



Trends and New Directions Area Agencies on Aging Survey 2014



National Association of
Area Agencies on Aging



MIAMI UNIVERSITY
SCRIPPS GERONTOLOGY CENTER

The mission of the National Association of Area Agencies on Aging (n4a) is to build the capacity of its members so that they can better help adults and people with disabilities live with dignity and choices in their homes and communities for as long as possible. We work with our members to achieve the collective vision of building a society that values and supports people as they age.

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Executive Summary

Today, there are 618 Area Agencies on Aging (AAAs), which help vulnerable adults aged 60+ in virtually every community in the nation live with dignity and independence in their homes and communities for as long as possible.



Established under the Older Americans Act (OAA) in 1973, AAAs operate a complex service delivery system that provides access to home and community-based services for older adults. These agencies play a key role in developing, funding, coordinating and delivering a wide range of long-term services and supports to consumers in their local planning and service area (PSA) including information and referral, congregate and home-delivered meals, health and wellness programs, in-home care, transportation, elder abuse prevention, caregiver support, adult day care and more.

With a service portfolio that has expanded to include integrated care, Medicaid managed care and care transition to help older adults make a successful transition from hospital to home, AAAs are increasingly positioning themselves as a critical source of support for older adults, caregivers and people with disabilities of all ages.

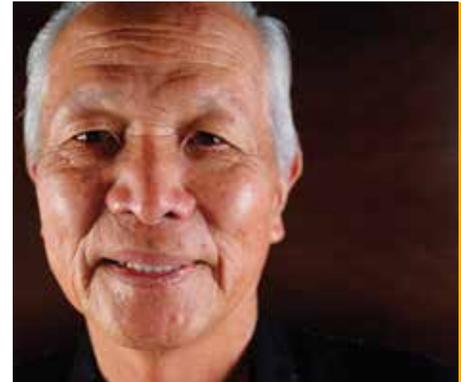
With a grant from the U.S. Administration for Community Living (ACL), the National Association of Area Agencies on Aging (n4a) partnered with Scripps Gerontology Center of Excellence to learn how AAAs are adapting, enhancing and expanding their operations and services to meet the current and future needs of their communities. In July 2013, a web-based survey was distributed to the 613 AAAs that could be contacted via e-mail. Data collection concluded in September 2013, with 63 percent (n=391) of AAAs responding.

Survey

The 2013 National Aging Network Survey of Area Agencies on Aging was designed to assess the evolving role of AAAs in a balanced long-term care system, especially their position in the new health care delivery system. The survey sought to learn more about AAAs' involvement in the following:

- Transition and diversion services to return and maintain individuals in the community
- Medicaid managed care
- Integrated care
- Sustainability strategies and business development

The survey results also highlight how AAAs are changing their services in response to changing demographics and funding environments. Significant findings are summarized in the following pages.



Building upon nearly five decades of experience providing older Americans with the support they need to live with dignity and independence, AAAs are taking advantage of opportunities to broaden their service offerings in the long-term and health care delivery systems.

Changing Services

Population and Services:

Despite the word “aging” in their name, today’s AAAs are serving a broader population base, including people under age 60 who qualify because of disability, impairment or chronic illness. Over three-quarters of AAAs (76.7 percent) provide at least one service to consumers under age 60. Nearly 30 percent of AAAs deliver services to veterans, a small increase from 2010, and almost 60 percent of AAAs serve caregivers of all ages.

In addition to core OAA services, AAAs are most likely to offer evidence-based health promotion and disease prevention programs (90 percent), insurance counseling (85 percent), case management (82 percent), respite care (79 percent) and assessment for care planning (70 percent).



Single Point of Entry:

Connecting to needed services, especially during times of crisis, can be a daunting task for people of any age. To respond to that need, in addition to serving seniors, a growing number of AAAs provide streamlined access to at least one service for consumers under age 60 who qualify because of disability, impairment or other chronic illness (78 percent); caregivers of all ages (76 percent); other consumers under age 60 (51.2 percent); and veterans of all ages (49.9 percent).

Aging and Disability Resource Center (ADRC):

ADRCs were created to serve as a highly visible and trusted place where people of all ages, incomes and disabilities go to get information and one-on-one, person-centered counseling on the full range of long-term services and supports (LTSS) options. The proportion of AAAs that also function as an ADRC, connecting older adults, people with disabilities and their caregivers with community resources and services, has increased to nearly three-quarters (72.1 percent). That number increased significantly from 2008, when fewer than 1 in 10 (8.7 percent) performed ADRC functions.

Partnerships:

AAAs are ideal partners for local organizations working to improve home and community-based services and LTSS. On average, AAAs have 11 informal partnerships—most commonly with long-term care facilities (65.5 percent), emergency preparedness agencies (59.1 percent) and advocacy organizations (57.3 percent)—and five formal partnerships—most often with State Health Insurance Assistance

Programs (SHIPs) (68.8 percent), transportation agencies (52.4 percent) and Medicaid (51.9 percent).

Livable Communities:

Recognizing the important role that community infrastructure plays in supporting the quality of life of people as they age, more than 70 percent of AAAs have taken steps to develop Livable Communities for all ages; they meet with other public entities to address housing, transportation, land use, workforce development and other key development issues, as well as leading or participating in planning efforts at the community level.

Health:

AAAs offer a range of health-related services that provide a critical bridge between the acute care services provided in medical settings and the health needs of older adults when they are at home. Nearly all AAAs—more than 90 percent—deliver at least one evidence-based health promotion program or service, and the proportion of AAAs offering these programs and services continues to grow. Just five years earlier, only 56 percent of AAAs were involved in health programming.

Elder Abuse:

Elder abuse is a growing epidemic in the United States. To respond to elder mistreatment, more than 98 percent of AAAs provide at least one service or program designed to address elder abuse, and 55 percent of all AAAs are involved in an elder abuse prevention coalition or multidisciplinary team; this is an increase of nearly 10 percent since 2008 (45.9 percent).



Transition and Diversion Services:

The number of AAAs providing diversion programs, to keep people living in their homes longer, has risen steadily in recent years. While more AAAs currently provide programs and services for diversion than for transition, it is common for AAAs to provide both services. Nearly 80 percent of AAAs providing transition programs and services also provide diversion programs and services—an increase of nearly 10 percent since 2010.

In 2008, less than one-third of AAAs provided diversion programs and services. Today, more than 70 percent

of AAAs are doing so by providing options counseling (77.6 percent), prioritizing services for those at high-risk of nursing home placement (65 percent) and providing supportive decision making (58.1 percent).

Community-based Care Transitions Program:

AAAs are prime partners in the Community-based Care Transitions Program (CCTP), which was created under the Patient Protection and Affordable Care Act (ACA). This program was established to improve care for high-risk Medicare beneficiaries as they are discharged from the hospital, preventing unnecessary

hospital readmissions and avoidable health care costs. To receive funding for the program, administered by the Centers for Medicare and Medicaid Services (CMS), hospitals must partner with community-based organizations that can ease patients' return to their homes.

The AAAs that received CCTP awards are connecting patients and families to non-medical community health support facilities (58.3 percent), providing home-delivered meals (53.1 percent), providing caregiver education (52.1 percent) and more.



Medicaid Managed Care:

As the majority of states are undergoing a dramatic shift in the way they deliver Medicaid, moving to a managed care system, AAAs are uniquely positioned to help. Concerns have been raised that most MCOs do not have experience with the complexity of programs and systems of coordinated care needed to deliver LTSS; this may increase the likelihood of disruptions in LTSS affecting people who are elderly, frail, disabled and economically disadvantaged. By partnering with health plans and managed care organizations, AAAs can ensure that, while costs are reduced, quality of services remain high.

Yet this critical integration is not happening in all states. Nearly half of AAAs are not involved in their state's planning and/or implementation, with 32 percent involved. Of the AAAs

who are involved, the most commonly planned or implemented activities are conducting intake and ongoing assessment (57.9 percent), providing caregiver support (50.4 percent), providing care management (48.8 percent), providing care transitions services from hospital to home (47.9 percent) and assisting in transitioning residents from nursing homes to the community (44.6 percent).

Integrated Care:

Integrated care initiatives combine delivery, management and organization of health services related to diagnosis, treatment, care, rehabilitation and health promotion across multiple systems such as behavioral health, LTSS and acute care. More than half of AAAs (55.2 percent) are involved in at least one integrative care initiative, in addition to Medicaid

managed care and CCTP. These initiatives include the Veteran-Directed Home and Community-Based Services (VD-HCBS) (31.9 percent of AAAs) and Section 1115 Medicaid Demonstration Waiver programs (21.8 percent).

Since the last AAA survey in 2010, AAAs have become involved with seven integrated care initiatives: State Duals Demonstration program (28.2 percent of AAAs), CMS Services Innovation Grants (21.8 percent), health homes (16.2 percent), Accountable Care Organizations (ACO) (14.4 percent), State Innovation Models Initiative: Model Design Awards (11.1 percent), primary care or medical homes (10.6 percent) and the CMS Financial Alignment Incentive (3.7 percent).

Sustainability Strategies and Business Development

Tight federal and state budgets make it extremely difficult for the Aging Network to maintain existing services under these traditional funding sources or even contemplate expanding those services to meet the current and future needs of a rapidly growing aging population. OAA funding is not sufficient to cover all of the services a community needs and now there are limited opportunities for growth given budget caps imposed through 2021 under the Budget Control Act of 2011 (BCA).

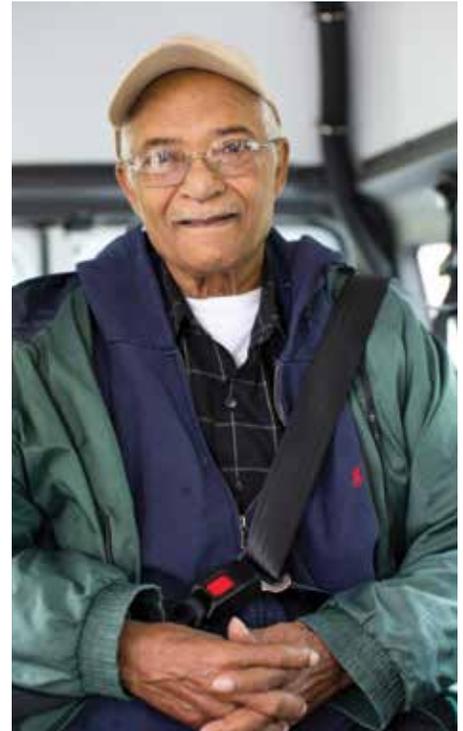
Yet the demand for LTSS is continuing to climb, as more people age and as the economic downturn strains AAA budgets. Nearly half of AAAs reported that their total budget has decreased over the past two years, and less than one-fourth of AAAs have seen a funding increase. Slightly over one-quarter of AAAs saw their total budget remain flat over the previous two years. More than 60 percent of AAAs reported a decrease in OAA dollars over the previous two years.

Nearly all AAAs (98 percent) draw on multiple sources of funding in addition to OAA dollars—most commonly, state general revenue funding, local funding, and Medicaid waiver programs. Yet the state funds on which AAAs rely heavily may also be in jeopardy.

While the average budget of AAAs increased nearly six percent in 2013, making the average budget more than \$9 million, the median budget decreased. More than half of AAAs have a budget below \$3.9 million.

More than 95 percent of AAAs are responding by exploring new funding opportunities (66.4 percent), reducing staff by not replacing those who left (58.9 percent) and instituting waiting lists (58.1 percent).

Increasingly, AAAs are expanding their services through private pay, charging customers who use those services. Nearly 25 percent of all AAAs receive funding from private pay consumers for non-core services. In 2013, more AAAs received funding from private pay customers than in 2010 in almost every service. In the past five years, the proportion of AAAs that are developing private pay practices has grown as well, continuing the trend.



Introduction

As America ages, with the number of people aged 60+ and older expected to double from 2000 to 2030, the nation has an opportunity to help people age with independence and dignity. Area Agencies on Aging (AAAs) help older adults do just that.



An important part of America's long-term services and supports (LTSS) system for more than 40 years, AAAs have been operating in every community in the United States since the Older Americans Act (OAA) established them in 1973.

Each AAA shares a clear mission: Preserve the independence and dignity of older adults by providing services and supports that enable them to remain living in their homes and communities for as long as possible.

While each AAA provides a set of core services under the OAA, including planning and program development, home and community-based services and caregiver support, they also may offer distinct services tailored to the needs of older adults in their community. AAAs coordinate and support a wide range of home and community-based services, including information and referral, meals, in-home care, transportation, employment services, senior centers, adult day care and more. However, as the needs of the target populations, funding landscape, community needs and methods of health care delivery change, so do the challenges and opportunities facing AAAs.

With a grant from the U.S. Administration for Community Living, the National Association of Area Agencies on Aging (n4a) partnered with Scripps Gerontology Center of Excellence to learn how AAAs are enhancing and evolving services to meet community needs in the coming years.

In addition to assessing trends and new directions, the 2013 National Aging Network Survey of Area Agencies on Aging specifically targeted the role of AAAs in a balanced long-term care system, especially their position in the new health care delivery system. The survey sought to learn more about AAAs' involvement in the following:

- Transition and diversion services to return and maintain individuals in the community
- Integrated care
- Medicaid managed care
- Sustainability strategies and business development

The web-based survey was launched in July, 2013 to 613 AAAs—all that could be contacted via e-mail. Data collection concluded in September 2013, with 63 percent (n=391) of AAAs responding.

Where appropriate, the report also provides comparison data from the 2007, 2008 and 2010 surveys to track changes in the Aging Network over time.

These statistics will enable the Aging Network and policymakers to better understand how AAAs are responding to challenges and opportunities today, and what scenarios may be most likely in the future.



Key Findings

This report provides key findings from the survey related to the following topics:

- Serving the needs of a growing population
- Delivering innovative health care
- Preventing elder abuse
- Expanding services and sustainable funding
- Training AAAs for tomorrow

Profile: Today's Area Agency on Aging

The Older Americans Act (OAA) provides the umbrella uniting AAAs in a common mission with a common set of roles and responsibilities to meet the needs of the nation's growing population of older adults and their caregivers.



The OAA emphasizes local control and decision-making and in response, each AAA has evolved in the context of a unique social, economic and political environment. AAAs are flexible and take advantage of emerging opportunities to mount new initiatives or expand services. The 2013 Survey of Area Agencies on Aging identifies four areas in which today's AAAs are focusing their attention.

AAAs Are:

1. Changing services to meet the needs of an expanding consumer base.

- Expanding their service base to include more people under age 60 who qualify because of disability, impairment or chronic illness, plus veterans of all ages
- Adding functions of an Aging and Disability Resource Center
- Offering consumers more self-directed services
- Forming partnerships with managed care/Health Maintenance Organization networks and other health organizations
- Taking steps to develop Livable Communities that address housing, transportation, land use and issues that support people across their lifespan

2. Continuing their focus on keeping people healthy and living in their homes.

- Delivering more evidence-based health promotion and disease prevention programs and services
- Implementing more transition and diversion services
- Improving care for high-risk Medicare beneficiaries being discharged from the hospital, preventing unnecessary re-hospitalizations and avoidable health care costs
- Playing key roles in implementing their state's Managed Long-Term Services and Supports System

3. Keeping older adults safe.

- Increasing involvement in elder abuse prevention coalitions or multi-disciplinary teams
- Leading training and education of community partners to respond to elder abuse, neglect, exploitation and disasters

4. Managing changes in the funding landscape.

- Facing decreasing funding and supplementing federal sequestration funding cuts with state and local funds that are only temporary measures
- Relying heavily on state funds, seeking more support from local funds, developing contracting programs and exploring more private pay opportunities
- Making organizational changes in response to funding changes including seeking new funding, reducing staff and forming waiting lists
- Expanding target groups served and fundraising and development efforts
- Tracking consumer outcomes to show results that can secure future funding



While the mission has not changed, the OAA has broadened the scope of core services provided by all AAAs over time. As the needs of older adults and people with disabilities have evolved, Area Agencies on Aging (AAAs) have adapted, enhanced and expanded their operations and services as well as explored and secured new funding sources.

Serving the Needs of a Growing Population

Area Agencies on Aging (AAAs) help vulnerable adults aged 60+ live with independence and dignity in their homes and communities for as long as possible. To achieve this goal, AAAs provide a range of options to help older adults choose the home and community-based services that meet their needs.



When it established AAAs under the Older Americans Act (OAA) in 1973, Congress authorized AAAs to identify the services that those aged 60 and older most needed in each community, develop plans of action to address those needs, contract for, or provide services and serve as advocates for older Americans. This type of “bottom-up” planning enables the creation of a wide range of services, and consumers can choose those that best meet their individual needs.

Although all AAAs share the OAA as their foundation, there is a great deal of variation in their structure, services and the range of their funding sources.

Over time, the OAA has broadened the scope of core services provided by all AAAs. Additionally, the majority of AAAs have augmented core services with a range of other services financed by various sources. As a result, AAAs now operate a complex service delivery system that provides access to assistance, home and community-based services, in-home and elder rights services, plus more.

AAAs play a key role in developing, funding, coordinating and delivering a wide range of long-term services and supports to consumers in their local planning and service area (PSA) including information and referral, congregate and home-delivered meals, health and wellness programs, in-home care, transportation, elder abuse prevention, caregiver support and adult day care.

AAAs often serve as portals to care, assessing multiple service needs, determining eligibility, authorizing or purchasing services and monitoring the appropriateness and cost-effectiveness of services. In most cases, services are delivered by AAAs through a multitude of contracts with private, public and nonprofit service providers at the local level. It is the role of the AAA to monitor provider contracts to ensure quality of service delivery.

Organizational Infrastructure

Budget:

In 2013, the budget of the average AAA was over \$9 million, a nearly six percent increase from 2010. While the average budget increased, the median budget decreased. More than half of AAAs have a budget below \$3.9 million.

Federal funding is crucial. The average AAA continues to receive about 40 percent of its budget from the OAA. However, the range of OAA support varies significantly. Some AAAs receive all of their funding from the OAA, others receive as little as one percent from that source.



AAAs play a pivotal role in assessing community needs and developing programs that respond to those needs.

According to ACL studies, AAAs also leverage other dollars from federal investments. For each dollar of OAA funding, AAAs leverage nearly \$3 in state, local and private funding, and with it, they build comprehensive local home and community-based systems.

Among AAAs who receive Medicaid funding, Medicaid now comprises a larger portion of their budgets than previously. The average proportion of each AAA's budget that comes from Medicaid has increased slightly since

2010 and now tops 25 percent (see Table 1A).

Staff:

Since 2010, staffing levels have risen slightly, recovering to 2008 levels. Full-time staff is back to the average of 41 and part-time staff to 22; only one staff member fewer than in 2008 (see Table 1B).

Volunteers:

The average number of volunteers increased by nearly 10 since 2010,

while the median number of volunteers returned to levels seen in 2008.

Recognizing that older adults have much to contribute, AAAs also serve as a conduit to engage older adults in the community. Such engagement benefits the community but provides benefits for older adults as well.

Location:

Most AAAs serve rural areas (43.7 percent), or a mix of rural, urban and suburban (25.6 percent) (see Table 1C).

Table 1A: Budget

	Average (Mean)		50th Percent (Median)		Range	
	2010	2013	2010	2013	2010	2013
Budget (in millions)	\$8.9	\$9.4	\$4.0	3.9	<150,000 – >167 million	<138,000 – 292 million
Proportion of budget from OAA	40.7	41.1	35.0	35.0	1 – 100	1 – 100
Proportion of Budget from Medicaid*	24.5	26.9	17.0	20.0	1 – 95	1 – 93
Proportion of Budget for contract services	50.4	49.0	50.0	50.0	1 – 100	1 – 100

Table 1B: Staff

	Average (Mean)		50th Percent (Median)		Range	
	2010	2013	2010	2013	2010	2013
Full-time staff	38	41	20	23	1 – 638	1 – 690
Part-time staff	20	22	6	5	0 – 530	0 – 550
Volunteers	158	167	54	60	0 – 1,850	0 – 2,200

*These numbers reflect only those agencies who received at least some portion of their budget from Medicaid.

Structure:

The structure of AAAs varies. The majority operate as:

- Independent, nonprofit agencies (39.1 percent)
- Part of a county government (27.9 percent)
- Part of a Council of Governments or Regional Planning and Development Area (26.3 percent)

The balance are part of a city government (2.8 percent) or “other” (3.8 percent) such as a nonprofit, like United Way, or a university.

Reflecting their expanding role in assuring access to a balanced system of services and supports, a majority of AAAs have other official designations.

- Nearly three-quarters (72.4 percent) also function as an Aging and Disability Resource Center (ADRC), connecting older adults, people with disabilities and their caregivers with information and one-on-one person-centered counseling on the full range of LTSS options.
- Six in ten (61.9 percent) serve as a designated State Health Insurance Assistance Program (SHIP), offering one-on-one counseling and

assistance to people with Medicare and their families.

- More than half (56.5 percent) serve as their area’s Long-Term Care Ombudsman Program, advocating for residents of nursing homes, board and care homes, assisted living facilities and similar adult care facilities.

AAA Profile: Volunteerism

Jefferson Area Board for Aging Charlottesville, VA

Friends in School Helping (FISH) is a school-based mentoring program providing intergenerational volunteer opportunities in local public schools for K-12 grades students with the goal of improving student engagement and social skills to positively affect academic performance. FISH, which began in 2003 in the city of Charlottesville and Albemarle County public schools, enables older volunteers to enjoy the satisfaction and fulfillment of working with students and teachers to help meet critical needs, thus fostering friendships across generations. FISH has since expanded to three additional neighboring counties and increased its presence at several locations by participating in summer and after-school programs. A unique aspect of the FISH program is its Leadership Team, consisting of volunteers who receive a key staff person’s guidance and support. The program offers strategic direction, training, event planning and administrative support that has furthered its sustainability and expansion.

Table 1C: Areas Served

Proportion of AAAs that Serve the following areas:	
Rural	43.7%
Mix of urban, suburban and rural	25.6%
Mix of suburban and rural	11.3%
A mix of urban and suburban	8.4%
Urban	5.1%
Suburban	3.8%
Remote or frontier	1.8%

Population and Services

(including self-directed services)

Who AAAs Serve:

Despite the word “aging” in their name, AAAs serve a wider variety of the population, including the following (see Figure 1):

- People age 60 and older: The target age for Older Americans Act services is 60+, so all AAAs serve this population. However, due to limited

funds, AAAs need to target these services to those most vulnerable.

- People under age 60 who qualify because of disability, impairment or chronic illness: Nearly two-thirds of AAAs (70 percent) provide services to these consumers including those who receive funding through Medicaid waivers. AAAs may also serve other people under age 60, depending on special programs available at the local level.
- Caregivers: Those who care for older adults or people with disabilities. Since 2010, the proportion of AAAs that provide services to caregivers of all ages has remained steady (58.8 percent of AAAs in 2010).

- Veterans: Veterans of all ages are increasingly served by AAAs—nearly 3 in 10 AAAs serve veterans, a small increase from 2010 (26.9 percent).

Services AAAs Provide:

The OAA mandates core services ranging from planning and program development to home and community-based services and caregiver support.

Core OAA Services:

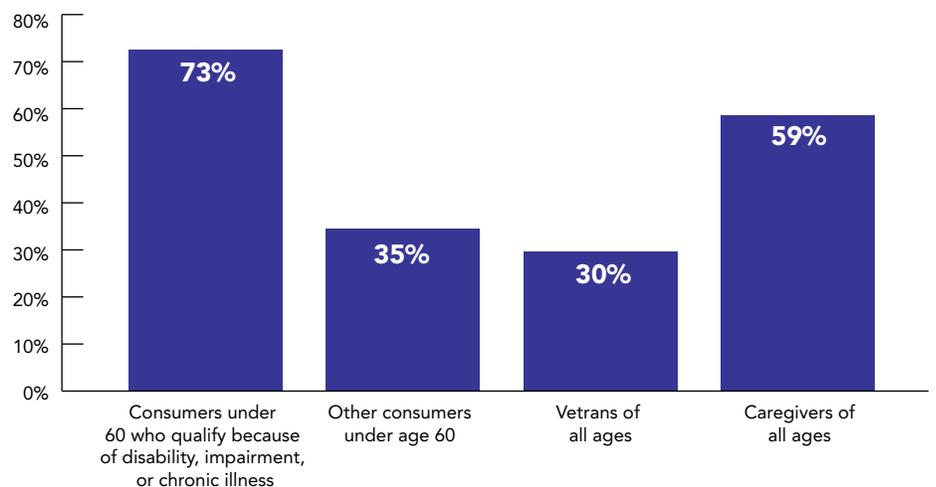
- Supportive Services (which include information and referral (I&R), outreach, transportation, legal services, in-home services and others)
- Nutrition
- Caregiver Support
- Health and Wellness

AAA Profile: Transportation

Olympic Area Agency on Aging Port Hadlock, WA

The Olympic Area Agency on Aging (O3A) operates a volunteer transportation program, with services in place to transport older persons to and from medical and health care services, social services and recreational activities across O3A’s four member counties. Without access to transportation, older adults and individuals with disabilities living in the rural communities of the Olympic peninsula, face serious challenges. Social isolation and the inability to access basic needs may ultimately pose significant risk to their health, well-being, independence and ability to age in place. The services volunteer drivers provided through the O3A volunteer transportation program play a critical role in increasing the region’s transportation resources.

Figure 1: Specific Consumers Served by AAAs (2013)



- Elder Rights (which include elder abuse prevention and long-term care ombudsman programs)

However, most AAAs offer even more services. The average AAA delivers 18.9 services.

These are the most common AAA services offered in addition to core OAA services (see Figure 2):

- Evidence-based health promotion and disease prevention (86 percent)
- Insurance counseling (85 percent)
- Case management (82 percent).
- Respite care (79 percent)
- Assessment for care planning (70 percent)

Self-directed Services: AAAs also provide self-directed services that give consumers greater control to determine how they want to meet their specific needs. With self-directed long-term services and supports (LTSS), people can hire, manage and dismiss their workers and decide how to spend the funds allotted for their needs.

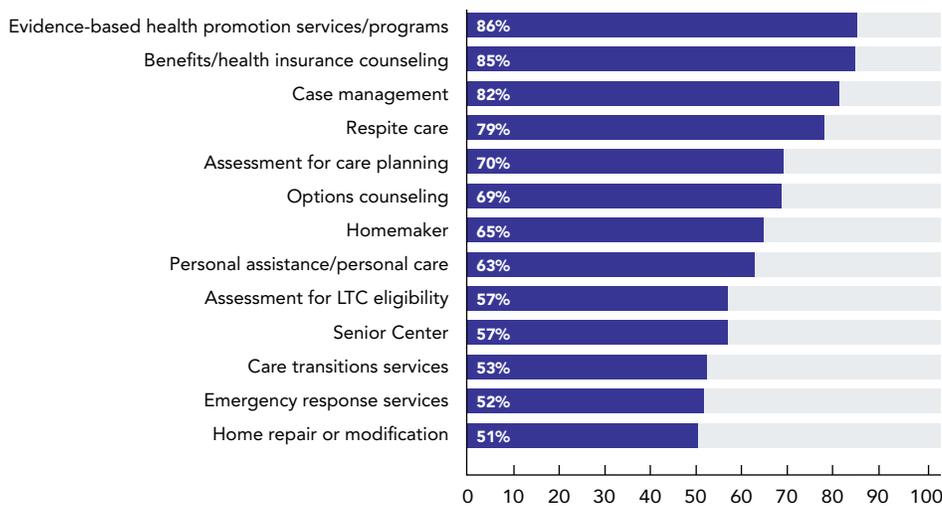
Since 2008, the number of AAAs providing consumers with a self-directed option continues to climb (from 48.4 percent in 2008 to 62.4 percent in 2013).

AAA Profile: Nutrition

Chautauqua County Office for the Aging (CCOFA) Mayville, NY

Chautauqua County is a rural county in Western New York State (bordering Pennsylvania) with 135,000 residents, of which 30,500 (23 percent) are seniors over 60. CCOFA serves close to 8,000 seniors, disabled adults and care-givers each year. CCOFA has close partnerships with three Meals On Wheels organizations and two hospital kitchens who collectively serve meals in the county to the aging and disabled. The AAA acts as the central intake for all home-delivered meal requests, coordinating and overseeing the provision of congregate meals and home-delivered meals in the county. These partnerships have great value, not only facilitating a cost-effective meal service to all who need it, but also ensuring that frail seniors and disabled adults who are discharged from the hospital have access to the good nutrition essential for their recovery and long-term health.

Figure 2: Commonly Delivered Services in Addition to Core OAA Services



Key Finding
 AAAs are increasingly serving younger people with disabilities, veterans of all ages and caregivers, in addition to people aged 60+.

Serving New Audiences

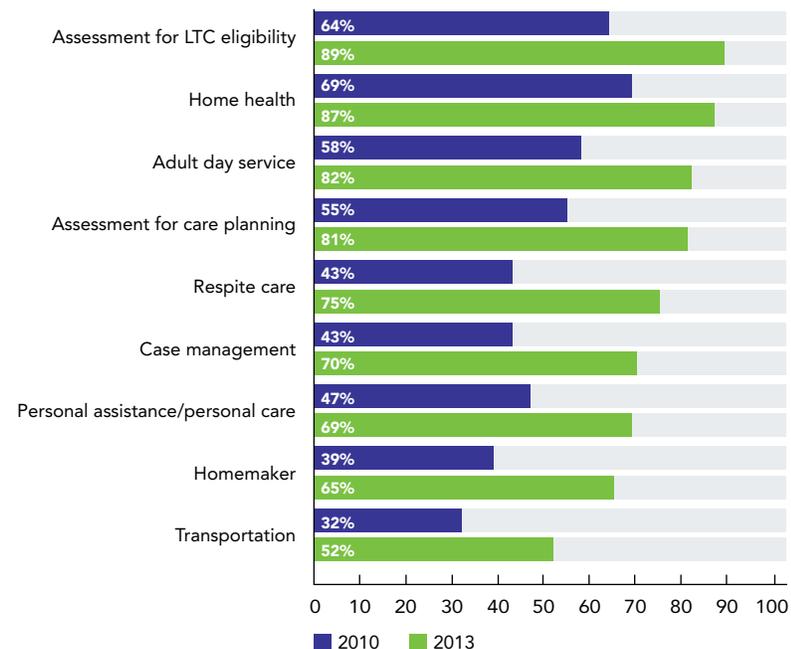
Today, AAAs are serving a broader base of the population than ever. Consistent with their mission to help all people stay in their homes and communities, AAAs are expanding their reach beyond older adults and caregivers, especially to younger people who have disabilities and to veterans. For OAA services, AAAs are charged by Congress to target services to those most in economic or social need, but there are no means tests and, if funding is available, anyone age 60 and older can access OAA services. For non-OAA services (such as Medicaid HCBS waiver programs), AAAs serve all eligible consumers.

Services to Consumers Under Age 60

The proportion of AAAs serving people younger than 60 is rising across all services (see Figure 3).

- Over three-quarters of AAAs (76.7 percent) provide at least one service to consumers under age 60.
- More than half (54 percent) of those AAAs serve only people under 60 who qualify because of a disability, impairment or chronic illness.
- Fewer than 5 percent serve only people under age 60 who qualify for reasons other than disability, impairment or chronic illness.
- The remaining AAAs provide services to both types of consumers under age 60.

Figure 3: Proportion of AAAs Serving Consumers in Addition to Those 60+ (among those who offer the services)



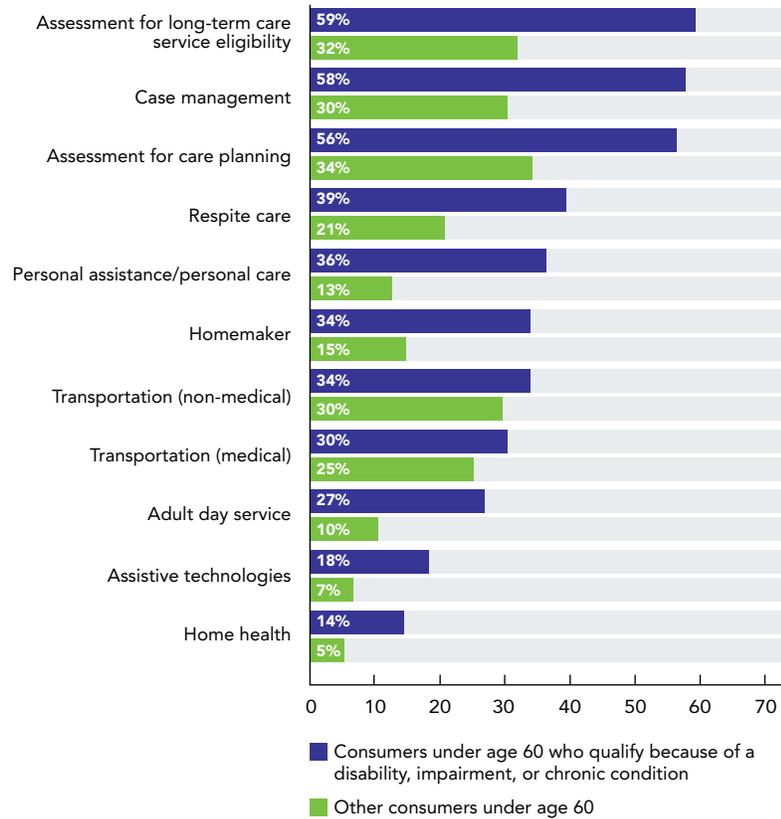
While some of the top services for other consumers under age 60 are the same—assessment for care planning (34 percent), assessment for long-term care (32 percent), case management (30 percent)—AAAs are more likely to offer transportation, both non-medical (30 percent) and medical (25 percent), to this demographic (see Figure 4).

Services to Caregivers and Veterans

Other target client groups helped by AAAs’ broad services include veterans and caregivers. AAAs increasingly serve veterans of all ages; nearly 30 percent deliver services to this audience, a small increase from 2010 (26.9 percent). Veterans are most likely to receive assessment for care planning, case management, assessment for long-term care eligibility, medical transportation and non-medical transportation (see Figure 5).

As in 2010, almost 60 percent of AAAs in 2013 delivered services to caregivers of all ages—mostly respite care, assessment for care planning, case

Figure 4: Services Provided to Consumers Under Age 60



management, assessment for long-term care eligibility and non-medical transportation (see Figure 5).

Single Point of Entry

Through their local AAA, consumers can get access to multiple services directly. This “one-stop shop” concept links consumers through a single point of entry, making it easier for consumers to gain information, referrals and connect directly to a broad range of services and supports.

Consistent with the expanded populations that AAAs are now serving, a growing number of AAAs serve as a

single point of entry for consumers of various ages. In fact, the proportion of AAAs that serve as a single point of entry for consumers age 60+ only has decreased since 2010.

Using this approach, AAAs provide streamlined access to at least one service for multiple population groups, including (see Figure 6):

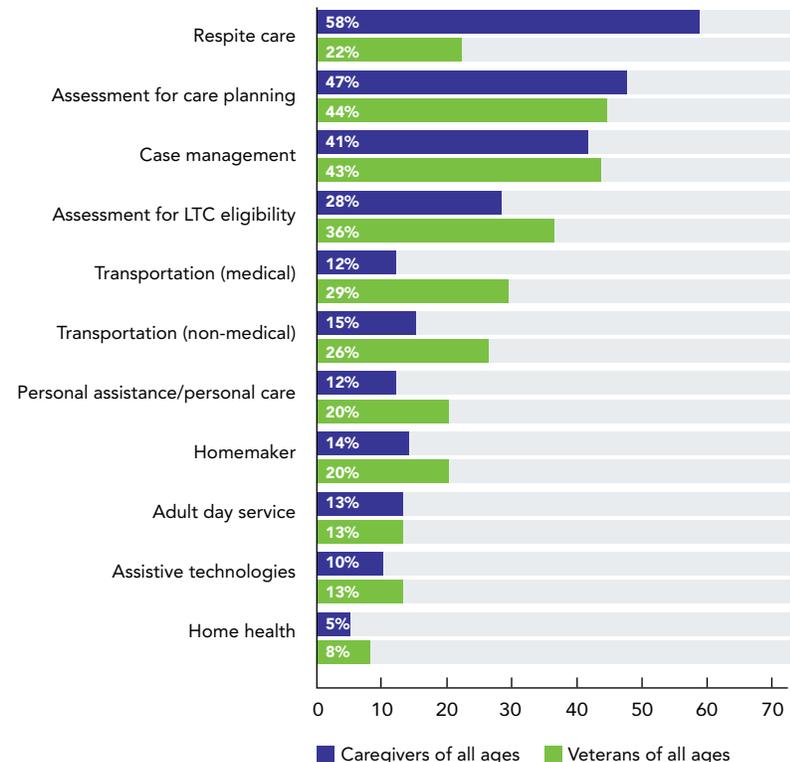
- Consumers under age 60 who qualify because of disability, impairment or other chronic illness (78 percent of AAAs)
- Caregivers of all ages (76 percent)
- Other consumers under age 60 (51.2 percent)
- Veterans of all ages (49.9 percent)

ADRC Functions on the Rise

Growing numbers of AAAs are providing streamlined access to long-term services and supports for older adults, people with disabilities of all ages, family caregivers and LTSS providers through an Aging and Disability Resource Center (ADRC) model. ADRCs help individuals and their families identify their LTSS needs, understand their LTSS options, put in place an LTSS plan and access public and private LTSS programs. This “no wrong door” model has proven to be valuable for consumers with LTSS needs.

The proportion of AAAs that also function as an ADRC has increased to nearly three-quarters (72.1 percent),

Figure 5: Services Provided to Caregivers and Veterans of All Ages



up significantly from 2008, when fewer than 1 in 10 (8.7 percent) performed ADRC functions.

Community Partnerships

Most AAAs have a variety of partnerships, both formal and informal. On average, AAAs have 11 informal partnerships and five formal partnerships. Less than one percent of AAAs have not established partnerships with other entities in their communities.

The most common formal partnerships (those with a contract or memorandum of understanding) are with the following:

- State Health Insurance Assistance Program (SHIPs) (68.8 percent of AAAs have a formal partnership)
- Transportation agencies (52.4 percent)
- Medicaid (51.9 percent)
- Disability service organizations (34 percent)
- Adult Protective Services (APS) (32 percent)

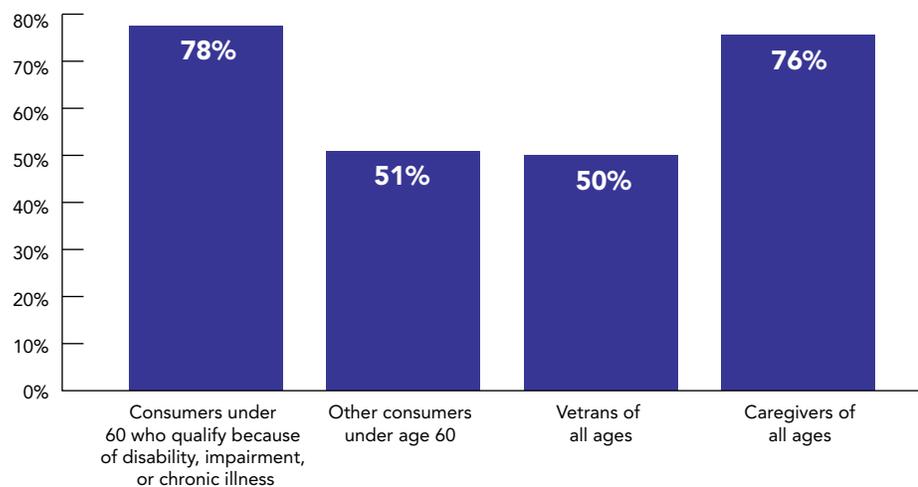
The most common informal partnerships are with these organizations:

- Long-term care facilities (65.5 percent)
- Emergency preparedness agencies (59.1 percent)
- Advocacy organizations (57.3 percent)

- Public housing authorities (57 percent)
- Faith-based organizations (55.5 percent)

AAAs are consistent partners. The most common primary partnerships that AAAs reported in 2013 were the same as those reported in 2010: SHIPs, APS, transportation agencies, state or local Medicaid programs and advocacy organizations (see Figure 7). In 2013, as in 2010, AAAs were least likely to form partnerships with the Indian Health Service (IHS), tribal organizations or consortiums, geriatricians, managed care/Health Maintenance Organizations (HMOs) and businesses.

Figure 6: Proportion of AAAs Serving as a Single Point of Entry for at Least Some Services by Target Population



Since 2010, a greater proportion of AAAs have developed new or expanded partnerships with Managed care/HMO networks, Intellectually Disabled (ID)/ Mentally Retarded (MR)/ Developmentally Disabled (DD) organizations, hospitals, faith-based organizations and mental health/behavioral health organizations (see Figure 8).

Livable Communities

By 2030, more than 70 million Americans—twice the number in 2000—will be 65 and older, and nearly 90 percent of older adults want to

age in place in their existing homes or communities. Although services and supports are critical to ensure that people can age in place, so too is the need for community infrastructure.

The rise in the number of aging citizens will affect the social, physical and economic fabric of our nation’s cities and counties. The new demographics will dramatically affect local policies, programs and services on multiple fronts: aging, health and human services; land-use, housing and transportation; public safety and disaster

planning; workforce and economic development; education and recreation; and volunteerism, lifelong learning and civic engagement.

Creating a Livable Community requires extensive collaboration across community organizations, a role for which AAAs are well-suited. More than 70 percent of AAAs have taken steps to develop Livable Communities by meeting with other public entities to address housing, transportation, land use and other key development issues and by carrying out other activities (see Table 2).

AAA Profile: Livable Communities

Monroe County Office for the Aging Rochester, NY

To ensure that the needs of its growing aging population are addressed, the Monroe County AAA—selected by n4a to participate in the Livable Communities Collaborative—is bringing together multiple local stakeholders from across the Rochester area to work on three long-term livability goals in the area of transportation: greater mobility independence through a well-coordinated system for providing transportation options; increased volunteer support for older adult mobility options; and tools to ensure that future developments give priority to addressing the needs of aging in future planning, zoning and policy making. Monroe County AAA and all other communities involved in the Livable Communities Collaborative are also developing self-directed volunteer teams as a key component in advancing their goals.

Figure 7: **Partnerships AAAs Have Formed**

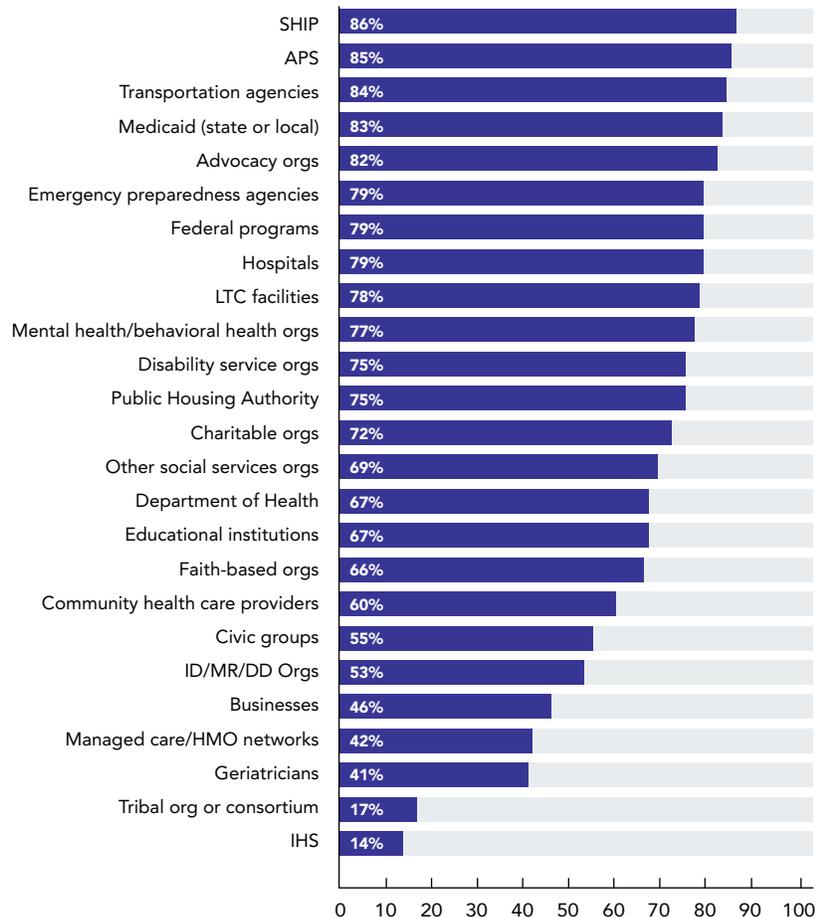


Figure 8: Organizations That Have Seen the Largest Increase in the Proportion of AAAs Who Have Formed Partnerships with Them

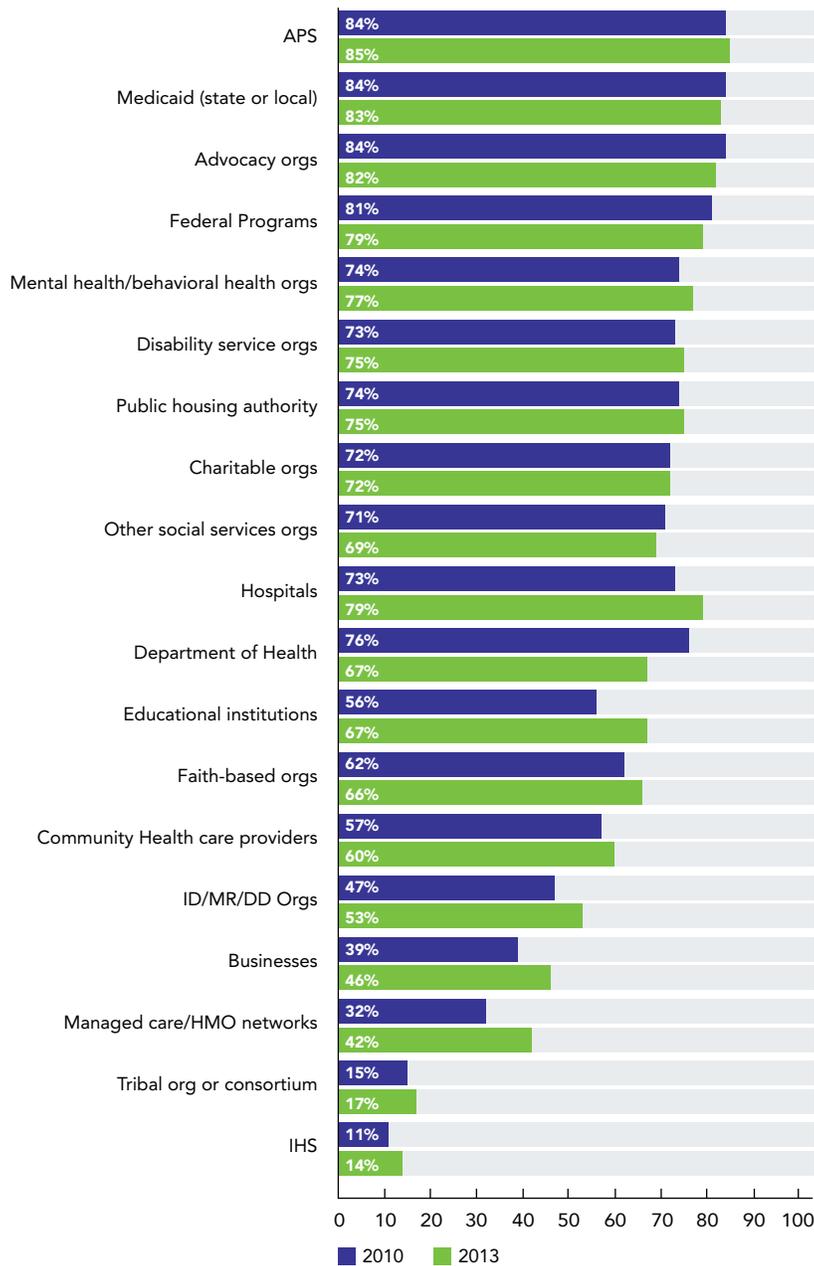


Table 2: Practices AAAs Have Adopted to Develop Livable Communities

Practice	Proportion of AAAs
Meeting with other public entities to address housing, transportation, land use and other key development issues	80.9%
Establishing coalitions with other entities to promote coordination across service sectors and initiatives/projects	54.3%
Developing projects to promote aging in place	49.7%
Meeting with other private entities to address housing, transportation, land use and other key development issues	44.0%
Developing an initiative to plan for livable communities	32.6%
Designating staff within the organizations to develop/work on Livable Communities initiatives projects	30.9%
Working with cities on planning and zoning	21.6%
Obtaining funding from other sources for Livable Communities planning/work	12.1%

Delivering Innovative Health Care

Good health can support successful aging and independent living. Today's Area Agencies on Aging (AAAs) are working harder than ever to keep older adults and their caregivers healthy. Almost every AAA delivers healthy aging programs. And, AAAs also offer critical long-term services and supports (LTSS) which increase patient safety, improve quality of care and reduce health care costs.



A AAs bridge the gap between acute care and long-term care and support in a patient's home by offering information on and access to LTSS, coordination of a range of home and community-based services, targeted assessments and referrals, cost-saving diversions and transitions from institutions to the community and evidence-based health promotion programs.

Through the limited, but essential, resources available through the Older Americans Act (OAA) for health and prevention services under Title III D, AAAs have effectively leveraged those federal funds at the local level from multiple sources to considerably expand the programs' reach.

Evidence-based Health Promotion Services and Programs

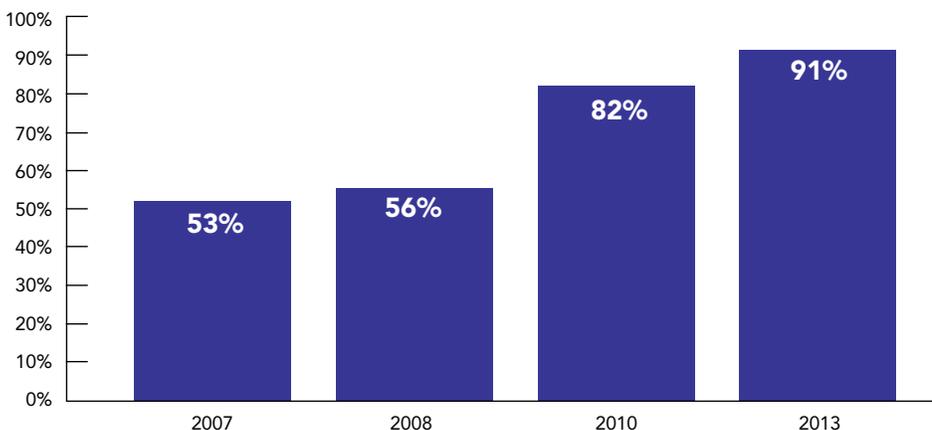
Each day, AAAs witness the effect of chronic health problems and loss of function on the lives and well-being of older adults. As such, they have been in the forefront of developing, adopting and/or expanding evidence-based health promotion and disease prevention programs endorsed by the Centers for Disease Control and Prevention and the U.S. Administration on Aging.

Nearly all AAAs—more than 90 percent—deliver at least one evidence-based health promotion program or service, and the proportion of AAAs offering these programs and services continues to grow (see Figure 9). Just five years earlier, only 56 percent of AAAs were involved in health programming.

Of the formally recognized programs, AAAs are most likely to deliver these:

- Chronic Disease Self-Management Program (78.5 percent)
- A Matter of Balance (45.8 percent)
- Diabetes Self-Management Training (31.1 percent)
- Powerful Tools for Caregivers (27.1 percent)
- Tai Chi Moving for Better Balance (23.7 percent)

Figure 9: Proportion of AAAs Involved in Evidence-based Health Promotion Programs



Key Finding

Almost all AAAs—more than 90 percent—are now offering evidence-based health promotion programs.

AAA Profile: Evidence-based Health Promotion

Alliance for Aging, Inc. Miami, FL

The Alliance for Aging joined forces with the Florida Department of Elder Affairs and the Health Foundation of South Florida to offer, not just one evidence-based program, but three—A Matter of Balance, Diabetes Self-Management and Living Healthy—offered in collaboration with four different types of sites—senior centers, meal sites, faith-based organizations and health-care providers. Because of the broad availability of services to older adults and their caregivers, including language and cultural adaptation for local Spanish speakers, over 1,000 seniors were able to participate in volunteer-led healthy aging workshops in just one year.

AAA Profile: Diabetes Self-Management Training (DSMT)

Community Council of Greater Dallas/Dallas Area Agency on Aging Dallas, TX

Better Choices, Better Health—Dallas’ Continuous Quality Improvement (CQI) Plan was developed as an evaluation tool to ensure that participants enrolled in the Diabetes Self-Management Training classes would have an annual A1C test performed (which measures average blood sugar in the previous three months to see if it has stayed within a target range), monitor their blood sugar level during the course of the class and thereafter, as well as start and/or maintain an exercise program. During the first year and a half, the program served 78 participants with pre-intervention data of 87 percent reporting success in healthy eating, 33 percent monitoring blood sugar levels and 80 percent being physically active. The random sample results one year later, showed 100 percent were physically active with continuous daily or weekly exercise and 62.5 percent performed A1C testing and other monitoring. The program received accreditation in 2013. Obtaining a Medicare Provider Number is a program goal for the Dallas Area Agency on Aging, as this will increase Medicare billing potential for program sustainability and enhancements.

One quarter of AAAs provide at least one evidence-based health promotion program or service that was not included in the survey. For example, 25 percent of AAAs offer Arthritis Foundation Exercise and Walk with Ease Programs; 12 percent provide fall prevention programs, other Tai Chi programs and home medication management programs.

Institutional Transition and Diversion Programs and Services

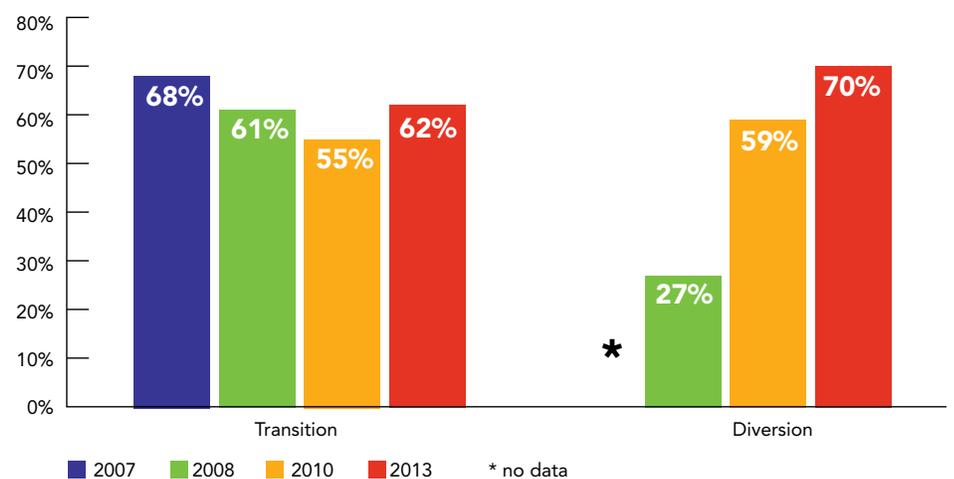
Approximately two-thirds of AAAs offer institutional diversion and transition programs, which enable older adults and people with disabilities to live at home longer. These programs either divert people from prematurely entering an institution, such as a

nursing home or assisted living facility, or ease people’s transition from an institution back into their homes

AAA involvement in diversion programs, in particular, has been increasing steadily over the past five years, and more AAAs currently provide programs and services for diversion than for transition (see Figure 10).

It is common for AAAs to provide both services. Nearly 80 percent of AAAs providing transition programs and services also provide diversion programs and services—an increase of nearly 10 percent since 2010. Of AAAs providing diversion services, nearly 70 percent also provide transition services.

Figure 10: AAA Participation in Transition and Diversion Programs (2007-2013)



Key Finding

The number of AAAs providing diversion programs to keep people living in their homes longer has risen sharply since 2007.

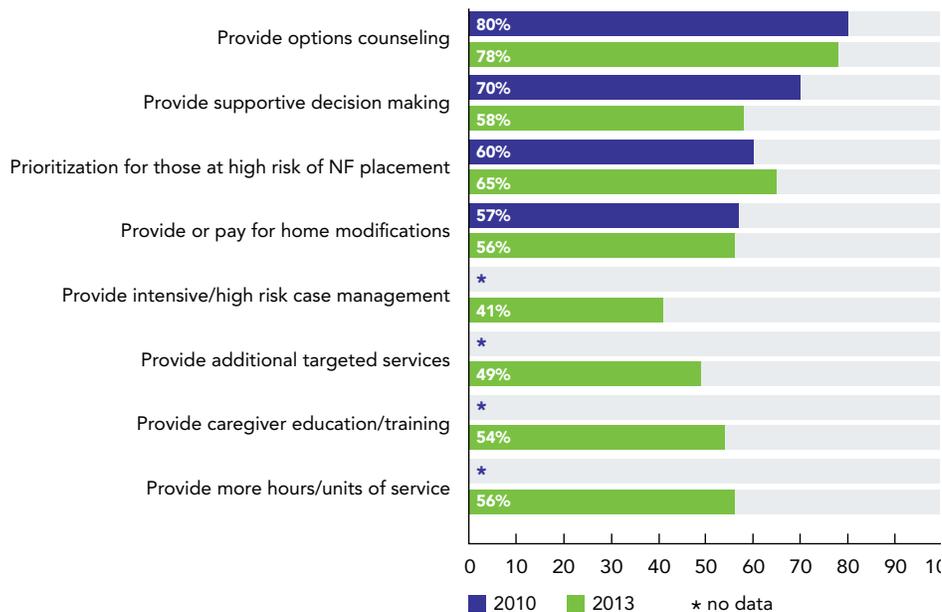
Diversions

In 2008, less than one-third of AAAs were providing diversion programs and services, while today, more than 70 percent of AAAs are doing so. The strategies used most in 2013 were also the most common in 2010 (see Figure 11):

- Providing options counseling (77.6 percent)
- Prioritizing services for those at high-risk of nursing home placement (65 percent)
- Providing supportive decision making (58.1 percent)



Figure 11: Strategies to Divert Individuals from Institutional Placement (2010 and 2013)





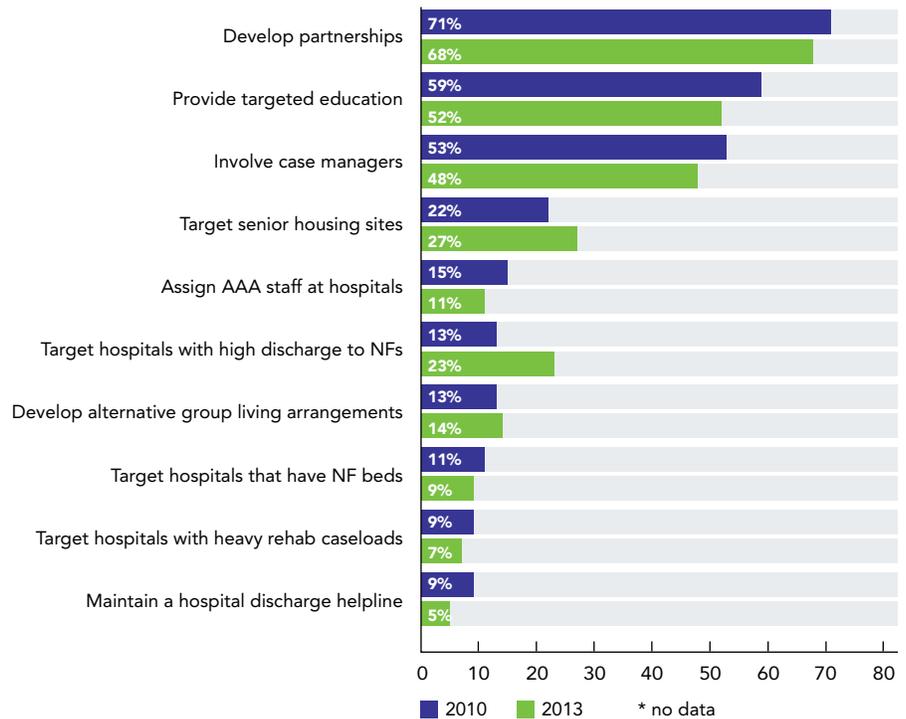
Programmatic Strategies

Similarly, the top 2013 programmatic strategies resemble those used in 2010 (see Figure 12):

- Developing partnerships with hospitals, rehabilitation facilities and other similar care providers (68.2 percent)
- Providing targeted education and/or outreach to discharge planners (52 percent)
- Involving case managers in the hospital discharge process (48 percent)

In this area, the nature of the AAA's work has changed. In 2010, AAAs were performing functions that were largely preparatory in nature (such as targeting hospitals that have nursing facility beds or high discharges to nursing facilities, developing alternative group living arrangements, etc.). Now, they are actively implementing diversion strategies: educating individuals, involving case managers, building partnerships to successfully keep individuals back in the community and more.

Figure 12: Programmatic Strategies Used to Divert Individuals from Institutional Placement (2010 and 2013)



Transitions

People who leave a nursing home or other institution often need help as they return home. A smooth transition increases the chances that people can stay at home long-term.

AAAs provide a number of programs and employ a number of strategies to help people readjust. In 2013 and 2010, these were the most common strategies (see Figure 13):

- Working with the care recipient’s family or social supports to prepare for return (74.8 percent)
- Providing additional services (65.3 percent)
- Providing or paying for home modification (55.4 percent)

Programmatic Strategies

AAAs employ a number of programmatic strategies, which changed little from 2010 to 2013 (see Figure 14):

- Reaching out to nursing facilities (NFs), assisted living facilities (ALFs) and rehabilitation facilities for referrals (67.4 percent)
- Working with local housing authorities (47.5 percent)
- Coordinating services with the Long-Term Care Ombudsman Program (LTCOP) (43.0 percent)

Figure 13: Strategies Used to Facilitate Transition from Institutional Placements Back into the Community (2010 and 2013)

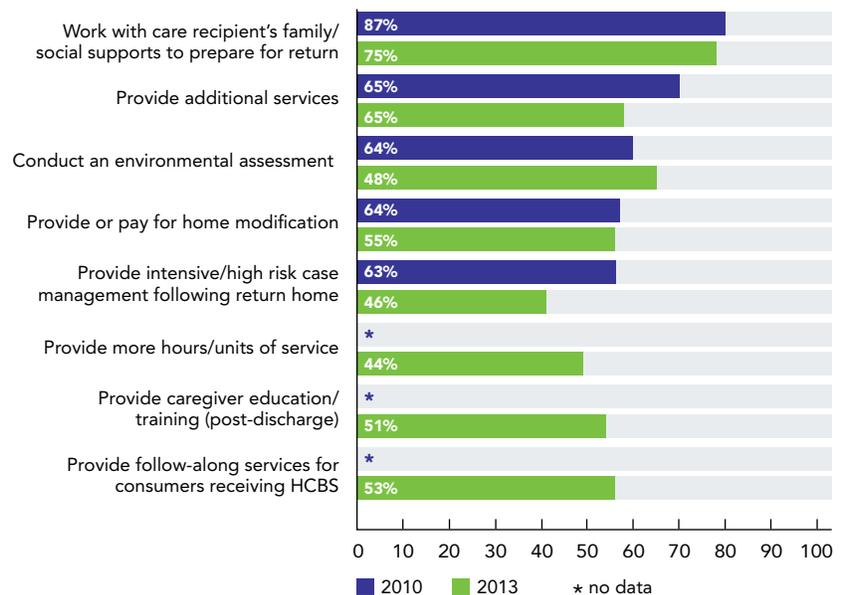
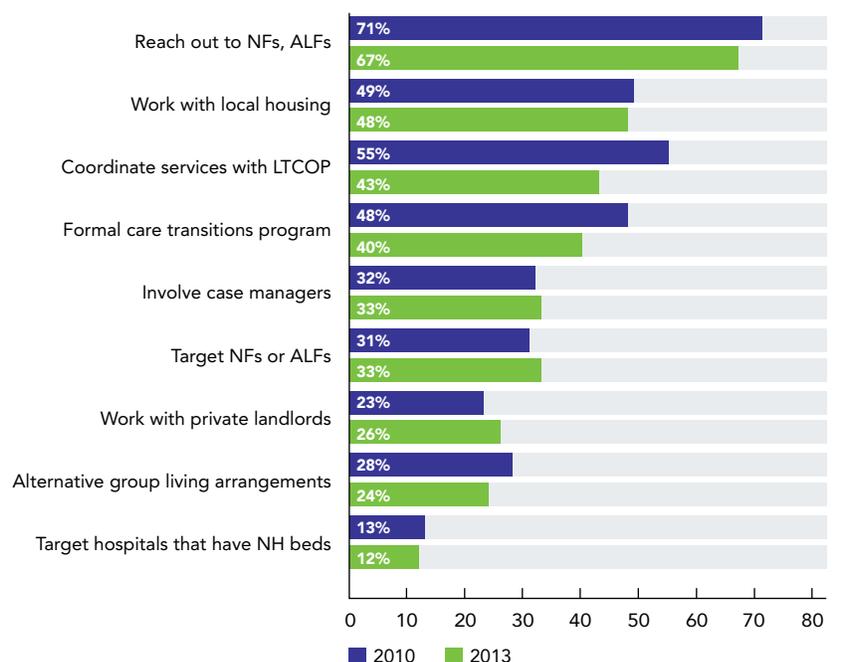


Figure 14: Programmatic Strategies Used to Transition Individuals from Institutional Placements Back into the Community (2010 and 2013)



Key Finding

AAAs play a large role in the Community-based Care Transitions Program—but often are not reimbursed for all of the services they provide.



CMS 3026 Community-based Care Transitions Program

Section 3026 of the Patient Protection and Affordable Care Act (ACA) created the Community-based Care Transitions Program (CCTP) to improve care for high-risk Medicare beneficiaries as they are discharged from the hospital, which prevents both unnecessary hospital readmissions and avoidable health care costs. To receive funding for the program, administered by the Centers for Medicare and Medicaid Services (CMS), hospitals must partner with community-based organizations that can help patients return to their homes. AAAs, with their local roots and expertise in providing home and community-based services, have taken the lead and are prime partners in this initiative

According to CMS.gov, CMS has awarded 102 CCTP program awards directly to AAAs and their partner organizations in the Aging Network. Respondents to this survey included over 90 percent of those parties (94.1 percent of CCTP awards).

AAA Profile: Community-based Care Transitions Program

Elder Services of Merrimack Valley Lawrence, MA

Elder Services of Merrimack Valley (ESMV) has achieved positive reductions in readmissions with its care transition program that relied primarily on health coaches/care managers and home visits. ESMV enhanced these efforts using new technology called Care at Hand (CAH)—a mobile (tablet) care coordination platform—to further bolster its impact on readmissions from hospital settings. With CAH, Elder Services puts a “care manager in the home with a nurse in their pocket.” Care managers use simple, non-clinical surveys of the patients’ conditions during each encounter and personalize the answers for each patient. An alert is sent to a Elder Services nurse coordinator if a condition requires medical attention. With the introduction of the tablet, ESMV was better able to empower low-cost providers, like care managers and nurses, to deliver the right care, at the right time, in the most cost-effective manner. The program reduced the readmission rate from 39 percent to 14 percent of individuals being discharged from the hospital.

Table 3: Services Provided by AAAs Under the CMS 3026 Community-based Care Transitions Program

Service	AAAs That Provide This Service Under a 3026 Award	Percent of AAAs Providing This Service Under a 3026 Award That are Fully Reimbursed
Connect patients and family to non-medical community health support agencies	58.3%	37.5%
Provide home-delivered meals	53.1%	15.7%
Provide caregiver education	52.1%	22%
Provide coaching for patients and family members	50.0%	68.8%
Follow up with patients after discharge via telephone	46.9%	68.9%
Ensure patient's understand warning signs and symptoms for monitoring health conditions	45.8%	59.1%
Provide transportation to medical appointments	45.8%	25%
Provide assessments	45.8%	25%
Explain medication management to patients	44.8%	58.1%
Provide culturally and linguistically relevant patient education tools	43.8%	26.2%
Short-term case management	42.7%	26.8%
Ensure follow up with primary care physician	42.7%	58.5%
Assist patients with developing a personal health record	41.7%	60%
Facilitate health information exchange between acute care setting to post-discharge healthcare providers	37.5%	36.1%
Develop a plan of care for post-discharge	30.2%	55.2%
Provide coaching and support for LTC facilities	29.2%	35.7%
Provide a patient advocate	25.0%	25%
Facilitate collaboration between specialty and primary physician after discharge from acute care setting	19.8%	21.1%
Maintain an alert system for patient readmission into a different hospital	15.6%	20%
Provide a weight scale	12.5%	0%
Provide support for palliative care consultation	12.5%	16.7%
Provide health screenings	10.4%	0%

The top five services that AAAs provide as part of these awards are:

- Connecting patients and families to non-medical community health support facilities (58.3 percent of respondents)
- Providing home-delivered meals (53.1 percent)
- Providing caregiver education (52.1 percent)
- Providing coaching for patients and family members (50 percent)
- Following up with patients by phone after discharge (46.9 percent)

However, the AAAs involved in CCTP provide services that are not being reimbursed through their program awards with CMS. For example, more than half of AAAs who have CCTP awards are providing home-delivered meals to consumers recently discharged from the hospital. Yet less than 16 percent of those who provide

home-delivered meals under a CCTP contract are being fully reimbursed by CMS for this service (see Table 3).

Medicaid Managed Care

The majority of states are undergoing a dramatic shift in the way they deliver Medicaid, moving to a managed care system. According to Medicaid.gov, 49 states are enrolled in either a voluntary (waiver) Medicaid managed care system or have had a state plan approved by CMS.

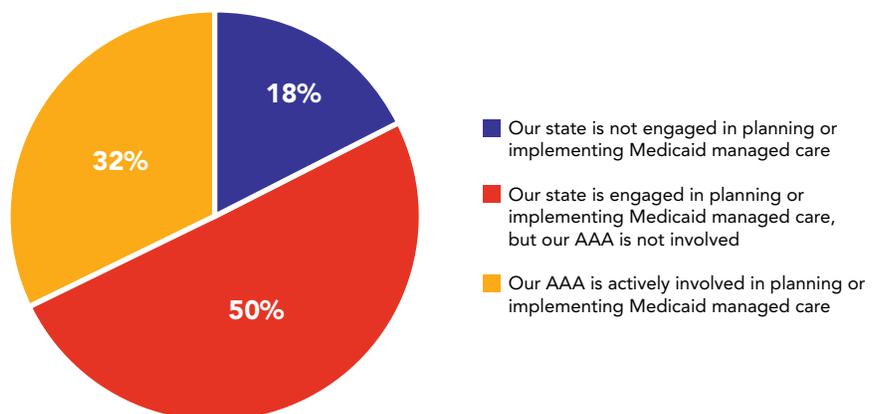
Instead of paying various fees per service to multiple providers for each Medicaid enrollee, these states are paying a single provider a fixed, capitated rate to care for that enrollee. By paying a single fixed-fee, states are hoping to pass their financial risk to managed care organizations (MCOs), that then would have an incentive to provide the most efficient care

possible. States also believe a managed care system can better coordinate care for enrollees. Older adults and people with disabilities increasingly are being moved into managed care programs for LTSS as well.

There is concern that most MCOs do not have experience with the complexity of programs and systems of coordinated care needed to deliver LTSS, thus increasing the likelihood of disruptions in LTSS affecting people who are elderly, frail, disabled and economically disadvantaged.

AAAs have provided LTSS for over 40 years, with proven success in providing information, counseling, case management, service integration and other assistance. As such, AAAs are uniquely positioned to ensure that older adults and people with disabilities can access quality care. By partnering

Figure 15: The Role of AAAs in Medicaid Managed Care



and contracting with health plans and managed care organizations, AAAs can ensure that, while costs are reduced, quality stays high; they can also save MCOs from start-up challenges and costs.

Yet this critical integration is not happening in all states. More than 30 percent of all AAAs report being actively involved in planning or implementing their state's Medicaid managed care system. However, nearly half of AAAs are in a state that is implementing Medicaid managed care—but are not involved in the planning and/or implementation (see Figure 15).

AAAs that are actively involved in planning or implementing Medicaid managed care are taking on numerous activities. The average AAA involved in managed care is working on or implementing 5.9 activities. Nearly 25 percent of active AAAs are planning or implementing 10 or more activities. The most commonly planned or implemented activities under Medicaid managed care are as follows:

- Conduct intake and ongoing assessment (57.9 percent)
- Provide caregiver support (50.4 percent)
- Provide care management (48.8 percent)
- Provide care transitions services from hospital to home or nursing homes (47.9 percent)
- Assist in transitioning residents from nursing homes to the community (44.6 percent)
- Participate in an interdisciplinary team (42.2 percent)
- Develop service/care plans (38.0 percent)



- Directly provide some services (35.5 percent)
- Conduct Level of Care determinations (34.7 percent)
- Assist in integrating/coordinating hospital and home-based services (34.7 percent)

Partnerships are important for a smooth delivery of managed care. As such, AAAs have partnered with an average of 4.8 entities to deliver their managed care activities. More than 15 percent of AAAs delivering services under Medicaid managed care have 10 or more partners.

AAA most commonly cultivate partnerships with these entities:

- Medicaid managed care org/insurer (62.8 percent)
- Other AAA (37.2 percent)
- Hospital or health care system (33.1 percent)
- Individual hospitals/medical centers (26.5 percent)

- Nursing homes (20.7 percent)
- Individual physicians or physician practices (18.2 percent)
- Publicly funded behavioral health organization/mental health system (17.4 percent)
- Mental health center (16.5 percent)
- Medicare Advantage organization (16.5 percent)
- State Quality Improvement Organization (QIO) (15.7 percent)
- Federally qualified health centers (15.7 percent)

They are least likely to partner with local/regional health information exchange (HIE)/electronic health records (HER) consortium (5 percent), state association of nursing homes (5 percent) and individual dentists or oral health practices (2.5 percent).

AAA Profile: Duals Demonstration

Bay Aging Urbanna, VA

Through the Eastern Virginia Care Transitions Partnership (EVCTP)—Bay Aging (lead CBO), Peninsula Agency on Aging, Eastern Shore Agency on Aging and Community Action Agency and Senior Services of Southeastern Virginia—four AAAs in Virginia are combining efforts to provide a one-stop shop for complex Care Coordination with Humana. Initiated on April 1, 2014, the partnership focuses on Elderly or Disabled with Consumer Directed waiver clients and those in nursing facilities. EVCTP agencies also have contracts to provide an array of services with all three MCOs in the Commonwealth—Humana, Virginia Premier and Anthem. This partnership provides opportunities for centralized referral, billing and payment services for the MCOs.

Integrated Care

More than half of AAAs (55.2 percent) are involved in at least one initiative involving integrated care, a program or approach that combines delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion across multiple systems such as behavioral health, LTSS and acute care. AAAs are offering these integrated care initiatives in addition to Medicaid managed care and the Community-based Care Transitions Program.

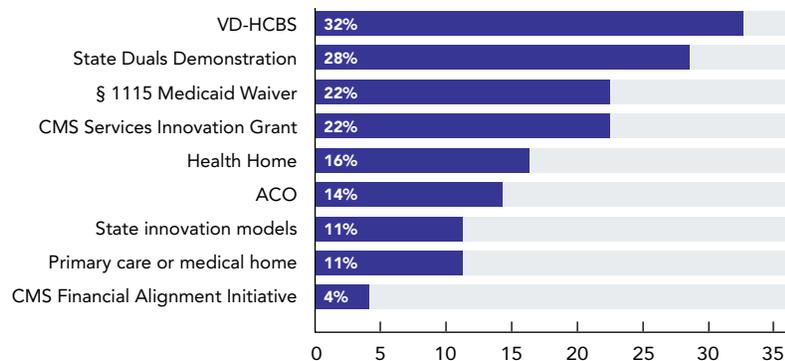
Some AAAs had already been providing Veteran-Directed Home and Community-Based Services (VD-HCBS) and Section 1115 Medicaid Demonstration Waiver programs, which are two of the top four integrated care initiatives that AAAs are most likely to offer (31.9 percent and 21.8 percent respectively). The VD-HCBS program provides veterans of any age, as well as their family caregivers, with home and community-based services that enable the veterans to avoid nursing

home placement and continue to live in their homes and communities. Section 1115 Medicaid Demonstration Waiver programs give states additional flexibility to improve their programs by expanding eligibility, providing services not typically covered, using innovative service delivery systems that improve care and efficiency and reduce costs, or through other policy approaches.

Since the last AAA survey in 2010, AAAs have introduced seven integrated care initiatives (see Figure 16).

- Through the new State Duals Demonstration program (28.2 percent of AAAs involved in integrated care), states work with CMS to integrate care and align financing for people eligible for both Medicare and Medicaid.
- 16.2 percent of AAAs are working with a health home to offer coordinated care to individuals with multiple chronic health conditions, including mental health and substance abuse disorders. The health home is a team-based

Figure 16: Integrated Care Initiatives Among Those AAAs Involved in Integrated Care



- clinical approach that includes the consumer, his or her providers and family members, when appropriate.
- 14.4 percent of AAAs are working with an Accountable Care Organization (ACO). An ACO is made up of groups of doctors, hospitals and other health care providers who come together voluntarily to give coordinated high-quality care to their Medicare patients. They strive to ensure that patients, especially the chronically ill, get the right care at the right time, and to avoid unnecessary duplication of services and medical errors.
 - 11.1 percent of AAAs are involved in a CMS State Innovation Model Initiative.
 - 10.6 percent of AAAs are partnering with a primary care or medical home to deliver the core functions of primary health care: comprehensive care, patient-centered care, coordinated care across the health care system, services that are more accessible and faster and dedication to quality and safety.
 - 3.7 percent of AAAs are involved in the CMS Financial Alignment Incentive. Through this program, CMS is partnering with states to test two new models for their effectiveness in better aligning the financial incentives of Medicare and Medicaid to provide Medicare-Medicaid enrollees with a better care experience.

AAAs perform an average of 5.7 activities related to their integrated care initiatives, though they may perform only a few activities or up to 15. Most commonly, they provide the following:

- Care management (50.5 percent of AAAs involved in integrated care)

- Developing care/service plans (43.1 percent)
- Assisting in the transitioning of residents from nursing homes to the community (40.3 percent)
- Conducting intake assessments (38.9 percent)
- Providing care transitions services from hospital to home or nursing home (36.6 percent)
- Integrating hospital and home-based services (31.9 percent).
- Resolving consumer complaints (29.2 percent)
- Directly providing some services (29.2 percent)
- Conducting level of care determinations (26.9 percent)
- Assisting in measuring the quality of systems or services (23.6 percent)

AAAs have formed a variety of partnerships for integrated care services delivery with a broad range of entities:

- Hospital or health care system (26.9 percent of AAAs)
- Medicaid managed care organization (21.3 percent)
- Individual hospitals/medical centers (18.5 percent)
- Other AAA (17.6 percent)
- VA (14.4 percent)
- Local community care coordination coalition (11.1 percent)
- Other (10.2 percent)
- Nursing homes (9.7 percent)
- State Quality Improvement Organization (9.3 percent)
- Individual physicians or physician practices (8.8 percent)

AAA Profile: **VD-HCBS**

Senior Resources Area Agency on Aging Norwich, CT

This program, a partnership between the Department of Health and Human Services/Administration for Community Living (ACL) and the Veterans Health Administration (VHA), provides veterans of all ages the opportunity to receive participant-directed home and community based services, thus enabling them to live in their homes (or home of a loved one) and communities. Under this program, the VA Medical Center refers eligible veterans to Senior Resources and other aging and disability providers who assist the individual in managing a flexible budget, deciding for themselves what mix of services will best meet their personal care needs, hiring their own personal care aides, including family or neighbors, and purchasing items or services in order to live independently, with choice, in their community.

Preventing Elder Abuse

The passage of the Elder Justice Act in 2010 signaled a strong national focus on preventing elder abuse. The Aging Network plays a significant role in promoting the legislation's goals through public awareness and direct assistance to elders.



More than 98 percent of AAAs provide at least one service or program designed to address elder abuse. The most common services, provided by more than half of AAAs, are legal assistance, community education or training, public awareness information directly to seniors, participation in an elder abuse prevention coalition or multidisciplinary team and case management for at-risk/vulnerable seniors (see Table 4).

Table 4: Services AAAs Deliver to Address and Combat Elder Abuse

Service	Proportion of AAAs
Legal assistance	87.2%
Community education or training	70.6%
Public awareness info directly to seniors	58.9%
Participation in elder abuse prevention coalition or multidisciplinary team	56.0%
Case management for at risk/vulnerable seniors	54.7%
Public awareness magnets, brochures, or other media	49.2%
Public awareness spots on radio, TV, print ads, or signs/billboards/messages	48.7%
Investigations of abuse, neglect, exploitation	40.1%
Case management for self-neglecting seniors	38.8%
Case management for victims of abuse, neglect, and/or exploitation	35.9%
Financial abuse prevention	35.9%

AAA Profile: Elder Abuse Prevention

Area Agency on Aging, Region One Phoenix, AZ

Through the Maricopa Elder Abuse Prevention Alliance, coordinated by the Area Agency on Aging, Region One, an Intergenerational Program called "Sensitizing With All Generations" (SWAG) was developed and implemented. SWAG is a proactive approach to prevent elder abuse through an eight-lesson curriculum pairing school-age children with older adults, featuring the topics of respect, the aging process, role models and the slogan "Be Cool, Don't Be Cruel." It attempts to create culture change wherein elder abuse is not acceptable from an early age. The two generations spend time together, dispelling assumptions about aging and illustrating that there are more similarities than differences.

Team Activities

Fifty-six percent of all AAAs are involved in an elder abuse prevention coalition or multidisciplinary team. This is an increase of nearly 10 percent since the Elder Abuse Prevention mini-survey launched in 2008 (45.9 percent).

In 2013, the most common activities within the multidisciplinary teams were updating members about services, programs and legislation (77.2 percent), planning and carrying out training events (72.6 percent), advocating for change (71.2 percent), identifying service gaps and systems problems (66.1 percent) and providing an opportunity for colleagues to offer support, advice and assistance on cases (65 percent).

Key Finding

A growing number of AAAs belong to a coalition or multidisciplinary team to prevent elder abuse.

Types of Teams

The structure of a team—formal, informal and/or voluntary—often shapes the team’s focus and activities.

Most AAAs (84.2 percent) are part of a voluntary elder abuse prevention team. These voluntary teams can be either formal (54.7 percent) or informal (45.3 percent).

Formalized coalitions are those created by legislation or administrative program or policy, and they give advantages to AAAs. AAAs that are part of a formalized coalition or voluntary/formal group are more likely to have a revenue source, to operate with formalized policies and procedures, and to maintain written materials to document or support policies and procedures (see Figure 17).

In formalized groups, higher proportions of members are focused on internal processes and on strengthening the coalition’s knowledge—updating coalition members on relevant resources, training members and enabling members to assist on cases (see Table 5).

Voluntary groups usually focus on actively responding to elder abuse—providing training, advocating for change, identifying service gaps and encouraging the investigation and prosecution of elder abuse crimes.

Both types of voluntary groups carry out essentially the same activities, starting with updating members and holding trainings.

More than 90 percent of AAAs have partners in their efforts to detect and/or intervene in elder abuse. The most

frequent partner is Adult Protective Services (92.1 percent), followed by the Long-Term Care Ombudsman Program (80.9 percent), law enforcement (76.3 percent), aging services providers (71.6 percent) and Senior Legal Services organizations (64.2 percent) (see Table 6).

The AAAs most likely to measure the results of elder abuse prevention activities are those who belong to an elder abuse prevention coalition or multidisciplinary team. Fewer than 20 percent (16.9 percent) of AAAs that deliver elder abuse prevention programs and services measure their programs’ impacts and more than 70 percent of those belong to a coalition. More than 20 percent of AAAs (21.4 percent) who are members of a coalition measure the impact of their programs.

Figure 17: Components of Elder Abuse Prevention Coalitions

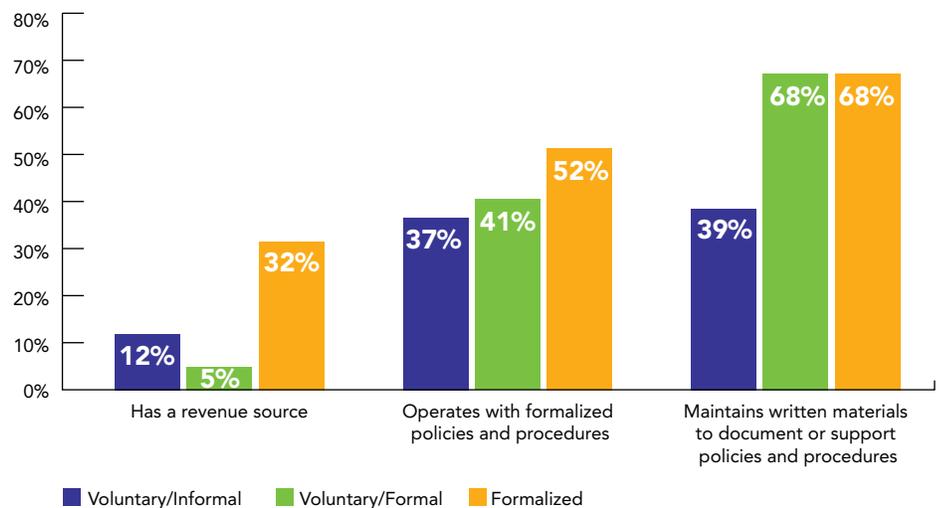


Table 5: Top 5 Activities Conducted by AAAs in Elder Abuse Prevention Coalition or Multidisciplinary Team, by Structure

Activity	Voluntary/Informal Coalition	Voluntary/Formal Coalition	Formalized Coalition
Update members about services, programs, and legislation	73.2%	76.8%	96.8%
Plan and carry out training events	72.0%	77.8%	64.5%
Advocate for change	69.5%	76.8%	61.3%
Identify service gaps and systems problems	64.6%	70.7%	58.1%
Provide an opportunity for colleagues to offer support, advice, and assistance on cases	65.9%	65.7%	67.7%

Table 6: AAA Partners in Preventing, Detecting, and/or Intervening in Elder Abuse

Adult Protective Services	92.11%	Emergency responders	35.49%
Long-Term Care Ombudsman Program	80.85%	LTC facilities or representatives	33.52%
Law enforcement	76.34%	Faith based communities	29.58%
Aging services providers	71.55%	Attorney General	29.30%
Senior Legal Services Providers	64.23%	Financial institutions/banks	28.45%
State unit on aging	61.97%	Domestic violence advocates	28.17%
ADRC	59.15%	Courts	26.76%
Aging related organizations	49.30%	State LTC facility licensing agency	22.54%
Mental health departments or organizations	43.66%	Pro Bono attorneys	21.13%
Prosecutors	40.00%	Private attorneys	20.85%
Health care organizations	38.59%	Citizen representatives 60+	20.28%

Expanding Services and Sustainable Funding

The Aging Network is continually making strides to expand its ever-changing role and business base in the long-term care and health care delivery systems. As demand has grown, Area Agencies on Aging are serving a more diverse group of clients. In addition to people age 60+ and their caregivers, AAAs are serving more veterans and people with disabilities under age 60.



To reach new clients, AAAs are carrying out business strategies such as contracting and marketing their agency and its services to new funders, developing long-range strategic plans, seeking and obtaining grants and expanding their services (see Figure 18).

From 2010 to 2013, AAAs began focusing their efforts on expanding the target groups served, as well as undertaking fundraising and development activities (see Figure 19).

Tracking Consumer Outcomes

The most frequently tracked consumer outcomes in 2013 were consumers' life satisfaction and health, as well as caregiver quality of life (see Figure 20). These results, which demonstrate program effectiveness, can be helpful in obtaining funding for future programs.

Changes Necessitated by Funding

The Older Americans Act (OAA) positioned AAAs to meet the service demands of a growing aging population. With *adequate resources*, this Network's expertise and ability to leverage resources make it the best option to provide nationwide and coordinated long-term services and supports (LTSS).

However, tight federal and state budgets make it extremely difficult for the Aging Network to maintain existing services. OAA funding is not sufficient to cover all of the services a community needs. As the number of older adults is increasing, funding has decreased or remained stagnant, making resources more scarce and reducing the ability of AAAs to provide services in their communities.



Figure 18: AAAs That Have Made Progress On or Have In Place Specific Business Strategies—2013

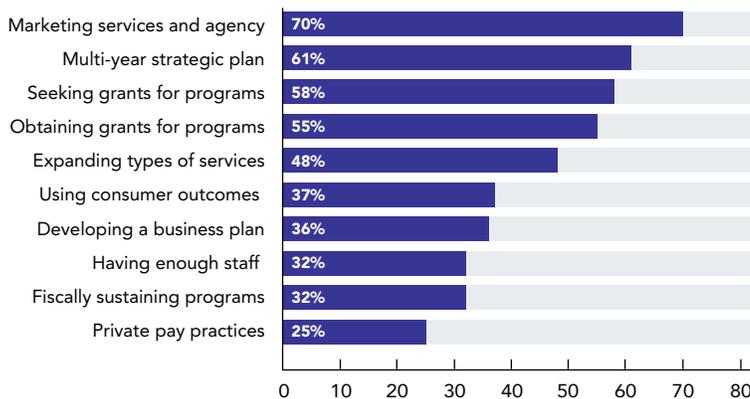
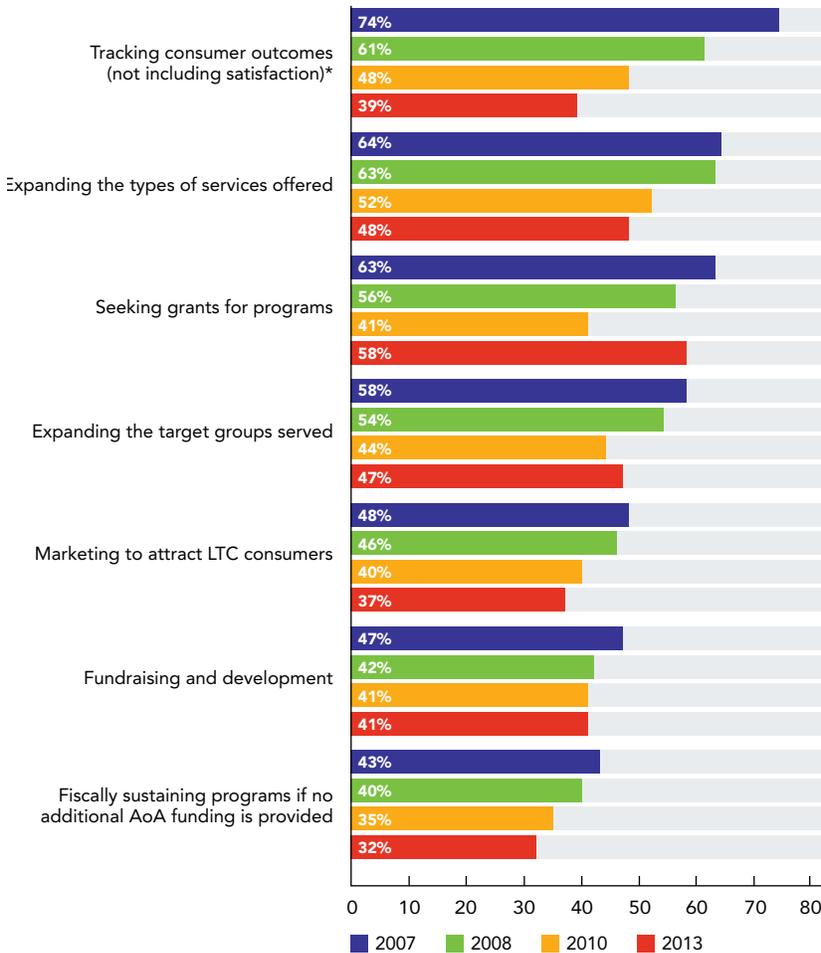


Figure 19: AAAs Business Practices (2007-2013)



* In previous surveys, this question permitted respondents to include satisfaction as a consumer outcome.

The demand for LTSS is continuing to climb, as more people age and as the economic downturn strains the budgets of people in need and their caregivers. Federal funding under the OAA now has limited opportunities for growth given budget caps imposed through 2021 under the Budget Control Act of 2011 (BCA). The BCA's sequester cuts are causing AAAs to suspend local programs, limit service hours, reduce staff and struggle to fund needed programs through a system that, while efficient, was already underfunded.

In addition, as their scope of responsibilities has evolved, AAAs have leveraged multiple funding sources in addition to the OAA, to meet the health and long-term needs of older adults in their communities. OAA funding provides the critical, unifying structure for the aging network, and without adequate funding levels, AAAs lose the opportunity to leverage those resources and use funds as they historically have done effectively.

Nearly half of AAAs reported that their total budget has decreased over the past two years, and less than one-fourth of AAAs have seen a funding increase. Slightly over one-quarter of AAAs saw their total budget remain flat over the previous two years.

AAAs appear to use their previous funding trends to anticipate funding changes in the future (see Figure 21). Among AAAs who reported funding decreases over the previous two years, 7 in 10 (70.1 percent) anticipated that their funding will further decrease over the next year.

AAAs have seen a steady decrease in many of their funding sources. More than 60 percent of AAAs reported a decrease in OAA dollars over the previous two years.

While few AAAs reported funding increases from any source, the most common came from Medicare dollars, with nearly 10 percent seeing an increase from this source. Funding was

most likely to have remained flat from the following sources (see Figure 22):

- Local funding (35.0 percent)
- Other state funding (26.6 percent)
- Transportation funding (26.1 percent)
- Funding from cost-share consumers (26.9 percent)
- Funding from private pay consumers (13.6 percent)

- Funding from the Veteran’s Administration (6.9 percent)

The continued economic downturn has had a strong impact on AAAs. More than 95 percent of AAAs have been affected and have responded by reorganizing, changing their operations and making changes that directly affect staff and clients. Most frequently, they are making these changes to

Figure 20: Types of Consumer Outcomes AAAs are Tracking

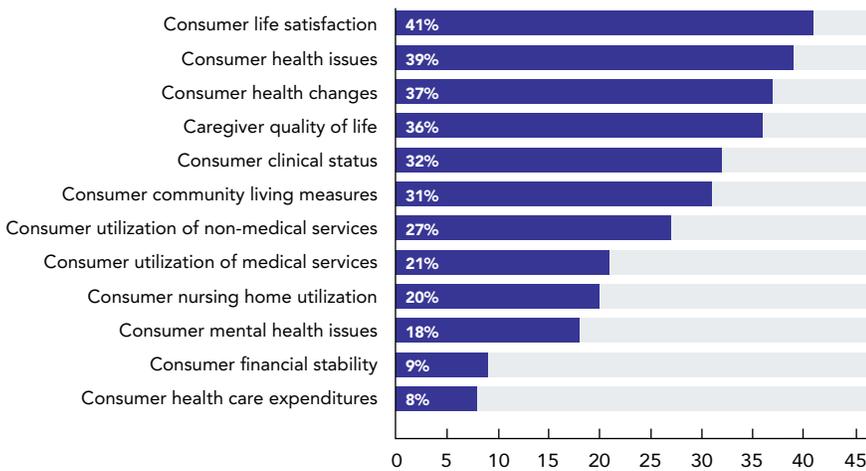


Figure 21: Proportion of AAAs Expecting Funding Changes by Past Budgetary Changes

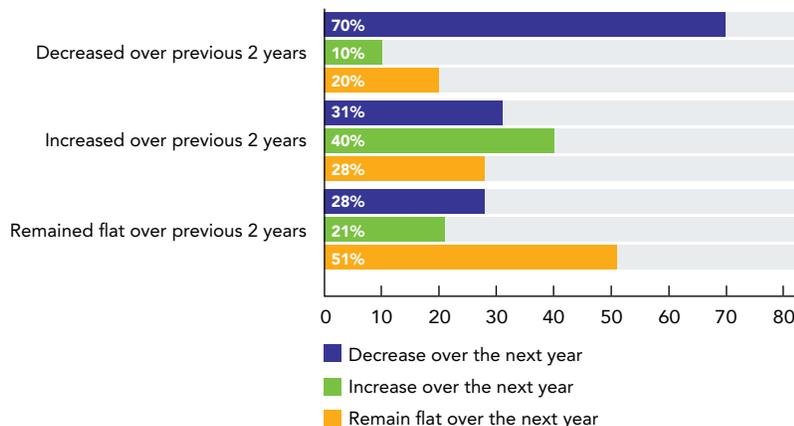
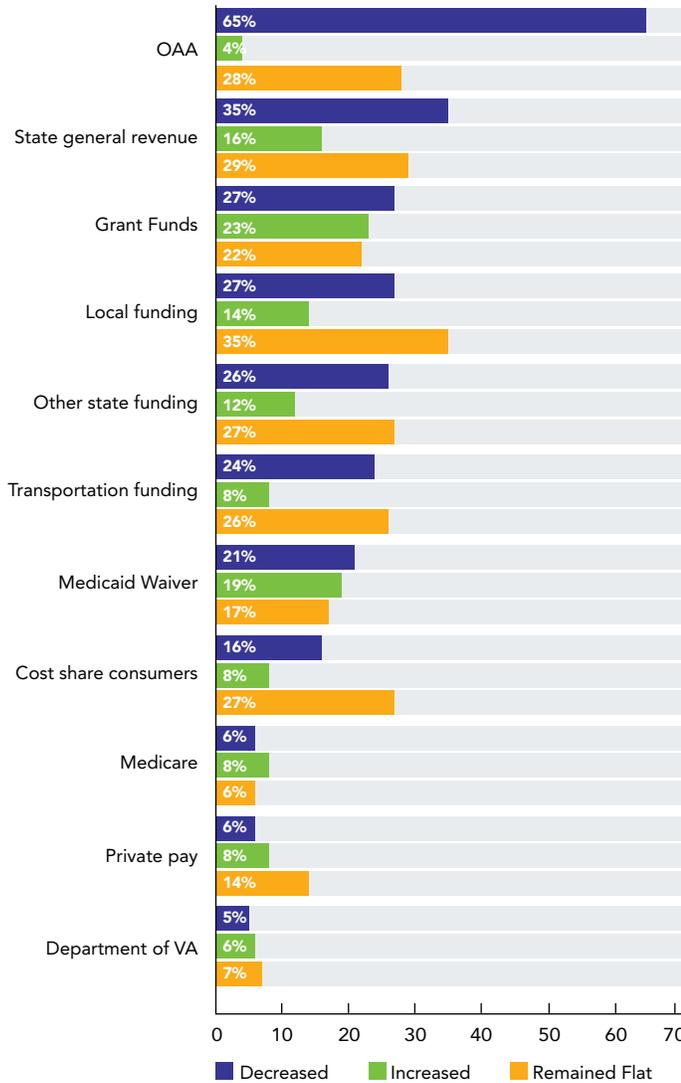


Figure 22: Funding Levels from Selected Sources



accommodate funding constraints (see Figure 23 and Table 7):

- Seeking new funding opportunities (66.4 percent)
- Reducing the total number of staff by not replacing those who left (58.9 percent)
- Instituting waiting lists (58.1 percent)
- Seeking new partnerships (52.8 percent)
- Increasing caseloads (48.5 percent)

So far, fewer numbers of AAAs have been forced to reduce staff salaries (3.5 percent), limit the hours of operation (9.3 percent), furlough at least some staff (9.6 percent), reduce office space (10.4 percent) and expand consumer/self-directed options for services (10.9 percent).

Survey respondents were asked to select whether any of the changes they made were due to sequestration, funding cuts other than sequestration and/or increased needs of consumers. While all three of these forces played a role in significant changes made by AAAs, funding cuts other than sequestration had the biggest effect (see Figure 24). They were the most commonly cited cause for reducing staff, exploring new funding opportunities, exploring new partnerships, instituting waiting lists and increased caseloads. Increased need was equally, or more important, than funding cuts in encouraging new partnerships and new funding opportunities.

Please note that because this survey was conducted in 2013 and the effects of cuts are unfolding rapidly, these numbers may be different today.

Table 7: Response to the Continued Economic Downturn (2010 and 2013)

Action Taken	Proportion of AAAs in 2010	Proportion of AAAs in 2013
Proactive and Strategic Reorganization Measures		
Explored new funding opportunities	61.4%	66.4%
Explored new partnerships	50.5%	52.8%
Reorganized the agency	39%	48.0%
Explored private pay options**	No data	32.5%
Renegotiated contracts with partners/providers	26.7%	23.5%
Increased program evaluations to determine time/money better spent	25.3%	21.3%
Changes to Operations		
Reduced total number of staff by not replacing those who left	49.3%	58.9%
Increased caseloads	52.7%	48.5%
Cut or eliminated business travel	44.1%	44.8%
Cut the budgets of at least some departments	47.7%	38.7%
Cut or eliminated staff training	39.3%	38.7%
Eliminated programs	18.7%	21.9%
Cut the budgets of all departments	12.8%	11.5%
Expanded consumer/self-directed options	12.6%	10.9%
Reduced office space**	No data	10.4%
Changes Directly Affecting Staff and Clients		
Instituted waiting lists	58.7%	58.1%
Restricted the number of clients served **	No data	42.9%
Froze staff salaries**	No data	33.1%
Eliminated or reduced staff salary increases	50.2%	30.4%
Reduced total staff hours by converting some positions from full-time to part-time	24.2%	26.1%
Reduced total number of staff through layoffs	23.3%	24.8%
Reduced staff benefits	22.8%	20.8%
Eliminated services	14.6%	15.2%
Redefined service eligibility	13%	13.6%
Furloughed at least some staff**	No data	9.6%
Reduced staff salaries**	No data	3.5%

** Denotes new category



Figure 23: Most and Least Common Responses to the Continued Economic Downturn (2010 and 2013)

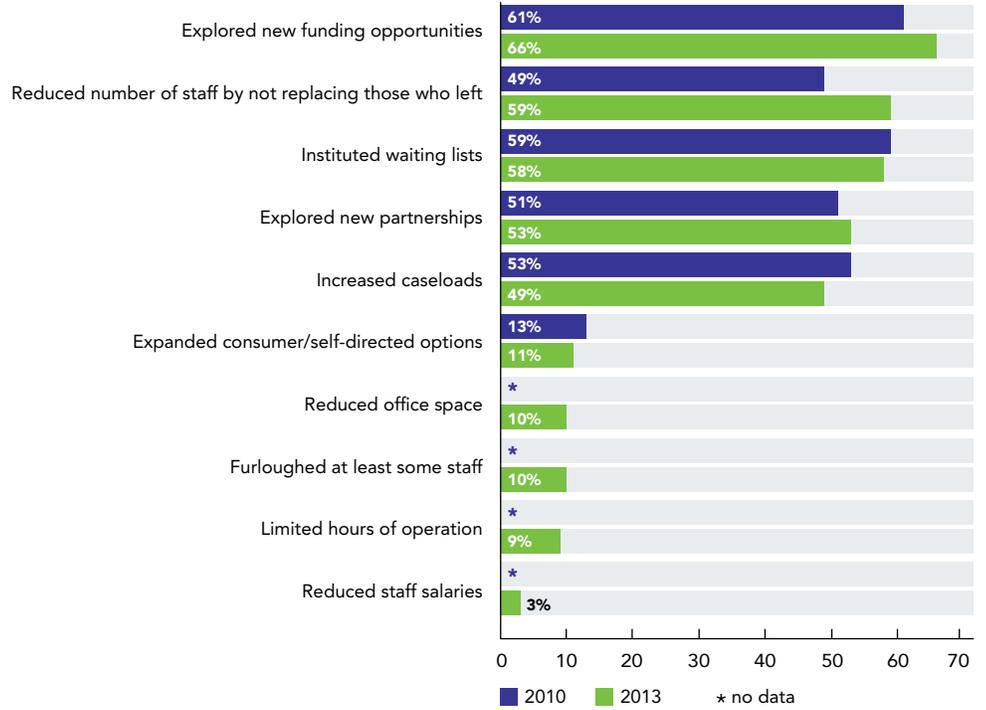
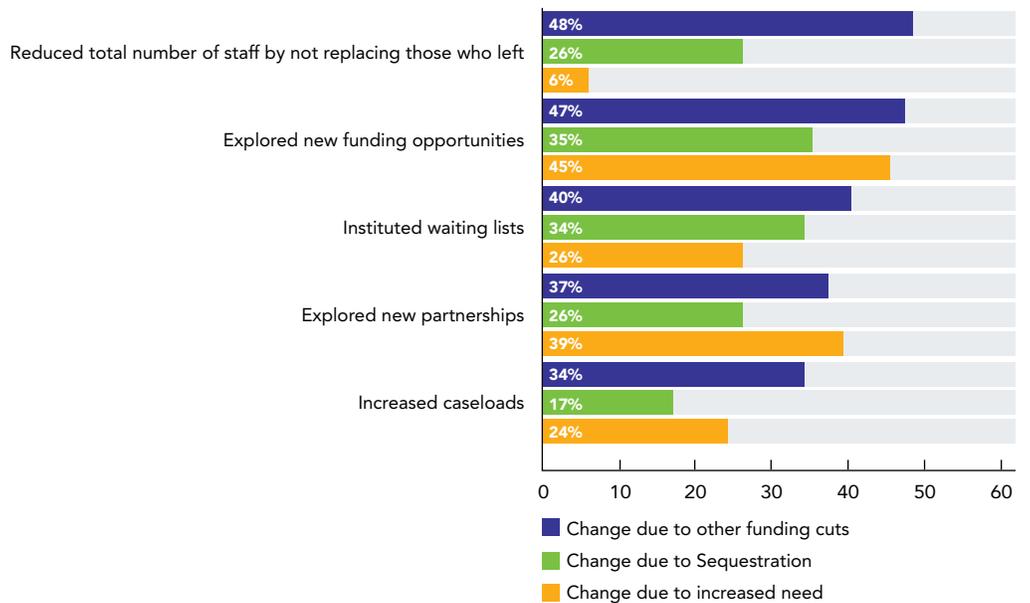


Figure 24: AAAs Making Changes by Impetus for Action



Key Finding
 AAAs continue to rely heavily on state funds that may also be in jeopardy.

Leveraging Multiple Funding Sources

Facing difficulties in securing enough federal funds to meet the needs in their communities, nearly all AAAs (98 percent) draw on multiple sources of funding in addition to OAA dollars.

In recent years, AAAs have relied heavily on additional funding from the state general funds to augment services. However, this approach comes with risk, as state budgets are now in crisis too. State-funded programs for older adults and caregivers, created to build upon or fill gaps in federal funds, may also be at risk to be dramatically cut or eliminated, forcing AAAs to once again search for new ways to provide the programs that cover those in need.

These sources most commonly pay for programs provided outside of OAA funding (see Figure 25):

- State general revenue funding
- Local funding
- Medicaid waiver programs

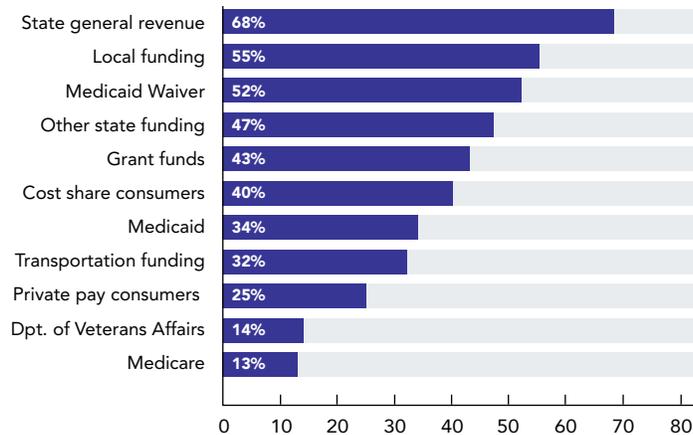
- Other state funding
- Grant funds
- Cost share consumers

The trend in heavy reliance on state-generated funds holds steady across time and across services. This report specifically looked at adult day service, assessment for care planning, assessment for long-term care eligibility, assistive technologies, case management, home health, homemaker, personal assistance/personal care, respite care, medical transportation and non-medical transportation (previous surveys combined medical and non-medical transportation).

In 2013, these services relied on (in order of importance) state general revenue funding, Medicaid waiver and local funding:

- Adult day service
- Assessment for care planning
- Case management
- Homemaker services
- Respite care

Figure 25: Common Funding Sources in Addition to OAA



These services depended on Medicaid waiver, state general revenue funding and other state funding:

- Assessment for LTC eligibility
- Assistive technologies
- Home health

Transportation, both medical and non-medical, depended on local funding, state general revenue funding and transportation funding in 2013.

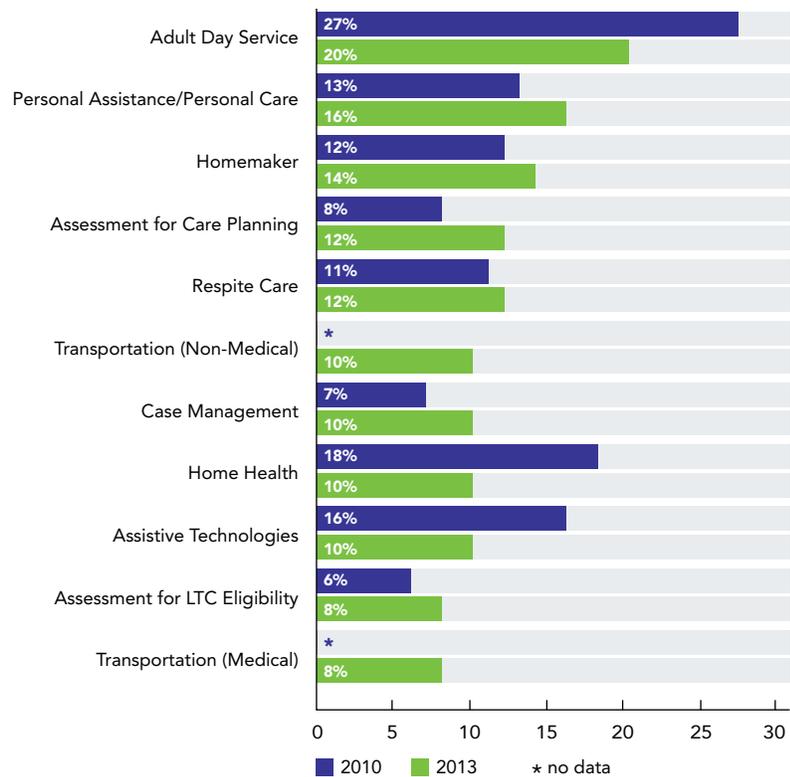
Key Finding

Increasingly, AAAs are expanding their services through private pay—charging customers who use those services.

Exploring Private Pay

Another way AAAs fund additional services is by charging fees directly to customers. Nearly 25 percent of all AAAs receive funding from private pay consumers. In 2013, more AAAs received funding from private pay consumers than in 2010 in almost every service, except for adult day service, home health and assistive technologies (see Figure 26).

Figure 26: Proportion of AAAs that Receive Funding From Private Pay Customers to Provide Specific Services (2010 and 2013)



In the past five years, the proportion of AAAs that are developing private pay practices has grown as well. This trend is continuing, with more AAAs reporting in 2013 that they are planning to begin developing private pay practices than have done so in previous years. Fewer than 20 percent of AAAs have no plans to develop private pay practices (see Figure 27).

To develop private pay practices, most AAAs are establishing a fee-for-service program for clients (72.7 percent), developing unit cost pricing (65.7 percent) and learning about private pay models used successfully by other AAAs (64.6 percent) (see Figure 28).

AAA Profile: Private Pay Program

Region IV Area Agency on Aging St. Joseph, MI

Custom Care, a private pay program developed by the Region IV Area Agency on Aging, was started as a result of a long-distance caregiver calling to see if the AAA would work with his mother in St. Joseph by packaging services from varied agencies, assuring they were delivered correctly to his mother and then billing him. Staff thought that if they already offered this under the Older Americans Act and Medicaid, why not a family? From simple consultation, to service arrangement and consolidated billing, to full assessment and management of care, Custom Care meets needs through a fee-based care service that can bypass the waiting lines and limitations of subsidized programs to provide prompt, private consultation and service.

Figure 27: AAA Involvement in Developing Private Pay Practices (2008-2013)

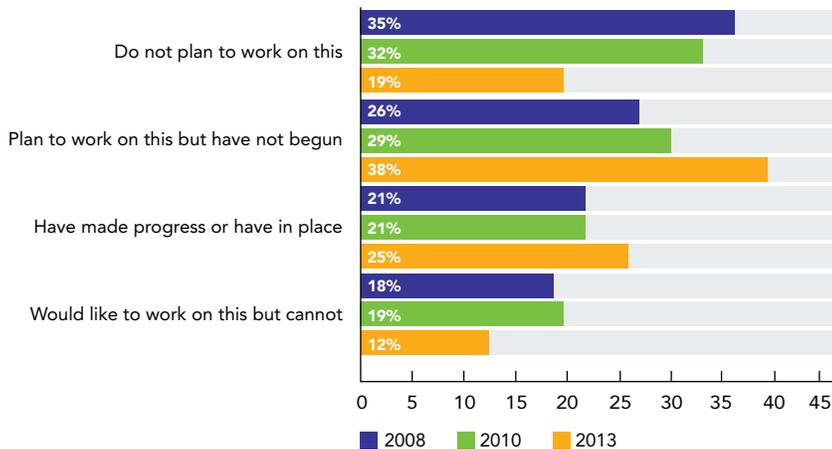
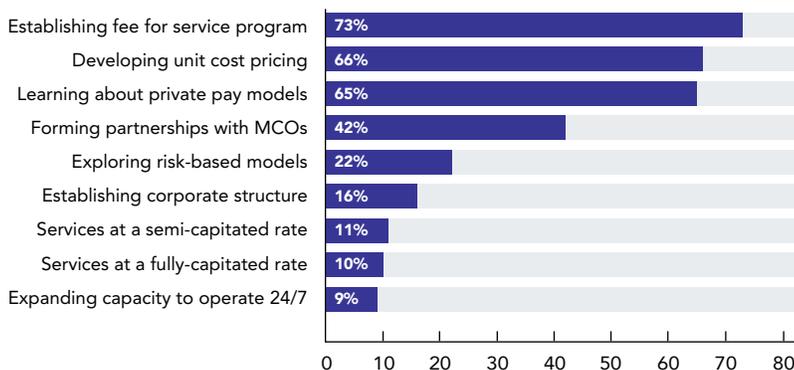


Figure 28: Activities of Those AAAs Who Are Developing Private Pay Practices



Training AAAs for Tomorrow

Since 2007, AAAs requested training and technical assistance related to business acumen more than any other category. This survey helped to identify, in greater detail, the types of business expertise AAAs are seeking.



Eager to learn more about ways to serve older adults and people with disabilities, more than 97 percent of Area Agencies on Aging (AAAs) report that there is some type of training or technical assistance that would benefit their agency.

The top six reported training needs are as follows (see Figure 29):

- Developing fee-for-service opportunities (38.4 percent)
- Developing outcome measures (36.6 percent)
- Working better with partners in managed care (33.9 percent)
- Business planning (32.9 percent)
- Strategic planning (30.3 percent)
- Strategic alliances within the local healthcare system (30.3 percent)



Figure 29: Proportion of AAAs Needing Training or Technical Assistance by Selected Topic



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1730 Rhode Island Avenue, NW, Suite 1200, Washington, DC 20036 • 202.872.0888
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