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KEEPING OUR PROMISES TO WEST VIRGINIA'S SENIORS: STRENGTHENING THE AGING NETWORK

HEARING

BEFORE THE

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MONDAY, FEBRUARY 13, 2012

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Charleston, WV.

The Committee met, pursuant to notice, at 9:46 a.m. in the 1st Floor Ceremonial Courtroom, W. Kent Carper Justice and Public Safety Complex, Hon. Joe Manchin presiding.

Senator Manchin [presiding].

Also present: Representative Capito.

OPENING STATEMENT OF SENATOR JOE MANCHIN III

Senator MANCHIN. Good morning. How are you all? Thank you all for coming. We really appreciate it.

Miss, are you ready? I can see we can start.

First of all, let me welcome all of you. I want to thank Congresswoman Capito for being with me. I want to thank Senator Rockefeller's office. Rocky is here, and their representatives are here, and my office is with me. I have Lauren Alfred with us, our senior age consultant, if you will. She runs our aging, our Medicaid and Medicare health care, and also education. So Lauren does a great job. We appreciate her.

I now call this Special Committee on Aging hearing to order, and I want to thank all of you for coming. I'm pleased to have the opportunity to bring the Aging Committee to West Virginia to discuss commonsense ideas for the future of senior services in this country, because in West Virginia we know how to set our priorities around our values, and I think we've done it well with the services we give.

As many of you know, when I was governor, we set a budget that got our fiscal house in order, but we did so while prioritizing our seniors and increasing resources for senior services by 83 percent. I have Sandy Vanin with us. Sandy was my senior director at that time, and we really put our money where our mouth was. We placed food trucks in all 55 counties. We targeted funding for Alzheimer's, respite care and elder watch programs, provided seniors with the support they needed to continue to live in the comfort of their own homes, and I am proud of what we have done in West Virginia, and I am committed to bringing these commonsense lessons to Washington so that we can keep our promises to our greatest generation.

In recent years, the need of senior programs and services has only increased as our seniors are living longer and facing difficult economic times. Last year, the first of the 77 million Baby Boomers turned 65, and now every day for the next 18 years over 10,000 seniors will turn 65 and become eligible for senior services and entitlements. I myself will turn 65, and I tried to find out who in my staff put that in.

[Laughter.]

They have all denied it, but we think it was Lauren, making these issues all the more salient to me. As my generation ages—and I don't think that I am; I'm still in denial, and we've talked about all this before, I'm having a hard time—there's no doubt that we will place unprecedented demands on the national budget and resources because of my age, not my needs right now, thank goodness. Now more than ever, we need to be ready to help seniors stay healthy and independent as they age.

Today's hearing will focus on how we can strengthen our system of Federal, state, and local senior service agencies known as the Aging Network to meet the growing needs and challenges of the Baby Boom generation and preserve these critical services for future older Americans. If you can think about how many times you hear us in government talk about one-stop shopping, even in the retail private sector, one-stop shopping, make it easy and convenient, we want one-stop service. I want to make sure that as we grow older, we know exactly that we can go one place and find out everything that we have available to us, are entitled to, and what we can access.

The Older Americans Act, which was signed into law in 1965, funds the majority of programs and supports for our seniors, including Meals on Wheels, caregiver help, health promotion, elder abuse prevention. Every five years, Congress takes a fresh look at programs in the Older Americans Act to assess whether they're meeting the needs of the people they serve. This year, Congress is due to reauthorize the Older Americans Act, and I look forward to bringing many of the ideas and comments that we receive today to Washington to improve the new bill.

As Congress revisits this legislation and at the same time works to tackle our rising deficit, I believe we must identify inefficiencies and redundancies in the system because wasteful spending should be the first to go. Our National Aging Network is made up of 56 state units on aging, 629 Area Agencies on Aging known as AAAs, 20,000 service providers and thousands of volunteers. In a system this big, there are bound to be inefficiencies and a great deal of room for improvement through coordination, flexibility, and innovation. This is one of the key issues that we'll address today.

I have asked stakeholders from across West Virginia's aging network, from the state government to local volunteers on the ground, to come together to discuss their ideas for bringing services to more seniors more efficiently, and you have come, and I appreciate that.

We're also fortunate to be joined by U.S. Assistant Secretary for Aging, Kathy Greenlee. Kathy comes from the State of Kansas, and the governor of the State of Kansas at the time was Kathleen Sibelius, who is now Secretary of DHHS. I worked with her as a governor. I know that Kansas has a lot of the same concerns and

demographics that we have, and I appreciate you being here, Kathy.

I'd like to thank all the witnesses who have joined us here this morning. I am eager to hear your thoughts and ideas for improving the way we deliver services to seniors.

What we're going to do, I'm going to turn to my friend and colleague, Congresswoman Capito, for her opening remarks now, and we will continue with our first panel.

Congresswoman.

STATEMENT OF HON. SHELLEY MOORE CAPITO, U.S. REPRESENTATIVE, SECOND CONGRESSIONAL DISTRICT, WV

Representative CAPITO. Thank you. I'd like to thank the Senator for including me today. This is a great display of bicameral bipartisanship.

Senator MANCHIN. The way it should be.

Representative CAPITO. Yes, the way it should be. But as you know, West Virginians are all pretty close, and the Senator and I have known each other for a very long time. So I appreciate him including me in this.

I'm just going to briefly say that there is no more timely issue for—even though I'm not turning 65 this year, I am in that sandwich generation where I have my parents and then still my children. They're almost out of the nest, but—well, they're out of the nest, but they would like to think—but you know what I'm saying here. There's a lot of pressures, and I think it's important in terms of coordination of care, of the financial resources, the legal issues that you touched on in terms of senior financial abuse, the vulnerabilities of our seniors, and the transitioning of our parents into a different way of living and a different way of coping with their situation.

And as you all probably know, I'm dealing with this very personally in my own way with my brother and my sister, and there is no single manual that says if you find A, then you do B; and once B happens, then you turn to C.

It is difficult to move through the systems. It's difficult to understand what's happening, not just as a daughter but for them to understand what's happening. And so this has been an educational experience for me, so I really take to heart what everybody is going to tell us today and what you all as advocates in the audience do every single day to make sure that families have access to care.

If you had a family that didn't—I mean, if you had a senior that didn't have a family, and the Senator alluded to this, it would just be tragically difficult for that senior to try to figure out on their own, or to even know where they are. I noticed there's a registry for Alzheimer's patients and folks that have been diagnosed. I'm guaranteeing you, it's way underestimating what is really going on in this state and in this nation, because I can guarantee you neither one of my parents is probably on that registry. So we need to talk about that.

But in any event, you can see it's a very personal thing for me, so I'm very, very pleased to be here today. We have a lot of great resources both at the Federal and state level. We just need to make sure that we have the coordination, the awareness, the education,

because we have the dedication and the love and the caring that we need to move forward in this very difficult arena.

So with that, thank you again for including me, and I look forward to hearing the witnesses.

Senator MANCHIN. Thank you, Congresswoman.

Before we start, I would like to reiterate what Congresswoman Capito said. Her parents, as they are needing some services, I can tell you my mother—I would like to know, if my mother did not have the family support, if my sister and my brother-in-law and my cousins and nephews weren't taking care of her on a daily basis, what type of life would she have right now? I think that's what I'm trying to find out, because I know other people aren't as blessed as I am to have the family support that we have.

And with that being said, that person still deserves that love and care no matter whether they have a family or not that can do it, and not everybody can do it. So that's really the purpose of what we're doing here today.

So with that, our first witness today is Kathy Greenlee. Kathy is Assistant Secretary for Aging at the United States Department of Health and Human Services. Kathy Greenlee brings over a decade of experience advancing the health and independence of seniors and their families. Prior to becoming Assistant Secretary, Ms. Greenlee served as Secretary of Aging for the State of Kansas, as well as the Kansas State Long-Term Care Ombudsman.

Ms. Greenlee, or better known as Kathy, thank you so much for being here, and we look forward to your remarks.

STATEMENT OF KATHY GREENLEE, U.S. ASSISTANT SECRETARY FOR AGING, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. GREENLEE. Thank you, Senator.

Do I need to turn this on?

Senator MANCHIN. No. We have you loud and clear.

Ms. GREENLEE. Very good.

Senator MANCHIN. This is the state of the art. Kent Carper and the County Commissioner——

Ms. GREENLEE. The light is red.

Senator MANCHIN. Oh, it stays red here. It stays red.

[Laughter.]

Ms. GREENLEE. Thank you, Senator. It's a pleasure to be with you today for a special hearing of the Senate Special Committee on Aging; and thank you, Representative Capito, for also being here to participate.

This has been a fabulous experience and tremendous honor to serve as United States Assistant Secretary for Aging, and this is the fourth time I've been able to attend a special committee hearing outside of Washington. I also travel the country, visit with seniors in all settings, from community services to long-term care settings, and what you are discussing today is happening all across the country, the number of seniors turning 65, the number of seniors who are now very old and very frail who need services and supports.

In December, I had the opportunity to participate in the 50th anniversary celebration of the Senate Special Committee on Aging. In

addition to talking about seniors that day, there was something that became very, very clear, something that we all know and that is reflected by the two of you joining us today. This is not a partisan issue. Aging and aging services, and certainly the Older Americans Act, has a history of bicameral, bipartisan support. I think it's a non-partisan issue and something that affects all of our families, all of our lives, and eventually ourselves. And so I just wanted to thank you for your leadership by being here to demonstrate that this is really about all of us and our families.

As I work with the Older Americans Act and the aging services network, there are a number of significant values that I see that we share, helping older Americans and persons with disabilities maintain their health and their well-being so they are able to live independently with dignity for as long as possible. We have developed and implemented person-centered approaches. We've supported self-determination, respect, empowerment, and inclusion.

The Older Americans Act helps protect the most vulnerable among us, and it helps provide basic respite care and support for families so that they are better able to help take care of their loved ones, which is what all Americans overwhelmingly prefer, that they have the support of their family and their friends and their communities as they age in place at home.

Last year, the national aging services network served nearly 11 million seniors and their caregivers, 11 million. And, Senator, that network is the one that you described. I oversee a very unusual Federal structure where we are very small at the Federal level. We send our money directly to the States, to the area agencies on aging, to tribal organizations, and through that network there are 20,000 service providers who provide direct care; in addition to that, thousands and thousands of volunteers who do everything from deliver meals to provide long-term care ombudsman support. These are the backbone of the nation. These are the backbone services that provide care.

Eighty percent of all long-term care in this country is still provided by families, and this is how we support this vital network. It's also important to note that the key distinction of the Older Americans Act is that it complements medical and health care assistance. It does not duplicate those systems. And this assistance is critical in helping seniors remain independent.

The flagship program that we have, the one that has always been the largest through the Older Americans Act has been the nutrition program. It's 40 percent of the support that we provide to local communities and to States, whether it's home-delivered meals or congregate meals. But often a meal is not enough. The people need other kinds of supports, the kinds of supports that you deliver here, transportation assistance and rides, bath assistance, in-home supports, caregiver supports. Seniors need a complex array of services.

The first time I testified at a field hearing for the Senate Special Committee before Senator Kohl in Milwaukee, not surprising since he is the committee chair, and he had someone testify there who pointed out something that I had not really realized until that hearing, hearing from a consumer who pointed out that the Older Americans Act is the original home- and community-based service

system. It has been around for a very long time and is the core strength that we have, often supplemented by State dollars to help seniors stay independent.

Here in West Virginia, in fiscal year 2010, nearly 50,000 persons over the age of 60 received supports through this aging services network. Of that 50,000, 30,000 lived in a rural part of the State. This is not a surprise to you as elected officials, that we must target the real parts of this State because often people are isolated and vulnerable and live alone in remote locations.

We provide rides, home-delivered meals, and support senior centers. This assistance is well represented by the panel that you have following me, the long-term care ombudsman, the people who work for the financial exploitation task force, the people who are providing direct services through the area agency on aging. This is the core of our network, senior centers are where the services are ultimately delivered.

I tremendously value the area agencies on aging, but I think the best place to visit is the senior center, because that's where the seniors come for services, supported, of course, by the area agency on aging. This is important community assistance but is challenged by the number that you pointed out, Senator, the number of seniors turning 65 every single day.

Fortunately, I believe we have some time to plan, not that we have time to waste, but most people do not need services at 65, but they need them by the time they're in their late 70s or 80s, and this is a critical time that we support the services that we have.

The Older Americans Act, which is the program that I'm responsible for, helps in three main ways. The Older Americans Act programs help Americans with severe disabilities remain independent and in the community. We can measure the frailty level of the people that we're serving, and we have put together one of the measurements that's called a nursing home predictor. Without these services, just as you said, Senator, what would happen to this individual, and we can tell over the course of the years that the people we serve through the Older Americans Act are more and more frail, more and more likely to need nursing home assistance without these vital community supports.

Our programs are efficient. Our funding has stayed primarily flat. But because the money is leveraged at the local and community level, we have been able to serve more clients with the same amount of dollars. And because of this leveraging, the Older Americans Act services help build capacity in the network. It was never designed to be the whole show, but always an anchor around which you wrap State supports, community supports, private support, faith-based organizations. This is really, I see, the center beam around which we provide a variety of community services. It's always meant to be and it's always designed to be a grassroots system, as you have reflected here with you today.

It is important that we continue to make advancements, that we take advantage of technology, that we have enough flexibility to try innovation. How can we use technology to help reach the remote seniors that you have in this State, as well as across the country? How can we be innovative in providing all of the services that we support and fund?

As you know, the Older Americans Act is up for reauthorization. It was actually up for reauthorization in 2011 and has not been reauthorized. Senator Sanders on the Senate HELP, Pension and Aging Subcommittee, who is in charge of reauthorization, is tremendously committed to reauthorizing the Older Americans Act, and we continue to work with the Senate very closely so that we can move this reauthorization.

There are some fundamentals that I would like to talk about before I close about the Older Americans Act. When I first started, I spent most of the first year as Assistant Secretary traveling the country to get input from local providers, and here's what I learned about the law. It's working. It's not broken. And this is an opportunity to talk about the future as we talk about the Older Americans Act. There's nothing wrong with the law, and this is not a time when we need to go in and fix something but go into the law and figure out how it can continue to be improved.

It is the glue that holds the entire national system of long-term support together. It is meeting the goals established by Congress. It meets the goals of targeting the people who are most vulnerable, people who are poor, people who have chronic diseases, people who have high risk for nursing home placement, people who are frail. It is meeting the objectives, and I always look forward to opportunities to figure out how we can do more, how we can find more partnerships.

I will give you an example of one that's not in my testimony. We have reinvigorated our relationship with the National Institute on Aging to find out what are the best evidences that they have on how they can help develop evidence-based programs that we can deliver through the aging network. We are ready to have good science behind the social services that we deliver, and the Older Americans Act and its network is as strong as ever.

We are here to partner with you. We believe that the pending reauthorization could be passed, needs to be passed, and by doing so we can really look at the challenges of an aging population that are increasing, help individuals maintain their health and independence, and continue to be able to focus on the person.

This is where I'd like to conclude, that the beauty of having this particular law is that it's able to do as you talked about, Representative Capito, come in and evaluate one person at a time regardless of their race or income or geographic location, regardless of their situation in life, to determine what do they need, what are their frailties, how can we provide assistance, and if those change next year, we'll provide different additional ones.

This is the beauty of how this law has always been developed, that it is person-centered, that it reflects the very unique needs of each individual senior as they age in this country. Thank you very much.

[The prepared statement of Kathy Greenlee appears in the Appendix on page 38.]

Senator MANCHIN. Secretary Greenlee, thank you so much for your remarks.

Let me preface. I have about three quick points to make, and then I'd like to hear your response.

Before I do that, the most sobering moment I've had as a senator was when I sat in the Armed Services Committee and I asked at that time Admiral Mullen, who was then chairman of the Joint Chiefs of Staff—this is the entire Department of Defense, military, everything that protects us in who we are as a country—and I asked him, I said what's the greatest threat the United States of America has right today? This was maybe three or four months ago.

Now, there's a lot of things I was expecting, an array of answers. Was it Al Qaeda? Afghanistan? Iraq? Was it Iran? North Africa? Or was it Russia? Or was it China building up their military? I could have gotten an array of answers.

He didn't even flinch. You know what he said? The deficit and debt of this nation is the greatest security risk we have as a nation. He didn't think there was an army that would pose that much of a threat. He didn't think that there was any foreign element that would pose a threat to us as a nation.

But our debt and what we're carrying right now, the financial burden—and we've talked about this—if we don't fix it—we're now, our debt ceiling is able to go to $16.4 trillion. If we don't bring this under control—so I'm prefacing it by saying what our challenges are and why we have to be so much better and smarter.

We will be the first generation to turn over the keys to our children in worse shape than our parents gave it to us. We'll be the first. All of us will be guilty to be the first to let that happen if we don't stand up.

With that being said, that's more to the point of what I'm going to be asking. We brought all the different people who are on the front lines in West Virginia, and you'll hear from them in a second panel.

Can you tell me more, Secretary, about how you're building collaborative partnerships with Federal and state community, how you're looking for that efficiency, and basically the point of service where it gets the most traction, if you will, the most good to the people?

Ms. GREENLEE. Let me answer your question in two parts and first talk about the debt part, the financing part that you prefaced.

What we know, those of us who provide services through the Older Americans Act systems, the people behind me who provide these services, is that if these services were not in place, many, many people would then become reliant more quickly or eventually on public programs; that it's very important that we help—Older Americans Act services are cost effective, they're fairly inexpensive, and they can help someone stay in their community for as long as possible.

Once someone has to leave and go to a nursing home that type of care in that setting is tremendously expensive, and many people who get to the nursing home spend down within the first year and become eligible for Medicaid. So from both good people policy and good fiscal policy, community services are much more cost effective, and I think that's the real value that we have in providing Older Americans Act services.

But the world has become increasingly more complex for seniors to navigate between the VA and Medicare and Medicaid and these

local services. The way the Administration on Aging has been addressing this was first realized in the mid-2000s. In the 2006 reauthorization of the Older Americans Act, we implemented for the first time aging and disability resource centers. All of your area agencies on aging here in West Virginia participate as aging and disability resource centers.

And the best way for me to describe to you what that is, it's a capability or a quality that the people in that resource center can help someone access everything they need in the community, whether its community supports from the government, whether it's social service supports in the community. What we have known in the aging services network for decades is that our best asset is sometimes not the services we deliver but the knowledge in our brains about how we put together services and supports, formal services, informal services.

What the aging and disability resource centers do is the piece that you're recommending. How do we have a one-stop shop, someplace where there's one person who an individual can call so you can say, oh my goodness, I don't know where to even begin. Where there's someone who can do an assessment of the loved one if they need it or help provide support for the family caregiver, or help figure out if there are other government services or other kinds of assistance that the senior may need?

It is an extremely complicated system, and often people will—I think people arrive at that system one of two ways, in a crisis where mom falls and breaks a hip and the mom is at the hospital, or with a family who has a senior who continues to age and need more and more care at home. We can provide assistance for all those scenarios.

Senator MANCHIN. Certainly with the budget crisis that we're facing in Washington, we've been blessed in West Virginia and we have our house in pretty good order, if you will, and they're working on making it even better, but the challenges are still there. But in Washington, knowing that we're going to be facing some—every agency is going to be asked—every agency is going to say, yes, but we're much more important, so we want you to protect us; if anything, increase our funding. We're going to have to make the hard realization that everybody can work better and more efficiently.

Where do you see the efficiencies that you could, in your crystal ball, looking at where you're seeing it from 40,000 feet now being in Washington, looking down at what every agency is facing, how can we provide more services to more seniors probably more efficiently, cut out the waste, fraud and abuse? The GAO last year said $125—we knew that $125 billion was misspent on most of our social services. When I say that, the abuse, fraud, and waste that went into it. And when I went to Washington, the first time I was there, they were going to cut Head Start, the poorest of our children. They were going to cut Social Security. They were going to cut Medicare and Medicaid. I think who else is left to throw under the bus?

But if we could run it more effectively and more efficiently, can we get better services and still have the responsibility of our budget crisis that we're having? How would you recommend and where do you see we can go?

Ms. GREENLEE. Senator, I am a long-time public servant as well, two decades in public service at the state level and the Federal level. I agree with you but also would like to, point out one key fact with regard to the programs that I run.

The Older Americans Act at the Federal level is a relatively small investment. My budget on an annual basis will sound big in West Virginia dollars, are real dollars, $1.6 billion. That's my annual budget. That's roughly what Medicare pays each and every business day in this country every year. So it is very small, and I always am concerned and responsive when people talk about fraud and abuse.

We have program integrity measures. Every couple of years there will be a provider in our network that runs off with some money. But this is not a network that's replete with fraud and abuse. It's not a network that drives significant enough dollars to attract criminals. It's just really small.

I think the best way that we leverage the resources is to partner with our bigger Federal partners. I believe there's a relationship, or there needs to be improved relationships between community services and medical services, for example, that the doctors and the hospitals provide something as basic as care transition to their home so people discharged from a hospital know about these local services and the need to help support the local services.

We have built silos of care, whether it's acute medical care or long-term care or community services, and the most holistic approach is to stitch them together so you've got one person who needs a little bit of community services, who needs a little bit of long-term care support, and they occasionally need to see the doctor or go to the hospital.

The opportunities in the Affordable Care Act that I see are for us to be innovative. I also think we have to look in other directions. I spend a great deal of time talking to my colleagues at the Health Resources Services Administration. There are Federally-qualified health clinics all around this country, and I have found since I came to Washington something that concerns me, which is there are parts of the country where the Federally-qualified health clinic doesn't know the area agency on aging, and they're all providing services to seniors.

So we have to do an increasingly better job of outreach both at the Federal level and at the community level to make sure that we can help seniors navigate all of these systems, because of the Federal budget and the strain on the State budgets, our budgets are not growing. They're remaining relatively flat, and we have more need.

Senator MANCHIN. A final one before I turn it over to my colleague. As you know, West Virginia is a small state, and we have about 15 percent of our population over 65 years of age, which makes us the second most aged state in the nation on a percentage basis.

With that, under the Older Americans Act, the funding is done based on size and not specifically on need, mostly in the nutrition. I'll tell you where I'm coming from. In nutritional services, Florida receives 10 times more dollars than we do but only serves four times more meals than we do, and that just seems inherently un-

fair, and that's what we're seeing based on need. And we're doing a heck of a job, but we have an awful lot of people in a rural area that depends on us.

So we're out there working and going out and being able to provide these services. So we're saying can fairness be brought to that system? Funding solutions and what you're saying, the story you just told us about efficiencies that you have, you need to tell that story more. When you start saying that we spend every day $1.6 billion in Medicare, and your total annual budget to help all 50 states and the territories is only $1.6 billion, it pretty much sends a message.

With that, we all still have to look for our efficiencies if we can do something better. But with what I just pointed out to you, the inequity in the system, the way the monies are spent, taking into consideration—I don't think they do—the rural state, the Older Americans Act—the ruralness of our state, the amount of people we're serving, and the dependency that people have, how would you approach that?

Ms. GREENLEE. Senator, the money that we have through the nutrition program, both on the congregate side and in the home-delivered program, is administered through an interstate funding formula to every State based on the number of people in the State over the age of 60. So it is a demographic distribution based on the people over the age of 60.

But to respond to the point that you made, which is what if we're serving more meals, we also have a smaller nutrition program that's not as well known, which is the Nutrition Services Incentive Program, which follows along afterward to help provide incentives and reward people who do the most with the money that they get, who serve more people with that money.

You are a particularly rural State. The Older Americans Act requires that the State and the area agencies target certain populations, and in West Virginia you would automatically target rural. In Florida, they have larger numbers of people of color and minorities. They're also listed as a high-profile State. There are States that have people who are also remote. I could talk to my friends in Alaska who also have tremendous transportation challenges.

So we do a base funding, and then we follow along to reward incentive because each State has kind of a slightly different high-needs area that they're serving.

Senator MANCHIN. Thank you so much, Kathy.

And now for Congresswoman Capito's questions.

Representative CAPITO. Thank you. I'm just going to follow briefly up on what the Senator said. With the $1.6 billion, if you could just kind of walk me through, that's the Older Americans Act appropriation for annual appropriation.

Ms. GREENLEE. Yes.

Representative CAPITO. So then parts of that is nutrition? How does that fold out, just really briefly? How does that fold down to the state? Because you said mostly it is then just pushed out to the states. So we're different pockets. Obviously nutrition is, what, about 40 percent of your budget?

Ms. GREENLEE. It's about 40 percent of our program dollars. Most of the money that we have is distributed based on a formula.

So we have some competitive grants. We've done a lot, for example, in the field of Alzheimer's and some other evidence-based programs. Almost all of the money is sent to the states based on the Census.

Representative CAPITO. So there's nutrition. And then what would your other pockets be?

Ms. GREENLEE. Then we have in-home supports.

Representative CAPITO. Okay.

Ms. GREENLEE. We have nutrition. We have the family caregiver program. We have some smaller parts. It's probably the smallest one we have, for health promotion, where we're doing a lot of chronic disease management, preventive services, as well as in Title VII, the Elder Rights Program, where we have some targeted efforts for elder abuse, long-term care ombudsman, and legal services. Those are divided out per State, per capita, based on the population of 60 or older, which is the age of eligibility.

We also have some smaller programs that are directed specifically to Native American programs, Alaska Natives, Hawaiian Natives. There's a nutrition program, a family caregiver program, and, of course, we have a direct government-to-government relationship with the tribal organizations.

Representative CAPITO. One of the questions when we were speaking with the media before we began was do you just need more money? I mean, we're talking about the constraints that we have. You mentioned them, too, and where we are for our future. So we know that that's the big conversation in Washington now. And certainly if you had your wish list of everything you could have, more money would probably be at the top of everybody, whether it's education, military, whatever the government is involved in.

But it seems like you've accomplished a lot of efficiencies with the money that you have. So I guess the message I'm receiving is while certainly more money would be great, you can still achieve great efficiencies with the $1.6 billion that is then granted down to the states. Is that a fair statement?

Ms. GREENLEE. May I address the money first and just point out that I was very pleased in FY 2011, Federal fiscal years 2011 and 2012. The President recommended that the Older Americans Act receive an additional $100 million in funding, and that was packaged together as a caregiver initiative. Roughly half of that money would have gone to provide support to family caregivers and half that money to the care recipient.

Those historic increases, we've not seen that sort of a recommendation for a decade for the Administration on Aging. Those increases were not realized, that our budgets have been flat funded.

Representative CAPITO. Do you know what he's doing in—he's putting his budget out today, I guess.

Ms. GREENLEE. Yes, but one rule is I don't want to get ahead of him. He's announcing his budget in a couple of hours. But I will say that these are tough times, and we have seen support from both the Secretary and the President regarding the value of these particular programs. They don't duplicate other programs. They're critical infrastructure. They complement other community services.

Yes, I think there's tremendous unmet need, and we do the most that we can to spend these dollars wisely and to partner with local communities as well.

Representative CAPITO. The other thing I just would reinforce, and we talked about this earlier too, is particularly in terms of the VA. Just in the brief comments that we had before when we were talking earlier and from my own personal experience, there's a disconnect between trying to figure out how to weave the VA and the Medicare and all the other services, whether you have your own private-pay personal care situation or hospice or all the different pockets of Federal.

I would encourage you, and you've said this in your remarks, that you're coordinating with the VA, because the VA has sort of opened up this area as an area of emphasis for them. When you look at—I mean, we're losing our World War II veterans, but we're going to have our Vietnam veterans, and then certainly we want to plan for the folks who are coming out now so that when in 40 or 50 years, or 30 and 40 years from now, when they are trying to access these systems, the VA has—and I know the VA is not your bailiwick, but the VA has morphed into an area that—and I think they are trying to change where they can meet those areas. So I would just encourage that.

And the other thing is I see Chuck back there from Roane County, and another thing I'd like to reinforce, because he does this at his senior center, is I like the way he has coordinated not just seniors in a building, but he has young people in the building, he has small businesses that are—he has a rather large building, but he has entrepreneurs who are coming in and trying to do building start-ups. He has after-school care in the building. So it really does reflect more for the senior who is getting the care more a community, because seniors don't live in a—I don't live in a community of 56—I'm going on 58.

[Laughter.]

of 58-year-olds.

Senator MANCHIN. I didn't want to remind you.

[Laughter.]

Representative CAPITO. Yes. Well, I am younger than you.

[Laughter.]

And, you know, seniors don't—the joy that I see, that most seniors see when they see a baby or a young child, or even an animal, a dog or a cat or a pet or something like that, I just think that those kinds of coordinations outside of the umbrella of senior care is something that we really ought to look at, and I know you all are looking at it, but it's something that maybe we ought to put more emphasis on as a nation and create communities that are more reflective of the general population, which then would lead to general better health, better mental health.

So with that, if you want to comment on that——

Ms. GREENLEE. Just briefly about both. With regard to the VA, I completely agree with you. I believe in this network, and we do the right thing even when we don't get paid for doing the right thing. In 2008, the Administration on Aging began to partner with the Department of Veterans Affairs (VA) because we had soldiers coming home from the two wars at that point who didn't have re-

sources in the community, that the VA had not built a home and community-based infrastructure.

So, because we saw the value of the network, what we could provide given our skill set, VA began a brokerage arrangement where we said VA, let's introduce you to our network so that they can bill directly for their services to the VA. The VA is completely committed to this program. It is growing. Every year they provide more resources, and they're moving to take this nationwide, to use that infrastructure.

And then on your second point, I never talked about this in a hearing before, but I will tell you there are occupational hazards in this job, that sometimes it makes you cry. It just does, and the people who do this work will tell you, and you'll probably start crying for different reasons, so I'll tell you about one where I did, and that was December, not last year but the year before, when I visited an Alzheimer's program in Washington, D.C.

Right after I began, I started to tour and look at the programs in Washington so I would be familiar with what we were providing, and we were providing services or are providing support to an Alzheimer's program. In that December, they brought the children in that were about age 4 to sing, and really, you just had to cry. When you see seniors and young people together, especially seniors in a nursing home or people with dementia, it's just special and very magical, and there are many places around the country that also see that, that bring together kind of the whole family, the whole community because it's valuable to both.

I think it's helpful to seniors, but I must tell you I think it's also helpful to children so that they continue to see a positive view of aging and learn all the things we would hope that they would learn about their elders. So there are wonderful things that we're doing.

Senator MANCHIN. Thank you, and thank you, Congresswoman, for your questions.

I want to thank you for your testimony. If you would, you're more than welcome to stay right there.

Ms. GREENLEE. Okay, I will.

Senator MANCHIN. And then we'll bring the others. I think we have enough seats, because I was going to bring you back anyway. So rather than sending you back and then bringing you back, you just stay right where you are.

Ms. GREENLEE. Okay.

Senator MANCHIN. Let me just say, first of all, I want to welcome Senator Ron Stallings, Dr. Ron Stallings for being with us.

Ron, if you'd stand up.

Ron does a great job.

[Applause.]

Ron is chairman of the Senate Health Committee. He's a practicing physician. He brings a world of practical experience to that committee, and I just enjoy working with him.

Thank you so much, Ron.

The first witness on the second panel is going to be Suzanne Messenger, and I would like for all of our panelists to come forward, and I'm going to read a little bio on all of you, and then we'll start right down, if you will. We have Brenda here, Janie, Helen, and James.

The first witness on the second panel will be Suzanne Messenger, and Suzanne is a West Virginia state long-term care ombudsman. I'm sure she'll explain her duties when she starts speaking. Her job is to empower seniors and their family members to make informed, long-term care decisions.

Then we will hear from Brenda Landers. Brenda is the Director of the Metro Area Agency on Aging, one of West Virginia's four regional Area Agencies on Aging. Her agency oversees programs delivery in southwestern West Virginia and contracts with local senior centers to provide meals, transportation, and other services.

After Brenda we'll be hearing from Janie Hamilton. Janie is the Executive Director of the Kanawha Valley Senior Services in Charleston. Her organization provides critical programs like in-home care, transportation and nutrition services to seniors of the Kanawha Valley. Janie is also an only child and caregiver of her 83-year-old mother that lives with her at her home. So she has the real hands-on experience.

We'll then hear from Helen Matheny. Helen is the Director of the Alzheimer's Disease Outreach Program at the Blanchette Rockefeller Neurosciences Institute at West Virginia University. The aim for her program is to provide physicians with training and tools to improve screening, diagnosis, treatment and care of patients with Alzheimer's disease and related dementias. Ms. Matheny also serves as a member of the National Advisory Council on Alzheimer's Research, Care and Services.

And finally we'll be hearing from James Clagg on behalf of himself and his wife, Ellen. James and Ellen volunteer at the Milton Senior Center. Ellen serves as assistant treasurer of the Center and works with the Center's kitchen. James calls bingo every Tuesday and drives the bus on Center trips. James and Ellen have been married for 23 years and have lived in West Virginia all of their lives.

So I want to thank each and every one of you for coming and taking time to be with us.

And with that, Suzanne, we'll call on you.

STATEMENT OF SUZANNE MESSENGER, STATE LONG-TERM CARE OMBUDSMAN, WEST VIRGINIA BUREAU OF SENIOR SERVICES, CHARLESTON, WV

Ms. MESSENGER. Thank you, Senator Manchin and Congresswoman Capito, for the opportunity to testify here today.

As state long-term care ombudsman, I advocate for the rights of long-term care residents with the goal of enhancing their quality of life—a lot of living goes on in long-term care facilities—and promoting self-determination.

By devoting our time and resources to the areas of preventing financial abuse and ensuring a robust long-term care ombudsman program, I believe we can improve the effectiveness and efficiency of our aging network and continue our mission of person-centered services.

Although there are many legal definitions of financial exploitation, it's basically stealing. It can be the simple unauthorized use of a credit card or it can be a really complicated fraud scheme.

In 2010, a MetLife study estimated that the annual financial loss suffered by seniors through financial exploitation was $2.9 billion. Remember, that's almost twice the budget of the Administration on Aging, $1.6 billion, $2.9 billion stolen from our seniors.

Exploiters are criminals, but sadly they're often friends and family members or others that the seniors thought they could trust. It can be even more complicated when the person is stealing through legal means, which sometimes happens through a durable power of attorney, a legal document that provides them access to the senior's money. These cases often come to the ombudsman's attention when residents are issued discharge notices.

The perpetrators spend the money. They don't save it. Many times the seniors are unaware that it's even happening, and they're reluctant to come forward because it's their family. They're also under the misunderstanding that this power-of-attorney representative holds some magic power over them and that somehow they can punish them or do something wrong to them if they challenge them, when really the reverse is true.

In order to stay this exploitation, we need better laws, and right now our legislature is considering reforming West Virginia's power-of-attorney law and enacting the Uniform Power of Attorney Act through Senate bill 449 or House bill 4390. This will provide some important protections for our seniors and agents, and even third parties who rely on that.

But we also need better education, and Older Americans Act programs are great at providing that kind of education, education to seniors that they're really the ones in charge here. They're the boss, not the agent, and that's sort of different from how many of them understand it now. And unfortunately, people in the community are under that same misconception, and even many attorneys. So we need better education to address financial exploitation.

If we can empower our seniors to take control over their money and prevent that, just think the good that we can do with $2.9 billion extra in our economy.

Another way to empower our seniors is by ensuring a robust ombudsman program. The long-term care ombudsman program is the only Older Americans Act program that's specifically designed to serve residents in residential care facilities. Through complaint investigation and consultation and information, our ombudsman supported residents in exercising their rights, staying free from abuse, receiving quality services, and enhancing their dignity.

When one administrator was asked what would be the situation if there was no ombudsman program—and this was a facility administrator—he said residents would lose a channel of communication and support that helps them exercise their rights and freedoms.

Reauthorization and adequate appropriation of the Older Americans Act is one way to provide a solid basis for ombudsman services. Fully funding the Elder Justice Act, which is a complementary act that can provide a strong safety net for the ombudsman program and many of its partner agencies, is another way to strengthen this. Enabling residents to solve problems before they escalate into major issues, helps assure that residents have the best quality of life and quality of care that they can.

Preventing financial exploitation and power-of-attorney abuse not only protects our vulnerable adults but it also allows for a more efficient system based on choice and autonomy rather than dependence and fear. Ensuring a robust ombudsman program empowers our residents and helps assure quality of life and quality of care, which are the hallmarks of an effective and efficient senior aging network.

Thank you for the opportunity.

[The prepared statement of Suzanne Messenger appears in the Appendix on page 49.]

Senator MANCHIN. Thank you.

We'll go down through the witnesses and then we'll go to questions, okay?

Brenda, if you would?

STATEMENT OF BRENDA LANDERS, DIRECTOR, METRO AREA AGENCY ON AGING, DUNBAR, WV

Ms. LANDERS. Good morning, Senator Manchin, Congresswoman Capito, Assistant Secretary Greenlee, and other distinguished members of the committee. Again, I'm Brenda Landers, the Director of Region 2 Metro Area Agency on Aging, located in Dunbar, West Virginia. Again, thank you for the opportunity to testify on behalf of the West Virginia Area Agency on Aging. I will attempt to explore the history of the AAAs, identify and address future challenges facing West Virginia's aging population, and provide recommendations for the reauthorization of the Older Americans Act.

West Virginia's AAAs assisted in establishing many non-profit organizations in the early 1970s. These organizations became the county aging programs, offering services such as nutrition, transportation, and social services which have become very visible and much-needed services in West Virginia.

The West Virginia Bureau of Senior Services, BOSS, is the state unit on aging designated to receive Federal and state funds for senior programs. BOSS contracts with the four regional AAAs to administer funds from the Older Americans Act and the West Virginia Bureau of Senior Services.

The AAAs develop or enhance comprehensive, coordinated community-based systems that serve all 55 counties through four regional offices located in Wheeling, Dunbar, Petersburg and Princeton, West Virginia. The AAAs contract with aging county providers for the provision of meals, transportation, and in-home services. The AAAs also have a monitoring system in place to address waste, fraud, and abuse.

It's the AAAs responsibility to provide assistance to the service providers, as well as to manage and monitor the responsible use of Federal funds utilized for specific programs. Each AAA employs a monitor and has a monitoring review process to determine compliance with the requirements of state and Federal funding entities, applicable laws and regulations, and stated outcomes. AAA monitoring activities include desk audits, review of reports submitted by the providers, site visits to review financial and programmatic records, and observation of daily operations.

Regarding the reauthorization of the Older Americans Act, on behalf of the West Virginia Area Agencies on Aging, I respectfully

submit the following recommendations: consolidate funding for congregate meals and home-delivered meals to allow flexibility and meeting the demands of the affected communities; expand the range of Title III services for which cost sharing is permitted; and require states to request a waiver for cost sharing for nutrition and case management. Also, provide additional funds to states as an incentive for high performance and achieving program goals. In addition, our West Virginia AAAs would recommend an increase in the monies for the core Titles of the Older Americans Act; and also new use of Federal monies to augment existing state funds for ADRCs.

West Virginia remains one of the oldest states in the nation. Planning for the future will make sure the needs of senior West Virginians and their families are met. The National Area Agency on Aging recommends establishing new provisions with dedicated funding, authorizing the AAAs to assist county and city governments in preparation for aging in their communities. These provisions would authorize funding and outline the roles and activities to be performed by full-time planner/community organizer position. The new position would take the lead role in working with other agencies and stakeholder organizations in the development of a comprehensive livability plan and implementation strategy.

West Virginia communities will need to provide an array of services, including facilitation of more accessible housing, preventive health care, including health and lifestyle education, and immunizations and screenings to reduce injuries and the onset of chronic diseases, and a range of in-home health assistance to keep people in their homes longer.

The four West Virginia AAAs received a $488,000 grant for Money Follows the Person or Take Me Home West Virginia program. This program will assist West Virginians as they move from a nursing facility or a hospital to a residential setting in a community. The West Virginia AAAs recently applied for the CMS' Health Care Innovation Challenge in the amount of $7 million. The intent of this program is to develop and utilize strategies to decrease the behavioral health risks for preventable chronic diseases in West Virginia's senior population.

The AAAs proactively carry out, under the leadership of the West Virginia Bureau of Senior Services, a wide range of functions related to advocacy, funding, planning, coordination, inter-agency linkage, information sharing, brokering, monitoring, and evaluations. West Virginia Aging and Disability Resource Center plays an integral part in meeting the needs of seniors and persons with disabilities. The ADRCs strive to reduce consumer confusion and build trust and respect by enhancing individual choice and informed decision-making.

It's important that the ADRCs remain independent since they are the first place to get accurate, unbiased information on all aspects of life related to aging and living with a disability. ADRCs are reaching many consumers who do not frequent the county senior centers. There's a great need for Federal dollars to accompany state monies to continue the ADRCs' mission.

It's very important that we view seniors and the aging Baby Boomer population as community assets, not simply the focus of burgeoning cost. West Virginians need to devote more efforts to fos-

ter job creation and create incentives for employers to hire this population. The modern focus of aging no longer remains on increasing the quantity of years but rather on enhancing the quality of years lived through a balance of physical, mental, and social healthful behaviors.

As West Virginia's 65 and older population increases, it's important that individuals have access to an array of services that promote physical activity, mental fitness, social health, and overall health and wellness support. The provision of health promotion and disease prevention programs are essential for effectively enhancing the health of our senior population while reducing the burden of their health care costs.

In conclusion, thank you for the opportunity to share with you the history and the goals of the West Virginia AAAs and their plans to address future challenges to our aging population.

[The prepared statement of Brenda Landers appears in the Appendix on page 56.]

Senator MANCHIN. Thank you so much, Brenda.

Janie.

STATEMENT OF JANIE HAMILTON, DIRECTOR, KANAWHA VALLEY SENIOR SERVICES, CHARLESTON, WV

Ms. HAMILTON. Senator Manchin, Congresswoman Capito, I'd like to thank you and your committee for the vision to come and look and hear from us who are advocating for the seniors of our country, and especially the State of West Virginia.

My agency, Kanawha Valley Senior Services, is the county-level agency that provides social services, in-home personal care and assistance through Waiver Medicaid Personal Care, Lighthouse, the FAIR program, the VA Homemaker Program, Creative Care, which is what we call our private-pay, in-home care program, the Family Caregiver Respite and Daycare—we have the social model located at the Tiskelwah Center in Charleston—and there is also a center, as you well know, at the Hansford Senior Center in St. Albans. There are health and wellness opportunities, computer literacy, transportation and support for 12 nutrition sites in Kanawha County.

As a local provider, my issue is to absolutely encourage you to reauthorize the Older Americans Act. And as Secretary Greenlee said, we have a flat funding for the last 10 years, and as the Baby Boomers are coming into this area of need, we are going to have to look at ways to increase funding. As she stated, her budget is very low for the amount of services we provide.

The oldest Americans are the fastest growing segment of our population, and that's going to continue for the next 20 years. So we really need to look at ways to increase the funding, as well as be efficient. We need to allow the cost sharing in the in-home care services, as has been already reported. We need to add more prevention and health education in all of the three program titles of BCMD, as well as Title 8.

We need to reduce and/or relax the excessive regulations and redundant regulations. Sometimes our reporting causes us to lose more time and money than we can be reimbursed for, and that

means every dollar we spend administering programs is a dollar less we have in providing service to the seniors themselves.

We definitely need more flexibility in the funding of the state units on aging, and we need a mechanism for the modernization of senior centers, perhaps adding an incentive for Federal community block grants to allocate money to senior center modernization.

You know, 30 years ago, when economies were in much better shape, the City of St. Albans reached out and funded their own senior center. No other community does that in our state. That should have been done. The original intent of the Older Americans Act was that the local level would embrace their seniors and fund their centers, and that isn't being done, and it can't be done now. There's no way we can go back to communities and municipalities and say you need to start funding your senior center at some level. The levels are very low, if any at all. So our senior centers are going to fall into disrepair because of the lack of funding because we're trying to just provide services.

At the county level, we don't really have the money to help them write their own grants and get monies from other sources.

As a county agent provider, my mission is to assist our aging population in attaining or maintaining a good quality of life for their remaining years using the resources available effectively. As economic problems prevail, the competition for available funds and other resources increase, making that part of my job a time-consuming endeavor. I spend way too much time seeking out funding instead of managing the programs.

With the surging boom in our aging adults just beginning to skyrocket, as you both alluded to, we are in the early stages of a challenge our country has never, ever seen before.

Another point I would like to make is there's a remarkable increase in Boomer generation grandparents raising their grandchildren. This is at the same time trying to assist their own aging parents. The number of grandparents raising grandchildren is increasing, currently 5.8 million children in the US. This adds a whole other dimension of need to the aging seniors.

Mental health services is another area of need. We are lacking severely in mental health services across the board, and right now I meet with 50- to 70-year-old adults whose parents are still living but suffering with some type of a mental health problem. The aging child doesn't know what to do for their parents, and they really don't have the time or energy to assist their parents, or even hook them up with what may be available for them. They're unprepared to cope, have no idea where to turn, and agencies like ours don't have advertising dollars. So that's where some of the flexibility needs to come in.

There are seniors facing addicted, mentally unstable adult children who are exploiting them, literally stealing their life savings out from under them, and they often have their medication stolen by family members who are addicted, or perhaps they're selling them on the street just for the money. Perhaps some funding for policing these things, educating the seniors about these things. We've had some movement in that area, but it definitely needs to be expanded upon.

We spend a lot of time in my agency showing proof of services. Extreme amounts of time is spent and not always reimbursed, again, for those hours. We have the layered challenge of complicated reporting requirements and excessive hoops to jump through to prove services. It causes us to spend money that we can't put toward assisting seniors.

As an example, the local VA has a slow reimbursement turnaround to the point where they're actually paying us interest because of their lateness in payments. VA cases are randomly assigned. So some more collaboration with the aging network and the VA definitely needs to be done so that we can bridge these services and work together to serve our senior veterans.

We need more flexibility in all of this. When Senator Manchin was our governor the Lighthouse program was developed. Right now, it is the most user-friendly service we have available. It allows for those who qualify to receive all that they need and not limited to personal care only. This is funded entirely by the State of West Virginia. There is a waiting list, but this model needs to be looked at at the Federal level for funding services.

The Family Caregiver Program is a wonderful program. Challenges by family member include availability of time, lack of training, their lack of health literacy, personal, physical, mental and financial issues, all that causes that adult family caregiver a lot of stress and then puts their health at risk. The success of the Alzheimer's Family Caregiver Respite programs is high, but we definitely need many, many more, as I'm sure Helen will attest to in the next few minutes.

We need to learn best practices and imitate them in all communities, and keep funding, if not increase it.

Community awareness of the symptoms of Alzheimer's is another thing, and elder abuse and exploitation, both in the urban and rural settings, must increase with some sort of maybe anonymous call-in line or a website where reporting can be done. We need to train local law enforcement, case management and social workers. EMTs and clergy all need to be included in awareness trainings that assist in detecting the symptoms at the earliest time so that plans for their care can be made by the individual before they become incompetent. A lot of times, family members don't realize that their parents are deteriorating mentally, and therefore they don't say "You need to make those plans for your future care before it's too late.", and then a family member is left to try to guess.

Transportation is definitely an issue, as you know, in a rural setting. We have a hard time providing all that's needed, and one thing that would be very helpful is routing software. If we had the funding, if there was specific funding or some collaboration with companies that provide this type of software, we could be much more efficient in our transportation efforts.

As a family caregiver and a sandwich generation participant, I'm the only child to my 84-year-old mother. She shares my home, and we have taken the steps to make her care needs as smooth as possible as they arise. I depend currently on the transportation services that my agency provides to get her to and from all her medical appointments.

We live in St. Albans. I work in Charleston now. It is much easier for me to meet her at her appointment. I'm her health advocate. But if I didn't have those transportation opportunities to get her up there, I would really, really be in a fix because I do need to work. I have a 20-year-old. That's the youngest of four children. And as you kind of mentioned, Shelley, kids don't just quit needing you just because they become of legal age. And so we're still sandwiched even though we don't have grade-school children at home or high-school children at home. We're still sandwiched between those two needs of our family members.

My mother enjoys the socialization opportunities available at the Hansford Senior Center in St. Albans, and I believe that these things have added to her quality of life, and she agrees. I couldn't work full time and help raise my children without this aging network that is in place, and I cannot imagine trying to do this in a rural area of our state.

So again, I will ask that you look at making sure that the Older Americans Act is reauthorized; if not, some funding increases put in place, and look at allowing cost-sharing for the in-home care programs. We need some support for the modernization of our senior centers, which you very well know is a very, very local level of quality of life for seniors in the area.

Our future is sure to test our country's ability to rise to the occasion and look to the good of those who are in need of protection rather than those who are capable of working towards their own support. We have had such a rich life here in our country. Those who have made this country great are living longer in larger numbers than ever before. We owe them all a debt of gratitude and all the support they need to spend their final years in peace and comfort. Don't forget, our children are watching.

Thank you so much for this opportunity.

[The prepared statement of Janie Hamilton appears in the Appendix on page 64.]

Senator MANCHIN. Thank you, Janie.

Helen.

STATEMENT OF HELEN MATHENY, DIRECTOR, ALZHEIMER'S OUTREACH AND REGISTRY PROGRAM, BLANCHETTE ROCKEFELLER NEUROSCIENCES INSTITUTE, MORGANTOWN, WV

Ms. MATHENY. Senator Manchin and Congresswoman Capito, thank you very much for this opportunity to testify on strengthening the aging network. Senator, as you mentioned, I serve as the Director of the Alzheimer's Outreach and Registry program at the Blanchette Rockefeller Neurosciences Institute. The institute is a unique, non-profit medical research institute dedicated to the study of memory and memory disorders, with its focus on Alzheimer's disease and related dementias. BRNI is operated in alliance with West Virginia University, as well as in collaboration with other academic institutions.

The Institute's Alzheimer's Outreach and Registry Program, the only one of its kind in the country, provides physicians with education and tools to improve screening, diagnosis, treatment and care of patients with Alzheimer's disease and related dementias. The continuing education sessions help connect the medical com-

munity with local resources to better link patient treatment and care, as well as to support caregivers through the disease progression.

The program also maintains the West Virginia Alzheimer's Disease Registry. The registry is a secure database that compiles demographic, diagnostic, and medical treatment conditions information about patients who have been diagnosed with Alzheimer's disease or a related dementia.

As I begin my discussion today, I would like for you to keep in mind a few key facts about Alzheimer's disease in West Virginia. I know you're well aware that, according to the Alzheimer's Association, 44,000 West Virginians age 65 and older have been diagnosed with Alzheimer's disease. Also, Alzheimer's shares similar risk factors as stroke and cardiovascular illnesses, including smoking, high cholesterol, obesity and diabetes.

Efforts to address this devastating disease must be bold. Until we find a cure for this disease, I strongly believe we need to develop a system of quality care for individuals with Alzheimer's disease and related dementias. This system would include four key components.

The first area is detection. It is important to distinguish dementia from temporary reversible conditions that may cause loss of cognitive functioning. Despite the availability of assessment tools, structured assessments for dementia have not routinely been incorporated into practice. One solution to this challenge is to utilize the Medicare annual wellness visit. It requires that detection of possible cognitive impairment be included in each visit, potentially resulting in earlier detection of dementia.

The next component is diagnosis and care planning. In primary care settings, physicians report insufficient time and reimbursement as important causes of misdiagnosis of care. Many times physicians will focus on the issue that brought the patient in that day. I recommend that Congress pass legislation to create Medicare coverage for a package of services that covers a clinical diagnosis of Alzheimer's disease, as well as care, planning, and coordination for the individual and their caregivers.

Next I suggest we build upon the medical home model and utilize technology to enhance quality and care coordination. An electronic medical record template could be standardized to include screening and diagnostic tools, educational information for the patient and caregivers, and links to resources. Finally, the system could include tools for advanced care planning such as advance directive and medical power-of-attorney forms.

The third area of the system is caregiver support. Approximately 70 percent of individuals with Alzheimer's disease and related dementia live at home and receive care from family and friends. In 2010, more than 105,000 Alzheimer's caregivers in West Virginia provided more than $120 million of unpaid care. I'm sorry, 120 million hours of unpaid care. West Virginia is fortunate to have the Family Alzheimer's In-Home Respite or FAIR program that can serve as a national model of care. I encourage expansion of quality, affordable home- and community-based services for individuals with Alzheimer's disease and their caregivers by increased funding for programs such as our FAIR program.

Another great resource for seniors is the new WVSeniorCare.com website that provides information about medical and social services, as well as health care facilities.

Finally, the fourth component of the system is workforce development. This is a critical piece that we must address the shortage of physicians, nurses, and other health care professionals to improve care for an aging population. Congress should explore the increased use of available tools such as tuition assistance, loan forgiveness, housing subsidies, and stipends that encourage health care professionals to pursue specializations in primary care and geriatrics, particularly providers who make a commitment to work in underserved communities.

The reality is that there are many West Virginians just like the Smiths. Mrs. Smith is 93 years old and is nearly blind. She's a diabetic, has congestive heart failure, and is in and out of the hospital numerous times a year. Her husband has hearing problems, and his vision is impaired due to a stroke. The Smiths live in their own home. Because of their illnesses, they're on multiple medications and they face high deductibles and medical co-payments. The Smiths, like many seniors, want and need high-touch, not necessarily high-tech, care. They need assistance with chores around the home and medication management. The Smiths need and deserve a quality system of care.

In conclusion, I applaud your interest in identifying ways we can improve the efficiency and the effectiveness of the aging network. I want to thank you, Senator Manchin and Congresswoman Capito, for the opportunity to share with you suggestions about developing a system of quality care. I look forward to continuing to work with you on these issues, and I'll be glad to answer any questions.

[The prepared statement of Helen Matheny appears in the Appendix on page 69.]

Senator MANCHIN. Thank you, Helen.

James.

STATEMENT OF JAMES CLAGG, VOLUNTEER, MILTON SENIOR CENTER, MILTON, WV

Mr. CLAGG. Mr. Chairman and members of the committee, thank you for the opportunity to testify before the Senate Special Committee on Aging. We are James and Ellen Clagg. We represent the Milton Senior Center and the Cabell County Community Service Organization.

"Why don't you go to the center with me today? We have a lot of fun over there."

This is how I was introduced to the Milton Senior Center. My wife had been attending for about a year, and she enjoyed it very much.

My first thought was, "How can a bunch of old people have fun?"

[Laughter.]

"What could they possibly be doing?"

When I started attending the center, the people I met were ordinary folks just like us. Some are still living in their own homes, but others are living below levels that they would prefer. Others are living alone in subsidized apartments, some in trailer parks. Most are failing in health and have limited income.

Where or how can they have fun?

At the senior center, they have a place to become part of another family.

I'm sorry.

The members may not be blood related. However, each one, in time, becomes a brother or a sister within the family.

We participate in a variety of games, bingo the favorite. We work table puzzles, exercising on our machines, have crafts to work on, sew, and make lap quilts for the shut-ins.

The Cabell County Community Service Organization, or CCCSO, as we know them, provides a warm meal daily. At this meal, we talk and exchange thoughts on any subject that might come to mind, a home atmosphere with family members.

The center provides a number of presentations by locals, as well as professionals. Senator Manchin visited us this past month and asked for our opinions and shared with us his on different subjects currently before Congress.

We have health screenings at least once a month where blood pressure and blood sugar levels are tested at no cost.

We also have monthly dinners where singers delight us with their music. Schoolchildren at Christmas have a wonderful program for our enjoyment.

Fun? You bet. But more than fun. A place where, for a few hours, we become a member of our family, members who will listen to our gripes, comfort each other in times of sorrow, and share in our joys. The center has become a major part of our lives.

In conclusion, we are grateful for the Milton Senior Center and CCCSO for all the help they provide the aging residents of Milton and Cabell County. We strongly urge you to support all senior citizen programs no matter what the organization may be called or what state they represent.

We are one family, all created by God, depending on him and each other. As our senator, we need your continued help and support.

Thank you for allowing us this brief time to testify before the committee.

[The prepared statement of James and Ellen Clagg appears in the Appendix on page 75.]

Senator MANCHIN. Thank you, James, to all of you.

Before we start our questions, again I want to recognize Mrs. Rocky Goodwin, representing Senator Jay Rockefeller here, who has been very involved in these issues also.

Rocky, would you have anything that you want to say?

Mrs. GOODWIN. The Senator apologizes that he couldn't be here today. He's been working diligently over the weekend on the surface transportation bill. But thanks, Senator Manchin, for convening this hearing today, and Congresswoman Capito for being here. He asked me to bring back all of the wisdom and recommendations of our stellar panel today.

Senator Rockefeller has a long history with supporting issues related to seniors. You may know that under his term as governor, we instituted all of the senior programs in every county, and he is proud that that has continued.

Certainly, from hearing from the ombudsman programs about the needs that you've expressed here today to the more detailed implementation of local programs from the Area Agencies on Aging and the county programs, and as you say, it's a family program, it's not just a county program in Milton, but also across the state, and has worked hard with obviously the Blanchette Rockefeller Neurosciences Institute on identifying need.

So the Senator has a staff in Washington, D.C. of legislative folks who deal with all of the issues that we've discussed today, legal help, the funding issues, and also has a number of case workers in the state, and you probably have dealt with his folks.

Please know that the door is always open to receive those recommendations that you have, as you here today on the front lines have the best information on policy moving forward. So, thank you.

Senator MANCHIN. Thank you, Rocky, appreciate it.

Let me start with our questioning now, and I'm going to go to each one of you, and I want to thank you again. Then Congresswoman Capito can proceed with hers.

First of all, to Suzanne Messenger, I know you talked about the exploitation—and I think, Jane, you did, too—of our seniors. Let me tell you how this came to light to me. One of my first Aging Committee meetings, Mickey Rooney came, and I don't know if you all read about that or heard about that, but having a high-profile person like Mickey Rooney that we grew up watching every one of his movies and just as a person you think, well, they're untouchable, they'll never fall into that trap, and when he tells you his story about what happened to him by a family member that just about literally wiped him out, I think it brought home to me. And I would never think of that because, you know, you think your family will take care and you don't have to worry about that in your family, but it can happen in any family.

How do you think that the best way to prevent that or educate residents and our caregivers? Is it the punishment, the laws? Is it the ombudsman overseeing? They don't want to talk. I mean, he even told us, he says I didn't want to believe it. He said I knew something was going on, and I knew my money was gone, but I didn't want to think it was my own flesh and blood or someone very close to me that I raised.

How do we do this?

Ms. MESSENGER. I think it has to be a multifaceted approach, Senator Manchin, and certainly good laws are a place to start. Our legislature is working on——

Senator MANCHIN. I guess, Suzanne, what I'm asking, do you see a lack? Have we missed laws that should be there? Is the punishment not severe enough for the crime they're committing in exploiting their own family?

Ms. MESSENGER. That's a good question, Senator Manchin, and I suspect that's a piece of it. Another piece of it is many of us don't realize—the awareness simply isn't there. I think Mickey Rooney, one of the best things he did was make it okay to talk about these sorts of things and not to think, well, I should have known better, that shouldn't have happened to me, I did something wrong because now this person has all my money, to reach out and ask for

help, to get better education among the people that help our seniors.

As I said earlier, many people think that a power of attorney gives me some magic power over somebody, and it works just the opposite. You have power under the person you're supposed to be helping, and I think many of our seniors and many of us in this room maybe don't have as good an understanding about that.

It's okay to ask questions, to do better education about what happens, and then we absolutely have to have prosecution. We have to enable our prosecutors and law enforcement. These are complicated cases. They're paper-specific. They take lots of bank records. The people that are involved are sick people who get sicker and may even pass away before this works its way through the court system. So maybe we need to think about having an expedited process to address financial exploitation.

Senator MANCHIN. The final on that to follow up is that basically you talked about drug abuse.

Ms. MESSENGER. I don't think that was me.

Senator MANCHIN. Okay. I'm sorry.

Ms. MESSENGER. I could talk about drug abuse if you'd like.

Senator MANCHIN. First of all, it's an epidemic in this nation, not just in West Virginia, not just in your county, or not someone in your family, because I don't think there's a person in this room right now, and I'm one of those people, that doesn't know someone in their immediate family or extended family, very close, that has not been affected by this. Most of it is legal prescription, and I did not realize how many family members are taking from their own family, especially their grandparents. I just did not realize the severity of this problem.

I don't know what we do on that except I'm thinking of this, and you chime in and help me on this, Janie. Let's say my mother is on prescription, whatever it may be, probably pain relief, a painkiller, and she has to go back because they're missing, and she doesn't know if she took too many or what happened to them. So she has to go back at more frequent times, more frequencies to make sure she has her medication. Now, something has happened. A pharmacist right then should be able to flag that and know, wait a minute now.

You see, I don't know what we're lacking. Is there some type of reporting, Good Samaritan reporting? Everything doesn't have to be criminal, but I know that family members don't want to tell on their grandkids or their children that's taking the drugs and using them not for the purpose they were prescribed to me for. But there has to be somebody that can get us on the trail of that to stop that.

Do you have any recommendations on that?

Ms. HAMILTON. Well, there's a lock box program in place that has been funded through some small grants that can be effective. But again, you've got a senior that has trouble with a medicine bottle, and you have a lock box with a combination of some sort, it's good for the storage of the medications maybe you don't take very often. There does need to be a system in place whereby a responsible caregiver can oversee.

Oftentimes, pain medication is only taken as needed. So if the person has a 30-day supply and they haven't taken but 5 or 6

throughout the 30 days, if the rest of them are gone and they go back for a refill, the pharmacist isn't going to catch that. He would assume that person has taken it every day.

Now, if the pharmacist could stop and say, "Well, Mrs. Smith, I see you've taken 30 of these in the last 30 days. Does that mean your pain has increased? Do you need to talk to your doctor?" And get a conversation going. But again, that's going to be up to the pharmacist.

Senator MANCHIN. Do you all have any conferences with—I think we have a tremendous network of pharmacists that do a wonderful job. But if they don't communicate and don't know what to look for, are you doing that? Could we help facilitate that on a state level?

Ms. HAMILTON. We should.

Senator MANCHIN. Okay.

Ms. HAMILTON. That's another person on our list of people who need to have this awareness.

Senator MANCHIN. I got you.

Ms. MATHENY. Senator, there are a lot of items that are being talked about right now in that regard. A lot of that responsibility falls on the primary care physician or the physician who wrote that original prescription. If they go back for a refill, that individual should probe and ask questions, what happened to the medication.

The other thing is the database now that we have, the pharmacy database, that will be an effective tool in that toolbox too, that you can track and see what medications are being prescribed.

Senator MANCHIN. Brenda, if you will, I know we talked about the consolidation of programs and things of this sort, and maybe you can tell us a little more about what it would mean to your organization if we were able to do some of this, how much better services could you do if you could consolidate some of them?

Ms. LANDERS. Consolidate nutrition? Right now, when we send out nutrition funding, they divide it between C1 and C2, which is a home-delivered meal or a congregate-setting meal. And at that point, if they go over in one, then they have to come back to the AAA and say I need to transfer funds. So I think it would be easier if the county had that liberty or that flexibility to be able just to serve the meals that they need, whether it be C1 or C2, because as we've often stated, every county is different. I may have a county that has more rural; they're going to need more C2. It would just give them the flexibility of being able to serve either a C1 or a C2 without coming back to the AAA and saying I need to transfer funds. Just give them that liberty to serve all the C1 or C2 that they need, and then they can bill us. And at the end of that grant period, then we can say this amount was served. So it would just give them some flexibility.

They have that ability to somewhat do that now, but then they have to come back to the AAA and say, you know, I need to transfer funds or I'm going to over-serve in one, and I think that time given is at the end of May they lose that opportunity to transfer funds. So it would just give them some flexibility to be able to serve what they need and not have to designate that we want to serve 15,000 C1 and 16,000 C2. If we could just give them a little more flexibility, to serve as needed in their communities.

Senator MANCHIN. Helen, if you could, explain the FAIR program. I think you're familiar with the FAIR program. And, Kathy, I think that you've heard from everybody about this program we started in West Virginia because of the need we have and how well it has worked. If you could explain a little bit, Helen, about how you think that could be looked upon on a larger scale, if you will?

Ms. MATHENY. Well, sure. From what I understand, it is a huge success, and it's available in every county in the state, the Family In-Home Respite Care program, and it just provides families that needed break with trained, screened people to come into the homes and to help provide some chores, some personal assistant bathing and those types of things. But it's a really valuable resource. The legislature increased funding last year by $1 million for it. There's still a waiting list. But again, I think it could be a national model, something to take a look at.

Senator MANCHIN. I will say this, Secretary. Our purpose for that was to reduce our cost but to give quality care and to have people have respect and dignity. We were wearing the family members out, and both of us, the Congresswoman and I both understand how much care it takes, and we have to have competent people. But let's just say the family members were trying. They wear out and they give up, and they say I can't do it any longer. Well, you know what happens then, and you know where the costs go. You just mentioned about the accelerated cost that's involved when they come into a nursing home.

That was the whole purpose, and it has I think worked extremely well and been extremely successful. We think it's the best, and Sandy Vanin, who was my commissioner at that time, really got it going, and we'd be happy to work with you to really show you the ins and outs and the things we think are great, the mistakes we made, how we could better improve upon it.

Sandy, if you would be helpful if the Secretary would need anything, I would appreciate that.

And finally, James, I want to thank you. I'm going to ask you a question. But first of all, you basically said everything, and the way you said it is why we're here. It's family. Whether you have your blood family with you or not you become family. Tell me how you and your lovely wife got into the whole volunteering. I guess she kind of brought you along. It was contagious, right?

Mr. CLAGG. Right.

Senator MANCHIN. How did she get involved? What made her——

Mr. CLAGG. She had retired recently, I think, and her sister and her are pretty close and they wanted to get out and find other activities now that they were retired, and they started going over to the senior center. And like I said, they came home and told me they had a lot of fun. I couldn't understand it, because I was still working at the time.

[Laughter.]

Mr. CLAGG. I just couldn't understand what was going on. But now I see much clearer now.

Senator MANCHIN. And you see the quality of life, right? It has improved the quality. I mean, people live for that, right? That's their family.

Mr. CLAGG. Exactly. They look forward to it every day to go to the senior center.

Senator MANCHIN. How many of you think that's the only nutritional meal they get? Just percentage wise, half of them, 10 percent, or a majority?

Mr. CLAGG. Well, basically let's say, go with 25 attending, I know 3 of the 25 ——

Senator MANCHIN. That's it.

Mr. CLAGG [continuing]. That's probably the only meal they get.

Senator MANCHIN. I know how true that is. And you know how hard it is to cook for one person. As you grow older, it's not worth the effort.

Yes, Janie?

Ms. HAMILTON. At the senior center in St. Albans, where 50, 60, 70 people a day would be a regular number, in the past I've seen them, the ones that are alone, take half their lunch and package it up to take home to have for dinner. They're there every day. So, you know, there's quite a few in that department.

And then the men who are widowed, in that generation the wife did the cooking. People go home and don't eat well, if at all, because of the fact there's no one there to fix his dinner.

And I know of a veteran who lived alone who is a widower who would walk with his walker from his home every evening or early afternoon, late afternoon to the Tudor's to get the beans and corn bread because that was cheap, and he would eat and go back home on the walker, because he wouldn't even call us for a ride because of his pride and not wanting to take something that he had not paid for. So you have every area of need being met at the senior centers.

Senator MANCHIN. I would like to have one more, and then I'm going to turn to the Congresswoman.

Secretary Greenlee, if you would, I know Brenda brought up the issue of older workers, and we've been blessed with some health. When we grow older, we still want to be contributing. I think it's very important for us to be productive for as long as we possibly can, and think that we've paid our way.

What are you all doing, or the Administration on Aging doing, that can help seniors who really want to work find work? Do we have a centralized—in West Virginia, are we networking to where a person that's looking for a more experienced—I hate the word "senior"—a more experienced person who has had a lot of life experience, can we match them up? Someone who says I need this type of person who has had 40 years' experience, they might be 65 or 70 years of age, is there anything that you know that we link them up in the state, or anything on the Federal that could be done?

Ms. GREENLEE. There is one section of the Older Americans Act that is not administered by the Administration on Aging, the Senior Community Services Employment Program. It's Title V of the Older Americans Act, and it's meant to provide support to low-income seniors so that they can continue working in the workplace. It's often administered at the State level by the Department of Labor. That's where it's administered Federally. But when it gets to the local organizations, many of them will run the Title V program. I took a trip to Los Angeles and met many of the people who

are getting this support, where seniors really need some extra income, to work.

One of the requirements for the staff who are working to help the seniors, the staff in the Title V program, is to also work with the one-stop shops from the Department of Labor. So if there are seniors who have more resources than the low-income seniors, you can also get them connected to the one-stop system. That's where, in the whole employment universe, they are a whole other world in terms of one-stop information assistance and employment. You want to make sure that the senior programs can address the high-risk populations, but then also get to the more mainstream or traditional Department of Labor supports for other people who want to stay working.

We all know, anecdotally and through data, the number of seniors, who because of the economy, have had to postpone retirement or need to go back to work in order to make ends meet.

Senator MANCHIN. Thank you all.

Congresswoman Capito? I'm sorry.

Representative CAPITO. Thank you. No, thank you. This has been great. I want to thank all of you all who have testified.

James, I'm going to start with you. Your comments I think touched everybody in this room, and obviously you give a lot, but you get a lot in return, and I think that's great.

I will say, as someone who has traveled, I don't go to Milton because that's over in Cabell. That's the next county over from my district. But when I go to Hansford and others, I gain a lot of wisdom that is at the senior center. So when you said you sit down for lunch and you saw problems, you could probably solve this debt problem for us right off the bat. So keep that up. I know that keeps you going, and bring all your comments to the senators and your congressmen because we appreciate that wisdom.

You mentioned that there might be 25 people at lunch, and I know the Hansford Center has 7. It's probably one of the largest ones, certainly. But there are a lot more seniors out there that, if they knew or if they maybe could get over the fact, like you had in the beginning, what could I really want to go to a senior center for, and it was mentioned that there was no dollars for advertising the senior center, how do you think we get more seniors to the senior center to realize all the good things that are going on?

I mean, obviously, transportation is an issue. But let's say that person didn't have a transportation issue. They had a family member or something. How would you reach out to those folks? Do you have any suggestions for that?

Mr. CLAGG. It would have to be a more one-on-one thing.

Representative CAPITO. Word of mouth kind of thing?

Mr. CLAGG. Word of mouth, or members that are already there participating spreading the word to others, because when you get to my age, and you're soon to be——

[Laughter.]

You do not care much about pamphlets being handed out to you.

Representative CAPITO. Right.

Mr. CLAGG. That's just something you don't understand to start with, and it's a waste of time. So there it goes, in a bookshelf or something.

So we need some kind of a one-on-one thing, or just like the programs you were talking about, the one-stop shop place, that's a terrific idea, terrific.

Representative CAPITO. Well, I don't know. I'm just sitting here sort of brainstorming and thinking if you had a volunteer corps, or I don't know. The press remembers—or the folks that are your frequent flyers, to go out and talk to other people, because you obviously know well. You can't advertise on the Internet because a lot of seniors aren't on the Internet, and you can't say how great it is. There aren't blogs around talking about what a great time we're having down at the senior center. I mean, that is just a generational thing.

But I will say in terms of technology, one thing that—I keep alluding to my own personal situation here. But one thing that I found that is a really neat tool for the future are iPads for seniors, same as they are for children. I mean, I can get my iPad out and show the family pictures, and it is a really great way to spend a day. So, anyway, I'll just put that little nugget out there. Maybe that's a good Federal-funded technology initiative.

[Laughter.]

I mean, I know you've got the computers, but there are even easier methods now.

I wanted to ask Suzanne Messenger about the ombudsman. Is your program state or federally funded?

Ms. MESSENGER. It's a blended program. I'm the state ombudsman, and I work for the Bureau of Senior Services. I'm a state employee. We get Federal dollars, and we also get some matching state dollars. I oversee the contract that the Bureau has with Legal Aid of West Virginia.

Representative CAPITO. Okay.

Ms. MESSENGER. That's the regional office.

Representative CAPITO. That's what I was going to ask you. What kind of coordination do you have with Legal Aid? Because I'm sure your resources are really slim, and to get to this, how do you network out from where you are? Through the legal community, or does the bar, the West Virginia Bar Association help you, or the law school?

Ms. MESSENGER. With ombudsman services?

Representative CAPITO. Well, just—yeah.

Ms. MESSENGER. Not so much with ombudsman services. We have a good partnership with our aging and disability resource centers. That kind of seems like a natural partnership. The aging and disability resource centers, as you've heard many times today, are that one stop, sort of that single entry point for long-term care.

Representative CAPITO. Right.

Ms. MESSENGER. And then if there are problems in residential care facilities, the ombudsman provides a good support.

Representative CAPITO. Right, right. And then, Brenda, staffing, there's a huge problem. I mean, traditionally low paying jobs for caregivers. As soon as they—many times, we have the issues with the abuse. If you pick somebody up that maybe is not bonded or with an agency, I think you have some safety issues and legal issues. Unless you have somebody right there—and even if you do, I guess like Mr. Rooney did, it still doesn't matter.

What are you doing to—are you looking—what kind of workforce development things are going on right now that are going to be able to meet this huge need?

Ms. LANDERS. As far as caregivers?

Representative CAPITO. Yeah.

Ms. LANDERS. We are working on a statewide registry for in-home workers to know that they've been through proper training, that they have looked at background searches and things, and that's one thing that we are working on.

Also, I think it would help with what we talked about, the drug abuse, that we have caregivers in the home that we know have passed background searches, that they're not stealing medications.

Representative CAPITO. You know, an individual family can't do a background check.

Ms. LANDERS. No, but we were working on a state registry so that these workers would go through the registry that we have somewhat for nurses. Now we have in-home workers that would be on this registry that you could go and pick a home worker and know that they're qualified and they have all of this, so families can pick up the phone and say I need a worker, and we have our ADRCs or our aged and disabled resource center that could go into this registry and be able to supply a worker.

Representative CAPITO. Is there a shortage right now?

Ms. LANDERS. Of workers? Yes, because of, as you say, because of income. I mean, the wages are just so ——

Representative CAPITO. And it's hard work.

Ms. LANDERS. It is hard work, and there's lifting and there's tugging. We just don't have enough money, but we're dealing with it.

Representative CAPITO. Then I want to go over to Helen, Ms. Matheny, on the medical professionals, because I think one thing that—while the primary caregiver has an experience in a myriad of different physical and mental issues, because that's why they're a general practitioner mostly, but there are certain specialized areas that a gerontologist, or in the area of gerontology

Are younger students going into this, medical students, to face this challenge? I mean, when you look around the state and try to find somebody who is an M.D. that has a specialization here, it's scarce.

Ms. MATHENY. Absolutely.

Representative CAPITO. Is it getting any better?

Ms. MATHENY. It's not getting any better. The number of board-certified geriatricians is very small in the state. And so that's why I'm encouraging Congress to help to continue to incentivize for that. And in the meantime, that's what we're trying to do with our continuing education classes, is to get out there to the primary care physicians to provide additional training with geriatrics to help them help their patients.

Representative CAPITO. I think you mentioned that some reimbursement services for these kinds of—when you talk about pharmacists, I know this has come up from time to time. Is the pharmacist going to get paid for the 15 minutes that they're going to work with the senior to find out if they have conflicting medicines or do they understand when to take it?

We went through this with the prescription drug bill when it was created in 2003, and I don't think we've solved this issue, because in a business that's made on the bottom line, time is money, and if you're getting paid to talk—are you getting paid to talk and to understand? And a lot of times, the first time you say it, you've got to say it more than once and in different ways.

Is this an issue? I mean, Janie, obviously——

Ms. HAMILTON. I have a health background as well, and there are a lot of health literacy issues. If I wasn't there to advocate for my mother, she wouldn't understand or remember half of what she was told, and she's not an ignorant person. She's fairly savvy, but the generational thing, the lack of health literacy—I mean, there are people across the board, all ages that have very low health literacy.

There's a movement in our state to eliminate that, but we have to start not only from the top down but from the bottom up.

Representative CAPITO. Well, you've asked for flexibility. Is this something that you think more flexibility in the Federal standards, and state, or either/or——

Ms. HAMILTON. Health care advocacy could be part of the aging network if we had the health field and the aging programs come together and fund, allow funding for a health care advocate for maybe each senior center, at the very least, to help do nothing but assist seniors with their communication skills with their physician, teach them how to take charge of their own health, help them understand what things mean, them and/or their family members that are maybe their advocates. A lot of times the family member is their advocate, but they don't understand it either.

Representative CAPITO. Is that different than the SCHIP? Because the SCHIP is mostly with the insurance?

Ms. HAMILTON. Yes. That's just assisting the seniors. You know, Medicare Part D, my goodness, that's a thing in itself that has been—so many seniors are completely just at the mercy of whomever they can get to help them make decisions. And a lot of times, when they get the letter for open enrollment in the mail, they just keep what they've got, and it may not be the best thing for them. They don't even understand that they have an option. The fact is they have to go through the process of getting the counseling through the SCHIP program in order to help them find that. There are a lot of complicated things that older adults don't understand and need that support to make better decisions for themselves.

Representative CAPITO. Well, I think this has been a very interesting, enlightening panel. One of my colleagues came to me last week. She's probably—I don't want to say how old she is, 68 or 70 maybe. She looks at me and she goes, "Guess what?" I said, "What?" She goes, "I'm going to live until I'm 100." And I said, "What do you mean?" And she goes, "Well, the statistics are that if you get to a certain age, that you're going to live to 100." And I'm thinking to myself, is that a good thing?

[Laughter.]

She says, "No, it's not a good thing." But when you look at what Alzheimer's is doing to not only young people but more increasingly as people get older, dementia just creeps in no matter what, and then to certain degrees we're just going to have all kinds of issues,

especially if we are living to 100. Maybe our bodies are taking us to 100, but our minds have left us at 88.

So it's a challenge, and I think you all have been great demonstrators that it can't be solved as a Federal issue no matter how aggressive and well funded and good intentioned. You've got to have James and Ellen at the senior center willing to dedicate their time and energy, and the family members that do that, too.

So I appreciate everything I've learned today, and I appreciate all of you all working in this field. I know it's rewarding, but it's very tough. So thank you for what you do.

Thank you, Senator, for including me.

Senator MANCHIN. Thank you for being here, Congresswoman.

And speaking of that, someone told me that if I start taking the fish oil pills, that it would help my memory. The only thing it's done is give me an urge to go swimming.

[Laughter.]

With that, let me just say this. Gaylene Miller, thank you so much. AARP, I know you do a great job, and Angela and all of you. And I hope this has been beneficial for you, too, because we interact so closely with you and your organization. If you could keep in touch with us, and also with Secretary Greenlee here. That's great.

And let me just say this to all of you. All of you have done a great job, and I appreciate it. The Secretary has been so accommodating, and I thank her for her graciousness and giving us her time.

But I don't want her to go back to Washington without at least each one of you giving her one recommendation of what needs to be fixed in your world, of what you're seeing. Something can make it better, and let her evaluate that, because if it works here, it will work anywhere. We have more challenging demographics, and our topography also, and I think I've said that. If you ever are looking for that pilot project, you have a theory, you don't have to throw money at us, and if we say give us a little flexibility, give us some maneuverability and we'll tell you if it works or not, that's what we're asking for, Kathy. And I just appreciate so much you being here, I really do.

So on behalf of all of us and all of you who have come, I hope it's been enlightening to a lot of you. And you're going to be around, I understand, and spend some time, and I would challenge you all to please share that with the Secretary because she's on the front line. She's going to be the one very much involved in the Older Americans Act and how we do this and how we go forth, and really basically lobbying for what needs to be done for all of us as we grow a little bit older.

Thank you, and that concludes our hearing.

[Whereupon, at 11:37 a.m., the hearing was adjourned.]

APPENDIX

Testimony of

Kathy Greenlee

Assistant Secretary for Aging

U.S. Department of Health and Human Services

Before the

Senate Special Committee on Aging

Hearing on

Strengthening the Aging Network

Charleston, West Virginia

February 13, 2012

Thank you very much, Senator Manchin, for the invitation to testify at this important hearing on the critical work of the national aging services network. It is an honor to serve as the U.S. Assistant Secretary for Aging and to listen to individuals and families in communities throughout the country, I have seen firsthand how the Older Americans Act (OAA) and the aging services network support the values I know we all share:

- Helping older Americans and persons with disabilities maintain their health and well-being so they are better able to live with dignity;
- Developing and implementing person-centered approaches;
- Promoting self-determination, respect, empowerment, inclusion and independence;
- Protecting the most vulnerable among us; and
- Providing basic respite care and other supports for families so that they are better able to take care of loved ones in their homes and communities for as long as possible, which is what Americans of all ages overwhelmingly tell us they prefer.

Last year the national aging services network served nearly 11 million seniors and their caregivers through home and community-based services. This was made possible by the Administration on Aging (AoA), 56 State and territorial units on aging, 629 area agencies on aging, 246 tribal and Native Hawaiian organizations, nearly 20,000 direct service providers, and hundreds of thousands of volunteers. These critical supports complement medical and health care systems, help to prevent

hospital readmissions, provide transportation to doctor appointments, and support some of life's most basic functions, such as assistance to elders in preparing and delivering meals, or helping them with bathing. This assistance is especially critical for the nearly three million seniors who receive intensive in-home services, half a million of whom meet the disability criteria for nursing home admission but are able to remain in their homes, in part, due to these community supports.

Here in West Virginia, in FY 2010 nearly 50,000 persons aged 60 and over received services and supports through the aging services network which helped them to better maintain their health and well-being in their homes and communities. Nearly 30,000 of these individuals lived in rural areas. These services included nearly 1.5 million home-delivered meals served to persons who are homebound, nearly one million meals in senior centers or other group settings, and more than 280,000 rides to and from doctors' offices and other important destinations.

We are proud of the assistance provided by the aging services network around the country and here in West Virginia, as represented by some of the witnesses you have invited here today. Dedicated people like Suzanne Messenger, the State Long-Term Care Ombudsman in West Virginia, and the regional ombudsman staff and volunteers of Legal Aid of West Virginia who advocate for persons living in nursing homes, assisted living and adult family care homes. They have been leaders in West Virginia's Financial Exploitation Task Force, which evolved from the work of the Ombudsman Advisory

Committee, and which successfully worked last year to make "financial exploitation" a crime in this State.

And also to dedicated leaders like Brenda Landers, the director of the Metro Area Agency on Aging, as well as the other three area agencies on aging in West Virginia, who listen to older individuals and their family caregivers and respond to their changing needs and preferences so that they can provide individualized supports and assistance.

And to people like Janie Hamilton, director of the Charleston Senior Center, and to the other senior center directors and staff who, day in and day out, help to ensure that older individuals better maintain their health and independence in their homes and communities.

This important support system of community-based assistance here in West Virginia, and across the United States, is facing many challenges due to our increasing aging population, but it has demonstrated its ability to effectively provide assistance. An analysis of the OAA's program data reveal that most indicators have steadily improved over the past eight years. Let me just summarize three important areas:

- **OAA programs help older Americans with severe disabilities remain independent and in the community**: One approach to measuring the value of the OAA's programs is the nursing home predictor score. The components of this composite score are predictive of nursing home admission based on scientific

literature and AoA's Performance Outcome Measurement Project which develops and tests performance measures. The components include such items as percent of program recipients who are transportation disadvantaged and the percent of congregate meal individuals who live alone. As the score increases, the prevalence of nursing home predictors in the OAA service population increases, meaning AoA is reaching those most in need of help. In 2003, the nursing home predictor score of program participants was 46.57. In FY 2009, this score increased to 61.0.

- **OAA programs are efficient:** AoA and the national aging services network have significantly increased the number of persons served per million dollars of OAA funding. In 2010 OAA programs served 8,459 clients per million dollars of funding compared to 6,103 clients in FY 2002.

- **OAA programs build system capacity:** One of the main goals of OAA program funding is to encourage and assist State agencies and area agencies on aging to concentrate resources in order to develop greater capacity, and foster the development and implementation of comprehensive and coordinated systems. This capacity-building at the State and community level is evidenced by the fact that for every dollar of Federal OAA funding for home and community-based services, States and communities leverage nearly three dollars in other funding from other sources.

I have seen firsthand how the advancement of new technologies, exciting innovations and an entrepreneurial spirit is assisting the aging services network in providing

support to families, older adults and persons with disabilities of all ages. It will be our families and caregivers that will remain the cornerstone of our support systems. We need to continue to work together and innovatively build upon what we have achieved since enactment of the OAA in 1965 in helping frail older Americans, persons with disabilities, and their family caregivers receive lower-cost, non-medical services and supports. These supports are critical for providing the means by which these individuals can remain out of institutions and live independently in their communities for as long as possible.

One of these important supports is prevention across the lifespan. The OAA, at its core, is about prevention - improving the social determinants of health. Additionally, the Affordable Care Act has begun to provide new preventive benefits and savings to millions of Medicare beneficiaries this year. Seniors and others covered by Medicare are already taking advantage of these important preventive services, including wellness visits, which can help prevent illness and save lives. If we can continue to encourage, support and establish more evidence-based prevention strategies that are applied to older adults and persons with disabilities, it well help address the epidemic of chronic diseases, and lower the health care costs associated with them. We need to work to ensure that older adults and all adults with disabilities are actively engaged in disease prevention and health promotion efforts. Positive and effective collaborations between the aging, disability and public health networks should continue to develop and expand.

Another important opportunity is to continue a holistic approach to health care through the integration of acute care, long-term care and community-based services. One of the basic concepts behind health care reform is to shift health care system incentives from one that is provider-driven to a system that is person-centered. Nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days – that is approximately 2.6 million seniors at a cost of over $26 billion every year.[1]

AoA and the national aging services network are working with the Centers for Medicare & Medicaid Services, hospitals, Accountable Care Organizations, and a number of other partners to better manage the transition from when an individual leaves a hospital for home or another care setting. The approach is to better ensure that individuals and families have the information, discharge plan, and individualized community services necessary to support these frail and vulnerable persons at home or in their new setting. By investing in this strategy we can reduce health care expenditures, better address chronic diseases, improve medication management, and enhance the quality of life for millions of Americans.

A third opportunity is that we need to continue to invest in community and person-centered services that can meet the needs of an increasingly diverse population. A key component of this strategy is supporting the concept of aging in place so that older persons and persons with disabilities of all ages can remain at home in the community with the appropriate supports and services for as long as possible.

[1] Centers for Medicare and Medicaid Services. http://www.healthcare.gov/compare/partnership-for-patients/index.html

Included in this approach will be coordinating, with family caregivers and others, assistance that is tailored to individual needs, such as transportation, affordable housing, and a range of supportive services.

One example of this approach is a collaboration between AoA, the aging service network and the Department of Veterans Affairs (VA), which has often provided assistance to disabled veterans through institutional supports. Increasingly, the VA is working with the national aging services network so that more person-centered community-based assistance can be provided to veterans of all ages in their homes.

As you are aware, Senator, the OAA is currently due to be reauthorized. It has historically enjoyed widespread, bipartisan support, due in large part because one of its great strengths is that it does not matter if an individual lives in a very rural or frontier area, or in an urban center – the programs and community-based supports it provides are flexible enough to meet the needs of individuals in diverse communities and settings. In preparation for the reauthorization process, beginning in early 2010 AoA conducted an open process to solicit public input from throughout the country. To that end, more than 60 listening sessions were held and online input was received that represented the interests of thousands of consumers of OAA services. During this process, we consistently heard that the OAA:

- "Is not broken" and that it works well as it is currently structured;
- Is helpful, flexible, person-centered and responsive to individual/community needs;

- Its national aging services network structure is the "glue" that holds everything together and is effective in coordinating services from multiple sources to build a seamless delivery system;
- It meets the goals established by Congress in providing assistance to help people maintain their health, independence, dignity, and avoid premature institutionalization.
- It is effective in targeting the poor, near poor and those who are frail and at risk of nursing home admission.

As the extensive public input we received shows, the Older Americans Act and the aging services network it supports is a strong base on which to build for the future. We believe that the pending reauthorization can strengthen the OAA and put it on a solid footing to meet the challenges of a growing population of seniors, while continuing to carry out its critical mission of helping elderly individuals maintain their health and independence in their homes and communities. It is important that we continue to increase alternatives to institutional care that are person-centered, consumer-driven and support individuals in their homes and where we continue to work together to test innovative ideas and implement the best evidence-based practices.

During our input process we were consistently told that, as it is currently structured, the OAA is very helpful, flexible and responsive to people's needs. We also heard a few themes, I will mention two today:

FIRST: Improve program outcomes by:

- Embedding evidence-based interventions in disease prevention programs;
- Creating incentives to enhance performance;
- Encouraging comprehensive, person-centered approaches;
- Providing flexibility to respond to local nutrition needs; and
- Continuing a strong commitment to efforts to fight fraud and abuse.

SECOND: Remove barriers and enhancing access by:

- Extending caregiver supports to senior parents who are caring for their adult children with disabilities;
- Providing ombudsman services to all nursing facility residents, not just older residents; and
- Using Aging and Disability Resource Centers as single access points for long-term care information to public and private services.

Let me give two brief examples of areas we would like to discuss as you consider legislation:

- Ensuring that the best evidence-based interventions for helping older individuals manage chronic diseases are utilized. These have been effective in helping people adopt healthy behaviors, improve their health status, and reduce their use of hospital services and emergency room visits.

- Improving the Senior Community Service Employment Program (SCSEP) by integrating it with other seniors programs. The President's 2013 budget proposes to move this program from the Department of Labor to the Administration on Aging at HHS. We would like to discuss adopting new models of community service for this program, ranging from intergenerational service that assists children, assistance with helping seniors remain independent in their homes, and continuing to support community organizations that rely on SCSEP participants for their valuable work contributions.

I commend you, Senator Manchin, for holding this important hearing and I look forward to working with you and with the Special Committee on Aging as the reauthorization process moves forward.

Thank you.

How We Can Improve Efficiency & Effectiveness of the Aging Network and Continue the Mission of Person-Centered Services at the Federal, State, & Local Level

Senate Special Committee on Aging Field Hearing
Charleston, WV
February 12, 2012

Testimony of Suzanne E. Messenger, State Long-term Care Ombudsman

Thank you Senator Manchin and Congresswoman Capito for the opportunity to testify today. As State Ombudsman I advocate for the rights of long-term care residents with the goal of enhancing their quality of life and while promoting self-determination. Consequently, I will limit my remarks to long-term care and its residents. I will discuss three areas this morning: (1) preventing financial exploitation of seniors; (2) providing services for residents with special care needs, include Alzheimer's disease and related dementias; and (3) ensuring a robust ombudsman program. I believe that by devoting our time and resources to these areas we can improve the efficiency and effectiveness of our aging network and continue our mission of person-centered services.

Prevent Financial Exploitation of Seniors

Although there are many legal definitions, financial exploitation is basically the unauthorized use of someone else's money or property. It can be as simple as using a credit card without permission or it can involve a complicated fraud scheme. The experts believe that statistics do not accurately reflect the magnitude of the problem. "There is wide consensus that currently a clear picture of the incidence and prevalence of elder abuse [including financial exploitation] in the United States is sadly lacking." (Executive Summary, *The Availability and Utility of Interdisciplinary Data on Elder Abuse: A White Paper for the National Center on Elder Abuse. April 27, 2006.*) Over a decade ago, estimates put the overall reporting of financial exploitation at only 1 in 25 cases, suggesting that there may be at least 5 million financial abuse victims each year. (*Wasik, John F. 2000. "The Fleecing of America's Elderly," Consumers Digest, March/April.*) As we heard from Mickey Rooney last year, things have not gotten better. In 2010, a MetLife study reported that the annual financial loss by victims of elder financial abuse is estimated to be at least $2.9 billion dollars, a 12% increase from the $2.6 billion estimated in 2008. (*The MetLife Study of Elder Financial Abuse, June 2011.*)

Exploiters are criminals, but sadly they are also often friends, family members, or others that the senior thought they could trust. Still another factor can make things even more

complicated --- when the alleged exploiter is acting under the authority of a legal document often referred to as a "durable power of attorney. Such cases often come to the ombudsman's attention because the resident receives a discharge letter for non-payment of his facility care. The perpetrator has legal access to the funds as the resident's agent and the resident victim is reluctant to make a report against a family member or unaware of the situation until nearly all of his money is gone. In addition, even if a resident finds the courage to report, law enforcement is either reluctant or unable to access the information necessary to prosecute. Victims are often sick and getting sicker. They may not be perceived as credible witnesses or may even die before they have their day in court. Finally, even when prosecutions occur, recovery of funds is rare. Perpetrators spend the purloined money. They do not save it. While punishment of the perpetrators is important, restoring the resident to her former position is equally important.

Consider Mr. Jones' experience: During a visit to an Assisted Living Facility, the ombudsman was stopped by Mr. Jones who complained that his son, who was his appointed medical and financial power of attorney representative, was trying to control his ability to leave the facility, receive visitors or even make phone calls. The son had moved Mr. Jones into the facility his wife of 60 years passed away. Mr. Jones was an intelligent man, but had never learned to read or write. For most of his life, he had relied on his wife and son to handle his financial affairs. The ombudsman intervened at Mr. Jones' request and attempted to work with the son, but the son insisted his father lacked capacity to make his own decisions and he had authority to control his father's communications and movement. His son's stubbornness angered Mr. Jones and he asked the ombudsman for help to revoke the power of attorney document that gave his son authority to make decisions on his behalf.

The ombudsman referred Mr. Jones to the local Legal Aid of West Virginia office, which quickly found a local attorney who agreed to revoke the power of attorney document and draft a new will for free. The ombudsman also connected Mr. Jones with the Legal Aid attorney assigned to the ombudsman program. Mr. Jones wanted help locating and securing his life savings. Mr. Jones had not been a wealthy man, but he and his wife had diligently saved throughout their lives so they could enjoy a comfortable retirement. Mr. Jones believed his savings were held in accounts at several area banks, but visits to those banks had proven fruitless and his son refused to tell him where his money was held. The son had also stopped paying his father's bills, including his rent at the Assisted Living Facility. The ombudsman found a bonded worker at the local Senior Center who agreed to come to the facility once a month to help Mr. Jones manage his small pension check.

In the meantime, the ombudsman attorney sent the son a letter and he hired an attorney to respond. Negotiations with the son's attorney were unproductive so at Mr. Jones'

direction, the ombudsman attorney and another Legal Aid attorney filed a lawsuit against the son to recover Mr. Jones' life savings. During this time, Mr. Jones' health declined and he required nursing home care. The ombudsman assisted Mr. Jones in locating an appropriate home and worked closely with him to ease his transition. After Mr. Jones was settled in the nursing home, the ombudsman continued to check in on him regularly and addressed a number of care issues at his request, including the onset of depression. The stress of the move, the loss of financial and physical independence, and the strained relationship with is son took its toll on Mr. Jones. The ombudsman brought in a Behavioral Health Advocate, also from Legal Aid, to work with Mr. Jones and help him find appropriate counseling services.

The Legal Aid attorneys continued to work closely with Mr. Jones, filing and successfully arguing a number of motions in court and engaging in mediation. After several months of mediation, Mr. Jones' son agreed to a settlement offer that ensured the return of approximately $180,000, his car and other personal property. A settlement order was signed by the judge only months before Mr. Jones passed away at the age of 96 — almost three years after initially contacting the ombudsman.

Mr. Jones' experience while moderately effective was certainly not efficient. We need legislation to strengthen the protections for durable powers of attorneys and make it more difficult for them to be abused. Our West Virginia legislature is currently considering enacting the Uniform Power of Attorney Act. This legislation contains important protection for residents who are the principals of these powers of attorneys. It provides a clear statement of the duties their representatives owe them. It also promotes the acceptance of powers of attorney the meet the act's requirements by holding third-parties liable for blanket refusals to honor them.

Additional education is also needed. Educational efforts could target residents and those who have access to their money, long-term care facility staff, financial institutions and law enforcement and prosecutors about the current laws and duties. For example, many residents, like Mr. Jones, currently believe that their representative can exercise powers over them and can punish them if they challenge or disagree with the representative. In reality, even under current West Virginia law, the representative is limited to the authority the resident gave them and owes him a fiduciary duty. The resident also retains the important power of revocation, firing the representative, as long as he has legal capacity. Many residents and their representatives, as well as a few attorneys, do not realize this. Had Mr. Jones and his son known this, perhaps much of what happened could have been avoided and Mr. Jones could have lived in the setting of his choice until he passed instead of fighting his son to regain control over his own money. Prevention of financial exploitation and a vigorous response, including restitution, is an important part of an efficient and effective aging network and continues our mission of person-centered services.

Provide Services for Residents with Special Care Needs

Many potential long-term care residents face obstacles in accessing care when they have special care needs, including needs that are associated with Alzheimer's disease and related dementias. A number of nursing homes refuse to admit people who have previously exhibited behaviors that are often associated with these dementias, including aggression, wandering, and sexual inappropriateness. Current nursing home residents who exhibit such behaviors may receive notices of involuntary discharge or may be sent to hospital psychiatric units and then refused readmission to their original nursing home. In the past, many of these individuals ended up in nursing homes in other states. However, as other states examine Medicaid expenditures and non-resident utilization of their systems they have restricted their eligibility requirements making even out-of-state placements difficult.

This obstacle to accessing services is partially attributable to West Virginia's relatively high nursing home bed occupancy rate. Most West Virginia nursing homes have no trouble filling their beds, so "cherry picking" is common. Providers prefer residents whose care may be less staff intensive and are able to maintain an acceptable census without admitting less preferable residents. But our high occupancy rate is not entirely to blame. Even providers who may be amenable to these types of admissions often find behavioral health supports are scarce. This leaves the providers struggling to meet these residents' needs without adequate support and needed resources. Additionally, when an individual is considered stabilized in a hospital setting, it is often based on an intervention, like the heavy use of psychotropic medications that may not be appropriate in a nursing home setting. Often, the nursing home cannot maintain these regimens and remain in regulatory compliance. The current reimbursement system does not allow for providers from the two settings to provide simultaneous services to the resident until an equilibrium can be reached. Instead, the resident often bounces like a ping-pong ball between the acute care setting and long-term care. This is not an efficient use of our medical resources and is rarely an effective way of caring for our residents.

Residents and their families must be assured that if they need specialized care in another setting, they can receive that care without risking their place in their nursing home. In order for this to occur, nursing home providers must have access to specialized services, including behavioral health services, and these providers must have an adequate reimbursement. Currently, there are not enough special needs providers in many areas of West Virginia and some existing providers intentionally choose not to serve long-term care residents because of the perceived low reimbursement. Reimbursement systems must be flexible enough to allow for two different providers to provide complementary services to residents with special needs rather than requiring the resident to bounce between settings in order to access care.

Residents with special care needs who also receive Medicaid assistance must be assured that their bed will be there if they need to go out to another setting to receive services. Medicaid bedhold currently provides this safety net for residents. Basically, bedhold pays the nursing home for an empty bed for a limited period of time while the resident is receiving care that the nursing home is unable to provide. Bedhold is an important part of special needs services.

Residents whose special care needs stem from terminal conditions or end-of-life issues must continue to have access to services, including hospice services, consistent with their directions to receive less aggressive treatment and instead receive services that are aimed at comfort and at allowing them to pass in the home of their choice, including the nursing home. Medicare and Medicaid's continued coverage of hospice services in a variety of settings, including a nursing home or assisted living residence, will enable this to occur.

Still another segment of people with Alzheimer's and related dementias find it difficult to access services when their needs can no longer be met in their own homes. This may occur when a caregiver falls ill or dies or when behaviors such as wandering or combativeness make it unsafe for the person to remain in their home. At this point, the person with Alzheimer's disease may be relatively physically sound but requires intensive supervision. Because she does not have high medical needs, she will most likely not qualify for nursing facility level of services. Although her needs could be met in assisted living, she cannot afford it. In West Virginia, there is no financial assistance for assisted living level of care. If people cannot pay for it out-of-pocket, they are absolutely barred from this level of care. Often they have to make do in the community, until they and/or their caregiver gets so sick that one or both require more expensive nursing facility care. Exploring other means of funding assistive living, including a Medicaid waiver, would expand access to services and increase their effectiveness while increasing the efficiency of our system.

Providing services for residents which special care needs and ensuring their ability to return to their preferred nursing home enhances the effectiveness of our long-term care system. End-of-life care, like hospice, allows residents to live out their lives in the place and the way that they choose. Ensuring that assisted living is an affordable option fills a niche in the long-term care continuum that may delay or even avoid more costly nursing home care. Together these services help to prevent residents from being shuffled across different settings and even states, promote a stable care system, and a stable quality of life for our residents. Our system is more efficient when services are delivered according to a well thought out system and not merely in response to real or created urgent needs.

Ensure a Robust Ombudsman Program

The Aging Network is made up of a diverse spectrum of services including direct service providers like nursing homes and county senior centers as well as in-direct support service providers like our Ombudsman Program and Aging and Disability Resources Centers. While the value of direct services is easy to quantify the importance of in-direct services can be harder to articulate

The Long-term Care Ombudsman Program is the only Older Americans Act program that specifically serves people who live in residential care facilities. In FY-2011 West Virginia's long-term care ombudsman program received 1009 complaints from, or on behalf of, long-term care residents. The ombudsmen verified nearly 70% of those complaints. They resolved, or partially resolved, 95% of the complaints they verified. They also provided over 1800 consultations to facility staff members and others. Through both complaint investigation and consultation, our ombudsman supported residents in exercising their rights, staying free from abuse, receiving quality services, and enhancing their dignity. When one administrator was asked what would be lost if there was no Ombudsman Program, he responded that "Residents would lose a channel of communication and support that helps them exercise their rights and freedoms."

Reauthorization and adequate appropriation of the Older Americans Act is one way to provide a solid basis for ombudsman services. Fully funding the protections and services contemplated by the Equal Justice Act, including funding for long-term care ombudsmen, Adult Protective Services, licensing and certification, and Aging and Disability Resource centers, will help to ensure a robust ombudsman program and many of its partners agencies and ensure that residents continue to receive quality, person-centered services. Enabling residents to solve problems before they escalate into major issues, helps assure that residents enjoy the best life and quality of care that they can and identifies inefficiencies in the delivery of care that compromise its effectiveness.

CONCLUSION

Improving the efficiency and effectiveness of the aging network requires all of our efforts. Preventing financial exploitation, and power of attorney abuse, not only protects our vulnerable citizens but also allows for a more efficient system based on choice and autonomy rather than dependence and fear. Providing services to residents with special care needs in the setting of their choice promotes a continuity of care and maintenance of support systems that can more effectively meet those needs while reducing the inefficient use of care in costlier settings. Ensuring a robust ombudsman

program empowers residents and helps assure quality of life and quality of care which are the hallmarks of an efficient, effective aging network.

Thank you again Senator Manchin for the opportunity to testify today and for your interest in these issues. I will be happy to answer any questions you may have or provide any additional information you require.

Respectfully submitted

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Testimony of
Brenda Landers, Director/WVSU Metro Area Agency on Aging
State of West Virginia

Good morning, Senator Manchin, Assistant Secretary Greenlee, and distinguished members of the committee. I am Brenda Landers, the Director of Region II Metro Area Agency on Aging located in Dunbar, WV. Thank you for the opportunity to testify on behalf of the West Virginia Area Agencies on Aging. I will explore the history of the AAAs, identify and address future challenges facing West Virginia's aging population, and provide recommendations for the Reauthorization of the Older Americans Act.

West Virginia AAAs assisted in establishing many nonprofit organizations in the early 1970s. These organizations became the county aging programs, offering services such as nutrition, transportation and social services which have become "very visible" and much needed services in West Virginia. The WV Bureau of Senior Services (BoSS) is the state unit on aging designated to receive federal and state funds for senior programs. BoSS contracts with the four regional AAAs to administer funds from the Older Americans Act and the WV Bureau of Senior Services.

West Virginia Area Agencies on Aging

AAAs administer and monitor $17,143,062 in federal and state funds for senior programs in specific geographic areas. The AAAs also operate 10 Aging and Disability Resource Centers (ADRCs) with State funds in the amount of $930,000. ADRCs also include the State Health Insurance Assistance Programs (SHIP).

The mission of the Area Agencies on Aging is to be the leader relative to all aging issues on behalf of all older persons in the planning and service areas. The AAAs proactively carry out, under the leadership and direction of the WV Bureau of Senior Services, a wide range of functions related to advocacy,

funding, planning, coordination, inter-agency linkage, information sharing, brokering, monitoring and evaluation. The AAAs develop or enhance comprehensive, coordinated community based systems that serve all 55 WV counties through 4 regional offices, located in Wheeling, Dunbar, Petersburg and Princeton, WV.

The AAAs contract with county aging providers for the provision of meals, transportation, and other in-home services.

The AAAs also have a monitoring system in place to address waste, fraud and abuse.

It is the AAAs responsibility to provide assistance to the service providers, as well as to manage and monitor the responsible use of federal funds utilized for specific programs. Each AAA employs a monitor and has a monitoring review process to determine compliance with the requirements of state and federal funding entities, applicable laws and regulations, and stated outcomes.

AAA monitoring activities include desk audits, reviews of reports submitted by the providers, site visits to review financial and programmatic records and to observe operations.

Accomplishments

The AAAs effectively ensure that the day-to-day needs of the aging and family caregivers are met through innovations and support services to older adults. According to the Bureau of Senior Services 2011 statistics:

- 164,284 unduplicated persons received services. A variety of home and community based services were included, such as support, congregate meals, home delivered meals, in-home care, preventative health and elder abuse programs, and outreach services.
- The WV State Health Insurance Program (SHIP) assisted 22,820 unduplicated individuals. The State Health Insurance Assistance Program provides free, objective, and confidential help to West Virginia Medicare beneficiaries and their families through one-on-one counseling and assistance via telephone.

- The WV Aging & Disability Resource Centers (ADRC) assisted 16,958 unduplicated individuals. The ADRCs assist seniors and persons with disabilities to navigate the state's long-term care system. ADRC professionals help individuals locate and apply for those services that most suit their independent living and long-term care needs. Statewide ADRCs began in 2007, as a result of funding provided by former Governor Joe Manchin III and the West Virginia's 78th Legislature.
- Personal Care Programs assisted 6,401 unduplicated individuals. Personal Care Programs provide assistance with activities of daily living to Medicaid recipients who have a chronic illness, medical condition or disability.
- The Money Follows the Person program or "Take Me Home WV" is a demonstration grant developed by the Centers for Medicare and Medicaid Services to assist West Virginians as they move from a nursing facility or hospital to a residential setting in the community.

Older Americans Act

The Older Americans Act has made possible significant opportunities to enhance the lives of aging West Virginians. Older West Virginians are more active in community life that ever before. Advances have been made in health care, education, technology, and financial stability which have greatly improved their vitality and standard of living. Older adults are out and about giving back and making a difference in their communities.

Reauthorization of the Older Americans Act

The AAAs support the recommendations offered by the National Association of Area Agencies on Aging to the Administration on Aging regarding Reauthorization of the Older Americans Act. West Virginia has a relatively small and diverse older population. That diversity is reflected in geography, income, literacy and health status. These WV demographics are challenging, and there is no "one size fits all" solution. On behalf of the West Virginia Area Agencies on Aging, I respectfully submit the following recommendations:

- Consolidate home and community based service funding. This would allow more flexibility to state agencies and local providers to decide how funds are allocated to best meet the needs of their communities. The needs of older West Virginians may exceed any one specific service program.
- Consolidate funding for the Congregate Meals and the Home-Delivered Meals to allow flexibility in meeting the demands of the affected communities.
- Expand the range of the Title III services for which cost-sharing is permitted, and require States to request a waiver to test cost-sharing for nutrition and case management, or to deny service to an individual for failure to participate in cost-sharing. Also, states will be required to demonstrate that no negative impact results from implementing cost sharing. Low-income individuals will continue to be excluded from paying under OAA cost sharing programs.
- Provide additional funds to the states as an incentive for high performance in achieving program goals.

Major Changes for West Virginia's Aging Population

"The problem will keep rising," said West Virginia University's Dr. Christiadi, of the state's aging population. Christiadi is a full-time demographer at WV Bureau of Business and Economic Research. The demographic program is a new program within the Bureau. Through specialized studies, the Bureau will be able to help people understand how the demographics fit into continued state and economic development.

West Virginia remains among one of the oldest states in the nation. The median age for West Virginians is 40.5 years, and the share of those who are 65 years or older is 15.8%.

Monongalia, Berkeley, and Jefferson counties have seen steady increases in population. They are also three of the counties with the youngest median population, which may make it easier for them to deal with the retiring baby boomers. On the other hand, Summers, Pocahontas, Tucker, Hancock and

Calhoun counties have experienced a drop in population and have even fewer young people and more older people than the West Virginia average.

Aging is a time of adaptation and change. Planning for the future will make sure the needs of senior West Virginians and their families are fully met. The National Area Agency on Aging recommends establishing new provisions with dedicated funding, authorizing AAAs to assist county and city governments across the state in preparation for the aging of their communities. These provisions would authorize funding and outline the role and activities to be performed by a full-time planner/community organizer position. The new planner/community organizer would take the lead role in working with other agencies and stakeholder organizations in the development of a comprehensive livability plan and implementation strategy, factoring in the range of community policies, programs and services.

To respond to the rapid rise in their aging population, West Virginia communities will need to provide an array of services, including: facilitation of more accessible housing; preventative health care, including health and "lifestyle" education, and immunizations and screenings to reduce injuries and the onset of chronic diseases; and a range of in-home health assistance to keep people in their homes longer.

The four West Virginia Area Agencies on Aging applied for, and received, a $488,000 grant for the Money Follows the Person or "Take Me Home WV" program. This program will assist West Virginians as they move from a nursing facility or hospital to a residential setting in the community.

The West Virginia Area Agencies on Aging recently applied for the CMS Health Care Innovation Challenge in the amount of $7,000,000. The intent of this program is to develop and utilize strategies to decrease the behavioral health risks for preventable chronic disease in West Virginia's senior population. The program will be a concentrated, statewide effort to reach individuals diagnosed with a chronic disease.

The program will concentrate on altering behavioral factors through a four-component process. The program will: (1) utilize the Stanford University Model for Chronic Disease Self-Management;

(2) improve nutrition through nutrition education, and the development of individual menu planning for participants by a Nutritionist/Registered Dietician (RD) to increase intakes of fruits and vegetables to 5 servings of each per day; (3) identify participants who need to increase physical activity based on ADLs, resulting in group and individualized plans for different levels of activity; and (4) enhance education and skills of in-home health workers employed by the county aging programs through training events focusing on nutrition education, food preparation skills, and recognizing symptoms of chronic disease. This initiative will be known as the West Virginia Senior Wellness Innovation Program (WVSWIP).

AAAs Role in the State's Long-term Plan for Community-Based Services

The AAAs proactively coordinate a wide range of services, under the leadership and direction of the WV Bureau of Senior Services, including advocacy, planning, coordination, inter-agency linkages, information sharing, brokering, monitoring and evaluation.

The Area Agencies on Aging plan, coordinate and fund a variety of programs that serve older adults, their families, and communities through four regional offices, serving all 55 West Virginia counties. The AAAs contract with county aging providers to provide meals, transportation, and other in-home program services. They also monitor the providers for programmatic and fiscal compliance.

WV Aging and Disability Resource Centers (ADRC) play an integral part in meeting the needs of seniors and persons with disabilities. The ADRCs are reaching many consumers who do not frequent the county senior centers. The ADRCs are designed to address many of the frustrations consumers and their families experience when trying to access needed information, services, and supports. ADRCs strive to create community-wide service systems that reduce consumer confusion and build consumer trust and respect by enhancing individual choice and informed decision-making. This breaks down barriers to community-based living by giving consumers information about the complete spectrum of long-term care options. West Virginia is also using ADRC funds to coordinate or redesign existing systems of information, assistance and access, and are doing so by forming strong state and local partnerships.

Challenges in Serving the Baby Boomers

Baby boomers are different in many ways from previous generations. First, they are more youth-focused and self-focused, and want not only to look good, but to stay healthy. Moreover, they are interested in achieving balance and flexibility in their work, leisure, and volunteer time, in their later years. Not content to use their retirement as a time to simply relax, baby boomers are interested in doing something real and substantial with their time, and in achieving meaningful and tangible results. They want to be able to choose the time, duration, and method of service, within broad guidelines. Through national and regional AAA conferences, participants have expressed that boomers want to be as free as possible of red tape, regulations, and bureaucratic barriers. And, importantly, they are interested in being recognized – either financially or otherwise – for their contributions.

It is very important that we view seniors and the aging baby boomer population as community assets, not simply as the focus of burgeoning costs. We can do this by creating incentives for employers to hire this population. West Virginia's labor force is getting smaller and older and is set to decrease significantly in coming years. West Virginia needs to devote more efforts to foster job creation for these boomers in order to reverse the decline.

Senior centers, policymakers, and community members play a vital role in the successful aging of West Virginia's older adults. The modern focus of aging no longer remains on increasing the quantity of years, but rather on enhancing the quality of years lived through a balance of physical, mental, and socially healthful behaviors.

As West Virginia's 65 and older population increases, it is important that individuals have access to an array of services that promote physical activity, mental fitness, social health, and overall health, wellness, and support. The provision of health promotion and disease prevention programs are

essential for effectively enhancing the health of the senior population while reducing the burden of their healthcare cost. The aging of the baby boomers is an inevitable reality, but one that can be embraced by the community through a new wave of collective health-support provisions and service-delivery approaches.

Conclusion

Thank you for this opportunity to address the history of West Virginia Area Agencies on Aging accomplishments, their plans to address future challenges to our aging population, and to provide recommendations to strengthen the Reauthorization of the Older Americans Act.

Testimony before the Senate Special Committee on Aging February 13, 2012
Janie Hamilton

Senator Manchin,

I want to thank you and your committee for the vision to look at and hear from those of us advocating for the aging citizens of our country and especially the state of WV. WV has the unique position of being one of the smaller states with one of largest percentage of older adults in our nation (US Census). Many of our residents have lived and served their country to return and work here in WV all or most of their lives. Many of their children moved away and are returning to care for their aging parents. Many yet, are aging alone and in need of support.

My agency provides social services; in-home personal care and assistance through waiver, Medicaid personal care, Lighthouse, FAIR (Family Alzheimer's In-home Respite), VA Homemaker program, Creative Care (private pay), Family Caregiver Respite/Day care (social model), health and wellness opportunities, computer literacy, transportation, support for twelve nutrition sites and many others.

Our Issues:

- Reauthorize Older American's Act and Increase Funding
  - Fund Title III-C increase and unidentified funding so the locals can determine highest need (congregate or home delivered meals)
  - Allow Cost Sharing
  - Add more prevention/health education in each of Title III-B, C, D, and E Programs
- Increase Flexibility in designation of funding to SUA's (State Units on Aging)
  - Reducing or relaxing excessive and redundant regulations
- Need mechanism for Modernization of Senior Centers
  - Add incentives for Federal Community Block Grants to allocate to Senior Centers for facility modernization
- Either allow us lobby privileges or do not allow other entities access to OAA monies

As a county aging services provider my mission is to assist our aging population in obtaining and or maintaining a good quality of life for their remaining years using the resources available. As economic problems prevail, *competition for available* funds and other resources increase making that part of my job a time-consuming endeavor. With the surging boom in aging adults just beginning to skyrocket, we are in the early stages of a challenge never before seen. It has been predicted for years and we are not ready. *More attention must be given to the issues of the aging boomer population and their parents.*

There is also a remarkable increase in boomer generation ***grandparents raising grandchildren*** *while often trying to* ***assist their own aging parents.*** The number of *grandparents raising*

grandchildren is increasing and is at approximately 5.8 million children in the US. This adds a whole other dimension to the needs of older adults.

Issues around this include:

- The difficulties in obtaining medical attention without formal custody
- Many insurance companies do not allow grandparents to carry their grandchildren as dependents
- Many schools will not admit a child unless the child's parent is living with the grandparent; thus grandparents are denied authority concerning the schooling of their grandchildren and even transportation to another school district.
- Grandparents often cannot obtain emergency medical care for their grandchild unless they have legal custody.
- Social security benefits are not payable to care-giving grandparents unless they adopt the child.
- Financial assistance, especially problems in receiving adequate financial help on a par with foster parents.
- The households of caretaking grandparents do not conform to the traditional definition of family as defined in zoning laws thus they may be excluded from living in a single family-zoned community.

Flexibility in Spending

I have met with family members in their late 50's up to the early 70's whose parents are still living and suffering with physical and *mental health* problems. The aging adult child is unable to spend the amount of time and or energy required to care for them.

Most of these middle-aged to young-old adult children are completely **unprepared to cope** and have **no idea of where to turn.** Agencies like ours **do not have the *funding to advertise our services*** effectively. More often than not, the boomer child is attempting to give care from another state often spending vacation days and money to travel to their parent's homes to see to their needs as best they can.

There are also seniors facing addicted, mentally unstable adult children living nearby exploiting them and literally stealing their life savings out from under them. These **vulnerable seniors** often have their medications stolen by their addicted family members or caregivers never realizing the theft. *Inadequate funding is spent on policing and protecting these victims. Fraud is abundant.*

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Funding Medicaid Fraud Patrol

Medicaid waste and exploitation is costing more than the services actually delivered to the truly needy. More attention to this issue is imperative. Unscrupulous doctors and medical services owned by corporations being crushed by federal regulations are driving the costs higher and higher.

Operating a senior service agency has the layered challenge of proving services with extremely complicated *reporting requirements, excessive hoops* to jump through for billing especially with VA services that seem to change with every new change in leadership. This causes many lost hours to the service provider that cannot be recouped that leads to a loss of service units provided.

- VA pays interest to our agency due to lateness in payment
- Cases are assigned randomly

Our challenge to end multi-layered, redundant requirements to provide services is important to ending waste. One, logical, solid way of accountability needs to be established and eliminate all the *middle-management waste* that has no real purpose but drains the system of funds.

- More flexibility needs to be integrated into service delivery to seniors
- If some viable option to the CLASS Act is not devised, then extension of the QI (Qualified Individual) Program allowing support for low-income seniors payment of their Medicare benefits

We are currently having a Medicaid-Waiver application freeze in our state. This means that many of those individuals eligible for nursing home placement that *choose* to waive that and receive the same services in-home, (proven to be less costly) must be sent to fill the empty beds in the nursing homes. This **takes away the rights of seniors** to choose where they spend their final days.

Under Senator Manchin, our state developed the Lighthouse Program. It is the most user friendly service we have available. Lighthouse allows for those who qualify to receive all that they need, and not limited to personal care only. Funded entirely by the state, there is a waiting list. This model works better than any other program for in-home care.

Family Caregiver Programs

Challenges to care giving by family members include; availability, lack of training, health literacy, personal physical, mental, and financial issues:

- Time divided by work responsibilities, children, grandchildren or other family needs

- Lack of time or willingness to be trained properly to provide proper care
- Poor mental or physical health
- Cannot afford to not work outside the home or spend the money to travel to parents home to provide care

The success of Alzheimer's Family Caregiver Respite Programs is high but many, many more are needed. We need to learn best practices and imitate them in all communities and **increase funding for these programs.**

Community awareness of the symptoms of Alzheimer's and of Elder Abuse and Exploitation both in urban and rural settings must be increased with an anonymous call- in line or web site. Local law enforcement; case management and social workers; EMT's and clergy all need to be included in *awareness trainings* to assist in detecting symptoms at the earliest time so plans for their care can be made by the *individual* before they become incompetent.

On that note, there needs to be a better way to deliver *competency testing* by qualified professionals **experienced** in Alzheimer's and dementia care. While we do not want to limit the rights of seniors to their freedoms, they are often in pure denial of their inability to safely drive and no one wants to be the "bad guy" and take away the car keys and operator's license. Of course, if we begin to make the roads safer by removing drivers with dementia, we will have to increase availability of transportation for seniors.

Funding for route scheduling software for counties providing transportation for seniors would be a way to make our scheduling more efficient thus allowing more services to more seniors and saving on overall costs of transportation.

Mental health services for older adults will become a very large need as baby boomers, which unlike their parents are not afraid to seek help for the myriad of mood disorders and other mental health issues. Right now these services are limited for all ages and adequate assessment and support will be vital.

As A Family Caregiver & "Sandwich Generation" Age:

As the only child to my 84 year old mother that shares my home, she and I have taken the steps to make her care needs a smooth transition as they may change. Currently, I depend on the transportation services available by my agency and will use the in-home services if and when the time comes. She enjoys the socialization opportunities available at the Hansford Center in St. Albans near our home. I believe these things have added to her quality of life and she agrees. I could not work full-time helping raise my children and care for my mother without the aging network. I cannot imagine trying this if I lived in a rural area.

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Our future is sure to test our country's ability to rise to the occasion and look to the good of those who are in need of protection rather than those who are capable of working towards their own support. We have had such a rich life here that those who made this country great are living longer in larger numbers than ever before. We owe them all a debt of gratitude and all the support they need to spend their final years in peace and comfort. Our children are watching!!

Thank you for this opportunity to testify before you today.

Testimony of
Helen M. Matheny, Director
Alzheimer's Outreach and Registry Program, Blanchette Rockefeller Neurosciences Institute and
Member, Advisory Council on Alzheimer's Research, Care and Services

before the Senate Special Committee on Aging
on Strengthening the Aging Network
February 13, 2012

Senator Manchin and Congresswoman Capito, thank you for this opportunity to testify on Strengthening the Aging Network. My name is Helen Matheny. I serve as the Director of the Alzheimer's Outreach and Registry Program of the Blanchette Rockefeller Neurosciences Institute (BRNI). In addition, last August I was appointed by United States Health and Human Services Secretary Kathleen Sebelius to serve as a member of the National Advisory Council on Alzheimer's Research, Care and Services.

The Blanchette Rockefeller Neurosciences Institute (BRNI) is a unique, non-profit medical research institute dedicated to the study of memory and memory disorders, with its focus on Alzheimer's disease and related dementias. Our mission is to expand and advance state-of-the-art scientific research of memory and memory disorders for purposes of prevention, diagnosis, and treatment and promote translation of resulting discoveries to practical medical applications. BRNI is operated in alliance with West Virginia University as well as in collaboration with other academic institutions.

The Institute's Alzheimer's Outreach and Registry Program, the only one of its kind in the country, provides physicians with education and tools to improve screening, diagnosis, treatment, and care of patients with Alzheimer's disease and related dementias. The education sessions help inform and connect the medical community with local resources to better link patient treatment and care as well as to support care givers through the disease progression. The program also maintains the West Virginia Alzheimer's Disease Registry. The Registry is a secure database that

compiles demographic, diagnostic, treatment and other medical condition information about patients who have been diagnosed with Alzheimer's disease or a related dementia.

As I begin my discussion today, I would like you to keep in mind a few key facts about Alzheimer's disease in West Virginia.

- According to the Alzheimer's Association, 44,000 West Virginians age 65 and older have Alzheimer's disease. The number of West Virginians with Alzheimer's is expected to rise dramatically as the state's more than 500,000 baby boomers reach age 65 and enter the age period of greatest risk for developing Alzheimer's disease.
- Alzheimer's shares similar risk factors as stroke and cardiovascular illness, including smoking, high cholesterol, obesity, and diabetes. As you are well aware, West Virginia consistently reports among the highest rates in the nation for all these risk factors.
- The Alzheimer's Association estimates that 70 percent of nursing facility residents has some degree of cognitive impairment, including Alzheimer's.

West Virginia is the 25th state in the nation to develop a statewide plan to address this growing crisis of Alzheimer's disease. The Make a Plan (MAP) for Alzheimer's initiative is chaired by the Alzheimer's Association, West Virginia Chapter and facilitated by the West Virginia Partnership for Elder Living. At the same time, as you know, Congress passed the National Alzheimer's Project Act in 2010. The law requires the Secretary of Health and Human Services, in collaboration with the Advisory Council on Alzheimer's Research, Care, and Services to create and maintain a national plan to overcome Alzheimer's disease.

Efforts to address this devastating disease must be bold. It is critical that we increase funding and accelerate the pace of scientific research and ensure that as evidence-based solutions are identified they are quickly translated, put into practice and brought to scale so that individuals with Alzheimer's disease can benefit from increases in scientific knowledge.

Until we find a cure for this devastating disease, I strongly believe we need to develop a **system of quality care** for individuals with Alzheimer's disease and related dementias. The system would include four key components:

1) Detection

The detection and diagnosis of dementia is key to effective treatment and care. It is important to distinguish dementia from temporary, reversible conditions that may cause loss of cognitive functioning. Despite the availability of several simple, validated, and inexpensive assessment tools, structured assessments for dementia have not routinely been incorporated into practice. One solution to this challenge is to utilize the Medicare Annual Wellness Visit. It requires that detection of possible cognitive impairment be included in each visit, potentially resulting in greater and earlier detection of dementia.

2) Diagnosis and Care Planning

In primary care settings, physicians report insufficient time and reimbursement as important causes of missed diagnosis of dementia. In many cases, physicians feel that there is a more pressing need to diagnose and treat a patient's other medical conditions. Lack of reimbursement and time constraints also precludes a very necessary discussion with the newly diagnosed patient and his/her family to help them understand the diagnosis and the medical treatment options as well as what services and supports are available. As a result, many people with dementia and their families are not effectively connected to services that could help them. I recommend that Congress pass legislation to create Medicare coverage for a package of services that covers the clinical diagnosis of Alzheimer's disease as well as care planning and coordination for the individual and their caregivers.

Next, I suggest we build upon the medical home model and utilize technology to enhance quality and care coordination. As many as 95 percent of all individuals with Alzheimer's disease have one or more other chronic conditions, such as diabetes, hypertension, or heart disease. Management of these conditions is severely compromised in individuals who are cognitively

impaired, which compromises the quality of care individuals receive and increases costs to Medicare. For example, an elderly person with both diabetes and Alzheimer's or other dementia costs Medicare 59 percent more than a senior with diabetes and no Alzheimer's. More so than for individuals with any other chronic condition, individuals who are cognitively impaired need a health care system with individualized needs assessments, care coordination, and integration of services. The Medical Home model provides comprehensive health care through partnerships between patients, their families and a team of physicians and other professionals to address the specific needs of the patient.

In addition, an electronic medical record template could be standardized to include screening and diagnostic tools, educational information for the patient and caregivers, and links to resources including local and state programs. Finally, the system could include planning tools such as advanced directive and medical power of attorney forms.

3) Caregiver Support

The Alzheimer's Association reports that approximately 70 percent of individuals with Alzheimer's disease and related dementia live at home and receive care from family and friends. In 2010, more than 105,000 Alzheimer caregivers in West Virginia provided more than 120 million hours of unpaid care. West Virginia is fortunate to have a Family Alzheimer's In-Home Respite (FAIR) program that could serve as a national model for respite care. I encourage the expansion of the availability of quality, affordable home and community-based services for individuals with Alzheimer's disease and their caregivers by increasing funding for programs such as our state-funded Family Alzheimer's In-Home Respite (FAIR) program to serve more families statewide and to alleviate waiting lists that frequently exist for the program.

Another resource for Alzheimer's disease patients and their caregivers is the new WV Senior Care website that provides information about medical and social services as well as health care facilities.

Finally, employers should consider implementing policies that are supportive of employees who also are caregivers.

4) Workforce

Because of the aging population, the number of Americans with Alzheimer's disease is expected to increase from an estimated 5.4 million Americans to as many as 16 million in 2050. This escalation in the number of Americans with the disease will necessitate a larger and better trained workforce. Sufficient educational opportunities and funding are critical to address the shortage of physicians, nurses and other healthcare providers to improve the delivery of care for an aging population. Congress should explore increased use of available tools, such as tuition assistance, loan forgiveness, housing subsidies, and stipends that encourage healthcare professionals to pursue specializations in primary care and geriatrics, particularly those providers who make a commitment to work in underserved communities.

The reality is there are many West Virginians like the Smiths. Mrs. Smith is 93 years old and is nearly blind. She is a diabetic, has congestive heart failure and is in and out of the hospital numerous times a year. Her husband has hearing problems and his vision is impaired due to a stroke. The Smiths live in their own home with no mortgage. Because of their illnesses they are on multiple medications and face high deductibles and medical co payments. The Smiths like many seniors want and need "high touch" not necessary high tech care. They need assistance with cores around the home, medication management and access to insulin. The Smiths need and deserve a quality system of care.

Conclusion

I applaud your interest in identifying ways we can improve the efficiency and effectiveness of the aging network as well as continuing the person-centered services at the federal, state, and local level. I want to thank you, Senator Manchin and Congresswoman Capitol for the opportunity to share with you suggestions about developing a system of quality care for our elderly citizens,

particularly those with Alzheimer's disease and related dementias. I look forward to continuing to work with you on these issues. I will be glad to answer any questions.

Testimony before the Senate Special Committee on Aging.
February 13, 2012
James and Ellen Clagg
Cabell County Community Services Organization and the Milton Senior Center located in Milton, West Virginia.

Chairman and members of the committee. Thank you for the opportunity to testify before the Senate Special Committee on Aging.

We are James and Ellen Clagg representing the Milton Senior Center and the Cabell County Community Services Organization.

Why don't you go to the center with me today? We have a lot of fun over there.

This is how I was introduced to the Milton Senior Center. My wife had been attending for about a year and she it enjoyed it very much.

My first thought was how can a bunch of old people have fun? What can they possibly be doing?

When I started attending the center the people I met were ordinary folks just like us. Some are still living in their own homes, but others are living below levels that they would prefer. Others living alone in subsided apartments, some in trailer parks. Most are failing in health and have limited income. Where or how can they have fun!

At the Senior Center they have a place to become part of another family. The members may not be blood related however, each one in time become a brother or sister within the family.

We participate in a variety of games, bingo the favorite. We work table puzzles, exercise on our machines, have crafts to work on, sew and make lap quilts for the shut-ins.

The Cabell County Community Services Organization, or CCCSO as we know them, provide a warm meal daily. At this meal we talk and exchange thoughts on any subject that might come to mind. A home atmosphere with family members.

The Center provides a number of presentations by locals as well as professionals. Senator Manchin visited us this past month and asked for our opinions and shared his with us on different subjects currently before Congress.

We have health screenings at least once a month where blood pressure and blood sugar levels are tested at no cost. We also have monthly dinners where singers delight us with their music. School children at Christmas have a wonderful program for our enjoyment.

Fun? You bet! But more than fun, a place where for a few hours we become a member of "our" family. Members who will listen to our gripes, comfort each other in times of sorrow and share in our joys.

The Center has become a major part of our lives.

In conclusion we are grateful for The Milton Senior Center and CCCSO for all the help they provide the aging residents of Milton and Cabell County.

We strongly urge you to support all senior citizen programs no matter what the organization may be called or what state they represent. We are one family all created by God, depending on Him and each other. As our Senator we need your help and support.

Thank you for allowing us this brief time to testify before the committee.

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