** DEPARTMENT**

**of HEALTH**

**and HUMAN**

**SERVICES**

**FY 2017 Report to Congress:**

**Older Americans Act**

**Prepared by**

**ADMINISTRATION**

**ON AGING**

**ADMINISTRATION FOR**

**COMMUNITY LIVING**

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***FROM THE ADMINISTRATION FOR COMMUNITY LIVING***

The Administration for Community Living (ACL) is committed to the fundamental principle that older adults and people of all ages with disabilities should be able to live where they choose, with the people they choose, and fully participate in their communities. ACL’s programs provide individualized, person-centered home and community-based services and supports, and invest in research and best practices, to make that principle a reality for millions of people. It does so by working with other federal agencies, states, localities, Tribal organizations, nonprofit organizations, businesses, and families to help older adults and people with disabilities live in their homes and fully participate in their communities. Those with disabilities or functional limitations of any type, regardless of age, have a common interest: access to home and community-based supports and services that help individuals fully participate in all aspects of society, including having the option to live at home, which can be vital to an individual’s well-being, instead of moving into an institutional setting.

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

The national aging services network is comprised of 56 state and territorial units on aging (SUA), 622 area agencies on aging (AAAs), 270 Indian tribal and Native Hawaiian organizations, more than 20,000 direct service providers, and hundreds of thousands of volunteers. AoA’s core programs, authorized under the Older Americans Act (OAA), help older adults aged 60 and over remain at home for as long as possible, promote the rights of older individuals, and advocate for individuals who live in long-term care facilities (nursing homes, board and care, assisted living, and similar settings).

For more than 50 years, the OAA has provided critical services that have better enabled millions of older Americans to live independently, with dignity, in their homes and communities. Its programs are highly successful because they are flexible and focus on the needs of each individual, better ensuring that their rights, choices, needs, and independence are maintained through their input and participation. I am pleased to present AoA’s Report to Congress for Fiscal Year (FY) 2017.

Lance Robertson

Administrator and Assistant Secretary for Aging

Administration for Community Living

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# EXECUTIVE SUMMARY

AoA’s core programs, authorized under the Older Americans Act (OAA), help people choose to remain in their homes and communities for as long as possible. These services complement efforts of the nation’s public health networks, as well as existing medical and health care systems, and support some of life’smost basic functions, such as bathing and preparing meals. These programs also support family caregivers; address issues of exploitation, neglect, and abuse of older adults; and adapt services to the needs of Native Americans. In FY 2017, AoA and the national aging services network rendered direct services to over 10 million individuals age 60 and over (one out of every seven older adults), including nearly three million clients who received intensive in-home services.[[1]](#footnote-1) Critical supports, such as respite care and a peer support network, were provided to over 760,000 caregivers.[[2]](#footnote-2)

**Overview of Performance**

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

Performance Highlights

An analysis of AoA’s program performance trends through FY 2017 illustrates that AoA programs continue to help individuals remain independent and in the community. Most performance measures and indicators have been maintained or steadily improved. Following are some key successes that are indicative of the potential of AoA and the aging network to meet demographic and fiscal challenges.

AoA programs provide high quality services that result in positive consumer outcomes and reflect effective delivery systems. Consumers report that services contribute in an essential way to maintaining their independence with, for example, over 40 percent of the caregivers indicating that the care recipient would be unable to remain at home without caregiver support services. With regard to effective delivery of evidence-based programs, OAA grantees were able to meet their participation targets for Chronic Disease Self-Management Education. AoA expanded the provision of quality services, such as through funding an additional 11 new unique organizations to provide specialized supportive services in the area of Alzheimer’s disease (ADI-SSS), to bring the total number funded to 32. Consumers also express a high level of satisfaction with these services. In 2017, over 97 percent of OAA transportation clients and nearly 94 percent of caregivers rated services good to excellent. To help ensure the continuation of these trends, AoA uses various mechanisms to promote innovative service-delivery models for state and local program entities that show promise for generating measurable improvements in program activities.

AoA programs reach at-risk populations and target services to help individuals remain independent and in the community. For example, older adults who have three or more impairments in Activities of Daily Living (ADL) are at a high risk for nursing home entry. Increasing services to this population is one proxy for nursing home delay and diversion. In FY 2005, one-third of home-delivered nutrition clients lived with three or more ADL impairments. By FY 2017, the proportion grew to nearly 42 percent, a 26 percent increase. AoA maintains nine core performance indicators supporting AoA’s commitment to improving client outcomes and program quality. While some indicators experience year-to-year variation, all indicators have trended in the desired direction and the vast majority meet or exceed targets annually.

AoA programs are efficient. The aging network is providing high-quality services and doing so in a prudent and cost-effective manner. In FY 2017 the aging network served over 8,800 people per million dollars of OAA Title III funding. The result is an 18 percent increase over the 2005 baseline.

AoA programs effectively address complaints of abuse, neglect, or violation of rights; advocate for system improvements; and support innovation. The Long-Term Care Ombudsman Program grantees are highly successful at meeting the needs of complainants. In FY 2017, 73 percent of all complaints were resolved to the satisfaction of the complainant. The program’s annual performance measure of reducing the number of complaints unresolved to the satisfaction of the complainant fell to below 9,000 exceeding the performance target.

The tables on the next page provide a summary of the persons served during FY 2017 through the OAA’s programs. Additionally, a listing of grant funding allocations by state, territory and tribal organization can be viewed in the Appendix.

**National Program Data on Services Provided**

|  |  |
| --- | --- |
| **Category** | **FY 2017** |
| Total Clients | 10,389,782 |
| Total Registered Clients | 2,732,825 |
| % Minority Clients[[3]](#footnote-3) | 31.2 |
| % Rural Clients | 34.7 |
| % Clients Below Poverty | 32.8 |
| # Senior Centers | 13,858 (6,830 receive OAA funding) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Service** | **Persons Served** | **Units of Service[[4]](#footnote-4)** | **Title III Expenditure** | **Total Expenditure** |
| Personal Care | 109,366 | 21,978,516 | $56,772,607 | $363,139,010 |
| Homemaker | 166,228 | 19,610,119 | $34,647,363 | $395,140,085 |
| Chore | 32,459 | 773,684 | $4,939,101 | $18,976,609 |
| Home Delivered Meals | 862,100 | 144,039,122 | $311,867,160 | $906,737349 |
| Adult Day Care | 18,516 | 10,355,876 | $12,130,622 | $102,582,660 |
| Case Management | 458,434 | 3,593,490 | $108,998,855 | $271,438,431 |
| Assisted Transportation | 47,859 | 2,078,827 | $4,682,973 | $28,754,065 |
| Congregate Meals | 1,2,104 | 76,229,704 | $298,788,943 | $653,960,831 |
| Nutrition Counseling | 34,316 | 78,398 | $1,148,075 | $2,292,609 |
| Transportation |  | 21,76,986 | $ 61,587,214 | $209,789,942 |
| Legal Assistance |  | 933,410 | $27,728,821 | $51,152,922 |
| Nutrition Education |  | 3,443,839 | $3,522,540 | $7,585,615 |
| Information and Assistance |  | 12,493,437 | $58,145,229 | $186,642,785 |
| Outreach |  | 2,024,423 | $11,750,934 | $24,782,245 |
| Health Promotion and Disease Prevention | 837,300 |  | $24,060,421 | $56,231,608 |
| Self-Directed Care | 5,652 |  | $184,813 | $47,728,120 |
| Other |  |  | $75,224,759 | $539,586,983 |

**National Family Caregiver Support Program**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Service** | **Caregivers Served** | **Service Units[[5]](#footnote-5)** | **Title III Expenditure** | **Total Expenditure** |
| Counseling, Support Groups, Training | 100,828 | 408,968 | $19,660,877 | $27,800,676 |
| Respite | 55,565 | 5,931,326 | $52,598,763 | $87,489,480 |
| Supplemental Services | 27,259 | 585,496 | $9,899,435 | $13,435,184 |
| Access Assistance | 535,012 | 1,208,489 | $30,355,664 | $44,631,751 |
| Self-Directed | 1,141 |  | $1,192,740 | $1,546,256 |
| Information Services | 19,016,364 | 428,607 | $11,280,915 | $15,528,186 |
| Unduplicated Caregivers Provided Service or Access | 762,706 |  |  |  |

# PART I: HEALTH AND INDEPENDENCE

Due in part to advances in public health and medical care, Americans are living longer and more active lives. The average life expectancy of an American has increased dramatically over the last century, from 50.9 years in 1917 to 78.6 years in 2017,[[6]](#footnote-6) [[7]](#footnote-7) and one consequence of this increased longevity is the higher incidence of chronic conditions. Multiple chronic conditions negatively affect quality of life, contribute to declines in functioning and the ability to remain in the community, adversely impact individuals’ health, and contribute to increased hospitalizations and health care costs. Many of the most common chronic conditions such as hypertension, heart disease, diabetes, and osteoporosis are related to nutrition as a primary prevention, risk reduction, or treatment modality. Medicare beneficiaries with multiple chronic conditions are the heaviest users of health care services. For example, two-thirds of Medicare beneficiaries have two or more chronic conditions and account for 94 percent of Medicare spending, and those with four or more chronic conditions account for three-fourths of Medicare spending.[[8]](#footnote-8) Among Medicare beneficiaries age 65 and over who are not dually eligible (enrolled in both Medicare and Medicaid), standardized Medicare per capita spending increases from $5,342 for persons with two to three chronic conditions to $27,968 for persons with six or more chronic conditions.[[9]](#footnote-9) Among Medicare beneficiaries age 65 and over who are dually eligible, standardized Medicare per capita spending increases from $6,874 for persons with two to three conditions to $33,774 for persons with six or more chronic conditions.[[10]](#footnote-10)

AoA’s Health and Independence programs provide a foundation of supports that assist older individuals to remain healthy and independent in their homes and communities, avoiding more expensive nursing home care. For example, 65 percent of congregate and 94 percent of home-delivered meal recipients reported that the meals enabled them to continue living in their own homes and 60 percent of seniors using transportation services rely on them for the majority of their trips to doctors’ offices, pharmacies, meal sites, and other critical daily activities that help them to remain in the community.[[11]](#footnote-11)

Between 2017 and 2020, the number of Americans age 60 and older will increase by over 6.2 million older adults, to reach 77.1 million.[[12]](#footnote-12) During this period, the number of Americans age 65 and over with severe disabilities (defined as three or more limitations in activities of daily living) who are most likely to receive nursing home admission and qualify for Medicaid eligibility (through the “spend down” provisions) is expected to increase by 10 percent.[[13]](#footnote-13) AoA’s Health and Independence programs help older adults in need maintain their health and independence.

In concert with other OAA programs, these services assist over 11 million older individuals and caregivers.[[14]](#footnote-14) AoA’s services are especially critical for the nearly three million older adults who receive intensive in-home services, more than 488,000 of whom meet the disability criteria for nursing home admission.[[15]](#footnote-15) These services help to keep these individuals from joining the 1.7 million older adult residents who live for extended periods of time in nursing homes.[[16]](#footnote-16)

## Home and Community-Based Supportive Services

***(Title III-B of OAA; FY 2017: $386,182,000)***

The Home and Community-Based Supportive Services (HCBSS) program, established in 1973, provides grants to states and territories based on their share of the population age 60 and over to fund a broad array of services. AoA’s programs, including the HCBSS program, serve seniors holistically: while each service is valuable in and of itself, it is often the combination of supports, when tailored to the needs of the individual that helps older persons remain in their own homes and communities instead of entering nursing homes or other types of institutional care.[[17]](#footnote-17)

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

While age alone does not determine the need for these home and community-based services, statistics show that both disability rates and the use of long-term supports increase with advancing age. Among those aged 85 and older, 54 percent are unable to perform critical activities of daily living and require long-term support.[[18]](#footnote-18) Data also show that over 91 percent of older Americans have at least one chronic condition and approximately two-thirds percent have at least two.[[19]](#footnote-19) Providing a variety of supportive services that meet the diverse needs of these older individuals is crucial to enabling them to choose to remain healthy and independent in their homes and communities, and therefore to avoiding unnecessary, expensive nursing home care that is often publicly financed. In light of limited long-term coverage under Medicare and constrictions in the long-term care insurance market, many Americans with few resources will continue to rely on Medicaid to furnish their long-term care. Supporting less costly community-based options is a critical function of government and will continue to be an important tool in managing federal expenditures.

Services provided by the HCBSS program in FY 2017 include:[[20]](#footnote-20)

*Transportation Services* provided 21.8 million rides to doctor’s offices, grocery stores, pharmacies, senior centers, meal sites, and other critical daily activities.

*Personal Care, Homemaker, and Chore Services* provided nearly 42.4 million hours of assistance to older adults unable to perform activities of daily living (such as eating, dressing, or bathing) or instrumental activities of daily living (such as shopping or light housework).

*Adult Day Care/Day Health* provided 10.4 million hours of care for program participants in a group setting that provides health, therapeutic, and social services and activities during some portion of a twenty-four hour day.

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

Reflecting AoA’s and the national aging service network’s efforts to target services to those in most need, nearly 49 percent of riders on OAA-funded transportation are mobility impaired, meaning they do not own a car or, if they do own a car, they do not drive and are not near public transportation.[[21]](#footnote-21) Many of these individuals cannot safely drive a car, as nearly 72 percent of transportation riders have at least one of the following chronic conditions that could impair their ability to navigate safely:[[22]](#footnote-22)

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

Of the transportation participants, 96 percent take daily medications, with 14 percent reporting they take 10 to 20 medications daily.[[23]](#footnote-23) Data from AoA’s National Survey of Older Americans Act Participants show that HCBSS are providing these seniors with the assistance and information they report help them to remain at home.[[24]](#footnote-24) For example, over 77 percent of clients receiving case management reported that as a result of the services arranged by the case manager they were better able to care for themselves.[[25]](#footnote-25) In addition, a study published in the *Journal of Aging and Health* shows that the services provided by the HCBSS program, “personal care services,” are the critical services that enable frail seniors to remain in their homes and out of nursing home care.[[26]](#footnote-26)

Nationally, 24 percent of individuals 60 and older live alone.[[27]](#footnote-27) OAA programs serve a disproportionate number of people who live alone compared to the general population. For example, 64 percent of transportation clients live alone.[[28]](#footnote-28) Living alone is a key predictor of nursing home admission, and HCBSS are critical for enabling them to remain at home, especially for those who do not have an informal caregiver to assist with their care. Research has also shown that childless older adults who live in a state with higher home and community-based services expenditures had significantly lower risk of nursing home admissions.[[29]](#footnote-29)

Federal support for OAA programs is not expected to cover the cost of serving every older American. These programs have strong partnerships with state and local governments, philanthropic organizations, and private donations that also contribute funding. States typically leverage resources of between two and three dollars per every federal OAA dollar, significantly exceeding the programs’ match requirements.

## Nutrition Services

Nutrition Services help older adults remain healthy and independent in their communities by providing nutritious meals, nutritional screening, education, and counseling. The Congregate Nutrition Services Program (NSP) is offered in a variety of settings (such as senior centers, public housing locations, local libraries, farmer’s markets, religious buildings or community centers). The Home-Delivered NSP meals are delivered to older adults who are homebound due to illness, disability, or geographic isolation.

Beginning in FY 2017, Congress authorized ACL to use up to 1% of the funds appropriated to ACL’s nutrition programs to develop, pilot or replicate innovative, evidence-informed practices for the NSP. In FY 2017, AoA awarded six Innovations in Nutrition (INNU) grants, totaling $742,872. Through these grants, ACL seeks to identify and promote innovative practices or programs. FY2017 grantee’s project areas of emphasis included: developing modified meals appropriate for reduced oral/dental functions; establishing an evidence-based framework for a new malnutrition education program; collaborating with community health partners to increase referrals to congregate meal sites; technology interventions to improve congregate and home-NSP for high-risk seniors; and a program to help people self-manage Type-2 diabetes to decrease diabetes-related hospitalizations and emergency room visits for older adults.

Nutrition Service Programs include:

**Congregate Nutrition Services Program (*Title III-C1; FY 2016: $438,191,000*)**: Provides funding for the provision of nutritious meals, nutrition education, screening and counseling in a variety of congregate settings, which helps keep older adults healthy and may decrease or prevent the need for more costly medical interventions. Established in 1972, the program centers around serving health-promoting meals, but it also presents opportunities for social engagement, health and wellness activities, and meaningful volunteer roles, all of which contribute to overall health and well-being.

**Home-Delivered Nutrition Services Program (*Title III-C2; FY 2016: $216,397,000*)**: Provides funding for the delivery of nutritious meals and nutrition-related services to homebound frail and/or isolated older adults. The deliveries provide opportunities for social engagement and, in many cases, an informal ‘safety check.’ Established in 1978, home-delivered meals are often the first in-home service that an older adult receives and serve as a primary access point for other home- and community-based services. Home-delivered meals are a key element in helping older adults, who may not be able to prepare their own meals, remain in the community.

**Nutrition Services Incentive Program (*Title III-A; FY 2016: $160,069,000*)**: Provides additional funding to states, territories, and eligible tribal organizations that is used exclusively to procure food products for use in the Title III- C-1 and C-2 and Title VI meal programs, and cannot be used to pay for other nutrition-related services or for administrative costs. Funds are awarded to states and tribes based on the number of meals served in a prior federal fiscal year. States and tribes have the option to purchase USDA Foods (previously referred to as commodities) directly from the U.S. Department of Agriculture (USDA) with any portion of their award if they determine that doing so will enable them to better meet the needs of older adults. In FY 2017, six states and five tribes elected to take some portion of the allotment in USDA Foods.

The meals provided through these programs fulfill the standards set by the current Dietary Guidelines for Americans and provide a minimum of 33 percent of the Dietary Reference Intake, as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences.[[30]](#footnote-30) Meals also comply with applicable provisions of state and local food safety codes, must be appealing, and meet special dietary needs such as health, religious, and cultural/ethnic needs, as feasible. The nutrition-related services provided through these programs may include nutrition education, nutrition counseling, and other nutrition services, as appropriate, based on the needs of NSP participants.

Nutrition Service Programs help approximately 2.4 million older adults receive the meals they need to stay healthy and decrease their risk of disability.[[31]](#footnote-31) Because the prevalence of multiple chronic conditions is higher among congregate and home-delivered program participants than for the general Medicare population, the provision of healthy meals, access to lifestyle modification programs and evidence-based advice such as nutrition education and counseling are important. Overall, 72 percent of community-living Medicare beneficiaries age 65 or older have multiple chronic conditions.[[32]](#footnote-32) Data from AoA’s 2018 National Survey of Older Americans Act Participants indicate that 51 percent of congregate and 64 percent of home-delivered participants have six or more chronic conditions. About 31 percent of congregate and 49 percent of home-delivered participants take more than six medications per day and some take as many as 20 medications. The congregate and home NSP participants are significantly less healthy than the general Medicare population and access to adequate healthy meals is essential to their well-being. Meals are also an important element in deferral or delay of institutional placement.

While the 75 year-old and over cohort makes up 30 percent of the U.S. population age 60 and over, half (53 percent) of congregate and almost two-thirds (62 percent) of home-delivered meal participants are aged 75 years or older.[[33]](#footnote-33) Because older adults served in the nutrition service programs are more generally older and more frail than the general Medicare population, it stands to reason that they have a demonstrated need for healthy, prepared meals, rather than simply access to food.

Approximately 9 percent of congregate and over 43 percent of home-delivered participants indicate that they have three or more impairments in instrumental activities of daily living (IADLs).[[34]](#footnote-34) The data also indicate that 16 percent of congregate and 52 percent of home-delivered participants have difficulty getting outside the house, thus limiting their ability to shop for food themselves.[[35]](#footnote-35) The number of home-delivered meal recipients with severe disabilities (three or more activities of daily living) totaled over 330,000 in FY 2017.[[36]](#footnote-36) This level of disability is frequently associated with nursing home admission, and demonstrates the extreme frailty of a significant number of older adults receiving home-delivered meals.

The number of older adults that live alone is higher for program participants vs the general public. Nationally, 24 percent of persons age 60 years and older live alone.[[37]](#footnote-37) However, through effective targeting, 48 percent of congregate NSP participants and 57 percent of home NSP participants live alone.[[38]](#footnote-38) Research has indicated that living alone often increases an older adult’s risk of inadequate social connections, which may exacerbate social isolation. Epidemiological studies have associated social isolation with high health risks. Individuals who lack social connections or report frequent feelings of loneliness tend to suffer higher rates of morbidity, infection, depression and cognitive decline[[39]](#footnote-39). In a recent national evaluation, when nonparticipants were compared to participants in the congregate meal program, participants were more satisfied with their socialization opportunities.[[40]](#footnote-40)

The NSP serves nutritious meals to older adults in an in an effort to improve or maintain the participant’s health status and improve the participant’s food insecurity status. Older adults that do not have reliable access to a sufficient quantity of affordable, nutritious food are considered food insecure. Although the majority of NSP participants were food secure, 16 percent of congregate meal participants and 23 percent of home-delivered meal participants are food insecure. Older adults that are food insecure are in poorer health when compared to food secure older adults. Food insecure older adults are 65 percent more likely to be diabetic, 2.3 times more likely to suffer from depression, 57 percent more likely to have congestive heart failure, 66 percent more likely to have experienced a heart attack, twice as likely to report having gum disease, and 91 percent more likely to have asthma.[[41]](#footnote-41)

Data from AoA’s National Survey of Older Americans Act Participants show that Nutrition Services are effectively helping older adults improve their nutritional intake and remain at home. For example, data indicate that 76 percent of congregate and 81 percent of home-delivered meal participants say they eat healthier meals due to the programs, and 65 percent of congregate and 94 percent of home-delivered meal recipients say that the meals enable them to continue living in their homes.[[42]](#footnote-42) Independent research has found that states that invest more in delivering OAA home-delivered meals to older adults’ have lower rates of “low-care” older adults in nursing homes after adjusting for several other factors.[[43]](#footnote-43) For every $25 per year per older adult that states spend on home-delivered meals, the state reduces their percentage of these lower needs nursing home residents by one percent when compared to the national average.[[44]](#footnote-44) This evidence is a testimonial to the savings gained from this foundational home- and community-based service.

AoA’s annual performance data further demonstrate that these programs are highly valued by older people who need assistance in order to remain healthy and independent in their homes. Nearly 88 percent of home-delivered meal clients and 90 percent of congregate participants rate the meal as good to excellent.[[45]](#footnote-45) According to a recent evaluation, congregate NSP participant’s diets provided more nutrient dense foods and nutrients when compared to nonparticipants. Congregate NSP participants had significantly higher intake percentages of dairy (69 vs 72), total fruit (97 vs 72) and total vegetables 87 vs 60). Home NSP participants consumed a significantly higher percentage of dairy when compared to nonparticipants (72 vs 58). The most recent data on how these nutrition programs are helping older adults remain healthy and independent in their homes include:[[46]](#footnote-46)

*Home-Delivered Nutrition Services* provided 144 million meals to over 860,000 individuals in FY 2017.[[47]](#footnote-47)

*Congregate Nutrition Services* provided over 76.2 million meals to more than 1.5 million older adults in a variety of community settings in FY 2017.[[48]](#footnote-48)

Consistent with the OAA’s requirement to target services to those most in need to help them maintain their health and independence, approximately 67 percent of home-delivered meal recipients have annual incomes at or below $20,000.[[49]](#footnote-49) Meals are especially critical for the 66 percent of home-delivered and 54 percent of congregate recipients who report these meals provide half or more of their food intake for the day.[[50]](#footnote-50)

Federal support for the Nutrition Services Programs is not expected to provide all needed funding for all participants, nor provide programming for every older adult. These programs have strong partnerships with state and local governments, philanthropic organizations and private donations that contribute funding. In FY 2017, state and local funding comprised two-thirds (66 percent) of all the funding for home-delivered meals and nearly 54 percent for congregate meals.[[51]](#footnote-51) Although all programs funded through the OAA rely on state and local funding in some part, funding for congregate and home-delivered meals leverages more state and local financial support than many other OAA services.

*State and Territory Flexibility*

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

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

**Table 1. FY 2017 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 | $347,222,912 | $445,817,602 | $225,053,917 |
| Final Allotment after Transfers | $400,935,612 | $353,625,519 | $263,533,300 |
| Net Transfer | $53,712,700 |  (-$96,787,424) | $38,479,383 |
| Net Percent Change | 15.47 | (-20.68) | 17.10 |

## Preventive Health Services

***(Title III-D of OAA; FY 2017: $19,664,225)***

Preventive Health Services, established in 1987, provide formula grants to states and territories based on their share of the population age 60 and over to support evidence-based disease prevention and health promotion programs. Older Americans are disproportionately affected by chronic disease and unintentional injury. There are many evidence-based health promotion programs that have been shown to be effective in reducing illness and injury, and improving older adult health. Preventive Health Services provide states and territories with the flexibility to allocate resources among the preventive health programs of their choice to best meet local needs. Priority has been given to providing services to those elders living in medically underserved areas of the state or who have the greatest economic need.

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

* *Physical activity*: Maintaining (or increasing) physical activity is a necessary component for staying healthy. There are a number of evidence-based programs focused on empowering older adults to stay or become active through strength training, cardiovascular workouts, balance exercises, and more.
* *Falls prevention*: Falls prevention programs help older adult participants improve strength, balance, and mobility; provide education on how to avoid falls and reduce fall risk factors; and some involve medication reviews and provide home assessments of ways to reduce environmental hazards.
* *Medication management:* Medication management programs focus on reviewing the multitude of medications that older adults are prescribed, focusing especially on high-risk medications. Medication management programs have been shown to reduce unnecessary duplication of prescriptions and cardiovascular problems.[[52]](#footnote-52) These programs have also been shown to improve medication usage rates and decrease medication errors among older adults.[[53]](#footnote-53)
* *Depression Care Management:*  Depression is not a normal part of aging, yet it is a prevalent and disabling condition among older adults. In 2017, 15 percent of Medicare Fee-for-Service Beneficiaries age 65 and older had a depression diagnosis.[[54]](#footnote-54) Depression in older adults has been associated with high direct medical costs (i.e., hospitalizations), as well as significant indirect costs (i.e., unpaid caregiving).[[55]](#footnote-55) Cost-effective, evidence-based interventions, such as the Program to Encourage Rewarding Lives for Seniors (PEARLS), developed in CDC’s Prevention Research Centers, have been shown to reduce depressive symptoms and improve quality of life in older adults.[[56]](#footnote-56)

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

## Chronic Disease Self-Management Education Programs

**((FY 2017: $8,000,000)**

In the United States, approximately three out of four older adults have multiple (two or more) chronic conditions, such as diabetes, arthritis, heart disease, chronic pain, and depression.[[57]](#footnote-57) This burden places older adults at greater risk for premature death, poor functional status, unnecessary hospitalizations, adverse drug events, and nursing home placement.[[58]](#footnote-58),[[59]](#footnote-59)  Chronic conditions also influence health care costs: 95 percent of health care costs for older Americans can be attributed to chronic diseases.[[60]](#footnote-60)

Chronic Disease Self-Management Education (CDSME) programs, such as the evidence-based Chronic Disease Self-Management Program (CDSMP) originally developed at Stanford University, are low-cost, evidence-based disease prevention models that use proven techniques to improve health and quality of life. These interventions allow peer leaders to help individuals with chronic disease address issues related to the management and treatment of their condition, improve their health status, and potentially reduce their need for more costly medical care.[[61]](#footnote-61) In addition to the CDSMP, which is appropriate for any type of chronic condition, there are other proven CDSME programs, including Tomando Control de su Salud (Spanish CDSMP), the Diabetes Self-Management Program (DSMP), Programa de Manejo Personal de la Diabetes (Spanish DSMP), Chronic Pain Self-Management Program, Positive Self-Management Program for HIV, Cancer: Thriving and Surviving, and online versions of many programs.

Additionally, ACL supports the implementation of self-management support programs, which are community-based, behavioral change interventions that are proven to increase one or more skills or behaviors relevant to chronic disease self-management such as physical activity and medication management. Examples of these programs include EnhanceFitness, Healthy IDEAS, Home Meds, PEARLS, and Walk With Ease.

CDSME programs have been shown repeatedly, through multiple studies (including randomized control trials with both English and Spanish speaking populations) to be effective at helping participants adopt healthy behaviors and improve their psychological and physical health status.[[62]](#footnote-62) A national study with over 1,100 CDSMP participants in 17 states documented many significant improvements relevant to CMS’s goals to promote better care, healthier communities, and wiser spending of health care dollars. Participants demonstrated improved communication with physicians, medication compliance, health literacy, self-reported health, less depression, and better quality of life, as well as reduced emergency room visits and hospitalizations and an estimated $360 per person net savings. The research team projected a national savings of $3.3 billion if CDSMP workshops were delivered to 5 percent of adults with multiple chronic conditions.[[63]](#footnote-63)

CDSMEs emphasize an individual’s role in managing his/her chronic condition(s). For example, the CDSMP in-person programs consist of a series of sessions that are conducted once a week for two and a half hours over six weeks in community settings such as senior centers, faith-based organizations, health care organizations, libraries, residential facilities, and tribal centers. CDSME workshops are facilitated by two trained leaders, and people with varying chronic conditions participate together. One or both of the leaders are non-health professionals who also have a chronic condition. Workshop topics include: 1) techniques to deal with problems such as frustration, fatigue, pain, and isolation; 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance; 3) appropriate use of medications; 4) communicating effectively with health professionals and family/friends; and 5) nutrition.

AoA funds CDSME through competitive grants awarded to domestic public or private nonprofit entities. An expert peer review panel evaluates project proposals. AoA awarded 12 forward-funded grants for a two-year project period beginning August 1, 2016, as well as eight forward-funded grants for a three-year project period beginning August 1, 2017. Additionally, a cooperative agreement for a National Chronic Disease Self-Management Education Resource Center was awarded for a five-year project period on August 1, 2016. The Resource Center assists states, the aging, disability and public health networks, and their partners to increase access to and sustain evidence-based prevention programs, particularly CDSME programs that improve the health and quality of life of older adults and adults with disabilities. The Center also serves as a national clearinghouse of tools and information on CDSME.

By September 30, 2017, grantees and various partners had reached more than 320,700 participants (2006-2017). During FY 2017, there were over 34,820 participants and over 22,895 “completers” (i.e., who attended at least four out of six classes, a retention rate of 74 percent [retention rate is specific to only those interventions with standard start/end dates, not ongoing interventions]). Grantees were successful in reaching their targeted underserved populations: of those participants reporting relevant data, 66 percent were age 60 or older, 65 percent reported having multiple chronic conditions, 37 percent reported a disability, and 30 percent were racial/ethnic minorities.[[64]](#footnote-64)

## Behavioral Health

Behavioral health is essential to overall health. Behavioral health issues, such as depression, anxiety, substance misuse, and suicidal thoughts or actions, are not a normal part of aging – yet one in four persons aged 55 and over have experienced a behavioral health disorder.[[65]](#footnote-65) Behavioral health issues can greatly impact the independence, health, and well-being of older adults and their family caregivers. Untreated behavioral health disorders can exacerbate health conditions, decrease life expectancy, and increase overall healthcare costs.[[66]](#footnote-66) Distinctive barriers to the treatment of behavioral health disorders among the older adult population exist, such as discrimination, under-diagnosis, and inappropriate treatment.

The good news is that prevention, brief intervention, self-directed treatment, and recovery from behavioral health conditions are possible for individuals of all ages, including older adults. While the most recent reauthorization of the OAA includes provisions focused on the prevention and treatment of behavioral health conditions, there is no funding in the OAA specifically designated for prevention, intervention, and treatment services. States and communities have had to be creative in how they support these programs and services. Many aging network providers are working closely with behavioral health, primary care, and other partners to connect older adults with behavioral health screening and intervention resources. In addition, some providers are delivering evidence-based community interventions, such as the Program to Encourage Rewarding Lives for Seniors (PEARLS), using a braided funding approach (i.e., using a combination of funds, such as those from the OAA, Substance Abuse and Mental Health Services Administration (SAMHSA) block grants, private foundations, etc.).

In FY 2017, ACL and SAMHSA continued their partnership to provide technical assistance aimed at increasing states’ capacities for reaching older adults who are experiencing or are at-risk for behavioral health disorders. Most recently, they worked together to support the development of a variety of tangible materials, such as epidemiological profiles, toolkits, issue briefs, and other learning opportunities, such as webinars. The materials developed through this partnership have been successful in helping many states enhance their efforts to reach older adults who are experiencing or are at-risk for behavioral health conditions.

## Falls Prevention Programs

***(FY 2017: $5,000,000)***

Falls can have a widespread and significant impact on health, can be deadly, and often result in high costs. One out of four older adults (those aged 65 or older) fall each year,[[67]](#footnote-67) but fewer than half of those who have suffered a fall talk to their healthcare providers about it.[[68]](#footnote-68) In 2017, nearly 3 million nonfatal falls among older adults were treated in emergency departments. Among these more than 900,000 patients were hospitalized.[[69]](#footnote-69) Each year approximately $50 billion is spent on healthcare related expenditures for falls.[[70]](#footnote-70)

Research has shown that falls, and the risk of falls, can be reduced through systematic risk identification and targeted intervention, including a combination of clinical and community-based interventions.[[71]](#footnote-71) Community-based falls prevention programs are low-cost, proven interventions that help reduce falls and/or address fall risk factors in older adults, and potentially reduce their need for more costly medical care. Examples of these programs include: A Matter of Balance (MOB); Tai Chi: Moving for Better Balance (Tai Chi: MBB); Otago; and Stepping On. A recent CMS report to Congress indicated that MOB is associated with medical cost savings,[[72]](#footnote-72) and a recent study showed a positive return on investment for the implementation of Tai Chi: MBB, Stepping On, and Otago.[[73]](#footnote-73) ACL continues to collaborate with our partners at CDC’s National Center for Injury Prevention and Control to leverage their research, surveillance, and clinical provider education efforts.

ACL received dedicated funding for falls prevention programs through the Prevention and Public Health Fund (PPHF) in FY 2017, as has been the case every year since 2014. ACL published a competitive funding announcement, and external experts reviewed applications for this opportunity. ACL awarded a total of seven grants to domestic public and private nonprofit entities in 2017, including state agencies, universities, and community organizations. These two-year grants are intended to increase the number of older adults and adults with disabilities who participate in evidence-based community programs to reduce falls, fall risks, and fear of falling. All of the grantees identified underserved target populations and partnering organizations to reach these populations, such as those living in rural areas, and organizations serving ethnically-diverse and/or limited English speaking populations. The funding is also fostering the development of innovative funding arrangements to support these falls prevention programs, while embedding the programs into an integrated, sustainable evidence-based prevention program network.

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

## Caregiver Services

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

Better support for informal caregivers is critical because often it is their availability – whether they are informal family caregivers or unrelated friends, neighbors, and others who have a significant relationship with the person who volunteers their time – that determines whether an older person can remain in his or her home. In 2014, approximately 34.2 million adult caregivers provided uncompensated care to those 50 years of age and older.[[74]](#footnote-74) In other words, approximately 14.3 percent of all adults provided care to someone age 50 years and older.[[75]](#footnote-75) AARP estimated the economic cost of replacing unpaid caregiving in 2013 to be about $470 billion, an increase from $450 billion in 2009 (cost if that care had to be replaced with paid services).[[76]](#footnote-76) Another recent study by the Rand Corporation estimated the economic cost of replacing unpaid caregiving to be about $522 billion annually.[[77]](#footnote-77) The cost to replace that care with unskilled paid care at minimum wage was estimated at $221 billion, while replacing it with skilled nursing care could cost $642 billion annually. These estimates differ because of differences in methodology and definitions rather than contradictory data.

The demands of caregiving can be considerable. Recent research has demonstrated that caregiving tasks can, and do, go well beyond providing regular assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). A 2012 study by AARP and United Hospital Fund revealed that, while family caregivers continue to perform the traditional ADL/IADL supports, their roles are expanding dramatically to include performing medical/nursing tasks of the type and complexity typically seen only in hospitals and other acute care settings.[[78]](#footnote-78)

Such demands on family caregivers can lead to a breakdown of their health and can increase the risk for institutionalization of the care recipient. While research is mixed on the exact physical health impacts of family caregiving, several recent studies show that caregivers reporting mental and emotional strain as a result of their caregiving role are at higher risk for earlier mortality.[[79]](#footnote-79),[[80]](#footnote-80),[[81]](#footnote-81) Providing support that makes caregiving easier for family caregivers, such as information, counseling and training, respite care, or supplemental services, is critical to sustaining caregivers’ ability to continue in that role. Seventy seven percent of the caregivers served by OAA programs report that these services allow them to provide care longer than they otherwise could.[[82]](#footnote-82)

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 15.6 million older adults living in the community age 65 and over with one or more ADL limitations, an increase of 1.4 million seniors (or a 10 percent increase between 2017 and 2020) needing caregiver assistance.[[83]](#footnote-83)

## National Family Caregiver Support Program

***(Title III-E of OAA; FY 2017: $150,586,000)***

The National Family Caregiver Support Program (NFCSP) provides grants to states and territories, based on their share of the population age 70 and over, to fund a range of supports that assist family and informal caregivers to care for their family member at home for as long as possible. The NFCSP includes five basic system components: information, access assistance, counseling and training, respite care, and supplemental services. These services work in conjunction with other OAA services – including transportation services, homemaker services, home-delivered meals, and adult day care – to provide a coordinated set of supports for older individuals that caregivers can access on their behalf.

The NFCSP provides a variety of supports to family and informal caregivers. In FY 2017, services provided included:[[84]](#footnote-84)

* *Access Assistance Services*, which provided over 1.2 million contacts to caregivers assisting them in locating services from a variety of public and private agencies.
* *Counseling and Training Services*, which provided over 108,000 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving.
* *Respite Care* Service, which provided almost 59,000 caregivers with more than 6 million hours of temporary relief – at home or in an adult day care or nursing home setting – from their caregiving responsibilities.

***The NFCSP Outcome Evaluation***

Following the completion of the Process Evaluation in March 2016, throughout 2017 ACL undertook the second part of the national evaluation of the NFCP by launching the Outcome Evaluation. The outcome evaluation will draw on information obtained from comprehensive telephone-based surveys of NFCSP client caregivers and a comparison group of caregivers who were not clients of NFCSP. The surveys will be administered to random samples of participants, based on probability samples of AAAs that will be surveyed as part of the ACL’s 11th National Survey of Older Americans Act Participants (NSOAAP). The nonparticipant comparison group will be formed by identifying clients of Older Americans Act services who indicated during the NSOAAP that they had someone who assisted them with activities of daily living (ADLs) and who were not recipients of NFCSP caregiver services. These clients were called and asked if they had a family caregiver. The evaluation team will complete phone interviews with each caregiver three times: (1) baseline in Winter 2016, (2) 6-month follow-up in Summer 2017, and (3) 12-month follow-up in Winter 2017. ACL anticipates releasing the results of the Outcome Evaluation later in 2018 and is available [here](https://acl.gov/sites/default/files/programs/2017-02/NFCSP_Final_Report-update.pdf).

The objectives of the outcome evaluation are to:

• Help ACL understand which kinds of services are most helpful for caregivers and identify any unmet needs of caregivers and gaps in the support for them;

• Identify any NFCSP resources, organizational characteristics, and implementation practices that appear to contribute to positive outcomes for caregivers receiving the key NFCSP caregiver services of respite care and/or education/training, individual counseling, and support groups;

• Assess the impact of services on the ability of caregivers to continue providing homebased caregiving as needed; for example, by examining the relationship between self-reported caregiver measures of mental health, physical health and well-being and the amount of caregiver services received; and

• Examine the relationship between NFCSP client outcomes and key processes and characteristics of the AAAs managing and/or providing NFCSP services.

Family and other informal caregivers are the backbone of America’s long-term care system. On a daily basis, these individuals, the majority of whom are women, assist relatives and other loved ones with tasks ranging from personal care and homemaking to more complex health-related interventions like medication administration and wound care. Data from AoA’s 2018 National Survey of OAA Participants show that 22 percent of caregivers are assisting two or more individuals. Seventy-three percent of Title III caregivers are 60 or older, making them more vulnerable to a decline in their own health, and 31 percent describe their own health as fair to poor.[[85]](#footnote-85) The demands of caregiving can lead to a breakdown of the caregiver’s health. Nationally, approximately 11 percent of caregivers report that caregiving has caused their physical health to decline.[[86]](#footnote-86) Caregivers often experience conflicts between work and caregiving. Among working caregivers caring for a family member or friend, 60 percent report work impacts due to caregiving such as having to rearrange their work schedule, decrease their hours or take an unpaid leave in order to meet their caregiving responsibilities.[[87]](#footnote-87)

Survey results from caregivers served by the NFCSP indicate that the types of supports provided through the NFCSP can enable them to provide care longer (79 percent) while often continuing to work,[[88]](#footnote-88) thereby avoiding or delaying the need for costly institutional care, including care financed by government. Additionally, another study indicates that counseling and support for caregivers of individuals with Alzheimer’s disease can permit the care recipient to stay at home at significantly less cost, on average, for an additional year before being admitted to a nursing home.[[89]](#footnote-89)

Data from AoA’s 2018 National Survey of Older Americans Act Participants reveal that OAA services, including those provided through the NFCSP, are effective in helping caregivers assist their loved ones at home. Caregivers receiving services were asked whether the care recipient would have been able to live in the same residence if the services had not been available. Thirty-eight percent of the caregivers indicated that the care recipient would be unable to remain at home without the support services.[[90]](#footnote-90) Those respondents were then asked to identify where the care recipient would be living without services. A significant majority of those caregivers, nearly 76 percent, indicated that the care recipient would most likely be living in a nursing home or an assisted living facility (see the chart below).[[91]](#footnote-91)



## Brain Health

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

Promoting brain health is critical to helping older adults maintain their cognition, independence and overall health. AoA works with the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) to develop and maintain a Brain Health Resource (the Resource) to promote brain health among older adults, people with disabilities, and their caregivers. The Resource is available at: <https://www.acl.gov/index.php/node/293>

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

There are four parts to the Brain Health Resource. *Brain Health Basics* helps people learn and teach others about the risks related to brain health and how to reduce them. *Medicine, Age and Your Brain* explains the impact of some medicines can have on an older adult’s brain, and the importance of talking with a doctor about this topic. *Brain Injury* helps people learn and teach others about how to prevent brain injury and how to get help when someone has one. *Dementia* explains how to create “dementia-capable” long-term services and supports at the state and local levels to help people who have Alzheimer’s disease and other types of dementia and their caregivers.

AoA, NIH, and CDC will continue their collaboration on the Brain Health Resource over time. This work occurs under the direction of the U.S. Department of Health and Human Services’ National Plan to Address Alzheimer’s Research, Care and Services.[[92]](#footnote-92)

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

***(FY 2017: $4,800,000)***

Established under Section 398 of the Public Health Services Act, as amended, (42 U.S.C. 280c-3), the Alzheimer’s Disease Supportive Services Program (ADSSP) funds competitive grants to states to expand the availability of dementia-capable community-level supportive services for persons with Alzheimer’s disease and related dementias (ADRD), their families, and their caregivers. The program is designed to prepare states to support the more than five million Americans estimated to have the disease, which is ranked as the sixth leading cause of death in the U.S.

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

ADSSP expands the aging services network’s capacity to assist those with ADRD and their families through provision of services and education, building awareness of Alzheimer’s disease and related dementias, and referrals for diagnostic, treatment and related services; as well as sources of assistance for services and legal rights assistance for people affected by dementia throughout a state’s long-term services and support system.

ADSSP grant projects are designed to ensure that states provide people with ADRD and their family caregivers with access to a sustainable home and community-based services system that is “dementia capable.” Such a system meets the unique needs of each person with ADRD by: 1) identifying those with a possible dementia and recommending follow-up with a physician; 2) ensuring that the staff they encounter have appropriate training, understand the unique needs/services available and know how to communicate with them; and 3) providing quality, person-centered services that help them remain independent and safe in their communities. Overall, these demonstration programs offer direct services and other supports to thousands of individuals and families, as well as supporting continuous quality improvement and evaluation of state HCBS systems. In FY 2017, 18 states were implementing ADSSP grants dedicated to the development of dementia-capable systems.

Family caregivers remain the major source of support for most people with ADRD and, as such, they access a variety of services from many different systems including the aging, medical, and mental health service systems. As the number of people living with ADRD grows, it is increasingly important to ensure the availability of dementia-capable HCBS. These important services, and the systems through which they are delivered, must be dementia-capable and efficiently and effectively coordinated. The ADSSP provides states the opportunity and resources to infuse dementia capability into their systems and provide appropriate direct services in support of persons living with ADRD and their caregivers. The delivery of dementia-capable services and supports that are cost-effective and result in demonstrated measureable outcomes in the communities they serve continue to be at the forefront of all ADSSP grants. The programs supported by the ADSSP include outcome measures to demonstrate the impact of the work on the persons served. Program outcomes to date include, but are not limited to, reduction of caregiver depression/stress/burden, delayed intent to place in a skilled nursing facility, increased caregiver self-efficacy and ADRD knowledge increases.

All entities participating in ACL’s ADRD programs benefit from extensive technical assistance provided through the [National Alzheimer’s and Dementia Resource Center (NADRC)](https://nadrc.acl.gov/). The NADRC provides expert technical assistance to AoA/ACL and its grantees, as well as making program information and resources available to individuals, organizations and the general public outside their immediate Alzheimer’s grantee community. In addition to individualized grantee technical assistance, the NADRC is responsible for an internationally well received annual series of educational webinars on issues related to ADRD, as well as the development and distribution of topic specific issue briefs (basics of dementia capability, living alone, etc.) and tools (compendium of evidence-based interventions, outcome measures, advance and disaster planning, etc.) to which a broad range of ADRD stakeholders have access.

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

***(FY 2017 - $10,500,000)***

In FY 2017, ACL received resources from the Prevention and Public Health Funds (PPHF-2017) within the Patient Protection and Affordable Care Act (PPACA) to fund cooperative agreements designed to fill identified gaps in long-term services and supports (LTSS) services for persons living with ADRD and their caregivers. In 2017, the ADI-SSS program was open to community-based entities operating within an existing dementia-capable system through which persons with ADRD and their caregivers receive quality, person-centered services to support their remaining independent and safe in their communities.

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

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

All grantees are required to implement programs that contain components addressing a minimum of three of the four above referenced gaps.

In FY 2017, 11 unique organizations received ADI-SSS program awards, joining the 32 organizations funded in FYs 2014, 2015 and 2016. The FY 2017 program recipients are implementing programs tailored to address the unique needs of the communities they serve, which include states and local governments, a health system and several community-based organizations. Each of the funded programs meet the requirement for the implementation of at least one dementia related evidence-based or evidence-informed intervention, dedicate a substantial percentage of program resources to the provision of direct services and 25 percent cost-sharing through either in-kind or cash match. Through targeted partnerships and community engagement, grantees are able to implement a broad range of services and supports to persons with ADRD and their caregivers. Examples of program activities include, but are not limited to, support programs for persons with dementia and their caregivers, a mobile dementia screening unit dispatched to underserved minority communities, care coordination through faith-based entities, behavioral symptom management training for caregivers, dementia capable care coordination and care transitions, and development of dementia capable community initiatives, including awareness training for a broad range of community entities.

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

## Nutrition and Supportive Services

***(FY 2017: $33,963,173)***

Native American Nutrition and Supportive Services provides grants to eligible tribal organizations for the delivery of nutrition and home and community-based supportive services to American Indian, Alaska Native, and Native Hawaiian elders. An estimated 945,000 persons age 60 and over identify themselves as American Indian or Alaska Native alone or in combination with another racial group.[[93]](#footnote-93) Over 549,000 of those elders identify as American Indian or Alaska Native with no other racial group.[[94]](#footnote-94)

Between 2000 and 2010, the number of older American Indian and Alaska Native (AI/AN) adults increased by 40.5 percent, a growth that is 2.7 times greater than that of the overall population of older adults over the same 10-year period.[[95]](#footnote-95) In addition, this rapidly growing population is also experiencing some of the highest rates of disability,[[96]](#footnote-96) chronic disease, and poverty[[97]](#footnote-97) in the United States. Because of the combined factors of an aging population and high disability rates, AI/ANs have a great need for home and community-based services access in their communities.

Native American Nutrition and Supportive Services grants support a broad range of services to older Native Americans, including adult day care, transportation, congregate and home-delivered meals, information and referral, personal care, help with chores, and other services. Currently, AoA’s congregate meals program reaches 42 percent of eligible Native American seniors in participating tribal organizations, home-delivered meals reach 12 percent of such persons, and supportive services reach 30 percent of such persons.[[98]](#footnote-98) These programs, which can help to reduce the need for costly nursing home care and medical interventions, are responsive to the cultural diversity of Native American communities and are an important part of each community’s comprehensive services.

Services provided by this program in FY 2017 included:

* *Transportation Services*, which provided over 772,000 rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical activities.[[99]](#footnote-99)
* *Home-Delivered Nutrition Services,* under which over 2.5 million meals were provided to over 31,000 homebound Native American elders; the program also provides critical social contacts that help to reduce the risk of depression and isolation experienced by many home-bound Native American elders.[[100]](#footnote-100)
* *Congregate Nutrition Services*, which provided over 2.4 million meals to over 109,000 Native American elders in community-based settings, as well as an opportunity for elders to socialize and participate in a variety of activities, including cultural and wellness programs.[[101]](#footnote-101)
* *Information, Referral and Outreach Services*, which provided over 825,000 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.[[102]](#footnote-102)

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, monthly webinars, e-newsletters, telephone and written consultations, and through the Native American Resource Centers (funded under Aging Network Support Activities).

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

## Caregiver Support Services

***(FY 2017: $7,478,530)***

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

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

Grants assist American Indian, Alaska Native and Native Hawaiian families caring for older relatives with chronic illness or disability and grandparents caring for grandchildren. The program provides a variety of direct services that meet a range of caregiver needs, including information and outreach, access assistance, individual counseling, support groups and training, respite care, and other supplemental services. Annually, tribal grantees provided over 100,000 hours of respite care, delivered just over 23,000 hours of caregiver training, and assisted 16,000 caregivers to access needed services.[[103]](#footnote-103) 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: ELDER RIGHTS

AoA works to promote the rights of older adults through several distinct but complementary programs. Among other things, these programs provide a full array of services designed to prevent, detect, and respond to elder abuse, neglect, and exploitation, both at home and in institutional settings.

## Prevention of Elder Abuse and Neglect

***(FY 2017: $7,985,000)***

The Prevention of Elder Abuse and Neglect program (Title VII, Section 721) provides states with formula grants for training and education, promoting public awareness of elder maltreatment, and supports state and local elder abuse prevention coalitions and multi-disciplinary teams. These activities are important elements of AoA’s enhanced focus on elder justice. This program coordinates activities with state and local adult protective services programs (over half of which are directly administered by state units on aging) and other professionals who work to address issues of elder maltreatment and elder justice. The importance of these services at the state and local level is demonstrated by states significantly leveraging OAA funds to obtain additional funding for these activities.

Elder abuse is a substantial public health and human rights problem. Available prevalence data suggest that at least 10 percent (or 5 million) of older Americans experience abuse each year, and many of them experience it in multiple forms.[[104]](#footnote-104) In addition, data from Adult Protective Services (APS) agencies show an increasing trend in reports of elder abuse,[[105]](#footnote-105) despite estimates that as few as 1 in 14 cases of elder abuse,[[106]](#footnote-106) and 1 in 44 cases of financial exploitation, come to the attention of authorities.

Elder abuse results in a wide range of negative health impacts, including the increased likelihood of injury and chronic health conditions, both of which significantly impact health care expenditures. On average, older people have more chronic diseases and access the health care system at higher rates than other age groups. Older adults who are victims of violence have additional health care problems and higher premature mortality rates than non-victims. Older victims of even modest forms of abuse have dramatically (300 percent) higher morbidity and mortality rates than non-abused older people.[[107]](#footnote-107) Research has also demonstrated that older adults who are victims of violence have more health care problems than other older adults, including increased bone or joint problems, digestive problems, depression or anxiety, chronic pain, high blood pressure, and heart problems.[[108]](#footnote-108)

Victims of elder abuse also have significantly higher levels of psychological distress and lower perceived self-efficacy than older adults who have not been victimized.[[109]](#footnote-109) For older victims of sexual violence the negative health impacts of abuse are even more pronounced. One study found that 12.7 percent of older women in the study group reported a history of sexual assault, all of whom experienced significantly increased risks of breast cancer and arthritis. Also, those who experienced repeated violence were up to four times more likely to develop these chronic conditions than women who were never abused.[[110]](#footnote-110)

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. Recent examples of state elder abuse prevention activities include:

* The AAA network in Massachusetts builds and promotes partnerships with community colleges, long-term care facilities, Protective Services agencies, law enforcement organizations, and other area community centers in order to assure that elder rights are prioritized across the state. Presentations across multiple organizations are a popular method for disseminating available services and programs. Advocating for elder rights includes commitments from many participants, including support groups, money management programs, Long Term Care Ombudsman programs, financial institutions, and housing advocacy groups. In building strong partnerships, the AAAs and community organizations join forces to advocate for and ensure that elders have necessary information available to access community resources for services and care decisions.
* North Dakota recognized World Elder Abuse Awareness Day by presenting and participating in activities at Elder Abuse Awareness Day Forum sponsored by the Standing Rock Sioux Tribe Elderly Protection Services Program in conjunction with ACL/National Indigenous Elder Justice Initiative. The Division also organized an event in Mandan in conjunction with the summer concert series to share information about how people can stay safe, avoid scams, and access elder abuse and neglect intervention services.
* The South Dakota SUA uses a portion of OAA 721 funds to attend the National Adult Protective Services Association (NAPSA) annual conference. The topics addressed at the NAPSA conference are consistent with the training subjects contained in Section 721. Also, in support of adult protective service training options, OAA 721 funds pay for the [NAPSA Certificate Program](http://www.napsa-now.org/the-napsa-certificate-program/) for the SUA staff and future APS specialists.

**National Center on Elder Abuse**

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

In FY 2017, NCEA accomplishments included:

* NCEA website was a valued resource on abuse, neglect, and exploitation for its users. The NCEA websites reached 70,309 unique users, totaling 194,614 page views. 83% of the visitors were new to the site with the remaining 17% previous visitors. 94.46% of the visitors to the site were from the United States. The inquiries trended as follows: 21% on financial abuse, including 2% on solicitation scams, and 5% about emotional abuse. While 17% reported multiple forms of alleged abuse, 40% were focused on only one type of abuse.
* The NCEA facilitated and moderated 378 conversations on its listserv and actively engaged 2,400 listserv participants. An average of six topics was discussed each week on the listserv.
* The NCEA initiated a request for information via the listserv to better understand the intersection of Elder Abuse and the Opioid Epidemic. Thirty professionals responded from APS (44%), Departments of Health Services (16%), Departments of Social Services (8%), and other/non-specified (32%). Respondents affirmed the correlation between opioid addiction and resultant elder abuse and there has been a surge in reports. It was also agreed that institutional mechanisms designed to strengthen older adults’ support systems must be implemented.
* During 2017, the NCEA collaborated with aging partners to learn, understand, and disseminate an elder abuse communication strategy designed by the Frameworks Institute. The strategy includes new “metaphors” for talking about elder abuse, designed to reframe and educate people and agencies who are in a position to improve policies and services relevant to elder abuse. Trainings and education on the use of the reframing messaging have been well received and adopted. NCEA has also reframed educational materials for national organizations such as USPIS and many state and local agencies.
* During 2017, the NCEA continued to develop collaborations with other national organizations and nationally recognized resource centers for collaborative purposes. These entities included organizations focused upon the needs of Asian and Other Pacific Islanders, Latino, Native American, LGBTQ, African American, and Alzheimer’s and related disorders resource centers. The National Asian Pacific Center on Aging assisted in the translation of several reframed Elder Abuse Fact sheets. NCEA also assisted the National Indigenous Elder Justice Initiative in editing their training materials.
* NCEA successfully conducted a 2017 World Elder Abuse Awareness Day (WEAAD) Campaign that featured national experts posting blogs and being available for twitter chats. The NCEA refreshed WEAAD materials to insure messages of dignity and respect for all older people and those afflicted by elder abuse. The NCEA also has created multiple online marketing components to keep various aging professionals and volunteers engaged during the WEAAD campaign. Social Media was fully deployed during this campaign with the following results:
	+ Facebook Reach
		- Page Likes: 6,133 (313 new page likes)
		- Total Post Engagements: 7,427 (Shares, Reactions, Comments, Post Clicks)
		- Total Reach on Posts: 86,393 (number of unique people who saw content)
		- Top Performing Post: News Article on S.178 Elder Abuse Prevention and Prosecution Act of 2017 (Post Reach: 6,698; Engagements: 512)
	+ Twitter Reach
		- Followers: 3,955 (increase 309 new followers during this period)
		- Profile Visits: 9,073
		- Tweet Engagements: 2,969 (Likes, Retweets, Replies, Post Clicks)
		- Tweet Impressions: 235,100
		- Top Performing Tweet: NCEA PSA – Strengthening the Structure of Justice to Prevent Elder Abuse (Tweet Impressions: 8,705; Engagements: 135)

##

**National Center on Law and Elder Rights**

 ***(FY 2017: $1,047,588)***

The National Center on Law and Elder Rights (NCLER) empowers aging and legal professionals with the tools and resources to provide older clients and consumers with high-quality legal assistance in areas of critical importance to their independence, health, and financial security. NCLER is a streamlined point of entry to resources for legal assistance and aging network professionals across the country. It serves to enhance the quality, cost effectiveness, and accessibility of legal assistance and elder rights protections available to older adults with social or economic need. NCLER provides resource support to a broad range of legal, elder rights, and aging services professionals and advocates, including:

* Legal assistance providers,
* Legal assistance developers,
* Long-Term Care Ombudsmen,
* State Units on Aging,
* Area Agencies on Aging and Aging & Disability Resource Centers,
* Senior Legal Helplines,
* Adult Protective services, and
* Others involved in protecting the rights of older adults.

NCLER provides legal case consultation, training, and technical assistance on a broad range of legal issues and systems development issues. NCLER assists professionals and advocates on a wide range of legal issues that has included in 2017:

* Saving an older adult’s home from foreclosure;
* Protecting against consumer scams and creditor harassment;
* Addressing elder abuse in the community and in long-term care facilities;
* Accessing public benefits essential to financial security, independence, and health; and
* Creating advanced directives that help avoid guardianship and facilitate supported decision-making arrangements.

NCLER attorneys apply subject matter expertise to offer resources on high-priority legal issues areas impacting older adults with economic or social need. NCLER provides expert technical assistance on the efficient, cost-effective, and targeted provision of statewide legal and elder rights advocacy services.

The NCLER website, ncler.acl.gov, serves as an entry point to the national legal assistance resource support system. NCLER serves the following core support functions for aging and legal networks:

* Case consultation for professionals and advocates in the field of law and aging to assist in the resolution of complex legal problems impacting older adults;
* Legal training for professionals and advocates from aging and legal services networks on a wide range of legal and elder rights issues experienced by older Americans with economic and social need; and
* Technical assistance in the development of legal service delivery systems that address priority issues impacting older adults.

The provision of case consultation, training, technical assistance, and other legal resources enhances the ability of legal and aging service providers and advocates to help older adults maintain independence, live in their homes and communities, make their own decisions, and maintain their financial security.

## Model Approaches to Statewide Legal Assistance Systems

***(FY 2017: $1,461,819)***

Model Approaches grants help states develop and implement statewide systems enhancements in the delivery of legal assistance to older adults with economic or social need experiencing priority legal issues set forth in the Older Americans Act. Systems enhancements include integrating Senior Legal Helplines, which provide brief service, advice and counsel and a portal to full legal representation, along with other low and no-cost legal services delivery mechanisms into a broad spectrum comprising a state’s legal service delivery network.

Model Approaches are led by Legal Assistance Developers at the state level and involve project partners including Older Americans Act Title III-B-funded legal services providers. An example of how legal assistance providers in states receiving Model Approaches grants were able to empower their older clients include:

* An Older Americans Act-funded legal assistance provider in Connecticut assisted in the resolution of a counterfeit check scam wherein an older adult received a letter stating that she had won a big prize. In order to collect the prize, she was told to deposit an attached $5,000 check into her bank account, draw it out in cash and send the money back to the company to cover “fees”. When she did so, the check bounced and the bank demanded she pay back the $5,000. Her only income was from Social Security, and she couldn’t afford to repay the bank. The legal assistance provider reached out to the bank, explaining that the older adult had been a victim of fraud, couldn’t afford to pay the bank back, and was judgment proof. The bank agreed to write off the loan debt and has not pursued repayment.

Model Approaches grants are awarded in two phases. In accordance with the Older Americans Act, grantees work to direct these services towards older Americans with social or economic need, with particular emphasis upon low-income, minority, rural, homebound, and limited-English speaking older adults.

In FY 2017, two states (Tennessee and Wisconsin) were awarded Phase I grants. Phase I grantees work to develop statewide legal service delivery systems that coordinate efforts of Senior Legal Helplines, pro-bono attorneys, law school clinics, self-help sites, and Older Americans Act-funded legal services providers to ensure maximum impact from limited resources. During 2017, the grantees convened their stakeholders and completed a legal needs assessment, and continued their assessments of the capacity of the existing legal assistance network to provide legal assistance to older Americans with social or economic need on OAA-identified priority case types[[111]](#footnote-111).

* In Tennessee, the legal assistance stakeholders convened for the Model Approaches grant secured significant and sustained funding from a local source to support launch of an elder-friendly component to their statewide toll-free legal aid helpline. The senior component is fully integrated into Tennessee’s statewide legal aid hotline infrastructure, helping to ensure that older Tennesseans have access to a full range of needed legal assistance. The funds are also used to increase the volume of complex cases the legal assistance providers are able to handle for older Tennesseans with economic and social need, including civil legal interventions to restore agency to those who have experienced elder abuse.

In FY 2017, the six Model Approaches Phase II grants (Connecticut, Florida, Massachusetts, Pennsylvania, Vermont and Virginia) continued the evolution of legal service delivery systems implemented through previous Model Approaches projects towards higher levels of capacity, performance and service delivery impact. Phase II Model Approaches grants are focused in part on enhancing civil legal responses to complex issues that emerge from elder abuse, neglect, and financial exploitation. Additionally, these grants seek to expand outreach to older adults with social or economic need and work to create legal service delivery guidelines that bring the laws and regulations related to the provision of legal assistance under the Older Americans Act to life within their states. In 2017, Phase II Model Approaches grantees completed capacity assessments that included recommendations for systemic enhancements to be implemented in Year 3 of their grants, and created legal services guidelines, as described above. They continued to implement their Senior Legal Helplines to provide legal advice and brief service to older adults, as well as referral to those who needed full service legal representation.

* Florida’s Model Approaches grant implemented a medical-legal partnership focused on the older population in the Gainesville area. Three Rivers Legal Services partners with the University of Florida medical Center in Gainesville for regularly scheduled onsite consultations with individuals and clinicians. The legal assistance program conducts direct intake, refers for more in-depth legal assistance; and consults with clinical staff about the needs of qualified patients. Joint trainings are offered on how to recognize and address priority legal issues as defined in the Older Americans Act and the interplay with social determinants of health. The Medical legal partnership model provides streamlined access to legal services for older, low-income patients while helping to improve health outcomes by addressing social and legal determinants. The Gainesville Medical Legal Partnership is one of only three nationwide that focuses on older populations.

## Pension Counseling and Information Program

***(FY 2017: $1,515,137)***

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

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

Benefits from employer-sponsored pensions and retirement savings plans are as critical today to the retirement security of Americans as they were when the pension counseling program was first established. The pension questions 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 (PCIP) is to help ensure that all older Americans have access to the help they need in order to secure the employer-sponsored retirement benefits they have earned --- benefits that are critical to their ability to live independently and with dignity after a lifetime of productive employment. The Pension Counseling and Information Program provides help that would be otherwise unavailable, by assisting individuals in understanding and exercising their pension rights. The program promotes the financial security of older individuals by offering them the help they need to receive the pension benefits they have earned. The income, in turn, provides increased opportunities for choice and independence.

AoA currently funds six regional counseling projects covering 30 states and a technical assistance resource center to assist older Americans in accessing information about their retirement benefits and to help them negotiate with former employers or pension plans for due compensation. The six regional counseling projects are:

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

The projects help with cases that private pension professionals are reluctant to take, where the benefits in question are small, as is often the case with low-income workers and those with limited English proficiency, but to whom these modest amounts make a huge difference in maintaining their financial security and independence.

Data show that since the program’s inception in 1993 through 2017, the Pension Counseling projects have recovered $243 million in retirement benefits for more than 60,000 retirees. With a relatively small federal investment, the program as a whole has brought in a return of more than $9.00 for every federal dollar invested in the program. These recoveries demonstrate that pension counseling is not only necessary, but that it can be provided efficiently and effectively. Some projects demonstrate an even higher return. For example, the Mid-America Pension Rights Project, operated by ElderLaw Michigan, calculated for their reporting period of July 1, 2017-December 21, 2017, recovering 26 individual pension benefits presently valued at $1,391,208.00—a return of $14 for every federal dollar invested in the operation of this project. In addition to the dollars recovered by PCIP-funded organizations on behalf of clients, ACL/AoA is able to measure efficacy of the program through number of clients served, which are tracked on a bi-annual basis through 6-month progress reports of project successes, recovered funds, and client intake.

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

* The New England Pension Assistance Project successfully provided help to a woman with disabilities from Connecticut who had been receiving benefits from her ex-husband’s plan pursuant to a qualified domestic relations order (QDRO) since 2003. In 2015, the plan notified her that she had been receiving the wrong benefit and had been overpaid by more than $22,000. The plan increasingly lowered her monthly benefit to correct for the alleged overpayment, plus interest. This was insufficient for the client to make ends meet, so she contacted her Congressman, who referred her to the project. With the help of the project, the plan agreed to stop further recoupment and restore her monthly benefit to a livable sum.
* The Upper Midwest Pension Rights Project was able to help an older adult obtain a significant amount of money from a former spouse’s pension plan. The project provided support to a client in drafting a QDRO for a Defined Contribution Plan. The Project drafted the QDRO for the client, got the QDRO approved, and assisted the client in obtaining the benefit for a total of $69,190.

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

## Long-Term Care Ombudsman Program

**(FY 2017: $ 15,814,316)[[112]](#footnote-112)**

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

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

The OAA requires LTC Ombudsman programs to:

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

Improving and Evaluating Ombudsman Program Services

In order to improve the quality and effectiveness of LTC Ombudsman program services to residents, ACL is undertaking the implementation of a LTC Ombudsman program evaluation in order to understand service delivery models. This process evaluation will help ACL lay the foundation to evaluate program impact and efficiency. Not since the Institute of Medicine’s 1995 report, has there been a comprehensive, national evaluation of the Ombudsman program. ACL completed its evaluation design in 2013, anticipates completing the process evaluation in 2019, and is beginning an outcome evaluation to obtain the perspectives of residents, their families and facility staff. Anticipated completion of the Outcome evaluation is 2021.

Complaint Investigation and Resolution

LTC Ombudsman programs provide a person-centered alternative dispute resolution service, working with (or on behalf of) long-term care facility residents to resolve complaints. Ombudsman programs nationwide:

* Completed resolution work on 201,460[[113]](#footnote-113) complaints and resolved 73 percent of these complaints to the full or partial satisfaction of the resident or complainant.
* Sixty-eight percent of complaint resolution work occurred in nursing facility settings; 30 percent occurred in board and care, assisted living or other residential care communities; and 2 percent were associated with non-facility settings or services to facility residents by an outside provider.
* Residents were the primary complainant in nursing facilities (42 percent) and in board and care, assisted living and other residential care communities (35 percent).[[114]](#footnote-114)

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

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

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

1. Improper eviction or inadequate discharge planning.
2. Administration and organization of medications.
3. Quality, quantity, variation and choice of food.
4. Lack of respect for residents, poor staff attitudes and
5. Building or equipment in disrepair or hazardous.

Long-Term Care Ombudsman programs devote significant effort to addressing improper discharge and eviction. This complaint is the most common among both nursing home and board and care residents in FY 2017 and is best illustrated by example of a successful case resolution.

* During the course of a routine visits the volunteer representative of the Office of Ombudsman met with a resident and her family. She learned that the resident was given a discharge notice; she had 30 days to find a new home. The facility reason for discharge was that they could no longer “meet her needs.” The family wanted to contest the discharge and requested Ombudsman program intervention. The resident has Alzheimer’s disease and the facility was not providing the individualized care necessary to support her. The persistence of the volunteer representative of the Office was instrumental in a successful resolution. She identified and followed up to ensure that staffing changes, addressing shower safety, lowering the dosage of medications which caused sleepiness, and providing assistance at meal times were implemented. Her advocacy helped the resident and with the implementation of new care practices, made a positive impact for all residents living in this facility.

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

Ombudsman Program Activities

In addition to resolving complaints, LTC Ombudsman programs provide services that prevent problems for residents and serve as a resource on rights, quality care and community options. In FY 2017, LTC Ombudsman programs provided:

* Routine visits to 68 percent of nursing facilities and 30 percent of board and care, assisted living, and other residential care communities at least quarterly. These visits ensure that residents have regular access to ombudsman services.
* Information and assistance to individuals (over 402,000 instances) on topics such as long-term services and supports options; Medicaid eligibility; discharge and eviction rights; and other federal and state policies affecting residents.
* Consultations and information to long-term care facility staff (over 127,068 instances), on topics such as residents’ rights, person-centered care practices, and discharge and eviction questions.
* Resident and family council support, providing technical assistance, training and information to resident councils (21,211 sessions) and family councils (1,788 sessions).
* Training of long-term care facility staff (4,426 sessions).
* Community education ( 10,170 sessions); and
* Coordination with licensing and survey entities, participating in 17,703 facility survey-related activities as resident advocates.

Systems Advocacy

In addition to individual problem resolution, Ombudsman programs advocate for resident interests in public policy arenas. The OAA requires Ombudsman programs to analyze, comment on and recommend changes in laws, regulations, and government policies and actions to benefit residents. In addition to addressing improper evictions, Ombudsman programs reported on work to address systems-level issues, including:

* Response to substance abuse and drug diversion; state Ombudsman programs are beginning to see the impact of substance abuse, resident challenges with access to pain medication and problems with drug diversion. Ombudsman programs report that they are establishing relationships with other governmental agencies to develop practices and education to combat these problems.
* Care requests - LTC Ombudsman programs worked to resolve over 9,600 complaints related to unanswered requests for assistance with care. Many Ombudsman programs note that the failure to respond to requests for assistance is due to the shortage of both direct care and nursing staff and facilities often resort to using staff from an agency, which often results in a lack of person-centeredness and consistency in care provided. State Ombudsmen attribute staffing shortages to the growing demand for long-term services and supports coupled with a shrinking labor pool, generally low wages, and they frequently observe inadequate training and limited on the job support which impact resident care and retention of qualified nursing staff.
* Examples of systems-level work to prevent or respond to staffing shortages included:
* Working in partnership with both the long-term care provider industry, state agencies, including workforce commissions, to identify solutions to the workforce shortage; including workforce preparedness to care for persons living with dementia or other cognitive brain injuries.
* Advocating for improved state laws or regulations to support adequate staffing; and
* Training facility staff on topics such as abuse prevention, person-centered care, and dementia care.
* Facility closures and Ombudsman responses - Ombudsman interventions include supporting residents as they move to a new setting, frequently upon very short notice. Ombudsman programs often participate as part of a team that responds to facility closures. Teams also generally include case managers, licensing and survey and other community partners such as the Aging and Disability Resource Centers.
* Community responses to elder abuse - Service on statewide or local multi-disciplinary teams, Financial Abuse Specialist Teams (FAST) and similar community networks to address financial exploitation and other forms of abuse.
* A local Ombudsman program attorney housed in a legal services agency focused her work on issues related to substitute decision-making and financial exploitation. Within a short period, it became clear that there was a dearth of legal resources for victims of financial exploitation in their state. With additional federal grant funds through the Victims of Crime Act (VOCA) the program was able to hire two additional attorneys to address the issues of financial exploitation throughout the state. The attorney assigned to the Ombudsman Program mentors these newer attorneys and works closely with them to identify issues, develop litigation strategies, working to limit exploitation and, when appropriate, assisting victims in the criminal prosecution of their exploiters. As a direct result, of the Ombudsman Program’s financial exploitation work, the legal services agency developed a new financial exploitation “unit” to serve vulnerable individuals in any setting.

How LTC Ombudsman Programs Operate

There are 53 State LTC Ombudsman programs (in 50 states, plus the District of Columbia, Puerto Rico, and Guam). In most states, the Office of the State LTC Ombudsman is within the state unit on aging or another state agency. In others, the Office resides in a private non-profit agency. Most states have contracts with or through area agencies on aging to provide direct ombudsman services to residents. There are 523 designated local Ombudsman entities.

In FY 2017, 1,319 full-time equivalent staff and 6,623 volunteers -- all trained and designated to investigate and resolve complaints and provide Ombudsman program services to residents. An additional 2,185 volunteers also served residents or assisted in program operations in ways other than complaint resolution.

Total FY 2017 funds expended from all sources nationwide were $106,681,267, an overall increase of five percent from the FY 2016 level. The federal sources represented over half (50.4 percent) of the program expenditures expended in FY 2017. States provided 43 percent of funds, and other non-federal sources funded the remaining seven percent.

National Long-Term Care Ombudsman Resource Center Activities

To effectively problem-solve with and for residents, Ombudsman programs must remain up-to-date on the latest long-term care developments. Therefore, ACL supports the National Ombudsman Resource Center (NORC), which provides training, technical assistance, and program management expertise to Ombudsman programs. In FY 2017, the National Consumer Voice for Quality Long-Term Care operated the NORC in coordination with the National Association of States United for Aging and Disabilities (NASUAD).

In FY 2017, the NORC provided training and technical assistance to Ombudsman programs on such issues as:

* Implementation of ACL’s final rule for State LTC Ombudsman programs;
* Volunteer management and technical assistance including risk management;
* Approaches to complaint resolution, with a focus on strategies to address improper discharge and eviction.

Additionally, the NORC provided quarterly orientation training for all new ombudsmen, and developed resource materials, the NORC website ([www.ltcombudsman.org](https://ltcombudsman.org/)), and quarterly newsletters customized for Ombudsman program staff and volunteers.

Program Results and Challenges

1. Volunteers help the program engage the local community.

Thousands of volunteers across the county donated their time, talents, and energy to visit residents, listen to their concerns and take action to resolve problems. Volunteers frequently provide residents with regular access to ombudsman services and provide cost-effective, community-based complaint resolution. Volunteers also engage in broader program initiatives as described by a state Ombudsman in the following state example.

* Several residents said they were not receiving enough food at meal times. During her visit, the volunteer Ombudsman representative observed small portions that may have met dietician's recommendations but left several residents still hungry. After talks with the facility administrator, he agreed to offer extra portions at meal times as requested. Because of her persistence, the Ombudsman representative was able to ensure residents were happy and no longer left hungry.
1. Ombudsman programs solve problems at the facility level.

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

1. Growth in home and community-based services (HCBS) and Medicaid managed Long-Term Services and Supports (LTSS) increase demands for ombudsman services.

Federal and state policy changes -- including the promotion of Medicaid HCBS through waivers and other statutory options, the rapid growth of Medicaid managed LTSS, and demonstration projects to serve persons receiving both Medicare and Medicaid (i.e. Financial Alignment Initiative, sometimes called the “duals demonstrations”) are creating opportunities, as well as some new challenges, for Ombudsman programs. As these services expand and provide more options for residents, Ombudsmen work to represent their interests and concerns and to ensure that strong beneficiary support systems are in place.

Increasingly, individuals live in residential settings other than nursing homes, including board and care homes, assisted living facilities, and other residential care communities (known by various names under state laws). As a result, LTC Ombudsman programs report increasing work, both at the individual complaint and the systems levels on behalf of these types of residential settings.

In additional to complaints about care and dignity, Ombudsman programs report challenges with other consumer protections such as a lack of supplies, including food, lack of staff and multiple violations which often lead to facility closure.

These case examples illustrates the effectiveness of Ombudsman program complaint resolution during this period:

* A board and care home voluntarily closed when unable to address significant deficiencies. Resident relocation across multiple counties was further complicated because of the home’s chronic infestation with bed bugs. Many facilities agreed to accept the residents, but refused to allow them to bring their personal items with them, out of concern for re-infestation. The residents filed a complaint with the local Ombudsman program to assist them in retrieving their personal items. Sadly, for some of the residents this marked their third involuntary relocation in less than two years. Many of the residents had low income and had no means by which to replace their personal items, while other family mementos were irreplaceable. The local Ombudsman program worked with multiple agencies, charitable organizations, the State Office, and the Office of the Secretary of Aging to procure bed bug treatment for their cherished personal effects. Once treated, the residents were able to retrieve their personal items and create a semblance of home in their new facility.
* Nursing home residents encountered daily hazards when attempting to go out into the neighborhood because there was no sidewalk, only a busy road and in fact, a car hit one resident. This residents became motivated to see a change to improve their safety and contacted the local Ombudsman program for assistance. The Ombudsman program worked with the residents, their local Ombudsman advisory council and then involved city leaders with the result being a new safe sidewalk outside the facility. Now residents can travel with greater freedom and safety.

In addition to service in these residential settings, 12 states have expanded their laws to authorize the LTC Ombudsman program to serve individuals receiving HCBS. In four states, LTC Ombudsman programs expanded to serve individuals participating in Medicare-Medicaid or in Medicare-Medicaid plans offered under the Financial Alignment Initiative, regardless of where they reside.

1. Ombudsman programs are credible sources of information.

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

1. Ombudsman programs leverage federal dollars.

Federal funds leveraged resources from other sources for ombudsman programs. During FY 2017, 49 percent of program expenditures came from non-federal sources. The Ombudsman program’s significant use of volunteers, further leverages limited resources. The value of volunteer time contributed to the program nationwide in FY 2017 was nearly $15 million.[[115]](#footnote-115)

# PART IV: SUPPORTING THE NATIONAL

# AGING SERVICES NETWORK

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

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

## Aging and Disability Resource Centers/No Wrong Door System

***(FY 2017 $6,105,000)***

The ADRC/No Wrong Door system[[116]](#footnote-116) supports state efforts to help individuals and caregivers connect to long-term services and supports (LTSS) as well as develop more efficient and cost-effective LTSS access systems. The current LTSS system involves numerous funding streams administered by federal, state and local agencies using different access processes involving screening, intake, needs assessment, service planning, and eligibility determination. In 2016, the United States spent an estimated $366 billion on Long Term Services and Supports (LTSS).[[117]](#footnote-117) This figure includes federal, state, local, and private funding. Individuals seeking LTSS frequently find themselves confronted with a variety of organizations and requirements at a time when they are vulnerable or in crisis. This often results in people making decisions based on incomplete, and sometimes inaccurate, information about their options. Consequently, they may make decisions to purchase and/or use LTSS options that are less than optimal for the individual and more expensive than necessary, including decisions to use costly options such as nursing facility care that can quickly exhaust an individual’s personal resources and result in their spending down to Medicaid eligibility.

In response to this challenge facing our citizens and our nation, AoA and CMS worked collaboratively in 2003 to create a joint funding opportunity to support state efforts to make it easier for people to access LTSS. This initiative, known as the ADRC program, was designed to provide consumers with “visible and trusted” sources of information, one-on-one counseling, and streamlined access to services and supports.

Another major development in the evolution of the ADRC/No Wrong Door (NWD) system model occurred in 2008 when the Veterans Health Administration (VHA) – the nation’s largest integrated health care system - recognized the value of the nationwide aging and disability network and decided to purchase an evidence-based self-directed HCBS program from the ADRC/NWD system instead of building a separate LTSS access system. Veteran Directed Care (VDC), formerly Veteran Directed Home and Community Based Services (VD-HCBS) is currently offered at 67 VA Medical Centers across the country, and 2,220 Veterans at a nursing home level of care are reportedly self-directing their HCBS at home in the community.

In 2012, recognizing the accomplishments of both HHS and the VHA, as well as the lessons learned from the experience of states, ACL, CMS and the VHA issued a special funding opportunity – known as the 2012 “ADRC Part A Grant Program.” With the 2012 funding opportunity announcement, the “No Wrong Door” system framework was adopted across ACL, CMS and VHA for the ADRC Part A grants. Lessons learned from these grants demonstrated that no one agency or network could successfully implement a LTSS access system for all populations and all payers without having multiple agencies and organizations at the state and local level formally involved in the system's operations.

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

Two additional outcomes resulting from this collaboration included NWD system guidance on 1) Key Functional Elements of NWD System and 2) Sustaining NWD functions through Medicaid Administrative Match. In January 2015, CMS posted the “No Wrong Door System Reference Document for Medicaid Administrative Claiming Guidance” to help sustain the infrastructure investments that states have made over the years. NWD System Medicaid Administrative Guidance was developed to inform states about the appropriate methods for claiming Medicaid federal matching funds.

Also posted on the CMS website is the NWD System Key Elements document that describes the vision and functions of the NWD System. The ACL/CMS/VHA vision is that each state will have a single statewide NWD System to LTSS for all populations and all payers. The NWD System functions include:

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

Public Outreach and Coordination with Key Referral Sources

To be a visible source of individualized counseling and help with accessing LTSS, the NWD system must proactively engage in public education to promote broad public awareness of the resources that are available. The goal is for residents in each state to know where they can turn to for unbiased and trusted help in understanding and accessing the LTSS options that are available in their communities. A NWD system’s public education efforts gives special attention to underserved and hard-to-reach populations, including people with hearing and visual impairments and limited English speaking populations.

A fully operational NWD system has formal linkages between and among all the major pathways that people travel while transitioning from one health care setting to another or from one public program payer to another. These pathways represent critical junctures where decisions are made – usually in a time of crisis - that often determine whether a person is permanently institutionalized or transitioned back to the community. The NWD system must have formal linkages with key sources of referral including information and referral entities, nursing homes and other institutions, acute care systems, and VA Medical Centers.

Person-Centered Counseling

Person-Centered Counseling (PCC) is the NWD system term for person-centered planning, which is an approach for working with individuals in the LTSS system. Through the use of PCC, the NWD system empowers individuals to make informed choices about their LTSS options that are consistent with their personal goals. PCC also helps them to successfully navigate the various organizations, agencies and other resources in their communities that provide LTSS. PCC is very different from and requires a different skill set compared to traditional case management and other commonly used techniques for counseling individuals with LTSS needs.

It will take time for our current LTSS workforce to develop the knowledge and skills required to fully embrace and effectively use PCC. However, ACL has entered into a public/private partnership to develop and deliver the first national training program for Person Centered Thinking, Planning and Practice. In 2016, ACL pilot tested the training in 13 NWD System states across 1,200 learners including representation from AAAs, ADRCs and CILs. This blended learning design, of online and in-person courses, allows learners to obtain key knowledge, skills, and abilities of person centered counseling that can be applied across all ADRC/NWD activity. As a result of this focus on person-centeredness, ADRC/NWD Systems have accelerated change by streamlining resources that put the focus on the needs of the people and their families.

Streamlined Access to Public LTSS Programs

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

For example, the NWD system person-centered counselors can help ensure applications are completely filled out with all the information needed when the applicant applies for public assistance, thereby reducing the burden of the application process for both intake staff and consumers. Even if the NWD system person-centered counselor is not designated to do the preliminary assessment, the data gathered by the NWD system person-centered counselor during the PCC process is incorporated into the preliminary assessment and then automatically transferred into the final assessment process.

State Governance and Administration

The governance and administration of a NWD system involves a collaborative effort among multiple state agencies, since no one state agency has the authority or expertise to carry out all of the functions involved in a NWD system as envisioned by ACL, CMS and VHA. Its governing body is responsible for coordinating the on-going development, implementation, financing, evaluation and continual improvement of the state's NWD system. It includes representatives from the State Medicaid Agency, the State Unit on Aging, and the state agencies that serve or represent the interests of individuals with physical disabilities, individuals with intellectual and developmental disabilities, and the state authorities administering mental health services. NWD systems also include a robust Management Information System (MIS) that builds on and leverages existing state MIS systems, which is essential for a state to be able to effectively gather and manage information from the many entities that will be carrying out NWD system functions, as well as from individual consumers who use the NWD system. The NWD system’s Continuous Quality Improvement process involves getting input and feedback from the many different customers who use or interact with the NWD system, including individuals and their families, system partners, advocates, providers and professionals in the health and LTSS systems, on the responsiveness of the NWD system to their varying needs.

A sample of results of ADRC/NWD system investments to date include:

* Over 1,322 access points are designated across 56 states, territories, and the District of Columbia. This includes: over 620 local Area Agencies on Aging and Aging and Disability Resource Centers, 331 Centers for Independent Living, 56 Statewide Independent Living Councils, 67 University Centers for Excellence in Developmental Disabilities Education, Research, and Service, and 242 Tribal Organizations;
* Over 27 million ADRC contacts have been made to help streamline access to LTSS;
* 41 states/territories have ADRC/NWD System legislation or gubernatorial support in response to this vision;
* 42 states/territories with ADRC program sites conducted care transitions through formal intervention; and
* 303 sites in 43 states/territories reported serving clients with institutional transition from nursing facility (both Money Follows the Person (MFP) demonstration funding and non-MFP related) back into the community.

## Aging Network Support Activities

***(FY 2017: $9,961,000)***

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

ACL awards competitive grants, cooperative agreements, and contracts for Aging Network Support Activities to eligible public or private agencies and organizations, states and area agencies on aging, institutions of higher learning, and other organizations representing and/or serving older people, including faith-based organizations. Grantees are required to provide a match equal to 25 percent of the project’s total cost. External experts review project proposals, and project awards are made for periods of one to four years.

To ensure that older Americans have access to the highest quality home and community-based services (HCBS) system, the national aging services network must continually enhance program design and delivery in key priority areas. To address this critical need, ACL supports a cooperative agreement that is documenting and reporting on Area Agency on Aging and Tribal organizations’ activities and expertise in the delivery of community-based services through surveys and the highlighting of best practices. In FY 2016, the project conducted data collection for the biannual [National Survey of Area Agencies on Aging](https://www.n4a.org/2017aaasurvey) which was released in 2017. Additionally, in 2016, the project released a report examining the state of IT in AAAs across the country. The report, “[Information Technology in Area Agencies on Aging](https://www.n4a.org/Files/UPDATE%20Information%20Technology%20in%20AAAs%20-%20Report%20from%202015%20National%20Survey.pdf),” identified issues and barriers AAAs face in addressing IT needs.

***National Eldercare Locator***

In FY 2017, ACL awarded a cooperative agreement in the amount of $1,577,451 to continue operation of the Eldercare Locator. The Eldercare Locator is the only national information and referral resource to provide support to older adults and family caregivers seeking assistance on a wide array of needs related to aging. Through its call center (800.677.1116), which operates five days a week from 9:00 a.m. to 8:00 p.m. Eastern Time, and website (eldercare.acl.gov), the Locator helps consumers navigate the maze of federal, state and local resources to find the assistance they need. The Eldercare Locator website contains a geographical search tool and offers users the ability to chat with an information specialist. Older adults and caregivers contact the Locator to find local resources involving a broad range of services including transportation and in-home services and supports. Call volume to the Eldercare Locator continues to increase with over 350,000 individuals served in 2017 compared to 308,637 in 2016. An additional 473,000 individuals accessed resources through the website.

***National Alzheimer’s Call Center***

In FY 2017, ACL awarded a cooperative agreement in the amount of $933,571 to continue operation of the 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. The National Alzheimer’s Call Center is available to people in all states, 24 hours a day, seven days a week, 365 days a year to provide expert advice, care consultation, and information and referrals at the national and local levels regarding Alzheimer’s disease. Trained professional customer service staff and master’s level social workers are available at all times. In 2017, the National Alzheimer’s Call Center handled over 307,000 requests for assistance with approximately 49,000 of these calls were referred for care consultations. Care consultants with master’s degrees in social work or counseling provide empathy, care planning, access to community resources and enlist the help of first responders in emergencies.

The National Alzheimer’s Call Center focuses on the consumer, not professionals. Information provided may include basic information on caregiving; handling legal issues; resources for long-distance caregiving; and tips for working with the medical community. In 2017, the top reasons callers contacted the Call Center included: assistance with handling challenging behaviors; tips for handling caregiver stress; caregivers seeking emotional support; and information on local care options.

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

The National Education and Resource Center on Women and Retirement Planning, established in 1998, provides women with access to a one-stop gateway that integrates financial information and resources on retirement, health, and planning for long-term care. This project has made user-friendly financial education and retirement planning tools available to traditionally hard-to-reach women, including low-income women, women of color, women with limited English speaking proficiency, rural, and other underserved women. Information is offered through financial and retirement planning programs, workshops tailored to meet women’s special needs, and publications in hard copy and web-based formats, including materials designed to identify and prevent fraud and financial exploitation of older persons. In 2017 the Center presented more than 20 trainings and workshops to underserved older women and professionals who serve them, in partnership with organizations such as the American Bar Association Commission on Law and Aging, the National Council on Aging, and the American Association of Service Coordinators. The Center is funded through a 5-year cooperative agreement between ACL and the Women’s Institute for a Secure Retirement (WISER). In FY 2017, ACL awarded WISER $231,526 (representing funds for year 4 of 5).

***National Minority Aging Organizations Technical Assistance Centers***

The National Minority Aging Organizations (NMAO) Technical Assistance Centers Program works to reduce or eliminate health disparities among racial and ethnic minority older individuals. In FY 2017, five national non-profit organizations received a total of approximately $1,150,000 for the third year of five-year cooperative agreements to continue providing training and technical assistance to professionals serving African American, Hispanic, Asian, Native Hawaiian or other Pacific Islander descent, American Indian and Alaska Native elders, and older lesbian, gay, bisexual, and transgender (LGBT) adults, as well as to older consumers and their families.

Each NMAO project develops and pilots practical, community-based interventions for reaching older individuals who experience barriers to accessing home and community-based services. Interventions focus on barriers due to language and low literacy, as well as those directly related to cultural diversity. Strategies developed under this program incorporate the latest technology and facilitate the generation and dissemination of knowledge in forms that can assist racial and ethnic minority older individuals to practice positive health behaviors and strengthen their capacity to maintain active, independent life styles. Select examples of technical assistance, training and related activities conducted by several of the grantees during FY 2017 include:

* The Asociacion Nacional Pro Personas Mayores (ANPPM) delivered a webinar for the 622 area agencies on aging on the importance of cultural diversity perspectives in service delivery. The webinar, which reached more than 1,800 professionals, also addressed cultural competency issues in the recruitment of personnel in the aging network;
* Services and Advocacy for LGBT Elders (SAGE) conducted virtual and in-person trainings reaching more than three thousand professionals nationwide, for a total of 17,500 over the life of the grant to date, to more competently and sensitively address the service and support needs of older LGBT individuals and their family caregivers and the development of over 62 new educational materials and resources;
* The National Asian Pacific Center on Aging (NAPCA), in conjunction with several of their co-grantees on this project and other national organizations developed 38 technical assistance products for the aging network, including fact sheets on caregiver support, emotional abuse, neglect and the *Dementia Friends Curriculum*. Products are developed in English and translated into Chinese, Korean, Vietnamese, Japanese, Samoan and other languages; and
* The National Caucus on Black Aging (NCBA) partnered with the American Society on Aging to co-host “The Washington DC Roundtable Training Series.” Attendees from across public, private, education and government organizations attended these sessions to learn about national and community-based trends, advances, and policy impacting the field of aging.

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

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

There are an estimated 100,000 to 130,000 survivors of the Holocaust living in the United States. The youngest survivors are in their early 70’s; however, many are much older and nearly 25 percent of them live in poverty.[[118]](#footnote-118) In FY 2015, Congress appropriated funds “to help provide supportive services for aging Holocaust survivors living in the United States.” That same year, AoA issued a funding opportunity intended to build capacity for providing person-centered, trauma-informed (PCTI) supportive services for Holocaust survivors and to expand the use of these practices by the broader aging services network with any older adult population who has a history of trauma.

In FY 2017, AoA funded the third year of a five-year cooperative agreement in the amount of $2,500,000 in which the grantee is focusing on two priority areas: 1) advancing innovations in the delivery of PCTI supportive services to Holocaust survivors living in the U.S., while 2) improving the nation’s overall capacity to delivery PCTI health and human services for older adults. The grantee worked closely with a second cohort of more than 20 sub-grantees to develop and administer a range of programs and interventions in the areas of physical and mental health, accessibility and family caregiver support. In FY 2017, the second year for which data was available from the grantee, the project reached over 15,100 persons, including providing services to Holocaust survivors and family caregivers, and the training of professionals who work with them. Preliminary outcome reported suggests that the interventions being developed and deployed are leading to decreases in isolation, loneliness, depression and increases in feelings of safety, security and independence among survivors while the family caregivers who are served are reporting reductions in stress. Additionally, many of the techniques developed for use specifically with Holocaust survivors are undergoing translation for use more broadly with other populations of older adults with histories of trauma resulting in greater awareness and understanding of the concept and practice of trauma-informed care in the aging services network.

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# Appendix

## Formula Grant Funding Allocations by State, Territory and Tribal Organizations

**U.S. Administration on Aging**

**Department of Health and Human Services**

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| --- | --- | --- | --- | --- | --- | --- |
| **State** | **Supportive Services** | **Congregate Meals** | **Home Meals** | **Preventive Services** | **NFCSP** | **Total Title III** |
| Alabama | $5,286,709  | $6,654,431  | $3,434,588  | $308,926  | $2,266,907  | $17,951,561  |
| Alaska | $1,736,115  | $2,229,088  | $1,125,270  | $98,321  | $746,423  | $5,935,217  |
| Arizona | $6,936,367  | $9,496,851  | $4,901,661  | $391,781  | $3,406,048  | $25,132,708  |
| Arkansas | $3,425,288  | $4,121,928  | $2,113,944  | $196,188  | $1,437,065  | $11,294,413  |
| California | $33,831,124  | $45,730,530  | $23,603,150  | $1,976,890  | $15,484,352  | $120,626,046  |
| Colorado | $4,713,557  | $6,453,514  | $3,330,888  | $266,214  | $2,027,990  | $16,792,163  |
| Connecticut | $4,309,094  | $5,189,037  | $2,555,699  | $242,170  | $1,730,978  | $14,026,978  |
| Delaware | $1,736,115  | $2,229,088  | $1,125,270  | $98,321  | $746,423  | $5,935,217  |
| District of Columbia | $1,736,115  | $2,229,088  | $1,125,270  | $98,321  | $746,423  | $5,935,217  |
| Florida | $24,715,567  | $32,559,130  | $16,804,923  | $1,444,234  | $12,289,080  | $87,812,934  |
| Georgia | $8,496,385  | $11,632,730  | $6,004,065  | $479,862  | $3,739,484  | $30,352,526  |
| Hawaii | $1,736,115  | $2,229,088  | $1,125,270  | $98,321  | $746,423  | $5,935,217  |
| Idaho | $1,736,115  | $2,229,088  | $1,125,270  | $98,321  | $746,423  | $5,935,217  |
| Illinois | $14,210,793  | $17,113,676  | $8,351,441  | $779,954  | $5,501,430  | $45,957,294  |
| Indiana | $6,777,591  | $8,533,317  | $4,404,348  | $396,043  | $2,886,096  | $22,997,395  |
| Iowa | $4,168,738  | $5,030,686  | $2,255,215  | $215,352  | $1,553,739  | $13,223,730  |
| Kansas | $3,358,672  | $4,049,004  | $1,931,835  | $177,748  | $1,298,812  | $10,816,071  |
| Kentucky | $4,638,742  | $5,928,874  | $3,060,102  | $271,061  | $1,976,309  | $15,875,088  |
| Louisiana | $4,692,188  | $5,825,212  | $3,006,599  | $274,184  | $1,919,754  | $15,717,937  |
| Maine | $1,736,115  | $2,229,088  | $1,130,464  | $98,321  | $746,423  | $5,940,411  |
| Maryland | $5,730,772  | $7,536,434  | $3,889,821  | $334,873  | $2,507,616  | $19,999,516  |
| Massachusetts | $8,031,575  | $9,682,464  | $4,718,223  | $431,595  | $3,146,938  | $26,010,795  |
| Michigan | $11,012,313  | $13,877,129  | $7,162,479  | $643,495  | $4,686,446  | $37,381,862  |
| Minnesota | $5,380,738  | $7,138,238  | $3,684,298  | $314,419  | $2,436,131  | $18,953,824  |
| Mississippi | $3,201,939  | $3,856,890  | $1,990,678  | $181,971  | $1,303,412  | $10,534,890  |
| Missouri | $6,964,495  | $8,382,377  | $4,290,047  | $392,454  | $2,893,349  | $22,922,722  |
| Montana | $1,736,115  | $2,229,088  | $1,125,270  | $98,321  | $746,423  | $5,935,217  |
| Nebraska | $2,245,310  | $2,711,414  | $1,261,576  | $115,812  | $851,506  | $7,185,618  |
| Nevada | $2,696,093  | $3,691,325  | $1,905,224  | $152,271  | $1,209,218  | $9,654,131  |
| New Hampshire | $1,736,115  | $2,229,088  | $1,125,270  | $98,321  | $746,423  | $5,935,217  |
| New Jersey | $10,041,037  | $12,068,583  | $6,053,936  | $575,762  | $4,076,037  | $32,815,355  |
| New Mexico | $2,065,826  | $2,828,401  | $1,459,839  | $118,125  | $956,216  | $7,428,407  |
| New York | $23,758,307  | $28,674,216  | $13,344,159  | $1,276,434  | $8,972,729  | $76,025,845  |
| North Carolina | $9,661,736  | $13,228,258  | $6,827,574  | $545,679  | $4,459,693  | $34,722,940  |
| North Dakota | $1,736,115  | $2,229,088  | $1,125,270  | $98,321  | $746,423  | $5,935,217  |
| Ohio | $13,518,024  | $16,229,847  | $8,349,511  | $775,056  | $5,525,464  | $44,397,902  |
| Oklahoma | $4,185,770  | $5,029,929  | $2,590,327  | $238,697  | $1,737,501  | $13,782,224  |
| Oregon | $4,253,413  | $5,823,512  | $3,005,722  | $240,226  | $1,925,376  | $15,248,249  |
| Pennsylvania | $17,493,327  | $21,066,919  | $9,742,844  | $944,437  | $6,680,302  | $55,927,829  |
| Rhode Island | $1,736,115  | $2,229,088  | $1,125,270  | $98,321  | $746,423  | $5,935,217  |
| South Carolina | $5,049,895  | $6,914,007  | $3,568,565  | $285,210  | $2,298,360  | $18,116,037  |
| South Dakota | $1,736,115  | $2,229,088  | $1,125,270  | $98,321  | $746,423  | $5,935,217  |
| Tennessee | $6,614,031  | $8,879,923  | $4,583,244  | $386,485  | $2,986,246  | $23,449,929  |
| Texas | $21,079,481  | $28,860,736  | $14,896,051  | $1,190,534  | $9,437,277  | $75,464,079  |
| Utah | $2,002,579  | $2,741,809  | $1,415,145  | $113,103  | $906,192  | $7,178,828  |
| Vermont | $1,736,115  | $2,229,088  | $1,125,270  | $98,321  | $746,423  | $5,935,217  |
| Virginia | $7,694,882  | $10,481,870  | $5,410,065  | $449,644  | $3,488,747  | $27,525,208  |
| Washington | $6,749,725  | $9,241,311  | $4,769,769  | $381,213  | $3,005,315  | $24,147,333  |
| West Virginia | $2,713,561  | $3,272,888  | $1,512,100  | $141,994  | $990,988  | $8,631,531  |
| Wisconsin | $6,252,199  | $7,958,356  | $4,107,590  | $362,965  | $2,721,498  | $21,402,608  |
| Wyoming | $1,736,115  | $2,229,088  | $1,125,270  | $98,321  | $746,423  | $5,935,217  |
| American Samoa | $462,103  | $588,895  | $140,659  | $12,290  | $93,303  | $1,297,250  |
| Guam | $868,057  | $1,114,544  | $562,635  | $49,161  | $373,212  | $2,967,609  |
| Northern Mariana Islands | $217,014  | $278,636  | $140,659  | $12,290  | $93,303  | $741,902  |
| Puerto Rico | $4,280,343  | $5,247,083  | $2,716,380  | $250,119  | $1,927,485  | $14,421,410  |
| Virgin Islands | $868,057  | $1,114,544  | $562,635  | $49,161  | $373,212  | $2,967,609  |
| **TOTAL** | **$347,222,912**  | **$445,817,602**  | **$225,053,917**  | **$19,664,255**  | **$149,284,615**  | **$1,187,043,301**  |

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| **State** | **Ombudsman** | **Elder Abuse** | **Total Title VII** |
| Alabama | $241,378  | $76,215  | $317,593  |
| Alaska | $79,072  | $23,712  | $102,784  |
| Arizona | $344,482  | $84,481  | $428,963  |
| Arkansas | $148,565  | $48,157  | $196,722  |
| California | $1,658,799  | $471,073  | $2,129,872  |
| Colorado | $234,091  | $57,391  | $291,482  |
| Connecticut | $179,611  | $59,907  | $239,518  |
| Delaware | $79,072  | $23,712  | $102,784  |
| District of Columbia | $79,072  | $23,712  | $102,784  |
| Florida | $1,181,028  | $344,252  | $1,525,280  |
| Georgia | $421,958  | $103,450  | $525,408  |
| Hawaii | $79,072  | $23,712  | $102,784  |
| Idaho | $79,072  | $23,712  | $102,784  |
| Illinois | $586,928  | $197,384  | $784,312  |
| Indiana | $309,532  | $98,224  | $407,756  |
| Iowa | $158,494  | $55,927  | $214,421  |
| Kansas | $135,767  | $45,843  | $181,610  |
| Kentucky | $215,060  | $66,595  | $281,655  |
| Louisiana | $211,300  | $68,518  | $279,818  |
| Maine | $79,448  | $23,712  | $103,160  |
| Maryland | $273,372  | $78,087  | $351,459  |
| Massachusetts | $331,591  | $109,606  | $441,197  |
| Michigan | $503,370  | $160,862  | $664,232  |
| Minnesota | $258,928  | $76,347  | $335,275  |
| Mississippi | $139,902  | $45,198  | $185,100  |
| Missouri | $301,499  | $97,643  | $399,142  |
| Montana | $79,072  | $23,712  | $102,784  |
| Nebraska | $88,662  | $29,770  | $118,432  |
| Nevada | $133,897  | $32,827  | $166,724  |
| New Hampshire | $79,072  | $23,712  | $102,784  |
| New Jersey | $425,463  | $143,950  | $569,413  |
| New Mexico | $102,596  | $26,393  | $128,989  |
| New York | $937,811  | $318,066  | $1,255,877  |
| North Carolina | $479,833  | $126,782  | $606,615  |
| North Dakota | $79,072  | $23,712  | $102,784  |
| Ohio | $586,793  | $197,185  | $783,978  |
| Oklahoma | $182,045  | $60,208  | $242,253  |
| Oregon | $211,238  | $56,795  | $268,033  |
| Pennsylvania | $684,715  | $242,944  | $927,659  |
| Rhode Island | $79,072  | $23,712  | $102,784  |
| South Carolina | $250,794  | $63,080  | $313,874  |
| South Dakota | $79,072  | $23,712  | $102,784  |
| Tennessee | $322,105  | $91,810  | $413,915  |
| Texas | $1,046,876  | $274,281  | $1,321,157  |
| Utah | $99,455  | $24,837  | $124,292  |
| Vermont | $79,072  | $23,712  | $102,784  |
| Virginia | $380,213  | $102,820  | $483,033  |
| Washington | $335,213  | $86,291  | $421,504  |
| West Virginia | $106,066  | $36,736  | $142,802  |
| Wisconsin | $288,676  | $90,309  | $378,985  |
| Wyoming | $79,072  | $23,712  | $102,784  |
| American Samoa | $9,884  | $2,964  | $12,848  |
| Guam | $39,536  | $11,856  | $51,392  |
| Northern Mariana Islands | $9,884  | $2,964  | $12,848  |
| Puerto Rico | $189,058  | $54,217  | $243,275  |
| Virgin Islands | $39,536  | $11,856  | $51,392  |
| **TOTAL** | **$15,814,316**  | **$4,742,357**  | **$20,556,673**  |

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| **State/Territory** | **Nutrition Services Incentive Program** |
| Alabama | $3,261,708  |
| Alaska | $482,222  |
| Arizona | $1,749,512  |
| Arkansas | $2,473,090  |
| California | $13,095,077  |
| Colorado | $1,381,678  |
| Connecticut | $1,549,754  |
| Delaware | $531,121  |
| District of Columbia | $787,624  |
| Florida | $6,116,211  |
| Georgia | $2,853,558  |
| Hawaii | $484,828  |
| Idaho | $772,996  |
| Illinois | $5,771,528  |
| Indiana | $1,402,692  |
| Iowa | $1,673,647  |
| Kansas | $2,071,571  |
| Kentucky | $1,639,806  |
| Louisiana | $3,408,033  |
| Maine | $595,649  |
| Maryland | $1,627,181  |
| Massachusetts | $5,122,935  |
| Michigan | $7,676,756  |
| Minnesota | $1,798,504  |
| Mississippi | $1,520,183  |
| Missouri | $3,981,217  |
| Montana | $813,098  |
| Nebraska | $1,118,879  |
| Nevada | $1,458,299  |
| New Hampshire | $1,332,416  |
| New Jersey | $3,558,963  |
| New Mexico | $2,328,708  |
| New York | $16,520,195  |
| North Carolina | $3,295,202  |
| North Dakota | $805,159  |
| Ohio | $5,678,193  |
| Oklahoma | $2,058,212  |
| Oregon | $1,889,136  |
| Pennsylvania | $6,349,218  |
| Rhode Island | $424,242  |
| South Carolina | $1,701,588  |
| South Dakota | $885,224  |
| Tennessee | $1,628,108  |
| Texas | $11,447,247  |
| Utah | $1,307,393  |
| Vermont | $810,909  |
| Virginia | $2,019,748  |
| Washington | $2,248,459  |
| West Virginia | $1,520,860  |
| Wisconsin | $2,795,630  |
| Wyoming | $855,934  |
| American Samoa | $135,437  |
| Guam | $400,139  |
| Northern Mariana Islands | $48,929  |
| Puerto Rico | $2,932,078  |
| Virgin Islands | $182,777  |
| **TOTAL** | **$152,379,461**  |

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| **State** | **Tribe No.** | **Grantee Name** |  **TITLE6 A/B** |  **TITLE6 C** | **NSIP** |
| AK | 01 | Aleutian Pribilof Islands Association, Inc. | $107,430 | $34,550 | $8,230 |
| AK | 02 | Association of Village Council Presidents | $137,640 | $0 | $21,307 |
| AK | 03 | Bristol Bay Native Association | $137,640 | $48,380 | $5,673 |
| AK | 04 | Central Council Tlingit & Haida Indian Tribes of AK | $180,720 | $55,280 | $1,368 |
| AK | 06 | Copper River Native Association | $83,960 | $20,730 | $7,428 |
| AK | 07 | Hoonah Indian Association | $83,960 | $20,730 | $1,453 |
| AK | 08 | Kodiak Area Native Association - Northern Region | $73,990 | $13,820 | $2,671 |
| AK | 09 | Kodiak Area Native Association - Southern Region | $73,990 | $13,820 | $3,568 |
| AK | 10 | Metlakatla Indian Community | $95,340 | $27,640 | $2,857 |
| AK | 11 | Native Village of Barrow | $118,820 | $41,470 | $24,672 |
| AK | 12 | Tanana Chiefs Conference for Kuskokwim subregion | $83,960 | $20,730 | $316 |
| AK | 13 | Tanana Chiefs Conference for Lower Yukon Subregion | $73,990 | $13,820 | $3,028 |
| AK | 14 | Tanana Chiefs Conference for Yukon Flats Subregion | $73,990 | $13,820 | $1,289 |
| AK | 15 | Tanana Chiefs Conference for Yukon Koyukuk Subregion | $83,960 | $20,730 | $1,721 |
| AK | 16 | Tanana Chiefs Conference for Yukon Tanana Subregion | $73,990 | $13,820 | $394 |
| AK | 17 | Fairbanks Native Association | $137,640 | $48,380 | $3,467 |
| AK | 19 | Maniilaq Association | $137,640 | $48,380 | $14,102 |
| AK | 20 | Native Villiage of Unalakleet | $83,960 | $20,730 | $7,171 |
| AK | 21 | Chugachmiut | $83,960 | $20,730 | $2,382 |
| AK | 22 | Arctic Slope Native Association, Limited | $83,960 | $20,730 | $20,312 |
| AK | 23 | Denakkanaaga, Inc. | $95,340 | $27,640 | $155 |
| AK | 24 | Klawock Cooperative Association | $73,990 | $13,820 | $1,033 |
| AK | 25 | Kootznoowoo Inc. | $73,990 | $13,820 | $1,595 |
| AK | 26 | Gwichyaa Zhee Gwich'in Tribal Government | $73,990 | $13,820 | $5,518 |
| AK | 27 | Native Village of Point Hope | $73,990 | $13,820 | $3,184 |
| AK | 28 | Seldovia Village Tribe | $73,990 | $13,820 | $1,331 |
| AK | 30 | Sitka Tribes of Alaska | $107,430 | $34,550 | $1,223 |
| AK | 32 | Ketchikan Indian Community | $137,640 | $48,380 | $7,300 |
| AK | 35 | Southcentral Foundation | $180,720 | $55,280 | $16,622 |
| AK | 36 | Kenaitze Indian Tribe | $137,640 | $48,380 | $6,690 |
| AK | 37 | Wrangell Cooperative Association | $83,960 | $20,730 | $1,489 |
| AK | 38 | Native Village of Savoonga | $83,960 | $20,730 | $11,821 |
| AK | 39 | Native Village of Gambell | $83,960 | $20,730 | $4,911 |
| AK | 40 | Native Village of Eyak Traditional Council | $73,990 | $13,820 | $1,760 |
| AK | 41 | Organized Village of Kake | $73,990 | $13,820 | $1,832 |
| AK | 42 | Chickaloon Native Village | $107,430 | $0 | $2,605 |
| AK | 44 | Galena Village (aka Louden Village Council) | $83,960 | $20,730 | $20,822 |
| AK | 45 | Asa'carsarmiut Tribe | $73,990 | $0 | $2,119 |
| AK | 46 | Orutsararmuit Native Council | $107,430 | $34,550 | $8,651 |
| AK | 47 | Chilkoot Indian Association | $83,960 | $20,730 | $652 |
| AK | 48 | Knik Tribe | $137,640 | $0 | $8,640 |
| AK | 49 | Yakutat Tlingit Tribe | $73,990 | $13,820 | $1,066 |
| AK | 50 | Craig Tribal Association | $73,990 | $13,820 | $1,043 |
| AK | 51 | Organized Village of Saxman | $73,990 | $13,820 | $730 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$4,255,500* | *$1,008,920* | *$246,201* |
| AL | 01 | Poarch Band of Creek Indians | $137,640 | $48,380 | $21,528 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$137,640* | *$48,380* | *$21,528* |
| AZ | 02 | Colorado River Indian Tribes | $137,640 | $48,380 | $6,102 |
| AZ | 03 | Gila River Indian Community | $137,640 | $48,380 | $24,972 |
| AZ | 04 | Hopi Tribe | $137,640 | $48,380 | $12,476 |
| AZ | 05 | Hualapai Tribe | $83,960 | $20,730 | $17,118 |
| AZ | 06 | Navajo Nation | $180,720 | $55,280 | $35,178 |
| AZ | 07 | Pascua Yaqui Tribe | $137,640 | $48,380 | $35,645 |
| AZ | 09 | Salt River Pima-Maricopa Indian Community | $118,820 | $41,470 | $13,395 |
| AZ | 10 | San Carlos Apache Older Adult Center | $180,720 | $55,280 | $8,296 |
| AZ | 11 | Tohono O'odham Nation | $180,720 | $55,280 | $10,463 |
| AZ | 12 | White Mountain Apache Tribe | $180,720 | $55,280 | $21,735 |
| AZ | 13 | Ak-Chin Indian Community | $73,990 | $0 | $8,287 |
| AZ | 14 | Yavapai-Apache Tribe | $83,960 | $0 | $4,254 |
| AZ | 15 | Havasupai Tribe | $83,960 | $20,730 | $3,358 |
| AZ | 16 | Inter-Tribal Council of Arizona, Inc. | $83,960 | $20,730 | $1,279 |
| AZ | 17 | Cocopah Indian Tribe | $73,990 | $0 | $13,730 |
| AZ | 18 | Quechan Indian Tribe | $95,340 | $27,640 | $13,421 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$1,971,420* | *$545,940* | *$229,709* |
| CA | 01 | Bishop Paiute Tribe | $83,960 | $20,730 | $3,870 |
| CA | 02 | Blue Lake Rancheria | $73,990 | $13,820 | $26,445 |
| CA | 06 | Karuk Tribe | $95,340 | $27,640 | $5,023 |
| CA | 07 | Pit River Health Service, Inc. | $107,430 | $0 | $5,537 |
| CA | 08 | Picayune Rancheria of the Chukchansi Indians | $73,990 | $13,820 | $6,421 |
| CA | 09 | Riverside-San Bernardino Co. Indian Health-Morongo | $95,340 | $27,640 | $1,779 |
| CA | 10 | Riverside-San Bernardino Co. Indian Health-Pechanga | $73,990 | $13,820 | $2,074 |
| CA | 11 | Riverside-San Bernardino Co. Indian Health-Soboba/ | $73,990 | $13,820 | $3,679 |
| CA | 12 | Sonoma County Indian Health Project - Sonoma | $73,990 | $0 | $9,480 |
| CA | 13 | Southern Indian Health Council, Inc. - Area I | $73,990 | $13,820 | $13,615 |
| CA | 14 | Southern Indian Health Council, Inc. - Area II | $73,990 | $13,820 | $12,388 |
| CA | 15 | Toiyabe Indian Health Project, Inc. - Northern | $73,990 | $13,820 | $10,311 |
| CA | 16 | Tule River Indian Health Center, Inc. | $83,960 | $20,730 | $19,357 |
| CA | 17 | United Indian Health Services Inc. for Resighini | $95,340 | $27,640 | $9,583 |
| CA | 18 | United Indian Health Services Inc. for Tolowa | $137,640 | $48,380 | $12,856 |
| CA | 20 | Indian Senior Center, Inc. | $83,960 | $20,730 | $13,313 |
| CA | 21 | Sonoma County Indian Health Project - Manchester | $73,990 | $0 | $4,832 |
| CA | 25 | Pala Band of Mission Indians | $83,960 | $0 | $13,887 |
| CA | 26 | Redding Rancheria | $137,640 | $48,380 | $5,368 |
| CA | 28 | Toiyabe Indian Health Project, Inc. - Southern | $73,990 | $13,820 | $7,365 |
| CA | 29 | K'ima:w Medical Center | $95,340 | $0 | $9,103 |
| CA | 30 | Round Valley Indian Tribes Senior Center | $83,960 | $0 | $8,963 |
| CA | 31 | Fort Mojave Indian Tribe | $83,960 | $20,730 | $4,339 |
| CA | 33 | CA Indian Manpower Consortium, Inc. - Chico, | $73,990 | $13,820 | $3,275 |
| CA | 34 | CA Indian Manpower Consortium, Inc. - Big Sandy, | $83,960 | $20,730 | $5,890 |
| CA | 35 | CA Indian Manpower Consortium, Inc. - Berry Creek, | $83,960 | $20,730 | $4,094 |
| CA | 36 | CA Indian Manpower Consortium, Inc. - Coyote Valley, | $83,960 | $20,730 | $5,465 |
| CA | 37 | CA Indian Manpower Consortium, Inc. - Enterprise, | $95,340 | $27,640 | $7,801 |
| CA | 38 | Santa Ynez Tribal Health Clinic | $73,990 | $0 | $2,396 |
| CA | 39 | CA Indian Manpower Consortium, Inc. - North Fork, | $73,990 | $13,820 | $6,088 |
| CA | 40 | CA Indian Manpower Consortium, Inc. - Robinson, | $73,990 | $13,820 | $4,290 |
| CA | 41 | Wilton Rancheria | $73,990 | $0 | $2,802 |
| CA | 42 | Wiyot Tribe | $83,960 | $20,730 | $13,134 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$2,808,860* | *$525,180* | *$264,823* |
| CO | 01 | Southern Ute Indian Tribe | $95,340 | $27,640 | $6,255 |
| CO | 02 | Ute Mountain Ute Tribe | $83,960 | $0 | $16,412 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$179,300* | *$27,640* | *$22,667* |
| CT | 01 | Mohegan Tribe of Indians of Connecticut | $83,960 | $0 | $3,027 |
| CT | 02 | Mashantucket Pequot Tribal Nation | $73,990 | $0 | $1,358 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$157,950* | *$0* | *$4,385* |
| HI | 01 | Alu Like, Inc. | $1,505,000 | $55,280 | $31,313 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$1,505,000* | *$55,280* | *$31,313* |
| IA | 01 | Sac & Fox Tribe of the Mississippi in Iowa | $83,960 | $20,730 | $9,193 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$83,960* | *$20,730* | *$9,193* |
| ID | 01 | Coeur d'Alene Tribe | $83,960 | $20,730 | $18,952 |
| ID | 02 | Nez Perce Tribe | $137,640 | $48,380 | $28,035 |
| ID | 03 | Shoshone-Bannock Tribes | $118,820 | $41,470 | $20,488 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$340,420* | *$110,580* | *$67,475* |
| KS | 01 | Kickapoo Tribe in Kansas | $83,960 | $20,730 | $9,671 |
| KS | 02 | Prairie Band Potawatomi Nation | $95,340 | $27,640 | $28,885 |
| KS | 03 | Iowa Tribe of Kansas and Nebraska | $73,990 | $13,820 | $6,698 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$253,290* | *$62,190* | *$45,254* |
| LA | 01 | Institute for Indian Development, Inc. | $107,430 | $0 | $16,418 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$107,430* | *$0* | *$16,418* |
| MA | 01 | Wampanoag Tribe of Gay Head (Aquinnah) | $83,960 | $20,730 | $1,068 |
| MA | 02 | Mashpee Wampanoag Tribe | $107,430 | $34,550 | $3,086 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$191,390* | *$55,280* | *$4,154* |
| ME | 01 | Pleasant Point Passamaquoddy | $95,340 | $27,640 | $28,915 |
| ME | 02 | Penobscot Indian Nation | $83,960 | $0 | $4,761 |
| ME | 04 | Aroostook Band of Micmacs | $83,960 | $20,730 | $18,893 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$263,260* | *$48,370* | *$52,569* |
| MI | 01 | Grand Traverse Band of Ottawa & Chippewa Indians | $95,340 | $27,640 | $15,047 |
| MI | 02 | Inter-Tribal Council of Michigan, Inc. | $83,960 | $20,730 | $2,759 |
| MI | 03 | Keweenaw Bay Indian Community | $95,340 | $27,640 | $23,224 |
| MI | 04 | Sault Ste. Marie Tribe of Chippewa Indians | $180,720 | $0 | $18,171 |
| MI | 05 | Little Traverse Bay Bands of Odawa Indians | $118,820 | $41,470 | $3,613 |
| MI | 07 | Bay Mills Indian Community | $83,960 | $20,730 | $6,309 |
| MI | 08 | Pokagon Band of Potawatomi Indians | $95,340 | $0 | $3,904 |
| MI | 09 | Little River Band of Ottawa Indians | $107,430 | $34,550 | $6,382 |
| MI | 10 | Nottawaseppi Huron Band of the Potawatomi | $73,990 | $0 | $5,385 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$934,900* | *$172,760* | *$84,794* |
| MN | 01 | Bois Forte Band of Chippewa | $83,960 | $20,730 | $11,200 |
| MN | 02 | Fond du Lac Band of Lake Superior Chippewa | $137,640 | $48,380 | $42,236 |
| MN | 03 | Leech Lake Band of Ojibwe | $137,640 | $48,380 | $25,079 |
| MN | 07 | Red Lake Band of Chippewa Indians | $137,640 | $0 | $55,728 |
| MN | 08 | White Earth Reservation Tribal Council | $137,640 | $48,380 | $12,158 |
| MN | 09 | Grand Portage Band of Lake Superior Chippewa | $73,990 | $13,820 | $4,760 |
| MN | 10 | Mille Lacs Band of Ojibwe | $83,960 | $20,730 | $25,940 |
| MN | 11 | Lower Sioux Indian Community | $73,990 | $13,820 | $4,730 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$866,460* | *$214,240* | *$181,831* |
| MS | 01 | Mississippi Band of Choctaw Indians | $137,640 | $48,380 | $23,989 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$137,640* | *$48,380* | *$23,989* |
| MT | 01 | Fort Peck Assiniboine and Sioux Tribes | $137,640 | $48,380 | $42,236 |
| MT | 02 | Blackfeet Tribe - Eagle Shield Center | $137,640 | $48,380 | $28,780 |
| MT | 03 | Chippewa Cree Tribe Senior Citizens Department | $107,430 | $34,550 | $52,735 |
| MT | 04 | Confederated Salish and Kootenai Tribes | $137,640 | $48,380 | $4,055 |
| MT | 05 | Fort Belknap Indian Community | $107,430 | $34,550 | $17,553 |
| MT | 06 | Northern Cheyenne Elderly Program | $118,820 | $41,470 | $29,023 |
| MT | 07 | Crow Tribal Elders Program | $137,640 | $48,380 | $49,638 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$884,240* | *$304,090* | *$224,020* |
| NC | 01 | Eastern Band of Cherokee Indians | $180,720 | $55,280 | $33,096 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$180,720* | *$55,280* | *$33,096* |
| ND | 01 | Spirit Lake Tribe | $95,340 | $27,640 | $42,875 |
| ND | 02 | Standing Rock Sioux Tribe | $137,640 | $48,380 | $69,057 |
| ND | 03 | Three Affiliated Tribes | $137,640 | $48,380 | $29,749 |
| ND | 04 | Trenton Indian Service Area | $95,340 | $27,640 | $1,482 |
| ND | 05 | Turtle Mountain Band of Chippewa Indians | $137,640 | $48,380 | $17,794 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$603,600* | *$200,420* | *$160,957* |
| NE | 01 | Omaha Tribe of Nebraska | $83,960 | $20,730 | $10,169 |
| NE | 02 | Santee Sioux Nation | $73,990 | $0 | $5,677 |
| NE | 03 | Winnebago Senior Citizen Center | $83,960 | $20,730 | $17,304 |
| NE | 04 | Ponca Tribe of Nebraska | $73,990 | $13,820 | $12,256 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$315,900* | *$55,280* | *$45,406* |
| NM | 01 | Eight Northern Indian Pueblos Council,Inc.(Picuris,etc) | $180,720 | $55,280 | $28,173 |
| NM | 02 | Eight Northern Indian Pueblos Council, Inc. (San | $107,430 | $34,550 | $6,742 |
| NM | 03 | Five Sandoval Indian Pueblos, Inc. | $107,430 | $34,550 | $8,154 |
| NM | 04 | Jicarilla Apache Nation | $118,820 | $41,470 | $23,151 |
| NM | 05 | Laguna Rainbow Corporation | $180,720 | $55,280 | $18,100 |
| NM | 06 | Mescalero Apache Tribe Elderly Program | $107,430 | $0 | $8,941 |
| NM | 07 | Pueblo de Cochiti Elder Program | $83,960 | $20,730 | $7,543 |
| NM | 09 | Pueblo of Isleta Elder Center | $137,640 | $0 | $26,798 |
| NM | 10 | Pueblo of Jemez Senior Citizens Program | $137,640 | $48,380 | $9,787 |
| NM | 11 | Pueblo of San Felipe Elderly Services Program | $137,640 | $48,380 | $32,806 |
| NM | 12 | Taos Pueblo Senior Citizens Program | $95,340 | $27,640 | $9,918 |
| NM | 13 | Zuni Tribe | $180,720 | $55,280 | $21,349 |
| NM | 14 | Ohkay Owingeh Senior Citizens Program | $137,640 | $48,380 | $14,651 |
| NM | 15 | Santa Clara Pueblo Senior Center | $137,640 | $48,380 | $29,036 |
| NM | 16 | Santo Domingo Tribe | $137,640 | $48,380 | $18,301 |
| NM | 17 | Pueblo of Tesuque | $73,990 | $13,820 | $7,424 |
| NM | 18 | Pueblo of Acoma | $107,430 | $34,550 | $15,460 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$2,169,830* | *$615,050* | *$286,334* |
| NV | 01 | Fallon Paiute-Shoshone Tribes | $83,960 | $20,730 | $21,025 |
| NV | 02 | Inter-Tribal Council of Nevada, Inc. (McDermitt, etc.) | $73,990 | $13,820 | $5,390 |
| NV | 03 | Inter-Tribal Council of Nevada, Inc. (Duckwater, etc.) | $73,990 | $13,820 | $5,196 |
| NV | 04 | Inter-Tribal Council of Nevada, Inc. (Ely, etc.) | $73,990 | $13,820 | $2,658 |
| NV | 05 | Shoshone-Paiute Tribes | $107,430 | $34,550 | $8,581 |
| NV | 06 | Walker River Paiute Tribe | $83,960 | $20,730 | $10,007 |
| NV | 07 | Washoe Tribe of Nevada and California | $83,960 | $20,730 | $15,471 |
| NV | 08 | Yerington Paiute Tribe | $73,990 | $13,820 | $7,272 |
| NV | 09 | Pyramid Lake Paiute Tribe | $83,960 | $20,730 | $7,043 |
| NV | 10 | Elko Band Council | $83,960 | $20,730 | $8,909 |
| NV | 11 | Reno-Sparks Indian Colony | $83,960 | $20,730 | $14,290 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$907,150* | *$214,210* | *$105,842* |
| NY | 01 | Saint Regis Mohawk Tribe | $137,640 | $48,380 | $10,839 |
| NY | 02 | Seneca Nation Area Office for the Aging | $137,640 | $48,380 | $19,465 |
| NY | 04 | Oneida Indian Nation Elders Program | $83,960 | $20,730 | $4,646 |
| NY | 05 | Shinnecock Indian Nation | $83,960 | $20,730 | $4,363 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$443,200* | *$138,220* | *$39,313* |
| OK | 01 | Apache Tribe of Oklahoma | $83,960 | $20,730 | $20,869 |
| OK | 02 | Caddo Nation of Oklahoma | $73,990 | $13,820 | $1,991 |
| OK | 03 | Cherokee Nation | $181,831 | $56,560 | $53,767 |
| OK | 04 | Cheyenne and Arapaho Tribes of Oklahoma | $137,640 | $48,380 | $6,757 |
| OK | 06 | Choctaw Nation of Oklahoma | $180,720 | $55,280 | $41,288 |
| OK | 07 | Citizen Potawatomi Nation | $180,720 | $55,280 | $12,567 |
| OK | 08 | Comanche Nation | $137,640 | $48,380 | $21,960 |
| OK | 09 | Delaware Nation | $78,960 | $13,820 | $8,846 |
| OK | 10 | Iowa Tribe of Oklahoma | $137,640 | $48,380 | $7,747 |
| OK | 12 | Kickapoo Tribe of Oklahoma | $100,000 | $20,730 | $10,587 |
| OK | 13 | Kiowa Tribe of Oklahoma | $180,720 | $55,280 | $5,421 |
| OK | 14 | Miami Tribe of Oklahoma | $137,640 | $48,380 | $38,783 |
| OK | 15 | Muscogee Creek Nation Elderly Nutrition Program | $180,720 | $55,280 | $160,095 |
| OK | 18 | Ottawa Tribe of Oklahoma | $137,640 | $48,380 | $27,995 |
| OK | 19 | Pawnee Nation of Oklahoma | $107,430 | $34,550 | $10,943 |
| OK | 20 | Peoria Tribe of Indians of Oklahoma | $118,820 | $41,470 | $13,796 |
| OK | 21 | Ponca Tribe of Indians of Oklahoma | $107,430 | $34,550 | $11,028 |
| OK | 22 | Quapaw Tribe Elders Center | $137,640 | $48,380 | $8,184 |
| OK | 23 | Sac and Fox Nation of Oklahoma | $137,640 | $48,380 | $21,890 |
| OK | 24 | Seminole Nation of Oklahoma | $137,640 | $48,380 | $14,477 |
| OK | 25 | Seneca-Cayuga Nation | $83,960 | $20,730 | $13,597 |
| OK | 26 | Wichita and Affiliated Tribes | $73,990 | $13,820 | $9,465 |
| OK | 27 | Wyandotte Nation | $137,640 | $48,380 | $16,036 |
| OK | 28 | Absentee Shawnee Tribe of Oklahoma | $180,720 | $55,280 | $25,101 |
| OK | 29 | Fort Sill Apache Tribe | $107,430 | $34,550 | $6,780 |
| OK | 31 | United Keetoowah Band of Cherokee Indians | $180,720 | $55,280 | $30,358 |
| OK | 32 | Chickasaw Nation | $180,720 | $55,280 | $129,722 |
| OK | 33 | Kaw Nation | $73,990 | $0 | $21,817 |
| OK | 34 | Osage Nation | $137,640 | $48,380 | $63,481 |
| OK | 35 | Delaware Tribes of Indians | $180,720 | $0 | $10,686 |
| OK | 36 | Alabama-Quassarte Tribal Town | $73,990 | $13,820 | $2,627 |
| OK | 37 | Eastern Shawnee Tribe of Oklahoma | $118,820 | $41,470 | $7,136 |
| OK | 38 | Otoe-Missouria Tribe of Indians | $83,960 | $20,730 | $14,301 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$4,290,721* | *$1,252,110* | *$850,098* |
| OR | 01 | Confederated Tribes of Siletz Indians | $118,820 | $41,470 | $2,455 |
| OR | 02 | Yellowhawk Tribal Health Center | $118,820 | $41,470 | $14,206 |
| OR | 03 | Confederated Tribes of Warm Springs | $137,640 | $48,380 | $10,857 |
| OR | 04 | Confederated Tribes of Grand Ronde | $107,430 | $34,550 | $12,680 |
| OR | 05 | The Klamath Tribes | $137,640 | $48,380 | $3,201 |
| OR | 06 | Confed. Tribes of Coos, Lower Umpqua & | $95,340 | $27,640 | $10,517 |
| OR | 07 | Cow Creek Band of Umpqua Tribe of Indians | $83,960 | $20,730 | $1,235 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$799,650* | *$262,620* | *$55,151* |
| RI | 01 | Narragansett Indian Tribe | $107,430 | $34,550 | $2,741 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$107,430* | *$34,550* | *$2,741* |
| SC | 01 | Catawba Indian Nation | $107,430 | $34,550 | $9,751 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$107,430* | *$34,550* | *$9,751* |
| SD | 01 | Cheyenne River Elderly Nutrition Services | $137,640 | $48,380 | $10,082 |
| SD | 02 | Crow Creek Sioux Tribe | $83,960 | $0 | $15,271 |
| SD | 03 | Lower Brule Sioux Tribe | $83,960 | $20,730 | $3,662 |
| SD | 04 | Oglala Sioux Tribe | $180,720 | $55,280 | $28,368 |
| SD | 05 | Rosebud Sioux Tribe | $180,720 | $55,280 | $32,688 |
| SD | 06 | Sisseton Wahpeton Oyate of the | $137,640 | $48,380 | $34,562 |
| SD | 08 | Yankton Sioux Tribe | $118,820 | $41,470 | $23,593 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$923,460* | *$269,520* | *$148,226* |
| TX | 01 | Alabama-Coushatta Tribe of Texas | $83,960 | $20,730 | $7,359 |
| TX | 02 | Kickapoo Traditional Tribe of Texas | $73,990 | $0 | $17,341 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$157,950* | *$20,730* | *$24,700* |
| UT | 01 | Unitah & Ouray, Ute Indian Tribe | $107,430 | $34,550 | $7,532 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$107,430* | *$34,550* | *$7,532* |
| WA | 01 | Confederated Tribes of the Colville Reservation | $137,640 | $48,380 | $17,344 |
| WA | 02 | Lower Elwha Klallam Tribe | $73,990 | $13,820 | $8,727 |
| WA | 03 | Lummi Nation | $107,430 | $34,550 | $22,019 |
| WA | 04 | Makah Tribe Senior Program | $83,960 | $20,730 | $10,995 |
| WA | 05 | Muckleshoot Indian Tribe | $83,960 | $20,730 | $48,325 |
| WA | 09 | Puyallup Tribe of Indians | $180,720 | $0 | $13,410 |
| WA | 10 | Quinault Indian Nation | $95,340 | $27,640 | $22,375 |
| WA | 13 | Swinomish Indian Tribal Community | $83,960 | $20,730 | $6,466 |
| WA | 14 | Spokane Tribes of Indians | $83,960 | $20,730 | $13,779 |
| WA | 16 | The Tulalip Tribes of Washington | $180,720 | $55,280 | $10,876 |
| WA | 17 | Jamestown S'Klallam Tribe | $83,960 | $20,730 | $12,381 |
| WA | 19 | Quileute Tribe | $73,990 | $13,820 | $5,166 |
| WA | 20 | S. Puget Intertribal Planning Agency - Shoalwater Bay | $95,340 | $27,640 | $6,107 |
| WA | 22 | Upper Skagit Indian Tribe | $73,990 | $13,820 | $2,061 |
| WA | 24 | Suquamish Indian Tribe of the | $95,340 | $27,640 | $9,462 |
| WA | 25 | Port Gamble S'Klallam Tribe | $83,960 | $20,730 | $9,371 |
| WA | 26 | Samish Indian Nation / Sauk Suiattle Tribal Consortium | $107,430 | $34,550 | $3,765 |
| WA | 27 | Cowlitz Indian Tribe | $180,720 | $55,280 | $5,205 |
| WA | 28 | Skokomish Indian Tribe | $95,340 | $27,640 | $2,499 |
| WA | 29 | Confederated Tribes of the Chehalis Reservation | $137,640 | $48,380 | $10,028 |
| WA | 30 | Nooksack Indian Tribe | $83,960 | $20,730 | $7,262 |
| WA | 31 | Yakama Nation | $137,640 | $48,380 | $2,115 |
| WA | 32 | Snoqualmie Indian Tribe | $73,990 | $13,820 | $1,567 |
| WA | 33 | S. Puget Intertribal Planning Agency - Nisqually | $137,640 | $48,380 | $3,402 |
| WA | 34 | Squaxin Island Tribe | $107,430 | $34,550 | $4,024 |
| WA | 35 | Sauk-Suiattle Indian Tribe | $73,990 | $13,820 | $6,844 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$2,754,040* | *$732,500* | *$265,575* |
| WI | 01 | Bad River Elderly Program | $83,960 | $20,730 | $10,040 |
| WI | 02 | Forest County Potawatomi Community | $73,990 | $13,820 | $9,817 |
| WI | 03 | Lac Courte Oreilles Band of Lake Superior Chippewa | $107,430 | $34,550 | $7,224 |
| WI | 04 | Lac du Flambeau Band of Lake Superior Chippewa | $95,340 | $27,640 | $16,854 |
| WI | 05 | Menominee Indian Tribe of Wisconsin | $137,640 | $48,380 | $3,600 |
| WI | 06 | Oneida Nation Elder Services | $137,640 | $48,380 | $9,444 |
| WI | 07 | Red Cliff Band of Lake Superior Chippewa | $83,960 | $20,730 | $15,475 |
| WI | 08 | St. Croix Chippewa Indians of Wisconsin | $83,960 | $20,730 | $8,054 |
| WI | 09 | Stockbridge-Munsee Community | $83,960 | $20,730 | $1,883 |
| WI | 10 | Ho-Chunk Nation | $118,820 | $41,470 | $14,132 |
| WI | 11 | Sokaogon Chippewa Community (SCC) | $73,990 | $13,820 | $3,802 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$1,080,690* | *$310,980* | *$100,325* |
| WY | 01 | Northern Arapaho Tribe | $137,640 | $0 | $13,100 |
| WY | 03 | Eastern Shoshone Tribe | $107,430 | $0 | $11,772 |
| *Subtotal* | *Subtotal* | *Subtotal* | *$245,070* | *$0* | *$24,872* |
| **Total** | **Total** | **Total** | **$30,272,931** | **$7,478,530** | **$3,690,242** |

1. AoA’s FY 2017 State Program Report. [↑](#footnote-ref-1)
2. Ibid. [↑](#footnote-ref-2)
3. Minority client refers to individuals who self-report at least one of the following racial or ethnic identities: Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islanders, American Indian or Alaska Native. [↑](#footnote-ref-3)
4. Service Units Definitions:

Personal Care = 1 Hour

Homemaker = 1 Hour

Chore = 1 Hour

Home-Delivered Meal = 1 Meal.

Adult Day Care/Adult Day Health = 1 Hour

Case Management = 1 Hour

Assisted Transportation = 1 One Way Trip

Congregate Meal = 1 Meal

Nutrition Counseling = 1 session per participant

Transportation = 1 One Way Trip

Legal Assistance = 1 hour

Nutrition Education = 1 session per participant

Information and Assistance = 1 Contact [↑](#footnote-ref-4)
5. Title III-E service units definition:

Counseling = 1 session per participant

Respite Care = 1 hour

Supplemental services = variable

Access Assistance = 1 contact

Self-Directed = variable

Information Services = 1 activity [↑](#footnote-ref-5)
6. 6 Arias E, Heron M, Xu J. United States life tables, 2013. National vital statistics reports; vol. 66 no 3. Hyattsville, MD: National Center for Health Statistics. April 11, 2017. Accessed May 1, 2019 at <https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_03.pdf> [↑](#footnote-ref-6)
7. Murphy SL, Xu JQ, Kochanek KD, Arias E. Mortality in the United States, 2017. NCHS Data Brief, no 328. Hyattsville, MD: National Center for Health Statistics. 2018. Accessed May 1, 2019 at https://www.cdc.gov/nchs/products/databriefs/db328.htm. [↑](#footnote-ref-7)
8. CMS Chartbook and Charts. Figure 13: Distribution of Medicare Fee-for-Service Beneficiaries and Medicare Spending by Number of Chronic Conditions: 2017. Chronic Condition Charts: 2017. Accessed May 1, 2019 at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook\_Charts.html [↑](#footnote-ref-8)
9. CMS Multiple Chronic Conditions Utilization/Spending State Level: All Beneficiaries by Medicare-Medicaid Enrollment and Age, 2007-2017. Accessed May 1, 2019 at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/MCC_Main.html>. [↑](#footnote-ref-9)
10. Ibid. [↑](#footnote-ref-10)
11. 2018 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>. [↑](#footnote-ref-11)
12. U.S. Census Bureau. Population Division. Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2017. Release Date: June 2018. Accessed May 1, 2019. U.S. Census Bureau, “2017 National Population Projections,” Table 3. Projected 5-Year Age Groups and Sex Composition of the Population for the United States: 2017 to 2060. Original Release Date: March 2018, Revised Release Date: September 2018. [https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html. Accessed May 1](https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html.%20Accessed%20May%201), 2019. [↑](#footnote-ref-12)
13. Ibid and Centers for Medicare & Medicaid Services, ACL analysis of 2015 Medicare Current Beneficiary Survey. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/. Accessed May 1, 2019. [↑](#footnote-ref-13)
14. AoA’s FY 2017 State Program Report. [↑](#footnote-ref-14)
15. Ibid [↑](#footnote-ref-15)
16. Centers for Medicare & Medicaid Services, ACL analysis of 2015 Medicare Current Beneficiary Survey. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/>. Accessed May 1, 2019. [↑](#footnote-ref-16)
17. Brock, D et al. “Risk Factors for Nursing Home Placement among OAA Service Recipients: Summary Analysis from Five Data Sources” Westat; U.S. Administration on Aging Contract No. 233-02-0087. http://www.aoa.gov/AoARoot/Program\_Results/POMP/docs/Risk\_Factors.pdf [↑](#footnote-ref-17)
18. Centers for Medicare & Medicaid Services, ACL analysis of 2015 Medicare Current Beneficiary Survey. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/>. Accessed May 1, 2019. [↑](#footnote-ref-18)
19. Ibid. [↑](#footnote-ref-19)
20. AoA’s FY 2017 State Program Report. [↑](#footnote-ref-20)
21. 2018 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>. [↑](#footnote-ref-21)
22. Ibid [↑](#footnote-ref-22)
23. Ibid [↑](#footnote-ref-23)
24. Ibid. [↑](#footnote-ref-24)
25. Ibid. [↑](#footnote-ref-25)
26. Chen, Ya Mei and Elaine Adams Thompson. Understanding Factors That Influence Success of Home- and Community-Based Services in Keeping Older Adults in Community Settings. 2010. Journal of Aging and Health. V. 22: 267. Accessed March 23, 2018 at: <http://jah.sagepub.com/cgi/content/abstract/22/3/267>. [↑](#footnote-ref-26)
27. Administration for Community Living, http://www.agid.acl.gov/DataGlance/. Data-at-a-Glance: American Community Survey (ACS) Public Use Microdata Sample (PUMS) 1-Year Files (2017), accessed May 1, 2019. [↑](#footnote-ref-27)
28. 2018 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov> [↑](#footnote-ref-28)
29. Muramatsu, Naoko. “Risk of Nursing Home Admission Among Older Americans: Does States’ Spending on Home and Community-Based Services Matter?” May 2007. Journal of Gerontology: Psychological Sciences. [↑](#footnote-ref-29)
30. <https://health.gov/dietaryguidelines/2015/guidelines/> and <https://www.nal.usda.gov/fnic/dietary-reference-intakes> [↑](#footnote-ref-30)
31. AoA’s FY 2017 State Program Report. [↑](#footnote-ref-31)
32. Centers for Medicare & Medicaid Services, ACL analysis of 2015 Medicare Current Beneficiary Survey. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/>. Accessed May 1, 2019 [↑](#footnote-ref-32)
33. U.S. Census Bureau, Population Division. Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2017. Release Date: June 2018, https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml.Accessed May 1, 2019 and AoA’s FY 2017 State Program Report. [↑](#footnote-ref-33)
34. 2018 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>. [↑](#footnote-ref-34)
35. Ibid. [↑](#footnote-ref-35)
36. AoA’s FY 2017 State Program Report. [↑](#footnote-ref-36)
37. Administration for Community Living, http://www.agid.acl.gov/DataGlance/. Data-at-a-Glance: American Community Survey (ACS) Public Use Microdata Sample (PUMS) 1-Year Files (2017), accessed May 1, 2019. [↑](#footnote-ref-37)
38. 2018 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>. [↑](#footnote-ref-38)
39. Cornwell, E, Waite L. Social Disconnectedness, Perceived Isolation, and Health among Older Adults. J Heath Soc Behav 2009 Mar; 50(1); 31-48 [↑](#footnote-ref-39)
40. Evaluation of Title III-C Elderly Nutrition Services Program Client Outcome Study 2017 [↑](#footnote-ref-40)
41. <http://nfesh.org/research/> (accessed January 23, 2018) [↑](#footnote-ref-41)
42. 2018 National Survey of Older Americans Act Participants. http://www.agid.acl.gov. [↑](#footnote-ref-42)
43. Thomas, K & Moe, V. The relationship between Older Americans Act Title III State Expenditures & Prevalence of Low-Care Nursing Home Residents. Health Services Research. 12.3.12. Accessed March 23, 2018 at: <http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12015/abstract> [↑](#footnote-ref-43)
44. Ibid. [↑](#footnote-ref-44)
45. 2018 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>. [↑](#footnote-ref-45)
46. Evaluation of Title III-C Elderly Nutrition Services Program Client Outcome Study 2017 [↑](#footnote-ref-46)
47. AoA’s FY 2017 State Program Report. [↑](#footnote-ref-47)
48. Ibid. [↑](#footnote-ref-48)
49. 2018 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>. [↑](#footnote-ref-49)
50. Ibid. [↑](#footnote-ref-50)
51. AoA’s FY 2017 State Program Report. [↑](#footnote-ref-51)
52. Meredith, S., Feldman, P., Frey, D., Giammarco, L., Hall, K., Arnold, K., Ray, W. A. (2002). Improving medication use in newly admitted home healthcare patients: A randomized controlled trial. Journal of the American Geriatrics Society, 50(9), 1484–1491. PubMed abstract available at <http://www.ncbi.nlm.nih.gov/pubmed/12383144>. Accessed March 23, 2018. [↑](#footnote-ref-52)
53. A summary of these studies can be found at: <https://www.acl.gov/programs/strengthening-aging-and-disability-networks/aging-and-disability-evidence-based-programs> [↑](#footnote-ref-53)
54. CMS Chartbook and Charts. Figure 2: Prevalence of Chronic Conditions among Fee-for-Service Beneficiaries by Age: 2017. Chronic Condition Charts: 2017. Accessed May 1, 2019 at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook\_Charts.html [↑](#footnote-ref-54)
55. 55 Snow, C.E.; Abrams, R.C. The Indirect Costs of Late-Life Depression in the United States: A Literature Review and Perspective. Geriatrics 2016, 1, 30. [↑](#footnote-ref-55)
56. Program to Encourage Rewarding Lives for Seniors (2012). Description available at: <http://www.pearlsprogram.org/> [↑](#footnote-ref-56)
57. Gerteis J, Izrael D, Deitz D, LeRoy L, Ricciardi R, Miller T, Basu J. Multiple Chronic Conditions Chartbook. AHRQ Publications No, Q14-0038. Rockville, MD: Agency for Healthcare Research and Quality. April 2014. [↑](#footnote-ref-57)
58. Parekh, AK, et al. 2011. Managing Multiple Chronic Conditions: A Strategic Framework for Improving Health Outcomes and Quality of Life. Public Health Rep. 126(4):460-71. [↑](#footnote-ref-58)
59. Kramarow, E et al. 2007. Trends in Health of Older Americans, 1970-2005. Health Affairs (Milwood). Sep-Oct; 26 (5):1417-25. [↑](#footnote-ref-59)
60. Centers for Disease Control and Prevention. The State of Aging and Health in America 2013. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2013. [↑](#footnote-ref-60)
61. Brady, T.J., et al. 2013. “A Meta-analysis of Health Status, Health Behaviors, and Health Care Utilization Outcomes of the Chronic Disease Self-Management Program.” Prev Chronic Dis 10:120112. [↑](#footnote-ref-61)
62. Centers for Medicare & Medicaid Services, Report to Congress: The Centers for Medicare & Medicaid Services’ Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act. <http://innovation.cms.gov/Files/reports/CommunityWellnessRTC.pdf> Accessed March 23, 2018. [↑](#footnote-ref-62)
63. Ahn S et al. The Impact of Chronic Disease Self-Management Programs: Healthcare Savings through a Community-Based Intervention. BMC Public Health. 2013. 13:1141. doi:10.1186/1471-2458-13-1141 Available at: <http://www.biomedcentral.com/1471-2458/13/1141> Accessed March 23, 2018. [↑](#footnote-ref-63)
64. Racial and/or ethnic minorities refer to individuals who self-report at least one of the following racial or ethnic identities: Asian, Black or African American, Hispanic or Latino, Native Hawaiian or other Other Pacific Islanders, American Indian or Alaska Native. [↑](#footnote-ref-64)
65. Substance Abuse and Mental Health Services Administration (SAMHSA). (2012). Older Americans Behavioral Health Issue Brief: Series Overview. Accessed January 5, 2018 at: <https://www.ncoa.org/wp-content/uploads/Series-Overview-Issue-Brief-1.pdf> [↑](#footnote-ref-65)
66. World Health Organization (2016). Mental Health and Older Adults: A Fact Sheet. Retrieved March 23, 2018 at <http://www.who.int/mediacentre/factsheets/fs381/en/> [↑](#footnote-ref-66)
67. Bergen G, Stevens MR, Burns ER. Falls and Fall Injuries Among Adults Aged ≥65 Years — United States, 2014. MMWR Morb Mortal Wkly Rep 2016;65:993–998. DOI: http://dx.doi.org/10.15585/mmwr.mm6537a2. [↑](#footnote-ref-67)
68. Stevens JA, Ballesteros MF, Mack KA, Rudd RA, DeCaro E, Adler G. Gender differences in seeking care for falls in the aged Medicare Population. American Journal of Preventive Medicine 2012; 43:59–62. [↑](#footnote-ref-68)
69. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web–based Injury Statistics Query and Reporting System (WISQARS) [online]. Accessed October 24, 2019. [↑](#footnote-ref-69)
70. Florence CS, Bergen G, Atherly A, Burns ER, Stevens JA, Drake C. Medical Costs of Fatal and Nonfatal Falls in Older Adults. Journal of the American Geriatrics Society, 2018 March, DOI:10.1111/jgs.15304external icon, [↑](#footnote-ref-70)
71. Tinetti, M.E., Dorothy I. Baker, D.I., King, M, Gottschalk, M.,Murphy, T.E., Acampora,D., Carlin, B.P., Linda Leo-Summers, L., and Allore, H.G. (2008) Effect of Dissemination of Evidence in Reducing Injuries from Falls. N Engl J Med;359:252-61. [↑](#footnote-ref-71)
72. Report to Congress: The Centers for Medicare & Medicaid Services’ Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act. Accessed February 13, 2018 from: <http://innovation.cms.gov/Files/reports/CommunityWellnessRTC.pdf> [↑](#footnote-ref-72)
73. Carande-Kulisa, V., et al. (2015), A cost–benefit analysis of three older adult fall prevention interventions, Journal of Safety Research, Accessed February 13, 2018 from: <http://www.cdc.gov/homeandrecreationalsafety/Falls/steadi/index.html#practice> [↑](#footnote-ref-73)
74. Research Report: Caregiving in the U.S. 2015: A Focused Look at Caregivers of Adults Age 50+. National Alliance for Caregiving and AARP Public Policy Institute. June 2015. <http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Care-Recipients-Over-50_WEB.pdf>. Accessed February 15, 2018. [↑](#footnote-ref-74)
75. Ibid. [↑](#footnote-ref-75)
76. Valuing the Invaluable: 2015 Update, The Growing Contributions and Costs of Family Caregiving. AARP Public Policy Institute. July 2015. <http://www.aarp.org/ppi/info-2015/valuing-the-invaluable-2015-update.html>. Accessed February 15, 2018. [↑](#footnote-ref-76)
77. *The Opportunity Costs of Informal Elder-Care in the United States.* TheRand Corporation, 2014. <http://www.rand.org/pubs/external_publications/EP66196.html>. Accessed February 15, 2018. [↑](#footnote-ref-77)
78. Home Alone: Family Caregivers Providing Complex Chronic Care. AARP and United Hospital Fund. October 2012. <https://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/home-alone-family-caregivers-providing-complex-chronic-care-rev-AARP-ppi-health.pdf>. Accessed February 15, 2018. [↑](#footnote-ref-78)
79. Perkins, M., Howard, V. J., Wadley, V. G., Crowe, M., Safford, M. M., Haley, W. E., Roth, D. L. (2013). Caregiving strain and all-cause mortality: Evidence from the REGARDS Study. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 68,* 504-512. doi:10.1093/geronb/gbs084. [↑](#footnote-ref-79)
80. Roth, D. L., Haley, W. E., Hovater, M., Perkins, M., Wadley, V. G., & Judd, S. (2013). Family caregiving and all-cause mortality: Findings from a population-based propensity-matched analysis. *American Journal of Epidemiology, 178,* 1571-1578. doi:10.1093/aje/kwt225 [↑](#footnote-ref-80)
81. Roth, D. L., Fredman, L., & Haley, W. E. (2015, Special Issue). Informal caregiving and its impact on health: A reappraisal from population-based studies. *The Gerontologist, 55,* 309-319. doi:10/1093/geront/gnu177 [↑](#footnote-ref-81)
82. 2017 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov> [↑](#footnote-ref-82)
83. U.S. Census Bureau. Population Division. Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2017. Release Date: June 2018. Accessed May 1, 2019. U.S. Census Bureau, “2017 National Population Projections,” Table 3. Projected 5-Year Age Groups and Sex Composition of the Population for the United States: 2017 to 2060. Original Release Date: March 2018, Revised Release Date: September 2018. [https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html. Accessed May 1](https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html.%20Accessed%20May%201), 2019 and Centers for Medicare & Medicaid Services, ACL analysis of 2015 Medicare Current Beneficiary Survey. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/. Accessed May 1, 2019. [↑](#footnote-ref-83)
84. AoA’s FY 2017 State Program Report. [↑](#footnote-ref-84)
85. 2018 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov>. [↑](#footnote-ref-85)
86. Center on Aging Society. (2005) How Do Family Caregivers Fare? A Closer Look at Their Experiences. (Data Profile, Number 3). Washington, DC: Georgetown University. [↑](#footnote-ref-86)
87. Research Report: Caregiving in the U.S. 2015- A Focused Look at Caregivers of Adults Age 50+. National Alliance for Caregiving and AARP Public Policy Institute. June 2015. <http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Care-Recipients-Over-50_WEB.pdf>. [↑](#footnote-ref-87)
88. 2018 National Survey of Older Americans Act participants. <http://www.agid.acl.gov>. [↑](#footnote-ref-88)
89. Mittelman, M., Ferris, S., Shulman, E., Steinberg, G., Levin, B. (1996). A family intervention to delay nursing home placement of patients with Alzheimer's disease - A randomized controlled trial. *The Journal of the American Association*, 276(21), 1725-1731. [↑](#footnote-ref-89)
90. 2018 National Survey of Older Americans Act Participants. <http://www.agid.acl.gov> [↑](#footnote-ref-90)
91. *Ibid.* [↑](#footnote-ref-91)
92. <https://aspe.hhs.gov/national-plan-address-alzheimers-disease-2015-update>. [↑](#footnote-ref-92)
93. U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population by Sex, Single Year of Age, Race Alone or in Combination, and Hispanic Origin for the United States: April 1, 2010 to July 1, 2017 Released June 2018, accessed March 2019. [↑](#footnote-ref-93)
94. U.S. Census Bureau, Population Division. Annual Estimates of the Resident Population by Sex, Single Year of Age, Race, and Hispanic Origin for the United States: April 1, 2010 to July 1, 2017. Released June 2018. Accessed March 2019. [↑](#footnote-ref-94)
95. Administration on Aging, U.S. Population by Age: 65+ Minority Population Comparison using Census 2000 and Census 2010 (July 1, 2011). [↑](#footnote-ref-95)
96. National Council on Disability, “Understanding Disabilities in American Indian and Alaska Native Communities: Toolkit Guide” (2003). [↑](#footnote-ref-96)
97. Centers for Disease Control and Prevention, “CDC Health Disparities and Inequalities Report – United States” (2013). [↑](#footnote-ref-97)
98. ACL’s OAA Title VI Program Performance Report, PY 2017. Title VI of the Older Americans Act permits tribes to establish age of eligibility for services below age 60. Calculation based on eligible population as reported in grantee applications [↑](#footnote-ref-98)
99. ACL’s OAA Title VI Program Performance Report, PY 2017 [↑](#footnote-ref-99)
100. Ibid. [↑](#footnote-ref-100)
101. Ibid. [↑](#footnote-ref-101)
102. Ibid [↑](#footnote-ref-102)
103. Ibid. [↑](#footnote-ref-103)
104. Beach SR, Schulz R, Castle NG, Rosen J. Financial Exploitation and Psychological Mistreatment Among Older Adults: Differences Between African Americans and Non-African Americans in a Population-Based Survey. Gerontologist 2010.

 Acierno R, Hernandez MA, Amstadter AB, Resnick HS, Steve K, Muzzy W et al. Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study. American Journal of Public Health 2010; 100(2):292-297. [↑](#footnote-ref-104)
105. Teaster, Pamela, et al. *The 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older*. <https://ncea.acl.gov/resources/docs/archive/2004-Survey-St-Audit-APS-Abuse-18plus-2007.pdf>. Accessed January 25, 2019. [↑](#footnote-ref-105)
106. National Research Council. Elder Mistreatment: Abuse, neglect and exploitation in an Aging America. Washington, D.C.: The National Academies Press, 2003. [↑](#footnote-ref-106)
107. 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. [↑](#footnote-ref-107)
108. Bitondo Dyer C., Pavlik V. N., Murphy K. P., and Hyman D. J. (2000). “The high prevalence of depression and dementia in elder abuse or neglect.” Journal of the American Geriatrics Society. 48:205-208.

 Burt, M. and Katz, B. “Rape, Robbery, and Burglary: Responses to Actual and Feared Criminal Victimization, with Special Focus on Women and the Elderly,” Victimology: An International Journal 10 (1985): 325-358.

 Mouton C. P., Espino D. V. (1999). “Problem-orientated diagnosis: Health screening in older women.” American Family Physician. 59: 1835.

 Fisher, B.S., and Regan, S.L. (2006). “The Extent and Frequency of Abuse in the Lives of Older Women and Their Relationship With Health Outcomes.” The Gerontologist, 46: 200-209.

 Coker, A., Davis, K., Arias, I. et al. (November 2002). “Physical and Mental Health Effects of Intimate Partner Violence for Men and Women.” American Journal of Preventive Medicine. Vol. 23 No. 4: 260-268.

 Stein, M. & Barrett-Connor, E. (2000). “Sexual Assault and Physical Health: Findings from a Population-Based Study of Older Adults.” Psychosomatic Medicine. Vol. 62: 838-843. [↑](#footnote-ref-108)
109. Fulmer, T., Rodgers, R. F., & Pelger, A. (2013). Verbal mistreatment of the elderly. Journal of Elder Abuse & Neglect, 26(4), 351–364; Mouton, C. P., Rodabough, R. J., Rovi, S. L. D., Robert, G., Brzyski, R. J., & Katerndahl, D. A. (2010). Psychosocial effects of physical and mental abuse in post-menopausal women. Annals of Family Medicine, 8, 206–213. doi: 10.1370/afm.1095

 Comijs, H.C., Penninx, B.W.J.H., Knipscheer, K.P.M., & van Tilburg, W. (1999). Psychological distress in victims of elder mistreatment: The effects of social support and coping. Journal of Gerontology, 54B (4), P240-P245. [↑](#footnote-ref-109)
110. Stein, M. & Barrett-Connor, E. (2000). “Sexual Assault and Physical Health: Findings From a Population-Based Study of Older Adults.”  Psychosomatic Medicine. Vol. 62; p 838-p843. [↑](#footnote-ref-110)
111. Older Americans Act, Section 307(a)(11)(e), 42 United States Code Section 3027(a)(11)(e). [↑](#footnote-ref-111)
112. This amount reflects Title VII-2 designated as Ombudsman Program Activity funds. States also utilize other Older Americans Act and other funding sources to operate the Ombudsman program. [↑](#footnote-ref-112)
113. FFY 2017 National Ombudsman Reporting System (NORS) is the source for this and other data in this section. States report NORS data annually to ACL. [↑](#footnote-ref-113)
114. In FY 2017, ombudsmen opened 131,727 new cases (a case contains one or more complaints originating from the same person(s)), and completed resolution on 128,091 closed cases, containing, 201,460 complaints. [↑](#footnote-ref-114)
115. The Independent Sector places the value of the volunteer time at $24.69 per hour placing the value of 591,363 hours at $14,600,752 https://independentsector.org/value-of-volunteer-time-2018/ Accessed January 9, 2019 [↑](#footnote-ref-115)
116. Key Elements of a NWD System of Access to LTSS for All Populations and Payers (<https://nwd.acl.gov/docs/NWD-National-Elements.pdf>), Aging and Disability Resource Centers as defined in the Older Americans Act 2006 [↑](#footnote-ref-116)
117. <https://fas.org/sgp/crs/misc/IF10343.pdf> [↑](#footnote-ref-117)
118. Kover, E. (2014). Testimony before the U.S. Senate Special Committee on Aging, January 15, 2014. [↑](#footnote-ref-118)