DEPARTMENT of HEALTH and HUMAN SERVICES

FY 2016 Report to Congress: Older Americans Act

Prepared by
ADMINISTRATION ON AGING

ADMINISTRATION FOR COMMUNITY LIVING

ACL
Administration for Community Living

THIS PAGE INTENTIONALLY LEFT BLANK

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), 622 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).

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) 2016.

Lance Robertson
Administrator and Assistant Secretary for Aging
Administration for Community Living

Table of Contents

THIS PAGE INTENTIONALLY LEFT BLANK

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. In FY 2016, AoA and the national aging services network rendered direct services to over 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.[1] Critical supports, such as respite care and a peer support network, were provided to over 700,000 caregivers.[2]

Overview of Performance

AoA facilitates achievement of its mission through improvements in the analysis and availability of performance data while also enhancing the rigor of program evaluations. AoA program activities have a fundamental common purpose: to develop and support a comprehensive, coordinated, and cost-effective system of long-term services and supports that help older adults maintain their health and independence in their homes and communities and family caregivers. This purpose led AoA to focus on the following performance goals: 1) providing high quality services that result in positive consumer outcomes and reflect effective delivery systems; 2) effectively targeting services to at-risk populations; 3) improving program efficiency; and 4) promoting rights and preventing abuse of older adults. Each performance goal reflects activities spanning across AoA programs; programs that address distinct issues and populations. AoA intentionally collects and reports information on a program-by-program basis to ensure that the results of programs that serve smaller numbers of people (e.g., chore services and adult day care) are not overwhelmed by the results of programs that serve much larger populations (e.g., nutrition services) and to ensure that the unique elements of the varied programs can be highlighted. Progress toward achievement is tracked using a number of performance measures. Taken together, the performance goals and their corresponding metrics are designed to reflect AoA's goals and objectives and in turn measure success in accomplishing AoA's mission.

Performance Highlights

An analysis of AoA's program performance trends through FY 2016 illustrates that AoA programs continue to help individuals remain independent and in the community. Most performance measures and indicators have been maintained or steadily improved. Following are some key successes that are indicative of the potential of AoA and the aging network to meet demographic and fiscal challenges.

AoA programs provide high quality services that result in positive consumer outcomes and reflect effective delivery systems. Consumers report that services contribute in an essential way to maintaining their independence with, for example, over 40 percent of the caregivers indicating that

[1] AoA's FY 2016 State Program Report.
[2] Ibid.

the care recipient would be unable to remain at home without caregiver support services. With regard to effective delivery of evidence-based programs, OAA grantees were able to meet their participation targets for Chronic Disease Self-Management Education. AoA expanded the provision of quality services, such as through funding an additional 11 new unique organizations to provide specialized supportive services in the area of Alzheimer's Disease (ADI-SSS), to bring the total number funded to 32. Consumers also express a high level of satisfaction with these services. In 2016, over 97 percent of OAA transportation clients and nearly 94 percent of caregivers rated services good to excellent. To help ensure the continuation of these trends, AoA uses various mechanisms to promote innovative service-delivery models for state and local program entities that show promise for generating measurable improvements in program activities.

AoA programs reach at-risk populations and target services to help individuals remain independent and in the community. For example, older adults who have three or more impairments in Activities of Daily Living (ADL) are at a high risk for nursing home entry. Increasing services to this population is one proxy for nursing home delay and diversion. In FY 2005, one-third of home-delivered nutrition clients lived with three or more ADL impairments. By FY 2016, the proportion grew to nearly 42 percent, a 26 percent increase. AoA maintains nine core performance indicators supporting AoA's commitment to improving client outcomes and program quality. While some indicators experience year-to-year variation, all indicators have trended in the desired direction and the vast majority meet or exceed targets annually.

AoA programs are efficient. The aging network is providing high-quality services and doing so in a prudent and cost-effective manner. In FY 2016 the aging network served over 8,800 people per million dollars of OAA Title III funding. The result is an 18 percent increase over the 2005 baseline.

AoA programs effectively address complaints of abuse, neglect, or violation of rights; advocate for system improvements; and support innovation. The Long-Term Care Ombudsman Program grantees are highly successful at meeting the needs of complainants. In FY 2016, 73 percent of all complaints were resolved to the satisfaction of the complainant. The program's annual performance measure of reducing the number of complaints unresolved to the satisfaction of the complainant fell to below 9,000 exceeding the performance target.

The tables on the next page provide a summary of the persons served during FY 2016 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

Category	FY 2016
Total Clients	11,310,796
Total Registered Clients	2,784,192
% Minority Clients[3]	30.32
% Rural Clients	35.43
% Clients Below Poverty	32.94
# Senior Centers	9,834 (5,595 receive OAA funding)

Service	Persons Served	Units of Service[4]	Title III Expenditure	Total Expenditure
Personal Care	112,375	21,177,683	$57,129,043	$345,235.565
Homemaker	167,653	18,772,011	$36,186,526	$375,378,281
Chore	32,758	819,652	$4,769,073	$18,832,177
Home Delivered Meals	868,332	145,470,409	$294,07,725	$887,669,451
Adult Day Care	18,805	10,589,267	$12,954,116	$104,521,304
Case Management	443,982	3,695,835	$28,795,550	$251,226,076
Assisted Transportation	49,782	2,251,284	$4,636,126	$28,681,468
Congregate Meals	1,573,477	79,401,368	$295,905,120	$655,272,808
Nutrition Counseling	35,610	78,381	$1,205,182	$2,745,782
Transportation	-	23,690,052	$27,313,621	$206,508,153
Legal Assistance	-	958,668	$27,313,621	$50,570,912
Nutrition Education	-	3,376,131	$3,384,495	$7,021,906
Information and Assistance	-	12,420,450	$56,307,803	$184,496,823
Outreach	-	2,736,498	$9,364,332	$21,186,817
Health Promotion and Disease Prevention	-	-	$21,643,471	$52,404,481
Self-Directed Care	-	-	$135,077	$25,619,355
Other	-	-	$80,139,778	$477,232,301

[3] 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 Islandesr, American Indian or Alaska Native.

[4] 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[5]	Title III Expenditure	Total Expenditure
Counseling, Support Groups, Training	120,340	453,453	$21,310,285	$32,267,469
Respite	62,096	5,960,760	$54,006,261	$97,042,538
Supplemental Services	35,915	645,477	$11,419,055	$16,693,122
Access Assistance	497,085	1,192,174	$31,334,251	$45,596,582
Self-Directed	1,245		$1,003,491	$1,537,660
Information Services	20,539,714	436,025	$12,178,248	$16,987,072
Unduplicated Caregivers Provided Service or Access	710,249			

[5] 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 78.6 years in 2016,[6] [7] 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, almost two-thirds of Medicare beneficiaries have two or more chronic conditions and account for 94 percent of Medicare spending, while one-third of those with four or more chronic conditions account for three-fourths of Medicare spending.[8] 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 dually eligible (enrolled in both Medicare and Medicaid), standardized Medicare per capita spending increases from $5,361 for persons with two to three chronic conditions to $30,071 for persons with six or more chronic conditions.[9] Among Medicare beneficiaries age 65 and over who are dually eligible, standardized Medicare per capita spending increases from $7,604 for persons with two to three conditions to $36,807 for persons with six or more chronic conditions.[10]

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, 65 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 55 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.[11]

Between 2016 and 2020, the number of Americans age 60 and older will increase by over 8.9 million older adults, to reach 77.6 million.[12] During this period, the number of Americans age 65

---

[6] Arias E, Heron M, Xu J. United States life tables, 2013. National vital statistics reports; vol. 66 no 3. Hyattsville, MD: National Center for Health Statistics. April 11, 2017. Accessed March 23, 2018 at https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_03.pdf

[7] Kochanek KD, Murphy SL, Xu JQ, Arias E. Mortality in the United States, 2016. NCHS Data Brief, no 293. Hyattsville, MD: National Center for Health Statistics. 2017. Accessed March 23, 2018 at https://www.cdc.gov/nchs/products/databriefs/db293.htm.

[8] CMS Chartbook and Charts. Figure 13: Distribution of Medicare Fee-for-Service Beneficiaries and Medicare Spending by Number of Chronic Conditions: 2015. Chronic Condition Charts: 2015. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts.html

[9] CMS Multiple Chronic Conditions Utilization/Spending State Level: All Beneficiaries by Medicare-Medicaid Enrollment and Age, 2007-2015. Accessed March 23, 2018 at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/MCC_Main.html.

[10] Ibid.

[11] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.

[12] 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, 2016. Release Date: June 2017. Accessed January 2018. U.S. Census Bureau. Population Division. Table

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 eligibility (through the "spend down" provisions) will increase by 15 percent.[13] 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 12 million elderly individuals and caregivers.[14] AoA's services are especially critical for the nearly three million older adults who receive intensive in-home services, more than 485,000 of whom meet the disability criteria for nursing home admission.[15] 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.[16]

Home and Community-Based Supportive Services

(Title III-B of OAA; FY 2016: $386,182,000)

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.[17]

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.[18] Data also show that over 92 percent of older Americans

---

9. Projections of the Population by Sex and Age for the United States: 2015 to 2060 (NP2014-T9). Release Date: December 2014. Accessed January 2018.

[13] 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 January, 2018.

[14] AoA's FY 2016 State Program Report.

[15] Ibid

[16] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 Medicare Current Beneficiary Survey. [Table 1.2 Demographic and Socioeconomic Characteristics of Medicare Beneficiaries, by Age and by Gender and Age, 2013]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html. Accessed January 2, 2018.

[17] 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

[18] 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 January 2018.

have at least one chronic condition and 76 percent have at least two.[19] 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 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 2016 include:[20]

Transportation Services provided 23.7 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 40.8 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 10.5 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 48 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.[21] Many of these individuals cannot safely drive a car, as nearly 73 percent of transportation riders have at least one of the following chronic conditions that could impair their ability to navigate safely:[22]

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

Of the transportation participants, 96 percent take daily medications, with about one in five (15 percent) reporting they take 10 to 20 medications daily.[23] Data from AoA's national surveys of

[19] Ibid.
[20] AoA's FY 2016 State Program Report. These data are preliminary and should not be taken as final
[21] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.
[22] Ibid
[23] Ibid,

elderly clients show that HCBSS are providing these seniors with the assistance and information they report help them to remain at home.[24] For example, over 82 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.[25] In addition, a study published in the *Journal of 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.[26]

Nationally, 24 percent of individuals 60 and older live alone.[27] OAA programs serve a disproportionate number of people who live alone compared to the general population. For example, 67 percent of transportation clients live alone.[28] Living alone is a key predictor of nursing home admission, and HCBSS 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.[29]

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 2016: $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 2016: $216,397,000*): Provides funding for nutritious meals, the delivery of meals and nutrition-related services to homebound frail and/or

[24] Ibid.
[25] Ibid.
[26] 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. Accessed March 23, 2018 at: http://jah.sagepub.com/cgi/content/abstract/22/3/267.
[27] 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 (2015), accessed January 2018. .
[28] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov
[29] 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.

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.

Nutrition Services Incentive Program (*Title III-A; FY 2016: $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. In FY 2016, six states and one tribe elected to take some portion of the allotment in USDA Foods.

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.[30] Meals also comply with applicable provisions of state and local food safety codes, are appealing, and meet special dietary needs such as health, religious, and 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.[31] 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.[32] Data from AoA's FY 2017 National Survey of Older Adult Participants indicate that 95 percent of home-delivered and congregate participants have multiple chronic conditions, and that 47 percent of congregate and 64 percent of home-delivered participants have six or more illnesses or conditions. Over 21 percent of congregate and 40 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.

[30] https://health.gov/dietaryguidelines/2015/guidelines/ and https://www.nal.usda.gov/fnic/dietary-reference-intakes
[31] AoA's FY 2016 State Program Report.
[32] 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]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html. Accessed 02 January 2018.

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 percent) of congregate and almost two-thirds (64 percent) of home-delivered meal participants are aged 75 years or older.[33]

Approximately 10 percent of congregate and over 41 percent of home-delivered participants indicate that they have three or more impairments in instrumental activities of daily living (IADLs).[34] The data also indicate that 15 percent of congregate and 54 percent of home-delivered participants have difficulty getting outside the house, thus limiting their ability to shop for food themselves.[35] The number of home-delivered meal recipients with severe disabilities (three or more activities of daily living) totaled nearly 364,000 in FY 2016.[36] 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, 24 percent of persons age 60 years and older live alone.[37] However, due to the OAA's requirement to target services to older adults most in need to help them maintain their health and independence, 47 percent of congregate and 58 percent of home-delivered participants live alone.[38] 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 81 percent of congregate and 79 percent of home-delivered meal participants say they eat healthier meals due to the programs, and 65 percent of congregate and 92 percent of home-delivered meal recipients say that the meals enable them to continue living in their homes.[39] 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.[40] 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.[41] This evidence is a testimonial to the savings gained from this foundational home- and community-based service.

---

[33] 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, 2016. Release Date: June 2017 https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2016_PEPAGESEX&prodType=table Accessed January 2018 and AoA's FY 2016 State Program Report.

[34] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov and AoA's FY 2015 State Program Report.

[35] Ibid.

[36] AoA's FY 2016 State Program Report.

[37] 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 (2015), accessed January 2018.

[38] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.

[39] Ibid

[40] 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. Accessed March 23, 2018 at: http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12015/abstract

[41] Ibid.

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 82 percent of home-delivered meal clients and over 90 percent of congregate participants rate the meal as good to excellent.[42] 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 145 million meals to over 868,000 individuals in FY 2016.[43]

Congregate Nutrition Services provided over 79 million meals to more than 1.57 million older adults in a variety of community settings in FY 2016.[44]

Consistent with the OAA's requirement to target services to those most in need to help them maintain their health and independence, approximately 71 percent of home-delivered meal recipients have annual incomes at or below $20,000.[45] Meals are especially critical for the 61 percent of home-delivered and 53 percent of congregate recipients who report these meals provide half or more of their food intake for the day.[46]

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 2016, state and local funding comprised two-thirds (67 percent) of all the funding for home-delivered meals and nearly 55 percent for congregate meals.[47] 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 (HCBSS) and Nutrition Services, states and territories have the flexibility to allocate resources to best meet local needs through intra-state funding formulas that 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

[42] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.
[43] AoA's FY 2016 State Program Report. These data are preliminary and should not be taken as final
[44] Ibid.
[45] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.
[46] Ibid.
[47] AoA's FY 2016 State Program Report.

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 2016 Transfer of Federal funds within Title III of the OAA

Category	Part B – Home and Community-Based Supportive Services	Part C1 – Congregate Nutrition	Part C2 – Home-Delivered Meals
Initial Allotment	$345,166,956	$445,047,800	$224,673,820
Final Allotment after Transfers	$403,913,406	$348,260,376	$262,714,794
Net Transfer	$58,746,450	(-$96,787,424)	$38,040,974
Net Percent Change	17.02	(-21.75)	16.93

Preventive Health Services
(Title III-D of OAA; FY 2016: $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.

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 through strength training, cardiovascular workouts, balance exercises, and more.

- *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.[48] These programs have also been shown to improve medication usage rates and decrease medication errors among older adults.[49]

- *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

[48] 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 available at http://www.ncbi.nlm.nih.gov/pubmed/12383144. Accessed March 23, 2018.

[49] A summary of these studies can be found at: https://www.acl.gov/programs/strengthening-aging-and-disability-networks/aging-and-disability-evidence-based-programs

beneficiaries age 65 and older have a depression diagnosis.[50] 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).[51] 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.[52]

Starting in 2012 and continuing every year since, ACL's appropriations language has specified 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 toward 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).

50 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CC_Main.html.

51 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.

52 Program to Encourage Rewarding Lives for Seniors (2012). Description available at: http://www.pearlsprogram.org/

Chronic Disease Self-Management Education Programs
(FY 2016: $8,000,000)

In the United States, nearly 70 percent of Medicare beneficiaries have two or more chronic conditions.[53] This burden places older adults at greater risk for premature death, poor functional status, unnecessary hospitalizations, adverse drug events, and nursing home placement.[54,55] Chronic conditions also impact health care costs: 95 percent of health care costs for older Americans can be attributed to chronic diseases.[56]

Chronic Disease Self-Management Education (CDSME) programs, such as the evidence-based Chronic Disease Self-Management Program (CDSMP) originally developed at Stanford University, 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.[57] 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, Cancer: Thriving and Surviving, 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.[58] 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.[59]

---

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

[54] 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.

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

[56] 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.

[57] 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.

[58] 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 March 23, 2018.

[59] 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 March 23, 2018.

CDSMEs emphasize an individual's role in managing his/her chronic condition(s). For example, the 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-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 eight grants for a two-year forward funded project period beginning September 1, 2015, as well as 12 forward-funded grants for a two-year project period beginning August 1, 2016. Additionally, a cooperative agreement for a National Chronic Disease Self-Management Education Resource Center was awarded for a five-year project period. The Resource Center assists states, the aging, disability and public health networks, and their partners to increase access to and sustain evidence-based prevention programs, particularly CDSME programs that 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.

By September 30, 2016, grantees and various partners had reached a cumulative total of over 178,000 participants. During FY 2016, there were over 37,700 participants and over 28,800 "completers" (i.e., who attended at least four out of six classes, a retention rate of 73 percent [retention rate is specific to only those interventions with standard start/end dates, not ongoing interventions]). Grantees were successful in reaching their targeted underserved populations: of those participants reporting relevant data, 74 percent were age 60 or older, 78 percent reported having multiple chronic conditions, 32 percent reported a disability, and 41 percent were racial/ethnic minorities.[60]

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 one in four persons aged 55 and over have experienced a behavioral health disorder.[61] 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,

[60] Racial and/or 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 Other Pacific Islanders, American Indian or Alaska Native.

[61] Substance Abuse and Mental Health Services Administration (SAMHSA). (2012). Older Americans Behavioral Health Issue Brief: Series Overview. Accessed January 5, 2018 at: https://www.ncoa.org/wp-content/uploads/Series-Overview-Issue-Brief-1.pdf

decrease life expectancy, and increase overall healthcare costs.[62] 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 2016, ACL and SAMHSA continued their 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 2016: $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,[63] but fewer than half of those who have suffered a fall talk to their healthcare providers about it.[64] 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.[65] In 2014, adjusted for inflation, the direct medical costs for fall injuries were $31 billion annually.[66]

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

[62] World Health Organization (2016). Mental Health and Older Adults: A Fact Sheet. Retrieved March 23, 2018 at http://www.who.int/mediacentre/factsheets/fs381/en/

[63] U.S Centers for Disease Control and Prevention. (2016). Facts About Falls. Accessed March 23, 2018 at: http://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html

[64] 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.

[65] 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.

[66] 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,

interventions.[67] 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,[68] and a recent study showed a positive return on investment for the implementation of Tai Chi: MBB, Stepping On, and Otago.[69] ACL continues to collaborate with our partners at CDC's Injury Prevention Center to leverage their research, data surveillance, and clinical provider education efforts.

ACL received dedicated funding for falls prevention programs through the Prevention and Public Health Fund (PPHF) in FY 2016. ACL published a competitive funding announcement, and external experts reviewed applications for this opportunity. ACL awared a total of seven grants 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 2016 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.

[67] 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.

[68] 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 13, 2018 from: http://innovation.cms.gov/Files/reports/CommunityWellnessRTC.pdf

[69] Carande-Kulisa, V., et al. (2015), A cost–benefit analysis of three older adult fall prevention interventions, Journal of Safety Research, Accessed February 13, 2018 from: http://www.cdc.gov/homeandrecreationalsafety/Falls/steadi/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 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.[70] In other words, approximately 14.3 percent of all adults provided care to someone age 50 years and older.[71] 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).[72] Another recent study by the Rand Corporation estimated the economic cost of replacing unpaid caregiving to be about $522 billion annually.[73] 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.[74]

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

---

[70] 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. Accessed February 15, 2018.

[71] Ibid.

[72] Valuing the Invaluable: 2015 Update, The Growing Contributions and Costs of Family Caregiving. AARP Public Policy Institute. July 2015. http://www.aarp.org/ppi/info-2015/valuing-the-invaluable-2015-update.html. Accessed February 15, 2018.

[73] *The Opportunity Costs of Informal Elder-Care in the United States.* The Rand Corporation, 2014. http://www.rand.org/pubs/external_publications/EP66196.html. Accessed February 15, 2018.

[74] Home Alone: Family Caregivers Providing Complex Chronic Care. AARP and United Hospital Fund. October 2012. https://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/home-alone-family-caregivers-providing-complex-chronic-care-rev-AARP-ppi-health.pdf. Accessed February 15, 2018.

and emotional strain as a result of their caregiving role are at higher risk for earlier mortality.[75,76,77] Providing support that makes caregiving easier for family caregivers, such as information, counseling and training, respite care, or supplemental services, is critical to sustaining caregivers' ability to continue in that role. Seventy seven percent of the caregivers served by OAA programs report that these services allow them to provide care longer than they otherwise could.[78]

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 over two million seniors (or a 15 percent increase between 2016 and 2020) needing caregiver assistance.[79]

National Family Caregiver Support Program

(Title III-E of OAA; FY 2016: $150,586,000)

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 that caregivers can access on their behalf.

The NFCSP provides a variety of supports to family and informal caregivers. In FY 2016, services provided included:[80]

- *Access Assistance Services*, which provided over 1.2 million contacts to caregivers assisting them in locating services from a variety of public and private agencies.

---

[75] 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.

[76] 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

[77] 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

[78] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov

[79] 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, 2016. Release Date: June 2017. Accessed January 2018, 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 January 2018, 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 January 2018.

[80] AoA's FY 2016 State Program Report.

- *Counseling and Training Services*, which provided over 120,000 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving.

- *Respite Care* Service, which provided nearly 62,000 caregivers with approximately 6 million hours of temporary relief – at home or in an adult day care or nursing home setting – from their caregiving responsibilities.

To evaluate the degree to which the NFCSP is meeting its goals and objectives, ACL undertook its first national evaluation of the program since implementation began. The first part of the evaluation was completed and the results were released in March, 2016. Known as a "process evaluation," it focused on two broad research questions: 1) how the program meets its goals, and; 2) has the program contributed to long-term care system efficiency. Results of this portion of the evaluation show the program has served as a catalyst for states to focus specifically on the needs of family caregivers and has resulted in meaningful progress in including family caregivers in broader systems of long-term services and supports.

For example, analysis of services available to caregivers before and after the NFCSP started, as reported by state units on aging (SUAs) found a 247 percent increase in support group services, a 227 percent increase in training and education services, and a 93 percent increase in the availability of respite care services. The NFCSP has also fostered the growth of partnerships among aging services network agencies and other organizations in supporting the needs of family caregivers. Approximately one-half (51.8 percent) of area agencies on aging indicated that Aging and Disability Resource Centers (ADRCs) were a key partner in serving family caregivers while more than 40 percent indicated that health care providers were among the three most partners for administering the program.[81]

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 2017 National Survey of OAA Participants show that over 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 over 30 percent describe their own health as fair to poor.[82] 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.[83] 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

[81] Process Evaluation of the Older Americans Act, Title III E: National Family Caregiver Support Program: Final Report (March 2016). Prepared for The Administration for Community Living by The Lewin Group, Inc. See: Final Report

[82] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.

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

such as having to rearrange their work schedule, decrease their hours or take an unpaid leave in order to meet their caregiving responsibilities.[84]

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 (77 percent) while often continuing to work,[85] 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.[86]

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.[87] Those respondents were then asked to identify where the care recipient would be living without services. A significant majority of those caregivers, nearly 77 percent, indicated that the care recipient would most likely be living in a nursing home or an assisted living facility (see the chart below).[88]

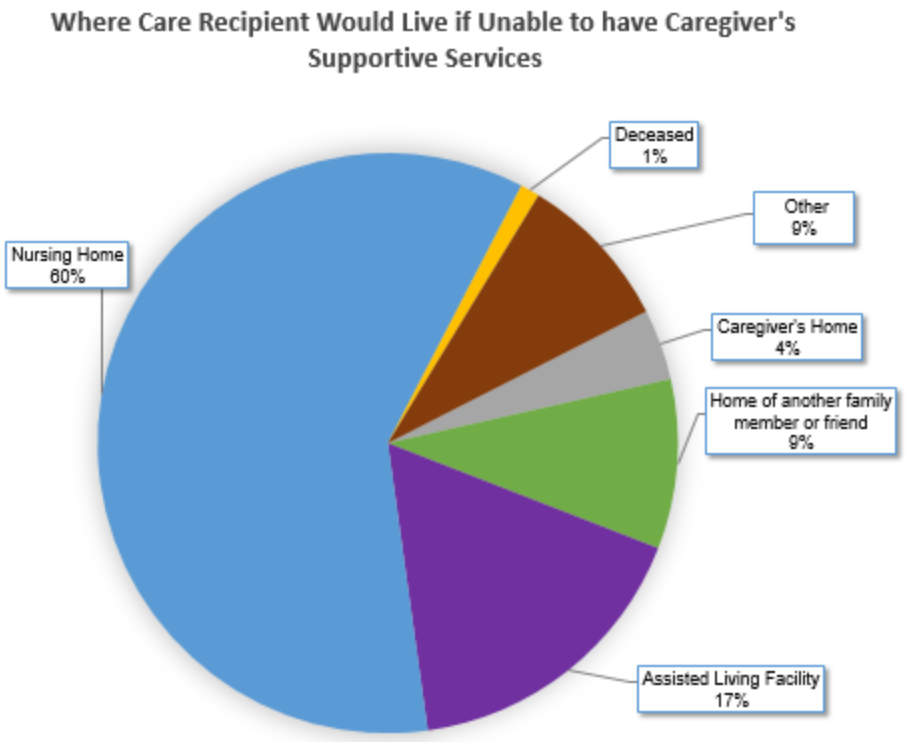
[84] Research Report: Caregiving in the U.S. 2015- A Focused Look at Caregivers of Adults Age 50+. National Alliance for Caregiving and AARP Public Policy Institute. June 2015. http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Care-Recipients-Over-50_WEB.pdf.

[85] 2017 National Survey of Older Americans Act participants. http://www.agid.acl.gov.

[86] 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.

[87] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov

[88] *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 is available at: https://www.acl.gov/index.php/node/293

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 four parts to the Brain Health Resource. *Brain Health Basics* helps people learn and teach others about the risks related to brain health and how to reduce them. *Medicine, Age and Your Brain* explains the impact of some medicines can have on an older adult's brain, and the importance of talking with a doctor about this topic. *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 U.S. Department of Health and Human Services' National Plan to Address Alzheimer's Research, Care and Services.[89]

Alzheimer's Disease Supportive Services Program (ADSSP)
(FY 2016: $4,800,000)

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 (ADRD), 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 (HCBS) for persons with ADRD, AoA presently focuses its ADSSP resources toward building dementia-capable systems within states. Dementia-capable systems are those that are designed to improve the responsiveness of home and community-based services systems to persons with dementia and their caregivers by ensuring access to sustainable, integrated long-term services and supports. The primary components of the ADSSP program includes delivery of supportive services for persons with dementia and their caregivers through dementia-specific, evidence-informed interventions, as well as advancing changes to the dementia-capability of states' overall systems of home and community-based care.

ADSSP expands the aging services network's capacity to assist those with ADRD and their families through provision of services and education, building awareness of Alzheimer's disease and related dementias, 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.

ADSSP grant projects are designed to ensure that states provide people with ADRD and their family caregivers with access to a sustainable home and community-based services system that is

[89] https://aspe.hhs.gov/national-plan-address-alzheimers-disease-2015-update.

"dementia capable." Such a system meets the unique needs of each person with ADRD 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 19 states implementing grants dedicated to the development of dementia-capable systems.

Through projects funded in new ADSSP grant projects states continue to implement dementia-specific, evidence-based and evidence-informed 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 state HCBS systems.

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 dementia-capable and efficiently and effectively coordinated. The ADSSP provides states the opportunity and resources to infuse dementia capability into their systems and provide appropriate direct services in support of persons living with ADRD and their caregivers. The delivery of dementia-capable services and supports that are cost-effective and result in demonstrated measureable outcomes in the communities they serve continue to be at the forefront of all ADSSP.

Alzheimer's Disease Initiative – Specialized Supportive Services (ADI-SSS)

(FY 2016 - $10,500,000)

In FY 2016, 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. In 2016, the ADI-SSS program was open to states and community-based entities operating within an existing dementia-capable system through which persons with ADRD and their caregivers receive quality, person-centered services to support their remaining independence and safety 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 2016, 11 unique organizations received ADI-SSS program awards, joining the 21 organizations funded in FYs 2014 and 2015. The FY 2016 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 meet the requirement for the implementation of at least one dementia related evidence-based or evidence-informed 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 2016: $31,158,000)

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 895,000 persons age 60 and over identify themselves as Native American or Alaska Native alone or in combination with another racial group.[90] Over 520,000 of those elders identify as Native American or Alaska Native with no other racial group.[91]

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.[92] In addition, this rapidly growing population is also experiencing some of the highest rates of disability,[93] chronic disease, and poverty[94] 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-third (38 percent) of eligible Native American seniors in participating tribal organizations, home-delivered meals reach 13 percent of such persons, and supportive services reach 56 percent of such persons.[95] 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.

Services provided by this program in FY 2016 included:

---

[90] 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, 2016 Released June 2017, accessed January 2018.

[91] 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, 2016. Released June 2017. Accessed January 2018.

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

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

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

[95] ACL's OAA Title VI Program Performance Report, PY 2016. 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

- *Transportation Services*, which provided over 1,000,000 rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical activities.[96]

- *Home-Delivered Nutrition Services,* under which over 2.5 million meals were provided to 20,300 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.[97]

- *Congregate Nutrition Services*, which provided over 2.6 million meals to nearly 59,000 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.[98]

- *Information, Referral and Outreach Services*, which provided nearly 922,000 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.[99]

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 2016: $7,531,000)

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

[96] ACL's OAA Title VI Program Performance Report, PY 2016
[97] Ibid.
[98] Ibid.
[99] Ibid

60 and over. Tribal organizations must represent at least 50 Native American elders age 60 and over and be receiving a grant under Title VI Part A or B to receive funding. There is no requirement for matching funds. Tribes may also decide the age at which a member is considered an elder and thus eligible for services. In addition, there is no limit on the percentage of funds that can be used for services to grandparents caring for grandchildren.

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 provided over 100,000 hours of respite care, delivered just over 23,000 hours of caregiver training, and assisted 16,000 caregivers to access needed services.[100] 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.

[100] 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 2016: $7,896,000)

The Prevention of Elder Abuse and Neglect program (Title VII, Section 721) provides states with 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 on elder justice. This 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 states significantly leveraging OAA funds to obtain additional 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.[101] 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.[102] 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.[103] 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.[104]

---

[101] Teaster, Pamela, et al. *The 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older*. https://ncea.acl.gov/resources/docs/archive/2004-Survey-St-Audit-APS-Abuse-18plus-2007.pdf. Accessed March 23, 2018.

[102] Tatara, Toshio, et al. *The National Elder Abuse Incidence Study Final Report*. https://www.acl.gov/sites/default/files/programs/2016-09/ABuseReport_Full.pdf. Accessed March 23, 2018.

[103] 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.

[104] 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.

Recent 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 their medical treatment; 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 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 promising practices and strategic approaches to for revealing and prosecuting fraud in areas such as telemarketing and sweepstakes scams that target the elderly.

In FY 2016, NCEA accomplishments included:

- The NCEA website is recognized as a viable resource on abuse, neglect, and exploitation for its users. A total of 166,979 users have accessed the NCEA website. Many of the users are located in the following states: California, Florida, Texas, New York, and Georgia. The inquiries trended as follows: 40 percent were about financial abuse, including five percent on solicitation scams, nine percent were queries about emotional abuse, and five percent were on the topic of discrimination and/or ageism. While 27 percent reported multiple forms of alleged abuse, 73 percent were focused on only one type of abuse.

- The NCEA facilitated and moderated a total of 172 conversations on its listserv and actively engaged 2,139 listserv participants. An average of six topics was discussed each week on the listserv.

- In June 2016, the NCEA collaborated with aging partners to learn, understand and disseminate an elder abuse communication strategy designed by the Frameworks Institute. The metaphors are designed to reframe and educate people and agencies who are in a position to improve policies and services relevant to elder abuse. Two metaphors were developed and have been introduced to aging network at conference.

- Developed collaborations with other national organizations and nationally recognized resource centers for collaborative purposes. These entities included organizations focused upon the needs of Asian and Other Pacific Islanders, Latino, Native American, LGBTQ, African American, and Alzheimer's and related disorders resource centers.

- The NCEA successfully conducted a four-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 3 million impressions; and hosted a "Finish this Sentence" campaign. The campaign was launched in May 2016 and continued through June 15, 2016. Social media users were asked to finish this sentence: "Together we can fight elder abuse by..." The "Finish this Sentence" campaign was launched in May 2016 and continued through June 15, 2016 and was an enormous success. Social media users were asked to finish this sentence: "Together we can fight elder abuse by...", reaching over 45,000 social media users. Answers were shared in English, Russian, Spanish, and several other languages.

National Legal Assistance and Support Projects

National Legal Resource Center

(FY 2016: $1,032,062)

The National Legal Resource Center (NLRC) is comprised of four national grants that, together, provide professionals in aging and legal services networks, including legal assistance providers, with tools and resources to deliver high-quality legal assistance that addresses substantive legal matters designated as priorities in the Older Americans Act, including independence, health, and financial security, to older Americans with economic or social need.

NLRC services underpin the leadership, knowledge, and systems capacity of legal and aging services provider organizations and enhance the quality, cost-effectiveness, and accessibility of legal assistance and elder rights protections available to older persons with social or economic needs. The target audience for the NLRC's services includes a broad range of legal, elder rights, and aging services professionals and advocates. These include 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 provides core resources through case consultation, training, and technical assistance on the Older Americans Act-designated priority legal matters and on associated systems development issues. Examples of common legal issues for which the NLRC provides assistance include preventing the loss of an older individual's home through foreclosure or due to elder abuse; protecting against consumer scams and creditor harassment; and addressing elder abuse in the community and in long-term care facilities. The NLRC also provides technical assistance on the efficient, cost-effective, and targeted provision of state-wide legal and elder rights education and outreach services.

In FY 2016, older consumers and the legal providers who serve them faced a host of legal challenges, including an increasing demand for legal resource support. The NLRC provided legal training on priority issues to 10,410 aging/legal service professionals nationwide. In addition, the NLRC delivered direct case consultation to 475 aging/legal professionals on complex legal issues. NLRC partners also provided important technical support to implement Model Approaches projects in 27 states, providing expertise to grantees about legal needs and capacity assessments, effective targeting and outreach methodologies, statewide reporting systems, and legal service delivery standards.

The combined efforts of the partnering organizations that comprise the NLRC offer subject matter expertise that enables the NLRC to achieve its broad resource support objectives. Through effective collaborations, interlocking work plans, and the leveraging of organizational resources, NLRC partners have been able to achieve national support for local organizations that can provide effective legal assistance services on high priority legal issues areas., which positively impact older Americans in the most social or economic need.

On September 9, 2016, the newly contracted National Center for Law and Elder Rights (NCLER) launched as the National Legal Resource Center (NLRC) concluded operations.

Model Approaches to Statewide Legal Assistance Systems

(FY 2016: $1,472,314)

Thirty-one states have received Model Approaches grants since this initiative began in 2006. These grants help states develop and implement statewide systems to deliver cost-effective, replicable and comprehensive approaches for legal assistance to older Americans with greatest economic and social need who experience the priority legal issues set forth in the Older Americans Act. Systems development includes integrating Senior Legal Hotlines (SLHs), which can provide brief service, advice and counsel and a portal to representational legal assistance, along with other low- and no-cost legal services delivery mechanisms into a broad spectrum comprising a state's legal service delivery network. Legal assistance services, when provided through well-integrated and cost-effective service delivery systems, as demonstrated through Model Approaches, enables 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 work to incorporate the components of the delivery network SLHs into the state's legal services delivery system. Key project partners

and service delivery components 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 older Americans most in need to access quality legal services to receive capable legal assistance to address their priority legal issue areas, income security, healthcare financing, housing and foreclosure prevention, and elder abuse and defense of guardianship to preserve independence and autonomy. 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.

Some illustrative recent examples of success made possible by the systems enhancement efforts of Model Approaches grantees in 2016 include:

- A 78-year-old widow in Maine was convinced to sell her home and move in with her daughter and her husband. They promised that they would look after her and manage her finances and medical issues. Instead, they moved her into a camper in their back yard in the heat of summer, where the woman's health declined and she eventually ended up needing nursing home care. Over the course of two years they spent her entire nest egg, leaving her without a home and disqualified from eligibility for Maine's Medicaid program, called MaineCare. LSE pursued litigation in Superior Court and ultimately came to a monetary settlement and also negotiated with the State of Maine to restore her MaineCare coverage upon exhaustion of her recovered funds.

- A 70-year-old military veteran called a SLH because overwhelming storms had flooded his apartment causing great hardship during a four month period. The Hotline attorney was very concerned about the veteran's unhealthy living conditions and made a call to the manager of the apartment complex to have the issue addressed. The manager apologized for the delay, and agreed to replace the client's carpet and take other measures to restore the apartment to a habitable condition.

Model Approaches grants are awarded in two phases. Phase I grantees work to develop statewide legal service delivery systems that coordinate efforts of senior legal helplines, pro-bono attorneys, law school clinics, self-help sites, and Older Americans Act-funded legal services providers to ensure maximum impact from limited resources. The target populations are underserved seniors, with particular emphasis upon low-income, minority, rural, homebound, Native American, and limited-English speaking older adults.

In 2016, two states (Tennessee and Wisconsin) were awarded Phase I grants. During 2016, these states convened their stakeholders and undertook a legal needs assessment and an assessment of the capacity of the existing network to provide legal assistance to targeted populations on Older Americans Act-identified legal priority case types[105].

[105] Older Americans Act, Section 307(a)(11)(e), 42 United States Code Section 3027(a)(11)(e).

Phase II Model Approaches grants are primarily focused on enhancing civil legal responses to complex issues that emerge from elder abuse, neglect, and financial exploitation. Additionally, these grants seek to expand outreach to older adults with greatest social or economic need and work to create legal service delivery guidelines or standards that promote quality and consistent statewide legal service delivery to older adults facing threats to independence, health, and financial security.

In FY 2016, ACL awarded six new Model Approaches Phase II grants (Connecticut, Florida, Massachusetts, Pennsylvania, Vermont and Virginia) 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.

Pension Counseling and Information Program

(FY 2016: $1,602,007)

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.

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 that 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 six regional counseling projects are:

- The Mid-American Pension Rights Project, serving Michigan, Ohio, Indiana, Tennessee, Pennsylvania, and Kentucky;

- The New England Pension Assistance Project, serving Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont (and also supporting pensioners in Illinois);
- The South Central Pension Rights Project, serving Arkansas, Louisiana, Missouri, New Mexico, Oklahoma and Texas;
- The Upper Midwest Pension Rights Office, serving Iowa, Minnesota, North Dakota, South Dakota, and Wisconsin;
- The Mid-Atlantic Pension Counseling Project, serving New York and New Jersey; and
- The Western States Pension Counseling Project, serving Arizona, California, Hawaii, and Nevada.

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 through 2016, the Pension Counseling projects have recovered $228 million in retirement benefits for more than 57,000 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:

- The Mid-American Pension Rights Project assisted a widow in Pennsylvania in obtaining her survivor pension, which was complicated for the client to access because the pension was split between two different companies for which her deceased husband had worked, each with unique requirements for the widow to follow in order to obtain the funds. The first company had denied the widow her surviving spouse benefits because their marriage was common law, and the project required proof that this marriage met the legal criteria of a common law marriage before paying her. The project was able to work with the first company and secure the survivor benefits for the client after providing the company the proper documentation to prove the common law marriage. The second company had overpaid pension benefits to the client's deceased husband, and was refusing to pay the client her surviving spouse benefit retroactively to the date of her husband's death. Once the project communicated with the company the applicable federal law and documentation that required the retroactive payment of benefits, the client received her full amount of the survivor pension. In total, the project secured a monthly payment of $900 for the rest of the client's life from company one and a retroactive payment from company two of more than $7,000.

- The New England Pension Assistance Project took the case of a 65-year old woman from Massachusetts who was living on less than $20,000 a year to secure her share of her deceased ex-husband's pension and survivor benefits. The client, who had divorced her ex-husband in 1991, had filed a Qualified Domestic Relations Order (QDRO) at the time of divorce in order to ensure she would receive her share of the husband's pension.

However, due to the ex-husband's company changing ownership in the following decades, the client was not receiving any pension at all, with the pension payment plan also changing hands through the acquisition of the company to a different entity. The project was able to track down the current corporate successor and the company's pension payment plan, which had no record of the QDRO designating a share of the ex-husband's pension to his ex-wife (the client); further, the plan had no record of a survivor benefit being owed to the client, as the QDRO had given her a right to a lifetime benefit while her ex-husband was still alive, and a survivor benefit if he pre-deceased her. The project filed a claim on the client's behalf arguing her right to the portion of the pension and a survivor benefit as laid out in the original QDRO, which resulted in the plan paying her a retroactive $9,885 to account for the funds paid solely to the ex-husband upon his retirement in 2005 that were owed to the client, in addition to her receiving an ongoing monthly share of his pension.

- In California, the Western States Pension Counseling Project assisted a low-income older adult with disabilities in accessing her community property portion of her former spouse's pension. The client was struggling to balance expenses for housing, food, and medicine, unable to make ends meet with her Supplemental Security Income (SSI) due to high medical costs. The project contacted the pension plan on her behalf, and was told by the plan that she was not entitled to any benefits, but would not provide written rules or documentation to support their denial. Over the course of two years, the project investigated the plan's denying the client access to the pension, coming to an agreement with the plan that the client was due $86,106. The project attorney working with the client on this case helped the client apply for the pension, as well as explained to the client the potential impact of the additional income on her public benefits.

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: http://www.PensionHelp.org..

Long-Term Care Ombudsman Program
(FY 2016: $15,837,665)[106]

State 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 designated by their State Ombudsman provide service to 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.
- Analyze, comment on, and recommend changes in laws and regulations pertaining to the health, safety, welfare and rights of residents.

<u>Improving and Evaluating Ombudsman Program Services</u>

To improve the quality and effectiveness of LTC Ombudsman program services to residents, ACL is undertaking two historic activities: 1) implementation 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 published a final rule (45 CFR Part 1324) to guide states in their implementation of the State Long-Term Care Ombudsman Program in February 2015 and the rule became effective on July 1, 2016. Since the rule's publication, ACL staff and the National Ombudsman Resource Center have provided 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 requirements of the new rule. ACL has proactively offered customized technical assistance to each state to assist in assuring compliance and 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.

[106] 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.

2. Evaluation of the Ombudsman Program

ACL is currently evaluating the LTC Ombudsman program to understand service delivery models. This process evaluation will help ACL lay the foundation to evaluate program impact and efficiency. Not since the Institute of Medicine's 1995 report,[107] has there been a comprehensive, national evaluation of the Ombudsman program. ACL completed its evaluation design in 2013[108] and anticipates completion of the process evaluation in 2019.

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 199,493[109] complaints and resolved 73 percent of these complaints to the full or partial satisfaction of the resident or complainant.
- 71 percent of complaint resolution work occurred in nursing facility settings; 26 percent occurred in board and care, assisted living or other residential care communities; and three percent were associated with non-facility settings or services to facility residents by an outside provider.
- Residents were the primary complainant in nursing facilities (42 percent) and in board and care, assisted living and other residential care communities (34 percent).[110]

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.

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

- Improper eviction or inadequate discharge planning.
- Administration and organization of medications.
- Quality, quantity, variation and choice of food.
- Lack of respect for residents, poor staff attitudes and

[107] "Real People, Real Problems: An Evolution of the Long-Term Care Ombudsman Program of the Older Americans Act," IOM (2995)
[108] https://www.acl.gov/programs/program-evaluations-and-reports
[109] FFY 2016 National Ombudsman Reporting System (NORS) is the source for this and other data in this section. States report NORS data annually to ACL.
[110] In FY 2016, ombudsmen opened 134,097 new cases (a case contains one or more complaints originating from the same person(s)), and completed resolution on 128,750 closed cases, containing, 199,493 complaints.

- Building or equipment in disrepair or hazardous.

Long-Term Care Ombudsman programs devote significant effort to addressing improper discharge and eviction. This complaint is the most common among both nursing home and board and care residents in FY 2016 and is best illustrated by example of a successful case resolution.

- The Ombudsman program received a complaint from the individual holding a power of attorney for a 90-year-old man who was told that he could not return to his residential care home after his stay in the hospital and skilled nursing facility. The resident's wife lived at the same residential care home and he was sad and distressed about the possibility of being separated from her. The residential care home staff stated that the resident had declined significantly both medically and cognitively and that they believed they could no longer provide for his care. The investigation conducted by Ombudsman representative indicated that resident had few medical needs and the skilled nursing facility was ready to send him back to his residential care home. The Ombudsman representative met with the administrator and residential care director, who explained their reasoning for the denial, and declined to discuss the matter further, indicating it was out of their hands. The Ombudsman representative then contacted the corporate office and after several calls, the administrator did agree to readmit the resident, allowing him to reunite with his wife.

Ombudsman program strategies to address inappropriate discharges include developing task forces, proposing legislation, training both hospital social workers and long-term care facility staff on relevant requirements; and training residents and their families on their rights regarding discharge and transitioning out of a long-term care facility.

Ombudsman Program Activities

In addition to resolving complaints, LTC Ombudsman programs provide services that prevent problems for residents and serve as a resource on rights, quality care and community options. In FY 2016, LTC Ombudsman programs provided:

- Routine visits to 68 percent of nursing facilities and 28 percent of board and care, assisted living, and other residential care communities at least quarterly. These visits ensure that residents have regular access to ombudsman services.
- Information and assistance to individuals (over 378,500 instances) on topics such as long-term services and supports options; Medicaid eligibility; discharge and eviction rights; and other federal and state policies affecting residents.
- Consultations and information to long-term care facility staff (over 115,700 instances), on topics such as residents' rights, person-centered care practices, and discharge and eviction questions.
- Resident and family council support, providing technical assistance, training and information to resident councils (22,205 sessions) and family councils (1,974 sessions).
- Training of long-term care facility staff (4,702 sessions).
- Community education (10,690 sessions).
- Coordination with licensing and survey entities, participating in 17,591 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 addressing improper evictions, Ombudsman programs reported on work to address systems-level issues, including:

- Mental health supports - 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.

- Care requests - LTC Ombudsman programs worked to resolve nearly 9,440 complaints related to unanswered requests for assistance with care. Many Ombudsman programs note that the failure to respond to requests for assistance is due to the shortage of both direct care and nursing staff and facilities often resort to using staff from an agency, which often results in a lack of person-centeredness and consistency in care provided. State Ombudsmen attribute staffing shortages to the growing demand for long-term services and supports coupled with a shrinking labor pool, and generally low wages. They frequently observe inadequate training and limited on-the-job support which also impact resident care and retention of qualified nursing staff. Not only is turnover high, with median turnover estimates of direct care and nursing staff at 50 percent, but it is increasingly difficult to fill vacant positions.[111]

- Examples of systems-level work to prevent or respond to staffing shortages included:

    - Working in partnership with both the long-term care provider industry, state agencies, including workforce commissions, to identify solutions to the workforce shortage;
    - Wage increases and/or expanded benefits; additional direct care worker training, including training on person-centered care; development of a public awareness campaign to elevate the profession;
    - Advocating for improved state laws or regulations to support adequate staffing;
    - Training facility staff on topics such as abuse prevention, person-centered care, and dementia care.

- Right to receive visitors - Resident rights to receive visitors, and informing guardians and powers of attorney of the limitations in their authority to determine who may visit residents.

- Facility closures and Ombudsman responses - Ombudsman interventions include supporting residents as they move to a new setting, frequently upon very short notice.

[111] In 2012 approximately 70,000 direct care staff positions were vacant in America's skilled nursing care centers. American Health Care Association 2012 Staffing Report.

Ombudsman programs often participate as part of a team that responds to facility closures. Teams also generally include case managers, licensing and survey and other community partners such as the Aging and Disability Resource Centers.

- Community responses to elder abuse - Service on statewide or local multi-disciplinary teams, Financial Abuse Specialist Teams (FAST) and similar community networks to address financial exploitation and other forms of abuse.

- Development of beneficiary support systems for Medicaid managed care recipients across states.

- Collaborating to address Healthcare Associated Infections (HAI).

    - The Office of the State Long-Term Care Ombudsman sought to raise awareness among local long-term care Ombudsman representatives about Catheter Associated Urinary Tract Infections (CAUTI) and healthcare-associated infections. The goal was to equip Ombudsman representatives with educational tools on these important topics so they can share the information with residents and family members. This project was accomplished in partnership with non-profit and governmental agencies including the Agency for Healthcare Research and Quality at the U.S. Department of Health and Human Services, the National Consumer Voice for Quality Long-Term Care, the Health Research and Educational Trust and the Health Services Advisory Group (the Medicare Quality Improvement Organization). The Office provided multiple training sessions for Ombudsman representatives: in various locations throughout the state. In total, close to 200 Ombudsman representatives received training to deliver the educational resources and messages to residents and their families to empower them to speak to staff about healthcare associated infections.

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 524 designated local Ombudsman entities.

In FY 2016, 1392 full-time equivalent staff and 7,331 volunteers -- all trained and designated to investigate and resolve complaints -- provided Ombudsman program services to residents. An additional 3,664 volunteers also served residents or assisted in program operations in ways other than complaint resolution.

Total FY 2016 funds expended from all sources nationwide were $101,911,106, an overall increase of 7.87 percent from the FY 2015 level. The federal government is the primary entity funding the Ombudsman Program, providing 53 percent of total funding in FY 2016. States provided 41percent of funds, and other non-federal sources funded the remaining six percent.

National Long-Term Care Ombudsman Resource Center Activities

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 2016, the National Consumer Voice for Quality Long-Term Care operated the NORC in coordination with the National Association of States United for Aging and Disabilities (NASUAD).

In FY 2016, NORC provided training and technical assistance to Ombudsman programs on such issues as:

- Implementation of ACL's final rule for State LTC Ombudsman programs;
- Volunteer management and technical assistance including risk management;
- Ombudsman services in managed long-term services and supports (LTSS); and
- Ombudsman services in home and community-based settings, including assisted living.

Additionally, the NORC provided quarterly orientation training for all new ombudsmen, and developed resource materials, the NORC website (www.ltcombudsman.org), and quarterly newsletters 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. Volunteers frequently provide residents with regular access to ombudsman services and provide cost-effective, community-based complaint resolution. Volunteers also engage in broader program initiatives as described by a state Ombudsman in the following state example.

- Over the course of the reporting period, there was increased scrutiny of the provision of memory care services in our state. This was largely due to the failure of a facility and the resulting publicity, which in turn led to legislative interest and involvement. In an effort to inform both our own office and external stakeholders, the Office of LTC Ombudsman opted to conduct a six month Memory Care Initiative. This process included the enhanced training, visit expectations, reporting and data collection efforts of roughly 25 volunteers who were already designated representatives of the Office. The initiative was divided into three two-month segments. The first segment focused on staffing and staff training in memory care units. The second focused on mealtime, and the third focused on activities. Ombudsman program "Memory Care Specialists" visited during weekends, evenings, all three scheduled meal times and times that activities were scheduled to occur. They also attended or completed the same training process that memory care staff attended. The data resulting from this initiative is currently being compiled and analyzed in order to determine barriers and recommendations for improvements.

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 accomplished without outside intervention, which can save on regulatory and legal costs while achieving the resident's desired outcome.

3. Growth in home and community-based services (HCBS) and Medicaid managed Long-Term Services and Supports (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 represent their interests and concerns and to ensure 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). 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 additional to complaints about care and dignity, Ombudsman programs report challenges with other consumer protections related to the disclosure of fees, and services provided in assisted living.

The following case example illustrates the effectiveness of Ombudsman program complaint resolution during this period:

- The Ombudsman program received a note from a resident that stated, "I tried to: Serve My Community, My Country, My Schools, My Family, My Church, My God. Now I need help. Who will Help Me? I am 97 years old." She had signed an agreement to pay an assisted living facility a set amount per month. However, the first bill received from the provider caused alarm and anger because the amount charged was nearly double the agreed amount. After reviewing the contract, the Ombudsman program confirmed that the assisted living facility did not disclose fees and charges prior to the resident signing the contract. Fees included a security deposit, "community fee" and additional in-home services. The Ombudsman program was able to convince the provider to refund about half the disputed amount and because of this advocacy, the provider agreed to change all of their contracts to disclose the service fees in one prominent location on the contract.

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 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 2016, 47 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 2016 was nearly $15 million.[112]

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 2016 $6,119,000)

[112] The Independent Sector places the value of the volunteer time at $24.14 per hour placing the value of 609,843 hours at $ 14,721,621. http://independentsector.org/resource/the-value-of-volunteer-time/. Accessed March 23, 2018.

The ADRC/No Wrong Door system[113] supports state efforts to help individuals and caregivers connect to long-term services and supports (LTSS) as well as develop more efficient and cost-effective LTSS access systems. 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 LTSS frequently find themselves confronted with a variety of organizations and requirements at a time when they are vulnerable or in crisis. This often results in people making decisions based on incomplete, and sometimes inaccurate, information about their options. Consequently, they may make 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 make it easier for people to access 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.

Another major development in the evolution of the ADRC/NWD system model occurred in 2008 when the Veterans Health Administration (VHA) – the nation's largest integrated health care system - recognized the value of the nationwide aging and disability network and decided to purchase an evidence-based self-directed HCBS program from the ADRC/NWD system instead of building a separate LTSS access system. VD-HCBS is currently offered at 62 VA Medical Centers across the country, and 1,993 Veterans at a nursing home level of care are self-directing their HCBS at home in the community.

In 2012, recognizing the accomplishments of both HHS and the VHA, 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, the "No Wrong Door" system framework was adopted across ACL, CMS and VHA 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.

In 2014, 25 states received one-year planning grants to develop plans to transform their multiple LTSS access programs and functions into a single statewide ADRC/NWD system for all populations and all payers. In 2015, five of the 25 state planning grantees received three-year awards to implement their planning grants and the eight states awarded three-year grants in 2012 received a one-year grant to continue their work in developing their ADRC/NWD system.

[113] Key Elements of a NWD System of Access to LTSS for All Populations and Payers (https://nwd.acl.gov/docs/NWD-National-Elements.pdf), Aging and Disability Resource Centers as defined in the Older Americans Act 2006

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 2015, CMS posted the "No Wrong Door System Reference Document for Medicaid Administrative Claiming 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 document that 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 residents 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. The NWD system must have formal linkages with key sources of referral including 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 in the LTSS system. Through the use of PCC, the NWD system empowers individuals to make informed choices about their LTSS options that are consistent with their personal goals. PCC also helps them 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. However, ACL has entered into a public/private partnership to develop and deliver the first national training program for Person Centered Thinking, Planning and Practice. In 2016, ACL pilot tested the training in 13 NWD System states across 1,200 learners including representation from AAAs, ADRCs and CILs. This blended learning design, of online and in-person courses, allows learners to obtain key knowledge, skills, and abilities of person centered counseling that can be applied across all ADRC/NWD activity. As a result of this focus on person-centeredness, ADRC/NWD Systems have accelerated change by streamlining resources that put the focus on the needs of the people and their families.

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 of 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 be more efficient, effective, 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 incorporated 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. 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 ADRC/NWD system investments include:

- Over 1,222 access points have been designated across 56 states, territories, and the District of Columbia. This includes: over 620 local Area Agencies on Aging and Aging and Disability Resource Centers, 331 Centers for Independent Living, 56 Statewide Independent Living Councils, 67 University Centers for Excellence in Developmental Disabilities Education, Research, and Service, and 242 Tribal Organizations. Each of these organizations and networks have formed proactive partnerships, with support from ACL and other federal partners, in order to coordinate and transform existing long-term service and support access functions for all populations and all payers.;
- Over 27 million ADRC contacts have been made to help streamline access to LTSS;
- 34 states/territories have ADRC/NWD System legislation or gubernatorial support in response to this vision;
- 42 states/territories with ADRC program sites conducted care transitions through formal intervention; and
- 303 sites in 43 states/territories reported serving clients with institutional transition from nursing facility (both Money Follows the Person (MFP) demonstration funding and non-MFP related) back into the community.

Aging Network Support Activities
(FY 2016: $9,961,000)

Aging Network Support Activities provide competitive grants and contracts to support ongoing activities of national significance that 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.

ACL awards competitive grants, cooperative agreements, and contracts for Aging Network Support Activities 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. External experts review project proposals, 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 (HCBS) system, the national aging services network must continually enhance program design and delivery in key priority areas. To address this critical need, ACL supports a cooperative agreement that is documenting and reporting on Area Agency on Aging and Tribal organizations' activities and expertise in the delivery of community-based services through surveys and the highlighting of best practices. In FY 2016, the project conducted data collection for the biannual National Survey of Area Agencies on Aging which was released in 2017. Additionally, in 2016, the project released a report examining the state of IT in AAAs across the country. The report,

"Information Technology in Area Agencies on Aging," identified issues and barriers AAAs face in addressing IT needs.

National Eldercare Locator

In FY 2016, ACL awarded a cooperative agreement in the amount of $1,577,451 to continue operation of the Eldercare Locator. The Eldercare Locator is the only national information and referral resource to provide support to older adults and family caregivers seeking assistance on a wide array of needs related to aging. Through its call center (800.677.1116), which operates five days a week from 9:00 a.m. to 8:00 p.m. Eastern Time, and website (www.eldercare.gov), the Locator helps consumers navigate the maze of federal, state and local resources to find the assistance they need. 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 308,637 callers and 559 website users in FY 2016.

National Alzheimer's Call Center

In FY 2016, ACL awarded a cooperative agreement in the amount of $933,571 to continue operation of the 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, 2017, the National Alzheimer's Call Center handled over 300,000 calls through its national and local partners, and its on-line message board community recorded over 5.7 million page views and over 260,000 active participants.

The National Alzheimer's Call Center is available to people in all states, 24 hours a day, seven 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. 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. In FY 2016, the top reasons callers contacted the Call Center included: assistance with handling challenging behaviors; tips for handling caregiver stress; caregivers seeking emotional support; and information on local care options.

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, including materials designed to identify and

prevent fraud and financial exploitation of older persons. In 2016, the Center presented more than 20 trainings and workshops to underserved older women and professionals who serve them, in partnership with organizations such as the American Bar Association Commission on Law and Aging, the National Council on Aging, and the American Association of Service Coordinators. The Center is funded through a 5-year cooperative agreement between ACL and the Women's Institute for a Secure Retirement (WISER). In FY 2016, ACL awarded WISER $231,526 (representing funds for year 3 of 5).

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. In FY 2016, five national non-profit organizations received a total of approximately $1,150,000 for the second year of five-year cooperative agreements to continue providing training and technical assistance to professionals serving African American, Hispanic, Asian, Native Hawaiian or other Pacific Islander descent, American Indian and Alaska Native elders, and older lesbian, gay, bisexual, and transgender (LGBT) adults, as well as to older consumers and their families.

Each NMAO project develops and 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. Select examples of technical assistance, training and related activities conducted by several of the grantees include:

- The National Indian Council on Aging (NICOA) developed and delivered *Money Smart for Older Adults* training to 47 Title VI program directors who will take the financial literacy training back to their elders. Additionally, NICOA has actively promoted intergenerational programming throughout Indian Country to emphasize and strengthen cultural bonds and traditions between generations;
- Services and Advocacy for GLBT Elders (SAGE) conducted virtual and in-person trainings reaching more than four thousand professionals nationwide to more competently and sensitively address the service and support needs of older LGBT individuals and their family caregivers and the development of over 60 new educational materials and resources;
- The Asociacion Nacional Pro Personas Mayores delivered a webinar to area agencies on aging on ensuring cultural diversity in service delivery. The webinar was targeted to more than 1800 aging network professionals; and
- The National Caucus on Black Aging (NCBA) collaborated with CMS' Office of Communications, Partner Relations, and the SHIP counselors to train existing and upcoming beneficiaries, their families and caregivers on how to maximize the benefits of Medicare, Medicaid, prescription drug and Medigap Plans. Over 4000 beneficiaries were trained this year.

In addition to the individual activities of each organization on behalf of the groups they represent, the NMAO Technical Assistance Centers conduct joint presentations at national, regional and local aging network events to educate and advocate for their specific member populations. These presentations reaffirm and expand knowledge about the provision and acceptance of services to racial and ethnic minority older persons, and allow for direct discussions and responses with the aging network. Professionals and consumers across the country report that they use the products to improve program design and implementation, refine service delivery approaches, and enable families to provide care to their elder loved ones for longer periods.

Advancing Person-Centered, Trauma-Informed Supportive Services for Holocaust Survivors

There are an estimated 100,000 to 130,000 survivors of the Holocaust living in the United States. The youngest survivors are in their early 70's; however, many are much older and nearly 25 percent of them live in poverty.[114] In FY 2015, Congress appropriated funds "to help provide supportive services for aging Holocaust survivors living in the United States." That same year, AoA issued a funding opportunity intended to build capacity for providing person-centered, trauma-informed (PCTI) supportive services for Holocaust survivors and to expand the use of these practices by the broader aging services network with any older adult population who has a history of trauma.

In FY 2016, AoA funded the second year of a five-year cooperative agreement in the amount of $2,500,000 in which the grantee is focusing on two priority areas: 1) advancing innovations in the delivery of PCTI supportive services to Holocaust survivors living in the U.S., while 2) improving the nation's overall capacity to delivery PCTI health and human services for older adults. AoA's grantee worked closely with their first cohort of 23 sub-grantees to develop and administer a range of programs and interventions in the areas of physical and mental health, accessibility and family caregiver support. In FY 2016, the first full year for which data was available from the grantee, nearly 8,500 Holocaust survivors and over 300 family caregivers received direct services while more than 2,000 professionals were trained in the use of PCTI supportive services. Preliminary outcome reporting suggests that the interventions being developed and deployed are leading to decreases in isolation, loneliness, depression and increases in feelings of safety, security and independence among survivors while the family caregivers who are served are reporting reductions in stress.

[114] Kover, E. (2014). Testimony before the U.S. Senate Special Committee on Aging, January 15, 2014.

Appendix

Formula Grant Funding Allocations by State, Territory and Tribal Organizations

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

THIS PAGE INTENTIONALLY LEFT BLANK

State	Supportive Services	Congregate Meals	Home Meals	Preventive Services	NFCSP	Total Title III
Alabama	$5,340,110	$6,658,222	$3,446,917	$312,046	$2,279,069	$18,036,364
Alaska	$1,725,835	$2,225,239	$1,123,369	$98,465	$747,367	$5,920,275
Arizona	$6,495,849	$9,360,431	$4,845,833	$379,579	$3,346,118	$24,427,810
Arkansas	$3,459,887	$4,163,564	$2,128,668	$198,170	$1,446,132	$11,396,421
California	$34,172,853	$45,269,354	$23,435,646	$1,996,859	$15,390,530	$120,265,242
Colorado	$4,106,001	$6,361,144	$3,293,123	$239,931	$2,005,562	$16,005,761
Connecticut	$4,352,620	$5,241,452	$2,571,861	$244,616	$1,751,433	$14,161,982
Delaware	$1,725,835	$2,225,239	$1,123,369	$98,465	$747,367	$5,920,275
District of Columbia	$1,725,835	$2,225,239	$1,123,369	$98,465	$747,367	$5,920,275
Florida	$24,965,219	$32,179,591	$16,659,162	$1,458,822	$12,175,645	$87,438,439
Georgia	$7,816,357	$11,497,595	$5,952,229	$456,742	$3,691,256	$29,414,179
Hawaii	$1,725,835	$2,225,239	$1,123,369	$98,465	$747,367	$5,920,275
Idaho	$1,725,835	$2,225,239	$1,123,369	$98,465	$747,367	$5,920,275
Illinois	$14,354,336	$17,286,541	$8,395,795	$787,832	$5,579,518	$46,404,022
Indiana	$6,846,052	$8,534,666	$4,418,340	$400,043	$2,913,777	$23,112,878
Iowa	$4,210,846	$5,081,501	$2,266,934	$217,527	$1,579,568	$13,356,376
Kansas	$3,392,598	$4,089,903	$1,937,158	$179,543	$1,313,589	$10,912,791
Kentucky	$4,685,598	$5,932,483	$3,071,207	$273,799	$1,989,094	$15,952,181
Louisiana	$4,739,584	$5,798,475	$3,001,832	$276,954	$1,925,518	$15,742,363
Maine	$1,725,835	$2,225,239	$1,134,584	$98,655	$747,367	$5,931,680
Maryland	$5,788,659	$7,497,316	$3,881,311	$338,256	$2,503,548	$20,009,090
Massachusetts	$8,112,702	$9,780,267	$4,720,820	$435,955	$3,168,410	$26,218,154
Michigan	$11,123,548	$13,877,388	$7,184,232	$649,995	$4,738,888	$37,574,051
Minnesota	$5,435,089	$7,101,910	$3,676,612	$317,595	$2,448,987	$18,980,193
Mississippi	$3,234,282	$3,891,114	$1,998,933	$183,809	$1,314,791	$10,622,929
Missouri	$7,034,843	$8,467,047	$4,309,755	$396,418	$2,922,404	$23,130,467
Montana	$1,725,835	$2,225,239	$1,123,369	$98,465	$747,367	$5,920,275
Nebraska	$2,267,990	$2,738,802	$1,264,078	$116,982	$862,082	$7,249,934
Nevada	$2,432,485	$3,627,769	$1,878,072	$142,140	$1,185,340	$9,265,806
New Hampshire	$1,725,835	$2,225,239	$1,123,369	$98,465	$747,367	$5,920,275
New Jersey	$10,142,462	$12,190,488	$6,078,857	$581,578	$4,121,143	$33,114,528
New Mexico	$2,041,926	$2,818,273	$1,459,002	$119,318	$952,990	$7,391,509
New York	$23,998,290	$28,963,855	$13,431,294	$1,289,327	$9,085,852	$76,768,618
North Carolina	$9,258,914	$13,132,620	$6,798,671	$541,037	$4,428,714	$34,159,956
North Dakota	$1,725,835	$2,225,239	$1,123,369	$98,465	$747,367	$5,920,275
Ohio	$13,654,570	$16,393,785	$8,391,051	$782,885	$5,613,283	$44,835,574
Oklahoma	$4,228,050	$5,080,736	$2,601,402	$241,108	$1,748,862	$13,900,158
Oregon	$4,085,823	$5,771,973	$2,988,113	$238,752	$1,912,618	$14,997,279
Pennsylvania	$17,670,027	$21,279,716	$9,807,313	$953,977	$6,797,425	$56,508,458
Rhode Island	$1,725,835	$2,225,239	$1,123,369	$98,465	$747,367	$5,920,275
South Carolina	$4,735,280	$6,833,310	$3,537,560	$276,703	$2,270,483	$17,653,336
South Dakota	$1,725,835	$2,225,239	$1,123,369	$98,465	$747,367	$5,920,275
Tennessee	$6,680,839	$8,857,622	$4,585,533	$390,389	$2,984,205	$23,498,588
Texas	$20,087,400	$28,490,410	$14,749,298	$1,173,791	$9,354,202	$73,855,101
Utah	$1,844,852	$2,699,962	$1,397,753	$107,803	$900,695	$6,951,065
Vermont	$1,725,835	$2,225,239	$1,123,369	$98,465	$747,367	$5,920,275
Virginia	$7,772,608	$10,410,071	$5,389,225	$454,186	$3,467,798	$27,493,888
Washington	$6,374,314	$9,122,298	$4,722,553	$372,478	$2,972,693	$23,564,336
West Virginia	$2,740,971	$3,305,947	$1,527,374	$143,428	$1,004,589	$8,722,309
Wisconsin	$6,315,353	$7,933,770	$4,107,261	$366,631	$2,746,803	$21,469,818
Wyoming	$1,725,835	$2,225,239	$1,123,369	$98,465	$747,367	$5,920,275
American Samoa	$466,771	$594,843	$140,421	$12,308	$93,421	$1,307,764
Guam	$862,917	$1,112,620	$561,685	$49,232	$373,684	$2,960,138
Northern Mariana	$215,730	$278,155	$140,421	$12,308	$93,421	$740,035
Puerto Rico	$4,323,579	$5,300,084	$2,743,818	$252,645	$1,929,864	$14,549,990
Virgin Islands	$862,917	$1,112,620	$561,685	$49,232	$373,684	$2,960,138
TOTAL	**$345,166,956**	**$445,047,800**	**$224,673,820**	**$19,692,964**	**$149,473,459**	**$1,184,054,999**

State	Ombudsman	Elder Abuse	Total Title VII
Alabama	$242,979	$76,215	$319,194
Alaska	$79,188	$23,759	$102,947
Arizona	$341,592	$86,912	$428,504
Arkansas	$150,054	$48,157	$198,211
California	$1,652,022	$471,073	$2,123,095
Colorado	$232,138	$59,061	$291,199
Connecticut	$181,295	$59,907	$241,202
Delaware	$79,188	$23,759	$102,947
District of Columbia	$79,188	$23,759	$102,947
Florida	$1,174,335	$344,252	$1,518,587
Georgia	$419,583	$106,751	$526,334
Hawaii	$79,188	$23,759	$102,947
Idaho	$79,188	$23,759	$102,947
Illinois	$591,835	$197,384	$789,219
Indiana	$311,457	$98,224	$409,681
Iowa	$159,800	$55,927	$215,727
Kansas	$136,554	$45,843	$182,397
Kentucky	$216,495	$66,595	$283,090
Louisiana	$211,605	$68,518	$280,123
Maine	$79,979	$23,759	$103,738
Maryland	$273,601	$78,087	$351,688
Massachusetts	$332,779	$109,606	$442,385
Michigan	$506,430	$160,862	$667,292
Minnesota	$259,171	$76,347	$335,518
Mississippi	$140,908	$45,198	$186,106
Missouri	$303,802	$97,643	$401,445
Montana	$79,188	$23,759	$102,947
Nebraska	$89,107	$29,770	$118,877
Nevada	$132,389	$33,682	$166,071
New Hampshire	$79,188	$23,759	$102,947
New Jersey	$428,510	$143,950	$572,460
New Mexico	$102,848	$26,393	$129,241
New York	$946,796	$318,066	$1,264,862
North Carolina	$479,251	$126,782	$606,033
North Dakota	$79,188	$23,759	$102,947
Ohio	$591,501	$197,185	$788,686
Oklahoma	$183,378	$60,208	$243,586
Oregon	$210,638	$56,795	$267,433
Pennsylvania	$691,335	$242,944	$934,279
Rhode Island	$79,188	$23,759	$102,947
South Carolina	$249,369	$63,445	$312,814
South Dakota	$79,188	$23,759	$102,947
Tennessee	$323,243	$91,810	$415,053
Texas	$1,039,705	$274,281	$1,313,986
Utah	$98,530	$25,068	$123,598
Vermont	$79,188	$23,759	$102,947
Virginia	$379,896	$102,820	$482,716
Washington	$332,901	$86,291	$419,192
West Virginia	$107,667	$36,736	$144,403
Wisconsin	$289,528	$90,309	$379,837
Wyoming	$79,188	$23,759	$102,947
American Samoa	$9,899	$2,970	$12,869
Guam	$39,594	$11,880	$51,474
Northern Mariana Islands	$9,899	$2,970	$12,869
Puerto Rico	$193,417	$54,217	$247,634
Virgin Islands	$39,594	$11,880	$51,474
TOTAL	**$15,837,665**	**$4,751,881**	**$20,589,546**

State/Territory	Nutrition Services Incentive Program
Alabama	$3,343,062
Alaska	$482,319
Arizona	$1,850,582
Arkansas	$2,547,704
California	$13,100,197
Colorado	$1,381,206
Connecticut	$1,538,793
Delaware	$500,490
District of Columbia	$795,581
Florida	$6,300,064
Georgia	$2,758,744
Hawaii	$409,291
Idaho	$737,226
Illinois	$6,134,768
Indiana	$1,467,482
Iowa	$1,758,186
Kansas	$2,036,030
Kentucky	$1,670,281
Louisiana	$3,472,592
Maine	$596,374
Maryland	$1,617,398
Massachusetts	$5,123,191
Michigan	$7,535,532
Minnesota	$1,813,004
Mississippi	$1,544,079
Missouri	$4,000,525
Montana	$952,920
Nebraska	$1,121,363
Nevada	$1,262,846
New Hampshire	$1,183,758
New Jersey	$3,697,546
New Mexico	$2,322,927
New York	$16,626,262
North Carolina	$3,271,673
North Dakota	$808,445
Ohio	$5,511,975
Oklahoma	$2,079,523
Oregon	$1,904,526
Pennsylvania	$6,322,179
Rhode Island	$399,849
South Carolina	$1,690,316
South Dakota	$877,494
Tennessee	$1,544,863
Texas	$11,187,189
Utah	$1,366,184
Vermont	$840,508
Virginia	$2,140,665
Washington	$2,263,353
West Virginia	$1,580,090
Wisconsin	$2,796,955
Wyoming	$860,761
American Samoa	$120,587
Guam	$406,456
Northern Mariana Islands	$53,085
Puerto Rico	$2,998,875
Virgin Islands	$184,443
TOTAL	**$152,892,317**

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
AK	01	Aleutian Pribilof Islands Association, Inc.	$97,340	$28,550	$8,031
AK	02	Association of Village Council Presidents	$140,520	-	$21,936
AK	03	Bristol Bay Native Association	$140,520	$49,980	$4,623
AK	04	Central Council Tlingit & Haida Indian Tribes of AK	$184,510	$57,120	$1,477
AK	06	Copper River Native Association	$85,720	$21,410	$2,028
AK	07	Hoonah Indian Association	$85,720	$21,410	$1,647
AK	08	Kodiak Area Native Association - Northern Region	$75,540	$14,270	$2,218
AK	09	Kodiak Area Native Association - Southern Region	$75,540	$14,270	$1,477
AK	10	Metlakatla Indian Community	$109,690	$35,700	$2,874
AK	11	Native Village of Barrow	$121,310	$42,850	$23,354
AK	12	Tanana Chiefs Conference for Kuskokwim subregion	$75,540	$14,270	$730
AK	13	Tanana Chiefs Conference for Lower Yukon Subregion	$75,540	$14,270	$3,175
AK	14	Tanana Chiefs Conference for Yukon Flats Subregion	$75,540	$14,270	$454
AK	15	Tanana Chiefs Conference for Yukon Koyukuk Subregion	$85,720	$21,410	$4,445
AK	16	Tanana Chiefs Conference for Yukon Tanana Subregion	$75,540	$14,270	$1,093
AK	17	Fairbanks Native Association	$140,520	$49,980	$2,597
AK	19	Maniilaq Association	$140,520	$49,980	$12,841
AK	20	Native Villiage of Unalakleet	$85,720	$21,410	$6,427
AK	21	Chugachmiut	$85,720	$21,410	$776
AK	22	Arctic Slope Native Association, Limited	$85,720	$21,410	$23,354
AK	23	Denakkanaaga, Inc.	$97,340	$28,550	-
AK	24	Klawock Cooperative Association	$75,540	$14,270	$834
AK	25	Kootznoowoo Inc.	$75,540	$14,270	$1,008
AK	26	Gwichyaa Zhee Gwich'in Tribal Government	$75,540	$14,270	$8,145
AK	27	Native Village of Point Hope	$75,540	$14,270	$1,861
AK	28	Seldovia Village Tribe	$75,540	-	$616
AK	30	Sitka Tribes of Alaska	$109,690	$35,700	$1,225
AK	32	Ketchikan Indian Community	$140,520	$49,980	$5,422
AK	35	Southcentral Foundation	$184,510	$57,120	$11,627
AK	36	Kenaitze Indian Tribe	$140,520	$49,980	$5,757
AK	37	Wrangell Cooperative Association	$97,340	$28,550	$1,808
AK	38	Native Village of Savoonga	$75,540	$14,270	$10,354
AK	39	Native Village of Gambell	$75,540	$14,270	$3,577
AK	40	Native Village of Eyak Traditional Council	$75,540	$14,270	$2,219
AK	41	Organized Village of Kake	$75,540	$14,270	$1,759
AK	42	Chickaloon Native Village	$97,340	-	$2,699
AK	44	Galena Village (aka Louden Village Council)	$75,540	$14,270	$11,723
AK	45	Asa'carsarmiut Tribal Council	$75,540	-	$3,475
AK	46	Orutsararmuit Native Council	$109,690	$35,700	$10,201
AK	47	Chilkoot Indian Association	$75,540	$14,270	$673
AK	48	Knik Tribal Council	$109,690	-	$1,528
AK	49	Yakutat Tlingit Tribe	$75,540	$14,270	$922
AK	50	Craig Tribal Association (Skagway Traditional Council)	$75,540	$14,270	$853
AK	Total	Total	$4,186,690	$985,060	$213,843
AL	01	Poarch Band of Creek Indians	$140,520	$49,980	$26,510
AL	Total	Total	$140,520	$49,980	$26,510
AZ	02	Colorado River Indian Tribes	$121,310	$42,850	$9,067
AZ	03	Gila River Indian Community	$184,510	$57,120	$20,774
AZ	04	Hopi Tribe	$140,520	$49,980	$12,818
AZ	05	Hualapai Elderly Services Program	$85,720	$21,410	$20,968
AZ	06	Navajo Nation	$184,510	$57,120	$35,947
AZ	07	Pascua Yaqui Tribe	$184,510	$57,120	$31,758
AZ	09	Salt River Pima-Maricopa Indian Community	$109,690	$35,700	$14,170
AZ	10	San Carlos Apache Tribe	$140,520	$49,980	$7,592
AZ	11	Tohono O'odham Nation	$184,510	$57,120	$2,432
AZ	12	White Mountain Apache Tribe	$140,520	$49,980	$21,636
AZ	13	Ak-Chin Indian Community	$75,540	$14,270	$9,475
AZ	14	Yavapai Apache Tribe	$85,720	-	$3,389
AZ	15	Havasupai Tribe	$75,540	$14,270	$6,604
AZ	16	Inter-Tribal Council of Arizona, Inc.	$85,720	$21,410	$1,769
AZ	17	Cocopah Indian Tribe	$75,540	-	$14,844

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
AZ	18	Quechan Indian Tribe	$85,720	$21,410	$12,632
AZ	Total	Total	$1,960,100	$549,740	$225,875
CA	01	Bishop Paiute Tribe	$97,340	$28,550	$15,950
CA	02	Blue Lake Rancheria	$75,540	$14,270	$23,103
CA	06	Karuk Tribe	$97,340	$28,550	$5,057
CA	07	Pit River Health Service, Inc.	$75,540	-	$3,541
CA	09	Riverside-San Bernardino Co. Indian Health-Morongo	$85,720	$21,410	$3,024
CA	10	Riverside-San Bernardino Co. Indian Health-Pechanga	$75,540	$14,270	$2,062
CA	11	Riverside-San Bernardino Co. Indian Health-Soboba/	$75,540	$14,270	$2,468
CA	12	Sonoma County Indian Health Project - Sonoma	$75,540	-	$8,556
CA	13	Southern Indian Health Council, Inc. - Area I	$75,540	$14,270	$13,040
CA	14	Southern Indian Health Council, Inc. - Area II	$75,540	$14,270	$13,134
CA	15	Toiyabe Indian Health Project, Inc. - Northern	$75,540	$14,270	$10,958
CA	16	Tule River Indian Health Center, Inc.	$85,720	$21,410	$20,253
CA	17	Coast Indian Community of Resighini Rancheria	$85,720	$21,410	$8,792
CA	18	United Indian Health Services for Smith River	$140,520	$49,980	$12,548
CA	20	Indian Senior Center, Inc.	$85,720	$21,410	$9,199
CA	21	Sonoma County Indian Health Project - Manchester	$75,540	-	$3,565
CA	25	Pala Band of Mission Indians	$85,720	-	$10,404
CA	26	Redding Rancheria	$140,520	$49,980	$5,128
CA	28	Toiyabe Indian Health Project, Inc. - Southern	$75,540	$14,270	$6,212
CA	29	Hoopa Valley Tribe / K'ima:w Medical Center	$85,720	-	$8,303
CA	30	Round Valley Indian Tribes	$85,720	-	$6,829
CA	31	Fort Mojave Indian Tribe	$85,720	$21,410	$7,856
CA	33	CA Indian Manpower Consortium, Inc. - Chico,	$75,540	$14,270	$3,935
CA	34	CA Indian Manpower Consortium, Inc. - Big Sandy,	$85,720	$21,410	$7,657
CA	35	CA Indian Manpower Consortium, Inc. - Berry Creek,	$85,720	$21,410	$4,966
CA	36	CA Indian Manpower Consortium, Inc. - Coyote Valley,	$85,720	$21,410	$6,493
CA	37	CA Indian Manpower Consortium, Inc. - Enterprise,	$97,340	$28,550	$8,375
CA	38	Santa Ynez Tribal Health Clinic	$75,540	-	$2,592
CA	39	CA Indian Manpower Consortium, Inc. - North Fork,	$75,540	$14,270	$3,813
CA	Total	Total	$2,498,000	$485,320	$237,813
CO	01	Southern Ute Indian Tribe	$85,720	$21,410	$4,503
CO	02	Ute Mountain Ute Tribe	$97,340	-	$15,818
CO	Total	Total	$183,060	$21,410	$20,321
CT	01	Mohegan Tribe of Indians of Connecticut	$85,720	-	$3,505
CT	Total	Total	$85,720	-	$3,505
HI	01	Alu Like, Inc.	$1,505,000	$57,120	$32,566
HI	Total	Total	$1,505,000	$57,120	$32,566
IA	01	Sac & Fox Tribe of the Mississippi in Iowa	$97,340	$28,550	$12,721
IA	Total	Total	$97,340	$28,550	$12,721
ID	01	Coeur d'Alene Tribe	$85,720	$21,410	$19,101
ID	02	Nez Perce Tribe	$97,340	$28,550	$21,958
ID	03	Shoshone-Bannock Tribes	$121,310	$42,850	$18,257
ID	Total	Total	$304,370	$92,810	$59,316
KS	01	Kickapoo Tribe in Kansas	$75,540	$14,270	$11,014
KS	02	Prairie Band of Potawatomi Nation	$97,340	$28,550	$27,859
KS	03	Iowa Tribe of Kansas and Nebraska	$75,540	$14,270	$6,354
KS	Total	Total	$248,420	$57,090	$45,227
LA	01	Institute for Indian Development, Inc.	$97,340	-	$16,723
LA	Total	Total	$97,340	-	$16,723
MA	01	Wampanoag Tribe of Gay Head (Aquinnah)	$85,720	$21,410	$916
MA	02	Mashpee Wampanoag Tribe	$97,340	$28,550	$1,496
MA	Total	Total	$183,060	$49,960	$2,412
ME	01	Pleasant Point Passamaquoddy	$97,340	$28,550	$26,280
ME	02	Penobscot Indian Nation	$85,720	-	$4,424
ME	04	Aroostook Band of Micmacs	$75,540	$14,270	$1,691
ME	Total	Total	$258,600	$42,820	$32,395
MI	01	Grand Traverse Band of Ottawa & Chippewa Indians	$97,340	$28,550	$13,437
MI	02	Inter-Tribal Council of Michigan, Inc.	$85,720	$21,410	$3,445
MI	03	Keweenaw Bay Indian Community	$85,720	$21,410	$22,087

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
MI	04	Sault Ste. Marie Tribe of Chippewa Indians	$184,510	-	$19,172
MI	05	Little Traverse Bay Bands of Odawa Indians	$85,720	$21,410	$3,952
MI	07	Bay Mills Indian Community	$85,720	$21,410	$5,633
MI	08	Pokagon Band of Potawatomi Indians	$85,720	-	$3,655
MI	09	Little River Band of Ottawa Indians	$109,690	-	$6,107
MI	10	Nottawaseppi Huron Band of the Potawatomi	$75,540	$14,270	$4,704
MI	Total	Total	$895,680	$128,460	$82,192
MN	01	Bois Forte Reservation Tribal Government	$85,720	$21,410	$11,146
MN	02	Fond du Lac Band of Lake Superior Chippewa	$140,520	$49,980	$42,493
MN	03	Leech Lake Band of Ojibwe	$184,510	$57,120	$20,363
MN	07	Red Lake Band of Chippewa Indians	$140,520	-	$61,649
MN	08	White Earth Reservation Tribal Council	$97,340	$28,550	$15,291
MN	09	Grand Portage Band of Lake Superior Chippewa	$75,540	-	$4,405
MN	10	Mille Lacs Band of Ojibwe	$85,720	$21,410	$22,815
MN	11	Lower Sioux Indian Community	$75,540	$14,270	$3,122
MN	Total	Total	$885,410	$192,740	$181,284
MO	99	Eastern Shawnee Tribe of Oklahoma	$109,690	$35,700	$20,821
MO	Total	Total	$109,690	$35,700	$20,821
MS	01	Mississippi Band of Choctaw Indians	$140,520	$49,980	$24,656
MS	Total	Total	$140,520	$49,980	$24,656
MT	01	Assiniboine and Sioux Tribes	$140,520	$49,980	$43,184
MT	02	Blackfeet Tribe - Eagle Shield Center	$140,520	$49,980	$26,040
MT	03	Chippewa Cree Tribe Senior Citizens Department	$121,310	$42,850	$48,484
MT	04	Confederated Salish and Kootenai Tribes	$140,520	$49,980	$7,863
MT	05	Fort Belknap Indian Community	$97,340	$28,550	$18,462
MT	06	Northern Cheyenne Elderly Program	$121,310	$42,850	$34,656
MT	07	Crow Tribal Elders Program	$140,520	$49,980	$49,863
MT	Total	Total	$902,040	$314,170	$228,552
NC	01	Eastern Band of Cherokee Indians	$184,510	$57,120	$34,462
NC	Total	Total	$184,510	$57,120	$34,462
ND	01	Spirit Lake Senior Services	$97,340	$28,550	$38,539
ND	02	Standing Rock Sioux Tribe	$140,520	$49,980	$106,476
ND	03	Three Affiliated Tribes	$140,520	$49,980	$29,719
ND	04	Trenton Indian Service Area	$97,340	$28,550	$1,099
ND	05	Turtle Mountain Band of Chippewa Indians	$140,520	$49,980	$18,640
ND	Total	Total	$616,240	$207,040	$194,473
NE	01	Omaha Tribe of Nebraska	$85,720	$5,860	$10,782
NE	02	Santee Sioux Nation	$75,540	-	$4,912
NE	03	Winnebago Tribe of Nebraska	$85,720	$21,410	$18,475
NE	Total	Total	$246,980	$27,270	$34,169
NM	01	Eight Northern Indian Pueblos Council (Picuris, etc.)	$140,520	$49,980	$29,388
NM	02	Eight N. Indian Pueblos Council (San Ildefonso, etc.)	$75,540	$14,270	$8,700
NM	03	Five Sandoval Indian Pueblos, Inc.	$97,340	$28,550	$12,174
NM	04	Jicarilla Apache Nation	$109,690	$35,700	$22,374
NM	05	Laguna Rainbow Corporation	$140,520	$49,980	$18,189
NM	06	Mescalero Apache Tribe	$109,690	-	$7,762
NM	07	Pueblo de Cochiti Elder Program	$85,720	$21,410	$7,544
NM	09	Pueblo of Isleta Elder Center	$140,520	$49,980	$26,053
NM	10	Pueblo of Jemez	$140,520	$49,980	$9,043
NM	11	Pueblo of San Felipe Elderly Services Program	$109,690	$35,700	$32,067
NM	12	Taos Pueblo Senior Citizens Program	$121,310	$42,850	$9,936
NM	13	Pueblo of Zuni	$140,520	$49,980	$20,722
NM	14	Ohkay Owingeh Senior Citizens Program	$140,520	$49,980	$14,045
NM	15	Santa Clara Pueblo	$140,520	$49,980	$19,044
NM	16	Santo Domingo Pueblo	$140,520	$49,980	$20,762
NM	17	Pueblo of Tesuque	$75,540	$14,270	$7,687
NM	18	Acoma Elderly & Assistance Program	$97,340	$28,550	$15,548
NM	Total	Total	$2,006,020	$621,140	$281,038
NV	01	Fallon Paiute Shoshone Tribes	$85,720	$21,410	$19,834
NV	02	Inter-Tribal Council of Nevada, Inc. (McDermitt, etc.)	$85,720	$21,410	$6,019
NV	03	Inter-Tribal Council of Nevada, Inc. (Duckwater, etc.)	$85,720	$21,410	$5,501

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
NV	04	Inter-Tribal Council of Nevada, Inc. (Ely, etc.)	$85,720	$21,410	$6,620
NV	05	Shoshone-Paiute Tribes	$85,720	$21,410	$8,629
NV	06	Walker River Paiute Tribe	$85,720	-	$10,507
NV	07	Washoe Tribe of Nevada and California	$85,720	$21,410	$31,190
NV	08	Yerington Paiute Tribe	$75,540	$14,270	$6,340
NV	09	Pyramid Lake Paiute Tribe	$85,720	$21,410	$6,609
NV	10	Elko Band Council	$85,720	$21,410	$8,799
NV	11	Reno-Sparks Indian Colony	$75,540	$14,270	$16,938
NV	Total	Total	$922,560	$199,820	$126,986
NY	01	St. Regis Mohawk Tribe	$184,510	$57,120	$10,633
NY	02	Seneca Nation of Indians	$140,520	$49,980	$18,861
NY	04	Oneida Indian Nation	$85,720	$21,410	$4,737
NY	05	Shinnecock Indian Nation	$85,720	$21,410	$5,171
NY	Total	Total	$496,470	$149,920	$39,402
OK	01	Apache Tribe of Oklahoma	$85,720	$21,410	$17,963
OK	02	Caddo Nation of Oklahoma	$85,720	$21,410	$739
OK	03	Cherokee Nation	$186,042	$58,547	$55,936
OK	04	Cheyenne and Arapaho Tribes	$184,510	$57,120	$7,486
OK	06	Choctaw Nation of Oklahoma	$184,510	$57,120	$43,963
OK	07	Citizen Potawatomi Nation	$184,510	$57,120	$11,766
OK	08	Comanche Nation	$140,520	$49,980	$19,768
OK	09	Delaware Nation	$78,960	$14,270	$8,421
OK	10	Iowa Tribe of Oklahoma	$140,520	$49,980	$8,709
OK	12	Kickapoo Tribe of Oklahoma	$100,000	$21,410	$11,023
OK	13	Kiowa Tribe of Oklahoma	$184,510	$57,120	$9,018
OK	14	Miami Tribe of Oklahoma	$140,520	$49,980	$38,207
OK	15	Muscogee (Creek) Nation/Elderly Nutrition Program	$184,510	$57,120	$149,649
OK	17	Otoe-Missouria Tribe of Indians	$97,340	$28,550	$14,367
OK	18	Ottawa Tribe of Oklahoma	$140,520	$49,980	$33,370
OK	19	Pawnee Nation of Oklahoma	$85,720	$21,410	$12,425
OK	20	Peoria Tribe of Indians of Oklahoma	$121,310	$42,850	$21,891
OK	21	Ponca Tribe of Oklahoma	$109,690	$35,700	$9,710
OK	22	Quapaw Tribe of Oklahoma	$140,520	$49,980	$26,174
OK	23	Sac and Fox Nation of Oklahoma	$140,520	$49,980	$18,456
OK	24	Seminole Nation of Oklahoma	$140,520	$49,980	$15,415
OK	25	Seneca-Cayuga Tribe of Oklahoma	$140,520	$49,980	$15,593
OK	26	Wichita and Affiliated Tribes	$140,520	$49,980	$8,469
OK	27	Wyandotte Nation	$140,520	$49,980	$20,350
OK	28	Absentee Shawnee Tribe of Oklahoma	$184,510	$57,120	$28,618
OK	29	Fort Sill Apache Tribe	$109,690	$35,700	$8,245
OK	31	United Keetoowah Band of Cherokee Indians	$184,510	$57,120	$21,319
OK	32	Chickasaw Nation	$184,510	$57,120	$130,473
OK	33	Kaw Nation	$85,720	-	$20,730
OK	34	Osage Nation of Oklahoma	$184,510	$57,120	$60,165
OK	35	Delaware Tribes of Indians	$140,520	$49,980	$8,557
OK	36	Alabama-Quassarte Tribal Town	$75,540	$14,270	$821
OK	Total	Total	$4,427,762	$1,379,387	$857,796
OR	01	Confederated Tribes of Siletz Indians of Oregon	$97,340	$28,550	$4,059
OR	02	Yellowhawk Tribal Health Center	$121,310	$42,850	$11,524
OR	03	Confederated Tribes of Warm Springs	$121,310	$42,850	$8,996
OR	04	Confederated Tribes of Grand Ronde	$109,690	$35,700	$13,004
OR	05	The Klamath Tribes	$140,520	$49,980	$4,391
OR	06	Confed. Tribes of Coos, Lower Umpqua &	$85,720	$21,410	$9,781
OR	07	Cow Creek Band of Umpqua Tribe of Indians	$75,540	$14,270	$467
OR	Total	Total	$751,430	$235,610	$52,222
RI	01	Narragansett Indian Tribe	$109,690	$35,700	$3,048
RI	Total	Total	$109,690	$35,700	$3,048
SC	01	Catawba Indian Nation Eldercare Program	$97,340	$28,550	$8,611
SC	Total	Total	$97,340	$28,550	$8,611
SD	01	Cheyenne River Elderly Nutrition Services	$140,520	$49,980	$7,879
SD	02	Crow Creek Sioux Tribe	$85,720	-	$14,382

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
SD	03	Lower Brule Sioux Tribe	$85,720	$21,410	$16,135
SD	04	Oglala Sioux Tribe	$184,510	$57,120	$31,497
SD	05	Rosebud Sioux Tribe	$184,510	$57,120	$30,833
SD	06	Sisseton Wahpeton Oyate	$140,520	$49,980	$31,212
SD	08	Yankton Sioux Tribe	$121,310	$42,850	$21,185
SD	Total	Total	$942,810	$278,460	$153,123
TX	01	Alabama-Coushatta Tribe of Texas	$85,720	$21,410	$6,693
TX	02	Kickapoo Traditional Tribe of Texas	$75,540	-	$84,756
TX	Total	Total	$161,260	$21,410	$91,449
UT	01	Ute Indian Tribe, Unitah & Ouray	$97,340	$28,550	$5,616
UT	Total	Total	$97,340	$28,550	$5,616
WA	01	Confederated Tribes of the Colville Reservation	$140,520	$49,980	$16,143
WA	02	Lower Elwha Klallam Tribe	$75,540	$14,270	$4,703
WA	03	Lummi Tribe	$109,690	$35,700	$21,107
WA	04	Makah Tribe Senior Program	$85,720	$21,410	$10,423
WA	05	Muckleshoot Indian Tribe	$140,520	$49,980	$44,133
WA	09	Puyallup Tribe of Indians	$140,520	-	$11,918
WA	10	Quinault Tribe of the Quinault Indian Reservation	$109,690	$35,700	$34,342
WA	13	Swinomish Indian Tribal Community	$85,720	$21,410	$3,381
WA	14	Spokane Tribes Senior Program	$97,340	$28,550	$12,527
WA	16	The Tulalip Tribes of Washington	$140,520	$49,980	$10,783
WA	17	Jamestown S'Klallam Tribe	$85,720	$21,410	$10,696
WA	19	Quileute Tribal Council	$75,540	$14,270	$4,877
WA	20	S. Puget Intertribal Planning Agency - Shoalwater Bay	$97,340	$28,550	$7,947
WA	21	Stillaguamish Tribe of Indians	$109,690	$35,700	$3,401
WA	22	Upper Skagit Indian Tribe	$75,540	$14,270	$2,704
WA	24	The Suquamish Tribe	$97,340	$28,550	$8,139
WA	25	Port Gamble S'Klallam Tribe	$85,720	$21,410	$12,991
WA	26	Samish Indian Nation	$97,340	$28,550	$4,095
WA	27	Cowlitz Indian Tribe	$184,510	$57,120	$4,051
WA	28	Skokomish Indian Tribe	$97,340	$28,550	$3,233
WA	29	Confederated Tribes of the Chehalis Reservation	$140,520	$49,980	$10,021
WA	30	Nooksack Indian Tribe	$97,340	$28,550	$8,767
WA	31	Yakama Indian Nation	$75,540	$14,270	$2,449
WA	32	Snoqualmie Tribe	$75,540	$14,270	$3,695
WA	33	S. Puget Intertribal Planning Agency - Nisqually	$140,520	$49,980	$3,414
WA	34	Squaxin Island Tribe	$85,720	$21,410	$4,404
WA	Total	Total	$2,747,040	$763,820	$264,344
WI	01	Bad River Elderly Nutrition Program	$85,720	$21,410	$13,704
WI	02	Forest County Potawatomi Community	$85,720	$21,410	$8,786
WI	03	Lac Courte Oreilles Band of Lake Superior Chippewa	$97,340	$28,550	$8,482
WI	04	Lac du Flambeau Band of Lake Superior Chippewa	$97,340	$28,550	$18,176
WI	05	Menominee Indian Tribe of Wisconsin	$140,520	$49,980	$4,164
WI	06	Oneida Tribe of Indians of Wisconsin	$140,520	$49,980	$8,632
WI	07	Red Cliff Band of Lake Superior Chippewa	$85,720	$21,410	$12,953
WI	08	St. Croix Chippewa Indians of Wisconsin	$85,720	$21,410	$7,274
WI	09	Stockbridge-Munsee Community	$85,720	$21,410	$1,548
WI	10	Ho-Chunk Nation	$109,690	$35,700	$11,008
WI	11	Sokaogon Chippewa Community	$75,540	-	$3,295
WI	Total	Total	$1,089,550	$299,810	$98,022
WY	01	Northern Arapaho Tribe	$97,340	-	$10,888
WY	03	Eastern Shoshone Tribe	$97,340	-	$11,904
WY	Total	Total	$194,680	-	$22,792
Total	**Total**	**Total**	**$29,773,242**	**$7,474,517**	**$3,734,285**