June 2, 2022

Administration for Community Living
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attention: Caldwell Jackson, Administration for Community Living

RE: Request for Information on Older Americans Act Regulations

For 57 years, the Older Americans Act (OAA) has been essential in developing, coordinating, and delivering home- and community-based services that help older adults age with independence and dignity in their own homes and communities. Even before its passage in 1965, the organized Jewish community had long championed the need for this groundbreaking legislation. Without the crucial services provided by and funded through the OAA, many individuals served by Jewish institutions would be at significant risk of hunger, isolation, and losing their ability to live healthily and with independence.

On behalf of the Jewish Federations of North America and the Network of Jewish Human Service Agencies, thank you for the opportunity to provide input for the Administration for Community Living's (ACL) Request for Information on the Older Americans Act Regulations as part of its first general regulatory input process since the Older Americans Act regulations were first compiled in 1988.

Since 1988, our country's senior population has changed significantly in size and diversity, with large increases in the number of older adults and life expectancy, as well as changing attitudes towards institutional care. Technology, of course, has also advanced significantly in the intervening years, with a tremendous impact on the delivery of human services. In 1988, the internet was virtually non-existent, the cell phone the size of a shoe box, and telehealth visits a figment of the Jetsons' imaginations. The COVID-19 pandemic revealed significant risks to older adults and the challenges to the nation in caring for our much larger older adult population while significantly accelerating much broader use of technology to facilitate the delivery of services. The regulations must reflect these changes. Holistically they should reflect best practices for service delivery and evidence-based research, while promoting program flexibility and reducing the administrative burden on providers.

The Jewish Federations of North America (JFNA) is the umbrella organization for 146 Jewish Federations and 300 independent communities across North America. Our network of hospitals, aging provider and assisted living facilities, group homes, family service and vocational training agencies, kosher food banks and supplemental meal programs, and community centers and camps provide a full continuum of care for our nation's most vulnerable citizens – older adults, persons with disabilities, children and at-risk youth, and immigrants and refugees. With the assistance of government support in a true public-private partnership, JFNA serves more than one million clients each year in every state of the country, in Israel and more than 60 countries around the world. We also oversee the exemplary Center on Holocaust Survivor Care/Institute on Aging and Trauma, an ACL-affiliated technical assistance center funded through the Older Americans Act.

The Network of Jewish Human Service Agencies (NJHSA) represents over 150 nonprofit organizations in the United States, Canada and Israel. NJHSA's members provide a full range of human services for the Jewish community and beyond, including supplemental food assistance, health care, career and employment services, and mental health services, as well as programs for seniors, youth and families, Holocaust survivors, immigrants and refugees, people with disabilities, and caregivers.

JFNA and NJHSA collectively serve hundreds of thousands of older adults each year, Jewish and non-Jewish alike, through affiliated Jewish family agencies, Jewish vocational service agencies, Jewish community centers, and other organizations that provide services funded through the OAA, including case management, transportation, congregate and home-delivered meals, adult day care, elder abuse prevention and intervention, family caregiver support, homecare, legal conservatorship, and support groups. In part, these core services are particularly necessary because the Jewish community has long had proportionally more older adults than the general population, with well over 25% of American Jews already over the age of 65. The fastest growing demographic within the Jewish community are those over the age of 85. Approximately 25% of the Jewish community also faces poverty, with a high proportion of those households including older adults.

As Jewish organizations, we believe that no matter a person's circumstance, every individual is entitled to live in dignity, utilizing home- and community-based services as appropriate, and on behalf of and with input from our networks, we share the following comments and recommendations and look forward to working with ACL as you undertake this exceptionally important administrative procedure in redrafting the OAA governing regulations.

Virtual Options

During the COVID-19 Public Health Emergency, telehealth services were significantly expanded to provide behavioral health care, home- and community-based care, home care, adult day programming, supported employment, case management and more, allowing older adults access to vital services while safeguarding them from infection. Despite access to the benefits offered by telehealth, many older adults disproportionately encountered challenges in actualizing telehealth for a variety of reasons, such as lack of access to broadband and smartphones, low digital literacy and readiness, low incomes, and the nature of their disabilities (e.g., visual, hearing, and cognitive impairment).

As the nation moves out of the Public Health Emergency, ***the OAA regulations should: (a) encourage an expanded virtual presence and older adults' access to both broadband and video-enabled devices such as smart phones to improve their digital readiness; (b) allow use of non-video options (audio-only technology) for those who lack access to newer technology or prefer not to be shown on camera but still want to take advantage of tele-opportunities; and (c) cover the cost of the accommodations they need to utilize telehealth comfortably and equitably.*** This would foster tele-opportunities for many of the services provided through the Older Americans Act including, for example, case management, legal services, family caregiving, and socialization.

Person-Centered, Trauma-Informed Care

The ability to serve older adults with a history of trauma is a growing concern for aging services providers. Reports estimate that between 70% and 90% of Americans aged 65 and older have experienced at least one traumatic event during their lives. They may have survived sexual or physical assault, a natural disaster or terrorism, a mass shooting, an automobile accident, or a major health condition. Some may be refugees, military veterans, first responders, or Holocaust survivors.

Traumatic events can leave victims in a state of fear, anxiety, and hyper-vigilance that can manifest years and even decades later as cardiovascular disease, gastrointestinal and endocrine disorders, and other chronic, painful, and costly health conditions. But because the symptoms of trauma in older adults often present differently than they do in younger populations, older adults with histories of trauma are frequently misdiagnosed, provided with inappropriate treatments and medications, and re-traumatized by policies and procedures that trigger the intense anxieties and emotions of their original trauma.

Aging Holocaust survivors have needs similar to those of other older adults, but the consequences of their premature or unnecessary institutionalization can be much more severe. The sights, sounds, and smells of institutionalization, such as unfamiliar showers, confined spaces, or restrictions on food, can trigger traumatic psychological effects in Holocaust survivors. JFNA and NJHSA are, of course, well aware of this issue because of our focus on Holocaust survivors and the pioneering work provided by the ACL-funded Center on Holocaust Survivor Care/Institute on Aging and Trauma.

An increase in awareness about the prevalence and impact of trauma in the lives of Americans today has led to new approaches supporting individuals and families who have experienced traumatic events. Collectively known as "trauma-informed" care, these models focus on creating holistic organizational environments that promote the safety and well-being of all clients, staff, volunteers, and visitors. When combined with the values and core principles of person-centered care such as self-determination and individual preference, the result is person-centered, trauma-informed (PCTI) care. Congress formally promoted PCTI care as one of the overarching objectives of the Older Americans Act in its 2020 reauthorization process. This focus directly applies to the wide range of "at risk" older adults with a history of trauma including refugees, immigrants, persons with disabilities, veterans, LGBTQIA, communities of color and indigenous populations.

As part of its regulations, ACL should require all organizational recipients of OAA funding throughout the entire aging services network to be trained on the principles of PCTI care and deliver services in accordance with these principles. This will ensure that older adults with a history of trauma will live with and receive care in a manner that promotes their dignity, strength, and empowerment.

Caregiving and Case Management

In the United States, about 42 million American adults – 1 in 6 Americans – are caring for someone 50 or older. As of 2017, the cumulative economic value of the unpaid care provided by family caregivers was estimated at $470 billion. While family caregivers often find their efforts to be fulfilling and rewarding, they also face numerous challenges that threaten their own health,

financial security, and emotional well-being. Caregiving can also leave caregivers feeling socially isolated, an outcome that can have negative health impacts on its own. Traumatic events as discussed above, have significant health implications not just for older adults, but for the family members who care for and support them. Nightmares, irritability, sudden outbursts of anger, anxiety, depression, hypervigilance, and difficulties maintaining relationships can all occur in the aftermath of a traumatic event, immediately or years afterwards, and can be hugely distressing for family caregivers.

The OAA caregiving regulations should help educate professionals on the multiple, varied, and complex tasks family caregivers engage in every day and the value they bring to the health and long-term care system. The regulations should raise awareness that women and members of racial, ethnic, and sexual minority communities have a high likelihood of having experienced trauma as well as a history of being disempowered by traditional health care settings and may be reluctant to engage with or be easily re-traumatized in these settings. ***The regulations should prioritize the safety and empowerment of these caregiving populations, while training family caregivers, staff and volunteers on the principles of person-centered, trauma-informed care.***

In addition to modernization of the caregiving regulations, the case management regulations need to be updated with more flexibility available for providers**.** With an exponential increase in older adults facing dementia-related disorders who live without any (or sufficient family support), new systems need to be developed to provide integrated case management in partnership with robust public guardianship and Adult Protective Services programs. Regulations should enable providers to meet client needs based on need level, not age. There are younger clients who require more support and older clients who require less.

Transportation and Aging in Place

While older adults largely utilize private cars for transportation, as they age the majority lose the physical, cognitive, and/or financial capacity to drive or maintain a car. Finding necessary transportation is difficult for older adults where destinations may be too far to walk, public transit is non-existent or poor, and private transportation, if available, is limited or prohibitively expensive. The result is often increasing isolation and deterioration in health and quality of life. In many locations, there is also a disconnect between qualification requirements and funding. Class B licenses are typically required for transportation drivers, even if those drivers are not driving Class B vehicles. Typically, it is more expensive and difficult to find these licensed drivers.

There also remains a tremendous need for curb-to-curb, door-to-door and door-through-door transportation options rather than just the default multi-person transport. While insufficient funding is often the major hurdle for nonprofits providing older adult transportation services, this is not the only barrier. ***The OAA regulations supporting transportation options should prioritize funding a) increased costs related to maintenance, b) personnel and fuel; c) volunteer driver mileage reimbursements; d) geographic transportation differences that recognize higher costs for particular locations; e) inter-agency rentals (allowing one nonprofit to rent a vehicle from another); f) enhanced service coordination and mobility management to improve program effectiveness and responsiveness to consumer needs; and g) allow for***

transportation to social services and anti-isolation events to receive equivalent resources and priority as transportation for health-related visits.

As a major goal of the Older Americans Act is to allow seniors to age in place, ***the regulations should be explicit in prioritizing funding for home modifications (i.e., stair glides, lifts, ramps) and adaptive equipment to make aging in place achievable.*** During the COVID pandemic, the CARES Act provided funding for limited home repairs for frail seniors. Older adults would greatly benefit from making this program permanent under OAA, under the auspices of ACL and Area Agencies on Aging. Funding should be available to support clients and increase their safe living at home, and funding should be flexible and allow for creativity in determining the best ways to keep those clients safe.

Meals and Nutrition

The OAA Nutrition Programs provide critical nutrition services to millions of older adults and individuals with disabilities, including home-delivered meals and meals provided in congregate settings. More than 5,000 local agencies in communities across the country provide congregate and home-delivered meals to older adults, programs that are supported by several million volunteers. These proven programs reduce hunger, food insecurity, and malnutrition. They also provide social interaction for older individuals and promote their health and well-being through access to disease prevention and other health services, allowing older adults to avoid hospitalization and premature institutionalization.

In some cases, older adults require special meals because of religious, cultural or health requirements. Special meals such as kosher, halal, nut-free, or low-sodium diets typically are more expensive to prepare than a standard OAA-funded meal. ***As part of its regulations, ACL should require that funding for special meals stemming from religious, cultural or ethnic requirements or health-related concerns should be prioritized (and subsidized at a higher rate) where there is sufficient demand in a community to warrant such special meals.*** The regulations should open the door to other mechanisms that provide culturally sensitive meals that honor the dietary preferences and restrictions of older adults. Nutritionally-balanced meals that follow newer menu plans, such as a Mediterranean diet, should be allowed and encouraged.

Current regulations require quarterly reassessments for home-delivered meal (HDM) eligibility. These should be reduced to once a year, consistent with other benefit determinations. Since home delivered meal clients are seen in person at a minimum of weekly, changes in status are captured more frequently. If a client is frail, homebound, and determined eligible for free meals, it is extremely unlikely that their multiple chronic conditions and economic status will improve such that they no longer qualify for HDM within three months. Minimizing unnecessary and burdensome paperwork reduces costs and allows providers to allocate more time in direct care and resources to clients.

In the last two years, local programs providing nutrition services for older adults have managed to continue their important service delivery and expand them as necessary while dealing with the unprecedented challenges of the COVID-19 pandemic. As pandemic meal delivery demonstrated, there can be important circumstances where a provider of congregate and/or home-delivered meals, wants to vary the service. ***While a food provider should apply for and receive funding for one (or both) of these nutrition programs, the OAA regulations should***

allow lenient transfers between the two programs to promote client wellbeing. This will allow providers to rapidly adjust to local changes and preferences.

Finally, if one older adult qualifies to receive nutrition services under the Older Americans Act, the ***regulations should explicitly allow a younger spouse, a disabled child, or a custodial grandchild to also participate and receive nutrition services.***

Thank you for offering the opportunity to provide input into this year's regulatory process.

Sincerely,

Stephan Kline
Associate Vice President for Public Policy
Jewish Federations of North America

Reuben D. Rotman
President & CEO
Network of Jewish Human Service Agencies