

NATIONAL SURVEY
OF AREA AGENCIES
ON AGING

Serving
America's
Older Adults

2017
REPORT



advocacy | action | answers on aging



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National Survey of Area Agencies on Aging 2017 Report Serving America's Older Adults

EXECUTIVE SUMMARY

The United States population is aging rapidly and in just over a decade, by 2030, more than 70 million Americans will be 65 or older.¹ The increasing number of older adults is leading to a greater need for the support of the nation's network of aging services organizations, including Area Agencies on Aging (AAAs), which are the local hubs of aging services across the United States.

AAAs were formally established in the 1973 reauthorization of the Older Americans Act (OAA) as the "on the ground" organizations charged with helping vulnerable older adults live with independence and dignity in their homes and community. They now operate in virtually every community in the nation.

AAAs are the local developers of a coordinated system of services and supports to provide person-centered care and a range of options for older adults. Services offered through AAAs include home-delivered and congregate nutrition programs, in-home assistance, information and referral, elder abuse prevention and legal services.



AAAs are part of the National Aging Network,* which also includes the federal Administration on Aging, State Units on Aging and other community-based organizations with which AAAs work to deliver services. AAAs and their direct service provider partners represent the front line of the Aging Network and ensure that older adults who need assistance as they age—and their caregivers—have a place to turn to for help.

This report summarizes findings from the National Survey of Area Agencies on Aging conducted in 2016 that gathered information on staffing, budget and services, as well as new and innovative initiatives underway at many AAAs across the country. Findings from the report include the following:

- AAAs offer, on average, 22 critical services to older adults in their communities, ranging from core services required under the OAA—supportive services, nutrition, disease prevention and health promotion, caregiver services and elder rights—to unique services driven by their local community needs such as care transitions programs, home repair assistance, emergency response systems and adult day services.
- While older adults are the primary focus of AAAs, the majority of AAAs are serving at least one population under age 60, such as veterans, caregivers or individuals with a chronic condition or disability.
- AAAs provide, either directly or by contract, an average of seven elder abuse prevention or intervention services.
- Seventy (70) percent of AAAs are involved in livable, age-friendly or dementia-friendly community activities.

The National Survey of Area Agencies on Aging, funded through the Administration on Aging in the Administration for Community Living and conducted every two to three years, tracks important new trends in programs, services and funding affecting older Americans in communities across the country, and serves as a barometer for new issues shaping the Aging Network.

* The Older Americans Act of 1965 (OAA) established a national network of federal, state and local agencies to plan and provide services that help older adults to live independently in their homes and communities. This interconnected structure of agencies is known as the Aging Network. The Aging Network is headed by the U.S. Administration on Aging and includes the 56 State Agencies on Aging, 622 Area Agencies on Aging, over 250 Title VI Native American aging programs and tens of thousands of service providers.

INTRODUCTION

America's population is aging rapidly and by 2030, one in five people will be age 65 or older. Aging Americans rely on services provided through the nation's network of Area Agencies on Aging (AAAs) to address common issues associated with aging that, if left unaddressed, can lead to institutional care.

Institutional care, such as care in a nursing home, is very expensive and burdens not only the older individual and their family but also Medicaid, which pays for long-term care for eligible low-income individuals.

Common issues experienced by older adults that AAAs have services to address include the following.

- Eighty (80) percent of older adults have at least one chronic disease, and 68 percent have at least two chronic diseases.² Chronic diseases can lead to high costs for the health care system and reduced quality of life for consumers. This is why all AAAs now offer evidence-based programs to help prevent and manage these chronic conditions, which can help lower costs and improve the quality of life for the older adults served.
- Five million Americans are living with Alzheimer's disease—60 percent of whom live in the community as opposed to an institutional setting. Supporting people with memory loss by providing AAA services such as information and referral, in-home help and case management can prevent or delay costly institutional care. AAA-provided services are estimated to cost one-third the amount of more expensive institutional care which is typically only covered by Medicaid.³
- Falls, many of which are preventable, are the leading cause of fatal and non-fatal injuries for older adults in the United States.⁴ Over half of AAAs offer falls prevention programming for their communities.
- One in six older adults struggle with access to healthy and nutritious meals.⁵ AAAs address this issue through the provision of congregate and home-delivered meals, yet food insecurity and hunger are growing concerns.



In addition to the core services required by the Older Americans Act (OAA)—supportive services, nutrition, health and wellness, caregiver services and elder rights—AAAs assess community needs and develop and fund programs that are tailored to older adults in their community. They also educate and provide assistance to consumers to ensure access to services. For example, beyond the mandated services, AAAs may offer services such as care transitions programs, assistive

technology programs and money management assistance. Many AAAs also reach out to unique target populations that have unmet needs, such as people under age 60 who qualify for services because of a disability, chronic condition, veteran status or diagnosis of dementia.

There are 622 Area Agencies on Aging in the United States. AAAs provide services and supports to help people age successfully in their homes and communities.

AAAs are charged, through the OAA, with targeting services to those with the most economic or social need, but—if funding is available—anyone age 60 and older can access OAA-funded services. AAAs are permitted to request voluntary contributions for some services, and for other services cost-sharing is allowed through consumer payment of a portion of the service cost. Consumer cost-sharing is typically based on income. In addition, some AAAs implement service contracts with other funding sources including Medicaid waiver programs or health care partnerships.

In recent years, as health care costs have continued on an upward trajectory, the health care sector has shifted its payment model to one focused on value in terms of quality of care *and* costs. The health care sector has also increasingly looked at ways it can address—or work with partners to address—social issues that affect patients' health. These social determinants of health include access to housing, employment, nutritious food, community services, transportation and social support.

AAAs face two simultaneous pressures. The aging of the population in the United States is growing faster than ever before, while AAA funding from traditional funding sources such as OAA has stagnated. Many AAAs are looking at other sources of sustainable revenue, such as partnerships with health care systems as a way to diversify their funding streams, potentially increase revenue and maintain a mission focus on enabling older Americans to age successfully in their homes and communities through a system of supports and services. Health care entities are more interested than ever before in working with community-based organizations as they strive to improve health outcomes while keeping costs contained.

About the Survey

With a grant from the Administration on Aging within the Administration for Community Living (ACL), the National Association of Area Agencies on Aging (n4a) partnered with Scripps Gerontology Center at Miami University of Ohio to conduct an online survey that gathers information about AAA services, staffing, budgets and their evolving involvement in activities such as integrated care initiatives and partnerships with health care entities.

The National Survey of Area Agencies on Aging, conducted every two to three years, tracks important new trends in programs, services and funding affecting older Americans in communities across the country and serves as a barometer for new issues shaping the Aging Network. The survey collects information on:

- Programs, services and staffing;
- Budgets and sources of funding;
- Livable, age-friendly and dementia-friendly community initiatives; and
- Participation in integrated care opportunities, such as Medicaid managed care and Centers for Medicare & Medicaid Services (CMS) waivers and demonstration initiatives.

The 2016 survey was launched in August 2016 and closed in October 2016. Of the 622 Area Agencies on Aging across the country, 412 completed the survey for a response rate of 66 percent. The response rate met criteria for a representative sample. The survey was disseminated electronically to all AAAs through an online survey system that tracked responses and allowed for targeted follow-up to ensure the highest response rate possible.



10,000 Americans turn 65 every day. By 2030, 20 percent of the U.S. population will be 65 or older.

ENSURING COMMUNITY LIVING THROUGH SERVICES AND SUPPORTS

AAAs Offer a Range of Services Tailored to Their Community

While each AAA offers a core set of services as established in the Older Americans Act (OAA), the OAA also emphasizes the importance of local flexibility and person-centered services, respecting the fact that each community has unique opportunities, challenges and demographics that may necessitate a unique mix of services to meet older adults' needs. AAAs adapt to the distinctive demands of the communities they serve and provide innovative programs that support their older residents' independence and ability to remain living at home or in the community as long as possible.

The OAA identifies services that all AAAs must provide. These are called core OAA services, and they include:

- **Supportive Services** (Title III B), which includes services such as transportation, outreach, information and referral, case management, adult day care, legal assistance and in-home services such as personal care, chore and homemaker services;
- **Congregate and Home-Delivered Meals** (Title III C), which can also include ancillary services such as nutrition screening, education and outreach;
- **Disease Prevention and Health Promotion** (Title III D), which are required to be implemented with an evidence-based intervention as of October 2016;
- **National Family Caregiver Support Program** (Title III E), which includes services such as information and assistance for caregivers; individual counseling, support groups and caregiver training; respite care; and other supplemental services for caregivers; and
- **Vulnerable Elder Rights Protection Activities** (Title VII), which includes provider training for recognizing elder abuse, outreach and education campaigns, efforts of coalitions or multidisciplinary teams.

While AAAs are the hub of aging services in communities across the country, not all services are necessarily provided directly by AAAs. In fact, most AAAs implement some services with the assistance of contracted direct service providers in their communities. AAAs serve an essential role in brokering and coordinating community services for older adults in their communities and work with direct service providers to seamlessly and efficiently coordinate care. In instances where

AAAs contract with partners to provide a direct service, the AAAs are responsible for the oversight, management and quality assurance of the services being provided.

Figure 1

Services Available at AAAs	Percentage of AAAs that Offer n=412
Legal assistance	92%
Respite care	89%
Benefits/health insurance counseling	85%
Transportation (non-medical)	85%
Case management	82%
Homemaker	74%
Personal assistance/personal care	74%
Options counseling	72%
Assessment for care planning	70%
Ombudsman services	70%
Enrollment assistance	64%
Home repair or modification	64%
Transportation (medical)	63%
Senior center	61%
Emergency Response Systems	58%
Assessment for long-term care service eligibility	58%
Chore services	57%
Adult day service	55%
Evidence-based caregiver programs	51%

Figure 1 displays the services, in addition to the services required by the OAA, that at least 50 percent of AAAs provide.

While the fundamental mission of AAAs has not changed over time, the scope of services provide by AAAs has broadened to address older adults' and community needs. Examples of other services offered by AAAs include nutrition counseling, hoarding counseling, guardianship services, housing assistance and friendly visiting programs.

AAAs offer an average of 22 services in their communities.



INNOVATIVE NUTRITION PROGRAM Southern Maine Agency on Aging Scarborough, ME

Many older patients leave the hospital at risk of malnutrition, which can increase their risk of readmission. “Simply Delivered for ME” was created to test the effect of home-delivered meals on the 30-day rate of readmission at the Maine Medical Center. Upon hospital discharge, participants and their caregivers were eligible to receive seven meals. The frozen meals were delivered to patients’ homes within a few days of discharge, and all recipients received a follow-up call near the end of the week to determine if the meals were helpful and to offer the home-delivered meals program to eligible individuals. Of the 1,058 enrollees during the study period, the readmission rate was 10.4 percent, which is lower than the medical center’s pre-intervention readmission baseline of 16.6 percent. Each meal cost \$10, including food and additional staff time for delivery and program management. The AAA raised a total of \$120,000 in private funds from foundations and a physician health organization to support the project.

Providing the Right Services at the Right Time

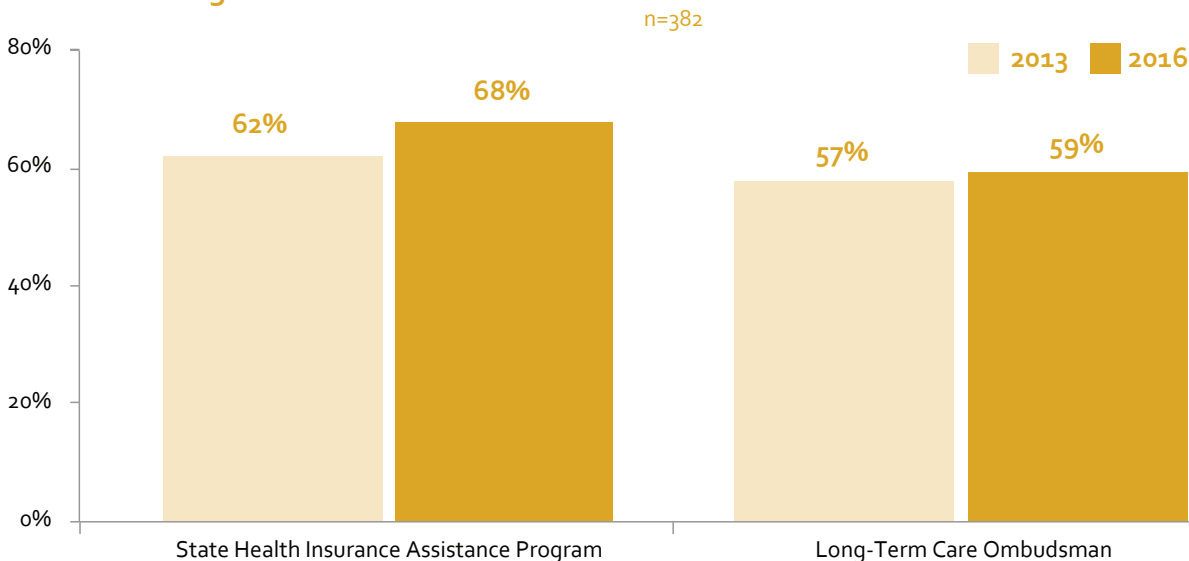
Connecting to the right services at the right time is critical for older adults and their caregivers. However, accessing needed services is not always easy for older adults and their caregivers given the multitude of services, agencies and eligibility requirements. Such challenges can lead to older adults receiving higher levels of care than they need, such as care in a nursing home, which not only drains their personal and family resources but is often at odds with their wishes and goals. Given the fact that Medicaid is the primary payer of nursing home care, it also strains state and federal budgets.

Timely, streamlined access to appropriate levels of community support can reduce unnecessary use of more intensive and expensive forms of care, and can enhance an individual’s ability to live safely and independently in the community. One way that the Aging Network is addressing this issue is through No Wrong Door programs, which are sometimes called Aging and Disability Resource Centers (ADRCs).

In a No Wrong Door system, multiple community agencies retain responsibility for their respective services while coordinating with each other to integrate access to those services through a single standardized entry process overseen by a coordinating organization. ADRCs began in 2003 with funding from the U.S. Administration on Aging (now part of ACL) and the Centers for Medicare & Medicaid Services to serve as a visible and trusted access point where people regardless of age, income or disability status can go for person-centered information and counseling on long-term services and supports.⁶

The proportion of AAAs that are running ADRCs has grown steadily. Currently, 77 percent of AAAs operate ADRCs in conjunction with other aging and disability organizations. This number represents a significant increase from 2008 when fewer than 10 percent of AAAs operated ADRCs.

Figure 2: AAAS DESIGNATED AS SHIP AND OMBUDSMAN PROGRAMS



Health Insurance Counseling and Long-Term Care Assistance

Many AAAs also have additional roles, including serving as the local entity running the State Health Insurance Assistance Program (SHIP) and the Older Americans Act's Long-Term Care Ombudsman Program (Ombudsman program) (Figure 2). SHIP is a federal program that offers free, personalized counseling and assistance to help older adults and their caregivers choose their Medicare benefits, including Medicare Advantage, Medicare Part D prescription drug coverage and Medigap coverage. Between 2013 and 2016, the percentage of AAAs operating SHIPs increased from 62 to 68 percent.

Many AAAs also serve as administrators for local Long-Term Care Ombudsman Programs. These programs assist residents of nursing homes, assisted living facilities and other adult care facilities by working with residents and their loved ones to address care concerns. The local Ombudsman serves as an advocate that helps residents and their families exercise their rights guaranteed by federal and state law, such as their right to be treated with dignity and respect, the right to be free from chemical and physical restraints, and the right to be given advance notice of transfer or discharge.⁷

Reaching Targeted, Younger Individuals

While AAAs were originally established to serve the 60 and over population, the majority of AAAs are also serving the under 60 population, as funding levels and funding requirements permit. Populations under age 60 that the majority of AAAs now serve include individuals with physical disabilities, people with chronic conditions, veterans and caregivers (Figure 3).

The majority of AAAs are also serving consumers under the age of 60.

Two examples of AAA programs serving individuals under age 60 are the National Family Caregiver Support Program (NFCSP, Title III E of the Older Americans Act) and the Veteran-Directed Home and Community-Based Services (VD-HCBS) program. NFCSP funding may be used to serve adult family members or informal caregivers who provide care to individuals 60 years and older or individuals with Alzheimer’s disease or a related

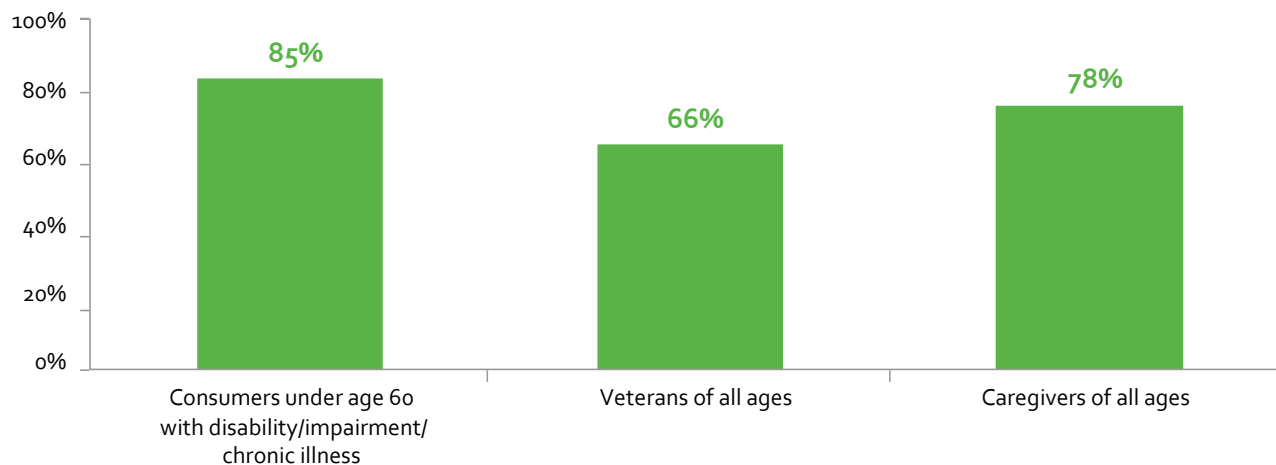
dementia of any age; caregivers age 55+ of adult children with disabilities; or older relatives raising children. The VD-HCBS program provides veterans who need nursing home care levels of support the opportunity to remain in the community and self-direct their long-term services and supports.

The top five services most AAAs offer to people under age 60 include assessment for long-term care service eligibility, information and referral/assistance, outreach, fiscal intermediary services for self-direction, options counseling and care transitions services.

Figure 3: PROPORTION OF AAAS SERVING INDIVIDUALS UNDER 60

Note: data reflects AAAs that offer at least one service to individuals under 60

n=412



Offering Evidence-Based Programs

An evidence-based health promotion or disease prevention program is one that demonstrates the highest level of evidence of effectiveness utilizing rigorous scientific evaluations and large scale studies of diverse populations, and achieves significant and sustained outcomes. ACL defines an evidence-based program as one that meets the following criteria:

- Demonstrated through evaluation to be effective for improving the health and well-being or reducing disease, disability and/or injury among older adults;
- Proven effective with older adult population, using experimental or quasi-experimental design;
- Research results published in a peer-review journal;
- Fully translated in one or more community site(s); and
- Includes developed dissemination products that are available to the public.

There has been rapid growth in the number of AAAs offering evidence-based programming. In 2008, approximately half of AAAs offered evidence-based programs. In 2016, the number rose to 93 percent of AAAs as displayed in Figure 4. By October 1, 2016, all AAAs were required to use Older Americans Act Title III D funds on disease prevention and health promotion interventions that meet the ACL definition of evidence-based. Note that since this survey was in the field prior to October 1, 2016, this requirement was not yet in place.



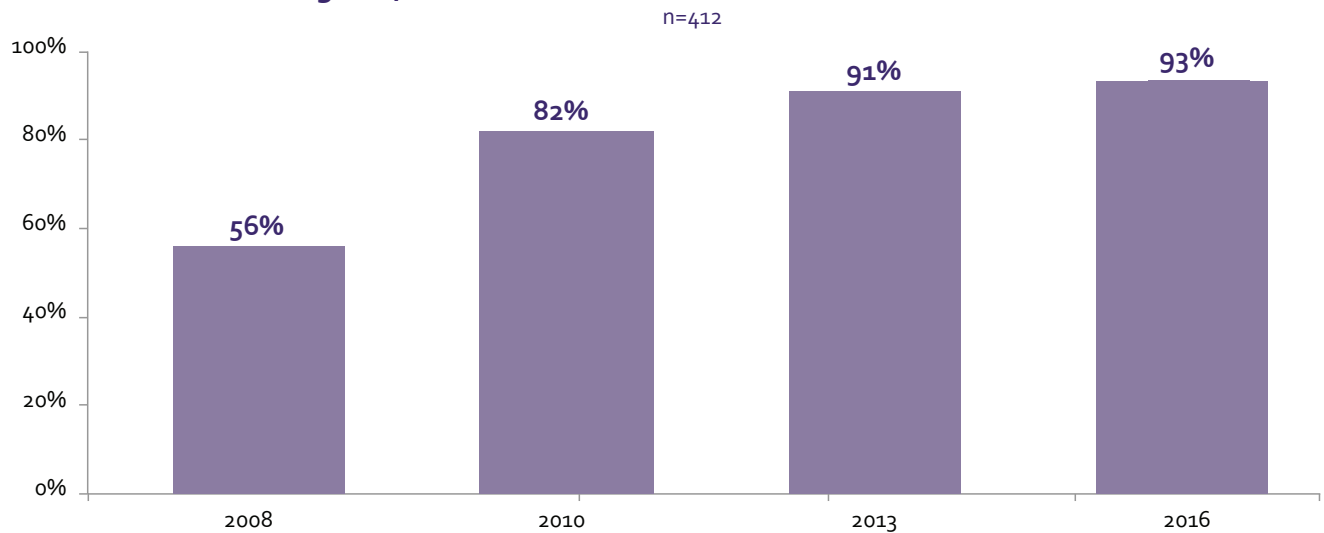
SUPPORTING VETERANS

Bear River Area Agency on Aging

Logan, UT

Bear River Area Agency on Aging led the development of Utah’s “COVER to COVER: Connecting Older Veterans (Especially Rural) to Community or Veteran Resources” project. Through this initiative, Utah AAAs partnered with the Veterans Health Administration Office of Rural Health to train a staff member from each AAA to become experts in Department of Veterans Affairs (VA) benefits. This offers veterans and their families an additional access point in local communities to learn about and get connected to VA benefits and programs. Bear River AAA developed a train-the-trainer program, provides peer mentorship to other veterans specialists and outreach to community partners, and created training materials and resource guides. Protocols are now in place to screen all agency callers for eligibility for VA resources and assist veterans in applying for benefits. To date, Bear River AAA has served 439 unduplicated veterans, 46 percent of whom are 80 years old or older. Of the veterans served, 72 percent reported they were not already connected to VA benefits. Veterans in Bear River report receiving more than \$790,881 in annual VA benefits to purchase health care and other services.

Figure 4: AAAS OFFERING EVIDENCE-BASED PROGRAMS



Among AAAs that offer some type of evidence-based programming, the most commonly offered programs are the Chronic Disease Self-Management Education (CDSME) program and A Matter of Balance (Figure 5). ACL has provided funding to the Aging Network in both of these areas.^{9,10} The CDSME program, developed by Stanford University, serves people with a variety of chronic conditions such as diabetes, heart disease and lung disease, and has been shown to be effective in improving health outcomes such as physical health, cognitive symptom management, self-reported health and communication with health care personnel.

A Matter of Balance is a nationally recognized program with the goal of reducing the fear and incidence of falls among older adults. A workshop-based program, it is offered by AAAs across the country over eight two-hour sessions and has been shown to improve participants' comfort in addressing their fears about falling, helping participants make changes to their environment, increasing their level of activity and encouraging them to continue exercising. ACL has funded a Falls Prevention Initiative since 2014. A Matter of Balance is one of several programs that have been proven to reduce falls or fall risk among older adults that have been implemented through this funding stream.¹¹

Twenty-seven (27) percent of AAAs provide evidence-based programs that were not listed in the survey. The most frequent were "Walk with Ease," "Tai Chi for Arthritis," "Stepping On," "Stress Busting for Family Caregivers" and "Bingo-cize."

Preventing and Addressing Elder Abuse

Elder abuse is a growing national concern. As the population ages, the number of older Americans with risk factors for elder abuse, neglect or exploitation also grows. Risk factors for elder abuse include low

social support, diagnosis of Alzheimer’s disease or a related dementia, life experience with previous traumatic events, and functional impairment or poor physical health.¹²

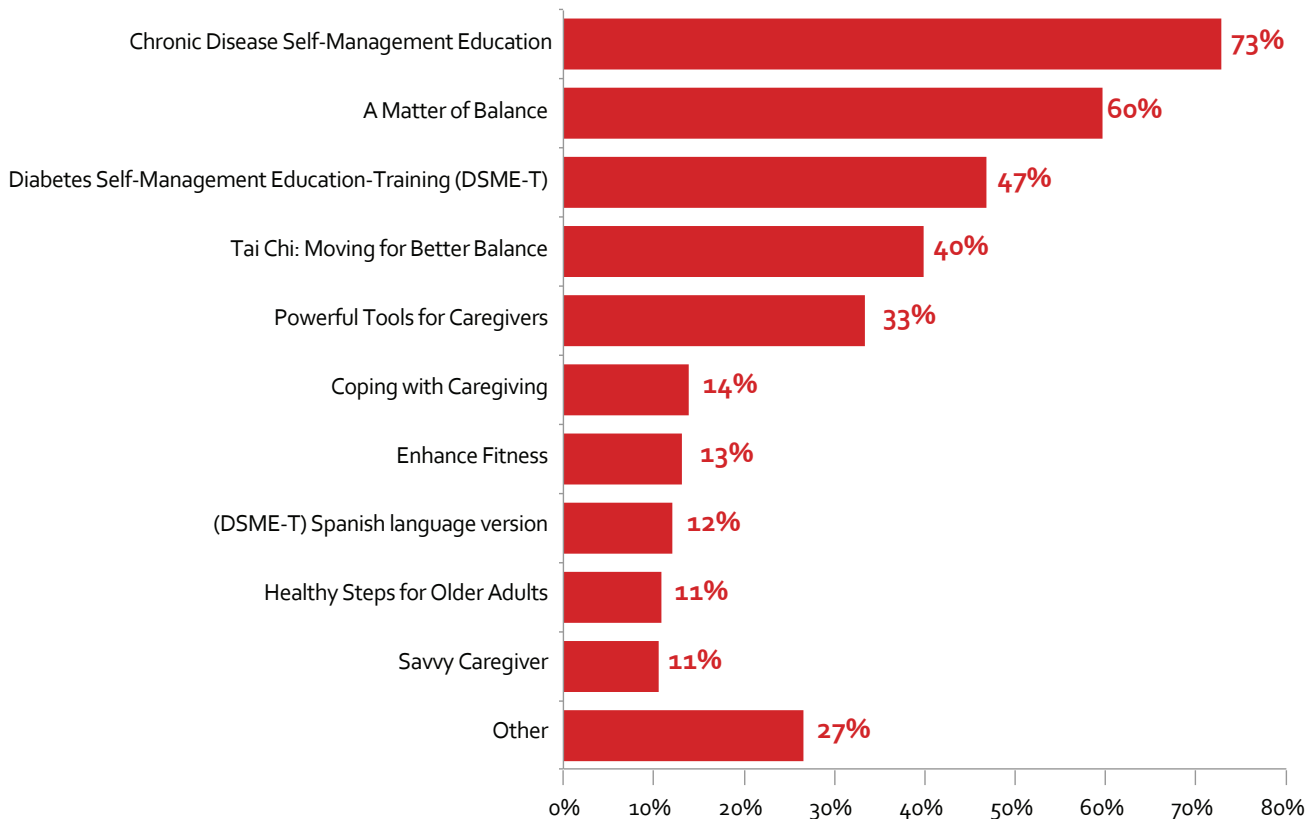
AAAs offer a range of services to help address this need (Figure 6). On average, AAAs provide seven elder abuse prevention and intervention services in their communities, with the most common types being legal assistance, case management and investigations of abuse. Virtually all AAAs offer at least one service related to elder abuse.

Additionally, over half of AAAs (58 percent) participate in or lead an elder abuse prevention coalition or a multi-disciplinary team. The purpose of these teams can vary but common activities include resolving difficult elder abuse cases, promoting coordination between agencies, identifying

One out of every 10 people age 60 or older who live at home experience elder abuse, including neglect or exploitation.

Figure 5: MOST COMMON EVIDENCE-BASED PROGRAMS

n=389

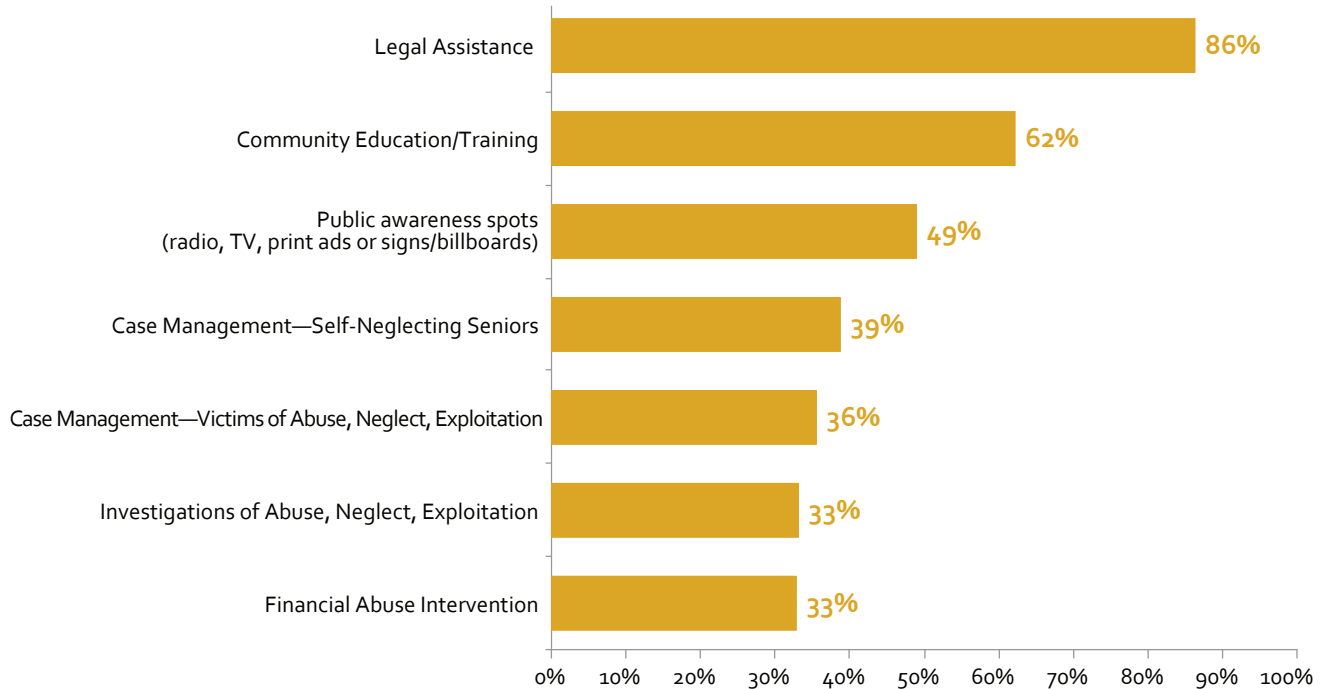


On average, AAAs provide, either directly or through contracted partners, seven elder abuse prevention or intervention services.

gaps in coordination or communication and exchanging information and resources. A multi-disciplinary team typically includes members from sectors such as AAAs, Adult Protective Services, mental health or substance abuse, financial, domestic violence and law enforcement or criminal justice.¹⁴ A small portion (approximately 12 percent) of these teams are formalized through legislation or administrative policy, with the remaining being informal and formal volunteer groups that come together to collaborate and coordinate on elder abuse issues.

Figure 6: MOST COMMON ELDER ABUSE PREVENTION AND INTERVENTION SERVICES

n=410



Supporting Empowered Consumers through Self-Directed Care Options

AAAs also provide self-directed services that give consumers greater control over how their specific needs are met. With self-directed long-term services and supports, individual clients are provided with a budget allotted for their care needs and they can use those funds to hire and manage workers or pay for services. Currently, 50 percent of AAAs offer self-directed services (n=211) (Figure 7).

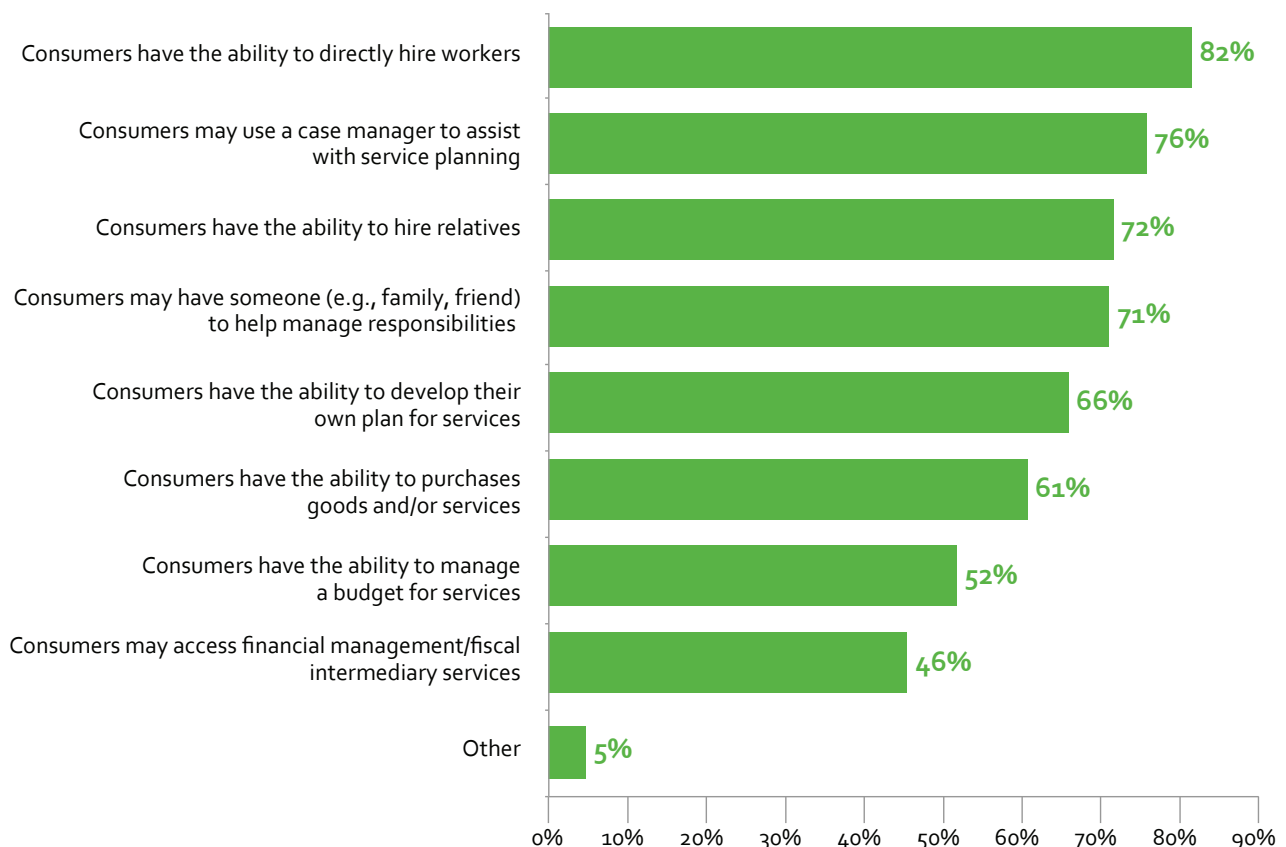


ELDER ABUSE PREVENTION Aging & Independence Services San Diego, CA

The “Don’t Get Hooked” campaign warns elders of the growing threat of elder financial abuse. Half of the cases investigated by Adult Protective Services in the San Diego, CA area have some element of financial abuse. The District Attorney’s Office, Aging & Independence Services (the AAA) and the County Board of Supervisors teamed up to develop prevention materials to educate older adults and their adult children about financial scams. The campaign includes two 30-second educational media spots featuring two victims telling their stories; free “Don’t Get Hooked” scam prevention events; and educational presentations about the “Don’t Get Hooked” toolkit. Since the campaign began, more than 780 seniors have participated in educational presentations. One man learned about the “Don’t Get Hooked” campaign the same day he was told he would receive a \$3 million Publishers Clearinghouse check if he sent several thousand dollars to pay taxes on his winnings. After confirming with Publishers Clearinghouse he was not a winner, he called Aging & Independence Services to say the campaign saved him from financial ruin.

Figure 7: SELF OR CONSUMER-DIRECTED SERVICES OFFERED BY AAAS

n= 211



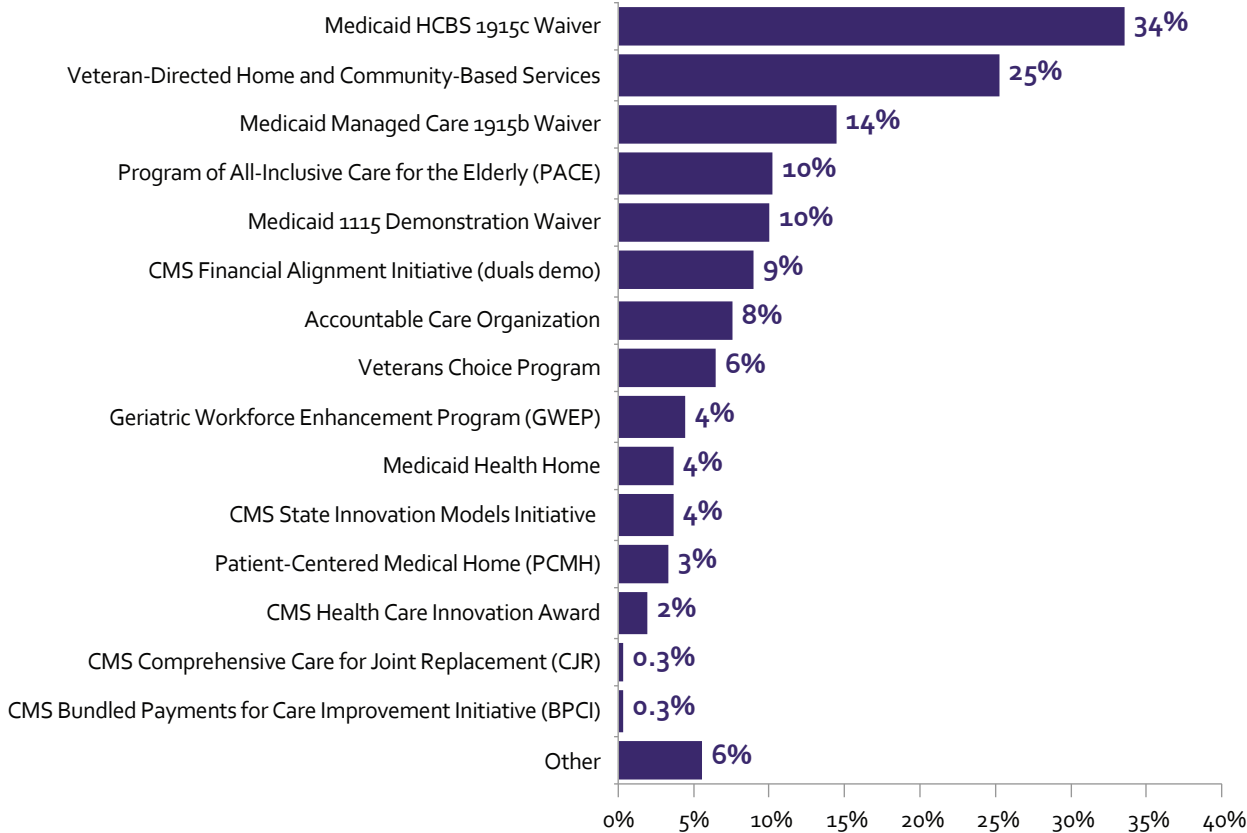
IMPROVING HEALTH CARE AND DIVERSIFYING FUNDING THROUGH INTEGRATED CARE

Integrated Care Overview

The U.S. health care system is undergoing dramatic changes as it shifts from one focused on volume to one focused on outcomes and value. Medicare and Medicaid programs are under pressure to better plan, coordinate and deliver appropriate high-quality care across care settings and payment models. Public budget pressures will intensify this focus on effectiveness and efficiency.

Figure 8: AAA INVOLVEMENT IN INTEGRATED CARE INITIATIVES*

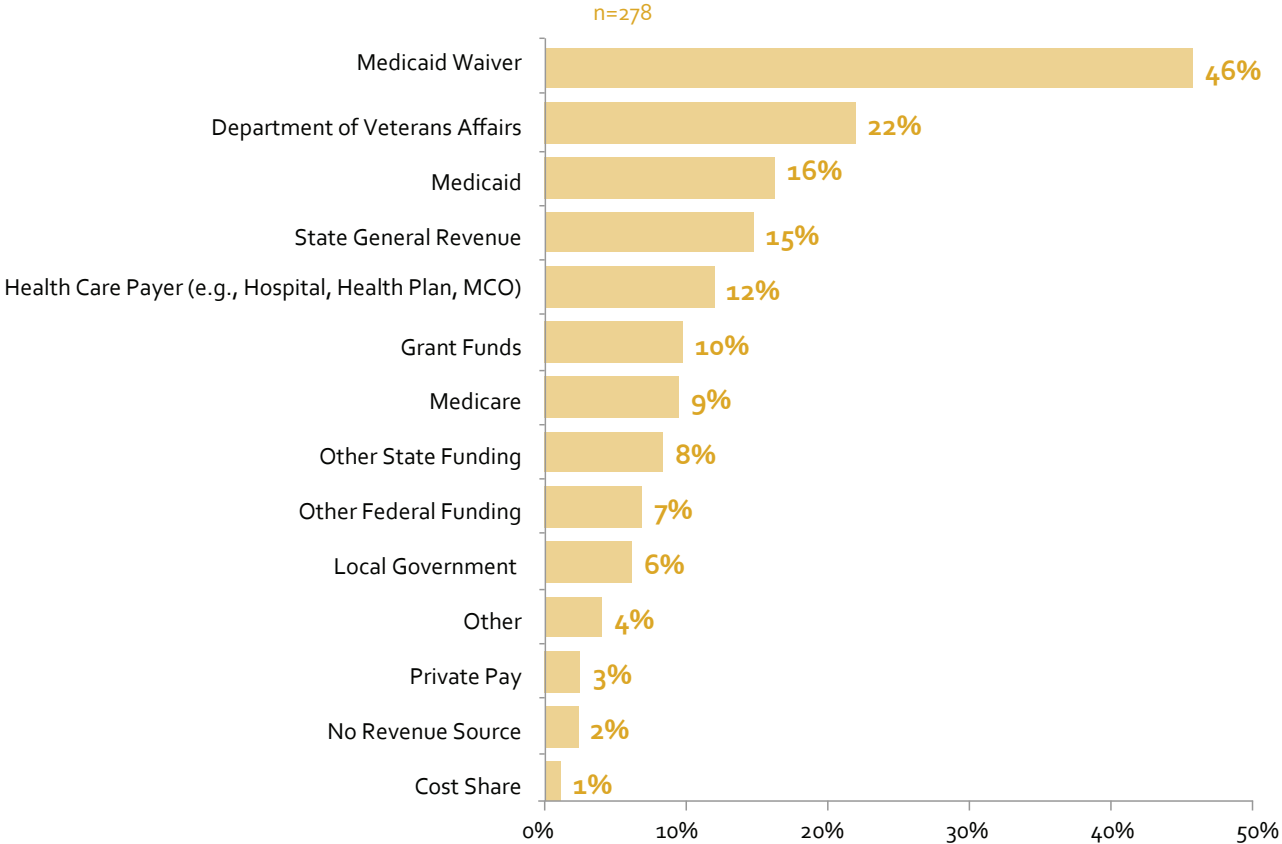
n=361



*See Appendix A on pages 30-32 for a glossary of terms

Although there are unknowns about the future direction of health care delivery and payment, the entities responsible for health care will most likely continue to look for ways to reduce costs and improve quality. AAAs are experts at providing services that improve the social determinants of health and are increasingly engaging in innovative models of service delivery. Addressing the social determinants of health—such as housing, employment, nutritious food and access to community services, health care, transportation and social support—is an important element of an effective and efficient health care system and has been shown to improve patient outcomes. Increasingly, AAAs are engaging in partnerships with the health care sector to address the social determinants of health. These partnerships also provide AAAs with diversified funding streams that support their mission while leading to less reliance on traditional funding sources such as the Older Americans Act. These partnerships focus on AAAs’ strengths in service development, implementation and coordination for older adults with greatest need.

Figure 9: COMMON INTEGRATED CARE FUNDERS



This data represents the most common sources of AAA funding for integrated care. It does not indicate funding proportions from these sources.

AAAs are carving out a niche as critical partners to help health care entities develop and implement new integrated care goals. Over 63 percent of AAA survey respondents now participate in at least one integrated care opportunity, with the most common being Medicaid Home and Community-Based Services (HCBS) 1915(c) Waiver, Veteran-Directed Home and Community-Based Services, Medicaid Managed Care 1915(b) Waiver and the Program of All-Inclusive Care for the Elderly (PACE), as displayed in Figure 8. Appendix A includes a glossary of integrated care initiatives.

The most common funding sources for integrated care include Medicaid Waiver/Medicaid, Department of Veterans Affairs, State General Revenue, grant funds and health care payers such as hospitals and managed care plans as indicated in Figure 9. For more details on AAAs role in integrated care, see Appendices B and C.



INTEGRATED CARE

Elder Services of the Merrimack Valley, Inc.

Lawrence, MA

The Elder Services of the Merrimack Valley, Inc. (ESMV) Healthy Living Center of Excellence and Senior Whole Health (SWH), a managed care program for older adults, are collaborating to address the social determinants that negatively impact the physical and behavior health of older adults in Massachusetts. Recognizing that SWH members with multiple chronic conditions could benefit from self-management programs to reduce readmissions and overall medical costs, SWH entered into a contract with ESMV and their Healthy Living Center of Excellence to serve as the centralized statewide infrastructure for program delivery. SWH reimburses them for every member who enrolls and completes an evidence-based program such as Chronic Disease Self-Management or A Matter of Balance. SWH reimburses the Healthy Living Center of Excellence an established rate per participant, which covers program costs, outreach and transportation. In 2017, the completion rate for SWH members in evidence-based programs through this project is 95 percent, almost 20 percent higher than the national standard. ESMV is replicating this model with additional managed care plans in Massachusetts and is providing technical assistance to other AAAs across the county to assist with replication.

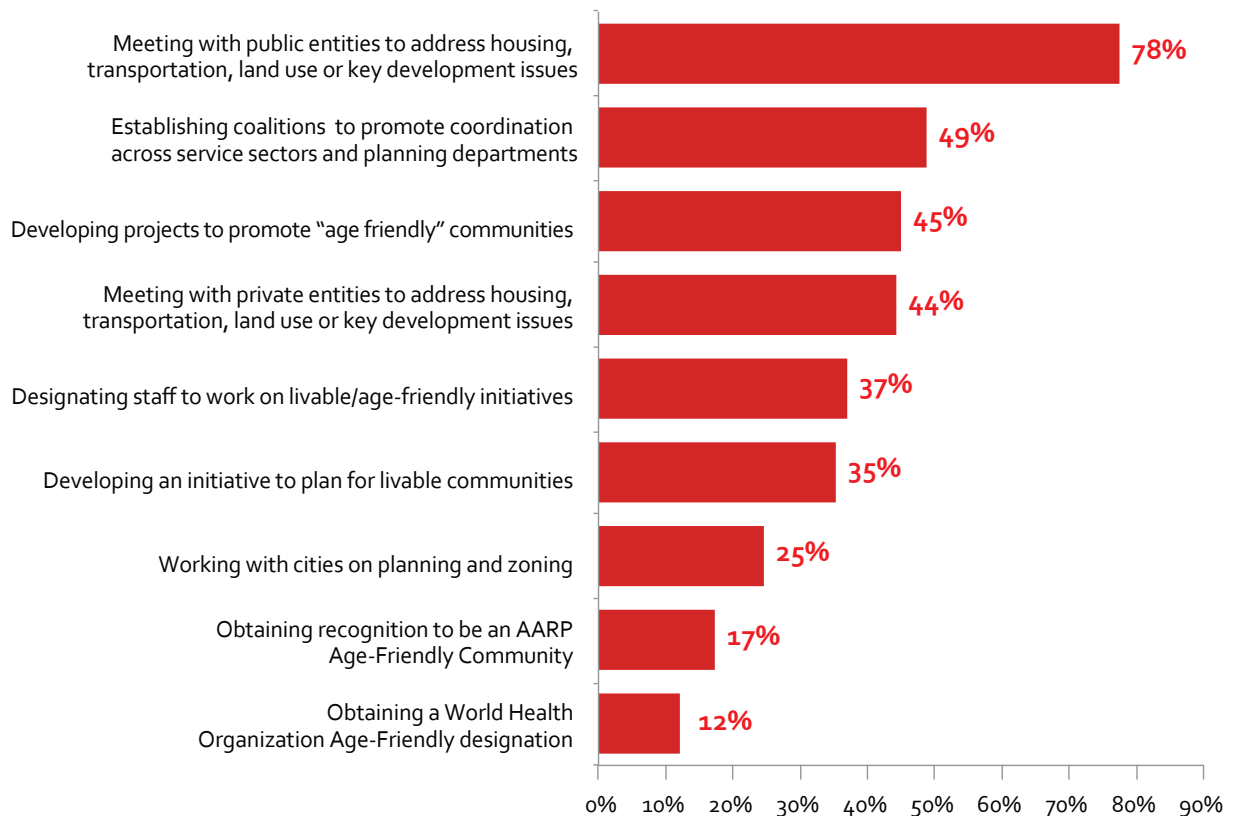
ENHANCING COMMUNITIES FOR PEOPLE OF ALL AGES

Given that, by 2030, people 65 and older will comprise almost 20 percent of the nation’s population and in many communities that increase is already a reality, community planning for an aging population is critical. The aging of America’s population will have a dramatic impact on every community in the nation. Many communities are looking for innovative ways to prepare for the surge in the aging population such as new approaches to enhancing aging in place, including livable, age-friendly and dementia-friendly community efforts. AAAs are playing a lead role in many of these efforts.

Livable communities are communities for all ages that value and support people across the lifespan. These communities provide a full range of options for engagement and intentionally

Figure 10: AAA INVOLVEMENT WITH LIVABLE AND DEMENTIA-FRIENDLY INITIATIVES

n=289





LIVABLE COMMUNITIES Denver Regional Council of Governments Denver, CO

The Denver Regional Council of Governments (DRCOG) and its AAA has advocated for over a decade for systemic change in the ways communities plan for and address the needs of the region's rapidly aging population. DRCOG launched Boomer Bond in 2011 to equip local governments with an assessment tool and resource directory to help older adults remain in their communities and homes longer. The resource directory features hundreds of best practices and provides access to an online database of age-friendly policies, strategies and tools that communities can adapt. The assessment tool helps communities identify local opportunities and challenges for supporting healthy and successful aging. Some outcomes include new and revised ordinances, a new older adult community resource center, a redesign of a local government website and increased awareness of older adult issues among law enforcement. DRCOG has helped other Colorado organizations replicate Boomer Bond and has shared key program elements with regional planning organizations and AAAs from across the country.

encourage the integration of community development, infrastructure development and services. Key issues for livability include housing, transportation, land use planning, workforce development and civic engagement. Many communities have also become engaged in age-friendly community activities that encourage states, cities, towns and rural areas to prepare for the rapid aging of the U.S. population by paying increased attention to the environmental, economic and social factors that influence the health and well-being of older adults. Others are preparing to be dementia-friendly communities—to more effectively support and serve those who are living with Alzheimer's and related dementias and their family and friend care partners.

About 70 percent of respondents are involved in partnerships and activities to build livable, age-friendly and/or dementia-friendly communities. As indicated in Figure 10, for example: to address housing, transportation, land use and key development issues, 44 percent of the AAAs involved in these initiatives are meeting with private entities and 78 percent are meeting with public entities. A quarter of AAAs that are active in livable community efforts are working with communities on planning and zoning issues.

Approximately 70 percent of AAAs are involved in a livable, age-friendly or dementia-friendly activity in their community.

MAKING IT HAPPEN: AAA STRUCTURE AND STAFFING

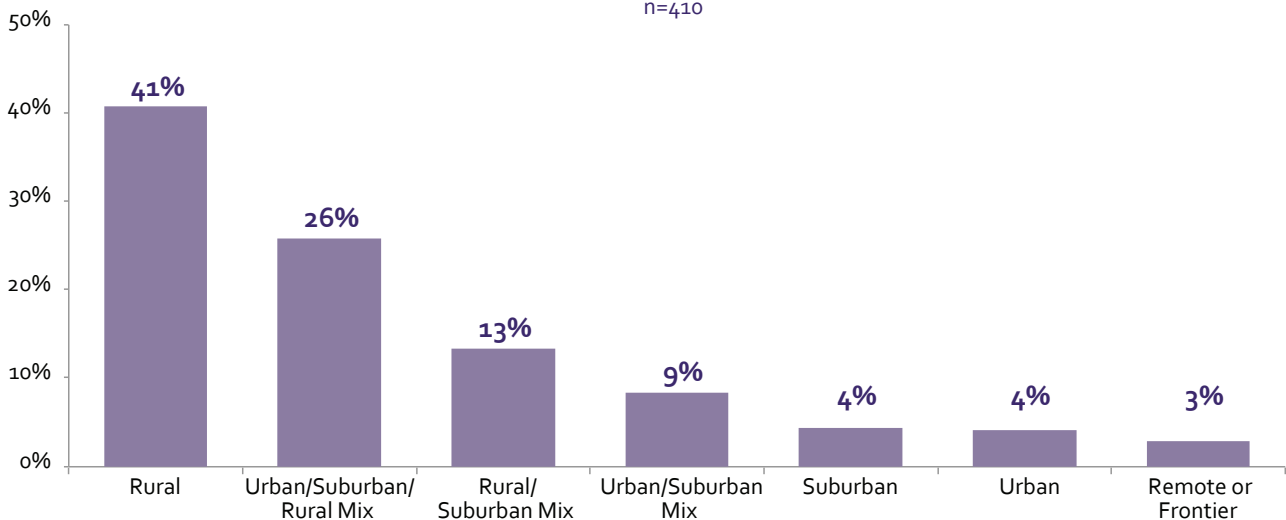
Organizational Structure

Although the core functions of AAAs are consistent and foundational across the AAA network, the budget size, organizational structure and staffing levels may vary. Some states, such as New Mexico and Wisconsin, have a few AAAs that cover large geographic areas. In other states, such as Pennsylvania and New York, AAAs are structured along individual county boundaries. The median number of AAAs per state is eleven with a range of two to 59. Each state determines how many Planning and Service Areas (PSAs) to establish, which then determines the number of AAAs in the state. As a result, states with sparsely populated regions and/or small land area tend to have fewer AAAs. In some instances, the state will serve the AAA function: single-PSA states include Alaska, Delaware, Nevada, New Hampshire, North Dakota, Rhode Island, South Dakota and Wyoming.



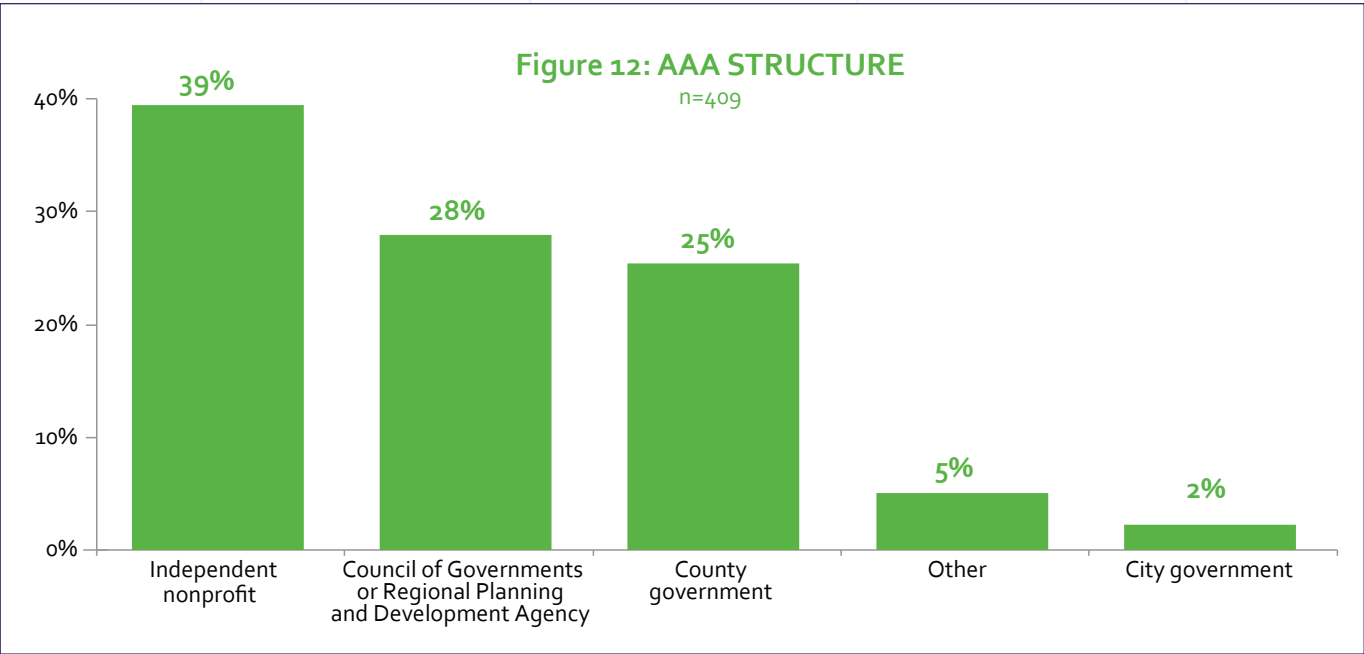
Figure 11: GEOGRAPHIC AREA SERVED BY AAAS

n=410



There is also significant variation in the areas served by AAAs depending on the location of the AAA and the geography of its particular state. As indicated in Figure 11, the majority of AAAs serve a primarily rural setting. However, given the size of many AAA PSAs, the second largest representation is of AAAs that service a mix of rural, urban and suburban areas.

In addition to different types of land areas, AAAs also have different governance structures, as depicted in Figure 12. While AAAs structured as independent nonprofit organizations are most common, other structures are also prevalent including Council of Governments (COG) or Regional Planning and Development Agency (RPDA) structures. AAAs that are part of county government are third most common. Examples of “other” structures that administer AAAs include AAAs that are part of universities or educational institutions, Community Action Agencies or United Way chapters.

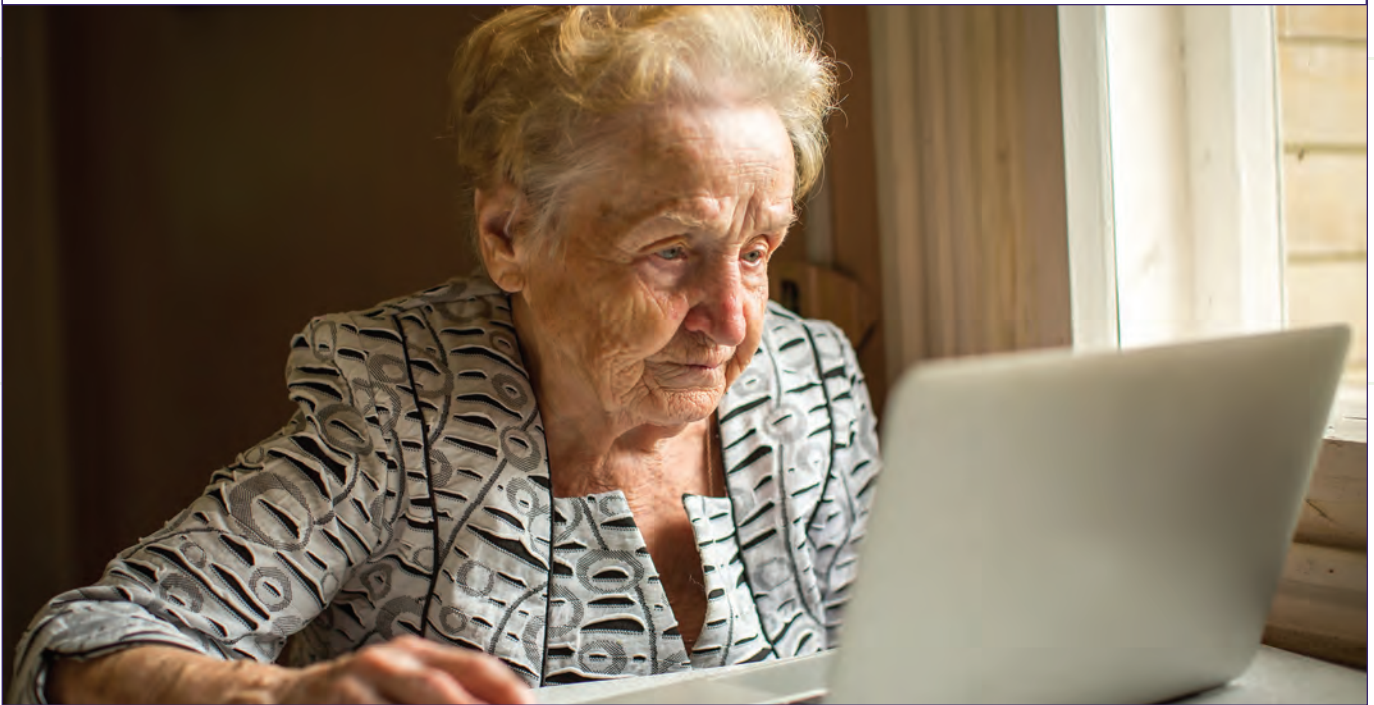
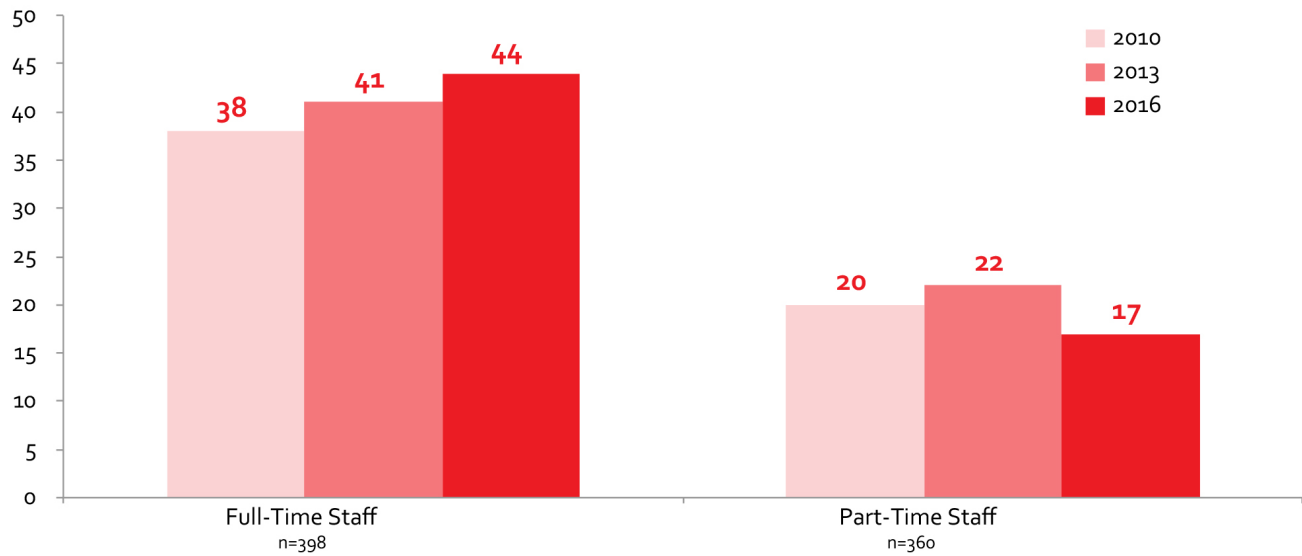


Employment and Volunteer Opportunities in AAAs

Full-time staffing levels at AAAs have risen incrementally since 2010. In 2016, the average AAA had 44 full-time staff members (Figure 13), although half of AAAs have 20 or fewer full-time staff. This exceeds 2010 levels where the average number of full time staff was 38. While the average number of full-time staff has increased, the number of part-time staff decreased between 2013 and 2016.

Typically, AAAs rely on volunteers to support their work. In 2016, the average number of volunteers per AAA, including volunteer board directors, advisory committee members and other committee members, was 149, although half of AAAs had 50 or fewer volunteers. Across all AAAs the number of volunteers ranged from none to over 2,400 volunteers.

Figure 13: AVERAGE AAA STAFFING LEVELS OVERTIME



THE BOTTOM LINE: SUSTAINABLE FUNDING FOR AAA SERVICES

Financial Overview

As the aging population continues to boom, the financial status of the agencies serving them becomes critical. The average AAA budget has increased by 13 percent while the median budget has increased by nearly 8 percent since 2007. While that may sound promising, the cumulative national inflation between 2007 and 2016 was approximately 16 percent.⁴⁵ Additionally, during the same period the number of older adults continued to grow, as did the demand for services, while traditional federal funding sources such as the Older Americans Act remained stagnant or decreased.

As shown in Figure 14, there is a large variation in funding, with the largest AAA budgets reaching the hundreds of millions and smaller AAA budgets leveling off in the hundreds of thousands.

Figure 15 depicts the average proportion of specific funding sources in AAA budgets, as well as the percent of AAAs receiving *any* funding from this source. For example, while all AAAs receive OAA funding, on average OAA funding comprises 39 percent of AAA budget (ranging from 2 percent to 100 percent). The majority of AAAs, at 69 percent, receive state general revenue funding and on average it comprises 22 percent of their budgets.

Health care payers represent a growing area of interest and revenue for AAAs. While they currently comprise a relatively small proportion of an overall AAA budget at 4 percent, it is expected health care payers as a proportion of AAA budgets will grow as AAAs gain more experience in pricing, negotiating and contracting for their services.

Figure 14: AAA BUDGETS

Year	Mean	Median	Range
2007	\$8.9 million	\$3.8 million	\$138,000 – \$286 million
2008	\$9.7 million	\$4.1 million	\$140,000 – \$281 million
2010	\$8.9 million	\$4.0 million	\$150,000 – \$320 million
2013	\$9.4 million	\$3.9 million	\$138,000 – \$292 million
2016	\$10.1 million	\$4.1 million	\$200,000 – \$284 million

Funding Patterns Are Changing

AAAs reported which funding sources have remained flat, increased or decreased within their budgets over the last two years, as displayed in Figure 16. For example, funding from OAA remained flat for most AAAs (61 percent). Funding from Medicaid waiver and health care payers has increased for 28 percent and 21 percent of AAAs, respectively. Given these funding limitations and increasing service demands, AAAs are positioning their agencies to pursue paid reimbursement from Medicaid/Medicaid Waiver and other health care payers. As health care entities look for ways to reduce costs while improving care and outcomes, AAAs have an opportunity to receive reimbursement for their services through direct contracts with health care entities.

70 percent of AAAs report implementing or working towards establishing a private-pay / fee-for-service program.

Given the limitation of traditional government funding sources, coupled with an increasing demand for services by older consumers, some AAAs

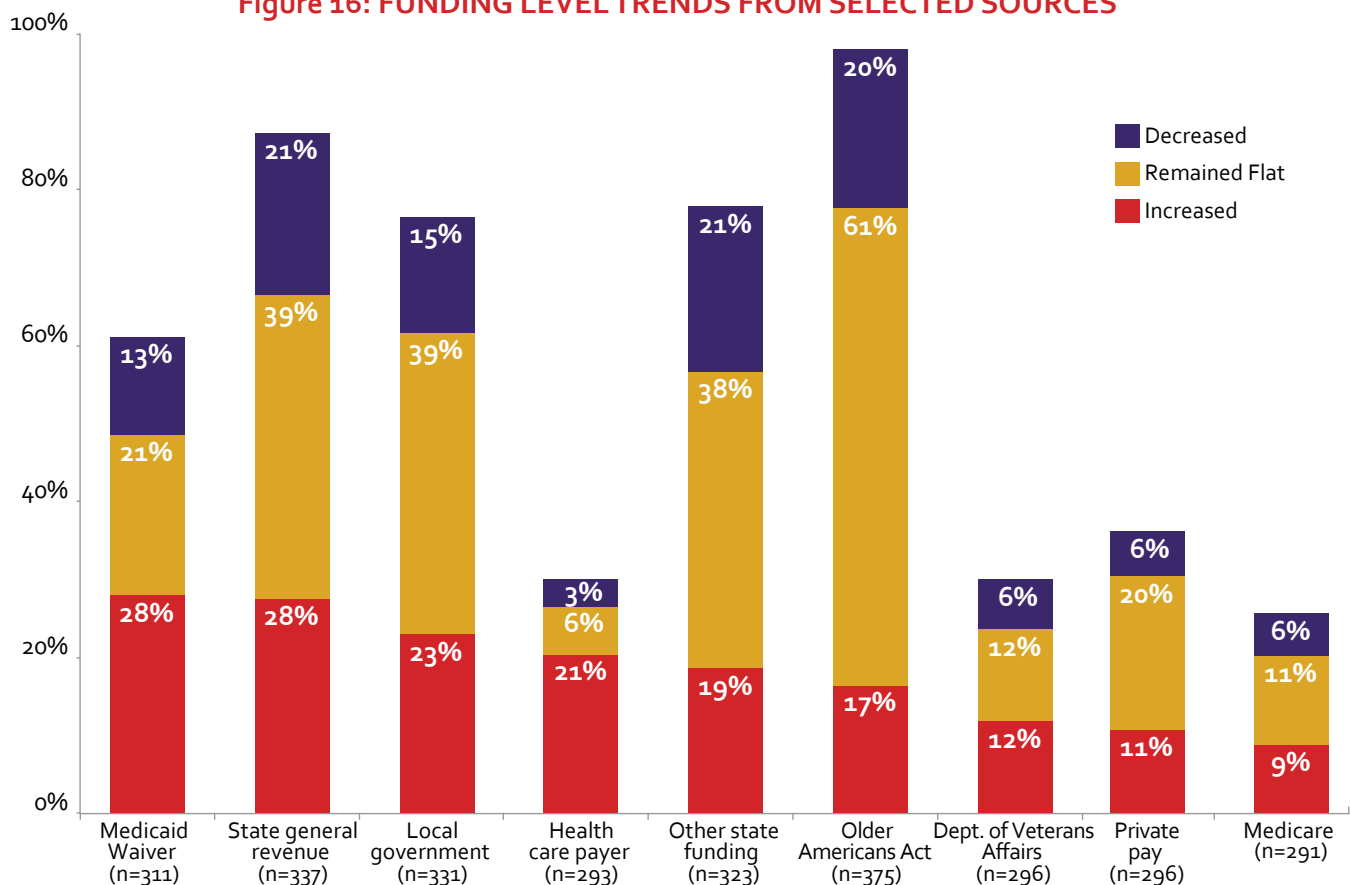
Figure 15: AAA BUDGETS BY BUDGET PROPORTION AND FUNDING SOURCE n=374

Answer	Average Proportion of Overall AAA Budgets	Percent of AAAs Reporting Any Funding from this Source
Older Americans Act	39%	100%
Medicaid Waiver, Medicaid	45%	65%
State general revenue	22%	69%
Other state funding	16%	45%
Local government	15%	56%
Medicare	6%	14%
Private pay	4%	17%
Health care payer (hospital, health plan, etc.)	4%	15%
Department of Veterans Affairs	3%	16%

developed private-pay. In general, private payment for services occurs when individuals pay the full cost of the services they receive. Private pay is an option for services not funded through federal or state dollars, and is different from cost-sharing, a voluntary contribution permitted for certain services under the OAA.

The last several years have seen a trend towards more AAAs developing or making progress in developing a private-pay program. In 2016, private pay was one of the funding sources where AAAs on average reported more increases in funding (11 percent) than decreases (6 percent). Of the agencies implementing or working towards private pay, the most common activities they are working on are establishing a fee-for-service model, learning about other successful private-pay models, establishing a billing system and developing policies and procedures.

Figure 16: FUNDING LEVEL TRENDS FROM SELECTED SOURCES



FUTURE DIRECTIONS

Supporting New Opportunities through Training and Technical Assistance

Ninety-five percent of AAAs indicated a need for further training or technical assistance to help their agencies meet new challenges and opportunities. The top training and technical assistance requests centered around skills related to business acumen and developing health care partnerships, such as partnering with managed care organizations (34 percent), developing alliances with the health care system (34 percent), developing fee-for-service opportunities (32 percent), conducting business planning (28 percent), pricing services (26 percent) and negotiation (25 percent). Since 2007, the majority of training requests have centered around business acumen skills that AAAs seek as they work to ensure their agency's financial sustainability.

To address this need, n4a, with funding from The John A. Hartford Foundation and support from ACL, launched the Aging and Disability Business Institute in 2016. The Aging and Disability Business Institute is led by n4a in partnership with experienced and respected partners in the Aging and Disability Networks. Its mission is to build and strengthen partnerships between community-based organizations and the health care system—a vision intended to improve the health and well-being of America's older adults and people with disabilities through improved and increased access to quality services and evidence-based programs. The Business Institute is also supported with funding from ACL.



CONCLUSION

True to their mission, AAAs across the country are working to preserve the independence and dignity of older adults by providing services and supports that enable them to remain living in their

homes and communities.

However, the increasing number of older adults with the concurrent increased demand for services comes at a time when traditional federal funding sources are stagnating or decreasing. This places increased pressure on AAAs to be innovative in their service delivery and seek new, sustainable sources of funding.

Many AAAs are developing and formalizing partnerships with health care entities as a way to diversify their funding streams, potentially increase revenue and maintain a mission focus on enabling

older Americans to age successfully in their homes and communities. The value proposition works both ways—health care entities are more interested than ever before in working with community-based organizations as they strive to improve health outcomes while keeping costs contained.

At the same time as they develop new funding partners, AAAs continue to develop and offer services tailored to the unique needs of older adults in their local communities and serve as the hub of aging services in their communities. AAAs are involved with community-wide planning efforts, such as age-friendly and dementia-friendly community initiatives. AAAs sustain a wide range of services in their communities, beyond the core services required by the Older Americans Act. More AAAs are serving as Aging and Disability Resource Centers as well as administering the State Health Insurance Assistance Program (SHIP) and Long-Term Care Ombudsman Program locally. Through these efforts, AAAs help to ensure that older adults and their loved ones have access to the services they need at the time that they need them most.



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APPENDIX A: GLOSSARY OF INTEGRATED CARE INITIATIVES

MEDICAID HOME AND COMMUNITY-BASED SERVICES 1915(C): Within broad Federal guidelines, States can develop home and community-based services waivers (HCBS waivers) to meet the needs of people who prefer to receive long-term care services and supports in their home or community, rather than in an institutional setting.¹⁷

VETERAN-DIRECTED HOME AND COMMUNITY-BASED SERVICES (VD-HCBS): VD-HCBS gives veterans who need nursing home level care but wish to live at home the opportunity to direct their long-term services and supports. Veterans are provided a budget for their services and supports which they manage, deciding for themselves which services and supports best meet their needs.¹⁹ VD-HCBS is administered through a partnership between ACL and the Department of Veterans Affairs.

SECTION 1915(B) WAIVER: Waiver authority for mandatory enrollment in Medicaid managed care on a statewide basis or in limited geographic areas.¹⁶

PROGRAM FOR ALL INCLUSIVE CARE FOR THE ELDERLY (PACE): Provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. For most participants, the comprehensive service package enables them to remain in the community rather than receive care in a nursing home. Financing for the program is capped, which allows providers to deliver all services participants need rather than only those reimbursable under Medicare and Medicaid fee-for-service plans. PACE is a program under Medicare, and states can elect to provide PACE services to Medicaid beneficiaries as an optional Medicaid benefit.²⁶

MEDICAID SECTION 1115 DEMONSTRATIONS: Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP) programs. Under this authority, the Secretary may waive certain provisions of the Medicaid law to give states additional flexibility to design and improve their programs. The purpose of these demonstrations is to demonstrate and evaluate policy approaches such as: expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible; providing services not typically covered by Medicaid; or using innovative service delivery systems that improve care, increase efficiency and reduce costs.¹⁸

CMS FINANCIAL ALIGNMENT

DEMONSTRATION: A longstanding barrier to coordinating care for Medicare-Medicaid enrollees has been the financial misalignment between Medicare and Medicaid. To begin to address this issue, the Centers for Medicare & Medicaid Services (CMS) launched the CMS Financial Alignment demonstration to test models with states that better align the financing of both programs and integrate primary, acute, behavioral health and long-term services and supports for their Medicare-Medicaid enrollees.²⁰

ACCOUNTABLE CARE ORGANIZATION

(ACO): Groups of doctors, hospitals and other health care providers that come together voluntarily to deliver coordinated, high-quality care to their patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves.²¹

VETERANS CHOICE PROGRAM:

The Veterans Access, Choice, and Accountability Act of 2014 requires the Department of Veterans Affairs (VA) to establish a temporary program (“the Choice Program”) to improve veterans’ access to health care by allowing eligible veterans to use eligible health care providers outside of the VA system.²²

GERIATRIC WORKFORCE ENHANCEMENT PROGRAM (GWEP):

Funded through the U.S. Health Resources and Services Administration, GWEP’s goal is to develop a health care workforce that maximizes patient and family engagement and improves health outcomes for older adults by integrating geriatrics with primary care. Special emphasis is on providing the primary care workforce with the knowledge and skills to care for older adults and on collaborating with community partners to address gaps in health care for older adults through individual, system, community and population-level changes.²³

MEDICAID HEALTH HOME:

The Affordable Care Act of 2010, Section 2703, created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions by adding Section 1945 of the Social Security Act. CMS expects states health home providers to operate under a “whole-person” philosophy. Health Home providers will integrate and coordinate all primary, acute, behavioral health and long-term services and supports to treat the whole person.²⁴



CMS STATE INNOVATION MODELS

INITIATIVE: The State Innovation Models (SIM) initiative partners with states to advance multi-payer health care payment and delivery system reform models. Each state-led model aims to achieve better quality of care, lower costs and improved health for the population of the participating states or territory. The initiative is testing the ability of state governments to utilize policy and regulatory levers to accelerate health system transformation to meet these aims.²⁵

PATIENT-CENTERED MEDICAL HOME:

A care delivery model that facilitates partnerships between individual patients their personal physicians, and, when appropriate, the patient's family. Care is facilitated by registries, information technology and health information exchanges.²⁷

CMS HEALTH CARE INNOVATION AWARD:

The Health Care Innovation Awards funded up to \$1 billion in awards to organizations implementing the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and the Children's Health Insurance Program, particularly those with the highest health care needs.²⁸

CMS COMPREHENSIVE CARE FOR JOINT REPLACEMENT:

Aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements. This model tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery.²⁹

CMS BUNDLED PAYMENTS FOR CARE

IMPROVEMENT: This initiative is comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost to Medicare.³⁰

APPENDIX B: SNAPSHOT OF AAA ACTIVITIES IN INTEGRATED CARE

Since they were established in 1973 through the Older Americans Act, AAAs have always played multiple roles in their communities while retaining the core mission of ensuring older Americans can age with health, independence and dignity in their homes and communities. AAAs implement their services through an array of partnerships. On average, AAAs have 11 informal and 5 formal partnerships through which they make referrals, provide services and meet their mission. AAAs are increasingly engaging with the health care system. AAAs and health care entities both face pressures. AAAs face an increasing volume of clients with traditional funding sources that are stagnant, and health care entities are seeing changes in their payment models. As a result, conditions are ripe for partnerships with mutual benefit.

The following charts showcase the most common activities that AAAs offer as part of specific integrated care activities. Knowing how some AAAs are positioning their activities in these integrated care opportunities may inform other AAAs wishing to pursue this work.

Figure 17: MOST COMMON AAA ACTIVITIES RELATED TO 1115 MEDICAID DEMONSTRATION WAIVER

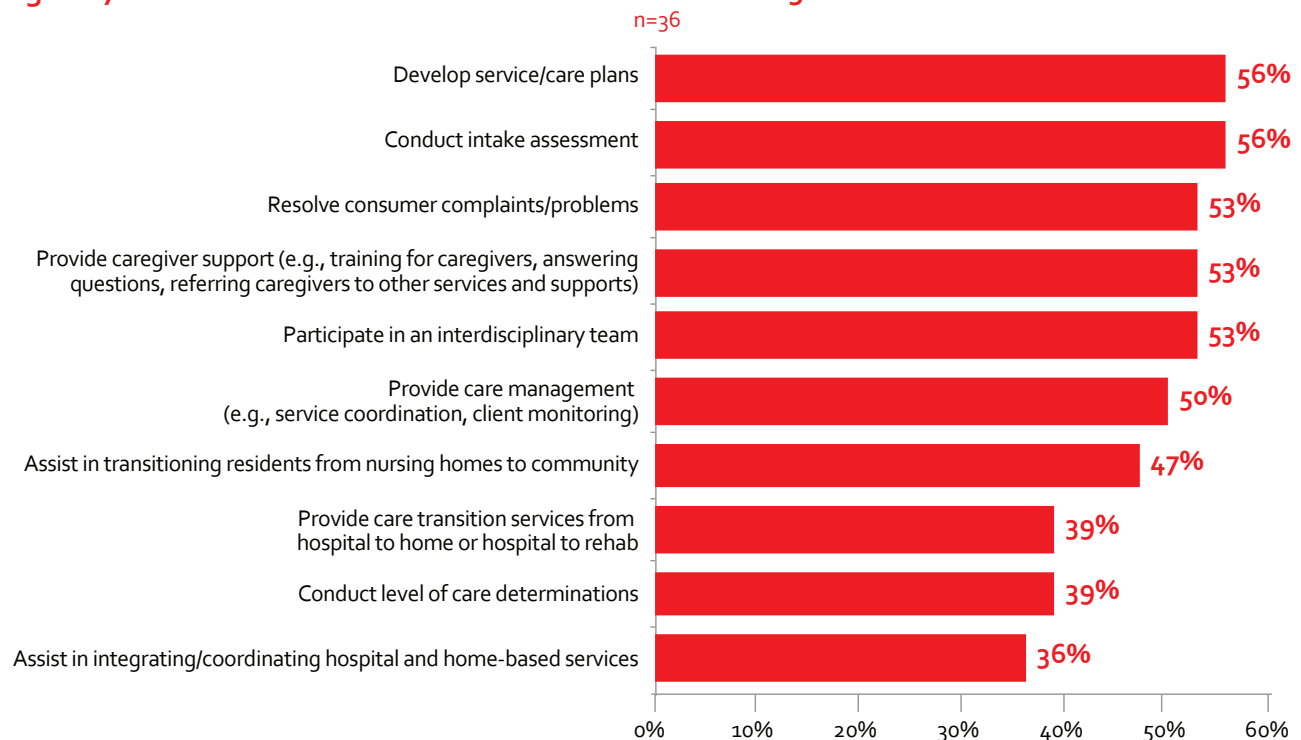


Figure 18: MOST COMMON AAA ACTIVITIES RELATED TO CMS FINANCIAL ALIGNMENT DEMONSTRATION

n=31

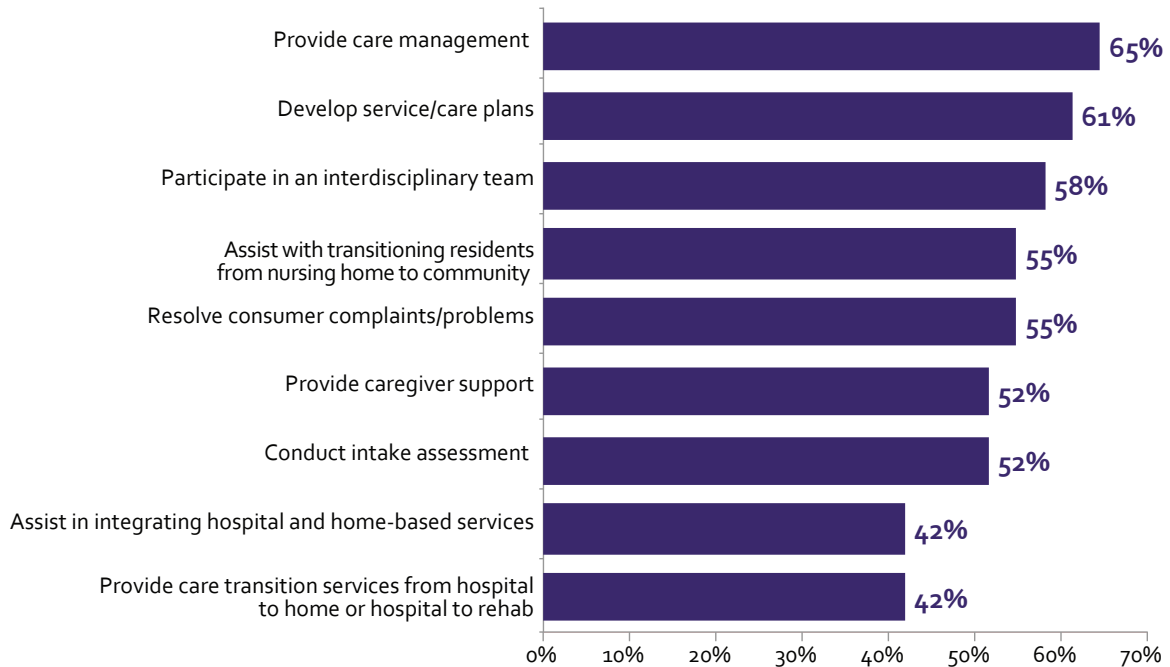


Figure 19: MOST COMMON AAA ACTIVITIES RELATED TO MEDICAID 1915(B) MANAGED CARE WAIVER

n=52

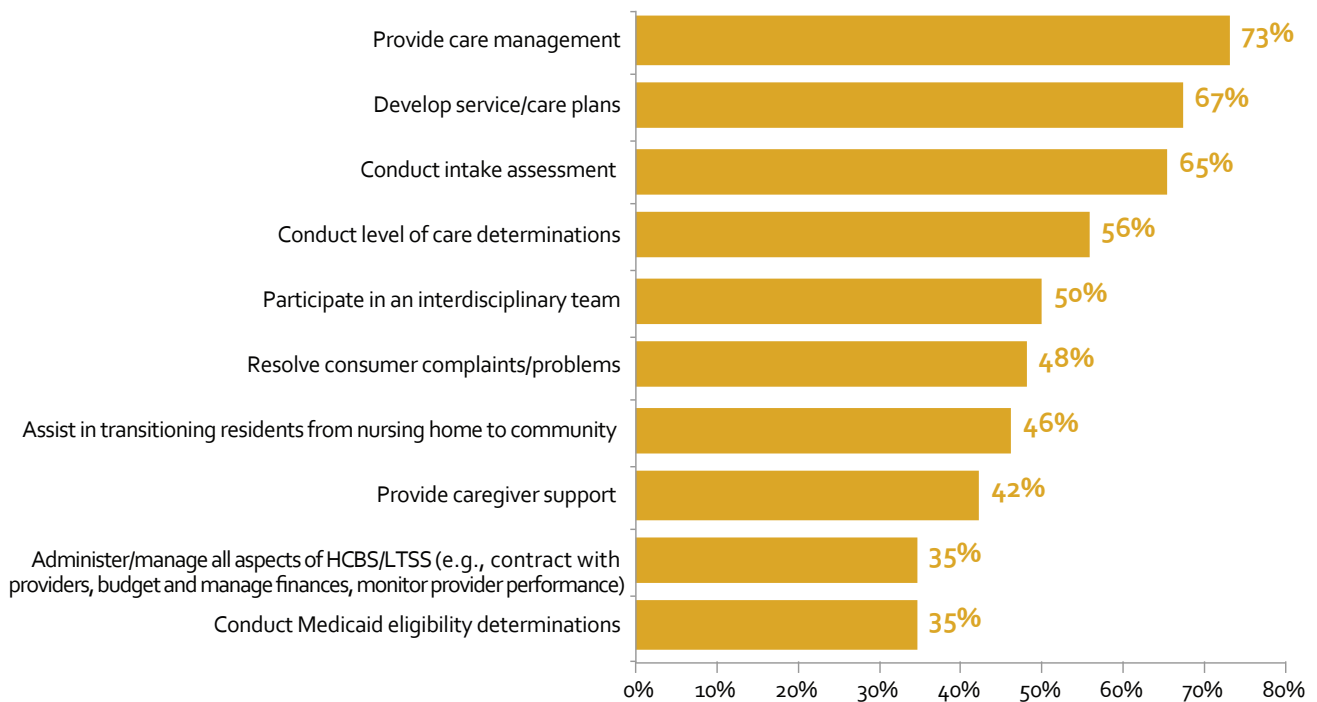


Figure 20: MOST COMMON AAA ACTIVITIES RELATED TO ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

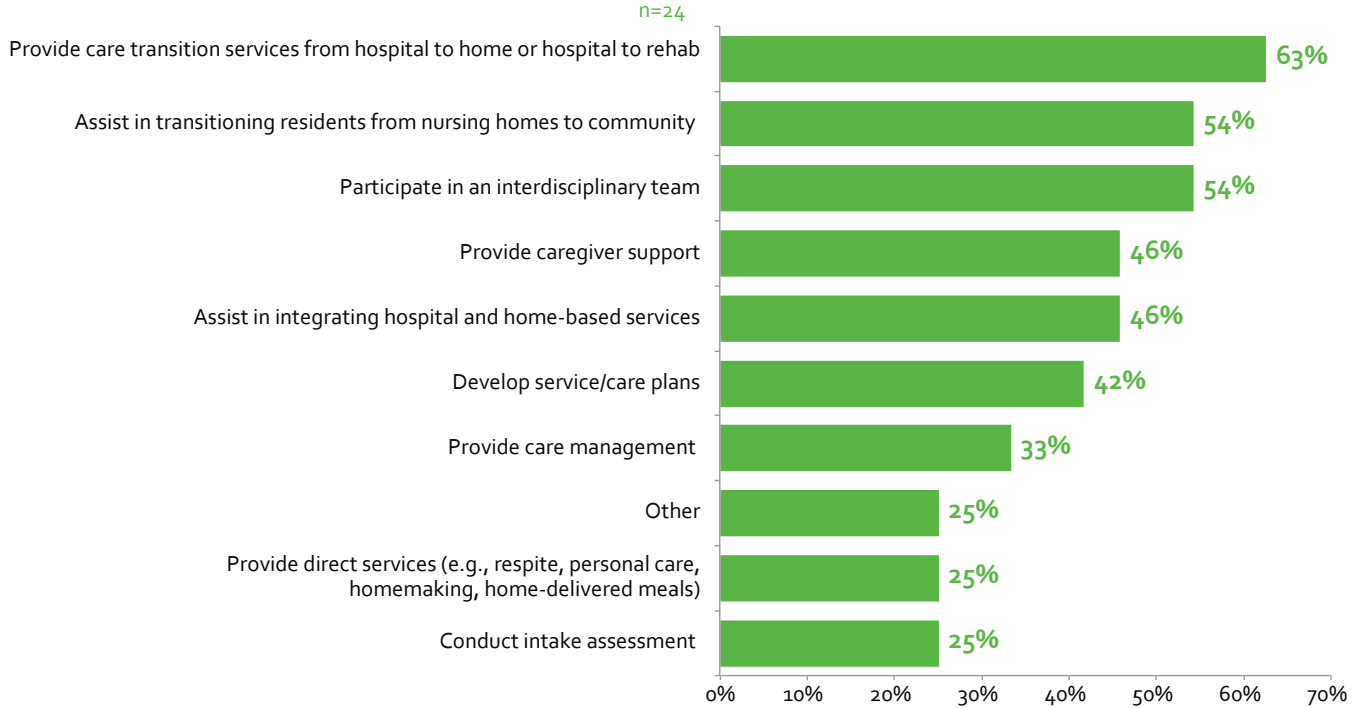


Figure 21: MOST COMMON AAA ACTIVITIES RELATED TO VETERAN-DIRECTED HOME AND COMMUNITY-BASED SERVICES (VD-HCBS)

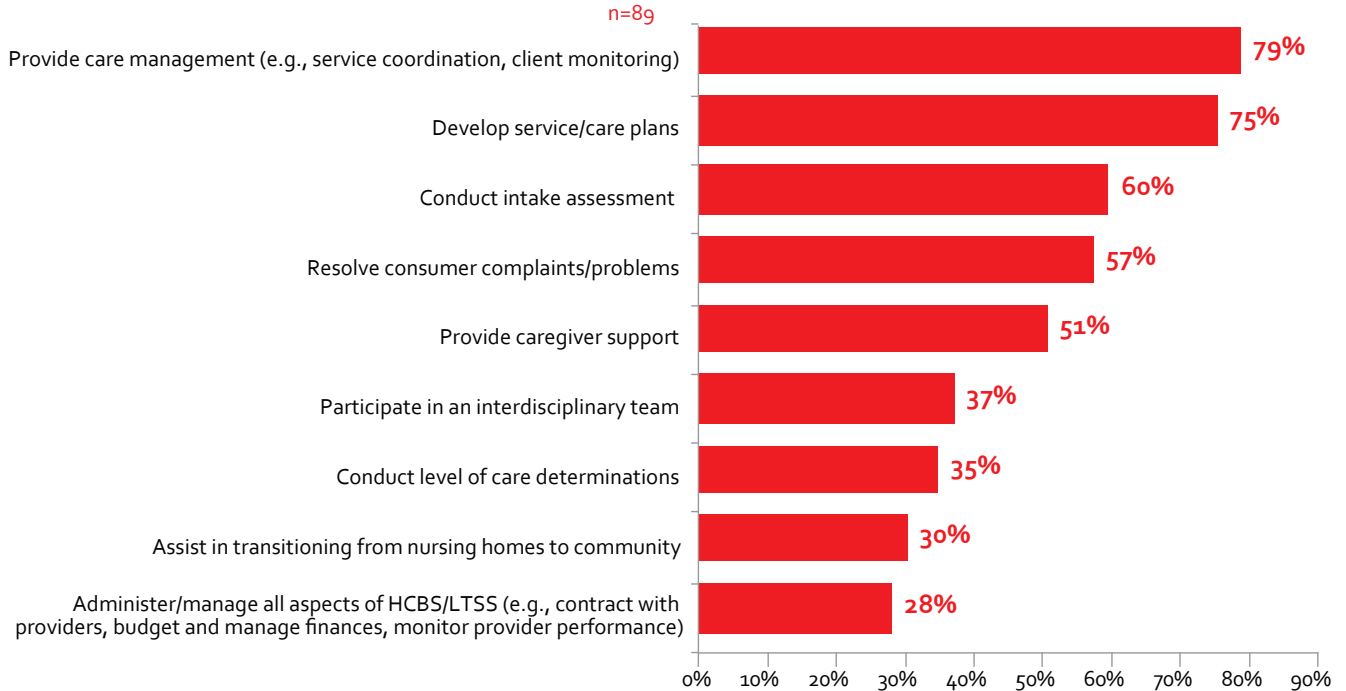
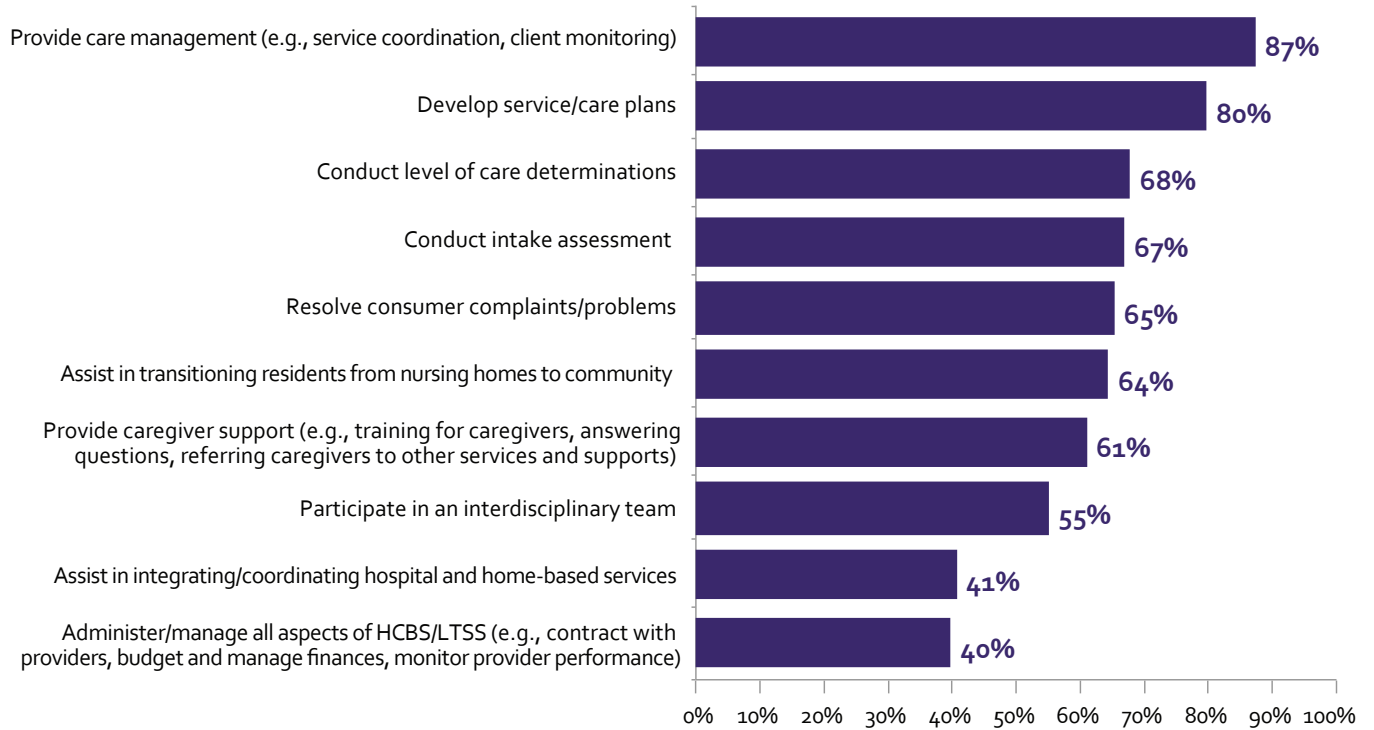


Figure 22: MOST COMMON AAA ACTIVITIES RELATED TO MEDICAID 1915(C) HCBS WAIVER

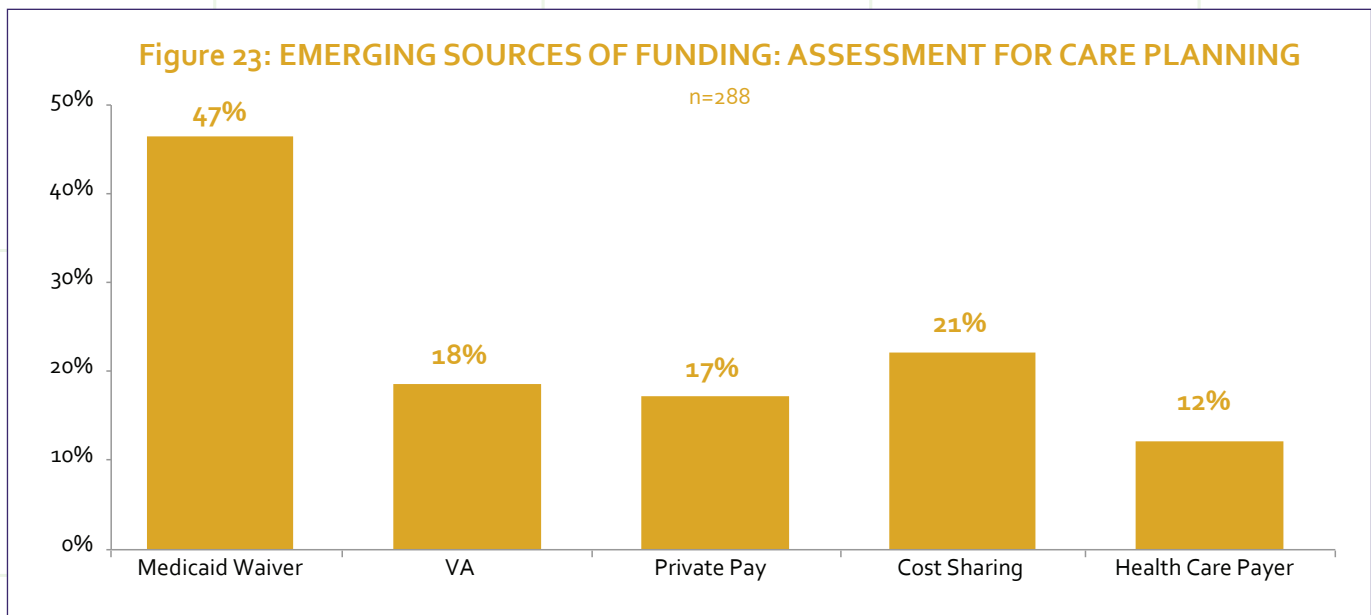
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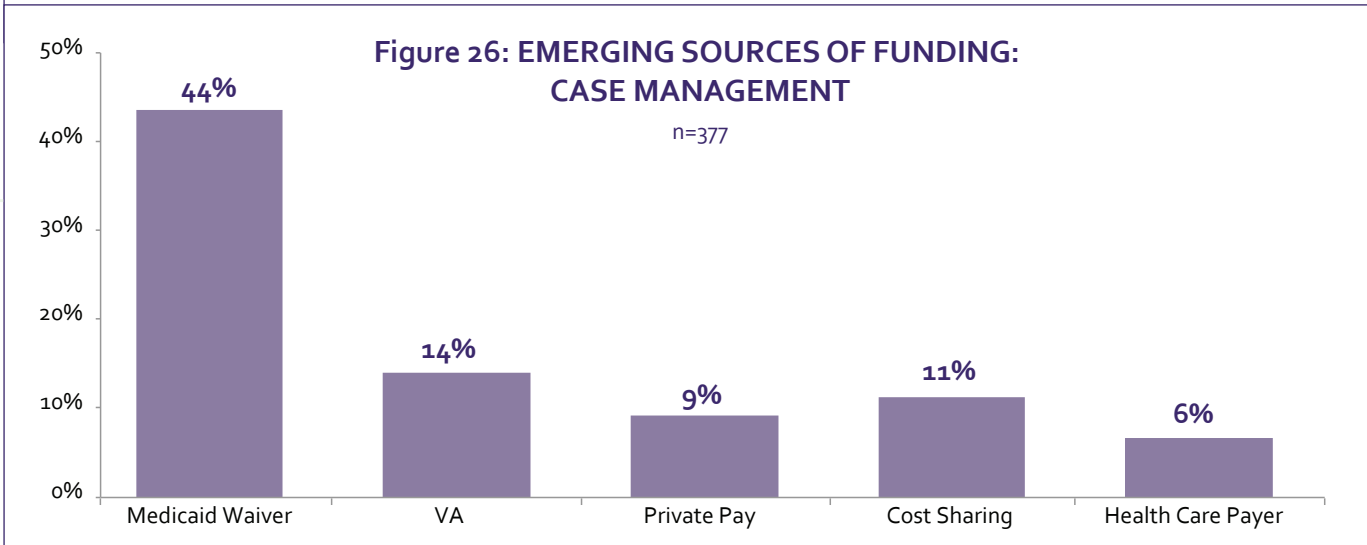
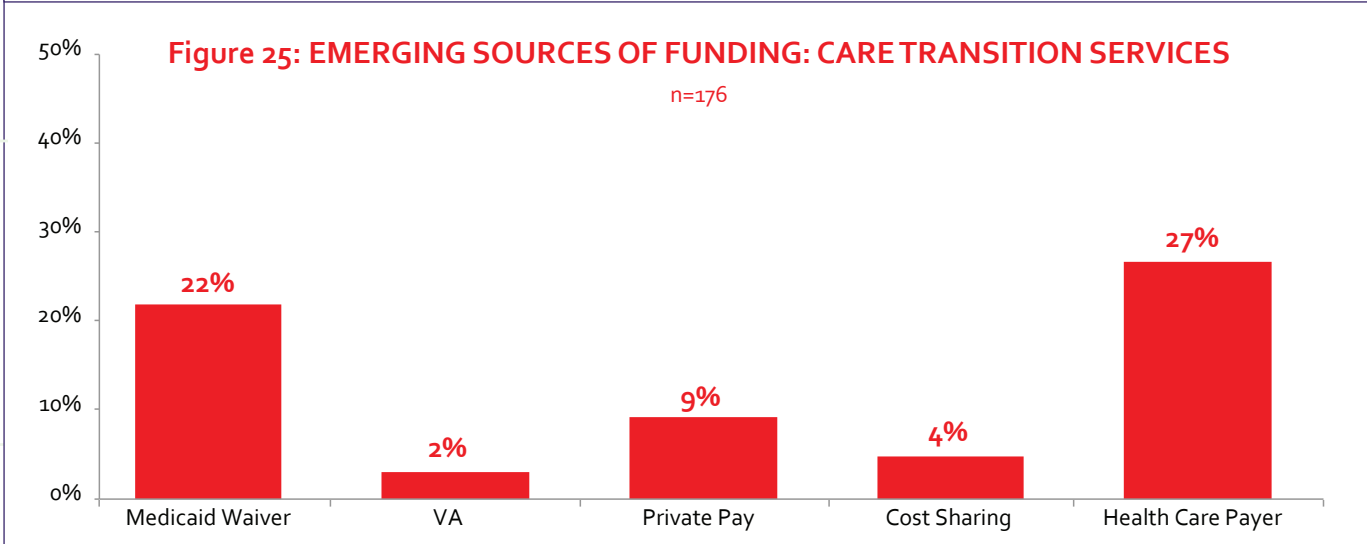
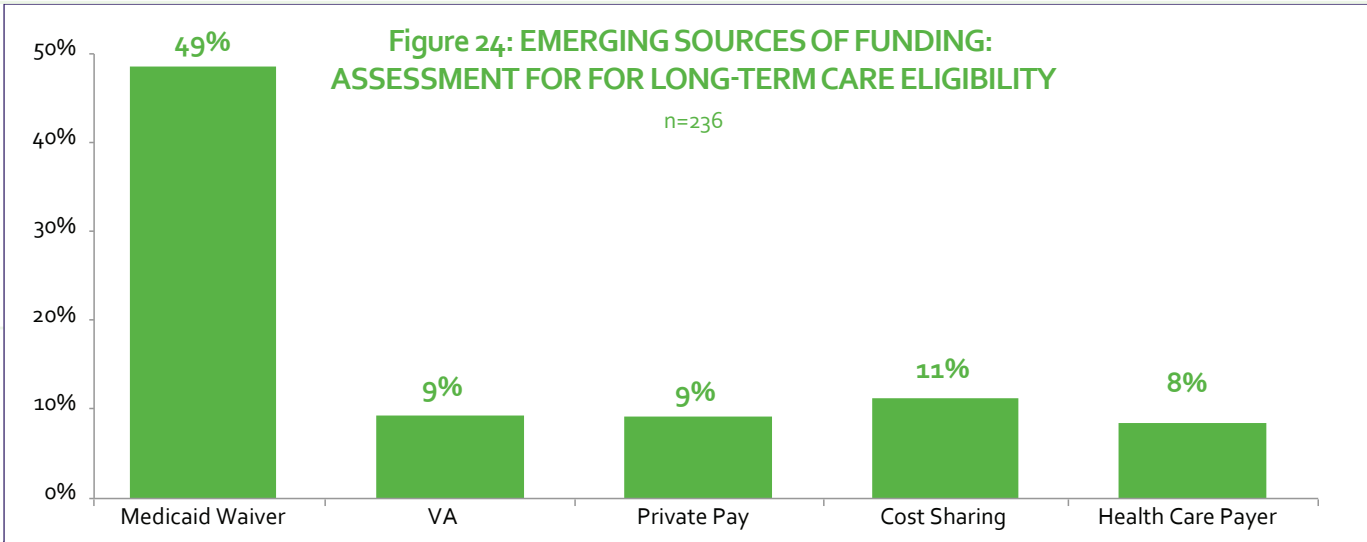


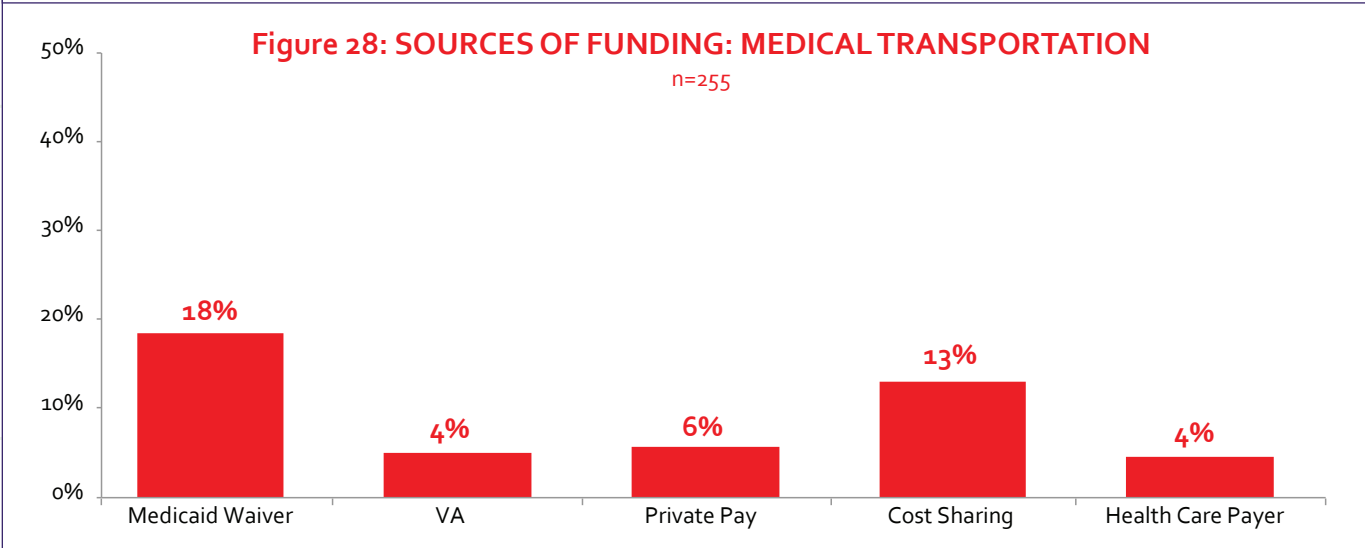
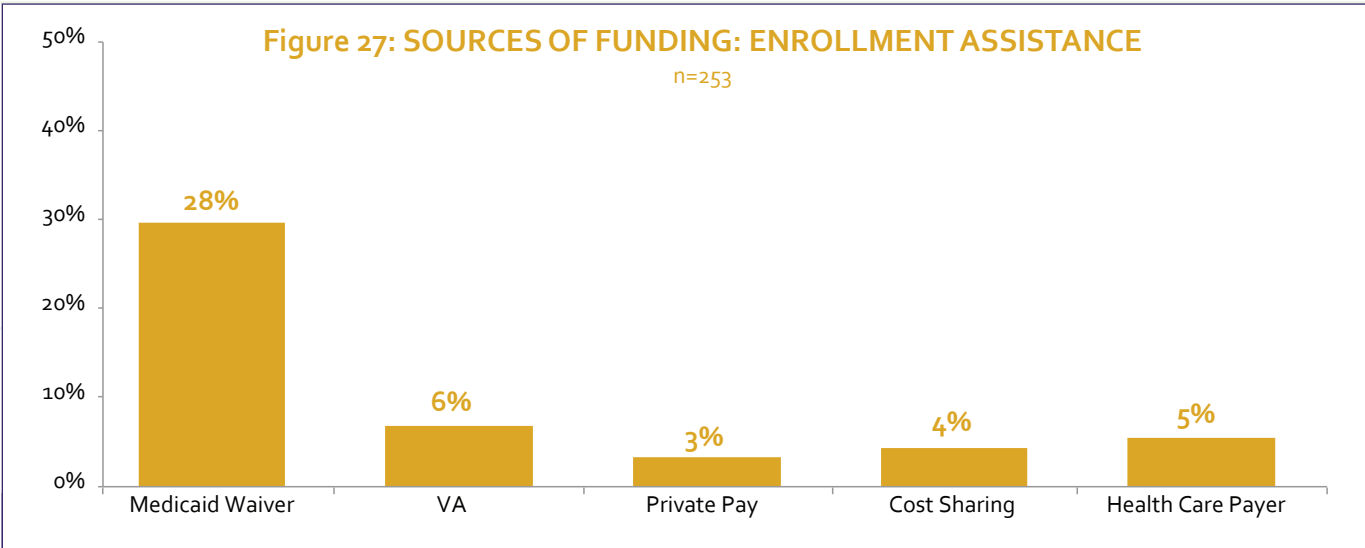
APPENDIX C: EMERGING SOURCES OF FUNDING BY SERVICE

The following charts highlight emerging sources of funding—Medicaid waiver, Department of Veterans Affairs (VA), private pay, cost-sharing and health care payer—by service. While data does not depict all of the funding sources for these services, these are funding sources that may have the most opportunity for potential growth. Other common funding sources not listed in the charts are Older Americans Act funding, state general revenue, federal funding and local government funding.

As shown in Figures 23 to 28, Medicaid Waiver is a common funding source assessment for care planning, assessments for long-term care eligibility and case management. Cost-sharing is most common with assessments for care planning and medical transportation. Private pay is most commonly a funder of assessments for care planning. Health care payers are most commonly funding care transition services, assessments for care planning and assessments of long-term care eligibility.



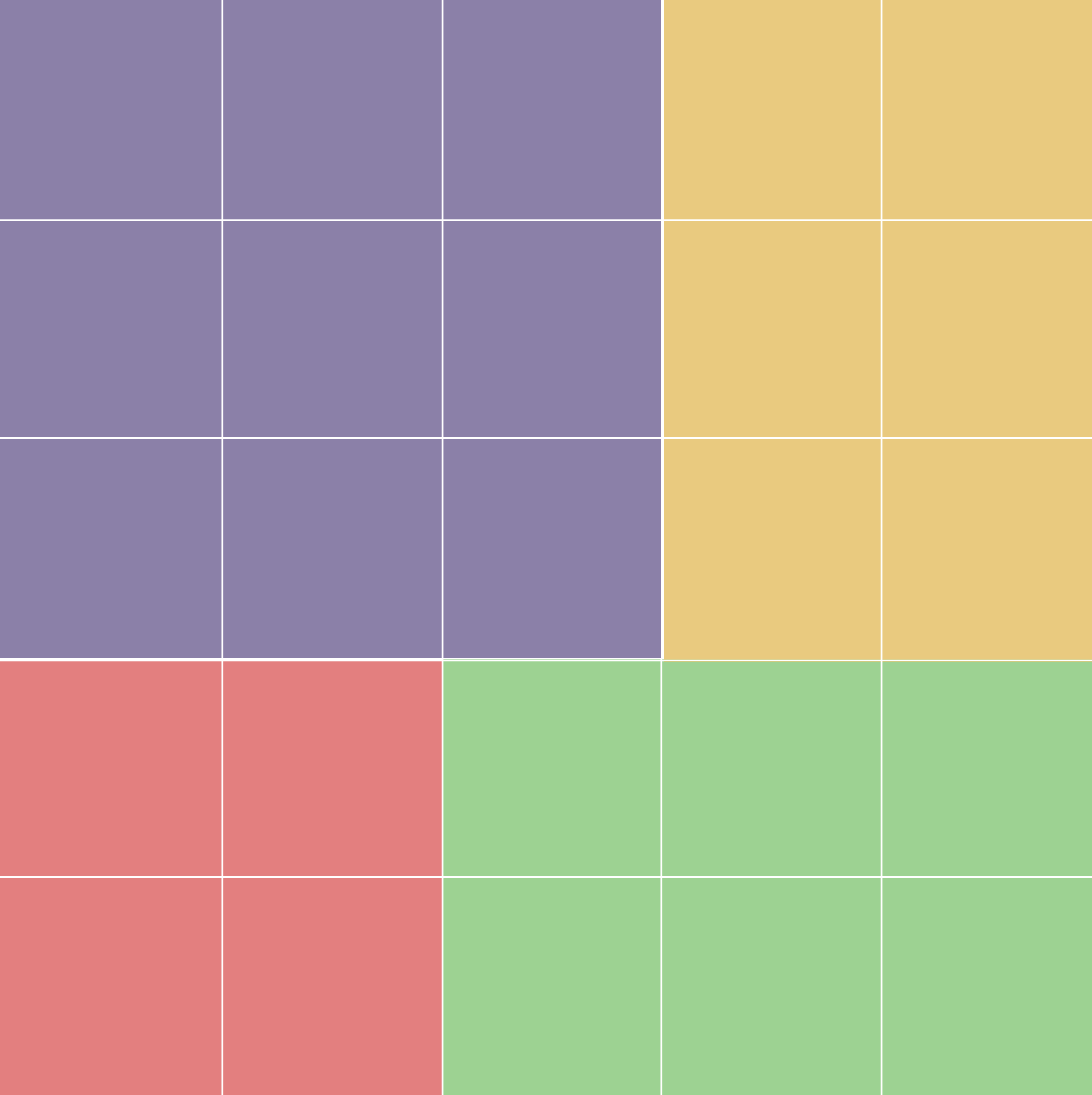




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