National I&R Support Center
Webinar: State of the States in Aging and Disability
February 14, 2018

>> Please stand by for real-time captions. >> Today's webinar will begin in 10 minutes. Thank you. >>
Welcome to all of our participants. We will begin at 3 PM Eastern time. We will get started in five minutes. >>

Hello. I would like to welcome everyone to today's webinar. My name is Nanette and I manage the national information and referral support center that is administered by NASUAD. I want to welcome everyone to today's webinar on the 2017 State of the States in Aging and Disability . Let me cover a few housekeeping items before we get started. These slides, audio recording and transcript from today's webinar will be posted to the NASUAD website within the next several days. Please visit the national I&R support center on the NASUAD website.

This web link is also posted in the chat box for your reference. So if it is easier for you to cut and paste from the chat box, go ahead. All of our listeners are on mute in the webinar to reduce background noise. But we welcome your questions and comments through the Q&A function on your screen. Please feel free to submit your questions at any time during today's presentation. We will address questions following the presentation. We also have real-time captioning for today's webinar. On your screen you should see an media viewer panel on the bottom right where the captioning will appear. You can minimize this panel or have it open. It will not block the slide presentation. You may need to enter your name and organization and click submit an order to be in the media viewer.

I am really pleased to have my coworker, Damon Terzaghi, join us this afternoon. Damon is a senior director at NASUAD and our public policy lead. Every other year, NASUAD conducts a comprehensive survey of our membership. These are state agencies that deliver long-term services and supports. Including aging and disability agencies and Medicaid programs. Damon has some really interesting and rich data to share with us and he loves to talk data. So without further introduction, I am going to go ahead and turn it over to Damon to get us started.

Great. Thanks so much, Nanette. Thanks everyone for joining us today. Today what we are going to do is talk about these survey results from last year's state of the states national survey as well as its implications for the information and referral network as well as many of the other entities in the aging and disability network. With that, why don't we go ahead and get started.

As Nanette mentioned, this is a national survey that we administer every other year. So the most recent time before 2017, was in 2015. We focus on long-term services and supports across the gamut. Really all of the programming that touches the lives of older adults and people with disabilities. This includes the Older Americans Act, Medicaid programs as well as state-funded services and an array of other

supports. Because the survey touches across a lot of different programs and agencies, we broken up into three main elements for data collection. I don't want to spend too much time on methodology but is important to understand how we collected the data. There were three parts to the survey. The first was one that focused on aging and disability agencies. This may vary from state to date but essentially it's the designated entity within state government that has responsibility for aging and disability policy and in many cases services as well. The second is really focusing on long term services and supports and home and community-based services. In a number of states this is really talking about Medicaid funded supports and services, but in many other states it also encompasses state-funded services and a wide array of other long-term services and supports. The last thing we did was we used prior-year information to develop summary charts that actually articulated what services are covered in a state. Which populations are covered . How the state agency is structured. A number of states specific data.

We put it together and then send it out to the states for their review to ensure that it was accurate and that nothing had changed in the two-year interim period. So in terms of how we ultimately administered the three different components, it was in the fields for several months in the spring and early summer of 2017. And we got complete data sets to the AG and disability surveys all 50 states and the District of Columbia. The LTSS survey we had 46 states in the district who administered or responded to the survey. And lastly, we have 34 states provide edits and changes to those summary tables of state specific information that we had developed. So all told, you can see there is a little bit disparate response rate depending on what topic we talked about. In general we got lost -- got robust responses. We did have a complete data set with all states responded.

So with that background let's go into a couple of key overarching items and policy issues before we dive into specific topics. So, this next section is really focused on agency priorities and the aging and disability policy priorities and agency specific information within each state. So this was contained within that aging and disability survey. It focuses on the entity with responsibility for policy for delivering services to these populations. We had a companion publication. It's not actually part of the broader state of the states Databook, but it is related to it so we like to talk about it in tandem with the information on presentations like this.

So what we did for the survey was we had a pre-populated list of 14 topics and then gave a 15th option for states to provide other . And tell us what your priorities are. And then he asked states to rank their top three priorities from the pre-populated list or other options. So we then took the responses and just used a very simple scoring system where if a policy topic was ranked as an agency's top priority, three points. Second if it was the second point. One point it was the agents third party. Aggregated it up based on the number of states that rank teach option. And ultimately ranked it. Just a couple notes on this. Like I said, it was really focused on the state agent and disability aging survey. And this one we received 49 states and

the District of Columbia response. One state said it was too hard for them to prioritize because they didn't want to minimize the importance of other policy and programmatic areas. So they did not want to say that some were more important than other. We had one state refraining from answering that question.

I would note that one of the things this really highlighted was how disparate the states are in terms of their priorities and their top issues that they are working on. So although we did house 50 responses from 49 states and the district, no topic received more than 19 votes for any of the three priorities. No topic received for second or third for more than cash from more than 19 states. However we also found that over half of the options we provided to states received at least one ranking from 11 or more states. So really what that shows us is from the pre-populated list of policy options, states are really all over the place in that particular area. A lot of states based on their structure, priorities, based on a lot of things will have different priority areas. What we did find however was there was a natural break in the scoring system between the top seven priorities in the remaining eight. So there was a really big gap where we added up all the scores and then there was a pretty big distance from the seventh priority to the eighth priority. So we thought we would highlight the top seven and talk a little bit about what the states are saying about them and why they are a little bit important.

So these are the top seven priorities. And you will see that a lot of them are really policy oriented. They are focused on regulation. Focused on service quality. For example, the first bullet point there was the one listed as the top priority. Was ensuring compliance with the Medicaid home and community-based services regulators. This is a regulation that I know we have spoken about with this network in the past. But just as a reminder, it was promulgated by the federal government in 2014, it contained a lot of different changes to the way that Medicaid, home and communicate home base services are regulated. Probably the most important and talked about change was this real shift in the way the services are provided at the local level. In a new definition and requirement around community integration and what a home and community-based setting actually is for purposes of the service. Obviously, it entails a significant transformation of the states home and community-based services system in many cases. So you can understand why that would be at the top of everyone's list in terms of their priorities.

The second was Adult Protective Services and elder justice related supports. I want to get into this too much now but we have a whole section discussing it later. It is such an important topic for our states and for the services. And I'm sure for all of you in this network as well. The next is around improving quality. This is an really limited to home and community-based services. To aging and disability supports. Quality is an area of topic across the health and human services system. How do we ensure that we are getting value for the payments we make? How do we ensure that individuals at the local level , individuals at the direct intervention level are receiving quality services that actually having meaningful impact on their lives

and their health status and other things like that? Manage long-term services and supports continues to be an issue. Again we'll talk about this in more detail later. I would just note that we continue to see expansion of this. We continue to see more states either evaluating or ultimately moving to a system where they contract with private managed care entities to deliver long term services and supports primarily in the Medicaid program to Medicaid eligible beneficiaries. The long-term care ombudsman regulation was also going alive around the time of this survey. So we did have a lot of states express that was one of their priorities ensuring that the changes that were required vertically around things like conflict of interest, delegation of authority, as well as requiring that the Albans men were exempt for mandatory reporting statutes. They were really at the top of people's minds when they answered the survey.

The next one is a little bit more service-oriented . Focused on hunger, nutrition, and food insecurity. There is been a lot of research recently and over the past several years, discussing some of the issues related to food insecurity in particular in the older adults population but I think we all know there is a lot of different factors that play into that whether it is poor oral health, or the inability to leave someone's home to go shopping, or even just economic constraints that prevent an individual from accessing as much food as they would like. I would highlight an ongoing publication that's released every year from the national food adoration -- Federation two and senior hunger. It looks at the prevalence of food insecurity and hunger across the country in the older adults population it definitely is an area that a number of states are concerned about. And looking at interventions to assist with.

And lastly, services for individuals with Alzheimer's and related to Mencius. I think we all know that this is an issue that is increasing in prominence as more and more individuals live longer. And reach points in their lives where they might experience Alzheimer's or dementia. We are seeing increased interest in ensuring that supports and services are provided kind of in a multifaceted way that first of all, protects the health and welfare and safety of individual. And second of all, really ensures that personal autonomy and individual freedoms and liberties are maintained to the greatest extent possible. I would personally argue that there is a little bit of an interface between this bullet point and the first one with the Medicaid home and community-based services regulation where states have to put a lot of effort and interest and policy development around maintaining those dual goals of assuring health and welfare. While also assuring individual liberties and personal autonomy, and maintain. So the last thing I wanted to highlight was we did give states the option to submit their own other priorities. Around where they want their system to move.

1915 (K) implementation was with the affordable care act. It provides states with some increased federal matching funds to deliver specific attending care services. Delivery and payment reform of long term services and supports. Some of that may be incompetent statement long term services and supports service reports. This is a more broad

reaching been looking at a managed-care system. ADRC reinvigoration, I love that term. As we know this is a model that has been around for a while and states are continuing to look at ways to strengthen the integration of services and really create that one-stop shop for individuals to access information referral and assistance with entering into the service system and receiving the support they need. Advancements of no one door systems is related. And every day is a specific model for community living promoting. Data sharing across public programs is another interesting one that came up. In some of the research and separate publications and surveys we have done we found that there really is a need for many states to ensure that the variety of health and human services programs have that touch people lives are integrated. So you can truly understand what our people are eligible for, what supports they are receiving, and what ultimately is the outcome and value of those supports. The last one we received from a couple of states was the veteran directed home and community-based services, that's what VDHCBS stands for. That's a model that has been developed between the administration for community living and the Veterans Administration to focus on providing a lot of that seem opportunity for home and community-based services and community integration to veterans with disabilities exist for other people in the Medicaid program. I would like to start with that.

Is a framing reference to understand. This is where the states are coming from. This is what is driving a lot of those specific data points and policy considerations that we will talk about moving forward. So what we did was when we collected all the information and analyze the data that states submitted to us, we organized it into several key themes. This is kind of like the findings section. Because it's not necessarily as statistically significant survey, we like to talk about themes as opposed to tangible findings. However, I would argue that this really is a way to think about how the state governments are moving. And where the keep points are and policy and service delivery in the network for the individuals we serve.

So that it seems that we identified from the survey data. This you will see a lot of correlation between this and the priorities listed before. Which is a good thing. Because the correlation between what the agency priorities are with what the actually service delivery and policy actions around the country are, then it shows there is actually a cohesive narrative that came up from the survey. It's always nice to see that high level of information is affirming your discrete data points and vice versa. The first of that is the move towards integrated health delivery continues to change long term services and supports. It integrated health delivery.

A number of the states our priorities. It goes beyond just manage long-term services and supports and manage community-based services. The second is major changes in the home and community-based and long-term services and support systems are continuing to impact the way these services are delivered. And these are often very regulatory focus. Talking about things like the home and community-based. What setting is appropriate regulate should there's another big regulation from the Department of Labor focused on how homecare workers should be treated

for minimum wage and overtime protections. That was going into place and a lot of states work continuing to implement at the time of this survey. The third is really around state budgets. We are seeing state budgets recovering. Particularly at the time of the survey. States were not reporting the same level of challenges with the revenue collection. The way they had been in prior years. But demographic trends are driving expenditure growth. So is still seeing pressure placed upon the overall long-term services and support system.

Elder justice services are a top priority for agencies. I mentioned that earlier in the priorities area. It was reinforced by the specific information provided around these topics. The last two are a little more bureaucratic agency focus. I do think it's important for this particular network to be aware of the direction that state aging and disability agencies are moving and the challenges and priorities they are focused with and how that might impact services and supports at the ground level. So the first is staffing and leadership at agencies can tune you to experience significant changes. A lot of turnover at the leadership level. Which is expected to continue. And even more so than that, it's also been a lot of turnover it and retirement at the career staff level which can lead to some loss of institutional knowledge and the need to reinvigorate the bench for lack of a better term.

And the last is the agency responsibilities are expanding to drive service integration. I think that this correlates to the first bullet as well. Your essay and integrated care models come out at the local delivery level. Agencies are really trying to respond to that. But also integrating their responsibilities and expanding the scope of their responsibilities so that they are able to encompass that broader integrated service model. So with that overview let's go into a little more detail on each theme.

So the first as I mentioned was talking a little bit about integrated health delivery. So this really looks at what are happening with long term services and supports and care coordination. How are states transforming the models they used to deliver services and sports to people with disabilities at the local level. At health homes, affordable care act, focused on integrated cared team's delivering supports to individuals severe mental illness or some commendation of chronic condition. Talked about contracts with capitated health plans. Managed long-term care supports model. Accountable care organization. A little more provider level. But they do still have a component of a separate payment model that is intended to drive better service integration and better service coordination with a lot of accountable care organizations are current hospitals.

But there are other potential entities that could be involved as well. State run care coordination can really be staff within the agency that are tasked with doing a little bit more direct supports to individuals. Showing they have opportunities to do care coordination and making sure they don't fall through the cracks and have individuals with disparate services and supports where they are unaware of medication prescriptions for the person or that the hospital stays me look like what ancillary supports they have in place. To address other sorts of

healthcare needs the person has. Primary care case management is a similar model where you have a primary care physician or physician assistant at that primary care practitioner model level ensuring that all of these services and supports are coordinated across the spectrum of needs for those individuals. And then provider of physician led entities. Those are little bit more ACO focus but drilling down farther thinking about these provider or physician led models of care receiving a global payment to deal with individuals.

For a more tangible example, at the time of the survey, Arkansas was really looking closely at using some of their behavioral health providers to deliver some of the integrated care models. That's what we're talking about here. To give a sense of what we're talking about when we say the contracts with capitated health plans, the growth in it, and what it looks like around the country. Given how much interest and emphasis is on in this mentor that -- managed tran not, we want to give a tangible sense of what it looks like across the country and what states are doing it.

The first thing we do is we show a map of our 2015 survey. These are the states where at that time were either considering bringing up a program that is the green tone on your screen. Dates that already had one operation at a state one level. That is the dark blue on your screen. Regional programs, is the red. And the orange is the dual demonstration. That is really a program that was done in connection with the centers for Medicaid and Medicare services. And only applies to individuals who are on both Medicare and Medicaid at the same time. A comprehensive for all Medicaid and Medicare, it's still good to have that implication that's what it looks like in 2015.

In 2017, the thing that I find fascinating about this particular map is that you see a slight decrease in the number of states who said that they are interested in it and is under consideration in this particular survey. And actually about the same number of states had programs in operation. When I look at the slide I see a couple states are in light dark blue versus likely. Essentially what you're seeing is that those states in one or more shades of blue, once with active programs in 2017, the dark gray ones are ones that are in active development bringing it up, and the green were the ones were under consideration. My take away from this one is that when you look at this particular map, it might look a little less filled and then the previous one so you might have fewer states that are highlighted, but what you have is a couple of things that actually makes it a little bit more impactful than it would look at first glance.

The first is that several states that were dual eligible only, are now more focused on all Medicaid long-term supports beneficiaries. I am highlighting Ohio and Virginia. We saw a couple of other states moved to statewide programs. And then we had a couple of other states continue to evaluate bringing up program on board. If we did this map again for 2018, a you would continue to see some states with under consideration. I would expect a couple of other states added to this particular list for 2008. Essentially what this map shows us that in previous surveys there was a huge spike in the number of the states

that when from long term services and supports, in this particular survey you are seeing yet slow down a little bit. A lot of that is because some of the larger states, California, Texas, Florida and New York are already in place. Some of the smaller states that don't have as much experience and sophistication of the managed-care space, kind of go a little more slowly and being more cautious with their integration initiatives.

I particularly love the slide. This is looking at which populations are included in managed long-term services and supports program. That chart with three different segments of populations included in managed long-term services and supports. Dark blue is these populations are already included in an existing program. The darker green is a managed long-term services and supports program not yet operation that operational but when it goes live these populations are intended to be included.. The lighter gray Ms. managed long term services and supports in place today. They do not include these populations but they are planning to include this population at a later date. That's what we mean by expansion of an existing program.

Now one of the things that I would highlight is that older adults in individuals with physical disabilities are the most common populations in managed long term services and supports. When we are talking about supports and services particular to the adult population, when you hear about the rollout of managed long term services and supports, it tends to be one of the first populations that is included and then it's the rush of states being on other population it tends to occur in not in every case but may be at a later date. Individuals with intellectual and developmental keep up -- disabilities you will see it's less common that those individuals are included in programs today. You are seeing more states begin to implement that and begin to include this program. So I would personally say this is something to highlight for the next five years. If you don't see a whole lot of additional states come on board, it's worth watching to see whether states that have a little bit more experience, more comfort, with managed long term services and supports program may look at including additional programs and populations down the line.

The other thing you see is that services included in managed long term services and supports program you have Medicaid home and community-based services. Medicaid primary and acute services are really the most common services and supports included. It's pretty rare when you have a managed long term services and supports program that doesn't have home and community-based services. And similarly it's pretty rare when you don't have an integration between the primary and acute supports with that HCBS services. The bottom of the slide has a typo. It should be existing program for the dark blue and planned expansion of the program for the green color. One thing I wanted to highlight is that we have seen over the past couple of years more and more states include the nursing facility services. In many cases nursing facilities have been excluded from managed care contract. There's a lot of financial as well as political reasons why they may have occurred. We are seeing more states include the supports and services within their managed-care contrast. An interesting approach to it because when you have the

nursing facility and the home and community-based services under the same contract a lot of states have really use that as a way to drive the institutionalization efforts up. And place incentives, financial and outcome-based contractual incentives on the plans to shift individuals from institutional settings to more integrated community-based settings.

This next slide we really wanted to highlight for this network since we know a lot of you are involved of the community-based service level out whether part of AAA's are ADR Caesar centers for independent living. Weren't partnership with epic one of the things we really have seen is when these community-based organization, CBOs on the slide, are in states that implement long-term services and supports, you tend to see sometimes struggles with those CBOs carving out a role within the managed long term services and supports system. Particularly, you look at this slide, case management only five out of the 27 states that responded to this question said that the CBOs perform case management. Other states in the previous models, the fee-for-service models, case management was frequently done by these particular entities. There is kind of an argument here for the CBOs to be cognizant of managed long term services and supports systems . And get in on the ground level so they can ensure that the error expertise knowledge and supports that they have available to the population are maintained in this type of a transition.

The most common role that CBOs played was choice counseling. Choice counseling in this context we are talking about helping the individuals understand the implications of which managed care organization may enroll in. And assisting them with that enrollment process. The one other thing I would say is that I know it's generally bad form to include something in a bar chart where there's no actual bar chart answer. A couple times I do it because I like to highlight that it didn't occur. Frankly we thought it would. And we were surprised to see that enrollment broker and in really doing that direct assistance with health facilitating a person entering a plan making sure they get enrolled in the plan that they wanted. We were surprised to see that did not occur in any state. Particularly given the emphasis on choice counseling and independent assistance with individuals. You see the choice counseling happen potentially a different entity during the enrollment broker. Some opportunity potentially for thinking for ways to better coordinate that and better integrate those supports.

You might ask what's the difference between the slide where talk about those community-based organization being engaged with integrated health entities versus the previous slide. That's really what I am talking about where we are drawing a distinction between managed long term services and supports and other models I discussed earlier. Providers and care coordination. Accountable care organizations, etc. What you are seeing in the slide is that when we asked the states what are happening with your CBOs, are they engaged with integrated health entity models that are occurring within your states ? More states said that they were not engaged then said they had actual contracts and engagement with the entities.

This is particularly striking on the disability side. You do tend to see disability organizations more likely to say not engaged and less likely to have one of these other engagement activities occurring. So when we talk about this we are saying aging or disability community-based organization talk about AAA's and those sorts of models, what are you actually doing and how are you engaged with these entities? You see on the far right side it is pretty rare when there are only engaged with a managed care organization. You do see when those CBOs are actually engaged with the entities. We are looking a little more broadly. How can we market our experience and engage people across the healthcare sector whether they are in managed care plans, the hospital ACO's, other things like that.

And when those entities are actually engaged with those entities and have con tracks in place, it's very interesting to see what supports the actually provide. The direct services were the most common we are talking about home delivered meals. Transportation, etc. Those of the most common things the entities said they were provided. The next most common was case management. An interesting juxtaposition with bad and the slider showed you a bit ago where there were few CBOs engage in case management with managed care plans specifically. But when you brought in the fields of community-based organization, there tends to be more engagement there and I think that the way we thought about this was it's much more likely that managed-care plans have their own in-house care management care coordination entities as opposed to other parts of the Health and Human Services network. And looking for outside expertise to help them in an integrated model.

The next theme we will talk a little bit about some of the major changes that are impacting home and community-based long term services and supports systems. This is a regulatory focus were talking about. I mentioned earlier there is a new requirement by the centers for Medicare services around what home integrated community based service looks like. We as states are you struggling with having supports and services and providers that might not meet these requirements? These are the types of providers that they said they were specifically concerned about. In residential settings where people live. Assisted living came to the top. Some of that is because our network focuses on aging and physical disabilities little more than IDD population. Also because assisted living facilities were built out of this model of services and howling being co-located in a communal setting which bumps up a little bit against the requirements of the role around personal autonomy and community integration in an individualized way.

It's not to say assisted living centers cannot be compliant, but there are a lot of strict provisions placed upon them. And when we look at bout service transformation moving forward, I would say that assisting limited facilities secure memory care facilities or more targeted basis are areas where there might be a lot of changes and evolution for the way services are delivered in this type of model. There ID/DD group homes as well as farmstead communities are focused on multiple individuals living together. That next slide we talk about nonresidential settings. Where people go during the day and then go live somewhere else at night. As you can see there is some correlation

here with it really the congregants centers. Whether adult day services or sheltered workshop. Work a healthcare facility. Those are really being services that may not be compliant.

Again, the regulation itself focuses on ensuring that individuals have person centered plans of care that promote and facilitate community engagement so you do have just a little bit of work that needs to be done to transform the service models into a manner that promotes individualized basis. That the adult day services in particular, is one we have a lot of conversations with her states around looking for support and assistance with developing policies and working with providers to ensure that these services are delivered in a way that the places compliant with the rule. While also maintaining their focus on integrated care and integrated health and social services.

The last thing I want to mention is earlier I talked about the fair labor standards act that put new requirements around wage and overtime. And so we were curious to see what ultimately happened with that when states implemented it because there were certain analysis around significant cause implications of these types of regulatory changes. And we actually didn't see a whole lot of state saying they made significant changes to the program. The most common ones only occurred in seven states. What that was basically to establish a limit to establish and ensure that no worker exceeded the overtime. No worker did more than 40 hours a week. And qualified for overtime threshold. Just a little bit of a different outcome than we would expect based upon what states were concerned about leading into the implementation of that regulation. So moving from some of the regulatory issues let's talk about the state budgets. And one of the things I would say is that one of the things we found that there's a lot of different experiences across the country.

This slide is a bit challenging to interpret. And we just try to find a way to show states were all over the map. You have some states where there budget increased by over 10%. More than 10 but less than 20%. There -- of their total aging and disability age. On the other side we had one state that said they experienced of funding cut by more than 20%. The thing I would say is that the take away from this is state budgets are generally improving, but it's not a uniform -- it's not uniform impact. States are all over the place in terms of what the funding impact would be for them.

So what you see then is although it we are talking about a number of states that had level or increase funding, there is still a lot of states that are discussing various programmatic reductions . Whether reducing allotments or payments to area agencies on aging. Freezing a reducing provider rates. Or limiting services. A lot of states have this under consideration and often times will go back to legislature for supplemental funding to try and alleviate that. But we do like to highlight that despite what we talked about the economic recovery in state budgets improving, there is still some practice put in place due to the disparate nature of recovery. Some states are doing better than ever. Some of it is due to this slide here. Which is really focusing on the fact that you are seeing the majority of states experiencing

increased caseloads across their Medicaid home and community-based population.

The should be no surprise. We have a population that is aging. We know the statistics around increased numbers of older adults across the country. What is ultimately happening even though we are experiencing increase revenues, we are also having a lot of service growth driving pressure on overall budgets.

I talked about this earlier but it's always worth reiterating. The elder justice issues and services that really promote health and welfare and adult protection are really a top priority for the agencies across the country. One of the things we found was that despite some of the slides I talked about earlier where disparate issues around state recovery, for this states that administer APS program is which you will see here, 27 -- 27 of our respondents encompass half the states. The majority of them actually in Cree -- received increase funding for their APS funding. Even though state funding seems to be scarce and pressure, you do actually see APS being a priority for the legislature and for the agencies. And putting increase funding into those printing -- program. Very few states reported receiving decreased APS funding despite some of those other challenges that they mentioned. Of those bash some of these states I mentioned on the last slide 27 states administered the APS program , we push the states to respond even if they didn't administer their APS funny. That is why you're seeing all 50 states responded to this one. Whereas we only had 27 states respond on the other.

I will say that the general fund appropriation, release date tax revenue, was the primary source of APS. When you think about the subset of states that reportedly saw increase funding, this is from state tax revenue. Often times one of the hardest places to get funding secured for your health and human services agencies. There's always an emphasis on leveraging federal funding. And maximizing resources. But this is an area where there's not a whole lot of federal funding available. And states have really record denies that need and continued to fund these services I'm push for Adult Protective Services.

The thing I would also highlight is that almost 20 states use social service block grants to fund their services. A particular area of challenge given there have been a lot of challenges to eliminate this through budgetary reduction discussions occurring in Washington over the last couple years. I don't anticipate it will happen. Something to keep aware of what we talk about APS.

This is another -- I think this slide highlights why this is important to states. As we move on to the next slide you will see that there is changes in APS staffing levels and changes in the average APA's -- APS caseload. You saw increase funding which logically led to most states either having increased staffing levels or at least being able to maintain their staffing levels. You only saw three states reporting decreased staffing levels. Yet despite that, it was extremely rare when you saw states say that they had a decrease in their APS caseload. So even when states increase the number of staff, they also saw increased

caseloads and that's really because you had the majority of states reporting increased reports to the APS system. There's a lot of increased incidence of abuse, neglect, and exploitation across the country. Really highlighting why Adult Protective Services and elder justice is such an important issue. Even when you are allocating more funding to it. Even increasing your casework is in staffing level, you are still seeing an increase caseload because the demand for these protections is outpacing the ability to provide the support. It's harrowing data when you think about that.

This next slide is drilling down a little bit further. You really see it's across the board. It's not any type of abuse, neck collect or expectation. That are subject to these increases. On the far right side of the slide you will see financial exploitation being the highest and in the most states importing -- reporting increases around reports by this type of abuse. That has been consistent every time you do this survey. We are seeing more and more issues of exploitation. Whether a family member or caregiver or whether some of the more common things you think about like mail or telephone scams. Across the gamut and something that I think is incumbent upon all of us in the aging and disability system to be aware of the signs of it. To be aware of how to recognize when it might happen. And to have the knowledge basis to ensure that reports are made and that the individuals can be protected.

So we are winding down towards the end of the hour. I did leave these at the end because I think that they are probably a little less engaging for people at the information referral and direct service levels. But we do think it is important to be aware of what is happening at the state level with the agencies and how it might play down to your programs. The first is that we are looking at the tenure of agency directors. How long have they been in the job? You see 92% of the agency directors have been in the job for less than 10 years. And 84% have been in the job for less then five years. It's extremely common to see rapid turnover.

And this leads to that thing I talked about earlier where there is a need to ensure that the bench is strong so that you can maintain programs and maintain the institutional knowledge even during a period pretty significant turnover. And frankly, I would say that this bar chart here -- this pie chart is going to look different next year. Will probably see quite a few more people with less than one year of tenure simply because we have a lot of elections coming up. Most of these people are gubernatorial appointees. So we do anticipate we will see in of -- another period of significant leadership chain. Significant priority change. In a need to educate the new directors on the importance of the programs and really wise some of these issues such as Adult Protective Services, such as hunger for nutrition related issues are so important to our network.

You will see on this slide the majority of directors or either a direct appointment or hired by someone in the -- basically the first to slide encompass the vast majority of states. The political appointees. When the administration changes the agency directors will change, too.

The last thing I would say I was talking about developing a strong bench. Bench for the individuals. It's good to ensure the programs are maintained and continue to evolve and strengthen. With that, you will see in this particular slide, these are the number of states where they have had a certain percentage of their staff retire. I'm stumbling over how to explain it. What we are showing here is the dark blue and light blue parts of the pie chart are those states that have seen more than 15% of their state agency staff retire of the past five years. A pretty significant proportion when you think about it. So you are really seeing a lot of state staff turnover. At the same time as the directors turnover, so again this makes it more incumbent on those of us who are not assigned government maintaining in the system to ensure that education is given and that the agencies are able to maintain their services and supports and rebuild that institutional knowledge.

The last thing I mentioned we talk about integration that the service delivery level. We are seeing that again at the state level. These states are evolving to ensure that they are able to serve these integrated broad reaching service delivery models. So what this does is it shows over the past three years starting in the 2014 survey going up to 2017, how many states are serving specific populations. And what you will see is that all of them serve older adults and that's by virtue of the agencies we directly work with but you are seeing more integration across physical disabilities, intellectual disabilities, the one that struck me was more than half of the agencies have integrated aging services with traumatic brain injury services. Seeing more and more of these populations included in these comprehensive aging and disability services. Which moves away from the previous aging state Eugen that she had on aging which we operated under for very long time. I think of you and the ADRC system this would resonate with you because a lot of those dynamics are occurring at the agency level. Are also occurring at the ADRC level.

The last thing on this areas that you are also seeing programmatic responsibilities run the gamut of the OAI. All of the agencies we work with administer that program. You will see emphasis on ADRC. One of the things we are seeing more of is Medicaid funded services and integrating those health and long-term care and social services at the agency level to promote that integrated service delivery at the local level as well. I love to show the slide because it corroborates that integration that is occurring across the country. With that, I'm at the end of the formal presentation. We did have one question come in with they asked to see the state specific data. On this slide there is a link to our website, www.nasuad.org. At the top of that website there is a toolbar that has a link to our publications. And in the publication page is the 2017 , state of the state survey. As well as state specific tables at the back. Something like 30 or 40 pages of charts that outline state specific programming and information that relates to this national data that we presented today.

Wow, Damon. You did it. That was a lot of wonderful data that we heard about. Again, I want to emphasize is Damon mentioned, we do have a printed publication that captures the data. You may want to spend some time at the data tables. They're all available in our online

publication. If you would like to have a hard copy, feel free to shoot us an email and we will be happy to get a hard copy publication to you as well. The majority of questions that came into us were basically on the same vein as Damon asked. We definitely encourage you to go and visit that day to report. If for some reason, you are interested in still need the report, feel free to reach out to Damon and he would be happy to work with you to devote a great possible.

We do have a comprehensive data set that can't even be adequately articulated in the publications without it being thousands of page. To the extent that we can, it's not always feasible, we do try to respond to specific data requests in mind through that data information.

We do have one question that has just come in from one of her viewers. To ask if there are any states not pursuing LTSS?

I think the question is about the managed care. I know we spent a lot of time talking about managed long term services and supports. There are states not pursuing long term services and supports . There are several that come to mind. Connecticut has moved away from me Medicaid managed care model over the past six or seven years. Actually longer than that. They moved away from that model. You have seen other states like North Dakota and, Montana, and Wyoming who have not done a whole lot of work or put a lot of time into developing these systems. I would say, however, even if they are not doing managed long term services and supports, states are really looking at ways to better coordinate and integrate care. It might not be through this capitated model, that we talked a lot about today, but through other models like provider operated models. Primary care case management models. Some of the other things that came up in today's discussion.

I guess we have time for one last question. One of our listeners ask if there is a way we can find out what states are thinking about the veterans directed home and community-based services? It sounds like this individual may be coming from a state that is getting -- giving some thought to that program.

We do have some more data about it. I don't have it available at the front of my stop. I don't want to sort through everything and try to find it on the call. I encourage you to reach out to us. I would say the veterans directed HCBS programmer received several inquiries from states in the past months about that particular program. It does feel like this is an area of renewed interest. A lot of program and policy development done around the. It seems like it is reinvigorated.

I will share that we will be fielding a [I&R/A] national survey of programs this year. Something we did in 2015. We have several specific questions about the veterans directed home and community-based services. Will be learning more about our that. I will be happy to share some of those results related here as well. There is also a report put out by the AARP Public policy Institute. They've done several reports looking at promising practices coming from the scorecard. One of them is specifically looking at veterans and

caregivers. Lots of links to state tools. State practices. State models. That is another resource at this time as well.

With that, I think we have reached the end of our time. I'm truly want to thank Damon. This is very dense data to go through. It has been very helpful to learn about this. Thank you for joining us today. Thank our caption are for captioning this rich conversation. Thank our listeners as well for joining us. Feel free to reach out if you have any follow-up questions or just want to connect with us more about the state of the state. Thank you, everybody.

>> [Event concluded]