FIFTH EDITION

Community Resources for OLDER ADULTS

Programs and Services in an Era of Change

Robbyn R. Wacker • Karen A. Roberto

Community Resources for Older Adults

Fifth Edition

I am dedicating this book to

Jani Malkiewicz, who, after 30 years, continues to be a steady and loving source of encouragement to me in all of my endeavors;

my UNC friends and colleagues whose support I am grateful to receive; the wonderful UNC Office of Development and Alumni team at the Judy Farr Center;

Dr. Robert C. Dickeson, a wonderful mentor and colleague, for his guidance and wisdom; and

finally, to my mother, Alta Wacker, who shared and modeled her passion for education and belief in its power to change lives and communities.

—RRW

I am dedicating this book to my husband, Steven Sheetz, for his never-ending love, support, and encouragement as I pursue the multiple facets of my academic career, as well as for making coffee in the early morning hours when most of my writing gets done, for the calming candlelit dinners to end each day, and for spending long weekends at the lake house to ensure I take time to decompress and reenergize.

—KAR

We both dedicate this book to the people who have chosen a career in gerontology and who work tirelessly and with compassion to provide older adults the support they need to live with the dignity they deserve in the last years of their lives—thank you.

—RRW

—KAR

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The Authors' Purpose

Students preparing for careers in gerontology and related areas need more than a description of existing community resources available for older adults. They need to understand how programs come to exist through federal legislation, who uses these resources, how they are delivered, and the challenges service providers face in meeting the needs of the aging baby boom cohort.

We have developed a text that gives students a basic understanding of aging policy that created the "aging network" and of theories that can be used to explain help-seeking behavior. Each chapter provides the reader with a summary of the legislation behind the development of pivotal programs and services, an in-depth review of the programs and services provided by the aging network and the private sector, current scholarship in each topic area, and international, national, and Internet resources. Students will learn to identify the challenges inherent in providing services to older adults through case studies, learning activities, and best-practice models. Instructors can use these learning activities to stimulate critical thinking about program and service delivery and to explore what changes might be needed to support future generations of individuals and families in their later years. We hope that *Community Resources for Older Adults* is a text that both students and faculty enjoy.

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Sara Miller McCune founded SAGE Publishing in 1965 to support the dissemination of usable knowledge and educate a global community. SAGE publishes more than 1000 journals and over 800 new books each year, spanning a wide range of subject areas. Our growing selection of library products includes archives, data, case studies and video. SAGE remains majority owned by our founder and after her lifetime will become owned by a charitable trust that secures the company's continued independence.

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Robbyn R. Wacker

Karen A. Roberto

PART

I

The Social Context of Community Resource Delivery

CHAPTER 1

On the Threshold of a New Era

What will society in the United States be like in the year 2030? It is hard to know exactly how different our daily lives will be, but we do know that by 2030, our society will be experiencing something that none other has experienced. As we move through the 21st century, more Americans than ever before will be in their seventh, eighth, and ninth decades of life. Between 2011 and 2030, about 10,000 baby boomers will turn 65 each day (Cohn & Taylor, 2010). By 2030, the first members of the baby boom generation, born in 1946, will be 84 years of age, and the youngest members, born in 1964, will be 65. By 2030, there will be about 74 million people age 65 and older—more than twice the number in 2000 (Federal Interagency Forum on Aging-Related Statistics, 2016). Demographically, the baby boom cohort is sandwiched between two smaller cohorts. As a result of its enormous size and vast racial and ethnic diversity, it has commanded attention at every stage of its life course. In the 1960s, school systems were forced to react to the soaring enrollments of the baby boom cohort; soon, social institutions that serve the older population will be challenged to respond to the baby boomers as well.

Will this graying of our population dramatically change our society? As demographers, economists, gerontologists, sociologists, and others debate this question, we can be relatively safe in predicting that, because of their unique characteristics, the aging baby boomers will cause a reexamination of current aging policies and services. Unlike the generations before them, collectively, they will be better educated, better off financially, living in the suburbs, and beneficiaries of the programs and services that were put in place for their grandparents. On the other hand, this giant cohort is tremendously diverse. About 84% of boomers have completed high school and 27% have a bachelor's degree or more (U.S. Census Bureau, 2015b). Although boomers' earnings are comparable to their parents' at a similar stage in life, the distribution of wealth in the United States has become more unequal in the past two decades; it is projected that 2% of boomers will live in poverty and 5% will live in near-poverty (up to 125% of the poverty line) in 2030 (K. Smith, 2003). Race and ethnicity are related to poverty in late life. In 2015, 6.6% of White elders lived below the poverty level, compared with 18.4% of Black elders, 11.8% of Asian elders, and 17.5% of Hispanic elders (Administration on Aging [AoA], 2017).

A Supplemental Poverty Measure (SPM) released by the U.S. Census Bureau in 2011 provides additional information about the economic profile of older Americans. In contrast to the official poverty rate, the SPM takes into account regional variations in cost of living, the impact of noncash benefits received (e.g., food stamps, low-income tax credits), and nondiscretionary expenditures including out-of-pocket medical costs. Using this measure, the number of older people living in poverty is significantly higher than the official poverty line indicates—14% versus 10% of all individuals 65 and older (Federal Interagency Forum on Aging-Related Statistics, 2016). While not replacing the official poverty measure, the SPM sheds light on the effect of social safety net programs and the marked impact of out-of-pocket medical expenses for older adults, raising awareness about how many older individuals are hovering dangerously close to poverty at any point in time (Tavernise & Gebeloff, 2011). In the coming decades, high rates of near-poverty and poverty will no doubt have implications for the financial well-being and quality of life of persons of all races and ethnicities in later life.

Another unique characteristic of the boomer cohort is their marriage and family patterns as compared with those of their parents and grandparents. Boomers tended to marry later, have smaller families, and have higher rates of divorce than their parents. In 2009, one in three boomers (aged 45 to 63 years) was unmarried (31% men; 37% women; Lin & Brown, 2012). This was a 50% increase in the number of unmarried individuals as compared with the same age cohort in 1980. Approximately 58% of these unmarried boomers were divorced, 32% were never married, and 10% were widowed (Lin & Brown, 2012). There is a greater tendency to never marry among younger boomers (born 1959–1964): 16.7% of men and 11.4% of women have never married, compared with 7.5% of men and 7.1% of women who make up the older boomer population (born 1946–1951; MetLife Mature Market Institute, 2010a, 2010b). These unmarried boomers are changing the economic and social landscape of late life—they have a poverty rate almost five times higher than among married boomers; more than three times the number of unmarried boomers rely on public assistance (e.g., food stamps, SSI) than do married boomers; and unmarried boomers report twice the disability rate of married boomers, but are less likely to have health insurance coverage (Lin & Brown, 2012).

Boomers also are redefining the traditional definition of "family" and thereby increasing the complexity of kin networks. Boomer families take many forms, including single-parent families, stepfamilies, cohabiting heterosexual and same-gender couples, childless families, intergenerational families, and transnational families (Roberto & Blieszner, 2015). Because families play a key role in providing instrumental and emotional support, as well as long-term care, to their older members, it is uncertain how these changes will influence family support patterns. Compared with their parents' generation, boomers are less likely to have a spouse to rely on and will have fewer adult children to serve as caregivers (L. H. Ryan, Smith, Antonucci, & Jackson, 2012). Thus, will adult children feel an obligation to care for both biological and stepparents? Will families who choose not to have children be at risk of having fewer informal resources? Will friends and families of choice be acknowledged and accepted as important sources of support and caregivers for lesbian, gay, bisexual, and transgender elders? Although the exact influence of family composition changes on the use of formal services is not known, we can anticipate that community programs and services will play a significant role in the lives of *all* older adults.

Collectively, these demographic characteristics will shape the type, amount, and nature of community resources in the future. They will increase the demand for home health care and retirement housing options. Many baby boomers will move into third, fourth, and even fifth careers and seek educational opportunities and greater flexibility in work and retirement options. The social safety net may need to be expanded for the underclass and lower class. The sheer numbers of aged boomers will challenge policy makers to rethink health care, retirement programs, and pension plans. Even now, projections—both dire and not so dire—are being made about Social Security and Medicare. Thus, demographic characteristics of the next generation of older adults will have direct implications on social policies that, in turn, support programs and services for older adults. In the next section, we discuss a few more of the salient demographic characteristics of the boomer cohort and the current populations of older adults.

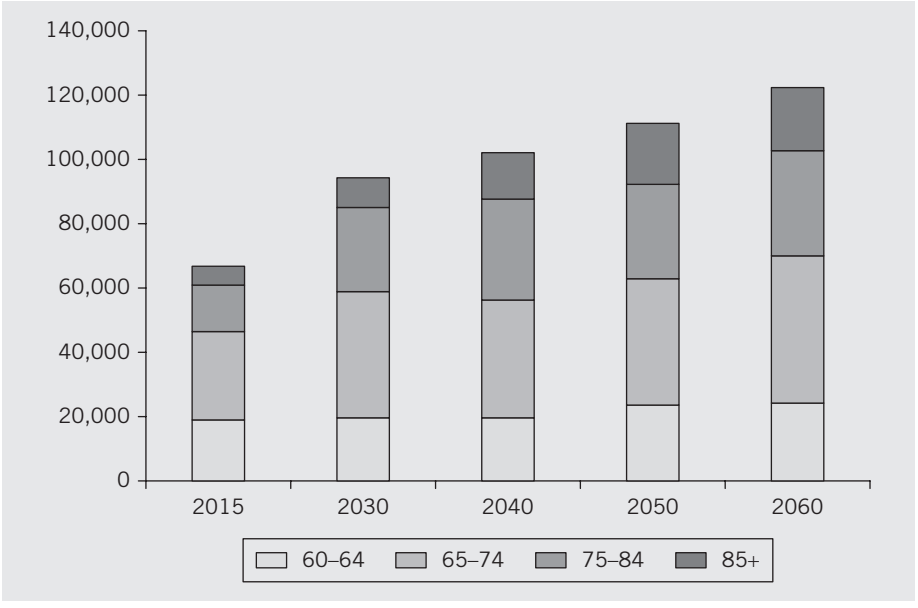
Growth of the Older Population

In 1950, 12.3 million persons (8.2% of the population) living in the United States were age 65 and older. By 2016, the number of persons age 65 and older had grown to 49.2 million (15.2% of the population; U.S. Census Bureau, 2017). The older population will continue to grow rapidly over the next few decades as approximately 10,000 baby boomers turn 65 every day, a trend that started in 2011 and will not end until 2030. The number of older adults is expected to reach 74.1 million (20.6% of the population) by 2030 and 98.1 million (23.6% of the population) by 2060 (Exhibit 1.1) (U.S. Census Bureau, 2014). Members of the older population are also aging. In 2010, 21.7 million persons were between the ages of 65 and 74, 13.1 million persons constituted the 75-to-84 age-group, and 5.4 million people were 85 years of age and older, including more than 53,400 people 100 years of age and over (L. A. West, Cole, Goodkind, & He, 2014). Moreover, persons 85 years of age and older represent the fastest-growing segment of the older adult population. The number of persons age 85 and older is expected to grow to 9.1 million in 2030 and reach 19 million by 2050 (U.S. Census Bureau, 2014).

While growth in the aging population will be seen across the United States, some states and regions will be more dramatically affected than others. In 2015, more than half of persons age 65 and older lived in 10 states: California, Florida, Illinois, Michigan, North Carolina, New Jersey, New York, Ohio, Pennsylvania, and Texas (AoA, 2017). Almost 80% of persons 65 and older lived in metropolitan areas, with 27% of these older adults living in principal cities (AoA, 2016). However, older adults also account for a larger proportion of the U.S. population living in nonmetropolitan rural areas than any other age-group (Rural Health Information Hub, 2017), with 18.6% of older adults living in rural areas. This relatively large proportion of older adults residing in rural communities has stimulated concern among some policy makers and human services providers about their access to affordable housing, transportation, general and specialized health providers, and social services (Goins & Krout, 2006).

States and regions of the country are seeing dramatic growth in their population proportion of older adults due to migration patterns. Over the past few decades, some

Exhibit 1.1 Actual and Projected Growth of the Population Aged 65+ (in thousands): 2015 to 2060



Source: Data from U.S. Census Bureau (2014).

Southern and Western regions have seen an increase in the older population because they have become popular retirement destinations, while some states in the Midwest and Northeast have seen a higher concentration of older adults largely due to out-migration of younger workers while older residents remained (L. A. West et al., 2014). Between 2005 and 2015, five states saw their 65 and older population increase by 50% or more: Alaska (63%), Nevada (55%), Colorado (54%), Georgia (50%), and South Carolina (50%; AoA, 2017). The geographic distribution of the older White population is similar to the geographic distribution of the total older population (L. A. West et al., 2014). However, among other racial and ethnic groups, the regional distribution is more skewed. For example, about 55% of Black older adults reside in the South compared with 9% who live in the West. Nearly 80% of American Indian and Alaska Native older persons live in the West, as do about 57% of Asian older adults. Hispanic older adults are more likely to live in the South (39.6%) and West (38.7%) than in other regions of the United States.

What are the social implications of such an increase in the older adult population? Many writers in the popular press suggest that the increase in the number of older adults signals an impending social and fiscal crisis (Debate.org, 2017) and that aged persons will become a financial burden to society (e.g., Samuelson, 2005; Thompson, 2012). Others argue that a "crisis mentality" overlooks other important demographic factors (e.g., Nikolova, 2016; Singer, 2011). Although it is true that the United States, along with other developed nations, will experience an increase in the older adult population, the number of older adults has steadily increased during the past 130 years. This steady increase has

allowed society to adapt to the changes of an aging population and provided new opportunities for scientific and business innovation and growth. Many scholars believe society will be able to adapt to this new cohort of older adults as well (J. H. Schulz & Binstock, 2006).

The assumption that older adults will place a burden on society is often based on the economic dependency ratio, which is the ratio of persons in the total population (including those in the armed forces overseas and children) who are not in the labor force per 100 of those who are in the labor force. In 2014, persons not in the labor force included 42 persons under the age of 16, 38 persons ages 16 to 64, and 24 persons 65 years of age or older per 100 workers (Toossi, 2015). The part of the economic dependency ratio that has been steadily increasing is the portion attributable to older persons, and with the aging of the baby boomers, the dependency ratio of the 65+ group is expected to increase to 30 by 2024.

The increase in the number of older adults, however, does not automatically result in a greater social burden. The aging population presents serious challenges, as well as major opportunities, for all sectors of society. Meeting these challenges and seizing opportunities will require a new vision of American life that reaches beyond the immediate challenge of the aging of the boomers and promotes active engagement and a high quality of life throughout the lifecourse (MacArthur Foundation Research Network on an Aging Society, 2008).

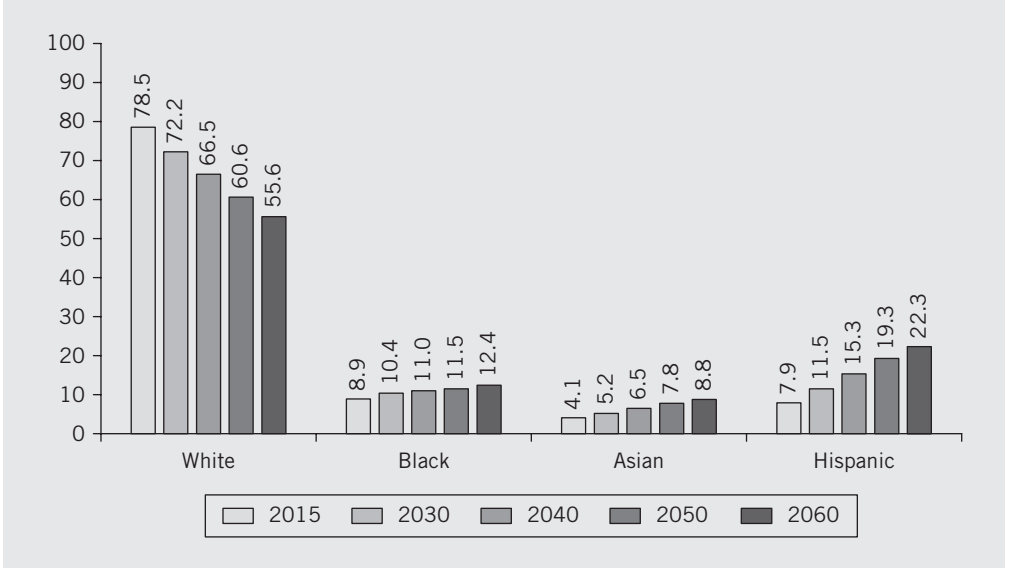
Growth of the Older Population of Racial and Ethnic Minorities

With the aging of the baby boomers, the older population is growing more diverse. Approximately 14% of baby boomers are from racial and ethnic minority groups: 8.7% are Black, 4.0% are Asian alone, and 1.3% represent all other races alone or in combination (Federal Interagency Forum on Aging-Related Statistics, 2016). Fewer than 10% of boomers are of Hispanic origin. Although non-Hispanic White older adults will still represent about 58% of persons over age 65 in 2050 (G. K. Vincent & Velkoff, 2010), the percentages of Hispanics and of non-Hispanic Blacks and Asian Americans will increase dramatically. Exhibit 1.2 shows the percentage of older adults by race for the years 2015, 2030, 2040, 2050, and 2060 (U.S. Census Bureau, 2008, 2012). This growing minority of the older population brings new challenges and opportunities for providers of community programs and services (Goins, Mitchell, & Wu, 2006; Padilla-Frausto, Wallace, & Benjamin, 2014; Villa, Wallace, Bagdasaryan, & Aranda, 2012).

Growth in the Number of Older Adults Living Alone

Another demographic characteristic with social service implications is the increase in the number of older adults who will be living alone. In 2016, 29% of all noninstitutionalized persons age 65 years and older lived alone, representing 37% of older women (9.2 million) and 20% of older men (4.1 million; AoA, 2017). Living arrangements also

Exhibit 1.2 Actual and Projected Distribution of Population Aged 65+ by Race: 2015, 2030, 2040, 2050, and 2060 (percentage)

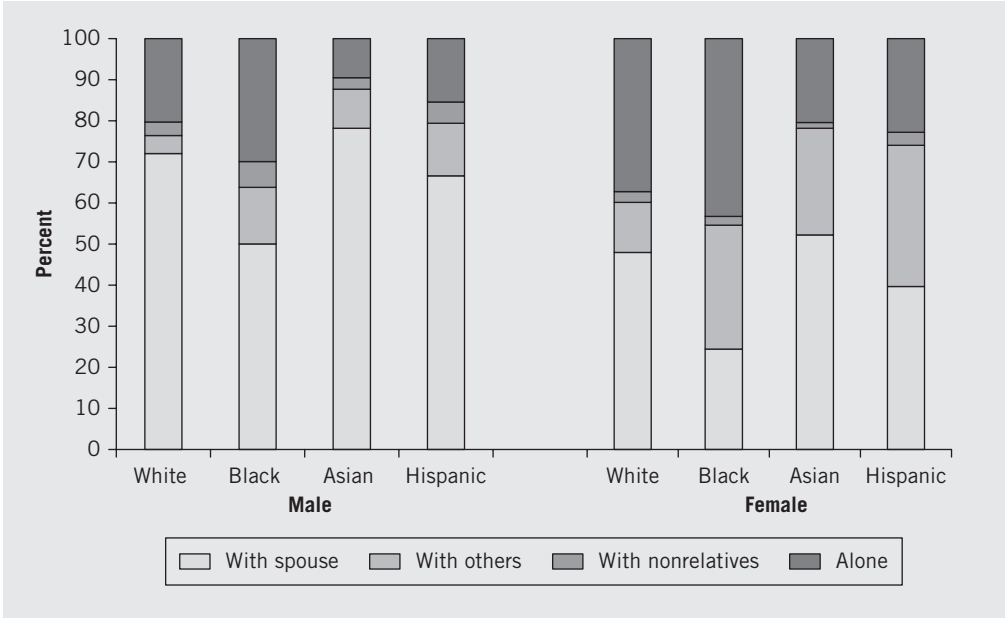


Source: Data from U.S. Census Bureau (2014).

varied by racial and ethnic group. A greater percentage of non-Hispanic White women (37%) and Black women (43%) age 65 and older lived alone, compared with 20% of Asian and 23% of Hispanic older women. In contrast, 30% of Black older men live alone, compared with 20% of non-Hispanic White, 10% of Asian, and 15% of Hispanic older men (Federal Interagency Forum on Aging-Related Statistics, 2016). Moreover, the percentage of older men and women living alone increased with age. Among women aged 75 and over, for example, 46.3% live alone compared with 27.7% of women ages 65 to 74 (Federal Interagency Forum on Aging-Related Statistics, 2016). Among men age 75 and over, 23.0% live alone, compared with 18.5% of men ages 65 to 74. Differences in living arrangements of adults age 65 and older by sex, race, and Hispanic origin can be seen in Exhibit 1.3. Most notable is the generally high percentage of men who live with their spouses, compared with women and the large percentage of women living alone, across all groups. Living with other relatives and nonrelatives occurs more than twice as often with Black and Hispanic women than with White women.

Older adults who live alone are more likely to live in poverty. In 2015, 15.4% of persons age 65 and older living alone were living in poverty compared with 5.7% of older persons living with families (AoA, 2017). Sex and ethnicity further differentiate the percentage of older adults living in poverty. For example, 40.7% of older Hispanic women living alone were in poverty, compared with 8.2% of older Hispanic women living with their spouses (U.S. Census Bureau, 2016b).

Exhibit 1.3 Living Arrangements of Older Adults by Sex, Race, and Hispanic Origin, 2015



Source: Federal Interagency Forum on Aging-Related Statistics (2016).

Growth in the Number of LGBT Older Adults

Of persons in the United States who are 50 or older, 2.4 million people identify as lesbian, gay, bisexual or transgender (LGBT),* and that number is expected to double by 2030 (S. K. Choi & Meyer, 2016). LGBT older adults are diverse with regard to many characteristics, including gender, race and ethnicity, marital status, socioeconomic status, living arrangements, and disability status. Unfortunately, most studies of LGBT older individuals are typically not large enough to assess the influence of diversity on their lives at these different intersections (S. K. Choi & Meyers, 2016; Otis & Harley, 2016).

In addition to the challenges that all older adults face, such as physical limitations and changes in income or relationships, LGBT older adults confront discrimination from informal and formal entities that most older adults traditionally rely on for support and assistance. Researchers and advocacy groups have identified four major obstacles to social support and community engagement for LGBT elders (Movement Advance Project & Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders, 2010, p. 48): (1) LGBT elders lack support from, and feel unwelcome in, mainstream aging programs; (2) LGBT elders lack support from, and feel unwelcome in, the broader LGBT community; (3) LGBT elders

*We use both lesbian, gay, bisexual or transgender (LGBT) and lesbian, gay, bisexual, transgender or queer (LGBTQ) throughout the text, and usage depends on how the source we cite referenced the LGBT/Q community.

lack sufficient opportunities to contribute and volunteer; and (4) housing discrimination adds to the challenges LGBT elders face in connecting to their communities. Helping LGBT older adults secure social support and community engagement requires action from mainstream aging services providers, LGBT advocates, researchers, and policy makers.

Implications of Demographic Characteristics for Community Resources

These selected demographic projections and unique characteristics have a number of implications for the delivery of community resources to older adults. The growth in the older adult population will increase the demand for all types of services. Professionals working to deliver the programs and services designed to improve the quality of life of older adults will thus be challenged to do even more with less. Because of the diverse nature of the boomer population with regard to ethnicity, income, family history, and life experience, professionals will be expected to be knowledgeable about a wide range of programs and services that serve both mainstream and disenfranchised individuals. Community programmers also must recognize and accommodate cultural diversity and remove the social and cultural barriers to service accessibility. A concerted effort needs to be made to design culturally appropriate programs and interventions that are responsive to the needs of minority communities (American Psychological Association Committee on Aging, 2009; Center on an Aging Society, 2004; National Center on LBGT Aging, 2017). Professionals must be visionaries in planning and developing programs and services to meet the needs of this new cohort with its diverse characteristics.

Now that we have had a chance to consider the challenges that lie ahead for programs and services that assist older adults, let's return to the present and consider more immediate issues. In every community, resources are designed to assist older adults in a variety of ways. Therefore, individuals working with older adults need to have a good understanding of these resources as well as the patterns of service use by older adults and their families. Anyone who has ever worked with older adults knows that the problems they confront tend to be complex and multifaceted.

Consider the case of Mrs. Duran, who confides that she is about to be evicted from her apartment. Further questioning reveals that she has not received her Social Security check for 2 months. She has limited resources for food, has received a utility shutoff notice, and has been unable to renew her insulin prescription for her diabetes. Or consider Mr. Jackson, who does not know what to do with himself since he retired. He has played golf or fished almost every day but is getting bored and disillusioned with retirement life. What community resources can be accessed to help Mrs. Duran and Mr. Jackson? Advocates who have an understanding of various programs and services assisting older adults can recommend appropriate options for both Mrs. Duran and Mr. Jackson.

A Text About Programs and Services in an Era of Change

Because of the multiple challenges that older adults can experience and the changing demographics of the older adult population, we have created a text that provides a

broad-based discussion of community resources. We believe that to effectively meet the needs of older adults who can benefit from using programs and services, professionals must understand the social and psychological dynamics of help-seeking behavior. It is not enough to know what services are available and appropriate; practitioners must also be armed with theoretical knowledge to understand *why* a daughter, despite her exhaustion, refuses to bring her father to the local adult day program and *why* an older adult, who barely survives on a small pension, refuses to apply for additional income support that would make life a bit more bearable. In addition, we believe that practitioners must understand service use patterns and how families interact with the formal network when they need assistance in caring for their older family members. Greater understanding of these patterns can better prepare students and practitioners for understanding the dynamics of when and how families choose to use the formal network.

We also believe that simple descriptions of existing programs and services that assist older adults provide an incomplete picture. Practitioners and students should benefit from the interplay that exists between research and practice because research results have practical applications for the delivery of programs and services. In each chapter, we draw from empirical research to describe who uses and who provides such programs and services. We also include information about program outcomes when available.

Next, professionals need to be alerted to the infinite number of programs and services in communities that exist outside those funded through the Older Americans Act (OAA) of 1965 and subsequent amendments. Thus, we attempt to introduce readers to many programs and services that are both publicly and privately funded. Moreover, we discuss the different ways in which aging programs and services have successfully networked with one another to develop public and private partnerships in an attempt to reach more older adults.

In preparing the fifth edition of this book, we maintained the organizational structure of previous editions while updating and expanding the content to address the changes in community programs and services available to older adults throughout the United States. In addition to including the most up-to-date statistical data available, we have described important updates and additions to federal policies that provide the underlying framework for aging services. Each chapter includes reference to the latest research and highlights some programs and services throughout the United States and across the globe that serve as examples of innovative ways in which communities are meeting the needs of older adults and their families. We acknowledge the increasing diversity among members of the aging population by addressing the need for cultural competency in service delivery and by including new research findings (when available) and illustrative examples of resources, programs, and services for older adults from different racial, ethnic, and cultural groups, as well as older persons living in rural areas, and for older adults who are gay, lesbian, bisexual, or transgender. The increasing availability of information online has allowed us to add many new web-based resources for readers to access further information about a particular issue, policy, program, or service.

Organization of the Book

This book consists of three parts. In addition to this chapter, Part I has two other chapters. Chapter 2 presents a brief review of major aging policies, including Social Security,

Medicare, and the OAA, the basis for the existence of many older adult programs and services. Chapter 3 explains the patterns of service use by older adults and the theories that can predict help-seeking behavior.

Part II is based on the concept of the continuum of care. Conceptually, the *continuum of care* is a system of social, personal, financial, and medical services that supports the well-being of any older adult, regardless of the person's level of functioning. The goal, of course, is to have the appropriate services available to match the presenting needs. The continuum is often conceptualized in a linear way—older adults move from one end of the continuum (independence) to the other (dependence), and services exist at every point along the continuum to meet their social, medical, and personal needs. In addition, services impinge differently on the personal autonomy of their participants. For example, those who attend senior centers come and go as they please and make choices about their level of participation. In contrast, a nursing home is the most restrictive environment and impinges a great deal on personal autonomy and choice.

We have opted to depict the continuum of services as a more dynamic and interactive system (see Exhibit 1.4). Rather than moving in a linear fashion from independence to dependence, older adults move in and out of areas of service need as they experience changing levels of independence and dependence, health and illness, and financial stability and instability. For example, older adults just discharged from the hospital may need in-home services as well as home-delivered meals. Yet, as they become less dependent, they may access services offered at the senior center. Those who are striving to maintain their independence can access services along the continuum.

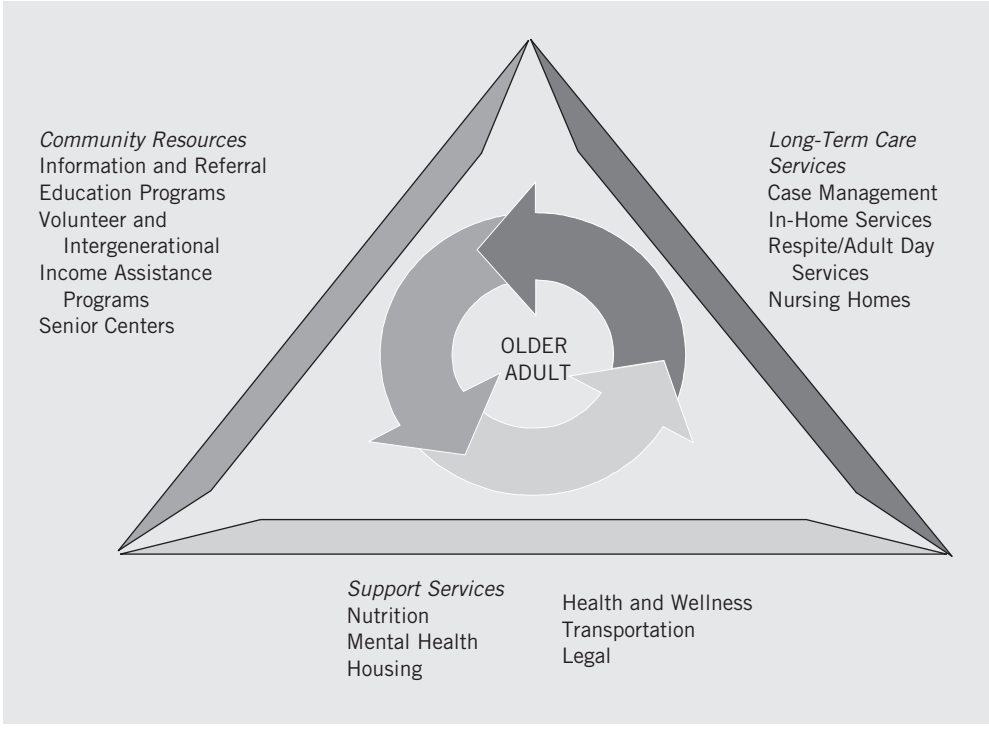
Therefore, Part II presents the variety of community resources available for older adults and is divided into three sections, based on our depiction of the continuum of services. The first section presents information about *community services*. These are services that benefit older adults with low levels of dependency and impinge little on their personal autonomy. These services offer participants opportunities to enhance personal and social well-being. Specifically, we address information and referral services (Chapter 4), volunteer and intergenerational programs (Chapter 5), education programs (Chapter 6), senior centers (Chapter 7), employment programs (Chapter 8), and income assistance programs (Chapter 9).

Support services are discussed in the second section of Part II. These services help older adults who need assistance in maintaining their level of functioning. Support services include nutrition programs (Chapter 10), health and wellness programs (Chapter 11), mental health services (Chapter 12), legal services (Chapter 13), transportation services (Chapter 14), and housing options (Chapter 15). In addition, new to this edition is the inclusion of specific programs and services designed to support family caregivers (Chapter 16).

The final chapters in Part II provide information about *community-based* and *institutional long-term care services*. These are services to assist individuals who have greater dependency needs. Chapters in this section are on care management (Chapter 17), home care (Chapter 18), and nursing homes (Chapter 19).

We have organized each chapter in Part II to include policy background, a description of users and programs and services, and future concerns. Each chapter includes case studies to help readers think critically about the service delivery issues. These cases were developed on the basis of actual experiences we have encountered (names

Exhibit 1.4 Continuum of Services



Source: Adapted from Levinson (1988, p. 44). Used by permission.

and situations were altered to protect individuals' identity). In addition, best-practice models that highlight creative and unique programs and sources for additional information are presented. The best-practice models are representative of the programs and services that exist in various communities. Learning activities designed to expand understanding of the issues are also included. Additional resources, including the names and addresses of professional organizations and Internet resources, are located at the end of each chapter.

Part III contains the final chapter on programs and services for the future (Chapter 20). This chapter presents an in-depth look at the challenges that lie ahead for the aging network.

Accessing Updated Information

Because statistical profiles of older adults are constantly being updated, and because Congress frequently enacts legislation that affects the existence of community resources and programs and services, information presented in texts such as this can become

quickly outdated. To keep up with these changes, we recommend regular visits to the following websites and others suggested throughout this book:

AARP International: www.aarpinternational.org

AARP Public Policy Institute: www.aarp.org/ppi/

Administration for Community Living: www.acl.gov

CDC Healthy Aging Data Portal: www.cdc.gov/aging/data/

Centers for Medicare & Medicaid Services: www.cms.gov/

Diverse Elders Coalition: www.diverseelders.org/

Federal Interagency Forum on Aging-Related Statistics: https://agingstats.gov/

Rural Health Information Hub—Aging: www.ruralhealthinfo.org/topics/aging

Social Security Administration: www.ssa.gov/policy/docs/chartbooks/fast_facts/

U.S. Census Bureau: www.census.gov

CHAPTER

2 Legislative Foundations for Programs, Services, and Benefits Supporting Older Adults

It had been a busy week at the Area Agency on Aging office. Dorothy, the administrative assistant, was tidying up her desk on Friday afternoon and thinking about all the people the office had helped that week. Eva Wright, in her early 80s, came first to her mind. Eva's husband Jack had just undergone surgery for throat cancer. For the next couple of months, he would be restricted to a liquid diet for most of his meals. A low-income couple, but not at poverty level, the Wrights could not afford the full cost of a nutritional food supplement at their local grocery store. The Wrights found out about the Area Agency on Aging's food supplement program from their doctor. It had saved them nearly half the cost of the two cases a week required for Jack while he was recovering. With her many years' experience working at the agency's front desk, Dorothy knew that this couple would not have qualified for welfare assistance. She realized, yet again, how important the Older Americans Act (OAA) programs were to many people.

In countless communities across the country, local Area Agencies on Aging (AAAs) work to help older adults such as the Wrights. All Americans aged 60 and older can benefit from services provided by the "aging network" because of legislation enacted more than 50 years ago. On July 14, 1965, President Lyndon B. Johnson signed into law the OAA, thus launching milestone legislation in the evolution of the nation's public policy for older adults. The OAA is one of many laws that have been enacted to assist older adults in maintaining their physical, social, psychological, and financial well-being. This chapter discusses some of the important laws that laid the foundation for the creation of programs, services, and benefits for older adults. We begin with a review of some of the more notable aging legislation that has been enacted.

Legislative Foundations of Social Programs and Services

Long before the enactment of the OAA, policies designed to protect older adults from the vicissitudes of old age were slowly put into place (see Exhibit 2.1). For example, in 1920, the Civil Service Retirement Act, a federal pension program, was enacted for government employees, members of Congress, and people in the uniformed and

civil service. Some 15 years later, the Social Security Act (1935) was passed. Social Security—now contained under the Old-Age, Survivor, and Disability Insurance legislation—was created to ensure that working American families had a measure of economic security. Social Security is one of the best-known legislative policies enacted for the benefit of retirees, and later for survivors, dependents, and persons with disabilities. It was the first legislation to represent a "social contract" that was "to provide protection as a matter of right for the American worker in retirement" (Ficke, 1985, p. 115). It has proved to be one of the most popular, as well as one of the most adaptable, pieces of legislation in existence.

Exhibit 2.1 National Policy on Aging: Selected Historical Highlights

1920	The CIVIL SERVICE RETIREMENT ACT was enacted to provide a retirement system for many government employees, including members of Congress and those in the uniformed and civil services.
1927	The AMERICAN ASSOCIATION FOR OLD AGE SECURITY was organized to further national interest in old-age legislation.
1935	The SOCIAL SECURITY ACT was passed and signed into law by President Roosevelt "to provide protection as a matter of right for the American worker in retirement."
1937	The RAILROAD RETIREMENT ACT was enacted to provide annuities pensions for retired railroad employees and their families. The U.S. HOUSING ACT stimulated passage of enabling legislation in a majority of states to provide low-rent public housing.
1950	The first NATIONAL CONFERENCE ON AGING was held in Washington, D.C., sponsored by the Federal Security Agency. The SOCIAL SECURITY ACT WAS AMENDED to establish a program of aid to permanently and totally disabled people and to broaden aid to dependent children to include relatives with whom the child is living.
1956	SPECIAL STAFF ON AGING was assigned coordinating responsibilities for aging within the Office of the Secretary of Health, Education, and Welfare.
1959	The HOUSING ACT was amended authorizing a direct loan program of nonprofit rental projects for the elderly at low interest rates. Provisions also reduced the eligible age for public low-rent housing for low-income older persons to 62 for women and 50 for disabled individuals.
1961	The First WHITE HOUSE CONFERENCE ON AGING was convened in Washington, D.C. SOCIAL SECURITY AMENDMENTS lowered retirement age for men from age 65 to 62, increased minimum benefits paid, broadened the program to include additional categories of retired persons, increased benefits to aged widows, and liberalized the retirement test.
1962	More than 160 BILLS INTRODUCED IN CONGRESS related to the aged and aging; EIGHT WERE ENACTED.

1964	The FOOD STAMP ACT provided for improved levels of nutrition among low-income households through a cooperative federal–state program of food assistance. Formalizing a loose confederation of state administrators of aging programs, the NATIONAL ASSOCIATION OF STATE UNITS ON AGING was officially established on April 26, 1964.
1965	The OLDER AMERICANS ACT was passed and signed into law. Major provisions included establishment of the ADMINISTRATION ON AGING (AoA) within the Department of Health, Education, and Welfare and grants to states for community planning, services, and training. The Act also stipulated that STATE AGENCIES ON AGING be established to administer the program. The MEDICARE health insurance program for the elderly was legislated. It was financed through the Social Security system. SOCIAL SECURITY AMENDMENTS established Title XIX, "Grants to States for Medical Assistance," commonly known as Medicaid.
1967	AMENDMENTS TO THE OLDER AMERICANS ACT extended its provisions for two years and directed the AoA to undertake a study of personnel needs in the aging field. The AGE DISCRIMINATION ACT OF 1967 was passed and signed into law by President Johnson. AMENDMENTS TO THE OLDER AMERICANS ACT extended its provisions for 3 years and authorized the use of Title III funds to support AREA-WIDE MODEL PROJECTS.
1971	The Second WHITE HOUSE CONFERENCE ON AGING was convened in Washington, D.C.
1972	The NUTRITION PROGRAM FOR THE ELDERLY ACT was passed and signed into law by President Nixon (redesignated Title VII of the Older Americans Act, as amended in 1973). SUPPLEMENTAL SECURITY INCOME was passed as a part of the Social Security Act.
1973	The OLDER AMERICANS COMPREHENSIVE SERVICE AMENDMENTS established AREA AGENCIES ON AGING under an expanded Title III. They also authorized grants for model projects, senior centers, and multidisciplinary centers of gerontology and added a new Title IX. The OLDER AMERICANS COMMUNITY SERVICE EMPLOYMENT ACT authorized funding for Title VII nutrition projects and extended the Act's provisions for 2 years. The DOMESTIC VOLUNTEER SERVICE ACT was passed and signed into law. Major provisions included the RSVP and Foster Grandparent programs. Title VI of the Older Americans Act, as a result, was later repealed.
1974	AMENDMENTS TO THE OLDER AMERICANS ACT added a special TRANSPORTATION program under Title III model projects. SOCIAL SECURITY AMENDMENTS authorized TITLE XX, "Grants to States for Social Services." Among the programs that could be supported under this provision were protective services, homemaker services, adult day care service transportation services, training, employment opportunities, information and referral, nutrition assistance, and health support.

(Continued)

Exhibit 2.1 (Continued)

1975	AMENDMENTS TO THE OLDER AMERICANS ACT added new language authorizing the Commissioner on Aging to make grants under Title III to INDIAN TRIBAL ORGANIZATIONS. PRIORITY SERVICES were mandated (transportation, home care, legal services, and home renovation repair). Amendments also made minor changes in Title IX, "Community Service Employment for Older Americans."
1977	AMENDMENTS TO THE OLDER AMERICANS ACT authorized changes in the Title VII nutrition services program, primarily related to the availability of surplus commodities through the U.S. Department of Agriculture.
1978	The COMPREHENSIVE OLDER AMERICANS ACT AMENDMENTS OF 1978 consolidated Titles III, V, and VII (social services, multipurpose centers, and nutrition services, respectively) into one Title III; redesignated the previous Title IX (Community Service Employment Act) as Title V; and added a new Title VI, "Grants for Indian Tribes." AMENDMENTS TO THE OLDER AMERICANS ACT extended the Act's programs for 3 years through September 30, 1984.
1984	The OLDER AMERICANS ACT AMENDMENTS OF 1984 clarified the roles of State and Area Agencies on Aging in coordinating community-based services and in maintaining accountability for the funding of national priority services (legal, access, and in-home services), provided for greater flexibility in administering programs by providing for increased transfer authority between parts B and C of Title III, and added a new Title VII, "Older Americans Personal Health Education and Training Program," for funding grants to institutions of higher education to develop standardized programs of health education and training for older persons to be provided in multipurpose senior centers.
1987	AMENDMENTS TO THE OLDER AMERICANS ACT required coordination of in-home, access, and legal services with ongoing activities of agencies working with persons with Alzheimer's disease. In-home support services for frail elders and disease prevention and health promotion services were now supported under Title III.
1991	The ADMINISTRATION ON AGING became an independent agency reporting to the U.S. Department of Health and Human Services (USDHHS).
1992	TITLE III PART C authorized school-based meals for older school volunteers and to help pay the costs of meals of older adults who volunteer in intergenerational programs. AMENDMENTS TO THE OAA added Part D authorizing support for frail elders. AMENDMENTS TO THE OAA added Part F to Title III titled "Disease Prevention and Health Promotion Services." The OFFICE OF LONG-TERM CARE OMBUDSMAN PROGRAMS was established within AoA. TITLE VII, "VULNERABLE ELDER RIGHTS PROTECTION," was enacted, combining many of the provisions under Title III.
2000	AMENDMENTS TO THE OLDER AMERICANS ACT moved Part D, In-Home Services, Part E, Special Needs, and Part G, Supportive Activities for Caretakers, to Part B, Supportive Services; created Part E, National Family Caregiver Support Program; and established a White House Conference on Aging in 2005.

2003	The MEDICARE PRESCRIPTION DRUG, IMPROVEMENT AND MODERNIZATION ACT provided seniors and individuals with disabilities with a prescription drug benefit.
2006	Reauthorization of the Older Americans Act created the NATIONAL CENTER ON SENIOR BENEFITS OUTREACH AND ENROLLMENT and CHOICES FOR INDEPENDENCE initiative. The MEDICARE PART D PRESCRIPTION DRUG PROGRAM went into effect. The LIFESPAN RESPITE CARE ACT (administered by AoA) was passed.
2010	The PATIENT PROTECTION AND AFFORDABLE CARE ACT was passed.
2012	AoA and three other areas in USDHHS were reorganized under the ADMINISTRATION FOR COMMUNITY LIVING.
2016	The OLDER AMERICANS ACT REAUTHORIZATION was passed.

Sources: Compiled by the authors from Ficke (1985); OAA of 1965, as amended; and AoA (2016).

The Social Security Act was signed into law by President Franklin D. Roosevelt on August 14, 1935. The main provision of the Act was to provide a social insurance program designed to pay retired workers age 65 or older a continuing income after retirement. The first payments began in 1937 and were made as lump sum payments averaging $58.06. Monthly payments began in January 1940. The first monthly retirement check was issued to Ida May Fuller of Ludlow, Vermont, in the amount of $22.54. Ida Mae died in January 1975 at the age of 100. During her 35 years as a beneficiary, she received more than $20,000 in benefits (Social Security Administration, n.d.). Originally, the amount received by Ida May—$22.54—would be the amount she would receive for the rest of her life. Not until 1952 did Congress legislate increases in the monthly benefit. From that point, increases came only when legislated by Congress until 1972, when Congress enacted a law providing for annual cost-of-living increases, the amount to be determined by the annual increase in consumer prices.

There have been hundreds of amendments to the Social Security Act. Most have made minor adjustments to the Act; several, however, have profoundly increased the responsibility of the Act to extend benefits to previously uncovered groups (see Exhibit 2.1). One such amendment, passed by Congress in 1950, extended benefits to permanently and totally disabled workers. This was eventually broadened to cover workers under age 50 and their dependents. By 1960, some 559,000 people were receiving disability benefits, with an average benefit of $80 per month. In 2017, 8.78 million disabled workers received an average benefit of $1,171 per month (Social Security Administration, 2017a).

Another significant amendment to the Social Security Act was passed in 1972 when, at the request of President Richard M. Nixon, the joint federal–state programs Old-Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled were streamlined to create the Supplemental Security Income (SSI) program. Under the SSI program, each eligible person over the age of 65 living in his or her own household and having no other income was provided, in 2017, an average monthly cash payment of $437.41 (Social Security Administration, 2017f). In 2000, the Social Security Act was

amended to reflect changing demographics and needs of older workers through the passage of H.R. 5, the Senior Citizens' Freedom to Work Act. Signed on April 7, 2000, by President Bill Clinton, this law amended Social Security to eliminate the Retirement Earnings Test, which required eligible retirees to have their benefits reduced if they were also working (Senior Citizens' Freedom to Work Act, Pub. L. No. 106-182 [2000]).

More recently, in 2015, the Supreme Court issued a decision in *Obergefell v. Hodges* stating that same-sex couples have a constitutional right to marry in all states and have their marriage recognized by other states. As a result, the Social Security Administration now recognizes same-sex couples' marriages for purposes of determining entitlement to Social Security benefits as well as eligibility for SSI payments (Social Security Administration, 2017h). Both Social Security and SSI are discussed in greater detail in Chapter 9.

Other early legislation benefiting older adults, enacted soon after the Social Security Act, included the Railroad Retirement Act of 1937 (providing pensions for railroad retirees) and the U.S. Housing Act of 1937 (enabling legislation for states to provide low-rent housing). Between 1940 and 1964, a number of other legislative and political activities occurred. In addition to the amendments added to the Social Security Act mentioned above, the Housing Act was amended and expanded, and the Food Stamp Act of 1964 was enacted.

The 1950s marked the emergence of another important influence on the evolution of aging policy—the White House Conferences on Aging. The first National Conference on Aging was held in Washington, D.C., in 1950, and the first White House Conference on Aging was held in 1961 (Ficke, 1985); conferences were held in 1971, 1981, 1995, 2005, and, most recently, 2015. The conference delegates—representatives of federal, state, and local governments as well as professionals in the field of gerontology and older adults—convened to develop specific recommendations for executive or legislative action on aging policy.

The next significant date in the history of aging policy is 1965, when two major laws were enacted—Medicare and the OAA. Sixteen days after President Johnson signed the OAA, he signed Medicare, the national health insurance program for older adults, into law on July 30, 1965, through amendments to the Social Security Act. The passage of both the OAA and Medicare in the same year has marked the mid-1960s as the most politically friendly period for older Americans' programs in history. The passage of Medicare was historic not only for the health benefits that it would afford millions of older Americans but also for the sheer significance of overcoming more than 30 years of political opposition, largely from the American Medical Association, to government-funded health coverage. All along, most proponents had intended for government-funded health coverage to be universal. After years of debate, a compromise was offered that adopted an incremental approach whereby older adults would be covered first, thereby pushing universal coverage into the distant future (Rich & Baum, 1984). The debate about universal health care coverage reemerged on the political scene in 2009 with the debate over and ultimate passage of the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA is a comprehensive piece of legislation that expands health care access and coverage to all Americans, including older Americans under Medicare. One component of the ACA was the Community Living Assistance and Supports program that was designed to establish a voluntary insurance program for American workers to help

pay for long-term care services and supports that they might need in the future. It was to be administered by the AoA, but the program was not implemented because it was uncertain whether it could meet the fiscal targets established in the law (U.S. Department of Health and Human Services [USDHHS], 2011b). Today, Medicare provides partial health coverage for 58.5 million Americans 65 years of age and older, as well as people of any age with permanent kidney failure and certain people with disabilities under the age of 65 (Centers for Medicare and Medicaid Services [CMS], 2017a). Specific benefits of Medicare and the changes to Medicare with passage of and changes to the ACA are discussed in Chapter 11.

Although not the first major legislation addressing the needs of America's older adults, the OAA has become a landmark in the evolution of the nation's public policy for older adults (Bechill, 1992) and is largely responsible for the development of what is frequently referred to as the *aging network*, which has been described as the "bedrock of community support" for older adults and their families (Lynch & Estes, 2001). The advocacy and coordination mandates of the Act, as we will discuss later, have played a significant role in encouraging our nation's systems of human services to come together to do a better job of meeting the needs of older Americans.

In the remainder of this chapter, we discuss the history of the passage of the OAA, followed by a review of each of the Act's titles, changes in the 2016 reauthorization, and the impact of the OAA on the lives of older adults. We conclude by presenting some of the controversial issues surrounding the OAA.

Emergence of the Aging Network

The origin of the OAA can be traced to the 1961 White House Conference on Aging. Health care coverage was the key issue that emerged from the many state aging conferences that were held prior to the White House Conference. After the White House Conference in 1961, a special committee drafted resolutions that eventually led to the 1965 enactment of both Medicare and the OAA. The OAA was the first program to focus on community-based services for older adults and the first legislation mandated to bring together a fragmented and uncoordinated public and private service delivery system to meet the basic needs of elders at the community level (J. J. Lee, 1991). This visionary nature of the OAA sets it apart from other previous and subsequent legislative initiatives.

The passage of the OAA created a network of services that is unique to social programming. Much more than a collection of agencies, the aging network is a formidable structure, made up of a well-defined system that links the AoA, 56 State Units on Aging (SUAs), 629 local AAAs, Title VI grants to 244 Indian tribes, two Native Hawaiian organizations, and thousands of providers across the country delivering services to older Americans (USDHHS, 2016). This network is bonded together around a central role—to support the federal government in transforming a patchwork of programs for the older population into a locally coordinated service system. Relying on partnerships among the three levels of federal, state, and local government; universities; and a wide range of voluntary organizations working with older people, the aging network's emphasis on planning, coordination, and advocacy has provided an infrastructure and point of entry for

other public and private initiatives that supplement OAA funding. These public–private initiatives represent an extraordinary record of achievement in making a small amount of federal money go a long way to help hundreds of thousands of older people remain living independently in the community. Today, aging network programs are supported by an array of sources in conjunction with the AoA, including Medicaid, social service block grants, state and local governments, the private sector, and individual contributions. With this combination of resources, more than 10.9 million older adults received services or participated in programs funded under the OAA in 2015 (Administration for Community Living, n.d.-i).

In 2012, three separate offices under the USDHHS—AoA, the Administration on Developmental Disabilities, and the Office on Disability—were reorganized under one office called the Administration for Community Living (ACL) and report to the ACL administrator, which is the assistant secretary for aging (see Exhibit 2.2; ACL, 2017b). The purpose of the reorganization was to establish a single, formal infrastructure in the USDHHS to ensure consistency and coordination in community living policy and to focus on community living support for older adults and people with disabilities while still meeting the unique needs of each population. Additional organizational changes have occurred since 2012, and the units under the ACL are now the AoA; Administration on Disabilities; National Institute on Disability, Independent Living, and Rehabilitation Research; Center for Integrated Programs; Center for Policy and Evaluation; Office of Regional Operations; and Center for Management and Budget (ACL, 2017b). The regional offices, which were previously under the AoA and supported only OAA activities, now report directly to the ACL administrator and broaden coordination activities at the regional level to include all of the programs and populations served under the ACL.

The reorganization has not changed the AoA's role and function as outlined in the Titles under the OAA (explained in more detail later in the chapter); however, the AoA office has also been reorganized into five offices (USDHHS, 2012a, 2012d; ACL 2017b):

1. The Office of Supportive and Caregiver Services is the focal point for supportive services programs and family caregivers programs under Title II Part B and Title III Part E of the OAA, and works with SUAs to implement and enhance systems for home- and community-based supportive services, the operation of multipurpose senior centers, and caregiver support and assistance services.

2. The Office of Nutrition and Health Promotion Programs is the focal point for the operation, administration, and assessment of the programs authorized under Title III Parts C and D of the OAA, which are the nutrition programs and programs related to preventive health, including the oral health program, chronic disease self-management education programs, falls prevention programs, and behavioral health information.

3. The Office of Elder Justice and Adult Protective Services is the focal point for the operation, administration, and assessment of the elder abuse prevention, legal assistance development, and pension counseling programs under Titles II and VII of the OAA. In addition, the office administers the Adult Protective Services systems and other related activities under Title IV of the OAA.

4. The Office of American Indian, Alaskan Native, and Native Hawaiian Programs is the focal point for programs authorized under Title VI of the OAA, including managing the National Resource Centers on Native American Elders, and assists in the evaluation of programs to native people under Titles III and VI. The office serves as the advocate within the USDHHS and with other departments and agencies of the federal government regarding all federal policies affecting older Native Americans. The office also works with state, local, and tribal governments by providing leadership and coordination of activities, services, and policies affecting American Indians, Alaskan Natives, and Native Hawaiian elders.
5. The Office of Long-Term Care Ombudsman Programs is the focal point for advocacy regarding federal policies and laws that may adversely affect the health, safety, welfare, or rights of residents of long-term care facilities. The office also works with the Office of Elder Justice and Adult Protective Services to administer the Long-Term Care Ombudsman Program and the National Ombudsman Resource Center.

Best Practice

Linking Public and Private Partnerships

Many local area agencies on aging have worked to develop partnerships with the private sector to meet the needs of older adults in their communities. Here are a few examples.

- The Westchester Public/Private Partnership for Aging Services is a partnership between the Westchester (New York) County government and the county's Department of Senior Programs and Services, other government agencies, businesses, voluntary service agencies, and consumers to support older adults in Westchester County with independence and dignity in their community. The motivation for this partnership was based on the current number of older adults in the county (193,000 adults age 60 and over) as well as projected growth in adults age 85 and older, who are the county's fastest growing sector of the senior population. The Westchester Public/Private Partnership for Aging Services utilizes private corporations to assist in the delivery of aging services, through unrestricted funds and in-kind services that significantly expand the capacity of services to meet growing demand. For more information, contact 914-813-6435, http://westchesterpartnership.org/.
- The Clearfield County (Pennsylvania) AAA's "Blizzard Box Program," launched

(Continued)

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in 1983, is a collaborative effort with the Clearfield, Curwensville, and DuBois Rotary Clubs and businesses such as Wal-Mart. Volunteers assemble the boxes at the local Wal-Mart distribution center and deliver Blizzard Boxes—emergency food kits—along with regular home-delivered meals during the fall to more than 1,000 older adults. The Blizzard Boxes, which contain the nutritional equivalent of three full meals, are to be used when bad weather prevents the delivery of regular meals. For more information, contact 800-225-8571, www.ccaaa.net/single-post/2017/08/01/August-2017-Lifespan.

Another notable aspect of the OAA and the network of services that has evolved from the Act is that this service network is a universal program. This universal emphasis recognizes that all older persons have needs and that programs and services should be available, as a result, to them all (Bechill, 1992). Therefore, there is no means test cutoff for programs and services funded under the Act; persons are eligible for services regardless of income or assets. Using an age-based criterion, all persons 60 years of age or older are eligible for services. Language in the Act, however, places emphasis on helping older persons with the greatest social and economic need, particularly low-income persons of color. Amendments to the OAA in 2000 and 2006 emphasized services to older adults who are frail, in addition to low-income, rural, and racial and ethnic elders, including those with limited English proficiency (see Exhibits 2.1 and 2.3). Specifically, the term *greatest social need* means the need caused by noneconomic factors such as these:

(A) physical and mental disabilities;

(B) language barriers; and

(C) cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that

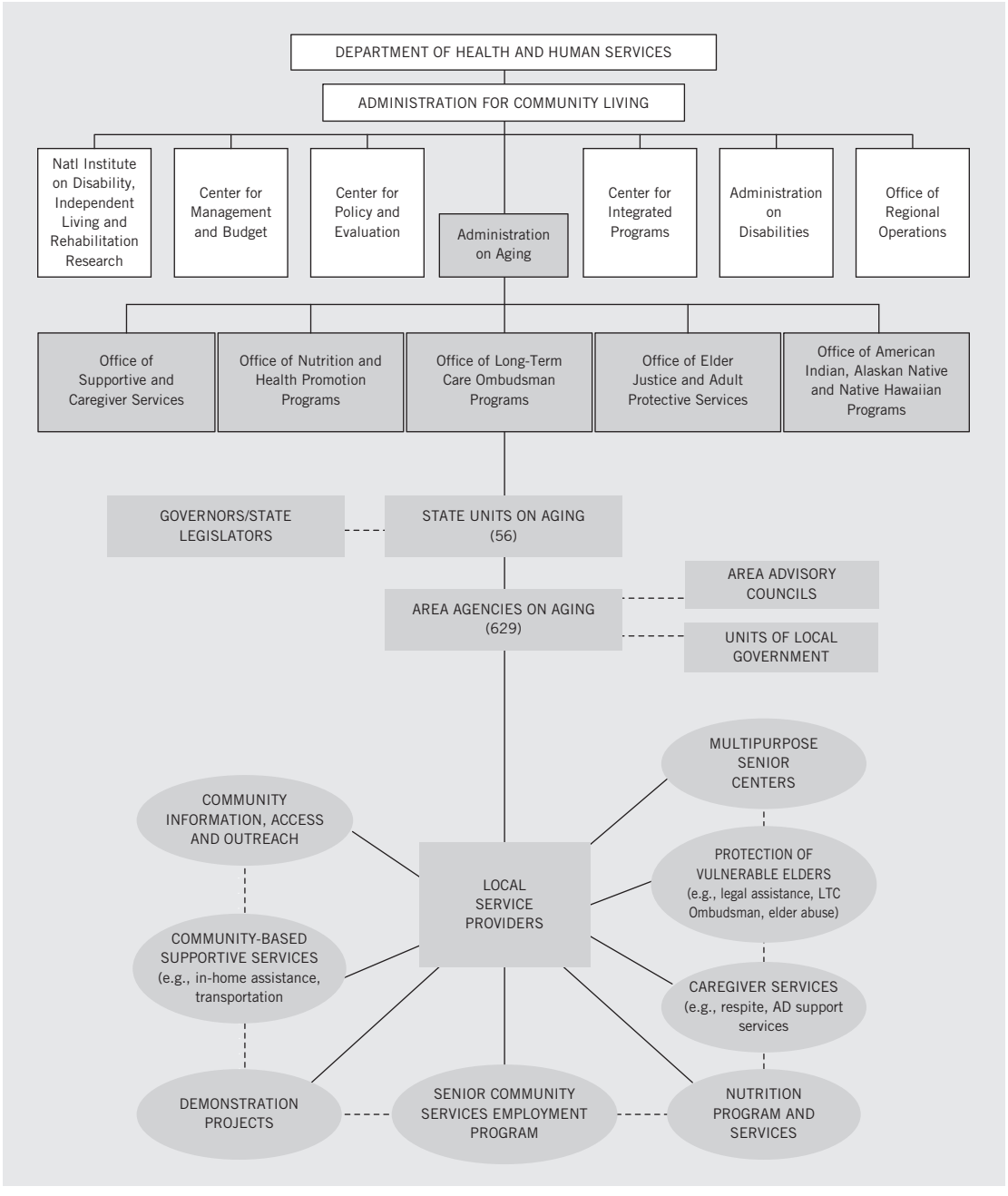
(i) restricts the ability of an individual to perform normal daily tasks; or

(ii) threatens the capacity of the individual to live independently (OAA of 1965, as amended, § 102[24]).

In 2012, the AoA further clarified the above definition of greatest social need under the OAA by stating that "greatest social need does not exclude isolated populations other than racial and ethnic minorities and may include, depending on the planning and service area, religious minorities, individuals isolated due to sexual orientation or gender identity or other special populations" (ACL, 2017k).

In the 2006 reauthorization of the Act, Congress included language allowing programs to establish cost-sharing with participants in some circumstances. Cost-sharing is

Exhibit 2.2 Organizational Structure of the Administration on Aging and the Older Americans Act Network



Sources: Adapted from Ficke (1985) and ACL (2017d).

not permitted for information and assistance, outreach, benefits counseling or case management services, ombudsman programs, elder abuse prevention, legal assistance or other consumer protection services, congregate and home-delivered meals, or any service delivered through tribal agencies. Individuals with self-declared incomes at or below the federal poverty level are exempt from cost-sharing. If a program is allowed to implement cost-sharing, a sliding scale based solely on income must be used; however, an older adult cannot be denied the service based on income or failure to make a payment. The cost-share amount is based on a confidential declaration of income made by the participant. The OAA also encourages providers of services to give participants whose self-declared income is at or above 185% of the poverty line the "opportunity" to donate toward the cost of a service, but the law strictly forbids denying anyone access to a service because of an inability to donate or pay the cost-share amount. The challenges arising from the emphasis on universality, targeting, and cost-sharing in the same legislation are discussed in more detail later in the chapter and in Chapter 20.

The reauthorization of the Older Americans Act in 2016 made some notable changes in programs and services (see Exhibit 2.4). The Act increases efforts to promote health, independence, and economic well-being, offers new support for modernizing multipurpose senior centers, focuses efforts for chronic disease self-management and falls prevention, and includes stronger elder justice and legal services provisions. These changes are discussed in more detail in related chapters.

Exhibit 2.3 Key Changes in the Reauthorization of the Older Americans Act, 2006

- Improved access to benefits programs for seniors with limited income through creation of a National Center on Senior Benefits Outreach and Enrollment
- Promoted evidence-based health promotion and disease prevention programs
- Provided broader opportunities for seniors' civic engagement
- Expanded eligibility for the National Family Caregiver Support Program to allow participation by a relative caregiver beginning at age 55 and to allow participation by a caregiver of any age who cares for a person with Alzheimer's disease or a related neurological disorder
- Authorized creation of Aging and Disability Resource Centers in all 50 states
- Targeted services to seniors with limited English proficiency
- Made more explicit the inclusion of mental health as a concern and target for programming under the Act

Source: Public Law 109-365, Older Americans Act Amendments of 2006.

Exhibit 2.4 Key Changes in the Reauthorization of the Older Americans Act, 2016

- Sought to improve Aging and Disability Resource Centers coordination with area agencies on aging and other community-based entities in disseminating information about home- and community-based services
- Directed the Administration on Aging to include training on elder justice and abuse prevention and screening for states, area agencies on aging, and service providers
- Added "oral health" to the definition of Disease Prevention and Health Promotion services
- Directed the assistant secretary to develop guidance on serving Holocaust survivors through Older Americans Act programs
- Directed the assistant secretary to develop a consumer-friendly tool to assist older individuals and their families in choosing home- and community-based services
- Authorized Long-Term Care (LTC) Ombudsman programs to serve all LTC facility residents, regardless of their age, and to serve residents transitioning from an LTC facility to a home-care setting
- Updated and clarified references of mental health to also include "behavioral health"
- Clarified that older adults caring for adult children with disabilities and older adults raising children under 18 are eligible to participate in the National Family Caregiver Support Program
- Clarified that supplemental foods may be part of a home-delivered meal at the option of a nutrition services provider and encouraged the use of locally grown foods in meal programs
- Encouraged efforts to modernize multipurpose senior centers and promote intergenerational shared-site models in area agency on aging plans
- Clarified that health screening includes mental and behavioral health screening and falls prevention screening
- Directed the assistant secretary to provide information and technical assistance on providing efficient, person-centered transportation services, including across geographic boundaries

Source: Administration for Community Living (2016).

Titles of the Older Americans Act

Currently, the OAA contains seven titles. *Title I* sets forth 10 broad policy objectives aimed at improving the lives of older people with regard not only to income (the principal objective of Social Security) but also to physical and mental health, housing,

employment, and community service. These broad objectives continue to be the philosophical cornerstone of this Act:

1. An adequate income in retirement in accordance with the American standard of living
2. The best possible physical and mental health that science can make available, without regard to economic status
3. The provision and maintenance of suitable housing, independently selected, designed, and located with reference to special needs and available at costs that older citizens can afford
4. Full restorative services for those who require institutional care and a comprehensive array of community-based long-term care services adequate to appropriately sustain older people in their communities and in their homes, including support to family members and other persons providing voluntary care to older individuals needing long-term care services
5. Opportunity for employment with no discriminatory personnel practices because of age
6. Retirement in health, honor, and dignity after years of contribution to the economy
7. Participation in and contribution to meaningful activity within the widest range of civic, cultural, and recreational opportunities
8. Efficient community services, including access to low-cost transportation, that provide a choice in supported living arrangements and social assistance in a coordinated manner and that are readily available when needed, with emphasis on maintenance of a continuum of care for vulnerable older individuals
9. Immediate benefit from proven research knowledge that can sustain and improve health and happiness
10. Freedom, independence, and the free exercise of individual initiative for older adults in planning and managing their own lives, full participation in the planning and operation of community-based services and programs provided for their benefit, and protection against abuse, neglect, and exploitation (OAA of 1965, as amended, Title I, p. 1)

These far-reaching goals are to be carried out jointly by federal, state, tribal, and local governments to achieve an adequate offering of community-based services for older adults. With a $1.4 billion budget in fiscal year (FY) 2017, the programs and services funded through OAA still make the OAA one of the smallest federal programs (USDHHS, 2017a).

For Your Files

Policy and Planning for Disaster Preparedness

A little more than 10 years ago, Hurricane Katrina brought devastation to the Gulf Coast, and a disproportionate number of older adults died in the storm and the chaos in the days after the storm. Although adults age 60 and over accounted for approximately 15% of the New Orleans population, 74% of the dead were 60 or older; nearly half were older than age 75 (T. A. Glass, 2006). The emergency response that occurred afterward often resulted in inappropriate displacements and deterioration in health and functioning (Gibson, 2006). In the aftermath of Katrina, AARP convened a diverse group of government officials at federal, state, and local levels; emergency preparedness and response experts; relief organizations; and aging and disability advocates to identify lessons learned and share promising practices in protecting older persons in disasters. The report, *We Can Do Better: Lessons Learned for Protecting Older Persons in Disasters,* is available at http://assets.aarp.org/rgcenter/il/better.pdf.

Natural disasters such as Hurricanes Sandy in 2012 and Harvey and Irma in 2017, annual wildfires in the western and southwestern United States, and crippling blizzards like the one in 2016 that produced up to 3 feet of snow in parts of the Mid-Atlantic and Northeast remind us that natural disasters occur with regularity. Scholars and advocates have continued their call for disaster preparedness policies and programs that address the unique evacuation needs of community-dwelling and institutionalized older adults, who face different risks in disasters due to physical and psychosocial limitations. Federal government entities such as the Administration for Community Living and the Federal Emergency Management Agency as well as advocacy groups such as the National Council on Disabilities, AARP, and National Disability Rights Network have worked to improve federal, state, and local disaster/emergency preparedness planning and response that is inclusive of older adults and help educate vulnerable populations about emergency planning. The Rooted in Rights project of the Disability Rights Washington agency released "The Right to be Rescued" (www.rootedinrights.org/righttoberescued/), a documentary that captures the experiences of older people and people with disabilities during a storm and the devastating consequences of the lack of emergency planning for their needs. FEMA and the Department of Homeland Security's website, www.ready.gov, has guides (e.g., *Prepare for Emergencies Now: Information for Older Americans*) and other resources to assist older adults in preparing for emergencies before they happen. The Centers for Disease Control and Prevention published *Identifying Vulnerable Older Adults and Legal Options for Increasing Their Protection During All-Hazards Emergencies* (www.cdc.gov/aging/emergency/pdf/guide.pdf), a guide that provides public health officials, the aging services network, emergency management, and other essential partners with critical information, strategies, and resources about planning for and protection of vulnerable community-dwelling older adults during all-hazards public health emergencies. Finally, the ACL offers *Just in Case: Emergency Readiness for Older Adults and Caregivers* (www.acl.gov/sites/default/files/programs/2016-10/Just_in_Case030706_links.pdf).

Title II created the AoA within the Office of the Secretary of the DHHS. AoA is headed by an assistant secretary on aging, appointed by the president, who now also serves as the administrator for the ACL. Through the years, there has been considerable debate about the placement of AoA within the executive branch of government. The

debate has centered on whether AoA should be an independent office at the White House level, be an office of the USDHHS, or be placed under a department of the USDHHS, and the debate continues with AoA now one of four offices reporting to the ACL. In 1992, President Clinton placed the AoA assistant secretary directly under the USDHHS secretary—a move applauded by aging advocates because the assistant secretary has the direct ear of the USDHHS secretary and even the president when necessary. Although the AoA has a different organizational structure under the USDHHS, the assistant secretary of aging continues to report directly to the USDHHS secretary and to be the federal focal point for aging issues and program planning. The AoA has two principal roles. First, it is responsible for carrying out the planning, coordination, and provision of services to older adults. AoA promotes training, technical assistance, and regulatory direction to help the states and local AAAs carry out their mandates. Essentially, every time the OAA is reauthorized and amended, AoA must interpret congressional intent through rule making and rule interpretation. States, local AAAs, and other interested parties may comment on the rules and frequently influence the way a particular rule is written. This is often a long and drawn-out process.

The second important role of AoA is to provide leadership on national policies affecting older adults. This is done by encouraging cooperation and coordination among the major federal agencies on federal aging policies. AoA is thus a major advocate for older adults throughout the federal government. For example, the U.S. Department of Housing and Urban Development plans and implements programs to address housing needs of *all* low-income population groups. The Federal Transit Administration helps develop policy and funding initiatives to respond to a wide range of transit issues, including transit infrastructure. AoA is the only federal agency that has the authority to cross agency boundaries to provide overall leadership on singularly aging issues and programs. When AoA was first established, Congress adamantly voiced its expectation that AoA have high visibility in the executive branch for developing and sponsoring a nationwide program to achieve the objectives set forth in the OAA (Ficke, 1985).

The OAA amendments of 2000 required the assistant secretary of AoA to improve the delivery of services to rural areas by developing a best practices resource guide showing how rural needs can best be met and to provide training and technical assistance to help states in implementing best practices. Another significant new mandate was the requirement that AoA, in coordination with SUAs, AAAs, tribal organizations, and service providers, develop and publish before January 1, 2002, performance outcome measures for planning, managing, and evaluating activities performed under the Act. The 2000 amendments also, under Title II, established the Eldercare Locator and pension counseling as permanent programs and commissioned a White House Conference on Aging to take place before the end of 2005.

One of the amendments made to the OAA in 2006 (see Exhibit 2.3) authorized the assistant secretary to promote three additional areas of focus. One is an effort called Principles of Choices for Independence, which is a demonstration project to advance consumer-directed and community-based long-term care options. This included the creation of Aging and Disability Resources Centers in all 50 states designed to be "one-stop shops" for older adults and their families to receive information about long-term care options. Another change in the Act in 2006 was authorization of the National Center on Senior Benefits Outreach and Enrollment program. The purpose of the program is to

provide web-based support and other tools to inform older adults about the full range of federal and state benefits for which they may be eligible. The third area, civic engagement, charged the assistant secretary to work with the Corporation for National and Community Service to encourage civic engagement activities for persons of all ages. Aging network support programs identified in the FY 13 budget under Title II included the Senior Medicare Patrol Program, the National Alzheimer's Call Center, the Pension Counseling and Information program, the National Resource Center on Lesbian, Gay, Bisexual and Transgender (LGBT) Aging, the National Education and Resource Center on Women and Retirement Planning, National Resource Centers on Native American Elders, National Minority Aging Organizations Technical Assistance Centers, and elder rights support activities (USDHHS, 2012a).

The 2016 amendments to the OAA added four new actions the assistant secretary must attend to: (1) provide information and technical assistance on providing efficient, person-centered transportation services; (2) identify model programs and provide information and technical assistance to support modernization of multipurpose senior centers; (3) provide technical assistance and share best practices to improve care coordination for individuals with multiple chronic illnesses; and (4) develop a consumer-friendly tool to assist older adults and their families in choosing home- and community-based services (OAA, 2016, § 202(a)(29)(30)(31); 202(b)(5)(D)). The assistant secretary is also charged with ensuring that OAA programs include appropriate training in the prevention of abuse, neglect, and exploitation and that services exist that address elder justice and exploitation of older adults.

The AoA is often charged with implementing programs targeted for older adults that have been authorized under non-OAA legislation. For example, the Lifespan Respite Care Program was enacted in 2006 as an amendment to the Public Health Service Act of 2006 and authorized the AoA with implementing the program. Lifespan Respite Care programs bring together federal, state, and local resources and funding to help support, expand, and streamline the delivery of planned and emergency respite services while also providing for the recruitment and training of respite workers and caregiver training and empowerment (ACL, 2017f). The Lifespan Respite Care Act is intended to expand and enhance respite services in the states, improve coordination and dissemination of service delivery between the various programs available, improve access to programs, and improve the overall quality of the respite services currently available. Another example is the Chronic Disease Self-Management Programs funded under the ACA and designed to use state-of-the-art techniques to help older adults manage and treat chronic conditions (USDHHS, 2012a).

Title III, the largest program under the OAA, authorizes the development of local services to help older persons. It has been described as the heart and soul of the OAA. Title III authorizes the development of programs to assist older persons through grants to states. States, in turn, award funds to local planning and service areas (PSAs) whose boundaries have been designated by the state. SUAs administer the AoA grants at the state level, and the AAAs administer the AoA grants for the PSAs. An allocation formula based on the number of persons age 60 and older residing in the state as of the most recent census determines the amount of funding each state receives. It follows, then, that Florida and California, which have large numbers of adults 60 years of age and older, will receive larger federal allocations than states with fewer older adults, such as Colorado and Vermont. The 2016 reauthorization mandates that for 2017–2019 no state will be

allotted an amount that is less than 99% of the previous year's allotment and in 2020 no state is to receive less than 100% of its 2019 allotment (OAA, § 304(a)(3)(D)(i)(ii)). States must provide a minimum 15% match to the federal AoA grant. These matching funds vary greatly by state and help to increase the overall resources available under the OAA. SUAs keep 10% of their federal allocation for administration of the SUA. The balance is allocated to the PSAs by a more complex formula devised by the SUA using federal guidelines. The allocation formulas typically are based on census data numbers for persons age 60 years or older—and for low-income, minority, rural, and frail individuals within this category—who reside in each PSA. AAAs must also provide local matching, which may be either cash or in-kind support, such as the value of volunteer hours or value of donated space and equipment to carry out a particular program.

The local AAA is responsible for

- developing the area plan for a comprehensive and coordinated system for supportive services, nutrition services, and establishment, maintenance, modernization, or construction of multipurpose senior centers (including a plan to use the paid or unpaid services of older adults) to meet the needs of older persons;
- funding service provider agencies to fill gaps in priority service areas; and
- serving as the advocate and focal point for older people within its PSA.

Throughout the country, AAAs exhibit many organizational designs and structures based on local needs and preferences. The AAA office within a PSA may be a unit of general-purpose local government, such as a county, city, or regional council of government, or a public or nonprofit private agency. In any given location, an AAA can be a part of a council of governments or regional planning commission, part of a county unit of government or city government, part of an educational institution, or a freestanding private nonprofit organization.

Under Part A of Title III of the OAA, both SUAs and AAAs must develop multiyear plans describing in detail how a coordinated, comprehensive service delivery system will be provided. AAAs must also designate, where feasible, a focal point for service delivery in each community, giving strong consideration to multipurpose senior centers. The Act requires that the AAA establish a council to advise the agency on the development of multiyear plans, funding, and administration, as well as programs and services. The local councils may conduct public hearings and review and comment on all community policies, programs, and actions that affect older persons in their regions. Advisory council membership must be made up of older adults (including individuals of color and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public. Other members may represent older individuals, local elected officials, and the general public. This mandate for grassroots participation in the planning and administration of local AoA programs has given a voice to thousands of older adults on services that affect their daily lives.