DEPARTMENT of HEALTH and HUMAN SERVICES

ADMINISTRATION ON AGING

FY 2009 Report to Congress

Introduction and Mission

The Administration on Aging (AoA), an agency of the U.S. Department of Health and Human Services (HHS), is the principal federal agency charged with 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 (aging network) to promote the development of comprehensive, coordinated home and community-based care that is responsive to the needs and preferences of older people and their caregivers. The aging network, led by AoA at the federal level, is comprised of 56 state and territorial units on aging (SUA), 629 area agencies on aging (AAA's), 244 tribal organizations, and two Native Hawaiian organizations, nearly 20,000 direct service providers, and thousands of volunteers.

AoA's core programs, authorized under the Older Americans Act (OAA) and administered by the aging network, help seniors remain in their homes for as long as possible. These services complement existing medical and health care systems and support some of life's most basic functions, such as providing assistance in elders' homes to help them with bathing or preparing food. The aging network also helps consumers learn about and access the services and supports that are available in the community and addresses issues related to caregivers. FY 2009 data show that AoA and its national network of aging service providers rendered direct services to nearly 11.5 million elderly individuals age 60 and over (nearly 20 percent of the elderly population) and their caregivers, including nearly three million clients who received intensive in-home services. Critical supports, such as respite care and a peer support network, were provided to more than 825,000 caregivers.

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, tribal and local levels through funding of lower-cost, non-medical services and supports that provide the means by which many more seniors can maintain their independence.

Mission

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

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Overview of Performance

AoA program activities have a fundamental common purpose that reflects the legislative intent of the OAA and AoA's mission: to help elderly individuals 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 aging network actively participate in supporting community-based services with particular attention to serving economically and socially vulnerable elders, led AoA to focus on three performance measurement areas: 1) improving efficiency; 2) improving client outcomes; and 3) effectively targeting services to vulnerable elder populations. Each measurement area is representative of several activities across the Aging Services Program structure, and progress in that area is tracked using a number of indicators. The efficiency measurement and corresponding indicators are reflective of the Office of Management of Budget (OMB) requirements to measure efficiency for all program activities. The client outcome measurement area 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 measurement area 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.

In addition to the basic performance measurement requirements of GPRA, which are discussed in detail below, and in recognition of this Administration's guidance 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 that are currently in development. 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 AoA's 2008 and 2009 national surveys of OAA program participants 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 U.S. 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.

Current Performance Information

An analysis of AoA's performance trends shows that through FY 2009, most indicators have steadily improved. It also points to some key observations about the potential of AoA and the aging 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 who have three or more impairments in Activities of Daily Living (ADLs) are at a high risk for nursing home admission. Measures of the aging network's success at serving this vulnerable population is a proxy for success of nursing home delay and diversion. In FY 2003, the aging network served home-delivered meals to 280,454 individuals with three or more ADL impairments. By FY 2009, that number has grown by 27 percent to 357,403 individuals. 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 admission based on scientific literature and AoA's Performance Outcome Measurement Project (POMP) which develops and tests performance measures. The components include such items as percent of program recipients who are transportation disadvantaged and the percent of congregate meal individuals who live alone. As the score increases, the prevalence of nursing home predictors in the OAA service population increases. In 2003, the nursing home predictor score was 46.57. In FY 2009, this score has increased to 61.0.

- **OAA programs are efficient:** The aging network is providing high-quality services to the neediest elders, and is doing so in a prudent and cost-effective manner. As an example, AoA and the aging network have significantly increased the number of persons served per million dollars of OAA funding. Without controlling for inflation, OAA programs have increased efficiency by over 36 percent between FY 2002 and FY 2009, serving 8,524 clients per million dollars of funding in FY 2009 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 2009 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 three dollars in other funds are leveraged for every dollar of OAA funds expended), as well as in the expansion of projects such as the Aging and Disability Resource Center initiative, which, in FY 2009, operates in 50 states, three territories, and Washington, D.C. at 290 locations.

OAA program participants 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 service recipients rated services as good to excellent;

while 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 providers 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.

Taken as a whole, AoA's performance measures and indicators form an interconnected system of performance measurement akin to the three legs of a stool (efficiency, outcomes and targeting) holding up AoA's mission and strategic goals that include:

1. Empowering older people, their families, and other consumers to make informed decisions about, and to be able to easily access, existing health and long-term care options;
2. Enabling seniors to remain in their own homes with a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers;
3. Empowering older people to stay active and healthy through Older Americans Act services and the prevention benefits under Medicare;
4. Ensuring the rights of older people and prevent their abuse, neglect and exploitation; and
5. Maintaining effective and responsive management.

Aging Services Program – Performance Summary

AoA has used a streamlined approach to performance measurement since FY 2005, by design. Most of the current performance indicators are cross-cutting and the established performance targets are usually dependent on multiple budget line items. The following table provides an overview of all targets established for each fiscal year.

Summary of Performance Targets and Results Table

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2006	15	15	100 percent	13	87 percent
2007	16	16	100 percent	13	81 percent
2008	14	14	100 percent	9	64 percent
2009	15	14	93 percent	10	71 percent

Supporting Community-Based Long-Term Care for Frail Seniors

From 2010 to 2015, the number of Americans age 60 and older will increase by 15 percent, from 57 million to 65.7 million.[1] During this period, the number of seniors with severe disabilities (defined as three or more limitations in activities of daily living) who are at greatest risk of nursing home admission and Medicaid eligibility (through the "spend down" provisions) will increase by more than 13 percent.[2]

AoA's 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, 58 percent of congregate and 93 percent of home-delivered meal recipients report that the meals helped enable them to continue living in their own homes and 48 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] These programs help seniors in need to maintain their health and independence.

OAA programs are assisting nearly 11.5 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.

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 them to take into account 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 funds 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 Nutrition Services (congregate and home-delivered meals) in order to meet the local needs of older adults. Additionally, for any fiscal year, if the transferred funds are insufficient to satisfy the need for nutrition services, the assistant secretary for aging may grant a waiver that permits the state to transfer an additional 10 percent of the funds to meet those needs. The OAA provides further flexibility to states by allowing them to transfer up to 30 percent of OAA funds for any fiscal year between Supportive Services programs and Nutrition Services programs. These are options

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[1] U.S. Census Bureau, "2008 National Population Projections," released August 2008, <http://www.census.gov/population/www/projections/2008projections.html>.

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

[3] 2008 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

open only to states and territories. A state agency may not delegate to an area agency on aging or any other entity the authority to make such transfers.

In FY 2009, states transferred over $77 million from congregate nutrition to home and community-based services and home-delivered meals, as illustrated in the following table.

Table 1. FY 2009 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	$359,188,415	$431,673,607	$213,177,293
Final Allotment after Transfers	$407,516,171	$355,106,340	$241,416,804
Net Transfer	+$48,327,756	($76,567,267)	+$28,239,511
Net Percent Change	13.45	(17.73)	13.24

Outreach and Targeting

The aging network conducted significant outreach activities in FY 2009. More than 4.5 million contacts were made. In addition, states and AAA's obtained substantial match from other funding sources obtaining an additional $1.50 for each federal dollar used in outreach. The effectiveness of these outreach efforts, in accordance with the OAA mandate to serve older adults in greatest social and economic need, is demonstrated by the substantial number of low-income, minority, rural and isolated individuals who receive OAA services, as outlined in the table below.

	US Population 60+ Years	**OAA Service Recipients**
Seniors at or below the HHS Poverty Guideline	9.3%*	30.5%
Rural	22%**	35.7%
Minority	19.8%*	25.0%

* Based on 2007 American Communities Surveys

** Based on 2000 Census

Program Evaluations in Progress

Program evaluations are complimentary to performance measurement. Their objective is to provide data that can relate program services to client outcomes and explain how and why program results are accomplished. The goal of these evaluations is to help inform budget decisions, policies and practices so that the AoA and the aging network may better serve more elders in the most efficient and effective manner.

AoA's program evaluation framework is an approach that places assessment of program effectiveness and efficiency as the primary focus, regardless of the program activity. All evaluations are designed to examine client outcomes as a key measure of program effectiveness along with a process evaluation component that collects data on each level of the aging network.

A Title III-C Elderly Nutrition Services program evaluation, currently in progress, will employ 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 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 & 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 the Agency for Health Care Research and Quality (AHRQ) and research contractors to finalize a design for an evaluation of the Chronic Disease Self-Management program utilizing an experimental design and is also working on an evaluation of the Aging and Disability Resource Centers.

The multi-year, comprehensive evaluation activities outlined above are anticipated to collect and analyze data over the course of the following five years. Several of these project evaluations include rolling recruitment of study participants and comparison groups over an extended period of time, with up to a 12-month follow-up period that includes additional data collection. The necessary time lag to obtain longitudinal Medicare data to measure healthcare utilization and costs may extend the timeframe for final analyses and reporting that incorporates these outcomes.

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, 58 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 48 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.[4]

From 2010 to 2015, the number of Americans age 60 and older will increase by 15 percent, from 57 million to 65.7 million.[5] 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.[6] These programs help seniors in need maintain their health and independence.

Home and Community-Based Supportive Services

The Home and Community-Based Supportive Services 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 serve seniors holistically. While each service is valuable in and of itself, it is often the combination of supports, when tailored to the needs of the individual, which helps to ensure that frail, elderly persons are able to remain in their own homes and communities instead of entering nursing homes.

The services provided to seniors through the Home and Community-Based Supportive Services 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, these programs also fund multi-purpose senior centers, which coordinate and integrate services for the elderly. In FY 2009, states reported that 10,942 senior centers were in operation nationwide, 5,900 of which receive OAA funding to help support their operations and activities.

While age alone does not determine the need for these long-term care supports, statistics show that both disability rates and the use of long-term supports increase with advancing age. Among those aged 85 and older, 55 percent are unable to perform critical activities of daily living and require long-term support. Data also show that over 80 percent of seniors have at least one chronic condition and 50 percent have at least two. Providing a variety of supportive services that meet the diverse needs of these older individuals is crucial to enabling them to remain

[4] 2008 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

[5] U.S. Census Bureau, "2008 National Population Projections," released August 2008, <http://www.census.gov/population/www/projections/2008projections.html>.

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

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 report that as a result of the services arranged by the case manager that they are better able to care for themselves.[7] In addition, a study published in the Journal of Aging and Health shows that these services, what the article calls "personal care services," are the critical services that enable frail seniors to remain in their homes and out of nursing home care.[8]

Services provided by the program in FY 2009, include:

- *Adult Day Care/Day Health* provided nearly eight 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 28 million rides to doctor's offices, grocery stores, pharmacies, senior centers, meal sites, and other critical daily activities.

- *Personal Care, Homemaker, and Chore Services* provided nearly 29 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 nearly 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 and the aging network's commitment to providing services to those most in need, nearly 50 percent of riders on OAA-funded transportation are mobility impaired, meaning they do not own a car or if they do own a car they do not drive, and are not near public transportation. 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:

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

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

[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.

- 2 percent have Multiple Sclerosis.

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

Funding for these services is a cost-effective means of enabling a growing senior population to remain healthy and independent, thereby avoiding more expensive nursing home care and medical interventions that increase costs to the Medicaid and Medicare programs. From 2010 to 2015, the population age 60 and older will increase by 15 percent, from 57 million to 65.7 million.[10] 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.[11]

AoA's core formula grant programs reach one in five seniors, serving over a half million individuals in their own communities who meet the disability criteria for nursing home admission, helping to keep them from joining the 1.7 million seniors who live in nursing homes. Nationally, about 26 percent of individuals 60 and older live alone. Living alone is a key predictor of nursing home admission, and HCBS services are critical to their ability to remain at home, especially for those who do not have an informal caregiver to assist with their care. Additionally, recent research has shown that childless seniors who live in a state with higher home and community-based service expenditures have significantly lower risk of nursing home admissions.[12]

Federal support for Older Americans Act programs is not intended to cover the cost of serving every senior. These programs have strong partnerships with state and local governments, philanthropic organizations, and private donations that contribute funding. Despite the fact that states are only required to match this program at 25 percent of their federal allocation, states have normally leveraged resources of two or three dollars for every OAA dollar received.

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. As currently authorized, Nutrition Services include:

[9] 2008 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.
[10] U.S. Census Bureau, "2008 National Population Projections," released August 2008, <http://www.census.gov/population/www/projections/2008projections.html >.
[11] Data extrapolated by AoA from U.S. Census Bureau, "2008 National Population Projections," released August 2008, <http://www.census.gov/population/www/projections/2008projections.html> and Health Data Interactive, National Center on Health Statistics, Centers for Disease Control and Prevention, "Functional limitations among Medicare beneficiaries, ages 65+: US, 1992-2006." Accessed 31 August 2009.
[12] "Risk of Nursing Home Admission Among Older Americans: Does States' Spending on Home and Community-Based Services Matter?" May 2007. Journal of Gerontology: Psychological Sciences.

- Congregate Nutrition Services (Title III-C1): 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): 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): Provides additional funding to states, territories, and eligible tribal organizations that is used exclusively to provide meals and cannot be used to pay for other nutrition-related services or for administrative costs. Funds are awarded to states and tribes based on the number of meals served in the prior federal fiscal year. States and tribes have the option to purchase commodities directly from the U.S. Department of Agriculture with any portion of their award if they determine that doing so will enable them to better meet the needs of seniors.

Formula grants for Congregate Nutrition Services and Home-Delivered Nutrition Services are allocated to states and territories based on their share of the population age 60 and over. 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. Studies have found that 50 percent of all persons age 85 and over are in need of assistance with instrumental activities of daily living (IADLs), including obtaining and preparing food; these nutrition programs help address their needs. *Serving Elders at Risk*, a national evaluation of AoA's nutrition program clients, found that recipients are older, poorer, more likely to live alone, more likely to be minorities, are sicker, in poorer health, in poorer nutritional status, more functionally impaired, and at higher nutritional risk than those in the general population.

Nutrition Services provide an important opportunity for social interaction that helps to improve the general health status of participants, particularly homebound elders. A comparison of the number of social contacts of congregate and home-delivered meal participants showed that nutrition program clients have significantly more social contacts than people who did not participate in the program. In addition, home-delivered meal and congregate meal participants have 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.[13] Seniors with deficiencies of these nutrients can experience osteoporosis, night blindness, decreased resistance to infection, fatigue, vasodilatation, and other illnesses.

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.[14]

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. In addition, the number of home-delivered meal recipients with severe disabilities (3+ ADL) totaled more than 357,000 in FY 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 nearly 149 million meals to over 880,000 individuals in FY 2009.

- *Congregate Nutrition Services* provided over 92.4 million meals to nearly 1.7 million seniors in a variety of community settings in FY 2009.

More detailed information about persons served, units of service and expenditures can be found in the table on the following page:

[13] *Serving Elders at Risk – National Evaluation of the Elderly Nutrition Program, 1993-1995,* pp.117-118
[14] 2008 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

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	FY 2009
Total Clients	11,476,655
Total Registered Clients	2,964,061
% Minority Clients	24.98%
% Rural Clients	35.67%
% Clients Below Poverty	30.51%
# Clients with 3+ ADLs	508,442
# of Persons Served at High Nutrition Risk	764,748
# Senior Centers	10,942 (5,900 receive OAA funding)

Service	Persons Served	Units of Service[15]	Title IIIE Expenditure	Total Expenditure
Personal Care	108,887	14,833,984	$11,194,758	$270,336,077
Homemaker	160,510	12,660,912	$28,222,264	$239,661,872
Chore	39,266	1,213,920	$5,751,464	$21,061,578
Home Delivered	880,135	149,188,917	$224,389,216	$790,488,570
Adult Day Care	23,547	7,909,015	$11,720,328	$84,376,141
Case	491,481	3,941,408	$31,251,465	$264,708,053
Assisted Trans.	38,103	1,421,668	$3,551,476	$15,143,273
Congregate	1,686,093	92,492,669	$263,999,420	$643,914,615
Nutrition Counseling	23,900	58,193	$1,368,862	$3,124,931
Transportation		26,175,683	$68,731,181	$199,084,035
Legal Assistance		931,776	$25,159,733	$50,491,019
Nutr. Education		1,988,487	$3,914,260	$6,819,616
I&A		12,406,397	$56,153,108	$151,056,286
Outreach		4,225,060	$10,524,273	$23,870,849
Other			$110,946,638	$628,075,076

[15] Title III-C service units definition:
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[16]	Title III Expenditure	Total Expenditure
Counseling, Support Groups, Training	137,203	456,537	$18,406,540	$26,213,647
Respite	69,017	6,406,159	$56,258,419	$94,572,799
Supplemental Services	47,426	1,322,240	$13,779,929	$21,124,526
Access Assistance	619,389	1,024,261	$32,105,954	$44,921,099
Unduplicated Caregivers Provided Service or Access	828,505			

Preventive Health Services

Preventive Health Services, established in 1987, provides formula grants to states and territories, based on their share of the population aged 60 and over. These services 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 20th 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 persons aged 85 and over, which is projected to total 5.8 million by 2010 and 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 those who have the greatest economic and social needs. 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,

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

AAAs, 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 and glaucoma, as well as dental, cholesterol, hearing, and vision.
- *Evidence-based Prevention Programs*, as described below.

Over the last few years, a number of states have chosen to use this funding to provide greater support to evidence-based approaches, especially in helping individuals manage chronic diseases. Examples of evidence-based models include enhanced fitness, enhanced wellness, falls prevention, and chronic disease self-management programs that have been demonstrated to be especially effective. Evidence-based programs are interventions that have been rigorously 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. AoA continues to encourage states and the aging 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 that is intended to promote physical activity among older adults. Strength training using soft wrist and ankle weights; cardiovascular workout using dancing, aerobics, or walking; and balance and posture exercises are used to increase the physical health of older adults. In addition, exercise has been proven to decrease depression, which studies have shown that nearly 20 percent of U.S. adults 65 years and older experience. Exercise may also act as a buffer against many illnesses impacted by stress.

Falls prevention: Falls prevention programs 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 U.S. more than one-third of adults age 65 and over fall each year. Of those who fall, 20 to 30 percent will experience serious injuries, such as head trauma, broken bones, or hip fractures. These injuries may limit the ability of older adults to 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.[17]

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 10 deaths and contribute to more than three-quarters of all Medicare expenditures.[18] Data

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

[18] 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.

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. Chronic disease self-management programs teach evidence-based disease prevention models that utilize state-of-the-art techniques to help people better self-manage their conditions and reduce their need for more costly medical care. Programs often consist of a series of workshops in community settings that are facilitated by leaders who are trained and certified to help persons with chronic diseases learn that they can change their health behaviors through action plans and goal setting.

In 2009, more than 400 services, such as blood pressure screening, walking clubs, yoga sessions, etc., were identified by states as being designed to improve seniors' health. Activities were 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 report that 5.9 million seniors were served in these health-related programs, which received $16 million in additional funding from states and local entities.

Part II: Caregiver Services

Families are the nation's primary provider of long-term care, but a number of factors, including financial constraints, work and family demands, and the many challenges of providing care, place great pressure on family caregivers. Caregiving responsibilities demand time and money from families who too often are already strapped for both. 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. Caregivers often experience conflicts between work and caregiving, with 25 percent reporting that they have had to make adjustments such as retiring or taking time away from work due to their caregiving responsibilities.

The demands of caregiving can lead to a breakdown of the caregiver's health, and the illness, hospitalization, or death of a caregiver increases the risk for institutionalization of the care recipient. Caregivers suffer from higher rates of depression than non-caregivers of the same age, and research indicates that caregivers suffer a mortality rate that is 63 percent higher than non-caregivers.[19] 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 continuing in that role. Seventy-seven percent of the caregivers served by AoA's programs report that the OAA services allow them to provide care longer than they otherwise could.[20]

At the same time, AoA recognizes that it must also address the growing need for more caregivers every day. In 2009, at least 43.5 million adult caregivers, or approximately 19 percent of all adults, provided uncompensated care to those 50 years of age and older.[21] By 2015, AoA projects that there will be 12.9 million non-institutionalized seniors age 65 and over with 1+ Activities of Daily Living (ADL) deficits, an increase of almost 2 million seniors or 18 percent since 2008, needing caregiver assistance.[22]

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. The economic value of replacing unpaid caregiving in 2007 was estimated to be about $375 billion, an increase from $350 billion in 2006 (cost if that care had to be replaced with paid services).[23]

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

[20] Ibid.

[21] National Alliance for Caregiving and AARP. Caregiving in the U.S.: A Focused Look at Those Caring for the 50+. 2009. <http://www.aarp.org/research/surveys/care/ltc/hc/articles/caregiving_09.html>

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

[23] Gibson M.J., & Houser, A.N. *Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update.* Washington, D.C.: AARP Public Policy Institute: 2008 November, Insight on the Issues #13.

Family Caregiver Support Services Program

The Family Caregiver Support Services 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 five basic system components: information, access assistance, counseling and training, 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. 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. Based on FY 2009 data, more than half a million caregivers (507,292) received services provided through this program, including:

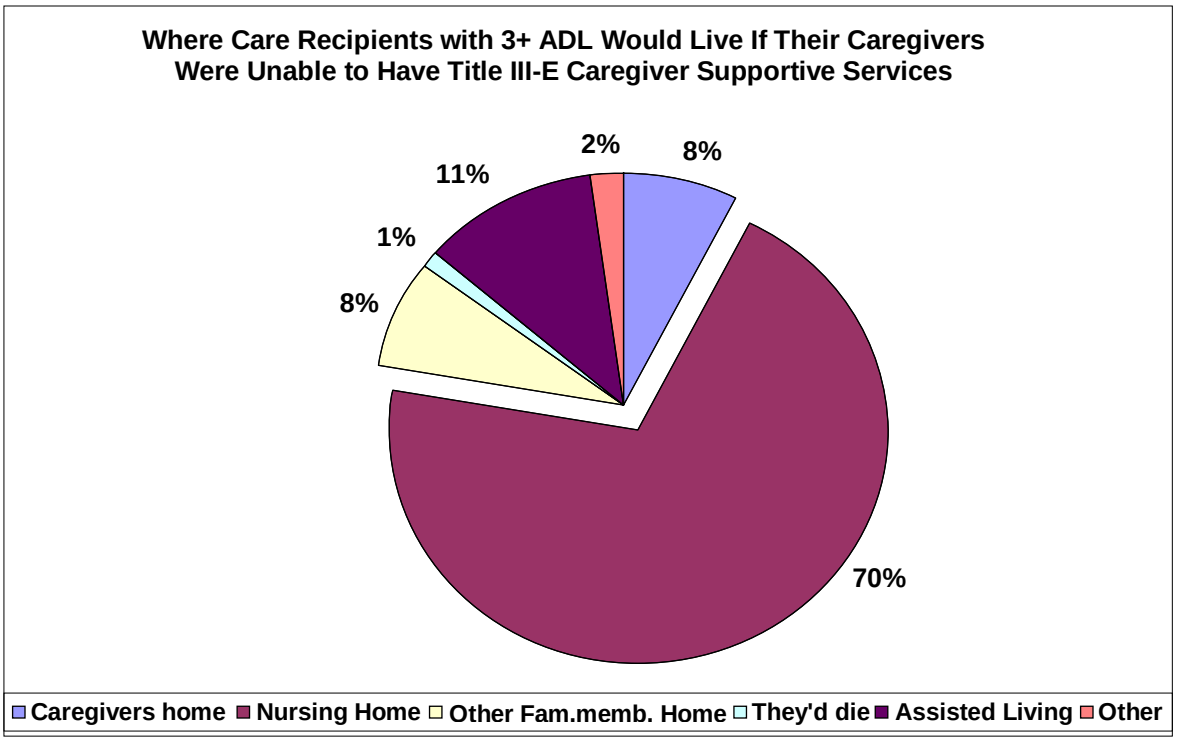
- *Access Assistance Services* provided 619,389 contacts to caregivers assisting them in locating services from a variety of private and voluntary agencies.

- *Counseling and Training Services* provided more than 137,000 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving.

- *Respite Care Services* provided more than 69,000 caregivers with 6.4 million hours with temporary relief -- at home, or in an adult day care or nursing home setting -- from their caregiving responsibilities.

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 81 percent of caregivers of program clients reported in 2009 that services enabled them to provide care longer than otherwise would have been possible.[24] 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, 81 percent, indicated that the care recipient would most likely be living in a nursing home or assisted living (see the chart on the next page).

[24] 2008 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.



Source: 2008 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

As reported in AoA's 2008 National Survey of Older Americans Act 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]

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 published in the Journal of the American Medical Association, *Intervention to Delay Nursing Home Placement of Patients with Alzheimer's Disease*[26], 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.

Lifespan Respite Care Program

The Lifespan Respite Care program was created by Congress in 2006 under Title XXIX of the Public Health Service Act (42 U.S.C. 201). It 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

[25] 2008 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.
[26] Mittelman, Mary S., et al, Journal of the American Medical Association (JAMA), Vol. 276, No. 21, December 4, 1996.

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 include 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.

The first grants for the program were awarded in FY 2009 to twelve recipients for up to $200,000 for three-year project periods. 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 Lifespan Respite Care program builds upon the existing infrastructure of multi-faceted caregiver services, providing training for caregivers, enhancing the provision of information about available respite and other supportive services, and assisting caregivers in accessing all services available to them, including respite, from across the spectrum of caregiver support.

Alzheimer's Disease Supportive Services Program

The Alzheimer's Disease Supportive Services Program (ADSSP), created by Congress in 1991 under Section 398 of the Public Health Service Act (P.L. 78-410; 42 U.S.C. 280c-3), 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.

AoA issued grant funding opportunities in FY 2009 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 2009, the ADSSP funded 16 grants with an average award of $646,764 and a range of grant awards from $203,155 to $1,000,000. 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 a promising intervention 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.[27] In 2009, the average nursing home cost was $219 daily ($79,935 annually), which

[27] 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.

would mean an average savings of nearly $122,000 in institutional costs per person with dementia.[28] 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 2009 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.

National Alzheimer's Call Center

The National Alzheimer's Call Center is a national information and counseling service for persons with Alzheimer's disease, their family members, and informal caregivers. The National Alzheimer's Call Center is available to people in all states, 24 hours a day, 7 days a week, 365 days a year to provide expert advice, care consultation, and information and referrals at the national and local levels regarding Alzheimer's disease. Trained professional customer service staff and masters degree social workers are available at all times. The Call Center is accessible by telephone, website or e-mail at no cost to the caller. In the 12-month period ending July 31, 2009, the National Alzheimer's Call Center handled over 250,000 calls through its national and local partners, and its on-line message board community recorded over 4.8 million page views, with nearly 75,000 individual postings. Services focus on consumers, not professionals. Information provided may include basic information on caregiving; handling legal issues; resources for long-distance caregiving; and tips for working with the medical community. Local community-based organizations are directly involved to ensure local, on-the-ground capacity to respond to emergencies and the on-going needs of Alzheimer's patients, their families, and informal caregivers. The Call Center has multilingual capacity and responds to inquiries in at least 140 languages through its own bilingual staff and through the use of a language interpretation service.

[28] 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

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

The number of older American Indian, Alaska Native, and Native Hawaiian (AI/AN/NH) is increasing. According to Census Bureau projections, there were about 225,000 American Indians and Alaska Natives age 55 and older in 2008. This represents about 16 percent of the AI/AN population. By the year 2020, about 22 percent, or nearly 811,000 individuals, of the American Indian and Alaska Native population will be age 55 and older.[29] The older Native Hawaiian population is expected to also increase, but at a lower rate. In 2008, about 14 percent (about 40,000 individuals) of the Native Hawaiian population in the state of Hawaii was age 55 and older. This is expected to increase to 16 percent (53,500 individuals) by 2020.[30] This increase in the older population of AI/AN/NH is the result of both the increased life expectancy and the aging of the baby boom generation.

Health and Functional Status

While it is good news that AI/AN/NH are living longer, increasing age also increases the risk of developing multiple chronic diseases and functional limitations which influence a person's ability to live independently. The National Resource Center on Native American Aging (NRCNAA) at the University of North Dakota has been collecting general information on health status, chronic diseases, activity limitations, health risks, social support, and demographics on Tribal elders since 1997.[31] Their data indicate that native elders have a greater prevalence of arthritis, asthma, breast cancer, congestive heart failure, diabetes, high blood pressure, prostate cancer, and stroke as compared to the U.S. general population over age 55. Their data also indicate that as the native elder population ages, there is generally an increasing prevalence of arthritis, cataracts, colon/rectal cancer, congestive heart failure, high blood pressure, prostate cancer, and stroke. In contrast, the prevalence of asthma and diabetes decreases with increasing age. One possible reason for this is that those with asthma or diabetes do not live as long as those without the diseases.

Older adults are at disproportionate risk for poor nutrition with corresponding adverse effects on their health and quality of life. Of the 9,416 AI/AN elders who completed a ten-question nutrition screening questionnaire to determine their nutritional risk in 2005, 22.3 percent were at high nutrition risk and 31.8 percent were at moderate risk.[32] Nutrition risk helps to identify warning signs for poor nutrition.

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[29] Population Division, U.S. Census Bureau. Table 16. Projections of the American Indian and Alaska Native Alone Population by Age and Sex for the United States: 2010 to 2050. August 14, 2008.

[30] Malone, J.J. Laupa'I kanaka: Native Hawaiian population forecasts for 2000 to 2050. Honolulu: Kamehameha Schools – PASE. 2005

[31] Moulton, P.L., McDonald, L.R., Muus, K.J., Knudson, A.D., and Ludtke, R.L. Chronic Disease in American Indian/Alaska Native Elders. IHS Primary Care Provider. 30:120-123, 2005.

[32] Jackson, M.Y. and Beard, H. Nutrition related health concerns for American Indian and Alaska Native elders. J. Native Aging and Health 1(1):15-19, 2005.

A decline in functionality is a normal part of aging but appears to be exacerbated with the presence of a chronic disease. The NRCNAA data indicate 13 percent of AI/AN elders reported three or more activities of daily living (ADL) limitations, which is the screening level for entry into a skilled nursing facility. Another seven percent indicated moderately severe functional limitations which would indicate assisted living level of care. Twenty-one percent indicated moderate functional limitations which may require home and community based services. Increased age, lower income, and lower educational level were all associated with the likelihood of more functional limitations.[33]

Home and Community-Based Long-Term Care Services

In general, American Indian reservations, Alaska Native villages, and Native Hawaiian homelands are located in rural areas and are often many miles from cities. This geographic isolation impacts the ability to access programs and services that are available in urban areas. Most AI/AN/NH elders wish to remain at home and in their communities in order to continue to participate in their cultural and religious ceremonies and traditions. They are unable to relocate in order to receive available home and community-based long-term care services. Thus, tribal governments are seeking ways to provide these necessary services in Indian Country.

Two studies on the status and need for long-term care services have recently been completed. One of the studies asked tribal health directors, community health representative directors, social service directors, Title VI directors and other service providers about long-term care planning, strengths and barriers to providing services, and interest in developing long-term care services.[34] A total of 68 percent of the 305 tribes that received the questionnaire responded to it. The major findings of the study included:

- Nearly two-thirds reported discussions within the past 12 months on developing long-term care services.
- The most commonly available long-term care services currently being provided were a senior center, nutrition/meals, transportation, information and referral, home maintenance/repair/modification, and wellness/disease management.
- Strengths in program development included leadership support, acknowledgement of the need for long-term care services, ability to secure funding, and community respect for elders.
- Common barriers to program development were related to funding issues.

The second study, conducted by Scripps Gerontology Center for the National Association of Area Agencies on Aging in 2007-2008, assessed Title VI involvement in home and community based long-term care services, including funding sources, partnerships, and challenges faced in

[33] McDonald, L.R., Ludtke, R.L., and Muus, K.J. Chronic disease and functional limitation among American Indian and Alaska Native elders. J Native Aging and Health 1(1):7-13, 2005.

[34] Goins, R.T. Results from the National Tribal Long-Term Care Study. West Virginia University Center on Aging. December 2008.

providing services.[35] Nearly 86 percent of the 246 Title VI program directors responded to the survey. The results indicated that the majority of Title VI programs also receive services funding from the tribe (76 percent) and the Indian Health Service (IHS) (71 percent) and many receive funding or services from Title III (38 percent) and the state (31 percent). At least 23 percent receive some gaming revenue to fund their services. The high rate of involvement between IHS and OAA Title VI programs reflect the complementary areas of focus and increased collaboration between AoA and IHS to support the critical needs of tribal members and families across the lifespan.

The survey also indicated Title VI programs partner with many other federal, tribal, state and local programs in order to provide home and community-based long-term care services. The most common partnerships are with IHS (89 percent); health care providers (84 percent); tribal, state, and local health departments (75 percent); housing programs (75 percent); and adult protective services (73 percent). Although many services are being provided and numerous partnerships have been developed, there are barriers to expanding service or developing new services. The greatest challenges to providing home and community-based long-term care services were identified as: 1) increasing expenses limit expanding services (94 percent); 2) tribal decisions limit what can be done (71 percent); and 3) the state, either through rules or legislation, limit our role in long-term care (58 percent).

Service Delivery, Outreach and Coordination

Outreach and coordination between Title III – Grants for State and Community Programs on Aging and Title VI – Grants for Native Americans have been assessed in a variety of ways. Both Title III state plans and Title VI applications were reviewed to assure provisions were included for outreach and coordination. Additionally, with a grant from the Administration on Aging, the National Association of Area Agencies on Aging partnered with Scripps Gerontology Center to assess Title VI and area agencies on aging involvement in home and community based long-term care services and programs. Nearly 71 percent of the Title VI directors responding to questions about Title VI and Title III coordination indicated they currently had, or were developing, collaborations with their local area agency on aging. Examples of outreach and collaborations include:

- Some states have established tribal liaison positions to help increase coordination and inclusion of tribal populations in state programs.
- Some states include tribal representatives on their Governors' Committees on Aging.
- Title VI programs, state units on aging and area agencies on aging have collaborated to provide a variety of training programs. For example, in 2009, the Oneida Tribe in Wisconsin partnered with the Milwaukee County Area Agency on Aging to train several tribal members as lay leaders for their chronic disease self management program. Additionally, the Wisconsin State Unit on Aging contracted with the Great Lakes Inter-Tribal Council to be the technical assistance center to meet the unique needs of the eleven tribal aging programs in a culturally competent manner.

[35] McGrew, K.B., Kunkel, S., Lackmeyer, A., and Straker, J.K. Preparing the Aging Network for choices for Independence: Title VI Survey Results. Scripps Gerontology Center. July 2008.

Nutrition and Supportive Services

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.

The 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 2009 grants were awarded to 246 tribal organizations (representing 400 tribes), including two organizations serving Native Hawaiian elders, with an average award of $107,477 and a range of grant awards from $74,650 to $1,505,000.

Caregiver Support Services

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.

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. AoA also partnered with the Admnistration for Native Americans and the Corporation for National and Community Service to work with tribal organizations 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.

Priority Needs

Although the needs of AI/AN/NH elders are similar to the needs of the general older adult population in the United States, there are challenges in accessing services. The geographical isolation, socio-economic situation of native elders, and limited availability of programs and services in AI/AN/NH communities creates unique challenges in addressing their needs. From needs assessment and other surveys and testimony from tribal leaders and program directors at both the FY 2009 AoA Tribal Listening Session and the Department of Health and Human Service Tribal Budget Consultation, the priority needs of AI/AN/NH elders are:

- Health promotion, disease prevention, and chronic disease management;
- Home and community-based long-term care in Native communities;
- Supportive services, especially transportation and housing;
- Elder protection; and
- Caregiver support, including respite.

Part IV: Protection of Vulnerable Older Americans

As the population of Americans age 60 and older increases, the problem of elder abuse, neglect, and exploitation continues to grow. Despite the absence 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 (NCEA) showed a 16 percent increase in the number of elder abuse cases from an identical study conducted in 2000.[36] 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.[37] Together, these data suggest that at least two million Americans age 65 or older are injured, exploited, or otherwise mistreated by someone on whom they depend for care or protection. Perpetrators of elder abuse may be paid attendants, family members, or employees of long-term care facilities.

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.[38] 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 that a growing number of seniors who access the healthcare system more frequently (including emergency room visits and hospital admissions), are ultimately forced to leave their homes and communities prematurely.[39]

In addition, the population age 85 and older is growing rapidly and is projected to reach nearly 20 million by the year 2030. As this population grows, the need for effective long-term care services will increase greatly. Many of these seniors will rely on the support of family and other informal caregivers to remain at home and in the community, while for others a nursing home may represent the best option for receiving the care they need. Regardless of the setting in which these vulnerable elders reside, one of the consequences of this growing population of frail elders is the likelihood of an increase in the instances of elder abuse.

The OAA's Protection of Vulnerable Older Americans programs provide a combination of training, outreach, and information dissemination activities that promote the rights of older people, help improve the quality of care for residents of long-term care facilities, and increase public and professional awareness of the problem of elder abuse.

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[37] 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

[38] 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.

[39] 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

Grants for the Prevention of Elder Abuse, Neglect and Exploitation are allocated by formula to the 56 states and territories based on their share of the population aged 60 and over. States and territories then have discretion to further allocate funding among the various activities authorized under each program and may choose to provide funding to area agencies on aging and local service providers. Section 721 activities of the OAA are focused primarily on protecting vulnerable adults residing at home, or in community-based settings.

Grants provide funding for training and education, promoting public awareness of elder abuse, and supporting state and local elder abuse prevention coalitions and multi-disciplinary teams. The program coordinates activities with adult protective services programs (over half of which are directly administered by state offices on aging) and other professionals who work to address issues of elder abuse and elder justice.

In FY 2009, the Prevention of Elder Abuse, Neglect and Exploitation program continued its efforts to support state and local efforts to train law enforcement officials, develop and distribute educational materials, conduct public awareness campaigns, and create community coalitions. States and area agencies on aging also use this funding to coordinate their activities with fraud and crime prevention partnerships organized by sheriffs, police chiefs, and community organizations.

Examples of elder abuse prevention activities initiated through these grants at the state level 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 for, and resource information to assist, victims of elder abuse. "Fraud Fighter" forms were produced and 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 statewide number for reporting information, hosting community trainings on the various forms of elder abuse, as well as other events and items to raise awareness in communities.

- Lifespan, located in 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.

National Center on Elder Abuse

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

In FY 2009, the NCEA:

- Continued its outreach by serving over 1,700 subscribers to its newsletter and over 1,600 members to the Elder Abuse Listserv.

- Responded to over 1,000 individual public inquiries and requests for information.

- Effectively utilized technology to provide cost-effective trainings to over 1,177 professionals though live webcast forums on issues relevant to elder rights and consumer protection, and maintained the NCEA training library with over 230 resources.

- Supported systems change in 12 local communities by providing funding, training, and technical assistance to new elder justice community coalitions to leverage local resources and expertise to prevent and combat elder abuse, neglect, and exploitation.

Model Approaches to Statewide Legal Assistance Systems

The *Model Approaches to Statewide Legal Assistance Systems* demonstration grants represent an innovative departure from AoA's past approach to the funding of Senior Legal Helplines (SLH). 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 array 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 FY 2009, SLHs within Model Approaches projects assisted 39,247 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.

Through effective targeting and outreach efforts, SLHs under Model Approaches have been very successful in reaching low income populations with 63% of older clients falling within 150 percent of federal poverty guidelines. Also, total minority clients receiving assistance through SLH in FY 2009 constituted 28 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 outcomes achieved in FY 2009 and anticipated for all Model Approaches projects include:

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

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

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

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

National Legal Assistance and Support Projects

National Legal Assistance and Support grants fund a comprehensive national legal assistance support system serving professionals and advocates working in legal and aging services networks. These grants form the National Legal Resource Center (NLRC) which provides resource support through a strategic combination of case consultation, training, and technical assistance on a broad range of legal and systems development issues. Types of pervasive legal issues 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 partners also provide technical assistance on the efficient, cost-effective, and targeted provision of state-wide legal and elder rights advocacy services.

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, area agency on aging and ADRC personnel, senior legal helplines, and others involved in protecting the rights of older persons.

In FY 2009, 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 4,100 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 of outreach methodologies, SLH operations, statewide reporting systems, and legal service delivery standards.

In addition, work on NLRC website in FY 2009 paved the way to the creation of 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. The NLRC is now accessible through http://www.nlrc.gov.

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 2009, nearly 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.

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 older Americans have access to the employer-sponsoredretirement benefits they've 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 to individuals that would be otherwise unavailable, by assisting them 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 27 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 nearly $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.

- Projects have directly served over 35,000 individuals by providing hands-on assistance in pursuing claims through administrative appeals processes; helping seniors to locate pension plans "lost" as a result of mergers and acquisitions; answering queries about complex plan provisions and the laws that govern them; and making targeted referrals to other professionals for assistance.

- 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.

- Through the distribution of fact sheets and other publications, websites, and conducting outreach, education and awareness efforts, Pension Counseling projects have also provided indirect services to tens of thousands of seniors and their families.

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 2009 the Center enhanced 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 (SMP) Program

In 1995, AoA became a partner in a government-led effort to fight fraud, error and abuse in the Medicare and Medicaid programs through the implementation of a demonstration project called Operation Restore Trust (ORT). During its demonstration phase, ORT returned $23 for every $1 spent looking at the fastest growing areas of Medicare fraud, including home health care, skilled nursing facilities and providers of durable medical equipment.

Since FY 1997, AoA has also received funds from the Heath Care Fraud & Abuse Control Account (HCFAC) (as created by the Health Insurance Portability and Accountability Act of 1996; P.L. 104-191), to support the effective training and mobilization of senior volunteers and professionals to provide consumer education to beneficiaries. The volunteer program became commonly known as the Senior Medicare Patrol or SMP.

The SMP program serves a unique role in the effort to identify and prevent health care fraud in the Medicare and Medicaid programs. Projects utilize the skills of retired professionals as volunteers to conduct community outreach and education and provide information that empowers 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 (CMS), the Office of Inspector General (OIG), healthcare providers, and other aging and elder rights professionals from around the country. In FY 2009, 54 SMP discretionary grants were awarded to fund projects in all 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

The National Consumer Protection Technical Resource Center (the Center), provided technical assistance, support and training to the SMP projects, ensuring a fully consolidated national approach to reaching Medicare and Medicaid beneficiaries. The Center promoted and disseminated the work of the projects during national forums and provided technical assistance through on-line training, workshops, and the SMP mentoring program.

AoA collaborated with the CMS Program Integrity Group to facilitate referrals of fraud complaints directly from SMP projects to the CMS fraud contractors (Program Safeguard Contractors—PSCs, Medicare Drug Integrity Contractors—MEDICs, and ZPICs--Zone Program Integrity Contractors).

AoA funded seven SMP Integration Grants, awarded in 2008, to develop innovations that could be successfully replicated by the SMP community to expand and integrate program outreach within rural and tribal areas. Additionally, funding was awarded to the National Hispanic SMP (NHSMP) to develop culturally appropriate outreach strategies for the Hispanic senior population. Due to cultural isolation and language barriers, Hispanic seniors are often at increased risk to be victimized by health care fraud.

The HHS Office of Inspector General (OIG) collects performance data from the SMP projects semiannually. The most recent report, dated May 19, 2010, documented the following program outputs and outcomes for calendar year 2009. Data show SMP projects:

- Maintained 4,444 active volunteers who worked almost 122,410 hours to educate beneficiaries about how to prevent Medicare and Medicaid fraud;

- Educated 217,227 beneficiaries in 7,177 group education sessions and held 33,855 one-on-one counseling sessions;

- Conducted 5,684 community outreach education events and over 311,377 media activities;

- Received 60,242 inquiries for information or assistance from beneficiaries;

- Resolved 2,588 complaints of potential fraud, error, or abuse from beneficiaries, families, or caregivers as a result of educational efforts; and

- Referred complaints of potential fraud, worth over $3,762,448, to the Centers for Medicare & Medicaid Services or other appropriate agencies for further investigation.

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

- Educated 2.8 million beneficiaries in almost 75,000 group education sessions and over 1 million one-on-one counseling sessions;

- Conducted close to1.3 million media outreach events and almost 69,000 community outreach education events; and

- Documented $105.937 million in savings, including Medicare and Medicaid funds recovered, beneficiary savings, and other savings attributable to the project as a result of beneficiary complaints, which does not attempt to quantify the savings that may occur from the SMP program deterring fraud.

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. Types of pervasive legal issues 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 partners also provide technical assistance on the efficient, cost-effective, and targeted provision of state-wide legal and elder rights advocacy services.

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 homes, assisted living, and similar adult care facilities. 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.

The following FY 2009 data and information are collected annually by AoA from State Long-Term Care Ombudsmen through the National Ombudsman Reporting System (NORS). The data are gathered from the Long-Term Care Ombudsman Program recipients nationwide and are based on state and local level activities.

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.

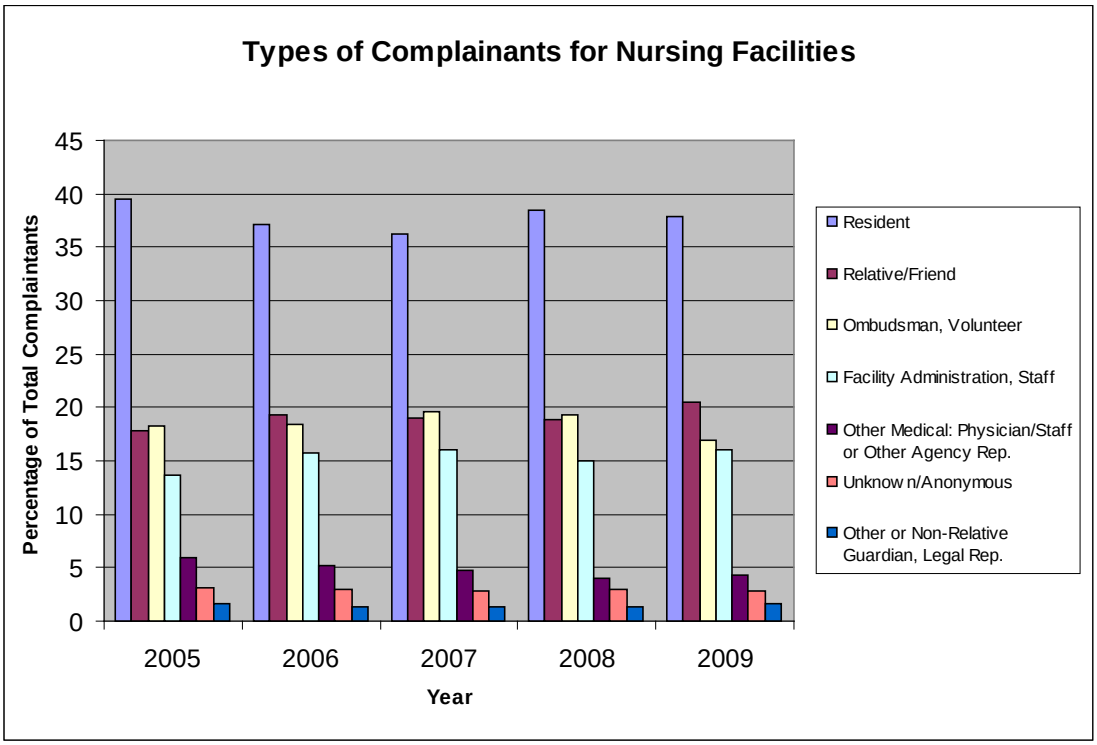
- Ombudsmen nationwide worked to resolve 233,025 complaints in FY 2009, opening 161,222 new cases (a case contains one or more complaints originating from the same person(s)).

- Ombudsmen resolved or partially resolved 75 percent of all closed complaints to the satisfaction of the resident or complainant.

- Of the cases closed, 122,857 (78 percent) were associated with nursing facility settings. Of the remaining cases, 33,766 (21 percent) were related to board and care, assisted living, residential care, and other facilities; and 1,207 (one percent) were associated with other settings or services to residents by an outside provider.

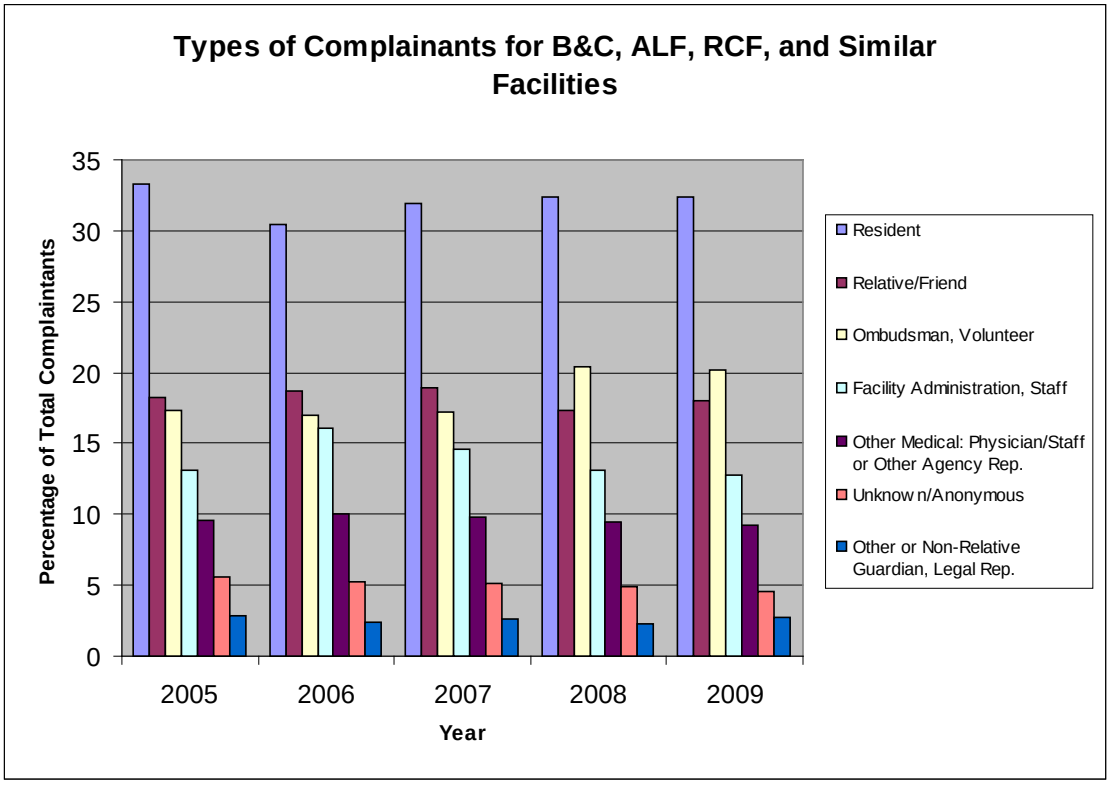
- Most cases were initiated by residents or friends and relatives of residents, with residents initiating over 38 percent of cases in nursing facilities and over 32 percent in board and care, assisted living, residential care, and other similar facilities (see Figures 1 and 2 below). Nearly 18 percent of complaints were issues identified proactively by ombudsmen, primarily by being present in facilities on a regular basis.

Figure 1:



Source: 2009 National Ombudsman Reporting System (NORS) Data

Figure 2:



Source: 2009 National Ombudsman Reporting System (NORS) Data

- The five most frequent nursing facility complaints in 2009 were:
  - *unanswered requests for assistance;*
  - *inadequate or no discharge/eviction notice or planning;*
  - *lack of respect for residents, poor staff attitudes;*
  - *quality, quantity, variation and choice of food; and*
  - *medications – administration, organization.*

- 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: Board and Care Residents

When a state's mental health agency initiated an emergency closure of a residential facility due to infestation of bed bugs, lack of staff supervision, and other quality of care issues, the ombudsman learned that some residents had been transferred to unsafe or inappropriate locations. She visited the facility where she found three residents, but no staff, present. Not only did the ombudsman assure that these residents were safely transferred to another facility, but she filed a formal complaint with the state agency. The complaint led to improved processes and coordination and better outcomes for residents in the agency's subsequent facility closure actions.

Ombudsman Presence in Facilities and Empowerment of Families and Residents

- Ombudsman staff and volunteers provided a regular presence to facility residents, visiting residents of 81 percent of nursing facilities and 45 percent of board and care and similar homes (including assisted living) at least quarterly.

- Ombudsmen provided 343,043 consultations to individuals in 2009. These consultations have increased by almost 82 percent since FY 1996. 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.

- Ombudsmen provided 140,263 consultations to long-term care facility staff in FY 2009 on a wide range of issues, including residents' rights, observations about care, working with resident behavioral issues, and transfer and discharge issues.

- In FY 2009, ombudsmen nationwide:
  - provided information to resident councils (21,273 sessions) and family councils (3,942 sessions);
  - provided 6,063 training sessions to facility staff;
  - facilitated or conducted 13,169 community education sessions; and

- participated as resident advocates in 17,856 facility surveys conducted by regulatory agencies.

Ombudsman Program in Action:
Culture Change and Resident-Centered Care

As resident advocates, long-term care ombudsmen have the opportunity to engage in both individual and systemic advocacy that supports the resident-centered principles of the culture change movement. Recognizing the dynamic interrelationship between quality of care and quality of life, culture change emphasizes the importance of identifying and responding to the unique life experiences, needs, and care preferences of each resident. Long-term care ombudsmen throughout the country have become vocal advocates for culture change, identifiers of good practices, and proponents for making culture change a reality in the facilities they visit.

- 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. In 2009, such work accounted for 20 percent or more of state staff time in almost half the states and 30 percent or more of state staff time in 17 of those states.

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 573 designated local entities across the nation.

In FY 2009, long-term care ombudsman services to residents were provided by 1,203 full-time equivalent staff and 8,661 volunteers, trained and certified to investigate and resolve complaints. Another 2,322 volunteers served residents or assisted the program in

Ombudsman Program in Action:
Outside Services to Facility Residents

Residents of a rural nursing facility who required specialized medical care often had to travel long distances by ambulance. The nursing facility had contracted with the area's only ambulance company to provide transportation services. When scheduled rides were repeatedly cancelled and residents missed medical appointments, a complaint was brought to the ombudsman.

The ombudsman initiated meetings with the ambulance service, the nursing facility administrator, and local government officials to seek a resolution. As a result of this collaboration, long-term care residents in this rural county now have better access to ambulances and an improved scheduling and reservation system. Today, these residents have more reliable transportation and better access to needed medical care.

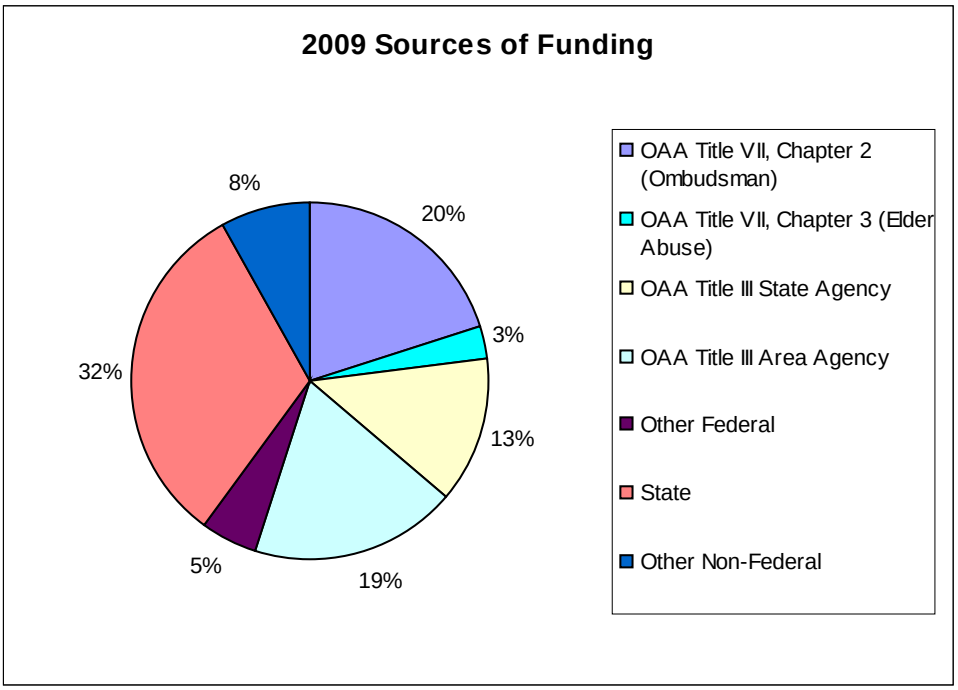
ways other than complaint resolution.

Program Funding

- Total FY 2009 funding from all sources for the Ombudsman Program nationwide was $84,843,109, an overall decrease of $1,519,897 from the FY 2008 total.

- The federal government continued to be the primary entity funding the Ombudsman Program, providing 60 percent of total funding in 2009. States provided 32 percent of funds, and other non-federal sources funded the remaining 8 percent. Figure 3 below shows the percentage of total program funding by source.

Figure 3:



Source: 2009 National Ombudsman Reporting System (NORS) Data

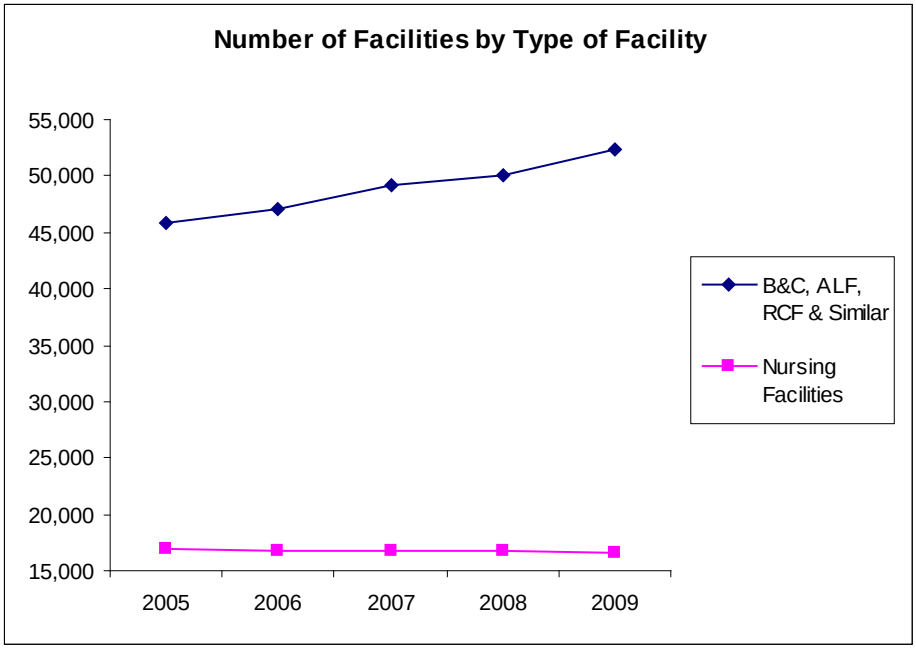
Where Long-Term Care Facility Residents Reside

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" continuum.

- In the last five years, the number of board and care, assisted living, residential care and similar facilities increased by 14 percent to 52,371, while the number of nursing facilities slightly decreased by 1 percent from a high of 16,862 in 2005 to 16,653 in 2009. Figure

4 below shows the growth in non-nursing home facilities relative to nursing homes.

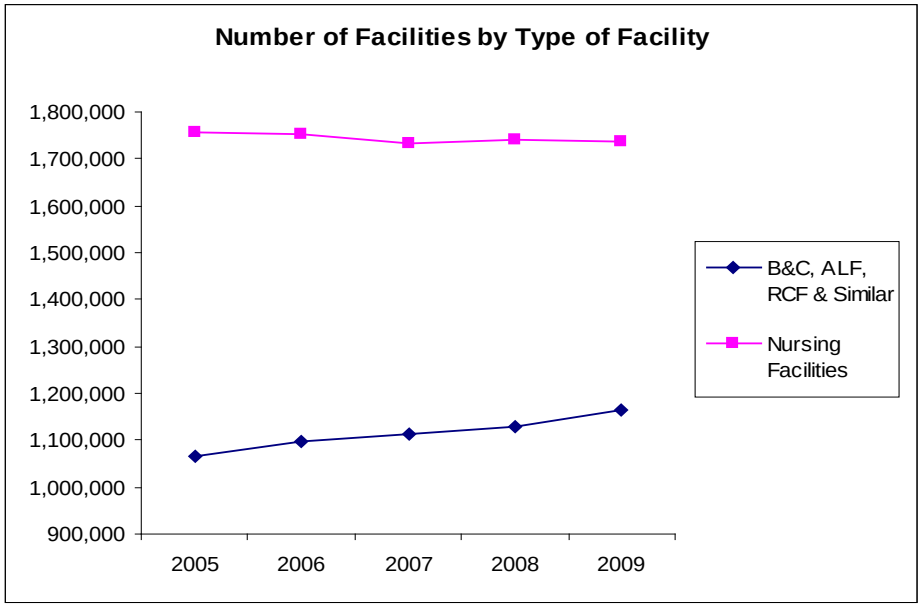
Figure 4:



Source: 2009 National Ombudsman Reporting System (NORS) Data

- The numbers of nursing facility beds remained relatively level during this period (1.7 million), decreasing by 1 percent, while the number of board and care and similar type facilities beds increased by 9 percent (to over 1.1 million), as shown in Figure 5.

Figure 5:



Source: 2009 National Ombudsman Reporting System (NORS) Data

National Long-Term Care Ombudsman Resource Center Activities:
In order to be effective advocates 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 2009, 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 2009, 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;
- Culture Change and Person-Centered Care;
- Advocacy in Assisted Living; and
- The Advancing Excellence Campaign and Consumer Involvement.

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.

Ombudsman Program in Action: Nursing Facility Resident

When a nursing facility threatened to discharge a resident without a discharge plan to meet his significant care needs, the ombudsman was contacted for assistance. The ombudsman assisted the resident in appealing the discharge notice.

While the resident claimed that he had no financial resources and was prepared to seek Medicaid eligibility, the facility did not assist the resident in seeking Medicaid, instead claiming that he had sufficient financial resources to pay the nursing facility bill. The facility hired an attorney to claim guardianship of the resident in an attempt to access the resident's supposed resources. Since the resident did not lack capacity to make his own decisions, guardianship was inappropriate. Next, the attorney asked the resident to provide the facility with a financial power of attorney, which the resident refused to sign. When the facility finally sued the resident, the ombudsman assisted the resident in accessing legal representation and in applying for Medicaid.

Ultimately, the resident was determined to be Medicaid-eligible. He asked the ombudsman for information about other nursing homes in the area, and he relocated to another nursing home where his health and well-being are significantly improving.

Conclusions

Residents rely on ombudsmen to resolve their problems -- 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, ombudsman work 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 consumer information -- Ombudsman programs served provided individualized consumer information more than 343,000 times in FY 2009, in addition to providing information to resident councils, 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 non-federal dollars -- Federal funds leveraged resources from other sources for ombudsman programs. More than 40 percent of program funds came from non-federal sources during FY 2009. 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, assisted living, residential care and other similar facilities.

Part V: Supporting the National Aging Services Network

AoA provides national leadership, funding, technical support and oversight to the national aging services network (aging network) which is charged under the OAA with the responsibility for promoting the development of a comprehensive and coordinated system of home and community-based services for older people and their family caregivers. The aging network consists of a variety of national organizations, 56 state units on aging, 629 area agencies on aging, over 244 tribal organizations, over 20,000 community services provider organizations, and 500,000 senior volunteers. This network reaches into every community in the nation and plays an important role in delivering services and supporting consumer-centered systems of care that enable older individuals to remain living in their own homes and communities for as long as possible.

Outreach on Long-Term Care in Home- and Community-Based Settings

AoA, through the aging network, broadly disseminated information and provided technical assistance and mobilization strategies to community and health care providers as they work with Medicare beneficiaries to fully understand their options in the Part D prescription drug program Low-Income Subsidy (LIS), including opportunities for the LIS and the Medicare preventative benefits in coordination with the Centers for Medicare & Medicaid Services (CMS). AoA leveraged resources within the aging network to develop true collaborative partnerships to directly engage beneficiaries to maximize personalized assistance, healthy living and promoting home and community-based living.

On June 1, 2009, HHS Secretary Kathleen Sebelius released $25 million in grants to the aging network to help older people, individuals with disabilities and their caregivers apply for special assistance through Medicare. These grants, made possible by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), provided valuable support at the state and community levels for organizations involved in finding and providing enrollment assistance to people likely to be eligible for the Medicare Part D Extra Help/Low-Income Subsidy, Medicare Savings Program (MSP), the Medicare Part D Prescription Drug Program, and other important public benefits such as the Supplemental Nutrition Assistance Program (SNAP), the Low-Income Home Energy Assistance Program (LIHEAP), and more. This initiative also included special targeting efforts to rural areas of the country and to Native American elders. AoA provided ongoing coordination with the CMS- funded State Health Insurance Assistance Program (SHIP) and funded a resource center (the National Center for Benefits Outreach and Enrollment) to support these valuable outreach and enrollment efforts.

Through an inter-agency agreement with CMS, AoA funded ten pilot programs to develop projects in the field for testing alternative methods of communication among generations about Medicare and Medicaid including but not limited to, activities that integrate technology and social interaction between people. Specifically, ten pilots were conducted at locations/agencies experienced in innovative services and programs to younger retirees and older persons receptive to new forms of communication. The projects demonstrated the creativity and versatility of the aging network in reaching a growing number of baby boomers, future retirees, and their families.

These project strategies are designed to be available for other members of the network to replicate and localize for their particular service areas and culture and reduce duplicative efforts.

A consistent key driver in assisting older adults to make long-term care services and support decisions is the ability to provide one-on-one counseling sessions by trained and trusted staff members. The aging network developed and utilized many successful practices, including targeted media campaigns, developing new messages to reach local seniors and strengthening local partnerships and referrals. Creating new uses for data and screening tools increased the agencies' abilities to target the most vulnerable populations. The activities performed to help in Medicare outreach was also successful in raising state and local awareness of the availability of other long-term services and supports programs under the OAA.

AoA and CMS have partnered closely on Medicare outreach to beneficiaries and their family members since 2004 and have participated either directly or in partnership in 90 percent of the outreach events, educational programs and one-on-one counseling sessions.

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 to streamline access to public services and 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 stemmed from best practice innovations known as "No Wrong Door"[40] 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 in 50 states, 3 territories and Washington, DC.

Over the next decade, AoA envisions ADRCs or some equivalent operation becoming every states' integrated access point and "No Wrong Door – Single Entry Point" system for individuals of all ages for information and access to the long-term services and support options they need. Further, AoA envisions ADRCs expanding their role and building upon their foundational infrastructure to include:

- 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,

[40] 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).

rehabilitation or skilled nursing facility visit;
- "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 services and support programs; and,
- integrated access-point to care transition and diversion support to veterans served through the Department of Veterans Affairs, the Veterans Health Administration (VHA) partnership, "Veterans Directed Home and Community-Based Services Program."

To achieve this goal, a well-established, effective ADRC needs to be able to build upon the foundational infrastructure that have successfully been developed and perform the following five key operational functions:

- *Information, Referral and Awareness*: ADRCs serve as a highly visible and trusted place that people know they can turn to for objective information on the full range of long-term care service and support options. ADRCs promote awareness of the various options, including Medicare benefits, that are available in the community, especially among underserved, hard-to-reach and private paying populations, as well as options individuals can use to "plan ahead" for their long-term care. ADRCs have the capacity to link consumers with needed services and supports – both public and private – through appropriate referrals to other agencies and organizations.

- *Options Counseling and Assistance*: ADRCs provide counseling and decision support to consumers and their family members and/or caregivers by identifying and understanding the needs of the clients and assisting them in making informed decisions about appropriate long-term service and support choices – including their Medicare options – in the context of their personal needs, preferences, values and individual circumstances.

- *Streamlined Eligibility Determinations for Public Programs*: ADRCs serve as a single point of entry to publicly-funded long-term supports, including those funded by Medicaid, the OAA, and other state and federal programs and services. ADRCs must have the necessary protocols and procedures in place to facilitate integrated and/or fully coordinated access (i.e., consumer intake, needs assessment, service or care planning, eligibility determination, and ensuring that people get the services they need) to publicly supported long-term services and supports – both community-based and institutional. The goal is to create a process that is seamless for consumers regardless of which service they choose.

- *Person-Centered Care Transitions*: ADRCs create formal collaborations between and among the major pathways that are used in health care and long-term services and supports, including preadmission screening programs for nursing home services, hospital discharge planning, physician services, and various community agencies and organizations. These linkages ensure that people with chronic conditions and disabilities have the information they need to make informed decisions about their service and

support options as they pass through critical transition points in the health and long-term services and support systems that cut across all payers and settings. These critical activities can help individuals break the cycle of readmission to the hospital and live longer in the community.

- *Quality Assurance and Continuous Improvement*: ADRCs must ensure that they are person centered and adhere to the highest standard of service in all areas. ADRCs should continually monitor the quality of their services and evaluate their own impact on consumers' lives, system efficiencies and public costs.

AoA and CMS have invested over $70 million in the ADRC program since 2003. As a result of these investments:

- Over 290 ADRC sites have been established in 50 states, 3 territories, and Washington, DC, often by expanding existing infrastructure in the aging network. Together these ADRC sites cover roughly 51 percent of the U.S. population.

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

- 25 states have developed statewide web-based directories available to consumers and service providers which improve the quality and consistency of the aging 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.

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 Minority Aging Organizations Technical Assistance Centers

The National Minority Aging Organizations (NMAO) Technical Assistance Centers Program works to reduce or eliminate health disparities among racial and ethnic minority older individuals. These centers design and disseminate front-line health promotion and disease prevention information that is culturally and linguistically appropriate for older individuals of African American, Hispanic, Asian American and Pacific Islander descent, and American Indian

and Alaska Native elders. 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.

Civic Engagement

The National Council on the Aging (NCOA) has been awarded a grant from AoA for a three-year project to create a National Center on Multi-Generational and Civic Engagement (the Center). The purpose of the Center is to identify and provide technical assistance and other support to local programs that can become national multi-generational and civic engagement models for using older volunteers in meaningful direct services.

The Center has identified 19 local projects which focus on three target populations: 1) older relatives caring for grandchildren; 2) families caring for children with special needs; and 3) caregivers of frail elderly. The projects are being examined for possible national replication based on four criteria: program effectiveness; impact; sustainability and ease of replicability in other communities. Throughout FY 2009, the Center conducted site visits and developed online training and webinars on a number of topics.

Additionally, as part of this initiative, AoA has entered into a Memorandum of Understanding with the Corporation for National and Community Service to provide twelve VISTA members to augment the project and work with six of the community models. Additional funding has also been leveraged and provided by The Atlantic Philanthropies and the Metlife Foundation. Partners to the grant are tasked with specific responsibilities designed to expand the capabilities of all. For example, Temple University focuses on training, while Easter Seals serves as the expert on caregiving and helps the projects develop plans and identify models of care.

One example of a team model that has proven to be beneficial to other projects is the Center's "Wisdom Works" program. Using this self-directed team model, the GRANDS Program, a grandparent raising grandchildren program, has been able to expand and promote its services throughout the city of Boston. The volunteers are always setting new goals for themselves, and using their creativity to provide engaging programming and services to the grandparents throughout the neighborhoods of Boston.

Next steps for this initiative include synthesis and dissemination of best practice approaches and on-line tools to test replication of the most promising models in other communities. The goal is to develop strategies that will be most helpful to the aging network, which is heavily dependent on the use of volunteers in providing community-based services.

Meeting the Need for Trained Personnel in Aging

The aging of America is creating new challenges and opportunities for the aging services network. 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 with long-term services and support needs.

The aging network, and in particular state and area agencies on aging, play an important role in planning, developing and managing the state's home and community-based service systems. In addition, most states have lead responsibly for home and community-based services for the elderly in their state and area agencies on aging, including responsibility for managing state-funded programs as well as Medicaid waivers.

AoA and other HHS agencies have been offering a variety of opportunities to the aging network in recent years to position them to take a lead role in the provision of long-term supports and services including home and community-based services for older adults and populations of non-elderly persons with disabilities. Through these opportunities, many state aging networks have created systems of care that are a recognized, accessible and person-centered source of information, options counseling, streamlined access to benefits and services, and seamless linkages to all available supports and services for older adults, their caregivers, and other populations of people with disabilities. In other states, the aging network is in earlier stages of the process of building their capacity to position themselves to play a lead role in the development of a modernized system of long-term care. Some states have not advanced along with the best available science on the delivery of long-term supports and services.

In recognition of the need to create more consistently prepared aging network organizations nationwide, AoA has awarded several training and technical assistance grants focused on training aging network personnel in key areas including aging, long-term supports and services, leadership and change management.

The National Long-Term Care Business Institute (NLTCBI) is a program funded by a grant from AoA to the National Association of Area Agencies on Aging (n4a) in partnership with the Scripps Gerontology Center (Scripps) at Miami University; Oxford, Ohio to provide business concepts and practices to area agencies on aging and Title VI Native American programs.

The NLTCBI frames its strategy around three central concepts: knowledge, application, and practice. The National Center teaches participants how to apply knowledge, strategies, and skills in their everyday operations in an intensive day and a half seminar. The curriculum of the NLTCBI is shaped by: (1) a comprehensive review of the literature on strategic planning for long-term care; (2) a key informant study in which experts, identified by the n4a, Scripps, and the AoA, participate in interviews and focus groups to help shape the curriculum for the training program; and (3) a web-based survey, conducted through the n4a website of AAA/Title VI Program senior staff to ascertain their current practices in, and perceptions of, strategic planning and the future of long-term care in the aging network. Curriculum encompasses the following areas:

- Using data to plan for growth and change in the older population, especially as related to needs for long-term care options;
- Change management and innovation in long-term care services;
- Quality improvement versus compliance models in long-term care;

- Business and strategic planning for long-term care; and
- Leadership and advocacy for community-based long-term care.

This training is aimed toward providing the tools necessary to conduct the business of the local aging network at the highest levels of effectiveness and professionalism possible

During FY 2009, a number of training and technical assistance initiatives were funded by AoA with the overall goal of ensuring an aging network workforce prepared to meet the needs of the nation's current and future older adults and their caregivers. Below is a summary of five of these initiatives and the activities they are undertaking.

- *Aging Network Business Practice, Planning and Program Development*
  The National Association on Area Agencies on Aging (n4a), in partnership with the Scripps Gerontology Center, conducted a survey of area agencies on aging. Through this activity, a number of training and technical assistance needs of AAAs were identified in order to modernize their systems to meet the needs of the growing number of older adults and their caregivers. To begin to provide this support, n4a and Scripps conducted a series of intensive Business Training Institutes introducing concepts for business and strategic planning, leadership development and focusing on key topic areas in the provision of home and community-based services, including single point of entry, person-centered approaches, participant-directed services and using evidence-based approaches.

- *Technical Assistance Support Center (TASC) Planning Zone*
  For the aging network to succeed in developing comprehensive and coordinated systems of long-term supports for aging baby boomers, persons with disabilities and their families, effective comprehensive planning skills are critical. AoA funded 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. Resources available include information useful for developing a mission and vision for aging services, information on federal priorities and strategic direction, potential challenges, demographic and programmatic data, and resources on quality improvement.

- *National Center on Benefits Outreach and Enrollment*
  With public benefits programs undersubscribed, a person-centered, community-wide approach to benefits outreach and enrollment can effectively find and enroll individuals into need-based programs. Since 2008, AoA has funded the National Center for Benefits Outreach and Enrollment to serve as a much-needed "hub" to inform, centralize and coordinate national, state and local efforts to enroll low-income seniors and younger adults with disabilities into benefits in a person-centered, cost-efficient manner. The overall goal of the center is to increase the coordination of benefits and participation of seniors and younger adults with disabilities in state and federal benefits programs.

- *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. The Center serves

as a resource center for aging service providers nationwide to implement healthy aging programs. Resources provided include manuals, toolkits, research, examples of model health programs, and links to websites on related health topics. The Center also serves as the technical assistance resource center for the AoA's Evidence-Based Disease and Disability Prevention grant program.

Each of these AoA-funded training and technical assistance initiatives report regularly to AoA on their progress in working with AoA grantees, and the broader aging network, and collaborate with AoA and others in the design and implementation of their technical assistance and training activities. 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. Key outcomes include:

- four Aging Network Business Institutes have been held involving staff and board members from over 100 AAAs and tribal organizations;
- all training content for the business institutes has been based on a series of surveys to AAAs and tribal organizations, all with response rates over 80 percent;
- approximately 200 aging network professionals attend monthly calls hosted by NASUAD on issues of importance to strategic planners;
- each month over 500 aging network professionals attend webinars on person centered benefits outreach and enrollment and over 2,500 receive new regular e-mail updates including issue briefs, best practice reports and information on new tools and resources.

Preparing for and Responding to Disasters

Approximately five percent of Americans over the age of 65 live in nursing homes. The rest live in the community, with about 30 percent living alone. Over 50 percent of these individuals have two or more chronic conditions which limit their mobility; many use various assistive devices. Two million are homebound.

Older persons and persons with disabilities are especially at risk in times of disaster. Family and community-based support systems are often disrupted or cease to function. If evacuation occurs, moving to a local shelter increases vulnerability.

Post-Hurricane Katrina reports indicate that 1,330 persons died as a result of the storm and its aftermath. Approximately 70 percent of these deaths were persons over the age of 60. A January 2009 report in the American Journal of Managed Care noted that New Orleans seniors affected by Hurricane Katrina had an illness rate four times greater than other U.S. residents and had a 21 percent increase in emergency rooms visits the post-hurricane year.

AoA's disaster assistance funding for federally declared disasters is statutorily set-aside out of Title III State and Community-Based Services funding. The total available is specified in section 310 of the OAA as an amount from Title III equal to two percent of the appropriation for Title IV Program Innovations. This funding helps states address unexpected disasters affecting the national aging services network. In 2009, there were 59 federally declared disasters.

Most of this funding is used to reimburse states and tribal organizations for the additional cost of assistance and services needed to respond to nationally declared disasters such as floods, fires, hurricanes, tornados, and other natural events. Funds enable states to fill gaps and provide services not readily available, such as: essential community supportive services; ongoing information and assistance; case management; replacement of shelf-stable meals and transportation; home repair; chore services and the continued clean up of debris from disasters so that individuals can return home.

Additionally, AoA works in partnership with the national aging services network to support training and emergency planning efforts, working with federal, state and local partners to increase preparedness and establish more responsive plans for assisting frail elderly individuals and their families before, during and after a disaster.

Examples of some of the planning activities conducted during FY 2009 included:

- AoA conducted five regional training sessions on emergency preparedness and disaster response. Participants included the directors and emergency managers from 33 agencies on aging. The sessions covered a wide range of emergency planning activities, focusing particular attention on natural disasters such as hurricanes, tornadoes, earthquakes and fires that more frequently occur in each of the various regions.
- Materials were prepared for inclusion in DHHS and FEMA emergency planning reports, playbooks and staff manuals related to the special needs of elderly individuals during disasters and strategies for strengthening health and human service response systems.
- AoA assisted in the review and implementation of a nationwide case management contract designed to focus assistance to persons with disabilities and special needs.
- AoA prepared a detailed Emergency Checklist for state and area agencies on aging. This checklist, which was used as a technical assistance document, was designed to strengthen state and area agency involvement in state and local preparedness efforts and improve planning for disaster response. Later in the year, the National Association of Area Agencies on Aging used this information as a guide for a nationwide survey of the 629 area agencies on aging, which had nearly an 80 percent response rate. Information from this survey is being incorporated into plans at the federal, state and local levels to improve emergency preparedness and response activities.

The aging network has access to up-to-date information about millions of frail elderly individuals living in the community who are served by OAA programs and are impaired due to two or more chronic health conditions. During emergencies, AoA works with the HHS Secretary's Operations Center and other federal, state and local partners to share information between the aging network and emergency response partners at all level to help coordinate assistance to older persons and persons with disabilities. If there is advance warning of a possible emergency, the aging network contacts vulnerable and homebound seniors to assess their situations and try to provide assistance that may be needed – both before and after the event. In situations where individuals may need to "shelter in place," the aging network distributes shelf stable meals in advance of the emergency. Long-term care ombudsmen staff and volunteers contact nursing home and assisted living facilities to determine the status of emergency plans should evacuation be necessary, and follow up after the event to check on the safety and well-being of residents.

Part VI: Program Innovations

Program Innovations is intended to provide a source of funding for AoA to use as a catalyst for tapping existing aging services network practices that represent 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. It also provides funds to address key AoA priorities to help seniors stay healthy, active, independent, and living in their own homes and communities.

These funds provide AoA with the flexibility to innovate and demonstrate practical methods that can then be more widely replicated by states and local communities to help strengthen and transform OAA core programs. Generally, these innovations are modeled after best practices developed within the aging services network that need further support, modeling, and evaluation before enabling widespread replication and adoption. This flexibility, for instance, provided the seed money for developing Aging and Disability Resource Centers and Evidence-Based Disease and Disability Prevention projects that are now being successfully implemented in locations across the nation.

When resources are available to AoA, Program Innovation grants are awarded 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) was authorized by Congress in the Older Americans Act (OAA) reauthorization of 2006 to assist communities in their efforts to enable older adults to sustain their independence and age in place in their homes and communities. Toward this end, Congress directed the assistant secretary for aging to make three-year grants, on a competitive basis, to community-based non-profit organizations to develop and carry out model aging in place projects. The Act specifies that the projects should be designed to promote aging in place for older individuals, including individuals who reside in Naturally Occurring Retirement Communities (NORCs) in order to sustain their independence. Congress further directed that innovative approaches under the CIAIP initiative should be based on needs assessments that identify community strengths and gaps in supporting aging in place as well as the unique needs of older individuals in the community. Funding was first authorized for the CIAIP initiative in FY 2009.

AoA published a funding opportunity announcement in May, 2009 soliciting proposals for awards of $250,000 to $500,000 for Community Innovations for Aging in Place. Applicants for funding under the CIAIP initiative were instructed to assess their communities to identify any barriers to independence and aging in place, and then, in collaboration with other community organizations, identify innovative strategies for providing and linking older individuals to programs and services that provide comprehensive and coordinated health and social services to older individuals and support aging in place. As identified in the OAA, health and social

services considered critical to aging in place include care management including health care management, evidence-based disease prevention and health promotion services, education, socialization, recreation and civic engagement opportunities. The solicitation identified collaboration as an important component of community-based innovative strategies to assist frail older adults to age in place. Successful projects were identified as those able to establish meaningful partnerships with local entities including ADRCs, AAAs, local providers of health and social services, housing entities, and others in order to develop and implement innovative aging in place intervention.

In response to the funding opportunity announcement, over 200 applications were received. Nineteen independent review panels were established, each consisting of three professionals with expertise in a variety of areas in the field of aging and home and community-based services. Based on the results of the independent review, late in FY 2009, the Administration on Aging funded fourteen (14) organizations representing diverse communities from across the country. In addition, a grant was awarded to the Visiting Nurse Service of New York City to provide training and technical assistance to the CIAIP grantees.

Funded late in FY 2009, CIAIP grantees did not begin their work until early in FY 2010. This report summarizes the diverse proposals of the 14 community grants. AoA's FY 2010 report will begin to report on lessons learned as identified at the end of year one of the three year projects.

Atlanta Regional Commission Area Agency on Aging – Atlanta, GA
The purpose of the Atlanta project, *Building Lifelong Communities in South Cobb County*, is to build capacity at the local community level for establishing a lifelong livable community where individuals of all ages can benefit throughout their lifetimes from comprehensive planning, design, programming and community involvement.

Boston Medical Center – Boston, MA
The Boston Medical Center's *Elders Living at Home Program* (ELAHP**)** will provide comprehensive services allowing low-income formerly homeless older adults who are at risk of recurring homelessness to remain in public housing, with maximum independence, improved health and healthcare, and meaningful activities and relationships. The approach is to provide comprehensive, individualized, ongoing case management targeted to the specific needs of formerly homeless older adults.

Catholic Charities – Stockton, CA
Catholic Charities - Diocese of Stockton proposed the *Older Adult Outreach and Engagement Project* in collaboration with Tuolumne and Calaveras County's social service agencies, the Area Agency on Aging, and community organizations supporting the needs of older adults. The project proposes to provide a comprehensive, community-coordinated case management system that is responsive to the diverse needs of older adults residing in a rural area, enabling more elderly residents to safely age in place, continue to live independently in their community while retaining the dignity and respect they have earned.

Catholic Charities – Kansas City, MO
Catholic Charities of Kansas City-St. Joseph proposes implementing *Caring Communities Resource Centers* in collaboration with senior centers and diverse community partners with

health and aging expertise. The approach takes health care assistance, social workers, chronic disease education and related health activities into senior neighborhood settings with an overall goal of enhancing the older adults' ability to live independently and to increase healthy behaviors through localized access to a continuum of health and social services focused on seniors and their caregivers.

City of Montpelier – Montpelier, VT
The City of Montpelier will lead a collaborative grassroots effort building on the community's awareness of Time Banking to create the *REACH (Rural Elder Assistance for Care & Health) Care Bank*: a network of people and organizations coordinating multiple avenues of support. *REACH Care Bank* is a new social enterprise that will foster health, wellness, and resiliency for elders and caregivers who need expanded services to build livable communities for elders of all income levels and facilitate aging-in-place by engaging the community at large in the exchange of services and time. The project will work to integrate informal and formal services into a single comprehensive services systems supporting aging in place.

Coordinating Center for Home and Community Care – Millersville, MD
The Coordinating Center proposes an aging in place project in collaboration with the Howard County Department of Aging (ADRC). The approach integrates innovative case management expertise with existing community-based services to sustain independence of older individuals. Actualizing aging in place principles, the project goal is to target older adults at risk of institutionalization and spend down to Medicaid and provide comprehensive assessment, case management and tailored services to assist them in their efforts to age in their own homes and avoid costly re-hospitalizations and inappropriate facility placement.

Easter Seals – Manchester, NH
Easter Seals New Hampshire proposes the Seniors *Count* Coordination Initiative in collaboration with the Catholic Medical Center, Elliot Senior Health Center, Dartmouth-Hitchcock, the Bureau of Elderly & Adult Services, Manchester Department of Public Health, and the Aging and Disability Resource Center. The overall goal is to create and implement a replicable person-centered model that enhances coordination between medical services, community living/social services, and caregiver support for frail seniors in the Manchester service area.

Family Eldercare – Austin, TX
Family Eldercare proposes a Community Innovations for Aging in Place project in collaboration with the area agency on aging and five other agencies. The program will be provided in subsidized housing with high concentrations of low-income older adults in three Central Texas communities. The approach is to deliver services through a Service Coordinator at each site, provide case management to persons at risk of premature institutionalization and provide activities, including evidenced based practices, that impact aging in place.

Jewish Family Services – Albuquerque, NM
Jewish Family Service proposes a Community Innovations for Aging in Place project in collaboration with the NM Aging & Long Term Services Department, the local area agencies on aging, NM Department of Health, Fort Sumner Community Development Corporation,

and other local providers. The goal of the project is to implement a culturally diverse, innovative, and cost-effective aging in place program for the delivery and coordination of community-based health and social services that support seniors and their caregivers at four sites: Native American; rural; urban; and suburban. The intervention at each site will be based on an assessment of the community's provider agencies as well as of a sampling of residents.

LA Gay and Lesbian Community Center – Los Angeles, CA
The L.A. Gay & Lesbian Center seeks funding for an aging in place initiative based on a unique intervention to provide lesbian, gay, bisexual and transgender (LGBT) seniors with targeted support services including services that will bring individuals together as a "community". The project will also develop and provide LGBT cultural competency training for mainstream aging service providers that assist area seniors as they age in place. The overarching goal of the project is to ensure that LGBT older adults in Los Angeles feel treated with dignity and respect as they access a comprehensive and coordinated continuum of aging-in-place support services.

Mount Sanford Tribal Consortium – Gakona, AK
In collaboration with the Alaska Native Tribal Health Consortium, the University of Alaska, Alaska Senior and Disability Services and regional service providers this project proposes the development of an aging in place program in two small frontier native Alaskan villages that will serve as a model for developing similar programs in other villages in Alaska. The goal of this project is to design and implement a cost effective, model that enables native elders living in an isolated frontier area to remain in their homes and villages for as long as possible by maximizing limited formal services and available informal supports.

Neighborhood Centers – Houston, TX
Neighborhood Centers, guided by the Aging Agenda for Houston and Harris County, will implement *Houston Aging in Place Innovations* with the Houston Health Department and Area Agency on Aging, the Care for Elders partnership, the YWCA, Interfaith Ministries of Greater Houston and Gateway to Care. The project will develop a new role for senior centers in serving naturally occurring retirement communities with a menu of evidence-based health promotion programs, case management teams that include certified community health workers and elder care field specialists, and neighborhood Elder-Care Action Teams. The project will target minority older adults in three neighborhoods to assist them to optimizing their ability to age in place.

NYC Department for the Aging – New York, NY
The New York City (NYC) Department for the Aging proposes to broaden the scope of existing naturally occurring retirement communities (NORC) in NYC to improve the health and mental health of residents and guide systems change for aging in place models. The *NORC Health Plus* program is designed to encourage a stronger community role for NORC programs, increase resident participation in the governance and development of NORC supportive services programs, and introduce evidence-based disease prevention interventions into NORC programming.

Supportive Older Women's Network – Philadelphia, PA

The Supportive Older Women's Network proposes *Growing Healthy Lives Together,* a comprehensive healthy living program for older adults, predominately women, who are aging in place in their homes. The project is targeted to serve a West Philadelphia neighborhood that has a very high percentage of minority low-income older adults living alone with multiple chronic health conditions. The project is based on a prevention model that is inclusive, open to all older residents in the targeted community. The *Healthy Lives* project provides an integrated approach to wellness, coupling physical and emotional health, is non-stigmatizing and provides on-going support to sustain healthy lifestyle changes.

Appendix

Formula Grant Funding

Allocation by

State, Territory and Tribal Organization

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

Title III - Grants for State and Community Programs on Aging
FY 2009 Final Allocation

9/3/2009

State	Supportive Services	Congregate Meals	Home Meals	Preventive Services	NFCSP	Total Title III
Alabama	$5,511,235	$6,625,002	$3,357,241	$333,168	$2,388,721	$18,215,367
Alaska	$1,795,942	$2,158,368	$1,065,886	$105,130	$766,492	$5,891,818
Arizona	$7,186,334	$8,638,621	$4,377,649	$405,273	$3,197,875	$23,805,752
Arkansas	$3,510,940	$4,215,426	$2,125,590	$211,585	$1,521,777	$11,585,318
California	$35,454,106	$42,619,031	$21,597,330	$2,132,032	$15,485,835	$117,288,334
Colorado	$4,564,582	$5,487,038	$2,780,574	$256,172	$1,847,782	$14,936,148
Connecticut	$4,416,847	$5,306,740	$2,544,147	$261,174	$1,867,650	$14,396,558
Delaware	$1,795,942	$2,158,368	$1,065,886	$105,130	$766,492	$5,891,818
District of Columbia	$1,795,942	$2,158,368	$1,065,886	$105,130	$766,492	$5,891,818
Florida	$26,072,475	$31,341,465	$15,882,387	$1,557,571	$12,409,192	$87,263,090
Georgia	$8,752,179	$10,520,908	$5,331,504	$487,659	$3,474,146	$28,566,396
Hawaii	$1,795,942	$2,158,368	$1,065,886	$105,130	$766,492	$5,891,818
Idaho	$1,795,942	$2,158,368	$1,065,886	$105,130	$766,492	$5,891,818
Illinois	$14,566,145	$17,501,863	$8,286,262	$841,161	$6,001,247	$47,196,678
Indiana	$7,018,309	$8,436,640	$4,275,294	$427,123	$3,066,134	$23,223,500
Iowa	$4,272,980	$5,144,796	$2,272,276	$232,252	$1,760,734	$13,683,038
Kansas	$3,442,659	$4,140,847	$1,901,319	$191,697	$1,430,357	$11,106,879
Kentucky	$4,892,022	$5,880,652	$2,980,039	$292,333	$2,070,600	$16,115,646
Louisiana	$4,809,520	$5,716,325	$2,824,249	$295,701	$1,987,302	$15,633,097
Maine	$1,795,942	$2,158,368	$1,065,886	$105,333	$766,492	$5,892,021
Maryland	$5,978,676	$7,186,907	$3,641,988	$361,152	$2,508,352	$19,677,075
Massachusetts	$8,232,411	$9,902,090	$4,603,113	$465,465	$3,412,029	$26,615,108
Michigan	$11,376,983	$13,676,158	$6,930,437	$693,994	$4,936,669	$37,614,241
Minnesota	$5,609,504	$6,743,129	$3,417,102	$339,094	$2,478,709	$18,587,538
Mississippi	$3,282,007	$3,939,582	$1,957,399	$196,251	$1,390,319	$10,765,558
Missouri	$7,138,648	$8,572,513	$4,213,292	$423,251	$3,053,274	$23,400,978
Montana	$1,795,942	$2,158,368	$1,065,886	$105,130	$766,492	$5,891,818
Nebraska	$2,301,456	$2,772,917	$1,235,779	$124,900	$945,715	$7,380,767
Nevada	$2,657,189	$3,194,181	$1,618,661	$151,762	$1,035,492	$8,657,285
New Hampshire	$1,795,942	$2,158,368	$1,065,886	$105,130	$766,492	$5,891,818
New Jersey	$10,292,122	$12,342,333	$6,090,428	$620,946	$4,425,545	$33,771,374
New Mexico	$2,169,925	$2,608,445	$1,321,837	$127,394	$942,470	$7,170,071
New York	$24,352,403	$29,324,630	$13,605,956	$1,376,603	$9,932,045	$78,591,637
North Carolina	$9,988,771	$12,007,403	$6,084,790	$577,661	$4,171,739	$32,830,364
North Dakota	$1,795,942	$2,158,368	$1,065,886	$105,130	$766,492	$5,891,818
Ohio	$13,856,054	$16,597,987	$8,207,423	$835,879	$6,013,361	$45,510,704
Oklahoma	$4,290,438	$5,144,022	$2,572,440	$257,429	$1,846,777	$14,111,106
Oregon	$4,399,453	$5,288,538	$2,679,984	$254,913	$1,879,727	$14,502,615
Pennsylvania	$17,930,762	$21,544,777	$9,858,253	$1,018,552	$7,582,087	$57,934,431
Rhode Island	$1,795,942	$2,158,368	$1,065,886	$105,130	$766,492	$5,891,818
South Carolina	$5,183,532	$6,231,073	$3,157,616	$295,433	$2,153,600	$17,021,254
South Dakota	$1,795,942	$2,158,368	$1,065,886	$105,130	$766,492	$5,891,818
Tennessee	$7,115,319	$8,553,255	$4,334,389	$416,815	$2,980,312	$23,400,090
Texas	$21,600,611	$25,965,881	$13,158,293	$1,253,246	$9,079,495	$71,057,526
Utah	$2,077,089	$2,496,848	$1,265,286	$115,100	$889,240	$6,843,563

State	Supportive Services	Congregate Meals	Home Meals	Preventive Services	NFCSP	Total Title III
Vermont	$1,795,942	$2,158,368	$1,065,886	$105,130	$766,492	$5,891,818
Virginia	$8,246,003	$9,912,439	$5,023,160	$484,930	$3,417,589	$27,084,121
Washington	$6,927,144	$8,327,051	$4,219,760	$397,692	$2,883,863	$22,755,510
West Virginia	$2,781,416	$3,347,126	$1,494,599	$153,137	$1,082,333	$8,858,611
Wisconsin	$6,429,923	$7,729,347	$3,916,871	$391,448	$2,887,829	$21,355,418
Wyoming	$1,795,942	$2,158,368	$1,065,886	$105,130	$766,492	$5,891,818
American Samoa	$473,659	$602,252	$138,905	$13,141	$95,811	$1,323,768
Guam	$897,971	$1,079,184	$532,943	$52,565	$383,246	$2,945,909
Northern Mariana Islands	$224,493	$269,796	$133,236	$13,141	$95,811	$736,477
Puerto Rico	$4,658,903	$5,600,421	$2,838,031	$269,747	$1,937,877	$15,304,979
Virgin Islands	$897,971	$1,079,184	$532,943	$52,565	$383,246	$2,945,909
TOTAL	**$359,188,415**	**$431,673,607**	**$213,177,293**	**$21,026,000**	**$153,298,310**	**$1,178,363,625**

Title VII - Allotments for Vulnerable Elder Rights Protection Activities
FY 2009 Final Allocation

State	Ombudsman	Elder Abuse	Total Title VII
Alabama	$256,575	$78,989	$335,564
Alaska	$81,457	$25,225	$106,682
Arizona	$334,558	$102,997	$437,555
Arkansas	$162,447	$50,011	$212,458
California	$1,650,561	$508,140	$2,158,701
Colorado	$212,503	$65,421	$277,924
Connecticut	$194,435	$59,907	$254,342
Delaware	$81,457	$25,225	$106,682
District of Columbia	$81,457	$25,225	$106,682
Florida	$1,213,801	$373,679	$1,587,480
Georgia	$407,457	$125,439	$532,896
Hawaii	$81,457	$25,225	$106,682
Idaho	$81,457	$25,225	$106,682
Illinois	$633,272	$197,384	$830,656
Indiana	$326,737	$100,589	$427,326
Iowa	$173,657	$55,927	$229,584
Kansas	$145,307	$45,843	$191,150
Kentucky	$227,748	$70,114	$297,862
Louisiana	$215,841	$68,518	$284,359
Maine	$81,457	$25,225	$106,682
Maryland	$278,337	$85,688	$364,025
Massachusetts	$351,790	$109,606	$461,396
Michigan	$529,654	$163,059	$692,713
Minnesota	$261,150	$80,397	$341,547
Mississippi	$149,593	$46,053	$195,646
Missouri	$321,998	$99,130	$421,128
Montana	$81,457	$25,225	$106,682
Nebraska	$94,444	$29,770	$124,214
Nevada	$123,705	$38,084	$161,789
New Hampshire	$81,457	$25,225	$106,682
New Jersey	$465,457	$143,950	$609,407
New Mexico	$101,021	$31,100	$132,121
New York	$1,039,826	$320,120	$1,359,946
North Carolina	$465,026	$143,162	$608,188
North Dakota	$81,457	$25,225	$106,682
Ohio	$627,247	$197,185	$824,432
Oklahoma	$196,597	$60,524	$257,121
Oregon	$204,816	$63,054	$267,870
Pennsylvania	$753,411	$242,944	$996,355
Rhode Island	$81,457	$25,225	$106,682
South Carolina	$241,319	$74,292	$315,611
South Dakota	$81,457	$25,225	$106,682
Tennessee	$331,253	$101,979	$433,232
Texas	$1,005,614	$309,587	$1,315,201
Utah	$96,699	$29,769	$126,468

State	Ombudsman	Elder Abuse	Total Title VII
Vermont	$81,457	$25,225	$106,682
Virginia	$383,892	$118,184	$502,076
Washington	$322,492	$99,282	$421,774
West Virginia	$114,224	$36,736	$150,960
Wisconsin	$299,344	$92,156	$391,500
Wyoming	$81,457	$25,225	$106,682
American Samoa	$10,182	$3,153	$13,335
Guam	$40,729	$12,612	$53,341
Northern Mariana Islands	$10,182	$3,153	$13,335
Puerto Rico	$216,895	$66,773	$283,668
Virgin Islands	$40,729	$12,612	$53,341
TOTAL	**$16,291,466**	**$5,044,997**	**$21,336,463**

Grants to Tribal Organizations
FY 2009 Final Allocation

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C
AK	01	Aleutian/Pribilof Islands Association	$96,180	$28,730
AK	02	Association of Village Council Pres.	$87,390	
AK	03	Bristol Bay Native Association	$138,850	$50,290
AK	04	Central Council, Tlingit & Haida Indian Tribes of AK	$138,850	$50,290
AK	06	Copper River Native Association	$84,700	$21,550
AK	07	Hoonah Indian Association	$74,650	$14,360
AK	08	Kodiak Area Native Association (Northern Section)	$74,650	$14,360
AK	09	Kodiak Area Native Association (Southern Section)	$74,650	$14,360
AK	10	Metlakatla Indian Community	$84,700	$21,550
AK	11	Native Village of Barrow	$96,180	$28,730
AK	12	Tanana Chiefs Conference for Kuskokwim subregion	$74,650	$14,360
AK	13	Tanana Chiefs Conference for Lower Yukon Subregion	$74,650	$14,360
AK	14	Tanana Chiefs Conference for Yukon Flats Subregion	$74,650	$14,360
AK	15	Tanana Chiefs Conference for Yukon Koyukuk Subregion	$84,700	$21,550
AK	16	Tanana Chiefs Conference for Yukon Tanana Subregion	$74,650	$14,360
AK	17	Fairbanks Native Association, Inc.	$138,850	$50,290
AK	19	Maniilag Association	$119,880	$43,110
AK	20	Native Villiage of Unalakleet	$74,650	
AK	21	Chugachmiut	$84,700	$21,550
AK	22	Artic Slope Native Association, Limited	$84,700	$21,550
AK	23	Denakkanaaga, Inc.	$84,700	$21,550
AK	24	Klawock, I.R.A.	$74,650	$14,360
AK	25	Kootznoowoo Inc.	$74,650	$14,360
AK	26	Gwichyaa Gwich'in Tribal Government	$74,650	$14,360
AK	27	Native Village of Point Hope	$74,650	$14,360
AK	28	Seldovia Village Tribe	$74,650	
AK	30	Sitka Tribes of Alaska	$96,180	$28,730
AK	31	Yakutat Native Association	$74,650	$14,360
AK	32	Ketchikan Indian Corporation	$96,180	$28,730
AK	33	Kuskokwim Native Association	$84,700	$21,550
AK	35	Southcentral Foundation	$182,320	$57,480
AK	36	Kenaitze Indian Tribe, IRA	$96,180	$28,730
AK	37	Wrangell Cooperative Association	$74,650	$14,360
AK	38	Native Village of Savoonga	$74,650	
AK	39	Native Village of Gambell	$74,650	$14,360
AK	40	Native Village of Eyak	$74,650	$14,360
AK	41	ORGANIZED VILLAGE OF KAKE	$74,650	$14,360
AK	42	Chickaloon Village	$84,700	
AK	Total	Total	$3,382,990	$775,720
AL	01	Poarch Creek Indians	$108,380	$35,920
AL	Total	Total	$108,380	$35,920
AZ	02	Colorado River Indian Tribes	$108,380	$35,920

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C
AZ	03	Gila River Indian Community	$138,850	$50,290
AZ	04	Hopi Tribal Council	$138,850	$50,290
AZ	05	Hualapai Tribal Council	$84,700	$21,550
AZ	06	Navajo Nation	$138,850	$50,290
AZ	07	The Pascua Yaqui Tribe	$138,850	$50,290
AZ	09	Salt River Pima-Maricopa Community	$119,880	$43,110
AZ	10	San Carlos Apache Tribe	$138,850	$50,290
AZ	11	Tohono o'Odham Nation	$138,850	$50,290
AZ	12	White Mountain Apache Tribe	$138,850	$50,290
AZ	13	Ak-Chin Indian Community	$74,650	$14,360
AZ	14	Yavapai-Apache Tribe	$84,700	
AZ	15	Havasupai Tribal Council	$74,650	$14,360
AZ	16	Inter-Tribal Council of Arizona	$74,650	$14,360
AZ	17	Cocopah Indian Tribe	$74,650	
AZ	18	Quechan Indian Tribe	$84,700	$21,550
AZ	Total	Total	$1,752,910	$517,240
CA	01	Bishop Indian Tribal Council	$84,700	$21,550
CA	02	Blue Lake Rancheria	$84,700	$21,550
CA	06	Karuk Tribe of California	$96,180	$28,730
CA	07	Pit River Health Services	$74,650	
CA	08	Picayune Rancheria	$74,650	
CA	09	Riverside-San Bernardino Co. Indian Health-for Morongo	$84,700	$21,550
CA	10	Riverside-San Bernardino Co. Indian Health-for Pechanga	$74,650	$14,360
CA	11	Riverside-San Bernardino Co. Indian Health-for Soboba	$74,650	$14,360
CA	12	Sonoma County Indian Health Project	$74,650	
CA	13	Southern Indian Health Council-Area I	$74,650	$14,360
CA	14	Southern Indian Health Council-Area II	$74,650	$14,360
CA	15	Toiyabe Indian Health Project - Northern	$74,650	$14,360
CA	16	Tule River Indian Health Center	$84,700	$21,550
CA	17	United Indian Health Services (for Resighini)	$84,700	$21,550
CA	18	United Indian Health Services (for Smith River, etc.)	$84,700	$21,550
CA	19	California Indian Manpower Consortium	$74,650	$14,360
CA	20	Indian Senior Center, Inc.	$84,700	$21,550
CA	21	Sonoma County Ind. Health Pro., Manchester	$74,650	
CA	23	CA Indian Manpower Consort-LaJolla & Susanville Ranche	$74,650	$14,360
CA	24	California Indian Manpower Consortium - Ysabel, Pasual	$84,700	$21,550
CA	25	Pala Band of Mission Indians	$74,650	
CA	26	Redding Rancheria Indian Health Services	$138,850	$50,290
CA	28	Toiyabe Indian Health Project - Southern	$74,650	$14,360
CA	29	Hoopa Valley Tribe	$74,650	
CA	30	Round Valley Indian Tribes	$74,650	
CA	31	Fort Mojave Indian Tribe	$74,650	$14,360
CA	32	Santa Ynez Band of Mission Indians	$74,650	
CA	Total	Total	$2,181,680	$380,660
CO	01	Southern Ute Indian Tribe	$84,700	$21,550
CO	02	Ute Mountain Ute Tribe of Indians	$84,700	
CO	Total	Total	$169,400	$21,550
HI	01	Alu Like, Inc.	$1,505,000	$57,480

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C
HI	02	Hana Community Health Center	$84,700	
HI	Total	Total	$1,589,700	$57,480
ID	01	Coeur d'Alene Tribe	$84,700	$21,550
ID	02	Nez Perce Tribe of Idaho	$108,380	$35,920
ID	03	Shoshone-Bannock Tribes	$96,180	$28,730
ID	Total	Total	$289,260	$86,200
KS	01	Kickapoo Nation in Kansas	$74,650	$14,360
KS	02	Prairie Band of Potawatomi Indians	$108,380	$35,920
KS	03	Iowa Tribe of Kansas and Nebraska	$74,650	$14,360
KS	Total	Total	$257,680	$64,640
LA	01	Institute for Indian Development, Inc.	$84,700	
LA	Total	Total	$84,700	
ME	01	Passamaquoddy Tribe	$96,180	$28,730
ME	02	Penobscot Indian Nation	$84,700	
ME	Total	Total	$180,880	$28,730
MI	01	Grand Traverse Band of Ottawa & Chippewa Indians	$84,700	$21,550
MI	02	Inter-Tribal Council of Michigan, Inc.	$74,650	$14,360
MI	03	Keweenaw Bay Indian Community	$84,700	$21,550
MI	04	Sault Ste. Marie Tribe of Chippewa Indians	$138,850	
MI	05	Little Traverse Bay Bands of Odawa Indians	$84,700	
MI	07	Bay Mills Indian Community	$74,650	$14,360
MI	08	Pokagon Band of Potawatomi Indians	$84,700	
MI	09	Little River Band of Ottawa Indians	$96,180	
MI	10	Nottawaseppi Huron Band of Potawatomi Tribe	$74,650	$14,360
MI	Total	Total	$797,780	$86,180
MN	01	Bois Forte Reservation Business Committee	$84,700	$21,550
MN	02	Fond du Lac Reservation Business Committee	$119,880	$43,110
MN	03	Leech Lake Reservation Business Committee	$138,850	$50,290
MN	05	Mille Lacs Band of Chippewa Indians	$96,180	$28,730
MN	06	Minnesota Chippewa Resource Development	$84,700	$21,550
MN	07	Red Lake Band of Chippewa Indians	$119,880	
MN	08	White Earth Reservation Tribal Council	$84,700	
MN	09	Grand Portage Reservation Business Committee	$74,650	
MN	Total	Total	$803,540	$165,230
MO	99	Eastern Shawnee Tribe of Oklahoma	$74,650	$14,360
MO	Total	Total	$74,650	$14,360
MS	01	Mississippi Band of Choctaw Indians	$138,850	$50,290
MS	Total	Total	$138,850	$50,290
MT	01	Assiniboine and Sioux Tribes	$119,880	$43,110
MT	02	Blackfeet Tribe	$138,850	$50,290
MT	03	Chippewa-Cree Tribe	$96,180	$28,730
MT	04	Confederated Salish and Kootenai Tribes	$138,850	$50,290
MT	05	Fort Belknap Community Council	$108,380	$35,920
MT	06	Northern Cheyenne Tribe	$84,700	$21,550
MT	07	Crow Tribal Elders Program	$138,850	$50,290
MT	Total	Total	$825,690	$280,180
NC	01	Eastern Band of Cherokee Indians	$182,320	$57,480
NC	Total	Total	$182,320	$57,480
ND	01	Spirit Lake Nation	$84,700	$21,550
ND	02	Standing Rock Sioux Tribe	$119,880	$43,110
ND	03	Three Affiliated Tribes	$138,850	$50,290
ND	04	Trenton Indian Service Area	$108,380	$35,920

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C
ND	05	Turtle Mountain Band of Chippewa Tribe	$138,850	$50,290
ND	Total	Total	$590,660	$201,160
NE	01	Omaha Tribe of Nebraska	$84,700	$21,550
NE	02	Santee Sioux Tribe of Nebraska	$74,650	
NE	03	Winnebago Tribe of Nebraska	$84,700	$21,550
NE	Total	Total	$244,050	$43,100
NM	01	Eight Northern Indian Pueblos Counc. (Picuris, etc.)	$138,850	$50,290
NM	02	Eight N. Indian Pueblos Council (San Ildefonso, etc.)	$84,700	$21,550
NM	03	Five Sandoval Indian Pueblos, Inc.	$96,180	
NM	04	Jicarilla Apache Tribe	$108,380	$35,920
NM	05	Laguna Rainbow Corporation	$138,850	$50,290
NM	06	Mescalero Apache Tribe	$96,180	
NM	07	Pueblo de Cochiti	$84,700	$21,550
NM	08	Pueblo of Acoma	$138,850	$50,290
NM	09	Pueblo of Isleta	$138,850	$50,290
NM	10	Pueblo of Jemez	$108,380	$35,920
NM	11	Pueblo of San Felipe	$108,380	$35,920
NM	12	Pueblo of Taos	$108,380	$35,920
NM	13	Pueblo of Zuni	$138,850	$50,290
NM	14	Ohkay Owingeh	$119,880	$43,110
NM	15	Santa Clara Pueblo	$96,180	$28,730
NM	16	Santo Domingo Pueblo Tribe	$96,180	
NM	17	Pueblo of Tesuque	$74,650	$14,360
NM	Total	Total	$1,876,420	$524,430
NV	01	Fallon Paiute-Shoshone Tribes	$84,700	$21,550
NV	02	Inter-Tribal Council of Nevada, Inc. (McDermitt, etc.)	$84,700	$21,550
NV	03	Inter-Tribal Council of Nevada, Inc. (Duckwater, etc.)	$74,650	$14,360
NV	04	Inter-Tribal Council of Nevada, Inc. (Ely, etc.)	$74,650	$14,360
NV	05	Shoshone-Paiute Tribes	$96,180	$28,730
NV	06	Walker River Paiute Tribe	$84,700	
NV	07	Washoe Tribe of Nevada and California	$96,180	$28,730
NV	08	Yerington - Paiute Tribe	$74,650	
NV	09	Pyramid Lake Paiute Tribe	$96,180	$28,730
NV	10	Elko Band Council	$74,650	$14,360
NV	11	Reno-Sparks Indian Colony	$74,650	$14,360
NV	Total	Total	$915,890	$186,730
NY	01	St. Regis Mohawk Tribe Office for Aging	$138,850	$50,290
NY	02	Seneca Nation of Indians	$119,880	$43,110
NY	03	Oneida Indian Nation	$74,650	$14,360
NY	Total	Total	$333,380	$107,760
OK	01	Apache Tribe of Oklahoma	$138,850	$50,290
OK	02	Caddo Tribe of Oklahoma	$138,850	$50,290
OK	03	Cherokee Nation of Oklahoma	$184,421	$58,667
OK	04	Cheyenne-Arapaho Tribes of Oklahoma	$138,850	$50,290
OK	05	Chickasaw Nation	$182,320	$57,480
OK	06	Choctaw Nation of Oklahoma	$182,320	$57,480
OK	07	Citizen Band Potawatomi of Oklahoma	$182,320	$57,480
OK	08	Comanche Indian Tribe	$138,850	$50,290
OK	09	Delaware Tribe of Western Oklahoma	$78,960	$14,360
OK	10	Iowa Tribe of Oklahoma	$138,850	$50,290

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C
OK	11	Kaw Tribe of Oklahoma	$138,850	
OK	12	Kickapoo Tribe of Oklahoma	$100,000	$21,550
OK	13	Kiowa Tribe of Oklahoma	$138,850	$50,290
OK	14	Miami Tribe of Oklahoma	$182,320	$57,480
OK	15	Muscogee (Creek) Nation	$182,320	$57,480
OK	16	Osage Nation of Oklahoma	$182,320	$57,480
OK	17	Otoe-Missouria Tribe	$96,180	$28,730
OK	18	Ottawa Tribe of Oklahoma	$138,850	$50,290
OK	19	Pawnee Tribe of Oklahoma	$138,850	$50,290
OK	20	Peoria Tribe of Oklahoma	$138,850	
OK	21	Ponca Tribe of Oklahoma	$84,700	$21,550
OK	22	Quapaw Tribe of Oklahoma	$96,180	$28,730
OK	23	Sac and Fox Tribe of Indians of Oklahoma	$138,850	$50,290
OK	24	Seminole Nation of Oklahoma	$119,880	$43,110
OK	25	Seneca-Cayuga Tribe of Oklahoma	$84,700	$21,550
OK	26	Wichita and Affiliated Tribes	$138,850	$50,290
OK	27	Wyandotte Tribe of Oklahoma	$138,850	$50,290
OK	28	Absentee Shawnee Tribe	$182,320	$57,480
OK	29	Fort Sill Apache Tribe	$96,180	$28,730
OK	31	United Keetowah Band of Cherokee Indians in Oklahoma	$138,850	$50,290
OK	Total	Total	$4,161,341	$1,272,817
OR	01	Confederated Tribes of Siletz Indians of Oregon	$96,180	$28,730
OR	02	Confederated Tribes of the Umatilla Indian Reservation	$119,880	$43,110
OR	03	Confederated Tribes of Warm Springs	$108,380	$35,920
OR	04	Confederated Tribes of Grand Ronde	$74,650	$14,360
OR	05	Klamath Tribe	$138,850	$50,290
OR	06	Confed. Tribes of Coos, Lower Umpqua & Siuslaw Indian	$74,650	$14,360
OR	Total	Total	$612,590	$186,770
RI	01	Narragansett Indian Tribe	$96,180	
RI	Total	Total	$96,180	
SC	01	Catawba Indian Nation Eldercare Program	$84,700	$21,550
SC	Total	Total	$84,700	$21,550
SD	01	Cheyenne River Sioux Tribe	$138,850	$50,290
SD	02	Crow Creek Sioux Tribe	$84,700	
SD	03	Lower Brule Sioux Tribe	$74,650	$14,360
SD	04	Oglala Sioux Tribe	$182,320	$57,480
SD	05	Rosebud Sioux Tribe	$182,320	$57,480
SD	06	Sisseton-Wahpeton Sioux Tribe	$138,850	
SD	07	Yankton Sioux Tribe	$84,700	
SD	Total	Total	$886,390	$179,610
TX	01	Alabama-Coushatta Tribe	$84,700	$21,550
TX	02	Kickapoo Traditional Tribe of Texas	$74,650	
TX	Total	Total	$159,350	$21,550
UT	01	Uintah and Ouray Business Committee	$84,700	$21,550
UT	Total	Total	$84,700	$21,550
WA	01	Colville Confederated Tribes	$138,850	$50,290
WA	02	Lower Elwha Klallam Tribe	$84,700	$21,550
WA	03	Lummi Indian Business Council	$108,380	$35,920
WA	04	Makah Indian Tribal Council	$84,700	$21,550
WA	05	Muckleshoot Indian Tribe	$138,850	$50,290

State	Tribe No.	Grantee Name	TITLE6 A/B	TITLE6 C
WA	08	Nooksack Indian Tribe	$84,700	$21,550
WA	09	Puyallup Tribe of Indians	$138,850	$50,290
WA	10	Quinault Indian Nation	$119,880	$43,110
WA	11	S. Puget Intertribal Plng. Ag.- Nisqually	$119,880	$43,110
WA	12	S. Puget Intertribal Plng. Ag.- Squaxin Island	$84,700	($21,360)
WA	13	Swinomish Indian Tribal Community	$74,650	$14,360
WA	14	Spokane Tribe of Indians	$84,700	$21,550
WA	15	Yakama Indian Nation	$74,650	$14,360
WA	16	Tulalip Tribes	$119,880	$43,110
WA	17	Jamestown S'Klallam Tribal Center	$84,700	$21,550
WA	19	Quileute Tribal Council	$74,650	$14,360
WA	20	S. Puget Intertribal Plng. Ag.- Shoalwater Bay	$96,180	$28,730
WA	21	Stillaguamish Tribe of Indians	$84,700	$21,550
WA	22	Upper Skagit Indian Tribe	$74,650	$14,360
WA	24	The Suquamish Indian Tribe	$96,180	$28,730
WA	25	Port Gamble S'Klallam Tribe	$84,700	$21,550
WA	26	Samish Indian Nation	$84,700	$21,550
WA	27	Cowlitz Indian Tribe	$96,180	$28,730
WA	28	SKOKOMISH INDIAN TRIBE	$96,180	$28,730
WA	29	Confederated Tribes of the Chehalis Reservation	$96,180	$28,730
WA	Total	Total	$2,426,370	$668,250
WI	01	Bad River Band of Lake Superior Chippewa	$84,700	$21,550
WI	02	Forest County Potawatomi Community	$74,650	$14,360
WI	03	Lac Courte Oreilles Band of Lake Superior Chippewa	$96,180	$28,730
WI	04	Lac du Flambeau Band of Lake Superior Chippewa Indians	$84,700	$21,550
WI	05	Menominee Indian Tribe of Wisconsin	$119,880	$43,110
WI	06	Oneida Tribe of Indians of Wisconsin	$119,880	$43,110
WI	07	Red Cliff Band of Lake Superior Chippewa	$84,700	$21,550
WI	08	St. Croix Chippewa Indians of Wisconsin	$84,700	$21,550
WI	09	Stockbridge-Munsee Community	$84,700	$21,550
WI	10	Ho-Chunk Nation	$108,380	$35,920
WI	Total	Total	$942,470	$272,980
WY	01	Northern Arapaho Business Council	$96,180	
WY	02	Shoshone Tribal Business Council	$108,380	
WY	Total	Total	$204,560	
Total	Total	Total	$26,439,461	$6,330,117