

## Improving the Health of Older Adults at Home and in the Community

### AAA Innovation in a Changing Health Care Landscape

For more than 40 years, Area Agencies on Aging (AAAs) have developed local systems of coordinated services and supports that provide person-centered, home and community-based services for older adults. Services offered through AAAs include meals provided in the home and in community settings, in-home care assistance, transportation, information and referral, evidence-based health and wellness programs, medication management, case management and more.



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The U.S. health care system is in the midst of a dramatic change as focus shifts from delivering volume to improving outcomes and value for patients. This evolution, combined with the rapid aging of the population, reinforces the need for health care systems **to tap the expertise of Area Agencies on Aging and their Aging Network partners to meet the health and wellness needs of our nation's aging population.**

In recent years, as health care costs have continued to grow, the health care sector has taken a closer look at ways it can address—or work with partners to address—social issues that affect consumers' health. Some of these social determinants of health are access to housing, employment, nutritious food, community services, transportation and social support, and addressing these factors has been shown to improve long-term health and wellness outcomes.

As experts at providing services that improve the social determinants of health, Area Agencies on Aging are looking for new ways to improve the health of older adults by engaging in innovative models of service delivery and establishing partnerships with health care entities. **The following examples highlight some of the ways AAAs are responding to this changing health care landscape and feature innovative local strategies for reducing costs while improving outcomes. ▶**

## Addressing the Social Determinants of Health

### Maine agency develops partnerships with health care entities to improve patient care through the provision of home and community-based services

The Southern Maine Agency on Aging (SMAA)—whose 85 full-time equivalent employees and 450 senior volunteers serve nearly 20,000 older adults and their caregivers annually—has shown how community-based organizations (CBOs) can build long-term, sustainable partnerships with health care entities.

SMAA has worked for more than a decade to improve health care outcomes of older adults by building a network of contracts with local hospitals, health plans, medical practices and now an Accountable Care Organization (ACO). SMAA has succeeded in embedding its staff in partner facilities and engaging older adults in volunteer programming that addresses the social determinants of health. Nominated by the MaineHealth ACO—one of its partners—SMAA received the first John A. Hartford Foundation Business Innovator Award in 2016 in recognition of these efforts. Highlights include:

- cultivating champions in the local health care community, including inviting heads of local health plans/hospitals to serve on the SMAA board of directors;
- embedding SMAA care transitions personnel into the staff of MaineHealth ACO, and participating in shared savings with the ACO;
- modifying the **SMAA home-delivered meals program to show a 17 percent reduction in 30-day admission rates for high-risk Medicare patients;**
- working with partners to convert the “A Matter of Balance” evidence-based falls prevention program to a lay-leader model, now used in 41 states and the U.S. Virgin Islands;
- serving 11,000 high-risk Medicare beneficiaries through a four-year Community-Based Care Transitions Program worth approximately \$5.2 million;
- reaching 2,100 people statewide through the Savvy Caregiver program for family caregivers of people with dementia; and
- establishing a three-year contract with a local hospital to cosponsor not only the “A Matter of Balance” program but also “Welcome to Medicare” classes, in which SMAA staff and volunteers counsel older adults on Medicare enrollments, **saving those adults—on average—nearly \$1,400 per person, per year, in out-of-pocket expenses.**

## Bridging Disability and Aging to Maximize Capacity

### New LLC offers coordinated package of wellness and supportive services for consumers

The Oklahoma Aging and Disability Alliance, LLC, was formed by two CBOs to maximize their capacity by creating a unified entity offering an array of services for which they can be paid by hospitals and insurers.

Ability Resources, a Center for Independent Living, and Indian Nations Council of Governments (INCOG), an Area Agency on Aging, first worked together more than eight years ago, and formalized that collaboration by creating a limited liability company (LLC) in 2015.

“In this time of stagnant government funding, both our networks needed to be better positioned to seek out new business opportunities,” said INCOG AAA Director Clark Miller. “The process of developing a LLC challenged our mindset of being grant-funded entities to one where we began to understand how new business opportunities can support our long-term sustainability.”

The LLC allows the two organizations to combine efforts to serve the community’s older adults and people with disabilities by offering more services together than they would separately. Ability Resources, as a disability nonprofit, provides transportation, housing and case management services, while INCOG, a local government-based entity focused on aging concerns, provides services such as nutrition, in-home care, health and wellness, and family caregiver support. The LLC offers potential payers a combined, comprehensive listing of services using a unified communications and marketing strategy. The structure of the LLC allows for other organizations to join in future.

The LLC spent 2016 building relationships with local health care entities; assessing the local market; and laying groundwork for future contracts. With its infrastructure in place, the LLC is now pursuing potential contracts for Veterans Directed Home and Community-Based Services (VDHCBS), as well as falls prevention programs.

## Positioning a Regional Network to Help Bend the Cost Curve

### Aging groups in western New York join forces to offer integrated care services to older adults

The Western New York Integrated Care Collaborative (WNYICC) transformed their organization from a loosely affiliated group of Aging Network providers (operating primarily within the parameters of traditional county-based service delivery) to a formal, taxable nonprofit corporation well positioned to pursue regional opportunities.

WNYICC—which includes two county Area Agencies on Aging, a local United Way, several neighborhood-level nonprofit CBOs, and a small number of regional CBOs—worked with the Health Foundation for Western and Central New York to explore how integrated care networks can best be organized to meet both organizational needs and community readiness in western New York. Although WNYICC believes it has a valuable role to play in bending the curve on health care and long-term care spending, they also recognize there are considerable obstacles to participating in the evolving marketplace as stand-alone organizations.

Recognizing that they were stronger and better positioned together, WNYICC members concluded that they needed an integrated care network with regional reach; low set-up and organizational costs; and the ability to evolve along with the work. They also needed a network that would eventually be able to offer a range of services to members to demonstrate their value to potential new partners, including those working under value-based payment systems, where patient outcomes matter most.

WNYICC then consulted other community members who had done similar network-building. Those conversations pointed to the success of incremental network development. WNYICC, however, wanted a more immediate formal structure in order to pursue its near-term goals of contracting with health care entities. To reach its immediate goals with flexibility to address future goals, WNYICC members decided to form a taxable nonprofit corporation, which could be established quickly while allowing for modifications to the structure as it grows; the deciding factor was that the corporation could be converted into a 501(c)(3) at a later date when needed.

## Care Transitions Program Drives Down Hospital Readmissions Rates

### Success opens the door to statewide collaboration for a Virginia regional partnership

The Eastern Virginia Care Transitions Partnership (EVCTP)—a formal partnership of AAAs, health systems, independent physicians' groups and other public and private health and human services groups—leveraged a successful care transitions program into the Virginia AAA Collaborative (VAAACares), a one-contract, one-stop coalition for statewide services.

Bay Aging, a AAA serving southeastern Virginia, teamed up with Riverside Health System to create EVCTP in 2013 in response to a funding opportunity under the federal Centers for Medicare and Medicaid Services' (CMS) Community-Based Care Transitions Program (CCTP).

EVCTP delivered remarkable results: **Hospital readmission rates decreased from a baseline of 23.4 percent in 2010 for the target population to an astounding 9.1 percent in 2015 for EVCTP enrollees, saving Medicare \$10 million.** EVCTP—the sixth-best overall performer in CCTP—then expanded to the Medicaid population through a state-funded pilot program. EVCTP works with multiple health plans to provide care transitions and complex care coordination in 22 hospitals. EVCTP's impact on Medicaid patients was clear as the average readmission rate of 25 percent dropped to 13 percent.

When Virginia moved to a managed long-term services and supports (MLTSS) system in 2017, the Virginia Center for Health Innovation, a nonprofit working to accelerate the adoption of value-driven models of wellness and health care throughout Virginia, along with the Department of Medical Assistance Services, encouraged the expansion of EVCTP into a statewide AAA collaboration.

In response, EVCTP developed VAAACares, a statewide coalition of AAAs that serves as the one-contract, one-stop legal entity for comprehensive care coordination, care transitions, and many other community-based services for dual-eligible health plan enrollees.

Bay Aging serves as the lead agency and representative legal entity for the VAAACares collaborative. This arrangement consolidates billing processes and sets up a single organization as the contracting vehicle in partnerships, which is a powerful marketing tool in outreach to health plans and providers. The other member AAAs have business associate agreements with Bay Aging, and AAA directors from all five VAAACares regions serve on the VAAACares steering committee.

# Using Evidence to Drive Healthy Aging

## Using a trusted community agency to help older adults manage chronic conditions

The Elder Services of the Merrimack Valley, Inc. (ESMV) Healthy Living Center of Excellence and Senior Whole Health (SWH), a managed care program for older adults, are collaborating to address the social determinants that negatively impact the physical and behavioral health of older adults in Massachusetts.

Recognizing that SWH members with multiple chronic conditions could benefit from self-management programs to reduce readmissions and overall medical costs, SWH entered into a contract with ESMV and their Healthy Living

Center of Excellence to serve as the centralized statewide infrastructure for program delivery. SWH reimburses them for every member who enrolls and completes an evidence-based program such as Chronic Disease Self-Management or “A Matter of Balance.”

SWH reimburses the Healthy Living Center of Excellence an established rate per participant, which covers program costs, outreach and transportation. In 2017, **the completion rate for SWH members in evidence-based programs through this project is 95 percent, almost 20 percent higher than the national standard.** ESMV is replicating this model with additional managed care plans in Massachusetts and is providing technical assistance to other AAAs across the country as they develop similar programs.

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The National Association of Area Agencies on Aging (n4a) is the membership organization for the 622 Area Agencies on Aging (AAAs) and a voice in the nation’s capital for the more than 250 Title VI Native American aging programs in the U.S. The fundamental mission of the AAAs and Title VI aging programs is to provide services that make it possible for older individuals to remain in their homes, thereby preserving their independence and dignity. These agencies 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.