the Federal poverty level to improve access for older workers struggling with financial security and employment.

The CHAIR. Well, thank you very much. Our next witness is Ms. Ellie Hollander, the President and CEO of Meals on Wheels America, which is a national membership organization that represents 5,000 local community based programs across the country dedicated to improving the nutrition and lives of seniors. Ms. Hollander, thanks so much for being with us.

STATEMENT OF ELLIE HOLLANDER, PRESIDENT AND CEO, MEALS ON WHEELS AMERICA, ARLINGTON, VA

Ms. HOLLANDER. Good morning, Chairman Sanders, Ranking Member Cassidy, and esteemed Members of the Committee. It is an honor to testify before you on such an important topic, and especially during March, the month in 1972 in which the nutrition program was added to the Older Americans Act.

Obviously, I am Ellie Hollander, and I am President and CEO of Meals on Wheels America, and I am so proud to present—to represent an incredibly dedicated and effective nationwide network of senior nutrition programs, an army of committed staff and volunteers, and the millions of older adults who rely on them as a lifeline.

Particularly relevant to the hearing today, I am driven to amplify the voices of the millions more who would benefit if only we had the resources to reach them, whether in their homes, in senior centers, or in other community settings.

There are a few Federal programs which exemplify a successful public, private partnership, much less set the gold standard. Congress should take a bow on this one, because the Older Americans Act is just that.

It has withstood the test of time, and it continues to deliver on its original purpose and intent, improving and even saving lives, and all while reducing taxpayer dollars. The program is appropriately focused on those in the greatest social and economic need, and in return delivers both a social and an economic benefit.

Not many programs can claim that. With that said, we are at a precipice that warrants action and there is no time to waste. Senior lives hang in the balance. That is because the gap between increasing need and our ability to provide resources continues to widen at an unprecedented rate.

Despite critical investments made during the pandemic, we cannot keep up with the demand at current funding levels. Under-

scoring that point, 12 million seniors struggle with hunger, which is greater than the populations of 44 states and the District of Columbia. 2.5 million low income, food insecure seniors are not receiving the meals for which they are eligible and likely need.

7 out of 10 Meals on Wheels programs report higher demand now than before the pandemic, and 1 in 3 has a waitlist with an average waiting time of 3 months for vital meals.

The good news is that thanks to the foresight of President Johnson for enacting the Older Americans Act, President Nixon for expanding upon it, and Congress for continuing to invest in it, the infrastructure already exists to solve for this growing gap.

That is because local programs have built incredible trust within their communities and developed immense expertise and resilience through nearly six decades of service, including operating through a pandemic. What these programs do on a daily basis is truly remarkable and irreplaceable.

There is more good news, these services offer a significant return on that investment. A recent report, The Case for Meals on Wheels, showed consistent findings from 38 studies that seniors receiving nutritious meals, companionship, and safety and wellness checks, the typical Meals on Wheels service model, experienced reductions in hospital visits and stays, health care services and costs, nursing home usage, loneliness and social isolation, falls, food insecurity, and nutritional risk.

For perspective, the annual cost of senior falls, malnutrition, and social isolation exceed $107 billion combined. And last, we can provide a senior, as Senator Sanders likes to say, Meals on Wheels for an entire year for the equivalent of roughly 1 day in the hospital or 10 days in a nursing home.

But the best news of all is that Congress has the power to propel a program that has received bipartisan and bicameral support throughout the years because, quite frankly, it works. Congressional support through this reauthorization is an investment in the seniors of today that will improve health, save lives, and reduce costs in the future.

To that end, here are three recommendations for your consideration. The first is to increase the authorization funding levels for all older Americans support programs to the maximum amount possible.

We estimate that a $774 million increase is needed for the nutrition program alone, just to close the current services gap. The second is to create a single Title 3 nutrition program, unifying the congregate, home delivered, and nutrition services incentive programs into one program and funding stream.

Local providers have told us repeatedly that this adjustment would improve efficiency and enable them to far more easily tailor services to their seniors. And the third is to prioritize community based programs in Older Americans Act contracts and grant awards.

Our programs provide a holistic service that starts with the meal but opens the door to so much more, leading to better health outcomes. Last, as you dig into the reauthorization process, as Senator

Sanders did, I would like to urge you to visit a Meals on Wheels program in your state, if you haven't recently, to go on a meal delivery, and to stop by a senior center because seeing is believing.

Thank you, Mr. Chairman, for your leadership on this important issue and for the letter that you and 41 other Senators sent—signed urging for a doubling of funding for programs authorized under the Older Americans Act.

We all share that belief that no seniors should be left hungry or isolated, and I stand ready to help in any way I can.

[The prepared statement of Ms. Hollander follows.]

PREPARED STATEMENT OF ELLIE HOLLANDER

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

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

For more than 50 years, the OAA has supported millions of our Nation's seniors and caregivers through a network of state, regional and local community-based programs. The local providers that we represent at Meals on Wheels America serve as a direct lifeline to those struggling with food insecurity, malnutrition, mobility, loneliness, and countless other difficulties of aging. We frequently say the service starts with the meal and opens the door to so much more. It's the purposeful and unique combination of nutritious meals and social connection that fosters a relationship with the individual senior, enabling Meals on Wheels providers to identify and deliver valuable services that promote independence and well-being. The impact not only saves lives but also saves taxpayer dollars by ensuring that our Nation's seniors live safer, longer and more nourished in their own homes and out of other more costly healthcare settings. In fact, we can serve a senior Meals on Wheels for an entire year for roughly the same cost as 1 day in the hospital or 2 weeks in a nursing home. [1]

The OAA is considered the gold standard of a successful public-private partnership, having delivered on its original intent and shown great resiliency and adaptability through challenging times, including a global pandemic. As its reauthorization approaches, Meals on Wheels America is focusing on several key legislative recommendations that further enhance the support and services provided to older adults. Given the significant need, changing demographics, and inflationary pressures, we are pushing for increased authorized funding levels across all OAA programs, with an emphasis on closing the existing needs gap for nutrition services and establishing incentives and funding for medically tailored and culturally appropriate meals. An important strategic proposal we are recommending involves unifying the Congregate and Home-Delivered Nutrition Services with the Nutrition Services Incentive Program (NSIP) under a single Title III-C Nutrition Program and funding stream. This shift would improve efficiency at all levels of the aging network and enable local service providers to tailor their offerings to meet the diverse needs of seniors in their community far more easily. Additionally, we believe there should

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

be a concerted effort to *prioritize* community-based organizations for nutrition services contracts, as local providers are delivering a holistic service and not just a meal. Finally, this reauthorization is also an opportunity to continue to modernize the OAA to incorporate innovations, flexibility, and successful practices that were leveraged during the pandemic, ensuring that the Act is adaptable and responsive to the evolving needs of America's older population.

The Foundation of the Older Americans Act

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

The Older Americans Act of 1965 (OAA) was signed into law on July 14, 1965, as an answer to improving access to social services and supports for older adults living in the community. Since then, the Act has served as the primary Federal legislation supporting community-based social services for adults 60 and older and the bedrock of Federal support to the nationwide network of senior nutrition programs that rely on Federal funding.

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

The largest title of the Act, accounting for 72 percent of the OAA's total funding in fiscal year 2023, is Title III Grants for State and Community Programs, which provides grants to states to help carry out a variety of supportive service and health promotion programs for older adults and their caregivers.[2] The Title III Nutrition Program, which includes congregate (Title III-C1) and home-delivered (Title III-C2) nutrition services, and the Nutrition Services Incentives Program (Title III-C), is a Federal program that supports the health and well-being of older adults through nutrition services. We are proud and thankful and want to underscore the significance of the OAA Nutrition Program, *which is the only Federal program designed specifically to meet older adults' nutritional and social needs*. The OAA Nutrition Program is a successful public-private partnership, with the critical Federal dollars provided leveraging an impressive funding match of approximately 3 to 1, from additional state, local, and private sources.[3]

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

The Pervasive Problem of Senior Hunger

Since its inception, the OAA Nutrition Program has provided billions of meals to seniors in need, improved countless lives, and saved considerable taxpayer dollars through well-established trust built at both the community and national levels. While this program has worked as it was designed for decades, it is not reaching all those in need. Eight out of ten (80.3 percent) low-income, food insecure older adults are not receiving the congregate or home-delivered meals that they are eligible for and likely need.[4] From a national survey, we found that one in three local Meals on Wheels programs maintain waiting lists, with seniors waiting on average 3 months for vital meals—an increase of 10 percent for program waitlists from

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

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

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

2021.[5] The same survey found an overwhelming majority of programs, 78 percent, have already or would need to add seniors to waitlists due to funding cuts. These are only the individuals we are aware of and know that it is an underrepresentation of the true need across the country. In fact, 97 percent in our survey indicated they believe that there is unmet need in their communities.

Additional research has found that older adults who seek Meals on Wheels services are already more vulnerable than the average American seniors, with poorer self-reported health, higher levels of depression and anxiety, greater fears of falling and more.[6] Simply put, while older adults are on waiting lists and struggling to have their nutritional and social needs met, their health is continuing to decline and are more likely to end up in a hospital or nursing home prematurely and at significantly higher cost to the individual and taxpayers.

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

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

The Costs and Consequences of Senior Hunger and Social Isolation

Today, millions of seniors are experiencing some degree of food insecurity and/or social isolation, leaving them at risk for a multitude of adverse health issues. Food-insecure older adults experience worse health outcomes than food-secure seniors, with greater risk for heart disease, depression, and decline in cognitive function and mobility.[9] Some of the most vulnerable seniors that the OAA serves—those who are frail, homebound, and socially isolated—rely on the home-delivered meal program. Despite the well-founded, inextricable link between healthy aging and access to nutritious food and regular socialization, millions of seniors struggle to meet these basic human needs. The infrastructure and cost-effective interventions to address these consequences already exist through the OAA network. As stated above, local, community-based organizations serve a critical role in addressing the nutritional and social needs of our Nation's older adults. The impact of these services on seniors' lives is powerful.

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

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

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

[7] See note 4.

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

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

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

Malnutrition, senior falls, and social isolation tell a similar story. The economic burden of senior malnutrition alone costs $51.3 billion annually (in 2010 dollars), while senior falls account for $50 billion (in 2015 dollars).[11], [12] Studies show the highest rates of social isolation are found among older adults, putting seniors at risk for high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline, Alzheimer's disease, and even death. Research demonstrates that social isolation among older adults leads to an extra $6.7 billion in Medicare spending a year (in 2012 dollars) similar expenditures to that of having high blood pressure or arthritis.

The Case for Meals on Wheels and the Older Americans Act

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

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

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

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

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

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

5. **Improved diet quality**: Home-delivered meals led to higher-quality diets among participants, as measured by nutrient intake, calories, vita-

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

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

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

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

mins, and other indicators. Participant feedback reinforced that meal delivery helped them eat healthier, more nourishing foods.

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

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

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

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

Older Americans Act Reauthorization Priorities

While the need for far greater Federal funding is the primary key to serving more seniors, especially in the years following the COVID–19 pandemic, there are opportunities to ease administrative burdens and improve our insight into the performance and operations of the network at all levels. The Act, including the Nutrition Program, must continue to be robust and successful and fulfill its original intent and core purpose to reduce hunger, promote socialization, and improve health and well-being for older adults in greatest social and economic need.

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

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

- Increase authorized funding, including sufficient funding for Title III Nutrition Services, to address existing waiting lists and reach the ever-growing number of older adults who would benefit from OAA programs.
- Authorize new funding streams and establish incentives for senior nutrition programs to offer medically tailored and/or culturally appropriate meals and expand reach in underserved areas.
- Improve and clarify authorization of funding for senior nutrition programs to maintain and invest in the infrastructure and resources needed to prepare and deliver services, including kitchen equipment, delivery vehicles, labor, etc.

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

- Create one authorized funding stream to remove administrative burden, improve efficiency, and enable community-based organizations to tailor nutrition services to seniors' needs more easily.
- Codify alternative nutrition services models, such as grab-and-go and drive-thru meals, proven to reach more older adults struggling with hunger and social isolation.
- Modernize the Nutrition Services Incentive Program through enhanced partnership and coordination with USDA, HHS, states, Area Agencies on Aging (AAA), and local providers to procure commodity foods for preparing OAA meals and coordinate other important Federal benefits and programs for seniors.

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

- Encourage states and AAAs to partner more closely with and leverage senior nutrition programs' established infrastructure, dedicated volunteer base, and experience serving their communities to deliver nutritious meals, socialization services, and safety checks to more older adults.
- Ensure timely payment and reimbursement processes for nutrition services provided.

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

- Reduce administrative and regulatory burdens on local nutrition and aging services providers seeking to establish contracts and partnerships with health care providers and payors.
- Provide additional resources and promote incentives for the aging services network to build the capacity, including infrastructure and technology, to meet the compliance and privacy standards for providing covered health care benefits.

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

- Facilitate continued innovation and implementation of many successful practices leveraged during the COVID–19 public health emergency, including new partnerships, programming, emergency preparedness and outreach.
- Support the expansion of evidence-informed and/or technology-based solutions that can help meet the needs of seniors, including their preferences for meals and social connectedness.

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

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

- Home-delivered meals—and a certain amount of congregate meals—may be provided via home delivery, pick-up, carry-out, or drive-through.
- Eligibility for home-delivered meals is not limited to people who are "homebound;" criteria may depend upon many factors (including ability to leave home unassisted, ability to shop for and prepare nutritious meals, mental health, degree of disability or other relevant factors about their need for the service, including social and economic need).
- Requirements regarding the use and transfer of funding for Title III programs, including clarification under Title III C–1 and C–2 that funds can be used for nutrition education, nutrition counseling, and other nutrition services, as well as cautioning against transitioning money away from Title III-B and Title III-C services for which they were appropriated and intended by Congress.
- States have the option to receive NSIP allocation grants as cash, commodities or a combination of both, and that funds can only be used to purchase domestically produced foods used in meals.

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

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

and making further legislative improvements during this OAA reauthorization process.

Conclusion

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

[SUMMARY STATEMENT OF ELLIE HOLLANDER]

The Foundation of the Older Americans Act: Meals on Wheels programs serve as a direct lifeline to older adults struggling with food insecurity, malnutrition, mobility, loneliness, and countless other difficulties of aging. In 2021, local, community-based programs supported by Federal funding from the Older Americans Act (OAA) delivered 251 million meals to 2.2 million of our Nation's seniors in greatest social and economic need.

OAA Reauthorization Priorities and Recommendations: Our recommendations are designed to protect the core purposes of the Act, underscore its importance as a solution to end senior hunger and social isolation, ensure it is sufficiently funded, and does no harm to seniors or the aging network. Our priorities include:

- Increasing authorization funding levels for all OAA programs and providing additional resources for enhanced nutrition services
- Unifying OAA Congregate, Home-Delivered and the Nutrition Services Incentive Program into a single Title III-C Nutrition Program
- Prioritizing community-based nutrition programs and experienced network providers in OAA grant awards and contracts
- Expanding senior nutrition program capacity and infrastructure support for further integration into the health care system
- Promoting innovations and successful practices learned during the COVID–19 pandemic

Understanding the Unmet Needs of Our Growing Senior Population: Waitlists for OAA nutrition services aren't an accurate picture of total need; waitlists measure pent-up demand, not unmet need.

- One in three local Meals on Wheels programs currently maintain waiting lists, with seniors waiting on average 3 months for vital meals and 97 percent of Meals on Wheels programs indicate they believe that there is unmet need in their communities
- Eight out of ten (80.3 percent) low-income, food insecure older adults are not receiving the congregate or home-delivered meals that they are eligible for and likely need

The Critical Role of OAA Nutrition Programs: Local, community-based organizations serve a critical role in addressing the nutritional and social needs of our Nation's older adults. Most seniors receiving OAA nutrition services report that participating in the program helps them feel more secure, prevents falls or fear of falling, and allows them to stay in their own homes. The impact not only saves lives but also saves taxpayer dollars by ensuring that our Nation's seniors can live healthy at home and out of other more costly healthcare settings, helping to avoid preventable emergency room visits, hospital admissions and readmissions, and extended rehab stays, ultimately reducing our Nation's health care costs.

- Nearly all (92 percent) home-delivered meal participants said the meals help them continue to live independently
- One study found that among individuals receiving medically tailored meals, average medical expenditures were 40 percent lower per month for those receiving meals than for a matched group not receiving meals ($843 vs. $1,413)

- The economic burden of senior malnutrition alone costs $51.3 billion annually (in 2010 dollars), while senior falls account for $50 billion (in 2015 dollars)
- Almost 95 percent of older adults have at least one chronic condition, while nearly 80 percent have two or more chronic conditions. It is estimated that $73 billion in January 2024 dollars is spent annually on disease-associated conditions

The Case for Meals on Wheels: *The Case for Meals on Wheels: An Evidence-Based Solution to Senior Hunger and Isolation* found that Meals on Wheels programs reduce healthcare utilization and costs, falls, nursing home use, social isolation and loneliness while improving food security, diet quality, and nutritional status and seniors' ability to age in place. Meals on Wheels services: reduce use of costly health care service; reduce nursing home use and increased ability to age in place; reduce health care costs attributed to reduced hospital and nursing home spending; increase food security; improve diet quality; reduce or slow decline in nutritional risk; and reduce social isolation and loneliness.

The CHAIR. Thank you very much, Ms. Hollander. Our next witness is Dr. Martha Kubik, Professor of Nursing at George Mason University. She will be introduced by Senator Kaine.

Senator KAINE. Thank you, Chairman and Ranking Member for stacking this panel. Four of the five are from Virginia. We don't demand 100 percent, but this ratio seems very acceptable to me. I will be glad to introduce Dr. Marti Kubik, who is a Professor of Nursing in the College of Public Health at George Mason University close by in Fairfax.

Dr. Kubik is a behavioral epidemiologist and advanced practice nurse with over 20 years of community based primary care experience as a nurse practitioner. She has extensively researched health promotion and disease preventions across the lifespan, with a particular focus on low income and minority populations.

Her testimony will focus on a pilot program connecting pre-licensed nursing students with older adults at congregate meal sites in Washington, DC. and Kentucky. Dr. Kubik, welcome.

STATEMENT OF MARTHA Y. KUBIK, PH.D., RN, FAAN, PROFESSOR OF NURSING, COLLEGE OF PUBLIC HEALTH, GEORGE MASON UNIVERSITY, FAIRFAX, VA

Dr. KUBIK. Thank you, Dr. Kaine. I appreciate the introduction. Thank you, Committee, for allowing me to visit this morning to the Committee and share the work and testify about the reauthorization of the Older Americans Act.

The Congregate Nutrition Services Section of the OAA, as you all know, provide seniors a nutritious meal in a familiar and easy to reach community setting. As a result, we have a unique national network of trust in gathering places for seniors.

Expanding services at these sites to address the increasingly complex health and social needs of a burgeoning and aging population, most with multiple chronic conditions as has already been noted by many, is one approach to help seniors age well and age in place.

As the older adult population continues to boom, access to primary care health services remains problematic, contributing to poor health outcomes and increase hospitalizations, as has been noted by Senator Sanders.

Establishing academic practice partnerships between senior centers and dining sites, and health professions schools, and particularly schools of nursing, to bring students to the community sites to provide health services holds great potential to improve health outcomes, while at the same time preparing a health workforce better equipped to meet the needs of community residing adults for years to come.

My funding partner, the National Foundation to End Senior Hunger, recently supported two proof of concept studies that I have led. One here in the District of Columbia that we completed last year, and the other in eastern Kentucky, which is currently ongoing and will wrap up May 2024.

Both were conducted in partnership with district or state level departments of aging, community nonprofits here in the district, Area Agencies on Aging in Kentucky, senior centers and dining sites, 6 per each of the locations for a total of 12, and local nursing programs, 2 at each location for a total of 4.

The faculty supervised pre-licensure nursing students, so students studying to be registered nurses typically in their last year of studies, delivered the program that we call ageWELL once weekly for 6 to 12 weeks at 5 of the 12 sites that we randomly selected.

Health services included one on one visits between a senior and a nursing student with a focus on medication management, blood pressure assessment, and health coaching guided by the senior's priorities and goals.

Other services delivered in an interactive group setting were focused primarily on healthy eating strategies and physical activity. Across sites both in the district and in Kentucky, nursing student engagement and program participation and satisfaction among seniors has been high. Outcomes are pending in Kentucky.

In the district, most of the seniors who participated in the ageWELL program self-reported improved diets and increased physical activity. Blood pressure that we measured before and after we delivered the ageWELL program, across all six sites, not just the sites where we delivered the program, demonstrated a 5.9mm of mercury decrease and systolic blood pressure.

We were able to lower the top number of the blood pressure by six points that favored the ageWELL group. While this was not a statistically significant difference in our study, likely due to the small sample size and the pilot nature, it is nonetheless very promising and merits further study. In closing, our study results support feasibility, acceptability, and potential of the ageWELL program to improve chronic disease self-management for seniors.

The time is right to expand services for the older adults that access community dining sites and senior centers and the congregate meal program.

In reauthorizing the OAA, we encourage the Committee to include support for further study of the ageWELL approach, so as to assess program effectiveness on health comes, such as blood pressure, and also scalability.

Thank you for your opportunity to speak today, and I am happy to answer questions.

[The prepared statement of Dr. Kubik follows.]

PREPARED STATEMENT OF MARTHA KUBIK

The Congregate Nutrition Services section of the Older Americans Act provides nutritious meals, health promotion programming and social engagement for seniors (age 60 and older) in congregate dining sites in a variety of neighborhood locations throughout the U.S., creating a unique national network of trusted gathering places for older adults. Expanding services at dining sites to address the increasingly complex health and social needs of a burgeoning aging population, most with multiple chronic conditions, is one approach to help seniors age well, while aging in place. The time is right to explore new partnerships and more curated programming for the older adults that access community dining sites and the congregate nutrition program.

Study Locations

The ageWELL proof of concept studies were funded by the National Foundation to End Senior Hunger. An academic practice partnership model was used to engage local nursing schools to bring faculty-supervised, prelicensure nursing students to senior centers/dining sites to provide health services to seniors to improve self-management of health, wellness and chronic conditions. The study was initially piloted in the District of Columbia (2022–2023) in partnership with the Department of Aging and Community Living, four local community-based nonprofit agencies, two university-based nursing programs and six community dining sites/senior centers, representing five of the district's eight wards. The study is presently being replicated in eastern Kentucky (2023–2024) in partnership with the University of Kentucky (research partner), KY Department of Aging and Independent Living, three Area Agencies on Aging, six senior centers and two university-based nursing programs.

Given the pilot nature of the study and funding and staffing constraints, the number of study sites at each location was limited to six. With the small sample size, the study was not powered (lacked a large enough sample) to detect a difference in health outcomes between groups, even if a difference was present. However, the pilot allowed evaluation of *proof of concept*, and an assessment of feasibility, acceptability and potential of the ageWELL program and an academic practice partnership model to improve program participants' self-management of health, wellness and chronic disease conditions.

The study's principal investigator (PI) is Martha (Marti) Kubik, Ph.D., RN, FAAN, a professor of nursing at George Mason University (GMU). For the District of Columbia study site, the GMU Institutional Review Board (IRB) approved the research study. The study period was 8/1/2022 to 9/30/2023.

For the Kentucky study, Martha Biddle, Ph.D., APRN, CCNS, FAHA, Professor, College of Nursing, University of Kentucky (UK), is the site PI. The UK IRB approved the research study. The study period is 9/1/2023 to 8/31/2024.

Study Sample and Study Design

The pilot studies used a two-group randomized controlled trial design. Dining sites were randomly selected to continue usual programming or supplement usual programming with ageWELL. This allowed a comparison of health outcomes (i.e. blood pressure) between the two groups. Randomization of dining sites occurred within pairs matched by shared group characteristics such as type of site and geographic location. Meal program participants across dining sites were also invited to take part in evaluation activities that included measuring blood pressure, height, weight and completing a survey, before (baseline) and after (follow-up) implementation of the 6–12 week ageWELL program. Program participants also completed a satisfaction survey. Nursing students documented their engagement with seniors (service counts) and following the program, completed an evaluation of the dining site experience.

Across locations, faculty-supervised, prelicensure nursing students delivered the ageWELL program once weekly for 6–12 weeks at 5 of the 12 sites. Health services included one-on-one visits between a senior and nursing student with a focus on management of medication, blood pressure assessment, and health coaching guided by the senior's priorities and goals. Other services, delivered in an interactive group setting, were focused mostly on healthy eating strategies and physical activity.

Among seniors (N=392) completing baseline measurement (DC=215; KY=177), most were female, lived alone, with average age 74 years. In DC, 94 percent were

non-Hispanic Black; in KY, 98 percent were non-Hispanic White, with 54 percent and 72 percent, respectively, reporting ≤ high school education. In DC, 189 seniors were measured following the nursing student program for an 88 percent retention rate. A brief summary of DC outcomes follows. KY outcomes are pending program completion and final measurement in May 2024.

Outcomes: DC study

Across the DC sites, there were 627 service counts, including tailored (57 percent) and targeted (22 percent) services and a health fair (21 percent). Most seniors participated weekly or twice monthly, with satisfaction with programming and nursing student engagement high. Nursing students were productive and engaged, with most reporting a better understanding of the health needs of community-residing older adults following the experience. Dining site leadership, nursing administrators and clinical faculty were interested in continuing the partnership and ageWELL programming. The small sample size limited evaluation of health outcomes. However, a decrease in systolic blood pressure of 5.9 mm Hg following the program that favored ageWELL compared to usual program participants was promising and merits further evaluation.

Conclusion

Study results from the DC pilot support proof of concept and feasibility, acceptability and potential of the ageWELL program to improve senior's self-management of health, wellness and chronic conditions. The DC pilot also confirmed the feasibility of conducting a fully powered randomized control trial to determine effectiveness of the ageWELL program to improve health outcomes. Finally, the KY pilot demonstrates potential for scalability and generalization across diverse populations of older adults.

[SUMMARY STATEMENT OF MARTHA KUBIK]

Thank you for the opportunity to speak with the Committee about my work and testify about the reauthorization of the Older Americans Act (OAA). The Congregate Nutrition Services section of the OAA provides seniors a nutritious meal in a familiar and easy-to-reach community setting, resulting in a unique national network of trusted gathering places for seniors. Expanding services at these sites to address the increasingly complex health and social needs of a burgeoning aging population, most with multiple chronic conditions, is one approach to help seniors age well, while aging in place.

As the older adult population continues to 'boom,' access to primary care health services remains problematic, contributing to poor health outcomes and increased hospitalizations. Establishing academic practice partnerships between senior centers and dining sites and health profession schools, and particularly schools of nursing, to bring students to the community sites to provide health services holds great potential to improve health outcomes, while also preparing a health workforce better equipped to meet the needs of community-residing older adults, for years to come.

My funding partner, the National Foundation to End Senior Hunger recently supported two proof of concept studies that I led, one in the District of Columbia (2022–2023), the other in eastern Kentucky (2023–2024). Both were conducted in partnership with district/state-level Departments of Aging, community nonprofits (DC), Area Agencies on Aging (KY), senior centers/dining sites (six per location) and local nursing schools (two per location). Faculty-supervised, prelicensure nursing students delivered the program (called ageWELL) once weekly for 6–12 weeks at 5 of the 12 sites (random selection). Health services included one-on-one visits between a senior and nursing student with a focus on medication management, blood pressure assessment, and health coaching guided by the senior's priorities and goals; other services, delivered in an interactive group setting, were focused mostly on healthy eating strategies and physical activity.

Across sites, nursing student engagement and program participation and satisfaction among seniors has been high. Outcomes are pending in Kentucky. In the District, most seniors reported improved diets and increased physical activity. Blood pressure measured before/after the program demonstrated a 5.9 mm Hg decrease in systolic blood pressure that favored the ageWELL group. While not a statistically significant difference, likely due to the small sample size, it is promising and merits further study.

In closing, our study results support feasibility, acceptability and potential of the ageWELL program to improve chronic disease self-management for seniors. The time is right to expand services for the older adults that access community dining sites and the congregate meal program. In reauthorizing the OAA, we encourage the Committee to include support for further study of the ageWELL approach so as to assess program effectiveness on health outcomes, such as blood pressure, as well as scalability.

Thank you again for the opportunity to speak today. I am happy to answer questions.

The CHAIR. Well, thank you very much, Dr. Kubik. Our next witness is Ms. Dorothy Hutchins from Alexandria, Virginia. And Senator Kaine is going to introduce his fellow Virginian.

Senator KAINE. Thank you, Chairman. And Ms. Hutchins, it is so great to see you. Dorothy Hutchins is 93 years old, and she joins us virtually from her home in nearby Alexandria. Dorothy has had a full life.

In her testimony, we are going to hear about her career as a geologist and her journey raising 5 children, 17 grandchildren, and now 27 great grandchildren. She receives Older Americans Act services through one of our state's regional Area Agencies on Aging, the Fairfax Agency on Aging.

This network of the agencies does superb work. And the services that she receives, like socialization provided at senior centers and nutritious meals through Meals on Wheels help her remain independent in her own home. Ms. Hutchins, it is great to have you here with us today. Unmute.

[Technical problems.]

Senator KAINE. Ms. Hutchins, we are still having a hard time hearing you. I don't know whether it is your end or our end. Nope. And Ms. Hutchins has some kind of staff assistant there with her. Perhaps, Mr. Chair, we should move to the fifth witness and then circle back to Ms. Hutchins? Should we try that?

The CHAIR. We can do that.

Senator CASSIDY. I think staff assistance is a euphemism for grandchild.

[Laughter.]

Senator KAINE. If only I could get assistance——

Senator KAINE. Before we get back to Ms. Hutchins, let's go to our final witness, Ms. Michelle Branham. She will be recognized by Senator Cassidy.

Senator CASSIDY. Yes. A pleasure to introduce Secretary Michelle Branham, appointed by Governor Ron DeSantis to serve as the agency head for the Department of Elder Services in December 2021.

Under her leadership, the department serves Florida's 6.3 million seniors over the age of 60, providing services and supporting initiatives through Florida's Aging Network to help those seniors live well and age well in their state.

Prior to that, I could just go through a whole list of ways that she has been involved serving those with Alzheimer's, addressing the needs, understanding, otherwise helping our society as a whole

address Alzheimer's. So, Secretary Branham, thank you for being with us.

STATEMENT OF MICHELLE BRANHAM, SECRETARY, FLORIDA DEPARTMENT OF ELDER AFFAIRS, TALLAHASSEE, FL

Ms. BRANHAM. Thank you, sir. Chairman Sanders, Ranking Member Cassidy, esteemed Committee Members and fellow panelists, I truly appreciate the opportunity to discuss how Florida champions seniors and the important role of the Older Americans Act in supporting our cherished elders.

I spent my first year and a half as Secretary on the road in the senior centers and adult day centers, working with our providers, as we have all mentioned. It is really exciting for us to share our story because, as we may already know, we are either seniors or we are seniors in the making.

If we are blessed to continue aging, it is imperative that we provide not only the seniors now, but the seniors of tomorrow the brightest and best possible future. Florida remains a top destination for seniors, as you mentioned, with over 6.3 million residents aged 60 and above.

We rank among the Nation's fastest growing and the third most populous state. And as the Secretary of the Florida Department of Elder Affairs, I am truly grateful for Governor Ron DeSantis' ongoing and steadfast commitment to prioritizing our seniors.

At our agency, we take great pride in leading the charge and ensuring the dignity, independence, and fulfillment of seniors in Florida. Serving as a designated standalone state unit on aging, and that is a distinction not many states have, our goal is to provide an environment where seniors can maintain their independence within their homes for as long as possible, thereby creating a happier, healthier lifestyle, while also promoting fiscal responsibility as aging in place is considerably more cost effective.

Under the leadership of Governor DeSantis, Florida excels nationally in addressing Alzheimer's and other related dementias, with pioneering initiatives, a first of the Nation mobile outreach program, and significant state funding each year, thus reflecting our commitment to those impacted by Alzheimer's and related dementia. And you just said Senator Cassidy, that is near and dear to my heart.

Our agency oversees $511 million in state and Federal funding, and that is including $154 million from the Older Americans Act, aiming to enable older adults to age well and live well in the place of their choosing, thus contributing to Florida's vibrant communities through our collective efforts with our Aging Network. As you know, the OAA tailors a range of services designed for seniors and caregivers.

These include, for us, in-home and community based support services to address cognitive decline, individual needs, fostering social connections, and ultimately reducing the impact of loneliness, isolation, and depression.

This approach has resulted in significant increased participation in our various programs and senior centers all across Florida. And

while the department continues to review the new OAA rule and its potential impact, I urge Congress and HHS to consider continuing to collaborate closely with states to ensure these new regulations do not unnecessarily hinder the process, especially in Florida over the past three decades.

Now I am just going to hit a few of the high points for the Older Americans Act in Florida. Over our entire state, we are witnessing increased participation in senior centers, congregate meal sites, and adult day centers.

Last year alone, we provided more than 10 million meals in Florida served through OAA. Supplemental services are also available in Florida to caregivers of vulnerable individuals 60 and older, and grandparents that are providing care for grandchildren.

Other types of services include home repairs, shore assistant, respite care, and specialized support for elders with Alzheimer's disease and related dementia. And one of my favorite programs, I know we mentioned it, was the Senior Community Center Service Employment Program, and that helps older Floridians who face challenges in the job market or reentering the job market.

The wonderful part of this program is that due to workforce shortages, it also helps fill essential gaps in Florida's job market with our vibrant seniors. So, I absolutely love this program.

Our centralized long term care ombudsman program, among other programs, plays a pivotal role in safeguarding our seniors from abuse, neglect, fraud, and exploitation. And this wonderful volunteer based program works tirelessly to protect, defend, and advocate for Florida's seniors living in the state's 4,000 long term care communities.

In summary, Florida is proud to be the most senior friendly State in the country, with the Older Americans Act serving as one of the most critical keystones of Florida's efforts to support and protect Floridians as they continue to age.

As Secretary of the Department of Elder Affairs, I have seen firsthand how our Governor has shown unwavering dedication to seniors from his time in Congress, all the way through the groundbreaking initiatives as Governor, like our Dementia Action Plan and the Florida Alzheimer's Center of Excellence.

He has reinforced training standards for senior care, increased funding for our memory disorder clinics throughout the state, and enacted comprehensive reforms to Florida's prescription drug market.

Florida, under his leadership, remains at the forefront of next generation initiatives, program explorations, critical funding, executive and legislative support, and collective research that promotes not only aging but aging well for all residents of the Sunshine State. I am happy to answer any questions at this time. Thank you.

[The prepared statement of Ms. Branham follows.]

PREPARED STATEMENT OF MICHELLE BRANHAM

Introduction

Chairman Sanders, Ranking Member Cassidy, esteemed Committee Members, and fellow panelists, I appreciate the opportunity to discuss how Florida champions seniors and the important role of the Older Americans Act in supporting our elderly population.

Florida, with over 6.3 million residents aged 60 and above, stands as a premier haven for seniors, ranking among the Nation's fastest growing and third most populous states. As the Secretary of the Florida Department of Elder Affairs, I am truly grateful for Governor Ron DeSantis' unwavering commitment to prioritizing our seniors.

Our agency is at the forefront, steering initiatives to ensure the dignity, independence, and fulfillment of Florida's senior population. Operating as the designated state unit on aging, our goal is to provide an environment where seniors can maintain their independence within their homes for as long as possible, fostering a contented, healthier lifestyle while promoting fiscal responsibility.

Under the leadership of Governor Ron DeSantis, Florida leads nationally in addressing Alzheimer's and other related dementias, with pioneering initiatives, a first in the Nation mobile outreach program, and significant funding increases, reflecting our commitment to those impacted by Alzheimer's and related dementias. Our agency oversees $511 million in state and Federal funding, including $154 million from the Older Americans Act, aiming to enable older adults to age in their homes and contribute vibrantly to Florida's communities through our collective efforts in the Aging Network.

Older Americans Act in Florida

As you know, the OAA tailors a range of services for seniors and caregivers, providing in-home and community-based support to address cognitive decline, individual needs, and foster social connections and reduces isolation, which has led to increased participation in various centers across Florida. **While the Department continues to review the new OAA rule and its potential fiscal impact, I urge Congress and HHS to work closely with states to ensure these new regulations do not unnecessarily hinder the progress Florida has made over the past three decades**.

Supportive Services

OAA funds provide crucial support for seniors, promoting independence at home and in the community. Services encompass transportation, outreach, and information, as well as in-home assistance like homemaking, home health aide support, companionship, and telephone reassurance. Additionally, services include home repairs, chore assistance, respite care, and specialized support for families facing Alzheimer's and related dementias.

Home-Delivered and Congregate Meals

In fiscal year 2022–2023, over 10 million OAA-funded meals were provided, addressing the need for senior nutrition. Recognizing that a meal is more than sustenance, these programs make a significant impact on the lives of older residents. Home-delivered and congregate meals not only enhance physical health but also combat loneliness and social isolation, offering vital opportunities for socialization and engagement. With over 300 congregate meal sites in Florida, thousands of meals are served daily, fostering a sense of community and connection for our elders.

Florida's Dementia Care and Cure Initiative (DCCI)

The Department of Elder Affairs and the Aging Network, mandated by the Older Americans Act, play a crucial role in coordinating aging services at the community level. Governor DeSantis showcases his commitment through initiatives like the Dementia Care and Cure Initiative (DCCI), addressing the significant impact of Alzheimer's in Florida. The DCCI establishes Dementia-Caring Communities, providing training and support. Governor DeSantis solidified this commitment with a five-point Dementia Action Plan in 2019, leading to the recent establishment of the Florida Alzheimer's Center for Excellence in June 2022. Operated through the Depart-

ment of Elder Affairs, this center marks a milestone in Florida's ongoing efforts against dementia, serving as a template for other states.

Health and Wellness

Florida's health and wellness programs empower seniors and caregivers with impactful interventions, fostering informed decision-making and proactive health practices. These initiatives, emphasizing medication management and lifestyle interventions, play a crucial role in averting nursing home placements. By preventing and managing chronic health conditions, these programs contribute to the sustained health and vitality of Florida's aging population, aligning with the objective of enabling older Americans to age in their preferred homes and communities.

Caregiver Support

Through OAA, Florida caregivers receive tailored support, including respite, adult day care, and assistance in health, nutrition, and financial literacy for individuals aged 60 and older. Caregiver Supplemental Services extend aid to caregivers of vulnerable individuals aged 60 and older or grandparents caring for grandchildren. Grandparent or Non-Parent Relative Support Services aid these caregivers, providing training, child day care, counseling, legal aid, and transportation.

Senior Community Service Employment Program (SCSEP)

The Senior Community Service Employment Program aids unemployed or low-income Floridians aged 55 and older, addressing job market challenges. With dual goals of community service job training and transitioning participants to unsubsidized employment, the program fosters economic self-sufficiency, contributing to Florida's workforce vitality. A key aspect is filling workforce shortages, making it mutually beneficial. Participants engage in community service activities at non-profit and public agencies, gaining valuable experience. In fiscal year 2022–2023, the Department received over $4.7 million in OAA funding to sustain this vital program.

Elder Abuse Prevention Program and Long-Term Care Ombudsman Program (LTCOP)

The Elder Abuse Prevention and Long-Term Care Ombudsman Programs, mandated by OAA Title VII in Florida, are pivotal in safeguarding seniors from abuse, neglect, and exploitation. While not directly involved in abuse investigations, the Department prioritizes prevention and education initiatives, with coordinators disseminating information statewide. The volunteer-driven Long-Term Care Ombudsman Program advocates for individuals in long-term care, emphasizing abuse prevention.

Prioritizing the Well-Being of Florida's Most Vulnerable Seniors

The OAA is a vital funding source for serving older Floridians, emphasizing responsible fund utilization. Prioritizing vulnerable seniors is facilitated by Population Maps, custom GIS maps for each Area Agency on Aging. These maps, integrating census and client data, identify concentrations of seniors needing assistance.

Summary

Florida proudly stands as the most senior-friendly state in the country, with the Older Americans Act being a key element in our efforts to address the needs of our seniors through their golden years. As Secretary of the Department of Elder Affairs, I have seen firsthand how Governor Ron DeSantis has shown unwavering dedication to seniors from his time in Congress through his groundbreaking initiatives like the Dementia Action Plan and the Florida Alzheimer's Center of Excellence. He reinforced training standards for senior care, increased funding for memory disorder clinics, and enacted comprehensive reforms to Florida's prescription drug market. Florida, under his leadership, sets a resolute example for other states to follow in prioritizing and supporting seniors.

I am happy to answer any questions you may have. Thank you.

[SUMMARY STATEMENT OF MICHELLE BRANHAM]

It is exciting for us to share our story, because, as you may know, Florida remains the top destination for seniors, boasting a population of over 6.3 million residents

aged 60 and older out of our 22.2 million residents. The Sunshine State is the second fastest-growing state in the Nation, also ranking as the third most populous state in the country and surpassing the populations of 15 other states combined. It's amazing to think that every day, an estimated 1,000+ individuals choose Florida as their new home; and nearly a quarter of these new Floridians are aged 60 and older.

With this ever-growing senior population continuing to age in our great state, I am proud to serve as the Secretary of the Florida Department of Elder Affairs (DOEA) during this time of continued advancement. Appointed by Governor Ron DeSantis in 2021, I have spent these past years in the field working closely with our Area Agency on Aging (AAAs) partners and their providers in our state's vast aging network.

Governor DeSantis' ongoing and steadfast commitment to prioritizing and supporting the needs of Florida's seniors has provided a well-forged path for our Agency. His unwavering dedication to enhancing the quality of life—for older adults across our state—underscores the tremendous value he sets on aging in place. With his leadership, Florida's mission continues to be that all of us—as we continue to get older—live in the place of our choosing, for as long as we choose, understanding that this essential concept undoubtedly frames our overall happiness, wellness, and comfort in later years. With support also from Florida's legislature, our Agency is empowered and funded to advance initiatives and services that ensure dignity, independence, and fulfillment of Florida's expansive senior population.

Our Agency plays a pivotal role as Florida's designated, stand-a-lone state unit on aging, a distinction not shared by all states—but further showcasing the immense value and importance placed on Florida's older adults. We serve as the primary state agency for administering human services and programs specifically tailored to meet the needs of our cherished seniors. A primary objective at the Department is to ensure our aging adults can maintain their independence, remaining in the comfort of their own homes for as long as possible. This not only fosters happier and healthier lives for us and our families as we age, but also promotes fiscal responsibility in the state and its communities—as aging in place is the most affordable and cost-effective option in choosing how we live in later years.

The DOEA oversees more than $511 million in state and Federal funding—including more than $154 million in funding from the Older Americans Act (OAA). We partner with our 11 (AAAs), 48 Lead Agencies, and thousands of direct service providers across Florida to assist seniors with the OAA, other Federal funding, and state-funded programs and services. This culmination of critical and collective offerings aims to wrap support around our older adults and their families so that our seniors can remain in their own homes as long as possible and continue to be vibrant contributors to our state's communities, no matter their age. Together, we lead Florida's Aging Network, leveling up as a collective team to meet the needs of an ever-changing and often difficult aging infrastructure that produced a host of challenges. Across the Nation, all aging networks feel the systemic presence of workforce shortages, senior homelessness, provider/lead agency challenges and funding shortfalls. With this, we are convinced Florida must work, not only to ensure we are monitoring our partners, but also providing them with key tools and acumen to stand them up for success. Our Agency, and our state, believe that leveling up together as an aging network will continue to guide our pathway to excellence in our service to seniors.

The CHAIR. Thank you very much. It appears that the technical problems with Ms. Hutchins were at our end, not at her end. And so, with that, we welcome back, Ms. Hutchins.

STATEMENT OF DOROTHY HUTCHINS, VIRGINIA OLDER ADULT, ALEXANDRIA, VA

Ms. HUTCHINS. My name is Dorothy Hutchins. In July, I will be 94 years old. I live alone, but I am blessed to have a large supportive family. I have 5 children, 17 grandchildren, and 27 great grandchildren.

I started my career in 1952 as a young geologist, part of the women's salary geologist at the time with the Geological Survey. I

wrote Gemstones of the United States under my maiden name, Dorothy Schlegel in 1956.

One highlight of my career was mapping the Verde Quadrangle in the deserts of Arizona. When my husband passed away in 1973, I retired from geology and stayed home with my family. I have gone on to live on services under the Older Americans Act since the early 1990's.

I attended two different local senior centers, Lincolnia in Alexandria and Bailey's in Falls Church. I was able to drive myself. At the senior centers, I would play bridge, take exercise classes, eat lunch with my peers, and participate in events on holidays and special occasions. The work they do is so important and should be available to all seniors.

I started attending the senior centers during COVID. During that time, I found out that I was eligible to receive meals delivered to my home. On Thursdays, six frozen dinners and six lunches are delivered to my home.

The same young woman from Peru comes every week and we chat a little. The food meets my needs and sometimes more than I can eat in one sitting. I fell and hurt my hip in January 2021. I then got surgery 1 week later.

After rehab, I came out and walked with a walker. Almost exactly 1 year later, I fell again and had another show started and rehab. I have had to be very cautious since my falls. I don't wear shoes in my home.

I wear a life alert around my neck and only shower when someone is in the house with me. I am fortunate to receive occupational and physical therapy in my home. I since stopped driving and can no longer attend the senior centers. I do get a little lonely. I lost my husband early in our marriage and I am an only child.

Most of our friends are dead. I have one friend in Syracuse in a senior living community. But she pays $8,000 each month and I can't afford that. I used to go to church every week, but I don't go to church anymore in person. I am able to watch it on my tablet.

I stay busy and I like to learn. I have a friend across the street brings me The New York Times and Wall Street Journal every day, and I get the Washington Post. I have plenty to read. I also do the crosswords and watch a lot of TV.

I have been in my home for 61 years. Thanks to my family support and services provided to me by the Fairfax area Agency on Aging, I am able to be independent and continue to live in my own home. I am also blessed not to have serious health problems.

Everyone deserves a chance to live more of a great choose, and for most of us, we want to remain in our home and communities. The services provided under the Older Americans Act make that possible for me and many other seniors.

I hope that Congress will continue to support this important work. Thank you, and I am happy to answer your questions.

[The prepared statement of Ms. Hutchins follows.]

PREPARED STATEMENT OF DOROTHY HUTCHINS

Chairman Sanders, Ranking Member Cassidy, and Members of the Committee, thank you for inviting me to testify today. It is an honor to be testifying from my home in Alexandria, Virginia, today.

My name is Dorothy Hutchins. In July, I will be 94 years old. I live alone, but am blessed to have a large supportive family. I have 5 children, 17 grandchildren, and 27 great grandchildren.

I started my career in the 1952 as a young geologist, part of the Women's Auxiliary Geologists at the time with the U.S. Geological Survey. I wrote "Gem stones of the United States" under my maiden name, Dorothy Schlegel, in 1956. One highlight of my career was mapping the Verde quadrangle in the deserts of Arizona. When my husband passed away in 1973, I retired from geology and stayed home with my family.

I have benefited from services under the Older Americans Act since the early 1990's. I attended two different local senior centers, Lincolnia in Alexandria and Bailey's in Falls Church, and was able to drive myself. At the senior centers, I would play bridge, take exercise classes, eat lunch with my peers, and participate in events on holidays and special occasions. The work they do is so important and should be available to all seniors.

I stopped attending the senior centers during COVID. During that time I found out that I was eligible to receive meals delivered to my home. On Thursdays, six frozen dinners and six lunches are delivered to my home. The same young woman from Peru comes every week and we chat a little. The food meets my needs and is sometimes more than I can eat in one sitting.

I fell and hurt my hip in January 2021 and had surgery 1 week later. After rehab I came home and walked with a walker. Almost exactly 1 year later I fell again and had another surgery and rehab. I have had to be very cautious since my falls. I don't wear shoes in my home, I wear a life alert around my neck, and only shower when someone is in the house with me. I am fortunate to receive occupational and physical therapy in my home.

I've since stopped driving and can no longer attend the senior centers. I do get a little lonely. I lost my husband early in our marriage and am an only child. Most of my friends are dead. I have one friend in Syracuse in a senior living community, but she pays $8,000 each month and I can't afford that. I used to go to church every week, but I don't go to church anymore in person. I am able to watch it on my tablet though.

I stay busy and I like to learn. I have a friend across the street who brings me his New York Times and Wall Street Journal every day and I get the Washington Post. I have plenty to read. I also do the crosswords and watch a lot of TV every day, too.

I have been in my home for 61 years. Thanks to my family's support and the services provided to me by the Fairfax Area Agency on Aging, I am able to be independent and continue to live in my own home. I am also blessed not to have serious health problems.

Everyone deserves the chance to live where they choose, and for most of us we want to remain in our homes and communities. The services provided under the Older Americans Act make that possible for me and many other seniors. I hope that Congress will continue to support this important work.

Thank you and I'm happy to answer your questions.

The CHAIR. Well, thank you very much, Ms. Hutchins, and we apologize for the technical problems. And you are a great witness. We appreciate it. Now, we begin our round of questions.

Let me start off with a very simple one to all of the expert panelists who are here, and Ms. Hutchins can jump in as well. What all of you have discussed is that we have a growing senior population, we have millions of seniors who have hunger issues, literally some dealing with malnutrition.

We have people who are staying home, who are lonely, who are isolated. We have people who are falling, causing serious injuries.

Do any of you doubts that investing in prevention—I mean, this is America.

I mean, we shouldn't be talking about the need to keep seniors from going hungry. That should be a given, I would hope, in the wealthiest country on earth. When we talk about doubling funding for the Older Americans Act, yes, we are talking about $2 billion, a lot of money.

Do any of you doubt that investment will not end up saving taxpayers money by preventing hospitalizations or nursing home visitation—nursing home care when people want to stay at home? Let me start with Ms. Alwin and we will go right down the line.

Ms. ALWIN. Well, thank you. Thank you for the question and thank you for elevating the issue. For over 55 years, the Older Americans Act has demonstrated a unique ability to provide these robust services, and, frankly, protect and enhance some of the other Federal resources.

The preventative service means savings for Medicare and Medicaid. And on average, the Older Americans Act funding represents less than one-third of 1 percent of all Federal discretionary spending, and yet the return on investment is amazing.

The local and state providers leverage other state resources, local resources, philanthropic as well as volunteers, providing services annually to over 11 million older adults and their caregivers.

The CHAIR. My question is——

Ms. ALWIN. Let's double——

The CHAIR [continuing]. Is the investment going to save money?

Ms. ALWIN. It is absolutely going to save money.

The CHAIR. Okay.

Ms. Hollander.

Ms. HOLLANDER. 100 percent. Absolutely. The best investment that we can make. It is a program that has worked, and it is continuing to keep people out of emergency departments, readmissions, admissions, and premature nursing home placements. It is a no brainer as far as I am concerned. You invest more, you will get a huge return on that investment.

The CHAIR. All right. While you have the mic, let me ask you this, in Vermont, and I think around the country, there are waiting lines to get into the Meals on Wheels program. Can you say a word about that?

Ms. HOLLANDER. Well, the waiting list is because, the resources aren't there. Programs are doing their very best to, if they need to, cut back, scale back so they can serve more seniors in need.

But the fact is that the resources have never kept pace. You mentioned that earlier, about the reduction 20 percent over time. And the population is growing, and we have never really adjusted for inflation.

With the pandemic, of course, everything is more expensive. All the things that are required to prepare, to deliver, to procure meals and food to do it. But I think the other thing I just want to mention real quick is it isn't just about the meal, right?

It is about those people that are needing to have socialization, social connectedness. Both of those have——

The CHAIR. Okay. I wanted to go down the line. Thanks very much, Ms. Hollander.

Dr. Kubik.

Dr. KUBIK. Yes. Senator Sanders, there is no question that, preventing an issue is preferred over waiting until an issue occurs. Unfortunately, our health care delivery system has mostly been set up to respond to conditions rather than prevent.

But as a public health professional, there is no question in my mind that continued support of the OAA for food, nutrition, and extended services is exactly what our seniors and our growing population of seniors need in order to stay home, and age well, and age in place.

The CHAIR. Thank you. Ms. Branham, does investing in prevention save money long term?

Ms. BRANHAM. Thank you, Senator Sanders. I think for us, we just went through a workshop with our Area Agencies on Aging, so I think maximizing the dollars that we have is something that is critical to me.

Making sure that our Aging Network knows how to spend, has the ability to spend, and the confidence to spend. So, right now we are focusing on maximizing the dollars that we do have, and I do think interventions are very helpful.

The CHAIR. Okay. Let me say a word. I have visited, as I think probably every Senator here has, senior centers and congregate meal programs. I love them. Are they getting the resources they need to pay for the meals that they serve?

Ms. Alwin.

Ms. ALWIN. Sure. With 12,000 people turning 65 every day, there is increasing demand. And as was shared, it is tough to keep up with the cost of inflation. There is growing demand, there are growing costs.

We need to elevate the support and funding both for congregate meals and home delivered. There is not enough support.

The CHAIR. All right. My time is expiring. Last question, in Vermont we have some senior centers that are doing really great. Some are really struggling in the rural areas. They just don't have the funding. Do we have the network of senior centers all over this country, the robust network that we need to satisfy the needs of seniors in general? Who wants to answer that one? Yes.

Ms. BRANHAM. Thank you, Senator. We have the network, 11,000 senior centers, but there is no designated funding stream for senior centers.

A third, if they are fortunate, receive dollars from the Area Agency on Aging, a third from Parks and Recreation, and the final third are left to their own devices to fundraise and scrape resources together. So, the quality of services, the options available varies greatly by your zip code. It doesn't have to be that way.

The CHAIR. Okay. Thank you very much.

Senator Cassidy.

Senator CASSIDY. I defer to Senator Collins.

Senator COLLINS. Thank you very much, Dr. Cassidy. Dr. Kubik, an issue that we, the panel has not discussed, but which Mrs. Hutchins brought up is the problem of falls among our seniors.

This often starts a spiral of downward health and is very serious. The Older Americans Act Title 5 or 4, I guess it is, does provide some funding to try to support health independence and longevity activities.

I know in the State of Maine, the Aroostook County Area Agency on Aging offers classes called a matter of balance, which is evidence based. And the Bangor Y also offers similar courses.

Can you tell me how important it is for us to try to ensure that there is funding to support programs to prevent falls, which can have such devastating consequences?

Dr. KUBIK. Yes. Thank you, Senator Collins, for the question. I think as our guest from Alexandria indicated, two falls 2 years in a row and with, good health care, good medical care, good support at home from an occupational therapist, likely a physical therapist, she has been able to stay at home.

But again, as we bump up the number of us who are over the age of 65, who are having varying levels of decline physically, if we can prevent and maintain mobility, if we can maintain safe mobility, if we can—what the nursing students have done with the seniors is they take them for a walk, they accompany them on a walk. And during those accompanying walks, you can talk about safety.

You can talk about preventing falls. We also implemented foot care at all the clinics. So, if you can take care of your feet, you have a firmer base to walk on, which is often overlooked when we go to primary care offices. So, I think it is critical that we work and prioritize fall prevention among our seniors.

Senator COLLINS. Thank you. Secretary Branham, welcome. We have worked together on Alzheimer's disease in the past and it is good to see you today. I want to talk about another issue that has been alluded to but not focused on, and that is the problem of widespread loneliness among American seniors.

We know that poses health risks that are as deadly as smoking 15 cigarettes a day. Social isolation and loneliness have been estimated to shorten a person's life span by as many as 15 years, and loneliness and isolation have also been linked to cognitive decline and an increased risk of dementia.

That problem was exacerbated during the pandemic, but even before the pandemic, approximately one in four older Americans suffered from loneliness. We tried to respond to this in the 2020 reauthorization of the older Americans Act, which I was a coauthor, but I am interested in hearing from you what more we could do.

Congregate feeding areas, meals, obviously help. Visits from home health nurses help enormously to have wellness checks, but also checking in. Delivering meals on wheels helps. But what else would you suggest?

Ms. BRANHAM. Thank you for the question, Senator Collins. I loved working with you. I think that is a major issue, and spending so much time in the field, seeing these vibrant senior centers open

with music and congregating and being together and taking tai chi classes and mobility classes for falls prevention, learning new things, learning IT, all of that has done a tremendous job in improving because isolation, loneliness, and depression is something that we saw even with our most vulnerable population to a degree that was just so sad. And I think there is so much more that we can do.

We talked about the companionship care, not just delivering a meal, but sitting there, talking with the person, making that meal more of an opportunity, an event, than just putting something down there. So that has been tremendous.

Even with a more flexibility with OAA, being able to grab and go and taking that home and maybe sitting down with a person in a park, having those capabilities and flexibilities with the new OAA rule has been significant and our Area Agencies on Aging love that.

But I think making sure that we have senior centers that are vibrant, adult day centers that are vibrant, help to mitigate the impact of isolation, loneliness, and depression. And there is absolutely more that we can continue to do.

Senator COLLINS. Thank you.

The CHAIR. Thank you, Senator Collins.

Senator Casey.

Senator CASEY. Mr. Chairman, thanks very much for calling this hearing. I want to thank you and Ranking Member Cassidy for the work that goes into and your teams' work to the planning of this hearing.

Of course, we want to thank our witnesses and thank both the Committee leadership as well as our witnesses for uplifting the Older Americans Act. A landmark piece of legislation that a lot of Americans only hear about every few years, so it is important for us to uplift it and celebrate how important it is, but also to make sure that we get this reauthorization right.

As Chairman of the Senate Aging Committee, I have worked on a bipartisan basis with colleagues over many years now to reauthorize the Older Americans Act before, and I am working again, and I am grateful to be at the negotiating table once more to begin this reauthorization process.

I think we can all agree, despite all of our divisions in the Senate and the House, I think we can all agree that older Americans deserve to age with dignity, and it is our obligation—it is not optional. It is an obligation, to make sure that we are doing everything possible to make that a reality.

I wanted to start with Ms. Alwin and Ms. Hollander about the question of the strategic plan for aging. As you both know, our population is aging so rapidly, and your testimony highlights that reality. Local communities and states still need to be able to provide more services and more supports to older adults in the years ahead.

We have heard testimony already, Ms. Hollander, about your good work at Meals on Wheels, and Ms. Alwin, on the National Council on Aging. Both provide invaluable services for older adults

and are critical to supporting our older adults as they continue to age.

Across the country, states, including my home State of Pennsylvania, have been working on multi-sector—so-called multi-sector or master plans for aging. These plans bring stakeholders, both public and private stakeholders, together to coordinate service delivery and transform infrastructure to better meet the needs of our aging population.

I recently introduced with Senator Gillibrand the Strategic Plan for Aging Act. Our bill would provide funding for states that are developing or implementing these long term care, or long term plans I should say, for aging.

We want to thank both Meals on Wheels and NCOA for your endorsement of the bill. I will be pushing to include this legislation in the reauthorization of the Older Americans Act.

Start with Ms. Alwin. How could long term planning and improved coordination across all levels of Government better support states, local providers, and of course, the older adults that they serve?

Ms. ALWIN. Well, thank you, Senator. Thank you for the question and for your leadership with the Special Committee on Aging and with the important legislation that really elevates lessons from these multi-sector plans.

We applaud that good innovation going on across the country and recognize there is an opportunity to pull that through into the reauthorization of the Older Americans Act. Because aging well means addressing all the domains of aging well, and long term planning around all the domains, as the multi-sector plans have initiated, is really an important step to make the most of the limited resources available and coordinate across Federal, state, and local administering agencies.

We also applaud the great work of the Administration on Community Living for leveraging the Inter Agency Coordinating Council opportunity already made available through the Act, really modeling that Federal coordination across the various departments that states have initiated with the multi-sector plans.

When those conversations and those stakeholders are around the same table, we can have thoughtful conversations about the demographic trends and provide more preventative services and supports, bringing in a greater savings ultimately and improving the quality of life.

Senator CASEY. Thank you.

Ms. Hollander.

Ms. HOLLANDER. I think Ramsey did a nice job of summarizing the benefit of that. I would say, from someone who is actually going through a strategic planning process for my own organization, I know how important it is to make sure that there is alignment, that all the stakeholders are at the table, and that you are creating, a plan that is flexible and adaptable because we have a very rapidly changing demographic in our Country. It is an explosion.

As you know, we have just been talking about the senior population, but there is also far greater diversity, and we need to have plans at the state level that are able to flex to that change.

I would just say that one of the things I think is really important is rather than having individual plans, there has to be some opportunity to look for cross organization—cross state synergies to be able to leverage those synergies, those learnings, but also to bubble up where there are gaps so that at the national level there is symbiotic planning between what is happening at the national level, what is happening at state levels.

I only want to caution that to say that we need to have people at the table that are sharing that information across, and I would also say one more thing, which is a plan is a living document, and what we can't do is put all our time into developing a plan.

We have to make sure part of that is making sure that we are accountable for delivering on that plan, tracking that plan, and making sure that we make adjustments along the way.

Senator CASEY. Thank you, Mr. Chairman.

The CHAIR. Thank you.

Senator Hassan.

Senator HASSAN. Well, thank you, Mr. Chairman. And thanks to you and the Ranking Member for holding this hearing. To all of our witnesses, thank you very much for your excellent testimony. Mrs. Hutchins, I wanted to start with a question for you. I want to highlight the epidemic of loneliness in our Country, which as we have been talking about, especially impacts older Americans.

A recent study shows that more than one in three older adults report feeling lonely or socially isolated. Loneliness not only has negative impacts on mental health, but can also lead to increased risk for dementia, heart disease, and stroke.

Mrs. Hutchins, you talked about your challenges with loneliness, about your personal experience with it. What tools and supports do you find most helpful in combating social isolation?

Ms. HUTCHINS. I am thinking.

[Laughter.]

Ms. HUTCHINS. I have periods of loneliness, but I have lived a long, very interesting life and I have many wonderful memories that I fall back on when I get lonely. And I, of course, talk on the phone to my family and my one friend who is up in Syracuse. And I watch certain programs on TV, and I make it through the day.

I am just grateful to have my son and my grandson stopping in from time to time and it is—and my church. I just try the best I can to make it through the day. But I have not been depressed. So, I just, if I feel a little low, I will just think of some wonderful thing that has happened to me in the past and that gets me over it. But most of the time, I am in good spirits.

Senator HASSAN. Well, that is excellent. And I think one of the things you are really describing is the importance of that social interaction, even if it is just by phone or seeing people and really having that connection is very important.

Ms. HUTCHINS. Oh, yes. I enjoyed the senior centers so much. I went for 20 years to Lincolnia.

Senator HASSAN. Yes.

Ms. HUTCHINS. Played bridge, art classes. I even volunteered on the desk, and it was very rewarding. I was there at least 3 days a week.

Senator HASSAN. Well, thank you.

Ms. HUTCHINS. Their meals were very good, too.

Senator HASSAN. Yes. Thank you very much for that. I want to turn to Secretary Branham now. One way to address loneliness is to create more opportunities for social connection across different generations.

One senior community in Hanover, New Hampshire, called Kendal at Hanover hosts a day care and early education program for children up to 6 years old. This model, also called intergenerational care, gives seniors the opportunity to volunteer in the classroom and participate in social activities with very young students.

For residents who enter the facility alone or who are experiencing health issues and may be more prone to social isolation, volunteering in the classroom and interacting with the kids has become their favorite part of the day.

Intergenerational programs can obviously benefit both of our seniors and our young people by giving them opportunities to build new relationships and learn from each other. So, Secretary, can you speak to how intergenerational care programs like this can be useful in combating loneliness?

Ms. BRANHAM. Yes. Thank you, Senator. I love our senior volunteer program. First, here at the department, we have seniors providing care for seniors. So, a lot of companionship care and I absolutely love that volunteer program.

We have so many testimonies from across the state of that because it is more than just, like I said, dropping off a meal. It is taking time to read or bake cookies and spend time. But on the intergenerational side, I think it is really exciting because through the First Lady of Florida's initiative, we have a mentoring program.

Seniors mentoring children at risk, children in the elementary school system, and children graduating out of foster care who need assistance. And I think that intergenerational connection has been a win, win, both for the people, the young people, the families surrounding them, and the seniors. So, it has been really exciting to watch that.

Senator HASSAN. Well, excellent. Thank you. And finally, to Ms. Alwin, I want to focus a little bit on family caregivers who obviously play such a central role in caring for loved ones. Congress recognized the key role of family caregivers when it added the Family Caregiver Support Program to the Older Americans Act in 2000.

It is critical that we reauthorize and build on the caregiver resources provided through the Older Americans Act to ensure that families have the support that they need. That is why I joined my colleagues in pushing for policies that support caregivers, such as

the Credit for Caring Act, which would give much needed tax relief to family caregivers. What are the other ways, Ms. Alwin, that Congress can support family caregivers?

Ms. ALWIN. Fabulous. Well, thank you for your leadership in introducing that important legislation, Senator. There are many different actions Congress can place, and we are supporters of the Raise Coalition and the incredible release of the National Family Caregiver Strategy, where there are over 350 actions that can be taken by Federal agencies already today to better support family caregivers.

Many of the services and supports provided by the Older Americans Act help those family caregivers. So, reauthorizing the Older Americans Act, doubling the funding so those services and supports, including respite care, are available to family caregivers is critical.

Senator HASSAN. Well, thank you very much, and I would add my support for respite services. They are really, really important. Thank you.

The CHAIR. Thank you, Senator Hassan.

Senator Cassidy.

Senator CASSIDY. Thank you, Chairman Sanders. And thank you all for being here. Really a great mission. Ms. Hutchins, you kind of inspire us all to live that better life. Secretary Branham, believe me, I just met with some fast food folks. They are talking about the cost of labor.

We know that inflation has really bit—I am sure it has bit your budget too. And yet, with all this growing population, you are expanding services. Clearly, you are collaborating with others. Can you speak about that collaboration? What are best practices?

Ms. BRANHAM. Something that we just—thank you, Senator, for the question. It is something that we just did is our SCSEP program out of OAA has been connected to career source.

Senator CASSIDY. SCSEP program. Please, for everybody watching who doesn't know acronyms?

Ms. BRANHAM. Yes. It is the Senior Community Employment Program. We love our acronyms. So that program has been really paramount for us because it takes seniors back into the workforce, educates and trains them, pays them while we are doing it, and then really helps with the gaps in service that we are seeing in Florida.

Now, we have added that SCSEP program, those seniors that are in the program, into Career Source Florida, so that we can really look at all the gaps across all of the industries in Florida.

Senator CASSIDY. If you will, you are not competing for the person who might be doing lawn work out there, but rather you are taking a group of folks who would have maybe more empathy with the clientele, and you are giving them another chance at employment.

Ms. BRANHAM. Yes, sir. And usually, I see through our SCSEP program, seniors helping seniors, and they traditionally go into the social work environment, which I really enjoy watching.

Senator CASSIDY. Yes. I know this is a different Committee, but do you run into problems with the retirement earnings test in which they get a decrease in their Social Security payment if they go back to work? Are you familiar with that?

Ms. BRANHAM. No, sir. I am not.

Senator CASSIDY. Dr. Kubik, I am a doc. I love the idea that you are using—you are finding the win, win, win, if you will. Elaborate a little bit on that, please.

Dr. KUBIK. I definitely agree, it is a mutually beneficial partnership. I think that we can do so much more to connect our health profession students to our seniors and our aging population. At this point, their exposure is mostly when that person is in the emergency room or in the hospital, very vulnerable, very frail.

Most of our seniors are not frail. Most of them are wanting to stay at home, wanting to be successful, wanting to be healthy, wanting to be productive, wanting to be able to go and visit with their friends and socialize.

Senator CASSIDY. Now, did I hear you correctly that you have lowered systolic blood pressure to 20 points?

Dr. KUBIK. Yes. Six point, almost. Yes. As you know, most of the high blood pressure we get when we get older is the top number. Our systolic blood pressure goes up.

Senator CASSIDY. That is the top number.

Yes. That is a bottom number for people who——

Dr. KUBIK. Right. So, we lowered that top number by almost six points in the group that received the ageWELL program.

Senator CASSIDY. Now, did you do that just by making sure they were compliant, by looking at their diet, and making sure they weren't eating Fritos for breakfast?

Dr. KUBIK. No. The intervention, the work that we did with the nursing students, it wasn't just one thing. It was a lot of medication management. Every week they were there, they were checking blood pressures.

We were writing blood pressures down. We were encouraging them to take their lists to their health care provider. We were getting up and walking with them. So, it wasn't just showing them exercise, it was taking them and exercising with them. So, in my opinion, it was all that coming together.

In our work, most of our seniors were taking three to five medications or more every day. Whether they needed all those medications or not is something that we need to look further into, but it is a challenge to manage all these chronic conditions that they have.

I think the feedback and the engagement that they were having with the nursing students was an incentive to, perhaps eat better, to be more active.

Senator CASSIDY. By the way, and I forget again, it was you or Ms. Hutchins, because I forget, but I think one of you said something about making sure that you minimize the risk for falls. I think about these throw rugs that are easy to slip upon and somebody breaks their hip.

Dr. KUBIK. Right. Exactly.

Senator CASSIDY. Or fall and——

Dr. KUBIK. That is right.

Senator CASSIDY. Let the record show I slapped my head. And so, if nothing else, you are creating that awareness among those who are——

Dr. KUBIK. Yes.

Senator CASSIDY. A comment on that, please.

Dr. KUBIK. Well, I think it is, again, that one on one engagement between the senior and the nursing student allowed the senior to prioritize concerns, but it also provided the nursing student an opportunity to provide prompts.

Tell me about safety in your home. Tell me about how you manage moving around your furniture and cooking and storing and putting things away. Next week, when you come back, let's talk about that some more. That is the other opportunity that the nurses take——

Senator CASSIDY. I am almost out of time, but I started off speaking about a partnership with an outside agency that would actually extend and leverage the dollars. And then you just gave us another great example of how that is actually training our next generation of nursing students. So, thank you both, and thank you all.

The CHAIR. Senator Markey.

Senator MARKEY. Thank you, Mr. Chairman. My mother had Alzheimer's. My father was a milkman. My mother was president of the senior class. So, my father said, Eddie, it was an honor that your mother married me. She is a brilliant woman.

She has Alzheimer's. There is something wrong. Shows you that the strongest brains can be attacked. So, we are going to keep her in the living room. That is going to be our job. She is never going to go to a nursing home at age 80, 82, 84, 86, 88, 90. And here is a milkman. So, the right arm of a milkman is like my upper thigh. He could do it. But it is hard. And so, all he had was a visiting nurse 1 hour a day.

23 hours, we had her in the living room. Very difficult. So, with Senator Wyden, I created a program called Independence at Home to help people with chronic illnesses to have the dignity of staying in their homes.

Ms. Branham, can you share how the Older Americans Act in-home services and outreach programs for individuals with Alzheimer's and others can provide for their families at home?

Ms. BRANHAM. Thank you, Senator Markey, for the question and touching my heart. I spent 10 years at the Alzheimer's Association alongside people living with the disease and their caregivers.

Some of the most courageous people I have ever witnessed. Yes, I think living at home and being able to stay at home is the best possible concept for someone living with dementia, but it is really hard to do that by yourself. And I applaud your father for doing that. So, having those wraparound services is not something that just the OAA provides.

But here in Florida, the Alzheimer's Disease Initiative is something that we fund. It has increased funding each year for—to supplement OAA for services like that, because staying at home and wrapping around care and services is not just for the person living with the disease, but the caregiver too, is really, really significant.

Senator MARKEY. Yes. And again two-thirds of Alzheimer's patients are women. It is a one-third, two-thirds split.

Ms. BRANHAM. Yes.

Senator MARKEY. There is a lot of work to be done to figure out what is going on here because women are the caregivers. In general, it is a reverse, and there aren't enough men to—that can do that for all those women.

I led my colleagues in writing to the U.S. Department of Agriculture and the Social Security Administration asking them to make it easier for seniors and people with disabilities applying for Social Security benefits to also get SNAP benefits.

My goal is to make sure that because they didn't know they could get help or got mixed up trying to fill out their paperwork. Ms. Hollander, in your testimony, you mentioned that over four in five low income food insecure are not receiving the meals that they are eligible because of long waitlists.

Meanwhile, you noted that various funding streams with different requirements and standards can make it very hard for nutrition service providers to partner with others in the community and tailor older Americans' meals to their specific health needs.

Can you elaborate on that and what has to be done in order to make sure that we make it easy for people to get access?

Ms. HOLLANDER. Thank you for the question, Senator Markey. Yes, I think we are talking about an older population that generally 76 on average. Most of whom are women, as a matter of fact.

I think some of the, for example, SNAP applications and so forth is a little more complicated for them than it is for others. But I, actually Senator Casey left, but I think he put forward recently an act to help facilitate that process, the Senior Hunger Prevention Act.

But I think just generally speaking, making sure that we have people that are working with seniors, that are familiar with all of the various benefits that might—they may be eligible for is very important, and making sure they are educated to do so.

Senator MARKEY. Thank you. Ms. Alwin, finally, how would mechanisms within existing Older Americans Act programs to support underserved populations like LGBTQ older adults help us meet their unique health and social needs?

Ms. ALWIN. Absolutely. So, to keep pace with the growing number of older adults and the greater diversity among older adults, we need to modernize and strengthen and fully fund the Older Americans Act.

But those senior centers really are a front door to all resources and services available for all older adults, including LGBTQ+ older adults. And making sure we have the right mechanisms in place to help support building the capacity of those senior centers, shar-

ing promising practices, providing technical assistance, and designated funding so they can build their relevance and capacity and culturally competent programing is critical.

Senator MARKEY. Yes. And the Congress is the right place to be, because the secret plan for every single Senator is to live to be a very old person, Okay. So, we are completely into your agenda to make sure that we help that population. Thank you so much. Thank you, Mr. Chairman.

The CHAIR. My understanding is that Senator Baldwin is on her way. So, I am going to give her two more minutes and I will take a minute and give a minute to Senator Cassidy just to ask another question.

I think the average American would be stunned to learn that millions of seniors are dealing with hunger issues or going hungry, that we have actually malnutrition in America today. I mean, that is rather an astounding reality. Ms. Hollander or Ms. Alwin, do you want to say a word on hunger among seniors in America?

Ms. HOLLANDER. Well, it is a silent epidemic. That is part of the challenge, that it is behind closed doors. And one of the things we have to do is we have to amplify the fact that this is a grave and growing issue, and we have the infrastructure to do it.

One of the things I neglected to mention earlier when you asked the question about funding, is that this is a successful public, private partnership. For every Federal dollar that comes in through the Older Americans Act, it is matched by about $3 by private and state local sources.

Even though we are making investments, it is not carrying the full freight of what we are asking. It is actually attracting additional funding to do that.

The CHAIR. Thank you.

Senator Cassidy, want to take a minute?

Senator CASSIDY. Yes. Ms. Hutchins, tell me, you are a recipient. You have received meals both I gather going to some place so called congregate and you have had meals delivered to you. Would you have any suggestions to how to make either of those programs a better program? You are on mute. Oh, go ahead——

[Technical problems.]

Senator CASSIDY. Thank you ma'am. Thank you.

The CHAIR. Thank you very much. Okay, let me thank all of our panelists. You did a great job. We look forward to working with you on this enormously important issue. Thank you very much.

We will now hear from our second panel. Okay. Our final witness, and our witness for this panel, is Ms. Alison Barkoff, the Acting Administrator and Assistant Secretary for Aging. Ms. Barkoff leads the Administration for Community Living.

The Administration's mission is to maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers. Thank you very much for being with us today, Acting Administrator. You may proceed with your testimony.

STATEMENT OF ALISON BARKOFF, PRINCIPAL DEPUTY ADMINISTRATOR AND PERFORMING THE DUTIES OF THE ADMINISTRATOR AND ASSISTANT SECRETARY FOR AGING, ADMINISTRATION FOR COMMUNITY LIVING, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. BARKOFF. Good afternoon, Chairman Sanders, Ranking Member Cassidy, and Members of the Committee. Thank you for the opportunity to provide testimony on the Older Americans Act and for the Committee's long standing support of the Older Americans Act programs and healthy aging.

I am Alison Barkoff, the Principal Deputy Administrator and Senior Official, performing the duties of Administrator and Assistant Secretary for Aging. I am pleased to share information today about our work to strengthen OAA programs and the aging services network that implements them, which ultimately will help ensure our Nation's ability to meet the needs of older adults.

OAA programs help older adults age in place, as the vast majority want to do. They provide meals, family caregiver support, preventative health services, personal care services, transportation, senior centers, legal assistance, elder abuse prevention, long term care ombudsman services, and so much more.

These programs reach nearly one in four—five older adults who tell us in survey after survey that OAA programs help them stay in their own homes. These effective programs are an incredible value.

With OAA dollars, the Aging Network leverages another $3 to $4 from other sources to support OAA programs. For the next 20 years, 10,000 people, the population of a small town, will turn 65 every single day.

Helping people age in place and avoid more costly institutional care will only become more important. For nearly 60 years, the structure of the OAA has driven its success. It sets broad policy but gives the Aging Network the flexibility to meet local needs. We saw the power of that during the pandemic.

The network pivoted quickly and creatively, working with us to use that OAA's flexibilities to continue services. They created contactless service options, grab and go meals, and more.

They increased coordination and forged new partnerships with public health, emergency management, and others, while ACL partnered with agencies across HHS to leverage our collective resources to meet the unique needs of older adults. Working through the pandemic highlighted the need to update the OAA regulations to clarify its flexibilities and disaster requirements.

Updating the rule also allowed us to provide guidance for programs authorized since the last update, like the family caregiver programs. We also aligned the regulations with changes made to the law during reauthorization and addressed questions that had arisen in the field about the statutory updates.

We received input from states, tribes, Area Agencies on Aging, and others. They sought greater clarity on requirements but underscored the importance of preserving flexibility. The final rule strikes that balance.

It reflects best practices from the field and provides the updated modern framework needed to strengthen the network and sustain the OAA's success. ACL is able to have an outsized impact on issues critical to older adults through partnerships, leveraging our programs and the Aging Network, and coordinating across Federal Government to prevent duplication between programs.

For example, we promote healthy aging with evidence based programs, many developed by NIH and CDC, that have been proven to improve overall health, prevent falls, and reduce health care expenditures.

We have partnered across HHS and with the Aging Network and nonprofits on our work to help older adults avoid social isolation. We are collaborating to improve support to the Nation's 53 million family caregivers, and we are working with partners across Government to address the dire shortage of direct care workers, which is jeopardizing community living for older adults and putting more on family caregivers.

We are also partnering with HUD to improve coordination of our programs to support community living and reduce older adult homelessness. With the updated regulations and the partnerships ACL and the aging services network are building across every level of Government, OAA programs and the network are well positioned to help older adults maintain their health and independence, both today and into the future.

Thank you for the opportunity to participate in today's hearing. ACL has appreciated the Committee's support of the Older Americans Act and the Aging Services Network, and we look forward to working with you in the future. I am happy to answer your questions.

[The prepared statement of Ms. Barkoff follows.]

PREPARED STATEMENT OF ALISON BARKOFF

Good afternoon, Chairman Sanders, Ranking Member Cassidy, and Members of the Committee. Thank you for the opportunity to provide testimony on the Older Americans Act (OAA) and for the Committee's longstanding support of the OAA programs and interest in healthy aging. I am pleased to share information today about the Administration for Community Living's recent efforts to ensure our Nation's ability to meet the needs of the growing population of older adults by strengthening the OAA programs and the national aging services network that implements them. These include the first comprehensive update to the OAA regulations in more than 30 years and a number of partnerships to address the issues most important to older Americans.

I am Alison Barkoff, the Principal Deputy Administrator and senior official performing the delegable duties of the Assistant Secretary for Aging and Administrator of the Administration for Community Living (ACL) at the U.S. Department of Health and Human Services (HHS). ACL was created around the fundamental principle that older adults and people with disabilities of all ages should be able to live where they choose, with the people they choose, and with the ability to participate fully in their communities. ACL makes this principle a reality for millions of older adults through implementation of the OAA, working with and through the national aging services network of states, tribes, area agencies on aging (AAAs), local service providers, and volunteers who provide services that enhance the health, independence, and dignity of our Country's older adults.

OAA Programs Are Critical to Meeting the Needs of America's Growing Aging Population

The OAA programs provide a range of community-based services to help older adults age in place, which is the preference of the vast majority of older adults, and

to maintain their health and engagement in their communities. These services include home-delivered and congregate meals, support for family caregivers, preventive health services, personal and home care services, transportation, senior centers, legal assistance, elder abuse prevention, and so much more. In addition, the OAA provides ombudsman services for people who live in long-term care facilities. The OAA programs reach nearly one in five adults in the United States.

OAA services are effective in helping millions of older adults stay in their own homes and communities instead of having to enter long-term care facilities. For example, over 65 percent of caregivers who receive OAA services like respite care and peer support report that without OAA services, their high-risk care recipients likely would have had to enter a nursing home or assisted living facility. Similarly, 82 percent of people who participate in the congregate meals program and 92 percent of home-delivered meal recipients report that meals received through the programs allowed them to continue to live independently. Likewise, 66 percent of older adults using transportation services rely on them for the majority of their trips to doctors' offices, pharmacies, meal sites, and other critical daily activities that help them to remain in the community. OAA services help prevent older adults from having to spend down to become eligible for Medicaid to enter a long-term care facility.

For nearly 60 years, the structure of the OAA programs has been a hallmark of its success. The OAA and its implementing regulations provide broad policy and guidance while allowing states, tribes, and AAAs the flexibility to work together to design programs that are responsive to local needs. In addition, the OAA programs are an incredible value with a strong return on investment; with every OAA dollar provided, the aging services network leverages another four dollars from state, local, and private sources.

Despite the excellent return on investment and the broad reach of the OAA programs, the demand for OAA services far exceeds capacity. While anyone over the age of 60 is eligible to participate in the OAA programs, not every older person needs the services and supports equally. That is why the OAA requires services to be targeted to older adults in the greatest economic and social need. This includes those who are low income, as well as those whose needs are caused by noneconomic factors, such as physical and mental disabilities, language barriers, and cultural, social, or geographic isolation, such as minority older individuals, older persons with limited English proficiency, older persons residing in rural areas, older persons with disabilities, and older individuals who are LGBTQ or living with HIV/AIDS. For example, over 92 percent of OAA program participants have multiple chronic conditions and are at risk for hospitalization; over 69 percent of case management clients take five or more medications; and more than 40 percent of home-delivered meal clients need support with three or more activities for daily living. In addition, five million older individuals live below the Federal poverty level, many of whom are served by the OAA programs.

The demand for—and importance of—the OAA programs continues to grow as the population in the United States rapidly ages. Every 7 seconds today, and for the next 20 years, someone in America will join the ranks of becoming an older adult; that is a rate of 10,000 a day, or the equivalent of a small town in America. One in six people are currently aged 65 or older, a 35 percent increase since 2010. By 2040, that number will increase to one in five people. Helping people age in place and avoid costly institutional care will only become more important.

Lessons Learned from the Pandemic and Updated Regulations Have Well-Positioned the Aging Services Network for the Future

Older adults were among the most impacted by the COVID–19 pandemic, at highest risk for severe complications, illness, and even death. The aging services network quickly pivoted with innovation and creativity, working with ACL to find new ways to use the OAA's flexibilities to serve older adults. For example, they modified programs to provide contactless service, grab-and-go meals, and virtual wellness checks to assess needs and combat social isolation.

Supplemental funding from Congress was also critical to their success. Throughout the pandemic, the aging services network increased coordination and forged new partnerships, including with public health and emergency management entities, faith-based organizations, and other community groups. At the Federal level, ACL partnered with sister HHS agencies, including the Administration for Strategic Preparedness and Response (ASPR), the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA), to bridge gaps, pool resources, and leverage each of our networks to meet the unique needs

of older adults and address barriers to accessing vaccines, treatment, and supports and services.

The pandemic underscored the need for ACL to update the OAA regulations, which had last been updated in 1988. Rulemaking was an opportunity not only to imbed lessons learned from the pandemic, such as the importance of the flexibilities allowable under the OAA and of inclusive disaster preparedness and response, but also to provide guidance for programs that had been authorized after the last regulations, such as the family caregiver programs. ACL also used the rulemaking process to align the regulations with changes made during reauthorizations of the OAA, including clarifying and answering questions that had arisen in the field about statutory updates.

In updating the regulations, ACL sought the input of states, tribes, AAAs, service providers, and older Americans themselves. ACL held listening sessions and sought public comment through a formal request for information in May 2022 and a notice of proposed rulemaking in June 2023. During this process, ACL heard from commenters—including state agencies and AAAs—seeking greater clarity from ACL on various statutory requirements, including fiscal requirements. At the same time, commenters also underscored the importance of flexibility to address local community-level needs within the framework of the statute.

The final rule strikes this balance, and sets forth an updated, modern framework that reflects best practices from the field and strengthens the aging services network. The regulations make clear that state plans must describe how state agencies and AAAs will use OAA funding, and how requirements for public participation are met. They also require state agencies and AAAs to ensure coordination between programs that serve all older adults, including tribal elders. Other requirements clarify the state agency's responsibility to establish and maintain policies and procedures to monitor the programmatic and fiscal performance of programs and activities.

The regulations also detail how greatest economic need and greatest social need are determined. Prioritizing people who have the greatest economic and social needs has always been a basic tenet of the OAA; the updated rule clarifies this requirement and sets expectations for serving these older adults and ensuring that their perspectives are incorporated into planning efforts by state agencies and AAAs. Consistent with ACL's approach to rulemaking, this portion of the rule also gives states flexibility to include additional populations based upon local considerations.

The final rule addresses questions from the field about how the aging services network can engage in business relationships to expand their reach, such as partnering with health plans to deliver services to older adults that address their health-related social needs. The final rule sets forth the appropriate roles, responsibilities, and oversight of such activities, and requires state agencies to establish flexible and streamlined processes for AAAs to receive approval for contracts and commercial relationships. The provision is intended to promote and expand the ability of the aging network to engage in business activities while ensuring that the unique roles of OAA grantees are preserved. Relatedly, the regulations define "conflicts of interest" and establish several requirements to prevent them. These provisions are intended to ensure the integrity of—and trust in—the activities carried out under the OAA, while preserving the ability of the aging network to innovate and partner with other entities that serve older adults.

The final rule also modernizes the OAA's senior nutrition programs. These essential programs not only reduce hunger and food insecurity, but they also improve health and address social isolation by providing opportunities for older adults to engage with other people and to be screened for other needs before they become crises. The COVID–19 pandemic both necessitated popular innovations across the programs and brought to light limitations in the previous regulations. For example, the new regulations clarify that home-delivered meals may be provided via home delivery, pick-up, carry-out, or drive-through; eligibility for home-delivered meals is not limited to people who are "homebound"; and home-delivered meal participants may also participate in congregate meals programs. The rule also clarifies that the OAA allows for grab-and-go meals to be provided through the congregate meals program in some circumstances. The regulation also clarifies requirements for transfers of funds between the congregate and home-delivered meals programs, as well as between the senior nutrition programs and supportive services and senior centers. These flexibilities allow states to tailor their programs to local needs and older adults' preferences.

Just as the pandemic led to innovations in the senior nutrition program, it also required the aging services network to think creatively about other services, including senior centers. The pandemic showed that for many older adults, especially

those living in rural areas, virtual senior center activities were welcomed and helped foster important social connections. In the process of seeking input from the field and stakeholders to inform the regulations, ACL heard from many participants that they prefer senior centers be a part of larger community centers, in part to encourage intergenerational opportunities. Based on this, ACL has been testing approaches to modernize senior centers, including transforming them into community hubs, expanding programming to support overall wellness, and improving their relevance to the current generation of older adults. The updated regulations provide flexibilities that will allow senior centers to evolve to continue to meet the needs and preferences of older adults.

The pandemic also highlighted that emergencies and disasters have disproportionate impacts on older adults and family caregivers, and often create unique challenges for the aging services network. However, the previous OAA regulations included limited guidance addressing these situations. The updated regulations create a new subpart regarding supports for older adults and family caregivers, including those in tribal communities, during emergencies and disasters. The new regulations require state agencies and AAAs to establish emergency plans and have policies and procedures in place for communicating and coordinating with state, tribal, and local emergency management entities within their jurisdictions. State agencies may set aside funding to exercise flexibilities during a major disaster declaration and procure items on a statewide level, subject to certain conditions. To further be responsive to the need for flexibility, the rule makes clear that the Assistant Secretary for Aging may modify emergency and disaster-related provisions in the regulation when a major disaster or public health emergency is declared.

The regulations also include important updates to OAA programs that protect the rights of older adults and prevent and address abuse and neglect. An estimated one in 10 adults over the age of 60 have experienced some form of elder abuse, which can reduce their quality of life and limit their independence. OAA programs play a critical role in promoting elder justice, ensuring that older adults can live safely in the community or in long-term care settings, and upholding older adults' rights to participate in decisions about their lives. The regulations outline how states must ensure the independence of long-term care ombudsman programs that work to resolve problems related to the health, safety, welfare, and rights of individuals who live in nursing homes, assisted living facilities, and other residential care communities. The updates also specify that efforts related to guardianship must include assisting older adults with less restrictive, more person-directed decisional supports whenever possible. Our elder abuse work under the OAA is coordinated with ACL's programs under the Elder Justice Act, including adult protective services (APS). We are in the process of the first-ever rulemaking for APS, following the first-ever annual appropriations for that program.

Finally, the updated OAA regulations provide guidance for the first time on the OAA's family caregiver programs, which were added as part of the OAA's 2000 reauthorization. The programs provide a range of supports, including counseling, case management, and respite care, to nearly 800,000 informal caregivers. Studies show that these services enable caregivers to provide care longer, making it possible for older adults to remain in their own homes and avoid or delay the need for costly institutional care. The regulations provide key definitions, implement statutory mandates, and clarify requirements for family caregiver support services, allowable uses of funds, and the method of funds distribution.

The final rule goes into effect on March 15, 2024, and the network has until October 1, 2025, to implement its changes. Over the coming months, ACL will continue to share resources and provide robust technical assistance to support states, tribes and tribal organizations, AAAs, and others in the aging services network in meeting the requirements of the new regulations. ACL also will work with states and other network partners in a supportive corrective action process if more time is needed to fully comply with specific provisions.

Through Partnerships, ACL and the Aging Services Network Are Helping Address the Most Pressing Issues Facing Older Adults

ACL and the aging services network are able to have an outsized impact on issues critical to older adults through partnerships, leveraging our programs and network and coordinating across Federal Government programs to ensure there is no duplication. For example, healthy aging is an important issue, particularly as people are living longer. ACL and the aging services network promote healthy aging by implementing an array of evidence-based and evidence-informed health promotion and disease prevention interventions—many developed by NIH and CDC—that have

been proven to improve overall health, better manage chronic disease and illness, reduce falls and risks of injury, and reduce healthcare expenditures. Falls prevention interventions are a particular focus for ACL, given the significant financial, physical, and social impacts falls can cause. Under the authority granted in the most recent reauthorization of the OAA and with funding first provided in fiscal year 2023, ACL is designing a research, demonstration, and evaluation center to study an expanded set of effective falls prevention approaches that can be implemented by the aging services network. In addition, ACL is collaborating with more than a dozen Federal agencies, including NIH and CDC, to create a strategic framework for a national plan on aging through the Interagency Coordinating Committee on Healthy Aging and Age-Friendly Communities (ICC), an interagency working group created by Congress in the 2020 reauthorization of the OAA and that ACL recently launched after receiving funding for the ICC for the first time in fiscal year 2023.

Social isolation is an epidemic that poses serious health risks to millions of older adults. To increase the impact and reach of the OAA programs that address social isolation, ACL has partnered with the HHS Office of the Assistant Secretary for Health, the aging services network, and non-profit organizations to establish Commit to Connect, a cross-sector initiative to reach people who are socially isolated. Commit to Connect has catalyzed a nationwide network of champions to increase awareness and availability of programs and strategies that address social isolation and loneliness and to strengthen partnerships to leverage efforts, resources, innovations, and activities related to social isolation.

ACL is also partnering across the Federal Government to address one of the most pressing issues facing older adults—the direct care workforce crisis and its impact on family caregivers. Because of workforce shortages, many older adults who need services to remain in the community cannot get them, and those who do receive services often experience disruptions and inconsistent quality, both of which jeopardize the health and safety of the people receiving services and increase demands on family caregivers. ACL launched the Direct Care Workforce Strategies Center (Strategies Center) in collaboration with the Department of Labor, the Centers for Medicare & Medicaid Services (CMS), and the HHS Office of the Assistant Secretary for Planning and Evaluation. The Strategies Center provides technical assistance and resources to strengthen collaboration across state agencies (including aging, disability, Medicaid, and workforce development), direct care professionals, people receiving services, and other stakeholders in order to improve recruitment, retention, and development of this critical workforce. ACL just announced several intensive technical assistance opportunities available to states through the Strategies Center, funded in part by the fiscal year 2023 OAA funding Congress directed toward workforce issues.

Interagency partnership and collaboration with stakeholders also are critical to ACL's efforts to support the more than 53 million family caregivers in the United States, including grandparents raising grandchildren. ACL facilitated the development of the first-ever National Strategy to Support Family Caregivers, submitted to Congress in September 2022, which included more than 300 commitments from almost 15 Federal agencies and recommendations for state and local government, business, and other stakeholders. ACL is leading the implementation and update of the strategy. With OAA funding provided to ACL in fiscal year 2023, ACL recently awarded the first-ever Caregiver Projects of National Significance to focus on implementation of recommendations in the strategy by the aging services network.

Older adults are the fastest growing age group among those experiencing homelessness, currently comprising nearly half of the homeless population, and their numbers are estimated to triple by 2030. To address this serious issue, ACL leads the Housing and Services Resource Center (HSRC), a partnership between the Department of Housing and Urban Development (HUD) and HHS, to coordinate across the healthcare, aging, disability, housing, and homeless sectors the affordable housing and community services that many older adults and people with disabilities need to remain stably housed in the community. The HSRC is funded in part through the OAA Aging Network Support Activities, and the aging network is a key partner and beneficiary of the HSRC activities. Jointly funded by ACL, HUD, and the Substance Abuse and Mental Health Services Administration, the HSRC recently launched a year-long intensive technical assistance initiative with nine states focused on coordinating housing and services to address homelessness, including among older adults.

Inclusive disaster preparedness and response is another priority area where ACL and the aging services network are leveraging partnerships to meet the unique needs of older adults during disasters. Inability to evacuate, loss of services, inacces-

sible shelters, and other issues can result in unnecessary institutionalization, poor health outcomes, and even death for older adults during disasters. Through ACL initiatives and supplemental funding during the pandemic, the aging services network built partnerships with their state and local public health and emergency management agencies to provide expertise and fill gaps in addressing the needs of older adults. ACL has partnered with other Federal agencies, including ASPR, CDC, HRSA, and the Federal Emergency Management Agency, to build upon and strengthen those partnerships. Recognizing the important role that ACL's programs and the aging and disability networks can play in disasters, HHS has established a Disaster Human Services Coordinating Council, co-chaired by ACL, the Administration for Children and Families, and ASPR, with participation of over a dozen HHS agencies, and HHS's legislative proposals related to disaster preparedness and response in the Fiscal Year 2024 President's Budget include a disaster human services emergency fund that would allow the HHS Secretary to provide real-time funding during disasters to vulnerable populations, including people with disabilities, older adults, and children and families.

Finally, ACL and the aging services network closely collaborate with CMS and state Medicaid agencies and service providers on the delivery of Medicaid-funded home and community-based services (HCBS). Many in the aging network partner to expand the reach of the OAA programs by also providing HCBS to low-income older adults, and as discussed above, through commercial relationships with health plans, many are able to help address health-related social needs like food insecurity.

Conclusion

The OAA and its aging services network proves its worth every day in the lives of older adults throughout the country. The importance of the OAA programs and the demand for its services have never been stronger and both continue to grow as the American population rapidly ages. The OAA has a long history and strong record of providing cost-effective services that successfully help older adults remain in their own homes and communities and avoid unnecessary and costly care in long-term care facilities. Key to the OAA's success has been the flexibility it provides to states to design programs responsive to local needs and the input received from older adults and the organizations that serve them. ACL is pleased to have had the opportunity to develop a comprehensive set of regulations that both maintains these critical features and the longstanding processes for effective stewardship of Federal resources and provides new opportunities to modernize and strengthen the OAA programs. ACL is excited to implement these regulations in partnership with the aging services network to build on the decades of successful programming and to position the aging services systems in the United States for tomorrow's challenges.

Thank you for the opportunity to participate in today's hearing. ACL has appreciated the Committee's support of the Older Americans Act and the national aging services network in the past, and we look forward to working with you in the future. I am happy to answer any questions you may have.

The CHAIR. You ended right on the button. Congratulations. Well, thank you very much for being with us, Ms. Barkoff, and the work that you do.

We have heard testimony today that millions of seniors are dealing with hunger issues in the United States of America, that a lot of seniors are suffering from loneliness, that too many seniors are falling, and that life expectancy is going down for those and other reasons.

What would increase funding for the Older Americans Act mean in terms of keeping seniors well nourished, keeping them in better mental health?

What do you think it would mean in terms of actually saving money in terms of cost of Medicare, Medicaid, nursing home costs, etcetera?

Ms. BARKOFF. Thank you, Senator Sanders.

The CHAIR. Try that mic. Is your mic on? Yes.

Ms. BARKOFF. Thank you, Senator Sanders. And as you heard from every single witness today, the OAA programs are incredibly effective.

The statistics are regarding senior nutrition, for the people we can serve, for the vast majority, we are their one healthy meal in every single day. Our preventative health programs help prevent people from entering emergency rooms.

Our programs focused on falls, whether it is the home modifications or evidence based programs like Tai Chi help prevent the incredibly challenging problems caused by falls, both health problems and incredible expenses.

The programs work. What we don't have is the resources to reach everyone. That is why in every single budget since this Administration has been in place, we have asked for more resources. We have to target our funding right now to reach those in the greatest need, but we know there are so many more people who could benefit from those services.

Additional funding would help our incredible networks reach more people, and it would help us prevent—increased health care costs from falls, from chronic illnesses, and help people age in place instead of going into expensive nursing homes.

The CHAIR. Help me out here. But my understanding is that the OAA does not directly provide funding to senior centers.

Senior centers utilize the funding, obviously, for congregate meal programs, for the Meals on Wheels program, and for other activities. In my state, I think we have, and I suspect I speak for many other rural states, a real checkered situation.

You have some senior centers that are really doing a great job in terms of exercising, in terms of disease prevention, really wonderful educational programs to engage seniors. Others really are not.

Rural areas are having a hard time staffing. Maybe they have a half time staffer inadequately paid. Do we need to take a new approach to senior centers across the country?

Ms. BARKOFF. Senator Sanders, senior centers are a critical part of OAA services, and they have absolutely served our Country's older adults well. They are part of Title 3(b) of the Older Americans Act and included under the Supportive Services and Senior Centers.

The statute does currently authorize acquisition, alteration, construction, modernization, as well as funding to the services provided there. We have seen and I have gone to a number of senior centers, kind of the evolving senior centers. They have gone from being a place to just going to get a meal to, like you said, really community hubs.

They are often places that provide—we heard a question from Senator Hassan about intergenerational programing. That is incredibly important. When people are there, we always say it is more than a meal.

We are able to evaluate people, connect them with preventative health services, the exercise programs. We are looking and we are working with our partners at NCOA, on strategies for modernizing

senior centers. It is a great initiative. Thank you for the funding to be able to do that.

I think we are trying to figure out how to best meet the needs of older adults in the future. People really want different kinds of things. And so, what I would say is, I think the infrastructure that we have in the Older Americans Act is an incredible foundation, and we would look forward to working with you on any changes that you think would help strengthen senior center services.

The CHAIR. Thank you very much.

Senator Cassidy.

Senator CASSIDY. Hey, thanks for being here. And thanks for being here because I will note that the Department of Labor has close to 20 percent of all OAA funding. I was going to ask them about the Senior Community Service Employment Program, and they declined to attend.

I am a little bit kind of befuddled how an agency over which we have jurisdiction declines to come to have oversight conducted. But that is not your issue. That is the DOL's issue. And by the way, that—is inexcusable in my mind. So, let me kind of get back comported, and find my question for you.

Your rule, give us some particulars as to what your rule is doing, is advocating that is going to make the senior, Ms. Hutchins' life better, or someone in Baton Rouge or Shreveport, Louisiana. Give me a, like, boom, boom, boom, three things.

Ms. BARKOFF. I think some of the things that were really important that we put into this rule, one, I would say that we never had any regulations related to the family caregiver program.

We heard a lot today about the incredible support from Ms. Hutchins too, about families, the need for respite, the need for those programs. And it was a real privilege to be able to do the first set of regulations there.

Senator CASSIDY. What were those regulations? An example of a new regulation.

Ms. BARKOFF. The regulations provide the rules around how to use the funding, how to leverage that. What is the definition of a family caregiver. Who is eligible——

Senator CASSIDY. How are you leveraging that?

Ms. BARKOFF. How are we leveraging that? Well, we were——

Senator CASSIDY. Or how would you suggest to leverage it, if you will?

Ms. BARKOFF. Sure. So, we have done a couple things with the family caregiver program. First of all, we have been very pleased to have additional funding from Congress over the last couple of years to really expand the reach of those programs.

For example, I know one thing the Committee has cared a lot about is grandparents who are raising grandchildren, and we have been able to expand that reach, something that we have seen really a growing population as part of that epidemic. We have worked—sure——

Senator CASSIDY. That is actually the abled grandparent helping the child. So, how does this—but it is not the incapacitated elderly

or the semi—the less able. So, it seems a little bit of a stretch of the original mission, if you follow what I am saying. So, elaborate on that. What are you doing for that grandparent caring for that grandchild?

Ms. BARKOFF. Sure. So, the family caregiver program and the statute itself defines who is a caregiver. We absolutely provide supports to family members who are caring for, as you said, an older adult who has disabilities and has needs.

The family caregiver program absolutely covers that. It also covers an older adult who is taking care of another family member. And again, we provide services——

Senator CASSIDY. Now, let me ask because—I don't mean to interrupt. I just got a few minutes. He is about to gavel me down. So, you have limited dollars. It does seem like you run the risk of the so-called woodworking effect, that the more you cover, far more, the more you cover—if you follow what I am saying.

If you extend the mission of—I am 66. I am kind of like eligible for your services. But at the same time, if you extend it, are you kind of detracting from the ability to care for that person who is caring for somebody with Alzheimer's, in which they truly need a respite program?

Ms. BARKOFF. We prioritize, consistent with Congressional intent, for all of our programs. Again, we don't have enough resources——

Senator CASSIDY. Now, you can't prioritize for all of your programs. That is kind of oxymoronic.

Ms. BARKOFF. Well, we do prioritize to those populations in the greatest social and economic need. We work with states, and they create a state plan where they look at how are they going to distribute funding across states and different communities using data, the census——

Senator CASSIDY. Okay, but particular because you are speaking—and I know you know your stuff, and so I am not trying to challenge. But so much and the people watching on C-Span, we got to drill down to something that they take away. They know it.

Can you give me a particular of something post-pandemic that we are now doing differently that would be recognized by Ms. Hutchins or by her family—by her family caring for her?

Ms. BARKOFF. Sure. Again, we, one of the new things that we have in the Older Americans Act, and I think something that maybe Miss Hutchins might experience is some of the work that we are doing around inclusive disaster preparedness. It is something that really people across——

Senator CASSIDY. Increasing disaster preparedness in Louisiana, I understand the need for that. So, drill a little bit on that, please.

Ms. BARKOFF. Sure, sure. We have, for the first time, put in place requirements about how state units on aging and AAAs can respond and help provide additional services when there are disasters that happen, which we are seeing happening more and more across——

Senator CASSIDY. If somebody is evacuated to an area of congregate living, a basketball stadium, for example, and they are on a cot, how would their experience be different because of what you are doing—knowing that there is many other people, how would their experience be different?

Ms. BARKOFF. Through the new regulations, the AAAs, we will be able to, again, hopefully in advance be having more of a plan to reach out.

They will be able to surge services through what is in the older Americans Act with some reimbursement services there and be able to really help identify who are people who need support from the AAA, who might be able to get in-home meals, who might need help with finding accessible housing.

That is another place where, again, we created an entirely new title to address some of these flexibilities.

Senator CASSIDY. Okay.

The CHAIR. Ms. Barkoff, thank you very much. And again, I thank all of the panelists for helping us deal with an enormously important issue, and I promise you, this Committee is going to do its best to address the many problems that all of you have raised.

That is the end of our hearing today, and I want to thank all of our witnesses for their participation. For any Senators who wish to ask additional questions, questions for the record will be due in 10 business days, March 21st at 5.00 p.m.

Finally, I ask unanimous consent to enter into the record eight statements from stakeholder groups outlining the priorities for the re-authorization of the Older Americans Act. Without objection.

[The following information can be found on page 60 in Additional Material.]

The CHAIR. The Committee stands adjourned. Thank you.

ADDITIONAL MATERIAL

AARP,
March 7, 2024.

Hon. BERNIE SANDERS, *Chair*,
Hon. BILL CASSIDY, M.D., *Ranking Member*,
Senate Committee on Health, Education, Labor, and Pensions,
Washington, DC.

DEAR CHAIRMAN SANDERS AND RANKING MEMBER CASSIDY:

AARP, which advocates for the more than 100 million Americans age 50 and older, thanks the Committee for holding this hearing, "*The Older Americans Act: Supporting Efforts to Meet the Needs of Seniors*." We appreciate the opportunity to work with you to advance support for older adults and their family caregivers through the Older Americans Act (OAA).

The OAA has a powerful legacy. Since 1965, it has supported older Americans so they can live at home with independence and dignity, deferring or eliminating more costly institutional services and hospitalizations. According to AARP's 2021 *Home and Community Preferences Survey*, the vast majority of adults age 50-plus—nearly 80 percent—want to remain in their communities and homes as they age. The OAA plays a critical role in making sure people in this country can age at home, where they want to be.

In a typical year, OAA programs provide services for approximately 11 million older adults. These include home care, congregate and home-delivered meals, case management, family caregiver support, transportation, adult day care, legal services, elder abuse prevention, and job training and employment opportunities for low-

income older adults. Additionally, OAA Native American programs provide nutrition, support and caregiver services to older American Indian, Alaska Natives and Native Hawaiians. OAA programs are cost-effective investments that serve the needs of older Americans while deferring or eliminating the need for costly institutionalization.

Unfortunately, the need for these programs outweighs OAA's current funding, which has not kept pace with inflation or increased demand. While the number of people age 60 and older has grown by 74 percent since 2001, OAA funding has lagged behind in that same time period, rising only 41 percent. When adjusted for inflation, total OAA funding over this time period has *declined* by 18 percent. Additionally, people age 80 and older are among the most likely to need help to live independently in their homes and communities, and this population is projected to nearly double from 2023 to 2040.

Put another way, America is on the brink of a serious aging crisis. Family caregivers are filling in the gaps, providing care to their loved ones at significant expense to themselves in terms of both time and money. As the population ages, the number of family caregivers is not likely to keep up with the demand. Now more than ever, OAA is essential for our Country.

As we approach OAA reauthorization, we look forward to continuing to build on OAA's many successful programs, including the National Family Caregiver Support Program (NFCSP) and Title VI Native American Caregiver Support Services, the Senior Community Service Employment Program (SCSEP), the Long-term Care Ombudsman Program (LTCOP), and the Nutrition Services Program, which are outlined below.

National Family Caregiver Support Program (NFCSP) and Title VI Native American Caregiver Support Services

NFCSP was created in 2000 to support a range of services that assist family and other unpaid caregivers. Similarly, OAA's Title VI Native American Caregiver Support Services provide support for American Indian, Alaskan Native, and Native Hawaiian families, including through information and outreach, access assistance, individual counseling, support groups and training, respite care, and other supplemental services. Protecting and increasing funding for NFCSP and Title VI Caregiver Support Services will allow grantees the ability to fully respond to local needs without having to shift resources from one caregiver population to another.

More than 48 million family caregivers are the backbone of the U.S. long-term care system, providing about $600 billion annually in unpaid labor to their loved ones. The care they provide ranges from bathing and dressing to paying bills and transportation, and their assistance helps save taxpayers billions of dollars by helping to delay or prevent expensive nursing home care and unnecessary hospital stays. However, despite the many benefits family caregivers contribute to the economy and the important role they play in preserving the health and well-being of their loved ones, family caregivers often face significant financial, physical, and emotional challenges. According to *Caregiving in the U.S. 2020*, nearly 60 percent of family caregivers perform medical and nursing tasks for their loved ones; too often, they have little preparation or training. By supporting family caregivers, we can help people stay at home, helping to delay or prevent more costly nursing home care and unnecessary hospitalizations. As part of the Act's reauthorization, we urge the Committee to help support our Nation's family caregivers and meet their needs.

Senior Community Service Employment Program (SCSEP)

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

Grantees include public workforce agencies and national nonprofit organizations. Participants are unemployed, disadvantaged older workers who work an average of 20 hours a week at minimum wage. Work experience is gained typically in community service activities at nonprofit and public facilities, serving as a bridge to unsubsidized employment opportunities. SCSEP has helped thousands of older jobseekers into jobs providing them work-based training and the opportunity to use their skills. According to the recent *Department of Labor Workforce GPS survey*, participants

strongly believe that the program helped prepare them for success in the workforce (8.4 on a 10-point scale). SCSEP adds needed value as the only Federal program targeted at lower income older jobseekers.

Long-Term Care Ombudsman Program (LTCOP)

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

Data from the 2022 *National Ombudsman Reporting System (NORS)*, shows that LTCOP's nearly 2000 full time staff and approximately 4000 certified volunteers investigated more than 182,000 complains nationwide and provided assistance to more than 400,000 individuals looking for information about long-term care. The COVID–19 pandemic highlighted the critical role these ombudsmen play in the long-term care system.

Nutrition Services Program

Congregate nutrition services and home-delivered nutrition services provided by the OAA Nutrition Services Program reduce hunger and support older adults' health and independence, including their ability to remain in their homes. A *2017 evaluation* found that 42 percent of congregate meal participants and 61 percent of home-delivered meal participants reported they would skip meals or eat less without the program. OAA-funded senior nutrition programs also provide more than a meal; they provide opportunities for social engagement, offer nutrition screening and counseling, and link participants to other home-and community-based supports. The majority of participants report that the program helped them to eat healthier and continue to live independently.

Congregate meals are offered in congregate or group settings, giving older adults and sometimes their caregivers the opportunity to socialize over food. Compared to nonparticipants, *research shows* lower-income congregate meal participants have fewer nursing home admissions, and those living alone have fewer hospital admissions. Other research has found that low-income congregate meal participants are less likely to be food insecure than nonparticipants.

Home-delivered meals serve many frail, homebound, or isolated older adults. Research finds that home-delivered meals may improve participants' nutritional status, with one study finding the program is also associated with increased well-being, reduced loneliness, and greater food security levels.

These OAA nutrition programs may also reduce social isolation, which is a significant risk factor for poor health status and increased mortality. A 2017 *AARP Public Policy Institute study* found social isolation costs Medicare $6.7 billion per year. Congregate meals participants report seeing friends more often due to the meals. Relatedly, the home-delivered meal program is associated with reduced loneliness among new participants, with delivery individuals often being the only human contact of the day for homebound clients. The reduced isolation can lead to improved health and reduced associated health care costs among program participants.

Conclusion

AARP welcomes the opportunity to collaborate and buildupon the success of these and other OAA programs through the 2024 reauthorization process. We look forward to working with the Committee on a bipartisan basis as the process moves forward. If you have additional questions, feel free to contact me or have your staff contact Lauren Ryan on our Government Affairs team.

Sincerely,

BILL SWEENEY,
SENIOR VICE PRESIDENT,
GOVERNMENT AFFAIRS.

ADVANCING STATES,
March 7, 2024.

Hon. BERNIE SANDERS, *Chair*,
Hon. BILL CASSIDY, M.D., *Ranking Member*,
Senate Committee on Health, Education, Labor, and Pensions,
Washington, DC.

DEAR CHAIRMAN SANDERS, RANKING MEMBER CASSIDY, AND SENATE HELP COMMITTEE MEMBERS:

ADvancing States is a nonpartisan association of state government agencies that represents the Nation's 56 state and territorial agencies on aging and disabilities. We work to support visionary state leadership, the advancement of state systems innovation, and the development of national policies that support home and community-based services for older adults and people with disabilities. Our members administer services and supports for older adults and people with disabilities, including overseeing Older Americans Act (OAA) programs and services in every state.

We deeply appreciate the Committee's focus on the reauthorization of the OAA and thank you for hosting this hearing as a forum for discussion on the past, present, and promising future of the OAA. The OAA is a pivotal piece of legislation that underscores the Nation's commitment to the well-being of its aging population. We believe this reauthorization presents an opportunity to incorporate lessons learned and successful innovative strategies implemented during the COVID–19 public health emergency (PHE).

We are grateful to the Committee for inviting Michelle Branham, Secretary of the Florida Department of Elder Affairs, to serve as a witness at this hearing. State units on aging (SUAs) serve as the linchpin for ensuring that the intent of the legislation translates into tangible benefits for older adults and their caregivers within their respective regions. **SUAs play a crucial role in the development, administration, and oversight of OAA programs and services, and their perspective is crucial to informing the upcoming reauthorization**.

As the Committee considers the upcoming reauthorization and improvements to strengthen the OAA, we urge you to consider the following:

- **Expand opportunities for state innovation**: During the COVID–19 PHE, the Administration for Community Living (ACL), SUAs, area agencies on aging (AAAs) and service providers had to shift quickly to implement necessary flexibilities and innovative solutions to continue service delivery. States continue to be interested in testing innovative strategies to meet the needs of older Americans. To support ongoing innovation, *we recommend allowing SUAs to reserve 1 percent of Title III funds to support piloting new programs and innovative strategies*.
- **Increase flexibility for the delivery of nutrition services**: Flexibility and innovation for nutrition services were especially important during the COVID–19 PHE. During that time, ACL authorized the transfer of nutrition funds to allow the provision of "grab & go" meals (under Title III, part C–1, congregate meals). The new OAA regulation makes this flexibility permanent. In addition, as aging networks move toward increased person-centered practices and individualized community-based models of supports, the need for flexibility with Title III C has increased. We recommend allowing states full flexibility to determine the level of funding for home delivered meals and congregate nutrition.
- **Establish a resource center within the Administration for Community Living to support states**: ACL currently houses several resource and technical assistance centers, but none are geared specifically toward SUAs. *We recommend creating a resource center for states*, to offer technical assistance, provide strategic planning support for new programs and initiatives, and serve as a hub for peer-to-peer collaboration and sharing of best practices.

Thank you for your focus on the reauthorization of the Older Americans Act, as well as your consideration of ADvancing States' recommendations for this vital piece of legislation. If you have any questions about ADvancing States or our priorities for the OAA reauthorization, please reach out to Rachel Neely.

Sincerely,

MARTHA ROHERTY,
EXECUTIVE DIRECTOR,
ADVANCING STATES.

ALZHEIMER'S ASSOCIATION AND ALZHEIMER'S IMPACT MOVEMENT

The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the Senate Committee on Health, Education, Labor, and Pensions (HELP) hearing entitled "The Older Americans Act: Supporting Efforts to Meet the Needs of Seniors." The Association and AIM thank the Committee for its continued leadership on issues important to the millions of individuals living with Alzheimer's and other dementias and their caregivers. This statement highlights the importance of policies and programs within the Older Americans Act (OAA) that can help meet the unique needs of our Nation's growing number of Americans living with Alzheimer's and other dementias.

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. Our mission is to eliminate Alzheimer's and other dementias through the advancement of research, to provide and enhance care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. AIM is the Association's advocacy affiliate, working in a strategic partnership to make Alzheimer's a national priority. Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease, including increased investment in research, improved care and support, and the development of approaches to reduce the risk of developing dementia.

An estimated 6.7 million Americans age 65 and older lived with Alzheimer's dementia in 2023. Total payments for all individuals with Alzheimer's or other dementias are estimated at $345 billion (not including unpaid caregiving) in 2023. Medicare and Medicaid were expected to cover $222 billion or 64 percent of the total health care and long-term care payments for people with Alzheimer's or other dementias, which are projected to increase to more than $1.1 trillion by 2050. These mounting costs threaten to bankrupt families, businesses, and our health care system. Unfortunately, our work is only growing more urgent.

As the prevalence of Alzheimer's disease and other dementias increases, so does the need for care and support services for those living with these diseases. The OAA provides Federal funding and the necessary infrastructure to deliver vital support programs and social services to our Nation's seniors, including those with Alzheimer's disease. These critical programs are utilized by millions of low-income Americans and provide for such services as home-delivered and congregate nutrition services; in-home supportive services; transportation; caregiver support; community service employment; health and wellness programs; the long-term care ombudsman program; services to prevent the abuse, neglect, and exploitation of older adults; and other supportive services. Twenty-four percent of older individuals with Alzheimer's disease and other dementias who have Medicare are also eligible for Medicaid, punctuating the need within the Alzheimer's community for such programs as Meals on Wheels and the National Family Caregiver Support Program.

We are grateful that the Supporting Older Americans Act of 2020 (P.L. 116–131) included the Younger Onset Alzheimer's Disease Act, championed by Senator Susan Collins (R-ME), to codify existing authority to provide services to individuals living with younger-onset Alzheimer's disease under the National Family Caregiver Support Program and the Long-Term Care Ombudsman Program. The services provided under the OAA are particularly helpful for individuals with younger-onset Alzheimer's disease and related dementias who need assistance with activities of daily living and accessing care.

Supporting Dementia Caregivers

Eighty-three percent of the help provided to older adults in the United States comes from family members, friends, or other unpaid caregivers. Nearly half of all caregivers who provide help to older adults do so for someone living with Alzheimer's or another dementia. And, for the over 11 million Americans caring for individuals with Alzheimer's and other dementias, the emotional, physical, and financial costs can be overwhelming. In 2022, caregivers of people living with Alzheimer's or other dementias provided an estimated 18 billion hours of unpaid care, a contribution valued at $339.5 billion. Of the total lifetime cost of caring for someone with dementia, 70 percent is borne by families—either through out-of-pocket health and long-term care expenses or from the value of unpaid care.

Community services provided under the OAA offer invaluable support for individuals living with dementia, and, due to the unique challenges they face, it is paramount to continue prioritizing care coordination efforts within communities during the reauthorization process. Dementia often requires a multi-disciplinary approach

involving medical professionals, caregivers, social workers, and community support services. Effective coordination helps caregivers navigate the complex healthcare and social service systems and ensures that caregivers and health care professionals collaborate seamlessly, providing comprehensive care tailored to their individual needs. Challenges such as cognitive decline, communication difficulties, and fluctuating symptoms necessitate specialized strategies for coordination. Initiatives promoting dementia-friendly communities and caregiver education programs play crucial roles in enhancing coordination and support networks. By prioritizing and refining care coordination, communities can offer a better quality of life and support for individuals living with dementia and their caregivers.

When developing legislation to reauthorize OAA, we ask that the Committee consider provisions to emphasize the unique and growing support services needed by Alzheimer's and dementia caregivers. We are grateful for the Committee's longstanding work to enhance access to the National Family Caregiver Support Program, and the swift implementation of the country's first National Family Caregiver Strategy as created by the Family Caregiving Advisory Council established by the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act. These dedicated caregivers greatly benefit from increased resources, training, and support to help them navigate the strain of caregiving and improve their health and quality of life.

Strengthening the Dementia Care Workforce

We ask that the Committee consider policies to reduce barriers and ensure individuals living with dementia have adequate access to long-term care and home-and community-based services (HCBS). People living with Alzheimer's and other dementias make up a significant portion of all long-term care residents, comprising 49 percent of all residents in nursing homes and 34 percent of all residents in assisted living communities and other residential care facilities. Given our constituents' intensive use of these services, the quality of this care is of the utmost importance. As a result, we encourage the Committee to consider policies to enhance long-term care and support services for the growing number of Americans with Alzheimer's and other dementias who are eligible to receive OAA services.

A strong dementia care workforce is needed to ensure quality care for aging populations. For example, individuals living with dementia make up a large proportion of all elderly people who receive home-and community-based services, and 31 percent of individuals using adult day services have dementia. Access to these services can help people with dementia live in their homes longer and improve the quality of life for both themselves and their caregivers. In-home care services, such as personal care services, companion services, or skilled care, can allow individuals living with dementia to stay in familiar environments and be of considerable assistance to caregivers. Adult day services can provide social engagement and assistance with daily activities. When drafting language to reauthorize the OAA, we urge the Committee to consider the unique needs of individuals with Alzheimer's and other dementias directly benefit from a well-trained workforce specialized in dementia care.

Conclusion

The Alzheimer's Association and AIM appreciate the Committee's steadfast support and commitment to advancing issues important to the millions of individuals living with Alzheimer's and other dementias, as well as their caregivers. We look forward to working with you as the Older Americans Act reauthorization effort moves through the legislative process and again ask that you keep individuals living with dementia in mind as you develop this bill.

DIVERSE ELDERS COALITION

CHAIRMAN SANDERS, RANKING MEMBER CASSIDY, AND MEMBERS OF THE COMMITTEE:

On behalf of *Diverse Elders Coalition* (DEC), I appreciate the opportunity to submit a statement for the record regarding "*The Older Americans Act: Supporting Efforts to Meet the Needs of Seniors*," and thank you for convening this important hearing.

Founded in 2010, the DEC advocates for policies and programs that improve aging in our communities as racially and ethnically diverse people; American Indians and Alaska Natives; and lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) people. Our member organizations—National Asian Pacific Cen-

ter on Aging (NAPCA), National Caucus and Center on Black Aging, Inc. (NCBA), National Hispanic Council on Aging (NHCOA), National Indian Council on Aging (NICOA), SAGE (Advocacy and Services for LGBTQ+ Elders), and Southeast Asia Resource Action Center (SEARAC)—are experts in the distinctive needs of the racial, ethnic, political, and cultural communities they represent. Through their actions in their respective communities, they are viewed as trusted members who provide services and resources for diverse caregivers and their aging loved ones. Together, we are uniquely positioned to effectively reach our communities in rural areas, cities, and regions throughout the United States.

Six Decades of Supporting Older Americans, but Funding Not Keeping Pace

Older people across the United States aged 60 years and above rely on critical programs and services funded by the *Older Americans Act* (OAA)—originally passed by Congress in 1965—to help them live safely in their homes and communities as they age. *Between 2010 and 2020, the number of Americans age 60 and older increased by 33 percent* from 57.5 million to 76.5 million. In just a few short years, it is projected that *one in five people in the U.S. will be age 65 or older by 2030*. By 2034, older adults will outnumber children for the first time in U.S. history. Increasing our investment in cost-effective OAA programs and services is a critical step in responding to the needs of our aging America.

The vital OAA dollars administered to states and communities every year provide a wide range of services that prevent unnecessary nursing home placement, promote healthy aging, and help people age with independence and dignity where they want to be, in their homes and communities. The OAA helps millions of older adults each year by providing in-home supportive services; family caregiver supports offered through OAA assist those who help older individuals. On that note, we encourage the Committee to ensure the OAA aligns with the *National Strategy to Support Family Caregivers* as enacted through the *Recognize, Assist, Include, Support, & Engage (RAISE) Family Caregivers Act*.

Unfortunately, OAA funding is lagging far behind senior population growth, as well as economic inflation. Meanwhile, 10,000 people turn 65 every day. We urge Congress to incrementally increase annual authorization levels over the 5-year reauthorization period to account for the rise in the older population, the greater need for services, and the impact of inflation on the cost of delivering these services.

A Growing and Diversifying Older Adult Population

Not only is the U.S. older adult population growing rapidly, but it is also becoming increasingly diverse. According to the *most recent U.S. Census*, the share of Americans 65 or older rose by more than a third from 2010 to 2020, the fastest increase in 130 years. Over the next two decades, the White (non-Hispanic) older population is expected to increase by 26 percent, while older racial and ethnic minority populations are expected to grow by 105 percent, including:

- Hispanic by 148 percent;
- African American (not Hispanic) by 73 percent;
- American Indian and Alaska Native (not Hispanic) by 58 percent; and
- Asian American (not Hispanic) by 93 percent.

Over one-third of adults ages 65 and older have some form of disability, and many need assistance with daily activities such as bathing, eating, toileting, housework, medication management, financial management, and grocery shopping. In fact, nearly half of Americans ages 75 and older and a quarter of those ages 65 to 74 report having a disability, according to estimates from *the Census Bureau's 2021 American Community Survey* (ACS). With respect to *adults from racial and ethnic groups*, the numbers with disabilities are:

- 3 in 10 American Indians/Alaska Natives;
- 1 in 4 Blacks;
- 1 in 5 Whites;
- 1 in 6 Native Hawaiians/Pacific Islanders;
- 1 in 6 Hispanics; and
- 1 in 10 Asians.

An estimated *3–5 million LGBTQ+ people have disabilities*, and finding affordable, accessible, and inclusive health-care services is more challenging for them. This is particularly true for those living in rural areas, where LGBTQ+ elders are more likely to have disabilities *and* be at a higher risk for isolation and discrimination, due to a lack of LGBTQ+ inclusive and fully accessible service providers in their communities. Furthermore, LGBTQ+ people with disabilities often report difficulties in having their identities fully recognized. For example, in spaces focused on disability, their unique experiences as LGBTQ+ people may not be accounted for—underscoring the need for intersectional approaches.

Compounding Effect of COVID–19 Pandemic on Diverse Older Adults and Their Caregivers

The COVID–19 pandemic's implications for social isolation, depression, complex risks and health issues for older adults underscored the importance of the *DEC's research on diverse family caregivers* (in partnership with the National Alliance for Caregiving). Anxiety (58 percent) and increased isolation (56 percent) were the top two selections by caregivers across all DEC-hosted webinars when asked about challenges they faced during the pandemic. Across all webinars, 56 percent of polled caregivers selected "taking care of myself" as their top concern. Additionally, 43 percent of diverse caregivers who were surveyed desired more emotional support, further emphasizing the mental health strain and social isolation brought on during the pandemic. By comparing the DEC's data from surveys, focus groups, and key informant interviews, we observed that the COVID–19 pandemic only exacerbated pre-pandemic mental health strain on diverse caregivers.

Along with mental health, participants also selected financial strain (35 percent average) as a top challenge during the pandemic. Unfortunately, financial challenges that have arisen during the pandemic will only worsen family caregivers' pre-existing financial burdens. In our research, on average, 4 out of 10 diverse family caregivers paid expenses for their loved ones' care.

We encourage continuous direct engagement with diverse family caregivers to ensure services and supports are meeting all communities in a way that is in line with personal and family preferences. It is without doubt that this much needed dialog with diverse communities must address a lack of culturally responsive resources to support caregivers' mental health, social isolation, and financial strain, without losing sight of the strengths inherent in the ways in which our communities exercise resilience. We must have the research, data collection, and reporting on all populations to avoid further marginalization, to enhance meaningfully multicultural patient and family engagement, and to be culturally responsive in a way that proactively supports caregivers of older adults, including racially and ethnically diverse family caregivers; American Indian and Alaska Native family caregivers; and LGBTQ+ family caregivers.

To that end, we encourage the Committee to consider continuing certain flexibilities in reauthorization and amending the OAA to sustain pandemic-era innovations that strengthened supports to our communities by making access to services more equitable.

DEC Policy Priorities

We at Diverse Elders Coalition recently released our *Policy Priorities*, which are intended to serve as a guidepost for Federal policymakers in recognizing and addressing the distinct, priority needs of diverse older adults and their caregivers when designing effective, equitable policy solutions for the communities represented by the DEC. As such, we strongly encourage Members of the Committee to consider these critical areas as they undertake the OAA reauthorization process and examine ways to strengthen OAA programs to better serve our communities.

1. Ensure Equitable Access to the Spectrum of Services and Lifelong Needs for Diverse Older Adults

a. Ensure all federally funded programs include person-centered, trauma-informed, culturally appropriate and accessible services to reduce disparities in aging services and supports for diverse older adults. When considering accessibility, programs should take into account the conditions where people live, or social influencers of health—including but not limited to housing, transportation, income, education, pollution, discrimination, lack of family or community support, and violence—that contribute to wide range of disparities and inequities impacting people's health, well-being, and quality of life.

b. Improve language access by making it easier for older adults with Limited English Proficiency (LEP) to navigate and receive quality language assistance; collecting and better utilizing language data to provide personalized language services across Social Security, Medicare, and Medicaid; and translating applications, notices, and resources into additional languages and improving access to in-language materials.

c. Close the digital divide for diverse older adults by bolstering programs that offer expanded eligibility and low-cost access to broadband services; ensuring digital inclusion through best practices on how to reach these communities; providing skills training to promote digital literacy; increasing uptake and utilization of services among those who already have access to broadband; and increasing the supply of affordable broadband.

d. Strengthen anti-discrimination protections in all federally funded programs—around race, ethnicity, Tribal affiliation, language, disability, age, sex, sexual orientation, gender identity, sex characteristics, and immigration status—and allow for intersectional analysis. Emerging research has revealed that historical discrimination and racism contribute to increased aging and cognitive decline.

2. Provide Adequate Resources to Enable Diverse Older Adults to Age in a Place of their Choice, within Age-Friendly Communities

a. Establish Federal standards for measuring and ensuring equitable access to Home and Community Based Services (HCBS) in Medicaid. Medicaid HCBS has turned into a patchwork of programs with wide variation among and within states. This has led to inequities in access and services needed to live in the community, that often leave institutional settings as the only available option for receiving care.

b. Invest in long-term, linguistically robust and culturally appropriate care to enable diverse older adults to self-determine how to age—in place; in congregate care; or as determined by their loved ones. Place special emphasis on Tribal lands, rural areas, and other hard-to-reach communities.

3. Address the Needs of Diverse Caregivers for Older Adults

a. Ensure that the eligibility criteria for programs and services designed for caregivers offer an inclusive definition of "family" to include siblings, aunts, uncles, cousins, nieces, nephews, grandparents, grandchildren, domestic partners, youth, members of the same tribe, friends, and/or community members that are not related by blood, but whose close association with the care recipient is the equivalent of a family relationship.

b. Expand access to programs, services, and resources for diverse caregivers, including low-income and LEP individuals, those with disabilities, and people in rural areas. Respite care, for example, is particularly important for caregivers for people with dementia. Likewise, recognize that a lack of technological literacy in rural, urban, and suburban areas alike may present a challenge for caregivers accessing formal supports.

c. Provide comprehensive, universal paid family and medical leave to family caregivers that includes a broad and inclusive definition of "family."

4. Expand Data Collection, Disaggregation, and Reporting both among and within Diverse Populations

a. Create and promote a Federal demographic data collection standardization requirement, modeled after DEC Members' and expert partners' best practices. Apply these standards to establish demographic data collection, analysis, and reporting to better understand how all programs along the continuum of care are serving individuals, particularly those who are most marginalized, including LEP older adults.

b. Disaggregate available data in order to collect more detailed information on population subgroups. The absence of specific subgroups for race, ethnicity, LGBTQ+ status, and disability has meant that many diverse older adults have fallen through the cracks. Disaggregated and intersectional data collection and reporting are crucial to identify community needs and target programs effectively and efficiently. Oversampling should

also be given strong consideration in all government surveys to help identify the needs of smaller sub-ethnic groups.

c. Provide strong consumer protections by safeguarding the data that has been collected to ensure that it cannot be used for discriminatory, profiling-related actions such as immigration or law enforcement, redlining or targeting of specific groups. Implement strict Federal standards around maintaining collected data safely and securely.

Conclusion

The *Older Americans Act* can—and should—ensure that the aging network has the tools it needs to better meet the needs of *all* older people, including individuals of every sex, sexual orientation, gender identity, race, religion, national origin, disability, and ethnic background. We look forward to working with Members of this Committee and other lawmakers to build upon the long history of bipartisan support for OAA-funded programs that serve older adults and their caregivers, particularly in hard-to-reach and underserved communities across the United States.

On behalf of the Diverse Elders Coalition, thank you again for the opportunity to submit a statement for the record. Should you have any questions, please contact DEC Director of Policy and Advocacy Didier Trinh.

ELDER JUSTICE COALITION

The Elder Justice Coalition commends Chairman Sanders and Ranking Member Cassidy for convening this first hearing for the Reauthorization of the Older Americans Act. Next year we will celebrate the 60th anniversary of this remarkable program and the 33rd anniversary of Title VII, which houses the Act's elder justice activities.

We are a nonpartisan coalition of 3,000 individuals and organizations dedicated to ending elder abuse, neglect and exploitation via Federal policy. In a reauthorized OAA, funding all of Title VII, especially tribal elder justice programs, is necessary to build and maintain the capacity to respond to abuse reports, and we call on the Committee to better recognize the reality of abuse, neglect, and exploitation of older adults and people with disabilities and provide adequate funding levels to address them. We have received multiple stories of older adults who could benefit from a fully funded program. One woman in Michigan whose daughter created an unnecessary guardianship to take money and jewelry. Or an elderly veteran in North Carolina taking care of her sick spouse taking out a $90k loan for her neighbor's credit debt, only to be financially exploited.

Our coalition has always recognized that APS agencies have a pivotal role as the primary line of defense for elder abuse victims, offering crucial assistance, support, and help in prevention. We believe that robust support and funding for APS agencies is integral to effectively meet the needs of elder abuse victims and their cases. Across the country, states have communicated current struggles with inadequate funding and staffing within their APS programs. Higher authorization levels can start to address these issues to ensure the effective implementation of APS initiatives.

Funding and support for the National Adult Protective Services Technical Assistance Resource Center (APS-TARC) and the National Long-Term Care Ombudsman Resource Center (NORC) should continue in the next reauthorization, as they are crucial to providing support, technical assistance, and training to state Long-Term Care Ombudsman Programs and Adult Protective Services.

As we have commented in past reauthorizations, we believe Title VII activities should be integrated further into Title III nutrition programs and call for elder abuse training for all who work in OAA programs. This is already taking place in states where nutrition providers are mandatory reporters, but all older adults could benefit from increased recognition and reporting of elder abuse.

We appreciate that the recently issued final OAA regulations established of expectations for legal service providers to help in elder abuse prevention and clarified that the aging network has a role to defend against the imposition of guardianship

and in promoting alternatives. We appreciate that the first-ever APS Regulations will soon be released.

Sincerely,

BOB BLANCATO,
National Coordinator Elder Justice Coalition.

THE NATIONAL ASSOCIATION OF NUTRITION AND AGING SERVICES (NANASP)

The National Association of Nutrition and Aging Services (NANASP) commends Chairman Sanders and Ranking Member Cassidy for convening this first hearing for the Reauthorization of the Older Americans Act. Next year we will celebrate the 60th anniversary of this remarkable program. This is the time in its 59th year to renew, reinvigorate, and modernize its programs and services for the future.

Our 1100+ members provide nutrition services to over 4 million older adults a year in both congregate and home delivered settings. In a reauthorized OAA, it is vital that both Titles III-C1 and C2 maintain their identity. This could be accomplished through a straight consolidation of funding, perhaps better achieved through a parity of funding, or by providing a higher transfer authority between C1 and C2. As with past reauthorizations, we would like transfers between Title III-C and III-B to give priority to nutrition-related services.

Authorization levels need to better reflect the realities on the ground including some aftermath issues from the pandemic. While the pandemic required an almost full shift to home delivered meals, prior to the pandemic, two thirds of older adults in the program were served in congregate settings. There is a strong desire among nutrition providers to get more congregate programs back into communities because these programs provide more than just a meal. Congregate sites offer important nutrition education and invaluable socialization opportunities. Congregate nutrition programs and senior centers both in-person and virtual are real solutions to the increased isolation and loneliness among older adults. We are supportive of separate and dedicated funding for both socialization programs and the senior centers which provide them.

We appreciate that the recently issued final OAA regulations continued many of the successful pandemic-era flexibilities for senior nutrition programs. We believe others could be included such as allowing carryout, groceries, or less frequent deliveries.

We believe it's important to ensure OAA funded meals are of high nutritional value to promote healthy aging while ensuring continued participation. We believe the current language that meals must meet both 1/3 Dietary Reference Intakes and will comply with the most recent Dietary Guidelines for Americans (DGA) should be updated to follow only the DGA as they focus on older adult nutrition needs.

We also support all efforts at the state and area level to incorporate malnutrition prevention programs. We would like to include malnutrition screenings in Title III-D health screenings and malnutrition in nutrition education provided in Title III.

In brief, some other early principles we would like to advance and provide greater depth in the future:

- We call on data collection to specifically define and include both waiting list and unmet need to ensure better allocation of resources
- We support greater recognition and support for medically tailored meals and culturally appropriate meals, the latter being important to helping to achieve better targeting in the nutrition program
- We would also like to explore the inclusion of language allowing Title III reimbursement of assistive technology which has been enhancing service older adults in the OAA since the last reauthorization

Sincerely,

BOB BLANCATO,
Executive Director NANASP.

PHILADELPHIA CORPORATION FOR AGING

Dear Esteemed U.S. Senate HELP Committee Members:

Good morning, my name is Najja Orr, and I am the President and CEO of Philadelphia Corporation for Aging, also known as PCA. PCA wants to thank Chairman Sanders, Ranking Member Cassidy and the Members of the Senate Committee on

Health, Education, Labor, and Pensions for the opportunity to provide input on the critical reauthorization of the Older Americans Act. PCA also wants to commend Senator Casey, Pennsylvania's senior Senator, and Chair of the Special Committee on Aging for his leadership on the Older Americans Act and issues facing older Pennsylvanians.

First and foremost, PCA wants to express its strong support for the reauthorization of the Older Americans Act to continue the essential work provided to older adults through the Aging Network. Area Agencies on Aging (AAAs) as authorized through the Older Americans Act serve a critical function in communities across the Nation. AAAs play an essential role in promoting the health, independence, and well-being of older adults, as well as supporting their caregivers and advocating for policies that benefit the aging population.

Philadelphia Corporation for Aging (PCA) is a 501c3 non-profit organization which has served for the past 50 years as the designated AAA for Philadelphia, Pennsylvania. PCA is the largest AAA in the Commonwealth of Pennsylvania and advocates on behalf of more than 316,000 older Philadelphians. Older Philadelphians are diverse with 44 percent identifying as white, 56 percent identifying as minority and 16 percent identifying as foreign born. Nearly 20 percent of Philadelphia's total population is over 60 and 28 percent of them are 75 or older. Older Philadelphians, like the overall population of the city, generally have a lower income with 30 percent below 150 percent of the Federal poverty level and more than 20 percent below 100 percent of the Federal poverty level. Philadelphia has consistently been among the cities with the highest proportion of impoverished older adults of the 10 largest cities in the United States.

As the state-designated AAA for Philadelphia County, PCA is responsible for coordinating and administering Federal, state, and local funds for older Philadelphians and adults with disabilities. The agency provides more than 30 services, including advocacy, care management for long-term care programs, protective services, home-delivered meals, and the administration of senior centers. PCA has coordinated a broad range of services for more than 140,000 older Philadelphians annually to fulfill our mission to improve the quality of life for older Philadelphians and people with disabilities, and to assist them in achieving their maximum level of health, independence, and productivity.

In fiscal year 2024, PCA projects to provide more than 1.27 million home-delivered meals and more than 315,000 congregate meals; serve more than 15,000 community members at senior community centers; provide approximately 325,000 personal care service encounters, approximately 1,100 home support visits, and approximately 1,700 adult day care sessions; subsidize more than 100,000 trips through our Shared Ride Program; and respond to more than 9,100 reports of need for suspected elder abuse.

Pennsylvania's State Unit on Aging is currently developing a Master Plan on Aging called "Aging Our Way, PA," with the support of the AAAs and other stakeholders throughout the Commonwealth. As a part of this process PCA coordinated 17 listening sessions in 14 different zip codes in Philadelphia. Six of the listening sessions had interpreters present to conduct the session in Spanish, Mandarin, or Korean. The agency also offered sessions for the LGBTQ+ elder community and professionals in the aging field. Many of the comments expressed were repeated across the city including the importance of safety in the community, affordable accessible housing, and reliable transportation. Older Philadelphians also underscored the need to feel respected by the community and health care providers, have access to interpretation services, and the desire for employment and volunteer opportunities.

It is important to note that the underlying core issue of ongoing, deep poverty is the driving force behind many of the concerns heard throughout the listening sessions and is seen daily in our work across the city. In reauthorizing the Older Americans Act PCA urges the Committee to ensure the continuing focus on addressing systemic poverty among older adults. This will alleviate the pressure on health systems, home and community-based services, and food insecurity as well as confront the realities of safe housing, and secure communities.

It is critical that the Older Americans Act continue to provide clarity regarding which factors may be used by states to demonstrate "greatest economic need," and "greatest social need," especially for use in intra-state funding formulas. PCA believes states should have a formalized process that provides transparency in the evaluation and selection of all measures beyond income and should include an explicit requirement that AAAs be included in this process.

Given the enormous body of research on the linkage of racial and ethnic status to disparities in health and social well-being, there should be an explicit separate

requirement that racial or ethnic status be a factor in this definition as outlined in the Older Americans Act. Evidence of this can be seen in Philadelphia where, according to Philadelphia's Department of Public Health, 2023 Health of the City Report, African Americans experience worse health outcomes, have lower life expectancy, and are dying at higher rates than other racial and ethnic groups in Philadelphia. [1]

Additionally, as the Committee considers the reauthorization and funding of services that benefit older adults, PCA urges you to address the alarming nationwide trend of at least 1 in 10 older adults experience some form of elder abuse, neglect, or exploitation, according to the National Center of Elder Abuse Report, Prevalence of Elder Mistreatment. [2] In Philadelphia, protective services reports of need have grown from approximately 5,000 in fiscal year 2016 to over 9,000 during fiscal year 2023. The challenge faced in funding protective services and other PCA services is in many ways compounded by two other major factors. First, many of PCA's core functions have been level funded for the past decade. Second, PCA, like all other human services and health agencies, is grappling with the dramatic changes in the labor market including the shortage of key personnel.

PCA would like to take this opportunity to echo many of the recommendations provided by USAging in their Policy Brief, Recommendations for the Reauthorization of the Older Americans Act [3] including:

"*Recommendation 1.1: Significantly increase authorized funding levels to meet the real and urgent needs of a rapidly growing older population and the rising costs of service delivery*."

As the older adult population continues to grow and needs increase in complexity, coupled with the rising costs of service, it is important that funding levels continue to meet the real needs of those AAAs are entrusted to serve and to protect the most vulnerable in our community including those at risk for elder abuse.

"*Recommendation 1.3: Allow Title III D health and wellness programs to be evidence-informed—not just evidence-based—to expand the Aging Network's ability to reach older adults with emerging interventions and to extend the reach especially in rural areas and other areas which have limited funding for this important work*."

PCA believes it is critical to call attention to the strict definition of evidence-based programs. There is no doubt that it is necessary to utilize programs that apply best practices and are validated, however the high bar of evidence-based can inhibit innovation and ability to utilize programs that address the unique needs of diverse communities. The Aging Network should be provided with the flexibility to use evidence-informed programming which will allow more opportunities to develop affordable and innovative programming.

"*Recommendation 2.1: Unify and modernize the Title III C nutrition funding streams and programs to reflect recent innovations, the changing needs of consumers and the goal of local decision-making inherent in the Act*."

Lessons learned from COVID–19 taught us of the importance of being flexible, adaptive, and innovative in our practices. Due to flexibility in funding allowed as a result of the pandemic, AAAs across the country devised incredibly innovative and unique models to ensure nutrition services were provided to their constituents. Allowing continued flexibility of funding will ensure local providers can meet the needs of their communities including person-centered approaches and cultural considerations in meal provision.

"*Recommendation 3.1: Increase the administrative funding ceiling by 2 percentage points to ensure appropriate program development, oversight and network management amid rising costs and eroding Federal OAA funding*."

Administrative funding is essential for AAAs to be able to explore opportunities for innovations, to bridge the gap between state and Federal funding and the increasing cost of labor, goods, and services, as well as to conduct strategic planning and research to ensure that growing communities in need are being reached.

Finally, PCA would also like to echo the Older Americans Act Modernization Priorities from The National Council on Aging to protect and strengthen the Senior

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[1] Philadelphia Department of Public Health (2023). Health of the City Report. Retrieved from *https://philadelphiapublichealth.shinyapps.io/health-of-the-city*.

[2] National Center of Elder Abuse (2024). Prevalence of Elder Mistreatment. Retrieved from *https://ncea.acl.gov/prevalenceofeldermistreatment#gsc*.

[3] USAging (2024). Policy Brief: Recommendations for the Reauthorization of the Older Americans Act. Retrieved from https://www.usaging.org//Files/USAging-OAAReauth-Recommendations-Final-Version.pdf.

Community Service Employment Program (SCSEP) and update eligibility requirements.[4] As mentioned previously, PCA heard from older Philadelphians a desire to find employment opportunities, and given the poverty faced by older adults in Philadelphia and across the Nation, there is a need for a strong support system.

Thank you for providing this opportunity to share my perspective about the important services enabled by the Older Americans Act and for your dedication to supporting older adults. The reauthorization and strengthening of the Older Americans Act will ensure that older adults will continue to have the opportunity to age in their communities of choice with dignity.

Sincerely,

NAJJA R. ORR, MBA, DBA,
President and CEO.

USAGING

Introduction

Thank you to the Senate HELP Committee for the opportunity to provide written testimony regarding the reauthorization of the Older Americans Act (OAA). I write to you from the vantage point of my two roles. One as the Chief Executive Officer of Senior Resources of West Michigan, an Area Agency on Aging, and the other as President of USAging, the national association representing Area Agencies on Aging and advocating for the Title VI Native American Aging Programs. Senior Resources provides services to three diverse counties on Michigan's west coast. We serve a rural county, one of the healthiest counties in the state and another county that is one of the unhealthiest counties in the state. However, one of the Act's guiding principles—local flexibility—supports our AAA's ability to identify, plan for and meet the needs of a diverse aging population in our service area.

In fiscal year 2023 the services we provided or funded through local community partners served nearly 13,000 participants. In keeping with the Act's charge to leverage funding to meet the needs of older adults and caregivers, our services are supported by Federal OAA dollars, state Older Michiganians Act funds and a county senior millage. We primarily utilize OAA funds to help older adults, especially those in greatest economic and social need, remain in their preferred home setting and community through the provision of home and community-based services, which include information and referral/assistance, care coordination, in-home services, nutrition, transportation, legal services, evidence-based health and wellness programs, caregiver support services and more.

The demand for these services significantly exceeds available funding and with the increased costs for direct care workers, food, transportation and business operations, our agency is currently unable to serve as many older adults and caregivers as we have in prior years. This is despite the fact that the aging population is growing in Michigan and nationwide due to dramatic demographic growth of those older than age 65, including the fastest-growing population in the country, which are those age 85 and older. This is why a significant increase in authorized OAA funding levels, followed by actual increased Federal appropriations, is sorely needed.

In addition, and separate from our OAA programs and services, our AAA is a 1915c Medicaid Waiver provider for approximately 1,300 participants; this is frequently true of other AAAs around the country. One of our most innovative recent programs is our Primary Care at Home service which is designed to address the medical needs of patients who have difficulty leaving their homes for medical appointments. We also offer Behavioral Health at Home services, participate in the VA Home and Community Based Services program and are currently developing an Institutionally Equivalent Special Needs Plan with two other AAAs to provide another long-term care option for older adults in the communities we serve. Our program development and innovation is rooted in the intent of the OAA and everything we do is with an eye to our mission to ensure that older adults can age with optimal health, independence and dignity and how we can better reach and serve older adults to achieve that goal.

That is why in addition to increased authorization levels and appropriations for the OAA, my agency and our national association, USAging, are calling for changes

[4] National Council of Aging (2024). NCOA Older Americans Act Reauthorization Priorities. Retrieved from *https://www.ncoa.org/article/ncoa-older-americans-act-reauthorization-priorities*.

to the OAA that currently impede the development of outside-of-OAA revenue sources so that AAAs can serve more older adults and better meet their missions. We must have clarity, transparency and flexibility so that the OAA's mission and assets are protected and prioritized, yet AAAs and providers in the Aging Network must be able to engage with health care entities to bridge the gaps between acute care and social care, to address the social drivers of health, support the healthy aging of older adults and ensure there are more home and community-based services available in every community in the Nation.

The health care system is shifting its focus to health equity and health-related social needs (HRSNs), and this has been reinforced and encouraged by the Biden administration in their recent efforts. These HRSNs are often, if not always, addressed by social care organizations, such as AAAs, and health care organizations are increasingly relying on AAAs to provide these services. It is important to ensure that there are no barriers in place to prevent AAAs from providing HRSN services to individuals, especially older adults, so that they can receive the social care they need to maintain their overall health and well-being.

OAA authorization will expire at the end of fiscal year 2024 and today, the vision and mission of OAA is even more important than it was nearly six decades ago, as our Nation faces an unprecedented demographic shift. Enabling aging in place should be a bipartisan national priority. Fostering a society in which aging at home and in the community is not only the collective desire but also the national expectation requires us to recognize, protect and bolster the foundation upon which this goal was built. The OAA is that foundation, and as Federal policymakers consider the Act's reauthorization, USAging urges Congress and the Administration to work toward policy decisions that honor the longstanding intent of the OAA while seeking legislative updates that enable continued innovation, flexibility and greater capacity to meet the needs of this Nation's rapidly growing aging population and their caregivers.

The following USAging recommendations reflect members' five decades of experience, innovative work and commitment to the needs of today's older adults and caregivers.

USAging 2024 OAA Reauthorization Recommendations

(DETAILS AVAILABLE AT *www.usaging.org/OAA*).

Goal 1: Serve More Older Adults Who Need to Age Well at Home

Recommendation 1.1: Significantly increase authorized funding levels to meet the real and urgent needs of a rapidly growing older population and the rising costs of service delivery. USAging's over-arching top priority for the 2024 reauthorization is that Congress significantly increase authorization levels for all titles of the Act. These are woefully underfunded programs and services that are needed by older adults, caregivers and families, now more than ever. A strong statement by reauthorizers to appropriators as to the value of these cost-effective services and the importance of investing in OAA to avoid higher health and long-term care costs is essential in this reauthorization.

Recommendation 1.2: Ensure that AAAs and other Aging Network community-based organizations are able to further meet their missions by securing health care or other private funding to serve more older adults. Nearly all AAAs' mission-driven programs and services go beyond just their duties under the OAA. Despite a growing older adult population, Federal OAA funding has eroded, forcing AAAs to seek other funding streams and relationships to supplement their OAA funding to better meet their missions. We urge Congress to clarify and rectify the conflicting and ambiguous language in multiple sections of the Act to ensure that when OAA funds are leveraged for health care contracts or establish private-pay programs, State Units on Aging have a clear, non-burdensome and appropriate oversight process for the AAAs' activities.

Recommendation 1.3: Allow Title III D health and wellness programs to be evidence-informed—not just evidence-based—to expand the Aging Network's ability to reach older adults with emerging interventions and to extend the reach especially in rural areas and other areas which have limited funding for this important work. The higher cost of evidence-based programs—due to ensuring fidelity to the proven method—makes it extremely difficult for AAAs with either a small allocation or a widely dispersed service population to stand up a successful program that reaches older adults who could greatly benefit from these interventions. Strict fidelity also creates barriers to offering culturally relevant pro-

gramming at times—as the model cannot be adapted to best reflect local needs and remain evidence-based. Therefore, we are requesting that Congress restore flexibility in III D, allowing AAAs to provide evidence-informed, or similar, programming as well as evidence-based models.

Recommendation 1.4: Expand Title VI, Grants for Native American Aging Programs, to include a dedicated Supportive Services funding stream and boost the capacity of grantees through more robust training and technical assistance. Congress should expand Title VI, Grants for Native Americans, to allow and authorize funding for a wider range of supportive services than is feasible with current funding and capacity, such as transportation and health and wellness programs. While Title VI Parts A and B allow grantees to offer supportive services similar to those authorized under Title III of the Act, the funding is primarily spent on nutrition services first, with little funding remaining for additional wraparound services such as transportation, in-home care, legal assistance and other supports that are so desperately needed.

Goal 2: Meet the Needs of Today's and Tomorrow's Older Adults

Recommendation 2.1: Unify and modernize the Title III C nutrition funding streams and programs to reflect recent innovations, the changing needs of consumers and the goal of local decision-making inherent in the Act. While maintaining the integrity and goals of the C1 congregate meals program and the C2 home-delivered meals program, it's time to create one funding stream and one nutrition program, with approved activities that reflect the history, present and future of nutrition service delivery. USAging believes that there should be a unified III C Nutrition Services, with several authorized program options under it.

Recommendation 2.2: Reduce social isolation and loneliness among older adults by authorizing a national resource center dedicated to providing training and technical assistance for Aging Network professionals on innovative strategies to build and expand social engagement programs and activities. Currently this work is dependent on ACL's decision to fund it from its discretionary pool of dollars. And as their attention has turned to more consumer-focused social isolation campaigns to broader audiences beyond older adults, professional resources stand to be lost. Adding authorization for a national center focused on the Aging Network professionals who deliver social engagement opportunities is not only needed but complements the 2020 statute additions and ensures that the Act addresses emerging needs through proven delivery systems.

Goal 3: Maintain Efficient Oversight and Management of Local Service Delivery to Ensure Quality

Recommendation 3.1: Increase the administrative funding ceiling by 2 percentage points to ensure appropriate program development, oversight and network management amid rising costs and eroding Federal OAA funding. The Act's current limit of 10 percent for administration of the Area Plan (Sec. 304 (d)(1)(A)) is no longer feasible due to many years of eroded funding and increased costs of doing business, such as but not limited to personnel, liability insurance, information technology, data collection and reporting requirements. To ensure the highest quality programming and services, AAAs must be able to maintain an adequate workforce, conduct quality assurance and oversight of providers, and successfully perform their planning and program development duties.

Authorized and actual funding levels have not increased over the past two decades to meet the rapidly growing size of the age 60+ population and their caregivers who need these services, nor the rising costs of labor, food, supplies and infrastructure. Therefore, the current 10 percent administrative percentage is insufficient. Given eroded funding and cost growth, it is necessary to increase the amount AAAs are able to draw from to efficiently and effectively plan, develop and administer this wide array of critical OAA programs and services. USAging recommends Congress increase the maximum administrative percentage to at least 12 percent in the 2024 reauthorization. This is well in line with standard administrative rates for other nonprofit organizations.

Conclusion

USAging has alerted policymakers for decades about this current demographic shift and the need to plan, prepare and create options in the community that help older adults stay healthy and independent—and out of institutions. The time now has come for Congress to recognize the value of the OAA as the critical non-Med-

icaid HCBS resource that meets these goals and invest accordingly. We urge Congress to preserve the essential infrastructure of the OAA and expand its capacity to serve the growing number of Americans who will need the vital services it provides. Thank you for the opportunity to share our OAA reauthorization recommendations and how they would help the Act better meet the needs of older adults and caregivers across the country, especially those who most need assistance.

[Whereupon, at 12:42 p.m., the hearing was adjourned.]

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