

February 1992

ADMINISTRATION ON AGING

Harmonizing Growing Demands and Shrinking Resources



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Program Evaluation and
Methodology Division

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February 12, 1992

The Honorable Brock Adams, Chairman
Subcommittee on Aging
Committee on Labor and Human Resources
United States Senate

The Honorable David Pryor, Chairman
The Honorable William S. Cohen, Ranking Minority Member
Special Committee on Aging
United States Senate

The Honorable Edward R. Roybal, Chairman
The Honorable Matthew J. Rinaldo, Ranking Minority Member
Select Committee on Aging
House of Representatives

The Honorable Thomas J. Downey, Chairman
The Honorable Olympia J. Snowe, Ranking Minority Member
Subcommittee on Human Services
Select Committee on Aging
House of Representatives

The Honorable Matthew G. Martinez, Chairman
Subcommittee on Human Resources
Committee on Education and Labor
House of Representatives

This report contains testimony presented to the Subcommittee on Human Services of the House Select Committee on Aging on June 12, 1991. (See appendix I.) We are publishing the statement as a report to make the information more widely available. The testimony responds to your request for information on the Administration on Aging (AOA), including the match between its resources and its mission and services.

As mandated by the Older Americans Act, AOA helps meet the special needs of the elderly by providing them with a wide array of social and nutritional services. The provision of these services has become increasingly important in light of the fact that the U.S. elderly population has increased by nearly 65 percent since the passage of the act in 1965. To meet the challenges of this rapidly growing population, the mission of AOA has been continually expanded to provide more programs and services, engage in

more extensive federal coordination, and conduct more program evaluation.

Over the last decade, however, the ability of AOA to perform these functions has been hampered by fiscal constraints. During the 1980's, AOA experienced a significant decline in inflation-adjusted program funds, staffing, and travel funds. As a result, new programs and mandates are unfunded, key leadership positions are vacant, and the monitoring capabilities of AOA are in question.

One area in particular in which there are deficiencies is the provision of technical assistance. AOA, through its regional offices, is mandated to provide technical assistance to state agencies on aging with respect to programs and services funded under the Older Americans Act. We found, however, that AOA's ability to provide such assistance is hindered by its staffing and travel constraints. As a result, as officials from many state

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Abbreviations

ADL	Activity of daily living
AOA	Administration on Aging
GAO	U.S. General Accounting Office

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It is a pleasure to be here to share with you the results of our work regarding Administration on Aging (AOA) programs and services. In our testimony today, we will present information on (1) the match between AOA's resources, on the one hand, and its mandated mission and services, on the other; (2) how AOA provides technical assistance and oversight to state units on aging; and (3) whether the technical assistance provided by AOA meets the needs of state units on aging.

Background

As you know, the Older Americans Act of 1965 was created during a time of rising societal concern for the needs of the elderly. It was the first major federal legislation to organize and deliver community-based social services to older persons. Its enactment marked the beginning of a variety of programs specifically designed to meet the special needs of our nation's elderly (that is, persons aged 60 and over).

When the Older Americans Act was passed in 1965, there were 26 million Americans aged 60 or older, representing about 13 percent of the population. By 1990, the number of such persons had grown to 42.3 million, about 17 percent of the total U.S. population. An estimated 83 million people will be 60 or over by the year 2030, and they will then represent nearly 28 percent of the population.

This growing population of elderly Americans has a lower economic status than other adults in our society. About 18 percent of the elderly population (7.1 million persons) were poor or nearly poor in 1989—that is, they had incomes below 125 percent of the poverty level—compared to about 14 percent of Americans between the ages of 18 and 59. Although federal programs are in place to provide a measure of economic security to the elderly (for example, Supplemental Security Income, Food Stamps, and Medicaid), budget constraints and other factors, such as inadequate benefit levels, stringent eligibility criteria, and low participation rates, have reduced their effectiveness.

While the overall level of poverty among persons 60 and over is high, it is especially pronounced for the minority elderly. In 1989, approximately one in every three elderly blacks (1 million individuals) and one in every five elderly Hispanics (318,000 individuals) were poor—compared to one of every ten elderly whites (3.2 million individuals). Furthermore, despite their considerable need, many minority elderly do not receive adequate services because of problems such as cultural barriers and a lack of awareness that services are available.

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Moreover, many of the elderly suffer from chronic health problems. Although such problems can occur at any time of life, their incidence—particularly of those chronic conditions that eventually result in disability—increases with age. According to the 1987 National Medical Expenditure Survey, about 11 percent of persons aged 65 to 74 living in the community have some limitation for which they need assistance; this figure climbs to 57 percent among those aged 85 or older. However, the presence of a chronic illness or condition in itself does not necessarily result in a need for long-term care, and most older persons are able to live independently in spite of these conditions. It is when these chronic conditions manifest themselves as limitations on “activities of daily living” (for example, bathing and dressing) or on “instrumental activities of daily living” (for example, shopping and preparing meals) that assistance may be required.

Such assistance may be given in institutions (for example, nursing homes) or in the community, including the older person’s own home. For every person aged 65 and older residing in a nursing home, there are nearly twice as many living in the community who require some form of long-term care. According to a Brookings Institution report, there were approximately 4.9 million noninstitutionalized elderly persons residing in the community in 1985 (18 percent of the population over age 65) who had limitations in activities of daily living (ADLs). About two thirds of these elderly persons had only moderate impairments—that is, fewer than three ADL limitations. However, some 850,000 elderly individuals with severe limitations (five or six ADLs) were also residing in the community.¹

These are some of the conditions that affect those served by programs authorized under the Older Americans Act. The act is intended to improve the lives of all older Americans in a variety of areas, including income, acute health care, nutrition, employment, and long-term care. Over the years, the essential mission of the Older Americans Act has remained very much the same: to foster maximum independence by providing a wide array of social and community services to those older persons in the greatest economic and social need, including low-income minorities.

Today, the programs under the act provide the major vehicle and only national network for the organization and delivery of social, nutritional, and other supportive services to older persons. This “aging network” consists of the Administration on Aging and its 10 regional offices, 57 state

¹A.M. Rivlin and J.M. Wiener, *Caring for the Disabled Elderly: Who Will Pay?* (Washington, D.C.: The Brookings Institution, 1988), p.6.

units on aging (including territories), 670 area agencies on aging, and nearly 25,000 local service providers throughout the nation. Millions of older citizens benefit directly from the services provided through the Older Americans Act, and millions more benefit indirectly as a result of a more informed public.

The Match Between AOA's Mission and Resources

The Older Americans Act exemplifies the kind of public policy that provides socially beneficial services to a population in need—in this case, a rapidly growing population. However, there is concern among many advocates for the elderly that the mission of AOA, as mandated under the Older Americans Act, has grown without a commensurate growth in resources to carry out that mission.

In order to understand the nature and the scope of the mission of AOA and the resources allocated to carry it out, we examined several sources of information. First, we reviewed and compared the original legislation of 1965 with the current law, documenting changes in the mandates imposed on AOA. Second, we examined budget documents and other administrative records. Third, we interviewed officials of AOA and other federal agencies, state units and area agencies on aging, national organizations (such as the American Association of Retired Persons, the National Association of State Units on Aging, the National Association of Area Agencies on Aging, the National Caucus and Center on the Black Aged, and the National Council on Aging), and experts from the academic community on the agency's mission and resources.

AOA's Mission

AOA's mission has been expanded significantly since the Older Americans Act was first passed in 1965. As stated in the congressional declaration of objectives, the act was aimed at improving the lives of all older Americans (that is, persons 60 years of age or older) in such areas as income, health, housing, employment, community services, and gerontological research and education. Subsequent legislation has added four additional objectives. These are (1) to make available comprehensive programs, including supportive services and services in the area of health and education; (2) to give special consideration to elderly people with special needs and poor elderly people when planning and making available such comprehensive programs; (3) to assure the coordinated delivery of essential services to the elderly and, where applicable, provide employment opportunities for many individuals, including the elderly; and (4) to ensure that the planning and operation of these programs are a partnership among older people,

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state and local government, the community, and the federal government (when necessary).

As the number of objectives has grown, so has the number of functions assigned to AOA. The original legislation mandated 8 functions for AOA; subsequent legislative changes have significantly increased the number of responsibilities to 24, including the functions of serving as the effective and visible advocate for the elderly within the Department of Health and Human Services and with other federal agencies and departments, reviewing and commenting on federal policies affecting the aged or aging, and coordinating and assisting public and private entities in the planning and implementation of programs for older individuals—all of this with a view to establishing a nationwide network of comprehensive and coordinated programs for older individuals. While some of the amendments clearly establish new responsibilities, other amendments seem to clarify responsibilities that might have been performed under the original legislation had it been given a broad interpretation. Many of these functions require substantial administrative resources and support. For example, to be an effective and visible advocate for the elderly, the Commissioner on Aging should have sufficient administrative support in the areas of legislative and public affairs.

In addition to the functions assigned to AOA, the Older Americans Act assigns functions to the Commissioner on Aging, as the head of AOA. Among the functions assigned to the Commissioner were to administer the grant programs and approve state plans that comply with the requirements imposed by the act.

Subsequent legislation substantially increased the functions of the Commissioner. In analyzing the current legislation, we found that the number of these functions has more than quadrupled. Many of the new functions require substantial administrative resources. We grouped the new functions into three specific categories: "consultation and coordination," "evaluation," and "reporting." New reporting requirements constitute the greatest number of responsibilities added since 1965.

When the act was originally passed in 1965, the Secretary was authorized to carry out community planning and coordination of services, demonstration programs, and the training of personnel in gerontology. Subsequent legislation has greatly expanded programs under the act to include separate authorizations for supportive services (for example, senior centers, transportation, outreach, information and referral, in-home services, and

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legal assistance); nutrition services (for example, congregate and home-delivered meals); in-home services for the frail elderly; health education and promotion services; elder abuse prevention services; long-term care ombudsman services; and outreach activities to persons who may be eligible for assistance under the Supplemental Security Income, Medicaid, and Food Stamp programs. All of these programs require staff expertise and leadership at the national level.

At the same time that AOA's mandated objectives, functions, and programs designed to serve all older Americans have broadened over the years, its mandate to target certain elderly populations has become more precisely focused. For instance, since 1984, the Older Americans Act has mandated that in the provision of services preference should be given to older individuals with the greatest economic and social needs, with particular attention to low-income minority individuals. This means that while AOA must widen its efforts to meet the needs of all older Americans (as required by its mandate, which has grown over the years), it must simultaneously attempt to target the special needs of a certain population of elderly.

Some of the amendments to the Older Americans Act clearly establish new responsibilities for AOA or the Commissioner on Aging. For example, the Commissioner must now advocate, coordinate, evaluate, and report on programs and services for special populations through the new Office of the Associate Commissioner on Native American, Native Alaskan, and Native Hawaiian Aging. Other amendments seem to make clearer some of the responsibilities that might have been included in the language of the original legislation if the original legislation had been given a broad interpretation. For instance, the original legislation mandated that the Commissioner provide technical assistance and consultation to the state units and area agencies on aging with respect to programs dealing with the elderly. Subsequently, the Congress directed the Commissioner to assist in the establishment and implementation of programs designed to meet the needs of older individuals for supportive services. Such legislation might have been included within the act's original language, if broadly interpreted, but is now more clearly specified.

In summary, the mission of AOA has increased substantially since its passage in 1965. As a consequence, AOA's administrative and programmatic responsibilities have increased substantially as well.

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AOA's Resources

As noted above, the Congress has significantly expanded the scope of the Older Americans Act programs and services, as well as the role and responsibilities of the office of the Commissioner on Aging. What then has happened to program funding?

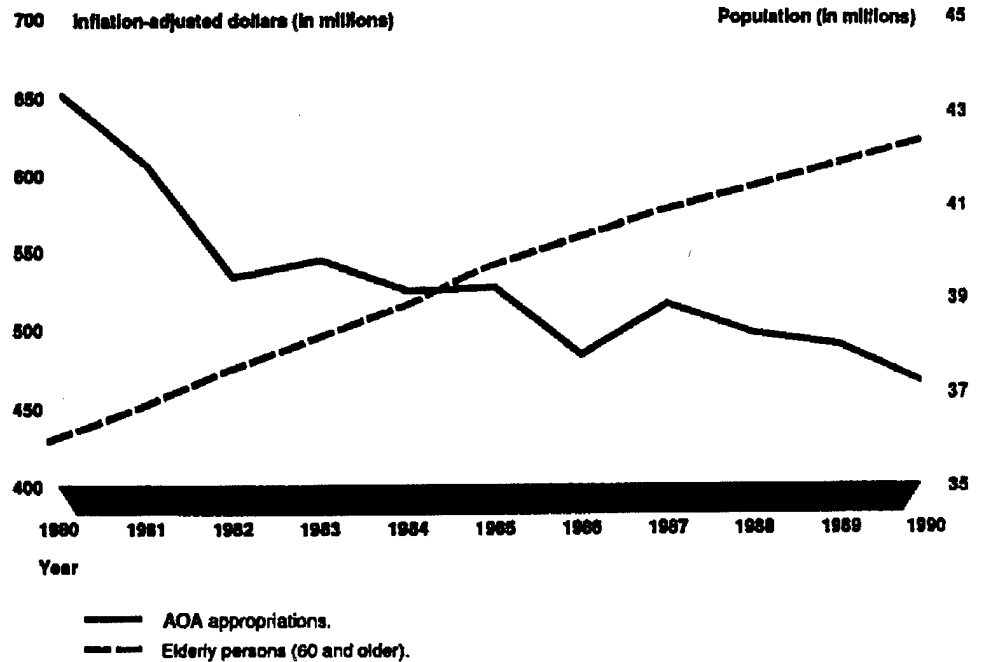
Program Funding

In fiscal year 1991, appropriations for Older Americans Act programs totaled more than \$1.3 billion. Of this, \$150 million was earmarked for commodities from the Department of Agriculture to supplement congregate and home-delivered meals (title III-C), and \$390 million was earmarked for the Department of Labor to administer the Senior Community Employment Program (title V) for low-income elderly persons, aged 55 and over. Thus, AOA received \$793 million for programs, services, research, and training in fiscal year 1991.

During the 1980's, appropriations for AOA programs and services increased, though they did not keep up with the rate of inflation. As seen in figure I.1, funding for AOA has decreased in inflation-adjusted dollars from \$650 million in 1980 to about \$460 million in 1990, while the number of elderly persons increased from about 36 million to 42 million. Some programs (for instance, title III-B supportive services) have experienced nearly a 40 percent decline in funding, when adjusted for inflation, while simultaneously experiencing an increase in the scope of the programs. For instance, the 1981 amendments to the Older Americans Act extended the scope of the ombudsman program to include board and care facilities, in addition to nursing homes. Despite this increase in responsibility, the minimum funding authorized for the program was not increased above the 1978 level. In addition, the 1987 amendments authorized separate appropriations for several programs (for example, elder abuse prevention activities and outreach activities for persons who may be eligible for Supplemental Security Income, Medicaid, and Food Stamp programs), yet most of the programs have not received funding under separate appropriations.

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Figure I.1: Trends in Aging: AOA Appropriations and the Aging Population, 1980-90



Source: U.S. Census Bureau, AOA, and GAO

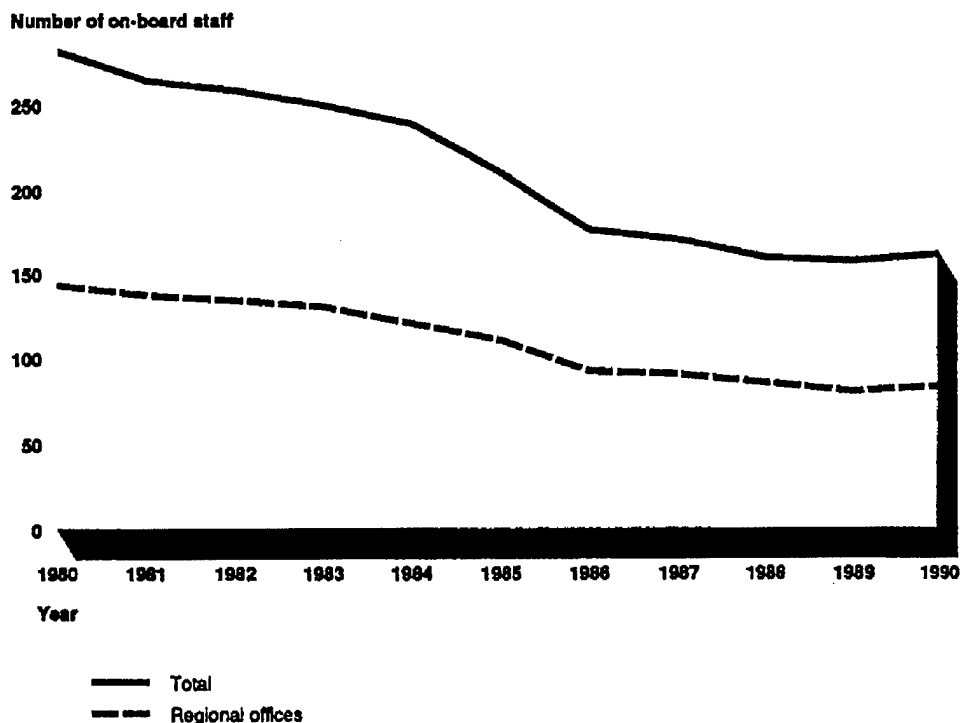
Administrative Resources

In addition to the decline in real dollars of program funds, AOA experienced a significant decline in administrative resources, such as personnel and travel funds, during the 1980's. As we reported earlier, the Office of Human Development Services (the operating division that houses AOA) experienced the largest share of personnel reductions within the Department of Health and Human Services between 1981 and 1988—46 percent, compared with a loss of 17-25 percent for the other operating divisions.² Figure I.2 shows AOA's share of that 46 percent reduction. In 1980, AOA had almost 300 staff on board at their headquarters and regional offices. By 1990, AOA staff had been diminished to a total of 160—a reduction of 47 percent. Moreover, many key leadership positions have been vacant for at least 2 years. For example, as shown in table I.1, the position of Director, Division of Policy, Planning, and Administration, Office of Management and Policy, has been vacant since 1988, while the position of Deputy Commissioner has been vacant since 1989.

²See *Management of HHS: Using the Office of the Secretary to Enhance Departmental Effectiveness*, GAO/HRD-90-54 (Washington, D.C.: February 1990).

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Figure I.2: AOA Staff, 1980-90



Note: Total is headquarters plus regional offices.

Source: AOA

Table I.1: AOA Vacancies as of April 19, 1991

Position	Date vacated
Director, Division of Policy, Planning, and Administration, Office of Management and Policy	February 1988
Director, Division of Technical Information and Dissemination, Office of Management and Policy	March 1988
Deputy Commissioner on Aging	February 1989
Associate Commissioner, Office of State and Community Programs	March 1989
Associate Commissioner, Office of Program Development	May 1989
Regional Program Director, Region VIII	June 1989
Director, Research and Demonstration Division, Office of Program Development	October 1989
Deputy Associate Commissioner, Office of Program Development	February 1990
Regional Program Director, Region VII	November 1990

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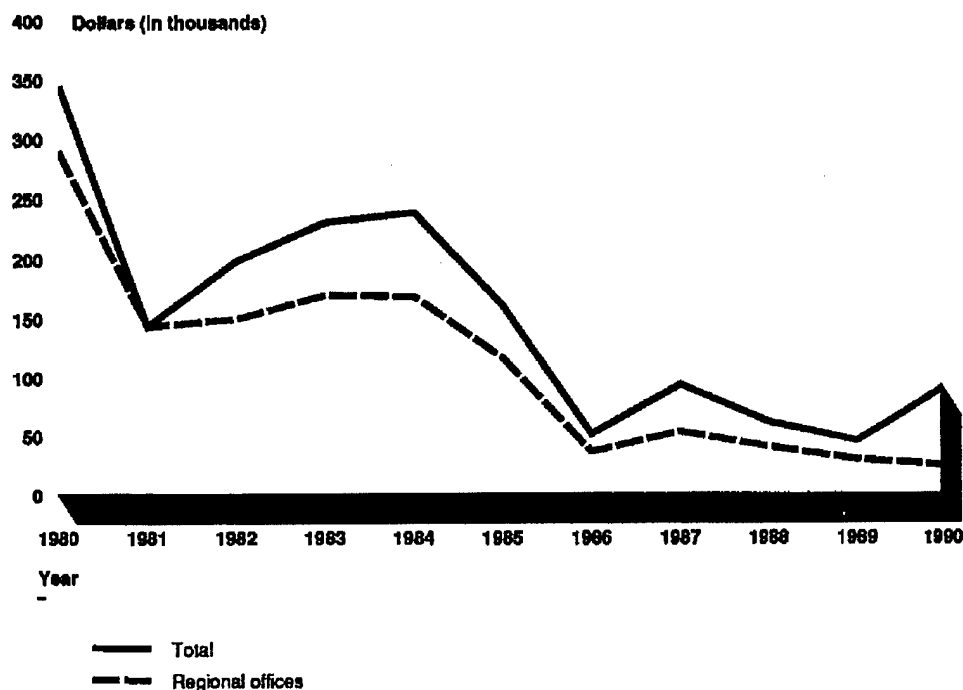
In addition to the vacancies that exist in allocated personnel slots, AOA lacks slots for other potentially important positions. For instance, the Older Americans Act states that the Commissioner on Aging shall serve as the effective and visible advocate for the elderly. Yet, AOA does not have positions for public affairs or legislative affairs personnel. Thus, according to officials at AOA, the Commissioner's ability to stay fully abreast of forthcoming legislation and to promote AOA's agenda is hindered. The Commissioner did have access to the Office of Policy, Planning, and Legislation within the Office of Human Development Services; however, the Office of Policy, Planning, and Legislation had only four staff persons to handle the affairs of the entire Office of Human Development Services.

Some of the programs under title III have been without leadership and expertise for a number of years. For example, AOA had, at one time, an office of nutrition in the central office with a medical doctor as chief and a support staff of three nutritionists. Moreover, each regional office had a registered dietician on its staff. At present, however, AOA has neither a leader for the nutrition programs nor qualified nutrition staff at the central office, and some regions no longer have nutritionists on board. For regional offices that do have nutritionists, those individuals usually have other responsibilities in addition to the nutrition program. All this is despite the fact that AOA spends \$450 million per year (over 56 percent of the total dollars allocated to AOA) on nutrition programs.

Similar to the reduction in staff, AOA has experienced a significant reduction in its travel funds. Figure I.3 illustrates their decline from \$343,940 in 1980 to \$90,000 in 1990, a 75-percent reduction even without taking inflation into account. This decline has particular importance since the travel funds affect the regional office provision of technical assistance and oversight to the state units on aging, as mandated by the Older Americans Act. The travel budget has been reduced to about \$2,000 per region. Yet, each region contains approximately six states, and regional officials are expected to visit each state within their respective regions at least once in every 2-year period. Regional program directors are also expected to use available travel funds to attend the annual meeting of the regional program directors in Washington, D.C. Given this limited travel budget, on-site technical assistance and oversight by the regions are more honored in the breach than in the observance. As a consequence, AOA has become further and further removed from the activities of the state units and area agencies on aging.

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Figure I.3: AOA Travel Funds, 1980-90



Note: Total is headquarters plus regional offices.

Source: AOA

Summary and Conclusions

As the foregoing discussion illustrates, AOA has experienced significant reductions in program funding, administrative resources, personnel, and travel funds over the past decade, while simultaneously facing a substantial growth in its constituency, mission, and mandates. Not only has there been a failure to accompany the increase in role and responsibilities with a commensurate increase in resources, but the latter instead have actually declined.

These contradictory forces have resulted in the consideration and even adoption of policies that are significantly changing the original direction of the legislation. One result of the disparity has been the adoption or consideration of policies and strategies that emphasize targeting services to those in greatest social and economic need. Another result has been the search for additional sources of funding—such as mandatory cost sharing, voluntary contributions, sliding-fee schedules, and public-private partnerships—in order to provide more than can be offered with the limited funding deriving from the Older Americans Act. Unfortunately, there is

little systematic evaluation research to demonstrate the net effect of any of these additional funding sources on the quality and quantity of services for the needy elderly. This is of some importance since each of these policies challenges the core value of the act, which is entitlement based on age alone.

For example, scarce funds are being transferred from wellness programs to serve persons with increased chronic illnesses and dependency, and mechanisms to increase resources (such as cost-sharing or sliding-fee scales) are leading away from entitlement toward means-testing. In addition, shortages are occurring even in priority funding areas. For example, waiting lists have developed for crucial services such as home-delivered meals. Finally, the lack of adequate administrative resources for AOA has had a negative impact on its ability to be a visible and effective advocate and resource for the aging network.

National Survey on Technical Assistance and Oversight

You also asked us to determine (1) how AOA provides technical assistance to state units and area agencies on aging, (2) whether the technical assistance provided by AOA meets the needs of the state units, and (3) how AOA carries out oversight of the state units on aging.

Scope and Methods of Our Study

To answer your questions, we reviewed legislation and relevant documents obtained from AOA. We also conducted a national survey of both providers and recipients of technical assistance. We mailed questionnaires to all 10 regional offices, the 11 national resource centers, and 51 state units on aging. (We included the District of Columbia, but excluded territories.) We had an overall response rate of 99 percent. We also interviewed officials from AOA's central office, the National Association of State Units on Aging, and the National Association of Area Agencies on Aging.

We asked the respondents to indicate whether technical assistance is provided with regard to 29 different issue areas (for example, targeting minority elderly, interpreting legislation, data collection, and so on). In presenting our results, we will discuss (1) the amount of technical assistance that regional offices and national resource centers say they provide to the state units and area agencies on aging and (2) the state units' assessment of their unmet needs, if any, for technical assistance provided by the regional offices and resource centers.

How AOA Provides Technical Assistance

Under title II of the Older Americans Act, one of the functions of the Commissioner on Aging is to provide technical assistance to state units and area agencies on aging with respect to programs and services funded under the act. To assist in the provision of technical assistance, AOA established 10 regional offices within the Department of Health and Human Services' regional office network, with each regional office responsible for providing technical assistance to the state agencies on aging within its region. Each regional office oversees from four to eight states or territories.

Title IV of the Older Americans Act provides that the Commissioner may also establish multidisciplinary centers of gerontology to provide technical assistance to the Commissioner, policymakers, service providers, and the Congress. Under this authority, AOA has established 11 multidisciplinary centers of gerontology, called national resource centers, throughout the nation to aid in the provision of technical assistance to state units and area agencies on aging. Each national resource center is responsible for providing technical assistance on particular issues. For instance, the National Resource Center on Minority Aging Populations at San Diego State University is responsible for providing technical assistance in the area of targeting minority elderly, while the National Resource Center for Rural Elderly at the University of Missouri-Kansas City is responsible for providing technical assistance in the continuing development of community-based systems serving the rural elderly.

We asked officials at AOA's regional offices to indicate how much technical assistance they currently provide to state units and area agencies on aging with regard to each of the 29 issue areas. As shown in table I.2, 9 of the 10 regional officials indicated that they provide a great or very great amount of technical assistance in the area of interpreting federal legislation, regulations, and policies.³ Similarly, 8 of the 10 regional officials responded that they provide a great or very great amount of technical assistance for (1) targeting elderly minority individuals and (2) targeting those elderly individuals in greatest social and economic need. In addition, 7 regional officials indicated that they provide a great or very great amount of technical assistance for administering aging programs. As table I.2 also indicates, there are several issue areas for which none of the 10 regional offices provides a great or very great amount of technical assistance. These areas are (1) demographic and census information, (2) model programs and best practices, (3) information and referral, (4) program evaluation, (5) training, and (6) needs assessments.

³Responses based on a 5-point scale: little or none, some, moderate, great, and very great.

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Table I.2: Percentage of Regional Offices and National Resource Centers Indicating They Provide Various Levels of Technical Assistance to State Units and Area Agencies on Aging^a

Type of technical assistance	Regional offices		National resource centers	
	Little or none	Great or very great	Little or none	Great or very great
Demographic/ census information	20%	0%	9%	18%
Model programs/ best practices	0	0	0	91
Targeting minorities	0	80	0	55
Targeting elderly with greatest social or economic needs	0	80	0	55
Outreach methods	0	10	9	64
Status of federal/ state legislation	0	50	18	45
Interpretation of federal legislation, regulations, and policies	0	90	27	36
Federal policy analysis	0	20	27	27
Preparation of state/area plans	0	40	36	18
Coordination (policies, plans, and requirements) ^b	0	40	0	50
Administering aging programs	0	70	9	55
Information and referral	10	0	18	55
Transportation	0	20	73	0
Legal assistance ^c	22	11	64	9
Ombudsman	0	40	55	9
Employment	0	20	82	0
Elder abuse	20	30	46	18
Congregate meals	0	50	55	0
Home-delivered meals ^b	0	40	60	0
In-home services for frail elderly	0	20	27	36
Contracts/grants	0	30	46	18
Program evaluation	10	0	27	36
Training	10	0	9	82
Technical assistance ^{bcd}	0	11	10	90
Coordination (administration and management)	0	20	18	55
Data collection	0	10	18	45

(continued)

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Type of technical assistance	Regional offices		National resource centers	
	Little or none	Great or very great	Little or none	Great or very great
Monitoring	0%	20%	46%	18%
Funding	10	10	18	18
Needs assessment	40	0	18	36

^aBased on the responses of all 10 regional offices and all 11 national resource centers.

^bThe response from one national resource center is missing.

^cThe response from one regional office is missing.

^dRefers to the provision of technical assistance by state units to area agencies on aging.

As was the case with regional offices, officials from the national resource centers indicated that they provide more technical assistance for some issue areas than others. This is not surprising since each resource center was established to provide technical assistance in a specific issue area. In fact, we did not expect the resource centers to provide a great deal of technical assistance for many of the issue areas. Nevertheless, as table I.2 indicates, most of the resource center respondents indicated that they provide a great or very great amount of technical assistance for such issues as (1) model programs and best practices, (2) helping states provide technical assistance, (3) training, (4) outreach methods, (5) targeting minorities, (6) targeting elderly with the greatest social or economic need, and (7) coordination in the areas of administration and management.

Table I.2 also indicates that, to some extent, the regional offices and resource centers complement one another's efforts. For instance, whereas none of the regional offices reported providing a great or very great deal of technical assistance for model programs and best practices, 91 percent of the resource centers reported providing such assistance. Similarly, whereas the regional offices do not provide a great deal of technical assistance for training, 82 percent of the national resource centers do.

In sum, officials from regional offices and national resource centers reported that they provide a great or very great deal of technical assistance for many important issue areas, including targeting minorities and the needy, interpreting federal legislation, training, and administering the aging programs. However, regional office and national resource center officials acknowledged that they generally do not provide the same level of technical assistance in such critical areas as program evaluation, needs assessment, and helping state units and area agencies obtain demographic information about the elderly populations in their respective geographic areas.

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Unmet Needs for Technical Assistance

To determine whether the technical assistance that is provided actually meets the perceived needs of state units on aging, we asked officials from the state units to indicate the extent of their unmet needs for technical assistance in each of the 29 different issue areas.

Although state unit officials generally noted that many of their technical assistance needs are met, many of them reported unmet needs in several critical areas. For instance, about half of the state unit officials reported at least moderate unmet needs in the areas of data collection, targeting elderly persons with the greatest social or economic needs, needs assessment, and targeting elderly minorities. About 40 percent reported having at least moderate unmet needs in the areas of outreach methods, model programs and best practices, program evaluation, obtaining demographic data, and monitoring. In addition, about 30 percent of the state unit officials reported having at least moderate unmet technical assistance needs in eight other categories.

We also asked state unit officials to identify which of their unmet needs for overall technical assistance represented serious concerns for them. Our respondents most frequently identified technical assistance on issues related to targeting, with 32 percent of the state unit officials noting that the lack of such technical assistance represents a serious concern for them. Specifically, in addition to targeting, they indicated a need for more technical assistance on outreach initiatives to low-income and minority elders, demographic data, and how to perform needs assessments.

Another unmet need that represented a serious concern for state unit officials was that for technical assistance regarding data collection. Twenty-eight percent of the state unit officials specifically identified this unmet need. Some expressed a specific need for technical assistance on how to develop and/or implement computerized data collection systems. We concur with this view of the importance of improved data collection because, as we have said elsewhere, the lack of accurate data on participation in Older Americans Act programs currently makes it impossible to determine the effectiveness of targeting initiatives.⁴

⁴U.S. General Accounting Office, "Minority Participation in Administration on Aging Programs," testimony before the Subcommittee on Aging of the Committee on Labor and Human Resources, U.S. Senate (GAO/T-PEMD-91-1), March 15, 1991.

Barriers to the Provision of Technical Assistance

We asked officials from the regional offices, national resource centers, and state units on aging to indicate what barriers, if any, currently hinder the provision of technical assistance. All 10 regional officials noted a general lack of funds. In addition, 8 regional officials said that, specifically, they lack adequate funds for on-site visits, and 7 that they lack funds to train their personnel and equip them with the necessary expertise to provide technical assistance.

Comments from the regional officials clearly demonstrated their frustration with the scarcity of their resources. Many regional officials lamented the lack of expertise in their offices and told us that they can no longer offer adequate and meaningful technical assistance to the state units on aging. One official wrote, "It is difficult for regional office staff to maintain credibility as experts who can offer assistance when we cannot even attend conferences, or subscribe to appropriate publications. Similar lack of expertise in the central office leaves us behind those we should be leading."

The statements of the regional officials were corroborated by the state unit officials. For instance, 60 percent of the state unit officials cited a general lack of funds as a barrier to the provision of technical assistance. Fifty percent indicated that the lack of on-site visits by regional office staff is a barrier to the provision of technical assistance. Forty-eight percent noted that regional office personnel lack the expertise (or the funds for training) to provide adequate technical assistance. Finally, 24 percent of the state unit officials said that there is a problem with outreach and information dissemination—that is, many state unit officials are apparently unaware of the technical assistance that is available to them. Indicative of this state of affairs, one state unit official wrote, "The key to good technical assistance is being able to talk with someone who is knowledgeable and willing to help problem solve AOA staff occasionally are able to do this, but for the most part their knowledge is limited to AOA requirements."

Our own analysis indicated that the concerns of regional officials and state unit officials are justified, given the paucity of staff at AOA's regional offices. Regional offices have approximately 7 to 8 staff, with limited funds for training. This means that regional office personnel are constrained in their ability to develop the necessary expertise for the provision of technical assistance. Moreover, as already noted (in figure I.3), AOA has limited travel funds to allow regional office staff to visit states and provide hands-on technical assistance. This is particularly important because, as several regional officials noted, technical assistance is often difficult to

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provide by phone—site visits are necessary to allow officials to diagnose problems and generate solutions. In fact, in the early 1980's, some regional officials visited state units each month and provided technical assistance on location.

Findings on Oversight

You also asked us to study how AOA carries out oversight of state units on aging. AOA officials told us that oversight includes monitoring, review, and evaluation activities intended to ensure the effectiveness and efficient operation of programs and activities that are carried out under the authority of the Older Americans Act. Oversight of Older Americans Act service programs is carried out by AOA through (1) the review and approval of state plans, (2) the receipt and review of fiscal and service program data, (3) on-going telephone and written contact with state units on aging by regional office personnel, and (4) on-site visits to states by regional office personnel.

We asked the regional officials to indicate what types of oversight activities they conducted during the previous year. As table I.3 shows, regional officials carried out a variety of oversight activities, including the review of state plans and intrastate funding formulas. However, four regional offices did not conduct any fiscal audits of the state units on aging within their regions. Moreover, 74 percent of the state unit officials indicated that AOA did not conduct a fiscal audit in their state during the 1990 calendar year.⁵

**Table I.3: Percentage of Regional Offices
Indicating That They Conducted
Oversight Activities^a**

Type of oversight activity	Percent conducting activity
Assessment, review, and approval of state plans	100
Requests for progress reports on state plans	90
Follow-up on implementation of state plans	100
Requests for and verification of program data needed for annual AOA report	100
Fiscal audits	60
Review of funding formula	100
Approval of funding formula	10

^aBased on the responses of all 10 regional offices

⁵There is no personnel slot for fiscal oversight in AOA. Before the recent reorganization in the Department of Health and Human Services, fiscal support was provided by the Office of Fiscal Operations, within the Office of Human Development Services. According to some regional officials, AOA was a low priority for Office of Fiscal Operations staff.

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We also asked regional officials which state units on aging they visited in 1989 and 1990 as part of their oversight activities, and how many site visits they made to each state unit. As noted earlier, regional officials are expected to visit each state unit at least once every 2 years. We found that officials from just five regional offices visited all the state units within their region during the period January 1989 through December 1990. Eight states were not visited at all by regional office personnel during this 2-year period.

During one of our site visits, officials from the New York regional office told us that it is the state units' responsibility to review annual fiscal audits of the area agencies, which are conducted as part of an overall county audit, and to resolve any findings. As part of its stewardship responsibilities, the regional office, in its visits to the state units, is expected to review (1) compliance with the requirement of an annual audit of the area agencies and (2) the state units' resolution of the findings. However, the regional officials noted that they have not conducted monitoring visits to the state units for some years because of staffing and travel constraints.

According to the regional officials, some troublesome oversight issues have emerged as a consequence of this lack of monitoring capability. For example, an audit of the Puerto Rico Gericulture Commission's activities from 1980 to 1983 revealed such inadequate fiscal management that a disallowance of \$14 million was taken against the agency. The Gericulture Commission was dissolved in 1988, and a new state agency, the Puerto Rico Governor's Office of Elderly Affairs, was established. Because of a massive effort by the new agency to supply documentation, this disallowance was reduced to about \$1 million in 1987. In the almost 4 years that the agency struggled to reduce the disallowance and reorganize the aging network in Puerto Rico, numerous requests were made for programmatic and fiscal on-site technical assistance. Because of a lack of travel funds, however, site visits were minimal. New fiscal problems have recently emerged in Puerto Rico, and a 1991 review by the Regional Inspector General for Audit stated, "It is imperative that the replacement grantee be held to the highest fiscal standards Therefore, we would strongly urge you to work on obtaining needed travel funds so that periodic monitoring of Administration on Aging funds can occur."

We also found oversight problems during our site visit to the Atlanta regional office. In one case, a fiscal audit of an area agency in Georgia revealed that Older Americans Act nutrition funds were used

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inappropriately for administrative purposes, from 1982 to 1985. Moreover, a portion of the nonfederal match of Older Americans Act funds was generated inappropriately by the area agency. Based on the audit, the regional program director in Atlanta recommended that \$1.1 million in federal funding to Georgia's state unit on aging be disallowed. In response to the disallowance, Georgia filed a suit in Federal District Court against the Department of Health and Human Services and AOA. The case is still in court.

These are but two examples of the fiscal problems experienced by state units on aging, troubles which are often not recognized in a timely fashion because of inadequate fiscal monitoring. Because we did not conduct a systematic review of the oversight problems experienced by the regional offices, we do not know how widespread such issues are throughout the country. However, we do know that both the New York and Atlanta regional offices are experiencing additional difficulties (with the Virgin Islands and Alabama, respectively) and that other regional offices are facing similar problems. Again, we must recognize AOA's shortage of staff and travel funds as an obstacle to conducting the necessary oversight of state units on aging.

Conclusions

We intend to issue our report on these important topics in a few months. But already, based on the results of our ongoing work, it seems clear that more consideration needs to be given to the effects that declining staff and travel funds are having on the ability of AOA to perform its oversight functions and to deliver the required technical assistance to state units and area agencies on aging. We also believe that the technical assistance needs of the state units on aging need to be better identified, prioritized, and resolved. Finally, it seems likely that there will need to be some overall conciliation process that can harmonize AOA's increasing responsibilities, the elderly population's growing demands for service, and shrinking funds.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions you may have.

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