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**The Community
Partnerships for Older
Adults Program**

**Are the Partnerships
Affecting Policy in Their
States and Communities?**

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In the United States, the performance of each local long-term care system reflects a unique composite of federal, state, and community factors. The federal government broadly shapes local long-term care systems by (1) setting national statutes on services and support for older adults (for example, through the enactment of the Older Americans Act); and (2) allocating funds for services directly to states, primarily through the Medicaid program and Area Agencies on Aging (AAAs). In turn, states create their own long-term care policies and programs and dispense federal and state funds to localities and individuals, often through counties, AAAs, or the Medicaid program. At the local level, each long-term care system is made up of a unique mix of providers and agencies that operate under the guidance of federal and state policies, as well as local ordinances, cultural norms, and market forces.

Although no local long-term care systems operate in exactly the same way, many share the same inadequacies, such as a lack of coordination between providers and insufficient capacity to handle the forthcoming deluge of baby boomers (Weiner and Stevenson 1997; National Council on the Aging 2001). As policymakers, providers, advocates, and consumers have become aware of system shortfalls, increased attention has been given to the development, coordination, and sustainability of comprehensive long-term care and supportive services.

The Community Partnerships for Older Adults (CPFOA) program is an eight-year, \$20 million, Robert Wood Johnson Foundation (RWJF) program designed “to improve long term care and supportive services systems to meet the current and future needs of older adults” (Community Partnerships for Older Adults website. Accessed: March 17, 2006). The program encourages community partnerships of providers of aging services, public officials, senior citizen groups, and other stakeholders to (1) improve long-term care and social services by creating greater awareness of the growing need for services; (2) improve access to long-term care by providing information on services to consumers, increasing communication and coordination

among service providers, and leveraging public and private resources; and (3) promote better quality of life for older adults and their caregivers by enhancing choices and responding to caregiver needs (Community Partnerships for Older Adults Call for Proposals 2001).

In August 2002, after a competitive process, RWJF awarded 18-month design grants to 13 communities to (1) form partnerships, (2) prioritize community long-term care needs, and (3) develop plans to improve long-term care in their area. In February 2004, RWJF awarded implementation grants to eight of these communities: Atlanta, Boston, Broome County (New York), El Paso, Houston, Maui, Milwaukee, and San Francisco.¹ The eight implementation grantees are currently using a variety of tactics in trying to achieve their community-specific goals.

Evaluation of the CPFOA Program. RWJF contracted with Mathematica Policy Research, Inc. (MPR) to evaluate the CPFOA program. The evaluation has two goals: (1) to identify changes in the long-term care system that result from the partnerships' actions; and (2) to identify lessons that the partnership communities, other communities, and policymakers will find valuable as they seek to improve their long-term care systems.

Because one of the program's goals is to leverage public and private resources to improve access to services, an important evaluation question is whether and how the partnerships are affecting long-term care or social services policy in their states and communities. Because a significant amount of the public resources used to provide long-term care and social services comes from state sources, influencing state policies could greatly improve long-term care. Indeed, RWJF challenged the CPFOA communities to "shape state and national policy as they

¹ These CPFOA partnerships are operating in seven states, rather than eight, because the state of Texas has two partnerships—one in El Paso and one in Houston. The seven states are California, Georgia, Hawaii, Massachusetts, New York, Texas, and Wisconsin.

develop and implement solutions for the future” (Community Partnerships for Older Adults Call for Proposals 2001). In addition, because local policies strongly shape community development and agency operations, influencing these policies also may improve long-term care.

In this paper, we survey several aspects of long-term care policy as it relates to the CPFOA. First, to provide context for the policy and advocacy activities the partnerships are undertaking, we describe some trends in long-term care legislation in the seven partnership states. Second, we discuss whether and how the partnerships have tried to affect policy in their states and communities. We focus not only on legislative policy changes, but also on changes made within agencies, such as administrative or regulatory changes—all of which can improve the long-term care system. The answers to these questions will help us understand the kinds of policy changes that community partnerships can affect. They also may provide valuable lessons for other communities striving to improve their local long-term care systems.

Methods. To explore the legislative policy environment that frames the activities of the CPFOA partnerships, we used the Legislative Tracking Service, Issue Brief series, and Snapshot series of the Health Policy Tracking Service of NETSCAN iPublishing, Inc. to collect information on long-term care legislative trends at the state level. The data covered activity from 2003, when the partnerships were in their planning phase, through 2005. NETSCAN analyzes and tracks all introduced legislation on long-term care, grouping the legislation into topical categories. We focused on the number of new laws concerning five long-term care topics: (1) adult day care, (2) assisted living, (3) ambulatory care services, (4) health workforce shortages, and (5) home health care.²

² These categories do not necessarily correlate with the most important types of laws for long-term care system reform. They were chosen as a convenient sample of long-term care topics based on how NETSCAN’s system is structured.

To learn whether and how the partnerships are affecting long-term care policy, we interviewed partnership project directors and state and community policymakers in the CPFOA states. To identify which policymakers to interview, we asked each partnership project director for the names of policymakers who would be knowledgeable about state- or community-level long-term care issues and who had experience working or interacting with the partnership. We were referred to several types of policymakers, including state senators and representatives, directors of departments on aging, and county board members. In each of the eight partnerships, we attempted to interview two state-level and two community-level policymakers.³ We conducted the interviews in fall/winter 2005. In the interviews, we asked about recent, major activities in the public sector on aging and long-term care policy issues (both regulatory and legislative) and partnership interactions with the policymakers. We completed interviews with 19 policymakers—at least two interviews (and up to four) for every partnership except El Paso and San Francisco, for which we were able to complete only one interview each.⁴

How Much Legislative Attention Is Long-Term Care Attracting in the CPFOA States?

The amount of new laws that each of the CPFOA states individually passed on adult day care, assisted living, ambulatory care services, health workforce shortages, and home health care varied greatly among the states.^{5,6} California enacted 33 new laws on these topics during the

³ Some sites have interacted with few or no state-level policymakers. In these sites, we sought to interview two community-level policymakers and up to two state-level policymakers (if possible). In addition to any state-level policymakers, we interviewed community-level policymakers in Atlanta, Boston, Houston, Maui, Milwaukee, and San Francisco.

⁴ For several months, we tried to schedule interviews with other policymakers in these locations, but time constraints kept them from participating.

⁵ All seven states had regular legislative sessions in 2003 and 2005. In 2004, Texas did not hold a regular legislative session.

⁶ Bill categorization into the five subcategories was not mutually exclusive. A bill might have impacts on several aspects of long-term care and, thus, be recorded under more than one category.

study period—the most of any CPFOA state. Wisconsin, on the other hand, did not enact any new laws on these topics during the study period—the least of any CPFOA state. The other five states fell in between these two in the number of new laws they enacted on these topics.

A qualitative exploration of the laws themselves uncovered a rich variety of topics that the CPFOA states covered in these new laws. Resident safety and level of care, especially for those with Alzheimer’s disease, certification standards, and facility licensure dominated new legislation concerning assisted-living policy across the country. Most legislation enacted on adult day care issues dealt with minimum staffing standards, facility capacity, and licensure requirements. Legislative activity on ambulatory care services and home health care also centered on agency standards and licensure requirements, as well as on patient safety and rights. Much of the legislation enacted on health workforce issues attempted to combat nursing shortages by providing incentives to nurses (such as scholarships and loan repayment programs), as well as by organizing commissions to study and track nursing shortages.

These findings tell us that, at the very least, all except one of the CPFOA states were dealing with long-term care policy issues during the study period. In most of the CPFOA states, therefore, there was state legislative action on topics the partnerships could have tried to shape if they wanted to.

Have the CPFOA Partnerships Affected Policy? To successfully influence long-term care policy, other community partnerships would benefit from knowing which tactics the CPFOA partnerships have found effective. Local community partnerships can choose how they try to influence the use of public resources. They can try to make changes by affecting legislation, regulations, or guidelines. Furthermore, they can attempt to make these changes at the state, regional, or local levels. Knowing where other partnerships have achieved success can help them target their efforts more effectively.

The CPFOA sites' attempts to influence policy vary widely. Two of the eight CPFOA partnerships—Milwaukee and San Francisco—have not tried to affect policy at any level.⁷ Five of the partnerships tried to influence policy at the state level, while three addressed local policy issues. This appears surprising at first, given the original intention to affect state-level policy. However, it is logical that they chose to pursue activities at the community level, because (1) RWJF expects the CPFOA partnerships to focus primarily on community-level improvements, (2) the size of the grant and length of the grant period limit the number of activities the partnerships can realistically pursue, and (3) grantees are not allowed to use RWJF grant funds for lobbying activities (although they can for general educational activities).^{8,9}

At the state level, it is unclear to what extent, if any, partnership activities affected policy. Many of the state policymaker respondents we interviewed did not know whether the CPFOA partnerships had tried to affect state policy. This is not surprising, because many activities the partnerships are performing at the state level are untargeted. For example, two partnerships have tried to affect policy by issuing responses to proposed state legislation on long-term care regulation and financing. The Houston CPFOA supported state legislation that would consolidate human services agencies at the local level. The Maui CPFOA has generally supported legislation that would grant tax credits for long-term care and budget requests for

⁷ These two CPFOAs are working on projects that have not yet required them to try to affect policy at the state or local level.

⁸ Although a community focus was selected for CPFOA, members of the CPFOA National Advisory Committee (NAC) told us that they engaged in an intense debate over whether the community level was the best choice for this program. Several members thought that the state level was better, because the states provided most of the funding available for long-term care. Others sought a community focus, because they believed that communities know best what their specific long-term care needs are. Early in program development, this debate was resolved in favor of the community focus (Personal communications from NAC members, April 3, 2004).

⁹ Some CPFOA partnerships have secured funds from other sources to pursue their advocacy goals.

long-term care services. Both partnerships have detailed their support in written responses and distributed them to individual partnership members, who could then act on their own. Other partnerships have tried to influence state policy by distributing data or white papers on critical long-term care issues. Because of the diffuse makeup of the target audience, it is difficult to trace the influence of this approach. For example, the Boston CPFOA wrote and distributed a white paper—intended for funders, policymakers, and service providers—on the impact that poor mental health is having on the elderly.

Some of the partnerships have used more targeted approaches to reaching state policymakers. For example, the Boston CPFOA undertakes a formal review process to decide whether to support proposed legislation, after which the partnership sends letters directly to legislators indicating its position. The Boston CPFOA used this process, for example, to support a bill that would allow consumers a choice of long-term care services through MassHealth (the state's Medicaid program), including more home care options. During a recent legislative session, the Atlanta CPFOA testified before the Georgia legislature on the importance of community-based services. Partnership members have sought seats on regional and state planning boards to raise long-term care/aging issues. For example, the Houston CPFOA project director sits on two regional transportation-planning committees, where she has pressed policymakers on transportation options for the elderly. Some partnerships have discussed specific partnership activities with policymakers directly. For example, the El Paso CPFOA has discussed its plans for a Supportive Living Initiative—a program that would have private agencies manage long-term care service provision for elderly residents of a low-income housing complex—with policymakers from the Texas Department on Aging and Disability and local legislators.

Even with these more targeted approaches, however, state policymakers could not attribute any of these activities to policy change. Sometimes, this was because no policy changes occurred. For example, El Paso's attempt to develop the Supportive Living Initiative received much support from El Paso's state legislators. However, their support alone was not enough to obtain the legislative action necessary to implement such a program.

When state policy change did occur, several policymakers noted the difficulty in attributing it to CPFOA activities, because so many other stakeholders and lobbyists also try to influence policy at the state level. These interest groups often include industry associations and unions for hospitals, assisted living, adult day care, nursing facilities, and the homecare workforce; state chapters of the AARP; and AAAs from throughout the state. One state policymaker observed, "I cannot draw a line directly from them (the partnership) to a piece of legislation because those things have so many different inputs."

In contrast, policymakers could pinpoint specific CPFOA activities that they believe led to policy changes at the local level. First, the Atlanta CPFOA provided charts and statistics to the Cobb County Board of Commissioners about senior traffic patterns and other residential trends to encourage the county to loosen its criteria as to where higher-density (senior) housing could be located. Two local policymakers stated that, as a result, the county modified its zoning ordinances to allow such housing in residential areas. Second, several local policymakers in Hawaii credit the Maui CPFOA for securing additional county budget funds for long-term care issues. The Maui CPFOA's presentations to county council members helped make the case for modifications in county budget allocations to provide for caregiving pilot projects and a long-term care workforce training program. Third, the Boston CPFOA analyzed Boston Police Department records on elder abuse reports and, with this information, made a case for more intensive police training on elder abuse issues and mandatory reporting guidelines. The Boston

Police Department acknowledged the need for additional training and responded by instituting an upgraded training on elder abuse for all new police recruits.

It is not surprising that those CPFOA partnerships that have tried to affect local policy have not only succeeded, but also have been credited by local policymakers for these policy changes. There are considerably fewer stakeholders and lobbyists at the local level with which the CPFOAs must compete for recognition. In addition, the CPFOA partnerships are made up of nearly all the long-term care and elderly services providers in each of their respective localities—they *are* the major stakeholder group at the local level. Most likely, many of the CPFOA partnerships also have more direct access to their local policymakers than they do to state policymakers. In fact, community leaders often are members of the partnerships, indicating that they buy into the partnerships' goals and may be more open to implementing policy changes to improve the local long-term care system.

Conclusions. The CPFOA partnerships have tried to influence policy at the state level, much as was expected when the program was envisioned. However, policymakers were unable to attribute changes in policy to the partnerships' activities, primarily because so many competing factors and players influence the development of state policy that it is both difficult to affect outcomes and be recognized for it.

At the local level, however, the voice of the partnerships is more likely to be heard. The three partnerships that undertook activities to influence community-level policies were recognized as having influenced the local decision-making process.

These findings have implications for any community-based partnership that wants to affect long-term care policy. Certainly, community-level partnerships can give voice to matters concerning state policy. Most of the money for long-term care does arise from state sources, so it is logical that partnerships would want to work at that level—where they have the greatest

opportunity to really change the long-term care system. At the state level, however, their voices often become part of a large chorus of other groups with similar or competing interests, making it difficult to have an influence. Furthermore, because the CPFOA is a community-level partnership, and states elect representatives on a geographic basis, there is no natural reason for policymakers from across the state to incorporate the partnerships' views. However, community-level partnerships do seem to have tangible effects on local-level policy. Therefore, it makes the most sense for community-based partnerships faced with limited time and financial resources to focus their energy on affecting local policies.

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