****

**DEPARTMENT**

**of HEALTH**

**and HUMAN**

**SERVICES**

# FY 2014 Report to Congress:

# Older Americans Act

**Prepared by**

**ADMINISTRATION**

**ON AGING**

**ADMINISTRATION FOR**

**COMMUNITY LIVING**

******

 **THIS PAGE INTENTIONALLY LEFT BLANK**

***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 was initially established on April 18, 2012 by bringing together the Administration on Aging (AoA), the Office on Disability, and the Administration on Developmental Disabilities. Since then, ACL has grown significantly. Through budget legislation in subsequent years, Congress moved several programs that serve older adults and people with disabilities from other agencies to ACL, including the State Health Insurance Assistance Program, the Paralysis Resource Center, and the Limb Loss Resource Center. The 2014 Workforce Innovation and Opportunities Act moved the National Institute on Disability, Independent Living, and Rehabilitation Research and the independent living and assistive technology programs from the Department of Education to ACL.

ACL’s mission is to maximize the independence, well-being, and health of older adults, people with disabilities, and their families and caregivers. As part of this important mission, I am pleased to present AoA’s Report to Congress for Fiscal Year (FY) 2014. AoA advances the concerns and interests of older people, whether living in their own home or in a long-term care facility, and works with and through the national aging services network to promote the development of comprehensive and coordinated systems of home and community-based care that are responsive to the needs and preferences of older people and their caregivers.

The national aging services network is comprised of 56 state and territorial units on aging (SUA), 618 area agencies on aging (AAA), 264 Indian tribal and Native Hawaiian organizations, more than 20,000 direct service providers, and hundreds of thousands of volunteers. AoA’s core programs, authorized under the Older Americans Act (OAA), help 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’smost basic functions, such as bathing or preparing food. AoA and the national aging services network annually serve nearly 11 million Americans aged 60 and over and their caregivers.[[1]](#footnote-1)

The population served through OAA programs and activities will grow at unprecedented rates over the next 20 years. An estimated 64.8 million older adults age 60 and over resided in the U.S. in 2014, comprising 20 percent of the population.[[2]](#footnote-2) By 2020, this age group is estimated to increase by 20 percent and reach 77.6 million seniors.[[3]](#footnote-3) During this period, the 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 more than 20 percent by the year 2020.[[4]](#footnote-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 disabilities will have increased by 60 percent since 2014.[[5]](#footnote-5) As these baby boomers age, the ranks of the oldest old (age 85+), who are frequently the most frail, will continue to swell.

Helping this population to maintain their health and continuing to invest in support for home and community-based services for older persons is important. Reports indicate that making reductions in these services could lead to higher government expenditures in areas such as Medicaid.[[6]](#footnote-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]](#footnote-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 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.

Kathy Greenlee

Assistant Secretary for Aging

Administrator, Administration for Community Living

Table of Contents

[EXECUTIVE SUMMARY 6](#_Toc436738867)

[National Program Data on Services Provided 9](#_Toc436738868)

[PART I: HEALTH AND INDEPENDENCE 11](#_Toc436738869)

[Home and Community-Based Supportive Services 12](#_Toc436738870)

[Nutrition Services 15](#_Toc436738871)

[Preventive Health Services 19](#_Toc436738872)

[Chronic Disease Self-Management Education Programs 21](#_Toc436738873)

[Behavioral Health 23](#_Toc436738874)

[Falls Prevention Programs 24](#_Toc436738875)

[Caregiver Services 25](#_Toc436738876)

[National Family Caregiver Support Program 26](#_Toc436738877)

[Lifespan Respite Care 28](#_Toc436738878)

[Brain Health 32](#_Toc436738879)

[Alzheimer’s Disease Supportive Services Program (ADSSP) 32](#_Toc436738880)

[Alzheimer’s Disease Initiative – Specialized Supportive Services (ADI-SSS) 34](#_Toc436738881)

[PART II: OLDER AMERICAN INDIANS, ALASKA NATIVES & NATIVE HAWAIIANS 35](#_Toc436738882)

[Nutrition and Supportive Services 35](#_Toc436738883)

[Caregiver Support Services 36](#_Toc436738884)

[PART III: PROTECTION OF VULNERABLE OLDER ADULTS 38](#_Toc436738885)

[Prevention of Elder Abuse and Neglect 38](#_Toc436738886)

[National Legal Assistance and Support Projects 40](#_Toc436738887)

[National Legal Resource Center 40](#_Toc436738888)

[Model Approaches to Statewide Legal Assistance Systems 41](#_Toc436738890)

[Pension Counseling and Information Program 43](#_Toc436738891)

[Senior Medicare Patrol Program 45](#_Toc436738892)

[Health Care Fraud and Abuse Control (HCFAC) 46](#_Toc436738893)

[Long-Term Care Ombudsman Program 48](#_Toc436738894)

[PART IV: SUPPORTING THE NATIONAL 57](#_Toc436738895)

[Aging and Disability Resource Centers/No Wrong Door System 57](#_Toc436738896)

[Aging Network Support Program Activities 60](#_Toc436738897)

[Appendix 64](#_Toc436738898)

**THIS PAGE INTENTIONALLY LEFT BLANK**

## EXECUTIVE SUMMARY

AoA’s core programs, authorized under the Older Americans Act (OAA), help families keep their loved ones at home for as long as possible. These services complement efforts of the nation’s public health networks, as well as existing medical and health care systems, and support some of life’smost 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 nearly 11 million individuals aged 60 and over (1 out of every 6 older adults), including nearly three million clients who received intensive in-home services.[[8]](#footnote-8) Critical supports, such as respite care and a peer support network, were provided to nearly one million caregivers.[[9]](#footnote-9)

In the ongoing management of its programs and strategic planning process, AoA is guided by a set of core values for 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 2014, 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 difficulties faced by federal and state budgets, and the expanding needs of both older Americans and their caregivers. The following are some examples of these successes:

* **OAA programs help older Americans with severe disabilities remain independent and in the community:** Older adults who have three or more impairments in activities of daily living (ADL) are at a high risk for nursing home placement. Measures of the national aging services network’s success at serving this vulnerable population is a proxy for success at 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 2014 the proportion grew to 42 percent, a 26 percent increase.[[10]](#footnote-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 placement based on scientific literature and AoA’s Performance Outcomes Measurement Project (POMP), which are developed and tested performance measures. The composite score is a weighted average; the components include such items as the percent of clients who are transportation disadvantaged and the percent of congregate meal clients who live alone. As the score increases, the prevalence of nursing home predictors in the OAA service population increases. In 2003, the nursing home predictor score was 46.57. Data indicate it has increased to 63.8, a 37 percent improvement over the FY 2003 baseline.
* **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 2014, the national aging services network served 8,930 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 2014, 92 percent of home-delivered nutrition clients reported that the services help them to continue living at home. In addition, 81 percent of case management service clients report the services they received have enabled them to better care for themselves.[[11]](#footnote-11) Clients across all services rate the quality of these services extremely high and are satisfied with OAA services. For example, 95.1 percent of transportation clients rated services good to excellent and 93.6 percent of caregivers rated services good to excellent.[[12]](#footnote-12) To help ensure the continuation of these trends in core programs, AoA uses its discretionary funding to test innovative service delivery models for state and local program entities that show promise for generating measurable improvements in program activities. For example, AoA has worked with 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 2014 through the OAA’s programs. Additionally, a listing of grant funding allocations by state, territory and tribal organization can be viewed in the Appendix.

## National Program Data on Services Provided

| **Clients** | **FY 2014** |
| --- | --- |
| Total Clients | 10,922,885 |
| Total Registered Clients | 2,734,801 |
| % Minority Clients[[13]](#footnote-13) | 28.62% |
| % Rural Clients | 36.51% |
| % Clients Below Poverty | 32.44% |
| # Senior Centers | 10,032 (5,464 receive OAA funding) |

| **Service** | **Persons Served** | **Units of Service[[14]](#footnote-14)** | **Title III Expenditure** | **Total Expenditure** |
| --- | --- | --- | --- | --- |
| Personal Care | 112,352 | 19,724,257 | $51,780,308 | $305,562,834 |
| Homemaker | 158,950 | 15,866,011 | $27,069,222 | $307,561,630 |
| Chore | 34,979 | 916,177 | $4,578,350 | $19,466,619 |
| Home Delivered Meals | 837,331 | 137,996,055 | $251,698,660 | $827,114,133 |
| Adult Day Care | 19,809 | 8,502,919 | $12,464,291 | $100,690,233 |
| Case Management | 432,932 | 3,290,580 | $25,433,329 | $259,050,408 |
| Assisted Transportation | 42,096 | 2,809,391 | $3,915,081 | $21,209,098 |
| Congregate Meals | 1,569,525 | 80,347,476 | $267,840,372 | $633,650,716 |
| Nutrition Counseling | 35,619 | 72,055 | $1,370,956 | $2,852,428 |
| Transportation | - | 22,179,467 | $63,601,566 | $193,164,761 |
| Legal Assistance | - | 919,036 | $26,599,760 | $49,881,077 |
| Nutrition Education | - | 3,157,503 | $3,715,913 | $6,916,465 |
| Information and Assistance | - | 13,197,278 | $57,385,660 | $174,318,017 |
| Outreach | - | 2,375,574 | $9,328,718 | $20,467,549 |
| Health Promotion and Disease Prevention | 2,208,041 | - | $20,863,076 | $49,782,314 |
| Self-Directed Care | 851 | - | $189,849 | $1,536,353 |
| Other | - | - | $70,618,974 | $434,528,046 |

## National Family Caregiver Support Program

| **Service** | **Caregivers Served** | **Service Units[[15]](#footnote-15)** | **Title III Expenditure** | **Total Expenditure** |
| --- | --- | --- | --- | --- |
| Counseling, Support Groups, Training | 125,134 | 464,211 | $20,139,847 | $28,558,502  |
| Respite | 66,703 | 6,175,321 | $53,218,616 | $94,584,242  |
| Supplemental Services | 37,363 | 741,832 | $12,595,045  | $17,999,962  |
| Access Assistance | 714,660 | 1,359,082 | $31,458,193  | $44,317,563  |
| Self-Directed | 1,467 | - | $1,175,734  | $1,394,487  |
| Information Services | 14,510,295 | 308,244 | $11,811,720  | $16,619,886  |
| Unduplicated Caregivers Provided Service or Access | 903,754 | **-** | **-** | **-** |

## PART I: HEALTH AND INDEPENDENCE

Due in part to advances in public health and medical care, Americans are living longer and more active lives. The average life expectancy of an American has increased dramatically over the last century and one consequence of this increased longevity is the higher incidence of chronic conditions. Multiple chronic conditions negatively affect quality of life, contribute to declines in functioning and the ability to remain in the community, adversely impact individuals’ health, and contribute to increased hospitalizations and health care costs. Many of the most common chronic conditions such as hypertension, heart disease, diabetes, and osteoporosis are related to nutrition as a primary prevention, risk reduction, or treatment modality. Medicare beneficiaries with multiple chronic conditions are the heaviest users of health care services. For example, two-thirds of beneficiaries with two or more chronic conditions account for 93 percent of Medicare spending, and one-third of beneficiaries with four or more chronic conditions account for almost three-fourths of Medicare spending.

AoA’s Health and Independence Programs provide a foundation of supports that assist older individuals to remain healthy and independent in their homes and communities, avoiding more expensive nursing home care. For example, 61 percent of congregate and 92 percent of home-delivered meal recipients reported that the meals enabled them to continue living in their own homes and 51 percent of seniors using transportation services rely on them for the majority of their trips to doctors’ offices, pharmacies, meal sites, and other critical daily activities that help them to remain in the community.[[16]](#footnote-16)

Between 2014 and 2020, the number of Americans age 60 and older will increase by over 12.8 million older adults, to reach 77.6 million seniors.[[17]](#footnote-17) 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 20 percent.[[18]](#footnote-18) AoA’s Health and Independence programs help seniors in need maintain their health and independence.

In concert with other OAA programs, these services assist over 11.8 million elderly individuals and caregivers.[[19]](#footnote-19) AoA’s services are especially critical for the nearly three million seniors who receive intensive in-home services, 473,000 of whom meet the disability criteria for nursing home admission.[[20]](#footnote-20) These services help to keep these individuals from joining the 1.9 million seniors who live for extended periods of time in nursing homes.[[21]](#footnote-21)

### Home and Community-Based Supportive Services

### *(Title III-B of OAA; FY 2014: $347,724,000)*

The Home and Community-Based Supportive Services (HCBSS) program, established in 1973, provides grants to states and territories based on their share of the population age 60 and over to fund a broad array of services. AoA’s programs, including the HCBSS program, serve seniors holistically: while each service is valuable in and of itself, it is often the combination of supports, when tailored to the needs of the individual that helps older persons remain in their own homes and communities instead of entering nursing homes or other types of institutional care.[[22]](#footnote-22)

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, 56 percent are unable to perform critical activities of daily living and require long-term support.[[23]](#footnote-23) Data also show that over 92 percent of older Americans have at least one chronic condition and 76 percent have at least two.[[24]](#footnote-24) 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 2014 include:[[25]](#footnote-25)

* *Transportation Services* provided 22.2 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 36.5 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 8.5 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 over 3.3 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, nearly 49 percent of riders on OAA-funded transportation are mobility impaired, meaning they do not own a car or, if they do own a car, they do not drive and are not near public transportation.[[26]](#footnote-26) Many of these individuals cannot safely drive a car, as nearly 77 percent of transportation riders have at least one of the following chronic conditions that could impair their ability to navigate safely:[[27]](#footnote-27)

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

Of the transportation participants, 96 percent take daily medications, with over 19 percent reporting they take 10 to 20 medications daily.[[28]](#footnote-28) Data from AoA’s national surveys of elderly clients show that HCBSS services are providing these seniors with the assistance and information they report helps them to remain at home.[[29]](#footnote-29) For example, over 81 percent of clients receiving case management reported that as a result of the services arranged by the case manager they were better able to care for themselves.[[30]](#footnote-30) 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.[[31]](#footnote-31)

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

Federal support for OAA programs is not expected to cover the cost of serving every older American. These programs have strong partnerships with state and local governments, philanthropic organizations, and private donations that contribute funding. States typically have leveraged resources of $2 or $3 per every OAA dollar, significantly exceeding the programs’ match requirements.

### Nutrition Services

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

* Congregate Nutrition Services (Title III-C1; FY 2014: $438,191,000): Provides funding for the provision of nutritious meals and nutrition-related services in a variety of congregate settings, which helps keep older adults healthy and may decrease or prevent the need for more costly medical interventions. Established in 1972, the program centers around serving health-promoting meals, but it also presents opportunities for social engagement, health and wellness activities, and meaningful volunteer roles, all of which contribute to overall health and well-being.
* Home-Delivered Nutrition Services (Title III-C2; FY 2014: $216,397,000): Provides funding for nutritious meals, the delivery of meals and nutrition-related services to homebound frail and/or isolated older adults. The deliveries provide opportunities for social engagement and, in many cases, an informal ‘safety check.’ Established in 1978, home-delivered meals are often the first in-home service that an older adult receives and serve as a primary access point for other home and community based services.
* Nutrition Services Incentive Program (Title III-A; FY 2014: $156,603,000): Provides additional funding to states, territories, and eligible tribal organizations that is used exclusively to procure food products for use in the Title III- C-1 and C-2 and Title VI meal programs, and cannot be used to pay for other nutrition-related services or for administrative costs. Funds are awarded to states and tribes based on the number of meals served in a prior federal fiscal year. States and tribes have the option to purchase *USDA Foods* (previously referred to as commodities) directly from the U.S. Department of Agriculture (USDA) with any portion of their award if they determine that doing so will enable them to better meet the needs of older adults.

The meals provided through these programs fulfill the standards set by the current Dietary Guidelines for Americans and provide a minimum of 33 percent of the Dietary Reference Intake, as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Meals also comply with applicable provisions of state and local food safety codes, are appealing, and meet special dietary needs such as health, religious, cultural/ethnic needs, as feasible. The nutrition-related services provided through these programs may include nutrition education, nutrition counseling, and other nutrition services, as appropriate, based on the needs of meal participants.

Nutrition Services help approximately 2.4 million older adults receive the meals they need to stay healthy and decrease their risk of disability.[[35]](#footnote-35) 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. Data from AoA’s national survey of older adult participants indicate that 95 percent of home-delivered and congregate participants have multiple chronic conditions, and that 43 percent of congregate and 56 percent of home-delivered participants have six or more illnesses or conditions. Over 30 percent of congregate and 51 percent of home-delivered participants take over six medications per day and some take more than 20 medications. The congregate and home-delivered program participants are significantly less healthy than the general Medicare population and access to adequate healthy meals is essential to their well-being.

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, half (50.3 percent) of congregate and almost two-thirds (64.3 percent) of home-delivered meal participants are aged 75 years or older.[[36]](#footnote-36)

Approximately 10 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).[[37]](#footnote-37) The data also indicate that 19 percent of congregate and 52 percent of home-delivered participants have difficulty getting outside the house, thus limiting their ability to shop for food themselves.[[38]](#footnote-38) The number of home-delivered meal recipients with severe disabilities (three or more activities of daily living) totaled over 310,000 in FY 2014. This level of disability is frequently associated with nursing home admission, and demonstrates the extreme frailty of a significant number of older adults receiving home-delivered meals.

Nationally, 25 percent of individuals age 60 years and older live alone.[[39]](#footnote-39) However, due to the OAA’s requirement to target services to older adults most in need to help them maintain their health and independence, 46 percent of congregate and 54 percent of home-delivered participants live alone.[[40]](#footnote-40) Living alone is a risk factor for social isolation, poorer health, and nursing home placement.

Data from AoA’s national surveys of older adult participants show that Nutrition Services are effectively helping older adults improve their nutritional intake and remain at home. For example, data indicate that 78 percent of congregate and 83 percent of home-delivered meal participants say they eat healthier meals due to the programs, and 61 percent of congregate and 92 percent of home-delivered meal recipients say that the meals enable them to continue living in their homes.[[41]](#footnote-41) Independent research has found that states that invest more in delivering OAA home-delivered meals to older adults’ homes have lower rates of “low-care” older adults in nursing homes after adjusting for several other factors.[[42]](#footnote-42) 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.[[43]](#footnote-43)

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. Nearly 90 percent of home-delivered meal clients and over 90 percent of congregate participants rate the meal as good to excellent.[[44]](#footnote-44) The most recent data on how these nutrition programs are helping older adults remain healthy and independent in their homes include:

* *Home-Delivered Nutrition Services* provided nearly 138 million meals to over 837,000 individuals in FY 2014.[[45]](#footnote-45)
* *Congregate Nutrition Services* provided over 80.3 million meals to nearly 1.6 million older adults in a variety of community settings in FY 2014.[[46]](#footnote-46)

Consistent with the OAA’s requirement to target services to those most in need to help them maintain their health and independence, approximately 67 percent of home-delivered meal recipients have annual incomes at or below $20,000.[[47]](#footnote-47) Meals are especially critical for the 60 percent of home-delivered and 52 percent of congregate recipients who report these meals provide half or more of their food intake for the day.[[48]](#footnote-48)

Federal support for Nutrition Services is not expected to serve every older adult. These programs have strong partnerships with state and local governments, philanthropic organizations and private donations that contribute funding. In FY 2014, state and local funding comprised 70 percent of all the funding for home-delivered meals and 58 percent for congregate meals.[[49]](#footnote-49) 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 (AAA). 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 2014, states transferred $77 million from congregate nutrition to home and community-based services and home-delivered meals, as illustrated in the table below.

Table 1. FY 2014 Transfer of Federal funds within Title III of the OAA

| **Funds** | **Part B –****Home and Community-Based Supportive Services** | **Part C1 –****Congregate Nutrition** | **Part C2 –****Home-Delivered Meals** |
| --- | --- | --- | --- |
| Initial Allotment | $345,694,467 | $435,633,445 | $215,133,972 |
| Final Allotment after Transfers | $389,921,295 | $358,323,946 | $248,216,643 |
| Net Transfer | $44,226,828 | (-$77,309,499) | $33,082,671 |
| Net Percent Change | 12.79 | (-17.75) | 15.38 |

### Preventive Health Services

### *(Title III-D of OAA; FY 2014: $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 and unintentional injury. There are many evidence-based health promotion programs that have been shown to be effective in reducing illness and injury, and improving older adult health. Preventive Health Services provide states and territories with the flexibility to allocate resources among the preventive health programs of their choice to best meet local needs. Priority has been given to providing services to those elders living in medically underserved areas of the state or who have the greatest economic need.

Due in large part to advances in public health and medical care, Americans are leading longer and more active lives. Average life expectancy has increased from less than 50 years at the turn of the 20th century to over 78 years today.[[50]](#footnote-50) On average, an American turning age 65 in 2014 can expect to live an additional 19.3 years.[[51]](#footnote-51) The population of older Americans is growing very rapidly and is projected to reach 9.1 million by the year 2030.[[52]](#footnote-52) One consequence of this increased longevity is the higher incidence of chronic diseases such as obesity, arthritis, diabetes, osteoporosis, and depression. Another consequence as the population ages, is the growing number of falls among older adults, and fall-related injuries, hospitalizations, and deaths.

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

* *Physical activity*: Maintaining (or increasing) physical activity is a necessary component for staying healthy and there are a number of evidence-based programs focused on empowering older adults to stay or become active. *EnhanceFitness* is a multi-component group exercise program that uses strength training, cardiovascular workouts, and balance and posture exercises, and has been shown to significantly reduce hospitalizations and healthcare costs for participants.[[53]](#footnote-53)
* *Falls prevention*: Falls prevention programs help older adult participants improve strength, balance, and mobility; provide education on how to avoid falls and reduce fall risk factors; and some involve medication reviews and provide home assessments of ways to reduce environmental hazards.
* *Medication management:* Medication management programs focus on reviewing the multitude of medications that older adults are prescribed, focusing especially on high-risk medications. Medication management programs have been shown to reduce unnecessary duplication of prescriptions and cardiovascular problems.[[54]](#footnote-54) These programs have also been shown to improve medication usage rates and decrease medication errors among older adults.[[55]](#footnote-55)
* *Depression Care Management:*  Depression is not a normal part of aging, yet it is a prevalent and disabling condition among older adults.  A 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 year.”[[56]](#footnote-56) Older adults with depression “visit the doctor and emergency room more, use more medication, and stay longer in the hospital” than those without depression.[[57]](#footnote-57)  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).[[58]](#footnote-58) 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.[[59]](#footnote-59)

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

### Chronic Disease Self-Management Education Programs

### (FY 2014: $7,086,000)

In the United States, sixty-six percent of all fee-for-service Medicare beneficiaries have multiple (two or more) chronic conditions,[[60]](#footnote-60) placing them at greater risk for premature death, poor functional status, unnecessary hospitalizations, adverse drug events, and nursing home placement.[[61]](#footnote-61),[[62]](#footnote-62),[[63]](#footnote-63) Chronic conditions also impact health care costs: 93 percent of Medicare expenditures are for beneficiaries with chronic conditions.[[64]](#footnote-64)

Chronic Disease Self-Management Education (CDSME) programs, such as the Stanford University Chronic Disease Self-Management Program (CDSMP), are low-cost, evidence-based disease prevention models that use state-of-the-art techniques, allowing 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.[[65]](#footnote-65) 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 (ASMP), and online versions of the CDSMP, ASMP and DSMP.

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

CDSMEs emphasize an individual’s role in managing his/her chronic condition(s). For example, the Stanford CDSMP in-person programs consist of a series of workshops that are conducted once a week for two and a half hours over six weeks in community settings such as churches, libraries, YW/MCAs, senior centers, public housing projects, 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. Topics covered in the workshop 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 2014, 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 partner 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 to embed and sustain these programs within the long-term services and supports and health care systems.

By September 30, 2014, grantees had reached a cumulative total of over 74,000 participants. During FY 2014, there were 39,274 participants and 29,100 “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, 68 percent were age 60 or older, 57 percent reported having multiple chronic conditions, 47 percent reported a disability, and 49 percent were racial/ethnic minorities.[[68]](#footnote-68)

Through financing from the FY 2014 PPHF, AoA also funded a National Resource Center to assist states, the aging, disability and public health networks, and their partners to increase access to and sustain evidence-based prevention programs, particularly CDSME programs which improve the health and quality of life of older adults and adults with disabilities. The Center also serves as a national clearinghouse of tools and information on CDSME.

The PPHF also financed a contract to maintain a national database on CDSME participants and to provide technical assistance to AAAs on sustaining evidence-based programs and sharpening general business acumen skills, 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.[[69]](#footnote-69) 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 conditions,[[70]](#footnote-70) decrease life expectancy,[[71]](#footnote-71) and increase overall healthcare costs.[[72]](#footnote-72) 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, there is no funding in the OAA specifically designated for prevention, intervention, and treatment services. States and communities have had to be creative in how they support these programs and services. Many aging network providers are working closely with behavioral health, primary care, and other partners to connect older adults with existing 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, Substance Abuse and Mental Health Administration (SAMHSA) block grants, private foundations, etc.).

In FY 2014, ACL and SAMHSA continued its partnership to provide technical assistance aimed at increasing states’ capacities for reaching older adults who are experiencing or are at-risk for behavioral health disorders. Most recently, they worked together to support the development of a variety of tangible materials, such as epidemiological profiles, issue briefs, and learning opportunities, such as webinars, and a series of five older adult policy academy regional meetings (attended by 43 states, the District of Columbia, Puerto Rico, and the Virgin Islands). The materials developed through this partnership have been successful in helping many states enhance their efforts to reach older adults who are experiencing or are at-risk for behavioral health disorders.

In June 2014, ACL partnered with CMS and the Veterans Health Administration (VHA) to issue a Funding Opportunity Announcement to help states plan for a No Wrong Door System (NWD) for all payers and all populations, including persons with mental and behavioral health issues. These NWD planning grants set 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.

### Falls Prevention Programs

***(FY 2014: $5,000,000)***

Falls can have a widespread and significant impact on health, can be deadly, and often result in high costs. One out of three older adults (those aged 65 or older) fall each year,[[73]](#footnote-73) but less than half talk to their healthcare providers about it.[[74]](#footnote-74) Among older adults, falls are the leading cause of both fatal and nonfatal injuries. In 2013, 2.5 million nonfatal falls among older adults were treated in emergency departments and more than 734,000 of these patients were hospitalized.[[75]](#footnote-75) In 2013, an estimated $34 billion a year was spent on treating older adults for the effects of falls.[[76]](#footnote-76)

Research has shown that falls and fall risks can be reduced through systematic risk identification and targeted intervention, including a combination of clinical and community-based interventions.[[77]](#footnote-77) Community-based falls prevention programs are low-cost, evidence-based disease prevention models that help reduce falls and/or fall risk factors in older adults, and potentially reduce their need for more costly medical care. Examples of these programs include: A Matter of Balance (MOB); Tai Chi: Moving for Better Balance (Tai Chi: MBB); Otago; and Stepping On. A recent CMS report to Congress indicated that MOB is associated with medical cost savings,[[78]](#footnote-78) and a recent study showed a positive return on investment for the implementation of Tai Chi: MBB, Stepping On, and Otago.[[79]](#footnote-79)

ACL received, for the first time, dedicated funding for falls prevention programs through the Prevention and Public Health Fund (PPHF) in FY2014. A competitive funding announcement was published, and applications for this opportunity were reviewed by external experts. A total of 14 grants were awarded; ten of the grants were awarded to domestic public and private nonprofit entities, including state agencies and community organizations, and four grants were awarded to tribes/tribal organizations. These two-year grants are intended to increase the number of older adults and adults with disabilities who participate in evidence-based community programs to reduce falls, fall risks, and fear of falling. All of the grantees identified underserved target populations and partnering organizations to reach these populations, such as those living in rural areas, and organizations serving ethnically-diverse and/or limited English speaking populations. The funding is also fostering the development of innovative funding arrangements to support these falls prevention programs, while embedding the programs into an integrated, sustainable evidence-based prevention program network. Grantees have a cumulative goal of reaching 17,000 older adults and/or adults with disabilities over the two-year period.

Through financing from the FY2014 PPHF, AoA also funded a National Falls Prevention Resource Center to work collaboratively – on behalf of the public, aging services network, and other stakeholders – to increase public education about the risks of falls and how to prevent them, as well as to support and stimulate the implementation and dissemination of evidence-based community programs and strategies that have been proven to reduce the incidence of falls among seniors.

### 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 ofproviding 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 2014, approximately 34.2 million adult caregivers provided uncompensated care to those 50 years of age and older.[[80]](#footnote-80) In other words, approximately 14.3 percent of all adults provided care to someone age 50 years and older.[[81]](#footnote-81) AARP estimated the economic cost of replacing unpaid caregiving in 2013 to be about $470 billion, an increase from $450 billion in 2009 (cost if that care had to be replaced with paid services).[[82]](#footnote-82) Another recent study by the Rand Corporation estimated the economic cost of replacing unpaid caregiving to be about $522 billion annually.[[83]](#footnote-83) The cost to replace that care with unskilled paid care at minimum wage was estimated at $221 billion, while replacing it with skilled nursing care could cost $642 billion annually. These estimates differ because of differences in methodology and definitions rather than contradictory data.

The demands of caregiving can be considerable. Recent research has demonstrated that caregiving tasks can, and do, go well beyond providing regular assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). A 2012 study by AARP and United Hospital Fund revealed that, while family caregivers continue to perform the traditional ADL/IADL supports, their roles are expanding dramatically to include performing medical/nursing tasks of the type and complexity typically seen only in hospitals and other acute care settings.[[84]](#footnote-84)

Such demands on family caregivers can lead to a breakdown of their health and can increase the risk for institutionalization of the care recipient. While research is mixed on the exact physical health impacts of family caregiving, several recent studies show that caregivers reporting mental and emotional strain as a result of their caregiving role are at higher risk for mortality.[[85]](#footnote-85),[[86]](#footnote-86),[[87]](#footnote-87) Providing support that makes caregiving easier for family caregivers, such as information, counseling and training, respite care, or supplemental services, is critical to sustaining caregivers’ ability to continue in that role. Eighty percent of the caregivers served by OAA programs report that these services allow them to provide care longer than they otherwise could.[[88]](#footnote-88)

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 3.2 million seniors (or a 22 percent increase between 2014 and 2020) needing caregiver assistance.[[89]](#footnote-89)

### National Family Caregiver Support Program

***(Title III-E of OAA; FY 2014: $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 older individuals which caregivers can access on their behalf.

The NFCSP provides a variety of supports to family and informal caregivers. In FY 2014, services provided included:[[90]](#footnote-90)

* *Access Assistance Services*, which provided nearly 1.4 million contacts to caregivers assisting them in locating services from a variety of public and private agencies.
* *Counseling and Training Services*, which provided over 125,000 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving.
* *Respite Care* Service, which provided nearly 67,000 caregivers with approximately 6.2 million hours of temporary relief – at home or in an adult day care or nursing home setting – from their caregiving responsibilities.

Family and other informal caregivers are the backbone of America’s long-term care system. On a daily basis, these individuals, the majority of whom are women, assist relatives and other loved ones with tasks ranging from personal care and homemaking to more complex health-related interventions like medication administration and wound care. Data from AoA’s 2015 National Survey of OAA Participants show that, nearly 20 percent of caregivers are assisting two or more individuals. Over 70 percent of Title III caregivers are 60 or older, making them more vulnerable to a decline in their own health, and 29 percent describe their own health as fair to poor.[[91]](#footnote-91) 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.[[92]](#footnote-92) Caregivers often experience conflicts between work and caregiving. Among working caregivers caring for a family member or friend, 60 percent report work impacts due to caregiving such as having to rearrange their work schedule, decrease their hours or take an unpaid leave in order to meet their caregiving responsibilities.[[93]](#footnote-93)

Survey results from caregivers served by the NFCSP indicate that the types of supports provided through the NFCSP can enable them to provide care longer (74 percent) while often continuing to work,[[94]](#footnote-94) 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.[[95]](#footnote-95)

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. Caregivers receiving services were asked whether the care recipient would have been able to live in the same residence if the services had not been available. Over 40 percent of the caregivers indicated that the care recipient would be unable to remain at home without the support services.[[96]](#footnote-96) Those respondents were then asked to identify where the care recipient would be living without services. A significant majority of those caregivers, nearly 80 percent, indicated that the care recipient would most likely be living in a nursing home or assisted living (see the chart below).[[97]](#footnote-97)

### Lifespan Respite Care

***(FY 2014: $2,342,000)***

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 2015 that 43.5 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: 19 percent report high levels of physical strain; 18 percent experience high levels of financial strain; and 38 percent of all family caregivers indicated they experienced high levels of emotional stress.[[98]](#footnote-98)

Numerous studies have shown respite to be among the most frequently requested supportive service for family caregivers.[[99]](#footnote-99) Respite is second only to direct financial assistance as a key policy priority of surveyed family caregivers. [[100]](#footnote-100) 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.[[101]](#footnote-101)

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.[[102]](#footnote-102) [[103]](#footnote-103) The population-specific barriers reported by caregivers include shortages of providers 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 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-two 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. 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. In FY 2014, 16 states received three-year grants to focus on the further integration of Lifespan Respite Programs in their long-term service and support systems while taking steps to ensure the long-term sustainability of program 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.

### Brain Health

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

Promoting brain health is critical to helping older adults maintain their cognition, independence and overall health. AoA joined the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) to develop a new Brain Health Resource (the Resource) to promote brain health among older adults, people with disabilities, and their caregivers. The Resource is available at: <http://www.acl.gov/Get_Help/BrainHealth/Index.aspx>.

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

There are three parts to the Brain Health Resource, with more on the way. Brain Health Basics helps people learn and teach others about the risks related to brain health and how to reduce them. Brain Injury helps people learn and teach others about how to prevent brain injury and how to get help when someone has one. Dementia explains how to create “dementia-capable” long-term services and supports at the state and local levels to help people who have Alzheimer’s disease and other types of dementia and their caregivers.

AoA, NIH, and CDC will continue their collaboration to expand and update the Brain Health Resource over time. This work was completed under the direction of the National Plan to Address Alzheimer’s Research, Care and Services.

### Alzheimer’s Disease Supportive Services Program (ADSSP)

***(FY 2014: $3,772)***

Established under Section 398 of the Public Health Services Act, as amended, (42 U.S.C. 280c-3), the Alzheimer’s Disease Supportive Services Program (ADSSP) funds competitive grants to states to expand the availability of dementia-capable community-level supportive services for evidence-based diagnostic and support services for persons with the Alzheimer’s disease and related dementias (ADRD), their families, and their caregivers. In its effort to improve home and community based services for persons with ADRD, AoA presently focuses its ADSSP resources toward building systems within states that are designed to ensure access to sustainable, integrated long-term services and supports that are capable of meeting the needs of persons with ADRD 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 also includes delivering of 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 ADRD and their families through provision of 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 ADSSP grant projects are designed to ensure that states provide people with ADRD and their family caregivers with access to a sustainable home and community-based services (HCBS) system that is dementia capable. Such a system meets the unique needs of each person with ADRD by: 1) identifying those with a possible dementia and recommending follow- up with a physician; 2) ensuring that the staff they encounter have appropriate training, understand the unique needs/services available and knowing how to communicate with them; and 3) providing quality, person-centered services that help them remain independent and safe in their communities. Presently, there are fourteen states implementing grants dedicated to the development of dementia-capable systems.

Through projects funded both in new ADSSP grant projects and those remaining from earlier program designs, 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 (NYUCI), a spousal caregiver support program that, in a randomized-control trial, delayed institutionalization of persons with dementia by an average of 557 days. 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 continuous quality improvement and evaluation of long- term services and supports. Family caregivers remain the major source of support for most people with ADRD. 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 to ensure the availability of dementia-capable community-based long-term services and supports. These important services, and the health care systems through which they are delivered, must be efficient and effectively coordinated. The ADSSP program provides states the opportunity and resources to develop the necessary dementia-capable systems and direct services in support of persons living with ADRD and their caregivers to better ensure that 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.

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

***(FY 2014 - $10,500,000)***

In FY 2014, ACL received resources from the Prevention and Public Health Funds (PPHF-2014) within the Patient Protection and Affordable Care Act (PPACA) to fund cooperative agreements designed to fill identified gaps in long-term services and supports (LTSS) services for persons living with ADRD and their caregivers. The program is open to states and community-based entities that are operating within an existing dementia-capable system through which persons with ADRD and their caregivers receive quality, person-centered services that help them remain independent and safe in their communities.

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

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

All grantees are required to implement programs that contain components addressing each of the above referenced gaps.

In 2014, ten unique organizations, which included states, local governments and community-based organizations, received cooperative agreements to implement programs in the communities they serve. Each funded program includes substantial direct service requirements and is designed to meet the needs of their local community. Through targeted partnerships and community engagement, grantees are able to implement a broad range of services and supports to persons with ADRD and their caregivers. Examples of program activities include, but are not limited to, peer support, phone-based support groups for caregivers, evidence-based behavior management, respite expansion, and gatekeeper programs.

## PART II: OLDER AMERICAN INDIANS, ALASKA NATIVES

## & NATIVE HAWAIIANS

### Nutrition and Supportive Services

***(FY 2014: $26,158,000)***

Native American Nutrition and Supportive Services provides grants to eligible tribal organizations for the delivery of nutrition and home and community-based supportive services to Native American, Alaska Native, and Native Hawaiian elders. An estimated 803,000 persons age 60 and over identify themselves as Native American or Alaska Native alone or in combination with another racial group.[[104]](#footnote-104) Over 295,000 of those elders identify as Native American or Alaska Native with no other racial group.[[105]](#footnote-105)

In the United States, the number of adults aged 65 years or older increased by 14.8 percent (5.2

million) between 2000 and 2010. This growth of the overall older adult population is also evident in Indian Country. Between 2000 and 2010, the number of older American Indian and Alaska Native (AI/AN) adults increased by 40.5 percent, a growth that is 2.7 times greater than that of the overall population of older adults over the same 10-year period.[[106]](#footnote-106) In addition, this rapidly growing population is also experiencing some of the highest rates of disability,[[107]](#footnote-107) chronic disease, and poverty[[108]](#footnote-108) 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 more than one-quarter (28 percent) of eligible Native American seniors in participating tribal organizations, home-delivered meals reach 20 percent of such persons, and supportive services reach 46 percent of such persons.[[109]](#footnote-109) These programs, which can help to reduce the need for costly nursing home care and medical interventions, are responsive to the cultural diversity of Native American communities and are an important part of each community’s comprehensive services.

Services provided by this program in FY 2014 include:[[110]](#footnote-110)

* *Transportation Services*, which provided over 750,000 rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical activities.
* *Home-Delivered Nutrition Services,* under which over 2.6 million meals were provided to over 42,000 homebound Native American elders; the program also provides critical social contacts that help to reduce the risk of depression and isolation experienced by many home-bound Native American elders.
* *Congregate Nutrition Services*, which provided over 2.5 million meals to over 60,000 Native American elders in community-based settings, as well as an opportunity for elders to socialize and participate in a variety of activities, including cultural and wellness programs.
* *Information, Referral and Outreach Services*, which provided over 900,000 hours of outreach and information on services and programs to Native American elders and their families, thereby, empowering them to make informed choices about their service and care needs.

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

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

### Caregiver Support Services

***(FY 2014: $6,031,000)***

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

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

Grants assist American Indian, Alaska Native and Native Hawaiian families caring for older relatives with chronic illness or disability and grandparents caring for grandchildren. The program provides a variety of direct services that meet a range of caregiver needs, including information and outreach, access assistance, individual counseling, support groups and training, respite care, and other supplemental services. In FY 2014, Tribal grantees provided over 80,000 hours of respite care, just over 15,000 hours of caregiver training, and assisted nearly 20,000 caregivers to access needed services.[[111]](#footnote-111) 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.

## 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.[[112]](#footnote-112) 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.[[113]](#footnote-113) 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.[[114]](#footnote-114) 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.[[115]](#footnote-115) 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.

### Prevention of Elder Abuse and Neglect

***(FY 2014: $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 2014 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 $30 million of expenditures for elder abuse prevention services come from non-OAA funds, a ratio of nearly $6.50 of non-OAA funds for every $1 investment of federal funds.[[116]](#footnote-116)

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

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 2014, the NCEA:

* Responded to over 450 individual public inquiries and requests for information regarding elder abuse and elder abuse in Indian Country.
* Provided cost-effective trainings to over 600 professionals though live webcast forums on issues relevant to elder justice, trained over 1,000 professionals through presentations at national conferences, and created and disseminated three research-themed training podcasts to promote continual learning.
* Continued to support systems change by identifying 342 local elder justice community coalitions and reaching out to those communities to learn how they leverage local resources and expertise to prevent and combat elder abuse, neglect, and exploitation, as well as to offer technical assistance on operating, invigorating, and sustaining coalitions; and compiling the first comprehensive inventory of tribal elder abuse codes, currently consisting of 48 codes from 17 states, the purpose of which is to provide best practice examples to other tribes in developing new codes to address elder abuse, neglect, and exploitation.

### National Legal Assistance and Support Projects

### National Legal Resource Center

***(FY 2014: $653,677)***

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 an older individual’s home through foreclosure; protecting against consumer scams and creditor harassment; addressing elder abuse in the community and in long-term care facilities; and difficulties in accessing public benefits essential to financial security, independence, and health. The NLRC also provides technical assistance on the efficient, cost-effective, and targeted provision of state-wide legal and elder rights advocacy services.

In FY 2014, 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 30 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 are 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 2014, 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**](http://www.nlrc.gov).

### Model Approaches to Statewide Legal Assistance Systems

***(FY 2014: $1,862,245)***

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

Model Approaches features strong leadership at the state level to achieve its service delivery integration objectives. State legal assistance developers have demonstrated effective leadership in incorporating the use of SLHs and other low-cost mechanisms into the state legal services 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 older persons in accessing quality legal services to ensure their rights and enhance their independence and financial security. In 2014, Model Approaches projects assisted 18,419 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 individuals 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 couple a mortgage modification, which resulted in a 20 percent 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 older woman with very limited English speaking proficiency, 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 75 percent of older clients having incomes at or below 200 percent of the federal poverty guidelines. Minority[[117]](#footnote-117) clients receiving assistance through SLHs in the last reporting period constituted 26 percent of all clients served. These figures illustrate the effectiveness of Model Approaches states in reaching key target populations under the OAA with much needed “priority” legal assistance.

An important purpose of the Model Approaches demonstrations is to position SLHs as coordinated and essential components of high quality and high impact legal service delivery systems that effectively target scarce resources to older persons most in need. Model Approaches partners across the country recognize the enormous value of the network relationships that have been forged in pursuit of essential project goals and objectives. Several Model Approaches states with completed grant award cycles (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 2014, 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 2014: $1,602,007)***

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

Today, there are more than 700,000 private (as well as thousands of public) pension and retirement plans in the United States. Thousands of Americans reach retirement age each year, only to be told that they will not receive the pension benefits they expected. Because individuals have generally worked for several employers, which may have merged, sold their plans, or gone bankrupt, it is very difficult for most 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 30 states and a technical assistance resource center to assist older Americans in accessing information about their retirement benefits and to help them negotiate with former employers or pension plans for due compensation. The projects help with cases that private pension professionals are reluctant to take, where the benefits in question are small, as is often the case with low-income workers and those with limited English proficiency, but to whom these modest amounts make a huge difference in maintaining their financial security and independence.

Data show that since the program’s inception in 1993, the Pension Counseling projects have recovered $206 million in retirement benefits for more than 52,000 retirees. With a relatively small federal investment, the program has brought in a return of more than $9.00 for every Federal dollar invested in the program. These recoveries demonstrate that pension counseling is not only necessary, but that it can be provided efficiently and effectively.

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

* A low-income widow contacted one of the regional counseling projects when she had trouble communicating with her recently-deceased husband’s pension plan representative. Her husband had passed away at a relatively young age and had not yet retired. The pension plan representative repeatedly failed to respond to the widow’s requests for information, but when the counseling project stepped in, the plan confirmed that the surviving spouse was indeed entitled to a pre-retirement survivor annuity. The widow, who is now the sole provider and caretaker for her two young children, will receive this much-needed survivor annuity for the duration of her life.
* A retiree contacted one of the regional counseling projects because he’d received notification from his pension plan that he had allegedly been overpaid pension benefits. Although this was through no fault of his own, and was entirely the result of careless administrative calculations by the plan, the law does allow pension plans to recover these payments. The plan was demanding that the retiree return all of the money, but the counseling project was able to advocate on his behalf, pointing out the significant financial hardship this would create. The plan agreed to reduce the overpayment recoupment from $107 to $43 per month and to waive any recovery against a survivor benefit. This reflects a projected savings of more than $17,000 over the client’s remaining life.
* An individual was advised by his employer that he had not earned enough service credit to vest in the company pension plan and was therefore ineligible for a pension benefit. He then contacted a regional pension counseling project, whose staff reviewed all the relevant documentation and determined that he was indeed eligible for a pension benefit. This individual received a retroactive payment and a lifetime monthly benefit which, though relatively small, doubled his monthly income, significantly impacting his economic security and quality of life.
* Another regional pension counseling project assisted a woman who had been separated – but not divorced – and whose husband had misrepresented his status as single in order to receive a higher benefit amount, meaning that his spouse would not be provided with benefits in the event he predeceased her. Because there was no evidence that the wife had waived her rights in writing, the project was able to obtain a reversal of the initial determination and a change of benefits to a joint and survivor annuity.

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 2014: $8,910,405)***

The Senior Medicare Patrol (SMP) program serves a unique role in the HHS’ efforts to identify and prevent health care fraud in the Medicare program. 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. These data are published as a report on the SMP program. This report for Calendar Year 2014 shows that SMP projects:

* Had 5,194 active volunteers who worked 117,300 hours to educate beneficiaries about how to prevent Medicare and Medicaid fraud;
* Educated over 450,720 beneficiaries in 14,618 group education sessions and held 202,064 one-on-one counseling sessions with or on behalf of beneficiaries;
* Conducted 12,190 community outreach education events reaching more than 1 million people; and
* Received nearly 100,000 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 4.9 million beneficiaries in approximately 138,367 group education sessions and held over 1.6 million one-on-one counseling sessions;
* Conducted 196,225 community outreach education events; and
* Documented over $122 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 2014: $6,590,974)***

AoA 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 SMP program.

HCFAC funds support the SMP program in two ways:

Firstly, a varying amount of HCFAC funding is set aside each year to provide additional funds to the SMP grantees. In FY 2014, the funding for SMP grantees was $3,212,652 which was a 56% decrease from FY 2013. In FY 2015, the funding rose to $5,331,814.

Secondly, HCFAC funds provide the administrative funding to support the SMP program. In FY 2014, HCFAC administrative funding was $3,378,322. Specifically, funding is used for the AoA staff to oversee the program nationally and to work with the SMP projects. In addition to AoA staff time, the HCFAC administrative funds provide the national data system, SMART FACTS, which collects the SMP data used for the annual OIG report and is a fraud reporting tool. The 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;
* outreach strategies for educating minority[[118]](#footnote-118) 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.

### Long-Term Care Ombudsman Program

**(FY 2014:$15,862,868)**[[119]](#footnote-119)

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

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

The OAA requires Ombudsman programs to:

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

#### Improving and Evaluating Ombudsman Program Services

ACL has been undertaking two historic activities to improve the quality and evaluate the effectiveness of Ombudsman program services to residents: 1) promulgation of the Ombudsman program rule and 2) planning for a program evaluation.

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

In February 2015, ACL published regulations to guide states in their implementation of the Ombudsman program and provide clarity on a number of provisions of the OAA (45 CFR Part 1327). Since the program’s creation in the 1970s, states have been required to develop and operate Ombudsman programs but, in the absence of regulations, there has been significant variation in the effectiveness of these programs among states. The development of more formal guidance to improve consistency and quality of program implementation had been called for by members of Congress, a wide variety of stakeholders, reports by the Institute of Medicine and HHS/OIG, and media reports.

The rule will become effective on July 1, 2016, providing states with time to evaluate their operations and make changes where necessary. Meanwhile, ACL staff and the National Ombudsman Resource Center have been providing training, technical assistance and support to facilitate implementation of the rule. Many states have reported to ACL that they have begun the process of reviewing their state laws and policies to determine if they meet the requirements of the new rule. ACL anticipates that states’ implementation of this rule will strengthen the ability of Ombudsman programs to be effective problem-solvers for older adults and people with disabilities who live in our nation’s long-term care facilities.

2. Evaluation of the Ombudsman Program

Not since the Institute of Medicine’s 1995 report,[[120]](#footnote-120) has there been a comprehensive, national evaluation of the Ombudsman program. ACL completed its evaluation design in 2013 and is developing plans for an initial evaluation to better understand service delivery and eventually to evaluate program impact and efficiency.

#### Complaint Investigation and Resolution

Ombudsman programs provide an alternative dispute resolution service, resolving complaints with or on behalf of long-term care facility residents.

* Ombudsman programs nationwide completed resolution work on 191,553 complaints.[[121]](#footnote-121)
* 75 percent of these complaints were resolved (or partially resolved) to the satisfaction of the resident or complainant.

* Of the 127,721 cases closed by Ombudsman programs,[[122]](#footnote-122) 91,225 (73 percent) were associated with nursing facility settings. Of the remaining cases, 31,591 (25 percent) were related to board and care, assisted living or other residential care communities; and 2,826 (two percent) were associated with non-facility settings or services to facility residents by an outside provider.
* Most cases were initiated by residents themselves or friends and relatives of residents. Residents initiated 42 percent of cases in nursing facilities and 33 percent in board and care, assisted living and other residential care communities.
* Ombudsman programs proactively identified issues in 12 percent of cases in all settings.

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

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

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

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

#### Improper Eviction/Inadequate Discharge Planning Complaints: A Closer Look at a Growing and Troubling Trend

Ombudsman programs are often the primary responders to complaints about eviction or inadequate discharge/planning. This complaint has been the most frequent complaint in nursing homes for the past three years, and also the most frequent complaint in board and care, assisted living, and other residential care communities for the first time in 2014.

Ombudsmen report that the number of eviction/discharge complaints is increasing due to:

* Increased complexity of residents’ needs, especially for individuals living with dementia or behavioral health needs, and inadequate specialized staff training to meet those needs.
* Lack of appropriate, affordable services and housing in community-based settings, resulting in placements that do not meet the resident needs.
* Lack of understanding of Medicaid financial eligibility requirements by the resident or resident representative, resulting in lack of a payment source for the resident.
* Resident representative failure to use the resident’s funds to pay for facility services.

Ombudsmen report that an eviction can cause displacement from the resident’s community, family and friends or even homelessness. When facilities transfer an individual to a hospital and then refuse to permit the resident to return, this may cause costly and avoidable hospital stays. These complaints are complicated by several barriers to satisfactory resolution, including discharge notices issued by facilities that do not clearly explain available protections and appeal rights, as well as inadequate resources (including legal services) to assist residents to respond to and appeal the eviction.

In response to these complaints, Ombudsman programs undertake strategies to prevent involuntary discharges, including: seeking legislative and regulatory changes, promoting coordination among agencies responsible for serving people who need LTSS and behavioral health services, working with the state Medicaid agency to reduce barriers for individuals applying for Medicaid, and making referrals to the state licensing and certification agency regarding improper discharge planning. One Ombudsman successfully requested the state legislature to create a “discharge specialist” to thoroughly address each discharge notice received, enabling focused attention to residents and their families and assisting with appeals and other remedies.

#### Ombudsman Activities

In addition to resolving complaints, Ombudsman programs work to prevent problems and perform other services. In FY 2014, Ombudsman program staff and volunteers nationwide provided:

* Routine visits to ensure that residents have regular access to ombudsman services, visiting residents of 69 percent of nursing facilities and 29 percent of board and care, assisted living, and other residential care communities at least quarterly.
* 370,310 consultations and information to individuals, including on: finding long-term services and supports options; Medicaid eligibility; discharge and eviction rights; and other federal and state policies impacting residents.
* 121,063 consultations to long-term care facility staff, including on: residents’ rights, person-centered care practices, and discharge and eviction issues.
* Resident and family council support, providing technical assistance, training and information to resident councils (22,214 sessions) and family councils (2,230 sessions);
* Training of long-term care facility staff (5,269 sessions);
* Community education (12,023 sessions); and
* Coordination with licensing and survey entities, participating in 16,414 facility survey-related activities as resident advocates.

#### Promoting Resident Self-Advocacy

Ombudsman programs promote resident self-advocacy. For example, one Ombudsman program supported a grassroots organization that connects facility residents across the state via monthly conference calls to identify issues and strategize for improvements. Residents worked on issues including: pain management, impact on residents of personal alarms, adequacy of personal needs allowance for Medicaid recipients, and fundraising for charitable organizations.

A resident of an assisted living community contacted the Ombudsman program, fearful that she was about to be displaced due to changes being made by new management. The resident feared that by speaking up for herself she could be evicted, and she had communication challenges due to her MS diagnosis. She asked an ombudsman representative to accompany her to a care planning meeting as staff assessed their ability to meet her needs. The ombudsman representative accompanied the resident, encouraging her to speak up for herself in the meeting despite her anxiety and disabilities. Afterwards, the resident credited the ombudsman representative’s support in giving her the confidence to communicate her needs to staff, indicating that she felt she had been given back her voice.

#### Systems Advocacy

A vital Ombudsman program function is systems advocacy, including analyzing, commenting on and recommending changes in laws, regulations, and government policies and actions to benefit residents. For example, Ombudsmen reported:

* Participating in multi-disciplinary task forces to develop comprehensive strategies to prevent and respond to abuse, neglect and exploitation.
* Convening stakeholders to promote educational strategies to maximize the autonomy and self-determination of residents with guardians.
* Supporting the Centers for Medicare and Medicaid Services (CMS) initiative to reduce inappropriate use of antipsychotic drugs in nursing homes. For example, one state coalition -- chaired by the Ombudsman program and in collaboration with the Quality Improvement Organization -- conducted webinars for physicians, statewide training for direct care staff, family education, and a presentation before the state legislature. The nursing homes in this state have achieved a 33.3% reduction in the use of antipsychotics, the highest rate in the country.

Combating Financial Exploitation

One local Ombudsman entity hired an attorney to focus on financial exploitation and surrogate decision-maker issues. According to the Ombudsman: “The addition of an attorney to the ombudsman team has brought about real change for our long-term care residents. In fourteen of the cases, property was recovered or facility bills paid. In virtually all of these ‘wins,’ the key to recovery was the work of the local ombudsman on the ground in conjunction with the attorney’s involvement. The added tool of someone willing and capable of going to court on behalf of exploited residents has improved both the recovery rate and also relationships with others in the system, including law enforcement, prosecutors, and protective services. The track record of success has also brought an increase in the number of referrals. While increased reporting is a good thing, unfortunately it also highlights the magnitude of the problem and the insufficiency of access to skilled legal services to combat it.”

#### Providing Ombudsman Services

There are 53 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. There are 554 designated local Ombudsman entities across the nation.

In FY 2014, 1,294 full-time equivalent staff and 8,155 volunteers -- all trained and designated to investigate and resolve complaints -- provided Ombudsman program services to residents. An additional 4,000 volunteers also served residents or assisted in program operations in ways other than complaint resolution.

Total FY 2014 funding from all sources nationwide was $94,038,915, an overall increase of 1.6 percent from the FY 2013 level. The federal government is the primary entity funding the Ombudsman Program, providing 56 percent of total funding in FY 2014. States provided 39 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 2014 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, assisted living, and other residential care communities (known by various names under state laws). While the number of beds and facilities in nursing homes are relatively steady, the growth of beds in these other residential settings is steadily increasing. Federal policy continues to accelerate the growth of home and community-based LTSS. In most states, Medicaid funds home and community-based services (HCBS) that provide an alternative to institutional settings. Ombudsman programs have found their work in these settings increasing dramatically.

#### National Long-Term Care Ombudsman Resource Center Activities

In order to effectively problem-solve with and for residents, Ombudsman programs must remain up-to-date on the latest long-term care developments. Therefore, ACL supports the National Ombudsman Resource Center (NORC), which provides training, technical assistance, and program management expertise to Ombudsman programs. In FY 2014, the NORC was operated by the National Consumer Voice for Quality Long-Term Care, in conjunction with the National Association of States United for Aging and Disabilities (NASUAD).

In FY 2014, NORC trained Ombudsman programs on such issues as:

* Volunteer management training and technical assistance;
* Strategies to combat illegal evictions;
* Ombudsman services in managed LTSS;
* Ombudsman services in HCBS settings;
* ACL’s final rule for State Long-Term Care Ombudsman Programs (issued February 2015).

Additionally, the NORC provided quarterly orientation training for all new Ombudsmen. It developed resource materials, the NORC website (www.ltcombudsman.org), and monthly newsletters, customized for all Ombudsman program staff and volunteers.

#### Program Results and Challenges

1. Volunteers help the program engage the local community

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

1. Ombudsman programs solve problems at the facility level

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

After losing both of his legs to diabetes and experiencing a debilitating stroke, Mr. R. was at a hopeless and helpless place in life. When an ombudsman representative visited him, she noticed that his room was dark, and he did not seem engaged in any activities or interactions with others. When she asked him about assessments, care planning, and therapy, Mr. R. stated he was aware of these services, but felt his participation was useless. The ombudsman representative visited regularly and continuously encouraged Mr. R to work with the care team to set goals for himself.

Eventually, Mr. R chose a goal of getting out of bed and dressing each day. As he became more confident, the ombudsman representative encouraged him to write down his goals and discuss his goals and concerns with facility staff. She taught Mr. R about his rights and holding the facility accountable for giving him quality care. She introduced Mr. R to key staff members at the facility and helped describe their role in his care. The more Mr. R was motivated, the more everyone was motivated. Together they worked to get Mr. R new glasses, physical therapy, and a better wheelchair to improve his mobility. As a result, Mr. R. began to get out of his room and participate more in life, activities and therapy. He began to increase in strength and set a goal to meet the criteria for fitted prosthetics.

In Mr. R’s words: “If (the ombudsman) was not there I don’t think I would be here. I was feeling extremely bad and was wanting to get out of this world. Now I want to get back to the world. I gotta do the work. I want to get out of that seat and in legs (prosthetics). I want to get where I am back in my life and out in the world.”

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

Federal and state policy changes -- including the promotion of Medicaid HCBS waivers, the rapid growth of Medicaid managed LTSS, and demonstration projects to serve persons receiving both Medicare and Medicaid (i.e. Financial Alignment Initiative, sometimes called the “duals demonstrations”) -- are creating new challenges and opportunities for Ombudsman programs. As these services expand and provide more options for residents, Ombudsmen work to ensure that their interests and concerns are represented. Currently 13 states have expanded their laws to provide for Ombudsman services to individuals receiving in-home care, while other programs provide Ombudsman services to individuals participating in Medicaid or in Medicare-Medicaid plans offered under the Financial Alignment Initiative. Many have been engaged in systems advocacy as states develop transition plans to implement the CMS HCBS settings rule (issued January 2014) or new models of Medicaid managed LTSS.

1. 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.

1. Ombudsman programs leverage federal dollars

Federal funds leveraged resources from other sources for ombudsman programs. During FY 2014, 46 percent of program expenditures came from non-federal sources. The Ombudsman program’s significant use of volunteers, further leverages limited resources. The value of volunteer time contributed to the program nationwide in FY 2014 was over $18 million.[[123]](#footnote-123)

## 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 older adults and people with disabilities so that they can access the services necessary for their independence. ADRCs serve as community-level “one stop shop” entry points into long-term care, including 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 2014: $6,067,000)*

Aging and Disability Resource Centers (ADRCs)/No Wrong Door System[[124]](#footnote-124) supports state efforts to help individuals access long-term services and supports (LTSS) as well as develop more efficient and cost-effective access systems into LTSS at the community level. The current LTSS system involves numerous funding streams administered by multiple federal, state and local agencies using different access processes involving screening, intake, needs assessment, service planning, and eligibility determination. Individuals seeking to access LTSS frequently find themselves confronted with a bewildering maze of organizations and bureaucratic requirements at a time when they are vulnerable or in crisis, which often results in people making decisions based on incomplete, and sometimes inaccurate, information about their options. This can lead to decisions to purchase and/or use LTSS options that are less than optimal for the individual and more expensive than necessary, including decisions to use expensive options such as nursing facility care that can quickly exhaust an individual’s personal resources and result in their spending down to Medicaid.

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

Another major development in the evolution of the ADRC model occurred in 2009 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 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 ACL/CMS/VHA vision is that each state will have a single statewide NWD System to LTSS for all populations and all payers. The NWD System functions include:

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

#### Public Outreach and Coordination with Key Referral Sources

To be a “visible” source of individualized counseling and help with accessing LTSS, the NWD system must proactively engage in public education to promote broad public awareness of the resources that are available. The goal is for citizens 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 determine whether a person is permanently institutionalized or transitioned back to the community. Among the key sources of referral the NWD system must have formal linkages with include information and referral entities, nursing homes and other institutions, acute care systems, and VA medical Centers.

#### Person-Centered Counseling

Person-Centered Counseling (PCC) is the NWD system term for person-centered planning which is an approach for working with individuals that is now being required in the LTSS system under multiple Medicaid regulations, including the person-centered planning provisions in the January 2014 rules for home and community-based services provided through waivers under §1915(c) or through state plans under §1915(i) of the Social Security Act.

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

#### Streamlined Access to Public LTSS Programs

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

The NWD system person-centered counselors can help ensure applications are completely filled out with all the information needed when the applicant goes to 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 envisioned by ACL, CMS and VHA. The NWD system is a critical component of any well-developed, person-centered state 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. NWD system should also include 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.

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

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

Through a No Wrong Door system, ADRCs will continue working with the Veterans Health Administration (VHA) to serve clients under the current ACL/VHA partnership. In FY 2009, the VHA and ACL 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 VHA made a strategic decision to use the aging and disability network infrastructure – including using the ADRCs 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. The VHA’s intent is to continue to expand access to this program with the goal of eventually moving nationwide. HHS and the VHA have worked together to develop program guidelines/national standards, web-based tools to track program activities and implement a national training program for the VD-HCBS. Currently, 31 states plus the District of Columbia and Puerto Rico are operating VD-HCBS programs with 55 operational VAMCs, 109 operational AAA/ADRCs and over 3,200 veterans served

### Aging Network Support Program Activities

*(FY 2014: $7,406,000)*

Aging Network Support Activities provide competitive grants and contracts to support ongoing activities of national significance which help older adults and their families to obtain information about their care options and benefits, 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, institutions of higher learning, and other organizations representing and/or serving older people, including faith-based organizations. Grantees are required to provide a match equal to 25 percent of the project’s total cost. Project proposals are reviewed by external experts, and project awards are made for periods of one to four years.

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

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

#### 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 252,340 callers and 425,522 website users in FY2014.

#### 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, 2015, 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 nearly 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 master’s level social workers are available at all times.  The Call Center is accessible by telephone, website or e-mail at no cost to the caller. Services focus on consumers, not professionals. Information provided may include basic information on caregiving; handling legal issues; resources for long-distance caregiving; and tips for working with the medical community.  Local community-based organizations are directly involved to ensure local, on-the-ground capacity to respond to emergencies and on-going needs of Alzheimer’s patients, their families, and informal caregivers.  The Call Center has multilingual capacity and responds to inquiries in at least 140 languages through its own bilingual staff and with the use of a language interpretation service.

#### National Education and Resource Center on Women and Retirement Planning

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

#### National Minority Aging Organizations Technical Assistance Centers

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

Each NMAO project pilots practical, community-based interventions for reaching older individuals who experience barriers to accessing home and community-based services. Interventions focus on barriers due to language and low literacy, as well as those directly related to cultural diversity. Strategies developed under this program incorporate the latest technology and facilitate the generation and dissemination of knowledge in forms that can assist racial and ethnic minority older individuals to practice positive health behaviors and strengthen their capacity to maintain active, independent life styles. Examples of products resulting from these grants include a chronic disease self-management curricula and manual tailored for racial and ethnic minority older persons, a referral dataset of chronic disease self-management workshops, and a culturally appropriate caregiver manual /toolkit for American Indian and Alaskan Native caregivers caring for elders with dementia.

**THIS PAGE INTENTIONALLY LEFT BLANK**

# Appendix

**Formula Grant Funding**

**Allocation by**

**State, Territory and**

**Tribal Organization**

**U.S. Administration on Aging**

**Department of Health and Human Services**

**THIS PAGE INTENTIONALLY LEFT BLANK**

| **State** | **Supportive Services** | **Congregate Meals** | **Home Meals** | **Preventive Services** | **NFCSP** | **Total Title III** |
| --- | --- | --- | --- | --- | --- | --- |
| Alabama | $5,348,272  | $6,555,683  | $3,335,440  | $312,667  | $2,215,784  | $17,767,846  |
| Alaska | $1,728,473  | $2,178,167  | $1,075,670  | $98,661  | $723,681  | $5,804,652  |
| Arizona | $6,505,775  | $8,955,525  | $4,556,446  | $380,335  | $3,116,605  | $23,514,686  |
| Arkansas | $3,465,174  | $4,163,564  | $2,077,421  | $198,565  | $1,414,772  | $11,319,496  |
| California | $34,225,074  | $43,518,332  | $22,141,521  | $2,000,831  | $14,764,434  | $116,650,192  |
| Colorado | $4,112,276  | $6,019,090  | $3,062,429  | $240,408  | $1,886,622  | $15,320,825  |
| Connecticut | $4,359,272  | $5,241,452  | $2,508,765  | $245,103  | $1,728,760  | $14,083,352  |
| Delaware | $1,728,473  | $2,178,167  | $1,075,670  | $98,661  | $723,681  | $5,804,652  |
| District of Columbia | $1,728,473  | $2,178,167  | $1,075,670  | $98,661  | $723,681  | $5,804,652  |
| Florida | $25,003,372  | $31,170,475  | $15,859,103  | $1,461,725  | $11,594,573  | $85,089,248  |
| Georgia | $7,828,303  | $11,046,885  | $5,620,501  | $457,651  | $3,469,595  | $28,422,935  |
| Hawaii | $1,728,473  | $2,178,167  | $1,075,670  | $98,661  | $723,681  | $5,804,652  |
| Idaho | $1,728,473  | $2,178,167  | $1,075,670  | $98,661  | $723,681  | $5,804,652  |
| Illinois | $14,376,273  | $17,286,541  | $8,116,594  | $789,400  | $5,495,916  | $46,064,724  |
| Indiana | $6,856,515  | $8,376,701  | $4,261,949  | $400,839  | $2,861,506  | $22,757,510  |
| Iowa | $4,217,281  | $5,081,501  | $2,202,744  | $217,960  | $1,583,975  | $13,303,461  |
| Kansas | $3,397,783  | $4,089,903  | $1,871,679  | $179,901  | $1,301,081  | $10,840,347  |
| Kentucky | $4,692,759  | $5,830,673  | $2,966,565  | $274,344  | $1,943,240  | $15,707,581  |
| Louisiana | $4,746,827  | $5,669,606  | $2,884,616  | $277,505  | $1,882,470  | $15,461,024  |
| Maine | $1,728,473  | $2,178,167  | $1,085,710  | $98,851  | $723,681  | $5,814,882  |
| Maryland | $5,797,506  | $7,293,435  | $3,710,798  | $338,929  | $2,406,406  | $19,547,074  |
| Massachusetts | $8,125,101  | $9,780,267  | $4,559,119  | $436,823  | $3,112,034  | $26,013,344  |
| Michigan | $11,140,548  | $13,614,899  | $6,927,071  | $651,289  | $4,637,617  | $36,971,424  |
| Minnesota | $5,443,395  | $6,880,685  | $3,500,797  | $318,227  | $2,384,100  | $18,527,204  |
| Mississippi | $3,239,225  | $3,891,114  | $1,933,706  | $184,175  | $1,286,424  | $10,534,644  |
| Missouri | $7,045,594  | $8,467,047  | $4,173,227  | $397,206  | $2,862,237  | $22,945,311  |
| Montana | $1,728,473  | $2,178,167  | $1,075,670  | $98,661  | $723,681  | $5,804,652  |
| Nebraska | $2,271,457  | $2,738,802  | $1,222,351  | $117,214  | $859,334  | $7,209,158  |
| Nevada | $2,436,202  | $3,443,786  | $1,752,150  | $142,423  | $1,091,617  | $8,866,178  |
| New Hampshire | $1,728,473  | $2,178,167  | $1,075,670  | $98,661  | $723,681  | $5,804,652  |
| New Jersey | $10,157,963  | $12,190,488  | $5,908,992  | $582,736  | $4,061,775  | $32,901,954  |
| New Mexico | $2,045,047  | $2,745,810  | $1,397,030  | $119,555  | $912,573  | $7,220,015  |
| New York | $24,034,966  | $28,963,855  | $13,082,577  | $1,291,893  | $8,994,285  | $76,367,576  |
| North Carolina | $9,273,064  | $12,700,854  | $6,462,017  | $542,114  | $4,212,980  | $33,191,029  |
| North Dakota | $1,728,473  | $2,178,167  | $1,075,670  | $98,661  | $723,681  | $5,804,652  |
| Ohio | $13,675,438  | $16,393,785  | $8,145,117  | $784,443  | $5,574,655  | $44,573,438  |
| Oklahoma | $4,234,511  | $5,080,736  | $2,524,832  | $241,588  | $1,710,491  | $13,792,158  |
| Oregon | $4,092,068  | $5,545,438  | $2,821,441  | $239,227  | $1,828,462  | $14,526,636  |
| Pennsylvania | $17,697,032  | $21,279,716  | $9,558,034  | $955,875  | $6,780,143  | $56,270,800  |
| Rhode Island | $1,728,473  | $2,178,167  | $1,075,670  | $98,661  | $723,681  | $5,804,652  |
| South Carolina | $4,742,517  | $6,565,955  | $3,340,666  | $277,253  | $2,134,663  | $17,061,054  |
| South Dakota | $1,728,473  | $2,178,167  | $1,075,670  | $98,661  | $723,681  | $5,804,652  |
| Tennessee | $6,691,049  | $8,666,047  | $4,409,164  | $391,166  | $2,875,433  | $23,032,859  |
| Texas | $20,118,099  | $27,242,320  | $13,860,513  | $1,176,127  | $8,880,068  | $71,277,127  |
| Utah | $1,847,672  | $2,573,508  | $1,309,366  | $108,017  | $857,154  | $6,695,717  |
| Vermont | $1,728,473  | $2,178,167  | $1,075,670  | $98,661  | $723,681  | $5,804,652  |
| Virginia | $7,784,487  | $10,126,333  | $5,152,137  | $455,090  | $3,315,098  | $26,833,145  |
| Washington | $6,384,056  | $8,745,109  | $4,449,390  | $373,219  | $2,820,547  | $22,772,321  |
| West Virginia | $2,745,160  | $3,305,947  | $1,497,781  | $143,714  | $1,001,865  | $8,694,467  |
| Wisconsin | $6,325,004  | $7,739,100  | $3,937,546  | $367,360  | $2,700,157  | $21,069,167  |
| Wyoming | $1,728,473  | $2,178,167  | $1,075,670  | $98,661  | $723,681  | $5,804,652  |
| American Samoa | $467,484  | $594,843  | $136,498  | $12,333  | $90,460  | $1,301,618  |
| Guam | $864,236  | $1,089,084  | $537,835  | $49,330  | $361,841  | $2,902,326  |
| Northern Mariana Islands | $216,059  | $272,271  | $134,459  | $12,333  | $90,460  | $725,582  |
| Puerto Rico | $4,330,186  | $5,291,025  | $2,692,000  | $253,148  | $1,864,363  | $14,430,722  |
| Virgin Islands | $864,236  | $1,089,084  | $537,835  | $49,330  | $361,841  | $2,902,326  |
| **TOTAL** | **$345,694,467**  | **$435,633,445**  | **$215,133,972**  | **$19,732,154**  | **$144,736,269**  | **$1,160,930,307**  |

| **State** | **Ombudsman** | **Elder Abuse** | **Total Title VII** |
| --- | --- | --- | --- |
| Alabama | $245,941  | $76,215  | $322,156  |
| Alaska | $79,314  | $23,832  | $103,146  |
| Arizona | $335,972  | $89,534  | $425,506  |
| Arkansas | $153,180  | $48,157  | $201,337  |
| California | $1,632,620  | $471,073  | $2,103,693  |
| Colorado | $225,810  | $60,176  | $285,986  |
| Connecticut | $184,985  | $59,907  | $244,892  |
| Delaware | $79,314  | $23,832  | $103,146  |
| District of Columbia | $79,314  | $23,832  | $103,146  |
| Florida | $1,169,381  | $344,252  | $1,513,633  |
| Georgia | $414,431  | $110,443  | $524,874  |
| Hawaii | $79,314  | $23,832  | $103,146  |
| Idaho | $79,314  | $23,832  | $103,146  |
| Illinois | $598,482  | $197,384  | $795,866  |
| Indiana | $314,257  | $98,224  | $412,481  |
| Iowa | $162,421  | $55,927  | $218,348  |
| Kansas | $138,009  | $45,843  | $183,852  |
| Kentucky | $218,741  | $66,595  | $285,336  |
| Louisiana | $212,699  | $68,518  | $281,217  |
| Maine | $80,056  | $23,832  | $103,888  |
| Maryland | $273,618  | $78,087  | $351,705  |
| Massachusetts | $336,169  | $109,606  | $445,775  |
| Michigan | $510,772  | $160,862  | $671,634  |
| Minnesota | $258,133  | $76,347  | $334,480  |
| Mississippi | $142,583  | $45,198  | $187,781  |
| Missouri | $307,715  | $97,643  | $405,358  |
| Montana | $79,314  | $23,832  | $103,146  |
| Nebraska | $90,131  | $29,770  | $119,901  |
| Nevada | $129,196  | $34,430  | $163,626  |
| New Hampshire | $79,314  | $23,832  | $103,146  |
| New Jersey | $435,703  | $143,950  | $579,653  |
| New Mexico | $103,011  | $27,451  | $130,462  |
| New York | $964,652  | $318,066  | $1,282,718  |
| North Carolina | $476,481  | $126,978  | $603,459  |
| North Dakota | $79,314  | $23,832  | $103,146  |
| Ohio | $600,585  | $197,185  | $797,770  |
| Oklahoma | $186,170  | $60,208  | $246,378  |
| Oregon | $208,041  | $56,795  | $264,836  |
| Pennsylvania | $704,768  | $242,944  | $947,712  |
| Rhode Island | $79,314  | $23,832  | $103,146  |
| South Carolina | $246,326  | $65,644  | $311,970  |
| South Dakota | $79,314  | $23,832  | $103,146  |
| Tennessee | $325,112  | $91,810  | $416,922  |
| Texas | $1,022,013  | $274,281  | $1,296,294  |
| Utah | $96,547  | $25,729  | $122,276  |
| Vermont | $79,314  | $23,832  | $103,146  |
| Virginia | $379,896  | $102,820  | $482,716  |
| Washington | $328,078  | $87,430  | $415,508  |
| West Virginia | $110,440  | $36,736  | $147,176  |
| Wisconsin | $290,337  | $90,309  | $380,646  |
| Wyoming | $79,314  | $23,832  | $103,146  |
| American Samoa | $9,914  | $2,979  | $12,893  |
| Guam | $39,657  | $11,916  | $51,573  |
| Northern Mariana Islands | $9,914  | $2,979  | $12,893  |
| Puerto Rico | $198,496  | $54,217  | $252,713  |
| Virgin Islands | $39,657  | $11,916  | $51,573  |
| **TOTAL** | **$15,862,868**  | **$4,766,350**  | **$20,629,218**  |

| **State/Territory** | **Nutrition Services Incentive Program** |
| --- | --- |
| Alabama | $3,035,666  |
| Alaska | $426,164  |
| Arizona | $1,845,223  |
| Arkansas | $2,627,043  |
| California | $12,480,105  |
| Colorado | $1,335,432  |
| Connecticut | $1,460,498  |
| Delaware | $466,497  |
| District of Columbia | $495,255  |
| Florida | $6,235,977  |
| Georgia | $2,769,753  |
| Hawaii | $393,248  |
| Idaho | $687,313  |
| Illinois | $6,060,437  |
| Indiana | $1,770,859  |
| Iowa | $1,929,436  |
| Kansas | $1,953,722  |
| Kentucky | $1,831,511  |
| Louisiana | $3,316,973  |
| Maine | $602,546  |
| Maryland | $1,562,235  |
| Massachusetts | $4,448,133  |
| Michigan | $7,434,636  |
| Minnesota | $1,935,940  |
| Mississippi | $1,623,757  |
| Missouri | $4,031,525  |
| Montana | $974,923  |
| Nebraska | $1,309,566  |
| Nevada | $1,053,945  |
| New Hampshire | $1,136,133  |
| New Jersey | $3,656,313  |
| New Mexico | $2,094,050  |
| New York | $15,833,848  |
| North Carolina | $3,363,269  |
| North Dakota | $804,666  |
| Ohio | $5,559,215  |
| Oklahoma | $2,142,370  |
| Oregon | $1,845,650  |
| Pennsylvania | $5,883,282  |
| Rhode Island | $423,849  |
| South Carolina | $1,409,733  |
| South Dakota | $890,188  |
| Tennessee | $1,568,871  |
| Texas | $11,715,933  |
| Utah | $1,370,903  |
| Vermont | $791,340  |
| Virginia | $2,068,902  |
| Washington | $2,130,829  |
| West Virginia | $1,677,726  |
| Wisconsin | $2,718,926  |
| Wyoming | $844,818  |
| Guam | $330,851  |
| Northern Mariana Islands | $58,093  |
| Puerto Rico | $3,004,666  |
| Virgin Islands | $185,407  |
| **TOTAL** | **$149,608,149**  |

| **State** | **Tribe No.** | **Grantee Name** |  **TITLE6 A/B** |  **TITLE6 C** | **NSIP** |
| --- | --- | --- | --- | --- | --- |
| AK | 01 | Aleutian Pribilof Islands Association, Inc. | $82,330 | $22,960 | $7,385 |
| AK | 02 | Association of Village Council Presidents | $118,860 | - | $15,485 |
| AK | 03 | Bristol Bay Native Association | $118,860 | $40,170 | $3,340 |
| AK | 04 | Central Council Tlingit & Haida Indian Tribes of AK | $156,070 | $45,900 | $1,675 |
| AK | 06 | Copper River Native Association | $72,500 | $17,220 | $1,280 |
| AK | 07 | Hoonah Indian Association | $72,500 | $17,220 | $1,474 |
| AK | 08 | Kodiak Area Native Association - Northern Region | $70,000 | $11,480 | $1,029 |
| AK | 09 | Kodiak Area Native Association - Southern Region | $63,900 | $11,480 | $762 |
| AK | 10 | Metlakatla Indian Community | $92,780 | $28,700 | $1,677 |
| AK | 11 | Native Village of Barrow | $102,620 | $34,430 | $15,014 |
| AK | 12 | Tanana Chiefs Conference for Kuskokwim subregion | $63,900 | $11,480 | $4,937 |
| AK | 13 | Tanana Chiefs Conference for Lower Yukon Subregion | $63,900 | $11,480 | $4,937 |
| AK | 14 | Tanana Chiefs Conference for Yukon Flats Subregion | $63,900 | $11,480 | $2,408 |
| AK | 15 | Tanana Chiefs Conference for Yukon Koyukuk Subregion | $72,500 | $17,220 | $2,317 |
| AK | 16 | Tanana Chiefs Conference for Yukon Tanana Subregion | $63,900 | $11,480 | $1,765 |
| AK | 17 | Fairbanks Native Association | $118,860 | $40,170 | - |
| AK | 19 | Maniilaq Association | $118,860 | $40,170 | $21,810 |
| AK | 20 | Native Villiage of Unalakleet | $72,500 | $17,220 | $4,536 |
| AK | 21 | Chugachmiut | $72,500 | $17,220 | $1,365 |
| AK | 22 | Arctic Slope Native Association, Limited | $72,500 | $17,220 | $15,014 |
| AK | 23 | Denakkanaaga, Inc. | $82,330 | $22,960 | - |
| AK | 24 | Klawock Cooperative Association | $63,900 | $11,480 | $1,212 |
| AK | 25 | Kootznoowoo Inc. | $63,900 | $11,480 | $1,639 |
| AK | 26 | Gwichyaa Zhee Gwich'in Tribal Government | $63,900 | $11,480 | $4,585 |
| AK | 27 | Native Village of Point Hope | $63,900 | $11,480 | $4,676 |
| AK | 28 | Seldovia Village Tribe | $63,900 | - | $958 |
| AK | 30 | Sitka Tribes of Alaska | $92,780 | $28,700 | $1,654 |
| AK | 32 | Ketchikan Indian Community | $118,860 | $40,170 | $4,002 |
| AK | 33 | Kuskokwim Native Association | $72,500 | $17,220 | $1,821 |
| AK | 35 | Southcentral Foundation | $156,070 | $45,900 | $11,630 |
| AK | 36 | Kenaitze Indian Tribe | $118,860 | $40,170 | $4,198 |
| AK | 37 | Wrangell Cooperative Association | $82,330 | $22,960 | $2,080 |
| AK | 38 | Native Village of Savoonga | $63,900 | $11,480 | $10,698 |
| AK | 39 | Native Village of Gambell | $63,900 | $11,480 | $10,047 |
| AK | 40 | Native Village of Eyak Traditional Council | $63,900 | $11,480 | $1,299 |
| AK | 41 | Organized Village of Kake | $63,900 | $11,480 | $1,939 |
| AK | 42 | Chickaloon Native Village | $82,330 | - | $2,922 |
| AK | 44 | Galena Village (aka Louden Village Council) | $63,900 | $11,480 | $8,186 |
| AK | 45 | Asa'carsarmiut Tribal Council | $63,900 | - | $2,289 |
| AK | 46 | Orutsararmuit Native Council | $92,780 | $28,700 | $9,294 |
| AK | 47 | Chilkoot Indian Association | $63,900 | $11,480 | $2,004 |
| AK | 48 | Knik Tribal Council | $92,780 | - | $8,229 |
| AK | 49 | Yakutat Tlingit Tribe | $63,900 | $11,480 | $3,506 |
| AK | 50 | Craig Tribal Association (Skagway Traditional Council) | $63,900 | $11,480 | $1,288 |
| AK | Total | Total | $3,619,960 | $809,240 | $208,366 |
| AL | 01 | Poarch Band of Creek Indians | $118,860 | $40,170 | $23,574 |
| AL | Total | Total | $118,860 | $40,170 | $23,574 |
| AZ | 02 | Colorado River Indian Tribes | $102,620 | $34,430 | $4,607 |
| AZ | 03 | Gila River Indian Community | $156,070 | $45,900 | $13,940 |
| AZ | 04 | Hopi Tribe | $118,860 | $40,170 | $9,279 |
| AZ | 05 | Hualapai Elderly Services Program | $72,500 | $17,220 | $19,239 |
| AZ | 06 | Navajo Nation | $156,070 | $45,900 | $64,416 |
| AZ | 07 | Pascua Yaqui Tribe | $156,070 | $45,900 | $36,480 |
| AZ | 09 | Salt River Pima-Maricopa Indian Community | $92,780 | $28,700 | $16,128 |
| AZ | 10 | San Carlos Apache Tribe | $118,860 | $40,170 | $6,900 |
| AZ | 11 | Tohono O'odham Nation | $156,070 | $45,900 | $3,527 |
| AZ | 12 | White Mountain Apache Tribe | $118,860 | $40,170 | $21,581 |
| AZ | 13 | Ak-Chin Indian Community | $63,900 | $11,480 | $5,964 |
| AZ | 14 | Yavapai Apache Tribe | $72,500 | - | $3,034 |
| AZ | 15 | Havasupai Tribe | $63,900 | $11,480 | $8,737 |
| AZ | 16 | Inter-Tribal Council of Arizona, Inc. | $72,500 | $17,220 | $2,137 |
| AZ | 17 | Cocopah Indian Tribe | $63,900 | - | $15,240 |
| AZ | 18 | Quechan Indian Tribe | $72,500 | $17,220 | $15,664 |
| AZ | Total | Total | $1,657,960 | $441,860 | $246,873 |
| CA | 01 | Bishop Paiute Tribe | $82,330 | $22,960 | $19,854 |
| CA | 02 | Blue Lake Rancheria | $63,900 | $11,480 | $28,778 |
| CA | 06 | Karuk Tribe | $82,330 | $22,960 | $4,120 |
| CA | 07 | Pit River Health Service, Inc. | $63,900 | - | $4,189 |
| CA | 09 | Riverside-San Bernardino Co. Indian Health-Morongo | $72,500 | $17,220 | $2,945 |
| CA | 10 | Riverside-San Bernardino Co. Indian Health-Pechanga | $63,900 | $11,480 | $5,769 |
| CA | 11 | Riverside-San Bernardino Co. Indian Health-Soboba/ | $63,900 | $11,480 | $10,016 |
| CA | 12 | Sonoma County Indian Health Project - Sonoma | $63,900 | - | $9,175 |
| CA | 13 | Southern Indian Health Council, Inc. - Area I | $63,900 | $11,480 | $8,673 |
| CA | 14 | Southern Indian Health Council, Inc. - Area II | $63,900 | $11,480 | $6,068 |
| CA | 15 | Toiyabe Indian Health Project, Inc. - Northern | $63,900 | $11,480 | $10,250 |
| CA | 16 | Tule River Indian Health Center, Inc. | $72,500 | $17,220 | $18,640 |
| CA | 17 | Coast Indian Community of Resighini Rancheria | $72,500 | $17,220 | $9,557 |
| CA | 18 | United Indian Health Services for Smith River | $118,860 | $40,170 | $12,726 |
| CA | 20 | Indian Senior Center, Inc. | $72,500 | $17,220 | $9,985 |
| CA | 21 | Sonoma County Indian Health Project - Manchester | $63,900 | - | $3,730 |
| CA | 25 | Pala Band of Mission Indians | $72,500 | - | $15,452 |
| CA | 26 | Redding Rancheria | $118,860 | $40,170 | $5,794 |
| CA | 28 | Toiyabe Indian Health Project, Inc. - Southern | $63,900 | $11,480 | $7,025 |
| CA | 29 | Hoopa Valley Tribe / K'ima:w Medical Center | $72,500 | - | $7,803 |
| CA | 30 | Round Valley Indian Tribes | $72,500 | - | $4,445 |
| CA | 31 | Fort Mojave Indian Tribe | $72,500 | $17,220 | $6,754 |
| CA | 33 | CA Indian Manpower Consortium, Inc. - Chico, | $63,900 | $11,480 | $9,356 |
| CA | 34 | CA Indian Manpower Consortium, Inc. - Big Sandy, | $72,500 | $17,220 | $7,708 |
| CA | 35 | CA Indian Manpower Consortium, Inc. - Berry Creek, | $72,500 | $17,220 | $4,816 |
| CA | 36 | CA Indian Manpower Consortium, Inc. - Coyote Valley, | $72,500 | $17,220 | $5,550 |
| CA | 37 | CA Indian Manpower Consortium, Inc. - Enterprise, | $82,330 | $22,960 | $11,871 |
| CA | 38 | Santa Ynez Tribal Health Clinic | $63,900 | - | $2,137 |
| CA | 39 | CA Indian Manpower Consortium, Inc. - North Fork, | $63,900 | $11,480 | $6,011 |
| CA | Total | Total | $2,112,910 | $390,300 | $259,197 |
| CO | 01 | Southern Ute Indian Tribe | $72,500 | $17,220 | $3,465 |
| CO | 02 | Ute Mountain Ute Tribe | $82,330 | - | $7,054 |
| CO | Total | Total | $154,830 | $17,220 | $10,519 |
| CT | 01 | Mohegan Tribe of Indians of Connecticut | $72,500 | - | $6,440 |
| CT | Total | Total | $72,500 | - | $6,440 |
| HI | 01 | Alu Like, Inc. | $1,505,000 | $45,900 | $28,830 |
| HI | Total | Total | $1,505,000 | $45,900 | $28,830 |
| IA | 01 | Sac & Fox Tribe of the Mississippi in Iowa | $82,330 | $22,960 | $8,447 |
| IA | Total | Total | $82,330 | $22,960 | $8,447 |
| ID | 01 | Coeur d'Alene Tribe | $72,500 | $17,220 | $17,532 |
| ID | 02 | Nez Perce Tribe | $82,330 | $22,960 | $33,523 |
| ID | 03 | Shoshone-Bannock Tribes | $102,620 | $34,430 | $18,803 |
| ID | Total | Total | $257,450 | $74,610 | $69,858 |
| KS | 01 | Kickapoo Tribe in Kansas | $65,000 | $11,480 | $13,396 |
| KS | 02 | Prairie Band of Potawatomi Nation | $82,330 | $22,960 | $21,667 |
| KS | 03 | Iowa Tribe of Kansas and Nebraska | $65,000 | $11,480 | $6,700 |
| KS | Total | Total | $212,330 | $45,920 | $41,763 |
| LA | 01 | Institute for Indian Development, Inc. | $82,330 | - | $11,148 |
| LA | Total | Total | $82,330 | - | $11,148 |
| MA | 01 | Wampanoag Tribe of Gay Head (Aquinnah) | $72,500 | $17,220 | $859 |
| MA | 02 | Mashpee Wampanoag Tribe | $82,330 | $22,960 | $2,160 |
| MA | Total | Total | $154,830 | $40,180 | $3,019 |
| ME | 01 | Pleasant Point Passamaquoddy | $82,330 | $22,960 | $25,430 |
| ME | 02 | Penobscot Indian Nation | $72,500 | - | $4,892 |
| ME | 04 | Aroostook Band of Micmacs | $63,900 | $11,480 | $5,645 |
| ME | Total | Total | $218,730 | $34,440 | $35,967 |
| MI | 01 | Grand Traverse Band of Ottawa & Chippewa Indians | $82,330 | $22,960 | $12,058 |
| MI | 02 | Inter-Tribal Council of Michigan, Inc. | $72,500 | $17,220 | $5,529 |
| MI | 03 | Keweenaw Bay Indian Community | $72,500 | $17,220 | $15,761 |
| MI | 04 | Sault Ste. Marie Tribe of Chippewa Indians | $156,070 | - | $22,317 |
| MI | 05 | Little Traverse Bay Bands of Odawa Indians | $72,500 | $17,220 | $4,751 |
| MI | 07 | Bay Mills Indian Community | $72,500 | $17,220 | $5,730 |
| MI | 08 | Pokagon Band of Potawatomi Indians | $72,500 | - | $3,106 |
| MI | 09 | Little River Band of Ottawa Indians | $92,780 | - | $9,782 |
| MI | 10 | Nottawaseppi Huron Band of the Potawatomi | $63,900 | $11,480 | $4,724 |
| MI | Total | Total | $757,580 | $103,320 | $83,758 |
| MN | 01 | Bois Forte Reservation Tribal Government | $72,500 | $17,220 | $10,068 |
| MN | 02 | Fond du Lac Band of Lake Superior Chippewa | $118,860 | $40,170 | $41,433 |
| MN | 03 | Leech Lake Band of Ojibwe | $156,070 | $45,900 | $21,148 |
| MN | 07 | Red Lake Band of Chippewa Indians | $118,860 | - | $52,201 |
| MN | 08 | White Earth Reservation Tribal Council | $82,330 | $22,960 | $12,276 |
| MN | 09 | Grand Portage Band of Lake Superior Chippewa | $63,900 | - | $4,725 |
| MN | 10 | Mille Lacs Band of Ojibwe | $72,500 | $17,220 | $27,757 |
| MN | 11 | Lower Sioux Indian Community | $63,900 | $11,480 | $13,417 |
| MN | Total | Total | $748,920 | $154,950 | $183,025 |
| MO | 99 | Eastern Shawnee Tribe of Oklahoma | $92,780 | $28,700 | $18,523 |
| MO | Total | Total | $92,780 | $28,700 | $18,523 |
| MS | 01 | Mississippi Band of Choctaw Indians | $118,860 | $40,170 | $21,334 |
| MS | Total | Total | $118,860 | $40,170 | $21,334 |
| MT | 01 | Assiniboine and Sioux Tribes | $118,860 | $40,170 | $34,816 |
| MT | 02 | Blackfeet Tribe - Eagle Shield Center | $118,860 | $40,170 | $28,157 |
| MT | 03 | Chippewa Cree Tribe Senior Citizens Department | $102,620 | $34,430 | $47,139 |
| MT | 04 | Confederated Salish and Kootenai Tribes | $118,860 | $40,170 | $4,004 |
| MT | 05 | Fort Belknap Indian Community | $82,330 | $22,960 | $16,908 |
| MT | 06 | Northern Cheyenne Elderly Program | $102,620 | $34,430 | $21,847 |
| MT | 07 | Crow Tribal Elders Program | $118,860 | $40,170 | $48,389 |
| MT | Total | Total | $763,010 | $252,500 | $201,260 |
| NC | 01 | Eastern Band of Cherokee Indians | $156,070 | $45,900 | $47,385 |
| NC | Total | Total | $156,070 | $45,900 | $47,385 |
| ND | 01 | Spirit Lake Senior Services | $82,330 | $22,960 | $16,780 |
| ND | 02 | Standing Rock Sioux Tribe | $118,860 | $40,170 | $104,322 |
| ND | 03 | Three Affiliated Tribes | $118,860 | $40,170 | $14,000 |
| ND | 04 | Trenton Indian Service Area | $82,330 | $22,960 | $2,072 |
| ND | 05 | Turtle Mountain Band of Chippewa Indians | $118,860 | $40,170 | $17,017 |
| ND | Total | Total | $521,240 | $166,430 | $154,191 |
| NE | 01 | Omaha Tribe of Nebraska | $72,500 | $17,220 | $9,882 |
| NE | 02 | Santee Sioux Nation | $65,000 | - | $3,093 |
| NE | 03 | Winnebago Tribe of Nebraska | $72,500 | $17,220 | $17,756 |
| NE | Total | Total | $210,000 | $34,440 | $30,731 |
| NM | 01 | Eight Northern Indian Pueblos Council (Picuris, etc.) | $118,860 | $40,170 | $44,011 |
| NM | 02 | Eight N. Indian Pueblos Council (San Ildefonso, etc.) | $63,900 | $11,480 | $12,777 |
| NM | 03 | Five Sandoval Indian Pueblos, Inc. | $87,500 | $22,960 | $24,305 |
| NM | 04 | Jicarilla Apache Nation | $92,780 | $28,700 | $20,373 |
| NM | 05 | Laguna Rainbow Corporation | $118,860 | $40,170 | $18,281 |
| NM | 06 | Mescalero Apache Tribe | $92,780 | - | $10,279 |
| NM | 07 | Pueblo de Cochiti Elder Program | $72,500 | $17,220 | $7,721 |
| NM | 09 | Pueblo of Isleta Elder Center | $118,860 | $40,170 | $24,909 |
| NM | 10 | Pueblo of Jemez | $118,860 | $40,170 | $8,891 |
| NM | 11 | Pueblo of San Felipe Elderly Services Program | $92,780 | $28,700 | $21,983 |
| NM | 12 | Taos Pueblo Senior Citizens Program | $102,620 | $34,430 | $8,209 |
| NM | 13 | Pueblo of Zuni | $118,860 | $40,170 | $26,854 |
| NM | 14 | Ohkay Owingeh Senior Citizens Program | $118,860 | $40,170 | $13,502 |
| NM | 15 | Santa Clara Pueblo | $118,860 | $40,170 | $18,519 |
| NM | 16 | Santo Domingo Pueblo | $118,860 | $40,170 | $18,096 |
| NM | 17 | Pueblo of Tesuque | $63,900 | $11,480 | $6,817 |
| NM | 18 | Acoma Elderly & Assistance Program | $82,330 | $22,960 | $12,699 |
| NM | Total | Total | $1,701,970 | $499,290 | $298,226 |
| NV | 01 | Fallon Paiute Shoshone Tribes | $72,500 | $17,220 | $21,590 |
| NV | 02 | Inter-Tribal Council of Nevada, Inc. (McDermitt, etc.) | $72,500 | $17,220 | $6,912 |
| NV | 03 | Inter-Tribal Council of Nevada, Inc. (Duckwater, etc.) | $72,500 | $17,220 | $5,003 |
| NV | 04 | Inter-Tribal Council of Nevada, Inc. (Ely, etc.) | $72,500 | $17,220 | $5,255 |
| NV | 05 | Shoshone-Paiute Tribes | $72,500 | $17,220 | $8,348 |
| NV | 06 | Walker River Paiute Tribe | $72,500 | - | $9,562 |
| NV | 07 | Washoe Tribe of Nevada and California | $72,500 | $17,220 | $32,442 |
| NV | 08 | Yerington Paiute Tribe | $63,900 | $11,480 | $7,814 |
| NV | 09 | Pyramid Lake Paiute Tribe | $72,500 | $17,220 | $5,939 |
| NV | 10 | Elko Band Council | $72,500 | $17,220 | $7,704 |
| NV | 11 | Reno-Sparks Indian Colony | $63,900 | $11,480 | $12,704 |
| NV | Total | Total | $780,300 | $160,720 | $123,273 |
| NY | 01 | St. Regis Mohawk Tribe | $156,070 | $45,900 | $11,247 |
| NY | 02 | Seneca Nation of Indians | $118,860 | $40,170 | $26,552 |
| NY | 04 | Oneida Indian Nation | $72,500 | $17,220 | $4,820 |
| NY | 05 | Shinnecock Indian Nation | $72,500 | $17,220 | $4,279 |
| NY | Total | Total | $419,930 | $120,510 | $46,898 |
| OK | 01 | Apache Tribe of Oklahoma | $72,500 | $17,220 | $5,983 |
| OK | 02 | Caddo Nation of Oklahoma | $72,500 | $17,220 | $4,093 |
| OK | 03 | Cherokee Nation | $157,443 | $47,362 | $42,922 |
| OK | 04 | Cheyenne and Arapaho Tribes | $156,070 | $45,900 | $9,111 |
| OK | 06 | Choctaw Nation of Oklahoma | $156,070 | $45,900 | $36,720 |
| OK | 07 | Citizen Potawatomi Nation | $156,070 | $45,900 | $9,016 |
| OK | 08 | Comanche Nation | $118,860 | $40,170 | $19,713 |
| OK | 09 | Delaware Nation | $78,960 | $11,480 | $8,420 |
| OK | 10 | Iowa Tribe of Oklahoma | $118,860 | $40,170 | $10,241 |
| OK | 12 | Kickapoo Tribe of Oklahoma | $100,000 | $17,220 | $13,645 |
| OK | 13 | Kiowa Tribe of Oklahoma | $156,070 | $45,900 | $7,756 |
| OK | 14 | Miami Tribe of Oklahoma | $118,860 | $40,170 | $40,628 |
| OK | 15 | Muscogee (Creek) Nation/Elderly Nutrition Program | $156,070 | $45,900 | $148,831 |
| OK | 17 | Otoe-Missouria Tribe of Indians | $82,330 | $22,960 | $10,196 |
| OK | 18 | Ottawa Tribe of Oklahoma | $118,860 | $40,170 | $29,996 |
| OK | 19 | Pawnee Nation of Oklahoma | $80,000 | $17,220 | $10,076 |
| OK | 20 | Peoria Tribe of Indians of Oklahoma | $102,620 | $34,430 | $31,018 |
| OK | 21 | Ponca Tribe of Oklahoma | $92,780 | $28,700 | $10,661 |
| OK | 22 | Quapaw Tribe of Oklahoma | $118,860 | $40,170 | $24,295 |
| OK | 23 | Sac and Fox Nation of Oklahoma | $118,860 | $40,170 | $16,185 |
| OK | 24 | Seminole Nation of Oklahoma | $118,860 | $40,170 | $14,924 |
| OK | 25 | Seneca-Cayuga Tribe of Oklahoma | $118,860 | $40,170 | $4,959 |
| OK | 26 | Wichita and Affiliated Tribes | $118,860 | $40,170 | $8,891 |
| OK | 27 | Wyandotte Nation | $118,860 | $40,170 | $19,234 |
| OK | 28 | Absentee Shawnee Tribe of Oklahoma | $156,070 | $45,900 | $30,473 |
| OK | 29 | Fort Sill Apache Tribe | $92,780 | $28,700 | $5,855 |
| OK | 31 | United Keetoowah Band of Cherokee Indians | $156,070 | $45,900 | $17,237 |
| OK | 32 | Chickasaw Nation | $156,070 | $45,900 | $125,285 |
| OK | 33 | Kaw Nation | $72,500 | - | $21,396 |
| OK | 34 | Osage Nation of Oklahoma | $156,070 | $45,900 | $67,222 |
| OK | 35 | Delaware Tribes of Indians | $118,860 | $40,170 | $6,266 |
| OK | 36 | Alabama-Quassarte Tribal Town | $63,900 | $11,480 | $8,501 |
| OK | Total | Total | $3,780,403 | $1,108,962 | $819,749 |
| OR | 01 | Confederated Tribes of Siletz Indians of Oregon | $82,330 | $22,960 | $1,631 |
| OR | 02 | Yellowhawk Tribal Health Center | $102,620 | $34,430 | $9,054 |
| OR | 03 | Confederated Tribes of Warm Springs | $102,620 | $34,430 | $61,626 |
| OR | 04 | Confederated Tribes of Grand Ronde | $92,780 | $28,700 | $11,145 |
| OR | 05 | The Klamath Tribes | $118,860 | $40,170 | $4,402 |
| OR | 06 | Confed. Tribes of Coos, Lower Umpqua & | $72,500 | $17,220 | $9,655 |
| OR | 07 | Cow Creek Band of Umpqua Tribe of Indians | $63,900 | $11,480 | $53,597 |
| OR | Total | Total | $635,610 | $189,390 | $151,110 |
| RI | 01 | Narragansett Indian Tribe | $92,780 | $28,700 | $2,692 |
| RI | Total | Total | $92,780 | $28,700 | $2,692 |
| SC | 01 | Catawba Indian Nation Eldercare Program | $82,330 | $22,960 | $8,972 |
| SC | Total | Total | $82,330 | $22,960 | $8,972 |
| SD | 01 | Cheyenne River Elderly Nutrition Services | $118,860 | $40,170 | $9,138 |
| SD | 02 | Crow Creek Sioux Tribe | $72,500 | - | $16,709 |
| SD | 03 | Lower Brule Sioux Tribe | $72,500 | $17,220 | $13,380 |
| SD | 04 | Oglala Sioux Tribe | $156,070 | $45,900 | $66,228 |
| SD | 05 | Rosebud Sioux Tribe | $156,070 | $45,900 | $46,268 |
| SD | 06 | Sisseton Wahpeton Oyate | $118,860 | $40,170 | $31,658 |
| SD | 08 | Yankton Sioux Tribe | $102,620 | $34,430 | $17,548 |
| SD | Total | Total | $797,480 | $223,790 | $200,929 |
| TX | 01 | Alabama-Coushatta Tribe of Texas | $72,500 | $17,220 | $7,685 |
| TX | 02 | Kickapoo Traditional Tribe of Texas | $63,900 | - | $16,212 |
| TX | Total | Total | $136,400 | $17,220 | $23,897 |
| UT | 01 | Ute Indian Tribe, Unitah & Ouray | $82,330 | $22,960 | $5,706 |
| UT | Total | Total | $82,330 | $22,960 | $5,706 |
| WA | 01 | Confederated Tribes of the Colville Reservation | $118,860 | $40,170 | $15,644 |
| WA | 02 | Lower Elwha Klallam Tribe | $65,000 | $11,480 | $5,454 |
| WA | 03 | Lummi Tribe | $92,780 | $28,700 | $13,783 |
| WA | 04 | Makah Tribe Senior Program | $72,500 | $17,220 | $9,464 |
| WA | 05 | Muckleshoot Indian Tribe | $118,860 | $40,170 | $34,923 |
| WA | 09 | Puyallup Tribe of Indians | $118,860 | - | $8,364 |
| WA | 10 | Quinault Tribe of the Quinault Indian Reservation | $92,780 | $28,700 | $29,418 |
| WA | 13 | Swinomish Indian Tribal Community | $72,500 | $17,220 | $6,328 |
| WA | 14 | Spokane Tribes Senior Program | $82,330 | $22,960 | $12,050 |
| WA | 16 | The Tulalip Tribes of Washington | $118,860 | $40,170 | $10,352 |
| WA | 17 | Jamestown S'Klallam Tribe | $72,500 | $17,220 | $6,047 |
| WA | 19 | Quileute Tribal Council | $63,900 | $11,480 | $5,497 |
| WA | 20 | S. Puget Intertribal Planning Agency - Shoalwater Bay | $82,330 | $22,960 | $7,949 |
| WA | 21 | Stillaguamish Tribe of Indians | $92,780 | $28,700 | $1,850 |
| WA | 22 | Upper Skagit Indian Tribe | $63,900 | $11,480 | $2,344 |
| WA | 24 | The Suquamish Tribe | $82,330 | $22,960 | $13,653 |
| WA | 25 | Port Gamble S'Klallam Tribe | $72,500 | $17,220 | $2,605 |
| WA | 26 | Samish Indian Nation | $82,330 | $22,960 | $2,505 |
| WA | 27 | Cowlitz Indian Tribe | $156,070 | $45,900 | $3,203 |
| WA | 28 | Skokomish Indian Tribe | $82,330 | $22,960 | $2,187 |
| WA | 29 | Confederated Tribes of the Chehalis Reservation | $118,860 | $40,170 | $2,966 |
| WA | 30 | Nooksack Indian Tribe | $82,330 | $22,960 | $8,840 |
| WA | 31 | Yakama Indian Nation | $63,900 | $11,480 | $2,415 |
| WA | 32 | Snoqualmie Tribe | $63,900 | $11,480 | $1,899 |
| WA | 33 | S. Puget Intertribal Planning Agency - Nisqually | $118,860 | $40,170 | $3,529 |
| WA | 34 | Squaxin Island Tribe | $72,500 | $17,220 | $7,814 |
| WA | Total | Total | $2,324,650 | $614,110 | $221,083 |
| WI | 01 | Bad River Elderly Nutrition Program | $72,500 | $17,220 | $11,228 |
| WI | 02 | Forest County Potawatomi Community | $72,500 | $17,220 | $8,045 |
| WI | 03 | Lac Courte Oreilles Band of Lake Superior Chippewa | $82,330 | $22,960 | $8,305 |
| WI | 04 | Lac du Flambeau Band of Lake Superior Chippewa Indians | $82,330 | $22,960 | $20,332 |
| WI | 05 | Menominee Indian Tribe of Wisconsin | $118,860 | $40,170 | $2,721 |
| WI | 06 | Oneida Tribe of Indians of Wisconsin | $118,860 | $40,170 | $7,167 |
| WI | 07 | Red Cliff Band of Lake Superior Chippewa | $72,500 | $17,220 | $16,186 |
| WI | 08 | St. Croix Chippewa Indians of Wisconsin | $72,500 | $17,220 | $4,259 |
| WI | 09 | Stockbridge-Munsee Community | $72,500 | $17,220 | $2,054 |
| WI | 10 | Ho-Chunk Nation | $92,780 | $28,700 | $23,626 |
| WI | 11 | Sokaogon Chippewa Community | $63,900 | - | $7,442 |
| WI | Total | Total | $921,560 | $241,060 | $111,365 |
| WY | 01 | Northern Arapaho Tribe | $82,330 | - | $8,077 |
| WY | 03 | Eastern Shoshone Tribe | $82,330 | - | $11,249 |
| WY | Total | Total | $164,660 | - | $19,326 |
| Total | Total | Total | $25,538,883 | $6,038,882 | $3,727,434 |

1. AoA FY 2014 State Program Report. [↑](#footnote-ref-1)
2. 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. [↑](#footnote-ref-2)
3. Ibid. [↑](#footnote-ref-3)
4. Ibid and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 Medicare Current Beneficiary Survey. [data tables 2.5a and 2.6a]. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html> Accessed 10 January, 2016. [↑](#footnote-ref-4)
5. Ibid. [↑](#footnote-ref-5)
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. [↑](#footnote-ref-6)
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 [↑](#footnote-ref-7)
8. AoA’s FY 2014 State Program Report. [↑](#footnote-ref-8)
9. Ibid. [↑](#footnote-ref-9)
10. AoA’s FY 2014 State Program Report.  [↑](#footnote-ref-10)
11. 2015 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>, [↑](#footnote-ref-11)
12. Ibid. [↑](#footnote-ref-12)
13. Minority client refers to individuals who self-report at least one of the following racial or ethnic identities: Asian, Black or African American, Hispanic or Latino, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native. [↑](#footnote-ref-13)
14. 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 [↑](#footnote-ref-14)
15. 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 [↑](#footnote-ref-15)
16. 2015 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>. [↑](#footnote-ref-16)
17. 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. [↑](#footnote-ref-17)
18. Ibid and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 Medicare Current Beneficiary Survey. [data tables 2.5a and 2.6a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html Accessed 10 January, 2016. [↑](#footnote-ref-18)
19. AoA’s FY 2014 State Program Report. [↑](#footnote-ref-19)
20. Ibid. [↑](#footnote-ref-20)
21. Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 Medicare Current Beneficiary Survey. [Table 1.2 Demographic and Socioeconomic Characteristics of Medicare Beneficiaries, by Age and by Gender and Age, 2013]. http://www.cms.gov/Research-Statistics-Dataand-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html. Accessed 10 January 2016. [↑](#footnote-ref-21)
22. Brock, D et al. “Risk Factors for Nursing Home Placement Among OAA Service Recipients: Summary Analysis from Five Data Sources” Westat; U.S. Administration on Aging Contract No. 233-02-0087. http://www.aoa.gov/AoARoot/Program\_Results/POMP/docs/Risk\_Factors.pdf [↑](#footnote-ref-22)
23. Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 Medicare Current Beneficiary Survey. [data tables 2.5a and 2.6a]. http://www.cms.gov/ResearchStatistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html. Accessed 10 January 2016. [↑](#footnote-ref-23)
24. Ibid. [↑](#footnote-ref-24)
25. AoA’s FY 2014 State Program Report. [↑](#footnote-ref-25)
26. 2015 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>, select AGID. [↑](#footnote-ref-26)
27. Ibid [↑](#footnote-ref-27)
28. 2015 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>, [↑](#footnote-ref-28)
29. Ibid. [↑](#footnote-ref-29)
30. Ibid. [↑](#footnote-ref-30)
31. Chen, Ya Mei and Elaine Adams Thompson. Understanding Factors That Influence Success of Home- and Community-Based Services in Keeping Older Adults in Community Settings. 2010. Journal of Aging and Health. V. 22: 267. Available: http://jah.sagepub.com/cgi/content/abstract/22/3/267. [↑](#footnote-ref-31)
32. Administration for Community Living, http://www.agid.acl.gov/DataGlance/. Data-at-a-Glance: American Community Survey (ACS) Public Use Microdata Sample (PUMS) 1-Year Files (2013), accessed January, 10, 2016. [↑](#footnote-ref-32)
33. 2015 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov> [↑](#footnote-ref-33)
34. Muramatsu, Naoko. “Risk of Nursing Home Admission Among Older Americans: Does States’ Spending on Home and Community-Based Services Matter?” May 2007. Journal of Gerontology: Psychological Sciences. [↑](#footnote-ref-34)
35. AoA’s FY 2014 State Program Report. [↑](#footnote-ref-35)
36. 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, 2014. Release Date: June 2015 (<http://www.census.gov/popest/data/index.html>). Accessed 25 August 2015 and AoA’s FY 2014 State Program Report. [↑](#footnote-ref-36)
37. 2015 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>. [↑](#footnote-ref-37)
38. Ibid. [↑](#footnote-ref-38)
39. 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 (2013), accessed January, 10, 2016. [↑](#footnote-ref-39)
40. AoA’s FY 2014 State Program Report. [↑](#footnote-ref-40)
41. 2015 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>.. [↑](#footnote-ref-41)
42. 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> [↑](#footnote-ref-42)
43. Ibid. [↑](#footnote-ref-43)
44. 2015 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>. [↑](#footnote-ref-44)
45. AoA’s FY 2014 State Program Report. [↑](#footnote-ref-45)
46. Ibid. [↑](#footnote-ref-46)
47. 2015 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>. [↑](#footnote-ref-47)
48. Ibid. [↑](#footnote-ref-48)
49. [↑](#footnote-ref-49)
50. National Center for Health Statistics. Health, United States, 2014: With Special Feature on Adults Aged 55-64. Table 16. Life Expectancy at birth, at age 65, and at age 75, by sex, race, and Hispanic origin: United States, select years: 1900 – 2013. Hyattsville, MD. 2015*.* <http://www.cdc.gov/nchs/hus.htm>. Accessed 25 August 2015. [↑](#footnote-ref-50)
51. Murphy SL, Kochanek, KD, Xu JQ, Arias, E. Mortality in the United States, 2014. NCHS data brief, no 229, Hyattsville, MD: National Center for Health Statistics 2015 [↑](#footnote-ref-51)
52. 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 January 8, 2015. [↑](#footnote-ref-52)
53. Ackermann, R. T., Williams, B., Nguyen, H. Q., Berke, E. M., Maciejewski, M. L., & LoGerfo, J. P. (2008). Healthcare Cost Differences with Participation in a Community‐Based Group Physical Activity Benefit for Medicare Managed Care Health Plan Members. Journal of the American Geriatrics Society, 56(8), 1459-1465. [↑](#footnote-ref-53)
54. 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>. [↑](#footnote-ref-54)
55. A summary of these studies can be found at: <http://www.acl.gov/Programs/CDAP/OPE/ADEPP.aspx>. [↑](#footnote-ref-55)
56. 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. [↑](#footnote-ref-56)
57. U.S. Centers for Disease Control and Prevention (2008). The State of Mental Health and Aging in America, Healthy Aging Program, Issue Brief #1. [↑](#footnote-ref-57)
58. 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. [↑](#footnote-ref-58)
59. Program to Encourage Rewarding Lives for Seniors (2012). Description available at: <http://www.pearlsprogram.org/> [↑](#footnote-ref-59)
60. Centers for Medicare & Medicaid Services, CMS’ Chronic Conditions among Medicare Beneficiaries Chartbook for 2014. [figure 13] Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook\_Charts.html. Accessed February 26, 2016. [↑](#footnote-ref-60)
61. 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/. [↑](#footnote-ref-61)
62. 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. [↑](#footnote-ref-62)
63. Parekh, A.K., et al. 2011. Managing Multiple Chronic Conditions: a Strategic Framework for Improving Health Outcomes and Quality of Life. Public Health Rep. 126(4):460–71. [↑](#footnote-ref-63)
64. Centers for Medicare & Medicaid Services, CMS’ Chronic Conditions among Medicare Beneficiaries Chartbook for 2014. [figure 13] Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook\_Charts.html. Accessed February 26, 2016. [↑](#footnote-ref-64)
65. Brady, T.J., et al. 2013. “A Meta-analysis of Health Status, Health Behaviors, and Health Care Utilization Outcomes of the Chronic Disease Self-Management Program.” Prev Chronic Dis 10:120112. [↑](#footnote-ref-65)
66. Centers for Medicare & Medicaid Services, Report to Congress: The Centers for Medicare & Medicaid Services’ Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act. http://innovation.cms.gov/Files/reports/CommunityWellnessRTC.pdf. Accessed August 4, 2015. [↑](#footnote-ref-66)
67. Ahn S et al. The Impact of Chronic Disease Self-Management Programs: Healthcare Savings through a Community-Based Intervention. BMC Public Health. 2013. 13:1141. doi:10.1186/1471-2458-13-1141 Available at: http://www.biomedcentral.com/1471-2458/13/1141. Accessed August 4, 2015. [↑](#footnote-ref-67)
68. Racial/ethnic minorities refer to individuals who self-report at least one of the following racial or ethnic identities: Asian, Black or African American, Hispanic or Latino, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native. [↑](#footnote-ref-68)
69. 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. [↑](#footnote-ref-69)
70. U.S. Department of Health and Human Services, Mental Health: A Report of the Surgeon General (Rockville, MD: 1999). [↑](#footnote-ref-70)
71. Husaini, B,A, et. Al (2000). Prevalence and cost of treating mental disorders among elderly recipients of Medicare services. Psychiatric Services, 51, 1245-1247. [↑](#footnote-ref-71)
72. Katon,W., Ciechanowski, P. (2002). Impact of major depression on chronic medical illness. Journal of Psychosomatic Research, 53, 859-863. [↑](#footnote-ref-72)
73. Tromp AM, Pluijm SMF, Smit JH, et al. Fall-risk screening test: a prospective study on predictors for falls in community-dwelling elderly. J Clin Epidemiol 2001;54(8):837–844. [↑](#footnote-ref-73)
74. Stevens JA, Ballesteros MF, Mack KA, Rudd RA, DeCaro E, Adler G. Gender differences in seeking care for falls in the aged Medicare Population. American Journal of Preventive Medicine 2012;43:59–62. [↑](#footnote-ref-74)
75. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web–based Injury Statistics Query and Reporting System (WISQARS) [online]. Accessed August 15, 2013. [↑](#footnote-ref-75)
76. Stevens JA, Corso PS, Finkelstein EA, Miller TR. The costs of fatal and nonfatal falls among older adults. Injury Prevention 2006a;12:290–5. [↑](#footnote-ref-76)
77. Tinetti, M.E., Dorothy I. Baker, D.I., King, M, Gottschalk, M.,Murphy, T.E., Acampora,D., Carlin, B.P., Linda Leo-Summers, L., and Allore, H.G. (2008) Effect of Dissemination of Evidence in Reducing Injuries from Falls. N Engl J Med;359:252-61. [↑](#footnote-ref-77)
78. Report to Congress: The Centers for Medicare & Medicaid Services’ Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act. Accessed February 10th, 2015 from:http://innovation.cms.gov/Files/reports/CommunityWellnessRTC.pdf. [↑](#footnote-ref-78)
79. Carande-Kulisa, V., et al. (2015), A cost–benefit analysis of three older adult fall prevention interventions, Journal of Safety Research, Accessed February 2nd, 2015 from: http://www.cdc.gov/homea ndrecreationalsafety/Falls/steadi/index.html#practice. [↑](#footnote-ref-79)
80. Research Report: Caregiving in the U.S. 2015- A Focused Look at Caregivers of Adults Age 50+. National Alliance for Caregiving and AARP Public Policy Institute. June 2015. http://www.caregiving.org/wp-content/uploads/2015/05/2015\_CaregivingintheUS\_Care-Recipients-Over-50\_WEB.pdf [↑](#footnote-ref-80)
81. Ibid. [↑](#footnote-ref-81)
82. Valuing the Invaluable: 2015 Update, The Growing Contributions and Costs of Family Caregiving. AARP Public Policy Institute. July 2015. <http://www.aarp.org/ppi/info-2015/valuing-the-invaluable-2015-update.html>. [↑](#footnote-ref-82)
83. *The Opportunity Costs of Informal Elder-Care in the United States.* TheRand Corporation. 2014. http://www.rand.org/pubs/external\_publications/EP66196.html. [↑](#footnote-ref-83)
84. 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> [↑](#footnote-ref-84)
85. Perkins, M., Howard, V. J., Wadley, V. G., Crowe, M., Safford, M. M., Haley, W. E., Roth, D. L. (2013). Caregiving strain and all-cause mortality: Evidence from the REGARDS Study. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 68,* 504-512. doi:10.1093/geronb/gbs084

. [↑](#footnote-ref-85)
86. Roth, D. L., Haley, W. E., Hovater, M., Perkins, M., Wadley, V. G., & Judd, S. (2013). Family caregiving and all-cause mortality: Findings from a population-based propensity-matched analysis. *American Journal of Epidemiology, 178,* 1571-1578. doi:10.1093/aje/kwt225 [↑](#footnote-ref-86)
87. Roth, D. L., Fredman, L., & Haley, W. E. (2015, Special Issue). Informal caregiving and its impact on health: A reappraisal from population-based studies. *The Gerontologist, 55,* 309-319. doi:10/1093/geront/gnu177 [↑](#footnote-ref-87)
88. 2015 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov> [↑](#footnote-ref-88)
89. 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. [data tables 2.5a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html. Accessed 23 October, 2014.. [↑](#footnote-ref-89)
90. AoA’s FY 2014 State Program Report.  [↑](#footnote-ref-90)
91. 2015 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>. [↑](#footnote-ref-91)
92. Center on Aging Society. (2005) How Do Family Caregivers Fare? A Closer Look at Their Experiences. (Data Profile, Number 3). Washington, DC: Georgetown University. [↑](#footnote-ref-92)
93. Research Report: Caregiving in the U.S. 2015- A Focused Look at Caregivers of Adults Age 50+. National Alliance for Caregiving and AARP Public Policy Institute. June 2015. http://www.caregiving.org/wp-content/uploads/2015/05/2015\_CaregivingintheUS\_Care-Recipients-Over-50\_WEB.pdf

. [↑](#footnote-ref-93)
94. 2015 National Survey of Older Americans Act participants. <http://www.agid.acl.gov>. [↑](#footnote-ref-94)
95. 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. [↑](#footnote-ref-95)
96. 2015 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov> [↑](#footnote-ref-96)
97. *Ibid.* [↑](#footnote-ref-97)
98. National Alliance for Caregiving and AARP. Caregiving in the U.S. 2015 – Focused Look at Caregivers of Adults Age 50+. http://www.caregiving.org/wp-content/uploads/2015/05/2015\_CaregivingintheUS\_Care-RecipientsOver-50\_WEB.pdf [↑](#footnote-ref-98)
99. 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 [↑](#footnote-ref-99)
100. National Family Caregivers Association. (2011). *Allsup Family Caregiver Survey.* Kensington, MD. [↑](#footnote-ref-100)
101. National Alliance for Caregiving and AARP, 2009. [↑](#footnote-ref-101)
102. National Alliance for Caregiving. (2012). *Multiple Sclerosis Caregivers.* Washington, DC: Author. [↑](#footnote-ref-102)
103. The Arc, 2011. [↑](#footnote-ref-103)
104. U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population by Sex, Single Year of Age, Race Alone or in Combination, and Hispanic Origin for the United States: April 1, 2010 to July 1, 2014 Released June 2015, accessed 25 August 2015. [↑](#footnote-ref-104)
105. 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 (2013), accessed 25 August 2015. [↑](#footnote-ref-105)
106. Administration on Aging, U.S. Population by Age: 65+ Minority Population Comparison using Census 2000 and Census 2010 (July 1, 2011). [↑](#footnote-ref-106)
107. National Council on Disability, “Understanding Disabilities in American Indian and Alaska Native Communities: Toolkit Guide” (2003). [↑](#footnote-ref-107)
108. Centers for Disease Control and Prevention, “CDC Health Disparities and Inequalities Report – United States” (2013). [↑](#footnote-ref-108)
109. .AoA’s FY 2014 Title VI Program Report.  Title VI of the Older Americans Act permits tribes to establish age of eligibility for services below age 60. Calculation based on eligible population as reported in grantee applications [↑](#footnote-ref-109)
110. AoA’s FY 2014 Title VI Program Report. [↑](#footnote-ref-110)
111. Ibid. [↑](#footnote-ref-111)
112. 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 [↑](#footnote-ref-112)
113. 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 [↑](#footnote-ref-113)
114. 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. [↑](#footnote-ref-114)
115. 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. [↑](#footnote-ref-115)
116. AoA’s FY 2014 State Program Report [↑](#footnote-ref-116)
117. Minority refers to individuals who self-report at least one of the following racial or ethnic identities: Asian, Black or African American, Hispanic or Latino, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native. [↑](#footnote-ref-117)
118. Minority refers to individuals who self-report at least one of the following racial or ethnic identities: Asian, Black or African American, Hispanic or Latino, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native. [↑](#footnote-ref-118)
119. This amount reflects Title VII-2 designated as Ombudsman Program Activity funds. States also utilize other Older Americans Act and other funding sources to operate the Ombudsman program (see Figure 1, on page 51 ) . [↑](#footnote-ref-119)
120. “Real People, Real Problems: An Evaluation of the Long-Term Care Ombudsman Program of the Older Americans Act,” IOM (1995) [↑](#footnote-ref-120)
121. National Ombudsman Reporting System (NORS) is the source for this and other data in this section. NORS data is reported annually by states to ACL. [↑](#footnote-ref-121)
122. 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. [↑](#footnote-ref-122)
123. The Independent Sector places the value of the volunteer time at $22.55 per hour placing the value of 786,861 hours at $18,152,893. [↑](#footnote-ref-123)
124. 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). [↑](#footnote-ref-124)