

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

*Suzanne R. Kunkel
Abbe Lackmeyer*

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

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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.

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 skew. 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

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

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.

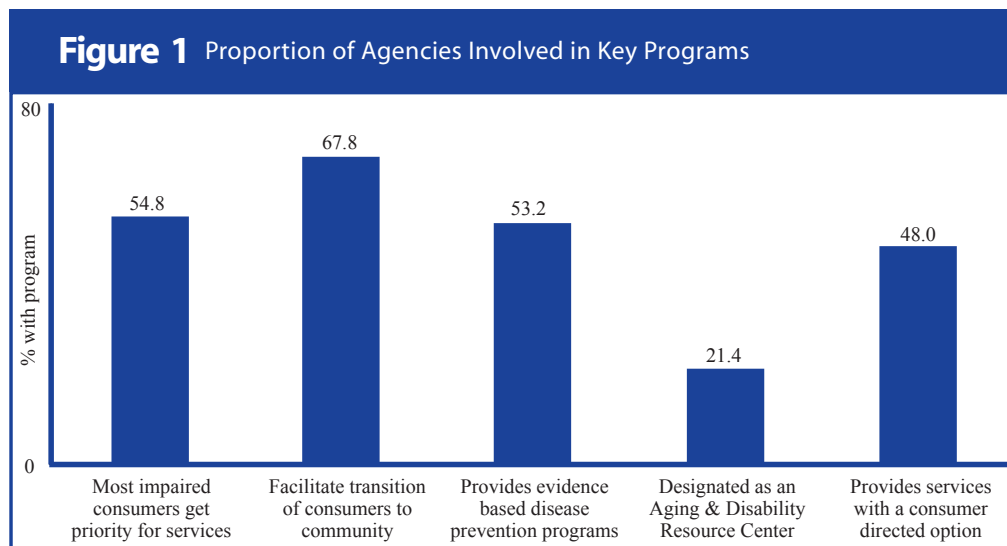
In addition, a number of AAAs are involved in innovative programming related to long-term care, including nursing home transitions, Aging and Disability Resource Centers, evidence-based health promotion programming, initiatives to streamline access; and consumer direction. Figure 1 shows the proportion 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

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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.

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,

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

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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.

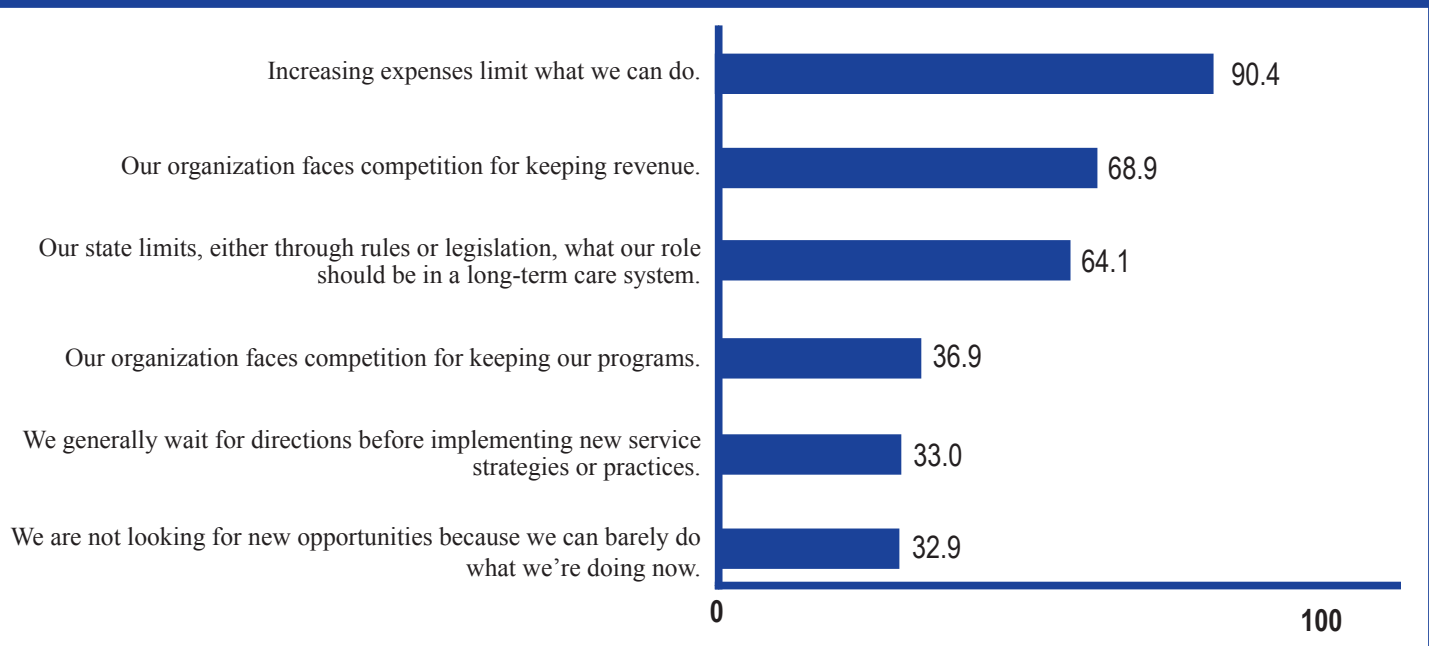
Add to this the complexity of the ways that aging service delivery systems are uniquely structured in each state, and the challenge of sorting out the aging network becomes daunting. For example, the Massachusetts system is structured around Aging Service Access Points that are sometimes but not always 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.

Susanne R. Kunkel, PhD, is the director of the Scripps Gerontology Center, and is a professor of sociology and gerontology at Miami University in Oxford, Ohio. Abbe Lackmeyer is a research associate at the Scripps Gerontology Center at Miami University in Oxford, Ohio.

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