mission. In addition to increasing training for health care providers in appropriate opioid prescribing practices and screening and treatment of opioid use disorders, existing prescription-drug monitoring programs could be improved to avert misprescribing and doctor shopping. Implementation of policies for providing opioid-dependent persons and their families with naloxone to prevent fatal overdoses and Good Samaritan laws preventing prosecution of people who report overdoses would also save lives.

HIV outbreaks among injection-drug users can escalate quickly. The literature is rife with examples from North America, Southeast and Central Asia, and Eastern Europe, where HIV prevalence among injection-drug users had been below 5% for decades but leapt to 80% or higher within a year owing to continuing high-risk behaviors in the absence of adequate HIV prevention and access to treatment. Such outbreaks can, however, be prevented and even reversed. An explosive HIV outbreak among injection-drug users in Vancouver, British Columbia, which resulted in an HIV incidence of 18.6 per 100 person-years in 1996, was controlled by expansion of needle-exchange programs and provision of opioid-agonist therapy and HAART free of charge through Canada's universal health care system.[5] More recently, providing HIV treatment as prevention reversed the HIV epidemic throughout British Columbia.

An audio interview with Dr. Strathdee is available at NEJM.org

We believe that threading the needle to prevent further HIV outbreaks among substance users requires aggressive implementation of evidence-based practices for HIV prevention (see box).[2] These practices cannot be implemented without resources for expanding HIV screening among substance users and offering HAART to those who test positive, while providing opioid-agonist therapy to those with opioid dependence. Primary care models that integrate screening for substance use and mental health disorders and testing and treatment for HIV, HCV, and sexually transmitted infections with concomitant provision of opioid-agonist therapy are therefore an urgent priority.

Permanently lifting the ban on using federal funds to support needle-exchange programs will be a critical component of HIV prevention, since these programs reduce HIV incidence and frontline exchange workers are often the first people injection-drug users reach out to for help.[2] There are currently 228 known needle-exchange programs in 35 U.S. states, the District of Columbia, the Commonwealth of Puerto Rico, and Indian Nations. However, the federal funding ban limits their scalability and quality of services, including their ability to provide critical ancillary services (e.g., on-site HIV and HCV testing and referrals for drug treatment). States can adapt prescription-drug monitoring programs so they are secure, enable searches in real time, and are used as clinical and public health tools rather than law-enforcement weapons. But such supply-reduction measures will work best when complemented by the harm reduction achievable with opioid-agonist therapy and needle-exchange programs.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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The Older Americans Act at 50 — Community-Based Care in a Value-Driven Era

Ravi B. Parikh, M.D., M.P.P., Anne Montgomery, M.S., and Joanne Lynn, M.D.

The Older Americans Act clearly affirms our Nation's sense of responsibility toward the well-being of all of our older citizens. . . . Every State and every community can now move toward a coordinated program of services and opportunities for our older citizens. We revere them; we extend them our affection; we respect them.

— Lyndon B. Johnson, 1965

In signing the Older Americans Act (OAA) into law 50 years ago, President Johnson challenged communities throughout the country to help older citizens age in place, in their homes and communities. An essential component of the Great Society programs, the OAA is authorized to provide grants to states for community-based social and health-related services for older adults. Nearly 13 million people receive regular OAA services, including meals, caregiver support, personal care, and transportation assistance.[1] Yet in an increasingly long-lived society, the proposed reach of the OAA — "all" older citizens — has never been fulfilled.

Funding for the OAA and other elder-support services has been flat for nearly a decade, while the population of older Americans has dramatically increased (see graph). With the United States now hurtling into the aging boom of the 21st century, the OAA's mission of supporting isolated and homebound older Americans is being tested as never before. Value-based health care delivery models offer an opportunity for health systems to provide a broader array of services for older adults that improve outcomes and reduce health care utilization. As the OAA turns 50, health systems can deliver value by implementing a new set of community-based priorities to better address older Americans' health and social needs.

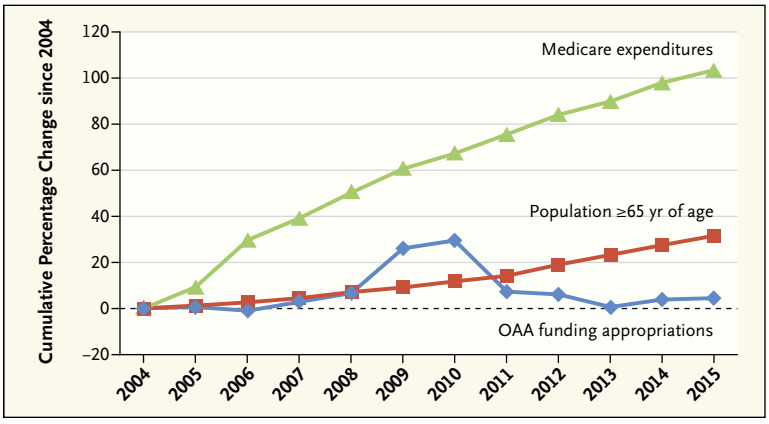
Inadequate preventive and post-hospital care, poor access to transportation and housing, and malnutrition all place a tremendous burden on a health care system that often uses medical services to backstop gaps in basic socioeconomic needs. The OAA delivers value by providing reliable food, housing adaptations, personal care, and other services. These services allow millions of seniors to grow old in their homes, rather than in costly and often undesired institutions. Currently, more than 40% of OAA funding goes to nutrition services (Meals on Wheels), primarily meals delivered to homes or community centers. In 2014, nearly 140 million home-delivered meals and 90 million congregate meals were served.[1] The remaining 60% of OAA funding is spent on health-related services, including home and adult day care, caregiver support, and elder-abuse protection. Programs are administered by the federal Administration for Community Living and local Area Agencies on Aging (AAAs) and Aging and Disability Resource Centers (ADRCs).

The OAA's successes are robust; for example, a randomized study involving 626 elderly Americans showed that recipients of Meals on Wheels had fewer falls and hospitalizations and less self-reported anxiety than their counterparts who did not receive a meal service. Recipients of daily meals also reported decreased isolation and worry about living at home.[2] Moreover, 1 year of home-delivered meals costs nearly the same as one emergency department visit and less than a 1-week nursing home stay.

Despite its successes, however, the OAA cannot forestall ominous socioeconomic trends now facing older Americans. Since the 2013 budget sequestration, nearly three quarters of Meals on Wheels programs have cut the number of meals served to seniors, and waiting times for nutrition services have tripled.[3] Growth in the elderly population has far outpaced OAA appropriations (see graph), threatening the OAA's ability to meet basic needs with dedicated public funding. Meanwhile, any potential legislation to reauthorize the OAA is not expected to substantially increase funding levels.

Health systems can advocate for appropriate funding of OAA services and develop measures that capture the impact of social services on health outcomes and costs for older Americans. Greater support for community-based care could also come from reinvesting savings from more efficient and appropriate Medicare expenditures, which have more than kept pace with population growth (see graph). But in uncertain economic and political times, health systems cannot assume that government funding will meet the evolving socioeconomic needs of older Americans who choose to remain in the community. The OAA's vision has been to allow seniors to age in place by providing adequate community-based supports to address socioeconomic determinants of health. To avert the need for costly institutional care, health systems can enhance those supports through novel care delivery models and innovative collaborations.

First, value-based health systems can partner with existing community-based initiatives for older adults. Chronic Disease Self-Management Programs (CDSMPs) are one example: their group workshops are led by peer facilitators and offered either online or in community-based settings such as senior centers or churches. They focus on developing personalized management skills related to diet, exercise, and other lifestyle areas. CDSMPs have been shown in longitudinal randomized trials to reduce disability and improve self-reported well-being while reducing hospital utilization.[4] Health care delivery systems can work to develop robust



Cumulative Growth in Funding for the Older Americans Act (OAA), as Compared with Growth in Medicare Expenditures and Growth of the U.S. Population Over 65 Years of Age.

Data are from the Congressional Research Service, the Centers for Medicare and Medicaid Services, and the U.S. Census Bureau and have not been adjusted for inflation.

referral networks with existing community-based health supports such as CDSMPs to ensure the availability of a better-integrated set of services throughout older people's lives.

Second, it's important to hold value-driven health systems accountable for ensuring that seniors can successfully navigate a network of medical, long-term, and social supports. Hennepin Health, a safety-net accountable care organization (ACO) based in Minnesota, has reinvested savings to hire community health navigators who connect Medicaid beneficiaries with vocational services and preferentially secure affordable housing. The ACO has shifted care away from hospitals and reduced emergency department visits by nearly 10%, while increasing outpatient visits and realizing savings.[5] Similar reinvestments by other delivery systems could bolster the impact of OAA funding for services such as transportation, nutrition, and employment support. Such contributions can help mitigate the effects of inadequate and sometimes volatile public funding supports.

Finally, health systems can directly provide and advocate for better social supports for elderly Americans. Providing services such as supportive housing and nutritious food has traditionally been viewed as outside the health system's scope. However, that attitude is changing in value-driven health systems, which must coordinate health and social supports in order to care for older adults. Some systems, for example, provide health and social services under one management framework, incorporating services such as food pantries or transportation to and from medical appointments. Others are contracting with local AAAs and ADRCs to provide transportation, caregiver support, and home-delivered food. For expanding health organizations, this pivot may require an initial investment. However, OAA programs have demonstrated that social supports engender value, in part by improving clinical outcomes and reducing utilization for vulnerable patients. Payment models that reimburse for care outside institutions, such as hospital community-benefit funds and Medicare Chronic Care Management codes, could also support providers and patients during the transition to community-anchored care for older populations.

The population of older Americans is rapidly growing. Health systems must plan for more reliable service delivery for this period of life. In shifting from volume- to value-driven services, health systems will face pressure to support older adults in their homes and communities, rather than in hospitals and nursing homes. Care coordination, primary care geared toward chronic disease, and affordable supportive housing and transportation will be more important than ever before. The OAA has provided these services for 50 years. Health systems can build on these successes through innovative partnerships and more comprehensive delivery models. In doing so, we can fulfill our responsibility to maximize the well-being of our older citizens for the next 50 years and beyond.

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