DEPARTMENT of HEALTH and HUMAN SERVICES

FY 2013 Report to Congress: Older Americans Act

Prepared by
ADMINISTRATION ON AGING

ADMINISTRATION FOR COMMUNITY LIVING

ACL
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FROM THE ADMINISTRATION FOR COMMUNITY LIVING

The Administration for Community Living (ACL) is the single agency charged to work with 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 brings together the efforts and achievements of the Administration on Aging (AoA), the Administration on Intellectual and Developmental Disabilities (AIDD), and the HHS Office on Disability to serve as the federal agency responsible for increasing access to community supports, while focusing attention and resources on the unique needs of older Americans and people with disabilities across the lifespan.

As part of this important mission, I am pleased to present AoA's Report to Congress for Fiscal Year (FY) 2013. 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 aging services network is comprised of 56 state and territorial units on aging (SUA), 618 area agencies on aging (AAA), 264 Indian tribal and Native Hawaiian organizations, nearly 20,000 direct service providers, and hundreds of thousands of volunteers. AoA's core programs, authorized under the Older Americans Act (OAA), help seniors remain at home for as long as possible and advocate for quality of care and promotion of rights for individuals who live in long-term care facilities (nursing homes, board and care, assisted living and similar settings). These services complement efforts of the nation's public health network as well as existing medical and health care systems, help prevent hospital readmissions and support some of life's most basic functions, such as bathing or preparing food. AoA and the national aging services network annually serve nearly 11.5 million Americans aged 60 and over and their caregivers.[1]

The population served through OAA programs and activities will grow at unprecedented rates over the next 20 years. An estimated 62.8 million older adults age 60 and over resided in the U.S. in 2013, comprising almost 20 percent of the population.[2] By 2020, this age group is estimated to increase by 23 percent and reach 77.6 million seniors.[3] During this period, the

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[1] AoA FY 2013 State Program Report.

[2] 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, 2013. Release Date: June 2014. (https://www.census.gov/popest/data/national/asrh/2013/index.html). Accessed 27 August 2014.

[3] Ibid and U.S. Census Bureau, "2014 National Population Projections," Table 1. Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: 2014 to 2060. Released December 2014, http://www.census.gov/population/projections/data/national/2014/downloadablefiles.html. Accessed 08 January 2015.

number of older adults (age 65 and older) with severe disabilities – defined as 3 or more limitations in activities in daily living - who are at greatest risk of nursing home admission will increase substantially. If current trends continue this population is projected to increase by 26 percent by the year 2020.[4] Ten years later, in 2030, when the last of the baby boomers turn age 65, twenty-one percent of the population, or one in five Americans will be age 65 or over and the number with severe disability will have increased by over 65 percent since 2013.[5] As these baby boomers age, the ranks of the oldest old (age 85+) who are frequently the most frail will continue to swell.

Maintaining support for home and community-based services for assisting this growing population is important. Reports indicate that making reductions in these services could lead to higher government expenditures in areas such as Medicaid.[6] Several state efforts to measure the impact of home and community-based programs on Medicare and Medicaid funding have shown signs of potential for savings.[7] AoA's services assist people to remain independent and in their communities, thereby having the potential to prevent or delay institutionalization. If even a small percentage of service recipients are able to delay institutionalization, it would have a significant impact on Medicaid expenditures.

The goal of the OAA, and the mission of AoA, is to ensure that older Americans have the opportunity to live independently, with dignity, in their homes and communities for as long as they are able to do so. We look forward to working with the Congress to strengthen these critical programs and further build the capacity of the national aging services network to continue to deliver high-quality services that improve the health, safety, and well-being of older Americans.

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[4] Ibid and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2012 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/2012CNP.html. Accessed 23 October, 2014.

[5] Ibid.

[6] Muramatsu, N., H. et al 2007. "Risk of Nursing Home Admission among Older Americans: Does States'Spending on Home- and Community-Based Services Matter?" Journals of Gerontology. Series B, Psychological Sciences and Social Sciences 62 (3): S169–78.
Kaye, H. S., M. P. LaPlante, and C. Harrington. 2009. "Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?" Health Affairs 28 (1): 262–72.

[7] Thomas, K. S. and Mor, V. 2013. "The Relationship between Older Americans Act Title III State Expenditures and Prevalence of Low-Care Nursing Home Residents." Health Services Research 48 (3): 1475-6773.
Shapiro, A. and Loh, C-P. August 2010. "Advanced Performance outcome Measures Project (POMP): Estimates of Medicaid and General Revenue Cost-Avoidance from HCBS Utilization: Final Report (Contract #XQ867)". Tallahassee, FL: Florida Department of Elder Affairs.
https://www.gpra.net/ppt/POMP2010_UNF_Final_Report.pdf
Chapin, R. et al. 2003. "Examination of the Use of Medicare Home Health Services and Informal Caregiving and Their Relationship to Successful Community Tenure and Appendices". Lawrence, KS: University of Kansas School of Social Welfare Office of Aging and Long Term Care. http://crado.ku.edu/publications/reports

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EXECUTIVE SUMMARY

AoA's core programs, authorized under the Older Americans Act (OAA), help older adults remain healthy and independent. 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 or preparing meals. These programs also support family caregivers, address issues of exploitation, neglect and abuse of older adults, and adapt services to the needs of Native Americans. The most recent data available show that AoA and its national network rendered direct services to 11.5 million elderly individuals age 60 and over (nearly 20 percent of the country's elderly population) and their caregivers, including nearly three million clients who received intensive in-home services.[8] Critical supports, such as respite care and a peer support network, were provided to over one million caregivers.[9]

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

Overview of Performance

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

An analysis of AoA's performance trends shows that through FY 2013, most outcome indicators have steadily improved and demonstrate that services are continuing to be effective in helping older persons remain at home. Some key successes are indicative of the potential of AoA and the national aging services network to meet the challenges posed by the growth of the vulnerable older adult population, the changing care preferences of aging baby boomers, the fiscal

[8] AoA's FY 2013 State Program Report.
[9] Ibid.

difficulties faced by federal and state budgets, and the expanding needs of both older Americans and their caregivers. Below are some examples of these successes:

- **OAA programs help older Americans with functional limitations remain independent and in the community:** Older adults who have three or more impairments in Activities of Daily Living (ADL) are at a high risk for nursing home placement. Measures of the national aging services network's success at serving this vulnerable population is a proxy for success at nursing home delay and diversion. In FY 2005, one-third of home-delivered nutrition clients lived with three or more ADL impairments and by FY 2013 the proportion grew to 43.5% percent, a 30 percent increase.[10] Another approach to measuring AoA's success is the nursing home predictor score. The components of this composite score are predictive of nursing home admissions based on scientific literature and AoA's Performance Outcomes Measurement Project (POMP) which developed and tested performance measures. The composite score is a weighted average; the components include such items as the percent of clients who are transportation disadvantaged and the percent of congregate meal clients who live alone. As the score increases, the prevalence of nursing home predictors in the OAA service population increases. In 2003, the nursing home predictor score was 46.57. Data indicate it has increased to 64.2 in FY 2013, a 38 percent improvement over the FY 2003 baseline.

- **OAA programs are efficient:** The national aging services network is providing high quality services to the neediest elders and doing so in a very prudent and cost-effective manner. Over the past decade, the number of clients served per million dollars of OAA Title III funding has increased significantly. During FY 2013, the national aging services network served 9,753 people per million dollars of OAA Title III funding. Since this measure's introduction in FY 2005, AoA and the national aging services network have met or exceeded efficiency targets.

- **OAA programs build system capacity:** OAA programs stay true to their original intent to "encourage and assist state agencies and area agencies on aging to concentrate resources in order to develop greater capacity and foster the development and implementation of comprehensive and coordinated systems." (OAA Section 301). This is evident in the leveraging of OAA funds with state/local or other funds (between two to three dollars in other funds for every dollar of OAA funds expended), as well as in the expansion of projects such as the Aging and Disability Resource Center (ADRC) initiative, over 500 ADRC sites have been established across 50 states, two territories, and Washington, DC.

- **OAA clients report that services contribute in an essential way to maintaining their independence and they express a high level of satisfaction with these services.** In 2013, 93 percent of home-delivered nutrition clients reported that the services help them to continue living at home. And, case management service clients report the service has enabled them to better care for themselves.[11] Clients across all services rate the quality of these services extremely high and are satisfied with OAA services. For example, 97 percent of transportation clients rated services good to excellent and 95 percent of caregivers rated services good to excellent[12]. To help ensure the continuation of these trends in core

[10] AoA's FY 2013 State Program Report.
[11] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov,
[12] Ibid.

programs, AoA uses its discretionary funding to test innovative service delivery models for state and local program entities that show promise for generating measurable improvements in program activities. For example, AoA has worked with the Centers for Medicare & Medicaid Services (CMS) and the Department of Veterans Affairs to better integrate funding for long-term care service delivery, eliminate duplication and improve access to services through Aging and Disability Resource Centers.

The tables on the next page provide a summary of the persons served during FY 2013 through the OAA's programs. Additionally, a listing of grant funding allocations by state, territory and tribal organization can be viewed in the Appendix.

FY 2013 National Program Services Summary Report

	FY 2013
Total Clients	11,484,509
Total Registered Clients	2,755,948
% Minority Clients	28.26%
% Rural Clients	35.93%
% Clients Below Poverty	31.6%
# Senior Centers	10,284 (5,546 receive OAA funding)

Service	Persons Served	Units of Service[13]	Title III Expenditure	Total Expenditure
Personal Care	107,479	15,317,426	$48,658,391	$277,041,663
Homemaker	149,670	13,602,359	$27,894,976	$268,016,553
Chore	34,176	926,656	$4,522,539	$19,024,932
Home Delivered	830,187	135,954,081	$250,155,904	$799,336,748
Adult Day Care	19,025	7,950,947	$13,802,761	$87,609,746
Case Mgt.	437,840	4,017,890	$25,801,820	$251,783,529
Assisted Trans.	31,989	1,147,587	$4,092,150	$15,896,869
Congregate	1,575,207	83,411,432	$272,854,675	$632,939,643
Nutrition Counseling	24,275	42,910	$1,305,999	$2,836,310
Transportation		24,206,274	$68,650,739	$199,969,768
Legal Assistance		878,374	$26,089,078	$48,436,875
Nutr. Education		3,099,943	$3,794,382	$7,077,408
I&A		12,610,209	$57,475,350	$166,006,427
Outreach		1,527,709	$10,099,347	$20352969
Health Promotion and Disease Prevention	1,534,983		$19,324,619	$42,660,275
Self-Directed Care	938			
Other			$75,507,224	$655,801,124

[13] 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 Title III-E

Service	Caregivers Served	Service Units[14]	Title III Expenditure	Total Expenditure
Counseling, Support Groups, Training	125,948	470,045	$19,763,801	$28,761,250
Respite	63,080	5,852,890	$58,080,517	$99,334,047
Supplemental Services	36,798	742,894	$11,214,513	$15,840,804
Access Assistance	810,592	1,148,615	$30,328,922	$42,749,384
Self-Directed	2,012		$1,126,757	$1,670,505
Information Services	13,403,326	787,027	$12,129,954	$16,748,187
Unduplicated Caregivers Provided Service or Access	203,392			

[14] 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

AoA's Health and Independence Programs provide a foundation of supports that assist older individuals to remain healthy and independent in their homes and communities, avoiding more expensive nursing home care. For example, 61 percent of congregate and 93 percent of home-delivered meal recipients reported that the meals enabled them to continue living in their own homes and 52 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.[15]

Between 2013 and 2020, the number of Americans age 60 and older will increase by over 14.8 million older adults, to reach 77.6 million seniors.[16] During this period, the number of seniors age 65 and over with severe disabilities (defined as 3 or more limitations in activities of daily living) who are at greatest risk of nursing home admission and Medicaid eligibility (through the "spend down" provisions) will increase by more than 26 percent.[17] AoA's Health and Independence programs help seniors in need maintain their health and independence.

In concert with other OAA programs, these services assist nearly 11.5 million elderly individuals and caregivers. AoA's services are especially critical for the nearly three million seniors who receive intensive in-home services, over half a million of whom meet the disability criteria for nursing home admission. These services help to keep these individuals from joining the 1.9 million seniors who live for extended periods of time in nursing homes.[18]

Home and Community-Based Supportive Services

(Title III-B of OAA; FY 2013: $347,724,000)

The Home and Community-Based Supportive Services (HCBSS) program, established in 1973, provides grants to states and territories based on their share of the population age 60 and over to fund a broad array of services. AoA's programs, including the HCBSS program, serve seniors holistically; while each service is valuable in and of itself, it is often the combination of supports,

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[15] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.

[16] 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, 2013. Release Date: June 2014. (https://www.census.gov/popest/data/national/asrh/2013/index.html). Accessed 27 August 2014 and U.S. Census Bureau, "2014 National Population Projections," Table 1. Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: 2014 to 2060. Released December 2014, http://www.census.gov/population/projections/data/national/2014/downloadablefiles.html. Accessed 08 January 2015. .

[17] Ibid and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2012 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/2012CNP.html. Accessed 23 October, 2014.

[18] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2012 Medicare Current Beneficiary Survey. [Table 1.2 Demographic and Socioeconomic Characteristics of Medicare Beneficiaries, by Age and by Gender and Age, 2012]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html. Accessed 23 October, 2014..

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.[19]

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

While age alone does not determine the need for these long-term care supports, statistics show that both disability rates and the use of long-term supports increase with advancing age. Among those aged 85 and older, 58 percent are unable to perform critical activities of daily living and require long-term support.[20] Data also show that over 90 percent of seniors have at least one chronic condition and 75 percent have at least two.[21] Providing a variety of supportive services that meet the diverse needs of these older individuals is crucial to enabling them to remain healthy and independent in their homes and communities, and therefore to avoiding unnecessary, expensive nursing home care.

Services provided by the HCBSS program in FY 2013 include:[22]

- *Transportation Services* provided over 24.2 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 30 million hours of assistance to seniors unable to perform activities of daily living (such as eating, dressing, or bathing) or instrumental activities of daily living (such as shopping or light housework).

- *Adult Day Care/Day Health* provided nearly eight million hours of care for dependent adults in a supervised, protective group setting during some portion of a twenty-four hour day.

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

Continuing AoA's commitment to provide services to those in most need, 47 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.[23] Many of these individuals

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[19] 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

[20] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2012 Medicare Current Beneficiary Survey. [data tables 2.5a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html. Accessed 23 October, 2014.

[21] Ibid.

[22] AoA's FY 2013 State Program Report.

[23] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov, select AGID.

cannot safely drive a car, as 75 percent of transportation riders have at least one of the following chronic conditions that could impair their ability to navigate safely:[24]

- 67 percent of riders had a doctor tell them they had vision problems (including glaucoma, macular degeneration or cataracts);
- 7 percent have Alzheimer's 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 12 percent report taking 10 to 20 medications daily.[25] Data from AoA's national surveys of elderly clients show that HCBSS services are providing these seniors with the assistance and information they report helps them to remain at home.[26] For example, 81 percent of clients receiving case management reported that as a result of the services arranged by the case manager they were better able to care for themselves.[27] In addition, a study published in the Journal of Aging and Health shows that the services provided by the HCBSS program, what the article calls "personal care services," are the critical services that enable frail seniors to remain in their homes and out of nursing home care.[28]

Nationally, almost 25 percent of individuals 60 and older live alone.[29] AoA programs serve a disproportionate number of people who live alone compared to the general population. For example, 67.5 percent of transportation clients live alone[30]. Living alone is a key predictor of nursing home admission, and HCBSS services are critical for enabling them to remain at home, especially for those who do not have an informal caregiver to assist with their care. Recent research has also shown that childless seniors who live in a state with higher home and community-based service expenditures had significantly lower risk of nursing home admissions.[31]

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 contribute funding. States typically have leveraged resources of $2 or $3 per every OAA dollar, significantly exceeding the programs' match requirements.

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[24] Ibid

[25] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov,

[26] Ibid.

[27] Ibid.

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

[29] 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 (2012), accessed January, 08, 2015.

[30] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov

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

Nutrition Services

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

- Congregate Nutrition Services (Title III-C1; FY 2013: $416,104,000): Provides funding for the provision of nutritious meals and related services in a variety of congregate settings, which helps to keep older Americans healthy and prevents the need for more costly medical interventions. Established in 1972, the program 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 2013: $205,489,000): Provides funding for nutritious meals, the delivery of meals and in most cases an informal 'safety check' for frail or isolated seniors who are homebound. Established in 1978, home delivered meals are often the first in home service that an older adult receives and serve as a primary access point for other home and community based services.

- Nutrition Services Incentive Program (Title III-A; FY 2013: $146,718,000): 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 the prior federal fiscal year. States and tribes have the option to purchase commodities directly from the U.S. Department of Agriculture (USDA) with any portion of their award if they determine that doing so will enable them to better meet the needs of seniors.

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.

Nutrition Services help 2.4 million older adults receive the meals they need to stay healthy and decrease their risk of disability.[32] 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 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

[32] AoA's FY 2013 State Program Report.

costs.[33] Many of the most common chronic conditions such as hypertension, heart disease, diabetes, and osteoporosis are related to nutrition as a primary prevention, risk reduction, or treatment modality. Medicare beneficiaries with multiple chronic conditions are the heaviest users of health care services. For example, two-thirds of beneficiaries with two or more chronic conditions account for 93 percent of Medicare spending, and one-third of beneficiaries with 4 or more chronic conditions account for almost three-fourths of Medicare spending.[34]

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 conditions.[35] Data from AoA's national survey of older adult participants indicate that 95% of home-delivered and congregate participants have multiple chronic conditions and large numbers of chronic conditions are common with 45 percent of congregate and 63 percent of home-delivered participants have six or more illnesses or conditions.[36] Over 30 percent of congregate and 51 percent of home-delivered participants take over 6 medications per day and some take more than 20 medications.[37] 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.

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 31 percent of the U.S. population age 60 and over, more than half (51 percent) of congregate and almost two-thirds (66 percent) of home-delivered meal participants are aged 75 years or older.[38]

Approximately 11 percent of congregate and over 40 percent of home-delivered participants indicate that they have three or more impairments in instrumental activities of daily living (IADLs)[39]. The data also indicate that about 16 percent of congregate and 51 percent of home-delivered participants need help in getting outside the house, thus limiting their ability to shop for food themselves.[40] The number of home-delivered meal recipients with severe disabilities (three or more Activities of Daily Living) totaled nearly 330,000 in FY 2013. This level of

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[33] Lochner KA, Cox CS. Prevalence of Multiple Chronic Conditions among Medicare Beneficiaries, United States, 2010. Prev Chronic Dis 2013; 10:120137. DOI http://dix.doi.org/10.5888/pcd10.12037.

[34] Ibid.

[35] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2012 Medicare Current Beneficiary Survey. [Table 2.6a Self-Reported Health Conditions and Risk Factors of Non-institutionalized Medicare Beneficiaries, by Living Arrangement and Age, 2012]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html. Accessed 23 October, 2014.

[36] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.

[37] Ibid.

[38] 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, 2013. Release Date: June 2014. (https://www.census.gov/popest/data/national/asrh/2013/index.html). Accessed 27 August 2014 and AoA's 2013 State Program Report

[39] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.

[40] Ibid.

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, almost 25 percent of individuals age 60 years and older live alone.[41] However, due to OAA's requirement to target services to older adults most in need to help them maintain their health and independence, 39 percent of congregate and 51 percent of home-delivered participants live alone.[42] Living alone is a risk factor for social isolation, poorer health and nursing home placement.

Data from AoA's national surveys of older adult participants show that Nutrition Services are effectively helping older adults improve their nutritional intake and remain at home. For example, data indicate that 77 percent of congregate and 84 percent of home-delivered meal participants say they eat healthier meals due to the programs, and 61 percent of congregate and 93 percent of home-delivered meal recipients say that the meals enable them to continue living in their homes.[43] The extra support provided by these programs can help older adults avoid more costly institutional care. 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" seniors in nursing homes after adjusting for several other factors.[44] For every $25 per year per older adult that states spend on home-delivered meals, the state reduces their percentage of low-care nursing home residents by one percent when compared to the national average.[45]

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

- *Home-Delivered Nutrition Services* provided 136 million meals to over 830,000 individuals in FY 2013.[47]
- *Congregate Nutrition Services* provided over 83.4 million meals to 1.6 million seniors in a variety of community settings in FY 2013.[48]

Consistent with the OAA's requirement to target services to those most in need to help them maintain their health and independence, approximately 66 percent of home-delivered meal recipients have annual incomes at or below $20,000.[49] Meals are especially critical for the 62

[41] Administration for Community Living, http://www.agid.acl.gov/DataGlance/. Data-at-a-Glance: American Community Survey (ACS) Public Use Microdata Sample (PUMS) 1-Year Files (2012), accessed January, 08, 2015.
[42] AoA's FY 2013 State Program Report.
[43] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov..
[44] Thomas, K & Moe, V. The relationship between Older Americans Act Title III State Expenditures & Prevalence of Low-Care Nursing Home Residents. Health Services Research. 12.3.12. http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12015/abstract
[45] Ibid.
[46] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.
[47] AoA's FY 2013 State Program Report.
[48] Ibid.
[49] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.

percent of home-delivered and 58 percent of congregate recipients who report these meals provide half or more of their food intake for the day.[50]

Federal support for Nutrition Services is not expected to serve every senior. These programs have strong partnerships with state and local governments, philanthropic organizations and private donations that contribute funding. In FY 2013, state and local funding comprised approximately 69 percent of all the funding for home-delivered meals and 57 percent for congregate meals.[51] Though all programs funded through the OAA rely on state and local funding in some part, funding for congregate and home-delivered meals leverages more state and local financial support than many other OAA services.

State and Territory Flexibility

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

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

In FY 2013, states transferred nearly $74 million from congregate nutrition to home and community-based services and home-delivered meals, as illustrated in the table below.

Table 1. FY 2013 Transfer of Federal funds within Title III of the OAA

	Part B – Home and Community-Based Supportive Services	**Part C1 – Congregate Nutrition**	**Part C2 – Home-Delivered Meals**
Initial Allotment	$345,665,953	$413,640,501	$204,272,497
Final Allotment after Transfers	$381,403,215	$339,871,695	$242,304,041
Net Transfer	+$35,737,262	(-$73,768,806)	+$38,031,544
Net Percent Change	10.34	(-17.83)	18.62

[50] Ibid.

Preventive Health Services

(Title III-D of OAA; FY 2013: $19,849,000)

Preventive Health Services, established in 1987, provide formula grants to states and territories based on their share of the population aged 60 and over to support evidence-based disease prevention and health promotion programs. Older Americans are disproportionately affected by chronic disease. Evidence-based programs can mitigate the negative impact of chronic diseases and related injuries, such as falls. Preventive Health Services provide states and territories with the flexibility to allocate resources among the preventive health programs of their choice to best meet local needs. Priority has been given to providing services to those elders living in medically underserved areas of the state or who have the greatest economic need.

Due in large part to advances in public health and medical care, Americans are leading longer and more active lives. Average life expectancy has increased from less than 50 years at the turn of the 20th century to over 78 years today.[52] On average an American turning age 65 in 2010 can expect to live an additional 19.2 years.[53] The population of older Americans, particularly the population age 85 and over, which is growing very rapidly, totaled six million in 2013[54] and is projected to reach 9.1 million by the year 2030.[55] One consequence of this increased longevity is the higher incidence of chronic diseases such as obesity, arthritis, diabetes, osteoporosis, and depression, as well as the greater probability of injury from a fall, which quickly limits physical activity.

Evidence-based programs empower older adults to take control of their health by maintaining a healthy lifestyle through increased self-efficacy and self-management. Evidence-based initiatives provide the greatest impact given available funding. Before the Preventive Health Services evidence-based requirement was implemented in 2012, states had already begun to shift their Preventive Health Services funding towards evidence-based approaches to achieve better results for their limited funding. Since 2012, all Preventive Health Services funding has been used for evidence-based approaches. Since evidence-based programs have demonstrated their effectiveness, AoA expects that states will be able to maximize the impact of these limited dollars. At the same time, if states wish to continue funding other health services, such as health screenings, they still

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[52] National Center for Health Statistics. Health, United States, 2013: With Special Feature on Prescription Drugs. Hyattsville, MD. 2014. [Web update: Table 18 Life expectancy at birth, at age 65, and at age 75, by sex, race, and Hispanic origin: United States, selected years 1900–2011] *Updated data when available, Excel, PDF, and more data years:* *http://www.cdc.gov/nchs/hus/contents2013.htm#018*. Accessed 12 January 2015.

[53] Ibid.

[54] 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, 2013. Released June 2014, accessed 27 August 2014.

[55] U.S. Census Bureau, "2014 National Population Projections," Table 1. Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: 2014 to 2060. Released December 2014, http://www.census.gov/population/projections/data/national/2014/downloadablefiles.html. Accessed 08 January 2015.

have the flexibility to continue to use funds provided under the HCBS program for this purpose.

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

- Physical activity programs: *EnhanceFitness* is an example of a multi-component group exercise program designed for community-based organizations and intended to promote physical activity among older adults. Strength training using soft wrist and ankle weights; cardiovascular workout using dancing, aerobics, or walking; and balance and posture exercises are used to increase the physical health of older adults. This program was developed by the Healthy Aging Research Network of the Prevention Research Centers Program of the Centers for Disease Control and Prevention.

- Falls prevention: Falls prevention programs help participants achieve improved strength, balance, and mobility; provide education on how to avoid falls and reduce fall risk factors; involve medication reviews and modifications; provide referrals for medical care management for fall risk factors; and provide home assessments of ways to reduce environmental hazards. In the United States, more than one-third of adults age 65 and over fall each year. Of those who fall, 20 to 30 percent will experience serious injuries, such as head trauma, broken bones, or hip fractures. These injuries may limit their ability to get around or live independently. Many people limit their activity after a fall, which may reduce strength, physical fitness, and mobility.

- *Medication management:* Medication management programs focus on reviewing the multitude of medications that older adults are prescribed, focusing especially on high-risk medications. Medication management programs have been shown to reduce unnecessary duplication of prescriptions and cardiovascular problems.[56] These programs have also been shown to improve medication usage rates and decrease medication errors among older adults.[57]

- *Depression Care Management:* Depression is not a normal part of aging, yet it is a prevalent and disabling condition among older adults. A recent national study found that 11.1 percent of Medicare beneficiaries age 65 and older living in the community reported feeling "sad or depressed much of the time over the previous

[56] Meredith, S., Feldman, P., Frey, D., Giammarco, L., Hall, K., Arnold, K., … Ray, W. A. (2002). Improving medication use in newly admitted home healthcare patients: A randomized controlled trial. Journal of the American Geriatrics Society, 50(9), 1484–1491. PubMed abstract available at http://www.ncbi.nlm.nih.gov/pubmed/12383144.

[57] A summary of these studies can be found at: http://www.acl.gov/Programs/CDAP/OPE/ADEPP.aspx.

year".[58] Older adults with depression "visit the doctor and emergency room more, use more medication, and stay longer in the hospital" than those without depression.[59] Those with depression and certain chronic conditions have been shown to have substantially higher total health care costs than those with these conditions but no depression ($22,960 vs. $11,956 per year).[60] 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.[61]

Chronic Disease Self-Management Education Programs

(FY 2013: $7,086,000)

Chronic Disease Self-Management Education (CDSME) programs, such as the Stanford University Chronic Disease Self-Management Program (CDSMP), are low-cost, evidence-based disease prevention models that use state-of-the-art techniques and lay leaders in the community 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.[62] In addition to the CDSMP, which is appropriate for any type of chronic condition, there are other proven CDSME programs, including the Spanish CDSMP, the Diabetes Self-Management Program (DSMP), Spanish DSMP, Chronic Pain Self-Management Program, Positive Self-Management Program for HIV, Arthritis Self-Management Program, and online versions of the CDSMP and DSMP.

In the United States, over 76 percent of community-living, older adults have multiple (two or more) chronic conditions,[63] placing them at greater risk for premature death, poor functional status, unnecessary hospitalizations, adverse drug events, and nursing home

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[58] Harris, Y., and J. K. Cooper (2006). "Depressive symptoms in older people predict nursing home admission", *Journal of the American Geriatrics Society*, 54(4):593-597.

[59] U.S. Centers for Disease Control and Prevention (2008). The State of Mental Health and Aging in America, Healthy Aging Program, Issue Brief #1.

[60] Unützer J, Schoenbaum M, et al. (2009). "Health care costs associated with depression in medically ill fee-for-service Medicare participants", *Journal of the American Geriatric Society*, 57:3, 375–584.

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

[62] 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.

[63] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2012 Medicare Current Beneficiary Survey. [Table 2.6a Self-Reported Health Conditions and Risk Factors of Non-institutionalized Medicare Beneficiaries, by Living Arrangement and Age, 2012]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html. Accessed 23 October, 2014.

placement.[64, 65] Chronic conditions also impact health care costs: 93 percent of Medicare expenditures are for beneficiaries with chronic conditions.[66]

CDSME programs have been shown repeatedly, through multiple studies (including randomized control experiments, with both English and Spanish speaking populations) to be effective at helping participants adopt healthy behaviors and improve their psychological and physical health status.[67] Some evidence suggests that CDSME programs may also reduce the use of hospital care and emergency room services, as well as reduce health care costs in older adults.[68]

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

AoA funds CDSME through competitive grants awarded to states. External experts review project proposals, and AoA awards grants for periods of up to three years. In FY 2013, AoA tracked the progress of the 22 state grantees funded through the Prevention and Public Health Fund (PPHF) in September 2012. These three-year grants are allowing states to provide CDSME programs to older adults and adults with disabilities to help them better manage chronic conditions. All of the grantees identified underserved target populations and partnering organizations to reach these populations including tribal entities, Centers for Independent Living, and a variety of minority organizations. The funding is also fostering the development of comprehensive, integrated delivery systems

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[64] Vogeli C, Shields AE, Lee TA, Gibson TB, Marder WD, Weiss KB, Blumenthal D. Multiple chronic conditions: prevalence, health consequences, and implications for quality, care management, and costs. J Gen Intern Med 2007;22(Suppl 3):391–395. http://www. ncbi.nlm.nih. gov/pmc/ articles/PMC2150598/

[65] Kramarow E, Lubitz J, Lentzner H, et al. Trends in the health of older Americans, 1970–2005. Health Aff (Millwood). 2007 Sep–Oct;26(5):1417-25. http://content.healthaffairs. org/content/ 26/5/1417.full. pdf+html

[66] Nawrocki J. CMS Provides Data on Care for Chronic Conditions to Find Better Care Models. NetNews. April 2, 2013 http://health.wolterskluwerlb.com/2013/04/cms-provides-data-on-care-for-chronic-conditions-to-help-find-better-care-models/

[67] Brady TJ, Murphy L, O'Colmain BJ, Beauchesne D, Daniels B, Greenberg M, et al. A Meta-Analysis of Health Status, Health Behaviors, and Health Care Utilization Outcomes of the Chronic Disease Self-Management Program. Prev Chronic Dis 2013;10:120112. http://dx.doi.org/10.5888/pcd10.120112

[68] *Ory, M. G., et al. 2013. Successes of a National Study of the Chronic Disease Self-Management Program: Meeting the Triple Aim of Health Care Reform. Medical Care 51(11), 992-998*

to embed and sustain these programs within the long-term services and supports and health care systems.

By September 30, 2013, grantees had reached 34,982 participants and 25,989 "completers" (i.e., who attended at least four out of six classes, a retention rate of 74 percent). Grantees were successful in reaching their targeted, underserved populations; of those participants reporting relevant data, 56 percent were age 60 or older, 57 percent reported having multiple chronic conditions, 45 percent reported a disability, and 48 percent were racial/ethnic minorities.

Through financing from the FY2013 PPHF, AoA also funded a National Resource Center to assist states, the aging, disability and public health networks and their partners to increase access to and sustain evidence-based prevention programs, particularly CDSME programs, 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.

Under the auspices of the Center, a National Study of CDSMP was completed in 2013. The study included over 1,100 participants recruited from 145 workshops in 17 states. Data were collected at baseline, six, and twelve months. The study documented the following positive, significant improvements relevant to the Institute for Healthcare Improvement's Triple Aim: better health—improvement in self-reported health, less depression, and better quality of life; better care—improved communication with physicians, medication compliance, and health literacy; and lower health cost—more than $360 per person net savings after factoring in program costs.[69]

The PPHF also financed a contract to help expand access and sustainability of diabetes self-management programs and to provide technical assistance to area agencies on aging and community-based organizations on general business acumen skills/issues, including situational analysis reports, onsite support, gap analysis services, and process implementation.

Behavioral Health

Good mental and behavioral health is essential to overall health. Mental and behavioral health issues, such as depression, anxiety, substance abuse and 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.[70] Behavioral health issues can greatly impact the independence, health, and well-being of older adults and their family caregivers. Untreated mental and behavioral health disorders can exacerbate health

[69] . 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.

[70] Jeste DV, Alexopoulos GS, Bartels SJ, et al. Consensus statement on the upcoming crisis in geriatric mental health: Research agenda for the next 2 decades. Archives of General Psychiatry. 1999; 56(9):848-853.2.

conditions,[71] decrease life expectancy,[72] and increase overall healthcare costs.[73] Distinctive barriers to the treatment of mental and 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 mental and 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 health disorders, these 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 mental and 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., use a combination of funds, such as those from the OAA – Title III-D, Substance Abuse and Mental Health Administration block grants, private foundations, etc.).

Beginning in June 2010, and continuing through FY 2013, AoA and the Substance Abuse and Mental Health Services Administration (SAMHSA) formally partnered to provide technical assistance aimed at increasing states' capacities for reaching older adults who are at-risk for behavioral health disorders. This partnership supported the development of a variety of tangible materials, such as epidemiological profiles, issue briefs, webinars, and a series of five older adult policy academy regional meetings (attended by 43 states, DC, PR, and the VI). The materials developed through this partnership have been successful in helping many states enhance their efforts to reach older adults who are at-risk for behavioral health disorders.

In June 2014, ACL partnered with CMS and VHA to issue a Funding Opportunity Announcement to help states plan for a No Wrong Door System for All Payers and All Populations. These No Wrong Door planning grants sets the stage for improved access, more effective and efficient systems and better outcomes for people who need long-term care services and supports. The vision for the NWD System governing body is to coordinate the on-going development, implementation, financing, evaluation and continual improvement of the state's NWD System. For successful state grantees, the planning process must involve meaningful input from key stakeholders, including state authorities administering mental health services.

[71] U.S. Department of Health and Human Services, Mental Health: A Report of the Surgeon General (Rockville, MD: 1999).
[72] Husaini, B,A, et. Al (2000). Prevalence and cost of treating mental disorders among elderly recipients of Medicare services. Psychiatric Services, 51, 1245-1247.
[73] Katon,W., Ciechanowski, P. (2002). Impact of major depression on chronic medical illness. Journal of Psychosomatic Research, 53, 859-863.

Caregiver Services

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

Better support for informal caregivers is critical because often it is their availability - whether they are informal family caregivers or unrelated friends and neighbors who volunteer their time - that determines whether an older person can remain in his or her home. In 2009, approximately 43.5 million adult caregivers provided uncompensated care to those 50 years of age and older.[74] In other words, approximately 19 percent of all adults provided care to someone age 50 years and older.[75] AARP estimated the economic cost of replacing unpaid caregiving in 2009 to be about $450 billion, an increase from $375 billion in 2007 (cost if that care had to be replaced with paid services).[76] A more recent study by the Rand Corporation estimated the economic cost of replacing unpaid caregiving in to be about $522 billion annually.[77] 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.

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.[78]

Such demands on family caregivers can lead to a breakdown of their health, and the illness, hospitalization, or even death and can increase the risk for institutionalization of the care recipient. Caregivers suffer from higher rates of depression than non-caregivers of the same age, and research indicates that caregivers suffer a mortality rate that is 63

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[74] Caregiving in the U.S.: A Focused Look at Those Caring for Someone Age 50 or Older. National Alliance for Caregiving. November 2009. http://www.caregiving.org/pdf/research/FINALRegularExSum50plus.pdf

[75] Ibid.

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

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

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

percent higher than non-caregivers.[79] 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.[80]

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 17.8 million non-institutionalized seniors age 65 and over with one or more ADL limitations, an increase of 3.7 million seniors (or a 26 percent increase between 2013 and 2020) needing caregiver assistance.[81]

National Family Caregiver Support Program

(Title III-E of OAA; FY 2013: $145,586,000)

The National Family Caregiver Support Program (NFCSP) provides grants to states and territories, based on their share of the population age 70 and over, to fund a range of supports that assist family and informal caregivers to care for their loved ones 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 seniors which caregivers can access on their behalf.

The NFCSP provides a variety of supports to family and informal caregivers. In FY 2013, services provided included:[82]

- *Access Assistance Services*, which provided over 1.15 million contacts to caregivers assisting them in locating services from a variety of public and private agencies.

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

[80] 2013 National Survey of Older Americans Act Participants. http://www.agid.acl.gov

[81] 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, 2013. Released June 2014, accessed 27 August 2014;
U.S. Census Bureau, "2014 National Population Projections," Table 1. Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: 2014 to 2060. Released December 2014, http://www.census.gov/population/projections/data/national/2014/downloadablefiles.html. Accessed 08 January 2015; and
Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2012 Medicare Current Beneficiary Survey. [Table 2.5a Perceived Health and Functioning of Non-institutionalized Medicare Beneficiaries, by Living Arrangement and Age, 2012]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html. Accessed 23 October, 2014.

[82] AoA's FY 2013 State Program Report l.

- *Counseling and Training Services*, which provided nearly 125,948 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving.

- *Respite Care* Service, which provided over 63,000 caregivers with 5.9 million hours of temporary relief - at home, or in an adult day care or nursing home setting - from their caregiving responsibilities. This number represents only 0.15 percent of the estimated 43.5 million caregivers[83] who provide uncompensated care for older Americans.

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 2014 National Survey of OAA Participants show that, 20 percent of caregivers are assisting two or more individuals. Seventy percent of Title III caregivers are 60 or older, making them more vulnerable to a decline in their own health, and 28 percent describe their own health as fair to poor.[84] 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.[85] Caregivers often experience conflicts between work and caregiving. Among working caregivers caring for a family member or friend, 69 percent report having to rearrange their work schedule, decrease their hours or take an unpaid leave in order to meet their caregiving responsibilities.[86]

Survey results for 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,[87] thereby avoiding or delaying the need for institutional care for their loved ones. 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.[88]

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

[84] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.

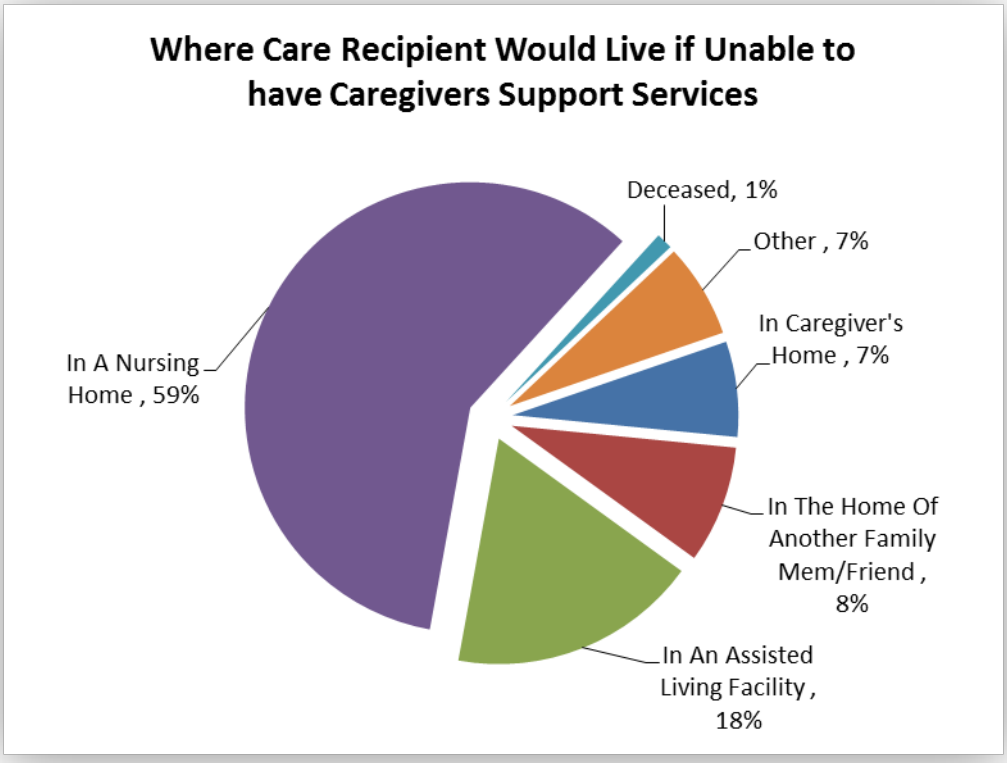
[85] Center on Aging Society. (2005) How Do Family Caregivers Fare? A Closer Look at Their Experiences. (Data Profile, Number 3). Washington, DC: Georgetown University.

[86] Valuing the Invaluable: 2011 Update: The Economic Value of Family Caregiving. AARP Public Policy Institute.

[87] 2014 National Survey of Older Americans Act participants.

[88] 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.

Additionally, 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 keep their loved ones at home. Approximately 77 percent of caregivers of program clients reported in 2013 that services enabled them to provide care longer than otherwise would have been possible.[89] Caregivers receiving services were also asked whether the care recipient would have been able to live in the same residence if the services had not been available. Over 40 percent of the caregivers indicated that the care recipient would be unable to remain at home without the support services. Those respondents were then asked to identify where the care recipient would be living without services. A significant majority of those caregivers, 77 percent, indicated that the care recipient would most likely be living in a nursing home or assisted living (see the chart below).



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

[89] *Ibid.*

Lifespan Respite Care

(FY 2013: $2,351,000)

Family caregiving for persons with disabilities occurs across the age spectrum from birth to death, with caregivers often being called upon to provide care to individuals of varying ages and disabilities. Most do so willingly, and often for many years. AARP estimated in 2009 that 65.7 million people served as unpaid family caregivers to an adult or child with special needs. For many of these caregivers, providing care can take a toll: a majority of caregivers (51 percent) caring for someone over age 18 have medium or high levels of burden and 31 percent of all family caregivers indicated they experienced high levels of stress.[90]

Numerous studies have shown respite to be among the most frequently requested supportive service for family caregivers.[91] [92] Respite is second only to direct financial assistance as a key policy priority of surveyed family caregivers. Even though respite services are often the preferred mode of family caregiver support, they are often under used, difficult to find and access, and are often unaffordable or in short supply. A 2009 survey found that "finding time for myself" was reported by 32 percent of family caregivers along with managing both physical and emotional stress (34 percent) and balancing work and family responsibilities (27 percent). Despite these compelling numbers, nearly 90 percent of family caregivers receive no respite at all.[93]

The barriers to accessing and using respite services are often significant for specific populations such as family caregivers of individuals with Multiple Sclerosis, persons with intellectual and developmental disabilities, and for caregivers of veterans and individuals with Alzheimer's disease, spinal cord injuries, autism, and serious emotional disorders.[94] [95] The population-specific barriers reported by caregivers include provider shortages and inadequate training, mistrust of formal service delivery systems, hesitancy to ask for help and lack of awareness of available programs and supports.

The Lifespan Respite Care program, authorized under the Lifespan Respite Care Act of 2006, focuses on easing the burdens of caregiving by providing grants to eligible state organizations to improve the quality of, and access to, respite care for family caregivers of children or adults of any age with special needs while promoting the statewide dissemination and coordination of community-based respite care services. Unlike the NFCSP, which focuses on broad caregiver support via a number of services, Lifespan Respite Care Programs focus on providing a mechanism for coordinating needed

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

[91] The Arc. (2011). *Still in the Shadows with Their Future Uncertain: A Report on Family and Individual Needs for Disability Supports (FINDS 2011).* Wash, DC: Author

[92] National Family Caregivers Association. (2011). *Allsup Family Caregiver Survey.* Kensington, MD.

[93] National Alliance for Caregiving and AARP, 2009.

[94] National Alliance for Caregiving. (2012). *Multiple Sclerosis Caregivers.* Washington, DC: Author.

[95] The Arc, 2011.

infrastructure changes at state and local levels, and on filling gaps by putting in place coordinated systems of accessible, community-based respite care services for family caregivers of children and adults with special needs.

The systems funded through the Lifespan Respite Care Program seek to better coordinate respite care services for family caregivers; support the training and recruitment of respite care workers and volunteers; and improve the provision of information, outreach, and access assistance to better enable family members to understand and avail themselves of available respite services. More importantly, Lifespan Respite Programs seek to identify and fill gaps in services. Within this context, Lifespan Respite Care Program grantees have focused their efforts in a number of broad areas, including:

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

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

- Integrating lifespan respite principles and practice into statewide activities designed to improve systems and services for family caregivers of individuals of all ages with disabilities;

- Engaging respite consumers to inform project activities;

- Capacity building and network development at the local level to recruit and train volunteers to fill gaps in respite services, particularly in rural areas through partnerships with universities, community-based organizations and communities of faith; and

- Developing and delivering gap-filling and emergency respite services via a range of participant-directed methods, voucher programs and other modalities designed to maximize choice and control.

The Lifespan Respite Care Program also supports Technical Assistance Resource Center (TARC) activities as authorized by statute. To date, the Lifespan Respite TARC has greatly expanded and enhanced a national database on lifespan respite care; provided extensive training, technical assistance and other print and electronic resources to grantees and state, community, and nonprofit respite care programs; and conducted public information, referral, and education programs on respite care.

Respite care services are highly valued by caregivers. By providing opportunities for family caregivers to receive this much needed short-term relief, the Lifespan Respite Care program helps to sustain family caregiver health and well-being, reduces the

likelihood of abuse and neglect, and allows care recipients to remain in their own homes for as long as possible.

Since 2009, AoA has held competitive grant competitions each year to make Lifespan Respite Program funds available to states interested in enhancing or building statewide programs. To date, thirty-one states and the District of Columbia have received grants of up to $200,000 each for three year projects. These projects have enabled the grantees to establish or enhance state infrastructures necessary to more effectively address the respite and related needs of family caregivers across the lifespan.

Competitive expansion supplements were awarded to a total of ten states (eight in FY 2011 and two in FY 2012) to focus specifically on providing respite services to meet demand, fill identified service gaps, and assess the impact of respite services on consumers. Finally, in FY 2012 and FY 2013, a total of 15 states received Integration and Sustainability Grants, thus enabling them to continue their work by focusing grant activities on service provision, respite care workforce development and training, performance measurement, and further program integration efforts. Examples of grantee accomplishments include:

- Development or enhancement of training programs for respite care providers and volunteers to expand the cadre of trained respite professionals;

- Replication and expansion of respite care delivery models with a particular focus on person centered planning and consumer direction;

- Expansion of toll-free "helplines" to provide caregivers with information about available respite care programs.

- The development and adoption of statewide respite care strategic plans and/or policies to guide future development of respite and other caregiver support services statewide;

- Development and deployment of marketing and awareness campaigns designed to educate caregivers about the importance of their work and the necessity to take a break;

- Development and launch of dedicated web sites to facilitate access to information about, and referral to, respite care services;

- The creation and/or expansion of participant-directed respite service options, including voucher programs;

- Mini-grant programs to promote the development of unique community-based respite care options;

- The development of respite care programs and services within communities of faith;

- The development of data collection methodologies to track service provision and outcomes development; and

- The delivery of respite services to nearly 2000 previously unserved family caregivers.

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

Alzheimer's Disease Supportive Services Program

(FY 2013: $3,785,653)

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 evidence-based diagnostic and support services for persons with the disease, their families, and their caregivers, as well as to improve the responsiveness of home and community-based services systems to persons with dementia. The primary components of the ADSSP program include delivering evidence-based supportive services; translating and replicating evidence-based interventions for persons with dementia and their caregivers at the community level; incorporating evidence-based research in the formulation of innovative projects; and advancing changes to a state's overall system of home and community-based care.

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

The most recent grant projects are designed to ensure that states provide people with dementia and their family caregivers with access to a sustainable home and community-based services (HCBS) system that is dementia capable. Such a system meets the unique needs of each person with dementia 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. In 2013, Arizona, California, Illinois, Maine and Oregon received three-year dementia capability project awards.

Through projects funded in prior years, seventeen states continue to translate and implement eight dementia specific evidence-based interventions into practice. One example of these promising evidence-based interventions is the New York University caregiver intervention, a spousal caregiver support program that, in a randomized-control trial, delayed institutionalization of persons with dementia by an average of 557 days.[96] In 2012, the average nursing home cost was $222 daily for a semi-private room and $248 daily for a private room ($81,030 and $90,520 annually), which would mean an average savings of between $124,000 and $138,000 in institutional costs per person with dementia.[97] California, Florida, Georgia, Minnesota, and Utah are currently translating this intervention. Preliminary results indicate findings similar to those from the original study.

Overall, these demonstrations offer direct services and other supports to thousands of families, as well as supporting the continuous quality improvement and evaluation of long- term services and supports. Family caregivers remain the major source of support for most people with Alzheimer's disease. The nature of the disease - a slow loss of cognitive and functional/physical independence - means that most people with Alzheimer's disease are cared for in the community for years. They may access a variety of services from many different systems including the aging, medical, and mental health service systems. As the number of people with Alzheimer's disease grows, it is increasingly important that service delivery and health care systems are responsive to persons with dementia and are effectively coordinated. It is also important to ensure the availability of dementia capable community-based long term services and supports.

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

[97] Metlife. (November 2012), "MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs",p.4, Accessed 5 June, 2013 from: https://www.metlife.com/assets/cao/mmi/publications/studies/2012/studies/mmi-2012-market-survey-long-term-care-costs.pdf.

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

Nutrition and Supportive Services

(FY 2013: $27,601,000)

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, Alaskan Native, and Native Hawaiian elders. An estimated 591,000 persons age 60 and over identify themselves as Native American or Alaska Native alone or in combination with another racial group.[98] Over 291,000 of those elders identify as Native American or Alaskan Native with no other racial group[99].

In the United States, the number of adults aged 65 years or older increased by 14.8% (5.2 million) between 2000 and 2010. This growth of the overall older adult population is also evident in Indian Country. Between 2000 and 2010, the number of older American Indian and Alaska Native (AI/AN) adults increased by 40.5%, a growth that is 2.7 times greater than that of the overall population of older adults over the same 10-year period.[100] In addition, this rapidly growing population is also experiencing some of the highest rates of disability,[101] chronic disease, and poverty[102] in the United States. Because of the combined factors of an aging population and high disability rates, AI/ANs have a great need for LTSS 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 supportive services. Currently, AoA's congregate meal program reaches nearly one-quarter of eligible Native American seniors in participating tribal organizations, home-delivered meals reach 12 percent of such persons, and supportive services reach 41 percent of such persons.[103] These programs, which can help to reduce the need for

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[98] U.S. Census Bureau, 2012 American Community Survey. S0201: Selected Population Profile In The United States. http://factfinder.census.gov. Accessed 12 January 2015. And 2010 Census Summary File 2. DP-1-Geography-United States POPGROUP-American Indian and Alaska Native alone or in combination with one or more other races (300, A01-Z99) & (100-299) or (300, A01-Z99) or (400-999): Profile of General Population and Housing Characteristics: 2010. Accessed 26 August 2013.

[99] 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 (2012), accessed January, 08, 2015.

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

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

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

[103] 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.

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 2013 include:[104]

- *Transportation Services*, which provided over 661,435 rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical activities.

- *Home-Delivered Nutrition Services*, under which nearly 2.6 million meals were provided to over 25,000 homebound Native American elders; the program also provides critical social contacts that help to reduce the risk of depression and isolation experienced by many home-bound Native American elders.

- *Congregate Nutrition Services*, which provided 2.4 million meals to over 52,00 Native American elders in community-based settings, as well as an opportunity for elders to socialize and participate in a variety of activities, including cultural and wellness programs.

- *Information, Referral and Outreach Services*, which provided over 920,000 hours of outreach and information on services and programs to Native American elders and their families, thereby, empowering them to make informed choices about their service and care needs.

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

Eligible tribal organizations receive nutrition and supportive services formula grants based on their share of the American Indian, Alaskan Native, and Native Hawaiian population age 60 and over. Tribal organizations must represent at least 50 Native American elders age 60 and over to receive funding. There is no requirement for matching funds. In addition, tribes may decide the age at which a member is considered an elder and thus eligible for services.

Caregiver Support Services

(FY 2013: $6,031,000)

Native American Caregiver Support Services provide grants to eligible tribal organizations to provide support for family and informal caregivers of Native American,

[104] Title VI FY 2013 data.

Alaskan Native and Native Hawaiian elders. This program, which helps to reduce the need for costly nursing home care and medical interventions, is responsive to the cultural diversity of Native American communities and 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, Alaskan Native, and Native Hawaiian population aged 60 and over. Tribal organizations must represent at least 50 Native American elders age 60 and over and be receiving a grant under Title VI Part A or B to receive funding. There is no requirement for matching funds. Tribes may also decide the age at which a member is considered an elder and thus eligible for services. In addition, there is no limit on the percentage of funds that can be used for services to grandparents caring for grandchildren.

Grants assist American Indian, Alaskan Native and Native Hawaiian families caring for older relatives with chronic illness or disability and grandparents caring for grandchildren. The program provides a variety of direct services that meet a range of caregiver needs, including information and outreach, access assistance, individual counseling, support groups and training, respite care, and other supplemental services. In FY 2013 Tribal grantees provided over 95,000 hours of respite care, over 17,000 hours of caregiver training, and assisted 21,000 caregivers to access needed services.[105] Tribal organizations coordinate with other programs, including the Volunteers In Service To America (VISTA) program, to help support and create sustainable caregiver programs in Native American communities (many of which are geographically isolated). A core value of the Native American Caregiver Support Services, as expressed by tribal leaders, is that the program should not replace the tradition of families caring for their elders. Rather, it provides support that strengthens the family caregiver role.

[105] Ibid.

PART III: PROTECTION OF VULNERABLE OLDER ADULTS

Protection of Vulnerable Americans consists of several distinct but complementary programs designed to prevent, detect, and respond to elder abuse, neglect, and exploitation. As the population of older Americans increases, the problem of elder abuse, neglect, and exploitation continues to grow. While there is no single set of national elder abuse prevalence data, the number of reported cases of elder abuse, neglect, and exploitation are on the rise. A 2004 national survey of State Adult Protective Services (APS) programs conducted by AoA's National Center on Elder Abuse showed a 16 percent increase in the number of elder abuse cases from an identical study conducted in 2000.[106] According to a 1998 national incidence study (the only such study ever conducted), 84 percent of all elder abuse incidents go unreported, meaning that for every reported case of abuse there are over five that go unreported.[107] Together, these data suggest that a minimum of 5 million elders are abused, neglected, and/or exploited annually.

The negative effects of abuse, neglect, and exploitation on the health and independence of seniors is extensive. Research has demonstrated that older victims of even modest forms of abuse have dramatically higher (300 percent) morbidity and mortality rates than non-abused older people.[108] Additional adverse health impacts include an increased likelihood of heart attacks, dementia, depression, chronic diseases and psychological distress. The result of these unnecessary health problems is a growing number of seniors who access the healthcare system more frequently (including emergency room visits and hospital admissions), and are ultimately forced to leave their homes and communities prematurely.[109] Protection of Vulnerable Adults programs address this problem through a full array of services designed to prevent, detect, and respond to elder abuse, neglect, and exploitation, both at home and in institutional settings.

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[106] Teaster, Pamela, et al. *The 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older*. http://www.ncea.aoa.gov/NCEAroot/Main_Site/pdf/2-14-06%20FINAL%2060+REPORT.pdf

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

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

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

Prevention of Elder Abuse and Neglect
(FY 2013: $4,773,000)

The Prevention of Elder Abuse and Neglect program (Title VII, Section 721) provides state formula grants for training and education, promoting public awareness of elder abuse, and supports state and local elder abuse prevention coalitions and multi-disciplinary teams. These activities are important elements of AoA's enhanced focus in FY 2013 on elder justice. The program coordinates activities with state and local adult protective services programs (over half of which are directly administered by State Units on Aging) and other professionals who work to address issues of elder abuse and elder justice. The importance of these services at the State and local level is demonstrated by the fact that states significantly leverage OAA funds to obtain other funding for these activities, including Social Services Block Grant and state general funds. Annually, more than $28 million of expenditures for elder abuse prevention services come from non-OAA funds, a ratio of nearly $7 of non-OAA funds for every $1 investment of federal funds.

Examples of State elder abuse prevention activities include:

- In Kentucky, the statewide network of Local Coordinating Councils on Elder Abuse has developed ―visor cards for law enforcement officers, which contain contact information and resource information to assist victims of elder abuse. Kentucky also produced Fraud Fighter forms that were distributed to thousands of seniors to help in the prevention of exploitation and scam artists. Other public awareness activities included renting billboards with elder abuse awareness messages and the state reporting number, hosting community trainings on the various forms of elder abuse, as well as other events and items to raise awareness in communities.

- Lifespan, out of Rochester, New York, used OAA funding to support training of non-traditional reporters, such as hairdressers, store clerks, and others who have frequent contact with the elderly, on what to look for and how to report suspected cases of elder abuse. Additionally, a series of television ads was developed and aired, which has resulted in an increased awareness of the problem of elder abuse.

- The Wisconsin Bureau of Aging and Disability Resources developed, in collaboration with the National Clearinghouse on Later Life, information designed to raise awareness of caregivers who have experienced abuse in the family, as well as of the risks and signs of abuse in later life. The information is available at: http://dhfs.wisconsin.gov/aps/Publications/publications.htm.

The Prevention of Elder Abuse and Neglect program demonstrates AoA's ongoing commitment to protecting the rights of vulnerable seniors and promoting their dignity and autonomy. Through education efforts, exposing problems that would otherwise be hidden

from view, and providing a voice for those who cannot act for themselves, the program helps ensure that all older Americans are able to age with dignity in a safe environment.

National Center on Elder Abuse

To support and enhance the activities of state and local programs to prevent Elder Abuse, Neglect, and Exploitation, AoA funds the National Center on Elder Abuse (NCEA). NCEA disseminates information to professionals and the public and provides technical assistance and training to States and community-based organizations. The NCEA makes available news and resources; collaborates on research; provides consultation, education, and training; identifies and provides information about promising practices and interventions; answers inquiries and requests for information; operates a listserv forum for professionals; and advises on program and policy development. NCEA also facilitates the exchange of strategies for uncovering and prosecuting fraud in areas such as telemarketing and sweepstakes scams.

In FY 2013, the NCEA:

- NCEA produced and distributed periodic e-newsletter on elder abuse. They released three editions to over 2700 e-news subscribers.

- A podcast series on "Elder Abuse Risk Factors" was created by NCEA in partnership with National Adult Protective Services Association and National Committee for the Prevention of Elder Abuse, reaching .

- Through NCEA email, voicemail, and Facebook, over 175 technical assistance requests were received and processed, averaging 29 per month.

- Redesigned the promising practices database to better gather best practices from the field.

National Legal Assistance and Support Projects
National Legal Resource Center
(FY 2013: $798,461)

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

As a streamlined and accessible point of entry, the NLRC supports the leadership, knowledge, and systems capacity of legal and aging provider organizations in order to enhance the quality, cost effectiveness, and accessibility of legal assistance and elder

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

In FY 2013, economic circumstances gave rise to a host of legal challenges for older consumers and the legal providers who serve them. In response to an increasing demand for legal resource support, the NLRC provided training and case consultation to over 10,714 aging and legal service professionals nationwide. NLRC partners also provided important technical support in the implementation of the Model Approaches projects in 31 states, featuring the provision of expertise in legal needs and capacity assessments, effective targeting and outreach methodologies, statewide reporting systems, and legal service delivery standards. With regard to technical support directed at SLHs, the NLRC provided assistance to 24 SLHs on various service deliver issues, including outreach, case management, data collection, and outcome measurement.

An essential structural feature of the NLRC is that the combined efforts of several partnering organizations with high levels of subject matter expertise is required to achieve its broad resource support objectives. Through effective collaborations, interlocking work plans, and the leveraging of organizational resources, NLRC partners have demonstrated the ability to achieve effective national coverage on high priority legal issues areas. In FY 2013, over 97 percent of professionals responding to surveys rated the quality and usefulness of the support service provided by the NLRC as either good or excellent.

In addition, the NLRC website continues to serve as a single entry point into a national legal assistance support system providing high quality resources and expertise on a broad range of legal and systems development issues: **www.nlrc.gov**.

Model Approaches to Statewide Legal Assistance Systems
(FY 2013: $1,966,323)

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

Model Approaches features strong leadership at the state level to achieve its service delivery integration objectives. State legal assistance developers have demonstrated effective leadership in incorporating the use of SLHs and other low-cost mechanisms into the state legal services planning and development process. Key project partners and service delivery components also include Title III-B legal services providers, private bar pro-bono attorneys, law school clinics, and self-help sites. By promoting the seamless integration of these vital legal service delivery components, Model Approaches enables seniors most in need to access quality legal services in priority legal issue areas involving income security, healthcare financing, consumer fraud, housing and foreclosure prevention, and elder abuse. This approach is also designed to increase the leveraging of limited resources within statewide legal service delivery systems.

In addition, by ensuring strong leadership at the state level, Model Approaches projects have created important partnerships and linkages between the existing legal assistance community and the broader community-based aging and elder rights networks, including AAAs, ADRC, state long-term care ombudsmen, and Adult Protective Services.

As a key centerpiece of the Model Approaches projects, SLHs assist seniors in accessing quality legal services to ensure their rights and enhance their independence and financial security. In 2013, Model Approaches projects assisted 29, 466 older consumers with the most social or economic needs on a wide range of priority legal issues related to public benefits, health care, housing, advance planning, and consumer protection. Some recent examples of the success of SLHs' experience in assisting seniors include:

A 93 year-old woman with a very low income called a SLH seeking assistance with a termination notice. She had recently come home from a hospital admission and brief stay in a rehab facility convalescing from a fall. The hospital and her doctor cleared her to return home. She had prearranged a support system that included a visiting nurse, a housekeeper/shopper, and regular visits by her daughter and son. The SLH lawyer

helped the client write a letter of response to the Housing Manager asserting her rights under the Federal Fair Housing Act. The letter resulted in the rescission of the termination notice and allowed the client to stay in her residence.

A 71 year-old man and his wife were struggling to pay their adjustable rate mortgage on a fixed income. They applied for a mortgage modification through a lender designated by the federal government to offer loan modifications to qualified homeowners. Due to inaction on the part of the lender, interest and late fees continued to accrue on the loan balance. A SLH attorney called the lender reminding them of federal rules governing loan modifications and provided additional documentation. Two weeks later, the lender offered the senior a mortgage modification, which resulted in a 20% reduction in the monthly mortgage.

A 64 year-old woman was granted a portion of her ex-husband's pension in her divorce decree. She desperately needed the pension income to pay her monthly bills, but could not afford to hire an attorney to draft the necessary Qualified Domestic Relations Order (QDRO) that would allow her to receive the benefits. The HelpLine attorney drafted a QDRO pursuant to the rules and regulations of the ex-spouse's pension plan, and the woman immediately began to receive monthly payments.

An elderly woman with very limited English speaking ability, called the SLH after a wage execution was placed on her limited wages and she immediately began falling behind on her bills. The SLH attorney prepared a Modification of Wage Execution form asking that her payment obligation be reduced by half. The advocate then guided her on how to file the form, what to expect in court and what evidence she should be prepared to present, including a budget showing that she could not afford her very basic expenses without a reduction in the execution amount. The client attended court on her own and, armed with the advocate's guidance, successfully persuaded the judge to reduce the amount of her wage execution by half.

In addition to providing assistance on priority legal issues, SLHs under Model Approaches have been very successful in reaching low income populations with over 76 percent of older clients having incomes at or below 200 percent of the federal poverty guidelines. Minority clients receiving assistance through SLHs in the last reporting period constituted 30 percent of all clients served. These figures illustrate the effectiveness of Model Approaches states in reaching key target populations under the OAA with much needed "priority" legal assistance.

An important purpose of the Model Approaches demonstrations is to position SLHs as coordinated and essential components of high quality and high impact legal service delivery systems that effectively target scarce resources to older persons most in need. Model Approaches partners across the country recognize the enormous value of the network relationships that have been forged in pursuit of essential project goals and objectives. Several Model Approaches states with completed grant award cycles (e.g. CT, FL, IA, KY, MD, MI, ND, NV, and PA) demonstrate that SLHs continue to serve

seniors as well-integrated and essential components of statewide senior legal services delivery systems, thus illustrating the sustainability of these projects beyond the demonstration period.

In FY 2013, ACL awarded seven new Model Approaches Phase II grants to continue the evolution of legal service delivery systems implemented through previous Model Approaches projects towards higher levels of capacity, performance, and service delivery impact. Model Approaches Phase II projects are primarily focused on enhancing legal responses to complex issues that emerge from elder abuse, neglect, and financial exploitation. In addition, these new projects are expanding outreach to older adults in the greatest social or economic need and implementing legal data collection/reporting systems that demonstrate the beneficial impact of legal services on the independence, health, and financial security of older adults.

Pension Counseling and Information Program

(FY 2013: $1,616,769)

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

AoA currently funds six regional counseling projects covering 29 states and a technical assistance resource center to assist older Americans in accessing information about their retirement benefits and to help them negotiate with former employers or pension plans for due compensation. The projects help with cases that private pension professionals are reluctant to take, where the benefits in question are small, as is often the case with low-income workers and those with limited English proficiency, but to whom these modest amounts make a huge difference in maintaining their financial security and independence.

Data show that since the program's inception in 1993, the Pension Counseling projects have recovered $190 million in retirement benefits for 50,000 retirees. With a relatively small federal investment, the program has brought in a return of more than $8.00 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 significance of the projects' work is best illustrated through presentation of two typical cases resolved during this period:

- A low-income senior contacted one of the regional counseling projects for assistance with locating a lost pension. He'd worked for a company from the late 1980s through the early 1990s and remembered being told he may be entitled to a pension at retirement. The senior could not find any contact information for his former employer. The counseling project researched the issue, located the employer – which had since merged with another company – and guided the individual through the claims process. The senior was approved for a pension of approximately $150 per month for the duration of his life. Without the project's assistance, it is likely that this low-income senior would not have received the benefit he had earned during his employment.

- An elderly widow sought assistance from another of the regional counseling projects to determine whether she was entitled to any benefits as the surviving spouse of a participant in a construction trades pension plan. Though she knew what her late husband had done for a living, she was uninformed of the plan's identity and of her rights. A project staff investigation located the correct plan and helped the senior apply for survivor benefits. Her claim was immediately approved, and she now receives a lifetime monthly survivor benefit of $342.25, with an estimated actuarial value of nearly $62,550.00, significantly impacting her economic security and quality of life.

- A retiree had selected a pension payment option that would provide a certain amount until he started receiving Social Security, at which point the pension plan would begin reducing his benefits. Upon reaching 65, the retiree called the plan to notify them he had begun to receive his Social Security. However, the plan assured him that his pension benefit did not need to be reduced. The retiree believed this and made financial decisions based on the amount that the plan told him he was entitled to. Eleven years later the plan came back to the retiree and told him that his pension should have been reduced, and demanded that he pay

back $120,000 to make up for the overpayments that were the result of the plan's mistake. Not surprisingly, he did not have $120,000. The retiree contacted a pension counseling project, which negotiated with the plan to obtain a waiver of this repayment on the grounds that it would cause the retiree a significant financial hardship. The plan ultimately forgave the entire overpayment thanks to the project's efforts.

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

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

Senior Medicare Patrol Program

(FY 2013: $8,875,274)

The Senior Medicare Patrol (SMP) program serves a unique role in the HHS' efforts to identify and prevent health care fraud in the Medicare. The mission of the SMP program is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report healthcare fraud, errors, and abuse through outreach, counseling, and education. The SMP program provides competitive grants to entities in 54 states and territories to support a national network of volunteers whose purpose is to educate Medicare beneficiaries on preventing and identifying healthcare fraud and abuse. Activities are carried out in partnership with the Centers for Medicare & Medicaid Services (CMS), the Office of Inspector General (OIG), healthcare providers, and other aging and elder rights professionals from around the country.

Annually, the OIG analyzes the Performance data housed in the SMARTFACTS data tracking system. This data is published as a report on the SMP program. This report for Calendar Year 2013 [110] shows that SMP projects:

- Had 5,406 active volunteers who worked 105,235 hours to educate beneficiaries about how to prevent Medicare and Medicaid fraud;

[110] Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013; p. 77. https://oig.hhs.gov/reports-and-publications/hcfac/index.asp .

- Educated 501,405 beneficiaries in 14,924 group education sessions and held 148,235 one-on-one counseling sessions with or on behalf of beneficiaries;

- Conducted 10,545 community outreach education events; and

- Resolved 114,387 requests for information or assistance from beneficiaries.

In addition, the report shows that since the program's inception in 1997, SMP projects have:

- Educated nearly 4.5 million beneficiaries in approximately 124,000 group education sessions and held over 1.4 million -one-on-one counseling sessions;

- Conducted nearly 184,000 community outreach education events; and

- Documented over $121.3 million in savings, including Medicare and Medicaid funds recovered, beneficiary savings, and other savings directly attributable to the project as a result of beneficiary complaints.

Health Care Fraud and Abuse Control (HCFAC)

(FY 2013: $10,865,469)

The Administration for Community Living (ACL) has received Health Care Fraud and Abuse Control (HCFAC) funding since FY 1997, as authorized by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191), as a partner in the Department's efforts to fight fraud, waste and abuse in the Medicare and Medicaid programs. HCFAC funds provide Federal support (including infrastructure, technical assistance, program support and capacity building) to the Senior Medicare Patrol (SMP) program.

HCFAC funds allow for 7.6 FTE at ACL to maintain effective oversight of and partnerships with each of the 54 SMP Projects. HCFAC funding also supports the SMP Resource Center (the Center), which provides training, technical assistance, support and information to SMP grantees. The Center has focused on:

- information and strategies to increase awareness of current scams and fraud schemes, such as wheelchair and scooter fraud;

- outreach strategies for educating minority and non-English speaking individuals, information and training, including fraud awareness information;

- volunteer recruitment and training;

- education to the traditionally hard to reach populations; and

- partnership strategies to involve health care providers, family caregivers, and health care professionals.

HCFAC funding also supported additional grants which include a research grant that would quantify or measure the effect of prevention methods currently used in the SMP program and an Integration grant that would support the SMP program expand the reach of the current SMP program by supporting the development of outreach and education strategies aimed at integrating traditionally hard-to-reach populations, such as Medicare beneficiaries under age 65; Lesbian, Gay, Bisexual, and Transgender (LGBT) seniors; and American Indian/Alaska Native seniors.

Long-Term Care Ombudsman Program

(FY 2013: $15,869,941)[111]

The Long-Term Care Ombudsman Program serves individuals living in long-term care facilities (nursing homes, board and care, assisted living and similar settings); and works to resolve resident problems related to inadequate care, violation of rights, and quality of life. Ombudsmen also advocate at the local, state and national levels to promote policies and consumer protections to improve residents' care and quality of life.

Begun in 1972 as a demonstration program, the Ombudsman Program today exists 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 Long-Term Care Ombudsman (Office), headed by a full-time state long-term care ombudsman (state ombudsman) who directs the program statewide. Thousands of local ombudsman staff and volunteers, designated by the state ombudsman as representatives, assist residents and their families by resolving complaints and providing information related to long-term care services and supports. Long-term care ombudsmen are the local problem-solvers for individuals living in long-term care facilities and is an invaluable resource to residents, their families and facility staff.

Section 712 of the Older Americans Act requires the state ombudsmen to:

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

The following provides data for FY 2013 from the Long-Term Care Ombudsman Program nationwide, based on state and local level activities, and are collected annually by AoA from state ombudsmen through the National Ombudsman Reporting System (NORS).

<u>Complaint Investigation and Resolution</u>

Long-term care ombudsmen provide an alternative dispute resolution service, resolving complaints for or on behalf of long-term care facility residents.

- Ombudsmen nationwide completed resolution work on 190,592 complaints.

[111] This amount reflects Title VII-2 designated as Ombudsman Program Activity funds. States also utilize other Older Americans Act and other funding sources to operate the Ombudsman program in their states (see Figure 1, below).

- Ombudsmen resolved or partially resolved 73 percent of these complaints to the satisfaction of the resident or complainant.

- Of the 123,666 cases closed by ombudsmen,[112] 89,760 (73 percent) were associated with nursing facility settings. Of the remaining cases, 31,047 (25 percent) were related to board and care and other similar facilities (including assisted living); and 2,859 (two percent) were associated with non-facility settings or services to facility residents by an outside provider.

- Most cases were initiated by residents or friends and relatives of residents, with the residents themselves initiating 39 percent of cases in nursing facilities and 32 percent in board and care and other similar facilities (including assisted living).

- Ombudsmen proactively identified issues in nearly 13 percent of cases in all settings.

<u>The five most frequent nursing facility complaints were:</u>

- improper eviction or inadequate discharge/planning;
- unanswered requests for assistance;
- lack of respect for residents, poor staff attitudes;
- quality of life, specifically resident/roommate conflict
- administration and organization of medications;

<u>The five most frequent board and care complaints were:</u>

- quality, quantity, variation and choice of food;
- administration and organization of medications;
- inadequate or no discharge/eviction notice or planning;
- lack of respect for residents, poor staff attitudes and building or equipment in disrepair or hazardous.

<u>Improper Eviction/Inadequate Discharge Planning – a troubling trend:</u>

Long-term care ombudsmen are often the primary responders to complaints about eviction or inadequate discharge/planning. This complaint has consistently been among the top ten complaint issues investigated and responded to by long-term care

[112] In FY 2013, ombudsmen opened 124,958 new cases (a case contains one or more complaints originating from the same person(s), and completed resolution work on 123,666 closed cases, containing 190,592 complaints.

ombudsmen. It has been the number one nursing home complaint topic over the past three years, and the third most common complaint of board and care residents.

State ombudsmen reported reasons for the growth in eviction complaints

- Increased complexity of residents' needs, especially with regards to supporting individuals with dementia or persons with other behavioral health needs, which require additional staff training to learn best approaches

- Family and resident lack of understanding of Medicaid requirements which has made some nursing home residents ineligible and therefore lacking a payment source; or

- Financial exploitation, where a responsible party chooses to not pay the bill.

State ombudsmen reported several barriers to satisfactory resolution of eviction complaints the most common include: the involuntary discharge notice issued to the resident is often faulty, with substantive errors that interfere with the residents' ability to understand and access available protections/appeal rights; a lack of available resources (including legal services) to assist residents and families to respond to and appeal the eviction; admission to the hospital and the facility then refuses to readmit in accordance with federal regulation and/or an administrative ruling. Eviction from what is often considered the resident's home creates risk of displacement from their community, family and friends, a risk of homelessness and unnecessary and costly hospitalizations.

Ombudsmen Advocacy Efforts - Evictions and Improper Discharge Planning

- Response to Prolonged Hospitalizations: One state is initiating a "Let Me Return Home" campaign designed to address the systemic problem of residents' being sent to the hospital from the nursing home and then not re-admitted once the medical issue has resolved. The state ombudsman collaborated with the department of health and provider organizations to develop a training program for hospital discharge planners. The materials developed provided a summary of federal regulations as well as advocacy tools and resources. The goal is to operationalize the important regulatory protections for residents through provider education. This project is now in its "roll-out" phase with local ombudsmen providing presentations and training for hospital and nursing facility staff.

- Response to Financial Exploitation: One state noted that their office receives many more involuntary discharge notices and requests for consultations with facility staff regarding lack of payment of the nursing facility bill. Too many times, the issue of non-payment arises despite that fact that a fiduciary—conservator, attorney in fact or representative payee—has been appointed. To work towards resolution of this issue, the state ombudsman participated with other stakeholders to review the current adult abuse system, criminal statutes and

resources available to assist victims of elder abuse, neglect and exploitation. The state ombudsman participation ensured that the resident perspective and issues particularly relevant to long-term care were discussed. A report outlining safeguards from financial exploitation, revisions to guardianship and abuse and neglect laws were among the recommendations submitted to the Governor and the legislature for further action.

Ombudsman Presence in Facilities and Empowerment of Families and Residents

In addition to receiving, responding to and resolving complaints, ombudsmen carry out a variety of duties designed to prevent problems; including providing routine visits to residents, consultations and technical assistance to residents, their families and facility staff. In FY 2013, ombudsmen staff and volunteers nationwide provided:

- Routine visits to provide a regular presence to facility residents, visiting residents of 70 percent of nursing facilities and 29 percent of board and care and similar homes (including assisted living) at least quarterly.

- 335,088 consultations to individuals, including: alternatives to institutional care; information on Medicaid; transfer, discharge and eviction; residents' rights; and federal and state rules and policies impacting residents.

- 129,718 consultations to long-term care facility staff on a wide range of issues, including residents' rights, person-centered care practices, and transfer and discharge issues.

- Resident and family council support – providing technical assistance, training and information to resident councils (21,812 sessions) and family councils (2371 sessions);

- Trained long-term care facility staff (5417 sessions);

- Educated the community (11,506 sessions); and

- Served as resident advocates and provided information to surveyors as part of long-term care facility surveys conducted by regulatory agencies (participating in 16,237 survey related activities).

Ombudsman as a Resource During a Facility Closure

The following is just one example of the important roles and follow-up provided by ombudsman program services:

A local Ombudsman Program assisted with back to back closures of two assisted living facilities after the licensing agency terminated the facilities' license. These closures

required the cooperation of the Ombudsman Program, Adult Protective Services, the health department, law enforcement, the Veterans Administration and the state licensing agency. The Ombudsman Program served as the lead coordinator due to their familiarity with the facilities and prior canvassing the region (a four county area) for the best options available for the residents. During the day of the first relocation, the Ombudsman noticed one of the residents sitting in a room and appearing ill. The facility owner and staff refused to assist with care, food, and packing of resident's properties. The Ombudsman requested of law enforcement to call Emergency Medical Services (EMS) to transport the resident to the hospital. The resident was admitted to the hospital's Intensive Care Unit. The Ombudsman received accolades from the assisting agencies for the attention and action provided on behalf of the resident. After the remaining 25 residents moved to new homes, the Ombudsman visited all residents within two weeks to determine if they were satisfied with their new homes. Three of the residents did not like their placement and asked to move. The Ombudsmen diligently worked with the residents and their families and were successful in assisting with a satisfactory placement. This experience lead to the Ombudsman to develop resident relocation protocols which includes that the Relocation Team meet after each closure to review actions taken and further refine the process.

Systemic Advocacy, including work on laws, regulations and government policies

A vital long-term care ombudsman function is systemic advocacy: analyzing, commenting on and recommending changes in laws, regulations, and government policies and actions to benefit long-term care residents. The following are a few examples of long-term care ombudsman systems advocacy efforts:

- Seeking legislative changes to strength protections against illegal or improper evictions; development of consumer fact sheets and training of ombudsmen on transfer and discharge rights

- Participation in multi-disciplinary task forces to develop comprehensive strategies to prevent and respond to abuse, neglect and exploitation.

- Recommending laws and government actions to improve on the services provided in long-term care facilities, including consumer protections such as the development of model disclosure standards to assist individuals to compare services prior to admission to a facility

- Training of facility staff on abuse and neglect prevention, resident rights and chemical and physical restraint reduction practices.

Providing Ombudsman Services

There are 53 state ombudsmen (50 states, plus the District of Columbia, Puerto Rico, and Guam). In most states, the office of the state long-term care 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 locally. There are 575 designated local entities across the nation.

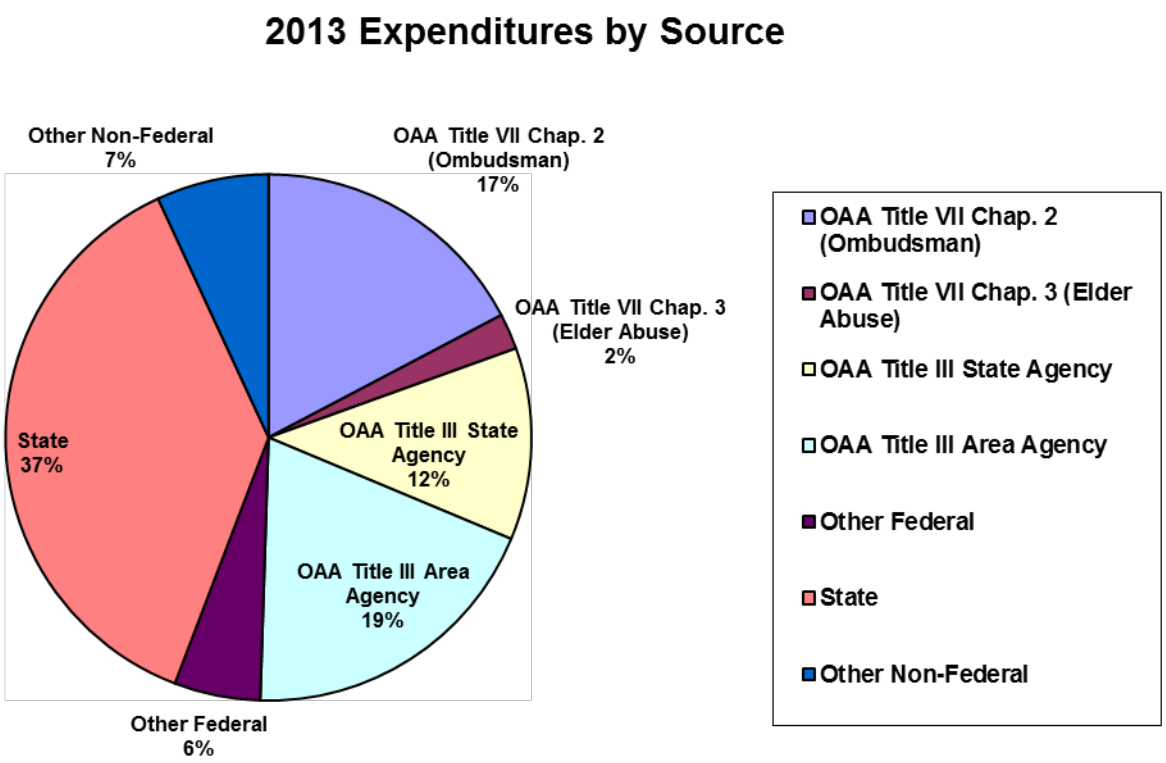
In FY 2013, long-term care ombudsman services to residents were provided by 1,233 full-time equivalent staff and 8,290 volunteers, trained and certified to investigate and resolve complaints. An additional 3,992 volunteers also served residents or assisted in program operations in ways other than complaint resolution.

Program Funding

Total FY 2013 funding from all sources for the ombudsman program nationwide was $92,501,893, an overall increase of 1.9 percent from the FY 2012 level.

The federal government is the primary entity funding the Ombudsman Program, providing 56 percent of total funding in FY 2013. States provided 37 percent of funds, and other non-federal sources funded the remaining seven percent. Figure 1 shows the percentage of total program funding by source

Figure 1 - FY 2013 Expenditures by Category:



Where Long-Term Care Facility Residents Live

Increasingly, long-term care residents live in residential settings other than nursing homes, including board and care homes and assisted living (known by various names under state laws). While the number of beds and facilities in nursing homes are relatively stagnant, the growth of beds in these other residential settings is steadily increasing. Federal policy continues to accelerate the growth of home and community-based long-term care services. In many states, Medicaid funding provides services in these non-nursing home residential settings as part of the "home and community-based services" array.

National Long-Term Care Ombudsman Resource Center Activities

In order to effectively advocate for residents, ombudsmen must remain up-to-date on the latest long-term care developments. Therefore, AoA supports the National Ombudsman Resource Center (NORC), which provides training, technical assistance, and program management expertise to state and local ombudsmen. In FY 2013, the NORC was

operated by the National Consumer Voice for Quality Long-Term Care (formerly NCCNHR), in conjunction with the National Association of States United for Aging and Disabilities (NASUAD).

In FY 2013, NORC provided ombudsmen with training from national experts on such issues as:

- Volunteer management training and technical assistance;
- Training on strategies to combat illegal evictions;
- Long-term services, supports and housing:
- Technical assistance and training on new service provisions through managed care and other home and community based services settings;
- Support for CMS nursing home quality initiatives such as:
    - Reduction of antipsychotic medication use in nursing homes;
    - Promotion of CMS developed training on person-centered dementia care and abuse neglect and exploitation prevention

The NORC provided access to quarterly orientation training activities for all new state ombudsmen and developed resource materials, the NORC website (www.ltcombudsman.org), and monthly newsletters, customized for long-term care ombudsman staff and volunteers.

AoA's Office of Long-Term Care Ombudsman Programs Activities

During the fiscal year, the Office of Long-Term Care Ombudsman Programs within AoA achieved several important goals which will strengthen the ability of Long-Term Care Ombudsman programs to serve residents of long-term care facilities:

1. Notice of Proposed Rule Making for State Long-Term Care Ombudsman Programs

The Administration on Aging posted a Notice of Proposed Rule Making in June 2013, designed to support States and territories in their implementation of the OAA and in serving long-term care facility residents through effective the Long-Term Care Ombudsman programs. Publication of the final rule is anticipated for early 2015.

Since its creation in the 1970s, the functions of Long-Term Care Ombudsman programs have been delineated in the Act. However, in the absence of regulations, there has been significant variation in the effectiveness of these programs among States. AoA anticipates that this rule will strengthen the ability of Long-Term Care Ombudsman programs to be effective problem-solvers for older adults and people with disabilities who live in our nation's long-term care facilities.

2. Program Evaluation Design

The Older Americans Act requires AoA to conduct evaluations of OAA programs. To

that end, AoA completed an evaluation design that proposed an evidence-based approach for determining program efficiency and effectiveness and developed logic models to guide program evaluation, The final report "Evaluation Study Design for Long-Term Care Ombudsman Programs under the Older Americans Act: Research Design Options" can be found at:
http://www.aoa.acl.gov/Program_Results/docs/LTCOP%20Evaluation%20Study%20Design_01312013.pdf.

3. Joint Guidance issued with Centers for Medicare and Medicaid Services

In June of 2013, the Centers for Medicare and Medicaid Services (CMS) and the Administration on Aging issued joint guidance and training regarding the use of Medicaid administrative funding to reimburse for certain activities performed by State Long-Term Care Ombudsman programs. This funding mechanism creates opportunities for Ombudsman programs to increase access to services to individuals applying for or receiving Medicaid.

4. Duals Demonstration Ombudsman Programs

AoA assisted CMS in designing a funding opportunity for Duals Demonstration Ombudsman Programs (Duals Ombudsman Programs) to ensure that states who are piloting integrated Medicare and Medicaid service models offer an independent advocate and problem-solver to beneficiaries. Duals Ombudsman Programs provide: services to empower beneficiaries and support their engagement; investigation and resolution of beneficiary problems with services (including health, behavioral health, as well as long-term supports and services; and systems-level analysis and recommendations.

ACL partners with CMS to provide technical assistance and support to these Dual Ombudsman programs. Of the five states with this Duals Ombudsman service, three are housed within Long-Term Care Ombudsman programs which have expanded their services to include problem-solving with and for individuals receiving services through a Financial Alignment Initiative.

Program Results and Challenges

Value of volunteers – Over $20 million donated in FY 2013. Volunteers designated to act on behalf of the State Long-Term Care Ombudsman add an invaluable service which benefits residents, their families and facility staff. Volunteers across the county donated their time, talents and energy to visit residents, listen to their concerns and take action. For some residents the ombudsman may be their only visitor. Volunteer ombudsmen frequently provide the routine ombudsman presence in many facilities and provide cost-effective complaint resolution. The Independent Sector places the value of the volunteer time at $ 22.55 per hour placing the value of 904,596 hours at $20,398,639.

Ombudsmen solve problems at the facility level -- Long-term care ombudsman programs resolve hundreds of thousands of complaints every year on behalf of long-term care

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

Home and community-based services are increasing demands for ombudsman services -- Long-term care services and supports continue to change over time; services that were once only available in a nursing home can now be received in an individual's home or in a setting such as assisted living or similar. Federal policy, including Medicaid waivers to pay for community-based long-term care and demonstration grants to provide managed long-term care for persons receiving both Medicare and Medicaid are creating new challenges and opportunities for Ombudsman programs. Currently 13 states have expanded their laws to provide for Ombudsman services to individuals receiving in-home care, while other programs are expanding to provide Ombudsman services to individuals on managed care plans. As these services expand and provide more options for long-term care residents, State Ombudsmen work to ensure that their interests and concerns are represented. Reported concerns include access to long-term care services and supports in the community, support services while transitioning from a nursing home to a community setting, consumer protections and oversight of service providers, and abuse, neglect and exploitation prevention.

Long-term care ombudsman programs are credible sources of information -- Ombudsman programs served 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.

Ombudsman programs leverage federal dollars -- Federal funds leveraged resources from other sources for ombudsman programs. During FY 2013, 44 percent of program funds came from non-federal sources.

PART IV: SUPPORTING THE NATIONAL AGING SERVICES NETWORK

Older Americans and Americans with disabilities face a vast array of choices when trying to determine the right services and supports to assist them to remain active and independent in their communities. As the number of choices available to assist them grows, so too does the complexity of navigating these programs and selecting among them 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 seniors 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 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 2013: $6,095,000)

Aging and Disability Resource Centers (ADRCs)/No Wrong Door System[113] supports state efforts to help individuals access long-term services and supports (LTSS) as well as develop a more efficient, and cost-effective access system into LTSS at the community-level. The current LTSS System involves numerous funding streams administered by multiple federal, state and local agencies using different, often fragmented and duplicative, access processes involving screening, intake, needs assessment, service planning, and eligibility determination. Individuals trying to access LTSS frequently find themselves confronted with a bewildering maze of organizations and bureaucratic 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. This can lead to decisions to purchase and/or use LTSS options that are less than optimal for the individual and more expensive than necessary, including decisions to use expensive options such as nursing facility care that can quickly exhaust an individual's personal resources and result in their spending down to Medicaid.

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

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

Another major development in the evolution of the ADRC model occurred in 2008 when the Veterans Health Administration (VHA) – the nation's largest health care system - recognized the value of ADRCs in helping consumers develop person-centered plans and direct their own care. In that year, the VHA entered into formal funding agreements with ADRCs to serve as the VHA's designated entity for delivering the Veterans-Directed Home and Community Based Services Program (VD-HCBS).

In 2010, the Affordable Care Act provided $50 million dollars over five years to support the further development of the ADRC Program. The Affordable Care Act also funded the CMS Balancing Incentive Program to incentivize states to rebalance their Medicaid LTSS spending and required participating states to make changes to their LTSS Systems, including developing statewide NWD programs. In 2012, recognizing the accomplishments of both the ADRC and Balancing Incentive Program initiatives, as well as the lessons learned from the experience of states, ACL, CMS and the VHA issued a special funding opportunity – known as the 2012 "ADRC Part A Grant Program." With the 2012 funding opportunity announcement, ACL officially adopted the "No Wrong Door" System for the ADRC Part A grants. Lessons learned from these grants demonstrated that no one agency or network could successfully implement a LTSS access system for all populations and all payers without having multiple agencies and organizations at the state and local level formally involved in the system's operations. The national aging services network needs to include agencies and organizations that serve or represent the interests of different LTSS populations.

The ACL/CMS/VHA vision is that each state will have a single statewide NWD System to LTSS for all populations and all payers. To support this effort, CMS and ACL continue to collaborate in developing current and relevant guidance on Medicaid administrative funding that could be available to support No Wrong Door systems that include Aging and Disability Resource Centers (ADRCs) and provide Person-Centered Counseling. The NWD System will make it easy for people of all ages, disabilities and income levels to learn about and access the services and supports they need. The NWD System will also provide states with a vehicle for better coordinating and integrating the multiple access functions associated with their various state administered programs that pay for LTSS.

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 from the NWD System. The goal is for citizens of the 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 should give 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 will have 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 determines whether a person is permanently institutionalized or transitioned back to the community. Among the key sources of referral the NWD System must have formal linkages with all of the following entities: 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 when working with individuals that is now being required in the LTSS System under multiple Medicaid regulations, including the Person-Centered Planning provisions in the recently issued Home and Community Based (HCBS) "Settings Rule"

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

ongoing follow-up. These components involve a fluid process where individuals can access different components at various stages.

Streamlined Access to Public LTSS Programs

NWD System's Streamlined Access to Public Programs function 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 population. All these public access processes and requirements must be part of, and integrated into, the state's NWD System's streamlined access function, so states can use their NWD System as a vehicle for optimally coordinating and integrating these processes to make them more efficient and effective, and more seamless and responsive for consumers.

The NWD System person centered counselors can help ensure applications are "camera ready" when they reach the Medicaid office, thereby reducing the burden of the application process for both Medicaid 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 should be fed into the preliminary assessment and then automatically transferred into the final assessment process.

State Governance and Administration

The governance and administration of a NWD System must involve 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 described in this FOA. The NWD System is a critical component of any well-developed, person-centered state LTSS System, and therefore, its governance and oversight should be lodged in a Cabinet level body - either a new or existing one - and should be part of the state's oversight of its LTSS System. The NWD System governing body should be responsible for coordinating the on-going development, implementation, financing, evaluation and continual improvement of the state's NWD System. It must include 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.
A robust Management Information System (MIS) that builds on and leverages existing state MIS systems is essential for a state to be able to effectively and efficiently 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 (CQI) process must involve 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 CQI process should also involve the administration of a complaint and grievance processes and tracking and addressing complaints and grievances. To be effective, the CQI process needs to include performance goals and indicators related to their NWD System's key aims.

ACL and CMS have invested over $100 million in the ADRC/NWD program since 2003. As a result of these investments:

- 509 sites have been established across 50 states, two territories, and Washington, DC.
- Thirty-three states and territories have achieved statewide coverage, and an additional 13 states have achieved 50 percent or more of statewide coverage.
- 42 states/territories with ADRC programs sites currently conduct care transitions through formal intervention.
- At least 41 states/territories with a system used for publicly accessible website
- 133 sites in 29 states/territories reported serving clients with institutional transition from nursing facility (both MFP and non-MFP related), 97 sites in 24 states/territories reported serving clients with institutional transition from nursing facility related to MFP, and 99 sites in 25 states/territories reported serving clients with institutional transition related to MFP.

ADRCs will continue, with Department of Veterans Affairs (VA) funding, to serve clients under the current ACL/VA partnership. In FY 2008, the VA and AoA began working together to develop the Veterans Directed Home and Community-Based Services Program (VD-HCBS), which is designed to serve veterans of any age who are at risk of admission to a nursing home by providing them the opportunity to self-direct their care and access services to help them remain in the community. Rather than build a separate infrastructure to serve veterans, the VA made a strategic decision to use the aging and disability network infrastructure – including using the ADRC as the integrated access point to empower the veterans to set-up their own service plan for long-term supports and services – as a delivery vehicle for VD-HCBS. Since inception of the program the VA has invested over $41 million to provide VDHCBS and expand access to this program with the goal of moving nationwide. HHS and the VA have worked together to develop program guidelines/national standards, web-based tools to track program activities and implement a national training program for the VD-HCBS. Currently, 28 states and the District of Columbia are operating VD-HCBS programs with 48 operational VAMCs, 104 operational AAA/ADRCs and over 1,500 veterans served with 23 percent under age 60.

Aging Network Support Program Activities

(FY 2013: $7,432,000)

Aging Network Support Activities provide competitive grants and contracts to support ongoing activities of national significance which help seniors and their families to obtain information about their care options and benefits, and which 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. These activities provide critical and ongoing support for the national aging services network and help support the activities of AoA's core service delivery programs.

Competitive grants, cooperative agreements, and contracts for Aging Network Support Activities are awarded to eligible public or private agencies and organizations, states and area agencies on aging (AAAs), institutions of higher learning, and other organizations representing and/or serving older people, including faith-based organizations. Grantees are required to provide a match equal to 25 percent of the project's total cost. Project proposals are reviewed by external experts, and project awards are made for periods of one to four years.

National Eldercare Locator

Older Americans and their caregivers face a complicated array of choices and decisions about health care, pensions, insurance, housing, financial management, and long-term care. The Eldercare Locator, created in 1991, helps seniors and their families navigate this complex environment by connecting those needing assistance with state and local agencies on aging that serve older adults and their caregivers. The Eldercare Locator can be accessed through a toll-free nationwide telephone line (800-677-1116) or website (http://www.eldercare.gov). The phone line and website both connect those in need to providers in every zip code in the nation. The Eldercare Locator served over 239,000 callers and 738,234 website users in FY2013.

National Alzheimer's Call Center

The National Alzheimer's Call Center is a national information and counseling service for persons with Alzheimer's disease, their family members, and informal caregivers. In the 12-month period ending January 31, 2014, the National Alzheimer's Call Center handled nearly 300,000 calls through its national and local partners, and its on-line message board community recorded over 5 million page views and over 100,000 individual postings.

The National Alzheimer's Call Center is available to people in all states, 24 hours a day, 7 days a week, 365 days a year to provide expert advice, care consultation, and information and referrals at the national and local levels regarding Alzheimer's disease. Trained professional customer service staff and masters degree social workers are available at all times. The Call Center is accessible by telephone, website or e-mail at no cost to the caller. Services focus on consumers, not professionals. Information provided may include basic information on caregiving; handling legal issues; resources for long-distance caregiving; and tips for working with the medical community. Local community-based organizations are directly involved to ensure local, on-the-ground capacity to respond to emergencies and on-going needs of Alzheimer's patients, their families, and informal caregivers. The Call Center has multilingual capacity and

responds to inquiries in at least 140 languages through its own bilingual staff and with the use of a language interpretation service.

National Education and Resource Center on Women and Retirement Planning

The National Education and Resource Center on Women and Retirement Planning, established in 1998, provides women with access to a one-stop gateway that integrates financial information and resources on retirement, health, and planning for long-term care. This project has made user-friendly financial education and retirement planning tools available to traditionally hard-to-reach women, including low-income women, women of color, women with limited English speaking proficiency, rural, and other "underserved" women. Information is offered through financial and retirement planning programs, workshops tailored to meet women's special needs, and publications in hard copy and web-based formats. Since its establishment, the Center has conducted more than 20,000 workshops on strategies to access financial and retirement planning information for women and disseminated financial and retirement planning information tailored to the specific needs of hard-to-reach women, in addition to materials designed to identify and prevent fraud and financial exploitation among older individuals.

National Minority Aging Organizations Technical Assistance Centers

The National Minority Aging Organizations (NMAO) Technical Assistance Centers Program works to reduce or eliminate health disparities among racial and ethnic minority older individuals. These Centers design and disseminate front line health promotion and disease prevention information that is culturally and linguistically appropriate for older individuals of African American, Hispanic, Asian American and Pacific Islander descent, and American Indian and Alaska Native elders.

AoA awarded individual cooperative agreements to four national organizations to continue partnering as a consortium, with the goal of assisting the Aging Network effectively serve an increasingly diverse older population. Each consortium partner pilots practical, nontraditional, community-based intervention for reaching their target population of older adults who experience barriers to accessing home and community-based services. Interventions focus on barriers due to language and low literacy, as well as those directly related to cultural diversity. Strategies developed under this program incorporate the latest technology and facilitate the generation and dissemination of knowledge in forms that can assist racial and ethnic minority older individuals to practice positive health behaviors and strengthen their capacity to maintain active, independent life styles. Examples of products resulting from these grants include culturally appropriate model workshops on identifying resources for caregivers and navigating community systems of services, and on helping the Aging Network understand and respect cultural differences.

Appendix

Formula Grant Funding

Allocation by

State, Territory and Tribal Organization

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

State	Supportive Services	Congregate Meals	Home Meals	Preventive Services	NFCSP	Total Title III
Alabama	$5,347,830	$6,068,408	$3,177,759	$312,653	$2,220,390	$17,127,040
Alaska	$1,728,330	$2,068,203	$1,021,362	$98,657	$723,620	$5,640,172
Arizona	$6,505,240	$8,135,056	$4,296,544	$380,319	$3,063,358	$22,380,517
Arkansas	$3,464,888	$4,163,564	$1,995,550	$198,557	$1,423,632	$11,246,191
California	$34,222,255	$39,623,562	$20,927,250	$2,000,744	$14,711,105	$111,484,916
Colorado	$4,111,937	$5,410,449	$2,857,538	$240,398	$1,856,698	$14,477,020
Connecticut	$4,358,913	$5,241,452	$2,402,675	$245,092	$1,749,484	$13,997,616
Delaware	$1,728,330	$2,068,203	$1,021,362	$98,657	$723,620	$5,640,172
District of Columbia	$1,728,330	$2,068,203	$1,021,362	$98,657	$723,620	$5,640,172
Florida	$25,001,310	$28,468,480	$15,035,675	$1,461,664	$11,527,293	$81,494,422
Georgia	$7,827,657	$10,014,735	$5,289,299	$457,632	$3,418,391	$27,007,714
Hawaii	$1,728,330	$2,068,203	$1,021,362	$98,657	$723,620	$5,640,172
Idaho	$1,728,330	$2,068,203	$1,021,362	$98,657	$723,620	$5,640,172
Illinois	$14,375,088	$17,286,541	$7,751,933	$789,367	$5,540,545	$45,743,474
Indiana	$6,855,949	$8,105,861	$4,062,628	$400,823	$2,878,077	$22,303,338
Iowa	$4,216,933	$5,081,501	$2,105,057	$217,951	$1,607,487	$13,228,929
Kansas	$3,397,503	$4,089,903	$1,788,240	$179,893	$1,320,014	$10,775,553
Kentucky	$4,692,372	$5,570,252	$2,830,077	$274,333	$1,950,378	$15,317,412
Louisiana	$4,746,436	$5,645,998	$2,744,355	$277,493	$1,887,778	$15,302,060
Maine	$1,728,330	$2,068,203	$1,028,376	$98,847	$723,620	$5,647,376
Maryland	$5,797,027	$6,666,347	$3,520,842	$338,915	$2,398,426	$18,721,557
Massachusetts	$8,124,430	$9,780,267	$4,339,413	$436,805	$3,135,868	$25,816,783
Michigan	$11,139,629	$12,926,499	$6,584,877	$651,262	$4,652,840	$35,955,107
Minnesota	$5,442,946	$6,398,439	$3,309,491	$318,214	$2,390,107	$17,859,197
Mississippi	$3,238,958	$3,891,114	$1,841,271	$184,167	$1,286,333	$10,441,843
Missouri	$7,045,013	$8,467,047	$3,986,638	$397,190	$2,877,048	$22,772,936
Montana	$1,728,330	$2,068,203	$1,021,362	$98,657	$723,620	$5,640,172
Nebraska	$2,271,269	$2,738,802	$1,165,501	$117,210	$871,922	$7,164,704
Nevada	$2,436,001	$3,109,985	$1,642,544	$142,417	$1,064,959	$8,395,906
New Hampshire	$1,728,330	$2,068,203	$1,021,362	$98,657	$723,620	$5,640,172
New Jersey	$10,157,125	$12,190,488	$5,650,333	$582,711	$4,097,131	$32,677,788
New Mexico	$2,044,878	$2,511,415	$1,326,408	$119,550	$909,221	$6,911,472
New York	$24,032,984	$28,963,855	$12,498,399	$1,291,839	$9,063,268	$75,850,345
North Carolina	$9,272,300	$11,542,567	$6,096,226	$542,091	$4,166,899	$31,620,083
North Dakota	$1,728,330	$2,068,203	$1,021,362	$98,657	$723,620	$5,640,172
Ohio	$13,674,310	$16,393,785	$7,783,568	$784,410	$5,629,924	$44,265,997
Oklahoma	$4,234,162	$5,080,736	$2,418,704	$241,578	$1,722,263	$13,697,443
Oregon	$4,091,730	$5,034,431	$2,658,943	$239,217	$1,820,218	$13,844,539
Pennsylvania	$17,695,572	$21,279,716	$9,152,573	$955,835	$6,876,661	$55,960,357
Rhode Island	$1,728,330	$2,068,203	$1,021,362	$98,657	$723,620	$5,640,172
South Carolina	$4,742,125	$5,968,512	$3,152,280	$277,242	$2,104,546	$16,244,705
South Dakota	$1,728,330	$2,068,203	$1,021,362	$98,657	$723,620	$5,640,172
Tennessee	$6,690,497	$7,942,564	$4,194,879	$391,150	$2,866,541	$22,085,631
Texas	$20,116,440	$24,742,235	$13,067,653	$1,176,078	$8,808,631	$67,911,037
Utah	$1,847,519	$2,332,537	$1,231,933	$108,013	$852,599	$6,372,601
Vermont	$1,728,330	$2,068,203	$1,021,362	$98,657	$723,620	$5,640,172
Virginia	$7,783,845	$9,237,708	$4,878,911	$455,071	$3,290,920	$25,646,455
Washington	$6,383,529	$7,951,293	$4,199,488	$373,204	$2,807,974	$21,715,488
West Virginia	$2,744,933	$3,305,947	$1,431,503	$143,708	$1,008,212	$8,634,303
Wisconsin	$6,324,483	$7,586,993	$3,726,193	$367,345	$2,709,247	$20,714,261
Wyoming	$1,728,330	$2,068,203	$1,021,362	$98,657	$723,620	$5,640,172
American Samoa	$467,446	$594,843	$136,498	$12,332	$90,453	$1,301,572
Guam	$864,165	$1,034,101	$510,681	$49,328	$361,810	$2,820,085
Northern Mariana Islands	$216,042	$258,525	$127,670	$12,332	$90,453	$705,022
Puerto Rico	$4,329,829	$4,883,248	$2,579,096	$253,137	$1,846,036	$13,891,346
Virgin Islands	$864,165	$1,034,101	$510,681	$49,328	$361,810	$2,820,085
TOTAL	**$345,665,953**	**$413,640,501**	**$204,272,497**	**$19,731,329**	**$144,724,010**	**$1,128,034,290**

State	Ombudsman	Elder Abuse	Total Title VII
Alabama	$246,892	$76,215	$323,107
Alaska	$79,350	$23,843	$103,193
Arizona	$333,813	$89,944	$423,757
Arkansas	$155,042	$48,157	$203,199
California	$1,625,913	$471,073	$2,096,986
Colorado	$222,012	$59,819	$281,831
Connecticut	$186,673	$59,907	$246,580
Delaware	$79,350	$23,843	$103,193
District of Columbia	$79,350	$23,843	$103,193
Florida	$1,168,176	$344,252	$1,512,428
Georgia	$410,945	$110,726	$521,671
Hawaii	$79,350	$23,843	$103,193
Idaho	$79,350	$23,843	$103,193
Illinois	$602,276	$197,384	$799,660
Indiana	$315,640	$98,224	$413,864
Iowa	$163,550	$55,927	$219,477
Kansas	$138,935	$45,843	$184,778
Kentucky	$219,879	$66,595	$286,474
Louisiana	$213,219	$68,518	$281,737
Maine	$79,898	$23,843	$103,741
Maryland	$273,547	$78,087	$351,634
Massachusetts	$337,145	$109,606	$446,751
Michigan	$511,603	$160,862	$672,465
Minnesota	$257,126	$76,347	$333,473
Mississippi	$143,055	$45,198	$188,253
Missouri	$309,736	$97,643	$407,379
Montana	$79,350	$23,843	$103,193
Nebraska	$90,552	$29,770	$120,322
Nevada	$127,615	$34,385	$162,000
New Hampshire	$79,350	$23,843	$103,193
New Jersey	$438,995	$143,950	$582,945
New Mexico	$103,054	$27,766	$130,820
New York	$971,046	$318,066	$1,289,112
North Carolina	$473,638	$127,617	$601,255
North Dakota	$79,350	$23,843	$103,193
Ohio	$604,734	$197,185	$801,919
Oklahoma	$187,918	$60,208	$248,126
Oregon	$206,583	$56,795	$263,378
Pennsylvania	$711,097	$242,944	$954,041
Rhode Island	$79,350	$23,843	$103,193
South Carolina	$244,912	$65,989	$310,901
South Dakota	$79,350	$23,843	$103,193
Tennessee	$325,915	$91,810	$417,725
Texas	$1,015,273	$274,281	$1,289,554
Utah	$95,714	$25,789	$121,503
Vermont	$79,350	$23,843	$103,193
Virginia	$379,060	$102,820	$481,880
Washington	$326,273	$87,911	$414,184
West Virginia	$111,219	$36,736	$147,955
Wisconsin	$289,501	$90,309	$379,810
Wyoming	$79,350	$23,843	$103,193
American Samoa	$9,919	$2,980	$12,899
Guam	$39,675	$11,922	$51,597
Northern Mariana Islands	$9,919	$2,980	$12,899
Puerto Rico	$200,379	$54,217	$254,596
Virgin Islands	$39,675	$11,922	$51,597
TOTAL	**$15,869,941**	**$4,768,638**	**$20,638,579**

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
AK	01	Aleutian Pribilof Islands Association	$88,310	$25,350	$15,340
AK	02	Association of Village Council Presidents	$127,490		$14,098
AK	03	Bristol Bay Native Association	$127,490	$44,370	$3,830
AK	04	Central Council Tlingit & Haida Indian Tribes of AK	$167,410	$50,710	$1,742
AK	06	Copper River Native Association	$77,770	$19,010	$2,106
AK	07	Hoonah Indian Association	$68,540	$12,670	$1,306
AK	08	Kodiak Area Native Association (Northern Section)	$70,000	$12,670	$1,171
AK	09	Kodiak Area Native Association (Southern Section)	$68,540	$12,670	$1,158
AK	10	Metlakatla Indian Community	$88,310	$25,350	$1,146
AK	11	Native Village of Barrow	$88,310	$25,350	$11,883
AK	12	Tanana Chiefs Conference for Kuskokwim subregion	$68,540	$12,670	$2,626
AK	13	Tanana Chiefs Conference for Lower Yukon Subregion	$68,540	$12,670	$4,230
AK	14	Tanana Chiefs Conference for Yukon Flats Subregion	$68,540	$12,670	$3,562
AK	15	Tanana Chiefs Conference for Yukon Koyukuk Subregion	$77,770	$19,010	$2,717
AK	16	Tanana Chiefs Conference for Yukon Tanana Subregion	$68,540	$12,670	$2,629
AK	17	Fairbanks Native Association	$127,490	$44,370	
AK	19	Maniilaq Association	$127,490	$44,370	$32,653
AK	20	Native Villiage of Unalakleet	$68,540	$12,670	$8,039
AK	21	Chugachmiut	$77,770	$19,010	$4,932
AK	22	Arctic Slope Native Association, Limited	$68,540	$12,670	$11,882
AK	23	Denakkanaaga, Inc.	$77,770	$19,010	
AK	24	Klawock Cooperative Association	$68,540	$12,670	$1,138
AK	25	Kootznoowoo Inc.	$68,540	$12,670	$1,216
AK	26	Gwichyaa Zhee Gwich'in Tribal Government	$68,540	$12,670	$4,181
AK	27	Native Village of Point Hope	$68,540	$12,670	$4,264
AK	28	Seldovia Village Tribe, IRA	$68,540		$687
AK	30	Sitka Tribes of Alaska	$88,310	$25,350	$1,441
AK	32	Ketchikan Indian Community	$127,490	$44,370	$1,902
AK	33	Kuskokwim Native Association	$77,770	$19,010	$2,247
AK	35	Southcentral Foundation	$167,410	$50,710	$10,664
AK	36	Kenaitze Indian Tribe	$110,070	$38,040	$4,042
AK	37	Wrangell Cooperative Association	$68,540	$12,670	$1,576
AK	38	Native Village of Savoonga	$68,540	$12,670	$9,462
AK	39	Native Village of Gambell	$68,540	$12,670	$2,393
AK	40	Native Village of Eyak	$68,540	$12,670	$790
AK	41	Organized Village of Kake	$68,540	$12,670	$1,642
AK	42	Chickaloon Native Village	$77,770		$2,091
AK	43	Yakutat Tlingit Tribe & Craig Community Association	$68,540	$12,670	$1,990
AK	44	Galena Village (aka Louden Village Council)	$68,540	$12,670	$7,165
AK	45	Asa'carsarmiut Tribal Council	$68,540		$650
AK	46	Orutsararmuit Native Council	$88,310		$9,680
AK	Total	Total	$3,499,850	$766,790	$196,271
AL	01	Poarch Creek Indians	$127,490	$44,370	$20,266
AL	Total	Total	$127,490	$44,370	$20,266
AZ	02	Colorado River Indian Tribes	$99,520	$31,690	$8,187
AZ	03	Gila River Indian Community	$127,490	$44,370	$14,979
AZ	04	Hopi Tribe	$127,490	$44,370	$11,036
AZ	05	Hualapai Tribe	$77,770	$19,010	$8,869
AZ	06	Navajo Nation	$167,410	$50,710	$52,594
AZ	07	Pascua Yaqui Tribe	$127,490	$44,370	$40,380
AZ	09	Salt River Pima-Maricopa Indian Community	$99,520	$31,690	$6,984
AZ	10	San Carlos Apache Tribe	$127,490	$44,370	$5,992
AZ	11	Tohono o'Odham Nation	$127,490	$44,370	$3,216
AZ	12	White Mountain Apache Tribe	$127,490	$44,370	$25,495
AZ	13	Ak-Chin Indian Community	$68,540	$12,670	$1,871
AZ	14	Yavapai Apache Tribe	$77,770		$3,048
AZ	15	Havasupai Tribe	$68,540	$12,670	$11,432
AZ	16	Inter-Tribal Council of Arizona, Inc.	$68,540	$12,670	$1,441
AZ	17	Cocopah Indian Tribe	$68,540		$13,650

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
AZ	18	Quechan Indian Tribe	$77,770	$19,010	$14,581
AZ	Total	Total	$1,638,860	$456,340	$223,755
CA	01	Bishop Tribal Council	$77,770	$19,010	$19,635
CA	02	Blue Lake Rancheria	$77,770	$19,010	$23,477
CA	06	Karuk Tribe of California	$77,770	$19,010	$3,290
CA	07	Pit River Tribal Office	$68,540		$4,155
CA	08	Picayune Rancheria of the Chukchansi Indians	$68,540		$8,029
CA	09	Riverside-San Bernardino Co. Indian Health-for Morongo	$68,540	$12,670	$7,088
CA	10	Riverside-San Bernardino Co. Indian Health-for	$68,540	$12,670	$5,208
CA	11	Riverside-San Bernardino Co. Indian Health-for Soboba	$68,540	$12,670	$8,345
CA	12	Sonoma County Indian Health Project - Sonoma	$68,540		$8,483
CA	13	Southern Indian Health Council, Inc.	$68,540	$12,670	$10,611
CA	15	Toiyabe Indian Health Project, Inc. - Northern	$68,540	$12,670	$6,891
CA	16	Tule River Indian Health Center, Inc.	$77,770	$19,010	$17,201
CA	17	Coast Indian Community of Resighini Rancheria	$77,770	$19,010	$7,963
CA	18	United Indian Health Services for Smith River	$88,310	$25,350	$10,631
CA	20	Indian Senior Center, Inc.	$77,770	$19,010	$10,737
CA	21	Sonoma County Indian Health Project - Manchester	$68,540		$2,836
CA	25	Pala Band of Mission Indians	$77,770		$13,045
CA	26	Redding Rancheria	$127,490	$44,370	$5,511
CA	28	Toiyabe Indian Health Project, Inc. - Southern	$68,540	$12,670	$7,655
CA	29	Hoopa Valley Tribe, K'ima:w Medical Center	$77,770		$7,045
CA	30	Round Valley Indian Tribes	$88,310		$3,409
CA	31	Fort Mojave Indian Tribe	$68,540	$12,670	$4,818
CA	33	CA Indian Manpower Consortium, Inc. - Chico,	$68,540	$12,670	$6,869
CA	34	CA Indian Manpower Consortium, Inc. - Big Sandy,	$68,540	$12,670	$7,113
CA	35	CA Indian Manpower Consortium, Inc. - Berry Creek,	$68,540	$12,670	$4,377
CA	36	CA Indian Manpower Consortium, Inc. - Coyote Valley,	$77,770	$19,010	$4,114
CA	37	CA Indian Manpower Consortium, Inc. - Enterprise,	$77,770	$19,010	$4,951
CA	38	Santa Ynez Band of Mission Indians	$68,540		$2,076
CA	Total	Total	$2,109,910	$348,500	$225,563
CO	01	Southern Ute Indian Tribe	$77,770	$19,010	$3,277
CO	02	Ute Mountain Ute Tribe	$77,770		$11,098
CO	Total	Total	$155,540	$19,010	$14,375
HI	01	Alu Like, Inc.	$1,505,000	$50,710	$28,053
HI	02	Hana Health	$77,770		$571
HI	Total	Total	$1,582,770	$50,710	$28,624
IA	01	Sac & Fox Tribe of the Mississippi in Iowa	$88,310	$25,350	$5,965
IA	Total	Total	$88,310	$25,350	$5,965
ID	01	Coeur d'Alene Tribe	$77,770	$19,010	$15,921
ID	02	Nez Perce Tribe	$110,070	$38,040	$23,781
ID	03	Shoshone-Bannock Tribes	$127,490	$44,370	$17,099
ID	Total	Total	$315,330	$101,420	$56,801
KS	01	The Kickapoo Tribe in Kansas	$68,540	$12,670	$11,714
KS	02	Prairie Band of Potawatomi Nation	$88,310	$25,350	$17,181
KS	03	Iowa Tribe of Kansas and Nebraska	$68,540	$12,670	$5,815
KS	Total	Total	$225,390	$50,690	$34,710
LA	01	Institute for Indian Development, Inc.	$77,770		$4,394
LA	Total	Total	$77,770		$4,394
MA	01	Wampanoag Tribe of Gay Head (Aquinnah)	$68,540	$12,670	$638
MA	Total	Total	$68,540	$12,670	$638
ME	01	Pleasant Point Passamaquoddy Tribe	$88,310	$25,350	$19,145
ME	02	Penobscot Indian Nation	$77,770		$4,799
ME	04	Aroostook Band of Micmacs	$68,540	$12,670	$1,086
ME	Total	Total	$234,620	$38,020	$25,030
MI	01	Grand Traverse Band of Ottawa & Chippewa Indians	$88,310	$25,350	$12,951
MI	02	Inter-Tribal Council of Michigan, Inc.	$77,770	$19,010	$4,780
MI	03	Keweenaw Bay Indian Community	$77,770	$19,010	$12,521
MI	04	Sault Ste. Marie Tribe of Chippewa Indians	$127,490		$18,008

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
MI	05	Little Traverse Bay Bands of Odawa Indians	$77,770		$4,044
MI	07	Bay Mills Indian Community	$77,770	$19,010	$5,196
MI	08	Pokagon Band of Potawatomi Indians	$77,770		$2,619
MI	09	Little River Band of Ottawa Indians	$88,310	$25,350	$4,626
MI	10	Nottawaseppi Huron Band of the Potawatomi	$68,540	$12,670	$3,294
MI	Total	Total	$761,500	$120,400	$68,039
MN	01	Bois Forte Reservation Tribal Government	$77,770	$19,010	$7,293
MN	02	Fond du Lac Band of Lake Superior Chippewa	$110,070	$38,040	$45,980
MN	03	Leech Lake Band of Ojibwe	$167,410	$50,710	$20,678
MN	07	Red Lake Band of Chippewa Indians	$110,070		$20,057
MN	08	White Earth Reservation Tribal Council	$99,520	$31,690	$10,891
MN	09	Grand Portage Band of Lake Superior Chippewa	$68,540		$3,761
MN	10	Mille Lacs Band of Ojibwe	$77,770	$19,010	$20,998
MN	Total	Total	$711,150	$158,460	$129,658
MO	99	Eastern Shawnee Tribe of Oklahoma	$88,310	$25,350	$14,166
MO	Total	Total	$88,310	$25,350	$14,166
MS	01	Mississippi Band of Choctaw Indians	$127,490	$44,370	$17,771
MS	Total	Total	$127,490	$44,370	$17,771
MT	01	Assiniboine and Sioux Tribes	$110,070	$38,040	$32,643
MT	02	Blackfeet Tribe - Eagle Shield Center	$127,490	$44,370	$26,261
MT	03	Chippewa Cree Tribe	$99,520	$31,690	$46,310
MT	04	Confederated Salish and Kootenai Tribes	$127,490	$44,370	$4,407
MT	05	Fort Belknap Indian Community	$99,520	$31,690	$15,418
MT	06	Northern Cheyenne Elderly Program	$99,520	$31,690	$21,777
MT	07	Crow Tribal Elders Program	$127,490	$44,370	$44,090
MT	Total	Total	$791,100	$266,220	$190,906
NC	01	Eastern Band of Cherokee Indians	$167,410	$50,710	$40,566
NC	Total	Total	$167,410	$50,710	$40,566
ND	01	Spirit Lake Tribe	$88,310	$25,350	$14,964
ND	02	Standing Rock Sioux Tribe	$127,490	$44,370	$94,486
ND	03	Three Affiliated Tribes	$127,490	$44,370	$12,793
ND	04	Trenton Indian Service Area	$88,310	$25,350	$2,572
ND	05	Turtle Mountain Band of Chippewa Indians	$127,490	$44,370	$16,646
ND	Total	Total	$559,090	$183,810	$141,461
NE	01	Omaha Tribe of Nebraska	$77,770	$19,010	$8,763
NE	02	Santee Sioux Nation	$68,540		$2,187
NE	03	Winnebago Senior Citizen Center	$77,770	$19,010	$19,265
NE	Total	Total	$224,080	$38,020	$30,215
NM	01	Eight Northern Indian Pueblos Council (Picuris, etc.)	$167,410	$50,710	$17,154
NM	02	Eight N. Indian Pueblos Council(San Ildefonso, etc.)	$88,310	$25,350	$8,900
NM	03	Five Sandoval Indian Pueblos, Inc.	$88,310		$17,875
NM	04	Jicarilla Apache Nation	$99,520	$31,690	$17,533
NM	05	Laguna Rainbow Corporation	$127,490	$44,370	$16,610
NM	06	Mescalero Apache Tribe	$88,310		$9,161
NM	07	Pueblo de Cochiti	$77,770	$19,010	$6,618
NM	09	Pueblo of Isleta	$110,070	$38,040	$20,044
NM	10	Pueblo of Jemez	$99,520	$31,690	$7,194
NM	11	Pueblo of San Felipe	$99,520	$31,690	$19,106
NM	12	Pueblo of Taos	$99,520	$31,690	$8,611
NM	13	Zuni Tribe	$127,490	$44,370	$24,296
NM	14	Ohkay Owingeh Senior Citizens Program	$127,490	$44,370	$12,771
NM	15	Santa Clara Pueblo	$167,410	$50,710	$16,964
NM	16	Santo Domingo Pueblo	$127,490	$44,370	$13,753
NM	17	Pueblo of Tesuque	$68,540	$12,670	$5,948
NM	18	Pueblo of Acoma	$88,310	$25,350	$11,580
NM	Total	Total	$1,852,480	$526,080	$234,118
NV	01	Fallon Paiute-Shoshone Tribes	$77,770	$19,010	$18,149
NV	02	Inter-Tribal Council of Nevada, Inc. (McDermitt, etc.)	$77,770	$19,010	$6,634
NV	03	Inter-Tribal Council of Nevada, Inc. (Duckwater, etc.)	$77,770	$19,010	$3,421

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
NV	04	Inter-Tribal Council of Nevada, Inc. (Ely, etc.)	$68,540	$12,670	$5,699
NV	05	Shoshone-Paiute Tribes	$77,770	$19,010	$7,144
NV	06	Walker River Paiute Tribe	$77,770		$8,692
NV	07	Washoe Tribe of Nevada and California	$77,770	$19,010	$40,718
NV	08	Yerington Paiute Tribe	$68,540		$6,392
NV	09	Pyramid Lake Paiute Tribe	$88,310	$25,350	$4,731
NV	10	Elko Band Council	$68,540	$12,670	$6,994
NV	11	Reno-Sparks Indian Colony	$77,770	$19,010	$11,443
NV	Total	Total	$838,320	$164,750	$120,017
NY	01	St. Regis Mohawk Tribe	$127,490	$44,370	$9,214
NY	02	Seneca Nation of Indians	$127,490	$44,370	$15,244
NY	04	Oneida Indian Nation	$68,540	$12,670	$3,588
NY	05	Shinnecock Indian Nation	$68,540	$12,670	$3,902
NY	Total	Total	$392,060	$114,080	$31,948
OK	01	Apache Tribe of Oklahoma	$127,490	$44,370	$7,483
OK	02	Caddo Nation of Oklahoma	$77,770	$19,010	$2,480
OK	03	Cherokee Nation	$168,476	$52,979	$38,827
OK	04	Cheyenne & Arapaho Tribes	$127,490	$44,370	$10,474
OK	06	Choctaw Nation of Oklahoma	$167,410	$50,710	$30,957
OK	07	Citizen Potawatomi Nation	$167,410	$50,710	$11,218
OK	08	Comanche Nation	$127,490	$44,370	$17,103
OK	09	Delaware Nation	$78,960	$12,670	$6,906
OK	10	Iowa Tribe of Oklahoma	$127,490	$44,370	$8,932
OK	12	Kickapoo Tribe of Oklahoma	$100,000	$19,010	$14,905
OK	13	Kiowa Tribe of Oklahoma	$127,490	$44,370	$6,168
OK	14	Miami Tribe of Oklahoma	$110,070	$38,040	$26,233
OK	15	Muscogee (Creek) Nation	$167,410	$50,710	$141,246
OK	17	Otoe-Missouria Tribe of Indians	$70,000	$12,670	$7,993
OK	18	Ottawa Tribe of Oklahoma	$127,490	$44,370	$28,554
OK	19	Pawnee Nation of Oklahoma	$80,000	$19,010	$10,964
OK	20	Peoria Tribe of Indians of Oklahoma	$99,520	$31,690	$12,032
OK	21	Ponca Tribe of Oklahoma	$77,770	$19,010	$9,393
OK	22	Quapaw Tribe of Oklahoma	$110,070	$38,040	$18,539
OK	23	Sac and Fox Nation	$77,770	$19,010	$11,990
OK	24	Seminole Nation of Oklahoma	$167,410	$50,710	$13,139
OK	25	Seneca-Cayuga Tribe of Oklahoma	$127,490	$44,370	$2,709
OK	26	Wichita and Affiliated Tribes	$127,490	$44,370	$7,612
OK	27	Wyandotte Nation	$127,490	$44,370	$16,323
OK	28	Absentee Shawnee Tribe	$167,410	$50,710	$27,080
OK	29	Fort Sill Apache Tribe	$99,520	$31,690	$6,187
OK	31	United Keetoowah Band of Cherokee Indians	$127,490	$44,370	$18,047
OK	32	Chickasaw Nation	$167,410	$50,710	$108,488
OK	33	Kaw Nation	$77,770		$21,697
OK	34	Osage Nation of Oklahoma	$167,410	$50,710	$60,213
OK	35	Delaware Tribes of Indians	$127,490		$4,517
OK	36	Alabama-Quassarte Tribal Town	$68,540	$12,670	$538
OK	Total	Total	$3,870,496	$1,124,169	$708,947
OR	01	Confederated Tribes of Siletz Indians of Oregon	$99,520	$31,690	$1,006
OR	02	Confederated Tribes of the Umatilla Indian Reservation	$110,070	$38,040	$7,792
OR	03	Confederated Tribes of Warm Springs	$99,520	$31,690	$38,651
OR	04	Confederated Tribes of Grand Ronde	$88,310	$25,350	$10,312
OR	05	The Klamath Tribes	$127,490	$44,370	$3,074
OR	06	Confed. Tribes of Coos, Lower Umpqua &	$77,770	$19,010	$7,034
OR	Total	Total	$602,680	$190,150	$67,869
RI	01	Narragansett Indian Tribe	$88,310	$25,350	$2,033
RI	Total	Total	$88,310	$25,350	$2,033
SC	01	Catawba Indian Nation Eldercare Program	$77,770	$19,010	$6,626
SC	Total	Total	$77,770	$19,010	$6,626
SD	01	Cheyenne River Elderly Nutrition Services, Inc.	$127,490	$44,370	$9,928

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
SD	02	Crow Creek Sioux Tribe	$77,770		$16,525
SD	03	Lower Brule Sioux Tribe	$77,770	$19,010	$12,594
SD	04	Oglala Sioux Tribe	$167,410	$50,710	$116,421
SD	05	Rosebud Sioux Tribe	$167,410	$50,710	$61,220
SD	06	Sisseton Wahpeton Oyate of	$127,490		$28,868
SD	08	Yankton Sioux Tribe	$88,310	$25,350	$8,251
SD	Total	Total	$833,650	$190,150	$253,807
TX	01	The Alabama-Coushatta Tribe of Texas	$77,770	$19,010	$8,177
TX	02	Kickapoo Traditional Tribe of Texas	$68,540		$14,784
TX	Total	Total	$146,310	$19,010	$22,961
UT	01	Ute Indian Tribe, Unitah & Ouray	$88,310	$25,350	$6,565
UT	Total	Total	$88,310	$25,350	$6,565
WA	01	Confederated Tribes of the Colville Reservation	$127,490	$44,370	$13,869
WA	02	Lower Elwha Klallam Tribe	$77,770	$19,010	$6,243
WA	03	Lummi Tribe	$110,070	$38,040	$13,440
WA	04	Makah Nation	$77,770	$19,010	$7,524
WA	05	Muckleshoot Indian Tribe	$127,490	$44,370	$27,044
WA	09	Puyallup Tribe of Indians	$127,490		$5,229
WA	10	Quinault Indian Nation	$99,520	$31,690	$23,560
WA	13	Swinomish Indian Tribal Community	$68,540	$12,670	$5,842
WA	14	Spokane Tribe of Indians	$77,770	$19,010	$13,139
WA	16	The Tulalip Tribes	$127,490		$10,875
WA	17	Jamestown S'Klallam Tribe	$77,770	$19,010	$2,196
WA	19	Quileute Tribal Council	$77,770	$19,010	$4,733
WA	20	S. Puget Intertribal Planning Agency - Shoalwater Bay	$88,310	$25,350	$6,482
WA	21	Stillaguamish Tribe of Indians	$88,310	$25,350	$790
WA	22	Upper Skagit Indian Tribe	$68,540	$12,670	$2,447
WA	24	The Suquamish Tribe	$88,310	$25,350	$47,113
WA	25	Port Gamble S'Klallam Tribe	$68,540	$12,670	$3,252
WA	26	Samish Indian Nation	$77,770	$19,010	$2,441
WA	27	Cowlitz Indian Tribe	$88,310	$25,350	$4,724
WA	28	Skokomish Indian Tribe	$88,310	$25,350	$2,271
WA	29	Confederated Tribes of the Chehalis Reservation	$88,310	$25,350	$2,311
WA	30	Nooksack Indian Tribe	$77,770	$19,010	$7,900
WA	31	Yakama Nation	$68,540	$12,670	$2,703
WA	32	Snoqualmie Tribe	$68,540	$12,670	$260
WA	33	S. Puget Intertribal Planning Agency - Nisqually	$110,070	$38,040	$3,435
WA	34	S. Puget Intertribal Planning Agency - Squaxin Island	$68,540	$12,670	$11,909
WA	Total	Total	$2,315,110	$557,700	$231,732
WI	01	Bad River Band of Lake Superior Chippewa	$77,770	$19,010	$11,028
WI	02	Forest County Potawatomi Community	$77,770	$19,010	$13,357
WI	03	Lac Courte Oreilles Band of Lake Superior Chippewa	$88,310	$25,350	$10,068
WI	04	Lac du Flambeau Band of Lake Superior Chippewa	$88,310	$25,350	$20,275
WI	05	Menominee Indian Tribe of Wisconsin	$127,490	$44,370	$1,567
WI	06	Oneida Tribe Elder Services	$127,490	$44,370	$6,467
WI	07	Red Cliff Band of Lake Superior Chippewa	$77,770	$19,010	$13,403
WI	08	St. Croix Chippewa Indians of Wisconsin	$77,770	$19,010	$4,067
WI	09	Stockbridge-Munsee Community	$77,770	$19,010	$2,199
WI	10	Ho-Chunk Nation	$99,520	$31,690	$10,372
WI	Total	Total	$919,970	$266,180	$92,803
WY	01	Northern Arapaho Tribe	$77,770		$9,709
WY	03	Eastern Shoshone Tribe	$88,310		$11,635
WY	Total	Total	$166,080		$21,344
Total	Total	Total	$25,746,056	$6,023,189	$3,269,944

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
AK	01	Aleutian Pribilof Islands Association	$88,310	$25,350	$15,340
AK	02	Association of Village Council Presidents	$127,490		$14,098
AK	03	Bristol Bay Native Association	$127,490	$44,370	$3,830
AK	04	Central Council Tlingit & Haida Indian Tribes of AK	$167,410	$50,710	$1,742
AK	06	Copper River Native Association	$77,770	$19,010	$2,106
AK	07	Hoonah Indian Association	$68,540	$12,670	$1,306
AK	08	Kodiak Area Native Association (Northern Section)	$70,000	$12,670	$1,171
AK	09	Kodiak Area Native Association (Southern Section)	$68,540	$12,670	$1,158
AK	10	Metlakatla Indian Community	$88,310	$25,350	$1,146
AK	11	Native Village of Barrow	$88,310	$25,350	$11,883
AK	12	Tanana Chiefs Conference for Kuskokwim subregion	$68,540	$12,670	$2,626
AK	13	Tanana Chiefs Conference for Lower Yukon Subregion	$68,540	$12,670	$4,230
AK	14	Tanana Chiefs Conference for Yukon Flats Subregion	$68,540	$12,670	$3,562
AK	15	Tanana Chiefs Conference for Yukon Koyukuk Subregion	$77,770	$19,010	$2,717
AK	16	Tanana Chiefs Conference for Yukon Tanana Subregion	$68,540	$12,670	$2,629
AK	17	Fairbanks Native Association	$127,490	$44,370	
AK	19	Maniilaq Association	$127,490	$44,370	$32,653
AK	20	Native Villiage of Unalakleet	$68,540	$12,670	$8,039
AK	21	Chugachmiut	$77,770	$19,010	$4,932
AK	22	Arctic Slope Native Association, Limited	$68,540	$12,670	$11,882
AK	23	Denakkanaaga, Inc.	$77,770	$19,010	
AK	24	Klawock Cooperative Association	$68,540	$12,670	$1,138
AK	25	Kootznoowoo Inc.	$68,540	$12,670	$1,216
AK	26	Gwichyaa Zhee Gwich'in Tribal Government	$68,540	$12,670	$4,181
AK	27	Native Village of Point Hope	$68,540	$12,670	$4,264
AK	28	Seldovia Village Tribe, IRA	$68,540		$687
AK	30	Sitka Tribes of Alaska	$88,310	$25,350	$1,441
AK	32	Ketchikan Indian Community	$127,490	$44,370	$1,902
AK	33	Kuskokwim Native Association	$77,770	$19,010	$2,247
AK	35	Southcentral Foundation	$167,410	$50,710	$10,664
AK	36	Kenaitze Indian Tribe	$110,070	$38,040	$4,042
AK	37	Wrangell Cooperative Association	$68,540	$12,670	$1,576
AK	38	Native Village of Savoonga	$68,540	$12,670	$9,462
AK	39	Native Village of Gambell	$68,540	$12,670	$2,393
AK	40	Native Village of Eyak	$68,540	$12,670	$790
AK	41	Organized Village of Kake	$68,540	$12,670	$1,642
AK	42	Chickaloon Native Village	$77,770		$2,091
AK	43	Yakutat Tlingit Tribe & Craig Community Association	$68,540	$12,670	$1,990
AK	44	Galena Village (aka Louden Village Council)	$68,540	$12,670	$7,165
AK	45	Asa'carsarmiut Tribal Council	$68,540		$650
AK	46	Orutsararmuit Native Council	$88,310		$9,680
AK	Total	Total	$3,499,850	$766,790	$196,271
AL	01	Poarch Creek Indians	$127,490	$44,370	$20,266
AL	Total	Total	$127,490	$44,370	$20,266
AZ	02	Colorado River Indian Tribes	$99,520	$31,690	$8,187
AZ	03	Gila River Indian Community	$127,490	$44,370	$14,979
AZ	04	Hopi Tribe	$127,490	$44,370	$11,036
AZ	05	Hualapai Tribe	$77,770	$19,010	$8,869
AZ	06	Navajo Nation	$167,410	$50,710	$52,594
AZ	07	Pascua Yaqui Tribe	$127,490	$44,370	$40,380
AZ	09	Salt River Pima-Maricopa Indian Community	$99,520	$31,690	$6,984
AZ	10	San Carlos Apache Tribe	$127,490	$44,370	$5,992
AZ	11	Tohono o'Odham Nation	$127,490	$44,370	$3,216
AZ	12	White Mountain Apache Tribe	$127,490	$44,370	$25,495
AZ	13	Ak-Chin Indian Community	$68,540	$12,670	$1,871
AZ	14	Yavapai Apache Tribe	$77,770		$3,048
AZ	15	Havasupai Tribe	$68,540	$12,670	$11,432

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
AZ	16	Inter-Tribal Council of Arizona, Inc.	$68,540	$12,670	$1,441
AZ	17	Cocopah Indian Tribe	$68,540		$13,650
AZ	18	Quechan Indian Tribe	$77,770	$19,010	$14,581
AZ	Total	Total	$1,638,860	$456,340	$223,755
CA	01	Bishop Tribal Council	$77,770	$19,010	$19,635
CA	02	Blue Lake Rancheria	$77,770	$19,010	$23,477
CA	06	Karuk Tribe of California	$77,770	$19,010	$3,290
CA	07	Pit River Tribal Office	$68,540		$4,155
CA	08	Picayune Rancheria of the Chukchansi Indians	$68,540		$8,029
CA	09	Riverside-San Bernardino Co. Indian Health-for Morongo	$68,540	$12,670	$7,088
CA	10	Riverside-San Bernardino Co. Indian Health-for	$68,540	$12,670	$5,208
CA	11	Riverside-San Bernardino Co. Indian Health-for Soboba	$68,540	$12,670	$8,345
CA	12	Sonoma County Indian Health Project - Sonoma	$68,540		$8,483
CA	13	Southern Indian Health Council, Inc.	$68,540	$12,670	$10,611
CA	15	Toiyabe Indian Health Project, Inc. - Northern	$68,540	$12,670	$6,891
CA	16	Tule River Indian Health Center, Inc.	$77,770	$19,010	$17,201
CA	17	Coast Indian Community of Resighini Rancheria	$77,770	$19,010	$7,963
CA	18	United Indian Health Services for Smith River	$88,310	$25,350	$10,631
CA	20	Indian Senior Center, Inc.	$77,770	$19,010	$10,737
CA	21	Sonoma County Indian Health Project - Manchester	$68,540		$2,836
CA	25	Pala Band of Mission Indians	$77,770		$13,045
CA	26	Redding Rancheria	$127,490	$44,370	$5,511
CA	28	Toiyabe Indian Health Project, Inc. - Southern	$68,540	$12,670	$7,655
CA	29	Hoopa Valley Tribe, K'ima:w Medical Center	$77,770		$7,045
CA	30	Round Valley Indian Tribes	$88,310		$3,409
CA	31	Fort Mojave Indian Tribe	$68,540	$12,670	$4,818
CA	33	CA Indian Manpower Consortium, Inc. - Chico,	$68,540	$12,670	$6,869
CA	34	CA Indian Manpower Consortium, Inc. - Big Sandy,	$68,540	$12,670	$7,113
CA	35	CA Indian Manpower Consortium, Inc. - Berry Creek,	$68,540	$12,670	$4,377
CA	36	CA Indian Manpower Consortium, Inc. - Coyote Valley,	$77,770	$19,010	$4,114
CA	37	CA Indian Manpower Consortium, Inc. - Enterprise,	$77,770	$19,010	$4,951
CA	38	Santa Ynez Band of Mission Indians	$68,540		$2,076
CA	Total	Total	$2,109,910	$348,500	$225,563
CO	01	Southern Ute Indian Tribe	$77,770	$19,010	$3,277
CO	02	Ute Mountain Ute Tribe	$77,770		$11,098
CO	Total	Total	$155,540	$19,010	$14,375
HI	01	Alu Like, Inc.	$1,505,000	$50,710	$28,053
HI	02	Hana Health	$77,770		$571
HI	Total	Total	$1,582,770	$50,710	$28,624
IA	01	Sac & Fox Tribe of the Mississippi in Iowa	$88,310	$25,350	$5,965
IA	Total	Total	$88,310	$25,350	$5,965
ID	01	Coeur d'Alene Tribe	$77,770	$19,010	$15,921
ID	02	Nez Perce Tribe	$110,070	$38,040	$23,781
ID	03	Shoshone-Bannock Tribes	$127,490	$44,370	$17,099
ID	Total	Total	$315,330	$101,420	$56,801
KS	01	The Kickapoo Tribe in Kansas	$68,540	$12,670	$11,714
KS	02	Prairie Band of Potawatomi Nation	$88,310	$25,350	$17,181
KS	03	Iowa Tribe of Kansas and Nebraska	$68,540	$12,670	$5,815
KS	Total	Total	$225,390	$50,690	$34,710
LA	01	Institute for Indian Development, Inc.	$77,770		$4,394
LA	Total	Total	$77,770		$4,394
MA	01	Wampanoag Tribe of Gay Head (Aquinnah)	$68,540	$12,670	$638
MA	Total	Total	$68,540	$12,670	$638
ME	01	Pleasant Point Passamaquoddy Tribe	$88,310	$25,350	$19,145
ME	02	Penobscot Indian Nation	$77,770		$4,799
ME	04	Aroostook Band of Micmacs	$68,540	$12,670	$1,086
ME	Total	Total	$234,620	$38,020	$25,030
MI	01	Grand Traverse Band of Ottawa & Chippewa Indians	$88,310	$25,350	$12,951
MI	02	Inter-Tribal Council of Michigan, Inc.	$77,770	$19,010	$4,780

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
MI	03	Keweenaw Bay Indian Community	$77,770	$19,010	$12,521
MI	04	Sault Ste. Marie Tribe of Chippewa Indians	$127,490		$18,008
MI	05	Little Traverse Bay Bands of Odawa Indians	$77,770		$4,044
MI	07	Bay Mills Indian Community	$77,770	$19,010	$5,196
MI	08	Pokagon Band of Potawatomi Indians	$77,770		$2,619
MI	09	Little River Band of Ottawa Indians	$88,310	$25,350	$4,626
MI	10	Nottawaseppi Huron Band of the Potawatomi	$68,540	$12,670	$3,294
MI	Total	Total	$761,500	$120,400	$68,039
MN	01	Bois Forte Reservation Tribal Government	$77,770	$19,010	$7,293
MN	02	Fond du Lac Band of Lake Superior Chippewa	$110,070	$38,040	$45,980
MN	03	Leech Lake Band of Ojibwe	$167,410	$50,710	$20,678
MN	07	Red Lake Band of Chippewa Indians	$110,070		$20,057
MN	08	White Earth Reservation Tribal Council	$99,520	$31,690	$10,891
MN	09	Grand Portage Band of Lake Superior Chippewa	$68,540		$3,761
MN	10	Mille Lacs Band of Ojibwe	$77,770	$19,010	$20,998
MN	Total	Total	$711,150	$158,460	$129,658
MO	99	Eastern Shawnee Tribe of Oklahoma	$88,310	$25,350	$14,166
MO	Total	Total	$88,310	$25,350	$14,166
MS	01	Mississippi Band of Choctaw Indians	$127,490	$44,370	$17,771
MS	Total	Total	$127,490	$44,370	$17,771
MT	01	Assiniboine and Sioux Tribes	$110,070	$38,040	$32,643
MT	02	Blackfeet Tribe - Eagle Shield Center	$127,490	$44,370	$26,261
MT	03	Chippewa Cree Tribe	$99,520	$31,690	$46,310
MT	04	Confederated Salish and Kootenai Tribes	$127,490	$44,370	$4,407
MT	05	Fort Belknap Indian Community	$99,520	$31,690	$15,418
MT	06	Northern Cheyenne Elderly Program	$99,520	$31,690	$21,777
MT	07	Crow Tribal Elders Program	$127,490	$44,370	$44,090
MT	Total	Total	$791,100	$266,220	$190,906
NC	01	Eastern Band of Cherokee Indians	$167,410	$50,710	$40,566
NC	Total	Total	$167,410	$50,710	$40,566
ND	01	Spirit Lake Tribe	$88,310	$25,350	$14,964
ND	02	Standing Rock Sioux Tribe	$127,490	$44,370	$94,486
ND	03	Three Affiliated Tribes	$127,490	$44,370	$12,793
ND	04	Trenton Indian Service Area	$88,310	$25,350	$2,572
ND	05	Turtle Mountain Band of Chippewa Indians	$127,490	$44,370	$16,646
ND	Total	Total	$559,090	$183,810	$141,461
NE	01	Omaha Tribe of Nebraska	$77,770	$19,010	$8,763
NE	02	Santee Sioux Nation	$68,540		$2,187
NE	03	Winnebago Senior Citizen Center	$77,770	$19,010	$19,265
NE	Total	Total	$224,080	$38,020	$30,215
NM	01	Eight Northern Indian Pueblos Council (Picuris, etc.)	$167,410	$50,710	$17,154
NM	02	Eight N. Indian Pueblos Council(San Ildefonso, etc.)	$88,310	$25,350	$8,900
NM	03	Five Sandoval Indian Pueblos, Inc.	$88,310		$17,875
NM	04	Jicarilla Apache Nation	$99,520	$31,690	$17,533
NM	05	Laguna Rainbow Corporation	$127,490	$44,370	$16,610
NM	06	Mescalero Apache Tribe	$88,310		$9,161
NM	07	Pueblo de Cochiti	$77,770	$19,010	$6,618
NM	09	Pueblo of Isleta	$110,070	$38,040	$20,044
NM	10	Pueblo of Jemez	$99,520	$31,690	$7,194
NM	11	Pueblo of San Felipe	$99,520	$31,690	$19,106
NM	12	Pueblo of Taos	$99,520	$31,690	$8,611
NM	13	Zuni Tribe	$127,490	$44,370	$24,296
NM	14	Ohkay Owingeh Senior Citizens Program	$127,490	$44,370	$12,771
NM	15	Santa Clara Pueblo	$167,410	$50,710	$16,964
NM	16	Santo Domingo Pueblo	$127,490	$44,370	$13,753
NM	17	Pueblo of Tesuque	$68,540	$12,670	$5,948
NM	18	Pueblo of Acoma	$88,310	$25,350	$11,580
NM	Total	Total	$1,852,480	$526,080	$234,118
NV	01	Fallon Paiute-Shoshone Tribes	$77,770	$19,010	$18,149

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
NV	02	Inter-Tribal Council of Nevada, Inc. (McDermitt, etc.)	$77,770	$19,010	$6,634
NV	03	Inter-Tribal Council of Nevada, Inc. (Duckwater, etc.)	$77,770	$19,010	$3,421
NV	04	Inter-Tribal Council of Nevada, Inc. (Ely, etc.)	$68,540	$12,670	$5,699
NV	05	Shoshone-Paiute Tribes	$77,770	$19,010	$7,144
NV	06	Walker River Paiute Tribe	$77,770		$8,692
NV	07	Washoe Tribe of Nevada and California	$77,770	$19,010	$40,718
NV	08	Yerington Paiute Tribe	$68,540		$6,392
NV	09	Pyramid Lake Paiute Tribe	$88,310	$25,350	$4,731
NV	10	Elko Band Council	$68,540	$12,670	$6,994
NV	11	Reno-Sparks Indian Colony	$77,770	$19,010	$11,443
NV	Total	Total	$838,320	$164,750	$120,017
NY	01	St. Regis Mohawk Tribe	$127,490	$44,370	$9,214
NY	02	Seneca Nation of Indians	$127,490	$44,370	$15,244
NY	04	Oneida Indian Nation	$68,540	$12,670	$3,588
NY	05	Shinnecock Indian Nation	$68,540	$12,670	$3,902
NY	Total	Total	$392,060	$114,080	$31,948
OK	01	Apache Tribe of Oklahoma	$127,490	$44,370	$7,483
OK	02	Caddo Nation of Oklahoma	$77,770	$19,010	$2,480
OK	03	Cherokee Nation	$168,476	$52,979	$38,827
OK	04	Cheyenne & Arapaho Tribes	$127,490	$44,370	$10,474
OK	06	Choctaw Nation of Oklahoma	$167,410	$50,710	$30,957
OK	07	Citizen Potawatomi Nation	$167,410	$50,710	$11,218
OK	08	Comanche Nation	$127,490	$44,370	$17,103
OK	09	Delaware Nation	$78,960	$12,670	$6,906
OK	10	Iowa Tribe of Oklahoma	$127,490	$44,370	$8,932
OK	12	Kickapoo Tribe of Oklahoma	$100,000	$19,010	$14,905
OK	13	Kiowa Tribe of Oklahoma	$127,490	$44,370	$6,168
OK	14	Miami Tribe of Oklahoma	$110,070	$38,040	$26,233
OK	15	Muscogee (Creek) Nation	$167,410	$50,710	$141,246
OK	17	Otoe-Missouria Tribe of Indians	$70,000	$12,670	$7,993
OK	18	Ottawa Tribe of Oklahoma	$127,490	$44,370	$28,554
OK	19	Pawnee Nation of Oklahoma	$80,000	$19,010	$10,964
OK	20	Peoria Tribe of Indians of Oklahoma	$99,520	$31,690	$12,032
OK	21	Ponca Tribe of Oklahoma	$77,770	$19,010	$9,393
OK	22	Quapaw Tribe of Oklahoma	$110,070	$38,040	$18,539
OK	23	Sac and Fox Nation	$77,770	$19,010	$11,990
OK	24	Seminole Nation of Oklahoma	$167,410	$50,710	$13,139
OK	25	Seneca-Cayuga Tribe of Oklahoma	$127,490	$44,370	$2,709
OK	26	Wichita and Affiliated Tribes	$127,490	$44,370	$7,612
OK	27	Wyandotte Nation	$127,490	$44,370	$16,323
OK	28	Absentee Shawnee Tribe	$167,410	$50,710	$27,080
OK	29	Fort Sill Apache Tribe	$99,520	$31,690	$6,187
OK	31	United Keetoowah Band of Cherokee Indians	$127,490	$44,370	$18,047
OK	32	Chickasaw Nation	$167,410	$50,710	$108,488
OK	33	Kaw Nation	$77,770		$21,697
OK	34	Osage Nation of Oklahoma	$167,410	$50,710	$60,213
OK	35	Delaware Tribes of Indians	$127,490		$4,517
OK	36	Alabama-Quassarte Tribal Town	$68,540	$12,670	$538
OK	Total	Total	$3,870,496	$1,124,169	$708,947
OR	01	Confederated Tribes of Siletz Indians of Oregon	$99,520	$31,690	$1,006
OR	02	Confederated Tribes of the Umatilla Indian Reservation	$110,070	$38,040	$7,792
OR	03	Confederated Tribes of Warm Springs	$99,520	$31,690	$38,651
OR	04	Confederated Tribes of Grand Ronde	$88,310	$25,350	$10,312
OR	05	The Klamath Tribes	$127,490	$44,370	$3,074
OR	06	Confed. Tribes of Coos, Lower Umpqua &	$77,770	$19,010	$7,034
OR	Total	Total	$602,680	$190,150	$67,869
RI	01	Narragansett Indian Tribe	$88,310	$25,350	$2,033
RI	Total	Total	$88,310	$25,350	$2,033
SC	01	Catawba Indian Nation Eldercare Program	$77,770	$19,010	$6,626

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
SC	Total	Total	$77,770	$19,010	$6,626
SD	01	Cheyenne River Elderly Nutrition Services, Inc.	$127,490	$44,370	$9,928
SD	02	Crow Creek Sioux Tribe	$77,770		$16,525
SD	03	Lower Brule Sioux Tribe	$77,770	$19,010	$12,594
SD	04	Oglala Sioux Tribe	$167,410	$50,710	$116,421
SD	05	Rosebud Sioux Tribe	$167,410	$50,710	$61,220
SD	06	Sisseton Wahpeton Oyate of	$127,490		$28,868
SD	08	Yankton Sioux Tribe	$88,310	$25,350	$8,251
SD	Total	Total	$833,650	$190,150	$253,807
TX	01	The Alabama-Coushatta Tribe of Texas	$77,770	$19,010	$8,177
TX	02	Kickapoo Traditional Tribe of Texas	$68,540		$14,784
TX	Total	Total	$146,310	$19,010	$22,961
UT	01	Ute Indian Tribe, Unitah & Ouray	$88,310	$25,350	$6,565
UT	Total	Total	$88,310	$25,350	$6,565
WA	01	Confederated Tribes of the Colville Reservation	$127,490	$44,370	$13,869
WA	02	Lower Elwha Klallam Tribe	$77,770	$19,010	$6,243
WA	03	Lummi Tribe	$110,070	$38,040	$13,440
WA	04	Makah Nation	$77,770	$19,010	$7,524
WA	05	Muckleshoot Indian Tribe	$127,490	$44,370	$27,044
WA	09	Puyallup Tribe of Indians	$127,490		$5,229
WA	10	Quinault Indian Nation	$99,520	$31,690	$23,560
WA	13	Swinomish Indian Tribal Community	$68,540	$12,670	$5,842
WA	14	Spokane Tribe of Indians	$77,770	$19,010	$13,139
WA	16	The Tulalip Tribes	$127,490		$10,875
WA	17	Jamestown S'Klallam Tribe	$77,770	$19,010	$2,196
WA	19	Quileute Tribal Council	$77,770	$19,010	$4,733
WA	20	S. Puget Intertribal Planning Agency - Shoalwater Bay	$88,310	$25,350	$6,482
WA	21	Stillaguamish Tribe of Indians	$88,310	$25,350	$790
WA	22	Upper Skagit Indian Tribe	$68,540	$12,670	$2,447
WA	24	The Suquamish Tribe	$88,310	$25,350	$47,113
WA	25	Port Gamble S'Klallam Tribe	$68,540	$12,670	$3,252
WA	26	Samish Indian Nation	$77,770	$19,010	$2,441
WA	27	Cowlitz Indian Tribe	$88,310	$25,350	$4,724
WA	28	Skokomish Indian Tribe	$88,310	$25,350	$2,271
WA	29	Confederated Tribes of the Chehalis Reservation	$88,310	$25,350	$2,311
WA	30	Nooksack Indian Tribe	$77,770	$19,010	$7,900
WA	31	Yakama Nation	$68,540	$12,670	$2,703
WA	32	Snoqualmie Tribe	$68,540	$12,670	$260
WA	33	S. Puget Intertribal Planning Agency - Nisqually	$110,070	$38,040	$3,435
WA	34	S. Puget Intertribal Planning Agency - Squaxin Island	$68,540	$12,670	$11,909
WA	Total	Total	$2,315,110	$557,700	$231,732
WI	01	Bad River Band of Lake Superior Chippewa	$77,770	$19,010	$11,028
WI	02	Forest County Potawatomi Community	$77,770	$19,010	$13,357
WI	03	Lac Courte Oreilles Band of Lake Superior Chippewa	$88,310	$25,350	$10,068
WI	04	Lac du Flambeau Band of Lake Superior Chippewa	$88,310	$25,350	$20,275
WI	05	Menominee Indian Tribe of Wisconsin	$127,490	$44,370	$1,567
WI	06	Oneida Tribe Elder Services	$127,490	$44,370	$6,467
WI	07	Red Cliff Band of Lake Superior Chippewa	$77,770	$19,010	$13,403
WI	08	St. Croix Chippewa Indians of Wisconsin	$77,770	$19,010	$4,067
WI	09	Stockbridge-Munsee Community	$77,770	$19,010	$2,199
WI	10	Ho-Chunk Nation	$99,520	$31,690	$10,372
WI	Total	Total	$919,970	$266,180	$92,803
WY	01	Northern Arapaho Tribe	$77,770		$9,709
WY	03	Eastern Shoshone Tribe	$88,310		$11,635
WY	Total	Total	$166,080		$21,344
Total	Total	Total	$25,746,056	$6,023,189	$3,269,944