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Leveraging Philanthropic Investments To Advance Policy Change

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Government-foundation partnerships.

In February 2005, Grantmakers In Health released a portfolio of articles entitled "Agents of Change: Health Philanthropy's Role in Transforming Systems." The portfolio was a response to the Institute of Medicine's (2001) recommendations for the transformation of the nation's health system. The articles in the portfolio address various approaches that foundations can take to address systems transformation. Foundation support can be critical in advancing new ideas, building the infrastructure required for their adoption, and accelerating the pace at which replication occurs.

This article describes how the U.S. Department of Health and Human Services' Administration on Aging leveraged the investments of a number of private foundations and entered into a partnership with them to develop, test, and support the initiatives that were eventually included in the Bush administration's Choices for Independence Reauthorization Proposal, embraced by the Congress, and incorporated into the federal Older Americans Act.

Choices for Independence

On October 17, 2006, President Bush signed the Older Americans Act Amendments of 2006 (P.L. 109-365) into law (U.S. Congress, 2006a). The reauthorized act includes a number of significant changes designed to modernize the delivery of aging services and long-term care for the twenty-first century. The amendments include new provisions that reflect the core principles of the administration's Choices for Independence Reauthorization Proposal.

Choices for Independence is an integrated set of strategies and tactics that are ideally suited for use by the aging services network to advance meaningful and important changes in our health and long-term-care system at the federal, state, and local levels. These are changes that will improve the quality of life for older Americans and their families, as well as other populations with disabilities, and result in a more cost-effective system of care. The Choices proposal builds on the mission and core values of the Older Americans Act (OAA) and the national aging services network, which is made up of state and area agencies on aging, tribal organizations, community service providers, volunteers, and caregivers.

The Choices proposal also reflects the latest research and best practice in the field and builds on several grant programs AOA has launched over the past four years in partnership with other

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Health and Human Services agencies and a number of private foundations. These programs were strategically designed to promote a "value-added" role for the aging services network in healthcare and long-term care and to complement the transformations occurring in Medicare and Medicaid.

Streamlining Access

The first system change that the Choices proposal advances is to make it easier for consumers to learn about and gain access to the existing services and supports that are available in their communities. Today, when families turn to the formal system for help, they often find themselves dealing with a bewildering maze of programs and bureaucracies. This fragmentation in our current system creates major barriers to access and informed decision-making. To help states eliminate these bureaucratic barriers, AOA and the Centers for Medicare and Medicaid Services (CMS) launched the Aging and Disability Resource Center grants program in 2003. This historic partnership represents the first time that AOA and CMS have pooled funding to advance systems change in long-term care. As partners, we are providing federal leadership, financial support, and technical assistance to help states and communities deploy a specific operational tactic, the resource centers, to re-engineer their systems of access for consumers through the establishment of "one-stop-shop" entry points.

The resource-center program is based on models developed by the aging services network in Oregon, Washington, and Wisconsin. Our long-range vision is to ensure that all consumers, regardless of their age, income, or disability, have visible and trusted sources to which they can turn for reliable and complete information, personalized assistance, and streamlined access to the full range of available long-term-care options. The 2006 OAA Reauthorization embeds the resource-center initiative in the OAA, directs the Assistant Secretary for Aging to promote implementation of the initiative in all states, and calls on state and area agencies on aging to ensure that the resource centers are included in state and community-wide efforts to bring about long-term-care systems change.

Building Prevention into Home- and Community-Based Care

The second system change advanced by the Choices proposal builds directly on foundation support and aims to make it easier for older adults to learn about and take advantage of evidence-based prevention programs that can empower them to take more control of their own health. We know that the aging of the baby boom will bring dramatic growth in the number of older people and in the incidence of chronic conditions and related impairments. Fortunately, there is a growing body of science, much of it funded by private philanthropy as well as government agencies, that documents the efficacy of low-cost programs that can help older people to better manage their chronic conditions, reduce their risk of falling, and improve their nutrition and their physical and mental health. However, we know that the process of translating scientific research findings into practice is not easy or quick.

Our national network of providers of community-based aging services, including senior centers, meal programs, faith-based organizations, adult daycare programs, and others, is uniquely positioned to play a major role in helping older people learn about and take advantage of evidence-based prevention programs. This network of providers consists of more than 29,000 organizations and reaches into every community in the nation. Of particular importance here is the network's demonstrated capacity to serve large numbers of older people, including low-income and minority elders who can benefit most from evidence-based interventions. Serving as a delivery vehicle for science-based programs can give the aging services network a strategic niche in healthcare—and a role that complements the increasing emphasis being given to prevention in Medicare.

The Chronic Disease Self-Management Program (CDSMP) developed at Stanford University, with support from the Agency for Healthcare Research and Quality, is an example of a program that is ideal for deployment through aging services provider organizations. CDSMP is a structured six-week training program targeted at older people with chronic diseases and is specifically

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designed to be offered in community settings by "peer" leaders and others who are not in healthcare. The program enables older people to better understand their chronic conditions and take practical steps to better manage those conditions. CDSMP has been shown through numerous controlled experiments and longitudinal studies to improve participants' health status and reduce the use of healthcare services, including hospital stays and emergency room visits. CDSMP has been widely adopted by several countries, including Canada, Australia, and England (Atlantic Philanthropies, 2006).

Models of Government-Community-Philanthropy Partnerships

In 2003, AOA decided to invest in a multi-year grants program to demonstrate the efficacy of deploying evidence-based programs through the aging network. In reviewing the state-of-the-art and consulting with other government agencies, it became clear that work previously funded by the John A. Hartford Foundation through the National Council on Aging (NCOA) provided an ideal platform for the initial rollout of our multi-year program. By building on, or leveraging, this Hartford investment, AOA was able to accelerate the pace at which we were able to advance our strategic agenda in this area.

The Hartford investment started in 2001 when the foundation awarded $1.3 million to NCOA to increase the capacity of community-provider organizations to more effectively address health promotion and disease prevention and to improve linkages with medical care providers. This work became known as the Model Programs Project because it focused on translating evidence-based interventions into model programs for widespread use by community organizations. The effort produced four evidence-based model health programs that effectively improve older adults' health in the areas of depression, diabetes, nutrition, and physical activity and exercise (John A. Hartford Foundation, 2004).

The project was important not only for its products but for its process. Although NCOA was the lead organization, the process of identifying interventions with strong scientific credibility and translating them into practical programs rested with community teams in Boston, Houston, Los Angeles, and Portland, Oregon. These teams included representatives from aging services, healthcare, research, public health, mental health, consumer groups, and other relevant organizations. The teams reviewed the literature, identified the strongest interventions, developed programs that embedded these interventions, and then tested their programs in local service agencies including case management programs, meal sites, senior centers, community centers, housing facilities, and others.

NCOA and other national advisors supported and guided these teams by helping teams share lessons learned and best practices, providing additional expertise and reviews of materials, pressing for fidelity to the original intervention, developing additional tools and materials, and overseeing national dissemination. The products of this work are available on NCOA's Center for Healthy Aging website, *www.healthyagingprograms.org*. The toolkits are Healthy Eating, Healthy Moves, Healthy Changes (for people with diabetes), and Healthy IDEAS (for people with symptoms of depression).

AOA used the same fundamental approach, including employing local partnerships across the aging, health, and research networks, when it launched its grant program in 2003 as a partnership with the NIA, other government agencies, and the John A. Hartford Foundation and the Robert Wood Johnson Foundation, which had also funded deployment of evidence-based programs through community services agencies. This initiative supported fourteen community-based projects to work on a variety of evidence-based prevention programs, including chronic disease self-management, physical activity, fall prevention, nutrition, and medication management. AOA also funded NCOA to serve as the National Resource and Technical Assistance Center on Evidence-based Prevention for recipients of demonstration grants and the aging network more generally.

Other philanthropies played important roles in the implementation of AOA's evidence-based prevention initiative. The California Healthcare Foundation and the Archstone Foundation fully funded one of the demonstrations in California, and several other AOA-funded projects

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received partial support from local foundations. The Horizon Foundation supported a complementary community planning effort that led to the implementation of evidence-based models in Howard County, Maryland. And various foundations provided support to NCOA's Center for Healthy Aging and other national programs, such as the National Blueprint on Physical Activity and Active for Life, that were instrumental in the design and rollout of AOA's evidence-based prevention initiative.

By late 2005, it was clear that AOA's evidence-based prevention initiative was a success—the project teams had mastered the necessary skills to oversee evidence-based programming, and participant outcomes showed positive impacts on health and well-being. In the first eighteen months, the local projects had successfully translated the evidence-based interventions, launched their programs and reached nearly 3,000 participants (nearly half from minority populations) through programs offered in over one-hundred diverse community settings. With this favorable experience, AOA included this strategy for promoting the health of older people into the administration's Choices for Independence Reauthorization Proposal for the Older Americans Act, which Congress has embraced. The act now authorizes the Assistant Secretary for Aging to establish standards for states and communities to use in implementing evidence-based programs for older people, and it encourages the network at all levels to promote their deployment through community-based aging services provider organizations.

In 2006, AOA expanded its evidence-based initiative to directly involve state governments in the systematic deployment of evidence-based prevention programs for older people at the community level through aging provider organizations. One of AOA's objectives was to ensure this strategy was incorporated into the states' overall efforts to build more emphasis on prevention into their health and long-term-care systems. The Atlantic Philanthropies expressed interest in partnering with AOA on this new initiative. Discussions between AOA and Atlantic led to a $15 million collaboration that Health and Human Services Secretary Mike Leavitt announced that summer, which has already provided support to sixteen states. The Atlantic contribution includes a $5 million grant to NCOA to support a supplemental competitive awards program for states wishing to build statewide infrastructures for the Stanford Chronic Disease Self Management Program. The Atlantic Philanthropies funds complement AOA state grants by strengthening national partnerships, improving technical assistance to the aging services network, and accelerating the development of systems that will ensure statewide self-care programming.

Putting Consumers in the Driver's Seat

The third systems change that the Choices proposal advances also builds directly on foundation investments. It is the use of flexible service models, including consumer-directed models of care, to help consumers who are at high risk of nursing home placement but not yet eligible for Medicaid to remain in their own homes and communities. A policy strategy that targets high-risk elders who are not on Medicaid has important implications for the quality of life of older adults and their families and also for our ability as a nation to control the growing costs of long-term care.

While only about 12 percent of the elderly are eligible for Medicaid at any point in time, older people account for a significant portion of state Medicaid long-term-care budgets—because older people often end up on Medicaid after they exhaust their own personal income and assets on long-term care, usually in a nursing home, most often by the end of the first year. By helping individuals who are at high risk to avoid unnecessary placement in nursing homes, we can help people conserve and extend the use of their own resources, improve the quality of their lives, and potentially save Medicaid dollars.

We believe that one way to ensure that our public programs can respond effectively to the unique needs and circumstances facing high-risk individuals and their families is through the use of consumer-directed models like Cash and Counseling, which empower individuals to determine the types of care they receive and the manner in which it is provided. Such a model would give people the option to hire their neigh-

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bors, and even some of their relatives, to provide their care. This approach is consistent with President Bush's New Freedom Initiatives and with current research and policy trends that have benefitted from foundation support.

The original Cash and Counseling Demonstration Program was targeted at Medicaid-eligible individuals in Arkansas, Florida, and New Jersey. This controlled experiment compared the Cash and Counseling model to the traditional Medicaid approach to delivering personal assistance services. The target groups were eligible to receive either Medicaid state plan personal care or Home and Community Based Services (HCBS) waiver services. Results for the treatment group—one-half of all participants—included increased satisfaction with services and quality of life, decreased unmet needs, and lower expenditures on other Medicaid services such as nursing home and home healthcare. In addition, consumers in the treatment group experienced no declines in health outcomes at all, and in some areas, had better health outcomes than consumers in the control group (for more information, see *http://www.cashandcounseling.org/index.html*).

Based on the success of the initial state demonstrations, a number of subsequent actions led to embedding this model in federal policy, first under Medicaid and most recently, under the new OAA. In 2003, AOA, in an effort to leverage the knowledge and experience developed under the original demonstration for use by the aging services network, became a partner with the Robert Wood Johnson Foundation and others in a new grant program to begin the national replication of Cash and Counseling. A total of twelve states were funded under this initiative, eleven by Robert Wood Johnson Foundation, and one in the State of Illinois by the Retirement Research Foundation. In 2005, the Bush administration and Congress embedded the Cash and Counseling program in Medicaid law as part of the Deficit Reduction Act. This law allows state Medicaid programs to cover the costs of self-directed personal care services—including those provided by family members—without having to seek a federal waiver (U.S. Congress, 2006b).

Building on these investments and emerging policy trends, AOA incorporated the Cash and Counseling option into the design of the Choices proposal and the administration's Reauthorization proposal. The Congress embraced the consumer-directed components of our proposal, and the act now encourages the network to use consumer-directed models of care. Our long-range goal is to ensure that older adults receiving services under the Act have the option to choose a consumer-directed model, if they want and are able to do so. Historically, most of the dollars under the OAA have been tied to specific service categories and do not provide the network with the flexibility necessary to offer Cash and Counseling–type models. The Robert Wood Johnson Foundation investment in Cash and Counseling has played an essential part in modernizing the act and in positioning the aging services network for a leadership role in the future of long-term care.

Conclusion

It is impossible in one article to mention all the support that foundations have given in shaping new policy directions, but what this article has done is to illustrate how foundation support can play a critical role in advancing new ideas and policy change and in improving the well-being of older adults. This partnership includes a role for foundations that have a state or community focus to their grant making. A good example of local or regional partnerships between the aging services network and foundations are the eight area agencies that are the lead agencies, in partnership with other local organizations and in collaboration with local funders, in projects funded under the Community Partnerships for Older Adults program, a $30-million national initiative of the Robert Wood Johnson Foundation.

In sum, there are many ways in which smaller foundations can play a pivotal role in bringing national initiatives into communities and in supporting the uptake of AOA initiatives. Even relatively small investments designed to demonstrate the feasibility of a concept can influence federal grant-making and policy deliberations and eventually lead to a lasting and significant change in public policy. For the United States, which will soon see a doubling in the size of its older population, these invest-

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ments are moving change forward on the right track. ᔕ

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