DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2013

Administration on Aging

Justification of Estimates for Appropriations Committee

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FROM THE ADMINISTRATION ON AGING

I am pleased to present the Administration on Aging (AoA) FY 2013 Congressional Justification.

AoA and the national aging services network annually serve nearly 11 million seniors and their caregivers. AoA's services are especially critical for the nearly three million seniors who receive intensive in-home services, half a million of whom meet the disability criteria for nursing home admission. From 2010 to 2015, the population age 60 and older will increase by 15 percent, from 57 million to 65.7 million. During this period, the number of seniors with severe disabilities who are at greatest risk of nursing home admission and Medicaid eligibility will increase by more than 13 percent. Further, Census Bureau demographic trends indicate at least 300,000 more seniors will be living in poverty in FY 2013.

As Assistant Secretary for Aging, my goal is to insure that all older Americans have the opportunity to live independently, with dignity, in their homes and communities for as long as they are able and choose to do so. My FY 2013 budget request continues the priorities that I introduced in my FY 2012 request. This includes a focus on, and funding for, elder rights and elder justice programs such as Adult Protective Services and continued funding support for our core formula grant programs that support seniors' health and independence. While the current budgetary environment necessitates a shared focus on reducing spending where possible, AoA's programs are critical not only to the seniors whom they serve, but also to reducing the burden that could be shifted to other government programs if seniors were forced to rely on living in institutional settings before otherwise necessary.

The FY 2013 budget also continues to propose the transfer to AoA of the State Health Insurance Assistance Program (SHIPs) from the Centers for Medicare and Medicaid Services (CMS) and the transfer of the Senior Community Service Employment Program from the Department of Labor (DoL). These transfers recognize that by putting these programs under the national aging services network, their participants should be able to benefit immensely from the supports currently available through AoA's existing Aging Services programs.

It is our privilege to continue to help prepare the country for the increasing numbers of older Americans and to continue to provide vital support programs for this country's most vulnerable citizens so that they can remain in their homes and communities for as long as possible.

Kathy Greenlee
Assistant Secretary for Aging

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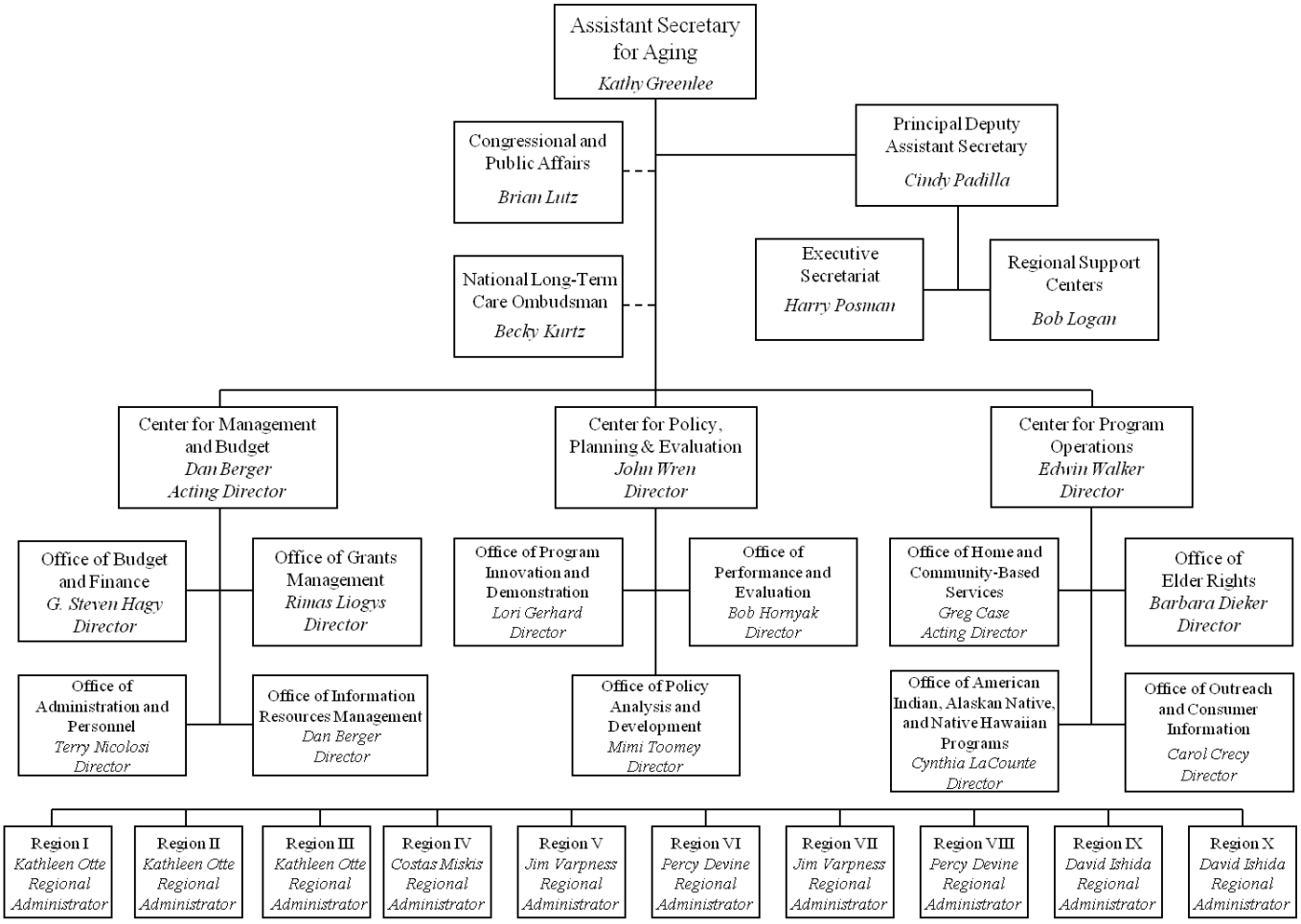

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Executive Summary

Introduction and Mission

The Administration on Aging (AoA), an agency of the U.S. Department of Health and Human Services (DHHS), is the principal Federal agency charged with helping elderly individuals maintain their dignity and independence in their homes and communities. AoA advances the concerns and interests of older people, and works with and through the national aging services network to promote the development of comprehensive, coordinated home and community-based care that is responsive to the needs and preferences of older people and their caregivers. The network, led by AoA at the Federal level, is comprised of 56 State and Territorial Units on Aging (SUA), 629 Area Agencies on Aging (AAA), 256 Indian Tribal and Native Hawaiian organizations, nearly 20,000 direct service providers, and hundreds of thousands of volunteers.

The mission of AoA is to develop a comprehensive, coordinated and cost-effective system of home and community-based services to help elderly individuals maintain their health and independence in their homes and communities.

AoA's core programs, authorized under the Older Americans Act (OAA) and administered by the national aging services network, help families keep their loved ones at home for as long as possible. These services complement existing medical and health care systems, help to prevent hospital readmissions, provide transport to doctors appointments, and support some of life's most basic functions, such as providing assistance in elders' homes to help them with bathing or preparing food. The network also helps consumers learn about and access the services and supports that are available in the community and addresses issues related to caregivers. OAA services are less expensive than institutional care and performance data show that they are very effective. The most recent data available (FY 2010) show that AoA and its national network rendered services, including referrals, to nearly 11 million elderly individuals age 60 and over (nearly 20 percent of the country's elderly population) and their caregivers, including nearly three million clients who received intensive in-home services. Critical supports, such as respite care and a peer support network, were provided to about 760,000 caregivers.

In the ongoing management of its programs and strategic planning process, AoA is guided by a set of core values in developing and carrying out its mission. These values include listening to older people, their family caregivers, and AoA partners who serve them; responding to the changing needs and preferences of an increasingly diverse and rapidly growing elderly population; producing measurable outcomes that significantly impact the well-being of older people and their family caregivers; and valuing and developing AoA staff.

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Overview of Budget Request

The FY 2013 discretionary request for AoA is $1,978,336,000, a net increase of +$7,052,000 from the comparable FY 2012 enacted level. This request builds on the FY 2012 enacted budget, proposing level funding for core areas with small increases where the need is greatest and making offsetting reductions in others. The request also includes $10,000,000 from the Prevention and Public Health Fund (PPHF) for Chronic Disease Self-Management Programs discussed in a separate narrative under the PPHF Tab at the end of this document.

One critical area for which additional funding is sought is the protection of vulnerable older adults. As the population of Americans age 60 and older increases, the problem of elder abuse, neglect, and exploitation continues to grow. While there is no single set of national elder abuse prevalence data, the number of reported cases of elder abuse, neglect, and exploitation are on the rise. Together, the data suggest that more than 5 million, or 10% of elders are abused, neglected, and/or exploited annually. The negative effects of abuse, neglect, and exploitation on the health and independence of seniors are extensive. Research has demonstrated that older victims of even modest forms of abuse have dramatically higher (300 percent) morbidity and mortality rates than non-abused older people.[1] Additional adverse health impacts include an increased likelihood of heart attacks, dementia, depression, chronic diseases and psychological distress. The result of these unnecessary health problems is a growing number of seniors who access the healthcare system more frequently (including emergency room visits and hospital admissions), and are ultimately forced to leave their homes and communities prematurely.[2]

To address this growing problem, the FY 2013 budget request includes $8 million in new funding for Adult Protective Services demonstrations, including $1,000,000 for grants to Native American communities. The budget also requests an additional $5,526,000 to restore funding for the Alzheimer's Disease Supportive Services program, which was reduced in the FY 2012 appropriation. This partial restoration of funding will allow AoA to continue implementing the only program within HHS which provides supportive services to patients suffering from Alzheimer's disease and their caregivers.

The request maintains funding at FY 2012 enacted levels for core AoA service programs, including Home and Community Based Supportive Services, Nutrition Services, Preventive Health, and programs to support caregivers. Maintaining funding is important because not only does the number of seniors (and consequently the need for services for older Americans) continue to grow, but reports indicate that[3] making reductions in these core services could lead to

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[1] Lachs, M.S., Williams, C.S., O'Brien, S., Pillemer, K.A., & Charlson, M.E. (1998). "The Mortality of Elder Mistreatment." JAMA. 280: 428-432. and Baker, M.W. (2007). "Elder Mistreatment: Risk, Vulnerability, and Early Mortality." Journal of the American Psychiatric Nurses Association, Vol. 12, No. 6, 313-321.

[2] Lachs M. S., Williams C., O'Brien S., Hurst L., Kossack A., Siegal A., et al. (1997). "ED use by older victims of family violence." Annals of Emergency Medicine. 30:448-454.

[3] Shapiro, Adam and Loh, Chung-Ping. (August 2010). *Advanced Performance outcome Measures Project (POMP): Estimates of Medicaid and General Revenue Cost-Avoidance from HCBS Utilization: Final Report (Contract #XQ867).* Tallahassee, FL: Florida Department of Elder Affairs. https://www.gpra.net/ppt/POMP2010_UNF_Final_Report.pdf

Chapin, R., Zimmerman, M., Macmillan, K., Rachlin, R., Reed, C., Hickey, A., Baca, B., Wiebold-Lippisch, L., Henning, E., Oslund, P., Hayes, J., Katz, B., & Shea, J. (2003). Examination of the Use of Medicare Home Health Services and Informal Caregiving and Their Relationship to Successful Community Tenure and Appendices. Lawrence, KS: University

higher government expenditures in areas such as Medicaid. Several State efforts to measure the impact of home and community-based programs on Medicare and Medicaid funding have shown signs of potential for savings. This would be because AoA's services assist seniors in remaining independent and in their communities, potentially delaying expensive institutionalization in settings more expensive to the government. If even a small percentage of OAA service recipients are able to delay the institutionalization so many do not want, it could have a significant impact on Medicaid expenditures.

For example, a recent AARP study found that in 2009, approximately 42.1 million family caregivers provided assistance to adults with limitations in daily activities.[4] These unpaid caregivers provided an AARP-estimated $450 billion in services, the cost of which, were caregivers more limited in their ability to provide this care, could otherwise be borne by Medicare and Medicaid.[5] The long-term needs of today's growing numbers of elderly place tremendous strain on families, and it is precisely this stress that AoA core programs endeavor to make more manageable. These caregivers underscore the critical importance of continuing to invest in AoA programs, since if they become overwhelmed by the burdens of caregiving, these additional costs (along with those of increased institutionalization) could fall upon already overtaxed government resources.

The FY 2013 budget also continues to support the transfer to AoA of the State Health Insurance Assistance Program (SHIPs) ($51,902,000) from CMS and the transfer of the Senior Community Service Employment Program (SCSEP) ($448,251,000) from the Department of Labor (DoL). These programs will benefit from AoA's connections to the Aging Services Network, and will be made more efficient and effective under AoA's administration.

In addition, the FY 2013 request Chronic Disease Self-Management Programs (CDSMP), Aging and Disability Resource Centers (ADRCs), and Senior Medicare Patrol (SMP) programs by continuing to propose dedicated funding lines for these activities. In the case of CDSMP and ADRCs, no discretionary funding is requested. Rather, CDSMP funding is proposed from the Prevention and Public Health Fund and ADRCs will rely on existing mandatory appropriations. AoA will use this mandatory ADRC funding to support states and communities in continuing to build the infrastructure needed to support the ongoing integration of the programs into state's Home and Community-Based Supportive Systems and to create greater integration with the medical system.

The FY 2013 request also maintains the FY 2012 realignment of AoA activities that support the national aging services network into two groups, one under Aging Network Support Activities that the other under Elder Rights Support Activities.

Finally, the request would provide an additional $196,000 for Program Administration over the FY 2012 level for AoA's planned relocation in FY 2013.

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of Kansas School of Social Welfare Office of Aging and Long Term Care. http://www.oaltc.ku.edu/Reports/Community%20Tenure%20Study%20Report%20SFY%202003.pdf

[4] *Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving*. AARP Public Policy Institute. July 2011. http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf

[5] *Id.*

Overview of Performance

AoA program activities have a fundamental common purpose which reflects the legislative intent of the Older Americans Act (OAA) and the AoA Mission: to develop a comprehensive, coordinated and cost-effective system of home and community-based services that helps elderly individuals maintain their health and independence in their homes and communities.

The Aging Services Program's fundamental purpose, in combination with the legislative intent that the National Aging Services Network actively participate in supporting community-based services with particular attention to serving economically and socially vulnerable elders, led AoA to focus on three measures: 1) improving efficiency; 2) improving client outcomes; and 3) effectively targeting services to vulnerable elder populations. Each measure is representative of several activities across the Aging Services Program budget and progress toward achievement of the measure is tracked using a number of indicators. The efficiency measure and corresponding indicators are reflective of the Office of Management of Budget (OMB) requirements to measure efficiency for all program activities. The client outcome measure includes indicators focusing on consumer assessment of service quality and outcome indicators focusing on nursing home predictors, successful caregiver program operation and protection of the vulnerable elderly. The targeting measure and indicators focus on ensuring that States and communities serve the most vulnerable elders. Taken together, the three measures and their corresponding performance indicators are designed to reflect AoA's strategic goals and objectives and in turn measure success in accomplishing AoA's mission.

Consistent with this Administration's emphasis on transparency and accountability, AoA has taken several steps to improve the analysis and availability of performance information while also enhancing the rigor of program evaluations. To this end, AoA has:

- Expanded the availability of performance information via an on-line system that enables Aging Network professionals and the public to develop benchmarks and examine trends nationally and at the State level.

- Submitted public use data sets to the http://www.data.gov/ system.

- Further analyzed the results from the 2011 National Survey of Older Americans Act Participants to help inform decision makers. Results show:

    - AoA is effectively reaching those most at risk of institutionalization;

    - Service recipients report Title III services enable them to remain in their own homes; and

    - Comparison of service recipients to the overall US population 60 and older shows that Title III serves older people who are less healthy and have more limitations than other older adults even after adjusting for demographic and socioeconomic differences between the groups.

- Tested through the Performance Outcomes Measurement Project (POMP) several methods for measuring the impact of services. Preliminary analysis for administrative data sets from four States, using Cox proportional hazards models, show a consistent lowering of the relative risk of nursing home placement with an increase in number of services utilized; and there was an increase in mean survival time in the community (i.e. months before placement) with increases in the total number of services used.

- Employed more rigorous program evaluation methods such as longitudinal data collection and experimental design.

    - The Title III-C Elderly Nutrition Services program evaluation employs a complex design that includes three major components and several subcomponents. The major components include a process study that surveys each level of the Aging Network on a large array of topics; a costs study that measures the actual cost of providing a meal by cost category (e.g. labor, food, overhead); and an individual outcome study. The individual outcome study will measure the program's success at meeting the legislative intent of the program (reduce hunger and social isolation while improving health and well-being of consumers). In addition, AoA and Centers for Medicare and Medicaid Services (CMS) have entered into an Inter-Agency Agreement that will enhance this evaluation to include prospective analysis of healthcare utilization and cost data of program participants compared to a matched group of seniors who do not participate in the program.

    - The evaluation of the Title III-E National Family Caregiver Support program will be the first for this OAA program. It is designed as a longitudinal study with a comparison group so that the effects of the five service categories can be measured over time.

    - AoA has finalized the design and operational plan for an evaluation of Aging and Disability Resource Centers (ADRC). Data collection is scheduled to begin in Spring 2012 pending OMB Paperwork Reduction Act clearance. The evaluation is a quasi-experimental design that compares consumer experiences and outcomes associated with accessing long-term care services and supports through an ADRC to those of consumers from non-ADRC communities. AoA is working with the HHS Office on Disability and the Department of Education's Rehabilitation Services Administration to include the younger disabled population in the study who access services through Centers for Independent Living.

    - In May 2011, AoA received a design framework report for the evaluation of the Chronic Disease Self-Management Program. The report proposes use of an experimental design in which individuals will be randomly assigned to receive the intervention or serve as a control group by delaying program participation for a minimum of six months. Using the recommendations as a foundation, AoA awarded a contract in the fall of 2011 for the conduct of a process evaluation and a more detailed outcome evaluation design. The process evaluation, including time for OMB PRA clearance, is expected to be completed during the summer of 2013.

AoA is coordinating its efforts with CMS to ensure that the data collected measure concepts important to both agencies. The results of an evaluation would influence future performance measures and indicators of the program.

Current Performance Information

An analysis of AoA's performance trends shows that through FY 2010 most outcome indicators have steadily improved. While service counts are declining due to flat funding and challenging economic times, AoA outcome indicators demonstrate that services are increasingly effective in helping older persons remain at home. Some key successes are indicative of the potential of AoA and the National Aging Services Network to meet the challenges posed by the growth of the vulnerable older adult population, the changing care preferences of aging baby boomers, the fiscal difficulties faced by State budgets, and the expanding needs of both the elderly and their caregivers. Below are some examples of these successes:

- **OAA programs help older Americans who are severely disabled remain independent and in the community:** Homebound older adults that have three or more impairments in Activities of Daily Living (ADL) are at a high risk for nursing home placement. Measures of the Aging Network's success at serving this vulnerable population is a proxy for success at nursing home delay and diversion. In FY 2003, the Aging Network served home-delivered meals to 280,454 clients with three or more ADL impairments and by FY 2010 that number grew by 24% to 348,669 clients. Another approach to measuring AoA's success is the nursing home predictor score. The components of this composite score are predictive of nursing home placement based on scientific literature and AoA's POMP which develops and tests performance measures. The components include such items as the percent of clients who are transportation disadvantaged and the percent of congregate meal clients who live alone. As the score increases, the prevalence of nursing home predictors in the OAA service population increases. In 2003, the nursing home predictor score was 46.57 and has increased to 60.5 in FY 2010.

- **OAA programs are efficient:** The National Aging Services Network is providing high quality services to the neediest elders and doing so in a very prudent and cost-effective manner. AoA has significantly increased the number of clients served per million dollars of AoA Title III funding over the last decade. In FY 2010 The National Aging Services Network served 8,438 people per million dollars of OAA Title III funding. Since this measure's introduction in FY 2005, AoA and the National Aging Services Network have met or exceeded efficiency targets.

- **OAA programs build system capacity:** OAA programs stay true to their original intent to "encourage and assist State agencies and Area Agencies on Aging to concentrate resources in order to develop greater capacity and foster the development and implementation of comprehensive and coordinated systems." (OAA Section 301). This is evident in the leveraging of OAA funds with State/local or other funds (almost $3 in other funds for every dollar of OAA funds expended), as well as in the expansion of

projects such as the Aging and Disability Resource Center initiative, which has grown to over 310 sites across 54 States and territories in FY 2010.

OAA clients report that services contribute in an essential way to maintaining their independence and they express a high level of satisfaction with these services. In 2010, over 98% of transportation clients rated services good to excellent and 94% of caregivers rated services good to excellent. To help ensure the continuation of these trends in core programs, AoA uses its discretionary funding to test innovative service delivery models for State and local program entities that show promise for generating measurable improvements in program activities. For example, AoA has worked with CMS and the Department of Veterans Affairs to better integrate funding for long-term care service delivery, eliminate duplication and improve access to services through Aging and Disability Resource Centers.

Performance for FY 2013

Federal support for OAA programs is not expected to cover the cost of serving every senior. For Home and Community-based Services, with the same funding levels in FY 2013 as FY 2011, some outcomes are projected to show similar or slightly improved performance; however, service counts and other outputs are projected to decline because of rising costs, declining State and local program contributions, and staffing constraints at the State and local level. OAA programs have strong partnerships with State and local governments, philanthropic organizations, and private donations that contribute significant funding. Despite States only having to match these programs at 15% or 25% of their Federal allocation, States typically leverage resources of $2 or $3 per every OAA dollar. Regardless of the historic nature of State and local support for these programs, AoA expects declining leveraged funds, as State, local, and private budgets face economic hardships. This will adversely impact performance through FY 2013.

Performance Detail

Taken as a whole, AoA's performance measures and indicators form an interconnected system of performance measurement akin to the three legs of a stool (efficiency, outcomes and targeting) holding up AoA's mission and strategic goals that include:

1. Empower older people, their families, and other consumers to make informed decisions about, and to be able to easily access, existing health and long-term care options;
2. Enable seniors to remain in their own homes with a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers;
3. Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare;
4. Ensure the rights of older people and prevent their abuse, neglect and exploitation; and
5. Maintain effective and responsive management.

Below is a summary of each measure, its indicators and their relationship to AoA's strategic goals.

Measure 1: Improve Efficiency

Program efficiency is a necessary and important measure of the performance of AoA programs for two principal reasons. First, it is important to be a responsible steward of Federal funds. Second, the OAA intended Federal funds to act as catalyst in generating capacity for these program activities at the State and local levels. It is the expectation of the OAA that States and communities increasingly improve their capacity to serve elderly individuals efficiently and effectively with both Federal and State funds.

Improvements in program efficiency support all of AoA's Strategic Goals. Through optimal utilization of resources, improvements in program efficiency ensure that affordable and accessible community-based long-term care is available to promote the well-being of seniors and their family caregivers.

For FY 2013, there are two efficiency indicators for AoA program activities. Indicator 1.1 addresses performance efficiency at all levels of the National Aging Services Network in the provision of home and community-based services, including caregiver services. Indicator 1.3 demonstrates the efficiency of AoA in providing services to Native Americans.
A summary of program efficiency indicators for FY 2013 follows:

> **Indicator 1.1:** For Home and Community-based Services, including Nutrition Services, and Caregiver services, increase the number of clients served per million dollars of Title III OAA funding.
>
> **Indicator 1.3:** Increase the number of units of service provided to Native Americans per thousand dollars of OAA funding.

Measure 2: Improve Client Outcomes

While improving efficiency, AoA is committed to maintaining quality and improving client outcomes. The FY 2013 performance budget includes nine core performance indicators supporting AoA's commitment to improving client outcomes. AoA has multiple quality assessment indicators in this plan reflecting separate assessments provided by elders for services such as meals, transportation and caregiver assistance. Also, in developing the outcome indicators, AoA included measures to assess AoA's fundamental outcomes: to keep elders at home and in the community, and to measure results important to family caregivers. The measures for the Ombudsman program focus on the core purposes of this program: advocacy on behalf of older adults.

Although this measure supports all of AoA's Strategic Goals, it is most strongly tied to Goal 2 to enable seniors to remain in their own homes with a high quality of life for as long as possible, Goal 3 to empower older adults to stay active and healthy, and Goal 4 to ensure the rights of older people and prevent their abuse, neglect and exploitation.

A summary of the client outcome indicators for FY 2013 follows:

Indicator 2.6: Reduce the percent of caregivers who report difficulty in getting services.

Indicator 2.9a: 90% of home delivered meal clients rate services good to excellent.

Indicator 2.9b: 90% of transportation clients rate services good to excellent.

Indicator 2.9c: 90% of National Family Caregiver Support Program clients rate services good to excellent.

Indicator 2.10: Increase the likelihood that the most vulnerable people receiving OAA Home and Community-based and Caregiver Support Services will continue to live in their homes and communities. This will be tracked by the use of a "nursing home predictor index" which measures the prevalence of select characteristics of the service population that research has shown to be predictive of nursing home placement. An increasing score shows an increased proportion of the client population is high risk with respect to institutionalization.

Indicator 2.11: Increase the percentage of transportation clients who live alone.

Indicator 2.12: Decrease the average number of complaints per long-term care facility.

Indicator 2.14: Decrease the number of complaints not resolved to the satisfaction of the nursing home resident.

Indicator ALZ.2: Increase number of individuals served with evidence-based interventions (Alzheimer Program).

Measure 3: Effectively Target Services to Vulnerable Elderly

AoA believes that targeting is of equal importance to efficiency and outcomes because it ensures that AoA and the National Aging Services Network will focus their services on the neediest, especially when resources are scarce. Without targeting, efforts to improve efficiency and outcomes could result in unintended consequences whereby entities might attempt to focus their efforts toward individuals who are not the most vulnerable. Such an outcome would be inconsistent with the intent of the OAA, which specifically requires the network to target services to the most vulnerable elders. It would also be inconsistent with the mission of AoA, which is to help vulnerable elders maintain their independence in the community. To help seniors remain independent, AoA and the National Aging Services Network must focus their efforts on those who are at the greatest risk of institutionalization.

Effective targeting of OAA services supports AoA's Strategic Goal 1 by ensuring access to long-term care options for the economically and socially vulnerable; Goal 2 by enabling the most vulnerable seniors to remain in their own homes with a high quality of life; and Goal 4 by

ensuring the rights of vulnerable elders. Thus, AoA's four indicators for effective targeting are crucial for ensuring that services are targeted to the most at risk client groups.

Indicator 3.1: Increase the number of caregivers served.

Indicator 3.2: Increase the number of older persons with severe disabilities who receive home-delivered meals.

Indicator 3.3: The percentage of OAA clients served who live in rural areas is at least 10% greater than the percent of all US elders who live in rural areas.

Indicator 3.4: Increase the number of States that serve more elderly living below the poverty level than the prior year.

Administration on Aging

Budget by HHS Strategic Plan Goal
(Dollars in Millions)

HHS Strategic Goals	FY 2011	FY 2012	FY 2013 Request
1.Transform Health Care	**60.184**	**59.988**	**59.775**
1.A Make coverage more secure	52.000	52.115	51.902
1.B Improve health care quality and patient safety	8.184	7.873	7.873
1.C Emphasize primary & preventative care, link to prevention			
1.D Reduce growth of health care costs promoting high-value			
1.E Ensure access to quality culturally competent care			
1.F Promote the adoption of health information technology			
2. Advance Scientific Knowledge and Innovation	**6.802**	**6.789**	**6.789**
2.A Accelerate scientific discovery to improve patient care			
2.B Foster innovation at HHS to create shared solutions			
2.C Invest in sciences to improve food & medical product safety			
2.D Increase understanding of what works in health & services	6.802	6.789	6.789
3. Advance the Health, Safety and Well-Being of the American People	**1,915.078**	**1,895.042**	**1,902.111**
3.A Ensure the children & youth safety, well-being & health			
3.B Promote economic & social well-being	1,621.704	1,599.612	1,607.612
3.C Improve services for people with disabilities and elderly	272.495	264.590	263.659
3.D Promote prevention and wellness	20.879	30.840	30.840
3.E Reduce the occurrence of infectious diseases			
3.F Protect Americans' health and safety during emergencies			
4. Increase Efficiency, Transparency and Accountability of HHS Programs	**32.670**	**43.175**	**43.371**
4.A Ensure program integrity and responsible stewardship	19.793	22.882	23.106
4.B Fight fraud and work to eliminate improper payments	12.731	20.112	20.112
4.C Use HHS data to improve American health & well-being			
4.D Improve HHS environmental performance for sustainability	.146	.181	.153
5. Strengthen the Nation's Health and Human Service Infrastructure and Workforce			
5.A Invest in HHS workforce to meet needs today & tomorrow			
5.B Ensure health care workforce meets increased demands			
5.C Enhance ability public health workforce to improve health			
5.D Strengthen the Nation's human service workforce			
5.E Improve national, State & local surveillance capacity			
TOTAL	**2,014.734**	**2,004.994**	**2,012.046**

AoA's Internal Performance Management Plan

AoA core programs provide formula grants to States or tribes and there is a great deal of flexibility in program implementation. States, in turn, provide flexibility to the Area Agencies on Aging, where the home and community-based programs are actually administered. Since AoA is not directly involved in hands-on service provision, for the past ten years the Agency has employed a program performance improvement strategy with multiple components that are

expected to yield performance improvements. Examples of activity supporting the overall strategy follow:

1. Collaboration with other Federal agencies.
2. Collaboration with non-governmental organizations.
3. Enhanced partnerships with State and Area Agencies on Aging.
4. Programmatic technical assistance.
5. Improved performance measurement capacity and information collection tools.
6. Rigorous program evaluation.
7. Program Innovations demonstration grants.
8. Senior leadership's involvement in performance management and reporting.

Some activities cited above are conducted directly by AoA Central and Regional Office staff, but most are conducted through discretionary grants and contracts.

AoA senior management is directly engaged in developing these activities through grants and procurement planning. There is a rigorous process in which each office within AoA develops "concept papers" which detail the proposed discretionary grant and procurement activities for the office and justify each proposed activity consistent with AoA strategic goals and overarching performance measures. Senior leadership has also implemented programs to better use performance data for management decision-making, including a quarterly discretionary dashboard, weekly reports for the Assistant Secretary, quarterly reviews of operating budgets, and bi-monthly managers meetings.

AoA also monitors senior manager performance by including measurable performance targets in performance plans. These performance targets must support AoA's strategic goals and performance measures.

AoA has initiated a Sentinel States Reporting Initiative (SSRI) that will create a consolidated data warehouse where detailed program data will be used for analytics to seek new insights about the national aging network and its consumers, and to evaluate trends in supporting seniors who reside in communities rather than long term care alternatives. AoA is in the early stages of building this warehouse, with five States currently participating, and is still exploring its potential related to research and performance. SSRI is not a pilot per se, but will continue to grow, as additional States are added each fiscal year. SSRI will serve as an "early warning" system allowing AoA to monitor data on its consumers and services on a more frequent basis. AoA also conducts rigorous program evaluations that demonstrate the efficacy of its programs and the results of these evaluations not only improve AoA's understanding of the effectiveness of its core and demonstration programs, but can inform the performance measurement process. All this and other performance information are used during the year to update AoA's Executive Leadership so that adjustments can be made as needed to AoA programs; it is also discussed and used as appropriate in AoA internal discussions as decisions are made each year regarding funding levels to propose to the Department and OMB.

By establishing a culture where performance improvement is expected and by working collaboratively with our State and AAA partners toward this end, the Aging Services Network has demonstrated very solid performance over the past ten years.

Administration on Aging

All-Purpose Table

(Dollars in Thousands)

Program	FY 2011 Enacted	FY 2012 Enacted	FY 2013 President's Budget Total	FY 2013 President's Budget +/- FY 2012
Health and Independence:				
Home & Community-Based Supportive Services	$ 367,611	$ 366,916	$ 366,916	$ --
Congregate Nutrition Services	439,901	439,070	439,070	--
Home-Delivered Nutrition Services	217,241	216,831	216,831	--
Nutrition Services Incentive Program 1/	160,693	160,389	160,389	--
Preventive Health Services	20,984	20,945	20,945	--
Chronic Disease Self-Management Programs (Prevention & Public Health Fund) 2/	--	10,000	10,000	--
Senior Community Service Employment Program 3/	449,100	448,251	448,251	--
Native American Nutrition & Supportive Services	27,653	27,601	27,601	--
Aging Network Support Activities	8,184	7,873	7,873	--
Subtotal, Health and Independence	$ 1,691,367	$ 1,697,876	$ 1,697,876	$ --
Caregiver Services:				
Family Caregiver Support Services	$ 153,912	$ 153,621	$ 153,621	$ --
Native American Caregiver Support Services	6,376	6,364	6,364	--
Alzheimer's Disease Supportive Services Program	11,441	4,011	9,537	5,526
Lifespan Respite Care	2,495	2,490	2,490	--
Subtotal, Caregiver Services	$ 174,224	$ 166,486	$ 172,012	$ 5,526
Protection of Vulnerable Adults:				
Adult Protective Services	$ --	$ --	$ 8,000	$ 8,000
Long-Term Care Ombudsman Program	16,793	16,761	16,761	--
Prevention of Elder Abuse & Neglect	5,046	5,036	5,036	--
Senior Medicare Patrol Program	9,420	9,402	9,402	--
Health Care Fraud and Abuse Control 4/ (Mandatory)	3,312	10,710	10,710	--
Elder Rights Support Activities 5/	4,096	4,088	4,088	--
Subtotal, Vulnerable Adults	$ 38,667	$ 45,997	$ 53,997	$ 8,000
Consumer Information, Access & Outreach				
Aging and Disability Resource Centers 6/	$ 16,469	$ 16,457	$ 10,000	$ (6,457)
ADRCs Mandatory (non-add)	*$ 10,000*	*$ 10,000*	*$ 10,000*	--
State Health Insurance Assistance Program 7/	52,000	52,115	51,902	(213)
National Clearinghouse for Long-Term Care Information 8/	3,000	3,000	3,000	--
Subtotal, Consumer Information, Access & Outreach	$ 71,469	$ 71,572	$ 64,902	$ (6,670)
Program Innovations	$ 19,068	$ --	$ --	$ --
Aging Services Programs Administration	$ 19,939	$ 23,063	$ 23,259	$ 196
Subtotal, Program Level	**$ 2,014,734**	**$ 2,004,994**	**$ 2,012,046**	**$ 7,052**
Less Funds From Other Sources:				
Health Care Fraud and Abuse Control 4/ (Mandatory)	(3,312)	(10710)	(10710)	--
Aging and Disability Resource Centers (Mandatory)	(10,000)	(10,000)	(10,000)	--
Long-Term Care Awareness Campaign (Mandatory) 8/	(3,000)	(3,000)	(3,000)	--
Chronic Disease Self-Management (Prevention & Public Health Fund) 2/	--	(10,000)	(10,000)	--
Total, Discretionary Budget Authority	**$ 1,998,422**	**$ 1,971,284**	**$ 1,978,336**	**$ 7,052**

1/ Includes $2,025,445 in FY 2012 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursuant to P.L. 110-19 and P.L. 112-74.

2/ Provided in FY 2012 and requested in FY 2013 from Prevention and Public Health Funds provided by Sections 311 and 317(k)(2) of the Public Health Service Act, [42 U.S.C. Sections 243 and 247b(k)(2)] as amended, and the Patient Protection and Affordable Care Act (ACA), Section 4002 [42 U.S.C. 300u-11].

3/ Reflects transfer of the SCSEP program from the Department of Labor to AoA in FY 2013. Funding is comparably displayed in FY 2011 and FY 2012

4/ AoA received $3,312,080 in FY 2011 and $10,709,503 from the Health Care Fraud and Abuse Control wedge funds recovered from fighting fraud. $10,709,503 is a placeholder amount for FY 2013. The Secretary and the Attorney General will determine the final amount.

5/ In FY 2011 activities were previously appropriated and requested in Aging Network Support and Program Innovations.

6/ Includes $10 million in mandatory funds per section 2405 of P.L. 111-148 (Affordable Care Act).

7/ Reflects transfer of the SHIPs program from CMS to AoA in FY 2013. Funding is comparably displayed in FY 2011 and FY 2012. Transfer of discretionary funds from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

8/ Funding in FY 2011 was via reimbursable agreement from CMS; funding in FY 2012 and FY 2013 is provided directly to AoA.

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Administration on Aging

Appropriations Language

For carrying out, to the extent not otherwise provided, the Older Americans Act of 1965 (``OAA''), section 398 and title XXIX of the PHS Act, section 119 of the Medicare Improvements for Patients and Providers Act of 2008, *and title XX-B of the Social Security Act,* [$1,473,703,000] *$1,926,434,000, together with $51,902,000 to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to carry out section 4360 of the Omnibus Budget Reconciliation Act of 1990*: *Provided*, That amounts appropriated under this heading may be used for grants to States under section 361 of the OAA only for disease prevention and health promotion programs and activities which have been demonstrated through rigorous evaluation to be evidence-based and effective: *Provided further, That, notwithstanding section 206(g) of the OAA, up to one percent of amounts appropriated to carry out programs authorized under title III of such Act shall be available for conducting evaluations, training and technical assistance: Provided further,* That none of the funds provided shall be used to carry out sections 1701 and 1703 of the PHS Act (with respect to chronic disease self-management activity grants), except that such funds may be used for necessary expenses associated with administering any such grants awarded prior to the date of the enactment of this Act: [*Provided further,* That the total amount available for fiscal year 2012 under this and any other Act to carry out activities related to Aging and Disability Resource Centers under subsections (a)(20)(B)(iii) and (b)(8) of section 202 of the OAA shall not exceed the amount obligated for such purposes for fiscal year 2010 from funds available under Public Law 111-117:]*Provided further*, That notwithstanding any other provision of this Act, funds made available under this heading to carry out section 311 of the OAA may be transferred to the Secretary of Agriculture in accordance with such section: *Provided further, That, of the amounts provided under this heading, $448,251,000 shall be available for carrying out title V of the OAA: Provided further, That, with respect to the previous proviso, such funds shall be available through June 30, 2014, and may be recaptured and reobligated in accordance with section 517(c) of the OAA.*

General Provision to transfer Older American Community Service Employment Program from Labor to HHS/AoA

SEC. 519 TRANSFER OF OLDER AMERICAN COMMUNITY SERVICE EMPLOYMENT PROGRAM TO DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Older American Community Service Employment (OACSE) program under title V of the Older Americans Act of 1965 (42 U.S.C. 3056), and the authority to administer such program, shall be permanently transferred from the Secretary of Labor to the Secretary of Health and Human Services, acting through the Assistant Secretary for Aging.

(b) TRANSFER OF FUNCTIONS, ASSETS, AND LIABILITIES.—The functions, assets, and liabilities of the Secretary of Labor relating to the OACSE program shall be transferred to the Secretary of Health and Human Services.

(c) EFFECTIVE DATE OF TRANSFER.---The transfer under this section shall be effective no later than the last day of the second full fiscal quarter following the quarter in which this section is enacted.

Administration on Aging

Language Analysis

Aging Services Programs

Language Provision	Explanation
and title XX-B of the Social Security Act,	Adds title XX-B of the Social Security Act to provide AoA the authority to carry out provisions of the Elder Justice Act of 2010. Such activities include activities of the Elder Justice Coordinating Council and Adult Protective Services demonstration grants.

Language Provision	Explanation
together with $51,902,000 to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to carry out section 4360 of the Omnibus Budget Reconciliation Act of 1990:	Indicates that in addition to the regular appropriation, $51,902,000 will be transferred to AoA from the Medicare Trust Funds to carry out the State Health Insurance Assistance Program (SHIPs) which is being transferred from the Centers for Medicare and Medicare Services (CMS) to AoA.
Provided further, That amounts appropriated under this heading may be used for grants to States under section 361 of the OAA only for disease prevention and health promotion programs and activities which have been demonstrated through rigorous evaluation to be evidence-based and effective:	Continues to require that States use the amounts that are appropriated for Preventive Health Services only for evidence-based disease prevention and health promotion programs and activities that have been demonstrated through rigorous evaluation to be effective.
Provided further, That, notwithstanding section 206(g) of the OAA, up to one-percent of amounts appropriated to carry out programs authorized under Title III of such Act shall be available for conducting evaluations, training and technical assistance:	Allows up to 1% of amounts appropriated to carry out Home and Community-Based Services programs, Nutrition Programs, Preventive Health Programs and Caregiver Programs under Title III of the Older Americans Act to be used for conducting evaluations, training and technical assistance related to these programs.
Provided further, That none of the funds provided shall be used to carry out sections 1701 and 1703 of the PHS Act (with respect to chronic disease self-management activity grants), except that such funds may be used for necessary expenses associated with administering any such grants awarded prior to the date of the enactment of this Act	Allows OAA dollars to be used to provide maintenance and closeout of chronic disease self-management activity grants awarded under the American Recovery and Reinvestment Act [FY 2009/2010 funds] with funds from the Public Health Service Prevention and Wellness Fund. OAA dollars could not be used for any other purposes related to the CDSMP program funded with these ARRA dollars.
[Provided further, That the total amount available for fiscal year 2012 under this and any other Act to carry out activities related to Aging and Disability Resource Centers under subsections (a)(20)(B)(iii) and (b)(8) of section 202 of the OAA shall not exceed the amount obligated for such purposes for fiscal year 2010 from funds available under Public Law 111-117:]	Deletes as unnecessary language limiting the FY 2012 discretionary appropriation for ADRCs to the amount of discretionary funding that was obligated for these activities in FY 2010; no discretionary funding is being requested in FY 2013 for this activity.

Administration on Aging

Amounts Available for Obligation

(Dollars in Thousands)

	FY 2011 Actual	FY 2012	FY 2013 Request
Discretionary Appropriation:			
Appropriation (Annual)	1,500,323	1,473,703	1,478,183
Rescission	(3,001)	(2,785)	--
Subtotal, adjusted appropriation	1,497,322	1,470,918	1,478,183
Transfer of Funds to: Department of Agriculture	--	(2,025)	--
Comparable Transfer from: Department of Labor	449,100	448,251	448,251
Total, Discretionary Appropriation	1,946,422	1,917,144	1,926,434
Mandatory Appropriation:			
Appropriation (PPACA) ADRCs	10,000	10,000	10,000
Appropriation (PPACA) National Long-Term Care Clearinghouse	3,000	3,000	3,000
Transfer from: (PPACA) Prevention Funds for CDSMP	--	10,000	10,000
Subtotal, adjusted mandatory appropriation	13,000	23,000	23,000
Offsetting collections from:			
Trust Funds: HCFAC	3,312	10,710	10,710
Trust Funds: SHIPs HI/SMI Trust Fund Transfer	52,000	52,115	51,902
Subtotal, Spending Authority from Offsetting Collections	55,312	62,825	62,612
Unobligated balance, lapsing	(466)		
Total obligations	**2,014,268**	**2,002,969**	**2,012,046**

Administration on Aging

Summary of Changes

(Dollars in Thousands)

2012	
Total estimated budget authority	1,971,284
(Obligations)	1,971,284
2013	
Total estimated budget authority	1,978,336
(Obligations)	1,978,336
Net Change	7,052

	FY 2012 Estimate FTE	FY 2012 Estimate Budget Authority	FY 2013 Change from Base FTE	FY 2013 Change from Base Budget Authority
Increases:				
A. Built-in:				
1. Additional Rent Due to HQ Relocation	-	23,063	-	2,363
2. FY 2013 Pay Raise	-	23,063	-	55
Subtotal, Built-in Increases				2,418
A. Program:				
1. Alzheimer's Disease Supportive Services Program	--	4,011	--	5,526
2. Adult Protective Services 1/	-	-	-	8,000
Subtotal, Program Increases				13,526
Total Increases				15,944

Decreases:				
A. Built-in:				
1. RWA to GSA for HQ-Related Moving Costs		23,063		(2,167)
2. Reduction in Contract Costs to Offset Payraise	-	23,063	-	(55)
Subtotal, Built-in Decreases				(2,222)
A. Program:				
1. Aging and Disability Resource Centers 2/	--	6,457	--	(6,457)
2. State Health Insurance Assistance Program	-	52,115	-	(213)
Subtotal, Program Decreases				(6,670)
Total Decreases				(8,892)
Net Change				7,052

1/ Funding was first authorized for this program in the Elder Justice Act of 2012.

2/ Combined funding from mandatory and discretionary appropriations will be replaced, in FY 2013, by funding from mandatory appropriations only.

Administration on Aging

BA by Activity

(Dollars in Thousands)

	FY 2011 Actual		FY 2012 Enacted		FY 2013 Request
Health and Independence:					
Home & Community-Based Supportive Services	$ 367,611		$ 366,916		$ 366,916
Nutrition Services	657,141		655,901		655,901
Nutrition Services Incentive Program 1/	160,693		160,389		160,389
Preventive Health Services	20,984		20,945		20,945
Community Service Employment for Older Americans 3/	449,100		448,251		448,251
Native American Nutrition & Supportive Services	27,653		27,601		27,601
Aging Network Support Activities	8,184		7,873		7,873
Subtotal, Health and Independence	$ 1,691,366		$ 1,687,876		$ 1,687,876
Caregiver Services:					
Family Caregiver Support Services	$ 153,912		$ 153,621		$ 153,621
Native American Caregiver Support Services	6,376		6,364		6,364
Alzheimer's Disease Supportive Services Program	11,441		4,011		9,537
Lifespan Respite Care	2,495		2,490		2,490
Subtotal, Caregiver Services	$ 174,224		$ 166,486		$ 172,012
Protection of Vulnerable Adults:					
Adult Protective Services	$ --		$ --		$ 8,000
Long-Term Care Ombudsman Program	16,793		16,761		16,761
Prevention of Elder Abuse & Neglect	5,046		5,036		5,036
Senior Medicare Patrol Program	9,420		9,402		9,402
Elder Rights Support Activities 5/	4,096		4,088		4,088
Subtotal, Vulnerable Adults	$ 35,355		$ 35,287		$ 43,287
Consumer Information, Access & Outreach					
Aging and Disability Resource Centers 6/	$ 6,469		$ 6,457		$ --
State Health Insurance Assistance Program 7/	52,000		52,115		51,902
Subtotal, Consumer	$ 58,469		$ 58,572		$ 51,902
Program Innovations	$ 19,069		$ --		$ --
Program Administration:					
Aging Services Programs Administration	$ 19,939		$ 23,063		$ 23,259
Total, Discretionary Budget Authority	**$ 1,998,422**		**$ 1,971,284**		**$ 1,978,336**

Health Care Fraud and Abuse Control 4/	3,312		10,710		10,710
Aging and Disability Resource Centers (mandatory)	$ 10,000		$ 10,000		$ 10,000
Long-Term Care Awareness Campaign 8/	3,000		3,000		3,000
Chronic Disease Self-Management 2/	--		10,000		10,000
Total, Program Level	**$ 2,014,734**		**$ 2,004,994**		**$ 2,012,046**
Total, FTE	**121**		**121**		**135**

1/ Includes $2,025,445 in FY 2012 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursuant to P.L. 110-19 and P.L. 112-74.

2/ Provided in FY 2012 and requested in FY 2013 from Prevention and Public Health Funds provided by Sections 311 and 317(k)(2) of the Public Health Service Act, [42 U.S.C. Sections 243 and 247b(k)(2)] as amended, and the Patient Protection and Affordable Care Act (ACA), Section 4002 [42 U.S.C. 300u-11]

3/ Reflects transfer of the SCSEP program from the Department of Labor to AoA in FY 2013. Funding is compably displayed in FY 2011 and FY 2012.

4/ AoA received $3,312,080 in FY 2011 and $10,709,503 from the Health Care Fraud and Abuse Control wedge funds recovered from fighting fraud. $10,709,503 is a placeholder amount for FY 2013. The Secretary and the Attorney General will determine the final amount.

5/ In FY 2011 activities were previously appropriated and requested in Aging Network Support and Program Innovations.

6/ Excludes $10 million in mandatory funds per section 2405 of P.L. 111-148 (Affordable Care Act).

7/ Reflects transfer of the SHIPs program from CMS to AoA in FY 2013. Funding is compably displayed in FY 2011 and FY 2012. Transfer of discretionary funds from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

8/ Funding in FY 2011 was via reimbursable agreement from CMS; funding in FY 2012 and FY 2013 is provided directly to AoA.

Administration on Aging

Authorizing Legislation

	FY 2012 Amount Authorized	FY 2012 Appropriation	FY 2013 Amount Authorized	FY 2013 Pres. Budget
1) Home and Community-Based Supportive Services: OAA Section 321	Expired	$366,916,000	Expired	$366,916,000
2) Nutrition Services Services: OAA Sections 331 and 336	Expired	$655,901,000	Expired	$655,901,000
3) Nutrition Services Incentive Program: OAA Section 311 1/	Expired	$160,389,000	Expired	$160,389,000
4) Preventive Health Services: OAA Section 361	Expired	$20,945,000	Expired	$20,945,000
5) National Family Caregiver Support Program: OAA Section 371	Expired	$153,621,000	Expired	$153,621,000
6) Community Service Employment for Older Americans Title V OAA Section 371	Expired	$448,251,000	Expired	$448,251,000
6) Native American Nutrition and Supportive Services: OAA Sections 613 and 623	Expired	$27,601,000	Expired	$27,601,000
7) Native American Caregiver Support Program: OAA Section 631	Expired	$6,364,000	Expired	$6,364,000
8) Long-Term Care Ombudsman Program: OAA Section 712	Expired	$16,761,000	Expired	$16,761,000
9) Prevention of Elder Abuse and Neglect: OAA Section 721	Expired	$5,036,000	Expired	$5,036,000
11) Senior Medicare Patrol Program OAA Sections 201 and 202, as amended	Expired	$9,402,000	Expired	$9,402,000
12) Elder Rights Support Activities OAA Sections 201, 202, and 411, as amended	Expired	$4,088,000	Expired	$4,088,000
14) Aging Network Support Activities: OAA Sections 202, 215 and 411	Expired	$7,873,000	Expired	$7,873,000
15) Alzheimer's Disease Demonstration Grants: PHSA Section 398	Expired	$4,011,000	Expired	$9,537,000
16) Lifespan Respite Care Lifespan Respite Care Act of 2006 Title XXIX of the Public Health Service Act	Expired	$2,490,000	Expired	$2,490,000

17) Program Administration:				
OAA Section 205.....	Expired	$23,063,000	Expired	$23,259,000
18) Aging and Disability Resource Centers				
OAA Section 202b.....	Expired	$6,457,000	Expired	$0
18) State Health Insurance Assistance Program:				
Omnibus Budget Reconciliation Act of 1990.....	Expired	$52,115,000	Expired	$51,902,000
Section 4360.....				
19) Adult Protective Services				
Section 6703, Patient Protection and Affordable Care....	$129,000,000	$0	$129,000,000	$8,000,000
Act, Subtitle B, Section 2042 (P.L. 111-148) &.....				
OAA Sections 751 and 752.....	Expired			
Total Request Level.....		$1,971,284,000		$1,978,336,000

Unfunded Authorizations:

1) Legal Assistance:				
OAA Section 731.....	Such Sums	$0	Such Sums	

Administration on Aging

Appropriations History

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2003	1,341,344,000	1,355,844,000	1,369,290,000	1,376,001,000
FY 2003 Rescission	--	--	--	-8,944,007
FY 2004	1,343,701,000	1,377,421,000	1,361,193,000	1,382,189,000
FY 2004 Rescission /1	--	--	--	-8,271,225
FY 2005	1,376,527,000	1,403,479,000	1,395,117,000	1,404,634,000
FY 2005 Rescission /2	--	--	--	-11,292,624
FY 2006	1,369,028,000	1,376,217,000	1,391,699,000	1,376,624,000
FY 2006 Rescission	--	--	--	-13,766,240
FY 2006 Transfer	--	--	--	-936,197
FY 2007	1,334,835,000	1,390,306,000	1,380,516,000	1,383,007,000
FY 2008 /3	1,335,146,000	1,417,189,000	1,451,585,000	1,438,567,000
FY 2008 Rescission	--	--	--	-25,131,765
FY 2009 /4	1,381,384,000	1,492,741,000	1,478,156,000	1,491,343,000
FY 2009 ARRA /5	--	--	--	100,000,000
FY 2010 /6	1,491,343,000	1,530,881,000	1,495,038,000	1,516,297,000
FY 2010 Transfer				-224,298
FY 2011	1,624,733,000	1,651,178,000	1,659,383,000	1,500,323,000
FY 2011 Recission				-3,000,646
FY 2012 7/	2,237,944,000	1,471,324,000	1,534,701,000	1,473,703,000
FY 2012 Recission				-2,785,299
FY 2013	1,978,336,000			

1/ Reflects two separate rescissions of - $8,154,255 and -$117,000.
2/ Reflects two separate rescissions of - $11,236,624 and -$56,000.
3/ Includes $2,659,000 in FY 2008 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursuant to Public Law 110-19.
4/ Includes $2,681,000 in FY 2009 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursuant to Public Law 110-19.
5/ American Recovery and Reinvestment Act of 2009, Public Law 111-5.
6/ Includes $2,544,103,000 in FY 2010 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursuant to Public Law 110-19.
7/ Includes $2,025,445 in FY 2012 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursant to Public Law 112-74.

Administration on Aging

Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations Requested in FY 2013
Alzheimer's Disease Supportive Services: PHSA Section 398	FY 2002	Such Sums	$11,483,000	$9,537,000
Older Americans Act 1/	FY 2011	Such Sums	$1,927,486,000	$1,906,407,000
Lifespan Respite Care: Lifespan Respite Care Act of 2006	FY 2011	$94,810,000	$2,495,000	$2,490,000
State Health Insurance Assistance Programs: Omnibus Budget Reconciliation Act of 1990	FY 1996	$10,000,000	N/A	$51,902,000

1/ Includes $448,251,000 for the Senior Community Service Employment Program (SCSEP) (Title V of the Older Americans Act) which, in FY 2013 is proposed for transfer to AoA from the Department of Labor.

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Health and Independence

Summary of Request

AoA's Health and Independence Programs provide a foundation of supports that assist older individuals to remain healthy and independent in their homes and communities, avoiding more expensive institutional care. These programs include home and community-based supportive services, nutrition services (both meals in congregate settings and those delivered to seniors in their homes), preventive health and chronic disease self-management services, and community service employment services.

The U.S. population over age 60 is projected to increase by 15 percent between 2010 and 2015, from 57 million to 65.7 million[6]. In addition, the number of seniors with severe disabilities-defined as 3 or more limitations in activities of daily living-who are at greatest risk of nursing home admission, is projected to increase by more than 13 percent[7] over the same period. AoA's Health and Independence Programs are vital to helping seniors remain in their homes and communities for as long as possible. For example, 60 percent of congregate and 92 percent of home-delivered meal recipients reported that the meals allowed them to continue living in their own homes, while 53 percent of seniors using transportation services rely on them for the majority of their trips to doctors' offices, pharmacies, meal sites, and other critical daily activities that help them to remain in the community.[8]

The FY 2013 funding request for Health and Independence services is $1,697,876,000; the same as the FY 2012 enacted level. For FY 2013, specific program requests include:

- $366,916,000 for Home and Community-Based Supportive Services (HCBSS); the same as the FY 2012 enacted level. HCBSS provides grants to States to fund a broad array of services that enable seniors to remain in their homes for as long as possible, including adult day care, transportation, case management, personal care services, chore services, and physical fitness programs. These services also aid caregivers, who might otherwise have to be even more intensively relied upon to provide care for their loved ones, taking more time away from their work and other family responsibilities.

- $816,290,000 for three Nutrition Services programs (Congregate Nutrition Services, Home-Delivered Nutrition Services and the Nutrition Services Incentives Program), the same as the FY 2012 enacted level. Nutrition Services help over 2.6 million older adults receive the meals they need to stay healthy and decrease their risk of disability. In FY 2013, these funds will support an estimated 219 million meals.

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[6] U.S. Census Bureau, "2008 National Population Projections," released August 2008, <http://www.census.gov/population/www/projections/2008projections.html>.

[7] Data extrapolated by AoA from U.S. Census Bureau, "2008 National Population Projections," released August 2008, <http://www.census.gov/population/www/projections/2008projections.html> and Health Data Interactive, National Center on Health Statistics, Centers for Disease Control and Prevention, "Functional limitations among Medicare beneficiaries, ages 65+: US, 1992-2006." Accessed 31 August 2009.

[8] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

- $20,945,000 for Preventive Health Services, the same as the FY 2012 enacted level. These services support activities that educate older adults about the importance of healthy lifestyles and promote healthy behaviors that can help prevent, delay, or enable seniors to better cope with and manage chronic disease and disability, thereby reducing the need for more costly medical interventions. AoA is continuing to include appropriations language that requires States to use their Preventive Health Services funds for proven evidence-based prevention activities.

- $10,000,000 for Chronic Disease Self-Management Programs (CDSMP), which would continue funding at the same level as in FY 2012. CDSMP programs have proven effective in helping people to better self-manage their chronic conditions and reduce their need for more costly medical interventions. This program was funded for FY 2010-FY 2011 using funds provided under the American Recovery and Reinvestment Act (ARRA). Funding is provided in FY 2012, and requested to continue in FY 2013 from the Prevention and Public Health Fund appropriated as part of the Affordable Care Act. The narrative request, because it involves funding from the Prevention and Public Health Fund, is included under a separate tab at the end of this document.

- $448,251,000 for the Senior Community Service Employment Program (SCSEP); the same as the FY 2012 enacted level. SCSEP provides subsidized community-service and employment on-the-job training to low-income, unemployed older adults (to allow participants to enter or re-enter the workforce). Like the FY 2012 budget, the FY 2013 budget proposes the transfer of this program to AoA from the Department of Labor which will allow it to be better integrated with other OAA community-based programs, while also enhancing participants' employment prospects.

- $27,601,000 for Native American Nutrition and Supportive Services, the same as the FY 2012 enacted level. These funds will provide approximately 4.5 million meals and 830,000 rides for Native American seniors to critical daily activities such as meal sites, medical appointments, and grocery stores.

- $7,873,000 for Aging Network Support Activities, the same as the FY 2012 enacted level. These funds support competitive grants and contracts for ongoing activities which help seniors and their families obtain information about their care options and benefits, and which assist States, Tribes, and community providers of aging services carry out their mission to help older people remain independent and live in their own homes and communities.

Home and Community-Based Supportive Services

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Home and Community-Based Supportive Services	$367,611,000	$366,916,000	$366,916,000	--

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

FY 2013 Older Americans Act Authorization..... Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

The Home and Community-Based Supportive Services (HCBSS) program, established in 1973, provides grants to States and Territories based on their share of the population age 60 and over to fund a broad array of services that enable seniors to remain in their homes for as long as possible. AoA programs, like the HCBSS program, serve seniors holistically; while each service is valuable in and of itself, it is often the combination of supports, when tailored to the needs of the individual, that ensures clients can remain in their own homes and communities instead of entering nursing homes.

The services provided to seniors through the HCBSS program include access services such as transportation; case management, and information and referral; in-home services such as personal care, chore, and homemaker assistance; and community services such as adult day care and physical fitness programs. In addition to these services, the HCBSS program also funds multi-purpose senior centers, which coordinate and integrate services for the elderly.

While age alone does not determine the need for these long-term care supports, statistics show that both disability rates and the use of long-term supports increase with advancing age. Among those aged 85 and older, 55 percent are unable to perform critical activities of daily living and require long-term support. Data also show that over 80 percent of seniors have at least one chronic condition and 50 percent have at least two. Providing a variety of supportive services that meet the diverse needs of these older individuals is crucial to enabling them to remain healthy and independent in their homes and communities, and therefore to avoiding unnecessary, expensive nursing home care.

Services provided by the HCBSS program in FY 2010, the most recent available data, include:

- *Transportation Services* provided nearly 26 million rides to doctor's offices, grocery stores, pharmacies, senior centers, meal sites, and other critical daily activities (Output C).

- *Personal Care, Homemaker, and Chore Services* provided over 35 million hours of assistance to seniors unable to perform activities of daily living (such as eating, dressing, or bathing) or instrumental activities of daily living (such as shopping or light housework) (Output D).

- *Adult Day Care/Day Health* provided over 10 million hours of care for dependent adults in a supervised, protective group setting during some portion of a twenty-four hour day (Output E).

- *Case Management Services* provided over 4 million hours of assistance in assessing needs, developing care plans, and arranging services for older persons or their caregivers (Output F).

Continuing AoA's commitment to provide services to those in most need, nearly 43 percent of riders on OAA-funded transportation are mobility impaired, meaning they do not own a car or if they do own a car they do not drive, and are not near public transportation. Many of these individuals cannot safely drive a car, as nearly 75 percent of transportation riders have at least one of the following chronic conditions that could impair their ability to navigate safely:

- 68 percent of riders had a doctor tell them they had vision problems (including glaucoma, macular degeneration or cataracts);

- 9 percent have Alzheimer's or dementia;

- 2 percent have Multiple Sclerosis;

- 19 percent have had a stroke;

- 3 percent have epilepsy; and

- 3 percent have Parkinson's disease.

Of the transportation participants, 98 percent take daily medications, with 14 percent taking 10 to 20 medications daily.[9] Data from AoA's national surveys of elderly clients show that services such as transportation are providing these seniors with the assistance and information they need to help them remain at home. For example, over half of seniors using transportation services rely on them for the majority of their transportation needs and would otherwise be homebound, while 80 percent of clients receiving case management reported that as a result of the services arranged by the case manager that they were better able to care for themselves.[10] In addition, a study published in the Journal of Aging and Health shows that the services provided by the HCBSS

[9] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.
[10] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

program, what the article calls "personal care services," are the critical services that enable frail seniors to remain in their homes and out of nursing home care.[11]

Funding History:

Funding for Home and Community-Based Supportive Services during the past ten years is as follows:

FY 2003.....$355,673,000
FY 2004.....$353,889,000
FY 2005.....$354,136,000
FY 2006.....$350,354,000
FY 2007.....$350,595,000
FY 2008.....$351,348,000
FY 2009.....$361,348,000
FY 2010.....$368,290,000
FY 2011.....$367,611,000
FY 2012.....$366,916,000

Budget Request:

The FY 2013 request for Home and Community-Based Supportive Services is $366,916,000, the same as the FY 2012 enacted level. HCBSS help to put off the need for much more expensive institutional services. In addition, the services funded by this program - particularly adult day care, personal care, and chore services – also aid caregivers, who might otherwise have to be even more intensively involved with the care of their loved ones, taking time away from work and their other family responsibilities and further straining family budgets. The overall budget request will support 7.5 million hours of adult day care for older adults; 18 million rides for critical daily activities such as visiting the doctor, the pharmacy, or grocery stores; and 30 million hours of assistance to seniors who are unable to perform daily activities.

AoA's core formula grant programs currently reach one in five seniors, serving over a half million seniors in their own communities who meet the disability criteria for nursing home admission and helping to keep them from joining the 1.7 million seniors who live in institutional settings. Nationally, about 26 percent of individuals 60 and older live alone, and in FY 2013 AoA projects 70 percent of the Older Americans Act transportation users will be individuals who live alone (Outcome 2.11). Living alone is a key predictor of nursing home admission, and HCBSS services are critical to their ability to remain at home, especially for those who do not have an informal caregiver to assist with their care. However, recent research has shown that childless seniors who live in a State with higher home and community-based service expenditures had significantly lower risk of nursing home admissions.[12]

[11] Chen, Ya Mei and Elaine Adams Thompson. Understanding Factors That Influence Success of Home- and Community-Based Services in Keeping Older Adults in Community Settings. 2010. Journal of Aging and Health. V. 22: 267. Available: http://jah.sagepub.com/cgi/content/abstract/22/3/267.

[12] Muramatsu, Naoko. "Risk of Nursing Home Admission Among Older Americans: Does States' Spending on Home and Community-Based Services Matter?" May 2007. Journal of Gerontology: Psychological Sciences.

Federal support for Older Americans Act programs is not expected to cover the cost of serving every senior. These programs have strong partnerships with State and local governments, philanthropic organizations, and private donations that contribute funding. States typically have leveraged resources of $2 or $3 per every Older Americans Act dollar, despite being required to meet a far lower (25%) ratio.

Nonetheless, AoA projects a decline in certain measures of performance for home and community-based services in FY 2013 compared to FY 2010, specifically transportation units provided and personal care, homemaker, and chore service units provided. Declines in outputs are projected to be largely attributable to declining leveraged funds, as State, local, and private budgets face economic hardships.

Outputs and Outcomes Table:

Home and Community-Based Supportive Services Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
2.9b: 90% of transportation clients rate services good to excellent. *(Outcome)*	FY 2010: 98% Target: 90% (Target Exceeded)	90%	90%	Maintain
2.11: Increase the percentage of transportation clients who live alone. *(Outcome)*	FY 2010: 68% Target: 70% (Target Not Met)	70%	70%	Maintain

Indicator	Most Recent Result	FY 2012 Projection	FY 2013 Projection	FY 2013 +/- FY 2012
Output C: Transportation Services units *(Output)*	FY 2010: 25.85 M	20.9 M	18 M	-2.9 M
Output D: Personal Care, Homemaker and Chore Services units *(Output)*	FY 2010: 35.13 M	30.0 M	30.0 M	--
Output E: Adult Day Care/Day Health units *(Output)*	FY 2010: 10.27 M	7.5 M	7.5 M	--
Output F: Case Management Services units *(Output)*	FY 2010: 4.12 M	3.5 M	3.5 M	--

Note: For presentation within the budget AoA highlighted specific measures that are most directly related to Home and Community-Based Supportive Services; however multiple performance outcomes are impacted by this program because AoA's performance measures (efficiency, effective targeting, and client outcomes) assess network-wide performance in achieving current strategic objectives.

Grant Awards Tables:

Home and Community-Based Supportive Services Grant Awards

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request
Number of Awards	56	56	56
Average Award	$6,525,038	$6,486,555	$6,486,555
Range of Awards	$228,376 - $36,232,873	$227,029 - $36,037,733	$227,029 - $36,037,733

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2013 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
Alabama	5,610,623	5,536,753	5,536,753	--
Alaska	1,827,011	1,816,235	1,816,235	--
Arizona	7,448,464	7,359,648	7,359,648	--
Arkansas	3,543,506	3,500,996	3,500,996	--
California	36,232,873	36,037,733	36,037,733	--
Colorado	4,862,516	4,854,891	4,854,891	--
Connecticut	4,404,337	4,404,337	4,404,337	--
Delaware	1,827,011	1,816,235	1,816,235	--
District of Columbia	1,827,011	1,816,235	1,816,235	--
Florida	26,238,773	26,054,949	26,054,949	--
Georgia	9,194,575	9,059,015	9,059,015	--
Hawaii	1,827,011	1,816,235	1,816,235	--
Idaho	1,827,011	1,816,235	1,816,235	--
Illinois	14,524,890	14,524,890	14,524,890	--
Indiana	7,165,491	7,065,226	7,065,226	--
Iowa	4,260,878	4,260,878	4,260,878	--
Kansas	3,432,908	3,432,908	3,432,908	--
Kentucky	4,989,594	4,915,884	4,915,884	--
Louisiana	4,838,530	4,795,898	4,795,898	--
Maine	1,827,011	1,816,235	1,816,235	--
Maryland	6,149,883	6,079,225	6,079,225	--
Massachusetts	8,209,095	8,209,095	8,209,095	--
Michigan	11,646,647	11,444,057	11,444,057	--
Minnesota	5,783,935	5,708,544	5,708,544	--
Mississippi	3,272,711	3,272,711	3,272,711	--
Missouri	7,118,429	7,118,429	7,118,429	--
Montana	1,827,011	1,816,235	1,816,235	--
Nebraska	2,294,938	2,294,938	2,294,938	--
Nevada	2,755,306	2,817,723	2,817,723	--
New Hampshire	1,827,011	1,816,235	1,816,235	--

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

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
New Jersey	10,262,972	10,262,972	10,262,972	--
New Mexico	2,237,028	2,283,731	2,283,731	--
New York	24,283,431	24,283,431	24,283,431	--
North Carolina	10,484,174	10,506,029	10,506,029	--
North Dakota	1,827,011	1,816,235	1,816,235	--
Ohio	13,816,810	13,816,810	13,816,810	--
Oklahoma	4,278,286	4,278,286	4,278,286	--
Oregon	4,576,322	4,563,036	4,563,036	--
Pennsylvania	17,879,977	17,879,977	17,879,977	--
Rhode Island	1,827,011	1,816,235	1,816,235	--
South Carolina	5,479,859	5,409,350	5,409,350	--
South Dakota	1,827,011	1,816,235	1,816,235	--
Tennessee	7,364,949	7,257,606	7,257,606	--
Texas	22,440,012	22,389,947	22,389,947	--
Utah	2,181,148	2,105,540	2,105,540	--
Vermont	1,827,011	1,816,235	1,816,235	--
Virginia	8,499,074	8,414,378	8,414,378	--
Washington	7,221,988	7,172,105	7,172,105	--
West Virginia	2,773,538	2,773,538	2,773,538	--
Wisconsin	6,539,594	6,468,835	6,468,835	--
Wyoming	1,827,011	1,816,235	1,816,235	--
Subtotal, States	358,049,207	356,225,354	356,225,354	--
American Samoa	472,317	472,317	472,317	--
Guam	913,505	908,118	908,118	--
Northern Mariana Islands	228,376	227,029	227,029	--
Puerto Rico	4,825,219	4,506,117	4,506,117	--
Virgin Islands	913,505	908,118	908,118	--
Subtotal, States and Territories	365,402,129	363,247,053	363,247,053	--
Undistributed 13/	2,208,871	3,668,947	3,668,947	--
TOTAL	**367,611,000**	**366,916,000**	**366,916,000**	**--**

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

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Nutrition Services

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Budget Request	FY 2013 +/- FY 2012
Congregate Nutrition	$439,901,000	$439,070,000	$439,070,000	--
Home-Delivered Nutrition	$217,241,000	$216,831,000	$216,831,000	--
Nutrition Services Incentive Program	$160,693,000	$160,389,000	$160,389,000	--
Total BA	$817,835,000	$816,290,000	$816,290,000	--

Authorizing Legislation: Sections 311, 331, and 336 of the Older Americans Act of 1965, as amended

FY 2013 Older Americans Act Authorization..... Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

Nutrition Services help seniors remain healthy and independent in their communities by providing meals and related services in a variety of settings (including congregate facilities such as senior centers) and via home-delivery to seniors who are homebound due to illness, disability, or geographic isolation. Nutrition Services, which help seniors remain healthy and independent in their communities, include:

- Congregate Nutrition Services (Title III-C1): Provides funding for the provision of meals and related services in a variety of congregate settings, which helps to keep older Americans healthy and prevents the need for more costly medical interventions. Established in 1972, the program also presents opportunities for social engagement and meaningful volunteer roles, which contribute to overall health and well-being.

- Home-Delivered Nutrition Services (Title III-C2): Provides funding for the delivery of meals and related services to frail seniors who are homebound. Established in 1978, home-delivered meals are often the first in-home service that an older adult receives and serve as a primary access point for other home and community-based services. Home-delivered meals also represent an essential service for many caregivers, helping them to maintain their own health and well-being.

- Nutrition Services Incentive Program (Title III-A): Provides additional funding to States, Territories, and eligible Tribal Organizations that is used exclusively to provide meals and cannot be used to pay for other nutrition-related services or for administrative costs. Funds are awarded to States and Tribes based on the number of meals served in the prior Federal fiscal year. States and Tribes have the option to purchase commodities directly

from the U.S. Department of Agriculture (USDA) with any portion of their award if they determine that doing so will enable them to better meet the needs of seniors. Eight States and five Tribes elected to spend approximately $2.3 million on commodities, including $190,403 assessed by USDA as administrative expenses in FY 2011.

Formula grants for Congregate Nutrition Services and Home-Delivered Nutrition Services are allocated to States and Territories based on their share of the population age 60 and over. Nutrition Services Incentive Program grants are provided to States, Territories, and Tribal organizations based on the number of meals served in the prior Federal fiscal year. The meals provided through these programs fulfill the standards set by the Dietary Guidelines for Americans and provide a minimum of 33 percent of the Dietary Reference Intake, as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences.

Nutrition Services help approximately 2.5 million older adults receive the meals they need to stay healthy and decrease their risk of disability. Studies have found that 50 percent of all persons age 85 and over are in need of assistance with instrumental activities of daily living (IADLs), including obtaining and preparing food; these nutrition programs help address their needs. *Serving Elders at Risk*, a national evaluation of AoA's nutrition program clients, found that recipients are older, poorer, more likely to live alone, more likely to be minorities, are sicker, in poorer health, in poorer nutritional status, more functionally impaired, and at higher nutritional risk than those in the general population. Nutrition Services provide an important opportunity for social interaction that helps to improve the general health status of participants, particularly homebound elders. A comparison of the number of social contacts of congregate and home-delivered meal participants showed that nutrition program clients had significantly more social contacts than people who did not participate in the program.

Data from AoA's national surveys of elderly clients show that the Nutrition Services are effectively helping seniors to improve their nutritional intake and remain at home. For example, 78 percent of congregate and 83 percent of home-delivered meal recipients say they eat healthier meals due to the programs, and 60 percent of congregate and 92 percent of home-delivered meal recipients say that the meals enabled them to continue living in their own homes.[14] In addition, home-delivered meal and congregate meal participants had significantly better food energy intake, protein, vitamins A, B_6 & D, Riboflavin, Calcium, Phosphorous, Potassium, Magnesium and Zinc intakes compared to matched non-participant group of senior citizens.[15] Seniors with deficiencies of these nutrients can experience osteoporosis, night blindness, decreased resistance to infection, fatigue, vasodilatation, and other illnesses.

AoA's annual performance data further demonstrate that these programs are an efficient and effective means to help seniors remain healthy and independent in their homes and in the community. Ninety percent of home-delivered meal clients rate service as good to excellent (Outcome 2.9a). Also, the number of home-delivered meal recipients with severe disabilities (3+ ADL) totaled nearly 349,000 in 2010 (Outcome 3.2). This level of disability is frequently associated with nursing home admission, and demonstrates the extreme frailty of a significant

[14] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.
[15] *Serving Elders at Risk – National Evaluation of the Elderly Nutrition Program, 1993-1995,* pp.117-118

number of home-delivered meal clients. The most recent data on how these nutrition programs are helping seniors remain healthy and independent in their homes include:

- *Home-Delivered Nutrition Services* provided over 145 million meals to over 860,000 individuals in FY 2010 (Output G).

- *Congregate Nutrition Services* provided over 96.4 million meals to over 1.7 million seniors in a variety of community settings in FY 2010 (Output H).

Funding History:

Comparable funding for Nutrition Services during the past ten years is as follows:

FY 2003.....$714,274,000
FY 2004.....$714,462,000
FY 2005.....$718,696,000
FY 2006.....$714,578,000
FY 2007.....$735,070,000
FY 2008.....$758,003,000
FY 2009.....$809,743,000
FY 2009 (ARRA).....$97,000,000
FY 2010.....$819,353,000
FY 2011.....$817,835,000
FY 2012.....$816,290,000

Budget Request:

The FY 2013 request for Nutrition Services is $816,290,000, the same as the FY 2012 enacted level. At this level, the budget request will support 219 million home-delivered and congregate meals to approximately two million elderly individuals in a variety of community settings.

Consistent with AoA's commitment to target services to those most in need to help them maintain their health and independence, approximately 73 percent of home-delivered meal recipients have annual incomes at or below $20,000. Meals are especially critical for the survival of the 28 percent of recipients who report these meals as the sole or majority of their food intake for the day and for the 297,000 home-delivered meal recipients with severe disabilities who are projected to be served in FY 2013 (Outcome 3.2). This population with severe disabilities is particularly important to serve since this level of disability is frequently an eligibility requirement for more costly nursing home admission.

Federal support for Nutrition Services is not expected to serve every senior. These programs have strong partnerships with State and local governments, philanthropic organizations, and private donations that contribute funding. In FY 2009, State and local funding comprised approximately 66 percent of all the funding for home-delivered meals and congregate meals. Though all programs funded through OAA rely on State and local funding in some part,

congregate and home-delivered meals have a higher rate of State and local financial support than many other OAA services.

In FY 2013 these programs are expected to continue to provide home-delivered meals that clients rate good to excellent (Outcome 2.9a) ensuring that clients continue to receive high quality services. However, as State and local funding tightens, some providers may look at cost cutting measures such as reducing menu choices or the frequency of deliveries. This could affect client satisfaction with the quality of service.

Outcomes and Outputs Table:

Nutrition Services Outcomes and Outputs

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
1.1: For Home and Community-based Services including Nutrition Services, and Caregiver services increase the number of clients served per million dollars of AoA funding. *(Outcome)*	FY 2010: 8,438 Target: 7,742 (Target Exceeded)	8,600	8,600	Maintain
2.9a: 90% of home delivered meal clients rate services good to excellent. *(Outcome)*	FY 2010: 90%[16] Target: 90% (Target Met)	90%	90%	Maintain
3.2: Increase the number of older persons with severe disabilities who receive home-delivered meals. *(Outcome)*	FY 2010: 348,669 Target: 325,000 (Target Exceeded)	311,000	297,000	-14,000

Indicator	Most Recent Result	FY 2012 Projection	FY 2013 Projection	FY 2013 +/- FY 2012
Output G: Number of Home-Delivered meals served *(Output)*	FY 2010: 145.5 M	135 M	135 M	--
Output H: Number of Congregate meals served *(Output)*	FY 2010: 96.4 M	84.2 M	84 M	-0.4 M
Outputs G& H: Total Number of Meals *(Outputs)*	FY 2010: 241.9 M	219.2 M	219 M	-0.2 M

Note: For presentation within the budget AoA highlighted specific measures that are most directly related to Nutrition Services, however multiple performance outcomes are impacted by this program because AoA's performance measures (efficiency, effective targeting, and client outcomes) assess network-wide performance in achieving current strategic objectives.

[16] Based on upper range of survey confidence interval.

Grant Awards Tables:

Congregate Nutrition Programs Grant Awards

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request
Number of Awards	56	56	56
Average Award	$7,808,176	$7,659,943	$7,659,943
Range of Awards	$273,286 - $43,454,221	$268,098 - $42,353,702	$268,098 - $42,353,702

Home-Delivered Nutrition Programs Grant Awards

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request
Number of Awards	56	56	56
Average Award	$3,855,985	$3,782,782	$3,782,782
Range of Awards	$134,959 - $21,832,514	$132,397 - $21,582,902	$132,397 - $21,582,902

Nutrition Services Incentive Program Grant Awards

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request
Number of Awards	308	308	308
Average Award[17]	$518,595	$515,537	$515,537
Range of Awards	$402 - $15,387,754	$402 - $15,327,968	$402 - $15,327,968

[17] If the 253 awards to Tribal organizations are excluded from the "average award" calculation, the average award to States, DC, and the territories is $2,845,943 in FY 2011; $2,829,044 in FY 2012 and FY 2013.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2013 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM: Congregate Nutrition Services (CFDA 93.045)

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
Alabama	6,728,841	6,646,863	6,646,863	--
Alaska	2,186,289	2,173,394	2,173,394	--
Arizona	8,932,970	8,835,245	8,835,245	--
Arkansas	4,249,740	4,177,866	4,177,866	--
California	43,454,221	43,263,238	43,263,238	--
Colorado	5,831,634	5,828,289	5,828,289	--
Connecticut	5,241,452	5,241,452	5,241,452	--
Delaware	2,186,289	2,173,394	2,173,394	--
District of Columbia	2,186,289	2,173,394	2,173,394	--
Florida	31,468,259	31,278,922	31,278,922	--
Georgia	11,027,088	10,875,332	10,875,332	--
Hawaii	2,186,289	2,173,394	2,173,394	--
Idaho	2,186,289	2,173,394	2,173,394	--
Illinois	17,286,541	17,286,541	17,286,541	--
Indiana	8,593,601	8,481,791	8,481,791	--
Iowa	5,081,501	5,081,501	5,081,501	--
Kansas	4,089,903	4,089,903	4,089,903	--
Kentucky	5,984,038	5,901,510	5,901,510	--
Louisiana	5,802,867	5,699,802	5,699,802	--
Maine	2,186,289	2,173,394	2,173,394	--
Maryland	7,375,577	7,298,099	7,298,099	--
Massachusetts	9,780,267	9,780,267	9,780,267	--
Michigan	13,967,867	13,738,571	13,738,571	--
Minnesota	6,936,695	6,853,097	6,853,097	--
Mississippi	3,897,686	3,891,114	3,891,114	--
Missouri	8,467,047	8,467,047	8,467,047	--
Montana	2,186,289	2,173,394	2,173,394	--
Nebraska	2,738,802	2,738,802	2,738,802	--
Nevada	3,304,449	3,382,671	3,382,671	--
New Hampshire	2,186,289	2,173,394	2,173,394	--

PROGRAM: Congregate Nutrition Services (CFDA 93.045)

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
New Jersey	12,190,488	12,190,488	12,190,488	--
New Mexico	2,682,876	2,741,615	2,741,615	--
New York	28,963,855	28,963,855	28,963,855	--
North Carolina	12,573,709	12,612,470	12,612,470	--
North Dakota	2,186,289	2,173,394	2,173,394	--
Ohio	16,533,997	16,393,785	16,393,785	--
Oklahoma	5,104,353	5,080,736	5,080,736	--
Oregon	5,488,400	5,477,917	5,477,917	--
Pennsylvania	21,279,716	21,279,716	21,279,716	--
Rhode Island	2,186,289	2,173,394	2,173,394	--
South Carolina	6,572,016	6,493,915	6,493,915	--
South Dakota	2,186,289	2,173,394	2,173,394	--
Tennessee	8,832,811	8,712,744	8,712,744	--
Texas	26,912,390	26,879,093	26,879,093	--
Utah	2,615,859	2,527,698	2,527,698	--
Vermont	2,186,289	2,173,394	2,173,394	--
Virginia	10,192,972	10,101,446	10,101,446	--
Washington	8,661,357	8,610,100	8,610,100	--
West Virginia	3,305,947	3,305,947	3,305,947	--
Wisconsin	7,842,960	7,765,825	7,765,825	--
Wyoming	2,186,289	2,173,394	2,173,394	--
Subtotal, States	428,416,509	426,229,395	426,229,395	--
American Samoa	594,843	594,843	594,843	--
Guam	1,093,145	1,086,697	1,086,697	--
Northern Mariana Islands	273,286	271,674	271,674	--
Puerto Rico	5,786,903	5,409,585	5,409,585	--
Virgin Islands	1,093,145	1,086,697	1,086,697	--
Subtotal, States and Territories	437,257,831	434,678,891	434,678,891	--
Undistributed 18/	2,643,169	4,391,109	4,391,109	--
TOTAL	**439,901,000**	**439,070,000**	**439,070,000**	**--**

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2013 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM: Home-Delivered Nutrition Services (CFDA 93.045)

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
Alabama	3,380,743	3,360,219	3,360,219	--
Alaska	1,079,676	1,073,311	1,073,311	--
Arizona	4,488,153	4,466,521	4,466,521	--
Arkansas	2,135,178	2,112,056	2,112,056	--
California	21,832,514	21,871,060	21,871,060	--
Colorado	2,929,963	2,946,401	2,946,401	--
Connecticut	2,533,609	2,554,038	2,554,038	--
Delaware	1,079,676	1,073,311	1,073,311	--
District of Columbia	1,079,676	1,073,311	1,073,311	--
Florida	15,810,460	15,812,575	15,812,575	--
Georgia	5,540,292	5,497,856	5,497,856	--
Hawaii	1,079,676	1,073,311	1,073,311	--
Idaho	1,079,676	1,073,311	1,073,311	--
Illinois	8,295,464	8,184,109	8,184,109	--
Indiana	4,317,645	4,287,838	4,287,838	--
Iowa	2,243,404	2,235,225	2,235,225	--
Kansas	1,895,162	1,888,402	1,888,402	--
Kentucky	3,006,534	2,983,417	2,983,417	--
Louisiana	2,915,509	2,881,447	2,881,447	--
Maine	1,079,676	1,082,056	1,082,056	--
Maryland	3,705,679	3,689,441	3,689,441	--
Massachusetts	4,663,308	4,581,199	4,581,199	--
Michigan	7,017,815	6,945,322	6,945,322	--
Minnesota	3,485,174	3,464,477	3,464,477	--
Mississippi	1,958,298	1,947,092	1,947,092	--
Missouri	4,251,524	4,215,343	4,215,343	--
Montana	1,079,676	1,073,311	1,073,311	--
Nebraska	1,227,879	1,231,109	1,231,109	--
Nevada	1,660,240	1,710,057	1,710,057	--
New Hampshire	1,079,676	1,073,311	1,073,311	--

PROGRAM: Home-Delivered Nutrition Services (CFDA 93.045)

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
New Jersey	6,073,137	5,996,154	5,996,154	--
New Mexico	1,347,946	1,385,981	1,385,981	--
New York	13,639,815	13,255,677	13,255,677	--
North Carolina	6,317,354	6,376,039	6,376,039	--
North Dakota	1,079,676	1,073,311	1,073,311	--
Ohio	8,307,104	8,230,098	8,230,098	--
Oklahoma	2,564,558	2,558,978	2,558,978	--
Oregon	2,757,513	2,769,276	2,769,276	--
Pennsylvania	9,854,900	9,723,903	9,723,903	--
Rhode Island	1,079,676	1,073,311	1,073,311	--
South Carolina	3,301,949	3,282,898	3,282,898	--
South Dakota	1,079,676	1,073,311	1,073,311	--
Tennessee	4,437,831	4,404,593	4,404,593	--
Texas	13,521,475	13,588,310	13,588,310	--
Utah	1,314,275	1,277,838	1,277,838	--
Vermont	1,079,676	1,073,311	1,073,311	--
Virginia	5,121,210	5,106,630	5,106,630	--
Washington	4,351,688	4,352,703	4,352,703	--
West Virginia	1,494,917	1,521,444	1,521,444	--
Wisconsin	3,940,504	3,925,893	3,925,893	--
Wyoming	1,079,676	1,073,311	1,073,311	--
Subtotal, States	211,676,511	210,583,407	210,583,407	--
American Samoa	136,498	136,498	136,498	--
Guam	539,838	536,655	536,655	--
Northern Mariana Islands	134,959	134,164	134,164	--
Puerto Rico	2,907,489	2,734,732	2,734,732	--
Virgin Islands	539,838	536,655	536,655	--
Subtotal, States and Territories	215,935,133	214,662,111	214,662,111	--
Undistributed 19/	1,305,867	2,168,889	2,168,889	--
TOTAL	**217,241,000**	**216,831,000**	**216,831,000**	--

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2013 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM: Nutrition Services Incentive Program (CFDA 93.053)

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
Alabama	2,757,851	2,741,475	2,741,475	--
Alaska	355,155	353,047	353,047	--
Arizona	2,137,183	2,124,493	2,124,493	--
Arkansas	2,631,552	2,615,926	2,615,926	--
California	12,422,425	12,348,663	12,348,663	--
Colorado	1,412,481	1,404,094	1,404,094	--
Connecticut	1,504,816	1,495,881	1,495,881	--
Delaware	606,130	602,531	602,531	--
District of Columbia	601,892	598,318	598,318	--
Florida	7,752,196	7,706,165	7,706,165	--
Georgia	2,827,339	2,810,550	2,810,550	--
Hawaii	474,893	472,073	472,073	--
Idaho	677,345	673,323	673,323	--
Illinois	7,020,289	6,978,604	6,978,604	--
Indiana	1,900,591	1,889,306	1,889,306	--
Iowa	1,960,304	1,948,664	1,948,664	--
Kansas	2,201,986	2,188,911	2,188,911	--
Kentucky	1,852,778	1,841,777	1,841,777	--
Louisiana	3,201,511	3,182,501	3,182,501	--
Maine	583,674	580,208	580,208	--
Maryland	1,899,261	1,887,983	1,887,983	--
Massachusetts	5,809,015	5,774,522	5,774,522	--
Michigan	7,267,382	7,224,229	7,224,229	--
Minnesota	1,974,728	1,963,002	1,963,002	--
Mississippi	1,201,461	1,194,327	1,194,327	--
Missouri	4,055,147	4,031,068	4,031,068	--
Montana	1,159,925	1,153,038	1,153,038	--
Nebraska	1,266,994	1,259,470	1,259,470	--
Nevada	1,083,744	1,077,309	1,077,309	--
New Hampshire	1,103,997	1,097,442	1,097,442	--

PROGRAM: Nutrition Services Incentive Program (CFDA 93.053)

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
New Jersey	3,813,364	3,790,721	3,790,721	--
New Mexico	1,980,506	1,968,746	1,968,746	--
New York	15,419,529	15,327,968	15,327,968	--
North Carolina	3,361,424	3,341,464	3,341,464	--
North Dakota	806,432	801,643	801,643	--
Ohio	5,577,024	5,543,908	5,543,908	--
Oklahoma	2,045,615	2,033,469	2,033,469	--
Oregon	1,797,863	1,787,187	1,787,187	--
Pennsylvania	7,162,223	7,119,695	7,119,695	--
Rhode Island	537,442	534,251	534,251	--
South Carolina	1,710,911	1,700,751	1,700,751	--
South Dakota	953,291	947,630	947,630	--
Tennessee	1,647,948	1,638,162	1,638,162	--
Texas	12,539,020	12,464,565	12,464,565	--
Utah	1,332,354	1,324,443	1,324,443	--
Vermont	755,471	750,985	750,985	--
Virginia	2,473,229	2,458,543	2,458,543	--
Washington	2,074,062	2,061,747	2,061,747	--
West Virginia	1,619,809	1,610,191	1,610,191	--
Wisconsin	2,651,426	2,635,682	2,635,682	--
Wyoming	788,892	784,207	784,207	--
Subtotal, States	152,751,880	149,845,819	149,845,819	--
American Samoa	--	--	--	--
Guam	393,220	390,885	390,885	--
Northern Mariana Islands	62,962	62,589	62,589	--
Puerto Rico	3,118,596	3,100,079	3,100,079	--
Virgin Islands	200,210	199,021	199,021	--
Subtotal, States and Territories	156,526,868	155,597,432	155,597,432	--
Tribal Organizations	3,200,411	3,187,965	3,187,965	--
Undistributed 20/	965,721	1,603,603	1,603,603	--
TOTAL	**160,693,000**	**160,389,000**	**160,389,000**	--

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

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Preventive Health Services

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Preventive Health Services…	$20,984,000	$20,945,000	$20,945,000	--

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

FY 2013 Older Americans Act Authorization..... Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

Preventive Health Services, established in 1987, provides formula grants to States and Territories, based on their share of the population aged 60 and over, to support activities that educate older adults about the importance of healthy lifestyles and promote healthy behaviors that can help to prevent or delay chronic disease and disability, thereby reducing the need for more costly medical interventions.

Due in large part to advances in public health and medical care, Americans are leading longer and more active lives. Average life expectancy has increased from less than 50 years at the turn of the 20th century to almost 78 years today. On average an American turning age 65 today can expect to live an additional 18.6 years. The population of older Americans is also growing, particularly the population age 85 and over, which is growing very rapidly, totaling 5.5 million in 2010 and projected to reach 8.7 million by the year 2030. One consequence of this increased longevity is the higher incidence of chronic diseases such as obesity, arthritis, diabetes, osteoporosis, and depression as well as the greater probability of injury from a fall, which quickly limits physical activity.

Preventive Health Services gives States and Territories flexibility to allocate resources among the preventive health activities of their choice to best meet local needs. Priority has been given to providing services to those elders living in medically underserved areas of the state or who have the greatest economic need. Services currently provided through the Preventive Health Services program include:

- *Information and Outreach,* including the distribution of information to seniors through Aging and Disability Resource Centers, Area Agencies on Aging, senior centers, community parks and recreation programs, housing programs, faith based organizations, chronic disease self-management programs, congregate meal sites, and the home-delivered meals program about healthy lifestyles and behaviors.

- *Health Screenings and Risk Assessments* for a variety of conditions, including hypertension, diabetes, dental issues, high cholesterol, hearing and vision loss, and glaucoma.

- *Evidence-based Prevention Programs*, as described below.

Over the last few years, some States have begun to shift their funding to provide greater support to evidence-based approaches, especially to help individuals manage chronic diseases. In FY 2012, AoA requested, and the Congress included in appropriations language a provision which requires States to use all of their title III-D Preventive Health funds to support proven evidence-based models that enhance the wellness and fitness of the aging community. Since evidence-based programs have demonstrated their effectiveness, AoA expects that States will be able to maximize the impact of these limited dollars. At the same time, if States wish to continue funding other health services, they still will have the flexibility to continue to use funds provided under the Home and Community-Based Services program for this purpose.

Evidence-based programs are interventions that have been tested through randomized control trials and have been shown to be effective at helping participants adopt healthy behaviors, improve their health status, and reduce their use of hospital services and emergency room visits. Some examples of evidence-based interventions are:

- *Enhanced fitness and enhanced wellness programs:* Enhanced fitness is a multi-component group exercise program designed for community-based organizations and intended to promote physical activity among older adults. Strength training using soft wrist and ankle weights; cardiovascular workout using dancing, aerobics, or walking; and balance and posture exercises are used to increase the physical health of older adults. In addition exercise has been proven to improve depression, which studies have shown that nearly 20 percent of U.S. adults 65 years and older experience. Exercise may also act as a buffer against many illnesses impacted by stress.

- *Falls prevention*: Falls prevention programs help participants to achieve improved strength, balance, and mobility; provide education on how to avoid falls and reduce fall risk factors; involve medication reviews and modifications; provide referrals for medical care management for selected fall risk factors; and provide home hazard assessments of ways to reduce environmental hazards. Recent studies have shown that in the United States more than one-third of adults age 65 and over fall each year. Of those who fall, 20 to 30 percent will experience serious injuries, such as head trauma, broken bones, or hip fractures. These injuries may limit the ability of older adults to get around or live independently. Those who are not injured may develop a fear of falling, which may increase their actual risk of falling. Many people limit their activity after a fall, which may reduce strength, physical fitness, and mobility.[21]

[21] Even, Jennifer. 2009. *Senior Series.* The Ohio State University Extension. 20 May 2009.

- *Medication management:* Medication management programs focus on reviewing the multitude of medications that older adults are prescribed, focusing especially on high-risk medications. Medication management programs have been shown to reduce unnecessary duplication of prescriptions and cardiovascular problems. These programs have also been shown to improve medication usage rates and decrease medication errors among older adults.

Preventive Health Services have been carried out at multi-purpose senior centers, meal sites, and other community-based settings, as well as through individualized counseling and services for vulnerable elders. States reported 5.9 million seniors served in these health-related programs which received $16 million in additional funding from States and local entities.

Funding History:

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

FY 2008 ..... $21,026,000
FY 2009 ..... $21,026,000
FY 2010 ..... $21,026,000
FY 2011 ..... $20,984,000
FY 2012 ..... $20,945,000

Budget Request:

The FY 2013 budget request for Preventive Health Services is $20,945,000, the same as the FY 2012 enacted level. AoA is continuing a key change in appropriations language that was included by the Congress for FY 2012 which requires States to use their Preventive Health Services funds to support proven evidence-based models that enhance the wellness and fitness of the aging community. Recognizing that the development of evidence-based programs is ongoing, AoA will continue to provide guidance regarding what meets the evidence-based requirement.

Each of the evidence-based programs that States could use these funds for have been rigorously evaluated and found to be effective. By requiring States to use funding for one or more of these proven programs, AoA seeks to maximize the impact of this funding on providing benefits to individuals and on achieving savings due to reduced medical costs. At the same time, States would continue to have the flexibility to use funding provided under the Home and Community-Based Services Program to fund related health services, such as health screenings and physical fitness programs that do not meet these evidence-based requirements.

Output Table:

Preventive Health Services Output

Indicator	Most Recent Result	FY 2012 Projection	FY 2013 Projection	FY 2013 +/- FY 2012
Output AB: The number of people served with health and disease prevention programs *(Output)*	N/A	Baseline	TBD	N/A

Grant Awards Tables:

Preventive Health Services Grant Awards

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request
Number of Awards	56	56	56
Average Award	$374,713	$374,006	$374,006
Range of Awards	$13,115 - $2,127,762	$13,090 - $2,123,756	$13,090 - $2,123,756

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2013 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM: Preventive Health Services (CFDA 93.043)

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
Alabama	332,502	331,874	331,874	--
Alaska	104,920	104,721	104,721	--
Arizona	404,463	403,699	403,699	--
Arkansas	211,162	210,763	210,763	--
California	2,127,762	2,123,856	2,123,856	--
Colorado	255,659	255,177	255,177	--
Connecticut	260,652	260,160	260,160	--
Delaware	104,920	104,721	104,721	--
District of Columbia	104,920	104,721	104,721	--
Florida	1,554,456	1,551,622	1,551,622	--
Georgia	486,684	485,765	485,765	--
Hawaii	104,920	104,721	104,721	--
Idaho	104,920	104,721	104,721	--
Illinois	839,479	837,894	837,894	--
Indiana	426,268	425,464	425,464	--
Iowa	231,787	231,350	231,350	--
Kansas	191,313	190,952	190,952	--
Kentucky	291,748	291,198	291,198	--
Louisiana	295,110	294,553	294,553	--
Maine	105,122	104,924	104,924	--
Maryland	360,430	359,750	359,750	--
Massachusetts	464,535	463,658	463,658	--
Michigan	692,606	691,299	691,299	--
Minnesota	338,416	337,777	337,777	--
Mississippi	195,859	195,489	195,489	--
Missouri	422,405	421,608	421,608	--
Montana	104,920	104,721	104,721	--
Nebraska	124,650	124,415	124,415	--
Nevada	151,459	151,173	151,173	--
New Hampshire	104,920	104,721	104,721	--

PROGRAM: Preventive Health Services (CFDA 93.043)

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
New Jersey	619,704	618,534	618,534	--
New Mexico	127,140	126,899	126,899	--
New York	1,373,850	1,371,257	1,371,257	--
North Carolina	576,505	575,417	575,417	--
North Dakota	104,920	104,721	104,721	--
Ohio	834,207	832,633	832,633	--
Oklahoma	256,914	256,429	256,429	--
Oregon	254,403	253,923	253,923	--
Pennsylvania	1,016,515	1,014,597	1,014,597	--
Rhode Island	104,920	104,721	104,721	--
South Carolina	294,842	294,285	294,285	--
South Dakota	104,920	104,721	104,721	--
Tennessee	415,981	415,196	415,196	--
Texas	1,250,740	1,248,379	1,248,379	--
Utah	114,870	114,654	114,654	--
Vermont	104,920	104,721	104,721	--
Virginia	483,960	483,047	483,047	--
Washington	396,896	396,147	396,147	--
West Virginia	152,831	152,542	152,542	--
Wisconsin	390,666	389,928	389,928	--
Wyoming	104,920	104,721	104,721	--
Subtotal, States	20,583,591	20,544,739	20,544,739	--
American Samoa	13,115	13,090	13,090	--
Guam	52,460	52,361	52,361	--
Northern Mariana Islands	13,115	13,090	13,090	--
Puerto Rico	269,207	268,699	268,699	--
Virgin Islands	52,460	52,361	52,361	--
Subtotal, States and Territories	20,983,948	20,944,540	20,944,540	--
TOTAL	**20,983,948**	**20,945,000**	**20,945,000**	--

Senior Community Service Employment Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Senior Community Service Employment Program.....	$449,100,000	$448,251,000	$448,251,000	--
FTE[22].....	--	--	8	+8

Authorizing Legislation: Section 502 of the Older Americans Act of 1965, as amended

FY 2013 Older Americans Act Authorization..... Expired

Allocation Method ..... Formula & Competitive Grants

Program Description and Accomplishments

The Senior Community Service Employment Program (SCSEP) provides time-limited subsidized community service positions and employment training to low-income, unemployed older adults to allow them to earn additional income in order to maintain their economic independence. Participants must be currently unemployed adults aged 55 and older whose income, including pensions and other income, is below 125% of the federal poverty level. The program's emphasis is on assisting those with the greatest social and economic needs and those living in rural areas. SCSEP's goals are to foster economic self-sufficiency through eventual unsubsidized employment and to provide opportunities for older individuals to serve their communities while gaining the marketable skills needed to obtain unsubsidized employment. Community service employment assignments are based at 501(c)(3) non-profits or government agencies (also referred to as "host agencies"), and are chosen based on their ability to prepare participants to enter or re-enter the workforce. Participants are paid the highest of the Federal, state, or local minimum wage. SCSEP is currently administered by the Department of Labor but is proposed for transfer to AoA in FY 2013.

In addition to wages and benefits, SCSEP provides the following programmatic services to participants:

- Orientation and assessments;
- Supportive services;
- Participant training (e.g., on the job or in a classroom setting); and

[22] Comparable FTE numbers are not available for the level of support provided by the Department of Labor in FY 2011 and FY 2012.

- Placement assistance into unsubsidized employment.

While enrolled in the program, all participants must be covered by workers' compensation and offered an annual physical examination. Each participant's skills and interests are assessed at least twice a year, leading to the development of an Individual Employment Plan (IEP). SCSEP's focus on assuring that workers are equipped with the skills and knowledge necessary to succeed will remain in place while better aligning it with programs that provide other supportive services to seniors.

SCSEP is funded by a formula set forth in Title V of the Older Americans Act. In general, the formula allocates funds to every state, the District of Columbia (DC) and Puerto Rico (PR) based on U.S. Census data on the number of individuals in that jurisdiction who are 55 and older with low per-capita income. Currently funds are reserved for the following purposes prior to determining the amount available to be allocated to the states, DC, and PR: a) up to 1.5 percent of the total authorization for pilots, demonstration and evaluation projects; b) a fixed percentage of .75 percent of the total allocation to the Territories of Guam, the U.S. Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands; and c) a portion determined by the Secretary for national public or non-profit agencies to serve eligible American Indian and Pacific Island /Asian American individuals.

Prior to the 2006 reauthorization, funds were allocated to and administered through one-year grants to States and to national non-profit agencies. Approximately 22 percent of formula funds are awarded to States, with 78 percent awarded to national non-profit agencies for services across the country. In 2006, DOL conducted a competition for the national grantees. As a result, 18 organizations received SCSEP funds, including three organizations under the Indian and Pacific Islands /Asian Americans set-aside. Under the OAA 2006 amendments, these grants are to be renewed annually for four years, with an optional one year extension. In Program Year (PY) 2008[23], the 74 national, state, and territorial SCSEP grantees enrolled over 89,000 individuals. SCSEP participants provided 48,611,568 hours of service to their local communities.

The next competition for national grantees will be conducted in 2012. AoA is collaborating with DOL on this competition to ensure a smooth transition if Congress authorizes the transfer of the program. Through this collaboration, AoA provided input and suggestions related to priorities and targeting: if the program is transferred to AoA.

In general, 75 percent of Federal funds must be spent on wages and benefits to participants with the remaining funds for other participant costs. There is a cap on administrative expenses of 13.5 percent. The Federal funds provided to each of the 74 grantees can be no more than 90% of the total project amount, with the non-federal matching requirement in either cash or in-kind.

[23] Funding for SCSEP is appropriated from July 1 – June 30, rather than on the typical fiscal year schedule.

Funding History

Funding for the Senior Community Service Employment Program during the past five years is as follows:

FY 2008.....$521,625,000
FY 2009.....$571,925,000
FY 2010[24].....$825,425,000
FY 2011 .....$449,100,000
FY 2012.....$448,251,000

Budget Request

The FY 2013 request for SCSEP is $448,251,000; the same as the FY 2012 enacted level. Funds will continue to be used to provide formula grants to States and competitive grants to national organizations. This funding will also provide necessary administrative support, monitoring, and technical assistance; including funding for 8 FTE.

This request again proposes to transfer responsibility for SCSEP from the Department of Labor to the Administration on Aging. SCSEP helps older individuals maintain their economic independence by providing much-needed employment income and training. The proposed transfer to the Administration on Aging will allow for the placement of the program in an agency that has as its primary focus the mission of helping older Americans maintain their independence (both economic independence and living arrangements) and active participation in communities. This shift reflects the recognition that the SCSEP participants can benefit immensely from the program's integration with supports provided by AoA's existing Aging Services programs.

Demographic analysis indicates that older workers will account for an increasingly large portion of the available workforce in the decades ahead. Seniors participation in SCSEP helps employers recognize the value of older workers as both needed employees and mentors to younger workers. AoA will leverage the experience of the Department of Labor to continue encouraging and expanding job opportunities for aging workers, and work with the One-Stop Career Center system to place job-ready older workers in unsubsidized employment, helping to break down the barriers to fair and diverse workplaces for these senior workers.

[24] Includes a one-time special appropriation of $225,000,000 to serve low-income seniors affected by the recession.

AoA will use the requested funds to continue the vital work done by SCSEP as well as create program efficiencies within the context of the aging services network. Millions of hours of community service are provided by SCSEP participants each year to non-profit organizations and government agencies; more than 45,000,000 hours in each of the last few years. Community service is an equally valuable aspect of SCSEP funding that is inextricably linked to the public service employment wages and training that seniors receive while in the program. In FY 2013, AoA, in partnership with the DOL, the aging services network, and workforce investment system, will continue to explore creative ideas that highlight opportunities for seniors to serve their communities while accessing employment training options.

Outcome Table

Measure	Most Recent Result	PY 2012 Projection	PY 2013 Projection	FY 2012 +/- FY 2012
Output 1.1: Average earnings in the second and third quarters after exit (Outcome)	PY 2009: $6,900	$7,626	TBD	TBD
Output 1.3: Percent of participants employed in the first quarter after exit (Outcome)	PY 2009: 46.2%	36.5%	TBD	TBD
Output 1.4: Percent of participants employed in the first quarter after exit still employed in the second and third quarters after exit (Outcome)	PY 2009: 70.0%	68.4%	TBD	TBD

These outcomes were developed and the data collected by the Department of Labor. Under the proposal to transfer SCSEP, AoA will work with all relevant parties to develop and refine performance measures and collect performance data.

Native American Nutrition and Supportive Services

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Native American Nutrition & Supportive Services	$27,653,000	$27,601,000	$27,601,000	--

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

FY 2013 Older Americans Act Authorization..... Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

Native American Nutrition and Supportive Services provides grants to eligible Tribal organizations to promote the delivery of nutrition and home and community-based supportive services to Native American, Alaskan Native, and Native Hawaiian elders. According to the 2009 American Community Survey, approximately 301,000 persons age 60 and over identified themselves as Native Americans or Alaskan Natives, and another 242,000 persons age 60 and over identified themselves as part Native American or Alaskan Native.

Native American Nutrition and Supportive Services grants support a broad range of services to older Native Americans, including adult day care, transportation, congregate and home-delivered meals, information and referral, personal care, chore, and other supportive services. Currently, AoA's congregate meal program reaches 32 percent of eligible Native American seniors in participating Tribal organizations, home-delivered meals reach 14 percent of such persons, and supportive services reach 52 percent of such persons. These programs, which help to reduce the need for costly nursing home care and medical interventions, are responsive to the cultural diversity of Native American communities and represent an important part of each community's comprehensive services.

Services provided by this program in FY 2010, the most recent year for which data are available, include:

- *Transportation Services*, which provided over 800,000 rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical daily activities (Output L).

- *Home-Delivered Nutrition Services*, under which 2.5 million meals were provided to nearly 37,694 homebound Native American elders, as well as critical social contacts that help to reduce the risk of depression and isolation experienced by many home-bound Native American elders (Output M).

- *Congregate Nutrition Services*, which provided 2.1 million meals to more than 59,754 Native American elders in community-based settings, as well as an opportunity

for elders to socialize and participate in a variety of activities, including cultural and wellness programs (Output N).

- *Information, Referral and Outreach Services,* which provided over 900,000 hours of outreach and information on services and programs to Native American elders and their families, thereby, empowering them to make informed choices about their service and care needs (Output O).

The Native American Nutrition and Supportive Services program also provides training and technical assistance to Tribal organizations to support the development of comprehensive and coordinated systems of services to meet the needs of Native American elders. Training and technical assistance is provided through national meetings, site visits, e--newsletters, telephone and written consultations, and through the Native American Resource Centers, funded under Aging Network Support Activities.

Eligible Tribal organizations receive nutrition and supportive services formula grants based on their share of the American Indian, Alaskan Native, and Native Hawaiian population age 60 and over. Tribal organizations must represent at least 50 Native American elders age 60 and over to receive funding. There is no requirement for matching funds. In addition, Tribes may decide the age at which a member is considered an elder and thus eligible for services. In FY 2011 grants were awarded to 256 Tribal organizations (representing 400 Tribes), including two organizations serving Native Hawaiian elders, with an average award of $107,964 and a range of grant awards from $73,940 to $1,505,000.

Funding History:

Funding for Native American Nutrition and Supportive Services during the past five years is as follows:

FY 2008	$26,898,000
FY 2009	$27,208,000
FY 2009 (ARRA)	$3,000,000
FY 2010	$27,704,000
FY 2011	$27,653,000
FY 2012	$27,601,000

Budget Request:

The FY 2013 request for Native American Nutrition and Supportive Services is $27,601,000; the same as the FY 2012 enacted Level. The services provided using these funds, particularly adult day care, personal care, chore services, and home-delivered meals, also aid caregivers, who might otherwise have to be even more intensively involved with the care of their loved ones, at the risk of their own health and careers.

These funds will provide 880,000 rides (Output L), 2.35 million meals at home (Output M), and 1.8 million meals at congregate sites (Output N) to approximately 65,600 Native American

seniors. Services will allow Native American elders, many of whom have limitations in activities of daily living that make it difficult to care for themselves, to remain at home, in the community, or on the reservation, which is what they prefer.

In FY 2013 the targeted number of units of service, such as home-delivered meals and transportation trips, provided to Native Americans per thousand dollars of AoA funding is projected at 300, a 36 percent increase over the FY 2002 base of 220 (Outcome 1.3). Over the past several years Native American services have met or exceeded their efficiency and output targets for meals and trips due in part to increased contributions from tribal organizations.

Outcome and Outputs Table:

Native American Nutrition & Supportive Services Outcome and Outputs

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2012 +/- FY 2012
Output 1.3: For Title VI Services, increase the number of units of service provided to Native Americans per thousand dollars of AoA funding. *(Outcome)*	FY 2010: 323 Target: 300 (Target Exceeded)	300	300	Maintain

Indicator	Most Recent Result	FY 2012 Projection	FY 2013 Projection	FY 2013 +/- FY 2012
Output L: Transportation Services units *(Output)*	FY 2010: 827,821	830,000	830,000	--
Output M: Home-Delivered Nutrition meals *(Output)*	FY 2010: 2.5 M	2.5 M	2.5 M	--
Output N: Congregate Nutrition meals *(Output)*	FY 2010: 2.1 M	2.0 M	2.0 M	--
Output O: Information, Referral and Outreach units *(Output)*	FY 2010: 903,913	900,000	900,000	--

Grant Awards Table:

Native American Nutrition & Supportive Services Grant Awards

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Budget Request
Number of Awards	256	256	256
Average Award	$107,964	$107,546	$107,546
Range of Awards	$73,940 - $1,505,000	$73,640 - $1,505,000	$73,640 - $1,505,000

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Aging Network Support Activities

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Aging Network Support Activities	$8,184,000	$7,873,000	$7,873,000	--

Authorizing Legislation: Section 201, 202, 215, and 411 of the Older Americans Act of 1965, as amended

FY 2013 Older Americans Act Authorization..... Expired

Allocation Method ..... Competitive Grants/Co-operative Agreements and Contracts

Program Description and Accomplishments:

Aging Network Support Activities provides competitive grants and contracts to support ongoing activities of national significance which help seniors and their families to obtain information about their care options and benefits, and which assist States, Tribes, and community providers of aging services to carry out their mission to help older people remain independent and live in their own homes and communities. These activities provide critical and ongoing support for the national aging services network and help support the activities of AoA's core service delivery programs.

Competitive grants, cooperative agreements, and contracts for Aging Network Support Activities are awarded to eligible public or private agencies and organizations, States and Area Agencies on Aging (AAAs), institutions of higher learning, and other organizations representing and/or serving older people, including faith-based organizations. Grantees are required to provide a match equal to 25 percent of the project's total cost. Project proposals are reviewed by external experts, and project awards are made for periods of one to four years. In FY 2011, Aging Network Support Activities funded 24 grants with an average award of $279,465.

National Eldercare Locator

Older Americans and their caregivers face a complicated array of choices and decisions about health care, pensions, insurance, housing, financial management, and long-term care. The Eldercare Locator, created in 1991, helps seniors and their families navigate this complex environment by connecting those needing assistance with State and local agencies on aging that serve older adults and their caregivers. The Eldercare Locator can be accessed through a toll-free nationwide telephone line (800-677-1116) or website (http://www.eldercare.gov). The phone line and website both connect those in need to providers in every zip code in the nation. The Eldercare Locator website continues to grow as a resource tool for older adults and their caregivers, serving over 300,000 individuals a year.

National Alzheimer's Call Center

The National Alzheimer's Call Center is a national information and counseling service for persons with Alzheimer's disease, their family members, and informal caregivers. In the 12-month period ending July 31, 2011, the National Alzheimer's Call Center handled over 228,000 calls through its national and local partners, and its on-line message board community recorded an estimated 13 million page views and over 100,000 individual postings. The National Alzheimer's Call Center is available to people in all States, 24 hours a day, 7 days a week, 365 days a year to provide expert advice, care consultation, and information and referrals at the national and local levels regarding Alzheimer's disease. Trained professional customer service staff and masters degree social workers are available at all times. The Call Center is accessible by telephone, website or e-mail at no cost to the caller. Services focus on consumers, not professionals. Information provided may include basic information on caregiving; handling legal issues; resources for long-distance caregiving; and tips for working with the medical community. Local community-based organizations are directly involved to ensure local, on-the-ground capacity to respond to emergencies and on-going needs of Alzheimer's patients, their families, and informal caregivers. The Call Center has multilingual capacity and responds to inquiries in at least 140 languages through its own bilingual staff and with the use of a language interpretation service.

Pension Counseling and Information

The Pension Counseling program, first funded in 1993, assists older Americans in accessing information about their retirement benefits and helps them negotiate with former employers or pension plans for due compensation. Currently, there are more than 700,000 private (as well as thousands of public) pension and retirement plans in the United States. Given that an employee may have worked for several employers, and these employers may have merged, sold their plans, or gone bankrupt, it is very difficult for the average person to know where to go to get help in finding out whether he or she is receiving all of their pension benefits. AoA currently funds six regional counseling projects covering 27 States. Data for the program shows that:

- Pension Counseling projects have successfully obtained a return of more than $5.50 for every Federal dollar invested in the program.

- Projects have directly served over 35,000 individuals by providing hands-on assistance in pursuing claims through administrative appeals processes; helping seniors to locate pension plans "lost" as a result of mergers and acquisitions; answering queries about complex plan provisions; and making targeted referrals to other professionals for assistance.

By producing fact sheets and other publications, hosting websites, and conducting outreach, education and awareness efforts, Pension Counseling projects also provide indirect services to tens of thousands of seniors and their families.

National Education and Resource Center on Women and Retirement Planning

The National Education and Resource Center on Women and Retirement Planning, established in 1998, provides women with access to a one-stop gateway that integrates financial information

and resources on retirement, health, and planning for long-term care. This project has made user-friendly financial education and retirement planning tools available to traditionally hard-to-reach women, including average-income and low-income women, women of color, women with limited English speaking proficiency, rural, and other "underserved" women. Information is offered through financial and retirement planning programs, workshops tailored to meet women's special needs, and publications in hard copy and Web based formats. Since its establishment, the Center has conducted more than 20,000 workshops on strategies to access financial and retirement planning information for women and disseminated financial and retirement planning information tailored to the specific needs of hard-to-reach women.

National Resource Centers on Native American Elders

The National Resource Centers on Native American Elders enhance knowledge about older Native Americans and thereby increase and improve the delivery of services to them. Each Resource Center addresses at least two areas of primary concern which are specified in the OAA. These include health issues, long-term care (including in-home care), elder abuse, mental health, and other problems and issues facing Native communities. The Resource Centers are administered under cooperative agreements by three institutions of higher education. The Resource Centers partner with Native American organizations and communities, educational institutions including Tribal Colleges and Universities, and professionals and paraprofessionals in the field. Resource centers have specialized areas of interest. The University of North Dakota Resource Center has assisted Title VI grantees in assessing needs of tribal elders to determine program planning and direction. This process has developed a database of information about American Indian, Alaska Native and Native Hawaiian Elders. The University of Hawaii Resource Center has focused on long term care needs of Native Hawaiian Elders. The University of Alaska Resource Center has focused on elder abuse and neglect issues within Native communities.

National Minority Aging Organizations Technical Assistance Centers

The National Minority Aging Organizations (NMAO) Technical Assistance Centers Program works to reduce or eliminate health disparities among racial and ethnic minority older individuals. These Centers design and disseminate front line health promotion and disease prevention information that is culturally and linguistically appropriate for older individuals of African American, Hispanic, Asian American and Pacific Islander descent, and American Indian and Alaska Native elders. For example, the Center for American Indian and Alaska Native elders is developing a culturally appropriate caregiver manual/toolkit for caregivers caring for elders with dementia. Each NMAO project pilots a practical, nontraditional, community-based intervention for reaching older individuals who experience barriers to accessing home and community-based services. Strategies are focusing on barriers due to language and low literacy as well as those directly related to cultural diversity. Strategies developed under this program incorporate the latest technology and facilitate the generation and dissemination of knowledge in forms that can assist racial and ethnic minority older individuals to practice positive health behaviors and strengthen their capacity to maintain active, independent life styles. Examples of products resulting from these grants include, but are not limited to:

- The African American National Minority Aging Technical Assistance Center has developed a chronic disease self management curricula and manual tailored for racial and ethnic minority seniors;

- The Hispanic/Latino National Minority Technical Aging Assistance Center developed a series of bilingual Influenza Vaccination Promotion materials entitled "Chispa a La Vida; and,

- The Asian American Pacific Islander National Minority Aging Technical Assistance Center developed a referral database of Chronic Disease Self-Management (CDSMP) workshops for use by the National Asian Pacific Center on Aging (NAPCA) Helpline. The database includes information about CDSMP workshops or organizations offering the program around the country, including availability of workshops in Asian or Pacific Islander languages.

National Technical Assistance Resource Center for LGBT Elders

Older lesbian, gay, bisexual and transgender (LGBT) adults face a number of unique challenges as they strive to maintain their independence. The Resource Center, established in 2010, strives to meet three primary objectives: educate mainstream aging services organizations about the existence and special needs of LGBT elders; sensitize LGBT organizations about the existence and special needs of older adults; and educate LGBT individuals about the importance of planning ahead for future long-term care needs. The national resource center formally began services in September 2010 with the launching of a website including training curricula and social networking tools. In 2013, with the groundwork and tools now in place and available, the Resource Center will focus on the provision of training and technical assistance for community providers across the country.

Multigenerational Civic Engagement

The Multi-Generational Civic Engagement (MGCE) initiative enhances discovery, documentation and support for existing, exceptional locally-developed program models and volunteer engagement strategies. Eighteen model programs launched in FY 2011 engage older adults in civic engagement projects aimed at increasing services to frail elders, families of children with special needs, and grandparents raising grandchildren. These model programs also partner with the Corporation for National and Community Service.

Program Performance and Technical Assistance

This activity supports cooperative efforts between AoA and selected States and AAAs to develop and test outcome measures, various performance measurement instruments, and sampling methods that can be used to effectively and efficiently identify the results produced through OAA programs on an ongoing basis. It also supports partnerships with National Aging Organizations to foster innovation and provide technical assistance to States, AAAs, and Tribal organizations in strategic planning, program assessment, and performance measurement.

Funding History:

Comparable funding for Aging Network Support Activities is as follows:

FY 2008 ..... $10,007,067
FY 2009 ..... $8,200,000
FY 2010 ..... $8,198,000
FY 2011 ..... $8,184,000
FY 2012 ..... $7,873,000

Budget Request:

The FY 2013 request for Aging Network Support Activities is $7,873,000, the same as the FY 2012 enacted level. The programs funded by this request provide critical and ongoing support for the national aging services network and are needed to support the activities of AoA's core service delivery programs. Not only do they provide a variety of services, some of which are not the responsibility of any other government agency, these programs considerably strengthen and streamline AoA's core services, and are critical to AoA's continuing success.

Aging Network Support Activities outcomes are reflected in performance targets for Health and Independence and Caregiver Services.

Aging Network Support Activities includes funding for the following projects[25]:

Activity	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Aging Network Support Activities:			
National Eldercare Locator	$ 1,175,644	$ 1,172,779	$ 1,172,779
National Alzheimer's Call Center	998,000	998,110	998,110
National Education & Resource Center on Women & Retirement	248,502	247,532	247,532
Pension Information and Counseling Program	1,715,562	1,712,757	1,712,757
National Resource Centers on Native Americans	691,614	690,692	690,692
National Minority Aging Organizations	932,132	930,238	930,238
National Technical Assistance Resource Center for LGBT Elders	300,000	299,433	299,433
Multigenerational Civic Engagement	980,036	978,148	978,148
Program Performance and Technical Assistance	1,142,110	843,403	843,403
Total, Aging Network Support Activities	**$ 8,183,600**	**$ 7,873,092**	**$ 7,873,092**

[25] Several projects have been moved to Elder Justice Support Activities and are comparably adjusted. Accordingly, actual expenditure amounts are shown for FY 2011 and reflected in FY 2012 and FY 2013

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Caregiver Services

Summary of Request

Families are the nation's primary provider of long-term care, but a number of factors including financial constraints, work and family demands, and the many challenges of providing care place great pressure on family caregivers. Caregiving responsibilities demand time and money from families who too often are already strapped for both. AoA's caregiver programs support services that address the needs of unpaid, informal caregivers, allowing many caregivers to continue to work while providing critically needed care.

Better support for informal caregivers is critical because often it is their availability - whether they are informal family caregivers, paraprofessionals or unrelated friends and neighbors who volunteer their time - that determines whether an older person can remain in his or her home. In 2009, approximately 43.5 million adult caregivers provided uncompensated care to those 50 years of age and older.[26] AARP estimated the economic value of replacing unpaid caregiving in 2009 to be about $450 billion, an increase from $375 billion in 2007 (cost if that care had to be replaced with paid services).[27]

The demands of caregiving can lead to a breakdown of the caregiver's health, and the illness, hospitalization, or death of a caregiver increases the risk for institutionalization of the care recipient. Caregivers suffer from higher rates of depression than non--caregivers of the same age, and research indicates that caregivers suffer a mortality rate that is 63 percent higher than non-caregivers.[28] Providing support that makes caregiving easier for family caregivers, such as information, counseling and training, respite care, or supplemental services, is critical to sustaining caregivers' ability to continue in that role. Seventy-eight percent of the caregivers served by AoA programs report that AoA services allow them to provide care longer than they otherwise could.[29]

At the same time, AoA recognizes that it must also address the growing need for more caregivers every day. By 2015, AoA projects that there will be 12.9 million non-institutionalized seniors age 65 and over with 1+ ADL deficits, an increase of almost 2 million seniors (or 18 percent since 2008) needing caregiver assistance.[30]

To address these caregiver-related needs, AoA requests a total of $172,014,000, an increase of $5,528,000 over the FY 2012 enacted level. The request includes:

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[26] *Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving*. AARP Public Policy Institute. July 2011. http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf

[27] *Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving*. AARP Public Policy Institute. July 2011. http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf

[28] Schulz R, Beach SR. Caregiving as a risk factor for mortality. The Caregiver Health Effects study. JAMA December 15, 1999;282:2215-9.

[29] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

[30] Data extrapolated by AoA from U.S. Census Bureau, "2008 National Population Projections," released August 2008, http://www.census.gov/population/www/projections/2008projections.html and Health Data Interactive, National Center on Health Statistics, Centers for Disease Control and Prevention, "Functional limitations among Medicare beneficiaries, ages 65+: US, 1992-2006." Accessed 31 August 2009.

- $153,621,000 for Family Caregiver Support Services, the same as the FY 2012 enacted level. This program makes a range of support services available to family and informal caregivers in States, including counseling, respite care, and training, that assist family and informal caregivers to care for their loved ones at home for as long as possible. Studies have shown that these supports can reduce caregiver depression, anxiety, and stress and enable them to provide care longer, thereby avoiding or delaying the need for costly nursing home care.

- $6,364,000 for Native American Caregiver Support Services, the same as the FY 2012 enacted level. This program makes a range of services available to Native American caregivers, including information and outreach, access assistance, individual counseling, support groups and training, respite care and other supplemental services.

- $9,537,000 for Alzheimer's Disease Supportive Services, an increase of $5,527,000 over the FY 2012 enacted level. This program's funding was significantly reduced in FY 2012, and this budget proposes to restore some of that funding in order to continue the only program at HHS dedicated to supportive services for those with Alzheimer's Disease and their caregivers. One critical focus of this program is to support the family caregivers who provide countless hours of unpaid care, thereby enabling their family members with dementia to continue living in the community. Another focus is to expand the availability of evidence-based diagnostic and support services to those with Alzheimer's.

- $2,490,000 for Lifespan Respite Care, the same as the FY 2012 enacted level. This program funds grants to improve the quality and access to respite care for family caregivers of children or adults of any age with special needs.

As a group, these programs support caregivers and elders by providing critical respite care and other support services for family caregivers, training and recruitment of care workers and volunteers, information and outreach, counseling, and other supplemental services.

Family Caregiver Support Services

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Family Caregiver Support Services	$153,912,000	$153,621,000	$153,621,000	--

Authorizing Legislation: Section 371 of the Older Americans Act of 1965, as amended

FY 2013 Older Americans Act Authorization..... Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

Family Caregiver Support Services provides grants to States and Territories, based on their share of the population age 70 and over, to fund a range of supports that assist family and informal caregivers to care for their loved ones at home for as long as possible. The program includes five basic system components: information, access assistance, counseling and training, respite care, and supplemental services. These services work in conjunction with other OAA services, including transportation services, homemaker services, home-delivered meals, and adult day care, to provide a coordinated set of supports for seniors that caregivers can access on their behalf.

Family Caregiver Support Services provide a variety of supports to family and informal caregivers. Based on FY 2010 data, the most recent available, services provided included:

- *Access Assistance Services* provided over one million contacts to caregivers assisting them in locating services from a variety of public, private and voluntary agencies (Output I).

- *Counseling and Training Services* provided over 135,000 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving (Output J).

- *Respite Care Services* provided over 67,000 caregivers with 6.4 million hours of temporary relief - at home, or in an adult day care or nursing home setting - from their caregiving responsibilities (Output K).

Family and other informal caregivers are the backbone of America's long-term care system. On a daily basis, these individuals assist relatives and other loved ones with tasks ranging from personal care and homemaking to more complex health-related interventions like medication administration and wound care. AARP estimated the economic value of replacing unpaid caregiving in 2009 to be about $450 billion (the cost if that care had to be replaced with paid

services).[31] Caregivers often experience conflicts between work and caregiving, with 25 percent reporting that they have had to make adjustments such as retiring or taking time away from work due to their caregiving responsibilities.

In 2009, at least 43.5 million adult caregivers, or approximately 19 percent of all adults, provided uncompensated care to those 50 years of age and older.[32] By 2015, AoA projects that there will be 12.9 million non-institutionalized seniors age 65 and over with 1+ ADL deficits, an increase of almost two million seniors or 18 percent since 2008, needing caregiver assistance.[33]

Research has shown that caregiving exacts a heavy emotional, physical, and financial toll. As reported in AoA's 2011 National Survey of OAA Participants, 24 percent of caregivers are assisting two or more individuals. Sixty-eight percent of Title III caregivers are 60 or older, making them more vulnerable to a decline in their own health, and thirty-four percent describe their own health as fair to poor.[34] Caregivers also suffer from higher rates of depression than non-caregivers of the same age, and research indicates that caregivers suffer a mortality rate that is 63 percent higher than non-caregivers.[35] The demands of caregiving can lead to a breakdown of the caregiver's health, and the illness, hospitalization, or death of a caregiver increases the risk for institutionalization of the care recipient.

Studies have shown that the types of supports provided through the Family Caregiver Support Services Program can reduce caregiver depression, anxiety, and stress and enable them to provide care longer while often continuing to work, thereby avoiding or delaying the need for costly institutional care for their loved ones. For example, a study, *Intervention to Delay Nursing Home Placement of Patients with Alzheimer's Disease*, indicates that counseling and support for caregivers of individuals with Alzheimer's disease can permit the care recipient to stay at home, at significantly less cost, for an additional year before being admitted to a nursing home.

Additionally, data from AoA's national surveys of caregivers of elderly clients also shows that OAA services, including those provided through Family Caregiver Support Services, are effective in helping caregivers keep their loved ones at home. Approximately 78 percent of caregivers of program clients reported in 2011 that services enabled them to provide care longer than otherwise would have been possible.[36] Caregivers receiving services were also asked whether the care recipient would have been able to live in the same residence if the services had not been available. Forty-five percent of the caregivers of nursing home eligible care recipients indicated that the care recipient would be unable to remain at home without the support services.

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[31] *Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving*. AARP Public Policy Institute. July 2011. http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf

[32] National Alliance for Caregiving and AARP. Caregiving in the U.S.: A Focused Look at Those Caring for the 50+. 2009. http://www.aarp.org/research/surveys/care/ltc/hc/articles/caregiving_09.html

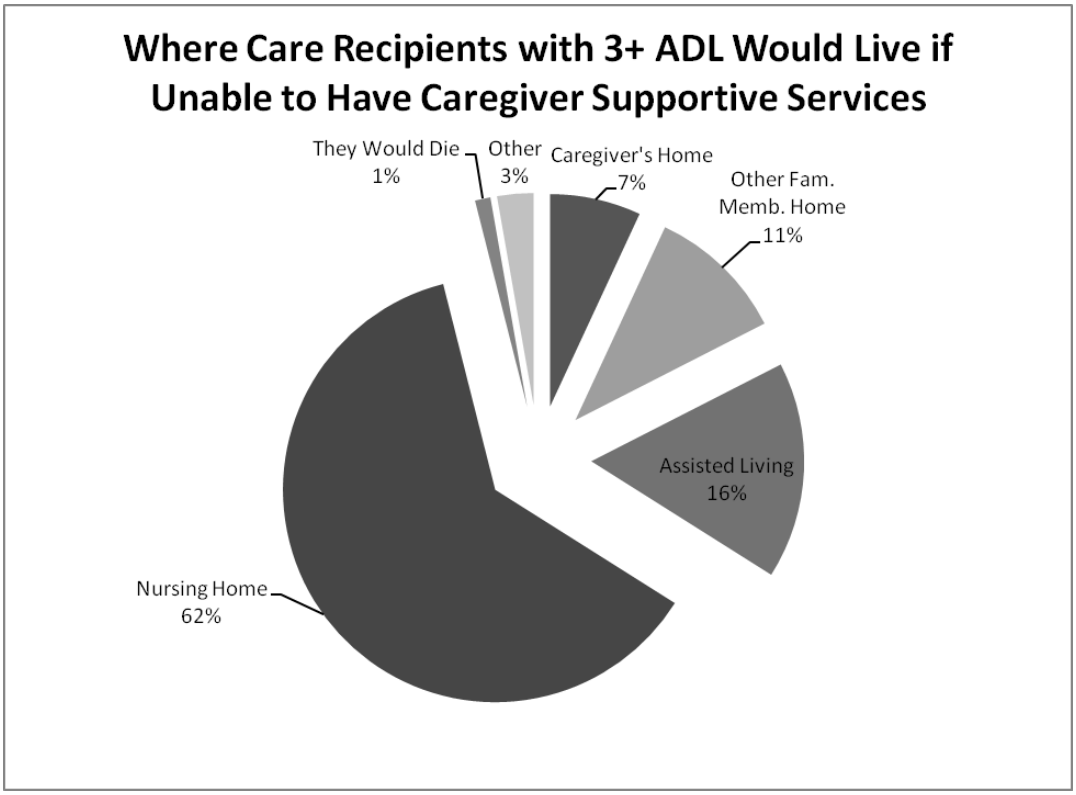
[33] Data extrapolated by AoA from U.S. Census Bureau, "2008 National Population Projections," released August 2008, http://www.census.gov/population/www/projections/2008projections.html and Health Data Interactive, National Center on Health Statistics, Centers for Disease Control and Prevention, "Functional limitations among Medicare beneficiaries, ages 65+: US, 1992-2006." Accessed 31 August 2009.

[34] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

[35] Schulz R, Beach SR. Caregiving as a risk factor for mortality. The Caregiver Health Effects study. JAMA December 15, 1999;282:2215-9.

[36] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

Those respondents were then asked to identify where the care recipient would be living without services. A significant majority of those caregivers, 78 percent, indicated that the care recipient would most likely be living in a nursing home or assisted living (see below).



(based on responses from care recipients unable to live independently)

Funding History:

Funding for Family Caregiver Support Services during the past five years is as follows:

FY 2008 ..... $153,439,000
FY 2009 ..... $154,220,000
FY 2010 ..... $154,197,000
FY 2011 ..... $153,912,000
FY 2012 ..... $153,621,000

Budget Request:

The FY 2013 request for Family Caregiver Support Services levels is $153,621,000, the same as the FY 2012 enacted level. With this proposed funding, 796,000 caregivers (Outcome 3.1) will be provided with supportive services, including respite care or temporary relief from their caregiving responsibilities. This represents 35,000 caregivers more than the levels served in FY 2010. Respite care is the service rated by caregivers as the most helpful. Nearly 128,000 caregivers will also have the opportunity to participate in counseling, peer support groups, and training to help them better cope with the stresses of caregiving (Output J).

Caregivers state that these programs help keep their loved ones at home, as 83 percent of caregivers report these supportive services enable them to provide care longer.

In FY 2013, AoA expects the aging services network to meet or exceed the target of only 28 percent of caregivers experiencing difficulty obtaining services (Outcome 2.6). This is a substantial accomplishment that occurred at the State level as a result of ongoing program development, better coordination and integration the Family Caregiver program into the array of State home and community-based services. Baseline levels from 2003 showed that 64 percent of caregivers had difficulty getting services, and by 2010 that rate had been reduced by more than half to 29 percent of caregivers reporting difficulty getting services.

For FY 2013, the performance target for Family Caregiver Support Services Program participants who rate services good to excellent is 90 percent (Outcome 2.9c). The substantive improvements in program performance can be attributed to the successful implementation of the program. Client-reported assessment of service quality and program outcomes is expected to remain at high levels, however some service outputs are expected to decline in FY 2013 compared to FY 2010. Declines are projected to be largely attributable to declining leveraged funds, as State, local, and private budgets face economic hardships.

Outcomes and Outputs Table:

Family Caregiver Support Services Outcomes and Outputs

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Outcome 2.6: Reduce the percent of caregivers who report difficulty in getting services. *(Outcome)*	FY 2010: 29% Target: 30% (Target Not Met)	28%	28%	Maintain
Outcome 2.9c: 90% of NFCSP clients rate services good to excellent. *(Outcome)*	FY 2010: 94% Target: 90% (Target Exceeded)	90%	90%	Maintain
Outcome 3.1: Increase the number of caregivers served. *(Outcome)*	FY 2010: 761,000 Target: 560,000 (Target Exceeded)	792,000	796,000	+4,000

Indicator	Most Recent Result	FY 2012 Projection	FY 2013 Projection	FY 2013 +/- FY 2012
Output I: Caregivers access assistance units of service. *(Output)*	FY 2010: 1.1 M	950,000	950,000	0
Output J: Caregivers receiving counseling and training. *(Output)*	FY 2010: 135,217	133,000	128,000	-35,000

CAREGIVER SERVICES

Indicator	Most Recent Result	FY 2012 Projection	FY 2013 Projection	FY 2013 +/- FY 2012
Output K: Caregivers receiving respite care services. *(Output)*	FY 2010: 67,073	67,000	63,500	-3,500

Note: For presentation within the budget AoA highlighted specific measures that are most directly related to Family Caregiver Support Services, however multiple performance outcomes are impacted by this program because AoA's performance measures (efficiency, effective targeting, and client outcomes) assess network-wide performance in achieving current strategic objectives.

Grant Awards Table:

Family Caregiver Supportive Services Grant Awards

	FY 2011 Actual	**FY 2012 Enacted**	**FY 2013 Budget Request**
Number of Awards	56	56	56
Average Award	$2,720,937	$2,715,802	$2,715,802
Range of Awards	$95,233 - $15,295,121	$95,053 - $15,382,313	$95,053 - $15,382,313

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2013 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM: Family Caregivers Support Services (CFDA 93.052)

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
Alabama	2,386,588	2,342,427	2,342,427	--
Alaska	764,933	760,424	760,424	--
Arizona	3,227,992	3,151,873	3,151,873	--
Arkansas	1,518,422	1,498,081	1,498,081	--
California	15,356,773	15,382,313	15,382,313	--
Colorado	1,902,436	1,918,939	1,918,939	--
Connecticut	1,821,050	1,867,429	1,867,429	--
Delaware	764,933	760,424	760,424	--
District of Columbia	764,933	760,424	760,424	--
Florida	12,255,674	12,023,622	12,023,622	--
Georgia	3,567,093	3,533,479	3,533,479	--
Hawaii	764,933	760,424	760,424	--
Idaho	764,933	760,424	760,424	--
Illinois	5,908,033	5,875,749	5,875,749	--
Indiana	3,059,403	3,042,278	3,042,278	--
Iowa	1,707,953	1,717,132	1,717,132	--
Kansas	1,392,604	1,402,676	1,402,676	--
Kentucky	2,069,945	2,051,857	2,051,857	--
Louisiana	2,025,081	1,983,538	1,983,538	--
Maine	764,933	763,461	763,461	--
Maryland	2,509,470	2,514,342	2,514,342	--
Massachusetts	3,356,283	3,336,098	3,336,098	--
Michigan	4,908,737	4,928,398	4,928,398	--
Minnesota	2,496,717	2,511,755	2,511,755	--
Mississippi	1,387,772	1,358,368	1,358,368	--
Missouri	3,040,466	3,038,044	3,038,044	--
Montana	764,933	760,424	760,424	--
Nebraska	919,551	929,554	929,554	--

CAREGIVER SERVICES

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
Nevada	1,066,391	1,091,664	1,091,664	--
New Hampshire	764,933	760,424	760,424	--
New Jersey	4,364,136	4,364,507	4,364,507	--
New Mexico	944,416	946,008	946,008	--
New York	9,759,795	9,642,088	9,642,088	--
North Carolina	4,306,356	4,343,778	4,343,778	--
North Dakota	764,933	760,424	760,424	--
Ohio	5,990,792	5,975,048	5,975,048	--
Oklahoma	1,827,039	1,815,391	1,815,391	--
Oregon	1,880,893	1,900,922	1,900,922	--
Pennsylvania	7,442,187	7,350,508	7,350,508	--
Rhode Island	764,933	760,424	760,424	--
South Carolina	2,237,296	2,175,994	2,175,994	--
South Dakota	764,933	760,424	760,424	--
Tennessee	3,033,344	2,994,573	2,994,573	--
Texas	9,215,393	9,140,595	9,140,595	--
Utah	910,038	884,912	884,912	--
Vermont	764,933	760,424	760,424	--
Virginia	3,446,280	3,432,115	3,432,115	--
Washington	2,900,557	2,912,402	2,912,402	--
West Virginia	1,067,786	1,075,032	1,075,032	--
Wisconsin	2,853,414	2,876,242	2,876,242	--
Wyoming	764,933	760,424	760,424	--
Subtotal, States	150,008,285	149,218,280	149,218,280	--
American Samoa	95,617	95,053	95,053	--
Guam	382,467	380,212	380,212	--
Northern Mariana Islands	95,617	95,053	95,053	--
Puerto Rico	2,022,170	1,916,085	1,916,085	--
Virgin Islands	382,467	380,212	380,212	--
Subtotal, States and Territories	152,986,623	152,084,895	152,084,895	--
Undistributed[37]	925,377	1,536,105	1,536,105	--

[37] Funds held for statutory related requirements are reflected in the undistributed line.

CAREGIVER SERVICES

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
TOTAL	**153,912,000**	**153,621,000**	**153,621,000**	**--**

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Native American Caregiver Support Services

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Native American Caregiver Support Services	$6,376,000	$6,364,000	$6,364,000	--

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

FY 2013 Authorization..... Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

Native American Caregiver Support Services provide grants to eligible Tribal organizations to provide support for family and informal caregivers of Native American, Alaskan Native and Native Hawaiian elders. This program, which helps to reduce the need for costly nursing home care and medical interventions, is responsive to the cultural diversity of Native American communities and represent an important part of each community's comprehensive services.

Native American Caregiver Support Services funding is allocated to eligible Tribal organizations based on their share of the American Indian, Alaskan Native, and Native Hawaiian population aged 60 and over. Tribal organizations must represent at least 50 Native American elders age 60 and over and be receiving a grant under Title VI Part A or B to receive funding. There is no requirement for matching funds. Tribes may also decide the age at which a member is considered an elder and thus eligible for services. In addition, there is no limit on the percentage of funds that can be used for services to grandparents caring for grandchildren. In FY 2011 grants for Caregiver Support Services were awarded to 218 Tribal organizations, including one organization serving Native Hawaiian elders, with a range of grant awards from $13,050 to $53,406.

Grants assist American Indian, Alaskan Native and Native Hawaiian families caring for older relatives with chronic illness or disability and grandparents caring for grandchildren. The program provides a variety of direct services that meet a range of caregiver needs, including information and outreach, access assistance, individual counseling, support groups and training, respite care, and other supplemental services. Tribal organizations coordinate with other programs, including the Volunteers In Service To America (VISTA) program, to help support and create sustainable caregiver programs in Native American communities (many of which are geographically isolated). A core value of the Native American Caregiver Support Services, as expressed by Tribal leaders, is that the program should not replace the tradition of families caring for their elders. Rather, it provides support that strengthens the family caregiver role.

Funding History:

Funding for the Native American Caregiver Support Services during the past five years is as follows:

FY 2008	$6,316,000
FY 2009	$6,389,000
FY 2010	$6,388,000
FY 2011	$6,376,000
FY 2012	$6,364,000

Budget Request:

The FY 2013 request for Native American Caregiver Support Services is $6,364,000, the same as the FY 2012 enacted level. Support for caregivers is critical since often it is their availability, whether they are informal family caregivers, paraprofessionals or unrelated friends and neighbors who volunteer their time, that determines whether an older person can remain in his or her home.

In the 2009 American Community Survey, approximately 301,000 persons age 60 and over identified themselves as American Indians or Alaskan Natives, and another 242,000 persons age 60 and over identified themselves as part American Indian or Alaskan Native. Caregiver support services will help Native American elders, many of whom have limitations in activities of daily living that make it difficult to care for themselves, to remain at home, in the community, or on the reservation, which is what they prefer. Studies have shown that providing assistance to caregivers can help them cope with the emotional, physical and financial toll associated with caregiving, thereby enabling them to provide care for their loved ones longer and avoid or delay the need for costly nursing home care.

Performance data indicates that these programs are an efficient means to help Native American Elders remain independent and in the community. It should be noted that some service outputs for FY 2011 are expected to decline due to the economic downturn impacting Tribal government budgets.

In FY 2013 the Native American Caregiver Support Program will continue to assist family caregivers, whose assistance is critical to enabling Native American elders with disabilities to remain at home, in the community, and on the reservation. It is estimated that in FY 2011 more than 320,000 units of caregiver-related services including respite care, information and referral, caregiver training, lending closets, and support groups will be provided by Native American Tribal organizations.

Outcome Table:

Native American Caregivers Supportive Services Outcome

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Outcome 3.1: Increase the number of caregivers served. *(Outcome)*	FY 2010: 761,000 Target: 560,000 (Target Exceeded)	792,000	796,000	+4,000

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Alzheimer's Disease Supportive Services Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Alzheimer's Disease Supportive Services Program	$11,441,000	$4,011,000	$9,537,000	+$5,526,000

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

FY 2013 Authorization..... Expired

Allocation Method ..... Competitive Grants/Co-operative Agreements and Contracts

Program Description and Accomplishments:

The Alzheimer's Disease Supportive Services Program (ADSSP) funds competitive grants for States to expand the availability of evidence-based interventions that help persons with dementia and their caregivers remain independent in the community as long as they desire it. The primary components of the ADSSP program include delivering evidence-based supportive services; translating and replicating evidence-based interventions for persons with dementia and their caregivers at the community level; incorporating evidence-based research in the formulation of innovative projects; and advancing changes to a State's overall system of home and community-based care.

These changes are focused on expanding the aging services network's capacity to assist those with dementia and their families by providing individualized and public information, education, and referrals about diagnostic, treatment and related services; sources of assistance for services; and legal rights of people affected by Alzheimer's disease throughout a state's long term services and support system.

Funding for ADSSP was reduced in FY 2012 and is sufficient only to issue continuation grants to the 11 grantees whose grants remain current. As a result of the funding reduction, no new grant awards will be made for this program. In FY 2011 the ADSSP program funded 36 grants with an average award of $284,503 and a range of grant awards from $108,736 to $700,200. Through these grant projects, seven States are in the process of translating four evidence-based interventions into practice and nine States are offering innovative programming for caregivers and their loved ones with dementia. One example of these promising interventions is the New York University Caregiver Intervention, a spousal caregiver support program that in a randomized-control trial delayed institutionalization of persons with dementia by an average of 557 days.[38] In 2009, the average nursing home cost was $219 daily ($79,935 annually), which would mean an average savings of nearly $122,000 in institutional costs per person with dementia.[39]

[38] Mittleman M, et al. (1996). "A Family Intervention to Delay Nursing Home Placement of Patients with Alzheimer's Disease: a randomized, controlled trial," Journal of the American Medical Association, 276; 1725-1731.

[39] Metlife. (October 2009)**, "**MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs", p. 4, Accessed August 17, 2010

Minnesota is translating this intervention now; early results appear to confirm the original study. Other FY 2011 grant projects focus on innovations in areas of great need, such as programs to ensure that the states' long term services and supports system are dementia capable. Overall, these demonstrations offer direct services and other supports to thousands of families, as well as support the continuous quality improvement and evaluation of these services.

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

Funding History:

Funding for the ADSSP program during the past five years is as follows:

FY 2008 ..... $11,464,000
FY 2009 ..... $11,464,000
FY 2010 ..... $11,462,000
FY 2011 ..... $11,441,000
FY 2012 ..... $4,010,000

Budget Request:

The FY 2013 request for the Alzheimer's Disease Supportive Services Program is $9,537,000, an increase of $5,526,000 over the FY 2012 enacted level. These additional funds are intended to restore much of the funding cut in FY 2012. Without continued funding, communities across the nation will lose the ability to implement the translations of the investments made to date in proven evidence-based interventions such as the New York University Caregiver Intervention referenced above. In addition AoA will unable to undertake subsequent translations of research funded by NIA, CDC and other science agencies. The need for cutting edge approaches to serving this population continues to grow rapidly. One study estimates that there were 454,000 new cases of Alzheimer's disease in 2010; by 2030 the number of new cases is projected to be 615,000 and by 2050, 959,000; currently over 5 million individuals have this disease[40].
The FY 2013 funding request will allow AoA to continue to respond to this growing need by supporting grants that provide direct services to approximately 3,680 persons with Alzheimer's disease and their family caregivers. Funds will be used to broadly disseminate those translated, evidence-based interventions that have proven successful over the past 4 years of funding and to

from: http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf

[40] Alzheimer's Association, (2011). "Alzheimer's Disease Facts and Figures"., p. 17 and p. 34. Accessed August 30, 2011 from: http://www.alz.org/alzheimers_disease_facts_figures.asp

test new evidence-based interventions as they are identified. In addition funds will be used to expand the delivery of dementia-capable home and community-based services, thereby potentially impacting the much broader population of families struggling to cope with this disease.

Today ADSSP is supporting 16 states in field testing 9 evidence-based caregiver interventions, with the goal of embedding successful translations in state programs and funding streams. AoA is looking at how these interventions can be effectively provided through Aging Network programs while attempting to ensure fidelity to the original intervention. Successful translation of these research interventions to community settings will have a significant impact on supporting and sustaining family caregivers[41].

By the close of FY2013, AoA anticipates the release of evaluation results from a six-state translation effort of the New York University Caregiver Intervention (referenced above) which aims to significantly delay institutionalization of persons with dementia by providing education, support, and counseling to spousal and other family caregivers. In addition, AoA will have completed an evaluation of a three state translation of the *Savvy Caregiver Intervention. This intervention* trains caregivers to think about their situation objectively and provides them with the knowledge, skills, and attitudes they need to manage stress and carry out the caregiving role effectively.

[41] The evidence-based projects have three year project periods to develop, implement and document fidelity of the translation to the original model. Actual dissemination/replication of the interventions occurs after the translations are shown to have proven fidelity to the original models in the new type of setting. Each of the States funded at the end of FY 2008 requested up to a 1-year no-cost extension to finalize their projects. Therefore, baselines to these and similar measures will be available starting in FY 2013 for the FY 2008 and subsequent grants after if/when the translation projects are proven successful.

Outcome and Outputs Table:

Alzheimer's Disease Supportive Services Program Outputs

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Outcome: ALZ2. Increase number of individuals served with evidence-based interventions – cumulative[42] *(Outcome)*	FY 2010: 3,322 Target: N/A	4,120	4,120	Maintain

Indicator	Most Recent Result	FY 2012 Projection	FY 2013 Projection	FY 2013 +/- FY 2012
Output AC: Number of individuals served – cumulative[43] *(Output)*	FY 2010: 6,248	4,120	7,800	+3,680
Output AD: Percent of individuals served that are of a racial/ethnic minority *(Output)*	N/A	TBD	TBD	N/A

Note: For presentation within the budget AoA highlighted specific measures that are most directly related to Alzheimer's Disease Supportive Services Programs, however multiple performance outcomes are impacted by this program because AoA's performance measures (efficiency, effective targeting, and client outcomes) assess network-wide performance in achieving current strategic objectives.

[42] Cumulative count began in 2008.
[43] Cumulative count began in 2008.

Lifespan Respite Care

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Lifespan Respite Care	$2,495,000	$2,490,000	$2,490,000	--

Authorizing Legislation: Lifespan Respite Care Act of 2006, Title XXIX of the Public Health Service Act

FY 2013 Authorization..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments:

The Lifespan Respite Care program focuses on easing the burdens of caregiving by providing grants to eligible State organizations to improve the quality of, and access to, respite care for family caregivers of children or adults of any age with special needs while promoting the statewide dissemination and coordination of community-based respite care services. Unlike the National Family Caregivers Support Program, which focuses on broad caregiver support via a number of services, Lifespan Respite Care programs focus on providing a testbed for needed infrastructure changes, and on filling gaps by putting in place coordinated *systems* of accessible, community-based respite care services for family caregivers of children and adults with special needs.

Caregiving is an activity that is needed across the age spectrum from birth to death. AARP estimated, in 2009, that 65.7 million people served as unpaid family caregivers to an adult or child with special needs. For many of these caregivers, providing care can take a toll: a majority of caregivers (51%) caring for someone over age 18 have medium or high levels of burden and 31% of all family caregivers indicated they experienced high levels of stress.[44]

The systems funded through the Lifespan Respite Care program bring together and seek to coordinate respite care services for family caregivers; training and recruitment of respite care workers and volunteers; and provision of information, outreach, and access assistance. They also seek to identify and to fill gaps in services. Select examples of grantee activities include:

- Conducting needs assessments/environmental scans to determine the respite funding streams available, programs in existence, populations served and gaps in each area;

- Broadening stakeholder collaborations to ensure representation of all age and disability groups, as well as the broadest possible cross section of the provider network;

[44] National Alliance for Caregiving and AARP. Caregiving in the U.S.: A Focused Look at Those Caring for the 50+. 2009. http://www.aarp.org/research/surveys/care/ltc/hc/articles/caregiving_09.html

- Convening focus groups of respite consumers to inform project activities; and

- Capacity building and network development at the local level to recruit and train volunteers to fill gaps in respite services, particularly in rural areas through partnerships with programs such as the Corporation for National Service (e.g., VISTA, Service Learning, Senior Companions, etc.)

Lifespan Respite also supports resource center activities designed to maintain a national database on lifespan respite care; provide training and technical assistance to grantees and State, community, and nonprofit respite care programs; and conduct public information, referral, and education programs on respite care.

Respite care services are highly valued by caregivers. According to a November 2009 study by the National Alliance for Caregiving, of six national policies or programs presented to caregivers as potential ways to help them, 26 percent of respondents ranked respite services as either their first or second most preferred option.[45] By providing opportunities for family caregivers to receive this much needed short-term relief, the Lifespan Respite Care program helps to sustain family caregiver health and well-being, reduces the likelihood of abuse and neglect, and allows care recipients to remain in their own homes for as long as possible.

To illustrate the importance of respite, in a recent National Survey of OAA service recipients a random sample of 1,795 caregivers (which represented over 223,626 active caregivers) answered questions about the impact of the caregiver program on their lives. Eighty-four percent of caregivers received respite care with services from the National Family Caregiver Support Program within the past twelve months. The respite care service recipients reported that as a result of the services they received:

- 77 percent had less stress;
- 81 percent said it was easier to care for their loved one;
- 77 percent reported that it was the most helpful service they received;
- 95 percent reported the care recipient benefited from the service; and
- 82 percent said that the services enabled them to care longer.

Grants for Lifespan Respite Care are awarded to eligible State organizations with a 25 percent matching requirement. Eligible State agencies include any of the following: the State agency that administers the State's OAA programs, the State's Medicaid program, or any other State-level agency designated by the Governor. Additionally, the eligible State agency must work in collaboration with Aging and Disability Resource Centers and a public or private non-profit statewide respite care coalition or organization. Priority consideration is given to applicants who demonstrate the greatest likelihood of implementing or enhancing lifespan respite care statewide and who are building or improving the capacity of their long-term care systems to respond to the comprehensive needs of care recipients.

[45] National Alliance for Caregiving and AARP. Caregiving in the U.S. Bethesda: National Alliance for Caregiving, and Washington, DC: AARP, 2009.

Since 2009, thirty states (twelve states in 2009, twelve more in 2010, and six additional states in 2011) have been awarded grants of up to $200,000 each for three year projects. Additionally, in FY 2011, eight states were awarded expansion grants to focus specifically on providing respite services to meet demand and fill gaps in service where identified.

Select examples of FY 2009 and 2010 grantee accomplishments to date include:

- Conducting needs assessments/environmental scans to determine the respite funding streams available, programs in existence, data collection, populations served and gaps in each area;
- Modification of select modules of the College of Direct Support respite training to adapt them for use with special needs respite populations;
- Identification of existing respite models in the state and the creation of a training guide entitled: *Lifespan Respite: An Information guide for Developing, Recruiting, Training and Retaining Volunteers*;
- Capacity building and network development at the local level to recruit and train volunteers to fill gaps in respite services, particularly in rural areas through partnerships with programs such as the Corporation for National Service (e.g., VISTA, Service Learning, Senior Companions, etc.)
- Expansion of a toll free "helplines" to provide caregivers with information about available respite programs.

Funding History:

Funding for the Lifespan Respite Care program during the past five years is as follows:

FY 2008	$0
FY 2009	$2,500,000
FY 2010	$2,500,000
FY 2011	$2,495,000
FY 2012	$2,490,000

Note: Funding for the Lifespan Respite Care Act was appropriated in FY 2009 under the General Departmental Management Account in the HHS Office of the Secretary. In FY 2010 funding was appropriated directly to the Administration on Aging.

Budget Request:

The FY 2013 request for Lifespan Respite is $2,490,000; the same as the FY 2012 enacted level. By continuing to invest resources in this program, AoA seeks to provide resources that will allow caregivers to continue to care for their loved ones longer and thereby allow more care recipients to remain at home and independent for longer periods at lower cost than could be realized if these same individuals had to be institutionalized.

Lifespan Respite is unique in that no other Federal program mandates *respite* as its sole focus; helps ensure respite quality and choice; or allows funds for respite development, training and

coordination regardless of age or disability. The Lifespan Respite Care program demonstrates AoA's commitment to include caregivers of children or adults of any age with special needs.

According to the National Respite Coalition, nearly 90% of family caregivers of care recipients age 18 and older, and 81% of family caregivers of children with special needs currently are unable to access or use respite services. Caregivers report numerous barriers ranging from cost considerations and restrictive eligibility criteria to waiting lists, limited respite options, inadequate supply of trained providers or appropriate programs and gaps in service availability.[46] The resources requested for FY 2013 will be used to address these issues by:

- Expanding and enhancing respite care services to family members;
- Improving the statewide dissemination and coordination of respite care; and
- Providing, supplementing, or improving access and quality of respite care services to family caregivers, thereby reducing family caregiver strain.

The request will also allow AoA to cover new States not funded in previous years, enabling these new States to establish and/or strengthen infrastructures that offer targeted Respite Information and Referral services. And it will further enable all States funded to date to meet the requirements of the Act through continued infrastructure development and better recruitment and training of respite providers and volunteers, the provision of emergency and planned respite, training of family caregivers, and providing direct respite services, thus reducing the percentages of caregivers who do not use respite.

The Lifespan Respite Care Program provides AoA with another vehicle to address the needs of caregivers. The program builds upon the existing infrastructure of multi-faceted caregiver services AoA's other caregiver programs now provide to leverage training for caregivers, enhance the provision of information about available respite and other supportive services, and to further assist caregivers in accessing all services available to them, including respite, from across the spectrum of caregiver support.

[46] National Respite Coalition Written Testimony to the House subcommittee on Labor, Health and Human Services, and Education Appropriations. April 12, 2010

Output Table:

Lifespan Respite Care Output

Indicator	Most Recent Result	FY 2012 Projection	FY 2013 Projection	FY 2013 +/- FY 2012
Output AE: Increase the number of people served as a result of Lifespan Respite Care *(Output)*	N/A	N/A	Baseline	--

To date, the 2009 and 2010 grantees have made substantial progress towards building sustainable programs capable of meeting the respite care needs of caregivers across the lifespan. It is anticipated that the six new states funded in 2011 will achieve similar results with their programs while the eight states to receive expansion grants will be able to demonstrate the capacity to deliver respite services more efficiently and effectively.

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Protection of Vulnerable Adults

Summary of Request

Protection of Vulnerable Adults consists of several distinct but complementary programs designed to prevent, detect, and respond to elder abuse, neglect, and exploitation. As the population of older Americans increases, the problem of elder abuse, neglect, and exploitation continues to grow. While there is no single set of national elder abuse prevalence data, the number of reported cases of elder abuse, neglect, and exploitation are on the rise. A 2004 national survey of State Adult Protective Services (APS) programs conducted by AoA's National Center on Elder Abuse showed a 16 percent increase in the number of elder abuse cases from an identical study conducted in 2000.[47] According to a 1998 national incidence study (the only such study ever conducted), 84 percent of all elder abuse incidents go unreported, meaning that for every reported case of abuse there are over five that go unreported.[48] Together, these data suggest that a minimum of 5 million elders are abused, neglected, and/or exploited annually.

The negative effects of abuse, neglect, and exploitation on the health and independence of seniors is extensive. Research has demonstrated that older victims of even modest forms of abuse have dramatically higher (300 percent) morbidity and mortality rates than non-abused older people.[49] Additional adverse health impacts include an increased likelihood of heart attacks, dementia, depression, chronic diseases and psychological distress. The result of these unnecessary health problems is a growing number of seniors who access the healthcare system more frequently (including emergency room visits and hospital admissions), and are ultimately forced to leave their homes and communities prematurely.[50] Protection of Vulnerable Adults programs address this problem through a full array of services designed to prevent, detect, and respond to elder abuse, neglect, and exploitation.

The total FY 2013 request for Protection of Vulnerable Adults is $43,287,000; an increase of $8,000,000 over the FY 2012 enacted level. For FY 2013, specific program requests include:

- $8,000,000 in first-time funding for the Adult Protective Services (APS) program authorized by the Elder Justice Act of 2010 (included in Subtitle H of the Affordable Care Act). APS funding will provide demonstration grants to test innovative approaches to reducing and addressing elder abuse in States and in Tribal settings. This funding will generate knowledge that can then be used to inform State and local efforts across the country to design and implement better approaches to protect our Nation's older adults from abuse. Federal funding will also support evaluation of interventions designed to

[47] Teaster, Pamela, et al. *The 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older*. http://www.ncea.aoa.gov/NCEAroot/Main_Site/pdf/021406_60PLUS_REPORT.pdf

[48] Tatara, Toshio, et al. *The National Elder Abuse Incidence Study Final Report*. 1998. http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Elder_Abuse/docs/ABuseReport_Full.pdf

[49] Lachs, M.S., Williams, C.S., O'Brien, S., Pillemer, K.A., & Charlson, M.E. (1998). "The Mortality of Elder Mistreatment." JAMA. 280: 428-432. and Baker, M.W. (2007). "Elder Mistreatment: Risk, Vulnerability, and Early Mortality." Journal of the American Psychiatric Nurses Association, Vol. 12, No. 6, 313-321.

[50] Lachs M. S., Williams C., O'Brien S., Hurst L., Kossack A., Siegal A., et al. (1997). "ED use by older victims of family violence." Annals of Emergency Medicine. 30:448-454.

detect and prevent elder abuse, including financial exploitation; and improvement of the knowledge base about how to best implement these important activities.

- $16,761,000 for the Long-Term Care Ombudsman Program, the same as the FY 2012 enacted level. This consumer advocacy program improves the quality of care for the residents of long-term care facilities in all States.

- $5,036,000 for Prevention of Elder Abuse and Neglect, the same as the FY 2012 enacted level. This program provides state formula grants for training, education, and campaigns promoting public awareness of elder abuse and prevention efforts.

- $9,402,000 for the Senior Medicare Patrol Program, the same as the FY 2012 enacted level. SMP funds competitive grants to support the volunteer-based network that helps to prevent and combat healthcare fraud and abuse and helps to preserve the financial integrity of Medicare and Medicaid.

- $4,088,000 for Elder Rights Support Activities, the same as the FY 2012 enacted level. This program provides funding for four resource centers and programs that provide information, training, and technical assistance on Elder Rights issues to the national Aging Services Network.

This enhanced focus on elder rights and elder justice will build a foundation and establish best practices for States to develop programs to expand and improve the protection of individuals living in their communities and in long-term care settings; increase the information and technical assistance available to the public, States, and localities in preventing and addressing abuse; protect the rights of older adults and prevent their exploitation; reduce health-care fraud and abuse; and provide assistance to Tribes in developing elder justice systems. This multifaceted approach to preventing, detecting, and resolving elder abuse, neglect, and exploitation is essential to successfully fulfilling the shared mission of the Older Americans Act and the Elder Justice Act to maintain the health and independence of older Americans and adults with disabilities.

Adult Protective Services Demonstration Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Adult Protective Services Programs.....	--	--	$8,000,000	+$8,000,000
FTE……...	--	--	1	+1

Authorizing Legislation: Title XX of the Social Security Act, Subtitle B, Section 2042, as amended by the Affordable Care Act, Subtitle H – Elder Justice Act, Sections 6701-6703; Section 751 of the Older Americans Act, as amended

FY 2013 Social Security Act Authorization..... $25,000,000

Allocation Method ..... Competitive Grants and Contracts

Program Description:

The Adult Protective Services (APS) Demonstration Program, as established in the Elder Justice Act, provides competitive grants to States to test and evaluate innovative approaches to preventing, detecting, and responding to elder abuse, neglect, and exploitation.

Current State and local APS programs provide a range of services designed to ensure the safety and well-being of elders who are in danger of being mistreated or neglected, are unable to take care of themselves or to protect themselves from harm, and who have no one to assist them. These services include:

- receiving and investigating reports of elder abuse, neglect, or exploitation;
- case planning, monitoring, evaluation, and other case work and services; and
- providing, arranging for, or facilitating the provisions of medical, social service, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

The increasing complexity of elder and adult abuse cases, coupled with a rising older population and different State and local budget conditions have presented challenges to State, local, and Tribal APS programs. [51] The FY 2012 budget request cannot fill the service holes, but the funding can be used to test new approaches, rigorously evaluate them, and then use the findings to inform and improve State, local and Tribal APS efforts. States, localities and tribes lack the

[51] Teaster, Pamela, et al. *The 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older*. http://www.ncea.aoa.gov/NCEAroot/Main_Site/pdf/021406_60PLUS_REPORT.pdf

resources to conduct these pilots, evaluate them and share lessons learned with others. That is the gap this request seeks to fill.

A number of obstacles have prevented APS programs from evaluating their services, including a lack of resources, the increasing number and complexity of abuse cases, and the absence or inadequacy of consistent data systems and uniform reporting requirements needed to conduct meaningful program evaluations. Many of these same challenges have limited efforts to develop new and innovative approaches to preventing, detecting, and responding to abuse, neglect, and exploitation. Demonstration funds will provide competitive grant funding to test new or previously unevaluated approaches and evaluate their effectiveness.

Funding History:

No prior funding has been appropriated to this program.

Budget Request:

The FY 2013 request for Adult Protective Services Program is $8,000,000 in new funding. The request includes funding for demonstration grants and associated evaluations and the piloting and assessment of an APS resource center. It also includes the funds to support one FTE to carry out these activities.

The budget request is consistent with the findings of the recent GAO report on Federal elder justice efforts, as well as an earlier HHS report to Congress assessing the feasibility of establishing uniform standards for data collection, reporting, and dissemination of best practices regarding Elder Abuse. This report to Congress included a detailed analysis of the significant level of effort required to address the data collection and reporting requirements for APS. Taken together, these activities will complement each other, and will advance efforts to develop innovative approaches and best practices that can then be disseminated to APS programs nationwide.

The FY 2013 request for $8 million includes approximately $5.5 million to fund competitive grants to test promising approaches to meeting the growing challenges that State and local APS programs face. Elder abuse, neglect, and exploitation present complex problems requiring multidisciplinary solutions that employ the most effective and efficient interventions available. These competitive grants will allow State and local APS programs to develop and evaluate innovative approaches and identify best practices that can then be disseminated to APS programs nationwide.

The ability of APS programs to employ tested, proven techniques is essential to ensuring that elders are able to receive protection and relief from abuse, neglect, and exploitation. Using the results of the APS State demonstrations, AoA will develop a compendium of best practices and lessons learned that APS programs across the nation can use to improve their programs. Additionally, AoA will present findings at conferences, conduct trainings and webinars to disseminate the results, and seek out ways to coordinate with other national, State and local

entities to distribute the information. The cumulative results of these projects will allow AoA to establish a strong evidence-base for current and future projects.

Critical to the success of these efforts, AoA will provide APS State demonstration grantees with uniform definitions and reporting requirements to be used to track APS program results and compare them with other programs throughout the nation. Currently, APS programs have wide ranging definitions of elder abuse, neglect, and exploitation that make the combination of output data unreliable and comparative evaluations impossible to conduct.

Additionally, in FY 2013 AoA will provide $1 million to support research and demonstration programs to test approaches to addressing the unique challenge of preventing, identifying, and responding to elder abuse, neglect, and exploitation within Tribal nations. At listening sessions with Tribal grantees, elder abuse has been repeatedly raised as an issue of concern in these communities. In an effort to respond to these concerns, funds will provide competitive grants to eligible Tribal organizations, public agencies, and nonprofit organizations to support Tribes in the development of informational, legal, and supportive services to assist in the prevention, detection, and resolution of elder abuse, neglect, and exploitation. Funding will support coalition-building, training, and technical assistance; the development of statutes and codes; elder rights program development; and research for effectively preventing and addressing elder abuse within Tribal nations.

Most of the balance of $1.5 million will fund contracts to evaluate these activities and support the continued development of data collection and reporting requirements associated with the state-level demonstration grants. These funds will also be used for the funding of an APS resource center, in keeping with a March 2011 GAO report on Elder Justice at the Federal level which indicated the need for additional resources that could provide more easily accessible and centrally available information on APS best practices. Lastly, a portion of the budget allocated for the evaluation and administration of APS State Demonstrations will be used to provide staff resources to support the grants management, technical assistance, coordination, and the development and dissemination of best practices that are essential to the success of the these demonstration projects.

Output Table:

Adult Protective Services Output

Indicator	Most Recent Result	FY 2012 Projection	FY 2013 Projection	FY 2013 +/- FY 2012
Output AP.1: Design Adult Protective Service evaluation to develop and test appropriate methods of addressing elder abuse, neglect and exploitation.	N/A	Evaluation Design	Baseline	N/A

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Long-Term Care Ombudsman Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Long-Term Care Ombudsman Program.....	$16,793,000	$16,761,000	$16,761,000	--

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

FY 2013 Older Americans Act Authorization..... Expired

Allocation Method ..... Formula Grants

Program Description and Accomplishments:

The Long-Term Care Ombudsman program is a consumer advocacy program that improves the quality of care for the estimated 2.9 million individuals who reside in 69,320 long-term care facilities.[52] Formula grants to States and Territories based on the number of individuals age 60 and older provide funding for the training, travel, and other operating costs of nearly 10,000 ombudsmen (both staff and certified volunteers) who resolve complaints on behalf of these residents and routinely monitor the condition of long-term care facilities.

A primary Ombudsman duty is to identify, investigate and resolve complaints that are made by, or on behalf of residents. These complaints relate to action, inaction, or decisions of providers, public agencies, and others that may adversely affect residents' health, safety, welfare or rights. Ombudsmen advocate on behalf of residents by representing their interests before government and administrative entities, providing information to residents and families about the long-term care system, and educating the general public about issues related to long-term care policies and regulations.

Much of the efficiency of the Ombudsman Program is due to the strong reliance on volunteers who make up the bulk of those who resolve resident issues.[53] All but five states have volunteer ombudsman programs. These certified volunteer ombudsmen donated over 811,440 hours in FY 2010, a five percent increase over FY 2009. FY 2010 output data for the Long-Term Care Ombudsman Program highlights the accomplishments achieved by this program and the important role that ombudsmen play in ensuring that the rights of long-term care facility residents are respected:

- 1,167 FTE and 8,800 certified volunteer ombudsmen regularly visited residents in 33,391 facilities, more than 74 percent of all nursing home facilities and nearly

[52] National Ombudsman Reporting System (NORS) – Federal Fiscal 2010

[53] Shaughnessy, Carol V. *The Role of Ombudsmen in Assuring Quality for Residents of Long-Term Care Facilities: Straining to Make Ends Meet*. National Health Policy Forum. December 9, 2009.

39 percent of all licensed board and care facilities (Output S). At least another 2200 volunteers support these paid staff and certified volunteer ombudsmen.

- Ombudsmen investigated and worked to resolve 211,937 complaints (Output Q).

- Ombudsmen provided over 381,299 consultations to individuals and facility managers and staff on such topics as residents' rights, staffing levels, malnutrition, dementia care, depression, discharge procedures, financial exploitation and strategies to reduce the use of restraints and prevent the abuse and neglect of residents (Output R).

Funding History:

Funding for the Long-term Care Ombudsman Program during the past five years is as follows:

FY 2008 ..... $15,577,000
FY 2009 ..... $16,328,000
FY 2010 ..... $16,825,000
FY 2011 ..... $16,793,000
FY 2012 ..... $16,761,000

Budget Request:

The FY 2013 request for the Long-Term Care Ombudsman program is $16,761,000, the same as the FY 2012 enacted level.

The number of older Americans is increasing rapidly. This is particularly true among the population age 85 and older. As a percentage of the population, the number of older Americans age 85 and older is growing faster than any other age cohort and is projected to reach nearly 20 million by the year 2030. As this population grows, the need for safe, high-quality long-term care services (including non-nursing home alternatives) will increase, even as we seek to help more people remain in the community for longer periods.

Outcome data (displayed in the summary tables at the end of this section) demonstrate the success of this program in protecting older Americans in an efficient and effective manner. The percentage of the complaints processed by ombudsmen that were fully or partially resolved to the satisfaction of the resident has consistently remained near 75 percent,[54] demonstrating both the efficiency of the program and its ability to produce positive outcomes for residents. The average number of complaints per facility at 3.05 is on track to meet the projected 2012 target. A new outcome measure was added to further evaluate the level of success in resolving resident problems. Outcome 2.14 will target a decrease in complaints that are not resolved to the satisfaction of the resident.

The FY 2013 request represents an important element of AoA's enhanced focus on elder rights, which expands and improves upon AoA's successful elder rights programs to create a full array

[54] NORS 2010 – Complaint resolution: 9% needing no further action; 4% withdrawn; 6% not resolved to the satisfaction of the resident; 6% referred to other agency for resolution.

of services to prevent, detect, and resolve elder abuse, neglect, and exploitation. This request also supports Federal policy for quality alternatives to nursing home care. LTC Ombudsmen advocate for quality care and individual rights and well-being in other congregate long-term care settings, such as board and care and assisted living. In addition, LTC Ombudsmen serve individuals in these settings regardless of the individuals' eligibility for Medicaid or other public benefits. Ombudsmen are the only Federally-funded entity providing services to all of these residents. Outreach, access, complaint investigation and advocacy in board and care require Ombudsmen to employ new strategies compared to the work done in nursing home settings. Supporting volunteers to work in these often more intimate environments requires additional support and training.

Outcomes and Outputs Table:

Long-Term Care Ombudsman Program Outcomes and Outputs

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Outcome 2.12: Decrease the average number of complaints per LTC facility *(Outcome)*	FY 2010: 3.05 Target: 4.06 (Target Not Met)	3.0	3.0	--
Outcome 2.14 : Decrease the number of complaints not resolved to the satisfaction of the resident *(Outcome)*	FY 2010: 11,809 Target: N/A	11,293	10,778	-515

Indicator	Most Recent Result	FY 2012 Projection	FY 2013 Projection	FY 2013 +/- FY 2012
Output Q: Decrease the Number of Complaints *(Output)*	FY 2010: 211,937	204,000	200,000	-4,000
Output R: Number of Ombudsman Consultations *(Output)*	FY 2010: 381,299	400,000	425,000	+25,000
Output S: Facilities regularly visited not in response to a complaint *(Output)*	FY 2010: 33,391	35,000	35,000	--

Grant Awards Table:

Long-Term Care Ombudsman Program Grant Awards

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	56	56	56
Average Award	$299,093	$296,315	$296,315
Range of Awards	$10,468 - $1,693,475	$10,371 - $1,690,679	$10,371 - $1,690,679

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2013 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
Alabama	262,233	259,752	259,752	--
Alaska	83,746	82,968	82,968	--
Arizona	348,130	345,272	345,272	--
Arkansas	165,619	163,266	163,266	--
California	1,693,475	1,690,679	1,690,679	--
Colorado	227,267	227,763	227,763	--
Connecticut	196,524	197,433	197,433	--
Delaware	83,746	82,968	82,968	--
District of Columbia	83,746	82,968	82,968	--
Florida	1,226,365	1,222,346	1,222,346	--
Georgia	429,742	424,996	424,996	--
Hawaii	83,746	82,968	82,968	--
Idaho	83,746	82,968	82,968	--
Illinois	643,452	632,649	632,649	--
Indiana	334,905	331,459	331,459	--
Iowa	174,013	172,788	172,788	--
Kansas	147,001	145,978	145,978	--
Kentucky	233,207	230,625	230,625	--
Louisiana	226,146	222,742	222,742	--
Maine	83,746	83,645	83,645	--
Maryland	287,437	285,202	285,202	--
Massachusetts	361,717	354,137	354,137	--
Michigan	544,348	536,888	536,888	--
Minnesota	270,333	267,812	267,812	--
Mississippi	151,899	150,514	150,514	--

PROTECTION OF VULNERABLE ADULTS

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
Missouri	329,777	325,855	325,855	--
Montana	83,746	82,968	82,968	--
Nebraska	95,242	95,167	95,167	--
Nevada	128,779	132,191	132,191	--
New Hampshire	83,746	82,968	82,968	--

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

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
New Jersey	471,073	463,516	463,516	--
New Mexico	104,556	107,140	107,140	--
New York	1,057,995	1,024,692	1,024,692	--
North Carolina	490,016	492,882	492,882	--
North Dakota	83,746	82,968	82,968	--
Ohio	644,354	636,204	636,204	--
Oklahoma	198,924	197,815	197,815	--
Oregon	213,891	214,071	214,071	--
Pennsylvania	764,412	751,679	751,679	--
Rhode Island	83,746	82,968	82,968	--
South Carolina	256,121	253,775	253,775	--
South Dakota	83,746	82,968	82,968	--
Tennessee	344,228	340,485	340,485	--
Texas	1,048,816	1,050,406	1,050,406	--
Utah	101,944	98,779	98,779	--
Vermont	83,746	82,968	82,968	--
Virginia	397,235	394,754	394,754	--
Washington	337,546	336,473	336,473	--
West Virginia	115,956	117,611	117,611	--
Wisconsin	305,652	303,480	303,480	--
Wyoming	83,746	82,968	82,968	--
Subtotal, States	16,419,028	16,278,537	16,278,537	--
American Samoa	10,468	10,371	10,371	--
Guam	41,873	41,484	41,484	--
Northern Mariana Islands	10,468	10,371	10,371	--
Puerto Rico	225,524	211,401	211,401	--
Virgin Islands	41,873	41,484	41,484	--
Subtotal, States and Territories	16,749,234	16,593,648	16,593,648	--
Undistributed 55/	43,766	167,352	167,352	--
TOTAL	**16,793,000**	**16,761,000**	**16,761,000**	--

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

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Prevention of Elder Abuse and Neglect

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Prevention of Elder Abuse and Neglect	$5,046,000	$5,036,000	$5,036,000	--

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

FY 2013 Authorization..... Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

The Prevention of Elder Abuse and Neglect program provides formula grants to States and Territories based on their share of the population 60 and over for training and education and promoting public awareness of elder abuse. The program also supports State and local elder abuse prevention coalitions and multi-disciplinary teams. These activities are important elements of AoA's enhanced focus on elder justice. The program coordinates activities with State and local adult protective services programs (over half of which are directly administered by State Units on Aging) and other professionals who work to address issues of elder abuse and elder justice. The importance of these services at the State and local level is demonstrated by the fact that States significantly leverage Older Americans Act (OAA) funds to obtain other funding for these activities. In FY 2009 over $35 million of the Elder Abuse Prevention services expenditures was leveraged from non-OAA funds, a ratio of approximately $7 of non-OAA funds for every $1 investment of AoA funds.

Examples of State elder abuse prevention activities in 2010 include:

- In Kentucky, the local area agencies on aging participate in the Local Coordinating Councils on Elder Abuse, which have developed emergency elder shelters, developed informational cards for law enforcement officers to have in the patrol cars which contain crucial resource information for victims of elder abuse, provided training on a regular basis to first responders, provided a friendly visitor program for home-based seniors, and produced a prevention tool called the Kentucky Fraud Fighter Form.

- In Illinois, the Illinois Department on Aging utilizes its elder abuse funds to support volunteer community based multi-disciplinary teams (M-Teams) that serve in a technical advisory role to more than 40 elder abuse provider agencies throughout the state. The objectives of the M-Team are to provide case consultation and assistance to caseworkers and to encourage cooperation among various service agencies. Each M-Team is composed of the M-Team Coordinator and representatives of the mental health, medical, legal, law enforcement, faith community, and financial professions.

PROTECTION OF VULNERABLE ADULTS

The Prevention of Elder Abuse and Neglect program demonstrates AoA's ongoing commitment to protecting the rights of vulnerable seniors and promoting their dignity and autonomy. Through education efforts, exposing problems that would otherwise be hidden from view, and providing a voice for those who cannot act for themselves, the program helps ensure that all older Americans are able to age with dignity in a safe environment.

Funding History:

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

FY 2008	$5,056,000
FY 2009	$5,056,000
FY 2010	$5,055,000
FY 2011	$5,046,000
FY 2012	$5,036,000

Budget Request and Anticipated Accomplishments:

The FY 2013 request for the Prevention of Elder Abuse and Neglect program is $5,036,000, the same as the FY 2012 enacted level. The FY 2013 request will maintain the ability of States and Territories to train law enforcement officials, develop and distribute educational materials, conduct public awareness campaigns, and create community coalitions and multidisciplinary teams to investigate and respond to elder abuse and neglect. States and AAAs also use this funding to coordinate their activities with fraud and crime prevention partnerships organized by sheriffs, police chiefs, and community organizations.

These activities are important elements of AoA's continued focus in FY 2013 on elder justice, which seeks to improve upon AoA's successful elder rights programs, including the Prevention of Elder Abuse and Neglect program. This enhanced focus will allow the creation of a full array of services to protect elder rights and prevent, detect, and resolve elder abuse, neglect, and exploitation. Prevention of Elder Abuse and Neglect programs complement Adult Protective Services by funding the infrastructure on which best practices may be developed and evaluated.

Output Table:

Prevention of Elder Abuse and Neglect Output

Indicator	Most Recent Result	FY 2012 Projection	FY 2013 Projection	FY 2013 +/- FY 2012
Output U: Elder Abuse prevention non-OAA service expenditures *(Output, results in thousands)*	FY 2010: $29,072	$20,000	$20,000	--

Grant Awards Table:

Prevention of Elder Abuse, Neglect, and Exploitation Grant Awards

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Number of Awards	56	56	56
Average Award	$89,868	$89,037	$89,037
Range of Awards	$3,145 - $503,223	$3,116 - $497,037	$3,116 - $497,037

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2013 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM: Prevention of Elder Abuse & Neglect (CFDA 93.041)

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2012 Estimate	Difference +/-FY 2012
Alabama	77,924	76,364	76,364	--
Alaska	25,163	24,930	24,930	--
Arizona	103,449	101,506	101,506	--
Arkansas	49,214	48,157	48,157	--
California	503,223	497,037	497,037	--
Colorado	67,534	66,959	66,959	--
Connecticut	59,907	59,907	59,907	--
Delaware	25,163	24,930	24,930	--
District of Columbia	25,163	24,930	24,930	--
Florida	364,420	359,354	359,354	--
Georgia	127,700	124,943	124,943	--
Hawaii	25,163	24,930	24,930	--
Idaho	25,163	24,930	24,930	--
Illinois	197,384	197,384	197,384	--
Indiana	99,519	98,224	98,224	--
Iowa	55,927	55,927	55,927	--
Kansas	45,843	45,843	45,843	--
Kentucky	69,299	67,801	67,801	--
Louisiana	68,518	68,518	68,518	--
Maine	25,163	24,930	24,930	--
Maryland	85,413	83,846	83,846	--
Massachusetts	109,606	109,606	109,606	--
Michigan	161,756	160,862	160,862	--
Minnesota	80,331	78,733	78,733	--
Mississippi	45,198	45,198	45,198	--
Missouri	97,995	97,643	97,643	--
Montana	25,163	24,930	24,930	--
Nebraska	29,770	29,770	29,770	--
Nevada	38,267	38,862	38,862	--
New Hampshire	25,163	24,930	24,930	--

PROTECTION OF VULNERABLE ADULTS

PROGRAM: Prevention of Elder Abuse & Neglect (CFDA 93.041)

State/Territory	FY 2011 Actual	FY 2012 Estimate	FY 2013 Request	Difference +/-FY 2012
New Jersey	143,950	143,950	143,950	--
New Mexico	31,069	31,498	31,498	--
New York	318,066	318,066	318,066	--
North Carolina	145,611	144,901	144,901	--
North Dakota	25,163	24,930	24,930	--
Ohio	197,185	197,185	197,185	--
Oklahoma	60,208	60,208	60,208	--
Oregon	63,559	62,934	62,934	--
Pennsylvania	242,944	242,944	242,944	--
Rhode Island	25,163	24,930	24,930	--
South Carolina	76,108	74,607	74,607	--
South Dakota	25,163	24,930	24,930	--
Tennessee	102,289	100,098	100,098	--
Texas	311,661	308,806	308,806	--
Utah	30,293	29,040	29,040	--
Vermont	25,163	24,930	24,930	--
Virginia	118,040	116,052	116,052	--
Washington	100,303	98,919	98,919	--
West Virginia	36,736	36,736	36,736	--
Wisconsin	90,826	90,309	90,309	--
Wyoming	25,163	24,930	24,930	--
Subtotal, States	4,934,164	4,892,787	4,892,787	--
American Samoa	3,145	3,116	3,116	--
Guam	12,582	12,465	12,465	--
Northern Mariana Islands	3,145	3,116	3,116	--
Puerto Rico	67,016	62,149	62,149	--
Virgin Islands	12,582	12,465	12,465	--
Subtotal, States and Territories	5,032,634	4,986,098	4,986,098	--
Undistributed 56/	13,366	49,902	49,902	--
TOTAL	**5,046,000**	**5,036,000**	**5,036,000**	--

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

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Senior Medicare Patrol Program

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Senior Medicare Patrol Program.....	$9,420,000	$9,402,000	$9,402,000	--

Authorizing Legislation: Sections 201 and 202 of the Older Americans Act of 1965, as amended

FY 2013 Authorization..... Expired

Allocation Method .....Competitive Grant

Program Description and Accomplishments:

The Senior Medicare Patrol (SMP) program provides competitive grants to 54 States and Territories to support a national volunteer-based network of retired seniors whose purpose is to educate older adults on preventing and identifying healthcare fraud and abuse. Projects use the skills of retired professionals as volunteers to conduct community outreach and education and provide information that empowers beneficiaries of Medicare and Medicaid and their families to prevent, identify and report fraud. Activities are carried out in partnership with the Centers for Medicare & Medicaid Services, the Office of Inspector General (OIG), healthcare providers, and other aging and elder rights professionals from around the country.

The HHS OIG collects performance data from the SMP projects for the annual performance report. The most recent report, dated May 6, 2011, documented the following program outputs and outcomes for the calendar year 2010. Data shows that compared to FY 2009, SMP projects:

- Maintained 4,964 active volunteers (12% increase) who worked over 129,662 hours (6% increase) to educate beneficiaries about how to prevent Medicare and Medicaid fraud;
- Educated 298,097 beneficiaries (37% increase) in 8,300 group education sessions (16% increase) and held 70,789 one-on-one counseling sessions with or on behalf of beneficiaries (109% increase);
- Conducted 6,231 community outreach education events (10% increase); and
- Resolved 89,612 inquiries for information or assistance from beneficiaries (50% increase).
- Documented $39,031 in actual savings and $248,064 in costs awarded for Medicare, Medicaid, beneficiaries and others. This does not include potential savings resulting from the sentinel effect, fraud deterrence, or calls to the fraud hotline or other non-SMP contracts.

In addition, the OIG reports that since the program's inception 14 years ago, SMP projects have:

- Educated over 4.2 million beneficiaries in 84,968 group education sessions and 1,112,887 one-on-one counseling sessions;

- Conducted 75,062 community outreach education events; and

- Documented over $105.976 million in savings, including Medicare and Medicaid funds recovered, beneficiary savings, and other savings as *directly* attributable to the project as a result of beneficiary complaints. This does not attempt to quantify the *total* savings that occur as a result of SMP program's impact on fraud deterrence.

The SMP program historically has been supported by approximately $3.2 million in Health Care Fraud and Abuse Control (HCFAC) funding au*thorized* by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for infrastructure, technical *assis*tance, and other SMP program support and capacity-building activities designed to enhance program effectiveness. Activities funded by HCFAC resources include support for project training and technical assistance provided by AoA's National Consumer Technical Resource Center (Center).

In the past two years, the critically important role of the SMP program continued to be recognized by partners in Medicare fraud prevention in the private and public sectors. In 2010, and again in 2011, the Centers for Medicare & Medicaid Services (CMS) provided funding for the award of an additional $9 million in grants from its Program Integrity funding, administered by AoA, targeted to help more than 50 Senior Medicare Patrol (SMP) programs fight Medicare fraud in high fraud states and expand the capacity of the program to reach more beneficiaries. In FY 2012, SMP will receive an additional $7.3 million from HCFAC funds to again fight Medicare fraud in high-fraud States.

In November 2010, AoA received a national level commendation for the SMP program from the National Health Care Anti-Fraud Association (NHCAA), considered the leading national organization focused exclusively on the fight against health care fraud. The NHCAA's members comprise more than 100 private health insurers and those public sector law enforcement and regulatory agencies having jurisdiction over health care fraud committed against both private payers and public programs. The award, given annually by the NHCAA, recognizes an organization or individuals "who have done the most in the past year to raise public awareness about the problem of health care fraud in our nation's health care system." This organization's decision to award the Administration on Aging's (AoA) Senior Medicare Patrol (SMP) program the NHCAA 2010 Excellence in Public Awareness Award is a major achievement, and a notable acknowledgement of the value of the SMP program.

Funding History:

Funding for the SMP discretionary appropriations is as follows:

FY 2008 ..... $9,274,000
FY 2009 ..... $9,439,000
FY 2010 ..... $9,438,000
FY 2011 ..... $9,420,000
FY 2012 ..... $9,402,000

Budget Request:

The FY 2013 request for the Senior Medicare Patrol (SMP) program is $9,402,000; the same as the FY 2012 enacted level. This amount will enable AoA to continue the proven fraud prevention activities of the SMP program.

Since the program's inception, SMP projects have educated over 4.2 million beneficiaries and received over 170,000 complex issues (complaints) from beneficiaries who have detected billing or other discrepancies based on that information. While SMPs make numerous referrals of potential fraud to CMS program integrity contractors, there is no mechanism for tracking the actions (investigation, prosecution, collection) required to realize actual savings to the government as a result of these referrals. Therefore, it is not possible to directly track the outcome of most of the cases reported and dollars recovered as a result of SMP program activities. Moreover, the impact of the SMP program's primary activities – deterrence resulting from the education of beneficiaries to prevent health care fraud - is difficult to measure and nearly impossible to quantify in dollars and cents. As the OIG indicated in the May 2011 report:

> We continue to emphasize that the number of beneficiaries who have learned from the Senior Medicare Patrol Projects to detect fraud, waste, and abuse and who subsequently call the OIG fraud hotline or other contacts cannot be tracked….In addition, the projects are unable to track substantial savings derived from a sentinel effect, whereby fraud and errors are reduced in light of Medicare beneficiaries scrutiny of their bills. [57]

Despite these evaluation challenges, the SMP program has documented nearly $106 million in savings to Medicare, Medicaid, program beneficiaries, and others since its inception in 1997, excluding any deterrent effect. During that same period, the program has educated over 4.2 million beneficiaries through the work of 24,431 volunteers who contributed a combined 673,466 hours of their time to preventing, detecting and reporting suspected incidents of fraud and educating and training community members about fraud prevention.[58]

[57] *Performance Data for the Senior Medicare Patrol Projects: May 2011 Performance Report,* OEI-02-11-00110. http://www.oig.hhs.gov/oei/reports/oei-02-11-00110.pdf

[58] The OIG has only begun collecting information on number of volunteers and volunteer hours since 2007.

Outcomes and Outputs Table:

Senior Medicare Patrol Program Outcomes and Outputs

Indicator	Most Recent Result	FY 2012 Projection	FY 2013 Projection	FY 2013 +/- FY 2012
Output W: Beneficiaries Educated and Served *(Output)*	FY 2010: 397,842	420,000	450,000	+30,000

Elder Rights Support Activities

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Elder Rights Support Activities.....	$4,096,000	$4,088,000	$4,088,000	--

Authorizing Legislation: Sections 201, 202, and 411 of the Older Americans Act of 1965, as amended

FY 2013 Older Americans Act Authorization..... Expired

Allocation Method .....Competitive Grants/Cooperative Agreements and Contracts

Program Description and Accomplishments:

Elder Rights Support Activities consists of four programs and resource centers that provide the necessary information, training, and technical assistance that AoA and States need to fulfill their shared mission to prevent, detect, and respond to elder abuse, neglect, and exploitation. The combination of legal systems development and assistance programs, the National Center on Elder Abuse, and the National Long-Term Care Ombudsman Resource Center create a supportive framework for AoA's Protection of Vulnerable Adults programs. The Elder Rights Support Activities described below are essential components of AoA's ongoing elder rights programs:

Model Approaches to Statewide Legal Assistance Systems
Model Approaches to Statewide Legal Assistance Systems helps States develop and implement cost-effective, replicable approaches for integrating senior legal helplines into the broader tapestry of state legal service delivery networks. The cornerstone of these projects is legal helplines, which assist seniors in accessing quality legal services. By ensuring strong leadership at the State level, Model Approaches projects create linkages within the existing legal assistance community and services providers and professionals in the broader community-based aging and elder rights networks, including AAAs, Aging and Disability Resource Centers, State Long-Term Care Ombudsmen, and Adult Protective Services. These linkages leverage the strengths of both elder rights and aging service networks for the provision of quality service to seniors most in need.

National Legal Assistance and Support Projects
National Legal Assistance and Support grants fund a comprehensive national legal assistance support system serving professionals and advocates working in legal and aging services networks. These grants provide funding for the National Legal Resource Centers, which support the leadership, knowledge, and systems capacity of legal and aging provider organizations. These centers work to enhance the quality, cost effectiveness, and accessibility of legal assistance and elder rights protections available to older persons with social or economic needs. AoA is funding four projects which provide core support functions for aging and legal networks

including case consultation, training, technical assistance/legal and aging systems development, and information development and dissemination.

National Center on Elder Abuse

To support and enhance the activities of State and local programs to prevent Elder Abuse, Neglect, and Exploitation, AoA funds the National Center on Elder Abuse (NCEA). NCEA disseminates information to professionals and the public; collaborates on research; provides consultation; identifies and provides information about promising practices and interventions; answers inquiries and requests for information; operates a listserv forum for professionals; and advises on program and policy development. NCEA also facilitates the exchange of strategies for uncovering and prosecuting fraud in areas such as telemarketing and sweepstakes scams. In 2010, the NCEA:

- Continued its outreach by serving over 1,700 subscribers to its newsletter and over 1,600 members to the Elder Abuse Listserv.
- Responded to over 1,000 individual public inquiries and requests for information.
- Effectively utilized technology to provide cost-effective trainings to over 1,100 professionals though live Webcast forums on issues relevant to elder justice, and maintained the NCEA training library with over 230 resources.
- Supported systems change in 22 local communities by providing funding, training, and technical assistance to new elder justice community coalitions to leverage local resources and expertise to prevent and combat elder abuse, neglect, and exploitation.

National Long-Term Care Ombudsman Resource Center

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

In FY 2010, the NORC engaged in numerous projects and activities in support of long-term care ombudsman programs. Highlights included supporting the success of CMS's Money Follows the Person (MFP) demonstration project by working with CMS, AoA, and National Association of State Long-Term Care Ombudsman Programs (NASOP) to promote ombudsman coordination with MFP grantees, Aging and Disability Resource Centers (ADRCs), Centers for Independent Living, and other single points of entry programs; and furthering Federal efforts to support consumer choice and access to alternatives to nursing home care. NORC also provided ombudsmen with training from national experts on such issues as: The Changing Long-Term Care System; Managing Program Goals and Priorities During Fiscal Crises**;** Minimum Data Set (MDS) 3.0 Section Q, Money Follows the Person, and Nursing Home Transition; Advocacy in Assisted Living. State and local ombudsman training was provided at two national conferences

and via web-based teleconferences. The Center's website continued high utilization *(over 40,000 monthly visits)* by ombudsmen, consumers, and agencies.

Funding History:

Comparable funding for Elder Rights Support Activities is as follows:

FY 2008 ..... $3,498,790
FY 2009 ..... $4,104,000
FY 2010 ..... $4,103,000
FY 2011 ..... $4,096,000
FY 2012 ..... $4,088,000

Budget Request:

The FY 2013 request for Elder Rights Support Activities is $4,088,000, the same as the FY 2012 enacted level. This request reflects continuation of the current level of support services for elder rights and elder justice. These activities are a critical component of AoA's successful elder rights programs and help to create a full array of services to prevent, detect, and resolve elder abuse, neglect, and exploitation.

The National Center on Elder Abuse, the National Long-Term Care Ombudsman Resource Center, and the Statewide Model Approaches and Legal Assistance programs provide the technical assistance, information, resources, referrals, and legal systems development and assistance activities that support the efforts of the entire spectrum of Protection of Vulnerable Adults programs. Continued support for these programs and resource centers will provide the best and most efficient services and supports possible to support AoA's efforts to promote elder rights and elder justice.

Elder Rights Support Activities includes funding for the following projects[59]:

Activity	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request
Elder Rights Support Activities:			
Model Approaches to Statewide Legal Assistance	$ 1,996,000	$ 1,992,228	$ 1,992,228
National Legal Assistance and Support Projects	744,508	743,592	743,592
National Center on Elder Abuse	809,378	807,471	807,471
National Long-Term Care Ombudsman Resource Center.....	545,906	544,968	544,968
Total, Elder Rights Support Activities	**$ 4,095,792**	**$ 4,088,259**	**$ 4,088,259**

[59] Several projects have been relocated from Aging Network Support Activities and are comparably adjusted. Accordingly, actual expenditure amounts are shown for FY 2011 and reflected in FY 2012 and FY 2013

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Consumer Information, Access, and Outreach

Summary of Request

Older Americans and Americans with disabilities face a vast array of choices when trying to determine the right services and supports to assist them to remain active and independent in their communities. As the number of choices available to assist them grows, so too does the complexity of navigating these programs and selecting among them so as to determine which best suit the needs of individuals.

A key part of AoA's emphasis on community living is providing consumers with the information they need to make decisions about their independence and connecting them with the right services. Aging and Disability Resource Centers (ADRCs) and the State Health Insurance Assistance Programs (SHIPs) help to address this need by providing information, outreach, and assistance to seniors and those with disabilities, so that they can access the services necessary for their independence. ADRCs serve as community-level "one stop shop" entry points into long-term care – including home and community-based services that can enable people to remain in their homes - for people of all ages who have chronic conditions and disabilities. SHIPs provide one-on-one counseling to help aging and disabled beneficiaries and coming-of-agers navigate complex health and long-term care-related topics.

The FY 2013 request for these programs is $64,902,000; a reduction of -$6,457,000 from the FY 2012 enacted level. This request would provide:

- $10,000,000 for ADRCs (mandatory funds provided by the Affordable Care Act). ADRCs support State efforts to develop more efficient, cost-effective, and consumer-responsive systems of information and integrated access by creating "one-stop shop" entry points into long-term care at the community-level. Under the request, $6,457,000 in ADRC funds would be eliminated;

- $51,902,000 for State Health Insurance Assistance Programs (SHIPs), which provide free, one-on-one counseling and assistance to help aging and disabled beneficiaries navigate the complexities of health and long-term care systems. The SHIPs, two-thirds of which are currently administered by State Units on Aging, fit naturally within AoA's mission of promoting community living, and will benefit from deeper connection to the aging services network from within AoA; and

- $3,000,000 for the National Clearinghouse for Long-Term Care Information (mandatory funds provided by the Deficit Reduction Act).

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Aging and Disability Resource Centers

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA (Discretionary)	$6,469,000	$6,457,000	--	-$6,457,000
BA (Mandatory)	$10,000,000	$10,000,000	$10,000,000	--
Total, Program Level	$16,469,000	$16,457,000	$10,000,000	-$6,457,000
Total, FTE	3	3	3	--

Authorizing Legislation: Section 202b of the Older Americans Act of 1965, as amended

Mandatory Appropriation: Section 2405 of the Affordable Care Act of 2010

FY 2013 Older Americans Act Authorization..... Expired

Allocation Method ..... Competitive Grants/Co-operative Agreements and Contracts

Program Description and Accomplishments:

Aging and Disability Resource Centers (ADRCs) support State efforts to develop more efficient, cost-effective, and consumer-responsive systems of information and integrated access by creating "one-stop shop" entry points into long-term care at the community-level. ADRCs help States make better use of taxpayer dollars by streamlining access to community services and supports and diverting individuals from more costly forms of care, including institutional care and unnecessary hospital re-admissions.

ADRCs are a key component in transforming States' long-term supports and services programs. Since 2003, AoA and CMS have provided grants to States to develop a foundational infrastructure for delivering person-centered systems of information, counseling, and access that make it easier for individuals to learn about and access their health and long-term services and support options. ADRCs grew out of best practice innovations known as "No Wrong Door"[60] and "Single Points of Entry" programs, where people of all ages may turn for objective information on their long-term services and support options.

ADRCs provide services including:

- "one-on-one" options counseling and advice to help consumers, including private pay individuals, and their caregivers fully understand the options available to them.

[60] In a "No Wrong Door" entry system, multiple agencies retain responsibility for their respective services while coordinating with each other to integrate access to those services through a single, standardized entry process that is administered and overseen by a coordinating entity (Allison Armor-Garb, *Point of Entry Systems for Long-Term Care: State Case Studies*, prepared for the New York City Department of Aging, 2004).

- streamlined access to all publicly supported long-term care services and support programs;

- targeted discharge planning, care transition and diversion support that integrates the medical and social service systems on behalf of older adults and individuals with disabilities to help them remain in their own homes and communities after a hospitalization, rehabilitation or skilled nursing facility visit;

- outreach and assistance to Medicare beneficiaries on their Medicare benefits including prevention and low-income subsidies; and,

- integrated access-point to care transition and diversion support for Veterans served through the AoA/Department of Veterans Affairs (VA) Veteran-Directed Home and Community Based Services Program partnership.

Effective ADRCs perform five key operational functions:

- *Information, Referral and Awareness*: ADRCs serve as a highly visible and trusted place that people know they can turn to for objective information on the full range of long term service and support options. ADRCs promote awareness of the various options, including Medicare benefits, that are available in the community, especially among underserved, hard-to-reach and private paying populations, as well as options individuals can use to "plan ahead" for their long-term care. ADRCs have the capacity to link consumers with needed services and supports – both public and private – through appropriate referrals to other agencies and organizations.

- *Options Counseling and Assistance*: ADRCs provide counseling and decision support to consumers and their family members and/or caregivers by identifying and understanding the needs of the clients and assisting them in making informed decisions about appropriate long term service and support choices – including their Medicare options – in the context of their personal needs, preferences, values and individual circumstances.

- *Streamlined Eligibility Determinations for Public Programs*: ADRCs serve as a single point of entry to publicly-funded long-term services and supports, including those funded by Medicaid, the Older Americans Act (OAA), and other State and Federal programs and services. ADRCs must have the necessary protocols and procedures in place to facilitate integrated and/or fully coordinated access (i.e., consumer intake, needs assessment, service or care planning, eligibility determination, and ensuring that people get the services they need) to publicly supported long-term services and supports – both community-based and institutional. The goal is to create a process that is seamless for consumers regardless of which service they choose.

- *Person-Centered Care Transitions*: ADRCs create formal collaborations between and among the major pathways that are used in health care and long-term services and supports, including preadmission screening programs for nursing home services, hospital discharge planning, care transition services, physician services, and various community

agencies and organizations. These linkages ensure that people with chronic conditions and disabilities have the information they need to make informed decisions about their service and support options as they pass through critical transition points in the health and long-term services and support systems that cut across all payers and settings. These critical activities can help individuals break the cycle of readmission to the hospital and live longer in the community with enhanced quality of life.

- *Quality Assurance and Continuous Improvement:* ADRCs must ensure that they are person centered and adhere to the highest standard of service in all areas. ADRCs should continually monitor the quality of their services and evaluate their own impact on consumers' lives, system efficiencies and public costs.

AoA and the Centers for Medicare & Medicaid Services (CMS) have invested over $100 million in the ADRC program since 2003. As a result of these investments:

- Over 310 ADRC sites have been established across 50 states, 3 territories, and Washington, DC, often by expanding existing infrastructure in the aging services network such as Area Agencies on Aging, etc. Together these ADRC sites can reach roughly 51 percent of the U.S. population.

- 21 States and Territories have achieved statewide coverage, and an additional 12 States have achieved 50 percent or more statewide coverage.

- 35 states with ADRC programs sites currently conduct care transitions through formal intervention with an additional 10 states currently planning to conduct activities also through formal interventions

- 25 States have developed statewide web-based directories available to consumers and service providers which improve the quality and consistency of the aging services network information and assistance provided across the state.

- As a result of these investments, in 2012 it is estimated that ADRCs will respond to over three million contacts to help individuals make better informed decisions about their health and long-term care options, with the vast majority of these decisions resulting in referrals for community-based services.

Funding History:

Comparable discretionary funding for Aging and Disability Resource Centers is as follows:

FY 2008	$2,250,000	0 FTE
FY 2009	$13,577,000	0 FTE
FY 2010	$13,684,000	3 FTE
FY 2011	$6,469,147	3 FTE
FY 2012	$6,457,000	3 FTE

Note: Discretionary funding for ADRC activities was provided under Aging Network Support Activities in FY 2009 and FY 2010 and requested under Health and Long-term Care Programs in FY 2011.

Comparable mandatory funding for Aging and Disability Resource Centers is as follows:

FY 2008	$0
FY 2009	$0
FY 2010	$10,000,000
FY 2011	$10,000,000
FY 2012	$10,000,000

Note: Mandatory appropriations of $10 million for FY 2010 through FY 2014 for ADRCs are made under Section 2405 of P.L. 111-148, the Affordable Care Act of 2010.

Budget Request:

No discretionary funding is requested for Aging and Disability Resource Centers. This represents a reduction of -$6,457,000 from the FY 2012 Enacted Level. Instead, ADRCs will continue to receive funding using the $10,000,000 in mandatory funding that was appropriated to AoA under the Affordable Care Act (section 2405 of P.L. 111-148) for each year from FY 2010 to 2014 for ADRC activities.

AoA intends to use this funding for ADRCs to support states and communities to continue to build the infrastructure needed to support the ongoing integration of the programs efforts into state's HCBS systems and create greater integration with the health care system. Special emphasis will be given to strengthening the capacity of existing ADRCs to carry-out options counseling, nursing home diversion, and care transitions that help reduce unnecessary hospital readmissions. As many ADRCs are increasingly integrated into their state's Home and Community-Based Supportive Services system, a reduction in funding is acceptable for FY 2013, however, its impact on ADRC performance will vary from state to state.

Continued funding for ADRCs, using mandatory funds, will provide an important means for ensuring the continued development and integration of these programs as part of States' overall long-term care reform efforts. This is illustrated by the fact that currently, 28 of the original 31 States awarded Money Follows the Person (MFP) program funds report direct involvement

with their ADRCs. This involvement has increased since October 2010, when CMS published new MDS 3.0 Section Q provisions. These provisions require State Medicaid agencies to designate Local Contact Agencies (LCAs) to provide information and referral to persons residing in nursing facilities who indicate a desire to return to community living. Nationally, 70% of States have designated ADRCs as Local Contact Agencies. In 12 States, ADRCs are the *only* Local Contact Agencies. Every effort will be made to capitalize on other funding sources such as MFP to support ADRC activities, but for some states that do not have access to these opportunities a discontinuation or reduction in ADRC funding could negatively impact their efforts to carry out their *Olmstead* and other rebalancing efforts which seek to insure that individuals can remain independently in their communities rather than in institutions.

Continued ADRC funding could also have an impact on Medicare spending. States use ADRCs to assist individuals in "critical pathways," defined as the times or places when people make important decisions about long-term care. This work includes several innovative interventions to facilitate the hospital discharge process to help reduce unnecessary readmissions to hospitals, as well as to help divert individuals from nursing home placement, and to help individuals already in nursing homes to return to the community.

In the 2010 ADRC grant program announcement, a special emphasis was placed on increasing the capacity of ADRCs to adopt evidence-based care transitions programs specifically designed to reduce hospital readmission. These formal interventions include the use of evidence based care transition models such as:

- Better Outcomes for Older Adults through Safe Transitions (BOOST)
- Bridge Program
- Care Transition Intervention
- Geriatric Resources for Assessment and Care of Elders (GRACE)
- Guided Care®
- Transitional Care Model

Currently, 97 ADRCs are actively partnering with 122 hospitals across 35 states. Between April 2011 and September 2011, 66 ADRC sites served 8,553 consumers with care transition services following an acute care episode.

In FY 2013, AoA plans to make available competitive grants to States and Territories to further develop programs under existing ADRCs to reach statewide coverage and ensure the five key operational functions of programs are at a fully-functional level. All States and Territories will have the opportunity to compete for funding to further bolster their capacity in the areas of Options Counseling and Assistance, Streamlined Eligibility Determinations for Public Programs, and Person Centered Care Transitions.

AoA will also partner with CMS to ensure these efforts assist states in reducing the growth in long-term care spending through effective and efficient increases in non-institutional services and supports. In particular, the implementation of ADRCs has and will continue to assist states to institute administrative changes that will aid states in meeting the requirements of the CMS State Balancing and Incentive Payment Program, including establishing a single entry point

system, conflict-free case management services, and the use of a statewide standardized assessment instrument for determining eligibility for HCBS.

ADRCs will also continue, with VA funding, to serve clients under the current AoA/Department of Veterans Affairs (VA) partnership. In FY 2008, the VA and AoA began working together to develop the Veterans Directed - Home and Community Based Services Program (VD-HCBS), which is designed to serve Veterans of any age who are at risk of admission to a nursing home by providing them the opportunity to self-direct their care and access services to help them remain in the community. Rather than build a separate infrastructure to serve Veterans, the VA made a strategic decision to use the aging services network infrastructure – including using the ADRC as the integrated access point to empower the veterans to set-up their own service plan for long-term supports and services – as a delivery vehicle for VD-HCBS. Since inception of the program the VA has invested $40.8 million to help expand this program nationwide. HHS and the VA have worked together to develop Program Guidelines/National Standards, web based tools to track and scale program and implemented a National Training program for the VD-HCBS. Currently, 19 states and the District of Columbia are operating VDHCBS programs with 33 operational VAMCs, 82 operational AAA/ADRCs and 775+ Veterans served (132 or 17% under age 60). In FY12, it is projected that additional 38 VAMCs will be added.

With ADRCs in place for nearly a decade, AoA believes it is appropriate to gather new information about the impact of ADRCs. AoA is partnering with the Agency for Healthcare Research and Quality and the Assistant Secretary for Planning and Evaluation to rigorously evaluate the effectiveness of ADRCs. In FY 2009, AoA initiated a design contract for the evaluation. In FY 2010, AoA invested $2.1 million to conduct an evaluation of the ADRC program based on recommendations from the design contract. This evaluation will look at both outcomes and process. Data collection is slated to start in the spring of 2012 and the final report is expected to be completed in late 2013 or early 2014. The results of this evaluation will influence future performance measures and indicators.

Outcome and Outputs Table:

Aging and Disability Resource Centers Outcome and Outputs

Measure	Most Recent Result	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
LTC.2: Percent of individuals who indicate ADRC information and counseling contribute to informed decision making *(Outcome)*	N/A	TBD	TBD	N/A

Indicator	Most Recent Result	FY 2012 Projection	FY 2013 Projection	FY 2013 +/- FY 2012
Output AF: Total number of ADRC contacts *(Output)*	FY 2010: 3,253,200	3.75 M	3.75 M	--
Output AG: Increase in the number of ADRC pilot programs *(Output)*	FY 2010: 310	310	310	--

Note: For presentation within the budget AoA highlighted specific measures that are most directly related to Aging and Disability Resource Centers; however multiple performance outcomes are impacted by this program because AoA's performance measures (efficiency, effective targeting, and client outcomes) assess network-wide performance in achieving current strategic objectives.

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State Health Insurance Assistance Programs

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
BA	$52,000,000	$52,115,000	$51,902,000	- $213,000
FTE[61]	--	--	5	+5

Authorizing Legislation: Section 4360 of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b-4).

FY 2013 Authorization..... Expired

Allocation Method ..... Formula and Competitive Grants/Contracts

Program Description and Accomplishments:

State Health Insurance Assistance Program (SHIP) grants to States provide infrastructure, training, and outreach support to over 12,000 (mostly volunteer) counselors in over 1,300 community-based organizations in all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. Under the direction and support of State program directors and trainers, SHIP counselors receive extensive training and continuous ongoing information updates about health plan options, Medicare entitlement and enrollment, Medigap, long-term care insurance, Medicare Part D prescription drug benefits, preventive benefits, and programs for beneficiaries with limited income and resources such as the Medicare Part D Extra Help/Low-Income Subsidy, the Medicare Savings Programs, and Medicaid.

SHIPs provide free, one-on-one counseling and assistance to help aging and disabled Medicare and Medicaid beneficiaries as well as coming-of-agers navigate the complexities of health and long-term care systems. Services are provided via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities. In FY 2010 SHIPs served 4.7 million clients. SHIP activities align with AoA's mission of developing a comprehensive, coordinated and cost-effective system of home and community-based services that helps elderly individuals and people with disabilities maintain their health and independence in their homes and communities.

The budget request would transfer the SHIP program from the Centers for Medicare and Medicaid Services to the Administration on Aging. This transfer reflects the natural synergies between the SHIP programs and the aging services network. About two-thirds of the 54 State SHIP programs are already administered by State Units on Aging, with most of the remaining programs administered by State Insurance Commissions. At the community level, many SHIPs are either housed in or create local partnerships with Area Agencies on Aging. Similarly, almost 50 percent of the SHIPs are co-located with the Senior Medicare Patrol program, which is also administered by AoA.

[61] Onboard staffing in FY 2013 is 10; FTE usage is half that amount reflecting the fact that staff will be brought on-board throughout the fiscal year.

SHIP activities complement programs authorized through the Older Americans Act, including but not limited to Information and Referral/Assistance (I&R/A), Aging and Disability Resource Centers (ADRCs), and Benefits Counseling. SHIPs also have a long history of outreach and assistance to underserved populations, including people with limited incomes, under-65 Medicare beneficiaries with disabilities, dual eligibles, and people with cognitive and/or mental disabilities.

Funding History:

Comparable funding for the State Health Insurance Assistance Program is as follows:

FY 2008 ..... $54,300,000
FY 2009 ..... $52,500,000
FY 2010 ..... $46,960,000
FY 2011 ..... $52,000,000
FY 2012 ..... $51,902,000

In addition, the following legislative action has taken place since FY 2008 which provided additional mandatory funding for the SHIPs:

- The Medicare, Medicaid, and SCHIP Extension Act of FY 2007 (MMSEA) provided the SHIPs with an additional $15.0 million in FY 2008.

- The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provided the SHIPs with an additional $7.5 million in FY 2009.

- The Affordable Care Act provides a total of $15 million to be distributed to states via formula grants in FY 2010 – FY 2012.

Budget Request and Anticipated Accomplishments:

The SHIP budget request for FY 2013 is $51,902,000, the same as the comparable FY 2012 enacted level. This includes funding for 10 staff (5 FTE) and related administrative expenses to administer the program.

Funds will be used to continue SHIP grants at current levels. This funding will allow States to continue the personalized counseling that they have been providing and to make further improvements to better streamline the program. Funds will also be used to provide administrative support for the SHIPs program.

The needs of the over 46 million Americans who depend on Medicare for their health care are multifaceted and diverse. More than one-quarter of beneficiaries have cognitive impairments; almost one-third have limitations in activities of daily living such as eating and dressing; almost one-third have not graduated from high school; and more than 1 in 10 are over 85 years of age. Yet these beneficiaries can face difficulties trying to navigate the health care system. Recent and upcoming changes in the system as a result of the Affordable Care Act (ACA) will provide

opportunities to beneficiaries for improved care, including increased Medicare preventive services. These opportunities will increase the responsibilities of the SHIP counselors in terms of training, outreach and one-on-one counseling. The counselor knowledge base will need to include the inter-relationship of Medicare, Early Retiree Insurance Program, Pre-Existing Condition Insurance Plan (PCIP), Medicare covered preventive benefits, state Medicaid programs, and planning for the State based Exchanges in addition to other long-term care support options that beneficiaries need to remain in the community.

Research has consistently found that Medicare beneficiaries prefer to receive information about Medicare and other supports through one-on-one assistance rather than through other means, such as written materials, mass media, and the internet. Given the large number and variety of private plan options available in the Medicare program and the new opportunities for beneficiaries through the ACA, the type of one-on-one beneficiary counseling and decisions support provided by SHIPs is an essential component to the information provided more generally through http://www.Medicare.gov and 1-800-MEDICARE. Due to AoA's unique connections to the aging services network as well as the greater efficiencies leveraged by a single point of management of these activities which are often co-located with ADRCs. Transferring the SHIPs program to AoA is a logical way to meet the needs of beneficiaries.

Outcomes and Outputs:

In grant year 2007, the total number of clients reached by SHIPs was 4.2 million. In grant year 2010, the number was 4.7 million. In FY 2009, the last year for which complete data is available, SHIPs reached over 4.7 million individuals through 54,656 public information and outreach events.

Funds will be used to make SHIP grants to States to continue the personalized counseling that they provide and to make further improvements, which are anticipated to include:

- Continuing the number of community outreach in public forums to include elderly, and pre-retirees to raise awareness of long-term care related topics including prevention and relevant ACA opportunities.
- Continuing the number of community outreach in public forums to include disabled to raise awareness of long-term care options.
- Continuing the number of individual client contacts to individuals on Medicare under the age of 65.
- Tracking the number of individual client contacts of pre-retirees.
- Continuing the number of local and field counselors (paid and unpaid).
- Continuing the number of individual personalized counseling sessions.

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Program Administration

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Program Administration.....	$19,939,000	$23,063,000	$23,259,000	+$196,000
Total, FTE 1/	112	107	107	--

1/ Overall FTE for AoA as a whole total 121 in FY 2011, 121 in FY 2012 and 135 in FY 2013. FTE numbers for Program Administration only reflect those FTE funded from the Program Administration budget line and FTE related to funding provided via Intra-Departmental Delegations of Authority (IDDA) and Interagency Agreements (IAA). Not included are reimbursable FTE supported with HCFAC funds (6.5 in FY 2011 and 8 in FY 2012 and FY 2013), FTE supported with mandatory funds (ADRCs and the National Clearinghouse on Long-Term Care Information (3 in FY 2011, 7 in FY 2012 and FY 2013), or FTE related to transferred or new programs (14 in FY 2013). These FTE are included in the appropriate narrative tables in other sections of this document.

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

FY 2013 Older Americans Act Authorization..... Expired

Allocation Method ..... Direct Federal/Contract

Program Description and Accomplishments:

Program Administration funds the direction of AoA programs established under the Older Americans Act (OAA), as well as the Alzheimer's Disease Supportive Services program and the Lifespan Respite Care program authorized respectively by Section 398 and Title XIX of the Public Health Services Act (PHSA). In addition, a very small portion of these funds will be used to oversee and to close-out activities originally funded under the American Recovery and Reinvestment Act (ARRA) of 2009.

Program Administration funding does not include resources necessary to carry out new programs that are proposed to come to AoA in FY 2013. Funding to support the 14 FTE and related administrative expenses for these programs is requested separately as part of each program's respective request. These new programs include the State Health Insurance Assistance Program (5 FTE), proposed for transfer to AoA from the Centers for Medicare and Medicaid Services; the Senior Community Service Employment Program (8 FTE), proposed for transfer from the Department of Labor; and the Adult Protective Services Demonstration program (1 FTE). Funding also does not include resources for 14 additional FTE that will continue to be charged to three existing mandatory programs: Aging and Disability Resource Centers (ADRC) funding (4 FTE), Health Care Fraud and Abuse (HCFAC) funding (8 FTE) and National Clearinghouse for Long-Term Care Information funding (2 FTE).

Funding History:

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

FY 2008	$18,064,000	99 FTE
FY 2009	$18,696,000	96 FTE
FY 2010	$19,976,000	93 FTE
FY 2011	$19,939,000	112 FTE
FY 2012	$23,063,000	107 FTE

FTE numbers exclude FTE paid for with HCFAC funds and with direct mandatory appropriations.

Budget Request:

The FY 2013 request for Program Administration is $23,259,000, a net increase of $196,000. This request will support the same level of FTE as were supported with these funds in FY 2012. Additional funds will be used to address costs related to AoA's Headquarters move as a result of the expiration of its current lease. None of these additional funds will be used for additional staffing needs or to meet the proposed 0.5% pay raise, which will be absorbed through offsetting reductions in contracts and related areas.

AoA Headquarters Lease Renewal Process

The ten year lease on AoA's Central Office space ends on September 30, 2012 and AoA has been working with the HHS Office for Facilities Management and Policy (OFMP) to determine how to move forward. Because the Department of Health and Human Services had a surplus of leased space relative to its needs, AoA worked with OFMP on assuming space under an existing HHS lease that would be available after October 2012.

The proposed space is currently being leased by the Office of the Assistant Secretary for Preparedness and Response (ASPR) which is scheduled to vacate in the fall of 2012. After ASPR completes its relocation, AoA would begin its renovation of the space to meet its own needs. Renovations would probably continue into 2013, with AoA able to assume occupancy no earlier than the spring of 2013, with the summer or fall of 2013 a more likely scenario.

Because the new space is not expected to be available until at least the Spring of 2013, AoA will need to extend its current lease. GSA recently negotiated the necessary lease extension, which due to changes in the real estate market is significantly higher for the period of the extension than the rent that AoA has been paying for the last 10 years. AoA expects to incur additional rental costs of approximately $85,677 more per month for each month that we remain in our current location after September 2012. In addition, AoA must also pay rent on two locations concurrently during the period that the new space is being renovated but AoA is unable to occupy. This rent on the new facility is estimated at $141,605 monthly, plus tax escalation.

Together, these rent increases are projected to total $2,331,000 in FY 2013. The FY 2012 appropriation included an increase of $2,167,500 to cover the estimated costs of payments to GSA related to AoA's planned Headquarters's relocation. This amount, which remains in the Program Administration base request for FY 2013, will be combined in FY 2013 with the $196,000 net increase over FY 2012, for a total of $2,363,500, and used in FY 2013 to pay projected rent over and above the rent that is currently budgeted for in the base. The remaining balance of $32,500 will be retained and used to offset tax escalation costs on the current facility.

Remaining relocation costs are currently estimated to total approximately $3,000,000 to cover procurement of systems furniture and IT, the physical move and to surplus outdated furniture at the current location have been included in a consolidated FY 2013 Departmental request for the Public Health and Social Services Emergency Fund associated with procuring new long term leases centrally. This estimate may be updated. AoA will continue to work closely with OFMP staff to refine our schedule and milestones and ensure that cost estimates are sufficient to cover all costs associated with the lease renewal, including build-out, moving, and rent.

Performance Measures

Improving program efficiency, improving client outcomes, and effective targeting of services to vulnerable elders are the three performance measures used to assess the performance of the AoA's Aging Services programs as a whole. Program Administration is not directly measured by AoA's performance indicators, nor by specific outcomes, and it does not have specific output measures. Rather, the program provides the administrative resources that enable AoA to carry out its programmatic activities and achieve its performance goals.

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Prevention and Public Health Fund

Chronic Disease Self-Management Programs

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Request	FY 2013 +/- FY 2012
Chronic Disease Self-Management Programs from Prevention and Public Health Fund	1/	$10,000,000	$10,000,000	+$10,000,000

1/ Funding totaling $32.5 million was provided under the American Recovery and Reinvestment Act (ARRA) to cover FY 2010 - FY 2011. No funding was provided from AoA's base funding for these years.

Authorizing Legislation: Sections 311 and 317(k)(2) of the Public Health Service Act, [42 U.S.C. Sections 243 and 247b(k)(2)] as amended, and the Patient Protection and Affordable Care Act (ACA), Section 4002 [42 U.S.C. 300u-11]

FY 2013 Public Health Service Act Authorization..... Expired

Allocation Method ..... Competitive Grants/Co-operative Agreements and Contracts

Intended Recipients…….States

Program Description and Accomplishments

The Chronic Disease Self-Management Program (CDSMP) is a low-cost evidence-based disease prevention model that uses state-of-the-art techniques to help those with chronic disease address issues related to the management and treatment of their condition, improve their health status, and reduce their need for more costly medical care.

Data show that as an individual's number of chronic conditions increases, there is a corresponding escalation in adverse outcomes including mortality, poor functional status, unnecessary hospitalizations, adverse drug events, duplicative tests, and conflicting medical advice, all of which lead to higher health costs and greater outlays for programs like Medicare and Medicaid. CDSMP has been shown repeatedly, through multiple studies (including randomized control experiments, with both English and Spanish speaking populations) to be effective at helping participants to adopt healthy behaviors, improve their health status and reduce their use of hospital stays and emergency room visits. Studies indicate that the program significantly improves participant health status, reduces the use of hospital care and physician services[62], and reduces health care costs.

[62] Sobel, DS, Lorig,KR, Hobbs,M. Chronic Disease Self-Management Program: From Development to Dissemination. *Permanente Journal*; Spring 2002.

CDSMP emphasizes an individual's role in managing his/her illness. The program consists of a series of workshops that are conducted once a week for two and a half hours over six weeks in community settings such as churches, libraries, YW/MCAs, senior centers, public housing projects, community health centers and cooperative extension programs. People with different chronic health problems attend together, and the workshops are facilitated by two leaders who are certified trainers. One or both of the leaders are non-health professionals or lay people with chronic diseases themselves. Topics covered include: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation; 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance; 3) appropriate use of medications; 4) communicating effectively with health professionals; and 5) nutrition.

Funding for CDSMP is awarded in the form of competitive grants to states. Grantees are required to provide a match equal to 25 percent of the project's total cost. External experts review project proposals, and project awards are made for periods of one to three years. In FY 2010 AoA funded 47 State grants for CDSMPs, with an average award of $574,468, using funding provided under the Recovery Act. AoA also funded a Technical Assistance Resource Center through a grant to the National Council on Aging. Competitive grants and contracts are also used to support evaluation and technical assistance activities.

Through these grants, as of January 31, 2012, 61,902 people had completed CDSMP courses across the country, well ahead of the programmatic goal to reach 50,000 completers within two years from the award date.

Funding History

Stand-alone funding for the nationwide deployment of CDSMP through the aging services network was requested for the first time in FY 2012 and provided from the Prevention and Public Health Fund.[63] Since FY 2011 no funding has been provided from AoA's base budget for this activity. In FY 2010, $30 million in Recovery Act funding was provided in coordination with the Centers for Disease Control and Prevention as part of its Recovery Act funding. An additional $2.5 million was also transferred from CDC to CMS for related evaluation and quality improvement purposes.

Budget Request

AoA requests FY 2013 funding totaling $10,000,000 for CDSMP from the Prevention and Public Health Fund, the same as the FY 2012 enacted level. The Prevention and Public Health Fund (Section 4002) is designed to target resources to activities that invest in prevention and public health programs to improve our nation's health while also restraining the rate of growth in public and private sector health care costs. CDSMP, by emphasizing an individual's role in managing his/her illness, helps participants to adopt healthy behaviors, improve their health status and reduce their use of hospital stays and emergency room visits. Studies noted above (footnote 65) indicate that the program significantly improves participant health status, reduces the use of

[63] Evidence-Based Programs including the Chronic Disease Self Management Program, together with Long-Term Care Programs (ADRCs and Community Living Programs) were funded in earlier years as subactivities that were part at one time or another of Aging Network Support and of Program Innovations.

hospital care and physician services, and reduces health care costs. This continued investment of resources will allow AoA, in coordination with its existing HHS partners and private philanthropy, to continue to build on past investments in CDSMP and on AoA's existing service delivery infrastructure as it pursues its goal of taking CDSMP to scale nationwide.

Older Americans are disproportionately affected by a vast array of chronic diseases and conditions. Over 80 percent of adults 65 and over have at least one chronic condition, and roughly half suffer from two.[64] Nearly half of older adults have hypertension and roughly one in five has heart disease, with a similar proportion having some type of cancer.[65] The average 75-year old has three chronic conditions and takes 4.5 medications.[66] More than 65 percent of Americans aged 65 and over have some form of cardiovascular disease. One million adults age 75+ have diabetes, a number that is expected to grow to 4 million by 2050 if nothing changes current growth rates.[67] Minority elders – the fastest growing segment of the elderly population – are especially at risk of chronic illnesses and conditions. For example, among adults age 65+, 65% of African-Americans had hypertension, compared to 47% of Whites; and 25% of Hispanics have diabetes, compared to 14% of Whites.

CDSMP serves this population and is especially well suited for delivery through AoA's network of community based organizations, including senior centers, congregate meal programs, faith-based organizations and senior housing projects. At the community level, aging services provider organizations work in collaboration with public health agencies and health care providers. Participant referrals to the CDSMP program come from both clinical and community-based organizations. Clinical referrals come from community-health centers, physicians, hospitals, managed care organizations, and other health system components. Community referrals come from a variety of sources, including the Aging and Disability Resources Centers. ADRCs serve as community-level "one stop shop" entry points into long-term care for people of all ages who have chronic conditions. Funds will support competitive grants to States, as well as related technical assistance and evaluation activities such as:

- A proposed interagency agreement with the CMS Center for Strategic Planning to evaluate the impact of CDSMP on participant health care utilization and cost by linking Medicare claims data to CDSMP Medicare participants (both elderly and younger people with disabilities);

- A survey of participants (pre- and post) to evaluate the impact of CDSMP on behaviors, health status, and quality of life; and

- Continued funding for a National Technical Assistance Center on Evidence-Based Prevention Programs.

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[64] NCCDPHP. Healthy Aging: Preventing Disease and Improving Quality of Life Among Older Americans. Available at http://www.cdc.gov/nccdphp/aag/aag_aging.htm. Accessed September 14, 2004.
[65] Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, National Health Interview Survey, 2000-2001.
[66] Alliance for Aging Research. Ten Reasons Why America Is Not Ready for the Coming Aging Boom. 2002.
[67] NCCDPHP. Available at http://www.cdc.gov/nccdphp/bb_aging/index.htm. Accessed September 14, 2004.

Accountability and quality assurance will include tracking a combination of inputs and outputs. AoA will track via State reports the number of programs being conducted and the number of participants completing the program. Participant surveys (pre and post) will be used to track self-reported behavioral change and health status. AoA and CMS will establish protocols and mechanisms to track CDSMP participants' Medicare claims data to assess the impact of CDSMP on health care utilization.

AoA will continue to monitor the performance of the CDSMP with the output measure that was provided in both the FY 2009 and FY 2010 budget submissions

Outputs and Outcomes Table

Indicator	Most Recent Result	FY 2012 Projection	FY 2013 Projection	FY 2013 +/- FY 2011
Output CD1: Total number of individuals with chronic conditions completing the CDSMP program *(Output)*	FY 2009: 8,426	20,000	20,000	Maintain
Output CD2: Percentage of individuals that report 1 or more health benefits (e.g. improved health status, increased physical activity, less fatigue, greater mobility, etc.) after completing the CDSMP program *(Outcome)*	N/A	Baseline	TBD	TBD

Evaluation

In its initial evaluation design work, AoA partnered with the Agency for Healthcare Research and Quality and the Assistant Secretary for Planning and Evaluation to determine the most promising approach for rigorously evaluating the effectiveness of employing CDSMPs in the Aging Services Network. In FY 2010, AoA initiated a design contract for recommendations on how to best carry-out an evaluation. The evaluation design recommendations were completed in the Spring of 2011. Using the recommendations as a foundation, AoA awarded a contract in Fall of 2011 for the conduct of a process evaluation and a more detailed outcome evaluation design. It is anticipated that the outcome evaluation would use a randomized control trial design. The process evaluation, including time for OMB Paperwork Reduction Act clearance, is expected to be completed during the summer of 2013. AoA is coordinating its efforts with CMS to ensure that the data collected measure concepts important to both agencies. The results of an evaluation would influence future performance measures and indicators of the program.

Administration on Aging
BA by Object Class

	2012 Enacted	2013 President's Budget	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	13,729	13,887	158
Other than full-time permanent (11.3)	325	328	3
Other personnel compensation (11.5)	141	142	2
Military personnel (11.7)	-	-	-
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**14,195**	**14,357**	**163**
Civilian benefits (12.1)	3,727	3,770	43
Military benefits (12.2)	-	-	-
Benefits to former personnel (13.0)	-	-	-
Total Pay Costs	**17,922**	**18,128**	**206**
Travel and transportation of persons (21.0)	750	750	-
Transportation of things (22.0)	11	11	-
Rental payments to GSA (23.1)	1,501	3,893	2,392
Communication, utilities, and misc. charges (23.3)	670	641	(29)
Printing and reproduction (24.0)	29	33	4
Other Contractual Services:			
Advisory and assistance services (25.1)	9,839	9,574	(265)
Other services (25.2)	57	57	-
Purchase of goods and services from government accounts (25.3)	8,372	5,602	(2,769)
Operation and maintenance of facilities (25.4)	1	1	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	67	67	-
Subsistence and support of persons (25.8)	-	-	-
Subtotal Other Contractual Services	**18,336**	**15,301**	**(3,034)**
Supplies and materials (26.0)	78	75	(3)
Equipment (31.0)	80	82	2
Land and Structures (32.0)	-	-	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	1,931,908	1,939,422	7,514
Interest and dividends (43.0)	-	-	-
Refunds (44.0)	-	-	-
Total Non-Pay Costs	**1,953,362**	**1,960,208**	**6,846**
Total Budget Authority by Object Class	**1,971,284**	**1,978,336**	**7,052**

Administration on Aging
Salaries and Expenses

	2012 Enacted	2013 President's Budget	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	13,729	13,887	158
Other than full-time permanent (11.3)	325	328	3
Other personnel compensation (11.5)	141	142	2
Military personnel (11.7)	-	-	-
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**14,195**	**14,357**	**163**
Civilian benefits (12.1)	3,727	3,770	43
Military benefits (12.2)	-	-	-
Benefits to former personnel (13.0)	-	-	-
Total Pay Costs	**17,922**	**18,128**	**206**
Travel and transportation of persons (21.0)	750	750	-
Transportation of things (22.0)	11	11	-
Rental Payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	670	641	(29)
Printing and reproduction (24.0)	29	33	4
	-	-	-
Other Contractual Services:	-	-	-
Advisory and assistance services (25.1)	9,839	9,574	(265)
Other services (25.2)	57	57	-
Purchase of goods and services from government accounts (25.3)	8,372	5,602	(2,769)
Operation and maintenance of facilities (25.4)	1	1	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	67	67	-
Subsistence and support of persons (25.8)	-	-	-
Subtotal Other Contractual Services	**18,336**	**15,301**	**(3,034)**
Supplies and materials (26.0)	78	75	(3)
Total Non-Pay Costs	**19,874**	**16,811**	**(3,062)**
Total Salary and Expense	**37,796**	**34,939**	**(2,857)**
Direct FTE (Discretionary) 1/	**119**	**120**	**1**

1/ Total FTE for AoA equal 121 in FY 2012 and 135 in FY 2013. The table above excludes 8 reimbursable FTE for HCFAC and 7 mandatory FTE for ADRCs and the National Clearinghouse on Long-Term Care in each of FY 2012 and FY 2013. Exact FTE usage for SHIPs and SCSEP by CMS and the Department of Labor are not known for FY 2012; therefore, the projected usage of 5 and 8 FTE respectively has been added to the totals in FY 2012 for purposes of comparability.

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Administration on Aging

Detail of FTE

	2011 Actual Civilian 1/	2011 Actual Military	2011 Actual Total	2012 Est. Civilian 1/	2012 Est. Military	2012 Est. Total	2013 Est. Civilian 2/	2013 Est. Military	2013 Est. Total
Immediate Office of the									
Assistant Secretary.....									
Direct:.....	25		25	14		14	13		13
Reimbursable:.....			0			0			0
Total:.....	25	0	25	14	0	14	13	0	13
Center for Management and									
Budget.....									
Direct:.....	20		20	25		25	27		27
Reimbursable:.....			0			0			0
Total:.....	20	0	20	25	0	25	27	0	27
Center for Policy, Planning									
and Evaluation 4/.....									
Direct:.....	23		23	24		24	26		26
Reimbursable:.....			0			0			0
Total:.....	23	0	23	24	0	24	26	0	26
Center for Program Operations.....									
Direct:.....	20		20	22		22	26		26
Reimbursable 3/:.....	2		2	3		3	3		3
Total:.....	22	0	22	25	0	25	29	0	29
Office of Regional Operations.....									
Direct:.....	26		26	28		28	35		35
Reimbursable 3/:.....	5		5	5		5	5		5
Total:.....	31	0	31	33	0	33	40	0	40
OPDIV FTE Total.....	**121**	**0**	**121**	**121**	**0**	**121**	**135**	**0**	**135**

	Average GS Grade
FY 2008	12.9
FY 2009	13.0
FY 2010	12.8
FY 2011	12.8
FY 2012	12.8

1/ FY 2011 and FY 2012 do not include FTE for either the State Health Insurance Assistance Program (SHIPs) or the Senior Community Service Employment Program (SCSEP) which are proposed for transfer to AoA. These figures are not currently available as regional staff work on these and multiple other programs.

2/ In FY 2013, FTE for SHIPs and for SCSEP have been annualized, to reflect the fact that not all of these staff will be on board at the beginning of the year. As a result, while AoA anticipates filling 10 positions for SHIPs and 16 positions for SCSEP in FY 2012, only 5 FTE and 8 FTE respectively are included in the FTE breakdown above.

3/ Reimbursable funding reflects FTE paid for with HCFAC funds.

4/ Includes FTE paid for with Mandatory funding.

Administration on Aging

Detail of Positions

	2011 Actual 1/	2012 1/	2013 Estimate
Executive level I			
Executive level II			
Executive level III			
Executive level IV	1	1	1
Executive level V			
Subtotal	1	1	1
Total - Exec. Level Salaries 2/	$196,136	$190,360	$191,074
ES-0	3	3	3
Subtotal	3	3	3
Total - ES Salary 2/	$609,600	$596,700	$596,700
GS-15	19	22	22
GS-14	19	20	22
GS-13	42	46	67
GS-12	8	7	9
GS-11	8	7	9
GS-10	2	2	2
GS-9	9	9	9
GS-8	0	0	0
GS-7	2	2	2
GS-6	1	1	1
GS-5	0	0	0
GS-4	0	0	0
GS-3	0	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal 2/	110	116	143
Total - GS Salary			
Average ES level	0	0	0
Average ES salary/benefits	$203,200	$198,900	$198,900
Average GS grade	12.8	12.8	12.8
Average GS salary/benefits	131,804	129,300	130,200

1/ Comparable numbers are not available in FY 2011 and FY 2012 for the two programs proposed for transfer to AoA in FY 2013, the State Health Insurance Assistance Program (SHIPs) or the Senior Community Service Employment Program (SCSEP).

2/ Excludes 17 positions related to the CLASS Program in FY 2011.

Administration on Aging

Programs Proposed for Elimination

No programs are proposed for elimination in FY 2013.

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Significant Items in House and Senate Appropriations Committee Reports

FY 2012 Senate Appropriations Committee Report Language (Senate Report 112-84)

Item

Elder Falls Prevention **-** The Committee recommends that $7,000,000 in mandatory funding be transferred from the PPH Fund for elder falls prevention activities at AoA, in coordination with CDC. This is a new activity that was not funded in fiscal year 2011. The administration did not request funding. The Committee notes that falls are the leading cause of fatal and nonfatal injuries for those 65 and older. Among older adults who sustain hip fractures in falls, 25 percent remain institutionalized for at least 1 year and 50 percent cannot return home or live independently. The Committee intends that funds provided to AoA should be used for public education about the risk of these falls, as well as implementation and dissemination of community-based strategies that have been proven to reduce the incidence of falls among seniors.

Action taken or to be taken

No funding was provided by the Congress for this activity. However, AoA has recognized for some time that Elder Falls Prevention is one of many evidence-based approaches with the potential to make positive differences in outcomes for seniors. AoA will continue to encourage States to look at this approach in conjunction with available Preventive Health funds which beginning in FY 2012 must be spent on evidence-based activities similar to a discretionary funding opportunity AoA made available in 2006.

During 2006-2007, AoA initiated its state-based Evidence-Based Disease and Disability Prevention Program. Through both public and private partnerships, 27 states have deployed evidence-based interventions whose primary focus is to help enable adults to maintain their health, wellness, and independence. AoA required each state to implement the Stanford University Chronic Disease Self-Management Program (CDSMP). In addition, each state participating in this grant program was required to select and implement one or more other evidence-based programs, including Falls Management programs such as Matter of Balance, which addresses fear of falling, and Stepping On and Tai Chi, which build muscle strength and improve balance to prevent falls.

Since 2004 AoA and CDC have partnered on three activities related to older adult falls:

- Supporting a collaborative initiative by the National Council on Aging (NCOA), the Archstone Foundation, the Home Safety Council, and other partners to address the growing problem of falls and fall-related injuries among adults aged 65 years and older. The Falls Free Coalition, formed in 2004 as a result of this initiative, includes more than 55 organizations and employs a collective approach to promoting a national fall prevention action plan.

- Assessing the long-term impact of *Matter of Balance*, a program designed to reduce fear of falling, increase self efficacy and a sense of control in relation to fall risk, and increase physical and social activity.
- Estimating the average program implementation and maintenance costs and comparing these costs across three AoA-funded fall prevention programs: *Matter of Balance*, *Tai Chi: Moving for Better Balance*, and *Stepping On*.

Finally, AoA will continue to coordinate with the Centers for Disease Control and Prevention around efforts like CDC's Unintentional Injury Program.

Item

Older Adults and Mental Health - The Committee urges AoA to expand its efforts to address the mental and behavioral health needs of older adults, including an emphasis on mental health screening, treatment services for older individuals and programs to increase public awareness and reduce the stigma associated with mental disorders in older individuals. The Committee is pleased with AoA efforts to implement the mental and behavioral health aspects of the Older American Act Amendments of 2006 and continues to urge AoA to designate an officer to focus on the mental health needs of older Americans. Within funding for Program Innovations, the Committee has provided $1,000,000 to continue the 24-hour call center that provides Alzheimer family caregivers with professional care consultation and crisis intervention.

Action taken or to be taken

The Administration on Aging (AoA) is an active partner with the Substance Abuse and Mental Health Services Administration (SAMHSA) on a variety of initiatives. AoA and SAMHSA entered into a Memorandum of Understanding in FY 2011 to formally collaborate on the Older Adult Targeted Capacity Expansion (TCE) Grant Program. Five grants were awarded to community organizations to provide services for older adults through aging-mental health partnerships. An Older Adults Technical Assistance Center was also established to provide assistance to the TCE grantees, State Units on Aging, Area Agencies on Aging, and other community aging and mental health providers to assist them in developing, implementing and sustaining effective mental health programs for older adults. Mental health screening, treatment services for older individuals and increasing public awareness and reducing the stigma associated with mental disorders in older individuals will be key components of the work of the grantees and the Center. AoA and SAMHSA will continue to collaborate on technical assistance activities for this program. In addition, AoA and SAMHSA have made two joint presentations at national conferences regarding older adults mental health programs.

AoA also participates in mental-health related workgroups and committees both inside and outside the Department of Health and Human Services (DHHS), including: the Federal Workgroup on Suicide Prevention; the Federal Mental Health Coalition; the Action Alliance for Suicide Prevention and its Clinical Care Workgroup; and the HHS Behavioral Health Coordinating Council and its Prescription Drug Abuse sub-committee. An Aging Services Program Specialist, with extensive knowledge in the prevention and treatment of mental health issues among older adults, has been designated to provide guidance both within and outside AoA, on behavioral health program and policy development. AoA also commissioned a study in FY2011 through the National Council on Aging's Center for Health Aging entitled "*Advancing*

Older Adult Mental Health: Lessons Learned from Partnerships between State Units on Aging and State Mental health Authorities". The purpose of this study was to learn from the experiences of five strong state partnerships that have increased or improved access to evidence-based or evidence-informed (EB/EI) interventions shown to improve the health of older adults and adults with/or at risk of mental health or substance use disorders. The results of this study will help inform AoA program and policy development in the area of mental health.

Through its health programs, AoA has also encouraged States and Area Agencies on Aging to use evidence-based programs designed to reduce reduce/prevent depression and improve quality of life in older adults including Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) and PEARLS (Program to Encourage Rewarding Lives for Seniors. State plan guidance developed by AoA for FY 2012, similar to past guidance, will direct States and Area Agencies on Aging to implement the provisions related to mental and behavioral health that were signed into law as part of the Older Americans Act Amendments of 2006.

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FY 2013 HHS Enterprise Information Technology and Government-Wide E-Gov Initiatives

OPDIV Allocation Statement:

The **AoA** will use **$152,377.00** of its **FY 2013** budget to support Department-wide enterprise information technology and government-wide E-Government initiatives. Operating Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, **$38,618.00** is allocated to developmental government-wide E-Government initiatives for **FY 2013**. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Developmental E-Gov Initiatives*	
Line of Business - Human Resources	$207.00
Line of Business - Grants Management	$1,374.00
Line of Business - Financial	$6,021.00
Line of Business - Budget Formulation and Execution	$4,421.00
Disaster Assistance Improvement Plan	$1,356.00
Federal Health Architecture (FHA)	$0.00
Integrated Acquisition Environment- Grants and Loans	$25,239.00
Line of Business - Geospatial	$0.00
FY 2013 Developmental E-Gov Initiatives Total	**$38,618.00**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from these initiatives are:

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital.

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. The Administration for Children and Families (ACF), is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead

costs for internal HHS users. Additionally, NIH is an internally HHS-designated Center of Excellence. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

In addition, **$113,759.00** is allocated to ongoing government-wide E-Government initiatives for **FY 2013**. This amount supports these government-wide E-Government initiatives as follows:

FY 2013 Ongoing E-Gov Initiatives*	
E-Rule Making	$2,978.00
Integrated Acquisition Environment	$4,105.00
GovBenefits	$4,149.00
Grants.gov	$102,527.00
FY 2013 Ongoing E-Gov Initiatives Total	**$113,759.00**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.