

A Call for the Modernization of the Older Americans Act

September 2021

For decades, Missouri's Area Agencies on Aging (AAAs) have advocated for a broad modernization of the federal 1965 Older Americans Act (OAA) — “the foremost federal law focused on the wellbeing of aging adults in the US.” (NIH)

In the 57 years since inception of the OAA, various amendments have introduced new areas of focus, resulting in more work for the states and AAAs, without further reimbursement. To compound the challenges of additional responsibility without further reimbursement, Area Agency requests for an update of many OAA standards have been met with decades of bureaucratic delay. As a result, outdated limitations within the OAA thwart the progress and innovations that must be made to meet the burgeoning *present and emerging* needs of an expanding population of older adults.

“The Older Americans Act was intentionally designed to mandate that AAAs use the flexibility granted by the Act to ensure that local needs and preferences of older adults are taken into consideration and that the resulting local delivery system is tailored to the community.”

National Association of Area Agencies on Aging

Despite this charter intent, the lack of timely and pertinent revision of the historic Older Americans Act over the years has resulted in the limiting — rather than the empowering — of flexibility in local community service delivery systems. The COVID public health pandemic has further sharpened focus on the outdated state of many of the policies and programs of the Older Americans Act and its need for modernization.

This is evidenced by the fact that during the health crisis, the federal government and State Units on Aging had to set aside a number of the limitations of the OAA to assure the most effective AAA service delivery. *Federal administrations granted smart liberties to Area Agencies on Aging through the pandemic because they recognized the importance of immediate relevance over outdated mandates.*

AAAs have been working within the realm of “emergency shortages” of funding, shortages of program liberties and exclusion from relevant program expansion *for decades*. We must leverage the awareness gained through the COVID crisis, and the great losses it has exacted, to assure an *improved* realm of services under the OAA, not just during times of formal disaster declaration, but for the future of all senior care. We advocate for *permanent* change to the OAA — *and the enduring importance of immediate relevance over outdated mandates.*

In specific, the modernizations we prioritize are:

1. Continued flexibility in the use of all Older Americans Act funding to meet locally determined needs that vary county to county.

The foundational premise of the OAA distribution of services is this: *Area Agencies on Aging identify local priority needs and gaps in services and build or link together a network of home- and community-based service responses specific to those identified needs and gaps.*

During the COVID crisis, many national AAAs have been allowed to use any portion of existing OAA allocations for any means of older adult disaster relief. Broad funding liberties were granted for alternative meal delivery systems, well-being checks via phone, in-person or virtual means of contact, grocery/pharmacy/supply delivery, or other services of critical assistance.

This flexibility entrusted AAAs with the good stewardship of conducting and properly reporting any and all services, parallel to the emergence of priority needs. **Regardless of whether or not we are in a pandemic, the continuance of this liberty in stewardship will always determine the scope of effective outreach — because AAAs always operate within an environment of chronic underfunding and burgeoning growth in the number of older Americans needing assistance.**

2. Eliminate the restrictive transfer language between Congregate (Title IIIC1) and Home Delivered Meals (Title IIIC2).

“Nutrition” allotment funding should simply be for

“nutrition.” We see the value in tracking the units of congregate vs. home delivered meal service, but we see no value in segregating the dollars for each. The budget for Title IIIC should be responsive to whichever service is being provided, without pre-determined partitioning of funding to one or the other.

3. Recognize pantry and shelf-stable nutrition assistance as qualifying nutritional support under Title IIIC.

Many homes need pantry items and liquid nourishment to mitigate hunger, rather than specific, daily meals. Area Agencies on Aging need flexibilities to provide the nutritional assistance most relevant to given circumstances. We are entrusted to coordinate the most beneficial palette of support services under other Titles, yet we are bound to a very narrow definition of what is accepted as nutritional support under Title IIIC.

Furthermore, provision of pantry foods and other forms of nutritional supplement (such as Boost and other items) is permitted under IIIB. **The segregation of this nutritional support into another support title mitigates the true picture of aggregate nutrition service needs, thus suppressing the heightened need for nutrition program funding.** It also burdens Title IIIB funding with budgetary expenses that could otherwise be put to use for broader care.

4. Expand eligible nutrition under IIIC to include “carry-out” or “curb-side” meal delivery.

Present strict interpretation of the OAA limits nutrition outreach to two delivery systems:

- “Congregate” dining within the senior center; and
- “Home delivery” to those who cannot participate in congregate dining.

This narrow recognition of who is qualified to receive nutrition support was softened during the pandemic to allow carry-out and curb-side pick-up of meals. We have been advocating for this change for decades.

Quite apart from the social distancing of pandemic concerns, there are many seniors who will not burden Area Agencies on Aging with home-delivery of their meals, but they also will not dine in congregate settings. Their reasons for not doing so are diverse and include debilitating conditions like Parkinson’s, social anxieties,

physical challenges or auto-immune compromises.

In addition, many simply cannot interrupt their working or caregiving schedules to take a 30-45-minute lunch break. They plead for the option of carry-out, drive-through or curbside meal pickup. Many of these working and caregiving seniors are seniors in the most need of nutritional help.

5. Eliminate the 10% state/county required match for any new investments in OAA programs or provide a means of waiver for this requirement.

Given the impact of varying economic conditions, it may not be possible to secure such a match without putting extraordinary pressure on other budgets. The very communities who are unable to present the 10% match may be in the most need of help.

6. Broaden the age eligibility criteria under Title IIIE to age 50 for care recipients. Title IIIE is the National Family Caregiver Support Program that provides older relative caregivers access to a variety of programs that help meet the mental, physical, educational and nutritional needs of older relative caregivers.

The number of older caregivers is rapidly diminishing across the nation. Many of them are aging into needing attention for their own care. If home- and community-based services are to be sustained most successfully, the OAA must recognize the need to broaden support to include a wider margin of care situations.

7. Amend the Long Term Care Ombudsman (LTCOP) requirements.

During the pandemic, the numbers of LTCOP volunteers dropped significantly. Flexibility is necessary to ensure the program can meet its mission and goal and should include the areas of program implementation, eligibility for volunteerism, and training requirements.

The amendments requested would allow for authorizing different types of volunteer experiences and allowing for recruits to complete in-person certification training through the alternate use of online learning and telephonic technology platforms.

As a result, LTCOP would have the ability to offer creative alternatives for volunteers who cannot meet traditional ombudsman certification training

requirements or are unwilling to enter a facility during the pandemic to complete their certification training.

Currently, in order for a volunteer to provide or perform the functions such as handle resident data, change a facility/setting, assure follow-up compliance, or conduct outreach to facility resident and staff — they must first complete the same training requirements to become certified as a frontline volunteer interacting with facility staff and residents.

8. Lift the restriction that limits OAA-funded capital improvements solely to an outdated definition of a “multi-purpose senior center.”

Community “senior centers” are modernizing and reinventing themselves in a multitude of ways. Many of these centers have substituted the traditional “noon meal” for carry out meals, are not open five days a week, but choose to offer evening programs. Some of them are collaborating with YMCAs, community clubs or parks and recreation programs. Some are walk-in sites for information and assistance, and care coordination, without pool tables and bingo. Because they do not meet the traditional definitions of “multi-purpose senior centers,” AAAs are not allowed to invest in their essential capital improvements.

In addition, our AAAs have the opportunity to create service delivery operations and production facilities to streamline outreach and benefit from economies of scale, but because these innovative production sites would be part of infrastructure and not public-facing “multi-purpose senior centers,” they are disallowed from capital improvement assistance under OAA funding.

9. Expand Older Americans Act eligibility for young onset Alzheimer’s and other neurocognitive diseases.

Many individuals under age 60 with Alzheimer’s or other neurocognitive diseases, do not have an identified caregiver and require long-term services and supports in home- and community-based settings. Early access to services and supports helps to maintain functionality, slow regression and delay both enrollment in Medicaid and placement in nursing homes. Not only does the state have savings to the Medicaid program, but OAA services and supports significantly contribute to an individual’s quality of life.

10. Increase the federal prioritization of funding for the Older Americans Act.

Although we have seen, during COVID and under certain administrations, greater support for programs of the Older Americans Act, historically there has not been funding consideration proportionate to the challenges of a significant growth in the older population. This growth is projected to continue for decades. By 2030, one in five Americans will be 65 or older — totaling over 70 million Americans. This represents a doubling of the 65+ population since the year 2000. (USAgging)

In the face of this growth, the aging services network is charged with addressing the social determinants of health, with helping older adults maintain their independence, with keeping economic and social resources in the community, and with preventing higher levels and higher costs of care.

The lack of OAA funding prioritization to meet realistic levels of current need has resulted in a widening chasm of unmet need. Underfunding challenges fail to address the following:

- Inability to expand existing services (resulting in expanding wait lists).
- Inability to generate relevant new services that could mitigate the trajectory of future need.
- The need to transition services from a system heavily reliant on volunteers to professional delivery of services.

In 1965, when the Older Americans Act was passed, it was heavily reliant on volunteers to deliver services. There is no other professional system structured this way. Over the past 20 years, the complexity of professional service delivery has escalated, the number of volunteers has eroded considerably, and the type of volunteer experience has changed. This has all had a major impact on our capacity to provide service.

The Area Agency on Aging network is a highly skilled, professional network that has enormous cross-system responsibilities. It is unconscionable to underpay essential staffing and expect reliance on a volunteer corps that is dwindling year by year. Our ability to provide consistent service is directly

proportionate to our ability to pay for employees to do the work.

- Covid has verified the critical need for technology-based service solutions.

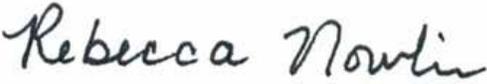
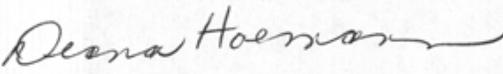
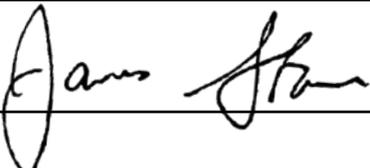
Telehealth, technology opportunities that combat social isolation, connectivity to information and assistance, on-line shopping, virtual care coordination and caregiving are critical solutions for seniors with limited mobility or marketplace access.

AAAs need the staff and resources to help provide the equipment, WIFI, training, troubleshooting and support these systems and solutions require. Without this modernization, the result will be Medicaid costs and diminished health outcomes.

AAAs, as well, are in desperate need of technology infrastructure upgrades that would streamline and modernize program delivery.

America and aging Americans are progressing and changing. Legislation designed to support older adults and individuals with disabilities should be modernized to meet emerging needs, respond to key opportunities, and eliminate outdated mandates that limit service and innovation. The adoption of these modernization priorities will ensure that the Older Americans Act continues to have an enduring impact and legacy in service to one of the country's greatest assets.

Note: Our appreciation to USAging, NIH and the aging networks of California and New York for assistance with various portions of this appeal.

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