The National Aging Network Survey

2013 Results

SUZANNE KUNKEL, HEATHER REECE
JANE STRAKER

Scripps Gerontology Center
An Ohio Center of Excellence

MIAMI UNIVERSITY

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Suzanne Kunkel
Heather Reece
Jane Straker

Scripps Gerontology Center
Miami University

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BACKGROUND

With a grant from the Administration on Community Living (ACL), the National Association of Area Agencies on Aging (n4a) partnered with Scripps Gerontology Center of Excellence to conduct the 2013 National Aging Network Survey of Area Agencies on Aging. The survey was designed to assess the evolving role of the aging network in a balanced long-term care system. This survey explored the expanding role of Area Agencies on Aging (AAAs) in the new health care delivery system, including:

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

The web-based survey was launched in July 2013 to all 613 AAAs who could be contacted via e-mail. Data collection concluded in September of 2013 with 63% (n=391) of AAAs responding. This report provides key findings from the survey related to the following topics: Organizational Infrastructure, Key Features and Services of Area Agencies on Aging, Innovative Care Delivery, Elder Abuse Prevention, Sustainability Strategies and Business Development, and Training Needs. In addition, the report provides comparison data from the 2007, 2008, and 2010 surveys — where appropriate — to track changes in the aging network over time.

ORGANIZATIONAL INFRASTRUCTURE

In 2013 the average AAA had a budget of over nine million dollars; a nearly six percent increase from 2010. While the average budget increased, the median budget decreased indicating that over half of AAAs have a budget below $3.9 million. The average AAA continues to receive around 40% of its budget from the Older Americans Act (OAA). However, there is significant variability in this proportion, ranging from 1% at the low end and 100% at the high end. The average proportion of budget that comes from Medicaid has increased slightly. In 2010 the average AAA received nearly 25% of its budget from Medicaid, while in 2013 the average AAA received more than 25% of its budget from Medicaid. As shown in Table 1, the median proportion contributed by Medicaid has also increased as well.

On average there has been a slight increase in the number of full-time staff persons since 2010, returning to the average of 41 full-time staff persons seen in 2008, and an increase in the number of part-time staff, returning to one fewer part-time staff person than in 2008. The average AAA is relying more heavily on volunteers with the average number of volunteers increasing by nearly ten since 2010 while returning to the same median number of volunteers as in 2008.

Table 1: Organizational Infrastructure

	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
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 proportion of their budget from Medicaid.

The areas served and the organizational structure of our AAA respondents are shown below.

Area served – proportion of AAAs that serve the following areas:	
Urban	5.1
Suburban	3.8
Rural	43.7
Remote or frontier	1.8
A mix of urban and suburban	8.4
Mix of suburban and rural	11.3
Mix of urban, suburban, and rural	25.6

Structure – proportion of AAAs that identify their structure as the following:	
Independent, non-profit	39.1
Part of a city government	2.8
Party of a county government	27.9
Part of COG or RPDA**	26.3
Other	3.8

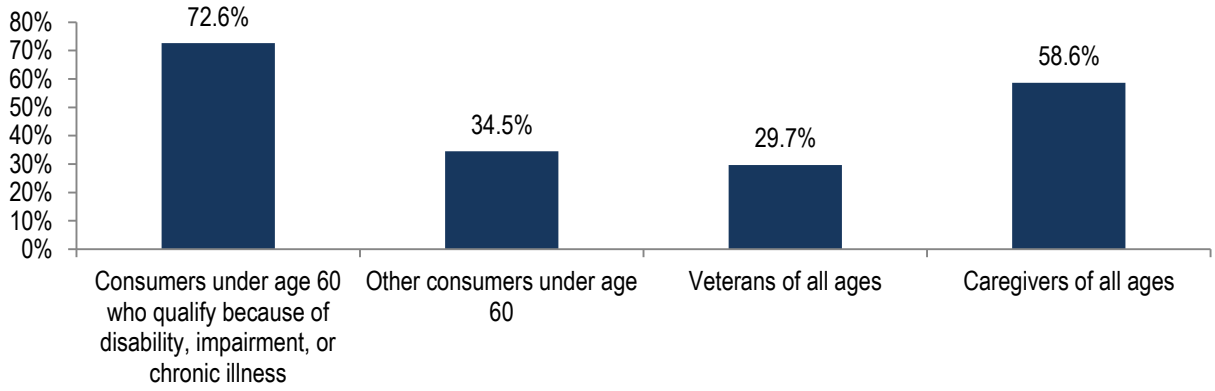
**Part of a Council of Governments or Regional Planning and Development Area.

Reflecting their expanding role in assuring access to a balanced system of services and supports, a majority of AAAs have other official designations and certifications. Nearly three-quarters (72.4%) are designated as an Aging and Disability Resource Center (ADRC), six in 10 (61.9%) are a designated State Health Insurance Program (SHIP) and well over half (56.5%) serve as their area's Long-Term Care Ombudsman Program (LTCOP).

POPULATION SERVED

While all AAAs serve older people, many of these agencies also serve other consumers. As Figure 1 shows, over seventy percent of AAAs provide services to consumers under age 60 who qualify because of disability, impairment, or chronic illness. Since 2010, the proportion of AAAs that provide services to caregivers of all ages has remained steady (58.8% of AAAs in 2010). Veterans of all ages are increasingly served by AAAs — nearly 3 in 10 AAAs serve veterans; a small increase from 2010 (26.9%).

Figure 1: Specific Consumers Served by AAAs (2013)

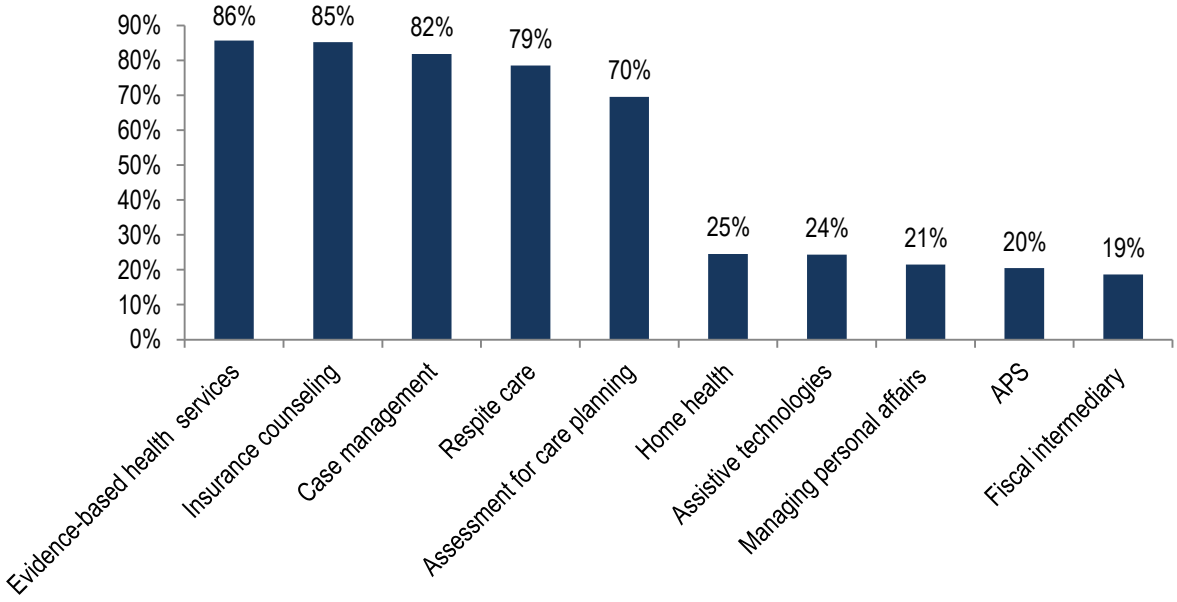


KEY FEATURES AND SERVICES OF THE AREA AGENCIES ON AGING

SERVICES

This year, respondents were asked whether or not they delivered a service either directly or through contract with a provider organization. This is a change from previous surveys where respondents were asked to specifically identify which services were provided directly and which services were provided through a contract. AAAs deliver a number of services in addition to those mandated by the Older Americans Act. The average AAA provides 18.9 services; this includes core services and additional services. In addition to the nine core services required by the OAA, the average AAA delivers 12.4 non-mandated services. As shown in Figure 2, the most commonly delivered services are evidence-based health promotion services/programs, benefits/health insurance counseling, case management, respite care, and assessment for care planning. The services that the fewest AAAs are providing are fiscal intermediary services for self-direction, Adult Protective Services (APS), managing personal affairs and finances, assistive technologies, and home health.

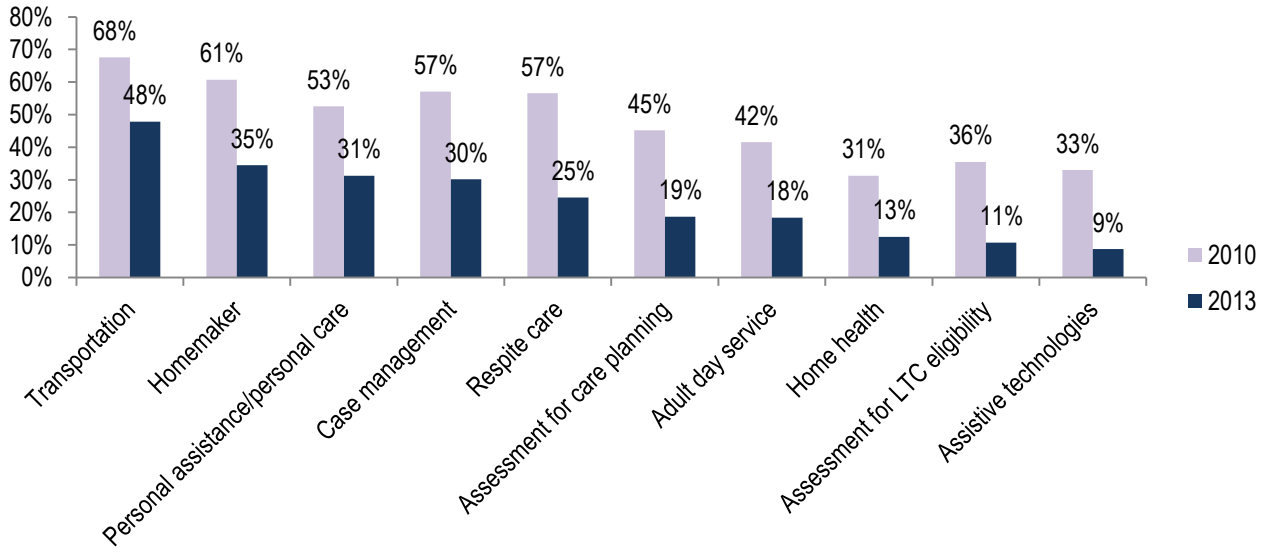
Figure 2: Additional Services AAAs are Most and Least Likely to Provide (2013)



SERVICES PROVIDED TO OTHER CONSUMERS

An important trend related to the specific services provided by AAAs is the expansion of the population served. Consistent with the mission of AAAs to assist all individuals to remain in their homes and communities, Figure 3 illustrates that the proportion of AAAs that offer services *only* to consumers age 60+ has decreased across all services.

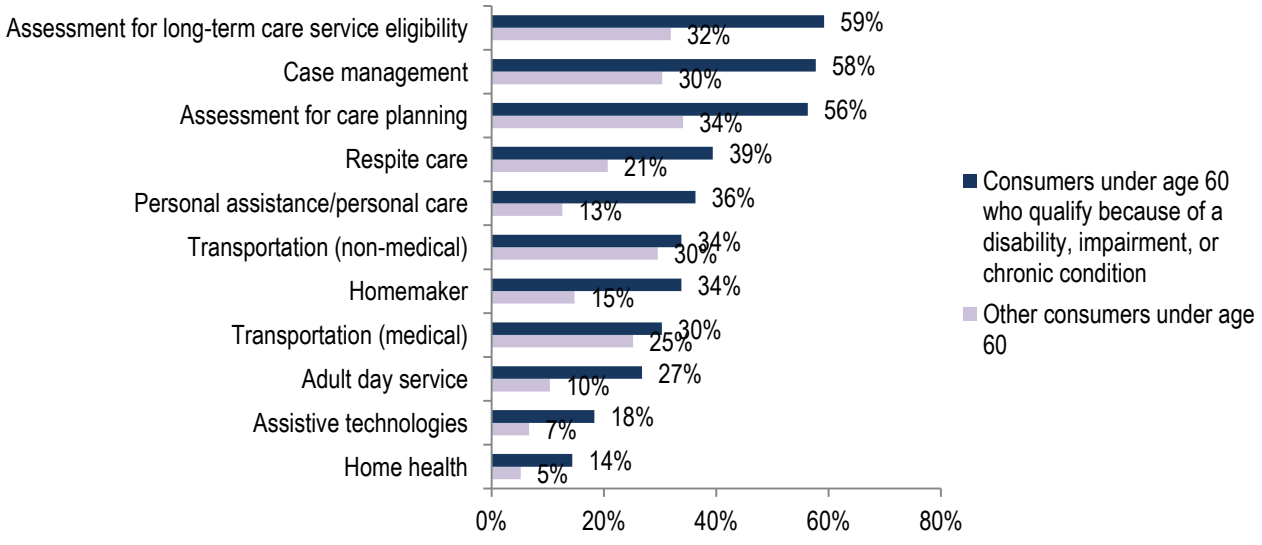
Figure 3: Proportion of AAAs Serving Only Consumers Age 60+ in Specific Services (2010 and 2013)



This trend is mirrored by an increase in the proportion of AAAs delivering a variety of services to consumers under the age of 60. Over three-quarters of AAAs (76.7%) provide at least one service to consumers under age 60. More than half (54%) of those AAAs serve only those persons under 60 who qualify because of a disability, impairment, or chronic illness. Fewer than five percent serve only consumers 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.

As illustrated in Figure 4, of those AAAs who provide services to consumers under age 60 who qualify because of a disability, impairment, or chronic illness and those AAAs that provide services to other consumers under age 60, the most commonly provided services to consumers under age 60 who qualify because of a disability, impairment, or chronic illness are assessment for long-term care eligibility, case management, assessment for care planning, respite care, and personal assistance/personal care services. Those services least likely to be provided to consumers under age 60 who qualify because of a disability, impairment, or chronic illness are home health, assistive technologies, adult day service, medical transportation, and homemaker services. Those services most likely to be provided to other consumers under age 60 are assessment for care planning, assessment for long-term care eligibility, case management, non-medical transportation, and medical transportation. Those least likely to be provided are home health, assistive technologies, adult day service, personal assistance/personal care, and homemaker services.

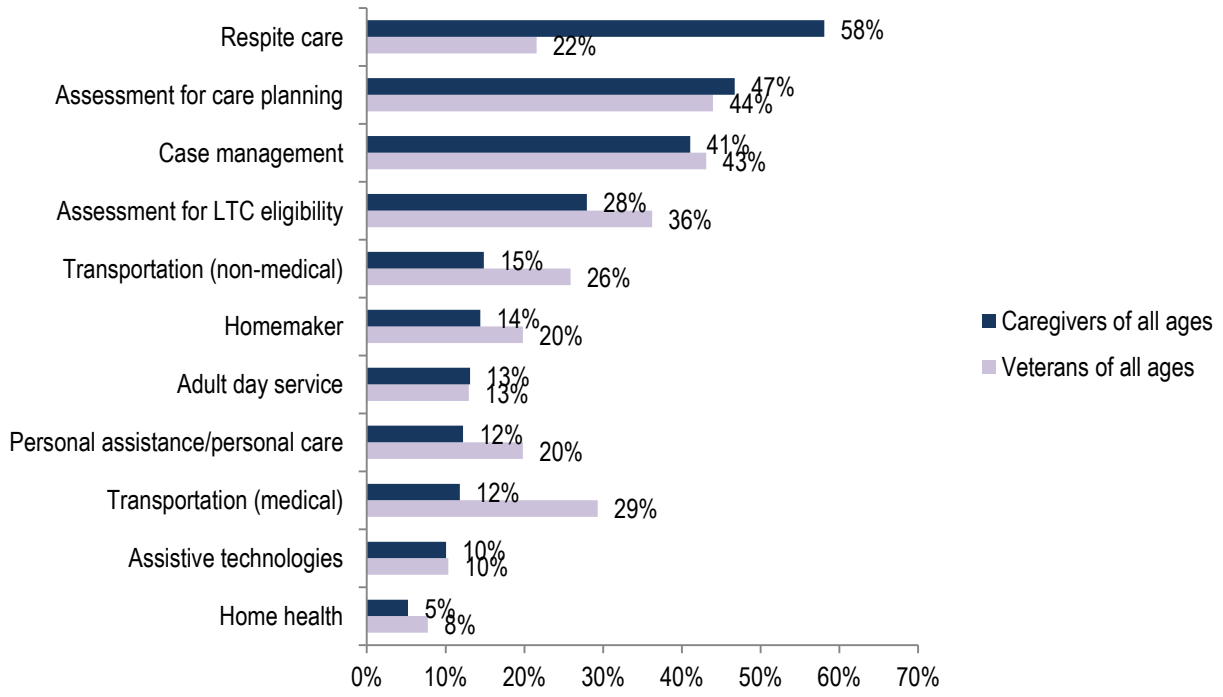
Figure 4: Services Provided to Consumers Under Age 60 (2013)



SERVICES TO SPECIFIC CONSUMER GROUPS

AAAs serve specific types of consumers — specifically caregivers and veterans of all ages. As noted in Figure 1 on page 3, almost 60% of AAAs deliver services to caregivers of all ages and nearly 30% deliver services to veterans of all ages. As shown in Figure 5, of those AAAs that provide services to either caregivers or veterans of all ages, the services most likely to be delivered to caregivers of all ages are respite care, assessment for care planning, case management, assessment for long-term care eligibility, and non-medical transportation. Those least likely to be delivered to caregivers of all ages are home health, assistive technologies, medical transportation, personal care/personal assistance, and adult day service. The services most likely to be delivered to veterans of all ages are assessment for care planning, case management, assessment for long-term care eligibility, medical transportation, and non-medical transportation. Those programs and services least likely to be delivered to veterans of all ages are home health, assistive technologies, adult day service, homemaker services, and personal assistance/personal care services.

Figure 5: Services Provided to Consumers Based on Their Role as Caregivers or Veterans (2013)

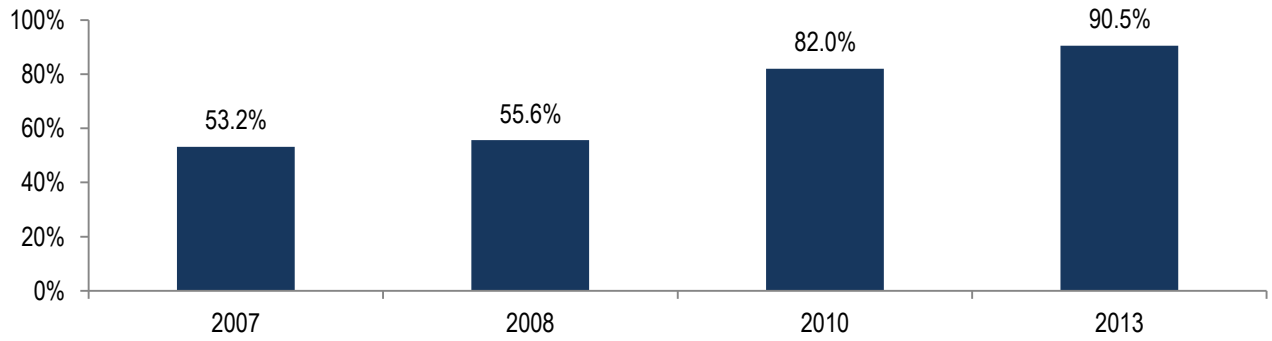


HEALTH PROMOTION SERVICES AND PROGRAMS

The proportion of AAAs involved in providing evidence-based health promotion services and programs continues to grow as illustrated in Figure 6. These programs and services assist older adults and their caregivers to remain active and healthy. In 2013 over 90% of AAAs delivered at least one evidence-based health promotion program or service. Of those AAAs delivering at least

one of these programs, the most commonly provided, formally-recognized programs are: Chronic Disease Self-Management Program (78.5%), A Matter of Balance (45.8%), Diabetes Self-Management Education Training (31.1%), Powerful Tools for Caregivers (27.1%), and Tai Chi Moving for Better Balance (23.7%). Twenty-five percent of AAAs provide at least one evidence-based health promotion program or service that was not listed in the survey: over 25% of AAAs offering other, non-specified evidence-based health promotion services. The most common evidence-based health promotion service added by AAAs were Arthritis Foundation Exercise and Walk with Ease Programs, fall prevention programs, other Tai Chi Programs, and home medication management programs.

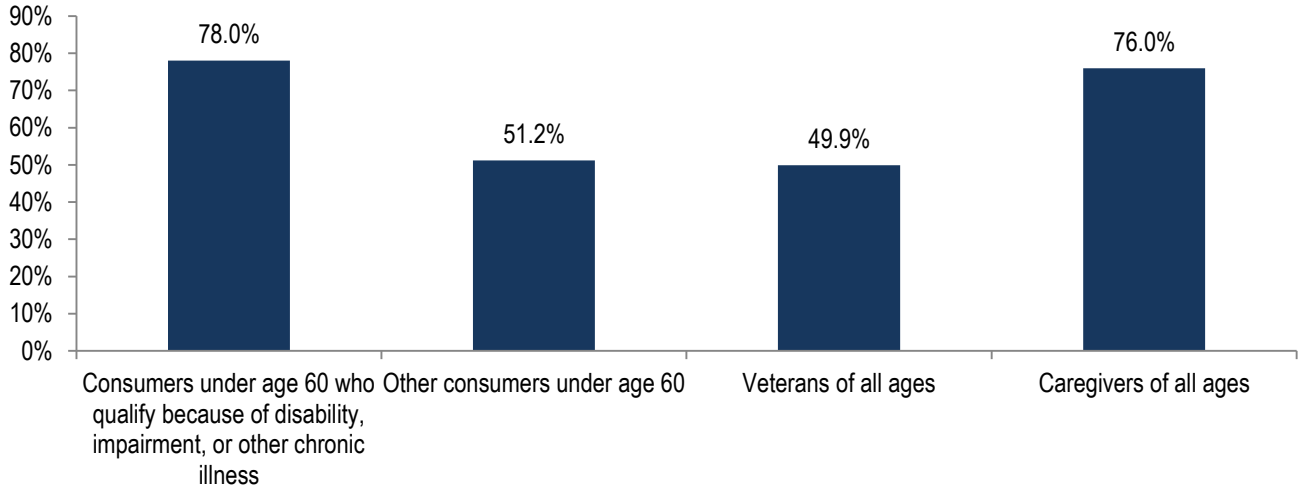
Figure 6: Proportion of AAAs Involved in Evidence-Based Health Promotion Programs (2007-2013)



SINGLE POINT OF ENTRY

In order to better assist consumers in getting the services that they need, AAAs serve as a single point of entry for many of their services. While expanding their service base, single points of entry make accessing services, referrals, and information simpler by providing a variety of consumers with a single source to receive assistance. The proportion of AAAs that serve as a single point of entry for only consumers age 60+ has decreased since 2010 (78.6%), reinforcing the broader reach of the network. As illustrated by Figure 7 AAAs are providing streamlined access to at least one service for a variety of consumers. Many of them are doing so through an ADRC model; the proportion of AAAs that operate as an ADRC has increased to nearly three-quarters (72.4%) — up significantly from 2008 when fewer than one in 10 (8.7%) were operating as an ADRC.

Figure 7: Proportion of AAAs That are the Single Point of Entry for at Least Some Services, by Target Population (2013)



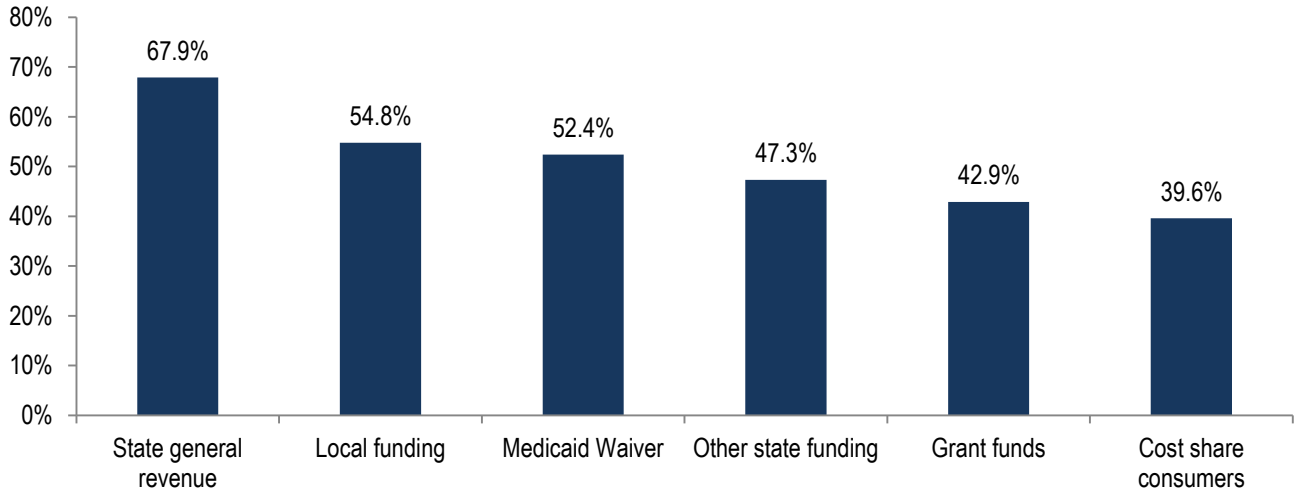
SELF-DIRECTED SERVICES

When consumers are provided with self-directed services they are able to exercise greater control over the services and supports that they are receiving. The self-directed component of long-term services and supports allows individuals to hire, manage, and dismiss their workers and will support them to financially manage their service plan. Since 2008, the number of AAAs providing consumers with a self-directed option continues to increase (from 48.4% in 2008 to 51.0% in 2010, to 62.4% in 2013).

LEVERAGING MULTIPLE FUNDING SOURCES

The aging network utilizes many sources of funding to assist the older adults in their communities. Nearly all (98%) AAAs seek funding in addition to Older Americans Act dollars to meet the needs of their participants. In order to provide services in addition to those required by the OAA, AAAs rely heavily on their home state for additional funding. The most common sources of funding for additional programs are: state general revenue funding, local funding, the Medicaid Waiver programs, other state funding, grant funds, and cost share consumers, as shown in Figure 8.

Figure 8: Common Funding Sources for AAAs (2013)



This trend of 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, and transportation (medical and non-medical: previous surveys have combined medical and non-medical transportation together). As shown in Table 2, the most commonly utilized funding sources are various combinations of Medicaid Waiver, state general revenue funds, other state funds, and local funds.

Heavy reliance on Medicaid Waiver, state general revenue funds, and local funding is similar to funding patterns in 2010. However, in 2010, there was a heavier reliance on funding from cost-share consumers than there was in 2013. In many instances, where AAAs commonly used funds from cost-share consumers, they now are more likely to seek support from local funding sources. Since not all AAAs provide transportation, transportation funding is the least likely source to fund any non-core services. In 2010, the least common funding sources were transportation funding, Department of Veterans Affairs funding, Medicaid funding, and payments from private pay consumers. This year, Medicare was added to the survey as a funding source AAAs could select. In 2013, the fewest AAAs received Medicare funding, transportation funding, and Department of Veterans Affairs funding.

Table 2: Top 3 Funding Sources Most Likely to be Received by AAAs (2010 and 2013)

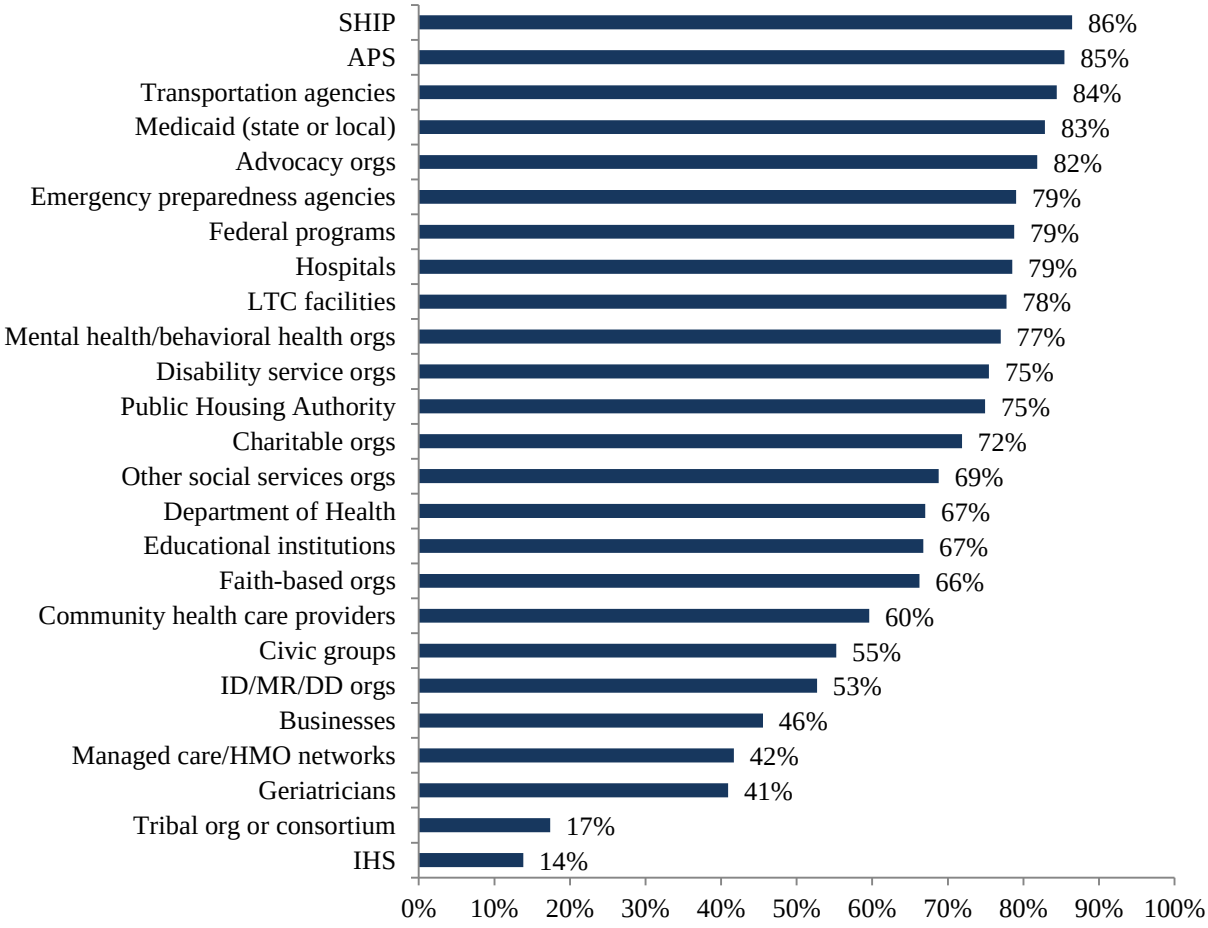
Service/program	2010	2013
Adult day service	1. Medicaid Waiver 2. State general revenue funding 3. Cost-share consumers	1. State general revenue funding 2. Medicaid Waiver 3. Local funding
Assessment for care planning	1. Medicaid Waiver 2. State general revenue funding 3. Local funding	1. State general revenue funding 2. Medicaid Waiver 3. Local funding
Assessment for LTC eligibility	1. Medicaid Waiver 2. State general revenue funding 3. Other state funding	1. Medicaid Waiver 2. State general revenue funding 3. Other state funding
Assistive technologies	1. Medicaid Waiver 2. State general revenue funding 3. Other state funding	1. Medicaid Waiver 2. State general revenue funding 3. Other state funding
Case management	1. Medicaid Waiver 2. State general revenue funding 3. Other state funding	1. State general revenue funding 2. Medicaid Waiver 3. Local funding
Home health	1. Medicaid Waiver 2. State general revenue funding 3. Other state funding	1. Medicaid Waiver 2. State general revenue funding 3. Other state funding
Homemaker	1. State general revenue funding 2. Medicaid Waiver 3. Cost-share consumers	1. State general revenue funding 2. Medicaid Waiver 3. Local funding
Personal assistance/personal care	1. Medicaid Waiver 2. State general revenue funding 3. Cost-share consumers	1. State general revenue funding 2. Medicaid Waiver 3. Cost-share consumers
Respite	1. Medicaid Waiver 2. State general revenue funding 3. Other state funding	1. State general revenue funding 2. Medicaid Waiver 3. Local funding
Transportation (medical)	1. * 2. * 3. *	1. Local funding 2. State general revenue funding 3. Transportation funding
Transportation (non-medical)	1. * 2. * 3. *	1. Local funding 2. State general revenue funding 3. Transportation funding

* The survey question in 2013 was changed to combine both medical and non-medical transportation.

CONNECTED TO THE COMMUNITY

AAAs are key partners in collaborations that strengthen home and community-based services and supports for older adults and other groups with a need for long-term services and supports. As shown in Figure 9, most AAAs have a variety of partnerships, both formal and informal. On average, AAAs have 11 informal partnerships and 5 formal partnerships. Less than one percent of AAAs have not established partnerships with other entities in their communities. The most common formal partnerships (i.e., those with a contract or memorandum of understanding) are with: SHIP (68.8% of AAAs have a formal partnership), transportation agencies (52.4%), Medicaid (51.9%), disability service organizations (34%), and Adult Protective Services (32.0 %). The most common informal partnerships are with long-term care facilities (65.5%), emergency preparedness agencies (59.1%), advocacy organizations (57.3%), public housing authorities (57%), and faith-based organizations (55.5%).

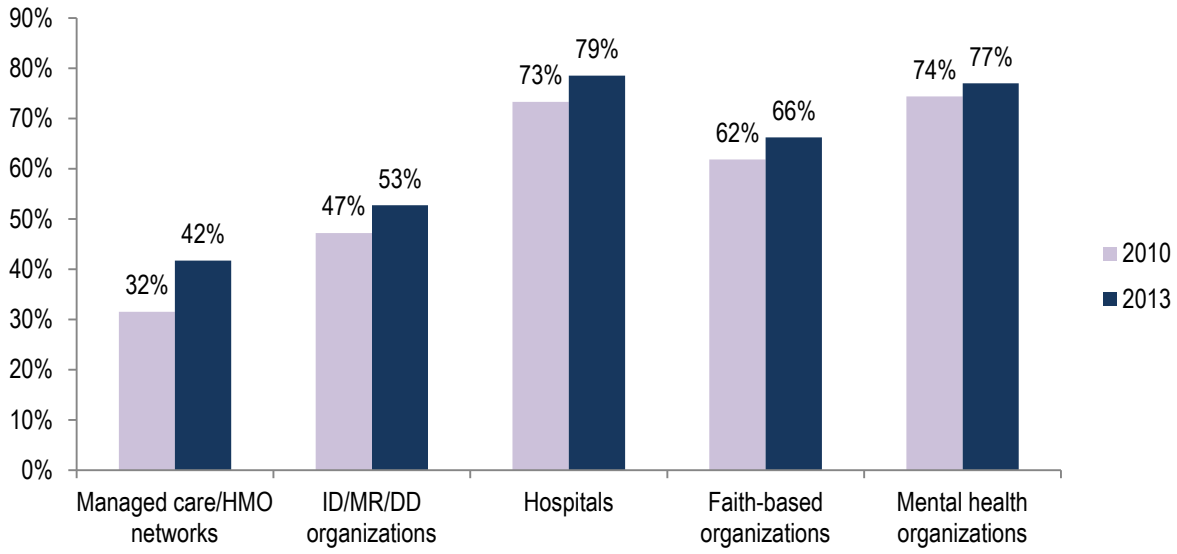
Figure 9: Partnerships AAAs Have Formed (2013)



The most common primary partnerships that AAAs reported in 2013 were the same as those reported in 2010 (i.e., SHIP, APS, transportation agencies, and Medicaid (state or local), and advocacy organizations). Additionally, those partnerships that were least likely to form in 2010 were the least likely in 2013 as well (i.e., Indian Health Service (IHS), tribal organization or consortium, geriatricians, managed care/HMO, and businesses).

Since 2010 there has been an increase in the proportion of AAAs who have developed various partnerships. As shown in Figure 10, the organizations that saw the largest increase in the proportion of AAAs who have formed partnerships with them are Managed care/HMO networks, ID/MR/DD organizations, hospitals, faith-based organizations, and mental health/behavioral health organizations.

Figure 10: Organizations That Have Seen the Largest Increase in the Proportion of AAAs Who Have Formed Partnerships With Them (2013)



LIVABLE COMMUNITIES

Over seventy percent of AAAs have taken steps to develop livable communities. The concept of a livable community requires extensive collaboration across community organizations and calls for the provision of affordable housing, accessible services, and transportation in order to promote the objective that individuals who choose to can remain living at home in their communities. Table 3 shows the practices most commonly engaged in by those AAAs who have taken steps to develop livable communities.

Table 3: Practices AAAs Have Adopted to Develop Livable Communities (2013)

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 org 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%

INNOVATIVE CARE DELIVERY

CMS 3026 COMMUNITY CARE TRANSITIONS PROGRAM

The Patient Protection and Affordable Care Act (ACA) created the Community-based Care Transitions Program (CCTP) with the intent to reduce the number of hospital readmissions for high-risk Medicare beneficiaries. According to CMS.gov, CMS has awarded 102 CCTP contracts directly to AAAs and their partner organization in the aging network. Respondents to this survey included over 90% of those parties (94.1% of CCTP contractors). The top five services being provided by AAAs as part of these contracts are connecting patients and families to non-medical community health support facilities (58.3% of respondents), providing home-delivered meals (53.1%), providing caregiver education (52.1%), providing coaching for patients and family members (50.0%), and following up with patients after discharge via the telephone (46.9%).

Under these transitions programs, AAAs are providing more services than the contracts' funds are reimbursing them for. For example, over 50% of AAAs who have been awarded contracts are providing home delivered meals to consumers recently discharged from the hospital, yet less than 20 percent (15.7%) of those who are providing home delivered meals under a 3026 contract are being fully reimbursed by CMS for this service. The services least likely to be fully reimbursed are providing a weight scale (0%), providing health screenings (0%), providing home

delivered meals (15.7%), providing support for palliative care consultation (16.7%), and maintaining an alert system for patient readmission into a different hospital (20.0%).

As shown in Table 4, the services most likely to be provided *and* fully reimbursed by CMS are following up with patients after discharge via telephone (68.8%), providing coaching for patients and family members (68.8%), assisting patients with developing a personal health record (60.0%), ensuring patients understand warning signs and symptoms for monitoring health conditions (59.1%), ensuring follow up with a primary care physician (58.5%), and explaining medication management to patients (58.1%).

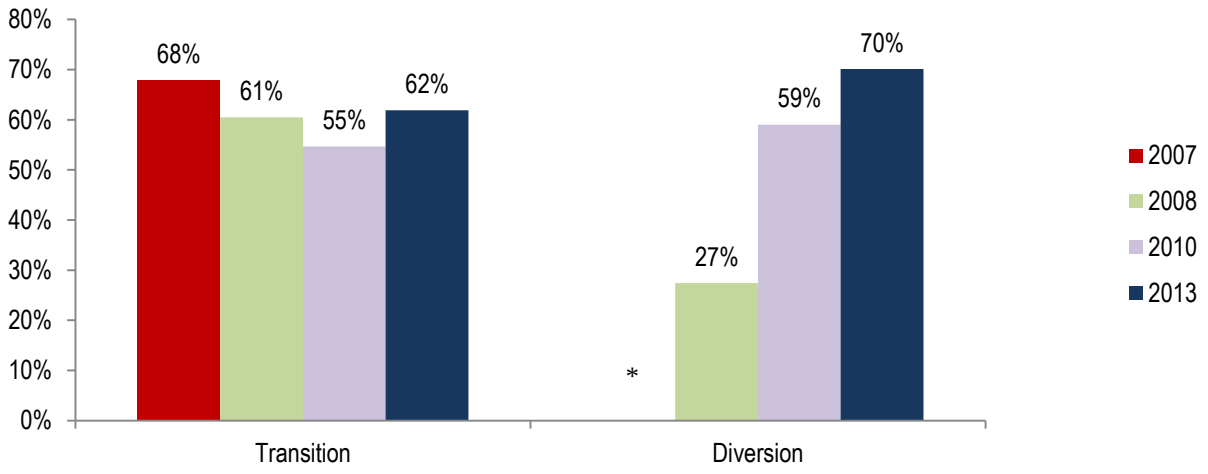
Table 4: Services Being Provided by AAAs Under a CMS 3026 Community-Based Care Transitions Program (2013)

Service	AAAs That Provide This Service Under a 3026 Contract (number of AAAs)	Percent of AAAs Providing This Service Under a 3026 Contract That are Fully Reimbursed
Connect patients and family to non-medical community health support agencies	58.3% (56)	37.5% (21)
Provide home delivered meals	53.1% (51)	15.7% (8)
Provide caregiver education	52.1% (50)	22% (11)
Provide coaching for patients and family members	50.0% (48)	68.8% (33)
Follow up with patients after discharge via telephone	46.9% (45)	68.9% (31)
Ensure patient's understand warning signs and symptoms for monitoring health conditions	45.8% (44)	59.1% (26)
Provide transportation to medical appointments	45.8% (44)	25% (11)
Provide assessments	45.8% (44)	25% (11)
Explain medication management to patients	44.8% (43)	58.1% (25)
Provide culturally and linguistically relevant patient education tools	43.8% (42)	26.2% (11)
Short-term case management	42.7% (41)	26.8% (11)
Ensure follow up with primary care physician	42.7% (41)	58.5% (24)
Assist patients with developing a personal health record	41.7% (40)	60% (24)
Facilitate health information exchange between acute care setting to post-discharge healthcare providers	37.5% (19)	36.1% (4)
Develop a plan of care for post-discharge	30.2% (29)	55.2% (16)
Provide coaching and support for LTC facilities	29.2% (28)	35.7% (10)
Provide a patient advocate	25.0% (24)	25% (6)
Facilitate collaboration between specialty and primary physician after discharge from acute care setting	19.8% (19)	21.1% (4)
Maintain an alert system for patient readmission into a different hospital	15.6% (15)	20% (3)
Provide a weight scale	12.5% (12)	0% (0)
Provide support for palliative care consultation	12.5% (12)	16.7% (2)
Provide health screenings	10.4% (10)	0% (0)

INSTITUTIONAL TRANSITION AND DIVERSION PROGRAMS AND SERVICES

Approximately two-thirds of AAAs are involved in institutional transition and diversion programs. Diversion services and programs have been steadily increasing over the past five years, as shown in Figure 11. The proportion of AAAs that deliver transition services and programs has fluctuated somewhat, with an increase this year after several years of decreasing participation. As shown in Figure 11, more AAAs currently provide diversion programs and services than transition programs and services. However, it is common that AAAs provide both transition and diversion programs and services. Of those AAAs providing transition programs and services, nearly 80% are also providing diversion programs and services. This is an increase of nearly 10% since 2010. Of those AAAs providing diversion services, nearly 70% also provide transition services; this is a slight decrease from 2010.

Figure 11: AAAs' Participation in Transition and Diversion Programs (2007-2013)

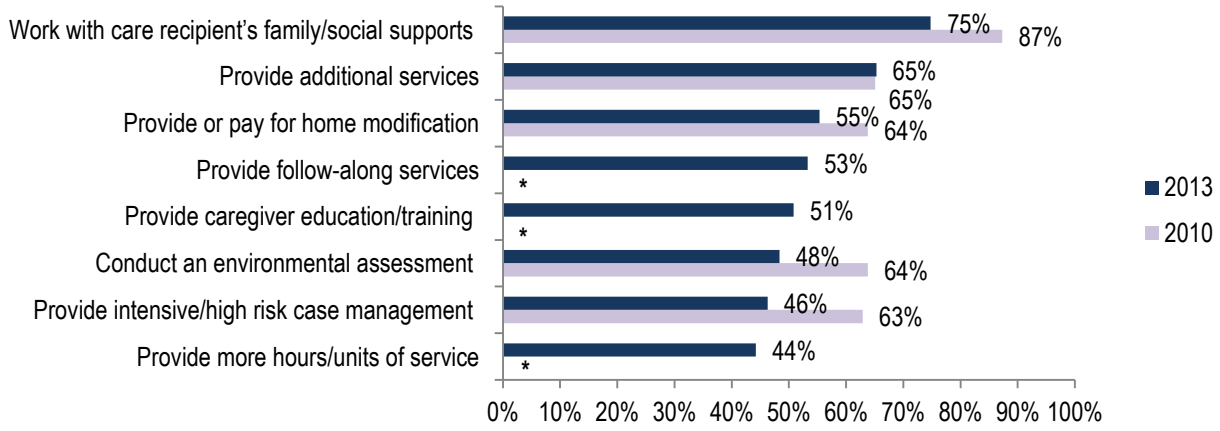


*No data

Strategies for Individuals

AAAs utilize a number of strategies to assist individuals to remain in/return to the community. Figure 12 shows that the three most common strategies utilized to return individuals to the community from an institutional placement (e.g., a nursing home, assisted living facility) in 2010 were also the most common strategies in 2013: working with the care recipient's family or social supports to prepare for return (74.8%), providing additional services (65.3%), and providing or paying for home modification (55.4%).

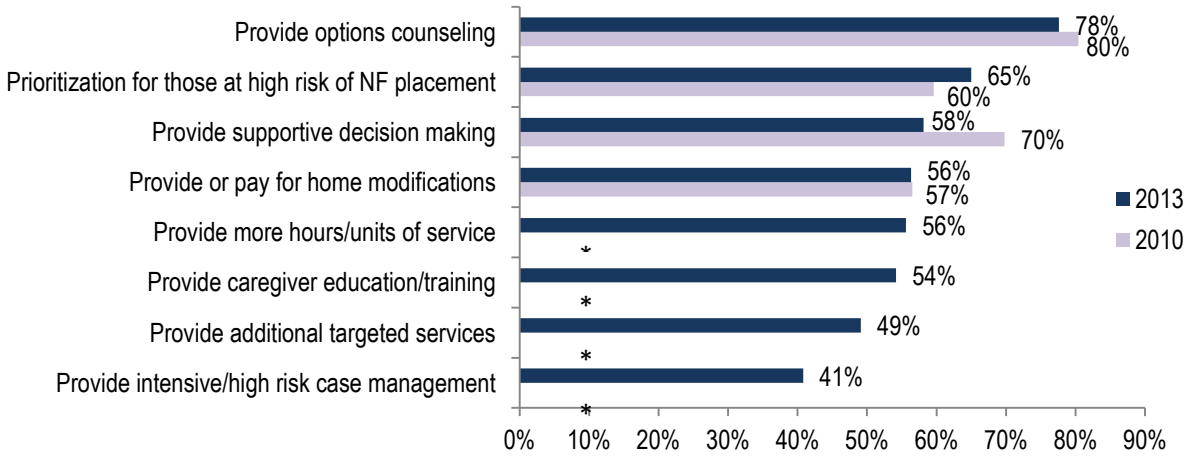
Figure 12: Strategies Used to Facilitate Individuals' Transition from Institutional Placements into the Community (2010 and 2013)



*No data

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. As shown in Figure 13, the top three strategies used in 2010 are the top three in 2013 as well: providing options counseling (77.6%), prioritization of services for those at high risk of nursing home placement (65%), and providing supportive decision making (58.1%).

Figure 13: Strategies Used to Facilitate Individuals' Diversion from Institutional Placements into the Community (2010 and 2013)

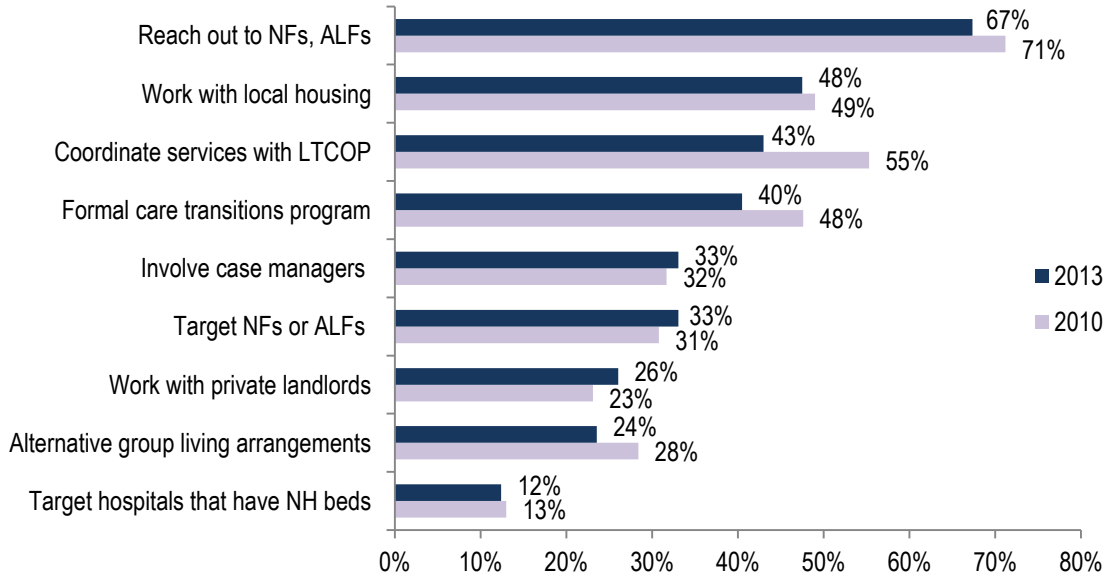


*No data

Strategies for Programmatic Changes

AAAs employ a number of programmatic strategies in order to assist individuals to transition from institutional placements back into the community. As demonstrated by Figure 14, the top three programmatic strategies in 2013 are highly similar to those used in 2010: reaching out to nursing facilities (NFs), assisted living facilities (ALFs), and rehabilitation facilities for referrals (67.4%), working with local housing authorities (47.5%), and coordinating services with the Long-Term Care Ombudsman Program (LTCOP) (43.0%).

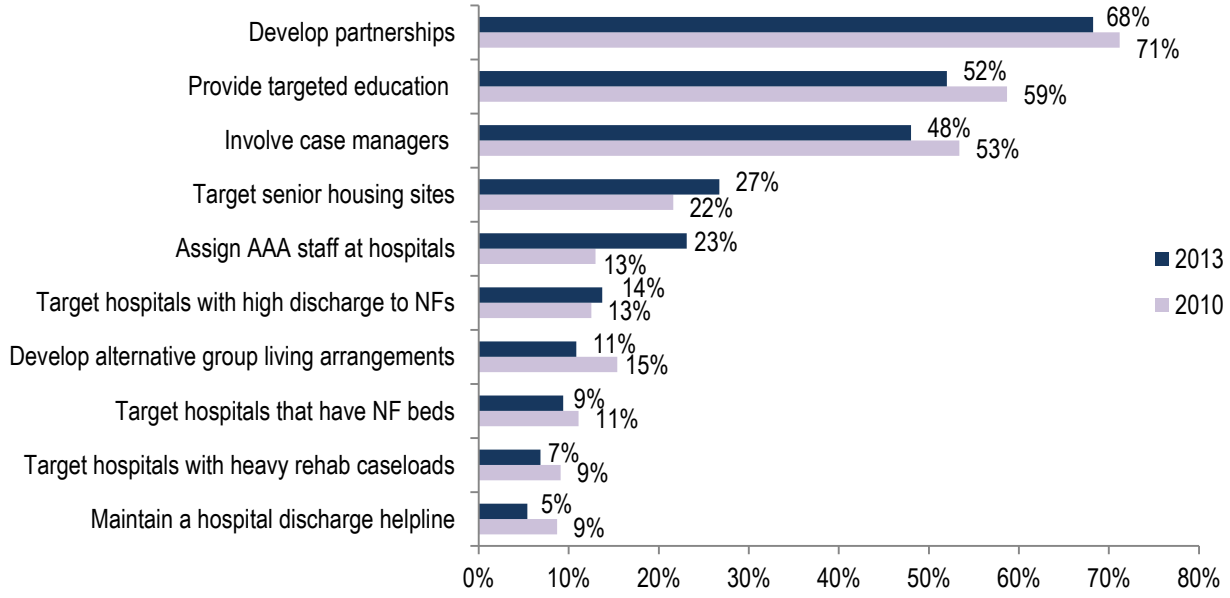
Figure 14: Programmatic Strategies Used to Transition Individuals from Institutional Placements into the Community (2010 and 2013)



Similarly, the programmatic strategies used to divert individuals from institutional placements to the community today are similar to those used in 2010. As illustrated in Figure 15, the top three strategies employed by AAAs in 2010 and 2013 when attempting to divert consumers from institutional placements to the community are developing partnership with hospitals, rehab facilities, and other similar care providers (68.2%), providing targeted education and/or outreach to discharge planners (52%), and involving case managers in the hospital discharge process (48%). This is another area where it appears that previously in 2010, AAAs were performing functions that were largely preparatory in nature (i.e., targeting hospitals with high discharges to nursing facilities, developing alternative group living arrangements, and targeting hospitals that have nursing facility beds) and now, they are implementing diversion strategies, such as

educating individuals and building partnerships to accomplish the process to successfully divert individuals from institutional placements back into the community.

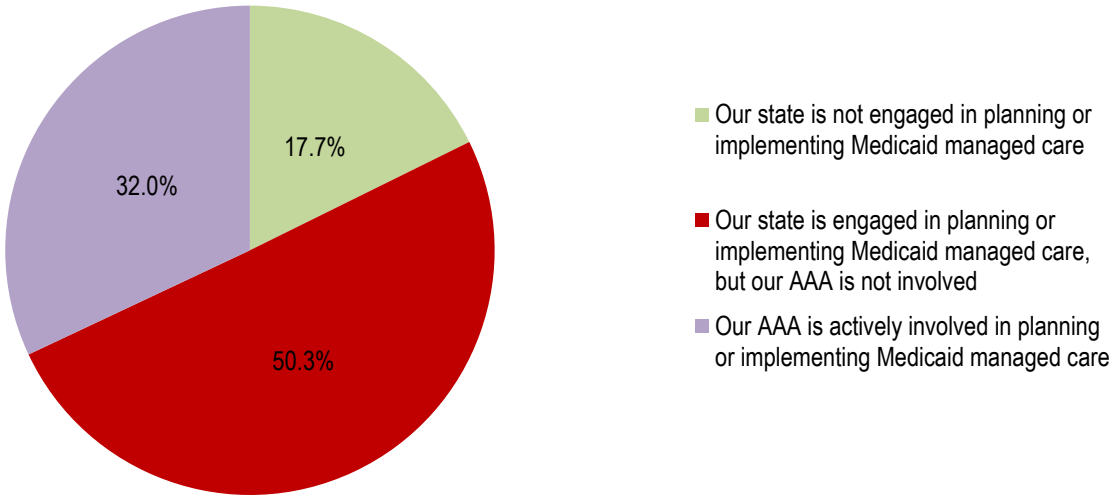
Figure 15: Programmatic Strategies Used to Divert Individuals from Institutional Placements to the Community (2010 and 2013)



MEDICAID MANAGED CARE

According to Medicaid.gov, 49 states are enrolled in either a voluntary (waiver) Medicaid managed care system (28 states) or have had a state plan approved by CMS (21 states). AAAs were asked to select the statement that best described their involvement in the implementation and planning of Medicaid managed care. As illustrated by Figure 16, over 30% of all AAAs report being actively involved in planning or implementing their state's Medicaid managed care system. However, nearly half of AAAs report that they are situated in a state that is implementing Medicaid managed care but they are not involved in the planning and/or implementation.

Figure 16: The Role of AAAs in Medicaid Managed Care (2013)



Among AAAs actively involved in planning or implementing Medicaid managed care, the number and type of specific activities they are undertaking is noteworthy. The average managed-care involved AAA is working on or implementing 5.9 activities related to managed care. Nearly 25 percent of actively involved AAAs are planning or implementing 10 or more activities. As shown in Table 5, the most commonly planned or implemented activities under Medicaid managed care are conducting intake and ongoing assessment (57.9%), providing caregiver support (50.4%), providing care management (48.8%), providing care transitions services from hospital to home or to a nursing home (47.9%), and assisting in the transitioning of residents from nursing homes to the community (44.6%). The three activities that AAAs are least likely to be involved in are acting as the MCO in their area (5%), providing fiscal intermediary services under consumer directed services (9.1%), and administering some aspects of HCBS (15.7%).

Table 5: Activities Implemented or Planned by AAAs Under Medicaid Managed Care (2013)

Activity	Proportion of AAAs From the Category "actively involved in planning or implementing Medicaid managed care"
Conduct intake and ongoing assessment	57.9%
Provide caregiver support	50.4%
Provide care management	48.8%
Provide care transitions services from hospital to home or nursing homes	47.9%
Assist in transitioning residents from NHs to the community	44.6%
Participate in an interdisciplinary team	42.2%
Develop service/care plans	38.0%
Directly provide some services	35.5%
Conduct LOC determinations	34.7%
Assist in integrating/coordinating hospital and home-based services	34.7%
Conduct Medicaid eligibility determinations	33.9%
Resolve consumer complaints/problems	28.1%
Administer ALL business aspects of HCBS	26.5%
Provide counseling services for managed care	18.2%
Administer SOME business aspects of HCBS	15.7%
Provide fiscal intermediary services under consumer directed services	9.1%
Act as the MCO in your area	5%

AAAs have partnered with an average of 4.8 entities to deliver their managed care activities. Over 15 percent of actively involved AAAs have 10 or more partners in delivering Medicaid managed care activities. As illustrated in Table 6, the most common partnerships AAAs have cultivated are with Medicaid managed care organizations/insurers (62.8%), other AAAs (37.2%), hospitals or health care systems (33.1%), individual hospitals or medical centers (26.5%), and nursing homes (20.7%). The three entities AAAs are least likely to partner with are individual dentists or oral health practices (2.5%), local/regional/Health Insurance Exchange (HIE)/Electronic Health Record (EHR) consortium (5%), and their state association of nursing homes (5%).

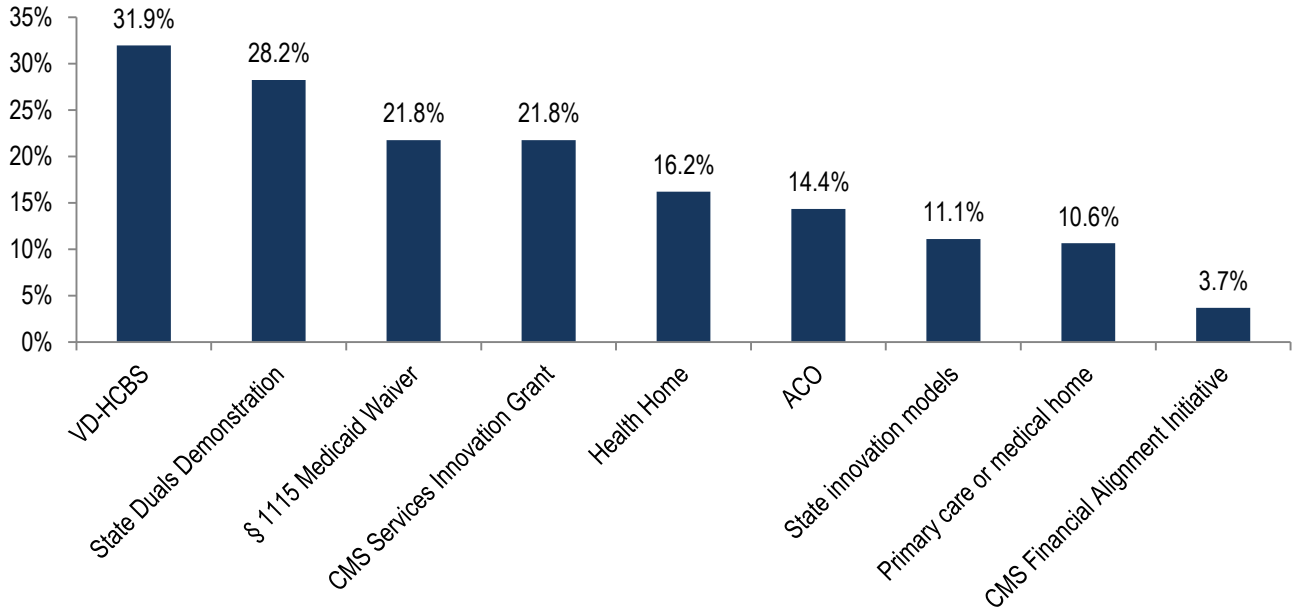
Table 6: Most Common AAA Partners in Managed Care Activities

Partners	Proportion of AAAs
Medicaid managed care org/insurer	62.8%
Other AAA	37.2%
Hospital or health care system	33.1%
Individual hospitals/medical centers	26.5%
Nursing homes	20.7%
Individual physicians or physician practices	18.2%
Publicly funded behavioral health org./mental health system	17.4%
Mental health center	16.5%
Medicare advantage organization	16.5%
State Quality Improvement Organization (QIO)	15.7%
Federally qualified health centers	15.7%

INTEGRATED CARE

Integrated care is 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, long-term services and supports, and acute care. More than fifty percent of AAAs (55.2%) are involved in at least one integrated care initiative. For those AAAs involved in an integrated care delivery system, the most common initiatives are Veterans Directed Home and Community Based Services (VD-HCBS; 31.9%), State Duals Demonstration (28.2%), Section 1115 Medicaid Demonstration Waiver (21.8%), CMS Services Innovation Grant (21.8%), Health Home (16.2%), and Accountable Care Organization (14.4%), as shown in Figure 17.

Figure 17: Integrated Care Initiatives Among Those AAAs Involved in Integrated Care (2013)



AAAs are engaged in a number of activities as part of their participation in an integrated care initiative. AAAs perform as few as one or as many as fifteen activities with the average at 5.7. As illustrated by Figure 18, the most common integrated care activities are providing care management (50.5%), developing care/service plans (43.1%), assisting in the transitioning of residents from nursing homes to the community (40.3%), conducting intake assessments (28.2%), and providing care transitions services from hospital to home or nursing home (36.6%).

Figure 18: AAA Integrated Care Activities (2013)

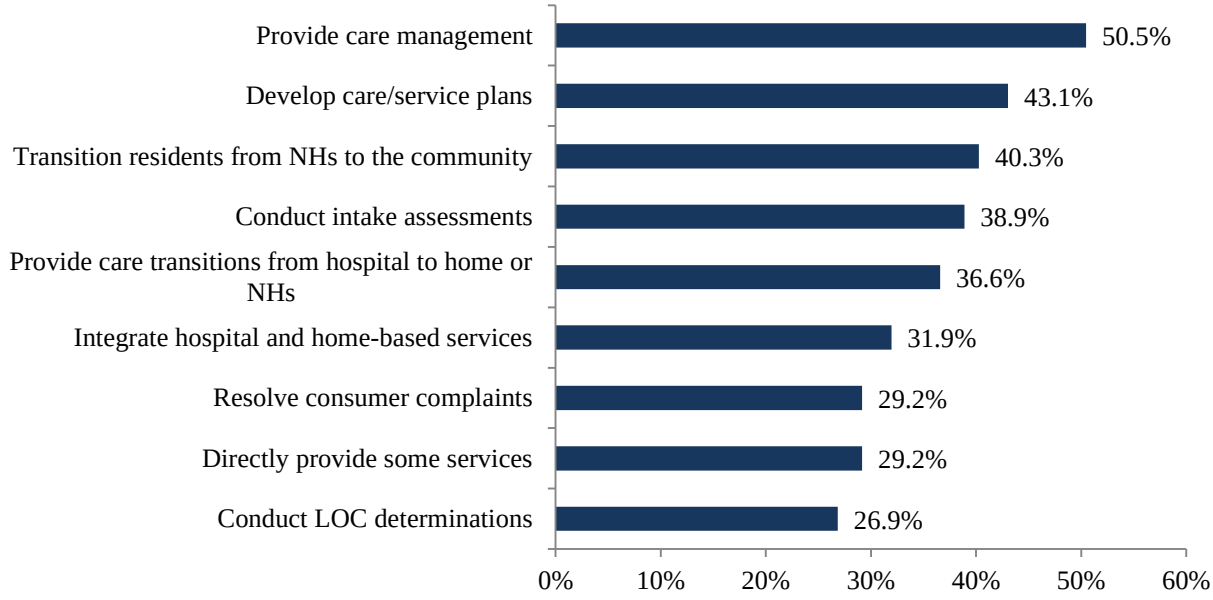


Table 7 shows the variety of partnerships AAAs have formed for integrated care services delivery. The top three entities that AAAs are most actively involved with are hospitals or health care systems (26.9%), a Medicaid Managed Care Organization (21.3%), and individual hospitals or medical centers (18.5%). Less than 1% of AAAs formed partnerships with individual dentists or oral health practices, individual counselors, psychologists, or psychiatrists, local or regional HIE/EHR consortium, other community health centers, and their State Association of Nursing Homes.

Table 7: Primary Partners of Those AAAs Involved in Integrated Care Activities

Partners	Proportion of AAAs
Hospital or health care system	26.9%
Medicaid managed care org	21.3%
Individual hospitals/medical centers	18.5%
Other AAA	17.6%
VA	14.4%
Local community care coordination coalition	11.1%
Other	10.2%
Nursing homes	9.7%
State Quality improvement org	9.3%
Individual physicians or physician practices	8.8%
Publicly funded behavioral health org/mental health system	6.5%
RCF/ALF	5.1%

ELDER ABUSE PREVENTION

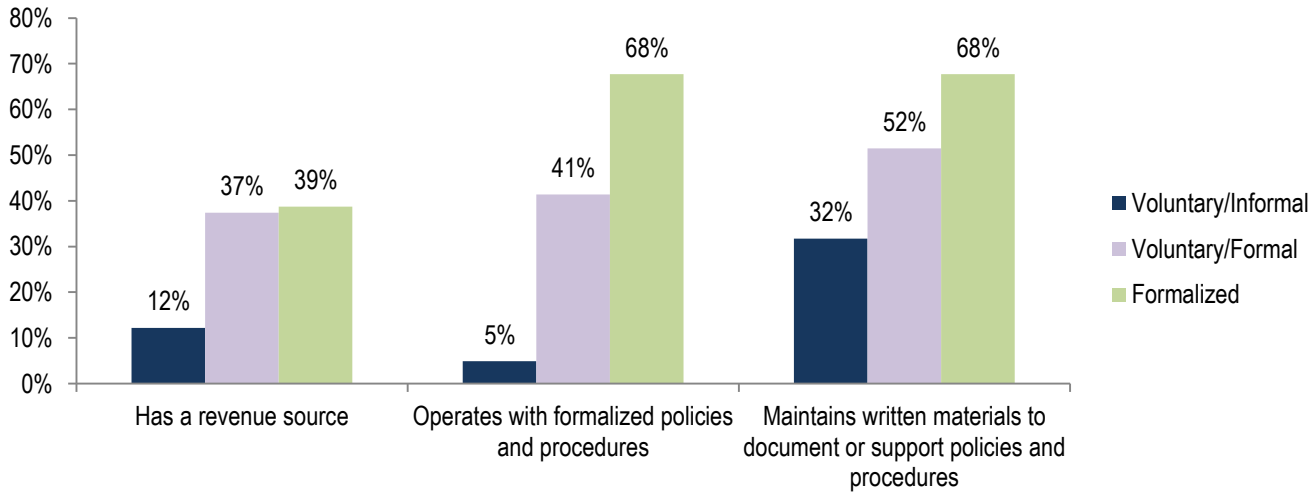
The passage of the Elder Justice Act in 2010 signaled a strong national focus on preventing and addressing elder abuse. The aging network plays a significant role in promoting the goals and values espoused by the legislation. More than 98% of AAAs provide at least one service or program designed to address elder abuse. As shown in Table 8, among those who provide elder abuse prevention services, the most common are legal assistance, community education or training, public awareness information directly to seniors, participation in an elder abuse prevention coalition or multi-disciplinary team, and case management for at risk/vulnerable seniors. The elder abuse prevention services that AAAs are least likely to provide are victim/witness assistance, safe havens or emergency shelters, short-term emergency services for victims, adult guardianship services, and services to combat hoarding.

Table 8: Services AAAs Deliver to Address and Combat Elder Abuse (2013)

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 multi-disciplinary 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%
Services to combat hoarding	22.9%
Adult guardianship services	21.6%
Short term emergency services for victims	17.2%
Safe havens or emergency senior shelters	8.1%
Victim/witness assistance	7.3%

Fifty-five percent of all AAAs are involved in an elder abuse prevention coalition or multi-disciplinary team. This is an increase of nearly 10 percentage points since the Elder Abuse Prevention mini-survey launched in 2008 (45.9%). Most AAAs are part of a voluntary elder abuse prevention team (84.2%). These voluntary teams can be either formal (54.7%) or informal (45.3%). As illustrated in Figure 19, being part of a formalized coalition (i.e., one that is formed by legislation or administrative program or policy) has advantages. AAAs that are part of a formalized coalition 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. Voluntary/formal groups are more likely than voluntary/informal groups to have a revenue source, to operate with formalized policies and procedures, and to maintain written materials to document or support policies and procedures.

Figure 19: Components of Elder Abuse Prevention Coalitions (2013)



The most common activities within the multi-disciplinary teams, as shown in Figure 20, are updating members about services, programs, and legislation (77.2%), planning and carrying out training events (72.6%), advocating for change (71.2%), identifying service gaps and systems problems (66.1%), and providing an opportunity for colleagues to offer support, advice, and assistance on cases (65.1%). The top elder abuse prevention activities that multi-disciplinary teams are engaged in have changed over the past five years. These results suggest that AAAs today are demonstrating their position as a knowledgeable entity that is able to train and educate their partners and the community; in comparison, in 2008, AAAs were engaged in activities that could be considered developmental and designed to help expand the function of elder abuse prevention coalitions (e.g., developing a coordinated community response, encouraging investigation and prosecution of elder abuse crimes).

Figure 20: Activities of AAAs Participating in an Elder Abuse Prevention Coalition or Multi-Disciplinary Team (2008 and 2013)

*No data

As shown in Table 9, the top five activities that both types of voluntary groups are engaged in are essentially the same.

Table 9: Top 5 Activities Conducted by AAAs in Elder Abuse Prevention Coalition or Multi-Disciplinary Team, by Structure (2013)

Activity	Voluntary/Informal Coalition	Voluntary/Formal Coalition	Formalized Coalition
Plan and carryout training events	72.0%	77.8%	64.5%
Update members about services, programs, and legislation	73.2%	76.8%	96.8%
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%

As shown in Table 9, higher proportions of members from formalized groups are focused on internal processes and strengthening knowledge of the coalition (i.e., updating members of the coalition about services, programs, and legislation, providing an opportunity for colleagues to offer support advice, and assistance on cases, and providing training to team members on methods to enhance their work) while voluntary groups are focused on activities to actively respond to elder abuse (i.e., planning and carrying out training events, advocating for change, identifying service gaps and systems problems, and encouraging the investigation and prosecution of elder abuse crimes).

Over ninety percent of AAAs have partners in preventing, detecting, and/or intervening in elder abuse. As illustrated by Table 10, the most common partnerships are formed between AAAs and Adult Protective Services (92.1%), the Long Term Care Ombudsman Program (80.9%), law enforcement (76.3%), aging services providers (71.6%), and senior legal services organizations (64.2%). The least frequently formed partnerships include insurance departments (7.3%), the media (11.3%), protection and advocacy agencies (11.8%), guardianship monitoring programs (11.8%), and sexual assault advocates (12.4%).

Table 10: AAAs' Most Common Partners in Preventing, Detecting, and/or Intervening in Elder Abuse

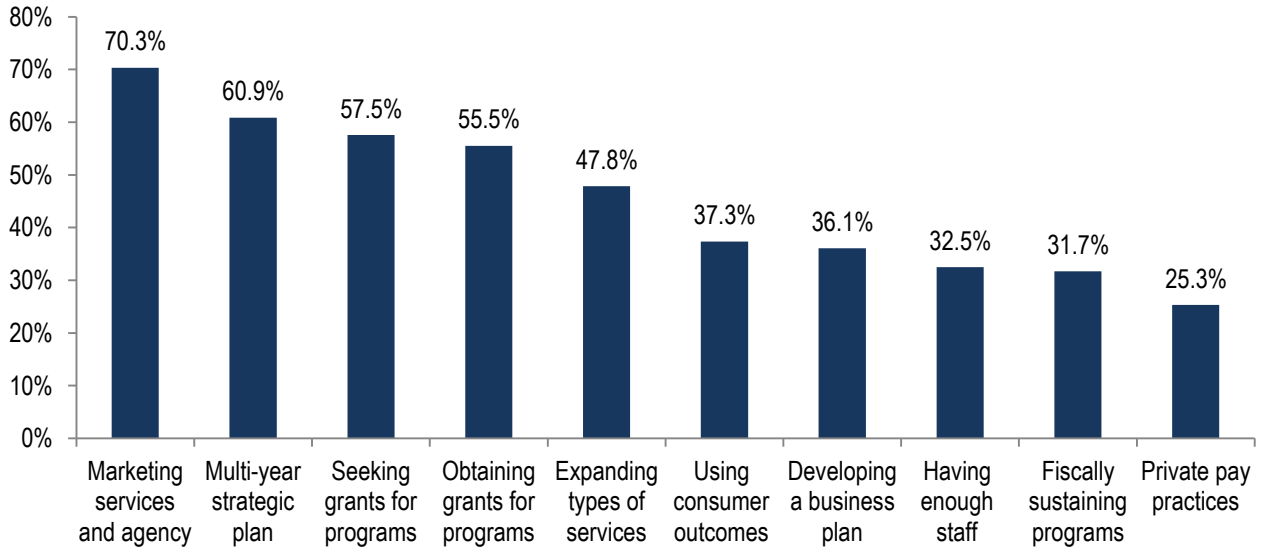
Partner	Proportion of AAAs
Adult Protective Services	92.1%
Long-Term Care Ombudsman Program	80.9%
Law enforcement	76.3%
Aging services providers	71.6%
Senior Legal Services Providers	64.%
State unit on aging	62.0%
ADRC	59.2%
Aging related orgs	49.3%
Mental health departments or orgs	43.7%
Prosecutors	40.0%
Health care orgs	38.6%
Emergency responders	35.5%
LTC facilities or representatives	33.5%
Faith based communities	29.6%
Attorney General	29.3%
Financial institutions/banks	28.5%
Domestic violence advocates	28.2%
Courts	26.8%

Fewer than 20 percent (16.9%) of AAAs that deliver elder abuse prevention programs and services measure the impacts of their programs or activities. However, AAAs who are members of an elder abuse prevention coalition or multi-disciplinary team are more likely to measure the impacts of their programs or activities. Over twenty percent of AAAs (21.4%) who are members of a coalition measure the impacts of their programs; they also comprise over 70% of the group of AAAs who do measure impacts.

EXPANDING SERVICES AND FINANCIAL SUSTAINABILITY

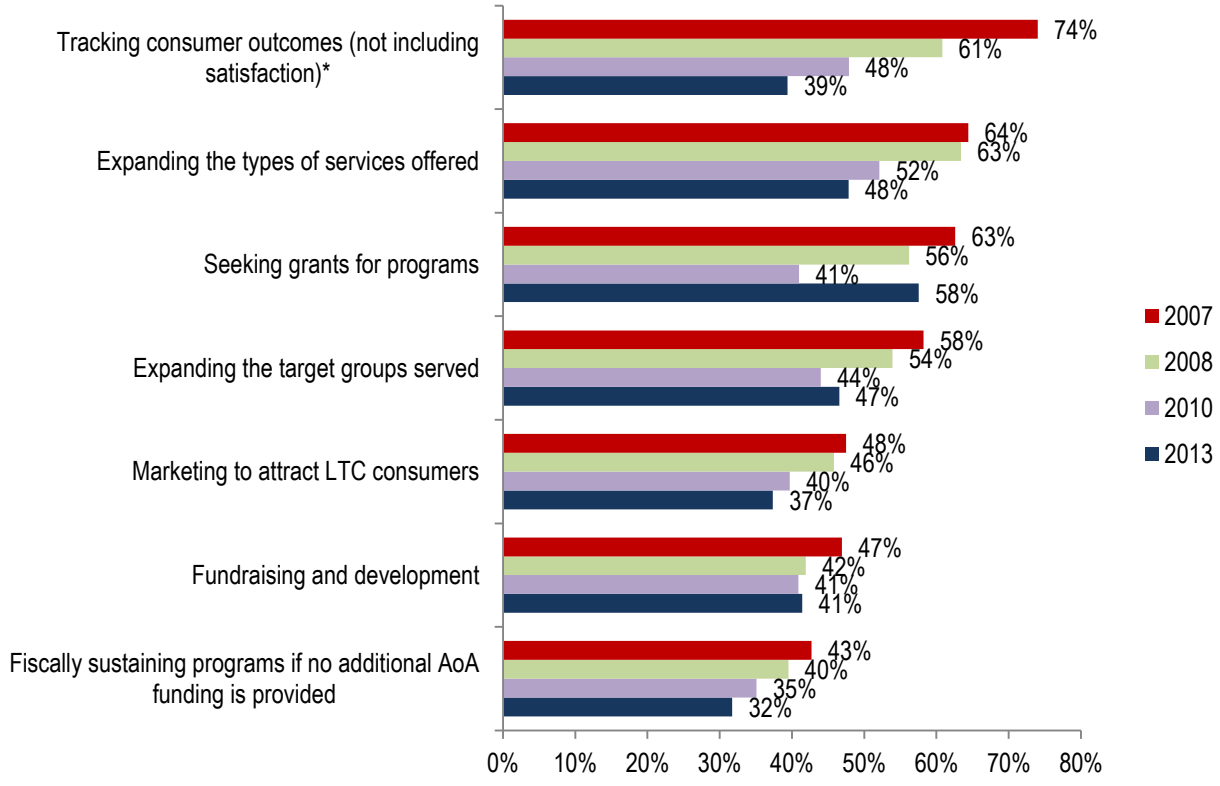
The aging network is continually making strides to expand its ever-changing role in the long-term care and health care delivery systems. In order to serve a more diverse group of clients, AAAs are most commonly engaged in strategies that seek to include new client groups such as consumers under age 60 who qualify for services because of disability, impairment, or chronic illness. As noted in Figure 21, the most common strategies are marketing the AAAs' services and the agency itself, developing a multi-year strategic plan, seeking grants for programs, obtaining grants for programs, and expanding the types of services provided.

Figure 21: AAAs That Have Made Progress on or Have in Place Specific Business Strategies (2013)



When looking at the most common strategies that were implemented in 2007 there has generally been a sustained decrease in the proportion of AAAs that are utilizing these strategies over time. As shown in Figure 22, the business strategies that increased in implementation from 2010 to 2013 were seeking grants for programs, expanding the target groups served, and fundraising and development. Over 50% of AAAs are seeking grants for new programs; it is the third most implemented strategy among AAAs in 2013.

Figure 22: AAAs' Business Practices (2007-2013)

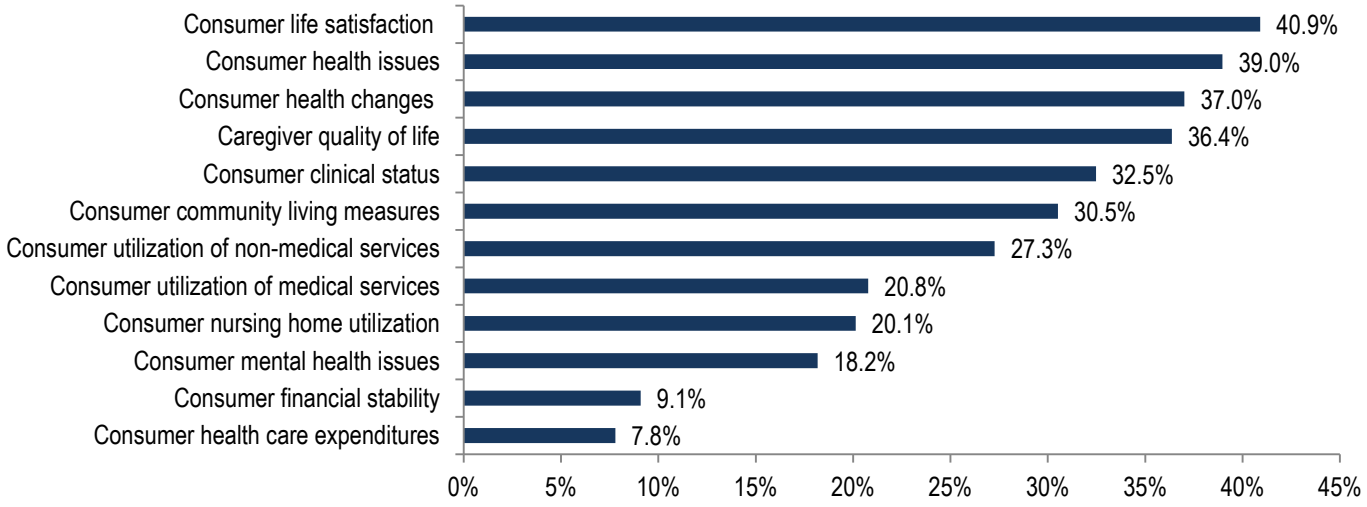


*In previous surveys, this question permitted respondents to include satisfaction as a consumer outcome.

TRACKING CONSUMER OUTCOMES

In 2013, nearly four in ten AAAs are tracking consumer outcomes. Of those who are tracking outcomes, consumer life satisfaction is the outcome most commonly tracked while consumer health care expenditures are the least commonly tracked, as demonstrated in Figure 23.

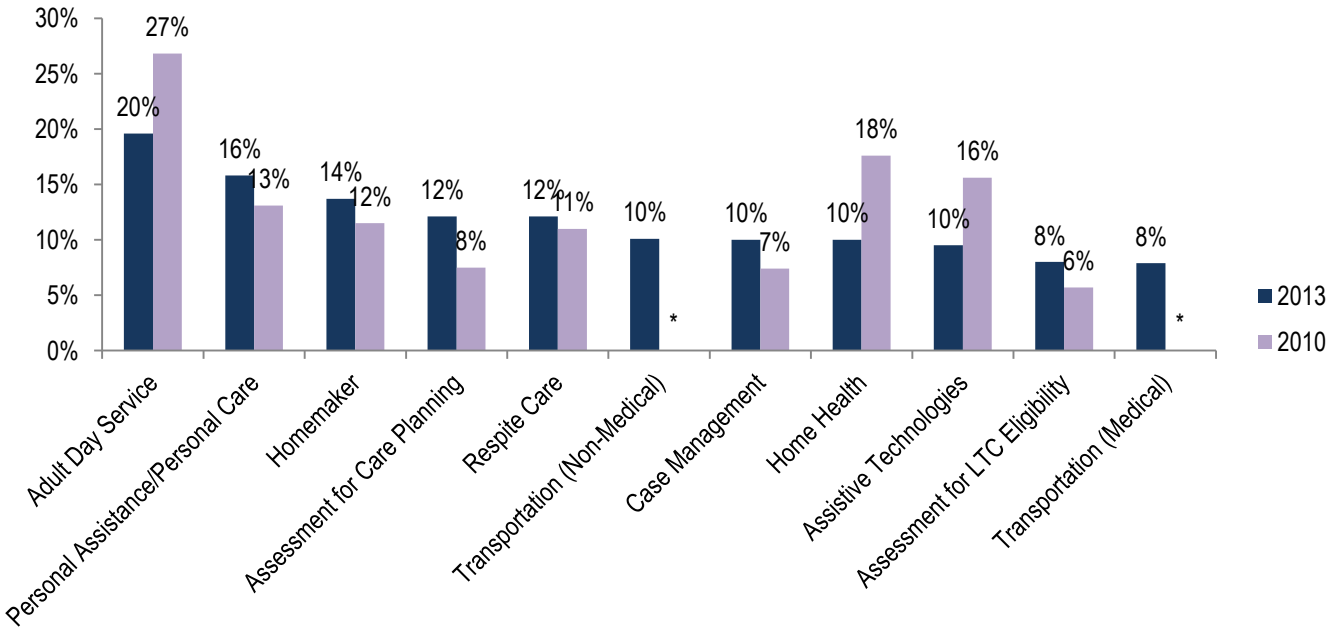
Figure 23: Types of Consumer Outcomes AAAs are Tracking (2013)



PRIVATE PAY

Area Agencies on Aging continue to build capacity to provide services to private pay customers with nearly twenty-five percent of all AAAs receiving funding from private pay consumers to provide additional (non-core) services. As shown in Figure 24, more AAAs received funding from private pay customers in 2013 compared to 2010 in almost every service except adult day service, home health, and assistive technologies.

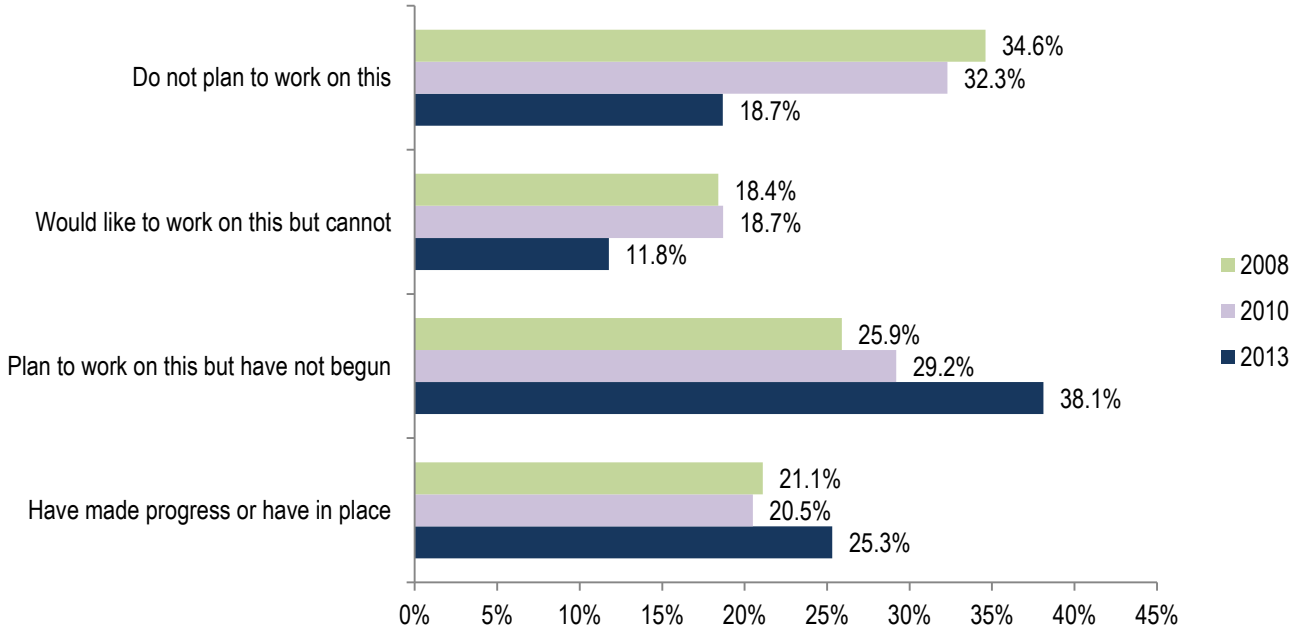
Figure 24: Proportion of AAAs that Receive Funding from Private Pay Customers to Provide Specific Services (2010 and 2013)



*No data

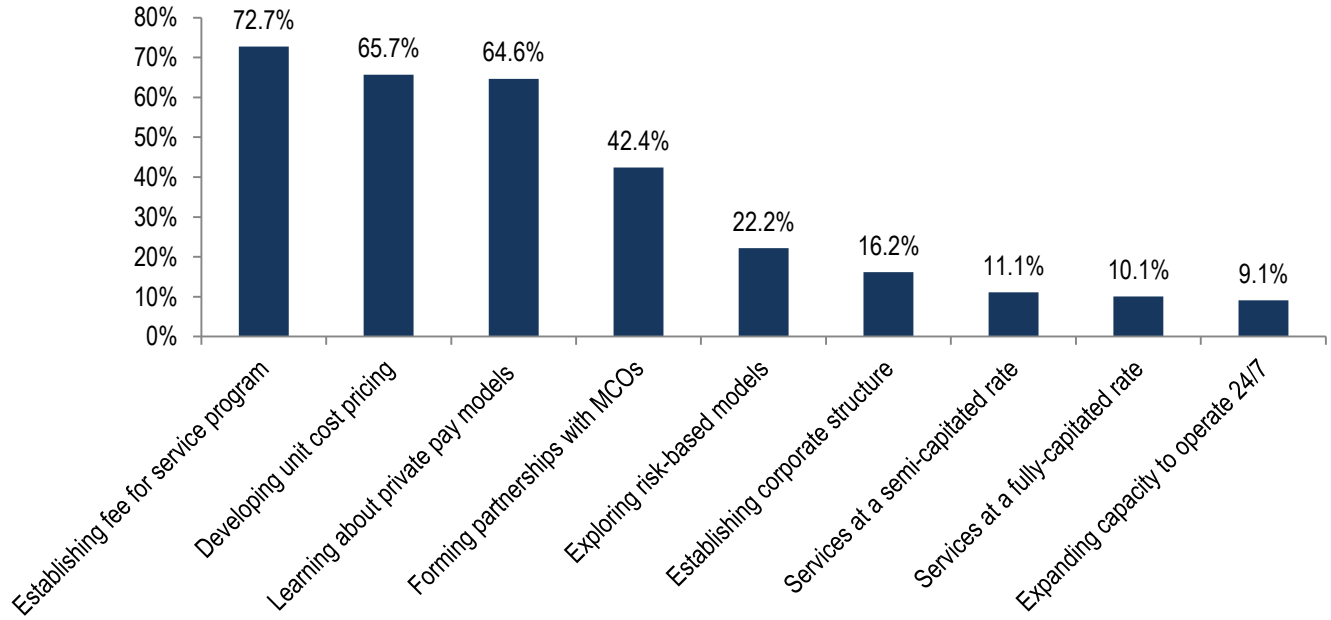
As shown in Figure 25, there has been an increase in the past five years in the proportion of AAAs that are involved in developing private pay practices. More AAAs are planning to begin work on developing private pay practices in 2013 than there have been in previous years. Fewer than twenty percent of AAAs have no plans to work on the development of private pay practices.

Figure 25: AAAs' Involvement in Developing Private Pay Practices (2008-2013)



As illustrated by Figure 26, the most common activities among AAAs who are developing private pay practices are establishing a fee-for-service program for clients (72.7%), developing unit cost pricing (65.7%), and learning about successful private pay models being used by other AAAs (64.6%). The activities they are least likely to be engaged in are expanding capacity to operate 24/7 (9.1%), contracting to provide services at a fully-capitated rate (10.1%), and contracting to provide services at a semi-capitated rate (11.1%).

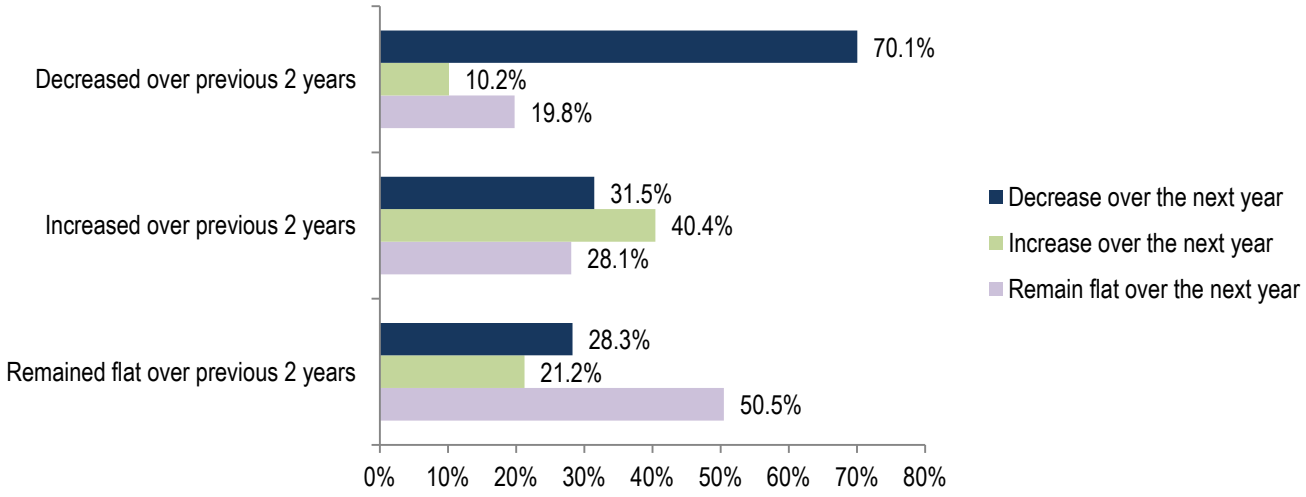
Figure 26: Activities of Those AAAs Who are Developing Private Pay Practices (2013)



CHANGES NECESSITATED BY FUNDING

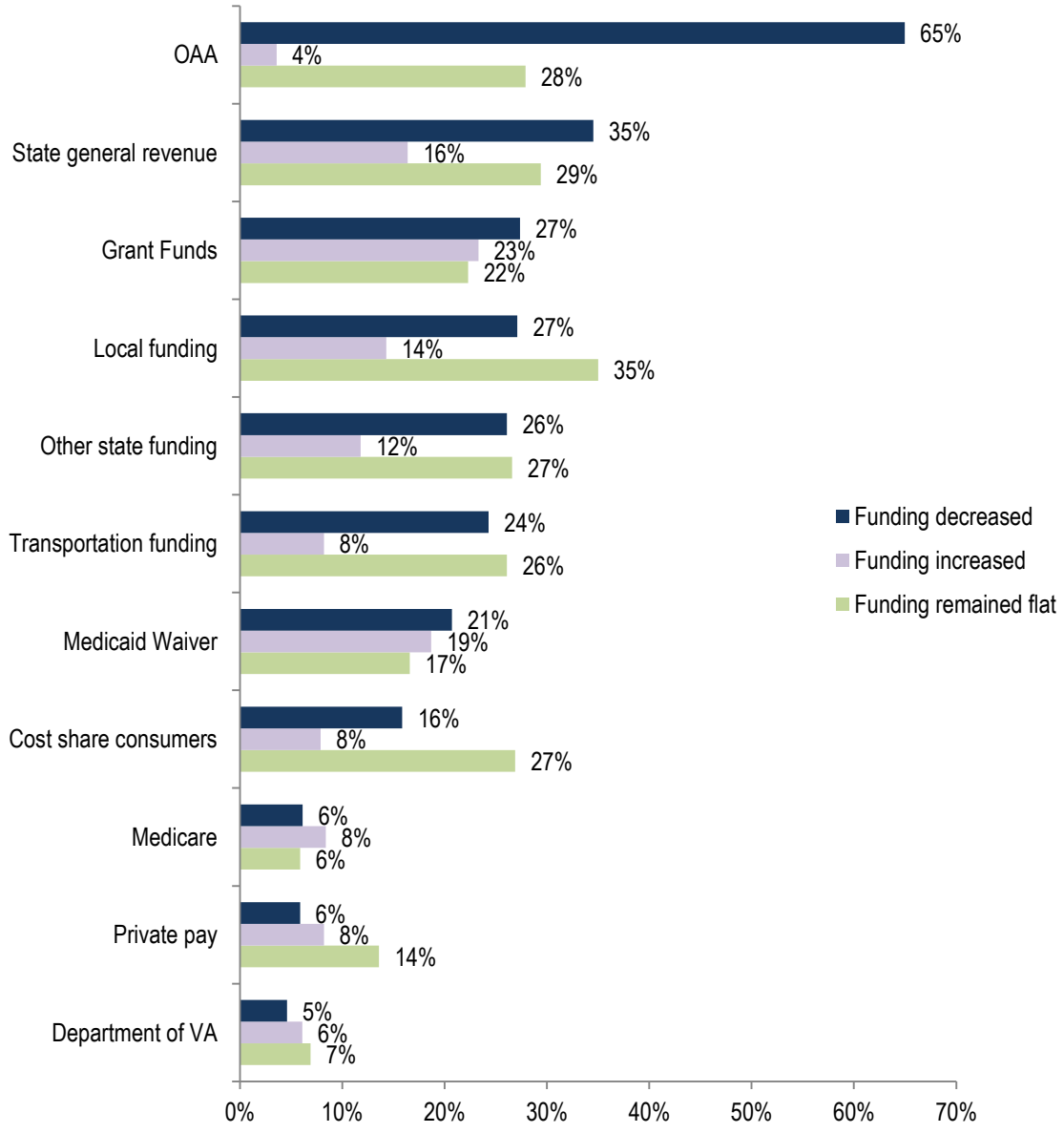
Nearly half of AAAs reported that their total budget over the past two years has decreased and less than one-fourth of AAAs have seen an increase in their funding. Slightly over one-quarter of AAAs saw their total budget remain flat over the previous two years. AAAs appear to use their previous funding trends to anticipate funding changes in the future; Figure 27 illustrates this pattern. Among AAAs who reported funding decreases over the previous two years, seven in ten (70.1%) anticipated that their funding will further decrease over the next year. Of the AAAs that reported an increase in funding over the previous two years, four in ten (40.4%) anticipate that their funding will continue to increase.

Figure 27: Proportion of AAAs Expecting Funding Changes by Past Budgetary Changes



AAAs have seen a steady decrease in many of their funding sources. More than 60% of AAAs reported a decrease in Older Americans Act dollars over the previous two years. While there were not many AAAs that reported funding increases from any source, the most common came from Medicare dollars, with nearly 10% seeing an increase from this source. As shown in Figure 28, funding was most likely to have remained flat from the following sources: local funding (35.0%), other state funding (26.6%), transportation funding (26.1%), funding from cost-share consumers (26.9%), funding from private pay consumers (13.6%), and funding from the Veteran's Administration (6.9%).

Figure 28: Funding Levels from Selected Sources



Over 95% of AAAs have taken action in response to the continued economic downturn. In 2013, the most common actions that AAAs have taken in response to the continued economic downturn were exploring new funding opportunities (66.4%), reducing the total number of staff by not replacing those who left (58.9%), instituting waiting lists (58.1%), exploring new partnerships (52.8%), and increasing caseloads (48.5%), as shown in Figure 29 and Table 11. The actions that the fewest AAAs have taken are reducing staff salaries (3.5%), limiting the hours of operation (9.3%), furloughing at least some staff (9.6%), reducing office space (10.4%), and expanding consumer/self-directed options for services (10.9%).

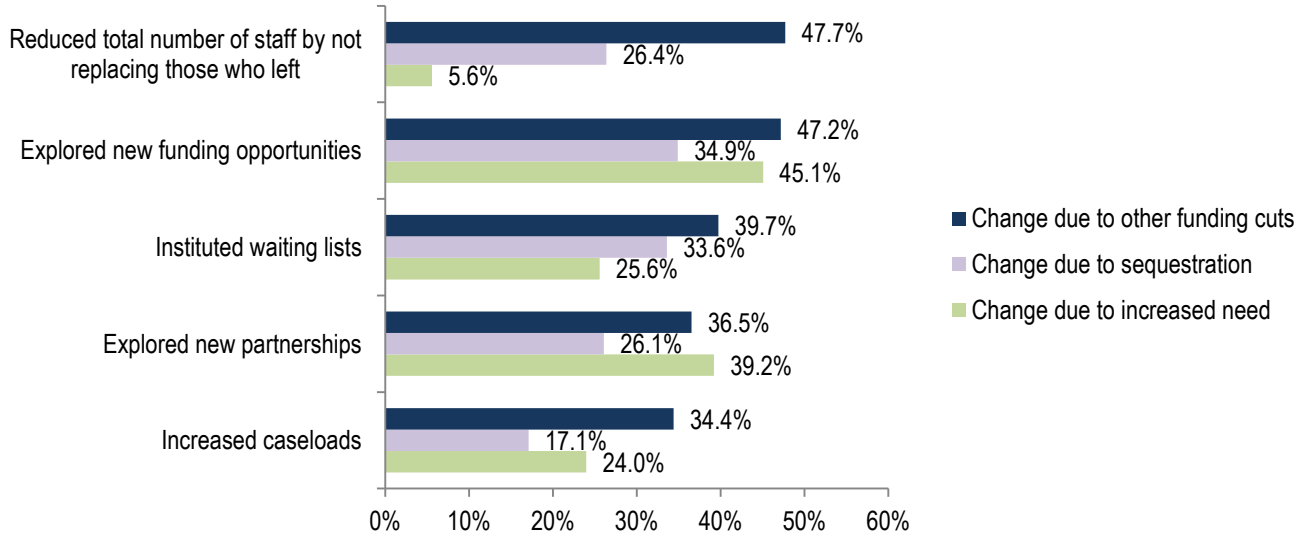
Table 11: AAAs who Have Made Specific Changes in Response to the Continued Economic Downturn (2010 and 2013)

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

AAA respondents were asked to provide more detail about the programmatic and business changes they had made in response to the changing economic environment and growing needs of the populations they serve. Specifically, they were asked to select whether any of the changes they had made (summarized in Table 11) were due to sequestration, funding cuts other than sequestration, and/or increased needs of consumers. All three of these forces played a role in significant changes made by AAAs, but, as Figure 30 shows, funding cuts other than sequestration was the most commonly cited cause overall 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.

Figure 30: AAAs Making Changes by Impetus for Action (2013)



TRAINING NEEDS

Over 97% of AAAs report that there is some type of training or technical assistance that would benefit their agency. As shown in Figure 31, the top six reported training needs are developing fee-for-service opportunities, developing outcome measures, working better with partners in managed care, business planning, strategic planning, and strategic alliances within the local healthcare system. The least commonly reported training needs are strategic alliances in areas other than the local healthcare system, writing a memorandum of understanding, workforce development, media relations, conducting a root analysis, and strategic alliances within local planning/development agencies.

Figure 31: Proportion of AAAs Needing Training or Technical Assistance by Selected Topic (2013)