DEPARTMENT of HEALTH and HUMAN SERVICES

ADMINISTRATION ON AGING

ADMINISTRATION FOR COMMUNITY LIVING

FY 2012 Report to Congress

FROM THE ADMINISTRATION ON AGING

All Americans, regardless of age and disability, should be able to live with dignity, make their own choices, live at home with the supports they need, and participate fully in communities that value their contributions. To help meet these needs, during 2012 the U.S. Department of Health and Human Services (HHS) created the Administration for Community Living (ACL).

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

As part of this important mission, I am pleased to present AoA's Report to Congress for Fiscal Year (FY) 2012. 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), including 53 state long-term care ombudsman programs, 629 area agencies on aging (AAA), 256 Indian tribal and Native Hawaiian organizations, nearly 20,000 direct service providers, and hundreds of thousands of volunteers. AoA's core programs, authorized under the Older Americans Act (OAA), help seniors remain at home for as long as possible and advocate for quality of care and promotion of rights for individuals who live in long-term care facilities (nursing homes, board and care, assisted living and similar settings). These services complement efforts of the nation's public health network as well as existing medical and health care systems, help prevent hospital readmissions and support some of life's most basic functions, such as bathing or preparing food. AoA and the national aging services network annually serve more than 12.7 million Americans aged 60 and over and their caregivers.

An estimated 61 million older adults age 60 and over resided in the U.S. in 2012.[1] By 2030, when the last of the baby boomers turn age 65, twenty percent of the population, or one in five Americans will be age 65 or over.[2] During this period, the number of seniors with severe

[1] Table 1. Annual Estimates of the Resident Population by Sex and Five-Year Age Group for the United States: April 1, 2010 to July 1, 2012. Source: U.S. Census Bureau, Population Division. http://www.census.gov/popest/data/national/asrh/2012/index.html. Estimates for U.S. Territories are taken from U.S. Census. International Data Base (IDB). <http://www.census.gov/population/international/data/idb/informationGateway.php>

[2] Table 12. Projections of the Population by Age and Sex for the United States: 2010 to 2050 (NP2008-T12). Source: Population Division, U.S. Census Bureau. <http://www.census.gov/population/www/projections/summarytables.html>

disabilities who are at greatest risk of nursing home admission will increase substantially. As these baby boomers age, the ranks of the oldest old (age 85+) will continue to swell.

Maintaining support for community-based services for assisting this growing population is important because reports indicate that making reductions in these services could lead to higher government expenditures in areas such as Medicaid.[3] 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. Because AoA's services assist people to remain independent and in their communities, they have the potential to prevent or delay institutionalization, which is more expensive to the government. If even a small percentage of service recipients are able to delay the institutionalization, it could have a significant impact on Medicaid expenditures.

The long-term care needs of today's growing numbers of older Americans place tremendous strain on families, and underscore the critical importance of continuing to invest in OAA programs, since if they become overwhelmed by the burdens of caregiving, the costs of providing this care could fall upon already overtaxed government resources.

The goal of the OAA and 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

[3] Shapiro, Adam and Loh, Chung-Ping. (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., Zimmerman, M., Macmillan, K., Rachlin, R., Reed, C., Hickey, A., Baca, B., Wiebold-Lippisch, L., Henning, E., Oslund, P., Hayes, J., Katz, B., & Shea, J. (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://www.oaltc.ku.edu/Reports/Community%20Tenure%20Study%20Report%20SFY%202003.pdf

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EXECUTIVE SUMMARY

The mission of the Administration on Aging (AoA), an agency within the Administration for Community Living (ACL) of the U.S. Department of Health and Human Services (DHHS), is to lead and support a comprehensive, coordinated and cost-effective system of home and community-based services. AoA advances the concerns and interests of older people, and works with and through the national aging services network, which is comprised of 56 state and territorial units on aging (SUA), 629 area agencies on aging (AAA), 254 tribal organizations, two Native Hawaiian organizations, nearly 20,000 direct service providers and hundreds of thousands of volunteers, to meet the needs and preferences of older Americans and their caregivers.

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's most basic functions, such as bathing or preparing meals. These programs also support family caregivers, address issues of exploitation, neglect and abuse of older adults, and adapt services to the needs of Native Americans. The most recent data available show that AoA and its national network rendered direct services to 12.7 million elderly individuals age 60 and over (over 20 percent of the country's elderly population) and their caregivers, including nearly three million clients who received intensive in-home services.[4] Critical supports, such as respite care and a peer support network, were provided to nearly 870,000 caregivers.

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

Overview of Performance

The fundamental purpose of OAA programs, in combination with the legislative intent that the national aging services network actively participate in supporting community-based services with particular attention to serving economically and socially vulnerable elders, led AoA to focus on three measures of performance: 1) improving efficiency; 2) improving client outcomes; and 3) effectively targeting services to vulnerable elder populations. Each measure is representative of several activities across OAA programs, and progress towards achieving each measure is tracked using a number of indicators. The efficiency measure and corresponding indicators are reflective of the Office of Management of Budget (OMB) requirements to measure efficiency for all program

[4] Data from AoA's FY 2012 State Program Report are preliminary and should not be taken as final.

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 2012, 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. Below 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 (ADLs) 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 2003, the national aging services network served home-delivered meals to 280,454 clients with three or more ADL impairments. By FY 2012, that number has grown by 30 percent to 365,000 clients.[5] 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 develops and tests performance measures. 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. Preliminary data indicate it has increased to 62.53 in FY 2012, which exceeds the program performance target score of 62.00.

- **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 2012, the national aging services network served 9,980 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.

[5] Data from AoA's FY 2012 State Program Report are preliminary and should not be taken as final.

- **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 (over $3 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, 509 ADRC sites have been established across 52 states, 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 2012, 97 percent of homemaker services clients reported that the services help them to continue living at home and transportation clients use the service to travel to critical appointments such as healthcare appointments (70 percent).[6] Over 90 percent of clients across all services are satisfied with OAA services. For example, over 97 percent of transportation clients rated services good to excellent and 96 percent of caregivers rated services good to excellent. 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 2012 through the OAA's programs. Additionally, a listing of grant funding allocations by state, territory and tribal organization can be viewed in the Appendix.

[6] 2012 National Survey of Older Americans Act Participants. http://www.agid.acl.gov,

FY 2012 National Program Services Summary Report[7]

	FY 2012
Total Clients	12,704,557
Total Registered Clients	2,855,661
% Minority Clients	25.82%
% Rural Clients	36.87%
% Clients Below Poverty	29.95%
# Senior Centers	10,000 (5,678 receive OAA funding)

Service	Persons Served	Units of Service[8]	Title III Expenditure	Total Expenditure
Personal Care	108,213	14,882,605	$11,630,184	$272,404,419
Homemaker	148,692	13,125,230	$25,658,650	$258,921,820
Chore	34,387	933,638	$5,133,308	$19,608,152
Home Delivered	851,632	137,411,560	$235,586,439	$786,976,426
Adult Day Care	19,269	8,000,089	$10,270,274	$87,100,442
Case Mgt.	452,642	3,982,975	$26,367,636	$265,409,004
Assisted Trans.	31,942	1,159,420	$3,290,182	$14,772,045
Congregate	1,627,434	86,287,771	$278,335,435	$677,572,324
Nutrition Counseling	19,269	8,000,089	$1,288,159	$2,559,513
Transportation		24,539,535	$68,809,383	$227,291,764
Legal Assistance		809,721	$24,845,042	$47,686,128
Nutr. Education		2,974,059	$4,188,469	$6,920,008
I&A		12,914,243	$53,873,941	$157,151,739
Outreach		1,690,959	$10,271,347	$21,008,081
Other			$84,687,224	$671,616,557

[7] Data from AoA's FY 2012 State Program Report are preliminary and should not be taken as final.

[8] 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

Caregivers Serving Elderly Individuals

Service	Caregivers Served	Service Units[9]	Title III Expenditure	Total Expenditure
Counseling, Support Groups, Training	127,933	451,797	$18,375,637	$26,674,741
Respite	64,975	6,009,218	$46,322,757	$93,964,821
Supplemental Services	33,664	699,749	$10,918,213	$15,072,966
Access Assistance	601,635	1,021,321	$25,584,554	$37,191,181
Unduplicated Caregivers Provided Service or Access	879,868			

[9] Title III-E service units definition:
Counseling = 1 session per participant
Respite Care = 1 hour
Supplemental services = variable
Access Assistance = 1 contact

PART I: HEALTH AND INDEPENDENCE

AoA's Health and Independence Programs provide a foundation of supports that assist older individuals to remain healthy and independent in their homes and communities, avoiding more expensive nursing home care. For example, 60 percent of congregate and 91 percent of home-delivered meal recipients reported that the meals enabled them to continue living in their own homes and 53 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.[10]

Between 2012 and 2020, the number of Americans age 60 and older will increase by nearly 16 million older adults, to reach 77 million seniors.[11] 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 30 percent.[12] 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 12 million elderly individuals and caregivers. AoA's services are especially critical for the nearly three million seniors who receive intensive in-home services, over half a million of whom meet the disability criteria for nursing home admission. These services help to keep these individuals from joining the 1.8 million seniors who live for extended periods of time in nursing homes.[13]

Home and Community-Based Supportive Services
(Title III-B of OAA; FY 2012: $366,916,000)

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

[10] 2012 National Survey of Older Americans Act Participants. http://www.agid.acl.gov, select AGID.

[11] U.S. Census Bureau, "2012 National Population Projections," Table 1. Projected Population by Single Year of Age (0-99, 100+), Sex, Race, and Hispanic Origin for the United States: July 1, 2012 to July 1, 2060 released December 2012, < http://www.census.gov/population/projections/data/national/2012/downloadablefiles.html> Accessed March 29, 2013.

[12] Ibid and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population (2011) [data table 2.5a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2011CharAndPerc.html . Accessed 25 July,2013.

[13] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population (2011) [data table 1.1]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2011CharAndPerc.html. Accessed July 25, 2013.

older persons remain in their own homes and communities instead of entering nursing homes or other types of institutional care.[14]

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, 59 percent are unable to perform critical activities of daily living and require long-term support[15]. Data also show that over 90 percent of seniors have at least one chronic condition and 75 percent have at least two.[16] 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 2012 include:[17]

- *Transportation Services* provided nearly 25 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 29 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 million hours of care for dependent adults in a supervised, protective group setting during some portion of a twenty-four hour day.

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[14] 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

[15] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population (2011) [data tables 2.1]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2011CharAndPerc.html. Accessed 25 July, 2013.

[16] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population (2011) [data tables 2.5a, 2.6a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2011CharAndPerc.html. Accessed 25 July, 2013.

[17] Data from AoA's FY 2012 State Program Report are preliminary and should not be taken as final.

- *Case Management Services* provided nearly 4 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, 45 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.[18] Many of these individuals cannot safely drive a car, as nearly 75 percent of transportation riders have at least one of the following chronic conditions that could impair their ability to navigate safely:[19]

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

Of the transportation participants, 95 percent take daily medications, while 14 percent report taking 10 to 20 medications daily.[20] 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.[21] For example, 80 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.[22] 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.[23]

Nationally, about 25 percent of individuals 60 and older live alone.[24] AoA programs serve a disproportionate number of people who live alone compared to the general population. For example, 64 percent of transportation clients live alone. 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

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[18] Ibid
[19] Ibid
[20] 2012 National Survey of Older Americans Act Participants. http://www.agid.acl.gov,
[21] Ibid.
[22] Ibid.
[23] 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.
[24] U.S. Census Bureau; American Community Survey, 2011, Special Tabulation on Aging; generated by AoA; using AoA's Aging Integrated Database (AgID) ; http://www.agid.acl.gov/CustomTables/; Accessed July 25, 2013.

assist with their care. Recent research has also shown that childless seniors who live in a state with higher home and community-based service expenditures had significantly lower risk of nursing home admissions.[25]

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.

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

Nutrition Services

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

- Congregate Nutrition Services (Title III-C1; FY 2012: $439,070,000): Provides funding for the provision of meals and related services in a variety of congregate settings, such as senior or community centers, which helps to keep older Americans healthy and prevents the need for more costly medical interventions. Established in 1972, the program also presents opportunities for social engagement and meaningful volunteer roles, which contribute to health and well-being.

- Home-Delivered Nutrition Services (Title III-C2; FY 2012: $216,830,000): Provides funding for the delivery of meals and related services to frail seniors who are homebound. Established in 1978, home-delivered meals are often the first in-home service that an older adult receives and serve as a primary access point for other home and community-based services. .

- Nutrition Services Incentive Program (Title III-A; FY 2012: $160,389,000): Provides additional funding to states, territories, and eligible tribal organizations that is used exclusively to provide meals and cannot be used to pay for other nutrition-related services or for administrative costs. Funds are awarded to states and tribes based on the number of meals served in the prior federal fiscal year. States and tribes have the option to purchase commodities directly from the U.S. Department of Agriculture (USDA) with any portion of their award if they determine that doing so will enable them to better meet the needs of seniors.

The meals provided through these programs fulfill the standards set by the Dietary Guidelines for Americans and provide a minimum of 33 percent of the Dietary Reference Intake, as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences.

Nutrition Services help approximately 2.5 million older adults receive the meals they need to stay healthy and decrease their risk of disability. Studies have found that 50 percent of all persons age 85 and over are in need of assistance with instrumental activities of daily living (IADLs),[26] including obtaining and preparing food. These nutrition programs help address their needs.

[26] Hung et al.: Recent trends in chronic disease, impairment and disability among older adults in the United States. BMC Geriatrics 2011 11:47.

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.[27] Many of the most common chronic conditions such as hypertension, heart disease, diabetes, and osteoporosis are impacted by 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 2 or more chronic conditions account for 93 percent of Medicare spending, and one-third of beneficiaries with 4 or more chronic conditions account for almost three-fourths of Medicare spending.[28]

Because the prevalence of multiple chronic conditions is higher among congregate and home-delivered meal 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, 68.4 percent of Medicare beneficiaries have two or more chronic conditions and 36.4 percent had four or more chronic conditions.[29] Data from AoA's national survey of older adult participants indicate that 47 percent of congregate and 60 percent of home-delivered meal participants have six or more illnesses or conditions. About 21 percent of congregate and 39 percent of home-delivered participants take over 6 medications per day and some take more than 20 medications.[30] The congregate and home-delivered meal program participants are significantly less healthy than the general Medicare population and access to adequate healthy meals is essential to their well-being.

Older adult participants served in the congregate and home-delivered nutrition programs demonstrate a need for healthy prepared meals, rather than simply access to food. Data from AoA's national survey of older adult participants indicate that about 16 percent of congregate and 60 percent of home-delivered meal participants indicate that they have three or more impairments in instrumental activities of daily living (IADLs). The data also indicate that about 17 percent of congregate and 58 percent of home-delivered meal participants need help in getting outside the house, thus limiting their ability to shop for food themselves.[31] Although many of these older adults may rely on family and friends for assistance, about 46 percent of congregate and 58 percent of home-delivered participants live alone.[32] 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.

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[27] Lochner KA, Cox CS. Prevalence of Multiple Chronic Conditions among Medicare Beneficiaries, United States, 2010. Prev Chronic Dis 2013; 10:120137. DOI http://dix.doi.org/10.5888/pcd10.12037
[28] *Ibid.*
[29] *Ibid.*
[30] 2012 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.
[31] *Ibid.*
[32] *Ibid.*

For example, data indicate that 77 percent of congregate and 83 percent of home-delivered meal participants say they eat healthier meals due to the programs, and 60 percent of congregate and 91 percent of home-delivered meal recipients say that the meals enable them to continue living in their homes.[33] The extra support provided by these programs can help older adults avoid more costly institutional care. Independent research has found that states that invest more in delivering OAA home-delivered meals to older adults' homes have lower rates of "low-care" seniors in nursing homes after adjusting for several other factors.[34] 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 1 percent when compared to the national average.[35]

AoA's annual performance data further demonstrate that these programs are highly valued by older individuals who need assistance in order to remain healthy and independent in their homes and communities. Ninety percent of home-delivered meal clients rate the service as good to excellent. Also, the number of home-delivered meal recipients with severe disabilities (3+ Activities of Daily Living) totaled nearly 365,000 in FY 2012. This level of disability is frequently associated with nursing home admission, and demonstrates the extreme frailty of a significant number of home-delivered meal clients. The most recent data on how these nutrition programs are helping seniors remain healthy and independent in their homes include:

- *Home-Delivered Nutrition Services* provided 137.4 million meals to over 850,000 individuals in FY 2012.
- *Congregate Nutrition Services* provided over 86.3 million meals to nearly 1.6 million seniors in a variety of community settings in FY 2012.

Consistent with the OAA's requirement to target services to those most in need to help them maintain their health and independence, approximately 72 percent of home-delivered meal recipients have annual incomes at or below $20,000.[36] Meals are especially critical for the 60 percent of recipients who report that these meals provide half or more of their food intake for the day.[37]

Federal support for Nutrition Services is not expected to serve every senior. These programs have strong partnerships with state and local governments, philanthropic organizations, and private donations that contribute funding. In FY 2012, state and local funding comprised approximately 65 percent of all the funding for home-delivered meals and congregate meals.[38] Though all programs funded through the OAA rely on state and

[33] *Ibid.*
[34] Thomas, K & Mor, 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
[35] *Ibid.*
[36] 2012 National Survey of Older Americans Act Participants. http://www.agid.acl.gov
[37] *Ibid*
[38] Data from AoA's FY 2012 State Program Report are preliminary and should not be taken as final.

local funding in some part, funding for congregate and home-delivered meals leverages more state and local financial support than many other OAA services.

State and Territory Flexibility
Under the core state formula grant programs for Home and Community-Based Supportive Services and Nutrition Services, states and territories have the flexibility to allocate resources to best meet local needs through intra-state funding formulas which distribute funds to area agencies on aging (AAAs). These formulas vary by state and allow states to take into account their own local circumstances to best serve their population. States are required to submit their formulas to AoA for approval and must take into account the geographic distribution of older persons and the distribution of older persons in greatest social and economic need. AAAs administers 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 2012, states transferred over $82 million from congregate nutrition to home and community-based services and home-delivered meals, as illustrated in the table below.

Table 1. FY 2012 Transfer of Federal funds within Title III of the OAA

	Part B – Home and Community-Based Supportive Services	**Part C1 – Congregate Nutrition**	**Part C2 – Home-Delivered Meals**
Initial Allotment	$365,402,129	$437,257,831	$215,935,133
Final Allotment after Transfers	$415,949,696	$354,909,823	$247,735,574
Net Transfer	+$50,547,567	($82,348,008)	+$31,800,441
Net Percent Change	13.83	(18.83)	14.73

Preventive Health Services

(Title III-D of OAA; FY 2012: $20,944,000)

Preventive Health Services, established in 1987, provides formula grants to states and territories based on their share of the population aged 60 and over to support activities that educate older adults about the importance of healthy lifestyles. These services also

promote healthy behaviors that can help to prevent or delay chronic disease and disability, thereby reducing the need for more costly medical interventions. Preventive Health Services provide states and territories with the flexibility to allocate resources among the preventive health activities 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. On average an American turning age 65 in 2010 can expect to live an additional 19.1 years.[39] The population of older Americans, particularly the population age 85 and over, which is growing very rapidly, totals 5.9 million in 2012 and is projected to reach 8.9 million by the year 2030.[40] One consequence of this increased longevity is the higher incidence of chronic diseases such as obesity, arthritis, diabetes, osteoporosis, and depression, as well as the greater probability of injury from a fall, which quickly limits physical activity.

In recent years, some states have increasingly shifted their funding to provide greater support for evidence-based approaches, especially to help individuals manage chronic diseases. Since evidence-based programs have demonstrated their effectiveness, AoA expects that states will be able to maximize the impact of these limited dollars. At the same time, if states wish to continue funding other health services, such as health screenings, they still have the flexibility to continue to use funds provided under the Home and Community-Based Services program for this purpose.

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

- *Enhanced fitness and wellness programs:* Enhanced fitness is a multi-component group exercise program designed for community-based organizations and intended to promote physical activity among older adults. Strength training using soft wrist and ankle weights; cardiovascular workout using dancing, aerobics, or walking; and balance and posture exercises are used to increase the physical health of older adults. Exercise has been proven to improve depression, which studies have shown is experienced by nearly 20 percent of U.S. adults age 65 and older. Exercise may also act as a buffer against many illnesses impacted by stress.

[39] National Center of Health Statistics, Health, U.S., 2012: With Special Feature on Emergency Care. Table 18. Hyattsville, MD 2013.
[40] U.S. Census Bureau, "2012 National Population Projections," Table 1. Projected Population by Single Year of Age (0-99, 100+), Sex, Race, and Hispanic Origin for the United States: July 1, 2012 to July 1, 2060 released December 2012, accessed 29 March 2013.

- *Falls prevention*: Falls prevention programs help adults 65 and over improve their strength, balance, and mobility; and provide education on how to avoid falls and reduce fall risk factors. Programs designed for health care providers give clinicians the tools needed to educate and care for their adult patients. Actions involve medication reviews and modifications; provide referrals for medical care management for fall risk factors. Recent studies have shown that in the United States more than one-third of adults age 65 and over fall each year. Of those who fall, 20 to 30 percent will experience serious injuries, such as head trauma, broken bones, or hip fractures. These injuries may limit their ability to get around or live independently. Many people limit their activity after a fall, which may reduce strength, physical fitness, and mobility.[41] Annually, older adult falls are responsible for over 21,000 deaths, 2.3 million emergency department visits, and over $30 billion in direct medical costs"

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

- *Depression Care Management:* Depression is not a normal part of aging, yet it is a prevalent and disabling condition among older adults. A recent national study found that 11.1 percent of Medicare beneficiaries age 65 and older living in the community reported feeling "sad or depressed much of the time over the previous year".[42] Older adults with depression "visit the doctor and emergency room more, use more medication, and stay longer in the hospital" than those without depression.[43] 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).[44] 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.[45]

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[41] Even, Jennifer. 2009. *Senior Series.* The Ohio State University Extension. May 20, 2009.

[42] 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.

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

[44] 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.

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

Chronic Disease Self-Management Education Programs

Chronic Disease Self-Management Education (CDSME) programs, such as the Stanford University Chronic Disease Self-Management Program (CDSMP), are low-cost, evidence-based disease prevention models that use state-of-the-art techniques and lay leaders in the community to help individuals with chronic disease address issues related to the management and treatment of their condition, improve their health status, and reduce their need for more costly medical care. In addition to the CDSMP, which is appropriate for any type of chronic condition, there are other proven CDSME programs, including the Spanish CDSMP, the Diabetes Self-Management Program (DSMP), Spanish DSMP, Chronic Pain Self-Management Program, Positive Self-Management Program for HIV, Arthritis Self-Management Program, and online versions of the CDSMP and DSMP.

In the United States, over 75 percent of older adults have multiple (two or more) chronic conditions,[46] placing them at greater risk for premature death, poor functional status, unnecessary hospitalizations, adverse drug events, and nursing home placement.[47] [48] Chronic conditions also impact health care costs: 93 percent of Medicare expenditures are for beneficiaries with chronic conditions.[49]

CDSME programs have been shown repeatedly, through multiple studies (including randomized controlled experiments, with both English and Spanish speaking populations) to be effective at helping participants adopt healthy behaviors and improve their psychological and physical health status.[50] Some evidence suggests that CDSME programs may also significantly reduce the use of hospital care and physician services, as well as reduce health care costs.[51]

CDSMEs emphasize an individual's role in managing his/her chronic condition(s). The in-person programs consist of a series of workshops that are conducted once a week for

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[46] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population (2011) [data tables 1.1]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2011CharAndPerc.html Accessed 25 July, 2013.

[47] 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/

[48] 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

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

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

[51] Sobel, DS, Lorig,KR, Hobbs,M. Chronic Disease Self-Management Program: From Development to Dissemination. *Permanente Journal*; Spring 2002.

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

AoA funds CDSME through competitive grants awarded to states. External experts review project proposals, and AoA awards grants for periods of up to three years. In FY 2012, AoA tracked the progress of the 47 state grantees funded through the American Recovery and Reinvestment Act of 2009. By September 30, 2012, grantees had reached over 91,000 completers, exceeding their 2-year goal of 50,000 completers. Grantees were successful in reaching their targeted, underserved populations; 73 percent were age 60 or older, over 60 percent reported having multiple chronic conditions, and over 31 percent were racial/ethnic minorities. A new round of grants, funded in September 2012 through the Prevention and Public Health Fund (PPHF), established by the Affordable Care Act, provided grants to 22 states to expand and target these activities. These three-year grants are allowing states to provide CDSME programs to approximately 80,000 older adults and adults with disabilities to help them better manage chronic conditions. All of the grantees identified underserved target populations and partnering organizations to reach these populations including tribal entities, Centers for Independent Living, and a variety of minority organizations. The funding is also fostering the development of comprehensive, integrated delivery systems to embed and sustain these programs within the long-term services and supports and health care systems.

Through financing from the FY2012 PPHF, AoA also funded a National Resource Center to provide technical assistance to the state grantees, evaluate progress in building sustainable distribution and delivery systems, and implement a national study to assess the impact of CDSMP activities in settings across the country. This study of over 1,100 participants is evaluating self-reported participant outcomes in general health, health interference in daily activities, symptoms, physical activity, use of medications, communication with health providers, and health care utilization. The PPHF also financed a contract to help expand access and sustainability of diabetes self-management programs by building the business acumen of the aging network and facilitating agreements with Medicare providers to obtain reimbursement for delivering those programs.

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 experience a behavioral health disorder.[52] 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, decrease life expectancy, and increase overall healthcare costs.[53,54,55] Distinctive barriers to the treatment of mental and behavioral health disorders among the older adult population exist, such as stigma, 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. The national aging services network is working closely with behavioral health, primary care, and other partners to reach older adults with mental and behavioral health interventions. Evidence-based programs, such as Screening, Behavioral Intervention and Referral to Treatment (SBIRT) and the Program to Encourage Rewarding Lives for Seniors (PEARLS), are being implemented through aging, behavioral health, and primary care partnerships. ADRCs in 40 states are collaborating with their state mental health authority to reach older adults who are at risk for mental and behavioral health disorders. In 38 of these states, ADRCs are partnering with community mental health clinics for a variety of prevention, assessment, and treatment services.[56]

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. Some that invest in mental and behavioral health services use a braided funding approach (i.e., use a combination of funds, such as those from the OAA – Title III-D, Substance Abuse and Mental Health Administration block grants, private foundations, etc.)

Beginning in June 2010, and continuing through FY 2012, AoA and the Substance Abuse and Mental Health Services Administration (SAMHSA) formally partnered to provide technical assistance aimed at increasing states' capacities for reaching older adults who are at-risk for behavioral health disorders. This partnership supported the development of a variety of tangible materials, such as epidemiological profiles, issue briefs, webinars, and a series of five older adult policy academy regional meetings (attended by 43 states, DC, PR, and the VI). The materials developed through this partnership have been

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[1]. 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

[53] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: 1999).

[54] Husaini, B,A, et. Al (2000). Prevalence and cost of treating mental disorders among elderly recipients of Medicare services. *PsychiatricServices*, 51, 1245-1247.

[55] Katon,W., Ciechanowski, P. (2002). Impact of major depression on chronic medical illness. *Journal of Psychosomatic Research, 53*, 859-863.

[56] Lugo, Joseph. (July 2013). "National Perspective NWD/ADRC System Activities". Presentation to the National Coalition of Mental Health and Aging.

successful in helping many states enhance their efforts to reach older adults who are at-risk for behavioral health disorders.

Caregiver Services

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

Better support for informal caregivers is critical because often it is their availability - whether they are informal family caregivers or unrelated friends and neighbors who volunteer their time - that determines whether an older person can remain in his or her home. In 2009, approximately 43.5 million adult caregivers provided uncompensated care to those 50 years of age and older.[57] AARP estimated the economic cost of replacing unpaid caregiving in 2009 to be about $450 billion, an increase from $375 billion in 2007 (i.e., the cost if that care had to be replaced with paid services).[58]

The demands of caregiving can lead to a breakdown of the caregiver's health, and the illness, hospitalization, or death of a caregiver increases the risk for institutionalization of the care recipient. Caregivers suffer from higher rates of depression than non-caregivers of the same age, and research indicates that caregivers suffer a mortality rate that is 63 percent higher than non-caregivers.[59] Providing support that makes caregiving easier for family caregivers, such as information, counseling and training, respite care, or supplemental services, is critical to sustaining caregivers' ability to continue in that role. Seventy-seven percent of the caregivers served by OAA programs report that these services allow them to provide care longer than they otherwise could.[60]

At the same time, AoA recognizes that it must also address the growing need for more caregivers every day. By 2020, it is projected that there will be 16.2 million non-institutionalized seniors age 65 and over with 1+ ADL deficits, an increase of four million seniors (or a 35 percent increase between 2011 and 2020) needing caregiver assistance.[61]

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

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

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

[60] 2012 National Survey of Older Americans Act Participants. http://www.agid.acl.gov

[61] U.S. Census Bureau, "2012 National Population Projections," Table 1. Projected Population by Single Year of Age (0-99, 100+), Sex, Race, and Hispanic Origin for the United States: July 1, 2012 to July 1, 2060 released December 2012, < http://www.census.gov/population/projections/data/national/2012/downloadablefiles.html> Accessed

National Family Caregiver Support Program

(Title III-E of OAA; FY 2012: $153,621,000)

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 in caring for their loved ones at home for as long as possible. The NFCSP includes five basic system components: information; access assistance; counseling and training; respite care; and supplemental services. These services work in conjunction with other OAA services - including transportation services, homemaker services, home-delivered meals, and adult day care - to provide a coordinated set of supports for seniors which caregivers can access on their behalf.

The NFCSP provides a variety of supports to family and informal caregivers. In FY 2012, these services included:[62]

- *Access Assistance Services,* which provided over 1.1 million contacts with caregivers, assisting them in locating services from a variety of public and private agencies.

- *Counseling and Training Services*, which provided over 138,000 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving.

- *Respite Care* Service, which provided nearly 68,000 caregivers with 6.3 million hours of temporary relief - at home, or in an adult day care or nursing home setting - from their caregiving responsibilities. This number represents only 0.16 percent of the 43.5 million caregivers who provide uncompensated care for older Americans.

Family and other informal caregivers are the backbone of America's long-term care system. On a daily basis, these individuals 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. Research has shown that caregiving exacts a heavy emotional, physical, and financial toll. As reported in AoA's 2012 National Survey of OAA Participants, 21 percent of caregivers are assisting two or more individuals. Seventy-one percent of Title III caregivers are 60 or older, making them more vulnerable to a decline in their own health, and 34 percent describe their own health as fair to poor.[63] The demands of caregiving can lead to a breakdown of the

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March 29, 2013 and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population (2011) [data table 2.5a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2011CharAndPerc.html . Accessed July 25,2013.

[62] Data from AoA's FY 2012 State Program Report are preliminary and should not be taken as final.

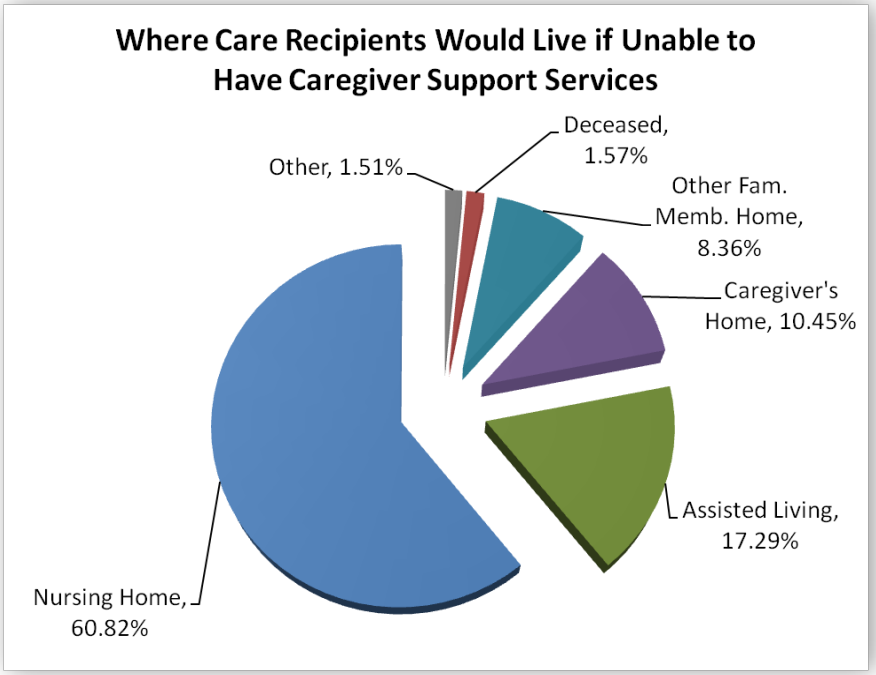
[63] 2012 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.

caregiver's health. The illness, hospitalization, or death of a caregiver increases the risk for institutionalization of the care recipient. Additionally, caregivers often experience conflicts between work and caregiving, with 25 percent reporting that they have had to make adjustments such as retiring or taking time away from work due to their caregiving responsibilities.

Studies have shown that the types of supports provided through the NFCSP can reduce caregiver depression, anxiety, and stress and enable them to provide care longer while often continuing to work, thereby avoiding or delaying the need for institutional care for their loved ones. For example, a recent 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.[64]

Additionally, data from AoA's national surveys of caregivers of elderly clients also show that OAA services, including those provided through the NFCSP, are effective in helping caregivers keep their loved ones at home. Approximately 77 percent of caregivers of program clients reported in 2012 that services enabled them to provide care longer than otherwise would have been possible.[65] Caregivers receiving services were also asked whether the care recipient would have been able to live in the same residence if the services had not been available. Forty-one percent of the caregivers indicated that the care recipient would be unable to remain at home without the support services. Those respondents were then asked to identify where the care recipient would be living without services. A significant majority of those caregivers, 78 percent, indicated that the care recipient would most likely be living in a nursing home or assisted living (see the chart on the next page).

[64] 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.
[65] *Ibid.*



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

Lifespan Respite Care

(FY 2012: $2,490,000)

Family caregiving for persons with disabilities occurs across the age spectrum from birth to death, with caregivers often being called upon to provide care to individuals of varying ages and disabilities. Most do so willingly, and often for many years. AARP estimated in 2009 that 65.7 million people served as unpaid family caregivers to an adult or child with special needs. For many of these caregivers, providing care can take a toll: a majority of caregivers (51 percent) caring for someone over age 18 have medium or high levels of burden and 31 percent of all family caregivers indicated they experienced high levels of stress.[66]

Numerous studies have shown respite care to be among the most frequently requested supportive service for family caregivers.[67, 68] Respite care is second only to direct financial assistance as a key policy priority of surveyed family caregivers. Even though respite services are often the preferred mode of family caregiver support, they are often under used, difficult to find and access, and are often unaffordable or in short supply. A 2009 survey found that "finding time for myself" was reported as a priority by 32 percent of family caregivers along with managing both physical and emotional stress (34 percent)

[66] National Alliance for Caregiving and AARP. Caregiving in the U.S.: A Focused Look at Those Caring for the 50+. 2009. http://www.aarp.org/research/surveys/care/ltc/hc/articles/caregiving_09.html
[67] 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
[68] National Family Caregivers Association. (2011). *Allsup Family Caregiver Survey.* Kensington, MD.

and balancing work and family responsibilities (27 percent). Despite these compelling numbers, nearly 90 percent of family caregivers receive no respite care at all.[69]

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.[70, 71] The population-specific barriers reported by caregivers include provider shortages and inadequate training, mistrust of formal service delivery systems, hesitancy to ask for help and lack of awareness of available programs and supports.

The Lifespan Respite Care program, authorized under the Lifespan Respite Care Act, 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 CareProgram bring together and seek to coordinate respite care services for family caregivers; training and recruitment of respite care workers and volunteers; and provision of information, outreach, and access assistance. They also 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 care 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 care principles and practice into statewide activities designed to improve systems and services for family caregivers of individuals of all ages with disabilities;

- Engaging respite care consumers to inform project activities; and

[69] National Alliance for Caregiving and AARP, 2009.
[70] National Alliance for Caregiving. (2012). *Multiple Sclersosis Caregivers.* Washington, DC: Author.
[71] The Arc, 2011.

- 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.

The Lifespan Respite Care Program also supports Technical Assistance Resource Center (TARC) activities as authorized by statute. To date, the Lifespan Respite Care 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.

To illustrate the importance of respite care, in a recent national survey of OAA service recipients a random sample of 1,926 caregivers (which represented over 186,450 active caregivers) answered questions about the impact of the caregiver program on their lives.[72] Fifty-six percent of caregivers received respite care services from the National Family Caregiver Support Program within the past twelve months. The respite care service recipients reported that as a result of the services they received:

- 79 percent had less stress;
- 87 percent said it was easier to care for their loved one;
- 73 percent reported that it was the most helpful service they received;
- 95 percent reported the care recipient benefited from the service; and
- 81 percent said that the services enabled them to care longer.

Since 2009, AoA has held competitive grant competitions each year to make Lifespan Respite Care Program funds available to states interested in enhancing or building statewide programs. To date, thirty states and the District of Columbia have been awarded initial 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.

Additionally, a total of ten states (eight in FY 2011 and two in FY 2012) were awarded expansion grants to focus specifically on providing respite services to meet demand, fill identified service gaps, and gather information about the impact of respite services on consumers. Finally, in FY 2012, seven of the original FY 2009 states received Integration

[72] 2012 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.

and Sustainability Grants to continue their work by focusing grant activities on service provision, respite care workforce development and training, performance measurement, and further program integration efforts. Examples of grantee accomplishments include:

- Development or enhancement of existing 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 plans and/or policies to guide future development of respite care and other caregiver support services;

- 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 or expansion of respite care 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; and

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

Grants for Lifespan Respite Care 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 that demonstrate the greatest likelihood of implementing or enhancing lifespan respite care statewide and are building or improving the capacity of their long-term care systems to respond to the comprehensive needs of care recipients.

Alzheimer's Disease Supportive Services Program
(FY 2012: $4,010,000)

Established under Section 398 of the Public Health Services Act, as amended, (42 U.S.C. 280c-3), the Alzheimer's Disease Supportive Services Program (ADSSP) funds competitive grants to states to expand the availability of evidence-based diagnostic and support services for persons with the disease, their families, and their caregivers, as well as to improve the responsiveness of home and community-based services systems to persons with dementia. The primary components of the ADSSP include delivering evidence-based supportive services; translating and replicating evidence-based interventions for persons with dementia and their caregivers at the community level; incorporating evidence-based research in the formulation of innovative projects; and advancing changes to a state's overall system of home and community-based care.

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

The most recent grant projects focused on integration of a statewide set of programs that includes a Single Entry Point/No Wrong Door access for individuals and ensuring access to a comprehensive, sustainable set of high quality services for persons with dementia. These three-year projects are being implemented in Georgia, Minnesota, New York and Ohio.

Through projects funded in prior years, fifteen states are in the process of translating nine evidence-based interventions into practice. One example of these promising evidence-based interventions is the New York University caregiver intervention, a spousal caregiver support program that, in a randomized controlled trial, delayed institutionalization of persons with dementia by an average of 557 days.[73] In 2012, the average nursing home cost was $222 daily for a semi-private room and $248 daily for a private room ($81,030 and $90,520 annually), which would mean an average savings of between $124,000 and $138,000 in institutional costs per person with dementia.[74] California, Florida, Georgia, Minnesota, Utah and Wisconsin are currently implementing this intervention. Preliminary results indicate findings similar to those from the original study. Additionally, 23 states, DC and Puerto Rico are offering innovative programming for

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

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

caregivers and their loved ones with dementia. States funded to implement innovative programs are focusing on areas of great need, such as working to ensure their long-term care services and support systems are dementia-capable.

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

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

Nutrition and Supportive Services

(FY 2012: $27,601,000)

Native American Nutrition and Supportive Services provides grants to eligible tribal organizations for the delivery of nutrition and home and community-based supportive services to Native American, Alaskan Native, and Native Hawaiian elders. According to the 2010 Decennial Census, approximately 325,000 persons age 60 and over identified themselves as Native Americans or Alaskan Natives, and another 267,000 persons age 60 and over identified themselves as part Native American or Alaskan Native.[75]

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 over one-fifth of eligible Native American seniors in participating tribal organizations, home-delivered meals reach 10 percent of such persons, and supportive services reach 41 percent of such persons.[76] 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 2012 include:[77]

- *Transportation Services*, which provided over 713,000 rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical activities.

- *Home-Delivered Nutrition Services,* under which 2.6 million meals were provided to over 22,000 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.

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[75] U.S. Census Bureau, "2010 Decennial Census," QT-P1. Age Groups and Sex. Population Group: American Indian Alaska Native alone, American Indian Alaska Native alone or in combination with one or more other races. released April 26, 2012, < http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t > Accessed August 26, 2013.

[76] 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.

[77] Title VI FY 2012 data are preliminary. Missing data have been imputed.

- *Congregate Nutrition Services*, which provided 2.3 million meals to more than 48,000 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 917,000 hours of outreach and information on services and programs to Native American elders and their families, thereby, empowering them to make informed choices about their service and care needs.

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

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

Caregiver Support Services

(FY 2012: $6,364,000)

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

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

Grants assist American Indian, Alaskan Native and Native Hawaiian families caring for older relatives with chronic illness or disability and grandparents caring for

grandchildren. The program provides a variety of direct services that meet a range of caregiver needs, including information and outreach, access assistance, individual counseling, support groups and training, respite care, and other supplemental services. 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.[78] 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.[79] 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.[80] 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.[81] 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.

These elder rights and elder justice programs will build a foundation and establish best practices for states to develop programs to expand and improve the protection of individuals living in their communities and in long-term care settings; increase the information and technical assistance available to the public, states, and localities in

[78] 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

[79] 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

[80] 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.

[81] 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.

preventing and addressing abuse; protect the rights of older adults and prevent their exploitation; reduce health-care fraud and abuse; and provide assistance to Tribes in developing elder justice systems. This multifaceted approach to preventing, detecting, and resolving elder abuse, neglect, and exploitation is essential to successfully fulfilling the shared mission of the Older Americans Act and the Elder Justice Act to maintain the health and independence of older Americans and adults with disabilities.

Prevention of Elder Abuse and Neglect

(FY 2012: $5,036,000)

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 2012 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 $35 million of expenditures for elder abuse prevention services come from non-OAA funds, a ratio of approximately $7 of non-OAA funds for every $1 investment of federal funds.

Examples of state elder abuse prevention activities include:

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

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

- The Wisconsin Bureau of Aging and Disability Resources developed, in collaboration with the National Clearinghouse on Later Life, information designed to raise awareness of caregivers who have experienced abuse in the

family, as well as of the risks and signs of abuse in later life. The information is available at: http://dhfs.wisconsin.gov/aps/Publications/publications.htm.

The Prevention of Elder Abuse and Neglect program demonstrates AoA's ongoing commitment to protecting the rights of vulnerable seniors and promoting their dignity and autonomy. Through education efforts, exposing problems that would otherwise be hidden from view, and providing a voice for those who cannot act for themselves, the program helps ensure that all older Americans are able to age with dignity in a safe environment.

National Center on Elder Abuse

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

In FY 2012, the NCEA:

- Continued its outreach by serving over 3,459 subscribers to its newsletter and over 1,800 members of the elder abuse listserv.

- Responded to over 450 individual public inquiries and requests for information.

- Effectively utilized technology to provide cost-effective trainings to over 600 professionals though live webcast forums on issues relevant to elder rights and consumer protection, and maintained the NCEA training library with over 230 resources.

- Supported systems change by identifying 342 local elder justice community coalitions and beginning to reach out to those communities to learn how they leverage local resources and expertise to prevent and combat elder abuse, neglect, and exploitation.

- Compiled 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 Adult Protective Services Resource Center

In response to the growing need for Adult Protective Services (APS) programs to improve investigation and response, train APS staff, and develop and disseminate best practices for interventions into reported incidents of elder abuse, neglect, and exploitation, AoA funded the first ever federal grant program to provide a national APS resource center (NAPSRC) in FY 2011. The goal of the NAPSRC is to provide current and relevant information and support to enhance the quality, consistency, and effectiveness of APS programs across the country. In FY 2012, the NAPSRC continued its work to enable state APS programs to enhance their critical role in responding to elders and adults with disabilities who are facing abuse, neglect, and exploitation by:

- Maintaining a NAPSRC webpage and social media accounts with best practices, promising practices, research, webinars, and other materials;
- Identifying evidence-based best practices for APS programs and interventions;
- Conducting an assessment of how state APS programs have successfully navigated the economic downturn and disseminating these "best practices" to other states; and
- Continuing to develop and disseminate information for APS programs.

Elder Abuse Prevention Interventions Program

In FY 2012, ACL received $5.5 million from the Prevention and Public Health Fund, established by the Affordable Care Act, to test and evaluate comprehensive approaches to preventing elder abuse involving multiple disciplines and systems, with the ultimate goal to use the findings to inform and improve state, local and tribal APS efforts.[82] This prevention project is focused on evaluating replicable best practices in support of the development of secondary and tertiary prevention and intervention strategies for elder abuse, neglect, and exploitation using a multidisciplinary approach that involves social services and health care providers, adult protective services, and the legal and justice systems. Using the results of these prevention projects, AoA is working to develop a compendium of best practices and lessons learned that APS programs across the nation can use to improve their programs. The cumulative results of these projects will allow AoA to establish a strong evidence-base for current and future projects.

Five states and three tribes received funding to conduct a three-year project to test their proposed interventions. These grantees were awarded all of their grant funding up-front to be used over a three-year budget period.

[82] This program is authorized by Section 411 of the Older Americans Act, Section 2042 of the Patient Protection and Affordable Care Act, and Section 4002 of the Affordable Care Act (PPHF)

Model Approaches to Statewide Legal Assistance Systems
(FY 2012: $1,992,228)

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

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

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

As a key centerpiece of the Model Approaches projects, SLHs assist seniors in accessing quality legal services to ensure their rights and enhance their independence and financial security. In 2012, Model Approaches projects assisted 24,379 older consumers with the most social or economic needs on a wide range of priority legal issues related to public benefits, health care, housing, advance planning, and consumer protection. Some recent examples of the success of SLHs' experience in assisting seniors include:

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

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

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

In addition to providing assistance on priority legal issues, SLHs under Model Approaches have been very successful in reaching low income populations with over 71 percent of older clients having incomes at or below 200 percent of the federal poverty guidelines. Minority clients receiving assistance through SLHs in the last reporting period constituted 37 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.

Other legal service delivery system outcomes achieved in FY 2012 and anticipated for all Model Approaches projects include:

- Comprehensive statewide legal needs assessments that identify the legal issues impacting seniors in target populations and assess the capacity of existing service delivery systems to meet those identified needs;

- Enhanced collaboration among area agencies on aging, ADRCs, SLHs, and legal providers in identifying and serving seniors most in need of assistance on priority legal issues;

- Enhanced service delivery capacity of legal services programs and SLHs through the leveraging of low cost service delivery mechanisms such as SLHs, private bar *pro bono* attorneys, law school clinics, and self-help sites; and

- Strengthened systems that reach underserved and hard-to-reach seniors most in need through effective targeting and outreach methodologies.

National Legal Assistance and Support Projects
(FY 2012: $743,592)

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

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

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

In FY 2012, 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 9,700 aging and legal service professionals nationwide. NLRC partners also provided important technical support in the implementation of the Model Approaches projects in nine 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 18 SLHs and provided resources to aging service professionals in an additional ten states.

An essential premise 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 issue areas. In FY 2012, 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 (see www.nlrc.gov).

Pension Counseling and Information Program

(FY 2012: $1,712,757)

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 that people face are just as complex, and good help is just as hard to find – even more so for those with only modest benefits at stake. The role of the Pension Counseling and Information Program is to help ensure that all older Americans have access to the help they need in order to secure the employer-sponsored retirement benefits they have earned --- benefits that are critical to their ability to live independently and with dignity after a lifetime of productive

employment. The Pension Counseling and Information Program provides help that would be otherwise unavailable, by assisting individuals in understanding and exercising their pension rights. The program promotes the financial security of older individuals by offering them the help they need to receive the pension benefits they have earned. The income, in turn, provides increased opportunities for choice and independence.

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

Data show that since the program's inception in 1993, the Pension Counseling projects have recovered over $175 million in retirement benefits for individual claimants. With a relatively small federal investment, the program has brought in a return of more than $8.00 for every federal dollar invested in the program. These recoveries demonstrate that pension counseling is not only necessary, but that it can be provided efficiently and effectively. For example, during the six-month period of July through December 2012, the projects recovered over $43 million in client benefits and assisted approximately 8,675 individuals.

The significance of the projects' work is best demonstrated through discussion of a typical case successfully resolved during this period:

- A 79-year-old widow contacted one of the regional counseling projects for assistance in obtaining survivor's benefits from her late husband's pension plan. Her husband had died in 2010 at the age of 79 without ever receiving his pension. The pension plan administrator incorrectly stated that the widow was ineligible for a survivor's benefit because her late husband had failed to file an election form giving her a Qualified Pre-Retirement Survivor Annuity. Project staff explained that the 50 percent survivor annuity is the automatic form of benefit payment for any vested participant who was alive as of August 23, 1984, and whose benefits were not yet in pay status on that date. After filing a claim on behalf of the widow, the company agreed to calculate and pay the survivor's benefit, retroactive to the date of her late husband's death.

As this case demonstrates, improper plan administration can deprive a plan participant and/or the surviving spouse of the benefit that he or she has legitimately earned. The project's expertise, knowledge and diligence were needed by the client to make sure that the plan had correctly interpreted and complied with pension law. Due to the complexity of the matter and the pension plan administrator's failure in applying the law, it is extremely unlikely either that the widow would have been able to pursue the case on her own, or that she could have found an attorney, agency, or organization to assist her.

Without the assistance of the project, she may well have been deprived of a lifetime retirement benefit. The retroactive lump sum and ongoing monthly lifetime benefits which the project secured have a value of over $27,000, which will have a significant impact on this individual's life and on her economic security.

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, 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 (see http://www.PensionHelp.org).

Senior Medicare Patrol Program

(FY 2012: $9,402,196)

The Senior Medicare Patrol (SMP) program provides competitive grants to 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. Projects use the skills of these volunteers to conduct community outreach and education and provide information that empowers Medicare beneficiaries, their families, and caregivers to prevent, identify, and report fraud. Activities are carried out in partnership with the Centers for Medicare & Medicaid Services, the HHS Office of Inspector General (OIG), healthcare providers, and other aging and elder rights professionals from around the country.

Annually, the OIG gathers and analyzes the data housed in the SMARTFACTS data tracking system. These data are published as a report on the SMP program. This report for Calendar Year 2012 shows that SMP projects:

- Had 5,137 active volunteers who worked 120,953 hours to educate beneficiaries about how to prevent Medicare and Medicaid fraud;

- Educated 449,509 beneficiaries in 14,748 group education sessions and held 113,457 one-on-one counseling sessions with or on behalf of beneficiaries;

- Conducted 10,032 community outreach education events; and

- Resolved 83,856 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 four million beneficiaries in 108,825 group education sessions and held 1,292,647 one-on-one counseling sessions;

- Conducted 93,894 community outreach education events; and

- Documented over $112 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. This does not attempt to quantify the *total* savings that occur as a result of the SMP program's sentinel effect, impact on fraud deterrence, or calls to fraud hotlines or other non-SMP contacts.

Health Care Fraud and Abuse Control (HCFAC)

(FY 2012: $10,769,050)

The Administration on Aging (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 error, fraud and abuse in the Medicare and Medicaid programs. HCFAC funds provide federal support (including infrastructure, technical assistance, program support and capacity building) to the Senior Medicare Patrol (SMP) program.

HCFAC funds allow ACL to maintain effective oversight of and partnerships with each of the 54 SMP Projects. The National Consumer Protection Technical Resource Center (the Center), which provides training, technical assistance, support and information to SMP grantees, is supported by HCFAC funding. The Center has focused on:

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

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

- volunteer recruitment and training;

- education to rural, geographically isolated, and low literacy individuals, including tribal members; and

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

Approximately 8.5 FTEs, supported with HCFAC funds, provide technical assistance and oversight in support of SMP projects. HCFAC funds also are used to provide ongoing technical support for the SMP management, tracking and reporting system.

In addition to the infrastructure and technical assistance described above, in FY 2012, SMP projects received an additional $7.3 million from HCFAC funds to increase program capacity and to expanded outreach and education efforts. These capacity-building activities were originally supported in 2010 and again in 2011 by CMS, which provided funding for the award of an additional $9 million in grants from its Program Integrity funding, and are targeted to help the 54 SMP programs fight Medicare fraud in high fraud states and expand the capacity of the program to reach more beneficiaries.

Long-Term Care Ombudsman Program
(FY: $16,761,000)

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

Each state has an Office of the State Long-Term Care Ombudsman, headed by a full-time state long-term care ombudsman who directs the program statewide. Thousands of local ombudsman staff and volunteers, designated by the state ombudsman as representatives, assist residents and their families by resolving complaints and providing information related to long-term care services and supports. The long-term care ombudsman is the local problem-solver for individuals living in long-term care facilities and is an invaluable resource to residents, their families and facility staff.

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

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

This report provides data for FY 2012 from the Long-Term Care Ombudsman Program nationwide, based on state and local level activities. The data and other information presented and analyzed in this report are collected annually by AoA from State Long-Term Care Ombudsmen through the National Ombudsman Reporting System (NORS).

<u>Complaint Investigation and Resolution</u>

Long-Term Care Ombudsmen provide an alternative dispute resolution service, resolving complaints for or on behalf of long-term care facility residents. In FY 2012:

- Ombudsmen nationwide resolved 193,650 complaints.

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

- Of the 126,398 cases closed by ombudsmen,[83] 93,311 (74 percent) were associated with nursing facility settings. Of the remaining cases, 30,194 (24 percent) were related to board and care and other similar facilities (including assisted living), and 2,893 (two percent) were associated with non-facility settings or services to facility residents by an outside provider.

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

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

The five most frequent nursing facility complaints 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 board and care complaints were:

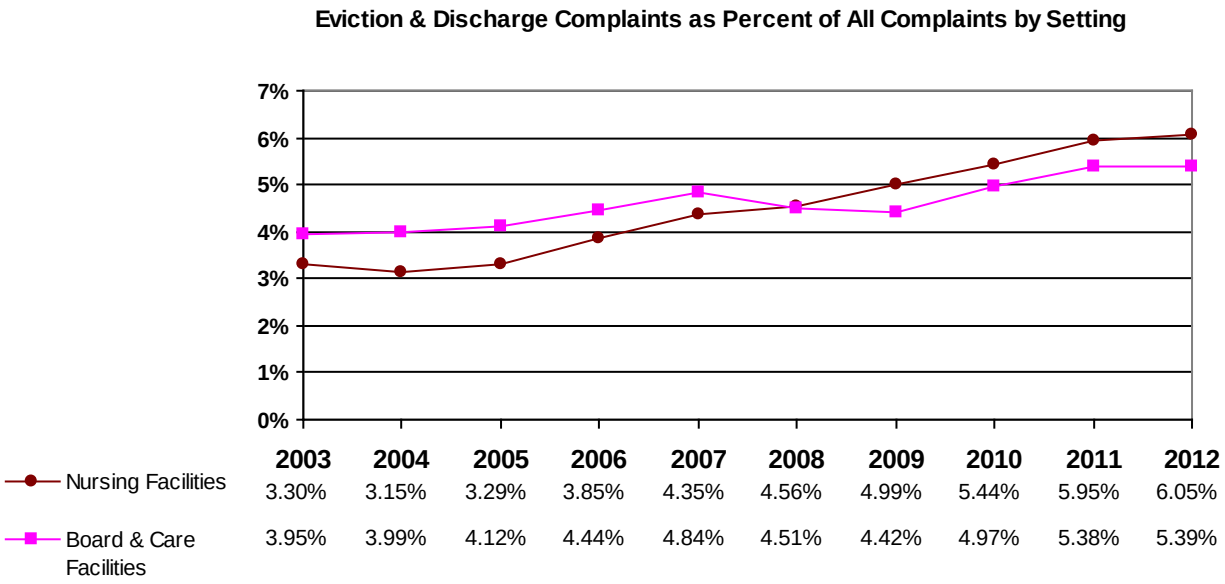
- administration and organization of medications;
- inadequate or no discharge/eviction notice or planning;
- quality, quantity, variation and choice of food;
- lack of respect for residents, poor staff attitudes; and
- equipment or building hazards.

Improper Eviction/Inadequate Discharge Planning – a troubling trend:

Long-term care ombudsmen are often the primary responders to complaints about eviction or inadequate discharge/planning. This complaint has consistently been among the top ten complaint issues investigated and responded to by long-term care ombudsmen, with the issue's prevalence rising to the top five within the last three years, and to the top complaint in nursing homes during FY 2012 and 2011. See Figure 1.

[83] In FY 2012, ombudsmen opened 127,896 new cases (a case contains one or more complaints originating from the same person(s), and completed resolution work on 126,398 closed cases, containing 193,650 complaints.

Figure 1



Reasons for the increase include the complexity of residents' needs, requiring additional training and skill of facility staff; a lack of understanding of Medicaid requirements, which has made some nursing home residents ineligible and therefore lacking a payment source; or financial exploitation, where a responsible party chooses to not pay the bill.

Barriers to successful resolution include a lack of available resources (including legal services) to assist residents and families in responding and appealing transfer/discharge notices; and unnecessary and prolonged hospitalizations of residents who linger because a nursing home has refused to readmit them in accordance with federal regulation and/or an administrative ruling. Eviction from what is often considered the resident's home creates risk of displacement from their community, family and friends, risk of homelessness and unnecessary and costly hospitalizations.

Ombudsmen Advocacy Efforts - Evictions and Improper Discharge Planning

- *Legal Advocacy*: An ombudsman attorney contested a discharge of a resident who was being moved from a skilled nursing home without the required notice and information on the location where the resident was to move. During the hearing, the judge granted a continuance and stayed the discharge. Although the facility allowed the resident to stay, they terminated all therapy services, which the family believed were essential to her recovery. The ombudsman attorney filed for clarification of the order and the judge confirmed that when he stayed the discharge, all services should continue. When the facility refused to comply, the attorney filed again to request compliance. The facility complied with the order and the resident received all of her necessary therapy services.

- *Agency Coordination & Education*: A state ombudsman, in collaboration with Medicaid and the Department of Public Health, made it a priority to address all nursing home discharges, including those for non-payment, to ensure that no resident is discharged because family/sponsors are not aware of, or are uninformed about, Medicaid application processes or their responsibility to provide documents to the Medicaid agency. The state ombudsman program contracted with a local law school to develop a toolkit on Medicaid eligibility application processes, and inappropriate discharges to educate local ombudsmen, facility staff, residents and family members on these topics. Training was held with local ombudsmen, family caregiver coordinators, and information and referral coordinators from area agencies on aging. The state ombudsman also coordinated efforts with the Medicaid agency to serve in an advisory capacity on Medicaid's Discharge Appeals Committee, and is now copied on all discharges from nursing homes.

Ombudsmen in Action

In addition to receiving, responding to, and resolving complaints, ombudsmen carry out a variety of duties designed to prevent problems, including routine visits to residents, consultations, and technical assistance to residents, their families and facility staff. In FY 2012, ombudsmen staff and volunteers nationwide provided:

- Routine visits to promote a regular presence to facility residents, visiting residents of 68 percent of nursing facilities and 25 percent of board and care and similar homes (including assisted living) at least quarterly.

- 309,423 consultations to individuals. Consultations most frequently addressed: alternatives to institutional care, information on Medicaid, transfer, discharge and eviction, residents' rights, and federal and state rules and policies impacting residents;

- 111,353 consultations to long-term care facility staff on a wide range of issues, including residents' rights, observations about care, working with resident behavioral issues, and transfer and discharge issues; and

- Resident and family council support – providing technical assistance, training and information to resident councils (21,365 sessions) and family councils (2,858 sessions).

They also:

- Trained long-term care facility staff (5,049 sessions);

- Educated the community (10,764 sessions); and

- Served as resident advocates and provided information to surveyors as part of long-term care facility surveys conducted by regulatory agencies (participating in 20,838 survey related activities).

Successful Complaint Resolution Supporting Resident Choice

"Mrs. Jones," a 90 year old veteran contacted her local ombudsman for assistance to return to her own home. She discussed her wish to return home and her passion for her work as a volunteer HAM operator. Mrs. Jones explained that she had become dehydrated while working in her yard and collapsed. After a stay in the hospital, she agreed to be admitted to a personal care home so that she could regain her strength.

After regaining her mobility and strength, she began to believe that her daughter did not want her to return home. She felt isolated in the remote area, far away from friends and family, and missed her association with fellow HAM operators. She explained that, in her community, she had access to everything she needed to remain independent at home, including elder transportation services. She was pleased with the care she received at the personal care home but she just wanted to go home.

With Mrs. Jones's approval, the ombudsman went to work to help her. The ombudsman explained her rights, including her right to self-determination, and arranged a meeting with the facility's administrative staff to discuss ways to help support Mrs. Jones's choice to move back into the community.

Today, she is living in her own home and reports to the ombudsman that she feels empowered and in control of her life again.

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

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

- Seeking legislative changes to strengthen protections against illegal or improper evictions; working with the provider industry to develop training and model forms to promote practices that support a resident's rights during discharge; training of ombudsmen and consumers on transfer and discharge rights.

- Promoting community living options and assisting nursing home residents who wish to return to the community to access transition programs, such as the Medicaid "Money Follows the Person" program.

- Recommending laws and government actions to prevent and improve responses to abuse, neglect and financial exploitation of vulnerable adults, including elders.

- Training of facility staff on strategies to reduce the use of anti-psychotic medications in nursing homes.

Partnerships to Identify and Eliminate Abusive Practices

Two local ombudsman programs participated with law enforcement, Adult Protective Services (APS), and the regulatory agency in a crackdown on unlicensed board and care providers who exploited vulnerable adults for their government benefits. These providers are subject to licensure as personal care homes, but have ignored the requirements, financially exploited the residents, and failed to provide adequate services.

Using an address list provided by the police department, teams located and inspected numerous houses, where residents with varying levels of mental and physical disabilities, were found living in deplorable conditions. The houses were filthy, roach infested, dark, hazardous, and lacked heat and food supplies. Many of these residents were afraid to talk to team members, and others were so afraid they requested to leave with the teams immediately. Residents recounted stories of physical abuse, withholding of medications, and financial exploitation. Throughout this long and arduous day, the long-term care ombudsmen served as a listening ear for the residents who had endured this situation, advocated for their rights and protections and provided support for the other team members.

This effort proved to be a resounding success. All of the residents who were living in these homes were relocated elsewhere. The operator of these homes, as well as some of her family members and employees, were arrested and charged with numerous counts of abuse, neglect, and exploitation of vulnerable adults.

A second collaborative effort with law enforcement, regulators, Adult Protective Services and the Ombudsman Program successfully closed a similar operation. The perpetrator in that case is also awaiting prosecution.

In response to the on-going problem of unlicensed homes, the long-term care ombudsman, along with other aging advocates, testified in support of, and advocated successfully with policy makers for, passage of a law that makes it a misdemeanor on the first offense to operate an unlicensed personal care home, and a felony on the second offense.

Providing Ombudsman Services

There are 53 state ombudsmen (50 states, plus the District of Columbia, Puerto Rico, and Guam). In most states, the office of the State Long-Term Care Ombudsman is housed within the state unit on aging or another state agency. In others, the office is housed in a

private non-profit agency. Most states have contracts with or through area agencies on aging to provide direct ombudsman services to residents locally. There are 573 designated local entities across the nation.

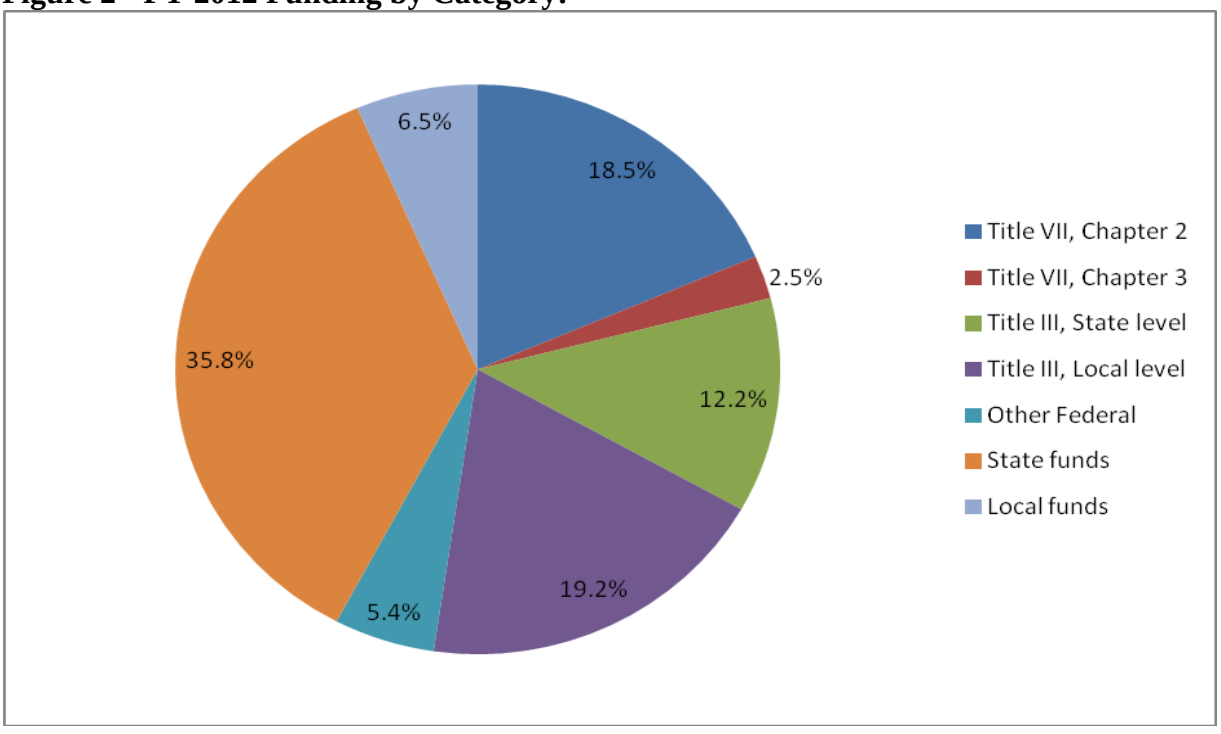
In FY 2012, long-term care ombudsman services to residents were provided by 1,180 full-time equivalent staff and 8,712 volunteers, trained and certified to investigate and resolve complaints. An additional 3,257 volunteers also served residents or assisted in program operations in ways other than complaint resolution.

Program Funding

Total FY 2012 funding from all sources for the Ombudsman Program nationwide was $90,418,662, an overall increase of three percent from the FY 2011 level.

The federal government is the primary funder of the Ombudsman Program, providing 58 percent of total funding in FY 2012. States provided 36 percent of funds, and other non-federal sources funded the remaining six percent. Figure 2 shows the percentage of total program funding by source

Figure 2 - FY 2012 Funding by Category:



Where Long-Term Care Facility Residents Live

Increasingly, long-term care residents live in residential settings other than nursing homes, including board and care homes and assisted living (known by various names

under state laws). While the number of beds and facilities in nursing homes are relatively stagnant, the growth of beds in these other residential settings is steadily increasing. Federal policy continues to accelerate the growth of home and community-based long-term care services. In many states, Medicaid funding provides long-term care services in home and community-based settings as an alternative to institutional care.

In the five years between 2008 and 2012, the number of board and care and similar facilities (including assisted living) increased by six percent to 52,928, while the number of nursing facilities decreased by one percent from 16,749 in 2008 to 16,528 in 2012.

National Long-Term Care Ombudsman Resource Center Activities

In order to effectively advocate for residents, ombudsmen must remain up-to-date on the latest long-term care developments. Therefore, AoA supports the National Ombudsman Resource Center (NORC), which provides training, technical assistance, and program management expertise to state and local ombudsmen. In FY 2012, the NORC was operated by the National Consumer Voice for Quality Long-Term Care (formerly NCCNHR), in conjunction with the National Association of States United for Aging and Disabilities (NASUAD).

In FY 2012, NORC provided ombudsmen with training from national experts on such issues as:

- Volunteer management training and technical assistance;
- Training on the National Ombudsman Reporting System (NORS) data coding and collection;
- Long-Term Services, Supports and Housing: Choices and Advocacy
- Resident transitions from nursing homes to other settings, including through implementation of federal initiatives such as:
  - Culture Change and Person-Centered Care.
  - Ombudsman coordination with ADRCs.
- Support for Centers for Medicaid & Medicare Services (CMS) Nursing Home Quality Initiatives such as:
  - Reduction of Antipsychotic Medication use in nursing homes
  - Ombudsmen training on Quality Assessment and Performance Improvement (QAPI) for Nursing Homes

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

Program Results and Challenges

Value of volunteers – Over $20 million donated in FY 2012.[84] Volunteers designated to act on behalf of the state long-term care ombudsman add an invaluable service which benefits residents, their families and facility staff. Volunteers across the county donated their time, talents and energy to visit residents, listen to their concerns and take action. For some residents the ombudsman may be their only visitor. Volunteer ombudsmen frequently provide the routine ombudsman presence in many facilities and provide cost-effective complaint resolution. The Independent Sector places the value of the volunteer time at $22.14 per hour placing the value of 919,749 hours at $20,363,243.

Ombudsmen solve problems at the facility level -- Long-term care ombudsman programs resolve hundreds of thousands of complaints every year on behalf of long-term care facility residents. The largest group that requested ombudsman assistance in resolving complaints were residents themselves, indicating that residents depend on ombudsmen to help them resolve their concerns. By resolving the vast majority of these complaints to the satisfaction of the resident or complainant, the work of ombudsmen improved the quality of life and quality of care for many residents of our nation's long-term care facilities.

Home and community-based services are increasing demands for ombudsman services -- Originally created as a service for nursing facility residents in 1978, providing a regular presence for nursing home residents continued to be a priority for ombudsman programs. Since the program authority expanded to other types of long-term care facilities in 1981, and as the number of residents in these settings has been rapidly increasing since that time, ombudsman programs are challenged to also serve individuals living in board and care and other similar facilities.

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

Ombudsman programs leverage federal dollars -- Federal funds leveraged resources from other sources for ombudsman programs. 42 percent of program funds came from non-federal sources during FY 2012.

[84] The Independent Sector places the value of volunteer time at $ $22.14 per hour placing the estimated value of 919.749 hours at $20,363,243 $. . http://independentsector.org/volunteer_time

PART IV: SUPPORTING THE NATIONAL AGING SERVICES NETWORK

Older Americans and Americans with disabilities face a vast array of choices when trying to determine the right services and supports to assist them to remain active and independent in their communities. As the number of choices available to assist them grows, so too does the complexity of navigating these programs and selecting among them to determine which best suit the needs of each individual.

A key part of AoA's emphasis on community living is providing consumers with the information and assistance they need to make decisions about their independence and connecting them with the right services. An Aging and Disability Resource Centers (ADRCs) system helps to address this need by providing information, outreach, and assistance to seniors and people with disabilities so that they can access the services necessary for their independence. ADRCs serve as community-level "one stop shop" entry points into long-term care - including home and community-based services that can enable people to remain in their homes - for people of all ages who have chronic conditions and disabilities.

Aging and Disability Resource Centers

(FY 2012: $6,457,000)

Aging and Disability Resource Centers (ADRCs) "No Wrong Door System"[85] supports state efforts to develop more efficient, cost-effective, and consumer-responsive systems of information and integrated access by creating "one-stop shop" entry points into long-term care at the community-level. ADRCs help states make better use of taxpayer dollars by streamlining access to community services and supports and diverting individuals from more costly forms of care, including institutional care and unnecessary hospital re-admissions.

ADRCs are a key component in transforming states' long-term supports and services programs. Since 2003, the Administration on Aging and the Centers for Medicare & Medicaid Services (CMS) have provided grants to states to develop the foundational infrastructure for delivering person-centered systems of information, one-on-one counseling, and access that make it easier for individuals to learn about and access their health and long-term services and support options. The Veterans Health Administration has partnered alongside AoA and CMS to help states develop a single ADRC No Wrong Door System for all populations and all payers. ADRCs grew out of best practice

[85] 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).

innovations known as “No Wrong Door” and “Single Points of Entry” programs, where people of all ages may turn for objective information on their long-term services and support options. ADRCs provide services including:

- “one-on-one” person-centered options counseling and assistance to help consumers, including private pay individuals, and their caregivers fully understand the options available to them.

- streamlined access to all publicly supported long-term care services and support programs;

- targeted discharge planning, care transition and diversion support that integrates the medical and social service systems on behalf of older adults and individuals with disabilities to help them remain in their own homes and communities after a hospitalization, rehabilitation or skilled nursing facility visit;

- outreach and assistance to Medicare beneficiaries on their Medicare benefits including prevention and low-income subsidies; and

- integrated options counseling and access-point to care transition and diversion support for veterans served through the ACL/Department of Veterans Affairs (VA) Veteran-Directed Home and Community-Based Services program partnership.

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

- More than 509 ADRC sites have been established across 52 states, territories, and Washington, DC, by increasing the coordination and capacity of existing infrastructure in the aging, disability and Medicaid networks. Together these ADRC sites can reach roughly 77 percent of the U.S. population.

- Thirty-two states and territories have achieved statewide coverage, and an additional 13 states have achieved 50 percent or more of statewide coverage.

- Forty-one states with ADRC programs sites currently conduct care transitions through formal intervention

- Thirty-seven states have developed statewide web-based directories available to consumers and service providers which improve the quality and consistency of the aging services network information and assistance provided across the state.

Person centered ADRC No Wrong Door System performs the following operational functions:

- *Access Points of Referral to Option Counseling:* ADRCs include numerous participating agencies which serve as local access points to refer individuals to their local ADRC Options Counseling Program. ADRCs serve as a highly visible and trusted source of objective information and assistance where people of all ages, disabilities, income levels and cultural backgrounds know they can turn to help in accessing the full range of long-term service and support options available in their communities. These referral partnerships should involve a wide array of local agencies and organizations within states' systems, including all agencies providing services to older adults and individuals with disabilities across the lifespan. An ADRC system should also ensure that individuals can access the system virtually or in person and receive the same set of information from any location within the state and have the knowledge to refer individuals to One-on-One Options Counseling.

- *One-on-One Person-Centered Options Counseling*: ADRCs provide options counseling to all persons and their respective family caregivers making long-term support decisions regardless of their income or financial assets. This includes individuals who can pay for supports, but can also be targeted across various settings and/or populations. Options Counseling is a seamless approach to helping individuals and their families to identify and understand their needs and assist them in making informed decisions about appropriate long-term service and support choices, with the goal of meeting individuals at the moment when they seek out services, including before they need them. Options Counseling includes the following key components: (1) *Conduct One-to-One Person-Centered Interview & Preliminary Assessment;* (2) *Support Individual Decision-Making to Develop Person-Centered LTSS Plans;* (3) *Facilitate Streamlined Access to LTSS; and (4) Ongoing Follow-Up and Documentation*.

- *Streamline Access to Public Programs*: ADRCs serve as the front door for publicly-funded long-term services and supports through a standardized process by which all individuals enroll, including those funded by Medicaid, the OAA, and other state and federal programs and services. ADRCs must have the necessary protocols and procedures in place to facilitate an integrated and fully coordinated approach to performing the administrative functions for home and community-based and institutional-based publicly funded programs. The goal is to create a process that is seamless for consumers regardless of which service they choose. This should include assisting and/or completing the comprehensive assessment, helping individuals in completing and submitting all required information and documentation, determining eligibility for programs and services, and ensuring that people receive the services need and want, and for which they are eligible.

- *Person-Centered Transition Support*: ADRCs create formal linkages between and among the major pathways that people travel while transitioning from one service setting to another (e.g. hospital, nursing home, community, etc.), or from one

public program payer to another. These linkages ensure that people, including those with chronic conditions and disabilities, have the information they need to make informed decisions about their service and support options as they pass through critical transition points in the health and long-term services and support systems that cut across all payers and settings. These critical activities help individuals break the cycle of readmission to the hospital,[86] avoid unnecessary admission to a nursing home or other institution, and live longer in the community with enhanced quality of life.

- *Quality Assurance:* ADRCs must ensure they adhere to the highest standard of service in all areas. ADRCs should continually monitor the quality of their services and evaluate their impact on consumers' lives, system efficiencies and public and private investments.

ADRCs will continue, with Department of Veterans Affairs (VA) funding, to serve clients under the current ACL/VA partnership. In FY 2008, the VA and AoA began working together to develop the Veterans Directed Home and Community-Based Services Program (VD-HCBS), which is designed to serve veterans of any age who are at risk of admission to a nursing home by providing them the opportunity to self-direct their care and access services to help them remain in the community. Rather than build a separate infrastructure to serve veterans, the VA made a strategic decision to use the aging network infrastructure – including using the ADRC as the integrated access point to empower the veterans to set-up their own service plan for long-term supports and services – as a delivery vehicle for VD-HCBS. Since inception of the program the VA has invested over $41 million to expand this program nationwide. HHS and the VA have worked together to develop program guidelines/national standards, web-based tools to track program activities and implement a national training program for the VD-HCBS. Currently, 25 states and the District of Columbia are operating VD-HCBS programs with 43 operational VAMCs, 102 operational AAA/ADRCs and over 1,500 veterans served with 23 percent under age 60.

Aging Network Support Program Activities

(FY 2012: $8,184,000)

Aging Network Support Activities provide competitive grants and contracts to support ongoing activities of national significance which help seniors and their families to obtain information about their care options and benefits, and which provide technical assistance to help states, tribes, and community providers of aging services to develop service systems that help older people remain independent and able to live in their own homes and communities. These activities provide critical and ongoing support for the national aging services network and help support the activities of AoA's core service delivery programs.

[86] Brock, J. et al. (1998). "Association Between Quality Improvement for Care Transitions in Communities and Rehospitalizations Among Medicare Beneficiaries." JAMA. 309: 381-391.

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

National Eldercare Locator

Older Americans and their caregivers face a complicated array of choices and decisions about health care, pensions, insurance, housing, financial management, and long-term care. The Eldercare Locator, created in 1991, helps seniors and their families navigate this complex environment by connecting those needing assistance with state and local agencies on aging that serve older adults and their caregivers. The Eldercare Locator can be accessed through a toll-free nationwide telephone line (800-677-1116) or website (http://www.eldercare.gov). The phone line and website both connect those in need to providers in every zip code in the nation. The Eldercare Locator website continues to grow as a resource tool for older adults and their caregivers, serving over 525,000 individuals a year.

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, 2013, the National Alzheimer's Call Center handled over 294,000 calls through its national and local partners, and its on-line message board community recorded over five million page views and over 113,000 individual postings.

The National Alzheimer's Call Center is available to people in all states, 24 hours-a-day, seven days-a-week, 365 days–a-year to provide expert advice, care consultation, and information and referrals at the national and local levels regarding Alzheimer's disease. Trained professional customer service staff and masters degree social workers are available at all times. The Call Center is accessible by telephone, website or e-mail at no cost to the caller. Services focus on consumers, not professionals. Information provided may include basic information on caregiving; handling legal issues; resources for long-distance caregiving; and tips for working with the medical community. Local community-based organizations are directly involved to ensure local, on-the-ground capacity to respond to emergencies and on-going needs of Alzheimer's patients, their families, and informal caregivers. The Call Center has multilingual capacity and responds to inquiries in at least 140 languages through its own bilingual staff and with the use of a language interpretation service.

National Education and Resource Center on Women and Retirement Planning

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

National Minority Aging Organizations Technical Assistance Centers

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

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AoA awarded individual cooperative agreements to four national organizations that form a consortium with the goal of assisting the aging network effectively serve an increasingly diverse older population. Each NMAO project pilots a practical, nontraditional, community-based intervention 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 culturally appropriate caregiver manual/toolkit for American Indian and Alaska Native caregivers of elders with dementia, chronic disease self management curricula and manual tailored for racial and ethnic minority seniors, a series of bilingual health promotion materials, information about heart disease and prostate cancer among Hispanic elders and a referral database of Chronic Disease Self-Management (CDSMP) workshops.

Appendix

Formula Grant Funding

Allocation by

State, Territory and Tribal Organization

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

State	Supportive Services	Congregate Meals	Home Meals	Preventive Services	NFCSP	Total Title III
Alabama	$5,571,772	$6,686,908	$3,373,334	$331,874	$2,351,563	$18,315,451
Alaska	$1,823,319	$2,181,871	$1,077,497	$104,722	$763,390	$5,950,799
Arizona	$7,406,195	$8,888,476	$4,483,954	$403,699	$3,164,166	$24,346,490
Arkansas	$3,502,121	$4,203,036	$2,120,299	$210,763	$1,503,924	$11,540,143
California	$36,265,662	$43,523,886	$21,956,423	$2,123,744	$15,442,307	$119,312,022
Colorado	$4,885,597	$5,863,402	$2,957,901	$255,177	$1,926,424	$15,888,501
Connecticut	$4,404,337	$5,241,452	$2,564,007	$260,160	$1,874,713	$14,344,669
Delaware	$1,823,319	$2,181,871	$1,077,497	$104,722	$763,390	$5,950,799
District of Columbia	$1,823,319	$2,181,871	$1,077,497	$104,722	$763,390	$5,950,799
Florida	$26,219,739	$31,467,368	$15,874,292	$1,551,522	$12,070,518	$87,183,439
Georgia	$9,116,311	$10,940,853	$5,519,314	$485,765	$3,547,261	$29,609,504
Hawaii	$1,823,319	$2,181,871	$1,077,497	$104,722	$763,390	$5,950,799
Idaho	$1,823,319	$2,181,871	$1,077,497	$104,722	$763,390	$5,950,799
Illinois	$14,524,890	$17,286,541	$8,216,052	$837,894	$5,898,667	$46,764,044
Indiana	$7,109,911	$8,532,891	$4,304,574	$425,464	$3,054,144	$23,426,984
Iowa	$4,260,878	$5,081,501	$2,243,949	$231,350	$1,723,829	$13,541,507
Kansas	$3,432,908	$4,089,903	$1,895,772	$190,952	$1,408,146	$11,017,681
Kentucky	$4,946,975	$5,937,065	$2,995,061	$291,198	$2,059,860	$16,230,159
Louisiana	$4,795,898	$5,734,142	$2,892,693	$294,553	$1,991,274	$15,708,560
Maine	$1,823,319	$2,181,871	$1,086,279	$104,924	$766,439	$5,962,832
Maryland	$6,117,674	$7,342,067	$3,703,841	$359,750	$2,524,149	$20,047,481
Massachusetts	$8,209,095	$9,780,267	$4,599,080	$463,658	$3,349,110	$26,401,210
Michigan	$11,516,437	$13,821,341	$6,972,430	$691,299	$4,947,620	$37,949,127
Minnesota	$5,744,649	$6,894,385	$3,477,999	$337,777	$2,521,552	$18,976,362
Mississippi	$3,272,711	$3,891,114	$1,954,691	$195,489	$1,363,666	$10,677,671
Missouri	$7,118,429	$8,467,047	$4,231,795	$421,608	$3,049,893	$23,288,772
Montana	$1,823,319	$2,181,871	$1,077,497	$104,722	$763,390	$5,950,799
Nebraska	$2,294,938	$2,738,802	$1,235,914	$124,415	$933,179	$7,327,248
Nevada	$2,835,544	$3,403,051	$1,716,732	$151,173	$1,095,922	$9,202,422
New Hampshire	$1,823,319	$2,181,871	$1,077,497	$104,722	$763,390	$5,950,799
New Jersey	$10,262,972	$12,190,488	$6,019,557	$618,534	$4,381,530	$33,473,081
New Mexico	$2,298,174	$2,758,132	$1,391,391	$126,899	$949,699	$7,524,295
New York	$24,283,431	$28,963,855	$13,307,414	$1,371,257	$9,679,695	$77,605,652
North Carolina	$10,572,477	$12,688,457	$6,400,925	$575,417	$4,360,720	$34,597,996
North Dakota	$1,823,319	$2,181,871	$1,077,497	$104,722	$763,390	$5,950,799
Ohio	$13,816,810	$16,393,785	$8,262,220	$832,633	$5,998,353	$45,303,801
Oklahoma	$4,278,286	$5,092,422	$2,568,966	$256,429	$1,822,471	$14,018,574
Oregon	$4,591,896	$5,510,920	$2,780,085	$253,923	$1,908,337	$15,045,161
Pennsylvania	$17,879,977	$21,279,716	$9,761,855	$1,014,597	$7,379,177	$57,315,322
Rhode Island	$1,823,319	$2,181,871	$1,077,497	$104,722	$763,390	$5,950,799
South Carolina	$5,443,562	$6,533,039	$3,295,711	$294,285	$2,184,482	$17,751,079
South Dakota	$1,823,319	$2,181,871	$1,077,497	$104,722	$763,390	$5,950,799
Tennessee	$7,303,508	$8,765,235	$4,421,784	$415,196	$3,006,252	$23,911,975
Texas	$22,531,556	$27,041,031	$13,641,345	$1,248,379	$9,176,247	$73,638,558
Utah	$2,118,857	$2,542,925	$1,282,826	$114,654	$888,363	$6,947,625
Vermont	$1,823,319	$2,181,871	$1,077,497	$104,722	$763,390	$5,950,799
Virginia	$8,467,596	$10,162,304	$5,126,561	$483,047	$3,445,502	$27,685,010
Washington	$7,217,466	$8,661,973	$4,369,691	$396,147	$2,923,761	$23,569,038
West Virginia	$2,773,538	$3,305,947	$1,527,382	$152,542	$1,079,225	$8,838,634
Wisconsin	$6,509,748	$7,812,612	$3,941,216	$389,928	$2,887,461	$21,540,965
Wyoming	$1,823,319	$2,181,871	$1,077,497	$104,722	$763,390	$5,950,799
American Samoa	$472,317	$594,843	$136,498	$13,090	$95,424	$1,312,172
Guam	$911,660	$1,090,936	$538,748	$52,361	$381,695	$2,975,400
Northern Mariana Islands	$227,915	$272,734	$134,687	$13,090	$95,424	$743,850
Puerto Rico	$4,534,616	$5,442,176	$2,745,406	$268,699	$1,923,559	$14,914,456
Virgin Islands	$911,660	$1,090,936	$538,748	$52,361	$381,695	$2,975,400
TOTAL	**$364,663,840**	**$436,374,287**	**$215,499,366**	**$20,944,340**	**$152,678,078**	**$1,190,159,911**

State	Ombudsman	Elder Abuse	Total Title VII
Alabama	$261,779	$77,420	$339,199
Alaska	$83,616	$25,125	$108,741
Arizona	$347,967	$102,909	$450,876
Arkansas	$164,541	$48,662	$213,203
California	$1,703,874	$503,913	$2,207,787
Colorado	$229,541	$67,886	$297,427
Connecticut	$198,974	$59,907	$258,881
Delaware	$83,616	$25,125	$108,741
District of Columbia	$83,616	$25,125	$108,741
Florida	$1,231,886	$364,324	$1,596,210
Georgia	$428,313	$126,671	$554,984
Hawaii	$83,616	$25,125	$108,741
Idaho	$83,616	$25,125	$108,741
Illinois	$637,587	$197,384	$834,971
Indiana	$334,046	$98,793	$432,839
Iowa	$174,136	$55,927	$230,063
Kansas	$147,117	$45,843	$192,960
Kentucky	$232,425	$68,738	$301,163
Louisiana	$224,480	$68,518	$292,998
Maine	$84,298	$25,125	$109,423
Maryland	$287,428	$85,005	$372,433
Massachusetts	$356,900	$109,606	$466,506
Michigan	$541,079	$160,862	$701,941
Minnesota	$269,902	$79,822	$349,724
Mississippi	$151,689	$45,198	$196,887
Missouri	$328,398	$97,643	$426,041
Montana	$83,616	$25,125	$108,741
Nebraska	$95,910	$29,770	$125,680
Nevada	$133,223	$39,400	$172,623
New Hampshire	$83,616	$25,125	$108,741
New Jersey	$467,133	$143,950	$611,083
New Mexico	$107,975	$31,933	$139,908
New York	$1,032,690	$318,066	$1,350,756
North Carolina	$496,728	$146,905	$643,633
North Dakota	$83,616	$25,125	$108,741
Ohio	$641,170	$197,185	$838,355
Oklahoma	$199,358	$60,208	$259,566
Oregon	$215,742	$63,805	$279,547
Pennsylvania	$757,545	$242,944	$1,000,489
Rhode Island	$83,616	$25,125	$108,741
South Carolina	$255,756	$75,639	$331,395
South Dakota	$83,616	$25,125	$108,741
Tennessee	$343,142	$101,483	$444,625
Texas	$1,058,604	$313,077	$1,371,681
Utah	$99,550	$29,442	$128,992
Vermont	$83,616	$25,125	$108,741
Virginia	$397,834	$117,658	$515,492
Washington	$339,099	$100,287	$439,386
West Virginia	$118,529	$36,736	$155,265
Wisconsin	$305,849	$90,453	$396,302
Wyoming	$83,616	$25,125	$108,741
American Samoa	$10,452	$3,141	$13,593
Guam	$41,808	$12,563	$54,371
Northern Mariana Islands	$10,452	$3,141	$13,593
Puerto Rico	$213,051	$63,009	$276,060
Virgin Islands	$41,808	$12,563	$54,371
TOTAL	**$16,723,160**	**$5,025,014**	**$21,748,174**

State/Territory	Nutrition Services Incentive Program
Alabama	$2,933,316
Alaska	$372,212
Arizona	$2,118,282
Arkansas	$2,637,872
California	$12,976,341
Colorado	$1,499,399
Connecticut	$1,423,479
Delaware	$495,729
District of Columbia	$505,439
Florida	$7,187,763
Georgia	$2,768,572
Hawaii	$483,221
Idaho	$701,581
Illinois	$6,902,253
Indiana	$1,788,180
Iowa	$2,119,990
Kansas	$1,972,161
Kentucky	$1,831,731
Louisiana	$3,277,072
Maine	$629,641
Maryland	$1,648,593
Massachusetts	$4,885,300
Michigan	$7,257,628
Minnesota	$1,956,106
Mississippi	$1,365,451
Missouri	$4,070,380
Montana	$930,440
Nebraska	$1,168,951
Nevada	$953,138
New Hampshire	$1,180,291
New Jersey	$3,667,607
New Mexico	$2,015,025
New York	$15,385,497
North Carolina	$3,330,755
North Dakota	$814,498
Ohio	$5,706,030
Oklahoma	$2,337,289
Oregon	$1,793,200
Pennsylvania	$7,112,252
Rhode Island	$449,215
South Carolina	$1,589,875
South Dakota	$965,896
Tennessee	$1,675,968
Texas	$12,079,291
Utah	$1,368,532
Vermont	$779,950
Virginia	$2,280,760
Washington	$2,093,766
West Virginia	$1,657,818
Wisconsin	$2,689,202
Wyoming	$793,487
Guam	$371,257
Northern Mariana Islands	$58,148
Puerto Rico	$2,893,191
Virgin Islands	$180,074
TOTAL	**$154,129,095**

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
AK	01	Aleutian Pribilof Islands Association	$93,050	$26,720	$20,270
AK	02	Association of Village Council Presidents	$134,330		$3,429
AK	03	Bristol Bay Native Association	$134,330	$46,770	$4,126
AK	04	Central Council Tlingit & Haida Indian Tribes of AK	$176,380	$53,450	$1,951
AK	06	Copper River Native Association	$81,940	$20,040	$2,240
AK	07	Hoonah Indian Association	$72,220	$13,360	$1,437
AK	08	Kodiak Area Native Association (Northern Section)	$72,220	$13,360	$1,206
AK	09	Kodiak Area Native Association (Southern Section)	$72,220	$13,360	$1,914
AK	10	Metlakatla Indian Community	$93,050	$26,720	$4,761
AK	11	Native Village of Barrow	$93,050	$26,720	$5,321
AK	12	Tanana Chiefs Conference for Kuskokwim subregion	$72,220	$13,360	$2,522
AK	13	Tanana Chiefs Conference for Lower Yukon Subregion	$72,220	$13,360	$4,157
AK	14	Tanana Chiefs Conference for Yukon Flats Subregion	$72,220	$13,360	$3,341
AK	15	Tanana Chiefs Conference for Yukon Koyukuk Subregion	$81,940	$20,040	$1,173
AK	16	Tanana Chiefs Conference for Yukon Tanana Subregion	$72,220	$13,360	$2,443
AK	17	Fairbanks Native Association	$134,330	$46,770	
AK	19	Maniilaq Association	$134,330	$46,770	$13,996
AK	20	Native Villiage of Unalakleet	$72,220	$13,360	$5,137
AK	21	Chugachmiut	$81,940	$20,040	$5,139
AK	22	Arctic Slope Native Association, Limited	$72,220	$13,360	$8,325
AK	23	Denakkanaaga, Inc.	$81,940	$20,040	
AK	24	Klawock Cooperative Association	$72,220	$13,360	$1,216
AK	25	Kootznoowoo Inc.	$72,220	$13,360	$1,191
AK	26	Gwichyaa Zhee Gwich'in Tribal Government	$72,220	$13,360	$4,454
AK	27	Native Village of Point Hope	$72,220	$13,360	$2,984
AK	28	Seldovia Village Tribe, IRA	$72,220		$462
AK	30	Sitka Tribes of Alaska	$93,050	$26,720	$1,504
AK	32	Ketchikan Indian Community	$134,330	$46,770	$2,109
AK	33	Kuskokwim Native Association	$81,940	$20,040	$2,676
AK	35	Southcentral Foundation	$176,380	$53,450	$8,198
AK	36	Kenaitze Indian Tribe	$115,980	$40,100	$5,030
AK	37	Wrangell Cooperative Association	$72,220	$13,360	$1,324
AK	38	Native Village of Savoonga	$72,220	$13,360	$9,558
AK	39	Native Village of Gambell	$72,220	$13,360	$6,366
AK	40	Native Village of Eyak	$72,220	$13,360	$625
AK	41	Organized Village of Kake	$72,220	$13,360	$1,690
AK	42	Chickaloon Native Village	$81,940		$1,627
AK	43	Yakutat Tlingit Tribe & Craig Community Association	$72,220	$13,360	$2,326
AK	44	Galena Village (aka Louden Village Council)	$72,220	$13,360	$9,959
AK	45	Asa'carsarmiut Tribal Council	$72,220		$5,505
AK	46	Orutsararmuit Native Council	$93,050		$13,735
AK	Total	Total	$3,686,120	$808,360	$175,427
AL	01	Poarch Creek Indians	$134,330	$46,770	$17,133
AL	Total	Total	$134,330	$46,770	$17,133
AZ	02	Colorado River Indian Tribes	$104,860	$33,400	$5,990
AZ	03	Gila River Indian Community	$134,330	$46,770	$17,591
AZ	04	Hopi Tribe	$134,330	$46,770	$9,870
AZ	05	Hualapai Tribe	$81,940	$20,040	$6,152
AZ	06	Navajo Nation	$176,380	$53,450	$13,835

AZ	07	Pascua Yaqui Tribe	$134,330	$46,770	$40,499
AZ	09	Salt River Pima-Maricopa Indian Community	$104,860	$33,400	$7,440
AZ	10	San Carlos Apache Tribe	$134,330	$46,770	$5,824
AZ	11	Tohono o'Odham Nation	$134,330	$46,770	$3,426
AZ	12	White Mountain Apache Tribe	$134,330	$46,770	$17,851
AZ	13	Ak-Chin Indian Community	$72,220	$13,360	$2,081
AZ	14	Yavapai Apache Tribe	$81,940		$2,910
AZ	15	Havasupai Tribe	$72,220	$13,360	$8,487
AZ	16	Inter-Tribal Council of Arizona, Inc.	$72,220	$13,360	$1,464
AZ	17	Cocopah Indian Tribe	$72,220		$13,689
AZ	18	Quechan Indian Tribe	$81,940	$20,040	$18,112
AZ	Total	Total	$1,726,780	$481,030	$175,221
CA	01	Bishop Tribal Council	$81,940	$20,040	$30,175
CA	02	Blue Lake Rancheria	$81,940	$20,040	$21,951
CA	06	Karuk Tribe of California	$81,940	$20,040	$3,107
CA	07	Pit River Health Services, Inc.	$72,220		$4,069
CA	08	Picayune Rancheria of the Chukchansi Indians	$72,220		$5,561
CA	09	Riverside-San Bernardino Co. Indian Health-for Morongo	$72,220	$13,360	$9,031
CA	10	Riverside-San Bernardino Co. Indian Health-for Pechanga	$72,220	$13,360	$3,328
CA	11	Riverside-San Bernardino Co. Indian Health-for Soboba	$72,220	$13,360	$6,621
CA	12	Sonoma County Indian Health Project - Sonoma	$72,220		$8,751
CA	13	Southern Indian Health Council, Inc.	$72,220	$13,360	$12,477
CA	15	Toiyabe Indian Health Project, Inc. - Northern	$72,220	$13,360	$5,691
CA	16	Tule River Indian Health Center, Inc.	$81,940	$20,040	$17,929
CA	17	Coast Indian Community of Resighini Rancheria	$81,940	$20,040	$8,202
CA	18	United Indian Health Services for Smith River	$93,050	$26,720	$10,853
CA	20	Indian Senior Center, Inc.	$81,940	$20,040	$11,438
CA	21	Sonoma County Indian Health Project - Manchester	$72,220		$3,275
CA	25	Pala Band of Mission Indians	$81,940		$14,028
CA	26	Redding Rancheria	$134,330	$46,770	$5,808
CA	28	Toiyabe Indian Health Project, Inc. - Southern	$72,220	$13,360	$3,672
CA	29	Hoopa Valley Tribe, K'ima:w Medical Center	$81,940		$7,873
CA	30	Round Valley Indian Tribes	$93,050		$2,826
CA	31	Fort Mojave Indian Tribe	$72,220	$13,360	$5,051
CA	33	CA Indian Manpower Consortium, Inc. - Chico,	$72,220	$13,360	$7,093
CA	34	CA Indian Manpower Consortium, Inc. - Big Sandy,	$72,220	$13,360	$8,322
CA	35	CA Indian Manpower Consortium, Inc. - Berry Creek,	$72,220	$13,360	$5,762
CA	36	CA Indian Manpower Consortium, Inc. - Coyote Valley,	$81,940	$20,040	$3,998
CA	37	CA Indian Manpower Consortium, Inc. - Enterprise,	$81,940	$20,040	$7,382
CA	38	Santa Ynez Band of Mission Indians	$72,220		$2,125
CA	Total	Total	$2,223,130	$367,410	$236,399
CO	01	Southern Ute Indian Tribe	$81,940	$20,040	$3,364
CO	02	Ute Mountain Ute Tribe	$81,940		$13,589
CO	Total	Total	$163,880	$20,040	$16,953
HI	01	Alu Like, Inc.	$1,505,000	$53,450	$31,556
HI	02	Hana Health	$81,940		$5,085
HI	Total	Total	$1,586,940	$53,450	$36,641
IA	01	Sac & Fox Tribe of the Mississippi in Iowa	$93,050	$26,720	$9,217
IA	Total	Total	$93,050	$26,720	$9,217

ID	01	Coeur d'Alene Tribe	$81,940	$20,040	$16,265
ID	02	Nez Perce Tribe	$115,980	$40,100	$26,923
ID	03	Shoshone-Bannock Tribes	$134,330	$46,770	$24,149
ID	Total	Total	$332,250	$106,910	$67,337
KS	01	The Kickapoo Tribe in Kansas	$72,220	$13,360	$6,912
KS	02	Prairie Band of Potawatomi Nation	$93,050	$26,720	$20,786
KS	03	Iowa Tribe of Kansas and Nebraska	$72,220	$13,360	$6,088
KS	Total	Total	$237,490	$53,440	$33,786
LA	01	Institute for Indian Development, Inc.	$81,940		$13,998
LA	Total	Total	$81,940		$13,998
MA	01	Wampanoag Tribe of Gay Head (Aquinnah)	$72,220	$13,360	$1,216
MA	Total	Total	$72,220	$13,360	$1,216
ME	01	Pleasant Point Passamaquoddy Tribe	$93,050	$26,720	$21,431
ME	02	Penobscot Indian Nation	$81,940		$5,067
ME	04	Aroostook Band of Micmacs	$72,220	$13,360	$2,639
ME	Total	Total	$247,210	$40,080	$29,137
MI	01	Grand Traverse Band of Ottawa & Chippewa Indians	$93,050	$26,720	$16,901
MI	02	Inter-Tribal Council of Michigan, Inc.	$81,940	$20,040	$6,207
MI	03	Keweenaw Bay Indian Community	$81,940	$20,040	$13,338
MI	04	Sault Ste. Marie Tribe of Chippewa Indians	$134,330		$22,010
MI	05	Little Traverse Bay Bands of Odawa Indians	$81,940		$4,385
MI	07	Bay Mills Indian Community	$81,940	$20,040	$5,264
MI	08	Pokagon Band of Potawatomi Indians	$81,940		$3,914
MI	09	Little River Band of Ottawa Indians	$93,050	$26,720	$2,032
MI	10	Nottawaseppi Huron Band of the Potawatomi	$72,220	$13,360	$3,631
MI	Total	Total	$802,350	$126,920	$77,682
MN	01	Bois Forte Reservation Tribal Government	$81,940	$20,040	$8,269
MN	02	Fond du Lac Band of Lake Superior Chippewa	$115,980	$40,100	$41,604
MN	03	Leech Lake Band of Ojibwe	$176,380	$53,450	$19,370
MN	07	Red Lake Band of Chippewa Indians	$115,980		$38,748
MN	08	White Earth Reservation Tribal Council	$104,860	$33,400	$7,732
MN	09	Grand Portage Band of Lake Superior Chippewa	$72,220		$4,009
MN	10	Mille Lacs Band of Ojibwe	$81,940	$20,040	$15,876
MN	Total	Total	$749,300	$167,030	$135,608
MO	99	Eastern Shawnee Tribe of Oklahoma	$93,050	$26,720	$16,848
MO	Total	Total	$93,050	$26,720	$16,848
MS	01	Mississippi Band of Choctaw Indians	$134,330	$46,770	$18,255
MS	Total	Total	$134,330	$46,770	$18,255
MT	01	Assiniboine and Sioux Tribes	$115,980	$40,100	$32,454
MT	02	Blackfeet Tribe - Eagle Shield Center	$134,330	$46,770	$31,814
MT	03	Chippewa Cree Tribe	$104,860	$33,400	$52,553
MT	04	Confederated Salish and Kootenai Tribes	$134,330	$46,770	$7,846
MT	05	Fort Belknap Indian Community	$104,860	$33,400	$13,747
MT	06	Northern Cheyenne Elderly Program	$104,860	$33,400	$19,252
MT	07	Crow Tribal Elders Program	$134,330	$46,770	$39,137
MT	Total	Total	$833,550	$280,610	$196,803
NC	01	Eastern Band of Cherokee Indians	$176,380	$53,450	$42,888
NC	Total	Total	$176,380	$53,450	$42,888
ND	01	Spirit Lake Tribe	$93,050	$26,720	$15,940

ND	02	Standing Rock Sioux Tribe	$134,330	$46,770	$97,042
ND	03	Three Affiliated Tribes	$134,330	$46,770	$15,654
ND	04	Trenton Indian Service Area	$93,050	$26,720	$2,746
ND	05	Turtle Mountain Band of Chippewa Indians	$134,330	$46,770	$17,458
ND	Total	Total	$589,090	$193,750	$148,840
NE	01	Omaha Tribe of Nebraska	$81,940	$20,040	$9,154
NE	02	Santee Sioux Nation	$72,220		$2,780
NE	03	Winnebago Senior Citizen Center	$81,940	$20,040	$21,497
NE	Total	Total	$236,100	$40,080	$33,431
NM	01	Eight Northern Indian Pueblos Council (Picuris, etc.)	$176,380	$53,450	$16,545
NM	02	Eight N. Indian Pueblos Council(San Ildefonso, etc.)	$93,050	$26,720	$5,172
NM	03	Five Sandoval Indian Pueblos, Inc.	$93,050		$13,717
NM	04	Jicarilla Apache Nation	$104,860	$33,400	$18,581
NM	05	Laguna Rainbow Corporation	$134,330	$46,770	$15,905
NM	06	Mescalero Apache Tribe	$93,050		$8,850
NM	07	Pueblo de Cochiti	$81,940	$20,040	$6,413
NM	09	Pueblo of Isleta	$115,980	$40,100	$23,846
NM	10	Pueblo of Jemez	$104,860	$33,400	$4,991
NM	11	Pueblo of San Felipe	$104,860	$33,400	$9,815
NM	12	Pueblo of Taos	$104,860	$33,400	$7,828
NM	13	Zuni Tribe	$134,330	$46,770	$25,790
NM	14	Ohkay Owingeh Senior Citizens Program	$134,330	$46,770	$13,674
NM	15	Santa Clara Pueblo	$176,380	$53,450	$15,287
NM	16	Santo Domingo Pueblo	$134,330	$46,770	$12,021
NM	17	Pueblo of Tesuque	$72,220	$13,360	$6,618
NM	18	Pueblo of Acoma	$93,050	$26,720	$10,946
NM	Total	Total	$1,951,860	$554,520	$215,999
NV	01	Fallon Paiute-Shoshone Tribes	$81,940	$20,040	$19,901
NV	02	Inter-Tribal Council of Nevada, Inc. (McDermitt, etc.)	$81,940	$20,040	$9,029
NV	03	Inter-Tribal Council of Nevada, Inc. (Duckwater, etc.)	$81,940	$20,040	$4,857
NV	04	Inter-Tribal Council of Nevada, Inc. (Ely, etc.)	$72,220	$13,360	$6,184
NV	05	Shoshone-Paiute Tribes	$81,940	$20,040	$10,033
NV	06	Walker River Paiute Tribe	$81,940		$9,989
NV	07	Washoe Tribe of Nevada and California	$81,940	$20,040	$41,386
NV	08	Yerington Paiute Tribe	$72,220		$4,563
NV	09	Pyramid Lake Paiute Tribe	$93,050	$26,720	$4,612
NV	10	Elko Band Council	$72,220	$13,360	$7,896
NV	11	Reno-Sparks Indian Colony	$81,940	$20,040	$12,423
NV	Total	Total	$883,290	$173,680	$130,873
NY	01	St. Regis Mohawk Tribe	$134,330	$46,770	$14,017
NY	02	Seneca Nation of Indians	$134,330	$46,770	$19,883
NY	04	Oneida Indian Nation	$72,220	$13,360	$3,766
NY	05	Shinnecock Indian Nation	$72,220	$13,360	$4,727
NY	Total	Total	$413,100	$120,260	$42,393
OK	01	Apache Tribe of Oklahoma	$134,330	$46,770	$11,218
OK	02	Caddo Nation of Oklahoma	$81,940	$20,040	$5,015
OK	03	Cherokee Nation	$177,704	$54,689	$42,113
OK	04	Cheyenne & Arapaho Tribes	$134,330	$46,770	$11,158
OK	06	Choctaw Nation of Oklahoma	$176,380	$53,450	$28,107

OK	07	Citizen Potawatomi Nation	$176,380	$53,450	$13,675
OK	08	Comanche Nation	$134,330	$46,770	$17,096
OK	09	Delaware Nation	$78,960	$13,360	$6,897
OK	10	Iowa Tribe of Oklahoma	$134,330	$46,770	$8,092
OK	12	Kickapoo Tribe of Oklahoma	$100,000	$20,040	$16,534
OK	13	Kiowa Tribe of Oklahoma	$134,330	$46,770	$5,363
OK	14	Miami Tribe of Oklahoma	$115,980	$40,100	$23,045
OK	15	Muscogee (Creek) Nation	$176,380	$53,450	$147,442
OK	17	Otoe-Missouria Tribe of Indians	$72,220	$13,360	$6,656
OK	18	Ottawa Tribe of Oklahoma	$134,330	$46,770	$27,972
OK	19	Pawnee Nation of Oklahoma	$81,940	$20,040	$12,522
OK	20	Peoria Tribe of Indians of Oklahoma	$104,860	$33,400	$15,984
OK	21	Ponca Tribe of Oklahoma	$81,940	$20,040	$14,814
OK	22	Quapaw Tribe of Oklahoma	$115,980	$40,100	$19,163
OK	23	Sac and Fox Nation	$81,940	$20,040	$11,552
OK	24	Seminole Nation of Oklahoma	$176,380	$53,450	$13,319
OK	25	Seneca-Cayuga Tribe of Oklahoma	$134,330	$46,770	$1,339
OK	26	Wichita and Affiliated Tribes	$134,330	$46,770	$7,712
OK	27	Wyandotte Nation	$134,330	$46,770	$15,476
OK	28	Absentee Shawnee Tribe	$176,380	$53,450	$29,889
OK	29	Fort Sill Apache Tribe	$104,860	$33,400	$5,217
OK	31	United Keetoowah Band of Cherokee Indians	$134,330	$46,770	$17,572
OK	32	Chickasaw Nation	$176,380	$53,450	$110,082
OK	33	Kaw Nation	$81,940		$23,981
OK	34	Osage Nation of Oklahoma	$176,380	$53,450	$28,277
OK	35	Delaware Tribes of Indians	$134,330		$4,518
OK	36	Alabama-Quassarte Tribal Town	$72,220	$13,360	$10,121
OK	Total	Total	$4,064,774	$1,183,819	$711,921
OR	01	Confederated Tribes of Siletz Indians of Oregon	$104,860	$33,400	$731
OR	02	Confederated Tribes of the Umatilla Indian Reservation	$115,980	$40,100	$7,652
OR	03	Confederated Tribes of Warm Springs	$104,860	$33,400	$19,327
OR	04	Confederated Tribes of Grand Ronde	$93,050	$26,720	$10,982
OR	05	The Klamath Tribes	$134,330	$46,770	$3,664
OR	06	Confed. Tribes of Coos, Lower Umpqua &	$81,940	$20,040	$8,357
OR	Total	Total	$635,020	$200,430	$50,713
RI	01	Narragansett Indian Tribe	$93,050	$26,720	$2,178
RI	Total	Total	$93,050	$26,720	$2,178
SC	01	Catawba Indian Nation Eldercare Program	$81,940	$20,040	$10,816
SC	Total	Total	$81,940	$20,040	$10,816
SD	01	Cheyenne River Elderly Nutrition Services, Inc.	$134,330	$46,770	$11,943
SD	02	Crow Creek Sioux Tribe	$81,940		$16,305
SD	03	Lower Brule Sioux Tribe	$81,940	$20,040	$13,609
SD	04	Oglala Sioux Tribe	$176,380	$53,450	$115,259
SD	05	Rosebud Sioux Tribe	$176,380	$53,450	$74,639
SD	06	Sisseton Wahpeton Oyate of	$134,330		$33,826
SD	08	Yankton Sioux Tribe	$93,050	$26,720	$6,444
SD	Total	Total	$878,350	$200,430	$272,025
TX	01	The Alabama-Coushatta Tribe of Texas	$81,940	$20,040	$9,898
TX	02	Kickapoo Traditional Tribe of Texas	$72,220		$15,748

TX	Total	Total	$154,160	$20,040	$25,646
UT	01	Ute Indian Tribe, Unitah & Ouray	$93,050	$26,720	$8,318
UT	Total	Total	$93,050	$26,720	$8,318
WA	01	Confederated Tribes of the Colville Reservation	$134,330	$46,770	$17,782
WA	02	Lower Elwha Klallam Tribe	$81,940	$20,040	$4,647
WA	03	Lummi Tribe	$115,980	$40,100	$13,694
WA	04	Makah Nation	$81,940	$20,040	$7,479
WA	05	Muckleshoot Indian Tribe	$134,330	$46,770	$23,142
WA	09	Puyallup Tribe of Indians	$134,330		$7,113
WA	10	Quinault Indian Nation	$104,860	$33,400	$24,178
WA	13	Swinomish Indian Tribal Community	$72,220	$13,360	$3,113
WA	14	Spokane Tribe of Indians	$81,940	$20,040	$13,874
WA	16	The Tulalip Tribes	$134,330		$13,026
WA	17	Jamestown S'Klallam Tribe	$81,940	$20,040	$3,934
WA	19	Quileute Tribal Council	$81,940	$20,040	$5,625
WA	20	S. Puget Intertribal Planning Agency - Shoalwater Bay	$93,050	$26,720	$6,110
WA	21	Stillaguamish Tribe of Indians	$93,050	$26,720	$1,709
WA	22	Upper Skagit Indian Tribe	$72,220	$13,360	$2,479
WA	24	The Suquamish Tribe	$93,050	$26,720	$10,753
WA	25	Port Gamble S'Klallam Tribe	$72,220	$13,360	$2,441
WA	26	Samish Indian Nation	$81,940	$20,040	$1,689
WA	27	Cowlitz Indian Tribe	$93,050	$26,720	$4,673
WA	28	Skokomish Indian Tribe	$93,050	$26,720	$3,404
WA	29	Confederated Tribes of the Chehalis Reservation	$93,050	$26,720	$2,714
WA	30	Nooksack Indian Tribe	$81,940	$20,040	$7,401
WA	31	Yakama Nation	$72,220	$13,360	$3,350
WA	32	Snoqualmie Tribe	$72,220	$13,360	$2,060
WA	33	S. Puget Intertribal Planning Agency - Nisqually	$115,980	$40,100	$3,589
WA	34	S. Puget Intertribal Planning Agency - Squaxin Island	$72,220	$13,360	$4,962
WA	Total	Total	$2,439,340	$587,900	$194,941
WI	01	Bad River Band of Lake Superior Chippewa	$81,940	$20,040	$12,551
WI	02	Forest County Potawatomi Community	$81,940	$20,040	$8,630
WI	03	Lac Courte Oreilles Band of Lake Superior Chippewa	$93,050	$26,720	$10,348
WI	04	Lac du Flambeau Band of Lake Superior Chippewa Indians	$93,050	$26,720	$22,011
WI	05	Menominee Indian Tribe of Wisconsin	$134,330	$46,770	$3,311
WI	06	Oneida Tribe Elder Services	$134,330	$46,770	$5,417
WI	07	Red Cliff Band of Lake Superior Chippewa	$81,940	$20,040	$7,450
WI	08	St. Croix Chippewa Indians of Wisconsin	$81,940	$20,040	$5,182
WI	09	Stockbridge-Munsee Community	$81,940	$20,040	$2,672
WI	10	Ho-Chunk Nation	$104,860	$33,400	$12,022
WI	Total	Total	$969,320	$280,580	$89,594
WY	01	Northern Arapaho Tribe	$81,940		$11,201
WY	03	Eastern Shoshone Tribe	$93,050		$13,170
WY	Total	Total	$174,990		$24,371
Total	Total	Total	$27,031,734	$6,348,039	$3,262,608