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The Aging Services Network: Broad Mandate and Increasing Responsibilities

Carol V. O'Shaughnessy

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 2006, the number of elderly had more than doubled, reaching 37.3 million people and 12.4 percent of the U.S. population. The first wave of the baby boom generation turned age 60 in 2006 and will turn age 65 in 2011—the year the Older Americans Act is due for reauthorization. By 2020, almost one in six people will be age 65 and older.

The purpose of the Older Americans Act is to help older people 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 long-term care 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) 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. Some observers have pointed out that the Act's funding has not kept pace with increasing responsibilities.

Today, the "aging services network," referring to the agencies, programs, and activities that are sponsored by the OAA, is comprised of 56 state agencies on aging, 655 area agencies on aging, 233 tribal and Native American organizations, and two organizations serving Native Hawaiians, as well as nearly 30,000 local service provider organizations. These agencies are responsible for the planning, development, and coordination of a

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The Evolving Aging Network

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The Evolving Aging Network

Robert B. Hudson, Editor

The aging network, a creation of the Older Americans Act (OAA) of 1965 and subsequent amendments, has gone through several stages since its inception. Emerging unexpectedly in the wake of President Richard Nixon's announcement to the 1971 White House Conference on Aging that he was increasing appropriations under the OAA by $100 million, the network has evolved from then, when it symbolized the needs and standing of elders in American communities, to today, where it is called upon to take a lead role in addressing the long-term health care crisis bearing down on a now rapidly aging America.

This transformation was hastened by the passage of the Family Caregiver Support Act in 2000, and has been further realized through the 2006 amendments to the OAA. A series of interrelated initiatives – Choices for Independence, Money Follows the Person, Cash & Counseling, Nursing Home Diversion Modernization Initiative, Project 2020 – herald the front and central place the network is to play in the world of home and community-based care. Given the network's enormous diversity – geography, budgets, mandates, and preferences – whether any one such model can or should fit all is itself a question. Cross-cutting these organizational challenges is an emerging philosophical one: to what extent should community-based care be driven by client and informal caregiver choice and, in turn, what role should fall to formal, bureaucratic, and publicly-funded agencies in addressing community-wide long-term care challenges.

Each of these issues is addressed here. Carol O'Shaughnessy's article (based on a previously released background paper at George Washington University) represents the definitive statement of the legislative and budgetary developments that have led to where the OAA and the network stand today. Suzanne Kunkel and Abbe Lackmeyer amplify many of the issues anticipated in O'Shaughnessy's treatment, reporting on a national survey of Area Agencies on Aging conducted by the Scripps Gerontology Center at Miami University. In particular they see intra-network variability as a major challenge. Richard Browdie and Melissa Castora find both continuity and change in the network's development. In particular, Browdie and Castora are struck by the political vagaries at the state level that network agencies encounter; governors, cabinet officials, and legislative committees are in constant flux, and agencies must be accountable to these state-level actors as well as to "the feds."

Jeffrey Kahana and Lawrence Force of Mount Saint Mary's College in New York use a different lens in viewing the network. It is one that sees many of the same vulnerable clients who are potentially in need of long-term care services but who, at the same time, have much to offer their communities. The authors urge that civic engagement efforts directed to older adults must involve the vulnerable as well as the advantaged. So doing gives "community" both a new meaning (in the context of long-term care) and an old one (in the context of maintaining elders as vital members in their communities in a manner in keeping with much of the original intent of the OAA).

We believe that this issue of *PP&AR* provides the readership with an updated and informed assessment of where the OAA and the aging network stand in the face of pressing demographic, economic, and health care issues.

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wide array of social, long-term care, and health-support services within each state (Figure 1).

The aging services network administers not only Older Americans Act funding, but also, at a state's option, funding under other federal programs, including Medicaid, the Social Service Block Grant (SSBG), the State Health Insurance Program (SHIP), and section 398 of the Public Health Service Act, as well as state and local funds.

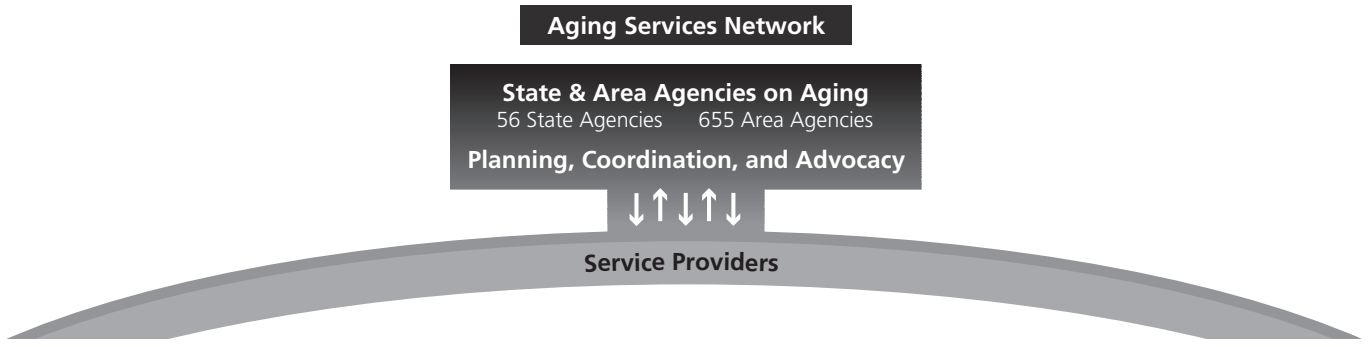
The Older Americans Act: The Foundation of the Aging Services Network

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. For example, in some states, state agencies on aging have been assigned responsibility for administering long-term care programs financed by Medicaid. State agencies on aging in some of these states have redesigned their Older Americans Act, Medicaid, and state long-term care programs to expand consumer choice in home and community-based services and to improve consumer access to the often complex web of community services. Building on the experience of these states, AoA has launched a series of discretionary grant initiatives in the past several years to help more states make systemic changes to help consumers plan for and gain access to home and community-based services.

Considering the broad sweep of its mission, the reach of the Act itself is constrained by limited resources. 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 broad groups of older people. For example, state agency on aging actions to redesign long-term care systems 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 Older Americans Act. In addition, the advocacy functions embedded in the Act's programs can make other programs' activities more accountable. For example, actions taken by long-term care ombudsmen to assist nursing home residents can improve care paid for 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

Figure 1 Major Services of the Aging Services Network



Access to Services	Nutrition	Home & Community-Based Long-Term Care	Disease Prevention & Health Promotion	Vulnerable Elder Rights Protection
Outreach, Information and Assistance Regarding Service Benefits	Congregate and Home-Delivered Meals	Home Care, Chore, Personal Care	Examples:	Long-Term Care Ombudsman
Care Management	Nutrition Counseling and Education	Adult Day Care	Physical Fitness	Prevention of Elder Abuse, Neglect, and Exploitation
Transportation		Family Caregiver Support	Nutrition Counseling	Legal Assistance
			Immunizations	

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 and Medicaid Services (CMS) has drawn heavily on the outreach and assistance capabilities of the aging network agencies. Whether the network can continue its momentum and fully meet its potential in the face of growing demand will be influenced by its ability to attract and retain additional resources and by policy decisions of federal, state, and local officials.

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) 2008 is $1.9 billion. Excluding Title V (a subsidized employment program for people age 55 and over and outside the scope of this article), total federal funding for AoA and aging services network programs is $1.4 billion. Figure 2 shows a description of each title and the breakdown of federal funding by title.

In general, AoA distributes Older Americans Act funds to states according to a population-based formula. 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 Older Americans Act 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.

Targeting the Vulnerable Older Population. While Older Americans Act services are available to all people age 60 and over who need assistance, the law requires that services be targeted to those with the greatest economic or social need.[1] 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.[2]

Means testing—considering a person's income, assets, savings, or personal property as a condition of receiving services—is prohibited.[3] Participants are encouraged to make voluntary contributions for services they receive in order to expand services to others. 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. Older people may not be denied services due to failure to make voluntary contributions or cost-sharing payments, where such policies exist.

Although the distribution of funds to states is determined on the basis of age alone, states and area agencies determine how to serve the target populations as 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, such as the long-term care ombudsman program, family caregiver support services, home and community-based long-term care services, and assisted transportation to those with limited mobility, are, by definition, targeted to vulnerable groups.

Population served. For FY 2006, AoA data show that about 6 percent of the 50.8 million people age 60 and older, or about 3 million people, received services funded by the Act, such as home-delivered meals, home care, and case management, on a regular basis. A larger proportion—about 20 percent of the older population, or about 10 million people—received other services such as transportation, information and assistance, or congregate meals on a "less than regular" (occasional) basis. In addition, Title III provided support services to almost 700,000 family caregivers.

Even though a small number overall receives services, vulnerable older people receive a disproportionate share of services. Of all people served under Title III programs, in FY 2006, 27 percent had income below the federal poverty level (FPL), compared with 9.7 percent in the total population age 60 and over in poverty. Further, about 19.8 percent of clients were members of a minority group, compared with about 15 percent in the total population age 60 and over (National Aging Program Information Systems (NAPIS), 2007; U.S. Bureau of the Census, 2007). Over one-third of people served lived in rural areas.

In many cases, state and local communities provide matching 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 services, especially for the nutrition program, augment federal, state, and local funds.

State and Area Agencies on Aging: Functions, Governance, and Staffing. Since their inception, the major functions of state and area agencies have been to 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 acting as advocates to encourage a "continuum of care" for vulnerable older people and to help them remain as independent as possible in home and community-based settings (OAA, 2006).

Each state has an agency designated by the governor to plan and coordinate services for older people, develop a statewide plan on aging, 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 and plan and coordinate services. State and area agency plans on aging are to reflect how the plans will meet the older peoples' needs, using both Older Americans Act funds as well as other funding resources. Area agencies contract with a wide variety of community service providers to deliver Older Americans Act–funded services, but they may also provide services directly if the state agency grants a waiver.

About half of state agencies on aging are located in state health and/or human services agencies; the remainder are independent departments or commissions of state government (Staff of the National Association of State Unites on Aging (NASUA), personal communication, September 11, 2007). The governance of area agencies on aging varies widely. According to a 2006 study, 41 percent of area agencies were private nonprofit organizations, 32 percent were part of county or city county governments, 25 percent were part of councils of government, and 2 percent were Indian tribal organizations or other entities (Burns et al., 2006).

Staffing of area agencies also varies considerably, from relatively small staffs, especially in rural areas, to very large staffs 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 2006, the 655 area agencies on aging were staffed by over 22,000 paid staff; volunteers numbered over 20,000 people (NAPIS, 2007). The variation in the governance as well as the staff and resources available contributes to wide differences in capacity among area agencies.

Expanding Responsibilities of State and Area Agencies on Aging. The original legislation, 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 the 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 (Estes, 1979). 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 funds were to act as catalysts, or "seed money" for drawing in state and local (non-Older Americans Act) funds to benefit the elderly. The decentralized planning and service model has meant that state and local 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 network's success in securing additional resources has depended on the political and economic circumstances in individual states and localities, and the 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. At the same time, Congress began to authorize targeted programs to respond to specific needs. (See Figure 3 for a timeline of major events in the evolution of the Older Americans Act.) In the latest amendments in 2006, Congress recognized the role that the aging services network can play in promoting use of home and community-based long-term care services 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 long-term care options and to coordinate and streamline consumer access to services (see below for information on ADRCs).

Generally, evaluations of individual Older Americans Act programs contain positive findings. However, with a few exceptions, evaluations are limited to overviews of program implementation, or are dated. While core Older Americans Act programs

are administered by all state and area agencies, 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 within states. For many social services, national standards or guidelines for best practices do not exist.[4] This can present challenges to state and local aging service administrators who may seek to achieve or approximate effectiveness as measured by any defined standards.

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. Title VII authorizes the long-term care ombudsman program, and activities to prevent elder abuse, neglect, and exploitation.

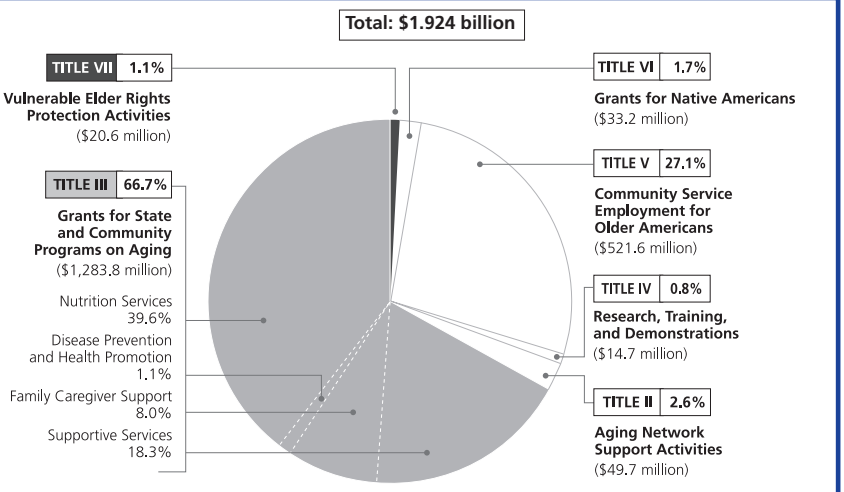
Supportive Services: Wide Range of Services to Help Older People Remain Independent in Their Communities. The supportive services program funds a wide range of services aimed at helping older people remain independent in their own homes and communities. These include services to help older people access services (such as transportation, outreach, information and assistance, and case management) as well as home and community-based long-term care services (such as personal care, homemaker, chore, and adult day care services). Due to its limited federal funding, the amount of services the program can buy is relatively small. Aging network agencies, however, use federal funds to leverage a substantial amount of non-Older Americans Act funds. According to one study and AoA data, for every $1 in federal funds, state and area agencies on aging acquire more than $2 from other funding sources (Rabiner et al., 2006).

Figure 4 shows FY 2006 federal expenditures for major services funded by the supportive services funding stream—access services and home and community-based long-term care services—as well as other services funded by Title III and Title VII.

Information and assistance. Central to the mission of the state and area agencies on aging is their role in providing information and assistance and acting as an access point 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, there are about 2,100 information and referral and assistance providers across the country (Administration on Aging (AoA), 2004). 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 (Rabiner et al., 2007). Area agency information and assistance providers are sometimes recruited to assist in special outreach efforts. For example, they devoted considerable effort to provide older Americans information and assistance to enroll in the Medicare Part D prescription drug benefit.

Transportation services. Transportation services is the largest category of supportive services spending, accounting for over $70 million in federal funds and serving about 47,000 people in FY 2006. An evaluation of program data for various years indicated that the program is well-targeted to vulnerable older people: about 75 percent of transportation users had at least some impairment (Rabiner et al., 2006). A 2004 survey found that about two-thirds of recipients lived alone, and three-quarters were age 75 or older. Over 80 percent of recipients said they could not drive, or had no vehicle available, and two-thirds reported that they relied on these services for at least half of their local transportation needs (AoA, 2004). Focus groups with area agency staff, conducted as part of a supportive services program evaluation, found that transportation

Figure 2 Older Americans Act, FY 2008 Appropriations



Source: Prepared by the National Health Policy Forum, based on appropriations data in Angela Napili, "Older Americans Act: FY2008 Funding and FY2009 Budget Request," Congressional Research Service, Report RL33880, updated March 27, 2008.

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 (Rabiner et al., 2007).

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. The number of people served nationally is small: in FY 2006, about 300,000 people received Title III-funded personal care or homemaker services (AoA, 2007, November). AoA 2004 data indicate that about three-quarters of homemaker services recipients lived alone and over two-thirds were age 75 or older; over four-fifths had an annual household income below $15,000 (slightly more than 1.5 times the federal poverty threshold for a one-person household in 2004) (AoA, 2004).

In FY 2006, Title III provided about $44 million for home care services. 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 be in need of skilled care under Medicare, Title III funds may be used to fill gaps left by these other programs.

Nutrition Services Program: Serving an At-Risk Population. The elderly nutrition program, the oldest and perhaps most well-known Older Americans Act service, provides meals to older people 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, and provide meals to the homebound. The program is intended to 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).[5]

Funding and meals provided. The program is the largest of Older Americans Act service programs, representing almost 40 percent of the Act's total funding. In FY 2006, about 2.6 million people received 238 million meals; 59 percent of meals were served to frail older people living at home, and 41 percent were served in congregate settings. 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 congregate services allotments to home-delivered services, state initiatives to expand services to frail older people living at home, and successful leveraging of nonfederal funds for home-delivered meals services.

Data on the unmet need for nutrition services are elusive; national data on waiting lists do not exist. Some anecdotal information indicates that there are waiting lists for home-delivered meals in some areas of the country.[6] In some areas, state and local funds may provide matching funds beyond the federal requirements to avoid waiting lists; in other areas, the absence of state and local funds may lead to waiting lists. Improved data collection by AoA and other organizations on unmet need among the frail population could assist in assessing program capacity and needs.

Family Caregiver Services: Serving Multiple Generations Through One Program. The vast majority of the elderly with long-term care needs receive care from their families and other informal, unpaid caregivers. About 7 million caregivers provide informal care to older people who need assistance with ADLs or other activities necessary to live in their own homes (Spector et al., 2001).[7] 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.

Services provided. The National Family Caregiver Support Program (NFCSP) provides grants to state agencies on aging that award funds to area agencies on aging for caregiver support.[8] Services 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. In FY 2006, a little more than half of funding was spent on more costly services, such as respite care, home care or adult day care, with the remainder spent on information, access assistance, or counseling to caregivers (AoA, 2006).

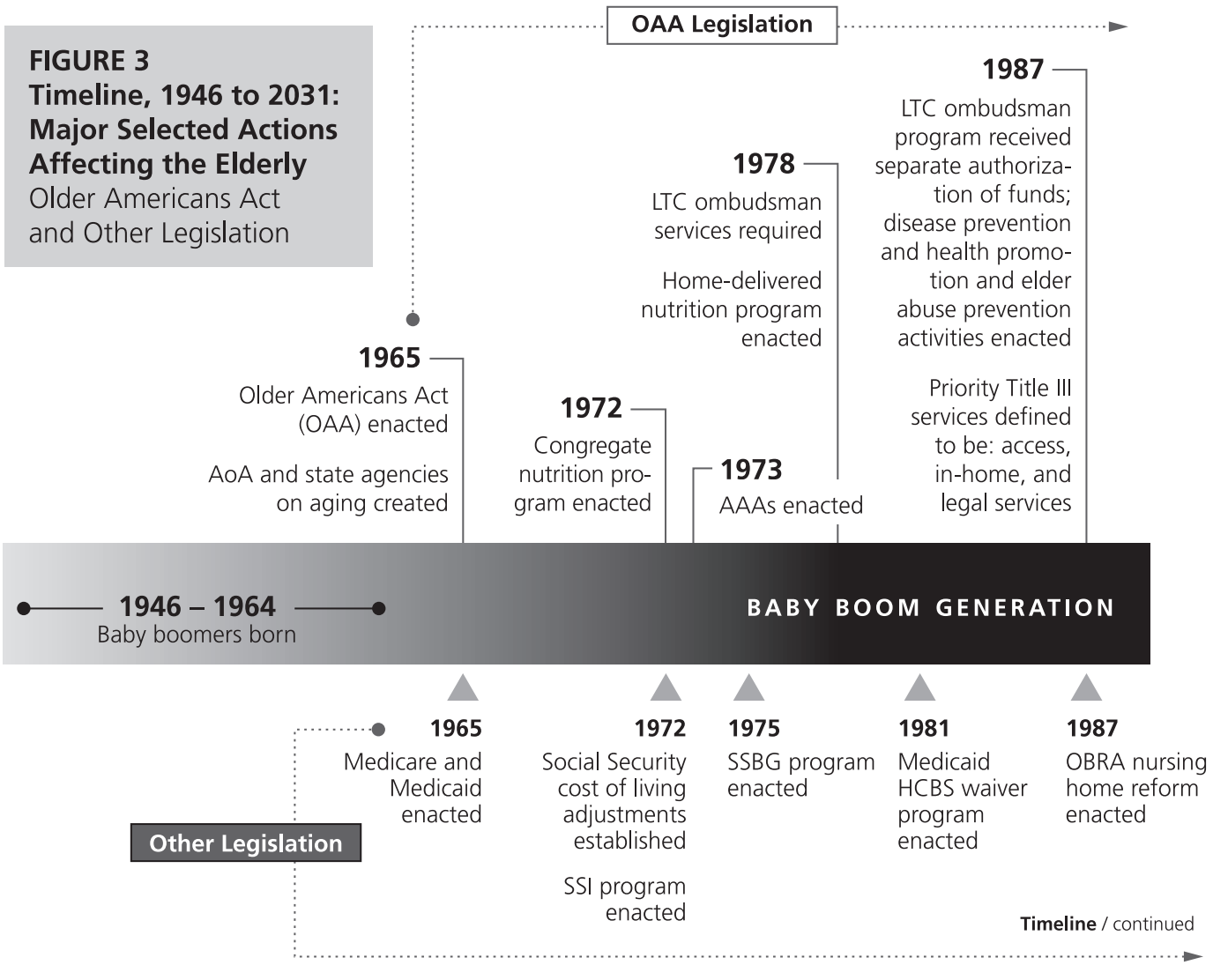
Recipients. The number of caregivers that the program serves is small in comparison to the estimated number of caregivers of older people nationwide. In FY 2006, about 533,000 people (about 7.6 percent of all caregivers for older people) received assistance in accessing caregiver services, counseling, or caregiver training, or participated in a support group. About

103,000 people received respite care or supplemental services (about 2 percent of all caregivers) (AoA, 2006; Spector et al., 2001). Caregivers served by the program are a particularly vulnerable group. In a 2004 survey of NFCSP caregivers, over three-quarters said they had been providing care for three years or longer and almost one-quarter were age 75 or older. Over 77 percent of care recipients were age 75 and older (with over one-third age 85 or older) (AoA, 2004).

Program results. A 2004 survey conducted with state officials regarding the initial years of implementation 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 long-term care programs [such as the Medicaid Section 1915(c) waiver program], 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 other long-term care services, the importance of developing methods to uniformly assess caregiver needs and provide caregiver training, and the need for additional funding for respite care services (Friss Feinberg et al., 2004).

Disease Prevention and Health Promotion Activities: Straining to Have Broader Reach. At least 60 percent of the elderly have multiple chronic conditions (Wolff, Starfield, and Anderson, 2002), and most health care spending is for people with chronic conditions (Anderson, 2007). Although the primary way the Older Americans Act addresses disease prevention and health promotion activities is through nutrition services, Congress has authorized specific funds for these activities as part of Title III (under subpart D). Funded at $21 million in FY 2008, disease prevention and health promotion activities are one of the smallest Older Americans Act programs. States

FIGURE 3
Timeline, 1946 to 2031: Major Selected Actions Affecting the Elderly
Older Americans Act and Other Legislation



use funds from the Act to support health promotion activities at various community venues, such as senior centers and congregate nutrition sites, among others.

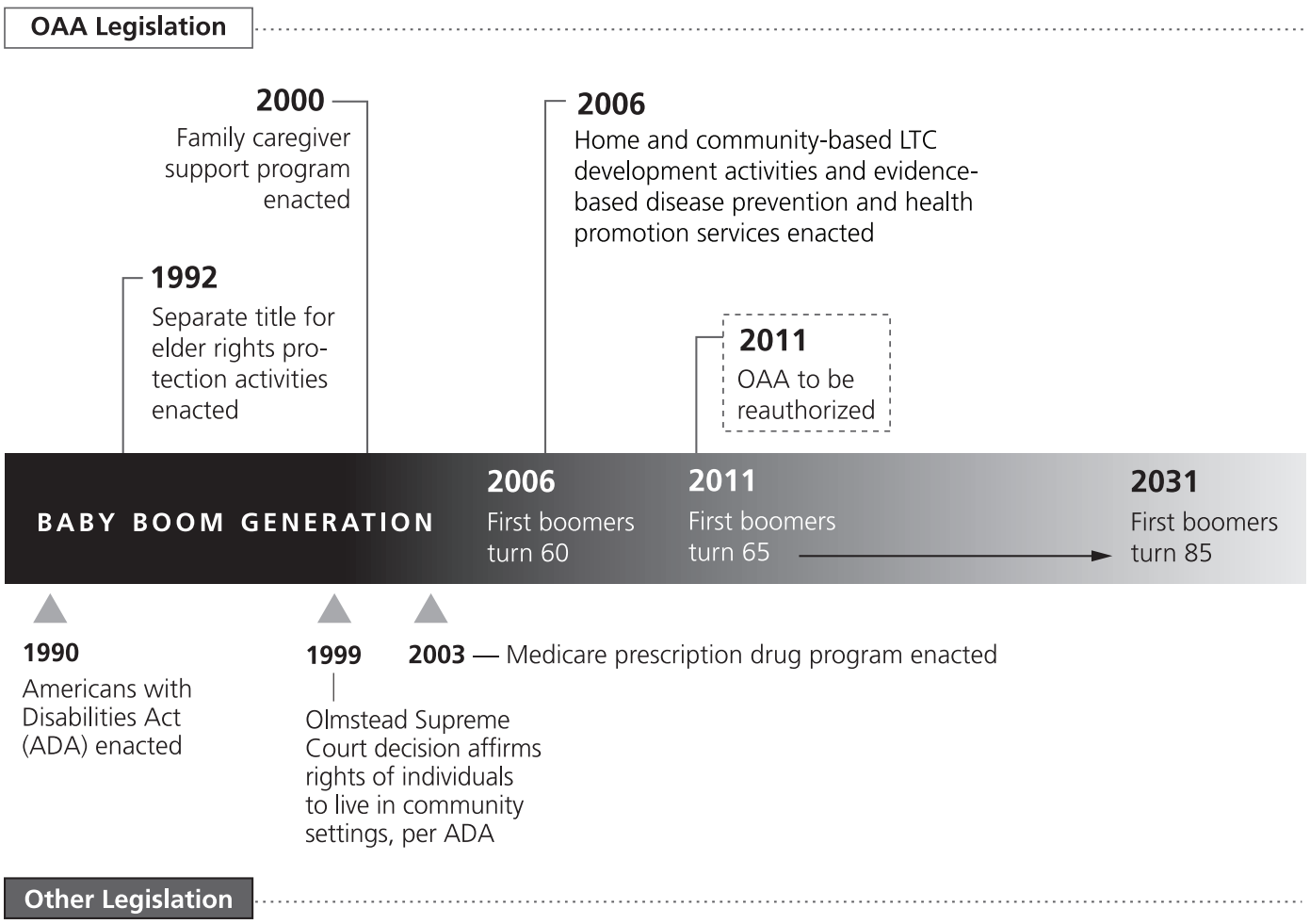
The types of activities that state and area agencies support with these funds vary widely. According to an assessment of eight programs completed for AoA, aging network health promotion activities include both group services, such as physical fitness and diabetes control classes and arthritis and nutrition 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 wide range of public and private health and social services organizations in planning and delivering these services (Wiener et al., 2006).

According to the AoA program assessment, the program faces 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 (Wiener et al., 2006).

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 1987 (OBRA 1987) and subsequent amendments. Licensure and/or certification of residential care facilities, other than nursing homes, are the province of state government.[9]

A complementary way to address quality of care in nursing facilities is through protection of resident rights and consumer advocacy. In 1978, Congress

FIGURE 3 — Timeline / continued



enacted a requirement in the Older Americans Act that state agencies on aging establish an ombudsman program to advocate for, and protect the rights of, residents of long-term care facilities. In 1987, 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.

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; representing the interests of residents before governmental agencies; seeking administrative and legal remedies to protect their rights; and providing consumer education.

Resident complaints. In FY 2006, the ombudsman program opened 194,000 new cases and closed 188,000 cases involving almost 307,000 complaints.[10] Most complaints related to resident care and rights and quality of life issues.

Funding and staff capacity. Funding for the program is rather modest considering its broad responsibilities, and the program relies on citizen volunteers to carry out its mission (Harris-Wehling, Feasley, and Estes, 1995). 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.

Federal funding comes primarily from two sources, Title III and Title VII, but state and local sources provide significant support as well. Of total FY 2006 expenditures ($77.8 million), almost 60 percent came from federal funds ($46.6 million), and the balance came from state and local sources ($30.9 million). Although the program carries a separate authorization of funds under Title VII, most federal funding comes from Title III.[11] The Title VII federal appropriation has grown slowly; from FY 1988[12] to FY 2008, funding grew by less than 1 percent a year.

In FY 2006, 1,300 paid ombudsmen (full-time equivalents) were responsible for oversight of 16,750 nursing facilities with 1.8 million beds, and 47,000 other residential care facilities with 1.1 million beds. However, most state programs could not operate effectively without volunteers who are certified by the state ombudsmen to investigate complaints—in 2005, there were 9,183 certified volunteers. Ombudsman programs rely on volunteers to maintain a presence in facilities and to investigate resident complaints.

A 1995 IOM study recommended that the staffing standard for the program be one paid full-time staff equivalent for every 2,000 beds (Harris-Wehling, Feasley, and Estes, 1995). In FY 2006, on average across all states, there was one paid full-time ombudsman for every 49 facilities and every 2,192 beds, approaching the IOM-recommended staffing standard. However, great variation in the ratio of paid ombudsmen to beds exists. In FY 2006, only about half the states had a paid staff-bed ratio meeting the IOM recommended standard.[13]

Evaluation. A number of program evaluations have taken place over the years, analyzing the value, capacity, and resources of the program. Despite repeated reports presenting evidence on the value of the program, recurring themes have pointed out that its broad mission is not supported with a corresponding level of resources. The most extensive evaluation of the program was conducted by the Institute of Medicine (IOM) in 1995 in response to a congressional directive in the 1992 Older Americans Act amendments (Harris-Wehling, Feasley, and Estes, 1995). The report concluded that the program "serves a vital public purpose" and has improved the long-term care system. However, it pointed out that not all residents had meaningful access to the program, the degree of implementation was uneven within and among states, and the program lacked sufficient resources to fulfill its basic mission.

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. The activities of the aging network agencies exemplify this especially in the area of home and community-based long-term care services financed by Medicaid. In addition, many agencies administer Social Service Block Grant (SSBG) funds, the State Health Insurance Program (SHIP), Public Health Service Act funds,[14] and state general revenue funds for myriad services for older people.

Management of Home and Community-Based Long-Term Care Services. 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 the home and community-based services system for vulnerable older people was underdeveloped and that a "continuum of care," as envisioned by the Older Americans Act, did not exist. At the same time, the federal government was giving more policy attention to "alternatives to institutional care" through various demonstration programs.[15]

Moreover, states were concerned about the growing budgets for nursing home care financed by Medicaid 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 elderly for home and community-based services over care in institutions. This led some states to begin 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 are otherwise available for Medicaid reimbursement. The waiver program also allows states to control the budget for these options by targeting services to specified groups and by not providing services statewide. Implementation of waivers during the 1980s and 1990s began to change the fabric of long-term care services 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 long-term care needs and limited income and resources.[16]

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. Many state governments began to assign responsibility for administration and day-to-day management of the Medicaid waiver services program to state and area agencies on aging. The aging infrastructure proved to be a ready-made network for waiver implementation.

Throughout most of the aging network, administration of Medicaid waiver programs is now a core component of aging services. According to a 2004 survey, state agencies on aging in 33 states were the designated operating agencies for the Medicaid home and community-based waiver programs: in 21 states they administered the waiver for both the elderly and younger people with disabilities, and in 12 states they administered the waiver for the elderly population only (National Association of State Units on Aging (NASUA), 2004). Most state agencies on aging also administer state-only funded home and community-based services for the elderly; in 32 states, state agencies on aging administer these programs for people younger than 60 who have disabilities (AoA estimate based on NASUA, 2004; Kitchener et al., 2007).

A 2006 AoA survey found that Medicaid funds are the second largest funding source administered by area agencies on aging. Thirty percent of area agency funds were from Older Americans Act sources; 26 percent from Medicaid home and community-based waivers or other Medicaid funding; and the balance from other federal, state, local, and private funds (Burns et al., 2006).

Redesigning Long-Term Care Services Delivery. Some states have redesigned their entire long-term care systems by making broad policy changes, using Medicaid funds for home and community-based services in combination with Older Americans Act and state funds. Long-term care redesign has taken various approaches including (i) restructuring state policies, administrative structures, and financing to redirect service delivery toward home and community-based services from institutional care, and (ii) integrating consumer access to services across multiple funding streams.

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 long-term care resources. In these cases, one agency is responsible for not only planning and development of long-term care 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. States that have restructured their systems include Oregon and Washington, where centralized systems are focused on a goal of eliminating any bias toward institutional care (Walters et al., 2003; Wiener et al., 2004).[17]

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. To improve consumer access, some states have developed integrated case management systems using single points of entry for consumers who are seeking information on long-term care services. Although single point of entry systems vary in their design, the rationale is to provide a "no wrong door" approach for consumers to access long-term care

services. Some systems have personnel who conduct functional and/or financial eligibility for public home and community-based long-term care programs; some systems provide enhanced consumer information for services.

Integrated case management systems may use a wide range of programs, including the Older Americans Act, Medicaid, and state funds, to finance services for consumers. In some cases, area agencies perform functional eligibility and ongoing case management once a person is determined financially eligible for services. Single point of entry systems using area agencies operate in Indiana, Massachusetts, Ohio, Oregon, and Pennsylvania (see for example, Gillespie and Mollica, 2005; O'Shaughnessy et al., 2003; Gage et al, 2004). In Washington, state officials provide the front door to services and area agencies perform ongoing case management for services once a person is determined eligible. In some states, area agencies perform a role in controlling access to nursing homes by carrying out pre-admission screening for entry into nursing homes (O'Shaughnessy et al.).

Prevention of Elder Abuse, Neglect, and Exploitation. Abuse, neglect, or exploitation of older adults in their own homes is a largely unrecognized, but growing, problem. Abuse in domestic settings may affect hundreds of thousands of older people each year. Although data on the full extent of the problem nationally are elusive, the best estimates indicate that between 1 and 2 million people age 65 and older have been injured, exploited, or otherwise mistreated by someone they depend on for care (Bonnie and Wallace, 2003). Generally victims are more likely to be women, and most abusers are family members. Types of abuse or neglect include self-neglect; caregiver neglect; financial exploitation; and emotional, psychological, verbal, physical, or sexual abuse (National Center on Elder Abuse, 2006).

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 31 states have been designated to administer APS programs (NASUA, 2004). In most states, APS programs are considered the first responders to reports of abuse, neglect, or exploitation (Teaster et al., 2006).

According to a national survey of APS programs, reports of suspected abuse and substantiated cases have increased in recent years.[18] Increasing numbers of cases are an indicator of growing demand for services, either for investigation by state APS personnel or intervention on behalf of abused clients. Estimating incidence of abuse across the country is problematic; 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. In addition, the number of incidents of abuse, neglect, and exploitation could be much higher, but because of problems in data collection and reporting, the full extent of incidence is not known (Wood, 2006).

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 adult protective services, it is primarily from the SSBG (Title XX of the Social Security Act). Under the SSBG, states decide how much of their block grant funds they will spend on many different service categories. In FY 2005, of the $2.5 billion SSBG funds for all services, states spent $164 million on APS programs (Administration for Children and Families (ACF), 2005a). In most states, SSBG funding far outweighs funds under the Older Americans Act (ACF, 2005b). Congress has appropriated a little more than $5 million for the Title VII elder abuse prevention program for each of the past several years.

State Health Insurance 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 make choices regarding Medicare supplemental insurance (Medigap). The program 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 (Centers for Medicare and Medicaid Services, 2005). In 2006, over 12,000 counselors served more than 4.5 million beneficiaries through one-on-one, in-person, and telephone counseling and assistance, as well as through public education programs.

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. In FY 2006, approximately half of the $30 million available to state SHIP programs was distributed to area agencies on aging that provided staff and volunteer assistance to Medicare

beneficiaries (M. Maultsby, CMS staff, personal communication, November 28, 2007).

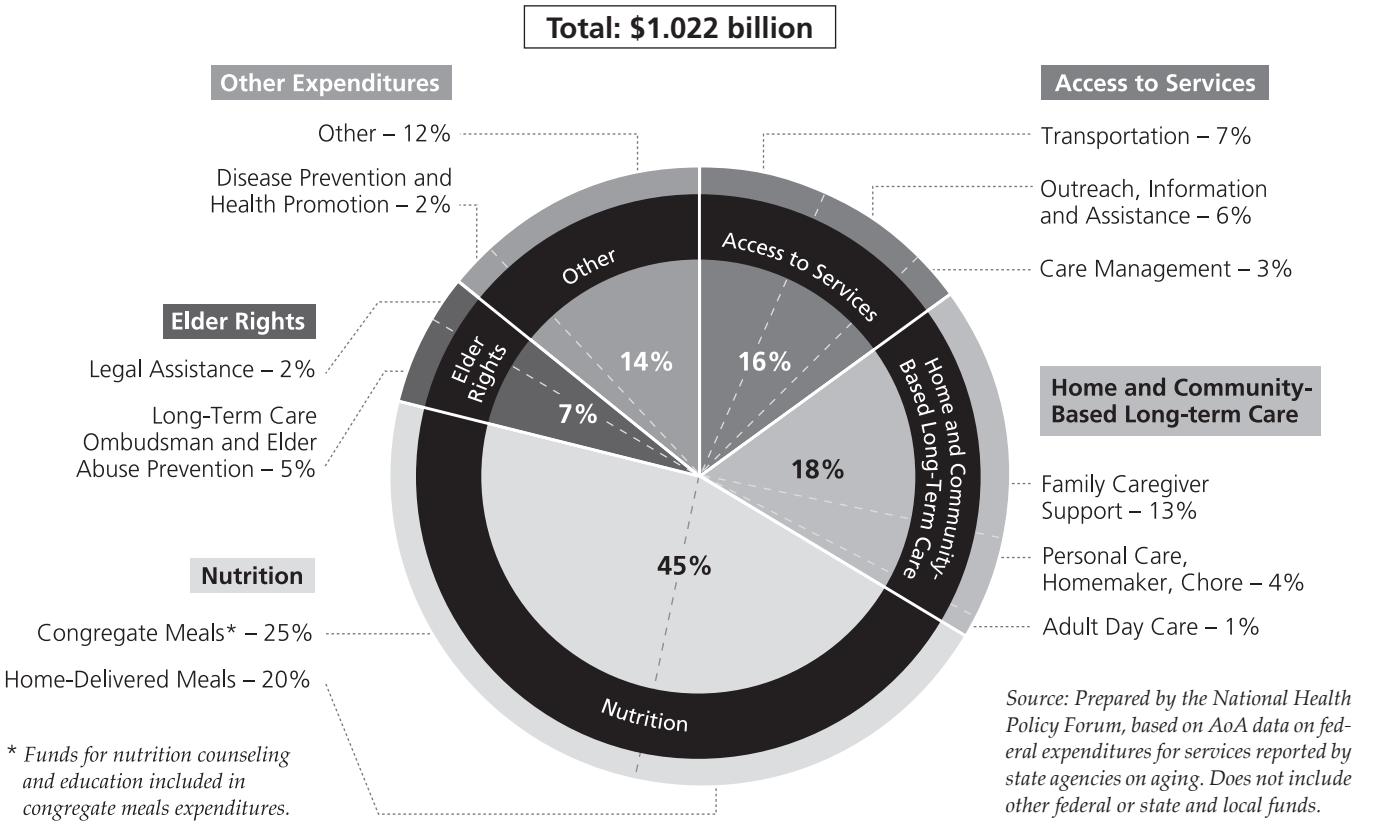
Recently, the SHIPs and aging services network agencies coordinated their efforts during implementation of the Medicare prescription discount drug card, the Medicare Part D benefit, and the Part D low-income subsidy for those with limited income and assets. During the initial stages of implementation, many aging services network agencies reassigned staff from other responsibilities due to overwhelming demand by beneficiaries for information and counseling on the new Medicare benefit. Over 90 percent of area agencies on aging have been involved in counseling and training efforts. During the past several years, AoA and CMS have developed a series of interagency agreements with CMS transferring $6.4 million to AoA and national, state, and area agency on aging partners to assist in Medicare counseling efforts (Staff of AoA, personal communication, November 28, 2007). As more people become eligible for Medicare, demand for counseling and assistance on Medicare issues is likely to increase.

Modernizing the Older Americans Act: Choices For Independence Initiative

Over the past few years, AoA has targeted the use of its discretionary funds[19] to launch a strategy to modernize and strengthen the aging services network. AoA has undertaken these efforts to help states and area agencies make systemic changes aimed at improving coordination and service delivery in long-term care and at reducing the risk of chronic illness among older people. AoA crafted three components as part of the initiative, referred to as Choices for Independence.

1. To help consumers and their families learn about and access existing long-term care options, AoA joined CMS to award funds to states to develop Aging and Disability Resource Centers (ADRCs). ADRCs are intended to be "one-stop shop" programs at the community level that will help people make informed decisions about their service and support options. Based on a model developed in Wisconsin (Moore,

Figure 4 Older Americans Act: Federal Expenditures for Services Authorized by Title III and Title IV, FY 2006



O'Shaughnessy, and Sprague, 2007), ADRCs provide information and assistance to individuals needing public or private services, and individuals planning for their future long-term care needs. Resource Center programs are designed to serve as the single entry point to publicly administered long-term supports, including those funded under Medicaid, the Older Americans Act, and state revenue programs. As of April 2008, AoA awarded funds for 143 pilots in 43 states (AoA, 2007, December).

2. To help people with impairments avoid nursing home placement, AoA has awarded funds to states to launch the Nursing Home Diversion modernization grant program. Through these grants, states use available home and community-based services funds to help people at the highest risk of nursing home placement remain at home and in community settings. Services are to be tailored to individual consumer needs. This program is structured to operate in concert with ADRC grants so that consumers can access a single point of entry for service planning and access. As of April 2008, AoA awarded funds to 12 states; federal and nonfederal commitment to the program is $8.8 million (AoA, 2007, September).

3. To complement its formula-based grant program for disease prevention and health promotion, AoA has awarded discretionary grants funds to states and community agencies to help them develop programs on evidence-based disease prevention programs. 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 to provide targeted efforts in health promotion activities. In 2003, AoA awarded 12 community-level projects and expanded the program in 2006 and 2007 to over 75 pilots (AoA, 2007, October).[20]

Broad Mission, Limited Resources: 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, however, the Older Americans Act resources are relatively limited. Some have observed that funding has not kept pace with increasing demands from a growing elderly population. As a result, some programs have grown very slowly over time, or funding has 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 almost 30,000 service providers offering a wide range of services across the nation. Older Americans Act funds reach limited numbers of older people, but serve the most vulnerable. 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 successfully leveraged other federal funding sources. Aging services network agencies have evolved from planning and coordination entities to managers of multiple sources of funds. The ability of the infrastructure to adapt to changing demands in aging programs has led to added responsibilities and resources for state and area agencies over time. 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. But this growth will also challenge the fabric of social and health-support services in communities across the nation and will affect families who care for their older family members. Aging service providers will face increasing challenges in financing and delivering a wide range of community services for vulnerable elderly. In the future, policymakers may need to focus on actions that will be necessary to sustain community services in the face of growing demand. These issues may become quite salient when the Older Americans Act is reviewed for reauthorization in 2011—the first year the baby boom population turns

age 65.

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Endnotes

1. "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 federal poverty level (FPL).

2. 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. In some cases, nonelderly people may receive services; for example, people under 60 may receive nutrition services under certain circumstances, and grandparent caregivers (age 55 and older) of children may receive caregiver support services.

3. 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.

4. 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, "Quality of Care Measures for Home and Community-Based Services Under Medicaid," updated May 2007; available at www.ahrq.gov/research/ltc/hcbs.htm.

5. Food stamp benefits may be used as contributions by older people toward the cost of meals. However, due to some administrative complications resulting from the conversion of food stamp benefits to the electronic benefit transfer (EBT) system, there is limited opportunity to use food stamps as contributions in aging nutrition programs even though participants may be food stamp–eligible.

6. For example, a recent report from Kentucky cited a waiting list of 4,000 seniors for home-delivered meals. Jessica Noll, "Aging Kentuckians: a Question of Care," KYPost, updated January 26, 2007; available at www.kypost.com/content/middleblue2/story.aspx?content_id=c603e9e5-0ec6-492a-ad77-7fea626ade7f.

7. 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 based on the 1999 National Long-Term Care Survey (NLTCS), a nationally representative survey of elderly Medicare beneficiaries. (See www.nltcs.aas.duke.edu for more information on NLTCS.)

8. 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.

9. 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.

10. Cases are equivalent to individuals who file complaints; complaints are the problems they identify.

11. Title III requires state and area agencies to fund the ombudsman program under a 2000 "hold harmless" requirement; that is, they are to provide at least as much support from Title III sources as they did in FY 2000. Title VII authorizes a separate appropriation.

12. FY 1988 was the first year the program received a separate appropriation.

13. For example, California had one paid ombudsman for every 1,472 beds; Iowa had one paid ombudsman for every 9,781 beds; and Wisconsin had one paid ombudsman for every 3,136 beds. AoA data on number of staff and beds by state. AoA, "Long-term Care Ombudsman National and State Data," updated November 9, 2007; available at www.aoa.gov/prof/aoaprog/elder_rights/ltcombudsman/national_and_state_data/2006nors/2006nors.asp.

14. 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. In FY 2007, competitive grants were made to 38 states, primarily state agencies on aging.

15. 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 and Medicaid Services and the Agency for Healthcare Research and Quality) 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/costeff.htm.

16. See also Cindy Shirk, "Rebalancing Long-Term Care: The Role of the Medicaid HCBS Waiver Program," National Health Policy Forum, Background Paper, March 3, 2006; available at www.nhpf.org/pdfs_bp/BP_HCBS.Waivers_03-03-06.pdf.

17. For other state approaches, see also Rosalie A. Kane et al., Management Approaches to Rebalancing Long-Term Care Systems: Experience in Eight States up to July 31, 2005, Centers for Medicare and Medicaid Services, May 26, 2006; executive summary available at http://hcbs.org/files/94/4668/Executive_Summary.pdf.

18. 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. Teaster et al., The 2004 Survey of State Adult Protective Services.

19. In FY 2008, funds for the Choices for Independence grants were appropriated under Title II of the Older Americans Act. In prior years, funds were appropriated under Title IV of the Act.

20. See also, National Council on Aging, Center on Health Aging, www.healthyagingprograms.com.

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Evolution of the Aging Network: Modernization and Long-Term Care Initiatives

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The aging network has evolved considerably since its inception, mandated by the Older Americans Act (OAA) of 1965. The original legislation described a far-reaching goal: "to assist our older people to secure equal opportunity [for] the full and free enjoyment" of a broad range of objectives (Older Americans Act (OAA), 1965, sec. 101), including adequate income, the best possible physical and mental health, suitable housing, opportunities for employment, meaningful activity, and a "comprehensive array of community-based, (sic) long-term care services that will enable them to stay healthy, active and remain in their homes and communities" (OAA, sec. 101 (4)). Significant amendments over the years include: the use of funding formulas and targeting particular groups within the aging population; the establishment of the federal, regional, state and local levels of the infrastructure we now recognize as the aging network; development of nutrition programs; and more recent initiatives aimed at modernizing the aging network. With each authorization of the Older Americans Act, the service mission of the aging network has broadened (Koff and Park, 1999). This article details recent changes in the network, which mark a stage of significant transition.

Modernizing the Aging Network

The 2006 reauthorization of the Older Americans Act expanded the role of the long-term care service system in all levels of the aging network to create more balance between community-based and institution-based services. Areas of focus include: health promotion and disease prevention; reliable information about long-term care options; support for planning and streamlined access to long-term care services; and enhanced options to enable older adults to remain at home in their communities. These priorities are supported through grants (made to states in collaboration with area agencies on aging (AAAs) for the development and implementation of nursing home diversion programs, single entry point models for long-term care access, and evidence-based disease prevention and health promotion programs.

Taken together, the 2006 amendments and the resulting grants represent an effort to modernize the aging network and its role in long-term care. The term "modernization" is used to refer to the goals of some of the specific new grant programs, such as the Nursing Home Diversion Modernization Initiative, in which modernization refers to a transformation of the funding received by the aging network "under the Older Americans Act, or other non-Medicaid sources, into flexible, consumer-directed service dollars" (AoA, 2007, p.1).

But modernization connotes an agenda for the network that is broader than any one program: to strengthen the position of the aging network along critical pathways in a more balanced long-term care system. In her prefatory remarks in the AoA report following the 2006 reauthorization of the Older Americans Act, Assistant Secretary for Aging, Josefina Carbonell described the new provisions of the act as "build[ing] on and strengthen[ing] the unique mission, capacity, and success of the [aging] Network" and "establish[ing] a unifying strategy for advancing long-term care systems change" (AoA, 2006, p. 3). The modernization of the aging network, and its role in long-term care, while deeply rooted in the language of the 1965 legislation—to promote the health, dignity, and independence of older people—also represents a time of significant transformation. The growing older population, current and future demand for long-term care, overwhelming pressures on state and federal budgets, and heightened awareness of the role of consumer choice have combined to create an opportunity for the aging network to help older people stay healthy longer, and to remain in their own homes as long as possible.

Broadened Mission: Helping Vulnerable Elders Remain in Their Communities

The Older Americans Act authorizes programs for all people age 60 and over, but particularly targets those with greatest social and economic need. Consistent with the challenges and opportunities described above, Older Americans Act services reach a more vulnerable group of elders than the general 60+ population. O'Shaughnessy (2008) points out that 800,000 people at high nutritional risk received OAA nutrition services in 2006. An analysis of data from AoA's Aging Integrated Database (AGID) reveals further examples of ways in which consumers of OAA services in 2006 were more vulnerable than the general 60+ population. Specifically, OAA

consumers were more likely to live in poverty than the overall 60+ population (27% v. 10%), more likely to live alone (35.4% v. 26%), and more likely to live in rural areas (33% v. 23%) where access to services is generally more problematic.

Markers of Change: Results from a National Aging Network Survey

In 2007, the National Association of Area Agencies on Aging (n4a) entered into a partnership with Scripps Gerontology Center to gather information about the current status of the aging network, and to track progress of programs related to federal initiatives to modernize the aging network's role in reforming a long-term care system. The web-based 2007 Annual Aging Network survey was distributed to every area agency on aging and every Title VI organization (those who serve American Indian, Alaskan Native and Native Hawaiian elders) in the nation. Eighty-one percent of the AAAs responded to the survey, as did 86 percent of the Title VI organizations. The distinct missions, target populations, and organizational structures of Title VI organizations are a very important aspect of the aging network, as is the relationship between Title VI and AAAs; however, these issues are beyond the scope of this article. The survey information presented here is based only on the AAA responses.

The current status of the aging network can be summarized by two overarching findings. First, there is tremendous variability across area agencies, giving credence to the adage that "if you've seen one area agency, you've seen one area agency." This variability is attributable to a variety of factors, including the role of states in designing their aging services delivery system, and state and local policies and politics. For example, some area agencies are involved in the administration of the state's home and community based (HCBS) Medicaid waiver program, while others are not; this involvement has tremendous implications for budget, services provided, and the current role of those agencies in the long-term care system.

Table 1 Organizational Capacity

	Average (mean)	50th Percentile (median)	Range
Budget (in millions)	$8.9	$3.8	<$150,000 - >$250 million
Proportion of budget from OAA (%)	41.9	38.0	0-100
Clients served	8607	3020	91 - 128,945
Full time employees	39	21	1-650
Part time employees	20	6	0-445

Second, AAAs show varying levels of innovation and interest in expanding the reach of the network. While the network was originally established by and operated only with money allocated through the Older Americans Act, today virtually every area agency receives outside funding in addition to OAA allocations, and performs functions that go beyond those mandated by the legislation.

Survey results provide an illustration of the current status of the aging network, and mark new directions within the aging network. Information about structure, operations, programming, innovations, and challenges give some insight into the ways in which the aging network has transformed over the past decades, and the challenges and opportunities it faces in moving ahead.

Budget, Operations, and Organizational Structure. The variability in the network is nowhere more evident than in the budgets of area agencies on aging. As shown in Table 1, survey data revealed that annual budgets range from about $150,000 to more than $250 million. Because the distribution of budgets is highly skewed, the average area agency budget is significantly higher than the median budget ($8.9 million and $3.8 million, respectively). Staff size and number of clients served show similar degrees of variability and scew. The number of full-time staff ranges from 1 to 650 and the number of clients served ranges from under 200 to over 125,000.

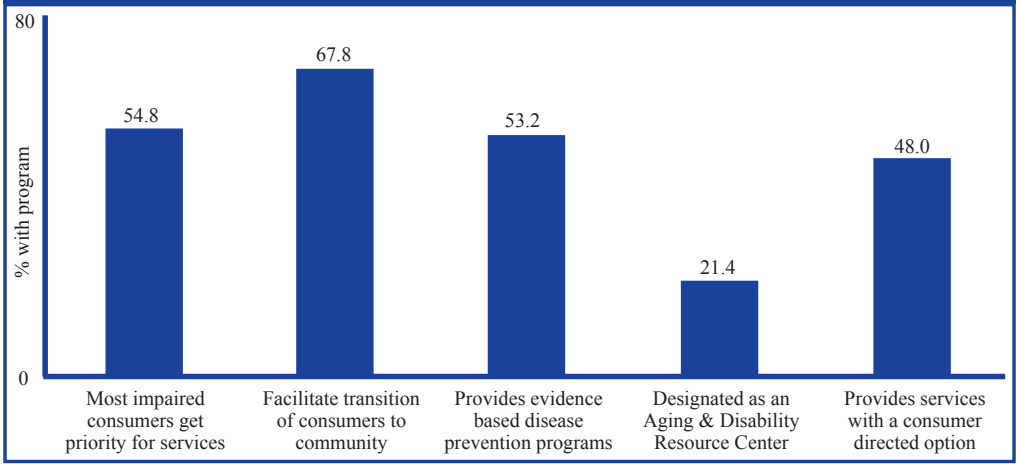
Organizational structure—where an area agency is housed and how it is governed—is another dimension of variability within the network. About 37 percent of agencies described their structure as an independent not-for-profit agency, 25 percent as part of county government and another 26 percent as part of a Council of Governments (COG) or Regional Planning and Development Area (RPDA). During workshops conducted by n4a and Scripps on business planning for long-term care, about 50 area agency directors who participated consistently discussed organizational structure as an important influence on the role that an area agency can play in the long-term care system. While this topic requires further investigation, there seems to be some consensus that independent not-for-profit agencies have a greater degree of flexibility in defining their mission and

priorities.

Leveraging Multiple Funding Streams. As noted above, nearly every area agency receives funding from sources beyond OAA allocations. The average proportion of an agency's budget that comes from OAA appropriations is 42 percent (ranging from 1 to 100). The most common source of additional revenue is local funding; 78 percent of AAAs reported that they receive funds from local sources, including city and county entities and tax levies. The second most common source of additional funds is state general revenue (70% reported revenue from this source). In addition to these, a large proportion of AAAs receive funding from a Medicaid waiver (about 60%), and over half receive grant funding.

Services Provided or Administered. Most agencies administer services beyond those mandated by the Older Americans Act, such as case management, personal care, benefits counseling, medication management and assessment for care planning. For example, 83.6 percent of AAAs provide case management services and over 87 percent provide medication management.

Figure 1 Proportion of Agencies Involved in Key Programs



In addition, a number of AAAs are involved in innovative programming related to long-term care, including nursing home transitions, Aging and Disability Resource Centers, evidence-based health promotion programming, initiatives to streamline access; and consumer direction. Figure 1 shows the proportion of area agencies involved in some of these initiatives. In keeping with area agencies' expanded role to help older people stay at home in their communities for as long as possible, the majority give priority to their most impaired consumers (those likely to be at highest risk for nursing home placement), and facilitate their transitions back to the community. More than half have evidence-based disease prevention programs, and nearly half offer some consumer-directed options for some of the services they provide. By the time this article is published, these numbers will be underestimates due to a new round of grants awarded to states and their collaborating AAAs that was announced by Health and Human Services (HHS) at the end of September, 2008. It will be important to track the diffusion and sustainability of these innovations both across and within states over time.

Strategic Partnerships. The modernization language of the 2006 Older Americans Act and the related documentation of priorities and initiatives places importance on partnerships. Area Agencies on Aging are actively involved in a number of formal and informal partnerships with federal, state and local organizations that assist in serving older adults. Most common partnerships are with Adult Protective Services (88.1%), advocacy organizations (87.4%), Medicaid (84.2%) and health care providers (82.7%). Area agencies are less likely to have formal or informal relationships with the business community, managed care organizations, and research institutions (51%, 33%, and 30%, respectively).

Progress and Challenges on the Path of Modernization

The 2007 n4a/Scripps survey included 38 items related to progress on modernization activities and initiatives of the aging network and its role in long-term care. A factor analysis of these items revealed four dimensions of progress: organizational capacity for modernization, involvement in consumer direction, development of systems for providing services to private pay consumers, and degree of involvement in outreach and business strategy. Scores for each of these dimensions were developed using a collapsed three-category response set: (1) Have this in place or are currently working on it ("actively involved"); (2) Plan to work on it but have not begun ("planning"); (3) Do not plan to work on it or would like to work on it but cannot ("no plans"). Responses to items within each dimension were summed to yield a progress score for each of the four dimensions. As

shown in Table 2, scores suggest that the network has already made significant progress on activities related to consumer direction and enhanced organizational capacity. The first dimension includes activities that involve consumers in the design and direction of their services. The second dimension captures improvements and innovations that support the agency's efforts to effectively provide OAA and community-based long-term care services.

The aging network has made less progress on reaching a private pay market and conducting business planning. Very few area agencies have private pay policies and procedures in place, though a relatively high percentage report that they are working on these issues. Outreach and business strategy—marketing, expanding services and types of clients served, and fundraising and resource development—is another area of potential growth for the network. In conjunction with AoA, n4a is seeking to support area agencies in their business planning with a series of workshops for the agencies that indicated they plan to, but have not yet begun, to make progress in this arena.

Table 2 Modernization of the Aging Network

Dimension	Standardized progress score
Organizational Capacity Items include: Electronically maintaining information about providers, clients, clients services, and client health information; acquiring board/governance support for home and community-based service provision; and conducting a needs assessment in area.	87.5
Private Pay Items include: developing policies and procedures to serve private-pay/insurance clients/cost-share clients; providing services to private-pay clients; and building billing systems for private-pay clients.	65.8
Consumer Direction Items include: Assisting consumers in managing their own workers; assisting consumers in directing their own services; asking consumers about their service preferences; and assessing consumer satisfaction with their services.	87.5
Outreach and Business Planning Items include: Expanding the types of services offered or groups served; marketing to attract long-term care clients; developing relationships with universities or research centers to evaluate programs and activities; seeking and obtaining grants; and fundraising and development.	76.9

These cross-sectional data illustrate the current status of the network. Because the survey is conducted annually, we will be able to track change and effectively measure progress within the aging network. For example, we will be able to report on the number of agencies that move from a planning stage to some degree of action, those who move from "no plans" to "planning," and those who move from "planning" to "actively involved." With repeated years of measurement, we can track the degree and pace of modernization in various dimensions of the aging network.

In addition to addressing progress, the survey also asks about barriers, fiscal threats and challenges faced by AAAs in their current operating environments. Data on several of these items are especially useful as part of the picture of where the network stands, and the issues it will have to tackle as it moves ahead.

Figure 2 shows that the majority of area agencies face financial pressures in the form of expenses that outpace revenues and in competition for maintaining revenue streams. Over 60 percent of area agencies reported that their state limits their role in the long-term care system. In many cases, this response is a factual report of the reality; in other cases, this may reflect an agency's implicit concern that a state views the appropriate role of the aging network as more limited than it is currently. Clearly, this item requires further exploration; it is not clear exactly why respondents gave their responses, nor is it clear whom the respondents had in mind as "our state." The section below addresses other aspects of the complex state-AAA relationship that need further analysis.

A Crossroads: Moving Ahead Together

While the survey provides convincing evidence that the aging network is well-positioned for an expanded role in long-term care, there are some challenging discussions ahead: what is and should be the nature of the relationships between states and their AAAs?; and how much variability within and across states—a major characteristic of the network at this time—is the right amount? Further research, and more importantly, collaborative discussions about the impact of this variability and the appropriate, effective, efficient, and desired level of variability will be crucial during this stage of transformation. Variability reflects important goals of local autonomy and responsiveness,

but too much variability might impede the ability of the entire network to move ahead as a player in long-term care system reform. State level information needs to be combined with the area agency data to get a better picture of the operations of the aging network. A final aspect covered in the AAA survey—the area served by the organization—is instructive because it illustrates complex questions about necessary and appropriate degrees of variability in the aging network. The survey question asked AAAs to identify whether the area they serve is predominantly rural, urban, suburban, or mixed. Among all AAAs in the country close to half (49.5%) serve predominantly rural areas with 37 percent serving a mix of urban, suburban and rural areas. Data aggregated at the state level, however, show that states vary on the populations they serve (adding to the opportunities and/or challenges they face in service delivery). For example, some states such as Indiana, Iowa, Oregon, and South Carolina reflect the characteristics of the nation, with predominantly rural areas being served by the highest proportion of AAAs in the state, followed closely by mixed areas. States such as Massachusetts and New Jersey have the highest proportion of AAAs serving predominantly suburban areas (52.4% and 43.8% respectively) and states such as Georgia, Idaho, Montana and Oklahoma have over 75 percent of AAAs in the state serving predominantly rural areas. All of the AAAs in Connecticut serve mixed geographic areas.

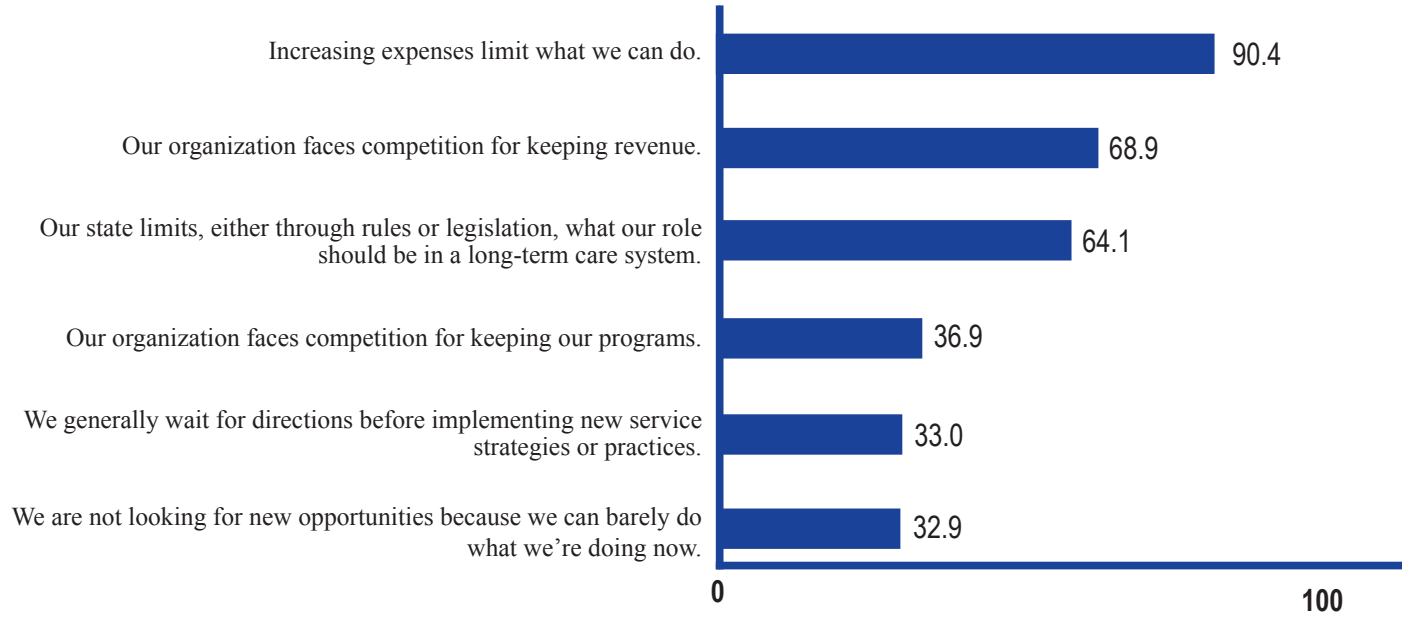
Add to this the complexity of the ways that aging service delivery systems are uniquely structured in each state, and the challenge of sorting out the aging network becomes daunting. For example, the Massachusetts system is structured around Aging Service Access Points that are sometimes but not always connected to area agencies on aging, and local councils on aging that provide some administrative and direct service functions; New York has a single county-based area agency system, except in New York City which has an area agency that encompasses five counties. Understanding these structures and the roles played by the aging network within the aging and long-term care services systems is essential as the network develops strategies for modernizing its long-term care position.

Beyond understanding the diversity across and within states, it is essential to establish common ground and a shared agenda for the entire aging network. The potential for a unifying agenda is well-exemplified by Project 2020.

Project 2020: Transforming the Role of the Aging Network in Long-term Care

In the Spring of 2008, n4a and the National Association of State Units on Aging (NASUA) collaborated to develop and advocate for Project 2020: Building on the Promise of Home and Community-Based Services. The goal of Project 2020 is to "provide the resources to implement consumer-

Figure 2 Challenges
(Percent who agree or strongly agree with the following statements)



centered and cost-effective long-term care strategies authorized in the 2006 reauthorization of the Older Americans Act" (National Association of State Units on Aging (NASUA) and the National Association of Area Agencies on Aging (n4a), 2008, p. 1) through three program areas: Person-Centered Access to Information, Evidence-Based Disease Prevention and Health Promotion, and Enhanced Nursing Home Diversion Services.

The programmatic features of Project 2020 are significant, including the degree of collaboration between two national constituency organizations (n4a and NASUA) across federal agencies and across all levels of the aging network. Its focus on long-term care for people of all ages, not just older people, is a very significant statement about the evolving role of the aging network in long-term care. Project 2020 is also remarkable for the fact that it proposes to deliver programs funded by the discretionary side of the federal budget in order to achieve savings on the mandatory side of the budget. A network organized around a non-Medicaid, non-entitlement program is taking a central role in saving Medicare and Medicaid dollars.

Initial estimates by n4a and NASUA predict that "the program has the potential to reach over 40 million Americans and will reduce federal Medicaid and Medicare costs by approximately $2.7 billion over the first five years of the initial investment requested, resulting in a net savings to the federal government of over $300 million." (NASUA and n4a, 2008, p. 3). The cost offset calculations, and the methodology by which they are derived, are available on the n4a and NASUA websites, as is a "cost offset calculator" for each state, based on their current client populations, programs and expenditures and projections assuming involvement in 2020 initiatives.

Conclusions

The aging network is undergoing perhaps the most significant transformations in its history. These changes are built upon the unique strengths of the aging network, expanding the reach of the network in terms of services and clients, and strengthening the position of the network in long-term care systems through strategic partnerships and collaborations. "Aging services network agencies have evolved from planning and coordination entities to managers of multiple sources of funds. The ability of the infrastructure to adapt to changing demands in aging programs has led to added responsibilities and resources for state and area agencies over time. Policymakers may want to consider other ways to build on the aging service network." (O'Shaughnessy, 2008: p. 26-27)

An excellent example of a new collaboration that acknowledges and at the same time strengthens the role of the aging network in long-term care is the partnership with the Veterans Administration (VA). In late September of 2008, representatives of the VA and the Administration on Aging announced grants to support collaboration between the aging network to work with the VA in provision of home and community based long-term care services, including consumer-directed options. There is no doubt that this is an exciting, challenging time of transformation in the aging network. To claim its place in a reforming long-term care system, the aging network is taking stock of its current situation, tracking progress, identifying ongoing challenges, and facilitating conversations and collaborations across all levels of the network and with federal, state, and local partners.

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The Aging Network: State of the States

Richard Browdie
Melissa Castora

The Aging Network today is composed of many agencies, all with vital roles in the care of our nation's aging population. The Administration on Aging, the State Units on Aging, the Area Agencies on Aging, and the thousands of provider organizations and advocacy groups throughout the country make up the Aging Network. The backbone of the Aging Network, the Administration on Aging (AoA), was created under the Older Americans Act in 1965 (United States Department of Health and Human Services, 2003); each state (and the District of Columbia) was asked to establish a State Unit on Aging (SUA). After a period of research and demonstration, the Comprehensive Services Amendments of 1973 established the Area Agencies on Aging (AAA) that operate in 43 states under the oversight of the State Unit on Aging. Together the SUAs and AAAs provide and manage services and advocate on behalf of the nation's elders, focusing on the interests of older adults in their own communities.

Variability in Institutions and Leadership

The fact that AoA and its SUA and AAA partners have been in existence for nearly 40 years creates an impression of great stability. Indeed, a strong sense of shared mission has endured. The structure and environment in which the Aging Network functions, however, has been under constant change since its establishment. One major reason for this constant state of change is the Network's design to reflect and respond to the features and needs of the communities it serves. No two communities are identical and each evolves differently, thereby producing a wide array of variation. Another reason for change in the Aging Network is the nature of state-level gubernatorial elections and cabinet changes. Given the hierarchical nature of government systems, a change at the state level can have a very powerful effect (whether positive or negative) upon the Aging Network within a state. Because cabinet level officers at the state level tend to change even more frequently than governors do, state organizational structure and organizational mission and responsibility are virtually always changing. The continual change in community needs and demographics, in combination with evolving state government, shifts the activities and responsibilities delegated to the local elements of the Network, most notably the AAAs.

The differing interpretations of the Network's mission across the states, coupled with their widely differing assigned responsibilities, availability of funding, and the actors involved in the Network have created Networks that in some states lack the capacities central to the development and management of home and community based services (HCBS) systems. Other states' Networks, on the other hand, are essential to executing these functions. A select number of states and communities have exemplary and comprehensive systems for long term care that offer a full range of cost effective service options to respond to a wide range of personal preferences within the communities they serve, while other states and communities have made little progress at all.

The Aging Network now strives to *rebalance*—shifting resources from institutional toward community-based care—long term care options reflecting the realities of population aging, limited state budgets, and the preferences of virtually all Americans for remaining in the community. Historically, federal policy has had an institutional bias; prior to the 1981 establishment of 1915(b) and 1915(c) Medicaid Waivers, formally supported long term care options through Medicaid were limited to institutional settings (Kaiser Family Foundation, n.d.; Research and Training Center on Community Living Institute on Community Integration/UCEDD, 2008). Therefore, the long term care environment was built around institutionalizing those individuals who were in need of such care. This population was and primarily still is comprised of the aged, the physically and mentally disabled, and those with mental retardation and developmental disabilities.

Isolated efforts to develop alternatives to institutionalization began in the 1970s. Since the advent of Medicaid waivers in 1981, there have been widening efforts to create more options for those in need of long term care. Both Medicaid eligible and non-Medicaid eligible individuals have had access to a steady increase in HCBS available to serve them in the community rather than in an institutional setting (Research and Training Center on Community Living Institute on Community Integration/UCEDD, 2008). Not only do many prefer to be served in the

community rather than in an institutional setting (Kaiser Family Foundation, 2001; Mattimore, Wenger, Desbiens, Teno, Hamel, Liu, et al., 1997), but home and community based options [debatably] save the state and federal governments money. Therefore, a strong wave of initiatives to create a system of stability for HCBS has been building over the last two decades.

The Need to Rebalance Long-Term Care

The need for this continuing effort to rebalance the long term care system is crucial in the current state of changing demographics and economic conditions. We even have witnessed political leaders becoming aware of these real demographic changes (call it "the graying of America," or the "Age Wave") that threaten to "swamp" existing long term care systems, and along with them, the taxpayers' ability and willingness to bear the costs of unimproved, inefficient systems.

To be certain, recent years have seen tremendous efforts by federal agencies to make progress towards a more balanced long term care system, including an unprecedented level of collaboration between the Centers for Medicare and Medicaid Services (CMS), the office of the Assistant Secretary for Planning and Evaluation (ASPE) and the Administration on Aging (AoA). Since 2001, the Centers for Medicare and Medicaid Services have awarded 332 grants, an approximate amount of $270 million, to all 50 states and 2 territories in order to build the infrastructure necessary for individuals to live in the community for life (U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, 2008). This effort, known as the Real Choice Systems Change Grants, supported four efforts: efforts to improve existing services and supports; efforts to create new services and supports; efforts to design, implement, and maintain systems and processes that enable services; and lastly, efforts to improve, recruit, train, and retain the direct service workforce.

Additional efforts include the New Freedom Initiative which, as it pertains to this article, modified policies that enable HCBS Medicaid Waivers to cover one-time costs for individuals transitioning to community living (e.g., security deposits on apartments and utility set-up fees), which led in turn to the Money Follows the Person Demonstration, noted below. The Deficit Reduction Act of 2005 furthered the effort to serve individuals in need of long term care within the community by adding the option for states to offer HCBS under the state Medicaid plan. This enables states to develop different functional eligibility criteria for HCBS, thus making it easier to qualify for community based care. Additionally, the rebalancing efforts of AoA, CMS, and ASPE include Money Follows the Person (CMS), Cash and Counseling (CMS), Aging and Disabilities Resource Centers (AoA/CMS), Evidence Based Health, Wellness and Prevention programs (AoA), Nursing Home Diversion grants (AoA), and Alzheimer's Disease Development Grants to States (AoA).

The impact of these initiatives on the State Units on Aging and the Area Agencies on Aging in many states has been, in many cases, profound. The Aging Network has been critically important to these efforts, especially as applied to services for elders and adults with physical disabilities. While data to document how critical their role has become is not available, it is without doubt that the Aging Network plays the central—or a critically important—role in states' rebalancing efforts.

The Challenge of "Lifting the Floor"

All of these efforts and initiatives were and are meant to encourage and support state efforts to develop and grow HCBS strategies that address the historic institutional bias in public long term care systems and to rebalance the long term care systems being managed by states. Although these (among other) efforts and initiatives have made a significant impact on the long term care system, one could argue that there has been an absence of a national effort to "lift the floor." In other words, those states and communities that have exemplary systems already in place continue to progress toward this mission of a balanced long term care system, while those states and communities that are lagging are left behind. Without a national effort that sets minimum expectations and offers adequate technical assistance and guidance to meet these standards, there is little reason to expect that a balanced long term care system will evolve systematically and nationally across all 56 states and territories.

In 2006, the Reauthorization of the Older Americans Act was the first piece of national legislation to place an affirmative policy responsibility on a federal agency to do something about the rising costs of long term care and to pursue rebalancing (Administration on Aging, n.d.). These provisions actually charge the Administration on Aging and the Aging Network with the following: 1) to develop a national network of long-term care information systems for Older Americans and their families; 2) to develop a national clearinghouse of evidence based programs that engage and empower older people

to use effective management strategies for chronic conditions and to avoid preventable adverse events; and 3) to develop a national program of services for people with long term care needs--*before* they exhaust their resources and become Medicaid eligible--who wish to remain in the community .

Additionally, recent developments that may lead to significant systematic national progress include an effort sponsored by an alliance between the National Association of State Units on Aging and the National Association of Area Agencies on Aging that is expected to result in a formal legislative proposal before the publication of this article (National Association of Area Agencies on Aging, 2008). The legislation would encourage the identification of cost effective strategies to make operational the long term care provisions contained in the 2006 reauthorization of the Older Americans Act, and would assure effective coordination of these new efforts with the development that has been done to date. While details are under negotiation and subject to the challenges and debate of the legislative process, the development effort will ideally establish criteria that state systems will have to meet, while giving states and their Aging Networks as much latitude as possible when designing their efforts to meet them. This kind of flexibility is needed to respond to the great diversity in states' and their Networks' evolution over the years. At the same time, the establishment of standards, even if articulated as minimum requirements, would constitute a major breakthrough in the history of long term care in this country.

Realistically, states differ in their preparedness to undertake the rebalancing of HCBS systems, both politically and bureaucratically. There are great state-by-state differences in the respective roles of SUAs and AAAs in HCBS management strategies. As a result, any description of the evolution or the current state of the Aging Network regarding HCBS from 1965 to date could reasonably have at least 50 chapters, and each would need to have at least two sections, since the state and local realities are usually very different. Moreover, depending on which state is being considered, the state Medicaid agencies play widely different roles in long term care, further compounding the state-by-state variation.[1]

Toward a Truly National Network

Significant amounts of variation and change don't mean that the Network isn't largely cohesive. As noted, amidst tremendous variation in practice methods and resources, the Aging Network in each state remains a vital source of implementing widespread, federally initiated change. For example, the Administration on Aging was able to mount and coordinate an extremely effective effort to help CMS with the challenges they faced in implementing Medicare Part D (Administration on Aging, 2005). Notably, this was accomplished despite the fact the there was very little money, time, effective advanced planning, and consumer support. Even with obvious disparateness, the Aging Network had enough interconnection and shared sense of purpose to convert its various and separate local connections into an asset when it came to implementing a complicated and perplexing national policy (Administration on Aging, 2007).

For over the more than forty years of its existence, the Aging Network has earned the confidence of older people, their families and public officials in communities all across the country. The looming "crisis" in long term care must be responded to appropriately, and it will be most effectively done if it builds on the productive partnerships and relationships that the Network has established. The leaders of the Network must keep in mind that some areas are in need of more "catching up" than others, and policy needs to develop some sort of minimum standard. It is certain that any passage of legislation that would bring to life the Long Term Care Provisions of the Older Americans Act would have an effect on the Aging Network unlike anything since the 1973 amendments. In our increasingly mobile and diverse society, only a national network will be able to accomplish national goals through locally adapted means. In fact, a national network is crucial in giving Americans the confidence in "the system" to provide access to affordable and attractive long term care options even if their family is not at hand to be their advocate. That was the promise of the Older Americans Act, and that is what America can do to make the public and private costs more affordable and sustainable for our aging society.

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Endnote

1. There are efforts underway, funded by the Administration on Aging, to develop a more comprehensive information source on the status of the Aging Network, the availability of HCBS, and the operating mechanisms for HCBS options across the country.

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Toward Inclusion: A Public-Centered Approach to Promote Civic Engagement by the Elderly

Jeffrey Kahana
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Public policy initiatives can enhance civic engagement in late life (Gomperts, 2006). Many seniors posses altruistic values (Logan and Spitze, 1995) and desire to participate in socially valued activities (Civic Ventures, 2005). Educated, affluent and active seniors are thus "well positioned to make major contributions to the civic engagement enterprise" (Hudson, 2006, p. 51). But because many older adults lack the independence, physical ability or resources required to be actively engaged, these individuals are unable to derive the social, psychological and health benefits associated with civic participation (Thoits and Hewitt, 2001), and similarly, society cannot benefit from their contributions (Hinterlong and Williamson, 2006; McBride, 2006). Public policies that minimize the economic and health related barriers to civic participation (Verba, Schlozman and Brady, 1995) can benefit a diverse population of seniors and help mobilize the full resources of our aged population to help reinvigorate America's public life (Freedman, 2002; Gomperts, 2006).

This paper recommends a three-pronged approach to advancing such public policies. First, it identifies the "public centered" responsibility for promoting civic engagement. Second, it provides a more expansive definition of civic engagement which includes frail and disadvantaged seniors. Third, it places responsibility for such services on Area Agencies on Aging (AAAs), reflecting the 2006 reauthorization of the Older Americans Act (OAA) and the existing legislative directives in Title III. Implementation of such policies can be facilitated through "organizational innovation" within the current framework of the OAA.

Gerontologists, government officials and leaders of non-profit organizations have recently made civic engagement for seniors a top priority. In the journal *Generations* (2006-2007) numerous aspects of civic engagement in later life are explored. In *Civic Engagement and the Baby Boomer Generation*, Wilson and Simson (2006) outline the current civic engagement initiatives of a variety of government and non-profit organizations. These initiatives come on the heels of the 2005 White House Conference on Aging, whose recommendations for civic engagement found some expression in the 2006 reauthorization of the Older Americans Act. Notwithstanding this attention, the aging network has made little progress in developing and implementing programming for civic engagement.

Recent research based on data from nationally representative samples (Cornwell, Laumann, and Schumm, 2008) has called attention to the challenges of maintaining social networks in late life, finding that "the oldest have smaller social networks, they are less close to network members, and they have fewer non-primary group ties than do younger adults" (p. 200). Nevertheless, evidence from this study also supports the adaptability of older persons and their desire to be socially engaged; older adults maintain greater frequency of interactions with neighbors and religious and volunteer participation. These findings further underscore the potential value of public initiatives to promote civic engagement in late life.

Given the established value of civic engagement for seniors and society at-large, a major criticism of the civic engagement movement remains its exclusion of the poor and vulnerable elderly (Barnes, 2004). Such exclusion may in part be due to the current private-centered and voluntaristic framing of civic engagement activities. The focus of private civic engagement initiatives is on the well elderly and those with transportation and financial resources that enable them to participate in volunteer and national service activities (O'Neill, 2006-2007). It is timely, therefore, to take a *de novo* look at the subject, with particular attention to ensuring that public policies are fair, inclusive, and can be implemented within the existing structure of the OAA.

Public Responsibility for Civic Engagement

Civic engagement in the United States has traditionally relied on voluntarism and private associational activity (Achenbaum, 2006; Putnam, 2000). Such civic participation, however, is not possible for many elderly without public support and assistance. Those with diminished social and physical resources (e.g., mobility limitations) need assistance to engage in social and political action (McBride, 2006). A public-centered approach to civic engagement has the benefit of moving the discussion beyond the pure voluntarism that underlies much of the civic engagement literature (Rotolo and Wilson, 2004) and

which has been criticized as symptomatic of a larger "risk shift" from public to private solutions (Hacker, 2007; Martinson, 2006).

Promoting civic engagement should thus be viewed as a community responsibility rather than a selective virtue assigned to a sub-group of seniors who are cast as the "new trustees of civic life in this country" (Freedman, 1999, p. 19; See also Estes, 2001). A public centered approach to civic engagement does not minimize the importance of volunteer and service initiatives that have been heralded by scholars and leaders of government and the non-profit sector (Wilson and Simson, 2006). Yet it recognizes the diversity of the aged community in terms of ability and resources that can be independently directed toward civic engagement activities (Martinson and Minkler, 2006). To include seniors who are disadvantaged and vulnerable in civic engagement activities, society—with some assistance from the AAAs—will as Lyndon Johnson hoped "find greater uses for the skills and the wisdom and the experience that is found in the maturity of our older citizens" (Woolley and Peters).

Attention is accordingly directed to AAAs as entities within the aging network with the capacity to expand the concept of civic engagement and to reach a diverse senior population. A search for creative programming to address the needs of diverse elders and their caregivers has been encouraged through recent legislation, in particular the reauthorization of the OAA as Public Law 109-365. This legislation calls for greater coordination between state and local agencies in community planning. It also urges innovation and entrepreneurship through use of technology-based service models. The goal is to use federal funds as a catalyst in bringing together public and private resources to allow for more flexible and creative programming. This could benefit the broadest range of seniors, including the physically impaired and economically disadvantaged.

Even with these provisions, the current mainstay of AAA programming is focused on needed health and homecare services to the frail elderly and support to their caregivers. Few AAAs offer services to promote social activities that they view as "discretionary" (Verbrugge 1990). The current focus of AAAs on provision of "obligatory" services is reflected in the results of "a national survey of health and supportive services in the aging network," undertaken by The National Council on the Aging (2001). Findings of the survey revealed that few programs facilitated access to community participation or to non-medically related social activities.

This primary focus on obligatory health and safety related services is understandable, given community need and federal financing mechanisms. Under the Older Americans Act, federal funds may only be used for limited services, targeting basic needs of older adults ranging from nutrition to home care and abuse prevention (OAA, 1321.63 (a) 1-9). Nevertheless, AAAs are encouraged to develop a wide range of programs, including those that support social and civic engagement activities for seniors. They need to secure additional resources from the state and/or private organizations to fund these initiatives. Through creative initiatives and organizational innovation, AAAs can offer such services according to the original principles of the Older Americans Act. That legislation envisioned "pursuit [by seniors] of meaningful activity within the widest range of civic, cultural, and recreational opportunities" (Older Americans Act, 1965, sec. 101 (7)).

Toward Fostering Civic Engagement by AAAs

Although many scholars have associated civic engagement in late life with volunteering and with service based activities (Morrow Howell, 2006), civic engagement also occurs when seniors are socially, politically, economically and religiously engaged (Putnam, 2000). Facilitating activities in which seniors informally convene for refreshments and general discussions or in which they are afforded opportunities to participate in cultural and religious events also promotes civic engagement (Idler, 2006). We thus adopt an inclusive definition of civic engagement, which can be furthered when AAAs offer services promoting social and civic participation. Such an inclusive definition is also recognized by the Older Americans Act (1965, sec. 101 (10)) which seeks to promote the "inherent dignity of the individual" by encouraging "freedom, independence and the free exercise of individual initiative."

AAAs are especially well situated to foster civic participation and social capital building activities among the disadvantaged elderly. They already tend to serve those elderly with "the greatest needs," with most of their clients characterized as "low income and/or over age 75." They are also successful in reaching minorities and those older adults who live in rural areas (National Council on the Aging, 2001, p. 6). The ability of AAAs to reach these diverse clients allows them to foster an inclusive approach to civic engagement and to strengthen senior social networks. The institutional framework of AAAs may further enable them to facilitate civic engagement in ways

that parallel the opportunities provided by schools and in the workplace for younger adults. The AAAs, however, have the advantage of working with an older generation that is already accustomed to volunteering, and may only need some modest additional help in order to access volunteer opportunities (Karner, 2001). Similarly, older adults are motivated to participate in associational networks and religious activities (Cornwell et al., 2008).

As we envision specific contributions for the aging network and for AAAs in promoting civic engagement, we note that steps have already been taken at the 2005 White House Conference on Aging (WHCA) to recognize promoting civic engagement among the elderly as an important national goal. Five resolutions had been put forth at this meeting to promote civic and social engagement. Three broad resolutions—advocating greater use of public libraries, promoting lifelong learning and literacy, and cultural and arts participation—were not actually adopted. However, two resolutions calling for new and meaningful activities and for reauthorization of the National Community Service Act to expand volunteering and civic engagement were included in the top fifty resolutions recommended for implementation (Morrow-Howell, 2006).

The following represent specific avenues through which AAAs can foster civic engagement: (1) creating databases for volunteer opportunities in the community; (2) disseminating home based volunteer opportunities; (3) offering computer training to seniors; and (4) providing transportation to community based learning, social and volunteer programs. The above examples of AAA programming represent varying degrees of organizational innovation, and many may be accomplished without high costs.

Some of these examples include creative use of existing transportation programs to take seniors to libraries and to educational programs. There are a multitude of free college programs which are open to older adults throughout the country at both public and private universities (Wilson and Simson, 2006). Innovative transportation services could facilitate greater access to these existing educational opportunities. Connecting older adults with educational programs can be complemented by reassessing the role of senior centers to embrace social participation and encourage civic engagement. Popular dance programs and culturally appealing meals that draw a broad cross-section of the local community to events can be combined with opportunities for older adults to learn more about existing volunteer programs, especially those that are specifically designed for the elderly (RSVP, the Foster Grandparents Program, and the Senior Companion Program).

AAAs can also provide direct educational services and skills training programs to promote civic engagement (Apps, 1994). "E-training" programs utilize technology to open new vistas for engagement with family and other significant members of one's social network, including physicians. Teaching older adults to use word processing and internet navigation systems can empower them to remain, and even become contributing members of society. Many opportunities exist for e-literate older adults to engage in paid work, volunteer activities and to provide informal help to others from the safety and comfort of their homes (Pew and Van Hamel, 2003).

The ability of AAAs to develop programs that support these expanded services can lead to improved well-being for seniors and to a general strengthening of civic society. As Neal Krause observes "people with strong social ties tend to enjoy better physical and mental health" (Krause, 2006, p. 181), and the involvement of AAAs in promoting such ties represents the type of intervention that can illuminate how health and well-being are improved by supporting social relationships. In particular, these interventions will likely involve the formation of new social relationships whose effects on the individual and society can be studied. Such programming can also provide a foundation from which to ascertain whether senior civic participation can help reverse more general trends of social disengagement (Putnam, 2000).

The Older Americans Act and Organizational Innovation by AAAs

The mandate of AAAs in Title III of the OAA explicitly calls for comprehensive, inclusive and innovative service delivery that fits with the policy of "organizational innovation" that we advocate. To appreciate the scope of this mandate it is useful to review some of the significant provisions of the OAA which provide the federal funds, legal authority and policy directives for AAAs. These agencies, however, are under the authority of the State Agency on Aging which is responsible for "designating" and monitoring Area Agencies within the state. Federal funds made available to states under the OAA are focused on "older individuals with the greatest economic or social need," and aim to serve as a "catalyst in bringing together public and private resources in the community" (OAA, Sec. 1321.1-7).

The mission of the AAAs under the OAA

includes "advocacy, planning, coordination, inter-agency linkages" that result in "community based systems […] designed to assist older persons in leading independent, meaningful and dignified lives in their own homes and communities as long as possible." AAA's are given wide latitude in developing these community based systems and are encouraged to engage in practices that can be viewed as innovative (OAA, 1965, 1321.53(a)).

AAAs are advised to pursue public and private partnerships to generate resources. They are also expected to engage in "collaborative decision-making," and to include an array of stakeholders from "public, private, voluntary, religious and fraternal organizations and older people in the community." A broad range of programs are also envisioned that include information dissemination, interagency referrals, and specially designed interventions targeted at maintaining the independence of "the most vulnerable older persons" (OAA, 1965, 1321.53 (b) 1-10). Use of federal funds, however, is limited to specific categories of services that generally do not include social, political or educational activities of the type that further civic engagement. Federal funds are typically used for such basic needs as nutrition, safety, and health maintenance (OAA, 1321.63 (a) 1-9).

To promote services that foster civic engagement will require a policy change that includes organizational innovation by agency leaders (Kimberly and Evanisko, 1981). Such innovation can expand programming through creative resource development based on the public/private partnerships encouraged by the OAA. These agency leaders are also expected to be "public advocates;" in this capacity the OAA envisions that they will raise public awareness of the needs of older individuals and establish collaborative relationships with public and private organizations to expand the range of services available to seniors.

Despite the appeal of innovative services, barriers exist to organizational innovation that can facilitate civic engagement by diverse seniors. These barriers include limited resources, competing service priorities, and beliefs that deter the introduction of new and future-oriented services (O'Shaughnessy, 2008). Yet, some AAA directors are able to provide services that promote civic engagement even with limited resources (National Council on the Aging, 2001). Some have applied for private grants to support these services, and others have worked in public-private partnerships to do so (Agranoff, 1991). Such initiatives to develop fiscal resources in addition to allocating funds to preventive programs are needed to further objectives of civic engagement by disadvantaged elderly (Gardner, 1996).

Commitment by leaders can facilitate civic engagement, even in resource limited environments. The absence of such commitment can serve as a barrier to civic engagement, even in a resource rich environment. Organizational leaders, such as AAA directors, are required to make strategic choices about services being offered. Provision of preventive services requires that directors believe in the value of such discretionary programs for the elderly, and make choices to pursue these programs, notwithstanding limited resources.

Conclusion

Much of service delivery to the aged is restricted to those elderly who are unable to perform activities of daily living (Clair, 1990). This policy framework runs counter to recent research in aging that shows disability to be a more complex phenomenon (Verbrugge, 1990). For instance, an inability to participate in social relationships, recreation and religious activities can be viewed as part of a broader definition of disability (Gibson, 2003). Accepting such a perspective challenges policy-makers to move beyond medically oriented services. It requires that services be provided to maintain meaningful activities and social relationships and to serve a preventive function in health maintenance (Rakowski and Clark, 2002) for both disabled and able-bodied elderly.

The decision by agency directors to promote "discretionary" activities is a first step to bringing the frail and marginalized elderly back into the domain of civil society. Without support, no amount of desire on the part of the elderly to "participate" can make up for not having "wheels" to go to church, volunteer, vote or to play a role in the vast associational network that links individuals to each other and to the state. But while such a focus may place additional demands on social resources, there is also much to be gained by society from including older individuals (Skocpol and Fiorina, 1999). Indeed, their inclusion can benefit younger generations with less experience and more apathy to the requirements of citizenship than those elderly who have participated so fully in the past, but who are unable to continue to do so without some forms of assistance.

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