



The Aging Services Network: Serving a Vulnerable and Growing Elderly Population in Tough Economic Times

BACKGROUND
PAPER NO. 83

CAROL V. O'SHAUGHNESSY, *Principal Policy Analyst*

DECEMBER 13, 2011

Anticipating consideration of proposals to reauthorize the Older Americans Act during the 112th Congress, this publication updates a background paper published by the Forum in 2008.

OVERVIEW — *In 1965, Congress enacted the Older Americans Act, establishing a federal agency and state agencies to address the social services needs of the aging population. The mission of the Older Americans Act is broad: to help older people maintain maximum independence in their homes and communities and to promote a continuum of care for the vulnerable elderly. In successive amendments, the Act created area agencies on aging and a host of social support programs. The "aging services network," broadly described, refers to the agencies, programs, and activities that are sponsored by the Older Americans Act. The Act's funding for services is supplemented by other federal funds, such as Medicaid, as well as state and local funds. As the number of older people increases with the aging of the baby boom population, the need for a wide spectrum of services is expected to place pressure on the aging services network. Research has shown that the Act's programs serve vulnerable older people, yet many more are likely to need, but not receive, certain services important to help them to live in their own homes. Whether the aging services network will be able to sustain its current capacity and fully realize its potential will depend on its ability to attract and retain additional resources. Its challenges have been heightened by the continuing budget constraints faced by state and local governments during stressed economic times.*

National Health Policy Forum

2131 K Street, NW
 Suite 500
 Washington, DC 20037

T 202/872-1390
F 202/862-9837
E nhpf@gwu.edu
 www.nhpf.org

Judith Miller Jones
Director

Sally Coberly, PhD
Deputy Director

Monique Martineau
*Director, Publications and
 Online Communications*

The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at www.nhpf.org.

CONTENTS

The Older Americans Act: The Foundation of the Aging Services Network3
 Figure 1: Major Services Authorized by the Older Americans Act 5
 Historical Development: Expanding Responsibilities of the Aging Services Network 6
 Figure 2: Timeline, 1946 to 2031: Major Selected Actions Affecting the Elderly8
 Structure and Funding of the Older Americans Act8
 State and Area Agencies on Aging: Functions, Governance, and Staffing 9
 Figure 3: Older Americans Act, FY 2011 Appropriations..... 10
 Targeting the Vulnerable Older Population13
 Services Authorized by the Older Americans Act14
 Distribution of Funds and Non-Federal Matching Requirements 14
 Supportive Services: Helping Older People Remain Independent in Their Communities 15
 Figure 4: Older Americans Act: Federal Expenditures for Services Authorized by Title III and Title VII, FY 2010 16
 Nutrition Services Program: Serving an At-Risk Population 18
 Table 1: OAA Nutrition Service Recipients: Age, Income, and Health Status, FY 2009..... 20
 Family Caregiver Services: Serving Multiple Generations Through One Program..... 21
 Disease Prevention and Health Promotion Activities: Straining to Have Broader Reach 23
 Long-Term Care Ombudsman Program: Protecting Resident Rights 25
 Figure 5: Long-Term Care Ombudsman Spending, 2010.....26
 Beyond the Older Americans Act26
 Management and Redesign of LTSS..... 27
 Prevention of Elder Abuse, Neglect, and Exploitation 30
 State Health Insurance Assistance Program (SHIP).....32
 The Older Americans Act in a Changing Service Delivery Environment ..33
 Broad Mission, Limited Resources:
 Summary of Challenges for the Future36
 Endnotes38
 Appendix.....46

In 1965, when Medicare, Medicaid, and the Older Americans Act were enacted, people age 65 and older represented slightly more than 9 percent of the nation's population. By 2010, the number of elderly had more than doubled, reaching over 40 million people and 13 percent of the U.S. population. The first wave of the baby boom generation began to turn age 65 in 2011. By 2020, one in six people will be age 65 and older. The growing elderly population is a recurrent and persistent theme in policy deliberations on the future of federal health, long-term services and supports (LTSS), and income security programs. In addition to concern about the fiscal pressures affecting Medicare and Medicaid, policymakers and practitioners have expressed concern about whether resources available under the Older Americans Act will keep pace with the growing elderly population, especially given its broad mission and scope of responsibilities. Budgetary pressures on domestic discretionary programs may place strain on aging services programs at the same time that some cohorts of the baby boom population are expected to create more demand for services.

This paper discusses the historical development, functions, and governance of the Older Americans Act aging services network. It also discusses its service programs and populations served as well as selected service programs administered by the network but financed by other sources. (The Appendix summarizes selected aging service network service programs.)

THE OLDER AMERICANS ACT: THE FOUNDATION OF THE AGING SERVICES NETWORK

The purpose of the Older Americans Act is to help people age 60 and older maintain maximum independence in their homes and communities, with appropriate supportive services, and to promote a continuum of care for the vulnerable elderly. The 1965 Act represented a

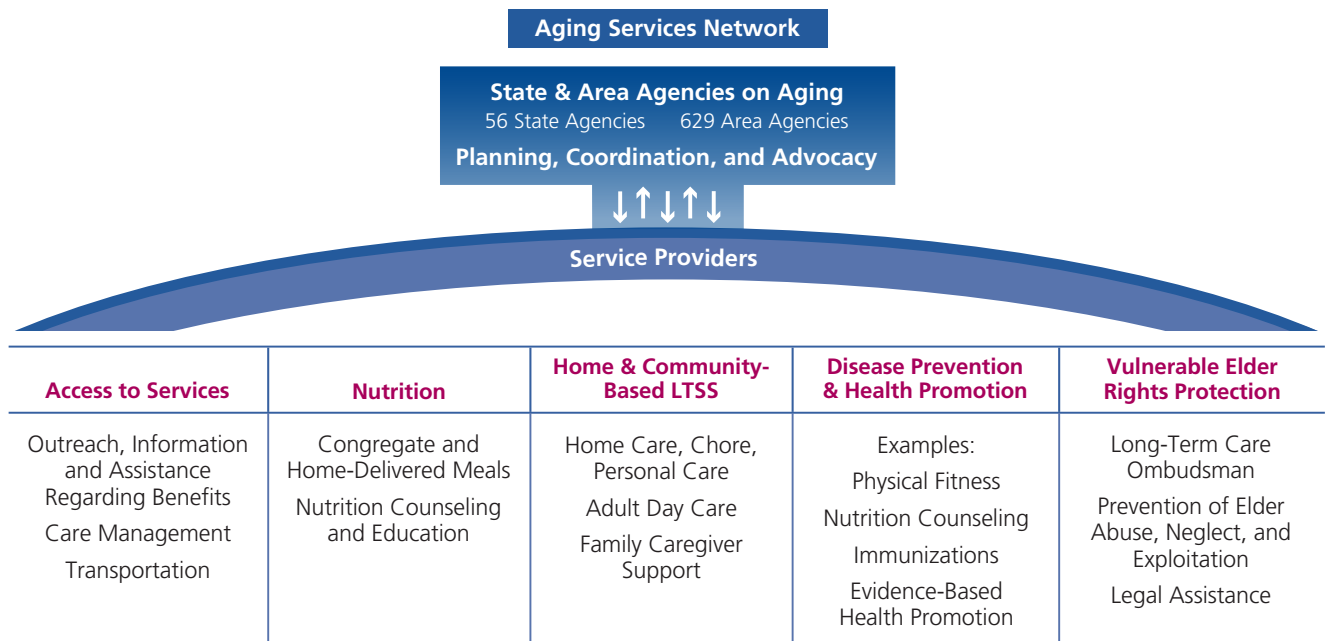
turning point in financing and delivering community services to the elderly. Before then, federal and state governments played a limited role in providing social services and LTSS to older people.

The Act's reach has evolved significantly through the years. Initially, it created authority for a then-new Administration on Aging (AoA) within the U.S. Department of Health and Human Services (HHS)¹ as well as state agencies to be responsible for community planning for aging programs and to serve as catalysts for improving the organization, coordination, and delivery of aging services in their states. It also created authority for research, demonstration, and training projects in the field of aging. Over the succeeding years, Congress expanded the scope, authority, and responsibilities of these agencies. The original legislation authorized generic social service programs, but in successive amendments Congress authorized more targeted programs under various titles of the Act to respond to specific needs of the older population. In 1973, Congress extended the reach of the Act by creating authority for sub-state "area agencies on aging" to be responsible for planning and coordination of a wide array of services for older people, as well as serving as advocates on their behalf.

Today, the "aging services network" is comprised of 56 state agencies on aging, 629 area agencies on aging, 246 Indian Tribal and Native Hawaiian organizations, nearly 20,000 service provider organizations, and thousands of volunteers.² These agencies are responsible for the planning, development, and coordination of a wide array of social, LTSS, and health-support services within each state (Figure 1). The Older Americans Act provides a framework for the delivery of a range of services for older people funded not only by the Act but also by other federal programs. For example, state and area agencies on aging, at a state's option, administer Medicaid LTSS programs as well as services funded by the Social Service Block Grant (SSBG), the State Health Insurance Program (SHIP), and the Public Health Service Act Alzheimer's Disease Supportive Services Program, as well as state and local funds. In addition, many state agencies on aging are responsible for administration of LTSS and other programs for younger people with disabilities.

While the infrastructure created by the Older Americans Act laid the foundation for the current aging services network, the law was not intended to meet all the community service needs of older people. The resources made available under the Act are intended to leverage other federal and nonfederal funding sources to serve older people.

FIGURE 1
Major Services Authorized by the Older Americans Act



A relatively small proportion of the older population receives services directly funded by the Act. However, the infrastructure created by the Act can influence service programs that reach a far larger proportion of the older population. Mandates given to state and area agencies on aging to act as planning, coordinating, and advocacy bodies can impact policies that affect broader groups of older people. For example, state agency on aging efforts to develop LTSS have the potential to change service patterns for older people and for younger people with disabilities who do not directly receive services funded by the Act. In addition, the advocacy functions embedded in the Act’s programs can make other programs’ activities more accountable. For example, actions taken by Older Americans Act-funded long-term care ombudsmen to assist nursing home residents can improve nursing home care financed by Medicaid and Medicare.

As federal and state governments strive to meet growing needs, they have increasingly looked to the aging services network to administer new programs and services and to expand the scope of their responsibilities. For example, in implementing the Medicare Part D prescription drug benefit, the Centers for Medicare &

*Prepared by the National Health Policy Forum.
Note: In addition to Older Americans Act programs, state and area agencies on aging manage services authorized by other federal programs. See text.*

Medicaid Services (CMS) drew heavily on the outreach and assistance capabilities of aging services network agencies. Also, in recent years, some health care systems have used the expertise and resources of the network to provide assistance to help patients make successful transitions from hospitals to post-acute care settings and from nursing facilities to their own homes.

Considering the broad sweep of its mission, the reach of the Act itself is constrained by limited resources. Whether the aging services network can sustain its current capacity and fully meet its potential in the face of growing demand by an increasing older population will be influenced by its ability to attract and retain additional resources and by policy decisions of federal, state, and local officials. As a result of the economic downturn in recent years, activities of many aging services network agencies have been affected by shrinking state and local resources. A 2010 survey of state agencies on aging found that state programs were experiencing increasing demand for services at the same time they were facing budget reductions.³ Similarly, a 2010 survey of area agencies found that many agencies have seen increased client caseloads, instituted waiting lists for services, and restricted the number of clients served, as a result of funding reductions.⁴

Historical Development: Expanding Responsibilities of the Aging Services Network

The original 1965 law and subsequent legislation in the 1970s emphasized the planning, coordination, and needs-identification functions of state and area agencies that continue as major functions today. The functions of state and area agencies on aging were designed to be carried out through a “bottom-up” planning process. The development of the aging services infrastructure in the early 1970s was partially influenced by national political trends toward decentralization of decision-making to state and local governments, exemplified by the New Federalism of the Nixon administration.⁵ It was believed that state and area agencies were in the best position to assess the needs of the elderly and to plan and coordinate services at their respective levels without federal directives on what services to provide. While the program goals were determined nationally, the program was to be state-administered with a great deal of state and local flexibility.

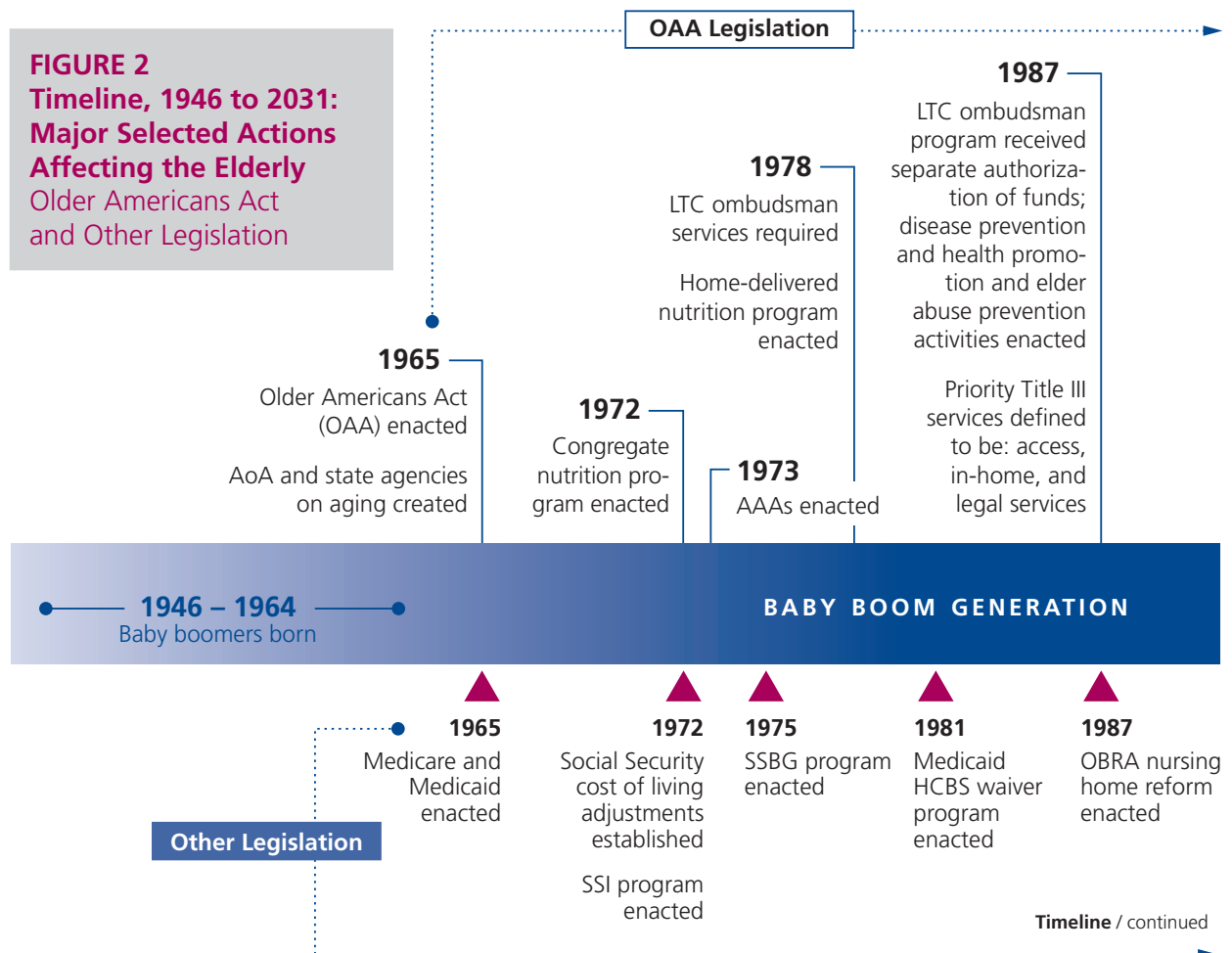
During the early years of implementation, Congress authorized limited dollars for social services and intended that federal funds were to act as catalysts, or “seed money” to draw in state and local (that is, non-Older Americans Act) funds to benefit the elderly. The decentralized planning and service model has meant that state and area agencies, working collectively within a state, are largely in control of their aging agendas and can be responsive to state and local needs, within federal guidelines and funding priorities. However, the flexibility given to state and area agencies on aging has also led to wide variability in the design, implementation, and scope of aging services programs they administer, outside the federally authorized Older Americans Act programs. Moreover, the aging services network’s success in securing additional resources depends on both the political and economic circumstances in individual states and localities and its ability to leverage private sector funds.

As state and area agencies implemented the planning process during the 1970s and 1980s, the needs of older people became more identified and differentiated. As a result, Congress began to authorize targeted programs to respond to specific needs. (See Figure 2, next page, for a timeline of major events in the evolution of the Older Americans Act and related legislation affecting the elderly.) The congregate and home-delivered nutrition services programs, created to address issues of nutritional inadequacy among the elderly, were added to the Act in 1972 and 1978, respectively. The long-term care ombudsman program to address quality of care for residents of long-term care facilities was added in 1978. In 1987, Congress required states to devote a portion of Title III services funds to certain “priority” services: (i) access services, defined as transportation services, outreach, information, and assistance to help older people obtain services, and case management; (ii) in-home services; and (iii) legal assistance. Also in 1987, the disease prevention and health promotion program was authorized. In 2000, the family caregiver support program was enacted. In the last amendments in 2006, Congress recognized the role that the aging services network can play in promoting home and community-based LTSS for people who are at risk for institutional care. These amendments required AoA to implement Aging and Disability Resource Centers (ADRCs) in all states to serve as visible and trusted sources of information on LTSS

options and to coordinate and streamline consumer access to services (see below for more information on ADRCs).

STRUCTURE AND FUNDING OF THE OLDER AMERICANS ACT

The Older Americans Act contains seven titles and authorizes myriad service programs. Total federal funding for the Act's programs in fiscal year (FY) 2011 is \$1.9 billion. Title III, which authorizes activities of state and area agencies, and various service programs, is the major component of Older Americans Act funding, representing 70 percent of the Act's FY 2011 appropriation. Figure 3 (p. 10) shows a description of each title and the breakdown of federal funding by title.



State and Area Agencies on Aging: Functions, Governance, and Staffing

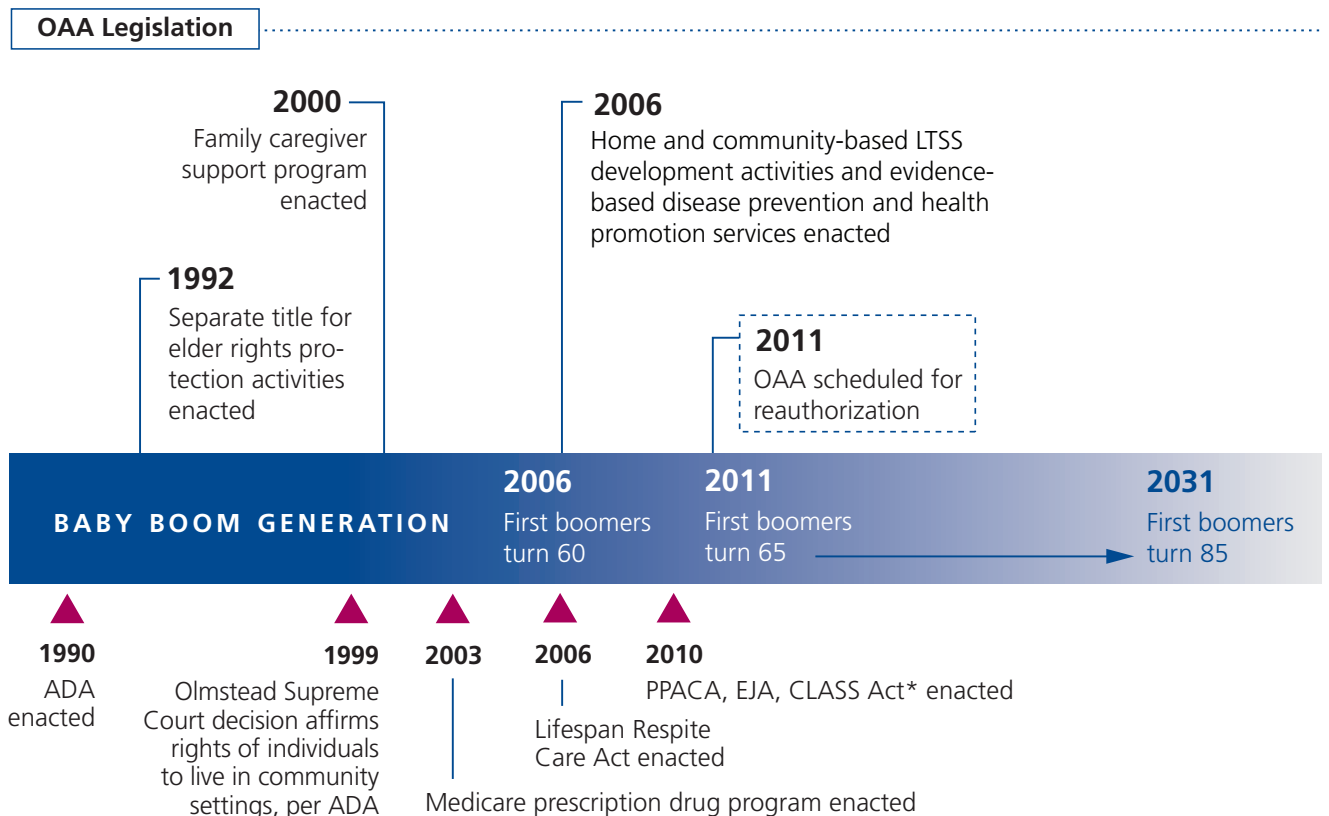
Since their inception, the major functions of state and area agencies on aging have been to advocate for, plan, and coordinate programs that will promote “comprehensive and coordinated services systems” and “maximum independence and dignity in a home environment with appropriate support services” for older people. These agencies are also charged with developing a “continuum of care” for vulnerable older people and to help them remain as independent as possible in home and community-based settings.⁶

Each state has an agency designated by its governor to plan and coordinate services for older people, develop a statewide plan on aging,

FIGURE 2: Acronyms Defined

AoA	Administration on Aging
AAA	Area Agencies on Aging
ADA	Americans with Disabilities Act
CLASS	Community Living Assistance Services and Supports Act*
EJA	Elder Justice Act
HCBS	Home and Community-Based Services
LTSS	Long-Term Services and Supports
OBRA	Omnibus Budget Reconciliation Act
PPACA	Patient Protection and Affordable Care Act
SSBG	Social Services Block Grant
SSI	Supplemental Security Income

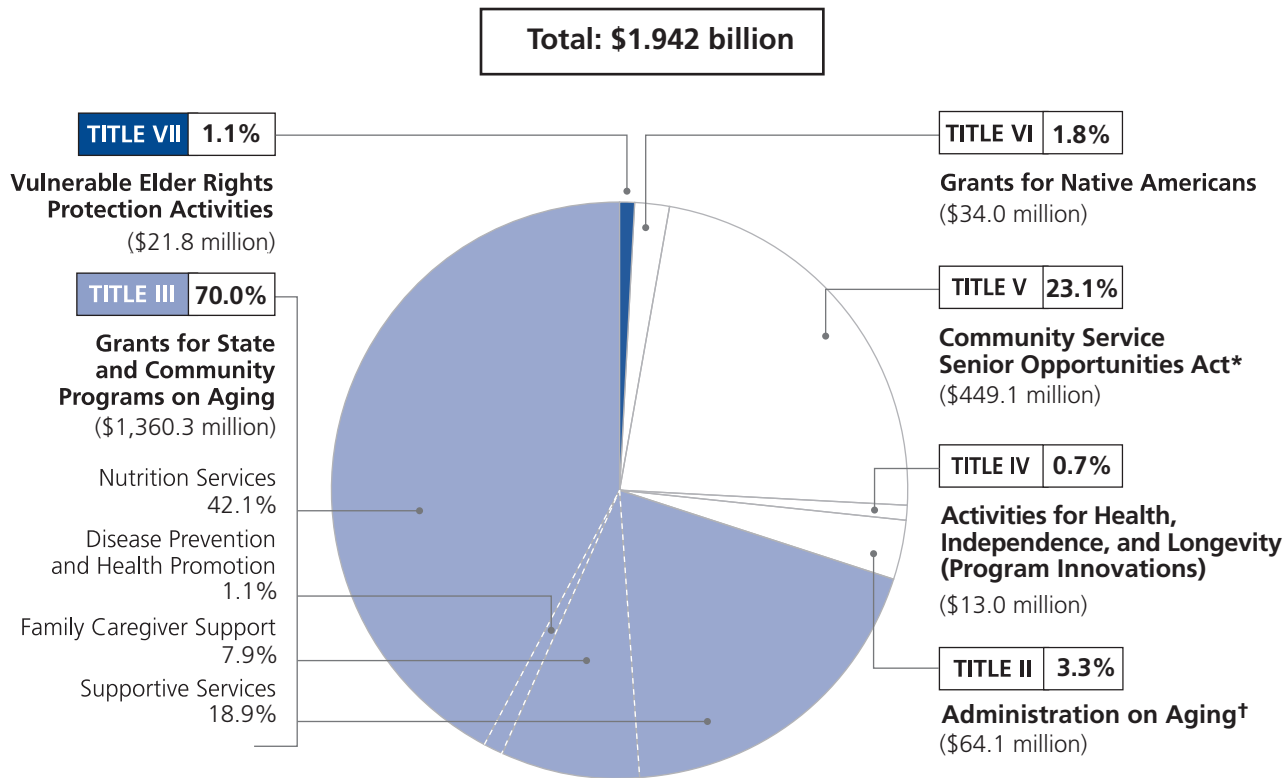
FIGURE 2 — Timeline / continued



* As of fall 2011, HHS has suspended work on implementation of the CLASS Act.

and administer Older Americans Act programs. State agencies on aging are required to divide the state into planning and services areas (PSAs), and, for all PSAs, designate area agencies on aging that develop area plans on aging. (A few state agencies operate as area agencies due to their small geographic size or population density.⁷) State and area agency plans on aging are to reflect how they will meet the needs of older people, using Older Americans Act funds as well as other funding resources.

FIGURE 3: Older Americans Act, FY 2011 Appropriations



* Also referred to as the Senior Community Service Employment Program (SCSEP) for Older Americans.

† Also referred to as Aging Network Support Activities. Includes funds for AoA administration and for health and LTSS programs, including \$10 million appropriated by the Patient Protection and Affordable Care Act (Section 2405 of P.L. 111-148) for Aging and Disability Resource Centers (ADRCs). ADRCs are authorized under Section 202 of the Older Americans Act. Also includes funding for national resource centers for elder abuse prevention and long-term care ombudsman programs, the national eldercare locator, and other activities.

Note: Not included in this chart is funding appropriated by Section 3302 of PPACA for various AoA programs to conduct outreach and assistance to low-income elderly. Section 3302 appropriated \$15 million for area agencies on aging for fiscal years 2010–2012; \$10 million for ADRCs for fiscal years 2010–2012; and \$5 million for the National Center for Benefits and Outreach Enrollment for fiscal years 2010–2012.

Source: Prepared by the National Health Policy Forum, based on appropriations data provided by the U.S. Administration on Aging and the U.S. Department of Labor.

In addition to their advocacy, planning, and coordination roles, area agencies provide, or contract with other agencies and organizations to provide, a set of service programs. Functions considered “core” functions and generally provided directly by area agencies are information, referral, assistance, and outreach services to help older people determine their service needs and options; long-term care ombudsman programs that help residents of care facilities resolve complaints about their care; and family caregiver and support services. Other services generally provided directly by area agencies are case management and assessment and development of care plans to assist vulnerable older people get the support services they need, and benefits counseling to help older people apply for and receive benefits from income, health, and LTSS programs. Area agencies generally contract with other agencies or organizations to provide a number of other services; these are congregate and home-delivered nutrition programs, medical and non-medical transportation, legal assistance, homemaker, chore, respite care, personal care assistance, and adult day care services.⁸

The majority of state agencies on aging are located in umbrella human service and/or health services agencies; the remainder are

At a Glance: Older Americans Act Structure

Title I	Declaration of Objectives. Sets out broad social policy objectives oriented toward improving the lives of all older people.
Title II	Administration on Aging (AoA). Establishes AoA within the Department of Health and Human Services (HHS) as the chief federal agency advocate for older persons and sets out the responsibilities of AoA and the Assistant Secretary for Aging. Establishes aging network support activities.
Title III	Grants for State and Community Programs on Aging. Authorizes activities of state and area agencies on aging and funds for supportive and nutrition services, family caregiver support, and disease prevention and health promotion activities.
Title IV	Activities for Health, Independence, and Longevity. Authorizes research, training, and demonstration projects in the field of aging.
Title V	Community Service Senior Opportunities Act. Authorizes funds to support part-time employment opportunities for unemployed low income people age 55 and older who have poor employment prospects.
Title VI	Grants for Native Americans. Authorizes grants for supportive and nutrition services to American Indians, Alaskan Natives, and Native Hawaiians.
Title VII	Vulnerable Elder Rights Protection Activities. Authorizes funds for the long-term care ombudsman program and services to prevent elder abuse, neglect, and exploitation.

independent departments or commissions of state government.⁹ The governance of area agencies varies widely. About 42 percent are independent non-profit agencies, about 30 percent are part of city or county governments; and about 23 percent are part of councils of government or regional planning and development agencies. The remainder are located in colleges, community action agencies, and other organizations.¹⁰

Staffing patterns of state and area agencies vary considerably based on each state's older population and the type and budgets of programs they administer. The staffing of state agencies on aging cluster around two ranges: about 33 percent of state agencies report between 21 and 75 full-time equivalent (FTE) staff and 41 percent, 126 or more FTEs.¹¹ Staffing of area agencies range from small staffs of just a few people, especially in rural states or rural areas within a state, to very large staffs of one-hundred or more in major metropolitan areas. In part, this reflects state policy decisions regarding geographic distribution of area agencies, the dispersion of the elderly population within a state, and funding. In FY 2010, the 629 area agencies on aging were staffed by over 23,000 paid staff in total; volunteers working in aging services programs numbered over 29,000 people.¹²

Variation on a theme — While all state and area agencies carry out advocacy, planning, and coordination functions, and administer core service programs, some observers have pointed to the wide variability in the design, implementation, and scope of aging services available to older people among states and across communities. The variation in the governance as well as the staff and resources available contribute to wide differences in capacity among these agencies. For many social service programs, national standards or guidelines for best practices do not exist.¹³ This can present challenges to state and local aging services administrators who may seek to achieve or approximate effectiveness as measured by any defined standards. To address this variability AoA has, in recent years, encouraged state and area agencies to use evidence-based programs that have been proven by objective data to be effective, including in areas of health promotion and education and services to help older people transition from hospitals to post-acute care. (See sections below on Disease Prevention and Health Promotion and Aging and Disability Resource Centers.) However, evidence-based programs do not exist for many aging services programs.

Targeting the Vulnerable Older Population

Older Americans Act services are available to all people age 60 and over who need assistance, but the law requires that services be targeted to those with the greatest economic or social need.¹⁴ (In certain instances people under the age of 60 may receive services.¹⁵) In successive amendments, Congress has added specific groups of older people to be targeted: those with low-income, members of minority or ethnic groups, older people living in rural areas, those at risk for institutional care, and those with limited English proficiency.¹⁶

Means testing—considering a person’s income, assets, savings, or personal property as a condition of receiving services—is prohibited.¹⁷ Participants are encouraged to make voluntary contributions for services they receive. In addition, states may implement cost-sharing policies for certain services (such as homemaker, personal care, or adult day care services) on a sliding fee scale, based on income and the cost of services. Where such policies exist, older people may not be denied services due to failure to make voluntary contributions or cost-sharing payments.

Although the distribution of Title III funds to states is determined on the basis of age alone, state and area agencies determine how to serve the target populations that are defined by federal law. A variety of methods are used to target services, including location of services in areas where vulnerable people reside, as well as strategic outreach to low-income and minority older people. Some services are targeted to vulnerable groups by definition. Examples of these, the long-term care ombudsman program, family caregiver support services, and home and community-based LTSS, are discussed below.

Population served — For FY 2010 AoA data show that about 5.1 percent of the 57.8 million people age 60 and older, or almost 3 million people, received services funded by the Act, such as home-delivered meals, home care, personal care, or case management services, on a regular, or intensive, basis.¹⁸ A larger proportion—about 14 percent of the older population, or almost 8 million people—received other services, such as transportation, information and assistance, or congregate meals, on a less-than-regular or -intensive basis.¹⁹ Even though a small number overall receives services, vulnerable older people are more likely to receive Title III services, as measured by poverty and minority status. Of all people served under Title III programs in FY 2010, 30 percent of those who received services on a regular or intensive basis had income

below the federal poverty level (FPL), compared with 9.5 percent in the U.S. population age 60 and over. About 25 percent of clients were members of a minority group, compared with about 22 percent in the U.S. population age 60 and over.²⁰

Title III participants are more likely to be among the oldest population groups and to have multiple chronic conditions and functional impairments. Analysis of AoA data by Mathematica Policy Research, Inc., found, for example, that 37 percent of Title III congregate nutrition participants, and 36 percent of transportation participants were in the oldest age category (age 75-84 years) compared with only 24 percent in that same age group in the overall national population. Participants in selected Title III services, such as homemaker services, home-delivered meals, and case management programs, were more likely to have multiple chronic conditions and limitations in activities of daily living (ADLs), than other older people.²¹

SERVICES AUTHORIZED BY THE OLDER AMERICANS ACT

Title III authorizes four service programs: supportive services, nutrition services, family caregiver support, and disease prevention and health promotion activities (see also Appendix for a summary). Title VII authorizes the long-term care ombudsman program, and activities to prevent elder abuse, neglect, and exploitation. The following section discusses selected major services programs, including available data on participant characteristics.

Evaluation studies, where they exist or are underway, are briefly described under individual service programs. With a few exceptions, however, evaluations are limited to overviews of program implementation, or are dated.

Distribution of Funds and Non-Federal Matching Requirements

AoA distributes Title III and Title VII funds to states according to population-based formulae. Except for family caregiver support services, each state receives Title III allotments for services proportionate to its population age 60 and over, compared with the total U.S. population age 60 and over. Family caregiver support program funds are allotted based on states' proportionate population age 70

and over. States allocate Title III funds to area agencies on aging based on a state-determined formula, which is generally a combination of population factors such as age, income, and racial or ethnic status of the older population throughout the planning and service areas of the state.

In general, states are required to provide matching funds to use federal Older Americans Act services funds. For supportive and nutrition services grants, states are required to provide 15 percent and for family caregiver grants, 25 percent, in state matching funds, as a condition of receiving federal funds. States may support long-term care ombudsman services with Title III and Title VII funds; in the case of Title III, a 15 percent state matching amount is required and, for Title VII, no matching amount is required. State and local communities often provide additional funds, above the federal requirements, to spread Older Americans Act funds more widely. In addition, voluntary contributions from older people to pay part of the costs of some services, especially for the congregate and home-delivered nutrition programs, augment federal, state, and local funds.

Supportive Services: Helping Older People Remain Independent in Their Communities

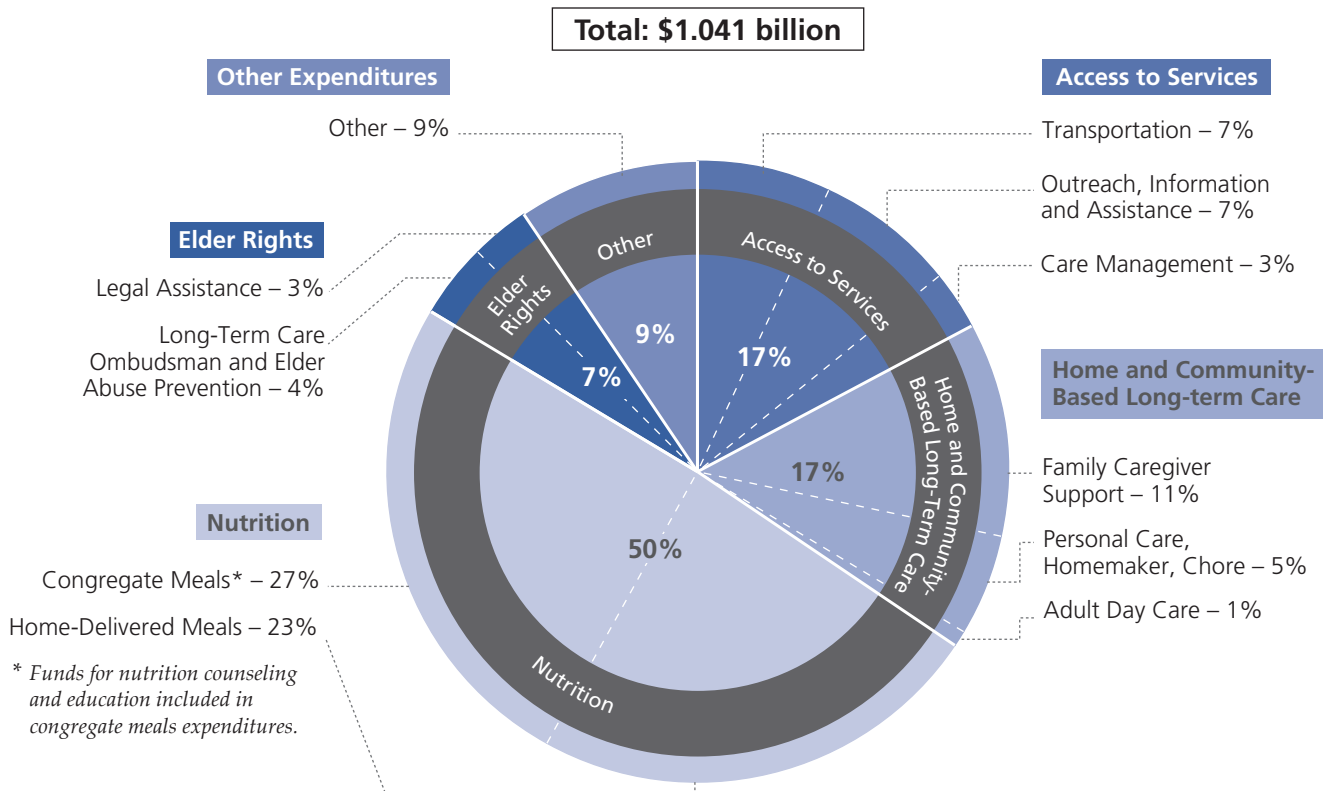
The supportive services program funds social services aimed at helping older people remain independent in their own homes and communities. Unlike other programs under the Older Americans Act that target a specific service, this program funds a wide range of services. These include services to help older people access services (such as information and assistance and transportation) as well as home and community-based LTSS (such as personal care, homemaker, chore, and adult day care services). Due to its limited funding, the amount of services the program can buy is relatively small.

Figure 4 (next page) shows FY 2010 federal expenditures for major services funded by the supportive services funding stream—access services and home and community-based LTSS—and other services funded by Title III and Title VII. (Note: Federal expenditures shown differ from appropriations for individual programs in part because states can transfer appropriated funds between programs.²²)

Information, assistance, and outreach — Central to the mission of the state and area agencies on aging is their role in providing information, assistance, and outreach services in order to act as access

In general, states are required to provide matching funds to use federal Older Americans Act services funds.

FIGURE 4
Older Americans Act: Federal Expenditures for Services Authorized by Title III and Title VII, FY 2010



Note: Expenditures for disease prevention and health promotion not readily available. In 2009, this spending was 2 percent of the total. Also, federal expenditures shown differ from appropriations for individual programs in part because states can transfer appropriated funds from some programs to others.

Source: Prepared by the National Health Policy Forum, based on AoA data on federal expenditures for services reported by state agencies on aging. Does not include other federal or state and local funds.

points for aging services programs for older people and their families. Area agencies on aging are tasked with providing convenient and direct access to information and referral services to help older people identify, understand, and effectively use services available in their communities. According to AoA data, about 2,700 information and referral and assistance organizations across the country are supported by Title III supportive services funds.²³ In FY 2010, total expenditures for information, assistance, and outreach by aging network agencies were \$178 million, with \$67 million, about 38 percent, from Title III funds.²⁴

A 2010 survey of area agencies found that over 90 percent provide information and assistance directly, rather than contracting with another agency.²⁵ Other data indicate that almost half of area agencies provide toll-free telephone lines. On average, each area agency

handles over 13,000 information and assistance calls annually, and most screen clients for their eligibility for home and community-based services programs.²⁶ Area agency information and assistance providers are sometimes recruited to assist in special outreach efforts. For example, they devoted considerable effort to provide Medicare beneficiaries information and assistance to help them enroll in the Medicare Part D prescription drug benefit.

Transportation services — Transportation services is the largest category of Title III supportive services spending, accounting for almost \$74 million in FY 2010. Title III funds constitute a little more than a third of all transportation funding managed by area agencies.

An analysis of Title III FY 2009 data show that transportation service recipients are in the oldest age categories and are more likely to live alone than their peers nationally. For example, although only 8 percent of older people nationally were age 85 and older, more than one-quarter of Title III transportation recipients were age 85 and older. More than two-thirds of recipients lived alone, compared with a little more than one-quarter nationally. Recipients also tended to have numerous health problems: more than 80 percent had four or more chronic conditions.²⁷ Other data show that over half of recipients said they had no vehicle available in the household, and 43 percent reported that they relied on these services for virtually all their local transportation needs. About one-third of recipients used Title III-funded transportation more than 12 times per month.²⁸

Focus groups with area agency staff, conducted as part of a supportive services program evaluation, found that transportation services were in short supply in certain areas, especially inner cities and rural areas, and that volunteers and waiting lists were being used to manage demand.²⁹ A 2011 GAO report found that the need for transportation services by older people is significant, especially among women, those who are age 80 or older, or those living below the poverty threshold. GAO reported a substantial need for transportation that cannot be met by state and local programs.³⁰

Home care services — State agencies on aging are required to devote some of their Title III funds to home care services, including homemaker, chore, and personal care services. Almost 300,000 people received Title III-funded personal care, homemaker, or chore services in FY 2010.³¹ Recipients are a particularly vulnerable group. An analysis of Title III FY 2009 data show that about 91 percent of homemaker

service recipients had four or more chronic conditions; of those with multiple chronic conditions, about 42 percent had three or more limitations in ADLs. Almost 70 percent of homemaker services recipients lived alone and almost three-quarters were age 75 or older.³²

In FY 2010, total expenditures for home care services by aging network agencies were \$527 million, with about \$51 million, or almost 10 percent, from Title III funds. Most of the funding for home care services comes from other sources, primarily Medicaid home and community-based waiver funds. Although the amount of funding devoted to home care is a small fraction of the amount spent under Medicaid and Medicare, the Title III program has the flexibility to serve people who may not otherwise be served under those programs. Because Older Americans Act services may be provided without the income and asset restrictions required under Medicaid, and without the restriction that beneficiaries need skilled care under Medicare, Title III funds may be used to fill gaps left by these other programs.

Evaluation — A 2006 evaluation of the supportive services program that primarily used AoA data concluded that the program serves a particularly vulnerable population. Moreover, analysis of data over a four-year period showed that for some services, such as home care and transportation, the proportion of vulnerable elderly (as measured by activity limitations and living alone status) increased. The evaluation also pointed out that agencies on aging use federal funds to leverage a substantial amount of non-Older Americans Act funds. According to this study and AoA data, for every \$1 in federal funds, state and area agencies on aging supplement with more than \$2 from other funding sources.³³

Nutrition Services Program: Serving an At-Risk Population

Many older people are at high risk for hunger and food insecurity. Food insecurity is defined as being uncertain of having, or unable to acquire, enough food for all household members because of insufficient money or other resources for food.³⁴ Using data from the Current Population Survey's Food Security Supplement, a GAO analysis reported that almost one-third of elderly households with income less than the poverty level, and about 19 percent of households with income less than 185 percent of poverty, were food insecure.³⁵ Other research shows that in recent years, the number of elderly facing

poor nutrition and hunger has been increasing.³⁶ Being poor, having low education, and living alone are indicators of risk for poor nutrition. Older people lacking adequate nutrition are more likely to suffer from poor health and to have functional limitations.³⁷

The elderly nutrition program, the oldest—and perhaps most well-known Older Americans Act service—is intended to address the nutritional problems of older people by providing meals in congregate settings, such as senior centers and churches (the “congregate meals” program), and meals to frail older people in their own homes (the “home-delivered meals” program). The purposes of the program are to reduce hunger and food insecurity, promote socialization among older people, provide meals to the homebound, and delay the onset of adverse health conditions among older people that result from poor nutritional health or sedentary behavior. Indirectly, the program acts as income support for many poor and near-poor older people by providing food that they would otherwise purchase (in groceries or at restaurants). The program has the potential to improve older people’s health by offering nutritionally adequate meals in compliance with USDA guidelines.³⁸ It also can offer nutrition counseling and education, though access to these services is quite limited.

AoA has recently awarded funds to establish a National Resource Center on Nutrition and Aging, which is tasked with building the capacity of the aging services network to provide nutrition services for both current and future older adult populations. The Center is expected to provide training and technical assistance to the aging services network, including scientific and clinical evidence that support nutrition services.³⁹

Funding and meals provided — The program represents about 42 percent of the Act’s total FY 2011 funding. In FY 2010, about 2.6 million people received 242 million meals; 60 percent of meals were served to frail older people living at home, and 40 percent were served in congregate settings.⁴⁰ In recent years, the growth in the number of home-delivered meals has outpaced congregate meals. A number of reasons account for this trend, including efforts by states to transfer funds from their federal congregate services allotments to home-delivered services (as allowed by the law), state initiatives to expand services to frail older people living at home, and successful leveraging of nonfederal funds for home-delivered meals services. In some cases, due to state or local budget reductions, home-delivered meals

The nutrition services program represents about 42 percent of the Older American Act’s total FY 2011 funding.

programs have been preserved at the expense of congregate meals programs.

Recipients — As shown in Table 1, recipients are older, more likely to live alone and have income below or near poverty, compared to all adults age 60 and over. Nutrition recipients are also very likely to suffer from multiple chronic conditions, with home-delivered meals recipients frequently experiencing three or more ADL limitations.⁴¹

Unmet Need for Nutrition Services — Until recently data on the unmet need for nutrition services generally have been elusive. However, a 2011 GAO report has shed some light on the issue of unmet need. It found that about 9 percent of low-income older adults received Older Americans Act meals services but many more were likely to

TABLE 1: OAA Nutrition Service Recipients: Age, Income, and Health Status, FY 2009

Recipient Characteristics	Congregate Nutrition Recipients	Home-Delivered Nutrition Recipients	U.S. Adults Age 60 and Older
Age 75 or Older	57%	70%	32%
Living Alone	48%	56%	27%
Income Below, At, or Near Poverty*	33%	52%	15%
Four or More Chronic Conditions	71%	83%	N/A
Three or More ADL Limitations and Presence of Chronic Conditions	9%	31%	N/A

* Income below, at, or near poverty refers to households in \$5,000 income bands that include or are below the federal poverty guideline. This includes households for one- or two-person households with income less than \$15,000 per year in 2009.

Source: Based on an analysis of a sample of randomly selected Title III recipients in 2009: Norma Altshuler and Jody Schimmel, Mathematica Policy Research, Inc. "Aging in Place: Do Older Americans Act Title III Services Reach Those Most Likely to Enter Nursing Homes?" Research Brief No. 1, July 2010, www.aoa.gov/aoaroot/program_results/docs/2010/AoA_1_NursingHomes_041311.pdf; Rebecca Kleinman and Leslie Foster, "Multiple Chronic Conditions Among OAA Title III Program Participants," July 2011, www.aoa.gov/AoARoot/Program_Results/docs/2011/AoA4_Chronic_508.pdf.

need them due to financial constraints or other difficulties. About 89 percent of low-income older adults who were considered food insecure did not receive either congregated or home-delivered meals. The report also indicated almost 90 percent of older people who were limited in two or more ADLs did not receive home-delivered meals. A number of factors may contribute to non-receipt of needed services. Some older people may not know these services exist or that they might be eligible, and, especially in the case of home-delivered meals, agency budgets do not allow expansion of services to meet identified needs.⁴²

While national data on waiting lists for nutrition services do not exist, recent surveys of state and area agencies on aging have indicated that the requests for these services have increased in some areas.⁴³ Even with increased requests, the national economic downturn has caused many aging service providers to reduce services.⁴⁴ For example, GAO found that since the beginning of the economic downturn almost 80 percent of local aging service providers have experienced increased requests for home-delivered meals.⁴⁵

Evaluation — The most recent major evaluation of the nutrition program is dated. Completed in 1996 by Mathematica, it found that the program is an important part of participants' overall nutrition, and that meals consumed were the primary source of daily nutrients. Participants were more likely than the general older population to have health and functional limitations that placed them at nutrition risk.⁴⁶ AoA has another national evaluation underway, also being conducted by Mathematica, that will include a participant outcome study, a cost analysis of meal services, and a review of program administration by state and area agencies and local service providers. The participant outcome study will include a matched comparison group and will measure nutrition, health and well-being, food insecurity and hunger, and socialization outcomes. Meals cost data will be measured by labor, food, and supplies costs and method of meal production.⁴⁷ The evaluation is not expected to be completed for several years.

Family Caregiver Services: Serving Multiple Generations Through One Program

The vast majority of the elderly with long-term supportive care needs receive care from their families and other informal, unpaid caregivers. Millions⁴⁸ of caregivers provide informal, unpaid care to older

people and younger adults who need assistance due to a physical, cognitive or mental impairment. The aging of society is expected to exacerbate demands on family caregivers and increase the number of families who will be called on to provide care. Because caregiving responsibilities often lead to physical and emotional stress, and because of the increasing numbers of caregivers, many people consider the stress of caregiving to be a health issue of growing concern.

Services provided — The National Family Caregiver Support Program (NFCSP), authorized under Title III of the Act, provides grants to state agencies on aging that award funds to area agencies on aging for caregiver support.⁴⁹ Services authorized include information and assistance about available services, individual counseling, organization of support groups and caregiver training, respite services to provide families temporary relief from caregiving responsibilities, and supplemental services (such as home care and home adaptations) on a limited basis to complement care provided by family and other informal caregivers. Aging network funding for family caregiver support in FY 2010 totaled \$188 million, with most (63 percent) from Title III. Almost half of all funding was spent on respite care, with the remainder spent on access assistance, counseling, support groups, caregiver training, or other assistance.⁵⁰

Recipients — The number of caregivers served is small compared with the estimated number of caregivers nationwide. Annually about 600,000 caregivers receive assistance through the program. In 2009, about 80 percent of caregivers served received information about, or help receiving, services; 60 percent received supplemental goods or services, such as canes or walkers, emergency response systems, or nutritional supplements for care recipients; half received respite services; and one-third participated in training, counseling or support groups.⁵¹

The program supports caregivers of all ages. About 47 percent of caregivers are adult children caring for a parent; 39 percent are spouse caregivers; and 14 percent are grandchildren, or other relatives or friends. Spouse caregivers are a particularly vulnerable group; most are older than 70, in fair or poor health, and have a health condition or disability that affects their ability to provide care. The majority of caregivers provide care to people who have significant physical or cognitive disabilities.⁵²

Program results and evaluation — A 2004 survey regarding the initial years of implementation conducted with state officials found that the program had increased the range of caregiver support that state and area agencies on aging offer. However, programs were found to be uneven across and within states. While states and area agencies have set up initiatives to coordinate the program with other home and community-based LTSS programs, a major barrier cited was differing eligibility requirements and administrative authorities. State officials interviewed pointed to the need for better coordination of caregiver services with social services programs, the importance of developing methods to uniformly assess caregiver needs and provide caregiver training, and the need for additional funding for respite care services.⁵³

Other than the 2004 survey, little evaluative information is available. Some information is available in a survey of Title III recipients; it found that 80 percent of caregivers rated services they received very highly, most saying that the services allowed them to provide informal care longer than they otherwise would have, and that the support they received helped them deal with the strain and difficulties involved in caregiving.⁵⁴ AoA has a national evaluation underway. A design contract was awarded to the Lewin Group, Inc., and the design phase is in process.

Disease Prevention and Health Promotion Activities: Straining to Have Broader Reach

At least 60 percent of the elderly have multiple chronic conditions,⁵⁵ and most health care spending is for people with chronic conditions.⁵⁶ Although the primary way the Older Americans Act addresses disease prevention and health promotion activities is through the nutrition services program, Congress has authorized specific funds for these activities as part of Title III (under subpart D). Appropriated at \$21 million in FY 2011, disease prevention and health promotion activities are one of the smallest Older Americans Act programs. States use these funds to support health promotion activities at various community venues, such as senior centers and congregate nutrition sites, among others.

The types of activities that state and area agencies support with these funds vary widely. According to an assessment of eight programs completed for AoA, aging services network health promotion

Although the Older Americans Act is intended to provide seed money for its programs, state and area agencies sometimes find it difficult to sustain funding for programs after they are initiated.

activities include both group services, such as physical fitness and diabetes control classes and arthritis and nutrition education, as well as more individualized services, such as medical and dental screening, nutrition counseling, medication management consultation, and immunizations. Area agencies work with a range of public and private health and social services organizations in planning and delivering these services.⁵⁷

According to an AoA program assessment, providing these services presents a number of challenges. Although the Older Americans Act is intended to provide seed money for its programs, state and area agencies have found it particularly difficult to leverage other funding for health promotion and disease prevention activities. In addition, not being able to sustain funding is a major impediment to continuing programs once they are initiated.⁵⁸ In recent years, some state agencies on aging have been working with state Medicaid programs to use Medicaid matching funds to help sustain their disease prevention and health promotion initiatives.

To complement its formula-based grant program for disease prevention and health promotion, in recent years AoA has awarded discretionary grants funds to states and community agencies to help them develop programs based on evidence-based disease protocols. In part, these programs have been developed using research supported by the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Disease Control and Prevention (CDC). The aim of the projects is to implement low-cost interventions that have proven effective in reducing the risk of disease, disability, and injury among older people. Programs are focused on a number of areas, including chronic disease self-management, falls prevention, physical activity, and depression. Through this grant program, state and area agencies are developing collaborative relationships with a variety of entities such as community agencies, public health departments, universities, physicians, and health plans. AoA has awarded its discretionary grants to states and community agencies to implement evidence-based health promotion programs, such as the Chronic Disease Self-Management Program (CDSMP),⁵⁹ and falls prevention programs, such as A Matter of Balance,⁶⁰ among others. A survey of area agencies indicated that about 82 percent are involved in implementation of these types of programs.

Even with these steps, increased support for health promotion and disease prevention initiatives may be needed as policymakers discuss ways to control costs for older people with chronic illnesses. As with other aging services network programs, a key issue is to identify effective and self-sustaining strategies.

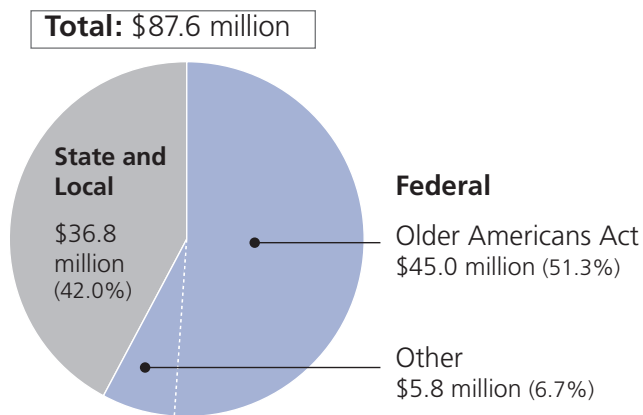
Long-Term Care Ombudsman Program: Protecting Resident Rights

For many years, policymakers have been concerned about the quality of care in various types of residential care facilities. While most attention has been directed at nursing home quality, Congress has also been concerned about care in other residential facilities, such as assisted living facilities and “board and care” homes. The primary way the federal government oversees quality of care in Medicare- and Medicaid-certified nursing homes is through enforcement of a series of requirements enacted in the Omnibus Reconciliation Act of 1987 (OBRA 1987) and subsequent amendments. Licensure and/or certification of residential care facilities other than nursing homes are the province of state government.⁶¹

A complementary way to address quality of care in nursing facilities is through protection of resident rights and consumer advocacy, which Congress established through the Older Americans Act. In 1978, Congress enacted a requirement that state agencies on aging establish an ombudsman program to advocate for, and protect the rights of, residents of long-term care facilities. In the 1987 Older Americans Act amendments, Congress gave more prominence to the program by adding a separate authorization of appropriations for the program. And in 1992, Congress added a new title to the Act for vulnerable elder rights protection activities. Facilities that come under the purview of ombudsmen include not only nursing homes but also assisted living facilities, board and care homes, and other similar adult residential care settings. All states, the District of Columbia and Puerto Rico, administer an ombudsman program. In most states the program is administered by state agencies on aging; in eight states, program administration is contracted to entities outside state government.⁶²

The functions of the ombudsman program are quite broad and include investigating and resolving resident complaints; providing services to protect resident health, safety, welfare, and rights;

FIGURE 5 | Long-Term Care Ombudsman Spending, 2010



Source: Prepared by the National Health Policy Forum based on data in AoA, 2010 National Ombudsman Reporting System Data Tables, table A-9, available at www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/National_State_Data/2010/Index.aspx.

representing the interests of residents before governmental agencies; seeking administrative and legal remedies to protect their rights; and providing consumer education. Funding for the program is rather modest considering its broad responsibilities, and the program relies on citizen volunteers to carry out its mission.⁶³ Some observers have raised concerns about the capacity of the program to meet its legislative mandate, given the low level of federal funding and paid staffing.

In FY 2010, total program support was \$87.7 million with 51 percent from the Older Americans Act. (see Figure 5). Significant support—42 percent—comes from state and local sources, well over the amount required by federal law to receive federal matching funds.⁶⁴ Because of the significant contributions of unpaid ombudsman volunteers, the program’s effective resources are higher.

The amount spent by the program nationally from both federal and state sources in FY 2010 is the equivalent of about \$30 per bed annually.⁶⁵

(For an in-depth analysis of the ombudsman program, see Forum background paper, “The Role of Ombudsmen in Assuring Quality for Residents of Long-Term Care Facilities: Straining to Make Ends Meet,” by Carol V. O’Shaughnessy, December 2, 2009, available at www.nhpf.org/library/details.cfm/2767.)

BEYOND THE OLDER AMERICANS ACT

Over the years, many state and area agencies have broadened their responsibilities beyond the administration of Older Americans Act funds. This is exemplified especially in their management and redesign of home and community-based LTSS financed by Medicaid and state funds. In addition, many aging services network agencies administer Social Service Block Grant (SSBG) funds for elder abuse prevention, the State Health Insurance Program (SHIP), Public Health Service Act funds,⁶⁶ and state general revenue funds for myriad services for older people, and programs for younger people with disabilities. (See Appendix for examples of other aging services programs.)

Management and Redesign of LTSS

As a result of the planning efforts undertaken by state agencies on aging during the 1970s and 1980s, it became clear to state aging administrators that home and community-based services for vulnerable older people were underdeveloped and that a “continuum of care,” as envisioned by the Older Americans Act, did not exist. At the same time, the federal government had been giving more policy attention to “alternatives to institutional care” through various demonstration programs.⁶⁷ Moreover, states were concerned about growing Medicaid and state spending for nursing home care and wanted to place more attention on reducing—or at least controlling—the rate of increase in expenditures for institutional care. They also wanted to become more responsive to the preferences of the frail elderly and other adults with disabilities for care in home and community-based settings rather than in institutions. As a result, some states began to focus more attention on developing home and community-based care options that could prevent or delay institutional care.

Calls by advocates and policymakers for greater access to a wider range of home and community-based care led Congress to enact the Medicaid section 1915(c) home and community-based waiver program in 1981. The program permits the Secretary of HHS to waive certain Medicaid statutory requirements, thus allowing states to provide a wider range of home and community-based services for the elderly and other groups than were otherwise available for Medicaid reimbursement. The waiver program allows states to control the budget for these services by targeting specified groups and by providing services on a less-than-statewide basis. Implementation of waivers during the 1980s and 1990s began to change the fabric of LTSS as states developed a broad span of services, such as care management, home care, adult day care, and respite care, to meet the needs of vulnerable populations living in the community. The program provides an opportunity to alter what some refer to as Medicaid’s “institutional bias.” Prior to the waiver program, care in Medicaid-financed nursing homes and other institutions was often the only option for elderly and other groups with LTSS needs and limited income and resources.

Administrators and advocates for the elderly recognized that their ability to provide home and community-based services could be significantly augmented by access to Medicaid funds. The aging infrastructure proved to be a ready-made network for waiver

implementation. Many state governments began to assign responsibility for administration and day-to-day management of the Medicaid waiver services program to state agencies on aging. Often, state agencies on aging designated area agencies on aging to deliver waiver services, including case management, assessment of individuals' care needs, and development of care plans. Medicaid now represents a significant part of funding for both state and area agencies on aging. A 2010 survey of state agencies on aging found that, after the Older Americans Act and state appropriations, Medicaid represented their third largest source of funding.⁶⁸ A similar finding was made by GAO with respect to funding for area agencies. Forty-two percent of area agency funds were from Older Americans Act sources; 24 percent from state funds; and 10 percent from Medicaid home and community-based waivers; and the balance from other federal, state, local, and private funds.⁶⁹

Throughout most of the aging network, administration of Medicaid waiver programs is now a core component of aging services. According to a 2010 survey, state agencies on aging in 32 states were the designated operating agencies for one or more Medicaid home and community-based waiver program. About half of state agencies on aging also administer state-only funded home and community-based services for the elderly.⁷⁰

In addition to management of Medicaid waiver programs, some state agencies on aging have been instrumental in redesigning their state LTSS programs by making broad policy changes, using Medicaid funds for home and community-based services in combination with Older Americans Act and state funds. LTSS redesign has taken various approaches including (i) consolidating administrative structures and financing with the aim of redirecting service delivery toward home and community-based services from institutional care, and (ii) restructuring the delivery of LTSS to help consumers more easily access services.

Some states have redesigned their systems by consolidating policy, financing, and administration into one single state agency that has control of, and is accountable for, all LTSS resources. In these cases, one agency is responsible for not only planning and development of LTSS policy, but also administration of eligibility determination, financing, regulation, service delivery, and quality for both institutional and home and community-based services. Consolidation allows state administrators to balance resources among all services

and to shift funds from institutional care to home and community-based services.

Aging and Disability Resource Centers — Navigating the care system, with its complex range of services and differing eligibility requirements for each program, is often a challenge for older people and their families. Over the past decade, an increasing number of states have restructured the delivery of LTSS through the development of single points of entry/no wrong door (SPEs)/NWD. SPEs/NWD are intended to provide consumers smooth access to LTSS through one agency or organization which considers the range of care alternatives and helps people make decisions about the best and most feasible care alternative.

These initiatives have been spurred on through the use of AoA and CMS discretionary grants to states to create Aging and Disability Resource Centers (ADRCs). The purpose of the ADRC program is to help people of all ages, disabilities, and income levels more easily access LTSS through SPEs/NWD, and make more efficient use of care options, and maximize choice of available services. In 2006, Congress formally recognized the ADRC program in amendments to the Older Americans Act (P.L. 109-365). The law requires AoA to implement ADRCs in all states. ADRCs are tasked with providing personalized counseling to assist individuals and their families with care choices; developing a single integrated approach to LTSS intake, assessment, assessment and eligibility determination; and serving as convenient entry points for all public and private LTSS programs.

Some ADRCs are also involved in care transition services, that is helping people transitioning from one setting of care to another or from one public program payer to another. The purpose of care transition programs is to help people avoid unnecessary placement in nursing facilities or other institutions or readmission to hospitals, and to provide for continuity of care through the transition process. AoA has specified that state ADRC grant recipients involved in care transition services must use an evidence-based care transition model; choices include the Care Transitions Intervention,⁷¹ the Transitional Care Model (TCM),⁷² Guided Care,⁷³ and Geriatric Resources for Assessment and Care of Elders (GRACE),⁷⁴ among others.

(For more information on the ADRC program, see NHPF background paper, “Aging and Disability Resource Centers (ADRCs): Federal and State Efforts to Guide Consumers through the Long-Term Services

Over the past decade, an increasing number of states have restructured LTSS delivery by offering single points of entry or “no wrong door” systems.

and Supports (LTSS) Maze,” by Carol V. O’Shaughnessy, November 19, 2010, www.nhpf.org/library/details.cfm/2835.)

Prevention of Elder Abuse, Neglect, and Exploitation

Abuse, neglect, and exploitation of older adults in their own homes and other non-institutional settings is a largely unrecognized, but growing, problem. Types of abuse or neglect include physical, emotional, or sexual abuse; neglect (or self-neglect); financial exploitation; and abandonment.⁷⁵ Although data on the full extent of the problem nationally are elusive, in a 2011 report GAO found that the most recent study on abuse estimated that 14.1 percent of non-institutionalized older adults had experienced physical, psychological, or sexual abuse, neglect, or financial exploitation in the past year. This study and others do not provide a full estimate of the extent of abuse, and many cases of potential abuse may go unreported to officials.⁷⁶

Data on abuse have not been measured consistently.⁷⁷ Various reports, however, have pointed to increases in the extent of the problem. A recent study of the impact of the economic downturn on state aging programs found that states had received increased calls for adult protective services, and many of these were reporting instances of financial exploitation.⁷⁸ GAO interviews with state officials confirmed this trend, and these reports have confirmed earlier studies.⁷⁹ Increasing numbers of cases are an indicator of growing demand for services, either for investigation by state personnel or intervention on behalf of abused clients. Data showing an increase in the number of cases could be due to an increase in abuse of the elderly, or to increased awareness by the public thus generating additional reports of abuse.⁸⁰ Despite increased reporting of potential cases, GAO indicated that adequate funding for staffing, training, and public awareness is difficult to maintain, especially in the face of state budget constraints.

Federal and state role — Three federal statutes define federal and state roles in addressing elder abuse, neglect and exploitation in domestic settings. The *Social Service Block Grant* (SSBG; Title XX of the Social Security Act) authorizes funds to states for a wide array of social services, including prevention of abuse, neglect, or exploitation of adults unable to protect their own interests. States decide how much of their block grant funds they will spend on protective services as well as many other service categories. The *Older Americans Act*

authorizes formula grants to states to develop and strengthen programs for the prevention, detection, and assessment and treatment of abuse, and to develop public education and outreach services to promote awareness of instances of abuse. The *Elder Justice Act* (EJA), enacted by the Patient Protection and Affordable Care Act of 2010 (PPACA), authorizes grants to state adult protective service programs under the SSBG.

Medicare and Medicaid statutes govern investigation of abuse in facilities that receive reimbursement under those programs, and the long-term care ombudsman program, discussed above, is responsible for investigating and resolving complaints of residents in long-term care facilities. (For more information on the EJA, see the Forum report, “Elder Justice Act: Addressing Elder Abuse, Neglect and Exploitation,” by Carol V. O’Shaughnessy, November 30, 2010, available at www.nhpf.org/library/details.cfm/2836.)

Each state has developed its own statutory, regulatory, and administrative authorities to address elder abuse issues. Most states have designated agencies, known as Adult Protective Services (APS) agencies, to administer services to protect adults from abuse, neglect, or exploitation. State agencies on aging in 22 states administer APS programs.⁸¹ In most states, APS programs are considered the first responders to reports of abuse, neglect, or exploitation.⁸²

Funding — Funding to prevent elder abuse, neglect, and exploitation comes from a variety of sources but is primarily from state and local sources. To the extent that federal funding supports APS, it is primarily from the SSBG. In FY 2009, of the \$1.9 billion⁸³ SSBG funding for all services, states spent \$216 million for APS programs, about 12 percent of their total allotments.⁸⁴ In most states, SSBG funding far outweighs funds under the Older Americans Act.⁸⁵ Congress has appropriated a little more than \$5 million for the Title VII elder abuse prevention program for each of the past several years. No funds have been appropriated under the EJA, as of the fall of 2011.

In 2011, AoA awarded funds to a national APS Resource Center to help state and local adult protective services systems respond more quickly and intervene more effectively in cases of adult abuse, neglect, and exploitation. The Center is tasked with identifying evidence-based practices for APS programs and interventions, compiling research relevant to APS programming, and providing technical assistance to state and local APS programs.⁸⁶

Program assessment — Congressional hearings and reports over the years have pointed to the need for greater federal-level attention on prevention of elder abuse, neglect, and exploitation. Among other things, experts have recommended improved national level data collection that would estimate and track the extent of the problem and increased funding to states to address prevention, detection, and investigation of abuse incidence, as well as to fund public awareness programs. Congressional concern and actions by advocates culminated in the enactment of the EJA in 2010. The law authorizes several grant programs including a new state formula grant program for APS under the SSBG.⁸⁷ It also establishes requirements for reporting of crimes in long-term care facilities, and creates advisory bodies on elder abuse with the Department of Health and Human Services (HHS).

In addition, GAO found that federal leadership on elder justice issues is lacking. It stated that the Older Americans Act requires AoA to develop a long-term plan to establish federal guidelines for state-level uniform data collection on abuse, but the agency has taken only limited steps to do so. According to GAO, state APS agencies face numerous challenges in preventing, identifying, and resolving elder abuse issues. Even though some agencies, such as AoA and the Department of Justice, have taken some steps to assist states, their activities have had a “limited impact on the elder justice field” and have been hampered by limited funding. The EJA, if funded, could assist federal and state agencies improve their efforts to address elder abuse.⁸⁸

State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP), created by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) and administered by CMS, provides grants to states for counseling, information, assistance, and outreach programs for Medicare beneficiaries and their families regarding health insurance. The program was originally established to help older people choose Medicare supplemental insurance (Medigap). It has expanded to provide counseling and information to beneficiaries on a wide range of Medicare and Medicaid issues, as well as Medigap, Medicare Advantage plans, long-term care insurance, and resolution of claims and billing problems.⁸⁹ A major program focus is to help older people choose prescription drug plans under Medicare Part D and enroll in Medicare

Savings Programs that help low-income beneficiaries pay for Medicare, premium, copayment and deductible amounts.

Of the 54 SHIP state grant programs, two-thirds are administered by state agencies on aging and the remainder are administered by state insurance commissions. The SHIP program recruits and trains counselors (primarily volunteers) to conduct one-on-one counseling to Medicare beneficiaries through over 1,300 local sponsoring agencies. In 2008, over 12,000 counselors served more than 4.8 million beneficiaries through one-on-one, in-person, and telephone counseling and assistance, as well as through public education programs. At the community level, most SHIPs are operated through area agencies on aging. As more people become eligible for Medicare, demand for counseling and assistance on Medicare issues is likely to increase.

(For more information on the SHIP program, see Forum report, "The State Health Insurance Assistance Program (SHIP)," by Carol V. O'Shaughnessy, March 29, 2010, available at www.nhpf.org/library/details.cfm/2778.)

THE OLDER AMERICANS ACT IN A CHANGING SERVICE DELIVERY ENVIRONMENT

In recent years, AoA has taken steps to modernize and strengthen the aging services network through targeted use of discretionary funds. It has helped states make system changes aimed at improving the coordination of LTSS delivery by implementing ADRCs, and, through application of evidence-based programs (see Aging and Disability Resource Centers, p. 29), address the risk of chronic illnesses among older people and improve transitions across care settings. While new or reprogrammed funding has made it possible for these efforts to take place, funding for the Act's core programs has remained relatively flat despite reports of increasing demand. Thus, efforts to modernize or improve the core programs, and to bring others to scale, have lagged.

Some observers have indicated that the quality of Older Americans Act programs should be assessed to determine what effect they have on the lives of older people. Limited evaluative information on the core programs is available, in part because variability in program models across states and sometimes within states makes it difficult to evaluate programs or draw conclusions that could inform national and state policy development. Although AoA is in the process of a

Funding for the Act's core programs has remained relatively flat despite reports of increasing demand.

number of program evaluations, results will not be available for several years. Most observers applaud the increasing use of evidence-based models for application to aging services in efforts to improve quality programming. However, evidence-based models do not exist for many social services programs; without national guidance or availability of information on proven models, quality of services is unlikely to be assessed.

GAO has suggested a number of improvements in AoA's data collection procedures on the need and unmet need for services by older people. Although AoA issues standardized definitions and measurement procedures for collecting information on the receipt of Title III services to state agencies, states have not been required to use uniform and standardized measures for assessing need and unmet need. According to GAO, this has made it difficult for state and area agencies to make decisions about how to prioritize services to those most in need. GAO recommended that the Secretary of HHS work with other agencies to (i) develop consistent definitions of need and unmet need and (ii) propose interim and long-term uniform data collection procedures for obtaining information on older people with unmet service needs. In response to the GAO recommendations, AoA cautioned that data collection is hampered by problems in defining need and unmet need across multiple services funded by different federal, state, and local sources. Also, additional reporting burdens on states during a time of fiscal constraints may not be feasible.⁹⁰ Despite the difficulties surrounding data collection, available AoA data has shown that programs are well-targeted and those older people who are served are among those in the lowest income groups and have characteristics, such as presence of multiple chronic conditions and limitations in daily living activities, that make them most vulnerable.

Some programs that have been central to the Older Americans Act are in the process of transformation. For example, the congregate nutrition program, in operation for almost 40 years, provides venues for nutrition and socialization for many older people. Expenditures for the congregate nutrition program are still higher than for the home-delivered nutrition program (53 percent and 47 percent, respectively, of total FY 2010 nutrition expenditures). However, given the rising numbers of frail homebound older people, states have increasingly transferred congregate nutrition services funds to bolster support for home-delivered nutrition services. As a result, some communities

have seen downsizing of their congregate programs. Other communities are developing innovative ways to modernize their congregate nutrition programs, for example, by placing nutrition sites in fitness and wellness centers for people of all ages. Nutrition administrators may need to seek ways to attract private sources of support by improving meal quality, choice, and types, and by diversifying socialization activities at congregate sites, as well as partnering with non-traditional community service providers.

In addition, some observers indicate that the baby boom population may demand improvements or modernization of particular services. For example, senior centers that offer Older Americans Act core programs may need to develop additional, privately supported programs that appeal to broad cross sections of older people in order to attract and sustain the interest and support of baby boomers who are able to pay for services. Some publicly funded senior center facilities may need capital improvements and additional professional staff to attract clientele. As with other aging services, an important goal will be to develop sustainable sources of revenue.

Constrained public resources may spur aging services network agencies to assess how to become social entrepreneurs by broadening their base of financial support. They may need to develop a full range of revenue streams, from private pay and cost-sharing services, as well as public funds, donations, and no-fee services, to help increasing numbers of retirees who need and can pay for supportive services. They may also need to conduct marketing to retirees who seek civic engagement, volunteer opportunities, or leisure activities. In doing so, area agencies may need to become competitive with private sector organizations that see the aging of society as a source of new business revenue and opportunities. This direction is not without some controversy. While some observers indicate that greater efforts should be made to develop private sector markets, others believe that doing so and serving those older people with resources to pay for the full cost of services is not the within network agencies' mission that calls for targeting programs to those who are most in need. Regardless, it appears that many area agencies have not pursued business development or marketing plans. This has been attributed, in part, to inadequate public sector resources that could be devoted to efforts to engage the private sector.⁹¹ Moreover, the Act allows state agencies to develop cost-sharing policies so that older people who can afford to pay for specified services do so; still, many

state agencies have not developed such policies, citing administrative burden and limited likelihood of collecting enough funds to be worthwhile.⁹² While these trends play out, AoA is helping area agencies develop a more entrepreneurial approach to aging programming and operations by providing support for an Aging Business Academy operated by the National Association of Area Agencies on Aging. The Academy provides learning opportunities to help area agencies build knowledge and skills in strategic and business planning, resource development, innovation, and performance management.⁹³ Several state agencies are developing business tools and training protocols targeted at empowering them to leverage new partnerships with the private sector.⁹⁴

Finally, an emerging trend that will affect aging services providers is the interest by some state Medicaid agencies in shifting from traditional fee-for-service arrangements to pay for LTSS for aging and disability populations to managed care arrangements whereby the state makes capitated payments to managed care organizations (MCOs) that arrange for and coordinate these services. While only a handful of states operate Medicaid managed LTSS programs now, it is expected that more states will move in this direction in the next few years. The interest by states is being spurred by state budgetary concerns with the hope that managed LTSS programs can save money and improve consumer outcomes through coordination of care.

Most area agencies on aging have been providers of LTSS for many years and, recently, some have become involved in care transition programs. States' movement toward Medicaid managed LTSS and other care coordination services, such as management of care transition programs, could potentially require those area agencies that have not operated under managed care arrangements to adopt new business models that will support their viability in a more competitive environment. While it may be too early to determine what impact these trends will have, federal and state policymakers may want to focus on what steps may be necessary to help aging network providers to operate under Medicaid managed LTSS arrangements.

BROAD MISSION, LIMITED RESOURCES: SUMMARY OF CHALLENGES FOR THE FUTURE

The mission of the aging services network set out by law is expansive and is aimed at addressing many competing needs of older

people across a wide spectrum of services. Despite its broad mandate and sweep of services, Older Americans Act resources are relatively limited. Some have observed that funding has always been small and not kept pace with increasing demands from a growing elderly population. As a result, some programs have grown very slowly over time, or have not been brought to scale. Some programs' capacity depends heavily on volunteers, thereby masking any need for additional staff resources to carry out program functions. Moreover, the aging services network's decentralized planning and service model has led to variability in program implementation across states and communities.

Nevertheless, despite its funding constraints and variability in implementation, over the last 40 years, the Older Americans Act has encouraged the development and provision of multiple and varied services for older people. State and area agencies have relationships with tens of thousands of service providers offering a wide range of services across the nation. Older Americans Act funds reach limited numbers of older people, but AoA data and other research suggests that they are well targeted to vulnerable older people. Because of the mandates that state and area agencies have to coordinate services and act as advocates, they have the potential to improve access to services for older people by integrating complex programs funded by multiple financing sources.

To create an expanding service delivery system and to complement limited federal Older Americans Act dollars, state and area agencies on aging have leveraged other federal and state funding sources. Thus, aging services network agencies have evolved from planning and coordination entities to managers of multiple sources of funds. The ability of the aging infrastructure to adapt to changing demands has led to added responsibilities and resources. In addition to the aging services network administration and management of Medicaid LTSS programs discussed above, a range of participant-directed home and community-based services are provided by area agencies on aging under an agreement between the Department of Veterans Affairs and AoA. Policymakers may want to consider other ways to build on the aging services network.

As the population ages, the sheer numbers of elderly will have significant impact on the nation's largest entitlement programs, Social Security, Medicare, and Medicaid. This growth will also test the strength of the fabric of social and health-support services in communities

The aging services network's decentralized planning and service model has led to variability in program implementation across states and communities.

across the nation and will affect families who care for older family members. Aging service providers will face increasing challenges in financing and delivering a wide range of community services for vulnerable elderly, such as assisted transportation, home care, adult day care, nutrition, elder abuse prevention services, and access and information about benefit programs.

In the future, policymakers may need to focus on actions that will enable communities to sustain services in the face of growing demand of the coming baby boom population. Many observers warn that challenges to aging services network programs have been heightened by the continuing budgetary constraints faced by state and local governments. In an environment where there is more competition for public resources, policymakers and practitioners in the field of aging may be forced to develop new advocacy, planning, and sustainability models. The increasing numbers and heterogeneity of the older population may demand more varied service models including those that will be able to attract increased private resources and support. All of these issues are more salient as Congress reviews the Older Americans Act for its scheduled reauthorization during the 112th Congress.

ENDNOTES

1. At the time the U.S. Administration on Aging (AoA) was created, it was located in the U.S. Department of Health, Education and Welfare (HEW).
2. AoA, "FY 2012 Budget Justifications," www.aoa.gov/AoARoot/About/Budget/DOCS/FY_2012_AoA_CJ_Feb_2011.pdf.
3. Jenna Walls *et al.*, "Weathering the Storm: The Impact of the Great Recession on Long-Term Services and Supports," AARP Public Policy Institute, January 2011, available at www.nasuad.org/documentation/nasuad_materials/weathering_the_storm/weathering_the_storm.pdf.
4. National Association of Area Agencies on Aging and the Scripps Gerontology Center (NAAAA and SGC), "Area Agencies on Aging: Advancing Health and Long-Term Services and Supports," July 2011, available at www.n4a.org/pdf/2011_AAA_Survey_Report.PDF.
5. Carroll L. Estes, *The Aging Enterprise: A Critical Examination of Social Policies and Services for the Aged* (San Francisco: Jossey Bass, 1979).
6. Older Americans Act of 1965, as amended, 45 USC 3025.
7. These states or jurisdictions are Alaska, Delaware, the District of Columbia, Nevada, New Hampshire, North Dakota, Rhode Island, and Wyoming.
8. NAAAA and SGC, "Area Agencies on Aging."

9. Preliminary findings from a 2010 survey of state agencies on aging by the National Association of States United for Aging and Disability (NASUAD), e-mail communication with author, November 15, 2011.
10. NAAAA and SGC, "Area Agencies on Aging."
11. Preliminary findings from a 2010 survey of state agencies on aging by NASUAD, e-mail communication with author, November 15, 2011.
12. AoA, National Aging Program Information System (NAPIS), "2010 Reports," available at www.aoa.gov/AoARoot/Program_Results/SPR/2010/Index.aspx.
13. For example, national standards for home and community-based services do not exist. The Deficit Reduction Act of 2005 directed the Agency for Healthcare Research and Quality (AHRQ) to develop quality measures for these services, covering performance and client function and measures of client satisfaction. AHRQ, "Medicaid Home and Community-Based Services Measure Scan: Project Methodology," updated May 2007; available at www.ahrq.gov/research/lc/hcbsmethods.htm#purpose.
14. "Greatest social need" is defined in law as those with low income and whose racial or ethnic status may heighten the need for services, as well as those who have needs related to social factors, such as those with a physical or mental disability or who experience cultural, social, or geographic isolation that restricts their ability to perform normal daily tasks or threatens their capacity to live independently. "Greatest economic need" is defined as having an income below the official federal poverty level (FPL).
15. In certain instances, people under the age of 60 may receive services. For example, younger spouses of nutrition services recipients, and younger people with disabilities who reside in elderly housing facilities where congregate meals are served, may receive nutrition services. Caregivers age 55 and older who are caring for children may receive caregiver services under certain circumstances.
16. Some Older Americans Act service programs have specific eligibility requirements. For example, in order to receive home-delivered meals, people must be homebound. Long-term care ombudsman services are available to all residents of nursing and other residential care facilities, regardless of age.
17. The exception is Title V of the Older Americans Act, which provides opportunities for low-income older people to work in subsidized employment. In order to participate, individuals must be age 55 or older and have income below 125 percent of the FPL. Title V is outside the scope of this publication.
18. AoA collects Title III data on total clients and "registered" clients, that is, those who receive services on "regular or intensive basis," such as home-delivered meals, and home care or personal care services. Others receive services, such as transportation and information and assistance, on a less-than-regular or -intensive basis.
19. NAPIS, "2010 Reports."
20. NAPIS, "2010 Reports."

21. AoA Research Briefs done by Mathematica Policy Research, Inc.: Norma Altshuler and Jody Schimmel, "Aging in Place: Do Older Americans Act Title III Services Reach Those Most Likely to Enter Nursing Homes?" Research Brief No. 1, July 2010, www.aoa.gov/aoaroot/program_results/docs/2010/AoA_1_NursingHomes_041311.pdf; Allison Barrett and Jody Schimmel, "OAA Title III Services Target the Most Vulnerable Elderly in the United States," August 2010, www.aoa.gov/AoARoot/Program_Results/docs/2010/AoA_2_HealthStatus_041311.pdf; Allison Barrett and Jody Schimmel, "Multiple Service Use Among OAA Title III Program Participants," September 2010, www.aoa.gov/AoARoot/Program_Results/docs/2010/AoA_3_Multiple-Services_041311.pdf; and Rebecca Kleinman and Leslie Foster, "Multiple Chronic Conditions Among OAA Title III Program Participants," July 2011, www.aoa.gov/AoARoot/Program_Results/docs/2011/AoA4_Chronic_508.pdf.
22. Within federally prescribed limits, states are allowed to transfer funds between supportive and nutrition services and between congregate and home-delivered nutrition services. States also use funds appropriated for prevention of elder abuse, neglect, and exploitation to support the long-term care ombudsman program.
23. NAPIS, "2010 Reports."
24. NAPIS, "2010 Reports."
25. NAAAA and SGC, "Area Agencies on Aging."
26. Donna J. Rabiner *et al.*, "Draft Final Report for the Evaluation of Select Consumer, Program, and System Characteristics under the Supportive Services Program (Title III-B) of the Older Americans Act," AoA, Final Report, June 2007; available at www.aoa.gov/aoaroot/program_results/docs/Program_Eval/III-B%20Final%20Report_6_26_07.pdf.
27. Analysis for AoA: Altshuler and Schimmel, "Aging in Place" and Kleinman and Foster, "Multiple Chronic Conditions Among OAA Title III Program Participants."
28. Jody Beauchamp and Lisa Trebino, Mathematica Policy Research, Inc., "Results from the Administration on Aging's Third National Survey of Older Americans Act Program Participants," Final Report, March 12, 2008, available at www.aoa.gov/AoARoot/Program_Results/docs/3rd_NPS_Final_Report_Mar2008_final.pdf.
29. Rabiner *et al.*, "Draft Final Report for the Evaluation of Select Consumer, Program, and System Characteristics."
30. U.S. Government Accountability Office (GAO), "Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services," GAO-11-237, February 2011, available at www.gao.gov/new.items/d11237.pdf.
31. NAPIS, "2010 Reports."
32. Analysis for AoA: Altshuler and Schimmel, "Aging in Place" and Kleinman and Foster, "Multiple Chronic Conditions Among OAA Title III Program Participants."
33. Rabiner *et al.*, "Draft Final Report for the Evaluation of Select Consumer, Program, and System Characteristics."

34. The Current Population Survey measures food security and insecurity by asking respondents to comment on a number of statements and questions including: “We worried whether our food would run out before we got money to buy more.” “The food we bought just didn’t last and we didn’t have money to get more.” “We couldn’t afford to eat balanced meals.” “In the last twelve months did you or other adults in the household ever cut the size of your meals or stop meals because there wasn’t enough for food?” See Mark Nord *et al.*, “Household Food Security in the United States, 2009,” U.S. Department of Agriculture, Economic Research Report No. 108, November 2010, p. 3, available at www.ers.usda.gov/Publications/ERR108/ERR108.pdf.
35. GAO, “Nutrition Assistance, Additional Efficiencies Could Improve Services to Older Adults,” GAO-11-782T, testimony by Kay E. Brown before the Committee on Health, Education, Labor and Pensions, U.S. Senate, June 21, 2011, available at www.gao.gov/new.items/d11782t.pdf.
36. James P. Ziliak and Craig Gunderson, “Senior Hunger in the United States, Differences Across States and Rural and Urban Areas,” report prepared for Meals on Wheels Association of America, September 2009, available at www.mowaa.org/document.doc?id=193.
37. James P. Ziliak, Craig Gunderson, and Margaret Haist, “The Causes, Consequences, and Future of Senior Hunger in America,” report prepared for Meals on Wheels Association of America, March 2008, available at www.mowaa.org/document.doc?id=13.
38. Congregate and home-delivered meals must comply with the U.S. Department of Agriculture’s “Dietary Guidelines for Americans” and provide the minimum dietary intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences.
39. AoA, “Administration on Aging Announces New National Resource Center on Nutrition and Aging,” press release, October 3, 2011, available at www.aoa.gov/AoARoot/Press_Room/For_The_Press/pr/archive/2011/October/2011_10_03.aspx.
40. NAPIS, “2010 Reports.”
41. Analysis for AoA: Altshuler and Schimmel, “Aging in Place” and Kleinman and Foster, “Multiple Chronic Conditions Among OAA Title III Program Participants.”
42. GAO, “Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services.”
43. NAAAA and SGC, “Area Agencies on Aging”; Walls *et al.*, “Weathering the Storm.”
44. Walls *et al.*, “Weathering the Storm.”; NAAAA and SGC, “Area Agencies on Aging.”
45. GAO, “Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services.”

46. AoA, "Serving Elders at Risk, The Older Americans Act Nutrition Programs – National Evaluation of the Elderly Nutrition Program, 1993-1995," completed by Mathematica Policy Research, Inc., Michael Ponza *et al.*, available at www.aoa.gov/AoARoot/Program_Results/Nutrition_Report/eval_report.aspx. For an overview of the results, see www.mathematica-mpr.com/nutrition/enp.asp.
47. AoA, "Evaluation of Title III-C Nutrition Services and Title VI Native American Nutrition, Supportive and Family Care Services Programs," available at www.aoa.gov/AoARoot/Program_Results/docs/Program_Eval/III_C_Assessment/Evaluation_Status_Report_11_09.html.
48. Due to lack of consistency in definitions of caregiving, estimates of the number of informal, unpaid caregivers vary widely and depend on the type and duration of care provided, and the disability and health status and the living arrangements of the care recipient. For example, the type of care may range from daily hands-on personal care to intermittent help with shopping or bill-paying. Care recipients in various estimates may include all those age 18 and over living in community settings, or those age 65 and over living in community-based settings, or other combinations. Activities of daily living (ADLs) refer to eating, bathing, using the toilet, dressing, walking, and getting in or out of bed. Other activities necessary for community living, or instrumental activities of daily living (IADLs), include preparing meals, managing money, shopping, performing housework, and doing laundry. Estimates from the 1999 National Long-Term Care Survey (a nationally representative survey of elderly Medicare beneficiaries; see www.nltcs.aas.duke.edu for more information on NLTCs). William D. Spector *et al.*, "The Characteristics of Long-Term Care Users," Agency for Healthcare Research and Quality, AHRQ Publication No.00-0049, January 2001, available at www.ahrq.gov/RESEARCH/ltcusers, showed that 7 million caregivers provide ADL or IADL assistance. Other estimates indicate that there are over 42 to 62 million caregivers. See Lynn Feinberg *et al.*, "Valuing the Invaluable: 2011 Update. The Growing Contributions and Costs of Family Caregiving," AARP Public Policy Institute, 2011, available at <http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf>.)
49. The primary groups served are caregivers of people age 60 and older, but the law allows grandparents or other individuals who are relative caregivers of children to be served under the program.
50. NAPIS, "2010 Reports."
51. Leslie Foster and Rebecca Kleinman, "Supporting Family Caregivers through Title III of the OAA," Mathematica Policy Research, Inc., for AoA, Research Brief No. 5, September 2011, available at www.aoa.gov/AoARoot/Program_Results/docs/2011/AoA5_SupportFamilyCaregivers.pdf.
52. Foster and Kleinman, "Supporting Family Caregivers through Title III of the OAA."
53. Lynn Friss Feinberg *et al.*, *The State of the States in Family Caregiver Support: A 50 State Study*, National Center on Caregiving, Family Caregiver Alliance, in collaboration with the National Conference of State Legislators, 2004, available at www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=1276.
54. Foster and Kleinman, "Supporting Family Caregivers through Title III of the OAA."

55. Jennifer L. Wolff, Barbara Starfield, and Gerard Anderson, "Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly," *Archives of Internal Medicine*, 162, (November 11, 2002): pp. 2269–2276, available at <http://archinte.ama-assn.org/cgi/reprint/162/20/2269.pdf>.
56. Gerard Anderson, "Chronic Conditions: Making the Case for Ongoing Care," Johns Hopkins University, November 2007.
57. Joshua M. Wiener *et al.*, "Assessment of Title III-D of the Older Americans Act: Disease Prevention and Health Promotion Services," AoA, Final Report, January 2006; available at http://www.aoa.gov/aoaroot/program_results/docs/Program_Eval/Final_Report_DPHP_Assessment.pdf.
58. Wiener *et al.*, "Assessment of Title III-D of the Older Americans Act."
59. Stanford University School of Medicine, Chronic Disease Self-Management Program, <http://patienteducation.stanford.edu/programs/cdsmp.html>. See also, AHRQ, "Preventing Disability in the Elderly with Chronic Disease," Research In Action, Issue #3, April 2002, available at www.ahrq.gov/research/elderdis.pdf. The CDSMP is a 17-hour course taught by trained lay people that teaches patients with chronic disease how to better manage their symptoms, adhere to medication regimens, and maintain functional ability.
60. Maine Health, "What is a Matter of Balance?" available at www.mmc.org/mh_body.cfm?id=432.
61. A wide range of terms is used to describe residential care facilities that are not nursing homes. These include assisted living facilities, board and care homes, adult foster care homes, personal care homes, congregate care homes, among others. Generally, there is lack of consistency among states in the use of terminology and the requirements these facilities must meet in order to be licensed.
62. These states or jurisdictions are Colorado, District of Columbia, Maine, Rhode Island, Vermont, Virginia, Washington, and Wyoming.
63. Jo Harris-Wehling, Jill C. Feasley, and Carroll L. Estes, Eds., *Real People, Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act* (Washington, DC: Institute of Medicine, 1995), p. 44, available at www.nap.edu/openbook.php?isbn=N1000028.
64. States are required to match federal Title III funds with 15 percent in matching funds. There is no required match for Title VII funds.
65. In FY 2010, AoA data reported a total of 2.9 million beds in both nursing facilities and board and care homes and similar facilities.
66. As shown in the Appendix, the Alzheimer's Disease Demonstration Grants to States authorized under Section 398 of the Public Health Service Act are administered by AoA. These grants fund home and community-based services to Alzheimer's patients and their families.
67. The largest and best known of these demonstrations was the National Long-Term Care Channeling Demonstration begun in the early 1980s. About a dozen other demonstration projects were funded by the then-Health Care Financing

Administration and the then-National Center for Health Services Research (now, the Centers for Medicare & Medicaid Services and the Agency for Healthcare Research and Quality, respectively) to test the cost effectiveness of adult day care and homemaker services compared to institutional care. Pamela Doty, "Cost-Effectiveness of Home and Community-Based Long-Term Care Services," U.S. Department of Health and Human Services, June 2000; available at <http://aspe.hhs.gov/daltcp/reports/2000/costeff.htm>.

68. Preliminary findings from a 2010 survey of state agencies on aging by NASUAD, e-mail communication with author, November 15, 2011.

69. GAO, "Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services."

70. Preliminary findings from a 2010 survey of state agencies on aging by the NASUAD, e-mail communication with author, November 15, 2011.

71. The Care Transitions Program, University of Colorado Denver, "The Care Transitions Intervention," www.caretransitions.org/overview.asp; "Program Structure," www.caretransitions.org/structure.asp; and University of Colorado Denver, "Definitions," www.caretransitions.org/definitions.asp.

72. "Transitional Care Model," available at www.nursing.upenn.edu/media/transitionalcare/Documents/Information%20on%20the%20Model.pdf.

73. Johns Hopkins University, "Guided Care," available at www.guidedcare.org.

74. Steven R. Counsell *et al.*, "Geriatric Care Management for Low-Income Seniors: A Randomized Controlled Trial," *Journal of the American Medical Association (JAMA)*, 298, no. 22 (December 12, 2007): pp. 2623–2633, available at <http://jama.ama-assn.org/cgi/reprint/298/22/2623>.

75. AoA, National Center on Elder Abuse, "What is Elder Abuse?" www.ncea.aoa.gov/ncearoot/Main_Site/FAQ/Questions.aspx

76. GAO, "Elder Justice: Stronger Federal Leadership Could Enhance National Response to Elder Abuse," GAO-11-208, March 2011, available at www.gao.gov/new.items/d11208.pdf.

77. GAO, "Elder Justice: Stronger Federal Leadership Could Enhance National Response to Elder Abuse,"

78. Walls *et al.*, "Weathering the Storm."

79. Adult Protective Services (APS) agencies received almost 566,000 reports of suspected abuse of adults of all ages in 2003, an increase of almost 20 percent from 2000. About 192,000 reports of abuse were substantiated after investigation by APS agencies, an increase of almost 16 percent from 2000. Pamela B. Teaster *et al.*, "The 2004 Survey of State Adult Protective Service: Abuse of Adults 60 Years and Older," National Center for Elder Abuse, February 2006, available at www.ncea.aoa.gov/NCEAroot/Main_Site/pdf/2-14-06%20FINAL%2060+REPORT.pdf.

80. Erica F. Wood, "The Availability and Utility of Interdisciplinary Data on Elder Abuse: A White Paper for the National Center on Elder Abuse," National Center for Elder Abuse, May 2006, available at www.ncea.aoa.gov/NCEARoot/Main_Site/pdf/publication/WhitePaper060404.pdf.
81. GAO, "Elder Justice: Survey of Adult Protective Services Program Administrators, GAO-11-129SP, March 2011, an E-Supplement to GAO-11-208," available at www.gao.gov/special.pubs/gao-11-129sp/index.htm.
82. Pamela B. Teaster *et al.*, "The 2004 Survey of State Adult Protective Service."
83. The SSBG received supplemental funding of \$600 million in FY 2009, not included in these data.
84. Administration on Children and Families (ACF), "SSBG Focus Reports, 2009: Adult Protective Services," table 1, available at www.acf.hhs.gov/programs/ocs/ssbg/reports/ssbg_focus_2009/adult_protective_services.html. (Not all states reported using SSBG funds for APS.)
85. ACF, "SSBG Focus Reports, 2009," table 1.
86. AoA, "Administration on Aging funds first national adult protective services resource center," press release, October 13, 2011, available at www.aoa.gov/aoaroot/Press_Room/For_The_Press/pr/archive/2011/October/2011_10_13.aspx.
87. The law is less expansive than originally contemplated in previous congressional proposals. For a chronology of various legislative actions of the U.S. Senate Committee on Finance over the years, see http://finance.senate.gov/search/?q=elder+justice+act&access=p&as_dt=i&as_epq=&as_eq=&as_lq=&as_occt=any&as_oq=&as_q=&as_site=search&client=finance&sntsp=0&filter=0&getfields=title&lr=&num=15&numgm=3&oe=UTF8&output=xml&partialfields=&proxycustom=&proxyreload=0&proxystylesheet=default_frontend&requiredfields=&site=finance&sitesearch=&sort=date%3AD%3A%3Ad1&start=0&ud=1.
88. GAO, "Elder Justice, Stronger Federal Leadership Could Enhance National Response to Elder Abuse," GAO-11-208, March 2011, p. 34.
89. Centers for Medicare & Medicaid Services (CMS), "State Health Insurance and Assistance Programs," updated December 14, 2005.
90. GAO, "Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services."
91. NAAAA and SGC, "Area Agencies on Aging."
92. GAO, "Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services."
93. NAAAA, e-mail communication with author, November 4, 2011.
94. In-person interview with staff of the NASUAD, November 11, 2011.

**APPENDIX: Selected LTSS and Health-Support Services
Managed by the Aging Services Network**

PROGRAM / SERVICE CATEGORY	Federal Legislative Authority, or, if applicable, Other Authority	Services Provided	Administrative Agency
Home and Community-Based LTSS	Older Americans Act (<i>Titles III and, for Native Americans, Title VI</i>); Medicaid home and community-based services programs (<i>Section 1915(c) of the Social Security Act and other Medicaid state plan options</i>); Social Services Block Grant (SSBG)	Wide range of services, including home care (for example, homemaker, home health, personal care), transportation, adult day care	AoA CMS ACF
Outreach, Information, and Assistance	Older Americans Act (<i>Titles III and, for Native Americans, Title VI</i>); SSBG; Medicaid (<i>state plan options</i>); state and local funds	Connecting older people and their families to information about programs and services	AoA ACF CMS
Care Management for Home and Community-Based LTSS	Older Americans Act (<i>Titles III and, for Native Americans, Title VI</i>); Medicaid home and community-based services programs (<i>Section 1915(c) of the Social Security Act and other Medicaid state plan options</i>); SSBG	Needs assessment, care planning, monitoring of services provided	AoA CMS ACF
Nutrition Services (Congregate and Home-Delivered Meals)	Older Americans Act; SSBG; Medicaid home and community-based waiver programs for home-delivered meals (<i>Section 1915(c) of the Social Security Act</i>); state and local funds	Meals in congregate settings, or in a person's home; nutrition counseling and education; socialization	AoA ACF CMS

- AoA** – U.S. Administration on Aging
- ACF** – U.S. Administration on Children and Families
- CMS** – Centers for Medicare & Medicaid Services
- DOL** – U.S. Department of Labor
- HHS** – U.S. Department of Health and Human Services

APPENDIX (continued)

PROGRAM / SERVICE CATEGORY	Federal Legislative Authority, or, if applicable, Other Authority	Services Provided	Administrative Agency
Family Caregiver Services	Older Americans Act (<i>Titles III and, for Native Americans, Title VI</i>); SSBG; state and local funds	Information and assistance to caregivers about available services, individual counseling, organization of support groups and caregiver training, respite services to provide families temporary relief from caregiving responsibilities, and supplemental services (such as home care and adult day care) on a limited basis that complement care provided by family and other informal caregivers.	AoA ACF
Prevention of Elder Abuse, Neglect, and Exploitation / Adult Protective Services	Older Americans Act (<i>Titles III and, for Native Americans, Title VI</i>); SSBG; state and local funds	OAA program provides support for outreach and education campaigns to increase public awareness of elder abuse, neglect and exploitation and prevention strategies; for example, support to elder abuse prevention coalitions. The SSBG provides funds for adult protective services.	AoA ACF
Disease Prevention and Health Promotion Services	Older Americans Act (<i>Title III</i>); SSBG; state and local funds	Health promotion services, such as screening for blood pressure, cholesterol, hearing, nutrition counseling, immunizations, exercise programs.	AoA ACF
Long-Term Care Ombudsman Program	Older Americans Act (<i>Titles III and VII, and, for Native Americans, Title VI</i>); SSBG; Medicaid in certain instances; state and local funds	Investigation of complaints of residents of long-term care facilities (nursing homes, assisted living facilities, board and care homes, similar adult care homes) and protection of residents' rights.	AoA CMS

APPENDIX (continued)

PROGRAM / SERVICE CATEGORY	Federal Legislative Authority, or, if applicable, Other Authority	Services Provided	Administrative Agency
Senior Community Service Employment Program	Older Americans Act (<i>Title V</i>); state and local funds	Part-time community service employment for unemployed people age 55 and over who have poor employment prospects.	DOL
Aging and Disability Resource Centers (ADRCs)*	Older Americans Act (<i>Title II</i>); PPACA of 2010; Medicaid in certain instances; state and local funds	Single point of entry for consumers to receive information on available public and private LTSS programs; personal counseling to assist individuals in assessing LTSS, and development and implementation of a plan to meet their needs; and help to consumers to access publicly supported LTSS programs for which they may be eligible.	AoA CMS
Alzheimer's Disease Supportive Service Grants	Public Health Service Act (<i>Section 398</i>); SSBG; state and local funds	Delivers supportive services and facilitates informal support for people with Alzheimer's Disease and Related Disorders (ADRD) and their family caregivers using proven models and innovative practice; translates evidence-based models that have proven beneficial for persons with ADRD and their family caregivers into community-level practice; and advances state initiatives toward coordinated systems of home and community-based care—linking public, private, and non-profit entities that develop and deliver supportive services for individuals with ADRD and their family caregivers.	AoA ACF

* For more information on ADRCs, see "Aging and Disability Resource Centers (ADRCs): Federal and State Efforts to Guide Consumers Through the Long-Term Services and Supports Maze," by Carol V. O'Shaughnessy, Background Paper No. 81, November 19, 2010, available at www.nhpf.org/library/details.cfm/2835.

APPENDIX (continued)

PROGRAM / SERVICE CATEGORY	Federal Legislative Authority, or, if applicable, Other Authority	Services Provided	Administrative Agency
State Health Insurance Program (SHIP)	Centers for Medicare & Medicaid Services (<i>Omnibus Budget Reconciliation Act (OBRA) of 1990</i>); SSBG; state and local funds	Counseling, information, assistance, and outreach programs for Medicare beneficiaries and their families regarding health insurance issues.	CMS ACF
Lifespan Respite Care Act	Public Health Service Act (<i>Title XXIX</i>)	Temporary relief for caregivers of children and adults with special needs.	AoA
Community Living Assistance Services and Supports (CLASS) Act [†]	Public Health Service Act (<i>Title XXXII</i>)	Federally administered voluntary insurance program to help adults age 18 and over with disabilities pay for LTSS, enacted March 23, 2010. Subsequent to passage of the law, HHS analyzed possible CLASS implementation options that are consistent with the statutory requirements that the program be actuarially solvent over the next 75 years and that it be self-funded. After a 19-month period of analysis, HHS officials stated in testimony before the House Committee on Energy and Commerce on October 26, 2011, that it had suspended work on the CLASS Act.	AoA

[†] For more information on CLASS, see "The Community Living Assistance Services and Supports (CLASS) Act: Major Legislative Provisions," by Carol V. O'Shaughnessy, *The Basics*, June 9, 2010, available at www.nhpf.org/library/details.cfm/2790.