GAO

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Report to the Special Committee on Aging, U.S. Senate

May 2019

OLDER AMERICANS ACT

HHS Could Help Rural Service Providers by Centralizing Information on Promising Practices

Why This Matters

Rural areas cover the vast majority of the country and tend to be "grayer" than urban areas, with higher percentages of older adults. Many older adults prefer to stay in their homes as they age, but it can be difficult to connect rural older adults to needed services.

Key Takeaways

To stay in their homes as they age, older adults often need services such as in-home care, meal delivery, and transportation to medical appointments. Under the Older Americans Act of 1965, the Department of Health and Human Services (HHS) funds grants to help state and local agencies provide these services. Rural older adults are identified as important service recipients because of their economic and social needs.

However, studies indicate that rural older adults received certain services, such as home-delivered meals, less frequently than urban older adults. Local officials and service providers told us how reaching older adults in remote, sparsely populated areas can add to the cost and effort of providing services, and how a dwindling working-age population can mean fewer caregivers and volunteers to help.

HHS supports over two dozen national resource centers that publish information on promising practices for delivering services to older adults, including some that may be useful for rural agencies. Yet this information is spread across national resource center websites and is not centrally accessible. Local officials were often not aware of pertinent resources. Several said that more information on rural promising practices or other resources would be helpful.

Rural and Urban Population Aged 65 and Older, by County
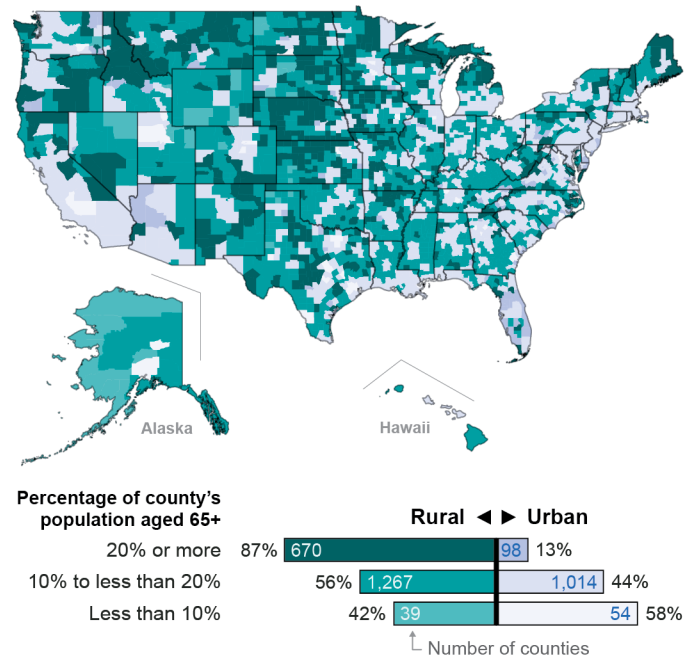
Source: GAO analysis of U.S. Census Bureau's American Community Survey data, 2012-2016 5-year estimates. | GAO-19-330

What GAO Recommends

HHS should centralize access to and promote awareness of promising practices or other useful information pertinent to serving rural older adults. HHS agreed.

How GAO Did This Study

We analyzed 2017 HHS survey data; reviewed relevant federal laws, agency documents, and studies; and interviewed service providers in 12 rural localities in eight states. We also interviewed HHS officials, national associations, and experts on rural issues.

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Abbreviations

ACL	Administration for Community Living
AAA	area agency on aging
CMS	Centers for Medicare and Medicaid Services
DOT	Department of Transportation
FORHP	Federal Office of Rural Health Policy
FTA	Federal Transit Administration
HCBS	home- and community-based services
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
OAA	Older Americans Act of 1965
OMB	Office of Management and Budget
SHIP	State Health Insurance Assistance Program
SSA	Social Security Administration
USDA	U.S. Department of Agriculture

May 23, 2019

The Honorable Susan Collins
Chairman
The Honorable Robert Casey
Ranking Member
Special Committee on Aging
United States Senate

The U.S. population is aging—the Census Bureau projects that 1 in 5 Americans will be aged 65 and older by 2030 and the number of people aged 85 and older will nearly double by 2035.[1] Many older adults are likely to need additional services and supports as they grow older. Further, many will want to receive such services and supports in their homes and communities rather than in an institution such as a nursing home. Title III grants provided under the Older Americans Act (OAA) of 1965, as amended, are a key source of federal funds for home- and community-based services (HCBS).[2] These services help older adults age in place—that is, remain in their homes and communities. Title III grants are overseen by the Administration for Community Living (ACL) within the Department of Health and Human Services (HHS), and are distributed through state and local programs on aging. Title III grants help fund a broad range of services, including congregate and home-delivered nutrition services; supportive services, such as transportation, case management, or homemaker services; and support and information for family caregivers of older adults.[3] In fiscal year 2018, Title III grants allocated to all 50 states, Washington, D.C., and U.S territories totaled about $1.3 billion.

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[1]J. Vespa, D. Armstrong, and L. Medina, *Demographic Turning Points for the United States: Population Projections for 2020 to 2060,* Current Population Reports, P25-1144, (U.S. Census Bureau, Washington, D.C.: March 2018).

[2]Home- and community-based services (HCBS) can include nutrition, personal care, home health, case management, transportation, and caregiver services, among others. These services can be provided under Title III or other federal programs, although programs may have different definitions of what are considered HCBS.

[3]Congregate and home-delivered nutrition services include the provision of meals, as well as other nutrition services, such as nutrition education and counseling. Congregate nutrition services are those provided in a variety of group settings, such as senior centers, community centers, or adult day care centers. Homemaker services include assistance such as preparing meals, shopping for personal items, managing money, using the telephone or doing light housework.

The OAA identifies rural older adults as one of several target populations having the greatest economic and social needs. Rural areas also tend to have higher concentrations of older adults than urban areas. Accordingly, you asked us to review older adults' access to HCBS in rural areas and any challenges they have accessing these services. This report examines (1) what is known about older Americans' access to HCBS in rural areas compared to urban areas; (2) the challenges that selected rural localities face in helping older Americans access these services and the strategies the localities are using to mitigate these challenges; and (3) the extent to which ACL makes resources available to help address those challenges. In addition, we obtained information related to how rural and urban older adults contact the Social Security Administration (SSA) for supports and services. This information is presented in appendix I.

To determine what is known about older Americans' access to HCBS in rural areas compared to urban areas, we analyzed data from ACL's 2017 National Survey of Older Americans Act Participants (2017 National Survey of OAA Participants), the most recent available. This nationally-representative, multi-part survey is sent to recipients of one or more of the following Title III services: case management, congregate meals, home-delivered meals, homemaker, transportation, and family caregiver services.[4] We assessed the reliability of these data by reviewing technical documentation, conducting electronic testing, and obtaining information on data reliability from ACL officials. As a result, we determined that the data were sufficiently reliable for the purposes of this report. (For more information on our analysis of the 2017 National Survey of OAA Participants, see app. II.)

Additionally, for this objective, we conducted a literature review of studies from the last 10 years (2009 through 2018) to assess what is known

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[4]These six services were all the modules available from the 2017 National Survey of OAA Participants and all were included in our analysis. Also, according to information from ACL, survey respondents who received more than one of these services are asked to complete the survey for one service (in a given year) to minimize respondent burden.

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about access to HCBS for older adults beyond Title III programs.[5] Our scope included studies that: (1) compared service access between rural and urban older adults; (2) were based on original research conducted in and published in the United States; (3) were published after 2008; (4) were not focused solely on American Indians or veterans (which were populations we excluded because they are primarily served through separate programs); and (5) provided clear descriptions of their methodologies and had no significant methodological limitations. Also, all of the studies we included in our review were national in scope and not focused on a state or local area. We identified 11 studies that met these criteria, which we then reviewed and summarized. (For more information on how we conducted our literature review, see app. III.)

To determine the challenges that selected rural localities face in helping older Americans access these services and the strategies the localities are using to mitigate those challenges, we conducted interviews with officials and gathered documents from 12 rural localities in a total of eight states (California, Maine, Mississippi, New Mexico, North Dakota, Oklahoma, Pennsylvania, and Wisconsin). The localities were selected for their concentration of elderly residents in rural areas, as well as for demographic and geographic diversity.[6] In each of the states, we interviewed officials from one to two rural area agencies on aging (AAA) or equivalent, who also completed a short survey on challenges in

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[5]In addition to OAA Title III grants, several other federal programs also support the provision of HCBS for older adults. Medicaid, for example, is the nation's primary payer for long-term services and supports, much of which is provided in the home and community. In prior work we have reported on the range of federal programs that support HCBS for older adults. See GAO, *Older Adults: Federal Strategy Needed to Help Ensure Efficient and Effective Delivery of Home- and Community-Based Services and Supports,* GAO-15-190 (Washington, D.C.: May 20, 2015). We have also reported on the use of HCBS among various populations in the Medicaid program specifically. See GAO, *Medicaid Home- and Community-Based Services: Selected States' Program Structures and Challenges Providing Services*, GAO-18-628 (Washington, D.C.: Aug. 30, 2018).

[6]Some of these localities included areas that were not rural. However, because all 12 served a significant number of rural older adults, we refer to them all as rural in this report. For more information on the demographics of each locality, see appendix V.

advance of our interviews.[7] (See app. IV for complete results of survey responses.) In four of the states (California, Maine, Mississippi, and North Dakota), we also conducted site visits and interviewed state-level officials and local providers. In total, we conducted almost 50 different interviews among our selected states and localities. To supplement our interviews, we reviewed state and area plans on aging and other relevant documents obtained from state or local officials, as well as pertinent information from prior GAO reports and existing research. The information gathered from interviews with officials from selected states and localities is meant to provide illustrative examples and is not generalizable to all states and localities. (See app. V for additional information on each of our selected localities.)

To determine the extent to which ACL makes resources available to help address the challenges identified, we reviewed the information ACL provides online through its national resource centers on aging issues. We also reviewed provisions in the OAA, as well as federal standards for internal control. In addition, we interviewed ACL officials from headquarters and four regional offices and obtained information from officials on relevant resources provided by ACL, such as technical assistance, information, and other support that could potentially help states and localities address challenges. We also interviewed officials and obtained information on relevant resources provided by the Department of Transportation (DOT) and HHS' Health Resources and Services Administration (HRSA), which are federal agencies with whom ACL collaborates regarding rural challenges. In our interviews with state and local officials, we also asked what ACL efforts were useful and what additional actions ACL could take to help address challenges. For all

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[7]We developed our survey on challenges using information collected through interviews with experts, associations, and federal agencies and initial research. We also pretested the survey with officials from three of our selected area agencies on aging (AAAs) to help ensure our questions were clear and unbiased and the layout understandable, and we incorporated their comments, as appropriate. Also, North Dakota does not provide aging services through AAAs, but provides them through the state office with assistance from regional offices. Accordingly, in North Dakota we identified two regional offices as equivalent to AAAs for our purposes.

three objectives, we interviewed selected national stakeholder groups and rural health experts.[8]

We conducted this performance audit from January 2018 to May 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

OAA Title III Services

OAA helps older adults (defined as 60 and older under the OAA) remain in their homes and communities to the extent possible through the support of HCBS, among other things. States receive separate allotments of OAA Title III funds based on a statutory funding formula for different types of services (see table 1). Although OAA requires states to provide some services with these funds, such as congregate and home-delivered meals, states have considerable flexibility in other areas. For example, Title III, Part B supportive services can be used to fund a wide range of services from in-home care to transportation services to minor home modifications. States also have the ability to transfer certain portions of funds within or among parts. For example, based on information from ACL, states collectively transferred a net total of $92.9 million in fiscal year 2017 from congregate meals to either supportive services or home-delivered meals.

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[8]These included AARP, Grantmakers in Aging, National Association of Areas Agencies on Aging, National Association of States United for Aging and Disabilities, National Rural Health Association, Rural Policy Research Institute, the Walsh Center for Rural Health Analysis at NORC, and Meals on Wheels America. We selected these groups and experts based on suggestions from federal agencies, recommendations from internal experts, and other exploratory research.

Table 1: Older Americans Act Title III Federal Grant Amounts by Part, Fiscal Year 2018

OAA Title III Parts	Amount (in millions)
Part B: Supportive services (personal care, chore, homemaker, adult day care, case management, transportation, outreach services, among others)	$381.7
Part C: Nutrition services	
Congregate meals and services	$484.7
Home-delivered meals and services	$243.5
Part D: Evidence-based disease prevention and health promotion (e.g., class-based physical activity programs, falls prevention programs, one-on-one health intervention services in the home, among others)	$24.6
Part E: National Family Caregiver Support Program (respite care, caregiver training, and information, among others)	$179.0

Source: Information from the Administration for Community Living. | GAO-19-330

Note: Total amounts for parts above include the 50 states, Washington, D.C., and U.S. territories. Services provided under Parts B through D are generally aimed at older adults themselves, while Part E services support adult family members or another individual who is an informal provider of in-home and community care to adults 60 and older or adults with Alzheimer's disease (or certain related disorder) of any age, as well as older relative caregivers. (Part A includes general provisions; for example, the purpose of the title and definitions of terms used in the law rather than provisions for particular services.)

Title III funds are administered by ACL to state agencies on aging, who then typically distribute funds to area agencies on aging (AAA). AAAs are public or private non-profit entities that are responsible for planning and delivering HCBS and related supports to older adults within their geographic service area. Service areas are determined by states and can consist of a single county or multiple counties. AAAs often provide services through contracts with community providers, but in certain circumstances may provide services directly. Eight states and the District of Columbia, which are small or sparsely populated, administer aging services on the state level instead of through AAAs.[9] Besides coordinating the provision of direct services, such as congregate meals, AAAs or their contracted providers may also provide information and assistance and refer older adults (or others inquiring on their behalf) to other programs and resources (e.g., housing assistance). State or area aging agencies sometimes also provide outreach, counseling, and information assistance to older adults or their families on Medicare and

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[9]These states include Alaska, Delaware, Nevada, New Hampshire, North Dakota, Rhode Island, South Dakota, and Wyoming.

other health insurance issues through a program separate from Title III, called the State Health Insurance Assistance Program (SHIP).[10]

As Title III services are not an entitlement, state aging offices work with ACL to determine how they will target their funds within federal guidelines.[11] For instance, the OAA identifies several groups of older adults as those having the greatest economic and social needs—including older adult who live in rural areas—and states must indicate ways they will target these groups in providing services.[12]

Older Adults in Rural Areas

About 19 percent of older adults (aged 65 and older) live in rural areas in the United States based on 2013-2017 estimates from the American Community Survey. On average, rural areas tend to have larger proportions of older adults than urban areas. For example, the vast majority of counties where more than 20 percent of the population is aged 65 and older are in rural areas based on American Community Survey estimates (see fig. 1).[13] This "graying" of rural areas is caused by several factors, including that working-age adults move out of rural areas to find more employment opportunities and that some older adults move to rural areas to retire.[14]

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[10]The Consolidated Appropriations Act, 2014 transferred SHIP administration from CMS to ACL in 2014. This transfer reflected the existing formal and informal collaborations between the state SHIP projects and ACL's existing aging network. Some states administer their SHIP program through their state insurance departments instead of their aging offices.

[11]According to ACL, its regional offices work closely with states in the development and revision of their intrastate funding formulas to ensure they meet the intent of the OAA.

[12]Other target groups identified in the act with high economic and social needs include older adults who are low-income, from minority groups, or have limited English.

[13]Also see discussion of rural areas as disproportionately older in other publications, such as A. Coburn, J. Lundblad et al. *Rural Long-Term Services and Supports: A Primer* (Rural Policy Research Institute), November 2017; and U.S. Department of Agriculture, Economic Research Service, *Rural America at a Glance: 2018 Edition,* Economic Bulletin 200, (Washington, D.C.: November 2018).

[14]U.S. Department of Agriculture, Economic Research Service, *Rural America at a Glance: 2018 Edition*; and additional correspondence with the author.

Figure 1: Percentage of Population Aged 65 and Older in Rural and Urban Areas by County, 2012-2016
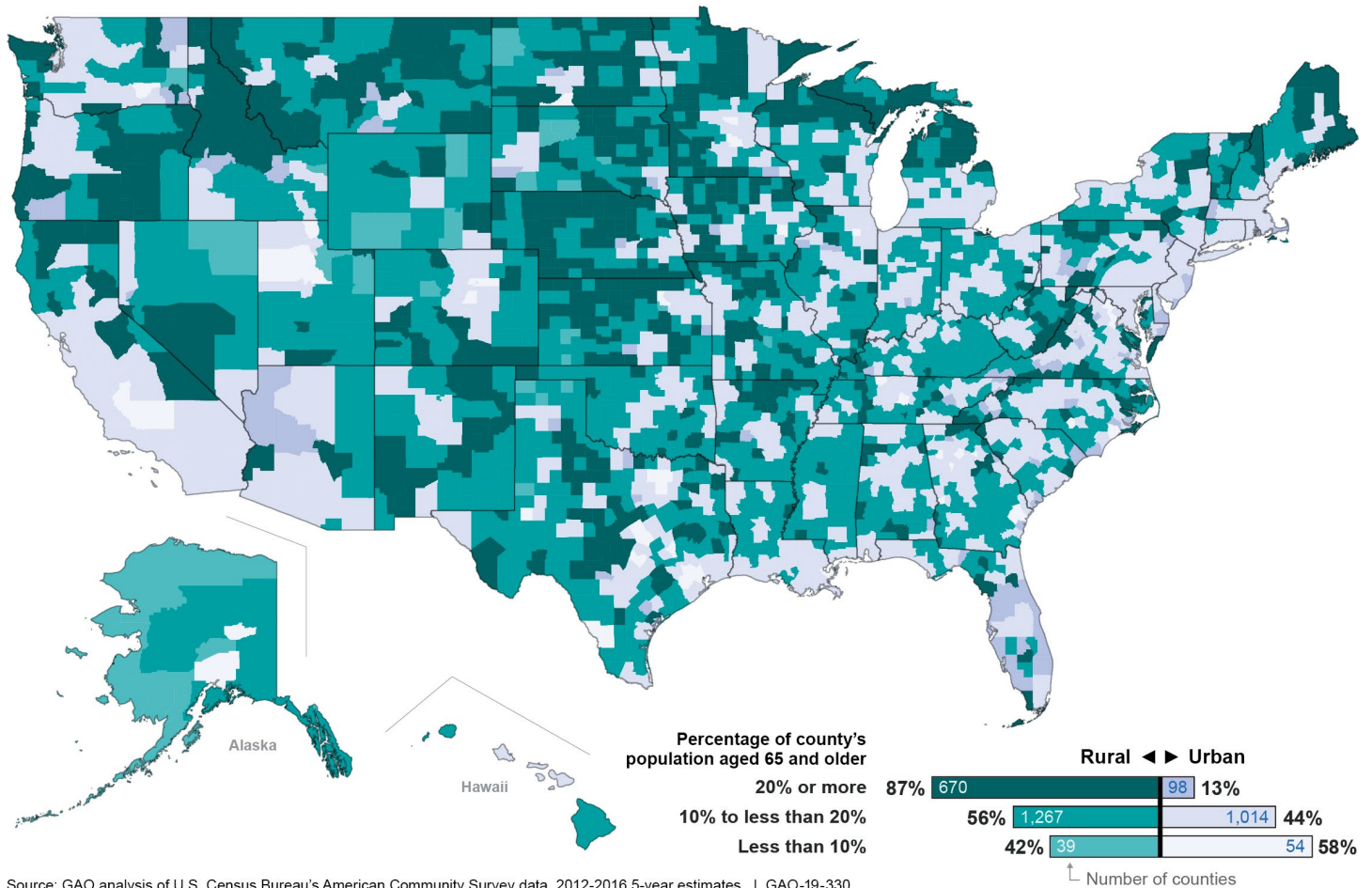
Alaska

Hawaii

Percentage of county's population aged 65 and older

Rural ◄ ► Urban

20% or more	87% 670	98 13%	
10% to less than 20%	56% 1,267	1,014 44%	
Less than 10%	42% 39	54 58%	

└ Number of counties

Source: GAO analysis of U.S. Census Bureau's American Community Survey data, 2012-2016 5-year estimates. | GAO-19-330

Note: Counties are classified as rural and urban using Rural-Urban Continuum Codes from the U.S. Department of Agriculture's Economic Research Service.

Many older adults may need long-term supports and services at some point in their lives, but those in rural areas confront particular risk factors that could enhance this need:

- **Health**: According to the National Center for Health Statistics, non-metropolitan adults of any age report higher rates of multiple chronic conditions, such as hypertension, coronary heart disease, stroke, or diabetes, among others. For instance, a higher percentage of adults in non-metropolitan areas (22.6 percent) had two to three chronic conditions in 2016 compared with adults in metropolitan areas (18.9

percent).[15] Older adults in rural areas also tend to have poorer health. Compared with urban and suburban older adults, those in rural areas reported higher rates of falls, obesity, physical inactivity, and smoking, while also reporting that they engaged in lower rates of preventative care such as health screenings and flu vaccines.[16]

- **Disability:** Among people of all ages who reported having a disability, the rate was higher among those who resided in rural areas (15.1 percent) than across the United States as a whole (12.6 percent), according to the 2013-2017 American Community Survey 5-year estimates.

- **Income:** The median household income is substantially lower in rural areas than in urban areas, although poverty varies greatly by region, race, and other factors. For instance, those in non-metro areas in the South and African Americans in non-metro areas across the country tended to experience particularly high rates of poverty.[17] Among those 65 and older of all races, the poverty rate was higher for those residing in rural areas (10.0 percent) than urban areas (9.1 percent), based on 2013-2017 estimates from the American Community Survey.

Limited Information Suggests Older Adults in Rural Areas May Have Less Access to Certain Services

Agency survey data and existing research suggest that older adults may have less access to certain HCBS in rural areas compared to urban areas, but limited information is available. For example, data from ACL's 2017 National Survey of OAA Participants indicate that older adults in rural areas used certain services less often than urban participants. However, this survey only included responses from Title III program participants; it does not capture the extent to which older adults who may need Title III services are not accessing them. It also does not capture when older adults may be accessing HCBS other than Title III. We

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[15]The percent of adults in 2016 with four or more chronic conditions was also higher for those living in non- metropolitan areas (5.1 percent) than in metropolitan areas (4.2 percent). See Department of Health and Human Services, National Center for Health Statistics, *Health, United States, 2017: With special feature on mortality* (Hyattsville, MD: 2018), Table 39.

[16]America's Health Rankings®, *Senior Report 2018 Editio*n (Minnetonka, MN: United Health Foundation, May 2018).

[17]For example, see https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/ (accessed February 2019) and U.S. Department of Agriculture, Economic Research Service, *Rural America at a Glance 2017 Edition,* Economic Bulletin 182 (Washington, D.C.: November 2017).

identified other research suggesting that differences in use between older adults in rural and urban areas may vary by type of service, and that certain services may be less available in rural areas. However, overall, we found a small number of studies (11) comparing rural and urban access to HCBS.

Survey Data Indicate Rural Title III Participants May Receive Certain Services Less Often

Our analysis of ACL's 2017 National Survey of OAA Participants, which surveyed older adults using Title III services, suggests that rural participants may have received certain services less often than urban participants.[18] Title III program data from fiscal year 2017 indicated that 34 percent of all older adults (aged 60 and older) served through Title III programs lived in rural areas.[19]

The 2017 National Survey of OAA Participants provides information specifically on recipients of these Title III services: case management, congregate meals, home-delivered meals, homemaker, and transportation services. For survey questions examining how frequently participants used these services, we grouped responses into categories of high and low rates of use and found statistically significant differences among those using case management services and those receiving home-delivered meals (see fig. 2). Specifically, among those using the case management service, a smaller percentage of rural participants reported that they had received the service within the last month (43 percent), compared with urban participants (60 percent). Similarly, among those using the home-delivered meal service, a smaller percentage of rural participants reported that they had received a meal within the last week (73 percent) compared with urban participants (83 percent).[20] For other services, such as congregate meals, the differences were not statistically significant. For example, 16 percent of rural participants reported that they ate lunch at a senior center four or more days per week

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[18]ACL's survey uses the Census Bureau's urban-rural classification, which identifies two types of urban areas: urbanized areas of 50,000 or more people, and urban clusters of at least 2,500 and less than 50,000 people. "Rural" encompasses all population, housing, and territory not included within an urban area. For our analysis, we combined the two types of urban areas into one "urban" category.

[19]This percentage is based on Title III Parts B, C, and D services and excludes Part E.

[20]The analysis did not distinguish whether people received daily meal deliveries or less frequent deliveries of multiple meals, such as five meals delivered once a week. The practice of delivering multiple meals at one time in rural areas is described in the next section.

compared with 22 percent of urban participants, but the differences in percentages between rural and urban participants were within the margin of error, as shown in the figure. [21]

Figure 2: Reported Use of Selected Title III Services for Participants in Rural and Urban Areas, 2017
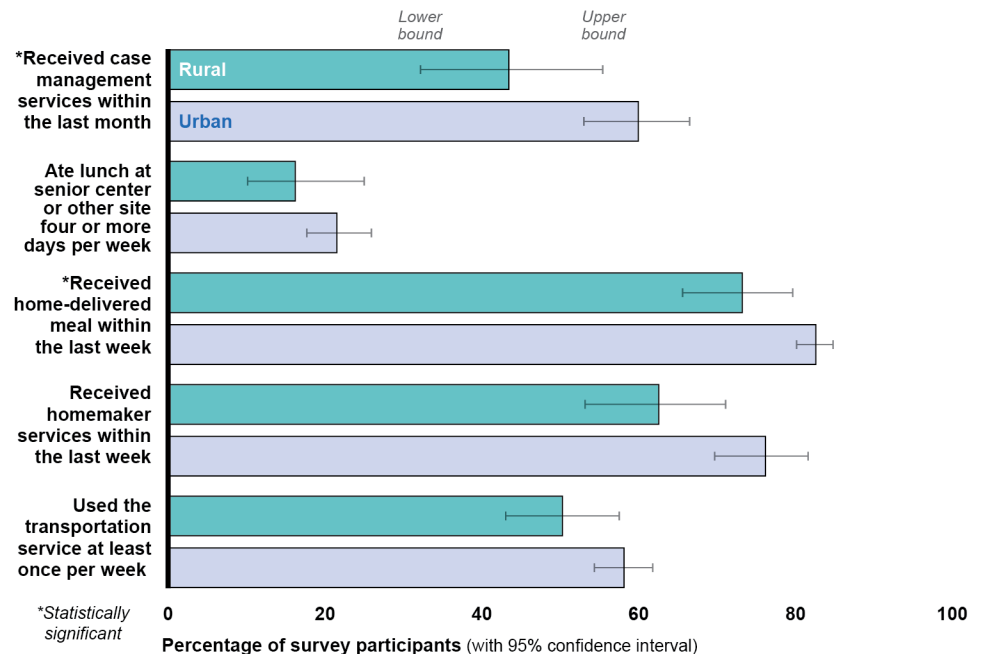
Source: GAO analysis of data from the Administration for Community Living (ACL)
2017 National Survey of Older Americans Act Participants. | GAO-19-330

Note: The results of each service type are based on a separate survey and sample of participants. Estimates of rural participants' service use have a larger margin of error than estimates of urban participants because the sample sizes were smaller in rural areas.

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[21]A 2018 report by Mathematica also contained some comparisons between rural and urban participants of Title III congregate and home-delivered meals. For instance, the report estimated that 56 percent of rural congregate meal participants ate at a meal site at least 4 days per week, compared with 67 percent of urban participants. Among home-delivered meal participants, it estimated that 80 percent of rural and 68 percent of urban participants received meals at least 5 days per week. This report, however, did not include information on statistical significance in comparing rural and urban participants. (See Mathematica Policy Research, *Needs of and Service Use Among Participants in the Older Americans Act Title III-C Nutrition Services Program,* prepared at the request of ACL, October 5, 2018.) Also, while both Mathematica's report and our analysis examined older adults who participated in Title III nutrition services, the findings apply to slightly different populations, due to differences in sampling and time periods when the data were collected.

The 2017 National Survey of OAA Participants also surveyed caregivers of older adults who received caregiver services provided through Title III, such as respite care, training, and information about other services and resources. Our analysis found that smaller percentages of rural caregiver participants reported receiving respite care and information or referral assistance compared with urban caregiver participants.[22] However, for caregiver training, the differences in percentages between rural and urban participants were within the margin of error (see fig. 3).

Figure 3: Reported Use of Title III Services for Caregivers in Rural and Urban Areas, 2017
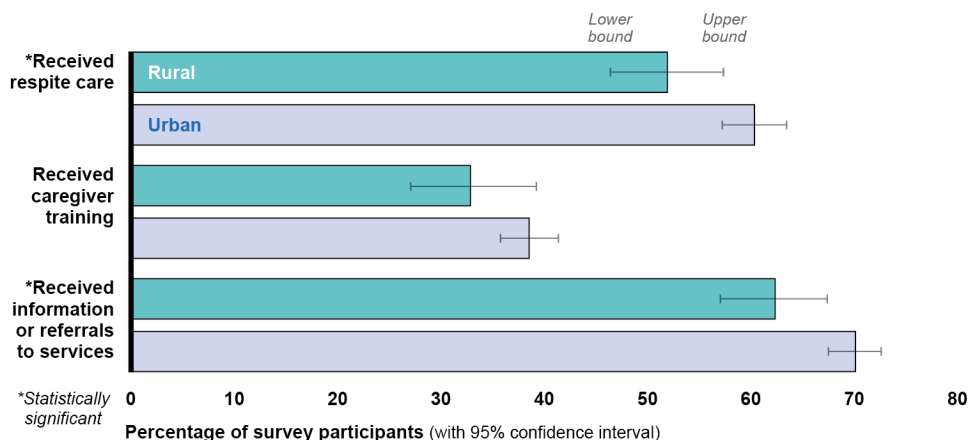

Source: GAO analysis of data from the Administration for Community Living (ACL) 2017 National Survey of Older Americans Act Participants. | GAO-19-330

Note: Estimates of rural participants' service use have a larger margin of error than estimates of urban participants because the sample sizes were smaller in rural areas.

Despite differences in the extent to which participants used Title III services, our analysis found that both rural and urban participants generally reported that the services they received met their needs. Among recipients of case management, home-delivered meals, and transportation services, the majority of both rural and urban participants reported that they received the service on-time and when needed. Further, across all services, the majority of both rural and urban participants reported that the services helped them remain in their homes.

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[22]Unlike the surveys on nutrition and supportive services, the caregiver survey questions most relevant to access were those focused on receipt of various caregiver services, rather than how often participants received a service.

Participants may receive help from caregivers to arrange services, but some caregivers reported that they had difficulty getting services for the older adults in their care. Across all services, between 23 and 45 percent of older adults reported that their friends and family helped arrange for services. A portion of both rural (41 percent) and urban caregivers (36 percent) reported that it had been difficult to access services for the older adults in their care.[23] (For a detailed table of results from our analysis of Title III participants, see app. II.)

An important limitation of the National Survey of OAA Participants is that it provides no information on access to services for non-Title III participants, due to its design and purpose. The survey was designed to provide information on older adults who received at least one Title III service, and it did not measure the extent to which access may differ between the broader rural and urban older adult populations. (See text box for information on certain characteristics of 2017 National Survey of OAA Participants.) In the future, ACL intends to use its National Survey of OAA Participants to better understand factors associated with service use. According to ACL officials, the survey has been redesigned from a cross-sectional survey to a longitudinal one to capture health outcomes of Title III participants over time and ACL plans to begin using the redesigned survey in 2019.

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[23]This survey question did not specify the type of services, such as Title III services or other HCBS for older adults.

OAA Participant Characteristics for Those Receiving Selected Title III Services

The National Survey of Older Americans Act Participants also gathers certain information on participant characteristics for those receiving Title III services, such as case management, congregate meals, home-delivered meals, homemaker, and transportation. These characteristics apply to the participants of each specified service type in the 2017 National Survey of Older Americans Act Participants and do not provide information on rural and urban older adult populations more broadly. Our analysis of these data from the 2017 survey showed that in some cases, rural and urban participants who received a specific Title III service (as noted in all caps below) varied in terms of their functional limitations and living situations.

For example, statistically significant results in the participant characteristics data indicate that among surveyed service participants, compared with urban participants:

- **Rural participants receiving CASE MANAGEMENT SERVICES**
    - Were less likely to live alone: 40 percent of rural participants reported that they lived alone, compared with 62 percent of urban participants.
    - Were more likely to be 85 or older: 41 percent of rural participants were aged 85 or older, compared with 22 percent of urban participants.
- **Rural participants receiving CONGREGATE MEALS**
    - Were less likely to live alone: 35 percent of rural participants reported that they lived alone, compared with 51 percent of urban participants.
- **Rural participants receiving HOME-DELIVERED MEALS**
    - Were less likely to have 3+ functional limitations: 29 percent of rural participants reported three or more functional limitations in instrumental activities of daily living (IADL), compared with 43 percent of urban participants. (IADLs include activities such as preparing meals and taking medication.)
- **Rural participants receiving HOMEMAKER SERVICES**
    - Were less likely to have 3+ functional limitations: 17 percent of rural participants reported three or more functional limitations in activities of daily living (ADL), compared with 30 percent of urban participants. (ADLs include activities such as bathing and eating.)
    - Were less likely to live alone: 57 percent of rural participants reported that they lived alone, compared with 74 percent of urban participants.
    - Were more likely to have higher household incomes: 36 percent of rural participants had annual household incomes greater than $20,000, compared with 20 percent of urban participants.

Source: GAO analysis of data from Administration for Community Living's (ACL) 2017 National Survey of Older Americans Act Participants. | GAO-19-330

Note: The results of each service type are based on a separate survey and sample of participants. Percentage estimates in this text box have a margin of error at the 95 percent confidence interval between 3.6 and 15.4 percentage points.

Other Research Suggests Service Use Varies between Rural and Urban Older Adults, and Certain Services May Be Less Available in Rural Areas

We identified a small number of studies—11 total—that examined differences in access to one or more types of HCBS between rural and urban older adults and that met other criteria.[24] The studies we identified examined either use of services or the availability of services, or both across the broader population of older adults—that is, beyond just those receiving Title III services.[25]

Each of these studies focuses on different groups of older adults and types of providers and thus helps shed light on potential differences in access to HCBS between rural and urban older adults. For example, studies used data on specific populations such as Medicaid or Medicare beneficiaries or certain age groups such as 85 and older. Additionally, services included as part of HCBS can vary among different federal programs.[26] Studies also focused on different service providers including AAAs, home health agencies, and assisted living facilities. The studies also used different rural definitions. For example, while some studies, including two prior GAO reports, compared two broad categories, such as metropolitan and nonmetropolitan areas, other studies compared three to five geographic categories and used narrower rural definitions (as shown in tables 2 and 3 below). In addition, some studies categorized areas as rural or urban based on measurable characteristics, while other studies used self-reported geographic categories.

With respect to use of services, the studies we reviewed suggest that differences in service use between older adults in rural and urban areas vary by the type of service (see table 2). For instance, two prior GAO

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[24]As described earlier, we focused on studies that included original research that met our methodological standards; were conducted in the United States, national in scope, and published between 2009 and 2018; and did not exclusively focus on American Indians or veterans. Our literature search included HCBS, such as nutrition services, personal care, home health, case management, transportation, and caregiver services, among others. Experts we interviewed noted that it can be more difficult to obtain sufficient numbers of respondents in rural areas, such as for large household surveys; thus, difficulties conducting rural research may limit the number of available studies on access to services. The 11 studies discussed in this section do not include the 2018 Mathematica report on the Title III nutrition services that is discussed in the previous section.

[25]See appendix III for a list of the studies included in our review.

[26]For example, Medicaid HCBS can consist of a broad range of health care, personal care, and supportive services to help individuals who would otherwise need institutional care maintain their quality of life, and states have options as to what services are included as part of Medicaid HCBS. In contrast, Medicare does not cover most long-term supports and services, including those provided in the home and community, but allows for doctor-ordered home health services under specific circumstances.

reports from 2011 and 2015, which both contained original research, found few differences in nutrition service participation among low-income older adults. However, the 2011 GAO report also found that older adults in urban areas were more likely to go without needed in-home care (through formal or informal help) than older adults in non-urban areas. A study that examined Medicaid beneficiaries who received long-term services and supports found that among this population, rural beneficiaries were less likely to use any type of HCBS and more likely to use services in nursing facilities, compared to urban beneficiaries (Coburn et al. 2016). This study also examined the likelihood of using certain HCBS, and found that rural users were less likely to receive adult day care, personal care, or home health services, but more likely to receive case management or transportation services compared to those in urban areas. While the Medicaid study indicated a difference in home health use, three other studies of Medicare beneficiaries also found that rural and urban older adults have similar rates of home health use (Iyer et al., 2014; Medicare Payment Advisory Commission, 2012; Paluso et al., 2018).

Table 2: Findings from Studies Examining Use of HCBS for Older Adults in Rural and Urban Areas

Service	Study author and year of publication	Key findings	Population and year of data	Rural and urban delineations used
Home health (Medicaid)	Coburn et al., 2016	Lower home health use among beneficiaries in non-metropolitan areas, as compared to those in metropolitan areas.	Medicaid beneficiaries aged 65 and older who used long-term services and supports, including home- and community based-services (HCBS) or nursing facility services (2008)	Metropolitan or non-metropolitan, using Rural-Urban Continuum Codes (RUCC)
Home health (Medicare)[a]	Iyer et al., 2014	Similar rates of home health use between the metropolitan and non-metropolitan populations for patients recovering from stroke or joint replacement. However, among older adults with diabetes, those in non-metropolitan areas received fewer home health visits and were less likely to see a rehabilitation specialist, such as a physical therapist, during these visits compared to those in urban areas.	Medicare beneficiaries aged 65 and older recovering from certain health conditions (2009)	Metropolitan or non-metropolitan, using Urban Influence Codes (UIC)

Service	Study author and year of publication	Key findings	Population and year of data	Rural and urban delineations used
Home health (Medicare, continued)	Medicare Payment Advisory Commission, 2012	Similar rates of home health use across most geographic areas, but older adults in frontier areas used home health services at a lower rate. The urban populations in the western states where most frontier areas are located also had lower home health use.	Medicare beneficiaries (2008)	Metropolitan, rural micropolitan, rural adjacent, or rural nonadjacent, using UIC, as well as an additional category for frontier
	Paluso et al., 2018	Similar rates of home health use between the metropolitan and non-metropolitan populations.	Medicare beneficiaries aged 85 and older (2007-2011)	Metropolitan or non-metropolitan, using Office of Management and Budget Metropolitan Statistical Areas
In-home care (personal services)[b]	Coburn et al., 2016	Among Medicaid beneficiaries who used long-term services and supports, those in rural areas were less likely to receive the services as HCBS, and more likely to receive services in a nursing facility. HCBS use also varied, as rural users were less likely to receive adult day care or personal care, and more likely to receive targeted case management services or transportation services compared to those in urban areas.	Medicaid beneficiaries aged 65 and older who used long-term services and supports, including HCBS or nursing facility services (2008)	Metropolitan or non-metropolitan, using RUCC
	GAO-11-237, 2011	Among older adults with a likely need for in-home care, based on their reported functional limitations, those in ex-urban areas may be more likely to use services or receive informal help, compared to those in urban areas.	Older adults aged 60 and older with a likely need for in-home care 2008)	Urban, suburban, or ex-urban, using RUCC
Nutrition	GAO-11-237, 2011 and GAO-15-601R, 2015	Older adults in non-metropolitan areas may be more likely to receive congregate meals than those in metropolitan areas based on analysis of 2008 data. However, analysis of 2013 data showed no significant difference in congregate meal receipt between these groups. Older adults in metropolitan and non-metropolitan areas may be equally likely to receive home-delivered meals in the analysis of both years of data.	Older adults aged 60 and older with household incomes below 185 percent of the federal poverty threshold, as well as spouses of older adults and individuals with disabilities living with older adults because they are also eligible for meals services. (2008 and 2013)	Metropolitan or non-metropolitan, using Office of Management and Budget statistical areas

Source: Studies GAO reviewed on use of home- and community-based services (HCBS). | GAO-19-330

Note: Some studies in the table are listed twice if they had results in multiple service categories. See appendix III for full citations of studies and methodology for study selection.

[a]Home health services for eligible Medicare beneficiaries include skilled nursing care, home health aide services, physical therapy, occupational therapy, medical social services, or speech-language pathology services.

[b]We considered in-home care to include HCBS, such as personal care, homemaker, adult day care or transportation, as well as assisted living.

With respect to the availability of services, some of the selected studies suggest that there may be fewer services available in rural areas, but that these differences vary by type of service (see table 3). A 2018 study by the National Association of Area Agencies on Aging examined a range of services that AAAs offered and found that while rural AAAs were less likely to offer adult day care, there were no differences in the offerings of other support services, such as homemaker or transportation, between rural and urban AAAs. However, service offerings may not always mean that services are provided throughout an entire service area. For example, another study of AAA services (Mabli et al., 2015) found that rural areas were the most common type of area that AAAs reported as not having home-delivered meal services throughout their entire service area. Wait lists may also affect whether services are available when people need them.[27] A 2016 evaluation of the Title III, Part E caregiver program by The Lewin Group found that rural AAAs were more likely to have wait lists for caregiver services compared to those in urban areas. In addition to services provided by AAAs, two other studies found that assisted living and home health services (both non-Title III services) may also be less available in rural areas (Probst et al., 2014; and Lenardson et al., 2014).

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[27]The use of waitlists in some rural areas is described in the next section.

Table 3: Findings from Studies Examining Availability of HCBS for Older Adults in Rural and Urban Areas

Service	Study and year of publication	Key Findings	Population and year of data	Rural and urban delineations used
Caregiver	The Lewin Group, 2016	Rural, frontier, and mixed area agencies on aging (AAAs) were more likely to have wait lists for any type of caregiver services, compared to those in urban and suburban areas.	AAAs and service providers (2015)	Urban, suburban, rural, frontier, or mixed area types, using self-reported identifications
Home health[a]	Probst et al., 2014	There are fewer home health agencies outside of urban areas. (The agencies provided information on whether they served a zip code, not whether they had patients there. In addition, zip code information was aggregated to the county level, so it does not measure the extent to which services cover all areas of the county.)	Home health agencies that provided care to Medicare beneficiaries (2008)	Metropolitan, micropolitan, small rural, or remote rural, using Urban Influence Codes
In-home care (personal services)[b]	Lenardson et al., 2014	Older adults in rural areas may face longer waiting lists to enter assisted living facilities.	Adult residential facilities (i.e. assisted living) (2010)	Urban, rural adjacent, or rural non-adjacent, using Rural-Urban Continuum Codes
	National Association of Area Agencies on Aging, 2018	Rural AAAs were less likely to provide adult day care services, but there were no statistically significant differences in the percentages of rural and urban AAAs that offered case management, homemaker, home modification, and non-medical transportation services.	AAAs (2016)	Rural or non-rural, using self-reported identifications
Nutrition	Mabli et al., 2015	Rural areas were the most commonly reported type of geographic area to not have home-delivered meal services throughout the entire area.	AAAs (2014)	Urban, suburban, rural, or frontier, using self-reported identifications

Source: Studies GAO reviewed on use of home- and community-based services (HCBS). | GAO-19-330

Note: See appendix III for full citations of studies and methodology for study selection.

[a]Home health services for eligible Medicare beneficiaries include skilled nursing care, home health aide services, physical therapy, occupational therapy, medical social services, or speech-language pathology services.

[b]We considered in-home care to include HCBS, such as personal care, homemaker, adult day care, or transportation, as well as assisted living.

Selected Rural Localities Face Distinct Challenges That They Mitigated with Use of Community Resources and Partnerships

Several distinct factors can make it challenging to connect older adults in rural areas to aging services, but localities have developed various strategies to mitigate these challenges. In a survey we conducted with rural AAAs in 12 selected localities and other interviews with various local service providers, officials explained that challenges such as limited infrastructure, including broadband internet; long distances with little public transportation; and a dwindling working-age population can result in fewer service options for older adults in their areas.[28] Also, consistent with rural trends nationally, these local officials reported that a growing population of older adults has increased the number of adults eligible for services in their areas, while funding for these services has remained flat. Many local officials we interviewed said they worked to mitigate these challenges by leveraging a variety of funding sources and other community resources. Some also developed practices to help address transportation and distance challenges, and collaborated with other state or local agencies to integrate or extend services.
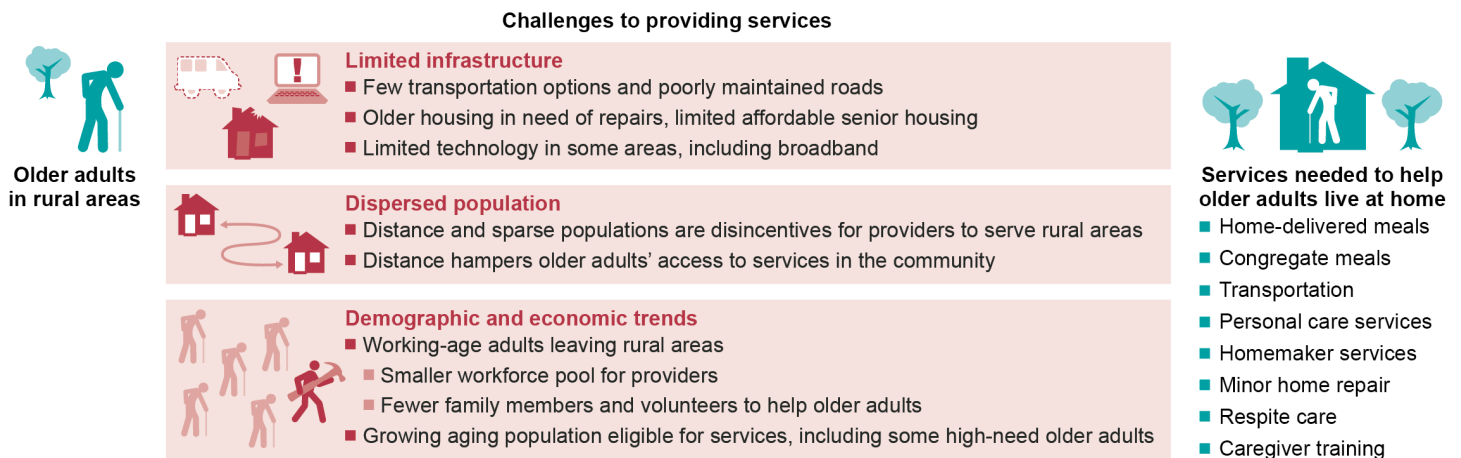
Limited Infrastructure, Dispersed Population, and Demographic Trends Are Particular Challenges in Rural Areas

Rural areas are often characterized by infrastructure limitations, dispersed populations and long travel distances, and demographic and economic trends that can make the provision of services challenging (see fig. 4). According to local officials in our 12 selected localities, difficulties accessing services, such as transportation or meals, can lead to adverse consequences for older adults. Several officials noted that missed doctor appointments, poor nutrition, and social isolation are some of the consequences that can occur when older adults have difficulty accessing services, all of which can negatively affect their health and well-being.

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[28]Based on initial interviews with agency officials, associations, and researchers, and a review of relevant publications, we developed a survey asking our selected localities to rate key challenges. We asked AAAs or their equivalents in each of the 12 localities to complete the survey and used their responses to guide our interviews with them and their service providers. Complete results of survey responses can be found in appendix IV. The challenges described in this section are based on survey responses, our interviews with these local officials, and additional literature we identified as relevant to the key challenges described.

Figure 4: Types of Challenges Rural Localities Face in Helping Older Adults Access Services

Challenges to providing services

Older adults in rural areas

Limited infrastructure
- Few transportation options and poorly maintained roads
- Older housing in need of repairs, limited affordable senior housing
- Limited technology in some areas, including broadband

Dispersed population
- Distance and sparse populations are disincentives for providers to serve rural areas
- Distance hampers older adults' access to services in the community

Demographic and economic trends
- Working-age adults leaving rural areas
  - Smaller workforce pool for providers
  - Fewer family members and volunteers to help older adults
- Growing aging population eligible for services, including some high-need older adults

Services needed to help older adults live at home
- Home-delivered meals
- Congregate meals
- Transportation
- Personal care services
- Homemaker services
- Minor home repair
- Respite care
- Caregiver training

Source: GAO analysis of interviews with selected state and local officials. | GAO-19-330

Limited Infrastructure

Infrastructure limitations—such as few transportation options, housing in need of repair, and lack of technology access—can hinder local agencies' ability to provide services to older adults. Officials in all 12 selected rural localities cited some kind of infrastructure limitation on our survey as a challenge. Specifically, among our 12 selected localities, limited transportation options to access services (11 of 12), difficulties related to suitable housing (12 of 12), and difficulties using technology to connect people to services (8 of 12) were cited as great or moderate challenges to providing services.

Few transportation options. Public transportation infrastructure is more limited in rural areas, if it exists at all, according to local officials we interviewed and other research.[29] AAAs can choose, but are not required, to use OAA funds to provide transportation services to older adults, and

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[29]We previously reported that rural areas have minimal public transit options and significant unmet transportation needs, according to state and local officials. GAO, *Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services,* GAO-11-237 (Washington, D.C.: February 28, 2011). We have also reported that in addition to funding challenges, rural transportation providers face operational challenges, such as weather and road conditions and difficulties planning routes in sparsely populated areas. GAO, *Public Transportation: Federal Role Key to Rural and Tribal Transit,* GAO-14-589 (Washington, D.C.: June 24, 2014). Limited transportation infrastructure and funding challenges were also among the rural transportation challenges identified in another study that surveyed 113 key rural transportation stakeholders. C. Henning-Smith et al., *Rural Transportation: Challenges and Opportunities*, Policy Brief, University of Minnesota Rural Health Research Center (Minneapolis, MN: November 2017).

many of the AAAs in the 12 selected localities reported offering some kind of transportation service. Those that did not provide such services generally had some kind of public transportation available in the area. However, consistent with prior research, officials said these services were often limited to certain days of the week or month, areas, or functions.[30] For example, in one rural Maine locality, officials told us that older adults in the hub communities (i.e., more populated towns) they serve had access to on-demand transportation services, while those in outlying areas may only have access to bus service once a week, if at all. Local officials in Pennsylvania and Oklahoma told us they were only able to offer older adults transportation to medical appointments, and not for shopping or social activities.[31] Officials in multiple localities also said that ridesharing services like Uber and Lyft were not available in the rural parts of their service areas. In addition, officials in a few localities told us that the state of rural roads presented challenges to older adults travelling to services, as well as to providers attempting to reach rural homes, and that road conditions could be made even worse by weather, such as snow or summer flooding.

According to some of the local officials we interviewed, boundaries can further complicate transportation challenges.[32] Some older adults must cross county or even state lines to access medical care, which creates additional challenges for agencies. Officials in one Mississippi locality we visited said that free transportation was available to seniors within each county, but there were no inter-county buses or vans. They added that free inter-county medical transport was available to older adults receiving Medicaid, but the rides for others could be expensive. Officials in a rural California locality reported that even when public transportation is available to take older adults out of the county, the process involved taking a bus to the county line and then transferring to another form of transportation.

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[30]GAO, *Transportation for Older Adults: Measuring Results Could Help Determine If Coordination Efforts Improve Mobility,* GAO-15-158 (Washington, D.C.: December 10, 2014); Henning-Smith et al., *Rural Transportation: Challenges and Opportunities*.

[31]We have also previously reported that there is a gap in senior transportation for social and recreational purposes. GAO-15-158.

[32]In GAO-15-158, we also reported on the challenges of cross-boundary coordination of transportation services in both rural and urban areas.

Housing in need of repair or modification. Local officials we interviewed also told us that housing stock in rural areas can be old and at risk of falling into disrepair. Officials in several localities said that needs for home repairs, as well as accessibility modifications, exceeded their AAAs' capacity to provide such services. As with transportation, AAAs can choose, but are not required, to provide minor home repair services with OAA funds.[33] In some cases, the state of an older adult's home can affect their ability to receive home-based services. For example, officials in one Maine locality told us that a home care nurse was unable to get into an older adult's home because the front steps were in such bad repair, and services were delayed for several days until Adult Protective Services intervened.

A lack of housing can also affect access to some services, according to local officials. AAAs do not provide housing services directly, but may often be aware of housing issues through their role of providing information and referral to other services and through their partnerships with local housing providers. Local officials we interviewed told us that older adults who want to move into hub towns to more easily access services, or who need to find new housing for other reasons, often face a limited supply, including long wait lists for affordable senior housing. (Older adults in urban areas may also face housing challenges, including wait lists.)[34]

Lack of technology access. Local officials reported difficulties with technology infrastructure—primarily lack of availability of broadband and in some cases cell phone service. Limited broadband internet availability

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[33]According to a 2016 survey by the National Association of Area Agencies on Aging and Scripps Gerontology Center at Miami University of Ohio, 64 percent of AAAs nationwide offer home repair services. National Association of Area Agencies on Aging, *National Survey of Area Agencies on Aging, Serving America's Older Adults: 2017 Report* (Washington, D.C.).

[34]We have previously reported on the decline in subsidized housing stock from the Department of Housing and Urban Development (HUD) and USDA, which is not limited to rural areas, and may particularly affect older low-income renters. GAO, *Older Adult Housing: Future Collaborations on Housing and Health Services Should Include Relevant Agencies and Define Outcomes,* GAO-18-232 (Washington, D.C.: April 26, 2018). In GAO-15-190, we also reported on wait lists for affordable senior housing in selected localities, which were primarily urban. For other GAO reports on rural and senior housing, see *Elderly Housing: HUD Should Do More to Oversee Efforts to Link Residents to Services,* GAO-16-758 (Washington, D.C.: September 1, 2016); and *Rural Housing Service: Better Data Controls, Planning, and Additional Options Could Help Preserve Affordable Rental Units,* GAO-18-285 (Washington, D.C.: May 17, 2018).

in rural areas can make it harder to provide older adults with information about services, according to these local officials. Limited broadband access can affect aging offices and service sites as well. For example, officials in one Maine locality told us they tried to expand access to their wellness classes by streaming them remotely at congregate meal sites, but were unable to do this due to limited broadband at the sites. Other research shows that the urban-rural gap in broadband use decreased slightly from 2007 to 2015, but persists despite significant investments.[35] Further, in 2015 we reported that availability remains a barrier to broadband use in rural areas.[36]

Although not necessarily a rural-specific issue, officials we interviewed also noted that older adults may not use the internet even when it is available, and that use appeared to vary based on age group. Baby boomers are often more technologically literate and willing to access information online than the generation before them, according to some officials. Others said that older adults may not be willing or able to pay for internet access, especially if they already struggle to afford necessities. A Census Bureau analysis of data for 2013 through 2017 supported this idea, finding that living in a rural location and having lower median household income were associated with lower internet subscription rates in a county.[37]

Dispersed Population

The sparse, dispersed populations in some rural areas can result in a need to travel long distances, both for service providers to reach older adults in these areas, and for older adults to reach community-based services and facilities meeting other crucial needs. Most selected localities (10 of 12) cited the added cost and effort of serving dispersed populations as a great or moderate challenge. (See fig. 5 for examples of sparsely populated areas observed during site visits.)

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[35]U.S. Department of Agriculture, Economic Research Service, *Rural America at a Glance: 2017 Edition.*

[36]GAO, *Broadband: Intended Outcomes and Effectiveness of Efforts to Address Adoption Barriers are Unclear,* GAO-15-473 (Washington, D.C.: June 2, 2015).

[37]Census Bureau, "Five-Year Trends Available for Median Household Income, Poverty Rates and Computer and Internet Use," December 6, 2018. Accessed December 18, 2018 from https://www.census.gov/newsroom/press-releases/2018/2013-2017-acs-5year.html.

Figure 5: Sparsely Populated Areas on Home-delivered Meal Routes in Selected Localities

Mississippi

North Dakota

Maine

California

Distance and sparse population are disincentives to serving rural areas. Local officials we interviewed told us that added travel costs and time are disincentives for providers to serve remote areas, sometimes

leaving areas with no providers at all for certain services.[38] A service provider in California told us they were only able to deliver meals to older adults living within 10 miles of their two offices, leaving those in more remote communities without this service. In a study on home-delivered meals, surveyed providers reported that older adults in rural and geographically isolated areas were the most difficult to serve, and some said that they could not afford to expand their delivery radius to serve all such rural adults.[39] In other selected localities we visited, officials reported having difficulty finding in-home service providers willing to travel to more remote locations, in part because, according to some of these officials, providers are not reimbursed for their travel time or gas. An official in one North Dakota locality told us that even providers listed as serving more rural counties often only travelled to the hub town in that county, leaving older adults in more remote areas struggling to find in-home providers willing to travel to them.[40]

Serving sparse and dispersed populations can also make it difficult for providers and AAAs to leverage economies of scale, in part because demand is less concentrated in these areas. For example, AAA officials we interviewed in one Mississippi locality were unsuccessful in getting their transportation provider to expand services to a sparsely populated

[38]It is unclear whether these travel costs equate to services being more expensive to provide in rural areas compared to urban areas. A 2015 HHS-funded cost evaluation of OAA nutrition programs found that the per-meal cost of home-delivered meals was slightly lower for providers serving rural areas than for those serving urban or suburban areas. The evaluation found that certain costs per meal—such as on-site labor costs—were higher for rural providers, but these were outweighed by other costs that were higher for urban or suburban providers, such as vendor payments; central administration labor; and delivery costs including vehicles, gas, and car insurance. J. Ziegler et al. *Older Americans Act Nutrition Programs Evaluation: Meal Cost Analysis: Final Report,* a report submitted to the Administration for Community Living, Department of Health and Human Services, September 25, 2015.

[39]J. S. Lee et al., "Targeting of Home-Delivered Meals Programs to Older Adults in the United States," *Journal of Nutrition for the Elderly,* 27:3-4 (2008): 405-415.

[40]Several local officials in North Dakota told us that, despite a state law establishing a differential reimbursement rate for providers serving rural areas that went into effect in 2014, they had not yet seen any increase in the number of providers serving these areas. One noted that the higher rate still may not make up for the additional cost of travel. Similarly, a CMS-funded resource center also reported hearing that the distance between rural consumers is a challenge for Medicaid providers of home-based supports and service, from various stakeholders who have consulted with the center. D. K. Brown et al., *Strengthening the Direct Service Workforce in Rural Areas*, The Lewin Group (Centers for Medicare and Medicaid Services, National Direct Service Workforce Resource Center, August 2011).

county because, despite the need, limited demand made it cost prohibitive to serve the county. A local official we interviewed in North Dakota noted that providers tend to prefer more urban areas, as it is easier to consistently schedule 40 hours a week of service work.[41] Officials we interviewed in a rural Pennsylvania locality told us that this is a particular challenge for respite care, which generally offers providers fewer hours than other services, making it harder to justify traveling long distances to do the work.

Limited demand in sparsely populated areas also affects businesses and services beyond those provided by aging agencies. The same Mississippi locality that struggled with providing transportation services due to limited demand had also recently seen its hospital and only grocery store close, according to local officials we interviewed. In a 2018 report, we found that the number of rural hospital closures had increased in recent years and that limited demand was one of several factors that may contribute to hospital closures.[42]

Distance hampers older adults' access. Distance also discourages older adults, and the family members who care for them, from traveling to community-based services and other businesses and facilities, according to most localities we interviewed. Officials we interviewed in one Maine locality told us that, on average, rural residents had to travel 25 to 50 miles to the nearest hub town to access congregate meals and wellness classes. In another Maine locality, officials said that some caregivers of rural older adults travel up to 2 hours to attend caregiver classes. In the Mississippi town that lacked transportation services, officials told us that residents now must travel 25 miles to the nearest grocery store.[43] Some

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[41]We previously reported that providers of Medicaid HCBS are often reluctant to drive long distances for only a few hours of work. GAO-18-628.

[42]GAO, *Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors,* GAO-18-634 (Washington, D.C.: August 29, 2018). Specifically, factors we identified included declining populations and increased competition for the small volume of rural residents, among other factors such as Medicare payment reductions.

[43]Some research suggests that travel distances are a challenge in other rural communities, as well. See, for example, Henning-Smith et al., *Rural Transportation: Challenges and Opportunities* and O. Lam, B. Broderick, and S. Toor, "How far Americans live from the closest hospital differs by community type," Pew Research Center. Accessed December 18, 2018 at http://www.pewresearch.org/fact-tank/2018/12/12/how-far-americans-live-from-the-closest-hospital-differs-by-community-type/.

local officials we interviewed also said that the hospitals in their rural areas did not offer surgery or specialty care, as they do in cities or larger towns. These and other officials told us that long distances to medical care combined with limited transportation options leads to significant travel time, in some cases an hour or more, for medical appointments.

Demographic and Economic Trends

Demographic and economic trends in rural areas also pose challenges to serving rural older adults. Specifically, the migration of working-age adults out of rural areas, due in part to limited job opportunities,[44] can limit the availability of both paid and unpaid service providers and caregivers, which almost all selected localities cited as a great or moderate challenge on our survey.[45] Meanwhile, as noted earlier, more older adults have stayed in rural areas and some of these areas have experienced an influx of retirees, leading to a growing aging population eligible for services.[46] Most selected localities (9 of 12) cited meeting the needs of this growing aging population as a great or moderate challenge on our survey.

Limited availability of paid providers. The departure of working-age adults from rural areas has limited the workforce pool available to provide services, according to officials we interviewed in many of the selected localities. For example, local officials in Wisconsin and California noted that the low pay and physical nature of in-home care work make these positions difficult to fill, regardless of location. In addition, officials in North Dakota and Maine explained that these challenges may be exacerbated by the disincentives to serving rural areas mentioned above, such as travel times and lack of economies of scale.

Limited availability of unpaid and informal providers. Fewer working-age adults in rural areas are also available to care for their aging parents, according to local officials we interviewed. Family caregivers may be particularly important as about half of localities we surveyed cited older

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[44]U.S. Department of Agriculture, Economic Research Service, *Rural America at a Glance: 2017 Edition* and *Rural America at a Glance: 2018 Edition.* According to this USDA research, although this migration trend may be reversing in some rural counties, rural job growth has lagged behind urban growth since 2005, and remains below pre-recession levels.

[45]On our challenges survey, 11 of 12 AAAs reported the lack of paid providers as a great or moderate challenge, and 12 of 12 reported the lack of unpaid providers or caregivers as a great or moderate challenge.

[46]U.S. Department of Agriculture, Economic Research Service, *Rural America at a Glance: 2018 Edition*.

adults' reluctance to seek help as a great or moderate challenge. Officials in North Dakota and California noted that a culture of self-reliance in rural communities makes older residents reluctant to ask for help, and other officials in North Dakota and Wisconsin, said that calls to AAAs tend to increase during the holidays, when adult children visit and discover their parents need services. Officials in Wisconsin and Maine also mentioned that some older adults do not ask for help until they are in a crisis that could have been prevented with earlier interventions. Other research has noted the declining availability of family caregivers in rural areas and rural residents' reluctance to seek help as challenges to helping older adults obtain needed care.[47]

The use of volunteers—another form of informal or unpaid providers—was common among the 12 selected localities, but some officials reported volunteer challenges related to demographic change. For instance, officials in California, North Dakota, and New Mexico observed that lower rates of baby boomers volunteering in their communities, compared with earlier generations, could be due to needing to work longer, having other obligations, or simply being less interested in senior center activities. As a result, the officials in California and North Dakota said many of their volunteers were advanced in age. An official in Wisconsin reported a similar challenge, noting that older volunteers had limited ability to perform manual tasks. In one Mississippi locality with several high-poverty counties, officials said they have almost no volunteers, which they attributed in part to local residents' need to work for pay. Officials in both California localities said that funding that they could use to recruit or recognize volunteers could help them increase their volunteer base.[48] (Our selected localities varied in their use of paid staff and volunteer staff, for helping with services such as providing congregate meals, as shown in fig. 6).

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[47]Brown et al., *Strengthening the Direct Service Workforce in Rural Areas* and C. Henning-Smith and M. Lahr, *Perspectives on Rural Caregiving Challenges and Interventions,* Policy Brief, University of Minnesota Rural Health Research Center (Minneapolis, MN: August 2018).

[48]ACL officials also noted that there is no Title III funding specifically designated for recruiting, retaining, or recognizing volunteers.

Figure 6: Use of Paid and Volunteer Staff to Provide Congregate Meals Varied in Selected Localities

Congregate meal staff in North Dakota

Older adults, served by employees, attend congregate meals in Mississippi and North Dakota (Mississippi staff not shown)

Congregate meal volunteers and staff in Maine

Source: GAO. | GAO-19-330

Growing aging population eligible for services. Officials we interviewed in several localities cited difficulties serving the growing population of older adults with their current funding levels. We previously reported on how demographics and funding trends can lead to challenges meeting the demand for HCBS for older adults.[49] Until fiscal year 2018, OAA Title III funding levels had remained below the fiscal year 2010 level,

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[49]GAO-15-190.

while according to Census estimates, the number of older adults grew by about 9 million in the same time period.[50]

Further, some older adults, such as those well advanced in age or poor, may have high service needs. State officials in Maine noted that the state's population of older seniors, who tend to have greater service needs, is growing. According to Census estimates for 2013 through 2017, adults 85 and older make up a slightly higher percentage of rural populations (2.2 percent) than urban ones (1.9 percent). Officials in two other localities also expressed concern with their ability to serve a growing population of older adults with dementia, who may have particularly high service needs, especially if they wish to remain in their homes. Poverty can also create the need for additional services, and as noted earlier, rural areas, on average, have higher poverty rates for those 65 and older, and lower median household incomes overall than urban areas. Officials in one Mississippi locality observed that, compared with the more urban counties in their service area, the more rural counties are poorer and have greater service needs.

Reported Practices to Mitigate Rural Challenges Include Leveraging Community Resources and Local Partnerships

Across the 12 selected rural localities, officials told us that they took steps to address the challenges of serving rural older adults.[51] While tailored to the varied unique aspects of their areas, the practices local officials described to address challenges reflected certain common themes. These themes included obtaining additional funding and leveraging other community resources, mitigating transportation and distance challenges, and collaborating with different types of agencies to integrate or extend services. Even with these practices, localities sometimes were unable to provide certain services to all older adults who requested them. In such cases, practices varied for prioritizing who would be served.

Leveraging Community and Other Resources

Officials we interviewed in the selected localities described leveraging a variety of community and other resources to extend their ability to serve

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[50]We have also previously reported on options for modifying the OAA Title III statutory funding formula to better target older adults with the greatest economic and social need under generally accepted equity standards. GAO, *Older Americans Act: Options to Better Target Need and Improve Equity,* GAO-13-74 (Washington, D.C.: November 30, 2012).

[51]We did not evaluate the effectiveness of any practices used by the selected localities, and our description of these practices does not imply endorsement. Rather, our goal is to provide illustrative examples of practices to address challenges described by selected localities.

Furry Friends Food Bank (Maine)

After staff discovered that some older adults were feeding their home-delivered meals to their pets, the Eastern Area Agency on Aging in Maine developed the Furry Friends Food Bank. Funded by grants and pet food donations from local stores, Furry Friends provides pet food for older adults with pets. The AAA developed this program in recognition of the key role pets can play in providing comfort and social opportunities to older adults.

Source: GAO interview with Eastern Area Agency on Aging nutrition official and website; GAO photo. | GAO-19-330

older adults. Such resources included finding additional sources of funding and leveraging other types of non-governmental resources.

Obtaining additional funding. Officials in most of the 12 selected localities said they obtained additional funding from a variety of sources, such as state or local governments, foundations, or other private grants.[52] Some of this funding was used to extend the services they provided with OAA funds. For example, an official with the Southern Oklahoma Development Association AAA said she used state nutrition assistance funds to provide additional congregate meals to older adults. Others used additional funds to help older adults in other ways, such as a donation-based program in Maine's Eastern AAA that delivered pet food to older adults for their pets (see sidebar). Local officials also said they received in-kind donations from foundations or grants from nonprofits, including California's Area 2 AAA that received a freezer and a refrigerator and others that received donated vans and other vehicles.

Referrals to other services in the community. Most localities we surveyed reported referring older adults to community or faith-based organizations when the AAA was not able to address their needs. These organizations provided older adults with various types of help, such as transportation, home repair, food, and assistance with bills, according to officials we interviewed. For example, some officials, including those in Potter County AAA in Pennsylvania, mentioned that organizations such as the American Cancer Society could sometimes give older adults rides to medical treatment when local agencies could not. Other officials, such as in Mississippi and Maine, said they could refer older adults to organizations for help obtaining or affording items like glasses and hearing aids. In addition, officials in several localities told us they regularly share information with other local agencies and community-based groups in their area to stay abreast of what services were available for older adults.

Recruiting volunteers. Despite recruitment challenges, most communities had at least some volunteers and used them for a variety of services. For example, officials in both of our selected North Dakota

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[52]We previously reported that aging agencies provide Title III services using funds from other federal programs, state and local governments, private sources, and clients. GAO-11-237. OAA requires a non-federal match of 15 percent for part B and C programs. See 42 U.S.C. § 3024(d)(1)(D). In this section, we describe funding beyond what states or localities might contribute to meet this requirement.

localities told us they rely on volunteers for home meal delivery, and officials in Iron County, Wisconsin, said they recruit high school students to shovel snow from older adults' driveways. Some localities were actively trying to increase their use of volunteers. In Mora County, New Mexico, local officials said they were working on recruiting volunteers to deliver meals to their most remotely located older adults, and officials in Aroostook County, Maine told us they were working with the state Commission for Community Service to better extend the reach of their programs by using volunteers.

Identifying informal community support. Officials in most of our selected localities said that older adults' informal networks can be an important resource, and some said they reached out to these networks when other resources were not available. For example, when a client has no other way of getting to a doctor's appointment or the grocery store, officials from Potter County, Pennsylvania said that they reach out to their churches and neighbors to help. Also, a home-delivered meal provider in California's Area 2 told us that when older adults living outside his service range ask for help, he tries to identify neighbors who can pick up frozen meals for them. A few officials we interviewed suggested that informal support networks are a strength of rural communities. Some AAAs we interviewed also reimbursed friends and family for providing certain OAA services.[53] For example, Maine and Pennsylvania localities said they offered friends or family reimbursement for providing respite care, and a California locality said they offered reimbursement for providing medical transportation. ACL officials noted, however, that not all states offer such reimbursement.

Mitigating Transportation and Distance Challenges

Our selected states and localities used a number of practices to help mitigate challenges with rural transportation and long travel distances. Their approaches included working with transit agencies and other local partners, identifying strategies to ensure rural older adults received home-delivered meals, and limiting the need for travel.

Collaborating with transit agencies and other local partners. Some AAAs or service providers worked with local partners to address transportation and distance challenges. For example, according to

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[53]This reimbursement model is also sometimes used in Medicaid HCBS waiver programs. For more information on these participant-directed service models, see GAO-18-628 and GAO, *Medicaid Personal Care Services: CMS Could Do More to Harmonize Requirements across Programs,* GAO-17-28 (Washington, D.C.: November 23, 2016).

The Director of Golden Age Center, Inc., a service provider in Trinity County, California said she collaborated with local partners to ensure that older adults travelling out of the county for medical appointments have a place to eat lunch. She recognized that many of the older adults she served were travelling to Redding, in neighboring Shasta County, for medical care, and that travelling to these appointments and back may take all day. To make these trips easier, Golden Age Center, Inc. coordinated with Trinity Transit, the Redding senior center, and a Redding medical provider so that older adults from Trinity County can be transported to and eat lunch at the Redding center while waiting for their appointments. According to the Director of Golden Age Center, Inc., this helps the older adults preserve their dignity and comfort on these trips.

Source: GAO interview with Golden Age Center, Inc., Trinity County, California (Area 2); Photo by Selena Barlow for Trinity Transit. | GAO-19-330

officials in California's Area 12 Agency on Aging, Amador County coordinated with the local transit agency, hospital, and other community organizations to develop a volunteer transit program. In the North Delta area of Mississippi, the provider of senior transportation services told us they participate in a regional coordination group with a variety of social service and faith-based agencies that discuss ways to fill transportation gaps.

Mitigating meal delivery challenges. Localities had developed several practices specifically to address challenges delivering meals to older adults in remote areas. Most of the selected localities reported delivering frozen or shelf-stable meals to rural older adults, usually once a week or every 2 weeks. Localities in North Dakota and Pennsylvania also used a service that delivers refrigerated meals via FedEx. Also, in Aroostook County, Maine officials said that to maintain regular contact despite less frequent deliveries, they relied on volunteers to check in on older adults.

Several localities also described how meal-delivery drivers worked around inclement weather. For example, an official in the Southern Oklahoma Development Association AAA said they create emergency plans to help older adults be prepared in the event of tornadoes or ice storms, which could involve giving older adults extra frozen or shelf-stable meals. Similarly, a nutrition official we interviewed in Maine's Eastern AAA told us that they give home-delivered meal clients a package of non-perishable food in the fall and multiple times each winter to have on-hand in case weather delays meal delivery. Some localities also went to great lengths to maintain service in inclement weather. For example, an official in Mora County, New Mexico said local law enforcement use their four-wheel drive truck to deliver meals across flooded roads, and a nutrition supervisor for Potter County, Pennsylvania told us she has personally delivered meals on a snowmobile when providers could not reach older adults by car.

Cutting down on travel needs. Local officials also described taking steps to reduce the need for rural older adults or providers to travel. For example, Maine's Eastern AAA connected caregivers to online training. In addition, multiple localities tried to reduce staff travel by hiring staff or volunteers or engaging with other agencies already located in remote areas to provide services. Officials in a few localities, including the Southern Oklahoma Development Association AAA, also said they organized multiple services and outreach efforts at the same rural event or location to reach as many older adults as possible on the same trip. In addition, Mississippi's North Delta and Southwest AAAs reported using

software to optimize routes for providers to travel to in-home care clients or provide transportation services to reduce inefficient trips. Service providers in California and North Dakota also said that they were aware that some of their clients received some medical services, such as psychiatric care, remotely through telehealth services, which can help address transportation challenges.[54]

In a few of our selected rural localities, SHIP counselors used mail and follow-up phone calls to counsel older adults on Medicare options, preventing clients from needing to come to a meeting in-person when they lived in remote areas or lacked internet availability (see side bar for more information on SHIP). For instance, in one rural Mississippi locality, officials told us they provide counseling to older adults living in remote areas by mailing Medicare information to them, since these older adults typically do not have access to e-mail or fax machines. Then they ask them to call back once they have received and reviewed the materials so that they can provide more counseling. Other practices included providing SHIP counseling at congregate meal sites (Oklahoma), sending SHIP information along with home-delivered meals (California), and using volunteers to provide counseling in more rural areas (Maine). Several local officials noted that SHIP activities were helpful for the older adults they served, given the complexity and often changing nature of Medicare and other health insurance options.

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[54]Telehealth and remote patient monitoring can provide alternatives to health care provided in person at a physician's office, particularly for patients who cannot easily travel long distances for care. We previously reported on factors affecting the use of telehealth and remote patient monitoring in Medicare. For instance, in that report, we found that the potential to improve or maintain quality of care is a significant factor that encourages the use of telehealth in Medicare, while concerns over payment, coverage restrictions, and infrastructure limitations, including the lack of broadband access, can create barriers to telehealth use. See GAO, *Health Care: Telehealth and Remote Patient Monitoring Use in Medicare and Selected Federal Programs,* GAO-17-365 (Washington, D.C.: April 14, 2017).

Inter-Agency Collaboration

Café 60 (North Dakota)

Are you over 60 years young?

café 60

Ask your server about our Café 60 restaurant voucher program

The aging administrator and nutrition provider (Elder Care) for North Dakota's Region VIII worked with local restaurants to develop the Café 60 program, which provides older adults with vouchers for approved, nutritionally balanced meals in those restaurants through the OAA congregate meal program. Some of the restaurants they partner with are in remote areas, where they previously had difficulty finding workers to maintain a meal site at a senior center. Officials said the program helps the state address the challenges of serving older adults in sparsely populated areas, and is also popular with older adults.

Source: GAO interview with officials from North Dakota Region VIII, state aging office, and Elder Care; Logo by Elder Care. | GAO 19 330

To integrate or extend services, AAAs and aging service providers we interviewed also said that they collaborated with state or local agencies or entities that were not specifically part of the aging network.[55] Examples of such solutions include collaborating with transportation agencies, health agencies, and schools.

Collaborating on transportation: According to North Dakota's state plan, the aging agency entered into a cooperative agreement with the state Department of Transportation to administer OAA transportation services, with aging agency input. Aging officials said this allows them to better leverage the transportation agency's infrastructure and expertise.[56]

Collaborating with health agencies and providers: AAA officials in Aroostook County, Maine worked with their local health systems to identify ways that both aging and health agencies could improve the health of the community, including local older adults. In addition, officials at California's Area 12 Agency on Aging told us they work to educate hospital discharge planners, local clinics, and rehab facilities about their services to ensure these facilities refer older adults in need to their agency.

Also, officials from AAAs we interviewed said that they coordinated with state or local agencies providing Medicaid HCBS in different ways. For example, two AAAs noted that they helped with initial eligibility determinations for Medicaid HCBS but then referred clients to other entities to continue the process (e.g. county social services offices), while officials from other AAAs said that they coordinated with the appropriate entities who determined Medicaid eligibility, but were not actually part of this process. Officials from two other AAAs noted that aging and Medicaid

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[55]We have previously reported on effective practices in interagency collaboration, including leveraging resources. See GAO, *Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies,* GAO-06-15 (Washington, D.C.: October 21, 2005); and *Managing for Results: Key Considerations for Implementing Interagency Collaborative Mechanisms,* GAO-12-1022 (Washington, D.C.: September 27, 2012). We did not evaluate the extent or effectiveness of collaboration or any other practices in our selected localities.

[56]For more information on state and local collaboration on transportation for older adults, see GAO-15-158. In that report, we noted a lack of data on the effects of such collaboration efforts.

services were run fairly separately and that their offices were not typically involved in Medicaid-related processes.[57]

Collaborating with school systems: North Dakota state officials told us that an aging service provider partnered with the local school system to serve multigenerational meals in schools, cutting down on the need for separate facilities and allowing contact between older adults and children while providing meals. Similarly, a provider in California's Area 2 said that a local school allows them to rent part of their building at a very low cost, which the provider uses for office, dining, and fitness class space.

Prioritizing Who Is Served

Despite various efforts to address challenges, rural localities sometimes were unable to provide certain services to all older adults who requested them. In such cases, officials at about half of the AAAs we interviewed said that they had wait lists for some services—particularly home-delivered meals.[58] (See fig. 7 for home-delivered meal deliveries among our site visit states.) These AAAs used different practices to administer their wait lists and to determine the order of priority for serving people on the lists. For example, some localities prioritized who to take off wait lists using measures such as functional limitations, age, other risk factors such as living alone or providers' overall assessment of the older adult's need for services. Other localities offered services on a first-come, first-served basis, bringing older adults off of wait lists in the same order they were placed on them.

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[57]According to a 2016 survey by the National Association of Area Agencies on Aging and Scripps Gerontology Center at Miami University of Ohio, 34 percent of AAAs nationwide are involved in providing integrated care through Medicaid HCBS 1915c waivers. National Association of Area Agencies on Aging, *National Survey of Area Agencies on Aging, Serving America's Older Adults: 2017 Report*.

[58]Wait lists exist in urban and suburban localities, as well. For more information on the prevalence of wait lists among AAAs nationally, and on wait list policies, see J. Mabli et al., *Process Evaluation of Older Americans Act Title III-C Nutrition Services Program: Final Report,* a report submitted to Administration for Community Living, Department of Health and Human Services, September 30, 2015.

Figure 7: Providing Home-Delivered Meals to Older Adults in Selected Localities

Meal delivery volunteer in Maine

Meal delivery employee in Mississippi

Meal delivery employee in North Dakota

Meal delivery employee in California

Source: GAO. | GAO-19-330

In addition, wait lists only reflect the needs of those who ask for services, and additional unmet needs may exist among those who have not asked for services for various reasons.[59] For example, officials in one Maine locality noted that some wait lists (such as those for senior housing) only include older adults living in the hub communities where services are actually available. Officials in this locality and one other said the awareness that wait lists exist can discourage some older adults from asking for services in the first place.

ACL Resources Are Available but Are Difficult to Navigate

ACL, on its own or in collaboration with other federal agencies, makes available information that could help states and localities address challenges in serving rural older adults, but these resources are spread across many websites and may be difficult to find. Officials we interviewed in 9 of the 12 selected localities were not aware of the range of informational resources pertinent to serving rural older adults, and those in 7 of the 12 localities expressed difficulties with finding information on ways to serve rural older adults or stated that additional information would be helpful.

ACL Provides Information and Collaborates with Other Federal Agencies to Help Address Challenges

ACL provides information and assistance that could help address challenges serving rural older adults through various means, including its national resource centers, its contacts with states and AAAs, and its collaborations with other federal agencies. The information available through ACL's around 30 resource centers on aging issues covers a range of topics, including those that focus on key issues, populations, or organizational practices (see table 4). Also, the information disseminated through the resource centers has broad reach, as it is aimed at the larger aging network, including state aging directors, AAAs, providers, and in some cases older adults and their families.

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[59]In 2011, we recommended that HHS partner with other agencies to develop consistent definitions of need and unmet need and to propose interim and long-term uniform data collection procedures for obtaining information on older adults with unmet needs for services provided from sources like Title III. HHS did not implement this recommendation, noting that what qualifies as unmet need may vary based on individual circumstances. GAO-11-237

Table 4: Resource Centers on Aging Issues Funded by the Administration for Community Living (ACL)

Category	ACL-funded resource centers
Key issues	Alzheimer's and other health
	• National Alzheimer's and Dementia Resource Center
	• National Alzheimer's Call Center
	• National Falls Prevention Resource Center
	• National Resource Center on Chronic Disease Self-Management Education Programs
	Elder abuse and rights
	• Adult Protective Services Technical Assistance Resource Center
	• National Center on Elder Abuse
	• National Center on Elder Abuse Information Clearinghouse
	• National Center on Law and Elder Rights
	• National Indigenous Elder Justice Initiative
	Financial protection and security
	• National Consumer Protection Technical Resource Center
	• National Education and Resource Center on Women and Retirement Planning
	• National Pension Assistance Resource Center
Organizational support or practices	Aging Network Business Practice, Planning, and Program Development
	Aging Network's Volunteer Collaborative
	Community Innovations for Aging in Place Technical Assistance Center
	National Center for Benefits Outreach and Enrollment
	National Resource Center for Engaging Older Adults (engAGED)
Populations	The Center for Advancing Holocaust Survivor Care
	National Aging Resource Consortium for Racial and Minority Seniors[a]
	National Resource Centers on Native American Elders[a]
Services	Eldercare Locator
	Lifespan Respite Technical Assistance Center
	National Aging Information and Referral Support Center
	National Clearinghouse for Long-term Care Information
	National Long-Term Care Ombudsmen Resource Center
	National Resource Center on Nutrition and Aging
	State Health Insurance Program Technical Assistance Center

Source: ACL information. Categorization of resource centers was based on GAO analysis. | GAO-19-330

Note: ACL awarded grants in fiscal year 2018 to develop a resource center for home modifications and another for financial literacy and preparedness for caregivers, which are not shown in this table.

[a]Includes several different resource centers.

Recent examples of information relevant for rural older adults that ACL has provided through its various national resource centers include the following:

- **Business practices:** The link to a webinar held in February 2018 on developing diversified business plans and funding sources from a rural AAA can be found on the Aging and Disability Business Institute resource center website: https://www.aginganddisabilitybusinessinstitute.org/event/diversified-business-planning-for-aaa-success-healthcare-partnerships-and-beyond/ (accessed October 2018).

- **Outreach:** Practices on conducting outreach to older adults in rural and frontier areas can be found on the National Center for Benefits Outreach and Enrollment website: https://www.ncoa.org/centerforbenefits/promising-practices/finding-people/cultural-approach-rural-frontier/ (accessed January 2019).

- **Volunteer support:** A case study on mobilizing volunteer support for rural older adults published in July 2013 can be found on the Community Innovations for Aging in Place (CIAIP) Technical Assistance Center website: http://www.ciaip.org/docs/ciaip_reach_vermont_case_study_july_2013.pdf (accessed September 2018).

- **Health and integrated care**: Case studies on serving rural individuals with dementia and their caregivers were presented during a seminar at a national aging conference in March 2018 and are available on the National Alzheimer's and Dementia Resource Center website: https://nadrc.acl.gov/node/134 (accessed January 2019). Also, the National Resource Center on Chronic Disease Self-Management Education programs published a document outlining tips, strategies, and resources for offering such programs in rural areas. https://www.ncoa.org/wp-content/uploads/Offering-CDSME-Programs-in-Rural-Areas.pdf (accessed February 2019).

ACL also provides more direct support to states—and sometimes AAAs—through its regional offices and, according to the ACL officials we interviewed in four regional offices, some of this direct support has been relevant to rural challenges described to us by AAAs. For instance, ACL regional officials said they review state plans on aging to ensure that the needs of rural older adults are addressed, such as by checking that the state is using accurate and current demographic data or by reviewing the

state's intrastate funding formula.[60] Additionally ACL officials from one region said they provide feedback to states about the different effects that policies could have on urban and rural areas. They described an example in which they discussed with a state aging office whether its plan to require certain advanced degrees of staff or providers would be difficult to implement in rural areas, given the challenges rural areas have with their limited workforce of providers even without these added requirements.

Some regional ACL officials also said they sometimes provide information, training, or technical assistance to states on specific programming or service issues, such as on transportation resources, the use of restaurant vouchers or how to transport food safely over long distances. Officials in all four regional offices also described the various promising practices that localities or states in their regions used to address rural challenges, and noted that states within their region share information with each other, such as during regional conferences or meetings.

Additionally, ACL provides relevant information or other support regarding services for rural older adults through its collaborations with offices within HHS and other federal agencies (see table 5).[61] For example, ACL has collaborated with DOT on transportation issues and with the Department of Housing and Urban Development on housing issues.[62] Efforts included

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[60]Intrastate funding formulas for OAA funds are determined by states and reviewed by ACL.

[61]ACL officials also described collaborations with federal agencies aimed at serving tribal elders or veterans, groups that we did not include in the scope of this report.

[62]We have examined some of these federal interagency collaborations in prior reports. For instance, in GAO-15-158, we found that the Coordinating Council on Access and Mobility—which is chaired by the Secretary of Transportation and in which ACL participates—lacked clearly defined outcomes and measures to track progress towards outcomes, which made it difficult to know whether its efforts were resulting in improved transportation outcomes for older adults. Accordingly, in that report, we recommended that the Department of Transportation (DOT) define and report on desired outcomes and collect related data to track and measure progress in achieving results, including the extent of coordination efforts under way. DOT partially concurred with the recommendation and plans to consider what information may be needed to measure and evaluate ongoing coordination efforts. Also, in GAO-18-232, we examined collaborative efforts to address the housing and health service needs of older adults who were living in federally assisted housing. In this report, we recommended that USDA be part of collaborative efforts between HHS and HUD on older adult housing and health services, particularly with respect to those living in rural areas, and define outcomes for their efforts. The three agencies agreed with these recommendations but, as of March 2019 had not yet taken action to address them.

guidance, informational resources, and some grant funding. ACL officials explained that some efforts, while not specifically targeted to the rural older adult population, would still benefit them.

Table 5: Examples of Federal Agency Collaboration with ACL Relevant to Serving Rural Older Adults

Federal agency collaborator	Description of collaboration with the Department of Health and Human Services' (HHS) Administration for Community Living (ACL)
Collaboration with Centers for Medicare and Medicaid Services (CMS) and other federal agencies	• **ACL participated in a daylong workshop in October 2018 with CMS, Housing and Urban Development, the U.S. Department of Agriculture (USDA) and other federal agencies examining housing and health needs for rural older adults and adults with disabilities.** The workshop enabled agencies to share information on cross-cutting issues and identify areas for additional work. For example, ACL collaborated with USDA on subsequent information sessions related to home care and respite care for rural populations, according to ACL officials. • **ACL, CMS, and the Department of Veterans Affairs have a collaborated for several years on various efforts under the No Wrong Door Initiative.** This initiative is aimed at simplifying how consumers, including older adults, people with disabilities, and veterans, navigate various complex programs to more easily access long-term services and supports. According to ACL officials, programs serving rural veterans have been developed through the No Wrong Door Initiative; however, other populations in rural communities in addition to veterans have also been served through this work.
Collaborations with Department of Transportation (DOT)	• **ACL provides guidance for the National Aging and Disability Transportation Center**, which is funded by DOT's Federal Transit Administration (FTA). This technical assistance center has published various tools for rural older adults, such as a rural best practices document and a resource sheet on strategies for providing accessible transportation in rural areas. • **ACL manages the "Demonstration Program to Improve Coordinated Transportation Systems for People with Disabilities and Older Adults Research" grant**, which was established in partnership with FTA. The grant is not specifically targeted to rural areas or populations; however, some grantees have served rural communities. • **ACL participates on the Coordinating Council on Access and Mobility**, chaired by the Secretary of Transportation**.** Although the council's efforts have not specifically focused on rural older adults, some of its efforts may benefit them, according to ACL and DOT officials. For example, collaborative efforts between ACL and FTA informed transit providers that Older Americans Act Title III, Part B funds can be used toward the local match requirement for FTA's transportation grant for older adults and people with disabilities, as well as its grant for rural areas.
Collaborations with HHS' Health Resources and Services Administration (HRSA)	• **ACL has coordinated with HRSA's Federal Office of Rural Health Policy (FORHP) to offer trainings or present at conferences. According to ACL officials, FORHP officials have presented and participated at ACL regional conferences.** FORHP officials have also presented information on rural older adults through some of ACL's national resource centers, such as on chronic disease management and falls prevention. Also, ACL officials have presented to regional HRSA staff on long-term care services and programs in home- and community-based settings. • **ACL regional official is an ex officio member of the National Advisory Committee on Rural Health and Human Services**, which is staffed by HRSA's Federal Office of Rural Health Policy, to help facilitate communication between the committee and ACL. The committee's reports have examined issues relevant to the needs of rural older adults, such as long-term care and caregiver support.

Source: GAO presentation of information from agency officials and agency documents. | GAO-19-330

Note: Examples are meant to be illustrative, not exhaustive.

Potentially Useful Information Is Spread across ACL's Many Resource Centers and Other Agencies' Websites

The OAA states that one of the functions of the Administration on Aging (now part of ACL) is to improve service delivery for rural older adults through: (1) synthesizing relevant research on how to best meet service needs of older adults; (2) developing a resource guide on best practices for states, AAAs, and providers on serving rural older adults; and (3) providing training and technical assistance to states to implement these best practices. In response to the addition of these provisions to the OAA, ACL officials said the agency developed a report on research and best practices in 2003 that was subsequently issued to Congress. The 2003 report is not publicly available, however, and may have limited use for rural AAAs and service providers given that many of its references are now over 20 years old and given its lengthy format (a 170-page chapter report). ACL officials said that more current information provided by its various resource centers and ongoing technical assistance provided to states are ways that the agency continues to address these portions of the act, but, as of January 2019, they had no plans to compile information on practices or research as they had done previously.

While pertinent information on rural older adults can be found across ACL's many resource centers, the information is difficult to find, in part because it is not synthesized or compiled in a way that makes it easily searchable. As noted above, ACL funds around 30 resource centers on aging issues run by different organizations covering a range of topics, but none of these resource centers focus specifically on rural older adults. ACL noted that this was in part because rural issues were cross-cutting and that various research centers may have pertinent information. Yet it is currently not possible to search across ACL's resource centers for information on a certain topic, such as rural older adults. While we identified informational resources pertinent to rural adults on websites of several resource centers, locating the information was time consuming, as each resource center had to be searched separately. For example, we found resources related to addressing transportation challenges for rural older adults—a key challenge cited by almost all of the localities we interviewed—on at least five different ACL resource center websites, but we had to search each of the five separate websites individually (see table 6). Because such resources are difficult to find, rural AAAs and others within the aging network may not be aware that such information exists.

Table 6: Various ACL Resource Centers' Information on Transportation Challenges for Rural Older Adults

Resource Center where information found	Examples of information
Aging and Disability Business Institute	Article on transportation and health care, including information on a rural AAA's practices and links to resources from the Federal Transit Administration, including the National Aging and Disability Transportation Center.
National Aging Information and Referral Support Center	Presentation on rural transportation and ways to enhance transportation information and assistance for rural older adults and adults with disabilities.
National Resource Center on Chronic Disease Self-Management Education Programs	Presentation on resources from the Federal Office of Rural Health Policy relevant to transportation and rural health.
National Resource Center for Engaging Older Adults (engAGED)	Case study on a rural community's use of volunteers to provide transportation to older adults, including for medical appointments, grocery trips, and social visits.
Lifespan Respite Technical Assistance Center	Fact sheet on how to overcome challenges to providing respite care for rural family caregivers, including those related to transportation.

Source: GAO presentation of information from Administration for Community Living's (ACL) resource center websites. | GAO-19-330

Note: Examples are meant to be illustrative, not exhaustive.

Further, while ACL has collaborated with other federal agencies on efforts to help serve rural older adults, it may not be sufficiently disseminating existing information on pertinent resources from these other agencies, as many rural AAAs we interviewed were not aware of these resources. For example, the Federal Office of Rural Health Policy (FORHP), an HHS office with which ACL has collaborated, sponsored the development of a "Rural Aging in Place Toolkit" in 2017. The aging toolkit includes links to research on rural aging issues, information on promising program models, examples of local practices, and strategies for sustaining programs, among other topics.[63] The aging toolkit and other evidence-based toolkits on rural transportation, service integration, health promotion and disease prevention are posted on the Rural Health Information Hub, a website supported by FORHP.[64] Officials from 9 of the 12 selected localities we interviewed, however, were not aware of FORHP or the Rural Information Hub and its resources.[65]

In addition, while transportation was cited as a key challenge among the localities we interviewed and ACL has collaborated with DOT on various efforts, officials from 5 of the 12 selected localities we interviewed told us

[63]https://www.ruralhealthinfo.org/toolkits/aging (accessed February 2019).

[64]https://www.ruralhealthinfo.org/toolkits (accessed February 2019).

[65]Officials from one locality did not respond to our questions on FORHP or on the National Aging and Disability Transportation Center below.

that they were not aware of the National Aging and Disability Transportation Center or knew of its website. Yet this DOT-funded center to which ACL provides guidance has posted potentially useful information for rural aging providers. Examples include a webinar on removing barriers to transportation and senior mobility with examples of rural challenges, a summary report on transportation services for older adults and people with disabilities in rural and small urban communities, and a pocket guide on planning for transportation in rural areas after the receipt of medical services, among other resources (examples also included in table 5 above).[66]

Officials from 7 of the 12 localities we spoke to stated that more information would be useful or expressed difficulties with finding information on ways to serve rural older adults. Specifically, officials from 5 of the 12 localities told us that more information on promising practices or other resources would be useful. Examples of information sought included strategies for mobilizing volunteers, grants or resources in rural areas, or innovative ways to provide Title III programs over large geographic areas with minimal resources. Additionally, officials from some of these localities, as well as two other localities expressed various difficulties with finding useful information. For example:

- **Difficult to find.** One AAA official said that although she was aware of many informational resources, there was a lack of "unity between them," making it more difficult to find what she needed. She noted that the development of a "national resource log by specific topics" could help her rural AAA more efficiently and effectively obtain the information it needed to do its work. Officials from a stakeholder organization echoed these thoughts, stating that local communities were challenged in understanding the range of federal assistance and resources available, and that information that better explained how the various pieces fit together could help localities work more efficiently and effectively.

- **Cost-prohibitive.** Besides ACL resources, some officials at the AAAs we interviewed indicated that they consult various sources for information at the local, state, or national level. However, officials from two AAAs said that the cost of membership can sometimes prohibit them for joining organizations that may have useful information.

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[66]https://www.nadtc.org/ (accessed February 2019). This website allows for searching by topic, including specifically on rural transportation, and by audience type, including aging professionals.

- **Not applicable.** Officials from one locality stated that available information on aging practices may not always be applicable for rural areas given constraints they face, such as the lack of infrastructure or resources. State officials from two of the selected states echoed similar sentiments. Similarly, a rural provider in California noted that when staff attend state conferences in which information is shared, sometimes the needs of and practices among large urban areas dominate.

Federal standards for internal control call for agencies to communicate necessary quality information to external parties in order to achieve the agency's objectives.[67] Further, Office of Management and Budget (OMB) guidance on using information as a "strategic resource" notes that making federal information "discoverable, accessible and usable" can fuel innovation, among other things, and recommend that federal agencies publish information online that promotes wide reuse. Facilitating easier access to useful practices or other pertinent information could help AAAs and local providers gain from others' experiences and use resources in more efficient or innovative ways, consistent with this guidance.[68] The OMB guidelines also recommend that agencies first satisfy new information needs through the sharing of information from other sources, where appropriate, before creating or collecting new information. Taking steps to better leverage and disseminate existing resources from other agencies, particularly those agencies with which ACL collaborates, could be helpful to rural service providers and would align with these federal guidelines, and help ACL carry out its function of improving the service delivery for rural older adults.

Conclusions

Rural areas cover the vast majority of the country and tend to be "grayer" than urban areas, with larger concentrations of older adults. Further, the older people who live in rural areas tend to be older, poorer, and less healthy than those in other areas, and also face distinct challenges to accessing the services needed to age in place, such as reliable transportation to faraway medical appointments. ACL provides potentially useful information about services for older adults in rural areas on its numerous websites, but these sites are not easily searchable and some

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[67]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C: Sept. 2014), 62.

[68]Office of Management and Budget, *Circular A-130, Managing Information as a Strategic Resource* (Washington, D.C.: July 27, 2016).

service providers did not know the information was available. While easier access to information is not a panacea for addressing the challenges rural adults face, it could help providers better serve rural communities. ACL is well-positioned to help facilitate information sharing through its website and those of its many resource centers, and to leverage pertinent rural aging resources from other agencies with whom it collaborates. For example, by making its free, existing online resources more easily searchable or by developing a compilation of resources focused on rural challenges, ACL could help rural AAAs and local providers more efficiently gain from others' experiences and innovations, and stretch resources further.

Recommendation for Executive Action

The Administrator of ACL should take steps to better centralize access to and promote awareness of information on promising practices or other useful information pertinent to serving rural older adults.

Agency Comments

We provided a draft of this report to HHS for review and comment. In its comments, which are reproduced in appendix VI, HHS concurred with our recommendation. HHS, as well as DOT and SSA, also provided technical comments, which we incorporated, as appropriate.

In its concurrence, HHS stated that it would encourage its resource centers to identify promising practices and other information specific to rural communities so that these resources would be searchable. We appreciate that ACL's planned action is a step toward helping rural agencies and providers find relevant information on each center's website. However, as we state in this report, pertinent information for rural communities is spread across many different ACL resource center websites, as well as the websites of other agencies with whom ACL collaborates, such as DOT and FORHP. Accordingly, to help rural agencies and providers more easily access pertinent information, we encourage ACL to centralize access to this information by making it searchable across these websites or compiling it other ways. Further, to help rural agencies and providers better leverage existing resources to the extent possible, ACL should take actions to promote awareness of this information, as we also recommended.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the appropriate

congressional committees, the Secretaries of Health and Human Services and Transportation, the Acting Commissioner of the Social Security Administration, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7215 or larink@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix VII.

Kathryn A. Larin
Director
Education, Workforce, and Income Security Issues

Appendix I: Rural and Urban Older Adults' Access to Social Security Administration Supports and Services

This appendix contains information related to how rural and urban older adults contact the Social Security Administration (SSA) for supports and services, such as for the purposes of applying for retirement or disability benefits or enrolling in Medicare. Beneficiaries can contact SSA through online transactions, by phone, or in-person visits to field offices. As we have reported in the past, SSA is increasingly serving people through online services and also has reduced its physical footprint in various ways, including the consolidation of some field offices.[1]

To describe how rural and urban older adults access SSA supports and services, we analyzed national data from SSA using a rural and urban classification scheme:[2]

- SSA collects data on the service delivery channels beneficiaries use to access SSA services, such as online transactions, phone calls, or in-person field office visits. We obtained SSA data on the number of unique beneficiaries 62 and older who used each service delivery channel by the beneficiaries' zip codes, cumulative for fiscal year 2017. We compared these to the number of beneficiaries 62 and older in each zip code as of December 2017.[3]

- SSA also maintains data on field office consolidations, including on the zip codes of beneficiaries who are affected by an office consolidation.[4] We analyzed data on beneficiary zip codes affected by SSA office consolidations from fiscal years 2010 through 2018.

For these analyses, we classified all beneficiary zip codes using rural-urban commuting area codes.[5] We assessed the reliability of these data

[1]GAO, *Social Security Administration: Improvements Needed in Facilities Planning and Service Delivery Evaluation*, GAO-17-597 (Washington, D.C.: July 25, 2017).

[2]Our data analysis included the 50 states and Washington, D.C., and excluded U.S. territories.

[3]SSA data on the of number of beneficiaries 62 and older were rounded and excluded some zip codes with very few beneficiaries. Also, we excluded from our analysis instances of missing data, such as because we were not able to match zip codes between data sets; however, these accounted for less than one percent of all cases in our analysis.

[4]SSA uses the term "office consolidation" to mean that beneficiaries who were served by a SSA field office that the agency closes are absorbed by another field office.

[5]For information on this classification scheme see
https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx
(accessed March 2019).

by conducting data checks and obtaining information on data reliability from SSA officials. As a result, we determined that the data were sufficiently reliable for the purposes of this report.

In addition to our data analysis, we interviewed SSA officials regarding agency efforts that could help address challenges older adults in rural areas may face in accessing SSA enrollment supports and services. We also reviewed prior GAO work on SSA service delivery.[6]

Beneficiaries' Use of Service Delivery Channels in Rural versus Urban Areas

Older adults use various SSA service delivery channels to apply for benefits, manage benefits, appeal benefit decisions, among other purposes.[7] As we described in our prior work, customers access SSA services primarily through four delivery channels: in-person at a SSA field office, by phone with field office staff, by phone through the national 800 number, and online.[8]

Smaller percentages of older SSA beneficiaries in rural areas used the various service delivery channels to access SSA services than those in urban areas, based on our analysis of 2017 data (see table 7).[9] For instance, 15 percent of rural beneficiaries used the national 800 number, compared with 25 percent of urban beneficiaries. Also, the percentages of rural beneficiaries who had an online account or conducted transactions were smaller than urban beneficiaries. Further, a smaller percentage of rural beneficiaries visited SSA field offices than urban beneficiaries. The only exception was calls to field offices, which rural and urban beneficiaries made at a similarly low rate (2 percent). Across both rural and urban beneficiaries, calling the national 800 number was the most

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[6]GAO-17-597.

[7]SSA provides financial assistance to eligible individuals through three major benefit programs: 1) Old-Age and Survivors Insurance, which provides retirement benefits to eligible older workers and their families and to survivors of deceased workers; 2) Disability Insurance, which provides benefits to eligible workers who have qualifying disabilities and their eligible family members; and 3) Supplemental Security Income, which provides income for aged, blind, or disabled individuals with limited income and resources. SSA may also assist individuals with applications for Medicare and the Supplemental Nutrition Assistance Program.

[8]GAO-17-597.

[9]Percentages were calculated based on the number of times beneficiaries 62 and older used each service delivery channel in fiscal year 2017 by zip code, divided by the number of beneficiaries 62 and older as of December 2017 by zip code.

common way of accessing SSA services. Also, while some urban and
rural beneficiaries had online SSA accounts (19 and 13 percent,
respectively), fewer beneficiaries actually conducted online transactions
(10 and 7 percent, respectively).

**Table 7: Percent of Urban and Rural Social Security Administration (SSA) Beneficiaries Aged 62 and Older in the United
States Who Accessed Each SSA Service Delivery Channel in 2017**

| Geography type of beneficiaries' residence	Had an online account	Conducted online transactions	Called the national 800 number	Visited an SSA field office	Called an SSA field office
All types	**17.7**	**9.4**	**22.5**	**12.7**	**2.1**
Urban	19.0	10.1	24.5	13.2	2.0
Urban core	19.4	10.4	25.4	13.7	2.0
Suburban	15.9	8.4	18.3	9.7	2.0
Rural	12.9	6.6	14.8	10.5	2.2
Large towns	13.4	6.8	14.9	11.9	2.0
Small towns/ isolated rural areas	12.4	6.3	14.8	8.8	2.3

Source: GAO analysis of SSA data on the number of unique beneficiaries 62 and older who accessed each service delivery channel in fiscal year 2017 by zip code and SSA data on the of number of
beneficiaries 62 and older by zip code as of December 2017. | GAO-19-330

Note: Rural and urban categories were determined by applying the rural-urban commuting area
coding scheme to beneficiary zip codes. SSA data on the number of beneficiaries using each service
delivery channel in fiscal year 2017 were unique users per channel. SSA data on the of number of
beneficiaries 62 and older were rounded and excluded some zip codes with very few beneficiaries.
Also, GAO's analysis included the 50 states and Washington, D.C. and excluded territories. Zip codes
that were not matched between the two data sources were also excluded, but these accounted for
less than one percent of all cases.

Use of SSA's different service delivery channels also varied between rural
and urban older beneficiaries in different states, based on our analysis
(see table 8). For instance, among our eight selected states, the
percentage of rural beneficiaries who had an online account ranged from
8 percent in Mississippi to 18 percent in California. (For urban
beneficiaries, the range was 13 to 21 percent for these states,
respectively.) The extent to which beneficiaries visited field offices also
varied in rural areas (ranging from 7 percent in Wisconsin to 17 percent in
New Mexico), as well as for urban beneficiaries (ranging from 10 percent
in Pennsylvania to 20 percent in California).

Table 8: Percent of Urban and Rural Social Security Administration (SSA) Beneficiaries Aged 62 and Older in Selected States Who Accessed Each SSA Service Delivery Channel in 2017

		Had an online account	Conducted online transactions	Called the national 800 number	Visited an SSA field office	Called an SSA field office
CA	Urban	20.6	10.8	26.8	19.9	2.8
	Rural	17.6	8.9	19.5	12.8	2.8
ME	Urban	17.7	10.0	14.9	10.0	3.4
	Rural	14.2	7.7	13.6	8.6	3.1
MS	Urban	13.2	6.7	17.9	11.8	2.7
	Rural	8.1	3.9	12.9	15.2	2.7
ND	Urban	16.5	9.9	13.2	11.8	2.0
	Rural	12.5	6.9	12.3	9.3	2.9
NM	Urban	21.0	11.8	24.2	15.1	1.5
	Rural	15.2	7.7	17.4	17.2	1.5
OK	Urban	19.1	10.0	20.9	10.5	1.8
	Rural	11.6	5.6	13.1	12.7	1.8
PA	Urban	16.8	9.0	23.5	9.8	2.0
	Rural	11.2	5.8	14.4	8.1	2.0
WI	Urban	15.7	9.0	17.0	11.1	1.7
	Rural	12.0	6.7	12.2	6.8	2.3

Source: GAO analysis of SSA data on the number of unique beneficiaries 62 and older who accessed each service delivery channel in fiscal year 2017 by zip codes and SSA data on the of number of beneficiaries 62 and older by zip code as of December 2017. | GAO-19-330

Note: Rural and urban categories were determined by applying the rural-urban commuting area coding scheme to beneficiary zip codes. SSA data on the number of beneficiaries using each service delivery channel in fiscal year 2017 were unique users per channel. SSA data on the number of beneficiaries 62 and older were rounded and excluded some zip codes with very few beneficiaries. Also, GAO's analysis included the 50 states and Washington, D.C. and excluded territories. Zip codes that were not matched between the two data sources were also excluded, but these accounted for less than one percent of all cases.

SSA Office Consolidations in Rural versus Urban Areas

In our 2017 report, we described SSA's efforts to consolidate its physical footprint in line with government-wide efforts, including the consolidation of field offices. In our update of the information on office closures for this report, we found that between fiscal years 2010 through 2018, SSA consolidated 65 field offices within the United States (excluding territories), and that the majority of areas affected by these office consolidations were urban and small town or rural areas, as shown in figure 8. Specifically, in this time period the 65 SSA offices that were consolidated served over 1000 beneficiary zip codes: 43 percent were those in urban areas and 28 percent were those in small town or isolated rural areas.

Figure 8: The Majority of Areas Affected by Social Security Administration Field Office Consolidations Were Urban and Small Town or Rural Areas, Fiscal Years 2010 through 2018
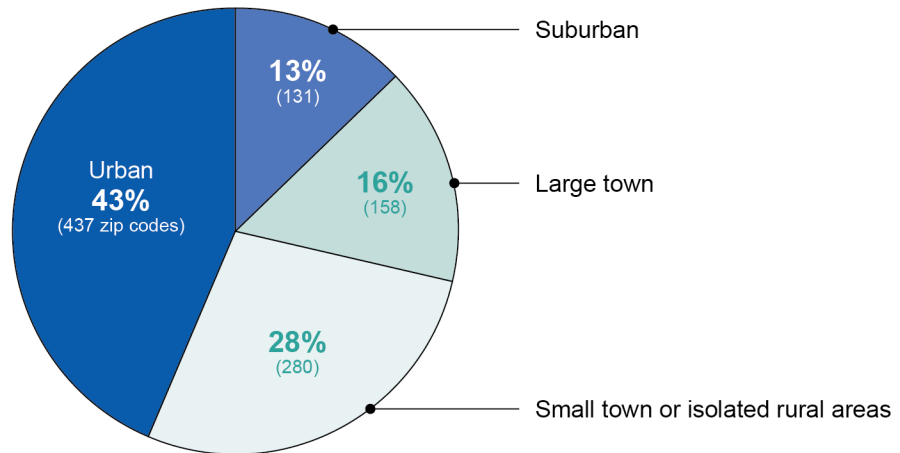
Source: GAO analysis of Social Security Administration (SSA) data. | GAO-19-330

Note: In this time period, there were 65 SSA office consolidations in the 50 states and Washington, D.C., which affected 1,012 beneficiary zip codes. Six zip codes were excluded from this analysis due to missing data. For the remaining 1,006 beneficiary zip codes, rural and urban categories were determined by applying the rural-urban commuting area coding scheme.

In our 2017 report, we also found that the use of online services compared with the use of field office services (in-person visits or calls) for beneficiaries of all ages varied widely among different service areas in the country. We noted that such variation could be due to particular population demographics and needs (e.g., computer literacy or English proficiency), as well as the ability to access online services. Also, our 2017 report described how difficulties in accessing online services could affect both rural beneficiaries (e.g., due to the lack of broadband in some rural areas), as well as low-income urban beneficiaries (e.g., due to cost of owning a computer or accessing the Internet).[10]

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[10]Given the variation in how people access SSA services, we recommended in our 2017 report that SSA develop a long-term facility plan that explicitly links to SSA's strategic goals for service delivery, and includes a strategy for consolidating or downsizing field offices in light of increasing use of and geographic variation in remote service delivery. SSA agreed with this recommendation and as of August 2018 was continuing planning efforts to determine the best approach to develop performance measures for alternative customer services.

In our 2017 report, we noted that a key part of SSA's strategy to address customers' challenges with access to online delivery of services has been to make these services available in more locations. SSA officials we interviewed for this report described some agency efforts that could help beneficiaries in rural areas access services.

- **Video service delivery** enables SSA to conduct business such as claims and hearings with customers in remote locations where field offices are not in near proximity. SSA had about 700 video service delivery sites at a variety of entities, including government agencies, American Indian tribal centers, hospitals and other community centers, as of March 2019.

- **Desktop icons** in third party locations, such as public libraries or social services agencies, allows customers to access SSA's online services in more locations. About 250 third-party locations have SSA desktop icons, as of March 2019.

- **Self-help personal computers** provide access to SSA online services for field office customers who are able to get to a field office, but lack access to the Internet. About 850 SSA field offices had self-help personal computers, as of March 2019.

Appendix II: Methodology for Analyzing Data from the National Survey of Older Americans Act Participants

To examine service use among Title III participants, we analyzed data from the Administration for Community Living's (ACL) 2017 National Survey of Older Americans Act Participants (2017 National Survey of OAA Participants). This is an annual survey that focuses on participants' assessments of service quality and participant-reported outcomes. The survey also collects demographic information, such as age, income, and physical and social functioning. We used the 2017 survey, which was the most recent data available at the time of our analysis.

The 2017 National Survey of OAA Participants collected data from older adults who had participated in one of five services (case management, congregate meals, home-delivered meals, homemaker, and transportation) and from caregivers of older adults and other specified populations who received caregiver support services. Participants were selected through a two-stage sample design, first selecting a sample of Area Agencies on Aging (AAA), and then a sample of clients for each service within each sampled AAA. For each of the six services, a separate sample of participants was selected and surveyed by phone. Data on the six services are nationally generalizable to participants who received that service.

The survey classified participants into three geographic categories, using the U.S. Census Bureau's urban rural classification:

- urbanized areas of 50,000 or more people;

- urban clusters of at least 2,500 and less than 50,000 people; or

- rural areas, which encompass all population, housing, and territory not included within an urban area.

For the purposes of our analysis, we combined the urbanized area and urban cluster categories into one urban category to compare participants in rural areas to those from all types of urban areas. We excluded participants with missing geographic information from our analysis. In each of the six datasets, we excluded between 17 and 57 participants due to missing geographic information.

For our analysis, we selected variables reflecting responses to questions related to older adults' access to services to help them age in place. We focused on variables related to frequency of service use, as well as those related to ease of service use, perceptions of independence, and additional assistance from family or friends to arrange other services as

shown in table 9. In some cases, we did not include all questions on a particular concept if the questions were very similar to each other.

Due to small sample sizes of rural participants, we recoded variables that had more than two categories into binary variables to increase the precision of our estimates. We determined the categories for the binary variables based on natural breaks in the data and our knowledge of the services. For variables related to frequency of service use, we compared two categories of high and low service use. For example, participants selected from four categories to report the last time that they had received case management services, but we recoded these four categories into two based on the natural break in their responses. While 42 percent of participants selected the highest category (more than a month ago), between 15 to 23 percent of participants selected each of the lower three categories. In addition to variables related to service access, we selected additional demographic variables to compare characteristics of participants in rural and urban areas.

Because the survey data are based on probability samples, estimates are calculated using the appropriate sample weights provided which reflect the sample design. Each of these samples follows a probability procedure based on random selection, and they represent only one of a large number of samples that could have been drawn. As a result, each estimate carries a different range of precision reflecting that particular sample's characteristics. In each case, we calculated the range of precision as a 95 percent confidence interval—that is, the interval that would contain the actual population value for 95 percent of the samples we could have drawn. We compared 95 percent confidence intervals to identify statistically significant differences between specific estimates and the comparison groups.

For variables that compared the difference of proportions of participants that reported low and high rates of service use, we conducted additional tests to assess whether the differences in proportions were statistically significant even if the confidence intervals overlapped. We tested these variables because they were most relevant to our research question on access to services.

To test for significance, we performed logistic regressions to assess the association between each variable of interest and the dichotomous rural-urban variable. If the p-value for a respective association was below the Bonferroni-adjusted significance level the difference in proportions between the rural and urban categories was determined to be statistically

significant. To determine the Bonferroni-adjusted significance level we divided the nominal significance level of .05 that is conventionally used in such testing by the number of tests being performed on distinct variables in each of the services.

We determined that the data we used from the survey were sufficiently reliable for the purposes of this report by reviewing technical documentation, conducting electronic testing, and obtaining information from officials from ACL on such issues as the completeness of data, checks done on the data for accuracy and reliability, and any known limitations of the data. Table 9 includes a list of selected survey questions we included in our analysis.

Table 9: Estimated Percentages of Rural and Urban Participant Responses for Selected Items of the 2017 National Survey of Older Americans Act Participants

Service and sample size of each survey (N)	Survey item response	Rural	Urban
Caregiver[a] N = 187,379	Received respite care	51.9	60.4[b]
	Received information from a case worker, case manager, or other AAA staff person to connect them to other available services and resources	62.3	70.1[b]
	Received caregiver training or education	32.9	38.5[c]
	Had difficulty getting services from agencies for the care recipient	40.5	35.8
Case management[d] N = 378,297	Received the service within the last month	43.4	59.9[b]
	Knew how to contact their case manager when needed	77.1	85.9
	Case manager returned calls in a timely manner	91.1	92.1
	Services helped them continue to live in their own home	86.6	92.2
	Friends and family helped arrange for services	69.9	38.0
Congregate meals[e] N = 1,507,074	Ate lunch at the senior center within the last week	55.9	58.4[c]
	Ate lunch at the senior center 4 or more times per week	16.2	21.5[c]
	Services helped them continue to live in their own home	65.0	65.6
	Friends and family helped arrange for services	23.7	22.8
Home-delivered meals[f] N = 804,856	Received a meal within the last week	73.2	82.6[b]
	Received meals 5 or more times per week	58.7	67.7[c]
	Meal was always or usually delivered on-time	96.6	93.7
	Services helped them continue to live in their own home	90.5	92.3
	Friends and family helped arrange for services	54.6	42.9
Homemaker[g] N = 160,673	Received the service within the last week	62.6	76.2[c]
	Received the service weekly	67.8	77.6[c]
	Received the service monthly	32.2	22.4[c]
	Services helped them continue to live in their own home	99.0	97.6
	Friends and family helped arrange for services	42.8	34.4
Transportation[h] N = 249,919	Received the service within the last month	65.6	69.9[c]
	Used the service at least once per week	50.3	58.1[c]
	Made more than 6 trips per month with the service	30.2	36.1
	Could always or usually get to places they need to go	89.1	92.7
	Could always or usually get rides when needed	86.4	90.2
	Services helped them continue to live in their own home	81.1	86.9
	Friends and family helped arrange for services	29.6	23.7

Source: GAO analysis of data from the 2017 National Survey of Older Americans Act Participants. | GAO-19-330

Note: Results for each service come from separate surveys. The sample size listed for each service is the maximum weighted sample size of the survey items we analyzed for that service, but sample sizes for some items may be lower.

[a]Percentage estimates in the caregiver survey have a margin of error at the 95 percent confidence interval between plus or minus 2.7 and 6.5 percentage points.

[b]Result is statistically significant using a Bonferroni-adjusted significance level.

[c]Tested for statistical significance, but was not significant using a Bonferroni-adjusted significance level.

[d]Percentage estimates in the case management survey have a margin of error at the 95 percent confidence interval between plus or minus 4.2 and 21.2 percentage points.

[e]Percentage estimates in the congregate meals survey have a margin of error at the 95 percent confidence interval between plus or minus 4.5 and 9.1 percentage points.

[f]Percentage estimates in the home-delivered meals survey have a margin of error at the 95 percent confidence interval between plus or minus 2.0 and 8.4 percentage points.

[g]Percentage estimates in the homemaker survey have a margin of error at the 95 percent confidence interval between plus or minus 1.9 and 13.0 percentage points.

[h]Percentage estimates in the transportation survey have a margin of error at the 95 percent confidence interval between plus or minus 2.2 and 9.9 percentage points.

Appendix III: Methodology for Conducting a Literature Review of Studies on Home- and Community-Based Services

To assess what is known about access to home- and community-based services for older adults in rural areas beyond those receiving Title III services, we conducted a literature review to identify studies that compared access to services between older adults in rural and urban areas. To begin our search, we compiled a list of potentially relevant studies recommended to us by experts, agency officials, and stakeholder groups we interviewed. We also searched for studies on websites that were recommended during our interviews. These websites included the Rural Health Information Hub and Rural Health Research Gateway, which are sponsored by the U.S. Department of Health and Human Services' Federal Office of Rural Health Policy and were identified as key resources for rural aging research by experts, agency officials, and stakeholder groups we interviewed. In addition, we searched various other databases, including Scopus, Dialog, Ageline, OCLC First Search, Harvard Think Tank Search, and Google to capture any additional studies using search terms such as "older adult", "rural", and "access".[1] Finally, we searched for studies in the citations of other relevant work discussed in the studies we identified.

We reviewed the search results to identify relevant studies that met five criteria. Studies met our criteria if they: (1) compared service access between rural and urban older adults; (2) were based on original research conducted in and published in the United States; (3) were published after 2008; (4) were not focused solely on American Indians or veterans (which were populations we excluded because they are served primarily through separate programs); and (5) provided clear descriptions of their methodologies and had no significant methodological limitations. Also, all of the studies we ultimately included in our review were national in scope and were not focused on a single state or local area.

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[1]We searched for studies that included at least one term on our population of interest (older adult, elderly, or senior), at least one on rurality (rural, non-metro/nonmetropolitan, frontier, or remote), at least one on access (access, use, participation, or available), and one service term (Older Americans Act, age/aging in place, home- and community based services, long-term support services, long-term care, meals, supportive services, in-home support, personal care, homemaker, home health, case management, transportation, or caregiver/caregiving). We also searched for studies on admission to a nursing home, nursing facility, institutional care, or residential facility.

Appendix III: Methodology for Conducting a
Literature Review of Studies on Home- and
Community-Based Services

We initially identified 17 studies that met all of the first four criteria.[2] To determine those that also met the fifth criteria regarding methodological soundness, we conducted an in-depth review of each study's findings and methods. We eliminated five studies because we determined that the methods were not appropriate or rigorous for our purposes. For example, we eliminated two studies that used survey data with a low response rate. We also eliminated one study that repeated findings from an earlier study. Based on this review, we determined 11 studies were sufficiently reliable for comparing access to services between older adults in rural and urban areas (see table 10).

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[2]We also identified a study conducted by Mathematica that met these criteria: Mathematica Policy Research, *Needs of and Service Use Among Participants in the Older Americans Act Title III-C Nutrition Services Program,* prepared for at the request of the Department of Health and Human Services' Administration for Community Living, October 5, 2018. Because this study examined the receipt of services provided by Title III, similar to the OAA survey, we decided to discuss this study when we discussed the OAA survey findings, rather than as part of our literature review.

**Appendix III: Methodology for Conducting a
Literature Review of Studies on Home- and
Community-Based Services**

Table 10: Studies That Compare Access to Home- and Community-Based Services in Rural and Urban Areas, 2009 through 2018

Title	Authors	Year of publication
Are Rural Older Adults Benefiting from Increased State Spending on Medicaid Home and Community-Based Services?	Coburn, Andrew; Eileen Griffin; Deborah Thayer; Zachariah Croll; and Erika Ziller	2016
GAO-11-237: Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services	GAO	2011
GAO-15-601R: Older Americans Act: Updated Information on Unmet Need for Services	GAO	2015
Intensity of Service Provision for Medicare Beneficiaries Utilizing Home Health Services: A Closer Look at Cerebrovascular Disease, Diabetes, and Joint Replacement	Iyer, Medha; Janice Probst; Kevin Bennett; and Grishma Bhavsar	2014
Profile of Rural Residential Care Facilities: A Chartbook	Lenardson, Jennifer; Eileen Griffin; Zach Croll; Erika Ziller; and Andrew Coburn	2014
Process Evaluation of the Older Americans Act Title III-E National Family Caregiver Support Program: Final Report	The Lewin Group	2016
Process Evaluation of Older Americans Act Title III-C Nutrition Services Program	Mabli, James; Nicholas Redel; Rhoda Cohen; Erin Panzarella; Mindy Hu; and Barbara Carlson	2015
Report to Congress: Medicare and the Health Care Delivery System: Chapter 5 - Serving rural Medicare beneficiaries	Medicare Payment Advisory Commission	2012
Rural AAAs Structure and Services Information & Planning Issue Brief	National Association of Area Agencies on Aging	2018
Residential Settings and Healthcare Use of the Rural "Oldest-Old" Medicare Population	Paluso, Nathan; Zachariah Croll; Deborah Thayer; Jean Talbot; and Andrew Coburn	2018
Home Health Care Agency Availability in Rural Counties	Probst, Janice; Samuel Towne; Jordan Mitchell; Kevin Bennett; and Robert Chen	2014

Source: Studies included in GAO's review. | GAO-19-330

Note: Our scope included studies that: (1) compared service access between rural and urban older adults; (2) were based on original research conducted in and published in the United States; (3) were published after 2008; (4) were not focused solely on American Indians or veterans (which were populations we excluded because they are served primarily through separate programs); and (5) provided clear descriptions of their methodologies and had no significant methodological limitations. Also, all included studies were national in scope and were not focused on a single state or local area.

Appendix IV: Results from Survey of Selected Rural Localities on Challenges Providing Services

Methodology

To determine the challenges that selected rural localities face in helping older Americans access these services and steps they are taking to address those challenges we conducted interviews with officials and gathered documents from 12 selected rural localities in eight states (California, Maine, Mississippi, North Dakota, New Mexico, Oklahoma, Pennsylvania, and Wisconsin). In each of these 12 rural localities, we asked officials to complete a short survey on challenges in advance of our interviews. During survey development, we pretested the draft instrument with three local areas during May and July 2018. In the pretests, we were interested in ensuring our questions were clear and unbiased and the layout of the survey was understandable. Based on feedback from the pretests, we made minimal revisions to the survey instrument. The final survey instrument was then completed by all 12 rural localities between July and October 2018.

Challenges Survey Results

The questions we asked in our survey of selected rural localities are shown below. Our survey was comprised of mostly closed- and one open-ended question. In this appendix, we include all the survey questions and aggregate results of responses to the closed-ended questions; we do not provide information on responses provided to the open-ended question.

1. Below is a list of ten types of potential challenges local communities may face in helping older adults in rural areas access services and supports needed to age in place. Using the possible responses below, please rate the extent to which your AAA experiences each type of challenge:

- Great challenge
- Moderate challenge
- Somewhat a challenge
- Not a challenge

Please provide one response for each type of challenge. If you are not able to rate the degree of challenge for an item, check the box for Don't know or Not applicable (N/A).

Potential challenge communities face in helping rural older adults access services needed to age in place				
a. **Limited transportation options to access services.** This can include difficulties for providers in connecting rural older adults to services due to limited transportation options in rural areas.				
Great challenge	Moderate challenge	Somewhat of a challenge	Not a challenge	Don't know or Not applicable
11		1		
b. **Added cost and effort of providing services to a dispersed population.** This can include added costs in providing services or conducting outreach due to traveling long distances to reach dispersed clients.				
Great challenge	Moderate challenge	Somewhat of a challenge	Not a challenge	Don't know or Not applicable
8	2	1	1	
c. **Limited availability of paid providers.** This can include the lack of service organizations or paid care providers.				
Great challenge	Moderate challenge	Somewhat of a challenge	Not a challenge	Don't know or Not applicable
7	4		1	
d. **Limited availability of informal or unpaid care providers.** This can include the absence of nearby family or friends. This can also include the lack of community volunteers.				
Great challenge	Moderate challenge	Somewhat of a challenge	Not a challenge	Don't know or Not applicable
10	2			
e. **Difficulties using technology to connect people to services.** This can include limited internet access or cell phone service. It can also include lack of computer usage among older adults.				
Great challenge	Moderate challenge	Somewhat of a challenge	Not a challenge	Don't know or Not applicable
7	1	3	1	
f. **Reluctance in seeking help.** This can include reluctance due to perceptions of stigma or self-reliance, or for cultural reasons, such as for minority groups.				
Great challenge	Moderate challenge	Somewhat of a challenge	Not a challenge	Don't know or Not applicable
2	5	3	2	
g. **Difficulties related to suitable housing.** This can include challenges related to helping people live in housing that is accessible (due to short-or long-term modification needs), in good repair or maintenance, and affordable. This may include helping people find suitable housing or helping people modify their existing homes.				
Great challenge	Moderate challenge	Somewhat of a challenge	Not a challenge	Don't know or Not applicable
9	3			

Potential challenge communities face in helping rural older adults access services needed to age in place				
h.	**Difficulties coordinating across different agencies or entities to provide services.** This can include difficulties for the AAA and its service providers in working across different government departments, programs, or funding streams to coordinate services.			
Great challenge	Moderate challenge	Somewhat of a challenge	Not a challenge	Don't know or Not applicable
2	2	2	6	
i.	**Difficulties coordinating across jurisdictions to provide service**s. This can include difficulties for the AAA and its service providers in working across county boundaries or state lines.			
Great challenge	Moderate challenge	Somewhat of a challenge	Not a challenge	Don't know or Not applicable
1	3	5	3	
j.	**Difficulties meeting the needs of a growing aging population:** This can include the growth in the number of older adults who are in need of services due to demographic trends (e.g., the aging Baby Boomer population or the increase in the number of frail or high-need older adults).			
Great challenge	Moderate challenge	Somewhat of a challenge	Not a challenge	Don't know or Not applicable
7	2	2	1	

2. Are there other types of challenges involved in providing services to older adults in rural areas that we did not list? If so, please describe them.

[Open-ended]

Appendix V: Profiles of Selected Rural Localities

This appendix provides additional information on our 12 selected localities, including information on selected demographic characteristics, key challenges faced in helping older adults access services in rural areas, and strategies used to mitigate challenges. The profiles on the following pages (listed in table 11) are based on information from the U.S. Census Bureau, area agencies on aging (AAA) plans, and interviews with AAA officials from selected localities.[1]

Table 11: Rural Localities Selected for Review

|	Census region	Census division	State	Rural locality
Profile 1	Northeast	New England	Maine	Aroostook AAA
Profile 2				Eastern AAA[a]
Profile 3		Middle Atlantic	Pennsylvania	Potter County AAA
Profile 4	Midwest	East North Central	Wisconsin	Iron County
Profile 5		West North Central	North Dakota	Region VI[a]
Profile 6				Region VIII
Profile 7	South	East South Central	Mississippi	North Delta AAA[a]
Profile 8				Southwest AAA
Profile 9		West South Central	Oklahoma	Southern Oklahoma Development Association AAA
Profile 10	West	Mountain	New Mexico	Mora County
Profile 11		Pacific	California	Area 2 Agency on Aging
Profile 12				Area 12 Agency on Aging[a]

Sources: GAO analysis of information from the U.S. Census Bureau and state listings of their area agencies on aging (AAA). | GAO-19-330

[a]Site visit location.

We selected these localities based on their concentration of older residents in rural areas, as well as to reflect demographic and geographic diversity (see fig. 9). In four of the states (California, Maine, Mississippi, and North Dakota), we conducted more in-depth work, including site visits and interviews with state-level officials and local providers.

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[1]We did not conduct an independent review of state laws and regulations.

Figure 9: Map of Rural Localities Selected for Review
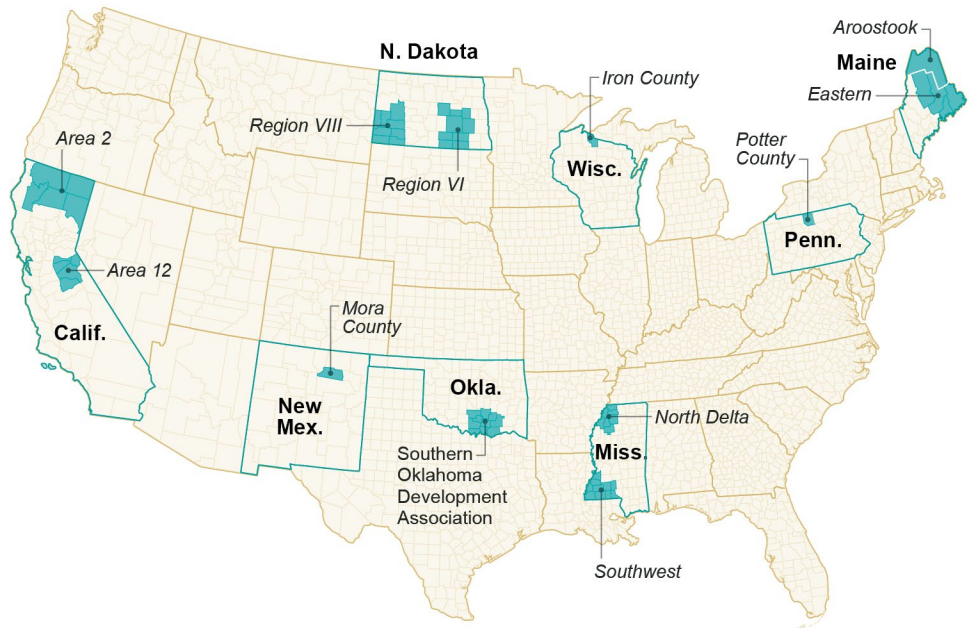
Source: GAO and National Atlas (base map). | GAO-19-330

Maine: Aroostook AAA

Area at a glance

County served: Aroostook County.

Extent rural: The largest county east of the Mississippi River, Aroostook, is entirely rural. Six towns, including Presque Isle and Caribou, are considered "hubs" for services.

Racial/ethnic groups: Most of the county's population is White, with very small representation from all other groups.

Services provided: The AAA provides almost all services directly, including congregate and home-delivered meals, information and assistance, and caregiver services. It contracts with a regional transportation provider for senior transportation services. Personal care services are also available through a combination of fee-for-service and outside funding. AAA officials told us the greatest service needs in the area include transportation, personal care, and caregiver services.

"In the outlying areas of Aroostook there are very few services available."—Aroostook AAA official

"Aroostook has few medical providers. Older adults have to go to Bangor for cardiac, neurological, or mental health care. Even for primary care, there can be delays in receiving services, in part due to doctor turnover." —Aroostook AAA official

Area in context

	Maine	Aroostook County
Population density, 2010 *(people per square mile)*	43.1	10.8
Number of older adults, 2017[a] *(aged 65+)*	250,131	15,138
Older adults as percent of population[a]	18.8%	22.0%
Number of older adults living in rural areas[a]	137,588	15,138
Percent of older adults living in rural areas[a]	55.0%	100.0%
Percent of older adults living below poverty level[a]	8.8%	12.9%

Source: GAO analysis of U.S. Census Bureau data. I GAO-19-330

[a]2013-2017 estimates from the American Community Survey. Margins of error are within 5 percent of numeric estimates or 5 percentage points of percentages unless otherwise noted.

Reported challenges to accessing services

Key challenges: Limited transportation, long distances and dispersed population, and provider workforce shortages.

- **Limited transportation:** Regional transportation service is available, but limited. Taxi services are very limited and there are no ride sharing services available, such as Uber or Lyft. Roads are winding and indirect, and may be inaccessible in winter.

- **Long distances and dispersed population:** The distance from a rural community to a hub town can be 25 to 50 miles. Service providers may not travel long distances to serve one rural customer.

- **Provider workforce shortages:** The younger adult population has been in decline, leaving industries in the area with a shortage of staff, including service providers. For instance, the shortage of doctors requires older adults to travel long distances for medical care.

Reported mitigating strategies

- Soliciting volunteers through the Retired and Senior Volunteer Program to visit older adults with limited informal support and help reduce their social isolation.

- Collaborating with the Maine Commission for Community Service to learn how to better leverage volunteers.

- Using a grant from the Maine Health Access Foundation to provide additional services, including adult day care, which they have continued to provide since the grant ended. Also, collaborating with local hospitals to reduce readmission.

Sources: GAO interviews with local officials and information from area plans (text); GAO (map). | GAO-19-330

Maine: Eastern AAA
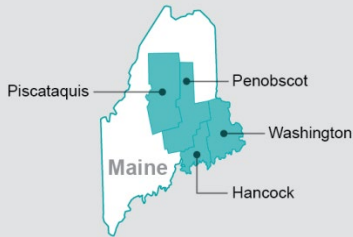
Area at a glance

County served: Hancock, Penobscot, Piscataquis, and Washington Counties.

Extent rural: All four counties covered by the Eastern AAA are at least partly rural. Penobscot county is home to Bangor, the most urban part of the area, while Washington County on the coast is entirely rural.

Racial/ethnic groups: Most of the county's population is White, with a small American Indian population in Washington County and very small representation from other groups.

Services provided: The AAA provides most services directly, including home-delivered meals, information and assistance, wellness classes, and caregiver services. Most congregate meal sites are also run by the AAA, but some are run by outside providers. The AAA also offers minor home repair through a combination of grant funds, client fees, and volunteers. AAA officials told us the greatest need is for nutrition services, particularly home-delivered meals.

"The AAA does not offer homemaker services because we know that Medicaid providers of these services already struggle to find enough working-age adults to hire."—Eastern AAA official

"Mainers have a lot of pride and will tough it out rather than ask for help."

"Older adults in some areas do not want help from outsiders, including AAA staff from Bangor."

—Two Eastern AAA officials

Area in context

	Maine	Eastern AAA
Population density, 2010 *(people per square mile)*	43.1	22.5 *(4.4 to 45.3 per county)*
Number of older adults, 2017[a] *(aged 65+)*	250,131	49,204
Older adults as percent of population[a]	18.8%	19.3% *(16.9% to 24.6% per county)*
Number of older adults living in rural areas[a]	137,588	27,026
Percent of older adults living in rural areas[a]	55.0%	54.9% *(23.9% to 100.0% per county)*
Percent of older adults living below poverty level[a]	8.8%	9.0% *(8.1% to 11.4% per county)*

Source: GAO analysis of U.S. Census Bureau data. I GAO-19-330
[a] 2013-2017 estimates from the American Community Survey. Margins of error are within 5 percent of numeric estimates or 5 percentage points of percentages unless otherwise noted.

Reported challenges to accessing services

Key challenges: Limited transportation, housing, and broadband infrastructure; provider workforce shortages; and coordination with other local agencies.

- **Limited transportation:** Transportation services are very limited outside of Bangor. Severe weather also creates travel challenges in delivering meals to people's homes.

- **Housing in disrepair:** Older housing in disrepair creates safety hazards. The most rural county in the area, Washington, has limited low-income housing.

- **Limited broadband:** Many households and some senior centers in the area have little to no access to broadband internet.

Reported mitigating strategies

- Participating in a local Farm Share program so that home-delivered meal clients in certain locations receive fresh produce along with their frozen meals.

- Recruiting volunteers already living in remote areas to provide caregiver training in their communities.

- Allowing caregivers to hire respite care providers from their own community, with reimbursement from state funds through the AAA.

- Piloting an outreach program, partnering with various local businesses (e.g., banks, hairdressers, fire department) to help distribute information on resources to older adults.

Sources: GAO interviews with local officials and information from area plans (text); GAO (map). | GAO-19-330

Pennsylvania: Potter County AAA
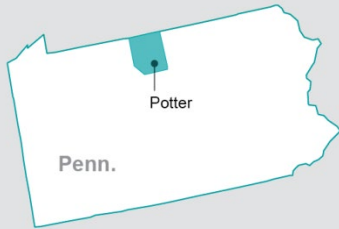
Area at a glance

County served: Potter County.

Extent rural: Potter County is entirely rural with a few small towns, such as Coudersport, the county seat.

Racial/ethnic groups: Most of the county's population is White, with very small representation from other groups.

Services provided: The AAA provides several services through contracted providers, including home-delivered meals, transportation, and in-home personal care. Congregate meals are provided at four senior centers run by the AAA. The AAA supplements OAA funds with donations and a sliding scale fee for all services except meals and transportation, among other sources. AAA officials told us the highest demand is for congregate and home-delivered meals.

"We have difficulty getting personal care providers to serve rural older adults. It is not cost-effective for providers to travel 45 minutes for an hour or two of service, especially when winter weather makes the trip more difficult."
—Potter County AAA official

"One of the most critical unmet needs is transportation to places other than doctors' appointments— for example, to pick up groceries or prescriptions or shop for clothes. It's one of the issues we get the most calls about."—Potter County AAA official

Area in context

	Pennsylvania	Potter County
Population density, 2010 *(people per square mile)*	283.9	16.1
Number of older adults, 2017[a] *(aged 65+)*	2,181,022	3,791
Older adults as percent of population[a]	17.1%	22.2%
Number of older adults living in rural areas[a]	314,029	3,791
Percent of older adults living in rural areas[a]	14.4%	100.0%
Percent of older adults living below poverty level[a]	8.2%	9.6%

Source: GAO analysis of U.S. Census Bureau data. I GAO-19-330

[a]2013-2017 estimates from the American Community Survey. Margins of error are within 5 percent of numeric estimates or 5 percentage points of percentages unless otherwise noted.

Reported challenges to accessing services

Key challenges: Limited transportation, disincentives for providers, and housing in disrepair.

- **Limited transportation:** Public transportation is limited to towns. Due to limited resources, the AAA can only provide senior transportation for medical appointments and not for other needs.

- **Disincentives for providers:** Providers are reluctant to travel long distances to rural areas for limited hours of work.

- **Housing in disrepair:** Older adults need home repair and modifications, which the AAA is unable to provide. For those wanting to move, low-income and senior housing communities have long wait lists.

Reported mitigating strategies

- Reaching out to churches and neighbors to provide older adults with transportation. They have also coordinated with the National Kidney Foundation and American Cancer Society on medical transportation for older adults with those health issues.

- Participating in a state program that allows caregivers to hire someone in their community to provide respite care and receive reimbursement from the AAA.

- Referring older adults needing home repairs to Habitat for Humanity.

Sources: GAO interviews with local officials and information from area plans (text); GAO (map). | GAO-19-330

Wisconsin: Iron County

Area at a glance

County served: Iron County. The Greater Wisconsin Agency on Aging Resources oversees 70 of 72 counties in the state and contracts with aging offices in each county it oversees, including Iron County, to provide services.

Extent rural: Iron County is entirely rural. Much of the population lives in Hurley, the county seat.

Racial/ethnic groups: Most of the county's population is White, with very small representation from other groups.

Services provided: The county aging unit provides all services directly, including transportation, congregate meals, and home-delivered meals. The aging office is integrated with the county Aging and Disability Resource Center, which provides information and assistance to both older adults and persons with disabilities who call in need of services and resources.

"Because the area is so spread out, we may not learn that an older adult is struggling until they are in crisis."—Iron County aging unit official

"Many older adults in the county are low-income. The challenge is to make sure they are connected to all the funding sources available to them to limit the amount they pay out of pocket."—Iron County aging unit official

Area in context

	Wisconsin	Iron County
Population density, 2010 *(people per square mile)*	105.0	7.8
Number of older adults, 2017[a] *(aged 65+)*	896,724	1,643[b]
Older adults as percent of population[a]	15.6%	28.6%
Number of older adults living in rural areas[a]	307,869	1,643[a]
Percent of older adults living in rural areas[a]	34.3%	100.0%
Percent of older adults living below poverty level[a]	7.7%	7.0%

Source: GAO analysis of U.S. Census Bureau data. I GAO-19-330

[a]2013-2017 estimates from the American Community Survey. Margins of error are within 5 percent of numeric estimates or 5 percentage points of percentages unless otherwise noted.
[b]Margin of error is 7.1 percent of the estimate.

Reported challenges to accessing services

Key challenges: Limited transportation, housing shortages, and coordination across state boundaries.

- **Limited transportation:** The county has struggled to extend bus service to the more rural areas, where sparse population makes it difficult to get enough riders. Heavy snow in the winter makes it difficult for older adults to leave the house for services and to ensure driver safety in delivering meals to homebound older adults.

- **Housing shortages:** The county has no assisted living facility, leaving older adults with fewer options to age in the community. Older adults needing low-income housing face long wait lists. For older adults in crisis, the nearest homeless shelter is 100 miles away.

- **Cross-border coordination challenges:** The closest hospital is in Michigan, which can make coordination between the hospital and Iron County agencies challenging when it comes to obtaining services for individuals with dementia or mental health crises.

Reported mitigating strategies

- Using a bus and van owned by the county for senior transportation to the hospital, shopping centers, and meal sites, even in areas not served by public transit.

- Maintaining close communication with low-income housing managers to learn of any new housing that becomes available.

- Referring older adults who are struggling to stay in their homes to rental, energy, and heating assistance programs.

Sources: GAO interviews with local officials and information from area plans (text); GAO (map). | GAO-19-330

North Dakota: Region VI

N. Dakota

Wells, Foster, Griggs, Stutsman, Barnes, Logan, La Moure, McIntosh, Dickey
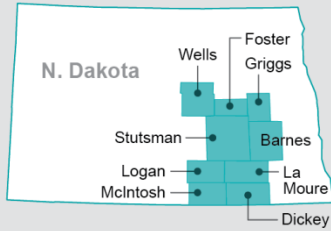
Area at a glance

Counties served: Barnes, Dickey, Foster, Griggs, LaMoure, Logan, McIntosh, Stutsman, and Wells Counties.

Extent rural: The nine counties in Region VI are entirely rural, although more populated areas exist in hubs such as Jamestown.

Racial/ethnic groups: Most of the population in these counties is White, with very small representation from all other groups.

Services provided: North Dakota administers aging services at the state level, as well as through eight regional offices, rather than through AAAs. Many services are provided through other entities: Transportation services are through a cooperative agreement with the state Department of Transportation; home-delivered and congregate meal services through providers in each region; and health maintenance services through the state's public health units. Information and assistance services are provided directly through one toll-free number serving the entire state.

"We get an uptick in calls during the holidays, when adult children come home to visit and find their parents in need of help."—Region VI aging official

"Qualified service providers may indicate to the state that they are willing to serve the more remote counties, but in reality they won't want to travel that far. I have a list of about seven people who said they would serve McIntosh County, but only one would serve someone in [remote] Ashley."—McIntosh County Social Services official

Area in context

	North Dakota	Region VI
Population density, 2010 *(people per square mile)*	9.7	5.3 *(2.0 to 9.5 per county)*
Number of older adults, 2017[a] *(aged 65+)*	107,196	12,049
Older adults as percent of population[a]	14.4%	21.7% *(17.8% to 32.1% per county)*
Number of older adults living in rural areas[a]	63,259	12,049
Percent of older adults living in rural areas[a]	59.0%	100.0% *(100.0% for all counties)*
Percent of older adults living below poverty level[a]	8.9%	9.2% *(5.1% to 16.6% per county)*

Source: GAO analysis of U.S. Census Bureau data. I GAO-19-330

[a]2013-2017 estimates from the American Community Survey. Margins of error are within 5 percent of numeric estimates or 5 percentage points of percentages unless otherwise noted.

Reported challenges to accessing services

Key challenges: Limited health care and transportation infrastructure; shortages of paid providers, family caregivers, and volunteers.

- **Limited health care and transportation infrastructure:** Rural older adults often travel long distances for medical care, and local transit is frequently unavailable to make these trips.

- **Provider workforce shortage:** There is a shortage of providers, especially to serve remote areas.

- **Shortage of family caregivers and volunteers:** Working-age adults move out of the area and are not available to care for their aging parents. As the population ages, some areas are having difficulty finding volunteers, and existing volunteers are often older themselves.

Reported mitigating strategies

- Subsidizing the cost of senior transporation with revenue from service contracts with companies to transport employees.

- Working with nurses who provide health maintenance services to help older adults plan their medical appointments around the bus schedule.

- Taking advantage of state programs that allow older adults' friends and family to receive reimbursement for providing care, and providing a higher pay rate for workers who travel further to provide care.

Sources: GAO interviews with state and local officials and information from state plan (text); GAO (map). | GAO-19-330

North Dakota: Region VIII
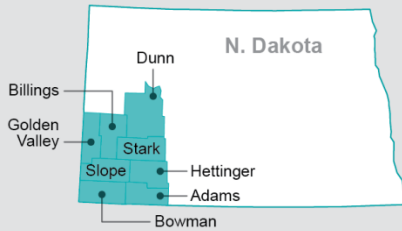
Area at a glance

Counties served: Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope, and Stark Counties.

Extent rural: The eight counties in Region VIII are entirely rural, although more populated areas exist in hubs such as Dickinson.

Racial/ethnic groups: Most of the population in these counties is White, with a sizeable American Indian minority in Dunn County and very small representation from all other groups.

Services provided: North Dakota administers aging services at the state level, as well as through eight regional offices, rather than through AAAs. Many services are provided through other entities: Transportation services are through a cooperative agreement with the state Department of Transportation; home-delivered and congregate meal services through providers in each region; and health maintenance services through the state's public health units. Information and assistance services are provided directly through one toll-free number serving the entire state.

"Several counties have no service providers; the workforce is simply not there unless someone living on a nearby farm or ranch decides to become a provider."—Region VIII aging official

"We see a lot of older adults who are depressed because they are homebound. They cannot drive and are at the mercy of the transit system. When they do go out, they are limited to going to the pharmacy or grocery store."
—Region VIII service provider

Area in context

	North Dakota	Region VIII
Population density, 2010 *(people per square mile)*	9.7	3.9 *(0.6 to 18.1 per county)*
Number of older adults, 2017[a] *(aged 65+)*	107,196	7,145
Older adults as percent of population[a]	14.4%	15.4% *(12.8% to 25.3% per county)*
Number of older adults living in rural areas[a]	63,259	7,145
Percent of older adults living in rural areas[a]	59.0%	100.0% *(100.0% for all counties)*
Percent of older adults living below poverty level[a]	8.9%	11.1% *(6.1% to 14.4% per county)*

Source: GAO analysis of U.S. Census Bureau data. I GAO-19-330

[a]2013-2017 estimates from the American Community Survey. Margins of error are within 5 percent of numeric estimates or 5 percentage points of percentages unless otherwise noted.

Reported challenges to accessing services

Key challenges: Limited health care, transportation, and other infrastructure; shortages of family caregivers, volunteers, and paid providers.

- **Limited health care, transportation, and other infrastructure:** Older adults in more remote parts of the region often travel long distances for medical care, grocery shopping, and other needs, and local transit is frequently unavailable to make these trips. Older adults may also have to travel long distances to even reach transit services.

- **Shortage of family caregivers and volunteers:** Some working-age adults move out of the area and are not available to care for their aging parents or serve as volunteers. Volunteers of any age are difficult to find.

- **Paid provider shortage:** The number of service providers varies by county, with some counties having very few or none.

Reported mitigating strategies

- Offering congregate meals in local restaurants with the Café 60 program, making it easier to offer meals in sparsely populated areas.

- Offering refrigerated meals to older adults in remote areas via FedEx through national provider Mom's Meals.

- Taking advantage of state programs that allow older adults' friends and family to receive reimbursement for providing care, and providing a higher pay rate for workers who travel further to provide care.

Sources: GAO interviews with state and local officials and information from state plan (text); GAO (map). | GAO-19-330

Mississippi: North Delta AAA
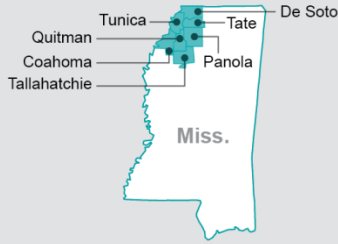
Area at a glance

Counties served: Coahoma, DeSoto, Panola, Quitman, Tallahatchie, Tate, and Tunica Counties.

Extent urban/rural: The North Delta AAA covers some communities in the northern counties that are suburbs of Memphis, TN, but much of the area is rural. The most rural counties, including Tallahatchie and Quitman also have the highest percentages of older adults in poverty (about 15 to 20 percent in 2013-2017 estimates).

Racial/ethnic groups: Five of the seven counties, including Tallahatchie and Quitman, have majority Black populations, while the rest are majority White. All counties have small representation from other groups as well.

Services provided: The AAA provides some services directly, such as congregate meals. The AAA provides other services via contracted providers, including transportation and home-delivered meals. AAA officials reported that meal delivery is their most requested service, followed by homemaker services, which they fund through the Social Services Block Grant.

"Home-delivered meal routes vary in length, but the average is between 100 and 175 miles per day."—North Delta provider

"Some people live in homes that are greatly in need of repair. There are few services we can refer them to, and those that exist may have wait lists or eligibility criteria that would keep our clients from getting help."—North Delta provider

Area in context

	Mississippi	North Delta AAA
Population density, 2010 *(people per square mile)*	63.2	78.8 *(20.3 to 338.7 per county)*
Number of older adults, 2017[a] *(aged 65+)*	437,027	37,872
Older adults as percent of population[a]	14.6%	12.9% *(10.7% to 15.5% per county)*
Number of older adults living in rural areas[a]	243,044	10,011[b]
Percent of older adults living in rural areas[a]	55.6%	26.4% *(0% to 100.0% per county)*
Percent of older adults living below poverty level[a]	13.1%	10.3% *(6.7% to 20.6% per county)*

Source: GAO analysis of U.S. Census Bureau data. I GAO-19-330

[a]2013-2017 estimates from the American Community Survey. Margins of error are within 5 percent of numeric estimates or 5 percentage points of percentages unless otherwise noted.
[b]Margin of error is 5.6 percent of the estimate.

Reported challenges to accessing services

Key challenges: Limited funding, transportation, and community support.

- **Funding:** Funds are being stretched as the number of older adults grows. Poorer older adults often need more help than the AAA can provide, particularly if they are not on Medicaid.

- **Transportation:** Transportation service outside of an older adult's county can be expensive, and Quitman County has no senior transportation. Rural roads often flood when it rains, making meal delivery difficult.

- **Community resources:** Volunteers are limited in the area, resulting in one AAA staffer providing Medicare counseling for the seven-county area.

Reported mitigating strategies

- Using the state Department of Agriculture's farmer's market voucher program, which offers $25 for low-income older adults once a year.

- Funding additional transportation programs for older adults with counties' local revenues, when greater revenues are available.

- Communicating regularly with other AAAs and service providers as avenues for sharing promising practices.

Sources: GAO interviews with local officials and information from area plans (text); GAO (map). | GAO-19-330

Mississippi: Southwest AAA

Miss.

Claiborne
Franklin
Lincoln
Jefferson
Adams — Lawrence
Wilkinson — Walthall
Amite — Pike

Area at a glance

Counties served: Adams, Amite, Claiborne, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, and Wilkinson Counties.

Extent rural: All counties served by the Southwest AAA are mostly or entirely rural, with some more populated hubs, such as Natchez in Adams County.

Racial/ethnic groups: Adams, Claiborne, Jefferson, Pike, and Wilkinson Counties have majority Black populations. The remaining counties are majority White. All counties have small representation from other groups as well.

Services provided: The AAA provides most services directly, including homemaker services and information and assistance. Transportation services, and congregate and home-delivered meals, are provided through contracted service providers. AAA officials reported that meal delivery is their most-requested service, followed by transportation and homemaker services.

"Some older adults choose not to apply for services if doing so will result in being placed on a long waiting list."—Southwest AAA official

"Many older adults have died while on the waiting list for services."—Southwest AAA official

Area in context

	Mississippi	Southwest AAA
Population density, 2010 *(people per square mile)*	63.2	35.0 (14.4 to 98.8 per county)
Number of older adults, 2017[a] *(aged 65+)*	437,027	30,139
Older adults as percent of population[a]	14.6%	16.8% (14.5% to 21.5% per county)
Number of older adults living in rural areas[a]	243,044	29,480
Percent of older adults living in rural areas[a]	55.6%	97.8% (69.0%[b] to 100.0% per county)
Percent of older adults living below poverty level[a]	13.1%	17.9% (10.1% to 35.3%[c] per county)

Source: GAO analysis of U.S. Census Bureau data. I GAO-19-330

[a] 2013-2017 estimates from the American Community Survey. Margins of error are within 5 percent of numeric estimates or 5 percentage points of percentages unless otherwise noted.
[b] Margin of error is 6.0 percentage points.
[c] Margin of error is 8.8 percentage points.

Reported challenges to accessing services

Key challenges: Added cost of serving a dispersed population, shortage of family caregivers, and serving a growing aging population with limited funds.

- **Added cost of serving a dispersed population:** The travel costs and time required to serve a dispersed population makes services more expensive to provide.

- **Shortage of family caregivers:** Working-age adults are not available to care for their aging parents due to moving out of the area to find jobs and changing priorities around caring for older relatives.

- **Serving a growing aging population with limited funds:** Funding is not sufficient to meet older adults' service needs. For instance, they have over 300 older adults on the waiting list for nutrition services.

Reported mitigating strategies

- Using software that identifies the best travel routes for providers of homemaker services, which allows them to serve dispersed older adults as efficiently as possible.

- Referring older adults on the waiting list for home delivered meals to food pantries, and offering a fee-for-service meal delivery option for those able to pay.

Sources: GAO interviews with local officials and information from area plans (text); GAO (map). | GAO-19-330

Okla.

Pontotoc
Murray   Coal
Garvin   Atoka
Carter   Johnston
Love
Marshall   Bryan

Oklahoma: Southern Oklahoma Development Association AAA
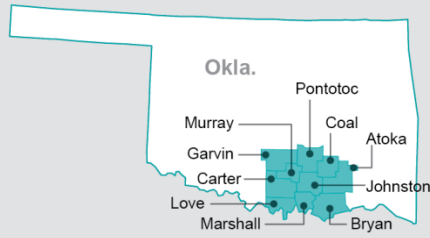
Area at a glance

Counties served: Atoka, Bryan, Carter, Coal, Garvin, Johnston, Love, Marshall, Murray, and Pontotoc Counties.

Extent rural: Most of the 10-county area served by the Southern Oklahoma Development Association (SODA) AAA is rural farmland, with small urban areas in Bryan and Garvin counties.

Racial/ethnic groups: All counties in the area have majority White populations. However, there are also two American Indian tribes in the area: the Chickasaw Nation and Choctaw Nation of Oklahoma. There is also small representation from other groups.

Services provided: The AAA provides all services through contracted service providers. These include medical transportation, nutrition (congregate and home-delivered meals), and health promotion in the form of Tai Chi classes. Chore services are also offered via vouchers that can be used for any provider. AAA officials reported that the highest demand is for transportation and nutrition services.

"The home-delivered meal and chore service programs rely on volunteers, and as a result some older adults may not be able to receive these services. It is more difficult to find volunteers in sparsely populated areas."—SODA AAA official

"Transportation is the AAA's number one challenge in serving older adults because it has limited funding for transportation and serves a large geographic area."—SODA AAA official

Area in context

	Oklahoma	SODA AAA
Population density, 2010 *(people per square mile)*	54.7	33.7 *(11.5 to 57.8 per county)*
Number of older adults, 2017[a] *(aged 65+)*	574,330	39,950
Older adults as percent of population[a]	14.7%	17.4% *(15.8% to 21.7% per county)*
Number of older adults living in rural areas[a]	253,756	37,824
Percent of older adults living in rural areas[a]	44.2%	94.7% *(77.5% to 100.0% per county)*
Percent of older adults living below poverty level[a]	8.8%	10.6% *(6.7% to 18.1% per county)*

Source: GAO analysis of U.S. Census Bureau data. I GAO-19-330

[a]2013-2017 estimates from the American Community Survey. Margins of error are within 5 percent of numeric estimates or 5 percentage points of percentages unless otherwise noted.

Reported challenges to accessing services

Key challenges: Limited transportation, added cost of serving a dispersed population, and limited funding.

- **Limited transportation:** Public transportation is only available in urban areas. Due to funding limitations, the AAA limits senior transportation services to medical appointments, leaving older adults to find their own transportation to other places, such as the grocery store or congregate meal sites.

- **Added cost of serving a dispersed population:** Travelling long distances to rural locations adds to the cost of services, particularly for staff or volunteers conducting outreach to rural older adults.

- **Limited funding:** State budget cuts mean that funding for several services runs out quickly. For example, last year's funding for respite care ran out in one month.

Reported mitigating strategies

- Reducing staff travel by providing multiple services—for example, Medicare counseling and congregate meals—at one location. Staff also share rides with personnel from other agencies, when possible.

- Leveraging state and private funding sources to provide additional services, including funds from a state program to provide additional meals and donations from Masonic lodges to provide dental services, ramps to improve home accessibility, and other services.

Sources: GAO interviews with local officials and information from area plans (text); GAO (map). | GAO-19-330

New Mexico: Mora County

Mora

New
Mexico

Area at a glance

Counties served: Mora County. The Non-Metro AAA serves 32 of the 33 counties in New Mexico (all but Bernalillo County and the City of Albuquerque).

Extent rural: Mora County is entirely rural and populated with small communities that are 70 or more miles from the nearest large town.

Racial/ethnic groups: Most of the county's population is Hispanic, with a sizeable non-Hispanic White minority, as well as a small American Indian population and very small representation from other groups.

Services provided: Counties are served through different local providers across the AAA. For Mora County, the AAA contracts with a provider located in a neighboring county (Colfax) to provide aging services to both counties, including transportation services, and congregate and home-delivered meals. This provider is also expected to provide older adults in the area with information and assistance on obtaining services.

"Hunger is a widespread issue in New Mexico, and the single daily meal that nutrition programs provide may not be sufficient to meet older adults' needs. Providers hear from older adults that the meal they receive is their only hot meal of the day, or even their only meal period."—Non-Metro AAA official

"Rural communities cannot take advantage of competitive pricing from vendors because there is often only one vendor."—Non-Metro AAA official

Area in context

	New Mexico	Mora County
Population density, 2010 *(people per square mile)*	17.0	2.5
Number of older adults, 2017[a] *(aged 65+)*	328,682	997[b]
Older adults as percent of population[a]	15.8%	21.7%[c]
Number of older adults living in rural areas[a]	111,606	997[b]
Percent of older adults living in rural areas[a]	34.0%	100.0%
Percent of older adults living below poverty level[a]	11.9%	14.1%

Source: GAO analysis of U.S. Census Bureau data. I GAO-19-330

[a]2013-2017 estimates from the American Community Survey. Margins of error are within 5 percent of numeric estimates or 5 percentage points of percentages unless otherwise noted.
[b]Margin of error is 25.4 percent of estimate.
[c]Margin of error is 5.5 percentage points.

Reported challenges to accessing services

Key challenges: Limited transportation to travel long distances, inadequate housing, and growing aging population.

- **Limited transportation to travel long distances:** Some transportation is available within the county, but is very limited for the longer distances often required for older adults to get to medical appointments or shopping centers. Also, dirt roads, which sometimes flood, can hamper delivery of meals to homebound older adults.

- **Housing disrepair and limited supply:** Older homes need restoration services, which the AAA does not have funds to provide. Assisted living facilities and other housing options are limited in rural areas, and rural older adults willing to move often cannot afford to pay the higher cost of housing in urban areas.

- **Growing aging population:** State funding has not kept up with the growing aging population, and local revenue is limited due to the low incomes of the population.

Reported mitigating strategies

- Using the assistance of local law enforcement with their four-wheel-drive vehicles to deliver meals when roads flood.

- Using volunteers to help the local service provider make meal deliveries to older adults in very remote areas.

- Partnering with the state Department of Health to encourage residents to donate their garden vegetables so that older adults attending congregate meals can take them home.

Sources: GAO interviews with local officials and information from area plans (text); GAO (map). | GAO-19-330

California: Area 2 Agency on Aging

Area at a glance

Counties served: Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties.

Extent rural: Modoc, Siskiyou, and Trinity counties are completely rural. Lassen County is largely rural with small urban areas, and Shasta County is primarily urban. The service area is large—over 22,000 square miles—and includes mountainous terrain.

Racial/ethnic groups: The majority of the population in the area is White, with a sizeable Hispanic minority, as well as a small American Indian population and very small representation from other groups.

Services provided: Most services, including nutrition (home-delivered and congregate meals) and transportation are delivered through contracted service providers. The AAA directly provides information and assistance to connect older adults to services in all its counties except Shasta, where it provides these services through a contractor.

"In some counties, no providers have applied for funding to carry out certain services, which means those services are not available in those areas. For example, homemaker services are only available in one of the five counties for this reason."—Area 2 official

"Older adults who live outside our service area have called requesting rides to medical appointments. We have to tell them we aren't able to serve them. We suggest they try to find a friend, neighbor, or family member to drive them, but that can be a challenge for some people."
—Area 2 service provider

Area in context

	California	Area 2
Population density, 2010 *(people per square mile)*	239.1	12.9 *(2.5 to 46.9 per county)*
Number of older adults, 2017[a] *(aged 65+)*	5,147,456	54,453
Older adults as percent of population[a]	13.2%	19.7% *(12.7% to 25.5% per county)*
Number of older adults living in rural areas[a]	372,595	21,139
Percent of older adults living in rural areas[a]	7.2%	38.8% *(5.2% to 100.0% per county)*
Percent of older adults living below poverty level[a]	10.2%	8.7% *(7.0% to 13.0% per county)*

Source: GAO analysis of U.S. Census Bureau data. I GAO-19-330
[a]2013-2017 estimates from the American Community Survey. Margins of error are within 5 percent of numeric estimates or 5 percentage points of percentages unless otherwise noted.

Reported challenges to accessing services

Key challenges: Limited transportation, housing disrepair and limited supply, growing aging population, and provider workforce shortage.

- **Limited transportation to travel long distances:** Some within-county transportation is available, but not for the longer distances often required for older adults to attend medical appointments. Winter weather and winding mountain roads hamper travel for both older adults and service providers.

- **Housing disrepair and limited supply:** Many older adults' homes are older and need repair, for which local resources are limited. Recent wildfires have destroyed over a thousand homes. For those willing or needing to move, older adult housing facilities have long wait lists.

- **Growing aging population:** Large numbers of older adults are moving into the area to retire, straining the AAA's limited resources. Constrained funding means providers often cannot serve some areas, despite the need for services in those areas.

Reported mitigating strategies

- Putting transportation funding into vouchers allowing older adult to use the local bus system, which one local provider found to be more economical than running a separate program.

- Extending services of a local provider by soliciting food donations, applying for grants, and raising funds through a thrift store.

Sources: GAO interviews with local officials and information from area plans (text); GAO (map). | GAO-19-330

California: Area 12 Agency on Aging

Area at a glance

Counties served: Alpine, Amador, Calaveras, Mariposa, and Tuolumne Counties.

Extent rural: Alpine and Mariposa Counties are entirely rural, and the remaining counties are largely so, with a few more urban areas.

Racial/ethnic groups: The majority of the population in the area is White, with a growing Hispanic minority, and very small representation from other groups.

Services provided: Transportation, nutrition (congregate and home-delivered meals), and legal services are provided through contracted service providers. Other services, including wellness classes, minor home repair, chore, homemaker and information and assistance on obtaining services are provided directly by the AAA.

"People in the communities we serve may be very isolated, without power or phones. It is important for the AAA to conduct outreach in these areas, but staff are unable to travel to remote areas due to budget cuts."—Area 12 official

"Older adults who do not have access to transportation may face social isolation, which can lead to loneliness and depression. The suicide rate for older adults is higher in the more isolated parts of our service area. Those who struggle to find transportation to medical care, which may be 20 or even 70 miles away, may not go to the doctor as often as they need to."—Area 12 Advisory Council member

Area in context

	California	Area 12
Population density, 2010 *(people per square mile)*	239.1	26.3 *(1.6 to 64.1 per county)*
Number of older adults, 2017[a] *(aged 65+)*	5,147,456	39,053
Older adults as percent of population[a]	13.2%	25.2% *(24.1% to 27.5%[b] per county)*
Number of older adults living in rural areas[a]	372,595	32,835
Percent of older adults living in rural areas[a]	7.2%	84.1% *(72.4% to 100.0% per county)*
Percent of older adults living below poverty level[a]	10.2%	6.6% *(3.9% to 9.5% per county)*

Source: GAO analysis of U.S. Census Bureau data. I GAO-19-330

[a]2013-2017 estimates from the American Community Survey. Margins of error are within 5 percent of numeric estimates or 5 percentage points of percentages unless otherwise noted.
[b]Margin of error is 5.9 percentage points.

Reported challenges to accessing services

Key challenges: Limited transportation, added cost of serving a dispersed population, provider workforce shortage, and housing disrepair and limited supply.

- **Limited transportation:** Isolated communities have limited or no access to public transportation. The AAA cannot afford to provide out-of-county medical transportation, which is an unmet need.

- **Added cost of serving a dispersed population:** Traveling to older adults in remote areas adds to costs for providers and AAA staff.

- **Housing disrepair and limited supply:** For older adults who own homes, many of the homes are older and need repair, and some older adults struggle to pay property taxes. For others, low-income senior housing facilities have long wait lists, and an increasing number of older adults are homeless.

Reported mitigating strategies

- Working with community organizations to develop lists of transportation options in each county, which the AAA distributes at key locations.

- Employing various strategies to extend senior transportation, including recruiting volunteers, utilizing transportation grants, and considering ways to reimburse family and friends for out-of-town medical rides.

- Leveraging community resources to find both paid and volunteer workers.

Sources: GAO interviews with local officials and information from area plans (text); GAO (map). | GAO-19-330

Appendix VI: Comments from the Department of Health and Human Services

MAY 0 1 2019

Kathryn A. Larin
Director, Education, Workforce and
  Income Security Issues
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Larin:

Attached are *comments* on the U.S. Government Accountability Office's (GAO) report entitled, *"Older Americans Act: HHS Could Help Rural Service Providers by Centralizing Information on Promising Practices"* (GAO-19-330).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Matthew D. Bassett
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN
SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT
REPORT ENTITLED – OLDER AMERICANS ACT: HHS COULD HELP RURAL
SERVICE PROVIDERS BY CENTRALIZING INFORMATION ON PROMISING
PRACTICES (GAO-19-330)**

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the
Government Accountability Office (GAO) to review and comment on this draft report.

Recommendation 1
The Administrator of ACL should take steps to better centralize access to and promote awareness
of information on promising practices or other useful information pertinent to serving rural older
adults.

HHS Response
HHS concurs with GAO's recommendations

The Administration for Community Living acknowledges GAO's finding that we are well-
positioned to help facilitate information sharing through our website and our many resource
centers. To enhance the ability of organizations and individuals to access information that may
be helpful to address rural challenges, in the future we will encourage resource centers to identify
promising practices and information that is specific to rural communities so that it is searchable
from their websites.

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Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

Kathryn A. Larin, 202-512-7215, larink@gao.gov

Staff Acknowledgments

In addition to the contact above, Margie K. Shields (Assistant Director), Theresa Lo (Analyst-in-Charge), Caroline DeCelles, and Lauren Gilbertson made key contributions to this report. Also contributing to this report were James Bennett, David Dornisch, Holly Dye, Laura Hoffrey, LaToya King, Won Lee, John Mingus, Thomas Moscovitch, Ellen Phelps Ranen, Almeta Spencer, Rachel Stoiko, Adam Wendel, and Amber Yancey-Carroll.

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