DEPARTMENT of HEALTH and HUMAN SERVICES

ADMINISTRATION ON AGING

FY 2010 Report to Congress

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FROM THE ADMINISTRATION ON AGING

I am pleased to present the Administration on Aging (AoA) FY 2010 Report to Congress.

AoA and the national aging services network, comprised of 56 state and territorial units on aging (SUA), 629 area agencies on aging (AAA), 244 tribal organizations, two Native Hawaiian organizations, nearly 20,000 direct service providers, and hundreds of thousands of volunteers, annually serve nearly 11 million seniors and their caregivers. AoA's services complement medical and health care systems, help to prevent hospital readmissions, provide transportation to doctor appointments, and support some of life's most basic functions, such as assistance to elders in preparing and delivering meals, or helping them with bathing. This assistance is especially critical for the nearly three million seniors who receive intensive in-home services, half a million of whom meet the disability criteria for nursing home admission but are able to remain in their homes, in part, due to these community supports.

The need for this support is growing rapidly. From 2010 to 2015, the population aged 60 and older will increase by 15 percent, from 57 million to 65.7 million. During this period, the number of seniors with severe disabilities who are at greatest risk of nursing home admission and Medicaid eligibility will increase by more than 13 percent.

The following summary of the Older Americans Act (OAA) program data reveals that:

- OAA programs help older Americans with severe disabilities remain independent and in the community.
- OAA programs are efficient: Without controlling for inflation, OAA programs have increased efficiency by nearly 40 percent between FY 2002 and FY 2010, serving 8,459 older Americans per million dollars of funding in FY 2010, compared to 6,103 individuals per million dollars of funding in FY 2002. This increase in efficiency is understated since the purchasing power of a million dollars in 2010 is significantly less than in 2002 due to inflation.
- OAA programs build system capacity: For every one dollar of OAA funds expended for home and community-based services, nearly three dollars is leveraged from state, local or other sources.

The Older Americans Act is due for reauthorization in FY 2012. During FY 2010, AoA convened three national listening sessions, held one joint session with the Department of Labor, and sparked hundreds of national, state and local sessions convened by stakeholders and involving all states and area agencies. In addition, targeted outreach to national minority aging organizations representing diverse cultures and populations was conducted. As a result, the critical internal and external stakeholders representing thousands of older individuals and their caregivers were engaged in providing input and recommendations for the next reauthorization. We look forward to working with Congress to strengthen and update these critical programs with an eye toward efficiency and effectiveness, and strengthening and building the capacity of the aging services network to deliver high-quality services that improve outcomes for seniors.

Kathy Greenlee
Assistant Secretary for Aging

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Executive Summary

The Administration on Aging (AoA), an agency of the U.S. Department of Health and Human Services (DHHS), plays a lead role in the mission of helping elderly individuals maintain their dignity and independence in their homes and communities. AoA advances the concerns and interests of older people, and works with and through the national aging services network of 56 state and territorial units on aging (SUA), 629 area agencies on aging (AAA), 244 tribal organizations, two Native Hawaiian organizations, and nearly 20,000 direct service providers, to promote the development of comprehensive and coordinated home and community-based care that is responsive to the needs and preferences of older people and their caregivers.

AoA's core programs, authorized under the Older Americans Act (OAA) and administered by the national aging services network, help families keep their loved ones at home for as long as possible. The network also helps consumers learn about and access the services and supports that are available in the community and addresses issues related to caregivers. OAA services are less expensive than institutional care and performance data show that they are very effective. The most recent data available show that AoA and its national network rendered direct services to 10.8 million elderly individuals age 60 and over (nearly 20 percent of the country's elderly population) and their caregivers, including nearly three million clients who received intensive in-home services.[1] Critical supports, such as respite care and a peer support network, were provided to nearly 700,000 caregivers.

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

Vision

In order to serve a growing senior population, AoA envisions ensuring the continuation of a vibrant aging services network at state, territory, local and tribal levels through the funding of lower-cost, non-medical services and supports that provide the means by which many seniors can remain out of institutions and live independently in their communities for as long as possible.

Mission

The mission of AoA is to develop a comprehensive, coordinated and cost-effective system of home and community-based services that helps elderly individuals maintain their health and independence in their homes and communities.

[1] Data from AoA's FY 2010 State Program Report are preliminary and should not be taken as final.

Overview of Performance

AoA program activities have a fundamental common purpose which reflects the legislative intent of the Older Americans Act (OAA) and the AoA mission: to help elderly individuals – and increasingly individuals with disabilities - maintain their dignity and independence in their homes and communities through comprehensive, coordinated, and cost effective systems of long-term care, and livable communities across the U.S. To reflect this unified purpose, AoA has aggregated all budget line items into a single Government Performance and Results Act (GPRA) program, AoA's Aging Services Program, for purposes of performance measurement.

The Aging Services Program's fundamental purpose, in combination with the legislative intent that the national aging services network actively participate in supporting community-based services with particular attention to serving economically and socially vulnerable elders, led AoA to focus on three measures: 1) improving efficiency; 2) improving client outcomes; and 3) effectively targeting services to vulnerable elder populations. Each measure is representative of several activities across the Aging Services Program budget and progress toward achievement of the measure is tracked using a number of indicators. The efficiency measure and corresponding indicators are reflective of the Office of Management and Budget (OMB) requirements to measure efficiency for all program activities. The client outcome measure includes indicators focusing on consumer assessment of service quality and outcome indicators focusing on nursing home predictors, successful caregiver program operation and protection of the vulnerable elderly. The targeting measure and indicators focus on ensuring that states and communities serve the most vulnerable elders, those that are most in need of these services. Taken together, the three measurement areas and their corresponding performance indicators are designed to reflect AoA's strategic goals and objectives and in turn measure success in accomplishing AoA's mission.

Consistent with this Administration's emphasis on transparency and accountability, AoA has taken several steps to improve the analysis and availability of performance information while also enhancing the rigor of program evaluations. To this end, AoA has:

- Expanded the availability of performance information via an on-line system that enables aging network professionals and the public to develop benchmarks and examine trends nationally and at the state level (http://www.data.aoa.gov).

- Submitted public use data sets to the http://www.data.gov/ system.

- Further analyzed the results from the 2008 and 2009 national surveys to help inform decision makers. Results show:
    - AoA is effectively reaching those most at risk of institutionalization.
    - Service recipients report Title III services enable them to remain in their own homes.
    - Comparison of service recipients to the elderly US population 60 and older shows that Title III serves older people who are less healthy and have more limitations

than other older adults even after adjusting for demographic and socioeconomic differences between the groups.

- Tested through the Performance Outcomes Measurement Project (POMP) several methods for measuring the impact of services. Preliminary analysis for administrative data sets from four states, using Cox proportional hazards models, show a consistent lowering of the relative risk of nursing home placement with an increase in number of services utilized; and there was an increase in mean survival time in the community (i.e. months before placement) with increases in the total number of services used.

- Employed more rigorous program evaluation methods such as longitudinal data collection and experimental design.
  - The Title III-C Elderly Nutrition Services program evaluation employs a complex design that includes three major components and several subcomponents. The major components include a process study that surveys each component of the aging services network on a large array of topics; a costs study that measures the actual cost of providing a meal by cost category (e.g. labor, food, overhead); and an individual outcome study. The individual outcomes study will measure the program's success at meeting the legislative intent of the program (reduce hunger and social isolation while improving health and well-being of consumers). In addition, AoA and the Centers for Medicare and Medicaid Services (CMS) have recently entered into an Inter-Agency Agreement that will enhance this evaluation to include prospective analysis of healthcare utilization and cost data of program participants compared to a matched group of seniors who do not participate in the program.
  - The evaluation of the Title III-E National Family Caregiver Support program will be the first for this OAA program. It is designed as a longitudinal study with a comparison group so that the effects of the five service categories can be measured over time.
  - AoA is working with a research contractor to finalize the design and operational plan for an evaluation of Aging and Disability Resource Centers (ADRC). The evaluation is a quasi-experimental design that compares the experiences and outcomes associated with accessing long-term care services and supports through an ADRC to non-ADRC communities. AoA is working with the HHS Office on Disability and the Department of Education's Rehabilitation Services Administration to better include the younger disabled population in the study who access services through Centers for Independent Living.
  - During FY 2010, AoA, through an Interagency Agreement with the Agency for Healthcare Research and Quality (AHRQ), contracted with a research team to design a framework report for the evaluation of the Chronic Disease Self-Management Program. This report indicated that the existing literature about the efficacy of CDSMP includes few subgroup analyses of the population AoA is mandated to serve, that is, people aged 60 or older, and that the studies that looked at the effects of CDSMP on older individuals either did not find positive effects or found only weak effects. A more recent study of CDSMP outcomes commissioned by the Centers for Disease Control and Prevention reveals that the

CDSMP was as effective in studies where the majority of participants were aged 65 years or older as it was with individuals in studies where the majority of participants were aged 65 years or younger.[2]

- The final evaluation design report was received in May 2011 and recommended an experimental evaluation design in which individuals will be randomly assigned to receive the intervention or serve as a control group by delaying program participation for a minimum of six months. Multiple data collection points will enable AoA to measure program effects on its target service population over time. Next steps involve finalizing design details, developing an operational plan and gathering process data.
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Current Performance Information

An analysis of AoA's performance trends shows that through FY 2010, most indicators have steadily improved. It also points to some key observations about the potential of AoA and the national aging services network in meeting the challenges posed by the growth of the vulnerable older adult population, the changing care preferences of aging baby boomers, the fiscal difficulties faced by state budgets, and the expanding needs of both the elderly and their caregivers. Below are some examples of these observations:

- **OAA programs help older Americans with severe disabilities remain independent and in the community**: Older adults that have three or more impairments in Activities of Daily Living (ADLs) are at a high risk for nursing home placement. Measures of the aging services network's success at serving this vulnerable population is a proxy for success at nursing home delay and diversion. In FY 2003, the aging network served home-delivered meals to 280,454 clients with three or more ADL impairments and by FY 2010 that number grew by 14 percent to 318,792 clients. Another approach to measuring AoA's success is the newly developed nursing home predictor score. The components of this composite score are predictive of nursing home placement based on scientific literature and AoA's POMP which develops and tests performance measures. The components include such items as percent of clients that are transportation disadvantaged and the percent of congregate meal clients that live alone. As the score increases, the prevalence of nursing home predictors in the OAA service population increases. In 2003, the nursing home predictor score was 46.57 and has increased to 61.0 in FY 2009. This increase indicates that AoA programs are serving a larger share of individuals who, without community support, would be more likely to move into institutional settings.

[2] *Sorting through the Evidence for Arthritis Self-Management Program and the Chronic Disease Self-Management Program*. Centers for Disease Control. May,2011.

- **OAA programs are efficient:** The national aging services network is providing high quality services to the neediest elders and doing so in a very prudent and cost-effective manner; as an example, AoA has significantly increased the number of clients served per million dollars of AoA funding. Without controlling for inflation, OAA programs have increased efficiency by nearly 40 percent between FY 2002 and FY 2010, serving 8,459 clients per million dollars of AoA funding in FY 2010, compared to 6,103 clients served per million dollars of AoA funding in FY 2002. This increase in efficiency is understated since the purchasing power of a million dollars in 2010 is significantly less than in 2002 due to inflation.

- **OAA programs build system capacity:** OAA programs stay true to their original intent to "encourage and assist state agencies and area agencies on aging to concentrate resources in order to develop greater capacity and foster the development and implementation of comprehensive and coordinated systems." (OAA Section 301). This is evident in the leveraging of OAA funds with state/local or other funds (almost $3 in other funds for every dollar of OAA funds expended for Home and Community-Based Services (Titles III-B, III-C and III-D), as well as in the expansion of projects such as the Aging and Disability Resource Center initiative, which has grown to 310 sites across 54 states and territories in FY 2010.

OAA clients report that these services contribute in an essential way to maintaining their independence and they express a high level of satisfaction with these services. In 2009, over 96 percent of transportation clients rated services good to excellent and 95 percent of caregivers rated services good to excellent. To help ensure the continuation of these trends in core programs, AoA makes extensive use of its discretionary funding to test innovative service delivery models for state and local program entities to attain measurable improvements in program activities. For example, AoA has worked with the Centers for Medicare & Medicaid Services and the Department of Veterans Affairs to better integrate funding for long-term care service delivery, eliminate duplication and improve access to services through Aging and Disability Resource Centers.

Part I: Health and Independence

AoA's Health and Independence Programs provide a foundation of supports that assist older individuals to remain healthy and independent in their homes and communities, avoiding more expensive nursing home care. For example, 62 percent of congregate and 93 percent of home-delivered meal recipients reported that the meals enabled them to continue living in their own homes and 53 percent of seniors using transportation services rely on them for the majority of their trips to doctors' offices, pharmacies, meal sites, and other critical daily activities that help them to remain in the community.[3]

From 2010 to 2015, the number of Americans age 60 and older will increase by 15 percent, from 57 million to 65.7 million.[4] During this period, the number of seniors with severe disabilities (defined as 3 or more limitations in activities of daily living) who are at greatest risk of nursing home admission and Medicaid eligibility (through the "spend down" provisions) will increase by more than 13 percent.[5] These programs help seniors in need maintain their health and independence.

In concert with other OAA programs, these services assist nearly 11 million elderly individuals and caregivers. AoA's services are especially critical for the nearly three million seniors who receive intensive in-home services, half a million of whom meet the disability criteria for nursing home admission. These services help to keep these individuals from joining the 1.7 million seniors who live in nursing homes. These increases will also help the national aging services network improve its capacity to assist the rapidly growing senior population.

State and Territory Flexibility

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

The OAA allows a state to transfer up to 40 percent of the funds between congregate and home-delivered meals for use as the state considers appropriate to meet the needs of the area served.

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[3] 2009 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

[4] Data compiled by AoA from U.S. Census Bureau, "2008 National Population Projections, Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: July 1, 2000 to July 1, 2050" released August 2008, <http://www.census.gov/population/www/projections/downloadablefiles.html> Accessed August 03, 2011.

[5] Data extrapolated by AoA from U.S. Census Bureau, "2008 National Population Projections," released August 2008, <http://www.census.gov/population/www/projections/2008projections.html> and Health Data Interactive, National Center on Health Statistics, Centers for Disease Control and Prevention, "Functional limitations among Medicare beneficiaries, ages 65+: US, 1992-2008." Accessed August 02, 2011.

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

In 2010, states transferred over $82 million from congregate nutrition to home and community-based services and home-delivered meals, as illustrated in the following table.

Table 1. FY 2010 Transfer of Federal funds within Title III of the OAA

	Part B – Home and Community-Based Supportive Services	**Part C1 – Congregate Nutrition**	**Part C2 – Home-Delivered Meals**
Initial Allotment	$366,038,034	$438,020,197	$216,311,617
Final Allotment after Transfers	$415,543,507	$355,452,956	$249,373,385
Net Transfer	+$49,505,473	($82,567,241)	+$33,061,768
Net Percent Change	13.52	(18.85)	15.28

Home and Community-Based Supportive Services

(Title III-B of OAA; FY 2010: $368,290,000)

The Home and Community-Based Supportive Services (HCBS) program, established in 1973, provides grants to states and territories based on their share of the population age 60 and over to fund a broad array of services that enable seniors to remain in their homes for as long as possible. AoA programs like the HCBS program serve seniors holistically; while each service is valuable in and of itself, it is often the combination of supports, when tailored to the needs of the individual, that ensures clients remain in their own homes and communities instead of entering nursing homes.

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

While age alone does not determine the need for these long-term care supports, statistics show that both disability rates and the use of long-term supports increase with advancing age. Among those aged 85 and older, 55 percent are unable to perform critical activities of daily living and require long-term support. Data also show that 90 percent of seniors have at least one chronic condition and over 70 percent have at least two[6]. Providing a variety of supportive services that meet the diverse needs of these older individuals is crucial to enabling them to remain healthy and independent in their homes and communities, avoiding unnecessary, expensive nursing home care.

Data from AoA's national surveys of elderly clients show that Home and Community-Based Supportive Services are providing seniors with the services and information they need to help them remain at home. For example, 48 percent of seniors using transportation services rely on them for the majority of their transportation needs and would otherwise be homebound, while 80 percent of clients receiving case management reported that as a result of the services arranged by the case manager they were better able to care for themselves.[7] In addition, a study published in the Journal of Aging and Health shows that the "personal care services" provided by the HCBS program are the critical services that enable frail seniors to remain in their homes and out of nursing home care.[8]

Services provided by the HCBS program in FY 2010 include:

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

[7] 2009 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

[8] Chen, Ya Mei and Elaine Adams Thompson. Understanding Factors That Influence Success of Home- and Community-Based Services in Keeping Older Adults in Community Settings. 2010. Journal of Aging and Health. V. 22: 267. Available: http://jah.sagepub.com/cgi/content/abstract/22/3/267.

- *Adult Day Care/Day Health* provided over ten million hours of care for dependent adults in a supervised, protective group setting during some portion of a twenty-four hour day.

- *Transportation Services* provided nearly 26 million rides to doctor's offices, grocery stores, pharmacies, senior centers, meal sites, and other critical daily activities.

- *Personal Care, Homemaker, and Chore Services* provided more than 35 million hours of assistance to seniors unable to perform activities of daily living (such as eating, dressing, or bathing) or instrumental activities of daily living (such as shopping or light housework).

- *Case Management Services* provided more than 4 million hours of assistance in assessing needs, developing care plans, and arranging services for older persons or their caregivers.

In continuing with AoA's commitment to provide services to those in most need, nearly 50 percent of riders on OAA-funded transportation do not own a car or if they do own a car they do not drive, and are not near public transportation. Many of these individuals cannot safely drive a car, as nearly 75 percent of transportation riders have at least one of the following chronic conditions that could impair their ability to navigate safely:

- 68 percent of riders had a doctor tell them they had vision problems (including glaucoma, macular degeneration or cataracts);
- 14 percent have had a stroke; and
- 7 percent have Alzheimer's or dementia.

Of the transportation participants 95 percent take daily medications, with 17 percent taking 10 to 20 medications daily.[9]

[9] 2009 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

Nutrition Services

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

- Congregate Nutrition Services (Title III-C1; FY 2010: $440,718,000): Provides funding for the provision of meals and related services in a variety of congregate settings, which help to keep older Americans healthy and prevent the need for more costly medical interventions. Established in 1972, the program also presents opportunities for social engagement and meaningful volunteer roles, which contribute to overall health and well-being.

- Home-Delivered Nutrition Services (Title III-C2; FY 2010: $217,644,000): Provides funding for the delivery of meals and related services to seniors who are homebound. Established in 1978, home-delivered meals are often the first in-home service that an older adult receives and serve as a primary access point for other home and community-based services. Home-delivered meals also represent an essential service for many caregivers, by helping them maintain their own health and well-being.

- Nutrition Services Incentive Program (NSIP) (Title III-A; FY 2010: $160,991,000): Provides additional funding to states, territories, and eligible tribal organizations that is used exclusively to provide meals. It cannot be used to pay for other nutrition-related services or for administrative costs. Funds are awarded to states and tribes based on the number of meals served in the prior Federal fiscal year. States and tribes have the option to purchase commodities directly from the U.S. Department of Agriculture with any portion of their award if they determine that doing so will enable them to better meet the needs of seniors. States and tribes elected to spend approximately $2.7 million on commodities in FY 2010.

Formula grants for Congregate Nutrition Services and Home-Delivered Nutrition Services are allocated to states and territories based on their share of the population age 60 and over. The meals provided through these programs fulfill the standards set by the Dietary Guidelines for Americans and provide a minimum of 33 percent of the Dietary Reference Intake, as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences.

Nutrition Services help over two million older adults receive the meals they need to stay healthy and decrease their risk of disability. Nutrition Services help over two million older adults receive the meals they need to stay healthy and decrease their risk of disability. Studies have found that 40 percent of all persons age 85 and over are in need of assistance with instrumental activities of daily living (IADLs)[10], including obtaining and preparing food; these nutrition programs help address their needs. *Serving Elders at Risk*, a national evaluation of AoA's

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

nutrition program clients, found that recipients are older, poorer, more likely to live alone, more likely to be minorities, are sicker, in poorer health, in poorer nutritional status, more functionally impaired, and at higher nutritional risk than those in the general population. Nutrition Services provide an important opportunity for social interaction that helps to improve the general health status of participants, particularly homebound elders. A comparison of the number of social contacts of congregate and home-delivered meal participants showed that nutrition program clients had significantly more social contacts than people who did not participate in the program.

Data from AoA's national surveys of elderly clients show that the Nutrition Services are effectively helping seniors to improve their nutritional intake and remain at home. For example, 73 percent of congregate and 85 percent of home-delivered meal recipients say they eat healthier meals due to the programs, and 58 percent of congregate and 93 percent of home-delivered meal recipients say that the meals enabled them to continue living in their own homes.[11] In addition, home-delivered meal and congregate meal participants had significantly better food energy intake, protein, vitamins A, B_6 & D, Riboflavin, Calcium, Phosphorous, Potassium, Magnesium and Zinc intakes compared to matched non-participant group of senior citizens.[12] Seniors with deficiencies of these nutrients can experience osteoporosis, night blindness, decreased resistance to infection, fatigue, vasodilatation, and other illnesses.

AoA's annual performance data further demonstrate that these programs are an efficient and effective means to help seniors remain healthy and independent in their homes and in the community. Ninety-one percent of home-delivered meal clients rate service as good to excellent (Outcome 2.9a). Also, the number of home-delivered meal recipients with severe disabilities (3+ ADL) totaled more than 342,000 in 2009. This level of disability is frequently associated with nursing home admission, and demonstrates the extreme frailty of a significant number of home-delivered meal clients. The most recent data on how these nutrition programs are helping seniors remain healthy and independent in their homes include:

- *Home-Delivered Nutrition Services* provided more than 145 million meals to nearly 870,000 individuals in FY 2010.

- *Congregate Nutrition Services* provided over 96 million meals to more than 1.7 million seniors in a variety of community settings in FY 2010.

[11] 2008 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.
[12] *Serving Elders at Risk – National Evaluation of the Elderly Nutrition Program, 1993-1995,* pp.117-118

Recovery Act Funding of Nutrition Services for Older Americans

The American Recovery and Reinvestment Act of 2009 (ARRA) empowered the U.S. Department of Health and Human Services to help boost the nation's economy, create or save jobs, maintain health care services, expand access to affordable health care, and protect and support those in greatest need. AoA distributed $100 million in ARRA funding to the national aging services network to help older Americans hardest hit by the economic downturn receive the right foods to help keep them healthy and active, and to assist those who may be too impaired to prepare nutritious meals for themselves. Without regular nutritious meals, the health of many older Americans declines; they become more susceptible to illness; their ability to manage their chronic diseases is reduced, and they may lose their ability to remain at home, independent in their community. The funds were expended in FY 2009 and FY 2010.

Of the $100 million in ARRA funding, $65 million was distributed by formula to 56 states and territories for congregate nutrition services provided at senior centers and other community sites and $32 million was distributed by formula to states and territories for the preparation and delivery of meals to frail elders in their homes. A total of $3 million was provided to 254 tribal organizations and two Native Hawaiian organizations. No ARRA funding was used to pay for AoA administrative costs associated with this activity. It is being used by the aging services network to augment existing resources, replace revenue lost from state, tribal, and local sources due to the economic downturn, and support the continued delivery of meals to vulnerable older Americans. As with funds provided through Title III OAA appropriations, states distributed funds to area agencies on aging or local providers, which coordinated the provision of meals to elderly individuals.

Given the economic downturn, the National Association of States United for Aging and Disabilities reported in FY 2009, that requests for community-based services for seniors increased, with about an 80 percent increase in requests for home-delivered meals and a 50% increase for congregate meals. Within this context, some examples of how senior nutrition service providers used ARRA funding to meet this increased demand for meals to homebound seniors are summarized below:

- Seminole County, FL reported having a long waiting list for home-delivered meals to homebound seniors. ARRA funds were used to serve prepare and deliver two meals per day to frail elderly clients who otherwise would have gone without proper nutrition and be at greater risk of entering a nursing facility
- Meals on Wheels of Syracuse, New York used ARRA funds to avoid what would have been their first ever waiting list for seniors in need in the area.
- In another county in NY, ARRA funding enabled the senior nutrition program to provide meals to 334 homebound elderly individuals, 59 of whom are over the age of 90.

Beginning in FY 2009, and continuing through the end of FY 2010, ARRA funding provided:

- 12,526,874 congregate meals to 729,690 individuals;
- 7,916,270 home-delivered meals to 33,791 individuals; and
- 408,436 home-delivered meals and 358,462 congregate meals to tribal and Native Hawaiian organizations.

Preventive Health Services

(Title III-D of OAA; FY 2010: $21,026,000)

Preventive Health Services, established in 1987, provides formula grants to states and territories, based on their share of the population aged 60 and over, to support activities that educate older adults about the importance of healthy lifestyles and promote healthy behaviors that can help to prevent or delay chronic disease and disability, thereby reducing the need for more costly medical interventions.

Due in large part to advances in public health and medical care, Americans are leading longer and more active lives. Average life expectancy has increased from less than 50 years at the turn of the 20^{th} century to almost 78 years today. On average an American turning age 65 today can expect to live an additional 18.6 years. The population of older Americans is also growing, particularly the population age 85 and over, which is growing very rapidly, from 5.8 million in 2010 to 8.7 million by the year 2030. One consequence of this increased longevity is the higher incidence of chronic diseases such as obesity, arthritis, diabetes, osteoporosis, or depression as well as the greater probability of injury from a fall, which quickly limits physical activity.

In recent years, states and territories have been statutorily required to use at least a portion of this funding for medication management, screening, and education activities, but otherwise have had flexibility to allocate resources among the preventive health activities of their choice to best meet local needs. Priority has been given to providing services to those elders living in medically underserved areas of the state or who have the greatest economic need. Services currently provided through the Preventive Health Service program include:

- *Information and Outreach*, including the distribution of information about healthy lifestyles and behaviors to seniors through Aging and Disability Resource Centers, area agencies on aging, senior centers, community parks and recreation programs, housing programs, faith-based organizations, chronic disease self-management programs, congregate meal sites, and the home-delivered meals program.

- *Health Screenings and Risk Assessments* for a variety of conditions, including hypertension, diabetes, dental issues, high cholesterol, and hearing and vision loss.

- *Evidence-based Prevention Programs*, as described below.

Over the last few years, some states have begun to shift their funding to provide greater support to evidence-based approaches, especially in helping individuals manage chronic diseases. Evidence-based programs are interventions that have been tested through randomized control trials and have been shown to be effective at helping participants adopt healthy behaviors, improve their health status, and reduce their use of hospital services and emergency room visits. Examples of evidence-based models include enhanced fitness, enhanced wellness, falls prevention, and Chronic Disease Self-Management Programs, all of which have been demonstrated to be especially effective and have shown the value of focusing dollars on proven interventions. AoA has encouraged states and the aging services network to adopt evidence-based prevention programs and more and more states are using these and other resources to do so. Some examples of evidence-based interventions are:

- *Enhanced fitness and enhanced wellness programs:* Enhanced fitness is a multi-component group exercise program designed for community-based organizations and intended to promote physical activity among older adults. Strength training using soft wrist and ankle weights; cardiovascular workouts using dancing, aerobics, or walking; and balance and posture exercises are used to increase the physical health of older adults. In addition, exercise has been proven to improve depression, which studies have shown that nearly 20 percent of U.S. adults 65 years and older experience.[13] Exercise may also act as a buffer against many illnesses impacted by stress.

- *Falls prevention:* Falls prevention programs teach participants to improve strength, balance, and mobility; provide education on how to avoid falls and reduce fall risk factors; involve medication reviews and modifications; provide referrals for medical care management for selected fall risk factors; and provide home hazard assessments of ways to reduce environmental hazards. Recent studies have shown that in the United States more than one-third of adults age 65 and over fall each year. Of those who fall, 20 to 30 percent will experience serious injuries, such as head trauma, broken bones, or hip fractures.[14] These injuries may limit the ability of older adults to get around or live independently. Those who are not injured may develop a fear of falling, which may increase their actual risk of falling. Many people limit their activity after a fall, which may reduce strength, physical fitness, and mobility.[15]

- *Medication management:* Medication management programs focus on reviewing the multitude of medications that older adults are prescribed, focusing especially on high-risk medications. These programs have been shown to reduce unnecessary duplication of prescriptions and cardiovascular problems. They have also been shown to improve medication usage rates and decrease medication errors among older adults.

- *Chronic disease self-management programs:* Older Americans are disproportionately affected by a vast array of chronic conditions, including diabetes, obesity, heart disease, cancer, arthritis, and depression, that collectively account for seven out of every ten deaths and contribute to more than three-quarters of all Medicare expenditures.[16]

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[13] Administration on Aging. (2001). *Older Adults and Mental Health: Issues and Opportunities.* Washington, DC: U.S. Department of Health and Human Services. Also, "*Mental Health: A Report to the Surgeon General,*" http://www.surgeongeneral.gov/library/mentalhealth/chapter5/sec1.html.

[14] Sterling DA, O'Connor JA, Bonadies J. Geriatric falls: injury severity is high and disproportionate to mechanism. Journal of Trauma–Injury, Infection and Critical Care 2001; 50(1):116–9.

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

[16] Deaths: Leading Causes for 2004. National Vital Statistics Report, V. 56, No. 5. Centers for Disease Control and Prevention. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_05.pdf . Accessed December 30, 2009. Follow the Money -- Controlling Expenditures by Improving Care for Patients Needing Costly Services. Bodenheimer, T., and Berry-Millett, R. New England Journal of Medicine. 15 October 2009.

Preventive Health Services have been carried out at multi-purpose senior centers, meal sites, and other community-based settings, as well as through individualized counseling and services for vulnerable elders. States reported 5.9 million seniors served in these health-related programs which received $16 million in additional funding from states and local entities.

Chronic Disease Self-Management Programs

Funding for the Chronic Disease Self-Management Program (CDSMP) is awarded in the form of competitive grants to states. External experts review project proposals, and project awards are made for periods of one to three years. In FY 2010, AoA funded 47 state grants for CDSMPs, with an average award of $574,468, using funding provided under the Recovery Act. CDSMP is a low-cost, evidence-based disease prevention model that utilizes state-of-the-art techniques to help those with chronic disease to manage their conditions, improve their health status, and reduce their need for more costly medical care. Older Americans are disproportionately affected by a vast array of chronic conditions (including diabetes, obesity, cancer, arthritis, and depression) that collectively account for seven out of every 10 deaths and more than three-quarters of all health expenditures.[17] Data show that as an individual's number of chronic conditions increases, there is a corresponding escalation in adverse outcomes including mortality, poor functional status, unnecessary hospitalizations, adverse drug events, duplicative tests, and conflicting medical advice, all of which lead to higher health costs and greater outlays for programs like Medicare and Medicaid. CDSMP is helping to reduce these adverse outcomes by empowering individuals, particularly those who have two or more chronic health conditions, to address issues related to the management and treatment of chronic disease.

CDSMP has been shown repeatedly through multiple studies (including randomized control experiments, with both English and Spanish speaking populations) to be effective at helping participants to adopt healthy behaviors, improve their health status and reduce their use of hospital stays and emergency room visits. The program has been shown to significantly improve participant health status, reduce the use of hospital care and physician services[18] as well as reduce health care costs.

CDSMP was developed by Stanford University and emphasizes a patient's role in managing his/her illness. The program consists of a series of workshops that are conducted once a week for two and a half hours over six weeks in community settings such as churches, libraries, YW/MCAs, senior centers, public housing projects, community health centers and cooperative extension programs. People with different chronic health problems attend together, and the workshops are facilitated by two leaders who are trained and certified by Stanford University, one or both of whom are non-health professionals or lay people with chronic diseases themselves. Topics covered include: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation; 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance; 3) appropriate use of medications; 4) communicating effectively with health professionals; and 5) nutrition.

[17] National Center for Chronic Disease Prevention and Promotion (NCCDPHP). Physical Activity and Good Nutrition: Essential Elements to Prevent Chronic Diseases and Obesity. Available at www.cdc.gov/nccdphp/aag/aag_dnpa.htm. Accessed September 14, 2004.

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

Since 2003, AoA has supported the deployment of CDSMP through the aging services network, in partnership with AHRQ, CDC, CMS, HRSA and over 30 private foundations. In the 2006 reauthorization of the OAA, Congress directed AoA to promote the nationwide implementation of evidence-based prevention programs through its network of community-based service provider organizations; and beginning in FY 2008, Congress appropriated funding specifically to support this initiative. AoA and its partners have invested over $50 million since 2003 in developing an infrastructure for delivering evidence-based programs at the community level. This infrastructure includes 1,200 community-based delivery sites, a national technical assistance center on evidence-based prevention programs for the elderly, a national CDSMP training and certification center at Stanford, local program training materials and guides, marketing materials, quality assurance mechanisms and fidelity protocols, and a variety of technologies, including an AHRQ sponsored Knowledge Transfer Program to support rapid diffusion. Over 12,000 individuals have participated in the CDSMP programs offered through this infrastructure.

Older Americans are disproportionately affected by a vast array of chronic diseases and conditions. Over 80 percent of adults 65 and over have at least one chronic condition, and roughly half suffer from two.[19] Nearly half of older adults have hypertension and roughly one in five has heart disease, with a similar proportion having some type of cancer.[20] The average 75-year old has three chronic conditions and takes 4.5 medications.[21] More than 65 percent of Americans aged 65 and over have some form of cardiovascular disease. One million adults age 75+ have diabetes, a number that is expected to grow to 4 million by 2050 if nothing is done to change current growth rates.[22] Minority elders – the fastest growing segment of the elderly population – are especially at risk of chronic illnesses and conditions. For example, among adults age 65+, 83 percent of Blacks had hypertension, compared to 69.97 percent of Whites;[23] and 27.8 percent of Hispanics have diabetes, compared to 17.5 percent of Whites.[24]

The Stanford University CDSMP represents the state-of-the-art in chronic disease self-management and is ideally suited for delivery through AoA's network of community based organizations, including senior centers, congregate meal programs, faith-based organizations and senior housing projects. Nationwide implementation will be accomplished at the community level by aging services provider organizations working in collaboration with public health agencies and health care providers. Participant referrals to the CDSMP program will come from both clinical and community-based organizations. Clinical referrals will come from community health centers, physicians, hospitals, managed care organizations, and other health system components. Community referrals will come from a variety of sources, including the Aging and Disability Resources Centers that are currently funded by HHS (AoA and CMS). ADRCs serve as community-level "one stop shop" entry points into long-term care for people of all ages who have chronic conditions.

[19] NCCDPHP. Healthy Aging: Preventing Disease and Improving Quality of Life Among Older Americans. Available at http://www.cdc.gov/nccdphp/aag/aag_aging.htm. Accessed September 14, 2004.
[20] Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, National Health Interview Survey, 2000-2001.
[21] Alliance for Aging Research. Ten Reasons Why America Is Not Ready for the Coming Aging Boom. 2002.
[22] NCCDPHP. Available at http://www.cdc.gov/nccdphp/bb_aging/index.htm. Accessed September 14, 2004.
[23] National Health and Nutrition Examination Survey, NHANES 2005-2008.
[24] National Health Interview Survey, NHIS 2010.

Caregiver Services

Families and other informal caregivers are the nation's primary provider of long-term care. On a daily basis, these individuals assist relatives and other loved ones with tasks ranging from assisting with personal care and homemaking to more complex health-related interventions like medication administration and wound care. The availability of a skilled caregiver – whether an informal caregiver, a paraprofessional worker or an unrelated volunteer – all too often determines whether an individual remains independent or is admitted to a nursing home. Research has shown that caregiving exacts a heavy emotional, physical, and financial toll. As reported in AoA's 2009 National Survey of Older Americans Act (OAA) Participants, 25 percent of caregivers are assisting two or more individuals. Sixty-five percent of Title III caregivers are 60 or older, making them more vulnerable to a decline in their own health, and nearly one-third describe their own health as fair to poor.[25] Caregivers also suffer from higher rates of depression than non-caregivers of the same age, and research indicates that caregivers suffer a mortality rate that is 63 percent higher than non-caregivers.[26] The demands of caregiving can lead to a breakdown of the caregiver's health, and the illness, hospitalization, or death of a caregiver increases the risk for institutionalization of the care recipient.

Better support for caregivers is critical since often it is their availability – whether they are informal family caregivers, paraprofessionals or unrelated friends and neighbors who volunteer their time – that determines whether an older person can remain in his or her home. In 2004, approximately 43.5 million adult caregivers provided uncompensated care to those 50 years of age and older.[27] The economic value of replacing unpaid caregiving in 2009 was estimated to be about $450 billion, an increase from $375 billion in 2007 (cost if that care had to be replaced with paid services).[28]

Providing support that makes caregiving easier for family caregivers, such as information, counseling and training, respite care, or supplemental services, is critical to sustaining caregivers' ability to continue in that role. Eighty-three percent of the caregivers served by AoA programs report that AoA services allow them to provide care longer than they otherwise could.[29]

At the same time, AoA recognizes that it must also address the growing need for more caregivers every day. By 2015, AoA projects that there will be 13.2 million non-institutionalized seniors age 65 and over with one or more ADL deficits, an increase of more than 2 million seniors or 21 percent since 2010, needing caregiver assistance.[30]

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[25] 2009 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

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

[27] National Alliance for Caregiving and AARP. Caregiving in the U.S.: A Focused Look at Those Caring for the 50+. 2009. <http://www.caregiving.org/pdf/research/FINALRegularExSum50plus.pdf>

[28] Feinberg L, Reinhard S.C., Houser A, Choula, R., Valuing the Invaluable: 2011 Update The Growing Contributions and Costs of Family Caregiving**.** (Washington, D.C.: AARP Public Policy Institute, July 1011). Available from: http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf .

[29] 2009 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

[30] Data extrapolated by AoA from U.S. Census Bureau, "2008 National Population Projections," released August 2008, <http://www.census.gov/population/www/projections/2008projections.html> and Health Data Interactive,

As a group, these programs support caregivers and elders by providing critical respite care and other support services for family caregivers, training and recruitment of care workers and volunteers, information and outreach, counseling, and other supplemental services.

National Family Caregiver Support Program

(Title III-E of OAA; FY 2010: $154,197,000)

The National Family Caregiver Support Program provides grants to states and territories, based on their share of the population age 70 and over, to fund a range of supports that assist family and informal caregivers to care for their loved ones at home for as long as possible. The program includes basic system components: information, access assistance, caregiver education, training and support groups, respite care, and supplemental services. These services work in conjunction with Health and Independence Services, such as transportation services, homemaker services, home-delivered meals, and adult day care, to provide a coordinated set of supports for seniors that caregivers can access on their behalf.

Family Caregiver Support Services provide a variety of supports to family and informal caregivers. In FY 2010, services provided include:

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

- *Counseling and Training Services* provided nearly 125,000 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving).

- *Respite Care Services* provided more than 64,000 caregivers with 6.8 million hours of temporary relief – at home, or in an adult day care or nursing home setting – from their caregiving responsibilities.

Studies have shown that these types of supports can reduce caregiver depression, anxiety, and stress and enable them to provide care longer, thereby avoiding or delaying the need for costly institutional care for their loved ones. A study, *Intervention to Delay Nursing Home Placement of Patients with Alzheimer's Disease*, indicates that counseling and support for caregivers of individuals with Alzheimer's disease can permit the care recipient to stay at home, at significantly less cost, for an additional year before being admitted to a nursing home.

National Center on Health Statistics, Centers for Disease Control and Prevention, "Functional limitations among Medicare beneficiaries, ages 65+: US, 1992-2008." www.cdc.gov/nchs/hdi.htm. Accessed 02 August 2011.

Additionally, data from AoA's national surveys of caregivers of elderly clients also shows that OAA services, including those provided through Family Caregiver Support Services, are effective in helping caregivers keep their loved ones at home. Approximately 83 percent of caregivers of program clients reported in 2009 that services enabled them to provide care longer than otherwise would have been possible.[31] Caregivers receiving services were also asked whether the care recipient would have been able to live in the same residence if the services had not been available. Nearly half the caregivers of nursing home eligible care recipients indicated that the care recipient would be unable to remain at home without the support services. Those respondents were then asked to identify where the care recipient would be living without services. A significant majority of those caregivers, 70 percent, indicated that the care recipient would most likely be living in a nursing home or assisted living.

Lifespan Respite Care

(FY 2010: $2,500,000)

Established under Title XXIX of the Public Health Service Act, 42 U.S.C. 201, the Administration on Aging began implementation of the Lifespan Respite Care Program in FY 2009 and those activities continued into FY 2010. Throughout the program development process, AoA has carefully considered the requirements of the Lifespan Respite Care Act as well as Congressional intent as specified in the Committee Report accompanying the authorizing statute.

To help ensure that state agencies and Aging and Disability Resource Centers use the funds to serve all age and disability groups, AoA employed the following strategies in FY 2010:

First, applications from eligible state agencies are minimally required to:

1. Demonstrate the support and active involvement of a range of government and non-government, private, nonprofit and other organizations with a stake in serving all populations eligible to receive services under the Lifespan Respite Care Act;

2. Demonstrate thorough understanding of the population to be served, including knowledge of the family caregiver population for whom lifespan respite program services are to be provided, or for whom respite care workers and volunteers will be recruited and trained;

3. Demonstrate a meaningful and active inclusion of the state's Respite Coalition or organization to ensure statewide implementation of lifespan respite programs across all age and disability categories; and

4. Demonstrate the broadest possible collaboration with relevant respite stakeholders from across the age and disability spectrum. Further, applicants must develop programs that immediately address the respite needs of caregivers assisting care recipients of all ages and special needs categories. No phase-in or preferences for age groups or disability categories are permitted.

[31] 2009 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

Second, grantees are being monitored via semi-annual and annual reports as well as through ongoing communication with the AoA program officer to ensure the required elements outlined above are being fulfilled. Additionally, AoA facilitates regular email and telephone communications with the individual grantees and the group to share information and strategies related to program development and implementation.

Finally, AoA recognizes the necessity of providing technical assistance (TA) to the grantees as well as states yet to be funded under the Lifespan Respite Program. To that end, AoA has a Cooperative Agreement with the Family Caregiver Alliance in San Francisco with a sub-contract to the ARCH National Respite Network and Resource Center (ARCH) to design and disseminate training materials and TA on a range of issues associated with Lifespan Respite Care Program development and implementation.

During the first year of funded TA, ARCH assessed grantee training and TA needs, conducted individual consultations via phone, email and in person with each of the grantees to identify specific training needs and to address specific program development issues. Additionally, ARCH has developed and archived webinars on Lifespan Respite programs, the importance of collaboration, and working with faith-based communities to develop respite programs. ARCH has developed and/or updated numerous fact sheets and publications on a range of issues of interest to grantees as they develop their programs.

The Lifespan Respite Care program provides grants to eligible state organizations to improve the quality and access of respite care for family caregivers of children or adults of any age with special needs while promoting the statewide dissemination and coordination of community-based respite care services. Respite care services are highly valued by caregivers. In the most recent National Survey of Older Americans Act service recipients a random sample of 1,795 caregivers (which represented over 223,626 active caregivers) answered questions about the impact of the caregiver program. Eighty-four percent of caregivers received respite care within the past twelve months. The respite care service recipients reported that as a result of the services they received:

- 77 percent had less stress;
- 81 percent said it was easier to care for their loved one;
- 59 percent reported they now know more about caring for their loved one’s condition;
- 77 percent reported that it was the most helpful service they received;
- 95 percent reported the care recipient benefited from the service; and
- 82 percent said that the services enabled them to care longer.

The activities funded by the Lifespan Respite Care program help to address this growing need, providing respite care services for family caregivers, training and recruitment of respite care workers and volunteers, information and outreach, access assistance, and program development.

The program also supports a grant to establish a National Lifespan Respite Resource Center to maintain a national database on lifespan respite care; provide training and technical assistance to state, community, and nonprofit respite care programs; and provide information, referral, and education programs to the public on lifespan respite care.

Grants for Lifespan Respite Care are awarded to eligible state organizations with a 25 percent matching requirement. Eligible state agencies include any of the following: the state agency that administers the state's OAA programs, the state's Medicaid program under Title XIX of the Social Security Act; or any other state-level agency designated by the governor. Additionally, the eligible state agency must work in collaboration with Aging and Disability Resource Centers and a public or private non-profit statewide respite care coalition or organization. Priority consideration is given to applicants who demonstrate the greatest likelihood of implementing or enhancing lifespan respite care statewide and who are building or improving the capacity of their long-term care systems to respond to the comprehensive needs of care recipients.

The first grants for the program were awarded in FY 2009 to twelve recipients for up to $200,000 for three-year project periods.

According to a November 2009 study by the National Alliance for Caregiving, of six national policies or programs presented to caregivers as potential ways to help them, 26 percent of respondents ranked respite services as either their first or second most preferred option.[32] By providing opportunities for family caregivers to receive the much needed short-term relief from caring for their loved ones, the Lifespan Respite Care program helps to sustain family caregiver health and well-being, reduces the likelihood of abuse and neglect, and allows care recipients to remain in their own homes for as long as possible.

States providing Lifespan Respite Care will, at a minimum:

- Expand and enhance respite care services to family members;
- Improve the statewide dissemination and coordination of respite care; and
- Provide, supplement, or improve access and quality of respite care services to family caregivers, thereby reducing family caregiver strain.

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[32] National Alliance for Caregiving and AARP. Caregiving in the U.S. Bethesda: National Alliance for Caregiving, and Washington, DC: AARP, 2009.

Alzheimer's Disease Supportive Services Program

(FY 2010: $11,462,000)

Established under Section 398 of the Public Health Services Act, as amended, (42 U.S.C. 280c-3), the Alzheimer's Disease Supportive Services Program (ADSSP) funds competitive grants for states to expand the availability of diagnostic and support services that help persons with Alzheimer's and dementia and the family members who care for them. A critical focus of these grants is to support the family caregivers who provide countless hours of unpaid care, thereby enabling their family members with Alzheimer's and dementia to continue living in the community. In order to maintain the quality of life of the caregiver and their family members, the ADSSP provides respite care, personal care, counseling, and informational assistance, using proven and innovative direct care practices and enhances the responsiveness and readiness of the home and community-based care system by improving service coordination and educating service providers about proven dementia care strategies.

ADSSP grants enable states to develop service and outreach programs that are specific to state needs and resources. The primary components of the ADSSP program include:

- Delivering supportive services including respite care, home health care, personal care, adult day care, and companion services to assist caregivers, families, and persons with Alzheimer's disease.

- Translating and replicating evidence-based interventions for dementia caregivers at the community level.

- Incorporating evidence-based research in the formulation of innovative projects and advancing changes to a state's overall system of home and community-based care.

- Providing individualized and public information, education, and referrals about diagnostic, treatment and related services; sources of assistance for services; and legal rights of people affected by Alzheimer's disease.

- Linking public and non-profit agencies that develop and operate respite care and other community-based supports, educational, and diagnostic services within the state to people who need services.

In 2008, a programmatic review was performed to determine the future direction of the program and how to enhance the program's operation and results. As a result of this review, AoA issued two grant funding opportunities in FY 2009 reflecting the new directions of the ADSSP that encourage states to 1) translate and replicate evidence-based interventions for people with dementia and their caregivers; and 2) develop or expand innovative service models for people with dementia and their caregivers, including a focus to expand services available to people in the early stages of dementia and to provide chronic care management.

In FY 2010, 32 cooperative agreements were awarded to 22 states, the District of Columbia and Puerto Rico to deliver evidence-based and innovative care coordination for persons with Alzheimer's disease and their families through the aging services network, community-based organizations, and partnerships with institutions of higher education. In particular, AoA awarded innovation grants for supportive services that enable individuals with Alzheimer's disease to remain in the community longer, promote early intervention and chronic care management, and enhance the ability of state systems to provide effective and cost-efficient supportive services for persons with Alzheimer's disease and their families. A key focus of the evaluation criteria for awarding Alzheimer's disease supportive services grants is reaching underserved and culturally-diverse populations.

In FY 2010, the ADSSP funded 32 cooperative agreements with an average award of $321,625 and a range of grant awards from $163,393 to $500,000. Through these grant projects, seven states are in the process of translating four evidence-based interventions into practice and nine states are offering innovative programming for caregivers and their loved ones with dementia. One example of these promising interventions is a spousal caregiver support program in New York City that, in a randomized-controlled trial, delayed institutionalization of persons with dementia by an average of 557 days.[33] In 2009, the average nursing home cost was $219 daily ($79,935 annually), which would mean an average savings of nearly $122,000 in institutional costs per person with dementia.[34] Minnesota is translating this intervention now; early results indicate that the project is achieving the outcomes that were found in the original study. Other FY 2010 grant projects focus on innovations in areas of great need, such as programs to identify and provide appropriate services for persons in the earliest stages of Alzheimer's disease. Overall, these demonstrations offer direct services and other supports to thousands of families, as well as support the continuous quality improvement and evaluation of these services.

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

[34] Metlife. (October 2009), **"**MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs", p. 4, Accessed August 17, 2010 from: http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf

FY 2010 National Program Services Summary Report [35]

	FY 2010
Total Clients	10,797,126
Total Registered Clients	2,978,385
% Minority Clients	24.81%
% Rural Clients	36.73%
% Clients Below Poverty	30.07%
# Senior Centers	11,401 (6,399 receive OAA funding)

Service	Persons Served	Units of Service[36]	Title III Expenditure	Total Expenditure
Personal Care	106,095	18,567,017	$16,094,289	$268,814,128
Homemaker	148,807	15,514,357	$28,878,723	$239,360,807
Chore	37,157	1,053,129	$5,974,725	$19,250,738
Home Delivered	868,076	145,454,444	$243,784,239	$776,792,256
Adult Day Care	20,724	10,269,894	$11,368,697	$86,194,921
Case Mgt.	464,491	4,123,835	$25,472,434	$276,843,452
Assisted Trans.	39,763	1,483,816	$4,452,178	$15,354,827
Congregate	1,733,176	96,426,593	$278,662,972	$639,881,574
Nutrition Counseling	25,739	48,422	$1,273,874	$2,711,607
Transportation		25,852,102	$69,133,540	$201,567,259
Legal Assistance		971,390	$26,179,732	$49,052,445
Nutr. Education		2,485,902	$5,198,889	$8,416,508
I&A		13,278,507	$56,766,621	$152,829,355
Outreach		3,238,615	$10,653,616	$25,021,294
Other			$93,518,560	$694,773,360

[35] Data from AoA's FY 2010 State Program Report are preliminary and should not be taken as final.

[36] Service Units Definitions:
Personal Care = 1 Hour
Homemaker = 1 Hour
Chore = 1 Hour
Home-Delivered Meal = 1 Meal.
Adult Day Care/Adult Day Health = 1 Hour
Case Management = 1 Hour
Assisted Transportation = 1 One Way Trip
Congregate Meal = 1 Meal
Nutrition Counseling = 1 session per participant
Transportation = 1 One Way Trip
Legal Assistance = 1 hour
Nutrition Education = 1 session per participant
Information and Assistance = 1 Contact

Caregivers Serving Elderly Individuals

Service	Caregivers Served	Service Units[37]	Title III Expenditure	Total Expenditure
Counseling, Support Groups, Training	124,690	429,130	$17,460,661	$24,797,942
Respite	64,131	6,826,578	$53,964,324	$88,939,076
Supplemental Services	31,371	1,182,663	$12,384,496	$17,898,591
Access Assistance	498,065	1,096,845	$29,323,825	$47,291,668
Unduplicated Caregivers Provided Service or Access	681,626			

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

Part II: Older American Indians, Alaska Natives and Native Hawaiians

(Title VI of OAA; FY 2010: $27,704,000)

Native American Nutrition and Supportive Services provides grants to eligible tribal organizations to promote the delivery of nutrition and home and community-based supportive services to Native American, Alaskan Native, and Native Hawaiian elders. According to the 2009 American Community Survey, approximately 301,000 persons age 60 and over identified themselves as Native Americans or Alaskan Natives, and another 242,000 persons age 60 and over identified themselves as part Native Americans or Alaskan Natives.

Native American Nutrition and Supportive Services grants fund a broad range of services to older Native Americans, including adult day care, transportation, congregate and home-delivered meals, information and referral, personal care, chore, and other supportive services. Currently, AoA's congregate meal program reaches 32 percent of eligible Native American seniors in participating tribal organizations, home-delivered meals reach 14 percent of such persons, and supportive services reach 52 percent of such persons. These programs, which help to reduce the need for costly nursing home care and medical interventions, are responsive to the cultural diversity of Native American communities and represent an important part of each community's comprehensive services.

Services provided by this program in FY 2009, the most recent available data, include:

- *Transportation Services* provided nearly one million rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical daily activities.

- *Home-Delivered Nutrition Services* nearly 2.5 million meals to nearly 20,500 homebound Native American elders, as well as critical social contacts that help to reduce the risk of depression and isolation experienced by many home-bound elders.

- *Congregate Nutrition Services* provided 2.1 million meals to more than 45,900 Native American elders in community-based settings, as well as an opportunity for elders to socialize and participate in a variety of activities, including cultural and wellness programs.

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

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

Eligible tribal organizations receive nutrition and supportive services formula grants based on their share of the American Indian, Alaskan Native, and Native Hawaiian population age 60 and over. Tribal organizations must represent at least 50 Native American elders age 60 and over to receive funding. There is no requirement for matching funds. In addition, Tribes may decide the age at which a member is considered an elder and thus eligible for services. In FY 2010, grants were awarded to 246 Tribal organizations (representing 400 Tribes), including two organizations serving Native Hawaiian elders, with an average award of $109,499 and a range of grant awards from $76,160 to $1,505,000.

Native American Caregiver Support Services
(FY 2010: $6,388,000)

Native American Caregiver Supportive Services provide grants to eligible tribal organizations to provide support for family and informal caregivers of Native American, Alaskan Native and Native Hawaiian elders. These programs, which help to reduce the need for costly nursing home care and medical interventions, are responsive to the cultural diversity of Native American communities and represent an important part of each community's comprehensive services.

Formula grants for the Native Americans Caregiver Supportive Services programs are allocated to eligible tribal organizations based on their share of the American Indian, Alaskan Native, and Native Hawaiian population aged 60 and over. Tribal organizations must represent at least 50 Native American elders age 60 and over to receive funding. There is no requirement for matching funds. Tribes may also decide the age at which a member is considered an elder and thus eligible for services. In addition, there is no limit on the percentage of funds that can be used for services to grandparents caring for grandchildren. In FY 2010, grants for Caregiver Support Services were awarded to 204 tribal organizations, including one organization serving Native Hawaiian elders, with an average award of $31,240 and a range of grant awards from $14,410 to $58,837.

Grants assist American Indian, Alaskan Native and Native Hawaiian families caring for older relatives with chronic illness or disability and grandparents caring for grandchildren. The program provides a variety of direct services that meet a range of caregiver needs, including information and outreach, access assistance, individual counseling, support groups and training, respite care, and other supplemental services. Tribal organizations coordinate with other programs, including the Volunteers In Service To America (VISTA) program, to help support and create sustainable caregiver programs in Native American communities (many of which are geographically isolated). A core value of the Native American Caregiver Support Services, as expressed by tribal leaders, is that the program should not replace the tradition of families caring for their elders. Rather, it provides support that strengthens the family caregiver role.

In the 2000 Census, approximately 213,000 persons age 60 and over identified themselves as American Indians or Alaskan Natives, and another 182,000 persons age 60 and over identified themselves as part American Indians or Alaskan Natives. Caregiver support services will help Native American elders, many of whom have limitations in activities of daily living that make it difficult to care for themselves, to remain at home, in the community, or on the reservation, which is what they prefer. Studies have shown that providing assistance to caregivers can help them cope with the emotional, physical and financial toll associated with caregiving, thereby enabling them to provide care for their loved ones longer and avoid or delay the need for costly nursing home care.

Part III: Protection of Vulnerable Adults

(Title VII of OAA; FY 2010: $39,200,000)

As the population of older Americans age 60 and older increases, the problem of elder abuse, neglect, and exploitation continues to grow. While there is no single set of national elder abuse prevalence data, the number of reported cases of elder abuse, neglect, and exploitation are on the rise. A 2004 national survey of state Adult Protective Services (APS) programs conducted by AoA's National Center on Elder Abuse showed a 16 percent increase in the number of elder abuse cases from an identical study conducted in 2000.[38] According to a 1998 national incidence study (the only such study ever conducted), 84 percent of all elder abuse incidents go unreported, meaning that for every reported case of abuse there are over five that go unreported.[39] Together, these data suggest that a minimum of 2.5 million elders are abused, neglected, and/or exploited annually.

The negative effects of abuse, neglect, and exploitation on the health and independence of seniors is extensive. Research has demonstrated that older victims of even modest forms of abuse have dramatically higher (300 percent) morbidity and mortality rates than non-abused older people.[40] Additional adverse health impacts include an increased likelihood of heart attacks, dementia, depression, chronic diseases and psychological distress. The result of these unnecessary health problems is a growing number of seniors who access the healthcare system more frequently (including emergency room visits and hospital admissions), and are ultimately forced to leave their homes and communities prematurely.[41]

Protection of Vulnerable Adults programs address this problem through a full array of services designed to prevent, detect, and respond to elder abuse, neglect, and exploitation. The focus of these programs and activities is to expand and improve the protection of individuals living in their communities and in long-term care settings; increase the information and technical assistance available to the public, states, and localities in preventing and addressing abuse; protect the rights of older adults and prevent their exploitation; reduce health-care fraud and abuse; and provide assistance to tribes in developing elder justice systems. This multifaceted approach to preventing, detecting, and resolving elder abuse, neglect, and exploitation is essential to successfully fulfilling the shared mission of the Older Americans Act and the Elder Justice Act to maintain the health and independence of older Americans and adults with disabilities.

[38] Teaster, Pamela, et al. *The 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older*. http://www.ncea.aoa.gov/NCEAroot/Main_Site/pdf/2-14-06%20FINAL%2060+REPORT.pdf

[39] Tatara, Toshio, et al. *The National Elder Abuse Incidence Study Final Report*. 1998. http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Elder_Abuse/docs/ABuseReport_Full.pdf

[40] Lachs, M.S., Williams, C.S., O'Brien, S., Pillemer, K.A., & Charlson, M.E. (1998). "The Mortality of Elder Mistreatment." JAMA. 280: 428-432. and Baker, M.W. (2007). "Elder Mistreatment: Risk, Vulnerability, and Early Mortality." Journal of the American Psychiatric Nurses Association, Vol. 12, No. 6, 313-321.

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

Prevention of Elder Abuse and Neglect

The Prevention of Elder Abuse and Neglect program provides state formula grants for training and education, promoting public awareness of elder abuse, and supports state and local elder abuse prevention coalitions and multi-disciplinary teams. These activities are important elements of AoA's enhanced focus in FY 2012 on elder justice. The program coordinates activities with state and local adult protective services programs (over half of which are directly administered by state units on aging) and other professionals who work to address issues of elder abuse and elder justice. The importance of these services at the state and local level is demonstrated by the fact that states significantly leverage OAA funds to obtain other funding for these activities, including Social Services Block Grant and state general funds. In FY 2010, over $35 million of the Elder Abuse Prevention services expenditures came from non-OAA funds, a ratio of approximately $7 of non-OAA funds for every $1 investment of AoA funds.

Examples of state elder abuse prevention activities include:

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

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

- The Wisconsin Bureau of Aging and Disability Resources developed, in collaboration with the National Clearinghouse on Later Life, information designed to raise awareness of caregivers who have experienced abuse in the family, as well as of the risks and signs of abuse in later life, or "domestic violence grown old." The information was distributed statewide and is available at http://dhfs.wisconsin.gov/aps/Publications/publications.htm.

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

Model Approaches to Statewide Legal Assistance Systems

The Model Approaches to Statewide Legal Assistance Systems (Model Approaches) demonstration grants represent an innovative departure from AoA's past approach to the funding of Senior Legal Helplines (SLH). The total budget for Model Approaches is $1,974,000. Thirty-one states have been awarded grants. Model Approaches seeks to address the nationwide challenge of what are often fragmented and inefficient legal service delivery systems that fail to achieve optimal access to quality service for older adults most in need. Model Approaches helps states develop and implement cost-effective, replicable approaches for integrating SLHs into the broader spectrum of state legal service delivery networks. Ultimately, legal assistance provided through well integrated and cost-effective service delivery systems as demonstrated through Model Approaches directly impacts the ability of seniors most in need to remain independent, healthy, and financially secure in their homes and communities.

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

In addition, by ensuring strong leadership at the state level, Model Approaches projects have created important linkages between the existing legal assistance community and the broader community-based aging and elder rights networks, including AAAs, Aging and Disability Resource Centers, State Long-Term Care Ombudsmen, and Adult Protective Services.

As a centerpiece of the Model Approaches projects, SLHs assist seniors in accessing quality legal services to ensure their rights and enhance their independence and financial security. In 2010, Model Approaches projects assisted 47,903 older consumers in the most social or economic need on a wide range of priority legal issues related to public benefits, health care, housing, advance planning, and consumer protection. Some examples of the success of SLHs' experience in assisting seniors include:

- An elderly man and his wife who were facing foreclosure contacted a Helpline for assistance. The couple had resided in their home for over 30 years and never had difficulty paying property taxes until they had to stop working due to declining health. A tax lien was placed on the property, and the couple faced automatic foreclosure because they were unable to pay the outstanding taxes. A Helpline attorney researched the tax abatement statute and discovered that the town had failed to comply with relevant law. Upon a review, the town granted a total abatement of the property taxes. As a result, the elderly man and his wife were able to remain in their home.

- A Helpline assisted an elderly woman in her 90s who had significant medical expenses. It appeared that she could be eligible for more benefits than she was receiving. After involving the Medicare Part D Appeals Unit, it was discovered that she was receiving far fewer benefits than she was entitled to receive. With a helpline attorney's assistance, the elderly client was able to recover more than $3,000 in a lump sum payment from the State and secured her ongoing benefits. The added benefits included nearly $100.00 a month in her Social Security check. In addition, she no longer has to pay a Medicare Part D premium and now pays nothing for her generic medications.

In addition to providing assistance on priority legal issues, SLHs under Model Approaches have been very successful in reaching low income populations with 64 percent of older clients having incomes at or below 200 percent of the federal poverty guidelines. Also, minority clients receiving assistance through SLHs in the last reporting period constituted 33 percent of all clients served. These figures illustrate the effectiveness of Model Approaches states in reaching key target populations under the Older Americans Act with much needed "priority" legal assistance.

An important purpose of the Model Approaches demonstrations is to position SLHs as coordinated and essential components of high quality and high impact legal service delivery systems that effectively target scarce resources to older persons most in need. Model Approaches partners across the country recognize the enormous value of the network relationships that have been forged in pursuit of essential project goals and objectives. Early indications show that some Model Approaches states (despite highly adverse economic conditions) are already beginning to adopt SLHs as permanent and essential components of their legal and aging service delivery systems. Key examples have emerged in North Dakota, Nevada, and Iowa, illustrating the sustainability of these projects beyond the demonstration period.

Other legal service delivery system outcomes achieved in FY 2010 and anticipated for all Model Approaches projects include:

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

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

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

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

A key example of legal service delivery systems enhancements resulting from Model Approaches projects emerged from the State of Florida, a 2007 grant recipient. Over the three-year project period, the state of Florida integrated its SLH and Title III-B legal services with the pro bono legal services network and pro se resources; developed statewide standards that will ensure consistent levels of quality among and between legal service providers; and established a meaningful statewide reporting system to capture data needed to improve efficiency and maximize resources.

National Legal Assistance and Support Projects

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

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

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

In FY 2010, economic circumstances gave rise to a host of legal challenges for older consumers and the legal providers who serve them. In response to an increasing demand for legal resource support, the NLRC provided training and case consultation to over 6,493 aging and legal service professionals nationwide. In addition, NLRC partners provided important technical support in the implementation of the Model Approaches projects in 18 states, featuring the provision of expertise in legal needs and capacity assessments, effective targeting and outreach methodologies, SLH operations, statewide reporting systems, and legal service delivery standards.

An essential foundational premise of the NLRC is that the combined efforts of several partnering organizations with high levels of subject matter expertise is required to achieve its broad resource support objectives. Through effective collaborations, interlocking work plans, and the leveraging of organizational resources, NLRC partners have demonstrated the ability to achieve effective national coverage. In FY 2010, 100 percent of professionals responding to surveys rated the quality and usefulness of the support service provided by the NLRC as either good or excellent.

In addition, the NLRC website continues to serve as a single entry point into a national legal assistance support system providing high quality resources and expertise on a broad range of legal and systems development issues: http://www.nlrc.gov The NLRC website received 1,181,909 hits in the first 12 months of operation.

Pension Counseling and Information Program

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

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

Benefits from employer-sponsored pensions and retirement savings plans are as critical today to the retirement security of Americans as they were when the pension counseling program was first established. The pension questions which people face are just as complex, and good help is just as hard to find – even more so for those with only modest benefits at stake. The role of the Pension Counseling and Information Program is to help ensure that all older Americans have access to the help they need in order to access the employer-sponsored retirement benefits they have earned --- benefits that are critical to their ability to live independently and with dignity after a lifetime of productive employment. The Pension Counseling & Information Program provides help that would be otherwise unavailable, by assisting individuals in understanding and exercising their pension rights. The program promotes the financial security of older individuals by offering them the help they need to receive the pension benefits they have earned. The income, in turn, provides increased opportunities for choice and independence.

AoA currently funds six regional counseling projects covering 29 states and a technical assistance resource center to assist older Americans in accessing information about their retirement benefits and to help them negotiate with former employers or pension plans for due compensation. Data for the program shows that since the Program's inception in 1993, the Pension Counseling projects have recovered close to $120 million in retirement benefits for individual claimants, representing a return of more than $5.50 for every Federal dollar invested in the program. These recoveries demonstrate that pension counseling is not only necessary, but that it can be provided efficiently and effectively.

For example, during a six-month reporting period in FY 2010, a single regional counseling project recovered over $1,200,000 in benefits (lump-sum benefits totaling $210,738, and monthly benefits with an actuarial value of $992,273). One 78-year old woman with limited English proficiency, and an annual income of under $20,000, contacted the project when her claim for survivor's benefits under her late husband's pension plan was denied. The project was able to obtain evidence that the husband had not been properly credited for all of his time in union work and, as a result, his widow will receive an ongoing benefit of $160 per month for her lifetime, in addition to a retroactive payment of $15,000.

This case underscores the significance of the Pension Counseling & Information Program. While the client had a legitimate claim to this benefit, she required assistance with the claims appeal process. Due to the complexity of the matter and the small benefit amount at stake, it is extremely unlikely that she would have been able to pursue the case on her own, or find a private attorney to handle it. Without the project's assistance, she may well have been deprived of the lifetime retirement benefit her late husband had earned. The additional $160 per month, though modest, will make a significant contribution to her financial security and independence.

Even when Pension Counseling projects are unable to secure benefits for clients, the information and assistance the projects provide can bring peace of mind to vulnerable elderly individuals, often after months or even years of searching for answers.

A critical component of the AoA Program is the National Pension Assistance Resource Center (the Center) which provides substantive training and back-up services to the counseling projects, SUAs, AAAs, and legal services providers. In addition to providing pension assistance to individuals in states not currently served by AoA's pension counseling projects, in FY 2010, the Center increased its focus on development of a comprehensive, nationwide dataset of pension-related information and assistance resources, providing nationwide information and referral services to consumers, legal and aging services providers and others free of charge.

Senior Medicare Patrol Program

The Senior Medicare Patrol (SMP) program provides competitive grants to 54 States and Territories to support a national volunteer-based network for the purposes of preventing and identifying healthcare fraud and abuse. As a program of growing importance to the Department's ongoing fraud prevention activities in conjunction with the Patient Protection and Affordable Care Act (P.L. 111-148).

The SMP program serves a unique role in the Department's fight to identify and prevent healthcare fraud in the Medicare and Medicaid programs. Projects use the skills of retired professionals as volunteers to conduct community outreach and education and provide toolkits that empower beneficiaries and their families to recognize and report suspected cases of Medicare and Medicaid fraud. Activities are carried out in partnership with the Centers for Medicare & Medicaid Services, the Office of Inspector General (OIG), healthcare providers, and other aging and elder rights professionals from around the country.

OIG collects performance data from the SMP projects semiannually. The most recent report, dated May 06, 2011, documented the following program outputs and outcomes for the calendar year 2010. Data show SMP projects:

- Maintained 4,964 active volunteers who worked 129,662 hours to educate beneficiaries about how to prevent Medicare and Medicaid fraud;

- Educated 298,097 beneficiaries in 8,300 group education sessions and held 70,789 one-on-one counseling sessions;

- Conducted 6,231 community outreach education events;

- Received 91,094 inquiries for information or assistance from beneficiaries and resolved 87,951 inquiries;

- Resolved or referred for further investigation 2,583 complaints of potential fraud, error, or abuse from beneficiaries, their families, or caregivers as a result of educational efforts; and

In addition, the OIG reports that since the program's inception 13 years ago, SMP projects have:

- Educated 3,098,309 million beneficiaries in 82,968 group education sessions and held 1,112,887 one-on-one counseling sessions;

- Conducted 75,062 community outreach education events; and

- Documented $105,975,979 million in savings, including Medicare and Medicaid funds recovered, beneficiary savings, and other savings as directly attributable to the project as a result of beneficiary complaints. This does not attempt to quantify the savings that may occur as a result of SMP program's impact on fraud deterrence, which are believed to be substantial.

Healthcare Fraud and Abuse Control (HCFAC) Funds:
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created the Health Care Fraud and Abuse Control (HCFAC) Program to combat fraud and abuse in health care. Under HIPAA, recoveries from health care investigations are set aside in the Medicare Trust Fund and distributed at the joint discretion of the Secretary and Attorney General to finance anti-fraud activities. The SMP program historically has been supported by about $3.2 million in HCFAC funding for infrastructure, technical assistance, and other SMP program support and capacity-building activities designed to enhance program effectiveness. This includes support for project training and technical assistance provided by AoA's National Consumer Technical Resource Center (Center). The Center's website is maintained as a comprehensive "one stop" resource that contains information including current fraud alerts and consumer information, an SMP program locator, and the latest best practices information.

In the past year, the critically important role of the SMP program was recognized by partners in Medicare fraud prevention in the private and public sectors. First, the Centers for Medicare & Medicaid Services (CMS) announced the award of $9 million in grants to help more than 50 Senior Medicare Patrol (SMP) programs fight Medicare fraud. This action by CMS is in support of President Obama's mandate to educate seniors and other Medicare beneficiaries about how to prevent fraud in Medicare.

More recently, in November 2010, AoA received a national level commendation for the SMP program. The National Health Care Anti-Fraud Association (NHCAA), considered the leading national organization focused exclusively on the fight against health care fraud, bestowed this honor upon AoA and the SMP program. The NHCAA's members comprise more than 100 private health insurers and those public sector law enforcement and regulatory agencies having jurisdiction over health care fraud committed against both private payers and public programs. This award is given annually by the NHCAA to an organization or individuals “who have done the most in the past year to raise public awareness about the problem of health care fraud in our nation’s health care system.” This organization’s decision to award the Administration on Aging’s (AoA) Senior Medicare Patrol (SMP) program the NHCAA 2010 Excellence in Public Awareness Award is a major achievement, and a notable acknowledgement of the value of the SMP program.

The SMP program continues to demonstrate its expanded efforts to effectively reach beneficiaries with fraud prevention information. The number of SMP volunteers increased by 12% between 2009 and 2010, from 4,444 to 4,964. In addition, the number of beneficiaries attending SMP-led group education sessions increased by 37% the past year, and the number of one-on-one counseling sessions increased from 33,855 to 70,789, or 109% between 2009 and 2010. In addition, the SMP projects resolved 47% more inquiries from beneficiaries in 2010 than in 2009.[42]

Since the program’s inception, SMP projects have educated close to 3.1 million beneficiaries in group education sessions, provided over 1.1 million one-on-one counseling sessions, and received over 172,000 complex issues (complaints) from beneficiaries who have detected billing or other discrepancies based on that information. While SMPs make numerous referrals of potential fraud to CMS program integrity contractors, there is no mechanism for tracking the actions (investigation, prosecution, collection) required to realize actual savings to the government as a result of these referrals. Therefore, it is not possible to directly track the outcome of most of the cases reported and dollars recovered as a result of SMP program activities. Moreover, the impact of the SMP program’s primary activities - education of beneficiaries to prevent health care fraud - is difficult to measure and nearly impossible to quantify in dollars and cents. As the OIG indicated in the May 2011 report:

> “We continue to emphasize that the number of beneficiaries who have learned from the Senior Medicare Patrol Projects to detect fraud, waste, and abuse and who subsequently call the OIG fraud hotline or other contacts cannot be tracked….In addition, the projects are unable to track substantial savings derived from a sentinel effect, whereby fraud and errors are reduced by Medicare beneficiaries’ scrutiny of their bills.”

Despite these evaluation challenges, the SMP program has documented nearly $106 million in savings to Medicare, Medicaid, program beneficiaries, and others since its inception in 1997, excluding any deterrent effect. During that same period, the program has recruited and trained 24,431 volunteers who contributed a combined 673,466 hours of their time to preventing, detecting and reporting suspected incidents of fraud and educating and training community members about fraud prevention.

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[42] May 2011, Performance Data for the Senior Medicare Patrol Projects, OEI-02-11-00110. http://www.oig.hhs.gov/oei/reports/oei-02-11-00110.pdf

Long-Term Care Ombudsman Program

The Long-Term Care Ombudsman Program advocates for residents of long-term care facilities, including nursing facilities, board and care and other similar facilities (including assisted living). The program resolves problems of individual residents and works at the local, state and national levels to improve residents' care and quality of life.

Each state has an Office of the State Long-Term Care Ombudsman, headed by a full-time State Long-Term Care Ombudsman who directs the program statewide. Thousands of local ombudsman staff and volunteers, designated by the State Ombudsman as representatives, assist residents and their families by resolving complaints and providing information related to long-term care.

Section 712 of the Older Americans Act requires State Long Term Care Ombudsmen to:

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

This report provides data for FY 2010 from the Long-Term Care Ombudsman Program nationwide, based on state and local level activities. The data and other information presented and analyzed in this report are collected annually by AoA from State Long-Term Care Ombudsmen through the National Ombudsman Reporting System (NORS).

Complaint Investigation and Resolution

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

- Ombudsmen nationwide completed resolution work on 211,937 complaints.

- Ombudsmen resolved or partially resolved 74 percent of these complaints to the satisfaction of the resident or complainant.

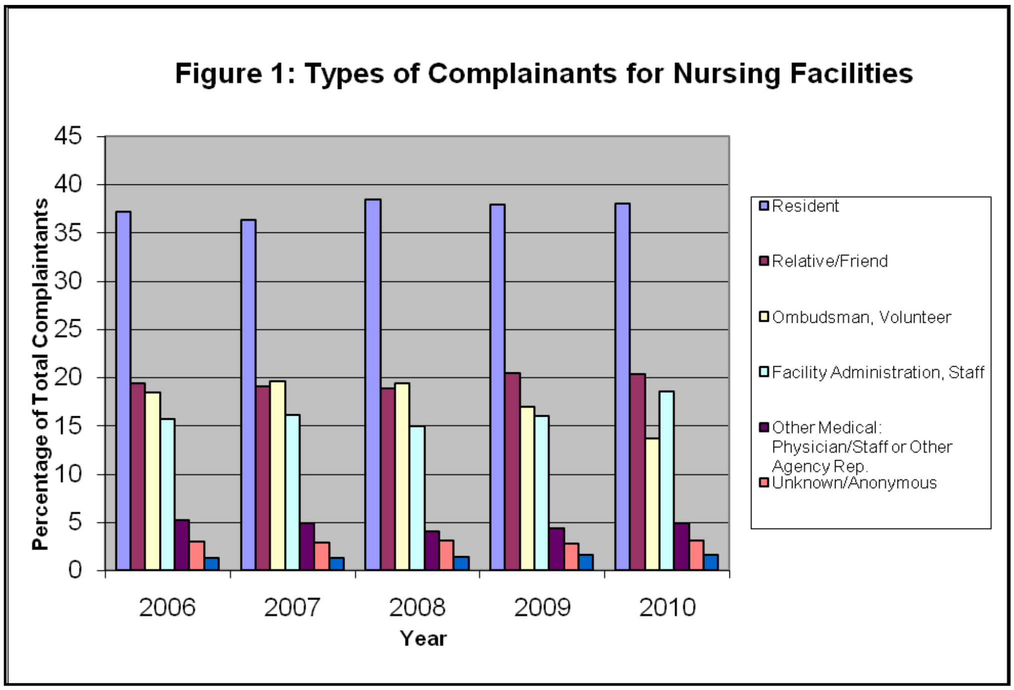
- Of the 139,296 cases closed by ombudsmen,[43] 106,640 (77 percent) were associated with nursing facility settings. Of the remaining cases, 30,909 (22 percent) were related to

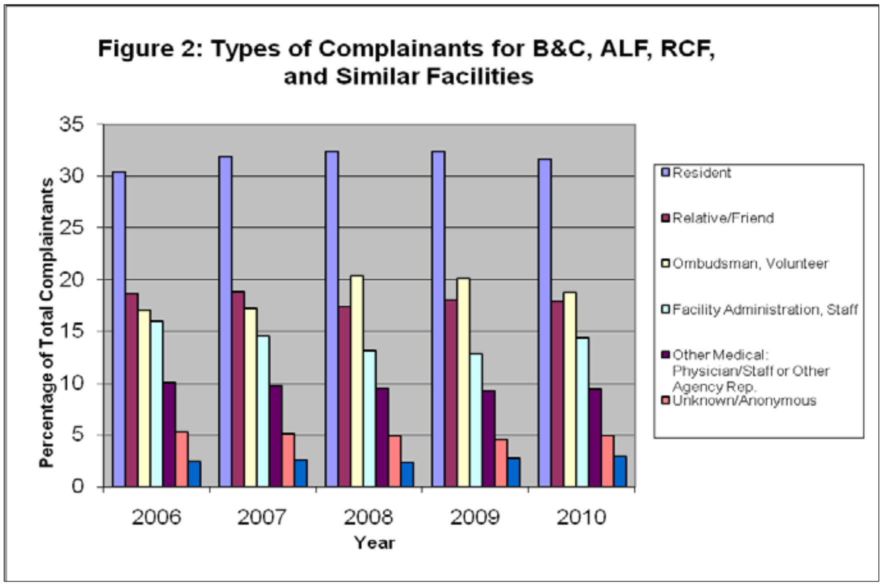
[43] In FY 2010, ombudsmen opened 143,062 new cases (a case contains one or more complaints originating from the same person(s)), and completed resolution work on 139,296 closed cases, containing 211,937 complaints.

board and care and other similar facilities (including assisted living); and 1,747 (one percent) were associated with non-facility settings or services to facility residents by an outside provider.

- Most cases were initiated by residents or friends and relatives of residents, with the residents themselves initiating 38 percent of cases in nursing facilities and 32 percent in board and care and other similar facilities (including assisted living). See Figures 1 and 2, below.

- Ombudsmen proactively identified issues in nearly 15 percent of cases in all settings.





- The five most frequent nursing facility complaints in 2010 were:
  - unanswered requests for assistance;
  - inadequate or no discharge/eviction notice or planning;
  - lack of respect for residents, poor staff attitudes;
  - medications – administration, organization; and
  - resident conflict, including roommate to roommate.

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

Ombudsman Program in Action:
Focusing Discharge Planning on the Needs of the Resident

A nursing home resident called the ombudsman to frantically report that she was going to be discharged that afternoon to a homeless shelter after 5 years of living in the facility. She wanted to live in another setting, but needed help finding housing and, because she no longer needed nursing home level of care, she did not qualify for Medicaid home and community based services. The resident had lost the appeal of her discharge notice and felt that the facility wanted to discharge her because they perceived her as a nuisance. Due to intervention by the ombudsman and Title III legal assistance provider, the facility delayed the move while the ombudsman helped the resident connect with more stable and appropriate housing options as well as access to needed medications and in-home services. After several weeks of planning, the resident was happy to move into her own apartment where she continues to live today.

Ombudsman Presence in Facilities and Empowerment of Families and Residents

- Ombudsman staff and volunteers provided a regular presence to facility residents, visiting residents of 74 percent of nursing facilities and 39 percent of board and care and similar homes (including assisted living) at least quarterly.

- Ombudsmen provided 278,104 consultations to individuals in 2010. Consultations most frequently addressed such topics as alternatives to institutional care, how to select and pay for a long-term care facility, residents' rights, and federal and state rules and policies impacting residents.

- Ombudsmen provided 103,195 consultations to long-term care facility staff in FY 2010 on a wide range of issues, including residents' rights, observations about care, working with resident behavioral issues, and transfer and discharge issues.

- In FY 2010, ombudsmen nationwide:
    - provided information to resident councils (20,775 sessions) and family councils (3,531 sessions);
    - trained long-term care facility staff (5,662 sessions);
    - educated the community (12,997 sessions); and
    - served as resident advocates and provided information to surveyors as part of long-term care facility surveys conducted by regulatory agencies (participating in 23,585 surveys).

Ombudsman Program in Action: Protecting Residents' Rights

Staff of an assisted living community contacted the ombudsman because a resident felt her guardian was not acting in her best interests. The guardian refused to pay for needed dentures or hearing aid repairs, claiming a lack of funds. When the ombudsman investigated, she determined that the resident had significant assets and informed the resident of this fact. With this knowledge, the resident successfully convinced the guardian to purchase dentures and repair the hearing aid.

Since that time, there have been significant improvements to the resident's ability to participate in social activities and eat a normal diet. The state ombudsman has been providing training to both ombudsmen and public guardians statewide regarding the right of the resident -- even where a guardian is appointed -- to access an ombudsman.

- A vital long-term care ombudsman function is systemic advocacy: analyzing, commenting on and recommending changes in laws, regulations, and government policies and actions to benefit long-term care residents.

Providing Ombudsman Services

There are 53 state ombudsmen (50 states, plus the District of Columbia, Puerto Rico, and Guam). In most states, the office of the State Long-Term Care Ombudsman is housed within the state unit on aging or another state agency. In others, the office is housed in a private non-profit agency. Most states have contracts with or through area agencies on aging to provide direct ombudsman services to residents locally. There are 578 designated local entities across the nation.

In FY 2010, long-term care ombudsman services to residents were provided by 1,167 full-time equivalent staff and 8,813 volunteers, trained and certified to investigate and resolve complaints. An additional 2,550 volunteers also served residents or assisted in program operations in ways other than complaint resolution.

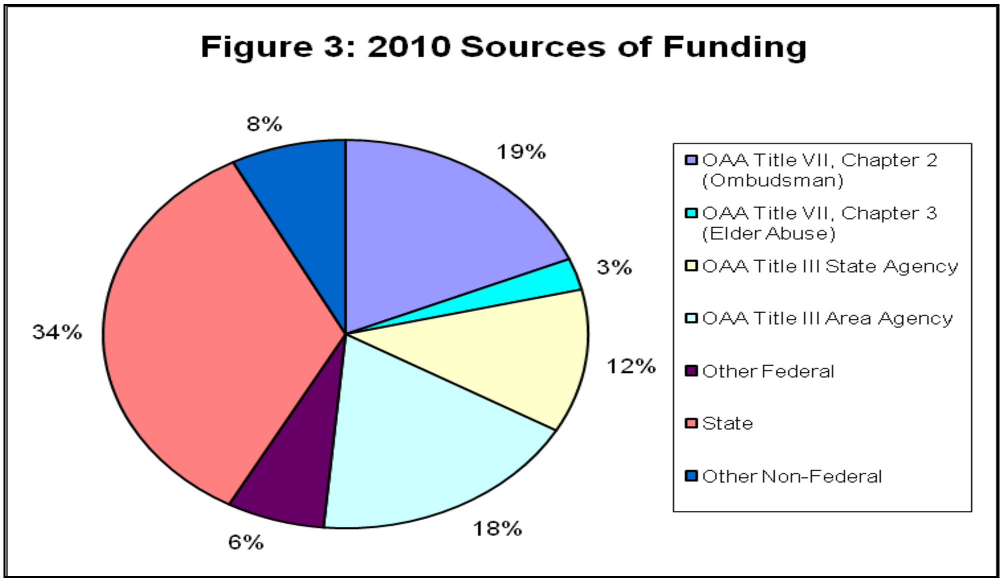
Ombudsman Program in Action:
Advocating for Quality Care

A nursing home resident's family reported to an ombudsman the circumstances surrounding the death of the resident's roommate. When the roommate's call bell went unanswered and he could wait no longer, he tried to make it to the restroom on his own. On the way, he fell, sustaining serious injury and the following day passed away. The family reported on-going issues with insufficient staff and slow responses to call lights. The ombudsman involved the regulatory agency which found violations in facility practice related to falls. Since then, the ombudsman program has been providing training for facility staff; increasing ombudsman presence in the facility to more closely monitor conditions related to staffing, falls, and responses to call lights; and working in collaboration with the regulatory agency to address the quality of care in this facility.

Program Funding

- Total FY 2010 funding from all sources for the Ombudsman Program nationwide was $87,671,325, an overall increase of $2,738,004 (approximately 3 percent) from the FY 2009 level.

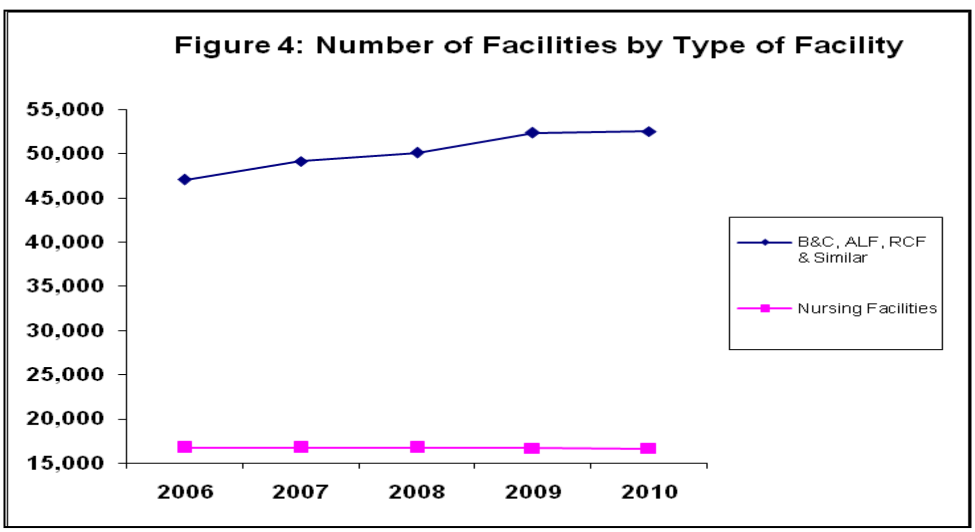
- The federal government is the primary entity funding the Ombudsman Program, providing 58 percent of total funding in FY 2010. States provided 34 percent of funds, and other non-federal sources funded the remaining 8 percent. Figure 3 shows the percentage of total program funding by source.



Where Long-Term Care Facility Residents Live

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

- In the five years between 2006 and 2010, the number of board and care and similar facilities (including assisted living) increased by 12 percent to 52,681, while the number of nursing facilities slightly decreased by 1 percent from 16,750 in 2006 to 16,639 in 2010.



National Long-Term Care Ombudsman Resource Center Activities:
In order to effectively advocate for residents, ombudsmen must remain up-to-date on the latest long-term care developments. Therefore, AoA supports the National Ombudsman Resource Center (NORC), which provides training, technical assistance, and program management expertise to state and local ombudsmen. In FY 2010, the NORC was operated by the National Consumer Voice for Quality Long-Term Care (formerly NCCNHR), in conjunction with the National Association of States United for Aging and Disabilities (NASUAD).

In FY 2010, NORC provided ombudsmen with training from national experts on such issues as:

- The Changing Long-Term Care System;
- Managing Program Goals and Priorities During Fiscal Crises;
- Resident transitions from nursing homes to other settings, including through implementation of federal initiatives such as:
    - MDS 3.0, Section Q – a new version of the Minimum Data Set (MDS) resident assessment tool used by Medicare and/or Medicaid-certified nursing facilities and implemented in FY 2010 by the Centers for Medicare and Medicaid Services (CMS). Section Q of the MDS instructs nursing facilities to ask all residents if they would like information regarding returning to the community and to link residents to local contact agencies for further information; and
    - Money Follows the Person – a demonstration project to assist individuals receiving Medicaid to move out of nursing homes and into other settings to receive long-term services and supports.
- Culture Change and Person-Centered Care; and
- Advocacy in Assisted Living.

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

<u>Program Results and Challenges</u>

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

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

Ombudsman programs leverage federal dollars -- Federal funds leveraged resources from other sources for ombudsman programs. Almost 42 percent of program funds came from non-federal sources during FY 2010. In addition, thousands of volunteer ombudsmen donated their time to assist long-term care residents.

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

Part IV: Supporting the National Aging Services Network

(FY 2010: $8,198,000)

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

Consumer Information, Access, and Outreach

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

Aging and Disability Resource Centers

Aging and Disability Resource Centers (ADRCs) support state efforts to develop more efficient, cost-effective, and consumer-responsive systems of consumer information and integrated access by creating "one-stop shop" entry points into long-term care at the community-level, ranging from in-home services to institutional care. ADRCs help states make better use of taxpayer dollars by streamlining access to public services, diverting individuals from more costly services and supports, and helping to overcome duplication and fragmentation in the long-term care system.

ADRCs are a key component in transforming states' long-term supports and services programs. Since 2003, AoA and CMS have provided grants to states to develop a foundational infrastructure for delivering person-centered systems of information, counseling, and access that make it easier for individuals to learn about and access their health and long-term services and support options. ADRCs grew out of best practice innovations known as "No Wrong Door"[44] and "Single Points of Entry" Programs, where people of all ages or disability may turn for objective information on their long-term services and support options.

ADRCs provide services including:

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

[44] In a "No Wrong Door" entry system, multiple agencies retain responsibility for their respective services while coordinating with each other to integrate access to those services through a single, standardized entry process that is administered and overseen by a coordinating entity (Allison Armor-Garb, *Point of Entry Systems for Long-Term Care: State Case Studies,* prepared for the New York City Department of Aging, 2004).

- “one-on-one” counseling and advice to help consumers and their caregivers fully understand the options available to them, including private pay individuals;

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

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

- integrated access-point to care transition and diversion support to veterans served through the AoA and the Department of Veterans Affairs (VA) Veteran Directed Home and Community-Based Services Program partnership.

AoA and the Centers for Medicare & Medicaid Services (CMS) have invested over $100 million in the ADRC program since 2003. As a result of these investments:

- More than 300 ADRC sites have been established across 50 states, 3 territories, and Washington, DC, often by expanding existing infrastructure in the aging services network such as AAAs, etc. Together these ADRC sites can reach roughly 51 percent of the U.S. population.

- Thirteen states and territories are achieving statewide coverage and an additional 13 states are achieving 50 percent or more statewide coverage.

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

- Standards have been established to provide guidance to states on the desired end result of how an ADRC should perform. For example, the standards require that each ADRC has a plan for reducing the average time from initial contact to determination of their eligibility for public services.

Evaluation

With ADRCs in place for nearly a decade, AoA is partnering with the Agency for Healthcare Research and Quality and the Assistant Secretary for Planning and Evaluation to rigorously evaluate the effectiveness of ADRCs. In FY 2009, AoA initiated a design contract for the evaluation. In FY 2010, AoA began a roughly $2.1 million evaluation based on recommendations from the design contract. The results of this evaluation will influence future performance measures and indicators.

National Eldercare Locator

Older Americans and their caregivers face a complicated array of choices and decisions about health care, pensions, insurance, housing, financial management, and long-term care. The Eldercare Locator helps seniors and their families navigate this complex environment by connecting those needing assistance with state and local agencies on aging that serve older adults and their caregivers. The Eldercare Locator can be accessed through a toll-free nationwide telephone line (800-677-1116) or website (http://www.eldercare.gov). The phone line and website both connect those in need to providers in every zip code in the nation. The Eldercare Locator website continues to grow as a resource tool for older adults and their caregivers, serving over 300,000 individuals a year.

National Resource Centers on Native American Elders

The National Resource Centers on Native American Elders (Resource Centers) enhance knowledge about older Native Americans and thereby increase and improve the delivery of services to them. Each Resource Center addresses at least two areas of primary concern which are specified in the OAA. These include health issues, long-term care (including in-home care), elder abuse, mental health, and other problems and issues facing native communities. The Resource Centers are administered under cooperative agreements by three institutions of higher education. The Resource Centers partner with Native American organizations and communities, educational institutions including tribal colleges and universities, and professionals and paraprofessionals in the field.

National Minority Aging Organizations Technical Assistance Centers

The National Minority Aging Organizations (NMAO) Technical Assistance Centers Program works to address health disparities among racial and ethnic minority older individuals. These Centers design and disseminate front line health promotion and disease prevention information that is culturally and linguistically appropriate for older individuals of African American, Hispanic, Asian American and Pacific Islander descent, and American Indian and Alaska Native elders. Each NMAO project pilots a practical, nontraditional, community-based intervention for reaching older individuals who experience barriers to accessing home and community-based services. Strategies are focusing on barriers due to language and low literacy as well as those directly related to cultural diversity. Strategies developed under this program incorporate the latest technology and facilitate the generation and dissemination of knowledge in forms that can assist racial and ethnic minority older individuals to practice positive health behaviors and strengthen their capacity to maintain active, independent life styles.

National Technical Assistance Resource Center for LGBT Elders

Older lesbian, gay, bisexual and transgender (LGBT) adults face a number of unique challenges as they strive to maintain their independence. To begin to address the special needs of LGBT elders, in FY 2010 AoA funded the National Technical Assistance Resource Center for LGBT Elders. The Resource Center strives to meet three primary objectives: educate mainstream aging services organizations about the existence and special needs of LGBT elders; sensitize LGBT organizations about the existence and special needs of older adults; and educate LGBT individuals about the importance of planning ahead for future long-term care needs. The national resource center began services in September 2010 with the launching of a website including training curricula and social networking tools.

Multigenerational Civic Engagement

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

AoA continues to support a grant to the National Council on the Aging to identify and provide technical assistance and other support to local programs that can become national multi-generational and civic engagement models for utilizing older volunteers in meaningful direct services. This grant, extended through 2011, focuses on three target populations: 1) older relatives caring for grandchildren; 2) families caring for children with special needs; and 3) caregivers of frail elderly.

Next steps include synthesis and dissemination of best practices and setting the stage for widespread replication of the most promising models, using strategies and on-line tools grounded in diffusion of innovations theory and practice. This will be most helpful to the aging services network, which is heavily dependent on volunteers in providing its services.

In 2010, AoA announced a grant competition to fund a National Aging Civic Engagement Technical Center (the Center). The National Association of Area Agencies on Aging was awarded the grant. The Center will help AoA and the national aging services network use volunteers, especially baby boomers, more effectively; develop AoA's and the aging network's leadership in civic engagement; and expand the aging network's existing use of volunteers. The Center, working together with the AARP Foundation, the National Association of State Units on Aging and Disabilities and Senior Service America Incorporated, will 1) conduct a systematic inquiry on civic engagement; 2) recommend an Action Plan in civic engagement for AoA and the aging network; 3) develop a national communication and outreach strategy; 4) provide training and technical assistance; 5) identify effective practices, develop and promote models; and 6) create a continuous quality improvement strategy. Outcomes include measurable change in the network's ability to meet needs and preferences of volunteers. Products include Action Plans, volunteer management toolkits, model practice fact sheets, conferences, website widgets, and a final report.

In addition to the above, AoA continues its relationship and coordination with the Corporation for National and Community Service. We expect to work closely with the Corporation as we expand our civic engagement efforts.

Meeting the Need for Trained Personnel in Aging

The number of older people is increasing rapidly, and those reaching age 65 are living longer than ever before. By 2050, it is estimated that there will be over 85 million people age 65 and over living in the United States. This shift in our nation's demography has profound implications for the assistance the aging network provides people who need long-term services and support. In addition, the Affordable Care Act provides new and important opportunities for the aging network to assist older adults to age in place and remain in the community.

The aging network, including state and area agencies on aging, plays an important role in planning, developing and managing home and community-based service systems. To assist them in these efforts AoA, through the funding of technical assistance resource centers, offers a variety of training and technical assistance opportunities to build the capacity of the aging network to play a lead role in the provision of long-term supports and services for older adults and non-elderly persons with disabilities.

- *Aging Network Business Practice, Planning and Program Development*
  Funding to the National Association of Area Agencies on Aging (n4a) provides support to area agencies on aging and Title VI tribal organizations in the areas of business and strategic planning, leadership development, single point of entry systems, person-centered approaches, consumer-directed services and using evidence-based approaches. Each year the this grant holds an Aging Business Academy attended by representatives from approximately 25 area agencies on aging (AAAs) to assist them in such areas as business and strategic planning. In addition they present at a number of conference every year in an effort to develop interest among AAAs for increasing their skills in business and strategic planning. The grantee has also developed a website called the Resource Exchange for Aging Data and Innovation or (READI) Center which averages about 2000 hits per year and offers a variety of tools to assist AAAs in learning new approaches. In addition to working with area agencies on aging, this project also assists Older Americans Act Tribal Organizations through conference presentations and training. The grantee also develops reports and briefs on a number of topics to assist the national aging services network. Examples include: Area Agencies on Aging: Advancing Access for Home and Community-Based Services (2009)**;** Area Agencies on Aging: Advancing Health and Long-Term Services and Supports (2010)**;** Building Capacity Through Our Workforce (2010)**;** Elder Abuse and Legal Assistance (2009); and an Online Board and Advisory Council Manual (2011).

- *Technical Assistance Support Center (TASC) Planning Zone*
  AoA funded the National Association of States United for Aging and Disability (NASUAD) to develop a web-based planning tool to serve as a one-stop source for state and area agencies on aging to support the development of comprehensive plans on aging. The TASC Planning Zone provides step by step guidance on the development of a plan, including a plan template, most recent AoA plan guidance or program instructions, and guidance on how to submit a state plan renewal or amendment. In terms of educating the Aging Network about such resources, NASUAD regularly holds conference calls among states as well one-on-one calls or meetings with new directors on the TASC Planning Zone, its resources and how to use the planning tools. NASUAD delivers presentations on the TASC Planning Zone and its utility at an array of conferences including, but not limited to AoA Regional Office meetings, NASUAD membership meetings, the National HCBS Conference, the National Association of Area Agencies on Aging (n4a) membership meetings, ADRC Grantee meetings, and the American Society on Aging

(ASA). NASUAD provides onsite state presentations on the TASC Planning Zone and its resources for state aging networks. NASUAD, in collaboration with AoA, also delivers targeted technical assistance to SUAs with State Plan Renewals due as well as to states that are developing off cycle amendments to their state plans. Additionally, NASUAD worked closely with n4a to add AAA specific information to better tailor the site to AAA needs. NASUAD continually updates the website both based on AoA requests as well as NASUAD additions which are vetted through AoA before posting or promulgation. Over the past two years, NASUAD has developed and posted a robust repository of Affordable Care Act (ACA) information and held technical assistance calls with states on how such opportunities could be integrated into state aging plans. NASUAD, in collaboration with AoA, maintains an array of links to AoA-analyzed Census data as well as links directly to appropriate Census databases. The TASC Planning Zone also includes a GIS mapping tool with state by state analyses. These analyses aid states and AAAs in plan development and maintenance. NASUAD also provides state-by-state training on how to use the mapping tool, TASC planning Zone data, as well as orientation to the Census data housed at or linked to via the TASC Planning Zone. Working closely with AoA Central and Regional Offices, NASUAD posts all state plans at the TASC Planning Zone and, with AoA guidance, highlights plans considered to be best practices. Conference calls on best practices are held regularly as well as incorporated into presentations delivered at an array of meetings including n4a and other Aging Network events.

- *National Center on Benefits Outreach and Enrollment*
  AoA funded the National Council on Aging (NCOA) to implement the National Center for Benefits Outreach and Enrollment (NCBOE) to increase the use of person-centered approaches to state and federal public benefits outreach and enrollment to maximize the economic security of seniors and younger adults with disabilities. The NCBOE does this through a number of programs. The NCBOE has funded 20 Benefits Enrollment Centers (BECs) across the country since 2009 and to date they have provided one-on-one counseling to 406,632 individuals and filed 214,660 applications for benefits worth up to $1.1 billion in support. The NCBOE also serves as a technical assistance resource center for the 51 state Medicare Improvements for Patients and Providers Act (MIPPA) grantees. Since 2009, MIPPA grantees have filed 453,529 applications for LIS and MSP worth $1.2 billion in Medicare savings for beneficiaries. The NCBOE also provides multi-faceted technical assistance to their grantees and the broader Aging Network. This includes: ongoing grantee support for both MIPPA and BEC grantees including one-on-one conversations to provide customized guidance, monthly group calls with BECs, and a separate listservs for MIPPA and BEC grantees which allows them to interact in real time. The NCBOE also offers the broader aging network a monthly webinar series on a variety of topics with a focus on expanding the knowledge base and skill sets of aging and disabilities community professionals. They present at a variety of conferences and meetings each year reaching between 500 and 1000 practitioners annually. Publications of the NCBOE include quarterly issue briefs, a case study series examining successful strategies in benefits access, promising practices and others. Finally the Center offers one-on-one assistance to any aging or benefits professional with questions related to benefits outreach and enrollment. More information can be found at

http://www.centerforbenefits.org. Online tools include BenefitsCheckup (http://www.benefitscheckup.org), My Medicare Matters (http://www.mymedicarematters.org), a data mapping tool for professionals and clients to help them better understand benefits programs (http://www.benefitscheckup.org/datamap), and *Beneifts Alert,* an e-newsletter published twice a month, goes to over 4,600 benefits counselors.

- *Center for Healthy Aging*
  The Center for Healthy Aging encourages and assists community-based organizations serving older adults to develop and implement evidence-based programs on health promotion, disease prevention and chronic disease self-management.

- *National Resource Center for Participant Directed Services*
  This center is dedicated to providing information, education and technical assistance to the aging network on the development and maintenance of consumer direction in long-term supports and services systems.

In 2010, AoA funded a new grant, "*Strengthening the Aging Network"* to increase the capacity of state units on aging (SUA) across the country to play strong leadership roles in the development and implementation of modernized systems of long-term services and supports. NASUAD was awarded this grant and is working with AoA to design and implement an intensive training for SUA directors and their senior staff. This effort will also assist AoA in gathering information about current performance standards used by states to measure the impact of their long-term services and supports systems as well as to assess SUA progress in key areas of systems change to give us a better sense of future training needs of personnel in the field of aging.

Collectively, these training and technical assistance efforts have reached aging network professionals in all states and territories including agency leaders, boards, advisory councils and front line staff at the state and community levels.

Part V: Program Innovations

(Title IV of OAA: FY 2010: $27,873,000)

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

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

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

Community Innovations for Aging in Place

The Community Innovations for Aging in Place Initiative (CIAIP), authorized by Congress in the Older Americans Act (OAA) reauthorization of 2006 and first funded in FY 2009, is intended to assist communities in their efforts to enable older adults to sustain their independence and age in place in their homes and communities. Congress directed the Assistant Secretary for Aging to award three-year grants, on a competitive basis, to community-based non-profit organizations to develop and carry out model aging in place projects targeted to individuals who reside in Naturally Occurring Retirement Communities (NORCs). Congress further directed that innovative approaches under the CIAIP initiative should be based on needs assessments of community strengths and gaps as well as the needs of older individuals in the community.

In FY 2009, the Assistant Secretary for Aging funded fourteen organizations representing diverse communities from across the country. In addition, a grant was awarded to provide training and technical assistance to the CIAIP grantees. CIAIP grantees are currently in the second year of funding.

During the first year of the CIAIP program, grantees focused on “start up” activities including hiring or training staff, refining their goals and objectives, surveying older adults in their communities, engaging in other assessment and research activities, finalizing partnerships, and developing evaluation plans. Most of the grantees are still in the early stages of project implementation. Six of the grantees, however, have made rapid progress. These grantees are implementing programs that build on previous work and already had a structure and staff in place when their CIAIP proposals were funded.

Grantees that have the most promise for successful and sustainable projects appear to have a combination of several of the following attributes:

- Strong leadership
- A good reputation in the community
- High aptitude for partnering and discerning who should be "at the table"
- Pre-existing relationships with a wide array of stakeholders, including those outside the aging network
- Organizational coherence and effectiveness
- Experienced staff
- Strong support from the grantees' parent agency
- Leadership and staff have a common vision and they can describe it succinctly
- Oversight and/or supporting roles for senior-leaders in the community being served
- Flexibility to change as opportunities or barriers arise

While each of the 14 CIAIP grantees is developing an aging in place initiative that is tailored to its own community, common themes, strategies, and benefits are emerging across CIAIP grantee programs:

- **Building capacity.** The CIAIP program is providing both an impetus and a framework for strengthening a community's ability to provide the services and supports necessary for supporting aging in place as well as assisting communities in developing partnerships to leverage existing community resources and to decrease service redundancy where it exists. Many grantees are also looking at how they can enhance community infrastructure to enhance aging in place.
- **Forging new partnerships.** CIAIP grantees are reaching beyond the aging network and involving other sectors to support older adults' aging in place. This strategy underscores the message that aging is a community-wide issue and provides an opportunity for these disparate sectors to work together to create a common community agenda. Examples include partnerships with the local disability network, affordable housing, faith-based organizations, tribal organizations, community planning departments, transportation networks, health care providers, public and affordable housing providers and others.
- **Tapping social capital.** Grantees are mobilizing the skills of older adults and the willingness of volunteers of all ages to contribute their time to improve and strengthen their communities.
- **Providing leadership.** Participation in the CIAIP program is allowing area agencies on aging and others within the aging network to assume new leadership roles.
- **Developing a community of practice.** Cross-fertilization of experiences and ideas among the CIAIP grantees, facilitated by the technical assistance provider, is leading to joint problem-solving and new approaches to common issues. Grantees are learning about best and evidence-based practices, sharing information about new resources including funding opportunities, and learning how to use technical assistance to support them in such areas as business plan development.

The CIAIP program is providing AoA with important data about what it takes to support older adults in their homes in innovative ways.

Appendix

Formula Grant Funding

Allocation by

State, Territory and Tribal Organization

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

State	Title IIIB: Supportive Services	Title III-C1 Congregate Meals	Title III-C2 Home Meals	Title III-D Preventive Services	Title III-E NFCSP	Total Title III
Alabama	$5,655,995	$6,769,708	$3,405,044	$333,168	$2,394,015	$18,557,930
Alaska	$1,830,190	$2,190,101	$1,081,558	$105,130	$766,267	$5,973,246
Arizona	$7,536,954	$9,021,043	$4,537,425	$405,273	$3,287,930	$24,788,625
Arkansas	$3,575,124	$4,279,096	$2,152,310	$211,585	$1,523,673	$11,741,788
California	$36,448,142	$43,625,084	$21,942,649	$2,132,032	$15,564,926	$119,712,833
Colorado	$4,762,294	$5,700,029	$2,867,014	$256,172	$1,863,239	$15,448,748
Connecticut	$4,414,911	$5,278,429	$2,542,112	$261,174	$1,828,019	$14,324,645
Delaware	$1,830,190	$2,190,101	$1,081,558	$105,130	$766,267	$5,973,246
DC	$1,830,190	$2,190,101	$1,081,558	$105,130	$766,267	$5,973,246
Florida	$26,729,390	$31,992,629	$16,091,728	$1,557,571	$12,466,239	$88,837,557
Georgia	$9,120,376	$10,916,254	$5,490,683	$487,659	$3,507,709	$29,522,681
Hawaii	$1,830,190	$2,190,101	$1,081,558	$105,130	$766,267	$5,973,246
Idaho	$1,830,190	$2,190,101	$1,081,558	$105,130	$766,267	$5,973,246
Illinois	$14,559,760	$17,408,492	$8,336,107	$841,161	$5,948,072	$47,093,592
Indiana	$7,178,800	$8,592,366	$4,321,809	$427,123	$3,054,571	$23,574,669
Iowa	$4,271,107	$5,117,349	$2,283,552	$232,252	$1,740,403	$13,644,663
Kansas	$3,441,149	$4,118,756	$1,920,469	$191,697	$1,418,364	$11,090,435
Kentucky	$5,039,351	$6,031,641	$3,033,809	$292,333	$2,082,732	$16,479,866
Louisiana	$4,819,982	$5,769,076	$2,901,744	$295,701	$2,008,607	$15,795,110
Maine	$1,830,190	$2,190,101	$1,081,558	$105,333	$766,267	$5,973,449
Maryland	$6,134,814	$7,342,810	$3,693,304	$361,152	$2,501,853	$20,033,933
Massachusetts	$8,228,803	$9,849,264	$4,624,607	$465,465	$3,353,928	$26,522,067
Michigan	$11,593,775	$13,876,686	$6,979,729	$693,994	$4,878,303	$38,022,487
Minnesota	$5,741,350	$6,871,870	$3,456,429	$339,094	$2,461,149	$18,869,892
Mississippi	$3,284,196	$3,930,881	$1,977,164	$196,251	$1,388,506	$10,776,998
Missouri	$7,135,518	$8,526,779	$4,253,437	$423,251	$3,035,089	$23,374,074
Montana	$1,830,190	$2,190,101	$1,081,558	$105,130	$766,267	$5,973,246
Nebraska	$2,300,448	$2,758,123	$1,246,551	$124,900	$939,403	$7,369,425
Nevada	$2,749,585	$3,291,001	$1,655,315	$151,762	$1,048,359	$8,896,022
New Hampshire	$1,830,190	$2,190,101	$1,081,558	$105,130	$766,267	$5,973,246
New Jersey	$10,287,611	$12,276,488	$6,096,854	$620,946	$4,365,417	$33,647,316
New Mexico	$2,249,693	$2,692,676	$1,354,369	$127,394	$959,260	$7,383,392
New York	$24,341,729	$29,168,186	$13,782,442	$1,376,603	$9,906,970	$78,575,930
North Carolina	$10,329,835	$12,363,865	$6,218,806	$577,661	$4,188,342	$33,678,509
North Dakota	$1,830,190	$2,190,101	$1,081,558	$105,130	$766,267	$5,973,246
Ohio	$13,849,980	$16,509,438	$8,269,111	$835,879	$5,957,778	$45,422,186
Oklahoma	$4,311,211	$5,160,125	$2,595,452	$257,429	$1,841,367	$14,165,584
Oregon	$4,555,027	$5,451,950	$2,742,235	$254,913	$1,881,639	$14,885,764
Pennsylvania	$17,922,902	$21,429,838	$9,870,666	$1,018,552	$7,449,148	$57,691,106
Rhode Island	$1,830,190	$2,190,101	$1,081,558	$105,130	$766,267	$5,973,246
South Carolina	$5,403,971	$6,468,058	$3,253,319	$295,433	$2,180,698	$17,601,479
South Dakota	$1,830,190	$2,190,101	$1,081,558	$105,130	$766,267	$5,973,246
Tennessee	$7,355,714	$8,804,116	$4,428,315	$416,815	$3,005,220	$24,010,180
Texas	$22,369,742	$26,774,531	$13,467,117	$1,253,246	$9,149,374	$73,014,010
Utah	$2,184,965	$2,615,203	$1,315,401	$115,100	$911,931	$7,142,600
Vermont	$1,830,190	$2,190,101	$1,081,558	$105,130	$766,267	$5,973,246
Virginia	$8,507,855	$10,183,122	$5,121,931	$484,930	$3,437,386	$27,735,224

State	Title III-B Supportive Services	Title III-C1 Congregate Meals	Title III-C2 Home-Deliv. Meals	Title III-D Preventive Services	Title III-E NFCSP	Total Title III
Washington	$7,172,705	$8,585,070	$4,318,139	$397,692	$2,894,555	$23,368,161
West Virginia	$2,780,196	$3,329,269	$1,505,721	$153,137	$1,073,857	$8,842,180
Wisconsin	$6,566,139	$7,859,067	$3,952,972	$391,448	$2,861,507	$21,631,133
Wyoming	$1,830,190	$2,190,101	$1,081,558	$105,130	$766,267	$5,973,246
American Samoa	$473,451	$599,039	$137,820	$13,141	$95,783	$1,319,234
Guam	$915,095	$1,095,050	$540,779	$52,565	$383,133	$2,986,622
Northern Mariana Islands	$228,774	$273,763	$135,195	$13,141	$95,783	$746,656
Puerto Rico	$4,802,050	$5,747,614	$2,890,949	$269,747	$1,974,516	$15,684,876
Virgin Islands	$915,095	$1,095,050	$540,779	$52,565	$383,133	$2,986,622
TOTAL	**$366,038,034**	**$438,020,197**	**$216,311,617**	**$21,026,000**	**$153,253,357**	**$1,194,649,205**

State	Title VII Ombudsman	Title VII Elder Abuse	Total Title VII
Alabama	$264,292	$78,707	$342,999
Alaska	$83,947	$25,224	$109,171
Arizona	$352,186	$104,883	$457,069
Arkansas	$167,058	$49,751	$216,809
California	$1,703,142	$507,205	$2,210,347
Colorado	$222,532	$66,271	$288,803
Connecticut	$197,313	$59,907	$257,220
Delaware	$83,947	$25,224	$109,171
District of Columbia	$83,947	$25,224	$109,171
Florida	$1,249,006	$371,960	$1,620,966
Georgia	$426,175	$126,917	$553,092
Hawaii	$83,947	$25,224	$109,171
Idaho	$83,947	$25,224	$109,171
Illinois	$647,031	$197,384	$844,415
Indiana	$335,450	$99,899	$435,349
Iowa	$177,244	$55,927	$233,171
Kansas	$149,063	$45,843	$194,906
Kentucky	$235,478	$70,126	$305,604
Louisiana	$225,227	$68,518	$293,745
Maine	$83,947	$25,224	$109,171
Maryland	$286,666	$85,371	$372,037
Massachusetts	$358,952	$109,606	$468,558
Michigan	$541,752	$161,337	$703,089
Minnesota	$268,281	$79,895	$348,176
Mississippi	$153,463	$45,702	$199,165
Missouri	$330,143	$98,318	$428,461
Montana	$83,947	$25,224	$109,171
Nebraska	$96,755	$29,770	$126,525
Nevada	$128,482	$38,263	$166,745
New Hampshire	$83,947	$25,224	$109,171
New Jersey	$473,225	$143,950	$617,175
New Mexico	$105,123	$31,306	$136,429
New York	$1,069,764	$318,581	$1,388,345
North Carolina	$482,691	$143,748	$626,439
North Dakota	$83,947	$25,224	$109,171
Ohio	$641,831	$197,185	$839,016
Oklahoma	$201,454	$60,208	$261,662
Oregon	$212,847	$63,387	$276,234
Pennsylvania	$766,140	$242,944	$1,009,084
Rhode Island	$83,947	$25,224	$109,171
South Carolina	$252,516	$75,200	$327,716
South Dakota	$83,947	$25,224	$109,171
Tennessee	$343,717	$102,361	$446,078
Texas	$1,045,289	$311,293	$1,356,582
Utah	$102,099	$30,406	$132,505
Vermont	$83,947	$25,224	$109,171
Virginia	$397,554	$118,394	$515,948
Washington	$335,165	$99,814	$434,979

State	Title VII Ombudsman	Title VII Elder Abuse	Total Title VII
West Virginia	$116,871	$36,736	$153,607
Wisconsin	$306,821	$91,373	$398,194
Wyoming	$83,947	$25,224	$109,171
American Samoa	$10,493	$3,153	$13,646
Guam	$41,974	$12,612	$54,586
Northern Mariana Islands	$10,493	$3,153	$13,646
Puerto Rico	$224,389	$66,824	$291,213
Virgin Islands	$41,974	$12,612	$54,586
TOTAL	**$16,789,432**	**$5,044,712**	**$21,834,144**

State/Territory	Nutrition Services Incentive Program
Alabama	$2,724,877
Alaska	$320,721
Arizona	$2,266,704
Arkansas	$2,638,692
California	$12,346,182
Colorado	$1,379,870
Connecticut	$1,441,385
Delaware	$493,229
District of Columbia	$639,886
Florida	$6,978,546
Georgia	$2,725,424
Hawaii	$487,594
Idaho	$624,476
Illinois	$7,030,610
Indiana	$1,856,248
Iowa	$1,684,532
Kansas	$1,954,524
Kentucky	$1,809,827
Louisiana	$3,213,739
Maine	$524,039
Maryland	$1,843,421
Massachusetts	$4,345,685
Michigan	$7,439,014
Minnesota	$1,984,038
Mississippi	$2,113,771
Missouri	$4,199,819
Montana	$871,753
Nebraska	$1,351,963
Nevada	$869,620
New Hampshire	$1,114,365
New Jersey	$3,946,325
New Mexico	$2,054,916
New York	$16,923,613
North Carolina	$3,322,232
North Dakota	$809,231
Ohio	$5,716,593
Oklahoma	$2,556,199
Oregon	$1,765,224
Pennsylvania	$5,980,007
Rhode Island	$501,008
South Carolina	$1,612,591
South Dakota	$986,347
Tennessee	$1,695,578
Texas	$12,180,903
Utah	$1,426,187
Vermont	$730,946

State/Territory	Nutrition Services Incentive Program
Virginia	$2,299,971
Washington	$1,913,507
West Virginia	$1,724,020
Wisconsin	$2,709,222
Wyoming	$760,086
Guam	$358,586
Northern Mariana Islands	$61,433
Puerto Rico	$2,775,055
Virgin Islands	$173,105
TOTAL	**$154,257,439**

State	Tribe No.	Grantee Name	TITLE VI A/B	TITLE VI C	NSIP
AK	1	Aleutian/Pribilof Islands Association	$98,120	$28,830	$24,949
AK	2	Association of Village Council Pres.	$87,390		$2,465
AK	3	Bristol Bay Native Association	$141,660	$50,460	$6,034
AK	4	Central Council, Tlingit & Haida Indian Tribes of AK	$141,660	$50,460	$1,988
AK	6	Copper River Native Association	$86,410	$21,620	$2,181
AK	7	Hoonah Indian Association	$76,160	$14,410	$1,441
AK	8	Kodiak Area Native Association (Northern Section)	$76,160	$14,410	$2,076
AK	9	Kodiak Area Native Association (Southern Section)	$76,160	$14,410	$2,714
AK	10	Metlakatla Indian Community	$86,410	$21,620	$3,685
AK	11	Native Village of Barrow	$98,120	$28,830	$9,522
AK	12	Tanana Chiefs Conference for Kuskokwim subregion	$76,160	$14,410	$1,979
AK	13	Tanana Chiefs Conference for Lower Yukon Subregion	$76,160	$14,410	$4,093
AK	14	Tanana Chiefs Conference for Yukon Flats Subregion	$76,160	$14,410	$2,174
AK	15	Tanana Chiefs Conference for Yukon Koyukuk Subregion	$86,410	$21,620	$1,898
AK	16	Tanana Chiefs Conference for Yukon Tanana Subregion	$76,160	$14,410	$162
AK	17	Fairbanks Native Association, Inc.	$141,660	$50,460	
AK	19	Maniilag Association	$122,290	$43,260	$12,947
AK	20	Native Villiage of Unalakleet	$76,160		$5,883
AK	21	Chugachmiut	$86,410	$21,620	$4,261
AK	22	Artic Slope Native Association, Limited	$86,410	$21,620	$6,850
AK	23	Denakkanaaga, Inc.	$86,410	$21,620	
AK	24	Klawock, I.R.A.	$76,160	$14,410	$973
AK	25	Kootznoowoo Inc.	$76,160	$14,410	$1,761
AK	26	Gwichyaa Gwich'in Tribal Government	$76,160	$14,410	$5,136
AK	27	Native Village of Point Hope	$76,160	$14,410	$2,119
AK	28	Seldovia Village Tribe	$76,160		$1,264
AK	30	Sitka Tribes of Alaska	$98,120	$28,830	$1,580
AK	31	Yakutat Native Association	$76,160	$14,410	$1,841
AK	32	Ketchikan Indian Corporation	$98,120	$28,830	$1,944
AK	33	Kuskokwim Native Association	$86,410	$21,620	$2,751
AK	35	Southcentral Foundation	$186,000	$57,680	$8,352
AK	36	Kenaitze Indian Tribe, IRA	$98,120	$28,830	$4,051
AK	37	Wrangell Cooperative Association	$76,160	$14,410	$1,346
AK	38	Native Village of Savoonga	$76,160		$7,928
AK	39	Native Village of Gambell	$76,160	$14,410	$5,778
AK	40	Native Village of Eyak	$76,160	$14,410	$622
AK	41	ORGANIZED VILLAGE OF KAKE	$76,160	$14,410	$1,609
AK	42	Chickaloon Village	$86,410		
AK	Total		$3,449,580	$778,370	$146,357
AL	1	Poarch Creek Indians	$110,570	$36,040	$15,235
AL	Total		$110,570	$36,040	$15,235
AZ	2	Colorado River Indian Tribes	$110,570	$36,040	$4,562
AZ	3	Gila River Indian Community	$141,660	$50,460	$26,997
AZ	4	Hopi Tribal Council	$141,660	$50,460	$6,925
AZ	5	Hualapai Tribal Council	$86,410	$21,620	$5,405
AZ	6	Navajo Nation	$141,660	$50,460	$59,111
AZ	7	The Pascua Yaqui Tribe	$141,660	$50,460	$35,420

State	Tribe No.	Grantee Name	TITLE VI A/B	TITLE VI C	NSIP
AZ	9	Salt River Pima-Maricopa Community	$122,290	$43,260	$15,291
AZ	10	San Carlos Apache Tribe	$141,660	$50,460	$5,256
AZ	11	Tohono o'Odham Nation	$141,660	$50,460	$9,414
AZ	12	White Mountain Apache Tribe	$141,660	$50,460	$15,316
AZ	13	Ak-Chin Indian Community	$76,160	$14,410	$1,826
AZ	14	Yavapai-Apache Tribe	$86,410		$7,263
AZ	15	Havasupai Tribal Council	$76,160	$14,410	$7,989
AZ	16	Inter-Tribal Council of Arizona	$76,160	$14,410	$1,105
AZ	17	Cocopah Indian Tribe	$76,160		$10,984
AZ	18	Quechan Indian Tribe	$86,410	$21,620	$10,126
AZ	Total		$1,788,350	$518,990	$222,990
CA	1	Bishop Indian Tribal Council	$86,410	$21,620	$21,249
CA	2	Blue Lake Rancheria	$86,410	$21,620	$18,453
CA	6	Karuk Tribe of California	$98,120	$28,830	$3,208
CA	7	Pit River Health Services	$76,160		$2,882
CA	8	Picayune Rancheria	$76,160		$4,426
CA	9	Riverside-San Bernardino Co. Indian Health-for Morongo	$86,410	$21,620	$8,596
CA	10	Riverside-San Bernardino Co. Indian Health-for Pechanga	$76,160	$14,410	$3,875
CA	11	Riverside-San Bernardino Co. Indian Health-for Soboba	$76,160	$14,410	$6,868
CA	12	Sonoma County Indian Health Project	$76,160		$6,165
CA	13	Southern Indian Health Council-Area I	$76,160	$14,410	$2,258
CA	14	Southern Indian Health Council-Area II	$76,160	$14,410	$7,918
CA	15	Toiyabe Indian Health Project - Northern	$76,160	$14,410	$6,460
CA	16	Tule River Indian Health Center	$86,410	$21,620	$12,230
CA	17	United Indian Health Services (for Resighini)	$86,410	$21,620	$7,407
CA	18	United Indian Health Services (for Smith River, etc.)	$86,410	$21,620	$8,583
CA	19	California Indian Manpower Consortium	$76,160	$14,410	$10,937
CA	20	Indian Senior Center, Inc.	$86,410	$21,620	$8,223
CA	21	Sonoma County Ind. Health Pro., Manchester	$76,160		$5,765
CA	23	CA Indian Manpower Consort-LaJolla & Susanville Ranche	$76,160	$14,410	$7,286
CA	24	California Indian Manpower Consortium - Ysabel, Pasual	$86,410	$21,620	$8,665
CA	25	Pala Band of Mission Indians	$76,160		$14,092
CA	26	Redding Rancheria Indian Health Services	$141,660	$50,460	$5,646
CA	28	Toiyabe Indian Health Project - Southern	$76,160	$14,410	$6,886
CA	29	Hoopa Valley Tribe	$76,160		$7,686
CA	30	Round Valley Indian Tribes	$76,160		$4,005
CA	31	Fort Mojave Indian Tribe	$76,160	$14,410	$5,229
CA	32	Santa Ynez Band of Mission Indians	$76,160		$1,909
CA	Total		$2,225,780	$381,940	$206,907
CO	1	Southern Ute Indian Tribe	$86,410	$21,620	$4,340
CO	2	Ute Mountain Ute Tribe of Indians	$86,410		$10,852
CO	Total		$172,820	$21,620	$15,192
HI	1	Alu Like, Inc.	$1,505,000	$57,680	$44,997
HI	2	Hana Community Health Center	$86,410		$6,060
HI	Total		$1,591,410	$57,680	$51,057
ID	1	Coeur d'Alene Tribe	$86,410	$21,620	$15,109
ID	2	Nez Perce Tribe of Idaho	$110,570	$36,040	$4,371

State	Tribe No.	Grantee Name	TITLE VI A/B	TITLE VI C	NSIP
ID	3	Shoshone-Bannock Tribes	$98,120	$28,830	$23,592
ID	Total		$295,100	$86,490	$43,072
KS	1	Kickapoo Nation in Kansas	$76,160	$14,410	$7,015
KS	2	Prairie Band of Potawatomi Indians	$110,570	$36,040	$18,705
KS	3	Iowa Tribe of Kansas and Nebraska	$76,160	$14,410	$6,696
KS	Total		$262,890	$64,860	$32,416
LA	1	Institute for Indian Development, Inc.	$86,410		$6,819
LA	Total		$86,410		$6,819
ME	1	Passamaquoddy Tribe	$98,120	$28,830	$18,730
ME	2	Penobscot Indian Nation	$86,410		$4,296
ME	Total		$184,530	$28,830	$23,026
MI	1	Grand Traverse Band of Ottawa & Chippewa Indians	$86,410	$21,620	$6,882
MI	2	Inter-Tribal Council of Michigan, Inc.	$76,160	$14,410	$11,590
MI	3	Keweenaw Bay Indian Community	$86,410	$21,620	$11,930
MI	4	Sault Ste. Marie Tribe of Chippewa Indians	$141,660		$24,370
MI	5	Little Traverse Bay Bands of Odawa Indians	$86,410		$5,111
MI	7	Bay Mills Indian Community	$76,160	$14,410	$4,410
MI	8	Pokagon Band of Potawatomi Indians	$86,410		$2,849
MI	9	Little River Band of Ottawa Indians	$98,120		
MI	10	Nottawaseppi Huron Band of Potawatomi Tribe	$76,160	$14,410	$2,890
MI	Total		$813,900	$86,470	$70,032
MN	1	Bois Forte Reservation Business Committee	$86,410	$21,620	$8,785
MN	2	Fond du Lac Reservation Business Committee	$122,290	$43,260	$40,314
MN	3	Leech Lake Reservation Business Committee	$141,660	$50,460	$15,357
MN	5	Mille Lacs Band of Chippewa Indians	$98,120	$28,830	$34,099
MN	6	Minnesota Chippewa Resource Development	$86,410	$21,620	$9,750
MN	7	Red Lake Band of Chippewa Indians	$122,290		$44,320
MN	8	White Earth Reservation Tribal Council	$86,410		$5,829
MN	9	Grand Portage Reservation Business Committee	$76,160		$3,843
MN	Total		$819,750	$165,790	$162,297
MO	99	Eastern Shawnee Tribe of Oklahoma	$76,160	$14,410	$18,611
MO	Total		$76,160	$14,410	$18,611
MS	1	Mississippi Band of Choctaw Indians	$141,660	$50,460	$17,294
MS	Total		$141,660	$50,460	$17,294
MT	1	Assiniboine and Sioux Tribes	$122,290	$43,260	$25,994
MT	2	Blackfeet Tribe	$141,660	$50,460	$27,593
MT	3	Chippewa-Cree Tribe	$98,120	$28,830	$41,051
MT	4	Confederated Salish and Kootenai Tribes	$141,660	$50,460	$2,245
MT	5	Fort Belknap Community Council	$110,570	$36,040	$14,808
MT	6	Northern Cheyenne Tribe	$86,410	$21,620	$15,564
MT	7	Crow Tribal Elders Program	$141,660	$50,460	$43,009
MT	Total		$842,370	$281,130	$170,264
NC	1	Eastern Band of Cherokee Indians	$186,000	$57,680	$28,944
NC	Total		$186,000	$57,680	$28,944
ND	1	Spirit Lake Nation	$86,410	$21,620	$19,490
ND	2	Standing Rock Sioux Tribe	$122,290	$43,260	$50,541
ND	3	Three Affiliated Tribes	$141,660	$50,460	$12,378
ND	4	Trenton Indian Service Area	$110,570	$36,040	$3,609
ND	5	Turtle Mountain Band of Chippewa Tribe	$141,660	$50,460	$19,823

State	Tribe No.	Grantee Name	TITLE VI A/B	TITLE VI C	NSIP
ND	Total		$602,590	$201,840	$105,841
NE	1	Omaha Tribe of Nebraska	$86,410	$21,620	$8,746
NE	2	Santee Sioux Tribe of Nebraska	$76,160		$3,231
NE	3	Winnebago Tribe of Nebraska	$86,410	$21,620	$17,389
NE	Total		$248,980	$43,240	$29,366
NM	1	Eight Northern Indian Pueblos Council (Picuris, etc.)	$141,660	$50,460	$10,683
NM	2	Eight N. Indian Pueblos Council(San Ildefonso, etc.)	$86,410	$21,620	$6,902
NM	3	Five Sandoval Indian Pueblos, Inc.	$98,120		$11,974
NM	4	Jicarilla Apache Tribe	$110,570	$36,040	$15,079
NM	5	Laguna Rainbow Corporation	$141,660	$50,460	$17,271
NM	6	Mescalero Apache Tribe	$98,120		$9,921
NM	7	Pueblo de Cochiti	$86,410	$21,620	$8,172
NM	8	Pueblo of Acoma	$141,660	$50,460	$9,136
NM	9	Pueblo of Isleta	$141,660	$50,460	$22,125
NM	10	Pueblo of Jemez	$110,570	$36,040	$5,854
NM	11	Pueblo of San Felipe	$110,570	$36,040	$9,314
NM	12	Pueblo of Taos	$110,570	$36,040	$9,349
NM	13	Pueblo of Zuni	$141,660	$50,460	$25,348
NM	14	Ohkay Owingeh	$122,290	$43,260	$12,650
NM	15	Santa Clara Pueblo	$98,120	$28,830	$10,199
NM	16	Santo Domingo Pueblo Tribe	$98,120		$9,590
NM	17	Pueblo of Tesuque	$76,160	$14,410	$3,434
NM	Total		$1,914,330	$526,200	$197,001
NV	1	Fallon Paiute-Shoshone Tribes	$86,410	$21,620	$18,913
NV	2	Inter-Tribal Council of Nevada, Inc. (McDermitt, etc.)	$86,410	$21,620	$7,230
NV	3	Inter-Tribal Council of Nevada, Inc. (Duckwater, etc.)	$76,160	$14,410	$5,067
NV	4	Inter-Tribal Council of Nevada, Inc. (Ely, etc.)	$76,160	$14,410	$4,714
NV	5	Shoshone-Paiute Tribes	$98,120	$28,830	$9,235
NV	6	Walker River Paiute Tribe	$86,410		$9,851
NV	7	Washoe Tribe of Nevada and California	$98,120	$28,830	$23,403
NV	8	Yerington - Paiute Tribe	$76,160		$3,736
NV	9	Pyramid Lake Paiute Tribe	$98,120	$28,830	$4,580
NV	10	Elko Band Council	$76,160	$14,410	$6,448
NV	11	Reno-Sparks Indian Colony	$76,160	$14,410	$10,482
NV	Total		$934,390	$187,370	$103,659
NY	1	St. Regis Mohawk Tribe Office for Aging	$141,660	$50,460	$12,561
NY	2	Seneca Nation of Indians	$122,290	$43,260	$18,793
NY	3	Oneida Indian Nation	$76,160	$14,410	$1,849
NY	Total		$340,110	$108,130	$33,203
OK	1	Apache Tribe of Oklahoma	$141,660	$50,460	$13,009
OK	2	Caddo Tribe of Oklahoma	$141,660	$50,460	$3,401
OK	3	Cherokee Nation of Oklahoma	$187,076	$58,837	$45,260
OK	4	Cheyenne-Arapaho Tribes of Oklahoma	$141,660	$50,460	$16,152
OK	5	Chickasaw Nation	$186,000	$57,680	$87,198
OK	6	Choctaw Nation of Oklahoma	$186,000	$57,680	$31,555
OK	7	Citizen Band Potawatomi of Oklahoma	$186,000	$57,680	$11,093
OK	8	Comanche Indian Tribe	$141,660	$50,460	$14,413
OK	9	Delaware Tribe of Western Oklahoma	$78,960	$14,410	$4,934
OK	10	Iowa Tribe of Oklahoma	$141,660	$50,460	$9,169

State	Tribe No.	Grantee Name	TITLE VI A/B	TITLE VI C	NSIP
OK	11	Kaw Tribe of Oklahoma	$141,660		$4,304
OK	12	Kickapoo Tribe of Oklahoma	$100,000	$21,620	$14,940
OK	13	Kiowa Tribe of Oklahoma	$141,660	$50,460	$5,871
OK	14	Miami Tribe of Oklahoma	$186,000	$57,680	$22,651
OK	15	Muscogee (Creek) Nation	$186,000	$57,680	$146,757
OK	16	Osage Nation of Oklahoma	$186,000	$57,680	$15,362
OK	17	Otoe-Missouria Tribe	$98,120	$28,830	$5,735
OK	18	Ottawa Tribe of Oklahoma	$141,660	$50,460	$17,260
OK	19	Pawnee Tribe of Oklahoma	$141,660	$50,460	$9,011
OK	20	Peoria Tribe of Oklahoma	$141,660		$15,303
OK	21	Ponca Tribe of Oklahoma	$86,410	$21,620	$7,683
OK	22	Quapaw Tribe of Oklahoma	$98,120	$28,830	$13,209
OK	23	Sac and Fox Tribe of Indians of Oklahoma	$141,660	$50,460	$13,093
OK	24	Seminole Nation of Oklahoma	$122,290	$43,260	$12,655
OK	25	Seneca-Cayuga Tribe of Oklahoma	$86,410	$21,620	$8,463
OK	26	Wichita and Affiliated Tribes	$141,660	$50,460	$6,676
OK	27	Wyandotte Tribe of Oklahoma	$141,660	$50,460	$12,795
OK	28	Absentee Shawnee Tribe	$186,000	$57,680	$34,028
OK	29	Fort Sill Apache Tribe	$98,120	$28,830	$4,440
OK	31	United Keetowah Band of Cherokee Indians in Oklahoma	$141,660	$50,460	$12,988
OK	Total		$4,240,746	$1,277,137	$619,408
OR	1	Confederated Tribes of Siletz Indians of Oregon	$98,120	$28,830	$2,573
OR	2	Confederated Tribes of the Umatilla Indian Reservation	$122,290	$43,260	$7,341
OR	3	Confederated Tribes of Warm Springs	$110,570	$36,040	$7,153
OR	4	Confederated Tribes of Grand Ronde	$76,160	$14,410	$8,931
OR	5	Klamath Tribe	$141,660	$50,460	$2,817
OR	6	Confed. Tribes of Coos, Lower Umpqua & Siuslaw Indian	$76,160	$14,410	$8,061
OR	Total		$624,960	$187,410	$36,876
RI	1	Narragansett Indian Tribe	$98,120		$2,711
RI	Total		$98,120		$2,711
SC	1	Catawba Indian Nation Eldercare Program	$86,410	$21,620	$7,970
SC	Total		$86,410	$21,620	$7,970
SD	1	Cheyenne River Sioux Tribe	$141,660	$50,460	$10,937
SD	2	Crow Creek Sioux Tribe	$86,410		$15,182
SD	3	Lower Brule Sioux Tribe	$76,160	$14,410	$10,598
SD	4	Oglala Sioux Tribe	$186,000	$57,680	$158,183
SD	5	Rosebud Sioux Tribe	$186,000	$57,680	$68,792
SD	6	Sisseton-Wahpeton Sioux Tribe	$141,660		$31,166
SD	7	Yankton Sioux Tribe	$86,410		$39,206
SD	Total		$904,300	$180,230	$334,064
TX	1	Alabama-Coushatta Tribe	$86,410	$21,620	$10,220
TX	2	Kickapoo Traditional Tribe of Texas	$76,160		$6,060
TX	Total		$162,570	$21,620	$16,280
UT	1	Uintah and Ouray Business Committee	$86,410	$21,620	$7,314
UT	Total		$86,410	$21,620	$7,314
WA	1	Colville Confederated Tribes	$141,660	$50,460	$17,218
WA	2	Lower Elwha Klallam Tribe	$86,410	$21,620	$3,210
WA	3	Lummi Indian Business Council	$110,570	$36,040	$17,025
WA	4	Makah Indian Tribal Council	$86,410	$21,620	$6,278

State	Tribe No.	Grantee Name	TITLE VI A/B	TITLE VI C	NSIP
WA	5	Muckleshoot Indian Tribe	$141,660	$50,460	$31,578
WA	8	Nooksack Indian Tribe	$86,410	$21,620	$3,878
WA	9	Puyallup Tribe of Indians	$141,660	$50,460	$6,489
WA	10	Quinault Indian Nation	$122,290	$43,260	$13,450
WA	11	S. Puget Intertribal Plng. Ag.- Nisqually	$122,290	$43,260	$2,568
WA	12	S. Puget Intertribal Plng. Ag.- Squaxin Island	$86,410		$4,398
WA	13	Swinomish Indian Tribal Community	$76,160	$14,410	$4,032
WA	14	Spokane Tribe of Indians	$86,410	$21,620	$10,251
WA	15	Yakama Indian Nation	$76,160	$14,410	$2,289
WA	16	Tulalip Tribes	$122,290	$43,260	$9,030
WA	17	Jamestown S'Klallam Tribal Center	$86,410	$21,620	$1,426
WA	19	Quileute Tribal Council	$76,160	$14,410	$5,909
WA	20	S. Puget Intertribal Plng. Ag.- Shoalwater Bay	$98,120	$28,830	$5,849
WA	21	Stillaguamish Tribe of Indians	$86,410	$21,620	$1,616
WA	22	Upper Skagit Indian Tribe	$76,160	$14,410	$2,525
WA	24	The Suquamish Indian Tribe	$98,120	$28,830	$6,272
WA	25	Port Gamble S'Klallam Tribe	$86,410	$21,620	$2,208
WA	26	Samish Indian Nation	$86,410	$21,620	$2,656
WA	27	Cowlitz Indian Tribe	$98,120	$28,830	$3,396
WA	28	SKOKOMISH INDIAN TRIBE	$98,120	$28,830	$2,371
WA	29	Confederated Tribes of the Chehalis Reservation	$98,120	$28,830	$2,155
WA	Total		$2,475,350	$691,950	$168,077
WI	1	Bad River Band of Lake Superior Chippewa	$86,410	$21,620	$10,958
WI	2	Forest County Potawatomi Community	$76,160	$14,410	$6,619
WI	3	Lac Courte Oreilles Band of Lake Superior Chippewa	$98,120	$28,830	$9,524
WI	4	Lac du Flambeau Band of Lake Superior Chippewa Indians	$86,410	$21,620	$14,518
WI	5	Menominee Indian Tribe of Wisconsin	$122,290	$43,260	$21,150
WI	6	Oneida Tribe of Indians of Wisconsin	$122,290	$43,260	$17,020
WI	7	Red Cliff Band of Lake Superior Chippewa	$86,410	$21,620	$12,713
WI	8	St. Croix Chippewa Indians of Wisconsin	$86,410	$21,620	$2,886
WI	9	Stockbridge-Munsee Community	$86,410	$21,620	$5,333
WI	10	Ho-Chunk Nation	$110,570	$36,040	$9,477
WI	Total		$961,480	$273,900	$110,198
WY	1	Northern Arapaho Business Council	$98,120		$10,678
WY	2	Shoshone Tribal Business Council	$110,570		$12,865
WY	Total		$208,690		$23,543
Total			$26,936,716	$6,373,027	$3,026,024