Final Fiscal Year 2001 GPRA Annual Performance Plan,

Revised Final Fiscal Year 2000 GPRA Annual Performance Plan,

And Fiscal Year 1999 GPRA Annual Performance Report

of the

Administration on Aging

Table of Contents

Part I – Agency Context for Performance Measurement
1.1 Agency Mission and Long Term Goals……. 1
1.2 Organization, Programs, Operations, Strategies and Resources….. 2
1.3 Partnerships and Coordination……. 4
1.4 FY 1999 Performance Report……. 6
1.4.A Client Characteristics……. 6
1.4.B Performance Measures……. 7
1.5 Performance Outcomes Measures Project……. 10
Part II – Performance Measures
Budget Level and Full-Time Equivalent Chart……. 12
Performance Measures by Performance Area
Strategic Goal 1: Provide Opportunities for Better Nutrition and Improved Health
2.1.A Home-Delivered Meals…….. 12
2.1.B Congregate Meals……. 12
2.1.C Grants to Indian Tribes……. 15
Strategic Goal 2: Provide access to services people need by reducing barriers, Bringing cultural competence to services, and providing opportunities for Social engagement
2.2.A Information and Assistance……. 20
2.2.B Transportation……. 23
2.2.C Case Management (discontinued)……. 26
2.2.D Alzheimer's Disease……. 27
Strategic Goal 3: Provide opportunities to live with safety, independence and Dignity
2.3.A Long-Term Care Ombudsman……. 29
2.3.B Caregiver Support……. 32
2.3.C Health Care Anti-Fraud Activities…….. 32
Strategic Goal 4: Develop comprehensive and coordinated services systems Based on local needs
2.4.A State and Local Innovations and Projects of National Significance -- Mental Health Initiative…….. 35
Part III – Appendices
A.1 Approach to Performance Measurement
A.1.A Evaluations……. 39
A.1.B Data Verification and Validation……. 39
A.1.C Performance Outcome Measures Project…….. 39
A.2 Changes and Improvements Over Previous Year…….. 40
A.3 Linkage to HHS Strategic Plan…….. 42
Budget Linkage Table……. 45

Part I – Agency Context for Performance Measurement

1.1 Agency Mission and Long-Term Goals

The Administration on Aging is the Federal agency whose goal is to improve the quality of life for all older Americans, primarily by assisting them to remain independent, actively engaged, and productive. Through the Older Americans Act, AoA works closely with its nationwide network of state, tribal and area agencies on aging to plan, coordinate and develop home and community-based systems of services that meet the unique needs of older persons and their families.

The agency's mission is reflected in statute. The Older Americans Act provides a broad organizing set of ten core national values and objectives for AoA's programs in language that articulates a vision as well as transcendent, fundamental aspirations for America's older population. The motivation for embracing these values and honoring the objectives is captured in the President's statement in his proclamation for Older Americans Month 1999: This year's theme "...reminds us of the profound debt of gratitude we owe to the generations of older Americans whose hard work, courage, faith, sacrifice and patriotism helped to make this nation great."

Strategic Goals of the Administration on Aging

- Provide opportunities for better nutrition and improved health;
- Provide access to services people need by reducing barriers; e.g., by utilizing culturally competent service delivery approaches and by increasing their participation and engagement;
- Provide opportunities to live with safety, independence and dignity; and at the systems level,
- Develop comprehensive and coordinated services systems based on local needs.

AoA's mission also relates closely to the strategic objectives of the Department as published September 30, 1997, and particularly to the following strategic goals and objectives:

Goal 1 -- Reduce the Major Threats to Health and Productivity of All Americans.

Strategic Objective 1.3: Improve the Diet and Level of Physical Activity of Americans.

Goal 2 — Improve the Economic and Social Well-Being of Individuals, Families and Communities in the United States

Strategic Objective 2.5: Increase Opportunities for Seniors to Have an Active and Healthy Aging Experience

Strategic Objective 2.6: Expand Access to Consumer-Directed Home and Community-Based Long-Term Care and Health Services

Goal 3 -- Improve Access to Health Services and Ensure the Integrity of the Nation's Health Entitlement and Safety Net Programs

Strategic Objective 3.5: Enhance the Fiscal Integrity of HCFA Programs and Ensure the Best Value for Health Care Beneficiaries

Strategic Objective 3.6: Improve the Health Status of American Indians and Alaska Natives

Goal 4 — Improve the Quality of Health Care and Human Services

Strategic Objective 4.1: Promote the Effective Use of Appropriate Health Services

Strategic Objective 4.2: Reduce Disparities in the Receipt of Quality Health Care Services

Strategic Objective 4.4: Improve Consumer Protection.

Along with statutory responsibilities and Departmental objectives, the agency's mission is shaped by the agency's strategic vision. In this regard, the Administration on Aging has adjusted its overall goals and priorities to respond to the phenomenon of dramatic longevity, which has become even more evident over the last decade. Such a reorientation is essential in light of growing societal recognition that America's social practices, institutions and individuals will be required to respond to the fundamental demographic shift which is occurring because human life expectancy has increased more during the last century than over the last four millennia.

It is now evident that Americans of all ages must begin to anticipate and plan for the likelihood that they will live to be 80, 90, and 100. The opportunity to live a longer life heightens the importance of:

- keeping active and healthy
- earning and saving as much as possible in order to live comfortably in the ;ater years;
- being involved in work or activities that are satisfying; and
- maintaining rewarding relationships with family and friends.

All of these are components of "lifecourse planning" in the broadest sense and are reflected in the priorities of the Administration on Aging. In response to a new biological phenomenon -- longevity -- programs that serve older Americans must emphasize how we can age productively and successfully by planning for longer life.

1.2 Organization, Programs, Operations, Strategies and Resources

The Administration on Aging

The Administration on Aging is an operating division of the Department of Health and Human Services, headquartered in Washington, D.C., with regional offices across the country. Total staffing is less than 150. This small size presents several challenges for the agency, not the least of which is assuring that staff continue to acquire the skills required to fulfill the agency's mission. AoA has begun a workforce planning and implementation process to prepare the agency to meet the changing demands placed on it by an ever-larger and more diverse older population, and to strengthen the core competencies and technical skills of its present workforce to meet those demands. The workforce planning process identified the essential core competencies and

technical skills which should underpin a functional model of the organization. The agency is utilizing the plan that was developed as an outcome of the process to ensure that both human resource development and recruitment activities result in the targeted generation and acquisition of those competencies and skills necessary to achieve the agency's mission, goals, and future objectives.

Based on these efforts, AoA is requesting funding for several additional FTEs. These staff are needed to ensure that AoA can effectively lead important departmental and federal initiatives that respond to and prepare the nation for the challenges and opportunities which accompany increased longevity.

The Aging Network

AoA awards grants under the authority of the Older Americans Act, which provides funds for services and for basic administrative support of the State, tribal and area agencies in the aging network. Many services provided through the Aging Network are funded by pooling a variety of sources, including other Federal programs, State programs (often substantial), local funds and program income received as donations by people who, for example, receive meals at a congregate nutrition site.

This ability to leverage and use funds for services from sources other than the Older Americans Act illustrates an essential *system outcome* of the Aging Network. The Act was never intended, in and of itself, to operate a discrete, independent services program. Rather, the Act put into place a nationwide service delivery system, the Aging Network, which identifies service needs and necessary service system modifications, offers state and local plans to remedy needs, coordinates other funding streams, and then weaves the services funded by these into a comprehensive services system. Services funded under the Act frequently are used to "fill gaps" in other programs, for example, by providing services to people who are ineligible for other programs but who still need support. We use the proportion of "leveraged" funding as a performance indicator for community-based access services in this plan.

The Aging Network is responsive to the diverse population of older Americans, meeting a wide range of needs, as determined by state and local agencies through needs assessment processes. Meals are served in congregate settings such as senior centers, for example, to people who are poor and socially isolated. Many older people with mild functional impairments need such supportive services as transportation. For older people with more severe limitations, the Aging Network provides home and community-based long term care services through a system which it began to develop in the 1970's. In communities throughout the nation, the home and community-based service systems led by the Aging Network provide a preferred alternative to nursing home care, enabling people to live as independently as possible for as long as possible.

The Older Americans Act

The Older Americans Act is currently being considered for reauthorization in the Congress, and AoA has attempted, through the Administration's proposal, to present a new vision to enable America and its communities and its people to prepare for the growing longevity of our population. The reauthorization proposal is designed to offer strong support to the Aging Network of state, tribal and local entities to enable them to best meet emerging challenges.

To improve and strengthen the flexibility of the OAA programs, the Administration proposes to streamline the operations of state programs, add flexibility by eliminating unnecessary Federal requirements, and build a more responsive customer orientation.

Linkage Between Goals

Consistent with the requirements of the GPRA, AoA has established a linkage between performance goals and strategic goals. Each performance goal supports the achievement of one or more of AoA's strategic goals. The successful pursuit of AoA activities contributes to the achievement of performance goals by helping assure excellence in the operation of state and area agency programs.

Achievement of strategic goals is dependent on the successful achievement of performance goals.

Fiscal Year 2001 Budget Proposal

The FY 2001 budget request is $1,083,619,000, +$150,771,000 above the FY 2000 appropriation. This amount includes an increase of $140 million for Supportive Services, an increase of $15 million for the base program and $125 million to support caregivers of older Americans. $5 million is included to increase core services for Grants to Native Americans and potentially to bolster caregiver support activities for caregivers of Native American elders. Also included is an additional $5 million for a new Mental Health Initiative. Finally, $1 million has been added for twelve new FTEs to support program activities.

1.3 Partnerships and Coordination

Collaboration with the Aging Network

AoA works collaboratively with its nationwide network of State and Area Agencies on Aging and tribes to plan, coordinate, and develop community-based systems of services for older persons and their caregivers. AoA's partnerships with other Federal agencies, national organizations, and representatives of the private sector help ensure that programs and resources available to older Americans are coordinated with those of the Aging Network.

Grant programs authorized by the Older Americans Act are administered by AoA. These programs provide meals and various supportive services to help vulnerable older persons remain in their own homes. These programs also offer older Americans opportunities to enhance their health and to be active contributors to their families, communities, and the nation.

Funding provided by AoA supports in-home and community-based services including nutrition, transportation, health promotion, nursing home ombudsmen, outreach, and elder abuse prevention efforts. Fifty-seven State Agencies on Aging are allocated funds for these services based on a formula that reflects the number of older residents in their state. Moreover, funds are used to plan, develop, and coordinate in-home and community-based service systems in their states. All but nine states are divided into Planning and Service Areas (PSAs). Each PSA is served by an Area Agency on Aging. The 655 Area Agencies on Aging (AAAs) receive OAA funds from their State Unit on Aging (SUA). In turn, AAAs contract with public or private providers

for services. While there are approximately 27,000 service provider agencies nationwide, some AAAs deliver services directly when no local contractor is available.

Federal Partnerships

AoA works closely with many Federal agencies on a wide range of issues. Our discussion here, however, is limited to several examples of collaboration related to this year's budget priorities and collaboration in the achievement of our performance outcomes.

In the area of nutrition, for example, we work with the U.S. Department of Agriculture on such issues as food security measurement and dietary guidelines used as standards for our programs. Within HHS, we work with the Office of Assistant Secretary for Public Health on Dietary Reference Intakes (DRIs), formerly known as Recommended Daily Allowances and on nutrition performance measures related to the Healthy People 2010 initiative. AoA is also represented on such bodies as the HHS Nutrition Policy Board; the HHS Dietary Guidance Committee; the HHS/USDA Food Security committee; the HHS/USDA Nutrition and Welfare committee; and the HHS Dietary Reference Intake Working Group.

In the achievement of our transportation performance outcomes, we work closely with officials of our Department and the U.S. Department of Transportation on the Coordinating Council on Access and Mobility – which works to reduce barriers by coordinating approaches to specialized and human services transportation.

Our fiscal year 2001 budget proposal features a new partnership with the Substance Abuse and Mental Health Administration for our mental health initiative.

The Health Care Financing Administration and the Administration on Aging are partners in the provision of information and assistance services to older Americans about the health care options available to Medicare beneficiaries. Through a cooperative agreement, HCFA transferred to AoA $1.9 million in fiscal year 1999 to support the efforts of the national aging network to educate older people about Medicare+Choice.

In addition, together we developed a training manual for information and assistance programs, so they could explain options and know where and when to refer beneficiaries for expert help. We are also cooperating with HCFA on several demonstration projects to develop new models for assuring quality of care in nursing homes.

In the area of health care anti-fraud activities, we work extensively with HCFA, the Department's Office of Inspector General, the U.S. Department of Justice, state Medicaid agencies, state survey and certification agencies, Medicare contractors, State and Area Agencies on Aging, and other members of AoA's National Aging Network. Our fiscal year 1999 performance report highlights the significant successes of these partnerships.

The Centers for Disease Control and Prevention is a federal partner on the Administration on Aging's Performance Outcome Measurement Project. Recognizing the efficiency of using existing national survey mechanisms to gather outcomes data and to serve as a general population baseline, AoA will utilize the CDC's annual Behavioral Risk Factors Surveillance System, which is conducted in each state by state health departments. AoA has agreed to provide support for the BRFSS in exchange for the inclusion, in the fiscal year 2000 survey, of questions of interest to our programs. They include a question about whether an individual has recently provided care for an elderly parent, relative or friend; and a question about whom one would contact to arrange care for an elderly parent or relative who is no longer able to care for themselves. For persons receiving help with personal needs, questions will be posed about the source and adequacy of that help.

Technical assistance will also be provided by CDC on the development of measures for "social functioning;" for example, by the number of contacts a person has outside his or her home. We believe people who participate in OAA programs have more social contacts than people in similar circumstances who are not participants.

AoA is also working collaboratively with the National Institute on Aging and the Assistant Secretary for Planning and Evaluation to support the caregiver supplement to the National Long Term Care Survey and follow-up surveys, which is essential to establishing baselines for caregiver support activities.

Further information about partnerships that advance specific program goals is available in the sections of this report that describe those program activities.

1.4 FY 1999 Performance Report Summary

The GPRA Performance Plan submitted with the fiscal year 1999 budget proposal relied upon AoA's basic administrative data system: the State Program Report. This was, at the time, a new data collection system in the first year of a three-year implementation period. The State Program Report provides profile data on the number and characteristics of the people we serve, the services they receive, the funds used to pay for those services, and the agencies that deliver services.

Because the State Program Report is a new administrative data system, the ongoing process of data verification and validation is time-consuming, but has been effective. Appendix 1 provides further information about data verification and validation.

Verification of data from fiscal year 1997 was completed recently. Currently, FY1998 data is being processed and is expected to become available in September, 2000. Data from FY1999 will be available in September, 2001. The current plan and report provides information about aging services and programs during fiscal year 1997 because that is the most recent year for which NAPIS / SPR information is available. AoA is now developing computer software that will allow States to validate and verify NAPIS / SPR information before submitting the information to AoA. As this is completed and as the system matures, we expect to reduce significantly the time lag in reporting data and to improve our ability to comply with GPRA requirements.

Thus, this performance report relies upon information drawn from data for FY1997, the most recent available. Fiscal year 1997 data on client characteristics are also presented. Fiscal year 1997 is the first year for which detailed data are available on client characteristics such as race and ethnicity, poverty status, and level of disability. This information is available for program participants who receive certain core services, although not all states are currently able to report this data.

1.4.A Client Characteristics

Older Americans Act services reach a significant percentage of all the people 60 years of age or over in the country. The aging network targets scarce resources to people in the greatest social and economic need. Our programs serve members of minority groups, the poor and people with disabilities at a rate greater than their proportion in the general population.

AoA employs Census Bureau estimates for 1993 as these estimates correlate data for people 60 years of age and older by race or Hispanic origin, and by poverty. The number of people in the country 60 years of age and older was 41,399,000. The number who received services under the Older Americans Act in 1997 was 7,045,360, or 17 percent of the total population age 60 and over, and 6,891,416, or 16.6 percent in 1996.

The number of African American individuals 60 and above in the country was 3,704,000, or 8.9 percent of the population. The number of African American individuals who participated in our programs in 1997 was 738,519, or 10.7 percent of all participants. The number in 1996 was 703,076, or 10 percent.

The number of individuals of Hispanic origin 60 and above was 1,776,000, or 4.2 percent of the population. The number of individuals of Hispanic origin who participated in our programs in 1997 was 525,304, or 7.6 percent of all participants. The number in 1996 was 444,430, or 6.3 percent.

The number of people in poverty age 60 and over was 3,376,000, which was a percentage of 10.5. The number of people in poverty who participated in our programs in 1997 was 2,681,008, or 38.9 percent of all participants. The number in 1996 was 2,671,772, or 37.9 percent.

Disability figures from the Census Bureau's Survey of Income and Program Participation show that in 1994 and 1995 14,679,000 people, or 47 percent of those age 65 and over, reported difficulty with one or more functional activities. Some 5 million people, or 16 percent, reported that they needed personal assistance with one or more of the instrumental activities of daily living or the activities of daily living.

Preliminary data from 16 states for 1997 show that people with limitations in the instrumental activities of daily living (IADLs) represent between 62.6 and 84.7 percent of all recipients of a group of "registered" services that includes personal care, chore, and homemaker services, home-delivered meals, adult day care and case management. People with limitations in the Activities of Daily Living (ADLs) represent between 57.6 and 77 percent of all recipients of registered services. Some of the people represented in the ADL chart also have IADL limitations, although this is not shown in the data.

1.4.B Performance Measures

Strategic Goal 1: Provide Opportunities for Better Nutrition and Improved Health

Home-Delivered Meals	Actual Performance
For fiscal year 1999, maintain the number of meals served at the 1995 baseline, 119,000,000 meals.	FY99: 9/01 FY98: 9/00 FY97: 123,455,000 FY96: 119,110,318 FY95: 119,000,000

Congregate Meals	Actual Performance
For fiscal year 1999, maintain the number of meals served at the 1995 baseline, 123,400,000 meals.	FY99: 9/01 FY98: 9/00 FY97: 113,147,407 FY96: 118,632,573 FY95: 123,400,000

Our performance goal in this area was to maintain the provision of services with level funding. We expect to have data for fiscal year 1999 by September, 2000. The trend, however, between fiscal years 1995 and 1997, was that home-delivered meals increased while congregate meals decreased, which is consistent with the pattern of states transferring funding from the congregate and general services programs to the home-delivered meals program.

Grants for Native Americans	Actual Performance
For fiscal year 1999, improve health and well-being, and reduce social isolation, among older American Indians, Alaska Natives and Native Hawaiians through the provision of community-based services by maintaining the level of service provision at the 1995 level: Home-Delivered Meals: 1,455,911 Congregate Meals: 1,321,728 Transportation: 763,287 Information and Referral 632,462 In-Home Services 741,859 Other 511,646	<u>Home-Delivered Meals</u> FY99: 9/01 FY98: 9/00 FY97 1,632,536 FY96 1,394,093 FY95 (corrected) 1,453,733 <u>Congregate Meals</u> FY99: 9/01 FY98: 9/00 FY97 1,438,908 FY96 1,273,584 FY95 (corrected) 1,285,447 <u>Transportation</u> FY99: 9/01 FY98: 9/00 FY97 665,063 FY96 701,969 FY95 (corrected) 740,262 <u>Information and Referral</u> FY99: 9/01 FY98: 9/00 FY97 678,979 FY96 698,258 FY95 (corrected) 630,950 <u>In-home Services</u> FY99: 9/01 FY98: 9/00 FY97 866,194 FY96 788,003 FY95 (corrected) 698,015 <u>Other Services</u> FY99: 9/01 FY98: 9/00 FY97 590,723 FY96 598,896 FY95 (corrected) 583,746

For the most part, Native American programs maintained the level of services, adjusted for inflation, in the face of level funding.

The baseline reported in the fiscal year 1999 performance plan, i.e., the level of service provision in 1995, has been updated in our data-collection system. Those figures, and those for 1996 and 1997, appear above. The data-collection system for the Native Americans program collects data on an April-through-March basis, rather than the October-through-September (Federal fiscal year) basis for the State Program Report.

Strategic Goal 2: Provide access to services people need by reducing barriers, bringing cultural competence to services, and providing opportunities for social engagement.

Information and Assistance	Actual Performance
For fiscal year 1999, maintain the number of information and assistance contacts at the 1995 baseline, 12,526,537 contacts.	FY99: 9/01 FY98: 9/00 FY97: 13,985,091 FY96: 13,739,633 FY95: 12,526,537 Contacts
For fiscal year 1999, increase the level of leveraged funding over by one percent over the 1995 baseline, from $38,105,352 plus $381,054 to $38,486,406	FY99: 9/01 FY98: 9/00 FY97: $47,293,671 FY96: $42,293,671 FY95: $38,105,352

Transportation	Actual Performance
For fiscal year 1999, maintain the number of one-way rides at the 1995 baseline, 39,496,946 one-way rides.	FY99: 9/01 FY98: 9/00 FY97: 46,578,352 FY96: 36,902,111 FY95: 39,496,946 rides
For fiscal year 1999, increase by one percent the amount of leveraged funding over the 1995 baseline, from $95,349,783 plus $953,497 to $96,403,280.	FY99: 9/01 FY98: 9/00 FY97: $100,576,352 FY96: 97,634,395 FY95: 95,349,783

Case Management	Actual Performance
For fiscal year 1999, maintain the number of hours of case management services at the 1995 baseline, 2,976,149 hours. (Discontinued in 1999)	FY99: 9/01 FY98: 9/00 FY97: 2,701,728 FY96: 3,426,542 FY95: 2,976,149 hours
For fiscal year 1999, increase the level of leveraged funding by one percent over the 1995 baseline, from $64,622,578 plus $646,226 to $65,268,804.	FY99: 9/01 FY98: 9/00 FY97: $53,364,889 FY96: $76,879,489 FY95: $64,622,578

The Older Americans Act defines the following as “access services:” information and assistance; transportation; and case management. We chose to measure the provision of these services as

representative of the strategic goal of providing access to services, and note that the receipt of access services often implies the receipt of other services.

In the area of information and assistance – often an individual's first contact with the aging network – we saw consistent and continued growth, both in the network's provision of services and their ability to "leverage" funding, that is, to obtain funds for the provision of the service from sources other than the Older Americans Act.

In the area of transportation, states chose to use less of their funding under Title III of the Older Americans Act for this service between fiscal years 1995 and 1996, while leveraged funding increased. Title III funding rebounded, however, between 1996 and 1997, and leveraged funding continued to increase. The decrease between 1995 and 1996 may be an artifact of the new data system. We expect some variation over the first three years of a phased, three-year implementation period for the State Program Report system. Fiscal year 1999 data will be available in September, 2000.

Case management services increased between fiscal years 1995 and 1996, both in provision of services and leveraged funding, but declined in 1997 in both areas to below 1995 levels. We believe this reflects practice in the field, where there is greater emphasis on "consumer directed" services -- where the individuals have relatively more influence over the services they receive, and agency-based case managers relatively less. As discussed in Section 2, we are discontinuing use of this measure based on consultation with state officials, who have commented that the continued use of this measure is inappropriate because of changes in the way the program is administered.

Strategic Goal 3: Provide opportunities to live with safety, independence and dignity

Long-Term Care Ombudsman Program	Actual Performance
Maintain the combined resolution/partial resolution rate of 71.48 percent of complaints in nursing homes.	FY99: 11/00 FY98: 70.6% FY97: 72.1% FY96: 74.0% FY95: 71.5%

Our program goal in this area is to assist residents, families, friends and others to resolve problems related to care and conditions in nursing homes. Our target for fiscal year 1999 is to resolve (or partially resolve) 71.48 percent of complaints involving nursing home care. Performance thus far has been generally consistent with this goal.

Strategic Goal 4: Develop comprehensive and coordinated services systems based on local needs.

See section 2.4.A for Accomplishments.

1.5 Performance Outcomes Measures Project

The fiscal year 2001 performance plan continues to rely primarily on output measures derived from the National Aging Program Information System (NAPIS). AoA has undertaken a project – the Performance Outcome Measures Project – to develop and test outcome measures related to the impact of Older Americans Act services on the lives of service recipients.

AoA has undertaken the Performance Outcome Measures Project in partnership with the National Association of State Units on Aging and the National Association of Area Agencies on Aging. Nineteen state and area agencies are collaborating on the Project.

Project participants have reached consensus on outcome measures that are relevant to the performance of the Aging Network that will be tested during FY2000. These measures emphasize individual characteristics of the people we serve – including their nutritional risk, physical functioning, emotional well-being, social functioning, and satisfaction with the services they receive. Other measures look at the impact of services that support caregivers and the degree to which caregivers are satisfied with the services they receive. In development are measures to assess the performance of the aging network in reducing barriers to services and in building the capacity of the aging services system.

AoA has contracted with researchers and academics who are regarded to have strong expertise in particular substantive areas to help develop data-collection instruments that proceed from the best available research. The participating state and local agencies and the national associations are full partners in the development of these instruments and will participate in the field-testing of performance outcome measures over the winter and spring. We expect to have data from the field tests by this time next year.

Participating agencies include:

Big Sandy Appalachian Development District -- Prestonburg, Kentucky	Iowa Department of Elder Affairs – Des Moines, Iowa
California Department of Aging -- Sacramento, California	Lifestream Services, Inc. – Yorktown, Indiana
CICOA, The Access Network – Indianapolis, Indiana	Los Angeles City Department of Aging – Los Angeles, California
The Council on Aging of the Cincinnati Area – Cincinnati, Ohio	New Jersey Division of Senior Affairs – Trenton, New Jersey
Connecticut Bureau of Elder Rights and Community Services – Hartford, Connecticut	Ohio Department of Aging – Columbus, Ohio
Connecticut Association of Area Agencies on Aging – Hartford, Connecticut	Area Agency on Aging, Region One – Phoenix, Arizona
Florida Department of Elder Affairs – Tallahassee, Florida	Area Agency on Aging of Western Arkansas – Fort Smith, Arkansas
Georgia Division of Aging Services – Atlanta, Georgia	Area Agency on Aging of Hunterdon County, New Jersey
Hawaii County Office of Aging – Hilo, Hawaii	Hawkeye Valley Area Agency on Aging – Iowa
Indiana Bureau of Aging and In-Home Services – Indianapolis, Indiana	

The fiscal year 2001 GPRA performance plan is consistent with earlier performance plans which relied exclusively on program *output* information. Future plans which will rely more on both outputs (e.g., how many home-delivered meals were served) and program *outcomes* now being developed and tested. Both the 2001 performance plan and the 1999 performance report will be available on AoA's web site following the release of the President's fiscal year 2001 budget.

Part II – Performance Measures

Budget Level and Full-Time Equivalent Chart

Performance Area	Request	FTE
Strategic Goal 1: Provide opportunities for better nutrition and improved health	$560,992	58
Strategic Goal 2: Provide access to services people need by reducing barriers; e.g., by utilizing culturally competent service delivery approaches and by increasing their participation and engagement	$331,052	60
Strategic Goal 3: Provide opportunities to live with safety, independence and dignity	$149,849	33
Strategic Goal 4: Develop comprehensive and coordinated services systems based on local needs	$ 26,162	16

Performance Measures by Performance Area

Strategic Goal 2.1: Provide opportunities for better nutrition and improved health

Resources, Strategic Goal 2.1		
FY 1999 Actual	**FY 2000 Appropriation**	**FY 2001 Requested**
$520,841	$555,992	$560,992

Performance Goal 2.1.A – Home-Delivered Meals	FY Targets	Actual Performance
For fiscal year 2000, increase by 32 million meals above the 1997 baseline, and for 2001, increase by 11 million meals over the 2000 goal.	FY01: 166,000,000 FY00: 155,000,000 FY99: 119,000,000	FY99: 9/01 FY98: 9/00 FY97: 123,455,000 FY96: 119,110,318 FY95: 119,000,000

Performance Goal 2.1.B – Congregate Meals	FY Targets	Actual Performance
Maintain the number of meals served at the 1997 baseline.	FY01: 113,147,407 FY00: 113,147,407 FY99: 123,400,000	FY99: 9/01 FY98: 9/00 FY97: 113,147,407 FY96: 118,632,573 FY95: 123,400,000

Introduction

AoA provides congregate and home-delivered nutrition services to older adults at risk of poor nutrition, poor health, social isolation and loss of independence. Although these services often include nutrition assessment, education, and counseling, the primary service provided is meals. The purpose of both nutrition services programs is to improve the dietary intake of participants, offer them opportunities for social participation and engagement and for the development and

maintenance of informal support networks, and to link participants to other health and social services, as needed and as appropriate. Nutrition services improve nutritional status, decrease the risk of disease and disease-related disability, help maintain cognitive and physical functioning and decrease food insecurity.

Scientific evidence supports the relationship between good nutrition, health, and functionality. Four of the ten leading causes of death and disability (heart disease, cancer, stroke, and diabetes) among older adults are tied to poor nutrition. A decline in cognitive functioning and a reduction of the risk of coronary artery disease are linked to adequate intake of vitamins B6, B12, and folic acid. The prevention and treatment of osteoporosis and the maintenance of mobility are tied to the consumption of adequate amounts of calcium and vitamin D. Evidence indicates that the development of blindness due to cataracts or age-related macular degeneration may be retarded if there are adequate amounts of the antioxidants -- vitamin E, beta-carotene and other carotenoids, and ascorbic acid -- in diets. Research has also found that antioxidants may play a role in the prevention of central nervous system disorders such as Alzheimer's, Parkinson's Disease, and atherosclerosis. Obesity caused by the interaction of poor nutrition and lack of physical activity decreases mobility, increases the risk of chronic diseases and disability and ultimately decreases the life span.

OAA funded nutrition services are targeted to those in greatest economic and social need, with particular attention given to low-income minorities. Compared to the general U.S. population, meal program participants are older, poorer, more likely to live alone; are more often minorities; are at higher nutritional, and health risk; and experience greater functional impairment. These programs are often the primary, daily food source for many participants, who are typically economically disadvantaged. The meals provided to program participants generally supply a significant proportion of their daily nutrients -- 40 to 50 percent – which they need to maintain health and functionality. As a result of this, the level of meal service provided is used to indicate the impact of the nutrition program.

Fiscal Year 1999 Accomplishments

National Nutrition Standards

The Older Americans Act prescribes National Nutrition Standards that must be met in meals for older adults. These standards require that the meals served through the Elderly Nutrition Program (ENP) promote health, are culturally appropriate, and meet the special health needs of older adults. Each meal must contain 1/3 of the Recommended Dietary Allowances (RDAs) as established by the Food and Nutrition Board, Institute of Medicine, National Academy of Sciences. Also, each meal must meet the Dietary Guidelines for Americans from the Department of Health and Human Services (HHS) and the United States Department of Agriculture (USDA). Moreover, the standards require that meals programs comply with state, tribal, and local food service laws to ensure meals served are safe to eat.

AoA's monitoring of nutrition service providers' compliance with the National Nutrition Standards and other service activities, provides assurance that the meals delivered through the ENP contribute to improved nutritional intake and promote the improved health of recipients.

Partnerships to Help Ensure the Needs of Older Adults Are Met

AoA officials have participated on the following interagency committees that addressed issues related to nutrition and health issues:

- the Nutrition Objective Sub-committee for the HHS Healthy People 2000
- Healthy People 2010 National Health Objectives

- HHS Nutrition Policy Board
- HHS Dietary Guidance Committee
- HHS/USDA Food Security committee
- HHS/USDA Nutrition and Welfare committee
- HHS Dietary Reference Intake Working Group to insure the needs and special concerns of the older population are addressed.

Efforts to Target Specific Recipient Groups

During FY 1999, AoA issued specific requirements to grantees for reporting on the delivery of specific nutrition services. This was conducted as an initiative to determine target groups for nutrition services. SUAs were asked to collect and report data related to "nutrition risk" for program participants. The SUAs were requested to use check-listed criteria from the National Screening Initiative (NSI) to identify older adults who are at risk of becoming malnourished or who are in need of other nutrition-related services to maintain a healthy life-style. The information collected by the SUAs and reported to AoA was used by AoA to assist the National Aging Service Network to target ENP nutrition services such as congregate and home-delivered meals, nutritional counseling, and case management services to older adults with the greatest need.

Promotion of Service Needs Awareness

In order to encourage collaborative planning and service activities which can produce the most beneficial outcomes, AoA has identified opportunities and resources for the Network through which greater awareness of the service needs of older Americans can be realized.

During FY 1999, AoA participated in HHS Healthy People 2000 and 2010, a national prevention initiative that has established national health targets and that calls for community collaboration in their achievement. In order to expedite efforts to promote health and prevent illnesses among older persons, AoA has encouraged the national Aging Network to participate in the Healthy People initiative and to strive to meet national health targets.

AoA is also actively engaged in the deliberations of the HHS Dietary Reference Intake (DRI) Working Group to determine the areas of the Recommended Daily Allowance (RDAs), now known as the Dietary Reference Intakes (DRIs), that require revision. The DRI Working Group provides funding and direction to the Food and Nutrition Board of the Institute of Medicine in developing new approaches to DRIs. It also recommends experts for discussion panels and provides assurance that the informational needs of the federal government and other recipients are met.

Finally, AoA is an active participant on a federal interagency working group for food security measurement that resulted in the first-ever questionnaire to measure food security in America. This questionnaire is used in both HHS and USDA food and health surveys to determine food security and is used annually as part of the Current Population Survey conducted by the Census Bureau.

Direct Technical Assistance

AoA personnel provide direct technical assistance via telephone; on-site assistance; presentations at national, regional, state, and tribal conferences; and through professional meetings. During FY 1999, AoA personnel provided more than 20 presentations on nutrition at national meetings. Two of AoA's regional offices held meetings on nutrition services that were attended by a total of 80 Indian tribes.

Technical assistance was directly provided to at least 30 Indian tribes on-site in conjunction with on-going program monitoring activities. Guidance has been provided to tribes via telephone technical assistance on issues such as: how to purchase blast freezing equipment; the implications of food service laws; constructing client and program outcome measures; interpretations of the OAA; the nutrient content of meals; and the nutrient needs of older adults.

As part of its information dissemination function, AoA supports a Nutrition Resource Center website that includes bibliographies on 45 topics related to nutrition and aging. The site is connected electronically to actual publication abstracts. The bibliographies include a wide range of topics including articles on service provision, innovations, minority issues, caregiver issues, and others. On a quarterly basis, the Center publishes an article in the general nutrition Newsletter which is read by approximately 2,500 nutritionists who work with programs that serve older adults. During the course of a year, Center personnel provide at least 20 presentations to various groups.

Performance Goal 2.1.C – Programs for American Indians, Alaskan Natives and Native Hawaiians	**FY Targets**	**Actual Performance**
Improve the health and well-being, and reduce social isolation, among older American Indians, Alaska Natives and Native Hawaiians through the provision of community-based services.	FY01: Increase service provision by ten percent over FY97 levels FY00: Maintain service provision at FY97 levels FY99: N/A Home-Delivered Meals FY01: 1,795,200 FY00: 1,632,000 FY99: 1,455,911 Congregate Meals FY01: 1,582,790 FY00: 1,438,908 FY99: 1,321,728 Transportation FY01: 731,569 FY00: 665,063 FY99: 763,287	Home-Delivered Meals FY99: 9/01 FY98: 9/00 FY97 1,632,536 FY96 1,394,093 FY95 (corrected) 1,453,733 Congregate Meals FY99: 9/01 FY98: 9/00 FY97 1,438,908 FY96 1,273,584 FY95 (corrected) 1,285,447 Transportation FY99: 9/01 FY98: 9/00 FY97 665,063 FY96 701,969 FY95 (corrected) 740,262

	Information and Referral FY01: 746,900 FY00: 678,979 FY99: 632,462 In-Home Services FY01: 952,600 FY00: 866,194 FY99: 741,859 Other Services FY01: 649,710 FY00: 590,723 FY99: 511,646	Information and Referral FY99: 9/01 FY98: 9/00 FY97 678,979 FY96 698,258 FY95 (corrected) 630,950 In-home Services FY99: 9/01 FY98: 9/00 FY97 866,194 FY96 788,003 FY95 (corrected) 698,015 Other Services FY99: 9/01 FY98: 9/00 FY97 590,723 FY96 598,896 FY95 (corrected) 583,746

Introduction

The 1990 Census counted almost 166,000 American Indians and Alaskan Natives over the age of 60. Although older adults represent only about eight percent of the total American Indian and Alaskan Native population, their numbers are increasing rapidly. This increase is due to better health and living conditions. Today, older American Indians, Alaskan Natives and Native Hawaiians can expect to live well into their eighties and nineties. This recent, but welcome trend will place even greater demands on home and community-based service delivery systems.

AoA's American Indian, Alaskan Native, and Native Hawaiian Program--Title VI of the OAA — is responsible for serving as the federal advocate on behalf of older Native Americans, coordinating activities with other federal departments and agencies, administering grants to Native Americans, and collecting and disseminating information related to the problems of older Native Americans.

Under Title VI of the OAA, AoA annually awards grants to provide supportive and nutrition services for American Indian, Alaskan Native and Native Hawaiian older adults living in the Title VI service area. In 1997, grants were awarded to 221 American Indian and Alaskan Native tribal organizations representing 300 tribes, and one organization serving Native Hawaiian older adults.

In addition to nutrition services, the Title VI program funds supportive services such as information and assistance, transportation, chore services, homemaker services, health aide services, outreach, family support, and legal assistance. Training and technical assistance in these areas is made available to Title VI grantees in a variety of ways, including on-site, telephone and written consultation, national meetings, newsletters, and electronically, by AoA staff and the Native American Resource Centers. Training and technical assistance are designed to further the development and strengthen the capacity of Title VI program directors and staff to

manage comprehensive and coordinated systems of nutritional and supportive services for American Indian, Alaskan Native and Native Hawaiian older adults.

Fiscal Year 1999 Accomplishments

Providing Outreach, Training, and Expansion of Awareness of the Aging Process

With funding from AoA's program for State and Local Innovations and Projects of National Significance, the University of Colorado and the University of North Dakota National Resource Centers on Native American Aging have provided outreach, training and heightened public awareness of the aging process as it relates to American Indians.

The University of Colorado disseminates information through a successful website. The University of North Dakota offered more than 12 Geriatric Leadership Seminars nationally in FY 1999, focusing on the empowerment of older Native Indian adults through enhanced services.

Results

During FY 1999, the University of Colorado website was contacted by 3500 individuals who subsequently accessed available training and outreach services aimed at improving quality of life in Indian communities. More than 250 individuals participated in the University of North Dakota's Geriatric Leadership Seminars. Information obtained by seminar participants has enabled them to implement program enhancements in numerous Indian communities.

Providing Home, Transportation, Information and Assistance Support Services to Indian Communities

Locally administered home and community-based programs and services are an important component of the long-term care delivery system necessary to meet the needs of functionally-impaired older adults. In recent years, Indian tribes have pursued the development of appropriate home and community-based long term care services to enable their elders to remain as independent as possible in community settings of their choice. Through 227 grants provided by AoA, a variety of in-home support services were provided to tribes, tribal organizations and Native Hawaiian organizations during FY 1999:

More than 750,000 older American Indians, Alaska Natives and Native Hawaiians received a variety of in-home services including personal care services, homemaker services, health aide services, case management assistance, and family support.

Over 600,000 rides were provided to older Native American adults to meal sites, medical appointments, grocery stores and other essential community services.

More than 600,000 older Native American adults received information and assistance on issues dealing with social security, food stamps, and other topics.

Results

In-home services are permitting Native American older adults to remain in their homes for as long as possible, containing costs associated with the premature institutionalization of older adults.

Recipients of rides were able to increase their access to programs and services and maintain greater independence within their communities.

Recipients of information and assistance have increased awareness about their right to receive social security, food stamps and other services which is improving their health and standard of living in their communities.

The identification of Home and Community Based Long-Term Care (HCBLTC) needs in Indian communities and barriers to addressing these needs.

To date, the design and development of strategies for HCBLTC in Indian communities have proceeded with limited involvement of federal and state agencies. Historical differences among various tribes in the availability and use of federal, tribal and state programs have resulted in an erratic and, in some cases, an essentially nonexistent infrastructure for HCBLTC. AoA is addressing this in two ways:

1) To better identify HCBLTC needs, AoA and two resource centers funded by AoA -- the Native Elder Health Care Resource Center at the University of Colorado and the National Resource Center on Native American Aging at the University of North Dakota -- surveyed key tribal program administrators from 108 Federally recognized tribes. During FY 1999, information was collected about the availability of home and community-based long-term care programs and resources in American Indian and Alaska Native communities. Information was also collected about how the programs and services are funded and about barriers to establishing such programs and services in Indian communities.

2) Also, through a cooperative agreement, funded by AoA, the National Resource Center on Native American Aging has developed a “Health and Social Needs Assessment” for Native Elders for use at the community level. It is currently being pilot-tested at various sites. Workshops are also being conducted on its use. Barriers, identified in the survey by tribal officials, to addressing HCBLTC needs include fragmented and insufficient funds, minimal appreciation of local need, limited access to decision-makers, and excessive regulations.

Results

During FY 1999 AoA, the Native Elder Health Care Resource Center, and the National Resource Center on Native American Aging successfully used survey information to improve the capacity of tribes to develop responsive home and community based programs. Many tribes have since demonstrated increased understanding of the issues and of potential resources and have begun to tap into available funding sources and identify and pursue training opportunities that will help them develop and improve HCBLTC services in their communities.

AoA intends to work with tribes and use data from needs assessments to help them plan necessary HCBLTC programs and services in their communities.

Coordinate with Other Federal Agencies and Private Organizations to Assist Tribes in Overcoming Barriers and Facilitating the Establishment of Home and Community Based Long-Term Care Programs and Services.

AoA’s American Indian, Alaskan Native, and Native Hawaiian Program, Title VI of the OAA, is responsible for serving as an advocate on behalf of older Native Americans, coordinating activities with other federal departments and agencies, administering grants to Native Americans, and collecting and disseminating information related to the problems of older Native Americans.

A permanent Interagency Task Force comprised of representatives of Federal departments and agencies with "an interest in older Indians and their welfare" is mandated legislatively for the purpose of improving services to older Indians. The Director of the Office of American Indian, Alaskan Native and Native Hawaiian Programs chairs this Task Force. Task Force members focus on three areas of concern: health, transportation, and data. Three subcommittees gather and analyze information, offer recommendations to the Task Force to further interagency collaboration and enhance services to older Indians, and identify problems that prevent or diminish collaboration.

During FY 1999, as an outgrowth of the discussions of the Interagency Task Force for Older Indians chaired by AoA, a subcommittee was formed to address the need for the development of culturally appropriate material to be disseminated to the tribes. Participating members of the subcommittees include representatives from the Veterans Administration (VA) and the Health Care Financing Administration (HCFA).

During FY 1999, meetings were held with HCFA and AARP on home and community-based waivers (Medicaid 1915C), with an eye toward training family caregivers to be eligible to receive Medicaid 1915C-waiver reimbursements for providing home and community based services.

Also during FY 1999, contacts with and meetings involving the Home and Community-Based Care Office of the VA were held to discuss methods of reaching and assisting elderly veterans who reside on reservations. As a result of these meetings, AoA has invited representatives from the VA to join its ongoing Interagency Task Force on Older Indians.

Results

The FY 1999 Interagency Task Force on Older Indians Subcommittee's efforts will lead to the dissemination of culturally appropriate materials to Indian tribes aimed at heightening their sensitivity to the needs of their elders and at increasing their understanding of changes in Medicare/Medicaid services.

Training and certification of family caregivers will empower them to care for their elderly family members in Indian communities in more culturally sensitive and acceptable ways.

The AoA-VA partnership has led to increased efforts to reach and assist elderly Indian veterans and to increase their knowledge of and access to services.

Strategic Goal 2.2: Provide access to services people need by reducing barriers; e.g., by utilizing culturally competent service delivery approaches and by increasing their participation and engagement

Resources, Strategic Goal 2.2		
FY 1999 Actual	**FY 2000 Appropriation**	**FY 2001 Requested**
$315,927	$316,052	$331,052

Performance Goal 2.2.A Information and Assistance	**FY Targets**	**Actual Performance**
Maintain, then increase the number of contacts for information and assistance programs over FY97 baseline.	FY01: 15,243,749 FY00: 13,985,091 FY99: 12,526,537	FY99: 9/01 FY98: 9/00 FY97: 13,985,091 FY96: 13,739,633 FY95: 12,526,537 Contacts
Increase level of leveraged funding over FY97 baseline.	FY01: 5% (+$1,943,373) increase in leveraged funding. FY00: 1% (+$381,054) increase in leveraged funding to $38,867,460. FY99: 1% (+381,054) increase in leveraged funding over the FY95 baseline of $38,105,352 to $38,486,406	FY99: 9/01 FY98: 9/00 FY97: $47,293,671 FY96: $42,293,671 FY95: $38,105,352

Introduction

Social and demographic trends are making the need for information services increasingly important to the average American family. Today, older Americans and caregivers face a complicated array of choices and decisions about services and programs available to assist them. Many need support and assistance to navigate the complex environment of public and private sector benefits and services. Information and Assistance (I&A), established by the 1973 Amendments to the OAA, is a federally required service intended to inform, guide, and link older adults to available, appropriate, and acceptable services to meet their needs. Currently, there are I&A programs operated by each State Unit on Aging and Area Agency on Aging, covering all geographic areas of the country.

Often the first point of contact for assistance, I&A programs receive the broadest range of inquiries for older persons. I&A programs assist older persons and caregivers in assessing their needs, identifying the most suitable services to meet their needs, and linking them to the organizations providing the services. Knowing that I&A services are the key to keeping older adults and their caregivers connected to needed services, AoA continues to play an important role in stimulating improvements to the operation of I&A systems.

Fiscal Year 1999 Accomplishments

Grants to States and Territories

AoA awarded grants for supportive services and senior centers, which enabled each state and territory to fund access services such as I&A throughout their jurisdictions.

Results

In FY97, the number of I&A contacts was 13,985,091.

Funding to the Eldercare Locator

Locating aging services and opportunities for social engagement can sometimes be difficult for older persons and their caregivers because there is no uniform way these services are listed in telephone directories and 411 directory assistance services. In the early 1990s, AoA launched the National I&A Initiative to reduce barriers to accessing these services. The initiative created the Eldercare Locator, a national toll free telephone directory service designed to link national callers to state and local I&A services as the gateway to the aging network. In addition, the Locator provides information on a wide variety of services such as meals, home care, transportation, housing, home repair, legal and community services.

AoA supports the Locator through a cooperative, on-going partnership with the National Association of Area Agencies on Aging (NAAAA) and the National Association of State Units on Aging (NASUA). AoA provides oversight of the Locator's operations and takes steps when necessary to improve its performance. For example, when the monthly statistics showed that older adults were disconnecting when the wait to speak with an information specialist became too long, AoA increased funding to allow for a greater number of telephone information specialists.

Results

Due to the increase in the number of telephone information specialists, the number of persons served per month has increased from 6,578 to 7,196 in fiscal year 1999, meaning that almost 10 percent more older people are being connected to the assistance they need. Further, the rate of calls going unanswered (due to the caller hanging up before making contact with an information specialist) has been reduced from over 20% to 10%.

Outreach to Minority and Women's Organizations

AoA, working in partnership with NASUA and NAAAA, undertook a two-fold outreach goal: (1) to encourage minority and women's organizations to help promote the Locator; and (2) to learn how the Locator could best serve the individual constituencies. Outreach activities included meeting with minority organizations, conducting workshops and exhibiting at minority conferences, distributing culturally specific promotional materials, and working with minority media. These efforts began with a series of focus groups with African-American, Asian, Caucasian, Hispanic, and Native American women to learn their perceptions on and planning for long-term care. For this purpose, AoA established the American Indian Advisory Group (AIAG), composed of representatives from various American Indian organizations across the country, to advise us on culturally competent ways to respond to the needs of American Indians.

Results

The results of the focus groups will be publicly released in February, 2000, and will launch a initiative to raise awareness about women and long-term care issues.

Support of National Aging Information & Referral Center

AoA continued to support the National Aging Information and Referral (I&R) Support Center in fiscal year 1999. The Center provides assistance to I&A providers to enhance the quality and professionalism of the I&A system and promotes improvements in management, operations, and staff development. In partnership with the Center, AoA sponsored in May the National Aging I&R Symposium and State I&R Liaison Retreat. The symposium brought I&A professionals together from all sections of the country to facilitate information exchange, identify and reduce barriers to service delivery, and promote adoption of best practices in service delivery.

Results

As a result of the symposium, states such as North Carolina, Minnesota and Virginia are working with Center staff to evaluate their current I&A systems and implement a plan to modernize service operations.

Partnership with HCFA

AoA partnered the HCFA to increase the availability of information for older persons about their health care choices under Medicare+Choice. Funds transferred from HCFA to AoA were awarded to State Agencies on Aging to enable them to conduct specialized training that enhanced the capacity of I&A programs to effectively advise and refer Medicare beneficiaries to informational resources about Medicare+Choice.

To support state and local programs, AoA collaborated with the National Association of State Units on Aging in the development of "Medicare+Choice: Training Manual for the Older Americans Act Information & Assistance Programs." This is a comprehensive training curriculum designed to acquaint state, area agency and local aging I&A systems with the new Medicare+Choice, including options and where and when to refer beneficiaries for expert help. The training manual was distributed to all State and Area Agencies on Aging, and over 5,000 people have been trained utilizing the package.

Results

As a result of training in North Carolina, 88% of the I&A program participants stated that they now know the Medicare options available and are comfortable in explaining Medicare+Choice to others. Clearly, this training will result in accurate Medicare information being provided to older people contacting I&A services in North Carolina. In Arizona there was a 25% increase in calls to the state health insurance hotline once the state's I&A specialists learned of the service through their Medicare+Choice training. This marked the beginning of a significant partnership between the state's I&A specialists and State Health Insurance Counseling Program.

Performance Goal 2.2.B – Transportation	**FY Targets**	**Actual Performance**
Maintain then increase the number of one-way rides over FY97 baseline.	FY01: 50,770,340 FY00: 46,578,352 FY99: 39,496,946	FY99: 9/01 FY98: 9/00 FY97: 46,578,352 FY96: 36,902,111 FY95: 39,496,946 rides
Increase level of leveraged funding over FY97 baseline.	FY01: 1% (+$1,005,760) increase	

	FY00: 1% (+$953,497) FY99: 1% (+$953,497) increase in leveraged funding over the FY95 baseline of $95,349,783 to $96,403,280.	FY99: 9/01 FY98: 9/00 FY97: $100,576,352 FY96: 97,634,395 FY95: 95,349,783

Introduction

As America's population ages and experiences longevity in record numbers, the issue of mobility rises in importance. Since 1900, the percentage of Americans age 65 and older has more than tripled. By 2030, there will be about 70 million older persons, more than twice their number in 1997.

According to a 1997 study, one-fourth of the 75-and-older age group does not drive. This number is expected to increase as our population ages, creating an even greater need for alternative transportation services. More non-drivers will be compelled to rely on public transportation systems, provided they exist in their community, or on specialized transportation services.

AoA supports the development of more options for access to transportation by:

- providing grants to states and territories to maintain service levels and, where possible, to leverage funding to increase these services;
- advocating for the coordination of transportation services;
- offering technical advice and guidance; and,
- funding demonstrations of promising alternatives.

Fiscal Year 1999 Accomplishments

Grants to States and Territories

In response to its goal of maintaining service provision levels, AoA provided 57 formula grants to states and territories for supportive services and senior centers. These OAA grants are used by states and territories to provide services assessed as needed and deemed most appropriate within each community. Supportive services can include transportation services which offer older persons access to senior centers, adult day care, doctor's offices, hospitals, clinics, grocery stores, congregate meal sites, and other programs and destinations. Besides helping older persons to meet the obligations and responsibilities which are part of daily life, transportation services make social participation and engagement possible, which is an important component of quality of life. National studies show that the greatest problem for older persons caused by the lack of transportation is a sense of loneliness and uselessness. A person overcome with these feelings is more likely to be a candidate for depression, declines in physical health, and early institutionalization, a costly and preventable fate.

The Supportive Services funds allocated to the 57 state and territories are distributed, following a needs assessment based state plan, to 655 Area Agencies on Aging, which in turn award grants or contracts to local service providers in keeping with a comparable area plan. Services are targeted to persons 60 years of age and over, with a focus upon those individuals with the greatest economic and social needs. Particular attention is given to low-income minorities.

State agencies report that during FY97, the latest fiscal year for which data are available, these grants were responsible for providing a total of 46,578,300 rides to senior centers, adult day care, doctor's offices, hospitals, clinics, grocery stores and congregate meal sites. The total number of one-way rides in fiscal year 1997 already exceeded AoA's FY99 goal. Further, in expending

$65,158,993 for the provision of transportation services, the states exceeded, in fiscal year 1997, AoA's FY99 goal for a 1% increase in leveraged funding. Statistics for FY98 and FY99 are being compiled by the states.

Results

A significant barrier to services among older adults is the lack of transportation. In some rural communities without public transportation systems, transportation services are most often available through Head Start and senior vans. Funding received through OAA Supportive Services grants helps states and territories provide older Americans with transportation alternatives which enable them to access vital services, remain independent, and continue to be engaged in their communities.

Coordinated Services

To create and improve transportation options, organizations collaborate and coordinate to pool their resources, avoid inefficiencies, and reduce operating costs. According to an October 1999 GAO report, coordinated services reduce federal transportation program costs by clustering passengers, using fewer one-way trips and sharing transportation personnel, equipment and facilitation. Another report by the Community Transportation Assistance Program (CTAP) based on five case studies, showed significant reductions in average cost per passenger trip (a decrease from $7.92 to $4.06) and vehicle hours (a decline from $12.83 to $6.89) as a result of coordination. An increase in the number of trips per month and total trips per passenger hour were also documented.

To generate more coordinated transportation options and resources for older Americans, AoA is a participating partner in the Department of Health and Human Services (HHS) / Department of Transportation (DOT) Coordinating Council on Access and Mobility. The Council is a policy and planning group organized as a consequence of mutual recognition of the potential jeopardies and missed opportunities which are inevitable when specialized and human services transportation are not coordinated. Together, Council members have produced the "Best Practices in Specialized and Human Services Transportation Coordination" guidebook, widely considered the definitive reference for the industry.

Results

As a Council member, AoA contributed through the guidebook to the identification of new resource opportunities in local communities. In providing specific advice on the issue of "excess capacity," AoA clarified client eligibility requirements and corrected the erroneous belief that providers serving older adults are not permitted to coordinate services or respond to the needs of other clients. AoA advised that the OAA does not contain categorical requirements which limit excess service capacities. Thus, provided that reimbursement is provided for transportation assistance rendered, providers can serve non-elderly persons and can pool their services. For Area Agencies on Aging, this advice represented a significant breakthrough, giving local communities the ability to share resources, include non-elderly clients for reimbursement, and accordingly expand and improve transportation services.

Technical Assistance and Guidance

The Department recognizes the important role of community transportation in the removal of barriers to service access and in increasing the likelihood of social participation and engagement among persons who might otherwise be isolated. HHS therefore funds the Community Transportation Assistance Program (CTAP) through the Community Transportation Association of America (CTAA). AoA is a member of CTAP's National Leadership Council, comprised of representatives from several national organizations of local human service providers. As a member, AoA's focus is upon ensuring that multidisciplinary, multi-agency technical assistance is

available for local aging transportation service providers. For example, AoA's efforts resulted in technical assistance for the state of New Hampshire in its development of a new transportation program.

AoA regularly provides technical assistance and guidance on transportation issues which pertain to older persons. As an example, it was a technical advisor for a DOT/HHS Coordinating Council contract for a study aimed at encouraging states and localities to rethink mobility and independence issues related to older drivers. As an outgrowth of this successful effort, a second study is currently being funded by the DOT and the National Transportation Research Board to identify ways to improve transit options for older adults.

Results

The State of New Hampshire has reported that it has received more than adequate technical assistance from AoA and has thus been able to design a transportation program that did not previously exist.

The studies conducted by the DOT are expected to shape transportation policy and particularly decisions regarding public transit needs and innovations to achieve quality transportation services for specialized populations, including older adults.

Funding of Demonstrations and Distribution of Information

AoA has funded several important transportation demonstrations that highlight coordinated transportation program models and disseminated findings from these projects to the Aging Network to encourage replication of "best practices." Examples include:

- Plains Area Agency on Aging, Wichita, Kansas, which launched a coordinated transportation brokerage system incorporating the paratransit service of Wichita's urban transit system. Rural public transit for the city's outlying areas and transportation services for both Medicaid beneficiaries and area residents with developmental disabilities are all features of the system.

- Care-A-Van, Ft. Collins, Colorado, and its sibling volunteer-based transportation system (SAINT), continue to serve frail, low-income, rural, and other at-risk, transit-dependent older adults. This system has expanded to provide complementary paratransit service for the city's "TransFort" public transit system.

- Portage Area Regional Transportation Authority (PARTA), Portage County, Ohio, Transit Authority demonstrates enhanced methods for serving persons with disabilities. In addition, the state of Ohio is continuing a vigorous campaign to improve the integration of AoA-funded transportation services with public transit activities in the rural areas of the state.

Results

A number of demonstrations funded by the AoA have received national recognition. The Wichita brokerage system has been recognized as a model of effective cooperation and of efficient service provision. CTAA's National Transit Resource Center continues to use Fort Collins' service as a model of effective volunteer-based coordinated transportation. As a result of all its initiatives, the Portage Area Regional Transportation Authority has been recognized nationally for its leadership in the effective coordination of public transit, human service transportation, and paratransit services. PARTA staff and consultants have given numerous presentations on their achievements at CTAA's EXPO and at many other state and national training events. More rides to more people and overall costs were reduced in some cases because of PARTA's work.

Performance Goal 2.2.C – Case Management	FY Targets	Actual Performance
Maintain the number of hours spent on case management activities at the FY97 baseline (Discontinued in FY99)	FY01: Not Applicable FY00: Not Applicable FY99: 2,976,149	FY99: 9/01 FY98: 9/00 FY97: 2,701,728 FY96: 3,426,542 FY95: 2,976,149 hours
Increase the level of leveraged funding over the FY97 baseline. (Discontinued in FY99)	FY01: Not Applicable FY00: Not Applicable FY99: 1% (+$646,226) increase in leveraged funding over the FY95 baseline of $64,622,578 to $65,268,804	FY99: 9/01 FY98: 9/00 FY97: $53,364,889 FY96: $76,879,489 FY95: $64,622,578

Introduction and Disclaimer

While we had previously used case management services as part of an approximate representation of community-based access services, discussions with state and local officials have convinced us that this is no longer an appropriate measure.

In states and localities, "consumer-directed care" is becoming increasingly popular. This means that, rather than having a professional manage a "case," people who receive care are making their own decisions about the most appropriate services to meet their needs. Consequently, the trend is toward reduced provision of this service.

AoA will report only numeric data in this area until information becomes available for fiscal year 1999.

Performance Goal 2.2.D – Alzheimer's Disease Demonstration Grants to States	FY Targets	Actual Performance
During the transitional period in which AoA will be assuming full responsibility for program administration from HRSA; AoA is seeking to ensure a successful transfer of ADDGS from HRSA.	FY01: Full program responsibility transferred and continuing coordination assured. FY00: N/A FY99: N/A	FY 1999: AoA and HRSA collaborated to ensure a smooth transition of the 15 Alzheimer's Disease Demonstration Grants awarded to individual states. These projects carry out diverse activities and have used creative approaches to leverage community resources to expand services to persons with Alzheimer's disease.

AoA is also seeking to achieve improved programmatic coordination with the National Aging Network.	FY01: Improve programmatic coordination of the Alzheimer's Disease Demonstration Grants to States program within the National Aging Network. FY00: N/A FY99: N/A	FY 1999: AoA routinely disseminates and shares information on program achievements to enhance awareness and improve programmatic coordination of ADDGS information within the National Aging Network.

Introduction

The Alzheimer's Disease Demonstration Grants to States Program (ADDGS) was established under Section 398 of the Public Health Service Act as amended by the Health Professions Education Partnerships Act of 1998. Beginning in FY 1999, the program was transferred from the Health Resources and Services Administration (HRSA) to the Administration on Aging.

Alzheimer's disease, the most common cause of dementia among older persons, is evidenced by a progressive, irreversible decline in mental functioning. As the disease progresses, individuals with Alzheimer's experience a loss of memory and gradually lose their capacity to reason, communicate, and carry out the simple tasks of daily life.

The type of assistance available to persons with Alzheimer's disease varies considerably from community to community. Eligibility criteria for different programs vary also. Estimates of the annual cost of Alzheimer's disease in the United States run from $80 to $100 billion a year which makes this disease a major public health concern.

AoA and HRSA collaborated to ensure a smooth transition of the 15 Alzheimer's Disease Demonstration Grants awarded to individual states. These projects carry out diverse activities and have used creative approaches to leverage community resources to expand services to persons with Alzheimer's disease and related conditions.

The major services offered through the projects are respite care, adult day care, care management, public education and information and transportation. Grantees have been particularly successful in outreach efforts to minority, low-income and rural Americans with Alzheimer's Disease. Since 1997, greater emphasis has been placed on working closely with health care providers for early diagnosis and improved care planning.

Fiscal Year 1999 Accomplishments

Planning and Coordination

Numerous meetings have been held to coordinate the transfer of the ADDGS Program from HRSA to AoA. The primary purpose of the meetings has been to clarify AoA's new role and the roles of program principals, communicate program transfer dates, methodologies, and timing for the transfer of physical and electronic program information, and build trust and acceptance for AoA program leadership. AoA program staff is continuing to work with providers in sharing their

technical expertise in the field of aging as well as gaining a better understanding of local Alzheimer's Program needs.

Results

Meetings and work with providers have resulted in improved planning and coordination, information sharing, encouragement of partnerships and sharing of best practices with the National Aging Network, all of which improves AoA's ability to provide program leadership and direction to the ADDGS Program.

Sharing of Information on Program Achievements

To enhance awareness and improve programmatic coordination of ADDGS information within the National Aging Network, AoA routinely disseminates and shares information on program achievements. This is done through:

- distribution of products catalogue – a compendium of products developed through the HRSA/AoA Altzheimer's Grant to States Project. It includes outreach materials, books, videos, training manuals, and two indexes which aid in finding products for specific populations such as the Legacy Express and El Portal programs discussed below;

- attendance and presentations at national meetings and conferences; and

- showcasing awards and other recognition.

"Legacy Express," a self-directed care model, has been developed to empower persons with Alzheimer's and their caregivers to choose and make arrangements for services that best meet their needs. This model, which promotes AoA's priority of consumer empowerment, emphasizes the role of older persons as consumers, by encouraging their participation in planning, managing and delivering the services they need. It is presently operating within 13 counties in Georgia and is being replicated in other parts of the country.

In FY 1999, AoA attended the annual National Public Policy Conference sponsored by local Alzheimer's Association Chapters. During the meeting, AoA provided extensive information on the progress of the ADDGS Program transfer from HRSA to AoA and what this will mean for Alzheimer's organizations and service providers. Updates on other AoA initiatives and an explanation of its organizational structure were also provided.

During FY 1999, AoA showcased awards and recognition for Alzheimer's program innovations at a variety of meetings and conferences to encourage the use of best practices and strengthen the National Aging Network's ability to deliver Alzheimer's programs and services. Examples of showcased activities included the State of Georgia's Mobile Day Care Program, California's El Portal Program and the successful tailoring of services and linkages with ethnic minority advocacy groups in the State of Washington:

Georgia's Mobile Day Care Program offers ambulatory day care through local churches and community centers to individuals in rural areas where no permanent sites exist. Communities "share" day care staff as they travel from region to region. The program more effectively lends itself to the needs of rural, isolated communities and can be shaped to meet similar needs in any given community.

The El Portal project in California focuses on Latino communities in the eastern and southeastern section of Los Angeles County and is designed to increase community outreach, networking and awareness and improve coordination and delivery of Alzheimer services. The program emphasizes expanding and developing culturally sensitive and linguistically appropriate materials and is a prime candidate for replication in other locations with under-served Latino populations.

The State of Washington developed its own community care program for individuals with Alzheimer's Disease. This project augmented existing in-home respite care, case management services, adult day care, and residential services and provided a variety of new programs such as, multilingual education and training, training sessions on cultural sensitivity, multilingual outreach, transportation services, and interpretation and translation assistance. It ultimately inspired collaboration and new linkages with ethnic minority advocacy groups and medical and social service agencies.

Results

Use of products featured in the "Resources for Serving Caregivers in Culturally Diverse Communities" is resulting in replication of best practices in the delivery of Alzheimer's services which is, in turn, improving programmatic coordination of ADDGS services within the National Aging Network.

AoA's attendance at the National Public Policy Conference is improving Alzheimer's Association organizations' understanding of AoA and is facilitating smooth transition of the ADDGS Program to AoA from HRSA.

AoA's showcasing of nationally recognized best practices is bringing about a greater awareness within the National Aging Network of new methodologies and program innovations for delivering Alzheimer's services and is improving programmatic coordination of these services.

Strategic Goal 2.3: Provide opportunities to live with safety, independence and dignity

Resources, Strategic Goal 2.3		
FY 1999 Actual	**FY 2000 Appropriation**	**FY 2001 Requested**
$ 18,581	$ 24,631	$149,849

Performance Goal 2.3.A – Long-Term Care Ombudsman	FY Targets	Actual Performance
Maintain the combined resolution/partial resolution rate of 70 percent of complaints in nursing homes.	FY01: 70% FY00: 70% FY99: 71.48%	FY99: 11/00 FY98: 70.6% FY97: 72.1% FY96: 74.0% FY95: 71.5%

Introduction

Long-term care ombudsmen are necessary advocates for residents of nursing homes, board and care homes, and adult care facilities. Since the Long-term Care Ombudsman Program began 25 years ago, thousands of paid and volunteer ombudsmen working in every state have made a dramatic difference in the lives of long-term care residents. Long-term Care Ombudsmen advocate on behalf of individuals and groups of residents as well as work to effect systems changes on a local, state and national level.

Ombudsman responsibilities outlined in Title VII of the Older Americans Act include:

- Identifying, investigating and resolving complaints made by or on behalf of residents;
- Providing information to residents about long-term care services;
- Representing the interests of residents before governmental agencies and seeking administrative, legal and other remedies to protect residents;
- Analyzing, commenting on and recommending changes in laws and regulations pertaining to the health, safety, welfare and rights of residents;
- Educating and informing consumers and the general public regarding issues and concerns related to long-term care and facilitating public comment on laws, regulations, policies and actions;
- Promoting the development of citizen organizations to participate in the program; and providing technical support for the development of resident and family councils to protect the well being and rights of residents.

A major goal of the Ombudsman Program is to enable residents of long-term care facilities and their families to be informed “long-term care consumers” and to facilitate the resolution of problems regarding care and conditions in long-term care facilities. Our target is to maintain the 70 percent resolution / partial resolution rate for complaints involving nursing homes.

Fiscal Year 1999 Accomplishments

AoA provides national leadership to the states in carrying out their ombudsman programs. AoA funds the National Long-Term Care Ombudsman Resource Center which provides training and technical assistance to ombudsmen throughout the country. Located in Washington, D.C., the Center is operated by the National Citizens' Coalition for Nursing Home Reform in conjunction

with the National Association of State Units on Aging. The Center provides essential support for the ombudsman network in its efforts to provide assistance to and empower long-term care residents, their families and other representatives of residents' interests. Some of the major Center objectives include:

- generating on-going communication with state and regional (local) ombudsman programs
- providing training and training materials directed at expanding ombudsman professional advocacy and management skills
- promoting public awareness of the ombudsman program

Over the last decade and through FY 1999, the Ombudsman Resource Center has provided information and training to ombudsmen on improper use of physical and chemical restraints and creative alternatives to the use of restraints. The marked decrease in the use of restraints in nursing homes, evidenced by significant reductions in deficiencies given to facilities for inappropriate use of restraints, has been due in part to the work of ombudsmen in this area.

Another primary area of focus in recent years and during FY 1999, is the involuntary discharge of residents from nursing homes. Ombudsmen continue to receive extensive training in this area and are now better equipped to assist residents and their families in these matters.

Increases in long-term care residents' complaints on uses of restraints and involuntary discharge demonstrate that residents and their families are aware of residents' rights in these and other areas and turn to the ombudsman program for help in securing their rights. (Nursing home residents' rights complaints to the ombudsman program increased by over 9 percent from 46,909 for FY 1996 to 51,385 for FY 1997, a trend that is expected to continue for FY 1998 and FY 1999.)

Results

Ombudsman training has improved Ombudsmen's abilities to assist long-term care residents in resolving complaints about conditions in long-term care facilities and other areas of concern and is helping to make older adults better healthcare consumers by improving their awareness of their health care rights and ensuring a better understanding of recourses available to them for addressing issues of dissatisfaction.

Producing and Disseminating the National Ombudsman Report

AoA compiles the National Long Term Care Ombudsman Report from information submitted by the states. The information is submitted in response to reporting requirements, which were developed by AoA in the early 1990's to comply with the requirements of the OAA and recommendations by the Office of the Inspector General and the General Accounting Office. The report includes program highlights, data on cases and complaints made to ombudsmen, information on program structure and operation; and major long-term care issues identified by states. The report is a valuable source of information available at the national level on experiences of long-term care residents and operation of the state ombudsman programs. Information in this report is used by legislators, researchers, public policy analysts, state and federal government officials, and ombudsmen themselves for a variety of purposes, including:

- understanding what is happening to long term care residents,
- addressing emerging and long-standing institutional care issues,
- having knowledge of ombudsman program structure and operation in other states, and

- targeting training provided to staff and volunteers to address the most prevalent types of complaints and designing public information which best meets the public need, as reflected in calls to the ombudsman program for information.

Because the report provides statewide data by program and per FTE, states are able to see how their programs and staffing allocations compare with one another. Where imbalances are noted, cases can be made with state legislatures for additional funding. For example, the state of Georgia secured an additional $114,000 in FY 1998 (using information from the report) leading to an updating of their statewide funding formula for the first time in many years as well as an anticipated increase in funding for FY 1999. These funds have enabled them to upgrade their Ombudsman Program and provide more services to their long term care consumers and their families.

Results

Information from the National Ombudsman Report is facilitating the improvement of many state and local ombudsman programs by enabling ombudsmen to target training in areas of need, concentrate volunteers and other resources in troubled areas, and to leverage statistical information to gain additional funding for programs from their state legislatures. .

Performance Goal 2.3.B -- Caregiver Support	**FY Targets**	**Actual Performance**
Obtain reliable baselines through support of the National Institute on Aging's Caregiver Supplement to the National Long Term Care Survey and follow-on surveys.	FY01, FY00: Baselines to be established FY99: N/A.	NA – New Program

Introduction

In the fiscal year 2001 budget proposal, AoA proposes to provide funding for caregiver support activities under the existing authority of Title III of the Older Americans Act. Help for caregivers is needed now more than ever. The population age 85 and over will continue to grow faster than any other age cohort, increasing by 50% from 1996 to 2010. Additionally, research has shown that caregiving exacts a heavy emotional, physical, and financial toll.

While the U.S. population is aging, the structure of the American family continues to evolve. More women are in the workforce, making it more difficult for them to be available as caregivers; family mobility has increased thus geographically separating older family members from younger ones; and family size has decreased resulting in fewer adult children being available to serve as caregivers. Thus, fewer family members will increasingly share caregiving responsibilities.

Support provided to informal caregivers can significantly benefit them while delaying the need of care recipients for nursing home services. For example, a recent NIH study found that caregiver stress is reduced when care recipients use adult day care and institutionalization of the care recipient is delayed.

Performance Goal 2.3.C – Health Care Anti-Fraud Activities	FY Targets	Actual Performance
Increase by 30% for fiscal year 2000 and an additional 30% for fiscal year 2001 the number of trainers who conduct activities to educate Medicare beneficiaries.	FY 2001: 23,150 additional volunteers trained FY 2000: 17,810 additional volunteers trained FY 1999: N/A	FY99 Baseline: 13,700 volunteers trained who are conducting educational sessions for Medicare beneficiaries.
Increase by 50% for fiscal year 2000 and an additional 50% for fiscal year 2001 the number of substantiated complaints generated through this program's activities.	FY 2001: 300 complaints FY 2000: 200 complaints FY 1999: N/A	FY99 Baseline: 133 complaints
Increase by 100% for fiscal year 2000 and another 150% for fiscal year 2001 the amount of Medicare funds recouped that are attributable to the project.	FY 2001: $6.75 million FY 2000: $2.70 million FY 1999: N/A	FY 99 Baseline: $1.34 million

Introduction

The General Accounting Office (GAO) estimates that billions of Medicare dollars are lost each year to waste, fraud and abuse. The Department of Health and Human Services has launched a comprehensive initiative which focuses on fighting and preventing such wasteful, fraudulent and abusive practices.

In 1995, the Administration on Aging (AoA) became a partner in a government-led effort to fight fraud, waste and abuse in the Medicare and Medicaid programs through the implementation of a ground-breaking demonstration project called Operation Restore Trust (ORT). ORT's purpose is to coordinate and target federal, state, local and private resources on those areas most plagued by fraud and abuse.

ORT is an outgrowth of a comprehensive anti-fraud initiative that began in five states -- California, Florida, Illinois, New York and Texas. This initiative created a partnership in the Department of Health and Human Services between the Health Care Financing Administration, the Office of Inspector General, and AoA, which work as a joint-team to carry out ORT. Other critical partners include the U.S. Department of Justice, state Medicaid agencies, state survey and certification agencies, Medicare contractors, State and Area Agencies on Aging, and other members of AoA's National Aging Network, including long-term care ombudsmen.

The ORT demonstration phase returned $23 for every $1 spent while focusing on the fastest growing areas of Medicare (including home health care, skilled nursing facilities, and providers of durable medical equipment).

AoA's program goal for ORT is to train National Aging Network staff and retired volunteers on ways to educate Medicaid and Medicare beneficiaries regarding how to protect themselves against fraudulent, wasteful, and abusive health care practices. This program goal relates to and supports the AoA strategic goal: opportunity to live with safety, independence and dignity, through planning and delivering quality health care services to older Americans.

Fiscal Year 1999 Accomplishments

Delivery of Grant Funded Technical Assistance and Training

AoA is committed to reducing waste, fraud and abuse in the Medicare and Medicaid programs and has been involved in ORT since its inception, providing technical assistance to state and local ombudsmen, health insurance counselors, and others to recognize and report suspected cases of fraud and abuse in nursing homes. It has since expanded these efforts by providing technical assistance and training in 18 states to other National Aging Network personnel, including staff and volunteers of State and Area Agencies on Aging, health insurance counselors, and other service providers.

One of the key components of AoA's anti-fraud efforts is the administration of its cooperative agreement demonstration projects designed to utilize the skills and expertise of retired professionals in identifying and reporting health care waste, fraud and abuse. In FY 1997 and 1998, AoA awarded 12 grants for the purpose of providing technical assistance and training in these and other related areas. During FY 1999, AoA expanded these efforts by awarding 29 new grants in 24 additional states and the District of Columbia and Puerto Rico, for a total of 41 grants designed to train retired volunteers on ways to educate Medicare and Medicaid beneficiaries regarding how to protect themselves from fraudulent, wasteful and abusive health care practices.

Through input from volunteers, partners and stakeholders, AoA also worked to develop numerous technical resources. These include:

- best practice recommendations
- a bimonthly newsletter for grantees
- a limited access internet communication system for sharing information and answering questions
- a web page which includes training manuals, pamphlets and brochures
- bi-regional conferences which bring together experts from the Office of the Inspector General, HCFA, Medicare carriers and others to develop and institutionalize strategies for preventing waste, fraud and abuse in the healthcare systems
- an annual conference for providing technical assistance and information exchange.

Results

During the initial demonstration stage of ORT, AoA staff trained an estimated 2,500 people in the five ORT states. The combined ORT effort by all of its partners led to the overall collection of $187 million in fines, recoveries, settlements, audit disallowance and civil monetary penalties owed to the federal government.

During FY 1998 and FY 1999, AoA and its grantees trained more than 16,000 volunteers to serve as Medicare and Medicaid educators in their communities. Working through group and one-on-one sessions, these volunteers educated over 325,000 beneficiaries on ways of identifying and protecting themselves against fraudulent, wasteful, and abusive health care practices. During FY 1999, more than 5,000 cases involving questionable charges for medical services were referred by the volunteers to health care providers, appropriate Medicare carriers, or the HHS Inspector General for follow-up and investigation

Delivery of Public Information

AoA has continued to provide a variety of valuable information to the general public regarding Medicare and Medicaid waste, fraud and abuse. This information helps to increase public awareness and empowers individuals to take greater personal responsibility for monitoring their own health care. The information is also designed to address the seriousness of this problem and

to subsequently provide advice and guidance on preventive techniques and methods that can help reduce victimization of older Americans through fraudulent health care practices. Examples of major presentations included:

- Information presented in public forums and other community education sessions, highlighted by a national "roll-out" event held on February 24, 1999, simultaneously in 30 sites around the country, which were linked by satellite.

- In FY 1999, AoA's grantees, developed a brochure in partnership with doctors, hospitals, and health care providers which is provided to beneficiaries when they are discharged from the hospital to inform them about the steps they can take to protect themselves from fraudulent or unscrupulous practices.

- Also in FY 1999, a series of locally-based training manuals and consumer education materials were developed, including information on Medicare and Medicaid and examples of fraudulent health care practices. Training sessions were delivered through a coordinated effort with other federal, state and local agencies.

- Another major FY 1999 activity was the creation of a health care journal for Medicare/Medicaid beneficiaries, which AoA developed in partnership with its grantees.

- Also in FY 1999, AoA funded 50 public service announcements and 1250 media events to increase public awareness on ways to protect against health care waste, fraud and abuse.

Results

Since the national "roll-out" event, dissemination of the training materials, and the informational brochures, calls from hospitals and health care personnel for additional materials and speakers have been increasing. There have also been noticeable increases in newspaper articles and a groundswell of invitations from senior centers for speakers and experts to present information on ways to combat fraudulent and unscrupulous healthcare practices. These trends highlight an increasing awareness among these groups to better understand and develop methods for dealing with this highly important healthcare issue – a primary goal of the ORT program.

During FY 1999, the health care journal was used by Medicare/Medicaid beneficiaries to record the medical care they receive. The journal facilitated communication and understanding between health care providers and patients and serves as a record for beneficiaries to use in reconciling their Medicare statements. The journal was used by beneficiaries to record such information as the purpose of health care visits, the date, the health care provider, etc. This information ultimately helped them to better understand their legitimate health care financial obligations as well as to recognize questionable and otherwise fraudulent health care charges. This increased understanding is, to a degree evidenced in the growing number of consumer complaints among these consumers.

Strategic Goal 2.4: Develop comprehensive and coordinated services systems based on local needs.

Resources, Strategic Goal 2.4		
FY 1999 Actual	**FY 2000 Appropriation**	**FY 2001 Requested**
$13,000	$21,162	$26,162

Program Goal 2.4.A -- State and Local Innovations and Projects of National Significance – Mental Health Initiative	**FY Targets**	**Actual Performance**
Create and distribute culturally-appropriate educational materials about mental illnesses common among older adults; Enable aging network professionals to recognize symptoms of mental illness, use culturally appropriate strategies for promoting good mental health, and strengthen ties with mental health professionals; Provide information resources to clinicians who work with older adults to help them improve diagnostic accuracy, make better use of age-appropriate treatments, and use community-based aging services as effective psychosocial treatments.	FY01: Increase over baseline by an appropriate amount. FY00: Establish baselines FY99: N/A	N/A -- New program

Introduction

Under its program of State and Local Innovations and Projects of National Significance, AoA's discretionary grants have developed, tested and incorporated innovative programs at the state and local levels. The contributions of several Title IV program initiatives (e.g., Operation Restore Trust and the Eldercare Locator) to the accomplishment of AoA's FY 1999 goals have been presented in other sections of this report. The focus for the 2001 performance plan is AoA's proposal to develop a mental health initiative.

Under this initiative, AoA will provide:

- Incentive-based competitive grants to states for the purpose of developing replicable models of innovations in mental health service delivery to older people. Preference for these incentive grants will be given to states that target Preventive Health funds for mental health activities.

- Development and provision of technical assistance and education to enhance the capacity of both the aging network and the mental health network to better serve older people. These capacity building efforts include:

  Customer Education – Development of educational materials to de-stigmatize mental illness among older adults, improve the ability of elders and their families to recognize the symptoms of mental illness, improve access to mental health services and treatment, and promote good mental health by teaching preventative health behaviors. Particular attention will be given to the special informational requirements which are appropriate for minority elders and for those with the highest rates of suicide (white males 85+, Asian women 65+, for example).

  Capacity for Building Aging Network Professionals – Development of a nationwide training and technical assistance effort to enable Aging Network professionals to recognize the symptoms of mental illness in older adults, to transmit best practices such as culturally appropriate strategies for promoting mental health in older people, and to promote appropriate, timely referrals between the aging and mental health networks.

  Physician Information -- Provide informational resources to physicians and other clinicians who work with older adults to help them improve accuracy of their diagnoses, to utilize age-appropriate mental health treatment protocols and resources, and to appropriately use community based aging and mental health services as supportive psychosocial interventions.

Fiscal Year 1999 Accomplishments

The program goal for AoA's program of State and Local Innovations and Projects of National Significance is to establish programs for model demonstrations, applied research and national resource centers to produce best practices, useful knowledge, and systems improvements that point policy makers and program administrators to well-reasoned courses of action in the field of aging.

This goal supports AoA's strategic goal of development of comprehensive and coordinated services system for older individuals.

During the 1980's, discretionary grants helped several states, including Colorado, Hawaii, Oregon, and Wisconsin develop cutting edge home and community-based service systems for frail older adults. Competitive grants have underwritten the necessary planning and implementation of systems of home and community-based long term care services.

In FY 1995, AoA created the National Mentors Programs in Aging to encourage states in learning about and sharing with one another their successes in developing long term care service systems. States with demonstrated proficiency in the operation of home and community-based care systems were organized as a corps of mentors and advised other states on best practices in developing long-term care systems.

Through its program of State and Local Innovations and Projects of National Significance, AoA has funded numerous community and regional coalitions to address the needs of at-risk older adults. By involving churches, businesses and other organizations, these coalitions have forged new partnerships and have yielded tangible benefits, such as additional volunteers and expanded resources for older adults in their communities.

On a national level, this program supports the Eldercare Locator, an effort to help local and long-distance caregivers find information they need. By calling a toll-free number, family members are

directed to appropriate sources of information about services for older persons in every locality in the U.S.

Results

In FY 1999, the National Mentors Programs in Aging project produced an updated "State Long-term Care Profiles Report," documenting the progress states have made toward a more balanced long term care system. Developing such a system will help to offset the current over-reliance on nursing facility care by promoting greater use of home and community-based care. The report is being used by states in developing strategies and programs to strengthen home and community based service systems.

PART III -- APPENDICES

A.1 Approach to Performance Measurement

A.1.A Evaluations

Major program evaluations have been used to inform AoA's GPRA efforts. For example, national program evaluations of the Elderly Nutrition and Long-Term Care Ombudsman Programs were completed in 1995 and 1996. These studies offered compelling evidence of the importance of performance measurement and the use of current research findings for professionals who manage and deliver these services. Furthermore, the studies helped to identify outcomes and areas where ongoing measurement can advance understanding of the relationship of particular interventions to desired outcomes. We believe the implementation of a program outcome information collection system would enable ongoing program evaluation, with basic performance information suggesting areas for policy inquiries answerable only by such formal evaluations.

A.1.B Data Verification and Validation

OMB approval to implement the State Program Report – mandated under the 1992 amendments to the Older Americans Act -- was obtained in time to establish a system which draws upon data from fiscal year 1995. AoA used a three-year phase-in of the system, with detailed client-registration data first required for fiscal year 1997.

Data verification has been accomplished through a labor-intensive data review process involving AoA regional staff, who also contact state officials to reconcile any inconsistencies. To reduce the amount of time required by this method, AoA has worked closely with states on implementation issues and is in the process of automating segments of the process.

Currently, the verification process takes more than a year. Data from fiscal year 1997 is available now. Preliminary data from fiscal year 1999 will be available in September, 2001.

A.1.C Performance Outcome Measures Project

As noted earlier, AoA is working in partnership with 17 State and Area Agency partners, which were selected in October 1998, and two national organizations which represent these components of the Aging Network. Major milestones completed under the Project include:

> November, 1998: Representatives of the 17 participating agencies (Partners) met to complete an in-depth review of the Project objectives and the four phases of work: data collection; determination of a core set of performance outcome measures; field-testing of the core set of measures; and dissemination and utilization activities.
>
> February, 1999: AoA convened an Expert Committee to advise the Project staff on such issues as the appropriateness of specific measures used by states and local agencies and their applicability for wider use throughout the aging network, and use of national data sets as indicators of program performance. The Expert Committee reviewed proposed outcome measures developed by the Partners. The Committee also requested that development of specific products to facilitate their work, including a literature review and annotated bibliography, as well as information about relevant data sets available through federal surveys. These products were completed by April, 1999.
>
> January through March, 1999: Project staff completed the administration of a semi-structured interview guide to document performance outcome measures currently in use or under development by participating agencies. The detailed results of this data collection are available in a document, "Performance Outcome Measures Project: Interim Report of Information Collection Activities."

March, 1999: A second meeting of the Partners was held to review the data collected, and to organize potential outcome measures suitable for inclusion in a core set around nine areas of concern, such as "access to services" and "social functioning." Participants subsequently prioritized the proposed outcome measures by availability and usefulness.

May, 1999: The second meeting of the Expert Committee involved the review and discussion of performance outcome measures suggested by the Partners, and the documented measures currently used by the Partners' agencies. The Committee also deliberated over the use of data from national surveys as indicators of performance for programs for older Americans.

June, 1999: Drawing from the recommendations received from the Expert Commmittee on the performance outcome measures suggested by the Partners, AoA and its contract researchers assembled and proposed a core set of performance outcome measures. The Project has adapted a theoretical framework developed by the United Way to guide its work.

November, 1999: Commitments were secured by Partners to field-test select measures. Based upon the measures they are testing, the Partners are participating on a variety of technical support and discussion groups led by staff and by contract researchers. Final work is now underway on data-collection instruments. Data collection from the field test will be completed by September, 2000.

A.2 Changes and Improvements Over Previous Year

There are four significant improvements to AoA's previous (FY 2000) Performance Plan. First, AoA restructured its plan to conform to the new HHS Department-wide format. HHS developed the standardized format to address GAO and OMB's concerns; i.e., plan components were inconsistent and difficult to cross-reference. The standardized format also allows HHS to meet the requirements of the FY 2001 Annual Performance Plan, the FY 2000 Revised Final Performance Plan, and the FY 1999 Performance Report in one document. AoA chose to organize this document around four strategic goals.

Second, AoA has clarified several of its objectives to provide a single, concise statement of its program activities. Third, AoA has progressed on several of its developmental goals. While targets have not been identified for all of these goals, both baselines and objectives have been refined. Finally, AoA dropped the case management goal, as the measure is no longer appropriate, and adjusted several FY 2000 targets consistent with appropriations levels.

Original FY 2000	Revised FY 2000	Rationale for Change
Performance Goal 2.2.C*:* Secure and maintain access to aging-related services and opportunities for older individuals and their families through the provision of case management services through the Older Americans Act and other funding sources.	***Performance Goal 2.2.C****:* Dropped.	AoA determined that this is not an appropriate measure because "consumer directed care" is becoming increasingly popular.
Performance Goal 2.1.A – Home Delivered Meals: Increase the number of home-delivered meals served to 146 million meals.	***Performance Goal 2.1.A*** – Home Delivered Meals: Increase the number of home-delivered meals served to 155 million meals.	Increased Congressional appropriation.
Performance Goal 2.1.B – Congregate meals: Maintain the	***Performance Goal 2.1.B*** – Congregate meals: Maintain the	Updated performance data; lack of increase in

level of service provision at the FY 1995 level of 123.4 million meals.	number of meals served at the 1997 baseline of 113,147,407.	Congressional appropriation; and pattern by States of transfer of funds from congregate to home-delivered meals programs.
Performance Goal 2.1.C – Programs for American Indians, Alaskan Natives and Native Hawaiians: Service delivery at FY95 levels: Home-Delivered Meals: 1,455,911 Congregate Meals: 1,321,728 Transportation: 763,287 Info & Referral: 632,462 In-Home Services: 741,859 Other: 511,646	***Performance Goal 2.1.C*** – Programs for American Indians, Alaskan Natives and Native Hawaiians: Service delivery at FY97 levels: Home-Delivered Meals: 1,632,000 Congregate Meals: 1,438,908 Transportation: 665,063 Info & Referral 678,979 In-Home Services: 866,194 Other: 590,723	Updated performance information: new targets reflect service provision at FY97, rather than FY95 levels.
Performance Goal 2.2.A – Information and Assistance: Maintain level of service provision at FY95 level of 12,526,526 contacts.	***Performance Goal 2.2.A*** – Information and Assistance: Maintain level of service provision at FY97 level of 13,985,091 contacts.	Updated performance information: new targets reflect service provision at FY97, rather than FY95 levels
Performance Goal 2.2.B – Transportation: Maintain level of service provision at FY95 level of 39,496,946 one-way rides	***Performance Goal 2.2.B*** – Transportation: Maintain level of service provision at FY97 level of 46,578,352 one-way rides	Updated performance information: new targets reflect service provision at FY97, rather than FY95 levels
Performance Goal 2.3.A – Long-Term Care Ombudsman: Maintain the combined resolution / partial resolution rate of 71.48 percent of complaints in nursing homes.	***Performance Goal 2.3.A*** – Long-Term Care Ombudsman: Maintain the combined resolution / partial resolution rate of 70 percent of complaints in nursing homes.	Fluctuations in reported performance levels have occurred as new data system is implemented; agency decided on 70 percent resolution / partial resolution rate as appropriate target.
Performance Goal 2.3.C – Health Care Anti-Fraud Activities: No numeric targets	***Performance Goal 2.3.C*** – Health Care Anti-Fraud Activities: Increase number of trainers – 17,810 additional volunteers trained. Increase substantiated complaints – 200 additional complaints Increase Medicare funds recouped – additional $2.7 million	Number targets established for the first time.

A.3 Linkage to HHS Strategic Plan

HHS Strategic Goal 1: Reduce the Major Threats to Health and Productivity of All Americans	
HHS Strategic Objective 1.3: Improve the Diet and Level of Physical Activity of Americans	
AoA Programs	Objectives
Nutrition Services • Home Delivered Meals	Prevent decline and/or improve nutritional intake of home-delivered meal recipients.
• Congregate Meals	Prevent decline and/or improve nutritional intake of congregate meal program participants.
Programs for American Indians, Alaska Natives, and Native Hawaiians	Improve the health and well-being, and reduce social isolation among older American Indians, Alaska Natives, and native Hawaiians through the provision of community-based services, such as those directed at improving the diet and physical activity of these groups.

HHS Strategic Goal 2: Improve the Economic and Social Well-Being of Individuals, Families and Communities in the United States	
HHS Strategic Objective 2.5: Increase Opportunities for Seniors to Have an Active and Healthy Aging Experience	
AoA Programs	Objectives
Nutrition Services	Improving or maintaining the nutritional intake of meal program participants.
Community-Based Services Information and Assistance	Provide older Americans with accurate, timely information so they may make informed choices, and, if appropriate, obtain available services and supports.
Transportation Services	Provide transportation services that help older Americans perform activities essential to their continued health and well-being.
Programs for American Indians, Alaska Natives and Native Hawaiians	Providing community-based services to improve the health and well-being, and reduce social isolation among American Indians, Alaska Natives and Native Hawaiians.
Alzheimer's Disease Demonstration Grants	Demonstrate effective ways to provide people with Alzheimer's and related disorders and their families with the services they need.
State and Local Innovations and Projects of National Significance—Mental Health Initiative	Address the mental health issues affecting older Americans.

HHS Strategic Objective 2.6: Expand Access to Consumer-Directed Home and Community-Based Long Term-Care and Health Services	
AoA Programs	Objectives
Long-Term Care Ombudsman	Assist residents, families, friends and others to resolve problems related to care and conditions in long-term care facilities.
Alzheimer's Disease Demonstration Grants	Demonstrate ways to provide people with Alzheimer's Disease and related disorders and their families with the home and community-based long-term care and health services they need.

HHS Strategic Goal 3:	**Improve Access to Health Services and Ensure the Integrity of the Nation's Health Entitlement and Safety Net Programs**
HHS Strategic Objective 3.5: Enhance the Fiscal Integrity of HCFA Programs and Ensure the Best Value for Health Care Beneficiaries	
Operation Restore Trust	Conduct activities to educate Medicare beneficiaries. Increase number of complaints about instances of possible fraud and abuse. Increase amount of Medicare funds recouped through investigation and prosecution of fraud and abuse.
HHS Strategic Objective 3.6: Improve the Health Status of American Indians and Alaska Natives	
AoA Program	Objective
Programs for American Indians, Alaska Natives and Native Hawaiians	Improve the health and well-being, and reducing social isolation among older American Indians, Alaska Natives, and native Hawaiians through the provision of community-based services.

HHS Strategic Goal 4:	**Improve the Quality of Health Care and Human Services**
HHS Strategic Objective 4.1: Promote the Appropriate use of Effective Health Services	
AoA Programs	Objectives
State and Local Innovations and Projects of National Significance—Mental Health Initiative	Promote the appropriate use of effective health services to address the mental health issues affecting older Americans.
Alzheimer's Disease Demonstration Grants	Promote the appropriate use of effective health services to provide people with Alzheimer's Disease and related disorders and their families with the services they need.
HHS Strategic Objective 4.2: Reduce Disparities in the Receipt of Quality Health Care Services	
AoA Programs	Objectives
State and Local Innovations and Projects of National Significance—Mental Health Initiative	

	Address the mental health issues affecting older Americans by reducing disparities in the quality of health care received by sufferers of physical and mental disorders.
Programs for American Indians, Alaska Natives and Native Hawaiians	Improve the health and well-being, and reduce social isolation of Native Americans, Alaska Natives and Native Hawaiians by reducing disparities in the receipt of quality health care among these groups.
HHS Strategic Objective 4.4: Improve Consumer Protection	
AoA Programs	Objectives
Long-Term Care Ombudsman	Improve consumer protection by assisting residents, families, friends and others to resolve problems related to care and conditions in long-term care facilities.

Budget Linkage Table
($ Amounts in 000's)

AoA FY 2001 Performance Plan Programs	Program/Budget Line Items	FY 1999 Appropriation	FY 2000 President's Budget	FY 2001 Proposed
Strategic Goal 1				
2.1.A Home-Delivered Meals	Home-Delivered Meals	$ 112,000	$ 147,000	$ 147,000
2.1.B Congregate Meals	Congregate Meals	$ 374,261	$ 374,412	$ 374,412
2.1.C Grants to Indian Tribes	Grants to Indian Tribes	$ 18,457	$ 18,457	$ 23,457
Preventive Health Services	Preventive Health Services	$ 16,123	$ 16,123	$ 16,123
	Strategic Goal 1 (Total)	$ 520,841	$ 555,992	$ 560,992
Strategic Goal 2				
2.2.A Information and Assistance	Supportive Services and Centers	$ 309,957	$ 310,082	$ 325,082
2.2.B Transportation				
2.2.C Case Management				
2.2.D Alzheimer's Disease	Alzheimer's Disease	$ 5,970	$ 5,970	$ 5,970
	Strategic Goal 2 (Total)	$ 315,927	$ 316,052	$ 331,052
Strategic Goal 3				
2.3.A Long Term Care Ombudsman	Vulnerable Older Americans	$ 12,181	$ 13,181	$ 13,181
2.3.B Caregiver Support	Supportive Services and Centers	$ --	$ --	$ 125,000
2.3.C Health Care Anti-Fraud Activities	State & Local Innovations-Projects of Nat'l Significance; HCFAC	$ 6,400	$ 11,450	$ 11,668
	Strategic Goal 3 (Total)	$ 18,581	$ 24,631	$ 149,849
Strategic Goal 4				
2.4.A State and Local Innovations and Projects of National Significance – Mental Health Initiative	State and Local Innovations and Projects of National Significance	$ 13,000	$ 21,162	$ 26,162
	Strategic Goal 4 (Total)	$ 13,000	$ 21,162	$ 26,162
	Total Budget	**$ 868,349**	**$917,837**	**$1,068,055**