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FROM THE ADMINISTRATION ON AGING

I am pleased to present the Administration on Aging (AoA) Report to Congress for FY 2011.

AoA advances the concerns and interests of older people, 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 network is comprised of 56 state and territorial units on aging (SUA), 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. These services complement 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.

An estimated 60 million older adults age 60 and over resided in the U.S. in 2011.[1] In this same year, persons born in the post World War II baby boom generation between 1946 and 1964 started turning age 65. The well known growth in the older adult population will continue until 2030 when the last of the baby boomers turn 65. By then 20 percent of the population, or one in five Americans will be age 65 or over.[2] As these baby boomers age, the ranks of the oldest old (age 85+) will continue to swell.

This expanding population translates into an equally expanding number of seniors with severe disabilities – defined as three or more limitations in activities of daily living – who are at greatest risk of nursing home admission. In 2010, 8.3 percent or an estimated 3.3 million community dwelling seniors age 65 and over had severe disability.[3] If this trend continues, by 2020, 4.4 million community dwelling seniors age 65 and will be living with severe disability, a 33 percent increase.[4]

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

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[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, 2011 (NC-EST2011-01). Source: U.S. Census Bureau, Population Division. Release Date: May 2012. < http://www.census.gov/popest/data/national/asrh/2011/index.html> Accessed 28 August 2012. 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> Accessed 28 August 2012.

[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. Release Date: August 14, 2008 <http://www.census.gov/population/www/projections/summarytables.html> Accessed 28 August 2012.

[3] Data extrapolated by AoA from U.S. Census Bureau, 2010 Census. Summary File 1, Tables P12, P13, and PCT12. And Health Data Interactive, NCHS, CDC, "Functional limitation among Medicare beneficiaries , ages 65+: US, 1992 – 2010 Accessed 28 August 2012

[4] Data extrapolated by AoA from 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. Release Date: August 14, 2008, and Health Data Interactive, NCHS, CDC, "Functional limitation among Medicare beneficiaries , ages 65+: US, 1992 – 2010 Accessed 28 August 2012

government expenditures in areas such as Medicaid.[5] 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.

For example, a recent AARP study found that in 2009, approximately 42.1 million family caregivers provided assistance to adults with limitations in daily activities.[6] These unpaid caregivers provided an estimated $450 billion in services. Were caregivers more limited in their ability to provide this care, these costs could otherwise be borne by Medicare and Medicaid.[7] 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.

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

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[5] 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
[6] *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
[7] *Ibid.*

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EXECUTIVE SUMMARY

The mission of the Administration on Aging (AoA), an agency 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 that help elderly individuals maintain their health and independence in their homes and communities. AoA advances the concerns and interests of older people, and works with and through the national aging services network of 56 state and territorial units on aging (SUA), 629 area agencies on aging (AAA), 254 tribal organizations, two Native Hawaiian organizations, and nearly 20,000 direct service providers, to promote the development of comprehensive and coordinated home and community-based care that is responsive to the needs and preferences of older people and their caregivers.

AoA's core programs, authorized under the Older Americans Act (OAA) and administered by the national aging services network, help families keep their loved ones at home for as long as possible. The network also helps consumers learn about and access the services and supports that are available in the community and addresses issues related to caregivers. OAA services are less expensive than institutional care and performance data show that they are very effective. The most recent data available show that AoA and its national network rendered direct services to 11.3 million elderly individuals age 60 and over (nearly 20 percent of the country's elderly population) and their caregivers, including nearly three million clients who received intensive in-home services.[8] Critical supports, such as respite care and a peer support network, were provided to nearly 730,000 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: 1) improving efficiency; 2) improving client outcomes; and 3) effectively targeting services to vulnerable elder populations. Each measure is representative of several activities across the OAA program budget, 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 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

[8] Data from AoA's FY 2011 State Program Report are preliminary and should not be taken as final.

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 2011, most outcome indicators have steadily improved. While service counts are declining due to flat funding, an increase in the population aged 60 and over, and challenging economic times, AoA's outcome indicators 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 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 that have three or more impairments in Activities of Daily Living (ADL) are at a high risk for nursing home placement. Measures of the national aging services network's success at serving this vulnerable population is a proxy for success at nursing home delay and diversion. In FY 2003, the national aging services network served home-delivered meals to 280,454 clients with three or more ADL impairments and by FY 2011 that number grew by 30 percent to 367,387 clients.[9] 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 60.62 in FY 2011.

- **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. AoA has significantly increased the number of clients served per million dollars of OAA Title III funding over the last decade. In FY 2011, the national aging services network served 8,881 people per million dollars of OAA Title III funding. Since this measure's introduction in FY 2005, AoA and the national aging services network have met or exceeded efficiency targets.

- **OAA programs build system capacity:** OAA programs stay true to their original intent to "encourage and assist state agencies and area agencies on aging to concentrate resources in order to develop greater capacity and foster the development and implementation of comprehensive and coordinated systems." (OAA Section 301). This is evident in the leveraging of OAA funds with State/local or other funds (almost $3 in other funds for every dollar of OAA funds expended), as well as in the expansion of projects such as the Aging and

[9] Data from AoA's FY 2011 State Program Report are preliminary and should not be taken as final.

Disability Resource Center initiative, which has grown to 467 sites across 51 states and territories to date.

- **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 2011, over 98 percent of transportation clients rated services good to excellent and 94% 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 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 2011 through the OAA's programs. Additionally, a listing of grant funding allocations by state, territory and tribal organization can be viewed in the Appendix.

FY 2011 National Program Services Summary Report [10]

	FY 2011
Total Clients	11,294,823
Total Registered Clients	2,879,521
% Minority Clients	25.11%
% Rural Clients	36.62%
% Clients Below Poverty	29.517%
# Senior Centers	10,951 (6,466 receive OAA funding)

Service	Persons Served	Units of Service[11]	Title III Expenditure	Total Expenditure
Personal Care	103,676	13,459,110	$14,558,411	$250,399,808
Homemaker	144,251	12,240,759	$27,894,405	$236,335,572
Chore	35,120	1,309,433	$5,704,231	$19,028,596
Home Delivered	856,471	139,145,530	$238,779,637	$774,212,155
Adult Day Care	18,977	8,013,251	$10,787,816	$83,479,297
Case Mgt.	453,005	3,644,394	$27,018,597	$259,808,722
Assisted Trans.	32,526	1,196,617	$4,173,099	$15,563,095
Congregate	1,656,585	88,587,614	$278,150,943	$632,291,636
Nutrition Counseling	31,917	64,412	$1,384,209	$3,155,498
Transportation		24,726,402	$68,701,262	$200,167,641
Legal Assistance		847,286	$26,096,826	$51,477,675
Nutr. Education		2,584,238	$4,808,267	$8,478,261
I&A		13,155,106	$61,224,971	$152,774,793
Outreach		4,052,347	$10,505,737	$25,544,367
Other			$106,423,264	$738,280,510

[10] Data from AoA's FY 2011 State Program Report are preliminary and should not be taken as final.

[11] 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[12]	Title III Expenditure	Total Expenditure
Counseling, Support Groups, Training	119,609	496,047	$17,196,730	$24,815,521
Respite	63,878	6,070,280	$47,345,010	$82,765,456
Supplemental Services	35,493	996,829	$12,127,899	$17,039,012
Access Assistance	565,665	1,256,417	$26,113,093	$37,130,615
Unduplicated Caregivers Provided Service or Access	819, 973			

[12] 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 92 percent of home-delivered meal recipients reported that the meals enabled them to continue living in their own homes and 54 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.[13]

Between 2011 and 2015, the number of Americans age 60 and older will increase by nearly six million older adults, to reach 65.7 million seniors.[14] 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 13 percent.[15] These programs help seniors in need maintain their health and independence.

In concert with other OAA programs, these services assist over 11 million elderly individuals and caregivers. AoA's services are especially critical for the nearly three million seniors who receive intensive in-home services, 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.[16]

Home and Community-Based Supportive Services
(Title III-B of OAA; FY 2011: $367,611,000)

The Home and Community-Based Supportive Services (HCBS) 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 that enable seniors to remain in their homes for as long as possible. AoA's programs, including the HCBS 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 ensures older persons can remain in their own homes and communities instead of entering nursing homes or other types of institutional care.

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[13] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

[14] Data compiled by AoA from U.S. Census Bureau, "2008 National Population Projections", released August 2008, <http://www.census.gov/population/www/projections/2008projections.html> and 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, 2011 (NC-EST2011-01). Source: U.S. Census Bureau, Population Division. Release Date: May 2012. < http://www.census.gov/popest/data/national/asrh/2011/index.html> Accessed 28 August, 2012.

[15] Ibid, and National Center on Health Statistics, Centers for Disease Control and Prevention, "Functional limitations among Medicare beneficiaries, ages 65+: US, 1992-2010." Accessed 28 August, 2012.

[16] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population (2010) [data tables 1.1]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2010-Char-and_Perc.html. Accessed 30 August, 2012

The services provided to seniors through the HCBS 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 HCBS 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, 55 percent are unable to perform critical activities of daily living and require long-term support. Data also show that over 80 percent of seniors have at least one chronic condition and 50 percent have at least two.[17] 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 HCBS program in FY 2011 include:[18]

- *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 over 27 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 over 8 million hours of care for dependent adults in a supervised, protective group setting during some portion of a twenty-four hour day.

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

Continuing AoA's commitment to provide services to those in most need, nearly 43 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.[19] 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:[20]

- 68 percent of riders had a doctor tell them they had vision problems (including glaucoma, macular degeneration or cataracts);

- 9 percent have Alzheimer's or dementia;

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[17] Anderson, Gerard, *Chronic Care: Making the Case for Ongoing Care*. Robert Wood Johnson Foundation. 2010 Princeton, NJ. Available: http://www.rwjf.org/files/research/50968chronic.care.chartbook.pdf.

[18] Data from AoA's FY 2011 State Program Report are preliminary and should not be taken as final.

[19] Ibid

[20] Ibid

- 2 percent have Multiple Sclerosis;
- 19 percent have had a stroke;
- 3 percent have epilepsy; and
- 3 percent have Parkinson's disease.

Of the transportation participants, 98 percent take daily medications, with 14 percent taking 10 to 20 medications daily.[21] Data from AoA's national surveys of elderly clients show that HCBSS services are providing these seniors with the assistance and information they need to help them remain at home. 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] Living alone is a key predictor of nursing home admission, and HCBS services are critical for enabling them to remain at home, especially for those who do not have an informal caregiver to assist with their care. Recent research has also shown that childless seniors who live in a state with higher home and community-based service expenditures had significantly lower risk of nursing home admissions.[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.

[21] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

[22] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

[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, 2010, Special Tabulation on Aging; generated by AoA; using AoA's Aging Integrated Database (AgID) ; http://www.agidnet.org/CustomTables/; August 29, 2012.

[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 2011: $439,901,000): Provides funding for the provision of meals and related services in a variety of congregate settings, which helps to keep older Americans healthy and prevents the need for more costly medical interventions. Established in 1972, the program also presents opportunities for social engagement and meaningful volunteer roles, which contribute to overall health and well-being.

- Home-Delivered Nutrition Services (Title III-C2; FY 2011: $217,241,000): 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. Home-delivered meals also represent an essential service for many caregivers, helping them to maintain their own health and well-being.

- Nutrition Services Incentive Program (Title III-A; FY 2011: $160,693,000): 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.

Formula grants for Congregate Nutrition Services and Home-Delivered Nutrition Services are allocated to states and territories based on their share of the population age 60 and over. Nutrition Services Incentive Program grants are provided to states, territories, and tribal organizations based on the number of meals served in the prior Federal fiscal year. 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. *Serving Elders at Risk*, a 1995 national evaluation of AoA's nutrition program clients, found that recipients are older, poorer, more likely to live alone, more likely to be minorities, are sicker, in poorer health, in poorer nutritional status, more functionally impaired, and at higher nutritional risk than those in the general population. Nutrition Services provide an important opportunity for social interaction that helps to improve the general health status of participants, particularly homebound elders. A comparison of the number of social contacts of congregate and home-delivered meal participants reveals that nutrition program clients had significantly more social contacts than people who did not participate in the program.

Data from AoA's 2011 national surveys of elderly clients show that the Nutrition Services are effectively helping seniors to improve their nutritional intake and remain at home. For example, 78 percent of congregate and 83 percent of home-delivered meal recipients say they eat healthier meals due to the programs, and 60 percent of congregate and 92 percent of home-delivered meal recipients say that the meals enabled them to continue living in their own homes.[27] In addition, home-delivered meal and congregate meal participants had significantly better food energy intake, protein, vitamins A, B_6 & D, Riboflavin, Calcium, Phosphorous, Potassium, Magnesium and Zinc intakes compared to a matched non-participant group of senior citizens.[28] Seniors with deficiencies of these nutrients can experience osteoporosis, night blindness, decreased resistance to infection, fatigue, vasodilatation, and other illnesses.

Multiple medical conditions predispose older individuals to risk of increased limitations in activities of daily living as well as the possibilities of increased hospital and nursing home stays. In addition, self-reported health and well-being declines as multiple chronic conditions increase. Two-thirds of Medicare costs are associated with individuals who have multiple chronic conditions. Individuals who are poorly nourished have higher rates of hospital readmissions, especially for those with nutrition-related conditions such as heart disease/heart failure, pneumonia, chronic obstructive pulmonary disease, gastrointestinal problems or surgeries such as leg, hip, or bowel. Nutrition Services provide meals to high risk congregate and home-delivered participants to help ameliorate some of these factors. Data from the 2011 national surveys of OAA program participants indicate that fifty-one percent of congregate participants and sixty-three percent of home delivered participants have more than six chronic conditions.[29] Multiple medication use is associated with multiple chronic conditions and predisposes individuals to increased risk for emergency room visits, hospitalizations and nursing home admissions. Data from AoA's 2011 national surveys indicate that about thirty-one percent of congregate and fifty-one percent of home-delivered meal participants take six or more medications.[30] Adequate nutrition support through meals as well as nutrition education and counseling help these vulnerable participants manage their chronic conditions as well as help them with their medication management issues.

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[26] Hung et al.: Recent trends in chronic disease, impairment and disability among older adults in the United States. BMC Geriatrics 2011 11:47.
[27] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.
[28] *Serving Elders at Risk – National Evaluation of the Elderly Nutrition Program, 1993-1995*, pp.117-118
[29] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID
[30] Ibid.

AoA's annual performance data further demonstrate that these programs are an efficient and effective means to help seniors remain healthy and independent in their homes and in the community. Ninety percent of home-delivered meal clients rate service as good to excellent. Also, the number of home-delivered meal recipients with severe disabilities (3+ ADL) totaled nearly 367,000 in FY 2011. 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 139.1 million meals to over 855,000 individuals in FY 2011.

- *Congregate Nutrition Services* provided over 88.6 million meals to nearly 1.7 million seniors in a variety of community settings in FY 2011.

Consistent with AoA's commitment to target services to those most in need to help them maintain their health and independence, approximately 73 percent of home-delivered meal recipients have annual incomes at or below $20,000. Meals are especially critical for the survival of the 29 percent of recipients who report these meals as the sole or majority of their food intake for the day.

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 2011, state and local funding comprised approximately 63 percent of all the funding for home-delivered meals and congregate meals. Though all programs funded through OAA rely on state and local funding in some part, funding for congregate and home-delivered meals leverages more state and local financial support than many other OAA services.

State and Territory Flexibility

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

The OAA allows a state to transfer up to 40 percent of the funds between congregate and home-delivered meals for use as the state considers appropriate to meet the needs of the area served. Additionally, for any fiscal year if the transferred funds are insufficient to satisfy the need for nutrition services, then 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 2011, 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 2011 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 2011: $20,984,000)

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 and 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 gives states and territories 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 today can expect to live an additional 19.2 years.[31] The population of older Americans is also growing, particularly the population age 85 and over, which is growing very rapidly, totaling 5.7 million in 2011 and projected to reach 8.7 million by the year 2030.[32] 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 to 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 control trials and have been shown to be effective at helping participants adopt healthy behaviors, improve their health status, and reduce their use of hospital services and emergency room visits. Some examples of evidence-based interventions are:

- *Enhanced fitness and enhanced 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. In

[31] National Center of Health Statistics, Health, U.S., 2011: With Special Feature on Socioeconomic Status and Health. Table 22. Hyattsville, MD 2012.

[32] Data compiled by AoA from U.S. Census Bureau, "2008 National Population Projections", released August 2008, <http://www.census.gov/population/www/projections/2008projections.html> and 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, 2011 (NC-EST2011-01). Source: U.S. Census Bureau, Population Division. Release Date: May 2012. < http://www.census.gov/popest/data/national/asrh/2011/index.html> Accessed 28 August, 2012.

addition exercise has been proven to improve depression, which studies have shown that nearly 20 percent of U.S. adults 65 years and older experience. Exercise may also act as a buffer against many illnesses impacted by stress.

- *Falls prevention*: Falls prevention programs help participants to achieve improved strength, balance, and mobility; provide education on how to avoid falls and reduce fall risk factors; involve medication reviews and modifications; provide referrals for medical care management for selected fall risk factors; and provide home hazard assessments of ways to reduce environmental hazards. 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 the ability of older adults to get around or live independently. Those who are not injured may develop a fear of falling, which may increase their actual risk of falling. Many people limit their activity after a fall, which may reduce strength, physical fitness, and mobility.[33]

- *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".[34] Older adults with depression "visit the doctor and emergency room more, use more medication, and stay longer in the hospital" than those without depression.[35] 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).[36] Cost-effective, evidence-based interventions, such as the Program to Encourage Rewarding Lives for Seniors (PEARLS), are available that have been shown to reduce depressive symptoms and improve quality of life in older adults.[37]

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

[34] 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.

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

[36] 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.

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

Chronic Disease Self-Management Program

The Chronic Disease Self-Management Program (CDSMP) is a low-cost, evidence-based disease prevention model that uses state-of-the-art techniques to help those 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.

Data show that as an individual's number of chronic conditions increases, there is a corresponding escalation in adverse outcomes including mortality, poor functional status, unnecessary hospitalizations, adverse drug events, duplicative tests, and conflicting medical advice, all of which lead to higher health costs and greater outlays for programs like Medicare and Medicaid. CDSMP has been shown repeatedly, through multiple studies (including randomized control experiments, with both English and Spanish speaking populations) to be effective at helping participants adopt healthy behaviors, improve their health status and reduce their use of hospital stays and emergency room visits. Studies indicate that the program significantly improves participant health status, reduces the use of hospital care and physician services[38], and reduces health care costs.

CDSMP emphasizes an individual's role in managing his/her chronic condition(s). The program consists of a series of workshops that are conducted once a week for two and a half hours over six weeks in community settings such as churches, libraries, YW/MCAs, senior centers, public housing projects, community health centers and cooperative extension programs. People with differing chronic health conditions attend workshops together, and the workshops are facilitated by two leaders who are certified trainers. One or both of the leaders are non-health professionals or lay people with one or more chronic conditions themselves. Topics covered 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 CDSMP through competitive grants awarded to states. External experts review project proposals, and AoA awards grants for periods of one to three years. In FY 2011, AoA tracked the progress of the 47 sate grantees funded through the American Recovery and Reinvestment Act of 2009. By September 30, 2011, grantees had already reached 52,200 completers, exceeding their 2-year goal of 50,000 completers (73 percent were age 60 or older and 60 percent reported having multiple chronic conditions). AoA also funded a Technical Assistance Resource Center through a grant to the National Council on Aging 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 1,000 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.

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

Caregiver Services

Families are the nation's primary provider 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 too often are already 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, paraprofessionals 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.[39] AARP estimated the economic cost of replacing unpaid caregiving in 2009 to be about $450 billion, an increase from $375 billion in 2007 (cost if that care had to be replaced with paid services).[40]

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.[41] 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-eight percent of the caregivers served by OAA programs report that these services allow them to provide care longer than they otherwise could.[42]

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 over 15 million non-institutionalized seniors age 65 and over with 1+ ADL deficits, an increase of almost four million seniors (or a 36 percent increase since 2010) needing caregiver assistance.[43]

[39] *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

[40] *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

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

[42] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

[43] Data extrapolated by AoA from U.S. Census Bureau, "2008 National Population Projections," released August 2008, http://www.census.gov/population/www/projections/2008projections.html and Health Data Interactive, National Center on Health Statistics, Centers for Disease Control and Prevention, "Functional limitations among Medicare beneficiaries, ages 65+: US, 1992-2006." Accessed 31 August 2009.

National Family Caregiver Support Program

(Title III-E of OAA; FY 2011: $153,912,000)

The National Family Caregiver Support Program (NFCSP) provides grants to states and territories, based on their share of the population age 70 and over, to fund a range of supports that assist family and informal caregivers to care for their loved ones at home for as long as possible. The program 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 2011, services provided included:[44]

- *Access Assistance Services* provided over 1.3 million contacts to caregivers assisting them in locating services from a variety of public and private agencies.

- *Counseling and Training Services* provided over 128,000 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving.

- *Respite Care Services* provided nearly 67,000 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.

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 2011 National Survey of OAA Participants, 24 percent of caregivers are assisting two or more individuals. Sixty-eight percent of Title III caregivers are 60 or older, making them more vulnerable to a decline in their own health, and thirty-four percent describe their own health as fair to poor.[45] 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. 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 Family Caregiver Support Services Program 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 costly institutional care for their loved ones. For example, a study, *Intervention to Delay Nursing*

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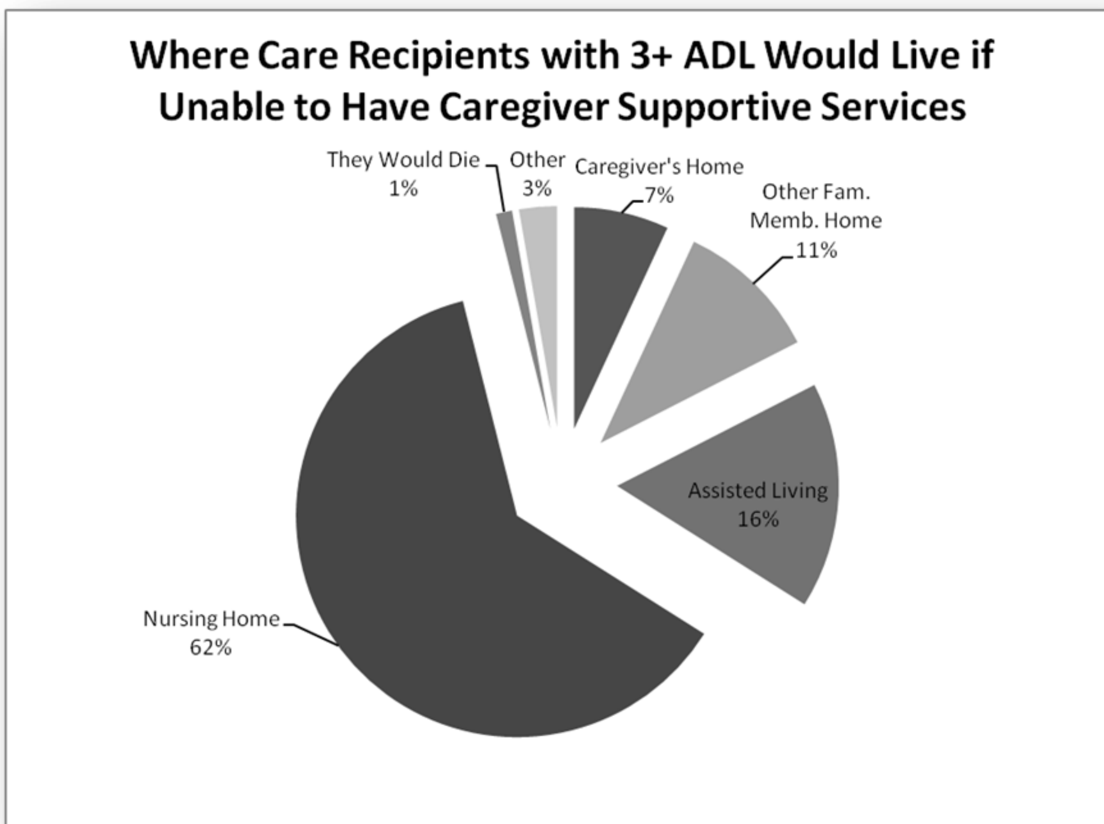
[44] Data from AoA's FY 2011 State Program Report are preliminary and should not be taken as final.
[45] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

Home Placement of Patients with Alzheimer's Disease, 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.

Additionally, data from AoA's national surveys of caregivers of elderly clients also shows that OAA services, including those provided through Family Caregiver Support Services, are effective in helping caregivers keep their loved ones at home. Approximately 78 percent of caregivers of program clients reported in 2011 that services enabled them to provide care longer than otherwise would have been possible.[46] 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-five percent of the caregivers of nursing home eligible care recipients 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 below).



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

[46] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

Lifespan Respite Care

(FY 2011: $2,495,000)

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.[47]

Numerous studies have shown respite to be among the most frequently requested supportive service for family caregivers.[48] [49] Respite is second only to direct financial assistance as a key policy priority of surveyed family caregivers. Even though respite services are often the preferred mode of family caregiver support, they are often under used, difficult to find and access, and are often unaffordable or in short supply. A 2009 survey found that "finding time for myself" was reported by 32 percent of family caregivers along with managing both physical and emotional stress (34 percent) and balancing work and family responsibilities (27 percent). Despite these compelling numbers, nearly 90 percent of family caregivers receive no respite at all.[50]

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. [51] [52] 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 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 National Family Caregiver Support Program, which focuses on broad caregiver support via a number of services, Lifespan Respite Care programs focus on providing a test bed for needed infrastructure changes, and on filling gaps by putting in place coordinated systems of accessible,

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[47] 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

[48] 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

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

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

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

[52] The Arc, 2011.

community-based respite care services for family caregivers of children and adults with special needs.

The systems funded through the Lifespan Respite Care program 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 to fill gaps in services. Within this context, Lifespan Respite Care Program grantees have focused their efforts in a number of broad areas, including:

- Conducting needs assessments/environmental scans to determine the respite funding streams available, programs in existence, 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;
- Engaging respite consumers to inform project activities; and
- 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.

Lifespan Respite also supports resource center activities designed to maintain a national database on lifespan respite care; provide training and technical assistance to grantees and state, community, and nonprofit respite care programs; and conduct 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, in a recent national survey of OAA service recipients a random sample of 1,795 caregivers (which represented over 223,626 active caregivers) answered questions about the impact of the caregiver program on their lives.[53] Eighty-four percent of caregivers received respite care with 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:

- 80 percent had less stress;
- 89 percent said it was easier to care for their loved one;
- 76 percent reported that it was the most helpful service they received;

[53] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

- 97 percent reported the care recipient benefited from the service; and
- 87 percent said that the services enabled them to care longer.

Since 2009, twenty-nine states and the District of Columbia have been awarded grants of up to $200,000 each for three year projects. Additionally, in FY 2011, eight states were awarded expansion grants to focus specifically on providing respite services to meet demand and fill gaps in service where identified. 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 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 programs.
- 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 services;
- The creation or expansion of respite voucher programs;
- Mini-grant programs to promote the development of unique community-based respite options; 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 which 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 2011: $11,441,000)

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 interventions that help persons with dementia and their caregivers remain independent in the community for as long as they desire. The primary components of the ADSSP program include delivering evidence-based supportive services; translating and replicating evidence-based interventions for persons with dementia and their caregivers at the community level; incorporating evidence-based research in the formulation of innovative projects; and advancing changes to a state's overall system of home and community-based care.

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

FY 2011 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 relevant to the population residing in the state's service area with an emphasis on incorporating dementia capability in services for people with dementia. These three-year projects are being implemented in Georgia, Minnesota, New York and Ohio.

Through projects funded in prior years, sixteen states are in the process of translating ten evidence-based interventions into practice. One example of these promising evidence-based interventions is the New York University Caregiver Intervention, a spousal caregiver support program that in a randomized-control trial delayed institutionalization of persons with dementia by an average of 557 days.[54] In 2011, the average nursing home cost was $214 daily for a semi-private room and $239 daily for a private room ($78,110 and $87,235 annually), which would mean an average savings of between $120,000 and $133,000 in institutional costs per person with dementia.[55] California, Florida, Georgia, Minnesota, Utah and Wisconsin are translating this intervention now; early results confirm the original study. In addition, 25 states, DC and Puerto Rico are offering innovative programming for caregivers and their loved ones with dementia. States funded to implement innovative programs are focusing in areas of great need, such as

[54] 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.

[55] Metlife. (October 2011), **"**MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs", p. 5, Accessed 31 August, 2012 from: http://www.metlife.com/assets/cao/mmi/publications/studies/2011/mmi-market-survey-nursing-home-assisted-living-adult-day-services-costs.pdf

programs to ensure that the states' long term services and supports system are dementia capable.

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

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

Nutrition and Supportive Services

Native American Nutrition and Supportive Services provides grants to eligible tribal organizations to promote the delivery of nutrition and home and community-based supportive services to Native American, Alaskan Native, and Native Hawaiian elders. According to the 2011 American Community Survey, approximately 301,000 persons age 60 and over identified themselves as Native Americans or Alaskan Natives, and another 242,000 persons age 60 and over identified themselves as part Native American or Alaskan Native.

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, chore, and other supportive services. Currently, AoA's congregate meal program reaches 32 percent of eligible Native American seniors in participating tribal organizations, home-delivered meals reach 14 percent of such persons, and supportive services reach 52 percent of such persons. These programs, which help to reduce the need for costly nursing home care and medical interventions, are responsive to the cultural diversity of Native American communities and represent an important part of each community's comprehensive services.

Services provided by this program in FY 2011 include:[56]

- *Transportation Services*, which provided over 855,000 rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical daily activities.

- *Home-Delivered Nutrition Services,* under which 2.5 million meals were provided to nearly 37,694 homebound Native American elders; the program also provides critical social contacts that help to reduce the risk of depression and isolation experienced by many home-bound Native American elders.

- *Congregate Nutrition Services*, which provided 2.1 million meals to more than 59,754 Native American elders in community-based settings, as well as an opportunity for elders to socialize and participate in a variety of activities, including cultural and wellness programs.

- *Information, Referral and Outreach Services*, which provided over 900,000 hours of outreach and information on services and programs to Native American elders and their families, thereby, empowering them to make informed choices about their service and care needs.

[56] Title VI FY 2010 are the most recently available data.

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

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 represent 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.[57] 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.[58] 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.[59] 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.[60] 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 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.

[57] 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

[58] 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

[59] 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.

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

Prevention of Elder Abuse and Neglect

(FY 2011: $5,046,000)

The Prevention of Elder Abuse and Neglect program provides formula grants to states and territories based on their share of the population 60 and over for training, education, and promoting public awareness of elder abuse. The program also supports state and local elder abuse prevention coalitions and multi-disciplinary teams. These activities are important elements of AoA's focus on elder rights and 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. In FY 2011, over $27.5 million of the Elder Abuse Prevention services expenditures was leveraged from non-OAA funds, a ratio of over $6 of non-OAA funds for every $1 investment of AoA funds.[61]

Examples of State elder abuse prevention activities include:

- In Kentucky, the local area agencies on aging participate in the Local Coordinating Councils on Elder Abuse, which have developed emergency elder shelters, developed informational cards for law enforcement officers to have in the patrol cars which contain crucial resource information for victims of elder abuse, provided training on a regular basis to first responders, provided a friendly visitor program for home-based seniors, and produced a prevention tool called the Kentucky Fraud Fighter Form.

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

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

National Center on Elder Abuse

To support and enhance the activities of state and local programs to prevent Elder Abuse, Neglect, and Exploitation, AoA funds the National Center on Elder Abuse (NCEA). NCEA disseminates information to professionals and the public; collaborates on research; provides consultation; identifies and provides information about promising practices and interventions; answers inquiries

[61] Data from AoA's FY 2011 State Program Report are preliminary and should not be taken as final.

and requests for information; operates a listserv forum for professionals; and advises on program and policy development.

Model Approaches to Statewide Legal Assistance Systems
(FY 2011: $1,999,569)

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 as of the end of FY 2011. Model Approaches seeks to address the nationwide challenge of what are often fragmented, inconsistent, and inefficient legal service delivery systems that fail to achieve optimal access to quality service for older adults 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 most in need 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, 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, Aging and Disability Resource Centers, 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 2011, Model Approaches projects assisted over 21,838 older consumers in the most social or economic need 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 SLH to seek assistance with a termination notice. She had recently come home from a hospital admission and brief stay in a rehab facility convalescing from a fall. The hospital and her doctor cleared her to return home. She had prearranged a support system that included a visiting nurse, a housekeeper/shopper, and regular visits by her daughter and son. The SLH lawyer helped the client write a letter of response to the Housing Manager asserting her rights under the Federal

Fair Housing Act. The letter resulted in the rescission of the termination notice and allowed the client to stay in her residence.

- A 71 year-old man and his wife were struggling to pay their adjustable rate mortgage on a fixed income. They applied for a mortgage modification through a lender designated by the federal government to offer loan modifications to qualified homeowners. Due to inaction on the part of the lender, interest and late fees continued to accrue on the loan balance. An 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.

In addition to providing assistance on priority legal issues, SLHs under Model Approaches have been very successful in reaching low-income populations with over 70 percent of older clients having incomes at or below 200 percent of the federal poverty guidelines. Also, minority clients receiving assistance through SLHs in the last reporting period constituted 33 percent of all clients served. These figures illustrate the effectiveness of Model Approaches states in reaching key target populations under the Older Americans Act 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 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 2011 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

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 2011, 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 9,120 aging and legal service professionals nationwide. NLRC partners also provided important technical support in the implementation of the Model Approaches projects in ten 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 21 SLHs and provided resources to aging services professionals in an additional 13 states.

An essential foundational 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 issues areas. In FY 2011, over 97 percent of professionals responding to surveys rated the quality and usefulness of the support service provided by the NLRC as either good or excellent.

In addition, the NLRC website continues to serve as a single entry point into a national legal assistance support system providing high quality resources and expertise on a broad range of legal and systems development issues: www.nlrc.gov The NLRC website received 1,019,915 hits in FY 2011.

Pension Counseling and Information Program

(FY 2011: $1,715,562)

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

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

Benefits from employer-sponsored pensions and retirement savings plans are as critical today to the retirement security of Americans as they were when the pension counseling program was first established. The pension questions which people face are just as complex, and good help is just as hard to find – even more so for those with only modest benefits at stake. The role of the Pension Counseling and Information Program is to help ensure that all older Americans have access to the help they need in order to secure the employer-sponsored retirement benefits they have earned --- benefits that are critical to their ability to live independently and with dignity after a lifetime of productive employment. The Pension Counseling & 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 for the program shows that since the Program's inception in 1993, the Pension Counseling projects have recovered over $130 million in retirement benefits for individual claimants. With a relatively small federal investment, the program has brought in a return of nearly $7.00 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 a six-month reporting period in FY 2011, a single regional counseling project recovered nearly $1,200,000 in benefits (lump-sum benefits totaling $46,298 and monthly benefits with an estimated actuarial value of $1,098,672).

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

A 72-year-old widow with an overpayment problem had a legitimate claim, but needed the project's expertise, knowledge and diligence to file the overpayment waiver claim with the plan administrator and to negotiate with the plan's attorney on her behalf. Her disability pension benefits should have stopped seven years earlier when her regular retirement began but, instead, through the corporation's error, she was overpaid $16,723, and was now being told she owed the corporation this amount. Collection agency letters had been received, and her efforts to deal with the large corporation's benefits center were fruitless, leaving her anxious and frightened that she might lose her home. Due to the complexity of the matter and the widow's limited financial resources, it is extremely unlikely that she would have been able to pursue the case on her own or find a private attorney to assist her. Without the assistance of the project, she may have been forced to forfeit all, or nearly all, of her monthly lifetime retirement benefit. Instead, an agreement was reached to reduce the client's pension by $25 per month to allow the corporation to partially recoup the overpaid amount.

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.

A critical component of the AoA 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 telephonically and through the PensionHelp America website, a nationwide database of pension assistance and information resources: http://www.PensionHelp.org.

Senior Medicare Patrol Program

(FY 2011: $9,420,000)

The Senior Medicare Patrol (SMP) program provides competitive grants to 54 states and territories to support a national volunteer-based network of volunteers whose purpose is to educate older adults 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 and their families to prevent, identify and report fraud. Activities are carried out in partnership with the Centers for Medicare & Medicaid Services, the 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. This data is published as a report on the SMP program. This report for Calendar Year 2011[62] shows that SMP projects:

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[62] "*Performance Data for the Senior Medicare Patrol Projects: June 2012 Performance Report*". OEI-02-12-00190. http://oig.hhs.gov/oei/reports/oei-02-12-00190.asp

- Had 5,671 active volunteers who worked over 88,169 hours to educate beneficiaries about how to prevent Medicare and Medicaid fraud;

- Educated 431,128 beneficiaries in 11,109 group education sessions and held 66,303 one-on-one counseling sessions with or on behalf of beneficiaries;

- Conducted 8,800 community outreach education events; and

- Resolved 76,224 inquiries for information or assistance from beneficiaries.

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

- Educated over 3.5 million beneficiaries in 94,077 group education sessions and held 1,179,190 one-on-one counseling sessions;

- Conducted 83,862 community outreach education events; and

- Documented over $106 million in savings, including Medicare and Medicaid funds recovered, beneficiary savings, and other savings as *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 SMP program's sentinel effect, impact on fraud deterrence, or calls to fraud hotlines or other non-SMP contacts.

The SMP program historically has been supported by approximately $3.3 million in Health Care Fraud and Abuse Control (HCFAC) funding authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for infrastructure, technical assistance, and other SMP program support and capacity-building activities designed to enhance program effectiveness. Activities funded by HCFAC resources include support for project training and technical assistance provided by AoA's National Consumer Technical Resource Center (Center).

The important role of the SMP program continued to be recognized by partners in Medicare fraud prevention in the private and public sectors. In 2010, and again in 2011, the Centers for Medicare & Medicaid Services (CMS) provided funding for the award of an additional $9 million in grants from its Program Integrity funding, administered by AoA, targeted to help the 54 Senior Medicare Patrol (SMP) programs fight Medicare fraud in high fraud states and expand the capacity of the program to reach more beneficiaries. In FY 2012, SMP projects will receive an additional $7.3 million from HCFAC funds to maintain expanded efforts to fight Medicare fraud, with added focus on high-fraud states.

In November 2010, the Administration on Aging received a national level commendation for the SMP program from the National Health Care Anti-Fraud Association (NHCAA), considered the leading national organization focused exclusively on the fight against health care fraud. The NHCAA's members comprise more than 100 private health insurers and those public sector law enforcement and regulatory agencies having jurisdiction over health care fraud committed against both private payers and public programs. The award, given annually by the NHCAA, recognizes an organization or individuals "who have done the most in the past year to raise public awareness about the problem of health care fraud in our nation's health care system." This

organization's decision to award the Senior Medicare Patrol program the NHCAA 2010 Excellence in Public Awareness Award is a major achievement, and a notable acknowledgement of the value of the SMP program.

Health Care Fraud and Abuse Control (HCFAC)

(FY 2011: $3,312,000)

The Administration on Aging 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 - infrastructure, technical assistance, program support and capacity building - to state Senior Medicare Patrol (SMP) programs.

HCFAC funds allow AoA 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 eight 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.

Long-Term Care Ombudsman Program

(FY2011: $16,793,000)

The Long-Term Care Ombudsman Program serves residents of 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 polices 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. The Long-Term Care Ombudsman is the local problem-solver for individuals living in long-term care facilities 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 2011 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).

Complaint Investigation and Resolution

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

- Ombudsmen nationwide completed resolution work on 204,044 complaints.
- Ombudsmen resolved or partially resolved 73 percent of these complaints to the satisfaction of the resident or complainant.
- Of the 132,325 cases closed by ombudsmen,[63] 99,305 (75 percent) were associated with

nursing facility settings. Of the remaining cases, 30,796 (23 percent) were related to board and care and other similar facilities (including assisted living); and 2224 (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 40 percent of cases in nursing facilities and 31 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 in 2011 were:
  - improper eviction or inadequate discharge/planning;
  - unanswered requests for assistance;
  - lack of respect for residents, poor staff attitudes;
  - medications – their administration and organization; and
  - accident or injury of unknown origin, falls, improper handling

- The five most frequent board and care and similar facilities complaints were:
  - quality, quantity, variation and choice of food;
  - medications – administration and organization;
  - inadequate or no discharge/eviction notice or planning;
  - equipment or building hazards; and
  - lack of respect for residents, poor staff attitudes.

Ombudsman Program in Action: Case Example

The ombudsman received a call from a nursing home resident. He said his brother had placed him in the nursing home after a hospitalization. The brother took his wallet and credit cards, would not let him go home and would not put any money in his account at the nursing home. Previously, the resident had given his brother Power of Attorney (PoA) for Health Care and now the brother was not relinquishing his responsibilities after the resident recovered. The ombudsman suggested a Care Plan transition meeting so nursing home staff and family members could begin planning for his return to the community. All agreed except the resident's brother who stated that the resident would have to hire an attorney to rescind the POA. The brother felt he had the right to make decisions and he felt the resident needed to stay in the nursing home even though nursing home medical staff said he had recuperated sufficiently and could go home. The ombudsman and facility staff supported the right of the resident to return home. The resident hired an attorney who assisted the resident in rescinding the Power of Attorney. The brother returned the wallet and credit cards and the resident went home the next day.

[63] In FY 2011, ombudsmen opened 134,775 new cases (a case contains one or more complaints originating from the same person(s), and completed resolution work on 132,325 closed cases, containing 204,044 complaints.

Ombudsman Program in Action: Protecting Residents' Rights

The State Ombudsman Program reported involvement in many facility foreclosures and bankruptcies involving both large facilities and small group homes (classified as Board & Care)

In one particular case an owner of a large group home licensed for 129 beds declared bankruptcy. The ombudsman was called in to investigate a complaint regarding resident trust accounts, it was discovered that many of these trust accounts had little to no balance. The residents involved had not been receiving their monthly personal needs allowance nor were they able to draw money out for personal needs. The LTC Ombudsman Program made a referral to the Attorney General's Office / Medicaid Fraud Control Unit which initiated a full investigation.

With the assistance of the LTC Ombudsman Program resident funds were re-deposited and access to accounts were granted to the involved residents. Further investigation revealed the owner was co-mingling operating funds and trust account funds.

Ombudsman staff and volunteers provided a regular presence to facility residents, visiting residents of 70 percent of nursing facilities and 33 percent of board and care and similar homes (including assisted living) at least quarterly.

➢ Ombudsmen provided 289,668 consultations to individuals in 2011. Consultations most frequently addressed such topics as alternatives to institutional care, how to select and pay for a long-term care facility, residents' rights, and federal and state rules and policies impacting residents.

➢ Ombudsmen provided 115,798 consultations to long-term care facility staff in FY 2011 on a wide range of issues, including residents' rights, observations about care, working with resident behavioral issues, and transfer and discharge issues.

➢ In FY 2011, ombudsmen nationwide:

- Provided information to resident councils (20,958 sessions) and family councils (3,321 sessions);
- Trained long-term care facility staff (5,144 sessions);
- Educated the community (12,456 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 22,640 survey related activities).

➢ 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.

Examples of Systems Issues Identified & Addressed by LTC Ombudsmen in 2011

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:

- ✓ Long-Term Care Ombudsmen are frequently appointed as Patient Care Ombudsmen under the Federal Bankruptcy Abuse Prevention and Consumer Protection Act of 2005. LTC Ombudsmen monitor facility activities to ensure that residents receive their required goods and services and report regularly to the Bankruptcy Court.

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

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

- ✓ Working to improve facility standards in board and care settings.

- ✓ Training of facility staff on strategies to reduce anti-psychotics in nursing homes.

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 576 designated local entities across the nation.

In FY 2011, long-term care ombudsman services to residents were provided by 1,185 full-time equivalent staff and 9065 volunteers, trained and certified to investigate and resolve complaints. An additional 3,320 volunteers also served residents or assisted in program operations in ways other than complaint resolution.

Long-Term Care Ombudsmen: Partners in Abuse Prevention:

Partnership with Resident Councils - Residents often fear raising concerns and reporting abuse, neglect and exploitation out of fear of retaliation. One program worked with a statewide association of resident councils to develop a training video: "Voices Speak Out against Retaliation." This video gives residents an opportunity to tell their story, including examples of mistreatment and steps taken to resolve their harm. It is now a training tool for facility staff, resident and family councils and ombudsmen.

Ombudsman Program in Action:
Advocating for Quality Care

Nursing Home Initiatives – Reducing the Use of Inappropriate Medications:

Ending overmedication of nursing home residents and halting the misuse of antipsychotic drugs as chemical restraints are issues and concerns that have garnered national and state attention. Inappropriately prescribed antipsychotic drugs, when prescribed for elders with dementia, can have serious medical complications, including death, loss of independence, over-sedation, confusion, and falls.

Twenty-six percent of all nursing home residents are on antipsychotic medications. Use is substantially higher (40 percent) among those with cognitive impairments and behavioral symptoms. The Food and Drug Administration has issued "Black Box" warnings that antipsychotics greatly increase the risk of death in persons with dementia.

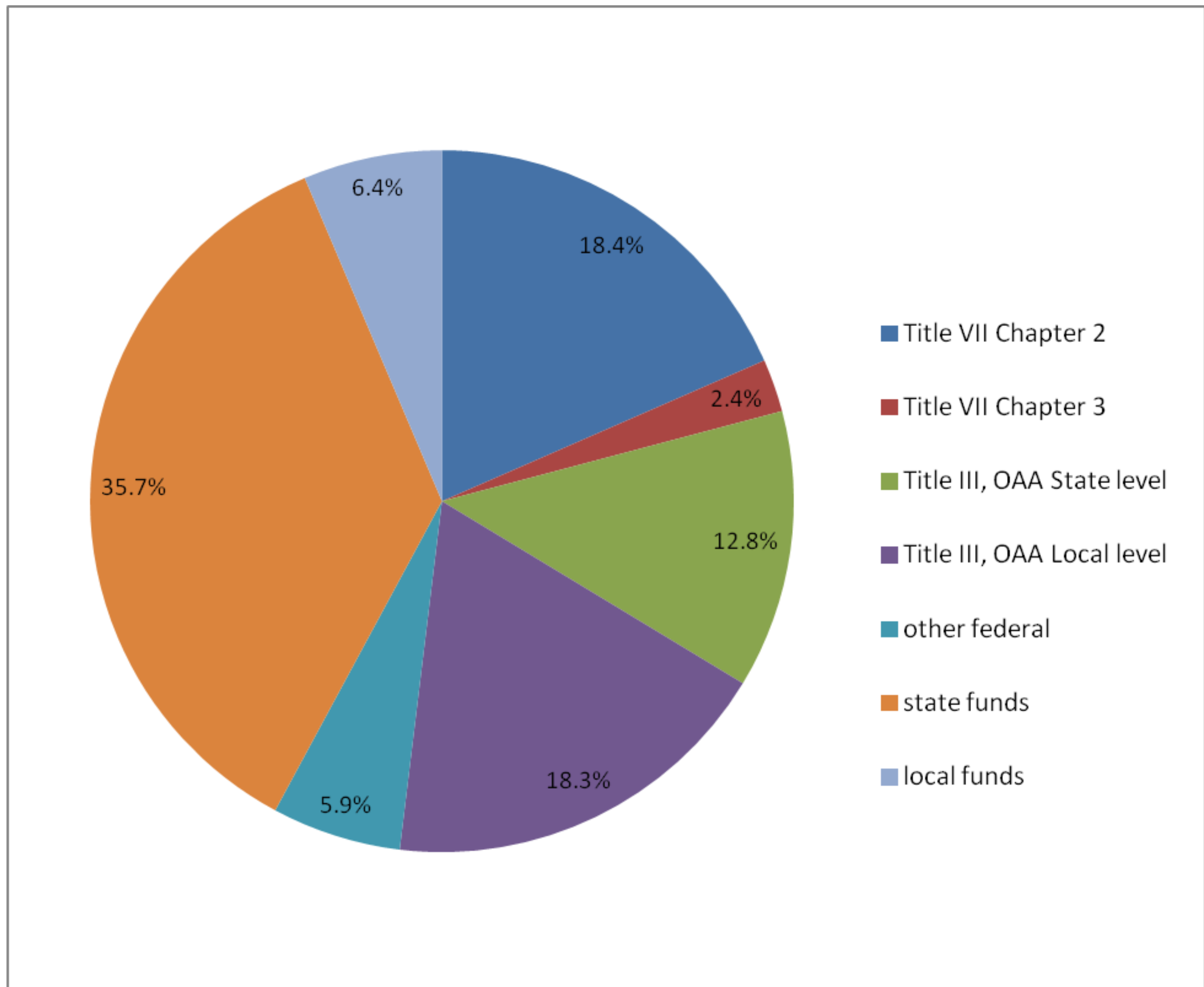
Three local Long-Term Care Ombudsman Programs and a statewide citizen's advocacy organization hosted approximately 1,000 people working in long-term care (LTC) at three, full day symposia on the topic of Dementia without Drugs. Local Ombudsman Programs in these counties each hosted their own event. Speakers presented on different aspects of the overuse of psychotropic medication for the treatment of dementia care. Issues discussed included the liabilities of prescribing psychotropic medications without the consent of the resident, the dangers of prescribing drugs for off label usage, and the importance of the licensing agency ensuring that facilities are obtaining informed consent from residents or their legal representatives.

Program Funding

- Total FY 2011 funding from all sources for the Ombudsman Program nationwide was $87,261,158, an overall decrease of $579,066 (less than one percent) from the FY 2010 level.

- The federal government is the primary entity funding the Ombudsman Program, providing 58 percent of total funding in FY 2011. States provided 36 percent of funds, and other non-federal sources funded the remaining six percent. Figure 3 shows the percentage of total program funding by source.

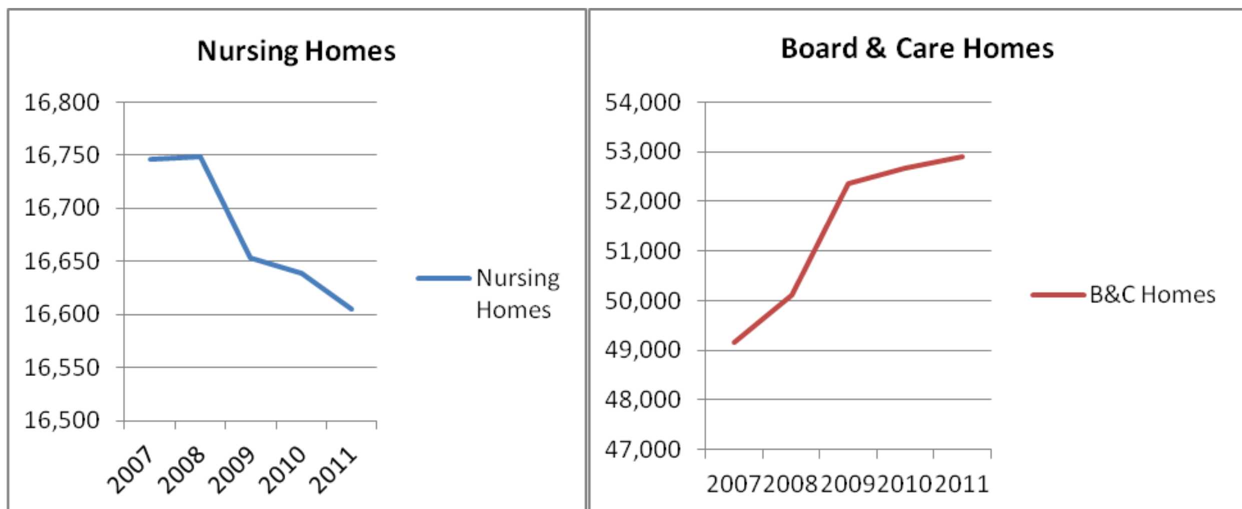
2011 Long-Term Care Ombudsman Programs - Sources of funding



Where Long-Term Care Facility Residents Live

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

- In the five years between 2007 and 2011, the number of board and care and similar facilities (including assisted living) increased by 8 percent to 52,903, while the number of nursing facilities decreased by nearly 1 percent from 16,746 in 2007 to 16,605 in 2011.



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 2010, 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 2011, 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:
    - MDS 3.0, Section Q – a new version of the Minimum Data Set (MDS) resident assessment tool used by Medicare and/or Medicaid-certified nursing facilities and implemented in FY 2010 by the Centers for Medicare & Medicaid Services (CMS). Section Q of the MDS instructs nursing facilities to ask all residents if they would like information regarding returning to the community and to link residents to local contact agencies for further information; and
    - Money Follows the Person – a demonstration project to assist individuals receiving Medicaid to move out of nursing homes and into other settings to receive long-term services and supports.
    - Culture Change and Person-Centered Care.

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 $16 million was donated in FY 2011:[64] 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 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 $21.79 per hour placing the value of 737,289 hours at $16,065,527.

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 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 2011.

[64] The Independent Sector places the value of volunteer time at $21.79 per hour placing the estimated value of $735,411 hours at $16,024,605. 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 so as 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 they need to make decisions about their independence and connecting them with the right services. Aging and Disability Resource Centers (ADRCs) help 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

Aging and Disability Resource Centers (ADRCs) support 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. ADRCs grew out of best practice innovations known as "No Wrong Door"[65] 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" options counseling and advice 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;

[65] 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).

- 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 467 ADRC sites have been established across 51 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 69 percent of the U.S. population.

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

- Thirty-eight states with ADRC programs sites currently conduct care transitions through formal intervention with an additional 10 states currently planning to conduct activities also through formal interventions

- 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.

Effective high performance ADRC Options Counseling Programs perform the following five key 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 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 key components of (1) a personal interview, (2) a facilitated decision-support process and (3) development of a service plan which connects people to the supports they need:

- *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, 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 also 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 $40.8 million to help 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 implemented a national training program for the VD-HCBS. Currently, 19 states and the District of Columbia are operating VD-HCBS programs with 33 operational VAMCs, 82 operational AAA/ADRCs and over 775 veterans served (132 or 17 percent under age 60).

Aging Network Support Program Activities

(FY 2011: $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.

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. In FY 2011, Aging Network Support Activities funded 24 grants with an average award of $279,465.

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, 2012, the National Alzheimer's Call Center handled over 257,000 calls through its national and local partners, and its on-line message board community recorded over 12 million page views and over 110,000 individual postings. The National Alzheimer's Call Center is available to people in all states, 24 hours a day, 7 days a week, 365 days a year to provide expert advice, care consultation, and information and referrals at the national and local levels regarding Alzheimer's disease. Trained professional customer service staff and masters degree social workers are available at all times. The Call Center is accessible

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

National Education and Resource Center on Women and Retirement Planning

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

National Resource Centers on Native American Elders

The National Resource Centers on Native American Elders enhance knowledge about older Native Americans and thereby increase and improve the delivery of services to them. Each Resource Center addresses at least two areas of primary concern which are specified in the OAA. These include health issues, long-term care (including in-home care), elder abuse, mental health, and other problems and issues facing Native communities. The Resource Centers are administered under cooperative agreements by institutions of higher education. The Resource Centers partner with Native American organizations and communities, educational institutions including Tribal Colleges and Universities, and professionals and paraprofessionals in the field. Resource centers have specialized areas of interest. The University of North Dakota Resource Center has assisted Title VI grantees in assessing needs of tribal elders to determine program planning and direction. This process has developed a database of information about American Indian, Alaska Native and Native Hawaiian Elders. The University of Hawaii Resource Center has focused on long term care needs of Native Hawaiian Elders. The University of Alaska Resource Center has focused on elder abuse and neglect issues within Native communities.

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. For example, the Center for American Indian and Alaska Native elders is developing a culturally appropriate caregiver manual/toolkit for caregivers caring for elders with dementia. 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 are focusing on barriers due to language and low literacy as well as those directly related to cultural diversity. Strategies developed under this program incorporate the latest technology and facilitate the generation and dissemination of knowledge in forms that can assist racial and ethnic minority older individuals to practice positive health behaviors and strengthen their capacity to maintain active, independent life styles. Examples of products resulting from these grants include a chronic disease self management curricula and manual tailored for racial and ethnic minority seniors, a series of bilingual Influenza Vaccination Promotion materials, and a referral database of Chronic Disease Self-Management (CDSMP) workshops.

National Technical Assistance Resource Center for LGBT Elders
Older lesbian, gay, bisexual and transgender (LGBT) adults face a number of unique challenges as they strive to maintain their independence. The Resource Center was established in 2010 to meet three primary objectives: educate mainstream aging services organizations about the existence and special needs of LGBT elders; sensitize LGBT organizations about the existence and special needs of older adults; and educate LGBT individuals about the importance of planning ahead for future long-term care needs. The national Resource Center formally began services in September 2010 with the launching of a website. The website includes sections directed towards each of the three target populations as well as a general resources section with resources on a variety of topics of interest. In addition, training curricula were developed for both mainstream aging and LGBT organizations to provide them with the knowledge they need to effectively serve these populations.

Multigenerational Civic Engagement
The Multi-Generational Civic Engagement (MGCE) initiative enhances discovery, documentation and support for existing, exceptional locally-developed program models and volunteer engagement strategies. Eighteen model programs launched in FY 2011 engage older adults in civic engagement projects aimed at increasing services to frail elders, families of children with special needs, and grandparents raising grandchildren. These model programs also partner with the Corporation for National and Community Service.

Program Performance and Technical Assistance
This activity supports cooperative efforts between AoA and selected states and AAAs to develop and test various performance measurement instruments that can be used to effectively and efficiently identify the results produced through OAA programs on an ongoing basis. It also supports partnerships with national aging organizations to foster innovation and provide technical assistance to states, AAAs, and tribal organizations in strategic planning, program assessment, and performance measurement.

PART V: PROGRAM INNOVATIONS

(FY 2011: $19,068,000)

Program Innovations grants provide a source of funding to use as a catalyst for tapping new approaches, translating cutting-edge research and evaluation results into practice, and demonstrating techniques and best practices that can be replicated across the states and communities in the network to strengthen core OAA programs. It also provides funds to address key AoA priorities to help seniors stay healthy, active, independent, and living in their own homes and communities.

Generally, these innovations are modeled after best practices developed within the aging services network that need further support, modeling, and evaluation before widespread replication and adoption. This effort, for instance, provided the seed money for developing Aging and Disability Resource Centers and Evidence-Based Disease Prevention projects that are now successfully implemented across the nation.

Program Innovation grants also provide a vehicle for the exploration of emerging opportunities or risks facing seniors and caregivers where the aging services network has limited expertise. In these cases, universities, consumer-focused organizations, and other entities may be brought collaboratively into the aging network as technical assistance partners to assist with these emerging challenges.

Community Innovations for Aging in Place

The intent of the Community Innovations for Aging in Place (CIAIP) program is to assist communities in their efforts to enable older adults to sustain their independence and age in place in their homes and communities. In 2009, Congress directed the Assistant Secretary for Aging to award three-year grants, on a competitive basis, to develop and carry out model aging in place projects. Entities eligible to submit applications included community-based non-profit organizations, area agencies on aging, local government agencies, as well as tribal and other appropriate organizations. Successful applications promoted older individuals sustaining their independence and aging in their community with a targeted audience that included individuals residing in Naturally Occurring Retirement Communities (NORCs). Congress directed that the proposed innovative projects under the CIAIP initiative include a needs assessment, which examines the needs of older individuals, as well as the service strengths and gaps within the community.

In FY 2009, the Assistant Secretary for Aging funded fourteen organizations representing diverse communities from across the country to implement innovative initiatives in support of older individuals aging within their communities. Funding for an additional grant to provide training and technical assistance to the grantees is also part of the program.

Many of the CIAIP grantees share characteristics that contribute to their promise for success and sustainability including:

- Strong leadership and support from the parent agency;
- Experienced and highly committed program staff;
- Shared leadership and staff vision and capability to articulate it;
- Organizational coherence and effectiveness;
- A positive relationship with and reputation within the community;
- High aptitude for identifying and engaging appropriate program partners;
- Pre-existing relationships with a wide array of stakeholders, including those outside the aging network;
- Engagement of community leaders, and
- Ability to adapt as programmatic opportunities or barriers present themselves.

All of the CIAIP grantees have developed and are implementing unique aging in place initiatives tailored to their own community. Common themes, strategies, and benefits continue to emerge across the funded programs including:

- **Capacity Building** The CIAIP program is providing both an impetus and framework for strengthening a community's ability to provide the services and supports necessary to allow older individuals the opportunity to age in place. The programmatic partnerships assist communities in leveraging existing community resources and decreasing potential and existing service redundancies. Many grantees are also exploring opportunities to enhance community infrastructure in support of aging in place.
- **Forging New Partnerships** CIAIP grantees are reaching beyond the aging network and engaging with non-traditional organizations to support older adults' aging in their communities. The partnership strategy underscores the message that aging is a community-wide issue and provides an opportunity for these disparate sectors to work together to create a common community agenda. Non-traditional community partnerships that support aging in place include local disability networks, affordable housing providers, faith-based organizations, tribal organizations, community planning departments, transportation networks, health care providers, public and affordable housing providers and others.
- **Tapping Social Capital** Grantees are mobilizing community members to identify and make use of the skills of volunteers of all ages. Contributions of time and expertise support the effort to develop a viable network for older individuals remaining in their homes and communities.
- **Providing Leadership** Participation in the CIAIP program is allowing area agencies on aging and others within the aging network to assume new community leadership roles.
- **Developing a Community of Practice** With the support of the technical assistance provider, grantees are cross-fertilizing experiences and ideas that are leading to joint problem-solving and innovative approaches to addressing common issues. In addition to learning about best and evidence-based practices, grantees are sharing information about financial and programmatic resources, as well as experiencing the value of technical assistance in a variety of areas, including business plan development.

As the grantees wrap up the final year of funding in FY 2011, they are focusing a portion of their efforts on program sustainability. In addition to providing continued support in the communities they serve, grantees, with the assistance of the technical assistance team, are identifying and applying for public and private funding in an effort to sustain their activities once federal funds are exhausted. Extensive program evaluations are also taking place, as grantees strive to understand better the impact of the work that has occurred over the life of the program. The

grantees and their partners have implemented a variety of programs with varied levels of success and deriving valuable lessons throughout the project period. The lessons learned compiled through CIAIP program activities, relative to successes and struggles, will inform the work of future innovators committed to assisting individuals in remaining in their homes and communities. In addition to the evaluative activities in which the grantees are engaged, they are also collecting and analyzing valuable data relative to the efforts to support older individuals remaining in their homes.

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Appendix

Formula Grant Funding

Allocation by

State, Territory and Tribal Organization

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

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State/Territory	Supportive Services	Congregate Meals	Home Meals	Preventive Services	NFCSP	Total Title III
Alabama	$5,610,623	$6,728,841	$3,380,743	$332,502	$2,386,588	$18,439,297
Alaska	$1,827,011	$2,186,289	$1,079,676	$104,920	$764,933	$5,962,829
Arizona	$7,448,464	$8,932,970	$4,488,153	$404,463	$3,227,992	$24,502,042
Arkansas	$3,543,506	$4,249,740	$2,135,178	$211,162	$1,518,422	$11,658,008
California	$36,232,873	$43,454,221	$21,832,514	$2,127,762	$15,356,773	$119,004,143
Colorado	$4,862,516	$5,831,634	$2,929,963	$255,659	$1,902,436	$15,782,208
Connecticut	$4,404,337	$5,241,452	$2,533,609	$260,652	$1,821,050	$14,261,100
Delaware	$1,827,011	$2,186,289	$1,079,676	$104,920	$764,933	$5,962,829
District of Columbia	$1,827,011	$2,186,289	$1,079,676	$104,920	$764,933	$5,962,829
Florida	$26,238,773	$31,468,259	$15,810,460	$1,554,456	$12,255,674	$87,327,622
Georgia	$9,194,575	$11,027,088	$5,540,292	$486,684	$3,567,093	$29,815,732
Hawaii	$1,827,011	$2,186,289	$1,079,676	$104,920	$764,933	$5,962,829
Idaho	$1,827,011	$2,186,289	$1,079,676	$104,920	$764,933	$5,962,829
Illinois	$14,524,890	$17,286,541	$8,295,464	$839,479	$5,908,033	$46,854,407
Indiana	$7,165,491	$8,593,601	$4,317,645	$426,268	$3,059,403	$23,562,408
Iowa	$4,260,878	$5,081,501	$2,243,404	$231,787	$1,707,953	$13,525,523
Kansas	$3,432,908	$4,089,903	$1,895,162	$191,313	$1,392,604	$11,001,890
Kentucky	$4,989,594	$5,984,038	$3,006,534	$291,748	$2,069,945	$16,341,859
Louisiana	$4,838,530	$5,802,867	$2,915,509	$295,110	$2,025,081	$15,877,097
Maine	$1,827,011	$2,186,289	$1,079,676	$105,122	$764,933	$5,963,031
Maryland	$6,149,883	$7,375,577	$3,705,679	$360,430	$2,509,470	$20,101,039
Massachusetts	$8,209,095	$9,780,267	$4,663,308	$464,535	$3,356,283	$26,473,488
Michigan	$11,646,647	$13,967,867	$7,017,815	$692,606	$4,908,737	$38,233,672
Minnesota	$5,783,935	$6,936,695	$3,485,174	$338,416	$2,496,717	$19,040,937
Mississippi	$3,272,711	$3,897,686	$1,958,298	$195,859	$1,387,772	$10,712,326
Missouri	$7,118,429	$8,467,047	$4,251,524	$422,405	$3,040,466	$23,299,871
Montana	$1,827,011	$2,186,289	$1,079,676	$104,920	$764,933	$5,962,829
Nebraska	$2,294,938	$2,738,802	$1,227,879	$124,650	$919,551	$7,305,820
Nevada	$2,755,306	$3,304,449	$1,660,240	$151,459	$1,066,391	$8,937,845
New Hampshire	$1,827,011	$2,186,289	$1,079,676	$104,920	$764,933	$5,962,829
New Jersey	$10,262,972	$12,190,488	$6,073,137	$619,704	$4,364,136	$33,510,437
New Mexico	$2,237,028	$2,682,876	$1,347,946	$127,140	$944,416	$7,339,406
New York	$24,283,431	$28,963,855	$13,639,815	$1,373,850	$9,759,795	$78,020,746
North Carolina	$10,484,174	$12,573,709	$6,317,354	$576,505	$4,306,356	$34,258,098
North Dakota	$1,827,011	$2,186,289	$1,079,676	$104,920	$764,933	$5,962,829
Ohio	$13,816,810	$16,533,997	$8,307,104	$834,207	$5,990,792	$45,482,910
Oklahoma	$4,278,286	$5,104,353	$2,564,558	$256,914	$1,827,039	$14,031,150
Oregon	$4,576,322	$5,488,400	$2,757,513	$254,403	$1,880,893	$14,957,531
Pennsylvania	$17,879,977	$21,279,716	$9,854,900	$1,016,515	$7,442,187	$57,473,295
Rhode Island	$1,827,011	$2,186,289	$1,079,676	$104,920	$764,933	$5,962,829
South Carolina	$5,479,859	$6,572,016	$3,301,949	$294,842	$2,237,296	$17,885,962
South Dakota	$1,827,011	$2,186,289	$1,079,676	$104,920	$764,933	$5,962,829
Tennessee	$7,364,949	$8,832,811	$4,437,831	$415,981	$3,033,344	$24,084,916
Texas	$22,440,012	$26,912,390	$13,521,475	$1,250,740	$9,215,393	$73,340,010
Utah	$2,181,148	$2,615,859	$1,314,275	$114,870	$910,038	$7,136,190
Vermont	$1,827,011	$2,186,289	$1,079,676	$104,920	$764,933	$5,962,829
Virginia	$8,499,074	$10,192,972	$5,121,210	$483,960	$3,446,280	$27,743,496
Washington	$7,221,988	$8,661,357	$4,351,688	$396,896	$2,900,557	$23,532,486
West Virginia	$2,773,538	$3,305,947	$1,494,917	$152,831	$1,067,786	$8,795,019
Wisconsin	$6,539,594	$7,842,960	$3,940,504	$390,666	$2,853,414	$21,567,138
Wyoming	$1,827,011	$2,186,289	$1,079,676	$104,920	$764,933	$5,962,829
American Samoa	$472,317	$594,843	$136,498	$13,115	$95,617	$1,312,390
Guam	$913,505	$1,093,145	$539,838	$52,460	$382,467	$2,981,415
Northern Mariana	$228,376	$273,286	$134,959	$13,115	$95,617	$745,353
Puerto Rico	$4,825,219	$5,786,903	$2,907,489	$269,207	$2,022,170	$15,810,988
Virgin Islands	$913,505	$1,093,145	$539,838	$52,460	$382,467	$2,981,415
TOTAL	**$365,402,129**	**$437,257,831**	**$215,935,133**	**$20,983,948**	**$152,986,623**	**$1,192,565,664**

State	Ombudsman	Elder Abuse	Total Title VII
Alabama	$262,233	$77,924	$340,157
Alaska	$83,746	$25,163	$108,909
Arizona	$348,130	$103,449	$451,579
Arkansas	$165,619	$49,214	$214,833
California	$1,693,475	$503,223	$2,196,698
Colorado	$227,267	$67,534	$294,801
Connecticut	$196,524	$59,907	$256,431
Delaware	$83,746	$25,163	$108,909
District of Columbia	$83,746	$25,163	$108,909
Florida	$1,226,365	$364,420	$1,590,785
Georgia	$429,742	$127,700	$557,442
Hawaii	$83,746	$25,163	$108,909
Idaho	$83,746	$25,163	$108,909
Illinois	$643,452	$197,384	$840,836
Indiana	$334,905	$99,519	$434,424
Iowa	$174,013	$55,927	$229,940
Kansas	$147,001	$45,843	$192,844
Kentucky	$233,207	$69,299	$302,506
Louisiana	$226,146	$68,518	$294,664
Maine	$83,746	$25,163	$108,909
Maryland	$287,437	$85,413	$372,850
Massachusetts	$361,717	$109,606	$471,323
Michigan	$544,348	$161,756	$706,104
Minnesota	$270,333	$80,331	$350,664
Mississippi	$151,899	$45,198	$197,097
Missouri	$329,777	$97,995	$427,772
Montana	$83,746	$25,163	$108,909
Nebraska	$95,242	$29,770	$125,012
Nevada	$128,779	$38,267	$167,046
New Hampshire	$83,746	$25,163	$108,909
New Jersey	$471,073	$143,950	$615,023
New Mexico	$104,556	$31,069	$135,625
New York	$1,057,995	$318,066	$1,376,061
North Carolina	$490,016	$145,611	$635,627
North Dakota	$83,746	$25,163	$108,909
Ohio	$644,354	$197,185	$841,539
Oklahoma	$198,924	$60,208	$259,132
Oregon	$213,891	$63,559	$277,450
Pennsylvania	$764,412	$242,944	$1,007,356
Rhode Island	$83,746	$25,163	$108,909
South Carolina	$256,121	$76,108	$332,229
South Dakota	$83,746	$25,163	$108,909
Tennessee	$344,228	$102,289	$446,517
Texas	$1,048,816	$311,661	$1,360,477
Utah	$101,944	$30,293	$132,237
Vermont	$83,746	$25,163	$108,909
Virginia	$397,235	$118,040	$515,275
Washington	$337,546	$100,303	$437,849
West Virginia	$115,956	$36,736	$152,692
Wisconsin	$305,652	$90,826	$396,478
Wyoming	$83,746	$25,163	$108,909
American Samoa	$10,468	$3,145	$13,613
Guam	$41,873	$12,582	$54,455
Northern Mariana Islands	$10,468	$3,145	$13,613
Puerto Rico	$225,524	$67,016	$292,540
Virgin Islands	$41,873	$12,582	$54,455
TOTAL	**$16,749,234**	**$5,032,634**	**$21,781,868**

State/Territory	Nutrition Services Incentive Program
Alabama	$2,757,851
Alaska	$355,155
Arizona	$2,137,183
Arkansas	$2,631,552
California	$12,422,425
Colorado	$1,412,481
Connecticut	$1,504,816
Delaware	$390,542
District of Columbia	$601,892
Florida	$7,752,196
Georgia	$2,827,339
Hawaii	$474,893
Idaho	$652,845
Illinois	$7,020,289
Indiana	$1,900,591
Iowa	$1,887,333
Kansas	$1,996,745
Kentucky	$1,852,778
Louisiana	$3,201,511
Maine	$583,674
Maryland	$1,899,261
Massachusetts	$4,703,430
Michigan	$7,267,382
Minnesota	$1,974,728
Mississippi	$1,201,461
Missouri	$4,055,146
Montana	$865,316
Nebraska	$1,266,994
Nevada	$1,016,007
New Hampshire	$1,103,997
New Jersey	$3,813,364
New Mexico	$1,980,506
New York	$15,419,528
North Carolina	$3,361,424
North Dakota	$806,432
Ohio	$5,577,024
Oklahoma	$2,045,615
Oregon	$1,797,863
Pennsylvania	$7,162,223
Rhode Island	$537,442
South Carolina	$1,710,911
South Dakota	$953,291
Tennessee	$1,647,948
Texas	$12,539,020
Utah	$1,332,354
Vermont	$755,471
Virginia	$2,473,229
Washington	$2,074,062
West Virginia	$1,619,809
Wisconsin	$2,651,426
Wyoming	$788,892
Guam	$393,221
Northern Mariana Islands	$62,962
Puerto Rico	$3,118,597
Virgin Islands	$200,210
TOTAL	**$154,540,637**

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP
AK	01	Aleutian Pribilof Islands Association	$94,700	$26,830	$19,809
AK	02	Association of Village Council Presidents	$136,700		$2,054
AK	03	Bristol Bay Native Association	$136,700	$46,950	$4,257
AK	04	Central Council Tlingit & Haida Indian Tribes of AK	$179,510	$53,660	$1,873
AK	06	Copper River Native Association	$83,390	$20,120	$2,495
AK	07	Hoonah Indian Association	$73,490	$13,410	$1,291
AK	08	Kodiak Area Native Association (Northern Section)	$73,490	$13,410	$833
AK	09	Kodiak Area Native Association (Southern Section)	$73,490	$13,410	$2,303
AK	10	Metlakatla Indian Community	$94,700	$26,830	$2,877
AK	11	Native Village of Barrow	$94,700	$26,830	$12,803
AK	12	Tanana Chiefs Conference for Kuskokwim subregion	$73,490	$13,410	$3,184
AK	13	Tanana Chiefs Conference for Lower Yukon Subregion	$73,490	$13,410	$4,311
AK	14	Tanana Chiefs Conference for Yukon Flats Subregion	$73,490	$13,410	$2,705
AK	15	Tanana Chiefs Conference for Yukon Koyukuk Subregion	$83,390	$20,120	$2,447
AK	16	Tanana Chiefs Conference for Yukon Tanana Subregion	$73,490	$13,410	$1,188
AK	17	Fairbanks Native Association	$136,700	$46,950	
AK	19	Maniilaq Association	$136,700	$46,950	$15,743
AK	20	Native Villiage of Unalakleet	$73,490	$13,410	$4,437
AK	21	Chugachmiut	$83,390	$20,120	$6,632
AK	22	Arctic Slope Native Association, Limited	$73,490	$13,410	$7,705
AK	23	Denakkanaaga, Inc.	$83,390	$20,120	
AK	24	Klawock Cooperative Association	$73,490	$13,410	$1,109
AK	25	Kootznoowoo Inc.	$73,490	$13,410	$1,412
AK	26	Gwichyaa Zhee Gwich'in Tribal Government	$73,490	$13,410	$3,720
AK	27	Native Village of Point Hope	$73,490	$13,410	$2,743
AK	28	Seldovia Village Tribe, IRA	$73,490		$914
AK	30	Sitka Tribes of Alaska	$94,700	$26,830	$1,665
AK	32	Ketchikan Indian Community	$136,700	$46,950	$2,591
AK	33	Kuskokwim Native Association	$83,390	$20,120	$3,691
AK	35	Southcentral Foundation	$179,510	$53,660	$7,615
AK	36	Kenaitze Indian Tribe	$118,020	$40,250	$4,517
AK	37	Wrangell Cooperative Association	$73,490	$13,410	$1,077
AK	38	Native Village of Savoonga	$73,490	$13,410	$10,499
AK	39	Native Village of Gambell	$73,490	$13,410	$5,794
AK	40	Native Village of Eyak	$73,490	$13,410	$575
AK	41	Organized Village of Kake	$73,490	$13,410	$1,480
AK	42	Chickaloon Native Village	$83,390		$954
AK	43	Yakutat Tlingit Tribe & Craig Community Association	$73,490	$13,410	$2,276
AK	44	Galena Village (aka Louden Village Council)	$73,490	$13,410	$9,661
AK	45	Asa'carsarmiut Tribal Council	$73,490		$5,340
AK	46	Orutsararmuit Native Council	$94,700		$13,324
AK	Total	Total	$3,751,160	$811,490	$179,904
AL	01	Poarch Creek Indians	$136,700	$46,950	$19,659
AL	Total	Total	$136,700	$46,950	$19,659
AZ	02	Colorado River Indian Tribes	$106,710	$33,540	$6,010
AZ	03	Gila River Indian Community	$136,700	$46,950	$19,279
AZ	04	Hopi Tribe	$136,700	$46,950	$7,580
AZ	05	Hualapai Tribe	$83,390	$20,120	$5,245
AZ	06	Navajo Nation	$179,510	$53,660	$66,336
AZ	07	Pascua Yaqui Tribe	$136,700	$46,950	$41,014
AZ	09	Salt River Pima-Maricopa Indian Community	$106,710	$33,540	$7,148
AZ	10	San Carlos Apache Tribe	$136,700	$46,950	$5,655
AZ	11	Tohono o'Odham Nation	$136,700	$46,950	$2,518
AZ	12	White Mountain Apache Tribe	$136,700	$46,950	$7,986
AZ	13	Ak-Chin Indian Community	$73,490	$13,410	$1,442
AZ	14	Yavapai Apache Tribe	$83,390		$1,535
AZ	15	Havasupai Tribe	$73,490	$13,410	$8,233

AZ	16	Inter-Tribal Council of Arizona, Inc.	$73,490	$13,410	$402
AZ	17	Cocopah Indian Tribe	$73,490		$12,491
AZ	18	Quechan Indian Tribe	$83,390	$20,120	$11,620
AZ	Total	Total	$1,757,260	$482,910	$204,494
CA	01	Bishop Tribal Council	$83,390	$20,120	$27,082
CA	02	Blue Lake Rancheria	$83,390	$20,120	$21,307
CA	06	Karuk Tribe of California	$83,390	$20,120	$2,695
CA	07	Pit River Health Services, Inc.	$73,490		$2,813
CA	08	Picayune Rancheria of the Chukchansi Indians	$73,490		$4,841
CA	09	Riverside-San Bernardino Co. Indian Health-for Morongo	$73,490	$13,410	$7,818
CA	10	Riverside-San Bernardino Co. Indian Health-for	$73,490	$13,410	$3,894
CA	11	Riverside-San Bernardino Co. Indian Health-for Soboba	$73,490	$13,410	$6,053
CA	12	Sonoma County Indian Health Project - Sonoma	$73,490		$8,161
CA	13	Southern Indian Health Council, Inc.	$73,490	$13,410	$12,104
CA	15	Toiyabe Indian Health Project, Inc. - Northern	$73,490	$13,410	$5,533
CA	16	Tule River Indian Health Center, Inc.	$83,390	$20,120	$20,804
CA	17	Coast Indian Community of Resighini Rancheria	$83,390	$20,120	$8,474
CA	18	United Indian Health Services for Smith River	$94,700	$26,830	$10,093
CA	20	Indian Senior Center, Inc.	$83,390	$20,120	$9,816
CA	21	Sonoma County Indian Health Project - Manchester	$73,490		$6,891
CA	25	Pala Band of Mission Indians	$83,390		$13,039
CA	26	Redding Rancheria	$136,700	$46,950	$5,769
CA	28	Toiyabe Indian Health Project, Inc. - Southern	$73,490	$13,410	$7,453
CA	29	Hoopa Valley Tribe, K'ima:w Medical Center	$83,390		$7,824
CA	30	Round Valley Indian Tribes	$94,700		$3,523
CA	31	Fort Mojave Indian Tribe	$73,490	$13,410	$4,616
CA	33	CA Indian Manpower Consortium, Inc. - Chico,	$73,490	$13,410	$6,880
CA	34	CA Indian Manpower Consortium, Inc. - Big Sandy,	$73,490	$13,410	$8,073
CA	35	CA Indian Manpower Consortium, Inc. - Berry Creek,	$73,490	$13,410	$5,589
CA	36	CA Indian Manpower Consortium, Inc. - Coyote Valley,	$83,390	$20,120	$3,879
CA	37	CA Indian Manpower Consortium, Inc. - Enterprise,	$83,390	$20,120	$7,161
CA	38	Santa Ynez Band of Mission Indians	$73,490		$2,877
CA	Total	Total	$2,262,350	$368,840	$235,062
CO	01	Southern Ute Indian Tribe	$83,390	$20,120	$3,723
CO	02	Ute Mountain Ute Tribe	$83,390		$14,490
CO	Total	Total	$166,780	$20,120	$18,213
HI	01	Alu Like, Inc.	$1,505,000	$53,660	$33,996
HI	02	Hana Health	$83,390		$5,831
HI	Total	Total	$1,588,390	$53,660	$39,827
IA	01	Sac & Fox Tribe of the Mississippi in Iowa	$94,700	$26,830	$8,941
IA	Total	Total	$94,700	$26,830	$8,941
ID	01	Coeur d'Alene Tribe	$83,390	$20,120	$16,313
ID	02	Nez Perce Tribe	$118,020	$40,250	$11,894
ID	03	Shoshone-Bannock Tribes	$136,700	$46,950	$23,862
ID	Total	Total	$338,110	$107,320	$52,069
KS	01	The Kickapoo Tribe in Kansas	$73,490	$13,410	$6,358
KS	02	Prairie Band of Potawatomi Nation	$94,700	$26,830	$19,293
KS	03	Iowa Tribe of Kansas and Nebraska	$73,490	$13,410	$6,338
KS	Total	Total	$241,680	$53,650	$31,989
LA	01	Institute for Indian Development, Inc.	$83,390		$7,281
LA	Total	Total	$83,390		$7,281
MA	01	Wampanoag Tribe of Gay Head (Aquinnah)	$73,490	$13,410	$1,180
MA	Total	Total	$73,490	$13,410	$1,180
ME	01	Pleasant Point Passamaquoddy Tribe	$94,700	$26,830	$15,649
ME	02	Penobscot Indian Nation	$83,390		$4,408
ME	04	Aroostook Band of Micmacs	$73,490	$13,410	$2,560
ME	Total	Total	$251,580	$40,240	$22,617
MI	01	Grand Traverse Band of Ottawa & Chippewa Indians	$94,700	$26,830	$7,911
MI	02	Inter-Tribal Council of Michigan, Inc.	$83,390	$20,120	$4,286
MI	03	Keweenaw Bay Indian Community	$83,390	$20,120	$13,295

MI	04	Sault Ste. Marie Tribe of Chippewa Indians	$136,700		$24,236
MI	05	Little Traverse Bay Bands of Odawa Indians	$83,390		$4,579
MI	07	Bay Mills Indian Community	$83,390	$20,120	$4,706
MI	08	Pokagon Band of Potawatomi Indians	$83,390		$3,200
MI	09	Little River Band of Ottawa Indians	$94,700	$26,830	
MI	10	Nottawaseppi Huron Band of the Potawatomi	$73,490	$13,410	$3,611
MI	Total	Total	$816,540	$127,430	$65,824
MN	01	Bois Forte Reservation Tribal Government	$83,390	$20,120	$8,681
MN	02	Fond du Lac Band of Lake Superior Chippewa	$118,020	$40,250	$51,563
MN	03	Leech Lake Band of Ojibwe	$179,510	$53,660	$20,365
MN	07	Red Lake Band of Chippewa Indians	$118,020		$21,377
MN	08	White Earth Reservation Tribal Council	$106,710	$33,540	$37,908
MN	09	Grand Portage Band of Lake Superior Chippewa	$73,490		$7,196
MN	10	Mille Lacs Band of Ojibwe	$83,390	$20,120	$3,545
MN	Total	Total	$762,530	$167,690	$150,635
MO	99	Eastern Shawnee Tribe of Oklahoma	$94,700	$26,830	$14,978
MO	Total	Total	$94,700	$26,830	$14,978
MS	01	Mississippi Band of Choctaw Indians	$136,700	$46,950	$17,681
MS	Total	Total	$136,700	$46,950	$17,681
MT	01	Assiniboine and Sioux Tribes	$118,020	$40,250	$29,088
MT	02	Blackfeet Tribe - Eagle Shield Center	$136,700	$46,950	$28,194
MT	03	Chippewa Cree Tribe	$106,710	$33,540	$46,807
MT	04	Confederated Salish and Kootenai Tribes	$136,700	$46,950	$7,767
MT	05	Fort Belknap Indian Community	$106,710	$33,540	$12,994
MT	06	Northern Cheyenne Elderly Program	$106,710	$33,540	$19,064
MT	07	Crow Tribal Elders Program	$136,700	$46,950	$36,550
MT	Total	Total	$848,250	$281,720	$180,464
NC	01	Eastern Band of Cherokee Indians	$179,510	$53,660	$38,782
NC	Total	Total	$179,510	$53,660	$38,782
ND	01	Spirit Lake Tribe	$94,700	$26,830	$23,225
ND	02	Standing Rock Sioux Tribe	$136,700	$46,950	$83,748
ND	03	Three Affiliated Tribes	$136,700	$46,950	$14,362
ND	04	Trenton Indian Service Area	$94,700	$26,830	$2,396
ND	05	Turtle Mountain Band of Chippewa Indians	$136,700	$46,950	$17,979
ND	Total	Total	$599,500	$194,510	$141,710
NE	01	Omaha Tribe of Nebraska	$83,390	$20,120	$8,786
NE	02	Santee Sioux Nation	$73,490		$2,838
NE	03	Winnebago Senior Citizen Center	$83,390	$20,120	$13,737
NE	Total	Total	$240,270	$40,240	$25,361
NM	01	Eight Northern Indian Pueblos Council (Picuris, etc.)	$179,510	$53,660	$5,811
NM	02	Eight N. Indian Pueblos Council(San Ildefonso, etc.)	$94,700	$26,830	$4,690
NM	03	Five Sandoval Indian Pueblos, Inc.	$94,700		$12,600
NM	04	Jicarilla Apache Nation	$106,710	$33,540	$16,590
NM	05	Laguna Rainbow Corporation	$136,700	$46,950	$14,464
NM	06	Mescalero Apache Tribe	$94,700		$9,180
NM	07	Pueblo de Cochiti	$83,390	$20,120	$7,661
NM	09	Pueblo of Isleta	$118,020	$40,250	$21,711
NM	10	Pueblo of Jemez	$106,710	$33,540	$6,444
NM	11	Pueblo of San Felipe	$106,710	$33,540	$9,859
NM	12	Pueblo of Taos	$106,710	$33,540	$7,934
NM	13	Zuni Tribe	$136,700	$46,950	$25,910
NM	14	Ohkay Owingeh Senior Citizens Program	$136,700	$46,950	$12,381
NM	15	Santa Clara Pueblo	$179,510	$53,660	$13,091
NM	16	Santo Domingo Pueblo	$136,700	$46,950	$9,643
NM	17	Pueblo of Tesuque	$73,490	$13,410	$5,413
NM	18	Pueblo of Acoma	$94,700	$26,830	$8,710
NM	Total	Total	$1,986,360	$556,720	$192,092
NV	01	Fallon Paiute-Shoshone Tribes	$83,390	$20,120	$19,379
NV	02	Inter-Tribal Council of Nevada, Inc. (McDermitt, etc.)	$83,390	$20,120	$7,912
NV	03	Inter-Tribal Council of Nevada, Inc. (Duckwater, etc.)	$83,390	$20,120	$4,669

NV	04	Inter-Tribal Council of Nevada, Inc. (Ely, etc.)	$73,490	$13,410	$4,868
NV	05	Shoshone-Paiute Tribes	$83,390	$20,120	$8,843
NV	06	Walker River Paiute Tribe	$83,390		$9,385
NV	07	Washoe Tribe of Nevada and California	$83,390	$20,120	$35,829
NV	08	Yerington Paiute Tribe	$73,490		$3,025
NV	09	Pyramid Lake Paiute Tribe	$94,700	$26,830	$4,274
NV	10	Elko Band Council	$73,490	$13,410	$7,192
NV	11	Reno-Sparks Indian Colony	$83,390	$20,120	$10,445
NV	Total	Total	$898,900	$174,370	$115,821
NY	01	St. Regis Mohawk Tribe	$136,700	$46,950	$13,081
NY	02	Seneca Nation of Indians	$136,700	$46,950	$18,634
NY	04	Oneida Indian Nation	$73,490	$13,410	$3,831
NY	05	Shinnecock Indian Nation	$73,490	$13,410	$4,585
NY	Total	Total	$420,380	$120,720	$40,131
OK	01	Apache Tribe of Oklahoma	$136,700	$46,950	$11,476
OK	02	Caddo Nation of Oklahoma	$83,390	$20,120	$3,489
OK	03	Cherokee Nation	$181,001	$54,967	$42,546
OK	04	Cheyenne & Arapaho Tribes	$136,700	$46,950	$9,690
OK	06	Choctaw Nation of Oklahoma	$179,510	$53,660	$24,711
OK	07	Citizen Potawatomi Nation	$179,510	$53,660	$11,924
OK	08	Comanche Nation	$136,700	$46,950	$15,055
OK	09	Delaware Nation	$78,960	$13,410	$7,185
OK	10	Iowa Tribe of Oklahoma	$136,700	$46,950	$8,339
OK	12	Kickapoo Tribe of Oklahoma	$100,000	$20,120	$15,099
OK	13	Kiowa Tribe of Oklahoma	$136,700	$46,950	$5,812
OK	14	Miami Tribe of Oklahoma	$118,020	$40,250	$22,363
OK	15	Muscogee (Creek) Nation	$179,510	$53,660	$154,576
OK	17	Otoe-Missouria Tribe of Indians	$73,490	$13,410	$6,514
OK	18	Ottawa Tribe of Oklahoma	$136,700	$46,950	$22,866
OK	19	Pawnee Nation of Oklahoma	$83,390	$20,120	$10,532
OK	20	Peoria Tribe of Indians of Oklahoma	$106,710	$33,540	$15,575
OK	21	Ponca Tribe of Oklahoma	$83,390	$20,120	$17,617
OK	22	Quapaw Tribe of Oklahoma	$118,020	$40,250	$16,640
OK	23	Sac and Fox Nation	$83,390	$20,120	$11,981
OK	24	Seminole Nation of Oklahoma	$179,510	$53,660	$11,966
OK	25	Seneca-Cayuga Tribe of Oklahoma	$136,700	$46,950	$8,392
OK	26	Wichita and Affiliated Tribes	$136,700	$46,950	$8,592
OK	27	Wyandotte Nation	$136,700	$46,950	$14,566
OK	28	Absentee Shawnee Tribe	$179,510	$53,660	$27,577
OK	29	Fort Sill Apache Tribe	$106,710	$33,540	$4,251
OK	31	United Keetoowah Band of Cherokee Indians	$136,700	$46,950	$16,507
OK	32	Chickasaw Nation	$179,510	$53,660	$107,995
OK	33	Kaw Nation	$83,390		$22,420
OK	34	Osage Nation of Oklahoma	$179,510	$53,660	$19,623
OK	35	Delaware Tribes of Indians	$136,700		$4,383
OK	36	Alabama-Quassarte Tribal Town	$73,490	$13,410	$9,818
OK	Total	Total	$4,133,621	$1,188,497	$690,080
OR	01	Confederated Tribes of Siletz Indians of Oregon	$106,710	$33,540	$1,740
OR	02	Confederated Tribes of the Umatilla Indian Reservation	$118,020	$40,250	$7,455
OR	03	Confederated Tribes of Warm Springs	$106,710	$33,540	$6,352
OR	04	Confederated Tribes of Grand Ronde	$94,700	$26,830	$10,770
OR	05	The Klamath Tribes	$136,700	$46,950	$3,117
OR	06	Confed. Tribes of Coos, Lower Umpqua &	$83,390	$20,120	$7,718
OR	Total	Total	$646,230	$201,230	$37,152
RI	01	Narragansett Indian Tribe	$94,700	$26,830	$2,973
RI	Total	Total	$94,700	$26,830	$2,973
SC	01	Catawba Indian Nation Eldercare Program	$83,390	$20,120	$6,695
SC	Total	Total	$83,390	$20,120	$6,695
SD	01	Cheyenne River Elderly Nutrition Services, Inc.	$136,700	$46,950	$10,695
SD	02	Crow Creek Sioux Tribe	$83,390		$15,308

SD	03	Lower Brule Sioux Tribe	$83,390	$20,120	$12,607
SD	04	Oglala Sioux Tribe	$179,510	$53,660	$152,292
SD	05	Rosebud Sioux Tribe	$179,510	$53,660	$70,552
SD	06	Sisseton Wahpeton Oyate of	$136,700		$31,396
SD	08	Yankton Sioux Tribe	$94,700	$26,830	$9,715
SD	Total	Total	$893,900	$201,220	$302,565
TX	01	The Alabama-Coushatta Tribe of Texas	$83,390	$20,120	$10,375
TX	02	Kickapoo Traditional Tribe of Texas	$73,490		$15,277
TX	Total	Total	$156,880	$20,120	$25,652
UT	01	Ute Indian Tribe, Unitah & Ouray	$94,700	$26,830	$7,198
UT	Total	Total	$94,700	$26,830	$7,198
WA	01	Confederated Tribes of the Colville Reservation	$136,700	$46,950	$17,716
WA	02	Lower Elwha Klallam Tribe	$83,390	$20,120	$3,655
WA	03	Lummi Tribe	$118,020	$40,250	$17,070
WA	04	Makah Nation	$83,390	$20,120	$7,135
WA	05	Muckleshoot Indian Tribe	$136,700	$46,950	$18,474
WA	09	Puyallup Tribe of Indians	$136,700		$7,867
WA	10	Quinault Indian Nation	$106,710	$33,540	$34,187
WA	13	Swinomish Indian Tribal Community	$73,490	$13,410	$4,874
WA	14	Spokane Tribe of Indians	$83,390	$20,120	$10,789
WA	16	The Tulalip Tribes	$136,700		$9,967
WA	17	Jamestown S'Klallam Tribe	$83,390	$20,120	$523
WA	19	Quileute Tribal Council	$83,390	$20,120	$7,280
WA	20	S. Puget Intertribal Planning Agency - Shoalwater Bay	$94,700	$26,830	$6,502
WA	21	Stillaguamish Tribe of Indians	$94,700	$26,830	$1,661
WA	22	Upper Skagit Indian Tribe	$73,490	$13,410	$2,406
WA	24	The Suquamish Tribe	$94,700	$26,830	$12,466
WA	25	Port Gamble S'Klallam Tribe	$73,490	$13,410	$2,214
WA	26	Samish Indian Nation	$83,390	$20,120	$1,939
WA	27	Cowlitz Indian Tribe	$94,700	$26,830	$3,512
WA	28	Skokomish Indian Tribe	$94,700	$26,830	$3,440
WA	29	Confederated Tribes of the Chehalis Reservation	$94,700	$26,830	$2,404
WA	30	Nooksack Indian Tribe	$83,390	$20,120	$3,512
WA	31	Yakama Nation	$73,490	$13,410	$3,371
WA	32	Snoqualmie Tribe	$73,490	$13,410	$1,999
WA	33	S. Puget Intertribal Planning Agency - Nisqually	$118,020	$40,250	$2,630
WA	34	S. Puget Intertribal Planning Agency - Squaxin Island	$73,490	$13,410	$6,164
WA	Total	Total	$2,482,420	$590,220	$193,757
WI	01	Bad River Band of Lake Superior Chippewa	$83,390	$20,120	$8,829
WI	02	Forest County Potawatomi Community	$83,390	$20,120	$7,369
WI	03	Lac Courte Oreilles Band of Lake Superior Chippewa	$94,700	$26,830	$9,857
WI	04	Lac du Flambeau Band of Lake Superior Chippewa	$94,700	$26,830	$19,316
WI	05	Menominee Indian Tribe of Wisconsin	$136,700	$46,950	$16,354
WI	06	Oneida Tribe Elder Services	$136,700	$46,950	$5,883
WI	07	Red Cliff Band of Lake Superior Chippewa	$83,390	$20,120	$6,052
WI	08	St. Croix Chippewa Indians of Wisconsin	$83,390	$20,120	$4,458
WI	09	Stockbridge-Munsee Community	$83,390	$20,120	$2,380
WI	10	Ho-Chunk Nation	$106,710	$33,540	$11,685
WI	Total	Total	$986,460	$281,700	$92,183
WY	01	Northern Arapaho Tribe	$83,390		$18,223
WY	03	Eastern Shoshone Tribe	$94,700		$11,727
WY	Total	Total	$178,090		$29,950
Total	Total	Total	$27,479,621	$6,373,027	$3,192,920