

# THE OLDER AMERICANS ACT: IMPROVING QUALITY OF LIFE FOR AGING AMERICANS

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## **FIELD HEARING**

BEFORE THE  
SUBCOMMITTEE ON SELECT EDUCATION  
OF THE  
COMMITTEE ON EDUCATION  
AND THE WORKFORCE  
U.S. HOUSE OF REPRESENTATIVES  
ONE HUNDRED NINTH CONGRESS  
SECOND SESSION

April 28, 2006, in Westerville, Ohio

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# C O N T E N T S

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	Page
Hearing held on April 28, 2006 .....	1
Statement of Members:	
Hinojosa, Hon. Rubén, Ranking Minority Member, Subcommittee on Select Education, Committee on Education and the Workforce .....	3
Prepared statement of .....	4
Tiberi, Hon. Patrick J., Chairman, Subcommittee on Select Education, Committee on Education and the Workforce .....	1
Prepared statement of .....	2
Statement of Witnesses:	
Bibler, David, executive director, Licking County Aging Program .....	11
Prepared statement of .....	13
Gehring, Charles W., president and chief executive officer, LifeCare Alliance .....	18
Prepared statement of .....	20
Geig, Elise, legislative liaison, Ohio Department of Aging .....	6
Prepared statement of .....	8
Horrocks, Robert, executive director of the Council for Older Adults of Delaware County .....	23
Prepared statement of .....	25
Ragan, Ginni, chair, Legislative Affairs Committee, Ohio Advisory Council for Aging .....	29
Prepared statement of .....	31
Additional Submissions for the Record:	
The National Council on Disability, prepared statement of .....	51



**THE OLDER AMERICANS ACT:  
IMPROVING QUALITY OF LIFE  
FOR AGING AMERICANS**

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**Friday, April 28, 2006  
U.S. House of Representatives  
Subcommittee on Select Education  
Committee on Education and the Workforce  
Westerville, OH**

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The subcommittee met, pursuant to call, at 2:30 p.m., at the Westerville Senior Center, 310 W. Main Street, Westerville, Ohio, Hon. Patrick Tiberi [chairman of the subcommittee] presiding.

Present: Representatives Tiberi and Hinojosa.

Staff Present: Kate Houston, Professional Staff Member; Lucy House, Legislative Assistant; Ricardo Martinez, Minority Legislative Associate; and Moira Lenahan-Razzuri, Legislative Assistant for Mr. Hinojosa.

Chairman TIBERI. Quorum being present, the Subcommittee on Select Education, the Committee on Education of the Workforce will come to order. We are meeting today to hear testimony on the Older Americans Act: Improving Quality of Life for Aging Americans. I ask for unanimous consent that the hearing record remain open 14 days to allow member statements and other extraneous material referenced during the hearing to be submitted for the official record. Without objection, so ordered.

Good afternoon. Thank you all for joining us this afternoon for a hearing of the Select Education Subcommittee of the Committee on Education of the Workforce. I have a prepared formal opening statement that I'll ask to be submitted for the record.

Let me begin by extending our sincere thanks to Tim and the folks here at the Westerville Senior Center for so graciously hosting and opening this room up for this hearing. I also want to thank my friend and my colleague from Texas, Ruben Hinojosa, for traveling to central Ohio to join us here today for this important hearing.

I'm especially proud to bring this hearing to central Ohio to hear from constituents and others to provide us with a local perspective and expertise on aging issues and inform us about this process that they work on every day.

I want to just acknowledge and also recognize the former Director of Aging for the State of Ohio and a constituent and former colleague, Joan Lawrence, who is here today. Joan, thank you for being here.

Over the past several months, this subcommittee has been examining the current program, learning about the evolving issues facing older Americans, listening to seniors in their own words, laying out a plan for strengthening services to seniors that are authorized by this Act and relied upon by millions of aging Americans each year.

It is with great pleasure to have my colleague and friend from Texas, Mr. Hinojosa, as a partner in this process. We had a hearing actually down in Texas recently; and as we move forward, I hope to work with not just my colleagues on the committee but all of you to ensure that the Federal Government is making the most out of the taxpayers' investment in this program and programs authorized by this Act.

Today we are honored to have with us a distinguished panel of experts to help us frame the issues for this hearing. I look forward to hearing your recommendations on the issues and actions for this subcommittee's consideration.

Before I introduce each of our witnesses, however, I do want to recognize my colleague, Mr. Hinojosa, for an opening statement.

Mr. Hinojosa?

**Prepared Statement of Hon. Patrick Tiberi, Chairman, Subcommittee on Select Education, Committee on Education and the Workforce**

Good morning. Thank you for joining us for this hearing of the Select Education Subcommittee of the Committee on Education and the Workforce. I want to extend my thanks to the Westerville Senior Center for so graciously hosting this hearing. I also want to thank my friend and colleague, Mr. Hinojosa, for traveling to the 12th District of Ohio.

This is the second and final field hearing on the Older Americans Act, which this Subcommittee is scheduled to consider this Spring. Field hearings offer Members of Congress a unique opportunity to listen to witnesses who can give us a local perspective on an issue. Field hearings are an important part of this reauthorization and I am especially proud to bring this hearing to the 12th Congressional District of Ohio to hear from constituents with tremendous expertise on aging issues to inform this process.

The Older Americans Act recognizes the specialized needs of all seniors. These needs may include meals and nutrition, transportation, employment, recreational activities and social services, information about prescription drug benefits or long term care—to name a few. We are fortunate that the United States has a sound infrastructure to support these needs. In fact, our robust aging network includes 655 local and 56 state agencies on aging. This year, the federal government invested nearly \$1.8 billion to support the delivery of these services.

Today, supporting the needs of older Americans is as important as ever. It is estimated that more than 36 million people in the United States are over the age of 65, making it the fastest growing age group in our country. According to the U.S. Census Bureau, by the year 2050, persons over age 65 will reach nearly 90 million and comprise almost a quarter of the total U.S. population. These astounding statistics make the upcoming reauthorization of the Older Americans Act all the more important. This year, the first baby boomers turn 60 making this a very relevant time to be considering amendments to the Act.

Over the past several months, this Subcommittee has been examining the current program, learning about the evolving issues facing older Americans, listening to seniors in their own words, and laying out a plan for strengthening services to seniors that are authorized by this Act and relied upon by millions of aging Americans each year. It is a great pleasure to have Mr. Hinojosa as a partner in this process. I am also pleased that each of you, and many advocates for seniors nationwide, are contributing to our effort. As we move forward, I look forward to working with all of you to ensure that the federal government is making the most out of the taxpayer's investment in the programs authorized by the Older Americans Act.

Today we are honored to have with us a distinguished panel of experts to help us frame the issues for this hearing. I look forward to hearing your recommendations on issues and actions for this Subcommittee's consideration. Before I introduce

our witnesses, I yield to the Ranking Member of the Subcommittee, Mr. Hinojosa, for his opening statement.

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Mr. HINOJOSA. Thank you very much, Chairman Tiberi. I want to express my appreciation for inviting me to Westerville, Ohio, to be able to participate in this public hearing, one that is very important.

My parents had 11 children; and my mother lived to the age of 95, and she taught me the importance of taking care of older Americans.

The Older Americans Act is one of the most important pieces of legislation that our subcommittee has the privilege to work on. I thank you again for calling this hearing. I am pleased to be in Ohio and to visit another part of your district. I would especially like to thank the Westerville Senior Center and all of the staff and participants for being such gracious hosts. I must share with you that we have a growing Ohio/Texas connection. At our last field hearing in Ohio, we met a number of students from my district in south Texas who were attending Ohio State University as part of a college assistance migrant program; and, of course, we now have a University of Texas/Ohio State football rivalry brewing.

It was ironic that we arrived here in Ohio at the airport and one of the students who had attended the last hearing that we had over at Ohio State University campus happened to see the chairman and me and hurriedly ran up to us and introduced herself and told us how she had weathered the first winter in Ohio. Coming from south Texas where we have semitropical weather—I don't think we have had snow except once in a hundred years. That was last Christmas. And this young lady was telling us how she had weathered the snow and all the winter here in this region and delighted to tell us a little bit about how she was enjoying the university.

Another connection is the growing number of Ohio residents who we adopt as winter Texans. We get approximately 150,000 winter Texans to my area because of the climate. And I must say that they do contribute a great deal to the economic successes that we are enjoying.

Last month, a couple of winter Texans from Ohio were featured in our local paper. These women, on the plus side of 85 years young, tutor and read to children in some of the poorest schools in my area. Their knowledge and caring make a real difference for our students. Our seniors are a valuable resource for our communities across the nation. We should look for ways to maximize their resource.

As we prepare for the reauthorization of the Older Americans Act, we should never lose sight of the great potential in our older population. Our nation cannot afford to waste it. I'm looking forward to our discussion today, and I'm looking forward to hear the witnesses who have an impressive record of service and experience. It's essential that we hear from people who are directly involved with making the Older Americans Act the success that it is. I share the witnesses' concern about the resources to meet the challenges of increased costs and a growing population. I share with you the concern that you all have expressed at lunch today regarding the reduction in the budget. We must work together to build the capac-

ity of our aging network to meet demographic challenges ahead. We have already asked you to do more with less, but there comes a time when a system stretched to the limit will break. We cannot allow that to happen with the Older Americans Act.

In closing, Mr. Chairman, I want to thank you for inviting me again. I want to invite those of you in the audience—thank you for coming to be with us. I am looking forward to the witnesses' testimony and continuing the dialog about how we can achieve our goal of enabling all of our older Americans to enjoy the dignity they deserve. And I yield back.

**Prepared Statement of Hon. Rubén Hinojosa, Ranking Minority Member, Subcommittee on Select Education, Committee on Education and the Workforce**

Thank you, Mr. Chairman. The Older Americans Act is one of the most important pieces of legislation that our subcommittee has the privilege to work on. Thank you for calling this hearing today.

I am pleased to be in Ohio again and visit another part of your district. I would especially like to thank the Westerville Senior Center and all of the staff and participants for being such gracious hosts.

I must share with you that we have a growing Ohio—Texas connection. At our last field hearing, we met a number of students from my district in South Texas who were attending the Ohio State University as part of the College Assistance Migrant Program. And of course, we now have a University of Texas—Ohio State football rivalry brewing.

Another connection is the growing number of Ohio residents who we adopt as winter Texans. Our winter Texans contribute greatly to our community. Last month, a couple of winter Texans from Ohio were featured in our local paper. These women—on the plus side of 85 years old—tutor and read to children in some of the poorest schools in my area. Their knowledge and caring make a real difference for our students.

Our seniors are a valuable resource for our communities across the nation. We should look for ways to maximize that resource. As we prepare for the reauthorization of the Older Americans Act, we should never lose sight of the great potential in our older population. Our nation cannot afford to waste it.

I am looking forward to our discussion today. The witnesses have an impressive record of service and experience. It is essential that we hear from people who are directly involved with making the Older American's Act the success that it is.

I share the witnesses' concern about resources to meet the challenges of increased costs and a growing population. We must work together to build the capacity of our aging network to meet the demographic challenges ahead. We have already asked you to do more with less, but there comes a time when a system stretched to the limit breaks. We cannot allow that to happen with the Older Americans Act.

Thank you for being with us today. I am looking forward to the witnesses' testimony and continuing the dialogue about how we can achieve our goal of enabling all of our older Americans to enjoy the dignity they deserve.

I yield back.

---

Chairman TIBERI. Thank you, Mr. Hinojosa.

Let's get right to our witnesses. And I will introduce all of you, and then we'll begin from left—my left to right with the testimony. First off, I want to recognize Merle Kerns, Director of Department of Aging, who couldn't be here today; but in her stead, we have Elise Geig, who is the legislative liaison for the Ohio Department of Aging. In this capacity, she tracks and reviews state and Federal legislation and makes policy recommendations to the Ohio Department's Director on issues concerning older Americans. Ms. Geig started her career in the Ohio House of Representatives where she served on the staff of State Representative Jim Hoops and as a legislative aide to the Chair of the House Education Committee Representative, Arlene Setzer.

Thank you for being here today.

Mr. David Bibler is the executive director of the Licking County Aging Program in Newark, Ohio. The Licking County Aging Program is a nonprofit organization that provides services supporting independent and healthy lifestyles for older individuals. Mr. Bibler is responsible for overall operations of the agency including overseeing the budget and preparing funding proposals, personnel policymaking, as well as Federal and state compliance.

Thank you for being here today as well.

Mr. Charles Gehring is president and chief executive officer of LifeCare Alliance, one of central Ohio's oldest and largest nonprofit organizations. LifeCare Alliance's mission is to provide health, nutrition services to those in need in central Ohio. LifeCare Alliance markets meals to other Meals on Wheels providers, child care programs, providers and hospitals.

In addition to his work at LifeCare Alliance, Mr. Gehring is a professor at Franklin University where he helps instruct students interested in the management of not-for-profit and public organizations.

Professor Gehring, thank you for being here.

Mr. Robert Horrocks is the executive director of the Counsel for Older Adults in Delaware County. He has led the organization through its early development; is credited with its successful growth. The counsel provides a variety of community services to help Delaware County become a better place to live and grow older. Prior to accepting the position as the executive director of the Counsel for Older Adults, Bob served as the assistant director of the Ohio Department of Aging. In 1997, Mr. Horrocks received the highest honor of the Columbus based Vision Center when he was selected to receive the Medic Award as the outstanding visually impaired citizen of Ohio.

Thanks for being here, Bob.

Last but not least, Ms. Virginia Ragan is here today to represent the senior community of Westerville, Ohio. She's an active and engaged member of the community currently serving on a number of boards and organizations that work to assist and improve the lives of older individuals. Ms. Ragan has served a long and distinguished career with the Ohio legislature and was serving on the staff of Representative John Ashbrook for a number of years. Her knowledge spans a wide range of issues including tax reform, financing, in addition to her expertise in issues involving older Americans. In 2002 and, again, in 2004, Ms. Ragan was appointed by Governor Bob Taft to the Ohio Advisory Counsel for Aging. She was also named as an Ohio delegate to the White House conference on aging held this past December.

Thank you for being here as well.

Before you all begin with your testimony, I want to remind each of our witnesses to please limit your statements to 5 minutes—your oral statements to 5 minutes. Your entire testimony that we have already received, Representative Hinojosa and I have already received, will be submitted in the record for this hearing in full and will be part of the official hearing record.

So with that, we will begin. Each of you will give oral testimony for 5 minutes; and then we will have at least one, maybe two,

maybe three or four rounds of questioning—just kidding. It's really painless. But we'll go ahead and have you all testify, and then we will both then question the witnesses. With that, I can't think of anything else that I missed.

Ms. HOUSTON. You're all set.

Chairman TIBERI. Ms. Geig.

**STATEMENT OF ELISE GEIG, LEGISLATIVE LIAISON, OHIO  
DEPARTMENT OF AGING**

Ms. GEIG. Thank you, Congressmen Tiberi and Hinojosa, for the opportunity to be here today. My name is Elise Geig, the legislative liaison for the Ohio Department of Aging. On behalf of Director Merle Grace Kearns, and Ohio's aging network, I want to thank the committee for scheduling this field hearing in Ohio.

A little less than a year ago, former director of the Ohio Department of Aging, Joan W. Lawrence, who is here today, provided testimony to this committee. On behalf of the Department, she acknowledged the wisdom of the 89th Congress, which created the Older Americans Act and praised the elegance, simplicity, and purpose of OAA. This afternoon I will discuss how Ohio's aging network is implementing the major objectives of the OAA and provides some recommendations for reauthorization.

OAA is the foundation of Ohio's dynamic aging network that includes the Ohio Department of Aging; 12 Area Agencies on Aging; the Long-term Care Ombudsman Program; and more than 1,200 service providers, including more than 400 senior centers like the one hosting this field hearing today.

In addition to managing OAA funded programs, our aging network manages the PASSPORT program, one of the largest Medicaid home and community-based service waivers in the country. ODA also has other programs that support older Ohioans, including the popular Golden Buckeye Card.

In 2005, Ohio received \$46 million in OAA funding. Every dollar Congress provides through the OAA leverages two additional dollars for services. In addition, Ohio participants contribute over 7.5 million toward the cost of services annually through contributions or costs sharing. Ohio is one of a handful of states that have implemented the cost sharing provisions allowed by the 2000 OAA reauthorization.

In 2005, the combination of Federal, state, and local dollars helped to support over 300,000 older Ohioans and their caregivers.

While these numbers sound impressive, the need for services exceeds supply across our state. Many service providers must place individuals on waiting lists and/or reduce service levels to existing consumers. Over the past year, service delivery has been drastically impacted by rising gas and food costs.

Prior to the White House Conference on Aging, we developed eight recommendations for reauthorization of OAA. Our recommendations include increase the authorized Federal funding level of OAA titles and parts by at least 100 million each above the fiscal year 2005 appropriated level, except Title III, Part E, National Family Caregivers Support Program, which should be authorized at 250 million more.

Please note that nationally from 1980 to 2005, there has been a 50 percent drop in buying power for OAA, Title III, nutrition and supportive funds. This drop is based on a comparison of per capita appropriation of OAA Title III, nutrition and supportive service funds in adjusted dollars versus age 60, plus, population.

Strengthen and broaden the Federal role of the Assistant Secretary for Aging to establish new partnerships with centers for Medicare and Medicaid Services.

Fund statewide initiatives that help communities address the needs of their growing aging populations.

During the past half century, we have built Peter Pan communities and housing for people who never grow old. Most communities require people to use automobiles to get to shopping and services. Our housing is typically multiple story and not conducive to aging in place. Now that our population is aging, we need to encourage smart growth that creates communities for all ages. This may include retrofitting our existing communities, neighborhoods, and housing. Funding statewide initiatives could support the capacity building and coordination that needs to occur to make age-friendly communities a reality. Provide grants to sustain and expand Aging and Disability Resource Centers.

While under the Administration on Aging's proposed Choices for Independence Program, which we support, funds can be used by states to fund ADRCs. States will have to compete for these funds and decide what initiatives to pursue, all while absorbing an estimated 25 percent overall cut in OAA funding for these specific activities. We recommend that if AoA and Congress believe that ADRCs are the front door to the aging network, funds be made available and awarded to states annually by formula to support the development and ongoing operation of ADRCs throughout the nation. Ensure that the Older American's Act promotes the effectiveness of the office of the State Long-term Care Ombudsman.

Congressman Tiberi, you will be pleased to learn that the Long-term Care Consumer Guide that you created through legislation in Ohio has been expanded. In March of this year, all licensed residential care facilities were added to the website.

Revised Title III, Part D, Disease Prevention and Health Promotion provides states with funds to support evidence-based prevention, disease management, and health promotion programs. AoA has proposed to eliminate Title III, Part D, in its 2007 budget request. While AoA's proposed Choices for Independence Program funds can be used by states to support evidence-based disease prevention, we recommend that AoA and Congress maintain Title III, Part D, in OAA.

Add provisions to OAA that will help the aging network promote senior mobility and coordinate human services transportation.

Currently there are 63 federally funded programs that provide community transportation. These programs each have their own union definitions and service delivery requirements. Coordination and expansion of transportation resources could be facilitated by having common service delivery requirements across all programs and funding sources.

And, finally, reduce statutory and regulatory barriers to participation in the Federal employment and training programs and in-

crease funding to train older adults to compete in a changing workplace.

We are concerned that the U.S. Department of Labor views the Senior Community Service Employment Program as an employment and training program and is proposing changes that would limit or potentially eliminate the important community service benefits of the program.

Ohio is very proud of the aging infrastructure we have developed over the past 40 years with the support of the Older Americans Act and is up to meeting the challenges that the future will bring.

Again, thank you, Representatives Tiberi and Hinojosa, for the opportunity to share Ohio's progress and recommendations.

[The prepared statement of Ms. Geig follows:]

**Prepared Statement of Elise Geig, Legislative Liaison,  
Ohio Department of Aging**

Thank you, Representatives Tiberi and Hinojosa for the opportunity to speak here today. My name is Elise Geig the Legislative Liaison for the Ohio Department of Aging. On behalf of our director Merle Grace Kearns and Ohio's aging network, I want to thank the committee for scheduling this field hearing in Ohio.

A little less than a year ago, former Director of the Ohio Department of Aging Joan W. Lawrence, who is here today, provided testimony to this committee. On behalf of the Department, she acknowledged the wisdom of the 89th Congress, which created the Older Americans Act (OAA) and praised the elegance, simplicity and purpose of the Act. This afternoon I will discuss how Ohio's aging network is implementing the major objectives of the Act and developing "a comprehensive array of community-based, long-term care services adequate to appropriately sustain older people in their communities in their homes." I will also provide some recommendations for reauthorization of OAA.

OAA is the foundation of Ohio's dynamic aging network that includes ODA, twelve area agencies on aging, the Long-term Care Ombudsman Program, and more than 1,200 service providers, including more than 400 senior centers like the one hosting this field hearing today.

In addition to managing OAA funded programs, our aging network manages the PASSPORT program, one of the largest Medicaid home and community based services (HCBS) waivers in the country, as well as other community long-term care programs. ODA also has other programs that support older Ohioans, including the popular Golden Buckeye Card which provides savings on goods and services for Ohioans age 60 or older and adults who are totally and permanently disabled.

Further, Ohio is one of a few states where local aging network partners generate revenue from county senior services property tax levies. Sixty-one of Ohio's eighty-eight counties have passed such levies, which collectively raise over \$100 million in additional funding.

The Office of the State Long-term Care Ombudsman and twelve regional programs, funded by Title VII of the OAA, advocate for the rights of home care consumers and residents of long term care facilities.

The Ombudsman program investigates more than 10,000 complaints and provides nearly 42,500 hours of advocacy and information services annually. They also collaborate with community organizations and provide abuse prevention education programs and consultation, and facilitate legal support for older adults.

The OAA funds the Senior Community Service Employment Program (SCSEP) administered by the U.S. Department of Labor, through grants to ODA and six national organizations (i.e., AARP Foundation, Senior Service America, Inc., Experience Works, Inc., Mature Services, Inc., National Center and Caucus on Black Aged, Inc., USDA/Forest Service) in Ohio. These funds provide for 2,611 SCSEP participant slots. However service level goals bring the total number of seniors served in Ohio through SCSEP to 3,655 annually.

In 2005, Ohio received \$46 Million in OAA funding for home and community based services. Every dollar Congress provides through the OAA leverages two additional dollars for services to Ohio seniors. In addition, Ohio participants contribute over \$7.5 million towards the cost of services annually through contributions or cost sharing. Ohio is one of a handful of states that have implemented the cost sharing provisions allowed by the 2000 OAA reauthorization.

The combination of federal, state and local dollars and participant contributions helped 300,000 older Ohioans and their caregivers. Nutrition and transportation services are Ohio's leading services, with more than 8.5 million meals and 1.4 million miles provided in 2005, respectively. In 2005, Ohio served 57,000 caregivers through the National Family Caregiver Support Act (Title III, Part B).

While these numbers sound impressive, need for services exceeds supply across our state. Many AAAs and service providers must place individuals on waiting lists and /or reduce service levels to existing consumers. The risk for institutionalization increases the longer these individuals remain on a waiting list and go without needed services. If not for the creativity of our aging network and the commitment of local voters to pass senior service property tax levies, waiting lists would grow and waits would be longer.

Population growth and the increasing cost of service delivery limits our ability to meet the needs of our seniors.

Population Growth: Census data confirms that during the past decade (1990 to 2000) Ohio's 85-plus age cohort grew by 28 percent (39,700 people.) Based on Census Bureau 2002 estimates, this cohort has grown an additional 11 percent (19,604) since the 2000 Census. It is this group that has the greatest level of disability and is most in need of nutrition and supportive services.

The first baby boomers began to turn age 60 in 2006. Based on 2000 Census Bureau estimates, Ohio's 55 to 60 age cohort includes 553,174 individuals, representing 5 percent of the state's population. As these individuals turn 60, they will be looking to Ohio's aging network for supports and services. The services baby boomers will seek are far different than the age 85-plus cohort and will likely include benefits counseling (e.g., Medicare, insurance and retirement benefits), caregiver support, and disease prevention and health promotion activities.

Costs of Services: Most of the costs associated with community services and nutrition programs are for the direct provision of services to older Ohioans. Costs vary by service, but generally include labor, supplies and transportation. Costs have increased over the past two years and are anticipated to increase at a rate equal to or more than the Consumer Price Index (CPI) for the foreseeable future.

Two cost categories have increased significantly during the past year: transportation and meals. Rising fuel costs have negatively impacted the provision of transportation-intensive services (e.g., home-delivered meals, medical and adult day care transportation). According to the American Automobile Association's Daily Fuel Gauge Report, cost of regular gasoline in Ohio has increased 29 percent and averaged \$2.77 per gallon in the last year (as of April 18, 2006).

Furthermore, approximately 43 percent of all state, federal and local service dollars support nutrition services. While in the past year (February 2005 to February 2006) the Consumer Price Index (CPI) for food and beverages has risen 2.7 percent. A major component of a nutritious diet is fresh fruits and vegetables, and during this period the CPI for this component increased 7.9 percent while the overall CPI increased 3.6 percent.

I am proud to say Ohio's aging network is a good steward of federal, state and local funds. We target our funds to those citizens most in need. We have been active in AoA's Performance Outcomes Measures Project (POMP) since its inception seven years ago. Partnering with AoA and other states, we have developed various service based outcome measurement tools. In 2004, we put these tools to work and surveyed our OAA consumers and found that we are doing an excellent job in delivering our services to those in greatest need and making a difference in the lives of our consumers and their caregivers. Some of what we learned:

Home-delivered meal consumers depend on this service to provide one-half or more of their daily food intake;

Transportation consumers use the service to get to a doctor or health care provider;

Homemaker consumers report annual incomes under \$15,000; and

Caregiver program consumers believe that services allow them to provide care longer than they could without services.

The survey also found that consumers were highly satisfied with their OAA services.

Prior to the White House Conference on Aging, we developed Ohio's Top Eight Recommendations for Reauthorization of the Older Americans Act that, if implemented, will have a positive impact on the lives of Older Ohioans and their caregivers. I am happy to say that our recommendations are consistent with the top ten WHCoA resolutions.

Our recommendations include:

Increase the authorized federal funding level of OAA titles and part by at least \$100 million each above the FY 2005 appropriated level except Title III Part E Na-

tional Family Caregiver Support Program which should be authorized at \$250 million more.

Please note that nationally, from 1980 to 2005, per capita appropriation of OAA Title III B & C in “adjusted dollars” vs. age 60+ population has dropped 50% in buying power. The result: support per older American has fallen dramatically since 1980. Support per capita fell from \$15.82 in 1980 to \$7.90 in 2005.

Strengthen and broaden the federal role of the Assistant Secretary for Aging to establish new partnerships with Centers for Medicare and Medicaid Services (CMS) for the administration of HCBS Medicaid Waiver and other long-term care programs.

Coordination across organizations is essential. Developing a coordinated long term care strategy has been a priority of the Taft Administration for the last seven years. Since 2001, multiple state departments, including the ODA and the Ohio Department of Job and Family Services (Ohio’s equivalent to CMS) have worked together to implement Ohio Access: Strategic Plan to Improve Long-Term Services and Supports for People with Disabilities.

Fund statewide initiatives that help communities address the needs of their growing aging populations.

Provide grants to sustain and expand Aging and Disability Resources Centers (ADRC) in Ohio and 42 other demonstration states and territories.

Last year Ohio received a grant from AoA and CMS to develop an ADRC. Our pilot ADRC, to be anchored in the Western Reserve Area Agency in Aging in Cleveland, will link local and regional entities and create a seamless service experience for consumers age 60 and older, as well as adults age 18 and older with physical disabilities. Consumers will access the network via Internet, phone or in person.

While under the AoA proposed Choices for Independence Program, which we support, funds can be used by states to fund ADRCs, states will have to compete for these funds and decide what initiatives to pursue (e.g., ADRC vs. disease prevention), all while absorbing an estimated 25% overall cut in OAA funding for these specific activities. We recommend that, if AoA and Congress believe that ADRCs are the front door to the aging network, then funds be made available and awarded to states annually by formula to support the development and ongoing operation of ADRCs throughout the nation.

Ensure that the OAA promotes the effectiveness of the Office of the State Long-Term Care Ombudsman at all levels in the context of a comprehensive elder rights system.

Congressman Tiberi, you will be pleased to learn that the Long-Term Care Consumer Guide that you created through legislation in Ohio has been expanded. The website was launched in 2002 to assist consumers in selecting a nursing home. The site includes regulatory compliance information, consumer satisfaction data, and federal quality measures in addition to information provided by each nursing home and is maintained by the office of the State Long-Term Care Ombudsman.

In March of this year, all licensed residential care facilities (assisted living) were added to the website. This year nursing home family members will be surveyed for new satisfaction data, and next year residential care facility residents will get their turn to tell the public how they like their home.

Revise Title III Part D Disease Prevention and Health Promotion and provide states with funds to support evidenced-based prevention, disease management and health promotion programs.

AoA has proposed to eliminate Title III Part D in its 2007 budget request. While AoA’s proposed Choices for Independence Program funds can be used by states to support evidenced-based disease prevention, we recommend that AoA and Congress maintain Title III Part D in the OAA.

Add provisions to the OAA (e.g., interagency coordination) that will help the aging network promote senior mobility and coordinate human services transportation.

Reduce statutory and regulatory barriers to participation in the federal employment and training programs and increase funding to train older adults to compete in a changing workplace.

We are concerned that the U.S. Department of Labor views the SCSEP as an employment and training program and is proposing changes that would limit or potentially eliminate the important community service benefits of the program. For 40 years the SCSEP program has had a dual-focus: community service, and employment and training. The community service element has provided SCSEP participants with the needed training and experience to compete for un-subsidized employment while affording the aging network (e.g., senior centers, nutrition programs) and other community organizations (e.g., libraries, hospitals, schools, police stations, and various governmental agencies) with needed support to operate their programs. If the community service element of SCSEP is dropped from the program, we con-

servatively estimate that 330-400 FTEs that directly support OAA activities and programs will be lost. This loss is magnified more when we consider that OAA funds are proposed to be cut in the FFY 2007 budget and the first of the baby boomers are turning age 60 this year.

Clarification of Congressional intent for SCSEP is needed. If the program is meant to serve as only an employment and training program, then SCSEP should be removed from the OAA and placed in the Older Worker Opportunity Act or as a title in the Workforce Investment Act. If you believe, as we do, that SCSEP is a vital resource for seniors and the OAA, then the program should remain a dual focused program on community service and employment and training.

Regardless of the decision of Congress, ODA is dedicated to advocating for older workers. We fully support the need for greater employment and training options for older Ohioans. To that end, the Ohio Department of Aging is actively pursuing the creation of a Mature Worker Council as part of the Governor's Ohio Workforce Policy Board. We believe this council will fill a desperately needed gap in understanding the benefits as well as needs of an aging workforce.

Ohio is very proud of the infrastructure we have developed over the past 40 years with the support of the Older Americans Act and is up to meeting the challenges that the future will bring.

Again, thank you Representatives Tiberi and Hinojosa for the opportunity to share Ohio's progress and recommendations.

Chairman TIBERI. Thank you, Ms. Geig.  
Mr. Bibler.

**STATEMENT OF DAVID BIBLER, EXECUTIVE DIRECTOR,  
LICKING COUNTY AGING PROGRAM**

Mr. BIBLER. Since its initial enactment in 1965, the Older Americans Act has made an enormous positive difference in the lives of millions of older Americans. Our challenge in 2006 and beyond is largely one of demographics. It is projected that the 65 years and older population, which numbered 35 million in 2000, will more than double in size in the next 26 years.

The delegates to the once-per-decade White House Conference on Aging held in December 2005 were asked to vote on their priorities from among 73 proposed resolutions. A majority from the over 1,200 delegates from across the Nation chose as their No. 1 priority the resolution advocating reauthorization of the Older Americans Act.

The Licking County Aging Program is a multipurpose senior center based in Newark, Ohio. From 1997 to 2005, our Title III services to seniors increased 34.8 percent while our funding increased only 1.8 percent. The funding clearly has not kept pace with the increased demand for services.

The services provided by agencies such as the Licking County Aging Program allow seniors to remain independent and living in their homes as long as possible. This is where they prefer to live. This is also a great savings to our government and taxpayers because institutional care can cost as much as \$60,000 per year, compared to \$12,600 for the annual cost of in-home care. It simply makes sense both economically and socially.

I would like to discuss with you what I think are four priority initiatives. The first initiative is to increase the authorization levels. The Aging Network seeks to raise the authorized funding levels of all the titles of the Older Americans Act by at least 25 percent above fiscal year 2005 over 5 years, except for Title III, E, which should be authorized at \$250 million. In Licking County, the number of meals we have served has risen for seven consecutive years.

In 1998, we served over 128,000 meals; and by 2005, that number had grown to 191,000 meals. During that timeframe, our food costs have increased 73 percent. We are on pace to exceed 200,000 meals this year.

Title III, E, the National Caregiver Grant, is relatively new but has been a great asset not only for the seniors that we care for but for the family members who care for their loved ones. The 24-hour caregiver faces a great amount of stress. At the Licking County Aging Program, we have been able to help caregivers in creative ways that have simplified their lives and given them peace of mind. We are helping family members who are caring for their loved ones at home, again, saving taxpayers millions of dollars that Medicaid doesn't have to pay for institutional care.

The second initiative is to senior mobility and transportation services. Include statutory language in the Older Americans Act that increases support to the Aging Network to promote senior mobility and to facilitate coordination of human services transportation. At the Licking County Aging Program, our aging vehicles traveled more than 300,000 miles in 2005. That is equal to circling the earth 12 times. For a rural county such as ours, transportation is vitally important to get clients to their much-needed destinations. We don't have public transit systems to get them there.

Strengthen Coordination to prevent elder abuse. The Aging Network seeks an increase in authorization of Title VII provisions and services to enhance the Aging Network's capacity to increase training of law enforcement officials and medical staff, broaden public education and community involvement campaigns, and facilitate coordination among all professionals and volunteers involved with the prevention, detection, intervention, and treatment of abuse and neglect of vulnerable older adults. Individuals and agencies that are dedicated to protecting older adults against abuse, exploitation, and neglect often do so within a fragmented system and with limited resources.

In Licking County, we have only case manager and Adult Protective Services for a senior population of more than 23,000. This is an injustice to our elderly. Too many seniors are abused and neglected, many by their own family members. This area needs to be addressed.

The fourth initiative is tapping the potential of civic engagement. Healthy older adults represent a powerful asset to meet the needs of frail elders and solve other serious social problems. The Older Americans Act has historically focused on the needs of the frail elderly while paying insufficient attention to the significant benefits to be derived from older adults making meaningful contributions. This reauthorization is the time to correct this increasingly costly oversight. Many older adults across the country could be strategically mobilized to bolster the long-term care system, tutor and mentor children, facilitate access to health services, strengthen families, give advice to businesses, and provide respite to caregivers.

I would like to thank Representative Tiberi for inviting me to share my perspective and the general views of my colleagues from Ohio senior centers, and also I would like to thank Representative Hinojosa for attending this hearing as well. We urge prompt and

decisive congressional action to renew the Older Americans Act in 2006.

[The prepared statement of Mr. Bibler follows:]

**Prepared Statement of David Bibler, Executive Director,  
Licking County Aging Program**

*Why Is It Needed?*

Since its initial enactment in 1965, the Older Americans Act (OAA) has made an enormous positive difference in the lives of millions of older Americans. The Act established the primary vehicle for organizing and delivering community-based services through a coordinated system at the state level. Nutrition, home care, senior center services, transportation, employment, protections against abuse and neglect, disease prevention, family caregiver support—all of these have been extremely beneficial to seniors over the years. These OAA programs provide vital support for elders who are at significant risk of losing their ability to remain independent in their own homes and communities, enabling them to avoid or delay costly nursing home care.

According to the Centers for Disease Control and Prevention (CDC), roughly 26 million older adults over the age of 65 have physical limitations or need assistance with activities of daily life, such as eating, bathing, dressing or getting around (2003). Among adults over age 80, almost three-quarters (73.6 percent) report at least one disability.

The most preferred form of long-term care is provided through home and community-based services, such as home-delivered meals, personal care, homemaker services and respite care. Community based supports and services allow older adults with physical limitations to remain independent and live where they choose, saving the federal government and the nation's taxpayers the cost of expensive institutional care.

Recent data from the Administration on Aging (AoA) show how successful OAA programs and services have been in assisting older adults and their caregivers. AoA reports that 86 percent of family caregivers of OAA clients said the services "allowed them to care longer for the elderly than they could have without the services." Additionally, OAA-provided meals and services have allowed the nearly one-third of elderly home-delivered meals clients who have health conditions that make them nursing home eligible remain in the community.

The breadth and depth of OAA programs and services provide essential support to older adults who wish to age in place. One of the reasons the OAA is so successful is that it is based on an effective and efficient system—the national Aging Network—which serves as the infrastructure for aging service delivery at the federal, state and local level. The OAA binds together all 650 Area Agencies on Aging (AAA) and 240 Title VI Native American aging programs across the country, providing a support structure for planning, service coordination, oversight, and advocacy on programs and services that reach more than eight million older Americans every year. AAAs serve as the focal point at the community level to link seniors and their family caregivers to a myriad of services.

AAA's and senior centers serve as points of entry for the complex and fragmented range of home and community-based services for older adults and their caregivers. AAAs and Title VI agencies leverage federal dollars with other federal, state, local and private funds to meet the needs and provide a better quality of life for millions of older adults. According to AoA: "In FY 2003 state and local communities leveraged approximately \$2 from other sources for every \$1 of federal funding; for intensive in-home services, the ratio was closer to \$3 to \$1."

Our challenge in 2006 and beyond is largely one of demographics. It is projected that the 65 years and older population, which numbered 35 million in 2000, will more than double in size to about 70 million in the next 26 years. By 2030, one out of every five people in the U.S. will be age 65 and older. People 85 and older are currently the fastest growing segment of the population, increasing at a rate four times faster than any other age group.

In 2006, the first of the 77 million baby boomers reach the age of 60. The aging of the baby boomers over the next 25 years will impact every aspect of American society. The rapid increase in the aging population will challenge the Aging Network to meet the accompanying rise in demand for adequate health and supportive services. The reauthorization of the Older Americans Act in 2006 provides an ideal opportunity for Congress to ensure that the necessary system of services is in place to meet the needs of the current aging population as well as the needs of the aging baby boomers.

The delegates to the once-per-decade White House Conference on Aging (WHCoA), held in December 2005, were asked to vote on their priorities from among 73 proposed resolutions. A majority of the over 1,200 delegates from across the nation were selected by members of Congress and the governors. Those delegates—leaders in the aging network from every part of the country—chose as their number one priority the resolution advocating reauthorization of the Older Americans Act. That is a powerful statement to Congress and the nation.

The aging network applauds the wisdom of those delegates and supports a non-contentious reauthorization of the OAA, with the hope that it can be accomplished this year. A small set of controversial issues delayed the last reauthorization for five years. We believe that, on balance, the Act is in good shape and that these same controversial issues should not be revisited in the upcoming reauthorization. We should learn from the experience of the previous reauthorization and not reopen carefully crafted compromises that are now working well.

#### *A Local Perspective*

Multi-purpose senior centers across the nation are an integral part of the service delivery system. The creation and long-term support of such senior centers was an important component of the original intent of the OAA. The Licking County Aging Program is a multi-purpose senior center based in Newark, Ohio. In 2005 we served 4,134 seniors, providing a total of 274,751 units of services, including 191,665 home delivered and congregate meals, 35,031 hours of home services (personal care, home-making, respite and chore), and 28,778 one-way trips to medical appointments and meals sites. In 1997 those respective numbers were 128,962 meals, 33,511 hours of home services and 26,990 one-way trips. By comparison, in 2005 we received \$361,973 in Title III funds and in 1997 we received \$355,449. During this 9-year period the services that we provided increased 34.8 percent while our funding increased only 1.8 percent. The funding clearly has not kept pace with the increased demand for services.

The services provided by agencies such as the Licking County Aging Program, allow seniors to remain independent and living in their homes as long as possible. This is where they prefer to live. This is also a great savings to our government and taxpayers because institutional care can cost as much as \$60,000 per year, compared to \$12,600 for the annual cost of in-home care. It simply makes sense both economically and socially.

I would like to share with you a story that epitomizes what our agency, and many others like us, is all about. Mrs. Potter called our office one day asking if the agency would send her a meal. She said she was tired of her son's macaroni cheese dishes. Our nutrition secretary could tell Mrs. Potter was quite elderly but was not prepared for her story. Mrs. Potter was born in 1894 during the second administration of Grover Cleveland. At the time we had initial contact with her she was 103 years old.

She had become bedridden and was dependent on her son for care. He was in his late 70's and caring for his mother was wearing down his health. The Licking County Aging Program responded with our noontime meal program, along with home services to care for Mrs. Potter's domestic and hygienic needs. Mrs. Potter had two favorite "dishes" from the agency as she called them: our applesauce and the man who delivered it, Brad, himself a senior citizen.

Brad is typical of our drivers. He does not just deliver a meal, he delivers a smile and some of his time. For some of our senior clients, our meal driver is the only person they see. That is what is so critical about our meal program. We deliver not just meals, but a knock at the door, a smile and a little conversation.

Mrs. Potter lived until she was 110 years old. Shortly after her death the Licking County Aging Program held one of our popular monthly events. Mrs. Potter's son read in our newsletter that we were going to be serving coconut cream pie for dessert and he thought no place made better coconut cream pies. When he called in his reservation, our nutrition department baked him an additional pie to take home.

This is a story behind our services. It is the story of people and caring. It is the story of a life connection for seniors who vitally need to know they matter, that people still care about them.

#### *Priority Initiatives*

##### *1. Increase Authorization Levels*

The aging network seeks to raise the authorized funding levels of all the titles of the Older Americans Act by at least 25 percent above FY 2005 over five years except for Title III E which should be authorized at \$250 million. The increased authorization levels will ensure the Aging Network has the necessary resources to adequately serve the projected growth in the numbers of older adults, particularly the

growing ranks of the 85 and older population who are the most frail, vulnerable and in the greatest need for aging supportive services.

The OAA is the major federal social services program for older adults in the United States. It has provided vital community-based supports to millions of older adults for almost forty years. Since 1980, however, there has been a substantial loss in the OAA program's capacity at the state and community levels to provide services to older Americans due to rising costs due to inflation, increasing numbers of older adults requesting services, and expanding service demands as life-spans have been extended.

As the aging population grows, so does the need for home and community-based services. The impending demographic shift will create an unprecedented level of demand for health and social services as millions of aging baby boomers begin seeking such supports. The OAA provides well-established, trusted, community-based infrastructure of services responsive to the needs of older people and their families.

To illustrate how the cost of providing services has risen over the last five years, I would like to share examples of a few situations in the state of Ohio. In many areas of Ohio, especially the more rural areas, a pattern that holds up across the country, transportation is one of the most requested services by older adults. It is also one of the most under-funded and suffers from the most rapidly rising costs. Lack of funding has forced the Toledo-based AAA to provide 40 percent fewer trips in 2005 than it did in 2002. Its AAA neighbor to the southeast, PSA 5 out of Mansfield, reports it had to offer transportation services to 21.5 percent fewer consumers between 2000 and 2005. Besides the oft-recognized increases in fuel costs, vehicle maintenance and insurance costs have also risen dramatically.

Food prices have also risen in recent years, driving up the cost of home-delivered and congregate meal programs that are funded under OAA Title III. The Central Ohio AAA paid \$4.60 for each home-delivered meal served in 2000; that same meal is \$5.05 today. In Southeastern Ohio, the cost of a home-delivered meal has reached \$6.53, up from \$5.81 five years ago.

The Perry County Senior Center reports that they keep waiting lists for home-delivered meals and homemaker services, but that "many of the clients are deceased before we can serve them." In Lucas County, the number of seniors enrolled in programs has increased by 42 percent since 2000.

In Licking County, the number of meals we have served has risen for seven consecutive years. In 1998 we served 128,613 meals and by 2005 that number had grown to 191,665 meals. During that time frame, our food costs have increased 73 percent. We are on pace to exceed 200,000 meals this year. Unfortunately, appropriations for OAA programs have not reflected this explosive growth and increased costs. Additional funding is needed.

Title III-E, the National Family Caregiver Grant is relatively new but has been a great asset not only for the seniors that we care for, but for the family members who care for their loved ones. The 24-hour caregiver faces a great amount of stress. At the Licking County Aging Program we have been able to help caregivers in creative ways that have simplified their lives and given them peace of mind. For example, we have used Title III-E funds to purchase an airline ticket to fly a client to Texas to live with her sister, her only living relative that was able to care for her. We have moved a washer and dryer upstairs for an elderly man who is caring for his wife but was unable to get up and down the stairs to wash their clothes. In addition, the National Family Caregiver Grant has allowed us to provide thousands of hours of respite to family members who desperately needed a few hours of relief from the responsibilities of care giving. We are helping family members who are caring for their loved ones at home, again saving taxpayers millions of dollars that Medicaid doesn't have to pay for institutional care. However, Title III-E is grossly under funded and much more is needed.

Another factor also needs consideration. In Ohio and nationwide this year, the roll-out of the new Medicare Part D prescription drug plan has placed additional responsibilities on local providers, largely without additional funding. Older adults and their families have turned to local senior centers en masse during the 2005-2006 enrollment campaign. Yet only a small number of local aging programs received new resources from states or national pilot projects to support their one-on-one counseling and enrollment assistance efforts.

To respond to the overwhelming demand for Medicare Part D assistance, senior center staff members were often shifted from other responsibilities to help with enrollment, making this level of effort unsustainable and taking them away from their other jobs. Even when the initial enrollment period ends, the public will continue to turn to local senior centers. Millions of seniors will continue to need counseling and enrollment assistance every year, as they become newly eligible for Medicare or seek to change their prescription drug plans.

In order for senior centers to continue the tremendous amount of work that Medicare Part D enrollment assistance has generated, we need new funding to support and sustain this effort.

### *2. Strengthen Senior Mobility/Transportation Services*

Include statutory language in the Older Americans Act that increases support to the Aging Network to promote senior mobility and to facilitate coordination of human services transportation. Mobility is essential for an individual to live at home and in the community. Transportation provides necessary access to medical care, employment, shopping for daily essentials and the ability to participate in cultural, recreational, and religious activities. As the population ages, enhanced efforts are needed to help older drivers remain on the road for as long as safely possible and to provide safe, reliable and convenient alternative means of transportation for those for whom driving is no longer an option.

Transportation is a priority service under Title III of the Older Americans Act. However, transportation competes for limited funding against many other support services. Coordination of transportation services among human service providers has been identified as a means of increasing the capacity of local providers to provide, in the most cost-efficient means possible, their older adult clients with the transportation services necessary to maintain their independence and quality of life.

At the Licking County Aging Program, our agency vehicles traveled more than 300,000 miles in 2005. That is equal to circling the earth 12 times. We have the second largest county geographically in the State of Ohio and we currently have seven vehicles with more than 200,000 miles on their odometers. Safety for our clients is our utmost concern and more funding is needed that would allow us to purchase vehicles and provide more services. For a rural county such as ours, transportation is vitally important to get clients to their much-needed destinations. We don't have public transit systems to get them there.

### *3. Strengthen Coordination to Prevent Elder Abuse*

The aging network seeks an increase in authorization of Title VII provisions and services to enhance the Aging Network's capacity to increase training of law enforcement officials and medical staff, broaden public education and community involvement campaigns, and facilitate coordination among all professionals and volunteers involved with the prevention, detection, intervention and treatment of abuse and neglect of vulnerable older adults. Abuse, exploitation and neglect are common occurrences for far too many of today's older adults and this problem will only be exacerbated by the rapid growth of the aging population over the next decade. To date there is no federal law that comprehensively addresses elder abuse and neglect, from prevention to intervention through prosecution. Individuals and agencies that are dedicated to protecting older adults against abuse, exploitation and neglect, often do so within a fragmented system and with limited resources.

In Licking County we have only one case manager in Adult Protective Services for a senior population of 23,534. This is an injustice to our elderly. Too many seniors are abused and neglected, many by their own family members. This area needs to be addressed.

### *4. Tapping the Potential of Civic Engagement*

Healthy older adults represent a powerful asset to meet the needs of frail elders and solve other serious social problems. Tapping healthy older adults as an asset to solve social problems is an economic imperative with the potential of raising our standard of living. An article in the June 27, 2005, Business Week stated: "If society can tap Boomer talents, employers will benefit, living standards will be higher, and the financing problems of Social Security and Medicare will be easier to resolve." The article goes on to say: "Increased productivity of older Americans and higher labor-force participation could add 9% to gross domestic product by 2045 on top of what it otherwise would have been. This 9% increase would add more than \$3 trillion a year, in today's dollars to economic output."

The OAA reauthorization creates the opportunity for AoA to play a central role in developing the resource potential of aging into real value for the nation. The OAA has historically focused on the needs of the frail elderly while paying insufficient attention to the significant benefits to be derived from older adults making meaningful contributions. This reauthorization is the time to correct this increasing costly oversight. As part of AoA's established aging network, many older adults across the country could be strategically mobilized to bolster the long-term care system, tutor and mentor children, facilitate access to health services, strengthen families, give advice to businesses and provide respite to caregivers; all civic activities shown also to contribute to their own well-being. There is much to gain by leveraging relatively

small investments in civic engagement into major returns on the value of contributions in education, health care, transportation, housing, and long-term care.

#### *5. Recommendations from the Administration on Aging*

We are supportive of the Administration on Aging's Choices for Independence initiative. AoA's Choices for Independence proposal can strengthen and improve the OAA and provide significant benefits to seniors in need.

The initiative has three components. The Consumer Empowerment component can provide important information on planning for long-term care, including using reverse mortgages to stay at home. The Community Living Incentives component can help address the expensive institutional bias in our nation's long-term care system by improving access to more cost effective home and community services for vulnerable, moderate income seniors. The Healthy Lifestyle component can build on AoA's current, highly successful Evidence-Based Prevention Demonstration Program to assist older adults to make behavioral changes that have proven to be effective in reducing the risk of disease and disability.

Although we appreciate the proposed \$28 million investment in the initiative, we believe additional resources will be needed to fully achieve the proposal's goals, and that funding should not be taken from current OAA programs such as Title III-D.

We oppose AoA's recommendation concerning consumer contribution, or cost sharing. This was one of the major controversies that held up reauthorization last time. To help break the logjam, the National Council on Aging (NCOA) and the National Association of State Units on Aging (NASUA) collaborated on a delicately balanced compromise that is the foundation of the current law provision. We oppose reopening this contentious issue for two basic reasons:

1) Nutrition providers are currently required to provide participants with an opportunity to make non-coercive, voluntary contributions, and AoA data show that many seniors do contribute. These voluntary contributions by seniors account for 32% of the total income in congregate meals programs and 25% in home-delivered meals. That system works well and should be retained. Congress should not be erecting additional barriers to participation in nutrition programs. Congress should do its utmost to assure that no senior who needs nutrition assistance is denied because of inability to pay mandatory cost-sharing.

2) The 2000 reauthorization required the AoA to complete a study of cost-sharing practices, to determine their impact on participation. That study has not been completed. Congress should await the results of this analysis before considering any change to the compromise in effect.

#### *6. Recommendations from the Department of Labor*

The Senior Community Service Employment Program (SCSEP), authorized by Title V of the OAA, is our nation's premier workforce program for low-income older Americans, and we strongly hope that it is not again a source of controversy in this reauthorization, as it was in the previous reauthorization. SCSEP builds employment skills, renews each individual's sense of self worth, and provides needed wages to low-income seniors. It also offers valuable social and economic benefits to communities, and extends the reach of community-based organizations. All across our nation SCSEP enrollees perform valuable community services in senior centers, libraries, schools, and health and social service institutions.

In sharp contrast to the approach that AoA has taken, the Department of Labor is pushing for revisions in OAA that will harm seniors, their families and their communities. The best course for Congress to take with Title V is to continue it as it is, with minor improvements.

We strongly oppose DoL's proposed far-reaching structural changes to SCSEP, such as block-granting the program to the states, eliminating national grants, de-emphasizing community service (which benefits program participants, the aging network, and communities served), eliminating participants under age 65, and eliminating fringe benefits for participants. These changes would make the program far worse, not better. Such changes are unwarranted, and would be disruptive and harmful to older workers and communities.

We support the broad consensus—which was recently developed by all 13 national SCSEP sponsors and subsequently supported by many other aging organizations—that the following principles should help guide Congress's efforts in reauthorizing Title V: (1) Continue the current system of funding both national and state grants, including the current percentage split of the funds; (2) Maintain the program's historic dual emphasis on both community service placements and unsubsidized placements for participants; (3) Maintain the current age and eligibility requirements for participants, so that services can be targeted to persons with the greatest economic and social need; (4) Retain current policy on program budgets; and (5) Strengthen

the role of the Administration on Aging in SCSEP, because Section 505(a) of the OAA does not appear to be working as intended.

SCSEP is a proven program that has a good track record of providing training and placement for difficult-to-serve populations of older adults. The program should be allowed to continue doing what it does well. Many not-for-profit organizations such as the Licking County Aging Program rely on the assistance of the Title V programs to provide employees at no cost, while at the same time we are giving them valuable job training. The paycheck they receive from their SCSEP sponsor is needed to supplement their social security income just so they can meet their basic daily needs.

I would like to thank Representative Tiberi for inviting me to share my perspective and the general views of my colleagues from Ohio's senior centers. We urge prompt and decisive Congressional action to renew the Older Americans Act in 2006.

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Chairman TIBERI. Thank you.  
Mr. Gehring.

**STATEMENT OF CHARLES W. GEHRING, PRESIDENT AND  
CHIEF EXECUTIVE OFFICER, LIFECARE ALLIANCE**

Mr. GEHRING. Thank you for allowing me this opportunity to share thoughts, and the thoughts of the thousands of clients served every day by LifeCare Alliance regarding the critical importance of the Older Americans Act. I'm Chuck Gehring, President and Chief Executive Officer of LifeCare Alliance, central Ohio's oldest and largest provider of services to seniors and chronically ill individuals. To give you some scope, founded in 1898, LifeCare Alliance prepares and serves over one million meals each year to more than 5,000 clients in Franklin and Madison Counties. We operate 28 congregate dining centers, which serve over 182,000 meals annually, where seniors and chronically ill individuals find friends and needed social contact. Over 4,200 people actively serve as volunteers in our Meals-on-Wheels program, contributing 116,000 volunteer hours and donating more than 350,000 miles of travel in their own vehicles. We also operate the federally funded Senior Farmers Market Program, which provides critical food to many needy seniors in our community.

Our Help-at-Home program provides over 18,000 homemaker visits and 14,000 home health aid visits annually. Our visiting nurse program, which is how we started, completes over 11,000 home visits annually, while our 11 senior wellness centers receive 6,400 annual visits. And we also provided 11,000 flu shots last year, and we are the chairs of the Central Ohio Flu Coalition.

We also operate two other agencies that have merged into us: Project Open Hand Columbus, which provides home-delivered meals and congregate dining centers for those living with HIV/AIDS; and the Columbus Cancer Clinic, which provides screenings and home care support to those living with cancers. Please note that most of these clients are in the later stages of their diseases, they have poverty-level income, and many are seniors. The vast majority of LifeCare Alliances are below the Federal poverty level. Seventy percent live on less than \$600 per month. Seventy percent see no other adult on a regular weekly basis other than our workers. Seventy percent have diabetes. All are homebound in need and hungry.

The work this subcommittee is doing today is of critical importance to LifeCare Alliance and our thousands of clients, and we commend you for holding this hearing. The reauthorization of the Older Americans Act in 2006 must be the highest priority for Congress. The Meals-on-Wheels program, paid for in part by the Older Americans Act, is about hunger in America. I understand that when hunger in America is discussed, we normally talk about children. The fact is that millions of elderly Americans would be hungry if not for the Older Americans Act and the Meals-on-Wheels program. They would also spend considerably more time in the hospital and die sooner. For many of our clients, our program provides the only meals they receive each day and the only visitor to their home.

Finally, without the Older Americans Act, American taxpayers would pay significantly more in taxes to support our senior clients in governmentally supported facilities and nursing homes where none of our clients want to be. In fact, the latest figures provided by AARP indicate that for each senior that we keep independent and in their own homes, where 100 percent of our clients tell us they want to be, taxpayers save over \$40,000 per year. This means that LifeCare Alliance alone saves Ohio taxpayers over \$300 million a year. What other act of Congress for the American people has this kind of return on investment for the American people while giving our seniors exactly what they want?

LifeCare Alliance, working with funds from the Older Americans Act saves taxpayers hundreds of millions of dollars additionally each year. By keeping seniors safe and healthy in their own homes, we keep them out of hospitals, saving significantly more by not using Medicare/Medicaid funds. The national average for seniors is that they spend nine and a half days each year in the hospital. Our clients, using services from the Older Americans Act, spend less than 1 day a year in the hospital.

As you can see, the practical side of the Older Americans Act is incredibly positive, providing staggering financial savings to taxpayers. It allows seniors to remain in their own homes where they want to. Meals-on-Wheels reduces and often eliminates hunger for seniors in America. Our nurses and home health aids keep clients clean and healthy. Nothing could make more sense in America. LifeCare Alliance works every day and has a dramatic and positive community impact every day. Our people and programs substantially improve and change lives every day saving billions of taxpayers' dollars nationally each year, reducing hunger among our seniors, providing quality of life, providing services and comfort that cannot otherwise be provided. And this is the legacy of the Older Americans Act.

Where do we go from here? Here are a couple of thoughts:

First, obviously, we encourage you to please reauthorize the Older Americans Act.

Second, the Older Americans Act needs more funding. In recent years, many of the titles of the Older Americans Act have been kept at existing levels or even reduced. The fact is that while LifeCare Alliance continues to fundraise aggressively, continues to initiate social entrepreneurship efforts to generate funds, continues to improve operational efficiencies, there is a limit to how much we

can raise. LifeCare Alliance's policy is to accept all clients who call; and with ever increasing numbers of seniors, we simply will run out of funds at the rate we are going.

Third, please consider linking the Older Americans Act funding increases to increases in senior populations. In Franklin and Madison Counties, and I know in Delaware County, the number of seniors will more than triple during the next 12 years, according to statistics from Scripps Gerontology Institute at Miami University. By linking funding to the number of seniors, we can better ensure services as the baby boomers reach senior age.

Fourth, please consider the discontinuation of moving funds from Title III, C, to Title III, B, that's meals to support services. All services funded by the Older Americans Act are critical and meals provide reduced hunger amongst seniors in America. Also Title III, C, can no longer act as the bank to support other services. In the last 5 years alone, \$174 million have been transferred from Title III, C, to Title III, B, representing a national loss of 38 million meals.

Fifth, please support increases in transportation funding, especially for individual trips for medical care. Transportation to doctors and treatment facilities continues to be a tremendous need in central Ohio.

Thank you for this opportunity to present critical information to your committee. I stand ready to assist you in any way I can with your efforts. Please feel free to call upon me or any of the other panelists in any way we can to help you.

And, finally, since we're in Westerville, may I just share a brief story. For many years, for the last 12 years, the students of Westerville North High School have—they were the fist high school in Columbus as part of a class to deliver Meals-on-Wheels. We now have 12 high schools in central Ohio delivering Meals-on-Wheels.

A year ago at Christmastime, two 18 year-old girls from Westerville North High School went to a client's house who was deaf. And, you know, deaf people cannot hear the knock on the door; but she did not answer. They knew how much she enjoyed her Meals-on-Wheels. They went the extra mile and found the manager. To make a long story short, the lady was found on her floor of her apartment passed out. She had terminal cancer. The girls didn't know this. Nobody can know this. It's private. But she had terminal cancer and that lady was going to die the next day anyway; but because of the program and because of what the Older Americans Act did and because of what these two Westerville North High School students did, this lady was able to die in her daughter's arms instead of on the floor of her home. Her daughter still tells us there is no greater gift she could have ever been given. That's the legacy of the Older Americans Act.

Thank you for your time.

[The prepared statement of Mr. Gehring follows:]

**Prepared Statement of Charles W. Gehring, President and  
Chief Executive Officer, LifeCare Alliance**

Thank you for allowing me this opportunity to share thoughts, and the thoughts of the thousands of clients served everyday by LifeCare Alliance, regarding the critical importance of the Older Americans Act.

I am Chuck Gehring, President and Chief Executive Officer of LifeCare Alliance, Central Ohio's oldest and largest provider of services to seniors and chronically ill individuals. Founded in 1898, LifeCare Alliance prepares and serves over one million meals each year to 5,000 clients in Franklin and Madison Counties. We operate twenty eight congregate dining centers, which serve over 182,000 meals annually, where seniors and chronically ill individuals find friends and needed social contact. We provide a wide selection of meals, including diet, vegetarian, pureed, soft, frozen, Kosher, Somali, and other ethnic meals. Over 4,200 people actively serve as volunteers in our Meals-on-Wheels program, contributing 116,000 volunteer hours, and donating more than 350,000 miles of travel in their own vehicles. Our volunteers equate to almost one hundred full time employees, saving millions for this critical program. We also operate the federally funded Senior Farmers Market Program, which provides critical food to needy seniors in our community.

Our Help-at-Home program provides over 18,000 homemaker visits and 14,000 home health aide visits annually.

Our Visiting Nurse Program completes over 11,000 home visits annually, while our eleven senior wellness centers receive 6,400 annual visits. We also provided over 11,000 flu shots last year, and provided the chair of the Central Ohio flu coalition. We assist in arranging medications, and have started a falls prevention program.

In addition, two other agencies have merged into LifeCare Alliance since December, 2004. Project Open Hand provides home delivered meals and congregate dining centers to those living with HIV/AIDS. The Columbus Cancer Clinic provides screenings and home care support to those living with cancer. Most of the Project Open Hand and Columbus Cancer Clinic clients are in advanced stages of their afflictions, unable to work, and with poverty level income. Many are seniors. Most would need to live in governmentally supported facilities if we did not assist them in remaining in their own homes.

The vast majority of LifeCare Alliance's clients are below the federal poverty level. 70% live on less than \$600 per month. 70% see no other adult on a regular basis other than our workers. 70% have diabetes. All are homebound, in need, and hungry.

The work this subcommittee is doing today is of critical importance to LifeCare Alliance and our thousands of clients, and we commend you for holding this hearing. The reauthorization of the Older Americans Act in 2006 must be the highest priority for Congress. The Meals-on-Wheels program, paid for in part by the Older Americans Act, is about hunger. I understand that when hunger in America is discussed, we normally talk about children. The fact is that millions of elderly Americans would be hungry if not for the Older Americans Act and the Meals-on-Wheels program. They would also spend considerably more time in the hospital, and die sooner. For many of our clients, our program provides the only meals they receive each day, and the only visitor to their home.

Finally, without the Older Americans Act, American taxpayers would pay significantly more in taxes each year to support our senior clients in governmentally supported facilities and nursing homes, where NONE of our clients wants to be. In fact, the latest figures provided by AARP indicate that for each senior LifeCare Alliance keeps independent and in their own homes, where 100% of our clients tell us they want to be, taxpayers save over \$40,000 per year. This means that LifeCare Alliance ALONE saves taxpayers over \$300 million each year.

What other act of Congress has this kind of return on investment for the American people, while giving our seniors exactly what they want.

LifeCare Alliance, working with funds from the Older Americans Act, saves taxpayers hundreds of millions of dollars each year. By keeping seniors safe and healthy in their own homes we keep them out of hospitals, saving significantly more by not using Medicare/Medicaid funds. The national average for seniors is that they spend 9.5 days each year in the hospital. Our clients average less than one day per year in the hospital.

As you can see, the practical side of the Older Americans Act is incredibly positive, providing staggering financial savings to taxpayers. It allows seniors to remain safe and healthy in their own homes, where they want to be. Meals-on-Wheels reduces, and often eliminates hunger for seniors in America. Our nurses and home health aides keep clients clean and healthy. Nothing could make more sense for America.

One of our clients is a 90 year old female, living alone in the home she has lived in for fifty years. Her husband was also a client until he passed away two years ago. She receives Meals-on-Wheels, and a homemaker to clean her home. She uses a walker and notes that while her health and mind remain reasonably sound, she simply can not cook for herself any more. "Standing at a stove, trying to cook is impossible", she says. "With a walker, I can't stand very long, and I'd lose my balance

and fall or burn myself. People just don't realize how hard it is to chop a carrot or cook food at my age". This client raves about our Meals-on-Wheels, takes advantage of our special lenten menu, and saves Ohio taxpayers over \$40,000 each year by remaining independent and in her own home, where she wants to remain.

Other clients report similar amazing stories. LifeCare Alliance engages over seventy businesses and schools to volunteer with delivering Meals-on-Wheels. One local high school, which has allowed their seniors to deliver Meals-on-Wheels as part of a class for the past eleven years, reported the following story. Two senior girls were delivering to a deaf client. When the woman did not answer the door, the girls searched for the building manager, knowing that this woman looked forward to her meal every day. They could have simply placed a notice on her door that they could not find her. But, being well trained volunteers of LifeCare Alliance, they cared about the client and went far beyond what was expected. These two eighteen years old girls were delivering the meal as volunteers because the Older Americans Act provided funding, and developed programs that could use volunteers, thus vastly reducing costs. To make a long story short, the girls' efforts resulted in finding the client on the floor, in distress. The girls did not know that this client had terminal cancer. The client's cancer would cause her to die the following day, and there was nothing they could do about that. However, their efforts by being LifeCare Alliance and Older Americans Act volunteers allowed this elderly client to die in the arms of her daughter, instead of alone, on the floor of her home. Her daughter has noted to us that being able to hold her mother in her final hours was perhaps the greatest gift she had ever received. As you can see, the value of the Older Americans Act is way beyond my previous calculations of savings to American taxpayers.

LifeCare Alliance, working with funds from the Older Americans Act, has a dramatic and positive community impact EVERY DAY. Our people and programs substantially improve and change lives EVERY DAY. Saving billions of taxpayers dollars nationally each year, reducing hunger among our seniors, providing quality of life, providing services and comforts that can not otherwise be provided, this is the legacy of the Older Americans Act.

Where do we go from here? I am listing below my thoughts for your committee as you continue your work to reauthorize the Older Americans Act.

First, please reauthorize the Older Americans Act.

Secondly, the Older Americans Act needs more funding. In recent years, many of the Titles of the Older Americans Act have been kept at existing levels, or even reduced. Retaining funding at existing levels means that the programs I have described receive annual cuts. As the funds are distributed by Area Agencies on Aging, those agencies must retain funds to pay for pay increases, and increased expenses. This results in funding cuts to organizations like LifeCare Alliance. The fact is that while LifeCare Alliance continues to fundraise aggressively, continues to initiate social entrepreneurship efforts to generate funds, continues to improve operational efficiencies, there is a limit to how much we can raise. LifeCare Alliance's policy is to accept all clients who call. With ever increasing numbers of seniors, we simply will run out of funds.

As an example, in the summer of 2003, Madison County Hospital contacted us about assuming their Meals-on-Wheels and Congregate Dining program in Madison County. The hospital had lost \$155,000 the previous year operating the program. We agreed to do this, because nobody else would. In the past three years, we have greatly reduced the loss, but we still have a loss. The Older Americans Act funding in Madison County is supplemented by funds from United Way, client contributions, and our new fundraising efforts. We constantly strive to obtain new volunteers to reduce our costs. We have reconfigured distribution routes, changed the way we deliver meals, and reduced staff. We still have a loss. The Madison County clients receive Meals-on-Wheels from LifeCare Alliance everyday because we know that nobody else will take over this program. How many other programs like the one in Madison County will cease to exist in the upcoming years? We can avoid this with reasonable increases in funding for the backbone of these critical senior programs-The Older Americans Act.

Thirdly, please consider linking Older Americans Act funding increases to increases in senior populations. In Franklin and Madison Counties, the number of seniors wills more than triple during the next twelve years, according to statistics from Scripps Gerontology Institute at Miami University. By linking funding to the number of seniors, we could better insure services as the "baby boomers" reach senior age.

Fourth, please consider the discontinuation of moving funds from Title IIIC to Title IIIB (Meals to Support Services). While all services funded by the Older Americans Act are critical, meals are the most needed to reduce hunger among seniors in America. Also, Title IIIC can no longer act as the "bank" to support other serv-

ices. All services must be supported with funding. In the last five years, \$174 million have been transferred from Title IIIC to Title IIIB, representing a loss of 38 million meals nationally.

Fifth, please support increases in transportation funding, especially for individual trips for medical care. Transportation to doctors and treatment facilities continues to be a tremendous need in Central Ohio.

Thank you for this opportunity to present critical information to your committee. I stand ready to assist in any way I can with your efforts. Please feel free to call upon me for information and assistance. Finally, thank you for all your efforts. I truly realize that you support the Older Americans Act, but struggle with federal budget reductions. I hope I have assisted in sharing information as to how important the Older Americans Act is. Thank you.

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Chairman TIBERI. Thank you.  
Mr. Horrocks.

**STATEMENT OF ROBERT HORROCKS, EXECUTIVE DIRECTOR,  
COUNCIL FOR OLDER ADULTS OF DELAWARE COUNTY**

Mr. HORROCKS. Congressman Tiberi and Congressman Hinojosa, thank you so much for this opportunity to testify; and thank you for bringing this field hearing into central Ohio. You'll forgive me—You have my written testimony. You'll forgive me for not reading a statement today. I thought it would be good to chat about our experiences up in Delaware County and the Counsel for Older Adults; and hopefully those experiences will be helpful as you go about the important work of reauthorizing the Older Americans Act.

I'm struck by the fact that as I listen to my colleagues today that many of the recommendations are the same and many are in my written testimony, and I guess that's just because they're so obvious. We haven't compared notes; and yet many of the recommendations surrounding the nutrition program, transportation, and family caregiving, and civic engagement are all very similar.

So I just want to share with you what we're doing in Delaware County. I don't have to remind Congressman Tiberi that we are the fastest growing county in the state. I think the last count was the 12th fastest in the country. Our older population has mirrored that growth. Our older population grew by 64 percent in the 90's; and we're projected by the Scripps Gerontology Foundation to grow from about 12,700 seniors in the year 2000 to almost 43,000 seniors by 2020. So we're right in the midst of that growth right now, and that's about a 337 percent increase. And so our community is struggling to keep pace in every way, and that also affects our older population.

Our nutrition program—through our nutrition program—and very similar to the situation that Chuck spoke of here, this is keeping people from being hungry. And it is also affecting their isolation because every one of our customers in our nutrition program gets a visit every day by a volunteer. And sometimes that visit is just as important as the meal. And as Chuck described, we have also found folks lying on floor and got them into the hospital because that volunteer knocked on the door with the meal.

We've gone from serving 61,000 meals in 1999 to serving 149,000 meals last year. We're projected to be close to 160,000 meals this year. The program—all of our programs are growing to—as our older population grows.

I would ask in terms of nutrition services to provide some flexibility. Every community is different. We have found that in Delaware County as we coordinate all of our services into one care plan and make things simple for clients and for their families, we use a sliding fee scale; and we would like to have the opportunity and the flexibility to use that similar scale with our nutrition program.

Transportation is a—is of vital importance as our older population grows, as the character of our community changes, as small rural roads become fast moving thoroughfares, it becomes dangerous for folks. And we have a lot of folks that don't go to certain places anymore even when they can drive, and keeping up with the transportation needs has been a real issue for us.

In Delaware County, we provide—we're one of the few non-profits in Ohio that does investigations of abuse, neglect, and exploitation. It is a big issue. Elder abuse is a big issue, and it's a shame. A lot of that neglect is self-neglect. And we think it's organizations that are able to provide services and response to the neglect is a good place to house those investigations, and we would invite you to take a look at Title VII of the Older Americans Act which addresses some of that. There is no national legislation that really is comprehensive in terms of elder abuse. Ohio, I believe, receives about \$200,000; and that's for 88 counties. And I ask just really what kind of significance can that play with that amount of money? And so most communities end up with maybe a part-time person for the whole county or, at best, a full-time person to investigate abuse, neglect, and exploitation of our elders.

I want to talk real quickly about the Family Caregivers Support Act. It's been wonderful. It's just been in place in the Older Americans Act for the last five or 6 years. That supports us working with caregivers. And as you know, caregivers really provide the bulk of the care this country for our elders. And we've seen some heroic efforts by sons and daughters and spouses caring for their loved ones. And we've also seen what it's like when family is not available and the kind of intensive services that are needed when family is not available. And this particular provision of the Older Americans Act/Family Caregivers Support Program, has really helped us keep people involved. It's helped us from keeping folks from burning out. It's helped us to do some training and education around how to care for a loved one, and it's allowed us to provide support for those folks so that they know that we're just a phone call away. And I can't tell you how important that program is for our caregivers, and I think it's time to expand that. It's been somewhat of an experiment. It's been just wildly successful throughout the country, and we've heard calls for large expansions of that program. I really do think it's time.

One last comment about civic engagement. Forty-three thousand folks in Delaware County that are going to be 60 years of age or older in 2020. Twenty-five thousand of those folks are going to be between the age of 60 and 69. I hope to be one of them. The fact is that that group of people is going to have a different set of issues, a different set of needs. Most of our resources right now are going for the very frail, the very vulnerable at the other end of the age span; but we need to pay attention to these younger older folks. There is so much opportunity. We tend to think of the older popu-

lation growth and think of problems and challenges. And there are some, but there is so much opportunity. If we are smart and if we position ourselves in ways and develop the kinds of programs that are going to bring those folks in, whether it be through life-long learning, whether that be through health and wellness programs; expanded, really sensitive targeted volunteerism programs. There's a lot of energy and experience there that we need to tap into. And it's going to be a big part of the solution. And I really encourage you to take a look at Part D of the act in terms of health promotion and disease prevention and also look in terms of volunteerism and civic engagement and what we can do to address that part of our population.

We've all talked about funding today. In my testimony today, I inserted a chart by one of my colleagues that I think the Department of Aging's testimony refers to the 50 cents on the dollar. It is true. It's real hard to run a business when you've got 50 percent of the dollar from what you had 25 years ago. And that's what we're all trying to do. We're trying to run businesses that serve people in a caring way. And it's—funding is really important. We all go out of our way to find other sources of funding, but the Older Americans Act is really the foundation and has really been a foundation from which many great things have grown.

And so I applaud you for your work in strengthening the Older Americans Act. And we'll be here to help in any way that we can. Thank you so much.

[The prepared statement of Mr. Horrocks follows:]

**Prepared Statement of Robert Horrocks, Executive Director of the Council for Older Adults of Delaware County**

Members of the House Committee on Education and the Workforce Subcommittee on Select Education, my name is Robert Horrocks and I am the Executive Director of the Council for Older Adults of Delaware County. Thank you for this opportunity to testify today about the work of our organization in Delaware County, Ohio and our thoughts about the Older American's Act. I want to emphasize that I am not an expert on the Older Americans Act. The Council for Older Adults does receive approximately \$300,000 a year in OAA funding from the Central Ohio Area Agency on Aging. I refer you to the written testimony of Cindy Farson, the director of the COAAA for the more comprehensive views of our Ohio Association of Area Agencies on Aging.

My purpose here is to simply provide the perspective of an organization which has focused on planning, program development and providing services at the local level for the past fourteen years. I have had the privilege of working and serving in Delaware County since the creation of the Council for Older Adults. It is my hope that this experience can help you as you deliberate about this important legislation.

*About Delaware County's Older Population*

A quick look at some of the demographic characteristics of Delaware County will put my remarks in perspective. Delaware County has been the fastest growing county in Ohio for the past two decades, as well as, one of the fastest growing counties in the nation. The growth of our older population has mirrored and in some cases surpassed the increase of our general population and this is projected to continue into the future.

While Ohio's population growth was 4.7% in the decade of the 90's, Delaware County's total population growth was 64% during the same period of time. Similarly, while the states older population grew by just 3% during the decade of the 90's, Delaware County's older population increased by 46%. It is projected that from the year 2000 to 2020 Delaware County's general population will grow by 90% while our older population will increase from 12,734 to 42,896—a 337% increase.

Another way of thinking about the growth of our older population in Delaware County is to understand that on average we will be adding about 1,500 seniors to our population each year for the 20 year period between 2000 and 2020. While about

9% of our county's older population was age 60 or above in the year 2000, it is projected that by 2020 this percentage will grow to nearly 20 percent of the general population. While the percentage increase of those aged 85 and older will be significant in the years ahead, much of the growth of the county's older population can be attributed to the aging of baby boomers during this time frame. Of the nearly 43,000 older adults projected to reside in Delaware County by the year 2020, over 25,000 of these individuals will be between the ages of 60 and 69.

The challenge for our community will be to continue to serve a growing number of disabled individuals age 85 and over while at the same time effectively responding to the very rapid growth of those younger seniors who are likely to have a very different set of needs as they adjust to a changing lifestyles and plan for their future.

#### *About the Council for Older Adults*

While formally incorporated in June of 1992, the organization's origins can be traced to over a year earlier when a group of concerned citizens, service providers, older adults and elected officials came together and began talking about the needs of the growing older population in Delaware County. From these discussions and subsequent community forums came the development of a task force which incorporated community concerns into a blueprint for an organization designed to meet the current and evolving needs of older adults throughout all of Delaware County. The Council for Older Adults emerged in 1992 to fill this void.

The Council is responsible for planning, coordinating, developing resources and providing services for the older population in Delaware County. The Council's mission is to improve the quality of life of the older population of Delaware County by being a catalyst to develop, sustain and continually improve a comprehensive, coordinated community based system of effective services and opportunities.

Looking back at the early 1990's, it is now easy to see why the community came together to create the Council. While a variety of services were available, the capacity of local service providers was very limited and large waiting lists were the norm. Services were often fragmented and not well coordinated causing those in need, if they were able to find local providers, to deal with a variety of differing administrative procedures and eligibility requirements. These roadblocks made it unlikely that the "system" could respond quickly or efficiently to individual needs for service. The result of these factors was that many local older adults found that nursing home care was the first and most viable option when they were having difficulties living at home. Not surprisingly, in the early 90's, local nursing homes were full to capacity. As the community examined these issues and began to understand how quickly our local older population was increasing in size, it became clear that action was needed to both increase the amount and quality of community-based care. Just as important, a local coordinated system was needed to improve the accessibility to services in a timely manner for those who were most in need.

One indication of the impact of our local system change is that now despite more than the doubling of our older population, nursing home bed occupancy is far below capacity in the county.

The Council directly manages the Senior Choices program, providing a one stop access to information, assistance and in-home services for older adults and their families. Through this program Care Consultants are in daily contact with local seniors and their families arranging for and overseeing the delivery of services designed to assist older people to remain as independent as possible in their own homes. In addition, the Council manages the countywide Senior Nutrition Program, Caregiver Support Programs including the designated Caregiver Resource Center, Adult Protective Services, Prescription Assistance Program, Insurance and Medical Bill Counseling, Income Tax Assistance, Durable Medical Equipment Loan and a number of smaller direct services. The Council also purchases services from a wide range of for profit and nonprofit businesses.

Due to the nature of the Council's origins, the manner in which the Council's Board of Directors is appointed and its mission, partnership building is and has always been a core and fundamental principle of this organization. The multi-disciplinary nature of aging services has required the Council to be actively engaged in multiple local partnerships. The Council has pursued working relationships with dozens of local entities and has in place dozens of formal and informal agreements with these entities. One of the goals of the Council has been to be "at the table" wherever major decisions are being made which will affect service delivery for older adults and this approach has led too much of the partnership building activities of the organization.

As an extension of its leadership role throughout Delaware County, the Council authors several publications, including: Senior Services Directory, listing available

services for seniors, LinkAge, a monthly newsletter, and Council Communicator, a bimonthly newspaper. The Council also sponsors a number of special events, educational seminars, legal clinics, and community forums.

The Council is uniquely organized to insure that it remains both responsive and accountable to the citizens of Delaware County. The Council's eighteen member volunteer Board of Director's is responsible for policy development and the overall direction of the Council for Older Adults. Board meetings are open to the public and are held at noon on the fourth Tuesday of each month at the office of the Council for Older Adults.

*Thoughts About Our Work in relation to the Older Americans Act*

I am sure that you have heard from national aging organizations and that have provided very comprehensive analysis and recommendations regarding the Older American's Act from a national perspective. I want to emphasize that my following thoughts about the Older American's Act are not intended to be comprehensive. These recommendations are intended to represent the view of someone working at the local level on those issues that are most important from our perspective. These include the following:

*Nutrition Services*

Good nutrition is obviously important. Poor nutrition can aggravate or lead to many costly healthcare issues. For our customers who receive in-home services, home delivered meals is our most frequently requested service. In addition to the hot healthy meals, local older adults also benefit from the daily contact by our volunteer drivers who delivery their meals. These relationships are very important and should be encouraged.

Currently the Older Americans Act prohibits cost sharing for nutrition services only. States are provided flexibility to allow cost sharing for other in-home services. In Delaware County we provide our in-home services on a sliding fee scale based upon our customer's ability to pay. Because Older Americans Act funds support our nutrition services we are required to exclude our nutrition service from our sliding fee scale. The result is that we are required to treat this service differently than any other service. We must spend time and effort to inform every nutrition customer of this difference. We believe that this leads to needless confusion in addition to increased administrative time and effort with no apparent benefit.

We are sensitive to the concern that cost sharing could lead to people in need not receiving services due to the inability to pay for these services. Our sliding fee scale has been carefully devised to make sure that this does not occur. It is also designed to insure that those who can afford to pay all or a portion of the cost of services do pay their fare share. Those who pay for services help enable us to provide free care for those less fortunate. Currently, about 68 percent of our customers pay nothing for their in-home services, 12 percent pay 100 percent of the cost of their services and the remaining 20 percent of our customers pay some portion of the cost of their care.

We recommend that you permit states to allow nutrition service providers the flexibility to use cost sharing and that where coordinated systems like ours exist, local communities be permitted to do so within the scope of the systems existing cost sharing policies .

*Transportation*

Adequate transportation service is a huge issue for seniors. Some can not drive, some increasingly can not afford to drive and others choose not to drive in certain situations. In rapidly growing areas like Delaware County once quiet roads have suddenly become very busy thoroughfares which creates the potential for increased confusion and risk for some older drivers who are not accustomed to these changed conditions. In our society, the inability to drive equals loss of independence. Affordable and convenient public transportation will help prevent isolation of those unable to drive and will help insure that these individuals remain active and involved in their community. We encourage increased funding for transportation services in the Older Americans Act.

*Family Caregiver Support Program*

As you are aware, family caregivers provide the bulk of the care provided to older adults in this country. We witness everyday the impact of this caring and we marvel at the heroic efforts that routinely occur as sons and daughters and spouses provide enormous amounts of care for loved ones. We also see what happens when family is not available to provide care or when informal caregivers become overwhelmed and burned out and resign this role in frustration.

The Council for Older Adults is the designated resource center in Delaware County for caregivers. These services are made possible through the Older Americans Act. These funds make it possible for us to provide education and support to our caregivers which provides them the tools and support to be better caregivers, understanding that help, if they need it, is just a phone call away. We have particularly appreciated the flexibility that these funds provide allowing us to provide the kind of assistance needed quickly and easily.

The need for these services continue to grow with the growth of our older population and we encourage a substantial expansion of this very successful program through the Older Americans Act. Money spent here helps insure better quality care by our caregivers. Additionally, caregivers save us all the cost of formal community based and/or institutional care. When caregivers remain in the picture, everybody wins.

*Civic Engagement, Health and Wellness, and, Volunteerism*

The growth of our older population is often discussed in terms of being a problem to be resolved. Certainly, rapid growth does create challenges and we need to be prepared for these challenges. However, there are also wonderful possibilities and opportunities that would be a grave mistake to ignore.

If we are smart we will recognize and prepare for the tremendous potential that exists to engage and tap into the wealth of talent, experience and energy that exists in this population. The more individuals who we can actively engage into our mission of service, the better we will be able to address the needs of those truly frail and vulnerable in our communities. The better job we do at providing meaningful opportunities to remain engaged, the more likely, I believe, it is that these individuals will remain active and well and not in need of costly services.

We are in the process of building a new senior enrichment center for Delaware County. This facility will bring together our social services headquarters, our nutrition program and local active seniors. We believe that making a commitment to life long learning, health and wellness, good nutrition, creative programming, meaningful volunteer opportunities and dynamic outreach will pay huge dividends not only for our older population, but our entire community.

Stable quality programs that engage people require an on-going commitment in terms of good management and coordination. These activities require both leadership and a stable funding source. Language and funding which recognizes the importance of these services would strengthen the Older Americans Act. Additional funding in Title IIID for health promotion and disease prevention would add capacity throughout the aging network and expand the impact of these services.

*Elder Abuse*

The Council for Older Adults through agreement with the Delaware County Department of Job and Family Services is responsible for the investigation of abuse, neglect and exploitation of older adults. This problem is far too common and we expect may grow as our older population increases. There is currently no federal law that comprehensively addresses this problem. Language in the Older Americans Act that would strengthen the role of the aging network and provide the resource to train and coordinate the efforts of those most likely to encounter abuse, neglect and exploitation of our elders would have a positive effect on the safety of our older population.

*Funding*

The attached chart illustrates the fact that despite incremental increases in funding over the years to implement this important legislation, we have fallen far behind funding level of 1980. When one considers the growth of our country's older adult population and Older Americans Act funding levels adjusted for inflation, per capita spending for Older Americans Act services has, in fact, been cut in half since 1980.

The Older Americans Act has been an important legislation of older Americans since its inception. It has provided a foundation of support from which many important services have emerged. It has been a catalyst for the development of much state and local funding and has provided a mandate and leadership for the development and expansion of community based services which have had and continue to have a substantial and meaningful impact on the health and independence of our older population.

I thank you for the opportunity to share my thoughts with you and I encourage you to continue to improve and strengthen this legislation and the impact of the aging network throughout our nation.

**ECONOMIC VALUE HISTORY OF OLDER AMERICANS ACT APPROPRIATIONS**

Prepared March 12, 2006 by Alan L. Burnett, Executive Director/CEO, AAA9/Eastern Ohio

\*per USDHHS/AAO \*\* based on Consumer Price Index calculator, US Dept of Labor-BLS at website <http://data.bls.gov/cgi-bin/cpicale.pl>

Actual Nat'l Appropriations*	(III-C Combined)			-----EARMARKED FUNDS - SPECIAL PURPOSES-----		
	III-B/General	III-C1/Meals	III-C2/HDMeals	Health III-D/F	Caregiver III E	Ombudsman VII
1980	\$246,970,000	\$270,000,000	\$50,000,000 (\$320,000,000)			
1990	272,960,765	351,849,415	78,981,410 (430,830,825)	5,756,409		
2000	310,020,000	374,336,000	146,970,000	16,120,000		13,179,000
2005	350,594,703	383,401,086	180,998,326 (564,399,412)	21,399,523	154,186,560	18,559,000

**"Purchasing Power" of the 2005 allocations compared to 1980 levels\*\***

In Real Dollars**:	(III-C Combined)		
	III-B/General	III-C1/Meals	III-C2/HDMeals
	147,921,000	161,763,000	76,366,000 (238,128,000)
Real Cents/\$1 vs. 1980:	\$0.60		\$0.74
Title III-B + C:		\$0.68	
Percent +/-:	(-40%)		(-26%)

**US Census- Age 60+ Population:**

	Title III-B + C per capita:		
	Actual	Reals/1980**	Change
1980.....	35,852,000	\$ 15.82	\$15.82 = -0-
1990.....	41,831,037	\$ 14.94	\$ 9.42 = (-)\$6.40
2000.....	45,797,200	\$ 18.15	\$ 9.02 = (-)\$6.80
2005.....	48,883,408	\$ 18.72	\$ 7.90 = (-)\$7.92
= +36% increase in target population		= -50% decrease per capita	

**1980-2005 SUMMARY:**  
 III-B+C @ \$568M in 1980 was equal to \$1.35B 'real dollars' purchasing power in 2005  
 Total III in 2005 = \$1.11B, including earmarks for Health, Caregiver and Ombudsman  
 The core III-B & III-C programs lost nearly \$435M in purchasing power (-32%) while the target population age 60+ grew by +36%.  
 From 1980 to 2005, per capita appropriation of III-B & C in adjusted "real dollars" vs age 60+ population **dropped -50% in buying power =**  
**50 cents/1980 dollar**  
 from \$15.82 to \$7.90 per older American.

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Chairman TIBERI. Thank you, Mr. Horrocks.  
 Ms. Ragan.

**STATEMENT OF GINNI RAGAN, CHAIR, LEGISLATIVE AFFAIRS COMMITTEE, OHIO ADVISORY COUNCIL FOR AGING**

Ms. RAGAN. Thank you, Representatives Tiberi and Hinojosa, for the opportunity to present my thoughts on the Older Americans Act. I am Ginni Ragan from Westerville, and I am a volunteer aging and Alzheimer's advocate and chair of the Legislative Affairs Committee of Ohio Advisory Council for Aging. The Ohio Advisory Council for Aging is appointed by the Governor to review and advise the Ohio Department of Aging on plans, budgets, and issues that affect older Ohioans and advocate specific administrative and legislative actions. I was also a member of the Ohio delegation to the 2005 White House Conference on Aging. I have extensive personal history as a family caregiver providing care for my husband, my father, and my mother.

In Ohio, a combination of Federal Older Americans Act and state and local funds are used to provide a wide array of home and community-based services to older adults at different points along the aging continuum, including:

Home delivered meals, home accessibility modifications and/or transportation services to older adults who need minimal support.

A package of case managed services, e.g., home delivered meals, adult day services, personal care to frail older adults at risk of being institutionalized.

Help for older adults to maintain their physical and mental health and prevent the onset of disabling disease. These funds support exercise classes, walking programs, and other wellness activi-

ties at local senior centers and recreation centers such as we are at today.

Supporting the needs of unpaid family caregivers that assist frail parents or relatives; in many cases allowing caregivers to continue to work and remain active in their communities; and giving older workers skills an experience to help them be part of a labor force that in the future will have to rely on mature workers.

The No. 1 priority of Ohio White House Conference on Aging Delegation going into the meeting in December of 2005 was the reauthorization of the Older Americans Act. Our top recommendation for reauthorization is to increase the authorized Federal funding level of Older Americans Act titles and parts by at least \$100 million each above the fiscal year 2005 appropriated level except for the Title III, Part E, National Family Caregiver support program which should be authorized at 250 million more.

While we recognize that the reauthorization and appropriation processes are separate, reauthorization provides the opportunity to increase the funding authorization for various titles and parts in the Act to ensure that the future appropriations can support and proactively prepare for the growth of the baby boomer generation.

I recognize that budget constraints make it difficult for Congress to meet this challenge; but with proper funding authority, a reauthorized Older Americans Act is a dynamic foundation that will help the aging network set the course for the future. A reauthorized Older Americans Act without proper funding authority is just words.

I am proud to say Ohio's Aging Network is well coordinated, efficient, and a very good steward of Federal, state, and local funds.

By being creative and innovative, we have saved taxpayers' dollars and have been able to aid more of our neediest, aged citizens and their families responsible for their care.

Coordination across organizations and programs is essential. In addition to managing OAA funded programs, Ohio Aging Network manages the PASSPORT Program, one of the largest Medicaid home- and community-based services waivers in the country as well as other community long-term care programs.

I am pleased to say that developing a coordinated long-term care strategy has been a priority of Governor Taft for the last 7 years. Since 2001, multiple state departments including the Ohio Department of Aging and the Ohio Department of the Job and Family Services, Ohio's equivalent of CMS, have worked together to implement Ohio Access: Strategic Plan to Improve Long-term Services and Supports for People with Disabilities.

Coordination of services across funding streams and populations works. We recommend that Congress follow Ohio's lead and reauthorize the Older Americans Act to strengthen and broaden the Federal role of the Assistant Secretary for Aging to establish new partnerships with CMS and other HHS agencies for the administration of HCBS Medicaid Waiver and other long-term care programs.

We also recommend that reauthorization also contains separate funding to sustain and expand aging and disability resources in Ohio and 42 other demonstration states and territories.

A good measure of society is how it cares for those most in need. In 2004, the Ohio Department of Aging surveyed Older Americans Act consumers and found that they were doing an excellent job in delivering our services to those in greatest need and making a difference in the lives of consumers and their caregivers. Some of what they learned: Home delivered meal consumers depend on this service to provide one half or more of their daily food intake; transportation consumers use the services to get to a doctor or health care provider or medical services; homemaker consumers report annual incomes under \$15,000; and caregiver program consumers believe that services allow them to provide care longer than they could without those services. The survey also found that consumers were highly satisfied with their Older Americans Act services.

I am proud of Ohio's Aging Network and the good work they do to serve older Ohioans and caregivers. I urge Congress to give the Aging Network through reauthorization of Older Americans Act the resources they need to serve the future generations of older Americans.

Thank you, Representatives Tiberi and Hinojosa, for allowing me to participate in today's field hearing.

I would like to leave you with what I believe is a very powerful statement authored by one of your former colleagues: The future of a society may be forecast on how it cares for its young, the quality of a civilization may be measured on how it cares for its elderly.

Thank you very much for this opportunity.

[The prepared statement of Ms. Ragan follows:]

**Prepared Statement of Ginni Ragan, Chair, Legislative Affairs Committee,  
Ohio Advisory Council for Aging**

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Giving older workers skills and experience to help them be part of a labor force that in the future will have to rely on mature workers.

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Home-delivered meal consumers depend on this service to provide one-half or more of their daily food intake;

Transportation consumers use the service to get to a doctor or health care provider;

Homemaker consumers report annual incomes under \$15,000; and

Caregiver program consumers believe that services allow them to provide care longer than they could without services.

The survey also found that consumers were highly satisfied with their Older Americans Act services.

I am proud of Ohio's aging network and the good work they do to serve older Ohioans and caregivers. I urge Congress to give the aging network, through reauthorization of the Older Americans Act, the resources they need to serve the future generations of older Ohioans.

Thank you Representatives Tiberi and Hinojosa for allowing me to participate in today's field hearing.

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Chairman TIBERI. Thank you. Thanks to all of you for very good written testimony and oral testimony as well. And thank you for showing our guests from Texas that Ohio and central Ohio specifically has a lot more going for it than just college football. You all did a very, very good job.

And we both have heard, quite frankly, loud and clear a couple issues. First and foremost, the White House Conference has told us, and you all have confirmed to us, that the No. 1 issue is to reauthorize the Older Americans Act. And as Mr. Hinojosa, I think, would tell you, as well, is there are a lot of issues in Congress today. If you read the Washington Post every day, they will tell you a lot of the important issues that are going on. And, unfortunately,

if you read the Washington Post or the New York Times or the Wall Street Journal or any other national newspaper, Older Americans isn't one of those things that they talk about. But we agree with what Mr. Gehring said that this is an extremely important issue; and so my commitment to you, and I know Ruben's commitment, is to try to move this process along to force others' hands.

And I think one of the ways that we're going to try to do that is in the month of May is try to move this piece of legislation through the process that we can best control—and the first is the subcommittee—that we will try to move in process through the subcommittee in May. And then I've got a commitment—I talked to the Chairman of the full committee, and he wants to be helpful in moving the process to the floor here soon, as well, through the committee—excuse me—to the floor. And then we have a former education and workforce chairman from Ohio now who is the majority leader who controls the floor calendar, so I like our odds. If we can get a bill out of committee, the two of us, at least, I think we can get some floor time.

But that's only part of the process. We have a Senate that we unfortunately have to work with; and they haven't started this process, and they will have a process and then that will go to conference committee. And hopefully both of us will participate in that. And so I think it's critically important for us to begin showing you that we hear you loud and clear, and that we're going to try to jump start this process in May, which will begin with a hearing next Tuesday in Washington, D.C., May 2nd; so we hear that loud and clear.

The funding issue is one that we hear all the time as well from everybody who testifies before any committee that we're on; and you all make a very strong argument, obviously, to your needs and what you do. And we obviously are sensitive to that. There, you know, obviously are a lot of pieces of the puzzle when you look at the whole scheme of things; but we want to be as supportive as possible. And I'll let Ruben speak to that as well. The process now—And those are the two big issues that I heard about. And I heard about a whole lot of other issues as well and read about other issues in your testimony.

What we'll do is we'll begin a series of give and take here with questions and hopefully answers. And I'll just go down the line. And I'll turn it over to my colleague from Texas; and he'll ask you questions as well, and they involve a number of different issues that I think many of you touched on.

First I'm going to ask Ms. Geig—By the way, thank you for mentioning the consumer guide. Joan Lawrence and I spent way too much time trying to get that done, and thank God she helped save it while I was gone. And I'm glad to hear that you strengthened it as well. And please thank Director Kearns, because I think it's a program for seniors to really have an opportunity to get more information and their families to get more information and compare.

Could you elaborate on the PASSPORT Program in our state? I'm obviously very familiar with it; but for the record and Mr. Hinojosa, how does it operate; and what lessons can the committee learn from Ohio's success on this program at the Federal level, in your mind?

Mr. HINOJOSA. Can we pass the mike?

Chairman TIBERI. The mike, yes. Thank you. Good point. If you could speak into the mike for the benefit of everybody in the room.

Ms. GEIG. OK. The PASSPORT program in Ohio is very successful. It's probably been one of our most popular Medicaid Waiver programs in Ohio, and most of our consumers have—

Chairman TIBERI. Can you explain the program? Because I'm familiar with it because I was on the legislature—but for the committee and Congressman.

Ms. GEIG. It is a Medicaid Waiver program that we have here in Ohio that allows a consumer who is in a nursing home to come out of a nursing home and have care inside of their home—to receive services inside their home. Someone could probably explain it much better than I can from our department. I'm fairly new to our Department. We can get more information to you on that. We have several other Medicaid Waiver programs within our department, but the PASSPORT program is probably our most popular program—to get them outside of the nursing home and into the community and receive care inside of their home.

Chairman TIBERI. Can you provide for the Department some documentation on the PASSPORT Program?

Ms. GEIG. Yes. That will be no problem.

Chairman TIBERI. Mr. Bibler, you mentioned in your written testimony and touched on transportation services for seniors in your oral testimony. Can you think of or describe maybe some specific ways in which the Act could help promote more senior mobility throughout the country?

Mr. BIBLER. I think one of the biggest issues we face is replacing vehicles. As I stated in my written testimony, we have seven vehicles with over 200,000 miles on them. There used to be a great program through the Ohio Department of Transportation called the specialized transportation program that made funds available to the counties to purchase handicapped accessible vehicles for this purpose. That money has since disappeared essentially. This year is the first year that there has not been any money allocated for that. It has slowly been drying up, but that is one of our biggest concerns right now with the number of miles we're putting on our vehicles is being able to replace those and keep our rolling stock in good condition, because the safety of our seniors, obviously, is one of our utmost concerns. So I think that would help us tremendously.

There's been a great effort within the state of Ohio for coordinated transportation. We have tried that with limited success in our communities; and I think that there would be some way to make funding available as well, too. For example, we have discussed about having a web-based program that we could use so that all the providers in our community could enter data into it so that the routes could be assigned to specific providers so that we wouldn't be duplicating the places that we would be going. However, that software runs over \$100,000; and obviously we don't have the resources to purchase something like that. That would help us tremendously, too, so that those of us that do have vehicles could work together to coordinate transportation so that we're not going up the street and 2 minutes later another service provider is

going up the same street picking up clients for their program and 2 minutes later another vehicle from another agency is going up the street.

Chairman TIBERI. OK. I want to switch to Mr. Gehring here. Can you describe some of the partnerships that you have? I was over at MidOhio Food Bank within the last few weeks, and they mentioned some of the work they do with you. Can you talk about partnerships, both public and private partnerships, that LifeCare Alliance has to the benefit of the seniors and how maybe the Act can better encourage some of the things that you guys have done so well?

Mr. GEHRING. We have literally, if you really added it up, dozens of public and private partnerships. The 28 dining centers that we have are all in cooperation with some other organization that allows us to use their facility at no cost to provide the meals and the socialization for the seniors. But those locations do not receive any funds from that. We have partnerships with people that provide specialty meals to us. We have—such as Kosher or Somali. We have a huge Somali population, as you know, in central Ohio. I think some of our better partnerships are with some of the folks that assist with the assessment of the clients; things like that, such as the Ohio Area Agency on Aging and Franklin County Agency on Aging and all these other counties have offices on aging generally. Those folks, COAAA and Franklin County Office on Aging, work hand in hand with us to try to divide up the work to ensure that we are not duplicating services as Dave just referred, to ensure that we are as efficient and effective as possible.

And I guess in answer to your question, What could the Act do to, you know, further those partnerships? Many—And I don't want to get this specific in the Act. I don't think anybody wants to get this specific in the Act. But I'll tell you, a lot of the grants we apply for anymore, both public and private, request collaborations. OK? And I know when we just finished our United Way reporting for the year, we probably listed 40 different partnerships that we have on a fairly large level in order to ensure that. Because United Way is a group that really values, here in central Ohio, collaborations—that you're working together, that you're truly not duplicating services as Dave was saying. So I think—I don't know how exactly you put that in the Act, and I don't know that we need more items in the Act that would restrict how we work; however, I would tell you that most of the grants we apply for anymore, if you don't have collaborative partnerships, you're not working with other groups; you're not taking care of other groups; it's difficult to get those grant funds.

Chairman TIBERI. Thank you.

Mr. HORROCKS, you obviously are aware of the long-term care consumer guide that Joan Lawrence and I worked on. I'm interested in learning more about how you all up in Delaware succeeded setting up a resource to help seniors make informed choices about long-term care needs and costs as well and—again, how you think that maybe more local offices can do that. And is there a place that we can encourage that?

Mr. HORROCKS. I have a tendency of telling folks that you never look for the computer ads in the newspaper unless you're thinking

about buying a computer. And I think that's real similar to—for caregivers, for older folks, for families. They don't think about these issues until the issue is there. And so what we try to do is to pull as much information—as much relevant information as possible and have it in one place and then to really go out of our way to be out in the community letting people know that those resources exist and reminding them that, you know, it may not be an issue for you today; but down the road, it might be. Or you might have a neighbor or somebody at church who it's an issue for now. And they need to be giving us a call if they think that we can help. So there's a ton of information available, and it's important to—sometimes too much information for any of us to sort through; and so having some people that are kind of experts in that and are, you know—work with it on a daily basis and then having an easy way for the community and individuals in the community to access that information. A lot of it is being out in the community and talking to groups every week. We have our own newspapers, as you know; and we do a lot of other things to communicate with folks of all ages that our office is there, and this is what it's for.

By the way, I thought of one thing that you could do to help with transportation.

Chairman TIBERI. OK.

Mr. HORROCKS. Just lower the price of gas a little bit.

Chairman TIBERI. I'm going to rely on my Texas friend here. I'll let you respond here a little bit.

Mr. HINOJOSA. I couldn't help but hear the word "transportation" and the problems that it is presenting throughout the presentations that were made by all five of you. And I think it was Mr. Bibler who said that it would be much easier if they had the software program. Was it not you?

Mr. BIBLER. Yes.

Mr. HINOJOSA. If they were able to avoid going to the same residence twice or more. And I was just thinking of an individual who came by my office not long ago. His name is Bill Gates, Sr.; and he runs the Melinda—Bill and Melinda Gates Foundation—and a very philanthropic individual. Have you thought of possibly communicating with Mr. Gates, Sr., and asking if they might be able to consider a donation of that—of a software program comparable to what you need and thus be able to reduce the costs by not having that, you know—repeating as you said, going to the same residence two or more times. That was one thought that came up.

The other one is to join a group of Texans who sent me several e-mails saying that they had come to the conclusion that the only way to reduce the cost of fuel prices was to reduce the demand. And the way they were doing it is they were sending out e-mails to at least a hundred people, and those hundred had to send it to another group of hundred to stop buying Mobile—Exxon Mobile gasoline—just to not buy from any Exxon gasoline station and thus reduce the demand and thus let them take note that if it is supply and demand, maybe they will have to reduce the prices and stop giving \$400 million bonuses to the head of the Exxon corporation as they announced last week for making such high profits. Those are things that sometimes we don't think about because dealing with the most basic problems of how to reach the senior citizens

and bring them to where they can socialize and be able to eat a meal and all of that seems to be our foremost priority; but the Congress, as you have learned from your very able Chairman, is going through some very difficult times because of our very high deficit as we debate the budget for 2007. And that has resulted in a lot of domestic cuts including Meals-on-Wheels as everyone in this audience has learned. So we are going to take recommendations that you all have given us and try to bring them to Congress, to other members, so that this next month of May as Pat was saying—that we can try to bring this to a vote in our committee and then eventually to the House. So we're going to certainly use your written statements, which will become part of the permanent record of this hearing; and we're going to see that this information gets into the right hands.

At lunch, I was convinced that all of you are very well informed, knowing so much about Ohio versus University of Texas Longhorns. And there is no doubt in my mind that you will find ways in which to begin collaborating with us. There's no sense in just fighting over football. I think that we have to find ways of collaborating with you to make each state get their share of the budget.

But I'm going to ask my first question of David. It's apparent that in Licking County, your food costs increased significantly, you said, about 73 percent over the last five or 6 years; and your waiting list grows larger every year. Do you have some estimate as to how much funding you would need just to stay even with your current and the projected demand over the next 2 years?

Mr. BIBLER. Well, that's a good question. No, I have not thought that far ahead to try and project how much additional funds that we would need. The 73 percent that I have in my testimony not only includes the costs for the number of increased meals that we've done but, of course, the cost of food as well. As we all know, the cost of food is affected by the cost of transportation. And we've certainly beat that horse enough today as well. But with the numbers that we're looking at continuing to increase our meals at a pace that soon is probably going to exceed our capacity to continue delivering those meals. We've been very fortunate to this point that we have never had a waiting list for our meals program. We continue to find a way to get those meals out and serve it to the people. But with the continued growth that I have expressed in my testimony, it would make it very difficult for us to continue to do that. So to answer your question, I really don't have, I guess, a projection at this point as to how much additional funding we would need. I guess if you could look at the growth and our food costs over the course of the last five or 6 years and project that over the course of the next couple years, we could be looking, again, at an additional 10 to 15 percent a year possibly in the growth of our meals program because it does continue to escalate. And I really don't see that slowing down, especially when I've heard this is the first year that the baby boomers will be hitting retirement age. And as those ranks continue to swell, those numbers are going to continue to grow.

Mr. HINOJOSA. Well, I'm going to yield to the Chairman so that he can finish his questions. But do know that Texas does have a

lot of oil and a lot of oil magnets, and I think that you will really get their attention when you stop buying Exxon oil along with some of my other Texans who have agreed to collaborate and let the demand come down.

Chairman TIBERI. I'm going ask one more question of our last witness, and then I'll go back to you for another round—we can go another round after that.

Ms. Ragan, I obviously know of your particular interest in helping people with Alzheimer's disease. I know it's something near and dear to your heart, and we're beginning to learn more and more about Alzheimer's. And one of the things that I think we're beginning to see is, obviously, you know, that Alzheimer's can strike someone prior to the age of 60.

Do you believe that under the Older Americans Act it would be helpful to allow for nutrition services to be provided to people under the age of 60?

Ms. RAGAN. Absolutely. I wouldn't stop at nutrition services. I would continue with a lot of services primarily because up until not long ago—and because of the advances in diagnosing Alzheimer's, when you had someone who was in their 30's, 40's or 50's who seemed to have had behavior problems, et cetera, it was diagnosed as mental illness. It was not conceivable that somebody 40 years old could have Alzheimer's or anyone of the other 26 definable dementias. Now we know—and in central Ohio, we have people in their 30's, 40's, 50's who are early onsets, frontal lobes, Pick's disease, Lewy Body disease. There are no services and no money for these people under any program that comes under the Ohio Department of Aging because of the age constraints. We go through this in the state budget every year. I believe that nutrition would be one, assistance—You save the state a lot of money; and we proved this last year in House Bill 66, which was the state budget. You proved—you saved the state a lot of money. You give people dignity. You give them choice by enabling them to remain in the community in the long-term care continuum that they choose to be in and with a little bit of help. On the other side with our Home First Program now, we have people coming out of nursing homes on the 525 funds. We're saving the state a tremendous amount of money on that in giving people the dignity that they deserve. I absolutely believe that if possible to have some of these services—nutrition would be a good start—but there are a lot of other services that also I would like to see available to Alzheimer's and related dementias and their caregivers—families, friends, et cetera—available under the Older Americans Act. Thank you very much.

Chairman TIBERI. Thank you. I want to turn it over for a round of questioning to my colleague.

Mr. HINOJOSA. Thank you, Mr. Chairman.

Elise, I'm going to ask you—because I notice that your state is doing a tremendous job with the resources available. I'm interested in your efforts to get 60 out of the 88 counties to pass levies to raise over the \$100 million in additional funding that you requested. Are there other states that you know of doing this?

Ms. GEIG. Yes. Chairman Tiberi and Congressman Hinojosa, Michigan; Kansas; Louisiana; and North Dakota have local senior levies as well.

Mr. HINOJOSA. That's good. That's good. Are any Ohio corporations or other industries helping to provide the financial resources to help you cover the growing unmet need of your clients in a collaborative manner with the other members who testified?

Ms. GEIG. I'm sure someone else on the panel would be better able to answer that.

Mr. HINOJOSA. Well, maybe Mr. Gehring can tell me what corporations are collaborating on it.

Mr. GEHRING. Many of them right into—and in a different ways. One is corporations and their foundations provide grants to assist us in our efforts, and it defrays our costs. And, second—I think this is a great way to do it—we have over 50 companies right now in central Ohio that volunteer their employees to deliver Meals-on-Wheels. And what happens with that is we even have one company here in central Ohio, the Huntington Bank, that has currently 355 employees actively delivering meals to eight routes, 5 days a week from four locations.

And just so you know, if we don't have a volunteer to deliver that route, we have to pay a driver. Now, a paid driver to us is generally a retired person earning to about 8 to \$9.00 an hour for 3 hours a day's work; plus mileage on their car, which they drive. But that still adds up to between 10 and \$12,000 a year. So if you have 50 companies running routes from 1 day a week to 5 days a week or 7 days a week, whatever it might be—normally they don't do the weekends for us—that defrays our costs incredibly. Last year alone with just the companies we added, we took—we saved almost \$190,000 in our budget alone last year by these companies doing it. And I would tell you that the Huntington Bank will tell you, one of their executive vice-presidents, that it's the best moral builder they have. So if we—

Mr. HINOJOSA. Not only would it be a big morale builder for the employees who do this work, I wonder if you're working with the newspapers and television stations to give credit where credit is due and help their name visibility as givers as they are to get their name into the newspapers.

Mr. GEHRING. We do that every single chance we have. And, in fact, last evening we had our volunteer recognition evening for our agency; and we honored a couple of the companies that are doing it. And there was a reporter there. Sometimes, though, those stories do not carry quite as well as we would like to see them. So any emphasis that someone like you could place on that and highlight it to the news media would really be helpful because throughout the country—I can tell you there's another major city in Ohio who really—until a couple years ago never used volunteers. They used all paid drivers. And we had helped them kind of get going with that. And I'll tell you the savings is just amazing. And it's a great thing that can really help us be more efficient and effective as the years go by with the Older Americans Act money.

Mr. HINOJOSA. I'm delighted to hear that you are working so hard to give them credit; and I can tell you that any time your Congressman comes to an event, it will certainly bring the media. And when he speaks, people hear; and they listen. So I'm sure that if you could just work it out so that our Chairman can be at some

of these recognition banquets that you're talking about that those individuals will get a lot of recognition.

Chairman TIBERI. There is a reporter present in the room.

Mr. HINOJOSA. Good. They're going to listen very well to you for sure.

I'm going to ask Charles Gehring, you have a tremendous organization; and you mentioned that the average for the senior stay in hospitals is something less than 10 days per year; however, your clients average less than 1 day per year. How have you been able to do this?

Mr. GEHRING. Through the services provided with the funding from the Older Americans Act such as Meals-on-Wheels. I'm very serious about that. If—When you do the research, the No. 1 reason when people come out of hospital that they go back into a hospital is that they do not get proper nutrition.

If you think through this for a minute, as I know you have—Let's say you're a senior. You have a problem that you have to go to the hospital for some surgery that perhaps you were not prepared to do. Maybe you need your gallbladder taken out or something like that. You have that 8-week recovery period afterwards. What do you do for yourself? I told you earlier that 70 percent of our clients say they see no other adults on a regular weekly basis other than our workers. And with our mobile society in this country, many times the kids who are my age, being a kid, live far, far away. So how do these seniors take care of themselves during that recovery period? And the answer is they end up eating what's ever on hand, which might be potato chips and cookies; and that's not going to keep them safe and healthy. They end up back in the hospital. So by being able to assist them with things like that—Like we'll do frozen meals for people coming out of the hospital, which reduces our costs a little bit. Anymore it doesn't, because we've become more efficient—and our hot meals. But just by giving them proper nutrition; sending nurses to their homes, which is Medicare/Medicaid sponsored often times—the Older Americans Act sponsors homemakers and home health aids that go out and clean their homes. You can imagine, once again, someone in distress who's a senior who's had surgery or just is elderly and is on a walker.

Perhaps—We have a 90-year-old client that I deliver to all time who's on a walker. She literally can't cook for herself, because she can't stand at a stove. She can't chop up a carrot, because she's on a walker. And what does she do about cleaning her home? For example, her bathroom? How would she do that? I can tell you she can't do that because she'd fall over.

So through the service funding of the Older Americans Act, these folks are allowed to stay safe and healthy in their own home; and they don't go back into the hospital. Because if they should go to the hospital, when they come out, there are services there to protect them and help them through their recovery period.

Now, let's say you didn't have the blip and you never went into the hospital in the first place. You just happen to be 85 years old and on a walker. The fact of the matter is, you know, if you're trying to take care of yourself, problems are going to occur.

We just started a falls prevention program at our place. It's a big, big issue for seniors if they fall. And often times they can't

rock themselves back up, et cetera, et cetera. So there's just a need for these types assistance for them.

The homemakers that are sponsored by the Older Americans Act—Gosh, what an important program that is. When you're an elderly person and you're not as mobile as you used to be, do you really clean your house? And the answer is they can't. So what happens? You end up in squalid conditions.

And I would tell you just as an aside to that, who does stay with these seniors every day? And the answer is the 64 percent of our clients have a dog and 62 percent have a cat. Those are their families.

I have a client that I deliver to, an elderly gentleman, he has a beagle like Snoopy. When you walk into his house, you smell beagle. OK? And we have had to go out and assist him many times in cleaning his house so that he has more hygienic conditions so that he does not get sick and then stays out of the hospital.

So it's just all these things; and I think, you know—We talk about congregate dining and the transportation and the congregate dining sites for socialization. When you don't have that, you get depressed because you're lonely. The clients we all service are lonely. And depression puts you in the hospital in one way or another, whether it calls you to be sad; not sleep at night; have a heart problem; fall; whatever it might be. All these things are issues that are bad for our seniors but are solved through the funding of the Older Americans Act.

Mr. HINOJOSA. Thank you for that input.

Bob, is it pronounced Horrocks?

Mr. HORROCKS. Horrocks.

Mr. HINOJOSA. I want to ask you a question, but let me first make a comment that we're moving in the amendments in our bill to increase the opportunities for organizations such as yours to help states plan for futures services for the aging.

You are very active. Are other counties in Ohio as supportive in this regard as is Delaware?

Mr. HORROCKS. There are 88 counties in Ohio, and there are 88 different counties; and, unfortunately, resources are not equal in every place. And so for example, when we were able to take PASSPORT, our state PASSPORT program statewide, that made a huge difference because no matter what county you live in, you will at least have that Medicaid Waiver Program in your county; and you will be treated equally. But for our Older Americans Act services, for example, you will find, you know, very poor counties in Ohio that just don't have available very many local resources. And they may rely totally on the Older Americans Act funding. And it's—You've heard about the problem with 50 cents on a dollar with Older Americans Act funding; and that has really impacted probably most the poorer counties in Ohio, because there's not other resources available to them. And so, yeah, I would think that we're fortunate in many ways to have a statewide—the waiver program. We're fortunate to have 12 strong Area Agencies on Aging in Ohio and our State Department of Aging. But we do have large pockets of poverty, and those folks are probably hurt the worst when it comes to not enough funding available for the Older Americans Act.

Mr. HINOJOSA. Let me ask you, you make a very compelling case in the presentation that you made on the financial resources for the Act due to loss of purchasing power for the services. We face some of the same issues trying to support Pell Grants for college students in our education committee. Mr. Tiberi and I are very sympathetic to your concerns; but we have to convince House and Senate colleagues as well as the White House—the administration will have given us the proposed budget for 2007. I'd urge you to contact every member, as we talked during lunch, at the right time that Mr. Tiberi sends a signal, because they're going to pay close attention when they get inundated with messages that all of you said is very important to Ohio. And I think that would make our work easier to bring back some of those cuts that were proposed.

I've learn a great deal from each one of you from your presentations, and I think I'll wait and ask any other questions that I have.

With that, I yield back to you, Chairman.

Chairman TIBERI. Thank you Mr. Hinojosa. You know, it's interesting, one of the things that I have found as a Member of Congress, probably the most important thing that a President budget provides—because I don't think it provides a whole lot other than a lot of controversy usually because it's very rarely implemented, it's usually dead on arrival—is that it does get people engaged in the Federal process; and if it weren't for the budget quite frankly, I think most people wouldn't be engaged in the Federal funding process. What do I mean by that? I have people constantly—and I'm sure you do too—complain to me that they never—you know, they pay a lot of taxes; but they don't get any Federal services. And people are shocked to find out that actually Federal services touch them a lot, and one of them is a the Older Americans Act.

I think—I had an aunt who was a Meals-on-Wheels volunteer; and she had no clue that Federal Government was involved, because she told me, "What a great program. You know, government always doesn't solve all the problems, and this is a perfect example. Meals-on-Wheels is a totally volunteer program."

And I said, "Well the Federal Government is a bit involved in the program."

Here's my point, though, Chuck, I think what's important about what we're today, having this hearing today and having one in Texas and having a debate on budgets—And I think if you walk through this senior center, it wouldn't surprise me that most of these seniors probably don't realize that the Federal Government is providing a service to them that they don't realize the Federal Government is providing. They might think the state's providing it, but the state may be only a pass through. They might be thinking the county provides it. And the county certainly is a partner as well as the state, but it really is all about partnerships. And LifeCare certainly as a nonprofit exemplifies that partnership more than most, both at the local; state; national; private sector; and nonprofit level.

To that point, Chuck, let me ask you a question. With respect to the private sector, do you think the Act currently makes it difficult for you all at LifeCare to generate income from private sources outside of what you do? And can we do something to help you?

Mr. GEHRING. I would say it does not make it difficult. The only way it might make it difficult is that there is a perception out there that because we or any other program receives governmental funding for our organization that that covers everything. OK? And I will tell you, I've had that said to me a number of times. So one thing that perhaps would help us is if we could better educate as we attempt to do every day of the week. And I know these folks around this table do this every day of the week, too, try to educate our private sector partners as to how the whole system works. And sometimes it's very difficult for them to understand. We're not going to kid you here. But with increased education, they start learning that they are a key part of it—different things that they can do, and then we move on from there.

Meals-on-Wheels of America for the Meals-on-Wheels program is really trying to promote to other areas some of these private/public partnerships, especially with the companies. You know, we think that the companies delivering meals for us—It's just a no-brainer, to use a technical term there. The fact of the matter is it costs them nothing. You know, companies nowadays—A few years ago there was a shift, and there was a lot of literature about this in the magazines and things like this—is that companies wanted to cut back. They had to cut back because of tight budgets in their own areas with how much they could give to charities in this country. You know, delivering meals doesn't cost them a dime, so it's a way for them to really get involved; to promote themselves.

We have a number of public companies that talk about this. They're volunteering constantly, because their shareholders like to hear about their involvement in the community; and that it's smart involvement. It's not just writing a check, walking away, and not knowing what happened to their money. So I think there's just—so from that standpoint, I think there is a perception that the governmental funding covers all, which, of course, it doesn't; and the more we can educate these folks, the better off we can be.

Chairman TIBERI. I think Ruben's right. If I were an aspiring reporter or a really important reporter, I think, writing a column about how LifeCare Alliance couldn't exist without the private sector support and how it complements the public sector. It's a great story for any inspiring reporter.

Mr. HORROCKS, I read in your testimony—You didn't talk about it in your oral testimony, but I read about your Senior Choice Program—your Senior Choices Program managed by the counsel. It appeared to me that it was very similar to what the Bush Administration has proposed called the Choices for Independence Plan in their proposed budget. Can you tell me how participants have responded to your program in Delaware County? Am I reading something wrong in the fact that it sounds—Has the Bush Administration come and copied you?

Mr. HORROCKS. I might have a hard time living that down in some circles. Well, the fact of the matter is that program started because we just listened to people in our community; and they were telling us two things. One was we don't know where to go for help. And usually in a crisis you're desperate, and it wasn't obvious where to go for help. The other thing we were told was when we do go—when we do find a place, there's most more often than not

a waiting list; and we wanted to—You know, if you need three or four different services in order to stay out of a nursing home and only a couple of them are available and you've got to wait for the others for a few weeks, a lot of the times the path of least resistance is to a much more expensive care environment. And if you only need a little bit of help—if some in-home services can help you stay at home, you know, that is absolutely the model of the state PASSPORT Program and our local Senior Choices Program. It's—That's where people want to stay; and it's less expensive to do it, so it's pretty much a no-brainer. So maybe that's where the Bush Administration's idea came from because it's obvious. It's less expensive to government, and it's what people want, and what we need to do is create a friendly system that makes it easy to access and gives people choices. And so I would hope that, you know, anyone would come to that same conclusion. That's why the PASSPORT Program is so popular. That's why our Senior Choices Program is popular. It provides a broad array of services that meet people's needs, and it's less expensive than going into a place where you don't want to be.

Chairman TIBERI. Are other counties doing that, to your knowledge as well?

Mr. HORROCKS. Yes. Again, it's not universal; but there are many counties in Ohio that are doing that.

Chairman TIBERI. Thank you.

Mr. Bibler, in your written testimony, one of the things that you stressed that I have not seen both in Washington and our hearing in Texas or the hearing here is your focus on the prevention of elderly abuse. Can you talk to us and explain to us how elderly abuse prevention efforts are fragmented out there and how maybe we can do better in putting more focus on the need to prevent elderly abuse?

Mr. BIBLER. Well, I don't think there's enough attention given to it. As I stated in my written testimony and my oral testimony, too, we only have one adult protective services worker in our county to cover the entire county. This is one issue that in the 10 years I've been director of the aging program, it's probably been the one that has disgusted me the most in how our elderly people are treated, especially by their family members. We have many older adults who have children living within the same county that never come over to see them; you know, will not bring them a warm meal on the weekend and will not come over and socialize with them; and if it wasn't for our employees and volunteers going out and delivering the meal and providing personal care and homemaking services, they would not get that contact.

A lot of it is probably more neglect than abuse, although, there are issues of abuse, as well, too, that we encounter; but the system is just so inundated that, you know—And the laws in the state of Ohio make it very difficult for Adult Protective Services to do their job; to go out and, you know, really help these folks out and also to bring the people to justice who are abusing or neglecting the elderly. And I think we just need to focus a little bit more of our attention to these folks.

I consider the elderly and our youth the two age groups that really as a community and as a government we need to protect be-

cause they're vulnerable. And I don't think enough attention has been given to elderly abuse. You hear a lot about children and child abuse and what Children Services does in each of our communities, but not enough attention is given to the abuse and neglect of our elderly. And I think this is something we need to look at.

Chairman TIBERI. Any thoughts of how we can do that through the Act, through the reauthorization of the Act?

Mr. BIBLER. Well, here again, it comes down, I think, to funding is a lot of it; also education. I don't think enough people are aware. When I go out and tell people about how our elderly are abused and neglected in our community, they are shocked to hear that. They don't realize there are so many indigent seniors living in our community. Because when you think of that, you think of the single parents with one income that, you know, don't have the money; but they don't realize their seniors don't either. So I think, you know, if there was some funding that could be made available to educate people about it, to make people aware of it, because it may be their neighbor; and they don't even realize it. Because we have become a society where we kind of stick to ourselves. Years ago you had neighborhoods where you would go out and talk with your neighbors and everybody knew who everybody was on the street. And I don't think we see that much anymore. And I think people need to know that it's out there. And if funding was available that could filter down to the states so that more people could be hired to go out and investigate incidents of abuse and negligent, it would certainly help out.

Chairman TIBERI. I don't know if you could answer this or maybe Chuck. Are volunteers who deliver meals—Are they taught to look for signs of neglect?

Mr. BIBLER. Our employees and volunteers become very close to their clients. They will actually come in and have arguments with me about their clients. You know, "These are my clients, and they some need help, and we're not doing enough." They become very attached to them. They become very defensive for them, and they will fight for them. So our employees—We do—As a matter of fact, just this past Tuesday we had the lady from Adult Productive Services in to speak at our staff meeting so that they would know what are things that they can look for, what are things that they can report, and who it is that they can report them to.

Chairman TIBERI. Chuck, could you follow up on that?

Mr. GEHRING. I agree with Dave. And our folks are trained. But also I would point out, the Older Americans Act funds for our counties here come through the Central Ohio Area Agency on Aging. And that organization, which is lead by Cindy Farson, who's sitting right over here, their director, has assessors who go out and assess the clients; and they also have case workers who go out and case manage clients. So those folks are out there on a regular basis. There are also requirements with some of the funding that you visit clients on regular bases. OK? You have to go out and see them, which is a great thing, but not just with a volunteer but with somebody who's really trained to do it. But I can tell you the volunteers—We have such a quality group of volunteers as Dave does and a quality group of employees. If they think something is wrong,

they can—Generally what will happen is they contact somebody else.

Chairman TIBERI. Bob, any thoughts on that?

Mr. HORROCKS. Similar situation with our volunteers. They're the best eyes of the community. They get to know folks. They know when something's different, and they let somebody know, and we train them to do that. They do it anyway. But the counsel is involved with doing investigations for neglect, abuse, and exploitation. We take the complaints. And I will tell you that those situations are the worst ones we deal with, the most difficult to deal with. A lot of it is self-neglect; and unlike our other clients who are coming to us and families who are coming to us and sons and daughters who are coming to us asking for us and are very appreciative of what we're able to do, this group of people generally doesn't want help. And they don't want to see you coming because you're coming because a neighbor complained about the smell or because of you know—If you're the daughter or son in the household and you're being accused of something, you don't want somebody coming into your house and investigating that. It takes a lot of time and a lot of energy. When I see the resources that we have in this state for this, it's ridiculous because this is the most time-intensive stuff that we work on. And so I would underscore the need for funding for that program.

Additionally, training for those folks that are going to see this out in the community; training for people that work in banks; training for people, you know, at the post office; fire fighters; police; sheriff's department. These folks all come in contact, and they need to be a lot more sensitive to some of the issues that are around them.

Chairman TIBERI. Did you have a point on this?

Ms. RAGAN. A year ago, January, Director Lawrence and Attorney General Pitro put out the elder abuse task force study. Subsequent to that, in Ohio, Senate Bill 175 was introduced by David Goodman. It ran into some problems. What it would do—And maybe this can come from a Federal level down the state level. Some of your local officials said it was an unfunded mandate. What you need to have is uniformity. What we're looking for now in the reintroduction of the APS Bill is some uniformity within—in the case of Ohio, all 88 counties so that when they get a report of abuse, that there are particular steps that are followed so that if you're in Delaware or Franklin or Licking, it's addressed. If you're in Adams or Vinton and Appalachia, they're not addressed; and that it is not an unfunded mandate. I think that it would help all of the states—And I can only speak to Ohio. I think it would help a lot of states if there was some involvement through the Older Americans Act that would enable or—I hate to use the term “force”—force the states to have a uniform reporting condition in each one of them.

Chairman TIBERI. Thank you.

Ms. RAGAN. Thank you.

Mr. HINOJOSA. Ginni, you were chosen to be part of the Ohio delegation to the 2005 White House Conference on Aging.

Ms. RAGAN. Yes, sir.

Mr. HINOJOSA. So you represent—you spoke for all Ohioans when you went to that conference. We've talked a lot about the difficulties of the transportation, the costs, the food; but we haven't talked at all about the rising costs in prescription medicine. And for these folks, senior citizens, that has become a very serious problem and our Medicare/Medicaid program that we worked on a couple years ago has not been able to give discounted medication to very low income families.

Tell me, please, do you all work with some of the large companies like Pfizer or Merck in trying to get medication—free medication or medication for maybe as low as \$10.00 for those individuals who probably are receiving less than a thousand dollars a month from Social Security and very little help from Medicaid? What are you all doing with those big companies?

Ms. RAGAN. First of all, several years ago—the director is sitting here—We started—were able to get through the legislature the Golden Buckeye prescriptive drug program, which gave discounts on prescriptive drugs. We also have pharmacies such as—or pharmaceutical companies such as Pfizer, et cetera that you can get discounted drugs from or those at no cost at all, I know from working with nurses who are out in the field with the elderly and with Alzheimer's. Our program has saved millions and millions of dollars for our people. We had another program put in, which was called Ohio's Best RX, which applied not only to our elderly. When Medicare, Part D, came in last year—And we did a tremendous amount of educating on that. We feel with those citizens that have used it and have used the forms that were provided by CMS—The tools are in the tool box. They're there. If you use them—It is not a system that you can't possibly negotiate. You can very easily. In the beginning there was snafoos. But when you look at all of the help with Medicare, Part D—which we thank you gentlemen for—when you look at the Golden Buckeye prescriptive drug card, when you look at Ohio's Best RX, yes, I think Ohio has done a tremendous job in trying to help our citizens, especially our elderly, with getting reductions on their prescriptive drug medicines.

Mr. HINOJOSA. Well, from listening to you, you all have a much better handle on this problem than we do this Texas. We had a public hearing, and we talked about this specific problem, and we need to make big improvements like you just described. I brought this up because this magazine just came out a few days ago, the Fortune magazine that lists the top 500 companies in our United States; and in the top 20, Pfizer is one of the most profitable. And the pharmaceutical industry reported this last year that out of every dollar that they brought in, in revenues, 15.7 percent—15.7 cents out of every dollar was profit. So they need to be in the forefront of some of the companies.

When I asked the question earlier, "Are we collaborating with big companies?" Well, they, particularly Pfizer and Merck, should be brought to the table to be one of our partners in this program because in Texas, in south Texas, we really count on them to help us with these families, these individuals who are far below the national poverty level and that medication. And the cost of prescription medication is a serious problem. So I'll get off of that, but I

did mention it because I just happened to be reading that magazine on my trip here to Ohio.

I want to ask you a question, Ginni, on volunteers. Has the advisory committee tried to increase volunteers for program resources from other Ohio state programs or other Ohio services?

Ms. RAGAN. Not being able to address all of them. With the advisory counsel, sir, the 12 of us that are appointed by the Governor, we send them back to their communities. We represent—I represent central Ohio. We send them back into their communities to get people involved with their senior centers, with their senior programs; and, of course, legislation and advocacy. I think through your local organizations such as your senior center that we are at here, I know mental health in Ohio—I know they look for volunteers all the time. I think a lot of us also are involved with nonprofits where we sit on boards where we volunteer a lot of time.

Is it a statewide volunteer effort under any one tent? Not that I'm aware of. I think—Excuse me. Yes. In the Ohio Department of Aging, we do have the state ombudsmen, and they are from all around the state. When there is any complaint filed by any individual resident in a nursing facility or care facility, they are empowered to go in, to investigate and to follow-up with anything that they find in their investigation. They do a tremendous job, absolutely tremendous job.

We just trained all of the state ombudsmen several weeks ago in dementia training, which was under our budget last year. And we have trained them all to look and see when they go in on a complaint if, in fact, there is cause and how to treat those complaints. But the ombudsmen do a tremendous amount of volunteer work. The rest of us—other than a statewide effort—I'm not aware of one big, huge umbrella in this state.

Mr. HINOJOSA. Well, if I may suggest it to you, I have some young children, ages 10 and 12. And we have been trying to talk to them about learning how to give back to the community and learn to volunteer. And just in looking at what is required to get accepted into some of the high schools there in North Virginia where we live, they have to not just have good grades, they have to show that they are volunteers for programs like yours. And so we're beginning to introduce them to that.

Last week they had Earth Day, and they worked all day Saturday in the rain and in the cold, and they picked up I don't know how many tons of trash and stuff. I said that's only one example.

Your program is a wonderful one for teenagers if they could just be introduced. And if they don't know about it, it's our fault. We need to consider how we can work with the schools and the counselors. So that if somebody needs to put in some hours in the community as volunteers that they begin to get acquainted with what your needs are, and then we bring them in.

I going ask another question of David. How can we in the reauthorization address this transportation problem that came up with three out of the five of you as a big concern, a big problem for you to get the job done?

Mr. BIBLER. What I think, as I had mentioned earlier, you know, one of the biggest issues that we face is the condition of our vehicles; and the fact that there is no longer state funding available.

And that was an 80/20 match. So we could get a \$40,000 wheelchair lift vehicle for \$8,000. That has dried up. And that's a big concern of ours right now is how we're going to continue to replace those vehicles. And Licking County is the second largest county geographically in the state of Ohio. So we put a lot of vehicles—or a lot of miles on our vehicles as I mentioned earlier trying to get out; transport people to medical appointments; and also transport people to the meal sites, which is primarily what we do. So I think additional funding that could be available in that area would certainly help us there.

And also as I mentioned, too, that there is some assistance available; and I had written down your suggestion of contacting the Bill and Melinda Gates Foundation for a program that would allow us to coordinate our transportation efforts because that would allow us to do more with the funds that we all have and could combine our resources to do that. And so that is certainly something, as well.

But, you know, again, most of it comes down to funding; being able to make the resources available to us so that we can have the vehicles to go out. As I told many people, if you gave us funding for 20 additional vehicles, we still probably could not meet all the transportation demands of the seniors in our community, being mostly a rural county. We are very fortunate that we have a very good taxing program within our city of where folks living within the cities of Newark and Heath can get to most places they want within those boundaries. Whereas, the people in those outlying areas that have a difficult time getting to doctors' appointments, whether it's into our—into Newark or whether it's going to Columbus. We transport a lot of people to Columbus where many of the specialists in central Ohio reside and work. And so we transport a lot of people for them—a lot of people over to the Columbus area as well.

Mr. HINOJOSA. I thank you for those suggestions. We'll do everything we can to include those in the reauthorization.

My last question is to Elise. Elise, do you have any recommendations for Pat and for me that we need to address in this report that we're going to be turning in for this public hearing that you consider to be your most important issue and concern that you want us to address?

Ms. GEIG. Well, definitely our top eight recommendations that you heard over and over again are our big priorities. I would have to say that definitely to reauthorize the bill. To reauthorize the Older Americans Act is a No. 1 priority. As everyone on the panel has said, increased funding for all of the titles and services to maintain those and to increase them is another priority. A lot of the titles and services have been maintained over the years—or services have been cut. Definitely we need those to be maintained or increased, definitely.

Recommendations that we have as a department—We felt very strongly—We have several programs that we feel very strongly about. Our EDRCs we feel very strong about, a lot of the Federal initiatives, the consumer directed care, long-term care on both of the programs we're very proud of. A lot of the feelings I've talked about—Mr. Bibler talked about the APS and how that's been some-

thing that needs to be addressed and our ombudsman program has been very strong in Ohio. As Ginni has also acknowledged, that's a very strong voluntary program. So we do want to maintain title funding for that. I think all of our top eight recommendations are very, very strong recommendations; and we don't want any of those to be ignored.

Mr. HINOJOSA. Thank you.

Mr. Chairman, I want to repeat that they have been excellent, our panelists have been excellent; and we—at least I feel that I have learned a great deal from you. And we'll commit to take that first and high priority of getting it reauthorized, to work closely with Chairman Tiberi and other members of our committee—sub-committee so we can report back to you that we got it done. Thank you.

With that, I yield back.

Chairman TIBERI. Thank you, Mr. Hinojosa, for coming out to Columbus and central Ohio today. And thank you to all the panelists. You got see a little glimpse of my colleague and my ranking member, and it's just a joy to work with him. He can use a soft glove and criticize corporate America at the same time while talking about how important it is for volunteers to be part of that solution and—with respect to his kids.

It reminds me a little bit of when I was in college and my parents encouraged me to volunteer at a nursing home in our neighborhood where we grew up, and it was called Norfolk Terrace. I'm sure all of you heard of you have heard of Norfolk Terrace. And it—you know, it provided me, not having grandparents in the United States because they were all in Italy, the opportunity to interact with not only elderly but folks who obviously had some severe needs, many of whom did not have families; and it provided me a different perspective, which I think is very helpful to all of us, providing us different perspectives.

And a great irony today is a good friend of mine from high school is now in that nursing home going through rehabilitation from a severe auto accident that he was in. It's now called Villa Angela. But, you know, how ironic life can be sometimes. But it really speaks to what the heart of what some of you see every day; and that this is complex—very important, but complex. And it requires so many different people, so many different organizations to be helpful and ultimately providing the goal of helping older Americans. I've got to tell you, if it was just as simple as Ruben and I agreeing, it would be reauthorized tomorrow. Unfortunately, not everybody has his disposition or the work—What's it called—the working environment together that we have to try to get things done. But we obviously both believe very strongly in trying to get this done as quickly as possible. So we're going to do everything within our power to reauthorize this and to make it as good as we can make it and get the bill reauthorized. I think that's ultimately our goal is to get it reauthorized.

Mr. HINOJOSA. Would the Chairman yield?

Chairman TIBERI. Yes.

Mr. HINOJOSA. It reminds me that his Italian heritage and my Mexican heritage have something in common. My mother was 95, as I said earlier; and she taught us a lot of things. And her daugh-

ters and her daughters-in-law would often times ask her, “Well, what’s your secret to be able to get to 94 and still remember so many things so many things and stories?”

And she said that there were lots of things that she could accredit that to. One was doing the crossword puzzle and the other one was to work outside on her garden.

And one of the daughters said—well, daughters-in-law said, “Well, Mama Marina, is there any truth that maybe a little bit of wine once in awhile.”

And she said, “Oh, no question about it. I keep my good red wines in the kitchen, and that’s a necessity as is—I’m sure that has taken me to this age of 94.”

So all I can say is that we’ll just have to look at our Italian and Mexican cultures and find ways in which to get this top priority passed by reminding the other Members of the Congress that there is hope if we could just work together.

Chairman TIBERI. I agree.

Thanks for coming in. Thank you to the panelists. Again, your testimony has been invaluable for us as we move forward. While we won’t get everything we want in this reauthorization, we will get as good a deal as we can get; and ultimately, the reauthorization of this act is obviously very, very important. So we’ll do that.

I want to thank the staff: Moira, Ricardo, Kate, and Angela, who is here from Washington but from Columbus. And we’ll get to visit with her family this evening. And thank you, Lucy, as well, coming from Washington. Thank you for coming as well and making this official. And with that, I just want to thank all the witnesses, again; the audience that is here for their participation. And if there is no further business before us, the subcommittee stands adjourned.

[Whereupon, at 4:38 p.m., the committee was adjourned.]

[Additional statement from the National Council on Disability follows:]

#### **Prepared Statement of the National Council on Disability**

The National Council on Disability (NCD) is an independent federal agency charged with making recommendations to the President and Congress to enhance the quality of life for all Americans with disabilities and their families. The overall purpose of the NCD is to promote policies, programs, practices, and procedures that guarantee equal opportunity for all individuals with disabilities, regardless of the nature or severity of the disability; and to empower individuals with disabilities to achieve economic self-sufficiency, independent living, and integration into all aspects of society. The NCD is required by its authorizing statute to advise the Administration and Congress regarding laws and issues that affect people with disabilities.

The NCD would like to submit the following executive summaries for the record of the Subcommittee on Select Education’s April 28, 2006 Field Hearing on the Older Americans Act. Attached please find the executive summary of our 2005 report, *The State of Long-Term Services and Supports: Financing and System Reform for Americans with Disabilities*, followed by the executive summary of our 2004 report, *Livable Communities for Adults with Disabilities*. Please note that a web-link for each complete report precedes its respective summary. A statement by Martin Gould to the Social Security Advisory Board describing the Long Term Services report has been included as an introduction to the subject matter. The *Livable Communities* report is accompanied by a brief excerpt from a press release. Information identical to the body of this email is attached as a Word document. Thank you.

*The State of 21st Century LTSS: Financing and Systems Reform for Americans with Disabilities, Remarks by Martin Gould to the Social Security Advisory Board, January 31, 2006*

In 2005, the National Council on Disability (NCD) engaged in research regarding the nation's LTSS "system" because it grew increasingly concerned about the (a) lack of a coherent national long-term services and supports (LTSS) public policy for all people with disabilities; (b) fragmented nature of service and support delivery systems, with uneven access and services provisions; and (c) LTSS costs of 22 percent or more of state budgets, which are fast becoming unsustainable. On December 15, 2005, NCD released *The State of 21st Century Long-Term Services and Supports: Financing and Systems Reform for Americans with Disabilities* (<http://www.ncd.gov/newsroom/publications/2005/longterm—services.doc>). The following facts and conclusions are drawn from that report.

*What Do We Know About the Status of LTSS in America?*

LTSS is not just for seniors. Most LTSS data and definitions are based on people 65 and older. It's impossible for policy makers and researchers to accurately calculate current and future costs without a clear consensus as to who is to be covered by a LTSS system and how eligibility will be calculated.

A growing senior population will need access to affordable LTSS. Today, twenty percent of people 65 and over will require assistance with at least one ADL and 50% will require assistance by age 85. By 2045, people over age 65 who are in need of assistance with 2 ADLs will grow from 1.8 million to 3.8 million.

The incidence of disability is rising for the younger population and the impact on future LTSS costs is unclear. Little data has forecast what this will mean for future LTSS costs and services. There is no aggregated data on the overall costs of LTSS using definitions (e.g., National Council on Disability) that includes transportation, nutrition, and housing.

It is unclear what LTSS truly looks like for people under age 65 across disabilities that are working and living in the community. There is little research on the disparities in LTSS needs and costs among diverse populations. The issues of poverty, lack of insurance and continued segregation from an affordable and consistent health care system will increase the future needs and costs for LTSS for diverse populations in the U.S. who are projected to make up 50 percent of the American population by 2050.

The growth in Medicaid spending is unsustainable. The ability of states to respond to current and future LTSS needs is beyond their capacity and resources if health care costs continue to rise at double-digit rates. Private long term care insurance is not designed for people under 65 years of age. Private long term care insurance targets individuals age 65 and older within specific disease categories. Over six million Americans own private long term care insurance and 50 percent of the claims paid are for Alzheimer's and other forms of dementia.

In understanding future LTSS costs, the role of care giving and workforce issues is unclear.

Nearly 44 million American caregivers age 18 and over provide unpaid care to an adult age 18 or older. Six out of ten of these caregivers are employed while providing care, most are women age 50 or older. Paid direct care workers are in short supply. The turnover rate in nursing facilities is nearly 100%, while home care agencies have annual turnover rates between 40% and 60%.

This nation faces major challenges to its LTSS workforce. LTSS workers who provide paid care are often without health insurance and other employee benefits and frequent turnover of staff occurs due to low wages and lack of benefits.

There is no coordinated, comprehensive response to LTSS needs despite the diversity of challenges associated with varying types of disabilities. The current system of response to individual LTSS needs is dependent on state specific differences in coverage, resource allocation and targeted populations. In addition, Medicaid LTSS provided to a person in one state does not transfer to another state if that person moves. Additionally, current costs are not a customized response to individual needs.

There is little political or public understanding of LTSS needs. Fifty-nine percent of Americans have given little or no thought at all to the issue of LTSS. Most Americans think of LTSS as long-term care for seniors with severe chronic disabilities who reside in nursing homes. This perception is a holdover from the 1960s when Medicaid and Medicare were first established and reflects a system of care that is outdated and no longer cost effective. Few Americans ever think of LTSS for individuals under the age of 65 with significant disabilities who are living and working in the community. Many people do not realize that there is no LTSS public policy for individuals of moderate to middle income whether over or under the age of 65. De-

spite the movement today to provide services and supports in the home and community, almost 70 percent of Medicaid resources for LTSS still supports individuals in nursing facilities or state institutions.

There is fragmentation of the Federal system of LTSS. Depending on where you live, your age, your economic status, and the nature of your disability, you will face different options and levels of response to LTSS needs. Furthermore, there is no single federal program, federal agency, or congressional committee is charged with the responsibility for the management, funding, and oversight of LTSS; however, 23 federal agencies are actively involved in LTSS using a broad based definition.

Policy makers are not asking the hard questions. Most exercises in forecasting future visions for long-term service and support policy do not address the hard questions: What services should be guaranteed to individuals who are unable to provide for themselves? What protections from catastrophic loss should be afforded? And, most importantly, who will pay?

Consumers are not providing real solutions. Perhaps most alarmingly of all the findings, Americans with disabilities are not leading the LTSS policy discussion(s).

Finally, no proposals have provided a total picture of what LTSS costs for people with lifelong disabilities would look like, and no studies exist that provide viable funding alternatives for a new system.

### *Conclusion*

It is imperative that our nation transform its LTSS programs, financing, and policies to promote and protect individual dignity and independence within the context of supportive families and communities and to circumvent the impending storm created by our growing demographic and economic challenges. If we are to achieve real change in our current system of LTSS, we will need to base the transformation on a: (a) broad definition; (b) fundamental set of operating assumptions that serve as the basis for real change to occur; and (c) series of action steps.

A broad definition of long-term service and supports will reflect people's essential needs for maintaining a quality of life with maximum dignity and independence. Housing, transportation, nutrition, technology, personal assistance, and other social supports should be included in a definition of long-term services and supports.

Furthermore, there are five operating assumptions that need to be addressed by policymakers who undertake any major effort intending to achieve meaningful change in LTSS. First, people who are elderly and people with disabilities both desire and deserve choices when seeking assistance with daily living in order to maintain their self-determination, dignity and independence. Second, without significant reform, the current financing mechanisms, both public and private, will become unsustainable in the near future. LTSS must be affordable to all Americans regardless of income level and we must consider opportunities to leverage public and private support in new ways without impoverishing beneficiaries. Third, there is an opportunity with the changing demographic picture of the United States to explore the possibilities of a universal approach to the design and financing of supports that is responsive to individuals with disabilities both under and over the age of 65 without sacrificing individual choice and flexibility. Fourth, formal and informal care giving must be sustained; and family needs and workforce recruitment and retention challenges must be addressed. Fifth, the approach to quality must examine consumer direction and control of resources in addition to traditional external quality assurance mechanisms.

Finally, we need to engage in a series of action steps and activities to make the transformation happen. These action steps include: Increase policymaker knowledge and understanding of public and private costs and benefits of LTSS for people with disabilities under age 65 and their families; design and implement an action plan to monitor and oversee states' activities to meet their ADA obligations as a result of the Olmstead Supreme Court decision; decouple eligibility for home and community-based waiver services from determination of nursing home eligibility; increase support for family members and others in their role as informal and unpaid caregivers for individuals with disabilities of all ages; improve the supply, retention, and performance of direct support workers to meet increasing demand; hold states accountable for rebalancing their system to increase home and community-based LTSS; explore possible relationships between private LTSS insurance products and publicly financed LTSS; and, improve consumer understanding, knowledge, and skills to develop a person-centered plan and self-direct an individual LTSS budget.

As the number of Americans requiring LTSS increases, the existing fragmented "system" will become increasingly incapable of being sustained. Without a dramatic change of direction, disaster is inevitable.

*The State of 21st Century Long-Term Services and Supports—Financing and Systems Reform for Americans with Disabilities*

December 15, 2005.

The complete version of this report can be found at: <http://www.ncd.gov/newsroom/publications/2005/longterm—services.doc>

*Executive Summary*

*Introduction*

Long-term services and supports (LTSS) is not only an issue for older Americans but also for younger individuals with disabilities, and any LTSS financing and system reform efforts must consider both populations.

The current LTSS system is funded primarily by state and federal programs. More specifically, Medicaid is the primary payer of LTSS in this country. Medicaid paid for 45 percent of the \$137 billion this country spent on LTSS in FY 2000. Yet, despite the amount of money that state and federal programs are allocating to LTSS, individuals and their families still pay out of pocket for nearly one-third of LTSS expenses.

Although the population of people who have disabilities and people who are elderly has indicated a preference for receiving LTSS in home- and community-based settings, a federal institutional bias exists. Presently, about 1.6 million people live in nursing homes, group homes, and other institutional facilities. At the same time, there are about 2 million to 2.4 million people on waiting lists or in need of some type of LTSS.

Options for LTSS are emerging. Aging and disability advocates are working with the health care industry to create a continuum of care, including such services as assisted living, adult day services, and home care. Governors have creatively used the Medicaid waiver process to increase home- and community-based services for people who are elderly and people with disabilities.

Although financing is the cornerstone of the LTSS issue, other issues are critical in building an adequate, seamless, and effective LTSS system to meet the increasing needs of aging baby boomers and the increasing numbers of individuals with disabilities who have LTSS needs. These issues include supporting family caregivers, addressing workforce shortages, improving the quality of LTSS services, and improving access to transportation and housing.

Recognizing, in particular, that the impending age wave of baby boomers will significantly increase the demand for LTSS in the coming decades, the National Council on Disability was interested in researching the issues of LTSS financing and systems reform. This report addresses those issues.

The development of long-term services and supports (LTSS) comprehensive policy will define the future economic independence of Americans with disabilities. Changing demographic and economic trends, here and abroad, will demand that the United States retool its programmatic and financial infrastructure to protect and promote individual dignity and independence of all Americans with disabilities. The development of sustainable and affordable LTSS public policy for the 21st century—funded through a unique combination of individual contributions, innovative private sector assistance, and public support—will provide a new security for Americans with disabilities to work and live independently. Although 20th century advances revolutionized the concept of health care and longevity for many Americans, increasing life expectancy by 30 years, they fell short in providing an affordable LTSS public policy for both the medical and nonmedical services and supports needed by many working Americans with disabilities. The United States is a world leader in extending life and eradicating disease, but it has failed to develop an LTSS public policy that truly integrates disability as a natural part of the human experience.

Few Americans think of LTSS for individuals under the age of 65 who are living and working in the community with significant disabilities. Many people do not realize that there is no LTSS public policy for individuals of moderate to middle income, whether over or under the age of 65. Private insurance is available for long-term care that, on average, is capped at a specific dollar amount, provides coverage for about three years, and is geared toward services and supports that cater to diseases of aging and not the needs of everyday working Americans with disabilities.

Ninety percent of Americans do not have long-term care insurance, and many do not have the financial savings to cover the costs of aging. Few insurance products are available that cover the costs of providing services and supports targeted for individuals and families challenged with lifelong disabilities under age 65. A recent actuarial study found that Americans at age 45 are more likely to become disabled than to die, and yet we continue to insure against loss of life rather than against the risk of disability. There are no risk pools or insurance products designed to sup-

plement the additional costs associated with living and working with a lifelong disability. There is little research or data that accurately captures what this means for planning the financial future of an individual born today with a lifelong disability.

Disability prevalence is rising in the under-age-65 population and, although it has decreased slightly for seniors, it will begin to rise sharply as the current senior population of 34 million doubles over the next 20 years. Inherently, most Americans think of LTSS as long-term care for seniors in nursing homes with severe chronic disabilities. This bias is a holdover from the 1960s, when Medicaid and Medicare were first established, and reflects a system of care that is outdated and no longer cost-effective. Although the movement today is to provide services and supports in the home and community through an array of waivers, more than 50 percent of Medicaid resources for LTSS continue to support individuals in nursing facilities or intermediate care facilities for the mentally retarded (ICF/MRs).

In 2001,<sup>1</sup> the United States spent \$1.24 trillion (or about \$5,500 per person) on personal health care services, with 12 percent (or \$151.2 billion) spent on LTSS. Although 70 percent of the 53 million Medicaid beneficiaries are children and mothers, more than half of the \$276.1 billion spent in 2003 was for populations who are aging (15 percent) and with disabilities (15 percent). The predominant disability populations receiving Medicaid LTSS are those with mental retardation and developmental disabilities (MR/DD) and low-income seniors who rely on both Medicaid and Medicare. Between 9 million and 12 million Americans need help with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), and 3.5 million are under 65 years of age. The literature also reports that 25 million individuals with chronic severe disabilities under age 65 are probably in need of some LTSS, but these individuals are often not counted or found eligible because of income or family assets, or they fall outside the realm of traditional functional assessments that use ADLs and IADLs as measurements. There is also confusion about what definition of disability should be used to assist policymakers in studying LTSS needs. Finally, LTSS are not portable and are highly dependent on the fiscal and budgetary priorities and obligations of each state.

In addition, about one-fifth of the U.S. population is uninsured or underinsured, with more than 18,000 American lives lost each year because of gaps in insurance coverage, at an economic cost between \$65 billion and \$139 billion annually from premature death, preventable disability, early retirement, and reduced economic output. Rising double-digit inflation costs for health care continue to confound state and federal efforts to reign in overall health and LTSS spending. The probability of sustaining future promises to current social policy and its beneficiaries is low if the demographics are correct: Fewer workers will mean lower payroll contributions and less money available to fund past and future commitments. The research suggests that the problem is beyond incremental reform and requires immediate attention.

A “rich picture” methodology was used to introduce the problem this report addresses. The picture captures the current health care and LTSS system. The field of management often uses a rich picture systems methodology, that is, “an innovative tool that encapsulates knowledge relevant to strategic reform.” For the disability field, the use of the rich picture allows people with intellectual impairments and other cognitive challenges to grasp the essence of the research through a visual representation and dialogue. The picture and narrative relied on the review of primary and secondary research documents; one-on-one open-ended interviews with key stakeholders in the disability, long-term care, and health care fields; review of congressional records and attendance at a number of hearings; and the convening of a national expert advisory panel on LTSS.

The setting for the rich picture is the ocean, with the current LTSS and health care ship heading toward an iceberg that represents the barriers and challenges to systems reform. The cast for this rich picture provided the substantive descriptions and main body of research and analysis about the barriers and challenges of navigating through the current system of LTSS. The presentation of the research in this format was purposeful so that the reader and the researcher could begin the voyage together with a snapshot of the problem. It was intended that a new picture would emerge as the researchers integrated the findings from the other chapters of the research. The final picture is a new ship, “AmeriWell,” that is designed to provide LTSS for all Americans regardless of income or category of disability through innovative funding from individuals and families, the private sector; and the Federal Government. AmeriWell will delink aging and disability populations from both Med-

<sup>1</sup>O’Shaughnessy, C. (2003). Long-Term Care Chart Book: Persons Served, Payers and Spending. Congressional Research Service: The Library of Congress (RS21518). P. 3

icaid and Medicare that require LTSS to form a new LTSS program that provides services and supports to middle-and low-income Americans with disabilities.

The purpose of this research is to produce new knowledge and an understanding of current experience with and the future need for affordable LTSS for people with disabilities. The following findings provide a broad overview of the four areas researched for this report. Chapter recommendations are provided here in brief, but a detailed summary is available in chapter 6. All footnotes and references can be found in the original text, except where otherwise noted.

### *Findings*

#### *1. Little Political or Public Understanding of Current and Future LTSS Needs (Chapter 1)*

A. There is little public or political interest in putting LTSS onto the national agenda, although state Medicaid spending represents 22 percent of overall state budgets and is fast becoming unsustainable.

B. Fifty-nine percent of Americans have given little or no thought to the issue of LTSS and the costs associated with aging or disability.

C. Most Americans do not understand the current system of LTSS, how it is funded, or who is eligible for services. Many people do not understand that Medicaid is the primary provider of LTSS for all populations-both young and old-and that eligibility is income sensitive.

D. The development of affordable LTSS is the missing link in making work a reality for many Americans with disabilities.

#### *2. Fragmentation of Federal System of LTSS (Chapter 1)*

A. There is no single federal program or federal agency charged with the responsibility for management, funding, and oversight of LTSS at home and in the community. More than 20 federal agencies and almost 200 programs provide a wide range of assistance and services to people with disabilities.<sup>11</sup>

B. There is no single entry point at a community level for individuals with disabilities and seniors to learn about and access service and support options.

C. There are multiple federal programs with varying policy objectives that embrace the values of consumer choice and independence in daily living, but there is no comprehensive, integrated delivery system that provides portability across states.

#### *3. Policymakers Continue to Avoid the Hard Questions (Chapter 1)*

A. Twenty years of research and exercises in forecasting future visions for LTSS have failed to answer the following questions: What services should be guaranteed to individuals unable to provide for themselves? What protections from catastrophic loss, financial or otherwise, should be afforded, and, most important, who will pay? How is the current LTSS policy working, and does it meet the needs of today's population with disabilities?

#### *4. Favorable Court Decisions Post-ADA for Future LTSS (Chapter 1)*

A. Positive forces for change began with the passage of the Americans with Disabilities Act (ADA) in 1990; they were followed by the Supreme Court decision in *Olmstead* in 1999 and the subsequent Administration actions in 2000, and continued to the present. They provide a platform to support policy and program changes for a long-term support system that embraces consumer choice to live in the least-restrictive environment at home and benefit from community participation.

#### *5. Future of LTSS Formal and Informal Workforce Unclear (Chapter 1)*

A. Population demographic changes because of aging, reduced fertility rates, increased women in the workforce, and changing family makeup predict there will be fewer unpaid family workers and an increased demand for paid workers.

B. The role of government in addressing the challenges of the current formal and informal workforce is unclear.

C. The majority of LTSS workers providing paid care are often without health insurance and other employee benefits and experience frequent job turnover.

#### *6. LTSS Policy Not Just for Seniors (Chapter 2)*

A. Most data for LTSS favors individuals age 65 and older with diseases of aging. Policymakers and researchers need accurate data to calculate current and future LTSS utilization and costs to develop a clear consensus as to who is to be covered by an LTSS system and how eligibility will be calculated.

<sup>11</sup>Finding added and not part of main body of research. Government Accountability Office. (June 2005). *Federal Disability Assistance: Wide Array of Programs Needs To Be Examined in Light of 21st Century Challenges*. Washington, DC: GAO (GAO-05-626). P. 5.

*7. Disability Definitions Need Clarification (Chapter 2)*

A. Disability definitions range from a medical diagnostic approach to a functional assessment approach that uses ADLs and IADLs. There is no aggregated data on the overall costs and utilization rates using the NCD/AARP definition for LTSS that includes transportation, nutrition, and housing.

B. There are 38 million people under age 65 reporting some level of disability and, of this Group, 25 million have a specific chronic disability; however, many of these individuals are not eligible for LTSS.

C. Using the functional definition of disability based on ADLs and IADLs, the estimated population in need of LTSS under age 65 ranges from a conservative figure of 3.5 million to more than 10 million.

*8. Future Demographic Trends Predict That Many Americans of All Income Levels Will Need Access to Affordable LTSS (Chapter 2)*

A. Regardless of the definition of the target population, there is clear and undisputable data that the number of people over age 65 with ADL and IADL limitations is growing and will double by 2030.

B. Twenty percent of people age 65 and over will require assistance with at least one ADL and 50 percent will require assistance by age 85. The number of people in need of assistance with two ADLs will grow from 1.8 million to 3.8 million by 2045.

*9. Disability Rates Declining for Seniors and Impact on Future LTSS Utilization and Costs Is Unclear (Chapter 2)*

A. The rate of disability has declined in the 65-and-older population, mostly for IADLs. It is less clear whether this decline is due to health improvements or environmental changes because of increased technology for durable medical equipment, including assistive technology. However, the rate of disability for individuals 85 years and older is expected to rise as this population triples over the next 30 years.

*10. Disability Rates Rising for Individuals Under Age 65 and Impact on Future LTSS Utilization and Costs Is Unclear (Chapter 2)*

A. The rate of disability for individuals under age 65 is rising in diabetes, obesity, and mental illness. Little data is available that accurately predicts how this will impact future LTSS utilization, costs, and service delivery.

B. It is unclear what LTSS truly looks like for individuals under age 65 across disabilities and specific age groups for those working and living independently. The research shows that individuals under age 65 are heterogeneous and have specific needs according to gender, age, and type of disability that are quite different from individuals over the age of 65.

*11. Individuals Under Age 65 Receive Less Personal Assistance and Are More Likely To Be Nonwhite (Chapter 2)*

A. Individuals with two or more ADL limitations and personal assistance needs under the age of 65 estimated a shortfall of 16.6 hours of help per week and were more likely to be nonwhite, female, and living alone.

B. Paid personal assistance services go primarily to people 65 and older, and working-age people 65 and under rely more on unpaid personal assistance services.

*12. Increased Life Expectancy for People with Lifelong Disabilities and Its Impact on LTSS Utilization and Costs Unstudied (Chapter 2)*

A. Individuals with lifelong disabilities, such as Down syndrome, cerebral palsy, and mental retardation, are living longer and the impact on utilization of LTSS services and future costs is unclear from the current literature.

B. It is unclear what future services and supports, including access to housing, transportation, and nutrition, will be in most demand for people under age 65 with lifelong disabilities living and working in the community.

*13. LTSS Needs Among Minority Populations and Impact on Future Utilization and Costs Needs Study (Chapter 2)*

A. Black children are 13 percent more likely than white children to have a reported ADL limitation. A recent Government Accountability Office study confirmed that the black population has higher disability rates and lower lifetime earnings and shorter life expectancies than whites.

B. The issues of poverty, lack of insurance, and continued segregation from affordable and consistent health care will increase the future needs and costs for LTSS for minority nonwhite populations in the U.S., which are projected to make up 50 percent of the American population by 2050.

*14. Growing Prevalence of Mental Illness and Its Impact on Future LTSS Utilization and Costs Unknown (Chapter 2)*

A. The prevalence of chronic disease and deaths caused by noncommunicable disease in the United States between 1990 and 2020 will increase from 28.1 million to 49.7 million, an increase of 77 percent.

B. Mental illness will rank number two after heart disease and replace cancer by 2010 as having a greater impact on death and disability. Medicaid is the principal public payer for mental health services and represents 36 percent of the \$48 billion in spending. It is unclear what the future LTSS needs and costs will be for people with mental illness.

*15. Medicaid LTSS Not Designed to Support Growing Need of Middle-Income Population (Chapter 2)*

A. The current system of LTSS is designed for low-income individuals and is unsustainable under the current system of health care that has expanded Medicaid options to provide services and supports to an array of middle-income and uninsured individuals.

B. There are 57 million working-age Americans between 18 and 64 with chronic conditions such as diabetes, asthma, or depression, and more than one in five (12.3 million) live in families that have problems paying medical bills. Many are not eligible for LTSS services because they have assets above prescribed limits.

C. The number of chronically ill people with private insurance who spend more than 5 percent of their income on out-of-pocket health care costs increased by 50 percent, to 2.2 million people, in 2003.

D. The impact on LTSS costs are unclear for 6.6 million individuals with chronic care needs who are uninsured and go without needed care (42%), delay care (65%), or fail to get needed prescriptions (71%), but they will impact future need and costs without timely intervention.

*16. Growth in Medicaid Spending Is Unsustainable (Chapter 2)*

A. Eligibility and service pathways to state Medicaid programs have expanded to meet the growing needs of 53 million low-income, middle-income, and uninsured acute care and LTSS beneficiaries, and reflect the growing challenges of economic downturns, increased health premiums, increased longevity, a low savings rate, and slower wage growth.

B. Twelve percent of \$329 billion combined state and federal funds in 2005 was spent on LTSS.<sup>iii</sup>

C. Seven million individuals are dually eligible for full Medicare and Medicaid benefits and another 1 million receive assistance with copays and deductibles; combined, this represents 42 percent of all Medicaid expenditures.

D. The ability of states to respond to current and future LTSS needs is beyond their capacity and resources as long as health care costs continue to rise at double-digit rates.

*17. Two-Thirds of Medicaid Spending for Optional and Not Mandatory Service (Chapter 2)*

A. Two-thirds of Medicaid spending is for population groups and services technically defined as optional, and 90 percent of all long-term care Medicaid services are optional. It is unclear how vulnerable people with disabilities are, with the majority of their services and funding falling under optional categories.

B. Seventy-five percent of home- and community-based services (HCBS) waivers are for people with MR/DD and are used to purchase LTSS. The other 25 percent are used for people with physical disabilities and older people. There are three small waiver programs that serve individuals with a primary diagnosis of mental illness, accounting for 0.2 percent of HCBS waiver expenditures. Further research is needed to explore the LTSS needs of the 25 percent population using HCBS.

*18. Medicaid Administrative Costs Need Further Research (Chapter 2)*

A. Research is needed to further determine whether Medicaid administrative costs meet the federal basic guidelines that "costs be allowable, reasonable, and allocable for reimbursement under Federal awards."<sup>iv</sup>

<sup>iii</sup> Medicaid Reform A Preliminary Report from the National Governors Association. June 15, 2005.

<sup>iv</sup> Finding added and not part of main body of research. Refers to Office of Management and Budget Circular A-87 that establishes cost principles for federal grants to state governments. April 2005. Department of Health and Human Services: Office of the Inspector General. Review of the Oklahoma Department of Human Services' Medicaid Administrative Costs. A-06-03-00046.

19. *Many Uninsured Americans Are Working (Chapter 2)*

- A. Forty-nine percent of the 45 million uninsured Americans are either self-employed or work for companies with fewer than 25 employees.
- B. More than 50 percent of low-income employees of small firms with incomes below 200 percent of the federal poverty level are uninsured.
- C. More than 2 million health care paraprofessionals report wages below the poverty line, do not work full time, and do not receive benefits.

20. *Long-Term Care Insurance Designed Mostly for Seniors and Not Individuals Under 65 with Disabilities (Chapter 2)*

- A. Private LTSS insurance is targeted to individuals age 65 and older and often to specific disease categories. One insurance company reported that more than 50 percent of its LTSS insurance claims paid are for Alzheimer's and other forms of dementia.

21. *Risk of Disability Is Higher Than Premature Death at Age 45 (Chapter 2)*

- A. The risk of disability is higher than premature death and is higher for older people than younger, and females are more likely to become disabled than males. A 45-year-old individual earning \$50,000 per year and suffering a permanent disability could lose \$1,000,000 in future earnings.
- B. The public overestimates the help that is available from public disability insurance programs—Social Security Disability Insurance (SSDI) and other state-mandated, short-term programs. Workers compensation benefits cover only disabilities caused by injury or illness arising on the job—only an estimated 4 percent of disabilities.

22. *Congress Needs Research on the Current and Future Utilization and Costs of LTSS for Individuals Under Age 65 and Their Informal Workforce (Chapter 2)*

- A. Congress needs sufficient data on LTSS costs and utilization for individuals across the spectrum of disabilities under age 65 to develop a sustainable and affordable LTSS policy.
- B. Congress needs sufficient data that responds to the demographics that predict a decrease in the current population of informal caregivers (valued at \$200 billion a year) and the impact of this trend on the development of a future LTSS workforce.
- C. Research is needed on the different public and private cost-sharing scenarios that focus on the under-age-65 population with disabilities and the relationship between public financing and private insurance to develop affordable products that insure against future risk of developing or being born with a disability.

23. *Changing Global Demographics and Economic Impact on Future LTSS Policy Unclear (Chapter 2)*

- A. The global economic picture and changing demographics, in addition to the current U.S. federal budget deficit, raise new questions about the sustainability of current entitlement and social programs and their impact on beneficiaries with disabilities.
- B. Current state and federal budget deficits and funding priorities jeopardize a patchwork system of services and supports that do not meet the current needs of the target population, let alone those projected into the future.

24. *Role of Caregiving and Workforce Issues in Understanding Future LTSS Costs Unclear (Chapter 2)*

- A. 44.4 million American caregivers age 18 and over provide unpaid care to an adult age 18 or older. Six out of 10 of these caregivers work while providing care; most are women age 50 years or older.
- B. Jobs for nurses' aids are expected to grow by 23.8 percent, while the employment of personal care and home health aides may grow as much as 58.1 percent between 1998 and 2008.
- C. It is unclear how many workers (the "gray market") are hired and supervised by consumers who pay for their own care, although the numbers are thought to be substantial.
- D. Direct care workers (3.1 million) are in short supply and have nearly a 100 percent turnover rate in nursing facilities; home care agencies have annual turnover rates between 40 and 60 percent.
- E. Direct care workers have low median hourly wages of \$9.20 an hour and one-fifth (far more than the national average of 12 to 13 percent) earn incomes below the poverty level; 30 to 35 percent of all nursing home and home health aides who are single parents receive food stamps.

25. *LTSS Not Portable Across States (Chapter 2)*

A. LTSS are not portable and cannot be moved with an individual from state to state, and current LTSS costs are not a customized response to individual needs.

B. Current costs reflect matching an individual's circumstances to available services and supports, based on federal eligibility criteria, with degrees of consumer choice and direction that vary based on the state in which the individual lives.

C. The fiscal health of each state (and its ability to provide the necessary match to draw upon federal Medicaid resources) determines the scope and array of the current LTSS system for low-income Americans with disabilities and seniors.

D. The personal assistance service needs of an individual in California could be similar to someone living in Mississippi, and yet the availability of services and funding may vary dramatically.

26. *LTSS Public Policy Is Necessary to Increase Positive Employment Outcomes for People with Disabilities (Chapter 2)*

A. It is unclear how Americans with lifelong disabilities under age 65 can become self-sufficient and economically independent through work and build careers without substantial LTSS reform that allows asset growth and more innovative public-private support for LTSS.

B. It is unclear how Americans with or without disabilities will provide for their own health care and LTSS in the future without changes in savings behavior and the development of insurance products that protect against the risk of disability.

27. *External Advisor and External Policymaker Findings for LTSS Action Similar to State Findings (Chapter 3)*

A. Similar to the state findings, the advisory group encouraged moving any LTSS policy discussion away from the current medical status and disability type to a standardized assessment process to evaluate functional needs related to ADLs and IADLs.

B. There is a need to reevaluate financial eligibility criteria and develop an expanded benefits menu that organizes service options from a presumption of individual preference for remaining at home and in community settings. The panel, without describing benefits coverage in detail, recognized that different people have different needs. As a result, the benefits coverage based on functional assessment must be flexible, individualized, and comprehensive. Nursing home level of care should be shifted from an entitlement status to an option of last resort.

C. The system should offer more consumer choice and direction in determining needs, creating a service plan, and directing and managing provider selection and service delivery.

D. The system should provide incentives to support and encourage family caregiving, and consider tax incentives to help defray expenses of dependent care for LTSS.

E. Federal authorities should agree on key outcomes and a measurement system. Shared information and data collection and analysis across agencies in multiple settings should help improve understanding of cost-effectiveness based on different service delivery models. Performance outcomes should focus on wellness, productivity, inclusion, and independence.

F. The cost should be spread across all wage earners over a lifetime as part of a social insurance financing framework. Similar to the approach of social security and Medicare, individual needs will vary over a life span.

G. The system should decouple eligibility for benefits from current requirements of impoverishment for individuals and families.

H. The system should provide support and incentives to encourage family support and informal caregiving to be balanced with public funding and responsibility. Key outcomes should be defined on an individual and systems level that focuses on wellness, productivity, inclusion, and independence.

28. *Selected State Strategies for LTSS Are Promising (Washington, Vermont, Minnesota, Texas, and Indiana) (Chapter 4)*

A. States have ongoing, intensive, comprehensive planning processes that involve a full range of stakeholders—from state officials to providers to advocates and people with disabilities themselves—and the commitment and support of the governor and legislature.

B. Planning includes realistic accounting of the state's fiscal situation, availability of federal money, community partnership building, implementation of cost-limited regulatory changes, and benchmark settings to measure results.

C. States are experimenting with merging, consolidating, and combining nursing home and HCBS dollars to better allocate funds according to the needs of people

with disabilities and developing single-point-of-entry systems at the local level to encourage easier access to LTSS.

D. States are experimenting with global budgeting that allows budgeting practices to blend (to some degree) institutional care and HCBS dollars and allows states the flexibility to respond to the preferences of people with disabilities to remain at home or in the community.

E. States are broadening HCBS to allow greater numbers of people with disabilities the opportunity to direct their own care (for example, hiring, training, and supervising their workers).

*29. States Are Living Laboratories for Future LTSS Policy Development (Chapter 4)*

A. The Olmstead decision stimulated executive and legislative review of the current system of service delivery, unmet needs of target populations, and where the dollars are being expended.

B. Cross-agency planning is most effective when the consumer stakeholder voice is included as part of the process to develop recommendations for systems reform.

C. Structural changes have involved substantial reorganization to an umbrella department for multiple target populations with long-term support and service needs.

D. Expanded use of Medicaid waivers is common to broaden benefits and LTSS to subpopulations.

E. The most restrictive policy most frequently identified was the Medicaid institutional bias.

F. There remains confusion in the use of language regarding long-term care and LTSS.

G. All selected states have waiting lists for specific target subpopulations, although states may limit services and operate the waiver on less than a statewide basis.

H. Current budget challenges at a state level have compelled states to reexamine the balance between public and private responsibility for LTSS, evaluate approaches to target individuals based on an assessment of level of need, and seek to identify strategies that encourage coverage of supports through some type of insurance coverage and other private sector resource sharing.

*30. Local and Individual Strategies for LTSS Require Fresh, Creative Thinking That Reanalyzes the Use of Public and Private Resources (Chapter 5)*

A. There is growing recognition that a fundamental shift in values is occurring as states move LTSS to the community and home and out of the institutions. Individuals with disabilities are being provided with more choices to live independently.

B. New housing models with cooperative organizational structures are providing a realignment of service and financial relationships at an individual and community level and recognize the importance of consumer choice and direction.

C. New economic models for managing assets include pooled trusts, supportive corporations, time banks, and child trust funds, and raise important questions about public versus private responsibility to create and manage a social safety net for individuals deemed in greatest need of long-term support.

*Recommendations for Incremental and Clean Slate Reform (See Chapter 6 for full text and implementation lead for each recommendation)*

*1. Increase Policymaker Knowledge and Understanding of Public and Private Costs and Benefits of LTSS for People with Disabilities Under Age 65 and Their Families (Chapter 5)*

A. The lack of data that presents a complete and accurate picture of the costs for LTSS for families with children or adults with disabilities was a key finding by NCD researchers. Despite multiple studies by the Congressional Budget Office (CBO) and other federally sponsored research centers on the costs of long-term care for seniors, the population under age 65 with disabilities has not been a priority. The traditional definition of long-term care identified acute care needs as well as nonmedical services and supports for seniors. Today's definition of long-term care has changed to reflect the ongoing growth and integration of disability into mainstream culture. LTSS for people 65 years and younger is about many nonmedical services and supports, such as personal assistance, assistive technology, financial management, housing, transportation, and nutrition. How people are assisted in compensating for loss of ADLs will define their future earnings potential and economic independence.

*2. Design and Implement a Multifaceted Action Plan of Monitoring and Oversight of State Activities to Meet Their ADA Obligations as a Result of the Olmstead Court Decision (Chapter 5)*

A. The Olmstead Supreme Court decision in 1999 provides important legal support for states' current efforts to rebalance their LTSS systems toward home- and community-based settings. The Administration, through an Executive Order and grant activities, has taken seriously the Court's decision and mandated a state planning process to improve and expand community-based choices for people with disabilities. More than \$200 million has been awarded by the Centers for Medicare and Medicaid Services (CMS) to states on a competitive basis to promote system changes. Despite these efforts, litigation continues to expand in class action suits. In more than 25 states, individuals with disabilities have been frustrated with the pace of change and the slow movement of funding away from nursing homes and institutional settings to communities.

B. The Office for Civil Rights at the Department of Health and Human Services (HHS) and the Justice Department have the responsibility to monitor and oversee Olmstead state plan implementation. As both agencies have done on numerous occasions in the past related to ADA, there is an opportunity to be proactive and design and implement an action plan that evaluates individual state efforts to meet the Olmstead community imperative mandate. Each state should be rebalancing its financing, reducing the number of individuals with disabilities residing in nursing homes, diverting others from entering nursing homes, and putting in place the infrastructure for expanded HCBS for individuals with disabilities.

*3. Decouple Eligibility for Home- and Community-Based Services Under an HCBS Waiver from a Determination of Nursing Home Eligibility (Chapter 5)*

A. It is necessary to remove the institutional bias in the Medicaid program to give Medicaid beneficiaries greater choice in how financial assistance is provided to cover a range of LTSS. The clear majority of stakeholders recognized the overwhelming consumer preference for HCBS. Two complementary options deserve immediate attention from Congress and bipartisan support.

B. The first option is to shift the HCBS program from its current waiver status to a state plan requirement. Eligibility would be delinked from nursing home eligibility and states would receive an increased federal match under their state cost-sharing agreement for services provided in this category as part of their Medicaid reimbursement for authorized expenditures. CMS would set guidelines for a functional assessment process and minimum threshold of services to be covered, including personal assistance services.

C. The second complementary option would be that federal funding follows the person from a nursing home to a community setting as part of a person-centered plan and self-directed budget. The Money Follows the Person (MFP) option would continue for a three-year period to help support successful community transition. Both options are currently part of legislative proposals before Congress. MFP and the Medicaid Community Attendant Services and Supports Act (MiCASSA) deserve to be the focus of hearings before the end of the year.

*4. Increase Support for Families and Significant Others in Their Role as Informal and Unpaid Caregivers for Individuals with Disabilities Over and Under the Age of 65 (Chapter 5)*

A. Eligibility for LTSS and the scope and intensity of covered services varies significantly from state to state. States have considerable discretion in determining who their Medicaid programs cover. Despite state variability in criteria for Medicaid eligibility and scope of benefits, in all states, individuals with disabilities are dependent on informal caregivers, including parents, family members, and significant others. The estimated benefit of informal caregiving exceeds \$200 billion annually. Services should be designed to support, not supplant, the role of the family and actions of informal caregivers. Increased support for informal caregiving could be achieved through implementation of a complementary set of recommendations. There is a need to address the lack of portability from state to state for Medicaid LTSS.

*5. Improve the Supply, Retention, and Performance of Direct Support Workers to Meet Increasing Demand (Chapter 5)*

A. As part of the Olmstead guidance, CMS should issue an advisory letter to state Medicaid directors directing corrective action to achieve parity of compensation across the environments where direct support workers are located.

B. CMS should continue to fund demonstration projects to allow states to test innovative strategies to improve the recruitment, supply, retention, and performance of direct support workers.

C. Funding should be authorized for collaborative demonstration projects between the U.S. Departments of Labor and HHS that promote collaboration between community colleges and disability-related organizations to develop a high-quality set of competencies to be taught in a new support worker certificate program that expands supplies of quality workers to meet market demand in home- and community-based settings.

D. Worker cooperatives should be piloted and tested with the assistance of the Departments of Agriculture, Labor, and HHS to explore improved consumer-caretaker relationships.

*6. Mandate Coordination and Collaboration Among Federal Agencies to Align Public Policy and Transform Infrastructure to Be Responsive to Consumer Needs and Preferences for a Comprehensive System of LTSS (Chapter 5)*

A. Although Medicaid and Medicare dominate the landscape of funding authorities for LTSS, NCD researchers documented the complexity and fragmentation of multiple systems with different rules of eligibility and lack of information on access to and availability of resources. The fragmentation and coordination challenges carry over from the executive to the legislative branches of government, in which different committees in the Senate have different controlling authority than committees in the House of Representatives. Although Program Assessment Rating Tool (PART) reviews by the Office of Management and Budget (OMB) are incorporating common performance measures across agencies and programs, there is no focus on cross-department and agency collaboration. The nature of LTSS requires more than 200 programs and 20 agencies to improve their coordination of resources at the community level, where they will benefit the end-user. No single recommendation can respond to this significant challenge. NCD recommends that the appropriate agencies and congressional committees implement the following set of recommendations:

- Hold congressional hearings to evaluate possible options for improvement of multiple department collaboration to provide access to information and supports and services to meet the long-term needs of people with disabilities under and over age 65.

- Require the Department of Housing and Urban Development (HUD) and HHS to document current efforts and future plans to improve and expand the availability of affordable, accessible housing that is coordinated with services/supports, when needed. Establish an Interagency Council on Meeting the Housing and Service Needs of Seniors and Persons with Disabilities.<sup>v</sup> (See chapter 6 for a description of the full role of the council.)

- Add to the PART performance criteria indicators that will evaluate documented outcomes from intra-agency and cross-agency collaboration to meet LTSS needs of people with disabilities. Consider possible financial incentives for agencies that document valued outcomes from LTSS system collaboration. Report annually to Congress on individual agency performance in this area.

- Issue a new Executive Order charging CMS to chair a time-limited workgroup (six months) on LTSS that includes representation by HUD, HHS, the Social Security Administration (SSA), and the Departments of Education, Labor, Justice, Transportation, Treasury, and Agriculture to identify policy barriers and facilitators to an improved comprehensive, coordinated system of LTSS for people with disabilities under and over age 65 that maximizes interagency collaboration, promotes consumer direction, and increases consumer choice and access to affordable supports and services in home- and community-based settings.

*7. Improve and Hold States Accountable for Rebalancing Their Systems to Support LTSS (Chapter 5)*

A. Study states that are having success with a global budgeting approach to move their LTSS system from an institutional bias to be anchored by HCBS and home- and community-based supports.

B. Develop a template in consultation with states to be used to evaluate and measure current expenditures for LTSS in institutional versus home- and community-based settings. Such a template would be developed jointly by CMS and CBO to allow for consistent, comparative benchmarking from year to year within and among states.

<sup>v</sup>Language added to U.S. Senate Bill, 109th Congress-S.B. 705 to include people with disabilities: Establish an Interagency Council on Meeting the Housing and Service Needs of Seniors, April 5, 2005, to include people with disabilities.

*8. Increase Understanding of the Possible Relationship Between an LTSS Insurance Product and Publicly Financed LTSS (Chapter 5)*

A. Congressional interest remains high to understand and explore further the possible relationship between the current market for long-term care insurance products and a reduced dependence on Medicaid and Medicare for long-term support needs. With the growing cost of Medicaid and Medicare documented by NCD researchers, there is growing interest in forging a new level of partnership with the insurance industry that explores both the expansion of product options and the possible cost savings to the public system. For people with disabilities under age 65, no such insurance product yet exists, and little is known about the risk factors in terms of potential utilization by the target population and how to achieve affordable pricing. Even with the adoption of several of the other major recommendations proposed in this report, it is unlikely that a revised Medicaid program will ever meet the needs of all people who are seeking LTSS.

B. Conduct a feasibility study of possible new insurance products and options regarding relationship to the Medicaid program to evaluate possible strategies to partner an LTSS insurance product with supplementary Medicaid coverage for people with disabilities under age 65. Consider price, benefit coverage, caps in coverage, and eligibility for Medicaid LTSS, and project market demand and needed incentives to share risk among stakeholders: the government, the consumer, and the insurance industry. The possible collaboration would include the assistant secretary for planning and evaluation (APSE) at HHS, CMS, and a private insurer.

C. Pilot test such a product or products to evaluate cost benefits to all critical stakeholders. Such a pilot must recognize that LTSS must be individualized to accommodate the needs and desires of the individuals receiving assistance and that the services and supports must reflect consumer preference for noninstitutional settings. Such an insurance product must achieve several objectives: It must be affordable, flexible, responsive to consumer needs and preferences, and sustainable over time with federal oversight.

*9. Improve Consumer Understanding, Knowledge, and Skills to Develop a Person-Centered Plan and Self-Direct an Individual Budget (Chapter 5)*

A. The Cash and Counseling Demonstrations and the Independence Plus Waivers have produced early positive findings of increased consumer satisfaction with the self-direction of individual budgets, the selection of support providers, and increased choice in development of person-centered plans. Individuals with disabilities and their families should be given the opportunity to plan, obtain control, and sustain the services that are best for them in preferred home- and community-based settings. For people with disabilities who have been given few choices in the past regarding services and supports and service delivery options, consumer self-direction requires information, education, and training to build the critical skills needed to make informed decisions.

B. Access to information about service options, streamlined procedures for determining eligibility for various public benefits, and new infrastructure will need to be developed to assist with programmatic and financial management.

C. Recommendations that recognize the principles of individual self-direction and responsibility for prudent and effective management of public resources are critical to the development of the LTSS system of the future.

D. The system should continue to provide competitive grants that establish Aging and Disability Resource Centers (ADRCs) in all 50 states that provide one-stop access to information and individualized advice on long-term support options, as well as streamlined eligibility determinations for all publicly funded programs.

E. The system should establish, with funding from CMS, a National Resource Center on Consumer Self-Direction that identifies and disseminates best practice information on person-centered plan development, self-directed management of individual budgets, and examples of multiple funders combining funds within an individual budget to achieve common negotiated performance objectives.

F. The system should require states, as part of their HCBS waiver implementation, to provide education and training to eligible Medicaid beneficiaries on effective and meaningful participation in person-centered planning, management of individual budgets, and negotiation with service and support providers.

G. The system should establish a cross-agency workgroup that involves CMS, the Administration on Aging (AOA), SSA, the Administration on Developmental Disabilities, HUD, the Office of Special Education and Rehabilitative Services at the Department of Education, and the Department of Labor to accelerate options for states to bundle and/or braid public funds within a self-directed individual budget with streamlined and accelerated eligibility procedures.

10. *Continue to Educate People with Disabilities, Their Families, and Other Critical Stakeholders About LTSS Challenges in Public Policy and Practice and Document Further Consumer Needs, Costs, and Preferences for a Comprehensive, Accessible, and Affordable System (Chapter 5)*

A. This report documents the current crisis and the impending “perfect storm.” It is a complex and confusing picture, not easy to grasp and even more difficult to change as we move forward. NCD must continue to put the spotlight on the critical set of challenges that in the next 20 years may touch more than half the population of our country. For people with unmet LTSS needs today, NCD must continue the public education process through outreach activities and direct discussion with the disability community and policymakers.

B. A series of audio conferences and a national summit of key leaders and stakeholders should be held to continue to document the findings and build consensus on possible policy and practical solutions.

*Recommendations for Clean Slate Reform: Year 2049 (See Chapter 6 for full text and implementation leads and future model)*

1. *AmeriWell is a Prefunded, Mandatory, Long-Term Services and Support Model That Provides All Americans of Any Age with Coverage from Birth Based on Criteria of Risk and Functioning, and Not Category of Disability (Chapter 6)*

A. AmeriWell delinks LTSS from Medicaid and Medicare, creating its own governing agency, regulations, oversight, and congressional committee.

B. The contributions of individuals and families, the private sector, and the Federal Government fund AmeriWell. A “penny pool” is established through private stock transactions to supplement LTSS costs for impoverished and vulnerable Americans previously served under Medicaid and Medicare.

C. Medicaid remains a primary safety net for mothers and children. Medicare continues to provide its health and acute care and limited home services to individuals 65 and older who are not Medicaid eligible or on SSDI.

*Livable Communities Report*

*From NCD’s November 2005 News Release:*

In 2004, NCD published its Livable Communities report. This report vividly showed how a variety of programs must work together efficiently in order to achieve a high quality of life for those they intended to benefit. As NCD’s work and common experience make clear, it is no longer possible to look at housing in isolation from transportation, at employment separately from health care, or at income supports in old age apart from long-term services and non-cash supports. The challenge is to shape this growing awareness into processes that will fulfill the promise of coordinated planning and programming.

*Livable Communities for Adults with Disabilities*

Publication Date: December 2, 2004.

The complete version of this report is available at: <http://www.ncd.gov/newsroom/publications/2004/LivableCommunities.htm>

*Executive Summary*

For the promise of full integration into the community to become a reality, people with disabilities need safe and affordable housing, access to transportation, access to the political process, and the right to enjoy whatever services, programs, and activities are offered to all members of the community at both public and private facilities.

*Introduction*

Communities in the United States are faced with increasingly difficult decisions about how to plan for change, and increase and improve the quality of life for adults with disabilities as well as elders who may develop disabilities as they grow older. People are living longer lives today than ever before and the population of people aged 65 and older is growing rapidly. By 2030, one in five people in the United States will be over the age of 65. Currently, more than 4.7 million Americans aged 65 years or older have a sensory disability involving sight or hearing, and more than 6.7 million have difficulty going outside the home. As the population of elders grows, it is likely that the number of people aged 65 and older with disabilities also will grow, particularly among those 75 years of age and older.

Adults with disabilities and elders want to live in their own homes as independently as possible for as long as possible. People want to live in supportive communities that encourage independence and a high quality of life. To facilitate independ-

ence, people often need the same kinds of services. In addition, people want to remain contributing members of the community. It makes sense, therefore, for the disability community and aging network—groups that traditionally work separately—to collaborate, align goals, and share resources to address the challenges and opportunities ahead.

As the demographic profile of the United States changes, there will be an increased need for livable communities that support the needs and aspirations of people with disabilities and older adults. To meet this demand, three factors must be considered: (1) the elements of a livable community; (2) existing examples of livable communities in the United States today that can serve as models for others; and (3) how these communities develop and sustain livability features.

#### *Framework of a Livable Community for Adults with Disabilities*

“Livable community” is a fluid term whose definition may change depending on the context and such considerations as community capacity, organizational goals, and the needs and desires of particular groups of citizens. For the purposes of this report, a Framework of a Livable Community for Adults with Disabilities was constructed to define the elements that need to be in place for a community to be considered livable for people with disabilities. It is clear, however, that the elements that make a community livable for people with disabilities make it a livable place for all members of the community. Thus, in improving its livability for one particular group of constituents, the community actually accomplishes considerably more.

The Framework of a Livable Community for Adults with Disabilities is inspired, in part, by a similar framework developed for the AdvantAge Initiative, a project that helps communities measure and improve their “elder-friendliness.”<sup>2</sup> It was informed further by research on the concept of livability, results of recent surveys of people with disabilities, countless interviews with key informants and people with disabilities, and a focus group session involving people with disabilities aged 30 and older in Washington, D.C. Similar themes emerged from each of these activities and were synthesized into the framework. Thus, a Livable Community for Adults with Disabilities is defined as one that achieves the following:

- Provides affordable, appropriate, accessible housing
- Ensures accessible, affordable, reliable, safe transportation
- Adjusts the physical environment for inclusiveness and accessibility
- Provides work, volunteer, and education opportunities
- Ensures access to key health and support services
- Encourages participation in civic, cultural, social, and recreational activities

Within each of these six areas, a livable community strives to maximize people’s independence, assure safety and security, promote inclusiveness, and provide choice.

While no one community in the United States has addressed all six of these livability goals to equal degrees, many states, counties, and local communities have made extraordinary improvements in their livability for people with disabilities in one or even several of these areas. Their experiences and achievements can serve as inspiration and provide replicable “best practices,” which other communities can emulate as they strive to become more livable.

#### *Strategies and Policy Levers*

Community efforts profiled in this report have employed a variety of strategies and policy levers to (1) expand access to affordable housing, transportation, and employment opportunities; (2) make the built environment more accessible; (3) reconfigure health and support service delivery systems to be more in line with the needs of people with disabilities; and (4) promote the social and civic engagement of these communities.

Nearly every initiative included in the report has depended, to one degree or another, on strategic partnerships that have worked together to achieve the following goals: (1) leverage resources, (2) reduce fragmentation in the service delivery system, (3) address consumers’ needs in a coordinated and comprehensive manner, (4) provide choice, and (5) implement policies and programs that help people remain independent and involved in community life. To maximize the potential for success, communities should use one or more of the following strategies and policy levers as well as develop all-important partnerships. These strategies and policy levers can and should be used at every level of government—including federal, state, county, and local—to affect change in any of the areas included in the Framework of a Livable Community for Adults with Disabilities:

- Consolidate administration and pool funds of multiple programs to improve ease of access to, and information about, benefits and programs for consumers. This

strategy is used to streamline operations, eliminate redundancies, and leverage resources.

- Use tax credits and other incentives to stimulate change in individual and corporate behavior and encourage investment in livable community objectives. This strategy is often used to stimulate affordable housing development, reduce tax burden on individuals, urge employers to hire people with disabilities, and encourage the private sector to make their businesses more accessible to elders and people with disabilities.

- Provide a waiver or other authority to help communities blend resources from multiple public funding streams to provide and coordinate different services. This is a common policy lever in the provision of coordinated health care and support services, allowing agencies to blend funding streams, increase the availability of home- and community-based services as an alternative to institutional care, and support comprehensive and consumer-directed care.

- Require or encourage a private sector match to leverage public funding and stimulate public-private sector partnerships. Several of the community initiatives profiled in the report depend on monetary or in-kind contributions from the private and nonprofit sectors for their continued existence.

In addition to these strategies and policy levers, successful community initiatives often depend on the ingenuity and persistence of community members who are able to mobilize resources, generate excitement, and stimulate action in their communities on behalf of people with disabilities and the elderly.

#### *Lessons Learned and Recommendations*

A number of lessons can be gleaned from the community initiatives described in this report, many of which can serve as recommendations to other communities that are planning to make greater livability a priority issue in their locales.

#### *Provide Affordable, Appropriate, Accessible Housing*

People with disabilities, including the focus group participants, say that satisfaction with housing arrangements is the determining factor for remaining in or moving from their communities, and this satisfaction depends on two key factors: housing affordability and accessibility. “With stable housing, people with disabilities are able to achieve other important life goals, including education, job training, and employment.”<sup>3</sup> According to the Public Policy Collaboration, however, people with disabilities “face a crisis in the availability of decent, safe, affordable, and accessible housing,”<sup>4</sup> and those with low incomes are the most likely to be affected by this shortage. One estimate says that as many as 1.8 million people with disabilities who receive Supplemental Security Income (SSI) benefits have severe housing problems.<sup>5</sup>

Model community efforts profiled in this report, which have expanded homeownership and rental housing options for people with disabilities, have developed strong partnerships and collaborations between the affordable housing system and the disability community. These relationships ensure that the housing created will meet the needs and preferences of people with disabilities and/or elders. Additional priority action steps in the area of housing include the following: (1) providing incentives for developers to maintain existing affordable housing units and/or increase such stock; (2) providing tax credits to help individuals with disabilities and seniors remain in the homes where they currently live; and (3) expanding awareness and encouraging incorporation of universal design and accessibility features into existing or new housing stock.

#### *Ensure Accessible, Affordable, Reliable, Safe Transportation*

According to the 2003 National Transportation Availability and Use Survey, about one in four individuals with disabilities needs help from another person and/or assistive equipment, such as a cane, walker, or wheelchair, to travel outside the home. Nearly 6 million people with disabilities have difficulty getting the transportation they need, because public transportation in the area is limited or nonexistent, they don’t have a car, their disability makes transportation difficult to use, or no one is available to assist them. The survey also found that more than 3.5 million people in the United States never leave their homes, and more than half of the homebound are people with disabilities. Of these, more than half a million indicate that, because of transportation difficulties, they never leave home.<sup>6</sup>

Providing accessible, affordable, reliable, and safe transportation is an enormous challenge to communities. To address this challenge, some states and counties have been thinking systemically. Priority action steps in the area of transportation include the following: (1) creating “coordinated transportation systems” that combine all the disparate transportation services and funding streams into one system that is more efficient, cost-effective, and universally accessible; (2) computerizing and

centralizing dispatch systems to make on-demand transportation more efficient and less frustrating for consumers; and (3) exploring the use of new technology to help people with disabilities and the elderly navigate their community's thoroughfares and transportation options.

*Adjust the Physical Environment for Inclusiveness and Accessibility*

Since the passage of the Americans with Disabilities Act (ADA), noticeable accommodations have been made in communities large and small to improve access for people with disabilities. In most communities, however, expanding access to the physical environment is still a work in progress. One of the greatest obstacles to improving access for people with disabilities is the expense associated with altering the built environment and making other needed accommodations. In addition to cost, in larger cities or towns, the sheer volume of work to be done causes delays in making necessary changes. In older communities where there are many historic structures that need to be retrofitted for accessibility, conflict sometimes arises between preservationists and disability advocates. An equally significant obstacle is lack of awareness among the public about the difficulties people with disabilities face as they try to negotiate the physical environment.

Fortunately, there are many resources available at all levels of government to help communities address these and other obstacles to accessibility. Priority action steps in this area include the following: (1) increasing awareness among community members by providing them with sensitivity training so that they can experience first-hand the access problems people with disabilities face; (2) educating city planners and public officials about how lack of access affects elders and people with disabilities and what they can do as professionals to improve the situation; (3) advocating for variances to zoning ordinances to accelerate improved access to the built environment.

*Provide Work, Volunteer, and Education Opportunities*

A fundamental principle of Title I of ADA is that people with disabilities who want to work and are qualified to work must have an equal opportunity to work. However, unemployment among people with disabilities remains unacceptably high. The 2004 National Organization on Disability (N.O.D.)/Harris Survey of Americans with Disabilities<sup>7</sup> shows that working-age adults with disabilities are half as likely as working-age adults without disabilities to be employed (35% versus 78%), and people with severe disabilities are less likely to be employed than those with slight disabilities (21% versus 54%).

Priority action steps to increase employment opportunities for and encourage the hiring of people with disabilities include the following: (1) using technology to facilitate education and training programs, to provide telework opportunities, and to match qualified job candidates with employers; (2) increasing awareness among community members about the value of employing people with disabilities; (3) setting an example by hiring people with disabilities for positions within government agencies; (4) helping businesses make reasonable accommodations for employees with disabilities by providing them with needed funding and/or technical assistance; and (5) removing any remaining disincentives to work, such as the potential loss of health care, SSI, or other entitlements.

*Ensure Access to Key Health and Support Services*

Results of a survey by the Henry J. Kaiser Family Foundation reveal that, despite their well above average use of health care services, individuals with disabilities face greater barriers to health care access than does the rest of the population.<sup>8</sup> People with disabilities have trouble finding doctors who understand their disabilities and are less likely than the general population to receive the range of recommended preventive health care services. In sum, people with disabilities face a fragmented health care delivery system that does not respond to their wishes or needs.

Priority action steps in the area of health care include the following: (1) designing health care systems that are consumer directed and provide care coordination to ensure that the right kind of care is provided to beneficiaries; (2) allowing "money to follow the person" to the most appropriate and preferred care setting to create a more equitable balance between institutional and community-based services, eliminate barriers to care, and provide consumers with choice over the location and type of services provided; (3) integrating the delivery of acute and long-term care services to provide "seamless" high-quality, consumer-centered, and continuous care across settings and providers, and (4) providing support services that are linked to housing to increase the availability and efficiency of service provision.

*Encourage Participation in Civic, Cultural, Social, and Recreational Activities*

According to the 2000 N.O.D./Harris Survey of Community Participation, overall, “people with disabilities feel more isolated from their communities, participate in somewhat fewer community activities, and are less satisfied with their community participation than their counterparts without disabilities.”<sup>9</sup> The survey attributes the lower rates of participation among people with disabilities, in part, to lack of encouragement from community organizations. A community can hardly be called livable for people with disabilities if the people are not involved in the community’s civic, cultural, or social activities.

The survey results suggest that it is not enough for community organizations to simply offer activities and provide information about them to people with disabilities. Thus the priority steps in this area include the following: (1) encouraging community organizations to actively reach out to people with disabilities to include them in activities, and (2) ensuring that people with disabilities have access to all of the opportunities that are offered to other members of the community.

It is reasonable to assume that communities will always face financial and structural obstacles to becoming more livable for people with disabilities. Intangible obstacles, like the public’s lack of awareness and understanding of the difficulties people with disabilities face in their communities on a daily basis, are perhaps even more pervasive and difficult to overcome. But, as the community examples in this report illustrate, where there is political will, there are many possible, creative ways to surmount obstacles that prevent communities from being more livable for us all.

