



**DEPARTMENT
of HEALTH
and HUMAN
SERVICES**

**FY 2015 Report to Congress:
Older Americans Act**

**Prepared by
ADMINISTRATION
ON AGING**

**ADMINISTRATION FOR
COMMUNITY LIVING**



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FROM THE ADMINISTRATION FOR COMMUNITY LIVING

The Administration for Community Living (ACL) is committed to the fundamental principle that older adults and people of all ages with disabilities should be able to live where they choose, with the people they choose, and fully participate in their communities. ACL's programs provide individualized, person-centered home and community-based services and supports, and invest in research and best practices, to make that principle a reality for millions of people. It does so by working with other federal agencies, states, localities, Tribal organizations, nonprofit organizations, businesses, and families to help older adults and people with disabilities live in their homes and fully participate in their communities. Those with disabilities or functional limitations of any type, regardless of age, have a common interest: access to home and community-based supports and services that help individuals fully participate in all aspects of society, including having the option to live at home, which can be vital to an individual's well-being, instead of moving into an institutional setting.

ACL's mission is to maximize the independence, well-being, and health of older adults, people with disabilities, and their families and caregivers. As part of this important mission, the Administration on Aging (AoA) advances the concerns and interests of older people, whether living in their own home or in a long-term care facility, and works with and through the national aging services network to promote the development of comprehensive and coordinated systems of home and community-based care that are responsive to the needs and preferences of older people and their caregivers.

The national aging services network is comprised of 56 state and territorial units on aging (SUA), 618 area agencies on aging (AAAs), 264 Indian tribal and Native Hawaiian organizations, more than 20,000 direct service providers, and hundreds of thousands of volunteers. AoA's core programs, authorized under the Older Americans Act (OAA), help older adults aged 60 and over remain at home for as long as possible, promote the rights of older individuals, and advocate for individuals who live in long-term care facilities (nursing homes, board and care, assisted living, and similar settings).

The population served through OAA programs and activities will grow rapidly over the next 20 years. An estimated 66.8 million older adults age 60 and over resided in the U.S. in 2015, comprising 21 percent of the population.¹ During this period, the number of older adults (age 65 and older) with severe disabilities – defined as three or more limitations in activities of daily living – who are at greatest risk of nursing home admission will increase substantially. If current trends continue, this population is projected to increase by more than 18 percent by the year 2020.² Ten years later, in 2030, when the last of the baby boomers turn age 65, twenty-one

¹ U.S. Census Bureau. Population Division. Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2015. Release Date: June 2016. Accessed November 2016.

² Ibid and U.S. Census Bureau. Population Division. Table 9. Projections of the Population by Sex and Age for the United States: 2015 to 2060 (NP2014-T9). Release Date: December 2014. Accessed November 2016.

And Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population.

Data from the 2013 Medicare Current Beneficiary Survey. [data tables 2.5a and 2.6a]. [2013 Characteristics and Perceptions of the Medicare Population](#) Accessed November 2016.

percent of the population, or one in five Americans, will be age 65 or over and the number with severe disabilities will have increased by 55 percent since 2015.³

As our diverse, older population grows we are seeing more resources shifting towards person-centered home and community-based services through a growing recognition that they can improve health outcomes, help avoid more costly interventions, and provide supports that individuals and families desire. OAA programs and services assist people to remain independent and in their communities. If even a small percentage of recipients are able to delay institutionalization, it would likely have a significant impact on their personal finances, and federal expenditures, including through the Medicaid program.

For more than 50 years, the OAA has provided critical services that have better enabled millions of older Americans to live independently, with dignity, in their homes and communities. Its programs are highly successful because they are flexible and focus on the needs of each individual, better ensuring that their rights, choices, needs, and independence are maintained through their input and participation. I am pleased to present AoA's Report to Congress for Fiscal Year (FY) 2015.

Edwin L. Walker
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Administration for Community Living

³ Ibid.

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EXECUTIVE SUMMARY

AoA's core programs, authorized under the Older Americans Act (OAA), help people choose to remain in their homes and communities for as long as possible. These services complement efforts of the nation's public health networks, as well as existing medical and health care systems, and support some of life's most basic functions, such as bathing and preparing meals. These programs also support family caregivers; address issues of exploitation, neglect, and abuse of older adults; and adapt services to the needs of Native Americans. The most recent data available show that, in FY 2015, AoA and the national aging services network rendered direct services to nearly 11 million individuals age 60 and over (one out of every six older adults), including nearly three million clients who received intensive in-home services.⁴ Critical supports, such as respite care and a peer support network, were provided to over 700,000 caregivers.⁵

Overview of Performance

The fundamental purpose of OAA programs, 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 of performance: 1) improving efficiency; 2) improving client outcomes; and 3) effectively targeting services to vulnerable elder populations. Each measure is representative of several activities across OAA programs, and progress towards achieving each measure is tracked using a number of indicators. The efficiency measure and corresponding indicators are reflective of the Office of Management and 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 goals and objectives and in turn measure success in accomplishing AoA's mission.

An analysis of AoA's performance trends shows that through FY 2015, most outcome indicators have steadily improved and demonstrate that services are continuing to be effective in helping older persons remain at home, supporting quality of life, and saving federal funds. 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 a vulnerable older adult population, the changing care preferences of aging "baby boomers", the fiscal difficulties faced by individuals and federal and state budgets, and the expanding needs of both older Americans and their caregivers. The following are some examples of these successes:

- **OAA programs help older Americans with severe disabilities remain independent and in the community:** Older adults who have three or more impairments in activities of daily living (ADL) are at a high risk for nursing home placement. Measures of the national aging services network's success at serving this vulnerable population is a proxy for success at

⁴ AoA's FY 2015 State Program Report. These data are preliminary and should not be taken as final.

⁵ Ibid.

nursing home delay and diversion. In FY 2005, one-third of home-delivered nutrition clients lived with three or more ADL impairments and by FY 2015 the proportion grew to 42 percent, a 26 percent increase.⁶ 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 Performance Outcomes Measurement Project (POMP), which are developed and tested performance measures. The composite score is a weighted average; 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. Data indicate it has increased to 63.8, a 37 percent improvement over the FY 2003 baseline, indicating a higher percentage of consumers served who are at increased risk for nursing home entry.

- **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. Over the past decade, the number of clients served per million dollars of OAA Title III funding has increased significantly. During FY 2015, the national aging services network served 8,785 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 (between two to three dollars 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 (ADRC) initiative, over 500 ADRC sites have been established across 50 states, two territories, and Washington, DC. OAA programs are a longstanding example of how the federal government, states, and localities can effectively work together to improve system performance.

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 2015, 92 percent of home-delivered nutrition clients reported that the services help them to continue living at home. In addition, 81 percent of case management service clients report the services they received have enabled them to better care for themselves.⁷ Clients across all services rate the quality of these services extremely high and are satisfied with OAA services. For example, 95.1 percent of transportation clients rated services good to excellent and 93.6 percent of caregivers rated services good to excellent.⁸ 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.

⁶ AoA's FY 2015 State Program Report. These data are preliminary and should not be taken as final

⁷ 2015 National Survey of Older Americans Act Participants. [AoA: AGing Integrated Database](#),

⁸ Ibid.

The tables on the next page provide a summary of the persons served during FY 2015 through the OAA's programs. Additionally, a listing of grant funding allocations by state, territory and tribal organization can be viewed in the Appendix.

National Program Data on Services Provided

	FY 2015
Total Clients	10,876,304
Total Registered Clients	2,765,020
% Minority Clients ⁹	29.41%
% Rural Clients	35.40%
% Clients Below Poverty	32.53%
# Senior Centers	9,781 (5,688 receive OAA funding)

Service	Persons Served	Units of Service¹⁰	Title III Expenditure	Total Expenditure
Personal Care	112,779	20,863,822	\$54,149,723	\$336,773,626
Homemaker	162,400	17,061,716	\$29,042,983	\$337,565,931
Chore	34,485	889,030	\$4,596,872	\$19,690,170
Home Delivered Meals	849,051	140,566,567	\$263,315,314	\$852,396,699
Adult Day Care	18,103	9,948,581	\$12,321,804	\$98,677,744
Case Management	439,812	3,623,855	\$25,074,986	\$244,452,706
Assisted Transportation	48,941	2,213,215	\$4,310,309	\$26,316,510
Congregate Meals	1,562,235	78,984,927	\$277,415,355	\$642,724,929
Nutrition Counseling	35,578	74,646	\$1,250,570	\$2,716,157
Transportation		23,318,905	\$62,396,486	\$201,634,235
Legal Assistance		933,481	\$26,460,825	\$49,510,096
Nutrition Education		3,324,491	\$3,623,516	\$6,237,524
Information and Assistance		12,627,783	\$59,257,891	\$181,809,168
Outreach		1,880,314	\$9,182,065	\$20,401,786
Health Promotion and Disease Prevention	1,469,726		\$20,761,438	\$51,091,734
Self-Directed Care	2,376		\$188,413	\$15,049,959
Other			\$67,960,406	\$431,332,440

⁹ Minority client refers to individuals who self-report at least one of the following racial or ethnic identities: Asian, Black or African American, Hispanic or Latino, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native.

¹⁰ Service Units Definitions:

Personal Care = 1 Hour

Homemaker = 1 Hour

Chore = 1 Hour

Home-Delivered Meal = 1 Meal.

Adult Day Care/Adult Day Health = 1 Hour

Case Management = 1 Hour

Assisted Transportation = 1 One Way Trip

Congregate Meal = 1 Meal

Nutrition Counseling = 1 session per participant

Transportation = 1 One Way Trip

Legal Assistance = 1 hour

Nutrition Education = 1 session per participant

Information and Assistance = 1 Contact

National Family Caregiver Support Program

Service	Caregivers Served	Service Units ¹¹	Title III Expenditure	Total Expenditure
Counseling, Support Groups, Training	116,297	431,994	\$20,474,216	\$29,775,579
Respite	66,808	6,233,867	\$52,254,644	\$92,594,130
Supplemental Services	40,553	664,545	\$11,389,463	\$16,413,947
Access Assistance	518,038	1,148,616	\$30,049,111	\$43,745,506
Self-Directed	1,409		\$1,449,181	\$2,037,733
Information Services	16,017,125	818,705	\$11,636,551	\$17,224,513
Unduplicated Caregivers Provided Service or Access	715,174			

¹¹ Title III-E service units definition:
 Counseling = 1 session per participant
 Respite Care = 1 hour
 Supplemental services = variable
 Access Assistance = 1 contact
 Self-Directed = variable
 Information Services = 1 activity

PART I: HEALTH AND INDEPENDENCE

Due in part to advances in public health and medical care, Americans are living longer and more active lives. The average life expectancy of an American has increased dramatically over the last century, from 54.5 years in 1915 to 78.8 years in 2015,^{12 13} and one consequence of this increased longevity is the higher incidence of chronic conditions. Multiple chronic conditions negatively affect quality of life, contribute to declines in functioning and the ability to remain in the community, adversely impact individuals' health, and contribute to increased hospitalizations and health care costs. Many of the most common chronic conditions such as hypertension, heart disease, diabetes, and osteoporosis are related to nutrition as a primary prevention, risk reduction, or treatment modality. Medicare beneficiaries with multiple chronic conditions are the heaviest users of health care services. For example, two-thirds of Medicare beneficiaries who have two or more chronic conditions account for 93 percent of Medicare spending, and one-third of those with four or more chronic conditions account for almost three-fourths of Medicare spending.¹⁴ Medicare beneficiaries with multiple chronic conditions are the heaviest users of health care services. For example, among Medicare beneficiaries age 65 and over who are not dual eligibles (enrolled in both Medicare and Medicaid), standardized Medicare per capita spending increases from \$4,914 for persons with two to three chronic conditions to \$28,076 for persons with six or more chronic conditions.¹⁵ Among Medicare beneficiaries age 65 and over who are dual eligibles, standardized Medicare per capita spending increases from \$5,736 for persons with two to three conditions to \$32,063 for persons with six or more chronic conditions.¹⁶

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 nursing home care. For example, 61 percent of congregate and 92 percent of home-delivered meal recipients reported that the meals enabled them to continue living in their own homes and 51 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.¹⁷

Between 2015 and 2020, the number of Americans age 60 and older will increase by over 10.8 million older adults, to reach 77.6 million.¹⁸ During this period, the number of Americans age 65 and over with severe disabilities (defined as three or more limitations in activities of daily living) who are most likely to receive nursing home admission and qualify for Medicaid

¹² Arias E. United States life tables, 2011. National vital statistics reports; vol 64 no 11. Hyattsville, MD: National Center for Health Statistics. 2015. Accessed at https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_11.pdf.

¹³ Xu JQ, Murphy SL, Kochanek KD, Arias E. [Mortality in the United States, 2015. NCHS data brief, no 267](#). Hyattsville, MD: National Center for Health Statistics. 2016.

¹⁴ Centers for Medicare & Medicaid Services. [Chronic Conditions among Medicare Beneficiaries](#), Chart Book. Baltimore, MD. 2012.

¹⁵ Centers for Medicare & Medicaid Services. [State Level Multiple Chronic Conditions \(MCC\) Table](#): Prevalence, Medicare Utilization and Spending. 2014.

¹⁶ Ibid.

¹⁷ 2015 National Survey of Older Americans Act Participants. [AoA: AGing Integrated Database](#).

¹⁸ U.S. Census Bureau. Population Division. Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2015. Release Date: June 2016. Accessed November 2016. U.S. Census Bureau. Population Division. Table 9. Projections of the Population by Sex and Age for the United States: 2015 to 2060 (NP2014-T9). Release Date: December 2014. Accessed November 2016.

eligibility (through the “spend down” provisions) will increase by 18 percent.¹⁹ AoA’s Health and Independence programs help older adults in need maintain their health and independence.

In concert with other OAA programs, these services assist over 11.6 million elderly individuals and caregivers.²⁰ AoA’s services are especially critical for the nearly three million older adults who receive intensive in-home services, more than 489,000 of whom meet the disability criteria for nursing home admission. These services help to keep these individuals from joining the 1.9 million older adult residents who live for extended periods of time in nursing homes.²¹

Home and Community-Based Supportive Services *(Title III-B of OAA; FY 2015: \$347,724,000)*

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. AoA’s programs, including 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 helps older persons remain in their own homes and communities instead of entering nursing homes or other types of institutional care.²²

The services provided 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 home and community-based services, statistics show that both disability rates and the use of long-term supports increase with advancing age. Among those aged 85 and older, 56 percent are unable to perform critical activities of daily living and require long-term support.²³ Data also show that over 92 percent of older Americans have at least one chronic condition and 76 percent have at least two.²⁴ Providing a variety of supportive services that meet the diverse needs of these older individuals is crucial to enabling them to choose to remain healthy and independent in their homes and communities, and therefore to avoiding unnecessary, expensive nursing home care that is often publicly financed. In light of limited long-term coverage under Medicare and constrictions in the long-term care insurance market, many Americans with few resources will continue to rely on

¹⁹ Ibid and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 Medicare Current Beneficiary Survey. [data tables 2.5a and 2.6a]. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html> Accessed 08 November, 2016.

²⁰ AoA’s FY 2015 State Program Report. These data are preliminary and should not be taken as final.

²¹ Ibid.

²² Brock, D et al. “Risk Factors for Nursing Home Placement Among OAA Service Recipients: Summary Analysis from Five Data Sources” Westat; U.S. Administration on Aging Contract No. 233-02-0087. http://www.aoa.gov/AoARoot/Program_Results/POMP/docs/Risk_Factors.pdf

²³ Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 Medicare Current Beneficiary Survey. [data tables 2.5a and 2.6a]. <http://www.cms.gov/ResearchStatistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html>. Accessed 10 January 2016.

²⁴ Ibid.

Medicaid to furnish their long-term care. Supporting less costly community-based options is a critical function of government and will continue to be an important tool in managing Federal expenditures.

Services provided by the HCBSS program in FY 2015 include:²⁵

Transportation Services provided 23.6 million rides to doctor's offices, grocery stores, pharmacies, senior centers, meal sites, and other critical daily activities.

Personal Care, Homemaker, and Chore Services provided nearly 39 million hours of assistance to older adults 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).

Adult Day Care/Day Health provided 10 million hours of care for program participants in a group setting that provides health, therapeutic, and social services and activities during some portion of a twenty-four hour day.

Case Management Services provided over 3.6 million hours of assistance in assessing needs, developing care plans, and arranging services for older persons or their caregivers.

Reflecting AoA's and the national aging service network's efforts to target services to those in most need, nearly 49 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.²⁶ Many of these individuals cannot safely drive a car, as nearly 77 percent of transportation riders have at least one of the following chronic conditions that could impair their ability to navigate safely:²⁷

- 67 percent of riders had a doctor tell them they had vision problems (including glaucoma, macular degeneration or cataracts);
- 10 percent have Alzheimer's disease or dementia;
- 3 percent have Multiple Sclerosis;
- 15 percent have had a stroke;
- 4 percent have epilepsy; and
- 3 percent have Parkinson's disease.

Of the transportation participants, 96 percent take daily medications, with about one in five (19 percent) reporting they take 10 to 20 medications daily.²⁸ Data from AoA's national surveys of elderly clients show that HCBSS services are providing these seniors with the assistance and information they report helps them to remain at home.²⁹ For example, over 81 percent of clients receiving case management reported that as a result of the services arranged by the case manager they were better able to care for themselves.³⁰ In addition, a study published in the Journal of

²⁵ AoA's FY 2015 State Program Report. These data are preliminary and should not be taken as final

²⁶ 2015 National Survey of Older Americans Act Participants. [AoA: AGing Integrated Database](#).

²⁷ Ibid

²⁸ Ibid,

²⁹ Ibid.

³⁰ Ibid.

Aging and Health shows that the services provided by the HCBSS program, “personal care services,” are the critical services that enable frail seniors to remain in their homes and out of nursing home care.³¹

Nationally, 25 percent of individuals 60 and older live alone.³² OAA programs serve a disproportionate number of people who live alone compared to the general population. For example, 68 percent of transportation clients live alone.³³ Living alone is a key predictor of nursing home admission, and HCBSS services are critical for enabling them to remain at home, especially for those who do not have an informal caregiver to assist with their care. Research has also shown that childless older adults who live in a state with higher home and community-based services expenditures had significantly lower risk of nursing home admissions.³⁴

Federal support for OAA programs is not expected to cover the cost of serving every older American. These programs have strong partnerships with state and local governments, philanthropic organizations, and private donations that also contribute funding. States typically leverage resources of between two and three dollars per every federal OAA dollar, significantly exceeding the programs’ match requirements.

Nutrition Services

Nutrition Services help older adults remain healthy and independent in their communities by providing nutritious meals and other nutrition services in a variety of settings (such as senior centers, public housing locations, religious buildings or community centers) and via home-delivery to older adults who are homebound due to illness, disability, or geographic isolation. Nutrition Services include:

Congregate Nutrition Services (Title III-C1; FY 2015: \$438,191,000): Provides funding for the provision of nutritious meals and nutrition-related services in a variety of congregate settings, which helps keep older adults healthy and may decrease or prevent the need for more costly medical interventions. Established in 1972, the program centers around serving health-promoting meals, but it also presents opportunities for social engagement, health and wellness activities, and meaningful volunteer roles, all of which contribute to overall health and well-being.

Home-Delivered Nutrition Services (Title III-C2; FY 2015: \$216,397,000): Provides funding for nutritious meals, the delivery of meals and nutrition-related services to homebound frail and/or isolated older adults. The deliveries provide opportunities for social engagement and, in many cases, an informal ‘safety check.’ 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 are a key element in helping older adults who may not be able to prepare their own meals remain in the community.

³¹ 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>.

³² Administration for Community Living, <http://www.agid.acl.gov/DataGlance/>. Data-at-a-Glance: American Community Survey (ACS) Public Use Microdata Sample (PUMS) 1-Year Files (2014), accessed November 2016.

³³ 2015 National Survey of Older Americans Act Participants. [AoA: AGing Integrated Database](#)

³⁴ 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.

Nutrition Services Incentive Program (Title III-A; FY 2015: \$160,069,000): Provides additional funding to states, territories, and eligible tribal organizations that is used exclusively to procure food products for use in the Title III- C-1 and C-2 and Title VI meal programs, 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 a prior federal fiscal year. States and tribes have the option to purchase *USDA Foods* (previously referred to as 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 older adults.

The meals provided through these programs fulfill the standards set by the current 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.³⁵ Meals also comply with applicable provisions of state and local food safety codes, are appealing, and meet special dietary needs such as health, religious, cultural/ethnic needs, as feasible. The nutrition-related services provided through these programs may include nutrition education, nutrition counseling, and other nutrition services, as appropriate, based on the needs of meal participants.

Nutrition Services help approximately 2.4 million older adults receive the meals they need to stay healthy and decrease their risk of disability.³⁶ Because the prevalence of multiple chronic conditions is higher among congregate and home-delivered program participants than for the general Medicare population, the provision of healthy meals, access to lifestyle modification programs and evidence-based advice such as nutrition education and counseling are important. Overall, 76 percent of community-living Medicare beneficiaries age 65 or older have multiple chronic conditions. Data from AoA's FY 2015 National Survey of Older Adult Participants indicate that 95 percent of home-delivered and congregate participants have multiple chronic conditions, and that 43 percent of congregate and 56 percent of home-delivered participants have six or more illnesses or conditions. Over 30 percent of congregate and 51 percent of home-delivered participants take more than six medications per day and some take more than 20 medications. The congregate and home-delivered program participants are significantly less healthy than the general Medicare population and access to adequate healthy meals is essential to their well-being. Meals are also an important element in deferral or delay of institutional placement.

Older adults served in the congregate and home-delivered nutrition programs demonstrate a need for healthy, prepared meals, rather than simply access to food. While the 75 year-old and over cohort makes up 30 percent of the U.S. population age 60 and over, half (51.7 percent) of congregate and almost two-thirds (64.8 percent) of home-delivered meal participants are aged 75 years or older.³⁷

Approximately 10 percent of congregate and over 80 percent of home-delivered participants indicate that they have three or more impairments in instrumental activities of daily living

³⁵ [2015-2020 Dietary Guidelines for Americans](#) and [USDA Dietary Reference Intakes](#)

³⁶ AoA's FY 2015 State Program Report. These data are preliminary and should not be taken as final

³⁷ U.S. Census Bureau, Population Division, [Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2015](#). Release Date: June 2016.

(IADLs).³⁸ The data also indicate that 19 percent of congregate and 52 percent of home-delivered participants have difficulty getting outside the house, thus limiting their ability to shop for food themselves.³⁹ The number of home-delivered meal recipients with severe disabilities (three or more activities of daily living) totaled nearly 330,000 in FY 2015.⁴⁰ This level of disability is frequently associated with nursing home admission, and demonstrates the extreme frailty of a significant number of older adults receiving home-delivered meals.

Nationally, 25 percent of individuals age 60 years and older live alone.⁴¹ However, due to the OAA's requirement to target services to older adults most in need to help them maintain their health and independence, 45 percent of congregate and 54 percent of home-delivered participants live alone.⁴² Living alone is a risk factor for social isolation, poorer health, and nursing home placement.

Data from AoA's national surveys of older adult participants show that Nutrition Services are effectively helping older adults improve their nutritional intake and remain at home. For example, data indicate that 78 percent of congregate and 83 percent of home-delivered meal participants say they eat healthier meals due to the programs, and 61 percent of congregate and 92 percent of home-delivered meal recipients say that the meals enable them to continue living in their homes.⁴³ Independent research has found that states that invest more in delivering OAA home-delivered meals to older adults' homes have lower rates of "low-care" older adults in nursing homes after adjusting for several other factors.⁴⁴ For every \$25 per year per older adult that states spend on home-delivered meals, the state reduces their percentage of these lower needs nursing home residents by one percent when compared to the national average.⁴⁵ This evidence is a testimonial to the savings gained from this foundational home- and community-based service.

AoA's annual performance data further demonstrate that these programs are highly valued by older people who need assistance in order to remain healthy and independent in their homes. Nearly 90 percent of home-delivered meal clients and over 90 percent of congregate participants rate the meal as good to excellent.⁴⁶ The most recent data on how these nutrition programs are helping older adults remain healthy and independent in their homes include:

Home-Delivered Nutrition Services provided over 140.5 million meals to over 849,000 individuals in FY 2015.⁴⁷

³⁸ 2015 National Survey of Older Americans Act Participants. [AoA: AGing Integrated Database](#). and AoA's FY 2015 State Program Report. These data are preliminary and should not be taken as final

³⁹ Ibid.

⁴⁰ AoA's FY 2015 State Program Report. These data are preliminary and should not be taken as final

⁴¹ Administration for Community Living, <http://www.agid.acl.gov/DataGlance/>. Data-at-a-Glance: American Community Survey (ACS) Public Use Microdata Sample (PUMS) 1-Year Files (2014), accessed November 2016.

⁴² AoA's FY 2015 State Program Report. These data are preliminary and should not be taken as final

⁴³ 2015 National Survey of Older Americans Act Participants. [AoA: AGing Integrated Database](#).

⁴⁴ Thomas, K & Moe, V. [The relationship between Older Americans Act Title III State Expenditures & Prevalence of Low-Care Nursing Home Residents](#). Health Services Research. 12.3.12.

⁴⁵ Ibid.

⁴⁶ 2015 National Survey of Older Americans Act Participants. [AoA: AGing Integrated Database](#).

⁴⁷ AoA's FY 2015 State Program Report. These data are preliminary and should not be taken as final

Congregate Nutrition Services provided nearly 79 million meals to nearly 1.6 million older adults in a variety of community settings in FY 2015.⁴⁸

Consistent with the OAA’s requirement to target services to those most in need to help them maintain their health and independence, approximately 67 percent of home-delivered meal recipients have annual incomes at or below \$20,000.⁴⁹ Meals are especially critical for the 60 percent of home-delivered and 52 percent of congregate recipients who report these meals provide half or more of their food intake for the day.⁵⁰

Federal support for Nutrition Services is not expected to serve every older adult. These programs have strong partnerships with state and local governments, philanthropic organizations and private donations that contribute funding. In FY 2015, state and local funding comprised nearly 70 percent of all the funding for home-delivered meals and nearly 57 percent for congregate meals.⁵¹ Though all programs funded through the OAA rely on state and local funding in some part, funding for congregate and home-delivered meals leverages more state and local financial support than many other OAA services.

State and Territory Flexibility

Under the core state formula grant programs for Home and Community-Based Supportive Services and Nutrition Services, states and territories have the flexibility to allocate resources to best meet local needs through intra-state funding formulas which distribute funds to area agencies on aging (AAAs). These formulas vary by state and allow states to take into account their own local circumstances to best serve their population. States are required to submit their formulas to AoA for approval and must take into account the geographic distribution of older persons and the distribution of older persons in greatest social and economic need. AAAs administer these grants and provide grants or contracts to local service providers based on identified needs.

The OAA allows a state to transfer up to 40 percent of the funds between congregate and home-delivered meals for use as the state considers appropriate to meet the needs of the area served. Additionally, for any fiscal year in which the transferred funds are insufficient to satisfy the need for nutrition services, the Assistant Secretary for Aging may grant a waiver that permits the state to transfer an additional 10 percent of the funds to meet those needs. The OAA provides further flexibility to states by allowing them to transfer up to 30 percent for any fiscal year between Supportive Services programs and Nutrition Services programs, for use as the state considers appropriate. These are options open only to states and territories. A state agency may not delegate to an area agency on aging or any other entity the authority to make such transfers.

Table 1. FY 2015 Transfer of Federal funds within Title III of the OAA

	Part B – Home and Community- Based Supportive Services	Part C1 – Congregate Nutrition	Part C2 – Home-Delivered Meals
Initial Allotment	\$345,666,022	\$435,597,598	\$215,116,272

⁴⁸ Ibid.

⁴⁹ 2015 National Survey of Older Americans Act Participants. [AoA: AGing Integrated Database](#).

⁵⁰ Ibid.

⁵¹ AoA’s FY 2015 State Program Report. These data are preliminary and should not be taken as final

Final Allotment after Transfers	\$403,613,829	\$338,177,768	\$254,588,295
Net Transfer	\$57,947,807	(-\$97,419,830)	\$39,472,023
Net Percent Change	16.76	(-22.36)	18.35

Preventive Health Services (Title III-D of OAA; FY 2015: \$19,848,000)

Preventive Health Services, established in 1987, provide formula grants to states and territories based on their share of the population age 60 and over to support evidence-based disease prevention and health promotion programs. Older Americans are disproportionately affected by chronic disease and unintentional injury. There are many evidence-based health promotion programs that have been shown to be effective in reducing illness and injury, and improving older adult health. Preventive Health Services provide states and territories with the flexibility to allocate resources among the preventive health programs 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.

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 over 78 years today.⁵² On average, an American turning age 65 in 2014 can expect to live an additional 19.3 years.⁵³ The population of older Americans is growing very rapidly and is projected to reach 74.1 million by the year 2030.⁵⁴ One consequence of this increased longevity is the higher incidence of chronic diseases such as obesity, arthritis, diabetes, osteoporosis, and depression. As the population ages, the number of falls and falls-related injuries grows, resulting in increased hospitalizations and deaths.

Evidence-based programs empower older adults to take control of their health by increasing knowledge, changing behavior, and improving self-efficacy and self-management techniques. They are established activities, inputs, and resources for implementing health interventions that have been tested in a controlled trial setting and have been shown to be effective at improving health and/or reducing disease, illness, or injury. Some examples are:

- *Physical activity*: Maintaining (or increasing) physical activity is a necessary component for staying healthy. There are a number of evidence-based programs focused on empowering older adults to stay or become active. *EnhanceFitness* is a multi-component group exercise program that uses strength training, cardiovascular workouts, and balance and posture exercises, and has been shown to significantly reduce hospitalizations and healthcare costs for participants.⁵⁵

⁵² National Center for Health Statistics. [Health, United States, 2015](#) With Special Feature on Racial and Ethnic Health Disparities. Hyattsville, Maryland: 2016 Table 15. Life expectancy at birth, at age 65, and at age 75, by sex, race, and Hispanic origin: United States, selected years 1900-2014. Accessed November 2016.

⁵³ Murphy SL, Kochanek, KD, Xu JQ, Arias, E. Mortality in the United States, 2014. NCHS data brief, no 229, Hyattsville, MD: National Center for Health Statistics 2015.

⁵⁴ U.S. Census Bureau. Population Division. Table 9. Projections of the Population by Sex and Age for the United States: 2015 to 2060 (NP2014-T9). Release Date: December 2014. Accessed November 2016.

⁵⁵ Ackermann, R. T., Williams, B., Nguyen, H. Q., Berke, E. M., Maciejewski, M. L., & LoGerfo, J. P. (2008). Healthcare Cost Differences with Participation in a Community-Based Group Physical Activity Benefit for Medicare Managed Care Health Plan Members. *Journal of the American Geriatrics Society*, 56(8), 1459-1465.

- *Falls prevention:* Falls prevention programs help older adult participants improve strength, balance, and mobility; provide education on how to avoid falls and reduce fall risk factors; and some involve medication reviews and provide home assessments of ways to reduce environmental hazards.
- *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.⁵⁶ These programs have also been shown to improve medication usage rates and decrease medication errors among older adults.⁵⁷
- *Depression Care Management:* Depression is not a normal part of aging, yet it is a prevalent and disabling condition among older adults. Claims data (2014) reported by the Centers for Medicare & Medicaid Services (CMS) reveal that 13.6 percent of Medicare beneficiaries age 65 and older have a depression diagnosis.⁵⁸ Depression in older adults has been associated with high direct medical costs (i.e., hospitalizations), as well as significant indirect costs (i.e., unpaid caregiving).⁵⁹ Cost-effective, evidence-based interventions, such as the Program to Encourage Rewarding Lives for Seniors (PEARLS), developed in CDC’s Prevention Research Centers, have been shown to reduce depressive symptoms and improve quality of life in older adults.⁶⁰

Starting in 2012 and continuing every year since, ACL’s appropriations language specifies that funds from OAA Title III-D can be used “only for disease prevention and health promotion programs and activities which have been demonstrated through rigorous evaluation to be evidence-based and effective.” Even before this evidence-based requirement, states had already begun to shift their Preventive Health Services funding towards evidence-based approaches to achieve better results with limited funding. Since 2012, all Preventive Health Services funding has been used for evidence-based programs. States can continue funding other health services, such as blood pressure screenings, using OAA funding for supportive services (Title III-B).

⁵⁶ Meredith, S., Feldman, P., Frey, D., Giammarco, L., Hall, K., Arnold, K., Ray, W. A. (2002). Improving medication use in newly admitted home healthcare patients: A randomized controlled trial. *Journal of the American Geriatrics Society*, 50(9), 1484–1491. [PubMed abstract](#).

⁵⁷ A summary of these studies can be found at: <https://acl.gov/Programs/CPE/OPE/ADEPP.aspx>.

⁵⁸ [CMS Prevalence and Medicare Utilization and Spending for Chronic Conditions](#).

Snow, C.E.; Abrams, R.C. The Indirect Costs of Late-Life Depression in the United States: A Literature Review and Perspective. *Geriatrics* **2016**, *1*, 30.

⁶⁰ Program to Encourage Rewarding Lives for Seniors (2012). [PEARLS Program Description](#)

Chronic Disease Self-Management Education Programs (FY 2015: \$8,000,000)

In the United States, nearly 70 percent of Medicare beneficiaries have two or more chronic conditions.⁶¹ This burden places older adults at greater risk for premature death, poor functional status, unnecessary hospitalizations, adverse drug events, and nursing home placement.^{62,63} Chronic conditions also impact health care costs: 95 percent of health care costs for older Americans can be attributed to chronic diseases.⁶⁴

Chronic Disease Self-Management Education (CDSME) programs, such as the Stanford University Chronic Disease Self-Management Program (CDSMP), are low-cost, evidence-based disease prevention models that use proven techniques, allowing peer leaders to help individuals with chronic disease address issues related to the management and treatment of their condition, improve their health status, and potentially reduce their need for more costly medical care.⁶⁵ In addition to the CDSMP, which is appropriate for any type of chronic condition, there are other proven CDSME programs, including Tomando Control de su Salud (Spanish CDSMP), the Diabetes Self-Management Program (DSMP), Programa de Manejo Personal de la Diabetes (Spanish DSMP), Chronic Pain Self-Management Program, Positive Self-Management Program for HIV, and online versions of many programs, as well.

CDSME programs have been shown repeatedly, through multiple studies (including randomized control trials with both English and Spanish speaking populations) to be effective at helping participants adopt healthy behaviors and improve their psychological and physical health status.⁶⁶ A 2013 national study with over 1,100 CDSMP participants in 17 states documented many significant improvements relevant to CMS's goals to promote better care, healthier communities, and wiser spending of health care dollars. Participants demonstrated improved communication with physicians, medication compliance, health literacy, self-reported health, less depression, and better quality of life, as well as reduced emergency room visits and hospitalizations and an estimated \$360 per person net savings. The research team projected a national savings of \$3.3 billion if CDSMP workshops were delivered to 5 percent of adults with multiple chronic conditions.⁶⁷

CDSMEs emphasize an individual's role in managing his/her chronic condition(s). For example, the Stanford CDSMP in-person programs consist of a series of sessions that are conducted once a week for two and a half hours over six weeks in community settings such as senior centers, faith-

⁶¹ Lochner KA, Cox CS. Prevalence of Multiple Chronic Conditions Among Medicare Beneficiaries, United States, 2010. *Prev Chronic Dis* 2013.

⁶² Parekh, AK, et al. 2011. Managing Multiple Chronic Conditions: A Strategic Framework for Improving Health Outcomes and Quality of Life. *Public Health Rep.* 126(4):460-71.

⁶³ Kramarow, E et al. 2007. Trends in Health of Older Americans, 1970-2005. *Health Affairs (Milwood)*. Sep-Oct;26(5):1417-25.

⁶⁴ Centers for Disease Control and Prevention. *The State of Aging and Health in America 2013*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2013.

⁶⁵ Brady, T.J., et al. 2013. "A Meta-analysis of Health Status, Health Behaviors, and Health Care Utilization Outcomes of the Chronic Disease Self-Management Program." *Prev Chronic Dis* 10:120112.

⁶⁶ Centers for Medicare & Medicaid Services, Report to Congress: The Centers for Medicare & Medicaid Services' Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act. <http://innovation.cms.gov/Files/reports/CommunityWellnessRTC.pdf>. Accessed August 4, 2015.

⁶⁷ Ahn S et al. The Impact of Chronic Disease Self-Management Programs: Healthcare Savings through a Community-Based Intervention. *BMC Public Health*. 2013. 13:1141. doi:10.1186/1471-2458-13-1141 Available at: <http://www.biomedcentral.com/1471-2458/13/1141>. Accessed August 4, 2015.

based organizations, health care organizations, libraries, residential facilities, and tribal centers. CDSME workshops are facilitated by two trained leaders, and people with varying chronic conditions participate together. One or both of the leaders are non-health professionals who also have a chronic condition. Workshop topics 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 family/friends; and 5) nutrition.

AoA funds CDSME through competitive grants awarded to domestic public or private nonprofit entities. External experts review project proposals. AoA awarded 22 grants for a three-year period spanning September 1, 2012 through August 31, 2015, as well as eight grants for a two-year forward funded project period beginning September 1, 2015. A thorough annual assessment of grantees funded through the Prevention and Public Health Fund (PPHF) from 2012-2015 tracked progress toward sustainable and integrated service systems, highlighting elements such as leadership, delivery infrastructure, business planning and financial sustainability, and centralized and coordinated logistical processes.⁶⁸ During the grant cycle, nine different CDSME programs were offered. Over the three-year period, there were significant gains in key elements of delivery infrastructure, with most grantees reporting an adequate pool of program facilitators and statewide delivery capacity. Key partners in CDSME delivery included area agencies on aging, federally qualified health centers, hospitals, health care systems, health insurers, and organizations serving ethnic minorities. Additionally, 65 percent of grantees reported to a large or moderate extent that they have an effective business plan and process in place to fund CDSME after the grant period. Areas that rated the strongest and showed the greatest gains were partnerships with health care organizations, calculated operating costs, an established per participant cost, and a statewide distribution system.

By September 30, 2015, grantees had reached a cumulative total of over 140,000 participants. During FY 2015, there were 51,680 participants and 37,702 “completers” (i.e., who attended at least four out of six classes, a retention rate of 73 percent). Grantees were successful in reaching their targeted underserved populations: of those participants reporting relevant data, 67 percent were age 60 or older, 58 percent reported having multiple chronic conditions, 45 percent reported a disability, and 48 percent were racial/ethnic minorities.⁶⁹

Through financing from the FY 2015 PPHF, AoA also funded a National Resource Center to assist states, the aging, disability and public health networks, and their partners to increase access to and sustain evidence-based prevention programs, particularly CDSME programs which improve the health and quality of life of older adults and adults with disabilities. The Center also serves as a national clearinghouse of tools and information on CDSME.

Behavioral Health

Behavioral health is essential to overall health. Behavioral health issues, such as depression, anxiety, substance misuse, and suicidal thoughts or actions, are not a normal part of aging – yet

⁶⁸ [Chronic Disease Self-Management Program Integrated Services Delivery System Assessment Tool Results](#). National Council on Aging. 2015. Accessed November 28, 2016.

⁶⁹ Racial/ethnic minorities refer to individuals who self-report at least one of the following racial or ethnic identities: Asian, Black or African American, Hispanic or Latino, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native.

one in four persons aged 55 and over have experienced a mental disorder.⁷⁰ Behavioral health issues can greatly impact the independence, health, and well-being of older adults and their family caregivers. Untreated behavioral health disorders can exacerbate health conditions, decrease life expectancy, and increase overall healthcare costs.⁷¹ Distinctive barriers to the treatment of behavioral health disorders among the older adult population exist, such as discrimination, under-diagnosis, and inappropriate treatment.

The good news is that prevention, brief intervention, self-directed treatment, and recovery from behavioral health disorders are possible for individuals of all ages, including older adults. While the 2006 reauthorization of the OAA included new provisions focused on the prevention and treatment of mental disorders, there is no funding in the OAA specifically designated for prevention, intervention, and treatment services. States and communities have had to be creative in how they support these programs and services. Many aging network providers are working closely with behavioral health, primary care, and other partners to connect older adults with existing behavioral health resources. In addition, some providers are delivering evidence-based community interventions, such as the Program to Encourage Rewarding Lives for Seniors (PEARLS), using a braided funding approach (i.e., using a combination of funds, such as those from the OAA, Substance Abuse and Mental Health Services Administration (SAMHSA) block grants, private foundations, etc.).

In FY 2015, ACL and SAMHSA continued its partnership to provide technical assistance aimed at increasing states' capacities for reaching older adults who are experiencing or are at-risk for behavioral health disorders. Most recently, they worked together to support the development of a variety of tangible materials, such as epidemiological profiles, toolkits, issue briefs, and learning opportunities, such as webinars. The materials developed through this partnership have been successful in helping many states enhance their efforts to reach older adults who are experiencing or are at-risk for behavioral health disorders.

Falls Prevention Programs **(FY 2015: \$5,000,000)**

Falls can have a widespread and significant impact on health, can be deadly, and often result in high costs. One out of four older adults (those aged 65 or older) fall each year,⁷² but less than half talk to their healthcare providers about it.⁷³ In 2014, 2.8 million nonfatal falls among older adults were treated in emergency departments and more than 800,000 of these patients were hospitalized.⁷⁴ In 2014, adjusted for inflation, the direct medical costs for fall injuries were \$31 billion annually.⁷⁵

⁷⁰ Substance Abuse and Mental Health Services Administration (SAMHSA). (2012). [Older Americans Behavioral Health Issue Brief: Series Overview](#).

⁷¹ World Health Organization (2016). Mental Health and Older Adults,: A Fact Sheet. Retrieved from <http://www.who.int/mediacentre/factsheets/fs381/en/>

⁷² U.S Centers for Disease Control and Prevention. (2016). Facts About Falls. Accessed November 28th, 2016 from <http://www.cdc.gov/homeandrecreationalafety/falls/adultfalls.html>.

⁷³ Stevens JA, Ballesteros MF, Mack KA, Rudd RA, DeCaro E, Adler G. Gender differences in seeking care for falls in the aged Medicare Population. *American Journal of Preventive Medicine* 2012;43:59–62.

⁷⁴ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. Accessed August 5, 2016.

⁷⁵ Burns EB, Stevens JA, Lee RL. (2016). The direct costs of fatal and non-fatal falls among older adults—United States. *Journal of Safety Research*,

Research has shown that falls, and the risk of falls, can be reduced through systematic risk identification and targeted intervention, including a combination of clinical and community-based interventions.⁷⁶ Community-based falls prevention programs are low-cost, evidence-based disease prevention models that help reduce falls and/or fall risk factors in older adults, and potentially reduce their need for more costly medical care. Examples of these programs include: A Matter of Balance (MOB); Tai Chi: Moving for Better Balance (Tai Chi: MBB); Otago; and Stepping On. A recent CMS report to Congress indicated that MOB is associated with medical cost savings,⁷⁷ and a recent study showed a positive return on investment for the implementation of Tai Chi: MBB, Stepping On, and Otago.⁷⁸

ACL received dedicated funding for falls prevention programs through the Prevention and Public Health Fund (PPHF) in FY 2015. A competitive funding announcement was published, and applications for this opportunity were reviewed by external experts. A total of 7 grants were awarded to domestic public and private nonprofit entities, including state agencies, a university, and community organizations. These two-year grants are intended to increase the number of older adults and adults with disabilities who participate in evidence-based community programs to reduce falls, fall risks, and fear of falling. All of the grantees identified underserved target populations and partnering organizations to reach these populations, such as those living in rural areas, and organizations serving ethnically-diverse and/or limited English speaking populations. The funding is also fostering the development of innovative funding arrangements to support these falls prevention programs, while embedding the programs into an integrated, sustainable evidence-based prevention program network. Grantees have a cumulative goal of reaching 16,876 older adults and/or older adults with disabilities over the two-year period.

Through financing from the FY 2015 PPHF, AoA also funded the National Falls Prevention Resource Center to work collaboratively – on behalf of the public, aging services network, and other stakeholders – to increase public education about the risks of falls and how to prevent them, as well as to support and stimulate the implementation and dissemination of evidence-based community programs and strategies that have been proven to reduce the incidence of falls among seniors.

⁷⁶ Tinetti, M.E., Dorothy I. Baker, D.I., King, M, Gottschalk, M.,Murphy, T.E., Acampora,D., Carlin, B.P., Linda Leo-Summers, L., and Allore, H.G. (2008) Effect of Dissemination of Evidence in Reducing Injuries from Falls. *N Engl J Med*;359:252-61.

⁷⁷ Report to Congress: The Centers for Medicare & Medicaid Services' Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act. Accessed February 10th, 2015 from:<http://innovation.cms.gov/Files/reports/CommunityWellnessRTC.pdf>.

⁷⁸ Carande-Kulisa, V., et al. (2015), A cost-benefit analysis of three older adult fall prevention interventions, *Journal of Safety Research*, Accessed February 2nd, 2015 from: <http://www.cdc.gov/homeandrecreationsafety/Falls/steady/index.html#practice>.

Caregiver Services

Families are the nation's primary providers of 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 often are strapped for both. AoA's caregiver programs provide services that address the needs of unpaid, informal caregivers, allowing many of them 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 or unrelated friends, neighbors, and others who have a significant relationship with the person who volunteers their time – that determines whether an older person can remain in his or her home. In 2014, approximately 34.2 million adult caregivers provided uncompensated care to those 50 years of age and older.⁷⁹ In other words, approximately 14.3 percent of all adults provided care to someone age 50 years and older.⁸⁰ AARP estimated the economic cost of replacing unpaid caregiving in 2013 to be about \$470 billion, an increase from \$450 billion in 2009 (cost if that care had to be replaced with paid services).⁸¹ Another recent study by the Rand Corporation estimated the economic cost of replacing unpaid caregiving to be about \$522 billion annually.⁸² The cost to replace that care with unskilled paid care at minimum wage was estimated at \$221 billion, while replacing it with skilled nursing care could cost \$642 billion annually. These estimates differ because of differences in methodology and definitions rather than contradictory data.

The demands of caregiving can be considerable. Recent research has demonstrated that caregiving tasks can, and do, go well beyond providing regular assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). A 2012 study by AARP and United Hospital Fund revealed that, while family caregivers continue to perform the traditional ADL/IADL supports, their roles are expanding dramatically to include performing medical/nursing tasks of the type and complexity typically seen only in hospitals and other acute care settings.⁸³

Such demands on family caregivers can lead to a breakdown of their health and can increase the risk for institutionalization of the care recipient. While research is mixed on the exact physical health impacts of family caregiving, several recent studies show that caregivers reporting mental and emotional strain as a result of their caregiving role are at higher risk for mortality.^{84,85,86}

⁷⁹ Research Report: Caregiving in the U.S. 2015- A Focused Look at Caregivers of Adults Age 50+. National Alliance for Caregiving and AARP Public Policy Institute. June 2015. http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Care-Recipients-Over-50_WEB.pdf

⁸⁰ Ibid.

⁸¹ [Valuing the Invaluable: 2015 Update, The Growing Contributions and Costs of Family Caregiving](#). AARP Public Policy Institute. July 2015.

⁸² *The Opportunity Costs of Informal Elder-Care in the United States*. The Rand Corporation. 2014. http://www.rand.org/pubs/external_publications/EP66196.html.

⁸³ [Home Alone: Family Caregivers Providing Complex Chronic Care. AARP and United Hospital Fund](#). October 2012.

⁸⁴ Perkins, M., Howard, V. J., Wadley, V. G., Crowe, M., Safford, M. M., Haley, W. E., Roth, D. L. (2013). Caregiving strain and all-cause mortality: Evidence from the REGARDS Study. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 68, 504-512. doi:10.1093/geronb/gbs084.

⁸⁵ Roth, D. L., Haley, W. E., Hovater, M., Perkins, M., Wadley, V. G., & Judd, S. (2013). Family caregiving and all-cause mortality: Findings from a population-based propensity-matched analysis. *American Journal of Epidemiology*, 178, 1571-1578. doi:10.1093/aje/kwt225

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. Eighty percent of the caregivers served by OAA programs report that these services allow them to provide care longer than they otherwise could.⁸⁷

At the same time, AoA recognizes that it must also address the growing need for more caregivers every day. By 2020, it is projected that there will be 16.4 million older adults living in the community age 65 and over with one or more ADL limitations, an increase of 2.5 million seniors (or an 18 percent increase between 2015 and 2020) needing caregiver assistance.⁸⁸

National Family Caregiver Support Program *(Title III-E of OAA; FY 2015: \$145,586,000)*

The National Family Caregiver Support Program (NFCSP) 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 family member at home for as long as possible. The NFCSP 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 older individuals which caregivers can access on their behalf.

The NFCSP provides a variety of supports to family and informal caregivers. In FY 2015, services provided included:⁸⁹

- *Access Assistance Services*, which provided over 1.1 million contacts to caregivers assisting them in locating services from a variety of public and private agencies.
- *Counseling and Training Services*, which provided over 116,000 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving.
- *Respite Care Service*, which provided nearly 67,000 caregivers with approximately 6.2 million hours of temporary relief – at home or in an adult day care or nursing home setting – from their caregiving responsibilities.

⁸⁶ Roth, D. L., Fredman, L., & Haley, W. E. (2015, Special Issue). Informal caregiving and its impact on health: A reappraisal from population-based studies. *The Gerontologist*, 55, 309-319. doi:10/1093/geront/gnu177

⁸⁷ 2015 National Survey of Older Americans Act Participants. [AoA: AGing Integrated Database](#)

⁸⁸ U.S. Census Bureau. Population Division. Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2015. Release Date: June 2016. Accessed November 2016, and U.S. Census Bureau. Population Division. Table 9. Projections of the Population by Sex and Age for the United States: 2015 to 2060 (NP2014-T9). Release Date: December 2014. Accessed November 2016, and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. [Data from the 2013 Medicare Current Beneficiary Survey](#). [data tables 2.5a and 2.6a]. Accessed November 2016.

⁸⁹ AoA's FY 2015 State Program Report. These data are preliminary and should not be taken as final

Family and other informal caregivers are the backbone of America's long-term care system. On a daily basis, these individuals, the majority of whom are women, 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. Data from AoA's 2015 National Survey of OAA Participants show that nearly 20 percent of caregivers are assisting two or more individuals. Over 70 percent of Title III caregivers are 60 or older, making them more vulnerable to a decline in their own health, and 29 percent describe their own health as fair to poor.⁹⁰ The demands of caregiving can lead to a breakdown of the caregiver's health. Nationally, approximately 11 percent of caregivers report that caregiving has caused their physical health to decline.⁹¹ Caregivers often experience conflicts between work and caregiving. Among working caregivers caring for a family member or friend, 60 percent report work impacts due to caregiving such as having to rearrange their work schedule, decrease their hours or take an unpaid leave in order to meet their caregiving responsibilities.⁹²

Survey results from caregivers served by the NFCSP indicate that the types of supports provided through the NFCSP can enable them to provide care longer (74 percent) while often continuing to work,⁹³ thereby avoiding or delaying the need for costly institutional care, including care financed by government. Additionally, another study 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, on average, for an additional year before being admitted to a nursing home.⁹⁴

Data from AoA's national surveys of caregivers of elderly clients also reveal that OAA services, including those provided through the NFCSP, are effective in helping caregivers assist their loved ones at home. Caregivers receiving services were asked whether the care recipient would have been able to live in the same residence if the services had not been available. Over 40 percent of the caregivers indicated that the care recipient would be unable to remain at home without the support services.⁹⁵ Those respondents were then asked to identify where the care recipient would be living without services. A significant majority of those caregivers, nearly 80 percent, indicated that the care recipient would most likely be living in a nursing home or an assisted living facility (see the chart on the next page).⁹⁶

⁹⁰ 2015 National Survey of Older Americans Act Participants. [AoA: AGing Integrated Database](#).

⁹¹ Center on Aging Society. (2005) How Do Family Caregivers Fare? A Closer Look at Their Experiences. (Data Profile, Number 3). Washington, DC: Georgetown University.

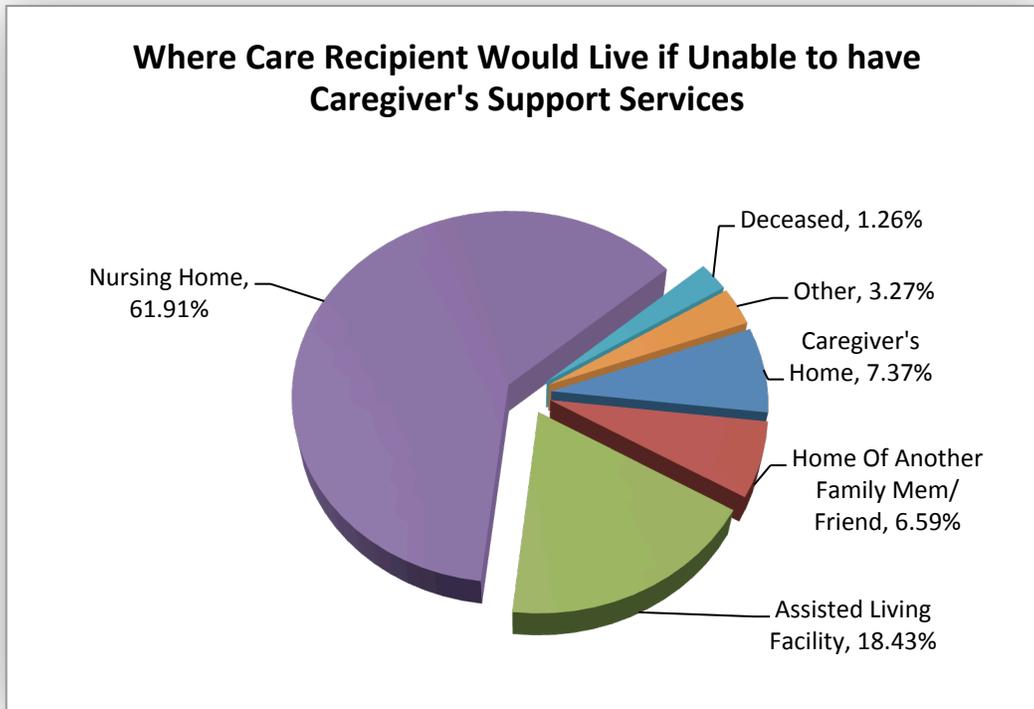
⁹² Research Report: [Caregiving in the U.S. 2015- A Focused Look at Caregivers of Adults Age 50+](#). National Alliance for Caregiving and AARP Public Policy Institute. June 2015.

⁹³ 2015 National Survey of Older Americans Act participants. [AoA: AGing Integrated Database](#).

⁹⁴ Mittelman, M., Ferris, S., Shulman, E., Steinberg, G., Levin, B. (1996). A family intervention to delay nursing home placement of patients with Alzheimer's disease - A randomized controlled trial. *The Journal of the American Association*, 276(21), 1725-1731.

⁹⁵ 2015 National Survey of Older Americans Act Participants. [AoA: AGing Integrated Database](#)

⁹⁶ *Ibid.*



Brain Health

The majority of older adults living in the community do not have problems with cognition; that is, the ability to think, learn, remember, and manage their lives. Aging can bring some changes in cognition that are normal, which includes some difficulty finding words, less ability to multi-task, and slight decreases in attentiveness. However, older adults can still learn new things, create new memories, improve vocabulary and language skills and manage their lives.

Promoting brain health is critical to helping older adults maintain their cognition, independence and overall health. AoA works with the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) to develop and maintain a [Brain Health Resource](#) (the Resource) to promote brain health among older adults, people with disabilities, and their caregivers.

The Resource addresses a number of risks to brain health, including: accidents; medication use; smoking and alcohol misuse; health conditions like heart disease and diabetes; poor diet; insufficient sleep; and lack of physical and social activity. For each of these risks the Resource supplies evidence-based information and governmental resources that can help professionals, older adults, and people with disabilities promote brain health. Many of the resources, like AoA's nutrition, chronic disease self-management education, falls prevention, and medication programs, promote overall health, including brain health.

There are three parts to the Brain Health Resource, with more on the way. Brain Health Basics helps people learn and teach others about the risks related to brain health and how to reduce them. Brain Injury helps people learn and teach others about how to prevent brain injury and how to get help when someone has one. Dementia explains how to create "dementia-capable"

long-term services and supports at the state and local levels to help people who have Alzheimer's disease and other types of dementia and their caregivers.

AoA, NIH, and CDC will continue their collaboration on the Brain Health Resource over time. This work occurs under the direction of the Department of Health and Human Services' National Plan to Address Alzheimer's Research, Care and Services.⁹⁷

Alzheimer's Disease Supportive Services Program (ADSSP) *(FY 2015: \$3,800,000)*

Established under Section 398 of the Public Health Services Act, as amended, (42 U.S.C. 280c-3), the Alzheimer's Disease Supportive Services Program (ADSSP) funds competitive grants to states to expand the availability of dementia-capable community-level supportive services for persons with Alzheimer's disease and related dementias (ARD), their families, and their caregivers. Alzheimer's disease is an irreversible, progressive brain disorder that destroys memory and thinking. Symptoms usually appear in a person's mid-60's, but they can occur earlier. More than five million Americans may have the disease, and it is ranked as the sixth leading cause of death in the U.S.

In its effort to improve home and community-based services for persons with ARD, AoA presently focuses its ADSSP resources toward building systems within states that are designed to ensure access to sustainable, integrated long-term services and supports that are capable of meeting the needs of persons with ARD and their caregivers, as well as to improve the responsiveness of home and community-based services systems to persons with dementia. The primary components of the ADSSP program includes delivery of evidence-based supportive services; translating and replicating evidence-based interventions, at the community level, for persons with dementia and their caregivers; and advancing changes to a state's overall system of home and community-based care.

ADSSP expands the aging services network's capacity to assist those with ARD and their families through provision of individualized and public information, education, and referrals for diagnostic, treatment and related services; as well as sources of assistance for services and legal rights assistance for people affected by dementia throughout a state's long-term services and support system.

The most recent ADSSP grant projects are designed to ensure that states provide people with ARD and their family caregivers with access to a sustainable home and community-based services system that is "dementia capable." Such a system meets the unique needs of each person with ARD by: 1) identifying those with a possible dementia and recommending follow-up with a physician; 2) ensuring that the staff they encounter have appropriate training, understand the unique needs/services available and knowing how to communicate with them; and 3) providing quality, person-centered services that help them remain independent and safe in their communities. Presently, there are 18 states implementing grants dedicated to the development of dementia-capable systems.

⁹⁷ [ASPE National Plan to Address Alzheimer's Disease: 2015 Update](#)

Through projects funded both in new ADSSP grant projects and those remaining from earlier program designs, states continue to translate and implement dementia-specific evidence-based interventions into practice. Overall, these demonstration programs offer direct services and other supports to thousands of individuals and families, as well as supporting continuous quality improvement and evaluation of HCBS.

Family caregivers remain the major source of support for most people with ADRD and, as such, they access a variety of services from many different systems including the aging, medical, and mental health service systems. As the number of people living with ADRD grows, it is increasingly important to ensure the availability of dementia-capable HCBS. These important services, and the systems through which they are delivered, must be efficient and effectively coordinated. The ADSSP program provides states the opportunity and resources to develop the necessary dementia-capable systems and direct services in support of persons living with ADRD and their caregivers. These cost-effective services and supports enhance the effectiveness of service delivery and health care systems in response to the needs of many persons with dementia and their caregivers.

Alzheimer's Disease Initiative – Specialized Supportive Services (ADI-SSS) *(FY 2015 - \$10,500,000)*

In FY 2015, ACL received resources from the Prevention and Public Health Funds (PPHF-2015) within the Patient Protection and Affordable Care Act (PPACA) to fund cooperative agreements designed to fill identified gaps in long-term services and supports (LTSS) services for persons living with ADRD and their caregivers. The program is open to states and community-based entities that are operating within an existing dementia-capable system through which persons with ADRD and their caregivers receive quality, person-centered services that help them remain independent and safe in their communities.

The existing gaps targeted through the ADI-SSS program align with the recommendations of the National Alzheimer's Project Act Advisory Committee and include the following areas:

- Provision of effective supportive services to persons living alone with ADRD in the community.
- Provision of effective care/supportive services to persons living with moderate to severe impairment from ADRD and their caregivers.
- Improvement of the quality and effectiveness of programs and services dedicated to individuals aging with intellectual and developmental disabilities associated with ADRD or those at high risk of developing ADRD.
- Delivery of behavioral symptom management training and expert consultation for family caregivers.

All grantees are required to implement programs that contain components addressing a minimum of three of the four above referenced gaps.

In FY 2015, eleven unique organizations received ADI-SSS program awards, joining the ten organizations funded in FY 2014. The FY 2015 program recipients will implement programs tailored to address the unique needs of the communities they serve, which include states and local governments, a health system and several community-based organizations. Each of the funded programs, which have demonstrated dementia capability, meet the requirement for the implementation of at least one dementia related evidence-based intervention, dedicate a substantial percentage of program resources to the provision of direct services and 25 percent

cost-sharing through either in-kind or cash match. Through targeted partnerships and community engagement, grantees are able to implement a broad range of services and supports to persons with ADRD and their caregivers. Examples of program activities include, but are not limited to, support programs dedicated to both persons with dementia and their caregivers, behavioral symptom management training, dementia capable care coordination training, as well as development of dementia capable community initiatives which include awareness training for a broad range of community workers and first responders.

PART II: OLDER AMERICAN INDIANS, ALASKA NATIVES & NATIVE HAWAIIANS

Nutrition and Supportive Services *(FY 2015: \$26,158,000)*

Native American Nutrition and Supportive Services provides grants to eligible tribal organizations for the delivery of nutrition and home and community-based supportive services to Native American, Alaska Native, and Native Hawaiian elders. An estimated 849,000 persons age 60 and over identify themselves as Native American or Alaska Native alone or in combination with another racial group.⁹⁸ Over 492,000 of those elders identify as Native American or Alaska Native with no other racial group.⁹⁹

In the United States, the number of adults aged 65 years or older increased by 14.8 percent (5.2 million) between 2000 and 2010. This growth of the overall older adult population is also evident in Indian Country. Between 2000 and 2010, the number of older American Indian and Alaska Native (AI/AN) adults increased by 40.5 percent, a growth that is 2.7 times greater than that of the overall population of older adults over the same 10-year period.¹⁰⁰ In addition, this rapidly growing population is also experiencing some of the highest rates of disability,¹⁰¹ chronic disease, and poverty¹⁰² in the United States. Because of the combined factors of an aging population and high disability rates, AI/ANs have a great need for home and community-based services access in their communities.

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, help with chores, and other services. Currently, AoA's congregate meals program reaches more than one-quarter (28 percent) of eligible Native American seniors in participating tribal organizations, home-delivered meals reach 20 percent of such persons, and supportive services reach 46 percent of such persons.¹⁰³ These programs, which can help to reduce the need for costly nursing home care and medical interventions, are responsive to the cultural diversity of Native American communities and are an important part of each community's comprehensive services.

⁹⁸ U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population by Sex, Single Year of Age, Race Alone or in Combination, and Hispanic Origin for the United States: April 1, 2010 to July 1, 2015 Released June 2016, accessed November 2016.

⁹⁹ U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population by Sex, Single Year of Age, Race, and Hispanic Origin for the United States: April 1, 2010 to July 1, 2015. Released June 2016. Accessed November 2016.

¹⁰⁰ Administration on Aging, U.S. Population by Age: 65+ Minority Population Comparison using Census 2000 and Census 2010 (July 1, 2011).

¹⁰¹ National Council on Disability, "Understanding Disabilities in American Indian and Alaska Native Communities: Toolkit Guide" (2003).

¹⁰² Centers for Disease Control and Prevention, "CDC Health Disparities and Inequalities Report – United States" (2013).

¹⁰³ AoA's FY 201 Title VI Program Report. Title VI of the Older Americans Act permits tribes to establish age of eligibility for services below age 60. Calculation based on eligible population as reported in grantee applications

Services provided by this program in FY 2015 included:¹⁰⁴

- *Transportation Services*, which provided over 750,000 rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical activities.
- *Home-Delivered Nutrition Services*, under which over 2.6 million meals were provided to over 42,000 homebound Native American elders; the program also provides critical social contacts that help to reduce the risk of depression and isolation experienced by many home-bound Native American elders.
- *Congregate Nutrition Services*, which provided over 2.5 million meals to over 60,000 Native American elders in community-based settings, as well as an opportunity for elders to socialize and participate in a variety of activities, including cultural and wellness programs.
- *Information, Referral and Outreach Services*, which provided 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.

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, Alaska 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.

Caregiver Support Services **(FY 2015: \$6,031,000)**

Native American Caregiver Support Services provide grants to eligible tribal organizations to provide support for family and informal caregivers of Native American, Alaska Native and Native Hawaiian elders. This program, which also helps to reduce the need for costly nursing home care and medical interventions, is responsive to the cultural diversity of Native American communities and represents 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, Alaska 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

¹⁰⁴ AoA's FY 2015 Title VI Program Report.

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.

Grants assist American Indian, Alaska 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. Annually, tribal grantees provide over 80,000 hours of respite care, just over 15,000 hours of caregiver training, and assisted nearly 20,000 caregivers to access needed services.¹⁰⁵ 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.

¹⁰⁵ Ibid.

PART III: ELDER RIGHTS

AoA works to promote the rights of older adults through several distinct but complementary programs. Among other things, these programs provide a full array of services designed to prevent, detect, and respond to elder abuse, neglect, and exploitation, both at home and in institutional settings.

Prevention of Elder Abuse and Neglect *(FY 2015: \$4,773,000)*

The Prevention of Elder Abuse and Neglect program (Title VII, Section 721) provides state formula grants for training and education, promoting public awareness of elder abuse, and supports state and local elder abuse prevention coalitions and multi-disciplinary teams. These activities are important elements of AoA's enhanced focus in FY 2015 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 OAA funds to obtain other funding for these activities.

As the population of older Americans increases, 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 2000.¹⁰⁶ 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.¹⁰⁷ Together, these data suggest that a minimum of five 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.¹⁰⁸ Additional adverse health impacts include an increased likelihood of heart attacks, dementia, depression, chronic diseases and psychological distress. One 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.¹⁰⁹

¹⁰⁶ 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/2-14-06%20FINAL%2060+REPORT.pdf

¹⁰⁷ 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

¹⁰⁸ 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.

¹⁰⁹ 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.

Examples of state elder abuse prevention activities include:

In Vermont, the AAA in the remote Northeast Kingdom region has developed a coalition of community partners who meet together regularly to address elder justice and elder abuse through collective action. Partners include: Vermont State Police, Caledonia County State's Attorney Office; Caledonia State's Attorney Victim Advocate, DOC Victim Advocate, Northeast Kingdom Human Services, Adult Protective Services, St. Johnsbury Health and Rehab, the SIU-Caledonia Special Investigations Unit, the local transportation provider, local hospital, Legal Aid long-term care ombudsman, and Office of Public Guardian. In addition to regular meetings, the partners together organized a community awareness event focused on elder justice and elder abuse prevention on World Elder Abuse Awareness Day in June.

Louisiana has invested Section 721 funds to: meet the medical needs of abandoned, incapacitated seniors who have nobody to consent to medical treatment of an appropriated residential placement; assist hospitals and other treatment facilities to reduce the number of abandoned, incapacitated senior needing medical care and residential placements; assist long-term care facilities with medical needs of abandoned, incapacitated seniors; and to assist abandoned, incapacitated seniors with asset/benefits management to see that their finances are being appropriately managed to pay for their care.

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.

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 and provides technical assistance and training to states and community-based organizations. The NCEA makes available news and resources, collaborates on research, provides consultation, education, and training; 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 that target the elderly.

In FY 2015, the NCEA:

- Responded to over 727 individual public inquiries and requests for information regarding elder abuse.
- Conducted 47 community based local and national presentations, including large scale conferences with an approximate reach of 2,500 individuals representing diverse backgrounds.
- Developed collaborations with membership organizations and other nationally recognized resource centers that identify information and connections to local supportive services for API, Latino, Native American, LGBTQ, African American, and Alzheimer's resource centers.

- Successfully conducted a ten-week World Elder Abuse Awareness Day (WEAAD) Campaign that featured national experts posting blogs and being available for twitter chats. Among the outcomes: social media tracking indicated that one segment alone had over 1,000,000 impressions; and hosted an International WEAAD webinar with over 300 participants from around the world.

National Legal Assistance and Support Projects
National Legal Resource Center
(FY 2015: \$653,677)

National Legal Assistance and Support grants funded a comprehensive national legal assistance support system for professionals and advocates working in legal and aging services networks. These grants collectively formed the National Legal Resource Center (NLRC), which is designed to empower professionals in aging and legal networks with the tools and resources necessary to provide older clients and consumers with high quality legal assistance in areas of critical importance to their independence, health, and financial security.

As a streamlined and accessible point of entry, the NLRC supported the leadership, knowledge, and systems capacity of legal and aging provider organizations in order to enhance the quality, cost-effectiveness, and accessibility of legal assistance and elder rights protections available to older persons with social or economic needs. The audience targeted to receive support services through the NLRC included a broad range of legal, elder rights, and aging services professionals and advocates. These included legal assistance providers, legal assistance developers, long-term care ombudsmen, State Unit on Aging directors, AAA and ADRC personnel, senior legal helplines (SLHs), and others involved in protecting the rights of older persons.

The NLRC provided core resource support through a strategic combination of case consultation, training, and technical assistance on a broad range of legal issues and systems development issues. Examples of common legal issues on which the NLRC provided assistance include preventing the loss of an older individual's home through foreclosure; protecting against consumer scams and creditor harassment; addressing elder abuse in the community and in long-term care facilities; and difficulties in accessing public benefits essential to financial security, independence, and health. The NLRC also provided technical assistance on the efficient, cost-effective, and targeted provision of state-wide legal and elder rights advocacy services.

In FY 2015, older consumers and the legal providers who serve them faced a host of legal challenges. In response to an increasing demand for legal resource support, the NLRC provided training and case consultation to over 9,500 aging and legal service professionals nationwide. NLRC partners also provided important technical support in the implementation of the Model Approaches projects in 24 states, featuring the provision of expertise in legal needs and capacity assessments, effective targeting and outreach methodologies, statewide reporting systems, and legal service delivery standards. With regard to technical support directed at SLHs, the NLRC provided assistance to 25 SLHs on various service delivery issues, including outreach, case management, data collection, and outcome measurement.

An essential structural feature of the NLRC is that the combined efforts of several partnering organizations with high levels of subject matter expertise were required to achieve its broad resource support objectives. Through effective collaborations, interlocking work plans, and the

leveraging of organizational resources, NLRC partners have demonstrated the ability to achieve effective national coverage on high priority legal issues areas.

In addition, the [NLRC website](#) continues to serve as a single entry point into a national legal assistance support system providing high quality resources and expertise on a broad range of legal and systems development issues.

Model Approaches to Statewide Legal Assistance Systems *(FY 2015: \$1,966,329)*

The Model Approaches to Statewide Legal Assistance Systems (Model Approaches) demonstration grants represent an innovative departure from ACL's past approach to the funding of Senior Legal Helplines (SLHs). Thirty-one states have been awarded Model Approaches grants, which seek to address the nationwide challenge of coordinating what are often fragmented and inconsistent legal service delivery systems that do not always provide access to quality services for older Americans who are most in need. Model Approaches helps states develop and implement cost-effective, replicable approaches for integrating SLHs and other essential low cost mechanisms into the broader spectrum of state legal service delivery networks. Ultimately, legal assistance provided through well-integrated and cost-effective service delivery systems, as demonstrated through Model Approaches, directly impacts the ability of older individuals to remain independent, healthy, and financially secure in their homes and communities.

Model Approaches features strong leadership at the state level to achieve its service delivery integration objectives. State legal assistance developers have demonstrated effective leadership in incorporating the use of SLHs and other low-cost mechanisms into the state legal services delivery system. Key project partners and service delivery components also include Title III-B legal services providers, private bar pro-bono attorneys, law school clinics, and self-help sites. By promoting the seamless integration of these vital legal service delivery components, Model Approaches enables seniors most in need to access quality legal services in priority legal issue areas involving income security, healthcare financing, consumer fraud, housing and foreclosure prevention, and elder abuse. In addition, by ensuring strong leadership at the state level, Model Approaches projects have created important partnerships and linkages between the existing legal assistance community and the broader community-based aging and elder rights networks, including AAAs, ADRC, state long-term care ombudsmen, and Adult Protective Services.

As a key centerpiece of the Model Approaches projects, SLHs assist older persons in accessing quality legal services to ensure their rights and enhance their independence and financial security. In 2015, Model Approaches projects assisted 19,995 older consumers with the greatest social or economic needs on a wide range of priority legal issues related to public benefits, health care, housing, advance planning, and consumer protection. Some recent examples of the success of SLHs' experience in assisting individuals include:

- An 84 year old women contacted a SLH for advice on how to have her grandchildren and great-grandchildren removed from her home. She stated that her great-grandson regularly abused drugs and alcohol and that she no longer felt safe in her own home. Through the assistance of the SLH attorney, the women was able to reclaim her home where she can now live in peace without fearing for her own safety.

- A 91-year woman was facing foreclosure on her home. When she was finally able to pay the overdue amount, the lender refused to accept the money and dismiss the foreclosure complaint. A SLH attorney was able to assist her with filing a pro se motion for extension of time to answer. She was then able to enlist the help of a volunteer attorney who had the foreclosure case dismissed and saved her home.

In addition to providing assistance on priority legal issues, SLHs under Model Approaches have been very successful in reaching low income populations with over 75 percent of older clients having incomes at or below 200 percent of the federal poverty guidelines. Minority¹¹⁰ clients receiving assistance through SLHs in the last reporting period constituted 26 percent of all clients served. These figures illustrate the effectiveness of Model Approaches states in reaching key target populations under the OAA with much needed “priority” legal assistance.

An important purpose of the Model Approaches demonstrations is to position SLHs as coordinated and essential components of high quality and high impact legal service delivery systems that effectively target scarce resources to older persons most in need. Model Approaches partners across the country recognize the enormous value of the network relationships that have been forged in pursuit of essential project goals and objectives. Several Model Approaches states with completed grant award cycles demonstrate that SLHs continue to serve seniors as well-integrated and essential components of statewide senior legal services delivery systems, thus illustrating the sustainability of these projects beyond the demonstration period.

In FY 2015, ACL awarded seven new Model Approaches Phase II grants to continue the evolution of legal service delivery systems implemented through previous Model Approaches projects towards higher levels of capacity, performance, and service delivery impact. Model Approaches Phase II projects are primarily focused on enhancing legal responses to complex issues that emerge from elder abuse, neglect, and financial exploitation. In addition, these new projects are expanding outreach to older adults in the greatest social or economic need and implementing legal data collection/reporting systems that demonstrate the beneficial impact of legal services on the independence, health, and financial security of older adults.

Pension Counseling and Information Program *(FY 2015: \$1,601,000)*

In 1992, Congress directed AoA to develop demonstration projects specifically designed to help individuals with pension problems. These demonstrations were so successful that Congress established pension counseling as a permanent program under Title II of the OAA in 2000.

Today, there are more than 700,000 private (as well as thousands of public) pension and retirement plans in the United States. Thousands of Americans reach retirement age each year, only to be told that they will not receive the pension benefits they expected. Because individuals have generally worked for several employers, which may have merged, sold their plans, or gone bankrupt, it is very difficult for most people to know where to get help in finding out whether or not they are receiving all of the pension benefits to which they are entitled.

¹¹⁰ Minority refers to individuals who self-report at least one of the following racial or ethnic identities: Asian, Black or African American, Hispanic or Latino, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native.

Benefits from employer-sponsored pensions and retirement savings plans are as critical today to the retirement security of Americans as they were when the pension counseling program was first established. The pension questions which people face are just as complex, and good help is just as hard to find – even more so for those with only modest benefits at stake. The role of the Pension Counseling and Information Program is to help ensure that all older Americans have access to the help they need in order to secure the employer-sponsored retirement benefits they have earned --- benefits that are critical to their ability to live independently and with dignity after a lifetime of productive employment. The Pension Counseling and Information Program provides help that would be otherwise unavailable, by assisting individuals in understanding and exercising their pension rights. The program promotes the financial security of older individuals by offering them the help they need to receive the pension benefits they have earned. The income, in turn, provides increased opportunities for choice and independence.

AoA currently funds six regional counseling projects covering 30 states and a technical assistance resource center to assist older Americans in accessing information about their retirement benefits and to help them negotiate with former employers or pension plans for due compensation. The projects help with cases that private pension professionals are reluctant to take, where the benefits in question are small, as is often the case with low-income workers and those with limited English proficiency, but to whom these modest amounts make a huge difference in maintaining their financial security and independence.

Data show that since the program's inception in 1993, the Pension Counseling projects have recovered \$216 million in retirement benefits for more than 55,000 retirees. With a relatively small federal investment, the program has brought in a return of more than \$9.00 for every federal dollar invested in the program. These recoveries demonstrate that pension counseling is not only necessary, but that it can be provided efficiently and effectively.

The impact of the projects' work is best illustrated through presentation of cases successfully resolved during this period:

- A low-income individual contacted one of the regional counseling projects to report her receipt of an alarming overpayment notice just before the winter holidays. Already struggling to make ends meet, she'd been informed that her pension had been overpaid for the past seven years, that her monthly benefit would be terminated, and that she owed \$32,000 to the pension plan to recoup the overpaid funds. When the counseling project attorney began examining the validity of the alleged overpayment, it was discovered that the underlying calculation of the client's benefit may have been incorrect and involved a lapse in the fiduciary duties of the plan administrator in calculating and administering the pension plan. These inquiries led the plan administrator to cease recoupment efforts, waive the overpayment, and reassure the relieved client that her case was closed.
- A widow had been informed that she wasn't entitled to a share of her husband's pension because the plan had no record that he had been married. Though they had been married for 53 years, she and her husband had been separated at the time of his death, but not divorced. The project submitted a corrected death certificate as well as appropriate records. After nearly five years of work on the widow's behalf, the counseling project finally succeeded in getting her rightful benefits to her: a retroactive payment of over \$86,000 and a pension of \$850 per month.

- A senior veteran in Hawaii had been pursuing a pension benefit from a union plan for several years. He first contacted the plan at age 60 and was told to call back at age 65 to commence his benefits. When he did so, he was told that he was not vested due to a permanent break in service and that there was no benefit available to him. The client's break in service was a result of time that he spent serving in the military, which is time that should be protected pursuant to both the pension plan and federal law. However, it was not until this was researched and reported by the pension counseling project that the plan ultimately awarded his earned pension benefit of \$506 per month, retroactive to age 65. This relatively small pension which he had earned has significantly impacted this veteran's economic security and quality of life.

Even when Pension Counseling projects are unable to secure benefits for clients, the information and assistance the projects provide can bring peace of mind to financially vulnerable elderly individuals, often after months or even years of searching for answers. By producing fact sheets and other publications, hosting websites, and conducting outreach and education efforts, Pension Counseling projects also provide indirect services to tens of thousands of seniors and their families.

A critical component of the program is the National Pension Assistance Resource Center (the Center) which provides support to the counseling projects and facilitates coordination among the projects, SUAs, AAAs, legal services providers, and others by providing substantive legal training, technical assistance, and programmatic consultation. The Center also assists individuals in states not currently served by AoA's pension counseling projects by providing nationwide referral and information services, both by telephone and through the [PensionHelp America website](#), a nationwide database of pension assistance and information resources.

Long-Term Care Ombudsman Program (FY 2015: \$15,885,051)¹¹¹

States' Long-Term Care (LTC) Ombudsman programs work to resolve problems related to the health, safety, welfare and rights of individuals who live in long-term care facilities (i.e. nursing homes, board and care, assisted living and other residential care communities). LTC Ombudsman programs promote policies and consumer protections to improve long-term services and supports (LTSS) at facility, local, state and national levels and play an important role in elder justice networks.

Begun in 1972 as a demonstration program, today the LTC Ombudsman program operates in all states, the District of Columbia, Puerto Rico and Guam, under the authorization of the OAA. Each state has an Office of the State LTC Ombudsman (Office), headed by a full-time State LTC Ombudsman (Ombudsman) who directs the program statewide. Across the nation, staff and thousands of volunteers are designated by Ombudsmen to directly serve residents.

The OAA requires LTC Ombudsman programs to:

- Identify, investigate and resolve complaints made by or on behalf of residents;
- Provide information to residents about long-term services and supports;
- Ensure that residents have regular and timely access to ombudsman services;
- Represent the interests of residents before governmental agencies and seek administrative, legal and other remedies to protect residents; and
- Analyze, comment on, and recommend changes in laws and regulations pertaining to the health, safety, welfare and rights of residents.

Improving and Evaluating Ombudsman Program Services

In order to improve the quality and effectiveness of LTC Ombudsman program services to residents, ACL is undertaking two historic activities: 1) promulgation of the LTC Ombudsman program rule and 2) implementation of a LTC Ombudsman program evaluation.

1. Promulgation of the State Long-Term Care Ombudsman Programs Rule

ACL has published regulations to guide states in their implementation of the Ombudsman program and provide clarity on a number of provisions of the OAA (45 CFR Part 1324). The final rule was published in February 2015 and became effective on July 1, 2016. Since the program's creation in the 1970s, states have been required to develop and operate Ombudsman programs but, in the absence of regulations, there has been significant variation in the effectiveness of these programs and adherence to OAA requirements among states. The development of more formal guidance to improve consistency and quality of program implementation had been called for by members of Congress, a wide variety of stakeholders, reports by the Institute of Medicine and HHS/OIG, and media reports.

Since the rule's publication, ACL staff and the National Ombudsman Resource Center have been providing training, technical assistance and support to facilitate its implementation by states. States have been reviewing their laws, regulations, and policies to determine if they meet the

¹¹¹ This amount reflects Title VII-2 designated as Ombudsman Program Activity funds. States also utilize other Older Americans Act and other funding sources to operate the Ombudsman program (see Figure 1, on page 51).

requirements of the new rule, as ACL has proactively offered customized technical assistance to each state to assist in assuring compliance. ACL anticipates that states' implementation of this rule will strengthen the ability of Ombudsman programs to be effective problem-solvers for older adults and people with disabilities who live in our nation's long-term care facilities.

2. Evaluation of the Ombudsman Program

ACL is currently evaluating the LTC Ombudsman program to better understand service delivery. This process evaluation will help ACL lay the foundation to eventually evaluate program impact and efficiency. Not since the Institute of Medicine's 1995 report,¹¹² has there been a comprehensive, national evaluation of the Ombudsman program. ACL completed its evaluation design in 2013¹¹³ and anticipates completion of the process evaluation in 2017.

Complaint Investigation and Resolution

LTC Ombudsman programs provide a person-centered alternative dispute resolution service, working with (or on behalf of) long-term care facility residents to resolve complaints.

- Ombudsman programs nationwide completed resolution work on 199,238 complaints.¹¹⁴
- 74 percent of these complaints were resolved (or partially resolved) to the satisfaction of the resident or complainant.
- Of the 129,559 cases closed by Ombudsman programs,¹¹⁵ 92,868 (71 percent) were associated with nursing facility settings. Of the remaining cases, 33,445 (26 percent) were related to board and care, assisted living or other residential care communities; and 3,246 (three percent) were associated with non-facility settings or services to facility residents by an outside provider.
- Most cases were initiated by residents themselves or friends and relatives of residents. Residents initiated 42 percent of cases in nursing facilities and 32 percent in board and care, assisted living and other residential care communities.
- Ombudsman programs proactively identified issues in 12 percent of cases in all settings.

The five most frequent nursing facility complaints handled by Ombudsman programs were:

- Improper eviction or inadequate discharge/planning;
- Unanswered requests for assistance;
- Lack of respect for residents, poor staff attitudes;
- Administration and organization of medications; and
- Quality of life, specifically resident/roommate conflict.

¹¹² "Real People, Real Problems: An Evaluation of the Long-Term Care Ombudsman Program of the Older Americans Act," IOM (1995)

¹¹³ [Evaluation Study Design for Long-Term Care Ombudsman Programs under the Older Americans Act: Research Design Options.](#)

¹¹⁴ National Ombudsman Reporting System (NORS) is the source for this and other data in this section. NORS data is reported annually by states to ACL.

¹¹⁵ In FY 2015, ombudsmen opened 131,438 new cases (a case contains one or more complaints originating from the same person(s)), and completed resolution work on 129,559 closed cases, containing 199,238 complaints.

The five most frequent complaints in board and care, assisted living, and other residential care communities handled by Ombudsman programs were:

- Administration and organization of medications;
- Improper eviction or inadequate discharge/planning;
- Quality, quantity, variation and choice of food;
- Lack of respect for residents, poor staff attitudes; and
- Building or equipment in disrepair or hazardous.

Issue Example: Financial Exploitation

LTC Ombudsman programs worked to resolve nearly 8,800 complaints related to financial exploitation and theft/missing property in FY 2015.¹¹⁶ Approximately 25% of these (2,241) related to allegations of financial exploitation by a family member or other third party.

LTC Ombudsman programs serve a distinctive elder justice function in supporting residents who face abuse, neglect or exploitation. When an Ombudsman program receives any complaint (including an abuse-related complaint), its goal is to resolve the complaint to the resident's satisfaction, but not to serve as the official finder of fact to substantiate whether the abuse or other allegation occurred. In most states, the substantiation determination is made either by adult protective services and/or the licensing and regulatory agency.

An individual living in an assisted living facility's secured memory care unit contacted the Ombudsman program for assistance. Her health and mental status had improved significantly since admission, but her living situation had remained unchanged. The resident's daughter had admitted her to the facility, arranged for a new physician, secured health care and financial powers of attorney, was living in the resident's home, and did not expect nor want her mother to return home. The Ombudsman program, with permission of the resident, worked together with adult protective services and the resident's attorney to explore the legality of the powers of attorney and to assist the resident in finding a different physician. The new physician evaluated the resident, recommending that she could return home with supportive services. The daughter then successfully petitioned to become guardian of the resident. The resident's attorney successfully challenged the guardianship, and the court ordered the daughter to move out of her mother's home so the resident was eventually able to return to her home. Throughout this long, seven-month process, the resident was supported and encouraged by the Ombudsman program. According to her, "As I learned, residents do have rights. Your ombudsman can empower you so that you can exercise those rights."

¹¹⁶ NORS complaint categories included in this total: A4 (Financial exploitation), A38 (Personal property lost, stolen, used by others, etc.); P121 (Financial exploitation or neglect by family or other not affiliated with facility).

A nursing facility contacted the Ombudsman program to report that it was unable to reach the private, professional guardian for 15 residents. The Ombudsman program visited the residents, several of whom were able to be interviewed. The guardian had moved hundreds of miles away and was failing to fulfill her duty to meet resident needs. Some residents owned no shoes; some could not access their personal funds or had missing funds; and the guardian was not participating in resident care plans. The Ombudsman program identified similar situations with the same guardian while visiting another nursing facility. Residents in both facilities were at risk of losing Medicaid eligibility and of discharge for non-payment. The Ombudsman program notified the judge who had appointed the guardian and filed complaints with the Judicial Branch Certification Commission (JBCC), which certifies private, professional guardians. The Ombudsman program provided needed evidence as the investigation proceeded and persistently followed up to ensure the investigation did not slip through the cracks as the compliance investigator changed. Assuring facility management that the Ombudsman program was tracking the case was essential to protecting the residents from discharge, for which the facilities had a valid reason to give 30 day notice.

Upon request of the judge, the Ombudsman program convened a meeting of stakeholders to develop options for the residents. Ultimately, the court, based largely on Ombudsman program evidence, replaced the guardian, put in place more limited guardianship orders, and/or fully restored the rights of each resident. The JBCC imposed a penalty on the guardian and refused to renew the guardian's certification. Referral was made to the district attorney for consideration of criminal prosecution of the guardian. After ten months of intensive work, the residents' financial and personal situations were stabilized. Residents had their basic needs met and were able to access their own money; and the facilities were being paid, resolving the risk of discharge.

When an assisted living resident received an involuntary discharge notice, he contacted the Ombudsman program for assistance. The notice stated that the reason for discharge was due to the resident's conversations about the admission contract and complaints made to state and city officials about the assisted living operations. Upon admission, the resident had been required to sign an admission contract agreeing to work at the facility for his spending money and to turn over his food stamps and other public benefits to the provider. The resident stated that he signed this contract because he had been homeless prior to admission and was afraid of remaining homeless. The Ombudsman program helped link the resident to civil legal services, meanwhile requesting investigations by the state's fraud examiner and assisted living regulatory authority. While the investigations are ongoing, the resident has able to move to another assisted living facility where he is no longer subject to forced labor or retaliation for making complaints to authorities; and he is able to collect his public benefits.

Ombudsman programs use the expertise acquired through complaint resolution to inform their work to advocate for systems change. Examples of systems-level work to prevent or respond to financial exploitation of residents included:

- Engagement in multidisciplinary teams to improve state elder justice policies, including working to improve criminal investigations and prosecution of financial crimes against older adults.
- Advocating to strengthen state laws/systems for guardianship, conservatorship, and/or powers of attorney through support of legislation and work on multidisciplinary groups.

Ombudsman Program Activities

In addition to resolving complaints, LTC Ombudsman programs provide services which prevent problems for residents, and perform other services. In FY 2015, LTC Ombudsman program staff and volunteers nationwide provided:

- Routine visits to ensure that residents have regular access to ombudsman services, visiting residents of 63 percent of nursing facilities and 26 percent of board and care, assisted living, and other residential care communities at least quarterly.
- 398,057 consultations and information to individuals, including on: finding long-term services and supports options; Medicaid eligibility; discharge and eviction rights; and other federal and state policies impacting residents.
- 122,213 consultations to long-term care facility staff, including on: residents' rights, person-centered care practices, and discharge and eviction issues.
- Resident and family council support, providing technical assistance, training and information to resident councils (22,281 sessions) and family councils (2,073 sessions);
- Training of long-term care facility staff (5,054 sessions);
- Community education (10,821 sessions); and
- Coordination with licensing and survey entities, participating in 16,043 facility survey-related activities as resident advocates.

Systems Advocacy

In addition to individual problem resolution, Ombudsman programs advocate for resident interests in public policy arenas. The OAA requires Ombudsman programs to analyze, comment on and recommend changes in laws, regulations, and government policies and actions to benefit residents. In addition to financial exploitation Ombudsman programs reported on work to address systems-level issues, including:

- Resident access to sufficient facility-based and/or home and community-based services to support residents with mental health needs or who exhibit behavioral symptoms of dementia. This lack of access to needed services has significant implications for

providers' inappropriate use of antipsychotics and involuntary (and often illegal) evictions.

- Resident rights to receive visitors, and informing guardians and powers of attorney of the limitations in their authority to determine who may visit residents.
- Adequate staffing in long-term care facilities.
- Inadequate supply of home and community-based services and affordable housing options.
- State-level implementation of the CMS Home and Community-Based Services Rule, especially as it relates to assisted living and other residential care communities.
- Development of beneficiary support systems for Medicaid managed care recipients across states.

How LTC Ombudsman Programs Operate

There are 53 State LTC Ombudsman programs (in 50 states, plus the District of Columbia, Puerto Rico, and Guam). In most states, the Office of the State LTC Ombudsman is housed within the state unit on aging or another state agency. In others, the Office is housed in a private non-profit agency. Most states have contracts with or through area agencies on aging to provide direct ombudsman services to residents. There are 552 designated local Ombudsman entities.

In FY 2015, 1,301 full-time equivalent staff and 7,734 volunteers -- all trained and designated to investigate and resolve complaints -- provided Ombudsman program services to residents. An additional 3,760 volunteers also served residents or assisted in program operations in ways other than complaint resolution.

Total FY 2015 funding from all sources nationwide was \$96,964,406, an overall increase of 3.1 percent from the FY 2014 level. The federal government is the primary entity funding the Ombudsman Program, providing 54 percent of total funding in FY 2015. States provided 39 percent of funds, and other non-federal sources funded the remaining seven percent.

National Long-Term Care Ombudsman Resource Center Activities

In order to effectively problem-solve with and for residents, Ombudsman programs must remain up-to-date on the latest long-term care developments. Therefore, ACL supports the National Ombudsman Resource Center (NORC), which provides training, technical assistance, and program management expertise to Ombudsman programs. In FY 2015, the NORC was operated by the National Consumer Voice for Quality Long-Term Care, in conjunction with the National Association of States United for Aging and Disabilities (NASUAD).

In FY 2015, NORC provided training and technical assistance to Ombudsman programs on such issues as:

- Implementation of ACL's final rule for State LTC Ombudsman programs;
- LTC Ombudsman services to tribal elders;
- Volunteer management training and technical assistance;

- Technical assistance on emergency preparedness and response;
- Ombudsman services in managed long-term services and supports (LTSS);
- Ombudsman services in home and community-based (HCBS) settings;
- ACL’s final rule for State LTC Ombudsman programs (issued February 2015).

Additionally, the NORC provided quarterly orientation training for all new ombudsmen, and developed resource materials, the [NORC website](#), and quarterly newsletters that were customized for Ombudsman program staff and volunteers.

Program Results and Challenges

1. Volunteers help the program engage the local community.

Thousands of volunteers across the county donated their time, talents and energy to visit residents, listen to their concerns and take action to resolve problems. For some residents the Ombudsman program volunteer may be their only visitor; these types of community connections are vital to health and well-being. Volunteers frequently provide residents with regular access to ombudsman services and provide cost-effective, community-based complaint resolution.

2. Ombudsman programs solve problems at the facility level.

Ombudsman programs resolve hundreds of thousands of complaints every year on behalf of residents. The largest group that requested ombudsman services to resolve complaints were residents themselves, indicating that residents depend on the program to help them resolve their concerns. By resolving the vast majority of these complaints to the satisfaction of the resident or complainant, the work of ombudsmen improved the quality of life and quality of care for many residents of our nation’s long-term care facilities. Ombudsman complaint resolution is often conducted without outside intervention which can save on regulatory and legal costs while achieving the resident’s desired outcome.

3. Growth in HCBS and Medicaid managed LTSS increase demands for ombudsman services.

Federal and state policy changes -- including the promotion of Medicaid HCBS through waivers and other statutory options, the rapid growth of Medicaid Managed LTSS, and demonstration projects to serve persons receiving both Medicare and Medicaid (i.e. Financial Alignment Initiative, sometimes called the “duals demonstrations”) -- are creating opportunities, as well as some new challenges, for Ombudsman programs. As these services expand and provide more options for residents, ombudsmen work to ensure that their interests and concerns are represented and that strong beneficiary support systems are in place.

Increasingly, individuals live in residential settings other than nursing homes, including board and care homes, assisted living facilities, and other residential care communities (known by various names under state laws). While the number of nursing home beds and facilities are relatively steady, the growth in capacity of these other residential settings is steadily increasing. Some of these settings are appropriately included within the array of Medicaid-funded HCBS options, and federal policy continues to accelerate the growth of HCBS. As a result, LTC Ombudsman programs report increasing work, both at the individual complaint and the systems levels on behalf of these types of residential settings.

In addition to service in these residential settings, 15 states have expanded their laws to authorize the LTC Ombudsman program to serve individuals receiving HCBS. In four states, LTC Ombudsman programs have been expanded to serve individuals participating in Medicare-Medicaid or in Medicare-Medicaid plans offered under the Financial Alignment Initiative, regardless of where they reside.

4. Ombudsman programs are credible sources of information.

Ombudsman programs serve as a credible source of information for residents (including through resident councils), their families (including through family councils), and facility staff. Based on their extensive experience resolving resident problems, ombudsmen represented resident interests to policymakers, influencing public policy related to long-term care.

5. Ombudsman programs leverage federal dollars.

Federal funds leveraged resources from other sources for ombudsman programs. During FY 2015, 46 percent of program expenditures came from non-federal sources. The Ombudsman program's significant use of volunteers, further leverages limited resources. The value of volunteer time contributed to the program nationwide in FY 2015 was over \$16 million.¹¹⁷

¹¹⁷ The Independent Sector places the value of the volunteer time at \$23.56 per hour placing the value of 708,322 hours at \$16,688,076.

PART IV: SUPPORTING THE NATIONAL AGING SERVICES NETWORK

Older Americans 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 to determine which best suit the needs of each individual.

A key part of AoA's emphasis on community living is providing consumers with the information and assistance they need to make decisions about their independence and connecting them with the right services. An Aging and Disability Resource Centers (ADRCs) system helps to address this need by providing information, outreach, and assistance to older adults and people 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 cost-effective 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.

Aging and Disability Resource Centers/No Wrong Door System (FY 2015: \$6,119,000)

The ADRC/No Wrong Door System¹¹⁸ supports state efforts to help individuals access long-term services and supports (LTSS) as well as develop more efficient and cost-effective access systems into LTSS at the community level. The current LTSS system involves numerous funding streams administered by federal, state and local agencies using different access processes involving screening, intake, needs assessment, service planning, and eligibility determination. Individuals seeking to access LTSS frequently find themselves confronted with a variety of organizations and requirements at a time when they are vulnerable or in crisis, which often results in people making decisions based on incomplete, and sometimes inaccurate, information about their options. This can lead to decisions to purchase and/or use LTSS options that are less than optimal for the individual and more expensive than necessary, including decisions to use costly options such as nursing facility care that can quickly exhaust an individual's personal resources and result in their spending down to Medicaid eligibility.

In response to this challenge facing our citizens and our nation, AoA and CMS worked collaboratively in 2003 to create a joint funding opportunity to support state efforts to create "one-stop-shop" access programs for people seeking LTSS. This initiative, known as the ADRC program, was designed to provide consumers with "visible and trusted" sources of information, one-on-one counseling, and streamlined access to services and supports. ADRCs grew out of best practice innovations known as "No Wrong Door" (NWD) and "Single Points of Entry" programs, where people of all ages may turn for objective information on their long-term services and support options.

¹¹⁸ 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).

Another major development in the evolution of the ADRC model occurred in 2009 when the Veterans Health Administration (VHA) – the nation’s largest integrated health care system - recognized the value of ADRCs in helping Veterans develop person-centered plans and self-direct their own care. In that year, the VHA entered into formal funding agreements with organizations within a No Wrong Door System (e.g., ADRCs, area agencies on aging, centers for independent living, state units on aging) to serve as the VHA’s designated entity for delivering the Veterans-Directed Home and Community Based Services program (VD-HCBS) to our nation’s veterans.

In 2010, the Affordable Care Act (ACA) provided \$50 million over five years to support the further development of the ADRC program. The ACA also funded the CMS Balancing Incentive program to incentivize states to rebalance their Medicaid LTSS spending and required participating states to make changes to their LTSS systems, including developing statewide NWD programs. In 2012, recognizing the accomplishments of both the ADRC and Balancing Incentive program initiatives, as well as the lessons learned from the experience of states, ACL, CMS and the VHA issued a special funding opportunity – known as the 2012 “ADRC Part A Grant Program.” With the 2012 funding opportunity announcement, ACL officially adopted the “No Wrong Door” system for the ADRC Part A grants. Lessons learned from these grants demonstrated that no one agency or network could successfully implement a LTSS access system for all populations and all payers without having multiple agencies and organizations at the state and local level formally involved in the system's operations. Two additional outcomes resulting from this collaboration included NWD system guidance on 1) Key Functional Elements of NWD system and 2) Sustaining NWD functions through Medicaid Administrative Match. In January 2016, CMS posted the NWD System Medicaid Administrative Guidance to help sustain the infrastructure investments that states have made over the years. NWD System Medicaid Administrative Guidance was developed to inform states about the appropriate methods for claiming Medicaid federal matching funds.

Also posted on the CMS website is the NWD System Key Elements which describes the vision and functions of the NWD system. The ACL/CMS/VHA vision is that each state will have a single statewide NWD System to LTSS for all populations and all payers. The NWD system functions include:

- Public outreach and coordination with key referral sources;
- Person-centered counseling;
- Streamlined access to public LTSS programs; and,
- State governance and administration.

Public Outreach and Coordination with Key Referral Sources

To be a visible source of individualized counseling and help with accessing LTSS, the NWD system must proactively engage in public education to promote broad public awareness of the resources that are available. The goal is for citizens in each state to know where they can turn to for unbiased and trusted help in understanding and accessing the LTSS options that are available in their communities. A NWD system’s public education efforts gives special attention to underserved and hard-to-reach populations, including people with hearing and visual impairments and limited English speaking populations.

A fully operational NWD system has formal linkages between and among all the major pathways that people travel while transitioning from one health care setting to another or from one public

program payer to another. These pathways represent critical junctures where decisions are made – usually in a time of crisis - that often determine whether a person is permanently institutionalized or transitioned back to the community. Among the key sources of referral the NWD system must have formal linkages with include information and referral entities, nursing homes and other institutions, acute care systems, and VA medical Centers.

Person-Centered Counseling

Person-Centered Counseling (PCC) is the NWD system term for person-centered planning which is an approach for working with individuals required in the LTSS system.

Through the use of PCC, the NWD system empowers individuals to make informed choices about their LTSS options consistent with their personal goals, and to successfully navigate the various organizations, agencies and other resources in their communities that provide LTSS. PCC is very different from and requires a different skill set compared to traditional case management and other commonly used techniques for counseling individuals with LTSS needs. It will take time for our current LTSS workforce to develop the knowledge and skills required to fully embrace and effectively use PCC. The NWD system PCC function involves five basic steps: 1) conducting a personal interview; 2) developing a person-centered plan; 3) facilitating access to private services and supports; 4) facilitating streamlined access to public programs; and 5) conducting ongoing follow-up.

Streamlined Access to Public LTSS Programs

NWD system's streamlined access to public LTSS programs includes all the processes and requirements associated with conducting formal assessments and/or determining an individual's eligibility that are required by any of the state administered programs that provide LTSS to any of the NWD system populations. All these public access processes and requirements must be part of, and integrated into, the state's NWD system's streamlined access function, so states can use their NWD system as a vehicle for optimally coordinating and integrating these processes to make them more efficient and effective, and more seamless and responsive for consumers.

For example, the NWD system person-centered counselors can help ensure applications are completely filled out with all the information needed when the applicant applies for public assistance, thereby reducing the burden of the application process for both intake staff and consumers. Even if the NWD system person-centered counselor is not designated to do the preliminary assessment, the data gathered by the NWD system person-centered counselor during the PCC process is fed into the preliminary assessment and then automatically transferred into the final assessment process.

State Governance and Administration

The governance and administration of a NWD system involves a collaborative effort among multiple state agencies, since no one state agency has the authority or expertise to carry out all of the functions involved in a NWD system as envisioned by ACL, CMS and VHA. The NWD system is a critical component of any well-developed, person-centered state LTSS system. Its governing body is responsible for coordinating the on-going development, implementation, financing, evaluation and continual improvement of the state's NWD system. It includes representatives from the State Medicaid Agency, the State Unit on Aging, and the state agencies that serve or represent the interests of individuals with physical disabilities, individuals with

intellectual and developmental disabilities, and the state authorities administering mental health services. NWD systems also include a robust Management Information System (MIS) that builds on and leverages existing state MIS systems, which is essential for a state to be able to effectively gather and manage information from the many entities that will be carrying out NWD system functions, as well as from individual consumers who use the NWD system. The NWD system's Continuous Quality Improvement process involves getting input and feedback from the many different customers who use or interact with the NWD system, including individuals and their families, system partners, advocates, providers and professionals in the health and LTSS systems, on the responsiveness of the NWD system to their varying needs.

The result of ADRD/NWD investments include:

- 545 ADRC sites have been designated across 50 states, two territories, and the District of Columbia;
- Over 27 million ADRC contacts have been made to help streamline access to LTSS;
- 33 states and territories have achieved statewide coverage;
- 42 states/territories with ADRC programs sites conducted care transitions through formal intervention; and
- 303 sites in 43 states/territories reported serving clients with institutional transition from nursing facility (both MFP and non-MFP related) back into the community.

Rather than build a separate infrastructure to serve veterans, the VHA made a strategic decision to use the aging and disability network infrastructure – including using the ADRCs as the integrated access point to empower veterans to set-up their own service plan for long-term supports and services – as a delivery vehicle for VD-HCBS. The VHA's intent is to continue to expand access to this program with the goal of eventually moving nationwide. ACL and the VHA have worked together to develop program guidelines/national standards, web-based tools to track program activities and implement a national training program for the VD-HCBS. Currently, 34 states plus the District of Columbia and Puerto Rico are operating VD-HCBS programs with 61 operational VAMCs, 120 operational sites and over 3,200 veterans served. This type of vital investment links individuals to a cost-effective, quality array of services benefits individuals, states, and communities.

Aging Network Support Activities *(FY 2015: \$9,961,000)*

Aging Network Support Activities provide competitive grants and contracts to support ongoing activities of national significance which help older adults and their families to obtain information about their care options and benefits. These activities provide technical assistance to help states, tribes, and community providers of aging services to develop service systems that help older people remain independent and able to live in their own homes and communities. They also 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, 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.

To ensure that older Americans have access to the highest quality home and community-based services system, the national aging services network must continually enhance program design and delivery in key priority areas. To address this critical need, targeted surveys are developed and implemented in order to analyze, assess, and better understand the ever-evolving needs of the network. The purpose of these activities is to improve management practices and methodologies, leadership enhancement, as well as to broaden roles in the delivery of home and community-based services within our nation's system of health and long-term care.

In July 2013, a web-based survey was distributed to 613 AAAs, with a 63 percent response rate. The survey resulted in the development and distribution of a comprehensive report in 2014. That report highlights how AAAs are changing their services in response to changes in both demographics and the resources to which they have access. In February 2014, a survey targeting the 256 Title VI Native American programs in the United States launched, resulting in responses from just under 90 percent of Title VI administrators. The results from these surveys provided key findings related to innovative care delivery, service expansion and sustainability and training and technical assistance needs. FY 2015 activities built on these findings by gathering data on the national aging service network's information technology systems in an effort to identify challenges and opportunities for future development.

National Eldercare Locator

The Eldercare Locator is one of our nation's most important and visible vehicles for connecting people needing assistance with state and local agencies on aging that serve older adults and their caregivers. Since its inception in 1991, the Eldercare Locator call center has connected over three million callers to local resources. Through its call center (800.677.1116), which operates five days a week from 9:00 a.m. to 8:00 p.m. ET, and [Eldercare.gov website](http://Eldercare.gov), the Locator serves as a trusted gateway for older adults and caregivers searching for information and resources which can be crucial to their immediate and long-term health, well-being and independence. Older adults and caregivers contact the Locator to find local resources involving a broad range of services including transportation and in-home services and supports. The Eldercare Locator served over 277,621 callers and 498,791 website users in FY2015.

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 January 31, 2016, the National Alzheimer's Call Center handled over 320,000 calls through its national and local partners, and its on-line message board community recorded over 6 million page views and over 190,000 active participants.

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 master's level 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.

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 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, in addition to materials designed to identify and prevent fraud and financial exploitation among older individuals.

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 health promotion and disease prevention information that is culturally and linguistically appropriate for older individuals of African American, Hispanic, Asian, Native Hawaiian or other Pacific Islander descent, American Indian and Alaska Native elders, as well as for older lesbian, gay, bisexual, and transgender (LGBT) adults.

Each NMAO project pilots practical, community-based interventions for reaching older individuals who experience barriers to accessing home and community-based services. Interventions focus 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: a chronic disease self-management curricula and a manual tailored for racial and ethnic minority older persons; a referral dataset of chronic disease self-management workshops; and a culturally appropriate caregiver manual /toolkit for American Indian and Alaskan Native caregivers caring for elders with dementia.

Appendix

Formula Grant Funding

Allocation by

State, Territory and Tribal Organization

**U.S. Administration on Aging
Department of Health and Human Services**

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State	Supportive Services	Congregate Meals	Home Meals	Preventive Services	NFCSP	Total Title III
Alabama	\$5,347,831	\$6,491,586	\$3,314,409	\$312,641	\$2,210,499	\$17,676,966
Alaska	\$1,728,330	\$2,177,988	\$1,075,581	\$98,653	\$723,622	\$5,804,174
Arizona	\$6,505,241	\$8,987,114	\$4,588,551	\$380,303	\$3,171,015	\$23,632,224
Arkansas	\$3,464,889	\$4,163,564	\$2,057,220	\$198,548	\$1,406,669	\$11,290,890
California	\$34,222,266	\$43,618,817	\$22,270,459	\$2,000,665	\$14,793,851	\$116,906,058
Colorado	\$4,111,937	\$6,099,151	\$3,114,043	\$240,388	\$1,914,700	\$15,480,219
Connecticut	\$4,358,914	\$5,241,452	\$2,487,455	\$245,082	\$1,717,627	\$14,050,530
Delaware	\$1,728,330	\$2,177,988	\$1,075,581	\$98,653	\$723,622	\$5,804,174
District of Columbia	\$1,728,330	\$2,177,988	\$1,075,581	\$98,653	\$723,622	\$5,804,174
Florida	\$25,001,315	\$31,088,385	\$15,872,796	\$1,461,605	\$11,694,400	\$85,118,501
Georgia	\$7,827,659	\$11,081,426	\$5,657,844	\$457,613	\$3,522,925	\$28,547,467
Hawaii	\$1,728,330	\$2,177,988	\$1,075,581	\$98,653	\$723,622	\$5,804,174
Idaho	\$1,728,330	\$2,177,988	\$1,075,581	\$98,653	\$723,622	\$5,804,174
Illinois	\$14,375,090	\$17,286,541	\$8,085,366	\$789,335	\$5,457,691	\$45,994,023
Indiana	\$6,855,951	\$8,321,546	\$4,248,732	\$400,806	\$2,844,470	\$22,671,505
Iowa	\$4,216,934	\$5,081,501	\$2,189,131	\$217,942	\$1,555,744	\$13,261,252
Kansas	\$3,397,503	\$4,089,903	\$1,863,982	\$179,886	\$1,284,858	\$10,816,132
Kentucky	\$4,692,373	\$5,782,727	\$2,952,487	\$274,322	\$1,933,943	\$15,635,852
Louisiana	\$4,746,436	\$5,645,998	\$2,877,419	\$277,482	\$1,873,003	\$15,420,338
Maine	\$1,728,330	\$2,177,988	\$1,086,911	\$98,843	\$723,622	\$5,815,694
Maryland	\$5,797,028	\$7,289,263	\$3,721,679	\$338,901	\$2,421,098	\$19,567,969
Massachusetts	\$8,124,432	\$9,780,267	\$4,545,091	\$436,787	\$3,095,082	\$25,981,659
Michigan	\$11,139,631	\$13,533,437	\$6,909,767	\$651,235	\$4,622,288	\$36,856,358
Minnesota	\$5,442,947	\$6,892,698	\$3,519,205	\$318,201	\$2,381,981	\$18,555,032
Mississippi	\$3,238,959	\$3,891,114	\$1,922,056	\$184,160	\$1,278,829	\$10,515,118
Missouri	\$7,045,015	\$8,467,047	\$4,151,744	\$397,174	\$2,847,841	\$22,908,821
Montana	\$1,728,330	\$2,177,988	\$1,075,581	\$98,653	\$723,622	\$5,804,174
Nebraska	\$2,271,270	\$2,738,802	\$1,216,914	\$117,205	\$845,425	\$7,189,616
Nevada	\$2,436,002	\$3,469,542	\$1,771,444	\$142,412	\$1,117,962	\$8,937,362
New Hampshire	\$1,728,330	\$2,177,988	\$1,075,581	\$98,653	\$723,622	\$5,804,174
New Jersey	\$10,157,127	\$12,190,488	\$5,863,371	\$582,688	\$4,034,488	\$32,828,162
New Mexico	\$2,044,879	\$2,736,402	\$1,397,125	\$119,546	\$916,363	\$7,214,315
New York	\$24,032,989	\$28,963,855	\$12,985,216	\$1,291,787	\$8,915,220	\$76,189,067
North Carolina	\$9,272,301	\$12,708,685	\$6,488,673	\$542,069	\$4,251,733	\$33,263,461
North Dakota	\$1,728,330	\$2,177,988	\$1,075,581	\$98,653	\$723,622	\$5,804,174
Ohio	\$13,674,313	\$16,393,785	\$8,089,852	\$784,378	\$5,508,674	\$44,451,002
Oklahoma	\$4,234,163	\$5,080,736	\$2,510,093	\$241,568	\$1,700,964	\$13,767,524
Oregon	\$4,091,731	\$5,570,464	\$2,844,111	\$239,207	\$1,837,888	\$14,583,401
Pennsylvania	\$17,695,575	\$21,279,716	\$9,481,622	\$955,797	\$6,690,013	\$56,102,723
Rhode Island	\$1,728,330	\$2,177,988	\$1,075,581	\$98,653	\$723,622	\$5,804,174
South Carolina	\$4,742,126	\$6,580,629	\$3,359,871	\$277,230	\$2,166,066	\$17,125,922
South Dakota	\$1,728,330	\$2,177,988	\$1,075,581	\$98,653	\$723,622	\$5,804,174
Tennessee	\$6,690,499	\$8,612,557	\$4,397,313	\$391,134	\$2,881,977	\$22,973,480
Texas	\$20,116,444	\$27,374,192	\$13,976,441	\$1,176,030	\$8,944,706	\$71,587,813
Utah	\$1,847,519	\$2,598,736	\$1,326,836	\$108,008	\$865,484	\$6,746,583
Vermont	\$1,728,330	\$2,177,988	\$1,075,581	\$98,653	\$723,622	\$5,804,174
Virginia	\$7,783,846	\$10,098,485	\$5,155,983	\$455,052	\$3,338,050	\$26,831,416
Washington	\$6,383,531	\$8,792,376	\$4,489,123	\$373,189	\$2,846,871	\$22,885,090
West Virginia	\$2,744,934	\$3,305,947	\$1,481,111	\$143,702	\$987,307	\$8,663,001
Wisconsin	\$6,324,484	\$7,716,339	\$3,939,731	\$367,330	\$2,680,209	\$21,028,093
Wyoming	\$1,728,330	\$2,177,988	\$1,075,581	\$98,653	\$723,622	\$5,804,174
American Samoa	\$467,446	\$594,843	\$136,498	\$12,332	\$90,453	\$1,301,572
Guam	\$864,165	\$1,088,994	\$537,791	\$49,326	\$361,811	\$2,902,087
Northern Marianas	\$216,042	\$272,248	\$134,448	\$12,332	\$90,453	\$725,523
Puerto Rico	\$4,329,830	\$5,193,402	\$2,651,595	\$253,127	\$1,854,832	\$14,282,786
Virgin Islands	\$864,165	\$1,088,994	\$537,791	\$49,326	\$361,811	\$2,902,087
TOTAL	\$345,666,022	\$435,597,598	\$215,116,272	\$19,730,530	\$144,724,360	\$1,160,834,782

State/Territory	Nutrition Services Incentive Program
Alabama	\$3,281,217
Alaska	\$467,080
Arizona	\$1,831,908
Arkansas	\$2,619,224
California	\$12,978,158
Colorado	\$1,387,880
Connecticut	\$1,502,950
Delaware	\$493,592
District of	\$656,726
Florida	\$6,367,358
Georgia	\$2,644,455
Hawaii	\$447,298
Idaho	\$697,880
Illinois	\$6,052,486
Indiana	\$1,576,234
Iowa	\$1,842,899
Kansas	\$2,017,649
Kentucky	\$1,722,895
Louisiana	\$3,493,777
Maine	\$599,938
Maryland	\$1,588,274
Massachusetts	\$4,858,202
Michigan	\$7,472,137
Minnesota	\$1,907,343
Mississippi	\$1,630,644
Missouri	\$4,035,332
Montana	\$870,814
Nebraska	\$1,140,833
Nevada	\$1,167,919
New	\$1,287,173
New Jersey	\$3,798,220
New Mexico	\$2,285,993
New York	\$16,839,154
North Carolina	\$3,325,731
North Dakota	\$826,510
Ohio	\$5,752,230
Oklahoma	\$2,103,579
Oregon	\$1,941,998
Pennsylvania	\$6,198,120
Rhode Island	\$428,005
South Carolina	\$1,531,920
South Dakota	\$900,010
Tennessee	\$1,559,730
Texas	\$11,404,726
Utah	\$1,255,197
Vermont	\$837,591
Virginia	\$2,047,999
Washington	\$2,177,605
West Virginia	\$1,661,411
Wisconsin	\$2,766,177
Wyoming	\$871,647
American	\$20,717
Guam	\$357,577
Northern	\$58,247
Puerto Rico	\$3,042,016
Virgin Islands	\$188,789
TOTAL	\$152,821,174

State	Ombudsman	Elder Abuse	Total Title VII
Alabama	\$244,521	\$76,215	\$320,736
Alaska	\$79,350	\$23,843	\$103,193
Arizona	\$338,520	\$89,768	\$428,288
Arkansas	\$151,771	\$48,157	\$199,928
California	\$1,643,005	\$471,073	\$2,114,078
Colorado	\$229,739	\$60,922	\$290,661
Connecticut	\$183,512	\$59,907	\$243,419
Delaware	\$79,350	\$23,843	\$103,193
District of Columbia	\$79,350	\$23,843	\$103,193
Florida	\$1,171,017	\$344,252	\$1,515,269
Georgia	\$417,408	\$110,687	\$528,095
Hawaii	\$79,350	\$23,843	\$103,193
Idaho	\$79,350	\$23,843	\$103,193
Illinois	\$596,499	\$197,384	\$793,883
Indiana	\$313,450	\$98,224	\$411,674
Iowa	\$161,503	\$55,927	\$217,430
Kansas	\$137,515	\$45,843	\$183,358
Kentucky	\$217,820	\$66,595	\$284,415
Louisiana	\$212,282	\$68,518	\$280,800
Maine	\$80,187	\$23,843	\$104,030
Maryland	\$274,567	\$78,087	\$352,654
Massachusetts	\$335,314	\$109,606	\$444,920
Michigan	\$509,768	\$160,862	\$670,630
Minnesota	\$259,630	\$76,347	\$335,977
Mississippi	\$141,800	\$45,198	\$186,998
Missouri	\$306,295	\$97,643	\$403,938
Montana	\$79,350	\$23,843	\$103,193
Nebraska	\$89,778	\$29,770	\$119,548
Nevada	\$130,688	\$34,656	\$165,344
New Hampshire	\$79,350	\$23,843	\$103,193
New Jersey	\$432,571	\$143,950	\$576,521
New Mexico	\$103,073	\$27,332	\$130,405
New York	\$957,985	\$318,066	\$1,276,051
North Carolina	\$478,702	\$126,941	\$605,643
North Dakota	\$79,350	\$23,843	\$103,193
Ohio	\$596,829	\$197,185	\$794,014
Oklahoma	\$185,182	\$60,208	\$245,390
Oregon	\$209,824	\$56,795	\$266,619
Pennsylvania	\$699,507	\$242,944	\$942,451
Rhode Island	\$79,350	\$23,843	\$103,193
South Carolina	\$247,875	\$65,731	\$313,606
South Dakota	\$79,350	\$23,843	\$103,193
Tennessee	\$324,412	\$91,810	\$416,222
Texas	\$1,031,113	\$274,281	\$1,305,394
Utah	\$97,888	\$25,958	\$123,846
Vermont	\$79,350	\$23,843	\$103,193
Virginia	\$380,383	\$102,820	\$483,203
Washington	\$331,185	\$87,823	\$419,008
West Virginia	\$109,269	\$36,736	\$146,005
Wisconsin	\$290,654	\$90,309	\$380,963
Wyoming	\$79,350	\$23,843	\$103,193
American Samoa	\$9,919	\$2,980	\$12,899
Guam	\$39,675	\$11,921	\$51,596
Northern Marianas	\$9,919	\$2,980	\$12,899
Puerto Rico	\$195,622	\$54,217	\$249,839
Virgin Islands	\$39,675	\$11,921	\$51,596
TOTAL	\$15,870,051	\$4,768,508	\$20,638,559

State	Tribe No.	Grantee Name	TITLE6 /B	TITLE6 C	NSIP
AK	01	Aleutian Pribilof Islands Association, Inc.	\$82,290	\$22,930	\$7,582
AK	02	Association of Village Council Presidents	\$118,790		\$16,098
AK	03	Bristol Bay Native Association	\$118,790	\$40,130	\$4,343
AK	04	Central Council Tlingit & Haida Indian Tribes of AK	\$155,990	\$45,860	\$901
AK	06	Copper River Native Association	\$72,460	\$17,190	\$1,343
AK	07	Hoonah Indian Association	\$72,460	\$17,190	\$1,943
AK	08	Kodiak Area Native Association - Northern Region	\$70,000	\$11,460	\$2,758
AK	09	Kodiak Area Native Association - Southern Region	\$63,870	\$11,460	\$2,151
AK	10	Metlakatla Indian Community	\$92,730	\$28,660	\$2,418
AK	11	Native Village of Barrow	\$102,560	\$34,400	\$15,607
AK	12	Tanana Chiefs Conference for Kuskokwim subregion	\$63,870	\$11,460	\$139
AK	13	Tanana Chiefs Conference for Lower Yukon Subregion	\$63,870	\$11,460	\$3,693
AK	14	Tanana Chiefs Conference for Yukon Flats Subregion	\$63,870	\$11,460	\$1,458
AK	15	Tanana Chiefs Conference for Yukon Koyukuk Subregion	\$72,460	\$17,190	\$4,556
AK	16	Tanana Chiefs Conference for Yukon Tanana Subregion	\$63,870	\$11,460	\$1,584
AK	17	Fairbanks Native Association	\$118,790	\$40,130	
AK	19	Maniilaq Association	\$118,790	\$40,130	\$18,270
AK	20	Native Villiage of Unalakleet	\$72,460	\$17,190	\$6,351
AK	21	Chugachmiut	\$72,460	\$17,190	\$1,419
AK	22	Arctic Slope Native Association, Limited	\$72,460	\$17,190	\$16,654
AK	23	Denakkanaaga, Inc.	\$82,290	\$22,930	
AK	24	Klawock Cooperative Association	\$63,870	\$11,460	\$1,166
AK	25	Kootznoowoo Inc.	\$63,870	\$11,460	\$2,107
AK	26	Gwichyaa Zhee Gwich'in Tribal Government	\$63,870	\$11,460	\$4,747
AK	27	Native Village of Point Hope	\$63,870	\$11,460	\$594
AK	28	Seldovia Village Tribe	\$63,870		\$1,155
AK	30	Sitka Tribes of Alaska	\$92,730	\$28,660	\$1,378
AK	32	Ketchikan Indian Community	\$118,790	\$40,130	\$4,939
AK	33	Kuskokwim Native Association	\$72,460	\$17,190	\$1,893
AK	35	Southcentral Foundation	\$155,990	\$45,860	\$13,037
AK	36	Kenaitze Indian Tribe	\$118,790	\$40,130	\$5,906
AK	37	Wrangell Cooperative Association	\$82,290	\$22,930	\$1,730
AK	38	Native Village of Savoonga	\$63,870	\$11,460	\$11,270
AK	39	Native Village of Gambell	\$63,870	\$11,460	
AK	40	Native Village of Eyak Traditional Council	\$63,870	\$11,460	\$1,497
AK	41	Organized Village of Kake	\$63,870	\$11,460	\$1,730
AK	42	Chickaloon Native Village	\$82,290		\$2,830
AK	44	Galena Village (aka Louden Village Council)	\$63,870	\$11,460	\$11,914
AK	45	Asa'carsarmiut Tribal Council	\$63,870		\$1,931
AK	46	Orutsararmuit Native Council	\$92,730	\$28,660	\$10,243
AK	47	Chilkoot Indian Association	\$63,870	\$11,460	\$2,083
AK	48	Knik Tribal Council	\$92,730		\$8,555
AK	49	Yakutat Tlingit Tribe	\$63,870	\$11,460	\$3,645
AK	50	Craig Tribal Association (Skagway Traditional Council)	\$63,870	\$11,460	\$1,339
AK	Total	Total	\$3,618,110	\$808,150	\$204,957
AL	01	Poarch Band of Creek Indians	\$118,790	\$40,130	\$25,904
AL	Total	Total	\$118,790	\$40,130	\$25,904
AZ	02	Colorado River Indian Tribes	\$102,560	\$34,400	\$25,924
AZ	03	Gila River Indian Community	\$155,990	\$45,860	\$20,147
AZ	04	Hopi Tribe	\$118,790	\$40,130	\$11,887
AZ	05	Hualapai Elderly Services Program	\$72,460	\$17,190	\$22,976
AZ	06	Navajo Nation	\$155,990	\$45,860	\$56,202
AZ	07	Pascua Yaqui Tribe	\$155,990	\$45,860	\$33,123
AZ	09	Salt River Pima-Maricopa Indian Community	\$92,730	\$28,660	\$16,767
AZ	10	San Carlos Apache Tribe	\$118,790	\$40,130	\$7,315
AZ	11	Tohono O'odham Nation	\$155,990	\$45,860	\$2,962
AZ	12	White Mountain Apache Tribe	\$118,790	\$40,130	\$16,067
AZ	13	Ak-Chin Indian Community	\$63,870	\$11,460	\$8,166
AZ	14	Yavapai Apache Tribe	\$72,460		\$2,841
AZ	15	Havasupai Tribe	\$63,870	\$11,460	\$5,149
AZ	16	Inter-Tribal Council of Arizona, Inc.	\$72,460	\$17,190	\$4,974

State	Tribe No.	Grantee Name	TITLE6 /B	TITLE6 C	NSIP
AZ	17	Cocopah Indian Tribe	\$63,870		\$16,121
AZ	18	Quechan Indian Tribe	\$72,460	\$17,190	\$13,245
AZ	Total	Total	\$1,657,070	\$441,380	\$263,866
CA	01	Bishop Paiute Tribe	\$82,290	\$22,930	\$19,490
CA	02	Blue Lake Rancheria	\$63,870	\$11,460	\$26,506
CA	06	Karuk Tribe	\$82,290	\$22,930	\$4,782
CA	07	Pit River Health Service, Inc.	\$63,870		\$4,437
CA	09	Riverside-San Bernardino Co. Indian Health-Morongo	\$72,460	\$17,190	\$3,313
CA	10	Riverside-San Bernardino Co. Indian Health-Pechanga	\$63,870	\$11,460	\$3,154
CA	11	Riverside-San Bernardino Co. Indian Health-Soboba/	\$63,870	\$11,460	\$6,180
CA	12	Sonoma County Indian Health Project - Sonoma	\$63,870		\$8,079
CA	13	Southern Indian Health Council, Inc. - Area I	\$63,870	\$11,460	\$9,016
CA	14	Southern Indian Health Council, Inc. - Area II	\$63,870	\$11,460	\$6,308
CA	15	Toiyabe Indian Health Project, Inc. - Northern	\$63,870	\$11,460	\$8,065
CA	16	Tule River Indian Health Center, Inc.	\$72,460	\$17,190	\$20,020
CA	17	Coast Indian Community of Resighini Rancheria	\$72,460	\$17,190	\$9,431
CA	18	United Indian Health Services for Smith River	\$118,790	\$40,130	\$12,859
CA	20	Indian Senior Center, Inc.	\$72,460	\$17,190	\$9,590
CA	21	Sonoma County Indian Health Project - Manchester	\$63,870		\$4,457
CA	25	Pala Band of Mission Indians	\$72,460		\$16,990
CA	26	Redding Rancheria	\$118,790	\$40,130	\$5,297
CA	28	Toiyabe Indian Health Project, Inc. - Southern	\$63,870	\$11,460	\$4,147
CA	29	Hoop Valley Tribe / K'ima:w Medical Center	\$72,460		\$7,649
CA	30	Round Valley Indian Tribes	\$72,460		\$6,721
CA	31	Fort Mojave Indian Tribe	\$72,460	\$17,190	\$7,134
CA	33	CA Indian Manpower Consortium, Inc. - Chico,	\$63,870	\$11,460	\$3,659
CA	34	CA Indian Manpower Consortium, Inc. - Big Sandy,	\$72,460	\$17,190	\$9,247
CA	35	CA Indian Manpower Consortium, Inc. - Berry Creek,	\$72,460	\$17,190	\$4,690
CA	36	CA Indian Manpower Consortium, Inc. - Coyote Valley,	\$72,460	\$17,190	\$5,968
CA	37	CA Indian Manpower Consortium, Inc. - Enterprise,	\$82,290	\$22,930	\$10,055
CA	38	Santa Ynez Tribal Health Clinic	\$63,870		\$1,157
CA	39	CA Indian Manpower Consortium, Inc. - North Fork,	\$63,870	\$11,460	\$6,249
CA	Total	Total	\$2,111,820	\$389,710	\$244,650
CO	01	Southern Ute Indian Tribe	\$72,460	\$17,190	\$4,376
CO	02	Ute Mountain Ute Tribe	\$82,290		\$10,596
CO	Total	Total	\$154,750	\$17,190	\$14,972
CT	01	Mohegan Tribe of Indians of Connecticut	\$72,460		\$6,695
CT	Total	Total	\$72,460		\$6,695
HI	01	Alu Like, Inc.	\$1,505,000	\$45,860	\$30,934
HI	Total	Total	\$1,505,000	\$45,860	\$30,934
IA	01	Sac & Fox Tribe of the Mississippi in Iowa	\$82,290	\$22,930	\$7,866
IA	Total	Total	\$82,290	\$22,930	\$7,866
ID	01	Coeur d'Alene Tribe	\$72,460	\$17,190	\$19,246
ID	02	Nez Perce Tribe	\$82,290	\$22,930	\$24,169
ID	03	Shoshone-Bannock Tribes	\$102,560	\$34,400	\$19,906
ID	Total	Total	\$257,310	\$74,520	\$63,321
KS	01	Kickapoo Tribe in Kansas	\$65,000	\$11,460	\$13,940
KS	02	Prairie Band of Potawatomi Nation	\$82,290	\$22,930	\$26,114
KS	03	Iowa Tribe of Kansas and Nebraska	\$65,000	\$11,460	\$7,131
KS	Total	Total	\$212,290	\$45,850	\$47,185
LA	01	Institute for Indian Development, Inc.	\$82,290		\$17,351
LA	Total	Total	\$82,290		\$17,351
MA	01	Wampanoag Tribe of Gay Head (Aquinnah)	\$72,460	\$17,190	\$739
MA	02	Mashpee Wampanoag Tribe	\$82,290	\$22,930	\$2,245
MA	Total	Total	\$154,750	\$40,120	\$2,984
ME	01	Pleasant Point Passamaquoddy	\$82,290	\$22,930	\$25,256
ME	02	Penobscot Indian Nation	\$72,460		\$4,665
ME	04	Aroostook Band of Micmacs	\$63,870	\$11,460	\$1,512
ME	Total	Total	\$218,620	\$34,390	\$31,433
MI	01	Grand Traverse Band of Ottawa & Chippewa Indians	\$82,290	\$22,930	\$12,865
MI	02	Inter-Tribal Council of Michigan, Inc.	\$72,460	\$17,190	\$3,525

State	Tribe No.	Grantee Name	TITLE6 /B	TITLE6 C	NSIP
MI	03	Keweenaw Bay Indian Community	\$72,460	\$17,190	\$17,221
MI	04	Sault Ste. Marie Tribe of Chippewa Indians	\$155,990		\$19,399
MI	05	Little Traverse Bay Bands of Odawa Indians	\$72,460	\$17,190	\$5,335
MI	07	Bay Mills Indian Community	\$72,460	\$17,190	\$5,448
MI	08	Pokagon Band of Potawatomi Indians	\$72,460		\$3,975
MI	09	Little River Band of Ottawa Indians	\$92,730		\$6,243
MI	10	Nottawaseppi Huron Band of the Potawatomi	\$63,870	\$11,460	\$4,623
MI	Total	Total	\$757,180	\$103,150	\$78,634
MN	01	Bois Forte Reservation Tribal Government	\$72,460	\$17,190	\$10,710
MN	02	Fond du Lac Band of Lake Superior Chippewa	\$118,790	\$40,130	\$43,068
MN	03	Leech Lake Band of Ojibwe	\$155,990	\$45,860	\$21,955
MN	07	Red Lake Band of Chippewa Indians	\$118,790		\$57,136
MN	08	White Earth Reservation Tribal Council	\$82,290	\$22,930	\$14,481
MN	09	Grand Portage Band of Lake Superior Chippewa	\$63,870		\$5,005
MN	10	Mille Lacs Band of Ojibwe	\$72,460	\$17,190	\$19,107
MN	11	Lower Sioux Indian Community	\$63,870	\$11,460	\$13,948
MN	Total	Total	\$748,520	\$154,760	\$185,410
MO	99	Eastern Shawnee Tribe of Oklahoma	\$92,730	\$28,660	\$20,566
MO	Total	Total	\$92,730	\$28,660	\$20,566
MS	01	Mississippi Band of Choctaw Indians	\$118,790	\$40,130	\$19,955
MS	Total	Total	\$118,790	\$40,130	\$19,955
MT	01	Assiniboine and Sioux Tribes	\$118,790	\$40,130	\$43,037
MT	02	Blackfeet Tribe - Eagle Shield Center	\$118,790	\$40,130	\$22,097
MT	03	Chippewa Cree Tribe Senior Citizens Department	\$102,560	\$34,400	\$49,151
MT	04	Confederated Salish and Kootenai Tribes	\$118,790	\$40,130	\$7,971
MT	05	Fort Belknap Indian Community	\$82,290	\$22,930	\$20,371
MT	06	Northern Cheyenne Elderly Program	\$102,560	\$34,400	\$24,701
MT	07	Crow Tribal Elders Program	\$118,790	\$40,130	\$50,489
MT	Total	Total	\$762,570	\$252,250	\$217,817
NC	01	Eastern Band of Cherokee Indians	\$155,990	\$45,860	\$35,789
NC	Total	Total	\$155,990	\$45,860	\$35,789
ND	01	Spirit Lake Senior Services	\$82,290	\$22,930	\$30,752
ND	02	Standing Rock Sioux Tribe	\$118,790	\$40,130	\$90,988
ND	03	Three Affiliated Tribes	\$118,790	\$40,130	\$12,243
ND	04	Trenton Indian Service Area	\$82,290	\$22,930	\$1,662
ND	05	Turtle Mountain Band of Chippewa Indians	\$118,790	\$40,130	\$17,009
ND	Total	Total	\$520,950	\$166,250	\$152,654
NE	01	Omaha Tribe of Nebraska	\$72,460	\$1,639	\$11,788
NE	02	Santee Sioux Nation	\$65,000		\$1,451
NE	03	Winnebago Tribe of Nebraska	\$72,460	\$17,190	\$18,448
NE	Total	Total	\$209,920	\$18,829	\$31,687
NM	01	Eight Northern Indian Pueblos Council (Picuris, etc.)	\$118,790	\$40,130	\$46,490
NM	02	Eight N. Indian Pueblos Council (San Ildefonso, etc.)	\$63,870	\$11,460	\$16,788
NM	03	Five Sandoval Indian Pueblos, Inc.	\$87,500	\$22,930	\$12,966
NM	04	Jicarilla Apache Nation	\$92,730	\$28,660	\$23,630
NM	05	Laguna Rainbow Corporation	\$118,790	\$40,130	\$17,536
NM	06	Mescalero Apache Tribe	\$92,730		\$8,883
NM	07	Pueblo de Cochiti Elder Program	\$72,460	\$17,190	\$7,786
NM	09	Pueblo of Isleta Elder Center	\$118,790	\$40,130	\$27,555
NM	10	Pueblo of Jemez	\$118,790	\$40,130	\$9,069
NM	11	Pueblo of San Felipe Elderly Services Program	\$92,730	\$28,660	\$28,128
NM	12	Taos Pueblo Senior Citizens Program	\$102,560	\$34,400	\$9,507
NM	13	Pueblo of Zuni	\$118,790	\$40,130	\$27,485
NM	14	Ohkay Owingeh Senior Citizens Program	\$118,790	\$40,130	\$14,466
NM	15	Santa Clara Pueblo	\$118,790	\$40,130	\$21,512
NM	16	Santo Domingo Pueblo	\$118,790	\$40,130	\$19,985
NM	17	Pueblo of Tesuque	\$63,870	\$11,460	\$7,594
NM	18	Acoma Elderly & Assistance Program	\$82,290	\$22,930	\$16,023
NM	Total	Total	\$1,701,060	\$498,730	\$315,403
NV	01	Fallon Paiute Shoshone Tribes	\$72,460	\$17,190	\$22,436
NV	02	Inter-Tribal Council of Nevada, Inc. (McDermitt, etc.)	\$72,460	\$17,190	\$7,309

State	Tribe No.	Grantee Name	TITLE6 /B	TITLE6 C	NSIP
NV	03	Inter-Tribal Council of Nevada, Inc. (Duckwater, etc.)	\$72,460	\$17,190	\$4,904
NV	04	Inter-Tribal Council of Nevada, Inc. (Ely, etc.)	\$72,460	\$17,190	\$5,252
NV	05	Shoshone-Paiute Tribes	\$72,460	\$17,190	\$8,430
NV	06	Walker River Paiute Tribe	\$72,460		\$30,241
NV	07	Washoe Tribe of Nevada and California	\$72,460	\$17,190	\$38,230
NV	08	Yerington Paiute Tribe	\$63,870	\$11,460	\$9,016
NV	09	Pyramid Lake Paiute Tribe	\$72,460	\$17,190	\$6,348
NV	10	Elko Band Council	\$72,460	\$17,190	\$8,918
NV	11	Reno-Sparks Indian Colony	\$63,870	\$11,460	\$13,888
NV	Total	Total	\$779,880	\$160,440	\$154,972
NY	01	St. Regis Mohawk Tribe	\$155,990	\$45,860	\$10,257
NY	02	Seneca Nation of Indians	\$118,790	\$40,130	\$24,585
NY	04	Oneida Indian Nation	\$72,460	\$17,190	\$5,013
NY	05	Shinnecock Indian Nation	\$72,460	\$17,190	\$7,123
NY	Total	Total	\$419,700	\$120,370	\$46,978
OK	01	Apache Tribe of Oklahoma	\$72,460	\$17,190	\$4,585
OK	02	Caddo Nation of Oklahoma	\$72,460	\$17,190	\$1,919
OK	03	Cherokee Nation	\$157,414	\$47,263	\$54,438
OK	04	Cheyenne and Arapaho Tribes	\$155,990	\$45,860	\$7,608
OK	06	Choctaw Nation of Oklahoma	\$155,990	\$45,860	\$42,265
OK	07	Citizen Potawatomi Nation	\$155,990	\$45,860	\$10,626
OK	08	Comanche Nation	\$118,790	\$40,130	\$11,043
OK	09	Delaware Nation	\$78,960	\$11,460	\$8,596
OK	10	Iowa Tribe of Oklahoma	\$118,790	\$40,130	\$7,399
OK	12	Kickapoo Tribe of Oklahoma	\$100,000	\$17,190	\$16,290
OK	13	Kiowa Tribe of Oklahoma	\$155,990	\$45,860	\$4,643
OK	14	Miami Tribe of Oklahoma	\$118,790	\$40,130	\$42,002
OK	15	Muscogee (Creek) Nation/Elderly Nutrition Program	\$155,990	\$45,860	\$150,828
OK	17	Otoe-Missouria Tribe of Indians	\$82,290	\$22,930	\$9,721
OK	18	Ottawa Tribe of Oklahoma	\$118,790	\$40,130	\$26,337
OK	19	Pawnee Nation of Oklahoma	\$80,000	\$17,190	\$10,592
OK	20	Peoria Tribe of Indians of Oklahoma	\$102,560	\$34,400	\$26,121
OK	21	Ponca Tribe of Oklahoma	\$92,730	\$28,660	\$11,428
OK	22	Quapaw Tribe of Oklahoma	\$118,790	\$40,130	\$26,945
OK	23	Sac and Fox Nation of Oklahoma	\$118,790	\$40,130	\$17,216
OK	24	Seminole Nation of Oklahoma	\$118,790	\$40,130	\$15,520
OK	25	Seneca-Cayuga Tribe of Oklahoma	\$118,790	\$40,130	\$9,778
OK	26	Wichita and Affiliated Tribes	\$118,790	\$40,130	\$7,849
OK	27	Wyandotte Nation	\$118,790	\$40,130	\$21,286
OK	28	Absentee Shawnee Tribe of Oklahoma	\$155,990	\$45,860	\$31,243
OK	29	Fort Sill Apache Tribe	\$92,730	\$28,660	\$8,152
OK	31	United Keetoowah Band of Cherokee Indians	\$155,990	\$45,860	\$31,565
OK	32	Chickasaw Nation	\$155,990	\$45,860	\$133,829
OK	33	Kaw Nation	\$72,460		\$21,573
OK	34	Osage Nation of Oklahoma	\$155,990	\$45,860	\$56,500
OK	35	Delaware Tribes of Indians	\$118,790	\$40,130	\$6,792
OK	36	Alabama-Quassarte Tribal Town	\$63,870	\$11,460	\$580
OK	Total	Total	\$3,778,534	\$1,107,763	\$835,269
OR	01	Confederated Tribes of Siletz Indians of Oregon	\$82,290	\$22,930	\$1,738
OR	02	Yellowhawk Tribal Health Center	\$102,560	\$34,400	\$17,739
OR	03	Confederated Tribes of Warm Springs	\$102,560	\$34,400	\$7,954
OR	04	Confederated Tribes of Grand Ronde	\$92,730	\$28,660	\$12,471
OR	05	The Klamath Tribes	\$118,790	\$40,130	\$4,047
OR	06	Confed. Tribes of Coos, Lower Umpqua &	\$72,460	\$17,190	\$8,282
OR	07	Cow Creek Band of Umpqua Tribe of Indians	\$63,870	\$11,460	\$55,717
OR	Total	Total	\$635,260	\$189,170	\$107,948
RI	01	Narragansett Indian Tribe	\$92,730	\$28,660	\$2,953
RI	Total	Total	\$92,730	\$28,660	\$2,953
SC	01	Catawba Indian Nation Eldercare Program	\$82,290	\$22,930	\$7,909
SC	Total	Total	\$82,290	\$22,930	\$7,909
SD	01	Cheyenne River Elderly Nutrition Services	\$118,790	\$40,130	\$8,398

State	Tribe No.	Grantee Name	TITLE6 /B	TITLE6 C	NSIP
SD	02	Crow Creek Sioux Tribe	\$72,460		\$17,370
SD	03	Lower Brule Sioux Tribe	\$72,460	\$17,190	\$19,725
SD	04	Oglala Sioux Tribe	\$155,990	\$45,860	\$35,837
SD	05	Rosebud Sioux Tribe	\$155,990	\$45,860	\$33,848
SD	06	Sisseton Wahpeton Oyate	\$118,790	\$40,130	\$31,348
SD	08	Yankton Sioux Tribe	\$102,560	\$34,400	\$21,411
SD	Total	Total	\$797,040	\$223,570	\$167,937
TX	01	Alabama-Coushatta Tribe of Texas	\$72,460	\$17,190	\$7,042
TX	02	Kickapoo Traditional Tribe of Texas	\$63,870		\$16,854
TX	Total	Total	\$136,330	\$17,190	\$23,896
UT	01	Ute Indian Tribe, Uintah & Ouray	\$82,290	\$22,930	\$3,632
UT	Total	Total	\$82,290	\$22,930	\$3,632
WA	01	Confederated Tribes of the Colville Reservation	\$118,790	\$40,130	\$16,366
WA	02	Lower Elwha Klallam Tribe	\$65,000	\$11,460	\$3,477
WA	03	Lummi Tribe	\$92,730	\$28,660	\$22,363
WA	04	Makah Tribe Senior Program	\$72,460	\$17,190	\$10,418
WA	05	Muckleshoot Indian Tribe	\$118,790	\$40,130	\$39,292
WA	09	Puyallup Tribe of Indians	\$118,790		\$9,799
WA	10	Quinault Tribe of the Quinault Indian Reservation	\$92,730	\$28,660	\$34,814
WA	13	Swinomish Indian Tribal Community	\$72,460	\$17,190	\$6,346
WA	14	Spokane Tribes Senior Program	\$82,290	\$22,930	\$12,598
WA	16	The Tulalip Tribes of Washington	\$118,790	\$40,130	\$12,086
WA	17	Jamestown S'Klallam Tribe	\$72,460	\$17,190	\$7,131
WA	19	Quileute Tribal Council	\$63,870	\$11,460	\$4,768
WA	20	S. Puget Intertribal Planning Agency - Shoalwater Bay	\$82,290	\$22,930	\$8,721
WA	21	Stillaguamish Tribe of Indians	\$92,730	\$28,660	\$2,241
WA	22	Upper Skagit Indian Tribe	\$63,870	\$11,460	\$2,825
WA	24	The Suquamish Tribe	\$82,290	\$22,930	\$13,481
WA	25	Port Gamble S'Klallam Tribe	\$72,460	\$17,190	\$9,676
WA	26	Samish Indian Nation	\$82,290	\$22,930	\$2,480
WA	27	Cowlitz Indian Tribe	\$155,990	\$45,860	\$3,786
WA	28	Skokomish Indian Tribe	\$82,290	\$22,930	\$2,674
WA	29	Confederated Tribes of the Chehalis Reservation	\$118,790	\$40,130	\$6,189
WA	30	Nooksack Indian Tribe	\$82,290	\$22,930	\$9,564
WA	31	Yakama Indian Nation	\$63,870	\$11,460	\$2,517
WA	32	Snoqualmie Tribe	\$63,870	\$11,460	\$2,618
WA	33	S. Puget Intertribal Planning Agency - Nisqually	\$118,790	\$40,130	\$3,818
WA	34	Squaxin Island Tribe	\$72,460	\$17,190	\$8,123
WA	Total	Total	\$2,323,440	\$613,320	\$258,171
WI	01	Bad River Elderly Nutrition Program	\$72,460	\$17,190	\$15,856
WI	02	Forest County Potawatomi Community	\$72,460	\$17,190	\$8,383
WI	03	Lac Courte Oreilles Band of Lake Superior Chippewa	\$82,290	\$22,930	\$7,202
WI	04	Lac du Flambeau Band of Lake Superior Chippewa Indians	\$82,290	\$22,930	\$16,657
WI	05	Menominee Indian Tribe of Wisconsin	\$118,790	\$40,130	\$4,750
WI	06	Oneida Tribe of Indians of Wisconsin	\$118,790	\$40,130	\$8,012
WI	07	Red Cliff Band of Lake Superior Chippewa	\$72,460	\$17,190	\$15,116
WI	08	St. Croix Chippewa Indians of Wisconsin	\$72,460	\$17,190	\$5,529
WI	09	Stockbridge-Munsee Community	\$72,460	\$17,190	\$2,105
WI	10	Ho-Chunk Nation	\$92,730	\$28,660	\$41,756
WI	11	Sokaogon Chippewa Community	\$63,870		\$7,736
WI	Total	Total	\$921,060	\$240,730	\$133,102
WY	01	Northern Arapaho Tribe	\$82,290		\$7,661
WY	03	Eastern Shoshone Tribe	\$82,290		\$12,009
WY	Total	Total	\$164,580		\$19,670
Total	Total	Total	\$25,526,394	\$6,015,922	\$3,782,470