FUELING INNOVATION: POLICY OPTIONS FOR CREATING VIBRANT COMMUNITIES THAT ARE CONDUCIVE TO HEALTHY AGING

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Overview of AARP

AARP
Nonprofit, nonpartisan, social welfare organization with a membership of nearly 38 million that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families — including health and long-term services and supports.

AARP Public Policy Institute
The Public Policy Institute provides research, analysis, policy development & thought leadership on a broad range of topics including long-term services & supports, health, financial security. We also craft innovative strategies and solutions to improve the quality of life for older Americans.

Long-Term Services & Supports and Livable Communities Group
We work to enhance consumer access and choice to an array of affordable LTSS options, to support family caregivers, and to promote the development of livable communities.
Four Things You Should Know

1. A large and growing aging population increases the likelihood and demand for long-term services & supports.

2. Where you live matters—there is significant variation in the delivery of long-term services and supports among states.

3. Rising sense of urgency to create equitable and sustainable communities that are livable and age friendly.

4. Policymakers and influencers can utilize tools that empower, inform and drive innovative solutions at the federal, state and local levels.
What is a High-Performing System?

Framework for Assessing LTSS System Performance

High-Performing LTSS System

is composed of five characteristics

Affordability and Access
Choice of Setting and Provider
Quality of Life and Quality of Care
Support for Family Caregivers
Effective Transitions

that are approximated in the Scorecard, where data are available, by dimensions along which LTSS performance can be measured, each of which is constructed from individual indicators that are interpretable and show variation across states

Source: State Long-Term Services and Supports Scorecard, 2014
What is the LTSS Scorecard?

- Concise performance tool to put long-term services and support (LTSS) policies and programs in context, prompt dialogue, and spark action
- Multidimensional approach to comprehensively measure performance over time
- Target areas for improvement
- View from a consumer perspective
- Engage public and private sectors
State Ranking on Overall LTSS System Performance

Source: State Long-Term Services and Supports Scorecard, 2017.
High Level Findings

• **States must pick up the pace of change** to meet the needs of a growing number of people aging and living with disabilities.

• Where you live matters because **states vary greatly** in how long-term services and supports are provided.

• Measurement, federal and state initiatives, and stakeholder engagement can accelerate the pace of change.

• **Ohio is ranked 34th overall**, and like all states could improve in multiple areas. This includes **support for family caregivers** and **effective transitions**.
Support for Family Caregivers

The needs of family caregivers are assessed and addressed so that they can continue in their caregiving role without being overburdened.

Support for Family Caregivers includes the extent to which:

- Legal and system supports provided by states to support working caregivers and person- and family-centered care.
- Registered nurses are able to delegate health maintenance tasks to non-family members and nurse practitioner scope of practice, which can significantly ease burdens on family caregivers.
- Transportation policies enable accessible public transportation for older adults, people with disabilities, and caregivers.
Support for Family Caregivers: Ranked 44

<table>
<thead>
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<th>Supporting Working Family Caregivers</th>
<th>32</th>
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<tbody>
<tr>
<td>- Exceeding federal FMLA</td>
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<tr>
<td>- Paid family leave/paid sick days</td>
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<tr>
<td>- Unemployment insurance for family caregivers</td>
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<tr>
<td>- Employment discrimination protection</td>
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<table>
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<th>Person- and Family-Centered Care</th>
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<td>- Medicaid spousal impoverishment</td>
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<tr>
<td>- Caregiver assessment</td>
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<tr>
<td>- Caregiver Advise, Record, Enable (CARE) Act</td>
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<th>Nurse Delegation and Scope of Practice</th>
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<th>Transportation policies</th>
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<tr>
<td>- Volunteer driver policies</td>
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<td></td>
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<tr>
<td>- Statewide transportation coordinating council</td>
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<tr>
<td>- Medicaid non-medical transportation</td>
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The Home Alone Alliance\textsuperscript{SM}

- AARP’s groundbreaking 2012 *Home Alone* study found that nearly half of family caregivers perform complex medical/nursing tasks, often without help or instructions from health care professionals.

- Based on the findings of *Home Alone*, we knew there was a gap between what family caregivers are expected to do as it relates to medical/nursing tasks, and what resources and supports are available to help them in doing so.

- The Home Alone Alliance\textsuperscript{SM} was formed to serve as a hub for identifying and developing solutions towards that end.

- Specific focus on medical/nursing tasks.
The Home Alone Alliance℠ Key Functions

• Collaborative of public, private, and nonprofit sector organizations dedicated to creating solutions that support family caregivers performing complex care tasks.

• Currently includes fifteen member organizations.

• A key resource from the Home Alone Alliance℠ are instructional videos.

Find our videos and resources at: www.aarp.org/nolongeralone
The National CARE Act Scan

AARP is leading a national scan of states and health systems that are implementing the CARE Act. To date, hospitals and health systems have reported multiple key practices toward implementing the CARE Act, including:

• **Standardizing** how hospitals and health systems interact with family caregivers throughout the discharge process.
• **Training** registrars and other staff to differentiate among the “next of kin,” “guardian,” or “family caregiver” who may be the same person or two or three different people.
• **Expanding** call center capacity to create a 24/7 toll-free line for family caregivers to call for support post-discharge.
• **Including** and specifically **inviting** family caregivers to participate in patient rounds.
• **Redesigning** information practices (e.g., white boards) to include family caregivers.

**2017 Site Visit Profile:**
• 18 visits with 16 health systems and 45 hospitals
• 7 states - NJ, NY, VA, MI, CO, NV, CA
• Community and teaching hospitals
• Rural and urban
• Non-profit, government, and for profit providers
• Bed size ranging from 25 to 837
Person- and family-centered care is designed to look at the whole person and his or her needs and preferences, including meaningfully involving the individual’s family caregivers.

**Effective Transitions**

- Nursing home residents with low care needs.
- Home health and nursing home hospitalizations.
- Burdensome hospital transitions at the end of life.
- Nursing home residents who have stays of 100 days or more.
- Transitions from nursing homes back to the community.
**Effective Transitions: Ranked 31**

<table>
<thead>
<tr>
<th>Category</th>
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<td>NH residents with low care needs</td>
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<td>Home health hospitalizations</td>
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<td>Nursing home hospitalizations</td>
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<td>✔️</td>
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<td>Burdensome transitions</td>
<td>32</td>
<td>✔️</td>
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<tr>
<td>Long nursing home stays</td>
<td>25</td>
<td>✔️</td>
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<tr>
<td>Transitions to the community</td>
<td>28</td>
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State Strategies to Address Long Nursing Home Stays

• Targeted efforts to identify and transition new residents back to community living (Minnesota)
• Diverting hospitalized patients to home with supportive services—rather than to a SNF—at point of discharge (Connecticut)
• NH quality improvement (e.g., payment incentives in Minnesota);
• Payments to downsize and diversify NH industry (Oregon, Connecticut)
• Statewide information, outreach, and education for people who need services to live independently (Maine, Connecticut)
• NH preadmission screening to counsel patients and families about community care options (Maine)
• Expansion of HCBS and continuum of residential care options (Maine, Connecticut).
If Ohio improved its performance to the level of the average of the top-five performing states:

• **155,408** more people of all ages would receive Medicaid LTSS to help them with daily activities.

• **39,004** more home health and personal care aides would be available to provide care in the community.

• **35,617** more low-/moderate-income adults with disabilities would have Medicaid coverage.

• **235,245** more place-based subsidized units and vouchers. would be available to help low-income people with LTSS needs afford housing.

• **$1.2 billion** more would go to HCBS instead of nursing homes.
The LIVABILITY INDEX
Great Neighborhoods for All Ages
The Livability Index: Great Neighborhoods for All Ages

How livable is your community?

enter your address, city, state or zip code

The Livability Index scores neighborhoods and communities across the U.S. for the services and amenities that impact your life the most.

Search for your city or learn more about how we define livability.
The Livability Index

- Research has shown that most people would like to age in their homes and communities.

- Unfortunately, many of America’s communities do not adequately support residents across the age spectrum in realizing their fullest potential.

The Livability Index provides insight to catalyze community conversations that can lead to positive change.
Why was the Livability Index created?

**Vision:** Communities support residents across the lifespan in realizing their fullest potential and ability to age in place

**Goal:** Provide residents and community leaders with an interactive, online tool that enables them to visualize their performance against key indicators of livability

**Main Objectives**
- State and local changes in policy, planning, and investment
- Inform key stakeholders
- Community resident participation
- Help communities become more livable for residents of all ages
The Livability Index Overview

Categories & Attributes

- **Housing**
  - Housing Accessibility
  - Housing Options
  - Housing Affordability
  - Commitment to Livability

- **Neighborhood**
  - Proximity to Destinations
  - Mixed-use Neighborhoods
  - Compact Neighborhoods
  - Personal Safety
  - Neighborhood Quality
  - Commitment to Livability

- **Transportation**
  - Convenient Transportation Options
  - Transportation Costs
  - Safe Streets
  - Accessible System Design
  - Commitment to Livability

- **Environment**
  - Water Quality
  - Air Quality
  - Resilience
  - Energy Efficiency
  - Commitment to Livability

- **Health**
  - Healthy Behaviors
  - Access to Health Care
  - Quality of Health Care
  - Commitment to Livability

- **Engagement**
  - Internet Access
  - Civic Engagement
  - Social Engagement
  - Equal Rights
  - Commitment to Livability

- **Opportunity**
  - Equal Opportunity
  - Economic Opportunity
  - Education
  - Multi-generational Communities
  - Local Fiscal Health
  - Commitment to Livability
Livability Index Example: Dublin, Ohio

TOTAL INDEX SCORE

53

CATEGORY SCORE

HOUSING
43
Affordability and access

NEIGHBORHOOD
48
Access to life, work, and play

TRANSPORTATION
56
Safe and convenient options

ENVIRONMENT
50
Clean air and water

HEALTH
53
Prevention, access, and quality

ENGAGEMENT
55
Civic and social involvement

OPPORTUNITY
69
Inclusion and possibilities
Livability Index Example: Dublin, Ohio

They say home is where the heart is—and the same holds true for the Livability Index. Housing is a central component of livability. Deciding where to live influences many of the topics the Index covers. We spend more time in our homes than anywhere else, so housing costs, choices, and accessibility are critical. Great communities provide housing opportunities for people of all ages, incomes, and abilities, allowing everyone to live in a quality neighborhood regardless of their circumstances.
Applying the Data

A county executive and staff want to know how to meet the housing needs of the growing population of older adults.

A real estate agent wants to market his walkable community as a place to find great housing near many local businesses and other amenities.

A non-profit organization wants to show the need for transportation services in the community.

A community advocate wants to make the streets safer for those who cannot afford to drive and those who can no longer drive.

An AARP member is deciding between two locations and wants to live close to medical services because she is taking care of a family member.

What will the Livability Index do for your community?
Supportive Housing

• People who use supportive housing are typically lower income individuals and families living with functional limitations and/or chronic conditions.

• 58% of individuals 65+ who receive supportive housing through HUD are Medicare and Medicaid enrollees (MMEs).

• HUD-assisted MMEs are likely to have more chronic conditions and utilize health care and LTSS more than unassisted MMEs.

• Lack of coordination between HUD and CMS has limited supportive housing and related efforts on the federal level.
Promising Practices: Support and Services at Home (SASH), Vermont

• SASH is a supportive housing model designed to connect residents with coordinated health care and supportive, community-based services.

• SASH services use a service coordinator and a wellness nurse, serving as an example for HUD’s SSD. These professionals work together to identify and connect SASH residents to services.

• SASH residents have more health care and LTSS needs than non-SASH residents and 68% are enrolled in Medicaid.

• Evaluation findings published in 2016 show savings to the Medicare program of $1,365 per beneficiary.
Promising Practices: CAPABLE, Baltimore, MD

• The Community Aging in Place - Advancing Better Living for Elders (CAPABLE) program is a supportive housing project funded through CMS and the NIH.

• Participants receive services from:
  – Occupational Therapist- 6 visits
  – Registered Nurse- 4 visits
  – Handyman- Up to $1,300 in home/environmental modifications.

• 83% of participants were Black, 87% were women, and the average participant age was 74. Participants had an average of 3-4 chronic conditions.
Promising Practices: CAPABLE, Baltimore, MD

• Initial outcomes data suggests the number of ADLs for which participants were having difficulty decreased by almost 50%.
• Participants also reported having less difficulty walking and performing self-care tasks.
• The initial cost of the 16-week program was $3,300 per person—significantly lower than nursing facility stays and hospital admissions.
Promising Practices: Villages

- Villages are membership-driven model of care in which older adults develop and direct services that promote independence and prevent relocations.
- Most Villages are funded in part by membership dues.
  - Average annual dues: $431/year
  - Most Villages offer discounted memberships
- Villages offer a variety of services and referrals to services, including home modifications, home/personal care, transportation support and care coordination.

<table>
<thead>
<tr>
<th>Common Village Service Referrals</th>
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<tbody>
<tr>
<td>Home Modification</td>
<td>61%</td>
</tr>
<tr>
<td>Home Care/Personal Care Providers</td>
<td>58%</td>
</tr>
<tr>
<td>Care Coordination or Social Services</td>
<td>50%</td>
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<table>
<thead>
<tr>
<th>Common Village Services by Volunteers and Staff</th>
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</thead>
<tbody>
<tr>
<td>Hosting Social Events</td>
<td>95%</td>
</tr>
<tr>
<td>Transportation Services</td>
<td>94%</td>
</tr>
<tr>
<td>Classes or Educational Events</td>
<td>90%</td>
</tr>
<tr>
<td>Companionship</td>
<td>90%</td>
</tr>
</tbody>
</table>
Promising Practices: Villages

• Over two-thirds of Villages made efforts to increase diversity in 2015, including by race, age, gender and income.
• More than 155 Villages exist in the U.S.
• There are 8 Villages in Ohio.
  – Columbus (4)
  – Cleveland (2)
  – Cincinnati
  – Athens
THANK YOU

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Real Possibilities