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The Safety Net Funders Network

Seniors and the Safety Net

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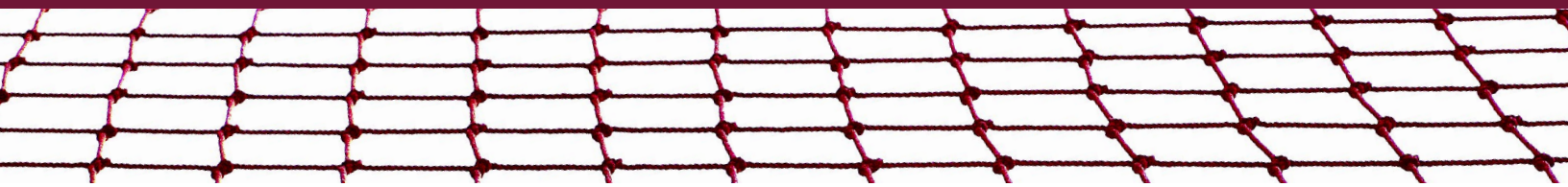

Overview of the Safety Net for Seniors

Target Population

Seniors represent a significant and growing proportion of the U.S. population, driven by the aging of the Baby Boomer generation. **Currently over 40 million Americans — or 13.1% of the U.S. population — are age 65 or older, and the number of seniors is projected to increase to 55 million by 2020.** In California, the current senior population numbers 4.25 million. People of color are currently underrepresented in the senior population, comprising only 20% of elderly Americans but 22% of the general population. However, the proportion of seniors of color is expected to grow to 24% by 2020. Women outnumber men in the senior population, with the proportion of women increasing with age.

Seniors are typically considered to be individuals age 65 or older (though sometimes as young as 50) — and thus they cover a nearly 40-year age range. Consequently, the safety net and support needs of seniors vary greatly across the senior population, with very different needs for active recent retirees compared to the frail eldest. Seniors of all income levels typically develop significant support needs as they age and require more assistance with daily living, but these needs are particularly pressing for low-income seniors with limited resources. Almost 9% of seniors had incomes below the official federal poverty line (FPL) in 2010. However, the federal Supplemental Poverty Measure (SPM), which takes into account regional variation in cost of living and actual expenditures for basic necessities, shows a poverty rate of 15.9% for older Americans, substantially higher than the FPL senior poverty rate, largely due to high medical out-of-pocket expenses for many seniors.

Service Needs

To meet the diverse needs of elderly individuals, the senior safety net and support system includes a wide array of services. For seniors who are still largely healthy and independent, support services include social and physical activities provided by senior centers, employment programs to supplement income, transit programs, and congregate meal programs to supplement nutrition and provide social stimulation. As individuals age and require more assistance with daily living, in-home support becomes important, including in-home personal assistance with daily activities (often provided through the federal In-Home Support Services program, or IHSS), Meals on Wheels, and home modification programs to improve accessibility and safety. Adult Day Health Care (ADHC) is another important service for seniors who are living in the community but require significant functional help, as it provides a supervised environment with social programs and healthcare support during the day, allowing more impaired seniors to continue to live in the community rather than in institutions.

For the most frail and disabled seniors, skilled nursing facilities provide round-the-clock residential care. Continuing care retirement communities also provide housing and supportive care for seniors, ranging from housing with on-site social activities for independent seniors to more intensive assisted living care for those with greater impairment, often in the same facility. Finally, case management and care coordination is important for seniors at all levels of functioning, as individuals develop different needs for services and support as they age, and often require assistance identifying and connecting with appropriate service providers.

While this formal service system provides vital support for seniors, in fact it is only one part of the senior safety net. **The largest share of care for seniors is provided informally, by family caregivers, who are sometimes spouses and often adult children.** In fact, two thirds of seniors with chronic disabilities living in the community receive only informal care. Moreover, many seniors receiving services through the formal system also rely on significant support from family caregivers, e.g. elderly individuals who attend Adult Day Health Care during the day, but live with and are cared for by their adult children at all other times. Caring for a chronically disabled elderly family member can be extremely stressful psychologically, socially, physically, and financially. Thus support for family caregivers is another critical component of the senior safety net.

Funding Sources

Funding for the senior service system for low-income seniors in California has traditionally derived from different sources for different types of care. For the highest levels of care — skilled nursing homes and Adult Day Health Care — the primary funding source is **Medicaid (known as MediCal in California)**. Services at lower levels of care — e.g. senior centers, congregate nutrition programs, employment programs, Meals on Wheels — have traditionally received the majority of their funding through the state **Older Californians Act**, combined with matching funds from the federal **Older Americans Act**.

At the federal level, funding for senior services has remained largely stable in recent years. However, at the state level, the California state budget crisis has driven major recent cuts in senior service funding. In 2011, the state attempted to eliminate Adult Day Health Care as a MediCal benefit in order to reduce costs. Advocates sued and successfully had the benefit restored, but with the requirement that all ADHC recipients be re-assessed for eligibility for the renamed Community-Based Adult Services (CBAS) benefit. Assessments and appeals are ongoing, but as of fall 2012 up to 20% of ADHC recipients have been found ineligible to continue to receive MediCal-funded services.

In addition, over the past few years, the state has substantially defunded the Older Californians Act in order to reduce its costs. These state funds are required to draw down federal matching funds through the Older Americans Act, thus the federal funding available for senior services in California has also shrunk. Funding cuts have particularly affected community-based service providers operating senior centers, nutrition programs, Meals on Wheels, and other services that have traditionally relied on these grants to support their operations. Some have seen reductions of 60% or more in state funding and are struggling to survive.

Another recent state policy development with major implications is a demonstration project to be launched in 2013 **to integrate MediCal and Medicare funding and programs for low-income seniors who are eligible for both programs, known as "dual eligibles."** The demonstration will also include integration with other long-term care and support programs historically funded by the Older Californians Act. Traditionally, these programs have not worked together well, so integrating them should theoretically allow for more efficient use of resources. Ideally, integration would also facilitate rebalancing the system of care to focus more on prevention and community-based care and less on acute and institutional care. This is particularly likely to occur if managed care providers for MediCal and Medicare are made financially responsible for nursing home expenditures, thus giving them a new incentive to keep seniors out of expensive institutionalized skilled nursing care by providing funding instead for community-based services like Meals on Wheels that enable seniors to remain in their homes. Moreover, such a shift could potentially enable community-based service providers to directly access federal funding through MediCal/Medicare, representing a new, larger, and more reliable funding source than the state funding through the Older Californians Act on which they have traditionally depended. Though MediCal/Medicare integration has significant potential for enhancing the senior service system, some advocates remain concerned that the planned pace of implementation and the cost savings anticipated by policymakers are unrealistic, thus threatening the success of the project.

Direct Services: Emerging Needs and Promising Practices

Integrating case management or care coordination into senior centers: Due to cutbacks in more acute care services and increasing family-based care for seniors with greater needs, senior centers are seeing more individuals who have more severe limitations, who may not be well-served by senior centers and/or who have a variety of additional support needs that cannot be met by senior centers. Posting a case manager or care coordinator at senior centers can be an effective way to connect these clients (and their family caregivers) with more appropriate or additional services outside of senior centers.

Integrating health services into senior centers: Seniors would like to have health care available at senior centers, and co-locating these services could be time- and cost-efficient. Although discussions with health care providers about partnering to integrate services have begun, securing funding has been challenging.

Supporting higher-need individuals at senior centers: Though senior centers are not appropriate for individuals requiring intensive care with daily living activities, they can provide support to facilitate participation of individuals with mild to moderate impairments. Such support is important for individuals who are not eligible for ADHC but require some help to participate in social and physical activities.

Improving Adult Day Health Center quality standards: ADHCs are required to follow regulations which dictate agency policies and practices such as the ratio of nurses to patients, number of therapy hours, etc., but there needs to be more standardization in terms of how ADHCs assess clients, what information they request from physicians, or what kind of therapy they provide. Members of the California Association of Adult Day Services (CAADS) do receive and share information about promising practices in ADHCs, including ensuring cultural and linguistic competence of staff and programming for specific client populations, and connecting clients (and their family caregivers) to community resources outside of ADHCs through social workers or case managers.

Funding Evidence-based practices in health promotion: Research has identified evidence-based best practices for a variety of health promotion programs targeting seniors, including fall prevention, disease management, and physical activity. Resources for identifying best practices include SCAN Foundation, LeadingAge, and CAADS.

Supporting family caregivers: Research has documented effective practices in helping family caregivers avoid depression, address stress, and build care skills, and effective programs should follow these evidence-based practices. Family caregivers often need or greatly benefit from training on basic care skills like body mechanics of lifting and behavioral management of seniors with cognitive impairments. Respite care and online social support programs also help caregivers address stress and isolation. Many family caregivers also need financial support as they are most often working women in their 50s, at a key age to save for their own retirement, but forced to reduce their work hours or quit to provide care for aging parents. Some receive payment from In-Home Support Services (IHSS) to provide care, but this provides only minimum wage without health insurance. Finally, formal care providers need to acknowledge the important role played by family caregivers by including them when assessing patient needs, making referrals, and making care decisions.

Adapting the village model for lower-income populations: In neighborhoods and communities with a large number of seniors aging in place, some seniors have collectively organized to create membership organizations or "villages" where membership fees fund a small nonprofit with staff who organize volunteers (including non-elderly neighbors), coordinate with existing community services, and sometimes provide individualized care coordination. This village model — also known as "naturally occurring retirement communities" or NORCs — works well for communities of seniors that have resources to pay for membership fees. Philanthropic support could make this model financially viable in lower-income or more income-diverse communities as well.

Investing in strategic volunteer management: Some (but not all) senior services can be provided by volunteers. Effective use of volunteers requires assessing whether they are appropriate for a particular service and investing in infrastructure such as thoughtful recruitment, high-quality training, and ongoing management.

Policy and Systems Change: Issues and Opportunities

Supporting advocacy for appropriate implementation details and timeframe for the integration of MediCal and Medicare in California:

Advocates are concerned that the planned pace of implementation is too fast for such a complex process, and they also believe that politicians have adopted unrealistic assumptions about short-term cost-savings that might result from integration. If savings are lower than expected, political support for integration could falter before it has a chance to show results.

Facilitating contracting between California community-based senior service providers and managed care plans participating in MediCal/Medicare integration:

- **Many community-based service providers need to build administrative capacity** in order to contract with managed care plans, particularly because such contracts require billing on an individual-patient basis, while funding for these agencies has traditionally comprised lump-sum grants to serve a set number of clients. Smaller community-based agencies also often lack the evaluation capacity to demonstrate that their services result in improved client outcomes and would thus be cost-effective expenditures for managed care contracts. ADHCs, however, have developed a successful model for interfacing with managed care providers that could potentially be a model for other community-based providers.
- **Alternatively, intermediary organizations could serve as brokers to link managed care** with community-based services, so that community-based providers would not need to directly contract with managed care providers. MSSP programs have been proposed to serve as this type of intermediary, but their infrastructure would need to be expanded to serve in this role. Only 39 of 58 California counties have MSSP programs, and the number of dual eligibles greatly exceeds the current management capacity of MSSP programs; for example, in Alameda County there are currently 49 MSSP slots and 49,000 dual eligibles.

Ensuring that California's low-income seniors in need of ADHC services retain their eligibility for the CBAS MediCal benefit:

Support is needed for both legal services to appeal inappropriate eligibility decisions, and for the financial and administrative costs of ADHC providers as they manage the appeal process and fund services out-of-pocket while waiting for appeal decisions.

Managing California State funding cuts among smaller community-based senior service providers:

Smaller agencies with budgets of $150K-$200K have historically been important providers of senior services in California, especially in ethnic communities, and these have particularly struggled to survive with the significant loss of state funding due to defunding of the Older Californians Act. Many of these agencies need support to develop new funding sources, partner with other entities and/or reduce costs in order to survive in this new funding environment.

Utilizing alternative poverty measures for senior safety net service planning and eligibility:

Eligibility for federally-funded senior services typically requires income below the federal poverty line (FPL), yet the FPL does not account well for the true basic expenses of seniors, particularly in areas with a high cost of living as in much of California. The number and characteristics of seniors requiring assistance are better reflected with poverty measures that are grounded in the actual costs to meet basic needs — such as the federal Supplemental Poverty Measure (SPM) or the California county-specific Elder Economic Security Index (EESI) (accessible at http://www.insightcced.org/index.php?page=cal-eesi). Individuals with incomes higher than the federal poverty line, but lower than the SPM or EESI, are particularly at risk — they do not have adequate income to meet their basic needs, but they are ineligible for most federally-funded safety net programs. In California, about 60% of Area Agencies on Aging as well as some local governments are using the EESI for planning purposes, and advocates are working to have it adopted for state-level planning, and hopefully for determining eligibility for services in the future.

Funding development and implementation of effective advocacy strategies:

Senior issues potentially affect most of the population (both directly and in terms of caregiving) and thus should have potential for broad-based political support, yet public funding for senior services, particularly in California, continues to shrink despite advocacy efforts.

- **Barriers and facilitators for effective advocacy:** Most people do not realize that the senior safety net has already been seriously eroded. Baby Boomers, in particular, need to be activated to realize that this is an issue that directly impacts them. Another challenge is the current political focus on escalating costs in Medicare and Medicaid/MediCal, pushing policymakers to prioritize cost containment for senior-focused policies. Articulating the cost-savings inherent in community-based care for seniors could potentially be an effective advocacy strategy aligned with the focus on cost containment, but hard data needs to be compiled to build the case. Several organizations — including SCAN Foundation and AARP — have created scorecards that rate states based on the adequacy of their services for seniors (e.g. proportion of seniors restrained in their beds in nursing homes). This type of "hard data" has been effective in motivating policymakers to act.
- **Strategies specific to California:** In California, state-level advocacy has been particularly challenging because of the ongoing severe state budget crisis, thus focusing on local (county- or city-level) advocacy might have more impact. Ligation has also been a successful strategy for addressing problematic state policies that affect seniors, as in the case of restoring MediCal funding for ADHC services in California.

Supporting and updating the Older Americans Act:

At the national level, the Older Americans Act is a major source of funding for senior services, and is currently up for reauthorization. As of fall 2012, the legislation in mark-up in Congress, and debate appears likely to continue into the 2013/14 legislative session. Thus this is a key window to advocate for support for the Act, as well as changes to enhance funding effectiveness, such as more updated nutrition program guidelines that would facilitate coordination of senior nutrition programs with mainstream food security providers like food banks.

Information Resources

National Council on Aging

AARP

LeadingAge

Aging Services of California

California Association of Area Agencies on Aging (C4A)

California Health Advocates

Family Caregiver Alliance

California Association for Adult Day Services (CAADS)

SCAN Foundation

The Safety Net Funders Network was launched in September 2009 in response to the "Great Recession" and its impact on the San Francisco Bay Area's social safety net. The Network aimed to inform safety net grantmaking priorities, identify longer-term systems change goals, and share knowledge gained about needs and emerging best practices in safety net grantmaking. This series of issue briefs described specific opportunities and strategies for philanthropic investment in targeted safety net areas, and follows a report on the scope of safety net grantmaking in the Bay Area, all of which can be downloaded at http://www.sff.org/programs/core-program-areas/community-health/safety-net-funders-network.

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