CALIFORNIA DEPARTMENT OF AGING | CA 2030 | PROMISING PRACTICES REPORT | SEPTEMBER 2023

This report offers the CA 2030 stakeholders ideas for a future-ready CA Aging Network by showcasing promising practices in designing, planning, and implementing programs and systems. Practices are sourced from aging services policies and practices and some non-aging services policies and practices from outside of California. We define promising practices as policies, standards, models, and/or activities designed, planned, and/or implemented to solve a system's external and/or internal challenges. Not all practices featured in this report may apply to California. Research methods involved desk research and key informant interviews. The promising practices are organized by the six focus areas of the CA 2030 initiative:

1. GOVERNANCE

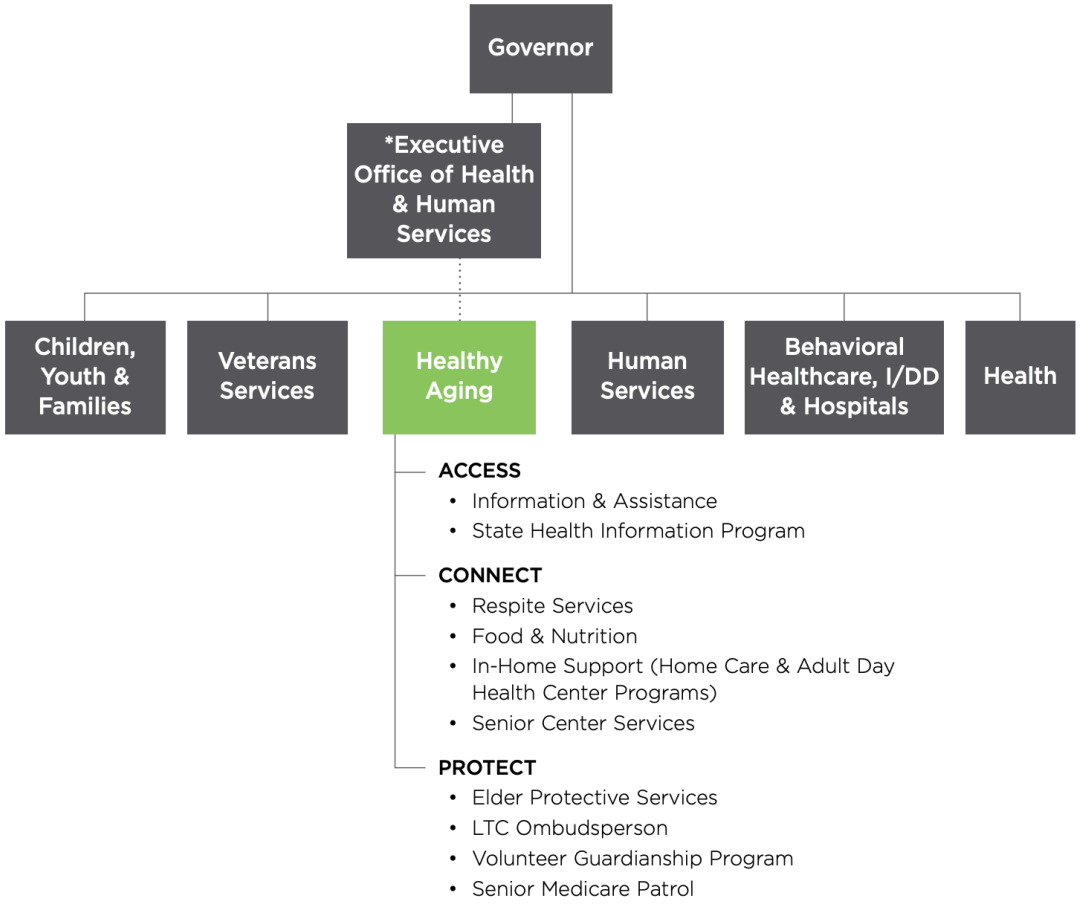
State Units on Aging (SUAs) reside in different places within state systems. SUAs are situated in various state-level entities, including departments that report to Governors (such as **New York, Illinois, Ohio,** and **Pennsylvania**), part of a state's public health department (such as **Wisconsin and Missouri**), or part of larger health and human services departments or executive offices (such as **Colorado, Georgia,** and **Maine**). Many SUAs operate parallel to their state Medicaid agencies under the same departmental umbrella, including **Arkansas** and **Delaware.** Some states have combined the coordination and oversight of aging and disability programs under one agency, such as **Connecticut**, **Kansas**, and **Oregon**.[1] Each of these structures has unique strengths:

SUA Orientations in State Government	Strengths
Independent department / reports to Governor	• Less bureaucracy / more efficiency in planning and implementation. • Greater strategic planning independence.
Part of larger health & human services dept.	• Access to state-level partners for special initiatives and programs, such as implementing integrated No Wrong Door (NWD) models.
Part of public health department	• Stronger emphasis on population health data. • Greater investment in evidence-based wellness programs.
Under the same umbrella as Medicaid agency	• Better integration of AAAs in Medicaid system. • Better AAA access to Medicaid funds.

[1] http://www.advancingstates.org/about/state-agencies/state-aging-and-disabilities-agency-profiles

Combined aging & disability oversight	• Better coordination with AAAs and Centers for Independent Living. • Stronger Aging & Disability Resource Center (ADRC) / No Wrong Door (NWD) systems.

Rhode Island's Office of Healthy Aging reports to the Governor and the Executive Office of Health & Human Services. They developed a three-part program and services-oriented framework ("Access, Connect, Protect") that communicates its mission goals and objectives:[2]



AAAs vary in organizational structure. There is no standard organizational structure for AAAs. The three types – nonprofit, government, and Council of Governments (COG) / Regional Planning and Development Agencies (RPDAs) / Joint Powers Agreements (JPAs) are nearly equally distributed across the country. However, nonprofit AAAs are less common in the Pacific West than in other regions of the US (see Appendix A for a map).[3] Some states, like **Florida**, have only nonprofit AAAs that outsource services. Other states, like **New York**, have only county government-based AAAs that provide many direct services while outsourcing other services. Many states, including **Colorado** and **Pennsylvania,** have a mix of nonprofit, government-based, and joint-government-based.

[2] http://www.advancingstates.org/sites/nasuad/files/u34008/Rhode%20Island%20State%20Profile%20April%202021.pdf
[3] https://www.usaging.org/Files/Fast%20Facts-AAA-Structure-508.pdf

State	Population (2020)	Number of Counties	Number of AAAs
AL	5,024,279	67	13 (Nonprofits, COGs/JPAs, Other)
CA	39,538,223	58	33 (Nonprofits, City/County, COGs/JPAs, Other)
CO	5,773,714	64	16 (Nonprofits, City/County, COG/JPA)
FL	21,538,187	67	11 (Nonprofits)
IL	12,812,508	102	13 (Nonprofits, City/County)
NY	20,201,249	62	59 (City / County)
OH	11,799,448	88	12 (Nonprofits, COG/JPA)
PA	13,002,689	67	52 (Nonprofits, City/County)
TX	29,145,505	254	28 (Nonprofits, City/County, COG/JPA)
WA	7,705,281	39	13 (City/County, COG/JPA)

Many states use manuals to easily communicate and update policies and procedures. Many SUAs will compile policies and procedures for federal and state-funded AAA programs and services into a single document – commonly called a *Policy & Procedure Manual* by states that include **Arizona,[4] Colorado,[5] Pennsylvania,[6] Texas,[7] and Wisconsin**.[8] Some states have developed systems and committees to routinely review, update, and communicate changes to policies and procedures. **Ohio** uses a policy management system, PowerDMS (a cloud-based policy management system), and an annual process to update policies and procedures. Policies are circulated across internal divisions and sent to AAAs for comment. **Colorado**'s SUA facilitates the Aging Policy Advisory Committee (APAC), which has representation from each of the state's AAAs and meets routinely.

States are modernizing their aging services statutes, policies, and practices to reduce administrative burdens, drive efficiencies, and promote equity. **Colorado's** modernization initiative in 2022 involved reorganizing and increasing the size of its Commission on Aging to coordinate better, implement, and inform the state's Strategic Action Plan on Aging (like a Master Plan for Aging). The state also created a new liaison position and advisory committee to work across state agencies to implement the plan.[9] The state reviewed its policies and procedures to determine which are still needed, relevant, and effective and which can be removed or updated. As part of **Iowa's** modernization effort, the state consolidated its PSAs and AAAs while instituting new statewide programs and initiatives, including a federally funded ADRC / No Wrong Door (NWD) development initiative.[10]

Some states have reduced the number of PSAs and AAAs to improve efficiencies. **Iowa's** General Assembly passed a bill in 2011 to reduce the number of AAAs due to state budget cuts and

[4] https://des.az.gov/services/aging-and-adult/partners/daas-policy-and-procedure-manual
[5] https://www.weld.gov/files/sharedassets/public/departments/human-services/documents/policy-and-procedure-manual-8-8-22.pdf
[6] https://www.aging.pa.gov/publications/policy-procedure-manual/Pages/default.aspx
[7] https://www.hhs.texas.gov/book/export/html/279146
[8] https://www.dhs.wisconsin.gov/library/collection/p-23203
[9] https://leg.colorado.gov/bills/hb22-1035
[10] http://publications.iowa.gov/21516/1/Iowa%20State%20Plan%20on%20Aging%20FFY2014-2015.pdf

changing demographics, requesting that the SUA develop a plan to reduce the number of PSAs from sixteen to five and the number of AAAs from thirteen to five (some AAAs were serving more than one PSA). The SUA held community forums and met with advocacy groups to gather input on how AAAs should consolidate. Conversations focused on the future needs of older Iowans, increasing demand for services, and priorities for building the capacity of Iowa's Aging Network. The SUA also invited the AAAs to work together on proposing a plan. Ten AAAs representing thirteen of the state's PSAs proposed the designation of five PSAs/AAAs by working through a concept to consolidate voluntarily; one PSA/AAA chose not to participate in discussions; and two PSAs/AAAs abstained as the SUA determined that their PSAs would not be changed through the plan.[11] The SUA prepared potential configurations to balance the numbers of older Iowans and funding by applying the funding formulas to each scenario before making a final decision.

Some states update PSAs and AAA designations as part of modernization processes. Iowa referred to the reduction process as an opportunity to modernize its aging network by activating structural change to accommodate programmatic advancements to the system, including:

- Building on a federal grant to establish an Aging and Disability Resource Center (ADRC) Network, each newly organized AAA hosted ADRCs / Networks throughout the state for enhanced access to information, support, and assistance.
- Integrating the state's State Health Insurance Assistance Program (SHIP) into newly formed ADRCs ensures appropriate Medicare information is available within ADRCs.
- Working with the state's Medicaid agency to ensure partnerships are in place at each ADRC for Medicaid and other state-supported programs.
- Pursuing funding sources, including self-pay opportunities, to develop and maintain the ADRC/Network system.
- Working with Iowa legislators to allow cost-sharing across Older Americans Act (OAA) programs and state funding of home and community-based services.
- Identifying efficiencies in the reporting required by AAAs to provide better data.
- Working with Iowa's universities to make Iowa an age-friendly state.

Iowa released a request for applications for organizations to pursue AAA designation in the new PSAs. Designated and redesignated AAAs were selected in 2012. A 2019 study used longitudinal service delivery data and key informant interviews to assess the consolidation results. Overall, consolidation had no detectable effect on the proportion of older adults served by AAAs. An analysis of subgroups showed that consolidation increased the proportion of older adults served in nonmetropolitan counties and those served through congregate meals. AAA staff and clients described positive and negative aspects of the consolidation, including better collaboration across agencies, improved consistency in services, financial costs of restructuring their AAAs, and challenges with serving expanded geographic areas.[12]

[11] https://www.legis.iowa.gov/docs/publications/DF/14793.pdf
[12] https://journals.sagepub.com/doi/abs/10.1177/0733464818821055

SUAs and state associations are focusing on training for their aging networks. In anticipation of new Medicaid billing and business opportunities, **Mississippi's** SUA is responsible for identifying and prioritizing the training needs of the state's aging network and contracts with universities and colleges to provide training.[13] **Alabama's** AAAs worked together to earn accreditation from the National Committee for Quality Assurance (NCQA) for case management for LTSS.[14] **Ohio's** AAAs are pursuing this accreditation to become more competitive in the Medicaid LTSS environment.[15] **Oregon** has an AAA employee handbook co-developed by the SUA and AAAs.[16] **New York** provides regular training in subjects like case management, elder abuse, healthy aging, and others for AAA staff and other providers, including family caregivers.[17] **Colorado** offers a four-day training program for new AAA directors after three months in the role and provides quarterly training for AAA staff on policy updates. The state also brings outside speakers, such as the demography office, to present on broader issues influencing AAA activities.

2. PROGRAMS AND SERVICES

States offer a set of core services. All states must provide minimum matching funds to receive federal OAA funds for programs and services. States align their funding to the OAA service categories, and many expand the allowable or required state-funded services beyond the OAA categories. AAAs provide core services in **New York**, including social isolation reduction, home modifications, case management, and ADRC functions.[18] New York AAAs also offer consumer-directed in-home services to the public.[19]

Illinois' Community Care Program was created in 1979 to prevent premature and unnecessary placement of older adults in nursing homes by providing in-home and community-based services. Services include comprehensive care coordination, adult day services, in-home care, emergency home response, and automated medication dispenser services. The program is currently operated under a Medicaid 1915(c) waiver.[20]

States offer additional services. AAAs may also provide other services to the community based on capacity or need. Nationally, AAAs administer an average of 27 services within their designated PSA directly or through contracted providers. The most common supplemental services delivered or supported by AAAs across the US are:[21]

[13] https://sos.ms.gov/ACProposed/00019111b.pdf
[14] http://www.advancingstates.org/sites/nasuad/files/RAISIN~1.PDF
[15] https://www.ncqa.org/comment-letter/ncqa-supports-acls-strategic-framework-for-action/
[16] https://www.oregon.gov/odhs/providers-partners/community-services-supports/Documents/aaa-employee-handbook-2012.pdf
[17] https://aging.ny.gov/training
[18] https://aging.ny.gov/about-new-york-state-office-aging
[19] https://aging.ny.gov/12-tam-05-implementing-consumer-directed-home-services-under-eisep-0
[20] https://ilaging.illinois.gov/programs/ccp.html
[21] https://www.usaging.org//Files/AAA-Survey-Report-new-identity-508.pdf

- Transportation
- Case management
- Benefits/health insurance counseling
- Homemaker
- Personal assistance/care
- Options counseling
- Assessment for care planning
- Elder abuse prevention
- Senior center programming
- Long-term care ombudsman services

States require AAAs to track and report consumer profile data to varying degrees. While all states pass down federal requirements stipulating that AAAs collect and report consumer demographic information (although it is optional for consumers to provide information to receive OAA-funded services), some states require a common consumer intake and assessment form. Setting minimum standard client data fields helps states measure their performance in reaching people most in need. **New York's** Comprehensive Assessment for Aging Network Community-Based Long Term Care Services (COMPASS) is a tool for collecting consumer information and developing person-centered plans.[22] Information gathered includes, but is not limited to, the following:

- Activities of Daily Living (ADLs)
- Instrumental ADLs (IADLs)
- Assistive devices
- Public benefits
- Caregiving status
- Chronic illness and or disability
- Elder abuse or neglect
- Fall risk factors
- Frail or disabled status
- Health status, medical insurance
- Home safety checklist
- Housing status
- Income
- Informal supports status
- Living arrangement
- Loneliness or isolation risk
- Medication list
- Nutrition status
- Care transitions assessments
- Psycho-social status
- Self-evacuation ability
- Tech-check
- Veteran status

Colorado's SUA requires AAAs and subcontractors to report demographic fields beyond OAA requirements, including ADL, IADL, and income data. AAAs are encouraged to collect additional information that may help them better understand and serve their consumers.[23] If AAAs attempt to understand a consumer's health-related social needs, the Centers for Medicare and Medicaid Services (CMS) standardized Screening Tool for Health-Related Social Needs could help assess the basic needs of individuals seeking services (i.e., housing, food, transportation, utilities, and safety).[24]

States are focusing on person-centered practices and customer service. The primary resource for AAAs and SUAs interested in strengthening person-centered practices is the National Center on Advancing Person-Centered Practices and Systems (NCAPPS). NCAPPS is an initiative from the Administration for Community Living (ACL) and the Centers for Medicare & Medicaid Services (CMS) that helps states, tribes, and territories implement person-centered thinking, planning, and practices in line

[22] https://aging.ny.gov/22-pi-04-pi-revised-comprehensive-assessment-aging-network-community-based-long-term-care-0
[23] https://coloradoagingwithnutrition.org/wp-content/uploads/2021/11/Frequently-Asked-Questions-10-19-21.pdf
[24] https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

with U.S. Department of Health and Human Services policy. [25] NCAPPS offers resources, programs, and initiatives, including learning collaboratives in racial equity and brain injury. NCAPPS also provided targeted technical assistance to SUAs in **Alaska**, **Delaware**, **Georgia**, **Iowa**, and **Kentucky**.[26]

Service innovations are emerging within and outside the state and in national aging networks.

- **Transportation:** The Aging Resources of Central **Iowa's** Rideshare Transportation Program offers on-demand transportation services to older adults through Uber and Lyft.[27] For seniors who don't have smartphones, are uncomfortable with technology, or can't afford the service, they access rideshare transportation by contacting a third-party call center, GoGoGrandparent.[28] The AAA screens clients for eligibility. GoGoGrandparent handles calls from consumers, arranges and monitors rides, and pays the rideshare companies. The program provides up to eight rides per month per client. An AARP grant, Title III-B, and contributions fund the program.

- **Social Isolation and Loneliness:** Identifying and evaluating loneliness can help consumers needing intervention and measure the impact of the intervention. **New York** utilizes the De Jon Gierveld Loneliness Scale in its COMPASS assessment. The Campaign to End Loneliness Measurement Tool was created to incorporate more positive language in the evaluation. There are four common loneliness measurement tools: the De Jon Gierveld Loneliness Scale, the Campaign to End Loneliness Measurement Tool, The UCLA Loneliness Scale, and the Single-Item Scales.[29]

- **Housing: Pennsylvania's Shared Housing and Resource Exchange (SHARE)** program is an affordable housing option that connects homeowners willing to share their homes with home seekers in exchange for rent and assistance with household tasks. Each arrangement is customized based on the needs and preferences of the participants. SHARE is not offered statewide.[30] **Pennsylvania** also operates the **Elder Cottage Housing Opportunity (ECHO)** project. Elder cottages are small, separate residences placed in the backyard of a caregiver. These cottages offer autonomy to older adults while providing easy access to family or friends who can assist them. The cottages are for lower-income seniors, and they pay no more than 30% of their monthly incomes to reside in the cottages. When the resident's living requirements change, the cottage will be moved to another host family's property. This program is expanding but is not yet offered statewide.[31]

- **Aging in Place: Community Aging in Place - Advancing Better Living for Elders (CAPABLE)** is a consumer-directed model developed by the Johns Hopkins School of Nursing that targets lower-income older adults.[32] The program provides an integrated team of an occupational therapist, a registered nurse, and a handy worker to incorporate durable medical equipment and home modifications into the consumer's home and change behaviors for improved health, safety, and independence. A study in **Michigan** demonstrated how the model can improve outcomes and reduce

[25] https://ncapps.acl.gov/home.html
[26] https://ncapps.acl.gov/docs/NCAPPS_Y4TASummary_508.pdf
[27] https://www.agingresources.com/aging-resources-of-central-iowa-was-an-aging-innovations-award-winner/
[28] https://gogograndparent.com/#Hero
[29] https://www.campaigntoendloneliness.org/wp-content/uploads/Loneliness-Measurement-Guidance1.pdf
[30] https://www.aging.pa.gov/aging-services/housing/Pages/SHARE.aspx
[31] https://www.media.pa.gov/pages/Aging_details.aspx?newsid=400
[32] https://nursing.jhu.edu/faculty_research/research/projects/capable/

avoidable health services utilization.[33] The U.S. Department of Housing and Urban Development (HUD) distributes grant funding for services and organizations aligning with the AAAs, including home modifications for low-income older adults.[34]

- **Behavioral Health:** The **Social Security Disability Insurance** (**SSDI**) **and Supplemental Security Income** (**SSI**) **Outreach, Access, and Recovery (SOAR)** course trains case workers to assist adults who are experiencing or at risk of homelessness and have a severe mental illness, medical impairment, and/or have a co-occurring substance use disorder to apply for the disability programs, SSDI, and SSI.[35] The **National Council for Mental Wellbeing** offers a free **Mental Health First Aid for Older Adults** certification program focusing on identifying and addressing mental health and substance use challenges among older adults. The council hosts a national directory of locations where the trainings are available.[36]

- **Nutrition:** Since the COVID-19 pandemic, Grab and Go meals have become a popular option. In **Pennsylvania**, AAAs have been allowed to continue offering meals.[37] **Colorado** has an online **Nutrition Menu Library** that collects and analyzes nutrition provider menu items, serving as a resource for nutrition providers across the state.

- **Caregiver Services:** **Kentucky**, **Missouri**, and **Iowa** have created respite needs assessments to target services to an individual's status and situation.[38] **Colorado** AAAs contract with multiple in-home service providers to allow consumers to choose from an approved list of providers that may best match their needs, such as those that serve rural areas, those that specialize in dementia care, or those that also take Medicaid funding. **Washington** permits the pooling of respite units for future use to account for flexibility in time-sensitive needs.[39] **Illinois**, **New York**, and **Washington** have supported innovative efforts and provided funding to incorporate technological caregiver assessment and care management tools such as **TCARE** into their AAA operations.[40] [41] [42]

- **Tribal and Indigenous Programs:** Recognizing that tribal caregivers are more likely to use respite services if the provider is also a member of the tribe, **Washington** is piloting a program that will increase the number of trained tribal members who offer respite care while also educating tribal families about the benefits of using trusted respite providers. There is a collaboration with established agencies within the tribal community to enhance awareness and outreach.[43] **Wisconsin** works with

[33] https://pubmed.ncbi.nlm.nih.gov/30548594/
[34] https://www.hud.gov/press/press_releases_media_advisories/hud_no_23_087
[35] https://soarworks.samhsa.gov/course/soar-online-course-adult-curriculum
[36] https://www.mentalhealthfirstaid.org/population-focused-modules/adults/older-adults/
[37] https://www.aging.pa.gov/service-provider-quicklinks/Guidance/Pages/default.aspx
[38] https://nashp.org/emerging-respite-care-strategies-in-medicaid-home-and-community-based-services-waivers-for-older-adults-adults-with-physical-disabilities-and-their-family-caregivers/
[39] https://nashp.org/emerging-respite-care-strategies-in-medicaid-home-and-community-based-services-waivers-for-older-adults-adults-with-physical-disabilities-and-their-family-caregivers/
[40] https://www.nashp.org/wp-content/uploads/2022/08/NASHP_Report_2-1.pdf
[41] https://www.nashp.org/wp-content/uploads/2022/08/NASHP_Report_2-1.pdf
[42] https://www.dshs.wa.gov/altsa/stakeholders/caregiver-assessment-and-planning-tcare
[43] https://nashp.org/emerging-respite-care-strategies-in-medicaid-home-and-community-based-services-waivers-for-older-adults-adults-with-physical-disabilities-and-their-family-caregivers/

tribes to ensure that each tribe has its own ADRC, with clear access points for connecting to services and supports available.

States integrate equity and equality into program planning and design. The National **Older Adults' Equity Collaborative (OAEC)** includes five ACL-funded **Minority Aging Technical Assistance and Resource Centers (TARCs),** focusing on serving a unique community.[44] They work to improve access and equity across aging services programs by providing technical assistance (TA) to the aging services network.[45] There are many ways aging networks can incorporate equitable approaches to the planning and design of programs and services, including:

- Communications materials and staff that reflect the languages of communities being served.[46]
- Vendors that reflect the linguistic and cultural compositions of the communities being served.[47]
- A call center with live operators that is open 24/7.[48]
- Self-service options for consumers to navigate, screen for, select, and access services without the assistance of a human administrator.[49] [50]
- Virtual program offerings to reach consumers.[51] [52] [53]

The **Illinois CARE Connections** is a collaboration between the Illinois Department of Aging and the Illinois Department of Human Services to provide technology devices to isolated seniors and people with disabilities.[54] Bundles are purchased, assembled, and shipped to eligible recipients. The bundles include a tablet device, headset, keyboard, hotspot, instructions, a Wellness Recovery Action Plan (WRAP) program information, and assistive technology for accessibility. Participants had to receive services through these agencies and be socially isolated due to COVID-19 restrictions.

States can use frameworks to integrate equity and equality into program planning and design. **Justice in Aging** developed an **HCBS Equity Framework** to support policymakers, payers, providers, advocates, and consumers in making equity a focus at every stage of the HCBS program design and implementation:[55]

- **Program Design:** In program design, inequities can arise from policies that establish who is eligible, where programs are available regionally, and what services are offered.
- **Provider Availability:** Inequities in provider availability can arise from policies that dictate network adequacy, reimbursement rates, provider investments, training, and support.

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[44] https://acl.gov/programs/diversity-and-cultural-competency/oaec
[45] https://acl.gov/programs/diversity-and-cultural-competency/oaec
[46] https://www.nia.nih.gov/health/providing-care-diverse-older-adult-population
[47] https://www.apa.org/pi/aging/programs/pipeline/multicultural-competency.pdf
[48] https://dhhs.ne.gov/Reports/ADRC%20Report%20-%20%202022.pdf
[49] https://journals.sagepub.com/doi/10.1509/jmkg.64.3.50.18024
[50] https://openminds.com/market-intelligence/executive-briefings/leveraging-the-self-service-paradigm/
[51] https://static1.squarespace.com/static/5b855bd5cef372d1e9a8ef0e/t/62a7835e4c882c407c2feffb/1655145314877/engAGED+Virtual+Programs_508.pdf
[52] https://www.aroostookaging.org/event-details/the-online-gathering-place
[53] https://games.aarp.org/
[54] https://www.ta-community.com/media/download/k91m8k/ICC%20Final%20Report%208-23-21%20A11Y.pdf
[55] https://justiceinaging.org/issue-brief-fact-sheet-hcbs-equity-framework/

- **Awareness and Enrollment:** Inequities arise when information on program availability and eligibility is unavailable, and application/service activation processes are overly burdensome.
- **Assessment for / Authorization of Services:** Implicit bias can be built into service assessment and authorization processes, leading to inequities in eligibility.
- **Provision of Services:** Inequities can arise when service recipients' needs and lived experiences are not considered in the accessibility of services and means of measuring the quality of services rendered.

SUAs are leading statewide programs and initiatives. Many states create new funding streams for initiatives that address critical challenges. To respond to significant increases in cases of Alzheimer's and dementia, **Florida's** 2022-23 budget included a record $52.3 million in funding for the **Alzheimer's Disease Initiative (ADI) Program**, which provides case management, respite care and caregiver support services. The state also created the **Florida Alzheimer's Center of Excellence (FACE)** in 2022, which supports caregivers and people with Alzheimer's and related dementias through evidence-based and NWD approaches. It includes public and private partnerships with universities and corporations to develop and make available cutting-edge treatments and resources for Alzheimer's disease.[56]

3. FUNDING SOURCES AND CAPACITIES

States revise intrastate funding formulas (IFFs) to reflect changing demographics and fill resource gaps across AAA networks. States develop at least two IFFs based on their OAA funding allocations – administrative and services. Many establish a minimum base amount for AAAs. In **Florida**, this amount is $230,000 per AAA, or 7% of the combined allocation of most OAA funds for services (see Appendix C for a visual of Florida's IFF).[57]

Iowa's IFF is based on population, county, and the AAA. AAAs receive minimum base funding ($24,000) plus additional base funding for each county they serve. Following these distributions, Iowa uses demographic-based formulas to distribute the remaining funds, including ages 75 and over, members of a racial minority, rural areas, and poverty numbers.[58] **Wisconsin's** funding formula allows each AAA to receive a base amount ($75,000). The remaining funds are distributed based on the number of county or tribal Aging Units served by each AAA, the low-income population, and the proportion of non-white, non-Hispanic populations served by the AAAs.[59] More states are incorporating new categories for their funding formulas and weights, including disability, population density, and living alone. In 2022, **Oregon** updated its IFF to increase minimum nutrition funding for rural AAAs. The state established a base amount of $25,000 for each AAA for meal services.[60]

Updating funding formulas is a sensitive process. **Minnesota** is proposing an update to its funding formula weighting for the first time in over ten years. The state's proposed IFF will allocate more funds to

[56] https://agingresources.org/elder-affairs-celebrates-record-funding-and-enhanced-support-for-floridas-aging-network-in-2022/
[57] https://elderaffairs.org/wp-content/uploads/FINAL-Florida-State-Plan-on-Aging-2022-2025-10182021.pdf
[58] https://iowaaging.gov/sites/default/files/field-page-docs/Funding%20Formula_0.pdf
[59] https://www.dhs.wisconsin.gov/aging/draft-aging-financial-plan-2022.pdf
[60] https://www.oregon.gov/odhs/providers-partners/community-services-supports/Documents/intrastate-funding-formula-2023.pdf

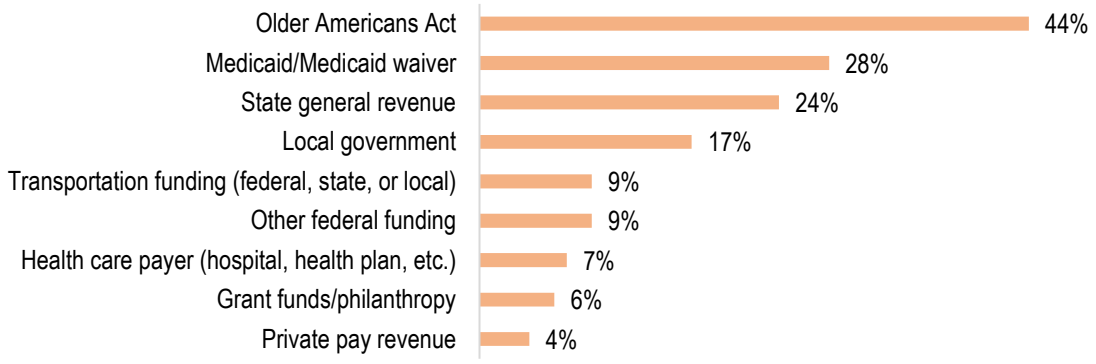
the state's urban AAA and fewer funds to the remaining AAAs serving predominantly rural counties. AAA camps are involved in campaigns to bring the proposal and their counterproposals to the public's attention (see Appendix D for examples of their advocacy efforts).[61] Below are Minnesota's previous, proposed, and two counter-IFF proposals from the two groups of AAAs:

	Previous State IFF	Proposed IFF (2023)	IFF Proposed by Rural AAAs	IFF Proposed by Urban AAA
Pop 60+	55%	30%	20%	n/a
Low Income	20%	20%	20%	n/a
Minority	10%	15%	15%	20%
Rural	10%	15%	25%	n/a
Pop. Density	5%	5%	5%	n/a
Disability Rate	0%	10%	5%	n/a
60+ Living Alone	0%	5%	10%	n/a

Pennsylvania created a frequently asked questions page to provide the rationale for their funding formula revision, articulating how the state's strategic priorities have evolved with the needs and demands of the state's population. Like other states, **Pennsylvania's** updated IFF and weights shifted to focus less on age (although weights did concentrate more on 75+ people), slightly less on minority status, somewhat more on living alone, and much more on poverty.[62]

States are phasing in changes to funding allocations. **Colorado**, **Minnesota**, **Pennsylvania**, and **Wisconsin** have policies where a AAA will not have more than a 5% reduction in funding distribution, assuming the distribution budget is the same. **New Jersey** takes the same approach but limits the reduction to 3%.[63] [64]

Average Budget Proportion for AAAs Nationally
(Calculated based upon AAAs that report any funding from these sources)



Source: USAging, National Survey of Area Agencies on Aging 2020. [65]

[61] https://www.greaterminnesotaaging.org/
[62] https://www.aging.pa.gov/publications/state-plan-on-aging/Pages/IFF-Updates---FAQs.aspx
[63] http://www.advancingstates.org/documentation/Surveys/OAA%20Intra-State%20Funding%20Formula.pdf
[64] https://www.aging.pa.gov/publications/state-plan-on-aging/Documents/Attachment%20C%20SPOA%202020-24%20re.pdf
[65] https://www.usaging.org/2020aaasurvey

State agencies operating as SUAs differ in funding sizes and compositions. Federal funding is less than 50% of the annual budgets of SUAs. However, on average, AAAs receive more OAA funds than other sources (see Appendix B for examples of different SUA budgets).[66]

Private pay is an allowable option for states and AAAs; some pursue it to expand services. Due to insufficient state funds, **New York** developed a fee-for-service model for middle- and higher-income residents.[67] Private pay protocols apply to all state- and locally-funded programs and cannot be used with federal funding. Allowable services include assessment, case management, personal care, ancillary services, home-delivered meals, social adult day services, transportation, caregiver supports and respite, personal emergency response systems, financial management, and others.[68]

Marketing visuals from **Maryland**'s private pay program, Community for Life.[69]

Maryland's Community for Life private pay program was developed by its Department of Aging to support older adults as they age at home. The program's services are designed to prevent the predictable challenges of aging that can require admittance into a high-level care facility, such as a nursing home or assisted living facility. Community for Life has three core services: home maintenance, service navigation, and transportation. Subscribers are entitled to an initial home safety assessment, minor home repairs, a list of vetted contractors for repairs, information to access services, and a fixed amount of monthly transportation. All Marylanders over 60 are eligible for enrollment without health or income qualifications. Membership fees vary by service area. [70] [71]

Voluntary contributions and cost-sharing models reinvest in core programs and services. The OAA allows for consumer contributions, which may take the form of an individual voluntarily contributing towards the cost of a service. The SUA establishes a cost-sharing policy for collecting sliding scale payments from some service participants for some services. Voluntary contributions allow consumers to support the services in their community and give to the agencies, making free or low-cost services available to them. They can also provide a sense of dignity for some consumers sensitive to receiving

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[66] http://www.advancingstates.org/about/state-agencies/state-aging-and-disabilities-agency-profiles.
[67] https://aging.ny.gov/implementing-private-pay-models-new-york-state
[68] https://aging.ny.gov/system/files/documents/2020/03/20-pi-02-private-pay-option-for-network-services.pdf
[69] https://aging.maryland.gov/SiteAssets/Pages/community-for-life/MDoA%20Community%20for%20Life%20(SM)%20PDF.pdf
[70] https://aging.maryland.gov/Pages/community-for-life.aspx#:~:text=Maryland%20Community%20for%20LifeSM%20is%20an%20innovative%20program%20developed,over%20the%20age%20of%2060.
[71] https://aging.maryland.gov/Pages/community-for-life.aspx#:~:text=Maryland%20Community%20for%20LifeSM%20is%20an%20innovative%20program%20developed,over%20the%20age%20of%2060.

free services. In 2021, AAAs reported nearly $166 million in program income for Title III-funded services.[72] **Ohio** has a provision in its state aging policy emphasizing that most OAA services are subject to voluntary cost-sharing by consumers based on their self-declared income. **Ohio** AAAs must administer a cost-sharing policy with a standard sliding fee schedule.[73] **Pennsylvania's** Help at Home, or OPTIONS program, also has an option for sliding scale co-payment based on income.[74]

State funding for aging services can expand and add flexibility to federally funded benefits. State funding provides valuable service expansion of the quantity of OAA services while adding opportunities for greater flexibility of service arrays of AAAs. States must match a portion of their allocated federal OAA funding to receive that federal funding; many states contribute more than their required match. States can transfer some allocated federal service funds to other categories. Below is a table demonstrating the differences among several other states' allocations and expenditures within Title III services in the federal fiscal year 2021:[75] [76]

STATE	FEDERAL ALLOCATION	TOTAL SERVICES EXPENDITURES	% OF SPENDING ON PERSONAL CARE	% OF SPENDING ON MEALS*	% OF SPENDING ON INFO. & ASSISTANCE
CA	**$145,019,105**	**$291,848,533**	**0.3%**	**62.5%**	**2.9%**
CO	$21,146,828	$52,959,159	0.5%	43.3%	6.5%
FL	$106,771,882	$938,307,940	26.7%	7.8%	.6%
IL	$50,854,934	$114,710,274	0%	71.8%	11.5%
NY	$81,402,724	$481,753,318	10.4%	34.3%	10.9%
OH	$50,782,556	$104,268,604	2.8%	67.2%	4.8%
TX	$94,106,893	$139,498,366	1.3%	73.9%	2.7%
WA	$29,959,667	$41,360,402	0.5%	59.1%	18.4%
WI	$25,295,424	$70,504,854	0.4%	68.3%	16.3%
US AVG.	**N/A**	**$93,115,421**	**12.9%**	**38.3%**	**4.4%**

States achieve funding increases through a variety of avenues. **Colorado** advocated at the state level for funding to address the growing population and needs of older adults by partnering with the state's demography office to demonstrate existing and anticipated increases in older adults. They received an additional $4 million a year over three consecutive years. **North Carolina** has achieved an overmatch of the OAA funds they receive. The state established a Home and Community Care Block Grant (HCCBG), which consolidated multiple funding sources, such as OAA funds and a Social Services Block Grant. The purpose of the HCCBG was to give counties more flexibility and authority in selecting services and providers for programs they offer to older adults. It was also used to make administrative processes more streamlined and efficient. States like **Wisconsin** have been making business cases to their elected officials, demonstrating the economic value of their services by how much their interventions

[72] https://www.federalregister.gov/documents/2023/06/16/2023-12829/older-americans-act-grants-to-state-and-community-programs-on-aging-grants-to-indian-tribes-for
[73] https://codes.ohio.gov/ohio-administrative-code/rule-173-3-07
[74] https://www.aging.pa.gov/aging-services/help-at-Home/Pages/default.aspx
[75] https://acl.gov/sites/default/files/about-acl/2021-05/FY%202021%20ARP%206%20Programs%204-30-21%20Values%20Only%20version%202.pdf
[76] Source: FFY 2021 (10/01/2020-09/30/2021) OAA Title III State Program Reports (SECTION II.A) as of 05/01/2022. % of Spending on Meals includes home-delivered meals and congregate meals.

save Medicaid and Medicare spending.[77] The state created a free public return on investment calculator that local agencies can use to demonstrate value.[78]

States are using waitlists to strengthen funding advocacy efforts. **New York** analyzed AAA waitlists to understand how many people were waiting for services and what they were experiencing while waiting for assistance in 2018. Over 8,000 older New Yorkers were on waiting lists. The SUA studied 25% of those on the waiting list and found that 7% entered the managed long-term care setting and 10% entered nursing homes. The group had a high rate of hospitalizations, ER visits, and death. The SUA used the data to make the case for increased state investments in the aging network. **Pennsylvania's** aging network secured an additional $5 million in the state's budget to reduce the number of older adults on waitlists for the Help at Home program that promotes aging in place through a bundle of four core services.[79] [80]

States source and distribute funding in a variety of ways. While general fund appropriations are the most common, other funding sources exist for several states. **Pennsylvania** uses the state lottery to fund services and supports for older adults. Since the program's inception in 1972, the fund has generated over $33 billion for older adults and over $1 billion for senior programs during the 2020-21 Fiscal Year (the 10th consecutive year it surpassed the $1 billion mark).[81] [82] **Washington's WA Cares Fund** is a first-in-the-nation program created by the legislature based on years of research on how to make long-term care affordable for working Washingtonians. In 2019, they established the long-term care insurance benefits program to help many who need long-term care. It is an automatic enrollment program, and all working Washingtonians contribute a small percentage of their income (0.58%) to the fund. Then, when they need care, they can access their earned benefit of $36,500 (adjusted to inflation) to pay for services.[83] The AAA serving St. Louis, **Missouri,** funds a part of their home-delivered meal programs with a Community Development Block Grant funded by the Department of Housing and Urban Development and the City of St. Louis Community Development Administration.[84]

State aging networks are becoming more integrated with Medicaid policies and activities. AAAs and entire state aging networks are reaching more clients and earning new revenue through waiver activities, managed care contracting, and fee-for-service arrangements with state Medicaid agencies. **Pennsylvania** AAAs have had contracts with the state to provide Medicaid screening, enrollment, and plan of care services for beneficiaries 60 years and older (with varying degrees of success).[85] **Washington's** AAAs are involved in the state's Medicaid LTSS care management system through contracts with the state's Medicaid agency.[86] AAAs have pursued fee-for-service opportunities by

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77 http://www.advancingstates.org/sites/nasuad/files/u34008/%28060%29%20Strengthening%20the%20No%20Wrong%20Door%20Business%20Case%20by%20Using%20Medicare%20and%20Medicaid%20Data.pdf
78 https://apps.metastar.com/Apps40/NWDROI
79 https://www.governor.pa.gov/newsroom/governor-shapiro-signs-into-law-commonsense-budget-that-makes-historic-investments-to-create-a-stronger-economy-safer-and-healthier-communities-and-better-schools/
80 https://www.aging.pa.gov/aging-services/help-at-Home/Pages/default.aspx
81 https://www.palottery.state.pa.us/benefits/local-services-senior-centers-meals.aspx
82 https://www.palottery.state.pa.us/Benefits-Info/Benefits-Info.aspx.
83 https://wacaresfund.wa.gov
84 https://www.stlouis-mo.gov/government/departments/human-services/aging-services/index.cfm
85 https://www.dhs.pa.gov/HealthChoices/HC-Providers/Documents/CHC%20Independent%20Assessment%20Final.pdf
86 https://generations.asaging.org/care-management-state-perspective

becoming verified Medicaid vendors and delivering Medicaid-covered benefits to Medicaid beneficiaries, such as in **Oregon**, where the AAAs, through the Oregon Wellness Network, offer the Diabetes Prevention Program, a Medicare-covered benefit.[87] Oregon also has a special designation for AAAs, known as Type B Area Agencies, that offer the same services across multiple payers and systems. These "under one roof" agencies earn this designation by managing AAA, Medicaid, ADRC, adult protective services, and several other programs.[88]

Medicaid Administrative Claiming is another way AAAs serve more consumers and earn revenue. The state legislature required the SUA to pursue Medicaid Administrative Claiming (MAC) to supplement Nebraska's ADRC and other AAA activities**.** AAAs can reinvest their MAC income into other programs where the need is the greatest. Quarterly MAC income reached nearly $600,000 for one AAA in 2022.[89] **Alabama** utilizes MAC funding at the 90/10 (development) and 75/25 (maintenance) matching rates to sustain an eligibility and enrollment system. **Alabama's** 13 AAAs (all operating ADRCs) receive MAC funds at the 50/50 matching rate for Medicaid outreach and facilitating eligibility functions.[90] The **Massachusetts** ADRC/NWD System established structures to use MAC funds to fund LTSS financial eligibility specialists who work within the MassHealth (Medicaid) Enrollment Center (MEC) system and provide technical expertise for ADRC and state agency staff. The LTSS eligibility specialists work within ADRCs, adding capacity to improve the navigation of the financial eligibility process and align the timing of functional determinations with financial determinations.[91]

4. KEY PERFORMANCE MEASURES

States are strengthening data systems to measure, monitor, and improve their aging networks' administrative and programmatic performance. Recognizing the need to use data to tell their story and demonstrate impact, **Colorado** assembled an SUA-AAA workgroup to review data systems and processes. The review led to developing a custom-built Salesforce-based data system managed internally within the SUA. The SUA is expanding its features and user-friendliness by creating a single point of data entry. **Pennsylvania's** state plan for the 2020 – 2024 period focused on data systems and technology. Two primary goals are to use technology to improve the quality of the network and to enhance transparency and user experience for consumers through electronically-based grants management, connectivity to health information exchanges, a public-facing self-reporting elder abuse tool, and an automated way to identify consumers at risk of social isolation based on risk factors presented in their data profiles.[92] **Indiana** recognized the need to address data and technology shortcomings when a study shed light on inconsistent data collection practices. The SUA committed to a new single data management system that connects funding and service delivery to improve data consistency and accountability.[93]

[87] https://oregonwellnessnetwork.org/
[88] https://na.eventscloud.com/file_uploads/28268e42aebf92dce55b9d7f883a0025_TransferMedicaidPresentation0715.pdf
[89] https://dhhs.ne.gov/Reports/ADRC%20Report%20-%20%202022.pdf
[90] https://www.longtermscorecard.org/~/media/Microsite/Files/2020/ADRC_NWD%202020%20Key%20Takeaways.pdf
[91] https://www.longtermscorecard.org/~/media/Microsite/Files/2020/ADRC_NWD%202020%20Key%20Takeaways.pdf
[92] https://www.pacourts.us/Storage/media/pdfs/20210516/230047-2020-2024_state_plan_on_aging.pdf
[93] https://www.in.gov/fssa/da/files/2019-2022-Indiana-State-Plan-with-Attachments-A-D.pdf

More states are assessing the needs of older adults at larger scales. The Community Assessment Survey of Older Adults (CASOA) is a popular tool for states to deploy a standardized survey to a random sample of older adults and learn about their experiences, thoughts, and concerns about aging. In **Colorado**, the AAAs have used the CASOA for over a decade to assess and address needs and inform their strategic plans.[94] **New York** completed their first statewide CASOA survey in 2023.[95] The CASOA tool allows states to compare region by region and over time if used as part of a state's planning cycle while alleviating resources needed by AAAs to conduct needs assessment surveys in their communities.

States are becoming more sophisticated at measuring and monitoring network performance. **New Mexico** creates a quarterly performance report, capturing performance across multiple programs and services, including ADRCs, Long-Term Care Ombudsman, Adult Protective Services, and AAAs.[96] The FY22 report included measures such as the percentage of calls to the ADRC that a live operator answers, the percentage of residents who remained in the community six months following a nursing home transition, and the percentage of older adults receiving aging network meals programs that are assessed with high nutritional risk. **New York** also compiles and publishes an annual report of the network's achievements.[97] **Florida** has long-range program plans with articulated goals, objectives, performance measures, and targets. The state's plan has an appendix with performance measure validity and reliability assessments.[98] The state conducts targeting performance assessments, as seen below:

FLORIDA 60+ POPULATION COMPARED TO SCREENED AND SERVED CLIENTS

Characteristic 60+	Florida 60+ Population	Percent 60+	Number of Service Recipients*	Receiving or Screened for Services*
Below 100% of Poverty Level	576,867	11%	52,472	43%
Living Alone	972,146	18%	43,804	36%
Minority	1,545,786	29%	61,972	51%
Minority Below 100% of Poverty Level	268,408	5%	36,242	30%
Rural Areas	505,588	9%	6,804	6%
Limited English Proficiency	347,573	6%	28,930	24%

Many states require AAAs to collect and report consumer satisfaction and experience. States are emphasizing the value of services being invested in and delivered. This is for various reasons, including greater public scrutiny of taxpayer dollars, the need to make a business case to policymakers for investing in programs, and ongoing efforts to improve health outcomes and reduce avoidable healthcare spending. **Colorado** utilizes Google Forms to create and distribute a statewide consumer satisfaction survey. The survey is a standardized template for the state, with some options for program-specific questions. The distribution survey is annual, and the local AAAs distribute it. Surveys can be provided to consumers, or consumers can be directed to the online survey for completion. The SUA receives survey

[94] https://cdphe.colorado.gov/prevention-and-wellness/injury-prevention/community-assessment-survey-for-older-adults-casoa
[95] https://aging.ny.gov/news/nysofa-seeks-input-individuals-60-states-first-ever-comprehensive-survey-older-adults
[96] https://aging.nm.gov/uploads/documents/Third_Quarter_FY23_KeyPerformanceMeasures_Report.pdf
[97] https://aging.ny.gov/system/files/documents/2022/07/2021-annual-report.pdf
[98] http://floridafiscalportal.state.fl.us/Document.aspx?ID=21186&DocType=PDF

responses in a centralized location, allowing for easy reporting and data analysis. ACL conducts a National Survey of Older Americans Act Participants that monitors AAA performance. States could adopt questions from this survey for their quality assessments.[99]

States use data to ensure accountability. **New York** utilized data around the economic impact of the aging network to advocate for a substantial increase in funding. The enacted FY 2023 State Budget appropriates $181,525,000 in total funds for state programs and AAA/network services[100]. **Colorado** has incorporated performance measures into their contracts with AAAs. They make multi-year contracts with AAAs, and for each contract, the AAAs must choose 1-2 performance measures they will be accountable for meeting. Examples of these measures include serving more of their target population, developing a new partnership with a health system, and increasing person-centered services. In addition to these measures, AAAs are accountable for statewide client satisfaction survey performance. AAAs can experience a 1% funding reduction if a measure is not achieved for two years.

The SUA, however, prefers a collaborative approach, working with the AAA to create a corrective action plan.[101] **Ohio's** policies have defined the SUA's ability to act with AAAs deficient in complying with laws, policies, or agreements. The first action is for AAAs to develop a self-imposed corrective action plan. Once created, the SUA must review and approve the plan, then AAAs must complete the corrections based on the timelines included in the plan. If there is a failure to correct, the SUA may impose a corrective action plan or take immediate action, which can range from removing all or part of the funding for an activity, terminating all or part of a contract and grant, and in the most severe cases the SUA can de-designate the AAA.[102]

State aging networks can leverage national datasets and tools. **AARP's LTSS Scorecard** is one tool states can use to understand the quality of their LTSS systems and identify measurable areas within those systems they can impact (such as ADRC/NWD activities).[103] **ADvancing States' National Core Indicators** dataset gauges the quality and effectiveness of LTSS systems among aging and disabled residents. Forty-six states use the Intellectual & Developmental Disabilities program, and twenty-two use the Aging & Disabilities program. The tool is powerful when measuring states' efforts to enhance person-centered planning.[104]

5. BRANDING, COMMUNICATIONS, AND OUTREACH

States brand some programs. States brand certain programs and require AAAs to follow branding, communications, and marketing requirements to receive grants and offer those programs. An example is through statewide information and referral, ADRC, and NWD programs. **New York's** NY Connects, **Florida's** Elder Helpline, and **Washington's** Community Living Connections are examples of SUAs

[99] https://agid.acl.gov/
[100] https://aging.ny.gov/fy-2023-state-budget-includes-unprecedented-support-aging-service-programs-and-innovations
[101] https://www.weld.gov/files/sharedassets/public/departments/human-services/documents/policy-and-procedure-manual-8-8-22.pdf
[102] https://codes.ohio.gov/ohio-administrative-code/rule-173-2-07
[103] https://www.longtermscorecard.org/
[104] http://www.advancingstates.org/sites/nasuad/files/u34008/10.00%20-%2011.00%20-%20%28125%29%20Put%20Your%20NCI%20%26%20NCI-AD%20Data%20to%20Work.pdf

utilizing an access point (e.g., phone number, website, etc.) and a shared information and referral system to develop a common identity that stakeholders within and peripheral to the aging network utilize.

Florida's standard banner promotes its information and referral system.

New York's standard banner promoting their information and referral system.

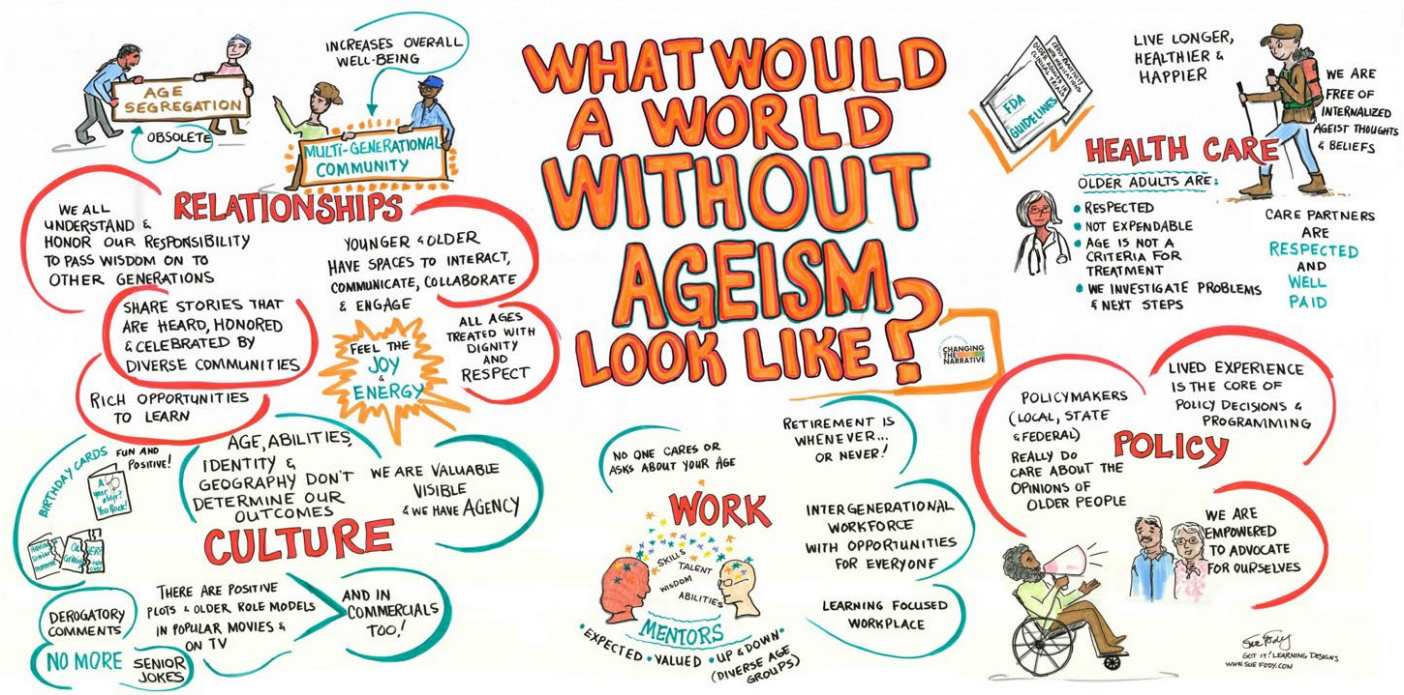
Some AAAs are radically reinventing themselves. Three AAAs - **AgeSpan (Massachusetts)**[105], **AgeOptions (Illinois)**[106]**,** and **Trellis (Minnesota)**[107] – are examples of rebranding efforts to reflect a new approach to delivering aging services, expanding beyond federal and state funding. While they incorporate AAA activities into the operating models, they have expanded into new areas to meet the evolving needs of their communities and seize opportunities to mainstream and normalize aging services.

Many state and local organizations are investing in reframing aging efforts to combat negative stereotypes and normalize aging. The **Reframing Aging Initiative** is supported by eight national aging organizations and nine funders who have conducted extensive research to develop evidence-based recommendations for reframing aging. The findings offer seven framing elements to boost knowledge, attitudes, and policy preferences on aging issues, including naming and defining ageism, showing examples of ageism, and explaining implicit bias. The initiative also identified practices to avoid, such as leading stories or calls to action with demographic shifts, using analogies that suggest society will be overwhelmed by older people (e.g., the Silver Tsunami), talking about aging as a civil rights issue, and portraying successful aging with portraits of extraordinary lifestyles and life experiences.[108]

The **New York City Department of Aging** sponsors the **Ageless New York** campaign to raise awareness about ageism against older adults. The campaign aims to reframe aging with images of New

[105] https://agespan.org/
[106] https://www.ageoptions.org/
[107] https://trellisconnects.org/
[108] https://www.frameworksinstitute.org/publication/framing-strategies-to-advance-aging-and-address-ageism-as-policy-issues/

Yorkers who are not defined by their age but by their passions, work, goals, and aspirations.[109] **Colorado's Changing the Narrative** initiative is a privately funded reframing program that has reached thousands of Coloradans and hundreds of Colorado organizations. The strategies align with the World Health Organization's three strategies to reduce ageism: education, intergenerational connection, and policy and law.[110] [111]



Changing the Narrative's sketch of a future without ageism.

Campaigns are designed to address issues and target audiences. **New York** and **Massachusetts** launched the **Any Care Counts** campaign, providing a tool for the public to score themselves and understand the extent to which they are caregivers. It measures unpaid caregiver intensity, identifies sources of stress, and provides web-based training and resources.[112] [113] The **Portraits of Care** ad campaign launched in **New York** and **Washington, DC,** features portraits of people with disabilities, aging adults, care workers, and family caregivers. The campaign highlights the joy of caregiving and pushes for greater recognition of caregiving.[114] **Minnesota's Own Your Future** campaign raises awareness around long-term care planning and develops affordable payment options for middle-income Minnesotans.[115]

[109] https://agelessnewyork.cityofnewyork.us/about/
[110] https://changingthenarrativeco.org/
[111] https://www.who.int/news/item/18-03-2021-ageism-is-a-global-challenge-un
[112] https://anycarecountsma.com/
[113] https://www.anycarecountsny.com/
[114] https://caringacross.org/blog/portraits-of-care-launches-in-nyc-and-dc-for-family-caregivers-day/
[115] https://mn.gov/dhs/ownyourfuture/

States and local agencies evaluate their communications campaigns to gauge success and improve future efforts. **Washington** identified metrics to determine the success of its ADRC marketing plan. For example, if the state logo is used effectively across ADRC sites, if the ADRC website and 800-number are referenced in state and local marketing collateral, and if ADRC services are reaching target populations.[116]

6. GEOGRAPHY AND DEMOGRAPHICS

States are tackling the challenges of serving rural older adults. Expanding the size of PSAs and reducing the number of AAAs is one way some states, like **Iowa,** have addressed the resource challenges facing rural AAAs. Fewer agencies equate to larger funding allocations per agency. AAAs in some states, like **Pennsylvania**, work together across PSAs to share resources for back-office functions or direct services. Some states are revising funding formulas to boost allocations to rural PSAs – directly by adding weight to the rural category and indirectly by adding weight to categories that apply to a greater share of rural residents, such as "lives alone." Some states add base funding allocations to AAAs that serve multiple counties, which are more common in rural PSAs.[117]

Investments in community services are needed to serve rural older adults better. There is growing evidence that rebalancing efforts to reduce institutionalization and promote greater utilization of HCBS may be stunted in rural communities due to access and utilization barriers, particularly around the lack of supply of LTSS and the availability of affiliated providers.[118] Solutions to rural challenges may involve strong volunteer programs (i.e., neighbors helping neighbors), improved broadband access for virtual programming and telehealth services, investments in public or private organizations, and programs that fill supply-side gaps in services and workforce.[119] [120]

States are supporting tribal and indigenous groups and organizations. In **Washington,** a Tribal Administrator team works with the Indian Policy Office of each agency and with tribal governments. Title VI funding is insufficient to address the needs of tribes, and not every tribe is a Title VI grantee. Tribal consultation processes are embedded in **Washington's** policy change process, including tribal advisory committees. Planning meetings are less formal than consultations but allow the state to collaborate with tribes and indigenous populations.[121] Planning meetings benefit the SUA, tribes, and consumers by strengthening state-tribal relationships, building mutual understanding, removing barriers to access, and improving service delivery.[122] **Arizona's SUA** has designated a tribal AAA that serves most of the tribes in the state; unlike most other PSAs, which are geographically bound, this AAA is run by the Intertribal Council for member tribes located in various areas across the state.[123] **Arizona** also has an agreement with **New Mexico** and **Utah** for a Navajo Nation AAA. **New Mexico** is focused on building better tribal collaborations, including establishing a leadership position at the state level to serve as a liaison.

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[116] https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/ADRC/Marketing%20Plan.pdf
[117] https://pubmed.ncbi.nlm.nih.gov/35590465/
[118] http://www.advancingstates.org/sites/nasuad/files/u34008/ADS%20Session%20-%20Rural%20LTSS%20Strategies%20%28PDF%29.pdf
[119] https://pubmed.ncbi.nlm.nih.gov/30827892/
[120] https://www.ruralhealthinfo.org/topics/community-living
[121] https://www.dshs.wa.gov/sites/default/files/oip/documents/DSHS-AP-07-01.pdf
[122] https://www.dshs.wa.gov/sites/default/files/ESA/dcs/documents/Tribal/701BestPracticesResource.pdf
[123] https://itcaonline.com/programs/aging/

AAAs are adopting community health worker programs to engage with minority clients and connect with healthcare organizations. Community Health Workers (CHWs) serve as a connection between medical services, social services, and their communities. AAAs are positioned to incorporate CHWs into their service models, particularly if they work with or desire to work with hard-to-reach populations and healthcare organizations. The **Juniper Network in Minnesota**, comprised of AAAs, relies on CHWs trained in evidence-based fall prevention programs.[124] CHWs typically come from their community and may be called different titles, such as peer health educators, lay health advocates, community health representatives, or promotores.

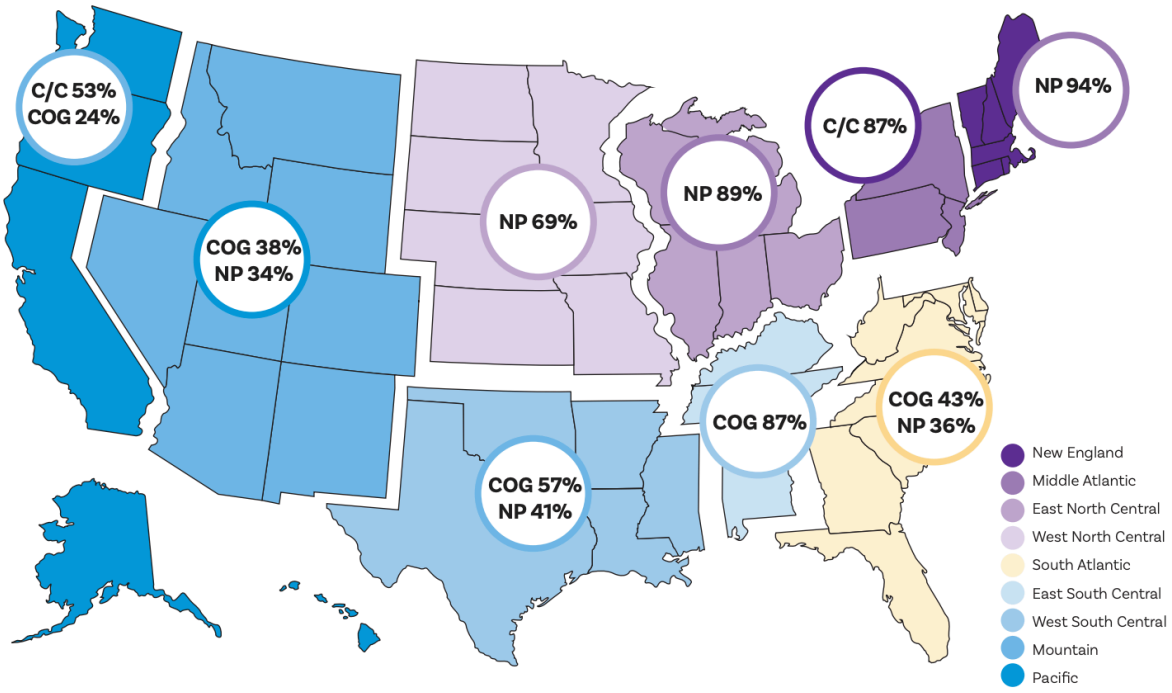
CONCLUSION

States are planning for the future. They are leveraging their systems to work for the needs of their current and future older residents. Across each of the CA 2030 focus areas, there are promising practices that offer inspiration and insights into directions California can explore to meet the evolving depth and breadth of needs of its aging residents. States are modernizing their aging networks, systems, and practices in several ways, including:

- De-cluttering state aging policies and procedures.
- Reviewing and, if necessary, updating PSA boundaries and AAA designations.
- Solidifying core services while allowing for greater flexibility in other service areas.
- Adding new funding formula categories to distribute funds more equitably across geographies and reflect the changing demographic profiles of older adults (older, disabled, living alone, minority, low income).
- Increasing base funding for AAAs to sustain or enhance administrative capabilities.
- Developing centralized and shared infrastructure, tools, and practices that enable statewide consistency and local efficiencies, reducing administrative, operational, and planning costs.
- Adopting an equity framework to critique and design policies and practices.
- Encouraging connections to parallel and peripheral systems that can help more people while drawing more financial resources into the aging network (i.e., housing/homelessness, transportation, mental health, Medicaid / healthcare, etc.).

[124] https://connect.ncoa.org/products/engaging-community-health-workers-in-evidence-based-programs#

APPENDIX A: FREQUENCY OF AAA ORGANIZATION STRUCTURES BY REGION

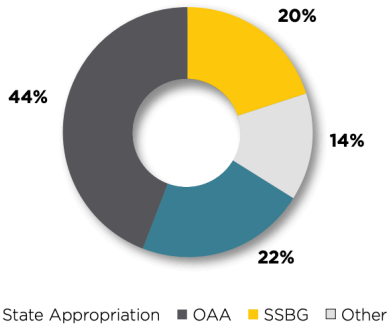


C/C = City / County Government COG = Councils of Governments (including JPAs / RPDAs) NP = Nonprofit

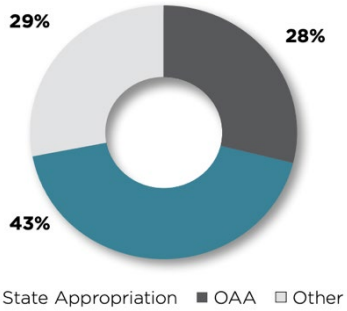
Map of regions of AAAs, indicating the share of different AAA organizational structures within each region. Source: USAging.

APPENDIX B: EXAMPLES OF DIFFERENT SUA BUDGETS

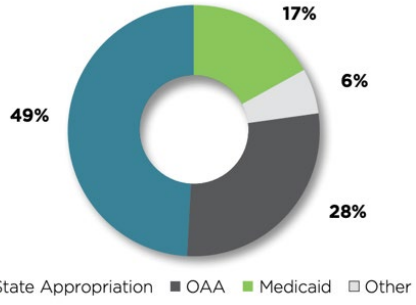
AZ Div. of Aging & Adult Services
FY20 Budget: $70.7M



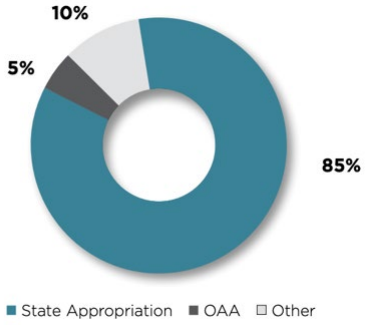
CO Div. of Aging & Adult Services
FY20 Budget: $66.8M



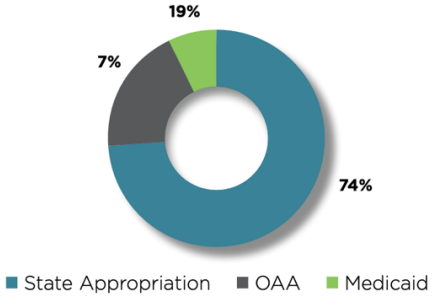
FL Dept. of Elder Affairs
FY20 Budget: $369.6M



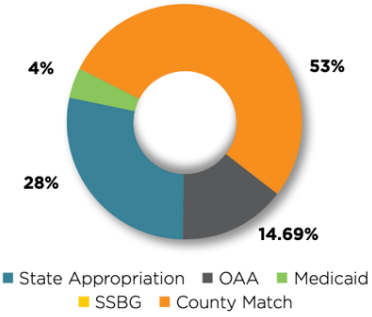
IL Dept. of Aging
FY20 Budget: $1.3B



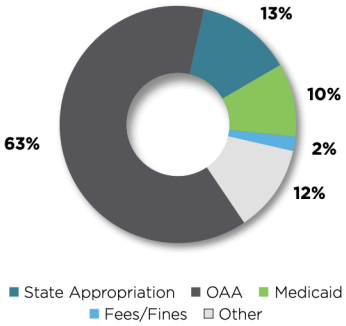
MA Executive Office of Elder Affairs
FY20 Budget: $597.1M



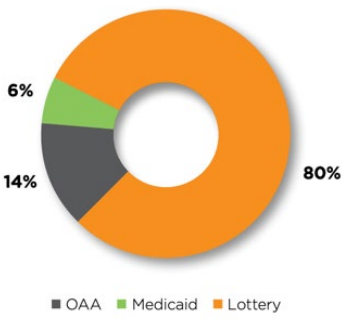
NY Office on Aging
FY20 Budget: $524M



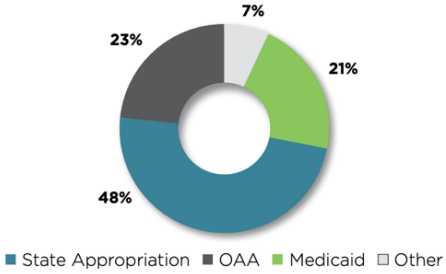
OH Dept. of Aging
FY20 Budget: $100.3M



PA Dept. of Aging
FY20 Budget: $652M



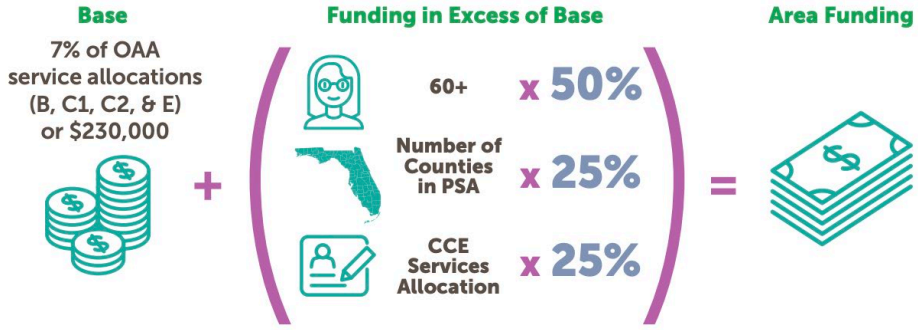
WI Bureau of Aging and Disability Resources FY20 Budget: $135.1M



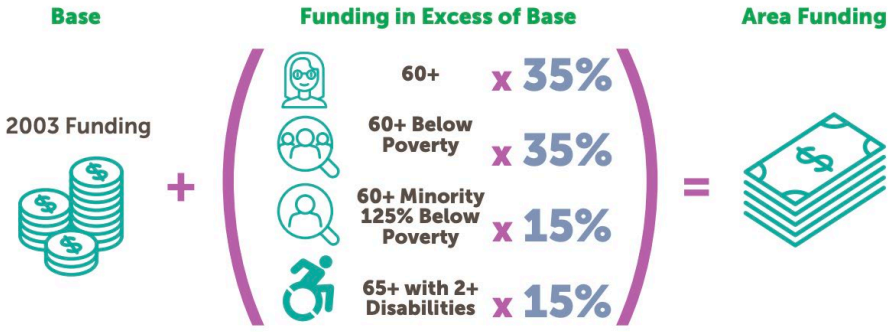
Source: http://www.advancingstates.org/about/state-agencies/state-aging-and-disabilities-agency-profiles

Note: Some of the larger budgets reported above account for an umbrella department's budget beyond aging services and programs and may also indicate states with SUAs that are more integrated within larger state entities.

APPENDIX C: PARTS OF FLORIDA'S MOST RECENT INTRASTATE FUNDING FORMULA



Florida's funding formula for OAA Administrative funds.[125]



Florida's funding formula for most Title III services.

[125] https://elderaffairs.org/wp-content/uploads/DRAFT-Florida-State-Plan-on-Aging-2022-2025_reduced.pdf

APPENDIX D: EXAMPLES OF THE IFF CHANGE ADVOCACY EFFORTS OF MINNESOTA AAAs

Enterprise

OPINION

Speak up and protect aging rural Minnesota

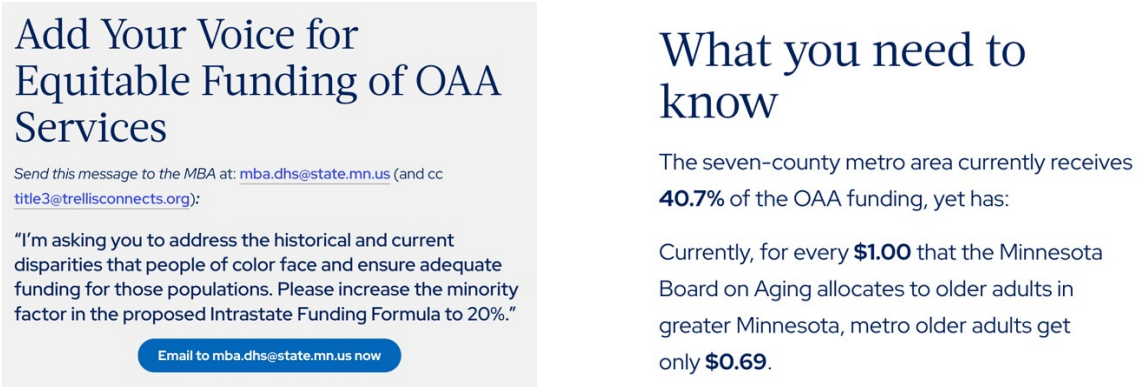
"Without your voice, Greater Minnesota stands to lose critical support for community-based services," writes Heather Pender in this guest commentary. The public is urged to comment on Minnesota's proposed 2024-2027 State Plan on Aging.

Without your voice, Greater Minnesota stands to lose critical support for community-based services.

The Minnesota Board on Aging is tasked to create an equitable funding formula. The outcome of the proposed formula would mean funding cuts to outstate Minnesota. This includes 21 counties in northwest Minnesota.

The existing formula is heavily weighted on population and not need. We need a formula that works for rural Minnesota.

AAAs in rural counties are advocating through the media and other channels for higher IFF weighting for rural older adults and those who live alone.[126]



Add Your Voice for Equitable Funding of OAA Services

Send this message to the MBA at: mba.dhs@state.mn.us (and cc title3@trellisconnects.org):

"I'm asking you to address the historical and current disparities that people of color face and ensure adequate funding for those populations. Please increase the minority factor in the proposed Intrastate Funding Formula to 20%."

Email to mba.dhs@state.mn.us now

What you need to know

The seven-county metro area currently receives **40.7%** of the OAA funding, yet has:

Currently, for every **$1.00** that the Minnesota Board on Aging allocates to older adults in greater Minnesota, metro older adults get only **$0.69**.

The AAA serving the Minneapolis region (Trellis) advocates for higher weighting for minorities in the new IFF.[127]

[126] https://www.parkrapidsenterprise.com/opinion/speak-up-and-protect-aging-rural-minnesota
[127] https://trellisconnects.org/iff/