



DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year
2006

Administration
on Aging

*Justification of
Estimates for
Appropriations Committees*

FROM THE ASSISTANT SECRETARY FOR AGING

The Administration on Aging (AoA) is pleased with the results of its partnership with other components of the Department of Health and Human Services (HHS) in producing AoA's first Performance Budget for FY 2006. At AoA, we view performance measurement as an opportunity to demonstrate the value and effectiveness of Older Americans Act (OAA) programs. For some time now, performance measurement has allowed us to justify our base programs and expenditures in support of older Americans. With the FY 2006 AoA Performance Budget, we are taking the next step by fully integrating our performance measurement activities with the overall budget we are requesting for FY 2006.

The AoA Performance Budget for FY 2006 is goal oriented and supports the HHS strategic goals, including *improving the economic and social well-being of individuals, families and communities, especially those most in need, and reducing threats to the health and well-being of Americans*. It also supports the five strategic priorities that we at AoA have established for our programs. A central result of our focus on outcomes has been the identification of the following three broad outcome measures that cut across all of our program activities and will help us monitor the achievement of our goals:

- Improve Program Efficiency: This budget includes efficiency measures for each of the programs historically included in AoA's performance plans. Program efficiency is a necessary and important measure of performance for AoA programs and recognizes the need to maximize the value of Federal funds as well as the need to generate capacity for these program activities at the State and local level. We are pleased that the OMB recognized AoA for the quality of its efficiency measures in the FY 2005 President's Budget.
- Improve Client Assessments and Outcomes: AoA will not compromise quality for the sake of efficiency, so we have initiated annual surveys of OAA clients to obtain their views on the quality of AoA programs. Customer satisfaction is a part of this measure, but our surveys also include assessments of the impact and usefulness of services to elderly individuals and their caregivers.
- Improve Targeting to Vulnerable Elders: The first two measures focus on the efficient production of high quality results as assessed by program clients. However, in an effort to improve efficiency and quality, entities could attempt to focus their efforts toward individuals who are not the most vulnerable. Instead, the targeting measure ensures that AoA serves the most needy as envisioned by the OAA.

With this budget request, AoA has reinforced its focus on providing high-quality, effective services to the most vulnerable elderly individuals. This budget will help elderly individuals remain in their homes and communities, which is where they want to be. We believe that the FY 2006 Performance Budget will also provide the Congress a better tool for making critical decisions on the resources needed to support AoA programs and seniors across the nation.

Josefina G. Carbonell

DEPARTMENT OF HEALTH AND HUMAN SERVICES

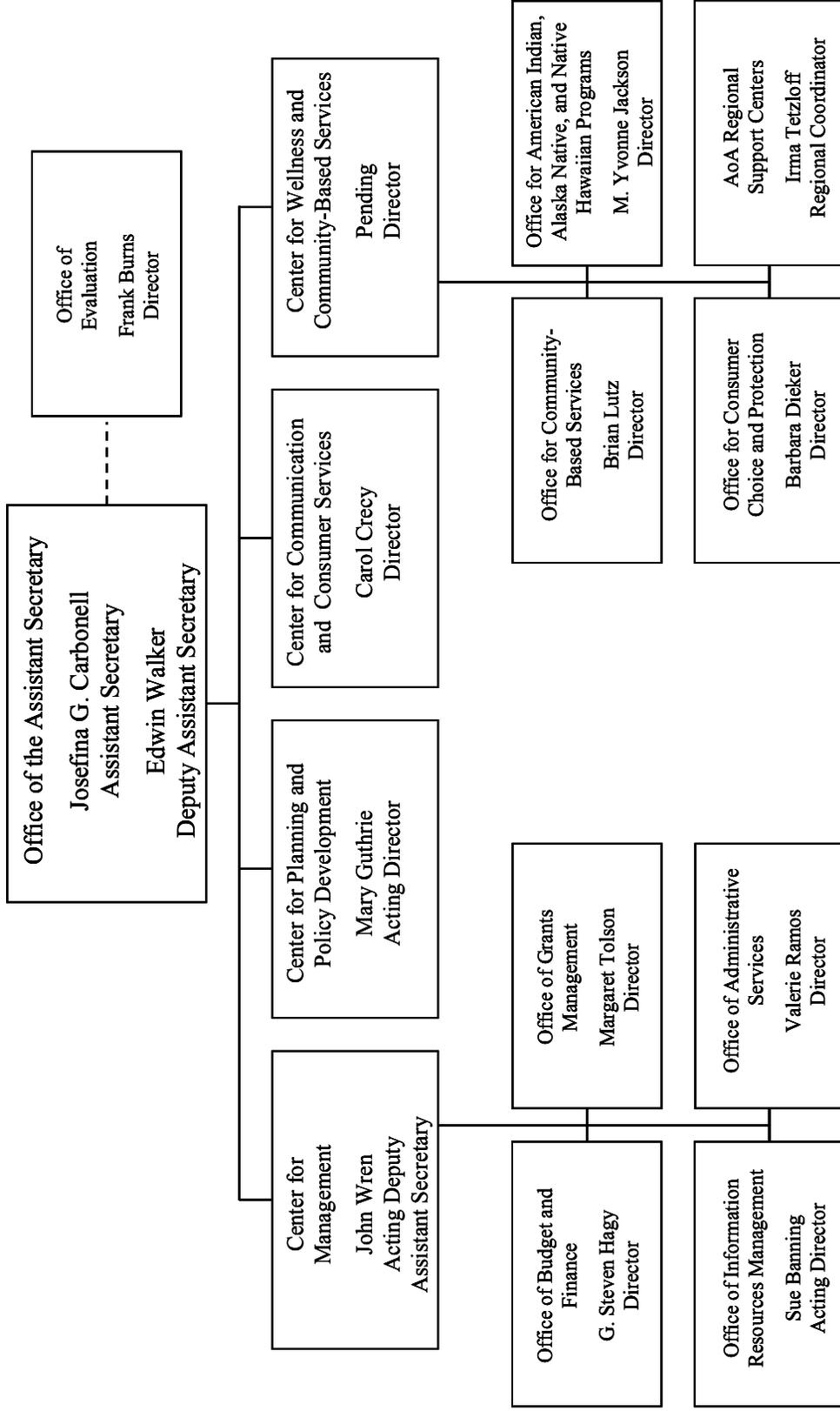
ADMINISTRATION ON AGING

AGING SERVICES PROGRAMS

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ADMINISTRATION ON AGING ORGANIZATIONAL CHART



Performance Budget Overview

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA	\$1,373,918,000	\$1,393,341,000	\$1,369,028,000	-\$24,313,000
FTE	117	126	123	-3

The FY 2006 request for the Administration on Aging (AoA) is \$1,369,028,000 and 123 FTE, a decrease of -\$24,313,000 and -3 FTE below the FY 2005 enacted level (excluding usage by the White House Conference on Aging, the FTE level is maintained at 120). Excluding one-year, one time congressional earmarks and funding for the White House Conference on Aging, the balance of the request represents a net decrease of -\$154,000 below the FY 2005 enacted level.

Statement of Agency Mission

AoA's mission is develop a comprehensive, coordinated and cost-effective system of long-term care that helps elderly individuals to maintain their independence and dignity in their homes and communities.

Discussion of Strategic Goals

The Assistant Secretary for Aging has established five strategic priorities to guide AoA in carrying out its mission under the Older Americans Act, which expires at the end of FY 2005. These five AoA strategic priorities support the HHS strategic plan, including *Goal 1: Reduce the threats to the health and well-being of Americans; Goal 3: Increase the percentage of the Nation's children and adults who have access to regular health care services, and expand consumer choices; Goal 5: Improve the quality of health care services; Goal 6: Improve the economic and social well-being of individuals, families, and communities, especially those most in need; and Goal 8: Achieve excellence in management practices.* AoA's five strategic priorities are:

- Priority 1: Make it easier for older people to access an integrated array of health and social supports.
- Priority 2: Help older people to stay active and healthy.
- Priority 3: Support families in their efforts to care for their loved ones at home and in the community.
- Priority 4: Ensure the rights of older people and prevent their abuse, neglect and exploitation.
- Priority 5: Promote effective and responsive management.

AoA’s budget funds a variety of services to seniors and their caregivers – including home and community-based supportive, nutrition, and preventive health services – that support the five strategic priorities established by the Assistant Secretary, as well as the strategic priorities of the Department. AoA program performance and outcome data demonstrates that these services are effective in helping to achieve the AoA and Departmental strategic goals and objectives. The following crosswalk shows the links between the AoA and HHS Strategic Goals and Objectives:

HHS Strategic Goals	AoA Strategic Goals
Reduce the threats to the health and well-being of Americans	Make it easier for older people to access an integrated array of health and social supports Help older people to stay active and healthy
Increase the percentage of the Nation’s children and adults who have access to regular health care services, and expand consumer choices	Make it easier for older people to access an integrated array of health and social supports Help older people to stay active and healthy
Improve the quality of healthcare services	Ensure the rights of older people and prevent their abuse, neglect and exploitation
Improve the economic and social well-being of individuals, families, and communities, especially those most in need	Make it easier for older people to access an integrated array of health and social supports Help older people to stay active and healthy Support families in their efforts to care for their loved ones at home and in the community Ensure the rights of older people and prevent their abuse, neglect and exploitation
Achieve excellence in management practices	Promote effective and responsive management

For information on the breakout of our budget by HHS strategic goal, please refer to the HHS Budget by Strategic Goal display in the FY 2006 HHS Annual Plan.

Overview of Agency Performance

In response to HHS and Office of Management and Budget initiatives and improvements in performance measurement (including recommendations resulting from the Program Assessment Rating Tool (PART) evaluation process) culminating in the first HHS performance budget, AoA has made significant modifications to better organize and present performance information under the Government Performance and Results Act (GPRA). First, following the guidance of the Office of the Assistant Secretary for Budget, Technology, and Finance, AoA has consolidated all

of its program activities into a single Aging Services GPRA program. AoA program activities have a fundamental common purpose that reflects the primary legislative intent of the Older Americans Act (OAA): to make home and community-based services available to elders who are at risk of losing their independence, to prevent disease and disability through community-based activities, and to support the efforts of family caregivers. It is intended further that States, Tribal Organizations and communities participate actively in funding community-based services and develop the capacity to support the home and community-based service needs of elderly individuals, particularly those who are disabled, poor, and minorities, and those who live in rural areas where access to services may be limited.

The second major improvement to AoA performance measurement – defining three performance measures that cut across all AoA program activities – stemmed from the first improvement and from the recognition that there is consistency of purpose and management across AoA programs. The common fundamental objectives of all of our programs led AoA to focus on three outcome areas in assessing all program activities through performance measurement: 1) improving program efficiency; 2) improving client assessments and outcomes, and 3) improving targeting to vulnerable elder populations.

- Measure 1 – Improve Program Efficiency: Program efficiency is a necessary and important measure of performance for AoA programs for two principal reasons. First, OMB recognizes the importance of the efficient use of Federal funds by both Federal agencies and the entities that administer Federal programs. Second, the OAA intended that Federal funds for these programs would help to generate capacity for these program activities at the State and local level. It is the expectation of the OAA that States and communities would increasingly improve their capacity to serve elderly individuals efficiently and effectively. The FY 2006 performance budget includes four indicators supporting AoA's measure to improve the efficiency of programs and services.
- Measure 2 – Improve Client Assessments and Outcomes: In the past year AoA achieved a critical performance measurement objective of obtaining data to measure performance outcomes from the perspective of the client. The FY 2006 performance budget includes eight indicators supporting AoA's measure to improve client assessment and results. To AoA, these are the core performance outcome indicators for our programs because they reflect assessments obtained directly from the elderly individuals and caregivers who receive the services. These include customer satisfaction indicators for services such as meals, transportation and homemaker, which OMB specifically required in the FY 2005 PART assessment for AoA. OMB staff was supportive of AoA's aggressive efficiency targets, but were concerned that without the satisfaction measures an excessive focus on efficiency could reduce service quality and consumer satisfaction. In addition, AoA uses outcome indicators directly associated with maintaining elderly individuals in the community and with successfully resolving the complaints of vulnerable elders in institutional settings.
- Measure 3 – Improve Targeting to Vulnerable Elders: The first two measures that AoA uses for program assessment focus on the efficient production of high quality results as assessed by program clients. The targeting measure and the four indicators associated with it are equally important because they ensure that AoA and the aging services network focus

services on the most needy. In an effort to improve efficiency and quality, entities could attempt to focus their efforts toward individuals who are not the most vulnerable. This would be inconsistent with the intent of the OAA, which specifically requires the targeting of services to the most vulnerable. It also would be inconsistent with the mission of AoA, which is to help vulnerable elderly individuals to maintain their independence in the community. To help these seniors to remain independent, AoA and the aging services network must focus their efforts on the most vulnerable elderly: disabled, poor, rural and minority elders.

Summary of Improvements to Measures: The performance budget for FY 2006 reflects the significant substantive and technical improvements in performance measurement sought by HHS and OMB, and initiated by AoA in the FY 2005 budget, including:

- Reductions in the number of goals and measures;
- Increases in outcome measures as a percent of total measures;
- Addition of efficiency measures for all programs;
- Addition of consumer assessment outcome measures;
- Introduction of aggressive long-term performance goals; and
- Use of performance data to support the agency's budget justification.

Throughout the justification, we identify the performance results and targets that underlie the budget activities contained herein. For example, the new outcome measures will assess the aging services network's results in response to the Administration's initiatives to create greater balance and better options in our State and community systems of health and long-term care, including improved access, more integrated services, and greater emphasis on prevention.

Successes, Challenges and Goals in Program Development Based on Performance Data: The data collected for the performance measures identified in this plan show that AoA programs are producing the types of outcomes intended by the OAA. Specifically, AoA and the aging services network:

- Provide services that are instrumental in enabling vulnerable older persons to live as independently as possible;
- Target services to vulnerable elderly individuals, including the poor, minorities, and individuals from rural areas;
- Receive very high consumer assessment ratings for the services it provides;
- Leverage funding from other sources in amounts that were almost double the funding provided by AoA;

- Leverage funding for critical in-home and adult-day-care services in amounts almost triple the funding provided by AoA; and
- Improve efficiency, as measured by the increasing number of elders served per million dollars of AoA funding from FY 1999 to FY 2003.

Significant Initiatives Related to Program Performance Data: Performance information has contributed significantly to major initiatives that have been put forth by AoA and other components of HHS, including initiatives to:

- Create more balance in long-term care and better integrate services: Performance data demonstrates that OAA programs: 1) serve a significant percentage of the vulnerable elderly population, 2) provide care at a significantly lower cost than institutional programs, and 3) involve communities and families more effectively than institutional care. This data contributed to the development of an HHS-wide initiative to pursue greater balance in long-term care by focusing on community-based and home care, which is preferred by the elderly.
- Nursing home quality standards: Performance data reflecting the effectiveness of the Ombudsman program in resolving complaints and providing information to nursing home residents contributed to an AoA/Center for Medicare and Medicaid Services (CMS) collaboration to use the Ombudsman program in the implementation of the new nursing-home quality standards.

Overview of Agency Budget Request

The FY 2006 request for AoA is \$1,369,028,000 and 123 FTE, a decrease of -\$24,313,000 and -3 FTE below the FY 2005 enacted level (excluding usage by the White House Conference on Aging, the FTE level is maintained at 120). Excluding one-year, one time congressional earmarks and funding for the White House Conference on Aging, the balance of the request represents a net decrease of -\$154,000 below the FY 2005 enacted level. The FY 2006 request will allow AoA to maintain support for core home and community-based supportive, nutrition, and caregivers services, and to continue to make targeted investments in innovation and demonstration grants that will create greater balance and better options in our State and community systems of health and long-term care, including improved access, more integrated services, and greater emphasis on prevention. These investments will further improve program efficiency and outcomes while also assisting the aging services network to maintain the current high level of consumer satisfaction with services; and to continue to target services to the most vulnerable elderly individuals.

A review of aging demographics shows how critical the need for cost-effective services that allow seniors to remain independent is and will continue to be in the future. There are over 47 million Americans age 60 and over, including more than 4.6 million who are age 85 and over, and these numbers are increasing rapidly. With the aging of the baby boom generation, the population of Americans age 60 and over is projected to reach almost 50 million in 2005 and approximately 91 million by the year 2030. Particularly dramatic is the growth of the population

of Americans 85 and over, which is growing faster than any other age cohort and is projected to total 5.1 million by 2005 and 9.6 million by the year 2030. While advances in medicine and technology and lifestyle changes are enabling seniors to live longer and more active lives than ever before, those of advanced age are also at increased risk of chronic disease and disability. Older Americans with chronic conditions are often unable to perform basic activities of daily living, and may require assistance to remain at home and avoid the need for institutional care. The May 1999 General Accounting Office report, *Adults with Severe Disabilities: Federal and State Approaches for Personal Care and Other Services*, found that “obtaining personal care on what is often a daily basis is critical for avoiding institutionalization... Without help from family, friends, or public programs, affording such assistance may be problematic”.

As the population of older Americans grows, the number of unpaid and informal caregivers (spouses, adult children, relatives, and friends) who are assisting vulnerable elders to remain at home is likewise growing. Mid-range estimates put the number of unpaid informal caregivers of elderly individuals at approximately 23 million. A study published in the journal *Health Affairs* estimated that this unpaid, informal care, if provided by home care aides, would cost \$257 billion annually. A May 2003 joint report by HHS and the Department of Labor, *The Future Supply of Long-Term Care Workers in Relation to the Aging of the Baby Boom Generation*, indicates that the number of informal caregivers is projected to rise to 40 million by the year 2050. Supporting this population so that they can continue to provide care for their loved ones is critical.

Despite the fact that data shows that home and community-based services are both economical and effective in assisting seniors to remain at home, and what they overwhelmingly prefer, approximately 67 percent of public long-term care funding still goes to institutional care. Studies have repeatedly found that if given the choice, older Americans overwhelmingly express a preference for long-term care services that allow them to remain at home. For example, in the April 2004 AARP study *Home and Community-Based Long-Term Care in Louisiana*, 88 percent of respondents reported that it is very important to have services that would allow them to remain in their home for as long as possible. HHS has started to address these challenges through its efforts to create a more balanced long-term care system and to focus on care in the community. The infrastructure of AoA’s aging services network – which is one of the nation’s largest providers of home and community-based long-term care services – as well as its focus on family caregivers, provides an important foundation for these efforts. The involvement of these established providers of cost-effective and consumer-friendly aging services is critical to ensuring the success of these initiatives.

AoA programs, for a fraction of the cost of institutional care, are helping families to keep their loved ones at home for as long as possible. These services complement existing medical and health care systems and support some of life’s most basic functions: food for the undernourished; transportation for the immobile; respite and counseling for caregivers; and personal care to those who need assistance getting in and out of bed, feeding and bathing themselves.

OAA services are not only less expensive, but performance data shows how effective they have been. In FY 2003, AoA and its national network of aging service providers rendered direct services to over 8.2 million elderly individuals age 60 and over (over 16 percent of the population), including over three million registered clients who received intensive in-home

services. Access assistance and other services were also provided to approximately 585,000 caregivers. Aging network services have assisted seniors and their families to:

- Access an integrated array of health and social supports by conducting over 12 million information and referral contacts; over 8 million outreach and information contacts about caregiver services; and by serving over 121,000 callers through the Eldercare Locator.
- Stay active and healthy by providing almost 36 million rides to meal sites, doctors' offices, grocery stores, pharmacies, senior centers, and other critical daily activities; by serving 251 million meals which help participants to prevent or manage chronic disease; and by providing physical activities, medication management, and the opportunity for conversation and social interaction through our senior centers, used by over 1.8 million people.
- Care for their loved ones at home and in the community by providing almost 10 million hours of homemaker services; over 9 million hours of personal care; over 1 million hours of chore services; almost 10 million units of adult day care; and by providing assistance and respite services to approximately 585,000 caregivers.
- Maintain their rights and be protected against abuse and neglect through 1.1 million hours of legal assistance, through ombudsmen who investigated approximately 286,000 complaints made by or on behalf of institutional care residents, through pension counseling projects which have helped over 25,000 seniors to recover over \$50 million in benefits, and through information and education activities that highlight ways to protect vulnerable elders' rights.

As intended under the OAA, programs successfully target services to the most vulnerable elderly. Over 75 percent of home-delivered meal recipients have a disabling condition and need assistance with activities of daily living. Whereas 10 percent of the elderly population is poor, approximately 28 percent of elderly clients are poor. Whereas over 22 percent of the elderly population lives in rural areas, 28 percent of elderly clients live in rural areas. Whereas 19 percent of the elderly population are minorities, almost 23 percent of elderly clients are minorities.

Performance data further demonstrates that not only do AoA programs provide cost-effective services to seniors and their families, but that these services make a real difference in helping older individuals to remain at home and in the community. AoA has contracted to conduct five independent national surveys of elderly clients to obtain an assessment of the services provided under the OAA. Services assessed were transportation services, nutrition services, information and referral services, and homemaker services. One survey also sought caregiver assessment of OAA services. Survey data show that not only do these services play an important role in allowing seniors to remain at home, but that service recipients are very satisfied with the services they are receiving. For example:

- 44 percent of seniors using transportation services rely on them for “virtually all” of their transportation needs – without these services, these individuals would be homebound.
- 72 percent of congregate meal recipients and 90 percent of home-delivered meal recipients report that the meals enabled them to continue living in their own homes.

- 52 percent of caregivers of program clients report that services definitely enabled them to provide care longer than otherwise would have been possible.
- 83 percent of callers to information and referral services said the information they received should help them to resolve their issue.
- 88 percent of congregate meal recipients are at either high or moderate nutritional risk, and 98 percent of home-delivered meal recipients are at either high or moderate nutritional risk.
- 43 percent of homemaker service and 30 percent of home-delivered meal clients reported limitations with three or more activities of daily living – a level of frailty consistent with nursing home residents.

Data also highlight how OAA programs are far less costly than institutional care. The statistical average annual cost for OAA services provided per elderly client is approximately \$600 (as reported by State units on aging). AoA estimates that the cost of providing OAA services to a vulnerable elderly individual receiving multiple services – such as homemaker, personal care, home-delivered meals, chore services, and assisted transportation – is \$3,000 annually. This is significantly less than the average annual cost of nursing home care, which in 2003 was approximately \$66,000.

This data tells a story of programs that are effectively supporting the achievement of the strategic goals and objectives established by the Secretary and the Assistant Secretary. The FY 2006 request will provide continued support for the achievement of these goals and objectives. It includes:

State, Tribal, and Community-Based Services

The FY 2006 request provides funding to maintain support for AoA's State and Tribal formula grant programs. The FY 2006 request includes \$1,250,192,000 for grants to States and Territories for home and community-based services, the same as the FY 2005 enacted level. These grants provide a broad range of services that assist seniors and their caregivers to remain healthy, active, and at home, including supportive, nutrition, and preventive health services. In addition, the FY 2006 request provides \$19,360,000 (an increase of +\$72,000 over the FY 2005 enacted level) for grants to States and Territories for protection of vulnerable elder activities, including long-term care ombudsman and prevention of elder abuse services.

The FY 2006 request also provides \$32,702,000 for grants to Tribal Organizations, the same as the FY 2005 enacted level, to support the provision of nutrition and supportive services to Native American elders and their caregivers. The services provided to seniors and families through these State and Tribal programs provide a critical foundation for the Department's efforts to create a more balanced long-term care system and to focus on care in the community.

Innovation and Demonstration

Program Innovations has been the primary vehicle over the last three years for beginning to refocus the way care is provided to aging individuals by creating greater balance and better options in our State and community systems of health and long-term care, including improved

access, more integrated services, and greater emphasis on prevention. While funding for Program Innovations represents only 2 percent of AoA's overall budget – compared to 95 percent for population-based grants for services which are provided to and controlled by States and Tribes – it is the primary vehicle for identifying more cost-effective and efficient ways of delivering services and effecting positive broad systemic changes. The knowledge gained from Program Innovations projects is shared with States and Tribes and is critical to ensuring that AoA's core formula grant programs remain effective in delivering services to seniors and enabling them to remain at home for as long as possible.

The FY 2006 request for Program Innovations is \$23,843,000, a decrease of -\$19,443,000 below the FY 2005 enacted level. Excluding one-year, one-time congressional earmarks, the balance of the program represents an increase of +\$196,000 over the FY 2005 enacted level. Projects supported by the program include Aging and Disability Resource Centers that will assist seniors to learn about and access public and private long-term care options and help States develop “one-stop shop” programs; Integrated Care Management projects that will seek to improve the quality of care for seniors by identifying and supporting innovations in aging services that involve partnerships with managed care organizations or capitated financing arrangements; Evidenced-Based Disease Prevention grants that translate research results into community-level prevention programs; partnerships to help States rebalance their long-term care systems, integrate services at the community level, and promote healthy and active aging; and outreach, education and assistance activities that help educate seniors, particularly hard-to-serve, limited English speaking, minority, low-literacy, low-income and rural beneficiaries about new benefits under the Medicare Modernization Act.

The FY 2006 request also maintains support for other discretionary grant activities. It includes \$11,786,000, the same as the FY 2005 enacted level, for demonstration grants to States to assist persons suffering with Alzheimer's disease. It also provides \$13,266,000, the same as the FY 2005 enacted level, for a variety of ongoing activities which assist seniors and families to obtain information about their care options and benefits, and which assist States, Tribes, and community providers of aging services to carry out their mission.

Program Administration

Program Administration funds salaries and related expenses which provide oversight and management support for all programs. The FY 2006 request provides \$17,879,000, a decrease of -\$422,000 below the FY 2005 enacted level. The request includes \$398,000 in funding for additional costs related to personnel benefits and compensation. The request also includes funding for additional costs related to rent and various “One-Department” initiatives, including the Unified Financial Management System (UFMS) and the Information Technology Service Center, offset by savings in other administrative areas, including information technology activities and support contracts.

Program Assessment Rating Tool (PART) Summary

FY 2004-FY 2006

(Dollars in Millions)				
FY 2004 PARTs	FY 2004 Enacted	FY 2005 Appropriation	FY 2006 Request	Narrative Rating
Aging Services Programs	\$1,373.9	\$1,393.3	\$1369.0	Results Not Demonstrated
FY 2005 PARTs				
Aging Services Programs	\$1,373.9	\$1,393.3	\$1369.0	Moderately Effective
FY 2006 PARTs				
N/A	N/A	N/A	N/A	N/A

Narrative: The FY 2006 request for Aging Services Programs is \$1,369,028,000, -\$24,313,000 below the FY 2005 enacted level. Aging Services Programs support the Secretary’s strategic priorities, including improving the economic and social well-being of individuals, families, and communities, especially those most in need, and reducing the threats to the health and well-being of Americans.

An initial PART for the Community-Based Services portion of this program was done in FY 2004, and the program received a score of Results Not Demonstrated. AoA immediately took corrective action that: 1) established critical long-term goals, 2) increased the rigor of annual and long-term performance targets, 3) developed efficiency measures, and 4) finalized the availability and use of consumer assessment outcome data. All recommendations for corrective action have been implemented, and on the basis of corrective actions taken, OMB reassessed the program in FY 2005, and the program received a score of Moderately Effective.

The PART process has had a significant effect on AoA’s management of its programs, particularly on its strategic planning and performance measurement activities. The information used to assess programs under PART is central to AoA’s budget development process, and was a primary contributor to the development of initiatives to improve performance across activities through investments that will help to create greater balance in long-term care funding and better integrate home and community-based services programs. These initiatives are also fundamental to AoA’s performance measures of efficiency, consumer outcomes, and targeting.

While reflecting the general effectiveness of the program, the PART evaluation did note that information for the Preventive Health Services component was not sufficiently comprehensive. AoA is currently conducting an evaluation of this activity and will use the findings to improve program performance. This evaluation is one of a series that are scheduled to occur over the next three years to ensure continued response to OMB recommendations.

Appropriations Language

Administration on Aging

Aging Services Programs

For carrying out, to the extent not otherwise provided, the Older Americans Act of 1965, as amended, and section 398 of the Public Health Service Act, [~~\$1,404,634,000~~] *\$1,369,028,000* of which \$5,500,000 shall be available for activities regarding medication management, screening, and education to prevent incorrect medication and adverse drug reactions[; and of which \$4,558,000 shall remain available until September 30, 2007, for the White House Conference on Aging].

Explanation of Changes

<u>Language Provision</u>	<u>Explanation</u>
[; and of which \$4,558,000 shall remain available until September 30, 2007, for the White House Conference on Aging].	Deletes language designating funds for the White House Conference on Aging, which is scheduled to occur in FY 2006.

Amounts Available for Obligation
(Dollars in Thousands)

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>
Appropriation:			
Annual.....	1,382,189	1,404,634	1,369,028
Enacted Rescission:			
P.L. 108-199, Division E: Section 515.....	(117)		
P.L. 108-199, Division H: Section 168.....	(8,154)	--	--
P.L. 108-447, Division F: Section 519a.....	--	(56)	--
P.L. 108-447, Division J: Section 122a.....	--	(11,237)	--
Subtotal, Adjusted Appropriation.....	<u>1,373,918</u>	<u>1,393,341</u>	<u>1,369,028</u>
Offsetting Collections From:			
Trust Funds: HCFAC.....	3,662	3,297	3,297
Unobligated Balance: Start of Year.....	176	2,009	3,591
Unobligated Balance: End of Year.....	2,009	3,591	--
Unobligated Balance: Lapsing.....	<u>(74)</u>	<u>--</u>	<u>--</u>
Total Obligations /1.....	1,375,673	1,395,056	1,375,916

1/ Excludes the following amounts for reimbursable activities carried out by this account: FY 2004 - \$347,383.

Summary of Changes
(Dollars in Thousands)

FY 2005 Appropriation.....	1,393,341
FY 2006 Estimate.....	1,369,028
Net Change.....	(24,313)

	FY 2005 Base Budget Authority	Change From Base Budget Authority
Increases:		
<u>A. Built-in:</u>		
1. Provide for January 2006 2.3% pay raise and related pay costs.....	12,409	398
2. Increased costs related to GSA rent.....	1,622	32
3. Increased costs related to Unified Financial Management System.....	546	98
Subtotal, Built-In Increases.....		528
<u>B. Program</u>		
1. State and Tribal Formula Grant Programs.....	1,302,182	72
2. Innovation and Demonstration Programs.....	48,699	196
Subtotal, Program Increases.....		268
Total, Increases.....		796
Decreases:		
<u>A. Built-in:</u>		
1. Decreased costs related to administrative savings.....	3,724	(107)
Subtotal, Built-In Decreases.....		(107)
<u>B. Program:</u>		
1. Elimination of One-Time Project Earmarks.....	19,639	(19,639)
2. Decreased costs related to travel, utilities, printing, supplies.....	1,063	(173)
3. Decreased costs related to administrative contractual services.....	2,661	(670)
4. White House Conference pay and pay-related costs /1.....	662	(662)
5. White House Conference other program related costs /1.....	3,858	(3,858)
Subtotal, Program Decreases.....		(25,002)
Total, Decreases.....		(25,109)
Total, Net Change.....		(24,313)

1/ FY 2006 obligations for the White House Conference on Aging will be funded by carryover balances of prior year appropriations.

Budget Authority by Activity
(Dollars in Thousands)

Program	FY 2004 <u>Actual</u>		FY 2005 <u>Appropriation</u>		FY 2006 <u>Estimate</u>	
	FTE	Amount	FTE	Amount	FTE	Amount
State & Community-Based Services:						
Home & Community-Based Supportive Services.....	--	\$353,889	--	\$354,136	--	\$354,136
Congregate Nutrition Services.....	--	386,353	--	387,274	--	387,274
Home-Delivered Nutrition Services.....	--	179,917	--	182,826	--	182,826
Nutrition Services Incentive Program.....	--	148,192	--	148,596	--	148,596
Preventive Health Services.....	--	21,790	--	21,616	--	21,616
National Family Caregiver Support Program.....	--	152,738	--	155,744	--	155,744
Subtotal, State & Community-Based Services.....	--	\$1,242,879	--	\$1,250,192	--	\$1,250,192
Services for Native Americans:						
Native American Nutrition & Supportive Services.....	--	\$26,453	--	\$26,398	--	\$26,398
Native American Caregiver Support Program.....	--	6,318	--	6,304	--	6,304
Subtotal, Services for Native Americans.....	--	\$32,771	--	\$32,702	--	\$32,702
Protection of Vulnerable Older Americans:						
Long-Term Care Ombudsmen Program.....	--	\$14,276	--	\$14,162	--	\$14,162
Prevention of Elder Abuse & Neglect.....	--	5,168	--	5,126	--	5,198
Subtotal, Vulnerable Older Americans.....	--	\$19,444	--	\$19,288	--	\$19,360
Innovation & Demonstration:						
Program Innovations.....	--	\$33,509	--	\$43,286	--	\$23,843
Aging Network Support Activities.....	--	13,294	--	13,266	--	13,266
Alzheimer's Disease Demonstration Grants.....	--	11,883	--	11,786	--	11,786
Subtotal, Innovation & Demonstration.....	--	\$58,686	--	\$68,338	--	\$48,895
Program Administration.....	109	\$17,324	113	\$18,301	113	\$17,879
White House Conference on Aging /1.....	1	\$2,814	6	\$4,520	3	\$ --
Total, Discretionary Budget Authority.....	110	\$1,373,918	119	\$1,393,341	116	\$1,369,028
<i>Health Care Fraud & Abuse Control /2.....</i>	<i>7</i>	<i>\$3,667</i>	<i>7</i>	<i>\$3,297</i>	<i>7</i>	<i>\$3,297</i>
Total, Discretionary Program Level.....	117	\$1,377,585	126	\$1,396,638	123	\$1,372,325

1/ 3 FTE in FY 2006 will be funded out of carryover balances of prior year appropriations for the White House Conference on Aging.

2/ FY 2006 is a placeholders, the Secretary and the Attorney General will negotiate final amounts.

Budget Authority by Object Class
(Dollars in Thousands)

	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or <u>Decrease</u>
Full-time equivalent employment /1.....	126	123	(3)
Full-time equivalent of overtime and holiday hours.....	--	--	--
Average SES Salary.....	124	128	4
Average GS Grade.....	12/4	12/5	
Average GS Salary.....	83	88	5
<hr/>			
Personnel Compensation:			
Full-time Permanent.....	10,043	10,220	177
Other than Full-Time Permanent.....	529	213	(316)
Other Personnel Compensation.....	391	281	(110)
Subtotal, Personnel Compensation.....	10,963	10,714	(249)
Personnel Benefits.....	2,109	2,093	(16)
Subtotal, Pay Costs.....	13,072	12,807	(265)
Travel and Transportation of Persons.....	2,196	391	(1,805)
Transportation of Things.....	106	13	(93)
Rental Payments to GSA.....	2,072	1,654	(418)
Communications, Utilities, and Miscellaneous.....	536	226	(310)
Printing and Reproduction.....	375	167	(208)
Other Contractual Services:			
Advisory and Assistance Services.....	6,994	6,232	(762)
Other Services.....	558	517	(41)
Purchases from Government Accounts.....	7,870	6,894	(976)
Operation and Maintenance of Equipment.....	66	55	(11)
Subtotal, Other Contractual Services.....	15,488	13,698	(1,790)
Supplies and Materials.....	121	72	(49)
Equipment.....	25	21	(4)
Grants, Subsidies and Contributions.....	1,359,350	1,339,979	(19,371)
Subtotal, Non-Pay Costs	1,380,269	1,356,221	(24,048)
Total, Budget Authority by Object Class.....	1,393,341	1,369,028	(24,313)

1/ FY 2006 FTE include 3 FTE for White House Conference on Aging that are funded out of carryover balances of prior year appropriations.

Exhibit J

Salaries and Expenses
(Dollars in Thousands)

	<u>FY 2005</u> <u>Appropriation</u>	<u>FY 2006</u> <u>Estimate</u>	<u>Increase or</u> <u>Decrease</u>
Personnel Compensation:			
Full-time Permanent (11.1).....	10,043	10,220	177
Other than Full-Time Permanent (11.3).....	529	213	(316)
Other Personnel Compensation (11.5).....	391	281	(110)
Subtotal, Personnel Compensation.....	10,963	10,714	(249)
Personnel Benefits (12.1).....	2,109	2,093	(16)
Subtotal, Pay Costs.....	13,072	12,807	(265)
Travel and Transportation of Persons (21.0).....	2,196	391	(1,805)
Transportation of Things (22.0).....	106	13	(93)
Communications, Utilities, and Miscellaneous (23.3).....	536	226	(310)
Printing and Reproduction (24.0).....	375	167	(208)
Other Contractual Services:			
Advisory and Assistance Services (25.1).....	6,994	6,232	(762)
Other Services (25.2).....	558	517	(41)
Purchases from Government Accounts (25.3).....	7,870	6,894	(976)
Operation and Maintenance of Equipment (25.7).....	66	55	(11)
Subtotal, Other Contractual Services.....	15,488	13,698	(1,790)
Supplies and Materials (26.0).....	121	72	(49)
Subtotal, Non-Pay Costs	18,822	14,567	(4,255)
Total, Salaries and Expenses.....	31,894	27,374	(4,520)

Significant Items in House and Senate Appropriations Committee Reports

FY 2005 House Appropriations Committee Report Language (House Report 108-636)

Item

Alzheimer's disease research – The Committee provides \$3,000,000 for social research into Alzheimer's disease care options, best practices and other Alzheimer's research priorities that include research into cause, cure and care, as well as respite care, assisted living, the impact of intervention by social service agencies on victims, and related needs. The Committee recommends this research utilize and give discretion to Area agencies on aging and their non-profit divisions in municipalities with aged populations (over the age of 60) of over 1 million, with preference given to the largest population. The Committee also recommends that unique partnerships to affect this research be considered for the selected Area agencies on aging.

Action Taken or To Be Taken

Funds provided for this purpose in FY 2004 were competitively awarded to the Fund for Aging Services, Inc. in New York and AoA is working with the grantee to implement this project. In FY 2005 AoA will continue to structure a grant award consistent with the objectives of the program and with the Congress's instructions.

FY 2005 Senate Appropriations Committee Report Language (Senate Report 108-345)

Item

Aging Grants to Indian Tribes and Native Hawaiian Organizations – The Committee recommends \$26,612,000 for grants to Native Americans, which is \$159,000 above the fiscal year 2004 comparable level and the same as the administration request. Under this program awards are made to tribal and Alaskan Native organizations and to public or nonprofit private organizations serving native Hawaiians which represent at least 50 percent Indians or Alaskan Natives 60 years of age or older to provide a broad range of supportive services and assure that nutrition services and information and assistance are available. The Committee recognizes that this program is the primary vehicle for providing nutrition and other supportive services to Indian, Alaska Native, and Native Hawaiian elders. The Committee urges the Administration on Aging to devote its attention toward this purpose.

Action Taken or To Be Taken

AoA provides grants to 241 American Indian and Alaskan Native organizations representing nearly 300 Tribes, and two public, nonprofit or private organizations serving Native Hawaiians. Grants assist in providing nutrition, information and assistance, transportation, homemaker and chore services, and a variety of other services to help keep Native American elders active and in their communities. These services are an integral part of AoA's mission under the Older

Americans Act, (OAA) which is to promote the dignity and independence of older Americans and to help society prepare for an aging population. AoA will work with the committee to ensure that Native American elders continue to receive the services they need to remain independent.

Item

Chronic disease of elderly American Indians – The Committee is aware of the high incidence of chronic diseases among elders in Indian Country. The Committee encourages the agency to carry out a demonstration program directed at decreasing health disparities through prevention and wellness outreach. The Committee also recommends that the agency continue and expand programs that focus on improving access to social services by elders in Indian Country.

Action Taken or To Be Taken

Helping older people to stay active and healthy and making it easier for them to access an integrated array of health and social supports are two of AoA's five strategic priorities. The services provided under Title VI of the OAA help Native American elders to preserve their health status and prevent and treat chronic diseases and disabilities. Services provided through these programs that are helping to keep Native American elders active and healthy include congregate and home-delivered meals, physical fitness and exercise, and health promotion education activities.

AoA is also currently funding a grant to the National Indian Council on Aging (NICOA) to conduct education and outreach on diabetes prevention and care. The effort has two goals: 1) preventing diabetes in those elders who do not have diabetes; and 2) increasing diabetes control for those elders who already have diabetes in an effort to prevent or delay the complications of diabetes. We will continue to work with NICOA to further decrease health disparities for this population.

Item

Geriatric Wellness Centers – The committee encourages the Administration on Aging to facilitate the expansion of demonstration projects gauging the efficiency of nurse-managed Geriatric Wellness Centers.

Action Taken or To Be Taken

Nurse-managed wellness programs located in senior centers provide a broad range of screening services, individual counseling, health educational programs, and management services for chronic diseases that are common among older adults. Research indicates that participants in nurse-managed Wellness Center programs report a more confident feeling concerning their ability to maintain an independent lifestyle. While AoA does not have a program targeted specifically at Geriatric Wellness Centers, we are funding an initiative designed to demonstrate the efficacy of using community-based aging services providers, including senior centers, to deliver prevention programs that have proven to be effective in reducing the risk of disease, disability and injury among the elderly. We are currently funding 12 community projects under

this initiative, as well as a national technical assistance center which is helping us disseminate information on evidence-based prevention programs to our State and local agencies and organizations. AoA will continue to include, as part of our national dissemination activities, information on nurse-managed Geriatric Wellness Centers.

Item

Mental illness among older Americans – The Committee is concerned about the prevalence of undiagnosed and untreated mental illness among older Americans. Disorders such as anxiety, depression, and dementia are common in older patients, but often go undetected. The Committee urges the Administration on Aging to study the benefits of integrating mental health treatment for older adults with primary medical treatment, commonly referred to as collaborative care.

Action Taken or To Be Taken

AoA is working with Federal partners, especially the Substance Abuse and Mental Health Services Administration (SAMHSA), to study and improve the mental health of older Americans. We have entered into a Memorandum of Understanding with SAMHSA to implement a State Policy Academy initiative that is designed to identify and provide funding, guidance, and technical assistance to States to integrate health (physical and mental) and social support services to better meet the needs of this population. A Center for Excellence funded by SAMHSA will support this initiative by disseminating information to States and communities on proven models of care, including those that integrate health and mental health components. In addition, in July of 2003, AoA developed a toolkit with SAMHSA and National Council on Aging called the “Get Connected! Toolkit,” to provide health and social services providers with information tools for linking with mental health providers.

Item

Senior legal services hotline – The Committee expects the Administration on Aging to continue to fund the national program of statewide senior legal services hotlines (also called legal helplines) at their current levels and ideally to provide an increase in the number of States served by these legal hotlines.

Action Taken or To Be Taken

AoA’s legal programs help to ensure that older Americans and their caregivers receive critical information in areas such as consumer protection, public benefits, resident’s rights, guardianship, and health and financial advance planning. Though technology has improved the quality and quantity of elder rights information and services, there remains a need to enhance seniors’ access to legal services. This is particularly true for underserved groups, such as ethnic minorities, low-income seniors, limited English speaking individuals, and seniors who reside in rural areas or are homebound or lack transportation to visit a traditional law office.

AoA currently funds 12 Grants to Enhance Access to Senior Legal Services, which provide States with a cost-effective way to increase the number of seniors who receive legal assistance.

Building upon methods previously tested under Title IV of the OAA, such as statewide senior legal services hotlines (also called legal helplines), self-help offices, interactive websites, and collaborative efforts, these grants enhance access to services for underserved seniors. AoA also funds one Technical Assistance Project to provide training, technical assistance, evaluation, and capacity-building services to the twelve AoA-funded projects under this program. AoA will continue to support statewide legal services hotlines/legal helplines through its funding of Grants to Enhance Access to Senior Legal Services, with the ultimate goal of increasing the number of States in which seniors are served by these programs.

FY 2005 Conference Committee Report Language (House Report 108-792)

Item

Alzheimer's disease care - Within the funding provided, the conference agreement includes \$3,000,000 for social research into Alzheimer's disease care options, best practices and other Alzheimer's research priorities that include research into cause, cure and care, as well as respite care, assisted living, the impact of intervention by social service agencies on victims, and related needs. The agreement recommends this research utilize and give discretion to area agencies on aging and their non-profit divisions in municipalities with aged populations (over the age of 60) of over 1,000,000 with preference given to the largest population. The conferees also recommend that unique partnerships to affect this research be considered for the selected area agency on aging.

Action Taken or To Be Taken

Funds provided for this purpose in FY 2004 were competitively awarded to the Fund for Aging Services, Inc. in New York and AoA is working with the grantee to implement this project. In FY 2005 AoA will continue to structure a grant award consistent with the objectives of the program and with the Congress's instructions.

Exhibit L**Authorizing Legislation**

	FY 2005 Authorized <u>Amount</u>	FY 2005 <u>Appropriation</u>	FY 2006 Authorized <u>Amount</u>	FY 2006 Budget <u>Request</u>
1) Home and Community- Based Supportive Services: OAA Section 321.....	Such Sums	\$354,136,000	Expired	\$354,136,000
2) Congregate Nutrition Services: OAA Section 331.....	Such Sums	\$387,274,000	Expired	\$387,274,000
3) Home-Delivered Nutrition Services: OAA Section 336.....	Such Sums	\$182,826,000	Expired	\$182,826,000
4) Nutrition Services Incentive Program: OAA Section 311.....	Such Sums	\$148,596,000	Expired	\$148,596,000
5) Preventive Health Services: OAA Section 361.....	Such Sums	\$21,616,000	Expired	\$21,616,000
6) National Family Caregiver Support Program: OAA Section 371.....	Such Sums	\$155,744,000	Expired	\$155,744,000
7) Native American Nutrition and Supportive Services: OAA Sections 613 and 623.....	Such Sums	\$26,398,000	Expired	\$26,398,000
8) Native American Caregiver Support Program: OAA Section 631.....	Such Sums	\$6,304,000	Expired	\$6,304,000
9) Long-Term Care Ombudsman Program: OAA Section 712	Such Sums	\$14,162,000	Expired	\$14,162,000
10) Prevention of Elder Abuse and Neglect: OAA Section 721.....	Such Sums	\$5,126,000	Expried	\$5,198,000
11) Program Innovations: OAA Section 411.....	Such Sums	\$43,286,000	Expired	\$23,843,000
12) Aging Network Support Activities: OAA Sections 202, 215 and 411.....	Such Sums	\$13,266,000	Expired	\$13,266,000

	FY 2005 Authorized <u>Amount</u>	FY 2005 <u>Appropriation</u>	FY 2006 Authorized <u>Amount</u>	FY 2006 Budget <u>Request</u>
13) Alzheimer's Disease Demonstration Grants: PHSA Section 398.....	Expired	\$11,786,000	Expired	\$11,786,000
14) Program Administration: OAA Section 205.....	Such Sums	\$18,301,000	Expired	\$17,879,000
15) White House Conference on Aging: OAA Section 211.....	Such Sums	<u>\$4,520,000</u>	Expired	<u>--</u>
Total Request Level.....		\$1,393,341,000		\$1,369,028,000

Unfunded Authorizations:

1) Legal Assistance: OAA Section 731.....	Such Sums	--	Expired	--
2) Native American Vulnerable Elder Rights Program: OAA Section 751.....	Such Sums	--	Expired	--

Appropriations History Table

Aging Services Programs

	<u>Budget Estimate to Congress</u>	<u>House Allowance</u>	<u>Senate Allowance</u>	<u>Appropriation</u>
FY 1997	828,137,000	810,545,000	830,168,000	830,168,000
FY 1997 Rescission	--	--	--	-37,000
FY 1998	838,168,000	815,545,000	894,074,000	865,050,000
FY 1999	871,050,000	861,020,000	876,050,000	882,020,000
FY 1999 Rescission	--	--	--	-9,000
FY 1999 Transfer	--	--	--	-281,000
FY 2000	1,048,055,000	881,976,000	928,055,000	934,285,000
FY 2000 Rescission	--	--	--	-1,437,000
FY 2000 Transfer /1	--	--	--	-184,000
FY 2001	1,083,619,000	925,805,000	954,619,000	1,103,135,000
FY 2001 Rescission	--	--	--	-42,000
FY 2001 Transfer	--	--	--	-151,000
FY 2002	1,097,718,000	1,144,832,000	1,209,756,000	1,199,814,000
FY 2002 Rescission /2	--	--	--	-143,000
FY 2003	1,341,344,000	1,355,844,000	1,369,290,000	1,376,001,000
FY 2003 Rescission				-8,944,007
FY 2004	1,343,701,000	1,377,421,000	1,361,193,000	1,382,189,000
FY 2004 Rescission /3				-8,271,225
FY 2005	1,376,527,000	1,403,479,000	1,395,117,000	1,404,634,000
FY 2005 Rescission /4				-11,292,624
FY 2006	1,369,028,000	N/A	N/A	N/A

1/ Reflects two separate transfers of -\$121,000 and -\$63,000.

2/ Reflects three separate rescissions of -\$37,000, -\$17,000, and -\$89,000.

3/ Reflects two separate rescissions of - \$8,154,255 and -\$117,000.

4/ Reflects two separate rescissions of - \$11,236,624 and -\$56,000.

Home and Community-Based Supportive Services

Authorizing Legislation: Section 321 of the Older Americans Act of 1965, as amended

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA	\$353,889,000	\$354,136,000	\$354,136,000	--

Statement of the Budget Request

The FY 2006 request for Home and Community-Based Supportive Services (HCBSS) is \$354,136,000, the same as the FY 2005 enacted level. HCBSS provides funding for a broad range of direct client services – including transportation, personal care, homemaker, chore, respite care, and adult day care – that enable older Americans to remain independent, at home and in the community.

Program Description

The HCBSS program provides grants to States and Territories to support the implementation of comprehensive and coordinated service systems for older individuals and their families. The program includes funding for multi-purpose senior centers which function as community focal points to coordinate and integrate services for the elderly. The infrastructure of the aging services network – which is one of the nation’s largest providers of home and community-based long-term care services – provides an important foundation for the Department’s efforts to create a more balanced long-term care system and to focus on care in the community.

The array of services provided by the HCBSS program helps to keep seniors as independent as possible and enables them to stay in their homes and communities, thereby reducing the need for costly institutional care. HCBSS also provides for critical intake and access services, such as transportation and information and referral, which serve as the gateway to other home and community-based services, including nutrition services, caregiver services, and prevention and management of chronic disease through low-cost community interventions. Services provided in FY 2003 under the HCBSS program include:

- *Transportation Services*, which provided almost 36 million rides to doctors offices, grocery stores, pharmacies, senior centers, meal sites, and other critical daily activities.
- *Information and Referral Services*, which provided service and program information to over 12 million seniors, family members, and friends, thereby empowering individuals and families to make informed choices about their service and care needs.
- *Personal Care Services*, which provided over 9 million hours of in-home assistance to persons with the inability to perform one or more of the following activities of daily living: eating, dressing, bathing, toileting, transferring in and out of bed/chair or walking.

- *Homemaker Services*, which provided almost 10 million hours of assistance to persons with the inability to perform one or more of the following instrumental activities of daily living: preparing meals, shopping, managing money, using the telephone or doing light housework.
- *Chore Services*, which provided over 1 million hours of assistance to persons having difficulty with one or more of the following instrumental activities of daily living: heavy housework, yard work or sidewalk maintenance.
- *Adult Day Care/Adult Day Health Services*, which provided almost 10 million hours of personal care for dependent adults in a supervised, protective, congregate setting during some portion of a twenty-four hour day.
- *Case Management Services*, which provided almost 4 million hours of assistance – including assessing needs, developing care plans, and arranging services – to older persons or caregivers who are experiencing diminished functional capacity or other personal conditions.

Formula grants for HCBSS are allocated to States and Territories based on their share of the population aged 60 and over. States and Territories provide funds to area agencies on aging, which in turn fund local agencies and service providers. States and Territories have flexibility to allocate resources among the various services authorized under the Older Americans Act (OAA) in order to best meet local needs. States and Territories may also transfer up to 30 percent of their funds between HCBSS and Congregate and/or Home-Delivered Nutrition Services in order to better meet the needs of their seniors.

Performance Analysis

HCBSS is part of AoA's Aging Services Government Performance and Results Act program. Improving program efficiency, improving client assessment and outcomes, and improving targeting of services to vulnerable elders are the three performance measures used to assess the performance of the Aging Services program. Indicators and FY 2006 targets for these measures that are associated with HCBSS include:

- Increasing the number of clients served per million dollars of AoA funding (with no decline in service quality) by ten percent above the FY 2001 baseline (*Efficiency Indicator*).
- Maintaining the percentage of transportation service recipients who rate the service as very good to excellent at 82 percent (*Assessment and Outcome Indicator*).
- Increasing the percentage of caregivers who report that OAA services definitely help them provide care longer to 68 percent (*Assessment and Outcome Indicator*).
- Increasing the number of severely disabled clients who receive selected home and community based services by 15 percent over the FY 2003 base (*Targeting Indicator*).

An analysis of prior year data for these indicators shows that AoA is already making progress toward achieving its aggressive performance targets. The number of clients served per million

dollars of funding increased each year from FY 1999 to FY 2003, demonstrating improvements in program efficiency. Clients report that services are meeting their needs, as demonstrated by the fact that 52 percent of caregivers, when asked to rank their level of confidence in the effect of aging network services, said that the services definitely enabled them to provide care longer. Clients also report high levels of satisfaction with the services provided, as evidenced by the 82 percent of transportation service recipients who rate the service as very good or excellent. And services are successfully targeting the most vulnerable elders, as demonstrated by the 43 percent of homemaker service clients with three or more limitations in activities of daily living, a level of frailty consistent with nursing home residents. Together, these positive results are reflected in the Program Assessment Ratings Tool (PART) evaluation score of Moderately Effective that was achieved in FY 2005.

AoA's budget request is closely linked to its performance plan and reflects a strategy for ensuring that core programs such as HCBSS maintain and improve performance in FY 2006 and beyond. The FY 2006 request maintains funding for HCBSS and other core service delivery programs, while continuing to make targeted investments in innovation and demonstration grants that over the long run will create greater balance and better options in our State and community systems of health and long-term care, including improved access, more integrated services, and greater emphasis on prevention. These investments will improve program efficiency and outcomes while also assisting the aging services network to maintain the current high level of consumer satisfaction with services; and to continue to target services to the most vulnerable elderly individuals. For more information on program performance, please refer to the Performance Analysis Detail on page 107.

Rationale for the Budget Request

The FY 2006 request for HCBSS is \$354,136,000, the same as the FY 2005 enacted level. HCBSS has demonstrated effective performance, as evidenced by its success in delivering high quality services such as transportation and personal care that help vulnerable seniors to remain at home, as well as by achieving a PART score of Moderately Effective.

The number of older Americans is increasing, particularly the population age 85 and over, which is growing faster than any other age cohort and is projected to total 5.1 million by 2005 and 9.6 million by the year 2030. This demographic trend, along with advancements in medical practices that are enabling seniors to live longer than ever before, have also led to more seniors needing assistance to remain at home. The May 1999 General Accounting Office report, *Adults with Severe Disabilities: Federal and State Approaches for Personal Care and Other Services*, found that "obtaining personal care on what is often a daily basis is critical for avoiding institutionalization.... Without help from family, friends, or public programs, affording such assistance may be problematic".

Assisting seniors to remain at home is not only more cost-effective; data overwhelmingly shows that it is what they prefer. For example, in the April 2004 AARP study *Home and Community-Based Long-Term Care in Louisiana*, 88 percent of respondents reported that it is very important to have services that would allow them to remain in their home as long as possible. Despite this

overwhelming preference, and the fact that community-based services are more cost-effective, approximately 67 percent of public long-term care funding still goes to institutional care.

Data demonstrates that the services provided through the HCBSS program are effective in meeting the needs of older individuals and assisting them to remain at home. AoA has contracted to conduct five independent national surveys of elderly clients to obtain an assessment of the services provided under the OAA. Services assessed include transportation, homemaker, and information and referral. Data show that not only do these services play an important role in assisting seniors to remain at home, but that service recipients are very satisfied with the services they are receiving. For example:

- 44 percent of seniors using transportation services rely on them for “virtually all” of their transportation needs – without these services, these individuals would be homebound.
- 83 percent of transportation service recipients rate the service as “excellent” or “very good” and 82 percent “would definitely recommend it to a friend”.
- 83 percent of callers to information and referral services said the information they received should help them to resolve their issue.
- 43 percent of homemaker service clients reported limitations with three or more activities of daily living – a level of frailty consistent with nursing home residents – and 95 percent rated the services as good to excellent.

The array of services provided through the HCBSS program represents a cost-effective and consumer friendly way of meeting the needs of seniors and helping them to remain at home. HCBSS directly supports the strategic priorities established for AoA by the Assistant Secretary, including Priority 2: Help older people to stay active and healthy; and Priority 3: Support families in their efforts to care for their loved ones at home and in the community. HCBSS are a key component of the Department’s efforts to create a more balanced long-term care system and to focus on care in the community. Without these services, it would be more difficult for many seniors to remain at home and in the community, thereby increasing costs to other programs that provide more expensive institutional care.

Funding History

Funding for HCBSS during the past five years is as follows:

FY 2001	\$325,027,000
FY 2002	\$356,981,000
FY 2003	\$355,673,000
FY 2004	\$353,889,000
FY 2005	\$354,136,000

Congregate Nutrition Services

Authorizing Legislation: Section 331 of the Older Americans Act of 1965, as amended

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA	\$386,353,000	\$387,274,000	\$387,274,000	--

Statement of the Budget Request

The FY 2006 request for Congregate Nutrition Services is \$387,274,000, the same as the FY 2005 enacted level. Congregate Nutrition Services provides funding for the provision of meals and related services that help keep older Americans healthy and prevent the need for more costly medical interventions.

Program Description

The Congregate Nutrition Services program provides grants to States and Territories to support the delivery of meals to seniors who are at higher nutritional risk than the overall older population. Meals are provided in a variety of congregate settings, including senior centers. These meals are the primary source of food for many participants, and the program presents opportunities for social engagement and meaningful volunteer roles, which contribute to overall health and well-being.

Scientific evidence shows that adequate nutrition is necessary to maintain cognitive and physical function, to reduce chronic disease and disability, and to sustain good quality of life. Congregate Nutrition Services help millions of older adults who would otherwise lack access to adequate amounts and quality of food to receive the meals they need to stay healthy and decrease their risk of disability. Meals provided through the Congregate Nutrition Services program comply with the Dietary Guidelines for Americans and provide a minimum of 33 percent of the Recommended Dietary Allowances, as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. While meals are the core service, the program also provides related services such as nutrition screening, assessment, education, and counseling. Data for the Congregate Nutrition Services program for FY 2003 shows that:

- Approximately 106 million meals were served to older individuals at multi-purpose senior centers and other sites.
- Over 1.8 million seniors received meals through the program.
- Over 1.1 million hours of nutrition education and more than 73,000 hours of nutrition counseling were provided through Older Americans Act (OAA) programs.

Formula grants for Congregate Nutrition Services are allocated to States and Territories based on their share of the population aged 60 and over. States and Territories provide funds to area

agencies on aging, which in turn fund local agencies and service providers. States and Territories may transfer up to 30 percent of their funds between Congregate Nutrition Services and Home and Community-Based Supportive Services, and up to 40 percent of their funds between Congregate Nutrition Services and Home-Delivered Nutrition Services, in order to better meet the needs of their seniors.

Funding for the Congregate Nutrition Services program is significantly leveraged, and about 61 percent of its funding comes from sources other than the OAA. Although there are no fees or charges for participation, older persons are encouraged to contribute by volunteering and offering financial support to help defray costs. Priority for the receipt of Congregate Nutrition Services is given to those who are in greatest economic or social need with particular attention to older adults who are low-income, minorities, or who reside in rural areas.

Performance Analysis

Congregate Nutrition Services is part of AoA's Aging Services Government Performance and Results Act program. Improving program efficiency, improving client assessment and outcomes, and improving targeting of services to vulnerable elders are the three performance measures used to assess the performance of the Aging Services program. Indicators and FY 2006 targets for these measures that are associated with Congregate Nutrition Services include:

- Increasing the number of clients served per million dollars of AoA funding (with no decline in service quality) by ten percent above the FY 2001 baseline (*Efficiency Indicator*).
- Maintaining the percentage of congregate meal recipients who are satisfied with the way the food tastes at 93 percent (*Assessment and Outcome Indicator*).
- Increasing the percentage of caregivers who report that OAA services definitely help them provide care longer to 68 percent (*Assessment and Outcome Indicator*).
- Increase the number of States that increase the percentage of clients served who are poor by seventeen States (*Targeting Indicator*).

An analysis of prior year data for these indicators shows that AoA is already making progress toward achieving its aggressive performance targets. The number of clients served per million dollars of funding increased each year from FY 1999 to FY 2003, demonstrating improvements in program efficiency. Clients report that services are meeting their needs, as demonstrated by the fact that 52 percent of caregivers, when asked to rank their level of confidence in the effect of aging network services, said that the services definitely enabled them to provide care longer. Clients also report high levels of satisfaction with the services provided, as evidenced by the 90 percent of congregate meal recipients who are satisfied with the way the food tastes. And services are being provided to minority, poor, and rural seniors at rates that exceed their percentage of the general elder population, demonstrating that AoA is targeting services to vulnerable elders as required by the OAA. These positive results are reflected in the Program Assessment Ratings Tool (PART) evaluation score of Moderately Effective that was achieved in FY 2005.

AoA's budget request is closely linked to its performance plan and reflects a strategy for ensuring that core programs such as Congregate Nutrition Services maintain and improve performance in FY 2006 and beyond. The FY 2006 request maintains funding for Congregate Nutrition Services and other core service delivery programs, while continuing to make targeted investments in innovation and demonstration grants that over the long run will create greater balance and better options in our State and community systems of health and long-term care, including improved access, more integrated services, and greater emphasis on prevention. These investments will improve program efficiency and outcomes while also assisting the aging services network to maintain the current high level of consumer satisfaction with services; and to continue to target services to the most vulnerable elderly individuals. For more information on program performance, please refer to the Performance Analysis Detail on page 107.

Rationale for the Budget Request

The FY 2006 request for Congregate Nutrition Services is \$387,274,000, the same as the FY 2005 enacted level. Congregate Nutrition Services has demonstrated effective performance, as evidenced by its success in providing nutritious meals that help vulnerable seniors to maintain their health status, as well as by achieving a PART score of Moderately Effective.

The number of older Americans is increasing, particularly the population age 85 and over, which is growing faster than any other age cohort. With advanced age comes an increased risk of chronic disease and disease-related disabilities, many of which are nutrition related. While improved dietary habits can reduce these risks, many elderly individuals have limitations in activities of daily living which make it difficult for them to care for themselves. For example, studies have found that half of all persons age 85 and over are in need of assistance with instrumental activities of daily living, including obtaining and preparing food. Without assistance, these seniors would be unable to remain at home and would require more costly institutional care.

Another nutrition related health problem that greatly affects seniors is obesity. Data shows that between 17 and 25 percent of persons age 60 and over are obese. The *Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity 2001* identifies the health risks of being overweight, including increased risk of diabetes, heart disease, stroke, hypertension, gallbladder disease, osteoarthritis, cancer, and high cholesterol. Nutrition and related services such as physical activity can assist seniors to manage weight and reduce these risks.

Serving Elders at Risk, a national evaluation of AoA nutrition programs, found that recipients of Congregate Nutrition Services tend to be seniors who are poorer, older, more likely to live alone, are in poorer health, poorer nutritional status, more functionally impaired, and more likely to be minorities than the general elder population. More recent data shows that the program serves a greater proportion of rural elders than is reflected in the general elder population. *Serving Elders at Risk* also found that Congregate Nutrition Services are effective in improving nutritional status, as well as in increasing social interaction, thereby improving overall health of participants and helping them avoid the need for more costly medical interventions and institutional care.

Data demonstrates that the services provided through the Congregate Nutrition Services program are effective in meeting the needs of older individuals. AoA has contracted to conduct five independent national surveys of elderly clients to obtain an assessment of the services provided under the OAA. One of the services assessed was nutrition services. Survey data show that not only are these services effective in targeting those at high nutritional risk, but that the services are helping recipients to maintain their health status and remain at home. For example:

- 39 percent of congregate meal recipients are at high nutritional risk and 49 percent are at moderate nutritional risk.
- 63 percent of congregate meal recipients are 75 years of age or older.
- 90 percent of congregate meal recipients report that they are very or somewhat satisfied with the way the meals taste.
- 72 percent of congregate meal recipients report that the meals enabled them to continue living in their own homes.
- 79 percent of congregate meal recipients say they eat more balanced meals due to the congregate meals program.

By providing meals and related services to vulnerable seniors, the Congregate Nutrition Services program helps to improve participants overall health and to prevent older adults from having to choose between food and other necessities, including medications. Congregate Nutrition Services directly support the strategic priorities established for AoA by the Assistant Secretary, including *Priority 2: Help older people to stay active and healthy*; and *Priority 3: Support families in their efforts to care for their loved ones at home and in the community*. These services are a key component of the Department’s efforts to create a more balanced long-term care system and to focus on care in the community. Without these services, it would be more difficult for many seniors to remain healthy and at home, thereby increasing costs to other programs that provide more expensive medical and institutional care.

Funding History

Funding for Congregate Nutrition Services during the past five years is as follows:

FY 2001	\$378,356,000
FY 2002	\$390,000,000
FY 2003	\$384,592,000
FY 2004	\$386,353,000
FY 2005	\$387,274,000

Home-Delivered Nutrition Services

Authorizing Legislation: Section 336 of the Older Americans Act of 1965, as amended

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA	\$179,917,000	\$182,826,000	\$182,826,000	--

Statement of the Budget Request

The FY 2006 request for Home-Delivered Nutrition Services is \$182,826,000, the same as the FY 2005 enacted level. Home-Delivered Nutrition Services provides funding for the delivery of meals and related services that help vulnerable elders to remain at home and avoid more costly medical and institutional care.

Program Description

The Home-Delivered Nutrition Services program provides grants to States and Territories to support the delivery of meals to persons age 60 and older that are homebound due to illness, disability, or geographic isolation. Meals provided through the Home-Delivered Nutrition Services program are often the first in-home service that an older adult receives, and the program is a primary access point for all other in-home services. Home-delivered meals also represent an essential service for many caregivers, by helping them to maintain their own health and well being.

Scientific evidence shows that adequate nutrition is necessary to maintain cognitive and physical function, to reduce chronic disease and disability, and to sustain good quality of life. Home-Delivered Nutrition Services help millions of older adults who would otherwise lack access to adequate amounts and quality of food to maintain their health status; to treat, manage and decrease the risk of complications resulting from acute and chronic disease and disability; and to avoid the need for institutional care. Meals provided through the Home-Delivered Nutrition Services program comply with the Dietary Guidelines for Americans and provide a minimum of 33 percent of the Recommended Dietary Allowances, as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. While meals are the core service, the program also provides related services such as nutrition screening, assessment, education, and counseling. Data for the Home-Delivered Nutrition Services program for FY 2003 shows that:

- Approximately 142 million meals were served to older individuals, including caregivers of home-bound elders.
- Approximately 950,000 seniors received meals through the program.
- Over 1.1 million hours of nutrition education and more than 73,000 hours of nutrition counseling were provided through Older Americans Act (OAA) programs.

Formula grants for Home-Delivered Nutrition Services are allocated to States and Territories based on their share of the population aged 60 and over. States and Territories provide funds to area agencies on aging, which in turn fund local agencies and service providers. States and Territories may transfer up to 30 percent of their funds between Home-Delivered Nutrition Services and Home and Community-Based Supportive Services, and up to 40 percent of their funds between Home-Delivered Nutrition Services and Congregate Nutrition Services, in order to better meet the needs of their seniors.

Funding for Home-Delivered Nutrition Services is significantly leveraged, and about 67 percent of its funding comes from sources other than the OAA. Although there are no fees or charges for the program, older persons are given the opportunity to contribute by volunteering and offering financial support to help defray the cost of services. Priority for the receipt of Home-Delivered Nutrition Services is given to those who are in greatest economic or social need with particular attention to older adults who are low-income, minorities, or who reside in rural areas.

Performance Analysis

Home-Delivered Nutrition Services is part of AoA's Aging Services Government Performance and Results Act program. Improving program efficiency, improving client assessment and outcomes, and improving targeting of services to vulnerable elders are the three performance measures used to assess the performance of the Aging Services program. Indicators and FY 2006 targets for these measures that are associated with Home-Delivered Nutrition Services include:

- Increasing the number of clients served per million dollars of AoA funding (with no decline in service quality) by ten percent above the FY 2001 baseline (*Efficiency Indicator*).
- Maintaining the percentage of home-delivered meal recipients who like the meals at 93 percent (*Assessment and Outcome Indicators*).
- Increasing the percentage of caregivers who report that OAA services definitely help them provide care longer to 68 percent (*Assessment and Outcome Indicator*).
- Increasing the number of severely disabled clients who receive selected home and community based services by 15 percent over the FY 2003 base (*Targeting Indicator*).

An analysis of prior year data for these indicators shows that AoA is already making progress toward achieving its aggressive performance targets. The number of clients served per million dollars of funding increased each year from FY 1999 to FY 2003, demonstrating improvements in program efficiency. Clients report that services are meeting their needs, as demonstrated by the fact that 52 percent of caregivers, when asked to rank their level of confidence in the effect of aging network services, said that the services definitely enabled them to provide care longer. Clients also report high levels of satisfaction with the services provided, as evidenced by the 93 percent of home-delivered meal recipients who like the meals. And services are successfully targeting the most vulnerable elders, as demonstrated by the 30 percent of home-delivered meal recipients with three or more limitations in activities of daily living, a level of frailty consistent

with nursing home residents. These positive results are reflected in the Program Assessment Ratings Tool (PART) evaluation score of Moderately Effective that was achieved in FY 2005.

AoA's budget request is closely linked to its performance plan and reflects a strategy for ensuring that core programs such as Home-Delivered Nutrition Services maintain and improve performance in FY 2006 and beyond. The FY 2006 request maintains funding for Home-Delivered Nutrition Services and other core service delivery programs, while continuing to make targeted investments in innovation and demonstration grants that over the long run will create greater balance and better options in our State and community systems of health and long-term care, including improved access, more integrated services, and greater emphasis on prevention. These investments will improve program efficiency and outcomes while also assisting the aging services network to maintain the current high level of consumer satisfaction with services; and to continue to target services to the most vulnerable elderly individuals. For more information on program performance, please refer to the Performance Analysis Detail on page 107.

Rationale for the Budget Request

The FY 2006 request for Home-Delivered Nutrition Services is \$182,826,000, the same as the FY 2005 enacted level. Home-Delivered Nutrition Services has demonstrated effective performance, as evidenced by its success in providing nutritious meals that help vulnerable seniors to remain at home, as well as by achieving a PART score of Moderately Effective.

The number of older Americans is increasing, particularly the population age 85 and over, which is growing faster than any other age cohort. With advanced age comes an increased risk of chronic disease and disease-related disabilities, many of which are nutrition related. While improved dietary habits can reduce these risks, many elderly individuals have limitations in activities of daily living, which make it difficult for them to care for themselves. For example, studies have found that half of all persons age 85 and over are in need of assistance with instrumental activities of daily living, including obtaining and preparing food. Without assistance, these seniors would be unable to remain at home and would require more costly institutional care.

Serving Elders at Risk, a national evaluation of AoA nutrition programs, found that recipients of Home-Delivered Nutrition Services are seniors who are older, poorer, more likely to live alone, more likely to be minorities, are sicker, in poorer health, in poorer nutritional status, more functionally impaired, and at higher nutritional risk than those in the general elder population. More recent program data shows that the program serves a greater proportion of rural elders than is reflected in the general population of older Americans. Home-Delivered Nutrition Services provide culturally appropriate nutrition services to home-bound seniors. These services improve the dietary intakes of participants while providing important social contact to individuals who are at increased risk of depression and isolation, thereby helping them avoid the need for more costly medical interventions and institutional care.

Data demonstrates that the services provided through the Home-Delivered Nutrition Services program are effective in meeting the needs of older individuals. AoA has contracted to conduct five independent national surveys of elderly clients to obtain an assessment of the services

provided under the OAA. One of the services assessed was nutrition services. Survey data show that not only are these services effective in targeting those at high nutritional risk, but that the services are helping recipients to maintain their health status and remain at home. For example:

- 79 percent of home-delivered meal recipients are at high nutritional risk and 19 percent are at moderate nutritional risk.
- 79 percent of home-delivered meal recipients have at least one limitation with activities of daily living, and 30 percent have limitations with three or more – a level of frailty consistent with nursing home residents.
- 99 percent of home-delivered meal recipients have one or more limitations with instrumental activities of daily living, including 43 percent who have difficulty getting around at home.
- 90 percent of home-delivered meal recipients report that the meals enabled them to continue living in their own homes.
- 86 percent of home-delivered meal recipients say they eat more balanced meals due to the home-delivered meals program.

By providing meals and related services to vulnerable seniors, the Home-Delivered Nutrition Services program helps to maintain participants overall health status and to prevent older adults from having to choose between food and other necessities, including medications. Home-Delivered Nutrition Services directly support the strategic priorities established for AoA by the Assistant Secretary, including *Priority 2: Help older people to stay active and healthy*; and *Priority 3: Support families in their efforts to care for their loved ones at home and in the community*. These services are a key component of the Department’s efforts to create a more balanced long-term care system and to focus on care in the community. Without these services, it would be more difficult for many seniors to remain at home and in the community, thereby increasing costs to other programs that provide more expensive medical and institutional care.

Funding History

Funding for Home-Delivered Nutrition Services during the past five years is as follows:

FY 2001	\$151,978,000
FY 2002	\$176,500,000
FY 2003	\$180,985,000
FY 2004	\$179,917,000
FY 2005	\$182,826,000

Nutrition Services Incentive Program

Authorizing Legislation: Section 311 of the Older Americans Act of 1965, as amended

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA	\$148,192,000	\$148,596,000	\$148,596,000	--

Statement of the Budget Request

The FY 2006 request for the Nutrition Services Incentive Program (NSIP) is \$148,596,000, the same as the FY 2005 enacted level. NSIP provides additional funding to States, Territories and Tribal organizations to support the delivery of meals to vulnerable elders, both at home and in congregate settings.

Program Description

NSIP provides additional funding to States, Territories, and eligible Tribal Organizations that is used exclusively to provide meals, and may not be used to pay for other nutrition-related services or for administrative costs. NSIP funds are awarded to existing congregate and home-delivered meal providers. The program gives States and Tribes the option to receive commodities in lieu of cash if they determine that doing so will enable them to better meet the needs of seniors.

Scientific evidence shows that adequate nutrition is necessary to maintain cognitive and physical function, to reduce chronic disease and disability, and to sustain good quality of life. Older Americans Act (OAA) Nutrition programs help millions of older adults who would otherwise lack access to adequate amounts and quality of food to maintain their health status; manage chronic disease, and decrease their risk of disability. Meals provided through OAA Nutrition programs comply with the Dietary Guidelines for Americans and provide a minimum of 33 percent of the Recommended Dietary Allowances, as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Data shows that OAA Nutrition programs provided a total of approximately 251 million meals in FY 2003:

- Approximately 142 million meals were served to older individuals, including caregivers of home-bound elders, through the Home-Delivered Nutrition Services program.
- Approximately 106 million meals were served to older individuals in a variety of community-based settings, including multi-purpose senior centers, through the Congregate Nutrition Services program.
- Approximately 3 million meals were served to American Indian, Alaskan Native, and Native Hawaiian elders, both at home and in congregate settings, through the Native American Nutrition and Supportive Services program.

Formula grants for NSIP are allocated to States, Territories and eligible Tribal organizations based on the number of meals served in the prior year. States, Territories, and Tribes have flexibility to determine the split of their allocation between cash and commodities, as well as the types of commodities they receive. The Food and Nutrition Service, a bureau of the Department of Agriculture (which administered the program prior to its transfer to AoA in FY 2003), runs the commodities component of the program through an interagency agreement with AoA.

Performance Analysis

NSIP is part of AoA's Aging Services Government Performance and Results Act program. Improving program efficiency, improving client assessment and outcomes, and improving targeting of services to vulnerable elders are the three performance measures used to assess the performance of the Aging Services program. Indicators and FY 2006 targets for these measures that are associated with NSIP include:

- Increasing the number of clients served per million dollars of AoA funding (with no decline in service quality) by ten percent above the FY 2001 baseline (*Efficiency Indicator*).
- Maintaining the percentage of congregate meal recipients who are satisfied with the way the food tastes at 93 percent (*Assessment and Outcome Indicator*).
- Maintaining the percentage of home-delivered meal recipients who like the meals at 93 percent (*Assessment and Outcome Indicators*).
- Increasing the percentage of caregivers who report that OAA services definitely help them provide care longer to 68 percent (*Assessment and Outcome Indicator*).
- Increasing the percentage of clients who live in rural areas to 10 percent greater than the percent of all elders who live in rural areas (*Targeting Indicator*).

An analysis of prior year data for these indicators shows that AoA is already making progress toward achieving its aggressive performance targets. The number of clients served per million dollars of funding increased each year from FY 1999 to FY 2003, demonstrating improvements in program efficiency. Clients report that services are meeting their needs, as demonstrated by the fact that 52 percent of caregivers, when asked to rank their level of confidence in the effect of aging network services, said that the services definitely enabled them to provide care longer. Clients also report high levels of satisfaction with the services provided, as evidenced by the 90 percent of congregate meal recipients who say they are satisfied with the way the food tastes and the 93 percent of home-delivered meal recipients who say they like the meals. And services are being provided to minority, poor, and rural seniors at rates that exceed their percentage of the general elder population, demonstrating that AoA is targeting services to vulnerable elders as required by the OAA. These positive results are reflected in the Program Assessment Ratings Tool (PART) evaluation score of Moderately Effective that was achieved in FY 2005.

AoA's budget request is closely linked to its performance plan and reflects a strategy for ensuring that core programs such as NSIP maintain and improve performance in FY 2006 and

beyond. The budget request maintains funding for NSIP and other core service delivery programs, while continuing to make targeted investments in innovation and demonstration grants that over the long run will create greater balance and better options in our State and community systems of health and long-term care, including improved access, more integrated services, and greater emphasis on prevention. These investments will improve program efficiency and outcomes while also assisting the aging services network to maintain the current high level of consumer satisfaction with services; and to continue to target services to the most vulnerable elderly individuals. For more information on program performance, please refer to the Performance Analysis Detail on page 107.

Rationale for the Budget Request

The FY 2006 request for NSIP is \$148,596,000, the same as the FY 2005 enacted level. NSIP has demonstrated effective performance, as evidenced by its success in providing nutritious meals that help vulnerable seniors to maintain their health status and to remain at home, as well as by achieving a PART score of Moderately Effective.

The number of older Americans is increasing, particularly the population age 85 and over, which is growing faster than any other age cohort. With advanced age comes an increased risk of chronic diseases and disease-related disabilities, many of which are nutrition related. While improved dietary habits can reduce these risks, many elderly individuals have limitations in activities of daily living which make it difficult for them to care for themselves. For example, studies have found that half of all persons age 85 and over are in need of assistance with instrumental activities of daily living, including obtaining and preparing food. Without assistance, these seniors would be unable to remain at home and would require more costly institutional care.

Serving Elders at Risk, a national evaluation of AoA nutrition programs, found that recipients of OAA Nutrition services are seniors who are older, poorer, more likely to live alone, more likely to be minorities, are sicker, in poorer health, in poorer nutritional status, more functionally impaired, and at higher nutritional risk than those in the general population. More recent data shows that the programs serve a greater proportion of rural elders than is reflected in the general older population. By providing meals as well as the opportunity for more social interactions than comparable non-participants engaged in, OAA Nutrition programs represent a cost-effective means of helping seniors prevent deterioration of health status and thereby avoid the need for more costly medical interventions, including institutional care.

Data demonstrates that the services provided through OAA Nutrition programs are effective in meeting the needs of older individuals. AoA has contracted to conduct five independent national surveys of elderly clients to obtain an assessment of the services provided under the OAA. One of the services assessed was nutrition services. Survey data show that not only are these services effective in targeting those at high nutritional risk, but that the services are helping recipients to maintain their health status and remain at home. For example:

- 88 percent of congregate meal recipients and 98 percent of home-delivered meal recipients are at either high or moderate nutritional risk.

- 90 percent of congregate meal recipients report that they are very or somewhat satisfied with the way the meals taste, and 93 percent of home-delivered meal recipients report they like the meals.
- 72 percent of congregate meal recipients and 90 percent of home-delivered meal recipients report that the meals enabled them to continue living in their own homes.
- 79 percent of congregate meal recipients and 86 percent of home-delivered meal recipients say they eat more balanced meals due to OAA Nutrition programs.

By providing approximately 251 million meals to vulnerable seniors, OAA Nutrition programs help to maintain participants overall health and to prevent older adults from having to choose between food and other necessities, including medications. OAA Nutrition programs, including NSIP, directly support the strategic priorities established for AoA by the Assistant Secretary, including *Priority 2: Help older people to stay active and healthy*; and *Priority 3: Support families in their efforts to care for their loved ones at home and in the community*. These services are a key component of the Department’s efforts to create a more balanced long-term care system and to focus on care in the community. Without these services, it would be more difficult for many seniors to remain at home and in the community, thereby increasing costs to other programs that provide more expensive medical and institutional care.

Funding History

Comparable funding for NSIP during the past five years is as follows:

FY 2001	\$150,000,000
FY 2002	\$149,670,000
FY 2003	\$148,697,000
FY 2004	\$148,192,000
FY 2005	\$148,596,000

Preventive Health Services

Authorizing Legislation: Section 361 of the Older Americans Act of 1965, as amended

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA	\$21,790,000	\$21,616,000	\$21,616,000	--

Statement of the Budget Request

The FY 2006 request for Preventive Health Services is \$21,616,000, the same as the FY 2005 enacted level. The request includes a statutory earmark of \$5,500,000 for medication management, screening, and education. Preventive Health Services provides funding for a range of activities – including health screenings, physical fitness, and medication management – that help older Americans to remain active and healthy.

Program Description

Preventive Health Services provides grants to States and Territories to support activities that educate older adults about the importance of healthy lifestyles and promote healthy behaviors that can help to prevent or delay chronic disease and disability. The program includes funding for group activities at multi-purpose senior centers, meal sites, and other community-based settings, as well as individualized counseling and services for vulnerable elders.

The activities funded by the Preventive Health Services program assist seniors to stay healthy and to manage and reduce the risk of complications resulting from chronic diseases and disease-related disabilities, thereby reducing the need for more costly medical interventions. Services provided through the Preventive Health Service program include:

- *Information and Outreach*, including the distribution of information to seniors – through senior centers, congregate meal sites, and the home-delivered meals program – about healthy lifestyles and behaviors.
- *Health Screenings and Risk Assessments* for a variety of conditions, including hypertension, diabetes, cholesterol, hearing, vision, and glaucoma.
- *Physical Fitness* programs, including physical activity and exercise programs that help to maintain both physical and mental well-being.
- *Health Promotion* programs, including alcohol and substance abuse prevention and smoking cessation programs.
- *Medication Management*, including screening and education activities to prevent incorrect medication and adverse drug reactions.

Formula grants for Preventive Health Services are allocated to States and Territories based on their share of the population aged 60 and over. States and Territories provide funds to area agencies on aging, which in turn fund local agencies and service providers. States and Territories are required to use at least the statutory earmarked level of funding for medication management, screening, and education activities, but otherwise have flexibility to allocate resources among the various activities in order to best meet local needs. Priority is given to providing services to those elders living in medically underserved areas of the State or who are of greatest economic need.

Performance Analysis

Preventive Health Services is part of AoA's Aging Services Government Performance and Results Act program. Improving program efficiency, improving client assessment and outcomes, and improving targeting of services to vulnerable elders are the three performance measures used to assess the performance of the Aging Services program. Indicators and FY 2006 targets for these measures that are associated with the Preventive Health Services program include:

- Increasing the number of clients served per million dollars of AoA funding (with no decline in service quality) by ten percent above the FY 2001 baseline (*Efficiency Indicator*).
- Increasing the percentage of caregivers who report that Older Americans Act (OAA) services definitely help them provide care longer to 68 percent (*Assessment and Outcome Indicator*).
- Increasing the percentage of clients who live in rural areas to 10 percent greater than the percent of all elders who live in rural areas (*Targeting Indicator*).

An analysis of prior year data for these indicators shows that AoA is already making progress toward achieving its aggressive performance targets. The number of clients served per million dollars of funding increased each year from FY 1999 to FY 2003, demonstrating improvements in program efficiency. Clients report that services are meeting their needs, as demonstrated by the fact that 52 percent of caregivers, when asked to rank their level of confidence in the effect of aging network services, said that the services definitely enabled them to provide care longer. And services are being provided to minority, poor, and rural seniors at rates that exceed their percentage of the general elder population, demonstrating that AoA is targeting services to vulnerable elders as required by the OAA. These positive results are reflected in the Program Assessment Ratings Tool (PART) evaluation score of Moderately Effective that was achieved in FY 2005.

AoA's budget request is closely linked to its performance plan and reflects a strategy for ensuring that core programs such as Preventive Health Services maintain and improve performance in FY 2006 and beyond. The FY 2006 request maintains funding for Preventive Health Services and other core service delivery programs, while continuing to make targeted investments in innovation and demonstration grants that over the long run will create greater balance and better options in our State and community systems of health and long-term care, including improved access, more integrated services, and greater emphasis on prevention. These investments will improve program efficiency and outcomes while also assisting the aging services network to maintain the current high level of consumer satisfaction with services; and to

continue to target services to the most vulnerable elderly individuals. For more information on program performance, please refer to the Performance Analysis Detail on page 107.

Rationale for the Budget Request

The FY 2006 request for Preventive Health Services is \$21,616,000, the same as the FY 2005 enacted level. Preventive Health Services has demonstrated effective performance, as evidenced by its success in targeting services such as medication management that help vulnerable elders to maintain their health status, as well as by achieving a PART score of Moderately Effective.

Due in large part to advances in public health and medical care, Americans are leading longer and more active lives. Average life expectancy has increased from less than 50 years at the turn of the 20th century to more than 76 years today. The population of older Americans is also growing, particularly the population age 85 and over, which is growing faster than any other age cohort and is projected to total 5.1 million by 2005 and 9.6 million by the year 2030. One consequence of this increased longevity is the higher probability of developing a chronic condition, such as obesity, arthritis, diabetes, or osteoporosis.

The Centers for Disease Control and Prevention has found that chronic diseases are the leading causes of mortality and disability in the United States, accounting for seven out of every ten deaths. Chronic diseases are also expensive, accounting for more than 75 percent of the approximately \$1.4 trillion the nation spends each year on medical care. Older Americans with chronic conditions suffer from long-term pain, disability, a significant decrease in their quality of life, and frequent depression.

Research reveals that many chronic conditions are growing problems among seniors. For example, data shows that between 17 and 25 percent of the adults over 60 are obese; that diabetes is the sixth leading cause of death for persons aged 65 years or older; and that the estimated annual number of persons 65 and over with self-reported asthma is approximately 1.45 million. Data also shows that at least 80 percent of seniors have at least one chronic condition, and 50 percent have at least two. Three million older adults say that due to these conditions they cannot perform basic activities of daily living, which places challenging demands on family and informal caregivers.

The development of improved medications has helped many seniors to manage their chronic conditions, but the more medications an elderly person takes, the higher the risk for an adverse reaction with other medications, food or alcohol. Because older adults are more likely to suffer from multiple chronic conditions, they may visit multiple physicians, each of whom may be unaware of other medicines that have been prescribed. Statistics show that 28 percent of hospitalizations of older people are due to noncompliance with drug therapy and adverse events. In addition, of elderly patients taking three or more prescription drugs for chronic conditions, more than one-third are re-hospitalized within six months of discharge, with 20 percent of the readmissions due to medication problems. The risk of adverse reactions may be exacerbated by the physiological changes associated with aging, other health problems, or by drug interactions.

While many people think that the problems of chronic disease are an inevitable consequence of old age, research has shown that a substantial number of the chronic illnesses that affect the elderly are either preventable or controllable. Low-cost programs that educate older Americans about good health care practices can help to identify conditions, such as hypertension, high cholesterol levels, and elevated blood sugar levels that if left untreated could lead to more serious illnesses and hospitalizations. Modifying certain risky behaviors, even in later life, can improve health and reduce the likelihood of chronic disease. Teaching older adults about how to manage medications safely can help prevent incorrect medication and adverse drug reactions, and reduce unnecessary and costly hospitalizations and illnesses.

The services provided through the Preventive Health Services program represents a cost-effective means of helping older Americans to remain active and healthy and to prevent the negative impacts that can result from chronic conditions. Preventive Health Services directly supports the strategic priorities established for AoA by the Assistant Secretary, including *Priority 2: Help older people to stay active and healthy*; and *Priority 3: Support families in their efforts to care for their loved ones at home and in the community*. These services are a key component of the Department’s efforts to create a more balanced long-term care system and to focus on care in the community. Without these services, it would be more difficult for many seniors to stay healthy and reduce their risk of chronic disease, thereby increasing costs to other programs that provide more expensive medical or institutional care.

Funding History

Funding for Preventive Health Services during the past five years is as follows:

FY 2001	\$21,120,000
FY 2002	\$21,123,000
FY 2003	\$21,919,000
FY 2004	\$21,790,000
FY 2005	\$21,616,000

National Family Caregiver Support Program

Authorizing Legislation: Section 361 of the Older Americans Act of 1965, as amended

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA	\$152,738,000	\$155,744,000	\$155,744,000	--

Statement of the Budget Request

The FY 2006 request for the National Family Caregiver Support Program (NFCSP) is \$155,744,000, the same as the FY 2005 enacted level. The NFCSP provides funding for support and assistance services – including respite care, counseling and training – for family and other informal caregivers.

Program Description

The NFCSP provides grants to States and Territories to support the development of multifaceted systems of services for family caregivers of disabled elders, as well as for grandparents caring for their grandchildren. Launched in FY 2001, the NFCSP represents the first significant, organized effort to devote public resources to help support and sustain the efforts of unpaid and informal caregivers.

The NFCSP, for a minimal cost, provides a variety of services to the caregiver in order to help them care for their loved one at home for as long as possible. By helping to avoid or delay the need for more costly institutional care, caregiver services significantly reduce costs to Medicare, Medicaid, and private payers. Services provided in FY 2003 by the NFCSP include:

- *Information and Outreach Services*, which provided information on available caregiver resources and services to over 8 million seniors and families.
- *Assistance Services*, which provided approximately 585,000 caregivers with assistance in locating services from a variety of private and voluntary agencies.
- *Counseling and Training Services*, which provided over 300,000 caregivers with counseling, peer support groups, and training to help them better cope with the emotional and physical stress related to caregiving.
- *Respite Care Services*, which provided almost 200,000 caregivers with temporary relief – at home, or in an adult day care center, nursing home, or an assisted living facility – from their caregiving responsibilities.
- *Supplemental Services*, which provided over 220,000 caregivers with a variety of services including home modification, assistive technology, and equipment.

Formula grants for the NFCSP are allocated to States and Territories based on their share of the population aged 70 and over. States and Territories provide funds to area agencies on aging, which in turn fund local agencies and service providers. States and Territories are required to put in place the five basic system components noted above, but have flexibility to allocate resources among the various activities in order to best meet local needs.

Performance Analysis

The NFCSP is part of AoA's Aging Services Government Performance and Results Act program. Improving program efficiency, improving client assessment and outcomes, and improving targeting of services to vulnerable elders are the three performance measures used to assess the performance of the Aging Services program. Indicators and FY 2006 targets for these measures that are associated with the NFCSP include:

- Increasing the number of clients served per million dollars of AoA funding (with no decline in service quality) by ten percent above the FY 2001 baseline (*Efficiency Indicator*).
- Reducing the percentage of caregivers who report difficulty getting services to 43 percent (*Assessment and Outcome Indicator*).
- Maintaining the number of caregivers of Older Americans Act (OAA) clients who are very or somewhat satisfied with case management services at 87 percent (*Assessment and Outcome Indicator*).
- Increasing the percentage of caregivers who report that OAA services definitely help them provide care longer to 68 percent (*Assessment and Outcome Indicator*).
- Increasing the total number of caregivers served to 900,000 (*Targeting Indicator*).

An analysis of prior year data for these indicators shows that AoA is already making progress toward achieving its aggressive performance targets. Perhaps most significantly, the aging services network has experienced great success in reaching out and providing services to caregivers, as is reflected by the fact that the number of caregivers served more than doubled the goal of 250,000. The number of clients served per million dollars of funding has increased since the launch of the program, demonstrating that the program is operating efficiently. Clients report that services are meeting their needs, as demonstrated by the fact that 52 percent of caregivers, when asked to rank their level of confidence in the effect of aging network services, said that the services definitely enabled them to provide care longer. In addition, 96 percent of caregivers report that they are very or somewhat satisfied with the case management services provided. Together, these positive results are reflected in the Program Assessment Ratings Tool (PART) evaluation score of Moderately Effective that was achieved in FY 2005.

AoA's budget request is closely linked to its performance plan and reflects a strategy for ensuring that core programs such as the NFCSP maintain and improve performance in FY 2006 and beyond. The FY 2006 request maintains funding for the NFCSP and other core service delivery programs, while continuing to make targeted investments in innovation and

demonstration grants that over the long run will create greater balance and better options in our State and community systems of health and long-term care, including improved access, more integrated services, and greater emphasis on prevention. These investments will improve program efficiency and outcomes while also assisting the aging services network to maintain the current high level of consumer satisfaction with services; and to continue to target services to the most vulnerable elderly individuals and their caregivers. For more information on program performance, please refer to the Performance Analysis Detail on page 107.

Rationale for the Budget Request

The FY 2006 request for the NFCSP is \$155,744,000, the same as the FY 2005 enacted level. The NFCSP has demonstrated effective performance, as evidenced by its serving far more caregivers than projected and its success in assisting caregivers to provide care longer, as well as by achieving a PART score of Moderately Effective.

Families are the major providers of long-term care in this country. Mid-range estimates put the number of unpaid informal caregivers (spouses, adult children, relatives, and friends) of elderly individuals at approximately 23 million. A study in the journal *Health Affairs* estimated that this informal care, if provided by home care aides, would cost \$257 billion annually. With the number of older Americans increasing – particularly the population age 85 and over, which is growing faster than any other age cohort and is projected to total 5.1 million by 2005 and 9.6 million by the year 2030 – the need for caregivers will also continue to grow. A May 2003 joint report by HHS and the Department of Labor, *The Future Supply of Long-Term Care Workers in Relation to the Aging of the Baby Boom Generation*, indicates that the number of informal caregivers is projected to rise to 40 million by the year 2050.

At the same time, societal changes are placing greater pressure on caregivers. More women in the workforce, geographic separation of families, and decreased family size have led to fewer adult children being available to share caregiving responsibilities. Twenty-two percent of caregivers are assisting two individuals, while eight percent are providing care to three or more. While women still provide the majority of caregiving (60 percent), the percent of men serving as caregivers is increasing. Many caregivers also work and provide care to their loved one at the same time. These caregivers often experience conflicts between their work and care-giving responsibilities, and 62 percent report that they have had to make adjustments such as changing or reducing work hours or taking time off to accommodate their caregiving.

Research has also shown that caregiving exacts a heavy emotional, physical and financial toll. The stresses and demands associated with caregiving can often lead to a breakdown of the caregiver's health, and the illness, hospitalization or death of a caregiver increases the risk for institutionalization of the care recipient. Half of all caregivers are over the age of 65, making them more vulnerable to a decline in their own health, and one-third of caregivers describe their own health as fair to poor. Caregivers also suffer from higher rates of depression than non-caregivers of the same age, and more recent research indicates that caregivers suffer a mortality rate that is 63 percent higher than that of non-caregivers.

While clearly depicting the stresses of caregiving, studies have also shown that providing services such as adult day care, support groups and counseling can reduce caregiver depression, anxiety, and stress and enable them to provide care longer, thereby avoiding or delaying the need for costly institutional care. A National Institutes of Health study, *Stress Reduction for Family Caregivers: Effects of Adult Day Care Use*, found that providing adult day care not only reduces caregiver stress but delays institutionalization of the care recipient. Another recent study, *Intervention to Delay Nursing Home Placement of Patients with Alzheimer’s Disease*, indicates that counseling and support for caregivers of individuals with Alzheimer’s disease can permit the care recipient to stay at home an additional year before being admitted to a nursing home.

Data demonstrates that OAA services, including those provided through the NFSCP, are effective in helping caregivers to keep their loved ones at home for as long as possible. AoA has contracted to conduct five independent national surveys of elderly clients to obtain an assessment of services provided under the OAA, including one that sought caregiver assessment of services. Data show that not only do these services play a key role in allowing caregivers to keep their loved one at home, but that they are highly regarded by those who use them. For example:

- 52 percent of caregivers of program clients report that services definitely enabled them to provide care longer than otherwise would have been possible.
- 74 percent of caregivers reported that the services have “helped a lot”; an additional 23 percent say the services have “helped a little”.
- 69 percent of caregivers are “very satisfied” with the services received, another 23 percent are “somewhat satisfied”.

The services provided through the NFSCP represent a cost-effective way of assisting families to keep their loved ones at home. The NFSCP directly supports the strategic priorities established for AoA by the Assistant Secretary, including *Priority 2: Help older people to stay active and healthy*; and *Priority 3: Support families in their efforts to care for their loved ones at home and in the community*. These services are a key component of the Department’s efforts to create a more balanced long-term care system and to focus on care in the community. Without these services, it would be more difficult for families to care for their loved one at home, thereby increasing costs to other programs that provide more expensive professional or institutional care.

Funding History

Funding for the NFSCP during the past five years is as follows:

FY 2001	\$119,981,000
FY 2002	\$135,992,000
FY 2003	\$149,025,000
FY 2004	\$152,738,000
FY 2005	\$155,744,000

Native American Nutrition and Supportive Services

Authorizing Legislation: Sections 613 and 623 of the Older Americans Act of 1965, as amended

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA	\$26,453,000	\$26,398,000	\$26,398,000	--

Statement of the Budget Request

The FY 2006 request for Native American Nutrition and Supportive Services (NANSS) is \$26,398,000, the same as the FY 2005 enacted level. NANSS provides funding for a broad range of services – including transportation, congregate and home-delivered meals, information and referral, personal care, chore, adult day care, and other supportive services – that enable older American Indians, Alaskan Natives, and Native Hawaiians to remain independent, at home and in the community.

Program Description

NANSS provides grants to eligible Tribal Organizations to support the development of comprehensive and coordinated systems of home and community-based services for Native American elders and their families. Services provided through the NANSS program are responsive to the cultural diversity of Native American communities, and represent an important component of the communities’ comprehensive services.

The array of services provided by the NANSS program helps Native American elders to remain healthy, independent and in the community, thereby reducing the need for costly medical interventions and institutional care. Services provided to Native American seniors in FY 2003 through the NANSS program include:

- *Transportation Services*, which provided approximately 631,000 rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical daily activities.
- *Home-Delivered Nutrition Services*, which provided almost 1.7 million meals to over 24,000 homebound Native American elders, as well as critical social contacts that help to reduce the risk of depression and isolation experienced by many home-bound elders.
- *Congregate Nutrition Services*, which provided over 1.2 million meals to almost 43,000 Native American elders in community-based settings, as well as an opportunity for elders to socialize and participate in a variety of activities, including cultural and wellness programs.
- *Information, Referral and Outreach Services*, which provided approximately 677,000 hours of outreach and information on services and programs to Native American elder and families, thereby empowering them to make informed choices about their service and care needs.

- *In-Home Services*, which provided approximately 735,000 hours of personal care, chore, homemaker, home health, and other services to Native American elders.

Formula grants for NANSS are allocated to eligible Tribal organizations based on their share of the American Indian, Alaskan Native, and Native Hawaiian population aged 60 and over. Tribal organizations must represent at least 50 Native American elders age 60 and over to receive funding. Tribal organizations have flexibility to allocate funds among the authorized activities in order to best meet local needs. In FY 2004, grants were awarded to 241 tribal organizations representing approximately 300 Tribes and two organizations serving Native Hawaiian elders.

The NANSS program also provides training and technical assistance to Tribal organizations through national meetings, site visits, e-newsletters, telephone and written consultation, and through the Native American Resource Centers (funded under Program Innovations). AoA is working closely with Tribal organizations to better identify and meet the needs of older Native Americans, and has conducted Listening Sessions with Tribal leaders to discuss issues such as health care, transportation, and housing. AoA has also worked with the University of North Dakota's National Resource Center on Native American Aging to conduct a needs assessment for Native American elders. As of September 30, 2004, 9,296 elders from 132 Tribes have completed the assessment. Tribal governments are using the data to build and strengthen their long-term care infrastructure and to develop health promotion programs in Native American communities.

Performance Analysis

NANSS is part of AoA's Aging Services Government Performance and Results Act program. Improving program efficiency, improving client assessment and outcomes, and improving targeting of services to vulnerable elders are the three performance measures used to assess the performance of the Aging Services program. Indicators and FY 2006 targets for these measures that are associated with the NANSS program include:

- Increasing the number of service units per thousand dollars of AoA funding (with no decline in service quality) by six percent above the FY 2002 baseline (*Efficiency Indicator*).

While data showed a small decline in program efficiency in FY 2003 as compared to the FY 2002 baseline, AoA will retain the aggressive improvement targets for this program. AoA plans to conduct a detailed evaluation of the program, which will address this among other significant issues affecting the NANSS program. AoA will continue to seek out the issues in this situation and, once that is done, to develop appropriate corrective actions.

AoA's budget request is closely linked to its performance plan and reflects a strategy for ensuring that core programs such as NANSS maintain and improve performance in FY 2006 and beyond. The FY 2006 request maintains funding for NANSS and other core service delivery programs, while continuing to make targeted investments in innovation and demonstration grants that over the long run will create greater balance and better options in our State and community systems of health and long-term care, including improved access, more integrated services, and

greater emphasis on prevention. These investments will improve program efficiency and outcomes while also assisting the aging services network to maintain the current high level of consumer satisfaction with services; and to continue to target services to the most vulnerable elderly individuals. For more information on program performance, please refer to the Performance Analysis Detail on page 107.

Rationale for the Budget Request

The FY 2006 request for NANSS is \$26,398,000, the same as the FY 2005 enacted level. NANSS has demonstrated effective performance, as evidenced by its success in delivering high quality services such as transportation and meals that help vulnerable Native American elders to maintain their health status and remain at home.

In the 2000 Census, approximately 213,000 persons age 60 and over identified themselves as American Indians or Alaskan Natives, and another 182,000 persons age 60 and over identified themselves as part American Indians or Alaskan Natives. As the older Native American population grows, the demand for home and community-based nutrition and supportive services will also continue to grow. Tribal representatives participating in listening sessions consistently indicate that these services are critical to allowing Native American elders to remain at home, in the community, or on the reservation, which is not only more cost-effective, but what they prefer.

Older Native Americans also suffer from high levels of chronic disease, such as obesity and diabetes. While researchers have found that lifestyle and dietary changes can help to treat and prevent these and other chronic conditions, and reduce the risk of disability and complications, many frail Native American elders have limitations in activities of daily living which make it difficult to care for themselves. *Serving Elders at Risk*, an evaluation of AoA nutrition programs, found that more than 50 percent of Native American congregate meal participants had incomes at or below the poverty level and that the congregate meal was the major or only source of food for the day for 45 percent of participants. The evaluation also showed that 29 percent of congregate and 28 percent of home-delivered meal participants were older Native Americans living alone.

By providing meals, transportation, and other home and community-based supports, the NANSS program represents a cost-effective and consumer friendly way of meeting the needs of older Native Americans and helping them to remain at home. NANSS directly supports the strategic priorities established for AoA by the Assistant Secretary, including *Priority 2: Help older people to stay active and healthy*; and *Priority 3: Support families in their efforts to care for their loved ones at home and in the community*. These services are a key component of the Department's efforts to create a more balanced long-term care system and to focus on care in the community. Without these services, it would be more difficult for many Native American elders to remain at home and in the community, thereby increasing costs to other programs that provide more expensive medical and institutional care.

Funding History

Funding for NANSS during the past five years is as follows:

FY 2001	\$23,457,000
FY 2002	\$25,722,000
FY 2003	\$27,495,000
FY 2004	\$26,453,000
FY 2005	\$26,398,000

Native American Caregiver Support Program

Authorizing Legislation: Section 631 of the Older Americans Act of 1965, as amended

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA	\$6,318,000	\$6,304,000	\$6,304,000	--

Statement of the Budget Request

The FY 2006 request for the Native American Caregiver Support Program (NACSP) is \$6,304,000, the same as the FY 2005 enacted level. The NACSP provides funding for support and assistance services – including respite care, counseling and training – for family and other informal caregivers of American Indian, Alaskan Native, and Native Hawaiian elders.

Program Description

The NACSP provides grants to eligible Tribal Organizations to support the development of multifaceted systems of services for family caregivers of disabled Native American elders, as well as for grandparents caring for their grandchildren. Services provided through the NACSP are responsive to the cultural diversity of Native American communities and represent an important component of the communities’ comprehensive services.

The NACSP, for a minimal cost, provides a variety of services to the caregivers of Native American elders in order to help them care for their loved one at home for as long as possible. By helping to avoid or delay the need for more costly institutional care, caregiver services significantly reduce costs to Medicare, Medicaid, and private payers. Preliminary findings from a review of the NACSP show that Tribal Organizations have made significant progress in implementing the program. Preliminary data from the 53 programs that were operational in FY 2002 indicate that Tribal Organizations are providing a variety of support services:

- *Information and Outreach Services* are being provided, with all the programs that reported indicating that they are conducting public awareness campaigns.
- *Assistance Services* were provided to at least 4,230 caregivers, each of whom received one or more support services.
- *Counseling and Training Services*, including support groups and individual counseling, were being provided by almost two-thirds of the programs, and caregiver training was being provided by 58 percent of the programs.
- *Respite Care Services* are being provided by 92 percent of the programs, including respite services for grandparents caring for grandchildren.

Formula grants for the NACSP are allocated to eligible Tribal organizations based on their share of the American Indian, Alaskan Native, and Native Hawaiian population aged 60 and over. Tribal organizations must represent at least 50 Native American elders age 60 and over to receive funding. Tribal organizations have flexibility to allocate resources among the various activities funded by the NACSP in order to best meet local needs. In FY 2004, grants were awarded to 175 tribal organizations.

The NACSP also provides training and technical assistance to help Tribal Organizations to overcome the barriers they have faced in developing and implementing the program. These barriers have included difficulty in obtaining trained staff members and trained respite workers. Program directors have also sought additional training on caregiver skills, safety, coping with caregiver burnout, and mental health issues. Tribal Organizations have been coordinating with other programs, including the Volunteers In Service To America (VISTA) program, to help support and create sustainable caregiver programs in Native American communities.

Performance Analysis

The NACSP is part of AoA's Aging Services Government Performance and Results Act program. Improving program efficiency, improving client assessment and outcomes, and improving targeting of services to vulnerable elders are the three performance measures used to assess the performance of the Aging Services program. Indicators and FY 2006 targets for these measures that are associated with the NACSP include:

- Increasing the number of service units per thousand dollars of AoA funding (with no decline in service quality) by six percent above the FY 2002 baseline (*Efficiency Indicator*).
- Increasing the total number of caregivers served – including Native American Caregivers – to 900,000 (*Targeting Indicator*).

An analysis of prior year data for these indicators shows that AoA is already making some progress toward achieving its aggressive performance targets. While data showed a small decline in program efficiency in FY 2003, the aging services network has experienced great success in reaching out and providing services to caregivers, as is reflected by the fact that the number of caregivers served more than doubled the goal of 250,000.

AoA's budget request is closely linked to its performance plan and reflects a strategy for ensuring that core programs such as the NACSP maintain and improve performance in FY 2006 and beyond. The FY 2006 request maintains funding for the NACSP and other core service delivery programs, while continuing to make targeted investments in innovation and demonstration grants that over the long run will create greater balance and better options in our State and community systems of health and long-term care, including improved access, more integrated services, and greater emphasis on prevention. These investments will improve program efficiency and outcomes while also assisting the aging services network to maintain the current high level of consumer satisfaction with services; and to continue to target services to the most vulnerable elderly individuals and their caregivers. For more information on program performance, please refer to the Performance Analysis Detail on page 107.

Rationale for the Budget Request

The FY 2006 request for the NACSP is \$6,304,000, the same as the FY 2005 enacted level. The NACSP has demonstrated effective performance, as evidenced by its serving far more caregivers than projected and its success in assisting caregivers to provide care longer.

The population of older Native Americans is growing. The 2000 Census reported that approximately 400,000 persons age 60 and over identified themselves as full or part American Indians or Alaskan Natives. These Native American elders are at increased risk of chronic disease and disability and often require assistance to avoid costly institutionalization. Family caregivers are critical to assisting Native American elders with disabilities to remain at home, in the community, or on the reservation.

Research has shown that caregiving exacts a heavy emotional, physical and financial toll. Caregivers suffer from higher rates of depression than non-caregivers of the same age. Many caregivers are employed and have experienced conflicts between their work and caregiving responsibilities. More recent research indicates that caregivers suffer a mortality rate that is 63 percent higher than that of non-caregivers of the same age. The geographic isolation of many Native American communities adds another layer of difficulty to the problems that caregivers of Native American elders face.

While clearly depicting the stresses associated with caregiving, studies have also shown that providing assistance to caregivers can help them to cope with these issues, thereby enabling them to care for their loved ones longer and avoid or delay the need for costly institutional care. For example, a National Institutes of Health study, *Stress Reduction for Family Caregivers: Effects of Adult Day Care Use*, found that providing adult day care not only reduces caregiver stress but delays institutionalization of the care recipient. Another recent study, *Intervention to Delay Nursing Home Placement of Patients with Alzheimer's Disease*, indicates that counseling and support for caregivers of individuals with Alzheimer's disease can permit the care recipient to stay at home an additional year before being admitted to a nursing home.

By providing a range of services to the caregiver, including counseling, training, and respite care, the NACSP represents a cost-effective way of assisting more Native American families to keep their loved ones at home, which is what they prefer. The NACSP directly supports the strategic priorities established for AoA by the Assistant Secretary, including *Priority 2: Help older people to stay active and healthy*; and *Priority 3: Support families in their efforts to care for their loved ones at home and in the community*. These services are a key component of the Department's efforts to create a more balanced long-term care system and to focus on care in the community. Without these services, it would be more difficult for family and friends to care for vulnerable Native American elders at home, in the community, or on the reservation, thereby increasing costs to other programs that provide more expensive professional or institutional care.

Funding History

Funding for the NACSP during the past five years is as follows:

FY 2001	\$5,000,000
FY 2002	\$5,500,000
FY 2003	\$6,209,000
FY 2004	\$6,318,000
FY 2005	\$6,304,000

Long-Term Care Ombudsman Program

Authorizing Legislation: Section 712 of the Older Americans Act of 1965, as amended

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA	\$14,276,000	\$14,162,000	\$14,162,000	--

Statement of the Budget Request

The FY 2006 request for the Long-Term Care Ombudsman Program (LTCOP) is \$14,162,000, the same as the FY 2005 enacted level. The LTCOP provides support for professional and volunteer ombudsmen who work to protect the rights and interests of residents of nursing homes, board and care homes, assisted living facilities, and other adult care facilities.

Program Description

The LTCOP provides grants to States and Territories to fund training, travel, staff support, and other operating costs for thousands of ombudsmen who regularly visit and monitor the condition of residents of long-term care facilities. The program assists States and communities to investigate and resolve complaints related to action, inaction, or decisions that may adversely affect the health, safety, welfare, or rights of long-term care facility residents.

The nation's professional and certified volunteer ombudsmen are responsible for identifying, investigating and resolving complaints made by or on behalf of residents of long-term care facilities, and ombudsmen represent the interests of individuals and groups of residents before government and administrative agencies. By exposing problems that would otherwise be hidden from view and providing a voice for those who cannot act for themselves, ombudsmen help ensure that the rights of long-term care facility residents are respected. FY 2003 data for the LTCOP shows that:

- Over 1,000 professional ombudsmen and 8,200 certified volunteer ombudsmen regularly visited approximately 86 percent of all nursing homes and 48 percent of all licensed board and care and similar facilities.
- Ombudsmen investigated approximately 286,000 complaints made by or on behalf of over 158,000 residents of long-term care facilities.
- Of the total complaints investigated, approximately 76 percent were either resolved or partially resolved.
- Ombudsmen provided information and assistance to another 297,000 consumers and over 110,000 long-term care facility staff and administrators.

In addition to helping to resolve the concerns of long-term care facility residents, ombudsmen play an important role in providing information to residents and their families about long-term care services, and in educating consumers and the general public about issues related to long-term care policies and regulations. The Centers for Medicare and Medicaid Services is utilizing the experience of these ombudsmen to help implement the Nursing Home Quality Indicator Initiative. This initiative trains ombudsmen to educate and advise consumers about how to use objective indicators to compare the quality of care in different facilities and make informed nursing home placement decisions.

Formula grants for the LTCOP are allocated to States and Territories based on their share of the population aged 60 and over. States and Territories may choose to provide funding to area agencies on aging and local service providers, but are not required to do so. Ombudsman programs operate in 53 States and Territories and support staff and volunteers in 578 local programs. The Long-Term Care Ombudsman Resource Center, funded by the Aging Network Support Activities program, supports the LTCOP by providing training and technical assistance to State and local ombudsman programs.

Performance Analysis

The LTCOP is part of AoA's Aging Services Government Performance and Results Act program. Improving program efficiency, improving client assessment and outcomes, and improving targeting of services to vulnerable elders are the three performance measures used to assess the performance of the Aging Services program. Indicators and FY 2006 targets for these measures that are associated with the LTCOP include:

- Increasing the number of complaints resolved or partially resolved per million dollars of funding by 14 percent above the FY 2002 base. (*Efficiency Indicator*).
- Improving the Ombudsmen complaint resolution rates in 15 States as compared to the FY 2001 baseline. (*Assessment and Outcome Indicator*).

An analysis of prior year data for these indicators shows that AoA is already making progress toward achieving its aggressive performance targets. The number of complaints investigated has increased, while the percentage of complaints that are fully or partially resolved has consistently remained at around 75 percent, demonstrating both the efficiency of the program and its ability to produce positive outcomes for seniors. While the LTCOP is not directly measured as part of AoA's targeting indicators, the program provides assistance to seniors in nursing homes and other institutional settings, many of whom have limitations with one or more activities of daily living, thereby supporting AoA's goal of targeting services to vulnerable elders as required by the Older Americans Act (OAA).

AoA's budget request is closely linked to its performance plan and reflects a strategy for ensuring that core programs such as the LTCOP maintain and improve performance in FY 2006 and beyond. The FY 2006 request maintains funding for the LTCOP and other core service delivery programs, while continuing to make targeted investments in innovation and demonstration grants that over the long run will create greater balance and better options in our

State and community systems of health and long-term care, including improved access, more integrated services, and greater emphasis on prevention. These investments will improve program efficiency and outcomes while also assisting the aging services network to maintain the current high level of consumer satisfaction with services; and to continue to target services to the most vulnerable elderly individuals. For more information on program performance, please refer to the Performance Analysis Detail on page 107.

Rationale for the Budget Request

The FY 2006 request for the LTCOP is \$14,162,000, the same as the FY 2005 enacted level. The LTCOP has demonstrated effective performance, as evidenced by its success in resolving resident's complaints and helping to protect the rights of vulnerable elders.

As the number of older Americans increases – particularly the population age 85 and older, which is growing faster than any other age cohort and is projected to total 5.1 million by 2005 and 9.6 million by the year 2030 – the need for effective long-term care services, including nursing homes and other institutional care, will also grow. While most of AoA's core programs are focused on providing cost-effective home and community-based services that assist vulnerable older Americans to remain at home and avoid institutional care, for some disabled elders, a nursing home, board and care home, assisted living facility, or other adult care facility represents the best option for receiving the care they need. It is essential that nursing homes and other long-term care facilities provide high quality services that allow these vulnerable elders to age with dignity in a safe, protective environment.

While most residents of long-term care facilities receive high quality care from trained and caring professional staff, too many are neglected, and incidents of physical, psychological, and other kinds of abuse do occur. The most frequent complaints heard from long-term care facility residents are about a lack of care due to shortages of adequately trained staff. Other common problems that may be experienced by long-term care facility residents range from call buttons that go unanswered and unappetizing food to unnecessary use of physical restraints and tranquilizing drugs.

Long-term care ombudsmen have been effective in identifying and helping to address these quality-of-care issues, such as the need for increased numbers of trained staff to care for residents. Research has also shown that ombudsmen may be able to help detect mood or health changes in residents that busy staff may overlook. A December 2000 report by the Institute of Medicine of the National Academy of Sciences, *Improving the Quality of Long-Term Care*, noted the importance of the routine on-site presence of ombudsmen in establishing resident confidence in long-term care facilities and in detecting problems before they become serious. Ombudsmen have also worked to train and provide technical assistance to facility managers and staff on alternatives to physical and chemical restraints.

By providing a community presence in long-term care facilities and promoting positive systems change, including the introduction of innovative approaches to enliven and enhance residents' lives, the LTCOP directly supports the strategic priorities established for AoA by the Assistant Secretary, including *Priority 4: Ensure the rights of older people and prevent their abuse*,

neglect and exploitation. Without these ombudsmen, there would be a marked decline in the quality of care for residents of long-term care facilities.

Funding History

Funding for the LTCOP during the past five years is as follows:

FY 2001	\$9,449,000
FY 2002	\$12,449,000
FY 2003	\$13,361,000
FY 2004	\$14,276,000
FY 2005	\$14,162,000

Prevention of Elder Abuse, Neglect, and Exploitation

Authorizing Legislation: Section 721 of the Older Americans Act of 1965, as amended

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA	\$5,168,000	\$5,126,000	\$5,198,000	+\$72,000

Statement of the Budget Request

The FY 2006 request for the Prevention of Elder Abuse, Neglect and Exploitation program is \$5,198,000, an increase of +\$72,000 above the FY 2005 enacted level. The Prevention of Elder Abuse, Neglect and Exploitation program provides funding for a variety of services – including training, systems development, and public education – that help to protect the rights and safety of vulnerable elders.

Program Description

The Prevention of Elder Abuse, Neglect and Exploitation program provides grants to States and Territories to help increase public awareness of the problem of elder abuse and train adult protective service personnel and other professionals to detect, deter, and prevent incidents of elder abuse. The program helps States and communities to prepare for and respond to incidents of domestic elder abuse involving the maltreatment of an older person by a caregiver or other person residing in the home, as well as incidents of self-neglect in which an older person living alone behaves in a manner which threatens their own health or safety.

Services provided through the Prevention of Elder Abuse, Neglect and Exploitation program are coordinated with other State programs which protect the rights of vulnerable adults, including adult protective services programs. States and Territories have discretion to allocate funding among the various activities authorized under the Prevention of Elder Abuse, Neglect and Exploitation program, which include:

- *Professional Training*, including workshops to train law enforcement, medical, and other professionals in how to recognize and respond to elder abuse.
- *Systems Coordination*, including development of elder abuse help lines and the formation of State-wide coalitions and local multi-disciplinary task forces.
- *Public Education*, including radio and television public service announcements, posters, flyers, videos, and curriculum for elementary and secondary students.
- *Technical Assistance*, including development of policy manuals and protocols for responding to incidents of elder abuse.

To help ensure a coordinated Federal response to the problem of elder abuse, AoA and the Department of Justice co-chair the Elder Justice Inter-agency Working Group. Participants on the working group include agencies dealing with elder abuse prevention, research, services, and prosecution. The inter-agency working group is also carrying out a national study on the problem of elder financial exploitation.

Formula grants for the Prevention of Elder Abuse, Neglect and Exploitation program are allocated to States and Territories based on their share of the population aged 60 and over. States and Territories may choose to provide funding to area agencies on aging and local service providers, but are not required to do so. The National Elder Abuse Resource Center, funded by the Aging Network Support Activities program, supports the Prevention of Elder Abuse, Neglect and Exploitation program by providing technical assistance and training to States and community-based organizations.

Performance Analysis

The Prevention of Elder Abuse, Neglect and Exploitation program is part of AoA's Aging Services Government Performance and Results Act program. Improving program efficiency, improving client assessment and outcomes, and improving targeting of services to vulnerable elders are the three performance measures used to assess the performance of the Aging Services program. The Prevention of Elder Abuse, Neglect and Exploitation program provides critical assistance to older Americans who are being abused or neglected, thereby supporting AoA's goal of targeting services to vulnerable elders as required by the Older Americans Act (OAA). The Prevention of Elder Abuse, Neglect and Exploitation program is not directly measured by AoA's performance indicators.

The FY 2006 request maintains funding for the Prevention of Elder Abuse, Neglect and Exploitation program and other core service delivery programs, while continuing to make targeted investments in innovation and demonstration grants that over the long run will create greater balance and better options in our State and community systems of health and long-term care, including improved access, more integrated services, and greater emphasis on prevention. These investments will assist the aging services network to maintain the current high level of consumer satisfaction with services; and to continue to target services to the most vulnerable elderly individuals. For more information on program performance, please refer to the Performance Analysis Detail on page 107.

Rationale for the Budget Request

The FY 2006 request for the Prevention of Elder Abuse, Neglect and Exploitation program is \$5,198,000, an increase of +\$72,000 above the FY 2005 enacted level. The Prevention of Elder Abuse, Neglect and Exploitation program has demonstrated effective performance, as evidenced by independent evaluations and studies that have found that these services are important for both detecting and deterring incidents of elder abuse.

Each year hundreds of thousands of seniors are abused, neglected and exploited by family members and others. Many victims are seniors who are older, frail, and dependent on the help of

others to meet their most basic needs. The 1998 *National Elder Abuse Incidence Study* found that in one year approximately 450,000 elderly persons in domestic settings were abused and/or neglected. The study also found that these statistics still underestimate the true extent of the problem, and that for every confirmed case of domestic elder abuse reported to adult protective services, between four and five were not reported.

Elder abuse includes physical, sexual and psychological abuse as well as neglect and financial exploitation. Elder financial exploitation, in particular, is a growing problem. Frail and isolated seniors make tempting targets and are often over-represented on telemarketers lists. A *Journal of Consumer Affairs* survey of the nation's police departments found that 99 percent of home improvement scams were directed at older Americans, typically women 65 or older who lived alone. These crimes often cause seniors to lose their independence because many are unable to replace lost assets through work, saving, or investing.

As the lead federal agency for older persons and their concerns, AoA is committed to helping protect seniors from elder abuse, exploitation, and neglect. A 1991 General Accounting Office report found that public and professional education are the most effective means of identifying new cases of elder abuse. The Prevention of Elder Abuse, Neglect and Exploitation program helps to provide this education and to ensure a coordinated response to elder abuse cases by law enforcement, medical professionals, and adult protective services workers. Examples of State elder abuse prevention activities that were conducted in FY 2002 and FY 2003 include:

- In California, funding helped to support Orange County's Fiduciary Abuse Specialist Team. This team of 50 multi-disciplinary public and private professionals met monthly to discuss exploitation cases, and the program coordinator provided 32 community and law enforcement education sessions to 1,650 people.
- In Kansas, funding supported statewide education programs, elder abuse task forces, and professional training, including public education and outreach targeted to caregivers, professionals, paraprofessionals, and law enforcement. Fifty-six workshops were held for attorneys, adult protective services staff, social workers, nurses, law enforcement, and State unit on aging staff, with a total of 1,755 people attending.
- In Louisiana, funding from the program was used to develop brochures and train approximately 3,500 professionals – including doctors, nurses, social workers, psychologists, police, and district attorneys – in responding to incidents of elder abuse.
- In North Dakota, funding supported the creation of local multi-disciplinary teams, and was used to conduct ten trainings sessions attended by 350 professionals, including social workers, attorneys, police officers, and aging services providers.

By providing a combination of training, outreach, information dissemination, and technical assistance to State and community programs which seek to prevent the abuse and neglect of seniors, the Prevention of Elder Abuse, Neglect and Exploitation program directly supports the strategic priorities established for AoA by the Assistant Secretary, including *Priority 4: Ensure the rights of older people and prevent their abuse, neglect and exploitation*. Without these

services, more incidents of elder abuse would go unreported, resulting in diminished quality of life and loss of independence for vulnerable elders.

Funding History

Funding for the Prevention of Elder Abuse, Neglect, and Exploitation program during the past five years is as follows:

FY 2001	\$4,732,000
FY 2002	\$5,232,000
FY 2003	\$5,198,000
FY 2004	\$5,168,000
FY 2005	\$5,126,000

Program Innovations

Authorizing Legislation: Section 411 of the Older Americans Act of 1965, as amended

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA	\$33,509,000	\$43,286,000	\$23,843,000	-\$19,443,000

Statement of the Budget Request

The FY 2006 request for Program Innovations is \$23,843,000, a decrease of -\$19,443,000 below the FY 2005 enacted level. Excluding one-year, one-time congressional earmarks, the balance of the program represents an increase of +\$196,000 over the FY 2005 enacted level. Program Innovations provides funding for demonstration projects that help to advance the Department’s strategic priorities and improve program efficiency and outcomes in AoA’s core home and community-based services programs, as well as for ongoing activities that provide support to the aging services network and information and assistance to seniors and families.

Program Description

Program Innovations provides a means for AoA to carry out its statutory responsibility for developing policies and programs that support the Department’s efforts to meet the needs of our nation’s rapidly growing older population. The program serves as a catalyst for developing new approaches and techniques that States and communities can use to help seniors to stay healthy, active, independent, and living in their own homes and communities for as long as possible. Helping older people to stay out of nursing homes and preventing unnecessary spend-down is a key objective of the Older Americans Act (OAA). While Program Innovations funding represents only 2 percent of AoA’s total budget – compared to 95 percent for population-based grants for services which are provided to and controlled by States and Tribes – it is the primary vehicle for identifying more cost-effective and efficient ways of delivering services through the aging services network and effecting positive systemic changes that compliment the Department’s larger agenda in health and long term care.

The knowledge gained from Program Innovations projects is shared with States, Tribes and local communities and is critical to ensuring that AoA’s core formula grant programs under Titles III, VI, and VII of the OAA remain highly effective in delivering services to seniors. The program adds significant value to the developmental efforts being undertaken in the Medicare and Medicaid programs. It also provides a means for taking the best scientific research conducted by the National Institutes of Health and other research agencies and moving it from theory to practice by applying the knowledge gained to the programs that serve elderly individuals. Funds are also used to support collaborations with other agencies – both inside and outside of HHS – in order to deliver more integrated services to seniors and their caregivers. Projects have been designed to:

- Examine and test new and innovative approaches that enhance the effectiveness of programs and services provided by the aging services network, and help position the aging network to respond to the needs of the aging baby boom generation.
- Evaluate the efficacy, quality, efficiency, and accessibility of programs and services for older individuals and their caregivers.
- Integrate services and systems addressing the needs of seniors across a whole range of programs and agencies.
- Acquire and synthesize knowledge about aging from multidisciplinary perspectives and expand our understanding of the older population.
- Enhance technical assistance to aging services provider network and meet the need for trained workers in the field of aging.

Because these demonstrations are designed to test and evaluate the efficacy of new approaches, each project includes an evaluation component. The results of these projects are disseminated to the aging services network through AoA's Internet web site and e-newsletter, as well as through the policy academies, grantee meetings and national conferences.

Competitive grants, cooperative agreements and contracts for Program Innovations are awarded to eligible public and nonprofit agencies, State units on aging, area agencies on aging, institutions of higher learning, and other organizations representing or serving older people, including community and faith-based organizations. Grantees are generally required to provide a match equal to 25 percent of the project's total cost. External experts review project proposals, and project awards are made for periods of one to four years.

Performance Analysis

Program Innovations is part of AoA's Aging Services Government Performance and Results Act (GPRA) program. Improving program efficiency, improving client assessment and outcomes, and improving targeting of services to vulnerable elders are the three performance measures used to assess the performance of the Aging Services program. The knowledge gained from the demonstration projects carried out under Program Innovations play a critical role in ensuring that over the long run AoA's core programs are able to maintain and improve performance. These demonstration projects are not directly measured by AoA's performance indicators.

AoA's budget request is closely linked to its performance plan and reflects a strategy for ensuring that core State and Tribal formula grant programs maintain and improve performance in FY 2006 and beyond. The FY 2006 request maintains funding for core service delivery programs, while continuing to make targeted investments in Program Innovations grants that over the long run will create greater balance and better options in our State and community systems of health and long-term care, including improved access, more integrated services, and greater emphasis on prevention. These investments will improve program efficiency and outcomes while also assisting the aging services network to maintain the current high level of

consumer satisfaction with services; and to continue to target services to the most vulnerable elderly individuals. For more information on program performance, please refer to the Performance Analysis Detail on page 107.

Rationale for the Budget Request

The FY 2006 request for Program Innovations is \$23,843,000, a decrease of -\$19,443,000 below the FY 2005 enacted level. Excluding one-year, one-time congressional earmarks, the balance of the program represents an increase of +\$196,000 over the FY 2005 enacted level. The knowledge gained from Program Innovations projects is critical to redirecting and better utilizing the resources available for AoA's core programs.

As the number of older Americans increases – particularly the population age 85 and over, which is growing faster than any other age cohort and is projected to total 5.1 million by 2005 and 9.6 million by the year 2030 – one of the major challenges the nation faces is the current bias in the long-term care system toward institutional care. Despite the fact that seniors express an overwhelming preference to remain at home and in the community for as long as possible, and that community-based services are far less costly than institutional care, approximately 67 percent of public funding for long-term care services still goes to institutional care.

HHS has started to address these challenges through the President's New Freedom Initiative and its efforts to create a more balanced long-term care system and to focus on care in the community. The infrastructure of AoA's aging services network – which is one of the nation's largest providers of home and community-based long-term care services – and its focus on family caregivers, who are the main providers of long term care, provides an important foundation for these efforts. The involvement of these established providers of cost-effective and consumer-friendly aging services is critical to ensuring the success of the Department's efforts to help States redirect their systems of care.

AoA began utilizing its Program Innovations resources to invest in these efforts in FY 2003 and has expanded these investments in FY 2004 and FY 2005. Without this investment, the critical social services component of the Department's initiative will remain relatively unchanged, with the loss of literally billions over time to related HHS programs due to a lack of alternatives to institutional care. The FY 2006 request includes \$17.2 million to continue investments in projects that improve program efficiency and outcomes by creating greater balance and better options in our State and community systems of health and long-term care, including improved access, more integrated services, and greater emphasis on prevention, such as:

- Aging and Disability Resource Centers: Working in partnership with the Centers for Medicare and Medicaid Services (CMS), AoA will continue its effort to establish Aging and Disability Resource Centers. These centers – the first twelve of which were funded in FY 2003, with an additional twelve funded in FY 2004 – are a key element of the Department's efforts to help States rebalance their systems of long term care. The Centers will serve as a highly visible and trusted resource for seniors and families looking for information on the full range of public and private long-term care options. The centers will help to empower individuals to make informed choices, reduce red tape and streamline

access to services by serving as single entry points for publicly funded long-term supports – including Medicaid, OAA, and State programs. Centers will assist States in helping people to remain at home, avoid unnecessary placement in nursing homes and prevent spend-down to Medicaid.

- Integrated Care Management: Investments that strengthen the role of community aging services programs in promoting a more balanced and integrated system of health and long-term care for older people are critical to reaping the full benefits of the re-balancing initiatives that HHS has launched at the Federal and State levels. As new options for older people are emerging in health and long-term care, managed care is playing an increasingly important role. Building on the fourteen demonstrations launched in FY 2004, projects will seek to improve the quality of care for seniors by identifying and supporting innovations in aging services that involve partnerships with managed care organizations or the use of capitated financing arrangements. Projects will include a broad mix of partnerships between community providers, area agencies on aging, managed care organizations and health plans.
- Long-Term Care Partnerships: Investments in partnerships with other Federal agencies, as well as with non-Federal entities, are critical to helping States rebalance their long-term care systems and integrate services at the community level. AoA is working with the Assistant Secretary for Planning and Evaluation (ASPE), CMS and the Robert Wood Johnson Foundation to replicate the Cash and Counseling consumer direction model, which provides participants with monthly budgets and allows them to purchase the services they need; CMS, the Centers for Disease Control and Prevention (CDC), ASPE, the National Governor's Association and the National Conference of State Legislators to educate State officials about ways to promote more balanced systems of long-term care; with and with the Federal Transit Administration to expand options and enhance coordination of transportation services for seniors. These investments will assist providers to use their resources more effectively, thereby enabling more seniors to remain at home.
- Evidence Based-Prevention: AoA plays a key role in translating research into practice nationwide through its network of community aging services provider organizations. HHS research investments – at the National Institute on Aging (NIA), CDC; the Agency for Healthcare Research and Quality (AHRQ) and other agencies – provide a knowledge base which can be used to help develop high quality preventive health interventions targeted at the elderly. Building on the twelve demonstrations begun in FY 2003, projects will show the efficacy of delivering evidence-based prevention programs for the elderly through community-based aging service provider organizations and will support local partnerships involving aging service providers, area agencies on aging, local health entities and research organizations.
- Health Promotion and Physical Activity: Investments in partnerships with other Federal agencies, as well as with non-Federal entities, are also critical to helping seniors to remain active and healthy and prevent or delay the onset of chronic disease and disability. AoA has launched the *YouCan! Steps to Healthier Aging Campaign* – in partnership with NIA, CDC, and President's Council on Physical Fitness and Sports – with the goal of enlisting at least 2,000 organizations as partners by the fall of 2005 and having at least 2 million seniors

participating in activities to help them eat better and exercise more by the fall of 2006. AoA is also working with the National Resource Center on Nutrition and Physical Activity to enhance knowledge on the benefits of good nutrition and physical activity for older adults, and to provide mini-grants to implement nutrition and walking program at the local level; and with CDC on the Aging States project, which is awarding evidenced-based mini-grants focusing on physical activity, clinical preventive services, chronic disease self-management, and oral health. These preventive efforts will assist seniors to maintain their health status and avoid the need for more costly medical interventions.

- Medicare Modernization Act Implementation: The Medicare Modernization Act made several changes to the Medicare program, including the introduction of new prescription drug and preventive health benefits. In partnership with CMS, AoA is utilizing its aging services network to provide outreach, education and assistance in enrolling Medicare beneficiaries in the Medicare drug discount card and the transitional assistance for low-income individuals. AoA and CMS jointly funded outreach programs to reach hard-to-serve, limited English speaking, minority, low-literacy, low-income and rural beneficiaries. AoA is also working with the CMS State Health Insurance Program Steering Committee to develop best practices and coordinate Medicare outreach activities at the local level that will help beneficiaries and their caregivers to understand the upcoming Medicare Part D benefit.

The FY 2006 request also includes \$6.6 million for ongoing projects that provide demonstrated benefits to elderly Americans and support the activities of the aging services network. These activities include:

- National Resource Centers: AoA supports several projects which assist States, Tribal Organizations, area agencies on aging, and community providers by providing information, technical assistance, and services. These resource centers focus on either specific aging related issues (such as legal assistance and retirement) or on the needs of vulnerable subgroups of the elderly, including minority populations.
- Intergenerational Opportunities – Family Friends/Volunteer Senior Aides: Projects link older, caring senior volunteers with families that need support for children suffering from chronic health conditions or disabilities. These services are targeted to at-risk groups such as poor rural families in distress, families and children living in homeless shelters, families of babies who are HIV-positive, and at-risk families that need respite care. Funding supports a national technical assistance center as well as local projects.
- Program Evaluation: This program also funds GRPA and related evaluation activities and supports a cooperative effort between AoA and selected State and area agencies on aging to develop and test outcome measures, various performance measurement instruments, and sampling methods that can be used to effectively and efficiently identify the results produced through OAA programs on an ongoing basis. Continued refinement of outcome measures is essential to fully implementing GPRA.

Program Innovations are critical for ensuring the continued effectiveness of AoA's core service delivery programs, and projects directly support the strategic priorities established for AoA by

the Assistant Secretary, including *Priority 1: Make it easier for older people to access an integrated array of health and social supports; Priority 2: Help older people to stay active and healthy; Priority 3: Support families in their efforts to care for their loved ones at home and in the community; and Priority 4: Ensure the rights of older people and prevent their abuse, neglect and exploitation.* Without these critical investments, AoA’s core programs will be unable to assist as many seniors to remain at home, thereby increasing costs to other programs that provide more expensive medical and institutional care.

Funding History

Comparable funding for Program Innovations during the past five years is as follows:

FY 2001	\$25,430,000
FY 2002	\$27,263,000
FY 2003	\$29,336,000
FY 2004	\$33,509,000
FY 2005	\$43,286,000

Aging Network Support Activities

Authorizing Legislation: Sections 202, 215 and 411 of the Older Americans Act of 1965, as amended

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA	\$13,294,000	\$13,266,000	\$13,266,000	--

Statement of the Budget Request

The FY 2006 request for Aging Network Support Activities is \$13,266,000, the same as the FY 2005 enacted level. Aging Network Support Activities funds a number of ongoing projects which help seniors and families to obtain information about their care options and benefits, and which assist States, Tribes, and community providers of aging services to carry out their mission.

Program Description

Aging Network Support Activities provides grants and contracts to eligible entities to support a variety of services that assist aging network providers, older Americans and their caregivers. These activities, many of which began as demonstration projects, provide critical and ongoing assistance to the aging services network and help to support the activities of AoA's core service delivery programs.

Activities funded through the program include the National Eldercare Locator and the Pension Counseling and Information program, which assist seniors and families in obtaining information and assistance in accessing services and benefits, and the Senior Medicare Patrols program, which supports projects that help empower Medicare beneficiaries to protect themselves against fraud. The program also funds both the National Long-Term Care Ombudsman and the National Elder Abuse Resource Centers, which provide training and technical assistance for programs that protect the rights of vulnerable elders in institutional settings and at home.

Competitive grants, cooperative agreements and contracts for Aging Network Support Activities are awarded to eligible public and nonprofit agencies, State units on aging, area agencies on aging, institutions of higher learning, and other organizations representing or serving older people, including faith-based organizations. Grantees are generally required to provide a match equal to 25 percent of the project's total cost. External experts review project proposals, and project awards are made for periods of one to four years.

Performance Analysis

Aging Network Support Activities is part of AoA's Aging Services Government Performance and Results Act program. Improving program efficiency, improving client assessment and outcomes, and improving targeting of services to vulnerable elders are the three performance measures used to assess the performance of the Aging Services program. Indicators and FY 2006

targets for these measures that are associated with the Aging Network Support Activities program include:

- Increasing the number of Medicare beneficiaries trained per million dollars of Senior Medicare Patrol funding by 20 percent over the FY 2002 base. (*Efficiency Indicator*).
- Increasing the percentage of Medicare beneficiaries who will read their Medicare Summary Notices as a result of Senior Medicare Patrol training by 20 percent over the FY 2002 base. (*Assessment and Outcome Indicator*).

While AoA does not have prior year trend data for these indicators, an analysis of related prior year performance data and program evaluations demonstrates the impact of the activities funded by the Aging Network Support Activities program. Data for the Senior Medicare Patrols program shows that the program has trained substantial numbers of volunteers and beneficiaries, and that Senior Medicare Patrols initiatives have combined to recoup over \$103 million in savings to Medicare, Medicaid, and other payers. The National Eldercare Locator and the Pension Counseling and Information program both provide an economical means of assisting seniors and families to access services and benefits and contribute to the overall efficiency of the aging services network. The National Long-Term Care Ombudsman and the National Elder Abuse Resource Centers both support core programs that provide assistance to seniors who are being abused or neglected, thereby supporting AoA's goal to target services to vulnerable elders as required by the Older Americans Act (OAA).

AoA's budget request is closely linked to its performance plan and reflects a strategy for ensuring that activities which provide critical support to AoA's core service delivery programs maintain and improve performance in FY 2006 and beyond. The FY 2006 request maintains funding for core service delivery programs, and for activities such as those funded under the Aging Network Support Activities that support these core programs, while continuing to make targeted investments in innovation and demonstration grants that over the long run will create greater balance and better options in our State and community systems of health and long-term care, including improved access, more integrated services, and greater emphasis on prevention. These investments will improve program efficiency and outcomes while also assisting the aging services network to maintain the current high level of consumer satisfaction with services, and to continue to target services to the most vulnerable elderly individuals. For more information on program performance, please refer to the Performance Analysis Detail on page 107.

Rationale for the Budget Request

The FY 2006 request for Aging Network Support Activities is \$13,266,000, the same as the FY 2005 enacted level. The activities funded under the Aging Network Support Activities program have demonstrated effective performance, as evidenced by their success in providing information and training to seniors and in recouping funds that would otherwise have been improperly expended. The program provides support for the following activities:

National Eldercare Locator

The National Eldercare Locator connects those needing assistance with State and local agencies on aging and private organizations that serve older adults and their caregivers. In FY 2003:

- More than 121,000 callers received services through the toll-free number.
- Over 335,000 users received program information on the website.

By calling the National Eldercare Locator or utilizing the website, individuals can access the resources of State and local information and referral service providers identified for every ZIP code across the nation.

Pension Counseling and Information

The Pension Counseling and Information program assists older Americans in accessing information about their retirement benefits and helps them to negotiate with current and former employers or pension plans for any rightful pension benefits. The program includes regional counseling projects and a technical assistance project providing substantive training and legal support services. Program highlights include:

- Since 1993, AoA's Pension Counseling and Information program has successfully obtained more than \$50 million in retirement benefits for seniors, a return of nearly \$5 for every Federal dollar invested in the program.
- Projects have directly served over 25,000 individuals by providing assistance in pursuing claims through administrative appeals; helping seniors to locate pension plans "lost" as a result of mergers, acquisitions, and terminations; providing plain English answers to queries about complex pension plan provisions; and making carefully targeted referrals to attorneys, actuaries, and other professionals to help them obtain their much-needed pensions.

Tens of thousands of older Americans are also served each year through the program's education and outreach activities, which include fact sheets, web-based material, training events and community seminars.

Senior Medicare Patrols

While most Medicare payment errors are simple mistakes and are not the result of physicians or other providers trying to take advantage of the Medicare system, there is a small minority of providers who are intent on defrauding Medicare. A seven-year analysis by the Office of Inspector General (OIG) found that over 80 percent of claims that did not meet reimbursement requirements were attributable to unsupported and medically unnecessary costs. This fraud results in billion of dollars in annual losses to Medicare and may compromise the health care of some beneficiaries.

New benefits in the Medicare Modernization Act (MMA), including the prescription drug benefit, will create new potential Medicare fraud opportunities. Educating beneficiaries about these benefits and the potential for new forms of fraud that may emerge is critical to the

successful implementation of MMA. Fraud is also a problem in Medicaid, which is the largest source of funding for medical and health-related services for people with limited incomes.

The Senior Medicare Patrols program helps to detect and report waste, fraud and abuse in the Medicare and Medicaid programs. The program empowers seniors to take greater personal responsibility for monitoring their health care and helps to minimize victimization of vulnerable elders and their families. Projects utilize the skills of retired professionals to help educate older persons and their families to recognize and report Medicare and Medicaid fraud. A total of 57 Senior Medicare Patrol projects operate in 52 jurisdictions (50 States plus the District of Columbia and Puerto Rico). Data reported by the OIG for FY 2003 shows that:

- Senior Medicare Patrol projects trained over 7,500 volunteers and retired professionals.
- Volunteers conducted over 160,000 one-on-one beneficiary counseling sessions and referred almost 15,000 complaints for action.
- AoA's initiatives have combined to recoup, save, and recover over \$22 million for Medicare, Medicaid, and other payers.

Activities are carried out in partnership with the Department of Justice, the Centers for Medicare and Medicaid Services, OIG, health care providers, and other professionals from around the country. Since the program's inception, AoA's initiatives in this area have educated more than 1.5 million beneficiaries and combined to recoup over \$103 million in savings to Medicare, Medicaid, and other payers.

National Long-Term Care Ombudsman Resource Center

The National Long-Term Care Ombudsman Resource Center provides training and technical assistance to support the activities of State and local ombudsman programs. The Center works to enhance the skills, knowledge and management capacity of State programs and to help them to handle residents' complaints and represent residents' interests. The Center also provides information to consumers and links them to ombudsmen who can help them navigate the long-term care system and resolve problems in nursing homes, board and care homes, and assisted living facilities.

National Center on Elder Abuse

The National Center on Elder Abuse provides training and technical assistance to support the activities of State Prevention of Elder Abuse, Neglect and Exploitation programs. The Center provides elder abuse information to professionals and the public and offers technical assistance and training to elder abuse agencies and related professionals. The center also conducts research on elder abuse issues and assists with elder abuse program and policy development.

The activities funded through the Aging Network Support Activities program provide critical support for AoA's core service delivery programs and directly support the strategic priorities established for AoA by the Assistant Secretary, including *Priority 1: Make it easier for older people to access an integrated array of health and social supports*; and *Priority 4: Ensure the rights of older people and prevent their abuse, neglect and exploitation*. Without these activities,

it would be more difficult for seniors to access the services and benefits they need to remain at home, thereby resulting in additional costs to other programs that provide more expensive medical and institutional care.

Funding History

Comparable funding for Aging Network Support Activities during the past five years is as follows:

FY 2001	\$12,234,000
FY 2002	\$13,373,000
FY 2003	\$13,286,000
FY 2004	\$13,294,000
FY 2005	\$13,266,000

Alzheimer’s Disease Demonstration Grants to States

Authorizing Legislation: Section 398 of the Public Health Services Act, as amended

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA	\$11,883,000	\$11,786,000	\$11,786,000	--

Statement of the Budget Request

The FY 2006 request for Alzheimer’s Disease Demonstration Grants to States (ADDGS) is \$11,786,000, the same as the FY 2005 enacted level. The ADDGS program helps States to translate scientific research into practice through the development and implementation of effective models of assistance for persons with Alzheimer’s disease.

Program Description

The ADDGS program provides competitive grants to assist States in providing and improving access to home and community-based long-term care services for individuals suffering with Alzheimer’s disease and their caregivers. The program encourages States to target underserved populations, including individuals who are members of racial or ethnic minority groups, who have limited English proficiency, or who live in rural areas.

Demonstration grants provided by the ADDGS program enable each State to develop service and outreach programs that are specific to its needs and resources. Primary components of the ADDGS program include:

- Development and operation of State Alzheimer’s disease programs in coordination with organizations that provide diagnostic, treatment, care management, legal counseling, respite care, and education services to individuals with Alzheimer’s disease or related disorders.
- Improvement of access to home and community-based long-term care services for persons with Alzheimer’s disease and their families.
- Provision of direct services including home health care, personal care, day care, respite care and companion care services.
- Provision of support services including information and counseling, case management, diagnostic and legal services.

Competitive grants are awarded to States to develop effective models of care for serving persons with Alzheimer’s disease and their caregivers. A total of 47 States (including the District of Columbia and Puerto Rico) have received grants through the program. Since its inception in 1992, the ADDGS program has provided thousands of families with home and community-based

supportive services through the efforts of over 600 local agencies. The program also supports the provision of technical assistance to grantees, including evaluations of programs and services.

Performance Analysis

ADDGS is part of AoA's Aging Services Government Performance and Results Act program. Improving program efficiency, improving client assessment and outcomes, and improving targeting of services to vulnerable elders are the three performance measures used to assess the performance of the Aging Services program. The knowledge generated by the ADDGS program helps to ensure that AoA's core programs, particularly its caregiver support programs, maintain and improve performance. The ADDGS program is not directly measured by AoA's performance indicators.

AoA's budget request is closely linked to its performance plan and reflects a strategy for ensuring that AoA's core service delivery programs and the activities that support these programs maintain and improve performance in FY 2006 and beyond. The FY 2006 request maintains funding for core service delivery programs, and for activities such as ADDGS that support these core programs, while continuing to make targeted investments in innovation and demonstration grants that over the long run will create greater balance and better options in our State and community systems of health and long-term care, including improved access, more integrated services, and greater emphasis on prevention. These investments will improve program efficiency and outcomes while also assisting the aging services network to maintain the current high level of consumer satisfaction with services; and to continue to target services to the most vulnerable elderly individuals. For more information on program performance, please refer to the Performance Analysis Detail on page 107.

Rationale for the Budget Request

The FY 2006 request for ADDGS is \$11,786,000, the same as the FY 2005 enacted level. The knowledge gained from ADDGS demonstration projects is critical to redirecting and better utilizing the resources available for AoA core programs, and to helping families to care for their loved ones at home for as long as possible.

Alzheimer's disease, the most common cause of dementia among older persons, affects as many as four million Americans. While most people diagnosed with Alzheimer's disease are age 65 and older, it is also possible for the disease to occur in people in their forties and fifties. Alzheimer's disease is evidenced by a progressive, irreversible decline in mental functioning. As the disease progresses, individuals with Alzheimer's disease experience a loss of memory and gradually lose their capacity to reason, communicate, and carry out the simple tasks of daily life such as brushing their teeth or combing their hair. At later stages, people with Alzheimer's disease may become anxious or aggressive, may wander away from home, and may eventually need continual care. Alzheimer's disease is not only devastating to the individuals who have it, but seriously disrupts the lives of those who care for them.

While more than \$100 billion is spent each year in Alzheimer's disease-related costs, family caregivers remain the major source of support for most people with Alzheimer's disease. The

nature of the disease – a slow loss of cognitive and functional independence – means that most people with Alzheimer’s disease are cared for in the community for years. They may access a variety of services from many different systems including the aging, medical, and mental health service systems. As the number of people with Alzheimer’s disease grows, it is increasingly important that service delivery and health care systems are responsive to persons with dementia and are effectively coordinated. It is also important to ensure the availability of dementia-competent community-based social and health care services.

Scientific research conducted by the National Institutes of Health and other parts of HHS have identified new medical and behavioral approaches that encourage greater independence for persons with Alzheimer’s and reduce instances of disturbing behavior. For example, a recent study, *Intervention to Delay Nursing Home Placement of Patients with Alzheimer’s Disease*, indicates that counseling and support for caregivers of individuals with Alzheimer’s disease can permit the care recipient to stay at home an additional year before being admitted to a nursing home. AoA is partnering with the National Institute on Aging to ensure that the ADDGS program is an important mechanism for the systematic application of these research findings to the development and implementation of models of care for persons with Alzheimer’s disease.

Through the ADDGS program, successful and cost-effective approaches for serving persons with Alzheimer’s disease can be tested and broadly implemented, thereby helping to reduce or delay the need for costly institutional care. Data for FY 2002 shows that approximately 7,420 families receive direct home and community-based services through the program, while an additional 125,000 Alzheimer’s families receive support services. Data for FY 2002 also shows that:

- On average, service recipients are approximately 80 years old; 61 percent are women; 60 percent live in rural areas or small towns or cities with populations less than 50,000; and 24 percent have incomes under \$8,000 per year.
- The program has been successful in reaching ethnic and cultural minorities: 12 percent of those served are African American; 9 percent are Hispanic/Latino; 4 percent are Asian or Pacific Islander, and 1 percent are Native Americans.
- The average number of impairments in activities of daily living in ADDGS clients is 4.2, meaning that the population the program serves is similar in functional impairment to those who qualify for nursing facility care and Medicaid Home and Community-Based Waiver programs in most States.

By providing assistance to persons with Alzheimer’s and their caregivers, the ADDGS program helps families to keep their loved ones at home. ADDGS directly supports the strategic priorities established for AoA by the Assistant Secretary, including *Priority 3: Support families in their efforts to care for their loved ones at home and in the community*; and *Priority 4: Ensure the rights of older people and prevent their abuse, neglect and exploitation*. These services are a key component of the Department’s efforts to create a more balanced long-term care system and to focus on care in the community. Without these services, it would be more difficult for those with Alzheimer’s to remain at home and in the community, thereby increasing costs to other programs that provide more expensive medical and institutional care.

Funding History

Funding for ADDGS during the past five years is as follows:

FY 2001	\$8,962,000
FY 2002	\$11,483,000
FY 2003	\$13,412,000
FY 2004	\$11,883,000
FY 2005	\$11,786,000

Program Administration

Authorizing Legislation: Section 205 of the Older Americans Act of 1965, as amended

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA	\$17,324,000	\$18,301,000	\$17,879,000	-\$422,000
FTE.....	116	120	120	--

Statement of the Budget Request

The FY 2006 request for Program Administration is \$17,879,000, a decrease of -\$422,000 below the FY 2005 enacted level. The FTE level for AoA, excluding usage by the White House Conference on Aging, is maintained at 120. Program Administration provides funding to support the management of programs that assist older individuals to remain healthy, active, independent, and at home.

Program Description

Program Administration funds salaries and related expenses for activities that provide management and oversight for all AoA programs. AoA is the lead Federal partner in the aging services network, and administers the programs established under the Older Americans Act (OAA). AoA also administers the Alzheimer’s Disease Demonstration Grants to States program, which is authorized under the Public Health Service (PHS) Act.

AoA is led by the Assistant Secretary for Aging. Recognizing the importance of measuring performance and the need to focus on results, the Immediate Office of the Assistant Secretary includes the *Office of Evaluation*, which is responsible for assessing the results of AoA programs and carrying out the Government Performance and Results Act (GPRA). The Immediate Office of the Assistant Secretary also includes the *AoA Executive Secretariat*, which coordinates review and response to correspondence, program, policy and management documents from all sources. AoA consists of four operating components in addition to the Office of the Assistant Secretary:

- The *Center for Communication and Consumer Services* provides a central strategic focus for AoA’s public information, education, consumer service and outreach activities. This center also oversees the National Eldercare Locator, which is authorized under Title II of the OAA.
- The *Center for Planning and Policy Development* is responsible for analyzing demographic trends and service needs and translating them into policies and programs to assist the elderly. This center also administers most of the activities authorized under Title IV of the OAA.
- The *Center for Wellness and Community-Based Services* focuses on topical areas of importance to the aging services network and America’s older persons and their families. Within this center are three offices:

- ▶ The *Office of Community-Based Services* carries out an array of programs that support older people, their families and caregivers and help them to remain independent and in their own homes and communities. This office administers the programs authorized under Title III of the OAA, as well as activities carried out under Section 398 of the PHS Act.
- ▶ The *Office of American Indian, Alaskan Native, and Native Hawaiian Programs* provides leadership and coordination of activities, services and policies related to Native Americans, Alaskan Natives and Native Hawaiian elders, and administers the programs authorized under Title VI of the OAA.
- ▶ The *Office of Consumer Choice and Protection* works to equip seniors with the knowledge to make better consumer choices and to protect vulnerable elders from abuse and exploitation. This office administers the programs authorized under Title VII of the OAA and the Pension Counseling and Information program authorized under Title II of the OAA, as well as the Senior Medicare Patrol program and related activities funded by the Health Care Fraud and Abuse Control program.
- ▶ In addition, the center includes the *AoA Central Office Regional Support Center*, which oversees and coordinates the activities of AoA's nine Regional Support Centers. These regional centers provide assistance to the AoA headquarters office in carrying out AoA's responsibilities under the OAA, and provide technical assistance to State, local and Tribal components of the aging services network.
- The *Center for Management* is responsible for administrative activities that support AoA's policy, programmatic and information functions. Within this center, there are four offices:
 - ▶ The *Office of Budget and Finance* is responsible for the formulation and execution of AoA's budget, for developing financial policies and procedures, and for providing analysis of financial resources.
 - ▶ The *Office of Grants Management* coordinates the distribution of approximately 500 grants annually and works with grantees to ensure compliance with applicable laws and regulations governing receipt of Federal funds.
 - ▶ The *Office of Information Resources Management* oversees AoA's information technology resources, including management of AoA's programmatic systems as well as oversight of support services provided by the Information Technology Service Center.
 - ▶ The *Office of Administrative Services* provides support to AoA in the areas of human resources, acquisitions, management analysis, logistics, records management, continuity of operations, and other administrative services.

Program Administration funds administrative expenses – including personnel compensation and benefits, rent, automated systems support, printing, travel, contractual services, supplies, and

equipment – for all components of AoA. Many of these services are provided to AoA through agreements with other entities, including the HHS Program Support Center (PSC).

Performance Analysis

Program Administration is part of AoA's Aging Services GPRA program. Improving program efficiency, improving client assessment and outcomes, and improving targeting of services to vulnerable elders are the three performance measures used to assess the performance of the Aging Services program. Program Administration is not directly measured by AoA's performance indicators, but the program provides the administrative resources that enable AoA to carry out its programmatic activities and thereby achieve its performance goals.

Program Administration also provides the resources needed to support improvements in the management of day-to-day operations, including the implementation of the President's Management Agenda (PMA). AoA is committed to the goals of the PMA and has made them an integral part of its strategic planning process. AoA has undertaken a variety of activities in support of the PMA, including:

- Strategic Management of Human Capital: In the Workforce Plan for FY 2004-FY 2005, AoA identified continuity and succession planning as two critical human capital issues facing the agency. A management workgroup was formed to explore a number of human capital issues, including retention. AoA's strategy is to use employee development as a method to retain, cross-train and advance our future leaders. The workgroup has met several times and has developed recommendations for the Assistant Secretary's consideration, and is currently developing a Strategic Human Capital Management Plan for FY 2005-FY 2006. AoA has also implemented a number of technological improvements, including the Employment Human Resources Program, which have helped to improve management's use of resources and at the same time enable employees to concentrate on programmatic functions. AoA will continue to implement new technologies, including e-Travel (a web-based, standardized HHS-travel system) and e-pay (consolidation of 22 Federal payroll providers to four which will reduce redundancies in payroll processing and reduce payroll costs).
- Competitive Sourcing: In the FY 2004 FAIR Act inventory, AoA identified 11 FTEs as commercial, mostly in the areas of administrative and clerical support, and 109 FTEs as inherently governmental. The two cost comparison studies that were completed in FY 2003 and FY 2004 for public inquiry and correspondence support functions resulted in private sector wins. The six FTE have been re-deployed to program functions within AoA. In accordance with the Department's OMB-approved Green Plan, AoA has developed a schedule to complete remaining competitions by 2008.
- Improved Financial Performance: AoA staff are actively involved in both the governance and the implementation of the Unified Financial Management System (UFMS). Staff have participated as subject matter experts in UFMS activities including conference room pilots and business process design workshops. AoA staff fully supported the Department's efforts on the accelerated, top-down FY 2004 audit, in which the Department maintained a clean opinion. AoA conducted a comprehensive evaluation of its internal control processes and as a

result is working to update its financial management policies and procedures and to improve the quality of financial data that supports management decision-making on program operations. AoA is also working with the Office of the Assistant Secretary for Budget, Technology and Finance to conduct a risk assessment of its programs as required by the Improper Payments Information Act, and is participating in the Department's recovery auditing mandate.

- Expanded Electronic Government: AoA was transitioned to the consolidated HHS Enterprise Email System (EES) in January, 2005 and worked closely with the HHS EES team and Information Technology Service Center to successfully manage the migration. As the first HHS operating division migrated to the HHS EES, AoA continues to promote and actively support the consolidation efforts for fulfillment of the "One HHS" goal. AoA is fully participating in the HHS Enterprise Architecture (EA) initiative and is working to assess AoA's EA in order to meet the Government Accountability Office's EA Management Maturity Program requirements. AoA was the pilot agency for the HHS Enterprise-Wide Grants Management System initiative and is now using the Administration for Children and Families' Grants Administration Tracking & Evaluation System (GATES) to issue grant awards. AoA also continues to work with HHS on consolidated funding announcements as posted through the Grants.gov portal. Communications to potential grantees on the use of Grants.gov is sent through various electronic means and AoA is actively encouraging all grantees to use Grants.gov when applying for funding opportunities.
- Budget and Performance Integration: AoA played an active role in the Department's efforts to develop specifications for an FY 2006 HHS performance budget, and the AoA submission of its FY 2006 performance budget, which fully integrates AoA program performance measures into the budget request for the first time, is AoA's most significant achievement on this initiative. The AoA performance budget reflects HHS' recommendations to consolidate all program activities into a single GPRA and Program Assessment Rating Tool (PART) program, and it includes three performance outcome measures (efficiency, consumer assessment and outcomes, and targeting) that cut across all AoA programs. The FY 2006 performance budget includes all measures identified in the FY 2005 PART process, in which AoA programs received a rating of Moderately Effective. The FY 2005 and FY 2006 AoA budget documents also comply with all requirements for the full costing of programs and performance measures. In addition, AoA has developed a strategic plan that contains a limited number of outcome-oriented goals and objectives, and the performance plans of all AoA managers and staff are linked back to the performance goals, objectives and measures in AoA's strategic plan and annual plans and budgets.

Rationale for the Budget Request

The FY 2006 request for Program Administration is \$17,879,000, a decrease of -\$422,000 below the FY 2005 enacted level. The FTE level for AoA, excluding usage by the White House Conference on Aging, is maintained at 120. The request includes \$398,000 in funding for additional costs related to personnel benefits and compensation. The request also includes funding for additional costs related to rent and various "One-Department" initiatives, including the Unified Financial Management System (UFMS) and the Information Technology Service

Center, offset by savings in other administrative areas, including information technology activities and support contracts.

UFMS is being implemented to replace five legacy accounting systems currently used across the Operating Divisions (OPDIV). The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. The system will also facilitate shared services among the Agencies and thereby, help management reduce substantially the cost of providing accounting service throughout HHS. Similarly, UFMS, by generating timely, reliable and consistent financial information, will enable the component agencies and program administrators to make more timely and informed decisions regarding their operations. AoA's request includes \$404,897 to support these efforts in FY 2006.

The Program Management Office (PMO) and the PSC have commenced Operations and Maintenance (O&M) activities for UFMS in FY 2004. The PMO and the PSC will provide the O & M activities to support UFMS. The scope of proposed O & M services includes post deployment support and ongoing business and technical operations services. Post-deployment services include supplemental functional support, training, change management and technical help-desk services. On-going business operation services involve core functional support, training and communications, and help desk services. On-going technical services include the operations and maintenance of the UFMS production and development environments, on-going development support, and backup and disaster recovery services. AoA's request includes \$238,935 to support these efforts in FY 2006.

AoA's request also includes funding to support the President's Management Agenda Expanding E-Gov initiatives and Departmental enterprise information technology initiatives. Agency funds will be combined with resources in the Information Technology Security and Innovation Fund to finance specific information technology initiatives identified through the HHS strategic planning process and approved by the HHS IT Investment Review Board. These enterprise information technology initiatives promote collaboration in planning and project management and achieve common goals such as secure and reliable communications and lower costs for the purchase and maintenance of hardware and software. Examples of HHS enterprise initiatives currently being funded are Enterprise Architecture, Enterprise E-mail, Network Modernization, and Public Key Infrastructure.

Funding History

Funding and FTE levels for Program Administration during the past five years is as follows:

FY 2001	\$17,216,000	120 FTE
FY 2002	\$18,053,000	120 FTE
FY 2003	\$17,869,000	117 FTE
FY 2004	\$17,324,000	116 FTE
FY 2005	\$18,301,000	120 FTE

White House Conference on Aging

Authorizing Legislation: Section 211 of the Older Americans Act of 1965, as amended

	FY 2004 <u>Actual</u>	FY 2005 <u>Appropriation</u>	FY 2006 <u>Estimate</u>	Increase or Decrease
BA*	\$2,814,000	\$4,520,000	--	-\$4,520,000
FTE**	1	6	3	-3

* Funds are available for three fiscal years.

** FTE in FY 2006 will be funded out of carryover balances remaining from the FY 2004 and FY 2005 appropriations.

Statement of the Budget Request

No funding is requested in FY 2006 for the White House Conference on Aging. Funding provided in FY 2004 and FY 2005 will be used to hold and then to close out the Conference in FY 2006.

Program Description

The White House Conference on Aging, held once each decade, has served as a catalyst for developing aging policy for the past 40 years. Approximately 1,200 delegates are expected to participate in the upcoming conference. Agenda items for the White House Conference include Planning Along the Lifespan, the Workplace of the Future, Our Community, Health and Long-Term Living, Social Engagement, and the Marketplace. Listening sessions have already been held across the country to get insight into issues of concern for older Americans that will be addressed by the Conference, and a series of solutions forums will be held in the months ahead to develop creative, thoughtful, innovative, and specific solutions to be presented at the Conference in Washington, D.C.

A 17-member Steering Committee was appointed in FY 2004 and provides programmatic direction for the Conference, while an Executive Director and staff manage day-to-day operations. The White House Conference on Aging is also working with a variety of cabinet agencies to prepare for the Conference, including HHS and the Departments of Education, Labor, Housing and Urban Development, Transportation, Treasury, Veterans Affairs and the Social Security Administration. HHS involvement and support includes the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, the Food and Drug Administration, the Health Resources and Services Administration, the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, and the Office of the Assistant Secretary for Planning and Evaluation.

Performance Analysis

The White House Conference on Aging supports HHS and AoA strategic goals by providing a forum for discussion of aging policies and program needs and ways to assist seniors and families to improve the quality of life for older Americans. There are no performance indicators specifically related to the White House Conference, which is a one-time, time-limited activity.

The White House Conference on Aging will produce a report for the White House and Congress with a set of recommendations for future policy consideration.

Rationale for the Budget Request

No funding is requested for the White House Conference on Aging for FY 2006. Funding provided in FY 2004 and FY 2005, which is available for three years from the year of appropriation, will be used for the Conference. FTE for FY 2006 will be funded out of carryover balances remaining from the FY 2004 and FY 2005 appropriations.

Funding History

Funding and FTE levels for the White House Conference on Aging during the past two years is as follows:

FY 2004	\$2,814,000	1 FTE
FY 2005	\$4,520,000	6 FTE

FY 2006 State Formula Grant Program Tables

PROGRAM: Home and Community-Based Supportive Services (CFDA 93.044)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
Alabama.....	5,534,723	5,465,037	5,465,037	--
Alaska.....	1,762,299	1,752,974	1,752,974	--
Arizona.....	6,559,073	6,544,975	6,544,975	--
Arkansas.....	3,535,507	3,503,924	3,503,924	--
California.....	34,819,878	34,810,642	34,810,642	--
Colorado.....	4,212,495	4,162,223	4,162,223	--
Connecticut.....	4,413,199	4,408,020	4,408,020	--
Delaware.....	1,762,299	1,752,974	1,752,974	--
District of Columbia.....	1,762,299	1,752,974	1,752,974	--
Florida.....	25,756,732	25,516,538	25,516,538	--
Georgia.....	7,924,174	7,900,998	7,900,998	--
Hawaii.....	1,762,299	1,752,974	1,752,974	--
Idaho.....	1,762,299	1,752,974	1,752,974	--
Illinois.....	14,554,116	14,537,038	14,537,038	--
Indiana.....	7,093,856	7,010,896	7,010,896	--
Iowa.....	4,269,451	4,264,441	4,264,441	--
Kansas.....	3,439,815	3,435,779	3,435,779	--
Kentucky.....	4,888,299	4,788,381	4,788,381	--
Louisiana.....	4,942,803	4,867,065	4,867,065	--
Maine.....	1,762,299	1,752,974	1,752,974	--
Maryland.....	5,887,899	5,895,429	5,895,429	--
Massachusetts.....	8,225,613	8,215,961	8,215,961	--
Michigan.....	11,534,829	11,410,347	11,410,347	--
Minnesota.....	5,609,123	5,566,062	5,566,062	--
Mississippi.....	3,279,296	3,275,448	3,275,448	--
Missouri.....	7,132,752	7,124,382	7,124,382	--
Montana.....	1,762,299	1,752,974	1,752,974	--
Nebraska.....	2,299,556	2,296,858	2,296,858	--
Nevada.....	2,366,948	2,408,695	2,408,695	--
New Hampshire.....	1,762,299	1,752,974	1,752,974	--

PROGRAM: Home and Community-Based Supportive Services (CFDA 93.044)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
New Jersey.....	10,416,110	10,271,555	10,271,555	--
New Mexico.....	2,064,007	2,062,998	2,062,998	--
New York.....	24,332,292	24,303,740	24,303,740	--
North Carolina.....	9,461,931	9,415,529	9,415,529	--
North Dakota.....	1,762,299	1,752,974	1,752,974	--
Ohio.....	14,015,956	13,828,366	13,828,366	--
Oklahoma.....	4,323,623	4,281,864	4,281,864	--
Oregon.....	4,163,085	4,158,889	4,158,889	--
Pennsylvania.....	17,915,954	17,894,931	17,894,931	--
Rhode Island.....	1,762,299	1,752,974	1,752,974	--
South Carolina.....	4,828,370	4,806,453	4,806,453	--
South Dakota.....	1,762,299	1,752,974	1,752,974	--
Tennessee.....	6,871,387	6,806,410	6,806,410	--
Texas.....	20,626,160	20,338,706	20,338,706	--
Utah.....	1,876,892	1,862,081	1,862,081	--
Vermont.....	1,762,299	1,752,974	1,752,974	--
Virginia.....	7,840,298	7,892,957	7,892,957	--
Washington.....	6,419,602	6,442,716	6,442,716	--
West Virginia.....	2,779,119	2,775,858	2,775,858	--
Wisconsin.....	6,518,077	6,444,658	6,444,658	--
Wyoming.....	<u>1,762,299</u>	<u>1,752,974</u>	<u>1,752,974</u>	--
Subtotal, States.....	\$345,642,887	\$343,785,512	\$343,785,512	\$ --
American Samoa.....	473,267	472,712	472,712	--
Guam.....	881,149	876,487	876,487	--
Northern Marianas.....	220,287	219,122	219,122	--
Puerto Rico.....	4,360,964	4,364,383	4,364,383	--
Virgin Islands.....	<u>881,149</u>	<u>876,487</u>	<u>876,487</u>	--
Subtotal, States/Territories.....	\$352,459,703	\$350,594,703	\$350,594,703	\$ --
Undistributed /1.....	1,429,297	3,541,297	3,541,297	--
Total.....	\$353,889,000	\$354,136,000	\$354,136,000	\$ --

1/ Funds held for statutory related requirements are reflected in the undistributed line.

PROGRAM: Congregate Nutrition Services (CFDA 93.045)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
Alabama.....	6,071,424	6,066,925	6,066,925	--
Alaska.....	1,923,965	1,917,005	1,917,005	--
Arizona.....	6,549,817	6,499,205	6,499,205	--
Arkansas.....	4,165,633	4,162,546	4,162,546	--
California.....	34,936,567	34,910,682	34,910,682	--
Colorado.....	4,206,318	4,132,827	4,132,827	--
Connecticut.....	5,244,057	5,240,171	5,240,171	--
Delaware.....	1,923,965	1,917,005	1,917,005	--
District of Columbia.....	1,923,965	1,917,005	1,917,005	--
Florida.....	25,718,968	25,336,323	25,336,323	--
Georgia.....	7,912,556	7,845,196	7,845,196	--
Hawaii.....	1,941,561	1,940,122	1,940,122	--
Idaho.....	1,931,757	1,930,325	1,930,325	--
Illinois.....	17,295,133	17,282,317	17,282,317	--
Indiana.....	8,109,889	8,103,880	8,103,880	--
Iowa.....	5,084,026	5,080,259	5,080,259	--
Kansas.....	4,091,936	4,088,904	4,088,904	--
Kentucky.....	5,573,021	5,568,891	5,568,891	--
Louisiana.....	5,648,804	5,644,619	5,644,619	--
Maine.....	1,997,145	1,995,665	1,995,665	--
Maryland.....	5,896,612	5,892,242	5,892,242	--
Massachusetts.....	9,785,128	9,777,877	9,777,877	--
Michigan.....	12,932,923	12,923,340	12,923,340	--
Minnesota.....	6,401,619	6,396,876	6,396,876	--
Mississippi.....	3,893,047	3,890,163	3,890,163	--
Missouri.....	8,471,255	8,464,978	8,464,978	--
Montana.....	1,923,965	1,917,005	1,917,005	--
Nebraska.....	2,740,163	2,738,132	2,738,132	--
Nevada.....	2,363,478	2,391,683	2,391,683	--
New Hampshire.....	1,933,637	1,932,204	1,932,204	--

PROGRAM: Congregate Nutrition Services (CFDA 93.045)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
New Jersey.....	12,196,546	12,187,509	12,187,509	--
New Mexico.....	2,060,980	2,048,428	2,048,428	--
New York.....	28,978,250	28,956,777	28,956,777	--
North Carolina.....	9,448,059	9,349,030	9,349,030	--
North Dakota.....	1,923,965	1,917,005	1,917,005	--
Ohio.....	16,401,932	16,389,779	16,389,779	--
Oklahoma.....	5,083,261	5,079,494	5,079,494	--
Oregon.....	4,304,087	4,300,898	4,300,898	--
Pennsylvania.....	21,290,291	21,274,516	21,274,516	--
Rhode Island.....	1,951,153	1,949,708	1,949,708	--
South Carolina.....	4,821,290	4,772,507	4,772,507	--
South Dakota.....	1,923,965	1,917,005	1,917,005	--
Tennessee.....	7,157,674	7,152,370	7,152,370	--
Texas.....	20,595,919	20,195,061	20,195,061	--
Utah.....	1,963,759	1,962,304	1,962,304	--
Vermont.....	1,923,965	1,917,005	1,917,005	--
Virginia.....	7,828,803	7,837,211	7,837,211	--
Washington.....	6,410,190	6,397,213	6,397,213	--
West Virginia.....	3,307,590	3,305,139	3,305,139	--
Wisconsin.....	7,590,764	7,585,139	7,585,139	--
Wyoming.....	<u>1,923,965</u>	<u>1,917,005</u>	<u>1,917,005</u>	<u>--</u>
Subtotal, States.....	\$377,678,742	\$376,315,475	\$376,315,475	\$ --
American Samoa.....	595,138	594,697	594,697	--
Guam.....	961,982	958,503	958,503	--
Northern Marianas.....	240,527	240,349	240,349	--
Puerto Rico.....	4,354,571	4,333,559	4,333,559	--
Virgin Islands.....	<u>961,982</u>	<u>958,503</u>	<u>958,503</u>	<u>--</u>
Subtotal, States/Territories.....	\$384,792,942	\$383,401,086	\$383,401,086	\$ --
Undistributed /1.....	1,560,058	3,872,914	3,872,914	--
Total.....	\$386,353,000	\$387,274,000	\$387,274,000	\$ --

1/ Funds held for statutory related requirements are reflected in the undistributed line.

PROGRAM: Home-Delivered Nutrition Services (CFDA 93.045)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
Alabama.....	2,850,233	2,869,785	2,869,785	--
Alaska.....	895,954	904,992	904,992	--
Arizona.....	3,377,747	3,436,879	3,436,879	--
Arkansas.....	1,820,691	1,822,095	1,822,095	--
California.....	17,931,299	18,279,672	18,279,672	--
Colorado.....	2,169,321	2,185,656	2,185,656	--
Connecticut.....	2,225,933	2,251,283	2,251,283	--
Delaware.....	895,954	904,992	904,992	--
District of Columbia.....	895,954	904,992	904,992	--
Florida.....	13,264,023	13,399,176	13,399,176	--
Georgia.....	4,080,736	4,148,951	4,148,951	--
Hawaii.....	895,954	904,992	904,992	--
Idaho.....	895,954	904,992	904,992	--
Illinois.....	7,228,307	7,273,682	7,273,682	--
Indiana.....	3,653,145	3,681,543	3,681,543	--
Iowa.....	2,021,681	2,021,508	2,021,508	--
Kansas.....	1,666,099	1,661,155	1,661,155	--
Kentucky.....	2,517,342	2,514,462	2,514,462	--
Louisiana.....	2,545,410	2,555,780	2,555,780	--
Maine.....	895,954	904,992	904,992	--
Maryland.....	3,032,110	3,095,792	3,095,792	--
Massachusetts.....	4,059,185	4,049,862	4,049,862	--
Michigan.....	5,940,126	5,991,771	5,991,771	--
Minnesota.....	2,888,547	2,922,835	2,922,835	--
Mississippi.....	1,683,903	1,691,957	1,691,957	--
Missouri.....	3,633,730	3,650,813	3,650,813	--
Montana.....	895,954	904,992	904,992	--
Nebraska.....	1,085,755	1,086,195	1,086,195	--
Nevada.....	1,218,915	1,264,847	1,264,847	--
New Hampshire.....	895,954	904,992	904,992	--

PROGRAM: Home-Delivered Nutrition Services (CFDA 93.045)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
New Jersey.....	5,364,016	5,388,080	5,388,080	--
New Mexico.....	1,062,907	1,083,317	1,083,317	--
New York.....	11,857,332	11,977,398	11,977,398	--
North Carolina.....	4,872,640	4,944,257	4,944,257	--
North Dakota.....	895,954	904,992	904,992	--
Ohio.....	7,217,840	7,254,265	7,254,265	--
Oklahoma.....	2,226,549	2,222,867	2,222,867	--
Oregon.....	2,143,876	2,183,905	2,183,905	--
Pennsylvania.....	8,871,976	8,880,407	8,880,407	--
Rhode Island.....	895,954	904,992	904,992	--
South Carolina.....	2,486,480	2,523,952	2,523,952	--
South Dakota.....	895,954	904,992	904,992	--
Tennessee.....	3,538,579	3,574,164	3,574,164	--
Texas.....	10,621,916	10,680,207	10,680,207	--
Utah.....	966,549	977,811	977,811	--
Vermont.....	895,954	904,992	904,992	--
Virginia.....	4,037,542	4,144,728	4,144,728	--
Washington.....	3,305,922	3,383,182	3,383,182	--
West Virginia.....	1,328,440	1,328,602	1,328,602	--
Wisconsin.....	3,356,634	3,384,201	3,384,201	--
Wyoming.....	<u>895,954</u>	<u>904,992</u>	<u>904,992</u>	<u>--</u>
Subtotal, States.....	\$175,800,838	\$177,551,938	\$177,551,938	\$ --
American Samoa.....	136,138	136,459	136,459	--
Guam.....	447,977	452,496	452,496	--
Northern Marianas.....	111,994	113,124	113,124	--
Puerto Rico.....	2,245,779	2,291,813	2,291,813	--
Virgin Islands.....	<u>447,977</u>	<u>452,496</u>	<u>452,496</u>	<u>--</u>
Subtotal, States/Territories.....	\$179,190,703	\$180,998,326	\$180,998,326	\$ --
Undistributed /1.....	726,297	1,827,674	1,827,674	--
Total.....	\$179,917,000	\$182,826,000	\$182,826,000	\$ --

1/ Funds held for statutory related requirements are reflected in the undistributed line.

PROGRAM: Nutrition Services Incentive Program (CFDA 93.053)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
Alabama.....	2,615,757	2,601,854	2,601,854	--
Alaska.....	302,197	300,591	300,591	--
Arizona.....	1,893,741	1,883,675	1,883,675	--
Arkansas.....	2,169,168	2,157,638	2,157,638	--
California.....	11,606,495	11,544,805	11,544,805	--
Colorado.....	1,277,613	1,270,822	1,270,822	--
Connecticut.....	1,971,464	1,960,985	1,960,985	--
Delaware.....	585,718	582,605	582,605	--
District of Columbia.....	602,000	598,801	598,801	--
Florida.....	8,007,699	7,965,137	7,965,137	--
Georgia.....	2,493,835	2,480,580	2,480,580	--
Hawaii.....	537,606	534,749	534,749	--
Idaho.....	781,179	777,027	777,027	--
Illinois.....	6,017,603	5,985,618	5,985,618	--
Indiana.....	1,662,180	1,653,346	1,653,346	--
Iowa.....	2,043,314	2,032,454	2,032,454	--
Kansas.....	1,982,338	1,971,802	1,971,802	--
Kentucky.....	1,924,858	1,914,627	1,914,627	--
Louisiana.....	2,886,492	2,871,150	2,871,150	--
Maine.....	638,262	634,870	634,870	--
Maryland.....	1,874,596	1,864,632	1,864,632	--
Massachusetts.....	4,746,808	4,721,578	4,721,578	--
Michigan.....	6,833,130	6,796,811	6,796,811	--
Minnesota.....	2,430,291	2,417,374	2,417,374	--
Mississippi.....	1,973,457	1,962,968	1,962,968	--
Missouri.....	3,994,667	3,973,435	3,973,435	--
Montana.....	906,435	901,618	901,618	--
Nebraska.....	1,300,761	1,293,847	1,293,847	--
Nevada.....	788,115	783,926	783,926	--
New Hampshire.....	814,209	809,882	809,882	--

PROGRAM: Nutrition Services Incentive Program (CFDA 93.053)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
New Jersey.....	3,368,041	3,350,139	3,350,139	--
New Mexico	1,654,088	1,645,296	1,645,296	--
New York.....	14,041,562	13,966,918	13,966,918	--
North Carolina.....	3,236,108	3,218,907	3,218,907	--
North Dakota.....	799,346	795,098	795,098	--
Ohio.....	5,122,199	5,094,974	5,094,974	--
Oklahoma.....	2,567,662	2,554,015	2,554,015	--
Oregon.....	1,559,339	1,551,051	1,551,051	--
Pennsylvania.....	6,691,615	6,656,048	6,656,048	--
Rhode Island.....	663,661	660,134	660,134	--
South Carolina.....	1,965,320	1,954,874	1,954,874	--
South Dakota.....	961,726	956,614	956,614	--
Tennessee.....	1,973,028	1,962,542	1,962,542	--
Texas.....	9,690,735	9,639,227	9,639,227	--
Utah	1,164,653	1,158,463	1,158,463	--
Vermont.....	596,862	593,689	593,689	--
Virginia.....	2,195,829	2,184,157	2,184,157	--
Washington.....	1,877,457	1,867,478	1,867,478	--
West Virginia.....	1,420,492	1,412,942	1,412,942	--
Wisconsin.....	3,118,141	3,101,568	3,101,568	--
Wyoming.....	<u>749,084</u>	<u>745,103</u>	<u>745,103</u>	<u>--</u>
Subtotal, States.....	\$143,078,936	\$142,318,444	\$142,318,444	\$ --
American Samoa.....	--	--	--	--
Guam.....	257,083	255,717	255,717	--
Northern Marianas.....	67,890	67,530	67,530	--
Puerto Rico.....	2,299,618	2,287,396	2,287,396	--
Virgin Islands.....	<u>115,917</u>	<u>115,301</u>	<u>115,301</u>	<u>--</u>
Subtotal, States/Territories.....	\$145,819,444	\$145,044,388	\$145,044,388	\$ --
Indian Tribes.....	2,076,335	2,065,304	2,065,304	--
Undistributed /1.....	296,221	1,486,308	1,486,308	--
Total.....	\$148,192,000	\$148,596,000	\$148,596,000	\$ --

1/ Funds held for statutory related requirements are reflected in the undistributed line.

PROGRAM: Preventive Health Services (CFDA 93.043)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
Alabama.....	345,240	339,343	339,343	--
Alaska.....	108,508	106,998	106,998	--
Arizona.....	409,136	406,400	406,400	--
Arkansas.....	220,535	215,457	215,457	--
California.....	2,171,966	2,161,516	2,161,516	--
Colorado.....	262,764	258,447	258,447	--
Connecticut.....	269,621	266,207	266,207	--
Delaware.....	108,508	106,998	106,998	--
District of Columbia.....	108,508	106,998	106,998	--
Florida.....	1,606,633	1,584,411	1,584,411	--
Georgia.....	494,288	490,601	490,601	--
Hawaii.....	108,508	106,998	106,998	--
Idaho.....	108,508	106,998	106,998	--
Illinois.....	875,544	860,090	860,090	--
Indiana.....	442,495	435,331	435,331	--
Iowa.....	244,880	239,037	239,037	--
Kansas.....	201,810	196,426	196,426	--
Kentucky.....	304,918	297,327	297,327	--
Louisiana.....	308,318	302,213	302,213	--
Maine.....	108,508	106,998	106,998	--
Maryland.....	367,271	366,068	366,068	--
Massachusetts.....	491,677	478,884	478,884	--
Michigan.....	719,510	708,508	708,508	--
Minnesota.....	349,881	345,616	345,616	--
Mississippi.....	203,966	200,069	200,069	--
Missouri.....	440,143	431,697	431,697	--
Montana.....	108,508	106,998	106,998	--
Nebraska.....	131,514	128,439	128,439	--
Nevada.....	147,644	149,564	149,564	--
New Hampshire.....	108,508	106,998	106,998	--

PROGRAM: Preventive Health Services (CFDA 93.043)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
New Jersey.....	649,728	637,124	637,124	--
New Mexico.....	128,747	128,099	128,099	--
New York.....	1,436,244	1,416,290	1,416,290	--
North Carolina.....	590,209	584,643	584,643	--
North Dakota.....	108,508	106,998	106,998	--
Ohio.....	874,276	857,794	857,794	--
Oklahoma.....	269,695	262,847	262,847	--
Oregon.....	259,682	258,240	258,240	--
Pennsylvania.....	1,074,637	1,050,080	1,050,080	--
Rhode Island.....	108,508	106,998	106,998	--
South Carolina.....	301,180	298,449	298,449	--
South Dakota.....	108,508	106,998	106,998	--
Tennessee.....	428,618	422,634	422,634	--
Texas.....	1,286,602	1,262,901	1,262,901	--
Utah.....	117,075	115,623	115,623	--
Vermont.....	108,508	106,998	106,998	--
Virginia.....	489,056	490,101	490,101	--
Washington.....	400,437	400,051	400,051	--
West Virginia.....	160,910	157,103	157,103	--
Wisconsin.....	406,579	400,171	400,171	--
Wyoming.....	<u>108,508</u>	<u>106,998</u>	<u>106,998</u>	<u>--</u>
Subtotal, States.....	\$21,294,033	\$20,994,775	\$20,994,775	\$ --
American Samoa.....	13,564	13,375	13,375	--
Guam.....	54,254	53,499	53,499	--
Northern Marianas.....	13,564	13,375	13,375	--
Puerto Rico.....	272,025	271,000	271,000	--
Virgin Islands.....	<u>54,254</u>	<u>53,499</u>	<u>53,499</u>	<u>--</u>
Subtotal, States/Territories.....	\$21,701,694	\$21,399,523	\$21,399,523	\$ --
Undistributed /1.....	88,306	216,477	216,477	--
Total.....	\$21,790,000	\$21,616,000	\$21,616,000	\$ --

1/ Funds held for statutory related requirements are reflected in the undistributed line.

PROGRAM: National Family Caregiver Support Program (CFDA 93.052)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
Alabama.....	2,336,741	2,371,595	2,371,595	--
Alaska.....	760,609	770,933	770,933	--
Arizona.....	2,845,555	2,908,196	2,908,196	--
Arkansas.....	1,509,895	1,521,782	1,521,782	--
California.....	15,152,874	15,429,224	15,429,224	--
Colorado.....	1,732,823	1,773,009	1,773,009	--
Connecticut.....	2,000,188	2,012,341	2,012,341	--
Delaware.....	760,609	770,933	770,933	--
District of Columbia.....	760,609	770,933	770,933	--
Florida.....	11,924,721	12,117,750	12,117,750	--
Georgia.....	3,170,271	3,248,393	3,248,393	--
Hawaii.....	760,609	770,933	770,933	--
Idaho.....	760,609	770,933	770,933	--
Illinois.....	6,203,879	6,242,411	6,242,411	--
Indiana.....	3,116,770	3,145,804	3,145,804	--
Iowa.....	1,838,996	1,843,149	1,843,149	--
Kansas.....	1,491,257	1,496,789	1,496,789	--
Kentucky.....	2,039,994	2,054,312	2,054,312	--
Louisiana.....	2,094,604	2,120,063	2,120,063	--
Maine.....	763,284	778,365	778,365	--
Maryland.....	2,492,054	2,538,560	2,538,560	--
Massachusetts.....	3,635,129	3,646,239	3,646,239	--
Michigan.....	5,079,856	5,122,790	5,122,790	--
Minnesota.....	2,507,814	2,552,762	2,552,762	--
Mississippi.....	1,383,735	1,400,929	1,400,929	--
Missouri.....	3,093,889	3,126,795	3,126,795	--
Montana.....	760,609	770,933	770,933	--
Nebraska.....	973,576	982,918	982,918	--
Nevada.....	908,670	951,698	951,698	--
New Hampshire.....	760,609	770,933	770,933	--

PROGRAM: National Family Caregiver Support Program (CFDA 93.052)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
New Jersey.....	4,665,845	4,709,071	4,709,071	--
New Mexico.....	858,751	882,292	882,292	--
New York.....	10,198,432	10,305,612	10,305,612	--
North Carolina.....	3,964,650	4,051,745	4,051,745	--
North Dakota.....	760,609	770,933	770,933	--
Ohio.....	6,263,768	6,292,228	6,292,228	--
Oklahoma.....	1,842,395	1,862,135	1,862,135	--
Oregon.....	1,849,740	1,890,388	1,890,388	--
Pennsylvania.....	8,105,048	8,122,026	8,122,026	--
Rhode Island.....	760,609	770,933	770,933	--
South Carolina.....	1,967,128	2,018,828	2,018,828	--
South Dakota.....	760,609	770,933	770,933	--
Tennessee.....	2,853,907	2,896,201	2,896,201	--
Texas.....	8,524,635	8,663,485	8,663,485	--
Utah.....	794,480	815,808	815,808	--
Vermont.....	760,609	770,933	770,933	--
Virginia.....	3,264,805	3,339,233	3,339,233	--
Washington.....	2,788,766	2,843,834	2,843,834	--
West Virginia.....	1,127,662	1,129,565	1,129,565	--
Wisconsin.....	2,956,587	2,982,393	2,982,393	--
Wyoming.....	760,609	770,933	770,933	--
Subtotal, States.....	\$149,450,482	\$151,441,914	\$151,441,914	\$ --
American Samoa.....	95,076	96,367	96,367	--
Guam.....	380,304	385,466	385,466	--
Northern Marianas.....	95,076	96,367	96,367	--
Puerto Rico.....	1,720,512	1,780,980	1,780,980	--
Virgin Islands.....	380,304	385,466	385,466	--
Subtotal, States/Territories.....	\$152,121,754	\$154,186,560	\$154,186,560	\$ --
Undistributed /1.....	616,246	1,557,440	1,557,440	--
Total.....	\$152,738,000	\$155,744,000	\$155,744,000	\$ --

1/ Funds held for statutory related requirements are reflected in the undistributed line.

PROGRAM: Long-Term Care Ombudsmen Program (CFDA 93.042)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
Alabama.....	224,842	222,325	222,325	--
Alaska.....	70,668	70,101	70,101	--
Arizona.....	266,455	266,258	266,258	--
Arkansas.....	143,626	141,160	141,160	--
California.....	1,414,519	1,416,146	1,416,146	--
Colorado.....	171,128	169,325	169,325	--
Connecticut.....	175,594	174,409	174,409	--
Delaware.....	70,668	70,101	70,101	--
District of Columbia.....	70,668	70,101	70,101	--
Florida.....	1,046,339	1,038,047	1,038,047	--
Georgia.....	321,911	321,423	321,423	--
Hawaii.....	70,668	70,101	70,101	--
Idaho.....	70,668	70,101	70,101	--
Illinois.....	570,209	563,499	563,499	--
Indiana.....	288,180	285,213	285,213	--
Iowa.....	159,481	156,608	156,608	--
Kansas.....	131,431	128,691	128,691	--
Kentucky.....	198,582	194,798	194,798	--
Louisiana.....	200,796	197,999	197,999	--
Maine.....	70,668	70,101	70,101	--
Maryland.....	239,190	239,834	239,834	--
Massachusetts.....	320,211	313,747	313,747	--
Michigan.....	468,590	464,188	464,188	--
Minnesota.....	227,865	226,435	226,435	--
Mississippi.....	132,836	131,078	131,078	--
Missouri.....	286,649	282,832	282,832	--
Montana.....	70,668	70,101	70,101	--
Nebraska.....	85,650	84,149	84,149	--
Nevada.....	96,155	97,989	97,989	--
New Hampshire.....	70,668	70,101	70,101	--

PROGRAM: Long-Term Care Ombudsmen Program (CFDA 93.042)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
New Jersey.....	423,143	417,420	417,420	--
New Mexico.....	83,848	83,926	83,926	--
New York.....	935,372	927,901	927,901	--
North Carolina.....	384,381	383,036	383,036	--
North Dakota.....	70,668	70,101	70,101	--
Ohio.....	569,383	561,995	561,995	--
Oklahoma.....	175,643	172,208	172,208	--
Oregon.....	169,121	169,189	169,189	--
Pennsylvania.....	699,870	687,974	687,974	--
Rhode Island.....	70,668	70,101	70,101	--
South Carolina.....	196,147	195,533	195,533	--
South Dakota.....	70,668	70,101	70,101	--
Tennessee.....	279,143	276,894	276,894	--
Texas.....	837,915	827,406	827,406	--
Utah.....	76,247	75,752	75,752	--
Vermont.....	70,668	70,101	70,101	--
Virginia.....	318,504	321,096	321,096	--
Washington.....	260,789	262,098	262,098	--
West Virginia.....	104,795	102,928	102,928	--
Wisconsin.....	264,790	262,177	262,177	--
Wyoming.....	<u>70,668</u>	<u>70,101</u>	<u>70,101</u>	<u>--</u>
Subtotal, States.....	\$13,868,014	\$13,754,999	\$13,754,999	\$ --
American Samoa.....	8,833	8,763	8,763	--
Guam.....	35,334	35,050	35,050	--
Northern Marianas.....	8,833	8,763	8,763	--
Puerto Rico.....	177,159	177,549	177,549	--
Virgin Islands.....	<u>35,334</u>	<u>35,050</u>	<u>35,050</u>	<u>--</u>
Subtotal, States/Territories.....	\$14,133,507	\$14,020,174	\$14,020,174	\$ --
Undistributed /1.....	142,493	141,826	141,826	--
Total.....	\$14,276,000	\$14,162,000	\$14,162,000	\$ --

1/ Funds held for statutory related requirements are reflected in the undistributed line.

PROGRAM: Prevention of Elder Abuse, Neglect, and Exploitation (CFDA 93.041)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
Alabama.....	81,382	80,483	81,603	1,120
Alaska.....	25,578	25,377	25,730	353
Arizona.....	96,445	96,387	97,729	1,342
Arkansas.....	51,986	51,101	51,812	711
California.....	511,990	512,651	519,786	7,135
Colorado.....	61,940	61,297	62,150	853
Connecticut.....	63,557	63,137	64,016	879
Delaware.....	25,578	25,377	25,730	353
District of Columbia.....	25,578	25,377	25,730	353
Florida.....	378,726	375,780	381,009	5,229
Georgia.....	116,517	116,357	117,977	1,620
Hawaii.....	25,578	25,377	25,730	353
Idaho.....	25,578	25,377	25,730	353
Illinois.....	206,389	203,990	206,829	2,839
Indiana.....	104,308	103,249	104,686	1,437
Iowa.....	57,725	56,693	57,482	789
Kansas.....	47,572	46,587	47,235	648
Kentucky.....	71,877	70,518	71,499	981
Louisiana.....	72,679	71,677	72,674	997
Maine.....	25,578	25,377	25,730	353
Maryland.....	86,575	86,821	88,030	1,209
Massachusetts.....	115,901	113,578	115,159	1,581
Michigan.....	169,608	168,039	170,378	2,339
Minnesota.....	82,476	81,971	83,112	1,141
Mississippi.....	48,080	47,451	48,111	660
Missouri.....	103,753	102,387	103,812	1,425
Montana.....	25,578	25,377	25,730	353
Nebraska.....	31,001	30,462	30,886	424
Nevada.....	34,803	35,473	35,966	493
New Hampshire.....	25,578	25,377	25,730	353

PROGRAM: Prevention of Elder Abuse, Neglect, and Exploitation (CFDA 93.041)

<u>State/Territory</u>	<u>FY 2004 Actual</u>	<u>FY 2005 Appropriation</u>	<u>FY 2006 Estimate</u>	<u>Difference +/- FY 2005</u>
New Jersey.....	153,158	151,109	153,212	2,103
New Mexico.....	30,349	30,382	30,805	423
New York.....	338,561	335,906	340,581	4,675
North Carolina.....	139,128	138,662	140,591	1,929
North Dakota.....	25,578	25,377	25,730	353
Ohio.....	206,090	203,446	206,277	2,831
Oklahoma.....	63,574	62,340	63,208	868
Oregon.....	61,214	61,248	62,100	852
Pennsylvania.....	253,320	249,051	252,517	3,466
Rhode Island.....	25,578	25,377	25,730	353
South Carolina.....	70,996	70,784	71,769	985
South Dakota.....	25,578	25,377	25,730	353
Tennessee.....	101,037	100,237	101,632	1,395
Texas.....	303,286	299,526	303,695	4,169
Utah.....	27,598	27,423	27,804	381
Vermont.....	25,578	25,377	25,730	353
Virginia.....	115,283	116,239	117,856	1,617
Washington.....	94,394	94,881	96,202	1,321
West Virginia.....	37,931	37,261	37,779	518
Wisconsin.....	95,841	94,910	96,231	1,321
Wyoming.....	<u>25,578</u>	<u>25,377</u>	<u>25,730</u>	<u>353</u>
Subtotal, States.....	\$5,019,564	\$4,979,395	\$5,048,690	\$69,295
American Samoa.....	3,197	3,172	3,216	44
Guam.....	12,789	12,688	12,865	177
Northern Marianas.....	3,197	3,172	3,216	44
Puerto Rico.....	64,123	64,274	65,168	894
Virgin Islands.....	<u>12,789</u>	<u>12,688</u>	<u>12,865</u>	<u>177</u>
Subtotal, States/Territories.....	\$5,115,659	\$5,075,389	\$5,146,020	\$70,631
Undistributed /1.....	52,341	50,611	51,980	1,369
Total.....	\$5,168,000	\$5,126,000	\$5,198,000	\$72,000

1/ Funds held for statutory related requirements are reflected in the undistributed line.

Detail of Full-Time Equivalent Employment

	FY 2004 <u>Actual</u>	FY 2005 <u>Estimate</u>	FY 2006 <u>Estimate</u>
Immediate Office of the Assistant Secretary.....	16	14	14
Center for Communication and Consumer Services.....	7	7	7
Center for Planning and Policy Development.....	7	11	11
Center for Wellness and Community-Based Services.....	26	26	26
Center for Management.....	24	24	24
Regional Offices.....	35	38	38
White House Conference on Aging.....	1	6	3
Total FTE Usage, End of Year.....	117	126	123
HCFAC-Funded FTE.....	(7)	(7)	(7)
Total Appropriation-Funded FTE.....	111	119	116

Average GS Grade

FY 2002	12/3
FY 2003	12/3
FY 2004	12/5
FY 2005	12/4
FY 2006	12/5

Exhibit R

Detail of Positions

	FY 2004 <u>Actual</u>	FY 2005 <u>Estimate</u>	FY 2006 <u>Estimate</u>
Executive Level I.....	--	--	--
Executive Level II.....	--	--	--
Executive Level III.....	--	--	--
Executive Level IV.....	1	1	1
Executive Level V.....	--	--	--
Subtotal Executive Level.....	1	1	1
Total Executive Level Salaries.....	\$137,000	\$142,000	\$147,000
Total SES.....	3	4	3
Total SES Salary.....	\$420,000	\$495,000	\$383,000
GS-15.....	20	23	21
GS-14.....	13	11	11
GS-13.....	45	52	50
GS-12.....	9	9	9
GS-11.....	5	10	8
GS-10.....	1	1	1
GS-9.....	8	7	5
GS-8.....	1	2	2
GS-7.....	6	7	7
GS-6.....	2	2	2
Subtotal GS.....	110	124	116
Total GS Salary.....	\$9,068,000	\$10,326,000	\$10,184,000
Average SES Salary.....	\$140,000	\$123,750	\$127,667
Average GS Grade.....	12/5	12/4	12/5
Average GS Salary.....	\$82,436	\$83,274	\$87,793

New Positions Requested

	<u>FY 2006</u>		
	<u>Grade</u>	<u>Number</u>	<u>Annual Salary</u>
No New Positions Requested.....	--	--	--

Exhibit T

**Budget and Performance Crosswalk
(Dollars in Thousands)**

Program Performance Area	Budget Activity	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate
Aging Services Programs	Home & Community-Based Supportive Services.....	\$353,889	\$354,136	\$354,136
	Congregate Nutrition Services.....	386,353	387,274	387,274
	Home-Delivered Nutrition Services.....	179,917	182,826	182,826
	Nutrition Services Incentive Program.....	148,192	148,596	148,596
	Preventive Health Services.....	21,790	21,616	21,616
	National Family Caregiver Support Program.....	152,738	155,744	155,744
	Native American Nutrition & Supportive Services.....	26,453	26,398	26,398
	Native American Caregiver Support Program.....	6,318	6,304	6,304
	Long-Term Care Ombudsmen Program.....	14,276	14,162	14,162
	Prevention of Elder Abuse & Neglect.....	5,168	5,126	5,198
	Program Innovations.....	33,509	43,286	23,843
	Aging Network Support Activities.....	13,294	13,266	13,266
	Alzheimer's Disease Demonstration Grants.....	11,883	11,786	11,786
	Program Administration.....	17,324	18,301	17,879
	White House Conference on Aging.....	2,814	4,520	--
Health Care Fraud & Abuse Control /1.....	3,667	3,297	3,297	
	Subtotal, Aging Services Programs.....	\$1,377,585	\$1,396,638	\$1,372,325
Total, Discretionary Program Level.....		\$ 1,377,585	\$ 1,396,638	\$ 1,372,325

1/ FY 2006 is a placeholder; the Secretary and the Attorney General will negotiate final amounts.

Performance Analysis Detail: FY 2006 Measures Summary

Beginning with FY 2006, for purposes of performance measurement, AoA has aggregated all budget line items into a single Government Performance and Results Act (GPRA) program: AoA's Aging Services GPRA Program. AoA program activities have a fundamental common purpose that reflects the primary legislative intent of the Older Americans Act (OAA): to make community-based services available to elders who are at risk of losing their independence, to prevent disease and disability through community-based activities, and to support the efforts of family caregivers. It is intended that States, tribal organizations and communities participate actively in funding community-based services and develop the capacity to support the home and community-based service needs of elderly individuals, particularly the disabled, poor, minorities and those who live in rural areas where access to services may be limited. These fundamental objectives led AoA to focus on three program results areas in assessing all program activities through performance measurement: 1) improving efficiency; 2) improving client assessments and outcomes, and 3) improving targeting to vulnerable elder populations. Each of these measures separately covers the full scope of AoA's program activities, and therefore each measure reflects the full cost of all program activities. For example, achieving the levels of efficiency for the program that AoA has projected requires the full cost of the program, including administrative costs. Similarly, achieving the projected improvements in consumer assessment and service targeting requires the full cost of the program. Each of the measures separately covers all AoA program activities.

For purposes of clarity in the presentation of the detailed results of AoA's performance measurement activity, we have divided the analysis into two parts: performance measures for FY 2006 and beyond, and performance measures for earlier years. With guidance from HHS and the Office of Management and Budget (OMB), AoA made very significant changes to its performance measurement approach beginning with its GPRA plan for FY 2005. We significantly reduced the number of measures tracked under GPRA, focused specifically on measures that were deemed most valuable in the Program Assessment Rating Tool (PART) process, and organized our performance indicators into the three broad measures of performance that were supported by OMB and HHS. The presentation for earlier years remains necessary to conclude reporting on performance related to earlier AoA GPRA plans.

The following tables present the performance measures and indicators that AoA has incorporated into its FY 2006 performance plan. As indicated previously, AoA, with guidance from HHS and OMB, utilizes three fundamental performance measures to assess program performance for all of its activities: 1) improve program efficiency, 2) improve client assessments and results, and 3) improve targeting to vulnerable elders. OMB now requires agencies to measure efficiency for all program activities, so AoA has developed and adopted such measures for its activities. AoA measures results from the perspective of the consumers who receive the services that we provide. We annually survey consumers across our programs to determine not only their satisfaction with services, but their assessment of the value and usefulness of the programs in helping them maintain their independence in the community. The targeting measures are important to AoA to ensure that States and communities are serving the elders who are most vulnerable and need services the most.

Measure 1: Improve Program Efficiency

Performance Goals	Targets	Actual Performance	Reference
Indicator 1.1: For Title III Services, increase the number of clients served per million dollars of AoA funding.	FY 07: Baseline + 15% FY 06: Baseline + 10% FY 05: Baseline + 8% FY 04: Baseline + 6% FY 03: Not applicable FY 02: Not applicable FY 01: New in FY 04	FY 07: 09/07 FY 06: 09/07 FY 05: 09/06 FY 04: 09/05 FY 03: 6,375 FY 02: 5,700 FY 01: 5,688 (baseline)	1 & 6
Indicator 1.2: For Title VII Services, increase the number of Ombudsman complaints resolved or partially resolved per million dollars of AoA funding.	FY 06: Baseline + 14% FY 05: Baseline + 4% FY 04: Baseline + 2% FY 03: New in FY 04	FY 06: 09/07 FY 05: 09/06 FY 04: 09/05 FY 03: 10,498 FY 02: 9,300 (baseline)	
Indicator 1.3: For Title VI Services, increase the number of units of service provided to Native Americans per thousand dollars of AoA funding.	FY 06: baseline + 6% FY 05: baseline + 4% FY 04: baseline + 2% FY 03: New in FY 04	FY 06: 09/07 FY 05: 09/06 FY 04: 09/05 FY 03: 206 FY 02: 230 (baseline)	
Indicator 1.4: For Senior Medicare Patrol activities, increase the number of beneficiaries trained per million dollars of AoA funding.	FY 06: baseline + 20% FY 05: baseline + 5% FY 04: baseline + 3% FY 03: New in FY 04	FY 06: 09/07 FY 05: 09/06 FY 04: 09/05 FY 03: 36,513 FY 02: 31,000 (baseline)	

Measure 1: Improve Program Efficiency

Program efficiency is a necessary and important measure of performance for AoA programs for two principal reasons. First, OMB recognizes the importance of efficient use of Federal funds by Federal agencies and the entities that administer Federal programs. Second, the OAA intended that Federal funds for these programs would help to generate capacity for these program activities at the State and local level. It is the expectation of the OAA that States and communities would increasingly improve their capacity to serve elderly individuals efficiently and effectively.

There are four efficiency indicators for AoA program activities as carried out under Titles III, VI and VII of the OAA, and for activities associated with Medicare fraud. The first addresses the efficiency of performance, including all levels of the aging services network, in providing community and home-based services, including caregiver services. The second addresses output efficiency for the Ombudsman program in the handling of complaints surrounding the care of seniors living in institutional settings. The third indicator addresses the efficiency of AoA in providing services to Native Americans. The fourth addresses the efficiency of the Medicare Senior Patrol program.

Performance Targets

In adopting the efficiency indicators, AoA observed that the aging network was already realizing success in improving efficiency for prior years. As a result of past performance and AoA's initiatives to improve integration and rebalance long-term care, AoA has set ambitious performance targets for its efficiency indicators. Recognizing AoA's commitment to aggressively improve program efficiency, OMB highlighted AoA's efficiency measures in the FY 2005 President's Budget. The following summarizes AoA's efficiency indicator targets.

- By FY 2006, for the nutrition, supportive services, caregiver and other program activities administered under Title III of the OAA, AoA will improve program efficiency by 10 percent over the FY 2001 target, which is double the annual improvement rate observed for FY 1999 to FY 2001. AoA projects an improvement of 15 percent by FY 2007, which is almost quadruple the current annual improvement.
- For Title VII services, AoA will increase the number of complaints resolved or partially resolved per million dollars of AoA funding from its baseline in FY 2002 of 9,300 to nearly 10,600 by FY 2006.
- For Title VI, AoA will increase the number of units of service provided to Native Americans from its baseline in FY 2002 of 230 units of service for each thousand dollars of AoA funding to 244 units of service per thousand dollars of AoA funding by FY 2006. This represents a 6 percent gain in efficiency over the baseline.
- For AoA's Senior Medicare Patrol activities, AoA's initiatives will provide increased training to beneficiaries such that the number of beneficiaries trained will increase from the baseline in FY 2002 of 31,000 people per million dollars of AoA funding to 37,200 people per million dollars of funding.

Linkage to Budget

AoA is not basing its performance improvements for the efficiency measures on increases in program budgets. For the most part, AoA and its program partners will use existing resources and focused management improvements to continue to improve the efficiency of its programs. The one exception to this rule is the ambitious target AoA has established for its Title III programs. The Assistant Secretary for Aging has initiated efforts to rebalance long-term care toward community care, and to improve the integration of home and community based service programs through demonstration grants to States and other entities. These efforts are intended to contribute significantly to the achievement of the efficiency improvements AoA has targeted for its Title III programs. AoA's performance targets, along with the agency's rebalancing and integration initiatives, reflect AoA's belief that improvements in the integration of services and more effective use of existing long-term care resources are the key factors that will improve efficiency in AoA programs.

Program Results

Although these measures are new to AoA, and there can therefore be no assessment of the extent to which we have achieved past efficiency performance targets, a review of data for prior years indicates that AoA and the Aging Network have consistently improved efficiency for Title III

from FY 1999 through FY 2003. The following summarizes the results for the Title III efficiency indicators:

- FY 2001: 5,688 clients per million dollars of AoA funding.
- FY 2002: 5,700 clients per million dollars of AoA funding.
- FY 2003: 6,259 clients per million dollars of AoA funding.

We believe that two factors affected the significant increase between FY 2002 and FY 2003: First, States reported that they served over 650,000 more elderly individuals in FY 2003 than in FY 2002. Also, the States reported serving over 140,000 more caregivers in FY 2003. With overall funding stable, these increases result in an efficiency increase of almost 9 percent. Although we expect continued growth in the number of caregivers served, we do not expect such increases in elderly clients each year.

There were similarly significant efficiency increases for the Ombudsman program and for the Senior Medicare Patrol program. Although we are surprised by the size of these improvements, there have been indicators of significant efficiency improvements for both. In a recent report to Congress about the Ombudsman program, AoA observed that productivity improvements from FY 1998 to FY 2001 seemed to indicate that residents long-term care facilities, their families, and facility managers seemed to be making greater use of ombudsman services. Similarly, the Senior Medicare Patrol program continues to expand its reach in training seniors, leading to significant efficiency improvements. The only AoA activity that saw a decline in efficiency was the Native American services activities. We believe that significant cost increases, especially the cost of fuel for transportation, can have a negative effect on an efficiency indicator such as this. Nevertheless, AoA will retain the improvement targets for this program. AoA plans to conduct a detailed evaluation of the program, which will address this among other significant issues for that program. AoA will continue to seek out the issues in this situation and, once that is done, to develop appropriate corrective actions.

Program Management

AoA uses the three types of performance measures to focus its efforts on continuous improvement in all its program activities. AoA makes extensive use of its discretionary funding to arrange for high-quality technical assistance to State and local program entities to support improvements that will yield measurable efficiency improvements across the network for all program activities. AoA has a number of support contracts and grants that specifically focus on helping network entities to better integrate funding for long-term care and long-term care service delivery specifically to yield the types of efficiency improvements the agency is measuring. AoA and the aging network are targeting integration efforts in order to eliminate duplication and to improve access to care for elderly individuals. For example, in the past two years, AoA in partnership with the Centers for Medicare and Medicaid Services has established Aging and Disability Resource Centers in 24 States, and will increase those numbers in future years. This initiative and others like it are focused on producing effective management improvements that will yield improved efficiency.

AoA also uses performance data to inform its program evaluation decisions. AoA has substantially increased its program evaluation activity over the past two years, partially in response to findings produced from GPRA performance measures. For example, in FY 2004 AoA initiated an evaluation of the Title III Home and Community-Based Supportive Services line item in part to identify the factors that are leading to reductions in service unit counts that AoA has observed in the GPRA process over the past two years.

Measure 2: Improve Client Assessments and Results

Performance Goals	Targets	Actual Performance	Reference
Indicator 2.1: Maintain high client satisfaction with home-delivered meals.	FY 06: 93% FY 05: 93% FY 04: Not in FY 04 plan FY 03: New in FY 05	FY 06: 02/07 FY 05: 02/06 FY 04: No Data FY 03: 93% (baseline)	
Indicator 2.2: Maintain high client satisfaction with transportation services.	FY 06: 82% FY 05: 82% FY 04: Not in FY 04 plan FY 03: New in FY 05	FY 06: 02/07 FY 05: 02/06 FY 04: 83% FY 03: 82% (baseline)	
Indicator 2.3: Maintain high client satisfaction among caregivers of elders.	FY 06: 87% FY 05: 87% FY 04: Not in FY 04 plan FY 03: New in FY 05	FY 06: 02/07 FY 05: 02/06 FY 04: 96% FY 03: 87% (baseline)	
Indicator 2.4: Maintain high client satisfaction with congregate meals.	FY 06: 93% FY 05: 93% FY 04: Not in FY 04 plan FY 03: New in FY 05	FY 06: 02/07 FY 05: 02/06 FY 04: 90% FY 03: 93%	
Indicator 2.5: Increase percent of caregivers who report that services <i>definitely</i> help them care longer for older individuals.	FY 07: 75% FY 06: 68% FY 05: 62% FY 04: Not in FY 04 plan FY 03: New in FY 05	FY 06: 02/07 FY 05: 02/06 FY 04: 52% FY 03: 48% (baseline)	
Indicator 2.6: Reduce the percent of caregivers who report difficulty in getting services.	FY 07: 35% FY 06: 43% FY 05: 50% FY 04: Not in FY 04 plan FY 03: New in FY 05	FY 06: 02/07 FY 05: 02/06 FY 04: 50% FY 03: 64% (baseline)	
Indicator 2.7: Improve the Ombudsman complaint resolution rates in 15 States over FY 2001.	FY 06: 15 FY 05: 10 FY 04: 7 FY 03: 5 FY 02: (New in 03)	FY 06: 02/08 FY 05: 02/07 FY 04: 02/06 FY 03: 24 FY 02: Not Applicable	
Indicator 2.8: Increase the percent of Medicare beneficiaries who will read their Medicare Summary Notices as a result of the Senior Medicare Patrol training by 20%.	FY 06: baseline + 20% FY 05: New in FY 04 FY 04: New in FY 04	FY 06: TBD FY 05: TBD FY 04: Developmental	

Measure 2: Improve Client Assessments and Results

The FY 2006 performance budget includes eight indicators supporting AoA's measure of client assessment and results. To AoA, these are the core performance outcome indicators for our

programs because they reflect program assessments obtained directly from the elderly individuals and caregivers who receive the services. AoA has multiple satisfaction indicators in this plan reflecting separate assessments provided by elderly individuals for services such as meals, transportation and homemaker help, and because OMB specifically required these measures in the FY 2005 PART assessment for AoA. As indicated above, OMB was very pleased with AoA's aggressive efficiency targets. However, concerned that an excessive focus on efficiency could reduce service quality and consumer satisfaction, OMB wanted AoA to include multiple satisfaction indicators in the AoA plan. AoA has also included indicators that directly assess AoA's most fundamental outcome (keeping elderly individuals at home and in the community) and measure results important to family caregivers. The results measures for Title VII (Ombudsman program) and for the Senior Medicare Patrol activities are also central to the core purposes of those activities. The outcome indicator for the Ombudsman program focuses on the successful resolution of complaints by residents of nursing homes and other institutions. The indicator for the Senior Medicare Patrol program focuses on increased scrutiny of Medicare bills by beneficiaries, which is the fundamental objective of the program. The consumer impact and results indicators included for FY 2006 are:

- Home-Delivered Meals Satisfaction: Maintain the high percentage of home-delivered meal clients reporting they like the meals.
- Transportation Satisfaction: Maintain the high percentage of transportation service recipients rating the service very good to excellent.
- Caregiver Satisfaction: Maintain the percent of caregivers rating case management services good to excellent.
- Congregate Meals Satisfaction: Maintain the percentage of congregate meal clients reporting they like the way the food tastes.
- Caregiver Impact Assessment: Increase the percentage of caregivers reporting that services have "definitely" helped them provide care for a longer period.
- Caregiver Difficulty Reduction: Decrease the number of caregivers reporting difficulties in dealing with agencies to obtain services.
- Improve Ombudsman Complaint Resolution: For 15 States, increase the percentage of complaints that are resolved over the number that were resolved in FY 2001.
- Increase Scrutiny of Medicare Notices: Increase by 20 percent the percentage of Medicare beneficiaries who review Medicare Summary Notices for accuracy as a direct result of the training provided by the Senior Medicare Patrol program.

Performance Targets

AoA has committed to maintain the high satisfaction rates established for its core programs and to achieve ambitious improvements in its other assessment and results measures. Because the satisfaction measures are so high, and because they are based on sample surveys, which are not

conducive to measuring annual changes, AoA is committed to maintaining the high levels of satisfaction observed. The target to maintain these high levels of performance is aggressive when taken in the context of the AoA commitment to aggressively improve program efficiency in the near and long term. It is essential that AoA maintain a high level of satisfaction with services even as the aging services network increases the number of elderly individuals served per million dollars of AoA funding. The performance targets related to caregiver assessments presented above are particularly aggressive. One indicator calls for a 14 percent increase in two years in the percent of caregivers who report that OAA services “definitely” help them care longer for the elderly they serve. The second caregiver indicator calls for a 14 percent reduction over the same time period in the percent of caregivers who report difficulty in getting services. To AoA, aggressive targeting for these indicators is critical because they represent more directly than any others the mission of AoA and the network to help vulnerable elderly individuals remain in the community.

Linkage to Budget

The consumer assessment and results measure and indicators were a significant element in AoA’s rebalancing and integration initiatives, and they complement the efficiency and targeting measures that also support the budget. The success of AoA’s initiatives in improving program efficiency must be balanced by the ability of the aging services network to maintain the current high level of satisfaction with services and improvements in results reported by consumers. Similarly, success in improving consumer results must be balanced by the critical need to ensure that the programs are reaching the most vulnerable elderly individuals. The AoA indicator to increase home-delivered meals clients who are nursing-home eligible is a fundamental and necessary outcome for the budget activity that supports the initiative to create more balance in the national long-term care service delivery system. AoA’s caregiver funding, along with AoA’s integration and evidence-based health promotion activities, will support the AoA performance target to reduce the percentage of caregivers who have difficulty with the system and will also support the goal to increase the percentage of caregivers who report that OAA services help them care longer for elderly individuals.

Program Results

The client assessment and results indicators presented in this measure are new, and so there can be no assessment of the extent to which we have achieved past efficiency performance targets. In addition, because the data sources did not exist in previous years, we can make no observations about results using these indicators for previous years. The only indicator for which we can make observations is the Ombudsman indicator for resolving complaints. Under the Ombudsman program the aging network has realized a very significant increase in the resolution of complaints. From FY 1998 to FY 2002 Ombudsmen increased their resolution rate from 71 percent of all complaints to 78 percent of all complaints. Recognizing that such a high rate was not consistent across the States, AoA has chosen to focus this indicator on improving performance in a significant number of States each year.

Program Management

AoA uses the three types of performance measures to focus its efforts on continuous improvement in all its program activities. AoA makes extensive use of its discretionary funding to arrange for high-quality technical assistance to State and local program entities to support

improvements that will yield measurable efficiency improvements across the network for all program activities. AoA has a number of support contracts and grants that specifically focus on helping network entities to better integrate funding for long-term care and long-term care service delivery specifically to yield the types of efficiency improvements the agency is measuring. AoA and the aging network are targeting integration efforts in order to eliminate duplication and to improve access to care for elderly individuals. For example, in the past two years, AoA in partnership with the Centers for Medicare and Medicaid Services has established Aging and Disability Resource Centers in 24 States, and will increase those numbers in future years. This initiative and others like it are focused on producing effective management improvements that will yield improved efficiency.

AoA also uses performance data to inform its program evaluation decisions. AoA has substantially increased its program evaluation activity over the past two years, partially in response to findings produced from GPRA performance measures. For example, in FY 2004 AoA initiated an evaluation of the Title III Home and Community-Based Supportive Services line item in part to identify the factors that are leading to reductions in service unit counts that AoA has observed in the GPRA process over the past two years.

Measure 3: Improve Targeting to Vulnerable Elders

Performance Goals	Targets	Actual Performance	Reference
Indicator 3.1: Increase the number of caregivers served to 900,000 by FY 2006.	FY 07: 1,000,000 FY 06: 900,000 FY 05: 800,000 FY 04: 500,000 FY 03: 250,000 FY 02: New in FY 03	FY 05: 02/07 FY 04: 02/06 FY 03: 585,000 FY 02: 439,000	
Indicator 3.2: Increase the number of severely disabled clients who receive selected home and community-based services by 8% over the FY 2003 base.	FY 07: Base + 25% FY 06: Base + 15% FY 05: Base + 8% FY 04: New in FY 04	FY 06: 02/08 FY 05: 02/07 FY 04: 02/06 FY 03: 280,454 (baseline)	
Indicator 3.3: Increase the percentage of OAA clients served who live in rural areas to 10% greater than the percent of all US elders who live in rural areas.	FY 06: Census + 10% FY 05: New in FY 04	FY 06: 09/07 FY 05: 09/06 FY 04: 09/05 FY 03: Census +5% FY 02: Census +5%	
Indicator 3.4: Increase the number of states that increase the percentage of clients served who are poor.	FY 07: 20 States FY 06: 17 States FY 05: 15 States FY 04: 12 States FY 03: 5 States	FY 06: 09/07 FY 05: 09/06 FY 04: 09/05 FY 03: 18 FY 02: New in FY 03	

Measure 3: Improve Targeting to Vulnerable Elders

The first two measures that AoA uses for program assessment focus on the efficient production of high quality results as assessed by program clients. The targeting measure and the indicators associated with it are equally important because they ensure that AoA and the aging network focus services on the most needy. In an effort to improve efficiency and quality, entities could attempt to focus their efforts toward individuals who are not the most vulnerable. This would be inconsistent with the intent of the OAA, which specifically requires the network to target services to the most vulnerable. It also would be inconsistent with the mission of AoA, which is to help vulnerable elderly individuals to maintain their independence in the community. To help these senior remain independent, AoA and the aging network must focus their efforts on those who are at most risk of institutionalization: the disabled, poor, and rural residents. The FY 2006 performance budget includes four critical targeting indicators for AoA, covering the vulnerable client groups addressed above and family caregivers. The caregiver program is still in its early stages of implementation, so the targeting indicator utilized here focuses on rapidly increasing the number of caregivers served in the early years of implementation.

Performance Targets

As it has with its other measures, AoA has established ambitious performance targets for the indicators under this measure. The targets for disabled elders and for caregivers are particularly aggressive because of the importance of these two groups to the success of AoA's mission.

- By FY 2006, AoA proposes to increase the number of severely disabled OAA clients we serve by 15 percent. This is one of AoA's most critical indicators because it reflects our commitment to demonstrate the capacity of the network to serve individuals who are effectively eligible to reside in nursing homes.
- In the early stages of implementation of the caregiver program it is essential that the network reach out to caregivers. As a result, AoA has established aggressive targets to serve 900,000 caregivers by FY 2006, which is more than 100 percent higher than the FY 2002 baseline for caregivers served.
- AoA's pursuit of a significant increase in the percentage of elderly clients who reside in rural areas is also an aggressive but important objective. In FY 2002, the percentage of OAA clients who lived in rural areas was 6 percent higher than the percentage of all elders living in rural areas. By FY 2006, AoA seeks to increase that percentage to 10 percent.
- The FY 2006 target is aggressive for the poverty indicator because it not only commits to improve performance in over 25 percent of all States over a short period of time, but it also commits to a significant 10 percent improvement in each of those States in that same time period.

Linkage to Budget

In the past few years, the observed success of the aging services network in targeting services to vulnerable elderly individuals has served as an impetus for AoA to pursue initiatives that will expand national use of the services of the network to improve the lives of elderly individuals across the nation. AoA's initiatives to integrate services and funding, to rebalance long-term care, and to increase the use of evidence-based health promotion activities will help state and community programs to focus resources toward difficult to serve populations. The initiatives address directly the intent of AoA and the network to increasingly target community-based services toward those who are most at risk of institutionalization, which includes the poor, those in rural areas, and other vulnerable elders.

Program Results

The aging services network has already demonstrated success in targeting services to poor individuals and those who live in rural areas. In each of the recent reporting years, approximately 28 percent of OAA clients are poor, while just over 10 percent of all elderly individuals are poor. While the percent of clients who live in rural areas appears to have declined in recent years, the 27 percent of OAA clients who live in rural areas is significantly higher than the 2000 Census estimate, which indicates that over 22 percent of all elderly individuals reside in rural areas. Despite the success, AoA believes that continued focusing on and improvement in targeting to vulnerable elders is basic to the mission of the agency and the intent of the OAA. The targeting indicators also reflect different aspects of performance monitoring that is important for the aging services network. The rural indicator focuses on improvement at the national level, while the

“poverty” indicator focuses in on the pursuit of improvements among the State agencies that administer the program.

Program Management

AoA uses the three types of performance measures to focus its efforts on continuous improvement in all its program activities. AoA makes extensive use of its discretionary funding to arrange for high-quality technical assistance to State and local program entities to support improvements that will yield measurable efficiency improvements across the network for all program activities. AoA has a number of support contracts and grants that specifically focus on helping network entities to better integrate funding for long-term care and long-term care service delivery specifically to yield the types of efficiency improvements the agency is measuring. AoA and the aging network are targeting integration efforts in order to eliminate duplication and to improve access to care for elderly individuals. For example, in the past two years, AoA in partnership with the Centers for Medicare and Medicaid Services has established Aging and Disability Resource Centers in 24 States, and will increase those numbers in future years. This initiative and others like it are focused on producing effective management improvements that will yield improved efficiency.

AoA also uses performance data to inform its program evaluation decisions. AoA has substantially increased its program evaluation activity over the past two years, partially in response to findings produced from GPRA performance measures. For example, in FY 2004 AoA initiated an evaluation of the Title III Home and Community-Based Supportive Services line item in part to identify the factors that are leading to reductions in service unit counts that AoA has observed in the GPRA process over the past two years.

Performance Analysis Detail: Measures For Prior Years Summary

The following tables and analytical presentation reflect a significant change to AoA's GPRA performance plan and report. Because of the necessary reduction in the number of performance measures in the AoA and HHS plans, there is little comparability between the FY 2006 plan and previous plans. Attempting to analyze the FY 2006 plan alongside the previous plans would cause tremendous confusion. As a result, AoA has opted to present separately the performance results for GPRA plans for previous fiscal years. For the sake of efficiency in presentation, AoA will not reiterate the rationale for the measures and targets which were included in those plans, but will focus the analysis on the extent to which performance goals and measures were achieved and how performance for those measures affected AoA initiatives. It should be noted that AoA will continue to internally track performance for many of the measures included in prior year plans, and may propose to include some of these measures as indicators of performance in future GPRA plans as appropriate. The following table presents measures that were included in previous GPRA plans, but are not included in the FY 2006 plan.

Community-Based Services Programs: Prior Year Measures

Performance Goals	Targets	Actual Performance	Reference
A significant percentage of OAA Title III service recipients are poor. [outcome measure] <u>Norm:</u> Percent of U.S. elderly population who are poor in 2000: 10.2%	FY 04: 32% FY 03: 32% FY 02: 25% FY 01: 25% FY 00: (New in FY 01)	FY 04: 02/06 FY 03: 28.2% FY 02: 28.1% FY 01: 29.3% FY 00: 30.3% FY 99: 31.7% FY 98: 36.2%	6
A significant percentage of OAA Title III service recipients live in rural areas. [outcome measure]	FY 04: 34% FY 03: 34% FY 02: 25% FY 01: 25% FY 00: (New in 01)	FY 04: 02/06 FY 03: 27.8% FY 02: 27.7% FY 01: 30.4% FY 00: 32.9% FY 99: 33.6% FY 98: 33.5%	6
Increase rural participation in States. [outcome measure]	FY 04: 9 States FY 03: 5 States FY 02: (New in FY 03)	FY 04: 02/06 FY 03: 18 FY 02: Not Available	6
Increase the ratio of family caregivers to registered clients.	FY 04: 1.5 to 10 FY 03: 1.0 to 10 FY 02: (New in FY 03)	FY 04: 02/06 FY 03: 1.8 to 10 FY 02: 1.4 to 10 (baseline)	6
A significant percentage of OAA Title III service recipients are minorities. [outcome measure] <u>Norm:</u> Percent of U.S. elderly population who are minorities in 2000: 16.3%	FY 04: 20% FY 03: 19% FY 02: 17% FY 01: 17% FY 00: (New in FY 01)	FY 04: 02/06 FY 03: 22.7% FY 02: 20.5% FY 01: 18.8% FY 00: 19.1% FY 99: 19.3% FY 98: 19.6%	6
Increase participation by disabled elderly in States. [outcome measure]	FY 04: 9 States FY 03: 5 States FY 02: (New in FY 03)	FY 04: 20 FY 03: 23 States FY 02: 9 States	6
Increase participation by senior elders in States. [outcome measure]	FY 04: 9 States FY 03: 5 States FY02: (New in FY 03)	FY 04: 02/06 FY 03: 22 FY 02: Not Available	6
Increase the ratio of leveraged funds to AoA funds. [outcome and efficiency measure]	FY 04: \$2.20 to \$1.00 FY 03: \$1.90 to \$1.00 FY 02: \$1.50 to \$1.00 FY 01: \$1.50 to \$1.00 FY 00: (New in FY 01)	FY 04: 02/06 FY 03: \$1.90 to \$1.00 FY 02: \$1.92 to \$1.00 FY 01: \$2.10 to \$1.00 FY 00: \$1.90 to \$1.00 FY 99: \$1.90 to \$1.00 FY 98: \$1.90 to \$1.00	6

Performance Goals	Targets	Actual Performance	Reference
Increase leveraged funding ratios for States. [outcome measure]	FY 04: 8 States FY 03: 5 States FY 02: (New in FY 03)	FY 04: 02/06 FY 03: 26 FY 02: 22	6
A high percentage of funding for Personal Care, Home-Delivered Meals, and Adult Day Care will come from leveraged funds. [outcome measure]	FY 04: 76% FY 03: 74% FY 02: 70% FY 01: 70% FY 00 (New in FY 01)	FY04: 02/06 FY03: 71.0% FY 02: 73.0% FY 01: 74.5% FY 00: 74% FY 99: 75% FY 98: 75%	6
Maintain a high ratio of network program income to AoA funding.[outcome measure]	FY 03: \$.35 to \$1.00 FY 02: \$.30 to \$1.00 FY 01: \$.30 to \$1.00 FY 00: (New in FY 01)	FY 03: \$.38 to \$1.00 FY 02: \$.44 to \$1.00 FY 01: \$.37 to \$1.00 FY 00: \$.35 to \$1.00 FY 99: \$.35 to \$1.00 FY 98: \$.37 to \$1.00	6
Increase program income ratios for States. [outcome measure]	FY 04: 5 States FY 03: 5 States FY 02: (New in FY 03)	FY 04: 02/06 FY 03: 18 FY 02: 20	6
Maintain high percentage of senior centers that are community focal points.	FY 04: 62% FY 03: 60% FY 02: 50% FY 01: 50% FY 00: (New in FY 01)	FY 04: 02/06 FY 03: 74.0% FY 02: 63.0% FY 01: 58.1% FY 00: 61.2% FY 99: 59.5%	6
Maintain high percentage of volunteer staff among area agencies on aging.	FY 03: 46% FY 02: 40% FY 01: 40% FY 00: (New in FY 01)	FY 03: 45.0% FY 02: 45.5% FY 01: 41.8% FY 00: 44.1% FY 99: 45.9% FY 98: 43.8%	6
Increase volunteer staff participation for State Agencies.	FY 04: 5 States FY 03: (New in FY 04)	FY 04: 02/06 FY 03: 11 States	
Increase the number of State agencies on aging that provide caregiver services in all five service categories.	FY 04: 10 States FY 03: 10 States FY 02: (New in FY 03)	FY 04: 02/06 FY 03: 45 States FY 02: 46 States	

Performance Goals	Targets	Actual Performance	Reference
Increase the number of home-delivered meals provided.	FY 04: 183.0 FY 03: 183.0 FY 02: 183.0 FY 01: 179.0 FY 00: 155.0 FY 99: 119.0	FY 04: 02/06 FY 03: 142.0 FY 02: 142.0 FY 01: 143.8 FY 00: 143.4 FY 99: 134.6 FY 98: 129.7	
Maintain the number of congregate meals provided.	FY 04: 115.2 FY 03: 115.2 FY 02: 115.2 FY 01: 115.2 FY 00: 113.1 FY 99: 123.4	FY 04: 02/06 FY 03: 105.8 FY 02: 108.3 FY 01: 112.2 FY 00: 115.8 FY 99: 112.8 FY 98: 114.1	
Maintain the number of Transportation units of service provided.	FY 04: 50.7 FY 03: 50.7 FY 02: 50.7 FY 01: 50.7 FY 00: 46.6 FY 99: 39.5	FY 04: 02/06 FY 03: 36.0 FY 02: 37.1 FY 01: 39.4 FY 00: 42.8 FY 99: 45.8	
Maintain the number of Information and Assistance units of service provided.	FY 04: 15.2 FY 03: 15.2 FY 02: 15.2 FY 01: 15.2 FY 00: 14.0 FY 99: 12.5	FY 04: 02/06 FY 03: 12.6 FY 02: 12.3 FY 01: 13.1 FY 00: 13.4 FY 99: 12.2	
Reduce time-lag (in months) for making NAPIS data available for GPRA purposes and for publication. [outcome and efficiency measure]	FY 09: 6 months FY 05: 12 months FY 04: 13 months FY 03: 15 months FY 02: 15 months FY 01: 15 months FY 00: (New in FY 01)	FY 03: 13 months FY 02: 15 months FY 01: 15 months FY 00: 19 months FY 99: 22 months FY 98: 26 months	

In previous years, AoA presented measures for the Community-Based Services program according to three categories: intermediate outcome targeting measures, intermediate outcome system measures, and service output measures. The analysis that follows maintains references to those categories to allow for the conduct of analysis in the same context in which the measures were originally presented in the plans for FY 2004 and prior years. This form of analysis will be maintained until GPRA requirements for the reporting of program results are met for all fiscal years prior to FY 2005.

In those plans, AoA established expectations for performance for the various categories of measures.

- Intermediate Outcome Targeting Measures: Does the network target services to vulnerable elderly individuals and have there been improvements in the delivery of these services?
- Intermediate Outcome System Measures: What do the State and local components of the network contribute to the elderly in the way of resources, coordination, and emphasis on the most vulnerable?
- Service Output Measures: What level of services will the network provide to elderly individuals each year for meals, transportation, and other services?

Performance Measures Analysis – Intermediate Outcome Targeting Measures:

In previous plans, AoA identified a set of targeting measures to track the effectiveness of the network in meeting the intent of the OAA to serve vulnerable elderly individuals, and to target measurable improvements where appropriate.

If AoA is to demonstrate that the network is targeting services to vulnerable individuals, then data should show that the percentage of clients who are poor, disabled, minorities and those in rural areas, is higher than the percentage of all elderly persons in the total population who fit these characteristics.

Results for Intermediate Outcome Targeting Measures:

For AoA targeting measures, the tables above indicate that the aging services network effectively targets services to the vulnerable elderly individuals in the Nation.

- Poverty Targeting Measures: Whereas 10 percent of all elderly over 60 years old were poor, approximately 30 percent of aging services network clients were poor for all years reported.
- Minority Targeting Measure: The percent of OAA clients who were minorities (22.7 percent in FY 2003) remains significantly higher than the total percent of all elderly minority individuals (19 percent).
- Disability Targeting Measure: National sample survey data show 79 percent of clients receiving home delivered meals have limitations in Activities of Daily Living (ADLs) and 86 percent of clients receiving homemaker services have limitations in ADLs. This data indicates that states, as a whole, are successfully targeting services to disabled elderly individuals.
- Senior Elders Targeting Measure: Data on age categories for 42 States show that a high percentage of clients (over 60 percent) receiving registered services are aged seventy-five and above. This data indicates that States as a whole are successfully targeting registered services to elderly individuals aged seventy-five and above.

- Caregiver Targeting Measure: The caregiver program was implemented in FY 2001. States served significantly more caregivers in FY 2003 (585,000) than AoA had anticipated (250,000), so the ratio of caregivers served to elderly clients is also higher than anticipated. State agencies served 1.8 caregivers for every 10 elderly individuals served in FY 2003.

Performance Measures Analysis – Intermediate Outcome Efficiency/System Measures

Intermediate Outcome System measures data should show that: (1) there is a significant contribution above and beyond funding provided by AoA; (2) there is a strong degree of coordination of services provided through the network; and 3) the network is efficient.

Results for Intermediate Outcome Systems Measures

The data reported above for AoA’s intermediate outcome system measures demonstrate the following:

1. The funds “leveraged” by the aging services network are significant in total, almost doubling AoA funds for all years reported.
 2. The leveraged funds substantially exceed the funding provided by AoA for home and community-based services to the elderly, particularly the disabled who required in-home services and adult day care.
 3. The network does not rely solely on funds provided by other sources, but every year generates a significant amount of revenue, which is put back into the program for services.
 4. The network is characterized by a strong community orientation, in which senior centers are not only places where elderly individuals receive services, but are places where services for the elderly are organized and coordinated.
 5. The network is committed to local solutions and resources in support of the elderly, as reflected in data that show that more than 40 percent of area agency staff are volunteers.
- Leveraged Funding Measures: For all years reported, FY 1997 through FY 2003:
 - ▶ Funds leveraged by State and local agencies exceeded funds provided by AoA by almost 100 percent; and
 - ▶ Over 70 percent of the funding that supported personal care, home-delivered meals, and adult day care combined, came from sources other than AoA.
 - Program Income Measure: Data for all five fiscal years indicate that revenue generated by the aging services network (e.g., voluntary contributions for meals) is a significant funding source, representing in over one-third of the amount provided by AoA each year.
 - Senior Center Focal Point Measure: Each year, over half of all senior centers participating in the program were community-service “focal points,”.

- Area Agency Volunteer Measure: The percentage of the staff of area agencies on aging that is made up of volunteers was between 40 and 50 percent in all FYs 1997 through 2003.
- Caregiver Measure: For the National Family Caregiver Support Program, our initial objective for the “system” has been to develop a well-rounded program that serves the various needs of caregivers as envisioned by the OAA. Performance by State agencies in providing services across all five caregiver service categories was significantly beyond AoA’s expectations as 46 State units reported meeting that objective in FY 2003.

Performance Measures Analysis – Service Output Measures

The service output measures in former plans were used to track the level of services that AoA and the other components of the network provide.

Service output data should show that over time performance outputs are consistent with the level of resources provided by AoA and the anticipated level of resources provided by other network sources through the States.

Results for Service Output Measures

The data on outputs for FY 2003 appear to indicate that costs for services may be rising at higher rates than anticipated, and that the fiscal difficulties confronted by States may have affected program outputs in FY 2003. The units of service provided in FY 2003 are somewhat lower than the units provided in FY 2002 for the categories of service tracked in earlier GPRA plans, including: home-delivered meals, congregate meals, transportation services, and information and assistance services. The number of home-delivered meals provided remains high compared to levels provided only a few years ago, but it is lower than the number reported for FY 2002. The service levels for home-delivered meals and other services were not as great as AoA had projected in its performance targets.

- Home Delivered Meals Output Measures: The data reflects a decrease in the number of home-delivered meals provided in FY 2003. We did not meet the higher targeted result, which we believe reflects three factors: 1) the difficulty of accurately targeting the number of meals that will be served in a given fiscal year, 2) cost increases (particularly fuel costs) associated with delivering the meals, and 3) fiscal difficulties encountered by State units on aging.
- Congregate Meals Output Measure: FY 2003 data indicates that the network did not meet its target for congregate meals, and that the number of congregate meals served declined further.
- Transportation Output Measure: The level of output performance for transportation service did not meet the FY 2002 target and declined for the fourth consecutive year.
- Information and Assistance Output Measures: The level of output performance for information and assistance also did not meet the FY 2003 target.

Vulnerable Older Americans: Prior Year Measures

Performance Goals	Targets	Actual Performance	Reference
Maintain a high combined resolution / partial resolution rate for complaints in nursing homes.	FY 04: 75% FY 03: 74% FY 02: 70% FY 01: 70% FY 00: 70% FY 99: 71.48%	FY 04: 02/06 FY 03: 76.0% FY 02: 77.0% FY 01: 76.7% FY 00: 74.1% FY 99: 74.3% FY 98: 70.6%	6
Improve combined resolution/ partial resolution rate for primary aging services network States (States and Territories).	FY 05: 10 States FY 04: 7 States FY 03: 5 States FY 02: (New in 03)	FY 05: 02/07 FY 04: 02/06 FY 03: 02/05 FY 02: Not applicable	

Performance Measures Analysis – Ombudsman Measures

For each of the years included in the table above, the network has achieved a high combined resolution/partial resolution rate in excess of 70 percent. For FY 2001 through FY 2003, the rate has risen to over 75 percent.

Native Americans Program: Prior Year Measures

Performance Goals	Targets	Actual Performance	Reference
Initially increase and then maintain units of service in the following categories:	(numbers in thousands)	(numbers in thousands)	
Home-delivered Meals	FY 04: 2,000 FY 03: 1,850 FY 02: 1,850 FY 01: 1,795 FY 00: 1,632 FY 99: 1,456	FY 04: 02/06 FY 03: 1,741 FY 02: 1,667 FY 01: 1,966 FY 00: 1,778 FY 99: 1,680	6
Congregate Meals	FY 04: 1,650 FY 03: 1,650 FY 02: 1,650 FY 01: 1,583 FY 00: 1,439 FY 99: 1,322	FY 04: 02/06 FY 03: 1,250 FY 02: 1,305 FY 01: 1,440 FY 00: 1,348 FY 99: 1,290	
Transportation Service Units	FY 04: 740 FY 03: 732 FY 02: 732 FY 01: 732 FY 00: 665 FY 99: 763	FY 04: 02/06 FY 03: 631 FY 02: 715 FY 01: 735 FY 00: 699 FY 99: 702	6
Information & Referral Service Units	FY 04: 747 FY 03: 747 FY 02: 747 FY 01: 747 FY 00: 679 FY 99: 632	FY 04: 02/06 FY 03: 525 FY 02: 699 FY 01: 659 FY 00: 651 FY 99: 633	
In-home Service Units	FY 03: 970 FY 02: 953 FY 01: 953 FY 00: 866 FY 99: 742	FY 03: 736 FY 02: 833 FY 01: 961 FY 00: 929 FY 99: 942 FY 98: 1,032	
Other Services	FY 03: 660 FY 02: 650 FY 01: 650 FY 00: 591 FY 99: 512	FY 03: NA FY 02: 776 FY 01: 776 FY 00: 682 FY 99: 702	

Performance Measures Analysis – Native American Measures

In analyzing program performance related to performance plans for earlier years, the FY 2003 data for the Native American program, the most recent available for this program, indicate that performance targets for most services were not reached. Across the board, units of service showed

relatively larger declines in the most recent three years , except for Information and Referral, which rose in FY 2002 and then fell in FY 2003; however, looking at all five years, the data for this program indicate that service provision overall remains fairly stable despite the decline.

In summarizing past performance for measures included in AoA plans for this program in years prior to FY 2005, the following can be said for all six measures: AoA met or exceeded the performance targets set for FY 1999, FY 2000 and FY 2001, in that the program initially increased and then maintained the higher levels of service units for each of the services measured. In FY 2002, however, AoA noted a slight shortfall in each of the reported measures, which raised some concern. Suspecting problems with data collection and other factors that would affect all six services, AoA has initiated a more detailed evaluation of the program and its support systems. At this time, this detailed evaluation is ongoing and we have not definitively discovered the reason or reasons that would have caused the continued decline in the reporting of program performance – both relative to the targets and relative to the prior year performance. AoA will continue to seek out the issues in this situation and, once that is done, to develop appropriate corrective actions.

Senior Medicare Patrols: Prior Year Measures

Performance Goals	Targets	Actual Performance	Reference
Increase the number of trainers who educate beneficiaries.	FY 03: 56,800 FY 02: 54,800 FY 01: 41,100 FY 00: 17,125 FY 99: (new in 2000)	FY 03: 64,607 FY 02: 57,061 FY 01: 48,076 FY 00: 39,300 FY 99: 13,700 (baseline) (a)	
Increase the number of beneficiaries who are educated by the volunteer trainers.	FY 04: 1,200,000 FY 03: 600,000 FY 02: 500,000 FY 01: (new in 2002)	FY 04: 1,813,608 FY 03: 1,417,694 FY 02: 955,000 FY 01: 570,000 FY 00: 350,000 (baseline) (b)	
Increase the number of substantiated complaints generated through AoA's activities (i.e. complaint results in some action taken).[outcome measure]	FY 04: 3,000 FY 03: 2,500 FY 02: 380 FY 01: 280 FY 00: 200 FY 99: (new in 2000)	FY 04: 40,747 FY 03: 17,329 FY 02: 2,708 FY 01: 2,190 FY 00: 1,241 FY 99: 133 (baseline) (c)	6

Numbers for training targets and results, are "cumulative" since inception of the projects – including projects funded under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

- (a) The cumulative total includes volunteers who were trained under HIPAA. This effort was succeeded by the Senior Medicare Patrol projects authorized by the Omnibus Consolidated Appropriations Act of 1997 (P. L. 104-209).
- (b) Cumulative including beneficiaries educated under the authority of HIPAA.
- (c) Baseline total is cumulative including complaints substantiated under HIPAA.
- (d) Preliminary data through June 2003, final for the fiscal year available April 2005.

Performance Measures Analysis – Senior Medicare Patrol Measures

To demonstrate that the network is educating older Americans to take an active role in their health care and protect the integrity of Medicare and Medicaid services, the data should show an increase in the number of trainers who educate beneficiaries, an increase in the number of beneficiaries educated by volunteer trainers, and an increase in the number of complaints that have been reported and acted upon as a result of the AoA programs.

For the measures presented in the table above, the data indicates that the aging services network effectively educates and informs older Americans on how to take an active role in their health care and maintain the integrity of the Medicare and Medicaid systems.

- Volunteers Trained Measure: This measure is directed at increasing the number of volunteers trained by AoA's grantees, who in turn educate an increasing number of beneficiaries on how to take an active role in protecting their health care. In FY 1999, the Senior Medicare Patrol Projects were just beginning to develop their training activities and materials. However, by

the end of FY 1999 the project had trained 13,700 (on a cumulative basis) community volunteers under the HIPAA and Senior Medicare Patrol projects. During FY 2000 and beyond, materials and effective training strategies were more widely utilized by the grantees, which meant that we trained over 57,000 by FY 2002, one year earlier than planned, and by FY 2003, that figure had reached nearly 65,000. We do not anticipate that the grantees will continue to train as many new volunteers during future years, however, the progress toward the ultimate goal of educating beneficiaries will build on the large pool of experienced volunteers who will continue to conduct sessions during those years. Also, because AoA wanted to focus on trained beneficiaries and their results, this measure was discontinued in the FY 2004 plan.

- Beneficiaries Educated Measure: This measure is directed toward increasing the number of beneficiaries who are educated by the volunteer trainers. This measure was new in FY 2002. It is the beneficiaries, who have to learn to detect possible fraud, waste and abuse in the Medicare payments. AoA substantially exceeded its FY 2002 target. The “trainers” trained over 950,000 beneficiaries for both HIPAA and the Senior Medicare Patrol projects and by FY 2004, that figure is approaching 2 million and 600,000 beyond our goal of 1,200,000.
- Inquiries Submitted and Acted Upon Measure: This measure consists of the number of inquiries submitted by AoA’s projects and volunteers to health care providers, the Centers for Medicare and Medicaid Services, the Office of Inspector General, and other appropriate sources that result in some action being taken. In FY 1999, this system of reporting was just beginning to be developed and AoA’s projects started with a baseline of 133 cases (for both the HIPAA and Senior Medicare Patrol projects) that resulted in some sort of corrective action being taken. In FY 2004, actual performance indicates that the complaints generated through AoA’s activities for which some action was taken exceeded the projected target: more than 40,747 substantiated cases were generated.

Program Management: Prior Year Measures

Performance Goals	Targets	Actual Performance	Reference
A high percentage of AoA hires will be based on a formal AoA Workforce Plan.	FY 03: 80% FY 02: 80% FY 01: (New in FY 02)	FY 03: 100% FY 02: 100%	
Increase the ratio of employees to supervisors.	FY 04: 5.0 to 1 FY 03: 5.0 to 1 FY 02: (New in FY 03)	FY 04: 5.5 to 1 FY 03: 5.7 to 1 FY 02: 5.2 to 1 FY 01: 4.3 to 1	
Decrease the average grade of AoA career employees.	FY 04: 12.2 FY 03: 13.0 FY 02: (New in FY 03)	FY 04: 12.5 FY 03: 12.3 FY 02: 12.3 FY 01: 13.5	
Increase the percentage of procurement dollars that are subjected to performance-based contracts.	FY 04: 20% FY 03: 20% FY 02: 20% FY 01: (New in FY 02)	FY 04: 15% FY 03: 10% FY 02: 5% FY 01: 0% (baseline)	
Increase the percentage of discretionary grant applications that are submitted and processed electronically, including via the Internet.	FY 04: +5% FY 03: 10% FY 02: (New in FY 03)	FY 04: NA FY 03: 12% FY 02: 10% FY 01: 0% (baseline)	
AoA will have no material weaknesses identified in the Departmental top-down audit.	FY 04: No weaknesses FY 03: No weaknesses FY 02: (New in FY 03)	FY 04: No weaknesses FY 03: No weaknesses	

Performance Measures Analysis – Program Management Measures

Financial Management Measures:

AoA received a clean opinion on the audit of its FY 2000 financial statements (balance sheet), and its complete FY 2001 financial statements. To improve the efficiency of financial audit processes and because the overwhelming majority of AoA financial management activity is performed at the Department level, HHS made the determination that it would not conduct separate audits of AoA accounts starting in FY 2003, but would include AoA in “top-down” HHS audits. As a result, independent financial audit opinions on AoA financial statements are no longer rendered, and as a result the clean opinion measure is no longer included in the measures tracked by AoA. However, maintaining its commitment to high quality financial management activity where AoA is directly involved, AoA adopted a new performance measure that the agency will have no material weaknesses cited in the HHS audit for AoA financial management activity. In both the FY 2003 and FY 2004 HHS audits, no material weaknesses were identified for AoA financial management activity.

Strategic Management of Human Capital Measures:

An extensive AoA review of workforce and structural conditions found that improvements were necessary and achievable in: 1) “de-layering” the organization, 2) grade structure, and 3) skill mix. To track its accountability for implementing improvements, AoA included three performance measures related to workforce planning and restructuring in its FY 2003 and FY 2004 GPRA performance plans. In FY 2002, one year ahead of the plan, AoA met its FY 2003 targets and continued to make dramatic progress towards these goals by increasing the employee to supervisor ratio for the agency, and by achieving a measurable reduction in the average grade of employees.

Although ahead of our established goals for all of these measures, by FY 2005, AoA expects that at least for one measure, the average grade of career employees, we may begin to experience a slight reversal, which is expected to continue over the next two years. This is due to the expected attrition of retirement age career staff and the need to replace them with journeymen-level professionals in order to be able to continue to function at our current level of service as we carry out the important work on behalf of older Americans.

A minor note, but nevertheless a positive one has been that in each year since the establishment of the Workforce Plan measure, 100 percent of all new hires have been based on a formal AoA Workforce Plan. In addition, our efforts at de-layering have been fruitful as well: the ratio of employees to supervisors has increased from 4.3 to 1 in FY 2001 and 5.2 to 1 in FY 2002 to 5.7 to 1 in FY 2003. Because so many of AoA’s staff is made up of contract employees rather than civil servants, however, the ratio tends to understate the effective outcome and if total workforce were to include contractors, the ratio of employees to supervisors would be 6.9 to 1 due to federal employees supervising contractor staff.

AoA will continue to seek to maintain these significant improvements and in the interest of reducing the number of measures in the AoA performance plan, we will track future compliance with this objective internally, but remove it from the GPRA Plan.

Acquisitions/Grants Management/E-Government Measures:

The grants application process is one of AoA’s most significant workload processes, and involves significant staff and related resources on the part of AoA and potential grantees. In support of Grants.gov, AoA is providing a broad range of technical support to its grantees to assist them in transitioning from our former Internet-based system (e-gov) to Grants.gov. We are also, at the same time, supporting the ONE-HHS policy for centralized grant processing systems by having transitioned from an agency-based grant processing system (GMS) to a consolidated Department-wide grant processing system (GATES). During the transition process, we have not reported performance on this measure. As part of its President’s Management Agenda activities, AoA will continue to work to increase the percentage of discretionary applications that are submitted via Grants.gov and processed electronically in GATES.

AoA had also included a performance measure in GPRA performance plans for the last three years to increase the use of performance-based contracts in its procurement activities to 20 percent of its procurement dollars. In our third year of progress toward this goal, AoA has made significant progress but has still been unable to achieve this objective due to technical

government-wide requirements for contract renewals. We did however manage to increase during this time from our first year level of 5 percent to 10 percent in the second year to 15 percent this year, which represents 3 new contracts in addition to our original IRM contract in force in the first year of this measure.

Summary of Full Cost of Program Performance Areas
(Dollars in Thousands)

Program Performance Area	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate
Aging Services Programs.....	\$ 1,377,585	\$ 1,396,638	\$ 1,372,325
Measure 1: Improve Program Efficiency.....	a/	a/	a/
Measure 2: Improve Client Assessment and Results.....	a/	a/	a/
Measure 3: Improve Targeting to Vulnerable Edlers.....	a/	a/	a/
Total, Full Cost.....	\$ 1,377,585	\$ 1,396,638	\$ 1,372,325

a/ The full cost of each measure is equal to the full cost of the Performance Program Area. Please see the explanation below for more detail.

Methodology

The FY 2006 Performance Budget reflects the decision to move to one consolidated GPRA program that covers all programmatic activities. The full cost of this consolidated program is equal to the total program level for AoA, which includes administrative resources and demonstration activities funded through annual appropriations as well as resources from the Medicare trust fund, which are used to support health care anti-fraud, waste and abuse activities. It does not include accrued liabilities not directly paid by AoA, such as employee health benefits and Federal retirement costs. Because the Performance Budget contains three measures (efficiency, client assessment and outcomes, and targeting) that each separately covers the full scope of AoA's program activities, and therefore reflect the full cost of all program activities, AoA has not included separate full cost by measure tables in the Performance Budget.

Changes and Improvements Over Previous Years

In FY 2006, in conformance with new formatting instructions from HHS and OMB, AoA made further consolidations in the number of measures reported, so that AoA now includes only three performance measures in the Performance Budget document. This was accomplished through the introduction of the concept of indicators and a hierarchical organization of program activities conducted to accomplish the overall mission of the organization. The result was a net decrease in performance measures, but an increase in the ability to measure the factors that contribute to accomplishing those goals. New efficiency indicators were added and new outcome indicators based on national survey data were introduced. The document also incorporates long-term performance activities from the AoA Strategic Plan.

The following table summarizes the changes and improvements to the measures and indicators in the performance plan.

Measures and Indicators	Changes From Previous Plan
Measure 1	Designed in FY 2006, includes indicators 1.1, 1.2, 1.3 and 1.4
Indicator 1.1	Previously Indicator 1.1.1, New efficiency measure in FY05
Indicator 1.2	Previously Indicator 2.1 - No Change
Indicator 1.3	Previously Indicator 3.1 - No Change
Indicator 1.4	Previously Indicator 4.1 - No Change
Measure 2	Previously Measure 1.2 - Designed in FY 2005, includes indicators 2.1-2.8
Indicator 2.1	Previously 1.2.1 - New in FY 2005
Indicator 2.2	Previously 1.2.2 - New in FY 2005
Indicator 2.3	Previously 1.2.3 - New in FY 2005
Indicator 2.4	Previously 1.2.4 - New in FY 2005
Indicator 2.5	Previously 1.2.5 - New in FY 2005
Indicator 2.6	Previously 1.2.6 - New in FY 2005
Indicator 2.7	Previously 1.2.7 - New in FY 2005
Indicator 2.8	Developmental
Measure 3	Previously Measure 1.3 - Designed in FY05, includes Indicators 3.1-3.5
Indicator 3.1	Previously 1.1.2 - No Change
Indicator 3.2	Previously 1.19 - No Change
Indicator 3.3	Previously 1.3.1 - No Change
Indicator 3.4	Previously 1.14 - No Change
Indicator 3.5	Previously 1.18 - No Change
Measure 1.14	Discontinued in FY 2005
Measure 1.15	Discontinued in FY 2005
Measure 1.16	Discontinued in FY 2004
Measure 1.17	Discontinued in FY 2005
Measure 1.18	Discontinued in FY 2005
Measure 1.19	Discontinued in FY 2005
Measure 1.20	Discontinued in FY 2005
Measure 1.21	Discontinued in FY 2005

Measures and Indicators	Changes From Previous Plan
Measure 1.22	Discontinued in FY 2005
Measure 1.23	Discontinued in FY 2005
Measure 1.24	Discontinued in FY 2005
Measure 1.25	Discontinued in FY 2005
Measure 1.26	Discontinued in FY 2005
Measure 1.27	Discontinued in FY 2005
Measure 1.28	Discontinued in FY 2005
Measure 1.29	Discontinued in FY 2005
Measure 1.30	Discontinued in FY 2005
Measure 1.31	Discontinued in FY 2005
Measure 1.32	Discontinued in FY 2005
Measure 1.33	Discontinued in FY 2005
Indicator 1.1.3	Discontinued in FY 2006
Measure 2.1	Designed in FY 2005
Indicator 2.1.1	Became Efficiency Indicator 1.2 in FY 2006; New Efficiency measure in FY 2004
Indicator 2.1.2	Discontinued in FY 2006, Converted to efficiency measure FY 2005
Measure 2.3	Discontinued in FY 2005
Measure 3.1	Designed in FY 2005, includes Indicator 3.1.1
Indicator 3.1.1	Became Indicator 1.3 in FY 2006; New efficiency measure in FY 2004
Measure 3.2	Discontinued in FY 2005
Measure 3.3	Discontinued in FY 2005
Measure 3.4	Discontinued in FY 2005
Measure 3.5	Discontinued in FY 2005
Measure 3.6	Discontinued in FY 2004
Measure 3.7	Discontinued in FY 2004
Measure 3.8	Discontinued in FY 2004
Measure 4.1	Designed in FY 2005, includes Indicator 4.1.1
Indicator 4.1.1	Became Indicator 1.3 in FY 2006; New efficiency measure in FY 2004
Measure 4.2	Discontinued in FY 2005
Measure 4.3	Discontinued in FY 2005
Measure 4.4	Discontinued in FY 2005
Measure 6.1	Discontinued in FY 2005
Measure 6.2	Discontinued in FY 2004
Measure 6.3	Discontinued in FY 2005
Measure 6.4	Discontinued in FY 2005
Measure 6.5	Discontinued in FY 2005
Measure 6.6	Discontinued in FY 2005
Measure 6.7	Discontinued in FY 2004

Linkages to HHS and AoA Strategic Plan

The Performance Budget Overview and the Performance Analysis Detail sections provide summary information on the linkages between the AoA GPRA performance plan, the AoA Strategic Plan, and the HHS Strategic Plan. The following chart is intended to provide a more descriptive and definitive illustration of the detailed links between individual AoA program activities and the detailed goals and objectives in the HHS Strategic Plan.

This year, at the urging of the Department, AoA’s performance factors are organized hierarchically, wherein three measures represent AoA’s overall goals, as described in greater detail earlier, are: (1) Improve Program Efficiency; (2) Improve Client Assessments and Results and (3) Targeting to Vulnerable Elders. Supporting these three measures are indicators or specific program activities performed to accomplish each goal. This hierarchical grouping has had the effect of reducing the total number of measures reported and making all Departmental measures easier to understand and evaluate.

HHS Strategic Goal 1: Reduce the Major Threats to Health and Well-Being of Americans

HHS Strategic Objective 1.1: Reduce behavioral and other factors that contribute to the development of chronic diseases.	
AoA Strategic Goal	FY 2006 Performance Measures and Indicators
Goal 2: Increase the number of older people who stay active and healthy.	Measures 1, 2, and 3

HHS Strategic Goal 6: Improve the Economic and Social Well-being of Individuals, Families, and Communities, Especially Those Most in Need

HHS Strategic Objective 6.2: Increase the proportion of older Americans who stay active and healthy.	
AoA Strategic Goal	FY 2006 Performance Measures And Indicators
Goal 1: Increase the number of older people who have access to an integrated array of services.	Measures 1, 2, and 3
Goal 2: Increase the number of older people who stay active and healthy.	Measures 1, 2, and 3
Goal 3: Increase the number of families who receive help in their efforts to care for loved ones at home and in the community.	Measures 1, 2, and 3
Goal 4. Increase the number of older people who benefit from programs that protect their rights and prevent elder abuse, neglect and exploitation.	Indicator 1.2, 1.4 and 2.7,

HHS Strategic Objective 6.3: Increase the independence and quality of life of persons with disabilities including those with long-term care needs.	
AoA Strategic Goal	FY 2006 Performance Measures and Indicators
Goal 1: Increase the number of older people who have access to an integrated array of services.	Measures 1, 2, and 3
Goal 3: Increase the number of families who receive help in their efforts to care for loved ones at home and in the community.	Measures 1, 2, and 3
Goal 4. Increase the number of older people who benefit from programs that protect their rights and prevent elder abuse, neglect and exploitation.	Indicators 1.2 and 2.7

Partnerships and Coordination

To administer the programs established under the Older Americans Act (OAA), AoA works in close collaboration with State units on aging, area agencies on aging, Tribal governments, and a variety of direct service providers. AoA also works closely with other Federal agencies, both inside and outside of HHS, to coordinate services for seniors and serve them better. These partnerships span a variety of activities and support the five strategic priorities that the Assistant Secretary has established for AoA.

Examples of partnerships that support *Strategic Priority 1: Make it easier for older people to access an integrated array of health and social supports*, and *Strategic Priority 3: Support families in their efforts to care for their loved ones at home and in the community*, include:

- Aging and Disability Resource Centers: AoA is partnering with the Centers for Medicare and Medicaid Services (CMS) to establish Aging and Disability Resource Centers. These centers are serving as a visible and trusted resource for information on the full range of public and private long-term care options, and streamlining access by serving as entry points for publicly funded long-term supports – including Medicaid, OAA, and State programs. Centers are also assisting States to develop “one-stop shop” programs at the community level and to better coordinate and design their systems of information, assistance and access.
- State Legislator Long-term Care Education: AoA is partnering with the Assistant Secretary for Planning and Evaluation (ASPE) and the National Council of State Legislators to educate State legislatures about the ways that they can promote more balance in their States’ systems of long-term care. This initiative will provide information on how the aging services network can be an effective partner in these efforts.
- Cash and Counseling/Next Steps Program: AoA is partnering with ASPE, CMS, and the Robert Wood Johnson Foundation to replicate the Cash and Counseling consumer direction model, which provides seniors with monthly budgets and allows them to purchase the services they need. This initiative will award mini-grants for demonstration projects and provide intensive technical assistance to ensure the success of these efforts.
- Coordinated Transportation Services: AoA is partnering with the Federal Transit Administration to implement regional technical assistance workshops; compile and distribute toolboxes on promising practices, such as Intelligent Transportation Systems; develop coordinated transportation plans; and assist communities to identify a full range of alternative transportation options for seniors.
- Policy Academy on State Long-term Care: AoA is partnering with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Governor’s Association to help 6-8 States to analyze and develop strategic action plans for rebalancing their long-term care systems. The Policy Academy will assist States to redirect long-term care funding to create a better balance between institutional and community-based care.

Examples of partnerships that support the *Strategic Priority 2: Help older people to stay active and healthy*, include:

- Evidence Based-Prevention: AoA is partnering with community aging services provider organizations to translate HHS research investments – at the Centers for Disease Control and Prevention (CDC); the National Institute on Aging (NIA); the Agency for Healthcare Research and Quality (AHRQ) and other agencies – into high quality preventive health interventions targeted at the elderly. These projects will show the efficacy of delivering evidence-based prevention programs for the elderly through community-based aging service provider organizations and will support local partnerships involving aging service providers, area agencies on aging, local health entities and research organizations.
- YouCan! Campaign: AoA is partnering with NIA, CDC, and the President’s Council on Physical Fitness and Sports to conduct a national outreach campaign to help provide local communities with the tools to encourage older people to eat better and exercise more. The campaign’s goals include enlisting at least 2,000 organizations as partners by the fall of 2005 and having at least 2 million seniors participating in activities to help them eat better and exercise more by the fall of 2006.
- Medicare Modernization Act Implementation: AoA is partnering with CMS to provide outreach, education and assistance in enrolling Medicare beneficiaries in the Medicare drug discount card and the transitional assistance for low-income individuals. AoA and CMS jointly funded outreach programs to reach hard-to-serve, limited English speaking, minority, low-literacy, low-income and rural beneficiaries. AoA is also working with the CMS State Health Insurance Program Steering Committee to develop best practices and coordinate Medicare outreach activities at the local level that will help beneficiaries and their caregivers to understand the upcoming Medicare Part D benefit.
- Aging States Project: AoA is partnering with CDC to enhance communication and coordination between State units on aging and State Health Departments. This initiative is supporting evidence-based mini-grants targeting seniors that focus on physical activity, clinical preventive services, chronic disease self-management, and oral health.
- Hispanic Health Outreach: AoA is partnering with the Food and Drug Administration (FDA) to develop bilingual and culturally sensitive health promotion and disease prevention strategies and materials targeted to Hispanic communities. This initiative will seek to build partnerships with organizations in the Hispanic community and focus on issues such as medication management, nutrition, antibiotic overuse, and adverse event reporting.

Examples of partnerships that support the *Priority 4: Ensure the rights of older people and prevent their abuse, neglect and exploitation*, include:

- Nursing Home Quality Indicators: AoA is partnering with CMS to utilize long-term care ombudsman to help educate Medicare beneficiaries to make better nursing home placement

decisions. The initiative is training ombudsmen to educate and advise consumers on how to use quality measures to compare performance across nursing homes.

- Financial Exploitation Study: AoA is partnering with ASPE to develop a conceptual model of financial exploitation and a description of key programs that work in the field to prevent this abuse. This effort will identify knowledge gaps and make recommendations for ways in which public policymakers, researchers and providers can address the problem.
- Elder Domestic Violence: AoA is partnering with the Office of Women's Health (OWH) to develop a model curriculum for how Adult Protective Service agencies and domestic violence shelters can provide services to older women. This includes a focus on providers that target services to traditionally under-served populations, including Native and African Americans, Hispanics, and Asian and Pacific Islanders.

Examples of partnerships that support the *Priority 5: Promote effective and responsive Management*, include:

- Grants Management System: AoA is partnering with the Administration for Children and Families (ACF) to implement the Grants Administration Tracking & Evaluation System (GATES). AoA served as the pilot agency for the Department's Enterprise-Wide Grants Management System initiative and is now using GATES to issue both discretionary and formula grant awards.
- Unified Financial Management System: AoA is partnering with the Office of the Assistant Secretary for Budget, Technology, and Finance (ASBTF), the Program Support Center (PSC), and other agencies to implement the Unified Financial Management System (UFMS), which will replace the Department's five legacy accounting systems. UFMS will provide managers with more consistent, timely, and reliable financial information and facilitate the provision of shared services across the Department.
- Information Technology Service Center: AoA is partnering with ASBTF and other agencies to use the HHS Information Technology Service Center (ITSC). AoA has effectively consolidated its information technology infrastructure and desktop computer support functions within the ITSC.

Data Verification and Validation

AoA has continued to make progress in the two data initiatives highlighted originally in the FY 2002 performance plan. AoA and State agencies engaged in a formal assessment effort that has resulted in the certification of National Aging Program Information System (NAPIS) data months earlier than originally anticipated. AoA has initiated a process to revise routine information collection activities to reduce reporting burden, improve timeliness and reliability of data, and incorporate reporting for the National Family Caregiver Support Program into the standard data collection process, and OMB has approved the proposed modifications. AoA continues to focus on the assessment of quality through the consumer where it counts the most, at the community level, through the Performance Outcome Measures Project. AoA conducted national surveys of performance outcomes in the past year, and incorporated these results into the new outcome measures and into the analysis included in this plan. Follow-up surveys featuring larger sample sizes will be conducted this year.

AoA and the aging services network face a significant challenge in obtaining data to measure performance for programs of this kind. All levels of the aging services network, from AoA through the State and area agencies on aging to local centers and service providers, know well the challenge of producing client and service counts by critical program and client characteristics for a program which *coordinates* service delivery through approximately 29,000 local providers. Many Older Americans Act (OAA) program services do not require a one-time registration for service on the part of clients; eligible clients may obtain services on an ad hoc and irregular basis. This makes the tracking of services to individuals and the generation of “unduplicated” counts of clients a very difficult task at the local level, particularly if local entities lack information technology that simplifies client and service record-keeping and information management. Federal and State reviews of data provided under NAPIS suggest that significant limitations in the adequacy of information infrastructure at the local level inhibit their ability to routinely and consistently produce the data that are required by law for the OAA programs and form the basis for many of AoA’s GPRAs performance measures. Extensive and repeated Federal and State efforts to provide technical assistance and to isolate and correct common data problems have been helpful for local areas in the majority of States and for most data elements required by the OAA through NAPIS. Nevertheless, much remains to be done to ensure that local service providers and area agencies have the capacity to reliably provide important data without excessive burden.

Technical Assistance, Standard Software Packages, Electronic Edits

AoA and the State units on aging have long recognized the effects that local capacity limitations could have on the generation of reliable data for programs and services of this type, and have taken significant steps to support local entities in producing the NAPIS data. There are at least two commercial packages now available to States and local entities to assist them in the preparation of the NAPIS data. These packages have fostered far greater consistency in the data generated for NAPIS than was possible in the early years of implementation. AoA developed an extensive set of electronic edits for all data elements, which are applied to the electronic

submissions of State entities. AoA contractors work with State data administrators to correct data elements that fail electronic edits to ensure that data meet standard logic checks. Following standard electronic checks, knowledgeable AoA regional and central office staff conduct extensive reviews of edited data for “reasonableness,” to ensure that significant value changes from one year to another reflect program circumstances and not the limitations of the program data. These processes have been extremely slow, burdensome and time consuming, and they must be modified. AoA and State agency representatives continue to investigate ways to streamline the data verification and validation process without compromising data quality.

Despite the data challenges that the network is addressing and the time-consuming validation processes that remain in place at the present time, AoA and the network have been able to certify NAPIS data on an increasingly more timely basis. The actions of AoA and its State and local partners have reduced the time required to make data available for performance measurement.

Performance Measurement Linkages

President's Management Agenda: AoA is committed to the goals of the President's Management Agenda (PMA) and has made them an integral part of its strategic planning process. While AoA uses a number of quantitative measures to track performance in support of the PMA, these are reported through a separate process and we have decided not to duplicate that information here. Please refer to the budget justification for Program Administration on page 80 for a brief description of some of the activities AoA has undertaken in support of the PMA.

HHS Strategic Plan: AoA also participates in the development of the strategic goals and objectives of the HHS each year. AoA program activities and strategies will continue to support the achievement of HHS goals and objectives, and AoA program performance measurement efforts will support HHS efforts to assess the progress of the Department in achieving the goals and objectives of the HHS Strategic Plan. The detailed roadmap of linkages of AoA goals and activities with the HHS Strategic Plan are presented on page 137.

Full Cost of Programs and Measures: The FY 2006 Performance Budget reflects the decision to move to one consolidated GPRA program that covers all programmatic activities. The full cost of this consolidated program is equal to the total program level for AoA, which includes administrative resources and demonstration activities funded through annual appropriations as well as resources from the Medicare trust fund, which are used to support health care anti-fraud, waste and abuse activities. It does not include accrued liabilities not directly paid by AoA, such as employee health benefits and Federal retirement costs.

Program Evaluation: The Office of Evaluation currently carries out a number of program evaluation exercises to produce the data included on our performance reports and expects to expand the base of that activity to include more administrative components.

Program: Administration on Aging

Rating: Moderately Effective

Program Type: Block/Formula Grant

Agency: Department of Health and Human Services

Bureau: Administration on Aging

Last Assessed: 1 year ago

Key Performance Measures from Latest PART	Year	Target	Actual
Annual Efficiency Measure: People served per \$million of AoA funding (with no decline in service quality).	2001		5,688
	2003		6,375
	2005	Baseline +8%	
	2007	Baseline +15%	
Long-Term Measure: By 2010, the number of states achieving a targeting index greater than 1.0 for rural and poverty measures.	2001	(poverty)	44
	2001	(rural)	41
	2010	51 States P	
	2010	50 States R	
Long-Term Measure: The percentage of caregivers reporting that services have definitely enabled them to provide care for a longer period.	2003		48%
	2004		52%
	2005	62%	
	2007	75%	

Recommended Follow-Up Actions from Latest PART

The Administration will publish a new set of performance measures that reflect program outcomes and appropriate performance targets as part of the agency's FY 2005 GPRA plan.

Status

Completed

Update on Follow-up Actions:

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
1,378	1,397	1,372

PART Recommendations FY 2004-FY 2005

Administration on Aging

State and Community-Based Services (Title III of the Older Americans Act)

Recommendation 1. Develop long-term performance measures.	Completion Date 09/03/03	On Track? (Y/N) Yes	Comments on Status Revised Measures submitted to OMB.
Next Milestone Action completed	Next Milestone Date N.A.	Lead Organization Office of Evaluation	Lead Official Frank Burns

Recommendation 2. Develop ambitious performance targets.	Completion Date 09/10/03	On Track? (Y/N) Yes	Comments on Status Revised targets submitted to OMB.
Next Milestone Action completed	Next Milestone Date N.A.	Lead Organization Office of Evaluation	Lead Official Frank Burns

Recommendation 3. Develop efficiency measures.	Completion Date 06/30/03	On Track? (Y/N) Yes	Comments on Status Efficiency Measures submitted to OMB.
Next Milestone Action completed	Next Milestone Date N.A.	Lead Organization Office of Evaluation	Lead Official Frank Burns

Recommendation 4. Include indirect costs in budget requests/Link changes in performance to changes in funding levels.	Completion Date 09/08/03	On Track? (Y/N) Yes	Comments on Status Included in FY 2005 budget request submitted to OMB.
Next Milestone Action completed	Next Milestone Date N.A.	Lead Organization Office of Evaluation	Lead Official Frank Burns

Summary of Measures

	Total Measures*	Output Measures	Outcome Measures	Efficiency Measures	Results Reported	Results Met	Results Not Reported
1999	18	18	0	NA	18	14	0
2000	18	18	0	NA	18	13	0
2001	23	15	5	3	23	17	0
2002	27	10	17	3	27	17	0
2003	39	13	30	3	39	29	0
2004	39	6	30	3	7	7	32
2005	16	0	16	7	NA	NA	NA
2006**	16	0	16	4	NA	NA	NA

* Total Measures are not intended to be the sum of Output, Outcome and Efficiency Measures since measures often serve the dual purpose of efficiency and outcome measures.

** FY 2006 reflects indicators.

Research Coordination Council Activities

Overview

AoA conducts program demonstrations and evaluation studies using results from research undertaken by other HHS components. Findings from these program demonstrations and evaluation projects are used to promote active aging and the development of a more balanced long-term care system that supports consumer choice and community living. AoA also uses HHS research to develop much needed training and technical assistance for the aging services network, including State and Area agencies on aging, Tribal organizations and community service provider organizations.

While AoA does not conduct basic research of its own, except as occasionally required by the Congress, AoA does work closely with other agencies through the HHS Research Coordination Council (RCC). AoA's involvement in the RCC has also led to collaborations with other agencies and improved coordination of demonstration and evaluation activities. For example, AoA's Evidence-Based Disease Prevention grants program, which was launched in FY 2003, is designed to use findings from HHS research investments at the National Institute on Aging, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality and other agencies to develop high quality preventive health interventions targeted at the elderly and delivered through community-based aging service provider organizations.

AoA supports a broad range of programs and services for the elderly, and the demonstrations funded by AoA also cover an extensive range of topics. The program priorities of AoA are:

- Making it easier for older people to access an integrated array of health and social supports.
- Helping older people to stay active and healthy.
- Supporting families in their efforts to care for their loved ones at home and in the community.
- Ensuring the rights of older people and preventing their abuse, neglect and exploitation.

AoA's research, demonstration and evaluation (RD&E) activities support these priorities. Our priorities are consistent with HHS Research Themes: "Promoting Active Aging and Improving Long-Term Care" and "Preventing Disease, Illness, and Injury". AoA RD&E activities, as well as our technical assistance efforts, are related to improving the on-going service programs of the aging services network.

Research, Development & Evaluation Activities

IV. Promoting Active Aging and Improving Long-Term Care

A. Active Aging

AoA activities which support active aging include a number of ongoing national projects. While these activities often have a demonstration component, the focus is to support the aging services network's need for information about advances and best practices in services and technologies (technical assistance). Some examples of ongoing national projects that support active aging include the National Education and Resource Center on Women and Retirement, Pension Information and Counseling demonstration projects, and the National Minority Aging centers, including those for Asian-Pacific, Native American, African-American, and Hispanic seniors.

B. Promoting Home and Community-Based Services

AoA activities that seek to promote the use of home and community-based services include a number of ongoing national projects, including the National Center on Elder Abuse, Senior Medicare Patrol projects, Family Friends/Volunteer Senior Aides projects, Legal Assistance and Support projects and the National Resource Centers on Native Americans. Furthermore, AoA is funding demonstration projects that test new approaches relating to delivering integrated services to seniors where they live and assisting them to remain in their own homes and communities.

C. Improving Nursing Home Quality

AoA provides support to the National Long-Term Care Ombudsman Resource Center. This Center provides training and technical assistance to state and local ombudsman programs, which help to improve the quality of nursing home and other institutional care.

D. Improving Long-Term Care Delivery and Financing

AoA's key initiative to improve the delivery and financing of long-term care is the Aging and Disability Resource Center project, a partnership with the Centers for Medicare and Medicaid Services. These centers are serving as a visible and trusted resource for information on the full range of public and private long-term care options, and streamlining access by serving as entry points for publicly funded long-term supports – including Medicaid, OAA, and State programs. Centers are also assisting States to develop “one-stop shop” programs at the community level and to better coordinate and design their systems of information, assistance and access. Previous efforts have included the National Family Caregiver Support Program demonstration projects.

X. Preventing Disease, Illness and Injury

A. Prevention – General

AoA is funding demonstration projects to test a selection of approaches to delivering evidence-based disease prevention programs, utilizing HHS research investments, through community-based aging service provider organizations.

RESEARCH, DEMONSTRATION, & EVALUATION ACTIVITIES
(Dollars in Thousands)

Research Priority:	FY 2006 Estimate
I. Working Toward Independence.....	--
II. Rallying the Armies of Compassion.....	--
III. No Child Left Behind.....	--
IV. Promoting Active Aging & Improving Long-Term Care.....	\$43,718
V. Protecting & Empowering Specific Populations.....	--
VI. Helping the Uninsured & Increasing Access to Health Insurance.....	--
VII. Realizing the Possibilities of 21st Century Health Care.....	--
VIII. Ensuring Our Homeland is Prepared to Respond to Health Emergencies.....	--
IX. Understanding Health Differences & Disparities -- Closing the Gaps.....	--
X. Preventing Disease, Illness, and Injury.....	\$2,500
XI. Agency-specific Priorities.....	--
Total, Research, Demonstration, & Evaluation.....	\$46,218