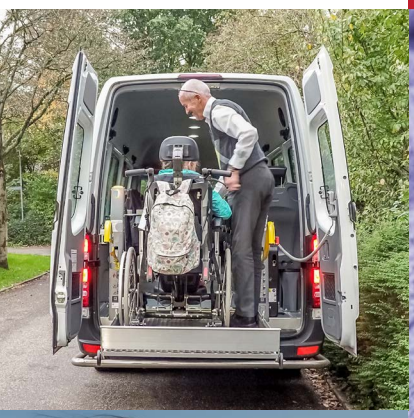
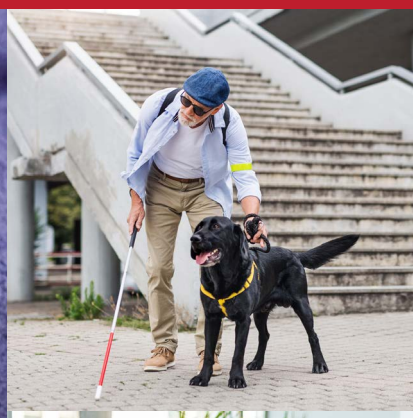
ACL
Administration for Community Living







# Overview of
# OLDER AMERICANS ACT
## Title III, VI, and VII Programs

2020 SUMMARY
OF HIGHLIGHTS AND
ACCOMPLISHMENTS

## Acknowledgment

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# FOREWORD

The United States is facing a surge in the aging population. By 2030, 73 million—or one in five—people in the United States will be 65 or older, and between 2020 and 2030 the number of people 85 and older is projected to rise by 35%.[1] As result, we will experience an increase in the demand for health care services as well as long-term services and supports that enable older adults to successfully age in place.[2,3]

Enacted in 1965, the Older Americans Act (OAA) created the foundation for a comprehensive system of services and supports that enables millions of older adults in this country to continue to live independently as they age. Today, programs funded by the OAA provide essential services to older adults (i.e., generally age 60 and older), targeting those with the greatest economic or social need, particularly low-income and minority persons, older individuals with limited English proficiency, and older persons living in rural areas. The programs play a vital role in helping to maintain the health and well-being of millions of seniors and their caregivers, reaching one in five older adults.

BY 2030

**1 IN 5**

PEOPLE IN U.S.
WILL BE OVER AGE 65

BETWEEN 2020-2030
THERE IS A

**35%**

PROJECTED RISE IN
PEOPLE OVER AGE 85

IN 2020 MORE THAN

# 10.1 MILLION

OLDER PERSONS RECEIVED TITLE III SERVICES

OAA FUNDED

**56**

STATE & TERRITORIAL AGENCIES

OAA FUNDED

**625**

LOCAL AGENCIES

OAA FUNDED

**30,000**

SERVICE PROVIDERS THRU AGENCIES

**Older Americans Act Title III** services account for the largest portion of the Act's funding, supporting a comprehensive national network of federal, state, and local agencies that plan and provide an average of 27 services to help older adults live independently in their homes and communities. These supportive services include case management, community services, in-home services, transportation, information and referral, and legal assistance; nutrition programs; family caregiver support; and health promotion and disease prevention services. **Title VI** authorizes grants to Indian tribal organizations, Alaskan Native organizations, and nonprofit groups representing Native Hawaiians to provide nutrition, supportive, and caregivers services that enhance the independence and well-being of tribal elders while being responsive to the cultural diversity of Native American communities.

IN 2020

**› 200,000**

INDIVIDUALS WERE SERVED BY TITLE VI GRANTEES IN TRIBAL COMMUNITIES

**~200,000**

VISITS TO LONG TERM CARE FACILITIES WERE CONDUCTED BY TITLE VII LTCOP STAFF AND VOLUNTEERS

**Title VII** focuses exclusively on the advocacy responsibility of states to protect and enhance rights, benefits, and independence of the nation's most vulnerable elders by provid ing state grants for "vulnerable elder rights protection" programs. Programs include the Long Term Care Ombudsman Program (LTCOP); programs dedicated to the prevention of elder abuse, neglect, and exploitation; and activities focused on elder rights and legal assistance development.

As the primary federal agency administering the OAA, the Administration for Community Living (ACL) collects reports and data on the Title III, VI, and VII programs. These data provide information about the performance of each program but also show the wide reach and positive impact the programs have on millions of older adults.

In 2020, Title III funded 56 state and territorial agencies on aging, 625 local agencies that coordinated and offered services to older adults, 6,072 senior centers, and almost 30,000 service providers. More than 10.1 million older persons received Title III services. In the 2020–2023 grant cycle, there were 282 Title VI grantees providing nutrition and supportive services and 251 Title VI grantees providing caregiver support services to tribal communities. Through their efforts, Title VI grantees were able to serve more than 200,000 individuals, including 198,591 indi viduals who received nutrition and supportive services and 7,873 individuals who received caregiver support services. Staff and volun teers for the Title VII LTCOP conducted almost 200,000 visits in 39,984 long-term care facilities and investigated more than 150,000 complaints.

This report is the first comprehensive report on the OAA Title III, VI, and VII programs, summarizing highlights and accomplish ments in 2020. It shows the immense value the programs have for reaching millions of older adults and providing much needed services and support in their communities.

# IMPROVING THE LIVES OF OLDER ADULTS AND PEOPLE WITH DISABILITIES THROUGH SERVICES, RESEARCH, AND EDUCATION

## WHAT IS COMMUNITY LIVING?

*Older Adults and People with Disabilities Have the Same Opportunities as Everyone Else to:*

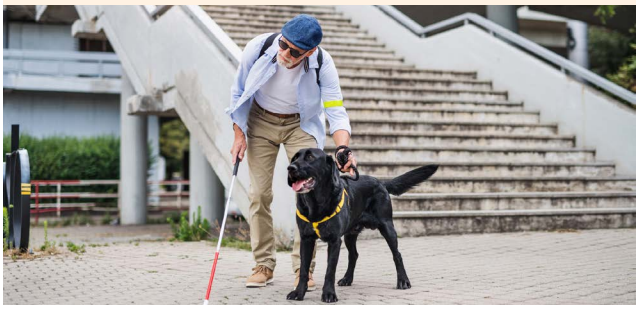
- Choose where to live
- Earn a living
- Participate in society
- Make decisions about their lives

## WHY IS COMMUNITY LIVING IMPORTANT?

- People prefer it
- It costs less
- It's a legal rRight
- Everyone benefits when everyone can contribute

## HOW DOES ACL SUPPORT COMMUNITY LIVING?

- **Funds** services that help people live independently
- **Invests** in research, innovation, training, and education
- **Advocates** for people with disabilities and older adults



## WHO ARE ACL'S PARTNERS?

- Nationwide aging and disability networks
- States, tribes, and communities
- Colleges and universities
- Nonprofit, faith-based, and industry partners
- Other federal agencies

# Abbreviations and Acronyms

| | |
|---|---|
| **AAA** | Area agency on aging |
| **ACL** | Administration for Community Living |
| **AI/AN** | American Indians and Alaskan Natives |
| **AoA** | Administration on Aging |
| **CARES Ac**t | Coronavirus Aid, Relief, and Economic Security Act |
| **COVID-19** | Coronavirus disease 2019 |
| **DRI** | Dietary Reference Intakes |
| **FY** | Fiscal year |
| **HHS** | U.S. Department of Health and Human Services |
| **IADLs** | Instrumental activities of daily living |
| **LAD** | Legal assistance developer |
| **LTCO** | Long-term care ombudsman |
| **LTCOP** | Long-Term Care Ombudsman Program |
| **NFCSP** | National Family Caregiver Support Program |
| **NORS** | National Ombudsman Reporting System (OAA Title VII Chapter 2) |
| **NSOAAP** | National Survey of Older Americans Act Participants (OAA Title III) |
| **OAA** | Older Americans Act |
| **OAAPS** | Older Americans Act Performance System |
| **PPR** | Program Performance Report (OAA Title VI) |
| **SPR** | State Performance Report (OAA Title III) |
| **SUA** | State Unit on Aging |
| **USDA** | U.S. Department of Agriculture |

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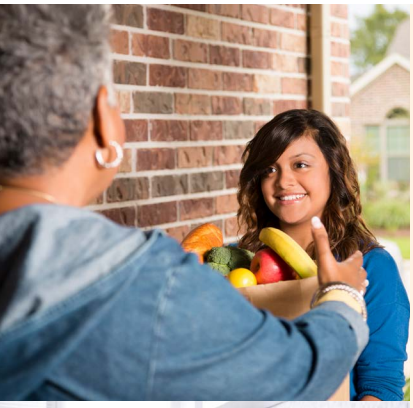
# Introduction



## Mission and Vision of the Administration for Community Living

Established in 2012, the Administration for Community Living (ACL) is one of 11 operating divisions within the U.S. Department of Health and Human Services (HHS). Its mission is to "maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers."[4] Therefore, all ACL programs are designed based on this principle:

> All people, regardless of age or disability, should be able to live independently and participate fully in their communities. Every person should have the right to make choices and to control the decisions in and about their lives. This right to self-determination includes decisions about their homes and work, as well as all the other daily choices most adults make without a second thought.[5]

Programs of ACL support state, tribal, and local community efforts to meet the needs of older adults and persons with disabilities and their families through advocacy, research, systems change, and capacity building. These efforts help individuals to access needed community services and other kinds of assistance so that they can maintain self-determination, independence, productivity, and inclusion in all facets of community life.[6]

Among ACL's many roles, it is the primary federal agency responsible for administering the Older Americans Act (OAA), the country's leading vehicle for delivering services and supports to older people nationwide. Importantly, this responsibility includes supporting the national aging services network and the millions of older adults and individuals with disabilities who depend on it for their health, safety, well-being, and independence.

In order to understand the reach, activities, and effectiveness of these programs, ACL conducts a number of program operations, management, and oversight activities, including requiring grantee reporting which allow ACL to regularly evaluate and report on grantee program performance. These activities produce rich data that can inform program staff and policy makers at federal, state, and local levels. The data also can fuel needed research to help us understand how effectively these programs reach older adults and individuals with disabilities in our communities and improve their lives.

## Older Americans Act

Originally enacted in 1965, the OAA was the first federal-level initiative aimed at comprehensively addressing the need for community social services for older adults. The act supports a range of essential home- and community-based services and elder abuse prevention services, including the Long-Term Care Ombudsman Program (LTCOP), designed to advocate for residents of long-term care facilities through resolution of problems on individual and system levels. Home-delivered and congregate meals, family caregiver support, in-home assistance, preventive health services, transportation, job training, promotion of long-term care residents' rights and protection from abuse, and other supportive services are ways that OAA programs help millions of older adults live as independently as possible in their homes and communities.[7] In addition, OAA services play a key role in preventing more costly institutional services and hospitalizations by helping people remain in their own homes and assisting family caregivers. While the program is open to all older individuals, generally defined as 60 and older, states must target "older individuals with the greatest economic need and older individuals with the greatest social need, with particular attention to low-income minority individuals, older individuals residing in rural areas, low-income individuals, and frail individuals."[8]

As part of the OAA, the Administration on Aging (AoA) was created to coordinate the OAA programs. The agency became part of ACL in 2012. Over the past 5 decades, Congress has amended and reauthorized the act. As a result, the act has created an infrastructure, known as the national aging services network, that coordinates the delivery of comprehensive home and community-based supportive services in every state. At present, the network consists of 56 state units on aging (SUAs), 281 tribal organizations, 1 Native Hawaiian organization representing 400 tribes, 618 area agencies on aging (AAAs), 53 state long-term care ombudsman programs, nearly 20,000 local service providers, and thousands of volunteers.[9] Today's OAA statutory language contains seven titles[10]:

- **Title I** declares the act's objectives and provides definitions for various terms under the act.
- **Title II** establishes the AoA to carry out the provisions of the act and establishes AAAs as local entities which, either directly or through contract with local service providers, oversee a comprehensive and coordinated service system to deliver social, nutrition, and long-term services and supports to older individuals, and to promote elder justice.
- **Title III** authorizes and provides grants to states and territories to advocate on behalf of older persons and their family caregiver and to coordinate programs for them. It covers supportive services, such as case management, community services, in-home services, transportation, information and referral, and legal assistance; nutrition programs, such as home-delivered meals and congregate



meals; family caregiver support; and health promotion and disease prevention services.

- **Title IV** authorizes and provides support for training, research, and demonstration projects in the field of aging.
- **Title V** authorizes the Senior Community Service Employment Program, managed by the Department of Labor, and provides support for part-time employment for individuals 55 and over who are low-income and unemployed and have poor employment potential.
- **Title VI** authorizes and provides grants directly from ACL to Indian tribal organizations, Native Alaskan organizations, and nonprofit groups representing Native Hawaiians—grants enabling them to advocate on behalf of older persons and their family caregivers and to coordinate programs for them. These programs provide supportive services, such as case management, community services, in-home services, transportation, and information and referral; nutrition programs, such as home-delivered meals and congregate meals; family caregiver support; and health promotion.
- **Title VII** authorizes and provides grants to states to operate the long-term care ombudsman programs, designed to promote and protect the rights of individuals living in nursing homes, assisted living, and similar residential care settings, and to implement programs for the prevention of elder abuse, neglect, and exploitation as well as programs for legal assistance development.

OAA programs help millions of older adults live as independently as possible in their homes and communities. In addition, OAA services play a key role in preventing more costly institutional services and hospitalizations by helping people remain in their own homes and assisting family caregivers.



# Time Line of Programs for Older Americans[11,12]

## 1920's – 1930's

### 1920

The Civil Service Retirement Act provided a retirement system for many governmental employees.

### 1935

The Social Security Act passed; it provided for old age assistance and old age survivors' insurance.

### 1937

Railroad Retirement Act provided pensions for retired railroad employees and spouses.

## 1950's

### 1950

President Truman initiated the first National Conference on Aging, sponsored by the Federal Security Agency.

### 1952

First federal funds were appropriated for social service programs for older persons under the Social Security Act.

### 1956

Special staff on aging were established within the Office of the Secretary of Health, Education, and Welfare to coordinate responsibilities for aging.

Federal Council on Aging was created by President Eisenhower.

### 1958

Legislation was introduced in Congress, calling for a White House Conference on Aging.

### 1959

Housing Act authorized a direct loan program for nonprofit rental projects for the elderly at low interest rates, and it lowered eligibility ages for public low-rent housing for low-income women up to age 62.

## 1960's

### 1960

Social Security Administration eliminated age 50 as minimum for qualifying for disability benefits and liberalized the retirement test and the requirement for fully insured status.

### 1961

First White House Conference on Aging was held in Washington, D.C.

Social Security Amendments lowered the retirement age for men from 65 to 62, liberalized the retirement test, and increased minimum benefits and benefits to aged widows.

### 1962

Legislation was introduced in Congress to establish an independent and permanent Commission on Aging.

### 1965

The OAA was signed into law on July 14, 1965. It established the AoA within the Department of Health, Education, and Welfare and called for the creation of SUAs.

# 1970's

William Bechill was named first Commissioner on Aging.

Medicare, Title XVIII, a health insurance program for the elderly, was established as part of the Social Security Act.

Medicaid, Title XIX, a health insurance program for low-income persons, was added to the Social Security Act.

### 1967

The OAA was extended for 2 years, and provisions were made for the AoA to study the personnel needs in the aging field.

*The Inaugural White House Conference on Aging in 1961*

Age Discrimination Act was signed into law.

Administration on Aging was moved from the Office of the Secretary of Department of Health, Education, and Welfare and placed in the newly created Social and Rehabilitative Service Agency within the department.

### 1968

John Martin was named Commissioner on Aging.

### 1969

Amendments to OAA provided grants for model demonstration projects, Foster Grandparents Program, and Retired and Senior Volunteer Program (RSVP).

### 1971

Second White House Conference on Aging was held in Washington, D.C.

### 1972

A new Title VII was created under the OAA, authorizing funds for a national nutrition program for the elderly.

On July 1, 1972, President Nixon signed Public Law 92-336, a bill to extend the public debt limit. The legislation also contained an amendment to the Social Security Act, raising the amount of monthly cash benefits and revising several financing provisions.

The LTCOP was established to represent the rights and advocate on behalf of older residents living in

nursing homes, assisted living, and other residential settings.

### 1973

Comprehensive Services Amendments to OAA established AAAs. The amendments added a new Title V, which authorized grants to local community agencies for multipurpose senior centers and created the Community Service Employment grant program for low-income persons age 55 and older, administered by the Department of Labor.

Arthur S. Flemming was named Commissioner on Aging.

Comprehensive Employment and Training Act was enacted; it included older persons.

### 1974

Title XX of the Social Security Amendments authorized grants to states for social services. These programs included protective services, homemaker services, transportation services, adult day care services, training for employment, information and referral, nutrition assistance, and health support.

Amendments to OAA added transportation under Title III model projects.

Housing and Community Development Act was enacted; it provided for low-income housing for the elderly and handicapped, pursuant to the Housing Act of 1937.

In 1974, the National Institute on Aging was created to conduct research and training related to the aging process and the diseases and problems of an aging population.

National Institute on Aging was created to conduct research and training related to the aging process and the diseases and problems of an aging population.

Title V of the Farm and Rural Housing Program of 1949 was expanded to include the rural elderly as a target group.

### 1975

Amendments to OAA authorized grants under Title III to Indian tribal organizations. Transportation, home care, legal services, and home renovation/repair were mandated as priority services.

### 1977

Amendments to OAA required changes in the Title VII nutrition program, primarily related to the availability of surplus commodities through the Department of Agriculture.

### 1978

Amendments to OAA consolidated the Title III AAA administration and social services, the Title VII nutrition services, and the Title V multipurpose senior centers, into a new Title III and added a new Title VI for grants to Indian tribal organizations. The old Title V became the Community Service Employment grant program for low-income persons, age 55 and older (created under the 1978 amendments as Title IX).

Robert G. Benedict was named Commissioner on Aging.

Congregate Housing Services Act authorized contracts with local public housing agencies and nonprofit corporations to provide congregate independent living service programs.

Amendments to OAA required each state to establish a long-term care ombudsman program to cover nursing homes.

# 1980's

### 1981

Third White House Conference on Aging was held in Washington, D.C.

Lennie-Marie Tolliver was named Commissioner on Aging.

The OAA was reauthorized; it emphasized supportive services to help older persons remain independent in the community. The act expanded ombudsman coverage to board and care homes.

The home- and community-based services waiver program was established by Section 2176 of the Omnibus Budget Reconciliation Act of 1981.

### 1984

The reauthorization of the OAA was clarified, and the accountability of SUAs and AAAs for coordinating community-based services and funding national priority services (legal, access, & in-home) was reaffirmed.

The 1984 amendments to the act replaced the term "legal assistance" with "legal services" and defined "older individual" for Title III purposes as "any individual who is 60 years of age or older." The amendments also required that, in the delivery of services, particular attention be paid to minority low-income individuals. "Greatest economic need" was defined as "income below the poverty threshold as established by the Bureau of the Census," and "greatest social need" was defined in terms of "noneconomic factors which include physical and mental disabilities, language barriers, and cultural or social isolation including that caused by racial or ethnic status and which restrain an individual's ability to perform normal daily tasks or which threaten his or her ability to live independently."

Carol Fraser Fisk was named Commissioner on Aging.

### 1987

The reauthorization of the OAA authorized appropriations for six additional services: in-home services for the frail elderly; long-term care ombudsman; assistance for special needs; health education and promotion; prevention of elder abuse, neglect, and exploitation; and outreach activities for persons who may be eligible for benefits under supplemental security income, Medicaid, and food stamps. Additional emphasis was given to serving those in the greatest economic and social need, including low-income minorities.

The Nursing Home Reform Act (Omnibus Budget Reconciliation Act) mandated that nursing facility residents have "direct and immediate access to ombudspersons when protection and advocacy services become necessary." Simultaneously, the OAA reauthorization charged states to guarantee ombudsman access to facilities and patient records, provided important legal protections, authorized state ombudsmen to designate local ombudsman programs, and required that ombudsman programs have adequate legal counsel.

### 1989

Joyce Berry was named Commissioner on Aging.

In 1987, with the reauthorization of the OAA, additional emphasis was given to serving those in the greatest economic and social need, including low-income minorities.

# 1990's

### 1990

The State Health Insurance Assistance Program was created under the Omnibus Budget Reconciliation Act of 1990.

The Americans with Disabilities Act extended protection from discrimination in employment and public accommodations to persons with disabilities.

Cranston–Gonzalez National Affordable Housing Act reauthorized the HUD Section 202 Elderly Housing program and provided for supportive service demonstration programs.

Age Discrimination in Employment Act made it illegal, in most circumstances, for companies to discriminate against older workers in employee benefits.

### 1992

Reauthorization of the OAA placed increased focus on caregivers, intergenerational programs, protection of elder rights, and calls for a 1995 White House Conference on Aging.

The Commissioner on Aging was elevated to Assistant Secretary for Aging.

Amendments to OAA added a new Title VII, "Vulnerable Elder Rights Activities," which included the long-term care ombudsman; prevention of elder abuse, neglect, and exploitation; elder rights and legal assistance development; and benefits outreach, counseling, and assistance programs. The legislation emphasized the value of the four programs coordinating their efforts. The amendments highlighted the role of local ombudsman programs and the state ombudsman's role as leader of the statewide program and advocate and agent for systemwide change.

### 1993

Fernando M. Torres-Gil was sworn in as the first Assistant Secretary for Aging in the Department of Health and Human Services on May 6, 1993.

### 1995

White House Conference on Aging was held in Washington, D.C.

The OAA, Medicare, Medicaid, and the Foster Grandparent Program observed 30th anniversaries.

This year was the 60th anniversary of Social Security.

Operation Restore Trust was initiated.

### 1997

Jeanette C. Takamura, Ph.D., was sworn in as Assistant Secretary for Aging in the U.S. Department of Health and Human Services on December 8, 1997.

### 1999

The U.S. Supreme Court's 1999 landmark decision in Olmstead v. L.C. found the unjustified segregation of people with disabilities is a form of unlawful discrimination under the Americans with Disabilities Act.

This year was the International Year of Older Persons: A Society for All Ages.

In 1990, the Age Discrimination in Employment Act made it illegal, in most circumstances, for companies to discriminate against older workers in employee benefits.

# 2000's

### 2000

Amendments of 2000 to OAA were signed into law (P.L. 106-501), establishing the new National Family Caregiver Support Program and reauthorizing the OAA for 5 years on November 13, 2000.

### 2001

Secretary of HHS Tommy G. Thompson released $113 million for first National Family Caregiver Support Programs grants to states on February 15, 2001.

Josefina G. Carbonell was sworn in as Assistant Secretary for Aging on August 8, 2001.

### 2002

Kick-off of the 30th Anniversary of the OAA Nutrition Program took place in March.

### 2003

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) was enacted.

### 2005

The fifth White House Conference on Aging was held in Washington, D.C.

### 2006

Medicare Part D prescription drug program (part of the Medicare Prescription Drug, Improvement, and Modernization Act) went into effect.

The Lifespan Respite Care Act (administered by AoA) was enacted.

Amendments of 2006 to OAA were signed into law (P.L. 109-365), reaffirming the principles of consumer information for long-term care planning, evidence-based prevention programs, and self-directed community-based services to older individuals at risk of institutionalization. Reauthorization added "assisted living facilities" to the definition of "long-term care facility," ensuring that the LTCOP provided services to residents of assisted living facilities. The OAA was reauthorized for 5 years on October 17, 2006. The 2006 amendments also created new responsibilities for the Assistant Secretary for Aging to serve as the effective and visible advocate throughout the federal government on elder justice issues, and to develop objectives, priorities, policies, and a long-term plan for facilitating the development, implementation, and continuous improvement of a coordinated, multidisciplinary elder justice system in the United States.

Expansion of home- and community-based long-term services and supports and evidence-based disease prevention and health promotion services was enacted.

### 2009

Kathy Greenlee was appointed by President Obama as fourth Assistant Secretary for Aging.

### 2010

The Patient Protection and Affordable Care Act, which contained the Elder Justice Act of 2009, was enacted.

### 2011

Authorization of the OAA expired on September 30, 2011. Although the authorization of appropriations under the OAA expired at the end of fiscal year (FY) 2011, Congress continued to appropriate funding for OAA-authorized activities through FY 2016.

### 2012

On April 18, 2012, ACL was established, bringing together the AoA, the Office on Disability, and the Administration on Developmental Disabilities.

> "One of the best measures of a country is how it treats its older citizens."
>
> *Former President Barack Obama, speaking at the 2015 White House Conference on Aging*

### 2014

The State Health Insurance Assistance Program was transferred to ACL.

The Workforce Innovation and Opportunity Act was signed into law, transferring three programs to ACL from the U.S. Department of Education: the Independent Living Services program; the Assistive Technology Act programs; and the National Institute on Disability, Independent Living, and Rehabilitation Research.

### 2015

The ACL issued the first comprehensive regulation for state long-term care ombudsman programs to further reinforce the authority of the office of the state long-term care ombudsman (LTCO) in each state, the District of Columbia, and territories.

### 2016

On April 19, 2016, President Obama signed the OAA Reauthorization Act of 2016 into law to further improve access and quality of comprehensive services to older adults in our country. The 2016 OAA reauthorized programs for FY 2017 through FY 2019. It included provisions to protect vulnerable elders by strengthening the LTCOP and elder abuse screening and prevention efforts. It also promoted the delivery of evidence-based programs, such as falls prevention and chronic disease self-management programs.

### 2019

Lance Robertson was appointed by President Trump as Assistant Secretary for Aging and ACL's Administrator.

The OAA expired on September 30, 2019.

### 2020

On March 18, 2020, President Trump signed into law the Families First Coronavirus Response Act, which provided additional funding for OAA programs (among other activities) to respond to the coronavirus disease 2019 (COVID-19) pandemic.

On March 25, 2020, President Trump signed H.R. 4334, the Supporting Older Americans Act, into law. The act reauthorized the OAA for 5 years and included a 7% increase in funding in the initial year and a 6% increase annually for the remainder through FY 2024. Along with these increases, the act established a new Research, Demonstration, and Evaluation Center for the Aging Network within the AoA, required additional research into the impact of social isolation on senior health, and affirmed the importance of local control and flexibility in the administration of OAA programs.

On March 27, 2020, President Trump signed the Coronavirus Aid, Relief, and Economic Security (CARES) Act, and on December 27, 2020, he signed the Consolidated Appropriations Act, 2021, which provided additional funding for select OAA programs to respond to the COVID-19 pandemic.

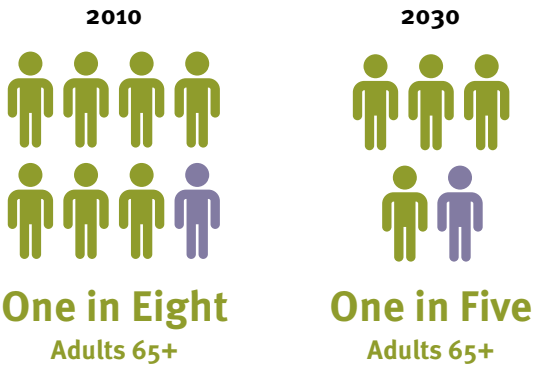
### 2021

On March 12, 2021, President Biden signed the American Rescue Plan Act of 2021, which provided additional funding for select OAA programs to respond to the COVID-19 pandemic.

## Projected Growth of the Aging Population

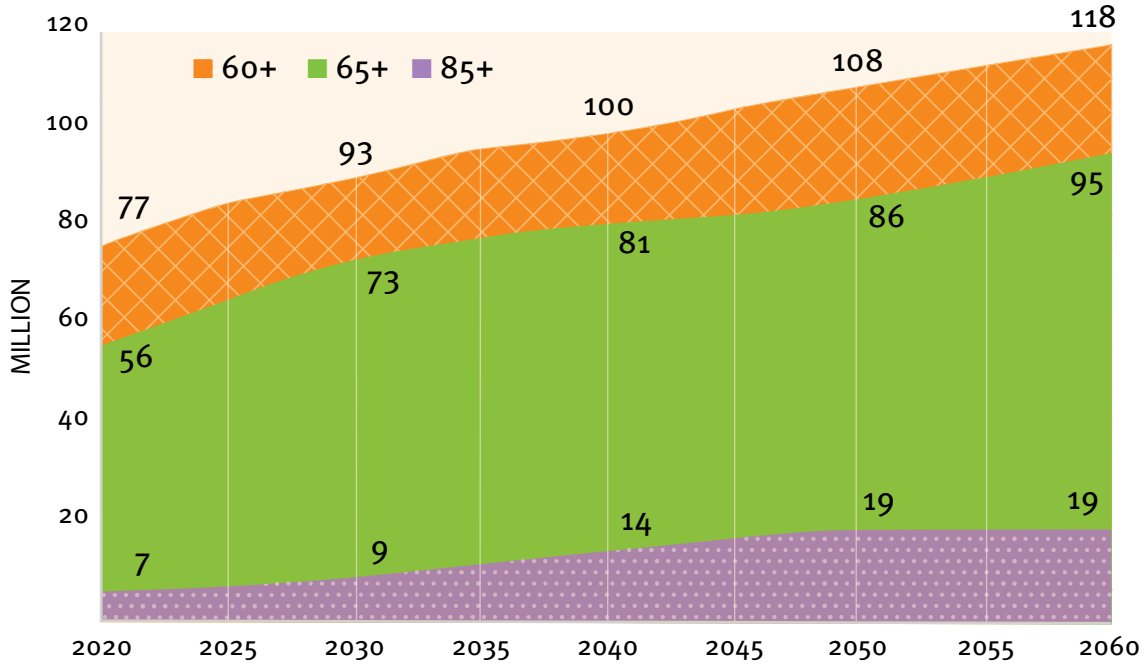
Today, the mission of the OAA is even more imperative than when the act was signed into law 5 decades ago, as the large U.S. baby boom generation (those born between 1946 and 1964) drives an unprecedented growth of the population age 65 and older. As shown in the graphs below, the number of older adults, including American Indian and Alaskan Native (AI/AN) elders, is projected to increase substantially over the next 40 years. The number of adults 60 and older will increase by more than 41 million, the number of adults 65 and older will increase by more than 38 million, and the number of adults 85 and older will increase by more than 12 million. These figures represent population increases of 53%, 69%, and 184%, respectively, for these three groups of older adults between 2020 and 2060. The number of non-Hispanic AI/AN elders age 65 and older is projected to more than double in the next 30 years, from 308,627 in 2020 to 648,555, making up 0.7% of the older American population, by 2060.[13] Given the growth of the aging population, the number of individuals in long-term care settings is also expected to increase significantly. Specifically, by 2050, the number of individuals using paid long-term care services in any setting (e.g., at home, residential care such as assisted living, or skilled nursing facilities) is expected to double from the 15 million in 2000 to 27 million people.[14]

**Figure 1.** Growth of the Older Population



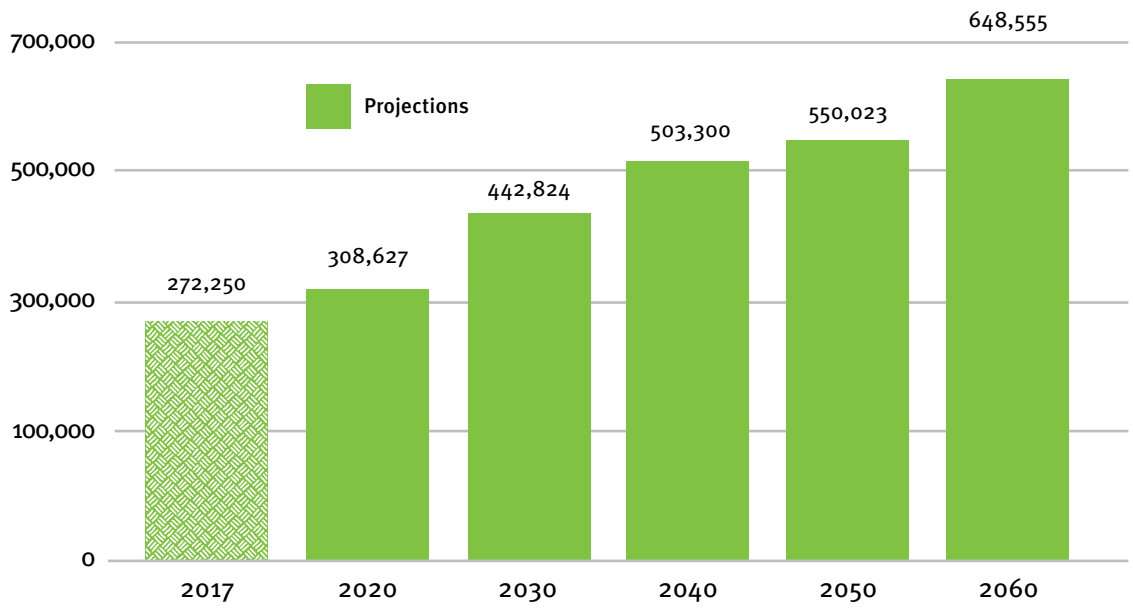

*Source: ADvancing States Infographic:* Aging in America http://www.advancingstates.org

**Graph 1.** Current and projected population of adults ages 60+, 65+, and 85+: 2018 – 2060[15]



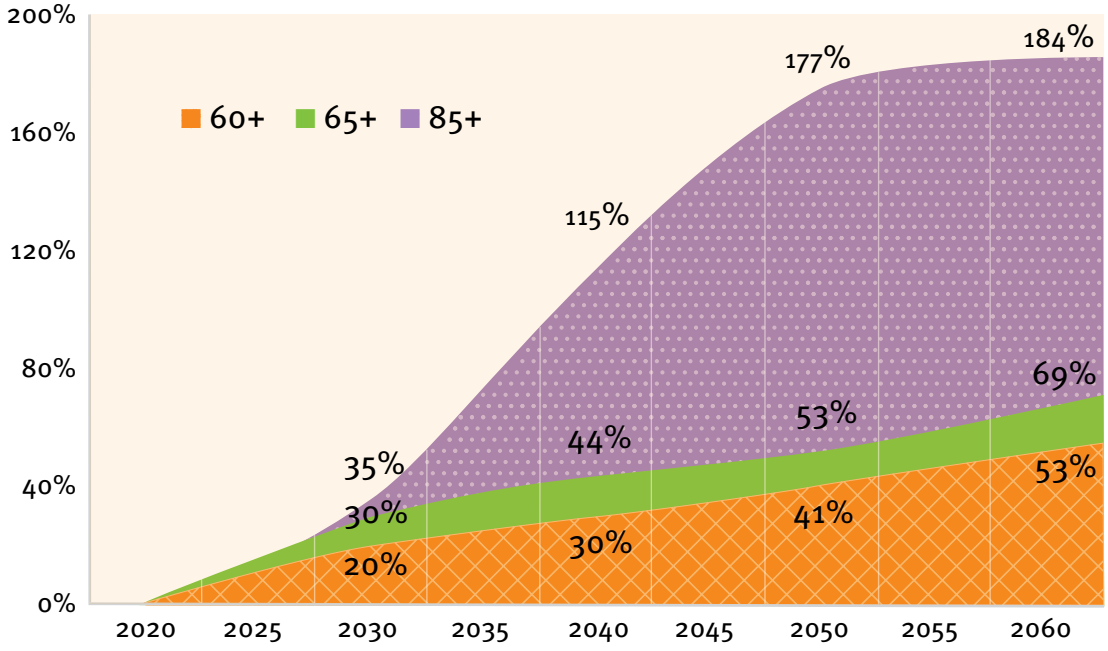

*Note. Percent reflects the change in population in reference to 2020.*

**Graph 2.** Population and projections of American Indians and Alaskan Natives 65 and over: 2020–2060[16]




*Source: U.S. Census Bureau, Population Estimates, 2017 and Population Projections, 2017 (revised)*
*Note: Increments in years are uneven. Solid bars indicate projections. The terms American Indians and Alaska Natives refer to American Indians and Alaska Natives who are not Hispanic and do not identify as more than one race.*

**Graph 3.** Percentage change in projected population of adults ages 60+, 65+, and 85+: 2020–2060[17]




*Note. Percent reflects the change in population in reference to 2020.*

## The Aging Network

The OAA established a national network of federal, state, and local agencies to provide services that maximize the independence and well-being of older adults in their homes and communities. The functions of the network are designed to be carried out through a community-focused planning process, which ensures that local communities have a role in the prioritization and implementation of services. Thus, while the overarching OAA program goals are determined nationally, it was designed to be state administered with a great deal of state and local flexibility. The flexibility given to states and local agencies has also led to wide variability in the design, implementation, and scope of aging services programs they administer, both within and outside the federally authorized OAA programs.[18]

**U.S. Department of Health and Human Services:** The HHS has designated ACL to carry out the provisions of the OAA and to administer the OAA programs. The department also provides funding for the OAA programs.

**Administration for Community Living:** As the primary federal agency responsible for administering the OAA programs, ACL authorizes grants to SUAs and AAAs to act as advocates on behalf of older persons and to coordinate programs and services for older persons. The ACL cherishes the continued collaboration with the aging services network, consisting of the SUAs, AAAs, tribal organizations, and local service providers.

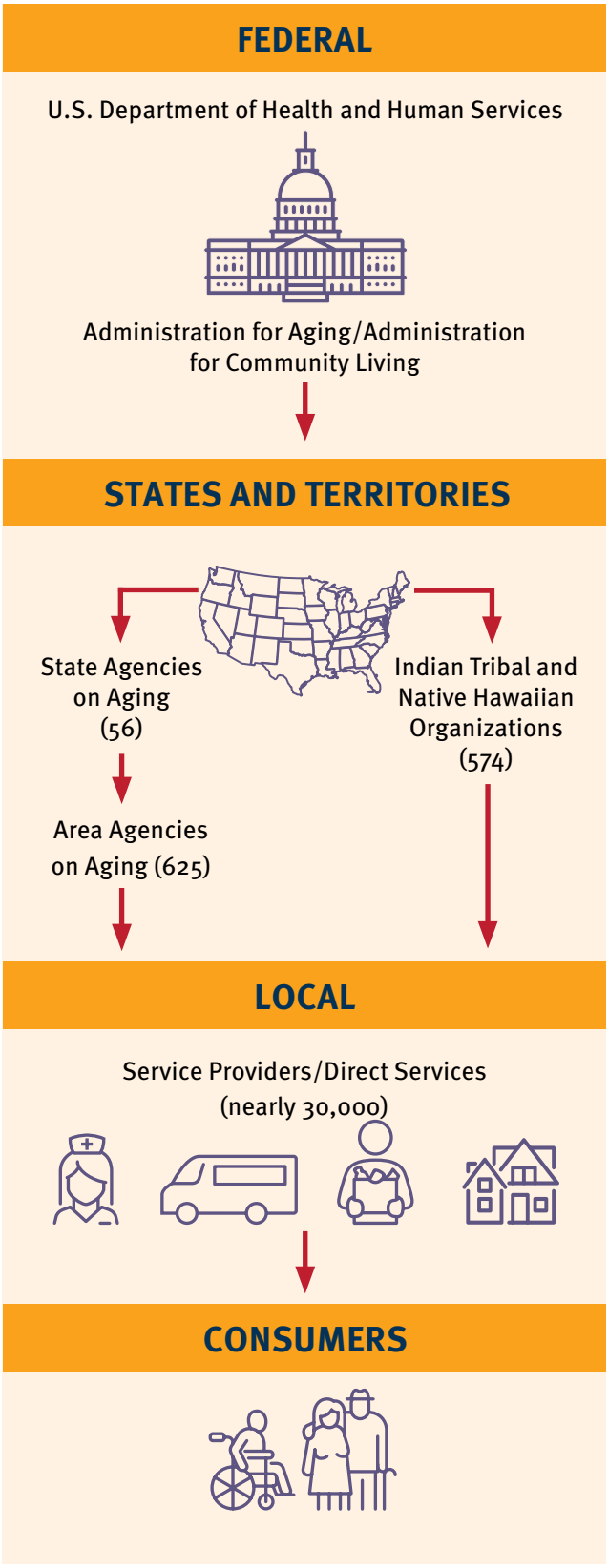
**State Units on Aging**[19]**:** The SUAs are designated state-level agencies that are responsible for the planning and policy development as well as the administration of OAA activities. In that role, SUAs develop and administer multiyear state plans that advocate for and aid older residents, their families, and, in many states, adults with physical disabilities. The 56 SUAs are in each of the 50 states, the District of Columbia, and U.S. territories (Guam, Puerto Rico, American Samoa, the Northern Mariana Islands, and the Virgin Islands). "State unit on aging" is a general term. The specific title and organization of the governmental unit varies, and it may be called a department, office, bureau, commission, council, or board for the elderly, seniors, aging, older adults, and/or adults with physical disabilities. The SUAs also coordinate with AAAs to collect and report state performance data to ACL on program performance.

**Tribal and Native Hawaiian Organizations:** Federally recognized tribes are sovereign nations that have direct political relationships with the U.S. government and the states within which they are geographically located. A federally recognized tribe is an AI/AN tribal entity that is both recognized as having a government-to-government relationship with the United States—with the responsibilities, powers, limitations, and obligations attached to that designation—and eligible for funding and services from the Bureau of Indian Affairs. Federally recognized tribes possess certain inherent rights of self-government (i.e., tribal sovereignty), and they are entitled to receive certain federal benefits, services, and protections because of their special relationship with the United States. At present, there are 574 federally recognized AI/AN tribes and villages. Native Hawaiians are not currently recognized as a sovereign nation or group.[20] Tribal and Native Hawaiian organizations are the grant recipients and direct service providers responsible for their planning and service areas, which may be reservations, native villages, single counties, multicounty districts, or, in the case of Hawaii, multiple islands.

> The functions of the network are designed to be carried out through a community-focused planning process, which ensures that local communities have a role in the prioritization and implementation of services.

**Area Agencies on Aging**[21]**:** The AAAs serve as local entities that, either directly or through contract with

**Figure 2.** The Aging Network[22]




local service providers, oversee a comprehensive and coordinated service system for the delivery of home- and community-based services. An AAA is a public or private nonprofit agency designated by a state to address the needs and concerns of all older persons at the local level. "Area agency on aging" is a general term; names of local AAAs may vary. They are "on-the-ground" organizations primarily responsible for a geographic area, also known as a planning and service area, that may be a city, a single county, or a multicounty district. An AAA may be categorized as representing a county, city, regional planning council, or council of governments. The AAAs vary widely in size as each state determines how many service areas to establish, which then determines the number of operating AAAs.

The AAAs coordinate and offer services that help older adults remain in their homes, if that is their preference, aided by services such as home-delivered meals, homemaker assistance, and other services that make independent living a viable option. By making a range of supports available, AAAs make it possible for older adults to choose the services and living arrangements that suit them best. The agencies focus on adults 60 years of age or older, regardless of income, assets, or ability to pay. Priority for services must be given to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals; older individuals with limited English proficiency; and older individuals residing in rural areas).

In coordination with consumers, service providers, and other interested stakeholders, each AAA also develops an Area Plan that outlines the needs and proposed recommendations for programs and services targeted to the needs of older adults. It then updates the plan every few years to reflect emerging trends. The AAAs are also tasked by the OAA to serve as advocates for older adults, enabling the agency's leaders to engage on local and state issues beyond the programs and services they fund or deliver.[23]

The OAA does not address specific implementation issues. It is the responsibility of the SUA to develop regulations, policies, procedures, guidance, and technical

assistance to address program accountability. The OAA requires that an SUA or AAA consult with local service providers to develop the best method of program administration. Administrative procedures should not prevent or discourage participation.

**Local Service Providers or Vendors:** Local service providers or vendors deliver aging services, such as meals, transportation, and in-home services.

**Consumers:** Consumers are older adults and caregivers receiving Title III, Title VI, and Title VII services. The OAA provides funding for programs that serve adults age 60 and over. However, AI/AN and Native Hawaiian grantees are allowed to determine at what age a person may receive services, which is often under the age of 60.*

The LTCOP services people of all ages who reside in long-term care facilities.

Some OAA services also expand eligibility to other groups. For example, under Title III Part C (see description below), programs also offer meals to spouses (of any age) of older adults and may offer meals to people who provide volunteer services during meal hours, people with disabilities who live in housing facilities where mainly older adults live and which also provide congregate nutrition services, and people with disabilities who reside with eligible older adults.

* This allowance is made because of the differences in health status and life expectancy among elders, compared to their peers in other groups. That is, AI/AN populations also have the lowest life expectancy compared to the average for the overall population.

*Note:* By congressional intent, the administration and functions of the LTCOP are in many ways distinct from other programs administered by SUAs. Therefore, state long-term care ombudsman programs do not easily fit into aging network structure. Specifically, while the state ombudsman may work as a state employee or under the direction of a state agency director, the state ombudsman does have specific functions that require independence and autonomy. The state ombudsman collaborates with the SUA to design and implement an elder rights agenda within the aging network but must represent long-term care residents autonomously.

*Source: National Association of States United for Aging and Disabilities. (2019). State Long-Term Care Ombudsman Program.* https://ltcombudsman.org/uploads/files/support/nasuad-ombudsman-acl-rpt-0319-web-final.pdf

## Older Americans Act Funding

Unfortunately, funding for OAA programs has not kept pace with the increase in the aging population, leaving many older adults without the essential services they need to remain independent in their communities. Annual HHS appropriations provide funding for most OAA programs, with the exception of Title V, which is supported by annual Department of Labor appropriations. However, programs under OAA are discretionary and subject to the annual appropriations process, meaning Congress may not provide the full increase allowed for in the reauthorization.

States are also required to provide a nonfederal match of 25% for family caregiver support and 15% for supportive services, preventive health, and meals.[24] No match is required for Title VI programs and long-term care ombudsman programs. Federal funding of OAA also allows states to leverage additional funds (e.g., state general revenue, Medicaid, block grants, donations).[25] In fact, the law was not intended to meet all the community service needs of older people. Instead, federal funding is intended to serve as a catalyst, or "seed money," to also draw in state and local funds to benefit older adults.[26]

In FY 2021, Title III accounted for 73.2% of the OAA's total funding ($1.558 billion out of $2.129 billion). Title VI programs received $46.0 million (2% of the total funding): $35.2 million for supportive and nutrition service, and $10.8 million for family caregivers), and Title VII programs were funded at a total of $23.7 million (1% of the total funding), with the majority of Title VII funding ($18.9 million, or 80%) directed at the LTCOP.[27] Ombudsman programs also receive funds as part of Title III-B supportive services funding. (In FY 2020, states reported $32,766,301 of Title III funds expended for LTCOPs.)

In response to the COVID-19 pandemic, Congress has passed several laws providing additional funding for OAA programs, among other activities:[28,29]

- Families First Coronavirus Response Act — On March 18, 2020, the President signed the Families First Coronavirus Response Act (P.L. 116–127), which provides $200 million in discretionary supplemental funding for home- and community-based services, $480 million for nutrition programs, and $100 million for the National Family Caregiver Support Program under Title III; $20 million for nutrition and related services for Native American Programs under Title VI; and $20 million for the long-term ombudsman program under Title VII.
- CARES Act—On March 27, 2020, the President signed the CARES Act (P.L. 116-136), which provides $870 million in discretionary supplemental funding for OAA nutrition services, supportive services, family caregiver services, Aging and Disability Resource Centers, long-term care ombudsman programs, and elder rights protection activities.

> Programs under OAA are discretionary and subject to the annual appropriations process, meaning Congress may not provide the full increase allowed for in the reauthorization.

- Consolidated Appropriations Act, 2021—On December 27, 2020, the President signed the Consolidated Appropriations Act, 2021 (P.L. 116-260). Division N provides $175 million in additional mandatory funding for OAA nutrition services to states and tribal organizations.
- The Coronavirus Response & Relief Supplemental Appropriations Act—This act became law in December 2020 as part of the Consolidated Appropriations Act of 2021. It directed $100 million to ACL programs to prevent, prepare for, and response to coronavirus domestically and internationally through activities authorized under Subtitle B of Title XX of the Social Security Act, with not less than $50 million for implementation of Section 2042(b) of the Social Security

Act, also known as the Elder Justice Act. The following Elder Justice Act programs were funded: $93.88 million for adult protective services and $4 million for long-term care ombudsmen.

- American Rescue Plan Act of 2021—On March 12, 2021, the President signed the American Rescue Plan Act of 2021 (P.L. 117-2). Title II, Subtitle L provides $1.434 billion in mandatory funding for OAA nutrition services, supportive services (among which are COVID-19 vaccination outreach, including transportation to vaccination sites, and activities to prevent and mitigate social isolation related to COVID-19), family caregiver services, health promotion and disease prevention, grants for tribal organizations, and the LTCOP. This act also provides $188 million for Elder Justice Act programs, including adult protective services and LTCOP, in FY 2022.[30]

In addition, states and tribes that received approval for a major disaster declaration were permitted to use any portion of the funds made available under sections of the OAA for disaster relief for older individuals. In this regard, flexibility was provided for states—without the need for a separate application, transfer request, or request for a waiver—to use existing allocations already made to them under the OAA for disaster relief. ACL considered disaster relief services for older individuals to be any services during the period covered by the state's major disaster declaration that are provided to eligible older individuals or family caregivers as defined under the OAA.[31]

### *Older Americans Act Distribution of Funding*

The majority of funding for Title III, VI, and VII programs flows from the federal to the state level and from there to the local level.

**Title III.** The ACL allots formula grants to SUAs in all 50 states, the District of Columbia, Puerto Rico, and the U.S. territories. Funds for Title III programs are distributed to each state and its aging network according to a formula based on the state's share of the U.S. population age 60 or older or, in the case of caregiver support programs, age 70 or older. The formula takes into account the geographical distribution of older individuals as well as the distribution of older individuals with the greatest economic and social need among specified planning and service areas.

The states and territories, in turn, award funds to the 618 regional programs known as AAAs, which facilitate the delivery of services to local areas. Eligible individuals can obtain a range of services to provide them with the help they need. States, the District of Columbia, and

territories use their federal program income and other income to pay for these important services. Services in Title III programs are also supported by funding from other sources, such as Medicare and Medicaid, states, private donations, and voluntary contributions from seniors for services received.[32]

**Title VI**. Funds are allocated by ACL to Indian tribal organizations, Native Alaskan organizations, and nonprofit groups representing Native Hawaiians, based on their share of the AI/AN and Native Hawaiian population aged 60 and over in their service area. To be eligible for funding, a tribal organization of federally recognized tribes must represent at least 50 Native Americans aged 60 and older. Unlike Title III and Title VII grantees, eligible tribal organizations must submit an application for funding. There is no requirement for matching funds. Separate formula grant awards are made for nutrition and supportive services (Part A/B grants) and caregiver support services (Part C grants). Title VI funds are often supplemented by the tribes themselves to ensure better service coverage for Native elders. Tribes may also decide the age at which a member is considered an elder and thus is eligible for services.

**Title VII**. As part of Title VII, each state is required to establish and operate a statewide Office of the State Long-Term Care Ombudsman, headed by a full-time state ombudsman. Long-term care ombudsman programs currently operate in all 50 states, the District of Columbia, Puerto Rico, and Guam. Funding for the LTCOP (Chapter 2) is to be used exclusively for ombudsman program services. Funds appropriated for Title VII activities are awarded to states based on a formula that takes into account the state's population age 60 or older compared to all states. States may implement the activities directly or through contracts or agreements with public agencies—such as other state agencies, AAAs, county governments, institutions of higher education, or Indian tribes—or private nonprofit service providers or volunteer organizations.[33] ACL allocates grants for programs for the prevention of elder abuse, neglect, and exploitation (Chapter 3) by formula to states and territories based on their share of the population age 60 and over. States and territories have the discretion to allocate funding among the various activities authorized under the program. They also may choose to distribute funds to AAAs and local service providers.[34]

## Older Americans Act Title III Services

Title III provides four categories of services, designated under Parts B, C, D, and E:

- Part B covers supportive services and senior centers, including case management; transportation; help with homemaker tasks, chores, and personal care; adult day care; and legal assistance.[35]
- Part C covers nutrition services, including home-delivered and congregate meals.[36]
- Part D covers evidence-based prevention and health promotion services.[37]
- Part E authorizes the National Family Caregiver Support Program, which provides counseling, support groups, and relief from caregiver duties (respite services) for caregivers.[38]

Title III services are available to all people age 60 and over who need assistance. Priority for services must be given to those with the greatest economic or social need, including those with low income, members of minority or ethnic groups, older people living in rural areas, those at risk for institutional care, and those with limited English proficiency.

### Priority for Title III Services

**"Greatest social need"** is defined in law as need caused by noneconomic factors, which include physical and mental disabilities; language barriers; and cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that restricts the ability of an individual to perform normal daily tasks or threatens the capacity of the individual to live independently.

**"Greatest economic need"** is defined as having an income at or below the official poverty level.

*Older Americans Act, as amended through P.L. 116–131, enacted March 25, 2020.*

### *Title III Part B: Support Services and Senior Centers*

**Purpose of the Support Services and Senior Centers Program:** Support services and senior centers that provide for a wide range of social services, including ombudsman activities, are authorized under Title III-B of the OAA. The program is designed to ensure that local communities can meet the individual needs of older adults and caregivers in their communities. The services are intended to help older adults remain independent in their own homes and communities.

**Local Support Services and Senior Centers Programs:** The funding for services provided through Title III-B is flexible, allowing agencies to develop programming to reflect community needs and provide tailored supports for older adults. There are more than 25 authorized services that local agencies can fund through Title III-B. They include services to help older people access supports such as transportation, case management, legal assistance, home- and community-based long-term services, and personal care and adult day care services as well as ombudsman program activities performed under the authority of Title VII. The program also funds multipurpose senior centers.[39]

Senior centers are the most visible presence of OAA programs and services in local neighborhoods. They are important gathering places, where people

participate in educational, nutrition, social, and cultural programs as well as physical activities, health education, and health screenings. Though senior centers vary widely, they are all community centers that bring together older adults and provide critical programs and services.[40]

**Target Populations and Eligibility:** Except for recipients of information services and ombudsman services,† those receiving senior services must be 60 years of age or older, regardless of income, assets, or ability to pay.

† Ombudsman programs serve consumers of all ages.

**Table 1.** Older Americans Act Title III Services, Part B[41]

| Service Category | Description of Services |
|---|---|
| **Adult Day Care/Health** | Personal care for dependent older adults in a supervised, protective, and congregate setting (group setting) during some portion of a day. Services offered typically include social and recreational activities, training, counseling, and services such as rehabilitation, medications assistance, and home health aide services for adult day health. |
| **Assisted Transportation** | Assistance and transportation, including escort, for a person who has difficulties (physical or cognitive) using regular transportation. |
| **Transportation** | Transportation from one location to another (e.g., to a medical appointment or grocery store). Does not include any other activity. |
| **Case Management** | Assistance with access or care coordination for an older person who has diminished functioning capacities, personal conditions, or other characteristics and so needs to receive services from formal service providers or family caregivers. Activities of case management include assessing needs, developing care plans, authorizing and coordinating services among providers, and conducting follow-up and reassessment as required. |
| **Chore Services** | Assistance with such activities as heavy housework, yard work, or sidewalk maintenance. |
| **Health Promotion and Disease Prevention** | Services that include health screenings and assessments; organized physical fitness activities; evidence-based health promotion programs; medication management; home injury control services; and/or information, education, and prevention strategies for chronic disease and other health conditions that would reduce the length or quality of life of a person 60 or older. |
| **Homemaker** | A service assisting a consumer with routine tasks to achieve and maintain a clean, safe, and healthy environment—e.g., preparing meals, shopping for personal items, managing money, using the telephone, or doing light housework. |

*Table 1. continued*

| Service Category | Description of Services |
|---|---|
| **Information and Assistance** | A service that provides individuals with information on services available within communities; links individuals to services and opportunities available within communities; and, as much as possible, establishes adequate follow-up procedures. |
| **Legal Assistance** | Legal advice, counseling and representation by an attorney or other person acting under the supervision of an attorney, by qualified providers contracted through AAAs. Legal assistance providers enable older Americans to assert their rights and remove barriers to economic and personal independence and self-determination. Legal assistance interventions address the social determinants of health and wellbeing to preserve older Americans' access to appropriate services and support their rights to live free from or recover from the experience of abuse, neglect, and financial exploitation.‡ |
| **Outreach** | Intervention with individuals initiated by an agency or organization for the purpose of identifying potential clients (or their caregivers) and encouraging them to use existing services and benefits. |
| **Personal Care** | A service that helps a consumer to achieve optimal functioning with activities of daily living and/or IADLs—e.g., personal assistance, stand-by assistance, supervision, or cues. |
| **Self-Directed Care** | An approach to providing services (including programs, benefits, supports, and technology) under this act intended to assist an individual with activities of daily living, in which<br>■ the services (including the amount, duration, scope, provider, and location of those services) are planned, budgeted, and purchased under the direction and control of the person served;<br>■ the service recipient is given the appropriate information and assistance necessary to make informed decisions about his or her care options; and<br>■ the AAA (or AAA-designated agency) assesses the service needs, capabilities, and preferences of the individual to be served as well as that individual's ability to direct and control the receipt of services. |
| **Other Services** | A service provided using Older Americans Act funds that does not fall into the listed service categories. |

‡ Administration for Community Living. (2020, September 21). *Legal Assistance Enhancement* Program. https://acl.gov/grants/legal-assistance-enhancement-program

Priority for services must be given to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals; older individuals with limited English proficiency; and older individuals residing in rural areas). In addition, the following criteria are used to reach older adults with the greatest need for chore, homemaker, and assisted transportation services:

- Chore services are targeted toward individuals who have difficulty with heavy housework, yard work, or sidewalk maintenance.
- Homemaker services are targeted toward individuals who have difficulty with one or more instrumental activities of daily living (IADLs), such as preparing meals, shopping for food or other personal items, managing money, using the telephone, or light housekeeping.
- Assisted transportation services are targeted toward individuals who have difficulty (physical or cognitive) with using private or public transportation.

**Program Highlights:** Millions of older adults rely on the supportive services provided under Title III-B. For example, in 2020, almost half a million older adults received case management services, and more than 190,000 older adults received homemaker services.[42] Programs provides millions of services to eligible older adults, including almost 30 million hours of personal care services, more than 20 million hours of homemaker services, and more than 13.5 million one-way trips. On average, clients received about 200 hours of adult day care/health services and about 15 hours of chore services.

### *Title III Part C: Nutrition Services*

**Purpose of the Nutrition Program:** Nutrition services are authorized under Title III-C of the OAA. The programs are designed to promote the general health and well-being of older individuals, and the services aim to

- reduce hunger, food insecurity and malnutrition of older adults,
- promote socialization of older individuals, and
- promote the health and well-being of older people
  - by assisting them in gaining access to nutrition and other disease prevention and health promotion services and
  - to delay the onset of adverse health conditions resulting from poor nutritional health or sedentary behavior.

**Local Nutrition Programs:** Through the OAA nutrition program, ACL's AoA provides grants to states to help support nutrition services for older people throughout the country. The nutrition program is the oldest, largest, and best-known of all OAA programs. It is funded (in part) by AoA, as well as state and local governments, foundations, direct payment for services, fundraising, and participants' voluntary contributions (time and/or money).

Program services at the local level include the Congregate Nutrition Program and the Home-Delivered Nutrition Program, which provide healthy meals in group settings such as senior centers and faith-based locations, as well as in the homes of at-risk older adults. Through the aging network's meal providers, the programs provide a range of services, including

**Table 2.** Older Americans Act Title III Services, Part C[43]

| Service Category | Description of Services |
|---|---|
| **Congregate Meals** | Meals provided to an eligible individual in a group setting (e.g., senior center, senior housing sites, restaurant programs, faith-based locations).<br><br>Meals must comply with the U.S. Department of Agriculture (USDA)/HHS Dietary Guidelines for Americans and provide a minimum of 33.3% of the Dietary Reference Intakes (DRI) if one meal is served, 66.6% if two meals are served for 1 day, and 100% if three meals are served for 1 day. Programs are encouraged to meet any special dietary needs of program participants, including meals adjusted for cultural considerations and preferences and medically tailored meals. The SUAs are encouraged to provide flexibility to local nutrition providers in designing meals that are appealing to program participants. |
| **Home-Delivered Meals** | A meal provided by a qualified nutrition project provider to an eligible individual and consumed in the individual's place of residence. Meals may be provided via home delivery, pick-up, carry-out, or drive-through.<br><br>Meals must comply with the USDA/HHS Dietary Guidelines for Americans and provides a minimum of 33.3% of the DRI if one meal is served, 66.6% if two meals are served for 1 day, and 100% if three meals are served for 1 day. Programs are encouraged to meet any special dietary needs of program participants, including meals adjusted for cultural considerations and preferences and medically tailored meals. The SUAs are encouraged to provide flexibility to local nutrition providers in designing meals that are appealing to program participants. |
| **Nutrition Counseling** | A standardized service as defined by the Academy of Nutrition and Dietetics that provides individualized guidance to individuals who are at nutritional risk because of their health or nutrition history, dietary intake, chronic illness, or medication use, or to caregivers. One-on-one counseling provided by a registered dietitian addresses the options and methods for improving nutrition status with a measurable goal. |
| **Nutrition Education** | An intervention targeting OAA participants and caregivers that uses information dissemination, instruction, or training with the intent to support food, nutrition, and physical activity choices and behaviors (related to nutritional status) in order to maintain or improve health and address nutrition-related conditions. Content is consistent with the Dietary Guidelines for Americans; is accurate, culturally sensitive, regionally appropriate, and considers personal preferences; and is overseen by a registered dietitian or individual of comparable expertise as defined in the OAA. |

nutrition screening and assessment as well as nutrition education and counseling.[44] Title III also funds the Nutrition Services Incentive Program, which provides incentives to encourage and reward effective performance by states in the efficient delivery of nutritious meals to older individuals. In addition, nutrition services provide an important link to other supportive in-home and community-based supports, such as homemaker and home health aide services, transportation, physical activity and chronic disease self-management programs, home repair and modification, and falls prevention programs.

*Congregate Nutrition Services*
*(OAA Section 331, sometimes called C1)*

The Congregate Nutrition Services section of the OAA authorizes meals and related nutrition services in group settings, which help to keep older Americans healthy and prevent the need for more costly medical interventions. The Congregate Nutrition Program, established in 1972, serves healthy meals while also presenting opportunities for social engagement, health and wellness activities, and meaningful volunteer roles, all of which contribute to health and well-being. The program serves individuals age 60 and older, their spouses, and, in some cases, their caregivers and/or persons with disabilities who are not older individuals, but who reside in housing facilities occupied primarily by older individuals at which congregate nutrition services are provided. Meals may also be provided to volunteers during meal hours.

*Home-Delivered Nutrition Services*
*(OAA Section 336, sometimes called C2)*

Established in 1978, The Home-Delivered Nutrition Services section of the OAA authorizes meals and related nutrition services for older individuals and their spouses of any age. Home-delivered meals are often the first in-home service that an older adult receives, and the program is a primary access point for other home- and community-based services. The program often serves frail, food-insecure, or isolated individuals age 60 and over, their spouses, and, in some cases, their caregivers, and/or persons with disabilities. This program serves much more than food. It provides a safety check and sometimes the only opportunity for face-to-face contact or conversation that day.

## Congregate Meal Programs: A Value Proposition

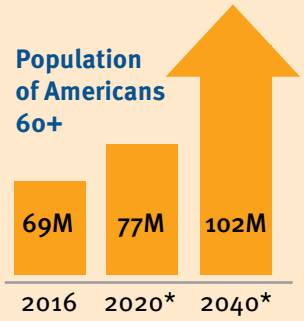
### CONGREGATE MEAL PROGRAMS

- *Serve adults 60+ (and in some cases, caregivers, spouses, and/or younger people with disabilities)*
- *Provide meals in senior centers, schools, churches, farmer markets, and other community settings*
- *Offer healthy meals, social engagement, access to community resources, volunteer roles*

### DEMAND ON THE HEALTH CARE SYSTEM WILL GROW WITH THE POPULATION

Nutrition/malnutrition have a tremendous impact on overall health and health care utilization

*Projected




### HOW THE HEALTH CARE SYSTEM BENEFITS

**FEWER ER VISITS**
leading to admissions

**5.4%**
vs. 10.4%

**FEWER HOSPITAL ADMISSIONS**

**8.5%**
vs. 13.7%

Participants vs. non-participants

The OAA requires that all OAA-funded meals adhere to the current Dietary Guidelines for Americans, provide at least one third of the DRI, meet state and local food safety and sanitation requirements, and be appealing to older adults. Because services are state administered, each SUA has the responsibility and authority (OAA Section 305) to implement the nutritional standards (OAA Section 339) to best meet the needs of the older adults that they serve. For example, a state may choose to use its funds to provide meals that focus nutrient standards on prevalent statewide chronic disease(s) or predominant health issues affecting older individuals. In practice, some states may require that menus for meals served using OAA funds be developed using nutrient analysis, meal patterns, or a combination. Projects must, when feasible, encourage the use of locally grown foods in meal programs and identify potential partnerships and contracts with local producers and providers of locally grown foods.

*Nutrition Services Incentive Program (OAA Section 311)*[45]

The Nutrition Services Incentive Program of the OAA provides grants to states, territories, and eligible tribal organizations to support the Congregate and Home-Delivered Nutrition Programs by providing an incentive to serve more meals. Grantees can choose to receive their grants as cash, commodities (food) from the United States Department of Agriculture, or a combination of cash and commodities.

**Target Population and Eligibility:** Services are not intended to reach every individual in the community. In general, under the OAA, a person must be 60 years of age or older to be eligible for the nutrition programs. However, the programs specifically target adults age 60 and older who are in greatest social and economic need, with particular attention to the following groups[46]:

- Low-income older adults
- Minority older individuals
- Older adults in rural communities
- Older individuals with limited English language ability
- Older adults at risk of institutional care

**Program Highlights**[47]**:** In 2020 over 4,000 providers served congregate meals and over 3,800 providers delivered home-delivered meals to over 2.7 million recipients. That year, almost 200 million meals were delivered to individual homes, and almost 40 million meals were served at congregate meal sites. On average, individuals received about 137 home-delivered meals and 47 congregate meals. In addition, more than 22,000 individuals received nutrition counseling for a total of over 38,000 counseling session. Programs also provided more than 3 million session of nutrition education.

**Table 3.** Older Americans Act Title III Services, Part D

| Service Category | Description of Services |
|---|---|
| **Evidence-Based Disease Prevention and Health Promotion Services** | Funds are provided for evidence-based disease prevention and health promotion services, including programs related to physical fitness, medication management, chronic disease self-management education, psychosocial behavioral health intervention, human immunodeficiency virus, arthritis, brain health, diabetes, falls prevention, depression, and chronic pain. |

### *Title III Part D: Evidence-Based Disease Prevention and Health Promotion Services*

**Purpose of the Program:** Title III-D of the OAA was established in 1987. It provides grants to states and territories, based on their share of the population aged 60 and older and other factors, for programs that support healthy lifestyles and promote healthy behaviors. The FY 2012 congressional appropriations law included, for the first time, an evidence-based practice requirement related to Title III-D funds. As a result, states that receive OAA funds under Title III are required to spend those funds on evidence-based programs§ to improve health and well-being and reduce disease and injury.

**Evidence-Based Programs:** Since 2003, the aging services network has been steadily moving toward wider implementation of disease prevention and health promotion programs based on scientific evidence that have been demonstrated to improve the health of older adults as they reduce the need for more costly medical interventions. Service activities may include programs related preventing and mitigating the effects of chronic diseases, including osteoporosis, hypertension, obesity, diabetes, and cardiovascular disease; reducing alcohol and substance abuse; and promoting smoking cessation, weight loss and control, stress management, falls prevention, physical activity, and improved nutrition.

Specific programs offered vary widely but include chronic disease self-management, falls prevention, medication management, fitness activities, mental health supports, and other interventions shown to be effective in enhancing health.[48]

The ACL National Chronic Disease Self-Management Education Resource Center maintains a database of evidence-based programs that meet ACL's criteria for evidence-based programs under Title III-D.¶ The database is updated periodically based on the results of an Evidence-Based Program Review Process. More information about that process is available here.**

**Target Population and Eligibility:** Priority is given to serving older adults living in medically underserved areas of the state and those with the greatest economic need. Title III-D funds must be used to provide evidence-based disease prevention and health promotion programs at senior centers, at congregate meal sites, and/or through home-delivered meal programs in the client's home or at other appropriate sites.

**Program Highlights:** Evidence-based programs empower older adults to take control of their health by maintaining a healthy lifestyle through increased self-efficacy

§ ACL defines evidence-based programs as those demonstrated through evaluation to be effective for improving the health and well-being or reducing disease, disability, and/or injury among older adults; *and* proven effective with the older adult population, using experimental or quasiexperimental design; *and* documented by research results published in a peer-review journal; *and* fully carried out in a real-world community setting with fidelity to the published research; and including developed dissemination products that are available to the public.

¶ https://www.ncoa.org/evidence-based-programs

** https://www.ncoa.org/article/apply-to-become-an-evidence-based-program

and self-management. These programs are based on research and provide documented health benefits. Specifically, they demonstrate reliable and consistently positive changes in important health-related and functional measures, such as improved balance and strength as a result of attending a physical

activity program or reduced chronic disease symptomatology as a result of a self-management program. In 2020, there were over 2,000 providers supported by Title III-D delivering disease prevention and health promotion services.

### *Title III Part E: Caregiver Services*

**Purpose of the Caregiver Programs:** Family caregivers are the backbone of America's long-term care system, with more than 65 million Americans, or nearly 30% of the general population, caring for an older adult or someone living with an illness or disability.[49] Family members are the people most likely to serve as caregivers to older adults, and when these caregivers become overwhelmed by the physical and emotional burdens of caregiving, their older loved ones are at increased risk of institutionalization.

**Table 4.** Older Americans Act Title III Services, Part E[50]

| Service Category | Description of Services |
|---|---|
| **Information for Caregivers About Available Services** | A service for caregivers that provides them with information on resources and services available within their communities. |
| **Assistance to Caregivers in Gaining Access to Services** | A service that assists caregivers in obtaining access to the services and resources available to them within their communities. As much as possible, it ensures that the individuals receive the services needed by establishing adequate follow-up procedures. |
| **Caregiver Training/ Education, Individual Counseling, Support Groups** | Counseling to caregivers to assist them in making decisions and solving problems relating to their caregiver roles. Services include counseling to individuals, support groups, and caregiver training (of individual caregivers and families). These services help caregivers better manage their responsibilities and cope with the stress of caregiving. |
| **Respite Care** | Services which offer temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Respite care includes in-home respite (personal care, homemaker, and other in-home respite); respite provided as the care recipient attends a senior center or other nonresidential program; institutional respite provided by placing the care recipient in an institutional setting such as a nursing home for a short period of time as a respite service to the caregiver; and, for grandparents caring for children, summer camps. |
| **Supplemental Services** | Services provided on a limited basis to complement the care provided by caregivers (e.g., transportation, home modifications, medical equipment, assistive technologies, legal and financial counseling, and emergency response systems). |

Recognizing the critical role families play in the nation's system of long-term services and supports, Congress established the National Family Caregiver Support Program (NFCSP) in 2000 as part of the reauthorization of the OAA. It was the first federal program making it possible for every state and community to provide family caregivers with a flexible base of services and supports to assist them in keeping their loved ones in the settings of their choice for as long as possible. Today, the NFCSP is an integral component of our nation's fabric of long-term services and supports. It is a trusted and reliable resource to support the needs of family or other informal caregivers as they lend assistance to aging adults, as well as the needs of grandparents and older relatives caring for minor children or adults with disabilities.[51]

**Caregiver Programs:** Through the NFCSP, states and territories offer five core services for caregivers, in partnership with AAAs and local service providers:

- information for caregivers about available services;
- assistance to caregivers in gaining access to services;
- caregiver education/training, individual counseling, and support groups;
- respite care; and
- supplemental services.

The NFCSP provides grants to state and territories to fund supports that help caregivers of all ages balance caregiving with other responsibilities. This assistance, in turn, helps ensure more adults can remain in their homes and communities.[52]

**Target Population and Eligibility**: The NFCSP was established in 2000 and is available for the following individuals:

- Adult family members or other informal caregivers age 18 and older providing care to individuals 60 years of age and older or to individuals of any age with Alzheimer's disease and related disorders
- Older relatives (not parents), age 55 and older, providing care to children under the age of 18
- Older relatives, including parents, age 55 and older, providing care to adults ages 18–59 with disabilities[53]

**Program Highlights.**[54] In 2020, there were more providers (9,263) for caregiver services to older adults than for any of the other Title III services categories. They provided support to over 186,000 caregivers serving elderly individuals, delivering more than 5 million hours of respite care and more than 530,000 counseling /support groups/caregiver training sessions to these caregivers. They also provided support to over 12,000 caregivers serving children, delivering more than 100,000 hours of respite care and approximately 64,000 contacts to assist these caregivers with access to assistance.

# Background Title VI

## Older Americans Act Title VI Services

Services for Native American programs were first established in 1978 with the provision of the nutrition and supportive services program. Today, Title VI authorizes grants to Indian tribal organizations, Alaskan Native organizations, and nonprofit groups representing Native Hawaiians to provide nutrition, supportive, and caregivers services for elders. Under Title VI, programs provided to AI/AN and Native Hawaiians are comparable to services provided under Title III.[55]

Title VI provides services through three programs: Part A (Indian Program), Part B (Native Hawaiian Program), and Part C (Native American Caregiver Support Program). Title VI Parts A and B authorize grants to Indian tribal, public, or non-profit organizations representing federally recognized tribes, Alaskan villages, and Native Hawaiians to provide nutrition and supportive services. Title VI Part C authorizes grants to Indian tribal, public, or nonprofit organizations representing federally recognized tribes, Alaskan villages, and Native Hawaiians to provide caregiver support services. Part C serves all programs within Parts A and B. To qualify for Title VI grants, tribes must have at least 50 Native members ages 60 year and above. Parts A/B (nutrition and supportive services) are considered the base grant, and programs have to have Parts A and B to quality for Part C (caregiver support services).[56] For the 2020–2023 grant cycle, ACL awarded 282 three-year grants for nutrition and supportive services, and 251 three-year grants for caregiver support services.[57]

### *Title VI Parts A/B: Nutrition and Supportive Services*

**Purpose of the Nutrition and Support Services Programs:** The purpose of nutrition and supportive services programs is to help reduce the need for costly institutional care and medical interventions, support the independence and well-being of tribal elders, and

be responsive to the cultural diversity of Native American communities.

**Nutrition and Supportive Services Programs:** These programs provide funding for services such congregate and home-delivered meals, information referral services, transportation, information and referral, and a wide range of home care services. Required nutrition services include congregate meals and home-delivered meals. Other nutrition-related services that grantees may provide include nutrition counseling, nutrition education, sponsorship of farmer's market programs, and distribution centers for food banks and charitable organizations. Required supportive services include information and assistance, but grantees may also use funds to provide transportation, chore services, and many other services that contribute to the well-being of elders. After meeting program requirements, tribal organizations have flexibility to allocate resources among the various allowable activities funded by each program.[58]

**Table 5.** Older Americans Act Title VI Services, Parts A/B (Nutrition Services)[59]

| Service Category | Description of Services |
|---|---|
| **Congregate Meals** | A meal provided to an eligible person at a nutrition site, senior center, or other congregate/group setting. The meal meets all the requirements of the OAA and state/local laws. Including complying with the USDA/HHS Dietary Guidelines for Americans, and provides a minimum of 33.3% of the DRI if one meal is served, 66.6% if two meals are served for 1 day, and 100% if three meals are served for 1 day. |
| **Home-Delivered Meal** | A meal provided to a qualified eligible person (one who is frail, isolated, or homebound due to illness or incapacitating disability) in their place of residence. The meal meets all the requirements of the OAA and State/Local laws. Including complying with the USDA/HHS Dietary Guidelines for Americans; and provides a minimum of 33.3% of the DRI if one meal is served, 66.6% if two meals are served for 1 day, and 100% if three meals are served for 1 day. |
| **Nutrition Education** | A targeted educational program provided by a dietitian or a similarly knowledgeable person. The program will promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants, caregivers, or participants and caregivers in a group setting (two or more participants). |
| **Nutrition Counseling** | Provision of individualized advice and guidance to individuals, who are at nutritional risk—because of their health or nutritional history, dietary intake, medication use, or chronic illnesses—about options and methods for improving their nutritional status. Counseling is performed by a registered dietitian or other health professional and addresses the options and methods for improving nutrition status with a measurable goal. |

*Note. Congregate meals and home-delivered meals are required services.*

**Table 6.** Older Americans Act Title VI Services, Part A/B (Supportive Services)[60]

| Service Category | Description of Services |
|---|---|
| **Information/ Assistance** | A service that:<br>■ provides the individual with current information on opportunities and services available within their communities, including information relating to assistive technology;<br>■ assesses the problems and capacities of the individual;<br>■ links the individual to the opportunities and services that are available;<br>■ ensures that the individual receives the services needed and is aware of the opportunities available to them by establishing adequate follow-up procedures; and<br>■ serves the entire community of older individuals. |
| **Outreach** | Conducting public outreach activities and providing information directed at individuals and groups to encourage potential elders (or their caregivers) to use existing services and benefits. |
| **Case Management** | A service provided to an elder, at the direction of the elder or a family member or caregiver.<br>■ The service should be provided by a trained or experienced person with case or care management skills.<br>■ The service includes assessing individual needs and developing a service plan for, arranging, coordinating, and monitoring services to meet the needs of the elder. The service should include periodic reassessment and revision based on the needs of the elder. |
| **Transportation** | Services or activities that provide or arrange for travel of individuals from one location to another, including travel costs. This service may include escort or other appropriate assistance for a person who has difficulties using regular transportation. |
| **Homemaker Service** | Providing light housekeeping tasks in an elder's place of residence. Tasks may include, but are not limited to, preparing meals, shopping for personal items, laundry, managing money, or using the telephone, in addition to other light housework. |

*Table 6. continued*

| Service Category | Description of Services |
|---|---|
| **Personal Care/Home Health Aid Service** | Providing assistance with activities of daily living, such as eating, dressing, and bathing, toileting, transferring in and out of bed/chair or walking. Assistance may also include health-related tasks, such as checking blood pressure and blood glucose, and assistance with personal care. Personal care may include IADLs, such as cleaning and maintaining the house, managing money, preparing meals. |
| **Chore Service** | Performance of heavy household tasks provided in a person's home. In addition to heavy housework, such as heavy cleaning, tasks may include yard work, sidewalk maintenance, minor home repair, wood chopping, water hauling, and other heavy-duty activities which the elder is unable to handle on their own and which do not require the services of a trained homemaker or other specialist. |
| **Visiting** | Going to see an elder to reduce social isolation, provide a wellness check (a visual check of an elder to see if they need anything), etc. Visiting services would include visiting in a personal home. Visiting may include a minimum of 15 minutes talking with an elder or an adequate amount of time to make an informed decision about the elder's well-being. |
| **Telephoning** | Phoning in order to provide comfort or check up on the elder. |
| **Social Events** | Events involving a public performance or entertainment function. |
| **Health Promotion and Wellness** | Activities conducted to improve the mental and physical health of persons, including walking groups, exercise classes, and other types of recreation. |
| **Visits to Persons in Nursing Facilities/ Homes or Residential Care Communities** | Visits* conducted to persons living in skilled nursing homes or facilities or living in a long-term care facility that provides, at a minimum, room and board and around-the-clock on-site supervision as well as help with personal care, such as bathing and dressing, or health-related services, such as medication management. Facility types include, but are not limited to, assisted living; board and care home; congregate care; enriched housing programs; homes for the aged; personal care homes; adult foster/ family homes; and shared housing establishments that are licensed, registered, listed, certified, or otherwise regulated by a state.<br><br>*These visits should not be counted as part of the long-term care ombudsman programs which report their visits to the state. |

*Note: Information and assistance services are required services.*

**Target Populations and Eligibility:** Title VI Part A is the Indian program and serves federally recognized tribes with at least 50 members age 60 years and above; Part B is the Native Hawaiian program, serving public or nonprofit private organizations that serve Native Hawaiians and represent at least 50 individuals age 60 years and above. Tribal organizations are allowed to determine the age at which a member is considered an elder and thus is eligible for services.[61] An eligible person is an elder; a spouse of an elder; an individual providing volunteer services for the Title VI program; or a nonelder person with a disability who resides at home with an elder and accompanies the elder to receive nutrition services, or who resides in a housing facility occupied primarily by older adults.

**Program Highlights:** An evaluation conducted with Title VI grantees found that nutrition services fulfill a critical need for elders. Specifically, for many recipients, the meal programs provide their only hot and nutritious meal of the day; congregate meal programs provide an opportunity to make social connections and provide a sense of belong to the community; and, for homebound elders, a visit from a meal delivery driver provides an opportunity for social contact and checking in regarding their health and overall well-being.[62] Support services have also been shown to be critical for elders. As a result, elders receiving any Title VI services were found to experience significantly fewer hospitalizations and falls per year and report more instances of social activity than elders who did not receive or participate in Title VI services, and to engage in cultural practices on a monthly basis. [63]

### *Title VI Part C: Caregiver Support Services*

**Purpose of the Caregiver Support Services Programs:** The Title VI Part C program assists AI/AN and Native Hawaiian families caring for older relatives with chronic illness or disability, grandparents caring for grandchildren, and elders caring for adult children with disabilities. In addition, the program helps tribes provide locally determined systems of support services for family caregivers. Specifically, a core value of the programs, as expressed by tribal leaders, is that they should not replace the tradition of families caring for their elders. Rather, Part C programs provide support that strengthens the family's caregiving role.[64]

**Caregiver Support Services Programs:** These programs offer a variety of services that address a range of caregiver needs, including information and outreach, access assistance, individual counseling, support groups and training, respite care, and other supplemental services. Tribal organizations coordinate with other programs, including the Volunteers in Service to America (VISTA) program, to help support and create sustainable caregiver programs in Native American communities, many of which are geographically isolated.

**Target Populations and Eligibility:** Title VI Part C authorizes grants to Indian tribal, public, or nonprofit organizations representing federally recognized tribes, Alaskan villages, and Native Hawaiians to enable them to provide caregiver support services. Eligible caregivers include

- informal caregivers,
- caregivers to elders of individuals of any age with Alzheimer's disease and related disorders,
- elder caregivers caring for children under the age of 18, and
- elder caregivers providing care to adults ages 18–59 with disabilities.

**Program Highlights:** An evaluation conducted with Title VI grantees found that caregiver support services help caregivers in important ways, particularly by providing relief from the stress of caregiving and helping to improve their overall quality of life. Specifically, resources and information about available caregiver services and referrals help ensure better care for their family members; support groups help caregivers learn from other caregivers who face similar issues and give them renewed strength to continue providing care; respite services provide an opportunity to take a needed break from the challenging work of caregiving and attend to other aspects of their lives; and supplemental services, such as the provision of wheelchairs or walkers, provide critical resources that help caregivers support their care recipients to remain as independent as possible.[65]

**Table 7.** Older Americans Act Title VI Services, Part C[66]

| Service Category | Description of Services |
|---|---|
| **Information Services** | Public and media activities that conveys information to caregivers about available services. Information services activities might include making an in-person interactive presentation to the public or putting together a social media post or a radio announcement that is shared with the broader community. |
| **Information and Assistance** | A service that<br>■ provides the individual with current information on opportunities and services available within their communities, including information relating to assistive technology;<br>■ assesses the problems and capacities of the individual;<br>■ links the individual to the opportunities and services that are available;<br>■ ensures that the individual receives the services needed and is aware of the opportunities available to them, by establishing adequate follow-up procedures; and<br>■ serves the entire community of caregivers. |
| **Counseling** | A service designed to support caregivers and assist them in their decision-making and problem solving. Counselors may be degreed service providers, trained to work with individuals, older adults, and families and specifically understanding and addressing the complex physical, behavioral, and emotional problems related to their caregiver roles. Informal counselors, like a peer who is or has been an informal caregiver, may also be used for this service. The service includes counseling provided to individuals or in group meetings. Counseling is a separate function from support group activities or training. The caregiver support services are eligible to those caring for older adults, persons with disabilities, or children not their own by birth or adoption. Counseling with an individual or group may be provided via phone, text, email, webinar, video chat, or other means to help participants navigate physical, behavioral, and emotional issues related to caregiving. |
| **Support Group** | A service that is led by an individual, moderator, or professional to facilitate caregivers discussing their common experiences and concerns and developing a mutual support system. Support groups are typically held on a regularly scheduled basis and may be conducted in person, over the telephone, or online. Caregiver support groups would not include caregiver education/training groups or other groups primarily aimed at teaching skills or meeting on an informal basis without a facilitator. Support groups are intended to facilitate caregivers sharing their experiences with each other and finding support within the group. |

*Table 7. continued*

| Service Category | Description of Services |
|---|---|
| **Caregiver Training** | A service that provides family caregivers with instruction to improve knowledge and performance of specific skills relating to their caregiving roles and responsibilities. Skills may include activities related to health, nutrition, and financial management; providing personal care; and communicating with health care providers and other family members. Training may include use of evidence-based programs, be conducted in-person or on-line, and be provided in individual or group settings. |
| **Supplemental Services** | Services provided on a limited basis to informal caregivers to complement the care these caregivers provide. These are services intended to support the caregiver so that they might continue to provide care to the elder, person with Alzheimer's disease or related disorder of any age, person with disability age 18–59, or grandchild under the age of 18. Service categories for supplemental services are the following:<br>■ Home modification/repairs: putting in ramps or handrails into a home<br>■ Consumable items: single use items such as incontinence supplies, Ensure, school supplies, uniforms for school or sports, cleaning supplies, groceries, etc.<br>■ Lending closet: items returnable to the Title VI program—clothing exchange; durable medical equipment (chair lifts, wheelchairs, walkers, emergency response systems); telephone; tablet; anything lent on a short-term basis<br>■ Homemaker/chore/personal care service: chopping wood, mowing a lawn, snow clearing<br>■ Financial support: limited (emergency) help with utility bills<br>■ Other: any services provided that do not fit into the program performance report services listed |
| **Respite Care** | A service for caregivers which offers temporary, substitute supports or living arrangements for care recipients in order to provide the caregivers a brief period of relief or rest. Respite care is to assist the informal caregiver. |

## Older Americans Act Title VII Services

Title VII focuses exclusively on the advocacy responsibility of states to protect and enhance rights, benefits, and independence of the nation's most vulnerable elders by providing state grants for "vulnerable elder rights protection" programs. Programs include the LTCOP (Chapter 2); programs dedicated to the prevention of elder abuse, neglect, and exploitation (Chapter 3); and activities focused on elder rights and legal assistance development (Chapter 4). Title VII strongly emphasizes coordination and linkage among these programs to support statewide systems change.

It is important to note that Title III contains some important funding requirements of relevance to Title VII programs. For example, funding for ombudsman services and *local* legal assistance providers is provided through AAAs under Title III, requiring all AAAs to fund legal assistance as a priority service. The Title VII requirements and responsibilities for development of legal assistance and elder rights advocacy are at the *state* level. Thus, unlike Title III programs, a state agency is not required to allot Title VII Chapter 3 funds to AAAs. A state agency may administer vulnerable elder rights protection activities (Chapters 3 & 4) either directly or through contracts or agreements with a variety of agencies, including public agencies, such as other state agencies and county governments; nonprofit private organizations; institutions of higher education; Indian tribes; or nonprofit service providers or volunteer organizations, as well as AAAs.[67,68,]

### *Chapter 2. Long-Term Care Ombudsman Program*

As part of Title VII Chapter 2, each state is required to establish and operate a statewide office of the state LTCO, headed by a full-time state LTCO. Most state LTCOs are state employees, and their roles and responsibilities are clearly stated in the OAA and the LTCOP regulation. Although the state LTCO must comply with

federal direction in fulfilling the duties of the office, the organizational structure can affect the execution of those responsibilities.

State long-term care ombudsman programs may be ***centralized*** or ***decentralized***. A ***centralized*** structure is generally defined as an organizational arrangement in which the state ombudsman and all regional/district/local ombudsman representatives of the office are employees of a single entity. In this structure, the state LTCO is responsible for the management of the entire program, including staff and all activities. A ***decentralized*** structure is defined as an organizational arrangement in which the state LTCO is an employee of the state, or a contracted entity, but the regional/district/local ombudsman representatives of the office are employed by another contracted entity (often the AAAs) designated by the state LTCO. In this structure, the state LTCO has programmatic oversight, but not personnel oversight. The local ombudsman entity con-

sists of representatives of the office of the state LTCO (i.e., staff and volunteers), but it is usually an entity within a larger "host agency."[69] ††

**Purpose of the LTCOP:** The purpose of the LTCOP is to improve quality of life and care for residents of long-term care facilities by helping to resolve problems related to the health, safety, welfare, and individual rights.

**Services of Long-Term Care Ombudsman Programs:** Ombudsman programs promote policies and consumer protections to improve long-term services and supports at the facility, local, state, and national levels. All states, the District of Columbia, Puerto Rico, and Guam have an office of the LTCO, headed by a full-time state LTCO. The state LTCO manages all aspects of the statewide program. Ombudsman staff and volunteers serving as designated representatives of the office of the LTCO assist in performing the activities and fulfilling the responsibilities of the program, including advocating on behalf of residents in long-term care settings. Across the nation, staff and thousands of volunteers are designated by state ombudsmen as representatives to directly assist residents to voice concerns, secure their rights, and resolve conditions affecting their care.

The purpose of the LTCOP is to improve quality of life and care for residents of long-term care facilities by helping to resolve problems related to the health, safety, welfare, and individual rights.

†† For additional details about structure, function, and responsibilities of long-term care ombudsman programs, see the National Association of States United for Aging and Disabilities. (2019). *State Long-Term Care Ombudsman Program: 2019 revised primer for state agencies.* https://ltcombudsman.org/uploads/files/support/nasuad-ombudsman-acl-rpt-0319-web-final.pdf

**Table 8.** Older Americans Act Title VII Services, Chapter 2

| Service Category | Description of Services |
|---|---|
| **Facility Visits** | Visits to nursing facilities or residential care communities (e.g., assisted living) by representatives of the office of the state LTCO as part of a regular presence. |
| **Investigations in Response to Complaints** | Requested ombudsman program complaint investigation services regarding one or more complaints made by, or on behalf of, residents. Anyone, including an ombudsman representative, may initiate a complaint on behalf of residents. |
| **Complaint Resolution** | Through a variety of strategies, resolving a problem to the satisfaction of the resident. |
| **Training** | Training provided to<br>■ individuals (paid or volunteers) to achieve certification which allows an individual to be eligible for designation as a representative of the office of the state LTCO<br>■ Nursing facility and residential care community staff to offer learning on a variety of topics (e.g., abuse prevention, residents' rights) |

*Table 8. continued*

| Service Category | Description of Services |
|---|---|
| **Information and Assistance** | Information provided about issues impacting residents (e.g., resident rights, care issues, services) and/or assistance provided to access services without opening a case and working to resolve a complaint. Also, consultation provided to facilities, including technical support and the provision of resource information. Information and assistance may be provided to<br>■ nursing facility staff,<br>■ residential care community staff, or<br>■ individuals. |
| **Participation in Facility Surveys** | Participation in both standard surveys and complaint surveys, or similar state surveys or inspections conducted in residential care communities. Survey participation includes, but is not limited to, providing presurvey information to surveyors, sharing complaint summary reports, and participating in resident group interviews and exit conferences and informal dispute resolution. |
| **Council Participation** | Participation in resident councils (at nursing facilities and residential care community facilities) or family councils. Participation includes meeting with council leadership, training the council, and/or attending a council meeting. |
| **Community Education** | Community education outreach sessions by ombudsman program, including outreach conducted at health fairs and community events. |
| **State and Local Level Coordination Activities** | Leadership activities and/or state/local-level coordination, where the state LTCO provides state-level coordination and support for coordination between local ombudsman programs and other entities with responsibilities relevant to the health, safety, well-being, or rights of residents of long-term care facilities. |
| **Systems Advocacy** | Analysis, commenting on, and monitoring the development and implementation of public policies, including facilitating public comment; recommending changes; and providing information to public and private agencies, legislators, the media, and others. |

**Target Populations and Eligibility:** Funds for long-term care ombudsman programs are allocated to SUAs, which may award funds for program activities to a variety of organizations, including other state agencies, AAAs, county governments, nonprofit service providers, and volunteer organizations. The program is the only OAA program that focuses solely on the needs of institutionalized persons. The law requires that ombudsmen serve residents of all long-term care settings, regardless of age. Such settings include nursing facilities, board and care settings, and other adult care homes, including assisted living or other similar settings.

**Program Highlights:** In 2020, long-term care ombudsman programs had 1,700 paid staff and 6,621 volunteer staff who conducted almost 200,000 visits in 39,984 long-term care facilities, investigated 153,324 complaints, and provided more than 640,000 instances of information and assistance to individuals and facility staff.

### *Chapter 3. Programs for the Prevention of Elder Abuse, Neglect, and Exploitation*[70]

**Purpose of Programs for the Prevention of Elder Abuse, Neglect, and Exploitation:** The purpose of programs for the prevention of elder abuse, neglect, and exploitation is to develop and strengthen prevention efforts at the state and local level.

**Elder Abuse, Neglect, and Exploitation Prevention Program Services:** The programs provide formula grants to states and territories, based on their share of the population 60 and over, for the prevention, detection, assessment, and treatment of, intervention in, investigation of, and response to elder abuse, neglect, and exploitation. Services include funding for state and local public awareness campaigns, training programs, and multidisciplinary teams. These activities are important elements of ACL's activities related to elder rights and elder justice. The program coordinates activities with state and local adult protective services programs, over half of which are directly administered by SUAs, and other professionals who work to address issues of elder abuse and elder justice.

**Target Populations and Eligibility:** Funds are allocated to states to assists SUAs and AAAs in carrying out programs to prevent abuse, neglect, and exploitation of older adults, including developing and strengthening the service systems through designated SUAs and AAAs. The program provides education that benefits a broad spectrum of older populations, aging services providers, and the general public. Like all OAA services, programs must address underserved populations of older individuals, including elders with greatest economic or social need, such as older individuals living in rural locations, older individuals in minority populations, and low-income older individuals.

The purpose of programs for the prevention of elder abuse, neglect, and exploitation is to develop and strengthen prevention efforts at the state and local level. The program provides education that benefits a broad spectrum of older populations, aging services providers, and the general public.

**Program Highlights:** Accomplishments reported by grantees highlight programs having implemented a wide range of activities in FY 2020 to support the prevention of abuse, neglect, and exploitation of older adults. For example, programs have continued to build partnerships with other government and nonprofit agencies, which facilitate sharing information, ideas, and strategies to better recognize incidents of abuse, neglect, and exploitation, and to coordinate efforts to serve the victims. Programs also have held legal assistance clinics and educational sessions to increase public awareness regarding issues such as advance directives/life care planning, general estate planning, fair housing rights, and financial abuse prevention. Other outreach activities have focused on adult protective services and have been provided to skilled nursing and senior home staff and residents, adult day care staff and participants, and conference attendees. These outreach activities helped to disseminate information and materials on aging services and to strengthen programs' relationship with key partner agencies. Other activities have focused on, among other things, data collection and analysis, such as enhancing the collection of demographic data, which has enhanced transparency and evaluation of equity issues.

**Table 9.** Older Americans Act Title VII Services, Chapter 3[71]

| Service Category | Description of Services |
|---|---|
| **Public Education and Outreach** | Public education and outreach to identify and prevent elder abuse, neglect, and exploitation, and to promote financial literacy and prevent identity theft and financial exploitation of older individuals. |
| **Coordination of Services** | Provision to AAAs of services instituted under the state adult protection service program, state and local law enforcement systems, and courts of competent jurisdiction. |
| **Development of Information and Data Systems** | Promotion of development of information and data systems, including elder abuse reporting systems, to quantify the extent of elder abuse, neglect, and exploitation in the state. |
| **Data Submission and Analysis** | Promotion of submission of data on elder abuse, neglect, and exploitation for the appropriate database of the Administration or another database specified by the Assistant Secretary; conducting analyses of state information concerning elder abuse, neglect, and exploitation and identifying unmet service, enforcement, or intervention needs. |
| **Training** | Conducting of training for individuals, including caregivers described in Part E of Title III, professionals, and paraprofessionals, in relevant fields on the identification, prevention, and treatment of elder abuse, neglect, and exploitation, with particular focus on prevention and enhancement of self-determination and autonomy. Conducting of special and ongoing training for individuals involved in serving victims of elder abuse, neglect, and exploitation, on the topics of self-determination, individual rights, state and federal requirements concerning confidentiality, and other topics determined by a state agency to be appropriate. |
| **Technical Assistance** | Provision of technical assistance to programs that provide or have the potential to provide services for victims of elder abuse, neglect, and exploitation, and for family members of the victims. |
| **Elder Abuse, Neglect, and Exploitation System** | Promotion of development of an elder abuse, neglect, and exploitation system to facilitate reporting and investigation of suspected instance of elder abuse, neglect, or exploitation. |
| **Examination and Testing** | Examination of various types of shelters serving older individuals, and testing of various models for establishing safe havens (at home or elsewhere) that recognize autonomy and self-determination and fully protect the due process rights of older individuals. |
| **Multidisciplinary Activities** | Support for multidisciplinary elder justice activities, such as supporting and studying team approaches for bringing a coordinated multidisciplinary or interdisciplinary response to elder abuse, neglect, and exploitation, including a response from individuals in social service, health care, public safety, and legal disciplines. |

### *Chapter 4. State Legal Assistance Development Program*[72]

**Purpose of the State Legal Assistance Development Program:** This chapter establishes that each state identifies a person to serve as the state legal assistance developer (LAD)‡‡. The LAD is intended to play a key role in statewide efforts to promote and preserve the autonomy, dignity, independence, and financial security of older persons, provide access to the system of justice, and advocate for the preservation of the rights and benefits of older persons. The person in this position has the opportunity to work with the SUA to set a vision for an effective legal services delivery system for older adults. The LAD is an important advocate for legal services and a strategic connector, working across the network to strengthen the legal services delivery system. From advocating for resources essential to legal providers to helping older adults find an attorney with proper expertise, the developer is critical to championing the rights of older adults and ensuring that the promise of the OAA is fulfilled.[73]

**State LAD Program Services:** Legal assistance developers provide leadership at the state level to coordinate certain elder rights activities in the state to ensure

- state leadership in securing and maintaining the legal rights of older individuals;
- state capacity for coordinating the provision of legal assistance;
- state capacity to provide technical assistance, training, and other supportive functions to area agencies on aging, legal assistance providers, ombudsmen, and other persons, as appropriate;
- state capacity to promote financial management services to older individuals at risk of conservatorship;
- state capacity to assist older individuals in understanding their rights, exercising choices, benefiting from services and opportunities authorized by law, and maintaining the rights of older individuals at risk of guardianship; and
- state capacity to improve the quality and quantity of legal services provided to older individuals.[74]

**Target Populations and Eligibility:** Activities of the program are intended to coordinate the availability of legal information, advice, assistance, and advocacy to persons 60 years of age and older in greatest social and economic need, as well as to caregivers of older adults.

**Program Highlights:** No funds have been appropriated under this section, and no data are collected on activities of LADs.

### *Subtitle B—Native American Organization and Elder Justice Provisions*

**Purpose of the Native American Organization and Elder Justice Provisions**: Sections 751 and 752 under this subtitle establish programs to promote elder justice in Indian country, similar to the provisions in Section 721, including promoting a comprehensive elder justice system and multidisciplinary teams.

**Services:** Activities and services authorized under this subtitle include establishment of a coordinating council, support to multidisciplinary teams, data collection, promotion of public awareness, and training.

**Target Population and Eligibility:** Eligible entities under Subtitle B are identified as Indian tribes or organizations serving older individuals who are Native Americans.

**Program Highlights:** No funds have been appropriated under this subtitle. Tribal elder justice activities are carried out under Title VI.

‡‡ The OAA calls for states to provide state leadership by designating an LAD. Title III requires that "(t)he plan shall provide assurances that each state will assign personnel (one of whom shall be known as a LAD) to provide state leadership in developing legal assistance programs for older individuals throughout the state." Chapter 4 of Title VII reinforces this mandate with very similar language and provides guidance on the role of the LAD. Source: https://acl.gov/sites/default/files/about-acl/2020-04/Older%20Americans%20Act%20Of%201965%20as%20amended%20by%20Public%20Law%20116-131%20on%203-25-2020.pdf

# Older Americans Act Data Collection and Access

As the primary federal agency responsible for administering the OAA, ACL collects information and reports on the performance of Title III, VI, and VII programs using grantee data collection tools, a centralized reporting system, and a publicly available program data portal. In compliance with the Government Performance and Results Act of 1993, the OAA and ACL's AoA, all 50 states, the District of Columbia, Guam, Puerto Rico, American Samoa, the Northern Mariana Islands, and the U.S. Virgin Islands report detailed information on OAA program participants, services, and expenditures annually.

## Data Collection Tools

### *Title III*

**State Performance Report**[75]

The SUAs and AAAs use the state performance report (SPR) to collect data and report on the activities carried out under Title III. The SPR includes demographic data, performance data on programs and services, and data on the infrastructure of home- and community-based services. Fiscal year 2021 was the final reporting year using the current version of the SPR.§§

Starting October 1, 2021, Title III grantees will begin collecting data using a new version of the SPR,¶¶ along with new definitions of terms in the SPR. The new version of the SPR reduces the number of data elements that grantees must collect and report by 70% compared to the current version of the SPR.

Beginning in January 2023, Title III grantees will submit SPR data to ACL using the new version of the SPR. Grantees will submit the data through ACL's new data reporting system, the Older Americans Act Performance[76] Reporting System (OAAPS; more information on OAAPS provided below).

**National Survey of Older Americans Act Participants**[77]

Since 2003, ACL has conducted the National Survey of Older Americans Act Participants (NSOAAP), an annual, nationally representative survey of OAA participants that assesses the effectiveness of Title III programs. Data from the NSOAAP help ACL to maintain program accountability and demonstrate the program's success in achieving legislative goals. The survey instruments include questions that measure client opinions of service quality and outcomes and also capture client characteristics, such as demographics and physical and social functioning.

The NSOAAP uses a two-stage sample design. First, a national sample of AAAs is selected. Second, a random sample of clients served by these AAAs is selected to participate in the survey. The NSOAAP consists of six separate surveys, one for each of the following Title III service areas: caregiver, home-delivered meals, congregate meals, homemaker, transportation, and case management. Types of measures within each service area include the length of time and frequency of service use, ratings of service quality, perceived benefits of services, social and physical function, and demographics.

**National Survey of Areas Agencies on Aging**

Since 2007, ACL, in collaboration with the National Association of Area Agencies on Aging (n4a), also conducts an online survey every 2 to 3 years to gather information about AAAs. The survey tracks important

*Please note, the NSOAAP was suspended in 2020 due to the COVID-19 pandemic. Skipping data collection for that year eliminated a potential additional burden on AAAs, which faced significant demands adjusting their programming and responding to new reporting requirements. For more information, see the section, "Impact of COVID-19 Pandemic on OAA Programs."*

§§ https://acl.gov/sites/default/files/programs/2020-01/State_Program_Report_0985-0008_Expires12312022.pdf
¶¶ https://omb.report/icr/202105-0985-002/doc/111857300

new trends in programs, services, and funding affecting older adults in communities across the United States. Topic areas include programs, services, staffing, budgets, and sources of funding. The most recent survey was completed in September 2019, receiving 485 responses from the 618 AAAs, which represented a response rate of 78.5%. For a detailed report on the 2020 survey findings, see this final report.***

### *Title VI*

**Annual Program Performance Report**

Title VI grantees use ACL's Annual Program Performance Report††† (PPR) to report on the activities carried out under Title VI. The PPR consists of two major parts. Part A/B collects information on clients and service units for Title VI nutrition and supportive services. Part C collects information on Title VI caregiver services. All Title VI grantees receive Parts A/B funding and therefore submit data for Parts A/B. Those Title VI grantees that also receive Part C funding submit data for both Part A/B and Part C of the PPR.

**National Survey of Title VI Programs**

Approximately every 3 years (2009, 2014, 2017, 2020), ACL helps support the National Title VI Program Survey to explore trends, new directions, and evolving needs of Title VI programs across the country. Topic areas include Title VI program budgets, staff, administration, service provision, and partnerships. In 2020, ACL conducted the survey for the fourth time, distributing the web-based version to 276 Title VI grantees. For a detailed report on the 2020 survey findings, see this final report.‡‡‡

### *Title VII*

**Annual Performance Report**

Data for Title VII Chapter 2 are collected and reported using the National Ombudsman Reporting System (NORS). See the *State Annual Long-Term Care OMBudsman Report,* OMB 0985-0005,§§§ for more information about NORS. Information on the efforts of long-term care ombudsman programs, including data on funding, staffing, facilities and beds, detail about complaints handled, and other program activities are reported annually by each state long-term care ombudsman program.

**State Performance Report**[78]

Data for Title VII Chapters 3 and 4 grants are collected using ACL's SPR (see details in Title III section above).¶¶¶ Data about program expenditures and elder rights accomplishments are collected.

## Data Reporting System

This year, ACL has launched a new data reporting system (software tool): the Older Americans Act Performance System (OAAPS)****, which is a centralized system for use by Title III, VI, and VII grantees to submit their annual performance/program reports. Access is restricted to authorized users (i.e., ACL staff members, ACL grantees). Grantees can upload their data to the system using an OAAPS upload template (available in CSV, XLSX, and XML file formats) or through manual data entry directly in the system. The OAAPS also allows grantees and ACL to validate data uploads and run reports on data housed in the system.

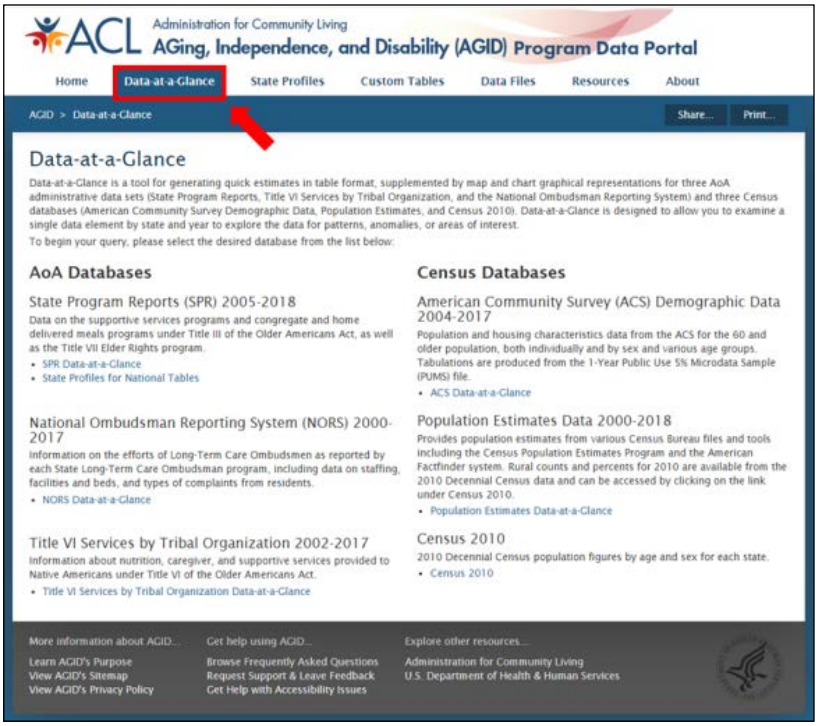
## Data Portal[79]

Data submitted to ACL by grantees via OAAPS is reviewed and processed by ACL and then published for public access on the AGing, Independence, and Disability (AGID) Program Data Portal†††† website.

The AGID website offers an online query system of aging and disability data from ACL and the U.S. Census Bureau. It offers four different data views: Data-at-a-Glance, State Profiles, Custom Tables, and Data Files.

*** https://www.usaging.org/Files/AAA-Survey-Report-2020%20Update-508.pdf
††† https://oaaps.acl.gov/api/upload/download?title=VI&downloadType=NewPPRForm
‡‡‡ https://www.usaging.org/Files/TitleVI-Survey-Report-508.pdf

§§§ https://omb.report/omb/0985-0005
¶¶¶ When states give Chapter 3 funding to ombudsman programs, the activity funded with those grants is reported in NORS.
**** https://oaaps.acl.gov/welcome
†††† https://agid.acl.gov/




## Using Title III, VI, and VII Data

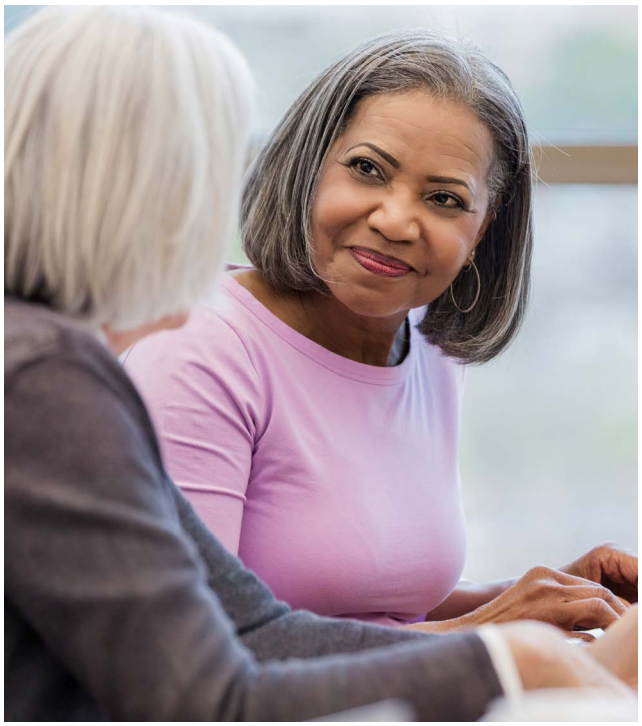
Policy makers, state leaders, advocates, and other stakeholders need accurate and timely information about Title III, VI, and VII programs to assess their reach, effectiveness, and potential impact. Data are key for monitoring ACL's progress toward achieving its strategic goals, objectives, and priorities; for supporting ACL's budget justifications; for monitoring program performance; and for supporting program improvement.[80] In addition, information about OAA programs can be used for research and analysis to inform federal, state, and local aging and social services policy.

The OAA programs produce rich data about Title III, VI, and VII clients and services. These data can help answer key questions about the programs, such as the following:

- How much funding is allocated to individual service types?
- How do expenditures differ by service type?
- How many individuals receive services?
- How many units of service (e.g., meals, hours of assistance) are delivered?
- What are the characteristics of service recipients?
- What is the health status of service recipients?
- How helpful are the services?

Although the OAA provides minimum requirements and guidance to the aging services network, states have flexibility to tailor programs and services to best meet the needs of older adults they serve. When interpreting OAA data, it is important to consider similarities and differences across states, such as the following:

- **Structure.** The structural organization of the state long-term care ombudsman program differs across states, which may affect the management and efficiency of programs, including how data are collected and reported. Specifically, programs may be centralized or decentralized, impacting who has programmatic and personnel oversight. In addition, state long-term care ombudsman programs may be located in different offices (e.g., SUA, an independent agency within state government, or a contracted entity outside state government). Thus, program data should be considered withing these structural differences.



- **Services**. Although authorized services under Titles III and VI are defined in the OAA, specific service design and implementation vary from state to state. The ACL provides detailed definitions to programs on services for which data are collected; however, these definitions are reasonably flexible to allow for variation at the local level. For example, "supplemental service" recipients can receive items such as wheelchairs, adjustable beds, personal emergency response systems, and a number of various medical equipment or supplies to support caregivers. Although this level of flexibility does not apply to all services, it is important to note when considering state level comparisons. Additionally, not all states provide data for all the services measured in the SPR.
- **Data systems.** Grantees differ in how they collect and maintain OAA program data. Depending on the age and sophistication of their data management systems, states may collect additional information, such as age and living arrangement sizes and types across funding authorities. Budget and staffing limitations are often mentioned among the top difficulties with collecting and extracting OAA program data.
- **Funding options.** Some states administer services and programs in cooperation with local governments and with the contribution of state and county dollars. This constitutes a distinct difference in funding that has implications for interpreting data on measures like the number of individuals served and availability of services.
- **Client feedback.** The NSOAAP provides nationally representative data about Title III services participants; however, these data are not representative for smaller geographic areas, such as individual states. Currently, data can only be stratified by the four regions identified by the U.S. Census Bureau (i.e., Northeast, Midwest, South, West).

We encourage readers to review data in light of these complexities. Detailed information about the surveys and operational definitions used for Title III, VI, and VII data can be found on the AGID program data portal website. It may also be helpful to check your state's website or check with your SUA director if you need further clarification on data issues.

# Impact of COVID-19 Pandemic on OAA Programs

As a result of the COVID-19 pandemic, decision makers at all levels of government had to adjust to a "new normal" that balances the need to prevent the spread of COVID-19 with efforts to continue to support the health, well-being, and independence of older adults.

Just like other service programs, OAA programs had to adjust and transform to respond to changes in the type and number of services needed and in the ways services could be safely delivered. Given these changes, the data reported by OAA grantees—such as number of clients served, number of service units provided, and types of services provided—may be different from data reported in previous years. It is also important to note that some of the changes to OAA programs may outlast the virus itself, thus leading to a "new normal" not only for what services are provided and how they are provided, but also for how data are reported and for what kind of story the data tell.

The following sections briefly describe the impact of the COVID-19 pandemic on general OAA program factors. Additional details about the impact of the pandemic on services for Title III, VI, and VII LTCOP are provided in the specific program results modules.

## Impact on OAA Funding and Spending

As highlighted in the introduction of this report, Congress passed several laws providing additional funding for OAA programs to help meet the needs of older adults during the COVID-19 pandemic.[81,82] As a result of these new laws, millions of dollars in additional funding were provided for nutrition programs, caregiver support programs, disease prevention, grants for tribal organizations, and long-term care ombudsman programs and other elder rights protection activities.

In addition, Congress allowed for flexibility to meet needs as they arose and to do so based on the unique needs in communities. For example, the CARES Act contained a provision allowing for transfers up to 100%, without prior approval, between funding under Subparts 1 (congregate nutrition services) and 2 (home-delivered nutrition services) of Title III-C; amended the definition of "homebound" for purposes of home-delivered meals eligibility to include an individual who is "unable to obtain nutrition because the individual is practicing social distancing"; and waived the nutrition requirements under these nutrition programs, while encouraging nutritious meals to be served. It also gave tribes flexibility to use Title VI Parts A/B and/or Part C for any disaster relief activities for older individuals or family caregivers served under the OAA. In addition, the CARES Act transfer flexibility allowed states to use OAA funding for operational changes needed to accommodate a shift from in-person to socially distanced service delivery, such as contactless home delivered meals, drive-through meals, phoned well-being checks, and expanded grocery/pharmacy/supply delivery.

However, the additional funding also required state and local agencies and providers to document and report how these funds were allocated and spent. Given the different funding streams, tracking the exact funding source used for each service and reporting on all activities created challenges for agencies and providers. (See section on impact on OAA program data collection below for more details.)

## Impact on OAA Providers and Staffing

Some providers had to close their doors for some period of time during the pandemic, with some reopening and closing again, in response to local COVID-19 positivity rates. Other programs were deemed essential and continued to provide essential services. To ensure staff were kept as safe as possible, providers developed and implemented safety protocols. For example, entities provided personal protective equipment, staff had to wears masks, and many providers switched to remote work and stopped in-person visits with clients.

Individuals of color and tribal elders were especially vulnerable during the pandemic and potentially required more services than other populations, and residents living in nursing homes were not able to receive in-person visits for an extended period of time.

Providers also assigned new job functions for staff to focus on the most urgent client priorities and expanded their provider networks to work with nontraditional partners, such as community groups, in more formal ways. However, providers also had to adjust to reductions in their numbers of paid staff and volunteer staff, due in part to staff being out sick, leaving their positions, or being laid off because of program closures. Given that the OAA service delivery system is heavily reliant on volunteers to deliver services, providers have likely faced challenges for continuing to meet the needs in their communities.

## Impact on OAA Services and Service Delivery

The AAAs' role as conduits for federal funding allowed them to receive additional funds quickly, while their role as community leaders and innovators afforded them flexibility in how they used the aid. In a survey administered to AAAs in May, 2020, 93% of respondents reported they were serving more clients since the pandemic began, and 69% saw an increased need for AAA services among clients they were already serving.[83] In addition, types of service needs by existing OAA clients, including those who receive services from AAAs, tribal organizations, and other community providers, shifted: there was greater demand for meal services and telephone reassurance and wellness checks but less demand for other services, such as transportation services. For legal assistance providers, case types changed with providers seeing an increase in eviction cases and cases related to the termination of benefits and essential services.

Due to structural and systemic inequities, which were exacerbated during the pandemic, service needs may also have changed across populations. Individuals of color and tribal elders were especially vulnerable during the pandemic and potentially required more services than other populations, and residents living in nursing homes were not able to receive in-person visits for an extended period of time.

Given changes in services needs and restrictions in providing in-person services, many providers also adjusted their methods of delivering services and tried new ways to continue to provide services. For example, many meal providers (funded under Title III and Title VI) shifted their congregate meal services to grab-and-go and home-delivery distribution or provided new supports, such delivering medication. Ombudsmen adjusted by contacting facilities, families, and residents by phone, email, or video calls while restrictions for entering nursing homes were in place. Court-based legal services were forced to become remote and provided remote access to communication tools, files, documents, case management systems, and mechanisms to have remote meetings. Other providers shifted from

in-person programs (e.g., health and wellness classes) to the virtual delivery of programs.[84]

Many providers also reduced the frequency or duration of in-home services; reserved in-home services for the most at-risk or vulnerable; prioritized personal care over chore support; and made other alterations to balance COVID-19 realities with their clients' very individual and significant needs.

## Impact on OAA Program Data Collection and Reporting[85]

States began receiving supplemental COVID-19 funds midway through FY 2020, which required ACL to quickly update its existing SPR guidance to include reporting requirements for states' use of supplemental funds. ACL asked states to report on their use of COVID-19 funds by including an open response "narrative" with their annual SPR. The COVID-19 narratives ACL received from states had varying levels of detail, due in part to the flexibility of ACL's reporting format.

Data on numbers of clients served and services unit were difficult to obtain due to grantees' challenges and additional burden related to collecting and managing OAA program data during the pandemic. For example, some grantees did not track clients and service units for the supplemental funds separately. Some providers changed what types of services they provided and how, and they may have experienced challenges aligning services with current data variables. (For example, should a boxed lunch be counted as a meal or a consumable supply?) Existing systems may not have provided sufficient flexibility to track additional and new data, and data for some service areas may not have been captured because some services had to be suspended during the pandemic.

Despite the challenges presented by the pandemic, OAA Title III, VI, & VII grantees and providers adjusted successfully to continue to serve their communities and provide much needed services. Grantees showed great creativity, flexibility, and resilience to use existing and new OAA funding to provide services to individuals with the greatest social and economic needs.

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# OLDER AMERICANS ACT

## Title III Programs

2020 PROGRAM RESULTS

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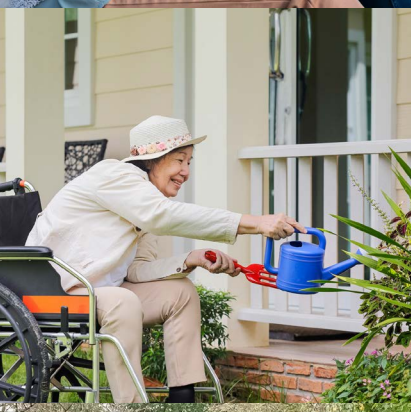


# Title III
# Program Highlights and Accomplishments

Older Americans Act (OAA) Title III programs are comprehensive and provide essential supports for older adults. In fact, one way or another, OAA programs and services touch almost every older American's life, directly or indirectly. For instance, senior centers are important gathering places where adults participate in essential programs focused on health, wellness, education, and social participation. The nutrition programs support food security for thousands of low-income and food-insecure people each day. Caregiver support programs help ensure that older adults can stay in their homes.[1] At the local level, older adults, caregivers, and other community stakeholders directly determine how current and future programs are implemented, based on the needs of each community.

Overall, the programs offer an impressive return on investment by leveraging state, local, and private dollars and mobilizing volunteers to help millions of older adults and caregivers age in their homes and communities every year. Also, because people aging in place are less likely to need more costly hospital and institutional care paid for through Medicare and Medicaid, the programs save taxpayer dollars as they enable older adults to remain independent and healthy in their own homes, where they prefer to be.[2]

In 2020, OAA Title III program data shows Title III funded 56 state agencies, 625 local agencies that coordinated and offered services to older adults, 6,072 senior centers, and almost 30,000 service providers. More than 10.1 million older persons received Title III services, including more than 198.6 million home-delivered meals; 39.6 million congregate meals; 26.9 million hours of personal care; 21.3 million hours of homemaker services; and 13.6 million rides to medical appointments, grocery stores, and other activities. In addition, Title III programs provided support to over 186,000 caregivers serving elderly individuals, delivering more than 5 million hours of respite care to these caregivers and more than 530,000 counseling/support groups/caregiver training sessions.

One of the key goals of the OAA Title III programs is ensuring the nation's most

**> 1/3**

**OLDER ADULT SERVICE RECIPIENTS LIVE IN POVERTY**

**1/3**

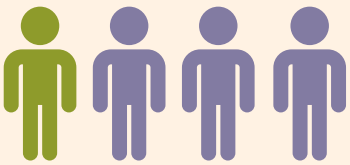
**OLDER ADULT SERVICE RECIPIENTS LIVE IN RURAL AREAS**

**1/2**

**OLDER ADULT SERVICE RECIPIENTS LIVE ALONE**

**1/4**

**OLDER ADULT SERVICE RECIPIENTS ARE AGE 85+**



vulnerable older adults have the services they need to remain independent in their communities. Thus, even though all Americans over the age of 60 are eligible to receive OAA services, states must target individuals with the greatest economic and social need, with a particular emphasis on those who are most vulnerable. The 2020 OAA Title III program data show services are indeed reaching the most vulnerable older adults in the nation—those most in need of services to remain independent. Specifically, the data reported by service recipients show that Title III services reached the following populations in 2020:

- Older adults living in poverty—over one third of service recipients
- Older adults living alone—almost half of service recipients
- Older adults living in rural areas—about one third of service recipients
- Older adults who require assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs)—more than half of service recipients requiring assistance with ADLs, about three out of four requiring assistance with IADLs
- The oldest of the older adults—almost a quarter of service recipients age 85+

## List of Exhibits



## Abbreviations and Acronyms

| | |
|---|---|
| **AAA** | Area Agency on Aging |
| **ADLs** | Activities of Daily Living |
| **COVID-19** | Coronavirus Disease of 2019 |
| **IADLs** | Instrumental Activities of Daily Living |
| **OAA** | Older Americans Act |
| **OMB** | Office of Management and Budget |
| **SHIP** | State Health Insurance Assistance Program |
| **SPR** | State Program Report |
| **SUA** | State Unit on Aging |

# Impact of Coronavirus Disease of 2019 Pandemic on Title III Services

## Funding Use

The president declared the coronavirus disease of 2019 (COVID-19) pandemic as a national emergency on March 13, 2020, authorizing states to use OAA Title III funds for disaster relief as they saw fit without having to submit a transfer request to ACL.[3] As a result, states were allowed to use Title III-B, C, D, and/or E funds for any disaster relief activities for older individuals or family caregivers served under the OAA, such as providing

- drive-through, take-out, or home-delivered meals;
- well-being checks via phone, in person, or via virtual means; and
- homemaker, chore, grocery/pharmacy/supply delivery, or other services.

## Title III Services

Over the last year, OAA Title III grantees have described how the COVID-19 pandemic has impacted their programs.[4,5] The bullets below provide a summary of the information shared by grantees for how the pandemic impacted Title III service needs and service provision.

- **Shifted to remote work.** Many providers, such as legal assistance providers, shifted to remote work to continue operations and keep clients and staff safe. For remote legal work, this shift entailed ensuring access to communication tools, files, documents, case management systems, and mechanisms to have meetings.
- **Experienced increase/decrease in demand for services.** In Fiscal Year (FY) 2020, states overall provided about 24 million more meals overall and about 32% more home-delivered meals—using COVID-19 and other funds—compared to FY 2019. Grantees also reported a large increase in calls for information, assistance, and referrals to services during the pandemic. The demand for in-home services decreased early in the pandemic, and public health orders led to the suspension of many in-person services, such adult day care centers.
- **Changed spending patterns.** Grantees reported spending more funds for meal programs as food costs increased and providers needed to purchase additional supplies, such as personal protective equipment and food delivery containers. Expenditures for some in-person services, such as homemaker services, remained steady, but expenditures for adult day care and transportation decreased.
- **Transformed meal programs.** Most states replaced congregate meals with home-delivered meals during the pandemic. While the number of congregate meals dropped, some states continued to provide congregate meals during the pandemic, and some providers replaced meals in traditional congregate settings with grab-and-go meals paired

with in-person or virtual socialization. Grantees also adjusted meal delivery approaches. For instance, some localities made single deliveries with multiple days' worth of meals, and some provided frozen meals instead of hot meals to limit the number of times they needed to make contact with the client.

- **Delivered food boxes and groceries and care packages.** Grantees provided groceries, food boxes, and care packages to their clients as either a supplement or an alternative to home-delivered meals. Care packages included shelf-stable foods and household items such as toilet paper, along with puzzles and games to provide their clients with activities during the stay-at-home order.
- **Experienced staff shortages.** Grantees reported experiencing shortages of staff and volunteers and implementing alternative solutions to continue providing essential services. For instance, some grantees reported that many of their traditional volunteers, often older adults themselves, no longer felt comfortable serving during the pandemic or were directed by state or local orders to stay at home. In response, grantees shifted staff roles to address most critical needs, used COVID-19 funding to hire additional delivery drivers for their home-delivered meals, or used their transportation services' vans to deliver meals to their clients.
- **Modified transportation services.** Many grantees reported suspending or significantly reducing their transportation services early in the pandemic due to safety concerns. However, as the pandemic continued, some localities modified transportation services to comply with social distancing measures and ensure older adults were able to get to their medical appointments. Once COVID-19 vaccines were available for older adults, grantees provided transportation services for older adults going to and from their vaccination appointments.
- **Cancelled in-person activities.** Evidence-based disease prevention and health promotion services program grantees reported having to cancel workshops that had already been initiated and were scheduled to be provided.
- **Shifted to virtual programs:** Programs provided virtual activities, including trainings, workshops,

and wellness classes (e.g., tai chi, chronic disease self-management, diabetes self-management). As part of this effort, grantees tested different platforms to determine whether programs were accessible to older adults. Grantees also developed statewide marketing tools to promote the use of technology and to reach target audiences, engaged a range of existing and new partners to deliver virtual programs, and developed materials to support activities and enhance communication with clients.

- **Temporarily suspended or reduced in-home care services.** Grantees reported temporarily stopping or reducing in-home supportive services for clients at the beginning of the pandemic.
- **Conducted phone/virtual check-ins.** Most programs reported conducting well-being checks via telephone instead of going into clients' homes. These calls allowed them to assess the needs of their clients and make sure clients had the support they needed during stay-at-home orders.
- **Temporarily suspended or reduced caregiver support services.** Early during the pandemic, several grantees reported shutting down caregiver support groups and respite care services. As the pandemic continued, most programs shifted to provide virtual support groups for caregivers and resumed offering limited respite care services to caregivers.

# Part 1 | 2020 State Performance Report Data Highlights*

## State Performance Report Data Categories

Data in State Performance Reports (SPRs) are categorized into registered and unregistered services. Registered services are services that require demographic and client characteristics to be reported. Cluster 1 registered services require detailed client profiles to be reported, whereas cluster 2 registered services require summary client profiles only.

- **Cluster 1 Registered Services:** Personal care, homemaker, chore, home-delivered meals, adult day care/health services, and case management.
- **Cluster 2 Registered Services:** Assisted transportation, congregate meals, and nutrition counseling.

Unregistered services, also known as a cluster 3 non-registered service, do not require demographic and consumer characteristics to be reported.

- **Cluster 3 Non-registered Services:** Transportation, legal assistance, nutrition education, information and assistance, outreach, other services, health promotion, and cash and counseling.

The SPRs also include Title III, Part E services (caregiver services) data. **Data on caregiver services** are grouped into two categories:

- caregivers serving elderly individuals (hereinafter "caregivers serving older adults") and
- grandparents and other elderly caregivers serving children (hereinafter "caregivers serving children").

* Reporting year 2020 for SPRs was October 1, 2019–September 30, 2020.

## Number of Agencies and Providers

The majority of funding for OAA programs flows from the federal to the state level and from there to the local level. Most states and territories have a state-level office on aging (State Unit on Aging, or SUA), responsible for developing and administering multiyear state plans that advocate for and aid older residents, their families, and, in many states, adults with physical disabilities. Most states and territories also have Area Agencies on Aging (AAAs).[6] These are public or private nonprofit agencies designated by a state to address the needs and concerns of all older persons at the regional and local levels. The AAAs work with service providers, such as senior centers, to deliver the services to eligible clients.

### *Number of Agencies and Providers*

- Total number of SUAs = 56
- Total number of AAAs = 625
- Total number of senior centers = 6,072
- Total number of service providers[†] = 29,258
  - Minority = 2,775
  - Rural = 7,102

### *Number of SUA Agency Staff*

- Total number of paid staff = 5,212

### *Number of AAA Staff*

- Total number of staff = 47,722
  - Paid staff = 25,976
  - Volunteers = 21,746

† Excluding AAAs providing direct services.

**56** | **State Units on Aging**

**625** | **Area Agencies on Aging**

### *Number of Providers by Service Type*

In 2020, caregivers serving older adults programs reported by far the largest number of providers (10,877), followed by personal care programs (4,150), and congregate meal programs (4,076). Nutrition counseling program and adult day care/health care programs had the fewest providers (340 and 774, respectively).

**Caregiver Programs**
**10,877**

**Congregate Meal Programs**
**4,076**

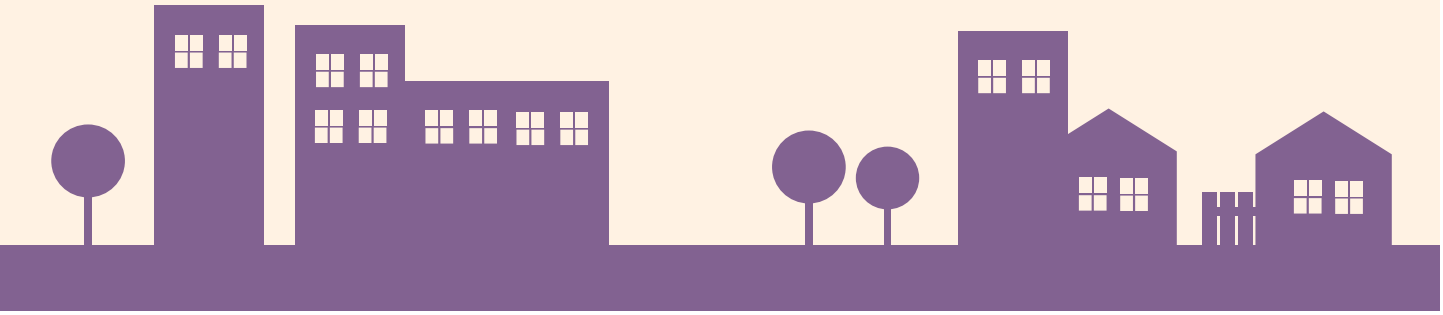
**Nutrition Counseling Programs**
**340**

**Personal Care Programs**
**4,150**

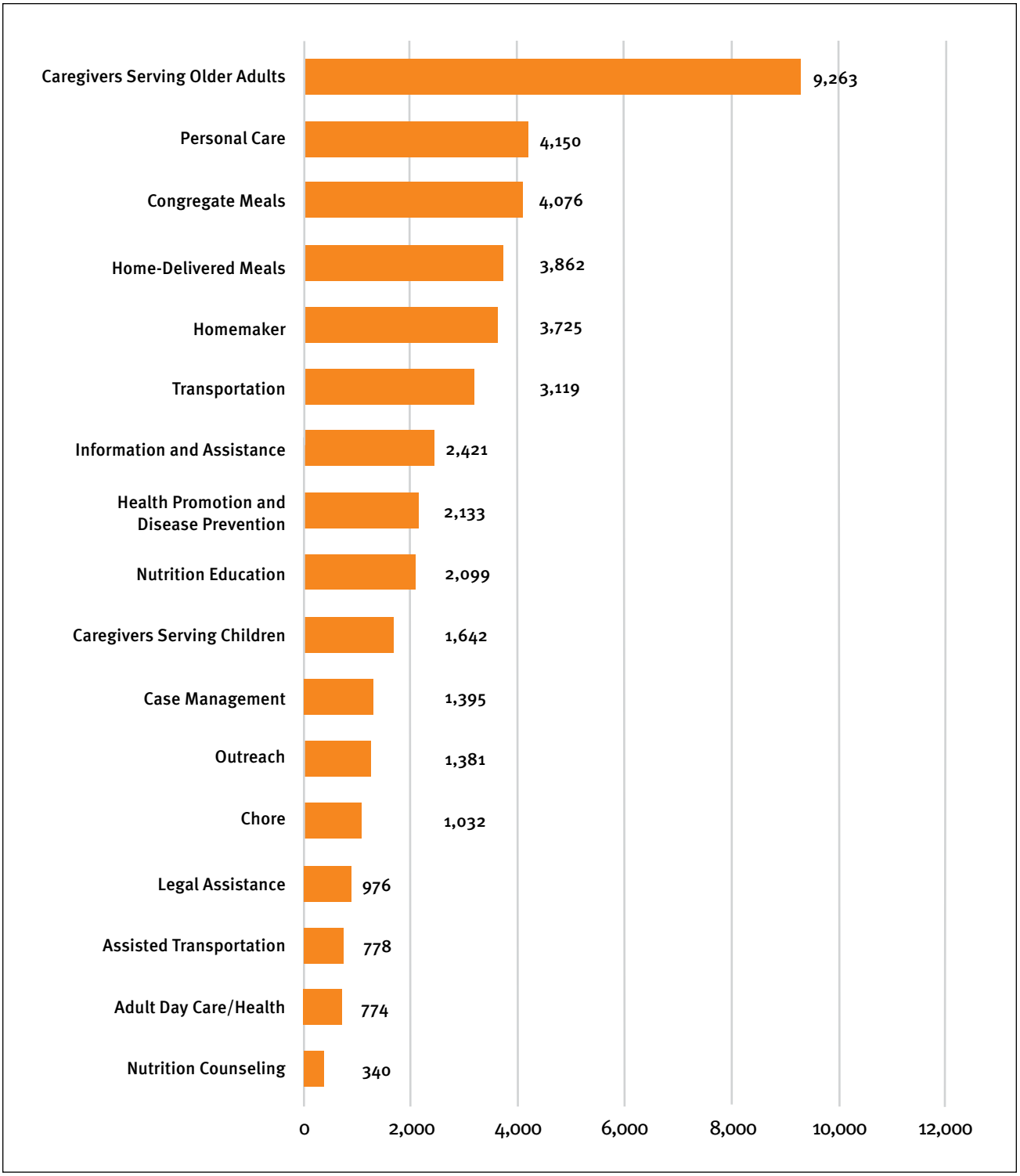
**Adult Day Care/ Health Care Programs**
**774**

**6,072** | **Senior Centers**

**29,258** | **Service Providers: Minority = 2,775 | Rural = 7,102**



## Exhibit 1. Number of Providers by Service Type




*Notes: Counts include registered and unregistered services as well as caregiver services.*

## Number and Characteristics of Service Recipients

### *Number of Title III Service Recipients‡*

In 2020, states and territories reported an estimated total of **more than 10 million (10,186,166)** unduplicated Title III service recipients (including registered and unregistered service recipients). Of those, **2,740,755** were recipients of registered services, and **8,419,937** were recipients of unregistered services§. Among clients receiving registered services, approximately 33% (908,174) represented ethnic/racial minority populations.

‡ Number does not include caregivers served.
§ Count of registered and unregistered services recipients does not sum to 19,186,166 since individuals may be receiving both types of services.

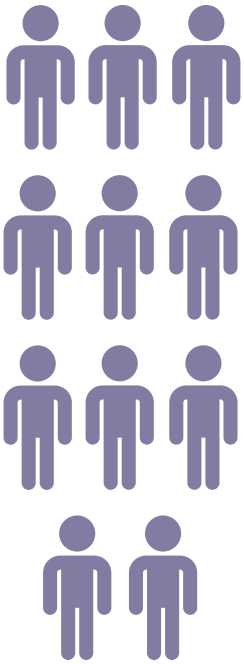
The following sections provide data for registered services. When available, data on service recipients for Title III, Part E (caregiver services) are provided separately.

### *Number of Title III Service Recipients by Service Type*

In 2020, home-delivered meal programs reported the highest number of service recipients (1,447,910), followed by congregate meal programs (1,329,203), and case management programs (487,548).

**Total Service Recipients**

**10,186,166**



**Number of Service Recipients by Service Type**

**Home-delivered meals**

**1,447,910**

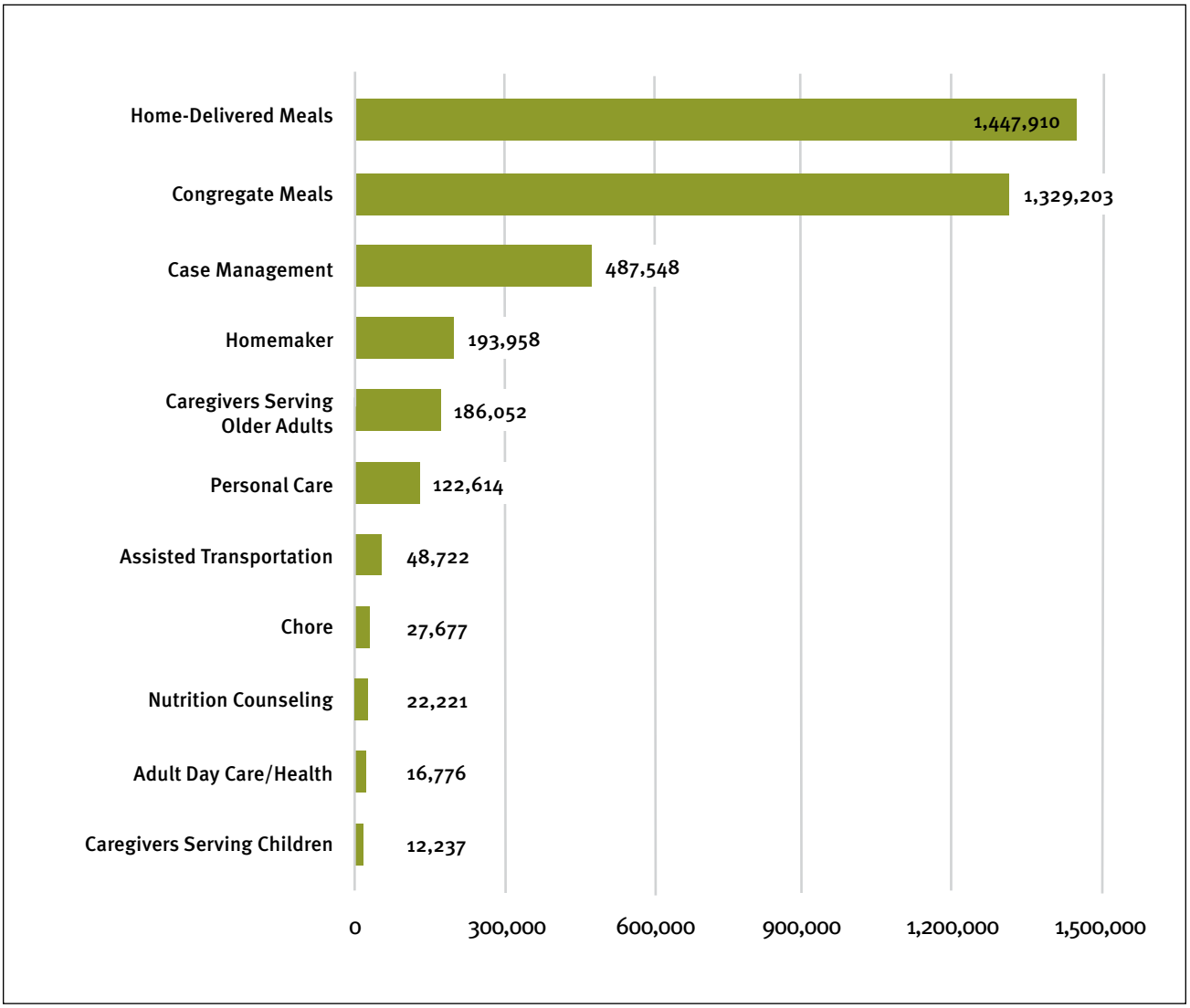
**Congregate meals**

**1,329,203**

**Case Management**

**487,548**

## Exhibit 2. Number of Unduplicated Persons Served by Service Type

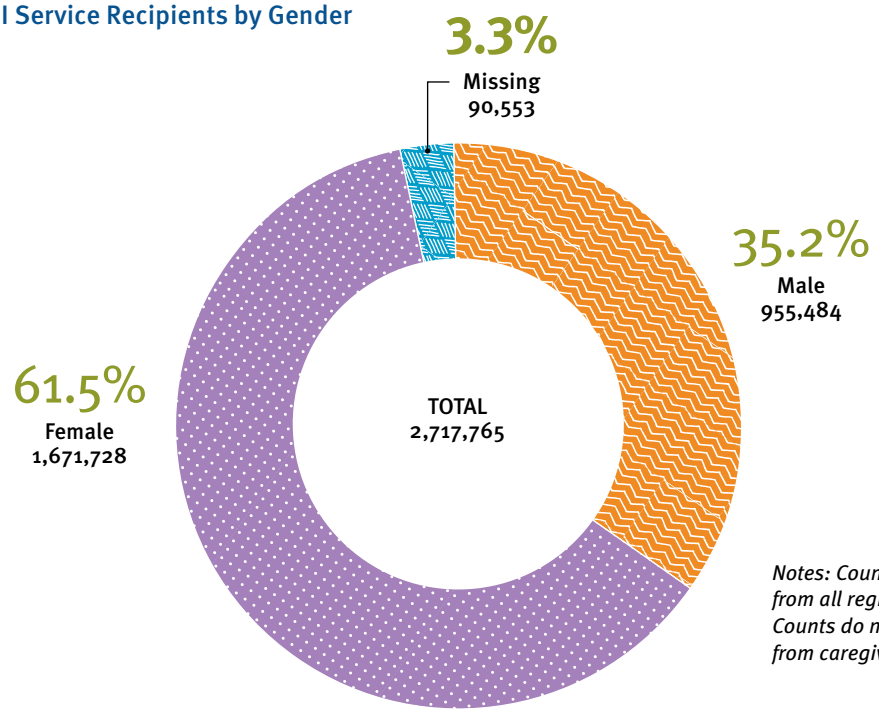



*Notes: Clients may be receiving more than one service. Counts include those from all registered services and caregiver services (unduplicated number of caregivers). Counts for unregistered services (cluster 3 services) are not collected and thus not included. Caregiver services do not include data from the service categories of access assistance and information services.*

### *Number of Title III Service Recipients by Gender*

In 2020, more than three out of five (61.5%) service recipients were female. The majority of caregivers serving older adults or children in 2020 (66.8% and 83.8%, respectively) were female also.

**Exhibit 3.** Title III Service Recipients by Gender




*Notes: Counts include those from all registered services. Counts do not include data from caregiver services.*

### *Caregivers Serving Older Adults by Gender*

| Gender | Number of Caregivers | Percent |
|---|---|---|
| Caregivers Serving Older Adults – Male | 37,280 | 25.4 |
| Caregivers Serving Older Adults – Female | 97,825 | 66.8 |
| Missing | 11,405 | 7.8 |
| **TOTAL** | **146,510** | **100** |
| Caregivers Serving Children – Male | 1,328 | 14.0 |
| Caregivers Serving Children – Female | 7,962 | 83.8 |
| Missing | 208 | 2.2 |
| **TOTAL** | **9,498** | **100** |

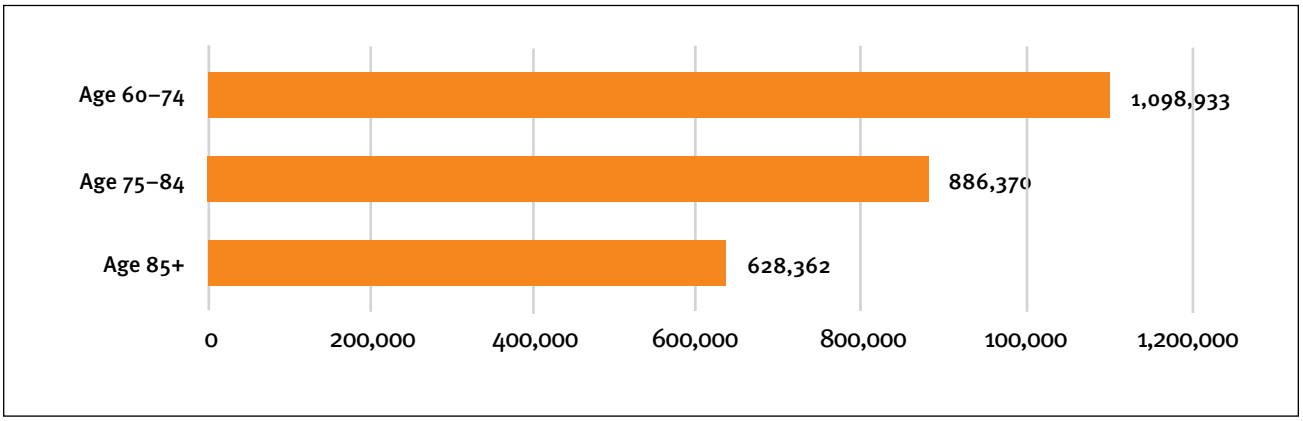
*Notes: Data are for Title III Part E Group 1 services only. Group 1 services include counseling/support groups/caregiver training, respite care, supplemental services, and self-directed care.*

### *Number of Title III Service Recipients by Age*

**41%**

In 2020, 41.3% of service recipients were between ages 60 and 74. One third (33.3%) of service recipients were between ages 75 and 80, and almost a quarter (23.6%) of service recipients were 85 years and older.

**Exhibit 4.** Title III Service Recipients by Age




*Notes: Clients may be receiving more than one service. Counts include those from all registered services. Age was missing for 48,603 service recipients.*

### *Caregivers Serving Older Adults by Age*

**35%**

Most caregivers serving older adults (161,384 caregivers) were in the age range of 60–74 years (35%). Most caregivers serving children (9,713 caregivers) were in the age range of 55–74 years (75.6%).

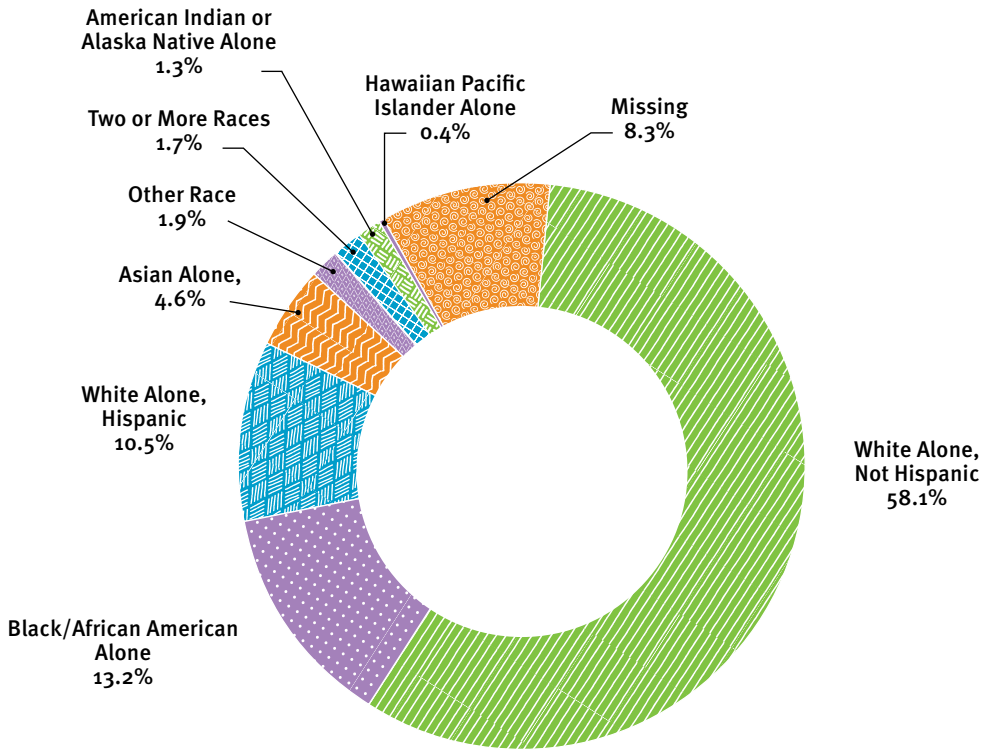
| Age Range | Number of Caregivers | Percent |
|---|---|---|
| Caregivers Serving Individuals – Age < 60 | 39,926 | 24.7 |
| Caregivers Serving Older Adults – Age 60–74 | 56,536 | 35.0 |
| Caregivers Serving Older Adults – Age 75–84 | 27,465 | 17.0 |
| Caregivers Serving Older Adults – Age 85+ | 10,650 | 6.6 |
| Missing | 26,807 | 16.6 |
| **TOTAL** | **161,384** | **100** |
| Caregivers Serving Children – Age 55–74 | 7,346 | 75.6 |
| Caregivers Serving Children – Age 75–84 | 1,154 | 11.9 |
| Caregivers Serving Children – Age 85+ | 335 | 3.4 |
| Missing | 599 | 9.0 |
| **TOTAL** | **9,434** | **100** |

*Notes: Data are for Title III Part E Group 1 services only. Group 1 services include counseling/support groups/caregiver training, respite care, supplemental services, and self-directed care.*

### *Number of Title III Service Recipients by Race/Ethnicity*

**70%** The majority of service recipients, approximately 70%, were white alone (Hispanic and not Hispanic), making up approximately 70% of service recipients.

**Exhibit 5.** Title III Service Recipients by Race/Ethnicity




*Notes: Counts include those from all registered services. "Alone," when appended to a racial category, means that the individual designated only one race category.*

| Race/Ethnicity | Number of Service Recipients | Percent |
|---|---|---|
| White Alone, Not Hispanic | 1,570,420 | 58.1 |
| Black/African American Alone | 357,110 | 13.2 |
| White Alone, Hispanic | 283,378 | 10.5 |
| Asian Alone | 123,365 | 4.6 |
| Other Race | 50,222 | 1.9 |
| Two or More Races | 46,578 | 1.7 |
| American Indian or Alaska Native Alone | 35,678 | 1.3 |
| Native Hawaiian/Pacific Islander Alone | 11,843 | 0.4 |
| Missing | 224,278 | 8.3 |
| **TOTAL** | **2,702,872** | **100** |

### *Caregivers Serving Older Adults*

**60%**

A majority of the caregivers serving older adults (60%) were white alone (Hispanic and not Hispanic).

| Race/Ethnicity | Number of Caregivers | Percent |
|---|---|---|
| White Alone, Not Hispanic | 80,513 | 49.9 |
| Black/African American Alone | 20,238 | 12.5 |
| White Alone, Hispanic | 16,130 | 10.0 |
| Asian Alone | 4,992 | 3.1 |
| Other Race | 2,758 | 1.7 |
| Two or More Races | 1,566 | 1.0 |
| American Indian or Alaska Native Alone | 610 | 0.4 |
| Native Hawaiian/Pacific Islander Alone | 483 | 0.3 |
| Missing | 34,113 | 21.1 |
| **TOTAL** | **161,403** | **100** |

*Notes: Data are for Title III Part E Group 1 services only. Group 1 services include counseling/support groups/caregiver training, respite care, supplemental services, and self-directed care.*

### *Caregivers Serving Children*

**30%** The largest racial/ethnic minority group of grandparents and other older caregivers serving children were Black/African American, making up over 30% of these caregivers.

| Race/Ethnicity | Number of Caregivers | Percent |
|---|---|---|
| White Alone, Not Hispanic | 4,361 | 45.8 |
| Black/African American Alone | 3,074 | 32.3 |
| White Alone, Hispanic | 1,058 | 11.1 |
| American Indian or Alaska Native Alone | 149 | 1.6 |
| Other Race | 119 | 1.3 |
| Two or More Races | 101 | 1.1 |
| Asian Alone | 58 | 0.6 |
| Native Hawaiian/Pacific Islander Alone | 47 | 0.5 |
| Missing | 545 | 5.7 |
| **TOTAL** | **9,512** | **100** |

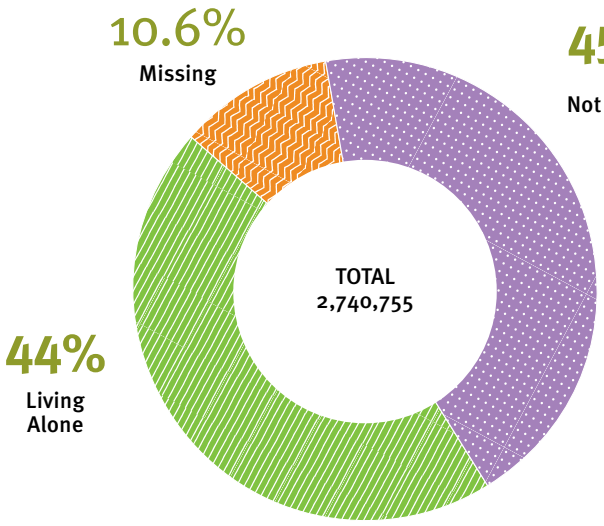
*Notes: Data are for Title III Part E Group 1 services only. Group 1 services include counseling/support groups/caregiver training, respite care, supplemental services, and self-directed care.*

### *Number of Title III Service Recipients by Living Alone Status*

**44%**

People who live by themselves are at higher risk of nursing home entry because they may be isolated or lack supports to assist with ADLs. In part because of this risk, OAA targets services to those who live alone, and participants in many Title III programs are more likely to live by themselves than older Americans nationally.[7]

In 2020, approximately equal percentages of service recipients reported living alone (44%) and not living alone (45.4%).



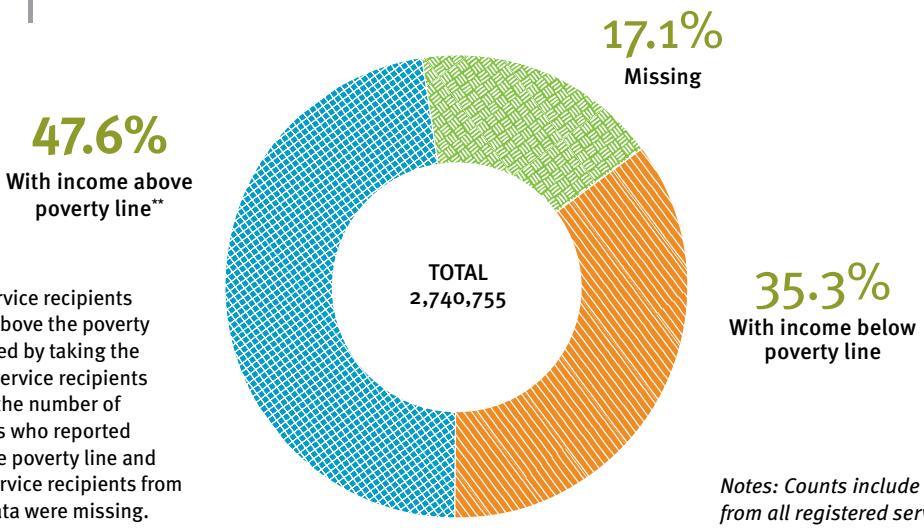

¶ Number of service recipients not living alone was calculated by taking the total number of service recipients and subtracting the number of service recipients who reported they lived alone and the number of service recipients for whom "living alone" data were missing.

*Notes: Counts include those from all registered services.*

### *Number of Title III Service Recipients by Poverty Status*

**36%**

About one third (35.8%) of Title III service recipients in 2020 lived in poverty.



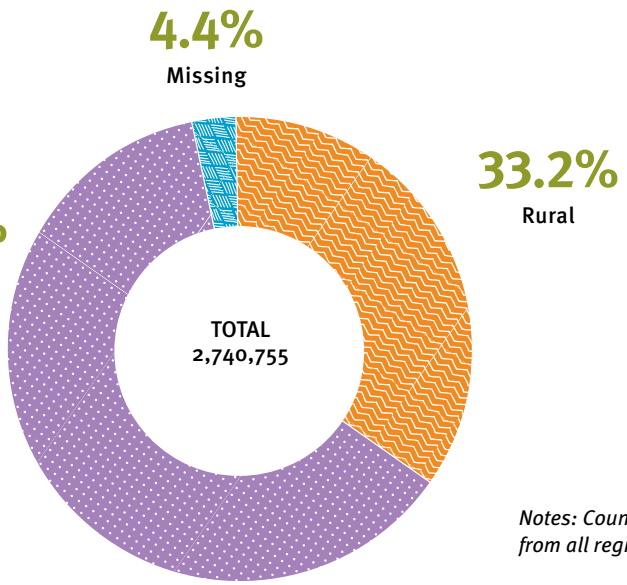

** Number of service recipients with an income above the poverty line was calculated by taking the total number of service recipients and subtracting the number of service recipients who reported income below the poverty line and the number of service recipients from whom poverty data were missing.

*Notes: Counts include those from all registered services.*

### *Number of Title III Service Recipients by Rurality*

**33%**

In 2020, about one third (33.2%) of service recipients reported living in rural areas.

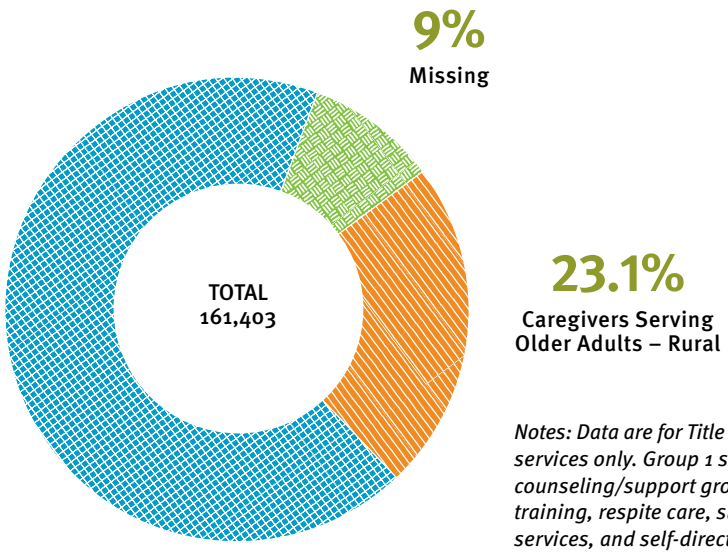



†† Number of non-rural service recipients was calculated by taking the total number of service recipients and subtracting the number of service recipients who reported living in rural areas and the number of service recipients from whom rurality data were missing.

*Notes: Counts include those from all registered services.*

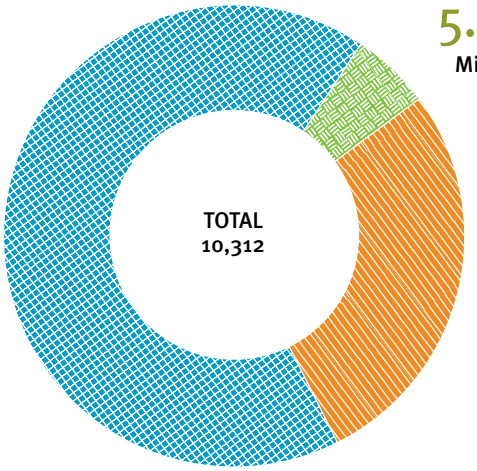
**23%**

In 2020, almost one in four caregivers serving older adults (23.1%) reported living in rural settings. Among grandparents and other older caregivers serving children, 27.9% reported living in rural settings.




‡‡ Number of non-rural service recipients was calculated by taking the total number of service recipients and subtracting the number of service recipients who reported living in rural areas and the number of service recipients from whom rurality data were missing.

*Notes: Data are for Title III Part E Group 1 services only. Group 1 services include counseling/support groups/caregiver training, respite care, supplemental services, and self-directed care.*




* Number of non-rural service recipients was calculated by taking the total number of service recipients and subtracting the number of service recipients who reported living in rural areas and the number of service recipients from whom rurality data were missing.

*Notes: Counts include those from all registered services.*

### *Need for Assistance With ADLs for Title III Service Recipients*

**31%**

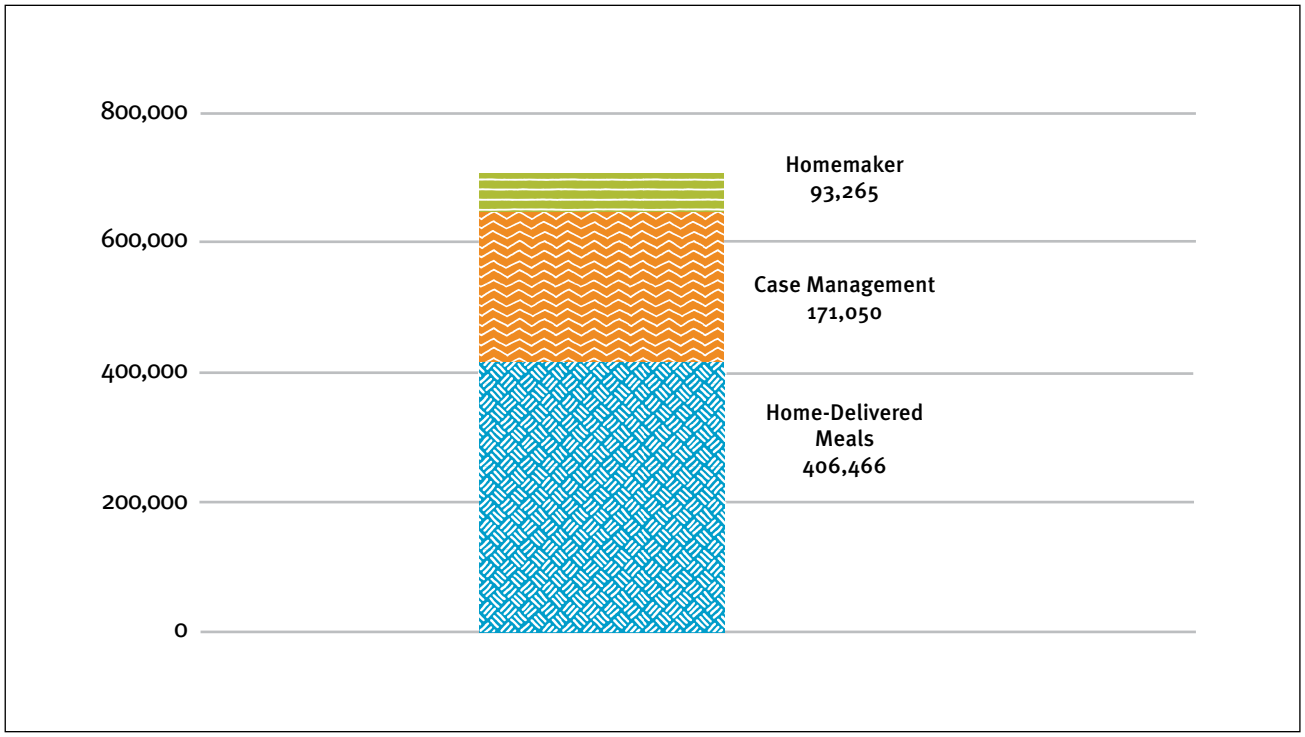
People who have difficulty performing three or more ADL or IADLs are at increased risk of nursing home placement. Among ADLs are eating, dressing, bathing, toileting, transferring in and out of bed/chair, and walking. Among IADLs are preparing meals, shopping for personal items, medication management, managing money, using telephone, doing heavy housework, doing light housework, and transportation ability (i.e., the individual's ability to make use of available transportation without assistance).[8] Thus, it is critical that people who need assistance with ADLs or IADLS receive services that allow them to remain in their homes.

Almost one third of service recipients (31.1%) reported requiring assistance with three or more ADLs. Most clients who had difficulty performing three or more ADLs were home-delivered meal service recipients (406,466).

| ADL Group | Number of Service Recipients | Percent |
|---|---|---|
| 0 ADLs | 536,945 | 30.8 |
| 1 ADL | 166,471 | 9.6 |
| 2 ADLs | 155,447 | 8.9 |
| 3+ ADLs | 541,676 | 31.1 |
| Missing | 341,772 | 19.6 |

*Notes: Results include clients receiving Cluster 1 registered services. Cluster 1 registered services include personal care, homemaker, chore, home-delivered meals, adult day care/health, and case management. Counts of impairment in ADLs are based on the inability to perform one or more of the following six ADLs without personal assistance or stand-by assistance, supervision, or cues: eating, dressing, bathing, toileting, transferring in and out of bed/ chair, and walking.*[9]

## Exhibit 6. Number of Clients With Difficulty Performing Three or More ADLs by Cluster 1 Registered Service




*Notes: Results include clients receiving Cluster 1 registered services. Cluster 1 registered services include personal care, homemaker, chore, home-delivered meals, adult day care/health, and case management. Counts of impairment in ADLs are based on the inability to perform one or more of the following six ADLs without personal assistance or stand-by assistance, supervision, or cues: eating, dressing, bathing, toileting, transferring in and out of bed/chair, and walking.*[10]

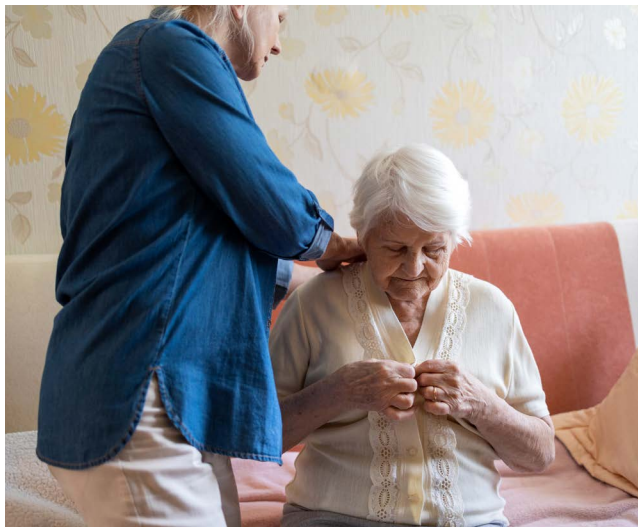
### *Need for Assistance With IADLs for Title III Service Recipients*

**56%**

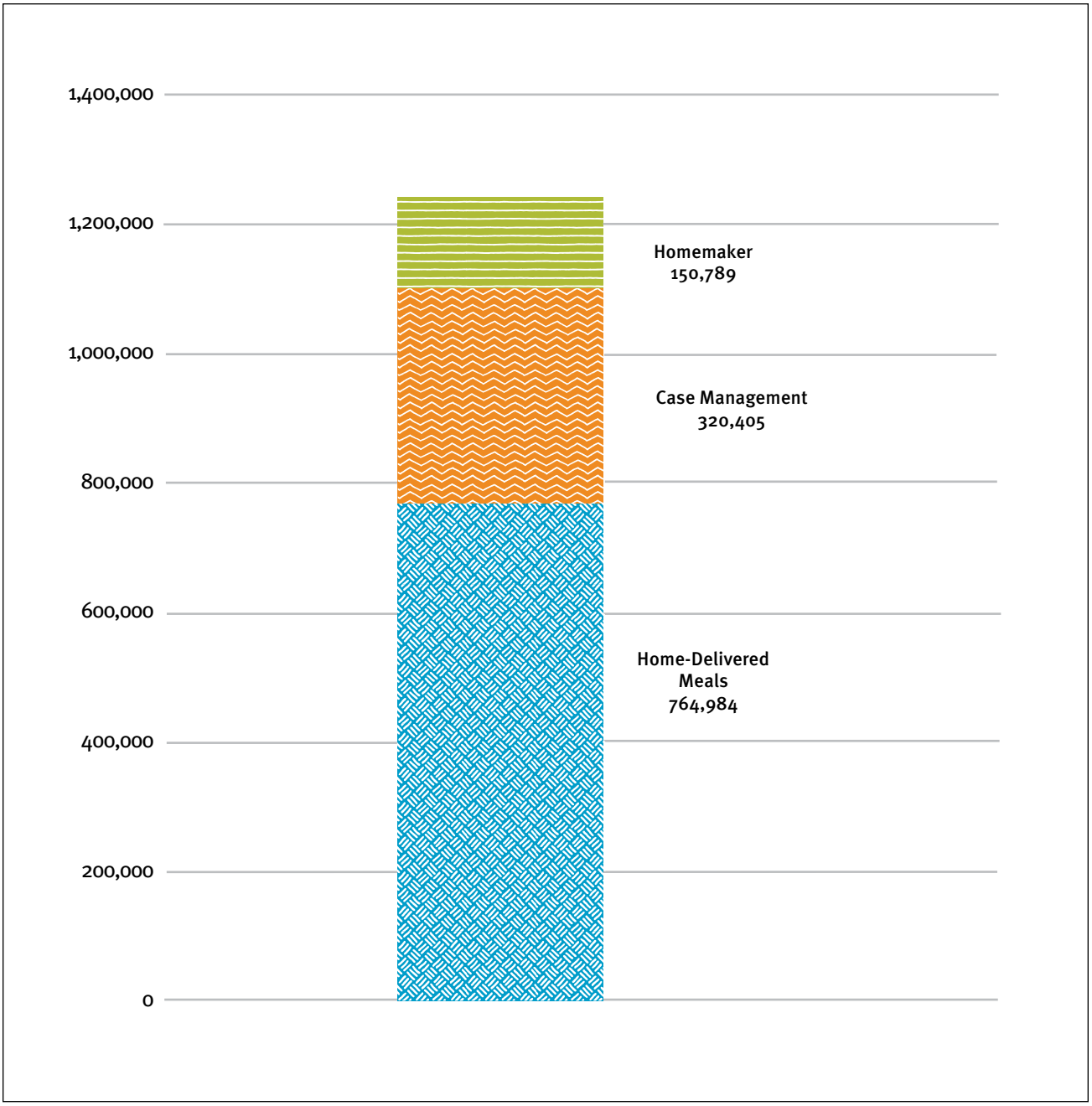
More than half of service recipients (56.2%) reported requiring assistance with three or more IADLs. Most clients who required assistance with three or more IADLS were recipients of home-delivered meal services (764,948).

| IADL Group | Number of Service Recipients | Percent |
|---|---|---|
| 0 IADLs | 254,448 | 14.6 |
| 1 IADL | 85,467 | 4.9 |
| 2 IADLs | 77,291 | 4.4 |
| 3+ IADLs | 981,131 | 56.2 |
| Missing | 348,019 | 19.9 |

*Notes: Results include clients receiving Cluster 1 registered services. Cluster 1 registered services include personal care, homemaker, chore, home-delivered meals, adult day care/health, and case management. Counts of impairment in IADLs are based on the inability to perform one or more of the following eight IADLs without personal assistance, stand-by assistance, supervision, or cues: preparing meals, shopping for personal items, medication management, managing money, using telephone, doing heavy housework, doing light housework, and transportation ability (the individual's ability to make use of available transportation without assistance).*[11]



## Exhibit 7. Number of Clients With Difficulty Performing Three or More IADLs by Cluster 1 Registered Service



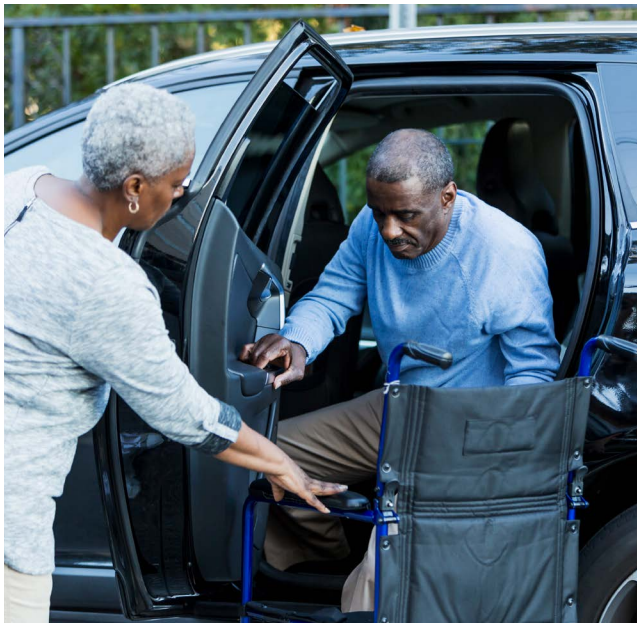

*Notes: Results include Cluster 1 registered services. Cluster 1 registered services include personal care, homemaker, chore, home-delivered meals, adult day care/health, and case management. Counts of impairment in IADLs are based on the inability to perform one or more of the following eight IADLs without personal assistance, stand-by assistance, supervision, or cues: preparing meals, shopping for personal items, medication management, managing money, using telephone, doing heavy housework, doing light housework, and transportation ability (the individual's ability to make use of available transportation without assistance).*[12]

## Service Units

The following section provides data highlights for delivered Title III service units. Service units refer to a specified quantity of a service.

### *Definition of Service Units for Different Services*

- **Access Assistance (1 contact)** – A service that assists caregivers in obtaining access to the services and resources that are available within their communities. To the maximum extent practicable, it ensures that the individuals receive the services needed by establishing adequate follow-up procedures.
- **Adult Day Care/Adult Day Health (1 hour)** – Personal care for dependent elders in a supervised, protective, and congregate setting during some portion of a day. Services offered in conjunction with adult day care/adult day health typically include social and recreational activities; training; counseling; and services such as rehabilitation, medications assistance, and home health aide services for adult day health.
- **Assisted Transportation (1 one-way trip)** – Assistance and transportation, including escort, provided to a person who has difficulties (physical or cognitive) using regular vehicular transportation.
- **Case Management (1 hour)** – Assistance in the form of either access or care coordination in circumstances where the older person is experiencing diminished functioning capacities, personal conditions, or other characteristics which require the provision of services by formal service providers or family caregivers. Activities of case management include such practices as assessing needs, developing care plans, authorizing and coordinating services among providers, and providing follow-up and reassessment, as required.
- **Chore (1 hour)** – Assistance such as heavy housework, yard work, or sidewalk maintenance for a person.
- **Congregate Meal (1 meal)** – A meal provided to an eligible individual in a congregate or group setting. The meal as served meets all requirements of the OAA and state/local laws.
- **Counseling (1 session per caregiver)** – Counseling to caregivers to assist them in making decisions and solving problems relating to their caregiver roles. This service includes counseling to individuals, support groups, and caregiver training (of individual caregivers and families).
- **Homemaker (1 hour)** – Assistance such as preparing meals, shopping for personal items, managing money, using the telephone, or doing light housework.
- **Home-Delivered Meal (1 meal)** – A meal provided to an eligible individual in their place of residence. The meal is served in a program administered by SUAs and/or AAAs and meets all requirements of the OAA and state/local laws.
- **Information Services (1 activity)** – A service for caregivers that provides the public and individuals with information on resources and services available to the individuals within their communities. Note: Service units for information services are for activities directed to large audiences of current or potential caregivers, such as disseminating publications, conducting media campaigns, and other similar activities.
- **Legal Assistance (1 hour)** – Legal advice, counseling and representation by an attorney or other person acting under the supervision of an attorney.
- **Nutrition Education (1 session per participant)** – A program to promote better health by providing accurate and culturally sensitive information about nutrition, physical fitness, or health (as it relates to nutrition) and instruction to participants, caregivers, or participants and caregivers in a group or individual setting overseen by a dietician or individual of comparable expertise.
- **Nutrition Counseling (1 session per participant)** – Individualized guidance to individuals who are at



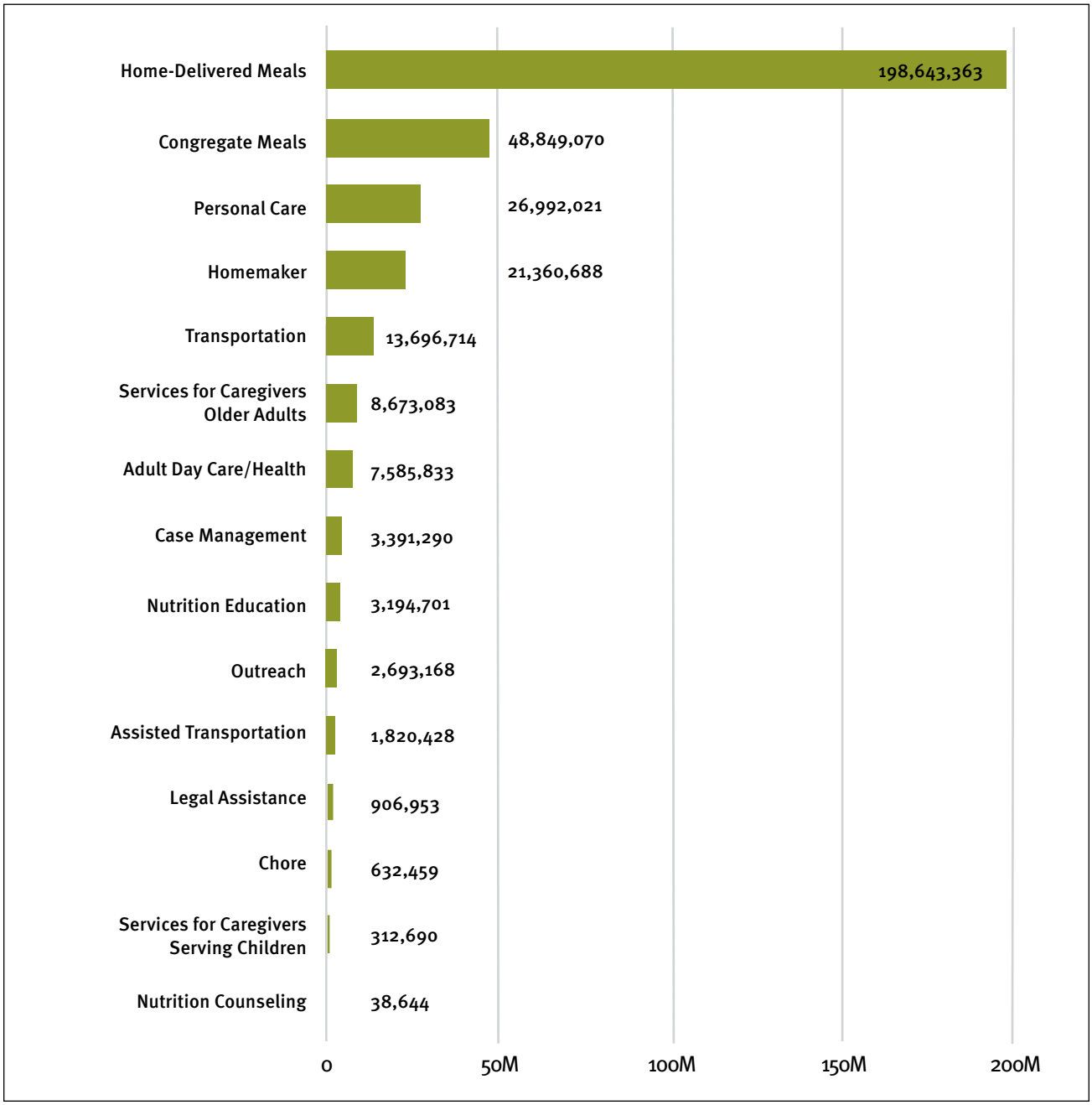
nutritional risk because of their health or nutrition history, dietary intake, chronic illnesses, or medications use, or to caregivers. Counseling is provided one-on-one by a registered dietician and addresses the options and methods for improving nutrition status.

- **Outreach (1 contact)** – Intervention with individuals initiated by an agency or organization for the purpose of identifying potential clients (or their caregivers) and encouraging their use of existing services and benefits.
- **Personal Care (1 hour)** – Personal assistance, stand-by assistance, supervision, or cues.
- **Respite Care (1 hour)** – Services which offer temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Respite care includes In-home respite (personal care, homemaker, and other in-home respite); respite provided by attendance of the care recipient at a senior center or other nonresidential program; institutional respite provided by placing the care recipient in an institutional setting such as a nursing home for a short period of time as a respite service to the caregiver; and (for grandparents caring for children) summer camps.
- **Services for caregivers** – Counseling (1 session per participant); respite care (1 hour); supplemental services; information services (1 activity); and access assistance (1 contact).
- **Supplemental services** – Services provided on a limited basis to complement the care provided by caregivers. Examples of supplemental services include, but are not limited to, home modifications, assistive technologies, emergency response systems, and incontinence supplies.
- **Transportation (1 one-way trip)** – Transportation from one location to another. Does not include any other activity.

### *Number of Service Units by Service Type*

In 2020, the largest number of service units by far was provided for home-delivered meal programs (198,643,363), followed by congregate meal programs (48,849,070). The fewest service units were provided for nutrition counseling (38,644).

**Exhibit 8.** Total Service Units, by Service Type




*Notes: Counts include those from all registered and unregistered services and caregiver services (except self-directed care).*

### *Number of Service Units by Caregiver Services*

For caregivers serving older adults, programs provided more than 5 million hours of respite care, approximately 1.5 million contacts to assist caregivers with access to assistance, 719,000 activities to provide information services, and over 530,000 counseling/support group/caregiver training sessions. Programs also provided more than 825,000 supplemental services.

**Exhibit 9.** Units of Services, Caregivers Serving Older Adults

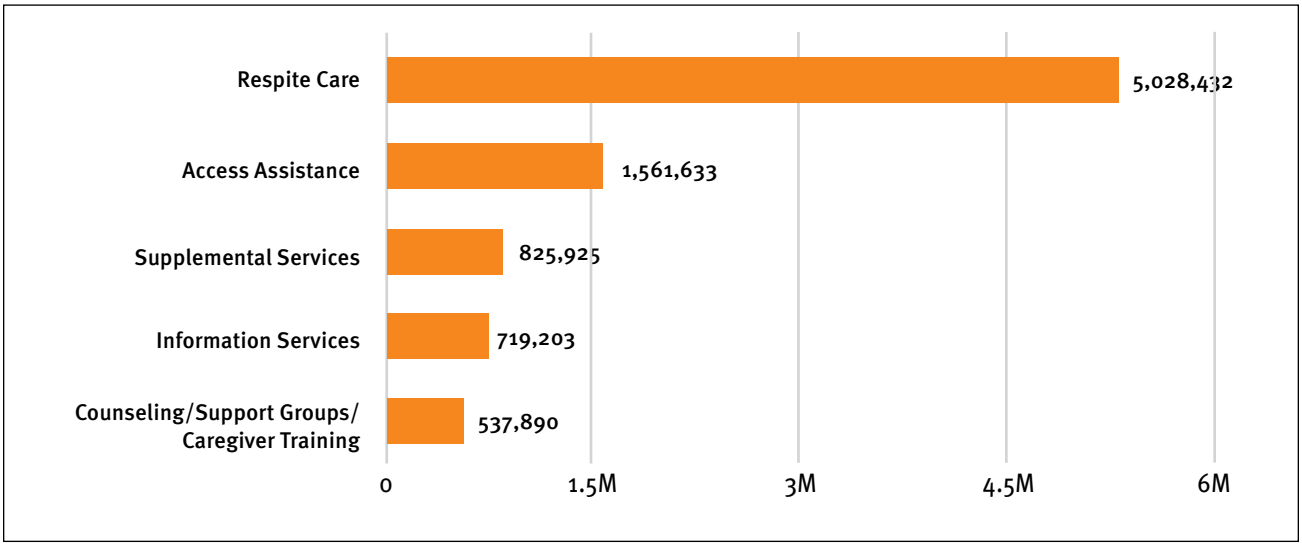
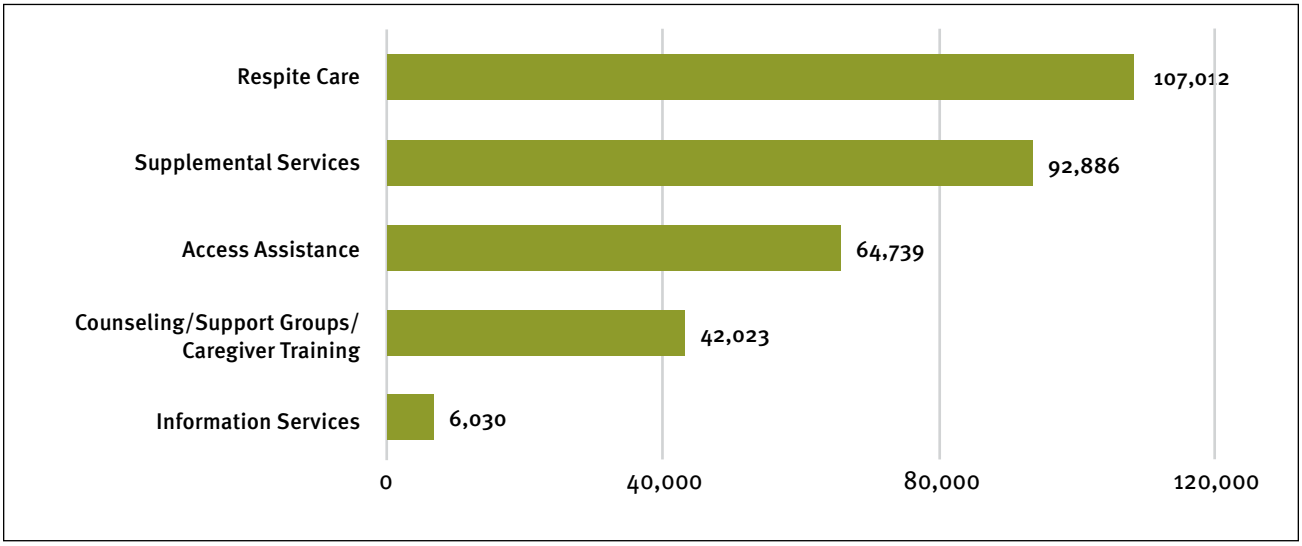



**Exhibit 10.** Units of Services, Caregivers Serving Children

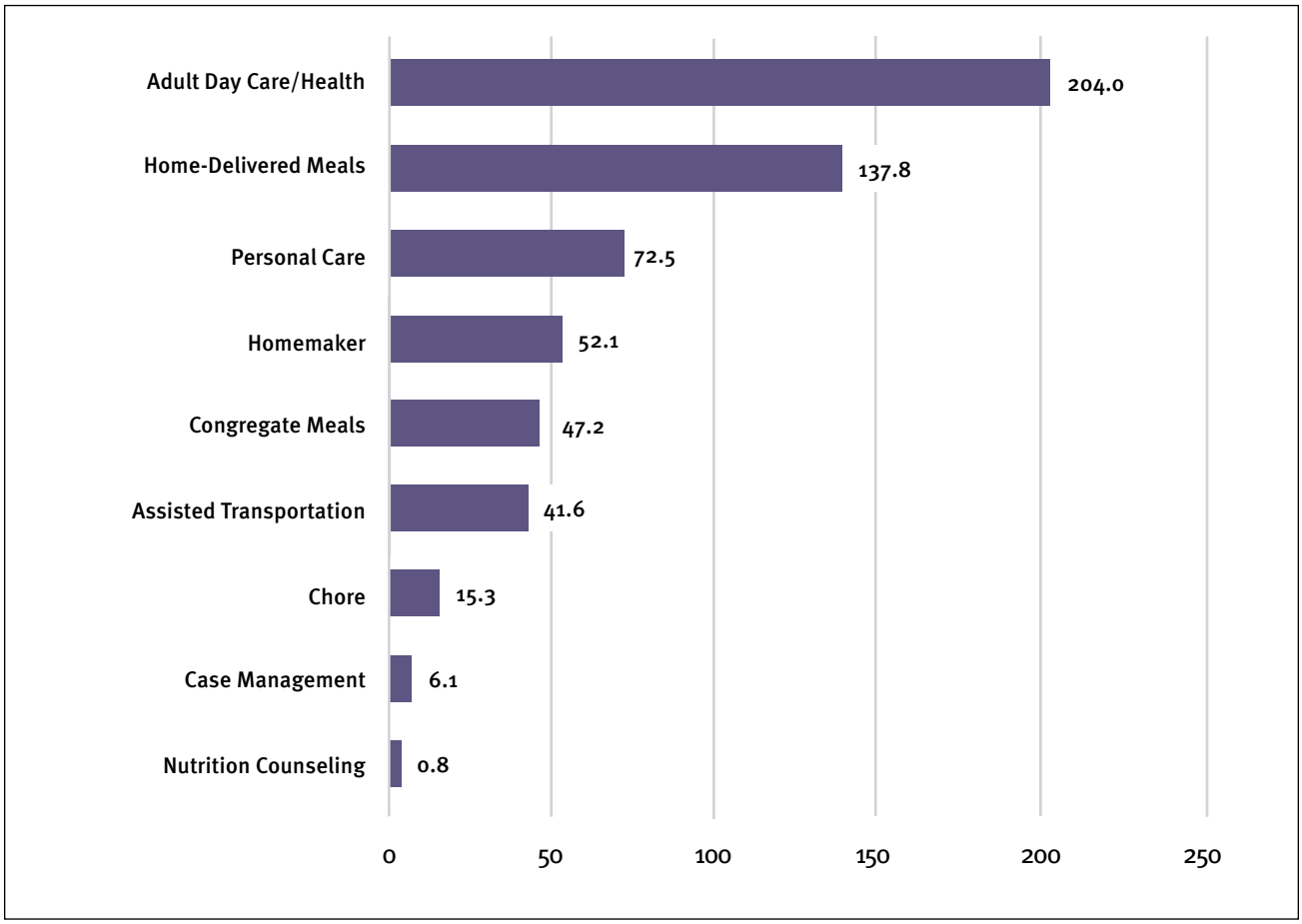


For caregivers serving children, programs provided more than 100,000 hours of respite care, approximately 64,000 contacts to assist caregivers with access to assistance, over 42,000 counseling/support group/caregiver training sessions, and 6,000 activities to provide information services. Programs also provided more than 92,000 supplemental services.

### *Total Units per Client by Service Type*

The most service units per client were provided for adult day care/health programs (204 units per client on average), followed by home-delivered meal programs (137.8 units per client on average). The fewest service units per client were provided for nutrition counseling (0.8 units per client on average) and case management (6.1 units per client on average).

**Exhibit 11.** Average Number of Services Units Provided per Client by Service



# Part 2 | 2019[§§] National Survey of Area Agencies on Aging

With a grant from ACL, the National Association of Area Agencies on Aging partnered with Scripps Gerontology Center of Excellence to conduct the 2019 national survey of AAAs. The results presented in Part 2 of this report are directly taking from the *AAA National Survey Report: Meeting the Needs of Today's Older Adults*. The complete report can be accessed here[¶¶].

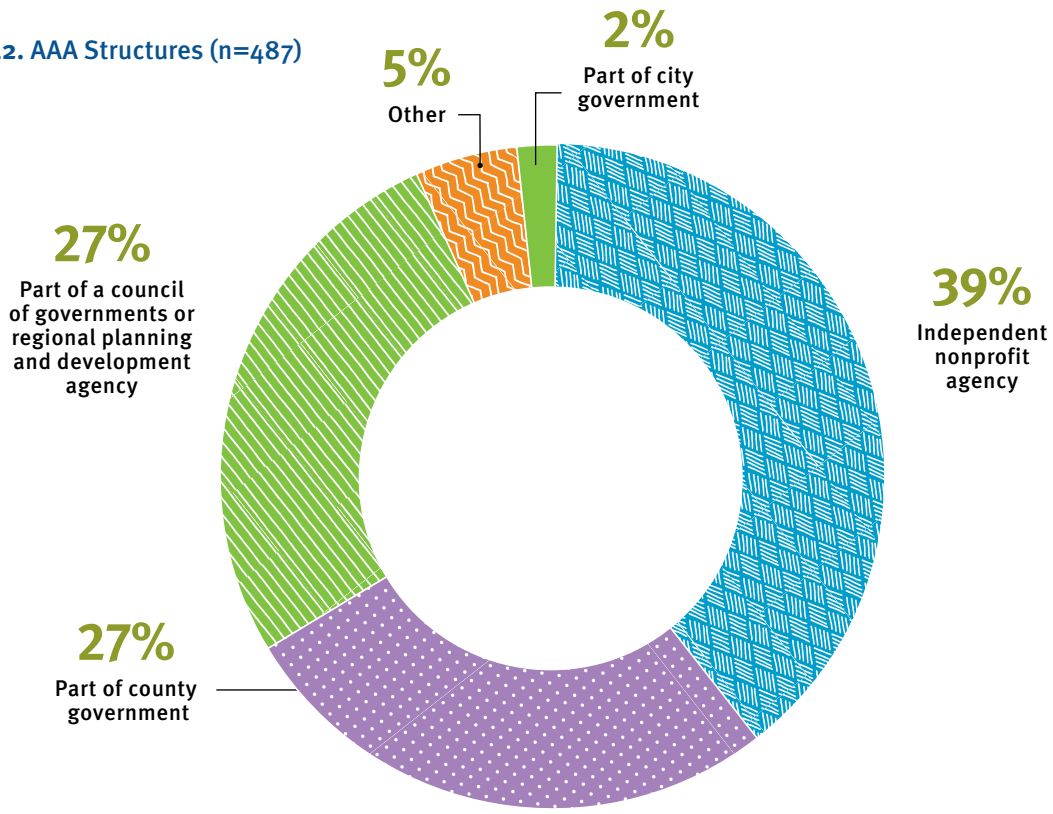
The web-based survey was distributed to 618 AAAs with 78.5% of AAAs (n=485) responding. Some questions were asked of every respondent, and other questions were shown to a subset based on their responses to earlier questions. The number of respondents to a particular question (n) is always reported in all tables. In the cases of text without accompanying tables, the n can be assumed to be the number of respondents overall, 485, unless noted otherwise.

## Program Structure

### *Program Location*

**39%** More than one third (39%) of AAAs are independent nonprofit agencies. A little over one quarter (27%) are housed in councils of government or regional planning and development agencies, and the same percentage is located within parts of county government. Few AAAs are part of city government (2%) or other structures (5%).

**Exhibit 12. AAA Structures (n=487)**




§§ The survey is conducted every 2 years in odd-numbered years (i.e., 2013, 2015, 2017, 2019). The 2019 survey was administered from June 2019 to September 2019.

¶¶ https://www.usaging.org/Files/AAA-Survey-Report-2020%20Update-508.pdf

### *Areas Served by Area Agencies on Aging****

**82%**

Area Agencies on Aging vary in terms of the type of areas they serve. Reflecting the OAA requirement that AAAs target those with the highest economic and social need, a large proportion of AAAs (82%) serve rural, remote, or frontier areas. The largest proportion of AAAs (43%) serve a predominantly rural area, with 25% serving a mixture of urban, suburban, and rural areas.

**Exhibit 13.** Area Served by AAAs

| Type of Area Served | Percent of AAAs Serving That Type of Area (n=478) |
|---|---|
| Predominantly rural | 43% |
| A mix of urban, suburban, and rural | 25% |
| A mix of suburban and rural | 11% |
| A mix of urban and suburban | 11% |
| Predominantly urban | 4% |
| Predominantly suburban | 4% |
| Predominantly remote or frontier | 3% |

*** Survey respondents were asked to choose the type of area they believed best represented their region.

## Programs

**Sixty-five percent** of AAAs lead or take part in Aging and Disability Resource Centers (ADRCs), which take a No Wrong Door approach to coordinating long-term resources and supports. This approach helps ensure that all individuals can find the information and help they need, regardless of where they start their search.[13]

**Sixty-two percent** of AAAs administer local State Health Insurance Assistance Programs (SHIPs), which help Medicare-eligible consumers and their caregivers make decisions about their health insurance coverage through no-cost and unbiased counseling, assistance, and outreach.

**Fifty-three percent** of AAAs operate local long-term care ombudsman programs (LTCOP), which advocate for the rights of residents of nursing homes, assisted living facilities, and other adult care facilities. They also investigate and mediate any problems with or concerns about residents' care.

**65%**
**Lead or take part in Aging and Disability Resource Centers**


**62%**
**Administer local State Health Insurance Assistance Programs**

**53%**
**Operate local long-term care ombudsman programs**

## Partnerships

### *Type of Partners*

Creating and strengthening partnerships is a hallmark of the way that AAAs operate in the community. The survey results showed that, on average, AAAs leverage 17 formal and informal partnerships with other agencies and organizations to expand the reach and impact of their programs in their communities.

Consistent with their core focus on elder justice, nearly all AAAs (92%) partner with adult protective services programs. Other common partners include transportation agencies (88%), SHIPs (86%), emergency preparedness agencies (83%), and federal programs/departments (81%). Additional partnership types are shown in Exhibit 14.

**Exhibit 14.** Type of Entities AAAs Partner With

| Type of Entity | Percent of AAAs That Partner With Entity (n=482) |
|---|---|
| Adult protective services | 92% |
| Transportation agencies | 88% |
| SHIPs | 86% |
| Emergency preparedness agencies | 83% |
| Federal programs/departments (e.g., Social Security, Veterans Health Administration Medical Center, Bureau of Indian Affairs) | 81% |
| Medicaid | 80% |
| Mental health/behavioral health organization | 80% |
| Public housing authority of other housing programs | 79% |
| Disability service organizations (e.g., Centers for Independent Living) | 78% |
| Long-term care facilities (e.g., nursing homes, skilled nursing facilities, assisted living residences) | 78% |
| Advocacy organizations | 77% |
| Hospitals and health care systems | 74% |

*Exhibit 14 continued on page 34*

*Exhibit 14 continued from page 33*

| Type of Entity | Percent of AAAs That Partner With Entity (n=482) |
|---|---|
| Charitable organizations (e.g., United Way, Easter Seals, Red Cross) | 72% |
| Department of health | 72% |
| Law enforcement/first responders | 72% |
| Other social service organizations | 70% |
| Faith-based organizations | 68% |
| Educational institutions | 66% |
| Health plans (e.g., commercial health plan, Medicaid managed care) | 62% |
| Community health clinics (e.g., Federally Qualified Health Centers) | 60% |

## Services

Area Agencies on Aging offer a set of core services as required by the OAA. These services fall in the service categories of Title III and VII. For Title III, AAAs offer supportive services (Title III, Part B), nutrition services (Title III, Part C), and evidence-based prevention and health promotion services (Title III, Part D). Title VII services include, among others, training to help providers identify elder abuse, outreach and education campaigns, and support for coalitions or multidisciplinary teams.

Survey results showed that, on average, AAAs provide 27 services. Many of the most common AAA services are provided through Title III, Part B funding, which allows AAAs to provide supportive services that can be tailored to meet individual needs. Exhibit 15 shows the services most commonly offered by AAAs, not including the core services previously mentioned.

### Exhibit 15. Most Commonly Services Provided by AAA

| Service | Percent of AAAs That Provide the Service (n=489) |
|---|---|
| Transportation | 89% |
| Case management | 86% |
| Other meals/nutrition programs (e.g., nutrition counseling, senior farmers' market program) | 84% |
| Benefits/health insurance counseling | 83% |
| Homemaker | 81% |
| Benefits/health insurance enrollment assistance | 80% |
| Options counseling | 79% |
| Other health promotion services/programs (e.g., health screening, health fairs) | 79% |
| Personal assistance/personal care | 79% |
| Assessment for care planning | 73% |
| Elder abuse prevention/intervention | 69% |
| Senior center programming and activities | 67% |
| Chore services | 66% |
| Long-term care ombudsman | 66% |
| Assessment of long-term care service eligibility | 64% |

*Exhibit 15 continued on page 36*

*Exhibit 15 continued from page 35*

| Service | Percent of AAAs That Provide the Service (n=489) |
|---|---|
| Home modification and repair | 61% |
| Adult day care | 57% |
| Personal emergency response systems | 57% |
| Telephone reassurance/friendly visiting | 55% |
| Translator/interpreter assistance | 53% |

# Appendix A: Title III Definitions[14]

**Adult Day Care/Adult Day Health:** Personal care for dependent elders in a supervised, protective, and congregate setting during some portion of a day. Services offered in conjunction with adult day care/adult day health typically include social and recreational activities, training, counseling, and services such as rehabilitation, medications assistance, and home health aide services for adult day health.

**American Indian or Alaskan Native:** A person who has origins in any of the original peoples of North America (including Central America) and who maintains tribal affiliation or community attachment.

**Area Agency on Aging (AAA):** Public or private nonprofit agency designated by a state to address the needs and concerns of all older persons at the regional and local levels. The term AAA is a general one; names of local AAAs may vary. The AAAs coordinate and offer services that help older adults remain in their homes, if that is their preference, aided by services such as home-delivered meals, homemaker assistance, and whatever else it may take to make independent living a viable option.

**Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

**Assisted Transportation:** Assistance and transportation, including escort, to a person who has difficulties (physical or cognitive) using regular vehicular transportation.

**Black or African American:** A person having origins in any of the black racial groups of Africa.

**Caregiver:** An adult family member or another individual who is an "informal" provider of in-home and community care to an older individual. "Informal" means that the care is not provided as part of a public or private formal service program.

**Case Management:** Assistance in the form of either access or care coordination in circumstances where the older person is experiencing diminished functioning capacities, personal conditions, or other characteristics which require the provision of services by formal service providers or family caregivers. Activities of case management include such practices as assessing needs, developing care plans, authorizing and coordinating services among providers, and providing follow-up and reassessment, as required.

**Child:** An individual who is not more than 18 years of age or an individual 19–59 years of age who has a disability. The term relates to a grandparent or other older relative who is a caregiver of a child.

**Chore Service:** Assistance such as heavy housework, yard work, or sidewalk maintenance for a person.

**Congregate Meals:** Meals provided to an eligible individual in a congregate or group setting. The meal as served meets all of the requirements of the OAA and state/local laws.

**Elderly Client:** An eligible elderly individual (60 years of age or older, or who is less than 60 and has a diagnosis of early onset dementia) who receives OAA services.

**Grandparent or Other Older Relative Caregiver of a Child:** A grandparent, step-grandparent or other relative of a child, by blood or marriage, who is 55 years of age or older and

- lives with the child;
- is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child; and
- has a legal relationship to the child, as such legal custody or guardianship, or is raising the child informally.

**Health Promotion and Disease Prevention:** Services that include health screenings and assessments;

organized physical fitness activities; evidence-based health promotion programs; medication management; home injury control services; and/or information, education, and prevention strategies for chronic disease and other health conditions that would reduce the length or quality of life of the person 60 or older.

**Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

**Home-Delivered Meals:** Meals provided to an eligible individual in his/her place of residence. The meal is served in a program administered by SUAs and/or AAAs and meets all of the requirements of the OAA and state/local laws.

**Homemaker:** Assistance such as preparing meals, shopping for personal items, managing money, using the telephone, or doing light housework.

**Information and Assistance**: A service that provides individuals with information on services available within the communities and links individuals to those services and opportunities, establishing adequate follow-up procedures to the maximum extent practicable. Web site "hits" are to be counted only if information is requested and supplied.

**Impairment in Activities of Daily Living (ADLs):** The inability to perform one or more of the following six ADLs without personal assistance, stand-by assistance, supervision, or cues: eating, dressing, bathing, toileting, transferring in and out of bed/chair, and walking.

**Impairment in Instrumental Activities of Daily Living (IADLs):** The inability to perform one or more of the following eight IADLs without personal assistance, stand-by assistance, supervision, or cues: preparing meals, shopping for personal items, medication management, managing money, using telephone, doing heavy housework, doing light housework, and transportation ability (the ability to make use of available transportation without assistance).

**Legal Assistance:** Legal advice, counseling, and representation by an attorney or other person acting under the supervision of an attorney.

**Living Alone:** A one-person household (using the census definition of household) where the householder lives by themself in an owned or rented place of residence not in an institutional setting, such as a board and care facility, assisted living unit, or group home.

**Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

**Nutrition Counseling:** Individualized guidance to individuals who are at nutritional risk because of their health or nutrition history, dietary intake, chronic illnesses, or medications use, or to caregivers. Counseling is provided one-on-one by a registered dietician and addresses the options and methods for improving nutrition status.

**Nutrition Education:** A program to promote better health by providing accurate and culturally sensitive information on nutrition, physical fitness, or health (as it relates to nutrition) and instruction to participants, caregivers, or participants and caregivers in a group or individual setting overseen by a dietician or individual of comparable expertise.

**Outreach:** Intervention with individuals initiated by an agency or organization for the purpose of identifying potential clients (or their caregivers) and encouraging their use of existing services and benefits.

**Personal Care:** Personal assistance, stand-by assistance, supervision, or cues.

**Poverty:** Persons considered to be in poverty are those whose income is below the official poverty guideline (as defined each year by the Office of Management and Budget (OMB)and adjusted by the Secretary of Health and Human Services [HHS]) in accordance with subsection 673 (2) of the Community Services Block Grant Act

(42 U.S.C. 9902 (2)). The annual HHS poverty guidelines provide dollar thresholds representing poverty levels for households of various sizes.

**Provider:** An organization or person which provides services to clients under a formal contractual arrangement with an AAA or SUA. Under Title III-E, in cases where direct cash payment is made to a caregiver and the ultimate provider is unknown, the number of providers may be omitted.

**Race/Ethnicity Status**: The following reflects the requirements of OMB for obtaining information from individuals regarding race and ethnicity. It constitutes what OMB classifies as the "two-question format." When questions on race and ethnicity are administered, respondents are to be asked about their ethnicity and race as two separate questions. Respondents should ideally be given the opportunity for self-identification and are to be allowed to designate all categories that apply to them. Consistent with OMB requirements, the following are the race and ethnicity categories to be used for information collection purposes:

**Ethnicity:**

- Hispanic or Latino
- Not Hispanic or Latino

**Race:**

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

**Registered Client**: A registered client is an individual who received at least one unit of the following specified services within the reported fiscal year: congregate meals, nutrition counseling, assisted transportation, personal care, homemaker, chore, home-delivered meals, adult day care/health, or case management. The count of registered clients does not include caregivers.

**Registered Services:** Services that require demographic and client characteristics to be reported: personal care, homemaker, chore, home-delivered meals, adult day care/health, case management, congregate meals, nutrition counseling, or assisted transportation. Does not include caregiver services.

> **Cluster 1 Registered Services**: Personal care, homemaker, chore, home-delivered meals, adult day care/health, and case management.
>
> **Cluster 2 Registered Services**: Assisted transportation, congregate meals, and nutrition counseling.

**Rural:** A rural area is any area that is not defined as urban. Urban areas comprise urbanized areas—with a central place and adjacent densely settled territories having a combined minimum population of 50,000—and incorporated places or census-designated places with 20,000 or more inhabitants.

**Senior Centers:** Serve as a gateway to the nation's aging network, connecting older adults to vital community services that can help them stay healthy and independent. More than 60% of senior centers are designated focal points for delivery of OAA services, allowing older adults to access multiple services in one place. Senior centers offer a wide variety of programs and services, including meal and nutrition programs; Information and assistance; health, fitness, and wellness programs, transportation services public benefits counseling; employment assistance; volunteer and civic engagement opportunities; social and recreational activities; educational and arts programs; and intergenerational programs. To maintain operations, senior centers must leverage resources from a variety of sources. They include federal, state, and local governments; special events; public and private grants; businesses; bequests; participant contributions; in-kind donations; and volunteer hours. Most centers rely on three to eight different funding sources.

**Services to Caregivers:**

- **Access Assistance:** A service that assists caregivers in obtaining access to the services and resources that are available within their communities. To the maximum extent practicable, it ensures that the individuals receive the services needed by establishing adequate follow-up procedures.
- **Counseling:** Counseling to caregivers to assist them in making decisions and solving problems relating to their caregiver roles. This service includes counseling to individuals, support groups, and caregiver training (of individual caregivers and families).
- **Information Services**: A service for caregivers that provides the public and individuals with information on resources and services available to the individuals within their communities. (Note: Service units for information services are for activities directed to large audiences of current or potential caregivers, such as disseminating publications, conducting media campaigns, and other similar activities.)
- **Respite Care**: Services which offer temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Respite care includes In-home respite (personal care, homemaker, and other in-home respite); respite provided by attendance of the care recipient at a senior center or other nonresidential program; institutional respite provided by placing the care recipient in an institutional setting, such as a nursing home, for a short period of time as a respite service to the caregiver; and (for grandparents caring for children) summer camps. If the specific service units purchased via a direct payment (cash or voucher) can be tracked or estimated, report those service unit hours. If not, a unit of service in a direct payment is one payment.
- **Supplemental Services**: Services provided on a limited basis to complement the care provided by caregivers. Examples of supplemental services include, but are not limited to, home modifications, assistive technologies, emergency response systems, and incontinence supplies.

**Transportation:** Transportation from one location to another. Does not include any other activity.

**Unduplicated** refers to individual people counted only once a year for a service.

**Unregistered Services (also known as a non-registered services):** Services that do not require demographic and consumer characteristics to be reported. They include transportation, legal assistance, nutrition education, information and assistance, outreach, other services, health promotion, and cash and counseling.

**Volunteer:** An uncompensated individual who provides services or support on behalf of older individuals. Only staff working under the AAA, not the AAA contractors, shall be included.

**White:** A person having origins in any of the peoples of Europe, the Middle East, or North Africa. "Alone," when appended to a racial category—e.g., "white alone"—means that the individual designated only one race category.

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ACL
Administration for Community Living

# OLDER AMERICANS ACT

## Title VI Programs

2020 PROGRAM
RESULTS

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# Title VI | Table of Contents

# Title VI
# Program Highlights and Accomplishments

**A component of the Administration for Community Living's (ACL's) mission is to support American Indian, Alaskan Native (AI/AN), and Native Hawaiian elders in living with dignity and choice, while participating fully in their communities. ACL implements this mission in part through its Older Americans Act (OAA) Title VI programs. The programs help assure successful outcomes in part by recognizing the strengths and resiliency of tribal elders across the United States and respecting Native communities' sovereignty, culture, and self-determination.[1]**

These programs are essential, especially in light of health disparities AI/AN and Native Hawaiian populations face. For example, in comparison with members of the overall population of the U.S., American Indians and Alaskan Natives have shorter life spans and higher death rates, experience more prevent able causes of death, and have more chronic conditions.[2,3] They also experience dispropor tionately high rates of certain mental health conditions, such as depression and substance abuse.[4] Combining federal funds, such as OAA Title VI funds, with state, local, and tribal funds, allows service providers to work collaboratively with tribal communities to address the needs of these communities while recognizing the health disparities they face.

In the 2020-2023 grant cycle, there are 282 Title VI grantees providing nutrition and supportive services and 251 Title VI grantees providing caregiver support services to tribal communities*.

Results from the 2020 National Survey of Title VI Programs showed that the majority of Title VI programs served elders in rural or frontier areas.[5] In addition, Title VI grantees partnered with a range of entities, including those within and external to their tribes. Survey respondents noted partnering with more than 20 different types of entities, such as Indian Health Services, the Veterans Administration, transportation agencies, and nontribal health care providers. Importantly, grantees, in collaboration with partners, provided an average of 26 services and supports to tribal communities that enabled trib al elders to live with independence and dignity in their homes and communities.

Given these efforts, Title VI grantees were able to serve more than 200,000 individuals, includ ing 198,591 individuals who received nutrition and supportive services and 7,873 individuals who received caregiver support services. In 2020 alone, providers ...

* In the 2017-2020 grant cycle, there were 272 Title VI grantees providing nutrition and supportive services and 238 Title VI grantees providing caregiver support services to tribal communities.

TITLE VI GRANTEES SERVED MORE THAN

# 200,000

INDIVIDUALS WITH SERVICES SUCH AS ...

DELIVERED MORE THAN

## 6.4 M

MEALS TO INDIVIDUALS' HOMES

MADE MORE THAN

## 550,000

CONTACTS TO PROVIDE INFORMATION/ASSISTANCE

to access needed services

CONDUCTED MORE THAN

## 450,000

VISITS TO ELDERS IN THEIR HOMES

and more than 2,700 visits to elders in nursing facilities or residential care communities

PROVIDED MORE THAN

## 200,000+

ONE WAY TRIPS

to the grocery store, pharmacy, doctors' office or other critical errands, to support elders' independence

PROVIDED MORE THAN

## 113,000+

COUNSELING SESSIONS

and more than 76,000 hours of respite care to caregivers who cared for elders or individuals of any age with Alzheimer's disease and related disorders

## List of Exhibits



## Abbreviations and Acronyms

| | |
|---|---|
| **AAA** | Area Agency on Aging |
| **ACL** | Administration for Community Living |
| **AI/AN** | American Indian and Alaskan Native |
| **COVID-19** | Coronavirus disease of 2019 |
| **HHS** | U.S. Department of Health and Human Services |
| **OAA** | Older Americans Act |
| **OPE** | Office of Performance and Evaluation |
| **PPR** | Program Performance Report |

# Impact of COVID-19 Pandemic on Title VI Services

## Funding Use

With the President declaring the coronavirus disease of 2019 (COVID-19) pandemic a national emergency on March 13, 2000, flexibility was provided for tribes—without the need for a separate application or request for a waiver—to use existing allocations already made to them under Title VI Part A/B and Part C for disaster relief.[6] As a result, tribes could use Title VI Part A/B and/or Part C for any disaster relief activities for older individuals or family caregivers served under the OAA, which may have included providing:

- drive through, take out, or home-delivered meals,
- well-being checks via phone, in-person, or virtual means, and
- homemaker, chore, grocery/pharmacy/supply delivery, or other services.

## Title VI Services

As part of an evaluation conducted by ACL in 2020 with a select number of ACL Title VI program grantees, participating grantee staff described their experiences related to the COVID-19 pandemic, including the impact the pandemic had on services and the strategies they implemented to continue to meet needs in their communities. For the full report, use this link.† In addition, as part of their fiscal year 2020 Annual Program Performance Report (PPR), Title VI grantees provided examples of how the Title VI program has helped individuals and their communities, including how programs have adjusted to meet needs of AI/AN and Native Hawaiian elders during the pandemic. The bullets below provide a summary of the information shared by grantees about the challenges they experienced during the pandemic in meeting Title VI service needs and the ways they met those challenges.

† https://acl.gov/sites/default/files/programs/2021-05/ACL_TitleVI_Evaluation_Final_Report_508.pdf

- **Increased demand for meals.** Many grantees reported a significant increase in the overall demand for meals.
- **Experienced limited availability of supplies.** Several grantees reported a loss of critical resources and supplies from vendors, such as food containers, paper products, and Styrofoam food trays, making meal provision more difficult. Others reported shortages of supplies for elders, such as tissues, paper towels, toilet paper, and cleaning products.
- **Delivered food boxes and groceries and care packages.** To continue meeting essential needs, grantees packaged and delivered food boxes and care packages (containing items such as toilet paper, face masks, hand sanitizer, gloves, etc.) to elders and worked with local grocery stores to order and deliver basic grocery items. Grantees also provided craft or activity care packages to elders to help keep them engaged.
- **Suspended congregate meals.** Grantees suspended in-person congregate meals for elders and caregivers.
- **Transformed and expanded home-delivered meals.** Grantees transformed the home-delivered meal program during the pandemic by establishing a socially distanced drive-up/pickup and take-out service approach that allowed elders to safely collect meals to take home. Some grantees also expanded their home-delivered meal program to include elders who normally participated in congregate meals and elders who had not previously participated in the nutrition program.
- **Suspended in-person activities and events.** Grantees suspended in-person activities and events, such as educational events, physical activity programs, and community events (e.g., holiday celebrations, powwows) for elders and caregivers.
- **Implemented virtual and socially distanced activities.** Grantees implemented virtual and socially distanced activities, such as nutritional counseling done by phone, virtual bingo and parking lot bingo, and virtual elders' talking circle. Some grantees also purchased phones and tablets for elders so they could participate in virtual activities.
- **Suspended or limited transportation for elders.** Grantees who normally provided transportation services for elders (e.g., taking elders to medical appointments, the post office, the senior center, and shopping), had to either suspend or limit these services.
- **Reduced caregiver program services.** Most grantees reported that caregiver support services, such as respite care and other in-home services, were suspended.
- **Increased check-ins.** To address elders' emotional well-being, including feelings of isolation, grantees conducted check-ins via phone or in person while maintaining social distance. Grantees also provided newsletters and used other innovative strategies to stay connected with elders (e.g., leaving notes in food boxes and care packages).
- **Provided support for obtaining vaccines**. Grantees also helped elders register for appointments to receive their COVID-19 vaccinations and arranged for transportation to and from these appointments.

# Part 1 | 2020 PPR Data Highlights‡

## Staffing

The majority of funding for OAA programs flows from the federal to the state level and from there to the local level. However, for OAA Title VI programs, funds are allocated by ACL directly to Indian tribal organizations, Native Alaskan organizations, and nonprofit groups representing Native Hawaiians. To be eligible for funding, a tribal organization of federally recognized tribes must represent at least 50 Native Americans aged 60 and older. Separate formula grant awards are made for nutrition and supportive services (Part A and B), and caregiver support services (Part C).

For the 2020–2023 grant cycle, more grants were awarded to nutrition and supportive services (282) than to caregiver support services (251). In 2020, nutrition and supportive services had more than twice as many staff (1,209) as caregiver support services (553).

‡ PPR reporting year 2020: April 1, 2020–March 31, 2021

### *Number of Grantees*

**For the 2020–2023 grant cycle, ACL awarded**

**282** 3-year grants for nutrition and supportive services

**251** 3-year grants for caregiver support services

### *Number of Grantee Staff*— Nutrition and Supportive Services*

| Full time | Part time |
|---|---|
| 754 | 464 |

### *Number of Grantee Staff— Caregiver Support Services*

| Full time | Part time |
|---|---|
| 329 | 224 |

* Grantee staff are defined as staff that are fully or partially paid by Title VI funding.

## Service Recipients

In 2020, OAA Title VI grantees served more than 206,464 persons. (Service recipients may be receiving more than one service and may be counted more than once.) They provided nutrition and supportive services to 198,591 persons[§] and caregiver support services to 7,873 caregivers.

§ Persons served received the following services: congregate meals, home-delivered meals, nutrition counseling, case management, transportation, homemaker, personal care/home health aide, chore, and/or health promotion and wellness activities.

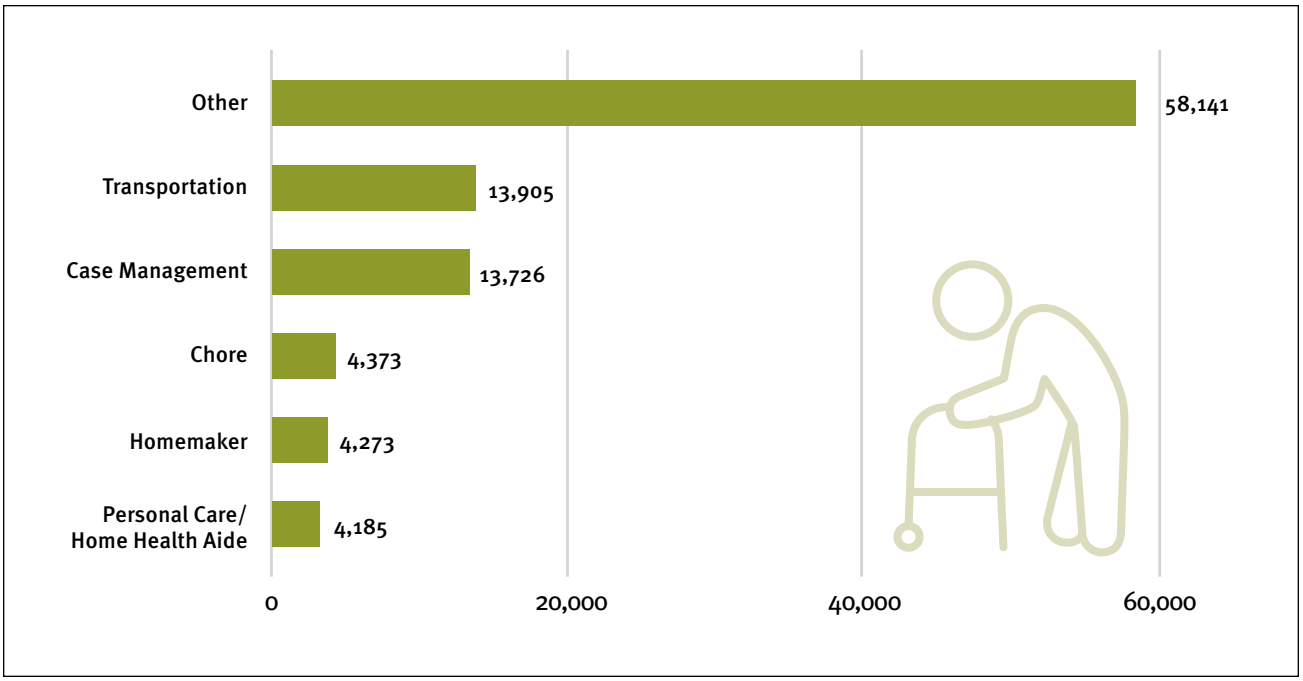
### *Number of Title VI Service Recipients by Supportive Services Type*

In 2020, 98,603 persons received supportive services. The largest number of persons received other services. That number includes 58,141 who received health promotion and wellness activities; 27,631 who received access related services, including case management and/or transportation services; and 12,831 who received in-home related services, including homemaker, personal care/home health aide, and/or chore services.

**Number of persons served by grantees**

**› 206,464**

**Exhibit 1.** Number of Title VI Service Recipients by Supportive Services Type




*Notes: Service recipients may be receiving more than one service. Other = health and promotion wellness activities.*

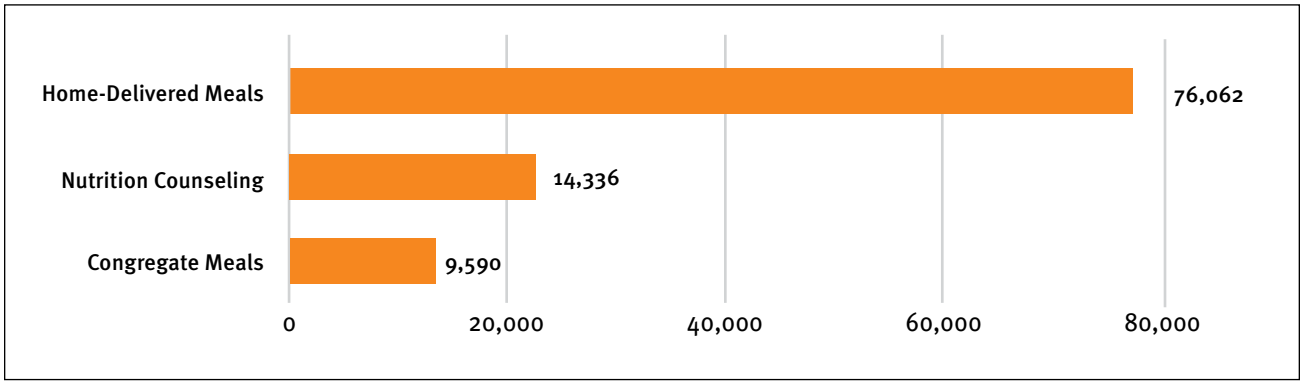
### *Number of Title VI Service Recipients by Nutrition Services Type*

In 2020, 99,988 persons received nutrition services. Home-delivered meal programs served the most persons (76,062), followed by nutrition counseling programs (14,336 persons). The number served via congregate meal programs was smaller (9,590 persons) than the numbers served via the other two service types due to COVID-19.

### *Number of Title VI Caregiver Support Services Recipients by Caregiver Type*

In 2020, the caregiver support services program served 7,873 caregivers. Most caregivers who received services cared for elders or individuals of any age with Alzheimer's disease and related disorders (4,149), followed by those who cared for children under the age of 18 (2,521) and those who cared for adults 18–59 years old with disabilities (1,203).

**Exhibit 2.** Number of Title VI Service Recipients by Nutrition Services Type




*Notes: Service recipients may be receiving more than one service.*

**Exhibit 3.** Number of Title VI Caregiver Services Recipients by Caregiver Type


*Notes: AD = Alzheimer's Disease.*

### *Number of Title VI Service Recipients by Caregivers Support Services Type*

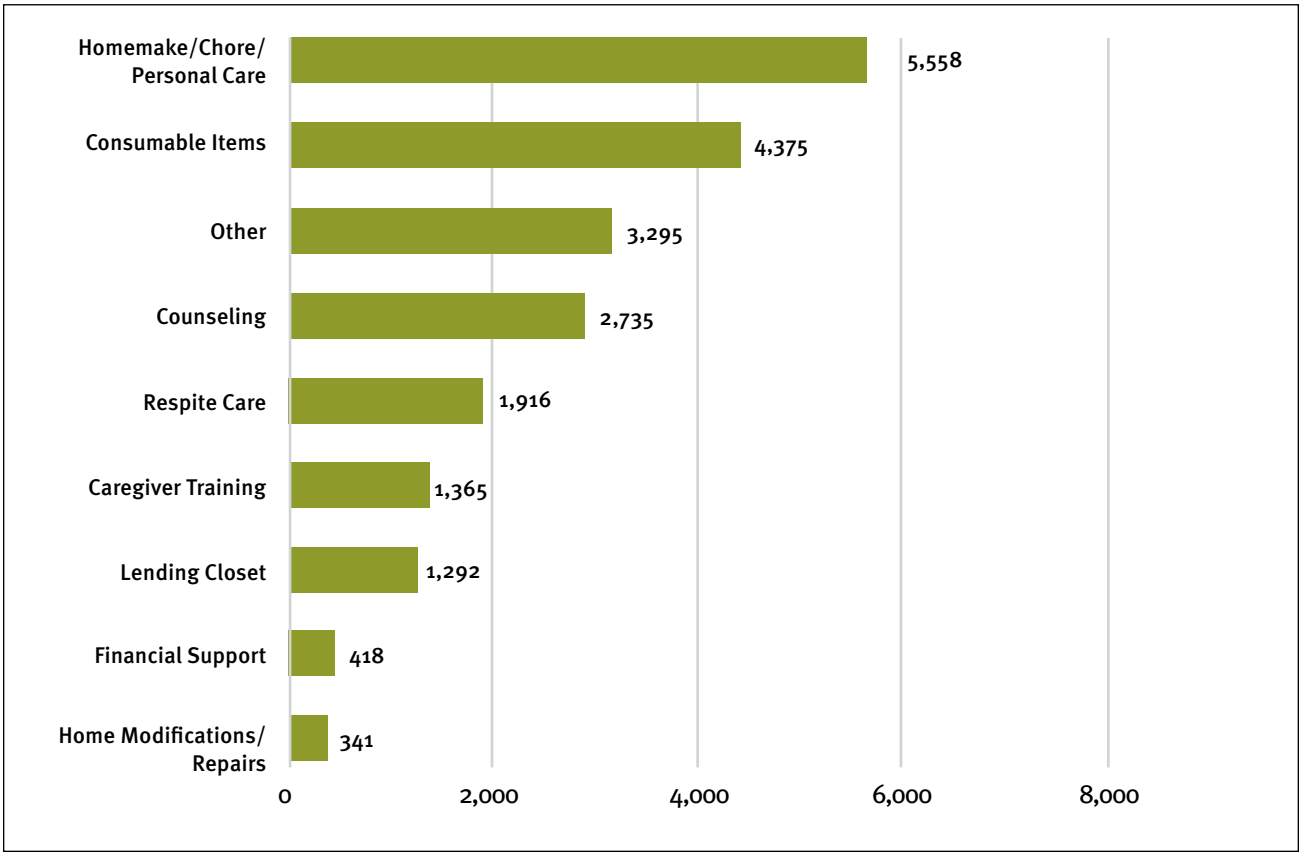
In 2020, the largest number of persons received supplemental services (15,279), which consist of homemaker/chore/personal care services (5,558 persons), the provision of consumable items (4,375 persons), other¶ (3,295 persons), lending closets (1,292 persons), financial support (418 persons), and/or home modifications or repairs (341 persons). Caregivers also received counseling (2,735 persons), caregiver training (1,365 persons), and/or respite services (1,916 persons).

**Number of persons who received supplemental services**

**15,279**

¶ For example, care packages

**Exhibit 4.** Number of Title VI Service Recipients by Caregiver Support Services Type




*Notes: Service recipients may be receiving more than one service. Other = health and promotion wellness activities.*

## Service Units

The following section provides data highlights for delivered Title VI service units. A service unit denotes a specified quantity of a service.

### *Number of Service Units by Nutrition Service Type*

In 2020, the largest number of service units for nutrition services was provided for home-delivered meal services (6,426,032), followed by congregate meal services (321,095), and nutrition education services (44,897). The fewest service units were provided for nutrition counseling services (12,186).

**6,426,032**

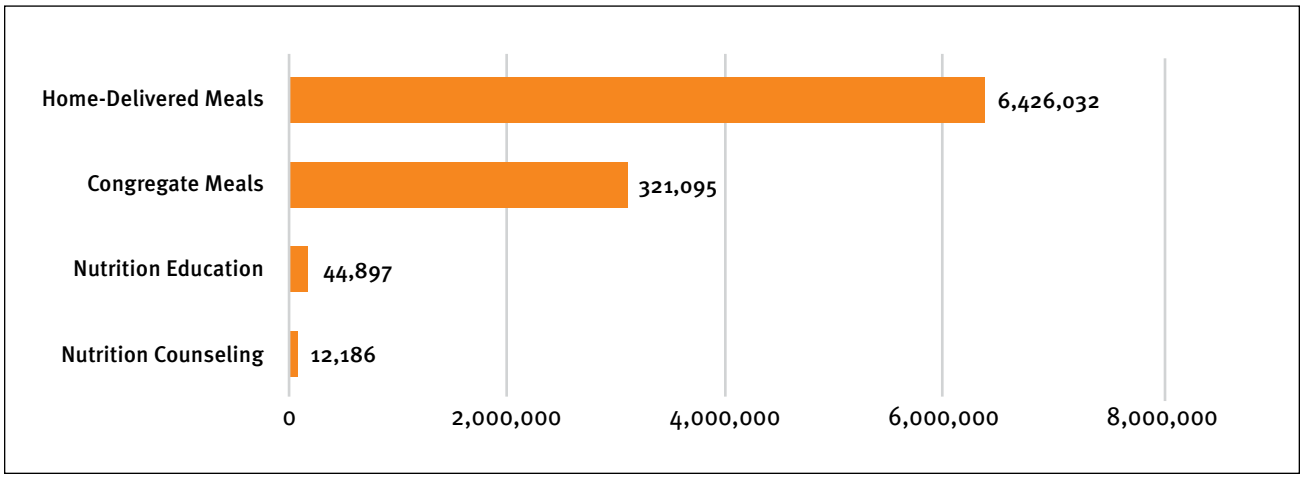
**Service Units provided for home-delivered meals**

## Service Units: Nutrition Services

### *Definition of Nutrition Service Units*

- **Home-delivered meal (1 meal):** A meal provided to an eligible individual in their place of residence.
- **Congregate meal (1 meal):** A meal provided to an eligible individual in a congregate or group setting.
- **Nutrition education (1 session):** A session spent with an elder to provide nutrition education. The session may be a meeting or a gathering dedicated to a specific activity. A nutrition education session does not include the time spent on preparing the program or compiling the information.
- **Nutrition counseling (1 hour):** An hour spent with an elder to provide nutrition counseling. A nutrition counseling hour does not include the time spent on preparing for the counseling meeting or compiling the advice or guidance.

**Exhibit 5.** Total Service Units, by Nutrition Service Type



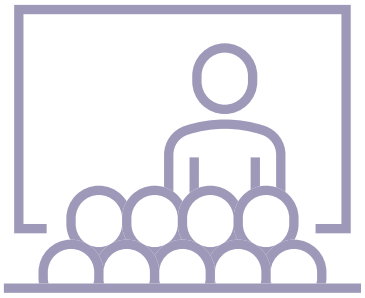
## Service Units: Supportive Services—Access Services

### *Definition of Access Service Units*

- **Information/assistance (1 contact):** A contact with an eligible individual to provide information or assistance to access services.
- **Outreach (1 activity):** A public outreach activity and providing information directed at individuals and groups to encourage potential elders (or their caregivers) to use existing services and benefits.
- **Case management (1 hour):** An hour spent on providing case management. Case management includes such activities as assessing needs and developing service plans—arranging, coordinating, and monitoring services to meet the needs of the elder. The service includes periodic reassessment and revision based on the needs of the elder.
- **Transportation (1 one-way trip):** One-way trip of transportation for an eligible person. A round trip is considered two one-way trips.

**587,098**

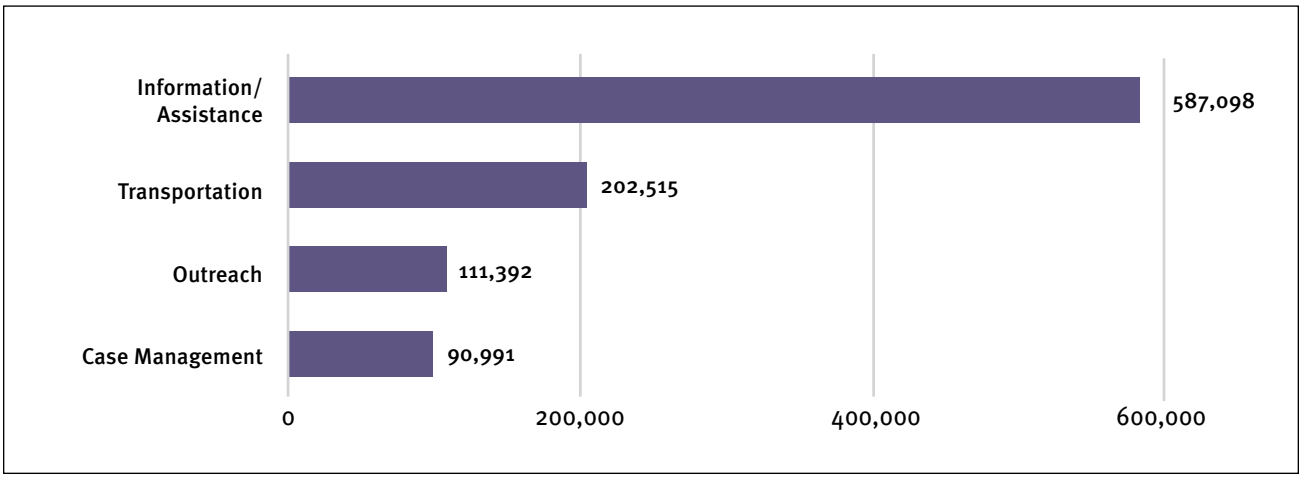
**Service Units provided for information/access services**



### *Number of Service Units by Access Service Type*

In 2020, the largest number of service units for access services was provided for information/assistance services (587,098), followed by transportation services (202,512), outreach services (111,392), and case management services (90,991).

**Exhibit 6.** Total Service Units, by Access Service Type



## Service Units: Supportive Services—In-Home Services

### *Definition of In-Home Service Units*

- **Homemaker (1 hour):** One hour spent providing homemaker services for an elder.
- **Personal care/home health aide (1 hour):** One hour spent with an elder to provide personal care/home health aide services.
- **Chore (1 hour):** An hour spent with an elder to provide chore services.
- **Visiting (1 contact):** A visit provided to an elder in their place of residence. Visit contacts are for visits in personal homes only.
- **Telephoning (1 contact):** A telephone call to an elder at their place of residence, including a call to a housing facility like a nursing home or assisted living facility or a call directly to their personal cell phone.

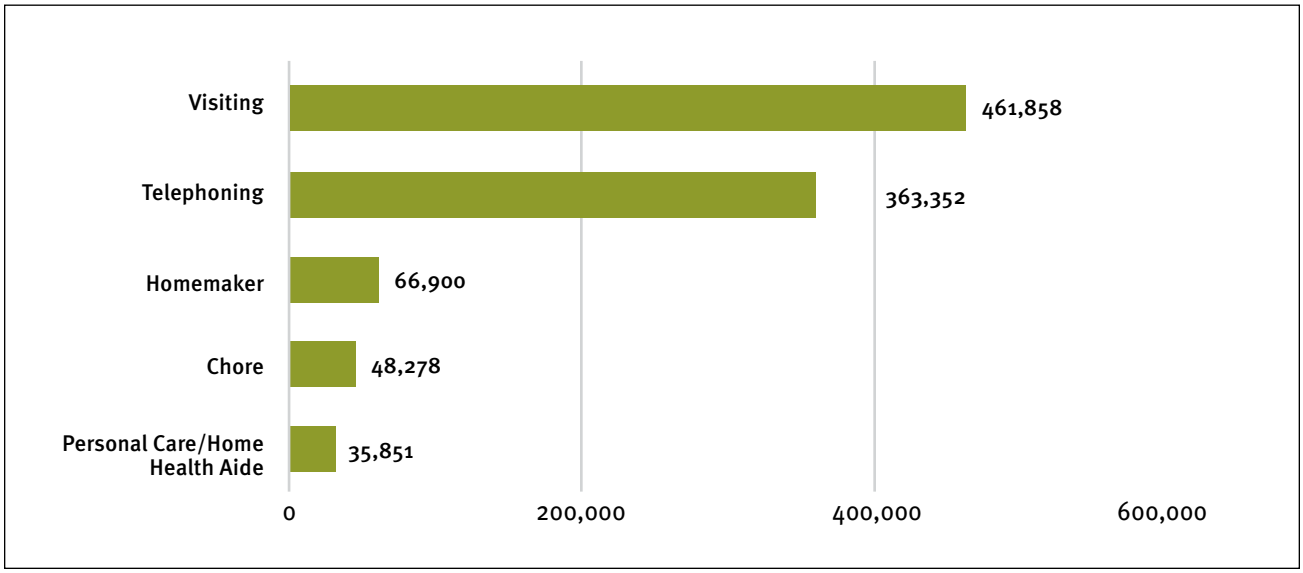
**461,858**

**Service Units provided for visiting services**

### *Number of Service Units by In-Home Service Type*

In 2020, the largest number of service units for in-home services was provided for visiting services (461,858), followed by telephoning services (363,352), homemaker services (66,900), and chore services (48,278). The fewest service units were provided for personal care/home health aide services (35,851).

**Exhibit 7.** Total Service Units, by In-Home Service Type



## Service Units: Supportive Services—Other Services

### *Definition of Other Service Units*

- **Social event (1 event):** An event held for elders.
- **Nursing facilities/home or residential care communities visit (1 visit):** A visit provided to an elder living in a nursing home or assisted living facility

### *Number of Service Units by Other Service Type*

In 2020, 2,771 visits to nursing facilities/homes or residential care communities were conducted under Title VI (compared to 461,858 visits to personal homes). Title VI providers also held 2,201 social events for elders.

## Service Units: Caregiver Support Services—Services for Caregivers

### *Definition of Caregiver Service Units*

- **Information services (1 activity):** An informational activity held for caregivers. Information services activities can include an in-person interactive presentation to the public or a social media post or radio announcement that is shared with the broader community.
- **Information and assistance (1 contact):** A contact with an eligible caregiver to provide information and assistance.
- **Counseling (1 hour):** An hour spent on providing counseling to a caregiver.
- **Support group (1 session):** A session spent on providing a support group to caregivers. It may be a meeting or a gathering dedicated to a specific activity. A support group session does not include the time spent on preparing the program or compiling the information.
- **Caregiver training (1 hour):** An hour spent on providing caregiver training to informal caregivers.

### *Number of Service Units by Caregiver Service Type*

In 2020, the largest number of service units for services for caregivers was provided for information and assistance (134,945), followed by counseling (113,042) and information services (96,481). The fewest service units were provided for caregiver training (1,365) and support groups (1,120).

## Service Units: Caregiver Support Services—Respite Care for Caregivers

### *Definition of Respite Service Units*

- **Respite care for caregivers (1 hour):** An hour spent on providing respite care for eligible caregivers.

### *Number of Respite Service Units by Caregiver Type*

In 2020, the largest number of respite service units was provided to caregivers who cared for elders or individuals of any age with Alzheimer's disease and related disorders (76,282), followed by those who cared for children under the age of 18 (21,568) and those who cared for adults 18–59 years old with disabilities (14,471).

**Exhibit 8.** Total Service Units, by Caregiver Service Type

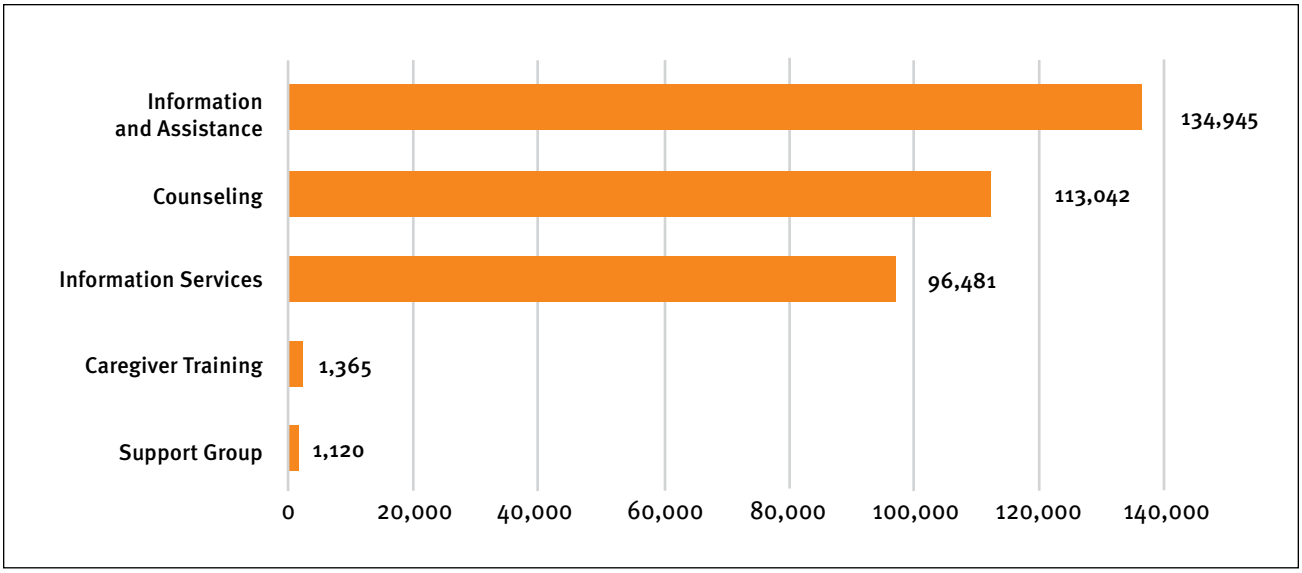
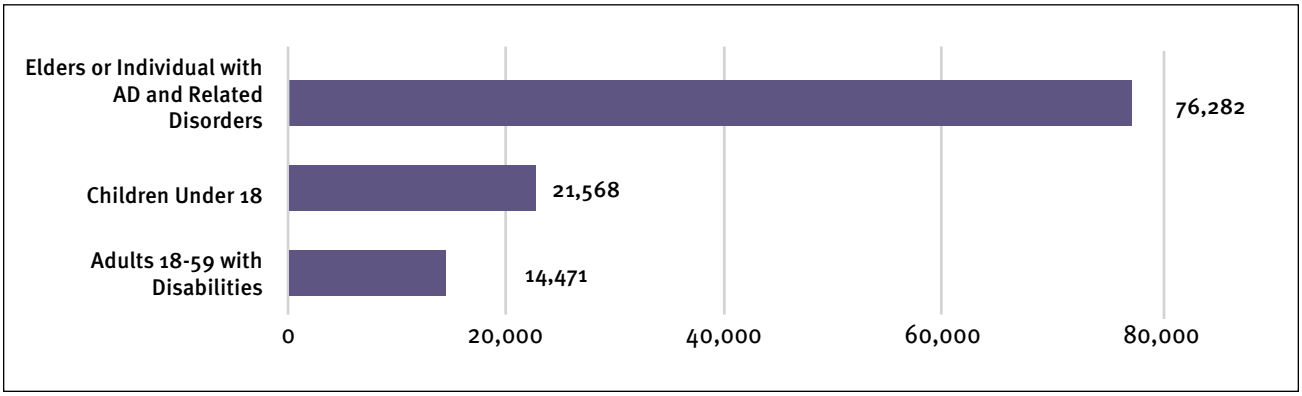



**Exhibit 9.** Total Respite Service Units, by Caregiver Type




*Notes: AD = Alzheimer's Disease.*

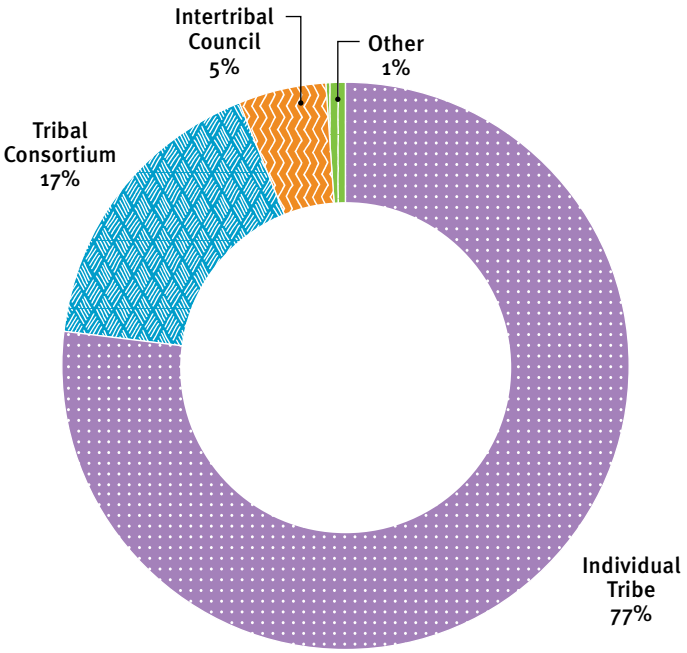
# Part 2 | 2020 National Survey of Title VI Programs**

With a grant from ACL, the National Association of Area Agencies on Aging partnered with Scripps Gerontology Center of Excellence to conduct the 2020 Title VI Native American aging program survey, which was the fourth comprehensive survey of Title VI programs. The results presented in Part 2 of this report are directly taken from the *National Survey of Title VI Programs 2020 Report: Serving Tribal Elders Across the United States*. The complete report can be accessed here.††

The web-based survey was distributed to 276 Title VI grantees in 2020, with 84% (n=231) of Title VI programs responding. Some questions were asked of every respondent, and other questions were shown to a subset based on their responses to earlier questions. The number of respondents to a particular question (n) is reported in all tables. In the cases of text without accompanying tables, the n can be assumed to be of the respondents overall, 231, unless noted otherwise.

†† https://www.usaging.org/Files/TitleVI-Survey-Report-508.pdf

**Exhibit 10.** Title VI Program Location (n=230)




** The data do not represent data from the National Survey of Older Americans Act Participants.

## Program Structure

### *Program Location*

Title VI grants are awarded to tribal entities in federally recognized tribes, as well as to organizations representing Native Hawaiian elders. Survey respondents noted that Title VI programs are most frequently part of an individual tribe (77%), with 17% being part of a tribal consortium,[‡‡] 5% being part of an intertribal council,[§§] and 1% being part of other administrative structures. Exhibit 10 shows this distribution of administrative locations.

‡‡ Grantees comprised of a group of federally recognized tribes or villages that do not meet the eligibility requirements of 50 elders age 60 or older may combine their smaller elder populations to form a population that is large enough to apply for the grants. A tribe or village that has enough elders to meet the eligibility requirements may choose to band together with other tribes/villages and authorize an administrative body to apply for and administer their grant on behalf of the tribe/village.

§§ Intertribal councils are similar to consortia in that they are made up of multiple tribes/villages and have authorized a representative body to apply for and administer the grant on their behalf.

### *Area Served by Program[¶¶]*

Reflecting the location of tribal lands, approximately 92% of Title VI programs serve regions that include rural areas. Nearly two-thirds (64%) of programs serve an area that is predominantly rural, remote, or frontier. Only about 9% of programs serve an area that is predominantly urban or suburban.

¶¶ Survey respondents were asked to choose the type of area they believed best represented their region.

**Exhibit 11. Area Served by Title VI Programs**

| Type of Area Served | Percent of Title VI programs that serve type of area (n=230) |
|---|---|
| Predominantly rural | 58% |
| A mix of suburban and rural | 16% |
| A mix of urban, suburban and rural | 12% |
| Predominantly urban, predominantly suburban, or a mix | 9% |
| Predominantly remote or frontier | 6% |

## Partnerships

### *Type of Partners*

Title VI programs partner with other entities both within and external to their tribes or organizations to meet the needs of elders. The most common partnerships are with tribal health care and the Indian Health Service (both 81%), tribal housing (80%), adult protective services (79%), tribal health department/tribal public health (77%) and the local Area Agencies on Aging or Title III providers (76%). Additional partnership types are shown in Exhibit 12.

**Exhibit 12. Type of Entities Title VI Programs Partner With**

| Type of Entity | Percent of Title VI programs that partner with entity (n=218) |
|---|---|
| Tribal health care (e.g., tribal health clinic or center) | 81% |
| Indian Health Service | 81% |
| Tribal housing | 80% |
| Adult Protective Services | 79% |
| Tribal health department/tribal public health | 77% |
| Area Agency on Aging/Title III provider | 76% |
| Veterans Administration | 70% |
| State unit or department of aging | 68% |
| Medicaid | 67% |
| Medicare | 66% |
| Disability service organizations | 65% |
| Nursing home, assisted living facility or group home | 65% |
| Transportation agencies | 64% |
| Bureau of Indian Affairs | 62% |
| Nontribal health care providers (e.g., hospital, clinic, physician office) | 62% |
| Nontribal health department/nontribal public health | 61% |
| County government | 61% |
| State Health Insurance Assistance Program | 60% |
| Charitable organizations | 60% |
| Churches | 59% |
| Bureau of Indian Education | 51% |
| Tribal colleges | 46% |
| Other colleges and universities | 46% |

### *Partnership Activities*

Title VI programs partner with tribal health care departments or entities to support the health needs of elders. The most common health care support activities that Title VI programs collaborate on with partners are shown in Exhibit 13. They include activities to provide nutrition and/or health education (78%), wellness checks (73%), and transportation (70%). Title VI programs also partner with entities to provide services such as diabetes wellness programs (67%), COVID-19 preparedness and response (67%), and annual health fairs (63%).

**Exhibit 13.** Partnership Activities

| Activity | Percent of Title VI programs that implement activity with partners (n=194) |
|---|---|
| Provide nutrition and/or health education | 78% |
| Conduct wellness checks | 73% |
| Provide transportation | 70% |
| Coordinate on diabetes wellness programs | 67% |
| Coordinate COVID-19 preparedness and response | 67% |
| Coordinate on annual health fair | 63% |
| Make home visits or deliver meals | 58% |
| Coordinate on flu clinic | 58% |
| Deliver medications | 56% |
| Approve meals and/or help with menu planning | 55% |

## Services

Title VI program directors noted that, overall, elders in their tribal communities have access to an average of 26 services. These services are funded fully through Title VI, or partially through Title VI, or through other funding sources. Exhibit 14 shows the services most likely to be delivered entirely with Title VI dollars. More than half of Title VI recipients fund their home-delivered and congregate meals programs only with Title VI funds. More than one-third provide family caregiver support and respite services that rely wholly on Title VI funding.

### Exhibit 14. Services Provided Exclusively Through Title VI Funds

| Service | Percent of Title VI programs that deliver the service through Title VI funds only (n=231) |
|---|---|
| Home-delivered meals | 55% |
| Congregate meals | 54% |
| Information and referral/assistance | 39% |
| Family caregiver support services | 37% |
| Outreach | 37% |
| Respite care | 36% |
| Telephone reassurance/friendly visiting | 36% |
| Senior center activities | 29% |
| Assistive devices or loan closet | 27% |
| Special events for elders | 25% |
| Homemaker help | 24% |
| Care/case management | 24% |
| Transportation (medical or nonmedical) | 22% |
| Help in home/personal care | 22% |
| Supportive services for grandparents raising grandchildren | 20% |

## Unmet Needs

Title VI grantees provide a wide range of services to elders, but available funding and/or staff levels cannot always meet every need. As shown in Exhibit 15, the most common significant unmet need reported by Title VI program directors was for home repair services (46%). Other commonly reported significant unmet needs are money management (42%) and legal assistance (36%), with more than 80% of Title VI programs reporting at least some unmet need in each of these areas.

**Exhibit 15.** Unmet Needs Among Elders (n=231)

| Percent with significant unmet need | Unmet Need | Percent with some unmet need |
|---|---|---|
| 46% | Home repair (e.g., replacing a broken window, repairing leaks) | 89% |
| 42% | Money management | 89% |
| 36% | Help in home/personal care | 89% |
| 36% | Home modification (e.g., ramps, grab bars, widened doorways) | 86% |
| 36% | Legal assistance | 80% |
| 33% | Chore services (e.g., yard work) | 79% |
| 32% | Emergency response system | 75% |
| 29% | Mental health services | 76% |
| 28% | Homemaker help | 81% |
| 27% | Help with medication | 74% |
| 25% | Supportive services for grandparents raising grandchildren | 77% |
| 24% | Dementia awareness | 77% |

# Appendix A: Title VI Definitions[7]

**American Indian or Alaskan Native:** A person having origins in any of the original peoples of North America (including Central America) and who maintains tribal affiliation or community attachment.

**Area Agency on Aging (AAA):** Public or private nonprofit agency designated by a state to address the needs and concerns of all older persons at the regional and local levels. The term AAA is a general one; names of local AAAs may vary. To help older adults remain in their homes, if that is their preference, AAAs coordinate and offer services including home-delivered meals, homemaker assistance, and whatever else it may take to make independent living a viable option.

**Caregiver to elders or Individuals of any age with Alzheimer's disease and related disorders:** An informal caregiver who

- is 18 years or older and
- provides services or support to an elder or elders (tribally determined age) or an individual or individuals of any age with Alzheimer's disease and related disorders (such as dementia).

**Caregiver training:** A service that provides family caregivers with instruction to improve knowledge and performance of specific skills related to their caregiving roles and responsibilities. Skills may include activities related to health, nutrition, and financial management; providing personal care; and communicating with health care providers and other family members. Training may include use of evidence-based programs and may be conducted in person or online, in individual or group settings.

**Case management:** A service provided to an elder, at the direction of the elder or a family member or caregiver.

- The service should be provided by a trained or experienced person with case or care management skills.
- The service includes individual needs assessment and developing a service plan for, arranging, coordinating, and monitoring services to meet the needs of the elder. The service should include periodic reassessment and revision based on the needs of the elder.

**Chore service:** Performance of heavy household tasks provided in an elder's home. Tasks may include yard work or sidewalk maintenance in addition to heavy housework—tasks such as heavy cleaning, yard work, walk maintenance, minor home repair, wood chopping, hauling water, and other heavy-duty activities which the elder is unable to handle on their own and which do not require the services of a trained homemaker or other specialist.

**Congregate meal:** A meal provided to and consumed by an eligible person at a nutrition site, senior center, or other congregate/group setting. The meal meets all the requirements of the OAA and state and local laws.

**Congregate meal eligible person:** An eligible person is an elder, a spouse of an elder, or an individual providing volunteer services for the Title VI program during the meal hour. It may also be a nonelder person with a disability who resides at home with and accompanies an elder to the meal or who resides in a housing facility occupied primarily by older adults.

**Consumable items:** Single-use items, such as incontinence supplies, Ensure®, school supplies, uniforms for school or sports, cleaning supplies, groceries, etc.

**Counseling:** A service designed to support caregivers and assist them in their decision-making and problem solving. Counselors may be degreed service providers, trained to work with individuals, older adults, and families and specifically understanding and addressing the complex physical, behavioral, and emotional problems related to their caregiver roles. Informal counselors, like peers who are or have been informal caregivers, may also be used for this service. Counseling may be provided to individuals or in group meetings. Counseling is a separate function from support group activities or training. Caregivers eligible to receive counseling are those caring for older adults, persons

with disabilities, or children not their own by birth or adoption. Counseling may be provided via phone, text, email, webinar, video chat, or other means with an individual or a group to help participants navigate physical, behavioral, and emotional issues related to caregiving.

**Elder caregivers caring for children under the age of 18**: An informal caregiver who

- is an elder,
- provides care for a child or children not their own by birth or adoption, and
- is caring for a child or children under the age of 18.

**Elder caregivers providing care to adults 18–59 with disabilities:** An informal caregiver who

- is an elder,
- may be the parent of the adult with disabilities, and
- provides care to an adult or adults 18–59 years old with disabilities.
  An individual with a disability is defined by the Americans with Disabilities Act as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.

**Financial support:** Limited (emergency) help with utility bills.

**Full-time staff:** People who work 35 hours or more per week in paid positions for the Title VI program, paid fully or partially with Title VI A/B or C funds. The term refers to the number of full-time positions in the Part A/B or C program. These positions may be permanent or temporary in nature.

**Health promotion and wellness:** Activities conducted to improve the mental and physical health of persons, including walking groups, exercise classes, and presentations on health and wellness topics.

**Home-delivered meal:** A meal provided to a qualified eligible person in their place of residence or via carry-out or drive-through. Does not include meals supported by other funds (e.g., Title III, Medicaid Title XIX waiver, state-funded means-tested programs).

**Home-delivered meal eligible person:** An eligible person is a qualified elder, a spouse of a qualified elder, a volunteer providing services during the meal hours, a nonelder person with a disability who resides at home with a qualified elder, or a person with a disability who resides in a housing facility occupied primarily by older adults.

**Home modification/repairs:** Putting ramps or handrails into a home.

**Homemaker service:** Providing light housekeeping tasks in an elder's place of residence. Tasks may include, but are not limited to, preparing meals, shopping for personal items, laundry, managing money, or using the telephone in addition to other light housework.

**Informal caregiver:** An unpaid provider of in-home and community care who may be a family member, neighbor, friend, or someone else.

**Information services:** A public or media activity that conveys information to caregivers about available services. Information services activities may include an in-person interactive presentation to the public, a social media post, or a radio announcement that is shared with the broader community.

**Information and assistance:** A service for caregivers that

- provides the individual with current information on opportunities and services available within their community, including information related to assistive technology;
- assesses the problems and capacities of the individual;
- links the individual to the opportunities and services that are available; and

- ensures, by establishing adequate follow-up procedures, that the individual receives the services needed and is aware of the opportunities available to them and serving the entire community of caregivers.

**Lending closet:** Items returnable to the Title VI program: clothing exchange; durable medical equipment (chair lifts, wheelchairs, walkers, emergency response systems), telephone, tablet, anything else lent on a short-term basis.

**Native Hawaiian or other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific islands that are U.S. territories.

**Nutrition counseling:** Provision of individualized advice and guidance to individuals who are at nutritional risk—because of their health or nutritional history, dietary intake, medication use, or chronic illnesses—about options and methods for improving their nutritional status. Counseling is performed by a registered dietitian or other health professional and addresses the options and methods for improving nutrition status with a measurable goal. Nutrition counseling can be provided in person or virtually to counsel older adults on an individual basis (via phone, text, email, webinar, video chat, or other means).

**Nutrition education:** A targeted educational program provided by a dietitian or a similarly knowledgeable person. The program promotes better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants, caregivers, or participants and caregivers in a group setting (two or more participants). Sessions include distribution of printed materials, provided in person or virtually by conducting a group call or online meeting (via phone, text, email, webinar, video chat, or other means) around how to continue to eat healthily and stay physically active.

**One-way trips:** When transporting an elder, every stop that is made is considered a one-way trip.

**Other supportive service**: Any additional supportive service the Title VI program offers that was not listed in the Program Performance Report form. It may include, but is not limited to, services such as consumable items or lending closet.

**Outreach:** Conducting public outreach activities and providing information directed at individuals and groups to encourage potential elders (or their caregivers) to use existing services and benefits.

**Part-time staff:** People who work less than 35 hours per week in a paid position for the Title VI program, paid fully or partially with Title VI A/B or C funds. The term refers to the number of part-time positions in a Part A/B or C program, whether permanent or temporary in nature.

**Personal care/home health aide service:** Providing an elder assistance with activities of daily living, such as eating, dressing, and bathing, toileting, transferring in and out of bed/chair, or walking. This service may also include assistance with an elder's health-related tasks, such as checking blood pressure and blood glucose, and assistance with personal care. Personal care may include assistance with instrumental activities of daily living, such as cleaning and maintaining the home, managing money, or preparing meals.

**Respite care:** A service for caregivers which offers temporary, substitute supports or living arrangements for care recipients in order to provide them a brief period of relief or rest. Respite care is provided to assist the informal caregiver.

**Social event:** An event involving a public performance or entertainment or a function to promote social interaction and decrease isolation. A social event should involve contact among more than two people, via phone, text, email, webinar, video chat, or other means, to provide reassurance and/or socialization to older adults.

**Supplemental services**: Services provided on a limited basis to support informal caregivers so that they might continue to provide care to the elder, person with Alzheimer's Disease and related disorder of any age, person 18–59 years old with disability, or grandchild under the age of 18. Examples are home modifications/repairs, consumable items, lending closet, homemaker/chore/personal care service, and financial support.

**Support group:** A service led by an individual, moderator, or professional to facilitate caregivers discussing their common experiences and concerns and developing a mutual support system. Support groups are typically held on a regularly scheduled basis and may be conducted in person, over the telephone, or online. Caregiver support groups would not include caregiver education/training groups or other groups primarily aimed at teaching skills or meeting on an informal basis without a facilitator. Support groups are intended to facilitate caregivers sharing their experiences with each other and finding support within the group.

**Telephoning**: Telephone services include phoning to provide comfort or check in on the elder. The elder should be reached and spoken to for the contact to be counted.

**Transportation:** Services or activities that provide or arrange for travel of an elder, including costs of individuals' travel from one location to another. This service may include escort or other appropriate assistance for a person who has difficulties using regular transportation.

**Visiting:** Visiting services include going to see an elder to reduce social isolation and/or perform a wellness check (a visual check of an elder to see if they need anything), etc. This service would include visiting in a personal home. Visiting involves a minimum of 15 minutes talking with an elder or an adequate amount of time to make an informed decision about the elder's well-being.

**Visits to persons in nursing facilities/homes or residential care communities:** Visits conducted to persons living in skilled nursing homes or facilities, or living in a long-term care facility that provides, at a minimum, room and board, around-the-clock on-site supervision, and help with personal care such as bathing and dressing or health-related services such as medication management. Facility types include, but are not limited to, assisted living, board and care homes, congregate care, enriched housing programs, homes for the aged, personal care homes, adult foster/family homes, and shared housing establishments that are licensed, registered, listed, certified, or otherwise regulated by a state.

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# OLDER AMERICANS ACT

## Title VII | Long-Term Care Ombudsman Program

2020 PROGRAM
RESULTS

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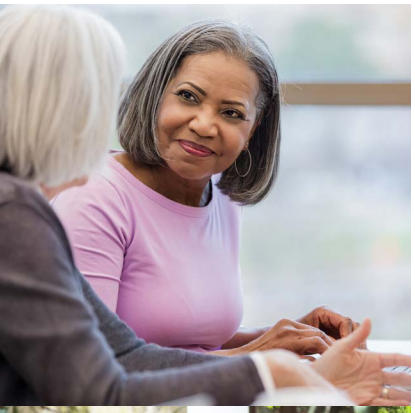
Administration for Community Living (2022). *Overview of Older Americans Act Title III, VI, and VII Programs: 2020 Summary of Highlights and Accomplishments*. U.S. Department of Health and Human Services. https://acl.gov/aging-and-disability-in-america/data-and-research.

# Title VII | Table of Contents



# Title VII
# Program Highlights and Accomplishments

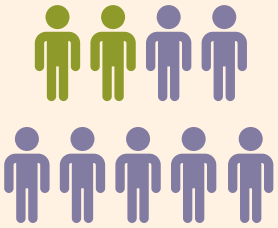
The Long-Term Care Ombudsman Program (LTCOP) is designed to protect and promote the health, safety, welfare, and rights of long-term care residents in all 50 states, as well as the District of Columbia, Puerto Rico, and Guam. Long-term care facilities include nursing homes, board and care and assisted living facilities, and other residential care communities. To achieve their mission, state and local long-term care ombudsman (LTCO) programs, with the help of paid staff and thousands of volunteers, engage in a range of activities at the individual, system, and community level.

At the individual level, Ombudsmen assist residents by resolving complaints about their care, and help ensure that their rights are protected. In addition to investigating and resolving problems, Ombudsmen play a sentinel role through the facility and resident visits they routinely conduct. Serving as the "eyes and ears" of the program, Ombudsman representatives help address residents' concerns before they rise to the level of complaints requiring intervention by preventing actions or inactions that unfavorably impact residents' care, rights, and quality of life. At the systems level, Ombudsmen advocate at the local, state, and federal levels for improvements in the long-term care system that benefit residents. These activities are not limited to legislative advocacy, but include coalition-building, speaking to the media, and other strategies that broadly advance residents' rights and well-being. To help build capacity for both individual and systems advocacy, the program also carries out education and outreach activities. These activities include providing information and consultation to facilities, residents and their families, collaborating with other agencies, supporting family and resident councils, developing citizen organizations, and empowering residents as well as their families and caregivers to be effective advocates.[1]

Data reported by state ombudsman programs in 2020 demonstrate these efforts:

PAID STAFF

**1,700**



VOLUNTEER STAFF

**6,621**

CONDUCTED ALMOST

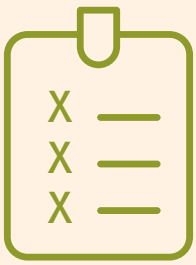
**200,000**

VISITS IN 39,894
LONG-TERM CARE
FACILITIES

INVESTIGATED

**153,324**

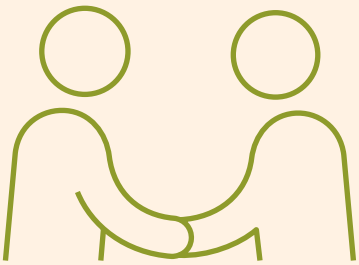
COMPLAINTS




PROVIDED MORE THAN

**640,000**

INSTANCES OF INFORMATION
AND ASSISTANCE TO INDIVIDUALS
AND FACILITY STAFF



# List of Exhibits



## Abbreviations and Acronyms

| | |
|---|---|
| **AAA** | Area agency on aging |
| **ACL** | Administration for Community Living |
| **COVID-19** | Coronavirus disease 2019 |
| **FY** | Fiscal year |
| **HHS** | U.S. Department of Health and Human Services |
| **LTCO** | Long-term care ombudsman |
| **LTCOP** | Long-Term Care Ombudsman Program |
| **OAA** | Older Americans Act |

# Impact of COVID-19 Pandemic on Title VII LTCOP Services

## Funding Use

Ombudsman programs are required to expend coronavirus disease 2019 (COVID-19) funds on allowable activities as defined by the Elder Justice Act, Coronavirus Aid, Relief, and. Economic Security (CARES) Act, and American Rescue Plan Act in accordance with state and local policy. This funding is intended to support the capacity of ombudsman programs as well as enhance, improve, and expand the ability to investigate allegations of abuse, neglect, and exploitation in the context of COVID-19 (called COVID for short). For example, funds could be used to

- enhance ombudsman program complaint investigations during the COVID public health emergency to address complaints related to abuse, neglect, and poor care;
- resume in-person visitation at such time as visitation is permitted, such as when the COVID vaccine is accessible to residents, facility staff, and individuals working for the LTCO program;
- conduct education and outreach on abuse and neglect identification and prevention during the COVID public health emergency to residents, their families, and facility staff;
- enable travel for representatives of the LTCO office to ensure all residents have access to an LTCO representative;
- continue purchase of needed personal protective equipment;
- continue purchase of technology as needed;
- enable participation in state-level "strike teams" to address complaints related to care and neglect; and
- provide information and assistance on transitions from long-term care facilities to community-based, home care settings, consistent with section 712(a)(3) of the Older Americans Act (OAA).[2]

## Title VII LTCOP Services

In-person visits with residents are a core part of ombudsman program outreach and advocacy. However, during the COVID-19 pandemic, visits have been dramatically curtailed, significantly restricting LTCO programs in pursuing their mission. The bullets below provide an overview of how the pandemic impacted Title VII LTCOP service needs and service provision.[3,4,5]

- **Suspended and modified facility visits.** On March 13, 2020, the Centers for Medicare & Medicaid Services issued guidance restricting everyone but essential personnel from entering nursing homes. As a result, the state ombudsman and ombudsman staff and volunteers serving as designated representatives of the office of the LTCO generally stopped visiting facilities in person during that time. When in-person visits slowly resumed, they would take place through windows, outdoors, or in a designated safe space until it was determined that in-room visits would resume. Since states and facilities had different protocols and policies for visits, ombudsmen had to spend extensive time to determine the requirements for visits and the most recent COVID-19 testing results to know if a visit could take place safely.
- **Contacted facilities and residents remotely.** While restrictions were in place, ombudsmen contacted facilities, families, and residents by phone, email, or video calls. Since restrictions were eased, ombudsmen have made contact with residents through a combination of phone contacts, virtual visits, and in-person visits.
- **Experienced reduced number of complaints.** Ombudsman programs have seen drops in the number of cases and number of complaints during the pandemic, which can be attributed to the lack of direct contact with residents by families and ombudsmen.
- **Continued to investigate complaints.** Ombudsman programs have continued to investigate complaints they receive and to provide information and assistance to residents, family members, the public, and long-term care staff, despite access to in-person visits having been restricted. Ombudsman programs have proactively reached out to residents and family members as well as facility staff by phone, email, and/or video calls to check in.
- **Experienced an increase in information and assistance.** Much of the ombudsman work this past year consisted of listening to stories of the impact of the COVID-19 pandemic and restrictions on facilities, staff, and residents. In addition, ombudsmen spent more time providing education on COVID-19 regulations and guidance. Consultations were conducted in person, by phone, or by email.
- **Conducted virtual meetings.** Ombudsman programs reported hosting virtual meetings (e.g., Facebook live, Zoom meeting) for family members of individuals living in long-term care facilities and the public to share information and respond to questions about COVID-19 and long-term care issues. Resident and family councils sometimes have used telecommunication platforms to hold their meetings rather than meeting in person.

# 2020 National Ombudsman Reporting System Data Highlights*

As part of Title VII Chapter 2 (LTCOP), each state is required to establish and operate a statewide office of the state LTCO, headed by a full-time state LTCO. These ombudsman programs currently operate in all 50 states, the District of Columbia, Puerto Rico, and Guam. The state LTCO manages all aspects of the statewide program. Ombudsman staff and volunteers serving as designated representatives of the office of the LTCO at the local level assist in performing the activities and fulfilling the responsibilities of the program, including advocating on behalf of residents in long-term care settings.

Funds are awarded to states based on a formula that takes into account the state's population age 60 or older compared to all states. States may implement LTCOP activities directly or through contracts or agreements with public or nonprofit private agencies or organizations, such as other state agencies, area agencies on aging (AAAs), county governments, institutions of higher education, Indian tribes, or nonprofit service providers or volunteer organizations.[6]

* Program Performance Report reporting year 2020: October 1, 2019 - September 30, 2020.

## Program Structure, Staffing, and Scope

### *Number of Ombudsman Entities*

Reporting data in FY 2020 were

- 52 state LTCO offices (all 50 states, the District of Columbia, and Puerto Rico)† and
- 438 local ombudsman entities.

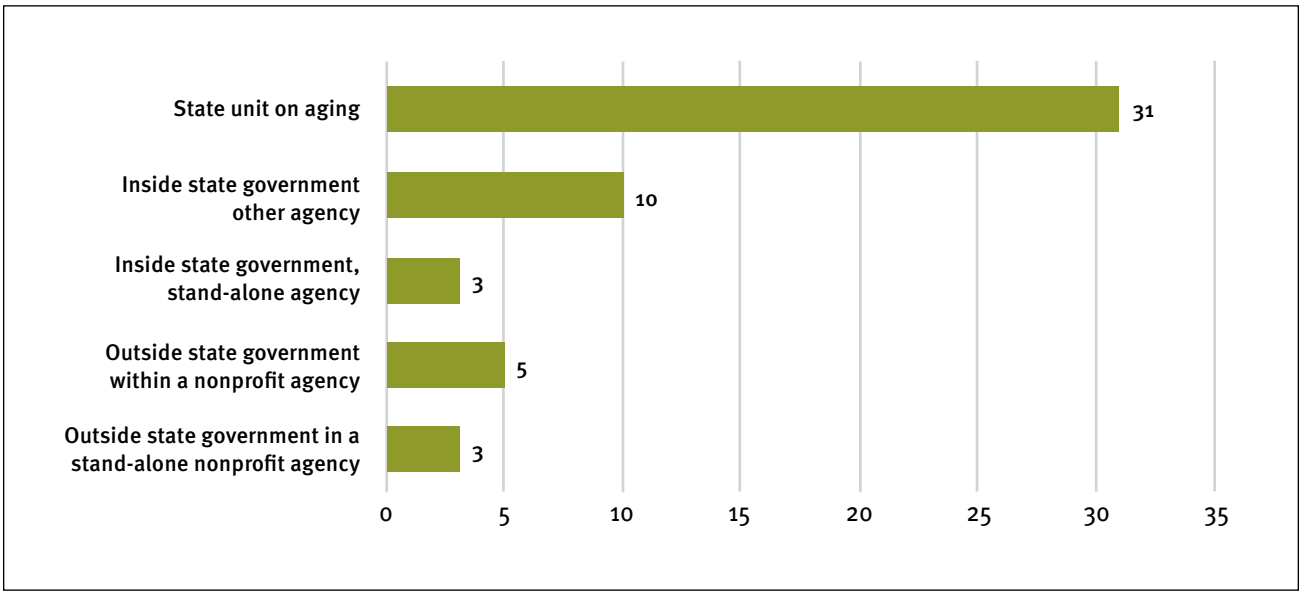
The majority (n=31) of state LTCO offices were located within state units on aging which served as the contracting entity for the state. Thirteen of the 52 state LTCO offices were located inside state government, either within another agency (n=10) or as stand-alone agencies (n=3). Eight state LTCO offices were located outside state government as part of a nonprofit agency (n=5) or representing its own stand-alone nonprofit agency (n=3).

† Guam has an ombudsman but does not report data. Guam has only one nursing home and an unknown number of assisted living facilities.

**52** | **State LTCO offices**

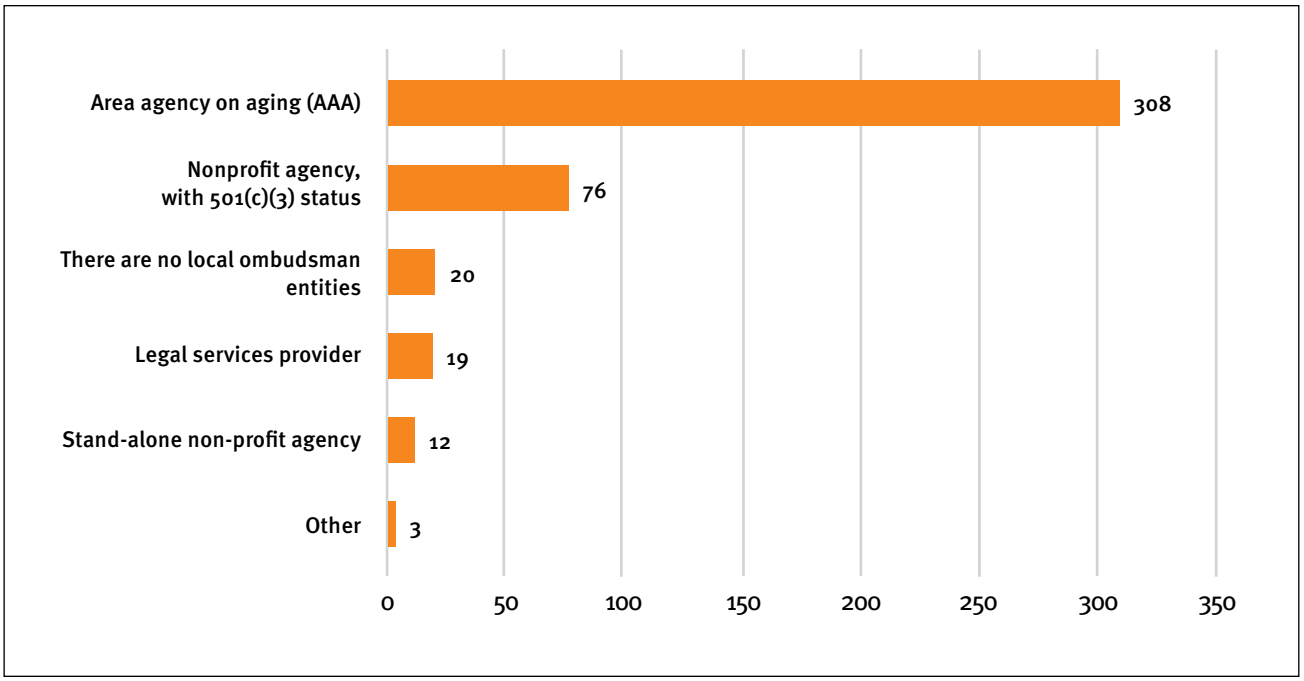
**438** | **Local ombudsmen entities**

**Exhibit 1.** Location of State LTCO Office




The majority (n=308) of local ombudsman entities were located within AAAs, with the local ombudsman representatives of the office being employed by the AAA. In 20 instances there were no local ombudsman entities.

**Exhibit 2.** Location of Local Ombudsman Entities



### *Number of Staff and Volunteers*

In FY 2020, the majority of LTCO program staff were volunteers (n=6,621), with 78% of volunteers (n=5,152) serving as certified ombudsman and 22% of volunteers (n=1,469) serving in other roles.‡ The majority of certified volunteer ombudsmen (79%, n= 4,075) and the majority of paid staff (75%, n= 1,283) worked at the local level. The other certified volunteer ombudsmen (21%, n= 1,077) and paid staff (25%, n= 417) worked at the state level.

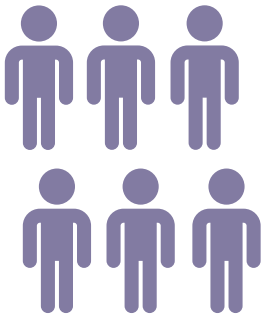
‡ Volunteers who serve on a program advisory or governing board, assist with fund raising, provide other in-kind services such as accounting or strategic planning, etc.

**Paid staff**

**1,700**

**Certified volunteer ombudsmen**

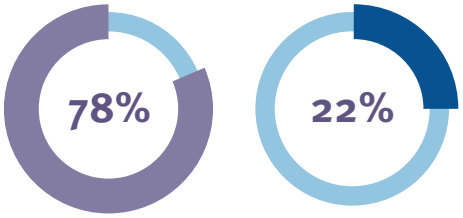
**5,125**



**Other volunteers (not ombudsmen representatives)**

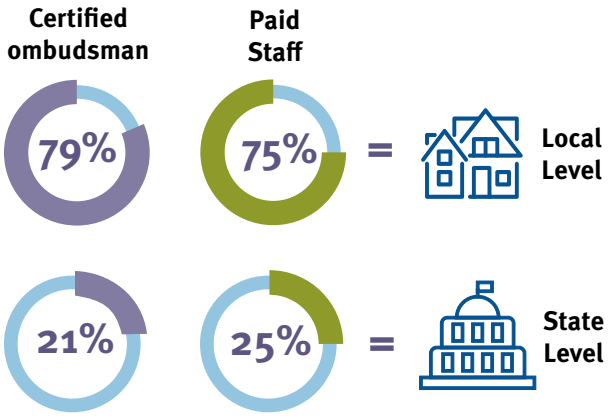
**1,469**

**Of 6,621 Volunteers**




**Served as certified ombudsman** | **Served in other roles**

**Majority of certified ombudsman and paid staff worked at the local level**



### *Number of Facilities and Capacity*

In FY 2020, LTCO programs and their representatives served more than 75,000 nursing homes and assisted living and similar residential care facilities, promoting and protecting the rights of more than 3 million residents.

**Facilities**

**75,795**

**Residents**

**3,192,209**

## Case Summary

### *Number of Complaints*

**153,324**

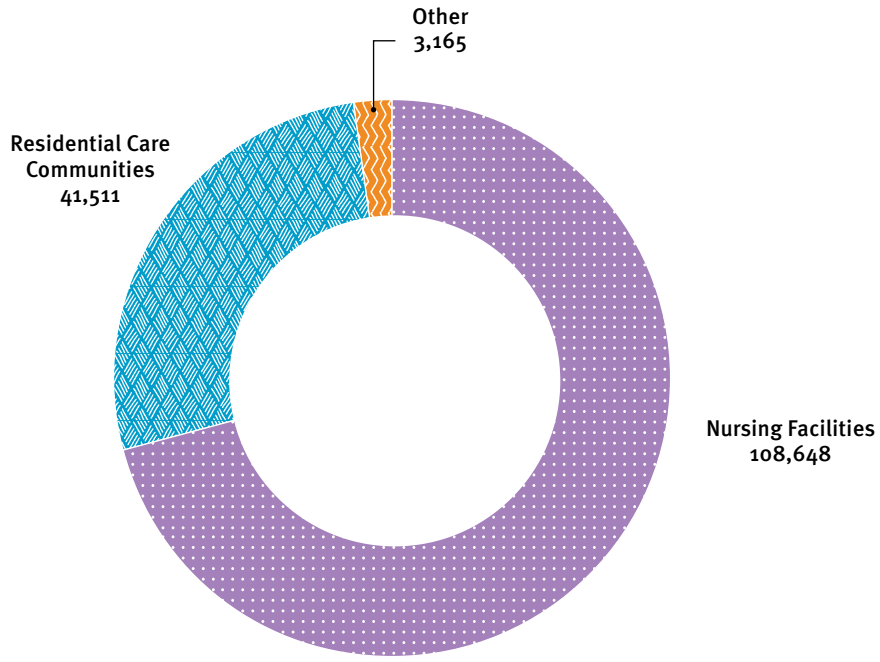
In FY 2020, there were a total of 153,324 complaints which required LTCOP investigation and resolution on behalf of one or more residents of a long-term care facility. Of the 153,324 complaints, the majority (n=108,648; 71%) originated in nursing facilities.

### *Complaint Verification Status*

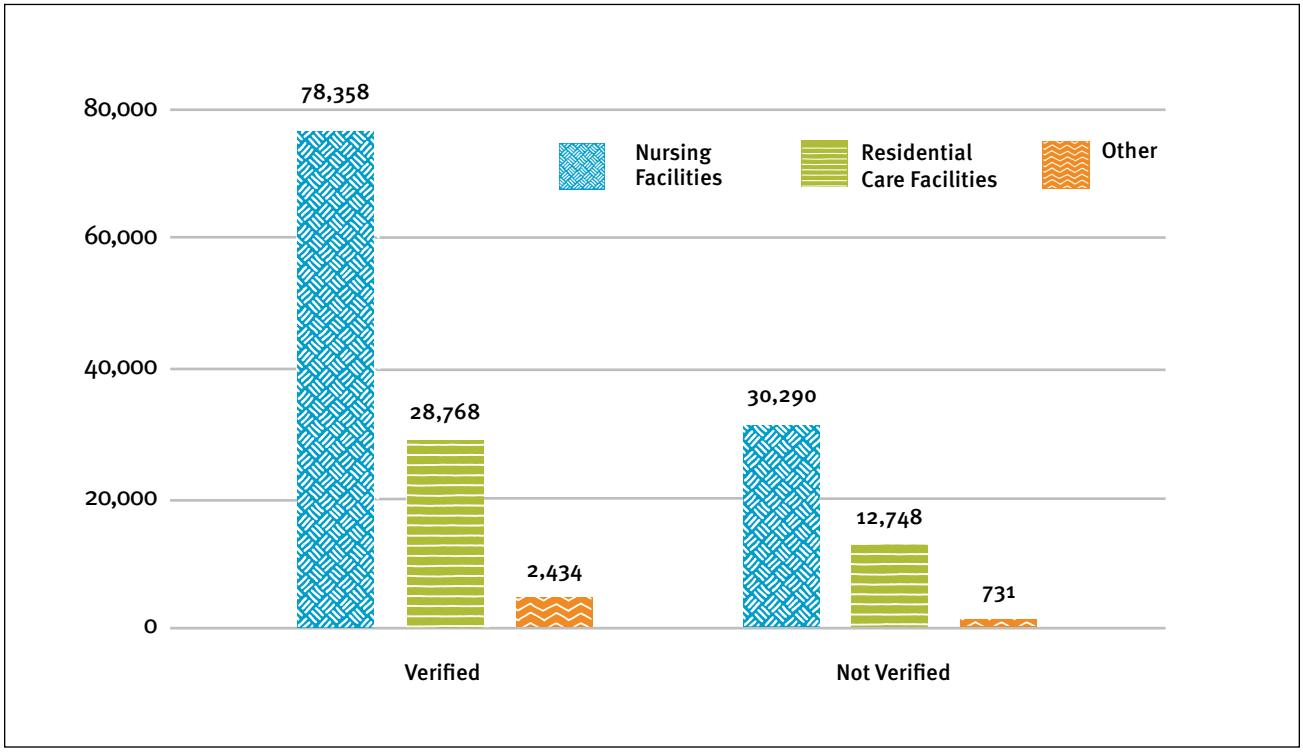
**71%**

Almost three quarters of all complaints (n=109,555; 71%) were verified, meaning that ombudsmen confirmed that most or all facts alleged by the complainant were likely to be true. In nursing facilities, 72% of complaints (n=78,358) were verified; in residential care facilities, 69% of complaints (n=28,763) were verified; and in other settings, 77% of complaints (n=2,434) were verified.

## Exhibit 3. Complaints by Type of Facility




## Exhibit 4. Complaints by Verification Status for Each Type of Facility



### *Complaint Dispositions*

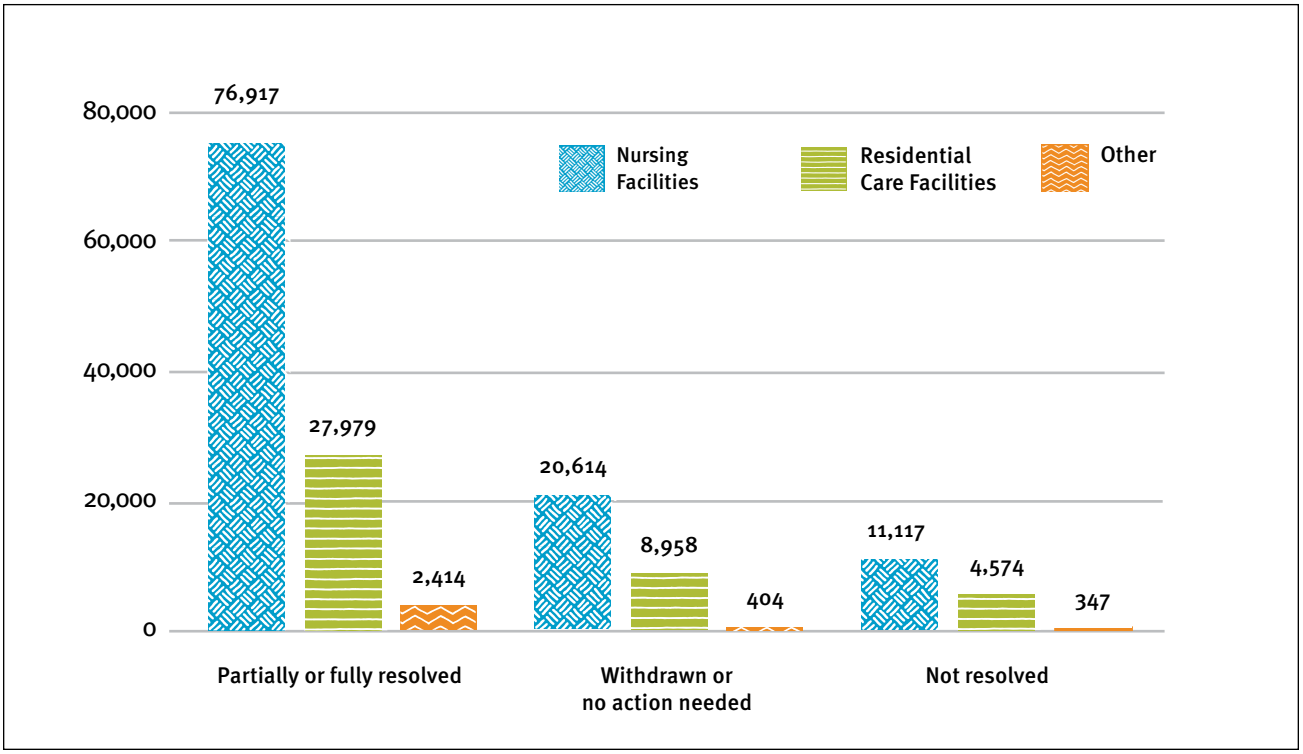
**70%**

More than two thirds of all complaints (n=107,310; 70%) were either partially or fully resolved.§ For another 20% (n=29,976), no action was needed or the complaint was withdrawn. In about 10% of cases (n=16,038), the complaints were not resolved.¶ In nursing facilities, 71% of complaints (n=76,917) were partially or fully resolved; in residential care facilities, 67% of complaints (n=27,979) were partially or fully resolved; and in other settings, 77% of complaints (n=2,414) were partially or fully resolved.

§ Verification and resolution were both affected by the pandemic.

¶ Resolution is based on the satisfaction of the resident, and some problems just cannot be resolved. For example, a resident might complain about insufficient staff, which may be resolved by the ombudsman working with the facility on a staff assignment plan (resolved). However, other times it may be about not having enough people to hire (not resolved).

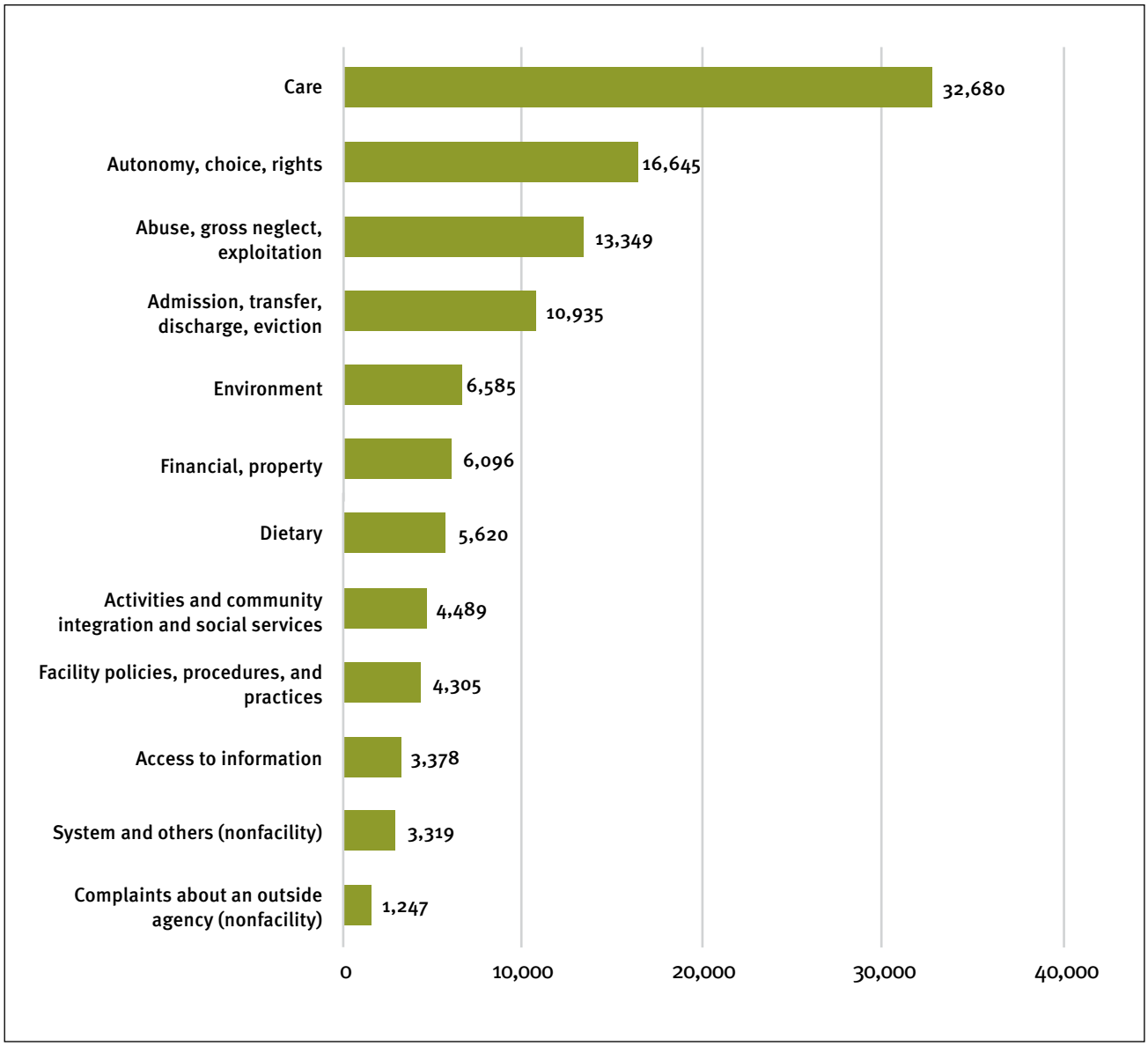
**Exhibit 5.** Complaints by Disposition for Each Type of Setting



### *Complaints Categories*

The largest number of complaints in nursing facilities (n=32,680; 30%) was related to care issues, including facility staff failure to provide care or providing poor quality care. The second most complaints (n=16,645; 15%) were related to facility staff failure to honor and promote a resident's autonomy, choice, and rights. There were also many complaints in nursing facilities (n=13,349; 12%) related to abuse, gross neglect, and exploitation—which involves the willful mistreatment of residents by facility staff, resident representative/family/friend, other residents, or an outside individual—as well as many complaints against nursing facilities (n=10,935; 10%) involving admission, transfer, discharge, and/or eviction.

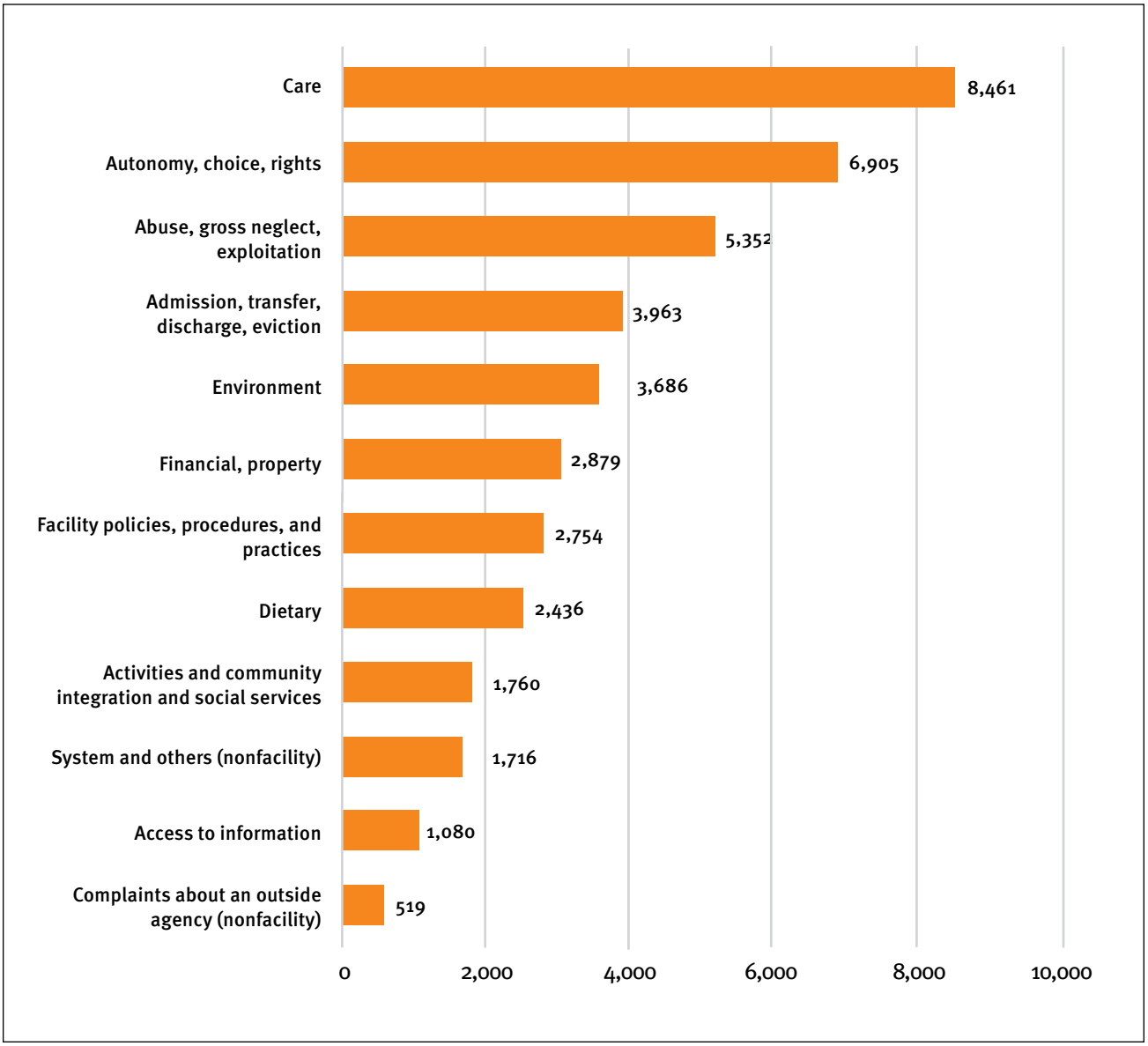
**Exhibit 6.** Complaints by Complaint Category, Nursing Facilities



**20%**

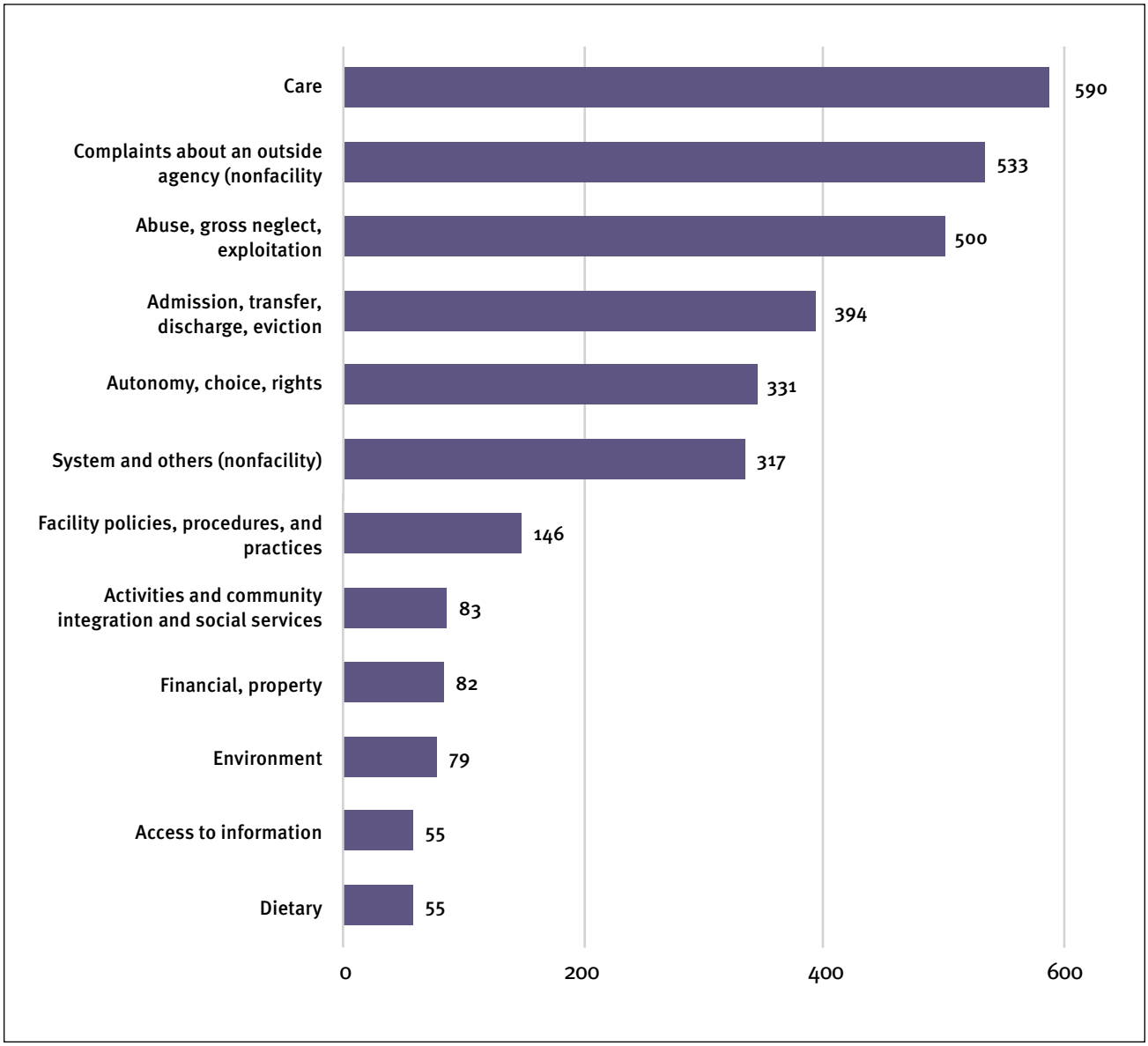
Complaints in residential care communities followed a pattern similar to those in nursing facilities, with the largest number of complaints related to care issues (n=8,461; 20%), followed by complaints related to autonomy, choice, and rights (n=6,905; 17%) and abuse, gross neglect, and exploitation (n=5,352; 13%).

**Exhibit 7.** Complaints by Complaint Category, Residential Care Communities



**19%** In other settings, too, the largest number of complaints (n=590; 19%) was related to care issues. The second largest number (n=533; 17%) was complaints about an outside agency, followed by complaints related to abuse, gross neglect, and exploitation (n=500; 16%).

**Exhibit 8.** Complaints by Complaint Category, Other Settings



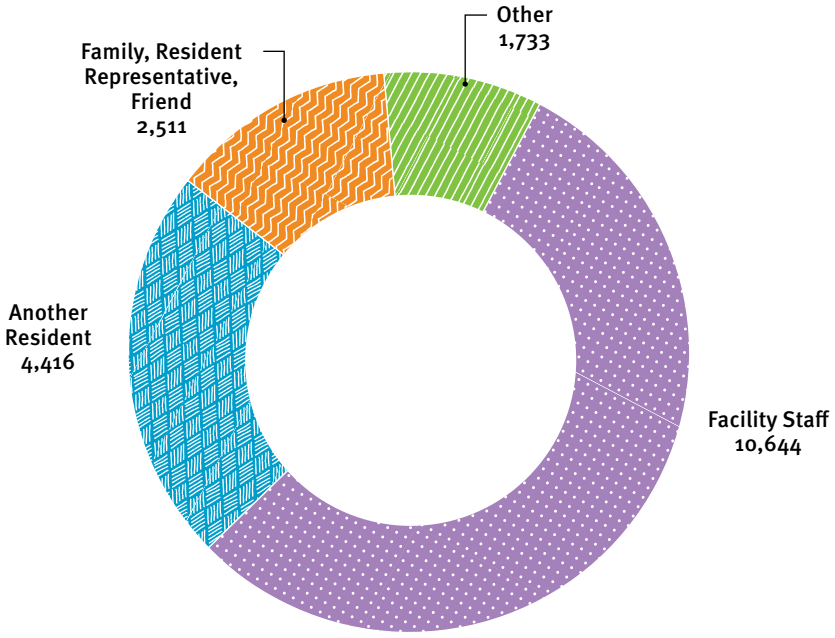
### *Perpetrator Type***

**55%**

For complaints related to abuse (physical, sexual, psychological), more than half of the complaints (n=10,644; 55%) involved a facility staff member, and almost a quarter of the complaints (n=4,416; 23%) involved another resident.

** Perpetrator type is reported for complaints related to abuse only. An ombudsman may select more than one type of perpetrator for a single abuse complaint. Thus, there are more perpetrators (n=19,303) than abuse complaints (19,201).

**Exhibit 9.** Perpetrator Type for Abuse Complaints

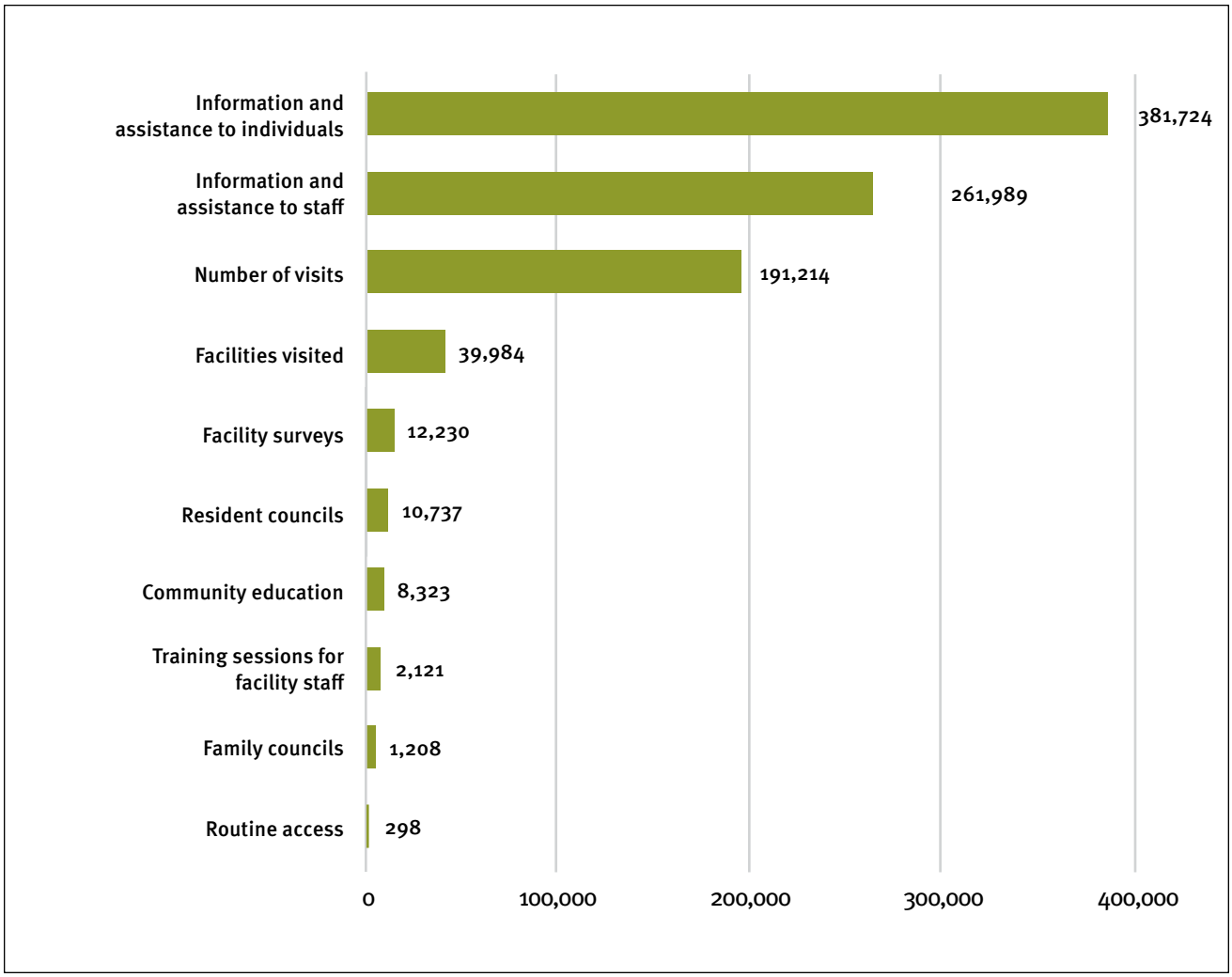


## Program Activities

In addition to investigating complaints, LTCO programs engage in a range of activities to improve quality of life and care for residents of long-term care facilities. In FY 2020, the largest number of activities completed by LTCO programs focused on information and assistance to individuals (n=381,174 instances) or resident staff (n=261,989 instances). These activities may include providing information about issues that impact residents (e.g., resident rights, care issues, services) and/or providing assistance to access services without opening a case and working to resolve a complaint. LTCO programs also completed almost 200,000 visits to 39,984 long-term care facilities, no matter the purpose of visit (complaint or noncomplaint related).††

†† These activities were also highly influenced by the pandemic.

**Exhibit 10.** Program Activities to Improve Quality of Life



# Appendix A: Title VII National Ombudsman Reporting System Definitions[7]

**Abuse:** Physical abuse: The intentional use of physical force that results in acute or chronic illness, bodily injury, physical pain, functional impairment, distress, or death. Sexual abuse: Forced and/or unwanted sexual interaction (touching and nontouching acts) of any kind. Psychological abuse: The infliction of anguish, pain, or distress through verbal or nonverbal acts, including but not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment.

**Abuse, Gross Neglect, Exploitation (Code A)**: Serious complaints of willful mistreatment of residents by facility staff, resident representatives/ family/friends, other residents, or outside individuals. Indicate who appears to be the cause of the abuse, neglect or exploitation: (1) facility staff; (2) another resident; (3) resident representative, family, friend; or (4) other.

**Access to Information (Code B)**: Complaints against the facility regarding access to information made by or on behalf of the resident. Use for willful interference with ombudsman duties.

**Activities, Community Integration and Social Services (Code G):** Complaint involving activities, community integration, or social services.

**Admission, Transfer, Discharge, Eviction (Code C):** Complaints against the facility involving issues regarding admission, transfer, discharge, and/or eviction.

**Area Agency on Aging (AAA):** Public or private nonprofit agency designated by a state to address the needs and concerns of all older persons at the regional and local levels. The term AAA is a general one; names of local AAAs may vary. The AAAs coordinate and offer services that help older adults remain in their homes, if that is their preference, aided by services such as home-delivered meals, homemaker assistance, and whatever else it may take to make independent living a viable option.

**Autonomy, Choice, Rights (Code D):** Complaints involving facility staff failure to honor and promote a resident's right or preferences.

**Care (Code F):** Complaints involving facility staff failure to provide care, including poor quality care, planning, and delivery.

**Certified Volunteer Ombudsmen:** Volunteers designated as representatives of the LTCO office.

**Community Education**: Community education outreach sessions by ombudsman program—e.g., attendance at health fairs, community events, general presentations, etc.

**Complaint:** An expression of dissatisfaction or concern brought to, or initiated by, the ombudsman program which requires ombudsman program investigation and resolution on behalf of one or more residents of a long-term care facility.

**Complaints About an Outside Agency (Nonfacility; Code K)**: Complaints involving decisions, policies, actions, or inactions by programs and agencies—including private and public benefits.

**Complainant:** An individual who requests ombudsman program complaint investigation services regarding one or more complaints made by, or on behalf of, residents.

**Complaint Disposition**: Final resolution or outcome of the complaint.

**Complaint Verification:** A confirmation that most or all facts alleged by the complainant are likely to be true.

**Dietary (Code H):** Complaints regarding food service, assistance.

**Environment (Code I):** Complaints involving the physical environment of the facility, including the resident's space.

**Facilities Visited:** Total number of facilities that received at least one visit by a representative of the LTCO office during the reporting year, regardless of the purpose of the visit.

**Facility Capacity:** Number of beds for which the facility is licensed, certified, or registered.

**Facility Policies, Procedures, and Practices (Code J)**: Acts of commission or omission by facility leadership/owners, including administrators, resident managers, etc.

**Facility Staff:** Any employee or contractor of a long-term care facility who brings a complaint to the ombudsman program regarding one or more residents.

**Facility Surveys:** Participation in survey activity conducted by regulatory agencies, including participation in both standard surveys and complaint surveys. Survey participation includes, but is not limited to, providing presurvey information to surveyors, sharing complaint summary reports, and participating in exit conferences and informal dispute resolution.

**Financial, Property (Code E):** Complaints involving facility staff mismanagement of residents' funds and property or billing problems.

**Gross Neglect:** Failure to protect a resident from harm or the failure to meet needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living, or shelter, which results in a serious risk of compromised health and/or safety relative to age, health status, and cultural norms.

**Information and Assistance:** Providing information about issues that impact residents (e.g., resident rights, care issues, services) and/or providing assistance to access services without opening a case and working to resolve a complaint. Information and assistance may be provided through various means, including but not limited to by telephone, by written correspondence such as email, or in person.

**Nursing Facility:** Any skilled nursing facility, as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)), or any nursing facility, as defined in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)). May also include noncertified nursing homes licensed by the state.

**Ombudsman Program:** The program through which the functions and duties of the LTCO office are carried out, consisting of the ombudsman, the office headed by the ombudsman, and the representatives of the office.

**Other Settings**: Settings beyond those defined as long-term care facilities in the Older Americans Act (OAA).

**Other Volunteers:** Other types of volunteers who are not representatives of the office.

**Perpetrator:** Person who appears to have caused the abuse or neglect or exploitation.

**Resident**: An individual who resides in a long-term care facility.

**Residential Care Community**: A type of long-term care facility as described in the OAA that, regardless of setting, provides, at a minimum, room and board, around-the-clock on-site supervision, and help with personal care such as bathing and dressing or health-related services such as medication management. Facility types include, but are not limited to, assisted living; board and care homes; congregate care; enriched housing programs; homes for the aged; personal care homes; adult foster/ family homes; and shared housing establishments that are licensed, registered, listed, certified, or otherwise regulated by a state.

**Resident or Family Council**: Organized, self-governing, decision-making group of long-term care residents (resident council) or families (family council) who meet regularly to voice their needs and concerns and to have input into the activities, policies, and issues affecting the facility.

**Resident Representative, Friend, Family**: Resident representative, as defined in 45 CFR 1324.1, may be

- an individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;

- a person authorized by state or federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
- a legal representative, as used in section 712 of the Act; or
- the court-appointed guardian or conservator of a resident.

Friend is a nonrelative with a personal relationship with the resident as identified by the resident or complainant. Family is spouse, sibling, other relative, or as identified by the resident or complainant.

**Routine Access:** Facilities visited, not in response to a complaint, in all four quarters by representatives of the LTCO office.

**State Units on Aging:** Designated state-level agencies that are responsible for the planning and policy development as well as the administration of OAA activities.

**System: Others (Nonfacility; Code L):** Other complaints, including resident representative or family member interfering with the resident's decision-making and preferences related to health, welfare, safety, or rights, but not rising to the level of abuse, gross neglect or exploitation; problems with services provided to a resident from an individual or entity not associated with or arranged by the facility; and barriers to transition to community—inadequate assistance with accessing housing, services, and supports not related to facility action or inaction.

**Training:** Training sessions provided by representatives of the LTCO office to facility staff. Training may be in person or web-based and typically includes an agenda and learning outcome(s).

**Visits**: Facility visits, no matter the purpose of visit (complaint or noncomplaint related), by representatives of the LTCO office.

# References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