DEPARTMENT of HEALTH and HUMAN SERVICES

FY 2018 Older Americans Act Report to Congress

Prepared by
ADMINISTRATION ON AGING
ADMINISTRATION FOR COMMUNITY LIVING

ACL
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, nonprofits, 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.

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 mission, the Administration on Aging (AoA), within ACL, 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), 629 area agencies on aging (AAAs), 270 American Indian, Alaska Native, and Native Hawaiian (AI, AN, NH) 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 over 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 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 OAA Report to Congress for Fiscal Year (FY) 2018.

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Administration for Community Living

Table of Contents

FROM THE ADMINISTRATION FOR COMMUNITY LIVING ..... **ii**

EXECUTIVE SUMMARY **1**

PART I: HEALTH AND INDEPENDENCE **6**

- **Home and Community-Based Supportive Services** **7**
- **Nutrition Services** **10**
- **Preventive Health Services** **16**
- **Chronic Disease Self-Management Education Programs** **17**
- **Falls Prevention Programs** **21**
- **National Family Caregiver Support Program** **24**
- **Alzheimer's Disease Programs Initiative (ADPI)** **27**

PART II: OLDER AMERICAN INDIANS, ALASKA NATIVES, & NATIVE HAWAIIANS **30**

- **Nutrition and Supportive Services** **30**
- **Caregiver Support Services** **32**

PART III: ELDER RIGHTS **33**

- **Prevention of Elder Abuse and Neglect** **33**
- **Elder Rights Support Activities** **34**
- **Long-Term Care Ombudsman Program** **37**
- **PART IV: SUPPORTING THE NATIONAL AGING SERVICES NETWORK** **41**
- **Aging and Disability Resource Centers/No Wrong Door System** **41**
- **Aging Network Support Activities** **44**

Appendix **49**

- **Formula Grant Funding Allocations by State, Territory, and Tribal Organizations** **49**

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EXECUTIVE SUMMARY

The core programs of the Administration on Aging, within the Administration for Community Living (ACL), authorized under the Older Americans Act (OAA), help people who choose to remain in their homes and communities for as long as possible. The services provided by AoA' programs complement efforts of the nation's public health networks, as well as existing medical and health care systems, and support some of life's most basic functions, such as bathing and preparing meals. The 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 fiscal year (FY) 2018, 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] Critical supports, such as respite care and a peer support network, were provided to more than 800,000 caregivers.[2]

Overview of Performance

ACL facilitates achievement of its mission through improvements in the analysis and availability of performance data while also enhancing the rigor of program evaluations. OAA program activities have a fundamental common purpose: to develop and support a comprehensive, coordinated, and cost-effective system of long-term services and supports (LTSS) that help older adults maintain their health and independence in their homes and communities. This purpose led ACL to focus on the following four performance goals:

1. Provide high quality services that result in positive consumer outcomes and reflect effective delivery systems;
2. Effectively target services to at-risk populations;
3. Improve program efficiency; and
4. Promote the rights of, and prevent the abuse of, older adults.

Each performance goal reflects activities spanning across OAA programs; programs address distinct issues and populations. ACL 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

[1] AoA's FY 2018 State Program Report.
[2] Ibid.

measures. Taken together, the performance goals and their corresponding metrics are designed to reflect ACL's goals and objectives and in turn measure success in accomplishing ACL's mission.

Performance Highlights

An analysis of OAA program performance trends through FY 2018 illustrates that OAA 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.

OAA 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; for example, over 40 percent indicating that the care recipient would be unable to remain at home without caregiver support services.[3] With regard to effective delivery of evidence-based programs, OAA grantees were able to meet their participation targets for Chronic Disease Self-Management Education. In 2018, AoA continued to expand the provision of quality dementia-capable services through previously funded Alzheimer's and dementia programs, as well as through the newly created Alzheimer's Disease Programs Initiative (ADPI) grants to states and communities. The ADPI funded 17 new unique public and private entities across the nation that will provide specialized supportive services to persons living with Alzheimer's and related dementias and their caregivers. In addition to the newly funded programs, grantees from 2014–17 continued to implement their active programs with many reporting decreases in caregiver burden and stress. To sustain 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.

OAA 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 (ADLs) are at a high risk for nursing home entry.[4] 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 2018, the proportion was nearly 39 percent, which was an 18 percent increase over the previous year.

ACL's AoA maintains nine core performance indicators supporting the agency'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

[3] 2019 National Survey of Older Americans Act Participants. https://agid.acl.gov/.
[4] The activities of daily living are classified into basic ADLs and Instrumental Activities of Daily Living (IADLs). The basic ADLs are those skills required to manage ones basic physical needs including personal hygiene or grooming, dressing, toileting, transferring or ambulating, and eating.

targets annually. OAA programs are also efficient. The aging network is providing high-quality services and doing so in a prudent and cost-effective manner. In FY 2018, the aging network served over 7,800 people per million dollars of OAA Title III funding. While costs for some services, such as transportation, have risen in recent years, costs for other services have held constant or were lower in FY 2018 (e.g., personal care, homemaker, chore services, and adult day care).

OAA 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 2018, 59 percent of all complaints were resolved to the satisfaction of the complainant.

The tables that follow provide a summary of the persons served during FY 2018 through the OAA's programs. Additionally, a comprehensive listing of grant funding allocations by state, territory, and Tribal organization can be viewed in the Appendix.

FY 2018 National Program Data on Services Provided

Total Clients	10,802,963
Total Registered Clients	2,716,201
Percent Minority Clients[5]	32.2
Percent Rural Clients	34.6
Percent Clients Below Poverty	33.5
Number of Senior Centers	11,212[6]

Service	**Persons Served**	**Units of Service[7]**	**Title III Expenditure[8]**	**Total Expenditure**
Personal Care	114,810	25,891,349	$60,224,327	$401,339,656
Homemaker	165,905	21,136,211	$31,469,688	$410,131,600
Chore	30,149	776,532	$5,016,122	$18,834,410
Home Delivered Meals	871,680	146,995,223	$316,983,465	$937,633,470
Adult Day Care	18,982	11,662,539	$12,510,015	$106,911,109
Case Management	482,148	3,515,043	$102,869,234	$284,099,729
Assisted Transportation	47,843	2,316,577	$4,530,741	$32,793,508
Congregate Meals	1,522,555	73,644,475	$310,527,403	$663,420,275
Nutrition Counseling	21,361	36,305	$778,975	$1,964,225
Transportation		20,259,508	$62,091,314	$201,325,235
Legal Assistance		949,991	$27,675,988	$50,785,240
Nutrition Education		3,495,943	$3,297,876	$7,407,946
Information and Assistance		11,926,483	$56,164,923	$184,659,241
Outreach		2,444,679	$10,759,247	$23,558,176
Health Promotion and Disease Prevention	755,096		$23,960,762	$57,907,818
Self-Directed Care	8,999		$164,797	$74,119,766
Other			$73,628,254	$583,537,507

[5] "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.
[6] 6,600 of these Senior Centers receive OAA funding.
[7] 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.
[8] Expenditures reflect outlays/payments made by the SUA and/or AAA's using OAA federal funds to provide an allowable service and may not match the total OAA federal funds available for that service.

National Family Caregiver Support Program

Service	**Caregivers Served**	**Service Units[9]**	**Title III Expenditure[10]**	**Total Expenditure**
Counseling, Support Groups, Training	111,571	527,370	$20,869,398	$33,456,997
Respite	58,576	6,214,442	$53,209,085	$97,367,229
Supplemental Services	32,006	668,987	$12,176,508	$17,355,460
Access Assistance	586,967	1,632,838	$33,138,472	$50,202,232
Self-Directed	1,639	-	$1,249,669	$1,841,611
Information Services	22,776,974	331,057	$12,256,030	$17,635,003
Unduplicated Caregivers Provided Service or Access	799,841			

[9] Title III-E service units definitions: counseling = 1 session per participant, respite care = 1 hour, supplemental services = variable, access assistance = 1 contact, self-directed = variable, information services = 1 activity.
[10] Expenditures reflect outlays/payments made by the SUA and/or AAA's using OAA federal funds to provide an allowable service and may not match the total OAA federal funds available for that service.

PART I: HEALTH AND INDEPENDENCE

Americans today are living longer and more active lives. This is due, in part, to advances in public health and medical care. The average life expectancy of an American has increased dramatically over the last century, from 50.9 years in 1917 to 78.7 years in 2016.[11, 12] With increased longevity, however, has come 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.[13, 14, 15]

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.[16]

In the United States, the population age 65 and older numbered 52.4 million in 2018 (the most recent year for which data are available). They represented 16 percent of the population, more than one in every seven Americans. The number of older Americans increased by 13.7 million (or 35 percent) from 2008 to 2018, compared to an increase of 4 percent for the under-65 population.[17] According to the U.S. Census Bureau's American Community Survey, 34 percent of people age 65 and older reported having some type of disability (i.e., difficulty in hearing, vision, cognition, ambulation, self-

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[11] Arias E, Xu J, Kochanek K. United States life tables, 2016. National vital statistics reports; vol. 68 no 4. Hyattsville, MD: National Center for Health Statistics. May 7, 2019. Accessed May 14, 2020, at https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_04-508.pdf.

[12] 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 14, 2020, at https://www.cdc.gov/nchs/products/databriefs/db328.htm.

[13] 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 14, 2020, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts.html.

[14] 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.

[15] Ibid.

[16] 2018 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.

[17] Administration for Community Living. 2019 Profile of Older Americans. https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2019ProfileOlderAmericans508.pdf

care, or independent living) in 2018. Along with the likelihood of acquiring a disability, the need for assistance also increases with age. In 2018, the percentage of older adults age 85 and older needing help with personal care was more than twice the percentage for adults ages 75–84 and five times the percentage for adults ages 65–74[18]. This is the population of older adults more likely to seek nursing home admission, and many will qualify for Medicaid eligibility at admission or soon after through "spend down" provisions.[19] AoA's Health and Independence programs help older adults in need maintain their health and independence.

In conjunction with other OAA programs, these services assist over 11 million older individuals and caregivers.[20] 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.[21] 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.[22]

HOME AND COMMUNITY-BASED SUPPORTIVE SERVICES

(OAA Title III-B; FY 2018: $384,118,437[23])

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. OAA 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, which help older persons remain in their own homes and communities instead of entering nursing homes or other types of institutional care.[24]

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.

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[18] Administration for Community Living. 2019 Profile of Older Americans. https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2019ProfileOlderAmericans508.pdf
[19] Ellen O'Brien for the Kaiser Commission on Medicaid and the Uninsured. Long-Term Care: Understanding Medicaid's Role for the Elderly and Disabled. Nov. 2005
[20] AoA's FY 2018 State Program Report.
[21] Ibid.
[22] 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.
[23] This is the final operating level for FY 2018 and does not include permissive transfers of $955,563. For additional information, refer to ACL Operating Plan for FY 2019 available at https://acl.gov/sites/default/files/about-acl/2018-12/FY2019_ACL%20Operating%20Plan.pdf.
[24] 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.

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 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.[25] 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.[26] 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 care 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 2018 include:[27]

- Transportation Services provided 22.6 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 47.8 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 11.6 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 3.5 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 58 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.[28] 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:[29] 1.5

[25] 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.
[26] Ibid.
[27] AoA's FY 2018 State Program Report.
[28] 2018 National Survey of Older Americans Act Participants. https://agid.acl.gov/CustomTables/NPS/Year/.
[29] Ibid.

percent have Parkinson's disease; 3 percent have multiple sclerosis; 4.9 percent have epilepsy; 7.1 percent have Alzheimer's disease or dementia; 15.7 percent have had a stroke; 63.1 percent of riders had a doctor tell them they had vision problems (including glaucoma, macular degeneration, or cataracts); and 69.4 percent have arthritis.

Of the transportation participants, 85 percent take daily medications, with 19 percent reporting they take 9 medications daily.[30] 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.[31] For example, over 77 percent of clients receiving case management services reported that, as a result of the services arranged by the case manager, they were better able to care for themselves.[32] 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.[33]

Nationally, 24 percent of individuals 60 and older live alone.[34] However, OAA programs serve a disproportionate number of people who live alone compared to the general population of older Americans. In 2018, 44.6 percent of registered clients (1,211,801 individuals) lived alone. 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.[35]

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.

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[30] Ibid.
[31] Ibid.
[32] Ibid.
[33] 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.
[34] 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 (2018), accessed May 14, 2020.
[35] Muramatsu, Naoko. "Risk of Nursing Home Admission Among Older Americans: Does States' Spending on Home and Community-Based Services Matter?" May 2007. Journal of Gerontology: Psychological Sciences.

NUTRITION SERVICES

(OAA Title III-C; FY 2018: $891,775,250[36])

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). 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 percent of the funds appropriated to nutrition programs to develop, pilot, or replicate innovative, evidence-informed practices for the NSP. In FY 2018, ACL awarded five Innovations in Nutrition (INNU) grants, totaling $1,197,205. Through these grants, ACL seeks to identify and promote innovative practices or programs. FY 2018 grantees' project areas of emphasis included:

- Work to enhance the identification of, and support for older adults with elevated suicide risk or in mental health distress;
- Decreasing the prevalence of food insecurity;
- 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 Services Programs include:

Congregate Nutrition Services Program

In 2018, under Title III-C1 of the AAA, the Congregate Nutrition Services Program provided $489,125,214 in 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. Ninety-three percent of congregate nutrition participants were socially active and were satisfied with their opportunities to spend time with other people. The typical

[36] This is the final operating level for FY 2018 and does not include permissive transfers of $4,977,750. For additional information, refer to ACL Operating Plan for FY 2019 available at https://acl.gov/sites/default/files/about-acl/2018-12/FY2019_ACL%20Operating%20Plan.pdf.

congregate nutrition participant does not experience loneliness, and only seven percent of congregate meal participants screened positive for depression.[37]

Home-Delivered Nutrition Services Program

In 2018, under Title III-C2 of the OAA, the Home-Delivered Nutrition Services Program provided $245,730,701 in 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." Eighty-one percent of home-delivered nutrition services participants reported being somewhat satisfied or very satisfied with their opportunities to spend time with other people, and 19 percent screened positive for depression.[38] Established in 1978, home-delivered nutrition services 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 nutrition is 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

In 2018, under Title III-A of the OAA, the Nutrition Services Incentive Program provided $156,919,335 in 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 nutrition 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. Of this amount, in FY 2018, six states and five tribes elected to take $2.7 million of the allotment in USDA Foods.[39]

The nutrition 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 National Academy of Medicine of the National Academy of Sciences.[40] It complies 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,

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[37] Evaluation of the Effect of the Older Americans Act Title III-C Nutrition Services Program on Participants' Food Security, Socialization, and Diet Quality 2017 https://acl.gov/sites/default/files/programs/2017-07/AoA_outcomesevaluation_final.pdf.
[38] Evaluation of the Effect of the Older Americans Act Title III-C Nutrition Services Program on Participants' Food Security, Socialization, and Diet Quality 2017 https://acl.gov/sites/default/files/programs/2017-07/AoA_outcomesevaluation_final.pdf.
[39] FY 2018 USDA Transfer Request.
[40] https://health.gov/dietaryguidelines/2015/guidelines/ and https://www.nal.usda.gov/fnic/dietary-reference-intakes

as feasible. The nutrition-related services provided through these programs may include nutrition education, counseling, and other nutrition services, as appropriate, based on the needs of participants.

Nutrition Service Programs help approximately 2.4 million older adults receive the nutrition they need to stay healthy and decrease their risk of disability.[41] 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. Data from the 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.[42] 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. Nutrition is 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 nutrition participants are aged 75 years or older.[43] Because older adults served in the nutrition service programs are 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 17 percent of home delivered and 8 percent of congregate nutrition clients report they needed to choose between buying food or buying medications (low food security); 33 percent of home delivered and 17 percent of congregate clients report not having enough money/food stamps to buy food (low food security); and 10 percent of home delivered and 7 percent of congregate clients indicate they had to skip a meal because they did not have money/food stamps to buy food (very low food security).[44] The data also indicate that 51 percent of congregate and 76 percent of home-delivered participants have difficulty getting outside the house, thus limiting their ability to shop for food themselves.[45] The number of home delivered nutrition recipients with severe disabilities (three or more activities of daily living) totaled over 350,000 in FY 2018.[46] This level of disability is

[41] AoA's FY 2018 State Program Report.
[42] 2018 National Survey of Older Americans Act Participants. https://agid.acl.gov/CustomTables/NPS/Year/.
[43] 2018 National Survey of Older Americans Act Participants. https://acl.gov/sites/default/files/programs/2018-10/NSPevaluation_healthcareutilization.pdf.
[44] 2018 National Survey of Older Americans Act Participants. https://acl.gov/sites/default/files/programs/2018-10/NSPevaluation_healthcareutilization.pdf.
[45] Ibid.
[46] AoA's FY 2018 State Program Report.

frequently associated with nursing home admission, and demonstrates the extreme frailty of a significant number of older adults receiving home-delivered nutrition.

As previously noted, the number of older adults who live alone is higher for program participants than it is for the general public. Nationally, 24 percent of persons age 60 years and older live alone.[47] However, through effective targeting, 59 percent of congregate NSP participants and 60 percent of home NSP participants live alone.[48] 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.[49] In a recent national evaluation, when nonparticipants were compared to participants in the congregate nutrition program, participants were more satisfied with their socialization opportunities.[50]

The NSP serves nutritious meals to older adults 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. Dr. James Mabli et al.'s 2017 *Evaluation of the Effect of the Older Americans Act Title III-C Nutrition Services Program on Participants' Food Security, Socialization, and Diet Quality* showed that lower-income older adults who participated in the congregate nutrition program were significantly less food insecure than nonparticipants (23.2 versus 31.0 percent).[51] 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.[52]

Data from the 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, 81 percent of congregate and 90 percent of home delivered nutrition participants stated the program had helped them to eat healthier foods, and 71 percent of congregate and 90 percent of home-delivered nutrition participants reported the program had helped them to live independently and remain in their own home. Independent research has found that states that invest more in delivering OAA home-delivered nutrition to older adults' have lower rates of "low-care" older adults in nursing homes after

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[47] 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 (2018), accessed June 25, 2020.
[48] 2018 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.
[49] Cornwell, E, Waite L. Social Disconnectedness, Perceived Isolation, and Health among Older Adults. J Heath Soc Behav 2009 Mar; 50(1); 31-48.
[50] Evaluation of Title III-C Elderly Nutrition Services Program Client Outcome Study 2017.
[51] Mabli, J. et al. (2017). Evaluation of the Effect of the Older Americans Act Title III-C Nutrition Services Program on Participants' Food Security, Socialization, and Diet Quality, April 21, 2017.
[52] http://nfesh.org/research/ (accessed January 23, 2018).

adjusting for several other factors.[53] For every $25 per year per older adult that states spend on home-delivered nutrition, the state reduces their percentage of these lower needs nursing home residents by one percent when compared to the national average.[54] This evidence is a testimonial to the savings gained from this foundational home- and community-based service.

Annual performance data 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 nutrition clients and 90 percent of congregate participants rate the meal as good to excellent.[55] 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 (72 vs 69), 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 programs are helping older adults remain healthy and independent in their homes include:[56]

- Home-Delivered Nutrition Services provided 147 million meals to over 871,680 individuals in FY 2018.[57]
- Congregate Nutrition Services provided over 73 million meals to more than 1.5 million older adults in a variety of community settings in FY 2018.[58]

Consistent with the OAA's requirement to help those most in need maintain their health and independence, approximately 46 percent of congregate nutrition recipients and 67 percent of home-delivered nutrition recipients have annual incomes at or below $20,000.[59] Nutrition Services Programs 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.[60]

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 donors that contribute funding. In FY 2018, state and local funding comprised 72 percent of all the funding for congregate and home-delivered nutrition services.[61] Although all programs funded through the OAA

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[53] 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.
[54] Ibid.
[55] 2018 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.
[56] Evaluation of Title III-C Elderly Nutrition Services Program Client Outcome Study 2017.
[57] AoA's FY 2018 State Program Report.
[58] Ibid.
[59] 2018 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.
[60] Ibid.
[61] AoA's FY 2018 State Program Report.

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

State and Territory Flexibility

Under the core state formula grant programs for 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 Nutrition Services programs 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. The table below outlines the transfers of Federal funds within Title III of the OAA for FY 18.

FY 2018 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 Nutrition**
Initial Allotment	$381,748,352	$484,669,154	$243,478,708
Final Allotment after Transfers	$440,403,031	$380,086,157	$289,407,026
Net Transfer	$58,654,679	(-$104,582,997)	$45,928,318
Net Percent Change	**15.36**	**(-21.58)**	**18.86**

PREVENTIVE HEALTH SERVICES

(OAA Title III-D; FY 2018: $24,786,339[62])

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. These programs include established activities and tools 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. Examples include:

- 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.[63] These programs have also been

[62] This is the final operating level for FY 2018 and does not include permissive transfers of $61,661. For additional information, refer to ACL Operating Plan for FY 2019 available at https://acl.gov/sites/default/files/about-acl/2018-12/FY2019_ACL%20Operating%20Plan.pdf.

[63] 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.

shown to improve medication usage rates and decrease medication errors among older adults.[64]

- 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.[65] 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).[66] Cost-effective, evidence-based interventions, such as the Program to Encourage Active 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.[67]

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

(OAA Title III-D; FY 2018: $8,000,000[68])

In the United States, approximately three out of four older adults have multiple (two or more) chronic conditions, such as diabetes, arthritis, heart disease, hypertension, chronic pain, and depression.[69] In addition, 42.8 percent of adults aged 60 and older are overweight or obese, increasing their risk factors for other chronic conditions.[70] This burden places older adults at greater risk for premature death, poor functional status, unnecessary hospitalizations, adverse drug events, and nursing home

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[64] 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.
[65] CMS Chartbook and Charts. Figure 2: Prevalence of Chronic Conditions among Fee-for-Service Beneficiaries by Age: 2017. Chronic Condition Charts: 2017. Accessed May 15, 2020 at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts.html.
[66] 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.
[67] Program to Encourage Active Rewarding Lives for Seniors Evidence (2012). Available at: https://depts.washington.edu/hprc/evidence-based-programs/pearls-program/pearls-evidence/.
[68] This figure represents funding provided by the Prevention and Public Health Fund.
[69] 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.
[70] Hales CM, Carroll MD, Fryar CD, Ogden CL. Prevalence of obesity and severe obesity among adults: United States, 2017–2018. NCHS Data Brief, no 360. Hyattsville, MD: National Center for Health Statistics. 2020.

placement.[71,72] Chronic conditions also influence health care costs: 95 percent of health care costs for older Americans can be attributed to chronic diseases.[73]

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.[74] 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 version of CDSMP);
- Diabetes Self-Management Program (DSMP);
- *Programa de Manejo Personal de la Diabetes* (Spanish version of DSMP);
- Chronic Pain Self-Management Program;
- Building Better Care Givers;
- Positive Self-Management Program for HIV;
- Cancer: Thriving and Surviving; and
- Online versions of many programs[75].

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.

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[71] 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.
[72] Kramarow, E et al. 2007. Trends in Health of Older Americans, 1970-2005. Health Affairs (Milwood). Sep-Oct; 26 (5):1417-25.
[73] Centers for Disease Control and Prevention. The State of Aging and Health in America 2013. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2013.
[74] 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.
[75] A sample of Chronic Disease Prevention Programs that are offered remotely is available at, http://www.eblcprograms.org/docs/pdfs/Remote_Programs_1_Pager.pdf

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.[76] 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.[77]

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 techniques to deal with problems such as frustration, fatigue, pain, and isolation; appropriate exercise for maintaining and improving strength, flexibility, and endurance; appropriate use of medications; communicating effectively with health professionals and family/friends; and nutrition.

ACL funds CDSME through competitive grants awarded to domestic public or private nonprofit entities following an expert peer review of proposals. ACL awarded 10 forward-funded grants for a three-year project period beginning July 1, 2018. 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.

From 2009 to the conclusion of FY 2018, grantees and various partners reached more than 375,000 participants. During FY 2018, there were 36,575 participants, 25,659 "completers" (participants who

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[76] 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.

[77] 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.

attended at least two thirds of a workshop), and a retention rate of 70 percent. Note, the retention rate is specific to interventions with standard start and end dates, not ongoing interventions.

Grantees were successful in reaching their targeted underserved populations. Of those participants reporting relevant data, 62 percent were age 60 or older, 79 percent reported having multiple chronic conditions, 34 percent reported a disability, 15 percent identified Hispanic or Latino ethnicity, and 31 percent identified their race as at least one of the following: Black or African American, American Indian or Alaska Native, Asian, Multi-Racial, Native Hawaiian or Pacific Islander, or other.[78]

Behavioral Health

While the 2016 reauthorization of the OAA included provisions focused on the prevention and treatment of behavioral health conditions, there is no funding in the OAA specifically designated for such prevention, intervention, and treatment services. Because behavioral health is essential to overall health, states and communities have had to be creative in how they support these programs and services.

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.[79] 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.[80] 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. Many aging network providers are working closely with behavioral health, primary care, and other partners to connect older adults with screening and intervention resources. In addition, some providers are delivering evidence-based community interventions, such as 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 2018, ACL and SAMHSA continued to provide technical assistance aimed at increasing states' capacities for reaching older adults who are experiencing, or are at-risk for, behavioral health

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[78] ACL National Falls Prevention Database. Accessed May 15, 2020.
[79] 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.
[80] 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/.

disorders. Most recently, they supported the development of a variety of materials, such as epidemiological profiles, toolkits, issue briefs, and other learning opportunities, such as webinars. ACL and SAMHSA also co-hosted the First Annual Older Adult Mental Health Awareness Day in May 2018 to raise awareness about older adult mental health and provide resources for professionals and consumers. The materials developed through this partnership have been successful in helping communities enhance their efforts to reach older adults affected by behavioral health conditions.

FALLS PREVENTION PROGRAMS

(OAA Title III-D; FY 2018: $5,000,000[81])

ACL received dedicated funding for falls prevention programs through the Prevention and Public Health Fund (PPHF) in FY 2018, as has been the case every year since 2014. 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,[82] but fewer than half of those who have suffered a fall talk to their healthcare providers about it.[83] In 2018, 3 million nonfatal falls among older adults were treated in emergency departments and more than 950,000 of these patients were hospitalized.[84] In 2015, the total medical costs for falls totaled more than $50 billion.[85]

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.[86] Community-based falls prevention programs are low-cost, evidence-based disease prevention models that help reduce falls, and potentially reduce their need for more costly medical care. Examples of these programs include:

- A Matter of Balance (MOB);
- Moving for Better Balance (Tai Chi: MBB);
- Otago;
- Stepping On; and
- Tai Chi

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[81] This figure represents funding provided by the Prevention and Public Health Fund.
[82] Moreland B, Kakara R, Henry A. Trends in Nonfatal Falls and Fall-Related Injuries Among Adults Aged ≥65 Years — United States, 2012–2018. MMWR Morb Mortal Wkly Rep 2020;69:875–881.
[83] 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.
[84] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web–based Injury Statistics Query and Reporting System (WISQARS) [online]. Accessed January 21, 2021.
[85] 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.15304.
[86] 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.

A recent study showed a positive return on investment for the implementation of Tai Chi: MBB, Stepping On, and Otago.[87] Additional programs such as Matter of Balance (MOB) help reduce fall risk factors in older adults (e.g., fear of falling) and lead to improved outcomes. A recent CMS report to Congress indicated that MOB reduced unplanned hospitalizations and is associated with medical cost savings.[88] ACL continues to collaborate with its partners at CDC's Injury Prevention Center to leverage their research, data surveillance, and clinical provider education efforts.

In 2018, ACL published a competitive funding announcement, and external experts reviewed applications for this opportunity. ACL awarded a total of ten grants to domestic public and private nonprofit entities, 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 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, however several factors including financial constraints, work and family demands, and the many challenges of providing care place great pressure on family, or informal, caregivers. Caregiving responsibilities demand time and money from families who often are strapped for both. ACL'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

[87] 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
[88] 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.

relationship with the person for whom they volunteer their time – that determines whether an older person can remain in his or her home. In 2014, approximately 34.2 million adult caregivers provided uncompensated care to those 50 years of age and older.[89] In other words, approximately 14.3 percent of all adults provided care to someone age 50 years and older.[90] AARP estimated the economic cost of replacing unpaid caregiving in 2017 to be about $470 billion, an increase from $450 billion in 2009 (cost if that care had to be replaced with paid services).[91] The same study showed that, on average, family caregivers nationwide provide 34 billion hours of unpaid care to care recipients. Another recent study by the Rand Corporation estimated the economic cost of replacing unpaid caregiving to be about $522 billion annually.[92] 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 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.[93]

Such demands on family caregivers can lead to a breakdown of their own 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 report mental and emotional strain as a result of their caregiving role and are at higher risk for earlier mortality.[94, 95, 96] Providing

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[89] 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.
[90] Ibid.
[91] Valuing the Invaluable: 2019 Update, Charting a Path Forward. AARP Public Policy Institute. November, 2019.https://www.aarp.org/content/dam/aarp/ppi/2019/11/valuing-the-invaluable-2019-update-charting-a-path-forward.doi.10.26419-2Fppi.00082.001.pdf. Accessed May 5, 2020.
[92] *The Opportunity Costs of Informal Elder-Care in the United States.* The Rand Corporation, 2014. http://www.rand.org/pubs/external_publications/EP66196.html. Accessed February 15, 2018.
[93] 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.
[94] 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.
[95] 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.
[96] 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.

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-five percent of the caregivers served by OAA programs report that these services allow them to provide care longer than they otherwise could.[97]

NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM

(OAA Title III-E; FY 2018: $180,137,875[98])

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 program also supports grandparents and other kinship caregivers raising children, as well as seniors providing care to aging family members or persons with disabilities. The NFCSP includes five basic system components: information, access assistance, counseling and training, respite care, and supplemental services. Each of these components 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 2018, services provided included:[99]

- Access Assistance Services, which provided over 1.4 million contacts to caregivers assisting them in locating services from a variety of public and private agencies.
- Counseling and Training Services, which provided over 104,000 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving.
- Respite Care Service, which provided almost 55,000 caregivers with nearly 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, ACL completed the second portion of the first national evaluation of the NFCSP throughout 2017. The outcome evaluation drew 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 were

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[97] 2019 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.
[98] This is the final operating level for FY 2018 and does not include permissive transfers of $448,125. For additional information, refer to ACL Operating Plan for FY 2019 available at https://acl.gov/sites/default/files/about-acl/2018-12/FY2019_ACL%20Operating%20Plan.pdf.
[99] AoA's FY 2018 State Program Report.

administered to random samples of participants, based on probability samples of AAAs that were surveyed as part of the ACL's 11th National Survey of Older Americans Act Participants (NSOAAP). The nonparticipant comparison group was formed by identifying clients of OAA services who indicated during the NSOAAP that they had someone who assisted them with 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 completed phone interviews with each caregiver three times:

- Baseline in winter 2016;
- Six-month follow-up in summer 2017; and
- Twelve-month follow-up in winter 2017.

In late 2018, ACL released the results in *Process Evaluation of the Older Americans Act Title III-E National Family Caregiver Support Program: Final Report*. The objectives of the outcome evaluation were 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 the 2019 National Survey of OAA Participants show that 21 percent of caregivers are assisting two or more individuals. Seventy-nine percent of Title III caregivers are 60 or older, making them more vulnerable to a decline in their own health, and 35 percent describe their own health as fair to poor.[100] The demands of caregiving can lead to a breakdown of the caregiver's health. Nationally, approximately 11 percent of caregivers

[100] 2019 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.

report that caregiving has caused their physical health to decline.[101] 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.[102]

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 (75 percent) while often continuing to work,[103] 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, on average, for an additional year before being admitted to a nursing home resulting in a significant cost savings due to this delay.[104]

Data from the 2019 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.[105] Those respondents were then asked to identify where the care recipient would be living without services. A significant majority of those caregivers, nearly 75 percent, indicated that the care recipient would most likely be living in a nursing home or an assisted living facility.[106] (Figure 1 below.)

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[101] Center on Aging Society. (2005) How Do Family Caregivers Fare? A Closer Look at Their Experiences. (Data Profile, Number 3). Washington, DC: Georgetown University.
[102] 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.
[103] 2019 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.
[104] 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.
[105] 2019 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.
[106] Ibíd.

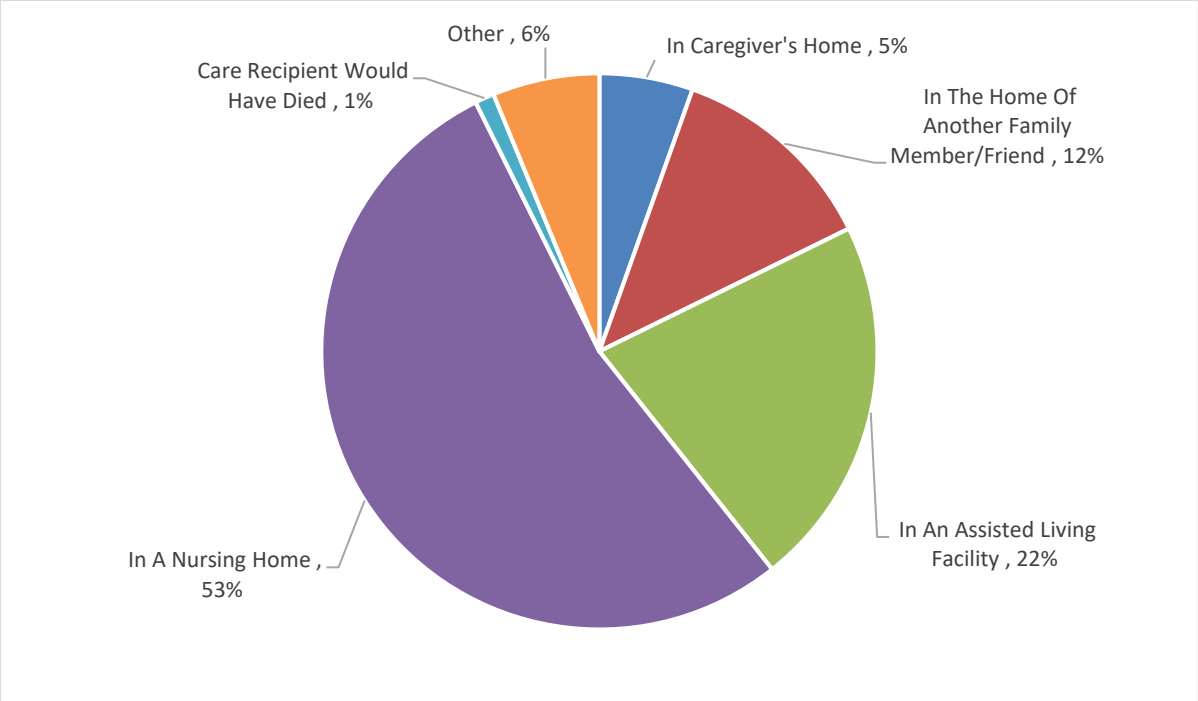

Figure 1. 2019 National Survey of Older Americans Act Participants' Responses to question asking them to identify where person receiving support would be living were it not for the availability of OAA services.

ALZHEIMER'S DISEASE PROGRAMS INITIATIVE

(Title IV of OAA; FY 2018: $23,478,163[107])

In FY 2018, the Congress enacted the President's proposal to consolidate three legacy AoA Alzheimer's programs – along with the Alzheimer's Call Center – into a single, more flexible program known to as the Alzheimer's Disease Programs Initiative (ADPI). The ADPI is a consolidated program that is helping to fill identified gaps in existing systems that support caregivers and people living with Alzheimer's disease and related dementias (ADRD) by dedicating resources for states and community organizations with proven capability in the provision of dementia services and training to targeted special populations.

Through the ADPI, ACL issued two classes of competitive grants: to states that want to improve or develop their dementia systems capability and to existing dementia-capable community-based

[107] This figure is composed of $14.7 million in funding provided by the Prevention and Public Health Fund and $8.778 million in final discretionary funding for FY 2018 net of permissive transfers of $21,837. For additional information, refer to ACL Operating Plan for FY 2019 available at https://acl.gov/sites/default/files/about-acl/2018-12/FY2019_ACL%20Operating%20Plan.pdf.

organizations that are prepared to address identified service gaps through expansion of their ongoing activities.[108]

ACL's ADRD grant projects are designed to ensure that states and communities provide people living with ADRD and their family caregivers with access to sustainable home and community-based services systems that are dementia capable. Such a system meets the unique needs of people living with ADRD and their caregivers by, including (1) identifying those with a possible dementia and recommending follow-up with a physician; 2) ensuring that the staff these individuals encounter have appropriate training, understand the unique needs/services available, and know how to communicate with the patient; and 3) providing quality, person-centered services that help these individuals remain independent and safe in their communities.

As the number of people living with ADRD grows, it is increasingly important to ensure the availability of dementia-capable HCBS. All funded ADRD project evaluations are designed to demonstrate the impact of the work on the persons served. ADPI-funded project 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 increases in ADRD knowledge.

In addition to fulfilling the systems requirements, community grantees are required to address specific service gap areas that align with recommendations from the National Alzheimer's Project Act Advisory Committee. In FY 2018, 35 states were implementing grants dedicated to the development and enhancement of dementia-capable systems.

To support this important work, ACL funds a training and technical assistance resource center. All entities participating in ADRD programs benefit from extensive technical assistance provided through the National Alzheimer's and Dementia Resource Center (NADRC). The NADRC provides expert technical assistance to ACL's AoA 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, intellectual and developmental disabilities and dementia, 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.

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[108] 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 competent, sustainable, integrated LTSSs. For more information, refer to https://acl.gov/sites/default/files/triage/BH-Brief-Dementia-Capable-Basics.pdf.

Brain Health

Promoting brain health is critical to helping older adults maintain their cognition, independence, and overall 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.

ACL 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 to promote brain health among older adults, people with disabilities, and their caregivers. The Brain Health Resource addresses several 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 Brain Health Resource supplies evidence-based information and governmental resources that can help professionals, older adults, and people with disabilities promote brain health. ACL, NIH, and CDC will continue their collaboration on the Brain Health Resource over time. This work occurs under the direction of HHS's National Plan to Address Alzheimer's Research, Care, and Services.[109]

[109] https://aspe.hhs.gov/national-plan-address-alzheimers-disease-2015-update.

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

NUTRITION AND SUPPORTIVE SERVICES

(OAA Title VI, Parts A & B: FY 2018: $33,129,345[110])

ACL provides grants for Native American Nutrition and Supportive Services to eligible tribal organizations to support the delivery of nutrition and home and community-based supportive services to American Indian, Alaska Native, and Native Hawaiian (AI/AN/NH) elders. An estimated 993,621 persons age 60 and over identify themselves as AI/AN alone or in combination with another racial group.[111] Over 578,800 of those elders identify as AI/AN with no other racial group.[112]

Between 2000 and 2010, the number of older 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.[113] In addition, this rapidly growing population is also experiencing some of the highest rates of disability,[114] chronic disease, and poverty[115] in the U.S. Because of the combined factors, 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, ACL's congregate nutrition program reaches 42 percent of eligible elders in participating tribal organizations, home-delivered nutrition services reach 12 percent of such persons, and supportive services reach 30 percent of such persons.[116] These programs, which can help to reduce the need for costly nursing home care and medical interventions, are responsive to the cultural diversity of tribal

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[110] This is the final operating level for FY 2018 and does not include permissive transfers of $78,655. For additional information, refer to ACL Operating Plan for FY 2019 available at https://acl.gov/sites/default/files/about-acl/2018-12/FY2019_ACL%20Operating%20Plan.pdf.
[111] 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, 2018. Released July 2019, accessed May 2020.
[112] 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, 2018. Released July 2019. Accessed March 2020.
[113] Administration on Aging, U.S. Population by Age: 65+ Minority Population Comparison using Census 2000 and Census 2010 (July 1, 2011).
[114] National Council on Disability, "Understanding Disabilities in American Indian and Alaska Native Communities: Toolkit Guide" (2003).
[115] Centers for Disease Control and Prevention, "CDC Health Disparities and Inequalities Report – United States" (2013).
[116] ACL's OAA Title VI Program Performance Report, PY 2018. 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.

communities and are an important part of each community's comprehensive services. Services provided by this program in FY 2018 included:

- Transportation Services, which provided over 778,000 rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical activities.[117]
- Home-Delivered Nutrition Services, which provided over 2.6 million meals to over 22,000 homebound 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.[118]
- Congregate Nutrition Services, which provided over 2.5 million meals to over 65,000 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.[119]
- Information, Referral, and Outreach Services, which provided over 765,000 hours of outreach and information on services and programs to elders and their families, thereby empowering them to make informed choices about their service and care needs.[120]

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 tribal elders. Training and technical assistance is provided through national meetings, site visits, monthly webinars, e-newsletters, telephonic 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 AI/AN/NH population age 60 and over. Tribal and Native Hawaiian organizations must represent at least 50 Native American or Native Hawaiian 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.

[117] ACL's OAA Title VI Program Performance Report, PY 2018.
[118] Ibid.
[119] Ibid.
[120] Ibid.

CAREGIVER SUPPORT SERVICES

(OAA Title VI, Part C; FY 2018: $9,528,536[121])

ACL provides grants for Native American Caregiver Support Services to eligible tribal organizations to provide support for family and informal caregivers of AI/AN/NH elders, and support for elders who are raising children or caring for an adult with a disability. 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 AI/AN/NH 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 or those elders caring for an adult child with a disability.

Grants assist AI/AN/NH families caring for elders 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 245,000 hours of respite care, delivered just over 26,000 hours of caregiver training, and assisted 18,000 caregivers to access needed services.[122] 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.

[121] This is the final operating level for FY 2018 and does not include permissive transfers of $27,464. For additional information, refer to ACL Operating Plan for FY 2019 available at https://acl.gov/sites/default/files/about-acl/2018-12/FY2019_ACL%20Operating%20Plan.pdf.
[122] Ibid.

PART III: ELDER RIGHTS

ACL 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

(OAA Title VII: FY 2018: $4,761,156[123])

The Prevention of Elder Abuse and Neglect program (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. This program coordinates activities with state and local adult protective services programs and other professionals who work to address issues of elder maltreatment and elder justice.

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.[124] In addition, data from APS agencies show elder abuse is increasing,[125] despite estimates that as few as 1 in 14 cases of elder abuse,[126] and 1 in 44 cases of financial exploitation, come to the attention of authorities.

The Prevention of Elder Abuse and Neglect program demonstrates ACL's ongoing commitment to protecting the rights of vulnerable older adults and promoting their dignity and autonomy. A recent example of a state's elder abuse prevention activities includes Nebraska's annual elder justice training which is streamed over the Internet for regional and national participation from a dedicated website. AAAs host watch locations throughout the state, while the SUA hosts the session at the Nebraska Educational Telecommunications location.

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[123] This is the final operating level for FY 2018 and does not include permissive transfers of $11,844. For additional information, refer to ACL Operating Plan for FY 2019 available at https://acl.gov/sites/default/files/about-acl/2018-12/FY2019_ACL%20Operating%20Plan.pdf.

[124] 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.

[125] Teaster, Pamela, et al. *The 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older*. http://www.napsa-now.org/wp-content/uploads/2012/09/2-14-06-FINAL-60+REPORT.pdf. Accessed October 31, 2019.

[126] National Research Council. (2003). Elder Mistreatment: Abuse, neglect and exploitation in an Aging America. Washington, D.C.: The National Academies Press. Available at: https://www.ncbi.nlm.nih.gov/books/NBK98802/.

ELDER RIGHTS SUPPORT ACTIVITIES

(OAA Titles II and IV: FY 2018 $15,812,772[127])

Elder Rights Support Activities provide information, training, and technical assistance to states and communities to prevent, detect, and respond to, elder abuse, neglect, and exploitation, and to support the development of coordinated systems of Adult Protective Services (APS). These activities, along with the Elder Justice and APS program, are important components of ACL's elder rights programs and help to create a full array of services to prevent, detect, and resolve elder abuse, neglect, and exploitation. These programs and resource centers help provide high-quality and efficient services and supports to further ACL's efforts to promote elder rights and elder justice.

National Center on Elder Abuse

ACL funds the National Center on Elder Abuse (NCEA) to disseminate information to professionals and the public on elder maltreatment and to provide 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.

In FY 2018, the NCEA website was a valued resource on abuse, neglect, and exploitation for its users. The NCEA websites reached over 85,000 unique users, totaling approximately 217,000 page views. NCEA connected with 1,188 constituents, with the three most frequent methods of contact being phone (56 percent), email (38 percent), and Facebook (3 percent).

In order to increase public understanding of elder abuse and how it can be prevented, NCEA incorporated a dynamic new communications strategy, Reframing Elder Abuse, into its technical assistance to members of the public who contact NCEA for information or referrals on elder abuse. This information was shared in response to nearly 600 inquiries about elder abuse submitted by phone, email, social media, and listserv. As part of the campaign, the NCEA published two Public Service Announcement Videos and a paid YouTube advertisement, which together were viewed 26,000 times on YouTube. In addition, NCEA created webinars, gave a presentation at the Grantmakers in Aging (GIA) Conference, and conducted eighteen Reframing Aging and Elder Abuse presentations for more than a thousand aging and elder justice professionals in 2018.

[127] This is the final operating level for FY 2018 and does not include permissive transfers of $61,228. For additional information, refer to ACL Operating Plan for FY 2019 available at https://acl.gov/sites/default/files/about-acl/2018-12/FY2019_ACL%20Operating%20Plan.pdf.

National Center on Law and Elder Rights

The National Center on Law and Elder Rights (NCLER) provides aging and legal professionals with 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 fulfills three core support functions for aging and legal networks. Case consultation assists professionals and advocates in the field of law and aging in the resolution of complex legal problems impacting older adults. Legal training ensures professionals and advocates from aging and legal services networks are prepared to respond to a wide range of issues experienced by older Americans with economic and social need. Finally, NCLER provides technical assistance in the development of legal service capacity to strengthen responses to priority legal issues impacting older adults.

In 2018, NCLER provided legal training on a broad range of priority issues that included civil litigation as a remedy for financial exploitation of older adults; elder financial abuse and Medicaid denials; Social Security reconsideration appeals; nursing home-to-community transitions; and Managed LTSS and service authorization. NCLER also provided case consultation on priority legal issues. Also in 2018, NCLER provided technical assistance and training on capacity-building for legal assistance programs and their community-based partners.

The NCLER website was redesigned in 2018. The website and other related websites are accessible through the ACL Elder Justice website.

Model Approaches to Statewide Legal Assistance Systems

Model Approaches to Statewide Legal Assistance Systems grants help states develop and implement statewide enhancements in the delivery of legal assistance to older adults with economic or social need experiencing priority legal issues set forth in the OAA.

In FY 2018, two states (Tennessee and Wisconsin) continued capacity-building with their grants. In addition, six states (Connecticut, Florida, Pennsylvania, Massachusetts, Vermont, and Virginia) continued objectives under Phase II grants. For example, in Florida, Three Rivers Legal Services partnered with the University of Florida Medical Center to conduct regularly scheduled onsite consultations with individuals and clinicians in the Gainesville area. Their Medical Legal Partnership (MLP) model provides streamlined access to legal services for older, low-income patients while helping to improve health outcomes by addressing social and legal determinants of health. The Florida MLP assisted older clients in addressing issues related to Medicaid, housing, estate planning, advance directives, and accessing public benefits.

Pension Counseling and Information Program

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 U.S. 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 difficult for most people to know whether they are receiving all of the pension benefits to which they are entitled.

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.

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.

ACL's 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.[128] The technical assistance resource center tries to assist individuals in the remaining states not served by the regional centers.

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 the Illinois Pension Assistance Project);
- The South Central Pension Rights Project, serving Arkansas, Louisiana, Missouri, New Mexico, Oklahoma, and Texas;

[128] 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.

- 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.

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. For every federal dollar invested in the program, PCIP has brought in a return of more than $9.00. 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, 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.

LONG-TERM CARE OMBUDSMAN PROGRAM

(OAA Title VII: FY 2018: $ 16,843,100[129,130])

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 LTSS at facility, local, state and national levels, and play an important role in elder justice networks.

The LTC Ombudsman (Ombudsman) program operates in all states, the District of Columbia, Puerto Rico, and Guam, under the authorization of the OAA. In most states, the Office of the State LTC Ombudsman (Office) 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 AAAs to provide direct ombudsman services to residents. There are 523 designated local Ombudsman entities. A full-

[129] This is the final operating level for FY 2018 and does not include permissive transfers of $41,900. For additional information, refer to ACL Operating Plan for FY 2019 available at https://acl.gov/sites/default/files/about-acl/2018-12/FY2019_ACL%20Operating%20Plan.pdf.
[130] States also utilize other Older Americans Act and other funding sources to operate the LTC Ombudsman program.

time State LTC Ombudsman directs the program statewide in each state's Office. Across the nation, staff and thousands of volunteers designated by their State Ombudsman provide services to residents.

The OAA requires Ombudsman programs to identify, investigate, and resolve complaints made by or on behalf of residents; provide information to residents about LTSS; 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.

In FY 2018, 1,297 full-time equivalent staff and 6,163 volunteers provided Ombudsman program services to residents through investigation and complaint resolution. An additional 1,886 volunteers also served residents or assisted in program operations in ways other than complaint resolution. Time contributed by volunteers was valued at nearly $14 million in FY 2018.[131]

Complaint Investigation and Resolution

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 194,516[132] complaints and resolved 74 percent of these complaints to the full or partial satisfaction of the resident or complainant. Seventy-one percent of complaint resolution work occurred in nursing facility settings; 27 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 (43 percent) and in board and care, assisted living, and other residential care communities (37 percent).[133]

In nursing facilities, the top five complaints handled 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.

In board and care, assisted living, and other residential care communities, the top five complaints handled 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.

Improper discharge and eviction was the most common complaint among both nursing home and board and care residents in FY 2018. Ombudsman program strategies to address inappropriate

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[131] The Independent Sector places the value of the volunteer time at $25.43 per hour placing the value of 543,175 hours at $13,812,940. https://independentsector.org/value-of-volunteer-time-2018/. Accessed October 29, 2019.
[132] FFY 2018 National Ombudsman Reporting System (NORS) is the source for this and other data in this section. States report NORS data annually to ACL.
[133] In FY 2018, Ombudsmen opened 128,415 new cases (a case contains one or more complaints originating from the same person(s)), and completed resolution on 123,066 closed cases, containing, 194,516 complaints.

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.

Program Activities

Ombudsman programs provide services that prevent problems for residents and serve as a resource on rights, quality care, and community options. In FY 2018, Ombudsman programs provided:

- Routine visits to 72 percent of nursing facilities and 32 percent of board and care, assisted living, and other residential care communities at least quarterly.
- Information and assistance to individuals (over 409,000 instances) on topics such as LTSS 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 134,000 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 (21,664 sessions) and family councils (1,757 sessions);
- Training of long-term care facility staff (4,287 sessions);
- Community education (9,361 sessions); and
- Coordination with licensing and survey entities, participating in 17,487 facility survey-related activities as resident advocates.

Systems Advocacy

The OAA requires Ombudsman programs to analyze, comment on, and recommend changes in laws, regulations, and government policies and actions to benefit residents. Examples of systems-level work to prevent or respond to staffing shortages and other workforce issues included 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.

National Ombudsman Resource Center (NORC)

Title II of the OAA requires AoA to administer the National Ombudsman Resource Center (NORC) to provide training, technical assistance, and program management expertise to Ombudsman programs. In FY 2018, the National Consumer Voice for Quality Long-Term Care operated the NORC in partnership with the National Association of States United for Aging and Disabilities. [134] In FY 2018, the NORC provided training and technical assistance to Ombudsman programs on such issues as:

[134] In 2019, the National Association of States United for Aging and Disabilities, rebranded to "ADvancing States."

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

Additionally, the NORC provided quarterly training for all new ombudsmen, and developed resource materials, the NORC website, and quarterly newsletters customized for Ombudsman program staff and volunteers.

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 ACL'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 older Americans and for people of all ages who have chronic conditions and disabilities.

AGING AND DISABILITY RESOURCE CENTERS/NO WRONG DOOR SYSTEM

(OAA Title II: FY 2018 $8,098,853[135])

The ADRC/No Wrong Door (NWD) System supports state efforts to help individuals and caregivers connect to LTSS, as well as develop more efficient and cost-effective LTSS access systems. In 2018, ACL and its 15 NWD-system grantees continued to develop systems and infrastructure to ensure "visible and trusted" sources of information, one-on-one counseling, and streamlined access to services and supports were available to individuals seeking and receiving services.

The current LTSS system involves numerous funding streams administered by federal, state and local agencies using different access processes involving duplicative screenings, intake processes, needs assessments, service planning, and eligibility determination. 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 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

[135] This is the final operating level for FY 2018 and does not include permissive transfers of $20,147. For additional information, refer to ACL Operating Plan for FY 2019 available at https://acl.gov/sites/default/files/about-acl/2018-12/FY2019_ACL%20Operating%20Plan.pdf.

exhaust an individual's personal resources and result in their spending down to Medicaid eligibility. In 2018, CMS released a study which examined Medicaid Analytic eXtract (MAX) data in 16 states from 2009 through 2014 and detailed differences in the use of institutional care for Medicaid beneficiaries and the impact of early HCBS intervention in various populations. One of the key findings from the national evaluation included significantly shorter stays in institutional care for beneficiaries who entered LTSS through community-based services compared to those who initiated their LTSS in an institutional setting. [136] 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.

The NWD System Key Elements, created in collaboration with NWD system grantees, describes the vision and functions of the NWD System. The ACL/CMS/Veterans Health Administration (VHA) vision is that each state will have a single statewide NWD System to LTSS for all populations and all payers. The four NWD System functions are:

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

In addition, the LTSS state scorecard[137] recognizes the No Wrong Door (NWD) System vision as a critical component of a high-performing LTSS access system. As part of the LTSS Scorecard, states completed a detailed self-reported survey fielded by AARP for the NWD System indicator of the LTSS Scorecard. The NWD System indicator reflects the four functions of a NWD System. The scorecard results reflect ongoing growth and sustainability of the LTSS access points across the country. Most states improved in their overall NWD scores.[138] The median scores improved for each of the NWD System functions as well.

NWD System ensures individuals do not need to "tell their story" repeatedly to different staff working for different agencies, access points, or providers. Rather, they can tell their story once, and the information they provide is automatically shared with the agencies that coordinate or provide appropriate services. 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 individuals seeking services. Even if the NWD System person-centered counselor is not designated to do the preliminary assessment, the data gathered during the person-centered counseling process is

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[136] *Does Early Use of Community-Based Long-Term Services and Supports Lead to Less Use of Institutional Care?* Kate Stewart and Carol V. Irvin (2018) Based on Medicaid Analytic eXtract (MAX) Data from 2009 through 2014 across 16 states

[137] For more information, see http://www.longtermscorecard.org/.

[138] The total number of possible points for the NWD indicator was 123. Percentage median scores reflect a states total number of points divided by 123. California and Iowa did not submit responses to the 2017 NWD System Scorecard Survey.

incorporated into the preliminary assessment and then automatically transferred into the final assessment process.

In 2018, ACL, CMS, and VHA issued a funding opportunity to support up to nine states in the development of a business case for high performing, streamlined NWD Systems. Building a strong business case creates the foundation for transforming a state's access system and provides information to address the challenge of sustainability. The purpose of this funding opportunity was for states to (1) assess current efforts in establishing a business case for NWD Systems; (2) collaboratively work with ACL and its external partners to develop a methodology and toolkit for calculating a return on investment (ROI) for NWD Systems; (3) share with ACL key data elements needed to test and calculate ROI at the national level; and (4) produce a business case model that demonstrates the impact of NWD Systems. For the purposes of this grant opportunity, ROI is being defined as a measure to show the value of various investments made in NWD Systems. A number of states achieved milestones in 2018; three key highlights include:

- Iowa's development of a mechanism to connect its NWD consumer and provider databases to the technology platforms utilized by healthcare systems and community providers. The state also implemented evidence-informed interventions for older Iowans who are transitioning from hospital or nursing facilities by formalizing key referral sources and increasing access to person-centered counseling and developed and implemented a consumer satisfaction survey to document the quantitative and qualitative benefits and outcomes provided by Iowa's NWD System.
- Oklahoma's partnership with Sooner SUCCESS to provide web based training.[139] The program also implemented the evidence-informed model of respite care, formalizing key referral sources and increasing access to Person-Centered Counseling by expanding Sooner SUCCESS's LifeSpan Respite grant staff capacity to provide one-on-one counseling using person-centered processes for all populations.
- Wisconsin's ongoing commitment to consistency and quality of services and increasing referrals. The state also measured the impact of ADRCs on utilization of health and long-term care services, while contributing to the development of ACL's national NWD ROI calculator and developing a business case for ADRCs.

[139] According to its website, Sooner SUCCESS promote a comprehensive, coordinated system of health, social and educational services for Oklahoma children and youth with disabilities in their communities.

AGING NETWORK SUPPORT ACTIVITIES

(OAA Titles II and VI: FY 2018: $12,430,078[140])

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.

AoA 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 older Americans have access to the highest quality HCBS system, the National Aging Services Network must continually enhance program design and delivery in key priority areas. To address this critical need, AoA continued to support a cooperative agreement that is documenting and reporting on AAA and Tribal organizations' activities and expertise in the delivery of community-based services through surveys and the highlighting of best practices. In FY 2017, the project conducted data collection for the biannual *National Title VI Program Survey: Serving Tribal Elders Across the United States*, which was released in FY 2018. Additionally, in 2018, the project released several reports identifying issues and barriers AAAs face in addressing key topics:

- *Rural AAAs: Structure and Services*
- *Measuring the Value of AAA Services: Making the Case to Health Care Partners*
- *Supporting America's Aging Prisoner Population: Opportunities & Challenges for Area Agencies on Aging*

National Eldercare Locator

In FY 2018, AoA 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

[140] This is the final operating level for FY 2018 and does not include permissive transfers of $30,922. Administration for Community Living. (2019). Operating Plan for FY 2018. Available at: https://acl.gov/sites/default/files/about-acl/2018-12/FY2019_ACL%20Operating%20Plan.pdf.

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, 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. In 2018, the volume of phone calls, emails and online chat inquiries to the Eldercare Locator rose to its highest levels ever, with 405,729 requests for assistance, an increase from 305,637 in 2016. An additional 427,269 individuals accessed resources through the website.

In FY 2018, the Eldercare Locator developed a new brochure, *Living Well with Dementia in the Community: Resources and Support*, which provides information on steps individuals can take if they suspect that a loved one may have dementia, and highlights the many community services and supports available for both older adults with dementia and their caregivers.

National Alzheimer's Call Center

In FY 2018, AoA awarded a cooperative agreement in the amount of $1,233,571 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. It 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 FY 2018, the National Alzheimer's Call Center received 302,979 calls and handled 10,521 online and email inquiries; 34,725 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 consumers, not professionals. Information provided may include basic information on caregiving; handling legal issues; resources for long-distance caregiving; and tips for working with the medical community. In 2018, 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 was established through a cooperative agreement between AoA and the Women's Institute for a Secure Retirement (WISER) in 1998. In FY 2018, AoA awarded WISER $231,525 for the fifth year of a five-year grant.

The Center 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 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 digital formats, including materials designed to identify and prevent fraud and financial exploitation of older persons.

In 2018, the Center reached more than 3,000 individual women directly at nine national conferences and hosted 28 training events across the country bringing programs to underserved rural areas and populations such as Latinas. In addition, AoA and WISER produced over 30 new consumer publications and the Center's work was featured in more than 50 media outlets. These included an article in Woman's Day magazine which reached 3,380,000 print subscribers and an audience of 18,800,000 through all mediums, and an interview on "The Ric Edelman Radio Show," a nationally syndicated radio talk show with a weekly reach of more than 1 million listeners. That interview focused on women's retirement.

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 2018, five national non-profit organizations received a total of approximately $1,150,000 for the fourth 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 lifestyles. Select examples of technical assistance, training and related activities conducted by three of the grantees during FY 2018 include:

- Services and Advocacy for LGBT Elders (SAGE) conducted virtual and in-person trainings reaching more than nine thousand professionals nationwide, for a total of 38,732 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 developed over 40 new educational materials and resources.

- The National Asian Pacific Center on Aging (NAPCA) focused efforts in FY 2018 to translate information and fact sheets about preventing elder abuse into six languages. Additionally, NAPCA developed factsheets and training materials related to family caregiving; tested the readiness of Tailored Caregiver Assessment and Referral (TCARE) with Korean and Vietnamese caregivers in Seattle, Washington; and published a cultural translation of TCARE for Korean and Vietnamese caregivers.
- The National Caucus on Black Aging (NCBA) and the American Psychological Association collaborated to host #Black Aging Matters, a Twitter chat to raise awareness about race-related stress and its impacts on African American and Black older adults, especially in the era of 24-hour news, "BlackLivesMatter, and "MeToo." As a result of #BlackAgingMatters, 1.5 million health and aging service providers dialogued, shared resources, and provided technical assistance that helped African American and Black older adults as well as health and aging service providers across the country more successfully meet mental health challenges.

In addition to the activities highlighted above, the NMAO Technical Assistance Centers conducted 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 70s; however, many are much older and nearly 25 percent of them live in poverty.[141] 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 that has a history of trauma.

[141] Kover, E. (2014). Testimony before the U.S. Senate Special Committee on Aging, January 15, 2014.

In FY 2018, AoA funded the fourth 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 third cohort of more than 40 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 2018, the third year for which data was available from the grantee, the project has reached and served nearly 25,000 individuals, including 13,000 Holocaust survivors and 2,400 family caregivers with PCTI services, and has trained approximately 2,400 professionals who work with them in the principles of PCTI services and support. Outcome data reported by the grantee continue to show that the interventions piloted by the project are leading to measurable decreases in isolation, loneliness, and 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 continue to be adapted 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.

Appendix

FORMULA GRANT FUNDING ALLOCATIONS BY STATE, TERRITORY, AND TRIBAL ORGANIZATIONS[142]

Administration on Aging

Administration for Community Living

Department of Health and Human Services

[142] ACL (September 3, 2018) Title III – Grants for State and Community Programs on Aging FY 2018 Final Allocation (Before any B/C1/C2 Transfers and Re-allotments). Retrieved from: https://acl.gov/sites/default/files/about-acl/2018-09/TitleIII-2018.pdf.

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State	Supportive Services	Congregate Meals	Home Meals	Preventive Services	NFCSP	Total Title III
Alabama	$5,748,745	$7,363,032	$3,703,525	$374,501	$2,709,415	$19,899,218
Alaska	$1,908,742	$2,423,346	$1,217,394	$123,103	$895,096	$6,567,681
Arizona	$8,329,543	$10,668,537	$5,366,158	$542,626	$4,162,295	$29,069,159
Arkansas	$3,515,790	$4,503,048	$2,264,985	$229,036	$1,707,413	$12,220,272
California	$39,627,417	$50,755,067	$25,529,249	$2,581,522	$18,613,674	$137,106,929
Colorado	$5,657,569	$7,246,253	$3,644,787	$368,561	$2,460,926	$19,378,096
Connecticut	$4,266,003	$5,459,141	$2,745,889	$277,665	$2,053,876	$14,802,574
Delaware	$1,908,742	$2,423,346	$1,217,394	$123,103	$895,096	$6,567,681
District of Columbia	$1,908,742	$2,423,346	$1,217,394	$123,103	$895,096	$6,567,681
Florida	$28,459,804	$36,451,512	$18,334,716	$1,854,009	$14,897,648	$99,997,689
Georgia	$10,147,824	$12,997,402	$6,537,552	$661,078	$4,525,861	$34,869,717
Hawaii	$1,908,742	$2,423,346	$1,217,394	$123,103	$895,096	$6,567,681
Idaho	$1,908,742	$2,423,346	$1,217,394	$123,103	$895,096	$6,567,681
Illinois	$14,068,685	$17,826,260	$8,966,416	$906,685	$6,519,625	$48,287,671
Indiana	$7,367,312	$9,436,104	$4,746,258	$479,942	$3,431,275	$25,460,891
Iowa	$4,127,051	$4,980,379	$2,419,826	$244,693	$1,832,214	$13,604,163
Kansas	$3,325,085	$4,139,537	$2,082,142	$210,546	$1,535,955	$11,293,265
Kentucky	$5,113,621	$6,549,562	$3,294,358	$333,126	$2,356,607	$17,647,274
Louisiana	$5,053,926	$6,473,104	$3,255,901	$329,237	$2,297,730	$17,409,898
Maine	$1,908,742	$2,423,422	$1,218,955	$123,261	$895,096	$6,569,476
Maryland	$6,531,229	$8,365,244	$4,207,627	$425,476	$3,014,406	$22,543,982
Massachusetts	$7,951,259	$10,118,736	$5,089,615	$514,663	$3,756,823	$27,431,096
Michigan	$11,974,311	$15,336,781	$7,714,234	$780,064	$5,566,469	$41,371,859
Minnesota	$6,193,264	$7,932,375	$3,989,898	$403,459	$2,909,295	$21,428,291
Mississippi	$3,325,997	$4,259,960	$2,142,714	$216,672	$1,553,735	$11,499,078
Missouri	$7,167,454	$9,180,125	$4,617,503	$466,923	$3,435,124	$24,867,129
Montana	$1,908,742	$2,423,346	$1,217,394	$123,103	$895,096	$6,567,681
Nebraska	$2,222,857	$2,705,657	$1,360,916	$137,616	$1,009,963	$7,437,009
Nevada	$3,238,178	$4,147,481	$2,086,138	$210,951	$1,481,560	$11,164,308
New Hampshire	$1,908,742	$2,423,346	$1,217,394	$123,103	$895,096	$6,567,681
New Jersey	$10,107,547	$12,945,816	$6,511,605	$658,454	$4,857,126	$35,080,548
New Mexico	$2,454,960	$3,144,329	$1,581,564	$159,928	$1,154,080	$8,494,861
New York	$23,520,724	$28,508,865	$14,339,650	$1,450,027	$10,679,449	$78,498,715
North Carolina	$11,522,447	$14,758,029	$7,423,129	$750,628	$5,377,865	$39,832,098
North Dakota	$1,908,742	$2,423,346	$1,217,394	$123,103	$895,096	$6,567,681
Ohio	$13,936,009	$17,849,336	$8,978,023	$907,859	$6,544,816	$48,216,043
Oklahoma	$4,324,666	$5,539,061	$2,786,088	$281,730	$2,069,518	$15,001,063
Oregon	$5,070,689	$6,494,574	$3,266,700	$330,329	$2,331,458	$17,493,750
Pennsylvania	$17,318,394	$20,856,250	$10,452,210	$1,056,929	$7,889,290	$57,573,073
Rhode Island	$1,908,742	$2,423,346	$1,217,394	$123,103	$895,096	$6,567,681
South Carolina	$6,056,589	$7,757,321	$3,901,848	$394,555	$2,798,605	$20,908,918
South Dakota	$1,908,742	$2,423,346	$1,217,394	$123,103	$895,096	$6,567,681
Tennessee	$7,689,859	$9,849,224	$4,954,053	$500,955	$3,582,430	$26,576,521
Texas	$25,222,348	$32,304,956	$16,249,043	$1,643,105	$11,430,354	$86,849,806
Utah	$2,405,572	$3,081,073	$1,549,746	$156,711	$1,094,914	$8,288,016
Vermont	$1,908,742	$2,423,346	$1,217,394	$123,103	$895,096	$6,567,681
Virginia	$9,114,734	$11,674,214	$5,872,003	$593,778	$4,210,006	$31,464,735
Washington	$8,090,592	$10,362,486	$5,212,218	$527,060	$3,645,963	$27,838,319
West Virginia	$2,686,425	$3,240,159	$1,609,708	$162,774	$1,173,471	$8,872,537
Wisconsin	$6,886,100	$8,819,765	$4,436,246	$448,594	$3,234,521	$23,825,226
Wyoming	$1,908,742	$2,423,346	$1,217,394	$123,103	$895,096	$6,567,681
American Samoa	$457,482	$583,006	$152,174	$15,388	$111,887	$1,319,937
Guam	$954,371	$1,211,673	$608,697	$61,552	$447,548	$3,283,841
Northern Mariana Islar	$238,593	$302,918	$152,174	$15,388	$111,887	$820,960
Puerto Rico	$4,509,310	$5,775,555	$2,905,042	$293,758	$2,358,249	$15,841,914
Virgin Islands	$954,371	$1,211,673	$608,697	$61,552	$447,548	$3,283,841
TOTAL	**$381,748,352**	**$484,669,154**	**$243,478,708**	**$24,620,602**	**$179,019,122**	**$1,313,535,938**

State	Ombudsman	Elder Abuse	Total Title VII
Alabama	$255,700	$76,215	$331,915
Alaska	$84,052	$23,710	$107,762
Arizona	$370,494	$84,438	$454,932
Arkansas	$156,380	$48,157	$204,537
California	$1,762,601	$471,073	$2,233,674
Colorado	$251,645	$57,332	$308,977
Connecticut	$189,583	$59,907	$249,490
Delaware	$84,052	$23,710	$107,762
District of Columbia	$84,052	$23,710	$107,762
Florida	$1,265,873	$344,252	$1,610,125
Georgia	$451,368	$103,321	$554,689
Hawaii	$84,052	$23,710	$107,762
Idaho	$84,052	$23,710	$107,762
Illinois	$619,063	$197,384	$816,447
Indiana	$327,693	$98,224	$425,917
Iowa	$167,071	$55,927	$222,998
Kansas	$143,756	$45,843	$189,599
Kentucky	$227,450	$66,595	$294,045
Louisiana	$224,795	$68,518	$293,313
Maine	$84,160	$23,710	$107,870
Maryland	$290,505	$78,087	$368,592
Massachusetts	$351,399	$109,606	$461,005
Michigan	$532,609	$160,862	$693,471
Minnesota	$275,472	$76,347	$351,819
Mississippi	$147,938	$45,198	$193,136
Missouri	$318,804	$97,643	$416,447
Montana	$84,052	$23,710	$107,762
Nebraska	$93,961	$29,770	$123,731
Nevada	$144,032	$32,814	$176,846
New Hampshire	$84,052	$23,710	$107,762
New Jersey	$449,577	$143,950	$593,527
New Mexico	$109,194	$26,393	$135,587
New York	$990,044	$318,066	$1,308,110
North Carolina	$512,511	$126,782	$639,293
North Dakota	$84,052	$23,710	$107,762
Ohio	$619,864	$197,185	$817,049
Oklahoma	$192,358	$60,208	$252,566
Oregon	$225,541	$56,795	$282,336
Pennsylvania	$721,646	$242,944	$964,590
Rhode Island	$84,052	$23,710	$107,762
South Carolina	$269,393	$63,080	$332,473
South Dakota	$84,052	$23,710	$107,762
Tennessee	$342,040	$91,810	$433,850
Texas	$1,121,873	$274,281	$1,396,154
Utah	$106,998	$24,837	$131,835
Vermont	$84,052	$23,710	$107,762
Virginia	$405,417	$102,820	$508,237
Washington	$359,864	$86,291	$446,155
West Virginia	$111,138	$36,736	$147,874
Wisconsin	$306,289	$90,309	$396,598
Wyoming	$84,052	$23,710	$107,762
American Samoa	$10,506	$2,964	$13,470
Guam	$42,026	$11,855	$53,881
Northern Mariana Islands	$10,506	$2,964	$13,470
Puerto Rico	$200,571	$54,217	$254,788
Virgin Islands	$42,026	$11,855	$53,881
TOTAL	**$16,810,358**	**$4,742,085**	**$21,552,443**

State/Territory	Nutrition Services Incentive Program
Alabama	3,319,558
Alaska	487,540
Arizona	1,800,014
Arkansas	2,498,525
California	13,516,400
Colorado	1,440,867
Connecticut	1,392,557
Delaware	536,372
District of Columbia	770,098
Florida	5,731,388
Georgia	2,775,301
Hawaii	504,188
Idaho	739,229
Illinois	6,227,388
Indiana	1,358,677
Iowa	1,618,397
Kansas	2,098,542
Kentucky	1,604,054
Louisiana	3,375,063
Maine	613,602
Maryland	1,699,590
Massachusetts	4,986,275
Michigan	7,645,465
Minnesota	1,799,028
Mississippi	1,481,338
Missouri	3,960,093
Montana	868,592
Nebraska	1,108,560
Nevada	1,539,458
New Hampshire	1,044,445
New Jersey	3,459,732
New Mexico	2,333,383
New York	16,454,534
North Carolina	3,332,614
North Dakota	804,287
Ohio	5,650,620
Oklahoma	1,953,617
Oregon	1,811,390
Pennsylvania	6,661,340
Rhode Island	446,318
South Carolina	1,750,463
South Dakota	933,266
Tennessee	1,634,416
Texas	11,528,360
Utah	1,190,694
Vermont	772,473
Virginia	1,965,257
Washington	2,199,137
West Virginia	1,547,458
Wisconsin	2,819,881
Wyoming	875,317
American Samoa	94,402
Guam	413,311
Northern Mariana Islands	63,371
Puerto Rico	2,777,299
Virgin Islands	103,692
TOTAL	**$152,117,236**

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP (Cash)
AK	01	Aleutian Pribilof Islands Association, Inc.	$113,170	$42,370	$9,022
AK	02	Association of Village Council Presidents	$144,990	$0	$19,687
AK	03	Bristol Bay Native Association	$144,990	$59,310	$6,390
AK	04	Central Council Tlingit & Haida Indian Tribes of AK	$190,380	$67,800	$1,035
AK	06	Copper River Native Association	$88,440	$25,420	$2,642
AK	07	Hoonah Indian Association	$88,440	$25,420	$1,481
AK	08	Kodiak Area Native Association - Northern Region	$77,950	$16,940	$2,773
AK	09	Kodiak Area Native Association - Southern Region	$77,950	$16,940	$3,263
AK	10	Metlakatla Indian Community	$100,430	$33,890	$14,720
AK	11	Native Village of Barrow	$125,170	$50,850	$18,682
AK	12	Tanana Chiefs Conference for Kuskokwim subregion	$88,440	$25,420	$3,370
AK	13	Tanana Chiefs Conference for Lower Yukon Subregion	$77,950	$16,940	$2,718
AK	14	Tanana Chiefs Conference for Yukon Flats Subregion	$77,950	$16,940	$1,390
AK	15	Tanana Chiefs Conference for Yukon Koyukuk Subregion	$88,440	$25,420	$3,445
AK	16	Tanana Chiefs Conference for Yukon Tanana Subregion	$77,950	$16,940	$72
AK	17	Fairbanks Native Association	$144,990	$59,310	$4,441
AK	19	Maniilaq Association	$144,990	$59,310	$18,214
AK	20	Native Villiage of Unalakleet	$88,440	$25,420	$4,611
AK	21	Chugachmiut	$88,440	$25,420	$1,521
AK	22	Arctic Slope Native Association, Limited	$88,440	$25,420	$10,661
AK	23	Denakkanaaga, Inc.	$100,430	$33,890	$321
AK	24	Klawock Cooperative Association	$77,950	$16,940	$1,041
AK	25	Kootznoowoo Inc.	$77,950	$16,940	$2,138
AK	26	Gwichyaa Zhee Gwich'in Tribal Government	$77,950	$16,940	$5,353
AK	27	Native Village of Point Hope	$77,950	$16,940	$5,341
AK	28	Seldovia Village Tribe	$77,950	$16,940	$5,343
AK	30	Sitka Tribes of Alaska	$113,170	$42,370	$1,387
AK	32	Ketchikan Indian Community	$144,990	$59,310	$7,253
AK	35	Southcentral Foundation	$190,380	$67,800	$21,843
AK	36	Kenaitze Indian Tribe	$144,990	$59,310	$7,278
AK	37	Wrangell Cooperative Association	$88,440	$25,420	$1,295
AK	38	Native Village of Savoonga	$88,440	$25,420	$19,297
AK	39	Native Village of Gambell	$88,440	$25,420	$249
AK	40	Native Village of Eyak Traditional Council	$77,950	$16,940	$1,389
AK	41	Organized Village of Kake	$77,950	$16,940	$2,305
AK	42	Chickaloon Native Village	$113,170	$0	$2,805
AK	44	Galena Village (aka Louden Village Council)	$88,440	$25,420	$21,179
AK	45	Asa'carsarmiut Tribe	$77,950	$0	$2,229
AK	46	Orutsararmuit Native Council	$113,170	$42,370	$10,206
AK	47	Chilkoot Indian Association	$88,440	$25,420	$646
AK	48	Knik Tribe	$144,990	$0	$9,287
AK	49	Yakutat Tlingit Tribe	$77,950	$16,940	$1,048
AK	50	Craig Tribal Association	$77,950	$16,940	$1,055
AK	51	Organized Village of Saxman	$77,950	$16,940	$742
Subtotal	*Subtotal*	*Subtotal*	*$4,482,880*	*$1,237,030*	*$261,168*
AL	01	Poarch Band of Creek Indians	$144,990	$59,310	$23,334
Subtotal	*Subtotal*	*Subtotal*	*$144,990*	*$59,310*	*$23,334*
AZ	02	Colorado River Indian Tribes	$144,990	$59,310	$9,335
AZ	03	Gila River Indian Community	$144,990	$59,310	$24,723
AZ	04	Hopi Tribe	$144,990	$59,310	$12,380
AZ	05	Hualapai Tribe	$88,440	$25,420	$20,927
AZ	06	Navajo Nation	$190,380	$67,800	$37,434
AZ	07	Pascua Yaqui Tribe	$144,990	$59,310	$29,845
AZ	09	Salt River Pima-Maricopa Indian Community	$125,170	$50,850	$14,809
AZ	10	San Carlos Apache Older Adult Center	$190,380	$67,800	$9,193
AZ	11	Tohono O'odham Nation	$190,380	$67,800	$6,774
AZ	12	White Mountain Apache Tribe	$190,380	$67,800	$23,854

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP (Cash)
AZ	13	Ak-Chin Indian Community	$77,950	$0	$6,720
AZ	14	Yavapai-Apache Tribe	$88,440	$0	$5,042
AZ	15	Havasupai Tribe	$88,440	$25,420	$5,882
AZ	16	Inter-Tribal Council of Arizona, Inc.	$88,440	$25,420	$2,035
AZ	17	Cocopah Indian Tribe	$77,950	$0	$11,536
AZ	18	Quechan Indian Tribe	$100,430	$33,890	$16,113
Subtotal	*Subtotal*	*Subtotal*	*$2,076,740*	*$669,440*	*$236,602*
CA	01	Bishop Paiute Tribe	$88,440	$25,420	$4,052
CA	02	Blue Lake Rancheria	$77,950	$16,940	$13,833
CA	06	Karuk Tribe	$100,430	$33,890	$5,632
CA	07	Pit River Health Service, Inc.	$113,170	$0	$4,026
CA	08	Picayune Rancheria of the Chukchansi Indians	$77,950	$16,940	$6,531
CA	09	Riverside-San Bernardino Co. Indian Health-Morongo	$100,430	$33,890	$2,960
CA	10	Riverside-San Bernardino Co. Indian Health-Pechanga	$77,950	$16,940	$2,100
CA	11	Riverside-San Bernardino Co. Indian Health-Soboba/	$77,950	$16,940	$5,989
CA	12	Sonoma County Indian Health Project - Sonoma	$77,950	$0	$8,698
CA	13	Southern Indian Health Council, Inc. - Area I	$77,950	$16,940	$12,944
CA	14	Southern Indian Health Council, Inc. - Area II	$77,950	$16,940	$12,118
CA	15	Toiyabe Indian Health Project, Inc. - Northern	$77,950	$16,940	$9,176
CA	16	Tule River Indian Health Center, Inc.	$88,440	$25,420	$19,179
CA	17	United Indian Health Services Inc. for Resighini	$100,430	$33,890	$9,920
CA	18	United Indian Health Services Inc. for Tolowa	$144,990	$59,310	$13,180
CA	20	Indian Senior Center, Inc.	$88,440	$25,420	$10,551
CA	21	Sonoma County Indian Health Project - Manchester	$77,950	$0	$4,839
CA	25	Pala Band of Mission Indians	$88,440	$0	$18,836
CA	26	Redding Rancheria	$144,990	$59,310	$6,634
CA	28	Toiyabe Indian Health Project, Inc. - Southern	$77,950	$16,940	$7,592
CA	29	K'ima:w Medical Center	$100,430	$0	$9,367
CA	30	Round Valley Indian Tribes Senior Center	$88,440	$0	$10,272
CA	31	Fort Mojave Indian Tribe	$88,440	$25,420	$9,331
CA	33	CA Indian Manpower Consortium, Inc. - Chico,	$77,950	$16,940	$2,605
CA	34	CA Indian Manpower Consortium, Inc. - Big Sandy,	$88,440	$25,420	$7,823
CA	35	CA Indian Manpower Consortium, Inc. - Berry Creek,	$88,440	$25,420	$2,895
CA	36	CA Indian Manpower Consortium, Inc. - Coyote Valley,	$88,440	$25,420	$5,095
CA	37	CA Indian Manpower Consortium, Inc. - Enterprise,	$100,430	$33,890	$4,839
CA	38	Santa Ynez Tribal Health Clinic	$77,950	$0	$2,467
CA	39	CA Indian Manpower Consortium, Inc. - North Fork,	$77,950	$16,940	$4,674
CA	40	CA Indian Manpower Consortium, Inc. - Robinson,	$77,950	$16,940	$4,364
CA	41	Wilton Rancheria	$77,950	$0	$2,850
CA	42	Wiyot Tribe	$88,440	$25,420	$13,359
Subtotal	*Subtotal*	*Subtotal*	*$2,958,950*	*$643,880*	*$258,731*
CO	01	Southern Ute Indian Tribe	$100,430	$33,890	$5,903
CO	02	Ute Mountain Ute Tribe	$88,440	$0	$20,532
Subtotal	*Subtotal*	*Subtotal*	*$188,870*	*$33,890*	*$26,435*
CT	01	Mohegan Tribe of Indians of Connecticut	$88,440	$0	$2,751
CT	02	Mashantucket Pequot Tribal Nation	$77,950	$0	$1,381
Subtotal	*Subtotal*	*Subtotal*	*$166,390*	*$0*	*$4,132*
HI	01	Alu Like, Inc.	$1,505,000	$67,800	$26,038
Subtotal	*Subtotal*	*Subtotal*	*$1,505,000*	*$67,800*	*$26,038*
IA	01	Sac & Fox Tribe of the Mississippi in Iowa	$88,440	$25,420	$10,021
Subtotal	*Subtotal*	*Subtotal*	*$88,440*	*$25,420*	*$10,021*
ID	01	Coeur d'Alene Tribe	$88,440	$25,420	$18,767
ID	02	Nez Perce Tribe	$144,990	$59,310	$24,895
ID	03	Shoshone-Bannock Tribes	$125,170	$50,850	$20,040
Subtotal	*Subtotal*	*Subtotal*	*$358,600*	*$135,580*	*$63,702*
KS	01	Kickapoo Tribe in Kansas	$88,440	$25,420	$8,968
KS	02	Prairie Band Potawatomi Nation	$100,430	$33,890	$30,592

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP (Cash)
KS	03	Iowa Tribe of Kansas and Nebraska	$77,950	$16,940	$6,883
Subtotal	*Subtotal*	*Subtotal*	*$266,820*	*$76,250*	*$46,443*
LA	01	Institute for Indian Development, Inc.	$113,170	$0	$15,793
Subtotal	*Subtotal*	*Subtotal*	*$113,170*	*$0*	*$15,793*
MA	01	Wampanoag Tribe of Gay Head (Aquinnah)	$88,440	$25,420	$1,061
MA	02	Mashpee Wampanoag Tribe	$113,170	$42,370	$3,139
Subtotal	*Subtotal*	*Subtotal*	*$201,610*	*$67,790*	*$4,200*
ME	01	Pleasant Point Passamaquoddy	$100,430	$33,890	$25,573
ME	02	Penobscot Indian Nation	$88,440	$0	$5,111
ME	04	Aroostook Band of Micmacs	$88,440	$25,420	$19,875
Subtotal	*Subtotal*	*Subtotal*	*$277,310*	*$59,310*	*$50,559*
MI	01	Grand Traverse Band of Ottawa & Chippewa Indians	$100,430	$33,890	$14,569
MI	02	Inter-Tribal Council of Michigan, Inc.	$88,440	$25,420	$4,382
MI	03	Keweenaw Bay Indian Community	$100,430	$33,890	$23,338
MI	04	Sault Ste. Marie Tribe of Chippewa Indians	$190,380	$0	$18,836
MI	05	Little Traverse Bay Bands of Odawa Indians	$125,170	$50,850	$3,843
MI	07	Bay Mills Indian Community	$88,440	$25,420	$6,695
MI	08	Pokagon Band of Potawatomi Indians	$100,430	$0	$4,455
MI	09	Little River Band of Ottawa Indians	$113,170	$42,370	$7,181
MI	10	Nottawaseppi Huron Band of the Potawatomi	$77,950	$0	$682
Subtotal	*Subtotal*	*Subtotal*	*$984,840*	*$211,840*	*$83,981*
MN	01	Bois Forte Band of Chippewa	$88,440	$25,420	$11,341
MN	02	Fond du Lac Band of Lake Superior Chippewa	$144,990	$59,310	$47,553
MN	03	Leech Lake Band of Ojibwe	$144,990	$59,310	$25,832
MN	07	Red Lake Band of Chippewa Indians	$144,990	$0	$56,609
MN	08	White Earth Reservation Tribal Council	$144,990	$59,310	$12,831
MN	09	Grand Portage Band of Lake Superior Chippewa	$77,950	$16,940	$6,190
MN	10	Mille Lacs Band of Ojibwe	$88,440	$25,420	$21,801
MN	11	Lower Sioux Indian Community	$77,950	$16,940	$5,534
Subtotal	*Subtotal*	*Subtotal*	*$912,740*	*$262,650*	*$187,691*
MS	01	Mississippi Band of Choctaw Indians	$144,990	$59,310	$24,182
Subtotal	*Subtotal*	*Subtotal*	*$144,990*	*$59,310*	*$24,182*
MT	01	Fort Peck Assiniboine and Sioux Tribes	$144,990	$59,310	$42,483
MT	02	Blackfeet Tribe - Eagle Shield Center	$144,990	$59,310	$32,338
MT	03	Chippewa Cree Tribe Senior Citizens Department	$113,170	$42,370	$17,179
MT	04	Confederated Salish and Kootenai Tribes	$144,990	$59,310	$4,154
MT	05	Fort Belknap Indian Community	$113,170	$42,370	$17,870
MT	06	Northern Cheyenne Elderly Program	$125,170	$50,850	$28,124
MT	07	Crow Tribal Elders Program	$144,990	$59,310	$50,489
Subtotal	*Subtotal*	*Subtotal*	*$931,470*	*$372,830*	*$192,637*
NC	01	Eastern Band of Cherokee Indians	$190,380	$67,800	$29,858
Subtotal	*Subtotal*	*Subtotal*	*$190,380*	*$67,800*	*$29,858*
ND	01	Spirit Lake Tribe	$100,430	$33,890	$48,241
ND	02	Standing Rock Sioux Tribe	$144,990	$59,310	$80,936
ND	03	Three Affiliated Tribes	$144,990	$59,310	$31,264
ND	04	Trenton Indian Service Area	$100,430	$33,890	$1,180
ND	05	Turtle Mountain Band of Chippewa Indians	$144,990	$59,310	$16,444
Subtotal	*Subtotal*	*Subtotal*	*$635,830*	*$245,710*	*$178,065*
NE	01	Omaha Tribe of Nebraska	$88,440	$25,420	$9,417
NE	02	Santee Sioux Nation	$77,950	$0	$5,951
NE	03	Winnebago Senior Citizen Center	$88,440	$25,420	$15,077
NE	04	Ponca Tribe of Nebraska	$77,950	$16,940	$12,466
Subtotal	*Subtotal*	*Subtotal*	*$332,780*	*$67,780*	*$42,911*
NM	01	Eight Northern Indian Pueblos Council,Inc.(Picuris,etc)	$190,380	$67,800	$30,263
NM	02	Eight Northern Indian Pueblos Council, Inc. (San	$113,170	$42,370	$5,584
NM	03	Five Sandoval Indian Pueblos, Inc.	$113,170	$42,370	$11,533
NM	04	Jicarilla Apache Nation	$125,170	$50,850	$24,648

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP (Cash)
NM	05	Laguna Rainbow Corporation	$190,380	$67,800	$19,719
NM	06	Mescalero Apache Tribe Elderly Program	$113,170	$0	$9,971
NM	07	Pueblo de Cochiti Elder Program	$88,440	$25,420	$8,547
NM	09	Pueblo of Isleta Elder Center	$144,990	$59,310	$24,971
NM	10	Pueblo of Jemez Senior Citizens Program	$144,990	$59,310	$9,807
NM	11	Pueblo of San Felipe Elderly Services Program	$144,990	$59,310	$36,041
NM	12	Taos Pueblo Senior Citizens Program	$100,430	$33,890	$8,241
NM	13	Zuni Tribe	$190,380	$67,800	$23,229
NM	14	Ohkay Owingeh Senior Citizens Program	$144,990	$59,310	$15,575
NM	15	Santa Clara Pueblo Senior Center	$144,990	$59,310	$19,396
NM	16	Santo Domingo Tribe	$144,990	$59,310	$18,864
NM	17	Pueblo of Tesuque	$77,950	$16,940	$7,189
NM	18	Pueblo of Acoma	$113,170	$42,370	$14,499
Subtotal	*Subtotal*	*Subtotal*	*$2,285,750*	*$813,470*	*$288,077*
NV	01	Fallon Paiute-Shoshone Tribes	$88,440	$25,420	$21,697
NV	02	Inter-Tribal Council of Nevada, Inc. (McDermitt, etc.)	$77,950	$16,940	$4,893
NV	03	Inter-Tribal Council of Nevada, Inc. (Duckwater, etc.)	$77,950	$16,940	$3,946
NV	04	Inter-Tribal Council of Nevada, Inc. (Ely, etc.)	$77,950	$16,940	$3,690
NV	05	Shoshone-Paiute Tribes	$113,170	$42,370	$7,716
NV	06	Walker River Paiute Tribe	$88,440	$25,420	$9,075
NV	07	Washoe Tribe of Nevada and California	$88,440	$25,420	$13,995
NV	08	Yerington Paiute Tribe	$77,950	$16,940	$6,608
NV	09	Pyramid Lake Paiute Tribe	$88,440	$25,420	$7,212
NV	10	Elko Band Council	$88,440	$25,420	$7,524
NV	11	Reno-Sparks Indian Colony	$88,440	$25,420	$17,126
Subtotal	*Subtotal*	*Subtotal*	*$955,610*	*$262,650*	*$103,482*
NY	01	Saint Regis Mohawk Tribe	$144,990	$59,310	$594
NY	02	Seneca Nation Area Office for the Aging	$144,990	$59,310	$20,092
NY	04	Oneida Indian Nation Elders Program	$88,440	$25,420	$5,715
NY	05	Shinnecock Indian Nation	$88,440	$25,420	$4,854
Subtotal	*Subtotal*	*Subtotal*	*$466,860*	*$169,460*	*$31,255*
OK	01	Apache Tribe of Oklahoma	$88,440	$25,420	$22,859
OK	02	Caddo Nation of Oklahoma	$77,950	$16,940	$3,420
OK	03	Cherokee Nation	$191,612	$69,253	$38,327
OK	04	Cheyenne and Arapaho Tribes of Oklahoma	$144,990	$59,310	$7,552
OK	06	Choctaw Nation of Oklahoma	$190,380	$67,800	$44,507
OK	07	Citizen Potawatomi Nation	$190,380	$67,800	$12,815
OK	08	Comanche Nation	$144,990	$59,310	$23,487
OK	09	Delaware Nation	$78,960	$16,940	$6,387
OK	10	Iowa Tribe of Oklahoma	$144,990	$59,310	$9,075
OK	12	Kickapoo Tribe of Oklahoma	$100,000	$25,420	$8,832
OK	13	Kiowa Tribe of Oklahoma	$190,380	$67,800	$9,671
OK	14	Miami Tribe of Oklahoma	$144,990	$59,310	$35,402
OK	15	Muscogee Creek Nation Elderly Nutrition Program	$190,380	$67,800	$157,938
OK	18	Ottawa Tribe of Oklahoma	$144,990	$59,310	$24,474
OK	19	Pawnee Nation of Oklahoma	$113,170	$42,370	$12,131
OK	20	Peoria Tribe of Indians of Oklahoma	$125,170	$50,850	$9,984
OK	21	Ponca Tribe of Indians of Oklahoma	$113,170	$42,370	$15,635
OK	22	Quapaw Tribe Elders Center	$144,990	$59,310	$22,827
OK	23	Sac and Fox Nation of Oklahoma	$144,990	$59,310	$14,110
OK	24	Seminole Nation of Oklahoma	$144,990	$59,310	$15,344
OK	25	Seneca-Cayuga Nation	$88,440	$25,420	$9,203
OK	26	Wichita and Affiliated Tribes	$144,990	$59,310	$10,723
OK	27	Wyandotte Nation	$144,990	$59,310	$17,541
OK	28	Absentee Shawnee Tribe of Oklahoma	$190,380	$67,800	$29,019
OK	29	Fort Sill Apache Tribe	$113,170	$42,370	$8,440
OK	31	United Keetoowah Band of Cherokee Indians	$190,380	$67,800	$25,589

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP (Cash)
OK	32	Chickasaw Nation	$190,380	$67,800	$132,706
OK	33	Kaw Nation	$77,950	$0	$21,612
OK	34	Osage Nation	$144,990	$59,310	$64,569
OK	35	Delaware Tribes of Indians	$190,380	$67,800	$10,012
OK	36	Alabama-Quassarte Tribal Town	$77,950	$16,940	$2,992
OK	37	Eastern Shawnee Tribe of Oklahoma	$125,170	$50,850	$18,463
OK	38	Otoe-Missouria Tribe of Indians	$88,440	$25,420	$14,546
Subtotal	*Subtotal*	*Subtotal*	*$4,577,522*	*$1,645,373*	*$860,192*
OR	01	Confederated Tribes of Siletz Indians	$125,170	$50,850	$3,126
OR	02	Yellowhawk Tribal Health Center	$125,170	$50,850	$14,780
OR	03	Confederated Tribes of Warm Springs	$144,990	$59,310	$7,472
OR	04	Confederated Tribes of Grand Ronde	$113,170	$42,370	$13,355
OR	05	The Klamath Tribes	$144,990	$59,310	$3,905
OR	06	Confed. Tribes of Coos, Lower Umpqua &	$100,430	$33,890	$10,539
OR	07	Cow Creek Band of Umpqua Tribe of Indians	$88,440	$25,420	$1,354
Subtotal	*Subtotal*	*Subtotal*	*$842,360*	*$322,000*	*$54,531*
RI	01	Narragansett Indian Tribe	$113,170	$42,370	$2,861
Subtotal	*Subtotal*	*Subtotal*	*$113,170*	*$42,370*	*$2,861*
SC	01	Catawba Indian Nation	$113,170	$42,370	$13,963
Subtotal	*Subtotal*	*Subtotal*	*$113,170*	*$42,370*	*$13,963*
SD	01	Cheyenne River Elderly Nutrition Services	$144,990	$59,310	$8,701
SD	02	Crow Creek Sioux Tribe	$88,440	$0	$15,533
SD	03	Lower Brule Sioux Tribe	$88,440	$25,420	$17,642
SD	04	Oglala Sioux Tribe	$190,380	$67,800	$53,422
SD	05	Rosebud Sioux Tribe	$190,380	$67,800	$34,721
SD	06	Sisseton Wahpeton Oyate of the	$144,990	$59,310	$29,226
SD	08	Yankton Sioux Tribe	$125,170	$50,850	$27,993
Subtotal	*Subtotal*	*Subtotal*	*$972,790*	*$330,490*	*$187,238*
TX	01	Alabama-Coushatta Tribe of Texas	$88,440	$25,420	$6,057
TX	02	Kickapoo Traditional Tribe of Texas	$77,950	$0	$18,950
Subtotal	*Subtotal*	*Subtotal*	*$166,390*	*$25,420*	*$25,007*
UT	01	Unitah & Ouray, Ute Indian Tribe	$113,170	$42,370	$8,649
Subtotal	*Subtotal*	*Subtotal*	*$113,170*	*$42,370*	*$8,649*
WA	01	Confederated Tribes of the Colville Reservation	$144,990	$59,310	$22,737
WA	02	Lower Elwha Klallam Tribe	$77,950	$16,940	$10,806
WA	03	Lummi Nation	$113,170	$42,370	$16,269
WA	04	Makah Tribe Senior Program	$88,440	$25,420	$13,990
WA	05	Muckleshoot Indian Tribe	$144,990	$59,310	$33,850
WA	09	Puyallup Tribe of Indians	$190,380	$0	$11,578
WA	10	Quinault Indian Nation	$100,430	$33,890	$38,803
WA	13	Swinomish Indian Tribal Community	$88,440	$25,420	$4,521
WA	14	Spokane Tribes of Indians	$88,440	$25,420	$13,621
WA	16	The Tulalip Tribes of Washington	$190,380	$67,800	$13,140
WA	17	Jamestown S'Klallam Tribe	$88,440	$25,420	$9,307
WA	19	Quileute Tribe	$77,950	$16,940	$4,927
WA	20	S. Puget Intertribal Planning Agency - Shoalwater Bay	$100,430	$33,890	$7,367
WA	22	Upper Skagit Indian Tribe	$77,950	$16,940	$1,824
WA	24	Suquamish Indian Tribe of the	$100,430	$33,890	$10,164
WA	25	Port Gamble S'Klallam Tribe	$88,440	$25,420	$7,686
WA	26	Samish Indian Nation / Sauk Suiattle Tribal Consortium	$113,170	$42,370	$1,824
WA	27	Cowlitz Indian Tribe	$190,380	$67,800	$5,002
WA	28	Skokomish Indian Tribe	$144,990	$59,310	$3,155
WA	29	Confederated Tribes of the Chehalis Reservation	$113,170	$42,370	$6,758
WA	30	Nooksack Indian Tribe	$100,430	$33,890	$7,303
WA	31	Yakama Nation	$144,990	$59,310	$2,589
WA	32	Snoqualmie Indian Tribe	$88,440	$25,420	$580
WA	33	S. Puget Intertribal Planning Agency - Nisqually	$144,990	$59,310	$2,961

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C	NSIP (Cash)
WA	34	Squaxin Island Tribe	$77,950	$16,940	$4,172
WA	35	Sauk-Suiattle Indian Tribe	$77,950	$16,940	$6,962
Subtotal	*Subtotal*	*Subtotal*	*$2,957,710*	*$932,040*	*$261,896*
WI	01	Bad River Elderly Program	$88,440	$25,420	$11,912
WI	02	Forest County Potawatomi Community	$77,950	$16,940	$10,347
WI	03	Lac Courte Oreilles Band of Lake Superior Chippewa	$113,170	$42,370	$8,524
WI	04	Lac du Flambeau Band of Lake Superior Chippewa	$100,430	$33,890	$21,580
WI	05	Menominee Indian Tribe of Wisconsin	$144,990	$59,310	$3,639
WI	06	Oneida Nation Elder Services	$144,990	$59,310	$10,346
WI	07	Red Cliff Band of Lake Superior Chippewa	$88,440	$25,420	$17,319
WI	08	St. Croix Chippewa Indians of Wisconsin	$88,440	$25,420	$7,785
WI	09	Stockbridge-Munsee Community	$88,440	$25,420	$1,850
WI	10	Ho-Chunk Nation	$125,170	$50,850	$13,511
WI	11	Sokaogon Chippewa Community (SCC)	$77,950	$16,940	$6,234
Subtotal	*Subtotal*	*Subtotal*	*$1,138,410*	*$381,290*	*$113,047*
WY	01	Northern Arapaho Tribe	$144,990	$0	$15,262
WY	03	Eastern Shoshone Tribe	$113,170	$0	$10,979
Subtotal	*Subtotal*	*Subtotal*	*$258,160*	*$0*	*$26,241*
Total	*Total*	*Total*	*$31,923,872*	*$9,372,923*	*$3,742,922*